NHS
Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
11.30, Thursday 14 July 2022
Room 3, Sandford Education Centre, Cheltenham General Hospital
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			11.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 9 June 2022**	Approval	Enc 1	11.35
5	**Matters arising from Board meeting held on 9 June 2022**	Assurance		
6	**Staff Story** *Katie Parker-Roberts, Head of Quality*	Information	Presentation	11.40
7	**Chief Executive's Briefing** *Mark Pietroni, Interim Chief Executive Officer*	Information	Enc 2	12.05
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	12.20
9	**Trust Risk Register** *Alex D'Agapeyeff, Interim Medical Director*	Assurance	Enc 4	12.25
10	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and Qadar Zada, Chief Operating Officer* • **Quality and Performance Report** • **Falls and Pressure Ulcers Harm Review** • **Learning from Deaths Report** • **Journey to Outstanding Visits Report**	Assurance	Enc 5 Enc 6 Enc 7 Enc 8 Enc 9	12.30
11	**Medical Appraisal and Revalidation Report** *Alex D'Agapeyeff, Interim Medical Director and Director for Safety*	Assurance	Enc 10	13.00
	Break (13.10-13.20)			
12	**Finance and Digital Committee Report** *Robert Graves, Non-Executive Director* • **Finance Report** • **Digital Programme Report**	Assurance	Enc 11 Enc 12 Enc 13	13.20
13	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director*	Assurance	Enc 14	13.35
14	**Provider Licence Self-Certification** *Kat Cleverley, Trust Secretary*	Approval	Enc 15	13.45
15	**Any other business**		None	13.50
16	**Governor Observations**			
	Close by 14.00			

Gloucestershire Hospitals NHS Foundation Trust

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 9 June 2022, 10.30, Lecture Hall Redwood Education Centre			
Chair	Deborah Evans	DE	Chair
Present	Alex D'Agapeyeff	AD	Interim Medical Director and Director of Safety
	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
	Mark Napier	MN	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
	Roy Shubhabrata	RS	Associate Non-Executive Director
	Elaine Warwicker	EW	Non-Executive Director
	Qadar Zada	QZ	Chief Operating Officer
Attending	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian (item 6 only)
	Alan Thomas	AT	Lead Governor
Observers	Four governors observed the meeting virtually.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting.
2	**Apologies for absence** Claire Feehily, Non-Executive Director, Alison Moon, Non-Executive Director.
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 12 May 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 12 May 2022** All matters arising were updated.
6	**Patient Story** The Board received a presentation on What Matters to You Day, with a particularly moving account from a patient's father on the personalised care of his son. The Board was advised on the shared decision-making model of One Gloucestershire's personalised care plans, which aim to promote conversations with patients and encourage questions to ensure optimal care is provided in accordance with the wishes of patients. The Trust had established a Hospital Carers' Group to look at what can be done differently in the organisation; the Board was advised that this Group would be established at system level.
7	**Chief Executive's Briefing**

	MP briefed the Board as follows: • Overall Trust elective performance was good, although pressure within the Emergency Department remained high. Challenges remained around ambulance handover delays and Medically Optimised for Discharge (MOFD) patients, which had not improved and continued to contribute to the pressure in the organisation. The Board was advised that conversations with system partners were being held to address the issue collectively. • A Local Government Association (LGA) peer review into urgent and emergency care had concluded, with a full report to be received in due course. • The Board was advised that Infection Prevention and Control guidance had changed on 8 June, with face masks no longer required except in clinical areas with immunosuppressed patients. • Phase two engagement of the Fit for the Future programme had started and was progressing well. • The Trust had recently received a visit from the national director of HR and Organisational Development. • A number of Jubilee events had been held across the Trust last week. RG queried the progress of the Urgent and Emergency Care Improvement Board, now that three meetings had been held. MP responded that the group aims to ensure that the Trust was doing everything it possibly can to demonstrate quality and safety of care, and to review what else the Trust could do to provide this. The group was focused on Emergency Department discharges and was pleased that improvements in triage times had been seen. The group was also working on No Criteria to Reside/No Criteria to Admit patients. The group was continually questioning the wellbeing of staff, as pressure on staff was relentless and this was continually and widely acknowledged and understood. The Board was advised that work around MOFD had contributed to the reduction in the number of patients, however there was further work to do as it was not significant enough to improve overall patient flow through the organisation.
8	**Board Assurance Framework** The Board Assurance Framework was received; the Board noted the continued work on the BAF to refine and embed the process of assurance and to rationalise risks into simpler and more succinct formats.
9	**Trust Risk Register** The Board noted that two new risks had been added to the register; one related to the risk of delayed review, identification and treatment for women attending triage, and inability to adequately meet required standards of care, the other related to the inability to manage resources within delegated budgets. The Board was assured that the score of 16 for the finance risk was reasonable.
10	**Quality and Performance Committee Report** EW provided feedback from the Committee, informing the Board that urgent and emergency care continued to be a red rated area. The other red rated area related to delay related harm, as the Committee had raised concern about the timescales of the report, however the Committee had acknowledged that an update was expected in June. The Committee had received assurance on the progress of maternity action plans, however pace was hindered due to staffing challenges. MN raised the issue of increasing violence and aggression incidents, some of which related to support for feeding patients. The Estates and Facilities Committee had also discussed this as an intolerable risk, as current arrangements were not sustainable. MHo advised the Board of the complexity of the issue, as there was a team of people required to support patient feeding that was clinically led and fully risk assessed. A review of the multi-disciplinary approach of the team responsible for supporting patient feeding would be undertaken, with a

	working group established to take responsibility for reviewing violence and aggression across the organisation. The working group would include colleagues from GMS, and from Gloucestershire Health and Care mental health liaison. Progress would be reported through Quality and Performance Committee. ***Quality and Performance Report*** Key points were noted as follows: • The Trust's diagnostic programme was performing well, although Echocardiography was a key challenge, with the Trust looking for opportunities for additional capacity. • Cancer performance was good, with 6 out of 9 standards met, and a slight improvement in meeting the 62-day standard. • The most significant challenges remained in urgent and emergency care. • The Board was advised that the Trust was providing mutual aid to Wye Valley for a period of time to support their haematology patients. Further information would be provided at July's meeting. • There were forty patients currently in hospital with covid, which had been found when patients were admitted. There had been a reduction in the number of lost bed days due to covid, which was now down to 74. • The Board was advised that there had been an increase in C-Diff and Ecoli cases, which was being investigated. The Board was assured that the absolute numbers of cases were not concerning, however the rise in cases was being reviewed to determine any particular cause. • Mixed sex accommodation breaches were now a reporting requirement, and were reflected in the report. • Friends and Family Test scores had reduced slightly, with the most significant reductions seen in urgent care and maternity, largely due to operational pressures. Patients were unhappy with waiting times and access. RG reflected on the scale of the challenge of urgent and emergency care in relation to the Trust's occupied bed base. QZ advised that the largest proportion of patients were allocated into pathways two and three, and needed to be reallocated into pathways one and zero. A systemwide innovation workshop had been established to discuss the interventions the Trust and the system could put in place to improve the position; this was known as the Sloman Plan. The agreed bed base figure of 160 would make some significant improvements to patient flow. ***Perinatal Quality Surveillance Report*** The report set out the quality surveillance model used to provide consistent and methodological reviews of maternity services to provide assurance that effective systems of clinical governance were in place to monitor the safety of maternity services. The Board was assured that maternity services had completed the NHSEI self-assessment tool which had informed the service's quality improvement and safety plan, and would be monitored on a quarterly basis at Maternity Delivery Group. The team continued to work closely with Maternity Voices Partnership to improve its Friends and Family Test feedback scores. Workshops had been held into incident reporting and reviews of national patient safety standards. ***Quality Account 2021-22*** The Board received and formally **approved** the Quality Account 2021-22 for publishing. RG welcomed the report as a reminder of the Trust's successes, and a positive reflection of committed staff.
11	**Finance and Digital Committee Report**

	RG advised the Board that the Committee had discussed the significant challenge around the Month 1 deficit. The capital programme had also been discussed, with the Committee acknowledging that the programme was slightly ahead of plan. The Committee had been pleased to hear that processes were being implemented around new schemes to ensure rigour around the completion of business cases and adherence to Standing Financial Instructions (SFIs). The Committee had also scrutinised the countywide CITS service and the capability to provide an efficient service and noted the plans in place to review capacity. ***Finance Report*** Key points were highlighted as follows: • The Trust reported a year-to-date deficit of £3.3m, which was £2.1m away from plan. • The Board noted the constrained financial position for this year, with no assumption of Elective Recovery Fund (ERF) monies. • The Trust maintained the planned forecast deficit of £9.2m, until review and agreement with Divisions had taken place. The Board was advised that support would be made available to Divisions to ensure ownership, including tools and policies. The Board was informed that Divisions were engaging with the conversation and looking to embed the approach as cultural change. • Trust had submitted an expenditure plan of £67.1m for 2022-23. At the end of Month 1, the Trust had goods delivered, works done or services received to the value of £3.5m, which was £0.2m ahead of plan. • The Board noted that conversations regarding overtime payments and mental health were underway at system level to review more efficient funding approaches. ***Digital Programme Report*** The Board was informed that the electronic prescribing and medicines administration project was progressing well, with increasing clinical involvement and engagement. Action plans had been put in place following the internal audit review into cyber security, with the majority of urgent projects completed.
12	**Estates and Facilities Committee Report** The increase and severity of violence and aggression incidents had been discussed in detail. The increase was putting additional burden on porters and was impacting on their ability to carry out their jobs. A wider discussion would be held on how the Trust provided and managed security. National cleaning standards had been rated 'amber' from 'red', with MN advising the Board that a review was ongoing to confirm the standards that would be adopted against which GMS would develop the cleaning service. A large number of vacancies across GMS remained, however there was a good recruitment plan in place. The Committee had discussed the capital programme, noting the overall challenge in relation to securing additional capacity for backlog maintenance and in addressing electrical resilience and capacity as the Trust implemented new facilities. The Board was informed that GMS had been pleased to be included in the Staff Awards, but suggested a separate category at the next celebration. MP advised the Board that a discussion around violence and aggression would be held at Executive level, and at the Violence and Aggression Group, to review the approach to security in the Trust.
13	**Audit and Assurance Committee Report**

	MN advised the Board that the year-end finalisation of audits had experienced some delays due to operational pressures within clinical teams. The Committee had received a verbal briefing from external auditors that good progress was being made on year-end accounts, and was much improved from the previous year.
14	**Any other business** None.
15	**Governor Observations** AT provided the following feedback: • The Quality Account was a good, thorough document that captured successes and challenges over the year. The development of metrics against improvements would be useful to monitor progress. • Governors would feel assured by the perinatal surveillance report, and would have an opportunity to discuss this at the Governors' Quality Group in June. • AT was pleased to hear about the work underway to address violence and aggression concerns. • AT welcomed the reporting change in relation to mixed sex accommodation breaches. • Fractured neck of femur performance had significantly reduced; this was mostly driven by workforce and capacity challenges. • Some challenges around waiting times for urgent Echocardiography were discussed, with communication to patients agreed as a key area of improvement. • The patient story was very powerful. AT informed the Board that he was a patient safety partner at system level.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Quality Account 2021-22	The Board formally approved the Quality Account 2021-22		

PUBLIC BOARD – JULY 2022

CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 The news of the day, of course, is the change in political leadership in the country which includes a new Secretary of State for Health and Social Care, Steve Barclay. So far, this hasn't resulted in any change in direction or policy nationally. This includes the decision to withdraw the staff terms and conditions section of the COVID-19 workforce guidance; specifically, that new episodes of COVID-19 absence will be treated in the same way as other sickness absence from 7 July 2022. Colleagues will no longer be able to access the provision of COVID-19 special leave from this date. It is unfortunate that this coincides with a rise in community transmission of covid. The latest projections suggest a peak by the end of July with inpatient numbers similar to those of March / April. While we are seeing higher numbers of patients admitted with other conditions who test positive for COVID-19, this has not manifested in many patients becoming seriously ill with covid pneumonitis. Mask wearing in all areas was reintroduced earlier in the week.

1.2 The delayed CQC Well Led inspection was completed in June. A letter has been received summarising their early feedback and the draft report is expected in August. The final Maternity Services report is expected later this month. Representations have been sent back to the CQC and action plans developed to address areas of concern. We have invited both the new Integrated Care Board and CQC to take part in this process.

1.3 The areas highlighted by the CQC in their early Well Led feedback are similar to those presented by the Trust to the CQC. These relate to organisational culture, especially tolerance of poor behaviours, staff feeling unable to speak up and not heard when they do, and a sense of disconnection across the organisation. At the same time the CQC noted that the Trust is aware of the issues, is developing plans to address them, that staff are committed, passionate and keen to be part of the solution, and that we have considerable expertise in Quality Improvement methodology.

Operational Context

2.1 Operationally, the picture is similar to last month. 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. We are in active discussions with NHSEI and other systems in the South West to provide mutual aid to the most challenged regions in specialities where we have capacity and can do this without disadvantaging patients in Gloucestershire.

2.2 Urgent care pathways remain under extreme pressure despite some recent improvements in ambulance handover delays. The number of patients who are Medically Optimised for Discharge remains static at about 240 and the number of patients who test positive for covid has increased from about 40 to 100 recently, although most of these patients do not have clinically significant covid pneumonitis. We remain one of the 6 worst performing Trusts in the country for ambulance handover delays and are coming under national focus and pressure to reduce ambulance handover delays effectively to zero. Work with system partners is continuing to

deliver meaningful improvements in discharge processes and pathways as well as internal work to ensure that we do all we can ourselves.

2.3 The operational plan was approved with a balanced budget and has been submitted to NHSEI.

3 Other Highlights

3.1 Despite the pressure our Maternity Services are under, Gloucester was voted the best place to give birth in the country in a recent NHS survey. The full story is here: https://www.gloucestershirelive.co.uk/news/health/gloucester-best-place-give-birth-7258918

3.2 We opened an additional endoscopy theatre in Cheltenham last month as well as new, larger male and female recovery areas. This is part of the expansion to enable us to deliver the regional Endoscopy Training Academy and meet the outstanding requirement for JAG accreditation – just received for 5 years.

3.3 It was good to be able to have the first face to fact 100 Leaders' meeting in the Sanford Education Centre (before mask wearing was reintroduced). The meeting discussed the early CQC Well Led feedback, plans for responding to the issues raised, as well as other areas of interest.

3.4 Finally, Deb Lee continues to make a good recovery and should be back at work in August.

Mark Pietroni
Interim Chief Executive Officer

7th July 2022

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Email

Our reference: RTE
Person Name: Mark Pietroni
Acting Chief Executive

Gloucestershire Hospitals NHS Foundation Trust
Alexandra House
Cheltenham General Hospital,
Sandford Road,
Cheltenham
Gloucestershire
GL53 7AN

Date: 7 July 2022

CQC Reference Number: INS2-12604187689

Dear Mark Pietroni,

Re: CQC Well-led inspection of Gloucestershire Hospitals NHS Foundation Trust

Following your feedback meeting with Catherine Campbell, Head of Hospital Inspection and Karen Hill, Inspection Manager on 16 June 2022. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 16 June 2022 and provides you with a basis to start considering what action is needed.

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

An overview of our feedback

- We found issues with culture were palpable throughout the inspection and staff at all levels told us about there being an acceptance and tolerance of poor behaviours.

- Staff articulated and had observed rudeness and incivility throughout the organisation.
- Some staff reported a lack of trust, psychological safety and fear of speaking up. We heard that when staff do raise concerns they were not always supported or treated with respect when they did.
- A common theme throughout was one of disconnection. This included aspects of; governance, communication, risk management and was from ‘ward to board’ and ‘board to ward’.
- We noted that a review of the effectiveness of the board committee structure and governance was underway.
- There were strong external stakeholder engagement relationships, evidence of system working, with leadership roles to support this.
- We met lots of committed and passionate staff and leaders who have a desire to make improvements. Middle and frontline leaders want to be trusted and included as part of designing solutions.
- There has clearly been an investment in Quality Improvement methodology and extensive rollout of training to support this approach. However, there was often not clear evidence of what improvements or changes had been made as a result.
- The culture issues have been recognised by the Trust and the recently appointed Director of People was clear about the direction of travel.

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

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

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

Telephone: 03000 616161

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

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

Yours sincerely

Catherine Campbell

Head of Hospitals Inspection

c.c. Deborah Evans, Chair of Trust
Ben Roe, NHS England and Improvement
John Scott, CQC regional communications manager

June 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	June 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	June 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	June 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	June 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 June 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	**Chief Nurse (CN)**	S3316 C2819N C2669N C1945NTVN D&S2976 Rad WC3536O bs M2353Diab D&S3103 Path C3223COVID C2667NIC C1850NSafe C3034N C3295COOCOVID WC3257Gyn WC3536Obs WC3685Obs M3682Emer C2628COO C1798COO S2715Th C2715 C3084

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Dec 2023	Dec 2024	-		2019/2020	
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.	2020/2021	
						2021/2022	
						2022 Q4	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• 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 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

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

• Quality Strategy and delivery plan • Risk Management processes • Quality priorities for 2022/23 (as identified in Quality Account 2021/22) • 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)	• NAAS ward accreditation paused.

ACTIONS PLANNED

Action	Lead	Due date	Update
Workforce - Monitoring of impact of workforce challenges on quality and performance	DoQ &CN	Q2 2022/23	- Safer staffing reviews due Sept so that there can be 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 has been delayed and will commence in July 2022 - Work underway - Complete - Draft received by QDG
External reviews of services - Develop action plans in response to recent inspections	DoQ &CN	End of Q2 2022/23	- Complete - CQC Medical Care and UEC Care report received action plan developed. - CQC Maternity focused inspection awaiting final report – draft received for factual accuracy - CQC unannounced core service inspection of surgery awaiting report – with Well Led report

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• NHSE/I Regional Maternity Team visit to Maternity Services • Cancer performance	• Below average NHS Staff Survey results (metrics for Quality Strategy Delivery).	• Inspection and review by an external body - CQC pilot ICS inspection Urgent and Emergency Care report.

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

• Planned recovery of elective and diagnostic activities in most specialities	• 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) • 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).	• Internal audit reviews 2022-25: ○ Outpatient Clinic Management ○ MCA and Consent ○ Discharge Processes ○ 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 June 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 recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce	

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, TNA Cohorts and student placement capacity
- Induction pilot of cohorts for HCA/HCSW
- Advanced Care and other alternative speciality roles
- Accreditation of Preceptorship module
- Technology Enhanced Learning and Simulation Based Education
- 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

- Delays in time to hire
- 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
- Absence of full roll out of e-rostering across all staff groups for improved productivity
- Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience
- Lack of time for staff to complete e-learning training
- Absence of co-joined educational planning throughout the Trust

ACTIONS PLANNED

Action	Lead	Due date	Update
Initial scope of e2e transactional recruitment leading to formal transformation change programme	DDfPOD	Commence 7th June 2022	Full recruitment review formally commences on 7th June 2002 reporting into the Workforce Sustainability Programme Board.

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

Development of a marketing and strategy / plan	AD of Resourcing	Commence May 2022	This will now form part of the Workforce Sustainability Programme structure and will include the procurement of an external marketing company to work in close partnership with the Trust to support the design and implementation of innovative and creative attraction solutions. Work has specifically commenced in May with plans to address the increasing challenges with admin & clerical vacancy levels.
Delivery of 2022/23 workforce plan including new roles, increased overseas recruitment and robust pipeline plans	DDfPOD	2022-23	Positive feedback was received from NHSE on the Trust's submission into the ICS workforce plan for 2022/23. Interventions and activities to deliver the workforce plan across the Trust has commenced. This will be formalised through the Workforce Sustainability Programme.
Immediate focussed planning in response to the 2021 Staff Survey outcomes	Head of L&OD/DoP	Commence April 2022	Commencement of a staff engagement and culture programme has been seen in May, with clear workstreams focussing on organisational values, staff engagement, staff survey responses, and Restorative and Just Learning.
Commencement of Workforce Sustainability Programme	DfPOD	2022-23	Presented to the Workforce Sustainability Programme Board in May 2022. Focus in the last month has seen the governance, structures and formal programme management frameworks being established to support the traction and pace critical for positive delivery outcomes.
Focussed planning of a Preceptorship Academy and commencement of a master accredited module	ADED	June 2023	Development of an accredited master module as part of the Preceptorship Programme for AHPs and RNs.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Ability to offer flexible working arrangements • Flexibility with the targeted use of 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

Key: **Blue: completed**
Green: on track to be delivered in timeframes
Amber: on track with some delays to the achievement timescale
Red: unlikely to be achieve in the time frame

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 June 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	GAPS IN CONTROL
• 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.	• 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	Q3/Q4	Scoping begun for new milestones
Development of the Just, Learning and Restorative approach	CB	March 23	Complete - 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 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 — June 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. The system has now submit a balanced plan but one that has a significant volume of non-recurrent benefits.	**Apr 2023**	**Jun 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. Targeted weekly financial oversight meetings in place for the two divisions who are experiencing adverse movement from budget. These meetings are chaired by the Chief of	
		3x4=12	**3x4=12**			

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

	Months 1 and 2 actuals are suggesting the financial position is under pressure. Financial sustainability remains a significant risk in terms of deliverability.				Service and Director of Finance is there to seek assurance. Early indications show an improved position but one that isn't at breakeven yet.		

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Service Development Group peer review business cases • 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 • Weekly financial recovery meetings in place with those adversely deviating from plan	• Finance strategy in draft and needs completing • Clear line of accountability • Robust benefits identification, delivery and tracking across major projects • Controls on the approval of WLIs needs strengthening • 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.
Set up weekly meetings for those division that are showing financial pressure	CoS	Jun 22	This has been set up and progress is good.
Trust wide communication is being developed and sent out to inform the organisation of the financial position to get the message understood	Comms	Jul 22	Initial comms going out in term briefs in July, Financial sustainability on the agenda for 100 leaders in July. Development of Trust wide workshops to gain more traction on ideas for medium term plan during the financial year.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22. • Achieved key annual financial targets in 2022-23 • Continued the monitoring of financial sustainability during the pandemic.	• 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.	Internal Audits planned 2022-25: • Cross health economy reviews • Shared Services reviews • Risk Maturity • Data Quality • Budgetary Control • Charitable Funds

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Financial balance June 2022

• Move of financial sustainability to Strategy and Transformation to give focus on quality of service which should drive financial improvement • ERF monies being generated by Trust. • Improved and co-ordinated system working. • External Audit VFM report, Sept 21.	• 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	• Payroll Overpayments NHSE/I scrutiny of Trust/system finances. ICS accountability and assurance on system wide transformational changes.

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

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	14 July 2022		
Title	Trust Risk Register		
Author **Director/Sponsor**	Lee Troake, Head of Risk, Health & Safety Alex D'Agapeyeff, 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.

Three risks were added to the TRR and one risk was closed at Risk Management Group on 6 July 2022.

Key issues to note

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- **C1437POD -** The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including; - Medical & Dental; Registered Nurses & Midwives and AHP professionals, thereby impacting on the delivery of the Trust's strategic objectives.

  Scores: Workforce C4 x L5 = 20

  Risk Cause: Staff pipeline shortages: Nationally, Regionally and Locally. Increased staff turnover post-Covid and with significant ongoing operational pressures. Inability to recruit to vacant posts and attract employees to the NHS and to the Trust. Staff leaving the Trust due to burnout, cost of living challenges, adversely impacted resilience, work life balance and disengagement with the NHS. Lack of resilience across key professional groups

- **D&S2938RT** - The Workforce risk that the Radiotherapy Service will not be able to recruit and retain enough staff to maintain the cancer waiting times and extended working due to a National shortage of Therapeutic Radiographers and difficulty recruiting & retaining due to our lower pay scales and increased opportunities from promotion elsewhere.

Scores: Workforce C4 x L4 = 16, Statutory C3 x L5 = 15, Quality C3 x L4 = 12, Safety C2 x L3 = 6

Risk Cause: There is a national shortage of therapeutic radiographers. The staff banding grades of the Therapy radiographers are lower for Band 6 and above, compared to all other surrounding Radiotherapy centres, and to 50/56 centres Nationally. The department will lose 15 radiography staff (12.5WTE) which is 27.4% of our Radiographic workforce between Jan 2022 - July 2022. The Swindon Satellite unit will be opening in June/July 2022 and has launched a recruitment drive at the beginning of May, which is another threat to our workforce. In addition, a Private centre with 2 linacs will be opening in Birmingham in 2023 and will require staffing end of 2022.

- **C3767COO –** The risk of harm to patients and staff due to being unable to discharge patients from the Trust

  Scores: Quality C4 x L4 = 16, Workforce C4 x L4 = 16, Safety C3 x L4 = 12

  Risk Cause: Inability to discharge patients in a timely way to non-hospital-based destinations; Community Hospitals and non-acute Hospital settings.

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL 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.
  Scores: Safety C4 x L4 = 16 reduced to C3 x L3 = 9, Quality C4 x L4 = 16 reduced to C3 x L3 = 9

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

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 title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
C1437POD	The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including; - Medical & Dental; Registered Nurses & Midwives and AHP professionals, thereby impacting on the delivery of the Trust's strategic objectives.	Trust Workforce Planning include as part of the Trust Business Planning Cycle template. Central workforce planning for the ICS is overseen by the ICS Workforce Steering Group Introduction of alternate/Advanced practice/new including Associate Specialists, Non- Medical Consultant, ACP, PA offering alternative solutions	Implementing Recruitment and Retention action plans ACP Business Case Multiple Recrtuitment and Retention Actions Workforce Planning Review 2022 Person-centred career 'plans on page' Establish Task and Finish Group for Radiographer Vacancies	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Recruitment Strategy Group		People and OD Committee	30/09/2022	Daniels, Shirley	Trust Risk Register
M1593Emer	The risk of physical and psychological harm to staff, patients and visitors as a result of verbal abuse, inappropriate behaviour, aggression, physical violence or assault in the medical division at Gloucester Royal and Cheltenham General	1. Installation of Pinpoint device on both sites for ED 2. Security Cameras in operation 3.Access to violence and aggression team 4.Safe holding/conflict resolution training for staff in the department of various banding 5.Alert on 'Patient First' on repeat offenders and detailed management plan regarding how to manage any behaviours 6.De- escalation online training delivered by MHLT 7.V&A policy 8.Sanctions panel review all V&A incidents where capacity is confirmed / issue warning letter as appropriate 9.Key pad lock installed at ambulance entrance GRH 10.Locked access to CGH after 11 pm when reception cover not available 11.Involvement with planned estate and environmental changes 12.liaison and support from onsite security manager 13.Working with multi agency partners 14.safeguarding policy to support vulnerable adult and children 15.mental health room - safe place in ED and AMU 16.Mental Health cards to support with any distress in the waiting area	redesign of rdepartment Discussion around moving security to ambulance entrance CGH Departmental participation in environmental project with PCSO liasion. Review current level of staff training to deal with incidents and de-escalate 3) Review environment that prohibits overcrowding to reduce patient stress and potential aggressive manifestation 4) Lack of access to sanctions and contracts OOH. MHLT working group Reinstate ED PEG to work on actions in FFT action plan Review the ED violence and aggression score ED staff to be trained in safeholding Meet with DB to Review and Agree Next Steps Please can this Risk be added to the next Div Quality Board meeting agenda for discussion and agreement of risk?	Medical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk		People and OD Delivery Group, Quality Delivery Group	GMS Health and Safety Committee		People and OD Committee, Quality and Performance Committee	01/07/2022	Hayes, Sally	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	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog To resolve outstanding areas of concern	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	Divisional Board - Corporate / DOG, Out Patient Board, Quality Delivery Group			Quality and Performance Committee, Trust Leadership Team	13/08/2022	Zada, Qadar	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Divisional Board - W & C, Quality Delivery Group, Safeguarding Strategic Group	Safeguarding Adults Operational Group, Safeguarding Children Operational Group / Board		Quality and Performance Committee, Trust Board, Trust Leadership Team	03/08/2022	Freebrey, Clare	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance +	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	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Quality and Performance Committee, Trust Leadership Team	01/07/2022	Bradley, Craig	Trust Risk Register

		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.	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													
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	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR New Elearning module in progress to complete bimonthly audit into inpatient care for diabetes	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Chief Nurse and Director of Quality	Divisional Board - Medical, People and OD Delivery Group, Quality Delivery Group	Medical Workforce Productivity Board, Medicines Optimisation Committee, Patient Experience Group		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	13/08/2022	Mani, Vinod	Trust Risk Register
D&S2404CHaem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place.	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	Divisional Board - D & S, People and OD Delivery Group, Quality Delivery Group	OHPCLI Board		People and OD Committee, Quality and Performance Committee	13/08/2022	Johny, Asha	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Write risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan arrange replacement valve and acurator for air handling unit TH1 reinstate quarterly ventilation meetings	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - Surgery, Estates and Facilities Committee			Quality and Performance Committee, Trust Leadership Team	27/07/2022	Dobb, Michael	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and	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	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - D & S	Pathology Management Board			31/08/2022	Lewis, Jonathan	Trust Risk Register

	sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	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	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.													
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	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board - Medical	Medical Devices Group, Medical Equipment Fund		Service Review Meetings	13/08/2022	Matthews, Kelly	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	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Out Patient Board		Quality and Performance Committee, Trust Leadership Team	13/08/2022	Zada, Qadar	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	Infection Control Committee			Quality and Performance Committee	01/07/2022	Bradley, Craig	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	Divisional Board - Corporate / DOG, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	01/07/2022	Bradley, Craig	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)	Divisional Board - Surgery, People and OD Delivery Group, Quality Delivery Group			People and OD Committee, Quality and Performance Committee	29/07/2022	Beamish, Sally	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Digital Care Board, Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Systems Safety Group, Resuscitation and Deteriorating Patient Group		Quality and Performance Committee, Trust Leadership Team	29/07/2022	Foo, Andrew	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	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;	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	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Finance and Digital Committee	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	08/08/2022	Lanceley, Simon	Trust Risk Register
D&S2938RT	The Workforce risk that the Radiotherapy Service will not be able to recruit and retain enough staff to maintain the cancer waiting times and extended working due to a National shortage of Therapeutic Radiographers and difficulty recruiting & retaining due to our lower pay scales and increased opportunities from promotion elsewhere.	New Band 5 radiographers are being recruited but we are seeing less than 25% of the numbers of applicants that we have seen in the past.(2019 - >40 applicants /2022 - 11 applicants) We are currently recruiting a Band 5 radiographer from overseas but there is a significant lag in time from recruitment to arrival in the Trust. We have been waiting 6 months. Attempts are being made to recruit agency staff although there is a national shortage of agency radiographers, so have only been able to recruit 3 agency radiographers in 7 months. This has changed as of 9.6.22 due to availability of staff as the Rutherford Centre has closed. There has been an agreement to increase the agency rate offered and also to look off framework for other Agencies. This has not resulted in any further agency staff being employed. As from 14th March we closed a Linac. This is to maximise use of resources by extending hours on other machines The remaining 3 machines at CGH will	Workforce 5 year plan to include this risk Proposal to recruit apprentice for Nov 2020 Write VCP Increase access to agency staff Over recruitment of Band 5 staff Present paper requesting Retention & Recruitment uplift Banding review for Radiographer grades Work through the findings of the departmental survey VCP for additional Band 7 post Recruit to 8 x Band 5 posts Submit bid for Capital financing of Apprentice posts Recruit to additional Band 7 post Add current staff to Bank Create Action Plan for stfaing in order to support recovery of waiting list	Diagnostics and Specialties	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse & Director of Quality	Divisional Board - D & S	OHPCLI Board, Other	Divisional Quality Board	Other	08/07/2022	Moore, Bridget	Trust Risk Register
S2976Breast	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting center widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee	25/07/2022	Hunt, Richard	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	29/07/2022	Holdaway, Matt	Trust Risk Register
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new,	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	Divisional Board - Corporate / DOG, Finance and Digital Committee, Trust Health and Safety Committee	Quality and Safety Systems Group		Finance and Digital Committee, Quality and Performance Committee, Trust Leadership Team	08/07/2022	Troake, Lee	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months.	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - D & S, Estates and Facilities Committee, Quality Delivery Group	Pathology Management Board		Finance and Digital Committee, Quality and Performance Committee	03/08/2022	Rees, Linford	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	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Interim Chief Nurse	COVID-19 Task and Finish Group, Capital Control Group, Infection Control Committee, Quality Delivery Group, Risk Management Group, Trust Health and Safety Committee	COVID-19 Incident Management Team, Case and Bed Modelling (Bronze COVID Group), Communications (Bronze COVID Group), Elective Business Continuity (Bronze COVID Group), Impact on Elderly and Vulnerable (Bronze COVID Group), Staffing (Bronze COVID Group)		People and OD Committee, Quality and Performance Committee	09/08/2022	Bradley, Craig	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	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	Divisional Board - W & C, Quality Delivery Group			Quality and Performance Committee, Trust Board, Trust Leadership Team	29/07/2022	Hutchinson, Becky	Trust Risk Register

C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals.	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Corporate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	Divisional Board - Corporate / DOG, Quality Delivery Group			Quality and Performance Committee, Trust Leadership Team	13/08/2022	Zada, Qadar	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	Divisional Board - Surgery, People and OD Delivery Group, Quality Delivery Group			People and OD Committee, Quality and Performance Committee	25/07/2022	Hendry, Tracey	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 Installation and commissioning of the machine	Diagnostics and Specialties	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Divisional Board - D & S	OHPCLI Board		Quality and Performance Committee	06/08/2022	Moore, Bridget	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Patient flow and quality coordinator (band 7) allocated on a daily basis	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required. staff consultation on call enhancement discussion	Women's and Children's	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Interim Chief Nurse	Divisional Board - W & C, People and OD Delivery Group			People and OD Committee	20/07/2022	Stephens, Lisa	Trust Risk Register
D&S3558Pharm	The risk of potential breakdown of air handling unit (due to age) The risk of poorer patient outcomes for	Planned preventative maintenance by GMS Outsourcing for some products in place	Liaise with GMS AHU motors report of AHU status	Diagnostics and Specialties	Business	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk		Divisional Board - D & S	Medicines Optimisation Committee		Cancer Services Management Board	15/07/2022	Pratt, Martin	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off. Progress VCPs for Flow Coordinator and ED Assistants Submit workforce paper to Exec COO Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners	Medical	Safety	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk	Medical Director	Divisional Board - Medical	Unscheduled Care Leaders Group		Quality and Performance Committee, Trust Leadership Team	23/07/2022	Nagle, Pat	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	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	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	Divisional Board - W & C, People and OD Delivery Group, Quality Delivery Group	Unscheduled Care Leaders Group		People and OD Committee, Quality and Performance Committee	29/07/2022	Harris, Rachael	Trust Risk Register
C3767COO	The risk of harm to patients and staff due to being unable to discharge patients from the Trust.	Clinical review and prioritisation Onward care team in place supporting discharge Prioritisation of end of life patients Currently GHT CHC process is reliant on ward staff to complete a number of the stages. OCT and SPC support where they are able, but there is not a constant provision of resource.	To resolve outstanding areas of concern	Ambulance Trust, Corporate, Diagnostics and Specialties, GP Services / NHS England, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	COO				Executive Management Team, Quality and Performance Committee	06/09/2022	Zada, Qadar	Trust Risk Register
F3806	Organisation is not able to manage resources within delegated budgets.	The controls that are in place to prevent the risk materialising are -sustainability programme Annual budget planning	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	Finance and Digital Committee			Executive Management Team, Finance and Digital Committee, Trust Board, Trust Leadership Team	17/06/2022	Johnson, Karen	Trust Risk Register

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 22 June 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	Key points were noted as follows: • Overall attendances were beginning to return to pre-pandemic levels. • Ambulance handovers remained a key challenge, although overall hours lost had reduced. • 12-hour breaches remained stable with no further deterioration. • Improvements from the Urgent and Emergency Care Board were anticipated to make a positive impact. • The system remained very challenged overall, with the Trust an outlier on ambulance handover performance. The Committee expressed concern at the pace of system level working on urgent and emergency care in supporting improvements for patients, but acknowledged the escalation process to ensure all partners were involved.	The Trust was escalating to the system to ensure all partners were involved in addressing the risk.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were noted as follows: • There had been an increase in cases of C.Diff which continued to be monitored and investigated. • The Friends and Family Test score was at 87% in May, with improvements seen in both urgent care and maternity. • The gynaecology bed base continued to be challenged, and the Committee raised concern in relation to the assurance provided in a previous meeting about the work in progress to resolve. • There were currently 1248 patients waiting over 52 weeks, with a total Patient Tracking List of 58k. The total PTL had grown by 700 due to an increase in overall referrals. • There were no 104-day breaches, however challenges in haematology were causing some concern. • The Trust had received a request to provide mutual aid to Hereford and Wye Valley. • Waiting times for urgent Echocardiography was an area of concern and was currently being reviewed. • Covid cases were increasing and being monitored. • There had been one case of monkeypox reported within the Trust, which had resulted in approximately twenty members of staff isolating for 21 days. • The 62-day standard for cancer performance was experiencing some challenge, particularly within skin and lower GI.	Additional information on the progress of gynaecology bed base work would be brought to the Committee for assurance.
Risk Register	The Committee discussed the risk process in detail, in particular how it provided assurance at Committee level. The Committee was assured around the work in progress to present emerging risks through the governance structure.	A review of the escalation of maternity risks would take place, particularly in relation to triage.
Serious Incidents Report	There had been one further Never Event related to wrong route medication, and five new serious incidents reported. No HSIBs had been reported.	The Committee requested that the coversheet was utilised to highlight key concerns in relation to serious incidents. Additional assurance would be

		provided in relation to the work around Never Events.
Delay Related Harm Report	The Committee received assurance that avoidable patient harm caused by healthcare delays was actively reviewed at executive level and controls and strategies were in place to ensure monitoring of the situation. The Committee was assured that a comprehensive improvement plan was in place for falls and pressure ulcers harm prevention. Challenges around data collation for falls and pressure ulcers in MOFD patients were noted. The Committee was advised that there would be a focus on deconditioning for MOFD patients, with End PJ Paralysis a key component.	An action plan on End PJ Paralysis would be brought to Committee in July. Performance monitoring of delay related harm would be taken through the Quality Delivery Group.
National Cleaning Standards	The Committee was assured that the proposed derogation rom national cleaning standards would be temporary, however further understanding was required around the cleaning standards for the organisation during this period and how compliance would be reached.	The Committee was supportive of the approach.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Learning from Deaths Report	The Committee was assured by the process of review for all deaths in the Trust, noting that other triggered deaths were further reviewed through the structured judgement process, serious incident investigation, and national programmes that drove local learning, feedback and system improvement.	The Committee was assured by the governance systems around reviewing deaths and compliance with the National Guidance on Learning from Deaths.
Internal Audit: Waiting List Management	The Committee was pleased to note that the Waiting List Management internal audit review had received a Substantial assurance rating for both design and operational effectiveness.	None.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		
The current risk score of 16 for SR1 *CQC regulations or other quality related regulatory standards are breached* was considered by the Committee; the score would be upgraded to 20 for July, with recent activity updated to reflect the score. This would be recommended to Board.		

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	10	Enclosure Number:	6
Date	14 July 2022		
Title	Quality and Performance Report		
Author /Sponsoring Director/Presenter	Neil Hardy-Lofaro, Deputy Chief Operating Officer Katie Parker-Roberts, Head of Quality Suzie Cro, Deputy Director of Quality Qadar Zada, Chief Operating Officer Matt Holdaway, Chief Nurse and Director of Quality Alex D'Agapeyeff, 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

This report summarises the key highlights and exceptions in Trust performance for the May 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 hospital-onset healthcare-associated Clostridioides difficile cases per month

During May 2022 there were 6 health care associated (HO-HA) case; compared to 10 in April 2022. 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 0 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.

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.

Falls Update

Number of falls per 1000 bed days

May 2022 saw a lower number of falls with the rate at 6.7 per 1000 bed days.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, we are now seeing the positive effect of this. 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.

Number of falls resulting in harm

May 2022 again 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.

% Breastfeeding initiation

Most antenatal classes are now back face to face and numbers of couples being able to attend have increased due to reduction in covid restrictions. Therefore information is being shared with more families and this should help to improve mothers wanting to initiate breast feeding. Staff are still being encouraged to do their mandatory training in addition to their contracted hours, to ensure most up to date information given. Due to staffing levels, this is still not possible for all staff. Sophie Ferguson, Infant Feeding Specialist Midwife, is linking in with Gloucestershire Infant Feeding Strategic Partnership to work collaboratively on the Infant Feeding Strategy.

% Women that have an induced labour

An audit will be undertaken by the service to see if there are any trends responsible for the increase.

Friends and Family Test

Our overall Trust FFT positive score has is 87.2% in May, with an increase across urgent care (66.9%) and maternity survey (85.2%) scores in particular. The main theme emerging focussed on wait times, which is reflective of the operational pressures. The divisions review their local comments and improvement plans and provide monthly 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 % of PALS Concerns closed within 5 days is 75.1%, and increase from 67% in April. The team have been looking to signpost enquiries to other appropriate routes or information sources, to enable more time for advisors to work on complex cases. In May, this led to a 34% reduction in the number of basic enquiries being managed by PALS, and has seen an improvement in the number of cases being closed. The data we capture through datix is being reviewed, to ensure that the data is reliable, with a new approach to capturing and reporting being developed. An update with proposals will be provided to QDG.

Performance

During May, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4-hour ED standard,

However, the Trust has maintained zero 104 weeks breaches and total incompletes less than 60,248.

Unscheduled Care

May continued to be a challenging month for the Emergency Department (ED) but saw a slight increase in performance from 67.11% to 68.46% compared to the previous month for Type 1 and 3 combined activity.

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 which are aimed to reduce the overall offload times, and duration of stay in the Department which have seen some modest improvement. A CAT1 'red-drop' SOP is in place to rapidly release vehicles back to the community. There is a refreshed plan being launched at the June UEC Board.

The Trust did not meet the diagnostics standard in May, however performance improved slightly on last month from 18.8% to 18.7% this month. The total number of patients waiting has increased from 8,915 to 9,941. There is a recovery plan in place to recover position over Q2.

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.

For elective care, the RTT performance did not meet the national standard however it has increased by just over 1% in month, with an estimated month-end position of 72.9%. The total incompletes continues to rise, primarily as a consequence of new referrals/clock starts and the unconfirmed May position being 58,936, which is c.700 higher than last month.

The number of patients waiting over 52 weeks has remained relatively static with around 1,248 (compared to a validated April position of 1,231).

Focus continues to be placed on patients over 70 weeks; Zero 104 week breaches was maintained in May.

The Elective Care Hub delivered a further 1,230 contacts via Healthcare Communications with just over a 50% return rate so far. Of these 120 have been escalated to services and 25 patients requested to be removed from the wait list.

Recommendation

The Board is asked to note the contents of the report.
Enclosures
• Quality and Performance Report

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period *May* 2022

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

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Gloucestershire Hospitals
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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 May, 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.

May continued to be a challenging month for the Emergency Department (ED) but saw a slight increase in performance from 67.11% to 68.46% 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 May, however performance improved slightly on last month from 18.8% to 18.7% this month. The total number of patients waiting has increased from 8,915 to 9,941. The overall number of breaches has increased by 188, if Echo's were to be excluded, performance for all other modalities would be 1.72% with just 130 breaches against 7,561 patients waiting.

