NHS
Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
10.30, Thursday 9 June 2022
G2, Redwood Education Centre, Gloucestershire Royal Hospital
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			10.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 12 May 2022**	Approval	Enc 1	10.35
5	**Matters arising from Board meeting held on 12 May 2022**	Assurance		
6	**Patient Story** *Katie Parker-Roberts, Head of Quality*	Information	Presentation	10.40
7	**Chief Executive's Briefing** *Mark Pietroni, Interim Chief Executive Officer*	Information	Enc 2	11.00
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	11.15
9	**Trust Risk Register** *Alex D'Agapeyeff, Interim Medical Director*	Assurance	Enc 4	11.20
	Break (11.30-11.40)			
10	**Quality and Performance Committee Report** *Elaine Warwicker, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and Qadar Zada, Chief Operating Officer* • **Quality and Performance Report** • **Perinatal Quality Surveillance Report** • **Quality Account 2021-22**	Assurance	Enc 5 Enc 6 Enc 7 Enc 8	11.40
11	**Finance and Digital Committee Report** *Robert Graves, Non-Executive Director* • **Finance Report** • **Digital Programme Report**	Assurance	Enc 9 Enc 10 Enc 11	12.25
12	**Estates and Facilities Committee Report** *Mike Napier, Non-Executive Director*	Assurance	Enc 12	12.50
13	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 13	13.00
14	**Any other business**		None	13.10
15	**Questions/Comments from Governors**			
	Close by 13.15			

Gloucestershire Hospitals NHS Foundation Trust

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Minutes of the Public Board of Directors' Meeting
12 May 2022, 12.45,
By Video Conference

Chair	Deborah Evans	DE	Chair
Present	Alex D'Agapeyeff	AD	Interim Medical Director and Director of Safety
	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Robert Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	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
	Alison Moon	AM	Non-Executive Director
	Mark Pietroni	MP	Interim Chief Executive Officer
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People and Organisational Development
	Elaine Warwicker	EW	Non-Executive Director
	Qadar Zada	QZ	Chief Operating Officer
Attending	Hilary Bowen	HB	Public Governor, Forest of Dean
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Suzie Cro	SC	Deputy Director of Quality (item 6 only)
	Anne Davies	ADa	Public Governor, Cotswolds
	Alan Thomas	AT	Lead Governor
Observers	Two governors and two members of the public observed the meeting virtually.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting.
2	**Apologies for absence** Mike Napier, Non-Executive Director, Roy Shubhabrata, Associate Non-Executive Director.
3	**Declarations of interest** None.
4	**Minutes of Board meeting held on 14 April 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 14 April 2022** All matters arising were updated.
6	**Staff Story** The Board received a presentation on International Nurses' Day and the celebrations that were taking place across the Trust. Along with SC, Beth, Hayley and Kiran attended the meeting to describe their experiences as nurses with the Trust and initiatives in place to support and engage colleagues.

	The Board discussed the following points: • Regular updates on the impact on international nursing recruitment would be useful. • The Board was interested in the clinical care shared decision-making councils and heard that although engagement had reduced recently, there were a number of listening events planned to increase attendance. The plan for the staff councils was that they would be key support for nursing structures. The Board noted that the councils had an inclusive, multi-disciplinary team approach for all staff to attend. • Next steps would focus on how to make councils business as usual, and embedding them within the organisation as a key tool to engage with nurses and commit to investment in staff.
7	**Chief Executive's Briefing** MP gave a briefing to the Board as follows: • Deborah Lee, Chief Executive Officer, had recovered well from her illness but would not return until August. There had been some changes to the executive portfolio as a result. • The Trust remained extremely busy, with exhausted staff who were seeking rest. • The Board was advised that ambulance delays continued, along with delays in the Emergency Department as patients waited for beds. Some improvements had been seen, with a reduction in the numbers of Medically Optimised for Discharge (MOFD) patients, however further work on patient flow within the organisation was required. • Waiting lists continued to reduce, although there was more work to do. • The Integrated Care Board would go live from 1 July. A number of appointments had been made to the Board. • The Trust was expecting its rescheduled CQC well-led inspection from 14-16 June. • The Trust's first Staff Awards since before the pandemic were being held next week, with both days fully booked. DE advised the Board of an Local Government Association (LGA) peer review and an external review into urgent and emergency care. BH requested the output from the review on the impact on social care, to include accountability as a whole system. AM raised a query in relation to the reduction of MOFD patients and whether this was attributable to anything in particular. QZ advised that this was related to a number of initiatives in place, including increased capacity in Home First and social care, continued patient reviews, and families' involvement in patient care.
8	**Board Assurance Framework** The first iteration of the new Board Assurance Framework was provided for discussion. The new process of regular executive and Committee review continued to be embedded, with further refinement and improvement expected over the next few months. EW commented positively on the readability and style of the BAF, which was shared by other members of the Board. RG requested that a mapping exercise was undertaken for additional assurance that risks from the previous BAF had been captured in the new risks. **Action**
9	**Trust Risk Register** The Board received the report for information, noting that one new risk related to the quality of care of patients remaining in recovery when ward-based care was required had been added, with one risk related to poorer outcomes and potential harm to patients throughout their hospital stay as a result of spending longer than eight hours in the Emergency Department removed from the register, as it was covered within another risk.

	AM commented on the gynaecology risk, noting that there had been no change to the risk score but assurance had been provided at Quality and Performance Committee that the risk had reduced. MHo advised that some issues remained with access and operational management, and that the changes that had been made would need to be seen consistently before the risk score could reflect appropriate improvements in the service. The Board was assured by the oversight and active management of the key risks within the organisation. **Action:** AD and KC to review the format and readability of the risk register.
10	**Quality Report** Key points were noted as follows: • Performance against the 62-day cancer standard was progressing well. Although significant progress was slow due to the need for faster diagnosis and treatment, pathways were under review and the Trust was responding well. • Additional capacity had been implemented to manage the waiting list, including optimising weekend and evening working. The number of patients on the waiting list was now at 59,000 despite an increase in referrals. The Trust had been approached to provide mutual aid to other organisations. • There continued to be limited flow through the hospital, however work continued to manage elective activity and front door issues. • The Board noted that 335 bed days had been lost to Covid outbreaks in March, however guidelines had changed recently and would have a positive impact on the number of patient moves required. Visiting guidelines had also changed to pre-pandemic guidelines, with patients being isolated only when practical. There was no longer a need to socially distance, however face masks were still worn in clinical areas. • Six C-Diff cases had been reported and were subject to post-infection reviews, which would include cleaning and antimicrobial stewardship. • The Board was advised that a discrepancy had been found in relation to pressure ulcers, which had resulted in over-reporting of incidents. • There had been a high number of falls resulting in harm, with nine reported in the last month. Two patients had died as a result and were subject to the Serious Incident Requiring Investigation (SIRI) process. The Board requested additional information on falls for assurance. **Action** • Friends and Family Test feedback had decreased to 88%, driven by urgent care pressures. The Board was assured that this continued to be monitored closely. • A new advisor had joined the PALS team in March, and improvements in cases closed within five days had already been reported. RG commented that there was a lot of work underway at the Trust, but performance reports were highlighting a number of 'red' areas; the Board would receive some specific detail to monitor progress being made against these areas. **Action** RP raised a query about eating disorders, noting that nationally there had been an increase in the number of patients presenting with eating disorders, and subsequently being admitted. The Trust was developing a Whole Person Care Strategy, which would encompass mental health, and the Board was advised that the ICB had commissioned a piece of work to review the creation of a community-based team to support. RG noted that the target related to patients admitted within four-hours and completion of a swallow screen was not being reached; MP would review the data. **Action**
11	**Guardian of Safe Working Hours Report** The Board received the Quarterly Report and Annual Report for information, noting particularly that there had been an increase in exception reports driven by an increase in workload. This often led to educational

	opportunities being sacrificed in order to carry out clinical duties. The Board was advised that the e-rostering system was key to supporting this. CF asked if the data within the report reflected the position within other organisations; AD advised that whilst the Trust carried out informal comparison, there was no formal benchmarking information available.
12	**Maternity Reports** ***Ockenden Gap Analysis*** The Board received the report, which detailed a gap analysis review of the maternity service against the fifteen Immediate and Essential Actions recommended in the Ockenden Report. Against 92 actions, the Trust was currently fully compliant with 35, partially compliant with 33, and non-compliant with 15. Further information was required in 4 areas, with 5 not applicable to the Trust. The Board was advised that both of the Trust's midwifery-led units had to be closed due to staffing challenges resulting from Covid absences, however Stroud had since reopened; Cheltenham would remain closed until it was safe to reopen. The Board discussed the sad case of Baby M, which had happened at the Trust two years ago and had recently been reported in the press. DE asked if the deficiencies in care of Baby M were issues that were reflected within the action plan, and assurance was provided that they were. The Board also discussed communication with families and how good this was around service closures. MHo assured the Board that closures were not an easy decision to take, and that communication to families is carried out very well by team in very difficult circumstances. Transparent and honest conversations were had with affected patients, and the disappointment patients' felt was well understood.
13	**Finance Report** The Board received the report for information and noted the following key points: • The month 12 position was a surplus of £516k, which was in line with the plan and reported to NHSEI. The overall year-end system position was a surplus of £6.8m. • The Trust's final capital position was a £326k overspend, which the Board was pleased to note and thanked the team for delivering. The system position was a reported £3k underspend, with £1.7m impairments. • The Trust was currently working through the system position for 2022/23 with system partners.
14	**Digital Programme Report** The report detailed the Trust's progression of its digital agenda, with three key pieces of work underway: the Sunrise EPR clinical documentation optimisation; a system-wide dashboard to improve patient flow with an "at a glance" functionality of the whole system which was in development by the Business Intelligence team; and the implementation of new Clinically Ready to Proceed reporting. The Board discussed the greater gains that would be achieved through the implementation of these systems, including improvements in the quality of patient care with quicker and more efficient clinical systems, and innovative solutions to system-wide issues.
15	**Use of Trust Seal Report** The Board endorsed the use of the Seal.
16	**Assurance Reports** The reports were noted for information.
17	**Any other business**

	None.
18	**Governor Comments** AT provided the following feedback: • The first hybrid Board meeting had received very positive feedback from governors observing via MS Teams. • The Board was encouraged to review how the Trust involved patients in the work of the Trust. • The new Board Assurance Framework was welcomed, with continued improvements noted. AT suggested that work around health inequalities and the deterioration of staff experience was reflected throughout. • The Whole Person Care Strategy, which also encompasses mental health, would be the subject of a Governors' Quality Group and Board development session. • Safeguarding performance within the Quality and Performance Report was not RAG-rated; a review of how progress was measured would be undertaken.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Board Assurance Framework	A mapping exercise would be undertaken for additional assurance that risks from the previous BAF had been captured in the new risks.	KC July 22	In progress
Trust Risk Register	A review of the risk register's format and readability would be undertaken.	AD/KC July 22	In progress
Quality Report	Additional detail on falls would be received at a future Board meeting.	MHo/SC	July 2022
	The Board would receive some specific detail to monitor progress being made against 'red' performance areas.	MHo/SC July 22	In progress
	Swallow screen data would be reviewed.	AD July 22	In progress

PUBLIC BOARD – JUNE 2022

CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 This is now my second Board Meeting as Interim Chief Executive. I continue to be well supported by those around me whether in the Trust or the system, for which I am very grateful. There are two issues that highlight the ups and downs of this role. Firstly, and sadly, there has been a significant amount of negative media coverage this month. We aim to be open and transparent and learn from things we have not got right such as the sad death of Baby M two years ago, but reported this month. We have also had to strongly refute an inaccurate and misleading article in the national press. Threats of violence against named nurses were posted on the paper's website. We take this very seriously and will not tolerate abuse of staff and have taken appropriate action.

1.2 On a more positive note, the Staff Awards on May18-19 were a huge success. It was wonderful to be back together again and I received numerous reports of the positive impact on morale in a number of departments. Having the event over two evenings seemed to work well – more people could attend and the award ceremony itself was not too long. It was great to see Deb Lee on the second evening who, together with Peter Lachecki, presented the Lifetime Achievement Award to Annie and Sean Elyan, as well as picking up her own Chair's Award for Exceptional Leadership.

Operational Context

2.1 Operationally, the Trust is performing well in its delivery of its elective programme, its performance against Diagnostics and Cancer. In each of these areas it remains in the top quartile within the South West. Sadly, this is not the case for the urgent care pathway which remains under extreme pressure although over recent weeks the number of patients attending has reduced the patients remain high in acuity. This is demonstrated by the numbers of patients that are returned to the Emergency Departments and subsequently admitted following consideration by Same Day Emergency Care. Average length of stay in the department remains higher than pre-pandemic levels and this can be attributed to a range of factors which include the high number of patients that are Medically Optimised for Discharge (MOFD) and are awaiting onward care. The current numbers of patients who are MOFD is approximately 220. This is showing a positive reduction from previous months, however this still remains high and equates to approximately half of our medical bed stock

2.2 Another positive is the continued reduction of the rate of community transmission of COVID-19 in Gloucestershire. At the time of writing, 53 of the Trusts beds are occupied with patients who also have a confirmed COVID-19 status, the majority of whom are admitted with other conditions and their infection with COVID-19 is incidental. There are no children with confirmed RSV (Respiratory Syncytial Virus) in our beds. The number of COVID-19 presentations is reducing and this has led to a reduction in the number of allocated beds for COVID-19.

2.3 The Urgent Care Improvement Board (UCIB) has now met on three occasions since its establishment 6 weeks ago. The purpose of this Board is to oversee improvement in Urgent and Emergency Care. The UCIB will drive improvements that will deliver against the performance and quality metrics that are challenged including:

- Ambulance handover delays
- Total time in the department (12-hour performance)
- Average time to triage
- Average time to clinician
- Early discharge
- Alternative pathways eg use of Same Day Emergency Care

Feedback from NHSEI on the operational plan has been received and as suspected the plan has not been approved, predominately due to the financial deficit position. The national message has become very clear over the last few weeks that financial balance is a must. The plan has to be credible and must triangulate with activity and workforce and reflect what has already been seen in month 1.

Further funding has been made available to support the increase in inflation costs, pressures on the ambulance service and contractual pressures around Continuing Health Care (CHC). This additional funding for the Gloucester system would see a reduction in the original deficit of £24.2m to £11.1m. This additional funding would only be available if the plan reaches a balanced position. Further discussions are now taking place at a system level to see how this gap can be closed even if on a non-recurrent basis.

The plan needs to be signed off by each organisational Board prior to submission on the 20th June.

3 Other Highlights

3.1 Our Fit for the Future 2 Engagement started on May 17 and runs until June 29th. This will seek the views of patients, public and staff on a number of specialist services: benign gynaecology, diabetes and endocrinology, frailty services, non-interventional cardiology, respiratory and stroke services. This is about the best way to provide these services as part of an Integrated Care System and not just where services are provided. There will be a number of ways to get involved including online getinvolved.glos.nhs.uk, email, by phone, face to face and via Facebook Live.

3.2 The Director of HR & OD for NHSEI took the opportunity to visit and spend time with the People & OD teams here at GHFT for International HR Day on the 20th May 2022. It was relaxed, informal and supportive, with a real interest shown in the priorities and key workstreams being delivered across the Trust's People agenda. The day gave the opportunity for the teams to connect, spending time with a colleague in another P&OD team to share both personal and work reflections.

3.3 The Trust marked the Queens Jubilee with a range of events for staff and patients. Our GMS colleagues hosted a 'Jubilee Street Party' within Fosters and Blu Spa Restaurants on 1 June, and teams were able to order and collect a free Jubilee Tea, with tea, coffee or squash and scone with jam and clotted cream. Sweet Success also offered a Jubilee cake and drink to staff from the Redwood and Sandford Education Centres. The multi-faith chaplaincy held an inclusive 'Act of Thanksgiving' on 1 June 2022 to mark the beginning of the Jubilee celebrations and allow colleagues the opportunity for some quite reflection. On Friday 3 June inpatients and staff were able to have a slice of Jubilee Cake as part of the menu and boxes of cakes were delivered to a wide range of services, from ED to porters, theatres and domestics to ensure they had another opportunity to celebrate and hopefully take some time out with a colleague for a break.

Mark Pietroni

Interim Chief Executive Officer

31 May 2022

May 2022

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges							
SR1	Breach of CQC regulations or other quality related regulatory standards.	July 2019	May 2022	CNO/DOQ	3x4=12	n/a	4x4=16
2. We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people							
SR2	Failure to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve.	April 2019	April 2022	DOP	3x4=12	n/a	5x4=20
3. Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other							
SR3	Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework	July 2019	May 2022	MD	2x3=6	n/a	3x3=9
4. We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners							
SR4	Risk that individual organisational priorities and decisions are not aligned.	July 2019	May 2022	COO	2x3=6	n/a	4x3=12
5. Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services							
SR5	Poor engagement and involvement with/from patients, colleagues, stakeholders and the public.	July 2019	April 2022	DoST	1x3	n/a	3x3=9
7. We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources							
SR7	Failure to deliver financial balance.	July 2019	April 2022	DOF	4x3=12	n/a	4x4=16
8. We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact							
SR8	Failure to develop our estate which will affect access to services and our environmental impact.	July 2019	April 2022	DST	4x3=12	n/a	4x4=16
SR9	Inability to access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings.	July 2019	April 2022	DST	4x3=12	n/a	4x4=16
9. We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care							
SR10	Our IT infrastructure and digital capability are not able to deliver our ambitions for safe, reliable, responsible care.	July 2019	April 2022	CDIO	2x1=2	n/a	2x2=4

Board Assurance Framework Summary

10. We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK							
SR11	Failure to meet University Hospitals Association (UHA), membership criteria, a pre-requisite for UHA accreditation.	July 2019	April 2022	DST	4x2=8	n/a	4x3=12
SR12	Inability to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio.	July 2019	April 2022	MD	3x3=9	n/a	4x3=12

Archived Risks (score of 4 and below)

We have established centres of excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within county	
SR6	Risk that the phased approach to implementation of our Centre of Excellence model is extended beyond reasonable timescales due to a range of dependencies e.g., estate, capital, workforce, technology delaying the realisation of patient benefits.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR1: Breach of regulatory activity — May 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**CQC regulations or other quality related regulatory standards are breached**	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	CN, MD, COO	S3316 C2819N C2669N C1945NT D&S2976 Rad WC3536O bs M2353Di ab D&S3103 Path C3223CO VID C2667NIC C1850NSafe C3034N C3295COOCOVID WC3257Gyn M3682Emer C2628COO C1798COO C2715

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Dec 2023	Dec 2024	-			
4X4=16	Risk, control and assurance identification and monitoring processes have highlighted a number of risks to quality and therefore to the strategic objective.	**3x4=12**	**3x4=12**		A number of quality and workforce plans focused on improved culture would have positive impact on quality.	2019/2020 2020/2021 2021/2022 2022 Q4	

CONTROLS/MITIGATIONS

- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents, complaints etc.
- Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer)
- Urgent and Emergency Care Board
- Monitoring of performance, access and quality metrics via Quality & Performance Report
- Operational Plan 2022/23
- Quality Strategy and delivery plan
- Risk Management processes
- Quality priorities for 2022/23 (as identified in Quality Account 2021/22)

GAPS IN CONTROL

- Quality Strategy in need of refresh due to key milestones needing to be reprioritised due to challenges caused by Covid-19 Pandemic and changes in personnel.
- Inability to match recruitment needs due to national and local shortages and the impact on quality of care (links with People and OD Strategy)
- Delay related harm
- Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience
- Quality and Performance Report in need of refresh to enable monitor of key metrics
- NAAS ward accreditation paused.

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

• QIA processes • Improvement programmes • Executive Review process • Internal audit plan adapted to respond to significant quality issues. • J20 Director walkabouts • Trust investment plans prioritised according to risk. • Inspection and review by external bodies (including CQC inspections). • GIRFT review programme. • External reviews of services • Patient Experience Reporting • Learning from deaths reporting • Key issues and Assurance Report (KIAR)	

ACTIONS PLANNED

Action	Lead	Due date	Update
Workforce - Monitoring of impact of workforce challenges on quality and performance	DoQ &CN	Q1 2022/23	- Close monitoring of workforce challenges impact on quality of care via Safer Staffing Report.
Operational Plan - Development of plan in response to NHSE/I planning guidance	COO	Q4 21/22 Q1/2 22/23 Q4 22/23	- Received by Q&P Committee - Agreement of Operational Plan for 2022/23 with external regulators - Delivery of defined planned operational improvements
Quality Strategy and QPR - Review and refresh strategy and delivery plan - Review of metrics within QPR - Define quality priorities for 2022/23 - Development of separate Mental Health Strategy	DoQ &CN	End of Q2 2022/23 21/22 Q4 Q2 22/23	- This work will commence in May 2022 - Work underway - Complete - Draft received by QDG
External reviews of services - Develop action plans in response to recent inspections	DoQ &CN	End of Q1 2022/23	- CQC Medical Care and UEC Care report received action plan being developed. - CQC Maternity focused inspection awaiting report - CQC unannounced core service inspection of surgery awaiting report.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• NHSE/I Regional Maternity Team visit to Maternity Services • Cancer performance • Planned recovery of elective and diagnostic activities in most specialities	• Below average NHS Staff Survey results (metrics for Quality Strategy Delivery). • Operational Plan 2022/23 not fully compliant in all domains (Activity agreed to delivery 104%; however not all quality measures planned to be met; Financial gap identified and not fully mitigated)	• Inspection and review by an external body - CQC pilot ICS inspection Urgent and Emergency Care report. • Internal audit reviews 2022-25: o Outpatient Clinic Management o MCA and Consent o Discharge Processes

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

	• Increased workforce sickness absence and significant workforce gaps which impact on quality of care delivery (increased pressure ulcers and falls with harm) • Never Events increase. • Quality and performance reporting metrics flagging – (for e.g. 12 hour breaches, ambulance handover delays, increased numbers of patients with No Criteria to reside (NCTR) • Decreased patient experience scores (inpatient, maternity and ED).	○ Divisional Governance ○ Cross health economy reviews ○ Risk Maturity ○ Patient Safety (Learning from Complaints/Incidents) ○ Clinical Programme Group ○ Environmental Sustainability ○ Data Quality ○ Patient Deterioration ○ Pressure Ulcer Management ○ Clinical Audit ○ Medical Records ○ Infection Prevention and Control

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Workforce — April 2022

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

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

CONTROLS/MITIGATIONS

- Diversity Network with three sub-groups (ethnic minority; LGBTQ+, and disability).
- Compassionate Behaviours Framework
- Compassionate Leadership mandatory training for all leaders and managers
- International recruitment pipeline
- Increased apprenticeships
- Advanced Care and other alternative speciality roles
- Technology enhanced learning and simulation
- Divisional colleague engagement plans
- Proactive Health and Wellbeing interventions
- Formalised workforce Operational Plan submission 2022/2023 to NHSE, integrated with the ICS

GAPS IN CONTROL

- Recruitment processes and practices require transformation
- No formalised marketing and attraction strategy / plan
- Inability to match recruitment needs (due to national and local shortages)
- Staff flight risk post pandemic
- Increased staff sickness absence including the impact of Long Covid related illness
- Pace of operational performance recovery leading to staff burnout
- Full roll out of e-rostering for improved productivity
- Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience

ACTIONS PLANNED

Action	Lead	Due date	Update
Initial scope of e2e transactional recruitment leading to formal transformation change programme	DDfPOD	Commence May 2022	
Development of a marketing and strategy / plan	AD of Resourcing	Commence May 2022	
Delivery of 2022/23 workforce plan including new roles, increased overseas recruitment and robust pipeline plans	DDfPOD	2022-23	
Immediate focussed planning in response to the 2021 Staff Survey outcomes	Head of L&OD/DoP	Commence April 2022	

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

Commencement of formal Workforce Sustainability Programme	DfPOD	2022-23	

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR3: Failure to deliver the Quality Strategy May 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	**Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework**	Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	MD	SR2 - Quality Improvement – 268 risks linked to this BAF / 15 of these risks are Trust risks (red)

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Mar 2023	Mar 2024	-			
3x3=9	The QS high level indicators are reflected in the staff survey results which have deteriorated	**3x3=9**	**2x2=4**		Implementation and embedding of the QS and Just, Learning and Restorative approach will take time to alter behaviours, staff perceptions and survey results		

CONTROLS/MITIGATIONS

- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents, complaints etc.
- Internal audit plan adapted to respond to significant quality issues.
- Trust investment plans prioritised according to risk.

GAPS IN CONTROL

- Development of larger scale change projects
- Regular update of QS and monitoring of goals

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of Programme team to incorporate improvement methodology	SL	March 23	Restructure of programme team completed
Review QS with new Chief Nurse on appointment	MH	March 23	Interviews April
Development of the Just, Learning and Restorative approach	CB	March 23	Initial planning team established

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Progress reported on QS to QPC in October 2021	• Staff survey results	• Update to QPC on QS • Improvement Programme for JL&R approach • Improvement Programme for Staff survey • Internal audit reviews: Workforce Planning; Discharge Processes; Cultural Maturity; Divisional Governance; Cross health economy reviews; Risk Maturity

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR4: Individual and organisational priorities not aligned May 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**Risk that individual and organisational priorities and decisions are not aligned, which would result in restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration**	We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	• New divisional Management teams • New COO and Deputy COO • C-19 extraordinary response and interim arrangements	Loss of some 'historical' context. Availability of resources and investment at a time of flux/pandemic. Usual planning cycles suspended/adjusted.	Quality and Performance	COO	M3682Emer D&S3507RT WC3536Obs C1850NSafe

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	-		Q2 2021/22	
4x3=12	Division of Medicine management support still not fully recruited to with some Directorate gaps. Substantive Triumvirate in place by Q2	**3x3=9**	**2x3=6**			Q4 2021/22	

CONTROLS/MITIGATIONS

- Weekly and monthly business cycles in place to monitor/deliver progress against all key KPIs
- Agreed Operational Plan (2022/23) to be in place by Q1/M1
- Substantive Triumvirates in place (or appointed to) for the Operational/Clinical Divisions
- Close working relationships between Operational Divisions and Finance/HR proven in delivery of H2 and other priorities
- Assurance meeting established twice per month to monitor and mitigate/escalate gaps in control identified (led by Finance/Operations/BI)

GAPS IN CONTROL

- Quality KPIs may not be met fully within the Operational plan
- Operational Plan 2022/23 not fully compliant in all domains (Activity agreed to delivery 104%; however not all quality measures planned to be met; Financial gap identified and not fully mitigated).

ACTIONS PLANNED

Action	Lead	Due date	Update
Continuation of Operational Plan delivery monitoring (led by BI, Finance and dCOO)	NHL	June 2022	Meeting confirmed and in diaries twice per month. Reporting being finalised
'Flow' Focussed strategy group planned. Sits with Strategy PMO.	IQ	June 2022	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place • Regular 'systemwide' planning meetings in place	• Operational Plan 2022/23 not fully compliant and not yet formally agreed	• Operational Plan 2022/23 to be established to monitor delivery on formal basis from June 2022.

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

• KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established		• 'Flow' focussed strategy and delivery group planned June '22
		• Internal audit reviews 2022-25:
		  ○ Outpatient Clinic Management
		  ○ Discharge Processes
		  ○ Cultural Maturity
		  ○ Clinical Programme Group
		  ○ Patient Safety: Learning from Complaints/Incidents
		  ○ Patient Deterioration
		  ○ Equalities, Diversity and Inclusion
		  ○ Infection Prevention and Control

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR5: Poor engagement — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	**Poor engagement and involvement with/from patients, colleagues, stakeholders and the public.**	Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services	Insufficient engagement and involvement approach, methodologies or timing.	Colleagues feel 'done to', external stakeholders feel uninformed	Quality and Performance	DoST	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	-			
3x3=9	External engagement has improved but internal engagement and involvement needs more work	**2x3=6**	**1x3**				

CONTROLS/MITIGATIONS

- Board approved Engagement and Involvement Strategy
- Quarterly Strategy and Engagement Governors Group
- Monthly Team Brief to cascade key messages
- Annual Members' Meeting
- Friends and Family Test
- NHS Staff Survey and NHS Pulse Survey
- Quarterly patient experience report to Quality and Performance Committee

GAPS IN CONTROL

- Objective measurement of how well key messages are being cascaded to colleagues.

ACTIONS PLANNED

Action	Lead	Due date	Update
Incorporate lessons learned from FFTF phase 1 into phase 2 engagement and consultation programme	DoST	May 2022	FFTF Phase 2 engagement to run in May and June 2022
Continue to develop Team Brief to improve cascade processes	DEI&C	From Jan 2022	Team Brief now launched and feedback being incorporated
New Communication & Engagement metrics report	DEI&C	May 2022	New report in development with regular reporting to S&T Delivery Group. Reporting to P&OD Committee to be established

POSITIVE ASSURANCES

- Approach and feedback from the Consultation Institute on Fit for the Future engagement and consultation programme
- Progress demonstrated in 2021/22 Engagement & Involvement Annual Review
- Level of engagement and involvement from Governors
- Inclusion of patient and staff stories at Trust Board including bi-annual learning report

NEGATIVE ASSURANCES

- Engagement score from 2021 NHS staff survey saw 0.3 point reduction on 2020 score (6.6 from 6.9) and is now below national average of 6.8

PLANNED ASSURANCE

Internal audit reviews 2022-25:

- Cultural Maturity
- Outpatient Clinic Management
- Patient Safety: Learning from Complaints/Incidents
- Equalities, Diversity and Inclusion
- Staff Engagement
- Recruitment and Retention

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Financial balance — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR7	**Failure to deliver financial balance**	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources.	• The ability to spend with minimal restrictions on the overall financial pot during the pandemic resulting in an increase to the underlying position; • Recovery financial regime conflicts with elective recovery; • History of delivering efficiencies by non-recurrent means; • Staff engagement in the agenda whilst balancing operational pressures.	The Trust and ICS continues to have an underlying financial baseline deficit which may grow in size. Higher efficiency targets for the following year, creating an increased risk of an impact on patient services; impact on future regulatory ratings and reputation; regulatory scrutiny/intervention leading to increased risk of impact on staff; inability to achieve strategic objectives, particularly investment plans.	Finance and Digital	DOF	F2895, F3633, F3679, F3393, F3680, F3387, F3681, F3339, F3336, F3434,

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY
4x4=16	Draft plan for 22/23 indicates a significant system deficit, of which the Trust is contributing. Increase cost of temporary staffing due to workforce challenges. The lack of flow in the hospital causing restrictions on elective recovery impacting on the ability to earn ERF. Pressure on operational capacity, limiting the focus on how to drive out efficiencies whilst improving patient outcomes.	**Apr 2023**	-	-	The Trust needs to develop a medium-term financial plan to understand how the financial health of the organisation moves over time (by August 2022). Full review of all revenue investments made during the pandemic to determine whether they are still to be supported or if financial commitment should be removed (by July 2022). Continued monthly monitoring to understand the drivers of the deficit. Drive the financial sustainability programme to start to see the recurrent benefits of financial improvement.	
		3x4=12				

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Service Development Group peer review business cases	• Finance strategy in draft and needs completing

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

• Programme Delivery Group for financial sustainability • ICS one savings programme to share ideas, resources and drive consistency • Monthly monitoring of the financial position • Controls around temporary staffing • Driving productivity through transformation programmes i.e., theatres and OP	• Clear line of accountability • Robust benefits identification, delivery and tracking across major projects • No accountability framework

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of the financial sustainability team reporting within the strategy and transformation portfolio	DOF/ DOS	Feb 22	This team has now moved across, training and development ongoing. Vacancies being filled by a combination of permanent and interim staff to get the governance and reporting in place by Mar 22. Detailed plans around deliverability of the financial sustainability programme will be in first draft by end of April.
Robust benefits identification, delivery and tracking across major projects	DOF/ DOS	Jun 22	Capacity now in place to develop the process, format and framework around how we capture the benefits. This will be tested during the financial year and where necessary adapted to ensure the process is robust and effective.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22. • Continued the monitoring of financial sustainability during the pandemic. • ERF monies being generated by Trust. • Improved and co-ordinated system working. • External Audit VFM report, Sept 21.	• Moderate/Limited assurance rating from internal auditor on key financial controls and payroll 2020-21. • Temporary staff spend consistently above target. • Planned Trust and System underlying deficit moving into 22/23 a significant concern. • Continuing under-delivery of recurring efficiency programme. • ERF tightening of trajectories has impacted upon the system and H2 outlook doesn't look positive • Lack of benefit realisation on schemes that should be delivering financial improvement; no real consequences of financial deviation, no review on whether to continue to stop a project if overspending	Internal Audits planned 2022-25: • Cross health economy reviews • Shared Services reviews • Risk Maturity • Data Quality • Budgetary Control • Charitable Funds • Payroll Overpayments NHSE/I scrutiny of Trust/system finances. ICS accountability and assurance on system wide transformational changes.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR8: Failure to develop estate — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	**Failure to develop our estate which will affect access to services and our environmental impact.**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact	• Capital constraints • Age and inefficiency of buildings & infrastructure • Limited shared use of estate across ICS	Access, financial and environmental impact of continuing to operate services from older building stock and infrastructure	Estates and Facilities	DoST	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	-			
4x4=16	£72m backlog maintenance (2021) of which £41m is critical infrastructure. Capital constraints and reliance on national capital to fund significant estate developments.	**4x3=12**	**4x3=12**		No route to securing additional significant capital in 2022-23 to address estates risks and infrastructure.		

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Estates Strategy – Phase1 approved by Board • Estates Strategy – Phase 2 approved by E&F Committee, to Board in June 22 • Strategic Site Development Programme (SSDP) rated as BREAM 'good' and in construction phase • Public Sector Decarbonisation Scheme (PSDS) £13M funding secured in 2021/22 • Board approved Green Plan, that has received national recognition • Green Plan governance structure with Executive Lead, including: Green Champions, Green Council, Climate Emergency Leadership Group into E&F Committee • ICS Estates Development plan defined for 2022/23	• Maturity of ICS Estates Group impacting on pace of shared use of ICS estate • ICS Estates Strategy that reflects organisational estate strategies • Lack of alternative routes to capital other than NHSE/I

ACTIONS PLANNED

Action	Lead	Due date	Update
ICS Estates Strategy	ICS DoF	Q3 22/23	
Oversight of Green Plan	DST	2022/23	DoST nominated Executive Lead from April 2022
Further PSDS applications	GMS	Q4 2023	
Targeted Investment Fund (TIF) bid for 5th Ortho theatre	DST	June 2022	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR8: Failure to develop estate — April 2022

• SSD Programme progressing to plan • Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I and grants • Declaration of Climate Emergency in 2020 • Big Green conversations • Move of Dermatology off-site to Aspen Centre (GP surgery) • 22/23 TIF bid – 5th Orthopaedic theatre at CGH • Vital energy contract performance – reducing emissions and returning power to national grid	• Scale of estates backlog at £72m of which £41m is rated as Critical Infrastructure Risk • Electrical infrastructure capacity constraints • Age of estate at GRH and CGH • Unsuccessful in PSDS bid in 2022/23 • ICS CDEL limits constrain level of capital investment and prevents the Trust using cash to address estates backlog at the scale required • Access to significant capital – New Hospital Programme funding is committed to 2025 and GHFT is not part of that programme	Internal audit reviews 2023-2025: • Environmental Sustainability • Estates Management

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Inability to access sufficient capital — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR9	**Inability to access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings.**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact	• Capital constraints • Age and inefficiency of buildings & infrastructure • List of equipment at >10 years • Scale of backlog maintenance @ £72M	Unable to address backlog and critical infrastructure risks and/or replace equipment within lifecycle impacting on service delivery, patient and staff experience	Estates and Facilities	DST	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY
		Aug 2022	Jan 2023	-		
4x4=16	Trust capital programme is c£24M per year of which the £8M allocated to estates is not at the scale required to address the £72M backlog or £41M Critical Infrastructure risk. £8M is also allocated to medical equipment	**4x3=12**	**4x3=12**		• ICS CDEL limits constrain level of capital investment and prevents the Trust using cash to address estates backlog and risks at the scale required • Access to significant capital – New Hospital Programme funding is committed to 2025 and GHFT is not part of that programme • Managed Equipment Service (MES) procurement on hold as business case did not demonstrate value for money and impact of IFRS16 was unknown in 21/22.	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Strategic Site Development Programme (SSDP) secured £39.5M of external funding to deliver Phase 1 of Estates Strategy by Summer 2023 • £13M secured through Public Sector Decarbonisation Scheme in 2021/22 • Good track record of securing ad-hoc capital for estate and equipment schemes: £14.6M in 20/21; £5.4M in 21/22 • Ensure all external bids for capital include element to address backlog maintenance risks in development areas • Charitable funded	• Strategy to explore and secure alternative routes to capital and infrastructure investment • Lack of a CDEL prioritisation process within the ICS that recognises the level of risk being carried by each organisation • Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025

ACTIONS PLANNED

Action	Lead	Due date	Update
Review MES business case	DoF/ DST	Q1 22/23	
Targeted Investment Fund (TIF) bid for 5th Ortho theatre	DST	June 2022	Business case in production
Review scope and priorities of ICS Estates Strategy Group	DST	Q1 22/23	

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

• Develop shortlist of business cases to address estate priorities in readiness for NHSE&I calls for capital	DST	Q1/Q2 22/23	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I and grants • Trust ability to secure grant funding e.g. PSDS • Regular engagement with local MPs to make case for investment • PFI is being maintained to 'Condition B' in line with contract	• Unsuccessful in PSDS bid in 2022/23 • £3M allocated to critical risks in 22/23 leaves significant and high risks unmitigated	Internal audit reviews 2023-25: • Environmental Sustainability • Estates Management

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR10: IT and Digital — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	Our IT infrastructure and digital capability are not able to deliver our ambitions for safe, reliable, responsible care.	Our electronic patient record system and other technology drives safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care.		• Reduced ability to innovate, keep pace with health care developments and undertake research. • Negative reputation in comparison with peers, impacting on recruitment and retention. • Inability to work effectively across the system, providing poor joined-up care. • Inefficient operational practice. • Inefficient systems/poor data can be a contributing factor in clinical errors. • Unable to meet expectations of patients, commissioners and regulators.	Finance and Digital	CDIO	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
2x2=4		2022			
		2x1=2			

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record established across the organisation • Increased electronic attendance, discharge and outpatient information sent to GPs • EPR Procurement of open APIs and FHIR compliant system meaning the EPR will use JUYI to link • Joining Up Your Information (JUYI) implemented in partnership with external partners • EPR delivery group • Digital Care Delivery Group representation includes representatives from Gloucestershire Health Partners. • Roll out of access to Sunrise EPR to primary care and some community colleagues • Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements. • Internal audit of cyber completed and action plan implemented to resolve issues and gaps in security • Digital Strategy	• As cyber security risk increases globally, focus needs to continue on identifying and mitigating new and increasing risks • Use of different systems across the organisation and ICS

ACTIONS PLANNED

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

Action	Lead	Due date	Update
Review GHC technical and digital representation on key groups	CDIO	Oct 22	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Regular reviews to Finance and Digital Committee	• Digital maturity assessment • Independent reviews	Internal audit reviews 2022-25: • Data Security and Protection Toolkit • Cyber Security • Risk Maturity

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

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

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

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

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

ACTIONS PLANNED

Action	Lead	Due date	Update

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

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Strong collaborative working and relationship with University of Gloucestershire e.g. Nursing and Radiographer programmes • Strong collaborative and working relationship with Bristol University e.g. Bristol Medical School • Developing relationship with University of Worcestershire e.g. Three Counties Medical School • Allocation of 51 additional F1 and F2 trainee doctors to GHFT in recognition of education programme and size of Trust • Availability of library, IT and teaching facilities for postgraduate and undergraduate education • Lead placement role in place responsible for undergraduate education	• UHA is currently closed to new applications • Establishing x20 honorary contracts is a challenge • Achieving NIHR research grant income of £725,000 per annum and the resulting RCF income of £200,000 by 2024 is a challenge given our baseline of £91k NIHR research grant income and £26k RCF	Internal audit reviews 2022-25: • Cultural Maturity • Cross health economy reviews • Risk Maturity • Environmental Sustainability

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR12	**Inability to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio.**	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	Investment of funding and time into both clinical teams and R&D teams. High vacancy rates within clinical teams and inability to backfill. Non-recurrent nature of external funding. Difficulty in supporting growth of portfolio due to limited capacity of R&D teams due to non-recurrent nature of external funding (CRN). Limited capacity within support services (pharmacy, labs, radiology etc) due to lack of infrastructure and ability to guarantee long term research funding. Restrictions on use of external main funding source (CRN) impede ability to grow support to develop grant applications in house.	If we are unable to at least maintain current activity levels they will decline as will the funding, creating a vicious downward spiral. Increasingly more stringent requirements of university hospital status mean that it is less likely the Trust will achieve the status without significant funding and commitment.	People and Organisational Development	MD	PR 10.1 PR 10.2

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

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

	become the growth limiting areas						

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Annual business plan to key funder NIHR CRN – details plans to increase the number of commercial studies, which are a source of income. • Progress against all High Level Objectives – defined by the National Institute Health Research (NIHR) – reviewed and reported quarterly internally to Research and Innovation Forum and externally to WE Clinical Research Network. Also reviewed regularly at Trust Research Senior Management Team meetings. • Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in Gloucestershire County Council. Statement of intent to work more closely with the University of Gloucestershire signed. • Annual business plan submitted to West of England Clinical Research Network (CRN), who provide the main source of income to research through non-recurring, activity-based funding. • Board Approved Research Strategy (October 2019) • Capability and capacity assessments for new studies to maximise workforce utilisation • Oversight of the research portfolio by C&C, Delivery Teams and SMT • Oversight of the research portfolio by CRN West of England • Review and closure of poor performing studies to release staff with regular review of staffing at relevant meetings via monthly 1:1s and SMT • Research interests & experience incorporated into consultant interview questions. Briefing paper developed in discussion with medical staffing presented at Dec PODDG. • University Hospital Programme Group reports into relevant groups inc Strategy and Transformation, People and OD, Research governance routes.	• Annual Business Plan that covers all research income streams rather than just NIHR funding. • Ability to produce a business case for investment that is financially neutral over the longer term • Review and refresh of strategy for final two years of strategic period (currently under development) • Progress has paused due to change in University criteria. • Model for non-medic staffing to be developed in tandem to complement the medic version to ensure a whole team approach. • Need to regroup University Hospital Implementation Group and ensure that all relevant stakeholder groups are covered.

ACTIONS PLANNED

Action	Lead	Due date	Update
Develop a business case to secure investment for the trailblazer team model to commit a number of PAs per team to support growth and development of research activity within that department. Each team taking part in this would commit to an income generation target and level of activity. In return the R&D department would also need to provide a level of activity to support that growth. The R&D department would also require investment to do this	SE/CS/ CJ	May 2022	Business case in development with relevant teams and University Hospital programme group.

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

Review and refresh of the research strategy for final two years of the strategic period	CS / CJ	May 2022	In progress
Develop an annual Business Plan that covers all research income streams rather than just NIHR funding.	CS	June 2022	To be started

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	9 June 2022		
Title	Trust Risk Register		
Author **Director/Sponsor**	Lee Troake, Head of Risk, Health & Safety Alex D'Agapeyeffe, Interim Medical Director and Director of Safety		

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

Summary of Report

Purpose

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

Two risks were added to the TRR and one risk was closed at Risk Management Group on 1 June 2022.

Key issues to note

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- **WC3685Obs** - The risk of delayed review, identification and treatment for women attending triage, in addition inability to adequately meet required standards of care.

  Scores: Safety C3 x L5 = 15, Quality C2 x L5 = 10, Workforce C3 x L5 = 15, Statutory C3 x L5 = 15

  Risk Cause: Maternity Triage - Inability to meet 15-minute wait times on a daily basis and daily Red Flag events due to women waiting longer than 30 minutes. Insufficient staffing to safely staff the triage service and to implement BSOTS

- **F3806** - The organisation is not able to manage resources within delegated budgets.

  Scores: Finance C4 x L4 = 16

  Risk Cause: The trust does not deliver against its Financial Plan as set within the ICS 22/23. The expenditure plans of the ICS are in excess of the resources available to it even after inclusion of sustainability schemes. As a consequence, the trust currently has a deficit financial plan

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

- **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

  Reason for closure: Project has been completed with only minor exceptions which are being managed. Risk scores reduced and risk agreed for closure by Exec lead

Recommendation

The Board is asked to note the report.

Enclosures

Trust Risk Register

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead	Review Date	Risk Lead	Register
F3806	Organisation is not able to manage resources within delegated budgets.	The controls that are in place to prevent the risk materialising are	Development of Divisional Recovery Plan Performance Management of Delivery of Recovery Plans	Corporate	Finance	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Karen Johnson	17/06/2022	Johnson, Karen	Trust Risk Register
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DISN commenced March 2021, funded by CCG for 12 month and a further one in June 2021 .4) 0.77 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding5) 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 Harris to raise this diabetes risk onto TRR New Elearning module in progress to complete bimonthly audit into inpatient care for diabetes	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Medical Director	31/07/2022	Mani, Vinod	Trust Risk Register
WC3257Gyn	The risk of not having a dedicated gynaecology bed base staffed by gynaecology nurses to keep women safe from avoidable harm and to provide the right care and treatment.	•specialist gynae nurses to support in-patient care and nursing staff regardless of patient location during daytime shift •Training provided to 2b staff •Written guidance provided to 2b staff •Set up of emergency gynae assessment unit in out-patient setting- to improve flow through ED •Women attending for SMOM and genetic abnormality STOP pre-operatively seen in GOPD in order to provide emotional support and complete necessary documentation while 2b not available- staff beginning 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• ANPs to carry bleep in roving nurse absent during clinical hours to provide advice to inpatient staff	Write a business case to ensure correct staffing write an action plan for changes to 2b to support gynaecology in-patients to rind suitable location for gynaecology in-patient service Identify suitable bed base with correct capacity both short and long term Work with site team to cohort gynaecology patients to identified bed base	Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Interim Director of Quality and Chief Nurse	29/07/2022	Hutchinson, Becky	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 Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place. No locums available (agency or NHS) for over 3 months.Urgent and chemotherapy patients being prioritised for appointments.Fixed term middle grade staff appointed and being trained to support consultant team Lack of capacity to accommodate even critical urgent and chemotherapy patients, now dependent on goodwill of staff to manage this workload.CEO agreement to use off-framework agency staff, however difficulty due to lack of locum availability, high rates and delay in HR response.VCP in place to advertise for consultant recruitment with additional incentive.Request support from Oncology to manage lymphoma workload (transferred from Oncology to Haematology mid 2020).	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	07/06/2022	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 Following presentation of W168912 N Jordan to attend ward to review completion of falls documentation and required management of patient following assessment by staff Following presenntation of W171436 to PHH N Jordan to forward information to purchase slippers for patients in ED W165353 Nadine Jordan to review with 9a x-ray identifying # and communication of #	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	29/04/2022	Bradley, Craig	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and/or borrow sufficient capital to cover its capital programme (estates backlog value @2021 £72M of which £43M is critical infrastructure), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation 8. Prioritise capital schemes through IDG - Equipment 1/12ly and plan done annually. Alternative funding mechanisms, including through capital receipts; ability to fund capital through char funds.	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Corporate, Gloucestershire Managed Services	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	03/10/2022	Lanceley, Simon	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	Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	31/05/2022	Mills, Joseph	Trust Risk Register
	The risk of non-compliance with statutory		Review performance and advise on improvement										

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 service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	30/06/2022	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	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	24/05/2022	Freebrey, Clare	Trust Risk Register
D&S2976Rad	The risk of breaching of national breast screening 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	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	05/06/2022	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 Project closure arrangements for when 2016 project hands over to BAU	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Business	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk		02/07/2022	Turner, Thelma	Trust Risk Register
WC3685OBS	The risk of delayed review, identification and treatment for women attending triage, in addition inability to adequately meet required standards of care.	Daily staffing review by matrons. A minimum of 2 midwives for all shift. However during a nightshift, if activity allows to reduce to 1 midwife at 02:00 .Redeployment of staff where possible. Additional hours such as twilight shifts put out to staff as bank. Bank incentives extended until end of February 2022. Rolling advert for band 5/6 staffing. Datix reporting all adverse events. Mitigation and control update: 18/02/22 Staffing establishment reviewed and discussed with Deputy Chief nurse. To await results from Birth rate plus. Currently staff on CDS rota are identified on a daily basis to support Triage	Address the safe staffing element audit acuity of unit and actual staffing within triage	Women's and Children's	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Medical Director	29/07/2022	Harris, Rachael	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities.	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialilities to support f/u clearance of backlog To resolve outstanding areas of concern	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	07/06/2022	Zada, Qadar	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. Mandatory training.o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	25/04/2022	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	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	31/08/2022	Dobb, Michael	Trust Risk Register

			Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan arrange replacement valve and acurator for air handling unit TH1									
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new, overdue risks, partially completed risks, uncontrolled risks and overdue actions etc Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk Assessment policy in place Training on risk register Risk Management group (ToR attached) Executive review meetings Patient safety group H&S Divisional meetings Trust H&S Committee People and OD delivery Group People and OD delivery Committee Water action group Infection Control Committee Access and egress group Quality delivery group	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	08/07/2022	Troake, Lee	Trust Risk Register
C2628COO	The risk of poor patient experience and poorer outcomes where there is a breach of the 18 week wait from referral to treatment due to a backlog of patients.	Monitoring by clinical urgency and prioritisation is in place Additional capacity is being sought for each specialty Weekly review of PTL by the COO Monthly oversight by Improvement Board, led by CEO	1.RTT and TrakCare plans monitored through the delivery and assurance structures Formally review the Bed modelling and scenarios proposed as part of H2 submission.	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	07/06/2022	Zada, Qadar	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Patient flow and quality coordinator (band 7) allocated on a daily basis Daily staffing call and twice weekly staffing review between matrons and HoM Use of women and Children's pandemic staffing plan available for consultation to make decisions about service configuration and provision (closures of individual birth centres) 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 plus on call Band 7 Rota to provide hands on support.On-going staffing action plan including Staffing and recruitment action plan includes a rolling program of recruitment,proactive recruiting into 50% maternity leave.Continuity midwives allocated intrapartum shifts since March 2022 BBA support withdrawn since September 2021 Planned homebirths on a case by case basis - letter sent to women to advise that homebirth service may not be supported .Reduction of minimal staffing levels at Cheltenham birth unit to one midwife inline with Stroud model; followed by Temporary closure .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. staff consultation on call enhancement discussion	Women's and Children's	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Interim Chief Nurse	30/06/2022	Stephens, Lisa	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to 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.	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	24/05/2022	Holdaway, Matt	Trust Risk Register
		Booking systems/processes:	COVID T&F Group to develop Recovery Plan to minimise harm										

C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	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. 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	To resolve outstanding areas of concern	Corporate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	30/05/2022	Zada, Qadar	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	Diagnostics and Specialties	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	10/06/2022	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	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	24/05/2022	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	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	24/05/2022	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	Surgical	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Interim Chief Nurse	29/07/2022	Hendry, Tracey	Trust Risk Register
S2715Th	The risk to quality of care of patients remaining in recovery when they require ward-based care	Use of agency staff in recovery overnight Daily sit-rep SOP for use of recovery as escalation area with breaches reported to site management DSU policy	escalate risk to divisional board escalate issues to execs and chief nurse monitoring of impact winter plan Monthly audit for overnight patients in PACU collect data on direct discharges from recovery As per request from Liz Bruce please take risk to ECDG Escalate issues to Div Tri and discuss increasing overnight PACU establishment review SOPs Discussion with specialty leads to accommodate patients within their bed base following surgery review of establishment as part of staffing risks	Surgical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Nurse and Director of Quality (Interim)	29/07/2022	Beamish, Sally	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 •minimise transfer of patients from ward to ward	CAFF inspections to be progressed	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Interim Chief Nurse	24/05/2022	Bradley, Craig	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews - Introduced "Review & Return" of ambulance arrivals to expedite diagnostics and reduce handover delays	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off. Progress VCPs for Flow Coordinator and ED Assistants Submit workforce paper to Exec COO Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners	Medical	Safety	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk	Medical Director	23/07/2022	Nagle, Pat	Trust Risk Register
			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.										

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.	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 suppt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Pride training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed Bespoke training to DCC staff for categorisation of pressure ulcers Bespoke training to ward 4a to include 1st hour priorities produce training document on wound measurements for Rendcomb The provision of RCA support/training for TV issues to be take to pressure ulcer council Work with Knightsbridge to support staff TVN training Bespoke training in management of pressure ulcer [revention on ward 7a TVN to d/w TVN lead regarding use of share care pathway in regards to EPR Implement training programme in management of patient pressure ulcers in ED Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	25/05/2022	Bradley, Craig	Trust Risk Register
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	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Business	Major (4)	Unlikely - Annually (2)	8	8 -12 High risk	CDIO	20/06/2022	Atherton, Andy	Trust Risk Register

KEY ISSUES AND ASSURANCE REPORT
Quality and Performance Committee, 25 May 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
Urgent and Emergency Care Improvement Board Update	A number of meetings had been held to review the terms of reference, the reporting dashboard, and parameters for discussion. Meetings were being held monthly.	Outputs from the Board would be formally reported through to the Committee for assurance.
Delay Related Harm Report	The delay related harm report had been deferred again due to challenges around data collation and narrative but would be reviewed at the Committee once the mechanism for reporting had been determined. The Committee was concerned about the timescales involved in receiving the required assurance on this significant issue,	The delay related harm report would be received at the Committee meeting in June. Further conversations would be held at a system-level on the delay related harm linked to MOFD patients.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Quality and Performance Report	• Cancer performance was stable, with the Trust achieving well against the 62-day standard. Numbers of patients were beginning to steady, following a high number of presentations post-pandemic. • The Trust was not reporting any 104-week breaches, and continued to perform well against the 52-week standard. • Workforce remained challenging. A number of beds had been recently returned to Surgery, however there was an issue with staffing the additional capacity. • Mixed sex accommodation breaches would be reported as standard following a review of the reporting framework to provide an oversight of all breaches regardless of escalation status. • Friends and Family Test scores had decreased, particularly across urgent care and maternity. The key driver was operational pressures, with feedback particularly related to long wait times. • The PALS team was now fully recruited to, and improvements were beginning to be seen. Performance would continue to be monitored. The Committee was concerned in relation to the high number of hospital-initiated cancellations and noted the workforce issues in connection to the patient waiting list communications.	The coding/data on hospital-initiated cancellations would be reviewed.
Trust Risk Register	The Committee was particularly concerned about the emerging risk related to the increased need for safe holding provision for patient feeding support within the organisation. This had also been raised at GMS Board as a key concern related to the wider issue of violence and aggression. The Committee also noted a new risk proposed for escalation to the TRR on the quality of care of patients remaining in recovery when they no longer require high dependency care.	The risk would be reviewed through appropriate channels and scored before coming back to Committee. A report on violence and aggression would be provided for additional review.
Serious Incidents Report	Two serious incidents had been reported since the last report, one related to a delay in the Emergency Department, and one related to a delay in the diagnosis of a significant concern with an unborn child, resulting in an emergency caesarean. The Committee was verbally apprised of a very recent incident related to the loss of a number of cervical screening samples, which had been	A communication plan and additional measures were in place to support the women who would be recalled for repeat cervical screening, including a helpline and access to clinicians.

	raised by NHSEI and was subject to a full review.	
Journey to Outstanding Maternity Action Plan	The Committee noted progress against the action plans, although also noted that remaining staffing challenges across the service continued to impact on performance, patient and colleague experience as well as delaying some actions.	Future reports would include an executive summary on progress and how the Trust was performing against actions.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Quality Account	The Committee approved the Quality Account.	The Quality Account would be presented at Board for approval.

Items not Rated		
System feedback	CQC update	Terms of Reference
Impact on Board Assurance Framework (BAF)		
The Committee was supportive of the new format and processes, and noted that further refinement of the BAF would take place over the coming months.		

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors			
Agenda item:	**10**	**Enclosure Number:**	**6**
Date	9 June 2022		
Title	Quality and Performance Report		
Author /Sponsoring Director/Presenter	Neil Hardy-Lofaro, Deputy Chief Operating Officer, Suzie Cro, Deputy Director of Quality, Katie Parker-Roberts, Head of Quality Qadar Zada, Chief Operating Officer, Matt Holdaway, Director of Quality and Chief Nurse, 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

This report summarises the key highlights and exceptions in Trust performance for the April 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

During April the Trust had 74 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.

Number of hospital-onset healthcare-associated Clostridioides difficile cases per month

During April there were 10 health care associated (HO-HA) case. All of these cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review. There were also 5 community onset health care associated (CO-HA) cases

Number of hospital-onset healthcare-associated ecoli cases per month

During April we had 9 health care associated cases (5 hospital onset cases and 4 community onset cases). It is noted that that since April 2022 the community onset healthcare associated cases have been included in the metric whereas before it included hospital onset cases. This is in line with the NHSE/I annual limit for E coli BSI which now sets an annual limit inclusive of all healthcare associated cases. Reducing E.coli BSI and all Gram negative bacteraemia continue to be a focus of the IPC strategy specifically related to urinary tract infection prevention, improving patient hydration and improving the management and care of invasive device.

Mixed Sex Accommodation breaches

Historically mixed sex accommodation breaches have been deemed non-reportable where the Trust escalation status is at OPEL level 3 or 4. Therefore, breaches have been not reported for an extended period as the Trust escalation status has remained at level 3 or 4. The Trust has worked with the CCG to alter the reporting framework to give oversight of breaches at all times, regardless of escalation status. this reporting will come through from April 2022. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse.

Pressure ulcers acquired as in-patient

We have seen an increase during the winter period in the development of Category 2, deep tissue injuries and unstageable pressure ulcers across different wards in both hospitals. Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers.

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

Number of falls resulting in severe or moderate harm

April 2022 saw a lower number of falls resulting in harm, such as fractures and head injuries. There were 4 occurrences. Every fall resulting in moderate harm or serious harm is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed.

The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing and prolonged length of stay which is associated with an increased number of ward moves.

Friends and Family Test

Our overall Trust FFT positive score has decreased to 87.2%, with a decrease across urgent care (62.7%) and maternity survey (78.2%) scores in particular. This is largely due to operational pressures, with a large increase in the comments focussing on wait times. The urgent care team are receiving reports on the feedback weekly, to

support local real time improvement in response to emerging themes, The divisions have been asked to review their local comments and improvement plans and provide updates to QDG, and the Patient Experience team are looking to review how we report feedback into divisions, combining PALS and FFT data and some thematic analysis to support local improvement plans

% PALS concerns closed in 5 days

The number of PALS concerns closed within 5 days is currently at 67% -the team are now fully recruited to, and risks have been updated to reflect current challenges. This continues to be monitored closely and reported monthly through QDG.

Patient Discharge Summaries sent to GP within 24 hours

There has been no significant change to % discharge summaries completed. Issues remain that await EPMA implementation.

Performance

RTT and Planned care

- Validation of April's data is ongoing with a submission date of 20th May. RTT performance for April is estimated around 71.75% with approximately 1,233 >52 week waits.
- The Total incompletes has increased in month, which has been a trend observed over recent weeks with an increase in New clock starts. The total for April is 58,299.
- Diagnostic performance has largely remained the same as last month, moving from 18.03% to a validated position of 18.77% this month. The only non- compliant speciality forecast for end of May is Echo. A revised specific recovery plan is under development.

Cancer

- In the published February figures, the trust met 6 of the 9 national metrics and were above the national figures in 9 out of the 9 metrics.
- The March performance (data as at 18/04/22) against the latest available national data is:
    - 2ww: GHFT 93.9%, National 80.7%
    - 28 Day: GHFT 83%, National 74.1%
    - 31 day: GHFT 98.6%, National 93.7%
    - 62 day: GHFT 71.2%, National 62.1%
- March 62 day performance is an improved position to February with work to do in particular areas to recover performance

Emergency Care

- The department failed to achieve the 95% operational standard 4 hour and the 12 hours DTA standard.
- March saw a fall in the ED 4-hour performance metric of 2.61% Trust wide, however still sitting much below the target at 54.62%.
- The departments saw 691 fewer patients compared to March.
- Ambulance handover performance deteriorated with increased handover delays for both 30 minutes and 60 minutes.

Recommendation

The Board is asked to note the report for assurance.
Enclosures
• Quality and Performance Report

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period *April* 2022

Presented at May 2022 Q&P and June 2022 Trust Board

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Executive Summary

Gloucestershire Hospitals
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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 continues to phase in the support for increasing elective activity into May and June and currently meets the gateway targets for elective activity.

During April, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4 hour ED standard, albeit have maintained the majority of the metrics achieved in H2, notably zero 104 weeks breaches and total incompletes less than 60,248.

April continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 68.71% to 67.11% compared to the previous month. Ambulance handover delays increased for delays over 30 and 60 minute handovers. 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 April, however performance deteriorated slightly on last month from 18.0% to 18.8% this month. The total number of patients waiting has increased from 8,790 to 8,915. The overall number of breaches has increased by 88, if Echo's were to be excluded, performance for all other modalities would be 2.59% with just 173 breaches against 6,682 patients waiting.

For cancer, in March submitted data, the Trust met 6 of the 9 CWT metrics and exceeded national performance in 9 out of 9 of the CWT metrics. A better month for Cancer waits performance with the Trust meeting 2ww performance, 28 day Faster Diagnosis Standard and 31 day new treatment standard. The Trust achieved 74.5% for 62 day GP referrals, which is an improvement from previous months but still room for significant improvement. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

For elective care, the RTT performance did not meet the standard at 71.3% (unvalidated) and remains similar to last month. With a few days of validation remaining performance stands at 71.75% which is a very slight improvement on last month. The total incompletes has increased significantly compared to last month moving from 56,139 to 58,299, primarily due to an increase in new clock starts. The number of 52 week breaches has increased compared to last month with an unvalidated figure of 1,233 breaches in month, compared to 1,125 last month. Focus continues to be placed on patients over 70 weeks, which has again reduced in month, moving from 148 to 130 in April. Zero 104 week breaches is maintained.

The Elective Care Hub continues to work with specialties in telephoning patients but more recently has rolled out a digital survey to increase the ability to contact a wider cohort of patients and more quickly. To date just over 3,300 patients have been contacted via this method and a similar number will be contacted week commencing 16th May. Although the rate of return is generally good, initial indications are that more patients are being escalated to the service, as completing questions via a form is less effective than having a conversation with the patient, where more detail can usually be teased out. The project still remains in its infancy and further refinements will be made.