For cancer, April performance data is yet to be published so no comparison this month against national performance but the Trust met 5 out of 9 standards (unvalidated). The Trust did not achieve the standard in April with 89.9% performance noting May shows improved performance (93.2% unvalidated) with continued good 28 day Faster Diagnosis Standard performance (April – 78.3%). The Trust currently shows 66.9% for 62 day GP referrals, which indicates a disappointing month. 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 national standard however it has increased by just over 1% in month, with an estimated month-end position of 72.9%. The total incompletes continues to rise, primarily as a consequence of new referrals/clock starts and the unconfirmed May position being 58,936, which is approximately 700 higher than last month. The number of patients waiting over 52 weeks has remained relatively static with around 1,248 (compared to a validated April position of 1,231). Although focus continues to be placed on patients over 70 weeks, this cohort has increased as a consequence of including approximately 40 additional Haematology patients which previously had not been recorded in Trakcare. The Haematology department have identified recovery solutions which are currently being worked through. Zero 104 week breaches was maintained in May.

The Elective Care Hub are continuing to systematically work through long waiting and priority areas, and have more recently turned their attention to patients awaiting an outpatient appointment (having contacted the majority of inpatients waiting more than 18 weeks on an RTT pathway). Since last month a further 1,230 have been contacted via Healthcare Communications with just over a 50% return rate so far. Of these 120 have been escalated to services and 25 patients requested to be removed from the wait list.

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		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	262	253	440	354	500	523	467	446	504	330	328	315	449
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	85	117	475	294	692	752	1074	952	1057	1093	1263	1357	1434
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	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.64%	68.71%	67.11%	68.46%
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	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%
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	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	71.44%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	2263	2016	1724	1554	1598	1590	1492	1430	1273	1112	1125	1231	1232
% 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	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.72%
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	95.40%	92.80%	91.90%	93.50%	92.00%	93.40%	92.10%	92.30%	87.20%	94.70%	94.00%	89.90%	93.00%
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	96.50%	90.70%	96.60%	93.20%	90.80%	89.80%	88.60%	84.90%	89.70%	94.60%	91.30%	89.70%	95.50%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	98.30%	98.50%	98.30%	97.10%	95.90%	97.80%	96.30%	95.60%	94.20%	97.70%	98.50%	95.10%	97.30%
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%	99.40%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	99.50%	99.50%	100.00%	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	97.70%	100.00%	97.50%	98.50%	99.40%	100.00%	97.90%	100.00%	99.40%	99.00%	100.00%	94.50%	78.80%
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	95.60%	95.80%	94.00%	92.60%	88.10%	91.50%	95.10%	94.40%	88.20%	93.00%	91.50%	88.70%	97.70%
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	90.60%	95.70%	92.00%	82.90%	90.80%	76.50%	81.80%	91.50%	85.50%	79.30%	90.90%	85.20%	80.80%
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	65.40%	70.60%	82.10%	63.60%	72.10%	84.10%	70.60%	73.10%	75.00%	69.70%	80.60%	70.40%	77.80%
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	76.30%	80.30%	77.60%	72.10%	71.00%	71.80%	70.90%	61.90%	65.80%	68.00%	74.50%	64.30%	55.60%

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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	% growth from previous year: Monthly (May)	% growth from previous year: YTD
GP Referrals	8,466	8,952	8,662	7,910	8,305	8,138	8,504	7,155	7,910	8,149	9,297	8,217	8,877	4.9%	0.4%
OP Attendances	51,179	54,944	52,155	47,546	52,912	49,516	56,469	47,714	51,644	49,089	57,049	47,262	54,930	7.3%	0.6%
New OP Attendances	16,328	17,228	16,158	14,662	16,658	15,956	18,297	15,354	16,408	16,097	18,572	14,789	17,333	6.2%	-0.6%
FUP OP Attendances	34,851	37,716	35,997	32,884	36,254	33,560	38,172	32,360	35,236	32,992	38,477	32,473	37,597	7.9%	1.2%
Day cases	4,558	4,751	4,801	4,525	4,310	4,187	4,536	3,941	4,121	4,202	4,949	4,096	4,615	1.3%	-0.5%
All electives	5,424	5,697	5,831	5,469	5,237	5,218	5,492	4,941	4,798	5,051	5,978	4,977	5,687	4.8%	1.8%
ED Attendances	11,930	11,976	12,295	12,006	13,186	13,044	11,988	10,943	11,433	10,545	12,307	11,616	12,551	5.2%	5.1%
Non Electives	4,398	4,642	4,531	4,333	4,244	3,998	3,867	3,445	3,462	2,949	3,310	3,035	3,382	-23.1%	-23.8%

Trust Scorecard - Safe (1)

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

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Infection Control																		
COVID-19 community-onset - First positive specimen <=2 days after admission	1,364	7	24	120	134	110	183	122	124	175	153	212	143	58	540	201	No target	
COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	423	4	11	17	12	14	16	28	52	63	86	120	126	59	269	185	No target	
COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	141	1	1	5	2	0	1	1	23	21	36	50	38	28	107	66	No target	
COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	241	1	1	3	9	1	9	4	23	32	79	79	68	38	190	106	No target	
Number of trust apportioned MRSA bacteraemia	2	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	Zero	
MRSA bacteraemia - infection rate per 100,000 bed days	0.6	0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	0.0	0.0	0.0	1.2	0.0	Zero	
Number of trust apportioned Clostridium difficile cases per month	113	14	11	10	15	7	4	12	8	3	7	8	15	8	18	17	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	69	7	7	5	9	4	1	8	5	2	5	6	10	6	13	10	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	44	7	4	5	6	3	3	4	3	1	2	2	5	2	5	7	<=5	
Clostridium difficile - infection rate per 100,000 bed days	30.5	60.2	42.6	34.9	51.1	23.5	13	40.6	27.3	10.2	25.9	27	53.9	27.6	20.9	40.5	<30.2	
Number of MSSA bacteraemia cases	33	2	2	2	5	5	0	2	5	3	3	2	2	1	8	2	<=8	
MSSA - infection rate per 100,000 bed days	9.9	8.6	7.7	7	17	16.8	0.0	6.8	17	10.2	11.1	6.8	7.2	3.5	9.3	7.2	<=12.7	
Number of ecoli cases	56	5	3	2	0	3	5	7	5	5	5	2	9	4	12	9	No target	
Number of pseudomona cases	6	2	0	0	1	1	0	1	0	0	0	0	0	1	0	0	No target	
Number of klebsiella cases	23	1	3	3	3	4	2	2	2	0	0	1	1	3	1	1	No target	
Number of bed days lost due to infection control outbreaks	2,381	6	161	15	60	1	93	176	453	444	637	335	74	2	1,416	74	<10	>30

Trust Scorecard - Safe (2)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding		1	1	1	0	0	0	1	1								Zero	
Number of falls per 1,000 bed days	7	6.2	6.2	7.1	7.5	7	6.7	7	6.7	7.3	7.6	8.2	7.5	6.9	7.7	7.2	<=6	
Number of falls resulting in harm (moderate/severe)	67	2	3	9	5	5	5	3	9	5	10	9	4	4	24	8	<=3	
Number of patient safety incidents - severe harm (major/death)	97	2	1	9	3	6	7	10	7	7	10	28	6	8	45	14	No target	
Medication error resulting in severe harm	4	0	0	0	0	0	2	1	0	1	0	0	0	0	1	0	No target	
Medication error resulting in moderate harm	47	2	1	2	3	2	14	4	6	6	2	3	3	5	11	8	No target	
Medication error resulting in low harm	91	4	13	6	4	7	5	11	3	9	8	11	9	11	28	20	No target	
Number of category 2 pressure ulcers acquired as in-patient	358	22	17	24	27	19	22	41	43	37	40	50	46	39	127	85	<=30	
Number of category 3 pressure ulcers acquired as in-patient	17	0	1	0	3	0	1	2	4	2	1	2	2	3	5	5	<=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	3	4	3	5	1	4	9	9	12	14	10	12	18	36	30	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	80	4	8	9	4	6	1	7	12	13	7	8	12	21	28	33	<=5	
RIDDOR																		
Number of RIDDOR		1	3	3	2			3	5								SPC	
Safeguarding																		
Number of DoLs applied for		73	57	55	59	69	53	48	68	64	53	69	47	67	186	114	No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	46	8	3	3	7	4	6	1	5	2	3	4	3	6	9	9	No target	
Total attendances for infants aged < 6 months, other serious injury		0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	No target	
Total admissions aged 0-17 with DSH	280	26	15	13	11	18	35	39	18	46	24	35	32	29	105	61	No target	
Total ED attendances aged 0-17 with DSH	951	99	84	65	52	73	102	115	54	125	69	113	90	75	307	165	No target	
Total number of maternity social concerns forms completed		58	77	63	46	72	58	65	52	67	70	71	72	72	208	142	No target	
Total admissions aged 0-17 with an eating disorder		14	9	9	6	9	11	5	8	5	7	10	7	10	23	17	No target	

Trust Scorecard - Safe (3)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Serious Incidents																		
Number of never events reported	11	2	0	0	1	0	1	1	2	1	2	0	0	0	3	0	Zero	
Number of serious incidents reported	44	3	2	4	4	6	4	4	4	4	3	4	6	5	11	11	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%	89.8%	89.3%	87.0%	87.1%	92.0%	92.3%	90.7%	90.9%	87.5%	87.1%	90.7%	90.8%	88.5%	88.5%	89.5%	>95%	

Trust Scorecard - Effective (1)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-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%	9.10%	12.10%	9.20%	No target	
% C-section rate (planned and emergency)	31.53%	28.88%	33.96%	29.04%	32.02%	30.42%	31.59%	31.63%	32.44%	33.19%	31.45%	33.48%	34.48%	35.73%	32.76%	35.12%	No target	
% emergency C-section rate	16.94%	17.72%	16.77%	15.58%	17.98%	16.76%	17.76%	17.05%	15.61%	17.77%	15.72%	18.03%	19.08%	19.61%	17.24%	19.35%	No target	
% of women booked by 12 weeks gestation	91.4%	91.9%	91.2%	91.9%	91.4%	88.8%	91.0%	91.7%	92.6%	91.1%	90.5%	92.1%	90.9%	91.5%	91.2%	91.2%	>90%	
% of women that have an induced labour	27.47%	27.92%	26.40%	25.90%	28.49%	25.41%	25.00%	25.66%	24.95%	29.42%	33.09%	31.21%	30.52%	35.22%	31.16%	32.93%	<=33%	>30%
% stillbirths as percentage of all pregnancies	0.17%	0.22%	0.42%	0.19%	0.00%	0.00%	0.19%	0.00%	0.00%	0.43%	0.00%	0.64%	0.00%	0.00%	0.37%	100.00%	<0.52%	
% of women smoking at delivery	10.10%	8.23%	9.56%	10.48%	8.19%	10.16%	10.07%	8.80%	11.86%	12.58%	10.78%	11.46%	8.88%	9.13%	11.65%	9.01%	<=14.5%	
% breastfeeding (discharge to CMW)	49.4%	48.7%	49.0%	51.1%	48.4%	53.9%	48.0%	50.3%	48.1%	47.1%	46.0%	46.3%	45.5%	48.8%	46.6%	47.2%		
% breastfeeding (initiation)	78.9%	75.9%	78.4%	78.5%	79.8%	80.8%	81.1%	79.5%	76.3%	78.8%	76.8%	78.2%	78.7%	77.6%	78.0%	78.2%	>=81%	
% PPH >1.5 litres	4.5%	5.0%	4.2%	5.2%	6.7%	4.9%	4.5%	3.4%	4.9%	3.6%	2.2%	3.9%	3.5%	2.4%	3.2%	2.9%	<=4%	
Number of births less than 27 weeks	11	0	2	0	0	1	2	2	0	1	0	1	3	0	2	3		
Number of births less than 34 weeks	123	15	13	8	11	18	13	9	10	7	4	9	13	8	20	21		
Number of births less than 37 weeks	446	44	34	41	33	47	49	32	44	33	19	43	49	35	95	84		
Number of maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	5,982	468	486	526	544	558	546	537	497	471	413	473	442	465	1,358	908		
Percentage of babies <3rd centile born > 37+6 weeks	2.0%	1.5%	1.7%	1.9%	0.9%	1.4%	1.1%	1.9%	2.4%	3.2%	1.7%	4.2%	1.4%	2.4%	3.0%	1.9%		
Mortality																		
Summary hospital mortality indicator (SHMI) - national data	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1							NHS Digital	
Hospital standardised mortality ratio (HSMR)	102.6	104.2	106.2	108.4	108.6	108.3	108.8	106.9	102.6	100.9	104.0						Dr Foster	
Hospital standardised mortality ratio (HSMR) - weekend	109.4	107.1	109.2	113.4	113.8	113.8	115.6	113.8	109.4	108	111.7						Dr Foster	
Number of inpatient deaths	1,943	154	146	182	156	163	183	191	189	218	183	178	185	174	579	359	No target	
Number of deaths of patients with a learning disability	23	4	0	4	2	2	2	4	1	3	1	1	3	2	5	5	No target	

Trust Scorecard - Effective (2)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	8.46%	8.62%	9.11%	9.42%	9.54%	9.04%	8.18%	8.10%	8.10%	8.05%	7.32%	7.05%	7.52%		7.47%	7.52%	<8.25%	>8.75%
Research																		
Research accruals	3,333	240	328	183	192	456	426	236	172	185	173	142	184	135	500	319	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	72.7%	48.9%				47.5%	51.9%	50.0%	45.8%	72.7%	70.0%	73.4%	69.2%	67.6%	67.8%	67.7%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.3%	89.3%	91.8%	82.7%	91.8%	84.9%	66.7%	72.7%	75.4%	46.3%	91.0%	96.3%	97.7%			97.7%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	9.10%	44.10%				12.70%	15.10%	16.70%	8.70%	9.10%	75.00%	56.40%	69.20%	71.00%	44.40%	54.70%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	54.50%	67.90%				44.60%	48.80%	40.50%	39.60%	54.50%	75.00%	59.50%	72.40%	70.40%	67.60%	64.70%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.0%	52.5%	66.3%	68.2%	60.7%	56.1%	43.5%	50.8%	47.9%	59.4%	43.4%	50.7%	24.3%	26.7%	51.8%	25.4%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.56%	52.54%	66.27%	68.18%	59.02%	56.10%	43.55%	50.77%	47.95%	57.97%	41.51%	50.68%	24.32%	26.67%	50.77%	25.37%	>=65%	<55%

Trust Scorecard - Caring (1)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	86.5%	90.2%	89.7%	87.0%	85.4%	86.4%	85.0%	88.0%	87.8%	89.1%	87.1%	88.3%	88.0%	87.2%	88.1%	87.6%	>=90%	<86%
ED % positive	67.5%	73.6%	74.8%	62.7%	70.5%	60.9%	66.7%	68.0%	78.8%	78.6%	67.6%	63.5%	62.7%	66.9%	70.2%	64.8%	>=84%	<81%
Maternity % positive	86.3%	93.0%	89.2%	92.9%	84.8%	87.7%	82.4%	89.7%	84.3%	94.1%	91.9%	85.7%	78.2%	85.2%	89.9%	81.7%	>=97%	<94%
Outpatients % positive	93.8%	93.6%	94.3%	93.1%	93.7%	93.2%	93.3%	93.9%	94.7%	94.3%	93.4%	93.2%	93.1%	92.8%	93.6%	93.0%	>=94.5%	<93%
Total % positive	88.1%	91.1%	91.2%	90.7%	88.5%	86.2%	85.4%	89.4%	91.2%	91.0%	88.6%	88.0%	87.2%	87.4%	89.2%	87.3%	>=93%	<91%
Number of PALS concerns logged	3,006	275	191	241	238	264	274	248	230	266	248	254	229	253	774	482	No Target	
% of PALS concerns closed in 5 days	79%	85%	90%	85%	82%	76%	65%	78%	71%	65%	73%	78%	67%	75%	73%	71%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	1	0	0	0	1	0	0	0	0	0	0	0	21	7	0	28	<=10	>=20

Trust Scorecard - Responsive (1)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Cancer																		
Cancer - 28 day FDS (all routes)	78.9%	77.7%	77.3%	79.9%	78.9%	78.3%	81.0%	78.9%	80.8%	77.6%	86.3%	84.8%	78.4%	79.8%	80.7%	79.1%	>=75%	
Cancer - urgent referrals seen in under 2 weeks from GP	93.2%	95.4%	92.8%	91.9%	93.5%	92.0%	93.4%	92.1%	92.3%	87.2%	94.7%	94.0%	89.9%	93.0%	90.2%	91.6%	>=93%	<90%
Cancer - 2 week wait breast symptomatic referrals	92.5%	96.5%	90.7%	96.6%	93.2%	90.8%	89.8%	88.6%	84.9%	89.7%	94.6%	91.3%	89.7%	95.5%	91.1%	92.8%	>=93%	<90%
Cancer - 31 day diagnosis to treatment (first treatments)	97.6%	98.3%	98.5%	98.3%	97.1%	95.9%	97.8%	96.3%	95.6%	94.2%	97.7%	98.5%	95.1%	97.3%	95.7%	96.3%	>=96%	<94%
Cancer - 31 day diagnosis to treatment (subsequent – drug)	99.9%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	99.5%	99.5%	100.0%	100.0%	99.5%	100.0%	>=98%	<96%
Cancer - 31 day diagnosis to treatment (subsequent – surgery)	93.0%	95.6%	95.8%	94.0%	92.6%	88.1%	91.5%	95.1%	94.4%	88.2%	93.0%	91.5%	88.7%	97.7%	89.7%	92.4%	>=94%	<92%
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	99.0%	97.7%	100.0%	97.5%	98.5%	99.4%	100.0%	97.9%	100.0%	99.4%	99.0%	100.0%	94.5%	78.8%	99.5%	89.1%	>=94%	<92%
Cancer - 62 day referral to treatment (urgent GP referral)	74.9%	76.3%	80.3%	77.6%	72.1%	71.0%	71.8%	70.9%	61.9%	65.8%	68.0%	74.5%	64.3%	55.6%	69.4%	59.5%	>=85%	<80%
Cancer - 62 day referral to treatment (screenings)	90.1%	90.6%	95.7%	92.0%	82.9%	90.8%	76.5%	81.8%	91.5%	85.5%	79.3%	90.9%	85.2%	80.8%	90.9%	80.8%	>=90%	<85%
Cancer - 62 day referral to treatment (upgrades)	84.1%	65.4%	70.6%	82.1%	63.6%	72.1%	84.1%	70.6%	73.1%	75.0%	69.7%	80.6%	70.4%	77.8%	73.1%	74.1%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	47	1	2	3	4	9	10	4	3	2	2	5	2	2	9	4	Zero	
Number of patients waiting over 104 days without a TCI date	229	10	11	9	12	18	21	23	25	14	22	50	73	58	86	131	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	18.03%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.72%	18.03%	18.72%	<=1%	>2%
The number of planned/surveillance endoscopy patients waiting at month end	1,455	1,680	1,527	1,482	1,439	1,435	1,397	1,410	1,422	1,334	1,269	1,286	1,365	1,367	1,296	1,366	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	60.9%	61.4%	62.2%	62.3%	61.1%	61.7%	60.5%	61.4%	58.4%	58.7%	62.0%	59.8%	60.2%		60.1%	60.2%	>=88%	<75%

Trust Scorecard - Responsive (2)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Emergency Department																		
ED: % total time in department - under 4 hours (types 1 & 3)	72.99%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.64%	68.71%	67.11%	68.46%	70.26%	67.82%	>=95%	<90%
ED: % total time in department - under 4 hours (type 1)	62.52%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%	59.74%	54.98%	>=95%	<90%
ED: % total time in department - under 4 hours CGH	81.54%	99.68%	94.75%	84.95%	88.74%	77.05%	83.00%	79.80%	79.03%	79.17%	73.72%	65.48%	65.44%	65.10%	72.50%	65.27%	>=95%	<90%
ED: % total time in department - under 4 hours GRH	55.65%	61.44%	63.34%	53.00%	57.55%	51.82%	52.48%	54.91%	53.96%	55.55%	52.12%	52.87%	49.00%	50.54%	53.54%	49.80%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2,459	0	1	10	1	15	53	448	631	653	394	606	690	616	1,653	1,306	Zero	
ED: % of time to initial assessment - under 15 minutes	19.1%	47.3%	43.1%	7.1%	14.8%	15.7%	19.3%	21.6%	29.6%	35.5%	30.0%	22.9%	20.1%	36.1%	29.3%	28.4%	>=95%	<92%
ED: % of time to start of treatment - under 60 minutes	11.4%	15.1%	14.4%	12.3%	13.8%	14.9%	10.7%	18.1%	24.6%	29.5%	24.1%	21.0%	19.6%	19.4%	24.8%	19.5%	>=90%	<87%
Number of ambulance handovers over 60 minutes	8,091	85	117	475	294	692	752	1,074	952	1,057	1,093	1,263	1,357	1,434	3,413	2,791	Zero	
% of ambulance handovers < 15 minutes	21.55%							23.11%	23.53%	24.72%	18.20%	15.73%	9.81%	11.80%	20.13%	10.87%	>=65%	
% of ambulance handovers < 30 minutes	40.14%							42.28%	45.54%	44.45%	34.48%	29.58%	21.14%	24.68%	37.12%	23.03%	>=95%	
% of ambulance handovers 30-60 minutes	11.60%	6.66%	6.73%	11.91%	9.48%	13.85%	14.55%	14.21%	13.90%	15.56%	13.25%	13.17%	13.32%	16.72%	14.13%	15.13%	<=2.96%	
% of ambulance handovers over 60 minutes	19.87%	2.16%	3.11%	12.86%	7.88%	19.16%	20.92%	32.67%	29.68%	32.62%	43.90%	50.70%	57.38%	53.39%	41.52%	55.26%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	81.58%	87.80%	87.50%	80.95%	89.06%	80.60%	73.75%	74.03%	80.23%	71.60%	93.48%	95.59%	76.90%	81.48%	86.89%	79.19%	>=95%	
Urgent cancelled operations	107	1	13	12	10	1	44	24	1	1	0	0	0	0	1	0	No target	
Number of patients stable for discharge	179	114	122	160	158	179	178	212	159	234	241	208	233	238	228	236	<=70	
Number of stranded patients with a length of stay of greater than 7 days	459	334	416	367	421	472	468	503	499	491	537	539	514	495	522	505	<=380	
Average length of stay (spell)	5.58	4.78	5.14	4.98	4.84	5.32	5.47	6.03	6.02	6.13	6.67	6.68	6.62	6.7	6.49	6.66	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	6.34	5.25	5.7	5.57	5.39	5.99	6.22	6.97	7	6.78	7.93	8.06	7.91	8.06	7.56	7.99	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.37	2.57	2.64	2.43	2.31	2.25	2.48	2.28	2.46	2.42	2.07	2.13	2.13	2.29	2.18	2.22	<=3.4	>4.5
% day cases of all electives	82.64%	84.02%	83.38%	82.32%	82.72%	82.28%	80.22%	82.57%	79.74%	85.87%	83.17%	82.77%	82.28%	81.13%	83.85%	81.67%	>80%	<70%
Intra-session theatre utilisation rate	87.21%	90.49%	88.47%	89.53%	89.43%	84.69%	88.13%	85.45%	83.06%	86.21%	85.20%	87.39%	87.55%	88.21%	86.37%	87.90%	>85%	<70%

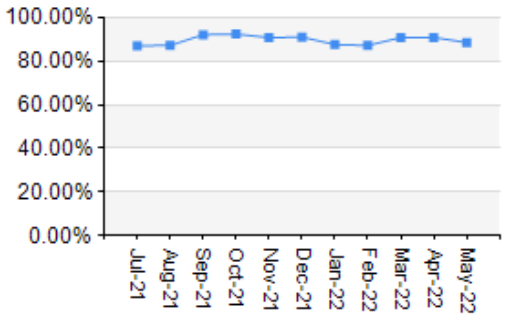
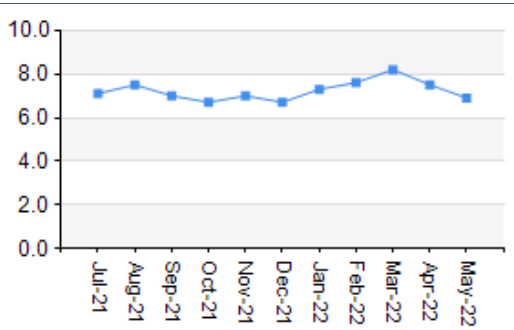
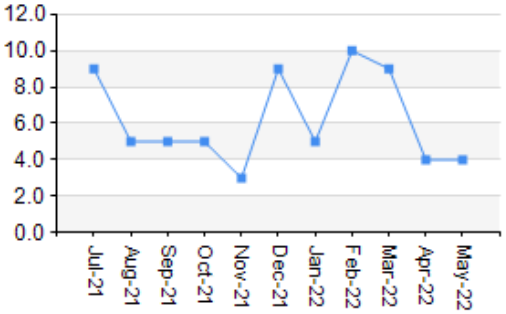
Trust Scorecard - Responsive (3)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.99	2.02	2.04	2.1	2.13	2	1.94	1.93	1.96	1.95	1.88	1.96	2.03	2.03	1.93	2.03	<=1.9	
Did not attend (DNA) rates	7.05%	6.02%	6.72%	7.05%	7.24%	7.15%	7.17%	7.03%	7.23%	7.62%	7.03%	7.32%	7.48%	6.83%	7.33%	7.13%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	72.30%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	71.44%	71.50%	71.62%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	5,720	6,426	6,159	5,713	5,582	5,642	5,593	5,642	5,847	5,272	5,087	5,135	5,419	5,420	5,165	5,420	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,840	3,657	3,320	2,854	2,906	2,946	2,935	2,641	2,605	2,292	2,165	2,182	2,421	2,482	2,213	2,452	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,653	2,263	2,016	1,724	1,554	1,598	1,590	1,492	1,430	1,273	1,112	1,125	1,231	1,232	1,170	1,232	Zero	
Referral to treatment ongoing pathway over 70 Weeks (number)	426	667	745	806	611	403	295	228	205	207	185	148	128	108	180	118	0	

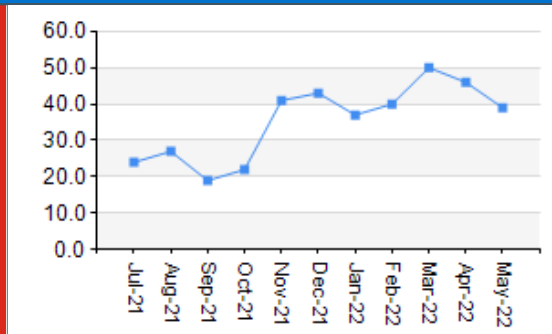
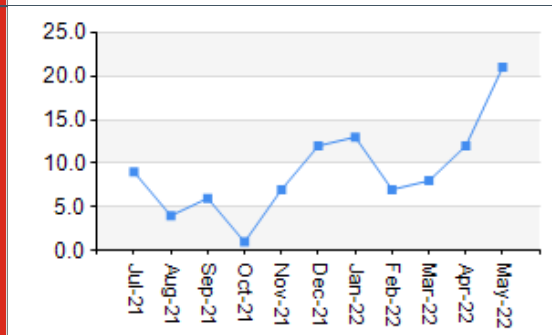
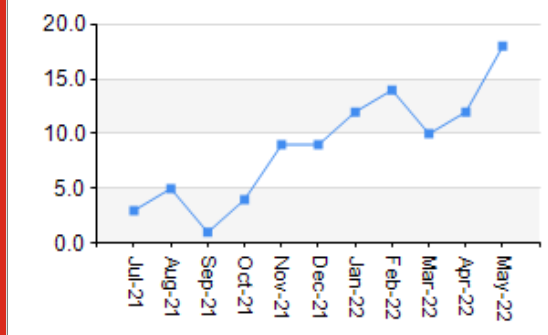
Trust Scorecard - Well Led (1)

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Q4	22/23	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	77.0%	85.0%	84.0%	80.0%	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%	78.0%	77.0%	78.0%	80.0%	77.0%		>=90%	<70%
Trust total % mandatory training compliance	86%	90%	91%	90%	90%	88%	87%	87%	87%	87%	87%	86%	86%	86%	86%		>=90%	<70%
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	93.00%	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%	96.05%	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%	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%	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%	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	5.5	5.3	5.3	4.7	4.6	5	5.1	5	4.9	4.8	4.9			4.9		>=5	
Care hours per patient day HCA	3.2	3.5	3.5	3.5	3.3	3.5	3.2	3.1	3.1	3	2.9	2.9			2.9		>=3	
Care hours per patient day total	8.2	9	8.7	8.8	8	8.1	8.1	8.3	8.1	7.9	7.8	7.7			7.8		>=8	
Vacancy and WTE																		
% total vacancy rate		7.12%		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%	10.45%	10.79%	10.61%			<=11.5%	>13%
% vacancy rate for doctors		4.15%		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%	7.99%	7.91%	7.79%			<=5%	>5.5%
% vacancy rate for registered nurses		6.60%		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%	14.09%	14.34%	14.60%			<=5%	>5.5%
Staff in post FTE		6672.09	6672.85	6680.26	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52	6707.09	6683.74	6683.28			No target	
Vacancy FTE		510		505.63	537.29	491.56	457.02	530.17	582.02	834.81	799.75	782.28	807.64	794.16			No target	
Starters FTE	1123.04	50.85	56.53	36.05	36.53	79.76	42.43	59.94	70.65	77.03	69.31	51.46	91.38	85.03			No target	
Leavers FTE	1128.86	57.02	62.03	52.16	78.84	68.51	89.94	66.53	81.1	88.76	47.74	84.88	67.55	83.93			No target	
Workforce Expenditure and Efficiency																		
% turnover		9.5%	10.0%	10.2%	10.7%	11.1%	11.7%	11.7%	12.3%	12.9%	11.8%	13.8%	14.2%	14.4%			<=12.6%	>15%
% turnover rate for nursing		8.96%	9.18%	9.80%	9.77%	9.72%	9.70%	10.52%	10.83%	10.99%	10.69%	12.15%	12.80%	13.03%			<=12.6%	>15%
% sickness rate		3.7%	3.6%	3.6%	3.8%	3.9%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.1%	4.2%			<=4.05%	>4.5%

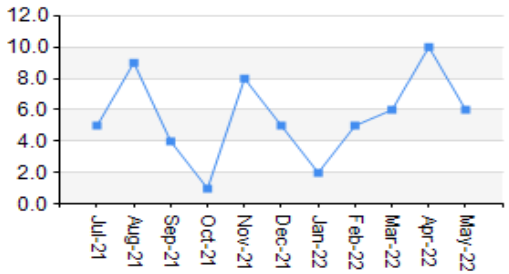
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The rate is consistent over time using a clinical audit approach, the implementation of E-prescribing remains the plan for improvement	**Quality Improvement & Safety Director**
Number of falls per 1,000 bed days **Standard: <=6**		May 2022 saw a lower number of falls with the rate at 6.7 per 1000 bed days. 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, we are now seeing the positive effect of this. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and prolonged length of stay.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		May 2022 again 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**

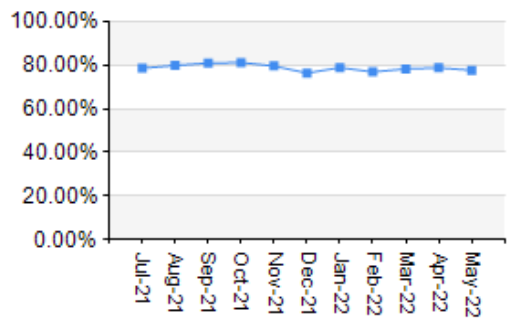
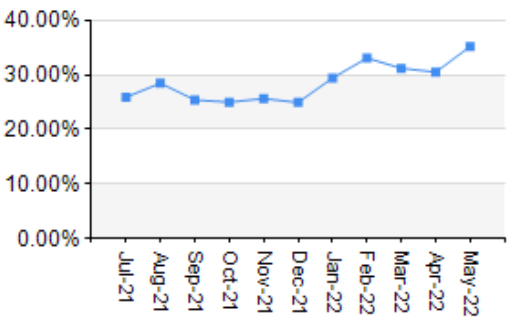
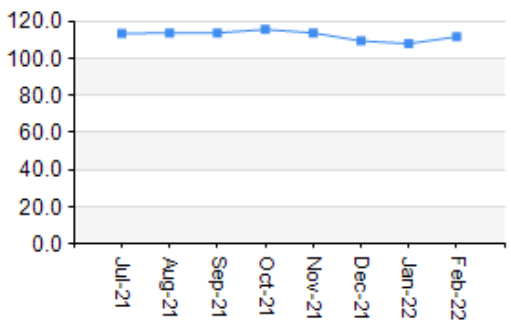
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
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**
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. React to red study days are now taking place monthly to increase throughput.	**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. React to red study days are now taking place monthly to increase throughput.	**Associate Chief Nurse, Director of Infection Prevention & Control**

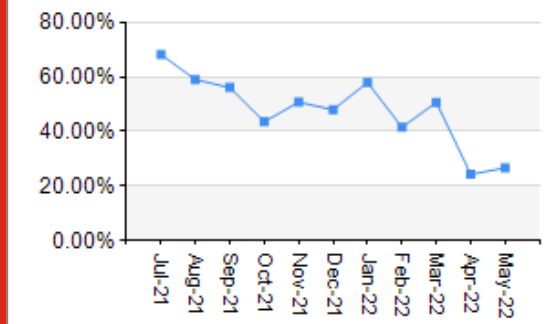
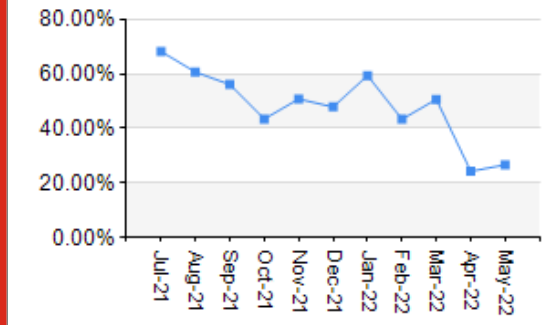
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		During May 2022 there were 6 health care associated (HO-HA) case; compared to 10 in April 2022. 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 0 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. In June 2022 in line with the national cleaning standards 2021 the audit have been changed to new functional risk assessment audit frequencies including the associated audit targets have been implemented. 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 4 AMS ward rounds 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**

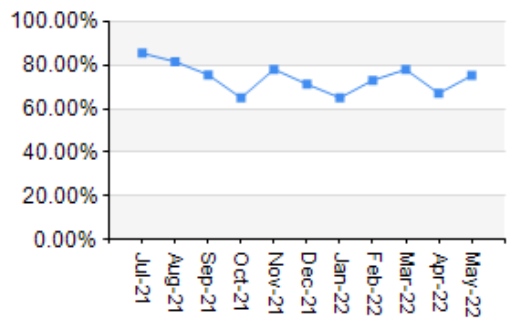
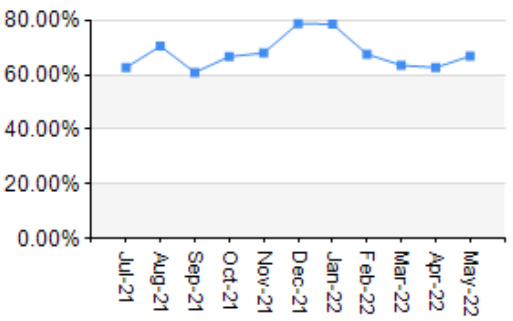
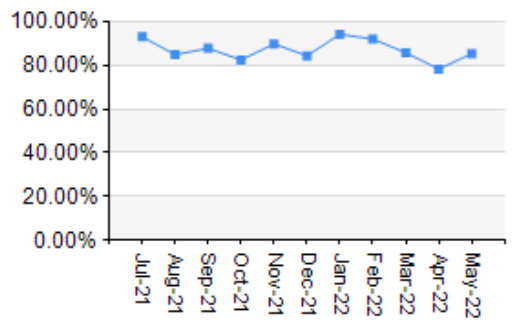
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Most antenatal classes are now back face to face and numbers of couples being able to attend have increased due to reduction in covid restrictions. Therefore information is being shared with more families and this should help to improve mothers wanting to initiate breast feeding. Staff are still being encouraged to do their mandatory training in addition to their contracted hours, to ensure most up to date information given. Due to staffing levels, this is still not possible for all staff. There is always going to be an element of choice, which is correct. Sophie Ferguson, Infant Feeding Specialist Midwife, is linking in with Gloucestershire Infant Feeding Strategic Partnership to work collaboratively on the Infant Feeding Strategy.	**Divisional Director of Quality and Nursing and Chief Midwife**
% of women that have an induced labour **Standard: <=33%**		An audit will be undertaken by the service to see if there are any trends responsible for the increase.	**Divisional Director of Quality and Nursing and Chief Midwife**
Hospital standardised mortality ratio (HSMR) - weekend **Standard: Dr Foster**		This metric is increased marginally this month but overall there has been an improvement due to the reduced effect of COVID on mortality. This will continue to be monitored in HMG, all other mortality metrics are within range	**Deputy Medical Director**

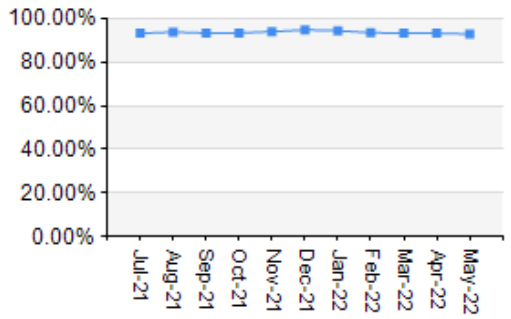
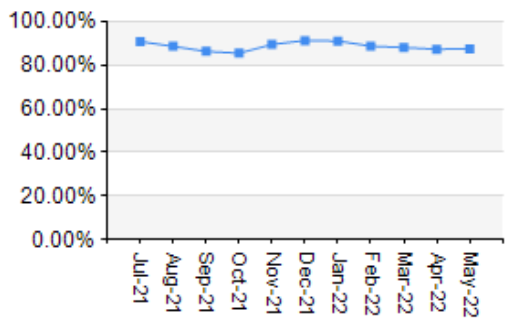
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% fractured neck of femur patients meeting best practice criteria **Standard: >=65%**		There has been an improvement in the delivery of surgical intervention in the surgical fractured neck of femur pathway in May (26.7%) compared to April (24.3%). There is still a significant recovery required to bring the performance back to the July 2021 position of 68.2% (the best position achieved in the last 12 months). The pathway deterioration can be attributed to the lack of available trauma beds on the GRH site since the loss of ward 2A to Vascular in COVID wave 1. The division are looking to move Vascular into another tower inpatient ward in order to return ward 2A back to the Trauma service. This is anticipated to take 12 months to achieve, owing to the Strategic Site Development estate works required to take place between August and May 2023 to facilitate the moves. In the meantime the service are looking at recovery actions on a local scale to facilitate more rapid admission to 3rd floor inpatient beds and reducing the length of stay on these wards associated with patients experiencing delayed discharge.	**General Manager – Trauma & Orthopaedics**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**			

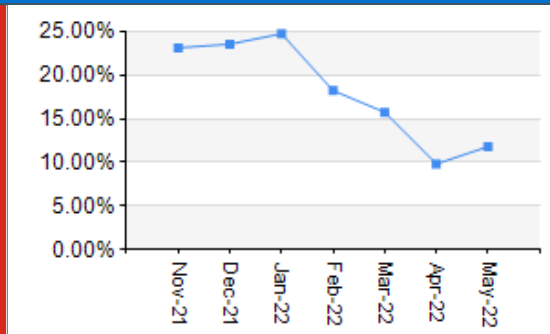
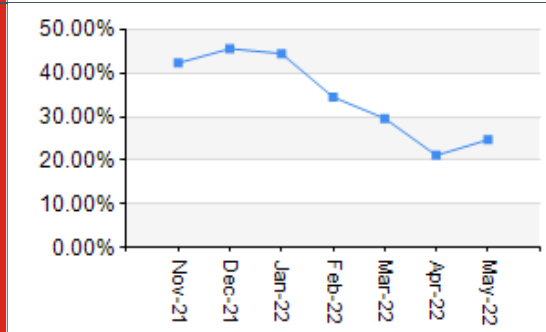
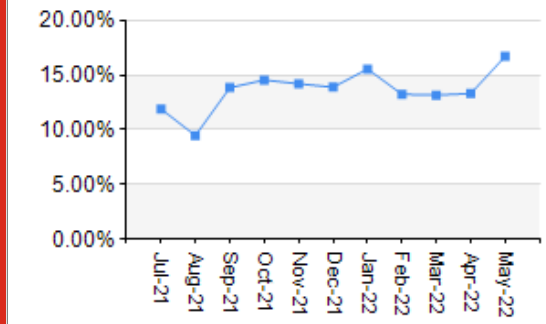
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The % of PALS Concerns closed within 5 days is 75.1%, and increase from 67% in April. The team have been looking to signpost enquiries to other appropriate routes or information sources, to enable more time for advisors to work on complex cases. In May, this led to a 34% reduction in the number of basic enquiries being managed by PALS, and has seen an improvement in the number of cases being closed. The data we capture through datix is being reviewed, to ensure that the data is reliable, with a new approach to capturing and reporting being developed. An update with proposals will be provided to QDG.	**Head of Quality**
ED % positive **Standard: >=84%**		The current positive FFT score for ED is at 66.9% across both sites, up from 62.7% in April, 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 85.2%, up from 78.2% in April. 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**

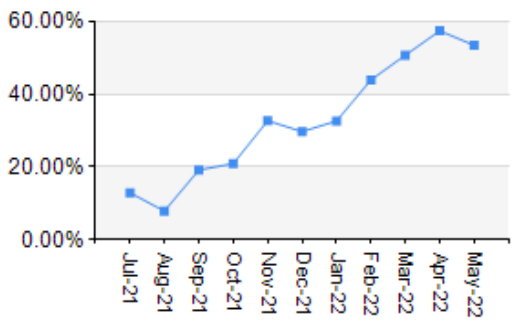
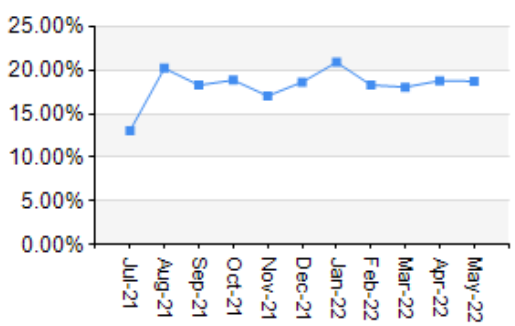
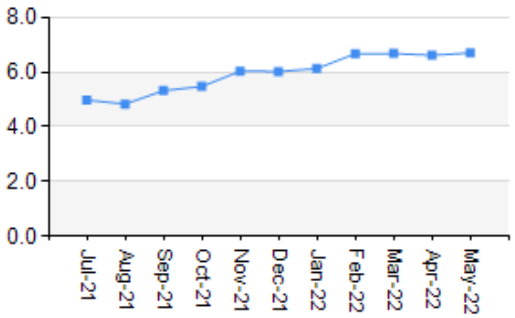
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Outpatients % positive **Standard: >=94.5%**		The current positive FFT score for outpatient services is 92.8%, a slight decrease from 93.1% in April. Teams review their FFT data within specialty and divisional reporting, with monthly updates from divisions provided through to QDG.	**Head of Quality**
Total % positive **Standard: >=93%**		The current positive FFT score for the Trust overall is at 87.4%, up slightly from 87.2% in April. 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**