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		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	316	262	253	440	354	500	523	467	446	504	330	328	315
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	237	85	117	475	294	692	752	1074	952	1057	1093	1263	1357
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	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.64%	68.71%	67.11%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%
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	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.32%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	2657	2263	2016	1724	1554	1598	1590	1492	1430	1273	1112	1125	1233
% 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	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.75%
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	94.80%	95.40%	92.80%	91.90%	93.50%	92.00%	93.40%	92.10%	92.30%	87.20%	94.70%	94.00%	88.30%
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	93.60%	96.50%	90.70%	96.60%	93.20%	90.80%	89.80%	88.60%	84.90%	89.70%	94.60%	91.30%	89.70%
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	96.60%	98.30%	98.50%	98.30%	97.10%	95.90%	97.90%	96.30%	95.60%	94.20%	97.70%	98.50%	95.30%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	99.50%	99.50%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.10%	97.70%	100.00%	97.50%	98.50%	99.40%	100.00%	97.90%	100.00%	99.40%	99.00%	100.00%	86.80%
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	90.00%	95.60%	95.80%	94.00%	92.60%	88.10%	91.00%	95.10%	94.40%	88.20%	93.00%	91.50%	86.40%
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	85.30%	90.60%	95.70%	92.00%	82.90%	90.80%	76.50%	81.80%	91.50%	85.50%	79.30%	90.90%	85.20%
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	90.80%	65.40%	70.60%	82.10%	63.60%	72.10%	87.10%	70.60%	73.10%	75.00%	69.70%	80.60%	90.90%
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	82.00%	76.30%	80.30%	77.60%	72.10%	71.00%	69.00%	70.90%	61.90%	65.80%	68.00%	74.50%	60.90%

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	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	% growth from previous year: Monthly (Apr)	% growth from previous year: YTD
GP Referrals	8,555	8,466	8,952	8,661	7,908	8,302	8,145	8,502	7,155	7,908	8,138	9,238	8,122	-5.1%	-5.1%
OP Attendances	50,410	51,179	54,944	52,155	47,546	52,912	49,516	56,452	47,698	51,626	49,004	56,917	47,122	-6.5%	-6.5%
New OP Attendances	15,998	16,328	17,228	16,158	14,662	16,658	15,956	18,295	15,353	16,401	16,093	18,555	14,742	-7.9%	-7.9%
FUP OP Attendances	34,412	34,851	37,716	35,997	32,884	36,254	33,560	38,157	32,345	35,225	32,911	38,362	32,380	-5.9%	-5.9%
Day cases	4,196	4,558	4,751	4,801	4,525	4,310	4,187	4,536	3,941	4,121	4,202	4,943	4,072	-3.0%	-3.0%
All electives	5,047	5,424	5,697	5,831	5,469	5,237	5,218	5,492	4,941	4,798	5,051	5,972	4,948	-2.0%	-2.0%
ED Attendances	11,063	11,930	11,976	12,295	12,006	13,186	13,044	11,988	10,943	11,433	10,545	12,307	11,616	5.0%	5.0%
Non Electives	4,018	4,398	4,642	4,531	4,333	4,244	3,998	3,867	3,445	3,463	2,951	3,314	3,152	-21.6%	-21.6%

Trust Scorecard - Safe (1)

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

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Infection Control																		
COVID-19 community-onset - First positive specimen <=2 days after admission	1,375	4	6	24	119	134	110	188	122	124	177	155	212	139	544	139	No target	
COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	424	0	4	10	14	12	14	16	28	54	63	87	122	125	272	125	No target	
COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	140	0	0	1	5	2	0	1	1	23	22	34	51	40	107	40	No target	
COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	232	0	1	1	3	9	1	9	4	26	28	70	80	65	178	65	No target	
Number of trust apportioned MRSA bacteraemia	2	0	0	1	0	0	0	0	0	0	1	0	0	0	1	0	Zero	
MRSA bacteraemia - infection rate per 100,000 bed days	.6	0.0	0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	0.0	0.0	1.2	0.0	Zero	
Number of trust apportioned Clostridium difficile cases per month	113	3	14	11	10	15	7	4	12	8	3	7	8	15	18	15	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	69	3	7	7	5	9	4	1	8	5	2	5	6	10	13	10	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	44	0	7	4	5	6	3	3	4	3	1	2	2	5	5	5	<=5	
Clostridium difficile - infection rate per 100,000 bed days	30.5	13.5	60.2	42.6	34.9	51.1	23.5	13	40.6	27.3	10.2	25.9	27	53.9	20.9	53.9	<30.2	
Number of MSSA bacteraemia cases	33	1	2	2	2	5	5	0	2	5	3	3	2	2	8	2	<=8	
MSSA - infection rate per 100,000 bed days	9.9	4.5	8.6	7.7	7	17	16.8	0.0	6.8	17	10.2	11.1	6.8	7.2	9.3	7.2	<=12.7	
Number of ecoli cases	56	4	5	3	2	0	3	5	7	5	5	5	2	9	12	9	No target	
Number of pseudomona cases	6	1	2	0	0	1	1	0	1	0	0	0	0	0	0	0	No target	
Number of klebsiella cases	23	2	1	3	3	3	4	2	2	2	0	0	1	1	1	1	No target	
Number of bed days lost due to infection control outbreaks	2,381	0	6	161	15	60	1	93	176	453	444	637	335	74	1,416	74	<10	>30

Trust Scorecard - Safe (2)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding		1	1	1	1	0	0	0	1	1							Zero	
Number of falls per 1,000 bed days	7	6.1	6.2	6.2	7.1	7.5	7	6.7	7	6.7	7.3	7.6	8.2	7.5	7.7	7.5	<=6	
Number of falls resulting in harm (moderate/severe)	67	4	2	3	9	5	5	5	3	9	5	10	9	4	24	4	<=3	
Number of patient safety incidents - severe harm (major/death)	97	7	2	1	9	3	6	7	10	7	7	10	28	6	45	6	No target	
Medication error resulting in severe harm	4	0	0	0	0	0	0	2	1	0	1	0	0	0	1	0	No target	
Medication error resulting in moderate harm	47	2	2	1	2	3	2	14	4	6	6	2	3	3	11	3	No target	
Medication error resulting in low harm	91	11	4	13	6	4	7	5	11	3	9	8	11	9	28	9	No target	
Number of category 2 pressure ulcers acquired as in-patient	358	16	22	17	24	27	19	22	41	43	37	40	50	46	127	46	<=30	
Number of category 3 pressure ulcers acquired as in-patient	17	1	0	1	0	3	0	1	2	4	2	1	2	2	5	2	<=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	78	4	3	4	3	5	1	4	9	9	12	14	10	12	36	12	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	80	1	4	8	9	4	6	1	7	12	13	7	8	12	28	12	<=5	
RIDDOR																		
Number of RIDDOR		4	1	3	3	2			3	5							SPC	
Safeguarding																		
Number of DoLs applied for		54	73	57	55	59		53	48	68	64	53	69	47			No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	49	3	8	3	3	7	4	6	1	5	2	3	4	1	9	1	No target	
Total attendances for infants aged < 6 months, other serious injury		1	0	0	0	0	0	0		0	0	1		0			No target	
Total admissions aged 0-17 with DSH	293	13	26	15	13	11	18	35	39	18	46	24	35	32	105	32	No target	
Total ED attendances aged 0-17 with DSH	1,013	62	99	84	65	52	73	102	115	54	125	69	113	85	307	85	No target	
Total number of maternity social concerns forms completed		68	58	77	63	46		58	65	52	67	70	71	72			No target	
Total admissions aged 0-17 with an eating disorder							9	11		8	5	7		7			No target	

Trust Scorecard - Safe (3)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis		70.00%															>=90%	<50%
Serious Incidents																		
Number of never events reported	11	0	2	0	0	1	0	1	1	2	1	2	0	0	3	0	Zero	
Number of serious incidents reported	44	4	3	2	4	4	6	4	4	4	4	3	4	6	11	6	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	89.5%	89.9%	89.8%	89.3%	87.0%	87.1%	92.0%	92.3%	90.7%	90.9%	87.5%	87.1%	90.7%	90.8%	88.5%	90.8%	>95%	

Trust Scorecard - Effective (1)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Maternity																		
% of women on a Continuity of Carer pathway	10.90%		10.40%	9.70%	9.70%	10.80%	10.90%	11.80%	10.30%	9.60%	10.20%	14.70%	12.60%	10.10%	12.10%	10.10%	No target	
% C-section rate (planned and emergency)	31.53%	30.43%	28.88%	33.96%	29.04%	32.02%	30.42%	31.59%	31.63%	32.44%	33.19%	31.45%	33.48%	34.33%	32.76%	34.33%	No target	
% emergency C-section rate	16.94%	16.30%	17.72%	16.77%	15.58%	17.98%	16.76%	17.76%	17.05%	15.61%	17.77%	15.72%	18.03%	19.12%	17.24%	19.12%	No target	
% of women booked by 12 weeks gestation	91.4%	93.2%	91.9%	91.2%	91.9%	91.4%	88.8%	91.0%	91.7%	92.6%	91.1%	90.5%	92.1%	90.8%	91.2%	90.8%	>90%	
% of women that have an induced labour	27.47%	28.05%	27.92%	26.40%	25.90%	28.49%	25.41%	25.00%	25.66%	24.95%	29.42%	33.09%	31.21%	30.59%	31.16%	30.59%	<=33%	>30%
% stillbirths as percentage of all pregnancies	0.17%	0.00%	0.22%	0.42%	0.19%	0.00%	0.00%	0.19%	0.00%	0.00%	0.43%	0.00%	0.64%	0.00%	0.37%	100.00%	<0.52%	
% of women smoking at delivery	10.10%	9.42%	8.23%	9.56%	10.48%	8.19%	10.16%	10.07%	8.80%	11.86%	12.58%	10.78%	11.46%	8.90%	11.65%	8.90%	<=14.5%	
% breastfeeding (discharge to CMW)	49.4%	54.0%	48.7%	49.0%	51.1%	48.4%	53.9%	48.0%	50.3%	48.1%	47.1%	46.0%	46.3%	45.5%	46.6%	45.5%		
% breastfeeding (initiation)	78.9%	81.0%	75.9%	78.4%	78.5%	79.8%	80.8%	81.1%	79.5%	76.3%	78.8%	76.8%	78.2%	78.7%	78.0%	78.7%	>=81%	
% PPH >1.5 litres	4.5%	5.9%	5.0%	4.2%	5.2%	6.7%	4.9%	4.5%	3.4%	4.9%	3.6%	2.2%	3.9%	3.5%	3.2%	3.5%	<=4%	
Number of births less than 27 weeks	11	2	0	2	0	0	1	2	2	0	1	0	1	3	2	3		
Number of births less than 34 weeks	123	7	15	13	8	11	18	13	9	10	7	4	9	13	20	13		
Number of births less than 37 weeks	446	28	44	34	41	33	47	49	32	44	33	19	43	49	95	49		
Number of maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	5,982	463	468	486	526	544	558	546	537	497	471	413	473	442	1,358	442		
Percentage of babies <3rd centile born > 37+6 weeks	2.0%	2.3%	1.5%	1.7%	1.9%	0.9%	1.4%	1.1%	1.9%	2.4%	3.2%	1.7%	4.2%	1.4%	3.0%	1.4%		

Trust Scorecard - Effective (2)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	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	1.1							NHS Digital	
Hospital standardised mortality ratio (HSMR)	102.6	103.2	104.2	106.2	108.4	108.6	108.3	108.8	106.9	102.6	100.9						Dr Foster	
Hospital standardised mortality ratio (HSMR) - weekend	109.4	104.6	107.1	109.2	113.4	113.8	113.8	115.6	113.8	109.4	108						Dr Foster	
Number of inpatient deaths	2,088	145	154	146	182	156	163	183	191	189	218	183	178	185	579	185	No target	
Number of deaths of patients with a learning disability	23	2	4	0	4	2	2	2	4	1	3	1	1	3	5	3	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	8.47%	8.53%	8.62%	9.11%	9.42%	9.54%	9.04%	8.18%	8.10%	8.10%	8.05%	7.32%	7.05%		7.46%		<8.25%	>8.75%
Research																		
Research accruals	3,333	575	240	328	183	192	456	426	236	172	185	173	142	93	3,308	93	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	72.7%	53.5%	48.9%				47.5%	51.9%	50.0%	45.8%	72.7%	70.0%	73.4%	69.2%	67.8%	69.20%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.3%	83.1%	89.3%	91.8%	82.7%	91.8%	84.9%	66.7%	72.7%	75.4%	46.3%	91.0%	96.3%				>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	9.10%	37.00%	44.10%				12.70%	15.10%	16.70%	8.70%	9.10%	75.00%	56.40%	69.20%	44.40%	69.20%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	54.50%	63.20%	67.90%				44.60%	48.80%	40.50%	39.60%	54.50%	75.00%	59.50%	72.40%	67.60%	72.40%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	56.6%	84.4%	52.5%	66.3%	68.2%	60.7%	56.1%	43.5%	50.8%	47.9%	59.4%	43.4%	50.7%	24.3%	51.8%	24.3%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	56.26%	84.44%	52.54%	66.27%	68.18%	59.02%	56.10%	43.55%	50.77%	47.95%	57.97%	41.51%	50.68%	24.32%	50.77%	24.32%	>=65%	<55%

Trust Scorecard - Caring (1)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	86.5%	88.3%	90.2%	89.7%	87.0%	85.4%	86.4%	85.0%	88.0%	87.8%	89.1%	87.1%	88.3%	88.0%	88.1%	88.0%	>=90%	<86%
ED % positive	67.5%	76.3%	73.6%	74.8%	62.7%	70.5%	60.9%	66.7%	68.0%	78.8%	78.6%	67.6%	63.5%	62.7%	70.2%	62.7%	>=84%	<81%
Maternity % positive	86.3%	96.2%	93.0%	89.2%	92.9%	84.8%	87.7%	82.4%	89.7%	84.3%	94.1%	91.9%	85.7%	78.2%	89.9%	78.2%	>=97%	<94%
Outpatients % positive	93.8%	94.4%	93.6%	94.3%	93.1%	93.7%	93.2%	93.3%	93.9%	94.7%	94.3%	93.4%	93.2%	93.1%	93.6%	93.1%	>=94.5%	<93%
Total % positive	88.1%	91.5%	91.1%	91.2%	90.7%	88.5%	86.2%	85.4%	89.4%	91.2%	91.0%	88.6%	88.0%	87.2%	89.2%	87.2%	>=93%	<91%
Number of PALS concerns logged	3,006	256	275	191	241	238	264	274	248	230	266	248	254	229	774	229	No Target	
% of PALS concerns closed in 5 days	79%	82%	85%	90%	85%	82%	76%	65%	78%	71%	65%	73%	78%	67%	73%	67%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	1	0	0	0	0	1	0	0	0	0	0	0	0	21	0	21	<=10	>=20

Trust Scorecard - Responsive (1)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Cancer																		
Cancer - 28 day FDS (all routes)	79.80%	79.1%	77.7%	77.3%	79.9%	78.9%	78.3%	83.1%	78.9%	80.8%	77.6%	86.3%	84.8%	81.7%	80.7%	81.7%	>=75%	
Cancer - urgent referrals seen in under 2 weeks from GP	92.1%	94.8%	95.4%	92.8%	91.9%	93.5%	92.0%	93.4%	92.1%	92.3%	87.2%	94.7%	94.0%	88.3%	90.2%	88.3%	>=93%	<90%
Cancer - 2 week wait breast symptomatic referrals	91.0%	93.6%	96.5%	90.7%	96.6%	93.2%	90.8%	89.8%	88.6%	84.9%	89.7%	94.6%	91.3%	89.7%	91.1%	89.7%	>=93%	<90%
Cancer - 31 day diagnosis to treatment (first treatments)	96.7%	96.6%	98.3%	98.5%	98.3%	97.1%	95.9%	97.9%	96.3%	95.6%	94.2%	97.7%	98.5%	95.3%	95.7%	95.3%	>=96%	<94%
Cancer - 31 day diagnosis to treatment (subsequent – drug)	99.8%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	99.5%	99.5%	100.0%	99.5%	100.0%	>=98%	<96%
Cancer - 31 day diagnosis to treatment (subsequent – surgery)	91.6%	90.0%	95.6%	95.8%	94.0%	92.6%	88.1%	91.0%	95.1%	94.4%	88.2%	93.0%	91.5%	86.4%	89.7%	86.4%	>=94%	<92%
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	99.2%	98.1%	97.7%	100.0%	97.5%	98.5%	99.4%	100.0%	97.9%	100.0%	99.4%	99.0%	100.0%	86.8%	99.5%	86.8%	>=94%	<92%
Cancer - 62 day referral to treatment (urgent GP referral)	72.6%	82.0%	76.3%	80.3%	77.6%	72.1%	71.0%	69.0%	70.9%	61.9%	65.8%	68.0%	74.5%	60.9%	69.4%	60.9%	>=85%	<80%
Cancer - 62 day referral to treatment (screenings)	87.0%	85.3%	90.6%	95.7%	92.0%	82.9%	90.8%	76.5%	81.8%	91.5%	85.5%	79.3%	90.9%	85.2%	90.9%	85.2%	>=90%	<85%
Cancer - 62 day referral to treatment (upgrades)	73.1%	90.8%	65.4%	70.6%	82.1%	63.6%	72.1%	87.1%	70.6%	73.1%	75.0%	69.7%	80.6%	90.9%	73.1%	90.9%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	47	2	1	2	3	4	9	10	4	3	2	2	5	2	9	2	Zero	
Number of patients waiting over 104 days without a TCI date	229	14	10	11	9	12	18	21	23	25	14	22	50	73	86	73	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	18.03%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.03%	18.77%	<=1%	>2%
The number of planned/surveillance endoscopy patients waiting at month end	1,455	1,773	1,680	1,527	1,482	1,439	1,435	1,397	1,410	1,422	1,334	1,269	1,286	1,365	1,296	1,365	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	61.0%	61.1%	61.4%	62.2%	62.3%	61.1%	61.7%	60.5%	61.4%	58.4%	58.7%	62.0%	59.8%		60.1%		>=88%	<75%

Trust Scorecard - Responsive (2)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Emergency Department																		
ED: % total time in department - under 4 hours (type 1)	62.67%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	59.74%	54.52%	>=95%	<90%
ED: % total time in department - under 4 hours (types 1 & 3)	73.41%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.64%	68.71%	67.11%	70.26%	67.11%	>=95%	<90%
ED: % total time in department - under 4 hours CGH	82.49%	99.73%	99.68%	94.75%	84.95%	88.74%	77.05%	83.00%	79.80%	79.03%	79.17%	73.72%	65.48%	65.44%	72.50%	65.44%	>=95%	<90%
ED: % total time in department - under 4 hours GRH	56.46%	64.75%	61.44%	63.34%	53.00%	57.55%	51.82%	52.48%	54.91%	53.96%	55.55%	52.12%	52.87%	49.00%	53.54%	49.00%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2,459	0	0	1	10	1	15	53	448	631	300	394	606	690	1,300	690	Zero	
ED: % of time to initial assessment - under 15 minutes	23.1%	40.9%	47.3%	43.1%	7.1%	14.8%	15.7%	19.3%	21.6%	37.4%	35.5%	30.0%	22.9%	20.1%	29.3%	20.1%	>=95%	<92%
ED: % of time to start of treatment - under 60 minutes	13.8%	17.5%	15.1%	14.4%	12.3%	13.8%	14.9%	10.7%	18.1%	30.3%	29.5%	24.1%	21.0%	19.6%	24.8%	19.6%	>=90%	<87%
Number of ambulance handovers over 60 minutes	8,091	237	85	117	475	294	692	752	1,074	952	1,057	1,093	1,263	1,357	3,413	1,357	Zero	
% of ambulance handovers < 15 minutes	21.55%								23.11%	23.53%	24.72%	18.20%	15.73%	9.81%	20.13%	9.81%	>=65%	
% of ambulance handovers < 30 minutes	40.14%								42.28%	45.54%	44.45%	34.48%	29.58%	21.14%	37.12%	21.14%	>=95%	
% of ambulance handovers 30-60 minutes	11.60%	8.61%	6.66%	6.73%	11.91%	9.48%	13.85%	14.55%	14.21%	13.90%	15.56%	13.25%	13.17%	13.32%	14.13%	13.32%	<=2.96%	
% of ambulance handovers over 60 minutes	19.87%	6.45%	2.16%	3.11%	12.86%	7.88%	19.16%	20.92%	32.67%	29.68%	32.62%	43.90%	50.70%	57.38%	41.52%	57.38%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	81.58%	92.00%	87.80%	87.50%	80.95%	89.06%	80.60%	73.75%	74.03%	80.23%	71.60%	93.48%	95.59%	76.90%		76.90%	>=95%	
Urgent cancelled operations	107	0	1	13	12	10	1	44	24	1	1	0	0	0	1	0	No target	
Number of patients stable for discharge	173	113	114	122	160	158	179	178	212	159	233	241	206	233	227	233	<=70	
Number of stranded patients with a length of stay of greater than 7 days	451	359	334	416	367	421	472	468	503	499	491	537	540	515	523	515	<=380	
Average length of stay (spell)	5.5	4.68	4.78	5.14	4.98	4.84	5.32	5.47	6.03	6.02	6.13	6.67	6.68	6.63	6.49	6.63	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	6.23	5.18	5.25	5.7	5.57	5.39	5.99	6.22	6.97	7	6.78	7.93	8.06	7.91	7.56	7.91	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.36	2.31	2.57	2.64	2.43	2.31	2.25	2.48	2.28	2.46	2.42	2.07	2.13	2.13	2.18	2.13	<=3.4	>4.5
% day cases of all electives	82.68%	83.12%	84.02%	83.38%	82.32%	82.72%	82.28%	80.22%	82.57%	79.74%	85.87%	83.17%	82.75%	82.28%	83.84%	82.28%	>80%	<70%
Intra-session theatre utilisation rate	87.48%	90.40%	91.01%	88.26%	89.56%	89.52%	85.33%	87.67%	85.46%	82.84%	86.25%	85.20%	87.17%	87.50%	86.28%	87.50%	>85%	<70%

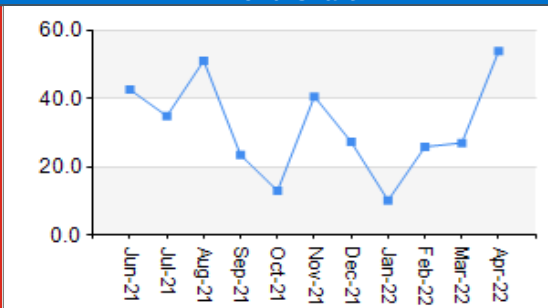
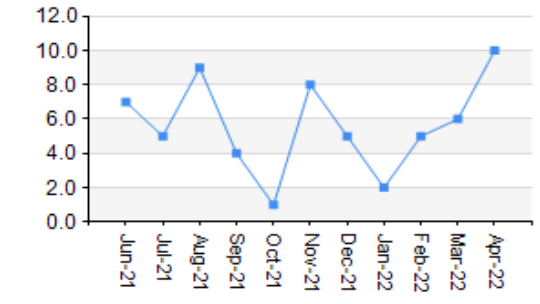
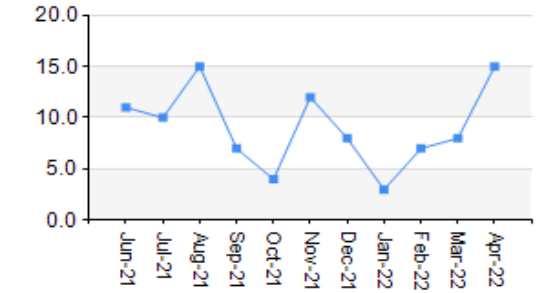
Trust Scorecard - Responsive (3)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.99	2.06	2.02	2.04	2.1	2.13	2	1.94	1.93	1.96	1.95	1.87	1.95	2.03	1.92	2.03	<=1.9	
Did not attend (DNA) rates	6.96%	5.89%	6.02%	6.72%	7.05%	7.24%	7.15%	7.17%	7.03%	7.23%	7.63%	7.04%	7.33%	7.46%	7.34%	7.46%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	72.30%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.32%	71.50%	71.32%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	5,720	6,541	6,426	6,159	5,713	5,582	5,642	5,593	5,642	5,847	5,272	5,087	5,135	5,513	5,165	5,513	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,840	3,572	3,657	3,320	2,854	2,906	2,946	2,935	2,641	2,605	2,292	2,165	2,182	2,444	2,213	2,444	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,653	2,657	2,263	2,016	1,724	1,554	1,598	1,590	1,492	1,430	1,273	1,112	1,125	1,233	1,170	1,233	Zero	
Referral to treatment ongoing pathway over 70 Weeks (number)	426	608	667	745	806	611	403	295	228	205	207	185	148	130	180	130	Zero	

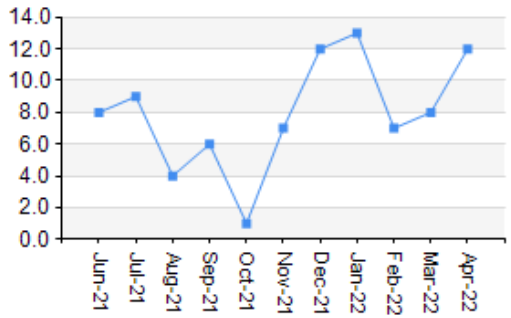
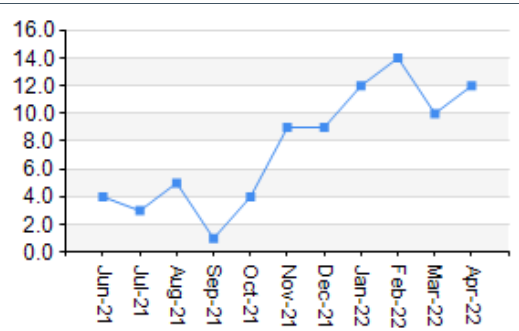
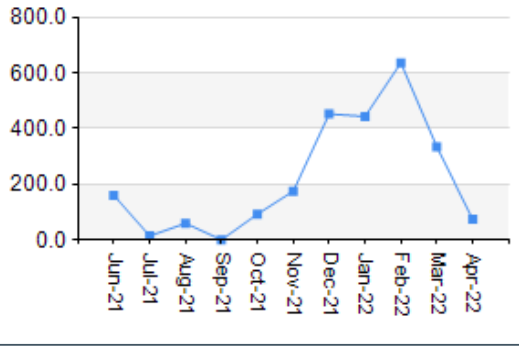
Trust Scorecard - Well Led (1)

	21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q4	22/23	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	77.0%	85.0%	85.0%	84.0%	80.0%	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%	78.0%	77.0%	78.0%	77.0%		>=90%	<70%
Trust total % mandatory training compliance	86%	91%	90%	91%	90%	90%	88%	87%	87%	87%	87%	87%	86%	86%	86%		>=90%	<70%
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	93.00%	98.29%	96.75%	91.64%	96.56%	97.22%	99.61%	97.11%	95.93%	89.16%	85.93%	87.53%	85.28%		86.16%		>=75%	<70%
% registered nurse day	91.30%	96.38%	96.05%	90.72%	94.84%	95.11%	98.11%	95.49%	94.07%	87.59%	84.20%	85.30%	82.60%		83.95%		>=90%	<80%
% unregistered care staff day	92.80%	106.08%	104.33%	95.67%	100.44%	98.32%	96.58%	95.82%	95.07%	84.77%	83.85%	83.66%	74.95%		80.50%		>=90%	<80%
% registered nurse night	96.06%	101.83%	97.99%	93.27%	99.57%	101.09%	102.46%	100.10%	99.31%	91.99%	89.02%	91.54%	90.13%		90.14%		>=90%	<80%
% unregistered care staff night	103.64%	111.13%	113.00%	103.77%	109.58%	111.39%	111.67%	105.90%	103.45%	94.98%	95.26%	97.78%	91.50%		94.66%		>=90%	<80%
Care hours per patient day RN	5	5.2	5.5	5.3	5.3	4.7	4.6	5	5.1	5	4.9	4.8	5		4.9		>=5	
Care hours per patient day HCA	3.3	3.7	3.5	3.5	3.5	3.3	3.5	3.2	3.1	3.1	3	3	2.9		3		>=3	
Care hours per patient day total	8.3	8.9	9	8.7	8.8	8	8.1	8.1	8.3	8.1	7.9	7.8	7.9		7.9		>=8	
Vacancy and WTE																		
% total vacancy rate		4.30%	7.12%		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%	10.45%	10.79%			<=11.5%	>13%
% vacancy rate for doctors		1.38%	4.15%		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%	7.99%	7.91%			<=5%	>5.5%
% vacancy rate for registered nurses		7.24%	6.60%		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%	14.09%	14.34%			<=5%	>5.5%
Staff in post FTE		6678.31	6672.09	6672.85	6680.26	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52	6707.09	6683.74			No target	
Vacancy FTE		298.88	510		505.63	537.29	491.56	457.02	530.17	582.02	834.81	799.75	782.28	807.64			No target	
Starters FTE	1123.04	86.69	50.85	56.53	36.05	36.53	79.76	42.43	59.94	70.65	77.03	69.31	51.46	91.38			No target	
Leavers FTE	1128.86	36	57.02	62.03	52.16	78.84	68.51	89.94	66.53	81.1	88.76	47.74	84.88	67.55			No target	
Workforce Expenditure and Efficiency																		
% turnover		9.2%	9.5%	10.0%	10.2%	10.7%	11.1%	11.7%	11.7%	12.3%	12.9%	11.8%	13.8%	14.2%			<=12.6%	>15%
% turnover rate for nursing		8.88%	8.96%	9.18%	9.80%	9.77%	9.72%	9.70%	10.52%	10.83%	10.99%	10.69%	12.15%	12.80%			<=12.6%	>15%
% sickness rate		3.7%	3.7%	3.6%	3.6%	3.8%	3.9%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.1%			<=4.05%	>4.5%

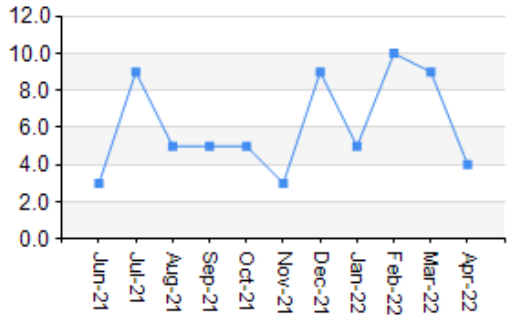
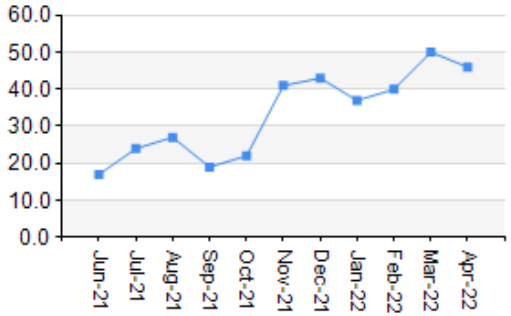
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Clostridium difficile - infection rate per 100,000 bed days **Standard: <30.2**		During April there were 10 health care associated (HO-HA) case. All of these cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review. There were also 5 community onset health care associated (CO-HA)cases The trust wide C. difficile reduction plan remains in place to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan addresses cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). Assurance of action completion will be monitored through the Infection Control Committee. The ICS also continues to engage in the NHSE/I region wide CDI improvement collaborative where as a system we are working on 3 key improvement areas which includes antimicrobial stewardship, optimisation of CDI treatment and management and environmental cleaning/ CDI IPC bundle. We are improving our post infection review form and process to include system wide patient reviews and risk factor data collection to target interventions for improvement. As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominately identified lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review. Also MDT AMS ward rounds across the trust are ongoing; these are ward based round and undertaken by the Lead Nurse for AMS, Antimicrobial Pharmacists and Consultant Microbiologist. The team make remedial interventions at the time of the round, providing feedback and education to ward teams and collect data on the types of interventions being completed during the round for impact review. These outcomes are feedback to the ward team via email. There are at least 2 AMS ward rounds per week; 1 per site and 1 infection rounds, one on AMU and one ACUC per week. Furthermore, Nurse-led C. difficile ward rounds continue to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**			
Number of trust apportioned Clostridium difficile cases per month **Standard: 2020/21: 75**			

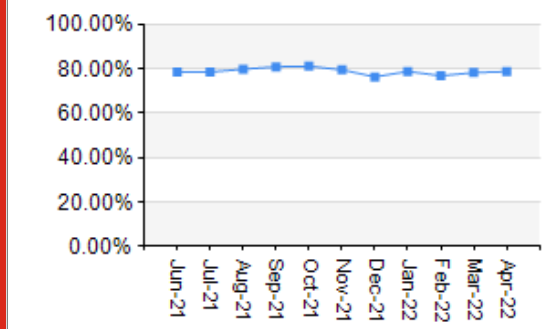
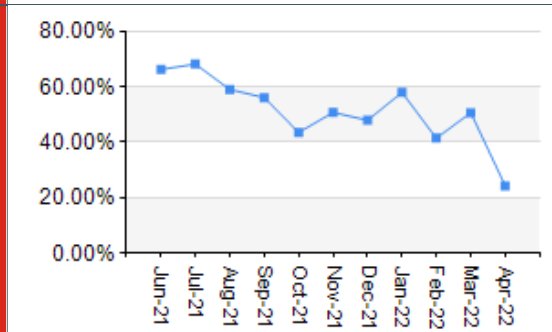
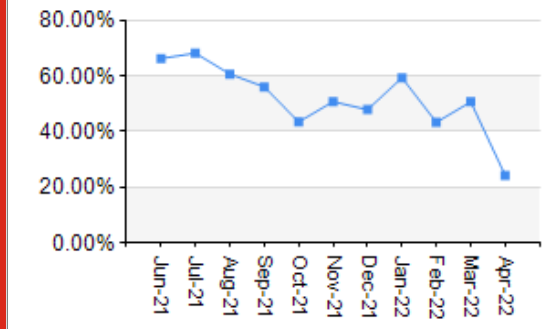
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of bed days lost due to infection control outbreaks **Standard: <10**		During April we had 74 closed empty beds 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 continued to ensure review of all closed areas. From May 2022 it was agreed that beds will no longer be closed to admission in bays where there are exposed asymptomatic COVID contacts, which should reduce further bed closures due to infection control reasons.	**Associate Chief Nurse, Director of Infection Prevention & Control**

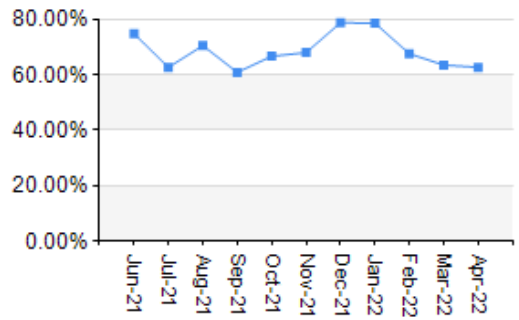
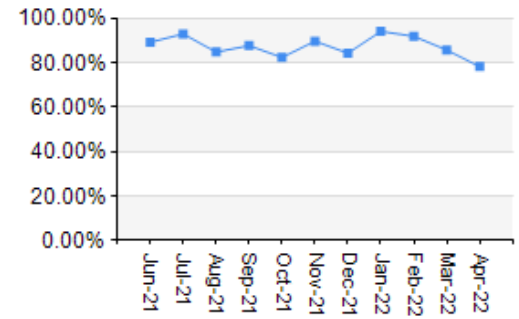
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		April 2022 saw a lower number of falls resulting in harm, such as fractures and head injuries. There were 4 occurrences. Every fall resulting in moderate harm or worse is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed. The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing and prolonged length of stay which is associated with an increased number of ward moves.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of category 2 pressure ulcers acquired as in-patient **Standard: <=30**		Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now taking place monthly to increase throughput.	**Associate Chief Nurse, Director of Infection Prevention & Control**

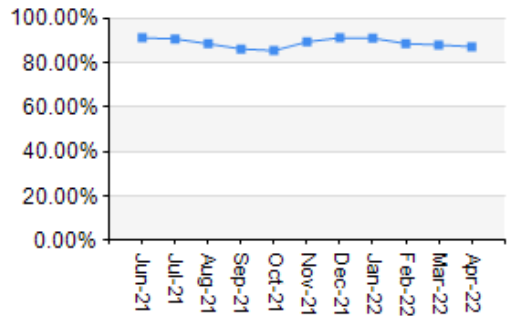
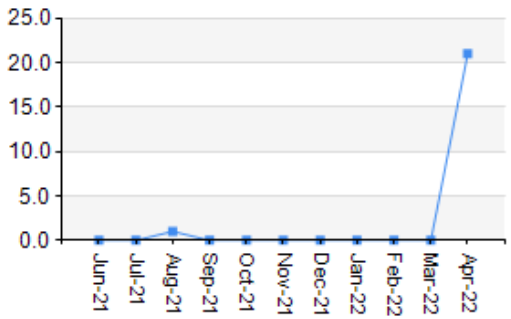
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Due to COVID antenatal classes, where feeding is discussed, is still not all face to face, so this is a potential factor. Staff training is still 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, along with general staff shortages, has also had an impact. There is also an element where personal choice comes into the equation.	**Divisional Director of Quality and Nursing and Chief Midwife**
% fractured neck of femur patients meeting best practice criteria **Standard: >=65%**		• Only 27% of patients got to theatre within 36 hrs • 73% of patients failed to get to surgery within 36 hours (of which 67% of patients were delayed because of logistical reasons) Patients are waiting in ambulance for 6-12hrs and then in ED for a bed. The patients can be waiting 24-40 hrs before going to a ward. Pressure sore rate is climbing as patients are not getting on an air mattress in that time. Theatre is delayed. Lists are lost nearly daily - No Theatre Staff, No Anaesthetist, No Radiographer. Recovery in theatre of C19 +ve patients fills theatre time.	**General Manager – Trauma & Orthopaedics**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		• Only 27% of patients got to theatre within 36 hrs • 73% of patients failed to get to surgery within 36 hours (of which 67% of patients were delayed because of logistical reasons) Patients are waiting in ambulance for 6-12hrs and then in ED for a bed. The patients can be waiting 24-40 hrs before going to a ward. Pressure sore rate is climbing as patients are not getting on an air mattress in that time. Theatre is delayed. Lists are lost nearly daily - No Theatre Staff, No Anaesthetist, No Radiographer. Recovery in theatre of C19 +ve patients fills theatre time.	**General Manager – Trauma & Orthopaedics**

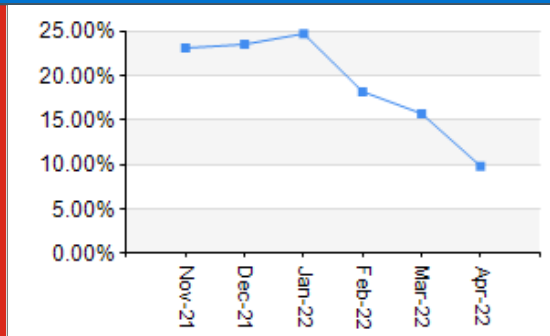
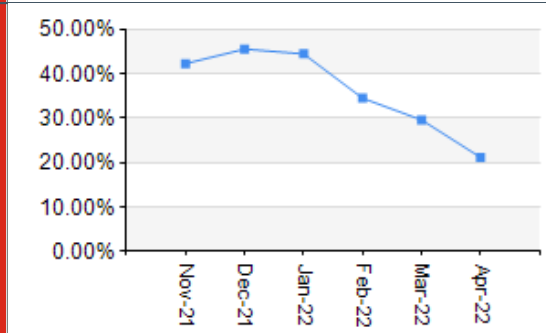
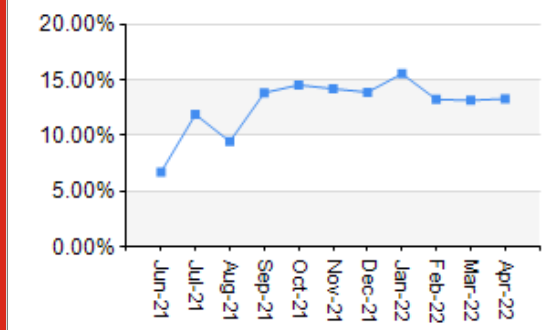
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED % positive **Standard: >=84%**		The current positive FFT score for ED is at 62.7% across both sites, with the main theme emerging focussed on wait times, which is reflective of the operational pressures in the department. The team are receiving reports on the feedback weekly, to support local real time improvement in response to emerging themes, and provide monthly updates through to QDG.	**Head of Quality**
Maternity % positive **Standard: >=97%**		The current positive FFT score for Maternity services is 78.2%. The division are working with the Maternity Voices Partnership to review feedback themes emerging from FFT and other sources, to put an improvement plan in place which is monitored in the division, and monthly updated provided through to QDG.	**Head of Quality**

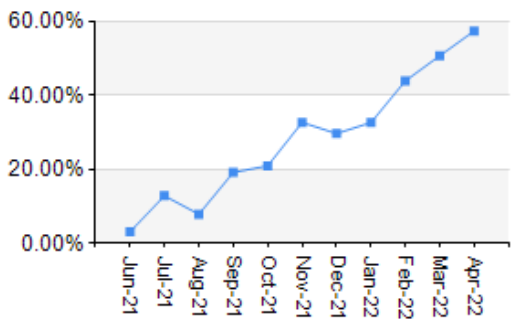
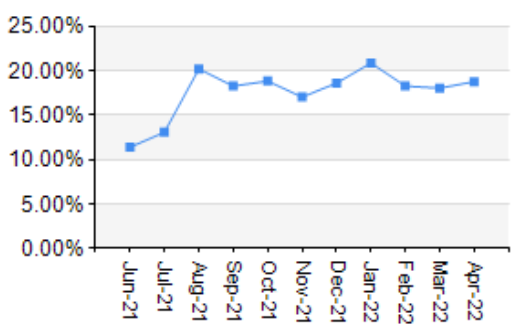
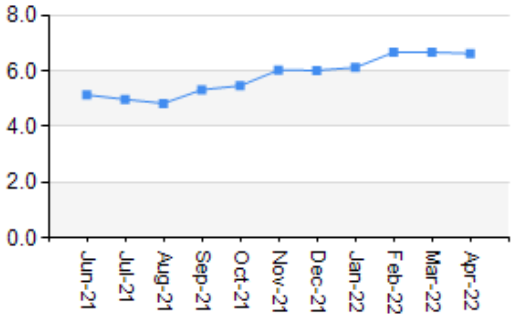
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Total % positive **Standard: >=93%**		The current positive FFT score for the Trust overall is at 87.2%. The main themes emerging this month were focussed on wait times, communication issues, and delays to appointments. Divisions provide updates through QDG each month on improvement plans happening within divisions, and the patient experience team are reviewing current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans.	**Head of Quality**
Number of breaches of mixed sex accommodation **Standard: <=10**		Historically mixed sex accommodation breaches have been deemed non-reportable where the Trust escalation status is at OPEL level 3 or 4. Therefore, breaches have been not reported for an extended period as the Trust escalation status has remained at level 3 or 4. The Trust has worked with the CCG to alter the reporting framework to give oversight of breaches at all times, regardless of escalation status. this reporting will come through from April 2022. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse.	**Associate Chief Nurse, Director of Infection Prevention & Control**

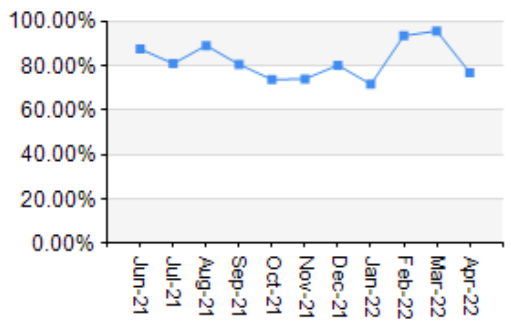
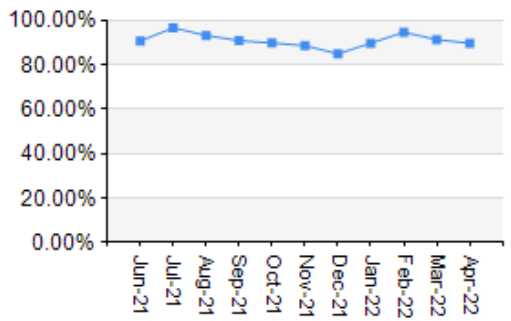
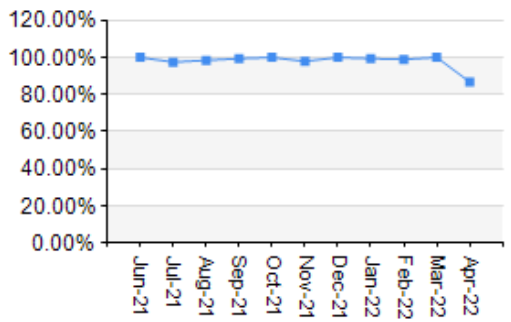
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers < 15 minutes **Standard: >=65%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision	**General Manager of Unscheduled Care**
% of ambulance handovers < 30 minutes **Standard: >=95%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision	**General Manager of Unscheduled Care**
% of ambulance handovers 30-60 minutes **Standard: <=2.96%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision	**General Manager of Unscheduled Care**

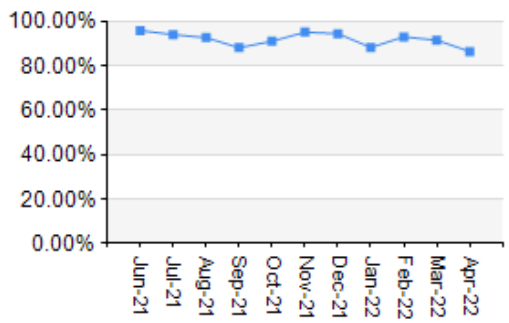
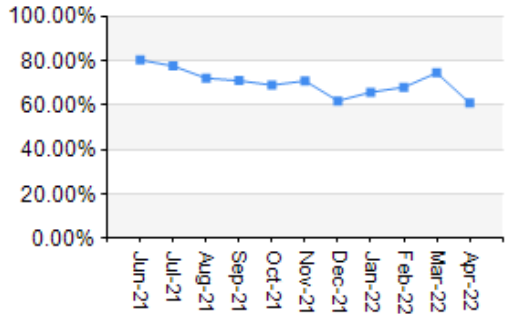
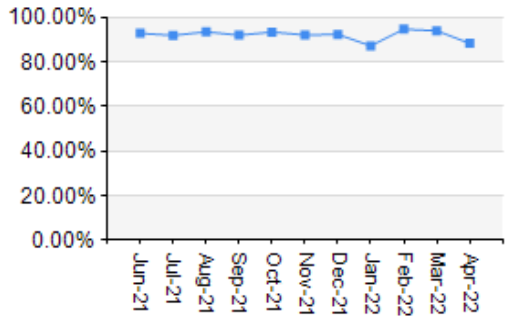
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers over 60 minutes **Standard: <=1%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision	**General Manager of Unscheduled Care**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Diagnostic performance has largely remained the same as last month, moving from 18.03% to a validated position of 18.77% this month. Over the past few months performance has remained around the 18-20%, and for the majority of modalities performance is consistent with relatively small number of breaches. However, this month we have seen all of the Endoscopy modalities deteriorate with an increase of breaches. As per previous months Echos continue to be the most challenged area and despite a 1.78% improvement in month, 1,500 patients exceed 6 weeks at month end.	**Associate Director of Elective Care**
Average length of stay (spell) **Standard: <=5.06**		There has been a slight decrease in the ALOS of 0.75%. There are no remarkable factors affecting this decrease.	**Deputy Chief Operating Officer**

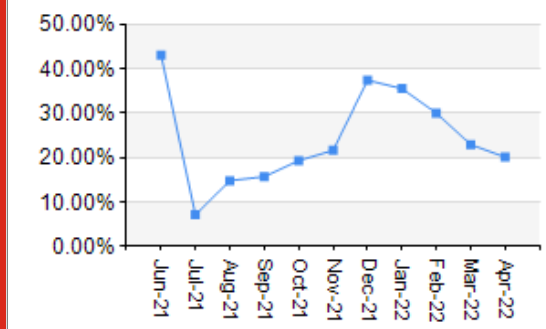
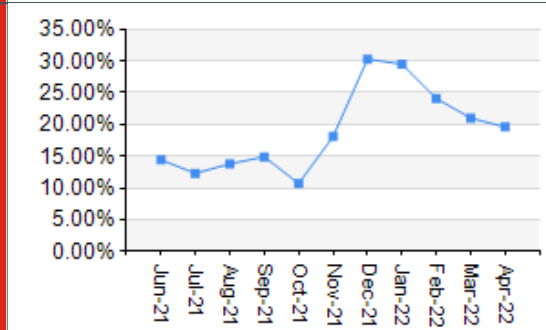
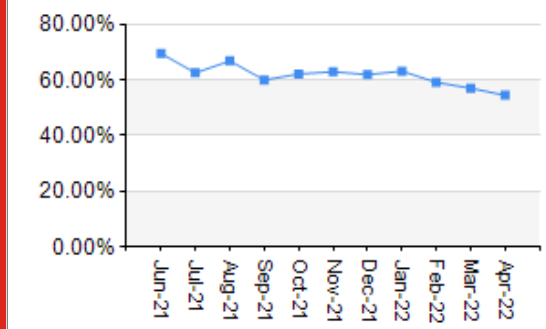
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In March there 9 patients cancelled on the day that could not be rescheduled within 28 days, which is a stepped change to the previous month. Reasons were varied but included equipment failures, graft failure, emergency case, admin error, patients arrived late etc.	**Associate Director of Elective Care**
Cancer - 2 week wait breast symptomatic referrals **Standard: >=93%**		2ww breast symptoms performance (unvalidated) Standard = 93% National = 59% GHFT = 89.7% DFS = 117 Breaches = 12	**General Manager - Cancer**
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		31 day subs radiotherapy performance (unvalidated) Standard = 94% National = 93% GHFT = 87.7% 92 treatments and 12 breaches RT capacity impacted by radiographer vacancies. Workforce paper worked up to implement golden handshakes and potentially re-banding staff to come in line with regional and national radiographer banding levels. Backlog has been prioritised and being overseen by	**General Manager - Cancer**

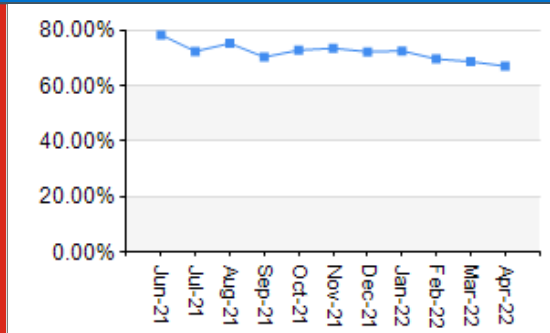
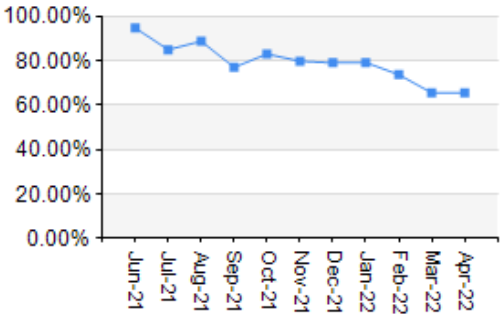
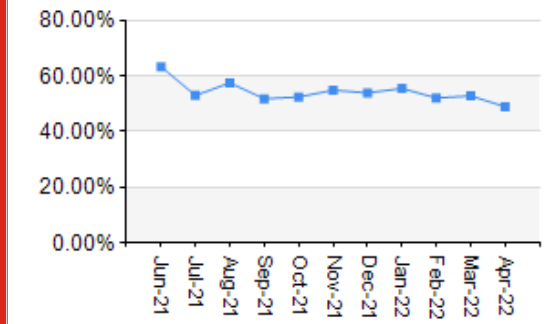
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		31 day subs surgery performance (unvalidated) Standard = 94% National = 82% GHFT = 86.4% 59 treatments and 8 breaches Breast 4; Uro 3 and Skin 1	**General Manager - Cancer**
Cancer - 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) Standard = 85% National = 67% GHFT = 61.7% 117.5 Treatments 45 breaches Uro 18; LGI 10; Gynae 5; Haem 4 21 breaches related to >104 day clearance LATP biopsy delays, PET scan delays both impacting on pathways 62 day recovery plan in formulation	**General Manager - Cancer**
Cancer - urgent referrals seen in under 2 weeks from GP **Standard: >=93%**		2ww Performance (unvalidated) Standard = 93% National = 80% GHFT = 88.3% Breaches mainly from endoscopy (LGI and UGI) and Skin. Endoscopy impacted by building work on CGH site. Additional lists being put on. Workforce issues relating to locum impacting skin capacity.	**General Manager - Cancer**

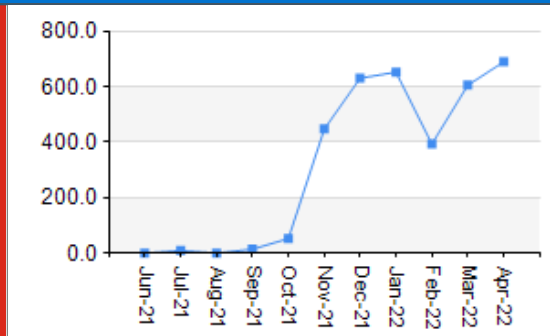
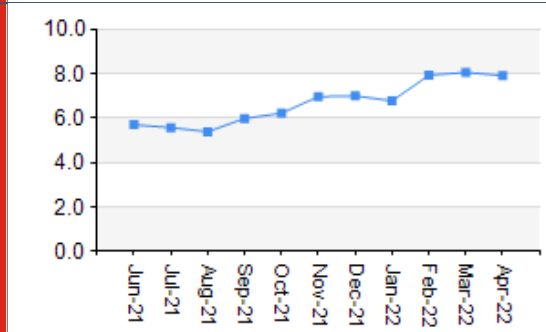
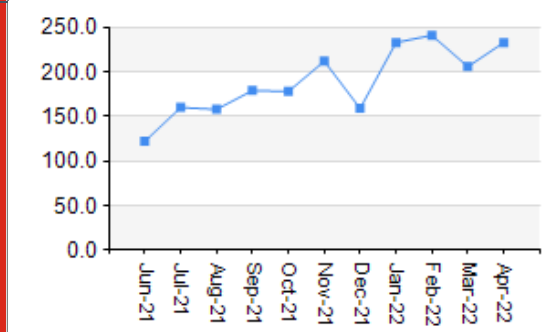
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment - under 15 minutes **Standard: >=95%**		This is also due to a slowing in the rate of patients medically fit for discharge, across the month, meaning a shortage of beds and thus prolonged trolley waits for the available beds.	**General Manager of Unscheduled Care**
ED: % of time to start of treatment - under 60 minutes **Standard: >=90%**		This is also due to a slowing in the rate of patients medically fit for discharge, across the month, meaning a shortage of beds and thus prolonged trolley waits for the available beds.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (type 1) **Standard: >=95%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision	**General Manager of Unscheduled Care**

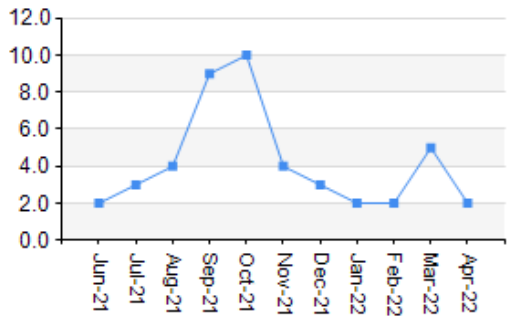
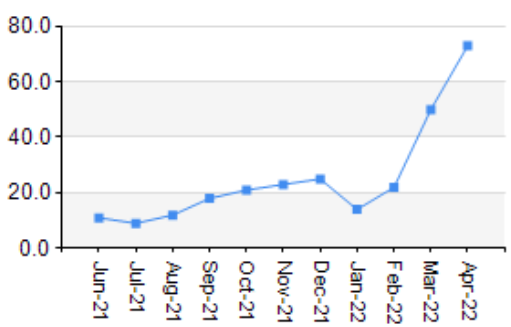
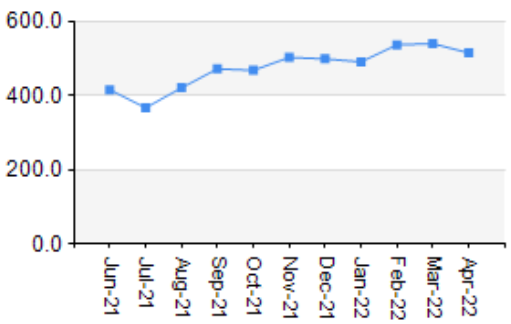
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department - under 4 hours (types 1 & 3) **Standard: >=95%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid-19 unavailability of 5.61% challenged the continuity of Service provision.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours CGH **Standard: >=95%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours GRH **Standard: >=95%**		This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision	**General Manager of Unscheduled Care**

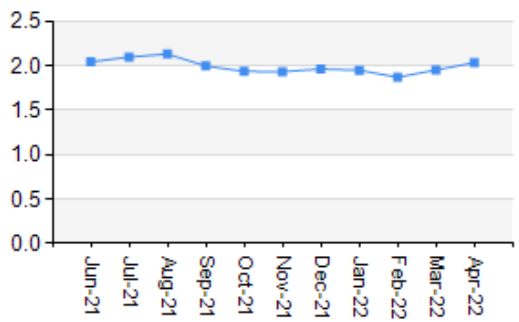
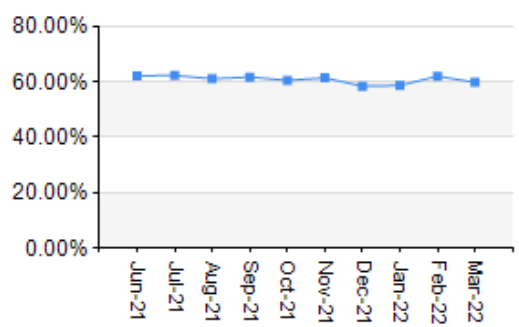
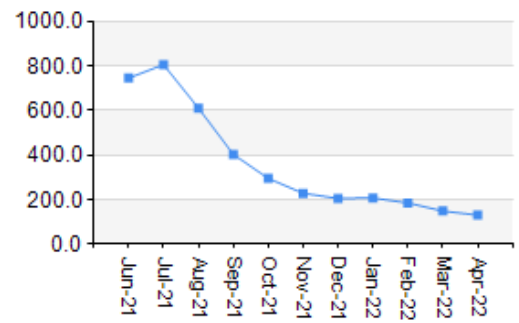
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		This is also due to a slowing in the rate of patients medically fit for discharge, across the month, meaning a shortage of beds and thus prolonged trolley waits for the available beds.	**General Manager of Unscheduled Care**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		The position remains relatively stable and unchanged from the previous month decreasing by 0.15 bed days. There are no remarkable factors affecting this indicator at this time.	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Current nCTR number 234. This remains far to high, but there has been significant improvement in line with ICS improvement plan agreed at beginning of March. nCTR have reduced from 272, whilst the 10+ day wait numbers have reduced from 163 to 118 at this point. Further conversations happening around further plans to reduce further, aiming for nCTR of 166 and 10+ day waits of less than 60.	**Head of Therapy & OCT**

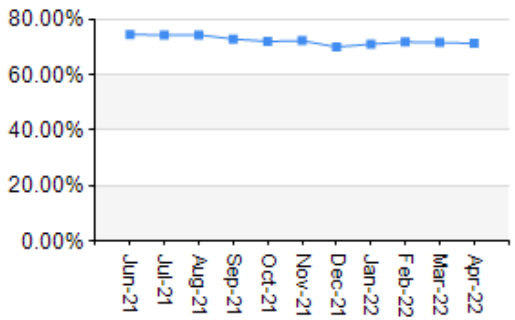
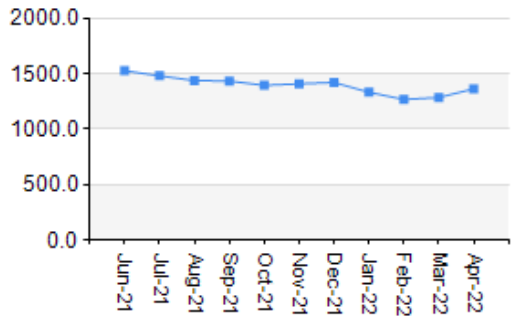
Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		77 patients >104 days Uro 55; LGI 15; UGI 3; Other 2; Lung 1; Haen 1 8 TCI's agreed 6 referred in late from other hospital Majority of backlog associated with delays to LATP biopsy	**General Manager - Cancer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		77 patients >104 days Uro 55; LGI 15; UGI 3; Other 2; Lung 1; Haen 1 8 TCI's agreed 6 referred in late from other hospital Majority of backlog associated with delays to LATP biopsy	**General Manager - Cancer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		The number of stranded patients with a lengths of seven days decreased slightly, from 540 to 515. The 21/22 average stands at 451, which is a 16% variance from target. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust have a robust grip on the position, and have co-ordinated discharge efforts in order to help discharge these patients where possible. The trust have been working with local commissioners to formulate plans which include the provision of discharge budgets, use of Pathway teams targeting stranded patients, speciality inreach to ED and daily ward rounds. These plans are expected to progress at pace.	**Deputy Chief Operating Officer**

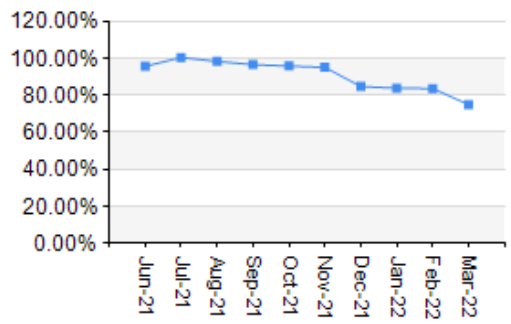
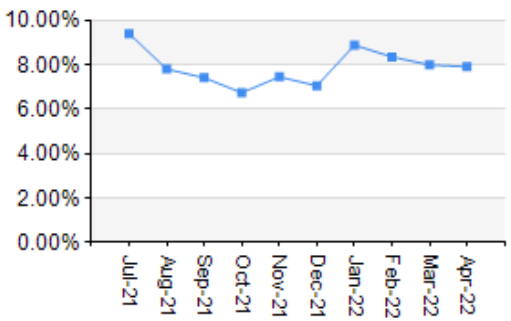
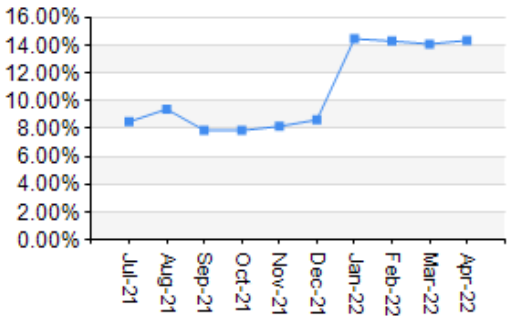
Exception Reports - Responsive (9)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Outpatient new to follow up ratio's **Standard: <=1.9**		Increased slightly in month, back to 2.03, just above the target.	**Associate Director of Elective Care**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		No significant change. Issues remain that await EPMA implementation.	**Medical Director**
Referral to treatment ongoing pathway over 70 Weeks (number) **Standard: 0**		This is the only cohort of patients where a reduction has been observed in month, with a reduction of approx 18 patients, which is testament to the continued focus on long waiters, and progressively chunking back.	**Associate Director of Elective Care**

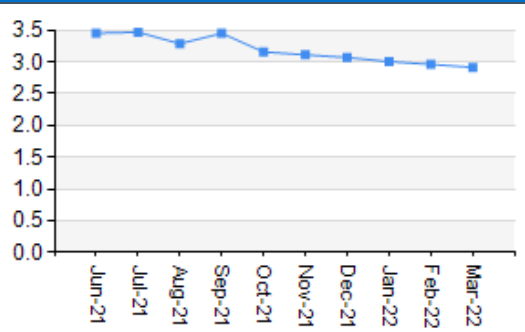
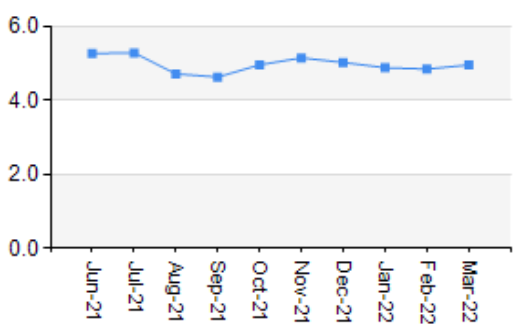
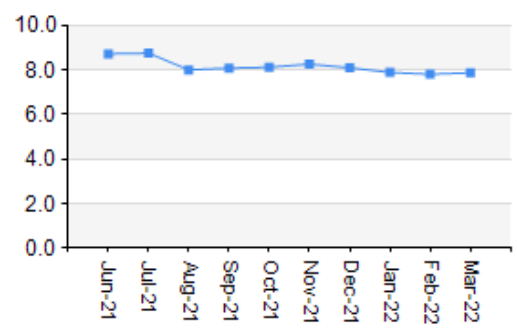
Exception Reports - Responsive (10)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Although RTT performance is reported at time of report a slight improvement in month-end performance is anticipated, at around 71.75%. GHT remains one of the better performing Trusts within the South West. In addition, RTT performance nationally would appear to around 63% so GHT remains above.	**Associate Director of Elective Care**
The number of planned/surveillance endoscopy patients waiting at month end **Standard: <=600**		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 has increased slightly due to the reduction in capacity of the academy build, it is expected to reduce in the coming months through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and additional carved out capacity in month.	**Deputy General Manager of Endoscopy**

Exception Reports - Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% unregistered care staff day **Standard: >=90%**		Under Review	**Deputy Director of Quality and Deputy Chief Nurse**
% vacancy rate for doctors **Standard: <=5%**		A targeted overseas recruitment campaign has commenced for the Emergency Department in partnership with an external agency with interviews taking place in Mumbai in May 2022.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		The Trust's planned pipeline of international registered nurses continues to be recruited with further overseas recruitment now in place for 2022/23, driven by ongoing workforce demand. A campaign for Return to Practice has commenced and an ongoing focus on closing the gap in place through the workforce planning round for the next year and beyond.	**Director of Human Resources and Operational Development**

Exception Reports - Well Led (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day HCA **Standard: >=3**		Under Review	**Deputy Director of Quality and Deputy Chief Nurse**
Care hours per patient day RN **Standard: >=5**		Under Review	**Deputy Director of Quality and Deputy Chief Nurse**
Care hours per patient day total **Standard: >=8**		Under Review	**Deputy Director of Quality and Deputy Chief Nurse**

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period April 2022

Presented at May 2022 Q&P and June 2022 Trust Board

Contents

Gloucestershire Hospitals
NHS Foundation Trust

Guidance

Gloucestershire Hospitals
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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 continues to phase in the support for increasing elective activity into May and June and currently meets the gateway targets for elective activity.

During April, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4 hour ED standard, albeit have maintained the majority of the metrics achieved in H2, notably zero 104 weeks breaches and total incompletes less than 60,248.

April continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 68.71% to 67.11% compared to the previous month. Ambulance handover delays increased for delays over 30 and 60 minute handovers. 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 April, however performance deteriorated slightly on last month from 18.0% to 18.8% this month. The total number of patients waiting has increased from 8,790 to 8,915. The overall number of breaches has increased by 88, if Echo's were to be excluded, performance for all other modalities would be 2.59% with just 173 breaches against 6,682 patients waiting.

For cancer, in March submitted data, the Trust met 6 of the 9 CWT metrics and exceeded national performance in 9 out of 9 of the CWT metrics. A better month for Cancer waits performance with the Trust meeting 2ww performance, 28 day Faster Diagnosis Standard and 31 day new treatment standard. The Trust achieved 74.5% for 62 day GP referrals, which is an improvement from previous months but still room for significant improvement. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

For elective care, the RTT performance did not meet the standard at 71.3% (unvalidated) and remains similar to last month. With a few days of validation remaining performance stands at 71.75% which is a very slight improvement on last month. The total incompletes has increased significantly compared to last month moving from 56,139 to 58,299, primarily due to an increase in new clock starts. The number of 52 week breaches has increased compared to last month with an unvalidated figure of 1,233 breaches in month, compared to 1,125 last month. Focus continues to be placed on patients over 70 weeks, which has again reduced in month, moving from 148 to 130 in April. Zero 104 week breaches is maintained.

The Elective Care Hub continues to work with specialties in telephoning patients but more recently has rolled out a digital survey to increase the ability to contact a wider cohort of patients and more quickly. To date just over 3,300 patients have been contacted via this method and a similar number will be contacted week commencing 16th May. Although the rate of return is generally good, initial indications are that more patients are being escalated to the service, as completing questions via a form is less effective than having a conversation with the patient, where more detail can usually be teased out. The project still remains in its infancy and further refinements will be made.

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

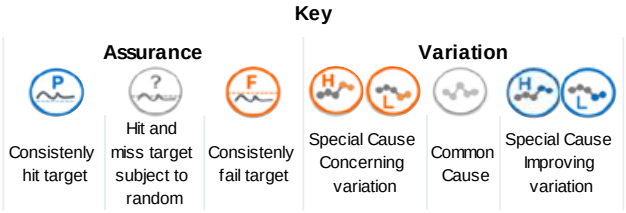
MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Cancer	Cancer - 28 day FDS (all routes)	>=75%		Apr-22	81.7%	
Cancer	Cancer - urgent referrals seen in under 2 weeks from GP	>=93%	?	Apr-22	88.3%	
Cancer	Cancer - 2 week wait breast symptomatic referrals	>=93%	?	Apr-22	89.7%	
Cancer	Cancer - 31 day diagnosis to treatment (first treatments)	>=96%	?	Apr-22	95.3%	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – drug)	>=98%	P	Apr-22	100.0%	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	>=94%	?	Apr-22	86.4%	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	?	Apr-22	86.8%	
Cancer	Cancer - 62 day referral to treatment (urgent GP referral)	>=85%	?	Apr-22	60.9%	
Cancer	Cancer - 62 day referral to treatment (screenings)	>=90%	?	Apr-22	85.2%	
Cancer	Cancer - 62 day referral to treatment (upgrades)	>=90%	?	Apr-22	90.9%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	?	Apr-22	2	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	?	Apr-22	73	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	F	Apr-22	18.75%	
Diagnostics	The number of planned/surveillance endoscopy patients waiting at month end	<=600	F	Apr-22	1,365	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	F	Mar-22	59.80%	
Emergency Department	ED: % total time in department - under 4 hours (type 1)	>=95%	F	Apr-22	54.52%	
Emergency Department	ED: % total time in department - under 4 hours (types 1 & 3)	>=95%	F	Apr-22	67.11%	
Emergency Department	ED: % total time in department - under 4 hours CGH	>=95%	?	Apr-22	65.44%	
Emergency Department	ED: % total time in department - under 4 hours GRH	>=95%	F	Apr-22	49.00%	

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		Apr-22	690	
Emergency Department	ED: % of time to initial assessment - under 15 minutes	>=95%	F	Apr-22	20.1%	
Emergency Department	ED: % of time to start of treatment - under 60 minutes	>=90%	F	Apr-22	19.6%	
Emergency Department	Number of ambulance handovers over 60 minutes	Zero	F	Apr-22	1,357	
Emergency Department	% of ambulance handovers < 15 minutes	>=65%	?	Apr-22	9.8%	
Emergency Department	% of ambulance handovers < 30 minutes	>=95%	?	Apr-22	21.1%	
Emergency Department	% of ambulance handovers 30-60 minutes	<=2.96%	F	Apr-22	13.3%	
Emergency Department	% of ambulance handovers over 60 minutes	<=1%	F	Apr-22	57.4%	
Maternity	% of women booked by 12 weeks gestation	>90%	?	Apr-22	90.8%	
Operational Efficiency	Number of patients stable for discharge	<=70	?	Apr-22	233	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	?	Apr-22	515	
Operational Efficiency	Average length of stay (spell)	<=5.06	?	Apr-22	6.6	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	?	Apr-22	7.9	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	?	Apr-22	2.1	
Operational Efficiency	% day cases of all electives	>80%	?	Apr-22	82.3%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%	?	Apr-22	87.5%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	?	Apr-22	76.9%	
Operational Efficiency	Urgent cancelled operations	No target		Apr-22	0	

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.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Outpatient	Outpatient new to follow up ratio's	<=1.9		Apr-22	2.03	
Outpatient	Did not attend (DNA) rates	<=7.6%		Apr-22	7.5%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%		Mar-22	7.1%	
Research	Research accruals	No target		Apr-22	93	
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Apr-22	71.32%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Apr-22	5,513	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Apr-22	2,444	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Apr-22	1,233	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	Zero		Apr-22	130	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Apr-22	69.2%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Mar-22	96.3%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Apr-22	69.2%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Apr-22	72.4%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Apr-22	24.30%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Apr-22	24.3%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
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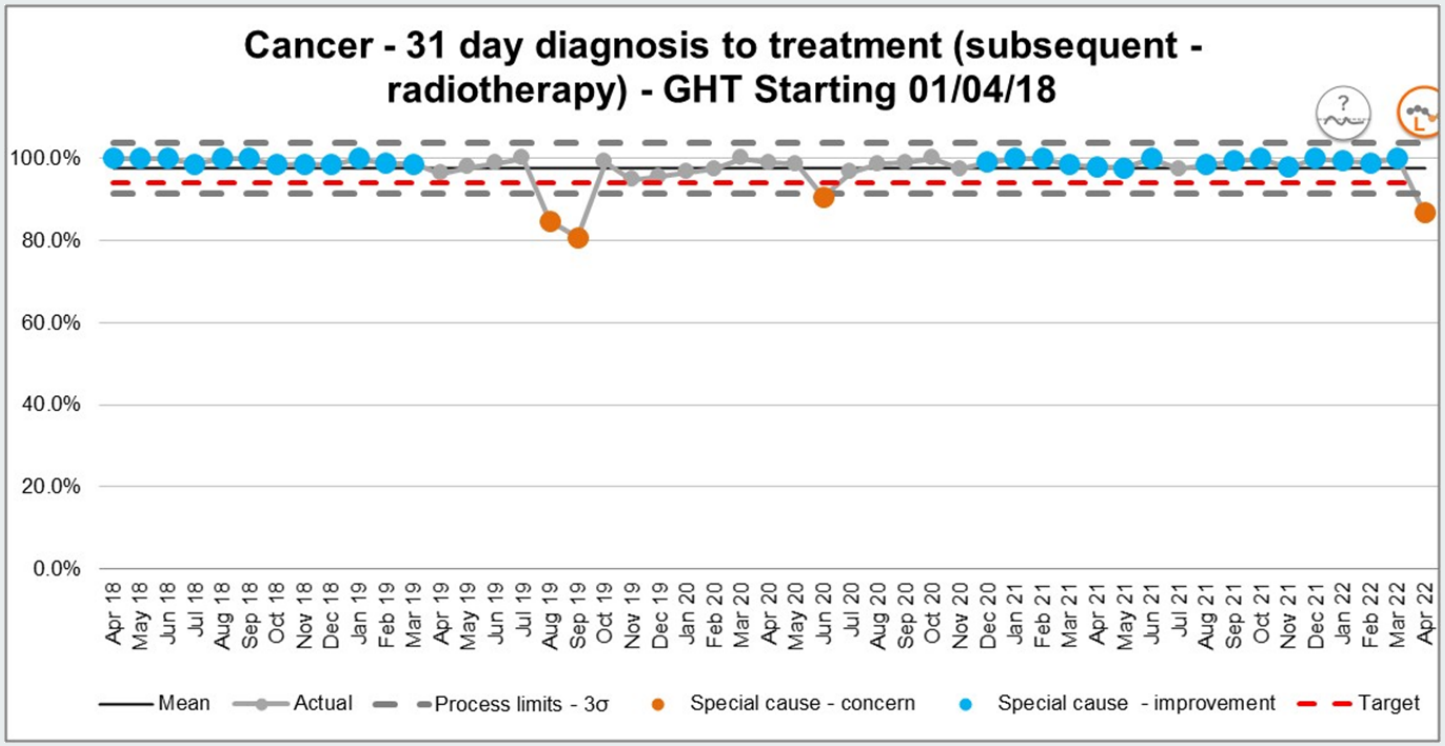


Commentary

Standard = 94%
National = 93%
GHFT = 87.7%
92 treatments and 12 breaches
RT capacity impacted by radiographer vacancies. Workforce paper worked up to implement golden handshakes and potentially re-banding staff to come in line with regional and national radiographer banding levels. Backlog has been prioritised and being overseen by Oncologist with weekly clinical review.

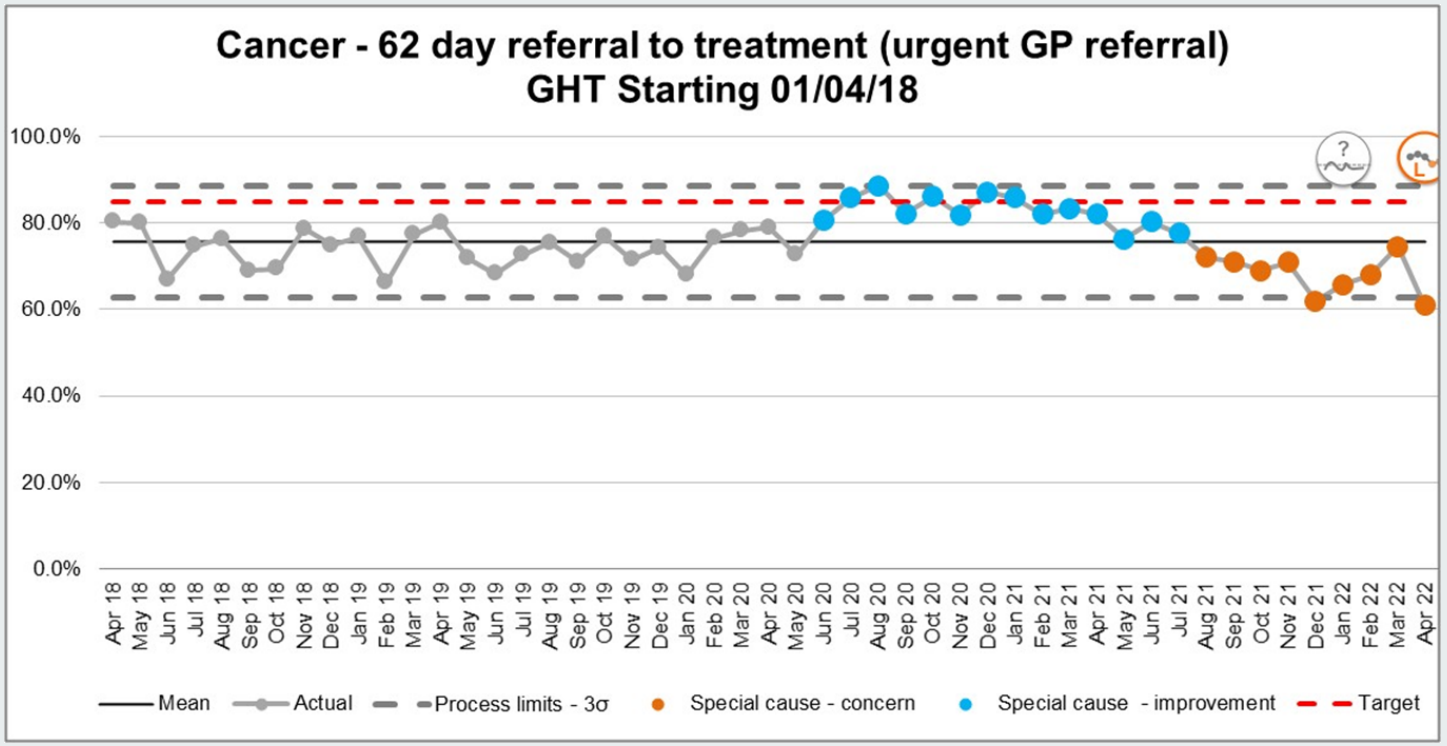
- General Manager - Cancer

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 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 the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Standard = 85%
National = 67%
GHFT = 61.7%
117.5 Treatments
45 breaches Uro 18; LGI 10; Gynae 5; Haem 4 (21 breaches related to >104 day clearance)
LATP biopsy delays, PET scan delays both impacting on pathways
62 day recovery plan in formulation
Number of treatments recorded still low so performance should improve
- 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 and below the mean.
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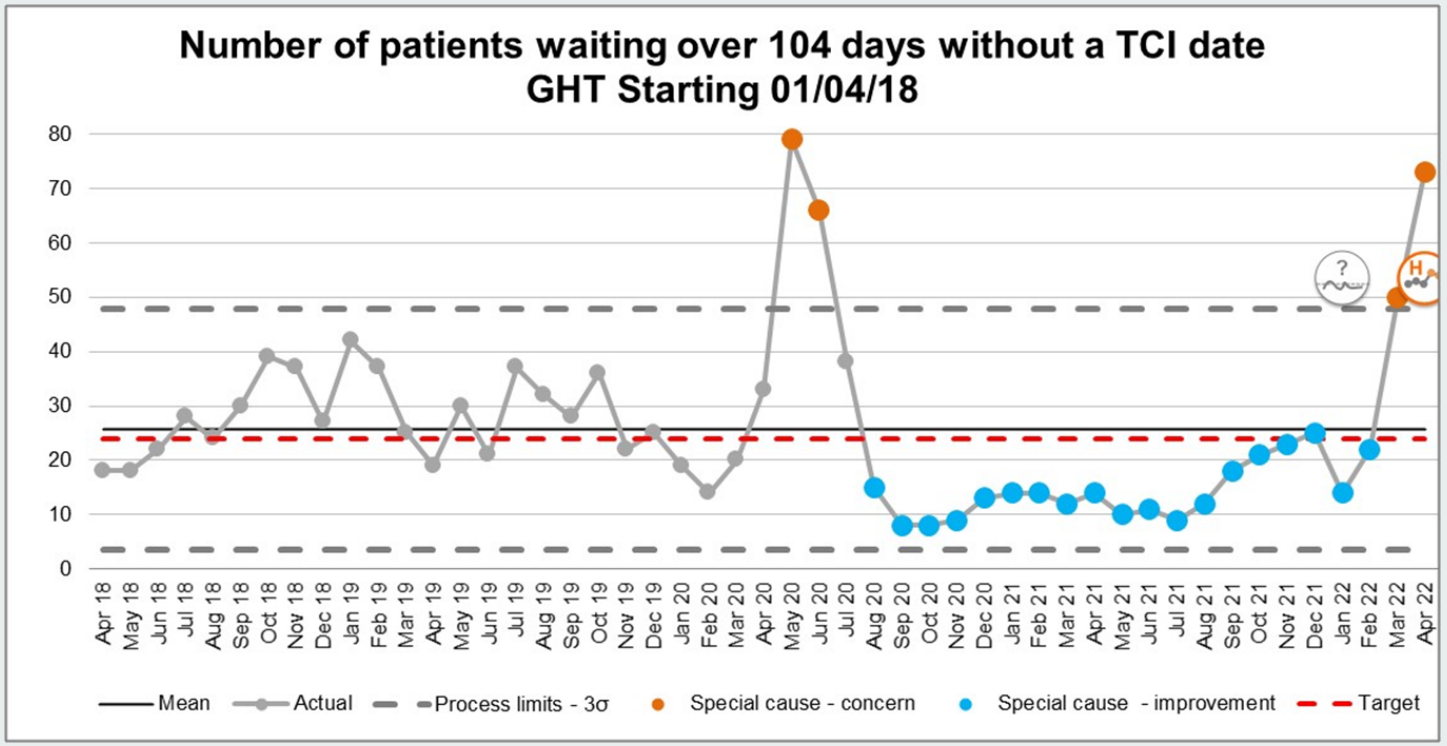

Commentary

77 patients >104 days
Uro 55; LGI 15; UGI 3; Other 2; Lung 1; Haen 1

8 TCI's agreed
6 referred in late from other hospital
Majority of backlog associated with delays to LATP biopsy

- 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 4 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.
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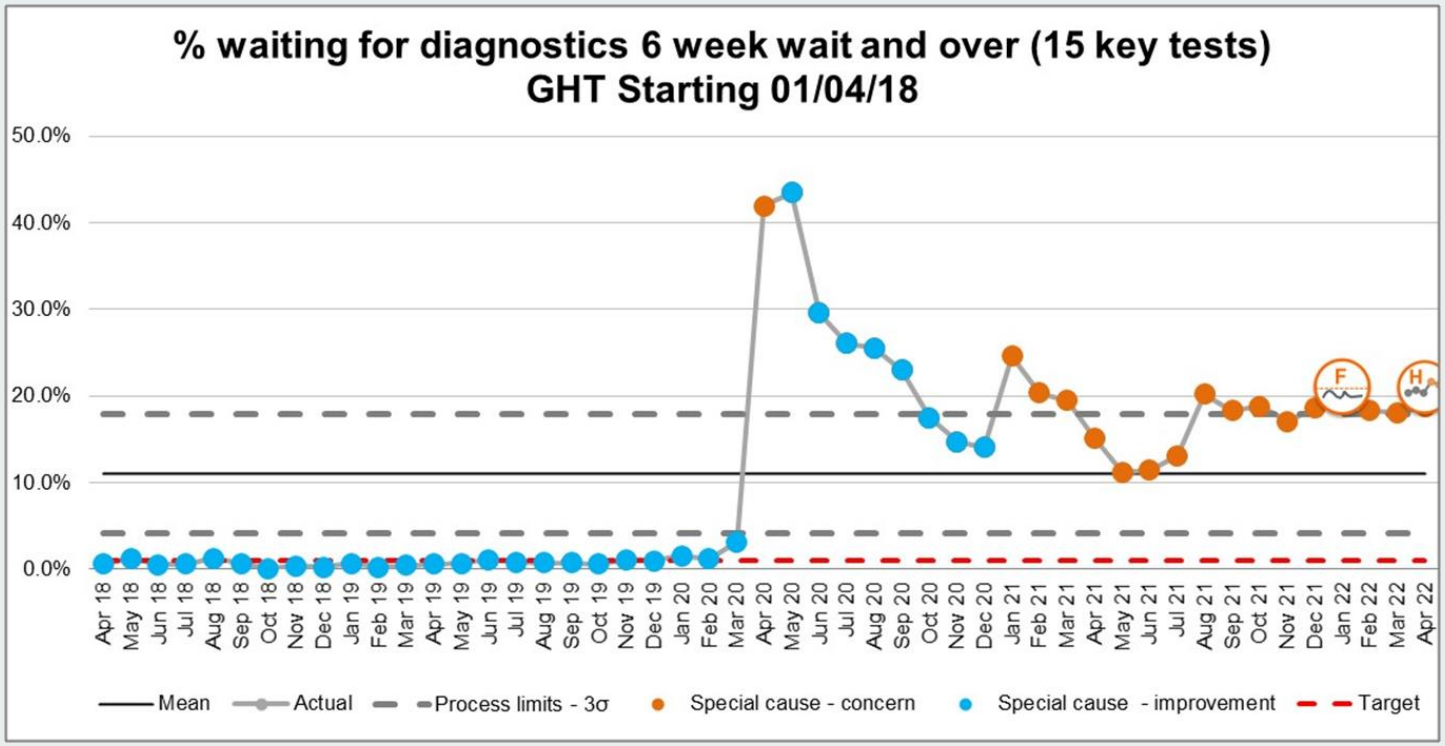

Commentary

Diagnostic performance has largely remained the same as last month, moving from 18.03% to a validated position of 18.77% this month. Over the past few months performance has remained around the 18-20%, and for the majority of modalities performance is consistent with relatively small number of breaches. However, this month we have seen all of the Endoscopy modalities deteriorate with an increase of breaches.
As per previous months Echos continue to be the most challenged area and despite a 1.78% improvement in month, 1,500 patients exceed 6 weeks at month end.

- 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 17 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
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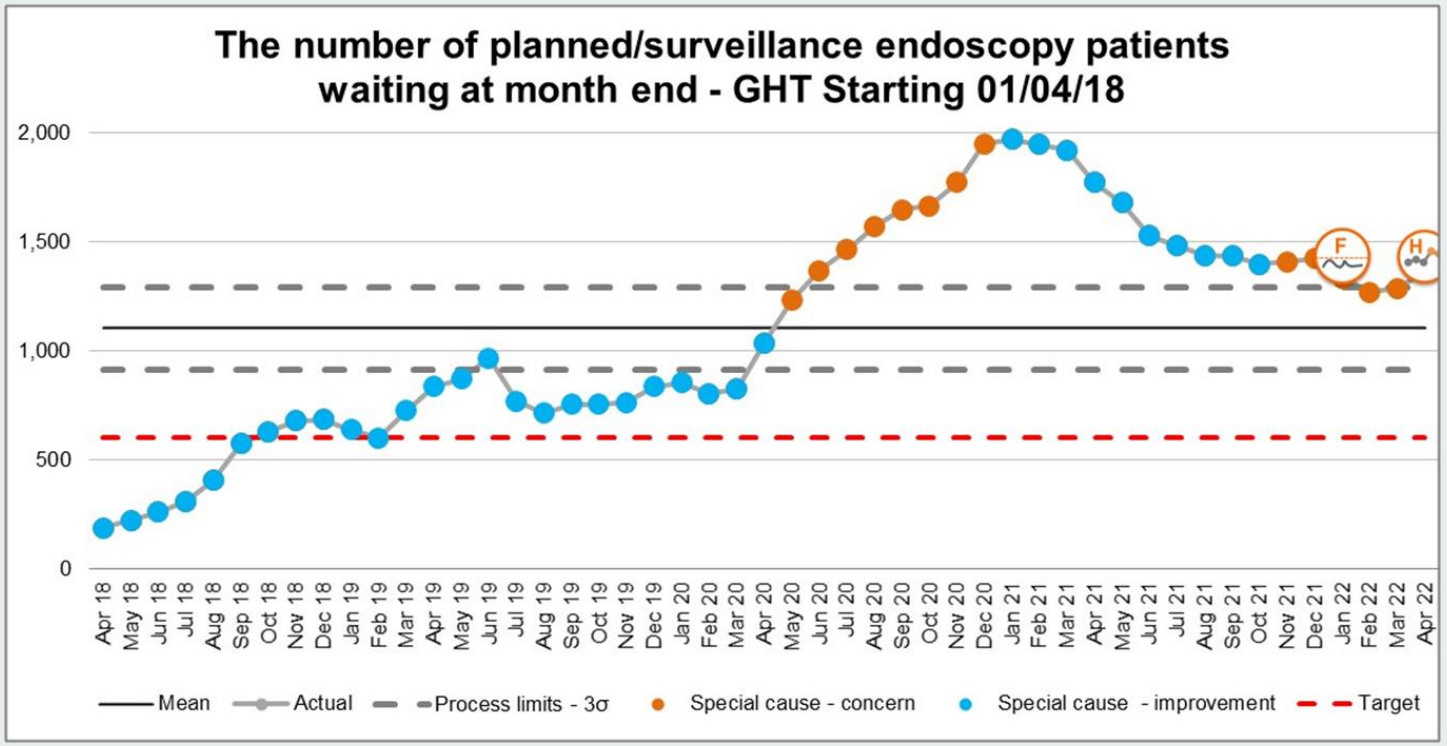

Commentary

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 has increased slightly due to the reduction in capacity of the academy build, it is expected to reduce in the coming months through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and additional carved out capacity in month.

- Deputy General Manager of Endoscopy

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 21 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
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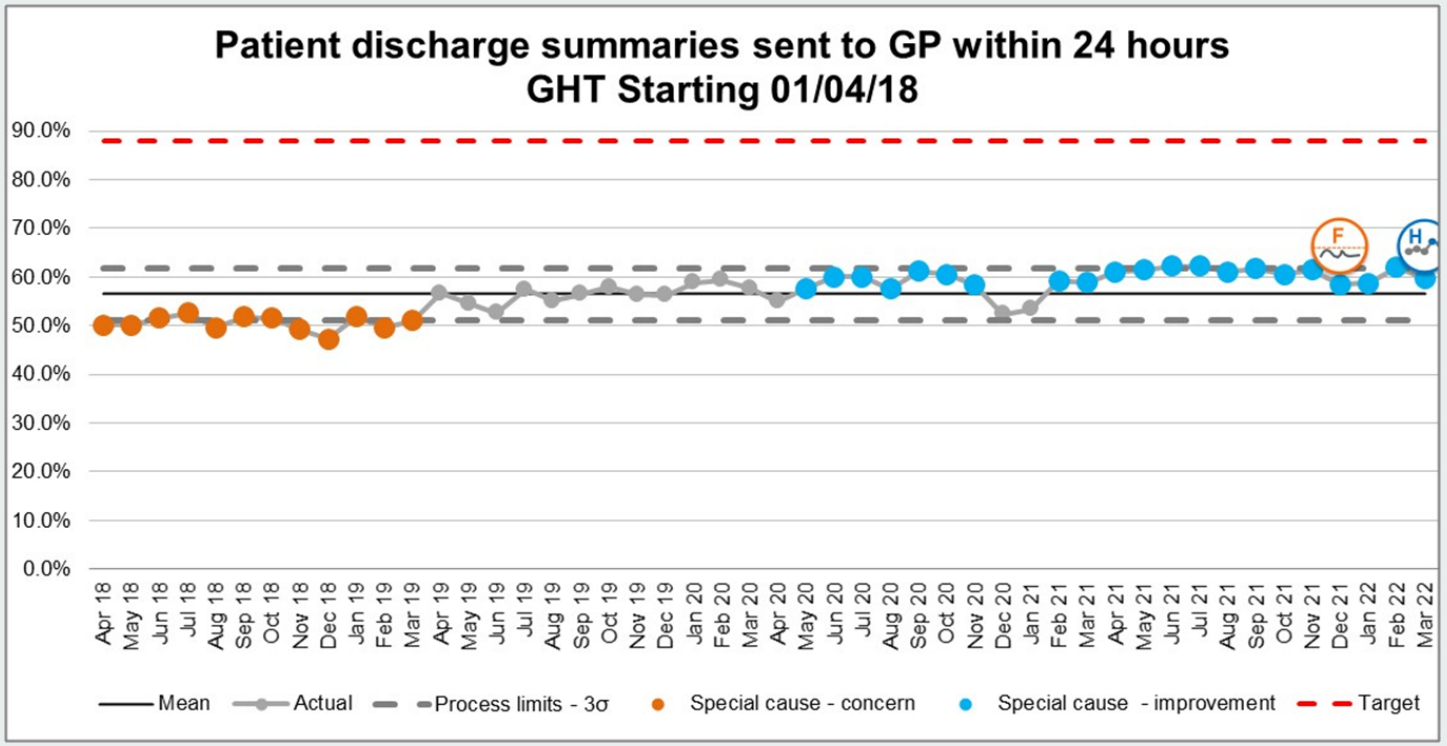

Commentary

No significant change. Issues remain that await EPMA implementation.

- 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 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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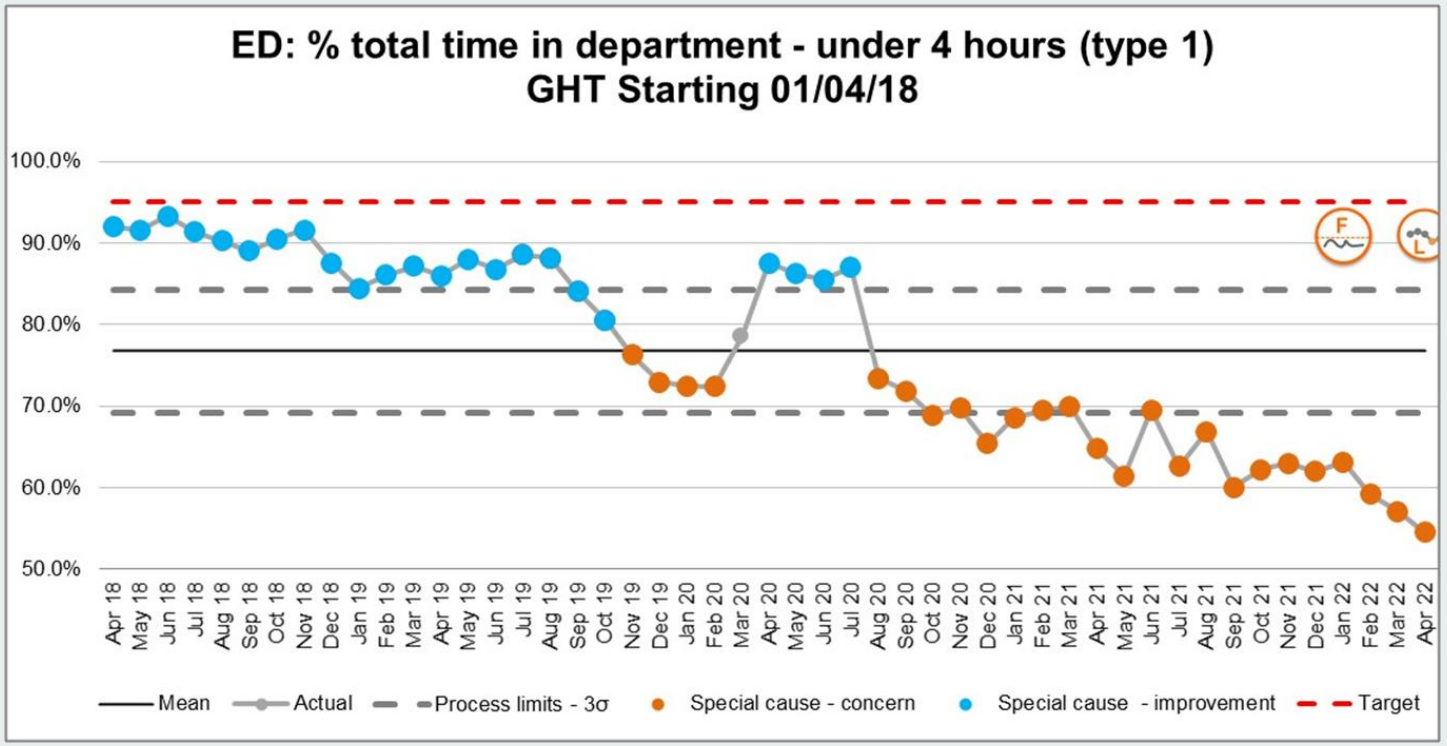

Commentary

This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision.

- 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 21 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 falling points
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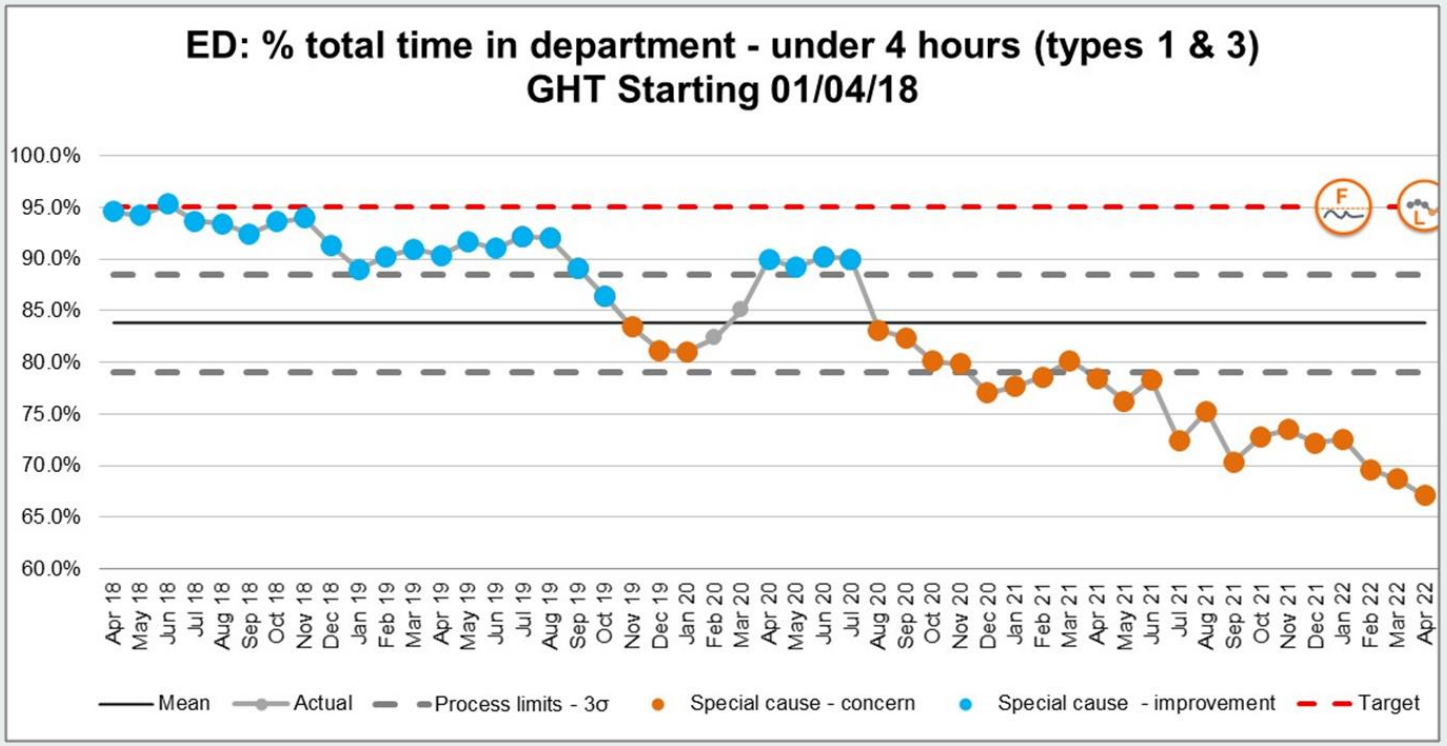

Commentary

This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 22 data points which are above the line. There are 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
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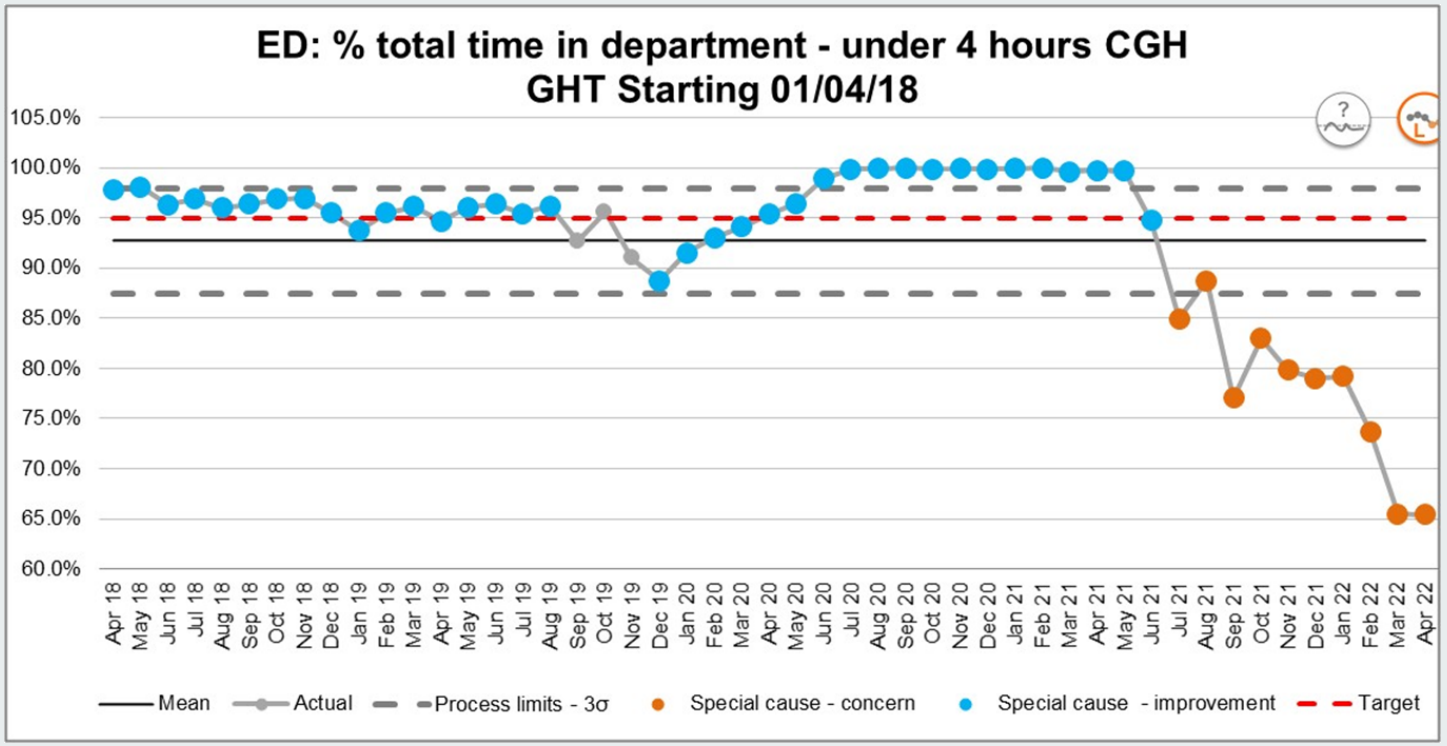

Commentary

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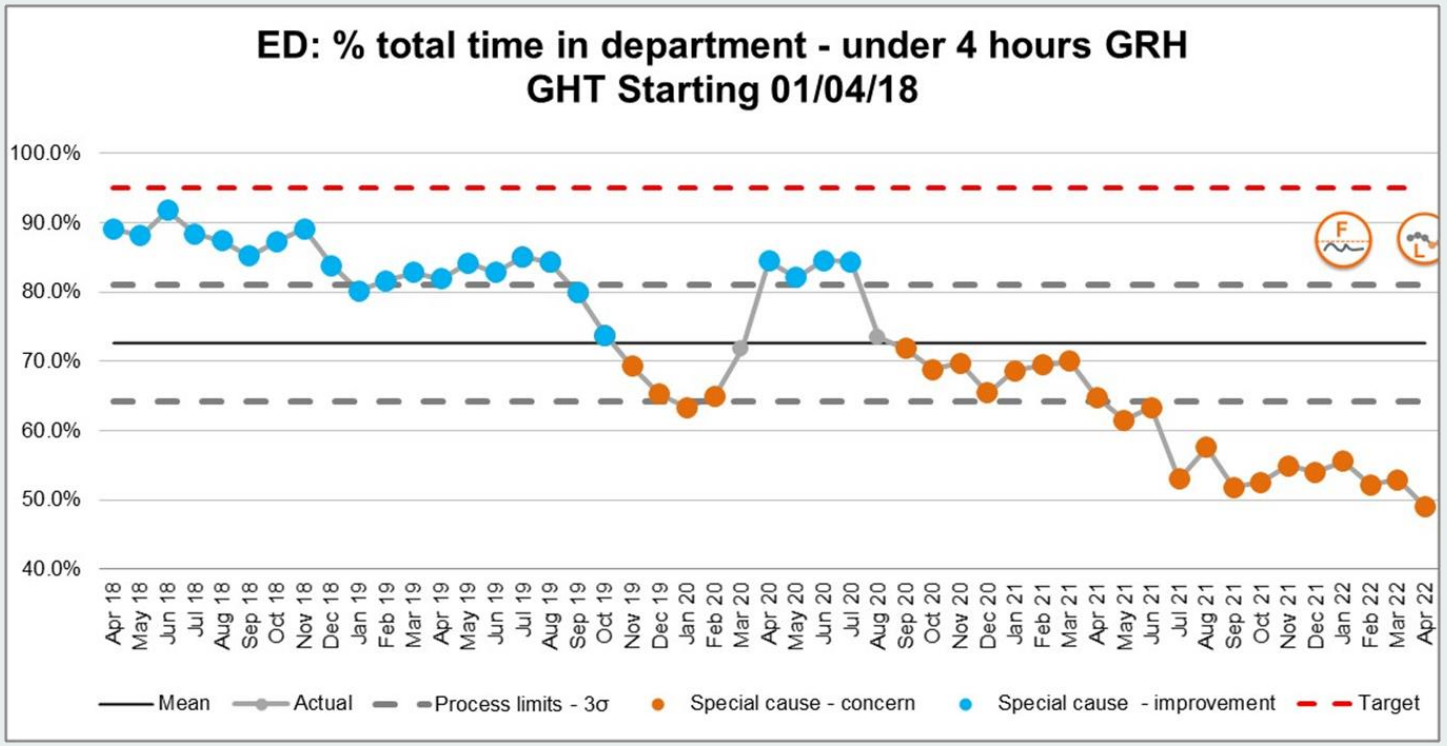
- General Manager of Unscheduled Care

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

This has been largely attributable to consultant sickness, which has run to 13.5% in the last month, and ENP sickness of 3.4% but Covid 19 unavailability of 5.61% challenged the continuity of Service provision.

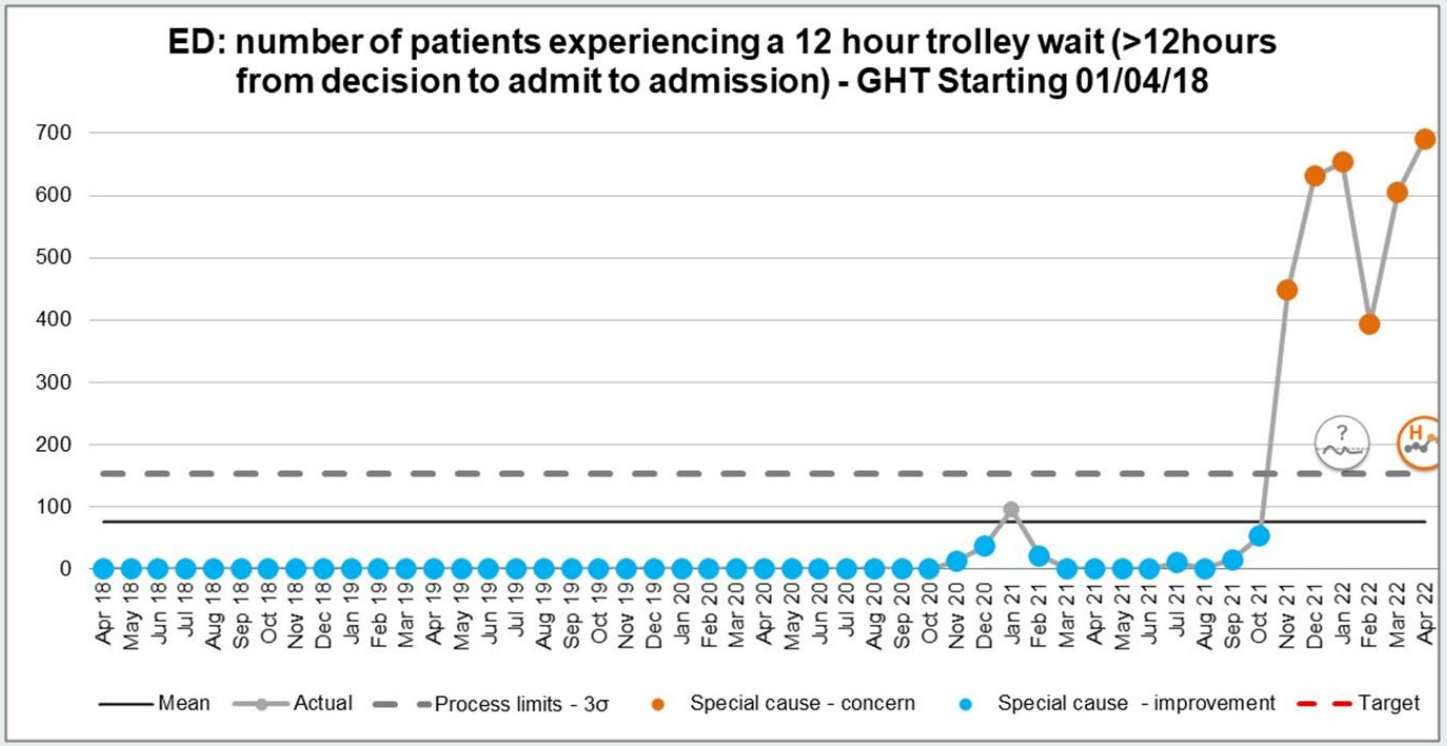
- General Manager of Unscheduled Care

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 20 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 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

This is also due to a slowing in the rate of patients medically fit for discharge, across the month, meaning a shortage of beds and thus prolonged trolley waits for the available beds.

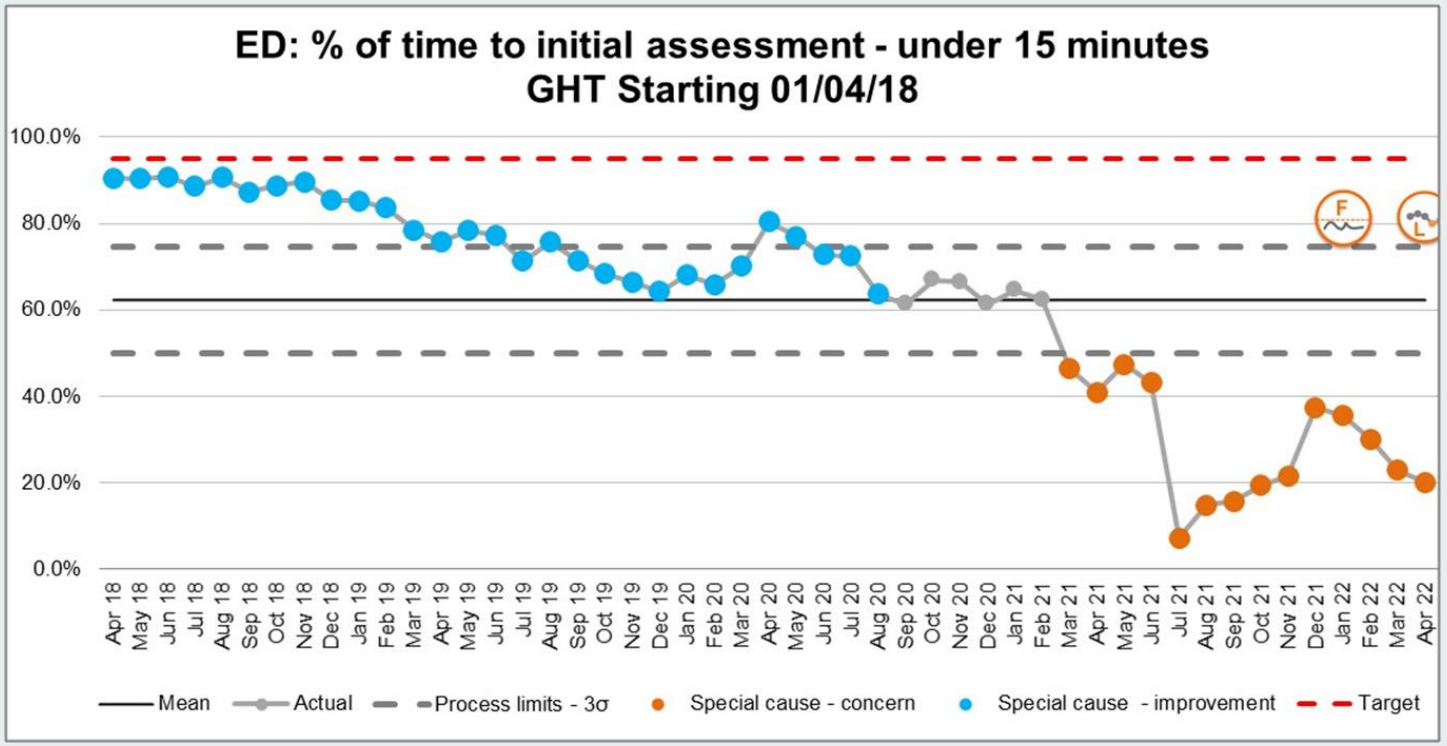
- General Manager of Unscheduled Care

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.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

This is also due to a slowing in the rate of patients medically fit for discharge, across the month, meaning a shortage of beds and thus prolonged trolley waits for the available beds.

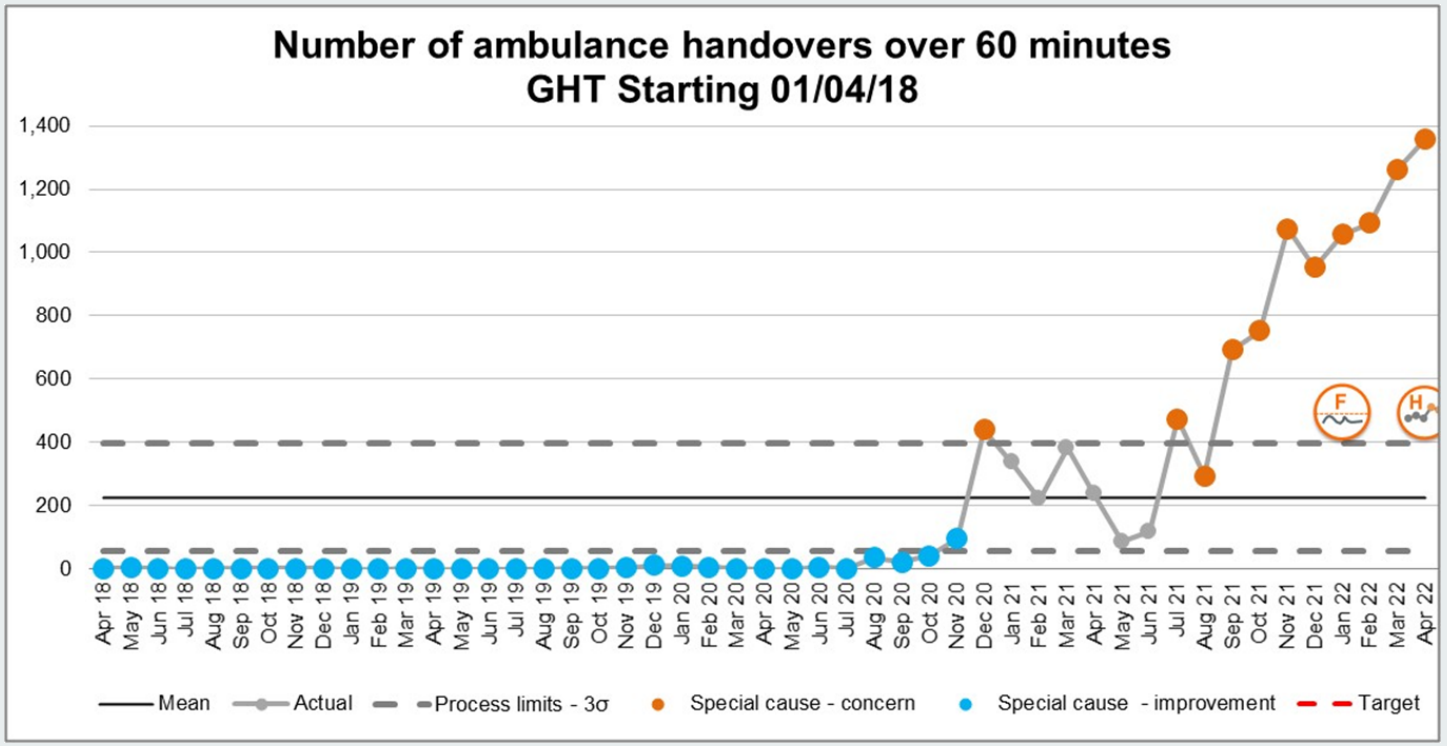
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 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.
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

The number of patients seen and treated in our SDECs reduced slightly in April while the conversion rate to admissions increased by 2%, putting more pressure on the front door.

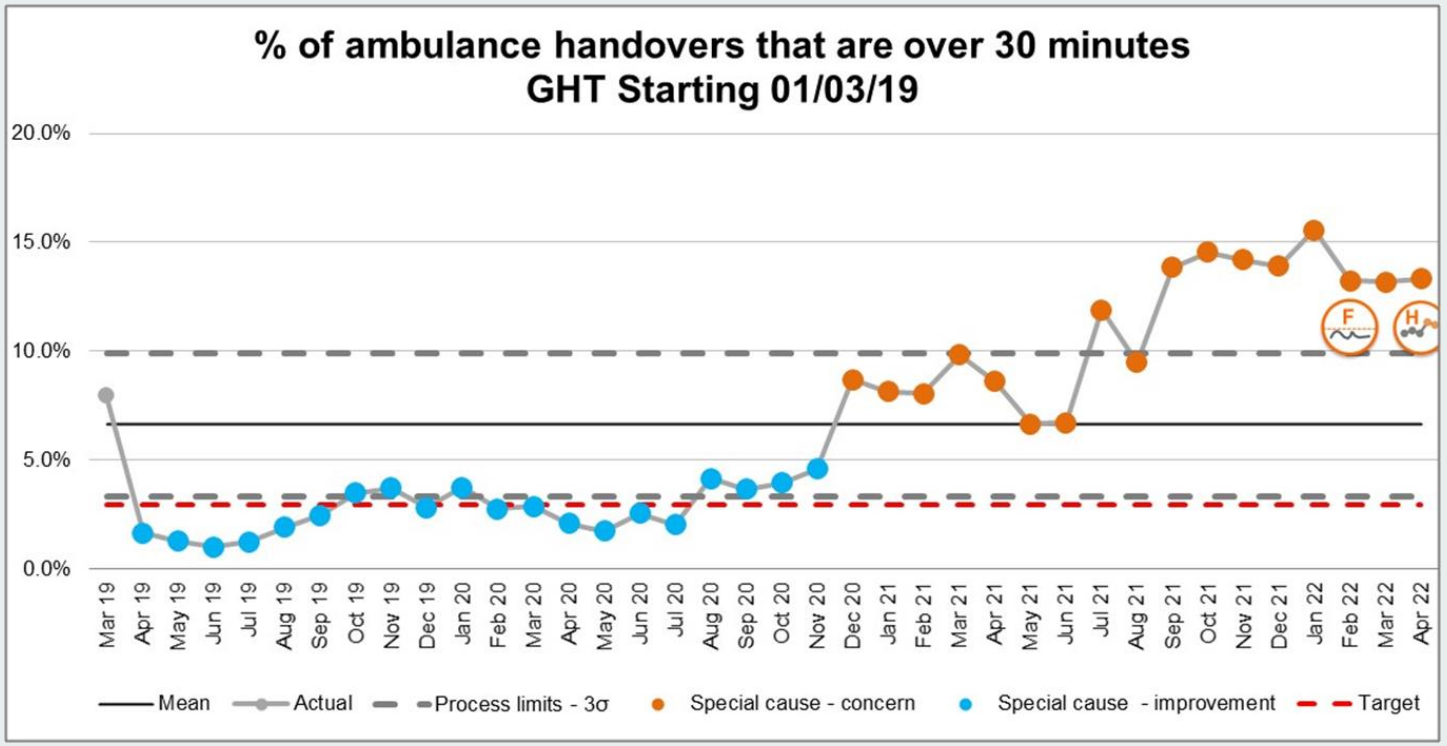
- General Manager of Unscheduled Care

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 10 data points which are above the line. There are 31 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

The number of patients seen and treated in our SDECs reduced slightly in April while the conversion rate to admissions increased by 2%, putting more pressure on the front door.

- 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 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.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
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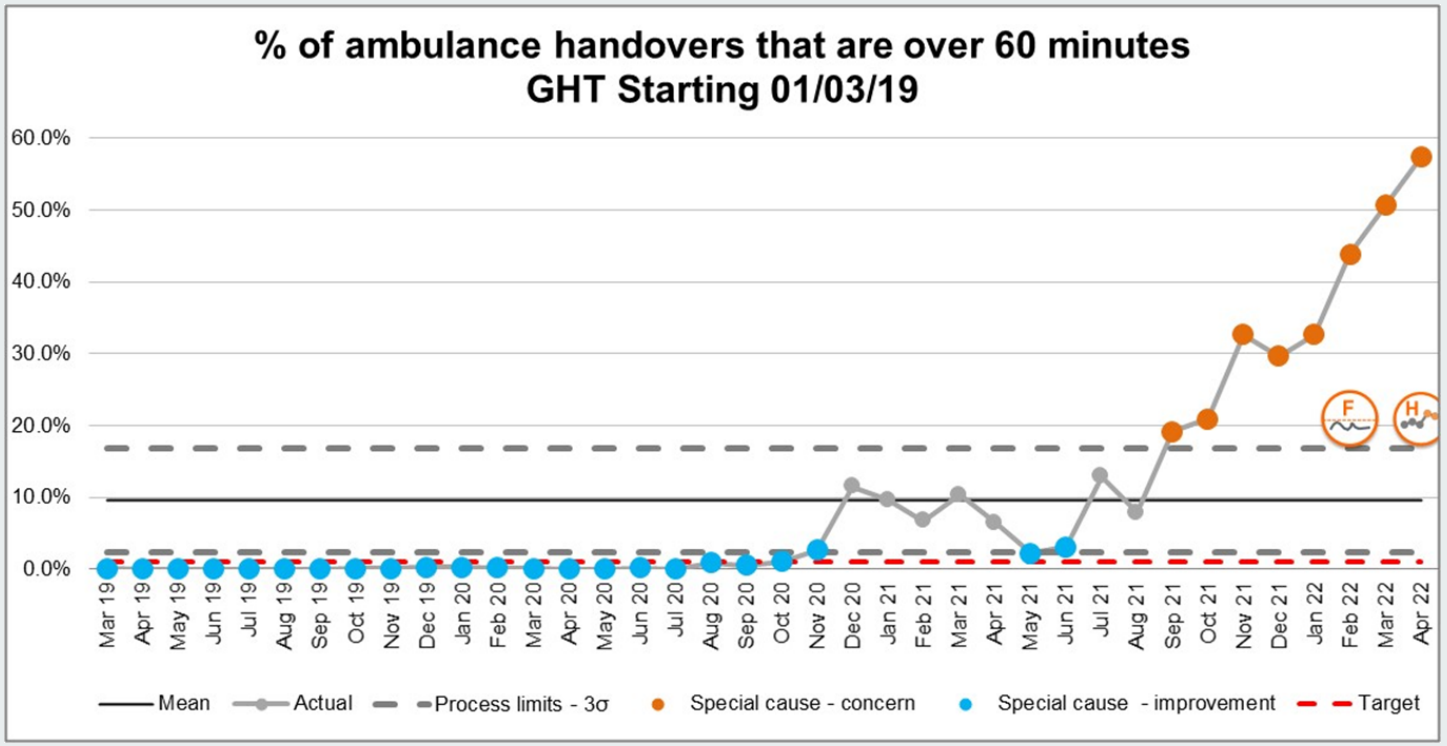
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The number of patients seen and treated in our SDECs reduced slightly in April while the conversion rate to admissions increased by 2%, putting more pressure on the front door.

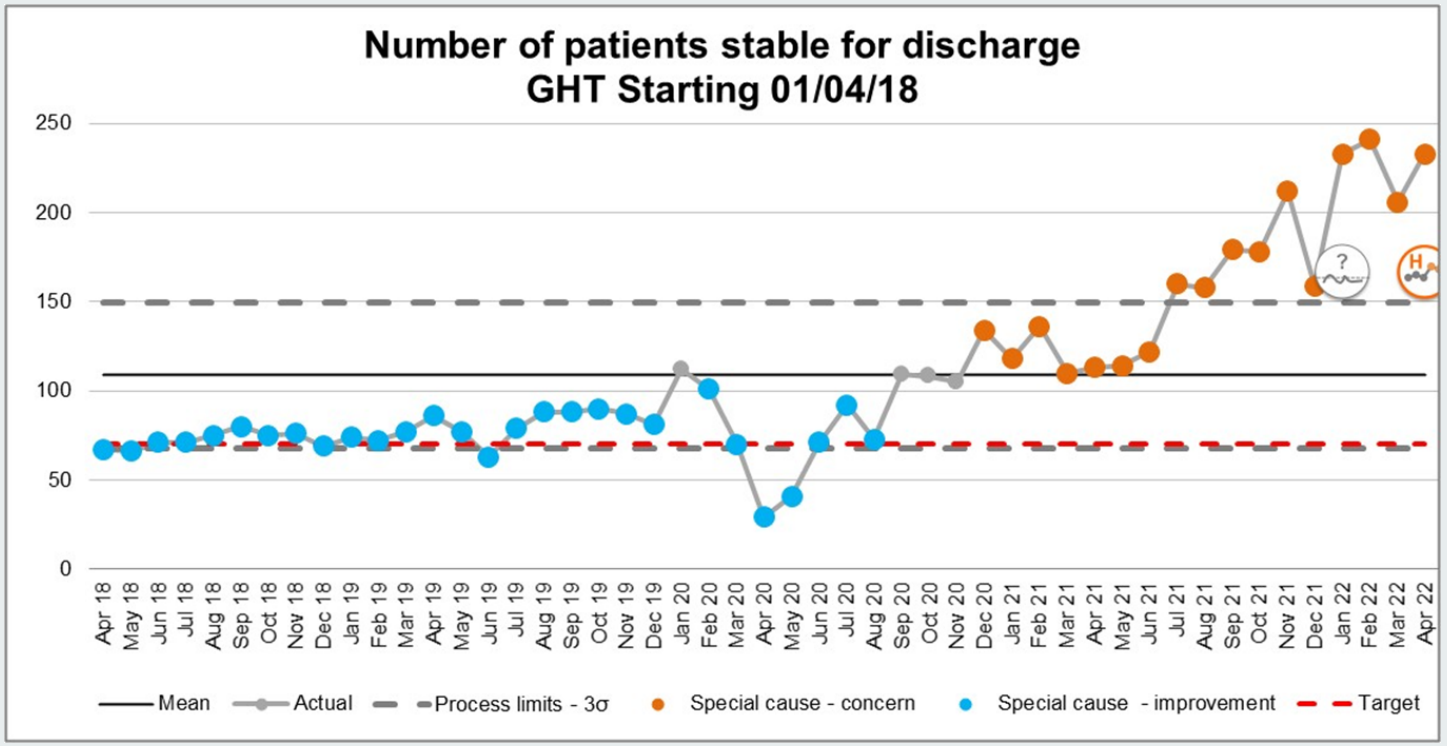
- General Manager of Unscheduled Care

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 7 data points which are above the line. There are 20 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Current nCTR number 234. This remains far to high, but there has been significant improvement in line with ICS improvement plan agreed at beginning of March. nCTR have reduced from 272, whilst the 10+ day wait numbers have reduced from 163 to 118 at this point. Further conversations happening around further plans to reduce further, aiming for nCTR of 166 and 10+ day waits of less than 60.

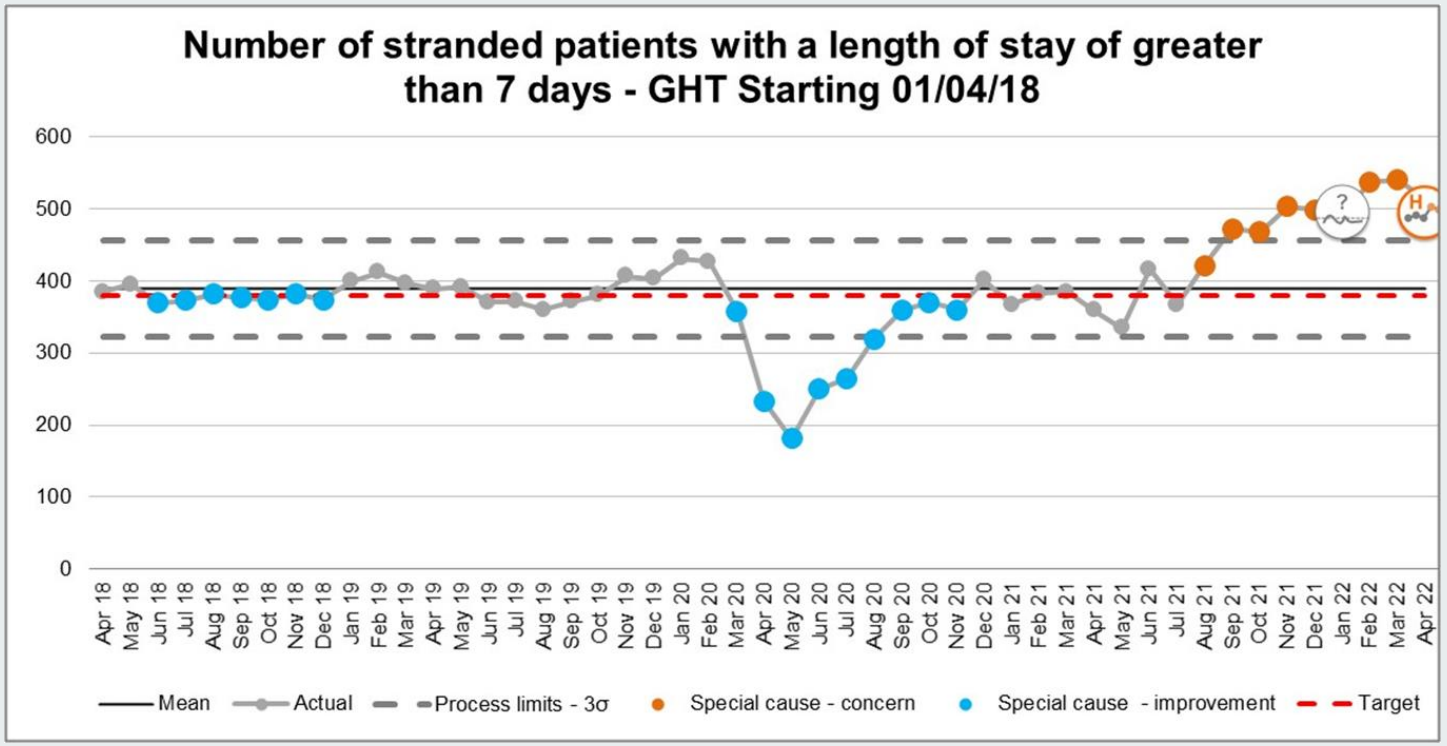
- Head of Therapy & OCT

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 10 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.
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

The number of stranded patients with a lengths of seven days decreased slightly, from 540 to 515. The 21/22 average stands at 451, which is a 16% variance from target. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust have a robust grip on the position, and have co-ordinated discharge efforts in order to help discharge these patients where possible. The trust have been working with local commissioners to formulate plans which include the provision of discharge budgets, use of Pathway teams targeting stranded patients, speciality inreach to ED and daily ward rounds. These plans are expected to progress at pace.

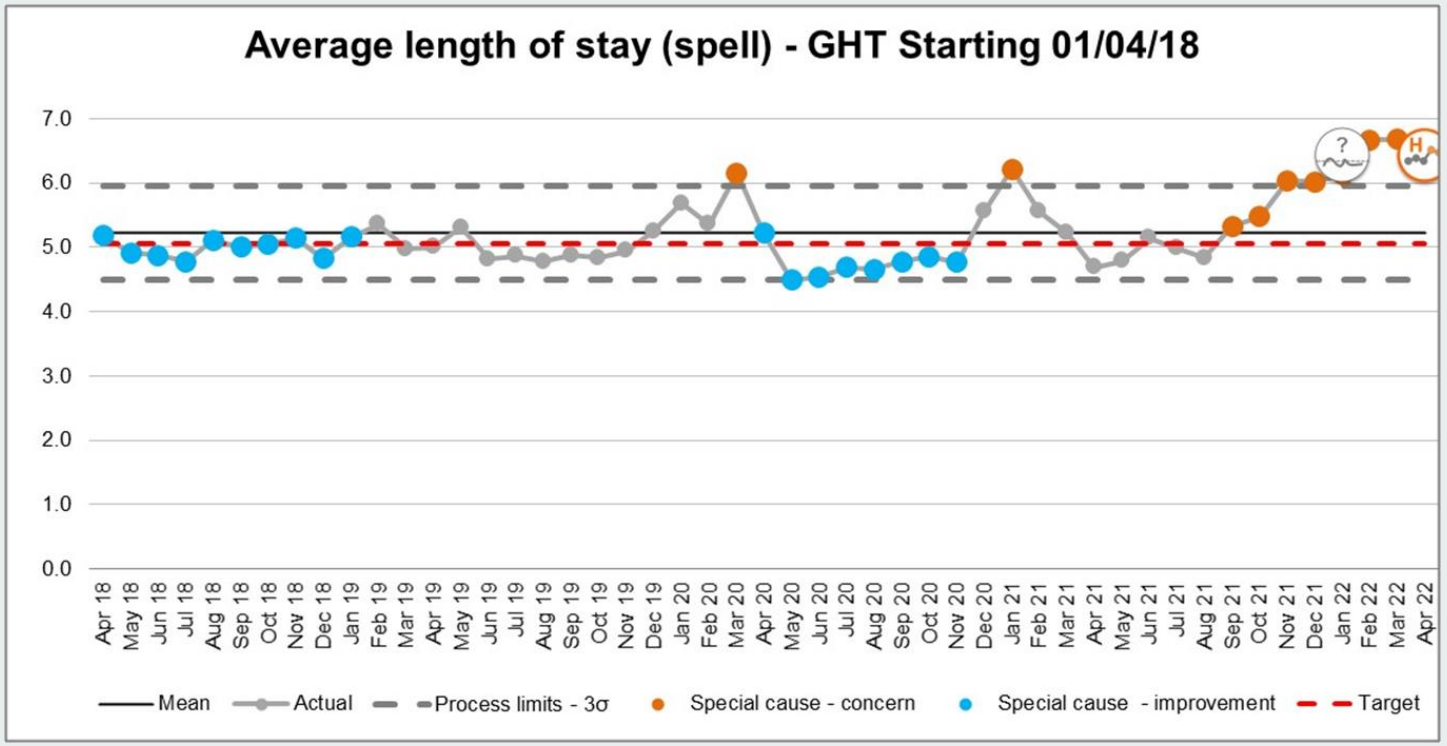
- Deputy Chief Operating Officer

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 8 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.
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

There has been a slight decrease in the ALOS of 0.75%. There are no remarkable factors affecting this decrease.

- 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 8 data points which are above the line. 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 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:
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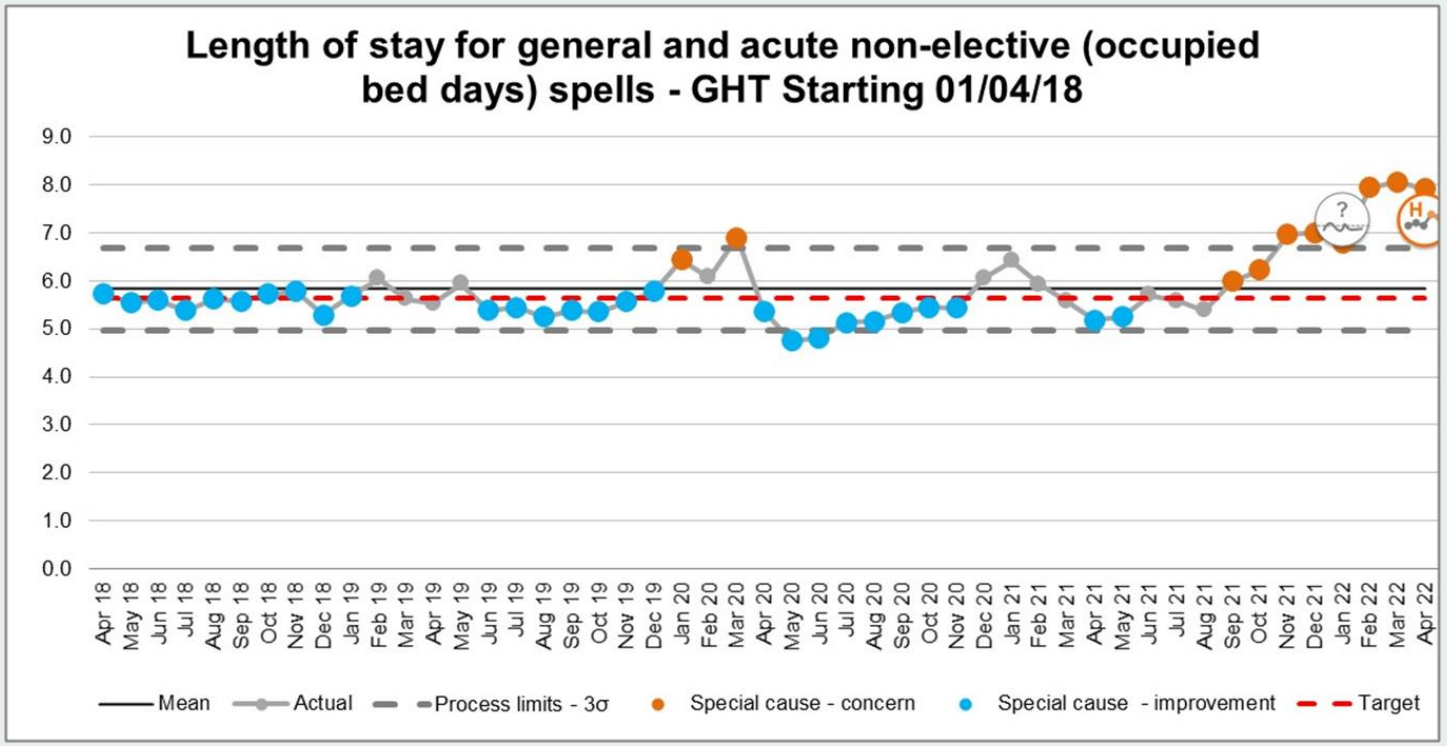
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The position remains relatively stable and unchanged from the previous month decreasing by 0.15 bed days. There are no remarkable factors affecting this indicator at this time.

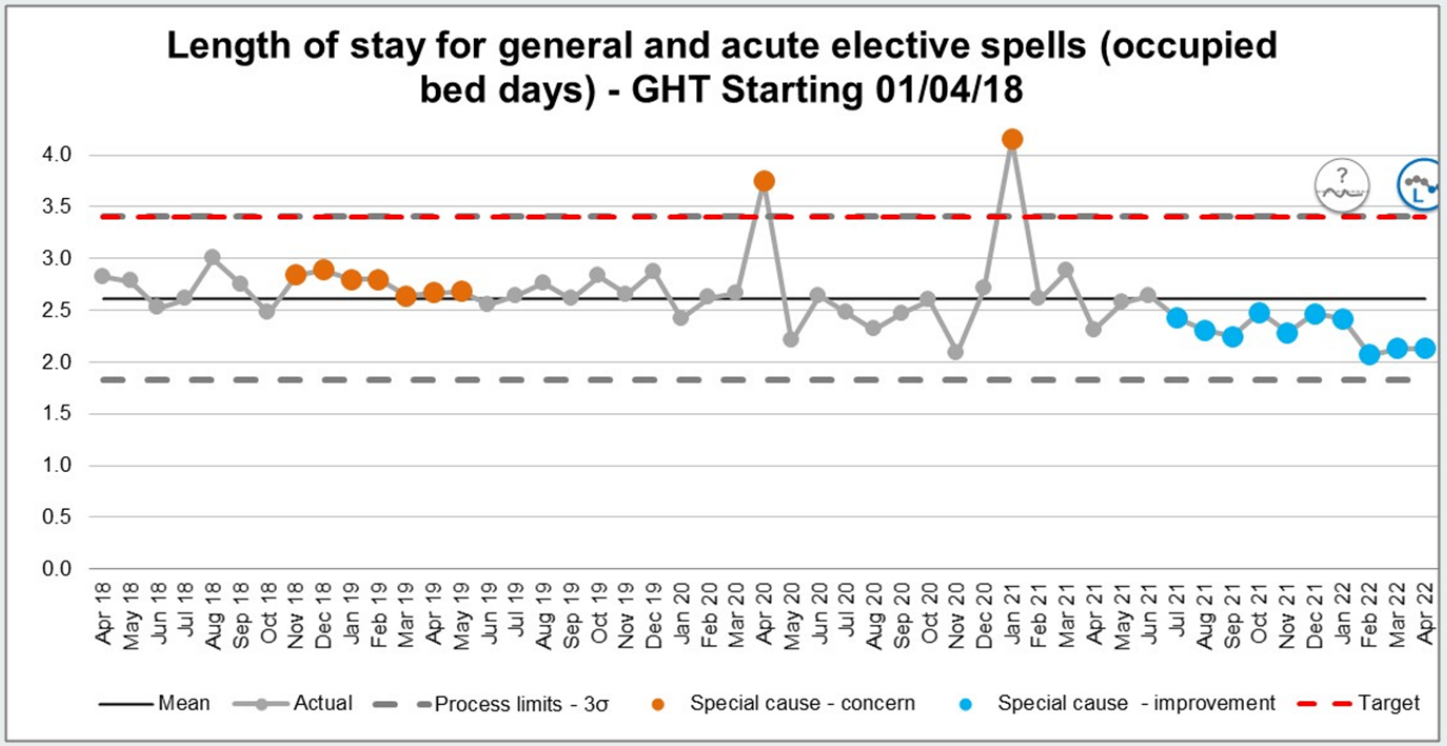
- Deputy Chief Operating Officer

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 7 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.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

This metric has remained the same from last month with a stabilised position. There is a need for some specific actions to drive down LoS as escalation beds are reduced and focus returns to maintaining elective capacity and delivery of 22/23 operational plan. There is a likely to be a positive impact as daycase activity increases and expands.

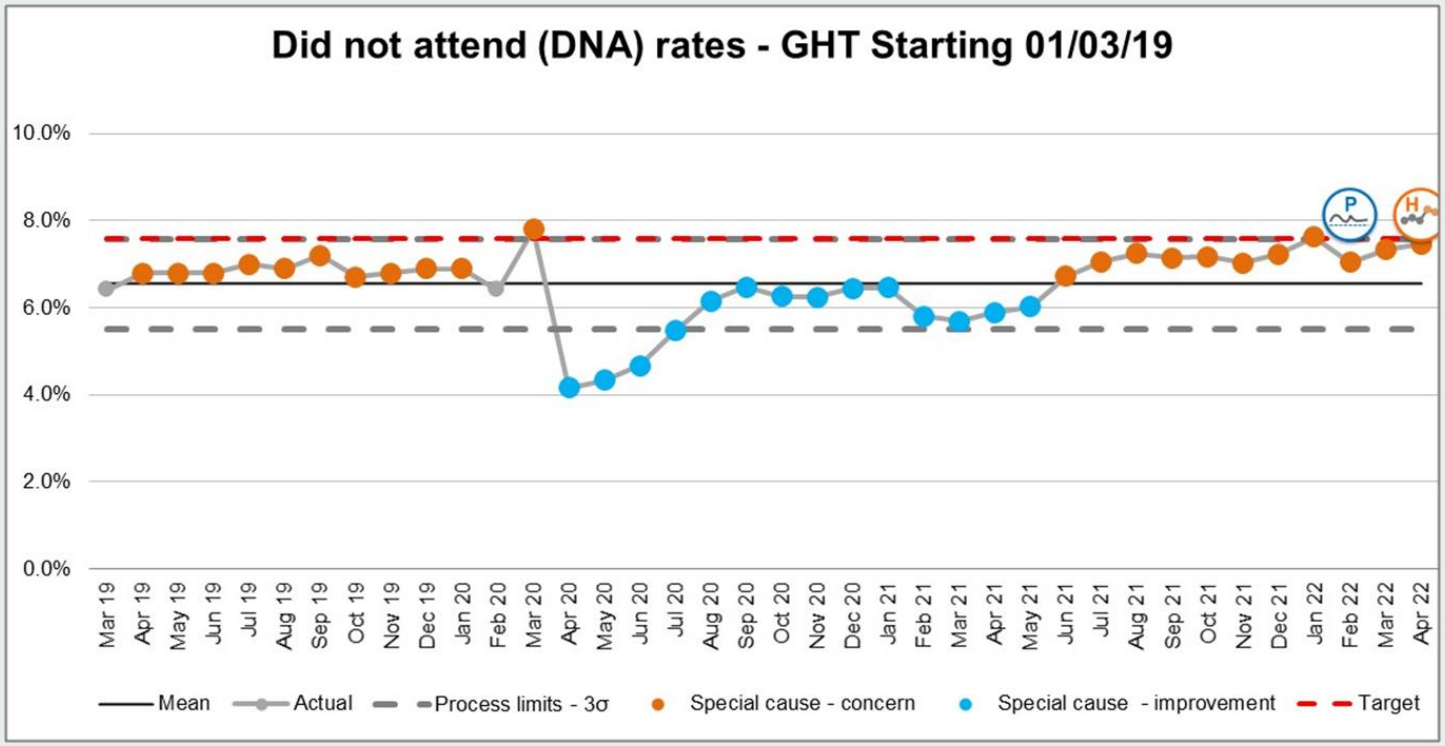
- Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The DNA rate remains within target, albeit again slightly increased to 7.46%. With the exception of one month, the DNA rate has been within target all year. Text reminder service resumed for CBO booked services on 3 May so improvement in following month anticipated.

- 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 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 the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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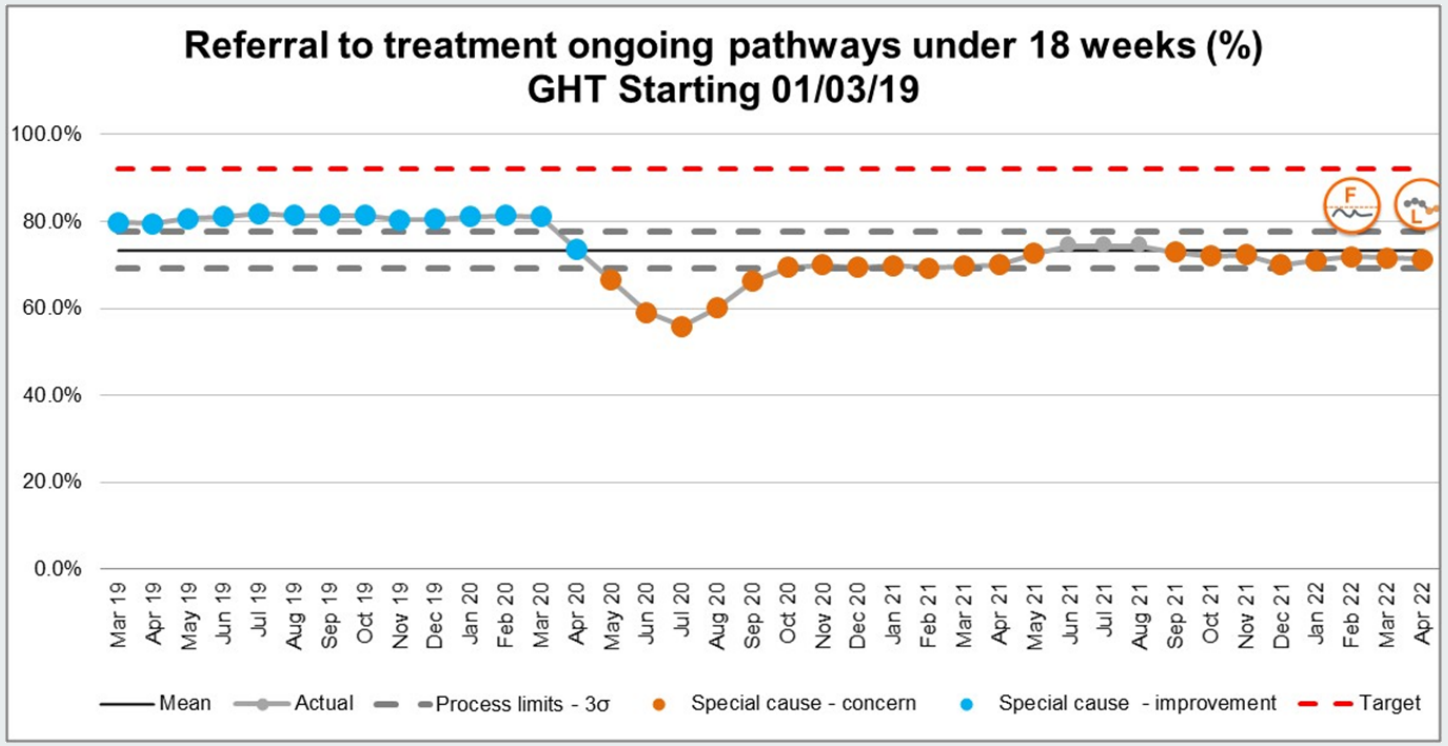
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

See Planned Care Exception report for full details. Although RTT performance is reported at time of report a slight improvement in month-end performance is anticipated, at around 71.75%. GHT remains one of the better performing Trusts within the South West. In addition, RTT performance nationally would appear to around 63% so GHT remains above.