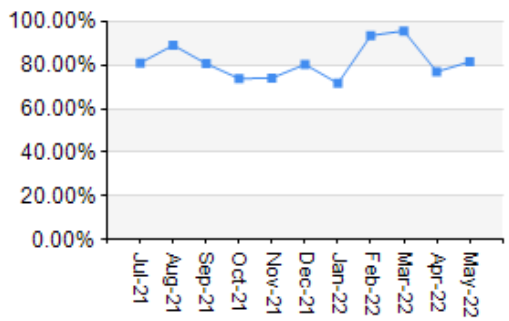
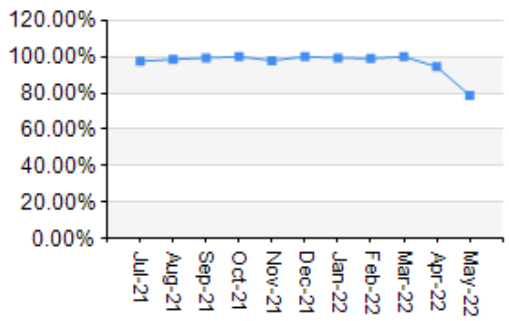
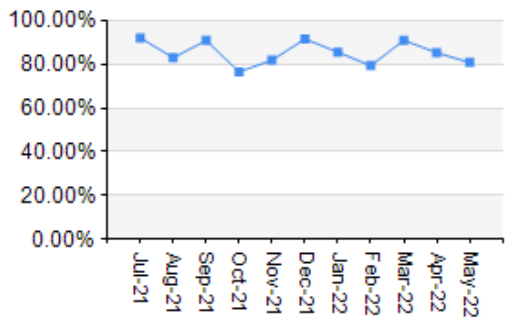
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers < 15 minutes **Standard: >=65%**		A 2% improvement from last month demonstrates a reduction overall in delays to ambulance offloads. A review of process, CAT1 "hot drop" compliance, and cohort capacity is underway to ensure this metric in on an improved trajectory. Targetted management input remains; Collaborative work with SWASFT colleagues; specific actions agreed and monitored by the UEC Board will contribute to continued improvement in June onwards.	**General Manager of Unscheduled Care**
% of ambulance handovers < 30 minutes **Standard: >=95%**		A 3.5% shift from last month has contributed to a reduction overall in delays to ambulance offloads. A review of process, CAT1 "hot drop" compliance, and cohort capacity is underway to ensure this metric in on an improved trajectory. Targetted management input remains; Collaborative work with SWASFT colleagues; specific actions agreed and monitored by the UEC Board will contribute to continued improvement in June onwards.	**General Manager of Unscheduled Care**
% of ambulance handovers 30-60 minutes **Standard: <=2.96%**		May has shown modest deterioration (3.5%) from the April position but represents overall a reduction in 60+ minutes handover delays. There is definitive left shift. This is a stubborn KPI to improve at pace. A review of process, CAT1 "hot drop" compliance, and cohort capacity is underway to ensure this metric in on an improved trajectory. Targetted management input remains; Collaborative work with SWASFT colleagues; specific actions agreed and monitored by the UEC Board will contribute to continued improvement in June onwards.	**General Manager of Unscheduled Care**

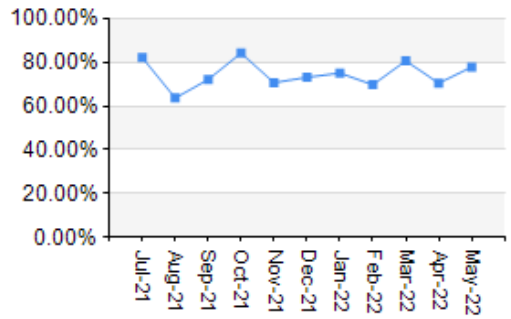
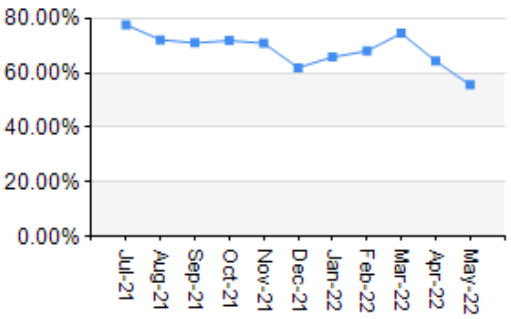
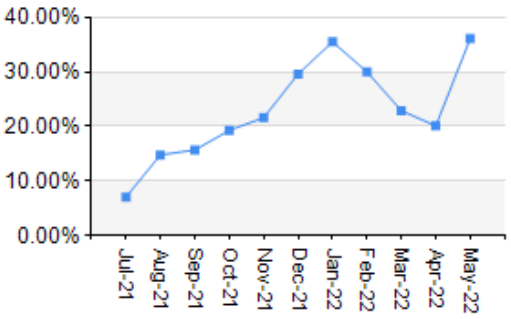
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers over 60 minutes **Standard: <=1%**		May has shown modest improvement from the April position with a 4% reduction in ambulance handovers exceeding 60 minutes. This is proving to be a stubborn KPI to improve at pace. A review of process, CAT1 "hot drop" compliance, and cohort capacity is underway to ensure this metric in on an improved trajectory. Targetted management input remains; Collaborative work with SWASFT colleagues; specific actions agreed and monitored by the UEC Board will contribute to continued improvement in June onwards.	**General Manager of Unscheduled Care**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Diagnostic performance continues to remain static with majority of the modalities performing within target. However, the typical figure of around 18% is predominantly associated with the number of breaches within the Echo service.	**Associate Director of Elective Care**
Average length of stay (spell) **Standard: <=5.06**		Very slight improvement in month mainly due to focussed efforts to create capacity ahead of the Bank Holidays at beginning and end of may. Improved complex discharge volumes and focus on 75+day length of stay has had a positive contribution overall. There is intended to be marked improvement in June, and an aspiration to ensure that AVLOS indicators reduce by at least 1.3 days.	**Deputy Chief Operating Officer**

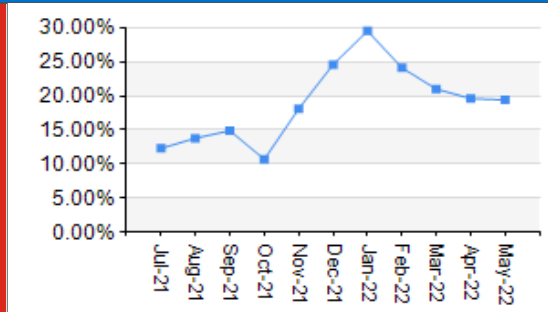
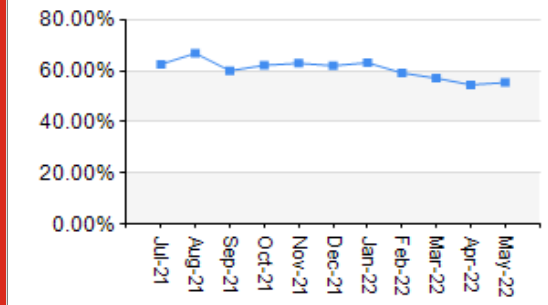
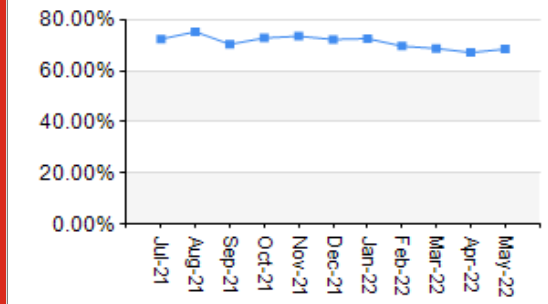
Exception Reports - Responsive (3)

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 April there were just 5 patients cancelled on the day that could not be rescheduled within 28 days, compared to 9 the previous month. Reasons were varied but included overrunning theatre list; staff sickness and unavailable equipment.	**Associate Director of Elective Care**
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		31 day subs radiotherapy performance (unvalidated) Standard = 94% National = 93% (March figures) GHFT = 79.1% Treated = 67 Breaches = 14 Radiotherapy under considerable pressure due to 15wte radiographer vacancies culminating in a treatment backlog. Risk going on Trust risk register. Mitigation plan in place.	**General Manager - Cancer**
Cancer - 62 day referral to treatment (screenings) **Standard: >=90%**		62 day screening performance (unvalidated) Standard = 90% National = 74% (March) GHFT = 80.8% Treated= 26, Breaches= 5 Lower GI 4.5 Breast 0.5 Three breaches relating to capacity for specialist surgery (TEMS).	**General Manager - Cancer**

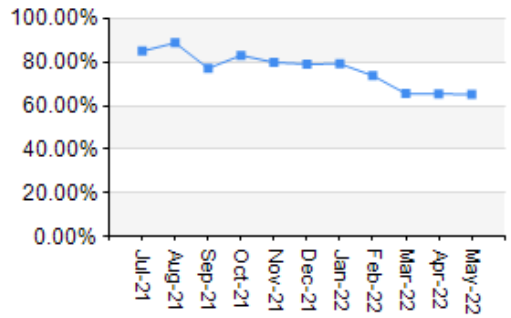
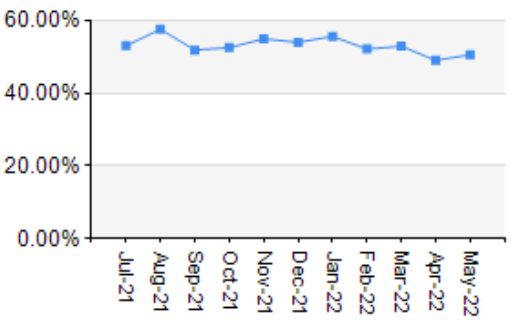
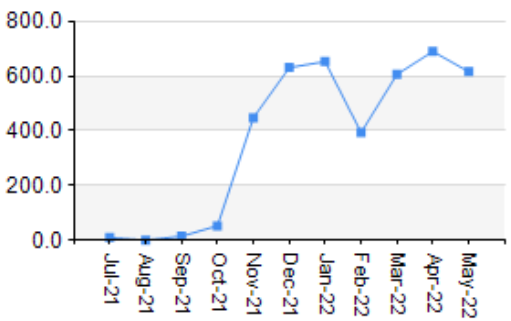
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated) Standard = N/A National = 77% (March) GHFT = 76.6% Treated= 12.5, Breaches=3 1 breach related to delays in IPT transfer 1 path report delay 1 patient with comorbidities	**General Manager - Cancer**
Cancer - 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) Standard = 85% National = 67% GHFT = 54.8% Treatments =160.5, Breaches 72, LGI=13.5, Urology=27.5, Gynae=10 Treatment levels very high and 38 patients have been treated >104 days indicating backlog clearance impacting on performance. High acuity with a number of complex patients especially rarer cancers (8 treated in month compared to 1-2). 19 breaches due to patients now being diagnosed and treated following LATP biopsy on prostate pathway	**General Manager - Cancer**
ED: % of time to initial assessment - under 15 minutes **Standard: >=95%**		Modest improvement from last month to focus on Triage times in department led by targetted clinical management. Appropriate capture and focus of skilled resource commenced mid-month and live data monitoring is demonstrated continued focus leading to an improved position and reducing time to triage. There were challenges on the CGH site on several occasions due to staff sickness required a temporary adhoc redistribution of skills between sites. There is focus on consistent cover being available; reduction in sickness absence amongst this small skilled cohort of staff; monitoring focus on time to triage performance at each bed/site meeting and ED huddle; Aim to reduce to 15 minutes for all patients where possible. This indicator contributes directly to duration of stay overall, and achievement of the 4hour standard.	**General Manager of Unscheduled Care**

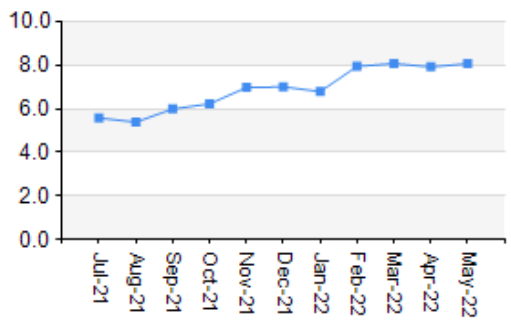
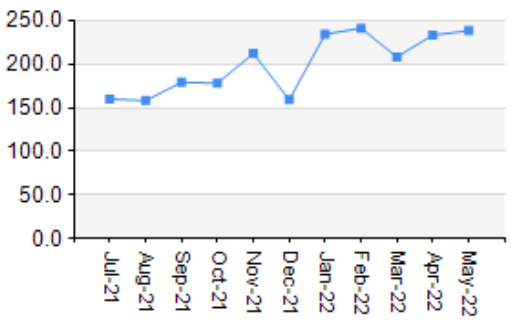
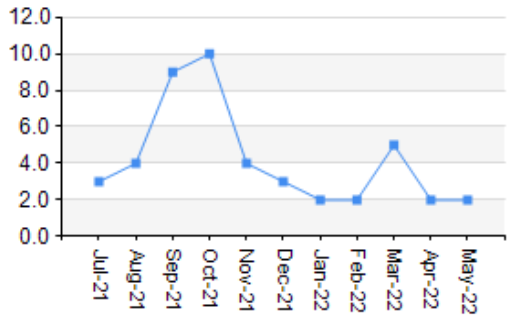
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to start of treatment - under 60 minutes **Standard: >=90%**		Predominant factor of medical staff availability, shift and rota fill, and available capacity within the department proved challenging throughout May. External support has been commissioned to provide expert assessment and recommendation for more appropriate roster fill, and international recruitment of doctors who are due to be onboarded in May, June and July have yet to be fully realised. Weekend late shifts are particularly challenged. Additional scrutiny and 6,4,2 methodology to be employed in June to ensure better shift fill 7days per week. There is focus on consistent cover being available; reduction in sickness absence amongst this small skilled cohort of staff; monitoring focus on time to triage performance at each bed/site meeting and ED huddle; Aim to reduce to 15 minutes for all patients where possible. This indicator contributes directly to duration of stay overall, and achievement of the 4hour standard. There will be an assessment on time stamps within the department to ensure times are captured effectively.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (type 1) **Standard: >=95%**		Very modest improvement in overall time in department. An increase in the numbers of patients staying less than 4 hours is intended to continue. Representing a very modest improvement in flow out of the department. Target set for June as returning to 60% as a minimum. Specific and targetted leadership is to continue.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (types 1 & 3) **Standard: >=95%**		Modest improvement supported by more consistent availability of MIIU capacity, commencement of CATU initiative and taregtted actions ahead of the May Bank Holiday and Jubilee Bank Holiday. Type 3 activity has remained high and has supported Type 1 performance overall.	**General Manager of Unscheduled Care**

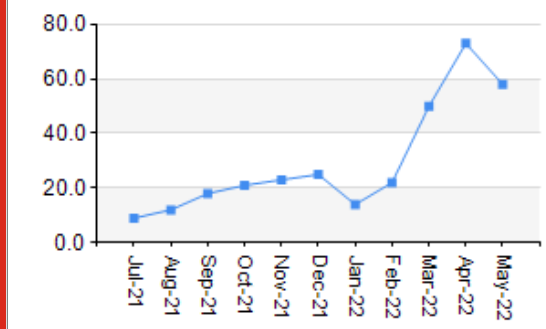
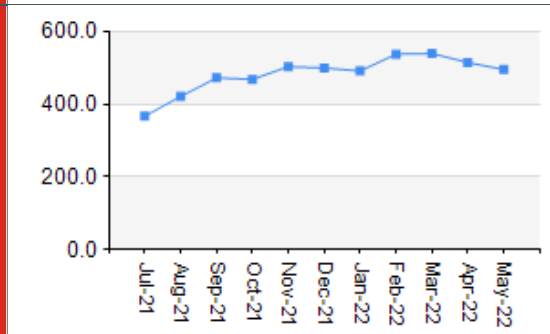
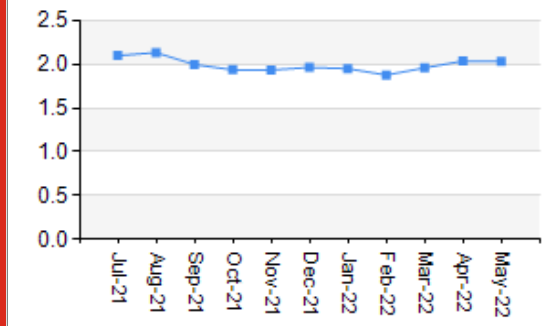
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department - under 4 hours CGH **Standard: >=95%**		Very modest improvement in overall time in department. An increase in the numbers of patients staying less than 4 hours is intended to continue. Representing a very modest improvement in flow out of the department. Target set for June as returning to 60% as a minimum. Specific and targetted leadership is to continue. Specific focus on ringfenced capacity for Cardiac, Acute Stroke and RED patients to be maintained at all time minimising the delay in patient placement continues.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours GRH **Standard: >=95%**		Very modest deterioration in overall time in department. An increase in the numbers of patients staying less than 4 hours is intended to continue. Focus for June ongoing is the need to minimise the duration of stay and reduce 12 hour DTA breaches. Some sustained improvement in triage times, time to clinician and specific actions at time of exceptional demand have contributed to a stabilised position. These actions will promote an improvement of compliance in June. Target set for June as returning to 60% as a minimum. Specific and targetted leadership is to continue.	**General Manager of Unscheduled Care**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		Significant reduction in latter half of May to create capacity ahead of the Bank Holiday weekend, a focus on creating capacity at ward level, and targetted management input have positively contributed to the reduction. Recording of DTA remains a challenge, but targetted work is underway to continue improvement.	**General Manager of Unscheduled Care**

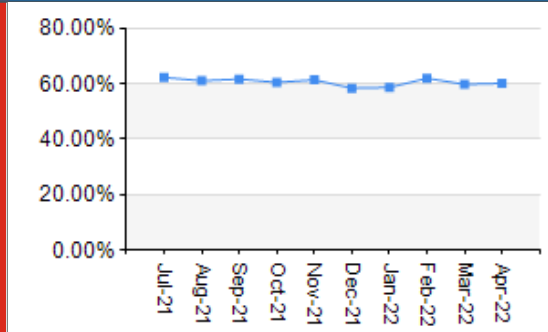
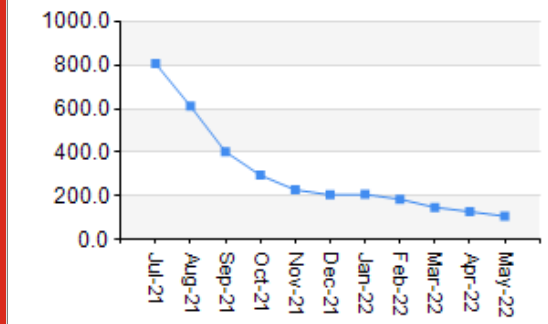
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		The position has increased by around 0.25days from April. There are no remarkable factors affecting this indicator at this time, it remains a focus of other contributory KPIs such as pre-ED length of stay and overall duration of time in ED, which manifests in a cumulative until discharge. Focus on these indicators should have a positive impact on this metric.	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		nCTR numbers have reduced from a peak of 272 to now being 238, following ongoing work to drive discharges and enable conversion to pathway 0. System conversations ongoing with the creation of the OneGlos SLOMAN plan and the undertaking of a peer review process through the LGA.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Urological 1; Skin = 1 Grand Total = 2 104's still impacted by prostate pathway. Patients now receiving biopsies but delays now seen in pathology and patients who remain on pathway for cancer treatment	**General Manager - Cancer**

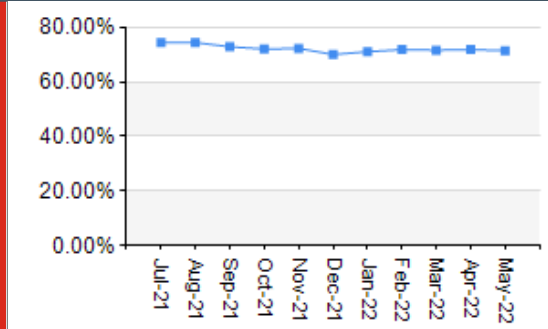
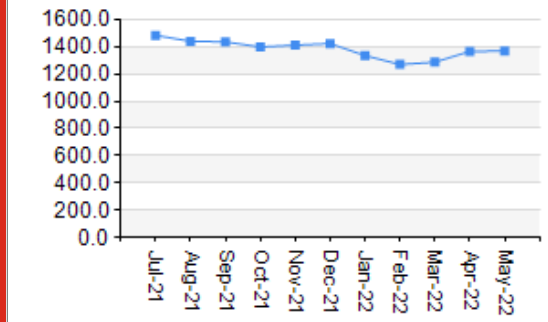
Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Urological = 50; Lower GI = 7; Upper GI = 2; Skin = 1; Other= 1; Haematological = 1; Head & neck = 1; Gynaecological = 1; Lung = 1 Grand Total = 65 104's still impacted by prostate pathway. Patients now receiving biopsies but delays now seen in pathology and patients who remain on pathway for cancer treatment	**General Manager - Cancer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		Improvements in 7+ day LOS, volume of complex discharges overall ahead of the bank holidays and additional non-acute hospital based capacity (Home first starts, reduced closures if Care environments for C-19; and commencement of CATU capacity) have contributed over all. Still specific work recorded on the system-wide "SLOMAN action plan" to be key drivers for continued improvement.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		Remained stable at 2.03, and just above the target.	**Associate Director of Elective Care**

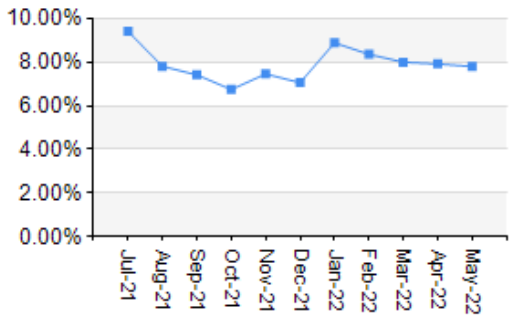
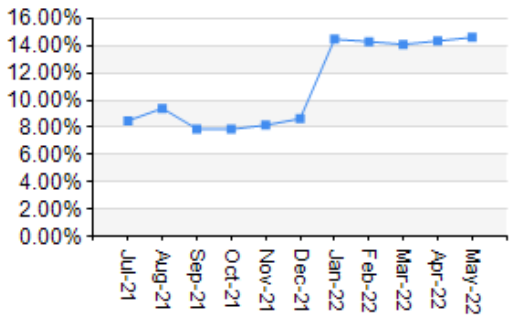
Exception Reports - Responsive (9)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		This metric remains static, we are awaiting EPMA implementation to review this whole process	**Medical Director**
Referral to treatment ongoing pathway over 70 Weeks (number) **Standard: 0**		Albeit this cohort is reported as reducing in month, please note that this figure is anticipated to increase with the pending inclusion of a further 40 patients from Clinical Haematology that all exceed 70 weeks.	**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. RTT performance is currently reported as 71.44%. However, validation continues and at the point of submission this is anticipated to be 72.5% which will demonstrate an improving performance. This is attributed to both increased activity in May coupled with increased referrals/new clock starts (under 18 weeks)	**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 Sickness and leave, but expected to continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From July 2022, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog.	**Deputy General Manager of Endoscopy**

Exception Reports - Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% 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 for People and OD**
% 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 for People and OD**

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period May 2022

Presented at June 2022 Q&P and July 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 May, 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.

May continued to be a challenging month for the Emergency Department (ED) but saw a slight increase in performance from 67.11% to 68.46% 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 May, however performance improved slightly on last month from 18.8% to 18.7% this month. The total number of patients waiting has increased from 8,915 to 9,941. The overall number of breaches has increased by 188, if Echo's were to be excluded, performance for all other modalities would be 1.72% with just 130 breaches against 7,561 patients waiting.

For cancer, April performance data is yet to be published so no comparison this month against national performance but the Trust met 5 out of 9 standards (unvalidated). The Trust did not achieve the standard in April with 89.9% performance noting May shows improved performance (93.2% unvalidated) with continued good 28 day Faster Diagnosis Standard performance (April – 78.3%). The Trust currently shows 66.9% for 62 day GP referrals, which indicates a disappointing month. 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 national standard however it has increased by just over 1% in month, with an estimated month-end position of 72.9%. The total incompletes continues to rise, primarily as a consequence of new referrals/clock starts and the unconfirmed May position being 58,936, which is approximately 700 higher than last month. The number of patients waiting over 52 weeks has remained relatively static with around 1,248 (compared to a validated April position of 1,231). Although focus continues to be placed on patients over 70 weeks, this cohort has increased as a consequence of including approximately 40 additional Haematology patients which previously had not been recorded in Trakcare. The Haematology department have identified recovery solutions which are currently being worked through. Zero 104 week breaches was maintained in May.

The Elective Care Hub are continuing to systematically work through long waiting and priority areas, and have more recently turned their attention to patients awaiting an outpatient appointment (having contacted the majority of inpatients waiting more than 18 weeks on an RTT pathway). Since last month a further 1,230 have been contacted via Healthcare Communications with just over a 50% return rate so far. Of these 120 have been escalated to services and 25 patients requested to be removed from the wait list.

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

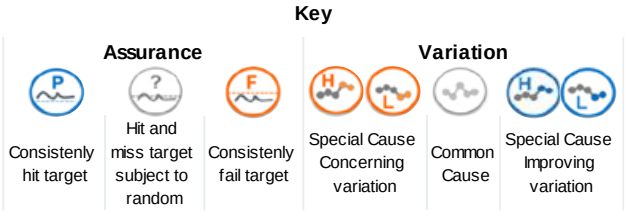
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer - 28 day FDS (all routes)	>=75%	May-22	79.8%
Cancer	Cancer - urgent referrals seen in under 2 weeks from GP	>=93%	May-22	93.0%
Cancer	Cancer - 2 week wait breast symptomatic referrals	>=93%	May-22	95.5%
Cancer	Cancer - 31 day diagnosis to treatment (first treatments)	>=96%	May-22	97.3%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – drug)	>=98%	May-22	100.0%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	>=94%	May-22	97.7%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	May-22	78.8%
Cancer	Cancer - 62 day referral to treatment (urgent GP referral)	>=85%	May-22	55.6%
Cancer	Cancer - 62 day referral to treatment (screenings)	>=90%	May-22	80.8%
Cancer	Cancer - 62 day referral to treatment (upgrades)	>=90%	May-22	77.8%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	May-22	2
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	May-22	58
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	May-22	18.72%
Diagnostics	The number of planned/surveillance endoscopy patients waiting at month end	<=600	May-22	1,367
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Apr-22	60.20%
Emergency Department	ED: % total time in department - under 4 hours (type 1)	>=95%	May-22	55.41%
Emergency Department	ED: % total time in department - under 4 hours (types 1 & 3)	>=95%	May-22	68.46%
Emergency Department	ED: % total time in department - under 4 hours CGH	>=95%	May-22	65.10%
Emergency Department	ED: % total time in department - under 4 hours GRH	>=95%	May-22	50.54%

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	May-22	616
Emergency Department	ED: % of time to initial assessment - under 15 minutes	>=95%	May-22	36.1%
Emergency Department	ED: % of time to start of treatment - under 60 minutes	>=90%	May-22	19.4%
Emergency Department	Number of ambulance handovers over 60 minutes	Zero	May-22	1,434
Emergency Department	% of ambulance handovers < 15 minutes	>=65%	May-22	11.8%
Emergency Department	% of ambulance handovers < 30 minutes	>=95%	May-22	24.7%
Emergency Department	% of ambulance handovers 30-60 minutes	<=2.96%	May-22	16.7%
Emergency Department	% of ambulance handovers over 60 minutes	<=1%	May-22	53.4%
Maternity	% of women booked by 12 weeks gestation	>90%	May-22	91.5%
Operational Efficiency	Number of patients stable for discharge	<=70	May-22	238
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	May-22	495
Operational Efficiency	Average length of stay (spell)	<=5.06	May-22	6.7
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	May-22	8.1
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	May-22	2.3
Operational Efficiency	% day cases of all electives	>80%	May-22	81.1%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	May-22	88.2%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	May-22	81.5%
Operational Efficiency	Urgent cancelled operations	No target	May-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		May-22	2.03	
Outpatient	Did not attend (DNA) rates	<=7.6%		May-22	6.8%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%		Apr-22	7.5%	
Research	Research accruals	No target		May-22	135	
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		May-22	71.44%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		May-22	5,420	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		May-22	2,482	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		May-22	1,232	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	0		May-22	108	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		May-22	67.6%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Apr-22	97.7%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		May-22	71.0%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		May-22	70.4%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		May-22	26.70%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		May-22	26.7%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
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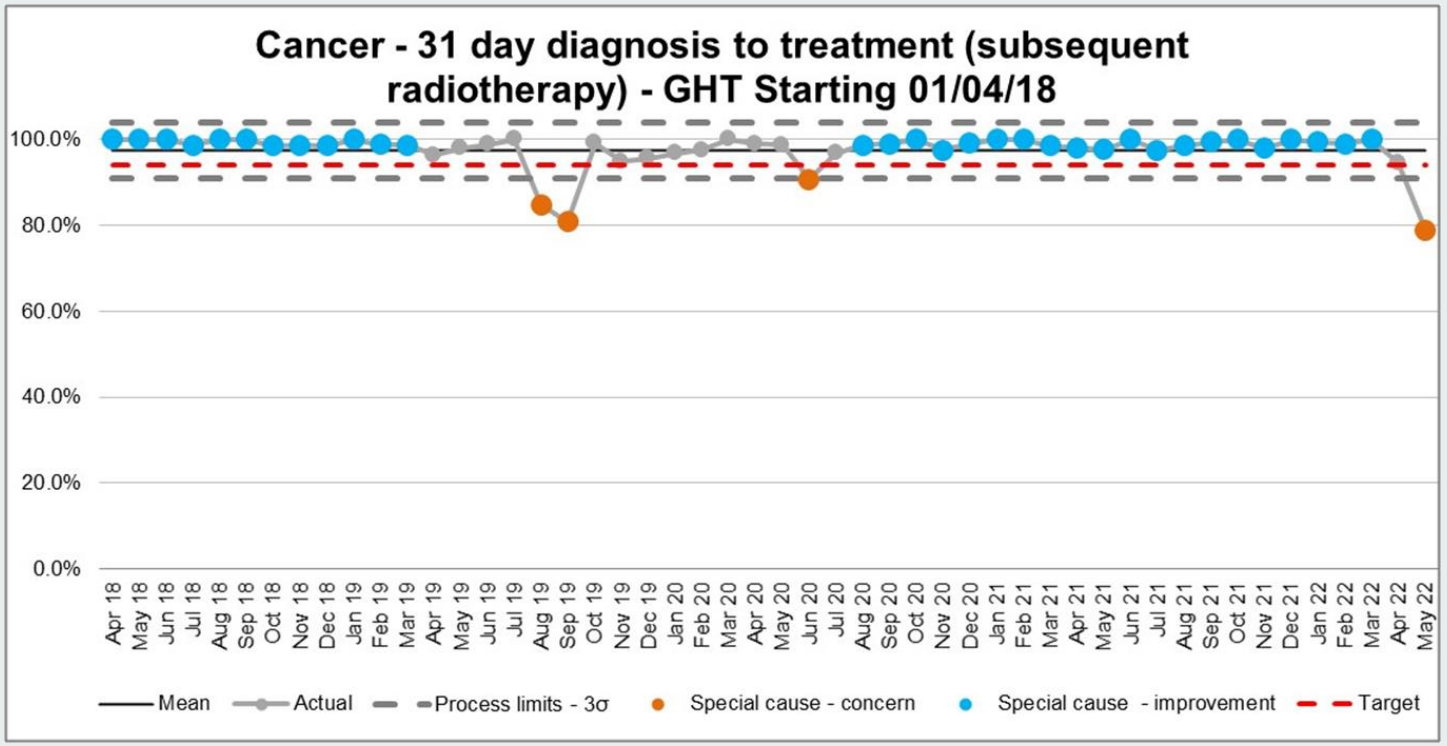


Commentary

Standard = 94%
National = 93% (March figures)
GHFT = 79.1%
Treated = 67 Breaches = 14
Radiotherapy under considerable pressure due to 15wte radiographer vacancies culminating in a treatment backlog. Risk going on Trust risk register. Mitigation plan in place.

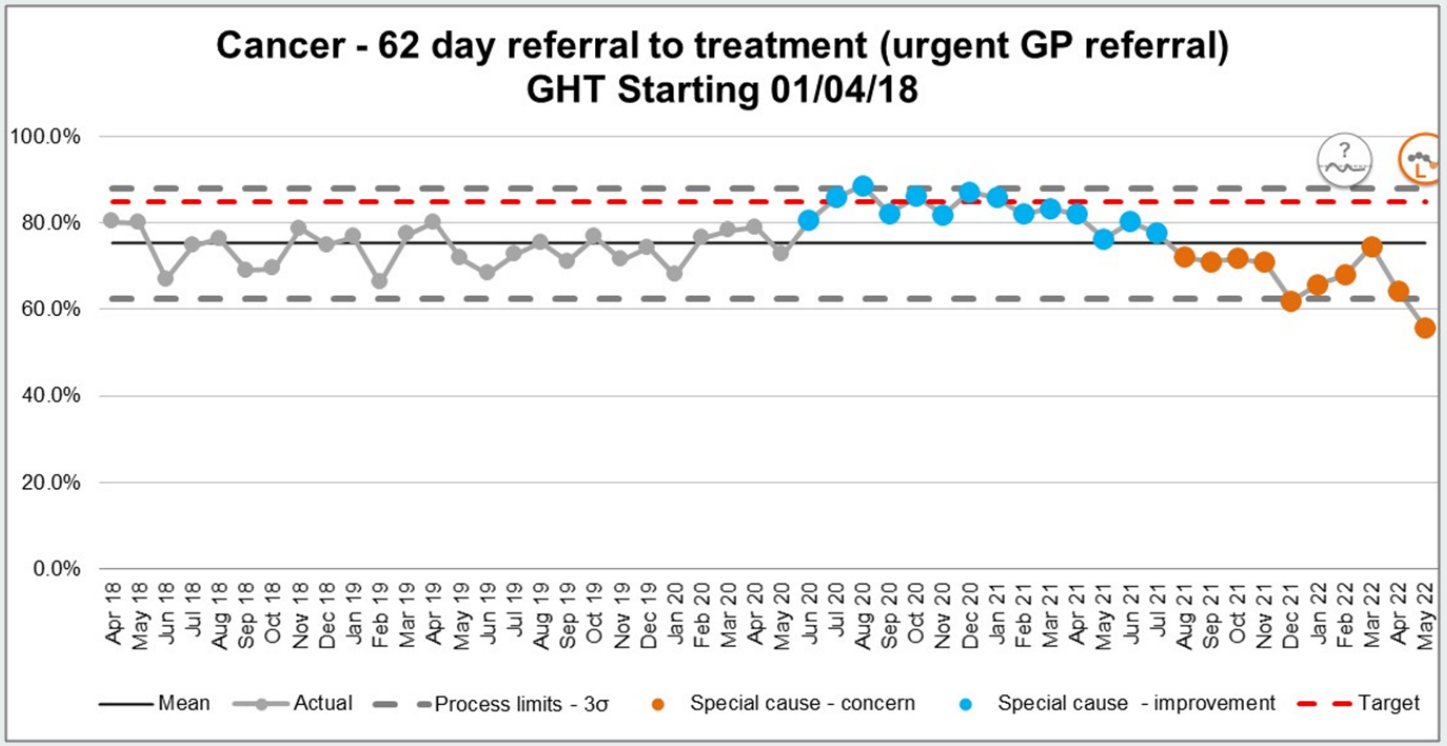
- General Manager - Cancer

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 = 90%
National = 74% (March)
GHFT = 80.8%

Treated= 26, Breaches= 5 Lower GI 4.5 Breast 0.5

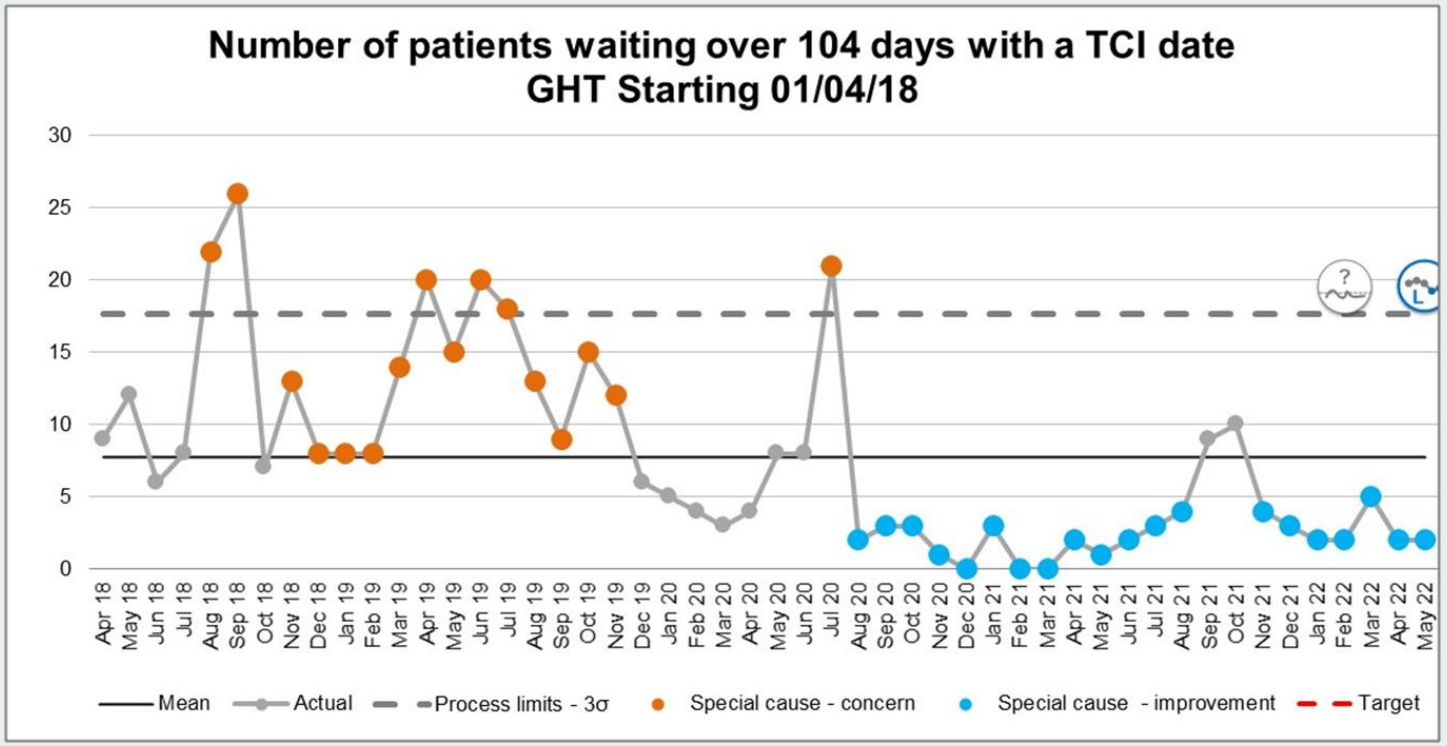
Three breaches relating to capacity for specialist surgery (TEMS).
- General Manager - Cancer

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.
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

Cancer category	No TCI	TCI	Cancer category	No TCI	TCI
Urological	50	1	Haematological	1	0
Lower GI	7	0	Head & neck	1	0
Upper GI	2	0	Gynaecological	1	0
Skin	1	1	Lung	1	0
Grand Total	65	2	Other	1	0

104's still impacted by prostate pathway. Patients now receiving biopsies but delays now seen in pathology and patients who remain on pathway for cancer treatment

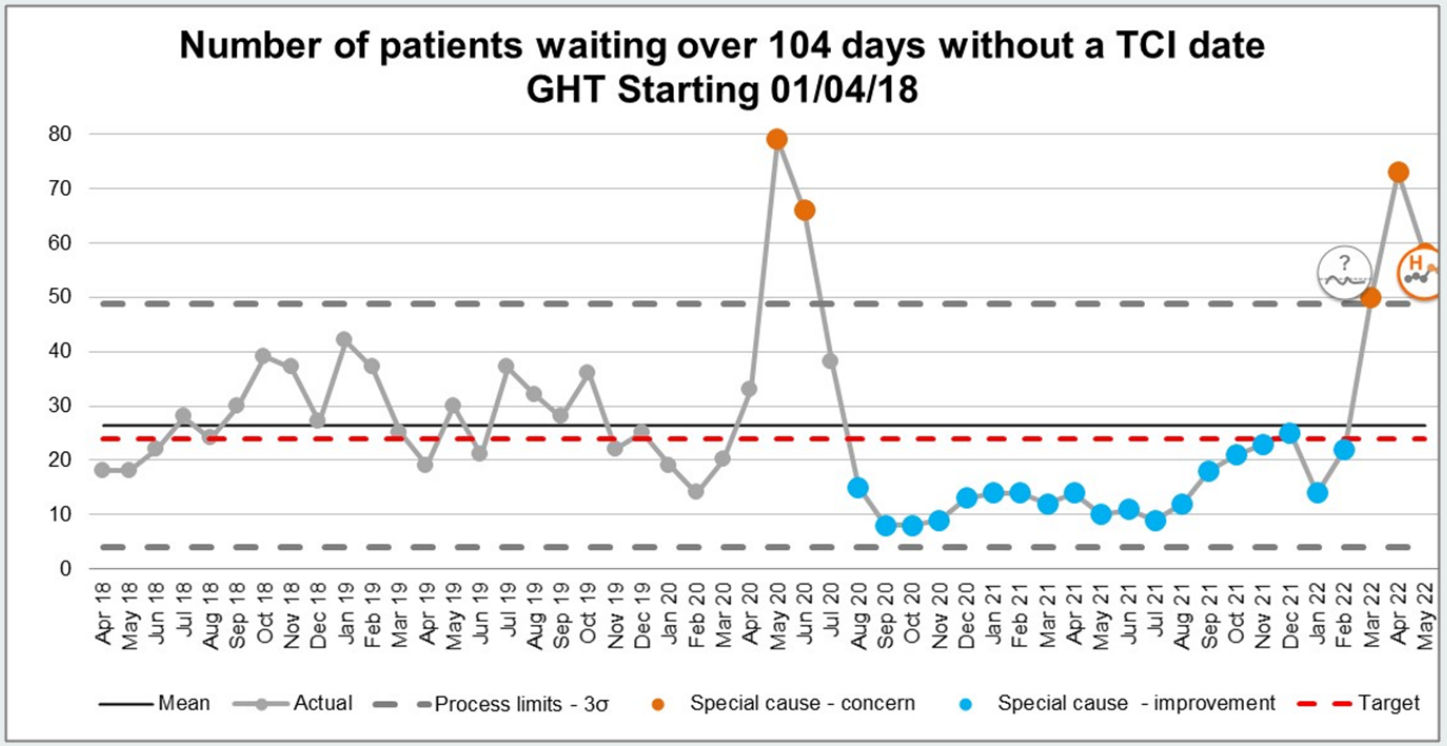
- General Manager - Cancer

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 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 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

Cancer category	No TCI	TCI	Cancer category	No TCI	TCI
Urological	50	1	Haematological	1	0
Lower GI	7	0	Head & neck	1	0
Upper GI	2	0	Gynaecological	1	0
Skin	1	1	Lung	1	0
Grand Total	65	2	Other	1	0

104's still impacted by prostate pathway. Patients now receiving biopsies but delays now seen in pathology and patients who remain on pathway for cancer treatment

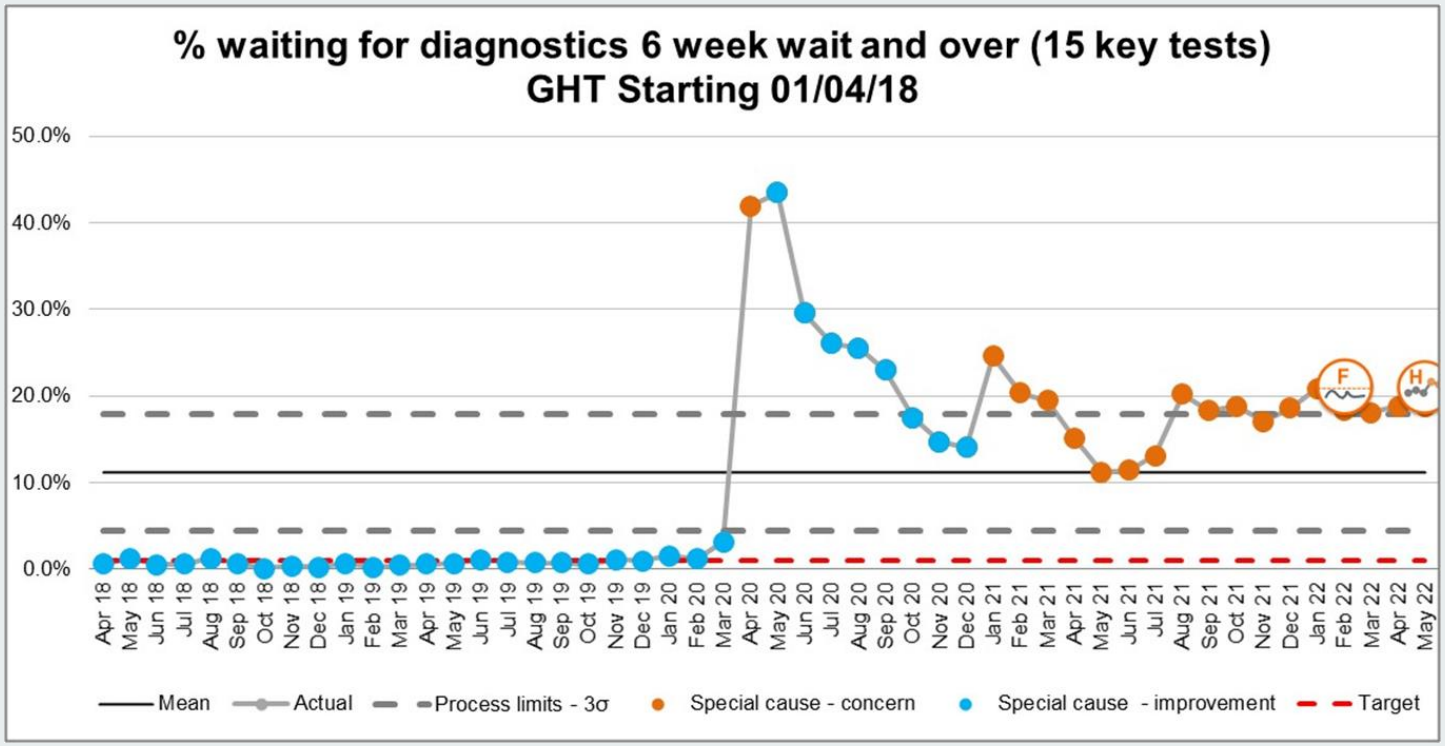
- General Manager - Cancer

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

Diagnostic performance continues to remain static with majority of the modalities performing within target. However, the typical figure of around 18% is predominantly associated with the number of breaches within the Echo service.