- 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
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.
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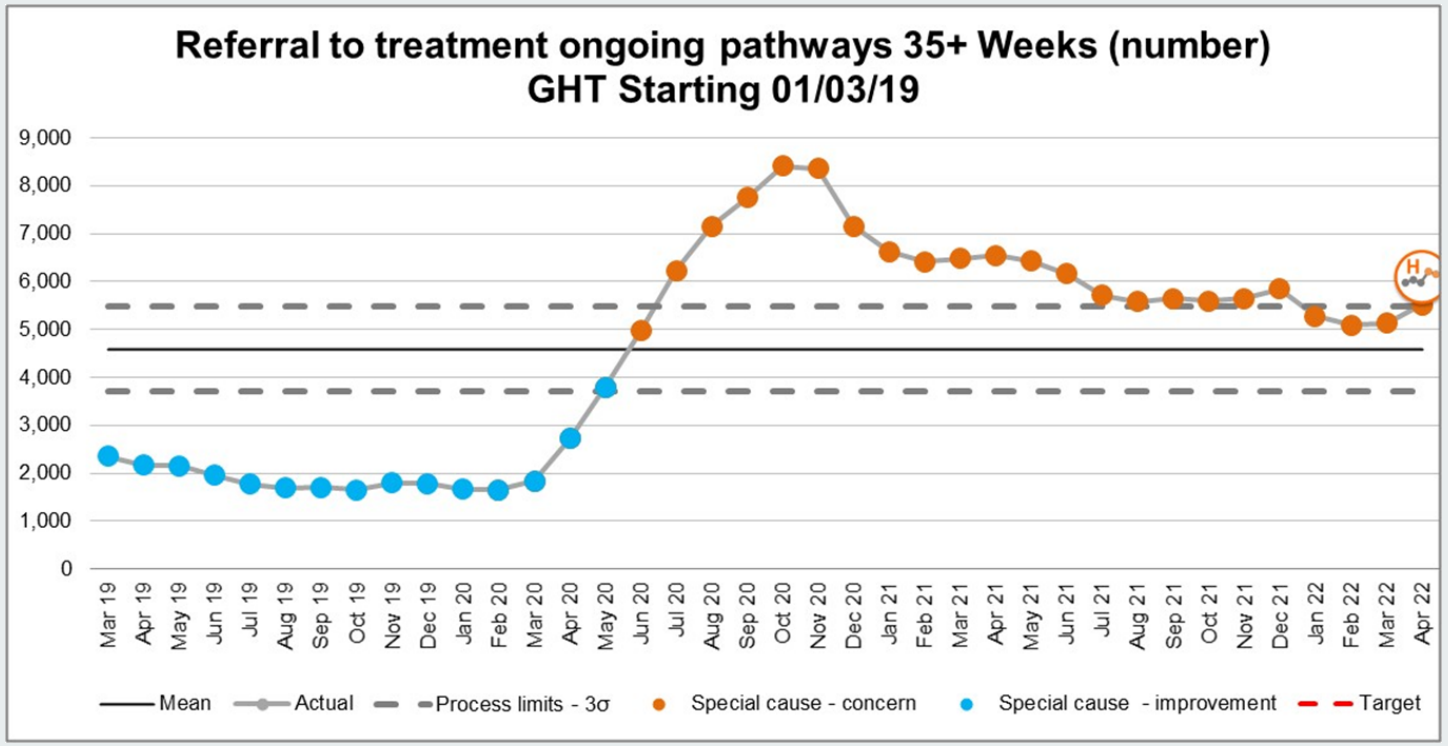

Commentary

A sizeable increase of around 400 patients in month, partly due to the focus on the long waiters but also a known increase in referrals around 12 months ago.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 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
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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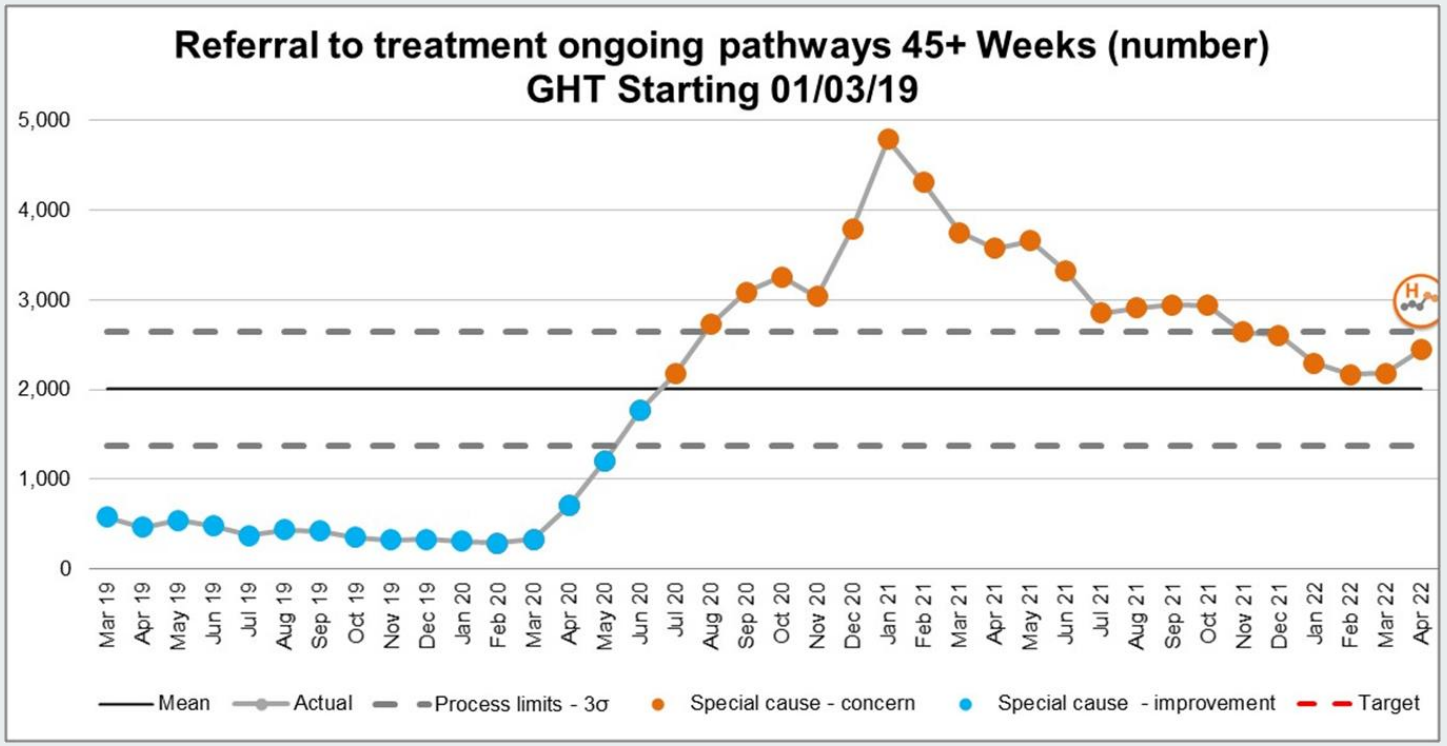
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

An increase of around 250 patients in month.

- Associate Director of Elective Care

Data Observations

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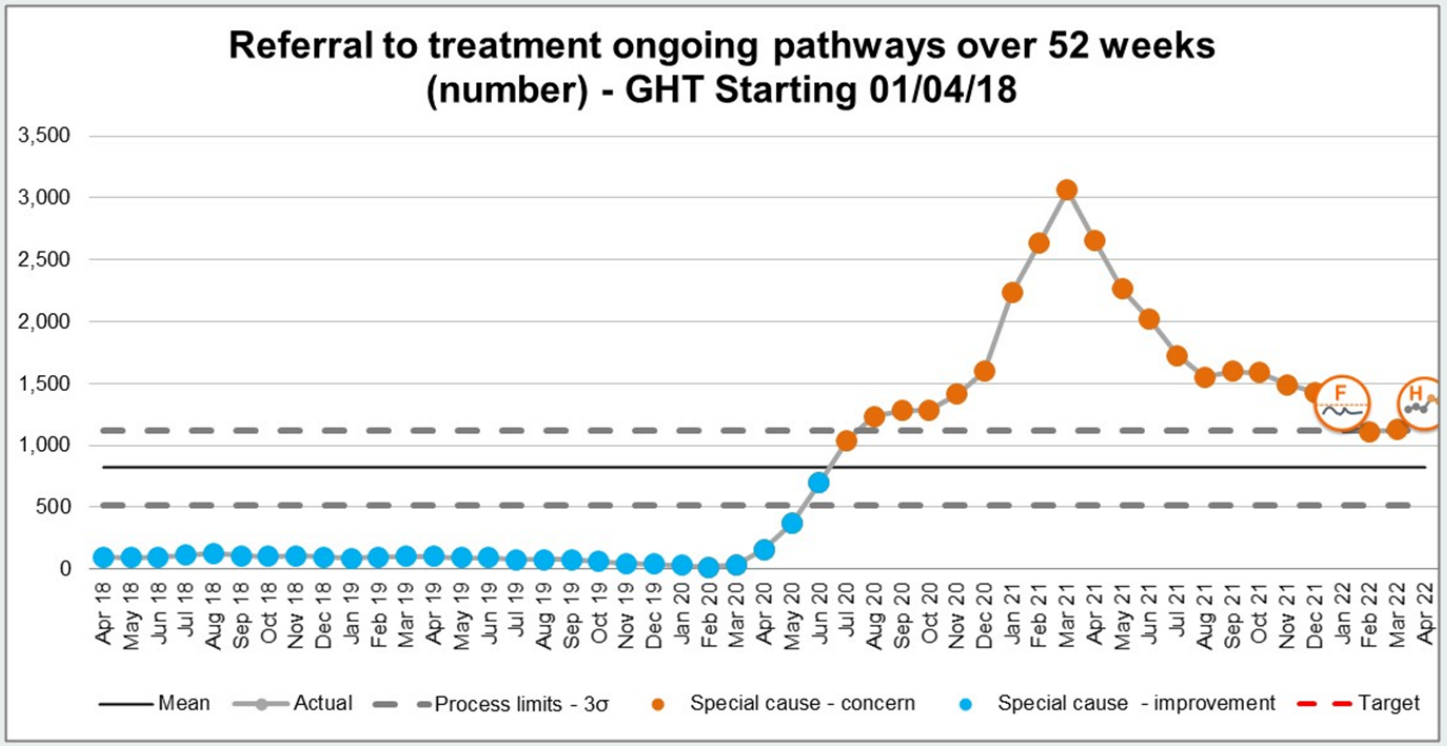

Commentary

See Planned Care Exception report for full details. An approximately increase of around 100 patients which is not anticipated to change with 3 days of validation remaining.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 20 data points which are above the line. There are 26 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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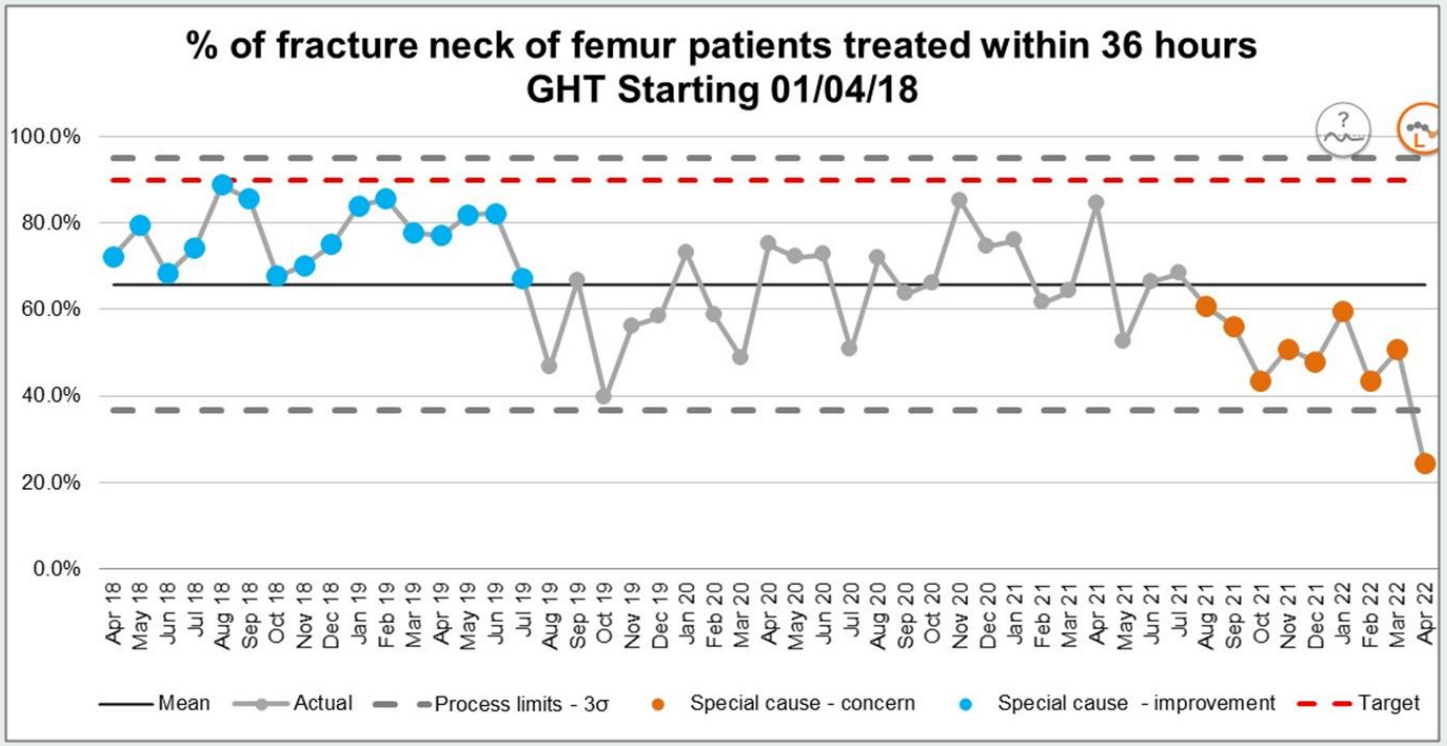

Commentary

- Only 27% of patients got to theatre within 36 hrs
- 73% of patients failed to get to surgery within 36 hours (of which 67% of patients were delayed because of logistical reasons)

Patients are waiting in ambulance for 6-12hrs and then in ED for a bed. The patients can be waiting 24-40 hrs before going to a ward.
Pressure sore rate is climbing as patients are not getting on an air mattress in that time.
Theatre is delayed. Lists are lost nearly daily - No Theatre Staff, No Anaesthetist, No Radiographer. Recovery in theatre of C19 +ve patients fills theatre time.

- General Manager - Trauma & Orthopaedics

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 and below the mean.
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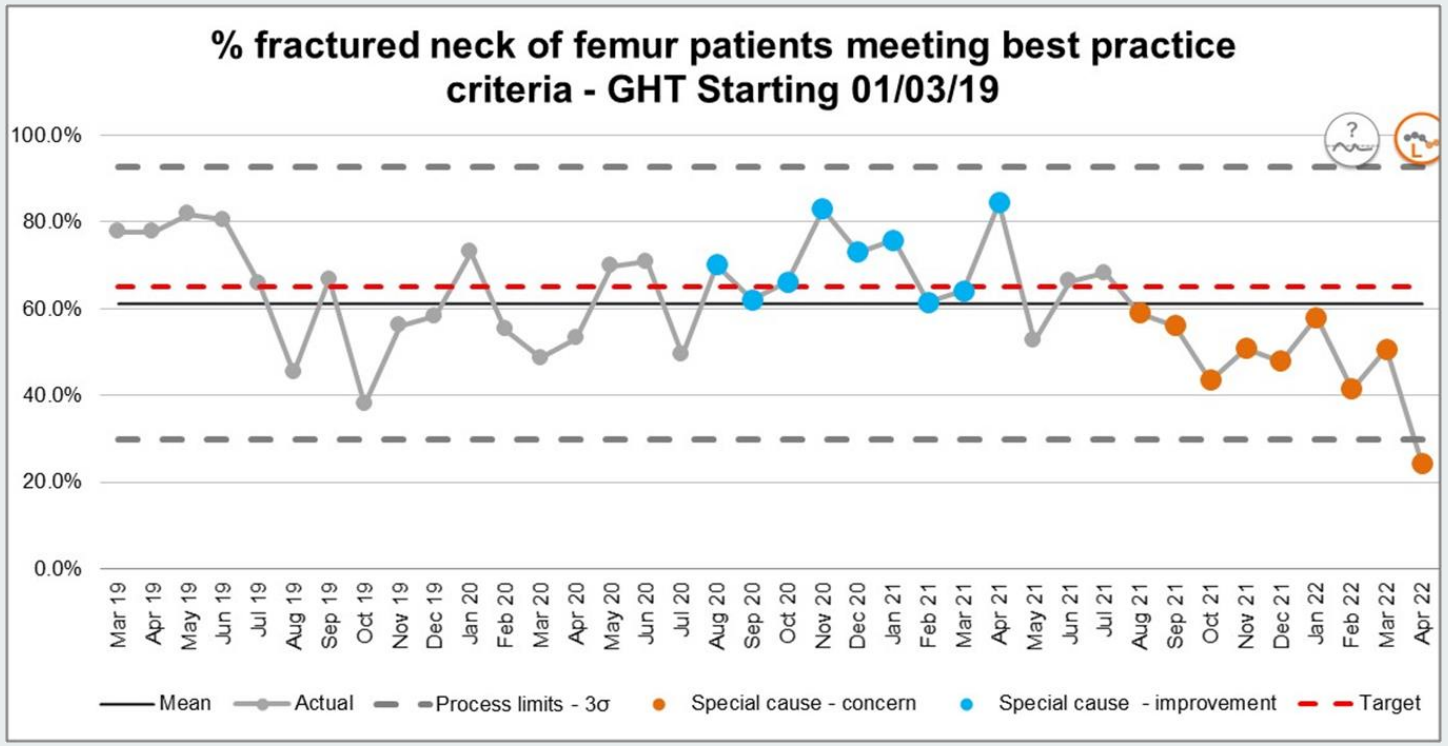

Commentary

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- General Manager - Trauma & Orthopaedics

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 and below the mean.

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	
Friends & Family Test	Inpatients % positive	>=90%	Apr-22	88.0%
Friends & Family Test	ED % positive	>=84%	Apr-22	62.7%
Friends & Family Test	Maternity % positive	>=97%	Apr-22	78.2%
Friends & Family Test	Outpatients % positive	>=94.5%	Apr-22	93.1%
Friends & Family Test	Total % positive	>=93%	Apr-22	87.2%
Friends & Family Test	Number of PALS concerns logged	No Target	Apr-22	229
Friends & Family Test	% of PALS concerns closed in 5 days	>=95%	Apr-22	67%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Apr-22	0
Infection Control	MRSA bacteraemia - infection rate per 100,000 bed days	Zero	Apr-22	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Apr-22	15
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Apr-22	5
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Apr-22	10
Infection Control	Clostridium difficile - infection rate per 100,000 bed days	<30.2	Apr-22	53.9
Infection Control	Number of MSSA bacteraemia cases	<=8	Apr-22	2
Infection Control	MSSA - infection rate per 100,000 bed days	<=12.7	Apr-22	7.2
Infection Control	Number of ecoli cases	No target	Apr-22	9
Infection Control	Number of pseudomona cases	No target	Apr-22	0
Infection Control	Number of klebsiella cases	No target	Apr-22	1
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Apr-22	74
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No target	Apr-22	139
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	No target	Apr-22	125
Infection Control	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	No target	Apr-22	40
Infection Control	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	No target	Apr-22	65
Maternity	% C-section rate (planned and emergency)	No target	Apr-22	0
Maternity	% emergency C-section rate	No target	Apr-22	19.1%
Maternity	% of women smoking at delivery	<=14.5%	Apr-22	0
Maternity	% of women that have an induced labour	<=33%	Apr-22	30.6%
Maternity	% stillbirths as percentage of all pregnancies	<0.52%	Apr-22	0.00%
Maternity	% of women on a Continuity of Carer pathway	No target	Apr-22	10.10%
Maternity	% breastfeeding (initiation)	>=81%	Apr-22	78.7%
Maternity	% PPH >1.5 litres	<=4%	Apr-22	3.5%
Maternity	Number of births less than 27 weeks	NULL	Apr-22	3
Maternity	Number of births less than 34 weeks	NULL	Apr-22	13
Maternity	Number of births less than 37 weeks	NULL	Apr-22	49
Maternity	Number of maternal deaths	NULL	Apr-22	0
Maternity	Total births	NULL	Apr-22	442
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Apr-22	1.36%
Maternity	% breastfeeding (discharge to CMW)	NULL	Apr-22	45.5%
Mortality	Summary hospital mortality indicator (SHMI) - national data	NHS Digital	Dec-21	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Jan-22	100.9
Mortality	Hospital standardised mortality ratio (HSMR) - weekend	Dr Foster	Jan-22	108

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.

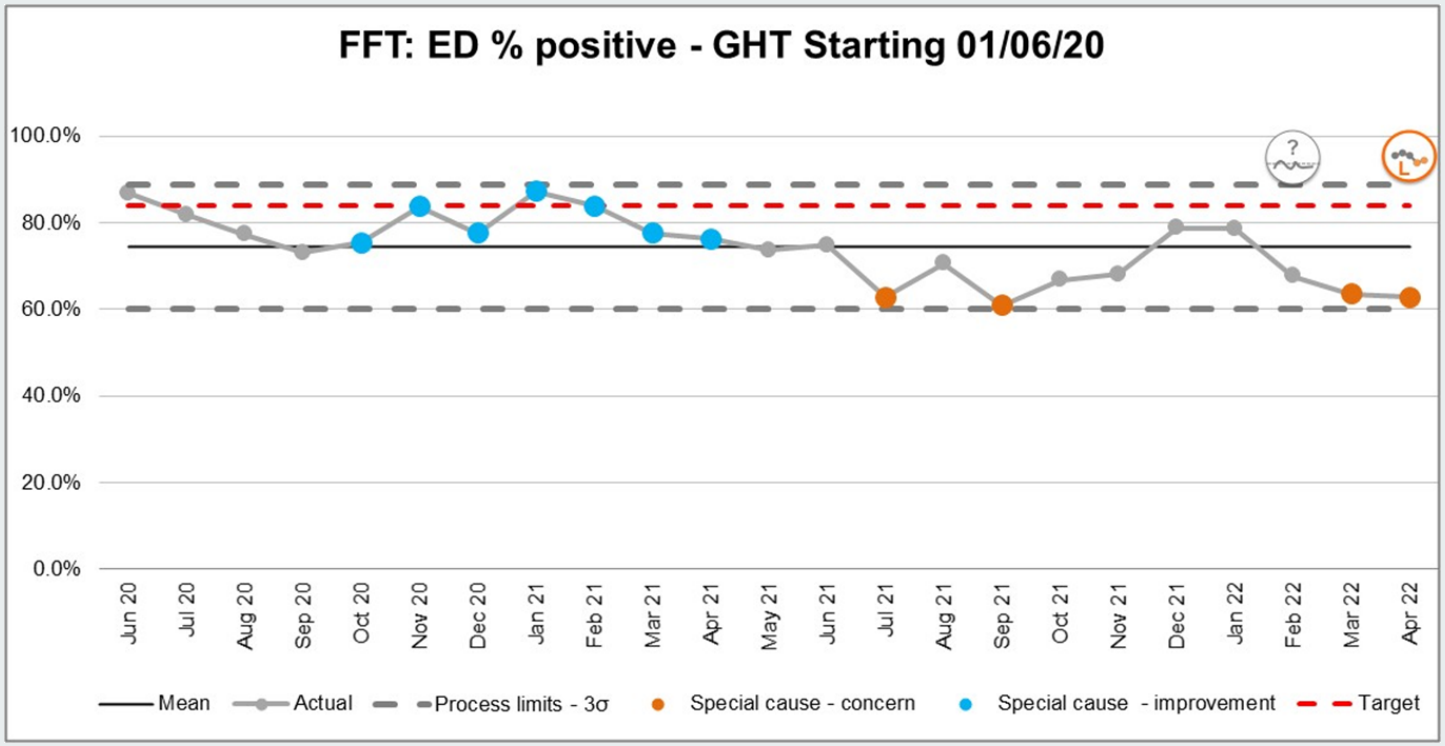
Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Apr-22	185	
Mortality	Number of deaths of patients with a learning disability	No target	Apr-22	3	
MSA	Number of breaches of mixed sex accommodation	<=10	Apr-22	21	
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	Apr-22	7.5	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Apr-22	4	
Patient Safety Incidents	Number of patient safety incidents - severe harm (major/death)	No target	Apr-22	6	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Apr-22	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Apr-22	3	
Patient Safety Incidents	Medication error resulting in low harm	No target	Apr-22	9	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Apr-22	46	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Apr-22	2	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Apr-22	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Apr-22	12	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Apr-22	12	
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	Apr-22	0	
Serious Incidents	Number of serious incidents reported	No target	Apr-22	6	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Serious Incidents	Serious incidents - 72 hour report completed within contract timescale	>90%	Apr-22	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Apr-22	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Apr-22	90.8%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%	
Safeguarding	Number of DoLs applied for	No target	Apr-22	47	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	Apr-22	1	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Apr-22	0	
Safeguarding	Total admissions aged 0-17 with DSH	No target	Apr-22	32	
Safeguarding	Total ED attendances aged 0-17 with DSH	No target	Apr-22	85	
Safeguarding	Total admissions aged 0-17 with an eating disorder	No target	Apr-22	7	
Safeguarding	Total number of maternity social concerns forms completed	No target	Apr-22	72	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The current positive FFT score for ED is at 62.7% across both sites, with the main theme emerging focussed on wait times, which is reflective of the operational pressures in the department. The team are receiving reports on the feedback weekly, to support local real time improvement in response to emerging themes, and provide monthly updates through to QDG.

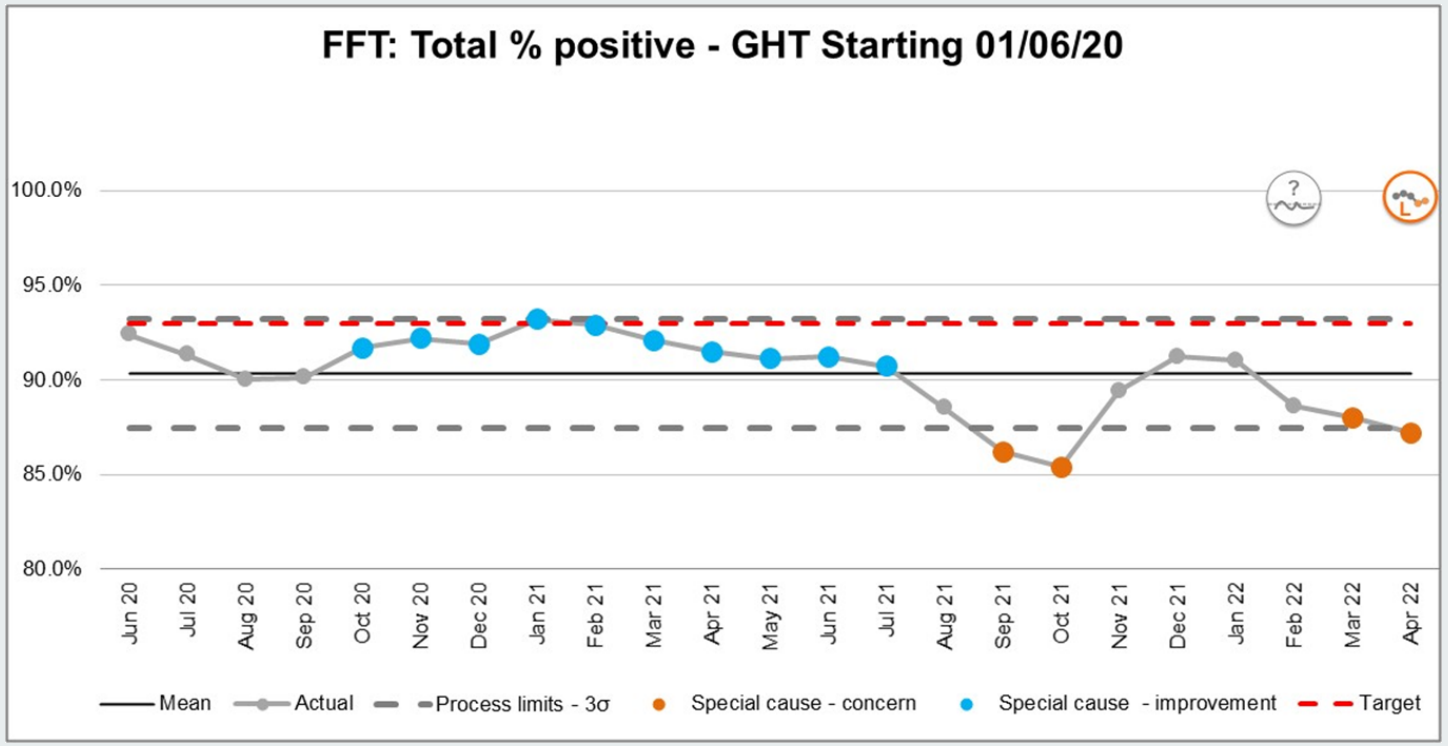
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The current positive FFT score for the Trust overall is at 87.2%. The main themes emerging this month were focussed on wait times, communication issues, and delays to appointments. Divisions provide updates through QDG each month on improvement plans happening within divisions, and the patient experience team are reviewing current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans.

- Head of Quality

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 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 the mean.
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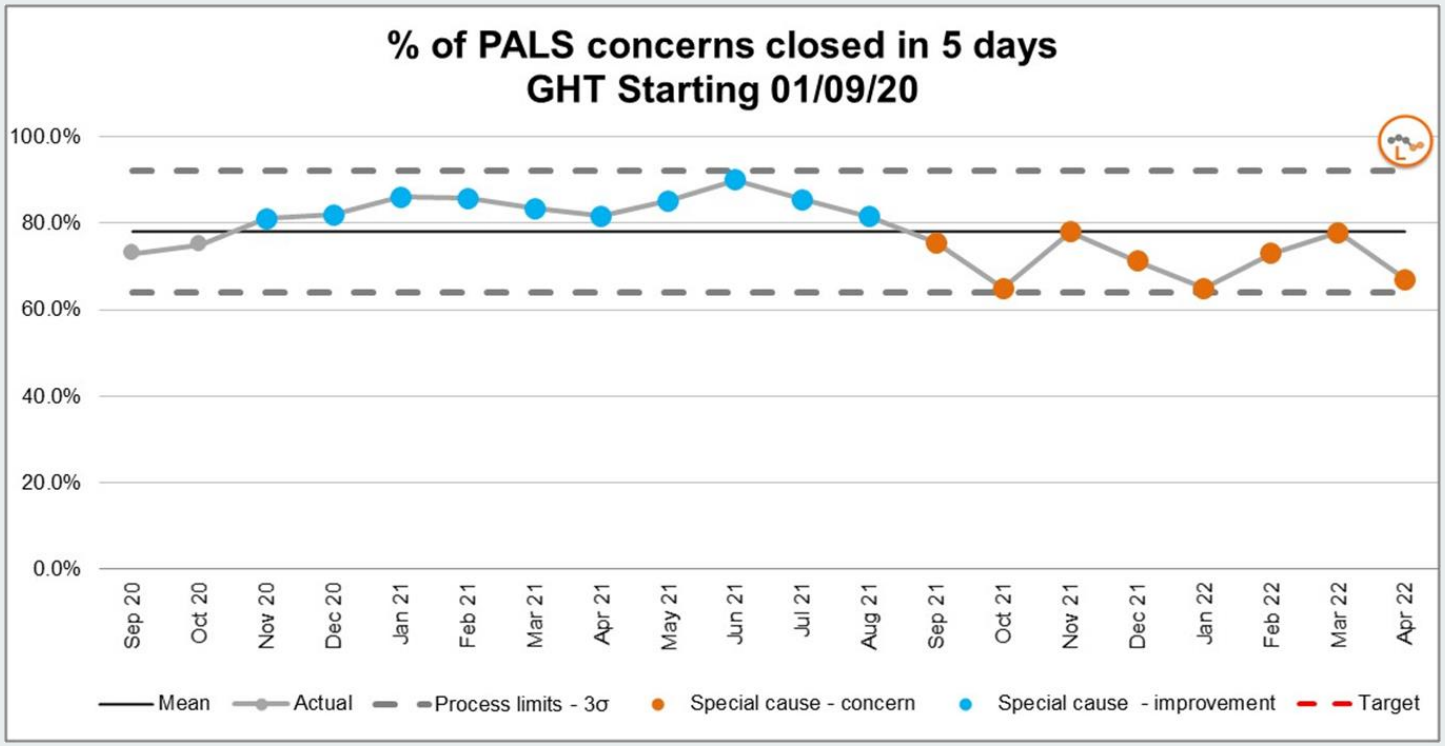
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The number of PALS concerns closed within 5 days is currently at 67% - the team are now fully recruited to, and risks have been updated to reflect current challenges. This continues to be monitored closely and reported monthly through QDG.

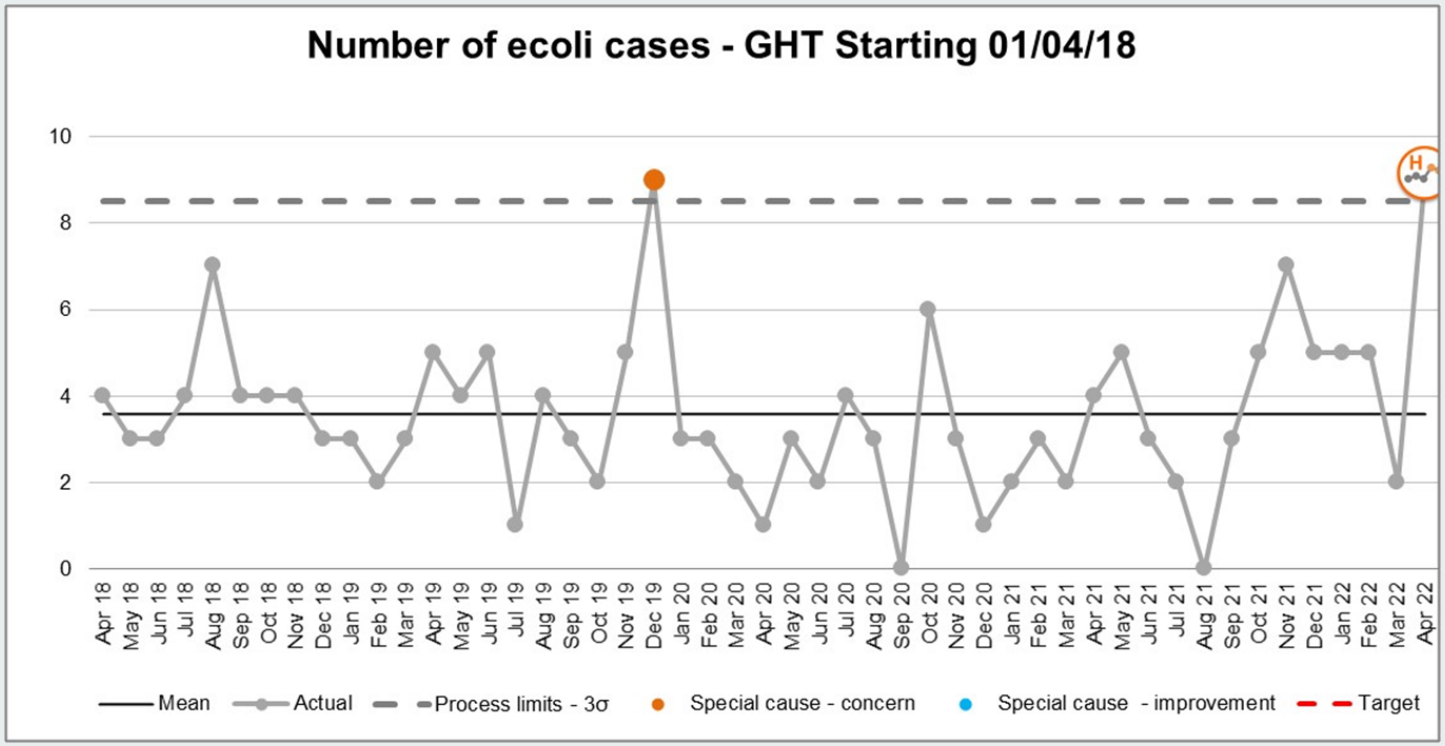
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

During April we had 9 health care associated cases (5 hospital onset cases and 4 community onset cases). It is noted that that since April 2022 the community onset healthcare associated cases have been included in the metric whereas before it included hospital onset cases. This is in line with the NHSE/I annual limit for E coli BSI which now sets an annual limit inclusive of all healthcare associated cases. Reducing E.coli BSI and all Gram negative bacteraemia continue to be a focus of the IPC strategy specifically related to urinary tract infection prevention, improving patient hydration and improving the management and care of invasive device. All patients with a healthcare associated E.coli BSI have a rapid review to understand contributing factors and a subsequent post infection review is completed if there lapses in care that require action

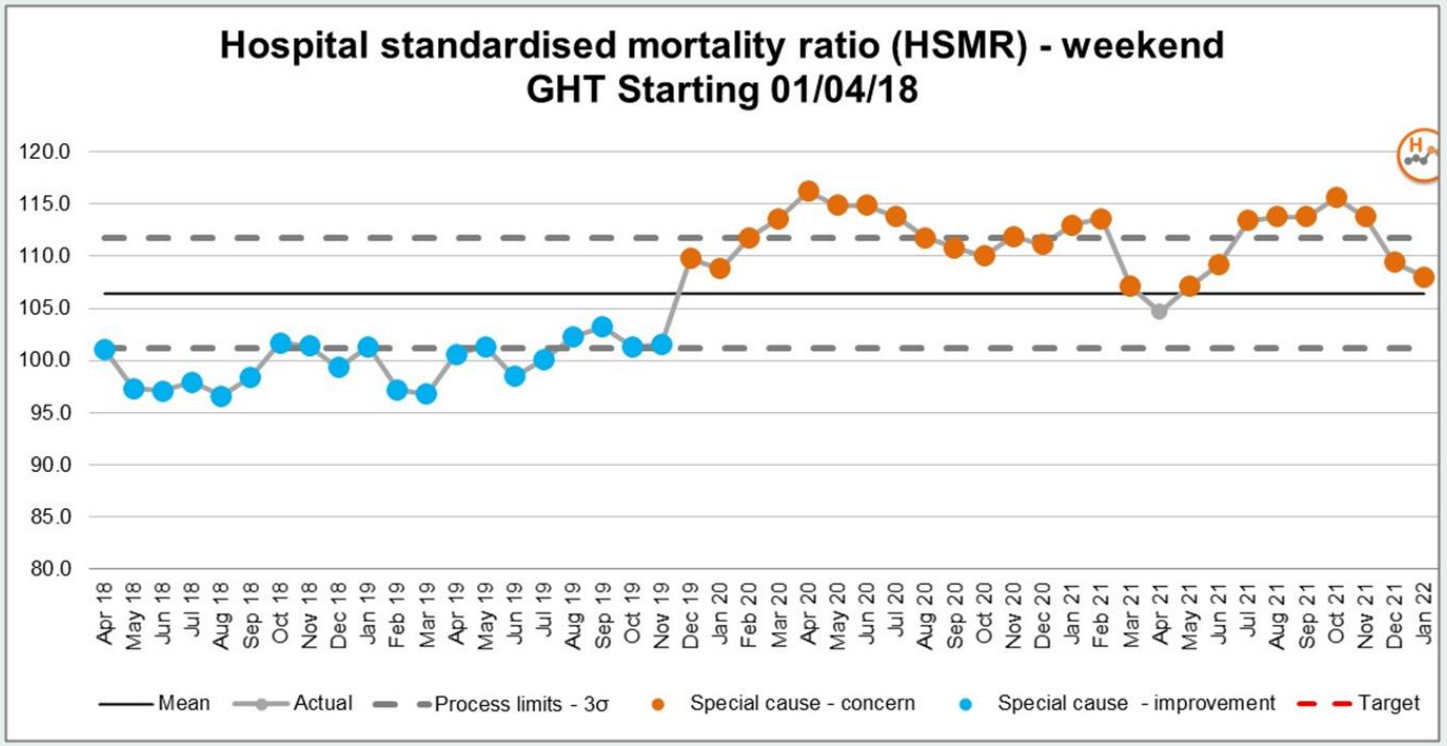
- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

This is now within the expected range which reflects the reduction in the effects of COVID on this metric.

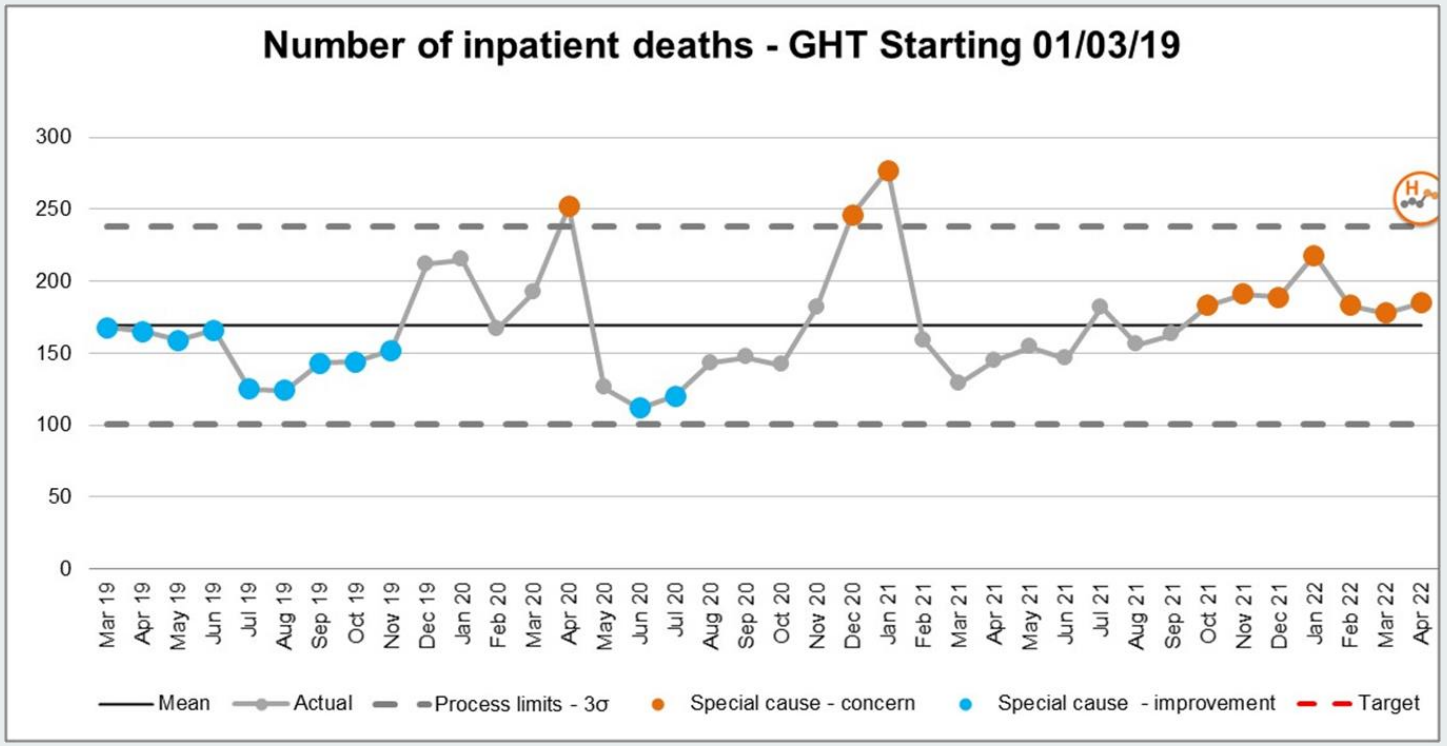
- Deputy Medical Director

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 12 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

Under Review

- Deputy Medical Director

Data Observations

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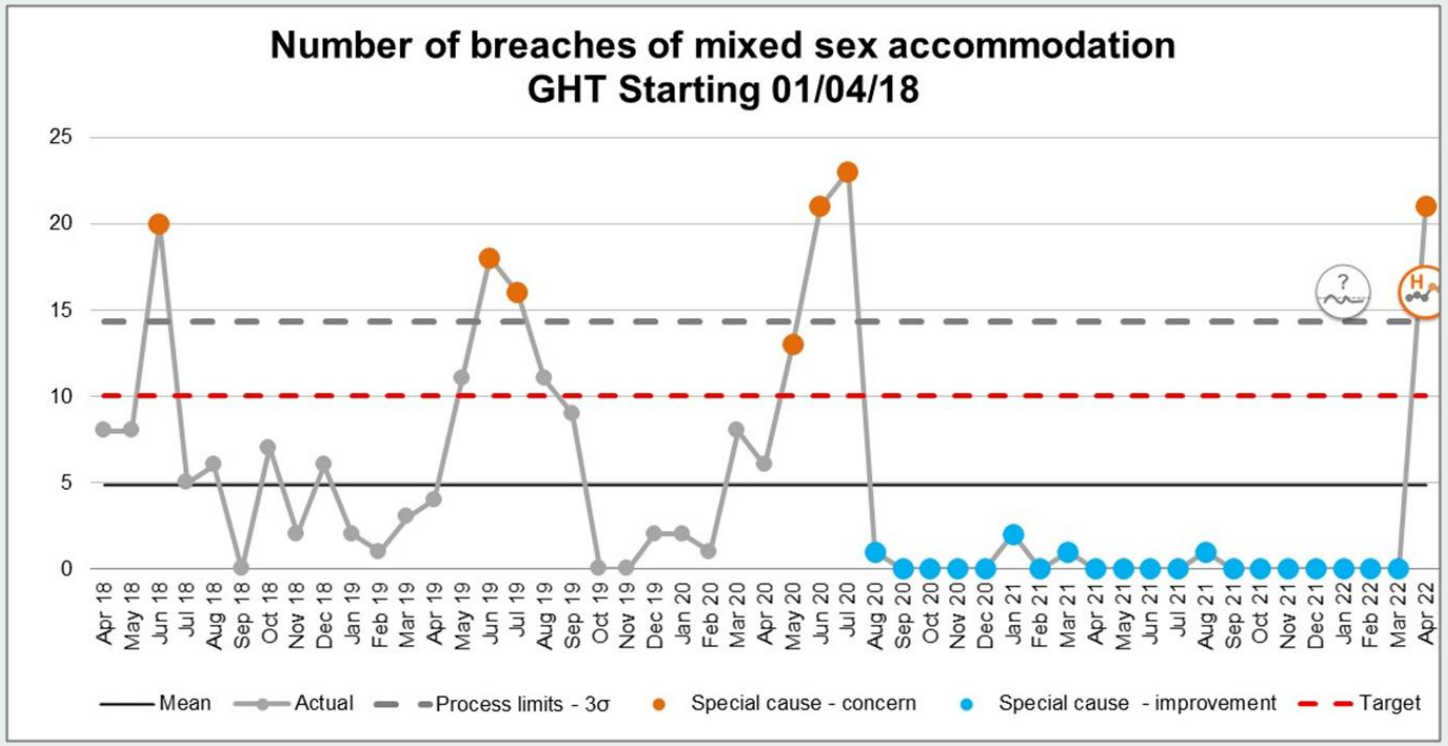
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Historically mixed sex accommodation breaches have been deemed non-reportable where the Trust escalation status is at OPEL level 3 or 4. Therefore, breaches have been not reported for an extended period as the Trust escalation status has remained at level 3 or 4. The Trust has worked with the CCG to alter the reporting framework to give oversight of breaches at all times, regardless of escalation status. this reporting will come through from April 2022. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse.

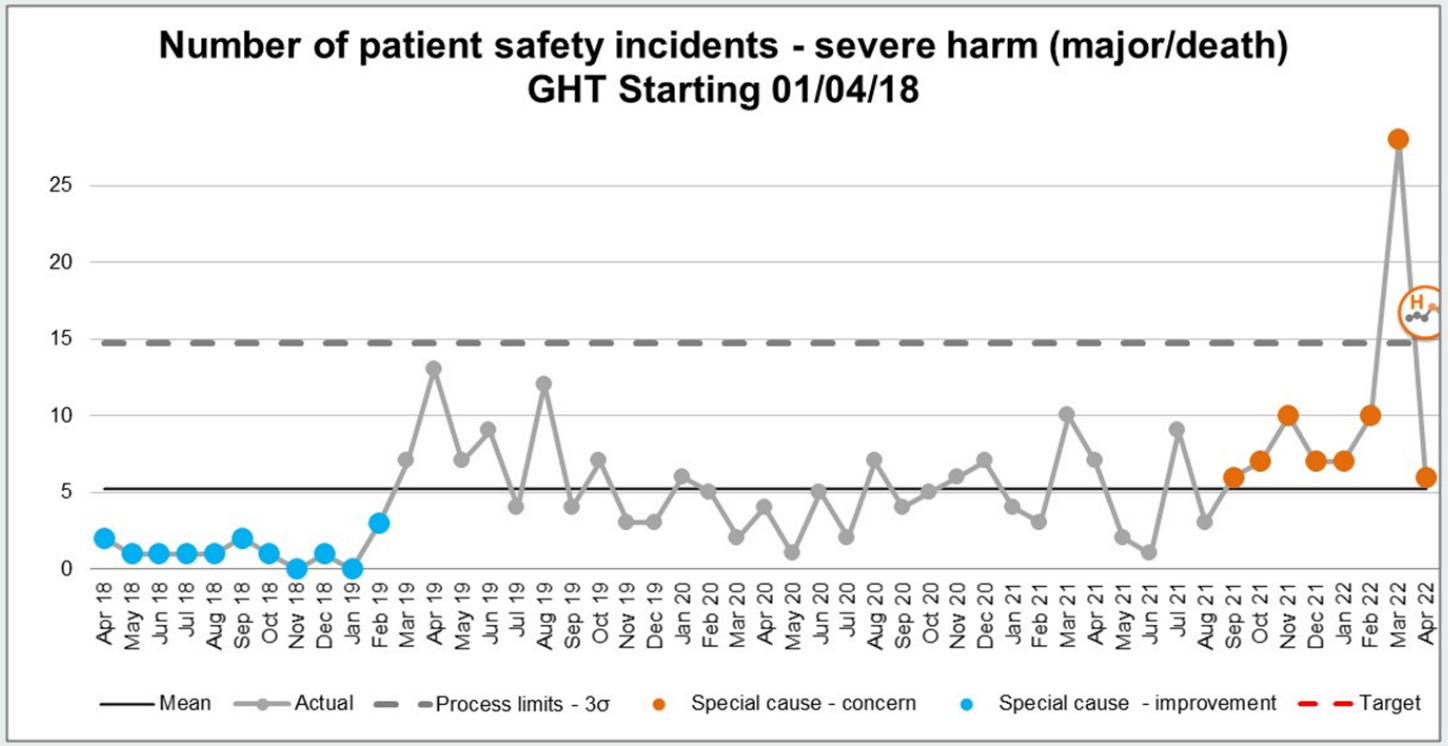
- Director of Quality and Chief Nurse

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

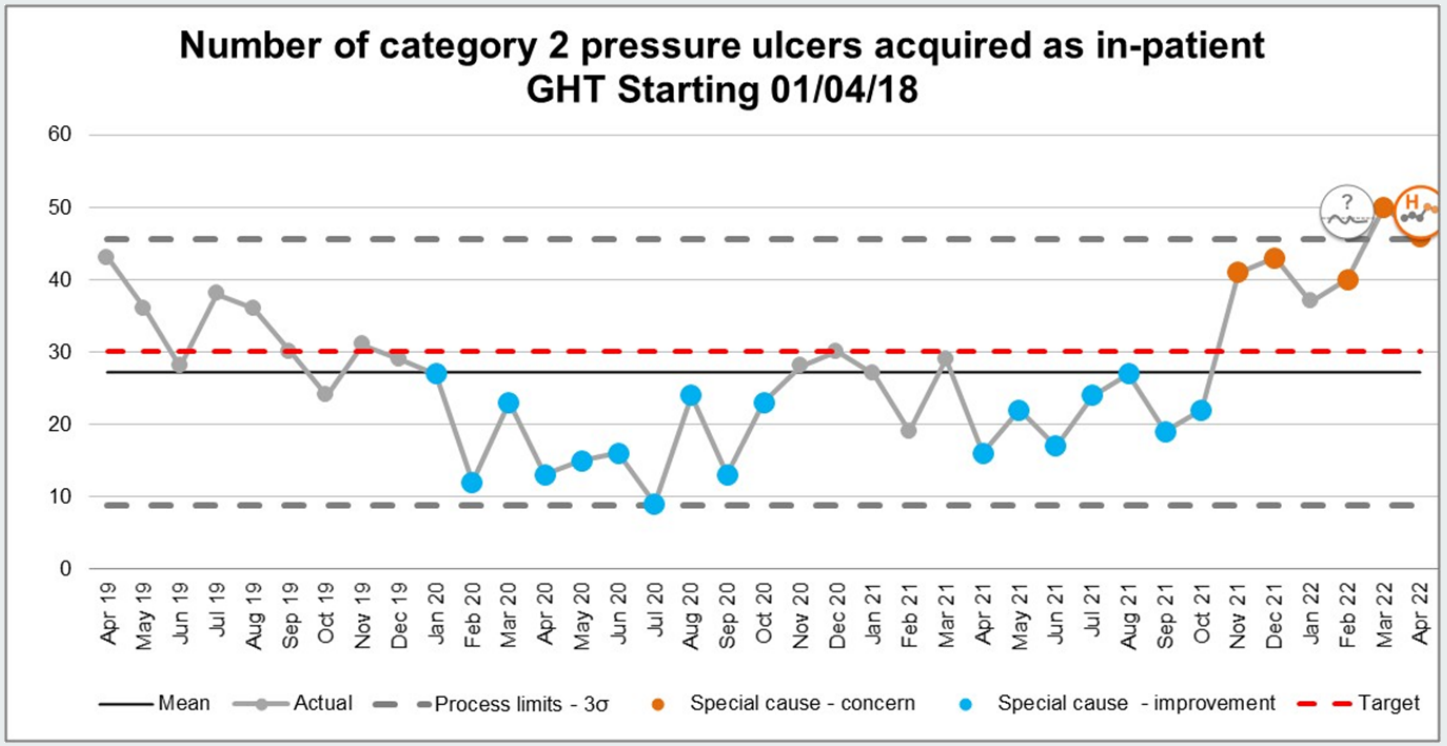
- Quality Improvement & Safety Director

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.

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers.

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

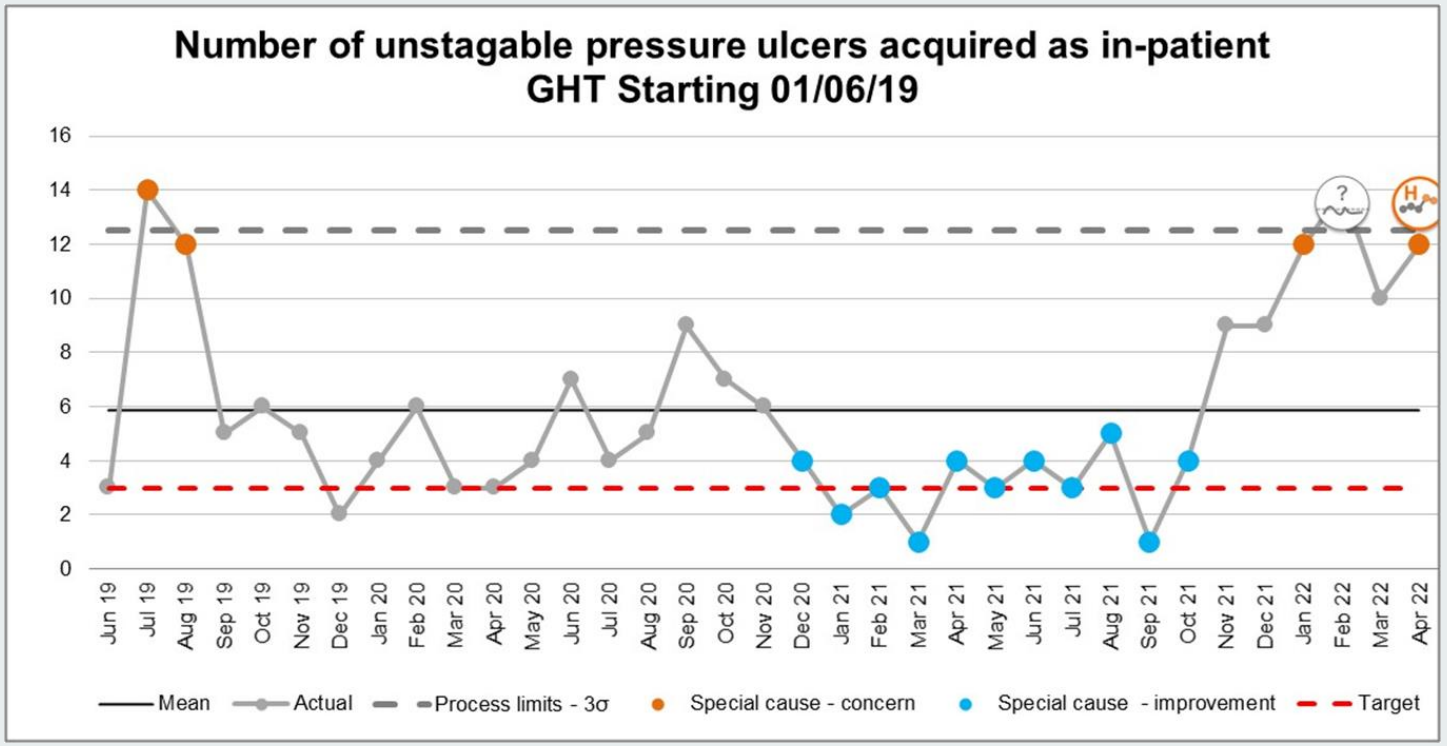
- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

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Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library.

- Associate Chief Nurse, Director of Infection Prevention & Control

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2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

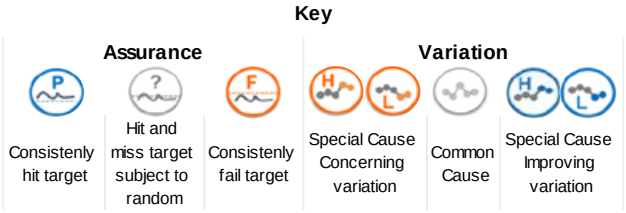
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

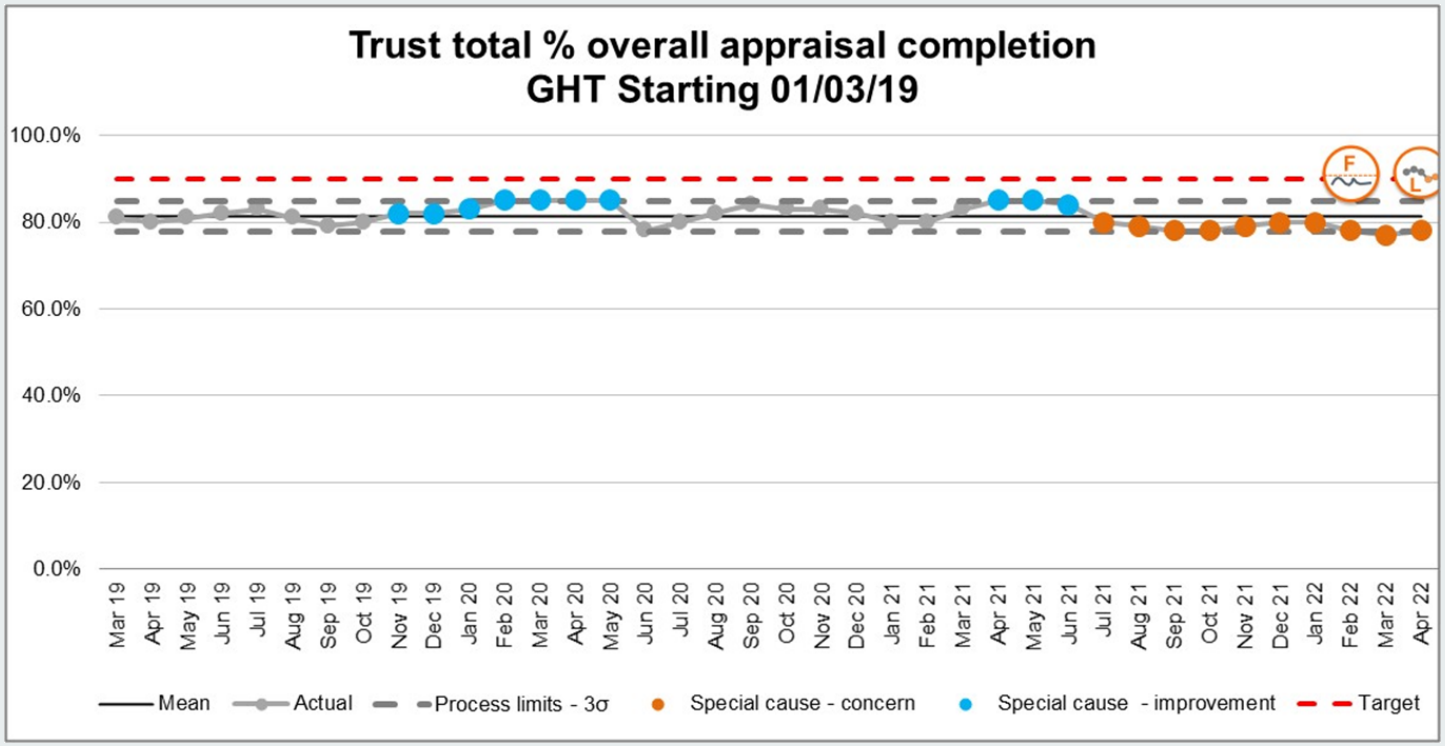
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	Apr-22	78%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	Apr-22	86%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	Mar-22	85.3%	
Safe Nurse Staffing	% registered nurse day	>=90%	Mar-22	82.6%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	Mar-22	75.0%	
Safe Nurse Staffing	% registered nurse night	>=90%	Mar-22	90.1%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	Mar-22	91.5%	
Safe Nurse Staffing	Care hours per patient day RN	>=5	Mar-22	5.0	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	Mar-22	2.9	
Safe Nurse Staffing	Care hours per patient day total	>=8	Mar-22	7.9	
Vacancy and WTE	Staff in post FTE	No target	Apr-22	6683.7	
Vacancy and WTE	Vacancy FTE	No target	Apr-22	807.64	
Vacancy and WTE	Starters FTE	No target	Apr-22	91.38	
Vacancy and WTE	Leavers FTE	No target	Apr-22	67.55	
Vacancy and WTE	% total vacancy rate	<=11.5%	Apr-22	10.79%	
Vacancy and WTE	% vacancy rate for doctors	<=5%	Apr-22	7.91%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	Apr-22	14.34%	
Workforce Expenditure	% turnover	<=12.6%	Apr-22	14.2%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	Apr-22	12.8%	
Workforce Expenditure	% sickness rate	<=4.05%	Apr-22	4.1%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The Trust appraisal rate continues to fall below the trust target of 90% and remains at 78%. Medicine (81%), Surgery (80%) and D&S (80%) Divisions have the highest compliance rates. The lowest Divisional Appraisal rates are Corporate (74%) and Women & Children (69%). Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process.

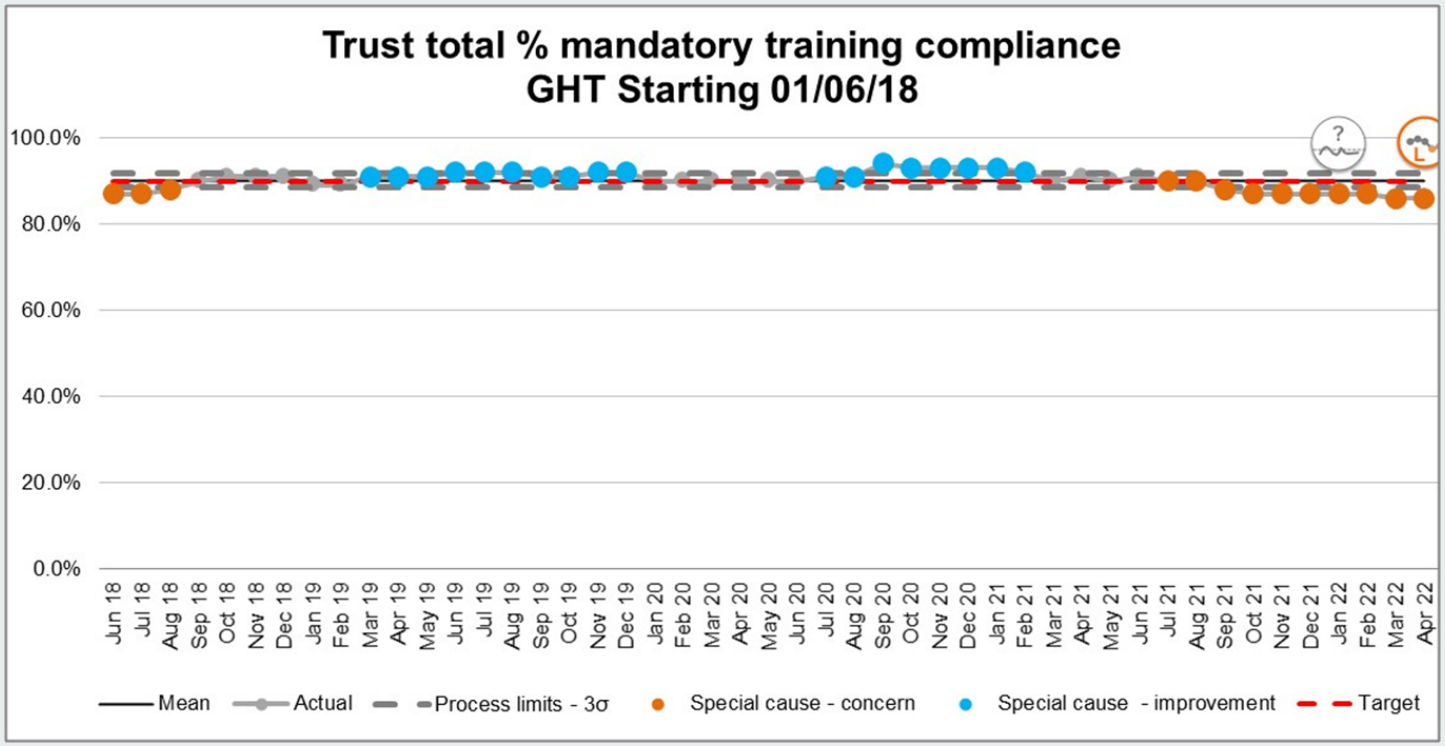
- **Director of Human Resources and Operational Development**

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 6 data points which are above the line. 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 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

Mandatory training compliance remains below the 90% target and has remained at 86% for the last couple of months. Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Specific work is being undertaken to identify how best to work with staff groups who fall well below the target.

- **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 11 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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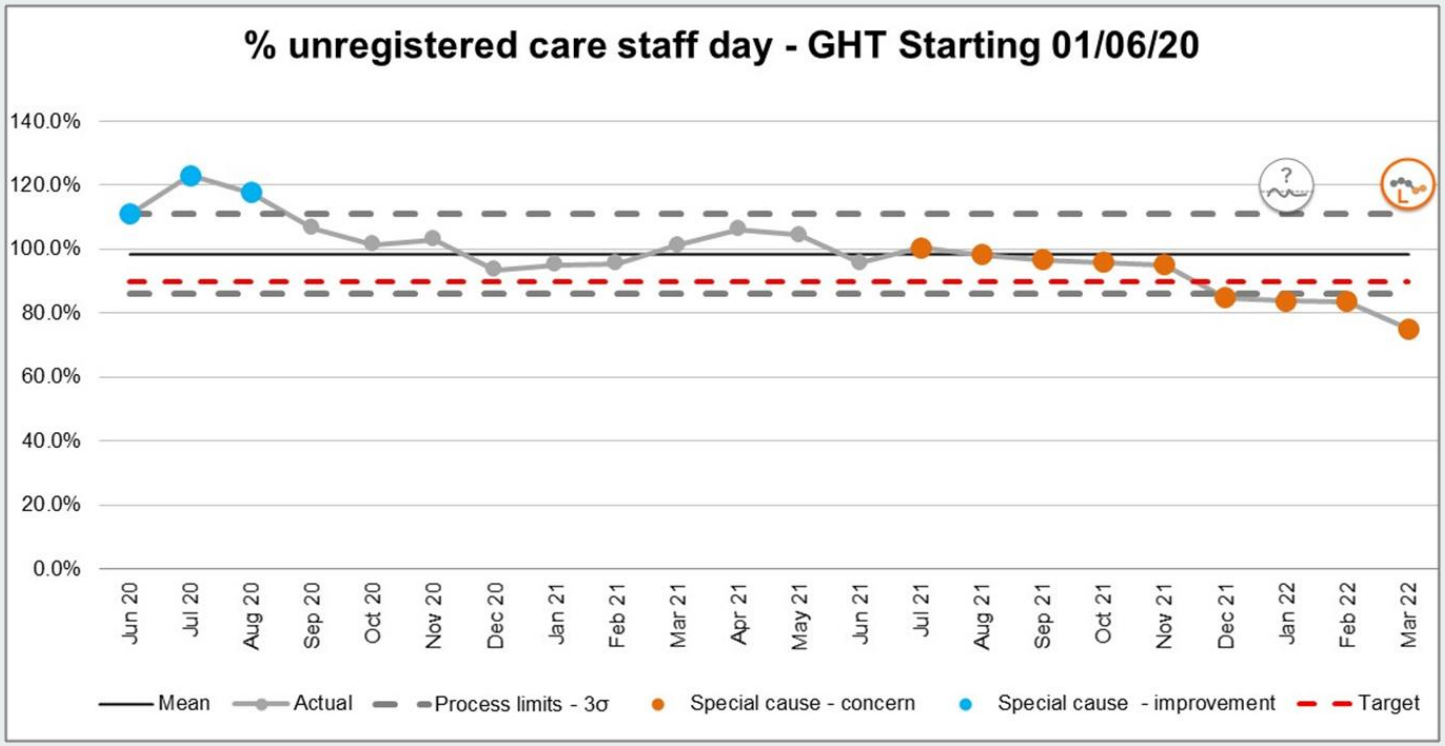
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

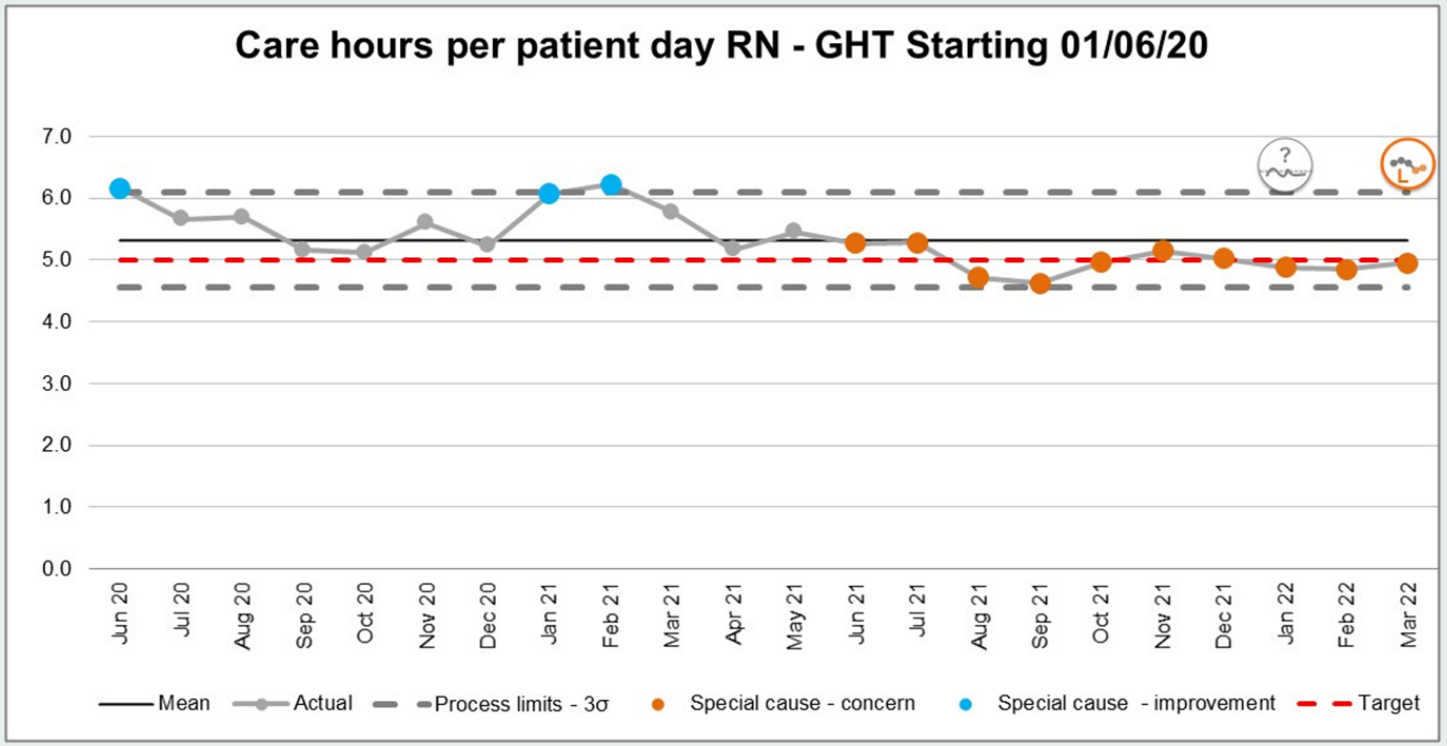
- **Deputy Director of Quality and Deputy Chief Nurse**

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. 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.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

- **Deputy Director of Quality and Deputy Chief Nurse**

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.
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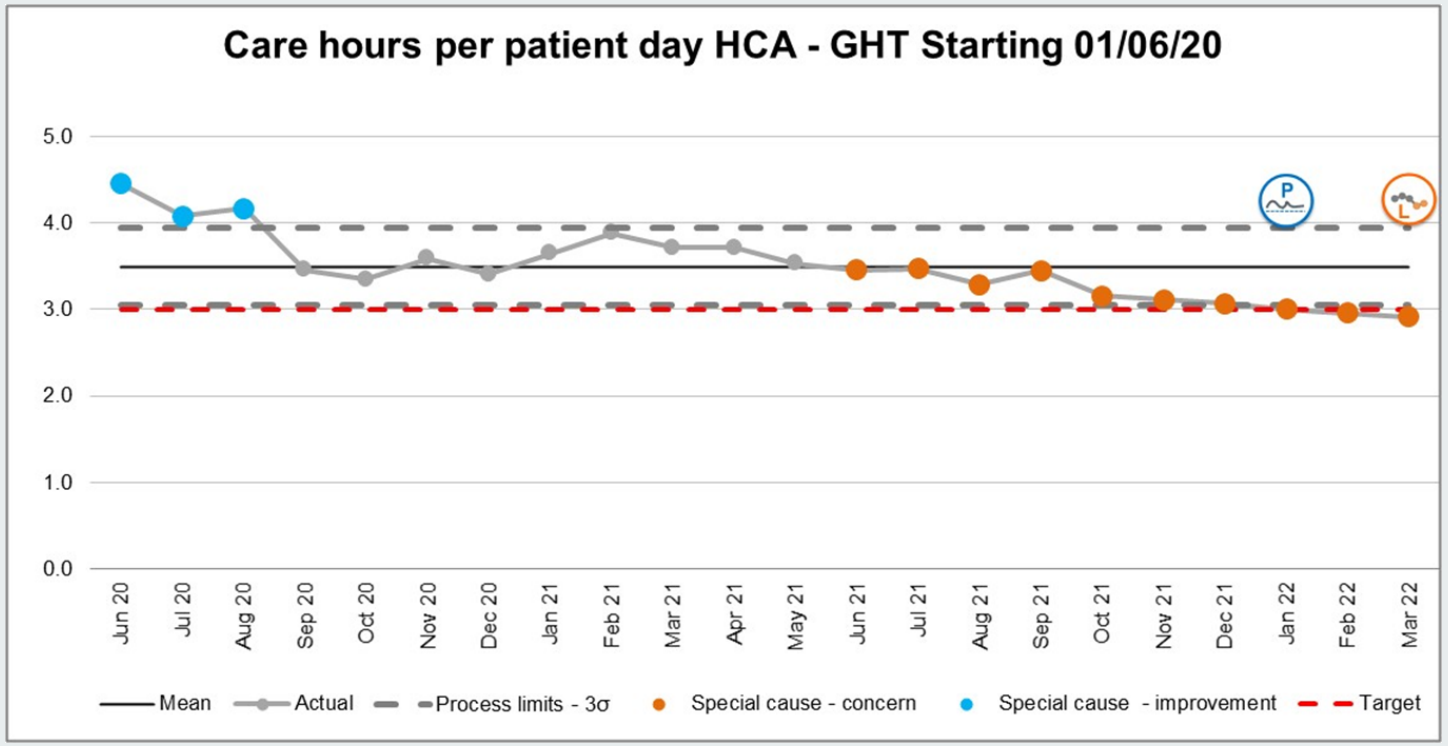
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

- **Deputy Director of Quality and Deputy Chief Nurse**

Data Observations

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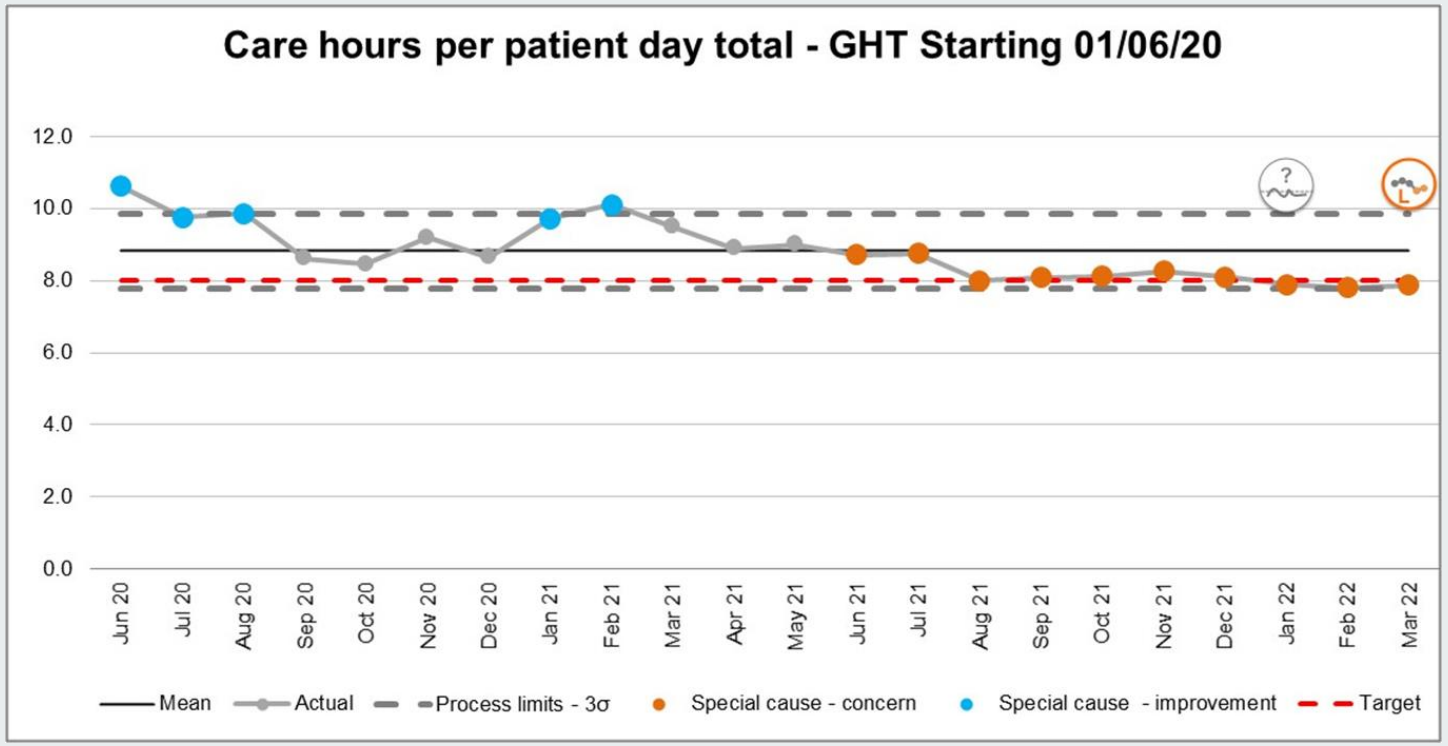
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control.In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

- **Deputy Director of Quality and Deputy Chief Nurse**

Data Observations

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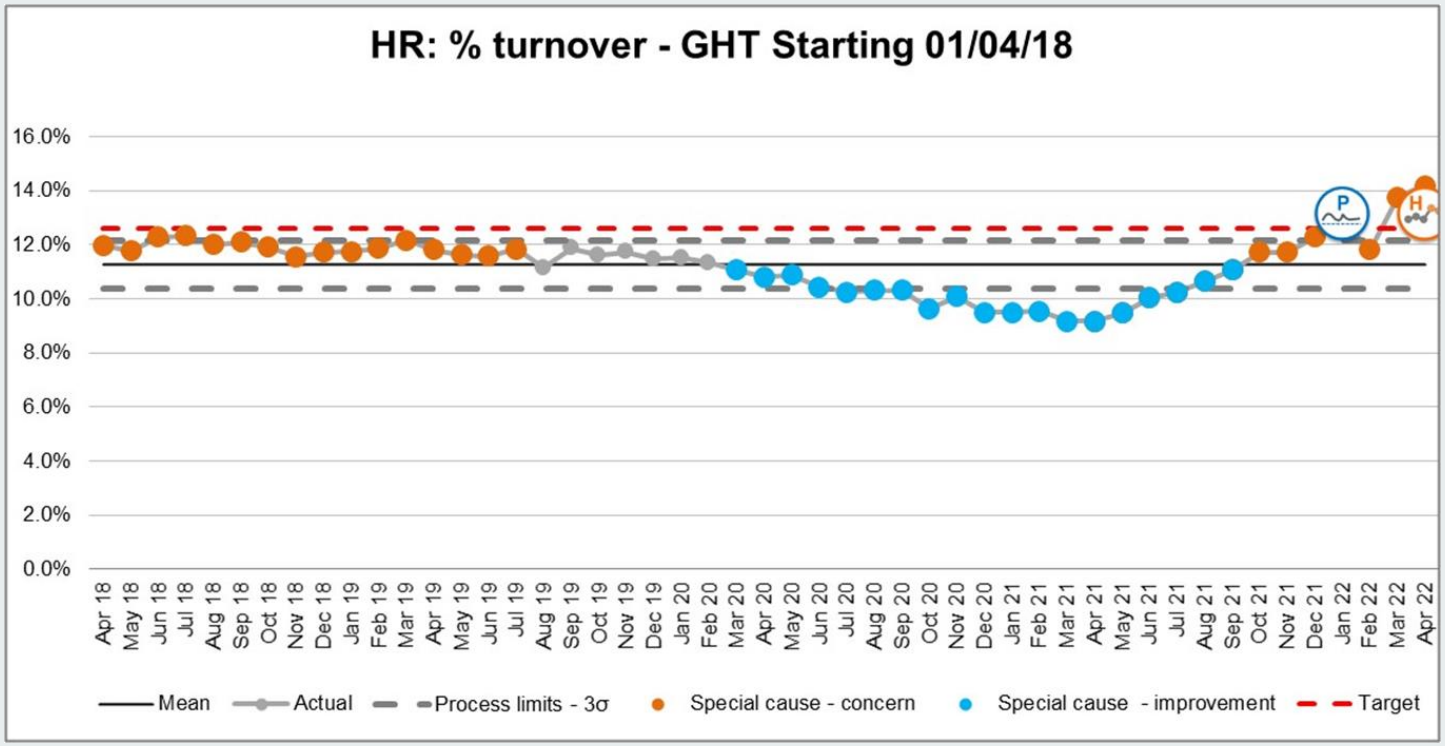


Commentary

Turnover continues to be of key focus across all staff groups. Understanding reasons for staff leaving remains a priority in order to support the development of informed retention initiatives. Responding to the outcomes of the Trust's Staff Survey remains a focus in the months ahead to ensure proactive and sustainable actions are in place across the organisation.

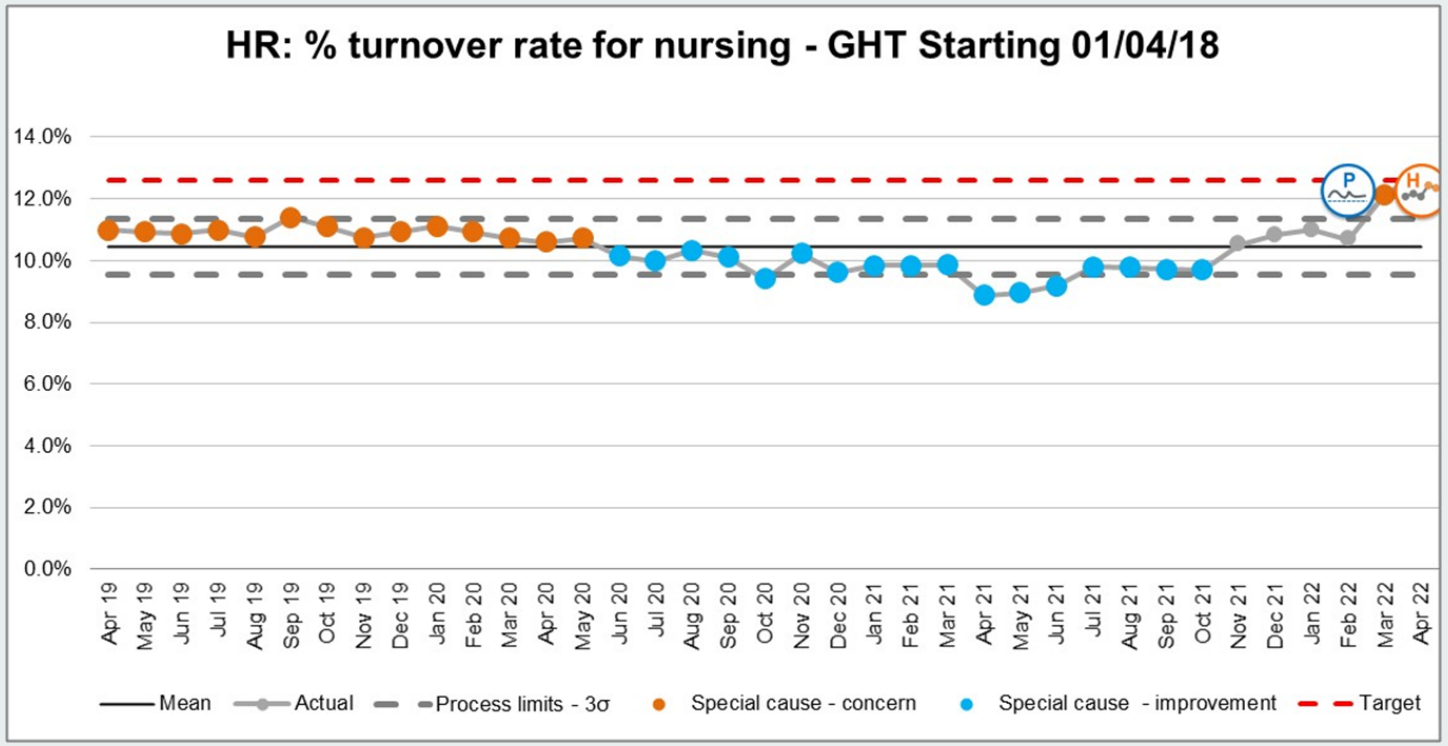
- **Director of Human Resources and Operational Development**

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 7 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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Focus on the retention of the Trust's registered nurse workforce is essential both in the immediate future and longer term, ensuring there is a sustainable workforce model. In particular, pastoral care and preceptorship for both newly appointed overseas and newly qualified nurses are key in ensuring the Trust invests sufficiently in a structured, quality transition to guide, transition and support all new nurses.

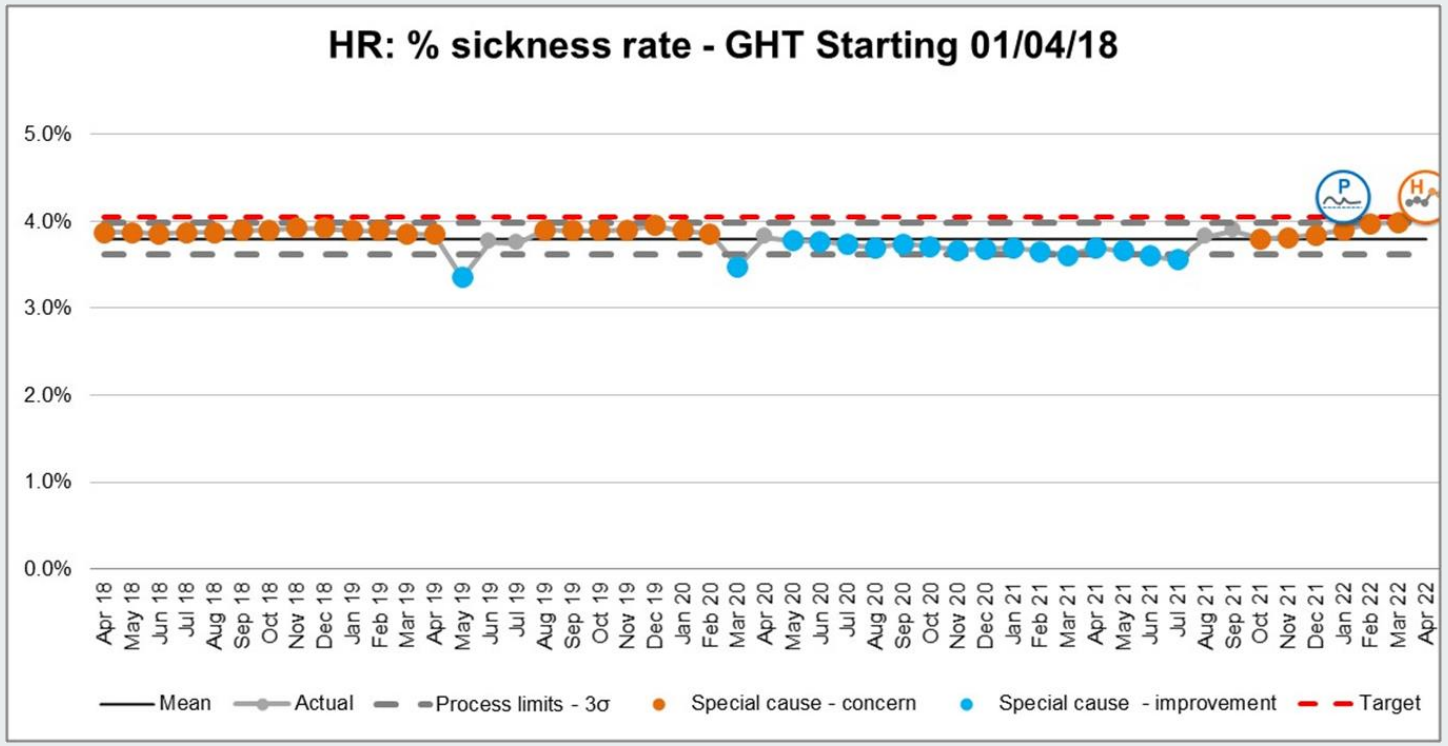
- **Director of Human Resources and Operational Development**

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 3 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.
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

Ongoing focus is being given to managing staff sickness absence with continuing concerns with staff health and wellbeing and indeed the ongoing long covid conditions being experienced.

- **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 2 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors			
Agenda item:	**10**	**Enclosure Number:**	**7**
Date	9 June 2022		
Title	Maternity Services Perinatal Quality Surveillance and Safety Report Quarter 4 (Maternity Incentive Scheme Compliance CNST)		
Author /Sponsoring Director/Presenter	Authors: Women's and Children's Lead for Quality and Governance - Josette Jones, Deputy Director of Quality – Suzie Cro, Divisional Director of Nursing and Quality and Chief Midwifery – Vivien Mortimore Sponsoring Director and presenter: Chief Nurse and Director of Quality Matt Holdaway (Board Maternity and Neonatal Safety Champion)		

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

In response to the need to proactively identify trusts that require support before serious issues arise NHSE/I (2020) developed a new quality surveillance model to provide consistent and methodological review of maternity services. The purpose of this report is to provide assurance to the Quality and Performance Committee and Trust Board that there is an effective system of clinical governance monitoring the safety of our maternity service with clear strategies for learning and improvement. This report covers the period of January to March 2022 – quarter 4 (Q4).

Summary

National Events, Regulatory and NHSE/I Reviews

- In Dec 2021 CQC carried out a focus group with maternity staff, as they had been contacted directly because of concerns raised about staffing and on calls and in Jan 2022 they made requests for additional data.
- In NHSE/I Regional Maternity Team visited for an informal Quality Visit on 28 Feb 2022 and provided improvement feedback for the service which is currently being actioned/implemented.
- 10 March Trust Board 2022 received an update from the Immediate and Essential Actions (IEAs) from the Ockendon First Report (Dec 2021).
- This quarter The Ockendon Final report was published (30 March 2022) and a gap analysis will be prepared and presented to the Quality and Performance Committee in April and Trust Board in May 2022.

NHSE/I Maternity Safety Support Programme (MSSP)

- The service is not on the NHSE/I MSSP programme currently as rated good overall by CQC.
- The service had completed the NHSE/I Self-Assessment Tool and presented this to the Maternity Delivery Group in February. The completion of the tool has informed the service's quality improvement and safety plan. The tool will be reviewed quarterly at the Maternity Delivery Group (MDG).

Learning from deaths – maternal, perinatal and neonatal mortality

- There were 4 early neonatal deaths and an additional death at the specialist services at Bristol (specialist care required).
- There were no maternal deaths.
- There were 5 stillbirths.
- 100% of deaths had the appropriate Perinatal Mortality Review Tool completed.

Maternity training compliance

- Mandatory maternity training compliance for the core competence framework is flagging as an issue at 81% for all staff groups (target set is 90%). The service has an improvement plan to recovery this to 90% by the end of December 2022 by adding in additional days and paying staff bank hours to attend in their own time

Safer staffing

- There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group.
- Midwifery staffing remains as a risk on the Trust risk register scoring 15 for Safety (WC35360bs).
- There were 352 unfilled midwifery shifts this quarter (Q4) which is a 45% increase from last quarter (Q3).
- There were 120 unfilled shifts for MCA/MSWs.
- Due to midwifery staffing issues, there were 2 occasions when the service consolidated care provision. This included the temporary closure of the Gloucester Birth Unit (closed for 12 days from 17-28 March) and the Cheltenham Aveta Birth Unit (closed for 62 days 8 Dec-7 March) to intrapartum care.
- There were no rota gaps in the Obstetric cover.
- 10 March Trust Board 2022 received a Maternity Workforce report.

Maternity Service user feedback

- Friends and Family Test scores have declined from 94% to 87% and a plan is in place to review this data and to carry out improvement work supported by the Maternity Voices Partnership.
- The last Picker National Maternity Survey data was provided to the Trust in Sept 2021 and an improvement plan is being developed in response.

Staff feedback to Maternity and Neonatal Safety Champions (MNSCs)

- Nil feedback from MNSC visits in Q4.

Clinical Incident Reporting

- The Director or Quality Improvement and Safety hosted an event reviewing the framework “Seven Features of Safety in a Maternity Units” and led conversations about the current position. The second workshop was held at the end of January 2022.
- A total of 2 cases were scoped and both were declared as Serious Incidents (SIs).
- One case met the criteria to be reported to HSIB.
- 3 final HSIB investigation reports were received and action plans have been. developed and agreed at the Safety and Experience Review Group (SERG).
- 3 investigations are being carried out by HSIB currently.
- HSIB meet on a quarterly basis with the maternity service and with Executive Leads to share learning and improvement.
- 1 case is being scoped by HSIB and is likely to be rejected as there is a normal MRI scan.

- There were no Prevention of Future Death Reports (Coroner regulation 28).

Themes from trainee or staff surveys

- The number of maternity staff agreeing that they would recommend the service was 75%.
- The proportion of trainees rating the quality of supervision as good or excellent was 87.5% and this was last reported in 2019 (the national average was 89.5%). There is currently a new survey in progress.

Progress against NHS Resolution Maternity Incentive Scheme (CNST)

- Due to the ongoing and unprecedented challenges on the 23 December 2021 NHSR sent a letter to all Trusts to pause the reporting procedures for the scheme for a minimum of 3 months.
- At the end of Q4 the scheme currently remained paused and further detail on progress can be seen at appendix 1 as it is expected that the scheme will recommence in Q1 2022.
- To note the scheme recommenced May 2022 with some modifications to the existing requirements. Work is ongoing within the service to map these and establish any gaps.

Recommendation

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

Enclosures

- Perinatal Quality Surveillance Report

Gloucestershire Hospitals
NHS Foundation Trust

Maternity Service
Perinatal Quality Surveillance and Safety Report (Maternity Incentive Scheme Compliance – CNST)

Quarter 4 Jan – March 2021/22

Authors:
Women's and Children's Lead for Quality and Governance - Josette Jones
Deputy Director of Quality – Suzie Cro
Divisional Director of Nursing and Quality and Chief Midwifery – Vivien Mortimore

Executive sponsor:
Director of Quality and Chief Nurse, Matt Holdaway

Contents page

Gloucestershire Hospitals NHS Foundation Trust

Perinatal Quality Dashboard – trend data

Gloucestershire Hospitals NHS Foundation Trust

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Good	Good	Good

Safe inspected 2017 all other ratings 2015. Unannounced inspection April 2022

Maternity Safety Support Programme	No	If No, enter name of MIA

	2021											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Findings of review of all perinatal deaths using the real time data monitoring tool	0	3	5	1	0	0	4	1	2	1	2	3
Findings of review all cases eligible for referral to HSIB.	0	0	0	2	0	0	1	1	1	1	0	1 (rejected)
The number of incidents logged graded as moderate or above and what actions are being taken	0	0	0	2 (SI's - these were the cases referred to HSIB	0	1 SI	2 (1 HSIB SI; 1 Moderate)	1 HSIB	2 SI (1 HSIB)	2 SI (1HSIB)	0	0
Maternity PROMPT Skills Drills					87.9							
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	90% Trust target 90%	90% Trust target 90%	92%. Trust target 90%			85% Trust Target 90%		83% Trust target 90%	81% Trust target 90%		83%	81%
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite & gaps in rotas	0 Gaps in rota. Locum shifts covered: 11 SHO; 10 Registrar	0 Gaps in rota. Locum shifts covered: 12 SHO; 15 Registrar	0 Gaps in rota. Locum shifts covered: 17 SHO; 15 Registrar	0 gaps in registrar rota, , 16 lcoum shifts covered. 10 gaps in SHO rota (could not fill with locum), with 29 shifts covered by locums	0 gaps in rota. Locum shifts covered 18	0 gaps in rota. Locum shifts covered: 7 SHO, 28 Registrar		0 gaps in rota. Locum shifts covered: 5 SHO, 18 Registrar	0 gaps in rota. Locum shifts covered: 10 SHO, 28 Registrar	0 gaps in rota. Locum shifts covered: 8 SHO; 22 Registrar	0 gaps in rota. Locum shifts covered: 4 SHO; 17 Registrar	0 gaps in rota. Locum shifts covered: 5 SHO; 17 Registrar
Minimum safe staffing in maternity services to include midwife minimum safe staffing planned cover versus actual prospectively.	**76 midwifery unfilled shifts . Appendix 3**	**All Clinical areas: A total of 76 unfilled midwifery shifts and 26 MCA shifts. Appendix 3**	**All Clinical areas: A total of 129 unfilled midwifery shifts and 20 MCA shifts. Appendix 3**	**All clinical areas: A total of 103 unfulfilled midwifery shifts, 26 MCA shifts and 1 co-ordinator shift. Appendix**	**All clinical areas:A total of 58 unfulfilled midwfery shifts, 21 MCA shifts**	**All clinical areas: A total of 101 unfulfilled midwifery shifts, 48 MCA, 4 housekeepers**	**All clinical areas: A total of 97 unfulfilled midwifery shifts, 50 MCA, 13 housekeepers**	**All clinical areas: A total of 98 unfulfilled midwifery shifts, 48 MCA, 1 band 7 co-ordinator in charge shift unfilled**	**All clinical areas: A total of 134 unfulfilled midwifery shifts, 49 MCA, 7 band 7 co-ordinator in charge shift unfilled**	**All clinical areas: A total of 154 unfulfilled midwifery shifts, 59 MCA, 7 band 7 co-ordinator in charge shift unfilled**	**All clinical areas: A total of 126 unfulfilled midwifery shifts, 23 MCA**	**All clinical areas: A total of 72 unfulfilled midwifery shifts, 38 MCA**
Service User Voice feedback	90.5% +ve	93.60%	91%	91%	84.80%	87.70%	81.2	89.90%	84.30%	94.10%	91.90%	85.70%
Staff feedback from frontline champions and walk-abouts	nil	nil		nil	nil	nil	nil	nil	nil	nil	nil	nil
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil
Coroner Reg 28 made directly to Trust	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil
Progress in achievement of CNST 10		completed	completed	completed								

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annuallly)	75% (Divisional total nursing and midwifery
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	Reported from 2019 results 87.5%. National average 89.54%

Gloucestershire Hospitals
NHS Foundation Trust

BOARD June 2022

REPORT ON THE SAFETY OF MATERNITY SERVICES

Perinatal Quality and Safety Report – Quarter 4 2021/22

1. Purpose of report

1.1 In response to the need to proactively identify trusts that require support before serious issues arise NHSE/I (2020) developed a new quality surveillance model to provide consistent and methodological review of maternity services. The purpose of this report is to provide assurance to the Quality and Performance Committee and Trust Board that there is an effective system of clinical governance monitoring the safety of our maternity service with clear strategies for learning and improvement. This report covers the period of January to March 2022 – quarter 4 (Q4).

2. Perinatal quality surveillance narrative summary and exception report Q4

2.1 Maternity Perinatal Quality Surveillance Q4 narrative (see dashboard for data)

2.1.1 National Events, Regulatory and NHSE/I Reviews

- In Dec 2021 CQC carried out a focus group with maternity staff, as they had been contacted directly because of concerns raised about staffing and on calls and in Jan 2022 they made requests for additional data.
- In NHSE/I Regional Maternity Team visited for an informal Quality Visit on 28 Feb 2022 and provided improvement feedback for the service which is currently being actioned/implemented.
- 10 March Trust Board 2022 received an update from the Immediate and Essential Actions (IEAs) from the Ockendon First Report (Dec 2021).
- This quarter The Ockendon Final report was published (30 March 2022) and a gap analysis will be prepared and presented to the Quality and Performance Committee in April and Trust Board in May 2022.

2.1.2 NHSE/I Maternity Safety Support Programme (MSSP)

- The service is not on the NHSE/I MSSP programme currently as rated good overall by CQC.
- The service had completed the NHSE/I Self-Assessment Tool and presented this to the Maternity Delivery Group in February. The completion of the tool has informed the service's quality improvement and safety plan. The tool will be reviewed quarterly at the Maternity Delivery Group (MDG).

Table: NHSE/I Self-assessment compliance – Feb 2022

RAG rating	Number of elements
Green	111
Amber	44
Red	5
Total number of elements	**160**

2.1.3 Learning from deaths – maternal, perinatal and neonatal mortality

- There were 4 early neonatal deaths and an additional death at the specialist services at Bristol (specialist care required).
- There were no maternal deaths.
- There were 5 stillbirths.
- 100% of deaths had the appropriate Perinatal Mortality Review Tool completed.
- See also NHS Resolution (NHSR) safety action 1 for more information at appendix 2.

2.1.4 Maternity training compliance

- Mandatory maternity training compliance for the core competence framework is flagging as an issue at 81% for all staff groups (target set is 90%). The service has an improvement plan to recovery this to 90% by the end of December 2022 by adding in additional days and paying staff bank hours to attend in their own time
- See also NHSR safety action 8 for more information at appendix 2.

2.1.5 Safer staffing

- There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group.
- Midwifery staffing remains as a risk on the Trust risk register scoring 15 for Safety (WC35360bs).
- There were 352 unfilled midwifery shifts this quarter (Q4) which is a 45% increase from last quarter (Q3).
- There were 120 unfilled shifts for MCA/MSWs.
- Due to midwifery staffing issues, there were 2 occasions when the service consolidated care provision. This included the temporary closure of the Gloucester Birth Unit (closed for 12 days from 17-28 March) and the Cheltenham Aveta Birth Unit (closed for 62 days 8 Dec-7 March) to intrapartum care.
- There were no rota gaps in the Obstetric cover.
- 10 March Trust Board 2022 received a Maternity Workforce report.
- See also NHSR safety action 4 & 5 for more information appendix 2.

2.1.6 Maternity Service user feedback

- Friends and Family Test scores have declined from 94% to 87% and a plan is in place to review this data and to carry out improvement work supported by the Maternity Voices Partnership.
- The last Picker National Maternity Survey data was provided to the Trust in Sept 2021 and an improvement plan is being developed in response.
- See also NHSR safety action 7 for more information appendix 2.

2.1.7 Staff feedback to Maternity and Neonatal Safety Champions

- Nil feedback from MNSC visits in Q4.
- See also NHSR safety action 10 for more information at appendix 2.

2.1.8 Clinical Incident Reporting

- The Director or Quality Improvement and Safety hosted an event reviewing the framework "Seven Features of Safety in a Maternity Units" and led conversations about the current position. The second workshop was held at the end of January 2022.
- A total of 2 cases were scoped and both were declared as Serious Incidents (SIs).
- One case met the criteria to be reported to HSIB.
- 3 final HSIB investigation reports were received and action plans have been. developed and agreed at the Safety and Experience Review Group (SERG).
- 3 investigations are being carried out by HSIB currently.

- HSIB meet on a quarterly basis with the maternity service and with Executive Leads to share learning and improvement.
- 1 case is being scoped by HSIB and is likely to be rejected as there is a normal MRI scan.
- There were no Prevention of Future Death Reports (Coroner regulation 28).
- See also NHSR safety action 10 for more information appendix 2.

2.1.9 Themes from trainee or staff surveys

- The number of maternity staff agreeing that they would recommend the service was 75%.
- The proportion of trainees rating the quality of supervision as good or excellent was 87.5% and this was last reported in 2019 (the national average was 89.5%). There is currently a new survey in progress.

2.1.10 Progress against NHS Resolution Maternity Incentive Scheme (CNST)

- Due to the ongoing and unprecedented challenges on the 23 December 2021 NHSR sent a letter to all Trusts to pause the reporting procedures for the scheme for a minimum of 3 months.
- At the end of Q4 the scheme remained paused and further detail on progress can be seen at appendix 1 as it is expected that the scheme will recommence in Q1 2022 and a further assessment will be done against the new requirements.
- To note the scheme recommenced May 2022 with some modifications to the existing requirements. Work is ongoing within the service to map these and establish any gaps.

Safety Actions progress can be seen at appendix 2
Action 1 National Perinatal Mortality Review Tool
Action 2 Maternity Service Data Set (MSDS)
Action 3 Transitional Care Services in place
Action 4 Workforce planning in place to the required standards
Action 5 Midwifery workforce planning in place
Action 6 Saving babies lives care bundle (SBLCBv2)
Action 7 Service user feedback and work with MVP to coproduce maternity services
Action 8 Local training plan in place to meet all 6 core modules of the core competency framework
Action 9 Maternity Safety Champions
Action 10 HSIB and NHSR reporting

3 Recommendation

The Maternity Delivery Group, Quality and Performance Committee and Board are asked to note the contents of the report and support the improvement plans.

4 Appendix 1 - Maternity Incentive Scheme (MIS) Progress Report Q4

Introduction – what are we trying to accomplish?
Maternity incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend. The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. NHS Resolution support this work through the Maternity Incentive Scheme. The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. The scheme rewards Trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. In the fourth year, the scheme further incentivises the 10 maternity safety actions from the previous year with some further refinement. Year four of the scheme began on 9 August 2021.

Due to the Covid-19 pandemic, in December 2021, a decision was made by the scheme's Clinical Advisory Group (CAG) to pause the reporting for year 4 of the scheme. Trusts were asked to continue to apply the principles of the scheme and to continue to report to MBRRACE-UK, NHS Digital and HSIB. The scheme's CAG reconvened on 28 February 2022 and a decision was made to relaunch the scheme on 6 May 2022.

How will we know if a change is an improvement?
As in year two, the scheme incentivises ten maternity safety actions. We need to demonstrate that we have achieved all of the ten safety actions so that we will recover the element of our contribution to the CNST maternity incentive fund and so that we can also receive a share of any unallocated funds.
Whilst the maternity incentive scheme is a self-certified scheme, with all scheme submissions requiring sign-off by our trust Board following conversations with trust commissioners, all submissions also undergo an external verification process and are sense-checked by the Care Quality Commission (CQC). The Trust must submit our completed declaration by 5 Jan 2023. This section updates our progress so far.

Table: Progress summary of all 10 safety actions in preparation for scheme to restart

Action	RAG Rating and current position	Actions required
Action 1 using the National Perinatal Mortality Review Tool	a) i 100% of perinatal deaths are notified within 7 working days and the surveillance form is completed within 7 days. ii Reviews are commenced within 2 months. b) At least 50% of deaths are reviewed with the PMRT by MDT c) 95% of parents have been told that a review will take place and that their perspective has been considered. d) Quarterly reports have been received by the Board from 6 May onwards and the reports have been discussed with the maternity safety champions RAG - GREEN	Quarterly reports to be received by Maternity Safety Champions and Trust board from 6 May 2022 onwards (add to MSC and Board planner).
Action 2 submitting data to the Maternity Service Data Set (MSDS)	By Oct 2022 Trust to have up to date digital strategy for our maternity service which aligns with the Trusts Digital strategy and reflects the 7 success measures and has been signed off by the LMNS. 9/11 Clinical Quality Improvement Metrics	The Maternity Service Digital strategy will be incorporated into the Maternity Strategy and is to be received in Aug/Sept 2022. This CQIMs data will be added to the QPR and the Maternity Service

Action	RAG Rating and current position	Actions required
	(CQIMs) will have passed the associated data quality criteria in July 2022 (published Oct 2022. RAG – AMBER	dashboard and be shared with MDG/MSCs. Trust Board to confirm that they have passed the data quality criteria by self-declaration (the data will be published in the Maternity Services Monthly Statistics publication in Oct 2022).
Action 3 Transitional Care Services in place	Atain reports received by Board Level Maternity Safety Champions. RAG – AMBER	Quarterly reports to be received by the Maternity Safety Champions meeting that meet all the correct defined criteria and action plans are developed for any metrics not meeting targets.
Action 4 Workforce planning in place to the required standards	On track report received by March Board 2022 and to be presented again in Sept 2022 (once RCOG staffing audit completed). RAG - GREEN	Board report received at March 2022 meeting and next report due Sept 2022. Audit to be completed on Consultant attendance in specified circumstances
Action 5 Midwifery workforce planning in place	On track - staffing report received by March 2022 Board and Birth rate plus review underway RAG - GREEN	Board report received at March 2022 meeting and next report due Sept 2022.
Action 6 The 5 elements of the saving babies lives care bundle have been implemented	The quarterly care bundle surveys are being completed and the service has fully implemented SBLv2 including the data submission requirements. Our current data does not meet target compliance in elements 1-4 we are not meeting the minimum requirements and no action plans have been received by MDG. RAG – AMBER	Trust will fail Safety Action 6 if the process indicator metric compliance is less than target and there are no action plans in place. Element 1-4 are amber rated and require action plans Element 1 – CO monitoring at 36/40 difficult to achieve due to the inability to pull data from Trak and requires manual notes audit (Element 5 – is green and meeting target compliance).
Action 7 mechanisms for gathering service user feedback and work with Maternity Voices Partnership (MVP) to coproduce maternity services	MVP meetings are going ahead. MVP has a work programme Monitor MVP chair is attending Maternity Clinical Governance meeting (MCG) EM Improvement plan Complaints are shared with MVP. RAG – AMBER	MDG to seek assurance that MVP Chair attending MCG – invited but unable to attend meetings on a Friday. Minutes to be shared with MVP Chair MDG to see the Ethnic Minorities improvement plan. Check complaints are shared with MVP.
Action 8 local training plan in place to meet all 6 core modules of the core competency framework	**Training compliance decreased to 81% (compliance target is 90%)** Local training plan includes all six core modules of the Core Competency Framework (CCF) 1. Saving Babies Lives Care Bundle 2. Fetal surveillance in labour 3. Maternity emergencies and multi-professional training. 4. Personalised care 5. Care during labour and the immediate postnatal period 6. Neonatal life support Training compliance has decreased due to	Educational review taking place and should include the plans for the remaining 2 components of the CCF - Personalised care - Care during labour Training compliance to be 90% by Dec 2022 (CNST will measure compliance over 18 month period). EWS (MEOWs and NEWTT) audits have not been completed since 2019.

Action	RAG Rating and current position	Actions required
	sessions being cancelled and Midwives only being able to attend if undertaken as bank payment rather than as part of substantive hours; reduction in staffing in Practice development due to leavers. Band 6 hours recruited into both substantively and as a 6 month secondment to provide some additional hours. However 0.5 WTE Band 7 leaving the service to take up alternative employment. Recruitment into this position not yet agreed whilst work is undertaken to establish feasbility of recrutment to an 8a educational post. Approval received to recruit a further 0.5WTE Band 7 into post. Delay in releasing band 6 PDM midwife into role as staffing shortages. PDM administrator currently on long term sick which is putting more strain on the service delivery. RAG – AMBER	
Action 9 Trust maternity Safety Champions are meeting bi monthly with the Board level champions	Safety intelligence pathway from ward to Board needs refresh to include **Perinatal Quality Surveillance** Model Report. Board level maternity service champions to present local PQS report and dashboard to Board quarterly. MCoC action plan to be reviewed by MSCs (paused/reviewed due to Covid and Ockendon 2022 IEAs) Oversight of the Neonatal Critical Care Recommendations Maternity Safety culture measurements and improvement plan. RAG – AMBER	Structure for Maternity reporting ward to Board to be reviewed by MSC meeting. Quarterly PQS Reports and dashboard to be presented to the Board by the Board MSC from June 2022 (this report) To include - SIs - Claims data - Walkabout data - Training compliance - Staffing - MatNeoSiP MSCs to have at least quarterly engagement meetings MSCs to review Midwifery Continuity of Care action plan MSC to review how the service is implementing the National Neonatal Critical Care Review
Action 10 Reported 100% of qualifying cases to HSIB and to NHSR	On track all cases reported.	

Table: Key for BRAG rating

Blue	Action complete and assurance provided
Red	Action not on track with major issues
Amber	Action mainly on track with some minor issues (mitigating activities should be identified)
Green	Action on track

5 Appendix 2 - NHSR MIS Safety Action Update

Safety action 1 – Perinatal Mortality Review Tool (PMRT)

The Trust has been able to continue to report to MBRRACE as advised by NHSR. All notifications are made and surveillance forms completed using the MBRRACE-UK reporting website. All (100%) of our stillbirths and early neonatal deaths are reviewed through the use of the national standardised Perinatal Mortality Review Tool (PMRT) which adopts a systematic, multidisciplinary, high quality review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

The speciality hold a multidisciplinary Mortality and Morbidity (M&M) Reviews and also engage with the M&M reviews of cases referred to the tertiary units when necessary. Work is in progress to ensure external opinion from the Local Maternity and Neonatal System (LMNS) from Bath, Swindon and North Somerset is also available at this meeting to achieve compliance with the Ockenden (Dec 2021) Immediate and Essential Action 1.

Table: Numbers of deaths in Q4

Deaths	Numbers
Early neonatal	4 (1 at Bristol)
Maternal	0
Stillbirths	5

Table: Perinatal mortality reviews Jan – March 2022 and action plans

MAT MRN	PMRT GRADE A		PMRT GRADE B		PMRT GRADE C or D		Action plans following PMRT reviews
	AN	PN	AN	PN	AN	PN	
January 2022							
0895148	√	√					None identified
February 2022							
1157006	√	√					None identified.
3175221	√	*					***Note on grading** Not able to be graded for the care of the baby from birth to death, as this case is subject to a higher-level review. Grading for the care provided to the mother following the birth of her baby = **B,** this was in light of the feedback from the patient's postnatal experience on the maternity ward. **Actions – none identified.**
March 2022							
4252457	√	√					**Action**: Following the discussion of the parent's perspectives as they questioned the decision of the paramedics not to take her to hospital by ambulance. The discussion at the review concluded that this was not felt to have impacted on the ultimate outcome. However, this will be followed up with the Ambulance Service.
3091634		√	√				**Action:** The mother to be referred to Preterm Birth Clinic and CMW team to be informed to ensure the aspirin has been recommended as the mother is now pregnant.
1159884	√	√					**Action:** Obstetric consultant to follow up the PM result as this will impact future pregnancy management/ counselling. Also, to check with GP to ensure renal function has been followed up.

PMRT Grading: (split into antenatal and postnatal)

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

Table: Perinatal Mortality Review Tool and Trust compliance with statements

Statement	Trust compliance
a) **i.** 100% of perinatal deaths eligible to be notified to MBRRACEUK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. **ii**. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death (100% of factual question answered). This includes deaths after home births where care was provided by your Trust.	100% 100%
b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	100%
c) For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required. **A recent change has been made with regard to gaining parents' perspectives/questions for PMRT. Parents are offered to complete an MBRRACE feedback form, and this then enables the parent's perspectives/questions to be addressed at the Perinatal Mortality Review of their case. The PMRT report is then completed in draft form within 1-2 weeks of the review. This is then available for the de-brief/counselling appointment between the parent's and the consultant to discuss the review findings and their perspectives/questions. This change has been made as a result of the Sands survey 2021 of parents' experiences of hospital reviews into their care and the recommendations made*	100% of parents advised of review

<u>Improvement action</u>
To meet the NHSR MIS Standard a report should be received every quarter by the Board and the report should include details of the deaths reviewed and the consequent action plans. The quarterly reports will also need to be discussed with the Maternity Safety Champions and the Board Level Safety Champions.

Safety action 2 - Maternity Service Data Set (MSDS)

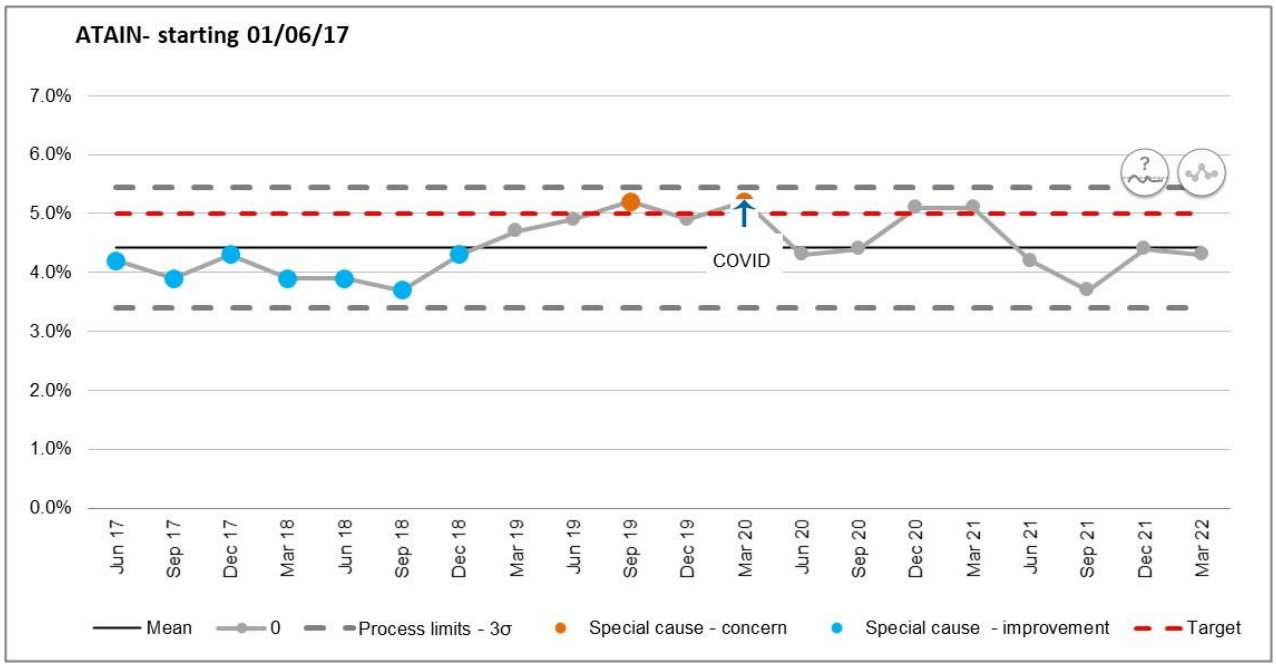
This relates to the quality and completeness of our submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. Currently we are developing are digital strategy for approval by the LMNS and this should be submitted to MDG in August 2022.

Improvement action
In July 2022, we will submit our data and then in Oct 2022 we will receive a file in the Maternity Services Monthly Statistics publication to confirm that we are meeting at least 9/11 Clinical Quality Improvement Metrics.

Safety action 3 - Transitional care services

Transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme. We have developed pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

Graph: Data demonstrates that we are currently below the National target of 5%



Improvement action
Progress with our ATAIN action plans will be shared with the maternity, neonatal and Board level safety champions, LMNS and our ICS quality surveillance meeting.

Safety action 4 & 5 demonstrate clinical workforce planning

The Board received a maternity workforce report in March 2022.

Maternity Unit temporary closures

There were no whole unit emergency closures during Q4 of maternity services. However, due to staffing issues there were occasions when the service consolidated care provision. This included closing the Gloucester Birth Unit; Aveta Birth Unit to intrapartum care; clinics and DAU work continues to operate from the freestanding birth units during the day.

Table: Unit and service closures

DATE	Days closed	AREA	RATIONALE
8th December – 7th Feb 2022	62 days	Aveta Birth Centre	Staffing – sickness and absence across the service
17th March – 28th March	12 days	Gloucester Birth Unit	Staffing – sickness and absence across the service
			2021/2 Quarter 4 total 2

Improvement action

The next Maternity Workforce report is due to be received by Board in Sept 2022. The Maternity Birthrate Plus review will commence in quarter 1 2022 and the report and recommendations will be received by Board within this next report.

Safety action 6 - demontrate compliance with all five elements of the Saving Babies Lives Care Bundle Version 2 (SBLCBv2)

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one. This version aims to provide detailed information on how to reduce perinatal mortality. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice. The new fifth element is reducing pre-term birth. This is an additional element to the care bundle developed in response to the Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births from 8% to 6%. This new element focuses on three intervention areas to improve outcomes which are prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable. While the majority of women receive high quality care, there is around a 25 per cent variation in the stillbirth rates across England. The Saving Babies' Lives Care Bundle addresses this variation by bringing together five key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. Our Q4 data has been summarised in the dashboard below. Ongoing audits to demonstrate compliance being prioritised. There is no permanent audit midwife in post -work and so work is being undertaken by bank midwife.

Picture: SBLCBv2 dashboard

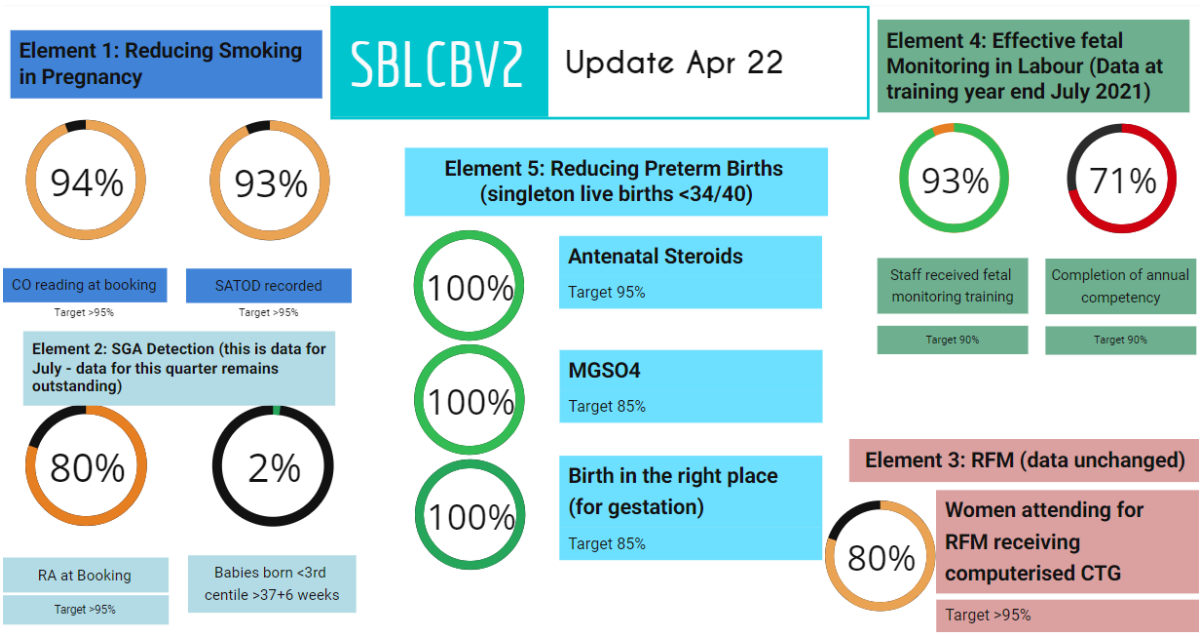


Table: SBLCBv2 element, BRAG rating and improvement plan

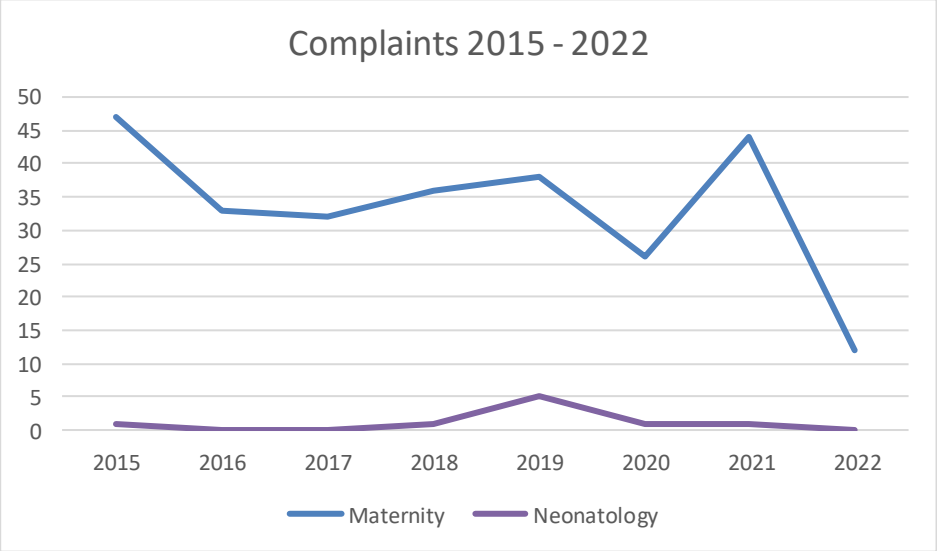
Element	BRAG rating	Improvement plan
Element 1 - Reducing smoking in pregnancy	AMBER	CO monitoring at 36/40 – data not available on Trak resulting in notes audit being undertaken. Compliance remains low on latest audit demonstrating 50% compliance. Smoking Cessation midwife working with community leads to address the issue and undetake teaching sessions locally with midwives. On-going audits continue to monitor improvement
Element 2 - Risk assessment and surveillance for fetal growth restriction	AMBER	Audit to commence
Element 3 – Raising awareness of reduced fetal movement	AMBER	On going audits for computerised CTG's undertaken. Poor compliance on recent audit (70%) Fetal monitoring midwife devised an action plan and will reaudit
Element 4 – Effective fetal monitoring during labour	RED	Fetal monitoring study days now recommenced and a plan to ensure >90% compliance being developed by the leads
Element 5 – Preterm care	GREEN	

Safety action 7 - service user feedback

Complaints

The following chart displays the number of complaints for both maternity and neonatal services since 2015. There were no complaints specifically attributed to Covid although it should be acknowledged that staffing factors and service delivery alterations throughout the pandemic will have impacted on the level and category of complaints received.

Table: Total number of complaints by year



The complaints team triage complaints as either standard or serious dependent on the complexity of individual complaints. Standard complaint response time 35 days, serious complaints 65 days. There were 2 serious complaints for the maternity service during Q4.

Table: Detail of the 2 serious complaints

Date received	Location (type)	Specific Location	Brief description of Patient Experience	Subject	Sub-subject	Subject notes
16/02/2022	Outpatient Department	Antenatal Clinic	Pt initially told steroids would be needed, subsequently overturned by another consultant. Baby born with breathing difficulties and spent time in NICU	Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Pt initially told steroids would be needed, subsequently overturned by another consultant. Baby born with breathing difficulties and spent time in NICU
21/02/2022	Outpatient Department	Triage - Obstetric	Maternity triage - Lack of initial pick up. Poor communication and advice. Attitude of triage nurse. Pt miscarried	Communications	Communication with patient	Maternity triage - Lack of initial pick up. Poor communication and advice.
				Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Maternity triage - Attitude of triage nurse. Pt miscarried

There were a further 9 complaints triaged as standard in the Maternity Service.

Table: Details of the 9 complaints

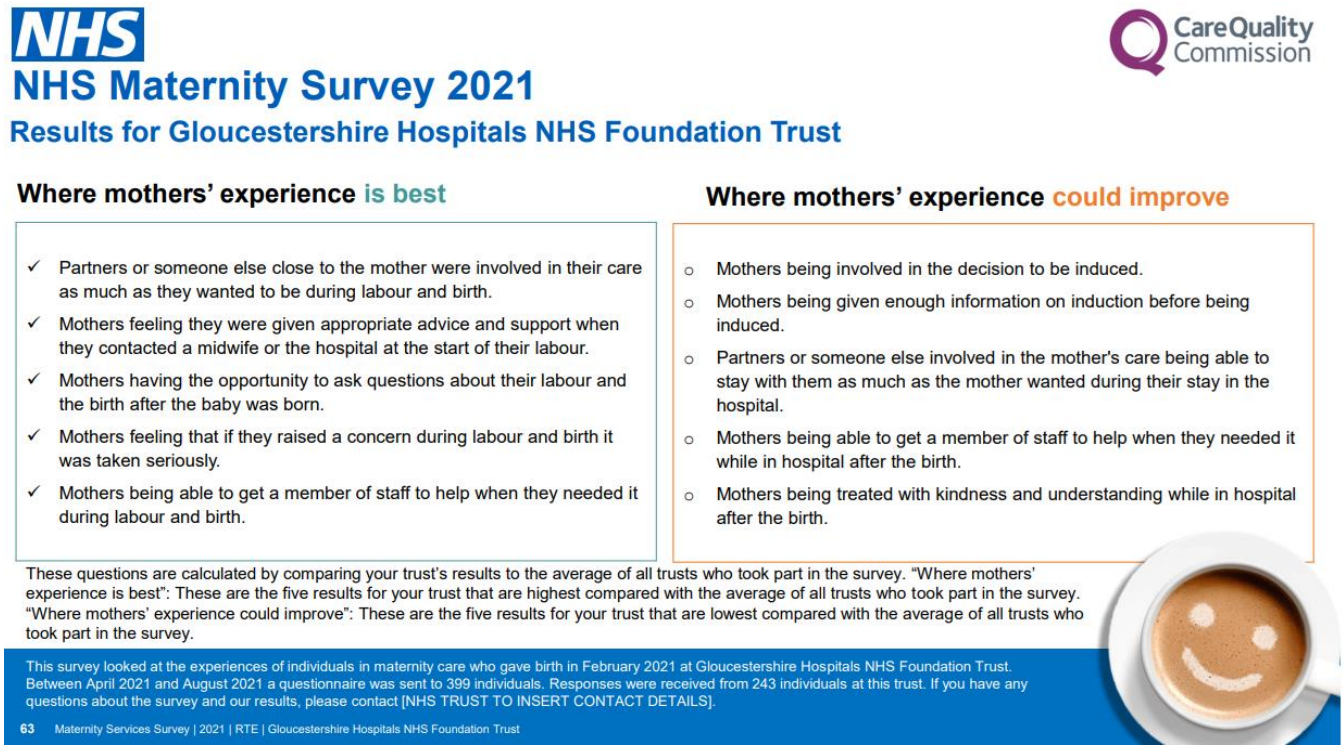
Date received	Specific Location	Brief description of Patient Experience	Subject	Sub-subject	Subject notes
11/03/2022	Birth Unit	Attitude and practice of Dr doing vaginal examination. Communication between midwife and Dr as Dr did not want to perform C section and wanted natural birth. Dr caused laceration in babies upper lip. Scar still evident.	Clinical treatment	Incorrect procedure	Attitude and practice of Dr doing vaginal examination
			Communications	Breakdown in communication between staff	Communication between midwife and Dr as Dr did not want to perform C section and wanted natural birth.
			Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Dr caused laceration in babies upper lip
14/01/2022	Maternity Ward Obstetrics	newborn baby not tagged	Trust admin/policies/ procedures including patient record management	Child Protection Process/Policy/Procedure	Newborn baby not tagged.
04/02/2022	Maternity Ward Obstetrics	Antenatal intervention undertaken without consent	Consent	Failure to obtain appropriate consent	Antenatal intervention undertaken without consent.
24/02/2022	Maternity Ward Obstetrics	Poor care. Catheter issues. Overhearing third party conversation. Lack of staff, space and resources.	Patient Care (Nursing)	Catheter care	Problems with catheter maintenance and care.
				Failure to provide adequate care (inc. overall level of care provided)	Query regarding why wait was so long to go into delivery suite
			Privacy, Dignity and Wellbeing	Noise disturbance	Needed private toilet
			Staff numbers	Staffing Levels	Patient felt there were not enough staff to deal with needs of herself and patients on ward
18/03/2022		Poor attitude of midwife	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Poor attitude of midwife
16/02/2022	Outpatients	Attitude of midwife and consultant	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Attitude of midwife
				Attitude of Medical Staff	Attitude of consultant
24/02/2022		Poor attitude of midwife - Lack of care - not following protocol	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Poor attitude of midwife
			Trust admin/policies/ procedures including patient record management	Specimen/sample - transport	Bloods not labelled at time of appointment.
			Communications	Insufficient information provided	Midwife did not answer patients questions
			Appointments	Referral - Failure	Midwife refused referral.
27/01/2022	CDS Central Delivery Suite	Lack of assistance from midwife during labour. PPH not recognised by midwife.	Patient Care (Nursing)	Failure to provide adequate care (inc. overall level of care provided)	Lack of assistance from midwife during final stages of labour.
			Clinical treatment	Failure to follow up on observations / recognise deteriorating patient	PPH not recognised by midwife.
28/01/2022	Maternity Ward Obstetrics	Poor communication to mother regarding baby's condition	Communications	Communication with patient	Lack of communication regarding baby having streptococcus. mother was not made aware.

Friends and family test

Friends & Family has recently been expanded to include further questions relating to Continutiy of Carer and also to endure feedback is attribital to the actual place of birth and not amalgamated into feedback on the postnatal ward these questions have been seperated. An improvement in scores has been seen since the start of the year with positive results of above 90% in both January and February.

National Patient Survey Programme – Maternity

We also received the CQC Maternity Survey results in Q4 with a summary below.



Improvement Plan

The Maternity Voices Partnership (MVP) have a plan for improvement and our patient action plan will co-designed with the MVP. Attendance at that meeting has been reduced due to staffing shortages.

Safety action 8 - evidence of local training plan is in place to ensure that all six core modules of the Core Compentency Framework

The service has fallen below target levels with mandatory training. Mandatory training including PROMPT and Midwives mandatory study days were cancelled in January. Midwives have been asked to undertake mandatory training as bank work until the end of April.

Picture: Maternity service mandatory training rates (target 90%)

Table: current PROMPT compliance – 2021-22 for training year commencing Sept 21

% Compliance for different elements PROMPT			
	Part 1 Virtual Update	Part 2 Skills Drills	Both elements completed
Midwives (incl. bank)	46	36.2	32.2
*Obs Drs Consultants	58.3	58.3	58.3
*Obs Drs Junior Grades	52.9	50	50
**Anaes Drs Consults	27.2	42.8	35.7

**Anaes Drs Jnr Grades	19.5	19.5	19.5
MCAs/MSWs	31.5	27.3	21.0
Theatre Staff	37.1	31.4	30

Table: Compliance with Midwives and MCA/MSW Mandatory Training

		Midwives Mandatory Update
Total		115
% Attendance Midwives		32.8

	% Attendance
Total	25.0
MCA/MSW	26.3

Improvement plan

Additional study days have been added in to the Training Plan. An educational training review has been commissioned to review the current requirements to make sure that we are making best use of opportunities. The plan is to have increased compliance to 90% by Dec 2022.

Safety action 9 - processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues

Maternity Safety Champions (MSCs) work at every level – trust, regional and national – and across regional, organisational and service boundaries. Safer maternity care called on maternity providers to designate and empower individuals to champion maternity safety in their organisation. The board-level maternity safety champion will act as a conduit between the board and the service level champions.

The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies. Maternity Service Champions build the maternity safety movement in our service locally.

The Trust Maternity Safety Champions have been meeting on a monthly basis.

Improvement action

- A Safety intelligence pathway from ward to Board needs to be refreshed to include the **Perinatal Quality Surveillance** (PQS) Model.
- The Board level maternity service champion will present the PQS Dashboard and Report to Board quarterly.
- Our MCoC action plan is to be reviewed by MSCs.
- The MSCs are to have oversight of the Neonatal Critical Care Review Recommendations.
- The MSCs should support the safety culture improvement plan.

Safety Action 10 - reported 100% qualifying cases to Health Care Safety Investigation Branch (HSIB) and to the NHS Resolution's Early Notification schemes

Serious incidents

The purpose of serious incident reporting and learning is to demonstrate good governance and safety for the most serious incidents. The aim of this Q4 update is to provide assurance to the Board that the maternity service is compliant with the contractual standards for investigations, that immediate learning happens (72 hour reports) and that recommendations made are developed in action plans which are then implemented. Where the incident meets the HSIB criteria these are referred to them to investigate.

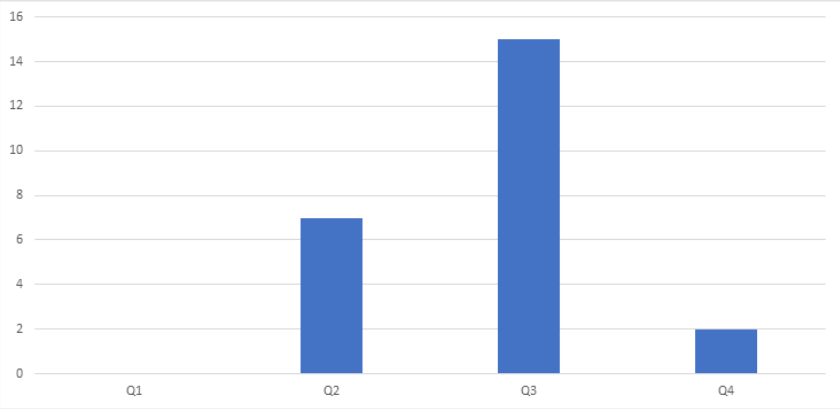
Governance

At the service level, the Maternity Clinical Governance Meeting has oversight of the serious incident management process. The Division reports through to the Trust level the Safety and Experience Review Group as they have detailed oversight escalating any concerns to the Quality Delivery Group. All incidents that have been scoped within maternity are presented to the weekly SI panel.

Serious incident reporting

Serious incidents must be declared as soon as possible and in order to do this incidents that have been identified as serious in nature undergo a scoping exercise. In Q4 there were a total of 2 incidents scoped and both were classed as serious incidents.

Table: Total number of incidents scoped 2021-22



Also, the Trust is required to report all qualifying cases to the HSIB and of the 2 incidents scoped 1 was reported to HSIB.

Table: Details of incidents scoped in Q4

Datix	Speciality	Incident Summary	Immediate actions including level of harm/referral to HSIB
W172609 / W172611	Maternity	Uterine Rupture/Baby transferred for cooling	HSIB/SI
W172553	Maternity	Baby born 31/12/2021. 3 VTE risk factors. Reg requested TEDS and Fragmin for 7/7. Patient aware of instruction and apparently asked 3 midwives for the Fragmin to take home. All 3 apparently said something along the lines of "I will sort it in a minute". Patient went home without Fragmin. Readmitted too GRH Sat 15th with chest pain and breathlessness diagnosed with multiple PE. Now on 15,000 units of Fragmin.	SI

HSIB Cases

The HSIB Maternity investigation programme is part of a national plan to make maternity care safer. HSIB investigate incidents that meet the HSIB and MBRRACE-UK criteria. HSIB investigations replace internal serious incident investigations. HSIB involve the Trust and

share the investigation reports once they are completed. The Trust continue to investigate maternity events that fall outside the HSIB specified criteria.

Governance

The maternity service remains responsible for Duty of Candour, 72-hour reports and reporting via the Strategic Executive Information System (STEIS). HSIB provide 2 weekly investigation progress reports to the Trust and meet with the Trust on a quarterly basis to share learning, themes and trends.