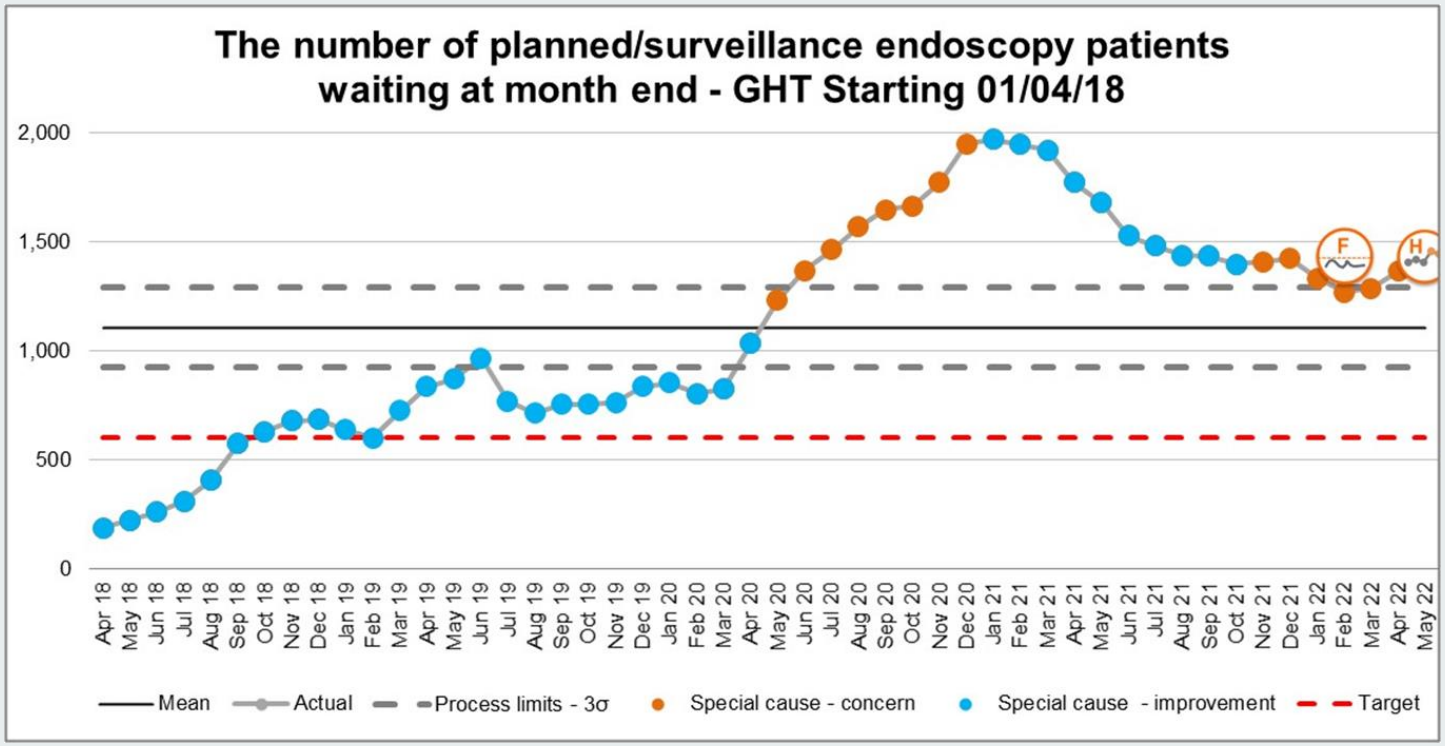
- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 24 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target - historically attempted to backfill with locum cover, and use of outsource capacity. Planned surveillance endoscopy breaches has increased slightly due to Sickness and leave, but expected to continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From July 2022, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog.

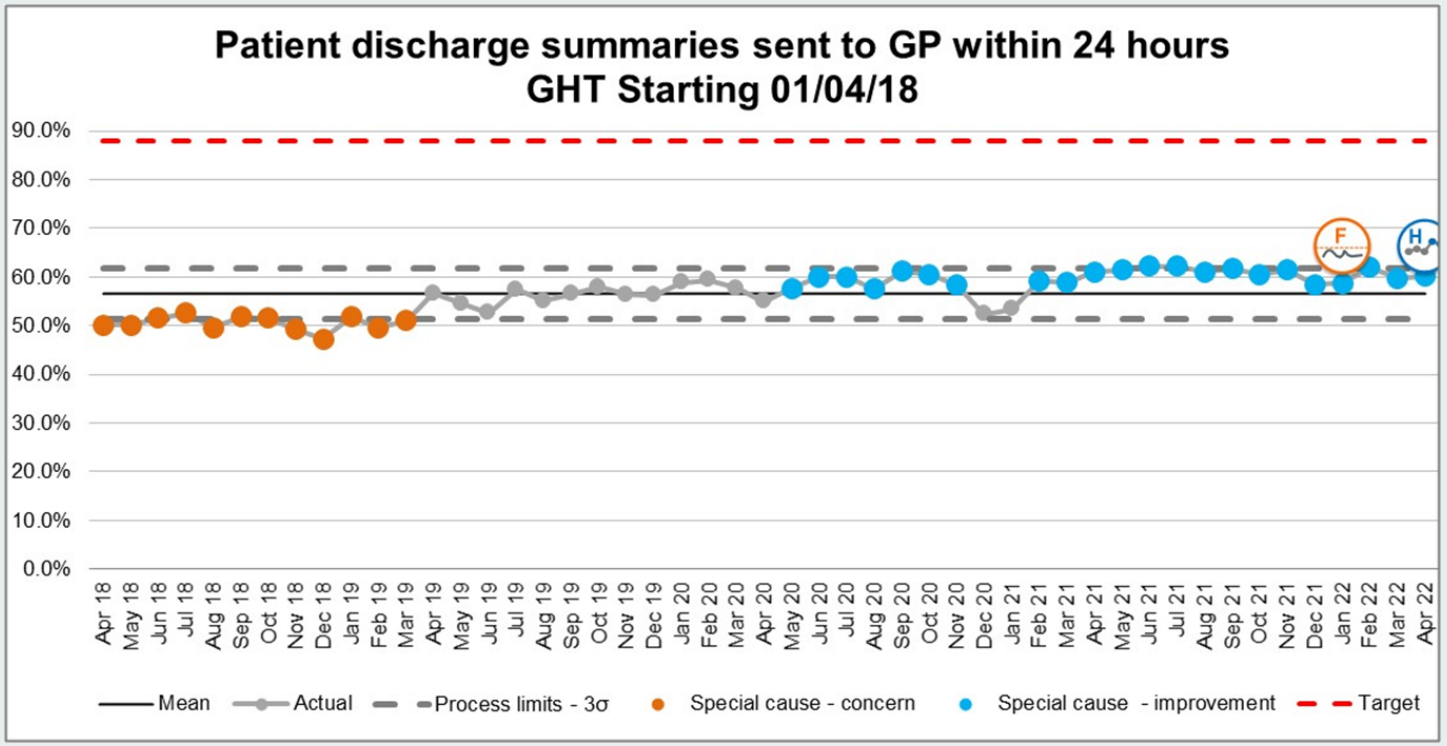
- Deputy General Manager of Endoscopy

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

This metric remains static, we are awaiting EPMA implementation to review this whole process

- 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.
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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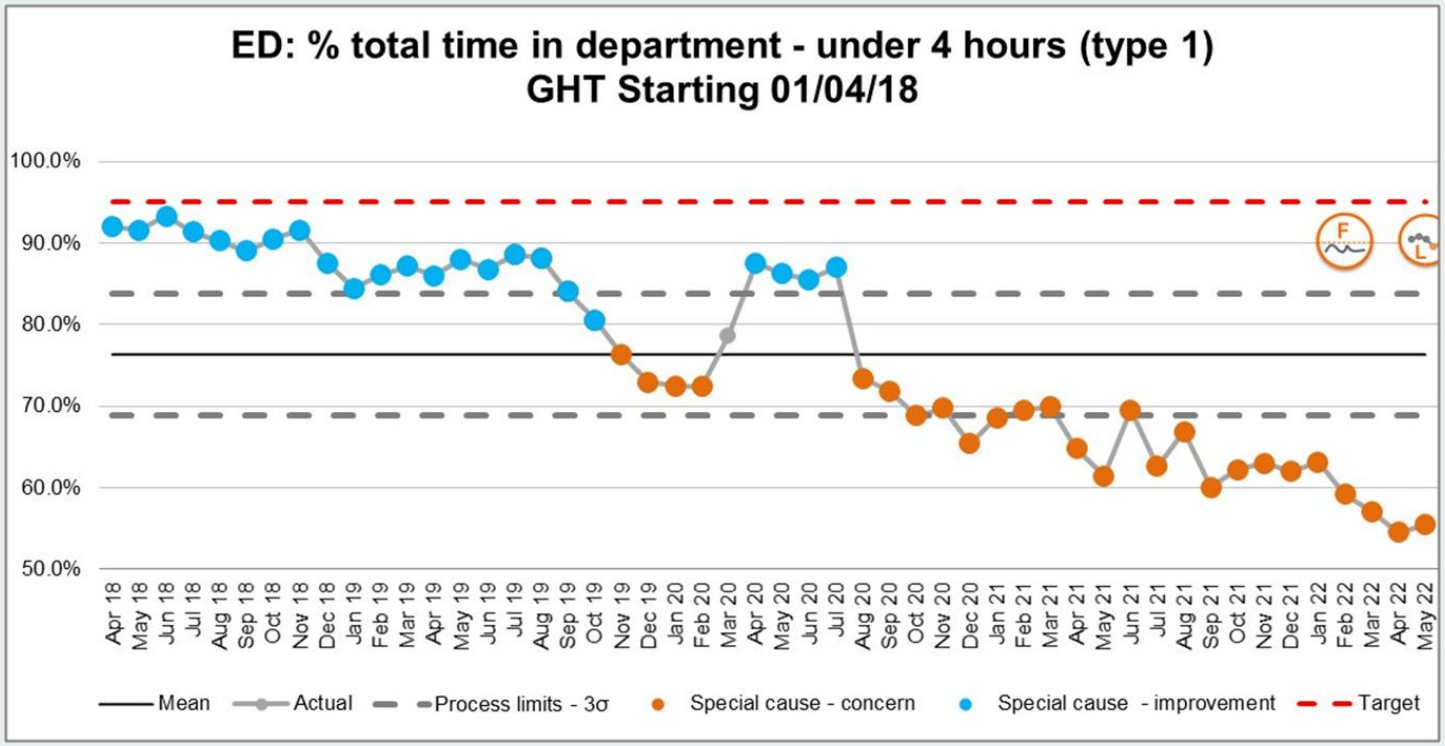

Commentary

Very modest improvement in overall time in department. An increase in the numbers of patients staying less than 4 hours is intended to continue. Representing a very modest improvement in flow out of the department. Target set for June as returning to 60% as a minimum. Specific and targeted leadership is to continue.

- 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
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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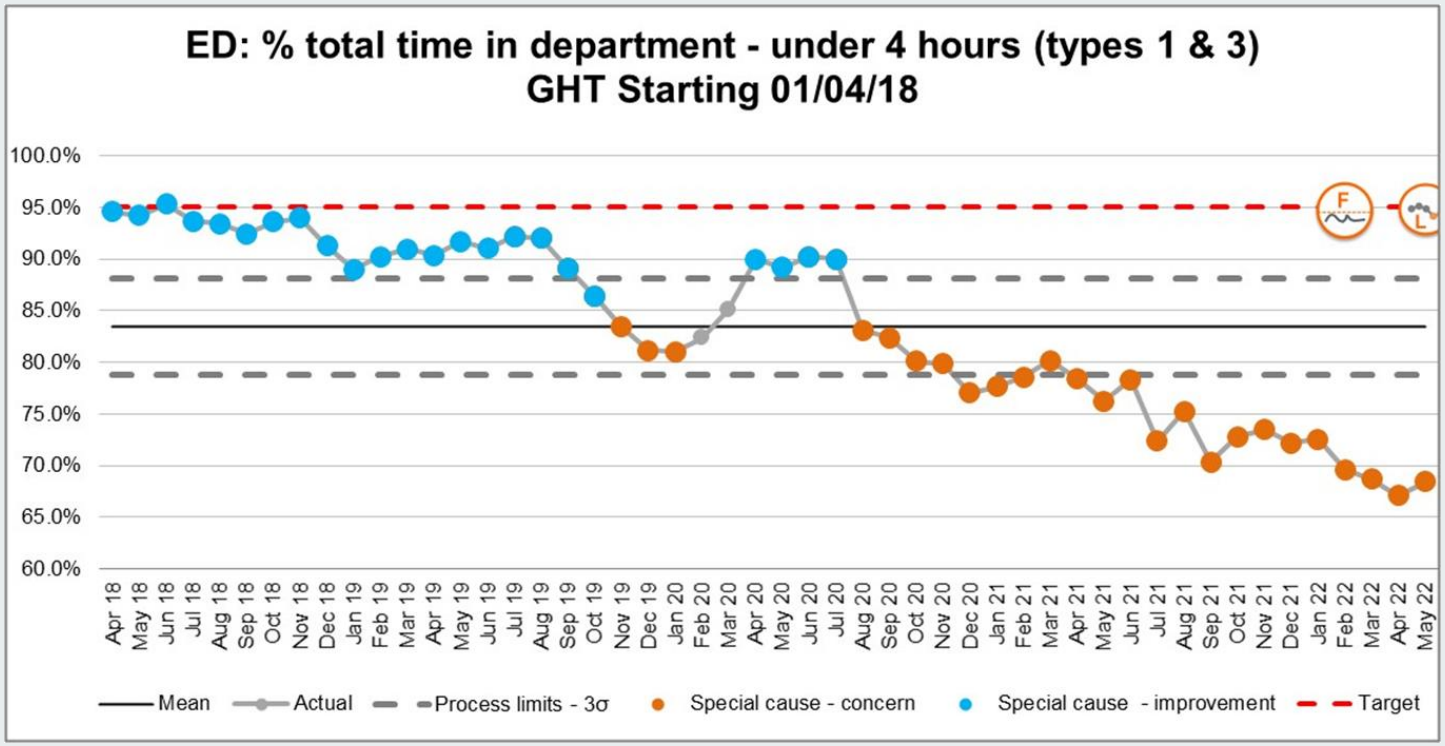
NHS Foundation Trust



Commentary

Modest improvement supported by more consistent availability of MIIU capacity, commencement of CATU initiative and targeted actions ahead of the May Bank Holiday and Jubilee Bank Holiday. Type 3 activity has remained high and has supported Type 1 performance overall.

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

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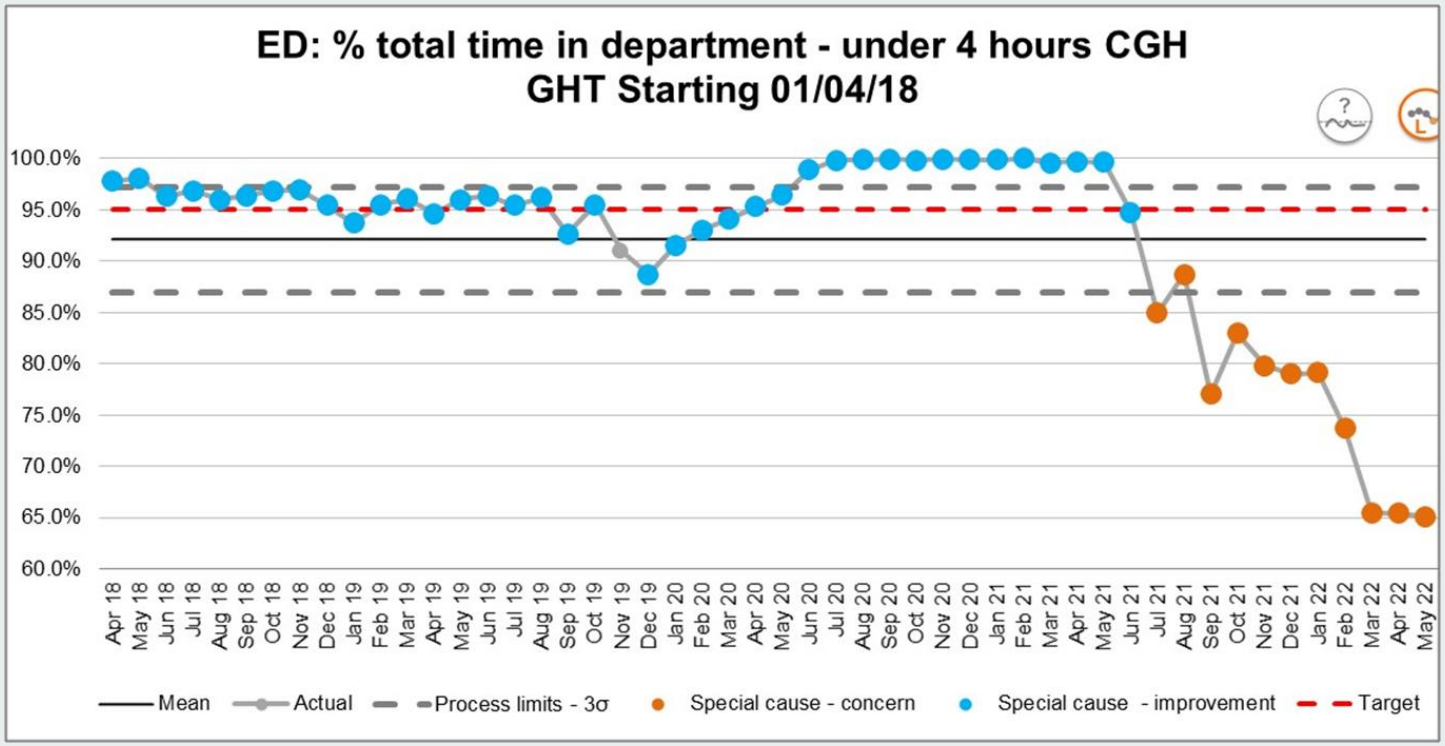
NHS Foundation Trust



Commentary

Very modest improvement in overall time in department. An increase in the numbers of patients staying less than 4 hours is intended to continue. Representing a very modest improvement in flow out of the department. Target set for June as returning to 60% as a minimum. Specific and targeted leadership is to continue. Specific focus on ringfenced capacity for Cardiac, Acute Stroke and RED patients to be maintained at all time minimising the delay in patient placement continues.

- 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 14 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above 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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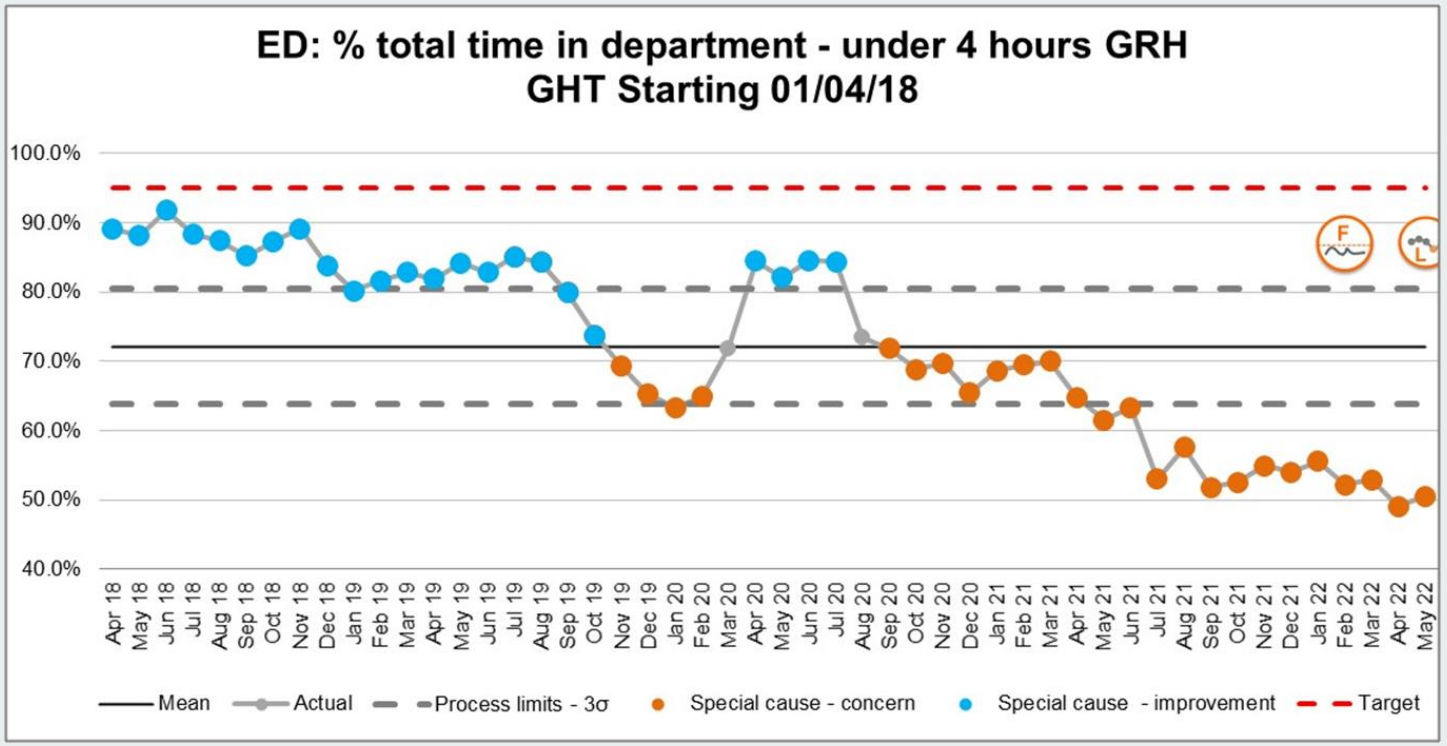
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Very modest deterioration in overall time in department. An increase in the numbers of patients staying less than 4 hours is intended to continue. Focus for June ongoing is the need to minimise the duration of stay and reduce 12 hour DTA breaches. Some sustained improvement in triage times, time to clinician and specific actions at time of exceptional demand have contributed to a stabilised position. These actions will promote an improvement of compliance in June. Target set for June as returning to 60% as a minimum. Specific and targeted leadership is to continue.

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

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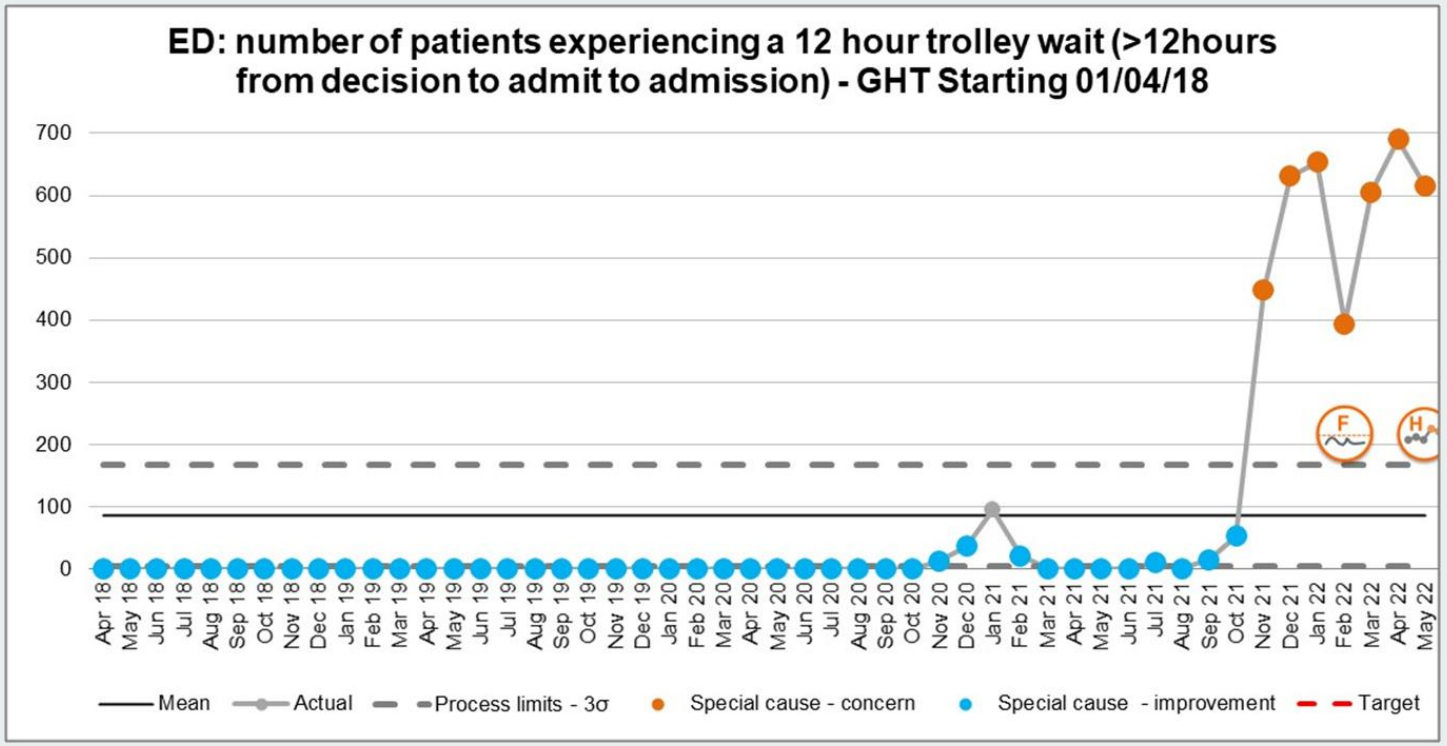
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Significant reduction in latter half of May to create capacity ahead of the Bank Holiday weekend, a focus on creating capacity at ward level, and targeted management input have positively contributed to the reduction. Recording of DTA remains a challenge, but targeted work is underway to continue improvement.

- 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 36 data points 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

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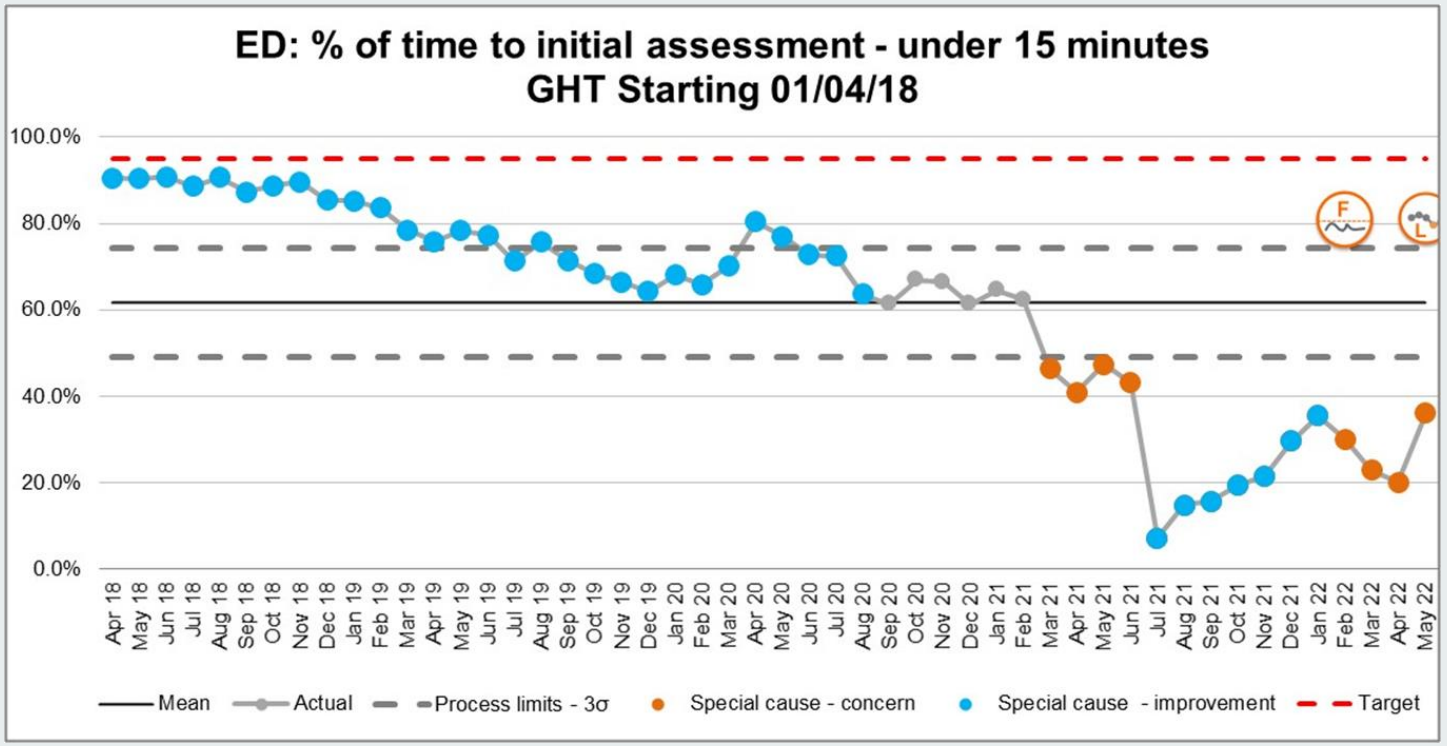
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Modest improvement from last month to focus on Triage times in department led by targeted clinical management. Appropriate capture and focus of skilled resource commenced mid-month and live data monitoring is demonstrated continued focus leading to an improved position and reducing time to triage. There were challenges on the CGH site on several occasions due to staff sickness required a temporary adhoc redistribution of skills between sites. There is focus on consistent cover being available; reduction in sickness absence amongst this small skilled cohort of staff; monitoring focus on time to triage performance at each bed/site meeting and ED huddle; Aim to reduce to 15 minutes for all patients where possible. This indicator contributes directly to duration of stay overall, and achievement of the 4hour standard.

- 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 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.
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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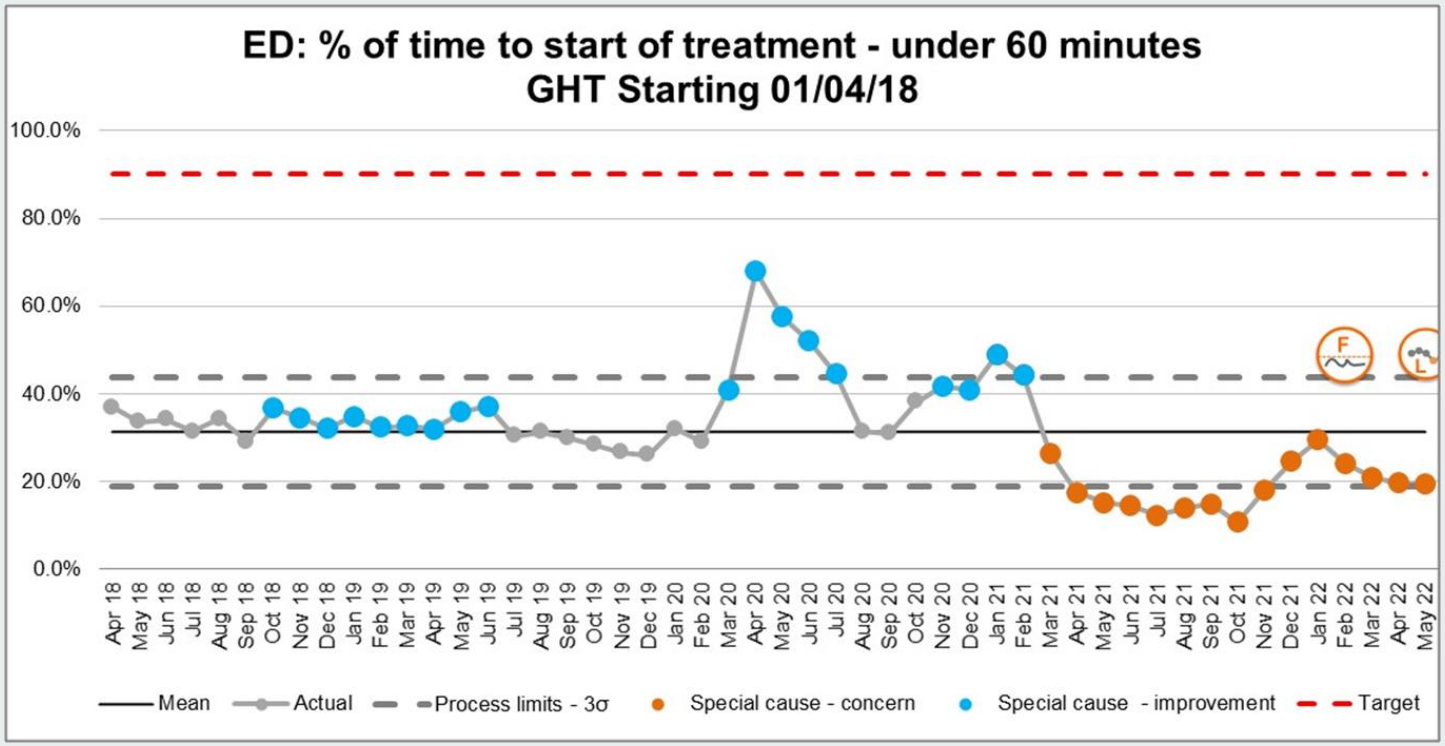
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Predominant factor of medical staff availability, shift and rota fill, and available capacity within the department proved challenging throughout May. External support has been commissioned to provide expert assessment and recommendation for more appropriate roster fill, and international recruitment of doctors who are due to be onboarded in May, June and July have yet to be fully realised. Weekend late shifts are particularly challenged. Additional scrutiny and 6,4,2 methodology to be employed in June to ensure better shift fill 7days per week. There is focus on consistent cover being available; reduction in sickness absence amongst this small skilled cohort of staff; monitoring focus on time to triage performance at each bed/site meeting and ED huddle; Aim to reduce to 15 minutes for all patients where possible. This indicator contributes directly to duration of stay overall, and achievement of the 4hour standard. There will be an assessment on time stamps within the department to ensure times are captured effectively.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above 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 this is a warning that the process may be changing

Access:
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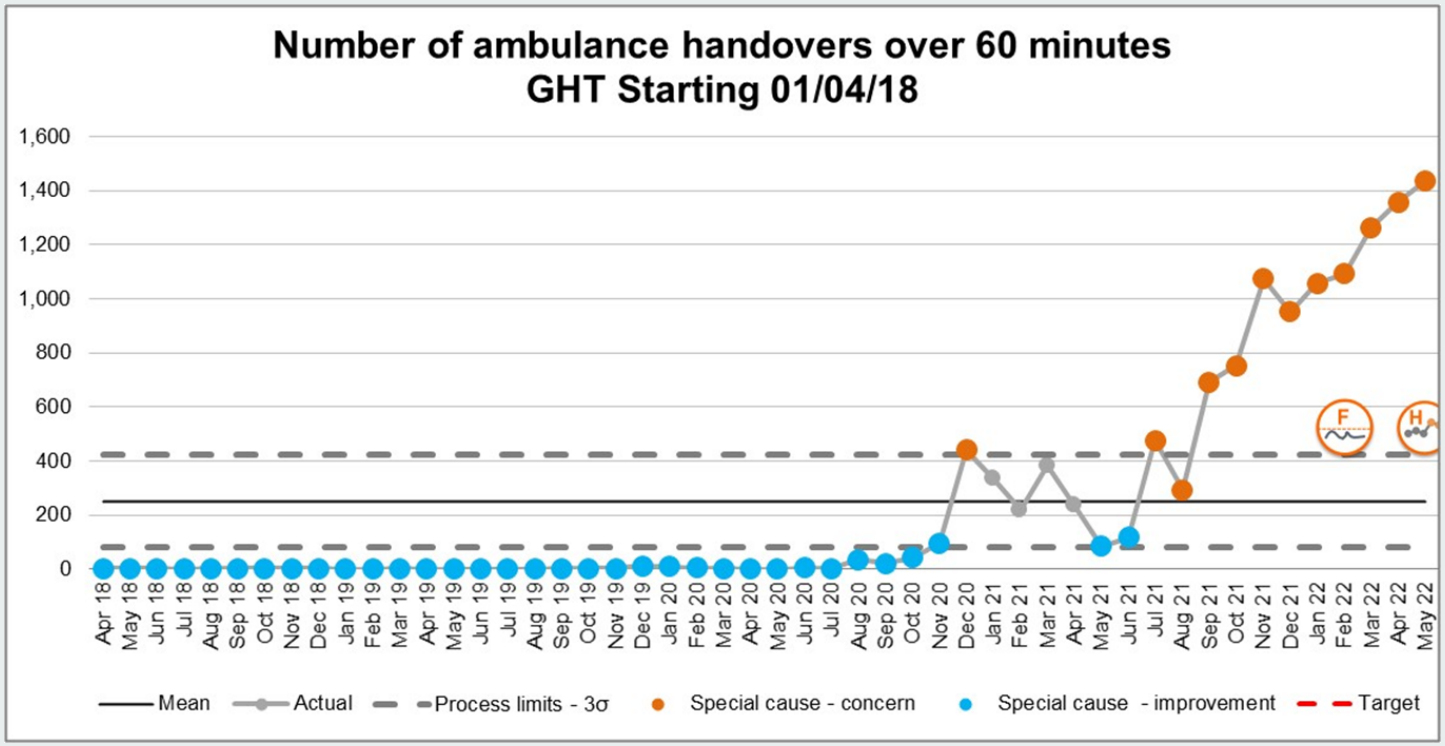
Gloucestershire Hospitals NHS Foundation Trust



Commentary

May has shown modest improvement from the April position with a 4% reduction in ambulance handovers exceeding 60 minutes. This is proving to be a stubborn KPI to improve at pace. A review of process, CAT1 "hot drop" compliance, and cohort capacity is underway to ensure this metric in on an improved trajectory. Targeted management input remains; Collaborative work with SWASFT colleagues; specific actions agreed and monitored by the UEC Board will contribute to continued improvement in June onwards.

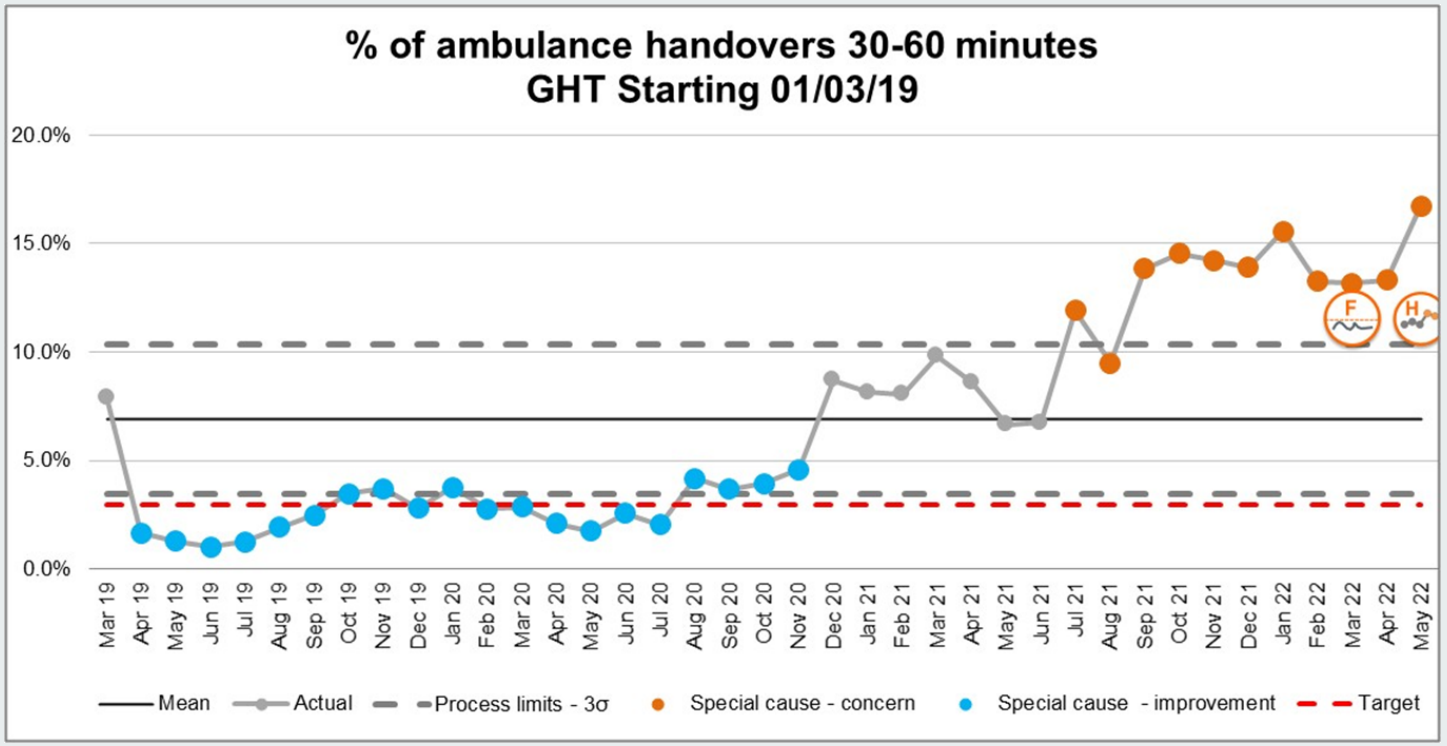
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 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

May has shown modest deterioration (3.5%) from the April position but represents overall a reduction in 60+ minutes handover delays. There is definitive left shift. This is a stubborn KPI to improve at pace. A review of process, CAT1 "hot drop" compliance, and cohort capacity is underway to ensure this metric in on an improved trajectory. Targeted management input remains; Collaborative work with SWASFT colleagues; specific actions agreed and monitored by the UEC Board will contribute to continued improvement in June onwards.