Table: Total HSIB investigation activity since April 2018

Cases to date	
Total referrals	42
Rejected (not including duplicate referrals)	13
Total investigations to date	29
Total investigations completed	25
Current active cases	4
Exception reporting to DHSC	0

Graph: Maternity investigation categories

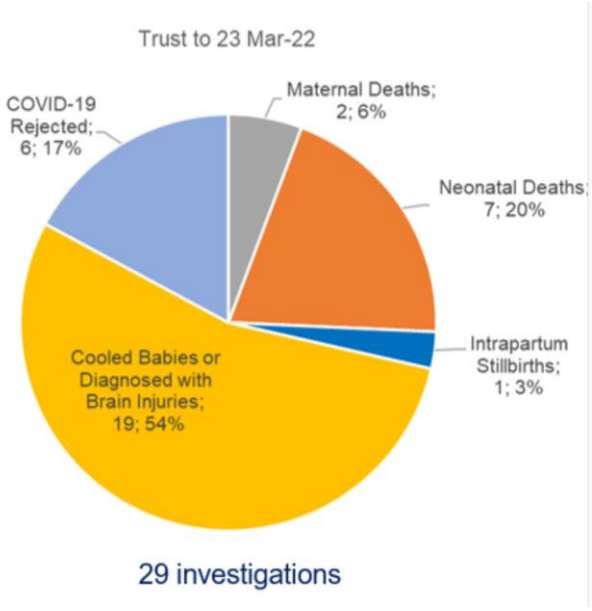


Table: HSIB activity in Q4

HSIB case number	Qualifying criteria	Investigation progress	Improvement
MI-003319	Maternal Death/massive PPH (March 2021)	Final report received January 2022	Action plan agreed and presented at SERG.
MI-003835	HIE3	Final report received.	Action plan agreed and presented at SERG.
MI-03888	Cooling/HIE3	Final report received December 2021	Action plan agreed and presented at SERG.
MI-004519	Maternal Death–@ 11/40	Investigation in progress	

HSIB case number	Qualifying criteria	Investigation progress	Improvement
MI-005438	Cooling. Head MRI normal HSIB investigation proceeding as parents raised concerns regarding care	Investigation in progress	
MI-006101	January referral HIE/Cooling 37+0 Contractions/Abdo Pain, Pathological CTG, Cat 1 EMCS, Uterine Rupture. Internal scoping report	Investigation in progress Trust staff interviews commenced. HSIB has made a request for information and staff interviews with SWAST on 16th March, this is to be escalated through HSIB internal processes. The family have not engaged since the baby was discharged home from the LNU. HSIB continue to make attempts to arrange a family interview.	
MI-007314	March referral Baby confirmed with a metabolic disorder	HSIB scoping they have requested a copy of the MRI report. To be rejected if confirmed as normal	

Table: Details of family involvement in HSIB investigations

Date range	Families not agreeing to contact from HSIB	Families contacted by HSIB but not agreeing to participate	Families engaging with HSIB
Q1 20/21	7.2%	8.6%	84.2%
Q2 20/21	7.3%	10.5%	82.2%
Q3 20/21	7.9%	7.1%	85.1%
Q4 20/21	7.4%	3.5%	89.1%
Q1 21/22	6.2%	6.2%	87.7%
Q2 21/22	6.7%	6.7%	86.6%
Q3 21/22	7.6%	8.5%	83.9%

NHS Resolution Early Notification Scheme

The scheme aims to provide a more rapid and caring response to families whose babies may have suffered harm. On completion of the HSIB safety investigation, where a case has progressed following referral for potential severe brain injury, a copy of the final report is shared with NHSR for them to review and decide whether there is any evidence that could potentially result in compensation.

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Report to Public Board of Directors

Agenda item:	10	Enclosure Number:	8
Date	9 June 2022		
Title	Quality Account 2021/22		
Author /Sponsoring Director/Presenter	Katie Parker-Roberts, Head of Quality and Lead Freedom to Speak Up Guardian Matt Holdaway, Director of Quality and Chief Nurse		

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

Summary of Report

Purpose

Our Quality Account is our annual report to the public about the quality of services we deliver. The primary purpose of our Quality Account is to assess quality across all of the healthcare services we offer. It allows us (leaders, clinicians, governors and staff) to demonstrate our commitment to continuous, evidence-based quality improvement, and to explain our progress to the public.

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining both what we are doing well and where improvement is needed. But, crucially, they also look forward, explaining what we have identified as our priorities for improvement over the coming year.

The Quality Account provides assurance on improvement work undertaken against the identified 14 Quality Indicators agreed for 2021/22. This document has been shared with external stakeholders, whose statements are included. This document was reviewed at Quality Delivery Group and Quality and Performance Committee, and is now being taken to Board for final approval before publication.

Conclusions

This is the final version of the Quality Account for approval by Trust Board

Implications and Future Action Required

This final draft has been circulated to external stakeholders for their review and statements, which are included in the document. Once approved by Trust Board, the Quality Account will be sent to NHSE/I for publication.

Recommendation

The Board is asked to approve the Quality Account, for publication with NHSE/I.

Enclosures
• Quality Account

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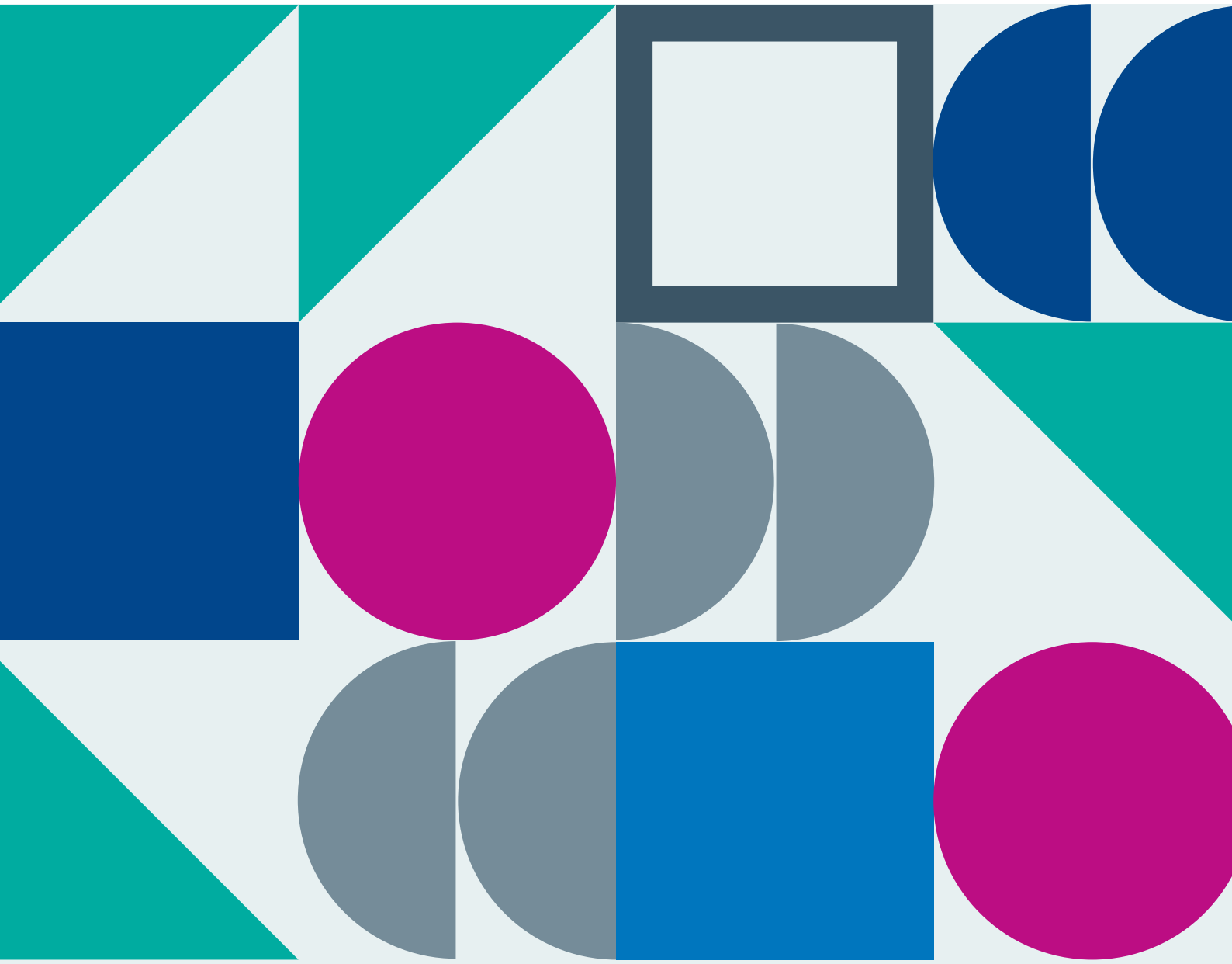
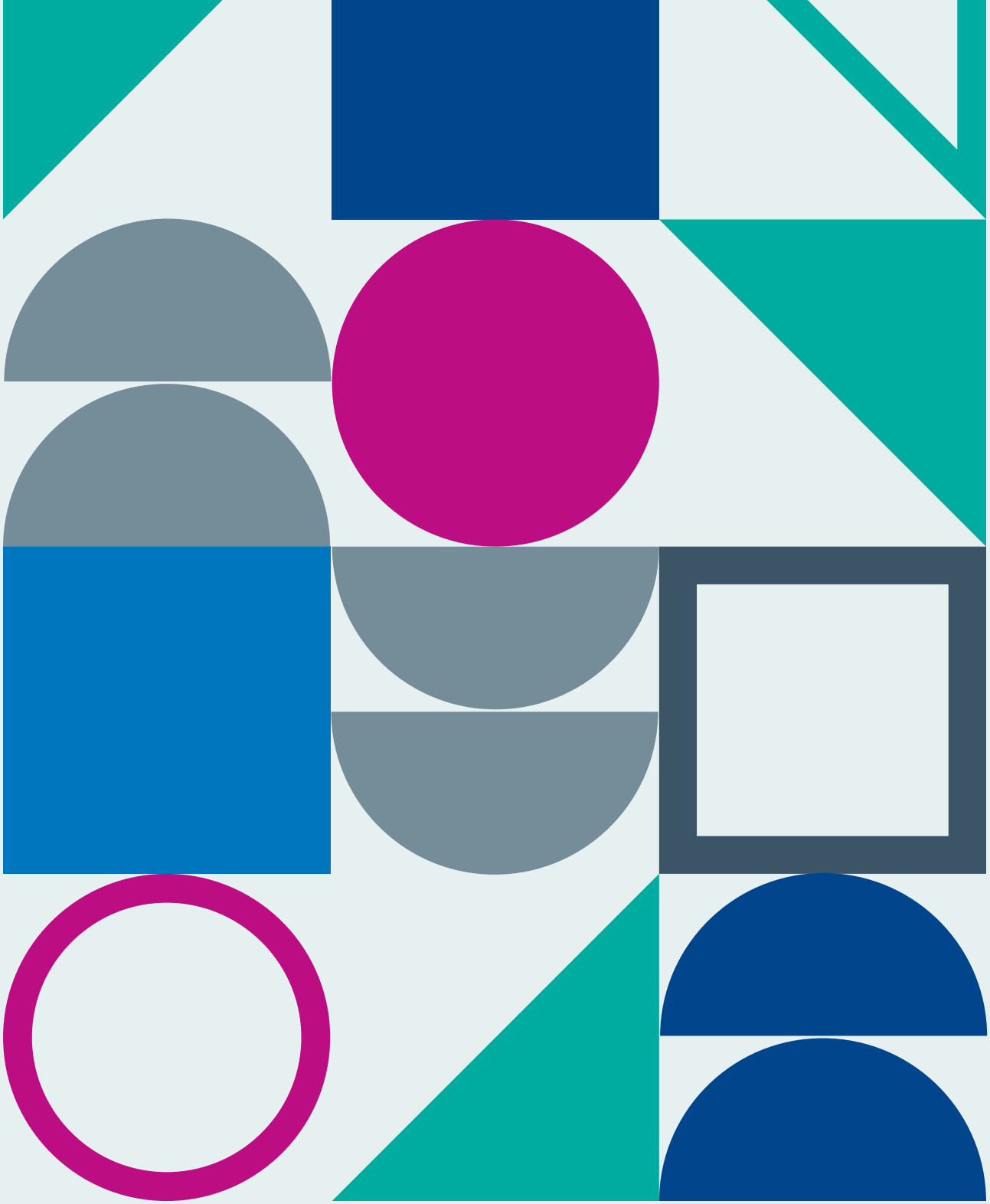


Quality Account 2021–2022



Our Quality Account 2021/22

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements. Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

Contents

Part 1

Statement on quality from the Chief Executive of Gloucestershire Hospitals NHS Foundation Trust

For decades to come the last two years will be remembered for the pandemic and the shadow it cast across every corner of the globe. Billions of people have been affected and we will be counting the true cost of COVID-19 for many more years to come.

The global death toll stands at 6.3 million while more than 1500 people in Gloucestershire have lost their life, with the ripples of these deaths reaching far and wide. Sadly, it has also highlighted the grave inequalities within our society. The stark reality is that we have not all been affected in the same way with, for example, people from minority ethnic backgrounds have been disproportionately impacted; those with a learning disability have poorer outcomes and those in older age groups, particularly those living in care homes, being especially vulnerable.

The huge success of the vaccination programme gives us real hope of improving times although as we emerge from the pandemic, and a new normal emerges, the pressures on our hospitals are greater than ever. I've heard colleagues best describe this as 'unrelenting' as up and down the country, images of queuing ambulances

outside our Emergency Departments are all too familiar while waits for planned care such as hips and knee replacements, cataract replacements remain too long.

The Year Just Gone

Whilst it is hard to frame the last 12 months in positive terms there is much to be celebrated and proud of in the Trust's response to the pandemic. Our teams at Cheltenham General and Gloucestershire Royal are rightly proud for continuing to provide a wide range of outpatient care, operations and specialist diagnostic tests throughout the pandemic. We delivered more elective surgery and cancer care than any other Trust in the Region, due to

the model of service we adopted. We are confident that by utilising our two hospital sites in the way that we did, we saved lives. It has also meant that we are in a stronger position as we emerge from the pandemic in terms of catching up on postponed work.

As a system Gloucestershire led its own vaccination programme resulting in more people receiving vaccines more quickly than anywhere else in the country. We also recruited more patients into the urgent COVID public health studies and trials than any other system in the Clinical Research Network helping to improve our understanding of the virus thus improving treatments.

The pandemic continues to have a significant impact on our colleagues who've had to cope through the toughest of times. The establishment of our 2020 Health and Wellbeing Hub has supported and guided colleagues throughout this period.

Since its inception in May 2019 the 2020 Hub has had 18,656 contacts of which 14,978 have been made during the two years of the pandemic. Our colleagues have told us how challenging the workplace remains, in the national staff survey.

What is very apparent in this year's results is that whilst we can mobilise many initiatives to support staff, to improve their experience and support their development, ultimately staff come to work to deliver high quality care and when they feel they can't do this it impacts on their sense of purpose and how they feel about the organisation.

However, this year hasn't just been about surviving a pandemic and, as such, we're especially proud of the progress we have made on many of our strategic objectives – as a Board this was something that we were determined to achieve. For example;

- We started works on our ambitious £100m-plus capital investment programme across both sites which will see significant investment in new buildings, equipment and improved practice across specialist services. This is the realisation of our centres of excellence vision, part of One Gloucestershire's longer term approach to health provision in the county. Patients are already starting to see the benefits of this following the opening of two new departments in the last months. At Cheltenham General, the Radiology Department has undergone a £6.5m programme of extensive refurbishment. Waiting areas have been redesigned, three new CT scanners installed, four new digital x-ray machines, two new ultrasound machines, a new MRI scanner and a new interventional suite. This means that patients accessing the town's A&E with sprains, fractures and breaks will benefit from improved services. At Gloucestershire Royal a newly repurposed Medical Same Day Emergency Care (SDEC) unit has opened. The unit will enable more patients to be seen and treated on the same day helping to avoid hospital admissions and avoiding the need for treatment at the Emergency Department (ED) altogether.
- We've made significant progress in digitalising our patient health records (Electronic Patient Record) using better, faster, safer technology to help us document patient care. The system, called Sunrise EPR, provides a single place for clinicians to go with up-to-date information on every bed and every adult inpatient that can be accessed anywhere. It is reducing our reliance on paper, helping to reduce risk, saving time, improving patient safety and releasing time to care.

- We have continued our commitment to being an organisation characterised by an inclusive culture and compassionate behaviours towards each other, our patients and their families. We've carried on in our journey to better understand why some groups of staff report a less good experience of working in the Trust than others; we are well advanced in our understanding of the areas where we need to make further improvements and work is underway to ensure we are an organisation that embraces the diversity of its workforce, and those it serves, and one that is truly inclusive of that diversity. This will remain one of the organisation's highest priorities in the coming year.

The Year Ahead

Despite the unprecedented scale of challenge ahead we enter 2022 with many goals within our grasp. The reconfigured landscape for system partners presents us with an opportunity for even closer joint working to help improve 'flow' through our hospitals thus improve turnaround times for ambulances and waiting times for patients at our Emergency Departments. We've already started to see the impacts of our elective catch up work which has seen the number of patients waiting more than 52 weeks drop a peak of 3,061 in April 2021 to ADD at the end of March 2022. There will be renewed focus and energy to reduce this further in the coming 12 months.

At Board we've started deeper discussions about how we support and enable colleagues to provide the best possible care they can in the current circumstances. We remain absolutely committed to listening and acting on what colleagues have told us and in our pursuit of making our organisation one where people feel valued and included.

We will also continue the good work started in relation to vulnerable adults and children including the work on caring for those with mental health conditions, those with a learning disability and young people as they transition from children's services to adult care.

Our exciting capital investment programme will take an enormous step forward in the coming 12 months with the completion of the programme expected in the summer of 2013. With this will come some real benefits aligned to our commitment to become a carbon neutral Trust by 2040.

Thank you

It serves for me to thank you, the reader, for everything that you have brought to the Trust whether as a colleague, a governor, a partner, a public member or a patient.

Finally, I can confirm that, to the best of my knowledge, the information included in this report has been subject to all appropriate scrutiny and validation checks and as such represents a true picture of the Trust's activities and achievements in respect of quality.

Deborah Lee
Chief Executive Officer

Part 2 and 3

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into four parts:

- **Part 2**
  - **Part 2.1**
    - **What our priorities for 2022/23 are:** explains why these priorities have been identified and how we intend to meet our targets in the year ahead.
    - **How well we have done in 2021/22:** looks at what our priorities were and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve
  - **Part 2.2:** Statements of assurance from the Board
  - **Part 2.3:** Reporting against core indicators
- **Part 3:** The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2.1

Our priorities

Our priorities for improving quality 2022/23

Our Quality Account is an important way for us to report on the quality of the services we provide and show our improvements to our services that we deliver to our local communities. The quality of our services is measured by looking at patient safety, the effectiveness of treatments our patients receive, and patient feedback about experiences of the care we provided. The quality priorities detailed in this report form a key element of the delivery of the Trust's objective to provide the "Best Care for Everyone".

Our ratified Quality Strategy outlines a clear approach to ensuring we have robust systems and processes in place to gather and analyse quality and patient experience data, and involve patients, colleagues and communities in a cycle of continuous improvement. The Quality Strategy was approved by the Quality and Performance Committee in October 2019.

The strategy outlines our approach to delivering Outstanding across the Trust and this is through the Insight, Involvement and Improvement model:

- Improve our understanding of quality by drawing insight from multiple sources (Insight).
- People have the skills an opportunities to improve quality through the whole system (Involvement).
- Improvement programmes enable effective and sustainable change in the most important areas (Improvement).

Our consultation process

Our quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas.

We have utilised a range of data and information, such as:

- Analysis of themes arising from internal and external quality reports and indicators.
    - **Patient experience insights:** National Survey Programme data, Complaints, PALs concerns, Compliments, feedback from the Friends and Family Test (FFT), and local survey data, focus groups, experience stories to Board.
    - **Patient safety data:** safer staffing data, national reviews, incidents, claims, duty of candour, mortality reviews and Freedom to Speak up data.
    - **Effectiveness and outcomes:** Getting It Right First Time reports, clinical audits, outcomes data.
- Staff, key stakeholders and public engagement – seeking the views of people at engagement events

- Engaging directly with our Governors on our quality priorities as they are required by law to represent the interests of both members of our Trust and of the public in Gloucestershire. Many of our Governors sit on steering groups and committees and so are able to influence and challenge quality of care.
- Review of progress against last year's priorities, carrying forward any work streams which have scope for on-going improvement.
- Ensuring alignment with national priorities and those defined by the Academic Health Science Network patient safety collaborative.
- Reviewing key policy and national reports.

As a result, we are confident that the priorities we have selected are those which are meaningful and important to our community. Progress against these priorities will be monitored through the Quality Delivery Group, chaired by the Executive Director of Quality and Chief Nurse, and by exception to the Quality and Performance Committee (a Governor sits on our Quality and Performance Committee).

The Quality Delivery Group is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Group meets every month and reviews a series of measures which give us a picture of how well we are doing. This will allow appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give us the best chance of achievement.

Our priorities for improving quality 2022/23

Priority for 2022/23	Why we have chosen this indicator
To improve children and young people's experience of transition to adult services	Transition for young people remains a Trust priority; the Trust has launched a pilot Diabetes transition service and learning will be embedded for review of other transition pathways
To improve maternity experience	The priority for 2022/23 will be focussed on improving the maternity ward experience in partnership with women, monitored through FFT and feedback from Maternity Voices Partnership
To improve Urgent and Emergency Care (ED) experience	Improving Urgent and Emergency Care remains a Trust priority area and is part of the Operational Planning Contract Guidance
To improve Adult Inpatient Experience	Inpatient experience has seen a decrease in positive score through the pandemic, and work is ongoing to improve this, with a particular focus on communication with relatives
To improve experience of discharge	This programme will include focus on Criteria to Reside, End PJ Paralysis and campaigns such as the perfect week
To enhance and improve our safety culture	Remains a Trust priority with the implementation of the National Patient Safety Strategy
To improve our prevention of harm through pressure ulcers and falls	To remain a quality priority on preventing harm, combining a focus on pressure ulcers and falls, echoing the Preventing Harm Council work
To improve our care of patients whose condition deteriorates	Introduction of new digital systems and work on sepsis
To improve mental health care for our patients coming to our acute hospital	Remains a Trust priority with development of a Trust Mental Health Strategy, and is part of the Operational Planning Contract Guidance

Priority for 2022/23	Why we have chosen this indicator
To improve our care for patients with diabetes	Diabetes inpatient services remain a Trust priority
To reduce health inequalities	New Health Inequalities programme being delivered by the Trust focussed on smoking cessation services for colleagues and inpatients

Part 2.1

How have we done in 2021/22?

1. Colleague Health and Wellbeing

The challenges that colleagues have faced in caring for our patients and communities over the last year have been huge, against a backdrop of COVID-related admissions, elective recovery, and staff COVID sickness absence In 2021/22 we have maintained and developed the health-wellbeing offers available to colleagues, with our 2020 Staff Advice and Support Hub, Peer Support Network, introduction of TRIM practitioners, Employee Assistance Programme (EAP) and the establishment of our Colleague Wellbeing Psychology Service..

How have we performed in 2021/22?

The 2020 Staff Advice and Support Hub

From 1st April 2021 – 31st March 2022 there have been 5,301 separate points of contact to the 2020 Hub by colleagues who work across both Gloucestershire Hospitals NHS Foundation Trust (GHT) and Gloucestershire Managed Services (GMS). Since the Hub's launch in May 2019, it has responded to a total of 18,656 contacts.

Method of contact as follows:

Contact Method	% of contacts
Telephone	87.5%
Email	12.5%

The 2020 Hub has remained the primary place for all staff to contact if they have any queries or concerns regarding the COVID-19 pandemic. This includes: symptoms, testing, isolation periods etc. COVID queries accounts for 63.9% of contacts.

There have been 742 contacts (14% of contacts) relating to anxiety and mental health (either directly relating to COVID-19 or other reasons) which includes engaging or referring colleagues to our new Colleague Wellbeing Psychology service, as well as signposting to wellbeing resources.

In addition to providing a responsive telephone, email and walk-in service to all staff, the following has been launched and embedded over the last 12 months:

- **Salary Finance** – a package of financial wellbeing packages and resources including access to the following: loans (with repayments made through salary/payroll); savings and the Government's Help to Save scheme;

financial education resources; advance access to salary already earned

- **Mobile Hub** – the Hub team now visits teams and departments to talk about the services available, attending meetings or hosting a stand for staff to learn more about the support they can access
- **Volunteer** – a volunteer now supports the Hub team on a weekly basis to distribute wellbeing information and resources to all wards and departments, including offering to fill colleagues' water bottles or make cups of tea
- **Menopause at Work** – a Menopause at Work group has been established which meets monthly on each site. An informal, safe space for colleagues to share their experiences of menopause and provide mutual support. Webinar talks have also been hosted with external speakers
- **Links with ICS health-wellbeing services** – the Hub team works in partnership with ICS colleagues to collaborate and share resources on areas of mutual concern. For example, an ICS-wide Long COVID support group has been established to support colleagues who are suffering from Long COVID.
- **Peer Support Network** – we continue to offer colleagues access to a Peer Supporter if they need someone to listen to them. Peer supporters are fellow colleagues who volunteer to listen with a confidential and non-judgemental ear, and offer to "walk alongside" someone who may be going through a difficult time in or outside of work. Between April 21 – March 22, just less than half of our trained Peer Supporters have reported giving support to colleagues on 63 occasions. At the time of writing this report we are still waiting to hear back from the other members of our Peer Support Network so we expect the total number to be well over 100 occasions.
- **Trauma Awareness Training for Managers** – 160 colleagues participated in half-day Trauma Awareness training for Managers which was delivered by the Trauma Specialist charity, PTSD Resolution.
- **TRiM model** – we have established a support system called TRiM (Trauma Risk Incident Management) which is a trauma-focused peer support system to help employees after traumatic events by providing support and education to those who require it. Fifty colleagues have been trained as a TRiM Practitioner or TRiM Manager. Since its launch, the model has been used on many occasions, predominantly in the Emergency department, Theatres, and the Women and Children division.

Vivup Employee Assistance Provision (EAP)

Vivup provides quarterly reports on access to their Employee Assistance Programme (EAP). The employee assistance programme offers colleagues someone to talk to any time of day or night, 365 days a year. They have trained counsellors with an NHS background and are available to provide help and support with pressures at work or at home and are completely confidential. They normally offer 5 to 6 sessions.

Overall 79 new clients have entered the counselling service in the last 12 months, and between them have accessed 299 individual counselling sessions. The top presenting issues raised by clients are work-related stress, non-work related stress, anxiety, trauma and relationship issues.

Colleague Wellbeing Psychology Service

The Colleague Wellbeing Psychology service was initially launched in October 2020 with 0.5 WTE Psychology Link Worker for six months following the pandemic. In 2021-22, additional investment has been secured using the Charities Together funds. Furthermore, colleague wellbeing vacancies in the Health Psychology team were redesigned and are now situated within the People & OD department to provide an integrated service, delivered in partnership with existing colleague health-wellbeing offers, including the 2020 Hub.

The service offers 1:1 support for individuals and managers, team interventions such as decompression groups and drop-in sessions. It provides specialised training such as Compassionate Resilience workshops as well as bespoke teaching sessions for junior doctors and teams. The team is comprised of the following:

- **Colleague Wellbeing Psychology Lead** – 0.8 WTE (0.5 WTE substantive; 0.3 WTE fixed-term until Feb 23)
- **Colleague Wellbeing Psychologist** – 1.4 WTE (2 roles fixed-term for 23 months)
- **Colleague Wellbeing Psychologist** – 0.4 WTE (substantive)
- **Colleague Wellbeing Psychologist Resilience Trainer** – 0.3 WTE (fixed term for 23 months)

Across the last 12 months there has been a total of 1572 direct points of contact with colleagues who have accessed support via the following:

- Individual support sessions (153 colleagues, attending 601 appointments)
- Drop-in sessions (102 sessions, attended by 198 colleagues)
- Group sessions (37 sessions, attended by 240 colleagues)
- Teaching/training sessions (37 sessions, attended by 275 colleagues)
- Compassionate Resilience workshops (10 workshops, attended by 105 colleagues)

Plans for improvement 2022/23

As we look to the year ahead the following actions are proposed:

- We will undertake granular analysis of the health-wellbeing related questions in the staff survey to identify priority areas around experiences of health-wellbeing. This will lead to an action plan for providing additional support to these areas, working in partnership with divisional tris and HR Business Partners.
- In Q1, we will develop a suite of additional short-term 'quick-win' actions which can be implemented swiftly to provide additional support to colleagues, along with formulation of medium-longer term actions that can be costed and approved accordingly.
- We will work with the Trust's Cancer team to devise a programme called 'Cancer at Work' which will provide pastoral and educational support to colleagues who have cancer, and their line managers/team members.
- We will pilot a 'Wellbeing Champion' role for three months with a selected number of departments/ teams. On completion of the pilot, we will take the learning from this to rollout the Wellbeing Champion role across the Trust.

- We will launch new training courses to support managers and colleagues in the following topics. These will be facilitated by the Health & Wellbeing Coordinator and EDI Training Specialist:
  - Disability Awareness training for Managers
  - Mental Health First Aid Awareness for Managers – half-day course.
  - Mental Health First Aid – full two-day course. This will be targeted at Peer Supporters, HR Advisory Team, Freedom To Speak Up Guardians
- We have recently purchased 500 licenses of a 4-week "Compassionate Mind Skills" online learning programme, which gives colleagues the opportunity to develop a more helpful approach to their own and others' feelings and struggles. Licenses will be allocated to individuals who want to develop and use these skills for themselves, and will also be issued to those who want to support the practices for their teams e.g., individuals who become the wellbeing champions for their local area.
- We have started designing a workshop aimed at managers to support their teams, which will commence in Q2 22/23. This is being developed in response to feedback from team leaders who have reported finding it difficult to know and understand the psychological and emotional distress of their colleagues, and how to respond. The focus of the workshop will be in two parts, firstly to support managers to be sensitive to and understand their own distress, which will then help them to apply this knowledge and understanding to the needs of their team.
- We are recruiting a full-time Assistant Psychologist role to support the Colleague Wellbeing Psychology service, who will act as a link to the 2020 Hub around triaging referrals as well as co-facilitating workshops, groups and training courses. The role will also hold and manage our database which will enable us to improve the immediate and long-term measurement of our clinical and teaching interventions.
- We will continue to strengthen our engagement and involvement with ICS-wide health-wellbeing initiatives, such as the ICS Wellbeing Line team
- We will work with the senior People & OD leadership team to develop a business case which considers the ongoing and long-term requirement for psychological support for colleagues. In early 2023-24 the 1.7 WTE charity-funded posts will come to an end. We will use evidence gained from the measuring the impact of current service provision to develop a more sustained model of colleague support going forwards.

2. To improve how we meet the NHSI learning disability and autism standards

Background

NHSE/I has developed standards to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both. The standards have been developed with a number of outcomes created by people and families — which clearly state what they expect from the NHS.

The four standards concern:

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

The standards are intended to help organisations measure quality of service and ensure consistency across the NHS in how we approach and treat people with learning disabilities, autism or both. They are prominent in the learning disability ambitions in the NHS Long Term Plan and included in the NHS standard contract 2019/20. The aim is to apply the standards to all NHS-funded care by 2023/24.

How we have performed 2021/22

The 2020 return asked for data such as number of outpatient appointments, number of occupied bed days, number of adverse incidents, number of complaints, how many patients have a learning disability marker on their records, readmission rates, number of safeguarding referrals received about patients with a learning disability, number of in-hospitals deaths, our workforce profile (whether we employ learning disabled or autistic staff), and a survey of both staff and patients with a range of detail under this.

It was obvious from collecting the information for the 2019/2020 return that the greatest impediment to having useful information to improve the service was not having Learning Disability data disaggregated from general data. Business Intelligence were able to do this in June 2021 and that has given much greater visibility of Learning Disabilities patients within all areas of our service and enabled us to see where improvements were needed. The 2020/2021 return has asked for different information with a focus on ante-natal screening and cancer services, which was not previously required.

The 2021 return was due on 31st January, but in view of another wave of COVID this was extended to the end of March. Most of our responses have been submitted and the patient and staff surveys have been undertaken. Clearly there are no results yet, due to the extended submission date.

What our data tells us

Having now disaggregated our data we know that LD patients make up 1% of our service users, but use our services more frequently than an average member of the Gloucestershire population, due to underlying physical comorbidities requiring our intervention.

Deaths of people with Learning Disabilities average 2 a month and that has been the case over the last several years. Generally these deaths mirror the general population in following an obvious frailty pathway, albeit at an earlier chronological age for those with multiple comorbidities. This is a tribute to all those involved in providing every type of healthcare to people with Learning Disabilities and Autism over several years.

What progress have we made?

We wrote an improvement plan based on what we could not answer positively for NHSI Benchmarking and learning points coming out of LeDeR reviews. These were grouped into four areas of focus:

Data capture and management

The disaggregation of LD data achieved by Business Intelligence has had the practical benefits of patients with LD being clearly visible on waiting lists, clinic lists and daycase lists and the ability to generate a daily inpatient, daycase and outpatient reports for the Learning Disability Liaison Nurses, releasing the equivalent of two days of clinical time per week.

Within elective care, being able to see how many patients with a Learning Disability are on which waiting list has enabled more nuanced prioritisation of those lists. The waiting list monitoring team have been able to adjust their approach to phone calls, knowing that they will be speaking to either a person with a Learning Disability or a carer about their condition. This has been very positively received.

Patient experience

After many years' of campaigning by Karen Pitcher, (mother of a patient) we were finally able to open our 'Changing Places' toilet facilities for disabled adults, enabling the same levels of basic dignity as the general population enjoy when visiting our premises. We have also taken delivery of a Sensory Voyager for each hospital site to provide structured sensory stimulation to patients.

Work in January 2021, as a response to large numbers of LD inpatients with COVID, illustrated the benefit of pre-emptively assessing all LD inpatients for signs of deterioration. The LD Liaison Nurses are making their own assessment of each LD inpatient now and are working on a project with the Acute Care Response Team to gauge the value of daily monitoring by ACRT. Primary Care colleagues are working on including ReSPECT form completion into Annual Health Checks to ease decision-making at the point of acute deterioration.

Relative/carer experience

Paediatrics have passed on a total of four Z-beds, two stored at each site, available for use by unpaid (family) carers staying overnight with LD patients.

The LD liaison nurses have worked hard to ensure family and paid carers are aware of the adjustments that can be made to visiting restrictions for patients with a cognitive impairment of any type. There are tensions with LD patients as the 'Triangle of Care' (patient, hospital, family) which works for all other patients tends to pull out into a 'Square of Care' for LD patients (patient, hospital, family, paid carers). To ease that tension the LD liaison nurses have been routinely asking families and

carers who should be our main/first point of contact and have found that many families and carers had not considered that question before and just assumed it would be them. Asking this question pre-emptively gives everyone the chance to agree what the expectation should be and takes some tension out of communications.

We have written a suite of leaflets about Best Interest meetings for patients and relatives, in collaboration with dementia specialist staff and the MCA lead for the county. These are likely to be adopted as the countywide standard for all professionals who hold Best Interest meetings once the approvals processes are complete.

Staff experience

The outstanding items on the improvement plan are related to making it easier for staff to care well for this group of patients. We planned to make several changes within EPR and to information available on the intranet. These are in the final stages of preparation before being launched.

Plans for improvement 2022/23

Work will continue to improve the care we provide for patients with Learning Disabilities and Autism, with a focus on improving data capture and management, as this remains a significant challenge for the teams. The priority workstreams include:

- All amber rated items on the current improvement plan to be completed
- Disaggregate complaints and incidents data to increase visibility of LD within these
- A better system for highlighting people with autism on hospital records
- A business case for augmenting the nursing team with specialists in neurodiversity
- Improved bathing facilities for those with physical disabilities whilst inpatients
- Pursue allocated consultant physician time for those with multiple complex disabilities

3. To improve children and young people's experience of transition to adult services

Background

Following the CQUIN implementation of the Ready Steady Go programme, a gap in service provision was identified in how we support young people transitioning into adult services. A review was completed against NICE guidance in 2019/20, and a need for joint working was identified, in partnership with Trust and system Paediatric and Adult leads, as well as the Clinical Commissioning Group Lead for Transition, to develop the transition work within the Trust further whilst maintaining the progress achieved following the CQUIN implementation of the Ready Steady Go Hello pathway.

The pandemic has meant our progress around the broader transition agenda has been delayed during 2021/2022. Although our transition programme has been delayed in some areas, there has been significant progress in developing a transition service for adolescents and young adults living with type one diabetes.

How we have performed 2021/22

The paediatric diabetes service is an award-winning team that values social prescribing and has strong values around patient experience and patient-centred care. An area for improvement within diabetes highlighted in the recent Diabetes Peer Review (Summer 2020) and National Diabetes Transition Audit was around the transition age group. The recent GIRFT report in to diabetes highlights the necessity of a dedicated transition service to support young adults with their diabetes care with an aim of reducing hospital admissions, reducing rates of diabetes keto-acidosis and improving long-term clinical and mental-health outcomes. As a result of recent data and guidance, the team were successful in their application to the CCG for a 12 month focus-project dedicated to developing a transition service for children and young people with diabetes aged 16-19 years.

Following success of the funding bid, the team was formally launched in November 2021. The estimated patient numbers were 50, but the actual number has been 226; as a result of this, the service have created a young adult (16+) team, with dedicated administration support, a Youth Worker, a Nurse Specialist and Dietetics. All patients age 16-21 who contacted the department after 1 Nov have now been re-directed to the 16+ team.

There have been difficulties with recruitment of key members of the team which has created a gap between the proposal and the professional capacity currently in place to deliver the service; however, new ways of working have been established and the following benefits are already being seen:

- The new Youth Worker has been engaging with young people, signposting to mental health services, building rapport and enabling patients to get HbA1c checks who would otherwise have gone with out
- New initiatives have been launched including HbA1c blitz, virtual appointments, and plans for socials to create peer groups

- Improved follow up responses obtained after >1yr no contact
- Administrative support has improved ability to evaluate out comes going forward and to ensure a cross reference with Infoflex

The team have worked with Business Intelligence colleagues to establish a dashboard to review Best Practice Tariff (BPT) parameters along with qualitative feedback from patient surveys and more in-depth patient experience interviews, hospital admissions and HbA1c (health check for diabetes).

The dashboard is being reviewed on a monthly basis, providing real-time data to monitor the service and its effectiveness. If overall the HbA1c improves, this will have significant cost savings for both the short and long term, along with reduced hospital admissions, which will be beneficial for the young adult. This will hopefully support an improved patient experience, and we hope the new service may lead to better self-efficacy and self-management of this chronic condition for the young people.

Plans for improvement 2022/23

This work will continue as a Quality Account Indicator in 2022/23, with the aim to provide full proposed service to patients who transition this year (43 patients), plus:

- Target those in list of 180 who have been out of contact the longest and bring them in
- Attend 16+ clinics and offer support to current patients, collecting data on how much of the full service has been provided.
- Data collection to better understand the staffing required to provide the full service to 225 patients as proposed at the outset

Work will continue to develop the service through:

- Implementing the NICE recommendation released on 31st March that CGM and Libre is available to all patients with Type 1 Diabetes. We anticipate a large volume of contacts regarding this and once funding is secured, we now have the patient information to efficiently upgrade our population to the new technology.
- Launching the Digibete app to share resources, send newsletters and allow the patients to track their medication and results. We will be aiming to provide education sessions and social events in person and virtually.
- Recruiting another youth worker or HCA to aid with launching additional social media such as Instagram and Facebook and creating newsletters for Digibete. They will also be able to assist in connecting people to clinic to share data. Our aim is still to recruit another member of clinical staff and we will continue to explore options with stakeholders.
- Providing education virtually as a webinar in April (inviting all patients to online training including update on the Insulin advice app, Digibete app, Libre/ CGM eligibility, youth worker introduction).
- Providing a social event at the Walk for Wards event in May to help answer topics raised in the Q&A in the April virtual meeting.
- Continued evaluation of the pilot against our agreed outcome measures and via patient and staff questionnaires

There is potential to learn from this model and scale up on a speciality basis, and this will feed into the wider Children and Young People's strategy work, including the delivery of a programme to transform outdated processes and pathways, which will incorporate transition into adults services.

4. To improve maternity experience through delivery of Continuity of Care programme

Background

Patient experience feedback provides a clear measure of the quality of service we are providing for women in our care. As a Trust, we actively seek to hear from the women who use our services, to identify how we can continue to improve the quality of care we offer, and reach our goal of providing Outstanding Care.

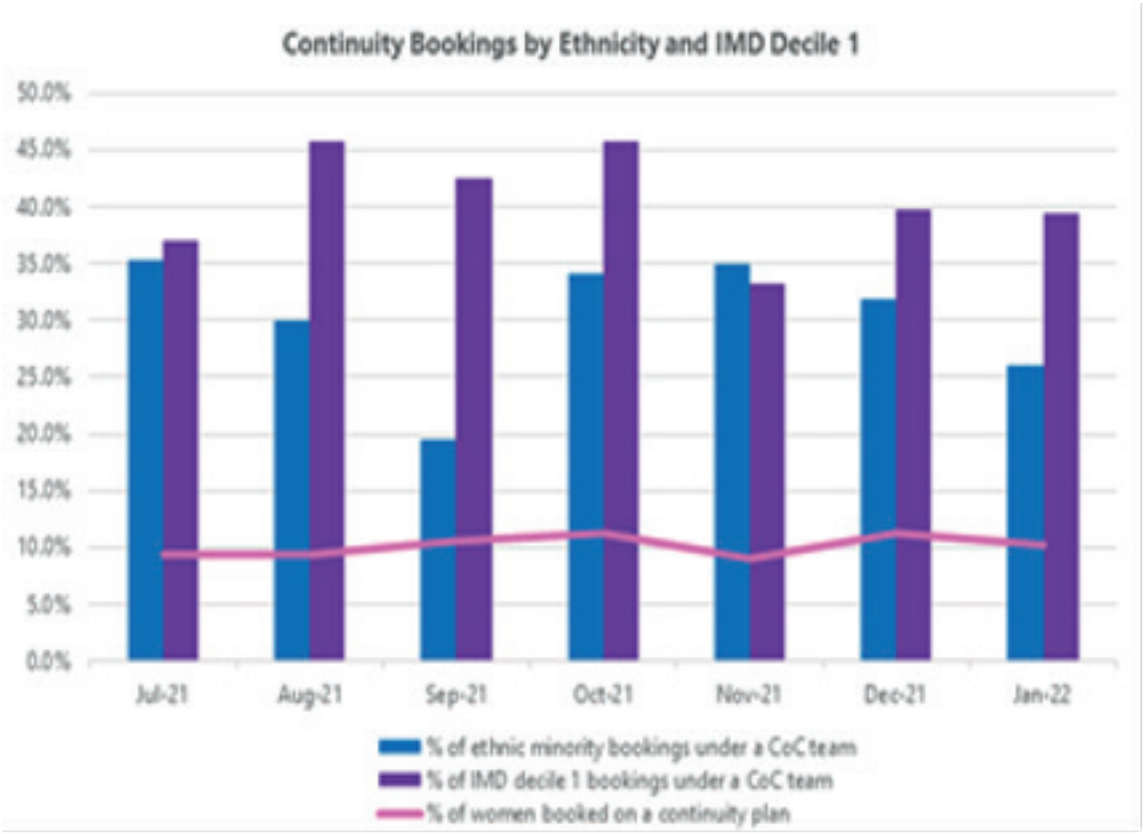
One key programme of work in 2021/22 to improve the experience of women using our services has been the Continuity of Care work. The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016).

How we have performed 2021/22

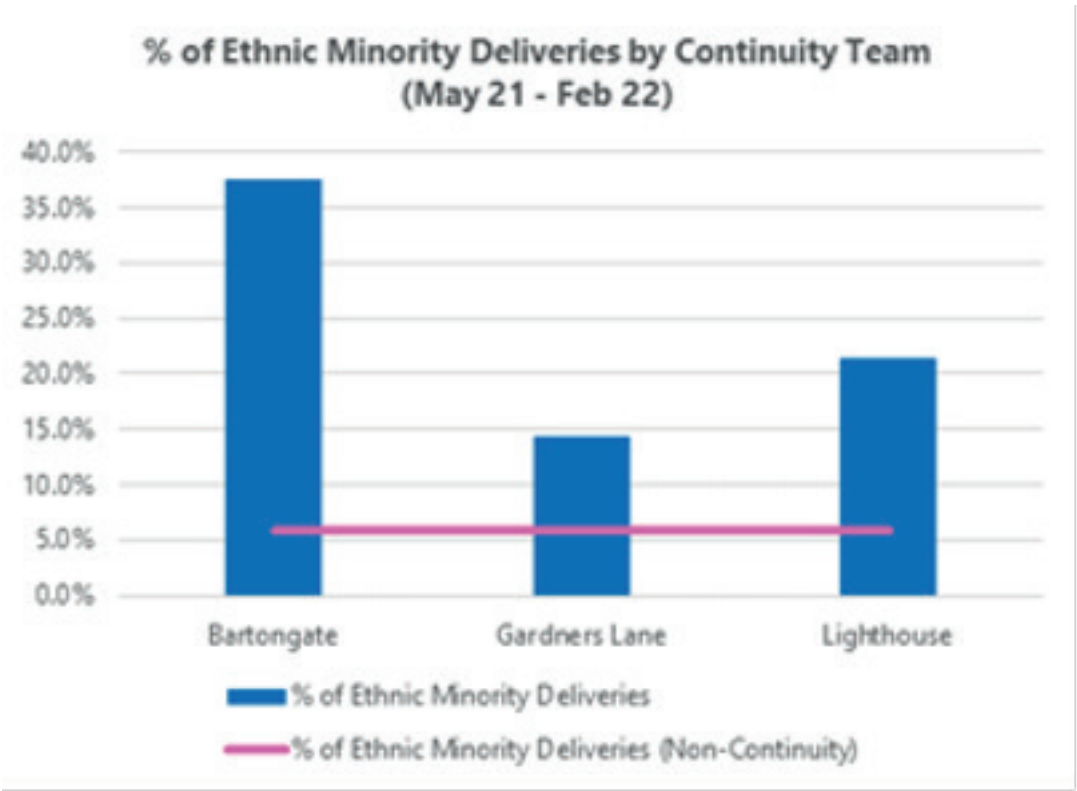
In spring 2021, three Continuity of Care teams were launched; Bartongate and Lighthouse in Gloucester, and Gardeners Lane team in Cheltenham. These areas were launched as the first three teams, as these areas include some of the higher areas of deprivation in the county. Tackling health inequalities is a key agenda for our teams, and prioritising the launch of Continuity of Care teams in these areas means that approximately 10% of the most vulnerable women in our county, including those from ethnic minority groups, will benefit from the Continuity of Care programme.

Maternity services are one of the CORE20 Plus5 areas where we are looking to make real improvements for people facing health inequalities in our county.

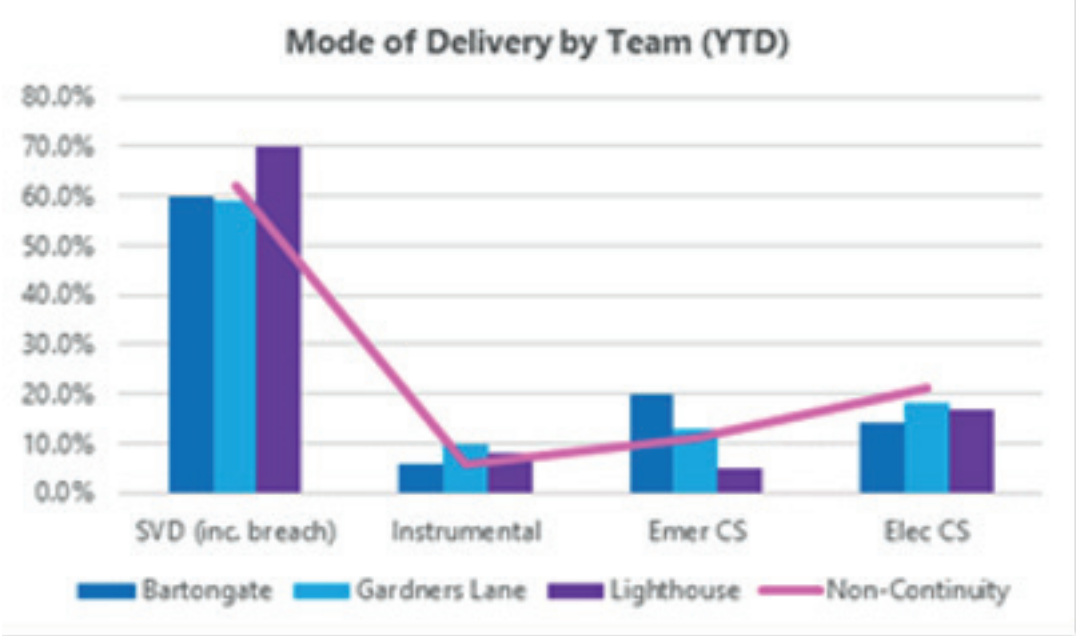
The graph below demonstrates the impact of launching Continuity of Care programme in the three teams, with a significant proportion of our Continuity of Care bookings being made for women who are in Index of Multiple Deprivation (IMD) decile 1 (the 10% most deprived communities in the country), or who are from an ethnic minority background. As a Trust, we have had XX% of all women booked onto a Continuity of Care programme, compared to XX% of ethnic minority women in our service and XX% of women from an IMD decile 1 areas.



The graph below shows greater detail about the percentages of women from an ethnic minority being supported by the Continuity of Care team through to delivery in the three areas, compared to an overall 5% of women who are from an ethnic minority who delivering their babies not through the Continuity of Care programme.



Evaluation of this work is ongoing, but early evaluation shows an encouraging positive impact on the mode of delivery for the women who are being supported by the three Continuity of Care teams, as illustrated in the graph below.



The original Business case has been revised and an implementation plan developed to support a model which consists of 21 Continuity of Care teams who will provide of Continuity of Care for 92.7% of women and birthing people by July 2024. The new Business Case includes plans to secure additional funding requires to recruit the additional midwives required to launch teams 14 to 21, which will support 60-92$ of women and birthing people with Continuity of Care. This was signed off by Divisional Board in December 2021, and is being progressed to the Trust Leadership team for approval before submission to the Regional and National teams.

A Birthrate Plus reassessment is currently in providing a review of the midwifery and maternity support worker workforce. This will confirm additional workforce required to support Continuity of Care roll out as default for all pregnant women/ birthing people in Gloucestershire.

Plans for improvement 2022/23

A focus on improving the experience of women using our maternity services as one of our Quality Indicators in 2022/23, aiming to ensure that all pregnant women and birthing people in Gloucestershire receive the best care.

Further evaluation of the work to date will be completed, as well as progressing the business case to secure additional funding to embed Continuity of Care as the default. The maternity services and the new Head of Midwifery are working closely with our Maternity Voices Partnership to ensure that the voice of women and birthing people continues to play a key role in developing our services.

5. To improve Urgent and Emergency Care (ED) experience

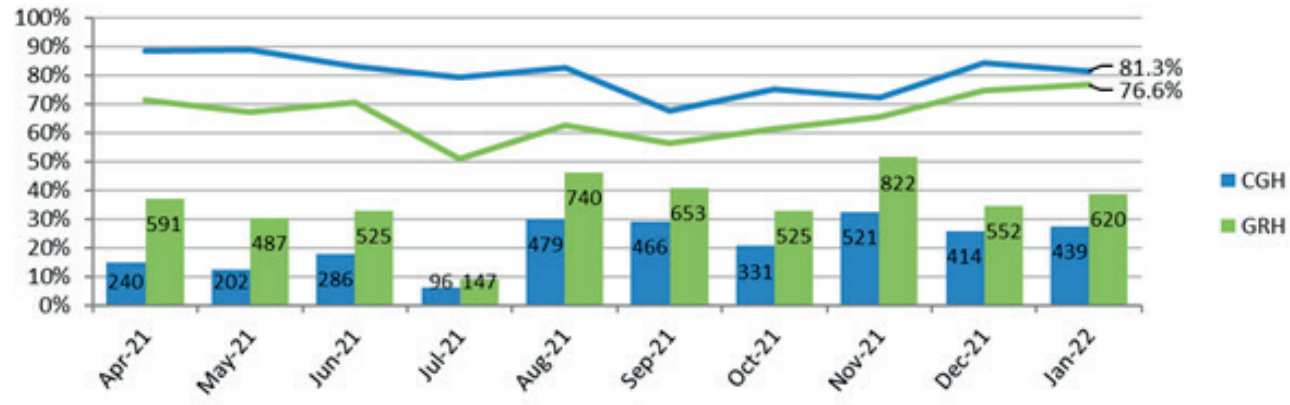
Background

Our patients have told us through our Friends and Family Test (FFT) and our National Survey programmes, that although we do provide good care for the majority of our patients, we don't always get it right for everyone. In 2021/22, 70.3% of patients reported they would recommend our urgent and emergency care services to their family friends, meaning that 29.3% of our patients did not feel that they received the outstanding care that we aim to deliver. This feedback provides us an opportunity to improve the quality of care that we deliver for our patients.

How we have performed 2021/22

The graph below shows the Emergency Department FFT total responses and positive score by site. In July, we had an issue with our systems during the EPR launch in Gloucester Emergency Department, which meant that less surveys were sent out to patients, and contributed towards our lowest positive score in the year.

ED FFT total responses and percentage of positive ratings



The main theme emerging across the comments which is impacting the positive score has been wait times, due to operational pressures in the Trust. To identify other areas in feedback where experience improvements can be made, the teams moved to receiving their FFT data weekly, so that trends in comments could be analysed and reviewed along with PALS themes and feedback, and actions taken quickly to improve experience for patients.

In November the team recruited a Patient Experience Lead to support with this work and the delivery of the Patient Experience Improvement Plan. This work has had a number of priority areas, with progress this year in the following areas:

- Communication within the department with patients and relatives
  - Information slide deck in the waiting area of Dept with relevant information

- Patient information leaflet and poster (with QR code) providing information regarding triage and managing expectations of timings and treatments
- Designated telephone line for relatives 8am -6pm
- Patient experience lead role in the department on secondment for 6 months who updates and communicates with patients and relatives
- Poster with QR code regarding pain management and medication instructions for patients
- You said we did boards for the department – using FFT comments to improve services

- Patient Care
  - Patients frail and elderly are moved onto appropriate beds and mattresses in 4 hours of arrival
  - All trolleys have soft mattress cover on for comfort
  - Falls red blanket initiative – to highlight to staff the need for careful observation
  - #Purpleprotect initiative where patients with cognitive impairment are provided with purple wrist band, arm band and slippers/ socks to inform staff of need for extra observation and support
  - Trial of use of social worker within the department working alongside the Hospital Homeward assessment team
  - Therapy Dog visiting the department for patients and staff wellbeing
  - QI project to produce an Epilepsy emergency department drugs box to ensure prompt and continuous use of routine medication when admitted
- Volunteer support
  - Recruited and trained volunteer team for patient facing roles in the department – supporting with refreshments / communication
  - Hot meals provided for patients awaiting admission to the ward
  - Sandwiches provided for patients in the department over meal periods
  - Activity boxes/ Newspapers – Volunteers supplying activities to support patients whilst waiting in the department

Plans for improvement 2021/22

A number of priority actions are ongoing in the patient experience improvement plan. The key focus areas for 2022/23 include:

- QI project producing a Dementia quiet space for patients in the department
- QI project producing a gynaecology quiet space in the department
- Working in conjunction with Macmillan on providing an information/display board for patients and relatives newly diagnosed with cancer and directing them to support services within the trust and community
- Working in conjunction with Age UK to provide an information hub/ volunteer for patients and relatives re home from hospital support
- Patient story videos from experience in Emergency department
- Continue to expand and support the role of the patient experience lead role across departments
- Continued recruitment of volunteers across site
- Complaints leads allocated in department to monitor and respond to complaints

6. To improve Adult Inpatient experience

Background

Our National Adult Inpatient Survey scores are used to help us understand what we are doing well, where we can improve, and how we benchmark against other similar organisations in providing quality care and patient experience.

Due to the pandemic, the 2020 National Adult Inpatient Survey was postponed, with the latest results published in Autumn 2021. Although our national survey results were postponed, as a Trust we continued with our Friends and Family Test throughout the pandemic, to ensure that we continued to understand the experience of our inpatients.

How we have performed 2021/22

Overall, our patients report a mostly positive experience of our inpatient services, with 89.5% of patients recommending our services through the Friends and Family Test (FFT). While this provides reassurance that we get it right for the majority, 10.5% of our patients are consistently not receiving a positive experience, and this has certainly been the case as we start our recovery journey.

In the last 12 months, the factors that have shaped our adult inpatient experience have changed significantly due to the pandemic. Of particular concern for our inpatients and relatives was the introduction of visiting restrictions, which meant relatives were often unable to get through to our patients and wards due to the volume of calls being put through to the wards at this time.

The tables below show our top and bottom 5 scores in the 2020 National Adult Inpatient Survey compared to the Picker average scores.

A number of the areas identified as needing further improvement through our National Adult Inpatient Survey results related to communication (explanations for changing wards, being provided with information, asked to give their views, or told who to contact if worried). These themes have been echoed in our Friends and Family Test and PALS data, with patients and families telling us that communication has been a challenge across all of our inpatient areas.

In February and March 2022, we put additional ward clerk shifts in to wards that had been identified through our PALS and FFT data as areas which had higher levels of concerns about communication. During this time, an additional 546 hours of ward clerk cover, to support ward teams in managing workload and improving communication. The evaluation of this additional support will inform a ward clerk service review happening in Summer 2022.

Top 5 scores vs picker average	Trust	Picker average
Q2. Did not mind waiting as long for admission	72%	68%
Q10. Able to take own medication when needed to	90%	89%
Q18. Nurses answered questions clearly	98%	97%
Q14. Got enough to drink	95%	95%
Q19. Had confidence and trust in the nurses	99%	98%

Bottom 5 scores vs picker average	Trust	Picker average
Q7. Staff completely explained reasons for changing wards at night	73%	83%
Q38. Given written / printed information about what they should or should not do after leaving hospital	64%	73%
Q47. Asked to give views on quality of care during stay	6%	14%
Q3. Did not have to wait long time to get to bed on ward	74%	82%
Q41. Told who to contact if worried after discharge	74%	78%

Additional support has also been made available to our PALS team to support a sustained increase in concerns from patients, carers and relatives, and this is monitored through our Quality Delivery Group to ensure we can continue to effectively support patients, carers and relatives.

One of the other key themes emerging through FFT and PALS data for our inpatients has been wait times, and not understanding the reasons for the waits. The Patient Experience team worked with colleagues on the Surgical Assessment Unit to create an infographic on the wall, that helps patients to understand their journey through SAU. This gives details about the time it takes for different diagnostic procedures, and links to more information.

Other inpatient areas are requesting a similar journey poster for their ward, to help managing expectations of patients and communicating change, and we will be looking to role an adapted version of this out to other areas in 2022/23.

Plans for improvement 2022/23

This will continue to be a Quality Priority in 2022/23, as our FFT, National Survey and PALS data still identify clear areas for improvement. Our work for 2022/23 will include:

- Reviewing our reporting into divisions, to provide more holistic patient experience reports that give themes across insight sources
- Introducing a focus on storytelling to support improvement, taking a community of inquiry approach
- Supporting teams with the patient experience improvement plans in divisions, providing QI coaching support
- Developing patient discharge support volunteer role to support wards and patients in enhancing the discharge experience
- Working with teams across the hospital and our Hospital Reflection Group to look at how we can continue to develop our offer to carers of patients in our hospital
- Increasing awareness of and access to our translation and interpretation services
- Roll out of projects such as the SAU journey poster which focus on informing patients and relatives, and improving communication of processes

7. To enhance and improve our safety culture

Background

Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support this.

Measuring safety culture is important because the culture of an organisation and the attitudes of teams have been found to influence patient safety outcomes. Using validated tools, we are able to measure this culture, identify areas for improvement and monitor change over time.

In 2019, the NHS Patient Safety Strategy published the intention to develop a more proactive approach to patient safety through the development of safer systems embedded in a just culture. The strategy included the introduction of the following:

- Patient Safety Specialists
- Learn From Patient Safety Events (LFPSE)
- Framework for involving patients in patient safety
- Patient Safety Syllabus
- Patient Safety Incident Response Framework (PSIRF)

How we have performed 2021/22

The SCORE (Safety, Communication, Operational Reliability & Engagement Survey) survey by Safe and Reliable Care was undertaken in September 2019 across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital & Cirencester Treatment Centre. 62% of staff surveyed responded, which was above the quantity required for the results to be considered representative of the surveyed staff groups. Unfortunately, due to the impact of COVID-19, the programme was paused but has now been incorporated into a wider Theatres improvement programme.

Trust-wide, work designed to generate a just and restorative culture commenced based on an approach utilised by Mersey Care NHS Foundation Trust. 9 staff from Gloucestershire Hospitals have been trained through Northumbria University and a Just and Restorative Steering Group has been established to coordinate the approach within Gloucestershire Hospitals.

A wider Patient Safety Plan has been developed, incorporating the requirements of the Patient Safety Strategy and local Trust initiatives. An accompanying improvement (Patient Safety Improvement Forum) and assurance (Patient Safety Systems Delivery Group) structure, chaired by the Quality Improvement & Safety Director and the Medical Director, respectively, has been established to oversee development and implementation.

The following actions have been taken so far:

- Two Patient Safety Specialists have been nominated within the Trust and are actively involved in the national networking and sharing activities.
- A new incident and risk management system has been purchased which is compatible with the LFPSE system. A project is currently underway configuring and testing the system prior to implementation.
- The nationally produced Level 1 and Level 2 patient safety training packages have been published and reviewed

by the Patient Safety Improvement Forum. A proposal to make the Level 1 training mandatory for all staff is to be submitted to the Trust Education and Learning Group.

- A draft PSIRF is being tested within the women's and children's division and the emergency department.

Plans for improvement 2022/23

- The Theatres improvement programme incorporating work to understand and generate a safety culture will continue to progress, led by the surgical division.
- The Just and Restorative Steering Group will work to plan, coordinate and implement a programme of work over the coming year with the aim of introducing ways of working that support the creation of a Just and Restorative Culture across Gloucestershire Hospitals.
- The new risk and incident management system will enable the Trust to report into the LFSPSE system
- Patient Safety Partners will be introduced in line with the Framework for involving Patients in Safety
- Level 1 and Level 2 Patient Safety Training will be rolled out to staff and any further national patient safety training that is released (levels 3 – 7 are outstanding), will be reviewed and an implementation strategy will be planned.
- Work to introduce the Patient Safety Incident Response Framework will continue.

8. To improve our prevention of pressure ulcers

Background

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".

Pressure ulcers can affect anyone from newborns to those at the end of life. They can cause significant pain and distress for patients. They can contribute to longer stays in hospital, increasing the risk of complications, including infection and they cost the NHS in the region of more than £1.4 million every day. They are mostly preventable.

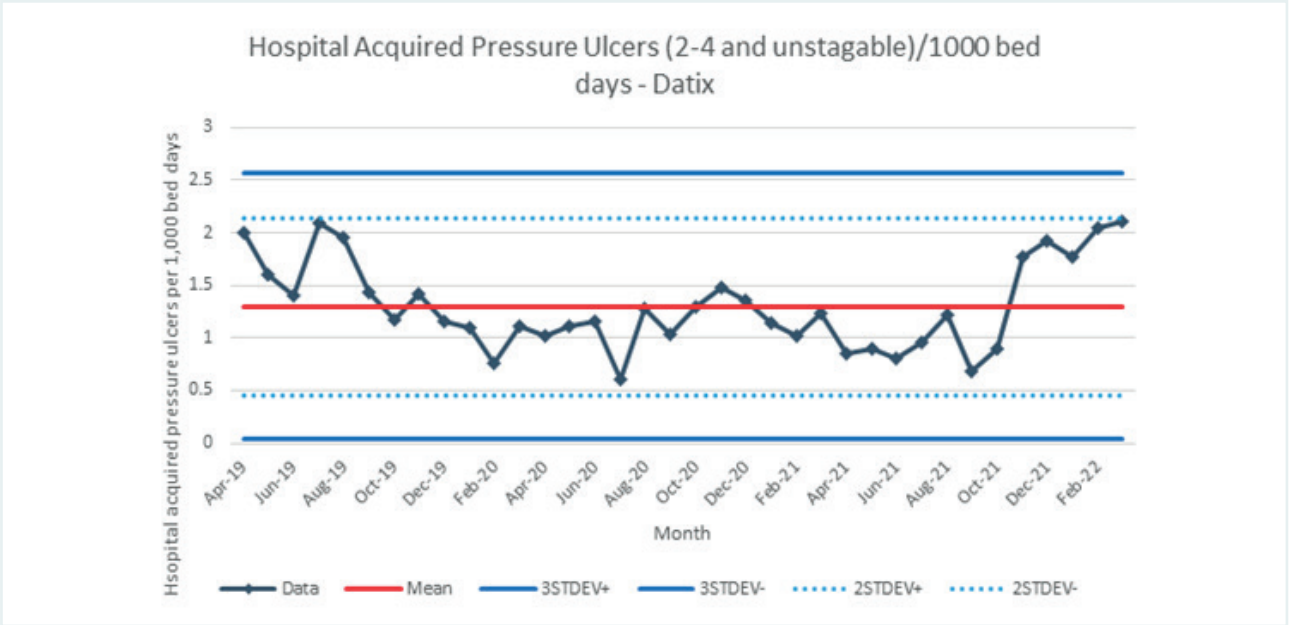
The national Stop the Pressure programme led by NHS Improvement has developed recommendations for Trusts in England. These support a consistent approach to defining, measuring and reporting pressure ulcers. Pressure ulcers are one of our key indicators of the quality and experience of patient care in our Trust.

This past year has been challenging for everyone, none more so than health care workers. Despite this staff in the Trust have adapted and continued to make improvements in pressure ulcer prevention ensuring that patient safety is a priority.

How we have performed 2021/22

Preventing pressure ulcers is a key priority and the number of hospital acquired pressure ulcers is a measure of the quality of care being delivered to our community. The Tissue Viability service provides specialist evidence-based advice on caring for skin and the management of wounds that are complex in nature and are failing to respond to treatment. The team provide advice to patients; families, care givers and healthcare professionals. All patients are eligible for referral to the Tissue Viability service.

The chart below shows our current data for category 2-4 and unstageable Hospital Acquired Pressure Ulcers/1000 bed days



There are two main contributory factors to this reported increase in the number of hospital Acquired Pressure Ulcers in 2021/22. The incidence of pressure damage in hospital is sensitive to nurse staffing levels, including safe Registered Nurse (RN) to Healthcare Assistant (HCA) ratios. Increases in pressure ulcers correlates with increased absence levels and use of temporary staffing, and we know from our data that 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.

All of cases of unstageable pressure ulcers 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.

There are a number of actions and workstreams in progress as part of the Pressure Ulcer Prevention Improvement plan, including:

- Rapid dissemination of learning from Preventing Harm Improvement Hub.
- Pressure Ulcer Prevention training (PUP), formerly React to Red training, attended by 286 members of staff since 2020 and a further 174 booked for year 01/04/22- 31/12/23 to date.
- Increase in offerings of PUP training from 4 times yearly to 15 times a year, to increase awareness of clinical risk assessment and SSKIN bundle completion.
- 636 views of the React to Red videos "The Skin and Pressure Ulcers".
- 62 link nurses for tissue viability identified across all divisions, Meetings in 2022
- #Stopthepressure 18th November 2021 (international pressure Ulcer awareness day)
- Continuation of the Shared Decision-Making Council for Pressure ulcers and falls
- Daily offering of spoke placements for clinical staff including, student Nurses, Dr's, TNA's, Dermatologists, Dieticians and HCA's.
- Bespoke monthly online PUP presentation for ED commenced February 2022.
- Tissue Viability News Letter (4 x yearly) with emphasis always on Pressure Ulcer Prevention.
- Gloucestershire Hospitals Pressure Ulcer Prevention Guidance updated and now live.
- Clinical review of all patients with a hospital acquired pressure ulcers.

There are also a number of improvements in progress, including:

- Extra support for teams as required for pressure ulcer prevention when identified at the learning and preventing harm hub.
- Gloucestershire Hospitals Pressure Ulcer Prevention curriculum is being developed as a new initiative to raise awareness and reduce pressure ulcers within the Trust. This is a whole package of training to include certificate on completion and induction into pressure ulcer hero's hall of fame

- Audit of hospital mattresses to assure quality and ongoing procurement.
- Delivering a bespoke tissue viability conference for midwives and children's nurses with emphasis on pressure ulcer prevention.

Plans for improvement 2022/23

The continuation of a comprehensive Pressure Ulcer Prevention Program for 2022/2023 provides an operational framework for achieving progress with our pressure ulcer improvement agenda. The approach is multi-faceted with leadership from across nursing and allied professional. There has been an increase in our deep tissue injuries and unstageable pressure ulcers which has prompted further improvement focused in the areas that require this. The themes emerging are lack of pressure ulcer prevention awareness from staff, evidence of which is seen in the documentation in EPR. Factors in particular include lack of appropriate risk assessment and completion of the SSKIN bundle. This work will continue as a Quality Priority for 2022/23 as part of a wider preventing harm focus, incorporating both Falls and Pressure Ulcers, echoing the shared decision making council approach we are taking.

9. To prevent hospital falls with injurious harm

Background

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2013, 2014). Over 800 hip fractures and about 600 other fractures are reported as a result of falls.

Nationally

- There are 130 per year deaths associated with falls.
- Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.
- Falls cause distress and harm to patients and put pressure on NHS services.
- Evidence from the Royal College of Physicians suggests that patient falls could be reduced by up to 25 to 30% through assessment and intervention.
- Older patients are both more likely to fall and more likely to suffer harm - falls among this group also have a disproportionate impact on costs as they account for 77% of total falls and represent around 87% of total costs. If inpatients falls are reduced by as much as 25-30%, this could result in an annual saving of up to £170 million

Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma. Costs for patients are high in terms of distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.

A fall in our hospital often affects plans for a patient to return home or to their usual place of care as it impacts on the person's confidence and the confidence of their family and carers. NICE Clinical Guideline 161 sets out recommendations for preventing falls in older people with key priorities for implementation for all older people in contact with healthcare professionals, and preventing falls during a hospital stay.

How we have performed 2021/22

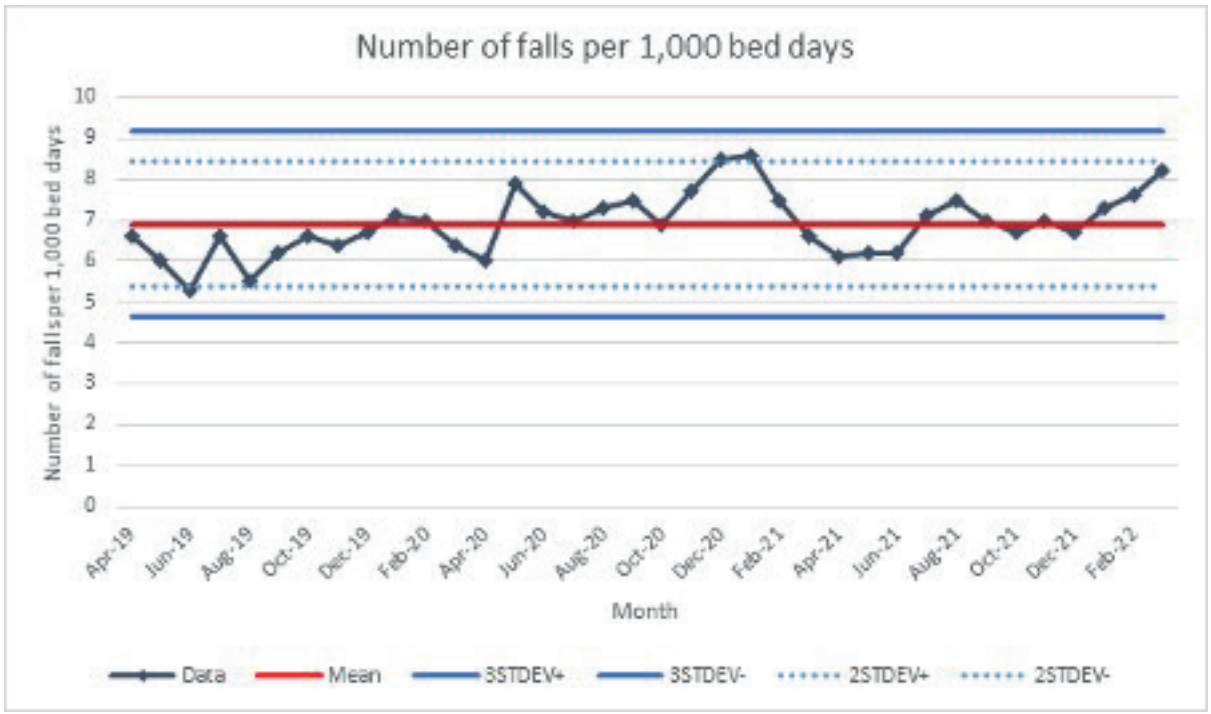
Covid 19 has continued to delay progress against the Falls Prevention Improvement plan. During the first wave the falls specialist nurse was redeployed, and staffing issues and increased work load on all staff, including the challenges of wards changing specialty and being flipped from green to red to manage the increase in Covid cases, has also hindered progress.

Work has continued however, and where there have been wards with high levels of falls identified, ward action plans have been produced and regularly reviewed with support of the Falls Specialist Nurse. Following this intervention, two wards that made significant improvements in their falls prevention work. Ryeworth ward saw a reduction of 15% in falls and 40% in falls with harm, and on AMU there was a reduction of 11% in falls and 14% in falls with harm.

Another example of where intervention had an impact was where a surgical ward turned to a medical ward, and had a large increase in falls during August, September and October 2021 (totalling 61). Specific ward training was put in place, with the support from the CPD team. During November, December and January the falls totalled 21, a reduction of 34%.

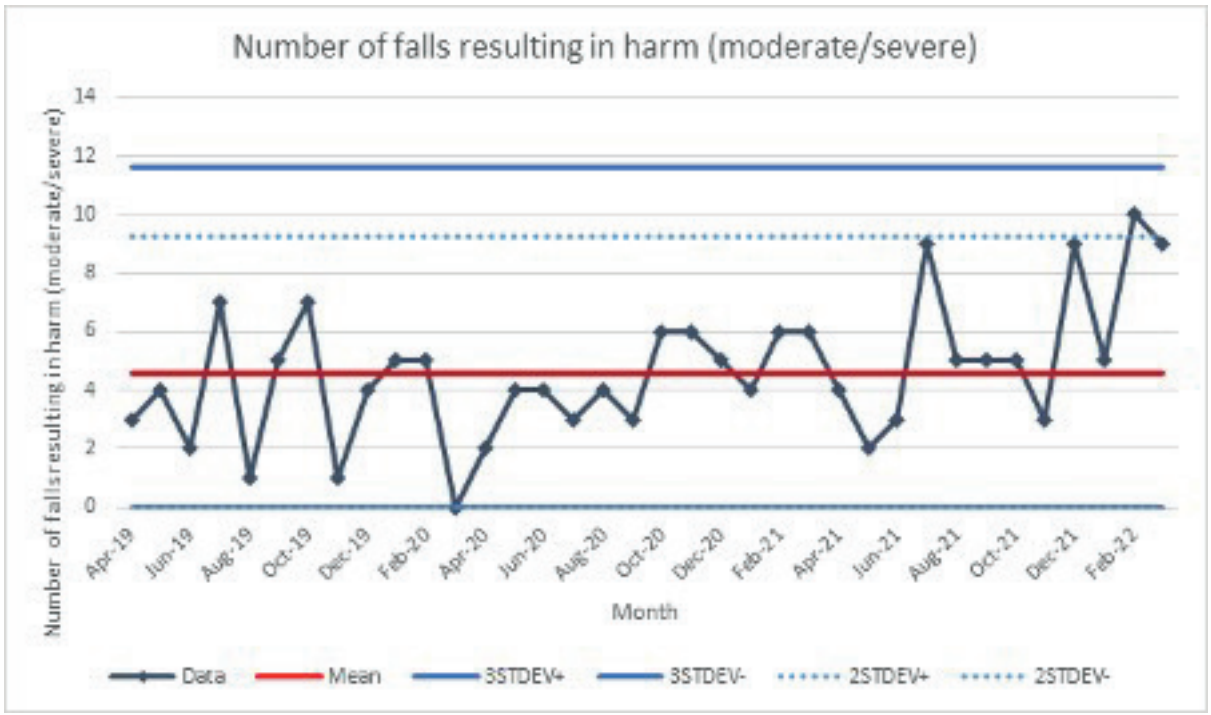
Overall, falls per 1000 bed days have remained within normal variation levels between April 21 and March 22, as seen in the graph below. We are around the same level as trusts of the equivalent size around the southwest.

Falls per 1000 bed days



We have seen an increase overall in the number of falls with harm reported this year, as seen in the graph below, although these still fall within normal levels of variation.

Falls with harm (Moderate/Severe/Death)



There are several reasons as to why falls with harm have been so variable during the year:

- The acuity of the patients is higher and older people are more deconditioned as result of the pandemic
- Patients who are medically 'fit for discharge' are waiting for availability from the community for either assessment of their ongoing needs, awaiting placements or an increase in a package of care
- Enhanced care shifts not always being covered
- Staff fatigue

A number of improvement projects have been in progress this year to support our falls prevention programme, including:

- Monthly falls prevention training has commenced trust wide. Numbers currently restricted due to Covid restrictions. Numbers will increase as restrictions are lifted
- In ED – use of red blankets (now yellow) for identification of people identified as at risk of falls. This is also rolled out to the COTE and Stroke wards. Too early to see any results at present due to ED capacity
- Following audit of falls assessment documentation on EPR for ED, education sessions around the falls risk identification and the completion of the documentation due to commence, for a period of 6 months, to improve awareness and completion
- End PJ paralysis, is a trust wide initiative, to aid in the reduction of deconditioning
- Engagement with falls links on wards escalated to Divisional Directors and Ward managers to allow protected time for links to attend meetings and to instigate falls prevention on their wards

Improvements that have been achieved 2021/22:

- Ward based education and trust wide education has taken place following actions identified following Preventing Harm Hub investigations. Between April 2021 and Jan 2022 – total 192 registered, non-registered and therapy staff have had attended falls prevention training.
- Improvement and understanding of EPR data collected by Business Intelligence has led to an improvement in the completion of the falls documentation on the Electronic Patient Record (EPR)
- Safety briefings embedded on COTE and Stroke wards to enable ongoing identification of patients who are at increased risk of falls
- Since November 2021 the falls team has expanded to 2 full time members, a nurse and a therapist. All patients who have sustained a 2nd fall during an admission have been reviewed and recommendations made. Total number of 2nd falls was 69. Only 13 patients went on to have further falls. Therefore 81% of the patients did not go on to have any further falls during their admission. Those who went on to have further falls were most likely to continue to fall regardless of interventions
- Themes from harm hub are presented at the Shared Decision Making Council for Falls Prevention and Tissue Viability, with wards presenting and celebrating their success at this council

Plans for improvement 2022/23

A focus on preventing harm will continue as a Quality Priority for 2022/23, focusing on how we reduce the number of both falls and pressure ulcers, and the harm they cause patients.

10. To improve our care of patients whose condition deterioriates

Background

Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care. They feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment. Yet there is evidence to the contrary. Patients who are, or become, acutely unwell in hospital may receive suboptimal care. This may be because their deterioration is not recognised, or because – despite indications of clinical deterioration – it is not appreciated, or not acted upon sufficiently rapidly. Communication and documentation are often poor, experience might be lacking and provision of critical care expertise, including admission to critical care areas, delayed (NICE, 2007).

Sometimes, the health of a patient in hospital may get worse suddenly (this is called becoming acutely ill). There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying.

Monitoring patients (checking them and their health) regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

We require that all adult patients in hospital have:

- a clear written monitoring plan specifying which vital signs should be recorded (and at what frequency),
- their severity of illness measured using the physiological National Early Warning Score (NEWS2) and
- a graded response strategy (NICE CG50 2007).

The NEWS2 was created to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients. The NEWS2 was founded on the premise that (i) early detection, (ii) timeliness and (iii) competency of the clinical response comprise a triad of determinants of clinical outcome in people with acute illness. When patients first arrive on the ward – either as a new patient or from a critical care area such as the intensive care unit – a healthcare professional should:

- measure the patient's pulse, blood pressure and temperature, how fast they are breathing, and the amount of oxygen in the blood
- look at how alert the patient is and whether the patient is aware of what is going on around them

The staff should write a plan for which of the patient's vital signs should be monitored and how often. The plan should take into account:

- why the patient is in hospital
- any other illnesses or health problems the patient has
- what the patient has agreed about your treatment.

If patient's vital signs show that health might be getting worse, or if a healthcare professional has concerns, the staff should respond according to how serious the problem is.

The ward/area should have a plan for the response, which should consist of three levels.

- For a minor problem (low NEWS2 score group), the nurse in charge should be told and the patient should be monitored more often to keep a closer watch on their condition.
- For a moderate problem (medium NEWS2 score group), the patient's consultant's team should be called urgently and healthcare professionals trained in assessing and treating patients whose health has become suddenly worse should be called at the same time (Acute Care Response Team (ACRT)).
- For a serious problem (high NEWS2 score group), there should be an emergency call to the Resuscitation Team (this team should include a critical care doctor trained in resuscitation).

If the problem is moderate or serious, the patient's healthcare team should review their condition and make the necessary changes to treatment. They should revise the care plan and consider whether the patient should be cared for in another unit, such as the **critical care area**.

Our electronic observation system - eObs

The NEWS2 can be readily transported into an electronic health system. There are potential advantages of automated calculation of the NEW score and automated alert systems. The standardised scoring systems and alert thresholds that underpin the NEWS should remain unaltered. In March 2020, we rolled out an e-Observation system that enables clinical staff to record their patient observations digitally as well as calculating the National Early Warning System (NEWS2) score. The NEWS2 calculates and reflects whether a patient's condition is improving or deteriorating and the appropriate escalation policy is presented to the clinician with a set of resulting actions. The eObs system has many benefits which have helped staff manage the care of the patient including: -

- Reducing cross infection as clinicians are using a digital system to input and retrieve information
- Tracking patients, and
- For the ACRT being alerted to patients who have deteriorated

How we have performed 2021/22

Our Electronic Vital Signs (eObs)

The general wards are now using electronic vital signs across the Trust and following further analysis around compliance minor modifications are being made to the system to ensure it is a better fit for the users.

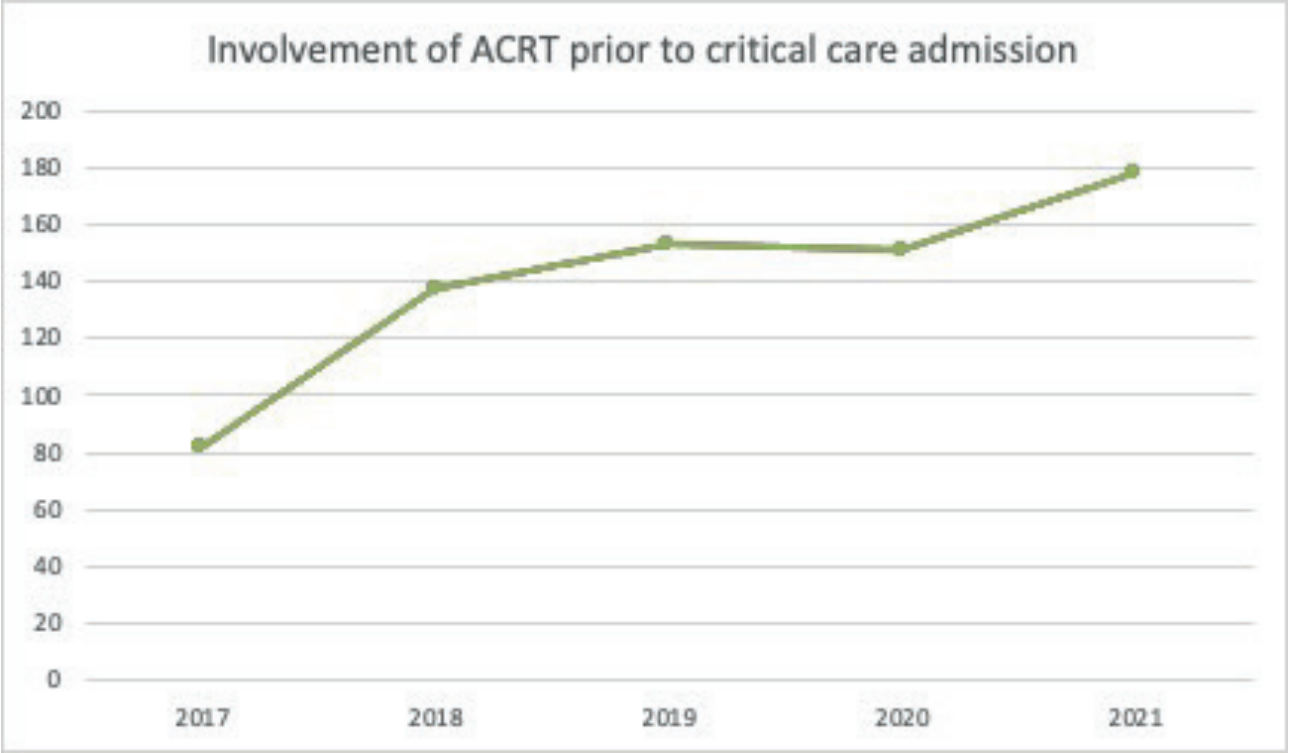
The Acute Care Response Team (ACRT) is using the information generated every shift and it has proved enormously useful for practitioners to prioritise their workload.

Acute Care Response Team (ACRT) involvement prior to DCC admission

If a patient deteriorates on the ward and is moved to critical care their chances of survival are significantly improved if they have 'optimal' ward based care prior to critical care admission. (McQuillan et al)

The involvement of ACRT in patients prior to admission to critical care has increased significantly in the last 5 years.

Year	No of Patients
2017	82
2018	137
2019	153
2020	151
2021	178



Plans for improvement 2022/23

- Staff are recording observations on paper prior to the data being entered on to the electronic system and the reasons for these behaviours need to be explored.
- NEWS2 excels at identifying those who are deteriorating due to serious infections such as sepsis, and enhances the timeliness of the identification. The sepsis toolkit has recently been launched in order to immediately flag up to staff what actions to take when they enter observations with a high 'NEWS' score. The ACRT are tracking its use and will work with Business Intelligence to ensure useful and timely data is maximised.
- Areas without electronic observations remain on the paper systems (including Critical care, Recovery, Paediatrics) and these areas will migrate to electronic systems in time.
- The direction of travel is that any patient who is deteriorating is referred to the ACRT even if there are ward doctors present. The future plans are for the ACRT to lead the care/management of all deteriorating patients but at present the service is not sufficiently resourced for this to be enacted.
- Staff surveys carried out by the ACRT suggest at present that 80% of staff would directly contact the ACRT regarding deteriorating patients.
- The sepsis toolkit has recently been launched in order to immediately flag up to staff what actions to take when they enter observations with a high 'NEWS' score. The ACRT are tracking its use and will work with Business Intelligence to ensure useful and timely data is maximised.
- The ACRT is exploring is value in supporting / managing vulnerable patient groups even before they deteriorate. The principle being that at admission it is known that certain patients are high risk or 'vulnerable' ACRT can potentially add an extra layer of protection for them.
- We will be taking part in the Commissioning for Quality and Innovation (CQUIN) scheme for 2022/23 for recording of NEWS2 score, escalation time and response time for unplanned critical care admissions. The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration, the importance of which has been emphasised during the pandemic. This measure would incentivise adherence to evidence-based steps in the identification and recording of deterioration, enabling swifter response, which will reduce the rate of cardiac arrest and the rate of preventable deaths in England. As many as 20,000 deaths in hospitals each year could be preventable and this CQUIN aims to reduce that figure by 4,000. Deterioration is linked to 90% of NHS bed days. Reducing the need f or higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.

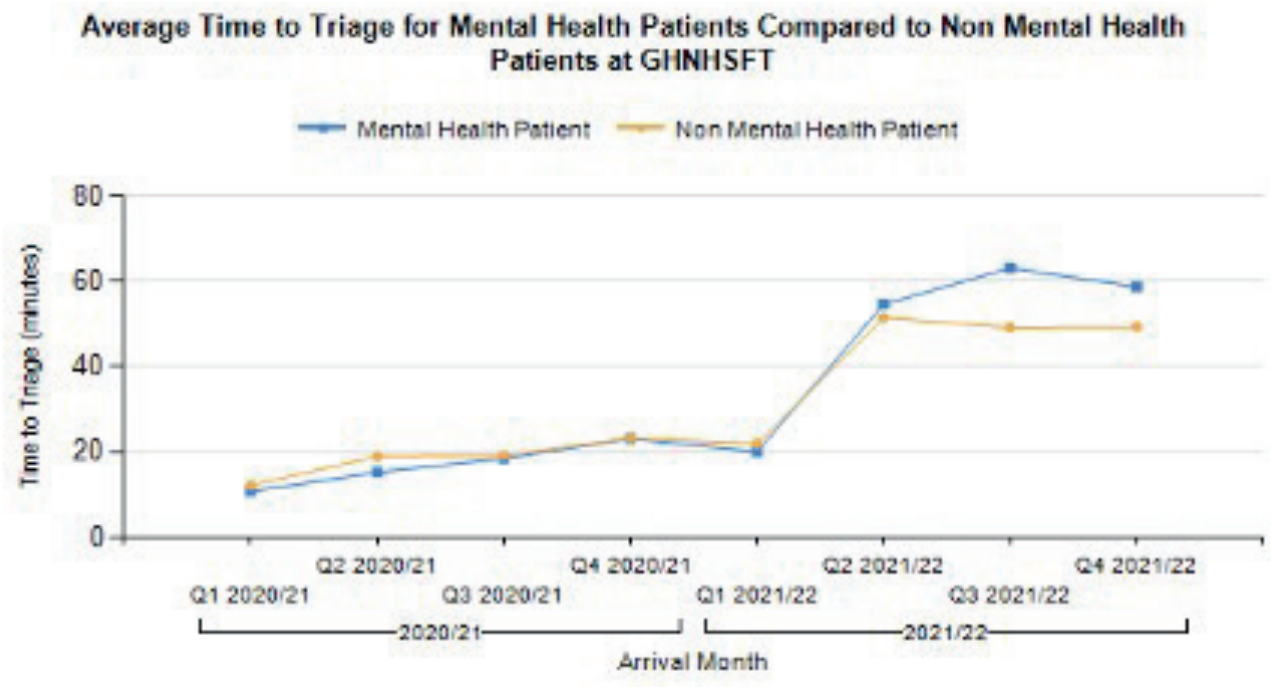
11. To improve mental health care for our patients coming to our acute hospital

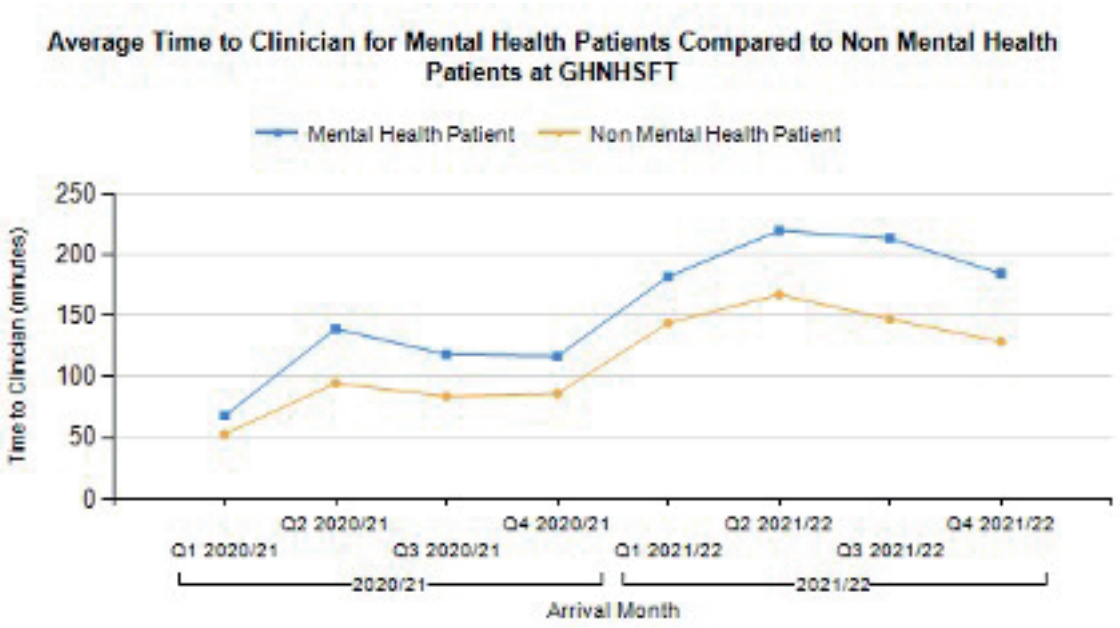
Background

Our mental health care model is to ensure that people presenting at the emergency department with mental health needs have these needs met more effectively through an improved, integrated service. We also have the aim of reducing future attendances. People with mental health problems coming to the Emergency Department in crisis will be aware that timely treatment can be difficult to deliver consistently and with our effective quality improvement programme we aim to make changes and monitor the impact of our changes.

How we have performed 2021/22

Leading on from the work of 2021, the Mental Health Working Group has continued its focus across the four main workstreams but also as a driving force behind the development of a trust mental health strategy. Although progress has been made in areas, in the domain of performance we continue to see increasing disparity between mental health and physical health in the metrics, with all Urgent and Emergency Care metrics worsening due to multiple factors (increasing volume, acuity and overcrowding in particular). This has had a disproportionate impact on mental health presentations and consequently we continue to see a widening of time to see clinician time metric and now time to triage metric, which previously had always been fairly well maintained (please see charts below).





There has been progress on a number of areas in our Mental Health improvement plan in our emergency departments, including:

Physical estate and Signposting

- Completion of improvements made to Mental Health Assessment room including soft furnishings and artwork developed and co-created by experts by experience and staff
- Similar improvements to be made to Cheltenham General Hospital assessment space also
- A number of bids have been made to charitable funds for further more comfortable soft furnishings, mobile phone chargers specific

Patient Flow and patient experience:

- Addressing long delays in a number of ways:
  - Review of risk assessment process and standard operating procedures
  - Co-streaming of patients by members of the liaison psychiatry team directly within the emergency department itself. Allows swift and early identification of those who need specialist mental health input. Particularly beneficial for vulnerable individuals who may not be able to wait.
  - Funding obtained for new role – "Emergency mental Health Practitioner" - The clinician will be based entirely within the emergency department and is a mental health specific practitioner whose only focus is to see and assess patients with mental health presentations. This new dedicated role will result in improvement across all unscheduled care metrics.
- Skill mix and staffing
  - Ongoing local training initiatives on shop floor for all clinicians
  - Foundation doctor shadowing Mental Health Liaison Team for the day – just about to start
  - Training offer from Gloucestershire Mental Health Crisis Care Workforce Development Group for multi-

agency training (comprehensive package – online and face to face)

- Identified requirement for a training needs analysis work which will be subsumed under the mental health strategy workstreams

Specialist services

- Drugs and alcohol:
  - Ongoing work with the drugs and alcohol teams to ensure locally responsive service within the emergency department.
  - Particular focus on opiates with the development of an emergency department specific guideline and the application for naloxone rescue treatment to now be included on the trust formulary.
- Eating disorders:
  - Huge focus of work in this area due to the rapid and huge increase in this presentation
  - Working group has been developed including stakeholders from GHT, GHC and Community eating disorders team
  - Working at pace to launch regular clinical multidisciplinary meeting, develop resources and guidance and systemwide work in place to consider future service models and provision.

High Impact Users Service development

- High impact users – disproportionate accumulation of health inequality, and the majority of these patients involve mental health issues and social isolation
- First Trust in the South West to launch a new monthly MDT clinic – coproduction of personal support plans with patients and clinicians
  - MDT includes: physical health consultant, Pain consultant, Safeguarding specialist, social prescriber, drug and alcohol practitioner and Homeless specialist nurse
- Immediate benefits to patient experience and outcomes including reduction in attendance and admission

In addition to the improvement plan progress, the Trust have been developing a Mental Health Strategy. This work has been co-produced with a cross section of people, including those with lived experience, staff and other key stakeholders.

A steering group was formed to enable clinical and strategic leaders in this trust and partner organisations to oversee and shape the development of the strategy, and a stakeholder reference group was established to provide objective and independent quality assurance of our approach to embedding stakeholder engagement throughout the development of the strategy.

A series of five bespoke engagement events were held between November 2021 and January 2022 to engage a cross section of stakeholders in developing the priorities and content of the strategy. More than 60 individuals participated in the events and shared their own experience and perspectives on the priorities that we should focus on to achieve the aims of this strategy.

Representatives from the steering group and stakeholder reference group have participated in a number of engagement events held in the One Gloucestershire Integrated Care System over the past 6

months, to listen to and understand the views and perspectives of a range of partner organisations and community groups.

The draft strategy has been tested with a small number of key reviewers and focus groups to ensure we have sufficiently considered views of specific groups and taken into account all equality, diversity and inclusion perspectives. Following this engagement, there has been a move away from a Mental Health specific label, to a broader approach about personalized and responsive care.

Plans for improvement 2022/23

This will continue as a Quality Account Indicator for 2022/23, with work continuing against the following areas:

- Within unscheduled care align mental health specific standard operating procedures for both trusts (GHC and GHT) to ensure processes working best for patients – current piece of work
- Operational priority to focus on young person's mental health
- Launch of unscheduled care specific social prescriber
- Look to involve our partners within voluntary and charitable sectors in providing support to patients and staff while in the Emergency Department ie Samaritans and Peer Supporters
- Approval and implementation of the new strategy:

12. To improve our care for patients with diabetes

Background

The Trust recognised that there were a rising number of insulin related incidents resulting in increased harm for our patients. The indicator of medication errors (related to insulin management) became a key focus for improvement in 2020/21 as a result.

Insulin mismanagement causes harm to patients by missing their medication and not measuring their blood glucose and ketone levels. These incidents result in moderate harm to patients and incur additional treatment costs, increased length of stay and poor patient experience.

In 2020/21, investment in inpatient diabetes specialist nursing correlated with an increase in the number of medication error incidents being reported. This demonstrates the impact of ward education where staff have a better understanding of insulin medication errors occurring on the ward and are therefore increasing the reporting of incidents. By increased reporting the Trust can understand the areas that require intensive support and education from the Diabetes inpatient team.

How we have performed 2021/22

Following from the work in 2021 to build the team, the Trust has invested in our diabetic specialist nurse team and have successfully recruited 2 Band 6 Posts, one of which was a development post from a Band 5.

Initial funding from NHS England has now been successfully converted to substantive establishment which was our ambition set out from the previous year. We still have 2.55 WTE Band 6 to recruit to.

The Benefits realisation of making the Diabetes inpatient service more robust includes:

- Reduced length of stay
- Education of ward staff (both Nursing and Medical)
    - E-learning for diabetes, which although not compulsory is encouraged to be completed by such initiatives such as Insulin Safety week, Hypo awareness week, Diabetes awareness week and World Diabetes Day.
- Reduced prescribing and medication errors
- Emergency admission avoidance
- Retention of existing staff
- Career development opportunities
- Point of contact/advice for urgent discharge reviews
- Ultimately a weekend morning attendance on Wards

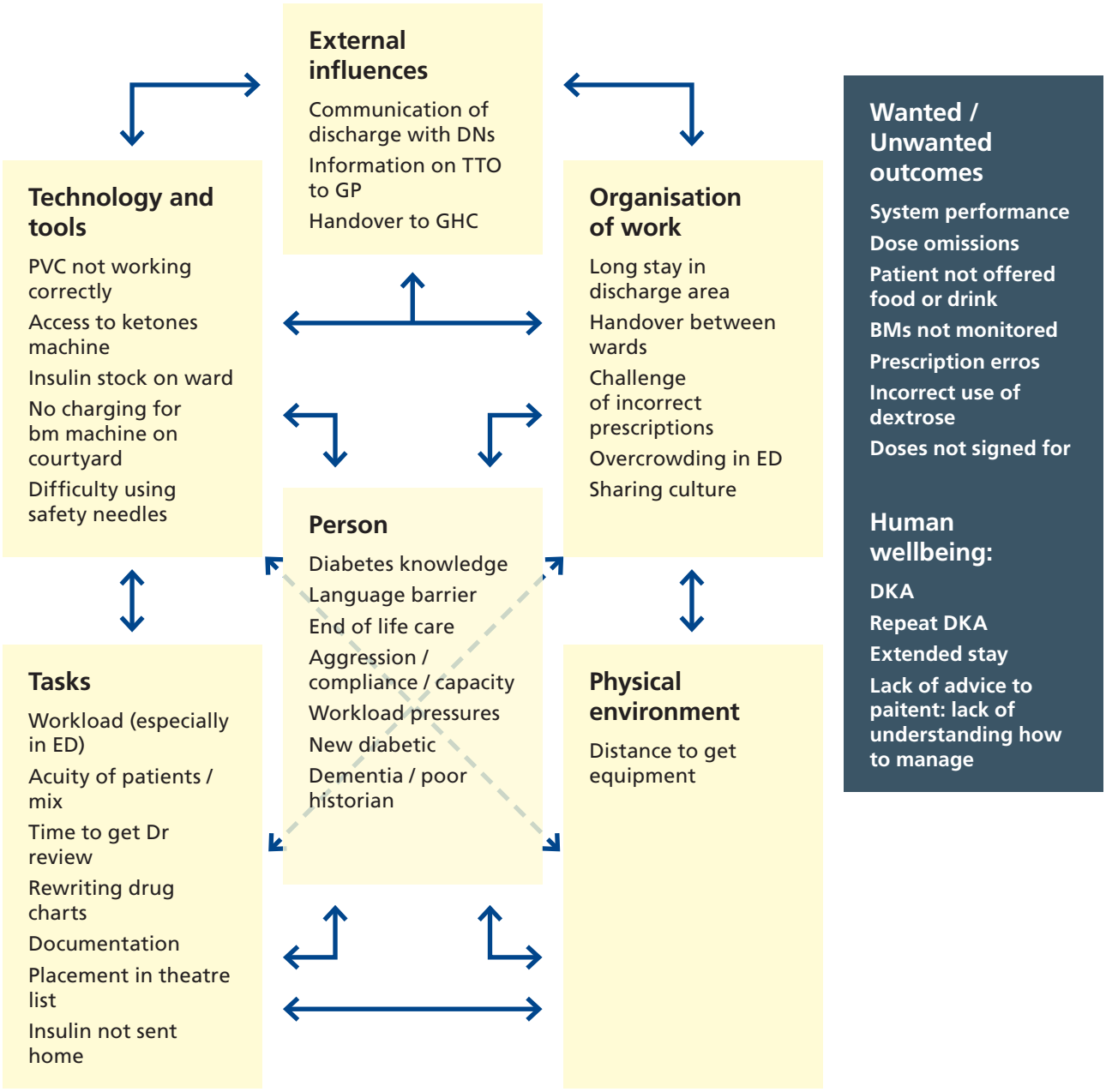
The number of medication incidents reported each month can be seen in the table below. Since the introduction of the remote monitoring and additional inpatient nurse workforce implementation the number of reported incidents has continued to increase.

Medication Incidents by Date (2021 – 2022)

Month	Number
Feb 2021	25
March 2021	25
April 2021	18
May 2021	28
June 2021	23
July 2021	13
August 2021	9
September 2021	19
October 2021	28
November 2021	17
December 2021	15
January 2022	15

A review of medication incidents in diabetes has highlighted contributory factors and areas where improvements can be made, which will continue to be a focus for improvement in 2022/23.

Medication incidents in diabetes



In 2021/22, a CCG Funded Review was commissioned across the whole service, focusing on identifying and repatriating type-2 patients who could be best managed in the community. This collaboration is ongoing and we are working towards re-assigning approximately 600 patients back to primary care, therefore freeing up opportunity for the specialist team within the acute Trust to focus on inpatients, patients managed with pump-therapy, transitional patients and the increasing antenatal service. Traditionally services such as Pump-therapy require 12 hours of Diabetes Specialist Nurse Contact time and safely commence treatment. With new Libre devices, this requires an hour-long face to face contact with patients in a 1-1 appointment.

The repatriation of Patients to primary care will free up valuable time to manage patients on the GDM App. This allows us to monitor Amber as well as Red measurement patients via text commentary/dashboard, reducing telephone calls and the need for face-to-face appointments, as well as enable greater focus on supporting our inpatients and the improvement programmes in our hospitals.

Plans for improvement 2022/23

This work will continue as a Quality Account Indicator for 2022/23, as a Trust priority, with a focus on continuing to grow and develop the diabetes inpatient service and the improvement programme to reduce the number of medication incidents in diabetes.

- With a more robust staffing structure, the team can target another key area for improvement – the antenatal diabetes service
  - Reduction in pre-term births- reduction in NICU admissions
  - Reduction in women transitioning to pharmacological treatment
  - Significantly higher patient satisfaction with care
  - Significantly better compliance with blood glucose monitoring increased
  - Significant reduction in caesarean sections unless clinically appropriate for other reasons
  - Enhanced education of those women with Diabetes who are considering pregnancy pro-actively

13. To improve our care of patients with dementia

Background

In June 2020, the Trust agreed to review our 2017 Dementia Strategy using the Trust's Quality Strategy framework of Diagnose Design Deliver to ensure a robust evaluation with an in depth analysis of research and data. This process helped to set out key priorities for dementia and the development of a Dementia Improvement Plan.

How we have performed 2021/22

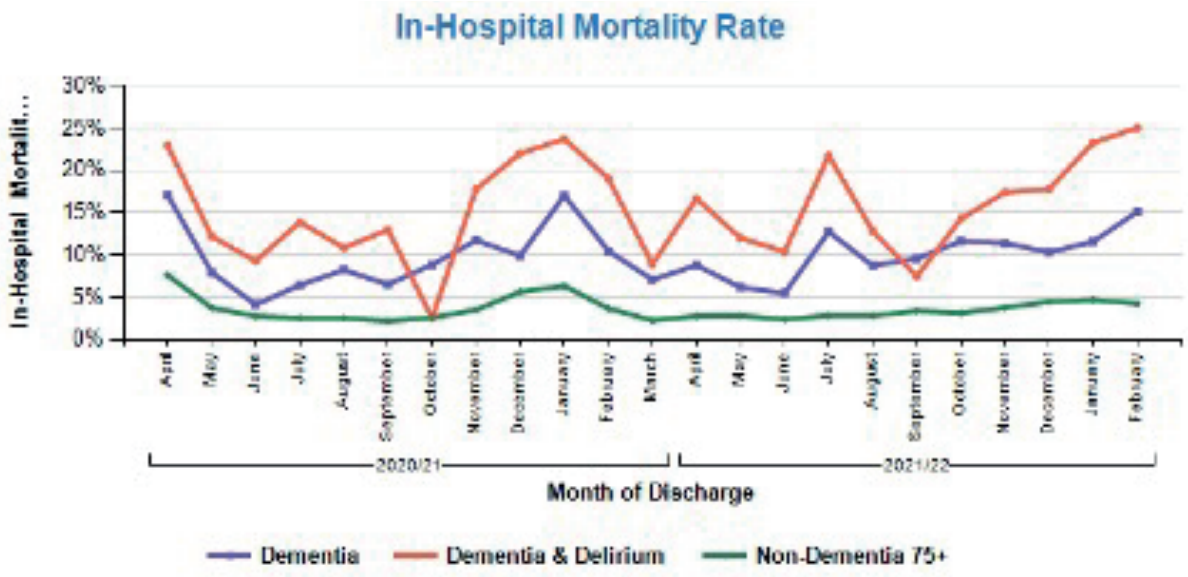
Over 2021/22 work has continued to address the 3 priorities set out in the Trust's Dementia Improvement Plan (DIP):

- Improve the Trust's performance in national dementia quality indicators and audit

During 2021 NHSE suspended the Dementia Assess Refer (FAIR) quality indicator, confirming its retirement in September 2021. However aspects of the indicator are relevant to the DIP, such as delirium screening and assessment and are included in the Dementia Dashboard.

The RCP's National Audit of Dementia (NAD) is a biennial audit that was last completed in 2018. The NAD team paused the 21/22 Round 5 audit, instead testing data collection and audit tools. Previous NAD audits were challenging in terms of the resources needed to collect the data manually from patient records, and separately for both hospitals. Business Intelligence (BI) analysts have worked hard to improve electronic data extraction for the NAD audit, successfully reducing the manual audit component and NAD have agreed to accept a single submission.

BI have further developed the Dementia Dashboard so that it is accessible on Insight and updated monthly. The Dementia Dashboard underlines the significantly poorer outcomes for 75+ with dementia & delirium (as seen in the graph below), experiencing more bed moves and longer length of stay. It is also worth noting that bed moves can lead to delirium, further compounding the issues.



- Develop a delirium pathway that aligns to an ICS approach

The 2019 Get It Right First Time (GIRFT) review recommended that the Trust develop a delirium clinical pathway and Mental Health Liaison Team's (MHLT) have produced both dementia and delirium clinical pathways available on the intranet. Work is continuing to include delirium screening & assessment tools on the Electronic Patient Record (EPR) system.

We have also worked with ICS partners to raise the profile and impact of unrecognised delirium by championing the need for a system-wide approach to delirium. GHT engaged in a delirium awareness raising campaign and contributed to a One Gloucestershire Delirium guide for family/friends.

An effective partnership has been established between Admiral Nurse (AN), MHLT and Care of The Elderly to reduce duplication of referrals, improve consistent communication with wards and families, quick assess to specialist advice. This way of working led to a Dementia & Delirium MDT proposal to could case find patients with dementia and those with delirium or at risk of delirium on admission. The MDT would either allocate & case-manage complex patients or direct support to the ward. The additional resources in the team would offer:

- AN cover at both sites
- Health Care Assistant (HCA) support to ANs for both sites
- dedicated MHLT support
- Access to specialist support out of hours and weekends.

The proposal needs a decision on whether/how to progress but in the short term, Dementia UK (Admiral Nurse) have secured a non-recurring grant of £50K to fund a second AN for 1 year and the Trust 3 months funding for the HCA posts.

- Develop a Trust Dementia Training Pathway to improve workforce awareness and skills

Trust dementia training was offered by a number of practitioners so a mapping process was undertaken by setting up a Dementia Training Community of Practice (CoP) with ICS training partners. Outcomes include:

- improved record of training delivered
- training content is up to date/consistent and includes signposting to AN and carers organisations
- aligns with county Dementia Training & Education Strategy (DTES)
- Included in Ward Managers and Porters training requirements.

The Trust's online dementia and delirium training modules are now revised and updated, with the dementia modules reduced from two to one.

The AN continues to deliver face to face training to support staff need and supports teams/departments to address specific issues. The AN also works closely with community partners such as Community Dementia Nurses, Complex Care @ Home Team and Dementia Advisors.

Plans for Improvement 2022/23

Work will continue in 2022/23 on the dementia improvement plan, with a particular focus on reducing multiple bed moves for patients 75+ with dementia and/or delirium. A pilot study of an approach documenting RAG risk to the patient from move was tested, providing additional data on falls and delays to discharge. Omicron has delayed next steps to date but work will continue in 2022/23.

14. Delivering the 10 standards for seven day services (7DS)

Background

In 2015 NHS Improvement identified ten clinical standards to be met by NHS Trusts, with 4 priority standards. Trusts were required, each year, to complete 7 Day Service self-assessments to understand if these standards were being met.

An audit of the ten clinical standards took place in July 2019 and the audit evidenced that two standards were not being met:

- Clinical Standard 2 –Time to first consultant review
  - All emergency admissions must be seen and have a thorough consultant assessment as soon as possible but at the latest within 14 hours of admission to hospital
  - Standard is met if compliance is 90%
- Clinical Standard 8 - Ongoing patient review
  - All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway. Measured for first 5 days of admission
  - Standard is met if compliance is 90%

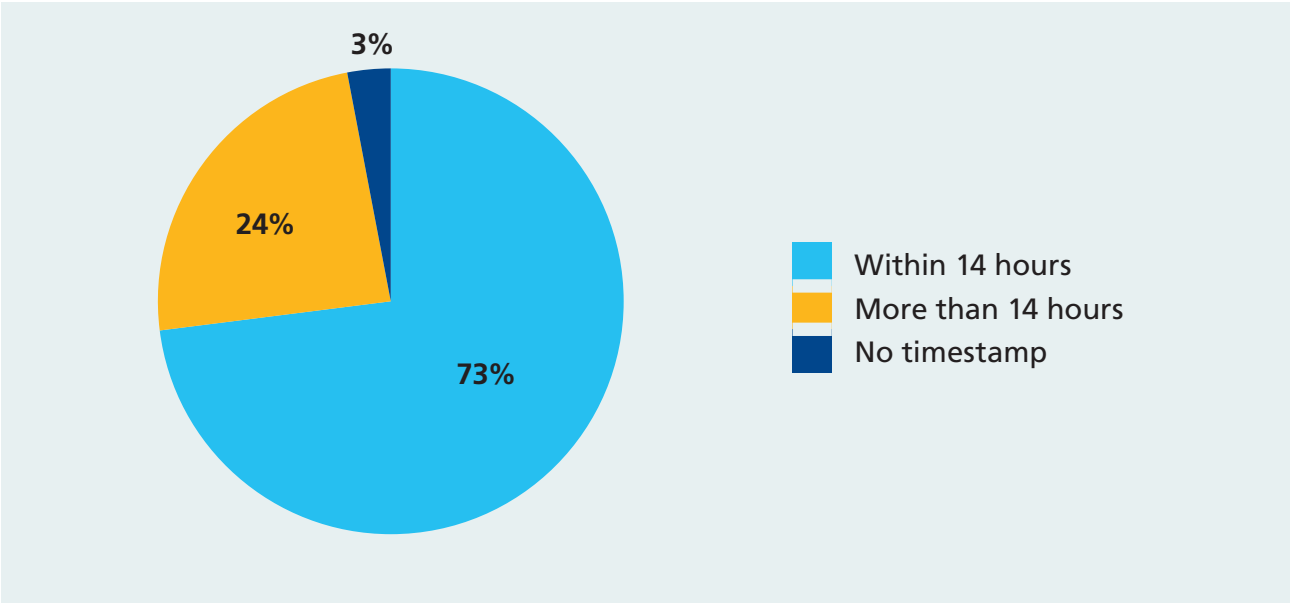
The requirement to complete a further self-assessment is now no longer required by NHSI. However, as part of an ongoing Trust commitment to improve medical review performance as well as a commitment to apply learning from the Trust's response to Covid, the Medical Director commissioned a review to:

- Compare performance against the 2019 assessment, with specific reference to Clinical Standard 2 and Clinical Standard 8
- Understand more fully how medical reviews are being carried out and learning from COVID
- Identify potential opportunities to improve Trust performance.

How we have performed 2021/22

This work has been led by the current chief registrar (Dr Giovanna Sheiybani) with support from Prof Mark Pietroni. The last audit was from 2020 and the re-audit for 2021 was unfortunately delayed due to Covid. The focus of the re-audit was on time to first consultant review within medicine to keep the scope focused, and to allow PDSA cycles to be tested here which can be rolled out. The decision to admit time to consultant review was measured. The main conclusion is that we are still falling below the national standard for medicine (our current position is at 73% vs national standard of 90%) and this varies depending on weekdays vs weekends and what time of the day the patient was clerked (see graph below). This is not directly comparable to the previous audit as the time was measured from front door rather than decision to admit.

Amount of time between deciding to admit and post take ward round



The team involving the Chief Registrar, a group of SHOs and input from acute medical consultants, have completed process mapping exercises as part of their QI work and developed a driver diagram.

From this work, one of the biggest issues identified was not having a proper take list or post-take list that has patients in time order. The first PDSA cycle coincided with the launch of the electronic clerking and take list (both of which the Chief Registrar has inputted in due to the results of this QI work).

As part of this QI work, the following measures have been identified:

- Outcome measure:
- Time from DTA to first consultant review
- Process measures:
- Time taken to clerk patients
- Time from clerking to first consultant review
- Balancing measures:
- Time of seeing patients of NEWS >4

Once launched, these measures will be tracked using SPC charts, and the team are aiming for three PDSA cycles focused on the take list and the process of post taking patients. Reporting will be supported by the EPR team.

Plans for improvement 2022/23

This work will continue in 2022/23, led by the Chief Registrar, supported by the Medical Director and our EPR teams. The PDSA cycles will be evaluated, and reporting developed, and work continuing on the wider quality improvement programme.

Part 2.2

Statements of assurance from the board

The following section includes response to a nationally defined set of statements which will be common across all Quality Reports. These statements serve to offer assurance that our organisation is:

- performing to essential standards, such as
- securing Care Quality Commission registration
- measuring our clinical processes and performance, for example through participation in national audits involved in national projects and initiatives aimed at improving quality such as recruitment to clinical trials.

Health services

During 2021/22 Gloucestershire Hospitals NHS Foundation Trust provided and/or subcontracted 111 NHS Services.

Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 111 of these relevant health services.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2021/22 financial year.

Information on participation in clinical audit

From 1 April 2021 to 31 March 2022, 50 national clinical audits and 3 national confidential enquiries covered relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 96% national clinical audits and 100% national confidential enquiries which it was eligible to participate in. Participation was suspended or delayed for some audits due to ongoing Covid recovery, in line with national agreements. Where national audits could not be undertaken, for non-Covid reasons, then local data was collected and reviewed.

The national clinical audits and national confidential enquiries that were appropriate to Gloucestershire Hospitals NHS Foundation Trust during 2021/22 are as follows:

	Eligible	Participated	Status
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Chronic Kidney Disease registry	Yes	Yes	Ongoing
British Spine Registry	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Emergency Medicine QIPS (RCEM): Pain in Children (care in Emergency Departments)	No	Yes	Ongoing
Emergency Medicine QIPS (RCEM): Severe sepsis and septic shock (care in Emergency Departments	No	n/a	Cancelled
Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database	Yes	n/a	n/a
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Yes	**Yes**	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	Yes	**Yes**	Ongoing
Inflammatory Bowel Disease (IBD) Audit	Yes	No	n/a
LeDeR - Learning Disabilities Mortality Review	Yes	Yes	Ongoing
Maternal, Newborn and Infant Review Programme Clinical Outcome			Requested
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death)			Requested

	Eligible	Participated	Status
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Transition from Child to Adult services	Yes	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Epilepsy	Yes	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Crohn's Disease	Yes	Yes	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	Yes	Yes	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma secondary care	Yes	No	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Ongoing
National Audit of Cardiovascular Disease Prevention	No	n/a	n/a
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Completed
National Audit of Dementia (NAD)	Yes	Yes	Completed
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)			Requested
National Bariatric Surgery Registry (NBSR)	Yes	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Ongoing

	Eligible	Participated	Status
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	Yes	Yes	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	Ongoing
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Ongoing
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit			Requested
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	Yes	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Yes	Yes	Ongoing
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Yes	Yes	Ongoing
National Child Mortality Database	Yes	Yes	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing
National Comparative Audit of Blood Transfusion - 2021 Audit of Patient Blood Management & NICE Guidelines	Yes	Yes	Completed
National Comparative Audit of Blood Transfusion - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	No	n/a	n/a
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Ongoing

	Eligible	Participated	Status
National Gastro-intestinal Cancer Programme - National Oesophago-gastric Cancer	Yes	Yes	Ongoing
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	Yes	Yes	Ongoing
National Joint Registry (NJR)	Yes	Yes	Ongoing
National Lung Cancer Audit (NLCA)	Yes	Yes	Ongoing
National Maternity and Perinatal Audit (NMPA)			Requested
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	Yes	Ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing
National Perinatal Mortality Review Tool			Requested
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Vascular Registry	Yes	Yes	Ongoing
Out-of-Hospital Cardiac Arrest Outcomes Registry	No	n/a	n/a
Respiratory Audits - National Outpatient Management of Pulmonary Embolism	No	n/a	n/a
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Ongoing
Serious Hazards of Transfusion (SHOT)	Yes	Yes	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	Complete

	Eligible	Participated	Status
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Yes	Ongoing
The Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing
UK Cystic Fibrosis Registry	Yes	Yes	Ongoing
Urology Audits - Cytoreductive Radical Nephrectomy Audit	No	n/a	n/a
Urology Audits - Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Yes	Yes	Complete

Ongoing – relates to continuous data collection, or data collection where the deadline has not yet ended

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Case Mix Programme (CMP)	The CMP is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland. Currently 100% of adult, general critical care units participate in the CMP. The results from CMP are reviewed at individual M&M meetings/ lessons shared. Specific COVID reports and rapid mortality meetings continue. The reports provide information on mortality rates, length of stay, etc. and provide the Trust with an indication of our performance in relation to other ICUs. Where trends are identified, these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. Standardised mortality rates in both units remain below 1 over the year. Despite the exceptional year in relation to the continued pandemic, both units are performing above national standards in areas assessed. Separate COVID reports suggest both units are meeting standards with similar admission demographics – with better survival outcomes than national average. The Trust also demonstrated the local model of running a RHC worked exceptionally well in only admitting sicker patients to ICU. This also resulted in better outcomes; with less elective surgery cancellations, low numbers of capacity transfers.
Chronic Kidney Disease registry	The UK Renal Registry (UKRR) collects and reports data annually on approximately 70,000 kidney patients on renal replacement therapy (RRT) in the UK. The Trust continues to participate in the registry. Data is submitted via the renal data system with a quarterly annual validation and query resolution. The 2021 report is due to be discussed summer 2022. Registry data also feeds in to other audit / QI activity and is discussed in other meetings, such as GIRFT, regional Kidney Quality Improvement Partnership, renal regional network. The audit publication is mainly reviewed as a quality assurance exercise to ensure Trust compliance. Local audit activity (alfacalcidol use and parathyroid hormone levels, line infection rates, PD tube complications) is often driven by registry report findings.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
British Spine Registry	The British Spine Registry (BSR) is a web-based database for the collection of information about spinal surgery in the UK. It was established with the aim to improve patient safety and monitor the results of spinal surgery. The Trust shares, discusses and reviews its BSR results at the regional Southwest Spine Network quarterly. The Trust results are in line with expectations.
Elective Surgery (National PROMs Programme)	Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement and knee replacements. It provides an indication of the outcomes or quality of care delivered to NHS patients. The results have been good and are an ongoing reflection of consultants' work, which are used as part of their appraisal.
Emergency Medicine QIPS (RCEM) - Pain in Children (care in Emergency Departments)	The purpose of this Royal College of Emergency Medicine (RCEM) QIP is to improve patient care by reducing pain and suffering. The RCEM will identify current performance in EDs against nationally agreed clinical standards and show the results in comparison with other departments. Data collection continues until October 2022.
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient	The National Audit of Inpatient Falls (NAIF) is a national clinical audit and part of the Falls and Fragility Fracture Audit Programme (FFFAP) managed by the Royal College of Physicians. This audit measures compliance against national standards of best practice in reducing the risk of falls within acute care. In this reporting period there has been an interim and final report. These reports are reviewed at Quality Delivery Group every 3 months. The falls annual plan has been updated to include recommendations following report publication.
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	The National Hip Fracture Database (NHFD) was established to measure quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform. The Trust completes online viewing as soon as the report is released (Dec 2021). Improvement work continued around consolidation and embedding of previous years' actions, together with looking at additional theatre availability. This year saw the continued additional need to manage COVID and try to ensure minimal disruption to hip fracture care.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
LeDeR - Learning Disabilities Mortality Review	The Trust submit data annually to the NHSI Learning Disability and Autism Benchmarking Audit. A patient survey is also sent out to every patient with a learning disability who has used Trust services during the year being audited, and it is a requirement to ask staff to complete a parallel survey. For the 2020/2021 survey, QR code posters were put up around the whole Trust to capture staff from all areas of work. Following previous patient survey feedback, Best Interests leaflets are now used and are likely to be used countywide by other providers, as the quality has been appreciated by everyone. Changing Places toilets were opened during the last year, offering the same level of privacy and dignity for severely disabled visitors to our hospitals as those without disabilities can expect. The NHSEI Benchmarking audit results were taken to the LD Steering Group and then reviewed at Safeguarding Strategy Group and thence to Quality and Performance Committee. An improvement plan was written based on the deficits and monitored by this same governance structure. The Trust was not a national outlier, but as the Trust is not exclusively a Learning Disabilities healthcare facility, it should not be expected to be in the top centile. Data for the 2020/2021 survey was submitted on time and is being analysed, but it has been identified that the Complaints and Adverse Incidents data needs to be disaggregated, so a change request has been put in for Datix and Datix Cloud.
Maternal, Newborn and Infant Review Programme Clinical Outcome	
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The reports for this year's studies have not yet been published. Previous years' reports for the Pulmonary Embolism Study and the Time Matters, Out of Hospital Arrest Study were disseminated and reviewed at the appropriate team meetings.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	NACAP aims to improve the quality of care, services and clinical outcomes for patients with asthma and COPD. NACAP includes strong collaboration with asthma and COPD patients, as well as healthcare professionals, and aspires to set out a vision for a service which puts patient needs first. The adult asthma clinical audit is a component of the National Asthma and COPD Audit Programme (NACAP) There have been a number of periods where the Trust's work on the asthma part of the audit has had to be paused because of COVID, winter pressures and lack of resource and time to enter cases. This has reduced the number of cases entered. The intention is to start up data entry again now things are settling down. This may be impacted by limited resources including staff sickness.
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma secondary care	The children and young people (CYP) asthma audit is a component of the National Asthma and COPD Audit Programme (NACAP). The Trust did not have capacity to participate in the audit until this year. In terms of Quality Improvement, the Trust now has a local Paediatric Asthma Lead. Time has been spent working with the CCG on the CYP Asthma care Bundle. Bristol Children's Hospital are in the process of developing a regional Asthma network.
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	NACAP is a programme of work that aims to improve the quality of care, services and clinical outcomes for patients. NACAP includes strong collaboration with asthma and COPD patients as well as healthcare professionals, and aspires to set out a vision for a service which puts patient needs first. In relation to COPD, the Trust has made improvements in our discharge bundle completion, which now sits above the regional and national average. The workforce has undergone a lot of change and the IT infrastructure still limits our ability to identify patients, but improvements are continually being made.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Audit of Breast Cancer in Older People (NABCOP)	NABCOP is a national clinical audit run by the Association of Breast Surgery (ABS) and the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England (RCS). The aim of NABCOP is to support NHS providers to improve the quality of hospital care for older patients with breast cancer by publishing information about the care provided by all NHS hospitals that deliver breast cancer care in England and Wales, and looking at the care received by patients with breast cancer and their outcomes. The NABCOP audit pulls the anonymised data it requires automatically. The Trust reviews cases and reports at specialist departmental meetings. The NABCOP Patient information sheet for >70s is now used within clinics.
National Audit of Care at the End of Life (NACEL)	The Trust participated in round 3 NACEL 2021 and is currently awaiting the publication of the report. NACEL is designed to measure the experience of care at the end of life for dying people and those important to them, and to provide audit outputs which enable stakeholders to identify areas for service improvement.
National Audit of Dementia (NAD)	The National Audit of Dementia (NAD) measures performance of general hospitals against standards relating to care delivery which are known to impact people with dementia while in hospital. NAD introduced a pilot audit of electronic data collection in which the Trust participated. Not all data was captured due to the electronic data collection, so NAD and the Trust are looking at different ways to capture data. Although NAD did not release a report last year, the following initiatives have been set up in the trust: 1: Purple protects in ED (an initiative set up to help identify people with cognitive impairments and thus to use purple items as a way of keeping them safe) 2: All about Me boards - on CoTE wards - a quick and easy way to communicate needs of people with dementia (this is due to be rolled out to other medical wards) 3: QI work on environmental changes that can be made to keep our hospitals safe - dementia friendly wards / spaces 4: Dementia and Delirium e-learning packages for staff have been reviewed and updated 5: Work is ongoing to try to reduce ward moves for people with dementia

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	
National Bariatric Surgery Registry (NBSR)	The National Bariatric Surgery Register is a comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland. It contains pooled national outcome data for bariatric and metabolic surgery in the United Kingdom. All cases performed in Gloucester are submitted to NBSR. These are then reported on the NBSR Website. The results are presented at the SQAG (Surgical Quality Assurance Group) Meeting and at the Upper GI Surgical Governance Meeting.
National Cardiac Arrest Audit (NCAA)	The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland. The aims of the audit are to: improve patient outcomes; decrease incidence of avoidable cardiac arrests; decrease incidence of inappropriate resuscitation; and promote adoption and compliance with evidence-based practice. All reports are reviewed as a department as well as within the Deteriorating Patient & Resuscitation Committee quarterly. The reports have also been made available on the Deteriorating Patient & Resuscitation Committee drive so that they can be accessed and be reviewed by appropriate clinicians who require access. The Trust also publishes the results quarterly in a newsletter that is made accessible on the Intranet as well as staff notice boards, and shared with department heads for dissemination. The Trust continues to share the results at Induction sessions. Any inappropriate CPR attempts are highlighted and reviewed, and if appropriate, simulated to help focus teaching and lessons learned. The Trust is in the process of using data to further investigate situations prior to the event by working closely with the Acute Care Response Team.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	The NACRM report details activity in cardiac rhythm management (CRM) device and ablation procedures for England and Wales and, where possible, Scotland and Northern Ireland in 2019/20. The Trust continues to participate in the NICOR programme. The report is seen by Specialists, Clinical Leads and all members of the pacing sub- speciality. It is discussed weekly at the Gloucestershire Arrhythmia Group (GAG) meeting. The NICOR data has a focus on numbers and the completeness of the data. It is acknowledged that the numbers for the centre are low. A local complications audit is also carried out and presented at the GAG alongside the countywide audit.
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	The data is used centrally to produce an annual NCAP report and also presented at the annual meeting of the representative specialist body, the British Cardiovascular Intervention Society. A local audit is produced on an annual basis also, presented at one of the departmental audit meetings. The Trust is an outlier in that we do not provide a 24/7 PPCI service as recommended by BCIS and, more recently, GIRFT. The principal reasons for this are shortages in certain staff groups (radiographers) that we share with other specialities and also inability to manage our speciality bed base.
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 to examine the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales. The Trust continues to enter all patients who are admitted with Acute coronary syndromes onto both our sites (GRH & CGH) using NICORs web portal. The current data and report will be reviewed at the Cardiology Audit meeting at the end of Q1 2022. The reports will be used to inform Quality improvements. The Trust continues to work on improving its data completeness and timeliness of entering the information.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	The National Heart Failure Audit is part of the National Cardiac Audit Programme (NCAP), the audit aims to improve the quality and outcomes of care for patients with unscheduled admission to hospital with heart failure. It captures data on clinical indicators which have a proven link to improved outcomes and encourages the increased use of clinically recommended diagnostic tools, disease-modifying treatments and referral pathways. The report was reviewed at the Cardiology audit meeting in December 2021, with a presentation on the report and the current year's progress. The Trust is compliant with the required data entry and in addition to the annual report review, a quarterly analysis is performed.
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)	The National Diabetes Inpatient Audit (NaDIA) –Harms is designed to help reduce serious inpatient harms identified by the NaDIA snapshot audits. This helps to enable NHS trusts to identify and analyse local occurrences of these key inpatient harms, supporting local quality improvement (QI) work. The Trust has continued to participate in the NaDIA alongside the core National Diabetes Audit. A seminar has recently taken place as a collaborative approach to review the most recent publications with a view to looking at improved ways of reviewing key life-threatening diabetes specific inpatient events (harms) and understanding why they have occurred. Across the Trust there have been updates to the inpatient prescription charts and updated protocols for managing hyperglycaemia on the wards. Other initiatives have included development of an e-learning package and enteral feeding charts being trialled, applicable to the surgical wards.
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	The National Pregnancy in Diabetes (NPID) Audit measures the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes. The report aims to support local, regional and national quality improvement in relation to diabetes in pregnancy. Data has been submitted for all T1/T2DM pregnancies managed in the Trust. Data is published nationally and usually reviewed at annual Diabetes in Pregnancy conference. There is an ongoing focus on diabetes care in pregnancy in the department. Because of evidence of poor pre-conception care nationally for the audit, the Trust has provided training to primary care and now has a pre-conception case load managed by our specialist team.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	The National Diabetes Audit (NDA) provides a comprehensive view of diabetes care in England and Wales. It measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. The Type 1 Diabetes report details the findings and recommendations relating to diabetes care process completion, treatment target achievement and structured education for people with Type 1 diabetes. The Trust participates in the NDA and reviews recommendations that are applicable, alongside the National Diabetes Inpatient Audit Harms (NaDIA-Harms) audit.
National Child Mortality Database	
National Early Inflammatory Arthritis Audit (NEIAA)	The National Early Inflammatory Arthritis Audit (NEIAA) is looking in detail at what happens to patients over 16 years of age in England and Wales with suspected early inflammatory arthritis (EIA) when they are referred to a rheumatology service. Timelines to referral and being seen in a specialist service are collected for all patients with suspected inflammatory arthritis; more detailed information is collected over a 12-month period for all patients with a confirmed rheumatoid arthritis (RA) pattern of inflammatory arthritis. The Trust has continued to participate in this audit for the 2021/22 period.
National Comparative Audit of Blood Transfusion - 2021 Audit of Patient Blood Management & NICE Guidelines	The 2021 Audit of Patient Blood Management (PBM) & NICE Guidelines audit is part of the National Comparative Audit of Blood Transfusion (NCABT) programme. It provides the opportunity to: evaluate local evidence of compliance with the four quality statements in the NICE Quality Standard for Blood Transfusion, to provide data to hospital teams to allow their understanding of what steps they can take to implement PBM, to measure their effectiveness in improving patient care, and to allow the transfusion community to benchmark the progress of PBM and its effect on improving patient outcomes. The report was reviewed and identified good practice regarding clinical review and potential improvement opportunities relating to documentation of blood transfusion consent. A new transfusion care record was introduced in December 2021 and this should significantly improve consent documentation. The Trust also plans to repeat the PBM audit against the NICE standards locally on an annual basis.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Emergency Laparotomy Audit (NELA)	Data continues to be uploaded to the NELA website, with quarterly joint surgical and anaesthetic NELA meetings to review results. Improvement projects and data reviews looking at pre-op sepsis, post-op delirium and the introduction of 'dignity boxes' with the aim of keeping glasses, hearing aid etc. with the patient ongoing.
National Gastro-intestinal Cancer Programme - National Oesophago-gastric Cancer	The Trust submits data for the NOGCA. The reports are reviewed at the appropriate specialty and governance meetings when they are published.
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	The Trust continues to submit data to NBOCA to assess the quality of care and outcomes of patients diagnosed with bowel cancer in England and Wales. NBOCA highlighted GHNHSFT as a potential negative outlier for 18-month stoma rate after major resection. Following a local review of cases submitted, it was found that due to various factors, a proportion of cases should not have been included within the results. Reducing the impact of any patients waiting longer than necessary for stoma closure is an area of focus in improving our overall colorectal cancer care
National Joint Registry (NJR)	The National Joint Registry (NJR) collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery. The results of the NJR are shared with the Medical Director and Chief Executive, and are discussed at hip and knee MDT meetings amongst all hip and knee surgeons. Individual reports are used as part of the appraisal process. New implants have been introduced to improve periprosthetic fracture rate. This year's National report has not yet been released but will be discussed alongside the Trust Annual report when published.
National Lung Cancer Audit (NLCA)	The National Lung Cancer Audit (NLCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works with a number of specialists to collect hospital and healthcare information and report on how well people with lung cancer are being diagnosed and treated in hospitals across England, Wales, (and more recently) Jersey and Guernsey. The outcomes are reviewed at the Lung AGM and appropriate specialty and governance meetings. Quality improvement projects to improve our service and pathways are ongoing.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Maternity and Perinatal Audit (NMPA)	
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care	The NNAP assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high quality care, and identify areas for quality improvement. The Trust reviews the report during the year, with quarterly reviews of data, so it can be seen where improvement is needed. Posters are provided for dissemination of results to staff and parents. Usually, the Trust is above National levels in most of the key areas. Where the Trust falls below, the causes are looked into, and Quality Improvement Initiatives are set up to help – for example, with admission temperatures. It should be considered, that the data in the NNAP report is not always in alignment with what it is felt that the Trust has submitted. The Trust has been positive outliers in some areas and negative in others. The pandemic contributed to this, especially with 2yr follow-up data, as so many face-to-face clinics were cancelled.
National Paediatric Diabetes Audit (NPDA)	The NPDA is delivered by the Royal College of Paediatrics and Child Health (RCPCH). Data is submitted by Paediatric Diabetes Units (PDUs) in England and Wales about the care received by children and young people with diabetes using their service. The annual report published this year (data April 2019 - March 2020) showed GHNHSFT to have results within the national average for responses, whilst HbA1c, BMI, thyroid testing, blood pressure and eye screening are above National average for England/Wales (nearly 100%). The result for foot exam screening of 84.3% is consistent with the national average and has been found to relate mostly to DNA/recording.
National Perinatal Mortality Review Tool	

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Prostate Cancer Audit	The National Prostate Cancer Audit (NPCA) is a national clinical audit assessing the process and outcome measures from all aspects of the care pathway for men newly diagnosed with prostate cancer in England and Wales. The findings help to define new standards and help NHS hospitals to improve the care they provide to patients with prostate cancer. The Trust submits data for NPCA and reviews the reports at the appropriate specialty and governance meetings when they are released. There is a clear improvement between the 2020 and 2021 data for the Trust. The improvements and developments made in service delivery has moved the Trust from an outlier to comparable and potentially better than the national average.
National Vascular Registry	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions.
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. The report is reviewed in Stroke Monthly business meetings. The Trust is able to access the SSNAP data directly and it is used to provide regular data for a number of purposes and is reviewed on a regular basis by ED, radiology, stroke nurses, consultants and the wider stroke team. It helps inform potential quality improvements within the stroke service. With a system of Score A (best) to E (worst), the Trust scored B for the first 3 quarters, and D in the last, challenged by bed pressures and difficulties due to accessing stroke beds and Covid issues. The Trust has redesigned the stroke service and moved HASU to CGH from 1st February, so is intending to see improvements.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Serious Hazards of Transfusion (SHOT)	SHOT collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the UK. Where risks and problems are identified, SHOT produces recommendations to improve patient safety. The recommendations are put into its annual report which is reviewed by the Trust. A gap analysis is ongoing with particular focus on identifying potential improvements to ensure transfusion delays are avoided.
Society for Acute Medicine Benchmarking Audit (SAMBA)	The Society for Acute Medicine Benchmarking Audit (SAMBA) 2021 provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 17th June 2021. This report is written for the benefit of all those involved in acute medical care, including healthcare professionals, healthcare commissioners, all UK governments and, most importantly, patients and public. This was the first clinical data collection for SAMBA since the start of the Covid-19 pandemic. Since the last round of SAMBA in January 2020, acute medicine services have worked through periods of intense pressure, rapidly adapting to changes in service pressures, clinical need, and measures for patient safety that have often required widespread physical reconfiguration of services. The Trust was a participant in the 2021 audit.
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment (RESECT)	RESECT aims to conduct a retrospective and prospective, multicentre, international study of urological practice of the management of non-muscle-invasive bladder cancer (NMIBC). The primary objective is to determine if audit and feedback can improve the quality of TURBT surgery and reduce early recurrence rates. The Trust is participating but no report has been published as yet.
The Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured. The Trust has continued to ensure 100% submission rates with cases submitted within the 40 day dispatched deadline. TARN reports are reviewed every two months within the Major Trauma meeting. In response to the report data, rehab co-ordinators have been introduced to ensure compliance with rehab prescription measures.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
UK Cystic Fibrosis Registry	The UK Cystic Fibrosis Registry is a secure centralised database, sponsored and managed by the Cystic Fibrosis Trust. It records health data on consenting people with cystic fibrosis (CF) in England, Wales, Scotland and Northern Ireland. The CF Registry provides data used by the Trust to compare as a site against either Bristol or nationally. Bristol is in line with most data sets published in the summary for example BMI, mean FeV1, IV courses. The Trust completed data submission for 2021 with a total of 37 patients. The report from the previous year is published in early summer and is usually shared at the AGM in July. It is also disseminated by the CF Registry team to data managers/ centre/site leads. The Trust is significantly above average for use of mucolytic nebulisers, due to having very proactive doctors and physio team. The Trust is lower than average in chronic pseudomonas infection. A main goal at present is the rollout of CFTR modifiers.
Urology Audits - Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Management of the lower end of ureter in nephroureterectomy varies widely because there is no clear evidence as to which procedure offers the best cancer control. The aims of this audit are: to determine which surgical technique offers the best cancer control in terms of survival and recurrence; to capture patient profiles at entry; to determine whether the different procedures are performed without significant morbidity; and to establish the recurrence and survival rates of patients who underwent procedures between 1 January 2017 and 31 December 2019. The Trust participated in this audit and currently awaits the report. The local data was presented and reviewed at the Urology QI meeting January 2022.

Local clinical audits

The reports of 120 local clinical audits were registered in 2021/22 and these are reviewed and actioned locally.

This includes 13 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2021/22 (graduation events were put on hold for most of the year due to clinical priorities relating to Covid).

Some examples of actions associated with audits and completed QI projects are as follows:

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Improving Postnatal Bladder Care	Bladder care is an important aspect of management in the postpartum period. Postpartum voiding dysfunction occurs in a significant number of women, which can potentially cause permanent damage to the detrusor muscle and long-term complications when left undetected or untreated. Previously once midwives were qualified, they had very little to no training on postnatal bladder care. The Urogynaecology Department would frequently be asked for advice and guidance and the postnatal bladder care pathway could be hard for midwives to interpret without any guidance or training. A QIP was introduced to ensure that all midwives have bladder care training as part of their mandatory training. The changes have made a benefit in improving documentation of postnatal bladder care and confidence of midwives treating these ladies postnatally. In order to ensure this improvement is sustained, there will be continuation of Postnatal Bladder Care to Midwives on mandatory training and a review of midwives' confidence and knowledge scores. It is also planned that Bladder Care "Champion" midwives will be present on wards to offer additional support and to be trained further in teaching of intermittent self-catheterisation (ISC).
Traction Removal of PEG tubes in Outpatients for Head & Neck Cancer Patients	Following treatment for head & neck cancer, patients are keen to have their PEG tubes removed as soon as possible when they are no longer required. As this is classed as a non-urgent procedure by Endoscopy, they often have to wait a long time, which can cause psychological distress and potential physical complications. The Head & Neck Dietitian and CNS looked at ways of being able to offer this service in an ENT outpatient setting. New ways of working needed to be introduced, such as sourcing a suitable clinic room, establishing clinic codes and getting clinic built on Trakcare. A competency needed to be developed as none existed in the Trust (or nationally that could be sourced). Once competency had been approved, CNS commenced training by Gastroenterologists. A patient feedback questionnaire was developed and implemented, showing patients' satisfaction with the new service and reduced waiting times There was an 81.5 % reduction in average waiting time for PEG removal by the end of 6 months with a range of 8 - 29 day wait, once the backlog of patients waiting for removal was cleared. There was a 100% Satisfaction with the PEG removal procedure by CNS. This QIP resulted in an improved patient quality of life and satisfaction in waiting times as well as offering cost savings.

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 3347.

Commissioning for Quality and Innovation (CQUINS)

Due to the pandemic, in 2021/22, there was a block payments approach for arrangements between NHS commissioners and NHS providers in England which was deemed to include CQUINS.

Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good". Gloucestershire Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2021/22

The CQC carried out a pilot system inspection focussed on Urgent and Emergency Care and Medical care services between 8 and 10 December 2021. The inspection report was published on 3 March 2022.

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2021/22 to NHS Digital for Commissioning Data Sets (CDS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: which included the patient's valid NHS number was:

- 99.9% for admitted patient care (national average: 99.7%) for the report period APR 2021 to MAR 2022
- 100% for outpatient care (national average: 99.8%) for the report period APR 2021 to MAR 2022
- 99.5% for accident and emergency care (national average: 98.2%) for the report period APR 2021 to MAR 2022. Please note we are missing part of this financial years data which is currently being investigated by NHS digital.