- 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 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

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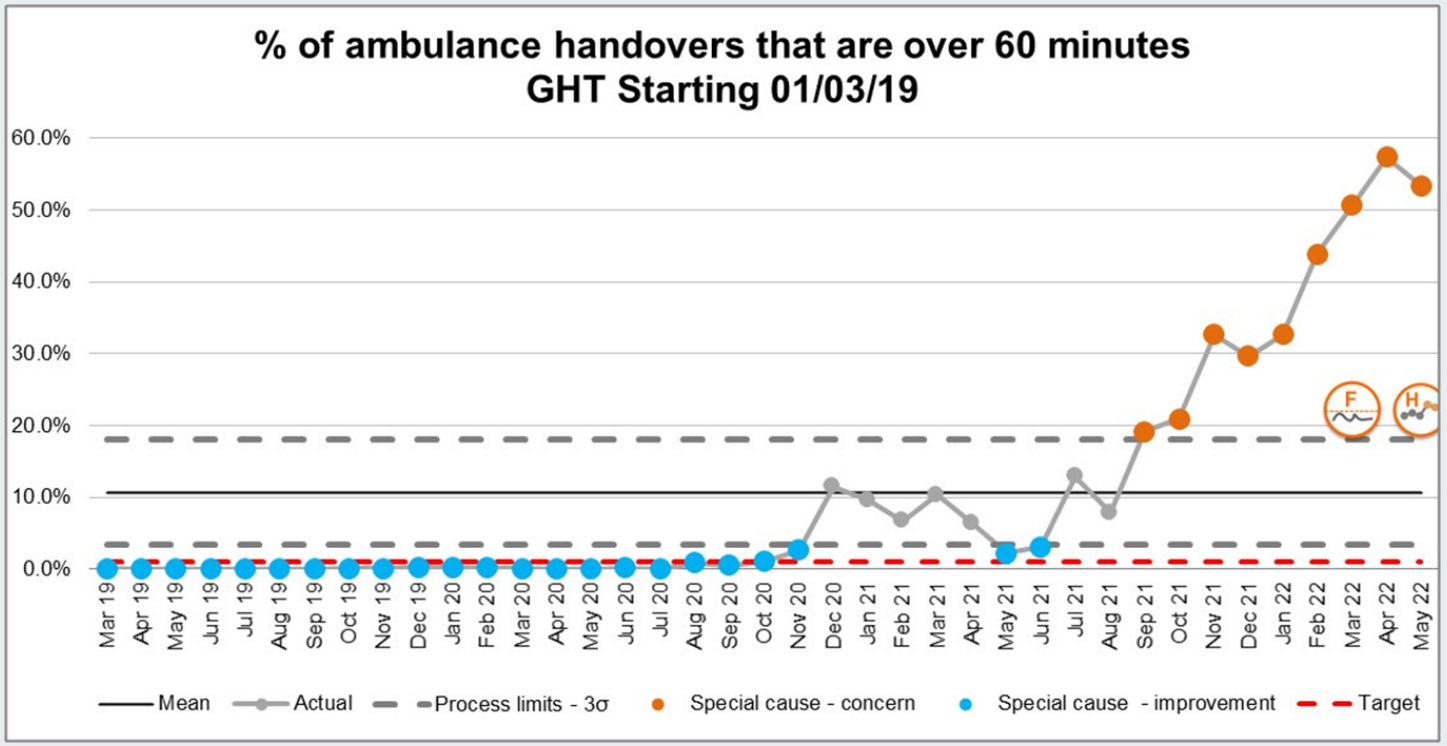

Commentary

May has shown modest improvement from the April position with a 4% reduction in ambulance handovers exceeding 60 minutes. This is proving to be a stubborn KPI to improve at pace. A review of process, CAT1 "hot drop" compliance, and cohort capacity is underway to ensure this metric in on an improved trajectory. Targeted management input remains; Collaborative work with SWASFT colleagues; specific actions agreed and monitored by the UEC Board will contribute to continued improvement in June onwards.

- 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 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 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

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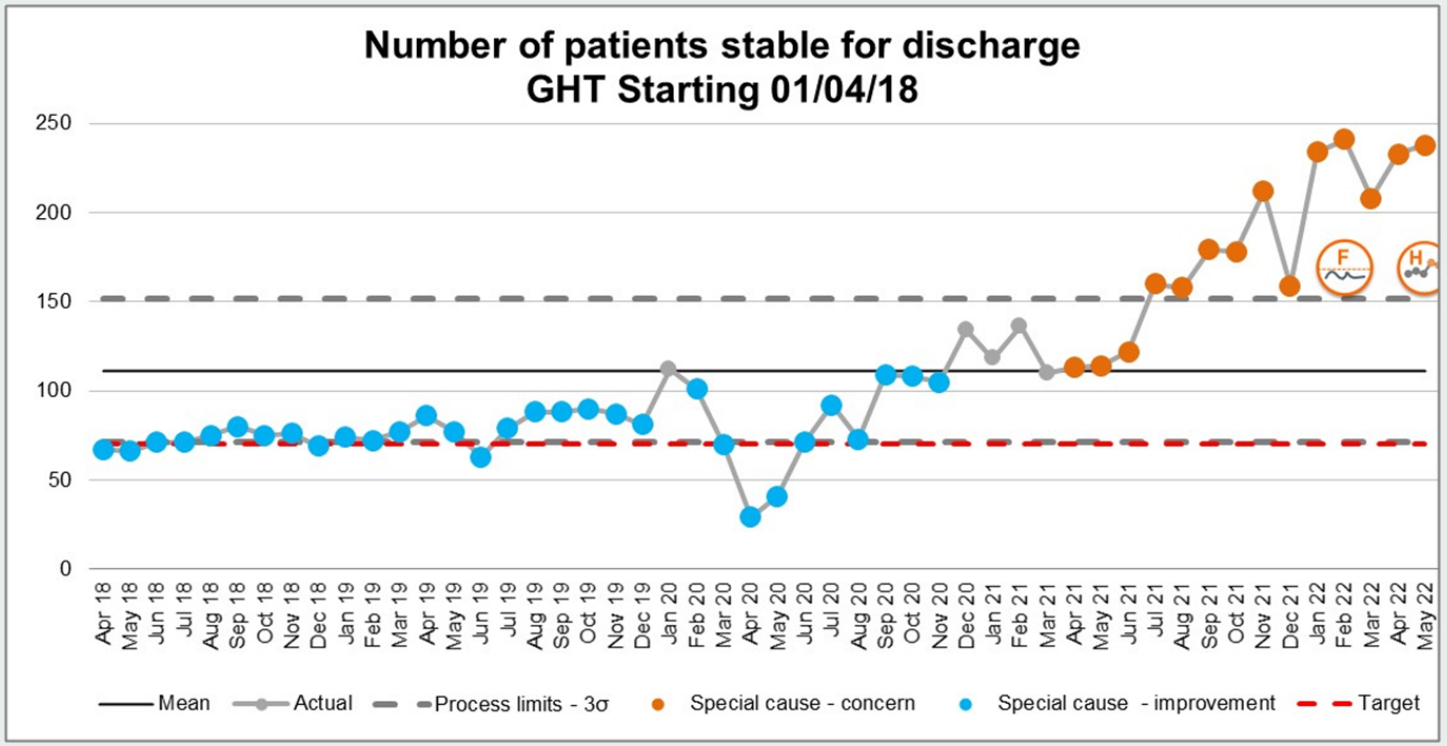

Commentary

nCTR numbers have reduced from a peak of 272 to now being 238, following ongoing work to drive discharges and enable conversion to pathway 0. System conversations ongoing with the creation of the OneGlos SLOMAN plan and the undertaking of a peer review process through the LGA.

- 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 11 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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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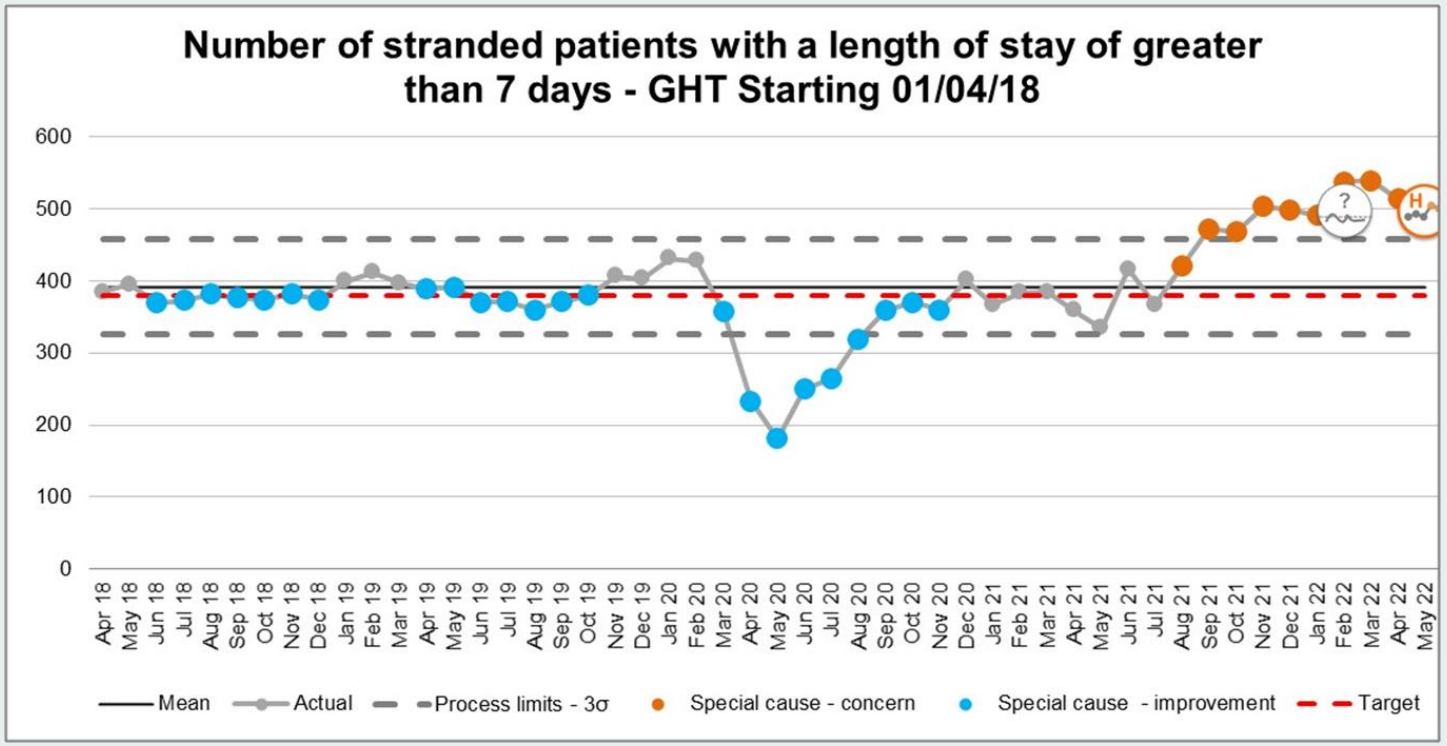

Commentary

Improvements in 7+ day LOS, volume of complex discharges overall ahead of the bank holidays and additional non-acute hospital based capacity (Home first starts, reduced closures if Care environments for C-19; and commencement of CATU capacity) have contributed over all. Still specific work recorded on the system-wide “SLOMAN action plan" to be key drivers for continued improvement.

- 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 9 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

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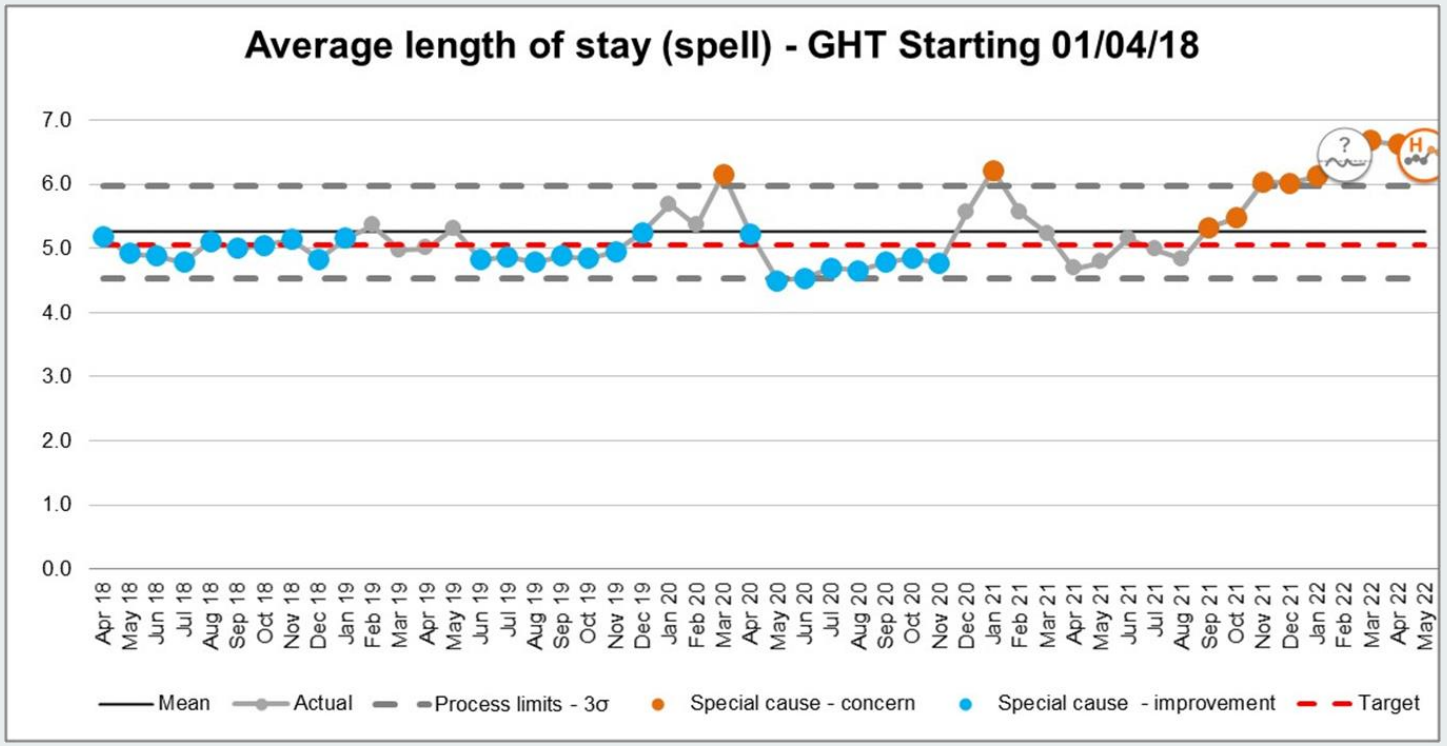

Commentary

Very slight improvement in month mainly due to focussed efforts to create capacity ahead of the Bank Holidays at beginning and end of may. Improved complex discharge volumes and focus on 75+day length of stay has had a positive contribution overall. There is intended to be marked improvement in June, and an aspiration to ensure that AVLOS indicators reduce by at least 1.3 days.

- 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 9 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

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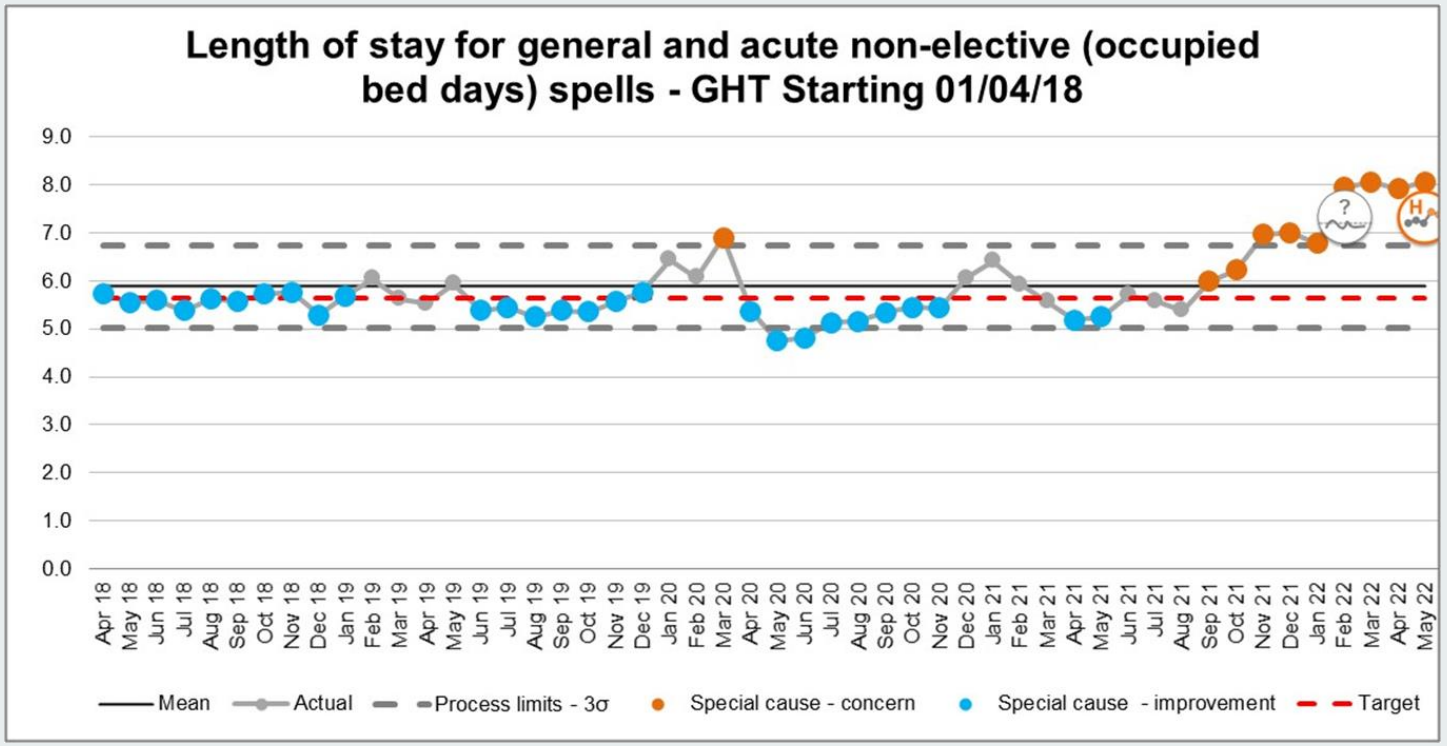

Commentary

The position has increased by around 0.25days from April. There are no remarkable factors affecting this indicator at this time, it remains a focus of other contributory KPIs such as pre-ED length of stay and overall duration of time in ED, which manifests in a cumulative until discharge. Focus on these indicators should have a positive impact on this metric.

- 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 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

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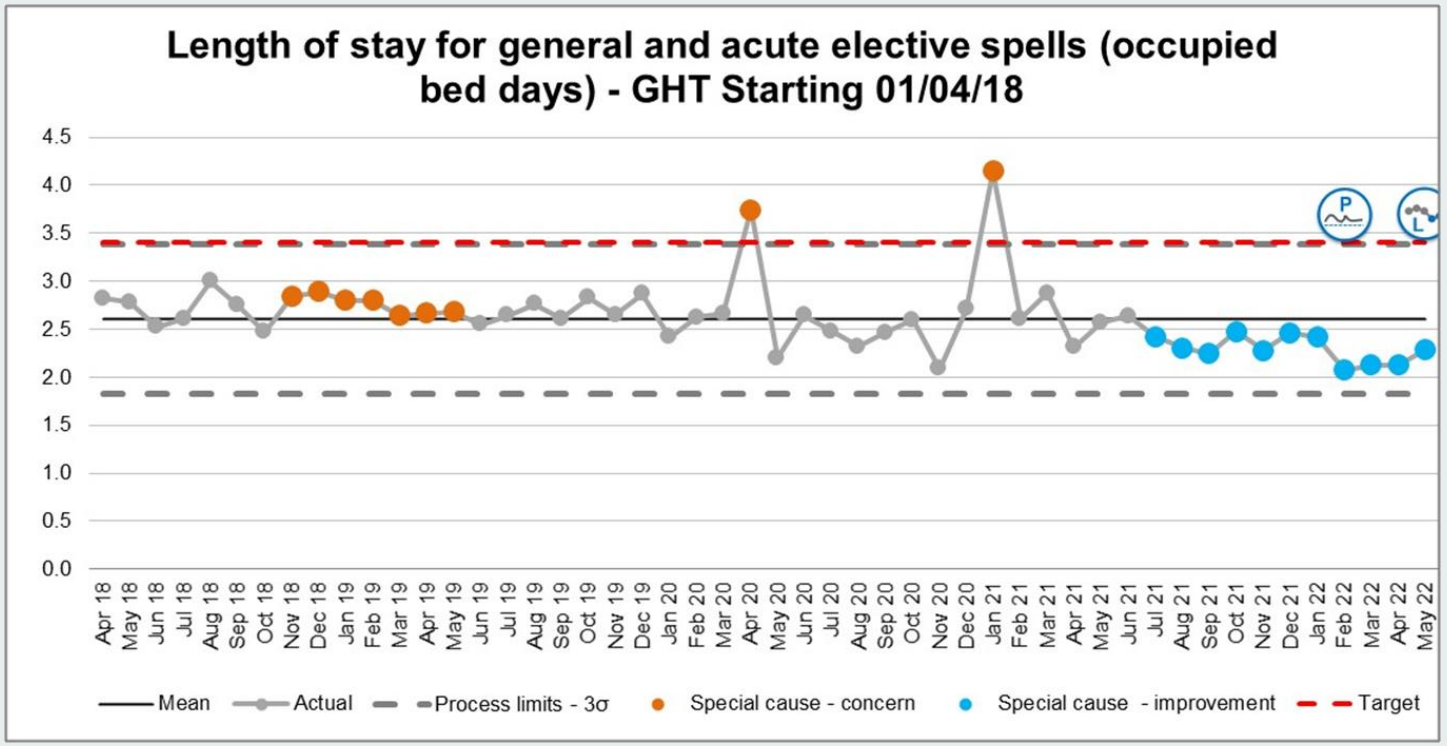

Commentary

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.

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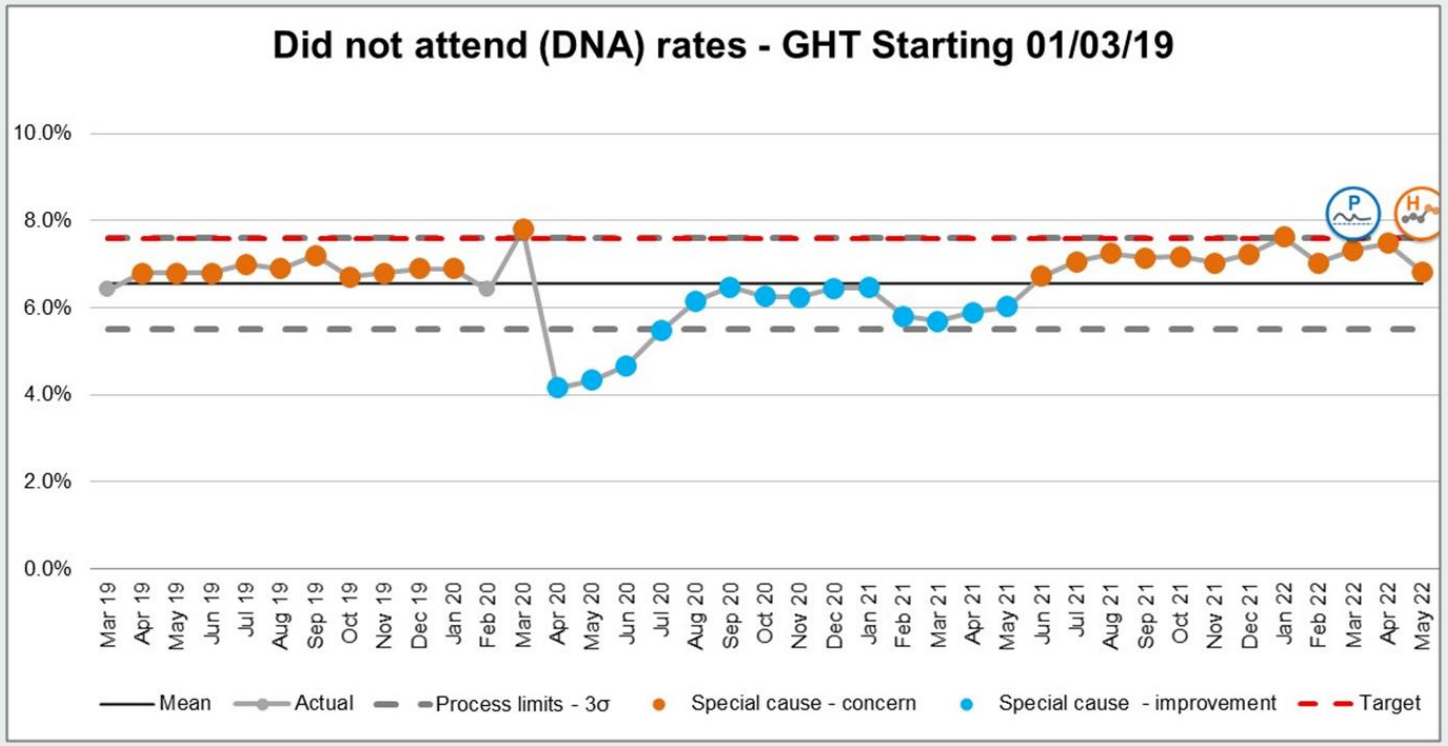

Commentary

The DNA rate continues to remain within target, although there was a stepped improvement, reducing from 7.48% to 6.83%. This improvement could potentially be attributed to the re-launch of the text reminder service for CBO booked services on 2nd May.

- 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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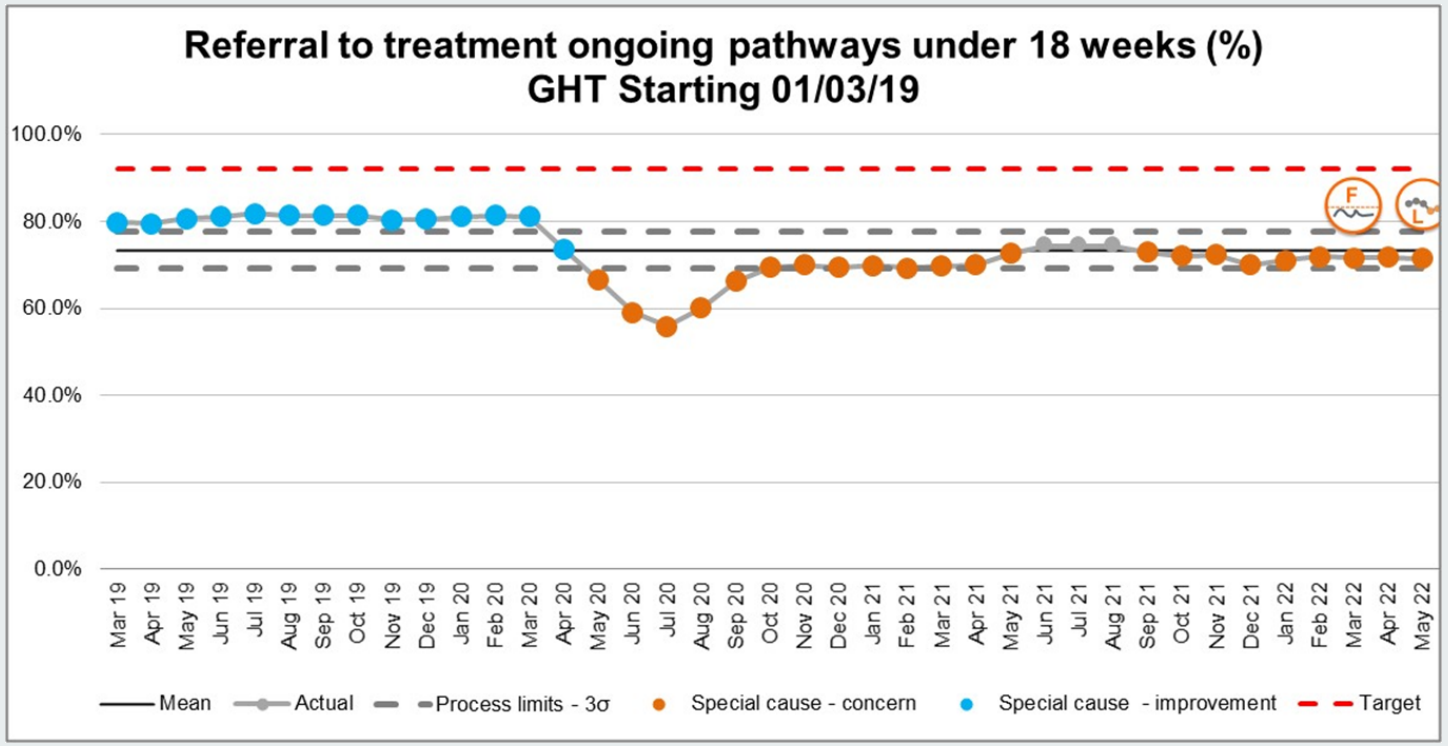

Commentary

See Planned Care Exception report for full details. RTT performance is currently reported as 71.44%. However, validation continues and at the point of submission this is anticipated to be 72.5% which will demonstrate an improving performance. This is attributed to both increased activity in May coupled with increased referrals/new clock starts (under 18 weeks)

- 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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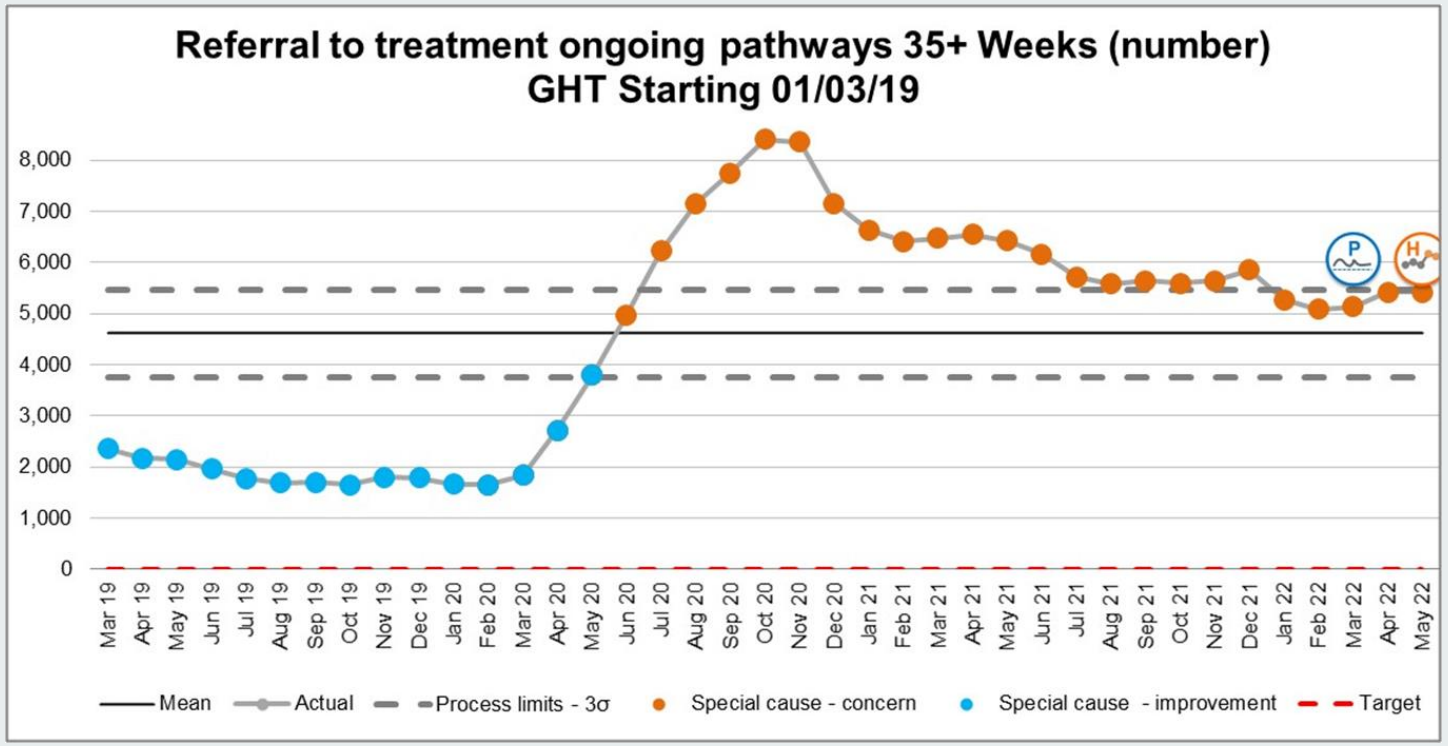

Commentary

The number of patients over 35 weeks has remained stable and comparable to last months position.

- Associate Director of Elective Care

Data Observations

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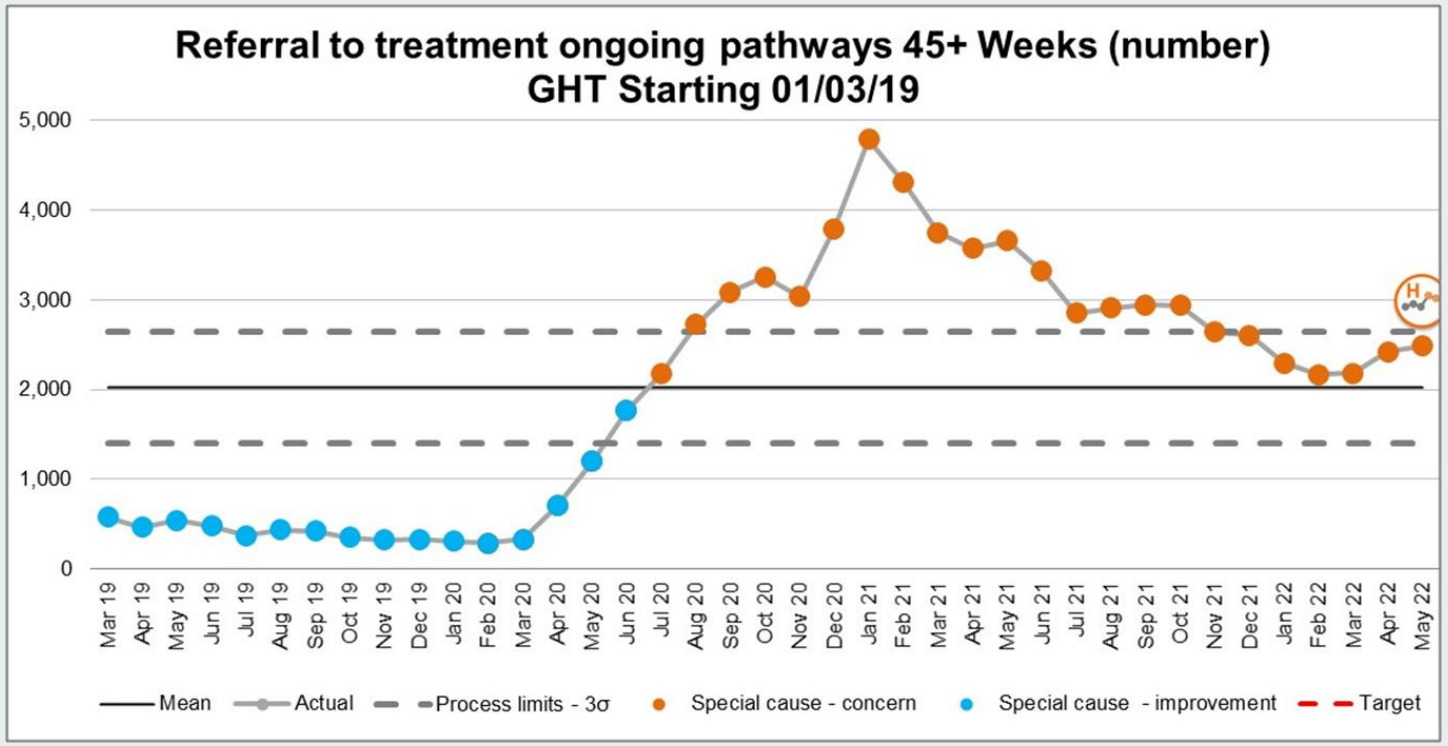


Commentary

As with the cohort over 35 weeks, this number has also remained very similar, with a slight increase of around 60 patients in month.

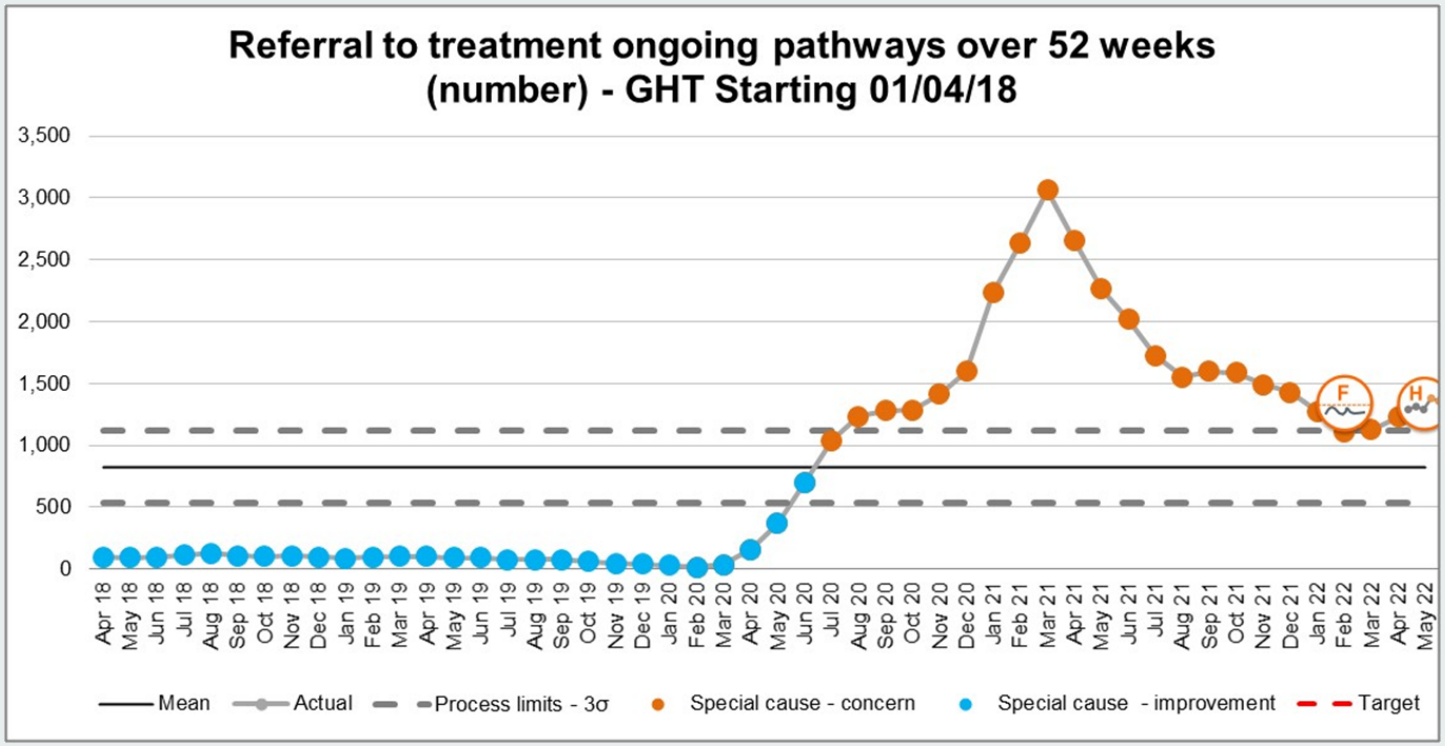
- Associate Director of Elective Care

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

See Planned Care Exception report for full details. Performance in May was forecast to be comparable to April. However a slight increase has occurred, partly compromised by an additional ~50 patients from Clinical Haematology being pulled into the data.