The percentage of published data which included the patient's valid GP practice code was:

- 100% for admitted patient care (national average: 99.7%) for the report period APR 2021 to MAR 2022
- 100% for outpatient care (national average: 99.6%) for the report period APR 2021 to MAR 2022
- 100% for accident and emergency care (national average: 99.2%) for the report period APR 2021 to MAR 2022. Please note we are missing part of this financial years data which is currently being investigated by NHS digital.

Information Governance Incidents

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

Six incidents have been reported to the ICO during the 2021/22 reporting period. This compares to ten reported in the previous period.

Summary of incidents reported to the Information Commissioner

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
May 2021	Patient discharge information given to wrong patient upon discharge. **Lessons learnt:** Human error. Staff reminded to double check discharge summary and TTO before sending / giving it to patient.	1	Patient contacted by the clinical team
July 2021	Member of staff accessed health records of a relative when there was no legitimate work related reason to do so. **Lessons learnt:** Managed through human resources process. Staff reminded of their responsibilities and code of confidentiality	2	Written communication following patient raising concerns
October 2021	Printout from one patient's medical records were accidentally included with printout from a second patient's records and filed in the patient's hand held record. Printout contained medical history and obstetric history of each patient. **Lessons learnt:** Reminder to the Community Midwives to check that when they generate multiple printouts they ensure they are separated before putting with patient proformas for filing.	2	Patient who wrongly received information telephoned the Patient whose records she had. Staff also phoned once they were aware and apologised.
January 2022	Employee left work and personal bags in car after shift. Car was stolen from outside employee's home. Contents containing patient identifiable information included pregnancy cards, booking forms, antenatal notes. **Lessons learnt:** Update sent out to all staff re confidential information not to be left in cars and paperwork to be transported in confidential carry bags.	24	All patients affected received written or verbal apology.

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
February 2022	Member of staff (A) left shift early with health issues. Colleague looked at the staff member's records on the Trust's Patient Administration System with a view to verifying or checking whether there was any record relating to the issue.	1	Investigations ongoing as part of HR process
	Lessons learnt – Investigations ongoing as part of HR process		
February 2022	A member of staff has accessed health records of former partner without apparent authority	1	Patient instigated. Investigations ongoing as part of HR process.
	Lessons learnt – Investigations ongoing as part of HR process		

Summary of confidentiality incidents internally reported 2021/22

All of these incidents have been now been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence, and requiring no further action, unless new matters came to light. With respect to the number of incidents of inappropriate access by staff there will be a further communications exercise to remind staff of the requirements of the Code of Confidentiality.

A large number of the 259 near miss reported incidents (185) relate to lost SmartCards which are disabled when reported as missing.

Reportable breaches	(detailed above) 06
Number of confirmed Non-reportable breaches	161
Number of no breach / Near miss incidents.	259
Total number of confidentiality incidents internally reported	436

The effectiveness and capacity of these systems has been routinely monitored by our Trust's Information Governance and Health Records Committee and will continue to be monitored by the Digital Care Delivery Group under new governance arrangements. A performance Summary is presented to our and Finance and Digital Committee and/or Trust Board annually.

Data Quality: relevance of data quality and action to improve data quality

Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is:

1. Complete
2. Accurate
3. Relevant
4. Up to date (timely)
5. Free from duplication (for example, where two or more different records exist for the same patient).

Gloucestershire Hospitals NHS Foundation Trust will be taking the following actions to improve data quality

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive DQ reports back from SUS. Based on SUS DQ reports we action all red and amber items highlighted in report to improve Data Quality.
- In data published for the period April 2019 to March 2020, the percentage of records which included a valid patient NHS number was:
  - 99.8% for admitted patient care (national average: 99.4%)
  - 100% for outpatient care (national average: 99.7%)
  - 99.1% for accident and emergency care (national average: 97.7%)
- The percentage of published data which included the patient's valid GP practice code was:
  - 99.9% for admitted patient care (national average: 99.7%)
  - 99.8% for outpatient care (national average: 99.6%)
  - 99.9% for accident and emergency care (national average: 97.9%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as: -

- Outpatients including attendances,
- Outcomes, invalid procedures
- Inpatients including missing data such as
- NHS numbers, theatre episodes
- Critical care including missing data, invalid
- Healthcare Resource Groups
- A&E including missing NHS numbers,
- Invalid GP practice codes
- Waiting list including duplicate entries, same day admission

On a daily basis, any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is available on the Trust's Intranet Policy pages.

Audit trails are used to identify areas of DQ concern within the Trust, which means that these areas can be targeted to identify issues. These could be system or user related. Training is offered and process mapping undertaken to improve any data quality issues.

Most of the Trust systems have an identified system manager with data quality as a specified duty for this role. System managers are required under the Clinical and Non- Clinical Systems Management Policy to identify data quality issues, produce data quality reports, escalate data quality issues and monitor that data quality reports are acted upon.

Data Quality is now part of the yearly mandatory training package for staff – a signed statement is needed that tells staff that Data Quality is everyone's responsible to ensure good quality and clinically safe data.

Learning from deaths 2021/2022

During 2021/2022 2281 of Gloucestershire Hospitals NHS Foundation Trust patients died. This comprised of the following number of adult in hospital deaths which occurred in each quarter of that reporting period:

- 471 in the first quarter
- 552 in the second quarter
- 616 in the third quarter
- 642 in the fourth quarter

These quarterly results are broken down by Division below:

- The total number of deaths across all Divisions for the reporting year 2021/2022 is 2281 of which 100% are reviewed by the Medical Examiner as per Trust policy.
- Of these 2281 deaths 510 have been triggered for an investigation by structured judgement review
- Of these 2281 deaths, 335 have so far been subjected to a detailed investigation by way of satisfying the criteria to trigger a Structured Judgement Review (SJR). (Q4 deaths may not have been completed due to 3 month time lag for review)
- Of these 2281 deaths 21 have been reviewed by other means (harm review/ investigation, PIR, complaint)
- Of these 335 SJRs carried out, 3 have identified that the cause of death is judged to be more likely than not to have been due to problems in the care provided to the patient. (ie that means went on to be a harm investigation or serious complaint) (Additional deaths awaiting 2nd review or scoping for serious incident panel)

Number of patient deaths

Division	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Divisional Year Total
Surgery	68	75	105	104	352
Medicine	374	445	476	509	1804
D&S	29	29	35	29	122
W&C	0	3	0	0	3
Total	**471**	**552**	**616**	**642**	**2281**

Therefore, across all four Divisions for Quarters 1 – 4:

- The percentage of deaths which were selected for SJR=22%
- The percentage of deaths which have been reviewed as an SJR=15% (Q4 deaths may not have been completed due to 4 month time lag for review)
- The percentage of deaths reviewed by other means =1%
- Out of all 335 SJRs conducted (up until 20/04/2022), the percentage of deaths identified as having sub-optimal care as a contributing factor to the death = 0%
- Therefore, out of the total number of deaths reported across the Trust, the percentage of deaths for which sub-optimal care was a contributing factor (up until 21/05/2021)= 0.9%

Learning themes

Learning themes from all deaths reported, with particular focus on any sub-optimal care, are brought on a rotating quarterly basis to the Hospital Mortality Group by the Divisional Mortality representative from where recommended suggestions for improvements are passed on to the relevant committee or group, in addition all serious incidents have individual action plans and national reports on deaths e.g. LedeR inform improvement plans. The most frequent high level theme involves the deteriorating patient and end of life decision making on admission.

The above data is taken from the following sources:

- Mortality stats report on the BI tool – Insight;
- SJR stats taken from Datix;
- Quarterly Learning from Deaths Reports authored by the Medical Director and taken through Quality & Performance Committee and then on to Main Board;
- Outcomes from the monthly Hospital Mortality Group, chaired by the Medical Director.

Additional information is provided in the supporting tables:

- Table 1 – breakdown of above data
- Table 2 – Summary of Learning Themes to come out of the SJR process
- Table 3 – Learning from Deaths – Using the SJR methodology

Table 1: Quarterly Breakdown of deaths which triggered an SJR and any poor care attributable

	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified
Surgical division				
Q1	68	68	9	0
Q2	75	75	10	0
Q3	105	105	20	0
Q4	104	104	15	0
Year Totals	**352**	**352**	**54**	**0**
Medical division				
Q1	374	374	138	3
Q2	445	445	129	6
Q3	476	476	85	0
Q4	509	509	95	2
Year Totals	**1804**	**1804**	**447**	**11**
D&S Division				
Q1	29	29	3	0
Q2	29	29	4	0
Q3	35	35	1	0
Q4	29	29	1	0
Year Totals	**122**	**122**	**9**	**0**
W&C Division (Paediatrics follow their own review process)				
Q1	0	0	0	0
Q2	0	0	0	0
Q3	3	3	1	0
Q4	0	0	0	0
Year Totals	**3**	**3**	**1**	**0**

2021/22 Summary by Division

Division	No. of deaths	Total No of ME reviews	No. of SJRs triggered	No. of deaths where poor care overall identified
Surgery	352	352	54	0%
Medicine	1804	1804	447	0.6%
D&S	122	122	9	0%
W&C	3	3	1	0%
Total	**2281**	**2281**	**510**	**0.4%**

In percentage terms, by Division:

Division	Total no. of deaths for Quarters 1–4	% of SJRs triggered vs total number of deaths – Qs 1 to 4	% where sub-optimal care was identified vs no. of SJRs undertaken	% of sub-optimal care identified vs total number of deaths: Qs 1–4
Surgery	352	15%	0%	0%
Medicine	1804	25%	2%	0.6%
D&S	122	7%	0%	0%
W&C	3	33%	0%	0%
Totals	**2281**	**22%**	**2%**	**0.4%**

Statement NHS doctors in training rota gaps

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided. As part of our Quality Account 2020/21 we are providing a statement on our Trust Doctors in Training Rota Gaps, which we are required to report on annually through the following legislation schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Monitoring, Delivery and Assurance

The Guardian of Safe Working presents a quarterly board report directly to Trust Board, providing an update and assurance on the monitoring of exception reports and medical rota gaps.

Improvements (2021/22)

We continued to review and analyse our data to provide early indicators of our issues which were hampered by ongoing COVID absences through our staff groups. In 2021/22 we took the following steps to make improvements:

- Looking at data to support hard to fill areas where there are pressures on certain rotas due to national supply and reviewing the demand requirements within departments to ensure that there is a transparency about safe staffing levels.
- Regular meetings continued with the Medicine Division Rota leads to discuss known issues and discussing ways of reducing gaps, along with an increase in overseas doctor recruitment to support known gaps
- Guardian of Safe Working proactively involved with rotas to ensure these maintain safe working hours along with good training/education opportunities, encouraging future applicants.

Next Steps (2022/23)

In 2022/23, we will see an increase in our training numbers from Health Education England to re-balance the number of trainees that we are allocated, along with our continuation of overseas doctor recruitment to support te known gaps in our workforce. We will maintain development of processes to support the ongoing delivery of our 5-year People and Organisational Development Strategy, to provide a robust picture of rotas and ensure that early intervention for service provision is agreed to mitigate gaps within the rota. We will look to build on the collaboration with departments, senior clinicians and junior doctors to agree on improved rotas which will support workforce plans, triangulating this information with other workforce, activity and quality indicators and with consideration of known labour market supply issues. In addition to this our Guardian of Safe Working will seek to improve the information dashboard relating to rota gaps, enabling a more proactive response and improving collaborative working with our clinical Divisions.

Veteran Aware Trust

The Trust was accredited by the Veterans Convenance Healthcare Alliance (VCHA) in 2019 in recognition for the work and relationships undertaken with the local Armed Forces Community.

NHS Providers that have been accredited demonstrate themselves as exemplars of the best care for veterans, helping to drive improvements in NHS care for people who serve or have served in the UK armed forces and their families.

Veteran Aware Trusts will:

- provide leaflets and posters to veterans and their families explaining what to expect
- train relevant staff to be aware of veterans' needs and the commitments of the NHS under the Armed Forces Covenant
- inform staff if a veteran or their GP has told the hospital they have served in the armed forces
- ensure that members of the armed forces community do not face disadvantage compared to other citizens when accessing NHS services
- signpost to extra services that might be provided to the armed forces community by a charity or service organisation in the trust
- look into what services are available in their locality, which patients would benefit from being referred to

Over a 12 month period the Trust had 1388 Veteran inpatients, however with EPR compliance to record this on admission at only 75.7%, the Veteran inpatient population within this 122 month period is likely to be considerably higher.

Figure 1: Veteran attendance and EPR compliance from March 2021-2022

Armed Forces Breakdown by Month

Month	Year	Armed Forces	Admission Documents	Completed	Compliance
March	2021	99	3462	2501	72.2%
April	2021	123	3922	2933	74.8%
May	2021	149	4320	3367	77.9%
June	2021	151	4341	3442	79.3%
July	**2021**	**127**	**4375**	**3373**	**77.1%**
August	**2021**	**142**	**4264**	**3253**	**76.3%**
September	**2021**	**110**	**3856**	**2899**	**75.2%**
October	**2021**	**114**	**3887**	**2955**	**76.0%**
November	**2021**	**109**	**3724**	**2872**	**77.1%**
December	**2021**	**103**	**3420**	**2533**	**74.1%**
January	**2022**	**71**	**3178**	**2288**	**72.0%**
February	**2022**	**90**	**3189**	**2433**	**76.3%**
Total		**1388**	**45938**	**34849**	**75.7%**

During the Covid-19 Pandemic the usual military dates normally celebrated within the Trust had to be recognised on social media and there was little activity undertaken by the Armed Forces Champions and the Operational Lead for the Armed Forces due to government restrictions.

Main points to note for 21/22

- Multi-faith Armistice Day in the Garden of Remembrance at Gloucestershire Royal Hospital
- Armistice Day cards sent to all Veterans on our wards to thank them for their service
- 3 year re-accreditation submission due by June 2022 to retain Veteran Aware status for 2022-2025
- Recruitment of two Armed Forces Advocates sponsored by the Armed Forces Covenant Fund Trust for a 2 year period.
- The Armed Forces Act 2021 was amended to include the Armed Forces Covenant as a Statutory requirement within the Private Sector
- Participant in the Veteran in an Acute Setting Programme, sponsored jointly by Armed Forces Covenant Fund Trust and NHSE/I

Objectives for 22/23

- Educate Trust workforce in relation to the Armed Forces Covenant and EPR compliance.
- Embed Armed Forces Covenant Training in to the Trust Induction Programme.
- Armed Forces Advocates to represent Gloucestershire Hospitals at Gloucester Armed Forces Day on 25 June 2022.
- Develop partner working across the ICS
- Trust representation at the SW NHS Challenge hosted by 243 Field Hospital.
- Continue to collect and submit data as part of the Veterans in an Acute Setting Programme

Part 2.3

Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC), now known as NHS Digital.

NHS Improvement has produced guidance for the Quality Account outlining which performance indicators should be published in the annual document. You can see our performance against these mandated indicators in the next Figure.

Figure: Reporting against core indicators

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1	1.178	0.68	2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04/21)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1	1.23	0.73		
	2017/18	1.09	1	1.11	0.89		
	2018/19	1.0462	1.0012	1.2058	0.7069		
	2019/20	1.0128	1.0036	1.1957	0.6909		
	2020/21	1.0		1.1	1.0		
	2021/22	1.0237	1.0001	1.1860	0.7193		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.60%	11.20%		
	2017/18	32.10%	32.80%	59%	12.60%		
	2018/19	35%	35.84%	60%	12%		
	2019/20	33%	36.81%	59%	11%		
	2020/21	36%		46%	31%		
	2021/22	37%	39.52%	64%	11%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	Pre 2019/20: data covers the last 6 months in the financial year. 2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04/21)	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932 / 22	4955 / 19	23,990 / 60	3,510 / 26		
	2017/18	7,523 / 35	5,449 / 19	19,897 / 51	1,311 / 0		
	2018/19	6,780 / 12	5,841 / 19	22,048 / 72	1,278 / 12		
	2019/20	7,216 / 15	6,276 / 19	21,685 / 95	1,392 / 20		
	2020/21	14,866 / 58		1,445 / 10	772 / 1		
	2021/22	14,882 / 36	24,805 / 58.4	37,572 / 50.7	3,169 / 27.2		
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	Pre 2019/20: data covers the last 6 months in the financial year. 2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04/21)	
	2016/17	41.82 / 0.13	39.89 / 0.15	71.81 / 0.6	21.15/0.06		
	2017/18	45.00 / 0.21	42.55 / 0.15	124.0 / 0.05	24.19 / 0.00		
	2018/19	41.32 / 0.07	46.06 / 0.15	95.94 / 0.32	16.90 / 0.16		
	2019/20	44.88 / 0.09	49.78 / 0.16	103.84 / 0.01	26.29 / 0.31		
	2020/21	52.67 / 0.21		55.51 / 0.39	49.14 / 0.06		
	2021/22	59.9 / 0.3	58.4 / 0.5	118.7 / 1.8	27.2 / 0.1		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	As at 29/03/22	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.4	13.1	90.4	0		
	2018/19	16.9	11.7	79.7	0		
	2019/20	not available	not available	not available	not available		
	2020/21	not available	not available	not available	not available		
	2021/22	not available	not available	not available	not available		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2021/22 data period: Apr21 - Dec21 (data as at 03/04/21)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group. The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17*	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.71%	96.70%	100%	74.30%		
	2019/20	93.79%	99.03%	100%	71.72%		
	2020/21	91.2%		94.6%	87.0%		
	2021/22	89.4%		92.3%	87.0%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Percentage of patients aged 0–15 readmitted to hospital within 28 days of being discharged	2011/12*	9.88%	10.26%	14.94%	6.40%	As at 29/03/22	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
	2020/21	n/a	n/a	n/a	n/a		
	2021/22	n/a	n/a	n/a	n/a		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%	As at 29/03/22	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
	2020/21	n/a	n/a	n/a	n/a		
	2021/22	n/a	n/a	n/a	n/a		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	As at 29/03/22	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	65.1	67.2	85.0	58.9		
	2019/20	not available	not available	not available	not available		
	2020/21	not available	not available	not available	not available		
	2021/22	not available	not available	not available	not available		
Staff Friends & Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.0%	65.0%	85.4%	46.0%	2021/22 data period: Survey in Oct21-Dec21 (as at 04/04/2022)	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64. 0%	70.0%	84.80%	48.9%		
	2017/18	61%	70 %	93 %	42%		
	2018/19	65%	70%	87%	41%		
	2019/20	64%	70%	88%	41%		
	2020/21	70.5%	74.3%	91.7%	49.7%		

Patient Reported Outcome Measures (PROMs)

The trust's patient-reported outcome measures scores for:

- groin hernia surgery
- varicose vein surgery
- hip replacement surgery and
- knee replacement surgery during the reporting period.

	EQ-5D		EQ VAS	
Procedure	**Trust %**	**England %**	**Trust %**	**England %**
Hip	96.30%	91.40%	76.60%	70.58%
Knee	90.32%	84.32%	62.50%	60.69%

Part 3

Other information

The following section presents more information relating to the quality of the services we provide.

In the figure below there are a number of performance indicators which we have chosen to publish which are all reported to our Quality & Performance Committee and to the Trust Board. The majority of these have been reported in previous Quality Account documents. These measures have been chosen because we believe the data from which they are sourced is reliable and they represent the key indicators of safety, clinical effectiveness and patient experience within our organisation.

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.28%	0.45%	3.16%	19.48%	**18.27%**	<1%	Mar 21 snapshot
Clostridium difficile year on year reduction	56	56	97	75	**95**	2019/20: 114	Total Apr 20 – Mar21
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4	6	2	0	**2**	0	Total Apr 20 – Mar 21
MSSA	100	80	18	18	**31**	<=8	Total Apr 20 – Mar 21
Never events	6	2	6	8	**11**	0	Total Apr 20 – Mar 21
Risk assessment for patients with VTE	87.03%	93.20%	93.19%	91.2%	**89.4%**	>95%	2017/18 = Jul to Mar based on submissions (did not have data Q1) Apr 18 – Mar 19
Crude mortality rate	1.24%	1.09%	1.19%	1.66%	**1.46%**	No target	Total Apr 19 – Mar 20
Dementia 1a: Case finding	0.80%	1.90%	0.80%	68.0%		>=90%	Total Apr 19 – Mar 20
Dementia 1b: Clinical assessment	65.00%	27.90%	29.40%			>=90%	Total Apr 19 – Mar 20
Dementia 1c: Referral for management	11.00%	2.80%	0%			>=90%	Total Apr 19 – Mar 20
% patients spending 4 hours or less in ED	86.70%	89.60%	81.58%	75.11%	**73.81%**	>=95%	Total Apr 19 – Mar 20
No. of ambulance handovers delayed over 30 minutes *(<=1hr)	506	666	1,177	2,151	**3,481**	Annual Target TBC (<=40 per month STP)	Total Apr 19 – Mar 20
No. of ambulance handovers delayed over 60 minutes	15	14	34	1,577	**3,171**	0	Total Apr 20 – Mar 21
Emergency readmissions within 30 days: elective and emergency	6.9%	6.9%	7.0%	8.0%	**3.36%**	<8.25%	Total Apr 20 – Mar 21
% stroke patients spending 90% of time on stroke ward	88.2%	90.8%	87.70%	83.5%	**82%**	>=80%	Total Apr 20 – Mar 21
% of women seen by midwife by 12 weeks	89.50%	89.80%	88.90%	92.8%	**91.3%**	>90%	Total Apr 20 – Mar 21

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	National target (if applicable)	Notes/ Other information
Number of written complaints	1031	898	781	614		No target	Apr18 – Mar 19
Rate of written complaints per 1000 inpatient spells	6.26*	5.65	4.72	5.08		No target	Apr18 – Mar 19
Cancer: urgent referrals seen in under 2 weeks from GP	82.30%	90.10%	92.50%	94.7%	**92.7%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
2 week wait breast symptomatic referrals	90.40%	95.90%	97.50%	92.5%	**91.2%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (first treatments)	96.30%	94.60%	93.40%	97.9%	**97%**	>=96%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – surgery)	94.80%	95.30%	93.60%	95.2%	**92.3%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – drug)	99.80%	99.90%	99.40%	99.4%	**99.8%**	>=98%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – radiotherapy)	99.10%	99.30%	94.90%	98.0%	**99.1%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (urgent GP referral)	75%	74.80%	73.10%	83.3%	**72.3%**	>=85%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (screenings)	92.20%	96.50%	95.40%	90.8%	**85.9%**	>=90%	Total Apr 20 – Mar 21 (unvalidated)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	79.79%	69.40%	**72.15%**	92%	Mar 21 snapshot
Delayed Transfer of Care rate	2.39%	3.15%	2.96%			<=3.5%	Mar20 snapshot
Number of delayed discharges at month end	34	43	15			<=38	Mar20 snapshot

Annex 1

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2021-22. The past year has continued to present major challenges across both Health and Social care in Gloucestershire as we continue to work through the COVID-19 pandemic. In the past year we have continued to see GHNHSFT working closely with partner organisations including the CCG to deliver a system wide approach in what has been some extremely difficult times. This joint working has enabled us to further develop, review and improve the quality of commissioned services and the outcomes for service users in Gloucestershire and none more so than the recent work of the Vaccination Programme with its successful roll out in the county and impact on the health of our residents.

The CCG would like to thank the Trust for all the continuing efforts, dedication and hard work over the past year in dealing with the ongoing COVID-19 pandemic. The CCG have continues to work with partners in both health and social care to monitor and support the effects of the pandemic on NHS staff and as we continue to move through the pandemic, NHS workers health and wellbeing has remained a priority area.

Over the past year the Trust has undergone a number of CQC visits and inspections, the CCG has good visibility of the Trust's response to the unannounced visits and CQC action plans, it further notes the plans for improvement in 2022/23. The CCG is also pleased to see that improving the Urgent and Emergency Care patient experience remains a priority for 2022/23 and looks forward to working in partnership with front door teams to support the work around the identified themes in the Patient Experience Improvement Plan.

The CCG is also pleased to note the other priorities listed in this year's Quality Account. In light of the recently published final report of the Ockenden review the CCG is keen to support the Trust with their work on improving maternity experiences and working in partnership with the Gloucestershire Maternity Voices. The CCG also recognises the importance of improving quality and experience for inpatients and are pleased to see this listed as a priority, as well as the focus on better discharge and work on the criteria to reside agenda. As per the previous year's report, the importance of the safety strategy and safety culture features heavily. The implementation of the new National Patient Safety Strategy, sitting alongside the ICS Journey for Quality will support this area of work and remains a key component of the operational planning.

The CCG endorses the Quality priorities that the Trust have selected for 2022/23 and are particularly pleased to see work to include the focus on falls prevention. Also the focus on the prevention of pressure ulcers, together with improved mental health care and addressing the health inequalities agenda, with improved engagement with ethnic minority communities in the development of services are to be commended. The CCG is also pleased to see the ongoing work around improving care for patient with diabetes and the deteriorating patient workstreams, with the introduction of new digital systems and enhanced technology to support sepsis management.

The CCG are aware of a number of Serious Incidents and Never Events that GHNHSFT have reported in the last year. The CCG continue to work with the Trust in relation to the management of these incidents and events in order to ensure that all the learning and improvement actions are monitored and embedded within the clinical environments. The CCG are also keen that there is wider system learning and development through shared feedback to system partners, community teams and Primary Care. The Trust's Safety and Experience Review Group, with representation and challenge from the CCG, continues to function successfully to retain detailed oversight of all Serious Incidents and Never Events and complaints. The Safety team alongside colleagues form the CCG and members of the Learning Academy, maintain a clear and robust system for ongoing monitoring of all action plans and recommendations. The high number of recent Never Event declarations at Gloucestershire Hospitals Trust was flagged as a concern by the Regional and National Quality Teams at NHSEI and as part of an additional support offer the CCG has met with colleagues from the Clinical Quality Team at NHSEI and the Patient Safety Lead for Never Events and regional learning has been shared. The Trust have worked incredibly hard in producing a robust programme of improvement and the team have demonstrated commitment to improving safety and enhanced staff engagement.

The CCG acknowledges the content of the Trust Quality Account and will continue to work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality safe and effective care with good outcomes for the people of Gloucestershire. The report is a clear, transparent and comprehensive document which demonstrates the Trust's commitment to continuous quality improvement. The CCG confirms that to the best of our knowledge we consider that the 2021/22 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT and we look forward to continued close working as we form the Integrated Care System in Gloucestershire this summer.

Dr Marion Andrews-Evans
Executive Nurse and Quality Director

Statement from Healthwatch Gloucestershire (HWG)

2021/22 has been another challenging year for the Trust in Gloucestershire, as for others around the country. We understand that pent up demand and the scale of the backlog created by Covid have led to extraordinary pressures. The current challenges in staffing and for staff have also been significant and the focus on staff wellbeing by the Trust is welcome. We know that a good working experience for staff leads to a good experience for patients.

We have been following the progress of the Trust's Mental Health Strategy with interest. We have welcomed the positive environmental changes made in A&E and the inclusion of people with lived experience in co-design. Although there is some distance to travel in rolling out the strategy, we believe that the Trust's approach of partnership working within the ICS and VCSE sector alongside public and patient involvement aims to achieve the best outcomes for people. We are also pleased to note the focus on service improvement for people with Learning Disabilities and Autism. We look forward to being able to test this out and contribute to continued improvement through our own work with people with autism in the coming year.

Healthwatch Gloucestershire has also received feedback about Maternity services that reflects experiences reported directly to the Trust and maternity services across the nation. We know that Maternity Voices is the expert in women's voices and will be watching closely to ensure that the local arrangements are effective.

We believe that the two main areas of significant pressure, those of A&E and delayed discharge with its associated risks around deconditioning, speak to the wider pressures within the system. We acknowledge and welcome the resources allocated and service improvement measures enacted by the Trust in helping to improve experiences of A&E. We also welcome the focussed attention on improving care for patients whose condition deteriorates, who develop pressure ulcers and who fall in hospital alongside the work on inpatient experience. However, we believe that action by the wider health and care system can help with long term solutions. We are hopeful that the Trust will be able to see positive change in their own services in part through the effectiveness of the Integrated Care System. Healthwatch Gloucestershire will continue to champion the experiences and positive outcomes of those using the system's services.

We are pleased to note that the Trust sets out its priority to improve safety and to foster a learning culture. Our own experience of the Trust at management and governance levels shows it to be an organisation with a constructive culture of honesty and active focus on the outcomes and experiences for patients. We are continually impressed by the Trust's constructive attitude to working with Healthwatch Gloucestershire and look forward to a continued strong relationship.

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Gloucestershire Health Overview and Scrutiny Committee, I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust Quality Account Report 2021/22.

In particular, I note and value the hard work and commitment of the Trust to review and make improvements to the delivery of services during and following the COVID-19 Coronavirus Pandemic.

I'm pleased to have this opportunity to publicly thank the senior management team at the Trust for the courteous and respectful way in which they engage with the Committee. I'm proud of the way in which the Committee and Trust work together to ensure that effective scrutiny of the Trust is able to be carried out and that there are no 'no go' areas.

I'm especially grateful that the Committee is kept fully up to date on the ongoing Fit For the Future plans, which are wide ranging. The regular updates are most welcome and useful. Together with our NHS Reference Group meetings, the regular updates ensure the Committee is never taken by surprise by any 'out of left field' decisions. It's vital that this close working relationship continues .

It's important, too, that we look at what is working well and to recognise where the Trust is at the cutting edge of advanced medicine. As we slowly emerge from the pandemic there will be issues arising which we cannot foresee and which will require us to be flexible in the way in which we scrutinise the work of the Trust .

Having thanked the senior management team at the Trust, I'd also like to thank every single member of staff at the Trust for the dedication to their vocation. I, personally, have benefitted hugely as an outpatient on both sites from their skills, knowledge and care. I hope I've been a good patient!

Cllr Andrew Gravells MBE (Chair of the Gloucestershire Health Overview and Scrutiny Committee)

Annex 2

Statement of directors' responsibilities for the quality reports

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the quality report, directors have taken steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2020/21
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2020 to March 2021
  - papers relating to quality reported to the board over the period April 2020 to March 2021
  - feedback from commissioners 20 May 2022

Our Governors have contributed to identifying the priorities for next year 2022/23 and have also provided us with feedback on this year's Quality Account.

- feedback from local Healthwatch organisations dated 16 May 2022
- feedback from overview and scrutiny committee dated 27 May 2022
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated TBC https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
- the 2020 national patient survey published by CQC 28/01/2022 https://www.cqc.org.uk/provider/RTE/survey/3
- the 2021 national staff survey published March 2022 https://www.nhsstaffsurveys.com/results/local-results/
- CQC inspection report dated 07/01/2019 and 23/04/2021 https://www.cqc.org.uk/provider/RTE

This quality report presents a balanced picture of the NHS foundation trust's performance over the period covered.

The performance information reported in the quality report is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

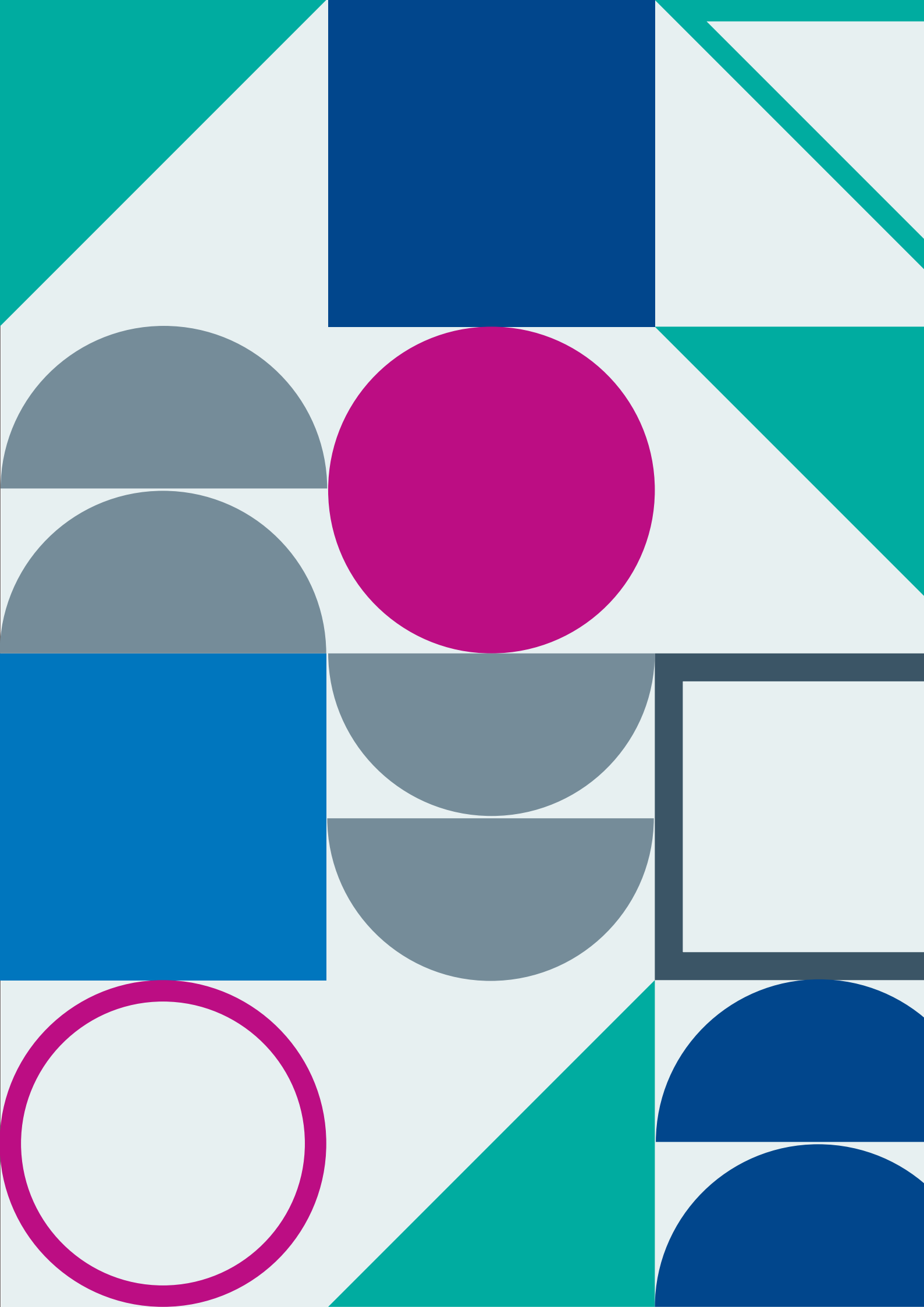
The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

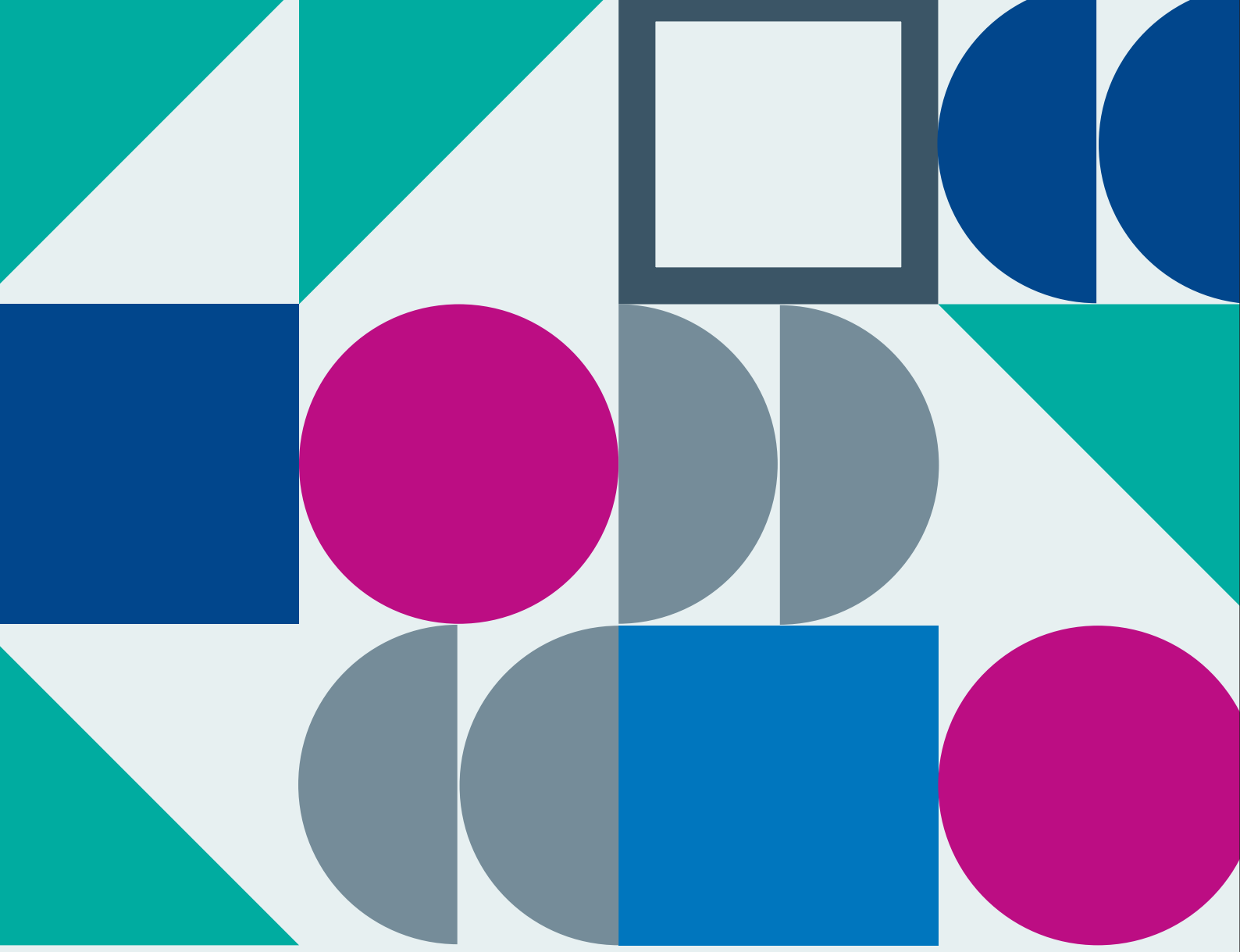
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Chairman

Chief Executive





Quality Account
2021–2022

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 26 May 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
Financial Performance Report	The following key points were noted: • The Trust had reported a year-to-date deficit of £3.3m, which was £2.1m adverse to plan. Key drivers for pay overspend related to the use of temporary staff in Medicine and Surgery. • The Trust maintained the planned forecast deficit of £9.2m until review had been undertaken with divisions. • Next steps and mitigations were detailed, including a review of causes of potential overspends and a number of actions in place to support the Trust's position in the absence of mitigations. • The total activity in Month 1 had decreased by 12% against Month 12 for 2021-22.	The Committee was assured that the financial situation was fully understood, but assurance around full control was not provided and instead the Committee requested additional scrutiny.
Capital Programme Report	The Trust had submitted a gross capital expenditure plan for the financial year, totalling £67.1m. At the end of Month 1, the Trust had delivered goods, works or servicers to the value of £3.5m, which was £0.2m ahead of plan.	£1.1m of open orders not allocated a 2022-23 budget would be reviewed and validated, and reprioritisation would subsequently take place within programme allocations.
Financial Sustainability Report	Work continued to drive forward identified divisional and cross-cutting workstreams to ensure a successful Financial Sustainability Plan. To help breach the gap between the £10.06m plan and the target of £12.9m, the Trust was exploring potential savings opportunities within Digital and Corporate divisions. Organisational workshops were being planned to discuss.	Benefits mapping was taking place in relation to the impact of the implementation of EPR on staffing and overall performance.
Procurement Review	The plan for the year focused on inflationary cost management and mitigation through engagement in national savings initiatives. There had been a significant number of price increases, a high turnover of staff, and high sickness absence which had contributed towards a challenging position.	The Committee acknowledged the challenging position and supported plans in place to address.
Agency Costs and Control	Significant vacancies remained within nursing staff. 74 nurses had been internationally recruited, and that continued to be successful. A plan was in place to over-deliver based on the Trust's current performance, and to develop Standard Operating Procedures for escalating agency shifts; further work was required to ensure timeliness and authorisation.	Discussions would take place across People and Organisational Development, and Quality and Performance committees.
Image Guided Interventional Surgery	The Board had approved the capital financial plan to enable the IGIS clinical model, following a tender exercise. The Committee supported the plan and supported the issue of a letter of intent to Kier to avoid any further time and cost increase.	The Committee supported the recommendations. A letter of intent would be issued to Kier by 27 May.
IT Services and CITS Performance	Performance continued to exceed the SLA for primary care and CGG customers, despite calls received exceeding the capacity of the service. Performance for the Trust had reduced to below target in April, due to mis-categorisation of some calls. Overall call volumes remained high, with a significant increase compared to the same period last year. This was reflected in slower call answer times, and an increase in open calls.	A review of staffing levels and capacity would be undertaken.

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.

Cyber Security	The report set out the actions taken in response to the seven recommendations, including three high level, highlighted in the cyber security audit undertaken in November 2021.	The Committee was assured by the plans in place to address the recommendations.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Digital and EPR Report	The Committee noted that three phases of the clinical documentation optimisation had been completed, following go-live in February. Two further phases would be completed in May. The electronic prescribing and medicines administration project was progressing well, with increased clinical involvement and engagement. Action plans following the internal audit into Cyber Security had been progressed, with the majority of high-level recommendations now completed.	A further report on the progress of the Digital Strategy would be received in July.
GMS Procurement Exemption List	A procurement exemption list was approved; the Committee was assured that the list had ten conditions which would be regularly reviewed by procurement at each point of use to ensure accurate application and record.	The Committee supported the recommendations.

Items not Rated			
Terms of Reference	ICS Update	Digital risk register	Information and Coding Update

Impact on Board Assurance Framework (BAF)
The first iterations of Finance and Digital risks were reviewed; the Committee noted that risks would continue to be refined over the coming months.

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	11	Enclosure Number:	10
Date	9 June 2022		
Title	Finance Report (Month 1)		
Author /Sponsoring Director/Presenter	Shofiqur Rahman, Craig Marshall Karen Johnson		

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

Summary of Report

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 1 to the Trust Board.

Key issues to note

- the Trust is reporting a year-to-date deficit of £3.3m deficit which is £2.1m adverse to plan.
- the Trust is maintaining the planned forecast deficit of £9.2m until review and agreement with Divisions.
- the Trust capital position is £0.2m ahead of plan.

Month 1 overview

M1 Financial position is reporting a deficit of £3.3m which is £2.1m adverse to plan. The main drivers for pay overspend are due to the usage of temporary staffing in both Medicine and Surgery Divisions for Nursing and Medical staff. The main reasons for usage are for vacancy cover and unscheduled care

Activity delivered 100% of the 19/20 activity levels, and 123% of the March 2020 levels.

The planned forecast deficit of £9.2m is maintained until review and agreement with Divisions. Currently if the run rate continues, the Trust and system will be significantly off plan and a number of suggested actions are noted.

The total activity in M1 22/23 decreased by 12% against M12 21-22. The total activity in M1 was 91% of the same period in 19/20 and 95% of the same period in 20/21.

22/23 Capital

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. As at the end of April (M1), the Trust had goods delivered, works done or services received to the value of £3.5m, £0.2m ahead plan.

Next Steps

The financial position at month 1 is highlighting a significant challenge which needs to be responded to. Further discussions around options will be undertaken as part of reviewing drivers with Divisions.

Conclusions

The Trust is reporting a year-to-date deficit of £3.3m deficit and is maintaining the planned forecast deficit of £9.2m until review and agreement with Divisions.

Recommendation

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

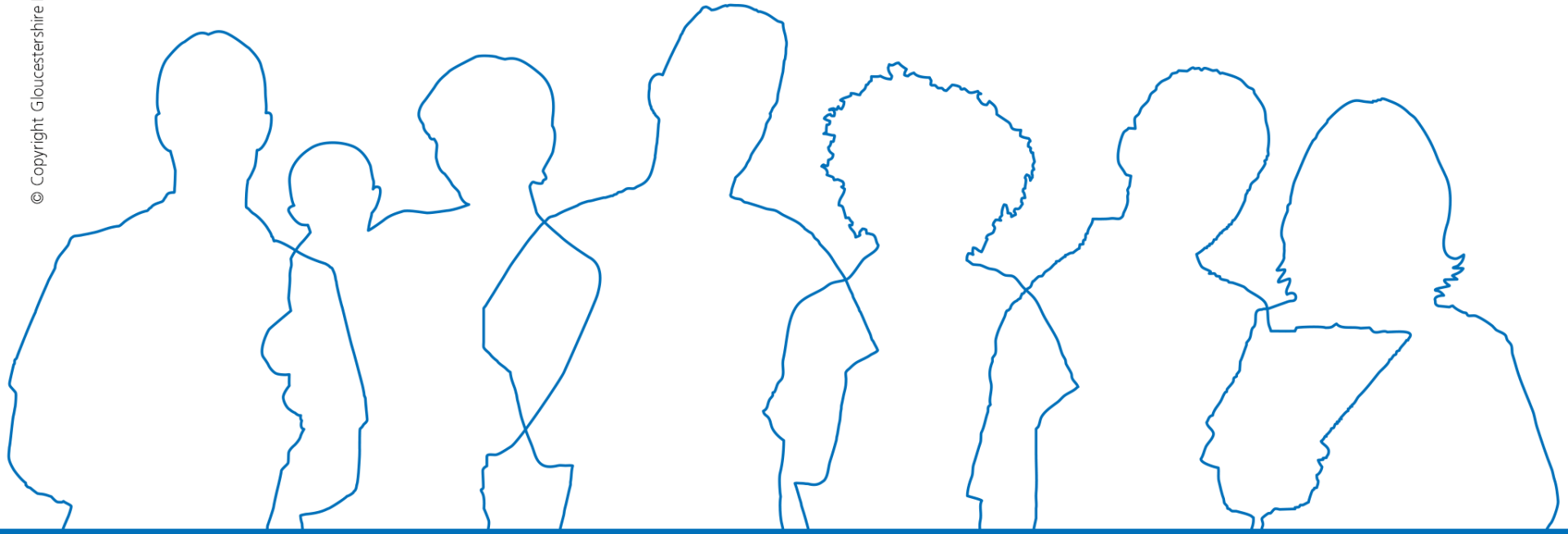
Enclosures

- Finance Report

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th April 2022



Revenue

Director of Finance Summary

Overview

As part of the 2022/23 ICS financial plan the Trust have submitted an overall plan that includes a FOT deficit position of £9.2m

Month 1

M1 Financial position is reporting a deficit of £3.3m which is £2.1m adverse to plan.

The main drivers for pay overspend are due to the usage of temporary staffing in both Medicine and Surgery Divisions for Nursing and Medical staff. The main reasons for usage are for vacancy cover and unscheduled care. The Covid in month spend is materially not different to budgeted plan.

Total efficiencies for the Trust are £18.7m which consist of £4.5m Covid reduction, £1.3m GMS savings and £12.9m Trust wide efficiencies. As at month 1 - £2.5m efficiencies have been allocated out to divisions and the full £1.3m to GMS. It is anticipated the remaining trust wide efficiencies will be allocated out to Divisions in month 2 in conjunction with the Finance Sustainability Team.

The total activity in M1 22/23 decreased by 12% against M12 21-22. The total activity in M1 was 91% of the same period in 19/20 and 95% of the same period in 20/21. As this is below plan level there is a significant impact on ERF delivery. Its unlikely other elements of system plan would have overperformed to compensate this.

Forecast Outturn

Further work is needed with operational colleagues to review and agree overall Divisional Forecast. The planned forecast deficit of £9.2m is maintained until review and agreement with Divisions. Currently if the run rate continues, the Trust and system will be significantly off plan and a number of suggested actions are noted. Further analysis of Covid expenditure will be provided in month 2.

Director of Finance Summary

Mitigations

The financial position currently includes the following assumptions in regards to mitigations:

-No contingent reserves available for release
-No assumed ESRF income
-No adjustment for future benefits from sustainability schemes – currently the balance of non-divisional identified schemes is showing as an unmitigated overspend

The potential non recurrent mitigations for the year include
-Release of the health and wellbeing annual leave accrual (c£2.7m accrued for the year)

Next Steps

The financial position at month 1 is highlighting a significant challenge which needs to be responded to. Further discussions around options will be undertaken as part of reviewing drivers with Divisions which include

- understanding the cause of an overspend and determine if we can
  - stop spending against it,
  - identify mitigating action(s)
- in the absence of issue mitigation(s)
  - hold underspends and transfer funding out NR
  - review non-essential spend
  - introduce controls on locum and WLIs
  - no new investments unless ROI>1 and with a return in the year
  - no increase establishments unless demonstrated to be affordable from skill mixing within budgets and signed off by lead exec
  - review of long-standing agency arrangements
  - review of WTE movement monthly
  - increase pace of change for financial sustainability

Month 1 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £3.3m deficit		M1 Financial position is reporting a deficit of £3.3m which is £2.1m adverse to plan.
Income is £55.2m which is £0.5m adverse to plan		M1 overall income position is reporting £55.2m income which is £0.5m adverse to plan. The SLA and commissioning income is showing a adverse position of £238k. The RTA income for month 1 is favourable to plan (£48k) with Private Patients showing an adverse variance to M1 plan.(£200k). The remainder of the income variance is linked to lower than anticipated pass through drugs funding however the associated assumed costs are also lower.
Pay costs are £36.2m which is £1.4m adverse to plan		M1 Pay costs are £36.2m which is £1.4m adverse to plan. The main drivers for pay overspend are due to the usage of temporary staffing in both Medicine and Surgery Divisions for Nursing and Medical staff. The total contracted vacancies in month 1 are 815 WTE
Non Pay costs are £21.7m which is £0.8m adverse to plan		M1 Non Pay costs are £21.7m. Drugs costs are favourable to plan at £761k. The other main drivers of the non pay overspends are establishment costs(£326k), Education and Training costs (£264k) offset by underspends in supplies and services (£126k) and transport costs (£101k)
Total Financial Sustainability schemes need to be allocated out to Divisions		Total efficiencies for the Trust are £18.7m which consist of £4.5m Covid reduction, £1.3m GMS savings and £12.9m Trust wide efficiencies. As at month 1 - £2.5m efficiencies have been allocated out to divisions.
The cash balance is £88.3m		Increase in cash is reflected in the increase of accruals and provisions.

M1 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of April 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 April the Group's consolidated position shows a £3.3m deficit which is £2.1m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 1 Financial Position	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	50,892	50,654	(238)			0	50,892	50,654	(238)
PP, Overseas and RTA Income	461	300	(161)			0	461	300	(161)
Other Income from Patient Activities	845	845	(1)			0	845	845	(1)
Operating Income	3,107	3,033	(74)	5,378	4,407	(971)	3,505	3,408	(97)
Total Income	**55,306**	**54,832**	**(474)**	**5,378**	**4,407**	**(971)**	**55,704**	**55,207**	**(497)**
Pay	(33,096)	(34,392)	(1,296)	(1,756)	(1,855)	(100)	(34,852)	(36,248)	(1,396)
Non-Pay	(22,594)	(23,400)	(806)	(3,343)	(2,349)	994	(20,959)	(21,718)	(759)
Total Expenditure	**(55,691)**	**(57,792)**	**(2,102)**	**(5,099)**	**(4,204)**	**895**	**(55,810)**	**(57,965)**	**(2,155)**
EBITDA	**(385)**	**(2,961)**	**(2,576)**	**279**	**202**	**(77)**	**(107)**	**(2,759)**	**(2,652)**
EBITDA %age	**-0.7%**	**(5.4%)**	**(4.7%)**	**5.2%**	**4.6%**	**(0.6%)**	**-0.2%**	**(5.0%)**	**(4.8%)**
Non-Operating Costs	(797)	(450)	347	(279)	(202)	77	(1,075)	(653)	423
Surplus / (Deficit)	**(1,182)**	**(3,411)**	**(2,229)**	**(0)**	**(0)**	**(0)**	**(1,182)**	**(3,411)**	**(2,229)**
Fixed Asset Impairments	0	0	0					0	0
Surplus / (Deficit) after Impairments	**(1,182)**	**(3,411)**	**(2,229)**	**(0)**	**(0)**	**(0)**	**(1,182)**	**(3,411)**	**(2,229)**
Excluding Donated Assets & Salix grant	(50)	57	107				(50)	57	107
Control Total Surplus / (Deficit)	**(1,232)**	**(3,354)**	**(2,123)**	**(0)**	**(0)**	**(0)**	**(1,232)**	**(3,354)**	**(2,123)**

* Trust position excludes £3m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £4.0m of inter-company transactions, including dividends

Balance Sheet

	Draft Opening Balance 31st March 2022 £000	GROUP Balance as at M1 £000	B/S movements from 31st March 2022 £000
Non-Current Assests			
Intangible Assets	13,760	13,553	(207)
Property, Plant and Equipment	307,146	335,350	28,204
Trade and Other Receivables	4,414	4,403	(11)
Total Non-Current Assets	**325,320**	**353,306**	**27,986**
Current Assets			
Inventories	9,370	9,484	114
Trade and Other Receivables	26,360	29,484	3,124
Cash and Cash Equivalents	71,530	88,317	16,787
Total Current Assets	**107,260**	**127,285**	**20,025**
Current Liabilities			
Trade and Other Payables	(80,104)	(92,192)	(12,088)
Other Liabilities	(14,401)	(14,784)	(383)
Borrowings	(3,626)	(3,696)	(70)
Provisions	(24,089)	(26,472)	(2,383)
Total Current Liabilities	**(122,220)**	**(137,144)**	**(14,924)**
Net Current Assets	**(14,960)**	**(9,859)**	**5,101**
Non-Current Liabilities			
Other Liabilities	(5,971)	(5,926)	45
Borrowings	(34,064)	(60,750)	(26,686)
Provisions	(3,600)	(1,489)	2,111
Total Non-Current Liabilities	**(43,635)**	**(68,165)**	**(24,530)**
Total Assets Employed	**266,725**	**275,282**	**8,557**
Financed by Taxpayers Equity			
Public Dividend Capital	361,345	361,345	0
Reserves	19,823	19,823	0
Retained Earnings	(114,443)	(109,157)	5,286
Total Taxpayers' Equity	**266,725**	**272,011**	**5,286**

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M1 balance sheet and movements from the 2021-23 draft closing balance sheet.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

Funding
The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m.

The programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£3.3m), Right of Use Assets (£15.4m), IFRIC 12 (£0.8m) and Government Grant/Donations (£1.3m)

YTD Position
As at the end of April (M1), the Trust had goods delivered, works done or services received to the value of £3.5m, £0.2m ahead plan.

21/22 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m.

The programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£3.3m), Right of Use Assets (£15.4m), IFRIC 12 (£0.8m) and Government Grant/Donations (£1.3m)

in £000's	Plan	Forecast	Variance
Operational System Capital	25,014	25,014	0
National Programme	3,350	3,350	0
STP Capital - GSSD	21,280	21,280	0
Donations via Charitable Funds	1,281	1,281	0
IFRIC 12	817	817	0
Right of use assets adjustment	15,355	15,355	0
Total Capital	**67,096**	**67,096**	**0**

21/22 Programme Spend Overview

Gloucestershire Hospitals
NHS Foundation Trust

As at the end of April (M1), the Trust had goods delivered, works done or services received to the value of £3.5m, £0.2m ahead plan. The expenditure by programme area is shown below.

		In Month			Year to date			Forecast Outturn		
Programme Area	**Funding**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Medical Equipment	Operational System Capital	445	427	18	445	427	18	1,894	1,894	0
Digital	Operational System Capital	317	619	(302)	317	619	(302)	5,709	5,709	0
Estates	Operational System Capital	29	34	(5)	29	34	(5)	16,398	16,398	0
IDG Contingency	Operational System Capital	0	0	0	0	0	0	1,013	1,013	0
National Programme - Digital	National Programme	57	185	(128)	57	185	(128)	3,350	3,350	0
STP Programme - GSSD	STP Capital - GSSD	2,395	2,220	175	2,395	2,220	175	21,280	21,280	0
Donations Via Charitable Funds	Donations via Charitable Funds	0	0	0	0	0	0	1,281	1,281	0
IFRIC 12	IFRIC 12	68	68	0	68	68	0	817	817	0
Right of Use Asset	Right of use assets adjustment	0	0	0	0	0	0	15,355	15,355	0
Gross Capital Expenditure		**3,310**	**3,553**	**(242)**	**3,310**	**3,553**	**(242)**	**67,096**	**67,096**	**0**
Less Donations and Grants Received	Donations via Charitable Funds	0	0	0	0	0	0	(1,281)	(1,281)	0
Less PFI Capital (IFRIC12)	IFRIC 12	(68)	(68)	(0)	(68)	(68)	(0)	(817)	(817)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Operational System Capital	27	27	0	27	27	0	318	318	0
Total Capital Departmental Expenditure Limit (CDEL)		**3,269**	**3,511**	**(243)**	**3,269**	**3,511**	**(243)**	**65,316**	**65,316**	**0**

There is £1.1m of open orders that need reviewed and validated within the three core programme areas (medical equipment, estates, digital) that have not been allocated against a 22/23 budget. Initial validation work suggests that many of these orders are to be closed or cancelled. If the orders remain valid then reprioritisation is required within the respective programme allocations. This work is expected to be completed in June.

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £3.3m deficit which is £2.1m adverse to plan.
- Note the Trust is maintaining the planned forecast deficit of £9.2m until review and agreement with Divisions.
- Note the assumptions around potential mitigations and next steps.
- Note the Trust capital position which is ahead of plan.

Authors:	**Shofiqur Rahman, Interim Associate Director of Financial Management** **Caroline Parker, Head of Financial Services** **Craig Marshall, Project Accountant**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**June 2022**

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	11	Enclosure Number:	11
Date	9 June2022		
Title	Digital and EPR Programme Report		
Author /Sponsoring Director/Presenter	Nicola Davies, Digital Engagement and Change Manager Mark Hutchinson, Executive Chief Digital & Information Officer		

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

Summary of Report

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

- Three phases have been completed of the clinical documentation optimisation drops following go-live in February. A further two will be completed in May.
- Electronic prescribing and medicines administration (ePMA) project is progressing significantly with increasing clinical involvement and engagement.
- Action plans following Cyber internal audit have progressed with the majority of urgent projects now complete.

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.

Recommendation

The Board is asked to note the report.

Enclosures

- Digital and EPR Programme Report

FINANCE & DIGITAL COMMITTEE – MAY 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 report 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 2022/3. *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	12th 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	30 Nove 2021
Clinical Data Storage Platform (Onbase)	Jan 2022	
Clinical documentation	February 2022	23 Feb 2022
EPR Additional nursing documentation	February 2022	23 Feb 2022
Electronic Prescribing & Medicines Administration (known as ePMA)	Early adopters Adult inpatient/ED Autumn 2022	
Blood transfusion results into EPR	Summer 2022	
Order Communications – Requests and Results (theatres & outpatients expansion)	TBC	

3. EPR Project Summaries and Status Updates

The following section provides updates on EPR projects currently reporting through the EPR Programme Delivery Group.

Clinical Documentation

There are five planned optimisation drops following the implementation of clinical documentation at the end of February. Three have been completed with two remaining. As well as regular engagement with stakeholders immediately impacted by the improvements, the SD Forum has taken on the role of formal feedback, discussion and decision making where required. This will continue with a monthly digital slot on the agenda.

EPMA

Targeted engagement is now happening as more clinicians are being involved in early demonstrations and development of different functionality. Broader comms will now begin as go live planning begins ready for the autumn.

3.1 Activity Planned for Next Period

- Work on the ePMA configuration and unit testing will continue with workstreams progressing towards early adopter deployment.
- The ePMA – EMIS interface will be delivered.

- The ePMA drug catalogue build will complete.
- Work towards delivering the Clinical Data Storage Platform will continue, end-to-end testing will take place, enabling the subsequent data load and the first phase of the project will progress to completion.
- Planning and work will continue for the TrakCare Upgrade, with testing continuing to completion.
- Planning and work will continue for the Transfusion Medicine module of TCLE, with testing continuing.
- Planning and work will continue for the deployment of additional optimisation for clinical documentation
- Planning and work will continue for the deployment of the pre-assessment digital workflows in preparation for a revised go-live.
- Re-planning and preparation for the new Maternity system will continue.

3.2 Risks

As the EPR programme expands its scope, the interdependencies with other projects and existing systems increases. Careful, regular scrutiny is needed in order to keep a view of these and prevent issues from occurring.

3.3 Conclusion

We are now clearly demonstrating that the development of Sunrise EPR is transforming the way that we deliver care. Working together in collaboration, clinicians and digital professionals are realising clear benefits in terms of efficacy, productivity and safety.

4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). The programme of work for 2022/23 has been submitted to Finance & Digital under a separate item 'Strategy & Funding Update'.

Since the last report one project has been completed and closed and one project has gone into closure.

The current status and numbers of those projects that report to the DCDG are as follows:

Key Trust Projects	Primary Care / CCG Projects	Projects Complete or in closure	On Hold	Red Rated Projects	Amber Rated Projects	Green Rated Projects
9	3	3	1	0	4	8

Key issues to note:

- The N365 for the GCCG project has moved has completed and closed.
- The Data Centre Refurbishment project remains in closure, with handover to BAU delayed owing to annual leave.

- The Tableau Visualisation and Reporting Platform Phase 1 project is in closure.
- The Civas project interface delays have been addressed and the project is about to enter UAT (user acceptance testing).
- The project to deliver a new Appraisal & Re-validation System (Phase 1 - Procurement) has progressed well and is approaching completion and the transition to the follow-on Phase 2 – Implementation.
- A project to relocate and merge two GP practices into a refurbished/refitted building and a joint practice, Five Valleys Medical Practice has commenced.

4.1 Areas of concern and mitigating actions

SQL Migration & Windows 2003 Upgrade
Work has increased pace owing to the increasing cyber risk associated with unsupported operating and database systems. The focus is on upgrading operating systems and migrating ageing SQL to the Always-on 2017 SQL Cluster.
Where this is not possible servers has been isolated and access to them limited using micro-segmentation (SDDC) or Windows firewall (VMWare), with Internet access removed and blocked. A number of remaining servers are dependent on the delivery of other projects and these are being documented by exception.

Windows 7 Dependant Applications Eradication
The remaining non-Windows 10 devices are now either subject to Extended Security Updates (ESU) or isolated on the network behind local firewalls. Work is continuing to remove and replace all the outstanding non-Windows 10 devices that remain.

5. Countywide IT Service (CITS) Annual Report

A performance report from Countywide IT Services (CITS) is submitted to Digital Care Delivery Group every month (in arrears) - see IT Services & CITS Performance Report.

- SLA performance for customers (Primary Care & CCG) continues to exceed SLA, despite calls received exceeding the capacity of the service. Capacity to be reviewed under SLA renegotiations.

- SLA performance for GHT dropped below target in April due to some calls being mis-categorised as P2, these are being reviewed and training updated for new Service Desk Staff. Total calls received nearly 50% above capacity, which is being reviewed.

- Call volumes overall remain high, with an increase of 2,750 calls received compared to the same period last year. This is reflected in the slower call answer times, and increased open calls year on year too. Staffing and capacity is being reviewed.

6. Cyber Security

The Trust currently has a small cyber team dedicated to monitoring and responding to cyber threats. This team provides cyber security support to GHT, CCG and GHC as part of the wider service level agreement in CITS.

Since 2018 a significant amount of investment has been made in updating infrastructure, systems and software to strengthen and protect the networks. A recent audit and internal review highlighted areas that are vulnerable to emerging threats. These actions are updated and monitored monthly and an update is provided to Digital Care Delivery Group and ICS Digital Execs. Key highlights this month:

- The three high and one of the medium areas of the audit action plan have been completed, with some follow up actions in place to ensure continued focus on these risks and progress continues against remaining three medium areas.
- Two high security threats issued nationally.
- Multi-factor authentication rolled out to all users of Citrix at home across GHT and CCG (virtual desktop) as well as GCC users.
- Improvement noted against national average comparison within March Windows Exposure Score and Server Exposure Score (MDE) KPI.

6.1 Global threat following the Russian invasion of Ukraine

During April the National Cyber Security Centre (NCSC) published a further advisory and advice against Russian state-sponsored and criminal cyber threats. The advisory complements recent NCSC advice on actions to take (reported last month). Organisations have now been urged to:

- prioritise the patching of known exploited vulnerabilities
- enforce multi-factor authentication (MFA)
- monitor remote desktop protocol (RDP), and
- provide end-user awareness and training.

What this means in reality for organisations it that we must be able to protect against, react to and educate our users about potential cyber threats. Key themes of work include:

- The need to be able to react to cyber threats and scale up and down the defences where appropriate.
- Changing user behaviour – this still remains one of the largest threats to cyber security, exposing the organisation to phishing attacks. Robust identity management is critical.
- Proactive defence. Understanding when an attack is taking place, or imminent; using logging and monitoring is critical.
- Cold, offline, backups must be available as a final line of defence against the impact of possible cyber threats.

-Ends-

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Estates and Facilities Committee, 26 May 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**
Violence and Aggression/Security Report	There had been a significant increase in incidents, particularly in the Emergency Department, which was impacting the ability of porters and clinical staff to deal with the increasing severity and volume of incidents. Options were set out in the report to support a better approach; the Committee noted a much-improved CCTV and recording system was in place. However, an holistic review of governance, management, resourcing and working practices needed to be conducted. The Committee was very concerned and considered the intolerable risk that this was raising within the organisation, and the impact on the services the Trust provides.	The issues and associated risks would be reflected in the Board Assurance Framework. The issue will be taken up as a matter of urgency by the Chief Nurse and Director of Strategy and Transformation. A discussion would take place at Quality and Performance Committee, and the People and OD Committee. The matter would be also raised at Board through committee assurance reports.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
GMS Capital Programme Update	The overall programme was reviewed for 2022/23. Funding for addressing the electrical infrastructure works has yet to be secured. This matter is still be explored through reviews of capital prioritisation and/or alternative sources of capital.	Update to be provided to the Committee at the next meeting.
National Cleaning Standards	As a matter arising from the March meeting, it was agreed that the Chair of Quality and Performance Committee would be approached to seek formal endorsement of the cleaning standards to be adopted by the Trust, via the Infection Prevention and Control team.	Quality and Performance Committee to confirm.
GMS Chair's Report	The GMS Board had discussed the use of additional overtime and agency; although GMS carried a significant number of vacancies, standards were achieved. GMS did not win any Staff Awards at the recent event; however, the deep clean team would be recognised internally for their work during the pandemic.	A GMS-specific category would be included in next year's Staff Awards.
Contract Management Group Report	Parking continued to be a particular pressure; a travel survey has been launched and was already generating significant feedback. Plans were in place to address ongoing issues with car park barriers and swipe card access.	Update to be provided to the Committee at the next meeting.
Operational Improvement Action Plan	An action plan to address the recommendations from PwC's GMS review was presented. The Committee was assured by the plan.	The Board-level session to review governance arrangements would be rescheduled, but would support some of the operational plans.
Workforce Action Plan	The Committee was assured that plans were in progression to address recommendations made in the Workforce Report that was discussed at March's meeting.	Regular updates would be received for assurance. The Committee wish to see positive impact of planned actions.
Risk Log	The Committee reviewed the high-scoring risks, and discussed the need to ensure clear risk processes and rationalisation. Challenges around managing the duplicate risks across the Trust and GMS registers were discussed. It was acknowledged that the Trust retains ultimate responsibility for its own risks as duty holder and	Work would continue to improve the transparency and clarity on risk ownership and action parties.

	registered care provider. Within that context, actions were agreed to improve reporting and management of risks.	
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
NHSEI Capital Bids	GMS had been successful in reaching the Expressions of Interest stage for elective recovery TIF monies; this was now being worked into a full business case. The business case would request £10.2m, and would need to be submitted by 30 June for notice in August. Two requests had been submitted to support mental health: one to upgrade two wards to ensure they were dementia friendly, and one to establish bays and side rooms to support young people presenting with self-harm. The two bids were supported by the integrated care system, and the team awaited confirmation for the need to submit a business case to support the requests.	The submission would be circulated to Committee members for information.
Community Diagnostics Hub	The Committee was assured by the report, noting that 'place' reviews were underway to ensure that Quayside House was accessible by public transport and to review communication plans for patients.	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
The first iteration of the Committee's BAF risks were reviewed; the Committee was supportive of the new style and direction of the Framework, and acknowledged that the process continued to embed. The Committee considered splitting the risks into Environmental and Estates risks. The violence and aggression risks would be reflected in SR2 and SR3 of the BAF.		

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Audit and Assurance Committee 25 May 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**
Internal Audit Progress Report	There had been ongoing delays due to operational pressures within the Trust, however remaining reports for 2021-22 were being finalised and would be presented to the next Committee meeting.	NHSEI guidance related to internal audit reviews of the HFMA checklist had been released and would be carried out accordingly.
Internal Audit Annual Report	The Head of Internal Audit opinion gave a moderate assurance rating on the adequacy and effectiveness of the Trust's internal control system, and the consistent application of controls. All audits during the year had provided at least moderate assurance, with over half given substantial assurance.	None.
Internal Audit Review: Recruitment Practices	The review gave a moderate assurance rating for both design and operational effectiveness, with four medium recommendations related to the following: • The Recruitment and Selection Policy: reflect the new minimum interview panel members required; refresher training for managers on recruitment processes and requirements; and a review of Trac to ensure necessary shortlisting and interview scores were recorded. • Person specification templates were reviewed by Inclusion leads; reminders to be sent to recruiting managers to use job description templates for consistency; the development of an accessibility checklist or assessment. • A section on application forms to be added, asking whether applicants are members of the Accelerated Development Pool and Chief Nurse Fellowship programmes. • The Recruitment and Selection Policy to be updated to include other areas identified in the internal audit, including issues related to performance measures, induction, probationary periods and risks.	The Committee was assured by the plans in place to address the recommendations.
Cyber Security Audit Programme	The report set out the actions taken in response to the seven recommendations, including three high level, highlighted in the cyber security audit undertaken in November 2021.	The Committee was assured by the plans in place to address the recommendations, and noted the positive position the Trust was now in.
Risk Assurance Report	Assurance was provided on the process of active management of key risks within the organisation.	Material concerns would be strengthened on the coversheet.
GMS Update	The final audit was in progress, with no issues raised to date. Three internal audit reviews were provided for information on Organisational Structure, Corporate Services, and Workforce Planning.	GMS sought approval from the Committee to appoint BDO as its internal auditor *(email approval sought as Committee was not quorate at this point).*
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Internal Audit Review: Waiting	A substantial assurance rating had been given on both design and operational effectiveness, with one low recommendation related to the	None.

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

List Management	maintenance of an audit trail of patient reviews. The Committee was assured by the review, which highlighted the number of good processes in place to continuously monitor and be aware of the impact of Covid-19 on patient waiting lists.	
External Audit	The Committee was assured that the interim audit was progressing according to plan, with nothing material to report. The Committee was advised that there were no issues with the GMS interim audit.	None.
Losses and Compensations Report	The Committee was assured by the management of the process of losses and compensations, and approved the write off of 45 invoices totalling £6,317.86.	The Patient Property Policy was in development and would be approved at Quality and Performance Committee. A briefing on the progress of the Policy would be brought to the Committee.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
The first iteration of the full BAF was reviewed. Risks continued to be reviewed and updated on a monthly basis. A mapping exercise of previous BAF risks and new BAF risks would be developed.		