- 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 21 data points which are above the line. There are 26 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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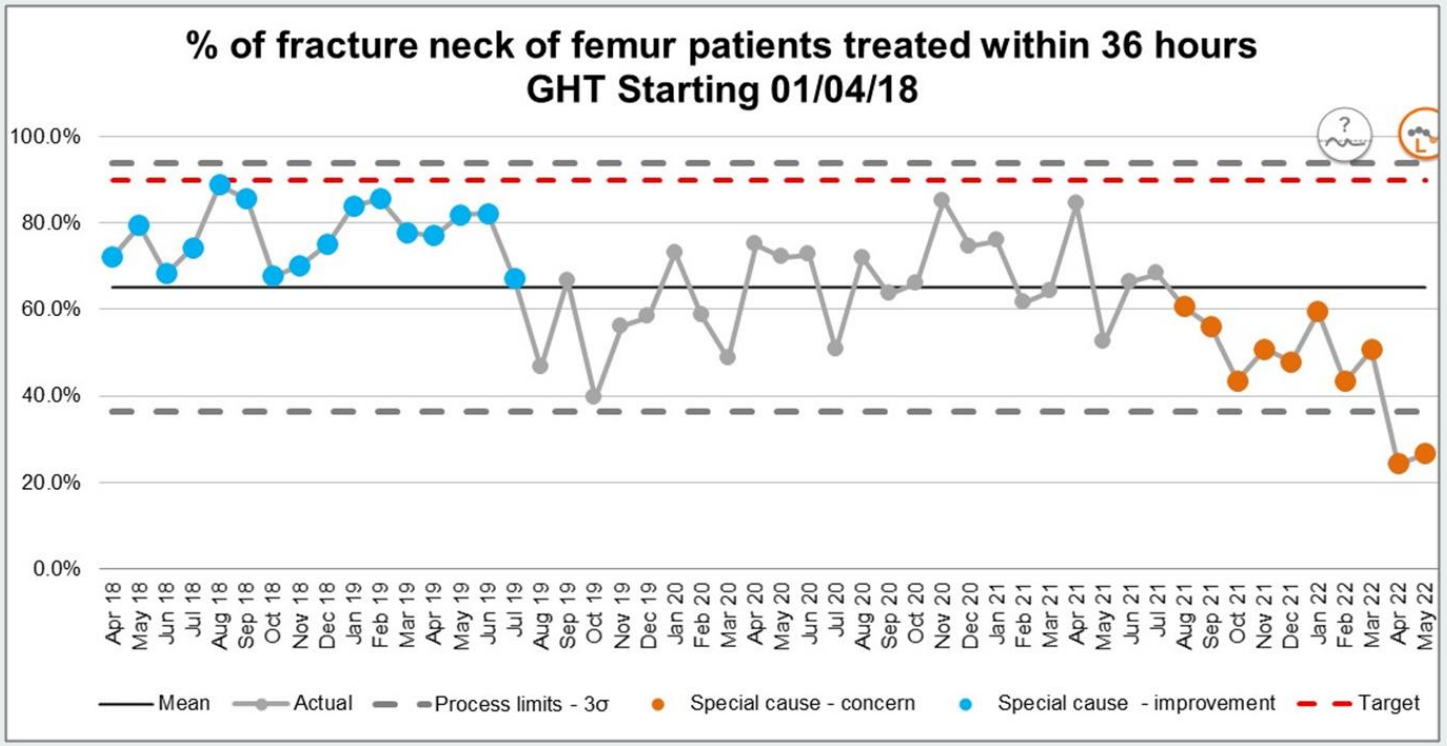
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

There has been an improvement in the delivery of surgical intervention in the surgical fractured neck of femur pathway in May (26.7%) compared to April (24.3%). There is still a significant recovery required to bring the performance back to the July 2021 position of 68.2% (the best position achieved in the last 12 months). The pathway deterioration can be attributed to the lack of available trauma beds on the GRH site since the loss of ward 2A to Vascular in COVID wave 1. The division are looking to move Vascular into another tower inpatient ward in order to return ward 2A back to the Trauma service. This is anticipated to take 12 months to achieve, owing to the Strategic Site Development estate works required to take place between August and May 2023 to facilitate the moves. In the meantime the service are looking at recovery actions on a local scale to facilitate more rapid admission to 3rd floor inpatient beds and reducing the length of stay on these wards associated with patients experiencing delayed discharge.

- 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 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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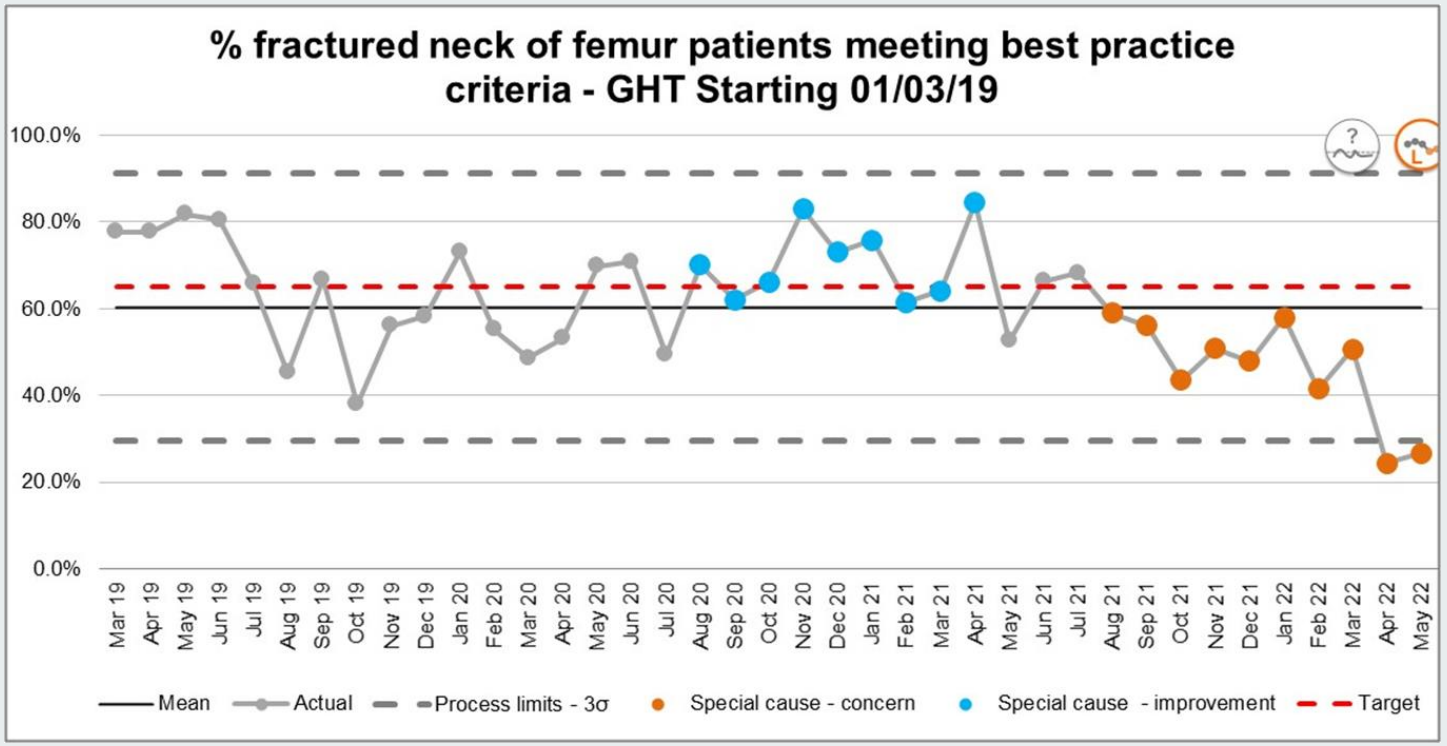
Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

There has been an improvement in the delivery of surgical intervention in the surgical fractured neck of femur pathway in May (26.7%) compared to April (24.3%). There is still a significant recovery required to bring the performance back to the July 2021 position of 68.2% (the best position achieved in the last 12 months). The pathway deterioration can be attributed to the lack of available trauma beds on the GRH site since the loss of ward 2A to Vascular in COVID wave 1. The division are looking to move Vascular into another tower inpatient ward in order to return ward 2A back to the Trauma service. This is anticipated to take 12 months to achieve, owing to the Strategic Site Development estate works required to take place between August and May 2023 to facilitate the moves. In the meantime the service are looking at recovery actions on a local scale to facilitate more rapid admission to 3rd floor inpatient beds and reducing the length of stay on these wards associated with patients experiencing delayed discharge.

- 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 are 2 data point(s) below the line
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2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Friends & Family Test	Inpatients % positive	>=90%	May-22	87.2%
Friends & Family Test	ED % positive	>=84%	May-22	66.9%
Friends & Family Test	Maternity % positive	>=97%	May-22	85.2%
Friends & Family Test	Outpatients % positive	>=94.5%	May-22	92.8%
Friends & Family Test	Total % positive	>=93%	May-22	87.4%
Friends & Family Test	Number of PALS concerns logged	No Target	May-22	253
Friends & Family Test	% of PALS concerns closed in 5 days	>=95%	May-22	75%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	May-22	0
Infection Control	MRSA bacteraemia - infection rate per 100,000 bed days	Zero	May-22	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	May-22	8
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	May-22	2
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	May-22	6
Infection Control	Clostridium difficile - infection rate per 100,000 bed days	<30.2	May-22	27.6
Infection Control	Number of MSSA bacteraemia cases	<=8	May-22	1
Infection Control	MSSA - infection rate per 100,000 bed days	<=12.7	May-22	3.5
Infection Control	Number of ecoli cases	No target	May-22	4
Infection Control	Number of pseudomona cases	No target	May-22	1
Infection Control	Number of klebsiella cases	No target	May-22	3
Infection Control	Number of bed days lost due to infection control outbreaks	<10	May-22	2
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No target	May-22	58

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	No target	May-22	59
Infection Control	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	No target	May-22	28
Infection Control	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	No target	May-22	38
Maternity	% C-section rate (planned and emergency)	No target	May-22	0
Maternity	% emergency C-section rate	No target	May-22	19.6%
Maternity	% of women smoking at delivery	<=14.5%	May-22	0
Maternity	% of women that have an induced labour	<=33%	May-22	35.2%
Maternity	% stillbirths as percentage of all pregnancies	<0.52%	May-22	0.00%
Maternity	% of women on a Continuity of Carer pathway	No target	May-22	9.10%
Maternity	% breastfeeding (initiation)	>=81%	May-22	77.6%
Maternity	% PPH >1.5 litres	<=4%	May-22	2.4%
Maternity	Number of births less than 27 weeks	NULL	May-22	0
Maternity	Number of births less than 34 weeks	NULL	May-22	8
Maternity	Number of births less than 37 weeks	NULL	May-22	35
Maternity	Number of maternal deaths	NULL	May-22	0
Maternity	Total births	NULL	May-22	465
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	May-22	2.37%
Maternity	% breastfeeding (discharge to CMW)	NULL	May-22	48.8%
Mortality	Summary hospital mortality indicator (SHMI) - national data	NHS Digital	Jan-22	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Feb-22	104
Mortality	Hospital standardised mortality ratio (HSMR) - weekend	Dr Foster	Feb-22	111.7

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.

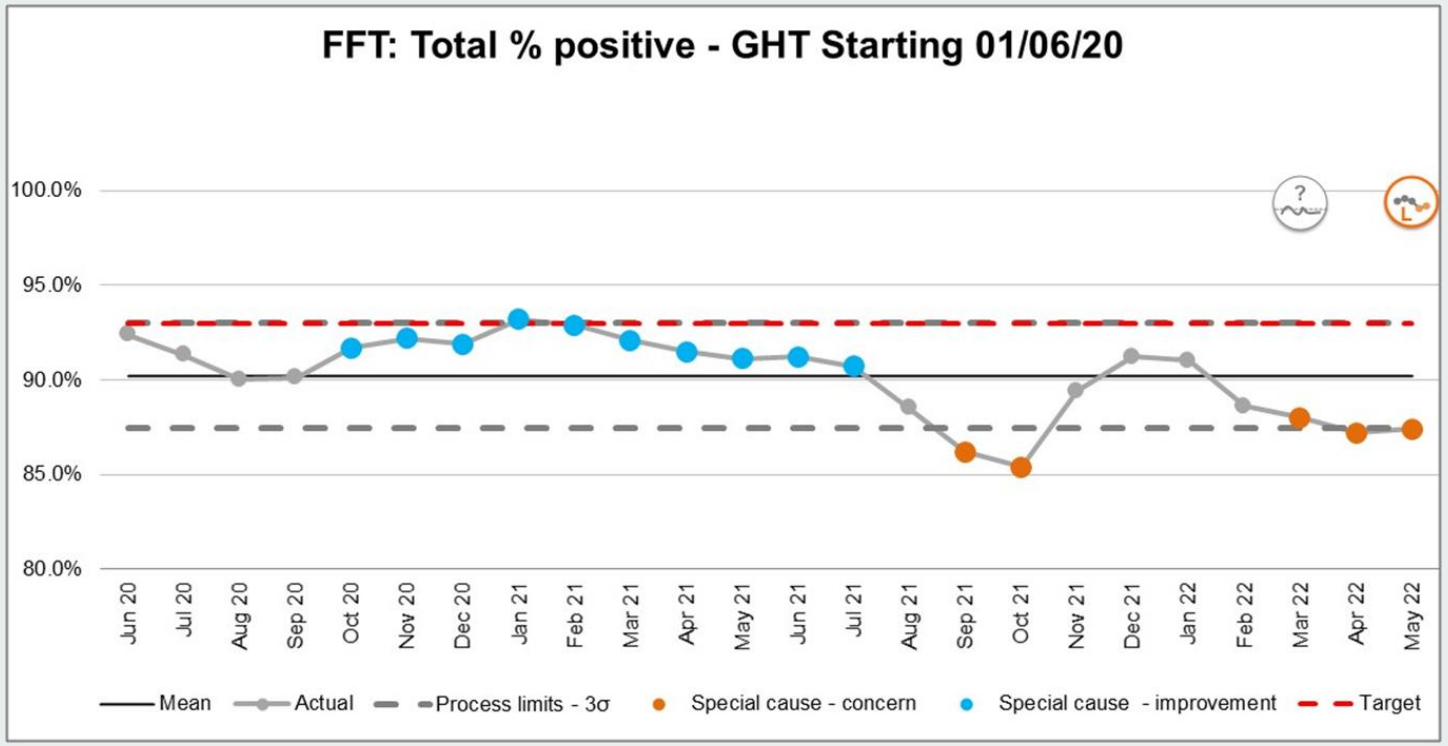
Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	May-22	174	
Mortality	Number of deaths of patients with a learning disability	No target	May-22	2	
MSA	Number of breaches of mixed sex accommodation	<=10	May-22	7	
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	May-22	6.9	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	May-22	4	
Patient Safety Incidents	Number of patient safety incidents - severe harm (major/death)	No target	May-22	8	
Patient Safety Incidents	Medication error resulting in severe harm	No target	May-22	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	May-22	5	
Patient Safety Incidents	Medication error resulting in low harm	No target	May-22	11	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	May-22	39	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	May-22	3	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	May-22	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	May-22	18	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	May-22	21	
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	May-22	0	
Serious Incidents	Number of serious incidents reported	No target	May-22	5	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Serious Incidents	Serious incidents - 72 hour report completed within contract timescale	>90%	May-22	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	May-22	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	May-22	88.5%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%	
Safeguarding	Number of DoLs applied for	No target	May-22	67	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	May-22	6	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	May-22	0	
Safeguarding	Total admissions aged 0-17 with DSH	No target	May-22	29	
Safeguarding	Total ED attendances aged 0-17 with DSH	No target	May-22	75	
Safeguarding	Total admissions aged 0-17 with an eating disorder	No target	May-22	10	
Safeguarding	Total number of maternity social concerns forms completed	No target	May-22	72	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The current positive FFT score for the Trust overall is at 87.4%, up slightly from 87.2% in April. 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.

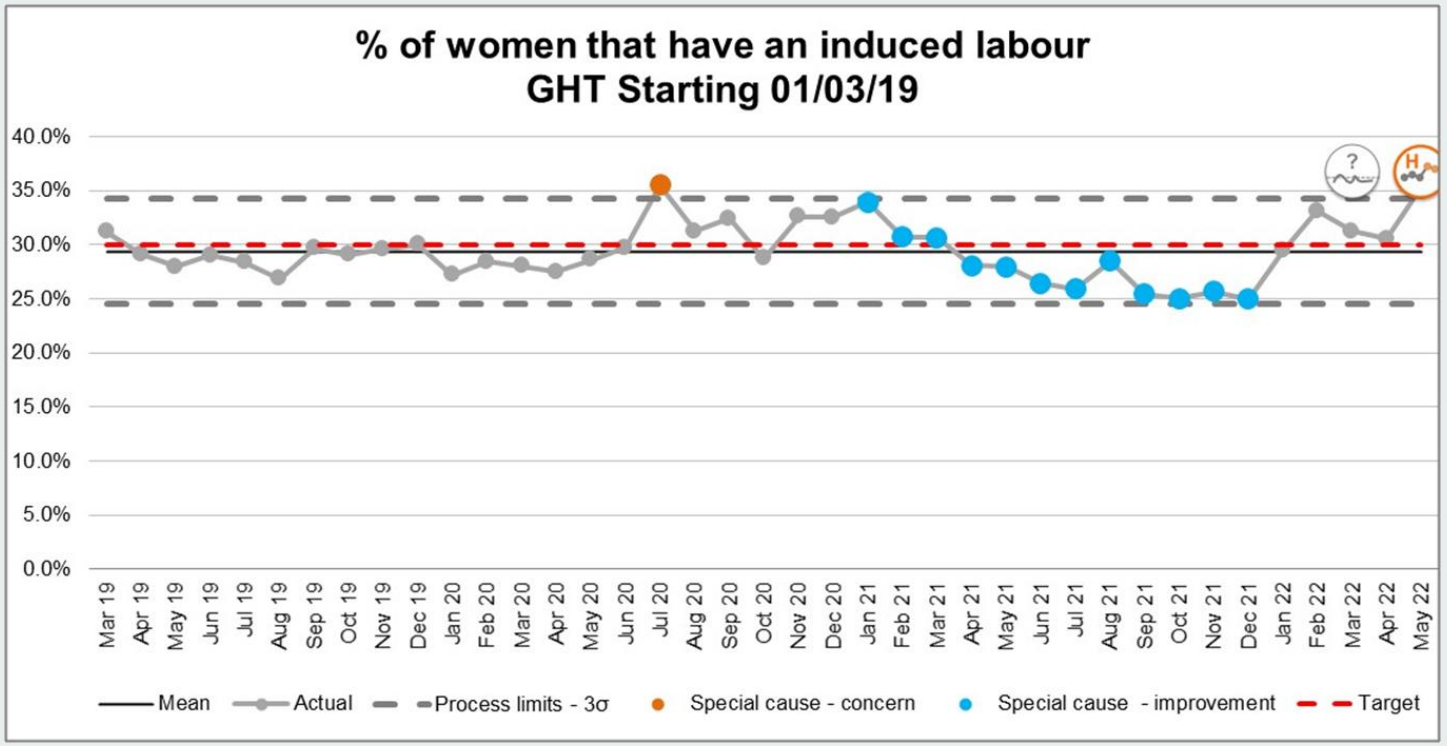
- Head of Quality

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 is 1 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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

An audit will be undertaken by the service to see if there are any trends responsible for the increase.

- Divisional Director of Quality and Nursing and Chief Midwife

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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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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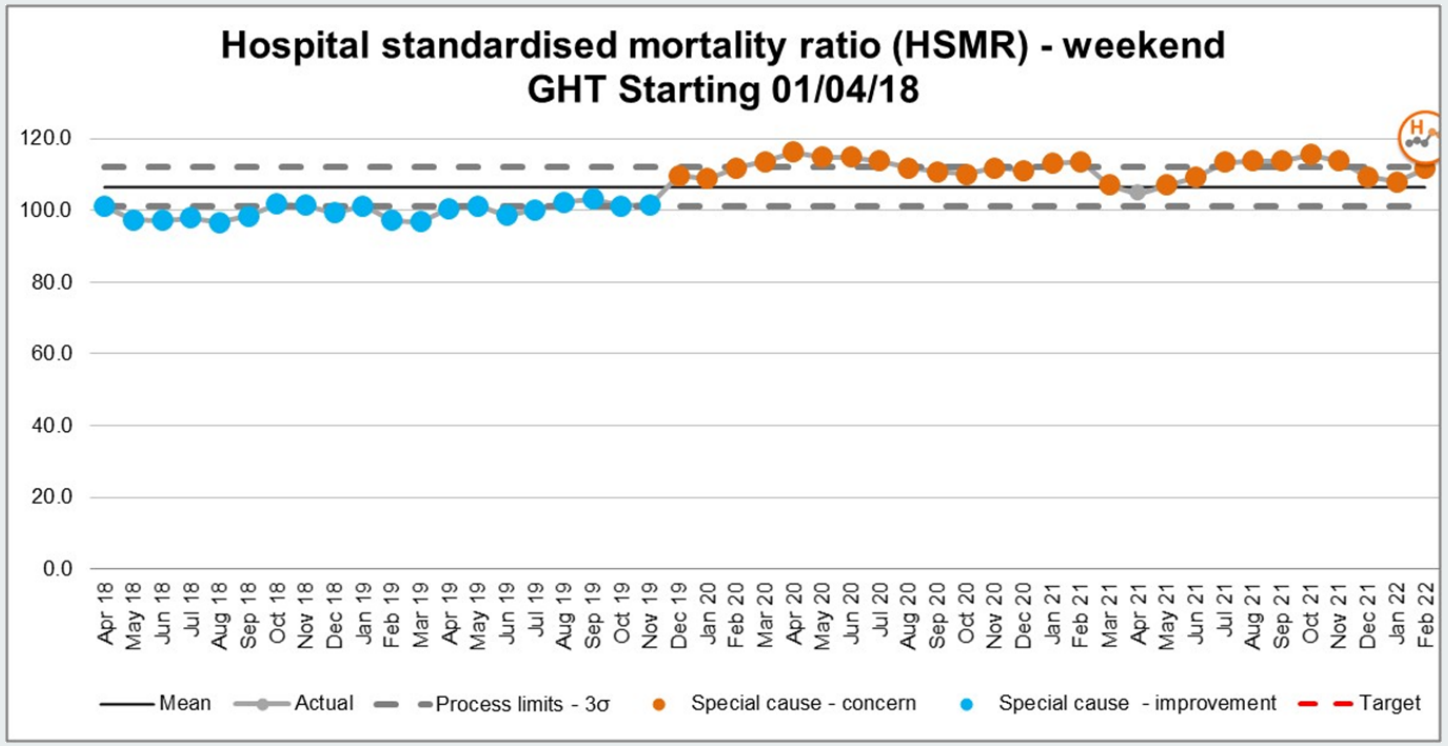
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

This metric is increased marginally this month but overall there has been an improvement due to the reduced effect of COVID on mortality. This will continue to be monitored in HMG, all other mortality metrics are within range

- 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 12 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.
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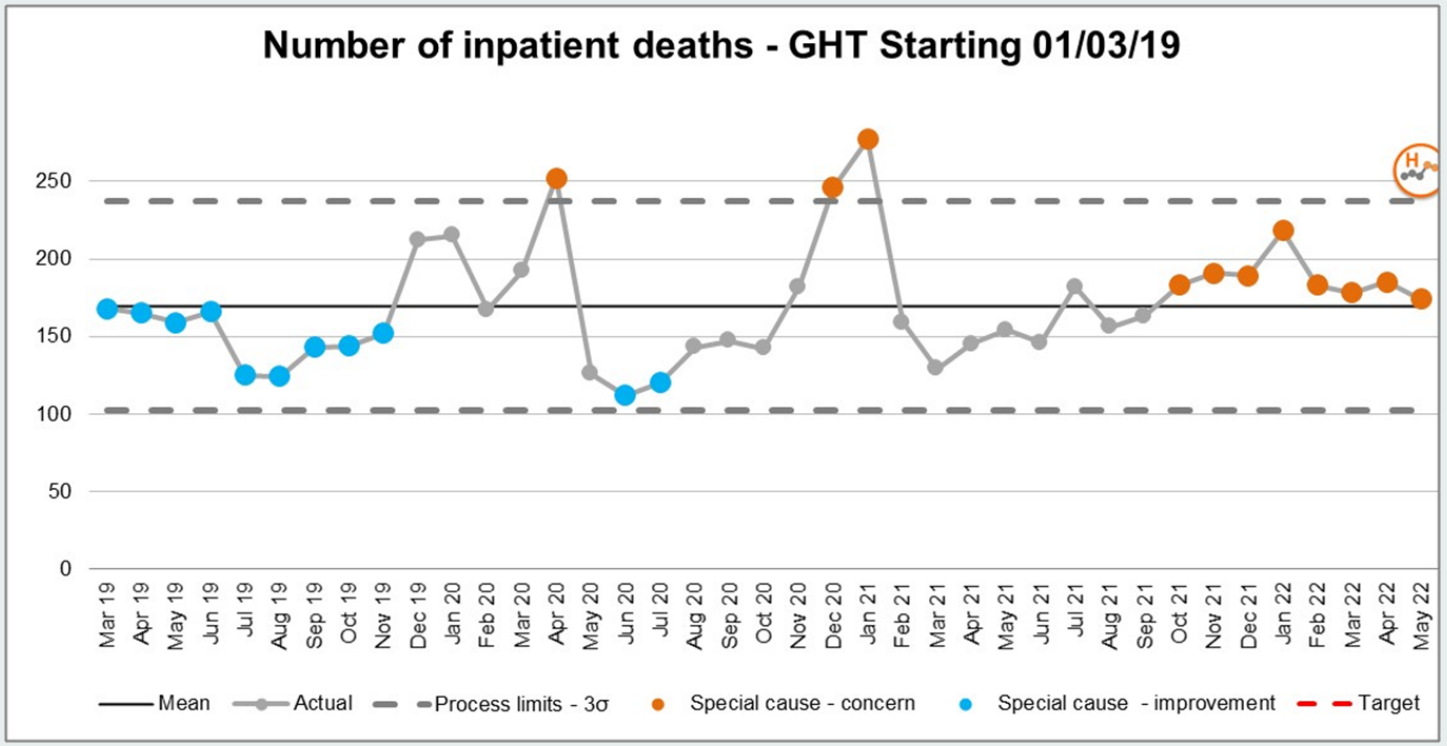
NHS Foundation Trust



Commentary

Total number of hospitals deaths will fluctuate month to month and is difficult to read into as there are so many factors that will effect this and the mortality ratios HSMR and SHMI are more comparable month to month

- 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 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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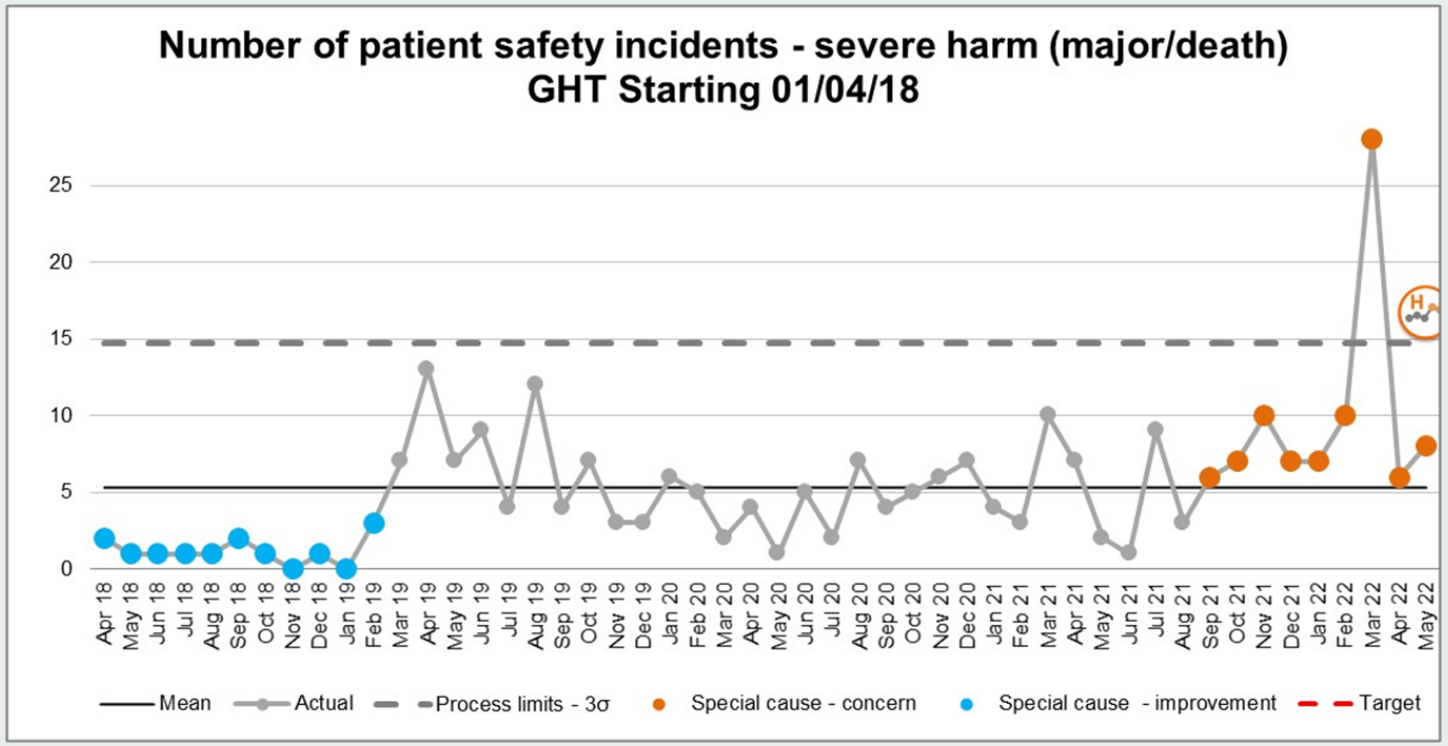
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The impact of congestion is still being clearly seen in SI reporting with the most recent incident involving delay to VTE treatment (W177616). The analysis of all ED incidents shows a range of themes, the top 5 incident themes from an analysis of 844 incidents include: Admission/Transfer category incidents e.g offload of ambulance; Abuse and Violence category incidents e.g patients on staff; Staffing/beds/systems category incidents e.g Lack of beds for stroke patients; Care, Monitoring, Review e.g lack of observations; Medication errors e.g drug omissions including some antibiotics & insulin
As a consequence of the 100%+ increase in ED incidents in the past 18months a new incident panel has been set up to manage the workload and respond more quickly to incidents. The panel sits within the ED specialty but is currently chaired by the QI & safety Director working with clinicians to speed action and escalation and to support local improvement.

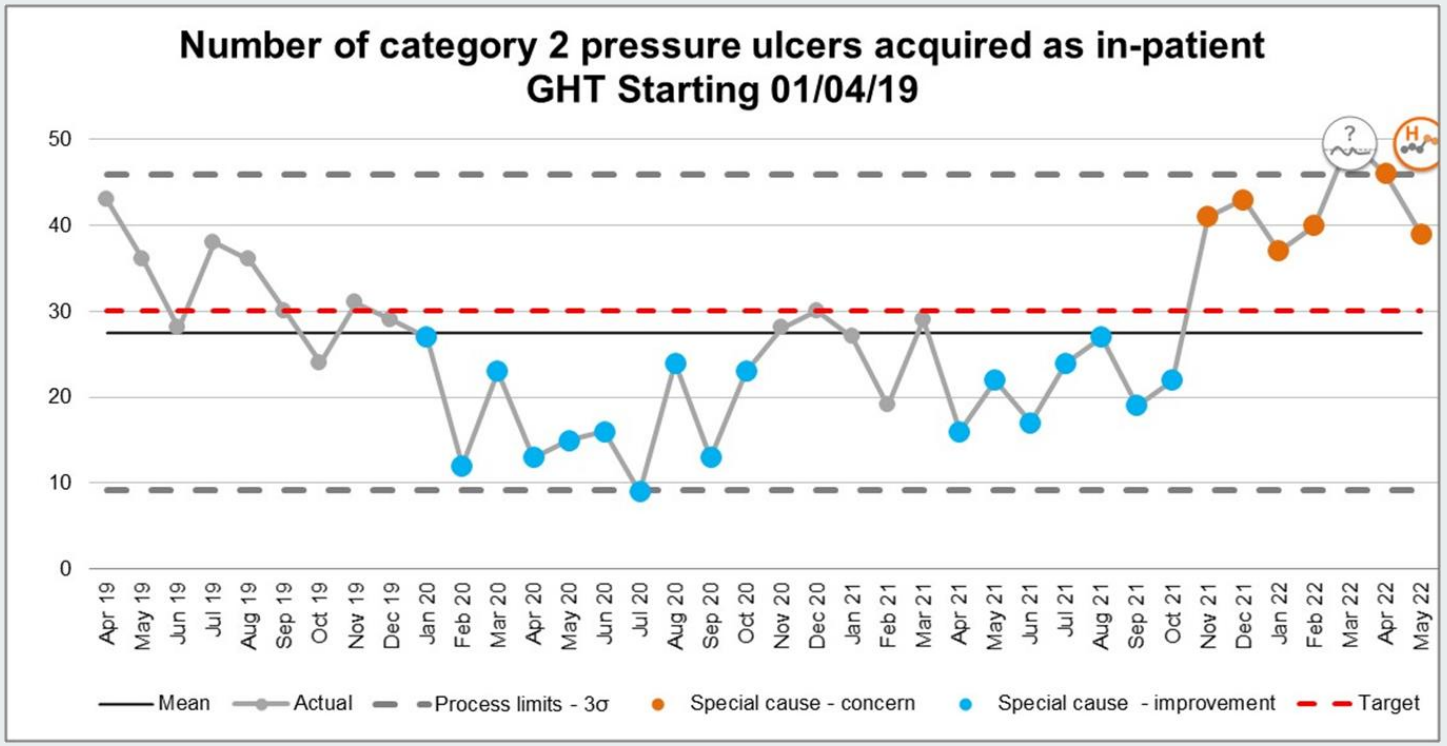
- Quality Improvement & Safety Director

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 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.
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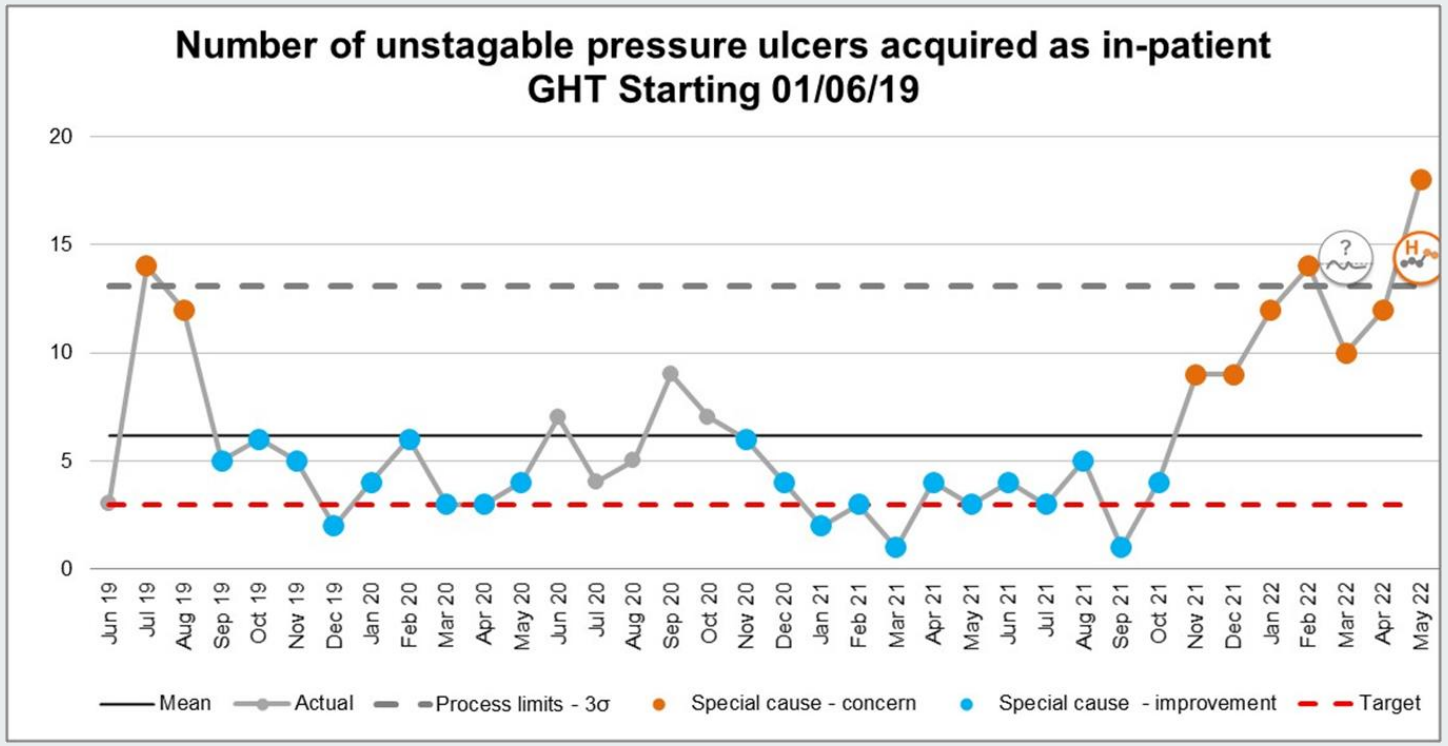
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

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- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which is above the line.
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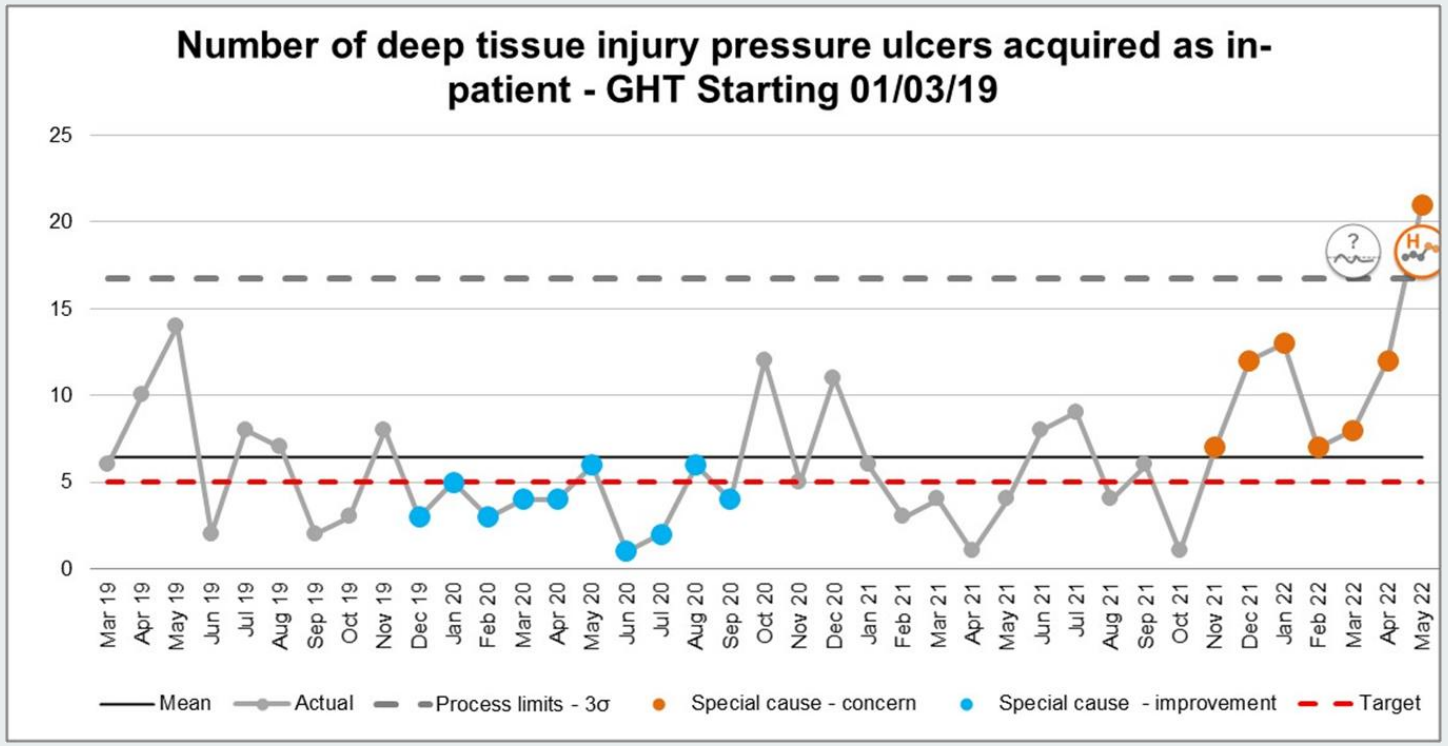
Quality:
SPC – Special Cause Variation

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 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.

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

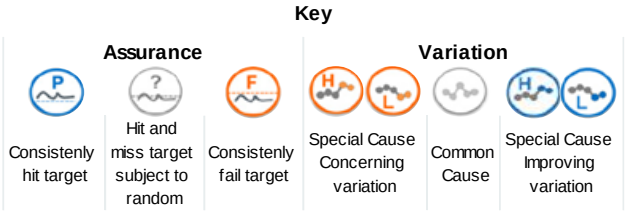
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

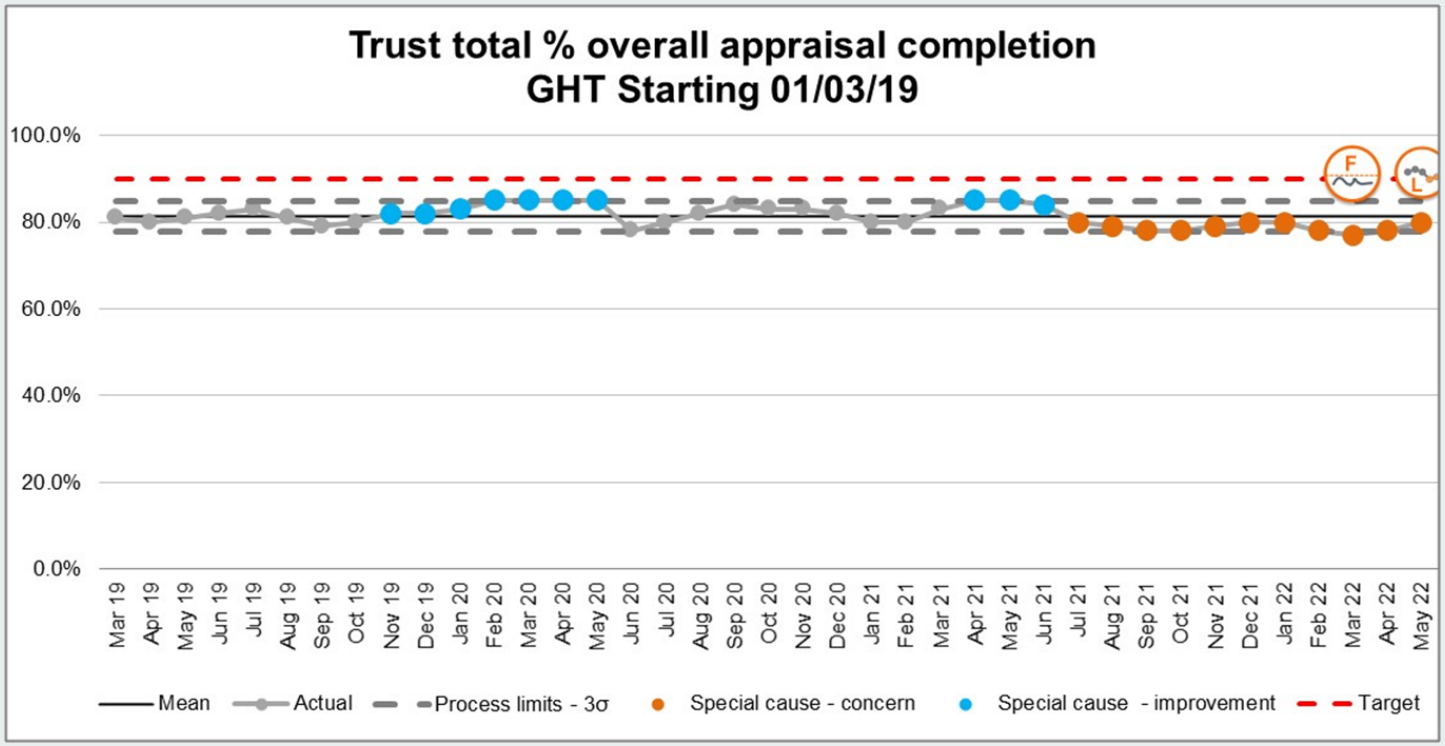
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	May-22	80%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	May-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	4.9	
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	7.7	
Vacancy and WTE	Staff in post FTE	No target	May-22	6683.3	
Vacancy and WTE	Vacancy FTE	No target	May-22	794.16	
Vacancy and WTE	Starters FTE	No target	May-22	85.03	
Vacancy and WTE	Leavers FTE	No target	May-22	83.93	
Vacancy and WTE	% total vacancy rate	<=11.5%	May-22	10.61%	
Vacancy and WTE	% vacancy rate for doctors	<=5%	May-22	7.79%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	May-22	14.60%	
Workforce Expenditure	% turnover	<=12.6%	May-22	14.4%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	May-22	13.0%	
Workforce Expenditure	% sickness rate	<=4.05%	May-22	4.2%	

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% but is showing signs of slow improvement from 78% to 80%. Medicine (86%), Surgery (82%) and D&S (81%) 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.

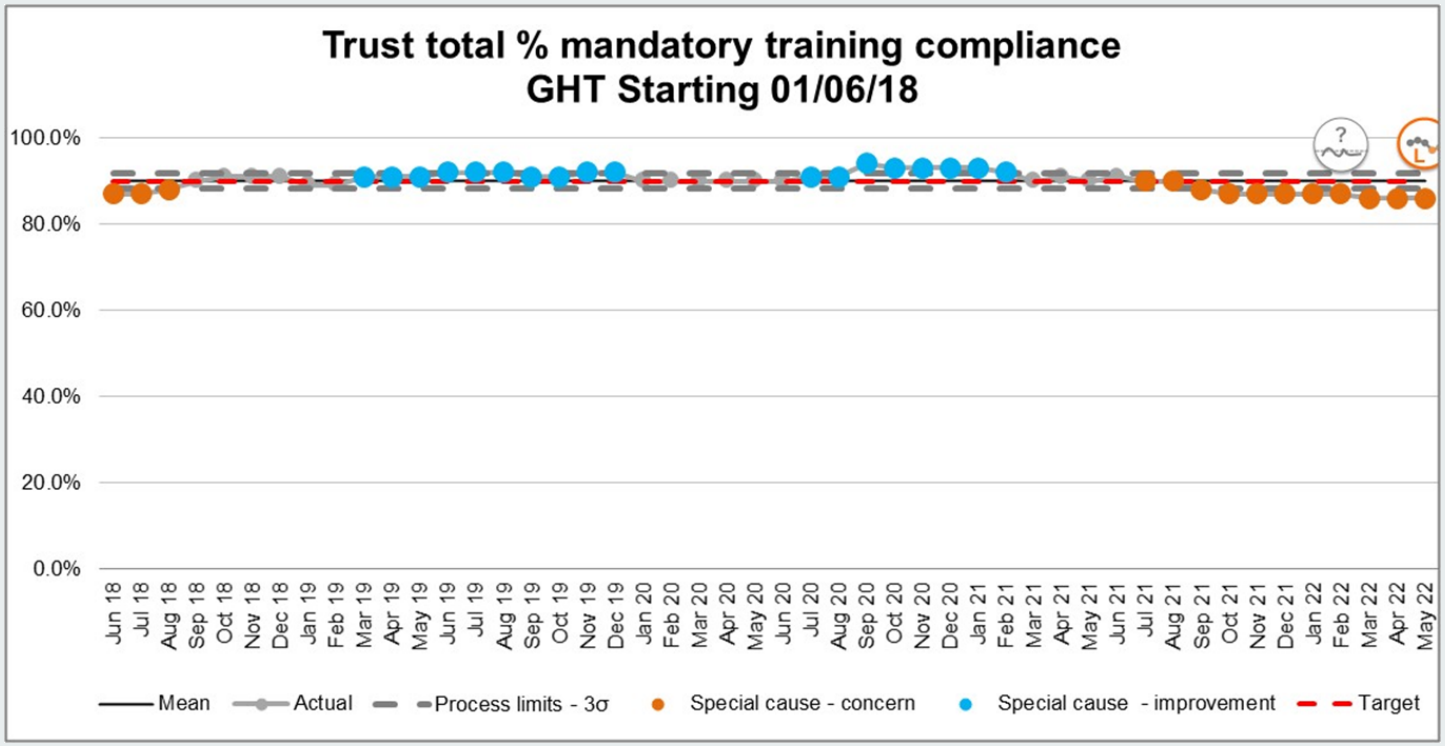
- **Director of Human Resources and Operational Development**

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 for example staffing groups who as a whole do not use computers as part of their role and therefore do not login regularly.

- **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 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

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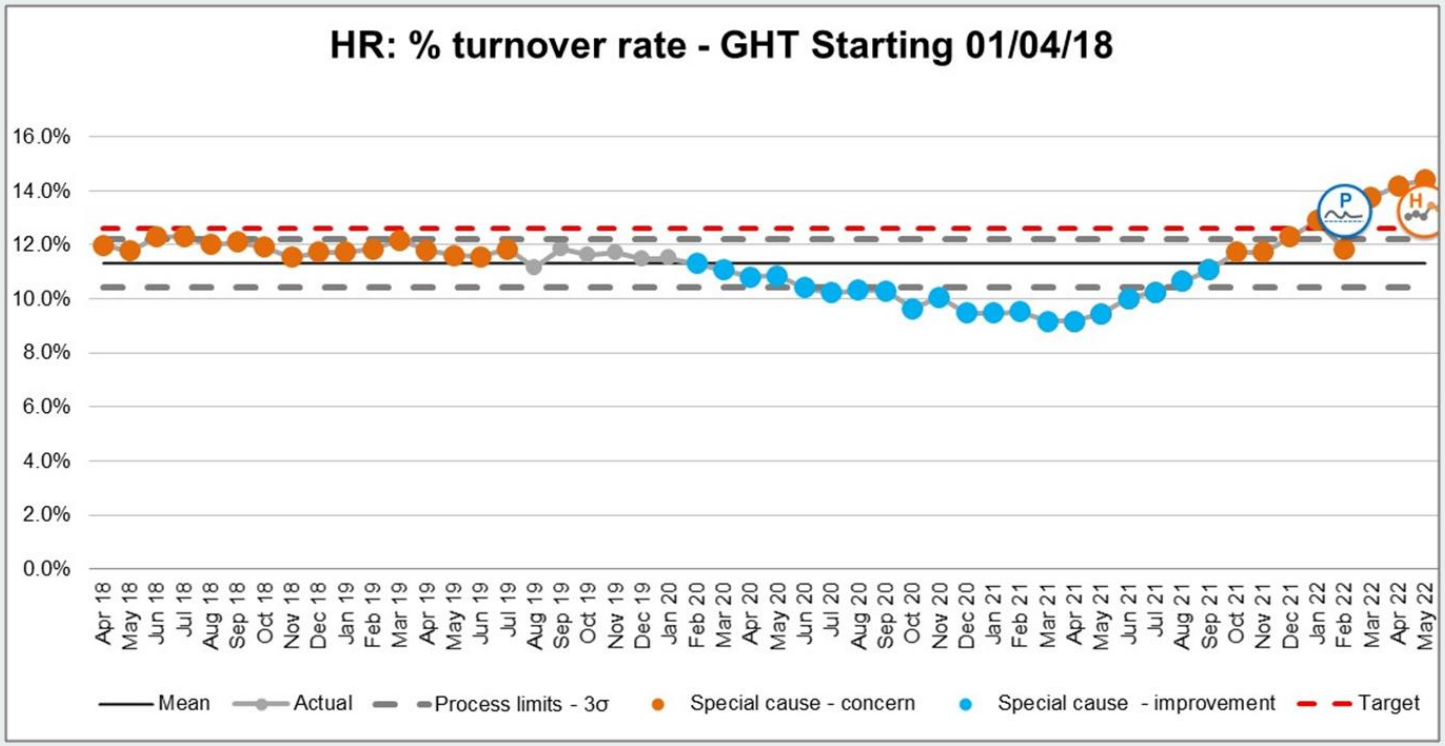


Commentary

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.

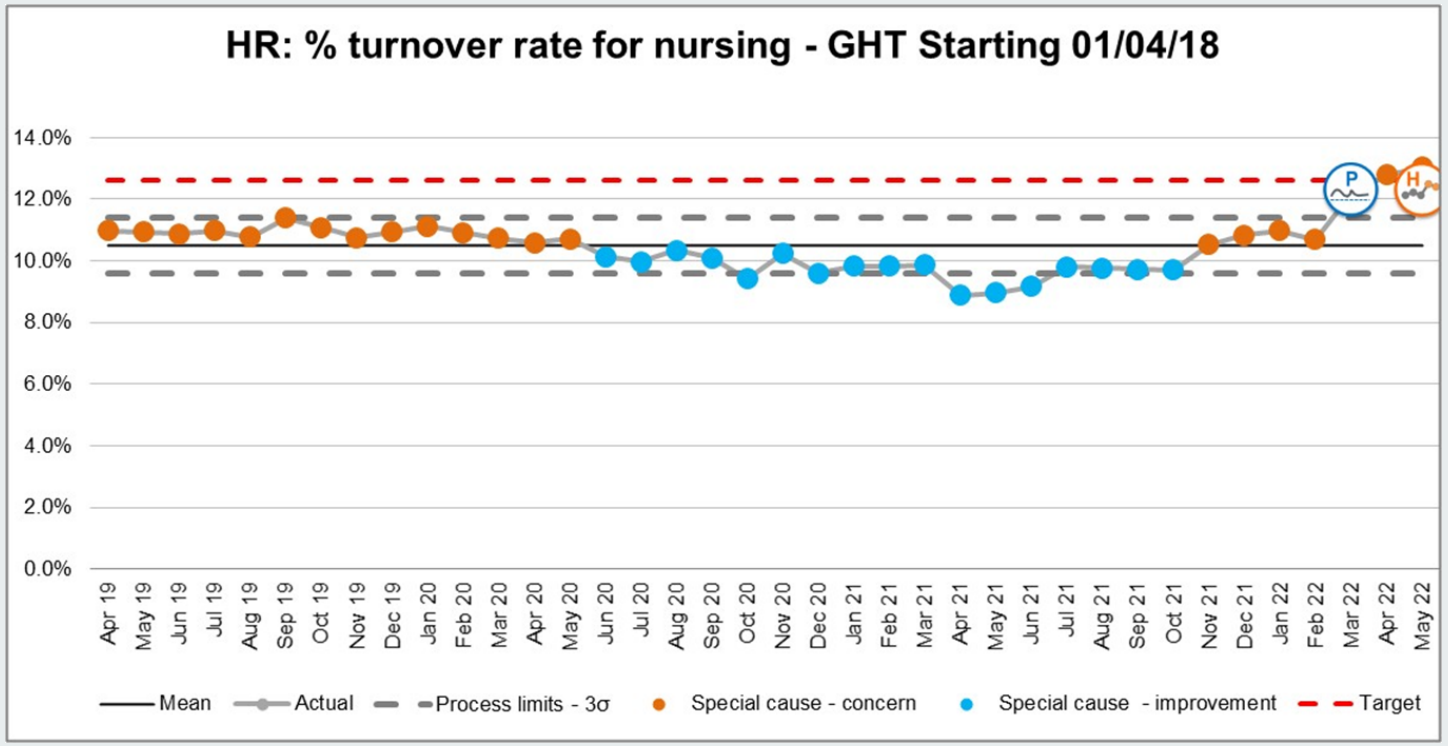
- **Director for People and OD**

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

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 for People and OD**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 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

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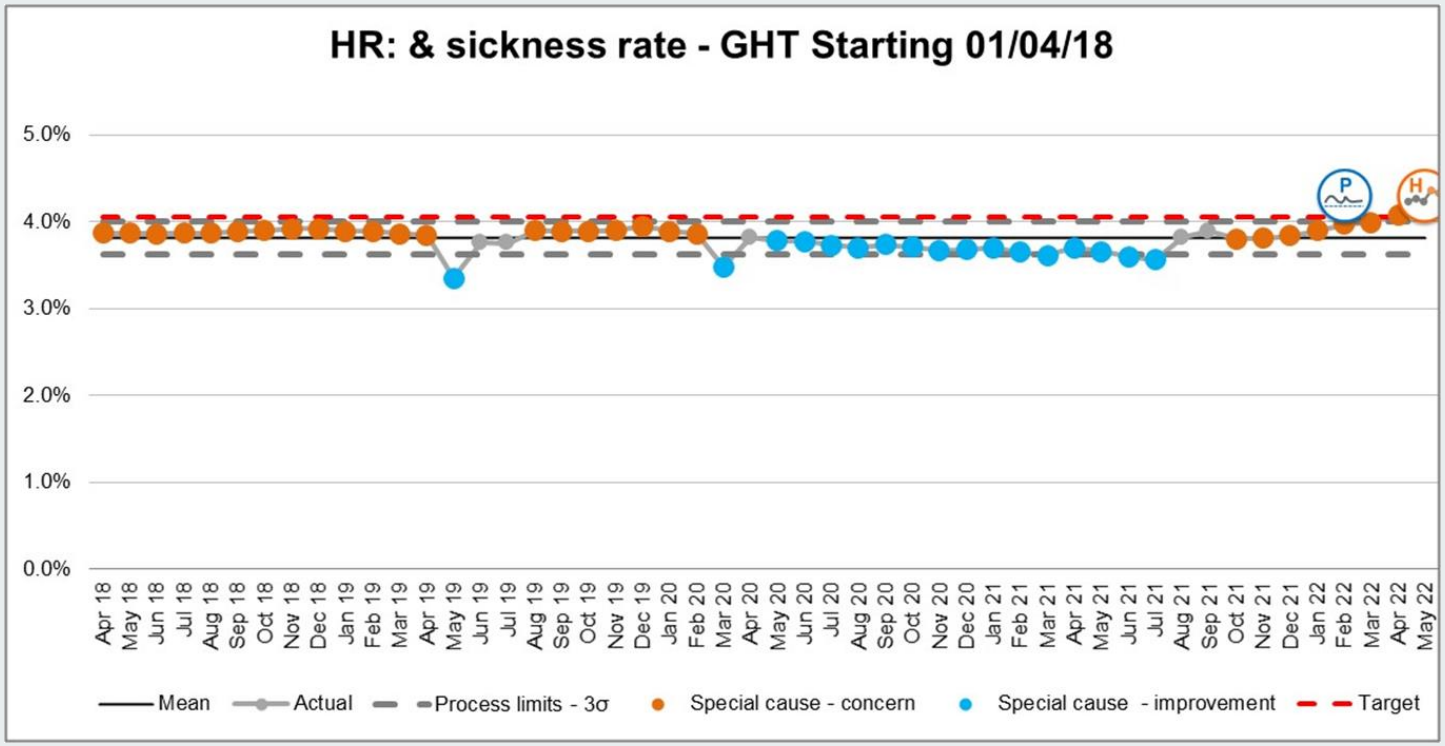
Gloucestershire Hospitals
NHS Foundation Trust



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 for People and OD**

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.
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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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	10	Enclosure Number:	7
Date	14 July 2022		
Title	Inpatient Falls and Pressure Ulcers: Harm Review		
Author /Sponsoring Director/Presenter	Craig Bradley, Deputy Chief Nurse 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

The paper, requested by Quality & Performance Committee, sets out the current situation in relation to in-patient falls and hospital acquired pressure ulcers and provides analysis of the associated harm. The paper is for assurance that there is an understanding of the risks and their causes and that mitigation in the form of our improvement plans will further improve performance and keep our patients safe.

Key issues to note

- Whilst the count of in-patient falls has increased the rate against activity has decreased 6% year-on-year.
- The falls with harm rate has decreased from 0.23 to 0.15 per 1000 bed days year-on-year, 6 falls resulted in a fatality, this is an increase.
- High incidence of falls is associated with care of the elderly wards.
- The rate of hospital acquired pressure ulcers decreased 9.4% year-on-year.
- The number of pressure ulcers reported has increased since the Autumn.
- The pressure ulcer data in Datix is being reviewed as a new report created in October does not replicate the data reported previously, this is being investigated.
- A comprehensive improvement plan is included in the paper.

Conclusions

- A comprehensive review of harm associated with falls and pressure ulcers has been undertaken.
- The number of falls and pressure ulcers are nursing sensitive indicators and this is clearly evident in our data, where care hours per patient day available are improved there are fewer cases of harm.
- Use of temporary workforce does not correlate with harm.
- The number of patients experiencing harm whilst MOFD is described.
- Association with harm and being moved between wards is not straightforward and requires further work to understand.

Recommendation

- The Board is asked to note the content of the report and support the improvement programme that has

been developed.

- The Board is asked to note that harm from falls and pressure ulcers are closely linked to the availability of registered nurse hours and this is not significantly dependent on either a substantive or temporary workforce.
- The Board is asked to note improvement in the rate of falls and pressure ulcers year-on-year and the work of our specialist and direct-care teams in improving the position.
- The Board is asked to note the ambition to further reduce the incidence of harm from falls and pressure ulcers.

Enclosures

- Falls and Pressure Ulcers Harm Review Report

Gloucestershire Hospitals
NHS Foundation Trust

In-patient falls and pressure ulcers: harm review

Report for 2021/22

Author: Craig Bradley, Deputy Chief Nurse
April 2022

IN-PATIENT FALLS AND PRESSURE ULCERS: HARM REVIEW

1. Introduction

1.1. Preventing hospital falls and patients acquiring pressure ulcers is a key priority and an important nursing sensitive indicator that we can use to monitor the quality and safety of care provision. This report details the current situation in relation to in-patient falls and pressure ulcers and the harm sustained as a result. The paper describes the contributing factors and actions to optimise prevention strategies.

1.2. Although the rate of harm seems stable, increasing demand for health services, and the increasing intensity and complexity of those services (people are living longer, with more complex co-morbidities, and expecting higher levels of more advanced care) imply that the number of patients harmed while receiving care will only increase, so we need to find new and better ways to improve safety. A significant factor contributing to this increased demand are the number of medically optimised for discharge patients that remain in the acute hospitals.

1.3. Safety management should therefore move from ensuring that 'as few things as possible go wrong' to ensuring that '**as many things as possible go right'**. This perspective is called Safety-II; it relates to the system's ability to succeed under varying conditions. A Safety-II approach assumes that everyday performance variability provides the adaptations that are needed to respond to varying conditions, and hence is the reason why things go right.

1.4. Humans are consequently seen as a resource necessary for system flexibility and resilience. In Safety-II the purpose of investigations changes to become an understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong.

1.5. Risk assessment tries to understand the conditions where performance variability can become difficult or impossible to monitor and control.

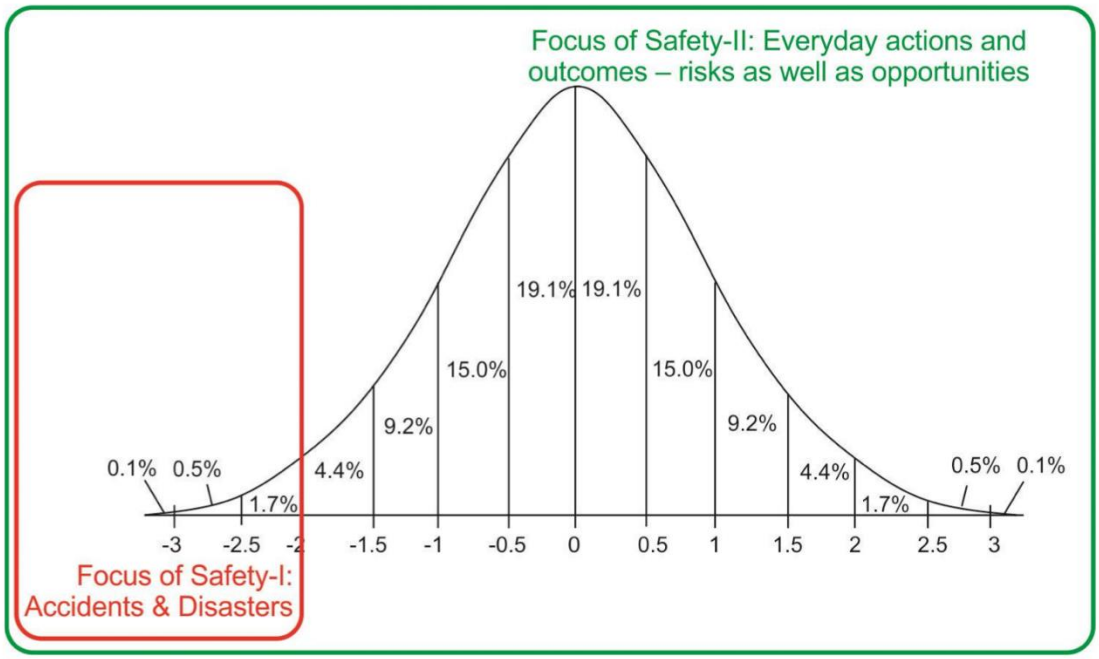
1.6. The safety management principle is to facilitate everyday work, to anticipate developments and events, and to maintain the adaptive capacity to respond effectively to the inevitable surprises.

1.7. The premises for safety management in today's complex clinical settings, then, can be summarised as follows:

- systems and clinical work cannot be decomposed in a meaningful way (there are no natural 'elements' or 'components').
- System functions are not bimodal, separated into 'functioning' or 'malfunctioning,' but everyday performance is—and must be—flexible and variable.
- Outcomes emerge from human performance variability, which is the source of both acceptable and adverse outcomes.
- While some adverse outcomes can be attributed to failures and malfunctions, others are best understood as the result of coupled

performance variability.

Focus for safety for safety I and safety II



2. Background

2.1. 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. Hip fractures can have a severe effect on patients often at the end of their life.

2.2. According to the NHS England Stop the Pressure campaign there are over 700,000 pressure ulcer incidents each year with more than 200,000 of these acquired in hospital. Pressure ulcers can be painful, reduce mobility and prolong hospital stays.

2.3. The system for monitoring improvement is through the Quality Delivery Group where divisions provide updates on improvement programmes linked to the corporate programme in appendix 3. The divisions are responsible for delivery of improvement and this is supported by the expertise provided from the corporate nursing teams.

2.4. The Trust's corporate falls prevention team consists of a band 7 specialist nurse and a band 6 specialist physiotherapist.

2.5. The corporate Tissue Viability Team consists of 4 full time nurses from band 8a to band 5.

2.6. Falls overview

2.6.1. There are 130 deaths per year 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 (RCP) suggests that patient falls could be reduced by up to 25 to 30% through assessment and intervention.

2.6.2. There is no readily available data by which to benchmark the number of falls between hospital trusts. NICE Guidelines specify not to benchmark across different organisations and to monitor trends internally due to the amount of variability between organisations.

2.6.3. The RCP recommend a multifactorial risk assessment to determine the interventions that can be put in place to reduce the risk of a fall in hospital. Not all falls are preventable. The Trust's Electronic Patient Record (EPR) has been designed according the RCP specification for the risk assessment.

2.6.4. The annual falls programme is devised and managed by the Preventing Harm Shared Decision Making Council, a recent successor of the Falls Steering Group which reports in to the Quality Delivery Group which reports to the Board via the Quality & Performance Committee.

2.7. Pressure ulcer overview

2.7.1. Pressure ulcers most commonly form where there is a bony prominence and the skin is subjected to pressure underneath. This could be from the surface of a mattress or chair. Common sites on the body are sacrum and heels. Pressure ulcers are categorised according to the severity. A description of the categories is available at appendix 1.

2.7.2. NHS England's Model Hospital benchmarking tool collects prevalence data on pressure ulcers reported in hospital settings and allows us to understand our performance against peer organisations.

2.7.3. The annual pressure ulcer prevention programme is devised and managed by the Preventing Harm Shared Decision Making Council, a successor of the Falls Steering Group which reports in to the Quality

Delivery Group which reports to the Board via the Quality & Performance Committee. The group have been meeting for a year now.

3. Surveillance and clinical governance

3.1. Falls and pressure ulcer resulting in moderate or significant harm are reviewed in the weekly Preventing Harm Hub (described in appendix 2) where rapid feedback is given by a panel to the clinical team who then agree an action or response.

3.2. We review prevalence of falls and falls resulting in harm and injury as well as trends from Preventing Harm Hub to provide insights and to diagnose the issues that require improvement. This is a key function of the Preventing Harm Shared Decision Making Council.

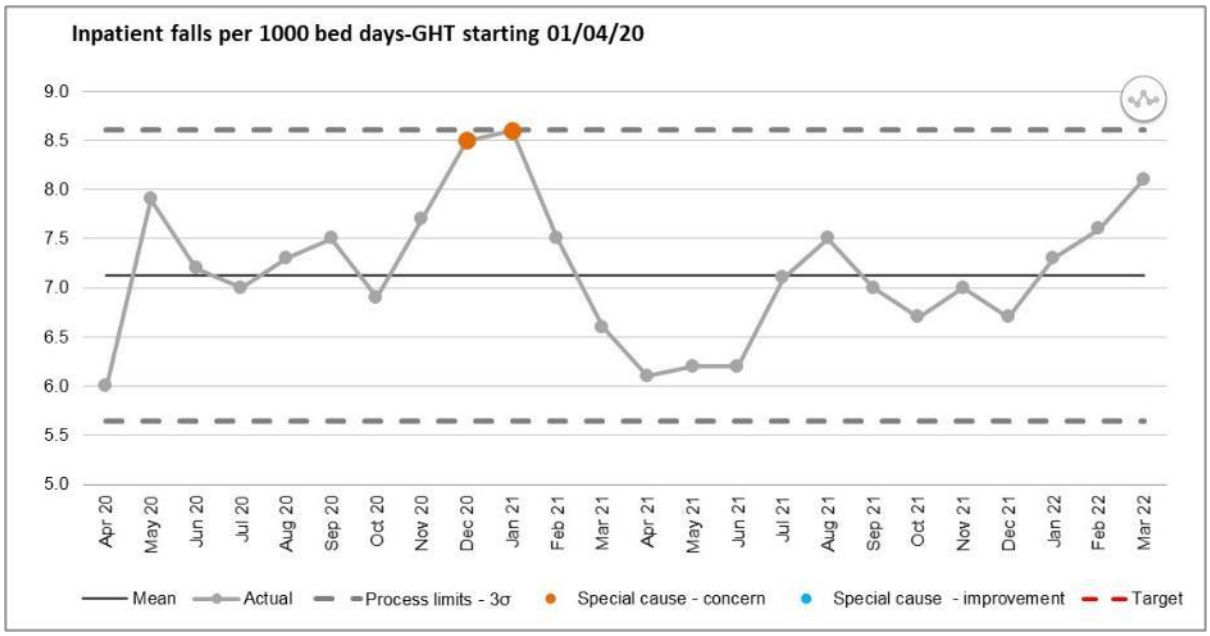
3.3. <u>Inpatient falls per 1000 bed days</u>

3.3.1. Inpatient falls across the trust are calculated against 1000 bed days, figure 1 is a statistical process control chart showing the monthly inpatient falls rate per 1000 bed days from April 2020.

3.3.2. In January 2022, there were 47 falls in inpatients who were medically optimised for discharge, 2 had moderate harm associated with their fall. In January 2022 22% of all inpatient falls were in those who were

medically optimised for discharge. In February 2022, there were 69 falls in inpatients who were medically optimised for discharge. Of these, 4 had moderate harm associated with their fall and 2 patients died. In February 2022 33% of all inpatient falls were in those who were medically optimised for discharge.

Figure 1: All falls per 1,000 bed days – April 2020 to March 2022

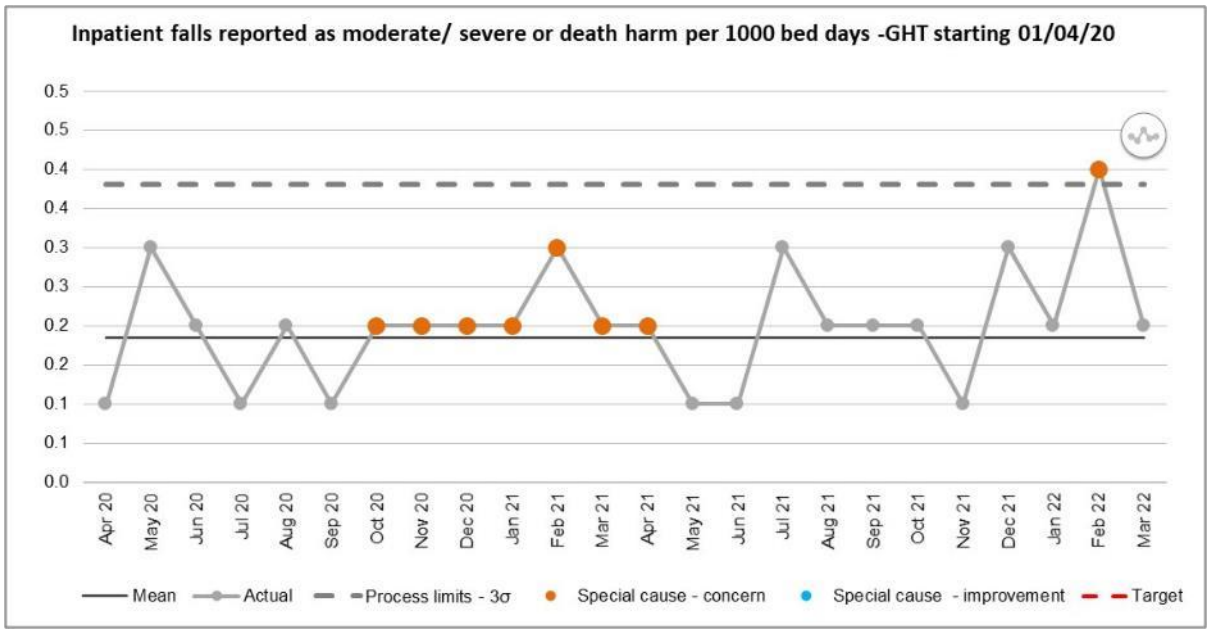


3.3.3. In 2021-22, the trust had a total of 2401 inpatient falls, with an average of 200 falls per month over those 12 months. The annual inpatient falls rate was 6.97 per 1000 bed days for 2021-22. In 2020-21 the annual inpatient falls rate was 7.42 inpatients falls per 1000 bed day; this therefore represents a 6% decrease year on year in the inpatients falls rate across the Trust

3.4. <u>Inpatient falls reported as moderate / severe harm or death</u>

3.4.1. Figure 2 is a statistical process control chart showing the monthly inpatient falls rate with harm per 1000 bed days from April 2020.

Figure 2: Falls causing harm (moderate/severe/death) – April 2020 to March 2022



3.4.2. In 2021-22, the trust has had a total of 67 inpatient falls with harm, with an average of 5 or 6 falls with harm per month over those 12 months. There were 2401 falls between April 2021 and March 2022. Excluding March 2022, as this data is yet to be validated, 384 of the total inpatients falls resulted in harm of some degree; 67% of those were catergorised as minor harm. Fifty caused moderate harm and 8 caused major harm. Six falls resulted in death; this is two more than was reported in 2020/21. The annual inpatient falls rate with harm was 0.15 falls per 1000 bed days for 2021-22. In 2020-21 the annual inpatient falls rate with harm was 0.23 inpatients falls per 1000 bed day; this therefore represents a 34% decrease year on year in the inpatients falls with harm rate across the Trust. Although the total number of cases resulting in severe harm or death are higher within the last year that is within the context of much higher bed occupancy.

3.4.3. The harm levels associated with falls are aligned to the national reporting requirements following a patient safety incident.

- No harm – minimal injury requiring no/minimal intervention
- Minor harm- minor injury requiring minor intervention, increased length of stay (LOS) 1 -3 days
- Moderate harm – injury requiring professional intervention, falls resulting in fracture but not requiring surgical intervention, LOS increased by 4 -15 days
- Severe – injury leading to long-term incapacity/disability. Falls requiring surgical intervention.
- Death - falls leading to death.

3.5. Falls by ward 2021-22

3.5.1. Tables 1-4 show the number of inpatient falls per ward/ department during 2021/22. Table 1 shows wards with 1-10 falls per ward, table 2 shows wards with 11-50 falls per ward, table 3 shows wards with 51-100 and table 4 shows wards with over 100 falls per ward.

Table 1: wards/ departments with 1-10 falls per ward during 2021/22

Ward name	Number of falls
AEC Ambulatory Emergency Care, CGH	1
Avening	1
Birth Unit	1
CDS Central Delivery Suite	1
Critical Care CGH	1
Hartpury suite, specialist investigations	1
HDU	1
Hospital grounds	1
ADU / MDU (Medical Day Unit)	2
Eyford ward Ophthalmology	2
AEC / AMIA (Ambulatory Emergency Care / Acute Medical Initial Assessment Unit) GRH	3
Childrens Inpatients Paediatrics	3
Cardiology 2, CGH	5
Knightsbridge	5
Maternity Ward Obstetrics	5
Critical Care GRH	6
Endoscopy Department	6
GPAU (Gloucestershire Priority Assessment Unit)	7
2a Trauma	8
Courtyard (Medicine)	9
Kemerton Day Surgery Unit	9
May Hill Unit (Day Surgery Unit)	9
Hazleton Orthopaedic Day Unit	10

Table 2: wards with 11-50 falls per ward during 2021/22

Ward name	Number of falls
Guiting Ward	12
Bibury Ward	21
Dixton Ward	21
Cardiac Cardiology, CGH	26
Knightsbridge	31

Alstone Ortho	38
5a / SAU	40
Lilleybrook Oncology	40
Snowshill Ward (surgical)	42
2b Head and Neck	45
8a Respiratory	46
5b Upper & Lower GI	48

Table 3: wards with 51-100 falls per ward during 2021/22

Ward name	Number of falls
7a Renal	52
9a Acute	57
Rendcomb Oncology	57
2a Vascular	62
CCU / HASU	65
7b Renal	67
Gallery Ward (MSFD), GRH	67
Guiting Ward (medicine)	77
3b Trauma	79
Frailty assessment unit/service (FAU)	79
8b Respiratory	80
ACUC	80
4a COTE	82
6a Neuro	83
Ryeworth Ward	83
9b Diabetology	87
4b COTE	98

Table 4: wards with over 100 falls per ward during 2021/22

Ward name	Number of falls
3a Trauma	105
6b COTE	124
Woodmancote Ward Stroke	127
ACUA / AMU	139
Prescott Ward GI	142

3.6. Inpatient falls with harm by division

3.6.1. Table 5 shows the inpatient falls by level of harm split by division for 2021/22

Table 5: Inpatient falls with harm level by division 2021/2022 (excluding March 2022)

Level of harm	Medical	Surgical	D and S
No harm	1263	520	122
Minor Harm	212	72	36
Moderate Harm	31	18	1
Severe harm	5	2	1
Death	5	1	0
TOTAL	**1485**	**613**	**160**

3.7. Data from EPR

3.7.1. Since the introduction of EPR we can audit in real time the completion of risk assessments. Compliance to completion of falls assessment on admissions, weekly, post fall and post transfer to another ward are detailed in table 6. Whilst D&S have sustained good compliance in the admission and weekly assessment both Medicine and Surgery require improvement. There is a considerable gap in the updating of falls risk assessments within 4 hours from transfer to another ward. This needs to be an area of improvement to focus on. We know from previous audit data that patients are less likely to fall if an assessment is completed.

Table 6: Falls assessment completion compliance snapshot – April 2021 to March 2022

Division	On admission	Weekly	Completed within 4 hours of fall	Completed within 4 hours from transfer to another ward
Medicine	60.5%	76.1%	76.2%	46.4%
D&S	96.1%	85.2%	83.3%	71.4%
Surgery	63.9%	75.8%	78.6%	23.4%

3.8. Time of fall

3.8.1. Monitoring the time patients fall can help target our improvement strategy. There are more falls in the late morning, early evening and overnight. This correlates with both increased activity on wards where care staff are busy with patients behind curtains in the late morning and before visiting commences and before and after meal times. Table 7 is a heat map by time of day.

Table 7: Heat map of falls by time of day

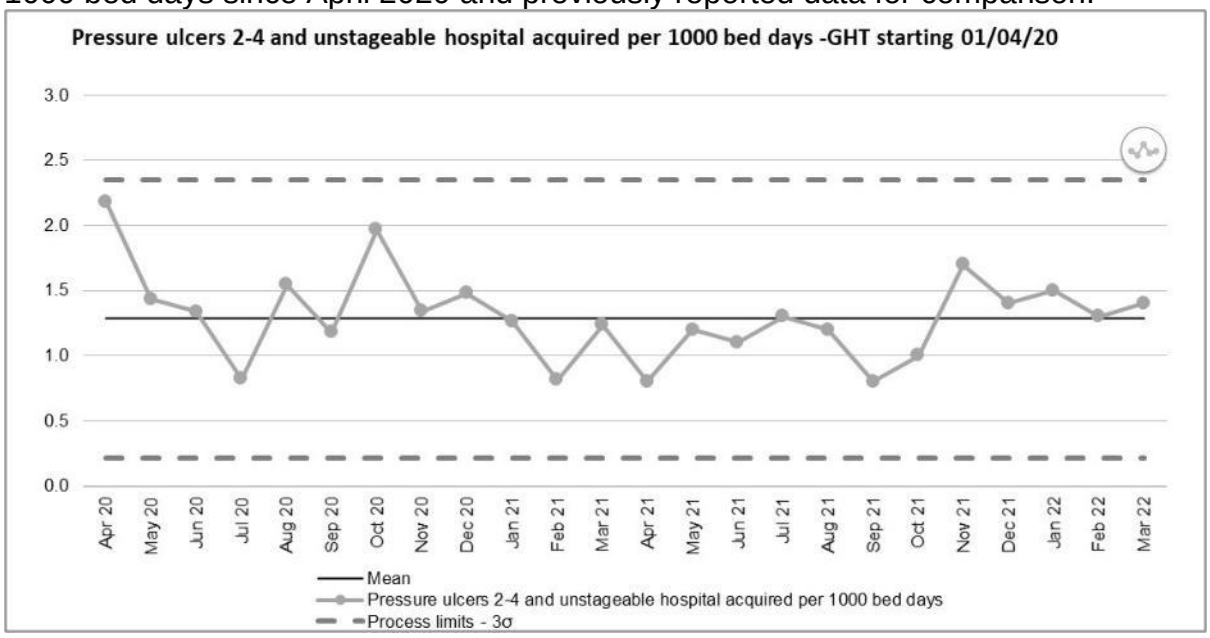
07:00-07:59	08:00-08:59	09:00-09:59	10:00-10:59
85	73	99	103
11:00-11:59	12:00-12:59	13:00-13:59	14:00-14:59
102	89	79	77
15:00-15:59	16:00-16:59	17:00-17:59	18:00-18:59
83	113	85	84
19:00-19:59	20:00-20:59	21:00-21:59	22:00-22:59
93	89	65	70
23:00-23:59	00:00-00:59	01:00-01:59	02:00-02.59
79	73	80	71
03:00-03:59	04:00-04:59	05:00-05:59	06:00-06:59
90	81	97	68

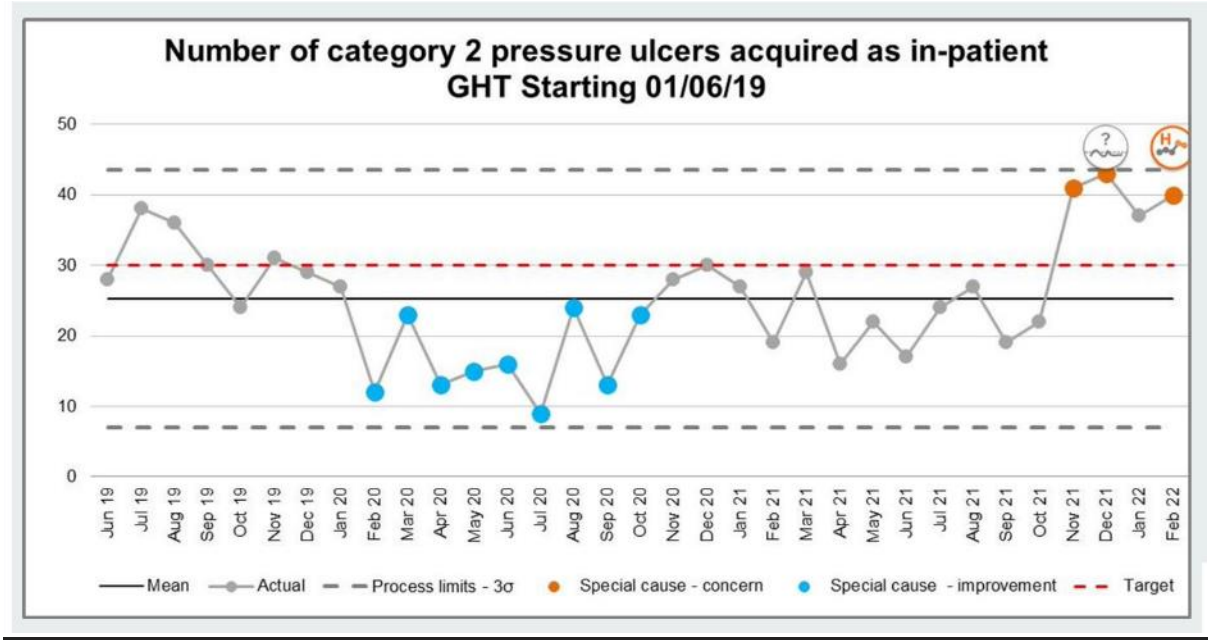
4.4 Hospital acquired pressure ulcers

4.4.1 In 2021-22, the trust has had a total of 426 hospital acquired grade 2-4 and unstageable pressure ulcers, with an average of 35 per month over those 12 months. The annual hospital acquired grade 2-4 and unstageable pressure ulcers rate was 1.23 per 1000 bed days for 2021-22. In 2020-21 the annual hospital acquired grade 2-4 and unstageable pressure ulcers rate was 1.36 per 1000 bed day; this therefore represents a 9.4% decrease year on year in the rate across the Trust. Figure 3 is a statistical process control chart showing the monthly hospital acquired 2-4 and unstageable pressure ulcer rate per 1000 bed days from April 2020.

4.4.2 The pressure ulcer data available here has been extracted from Datix and is different to the monthly data submitted to Q&P over the past year. We are currently investigating the difference but this is thought to be due to inclusion of Tissue Viability verified pressure ulcers when the previous dataset only included the originally reported, non-verified category. As the report has been amended in Datix we are unable to replicate the previous logic for production of the information. Both datasets are provided for comparison. We are confident that the data provided here is accurate and reproducible from Datix.

Figure 3: Monthly hospital acquired 2-4 and unstageable pressure ulcer rate per 1000 bed days since April 2020 and previously reported data for comparison.

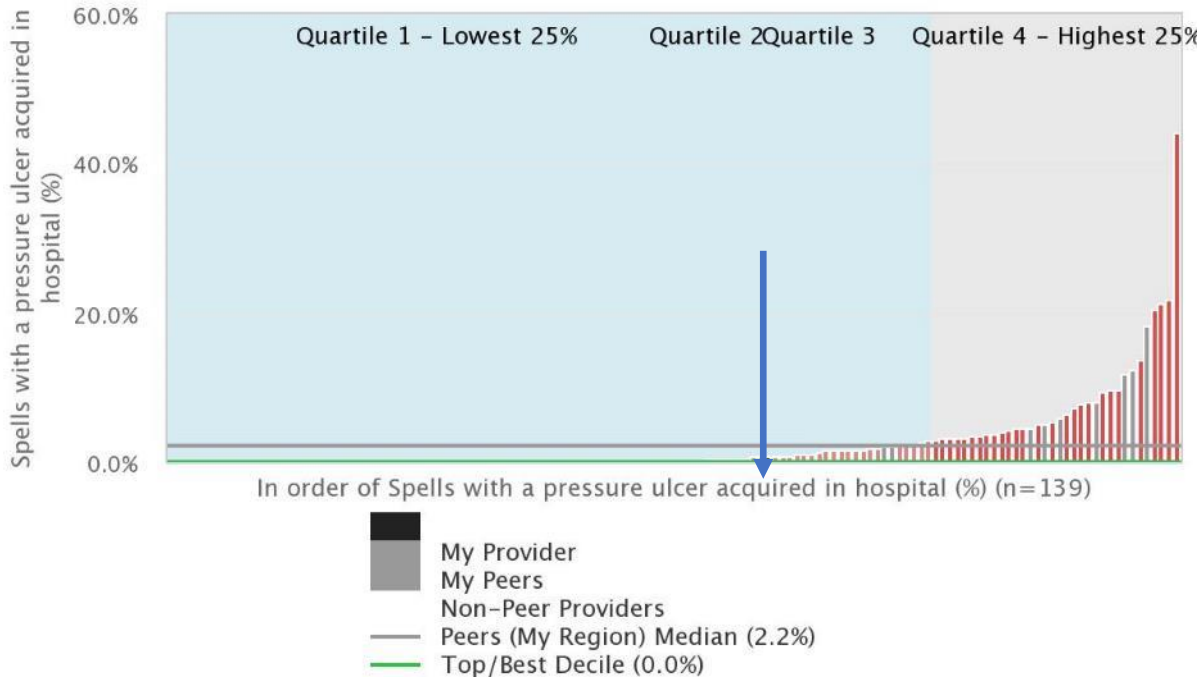




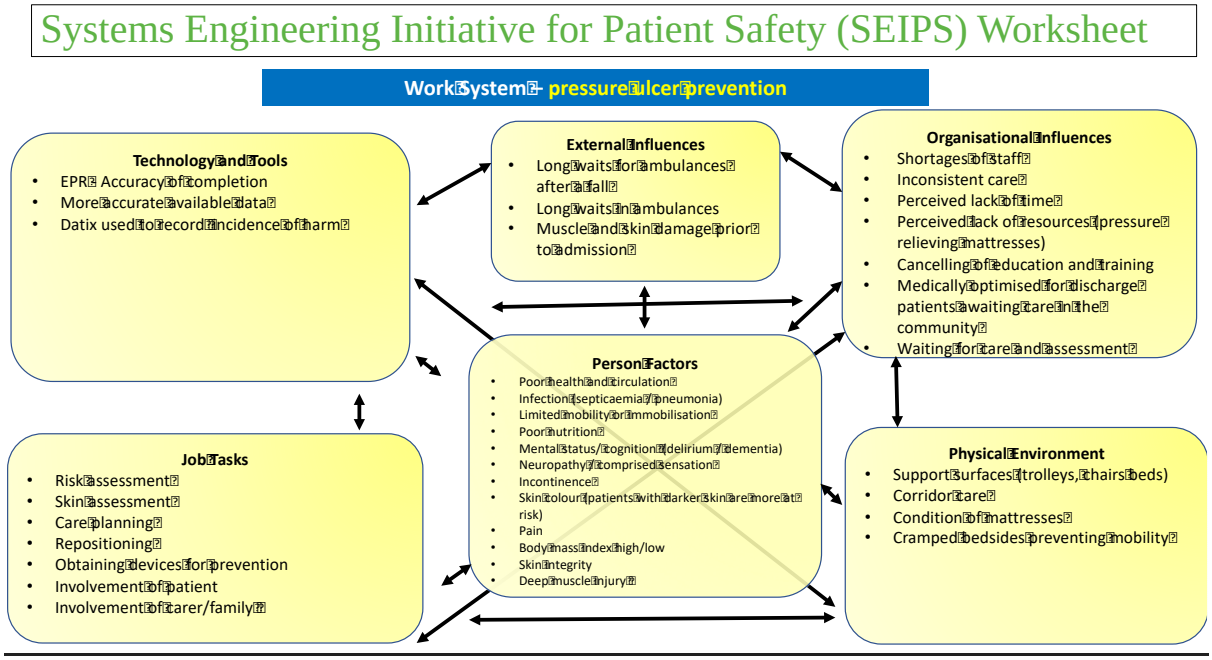
4.5 Model Hospital Benchmarking

4.5.1 NHS England collect data on pressure ulcers and provide this to allow organisations to benchmark. The most recent dataset available is from December 2021 where the Trust is amongst the lowest percentage spells with a hospital acquired pressure ulcer as detailed in Figure 4 below.

Figure 4: Spells with a pressure ulcer acquired in hospital (%), National distribution



4.6 Contributing factors



4.6.1 Contributing factors are recorded as part of our process for reporting hospital acquired pressure ulcers. The most frequently mentioned factors are:

- Staffing shortfalls
- Patient clinical condition
- Written communication (risk assessments)

- Not following policy

4.4..1 Contributing factors relating to falls were found to be:

- Patient clinical condition
- Not following policy
- Written communication (risk assessments)
- Staffing shortfalls

4.4..1 In addition to the recorded contributing factors we are currently investigating how many patients come to harm from falls and pressure ulcers that are medically optimised for discharge (MOFD). We know that a third of the patients that suffer fractures following a fall are determined to be MOFD already. There is a correlation between number of moves between wards and chance of harm but this may be explained by the association with extended length of stay which also statistically increases the risk of a fall or pressure ulcer. It is thought to be of little value to focus specific harm prevention strategies on length of stay reduction and MOFD transfer out. However, there are many quality benefits to be gained from focussing on reducing ward moves.

5 Impact of nurse staffing on falls and pressure ulcers

Safe Nurse Staffing																	
Overall % of nursing shifts filled with substantive staff	94.82%	95.00%	93.10%	98.29%	96.75%	91.64%	96.56%	97.22%	99.61%	97.11%	95.93%	89.16%	85.93%		93.74%	94.41%	>=75%	<70%
% registered nurse day	93.97%	93.14%	90.71%	96.38%	96.05%	90.72%	94.84%	95.11%	98.11%	95.49%	94.07%	87.59%	84.20%		92.07%	92.88%	>=90%	<80%
% unregistered care staff day	104.90%	95.53%	101.28%	106.08%	104.33%	95.67%	100.44%	98.32%	96.58%	95.82%	95.07%	84.77%	83.85%		91.37%	95.72%	>=90%	<80%
% registered nurse night	96.36%	98.22%	97.31%	101.83%	97.99%	93.27%	99.57%	101.09%	102.46%	100.10%	99.31%	91.99%	89.02%		96.78%	97.18%	>=90%	<80%
% unregistered care staff night	113.19%	113.17%	108.91%	111.13%	113.00%	103.77%	109.58%	111.39%	111.67%	105.90%	103.45%	94.98%	95.26%		101.01%	105.58%	>=90%	<80%
Care hours per patient day RN	6	6.2	5.8	5.2	5.5	5.3	5.3	4.7	4.6	5	5.2	5.1	5		5.1	5.1	>=5	
Care hours per patient day HCA	3.8	3.9	3.7	3.7	3.5	3.5	3.5	3.3	3.5	3.2	3.1	3.1	3.1		3.1	3.3	>=3	
Care hours per patient day total	9.8	10.1	9.5	8.9	9	8.7	8.8	8	8.1	8.1	8.3	8.1	8.1		8.2	8.4	>=8	
Vacancy and WTE																		
% total vacancy rate		4.36%	4.75%	4.30%	7.12%		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%			<=11.5%	>13%
% vacancy rate for doctors		1.83%	0.73%	1.38%	4.15%		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%			<=5%	>5.5%
% vacancy rate for registered nurses		5.08%	7.92%	7.24%	6.60%		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%			<=5%	>5.5%
Staff in post FTE		6666.58	6653.99	6678.31	6672.09	6672.85	6680.26	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52			No target	
Vacancy FTE		286.96	330.61	298.88	510		505.63	537.29	491.56	457.02	530.17	582.02	834.81	799.75			No target	
Starters FTE		48.84	67.2	86.69	50.85	56.53	36.05	36.53	79.76	42.43	59.94	70.65	77.03	69.31			No target	
Leavers FTE		34.82	45.79	36	57.02	62.03	52.16	78.84	68.51	89.94	66.53	81.1	88.76	47.74			No target	

5.4.1 The number of inpatient falls and hospital acquired pressure ulcers are sensitive to the number of available nursing staff however there are multiple factors that are known to contribute such as the availability of therapy and medical staff, the knowledge and skills of the staff available, the safety of the environment and access to equipment.

5.4.2 The greatest number of falls have been on the following wards (Table 9). In relation to staffing the CHpPD and RN to HCA ratio is also provided. As a comparator the 10 wards with lowest falls is also provided.

5.4.3 On 22nd December 2021 the decision was made to remove beds for social distancing, with the view to implement the removal in a phased approach. It was agreed that beds were to be removed from phase 1 wards by 26th December 2021. At total of 62 beds were removed from across seven wards. This had the effect of increasing the number of care hours per patient day available as the staffing was largely unchanged during this period. We have no evidence of a correlation between increasing the nursing time available per patient and a reduction in harm.

5.4.4 Whilst we had the intended outcome of not seeing a single COVID-19 outbreak in any of the phase 1 wards and therefore no subsequent ward closures further positive outcomes were identified through bed removals related to the number of falls, falls with harm and pressure ulcer (PU) acquisition rate on phase 1 wards. See table 8 for the overall percentage change pre and post bed removal across these three patient harm related areas. In summary, across the seven areas all but one of the wards saw a reduction in the number of falls per 1,000 beds days after the removal of beds. The falls rate per 1,000 bed days has decreased by a rate ranged between 0.5% - 100%. Three of the seven wards also saw a 100% reduction in the rate of falls with harm per 1,000 beds days; however, two wards had an unchanged rate in their falls with harm and two wards had an increased rate following their bed removals. Furthermore, six of the seven wards have seen reductions in their pressure acquisition rate; with five wards seeing a 100% reduction in acquisition rates per 1,000 beds days with only one ward, Prescott ward, having an increase in PU rates. Beds removed for social distancing were re-instated on 7th February 2022.

5.4.5 Table 9 and 10 examine the use of temporary staff on the number of falls and compare the 10 wards with most falls and the 10 wards with least. There is little difference in the average use of temporary workforce with table 9 having an average of 23% temporary workforce demand and table 10 having 19% on average.

Table 8: Harm related to falls and pressure ulcer acquisition before and after beds removed for social distancing

Ward	Falls	Falls rate	**% change**	Falls with harm	Falls harm rate	**% change**	PU	PU Rate	% change
4B	1	**3.5**	**-55.0%**	0	0.0	**-100.0%**	0	0.0	**-100.0%**
6B	4	**8.1**	**-72.3%**	0	0.0	**-100.0%**	0	0.0	**-100.0%**
9B	4	**7.0**	**-0.5%**	0	0.0	**-100.0%**	1	1.8	**-66.8%**
ACUC	5	**10.6**	**-29.3%**	2	4.2	**97.9%**	0	0.0	**-100.0%**
GW1	0	**0.0**	**-100.0%**	0	0.0	**0.0.%**	0	0.0	**-100.0%**
Guiting	7	**54.8**	**3764.6%**	1	7.8	**0.0%**	0	0.0	**-100.0%**

Prescott	1	**4.4**	**-26.7%**	1	4.4	**340.0%**	2	8.9	**76.0%**
Total	**22**	**9.1**	**12.1%**	**4**	**1.7**	**-9.2%**	**3**	**1.2**	**-46.5%**

Table 9: Wards with most falls resulting in harm

Ward	% demand to temporary workforce
3a	12.5%
6b	25.9%
Woodmancote	17%
AMU	31.8%
Prescott	25.1%
4b	23.9%
9b	24.9%
Ryeworth	7%
6a	37.9%
4a	23.7%

Table 10: Wards with fewest falls resulting in harm

Ward	% demand to temporary workforce
Cardiology CGH	17.4%
Knightsbridge	12.9%
2a	19.7%
Guiting	26.3%
Bibury	26.5%
Dixton	19.5%
Alstone	19.5%
5a	22.5%
Lilleybrook	1.8%
Snowshill	26.5%

5. Conclusions

- Whilst we have seen an increase in the count of both falls and pressure ulcers year-on-year this is in the context of increased activity. When reviewing the rates for both years 2020/21 and 2021/22 there has been a decrease in the number of falls by 6%, falls with harm rate has decreased by 34%. Although, there has sadly been 6 deaths within the year as a result of a hospital fall. Hospital acquired pressure ulcers have decreased 9.4% year-on-year although there has been an increase over the winter but that has not adversely affected the overall reduction seen.

- A comprehensive review of the harm from falls and pressure ulcers has been

undertaken to ensure we are aware of the current situation and can focus our improvement activity accordingly.

- A review of the contributing factors has been carried out with a deep dive on the impact of staffing, EPR assessments and timing of falls.

- Availability of care hours per patient day has a significant effect on harm from falls and acquisition of hospital acquired pressure ulcers but not on the overall number of falls.

- High use of temporary workforce is not a factor in the risk of falls.

- Assessment of patients' risks relating to falls requires improvement and is likely linked to availability of staff.

6. Plans for improvement in 2022/23

6.1. Our aim of building on the reduction in falls and pressure ulcers during 2021/22 with a further 10% reduction can now be realised with a greater understanding of the issues. Staffing availability is a key factor and significant work is underway to close the gap in vacancies that will have a demonstrable effect on harm. Staffing availability is intrinsically linked to completion of risk assessments and most importantly the measures to prevent harm following that risk assessment. The focus this year is to mitigate risk and further recover our position and aim to achieve the goals we have set within the improvement programmes. Divisional Directors of Quality & Nursing are leading on production of harm prevention plans specific to their divisions to ensure the strategic aims of the improvement plans can be operationalised and tailored. These will come through Quality Delivery Group during Quarter 1 and be monitored regularly. The Trust improvement plan overview is available in appendix 3.

6.2. NHS England regional team have been invited to review the falls prevention service provision within the Trust and will join the team on site during June 2022 and will be asked to make recommendations for improvement.

7. Recommendation

7.1. The Trust Board are asked to note the content of this report and support the improvement programme that has been developed.

7.2. The Trust Board are asked to note that harm from falls and pressure ulcers are closely linked to the availability of registered nurse hours and this is not significantly dependent on either a substantive or temporary workforce.

7.3. The Trust Board are asked to note improvement in the rate of falls and pressure ulcers year-on-year and the work of our specialist and direct-care teams in improving the position.

7.4. The Trust Board are asked to note the ambition to further reduce the incidence of harm from falls and pressure ulcers.

Appendix 1: Pressure Ulcer Categories

EPUAP: Category 1

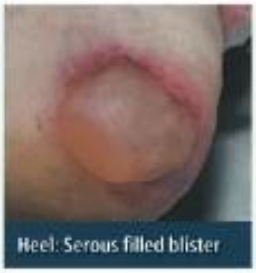
- Non-blanchable erythema of intact skin: persistent redness in light pigmented skin. This may be difficult to detect in darkly pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple
- Warmth, oedema, induration or hardness as compare to adjacent tissue may also be used as indicators, particularly on individuals with darker skin
- May include sensation (pain, itching)


Category 1

EPUAP: Category 2

- Partial thickness skin loss involving epidermis, dermis or both
- Presents clinically as an abrasion or clear blister
- Ulcer is superficial without bruising


Category 2


Heel: Serous filled blister

EPUAP: Category 3

REFER INTO THE TISSUE VIABILITY SERVICE

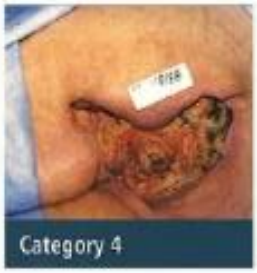
- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunnelling
- The depth varies by anatomical location eg. bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and category 3 ulcers can be shallow.
- In contrast areas of significant adiposity can develop extremely deep category 3 pressure ulcers
- Bone / tendon is not visible or directly palpable


Category 3

EPUAP: Category 4

REFER INTO THE TISSUE VIABILITY SERVICE

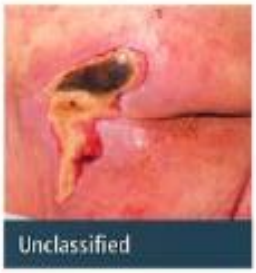
- Full thickness tissue loss with exposed bone (or directly palpable) tendon
- Often include undermining and tunnelling
- The depth varies by anatomical location (bridge of the nose, ear occiput and malleolus do not have (adipose) subcutaneous tissue and category 4 ulcers can be shallow.
- Category 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).

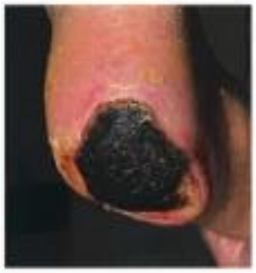

Category 4

Unclassified Pressure Ulcer

REFER INTO THE TISSUE VIABILITY SERVICE

- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by the slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either category 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as the body of natural (biological) cover and should not be debrided until assessed by the Tissue Viability/Vascular Nurse.

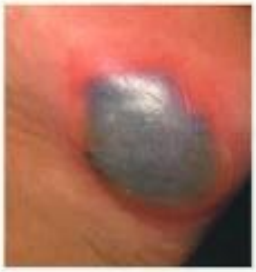

Unclassified



Suspected Deep Tissue Injury: Depth unknown

- Purple or maroon localized area of discoloured intact skin with a bruising like appearance or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.
- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may include a thin blister over a dark wound bed
- The wound may further evolve and become covered by thin eschar
- Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

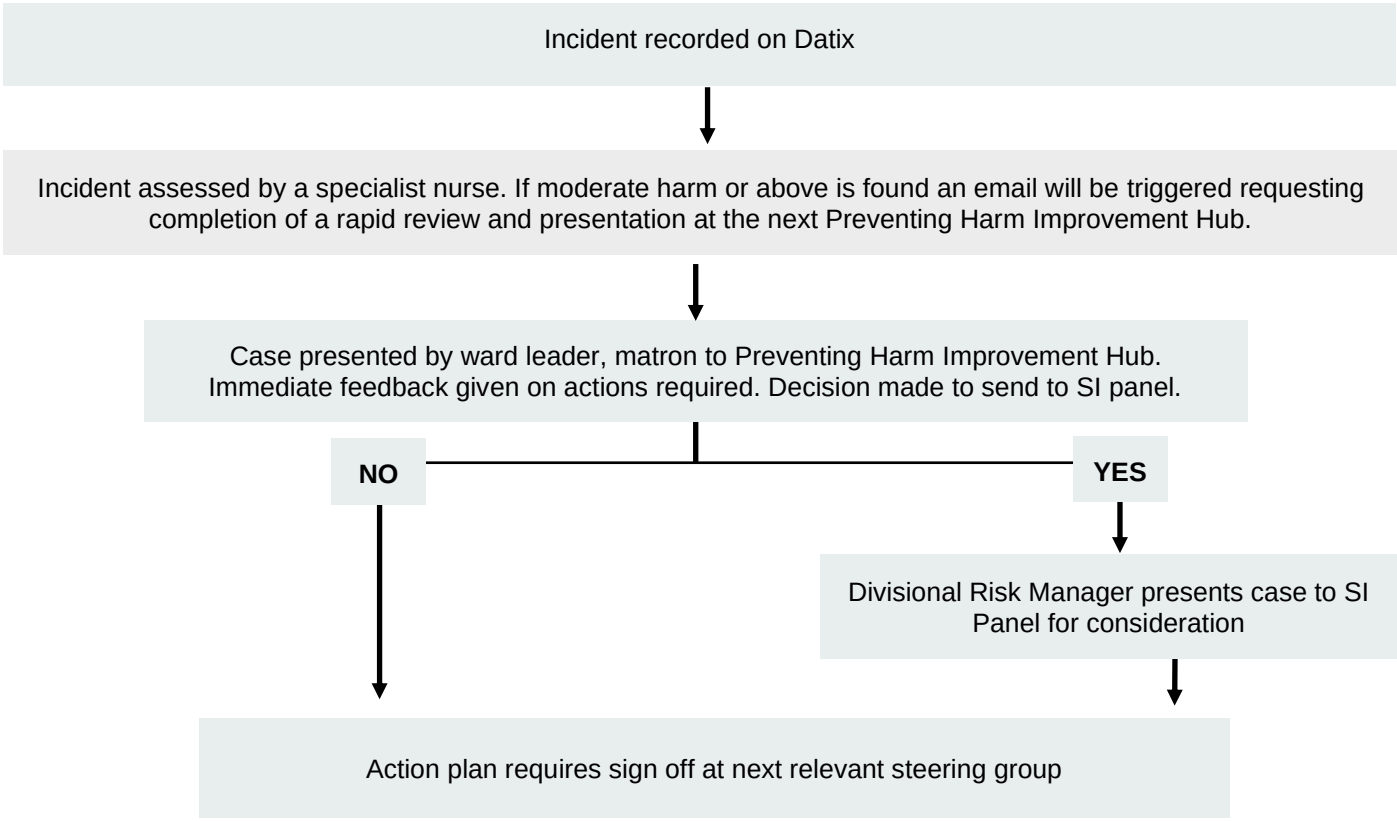
REFER INTO THE TISSUE VIABILITY SERVICE



Appendix 2: Preventing Harm Improvement Hub Flowchart

Preventing Harm Improvement Hub Process

Rapid review panel for pressure ulcers and falls resulting in moderate harm or above



Preventing Harm Improvement Hub
Meets weekly
- Lead: Deputy Chief Nurse
- Specialist Falls Prevention Nurse
- Lead Nurse for Tissue Viability
- Risk Manager
- Patient Safety Investigations Team

Gloucestershire Hospitals
NHS Foundation Trust

Falls & Pressure Ulcer Prevention

Annual Programme
2022-23

Gloucestershire Hospitals
NHS Foundation Trust

Introduction

Preventing harm from falls and pressure ulcers is a top priority for Gloucestershire Hospitals NHS Foundation Trust. Keeping our patients safe from avoidable harm is everyone's responsibility. The Falls Prevention Team and Tissue Viability Team have a wide ranging programme of activity that focusses on continual improvement in order to deliver the best care for everyone and keeping our patients at the heart of everything we do.

This programme covers 3 strategic themes we have identified as areas of focus for the financial year 2022/23. The aim is to reduce the number of falls resulting in moderate harm or above by a further third, building on the annual improvement already seen.

INSIGHT

Reducing harm by analysing the data

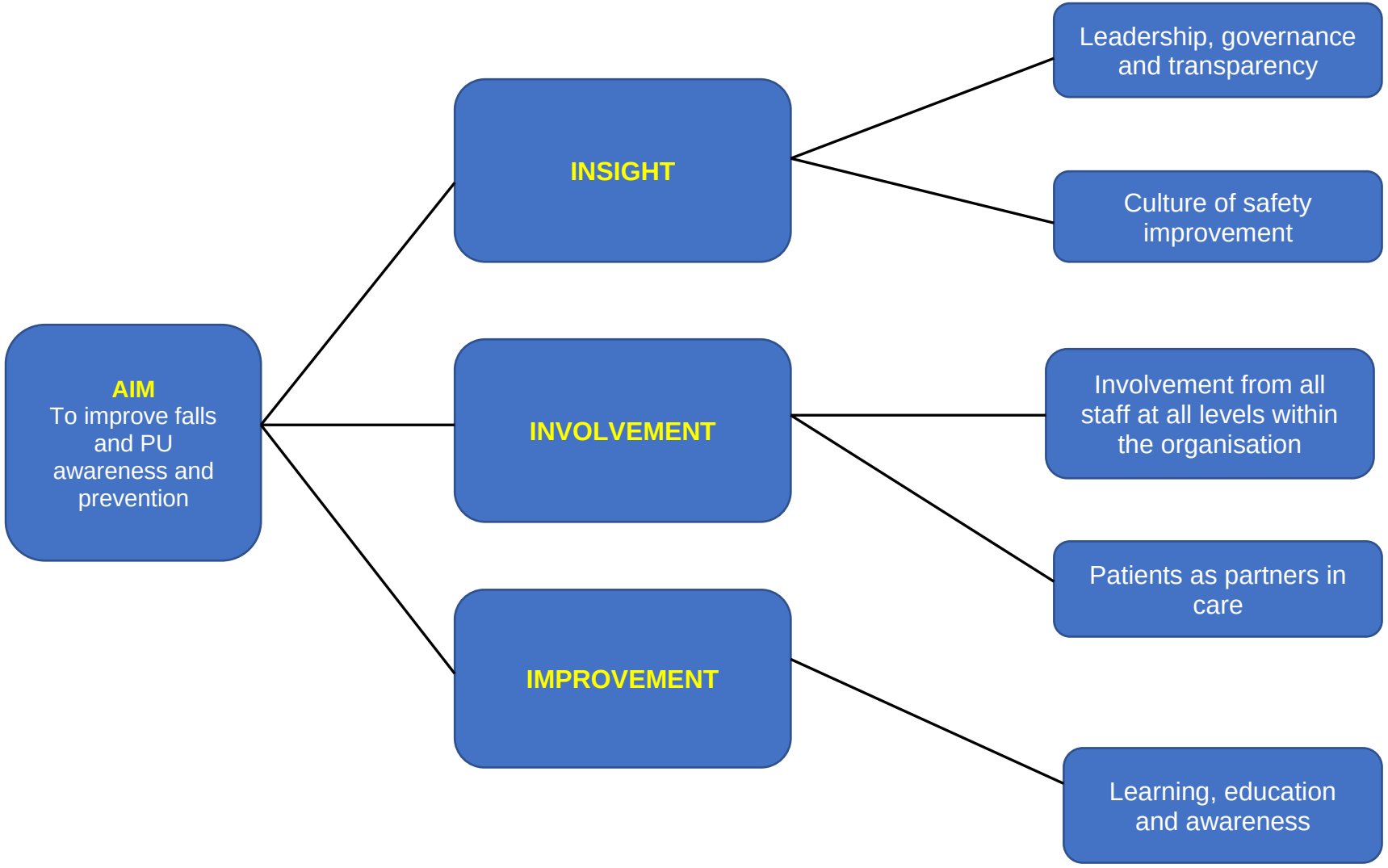
INVOLVEMENT

We will provide an expert, holistic, patient focused service, by involving direct care staff in the development of the improvement programme.

IMPROVEMENT

Design and support programmes that deliver effective and sustainable change

Improvement plan for preventing harm



Annual Programme

The annual programme provides an operational framework for achieving progress with our ambitions for improvement across the trust. Our approach to falls prevention is multifaceted with leadership from across nursing, medicine and allied health professionals. Progress against this plan is reported by the Divisional Directors of Quality & Nursing to Quality Delivery Group, the programme is monitored at Quality Delivery Group.

Strategic Theme	Operational Objective	Action
INSIGHT	To reduce falls with injurious harm and pressure ulcers Category 2 and above.	Set divisional and ward level targets for compliance with high impact actions based on Preventing Harm Hub investigation outcomes Use EPR data to drive improvement with assessments, particularly ongoing assessments Falls Prevention Nurse Specialist and Physiotherapist will review repeat fallers and provide expert guidance on preventing further occurrences. Share information gathered at Preventing Harm Hub widely across the organisation Assess all hip fractures for severe harm Presentation of cases that result in severe harm to be shared at NAME or Nursing Delivery Group Tissue Viability Specialist Nurses to review all hospital acquired pressure ulcers, and on-going review of category 3 pressure ulcers and above Monthly face to face meetings with senior staff of areas identified as having increasing numbers of hospital acquired pressure ulcers

Strategic Theme	Operational Objective	Action
INVOLVEMENT	Development of harm free care	Establish collaboratives to improve completion of assessments and monitor at Council Ensure all wards use Safety Briefings at the beginning of shifts and discuss patients at risk of falls and patients requiring enhanced supervision Collaborate with Physiotherapy to improve access to mobility assessments and equipment Further develop falls and pressure ulcer prevention champions role within the wards, empowering them with the expertise to undertake mobility assessments and to disseminate this Establish a non-executive director with responsibility for falls and invite them to participate in improvement programme Ensure pressure relieving equipment is readily available through the new medical equipment fund

Strategic Theme	Operational Objective	Action
IMPROVEMENT	Learning, Education and Improvement	Focus education and training package on high impact actions in high risk areas using the top 10 high incidence wards Test improvement initiative effectiveness by continuously reviewing data at Council Ensure Executive Review captures performance of the divisional improvement programmes Inpatients will receive a multifactorial assessment of their risk of falls including lying and standing BP and a mobility assessment and have the SKINN bundle applied if required. This will be measured and reported to QDG. Special focus on pressure ulcer prevention support package in the ED. Patients that fall will be retrieved safely from the floor suing the most appropriate equipment. This will be measured and reported to QDG. Staffing reviews to include details of harm from falls and pressure ulcers to drive improvements in meeting the demand care hours per patient day.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date	14 July 2022
Title	Learning from Deaths Report
Author **Director**	Andrew Seaton, Quality Improvement and Safety Director Dr Alex D'Agapeyeff, Interim Medical Director and Director for 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

To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

Key issues to note

- All deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.

- All families communicate with the bereavement team and have the opportunity to feedback any comments on the quality of care which are fed back to wards for their learning and onto the End of Life group for learning. The rate of positive feedback has improved consistently and stabilised around 85%.

- The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level (Appendix 4 for QPC only). The rate of reviews within 3 months decreased to 53% from 63% which reflects a significantly busy time for the Trust as we moved into winter last year (Appendix 1) Each Division have been asked to review their triggers to ensure sufficient deaths are captured for reviews.

- All serious incidents have action plans based on the identified learning which are monitored to completion. (Appendix 2 for QPC only).

- Mortality statistic for HSMR, SMR are now within normal limits with weekend\weekday mortality also within the normal range (Appendix 3). The COVID impact on mortality maintains a complex picture but when COVID is removed from these data the Trust remains within normal variation.

  HSMR is now 102.8 from the previous reported position of 108.4
  SMR is now 101.1 from the previous reported position of 106.9
  SHIMI for period Sept 2020 - Aug 2021 remains in the expected range at 104.97 from 101.32

Recommendation

To RECEIVE the report as a briefing and source of assurance that Trust is continually reviewing and learning from deaths
Enclosures
• Learning from Deaths Report • Appendices (separate reading pack)

LEARNING FROM DEATHS REPORT

1. Aim

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 With the exception of mortality data the period covered reflects October - December 2021 and is an update from the previous report.

2. Learning From Deaths

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties. (Appendix 1)

c. Serious incident review and implementation of action plans. (Appendix 2 for Q&PC only)

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports and national audits.

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. These deaths are entered on to the Datix system to support the SJR process.

2.3 All families are given the opportunity to provide feedback to the bereavement team on the quality of care. The feedback is overwhelmingly positive and is routinely shared with the relevant ward area via Datix.

2.4 The family feedback analysis from Bereavement will in future be sent through to the End of Life meeting and triangulated with the national end of life survey data. Highlights and recommendations from the End of Life Group will be noted in this report. Interim data shows a general improvement in positive feedback.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings feedback to HMG is a rolling basis an example of this can be seen in appendix 3 (Q&PC only). A common theme involves planning at End of life and the communication of this to team, the RESPECT form has improved this but a new ReSPECT Working Group to improve this further has been created and led by Resuscitation committee chair.

2.5 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups. Summary reports on closed action plans are included in the report.

3. Mortality Data (Appendix 4 pdf attachment)

3.1 HSMR and SMR have moved back to the expected range from the previous report. SHIMI remains within the expected range. The COVID impact on mortality maintains a complex picture but when COVID is removed from these data the Trust remains within normal variation.

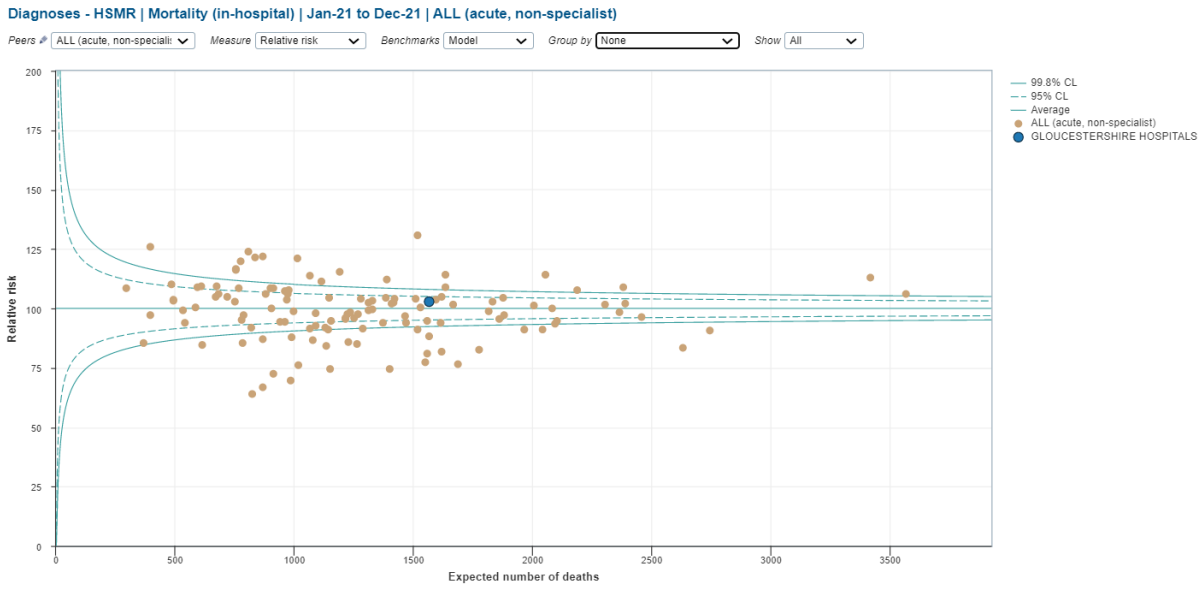
3.2 HSMR &SMR for the period Jan 2021- Dec 2021 is within the expected range:

- HSMR is now 102.8 from the previous reported position of 108.4 and within normal limits when COVID activity is removed

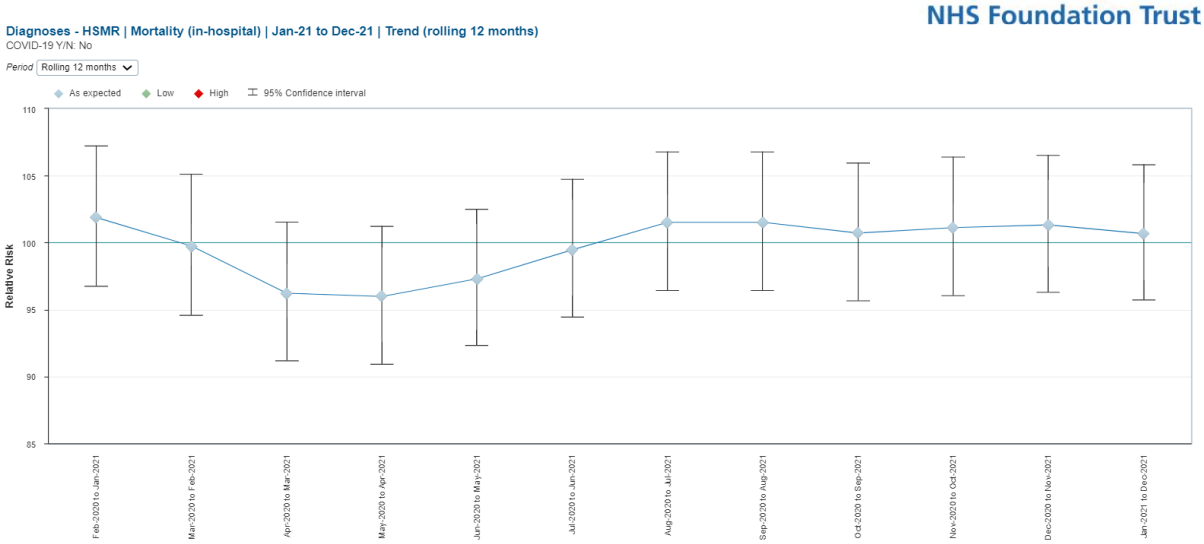
- SMR has now 101.1 down from the previous reported position of 106.9 which is within normal range, and stays within normal limits when COVID activity is removed

- SHIMI for period Dec 2020 – Nov 2021 remains in the expected range 104.97 from 101.32 This data has COVID removed before calculation

3.3 HSMR Jan 2021 – December 2021

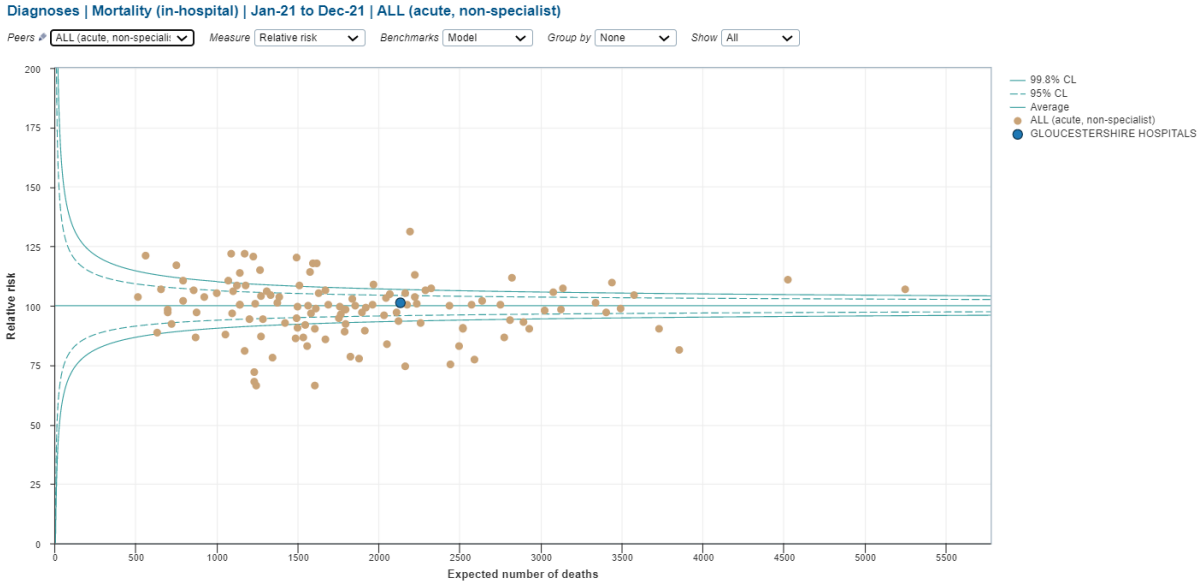


If COVID-19 activity is removed from the HSMR (where it is in a secondary diagnosis position), it reduces to 100.7 (95.7 – 105.8) for the latest 12 month period, this is statistically 'as expected'. The rolling 12 month trend without COVID (below) shows a similar trend to the rolling HSMR trend with COVID included.

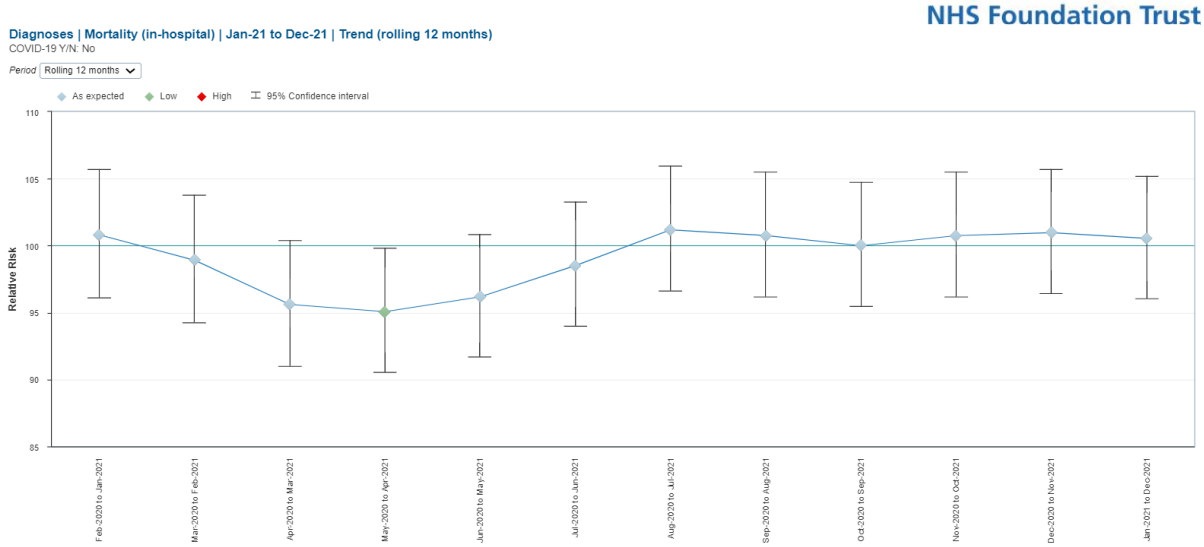


3.4 SMR

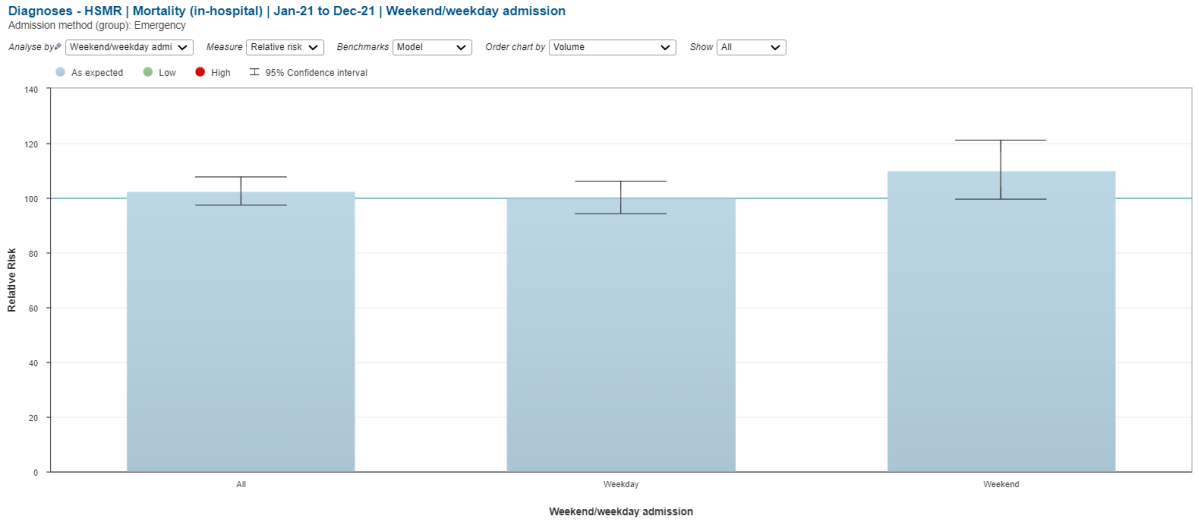
The SMR for the Trust is statistically significantly higher for this period Jan 2021 – Dec 2021.



If COVID-19 activity is removed from the SMR (primary or secondary diagnosis position), it reduces to 100.5 (96.0 – 105.2) for the latest 12 month period, this is statistically significantly 'as expected'. The rolling 12 month trend shows a stable trend since July 21. See below



Both Weekday and weekend HSMR relative risk are considered 'as expected' for emergency admissions. This represents a banding change for weekday HSMR.



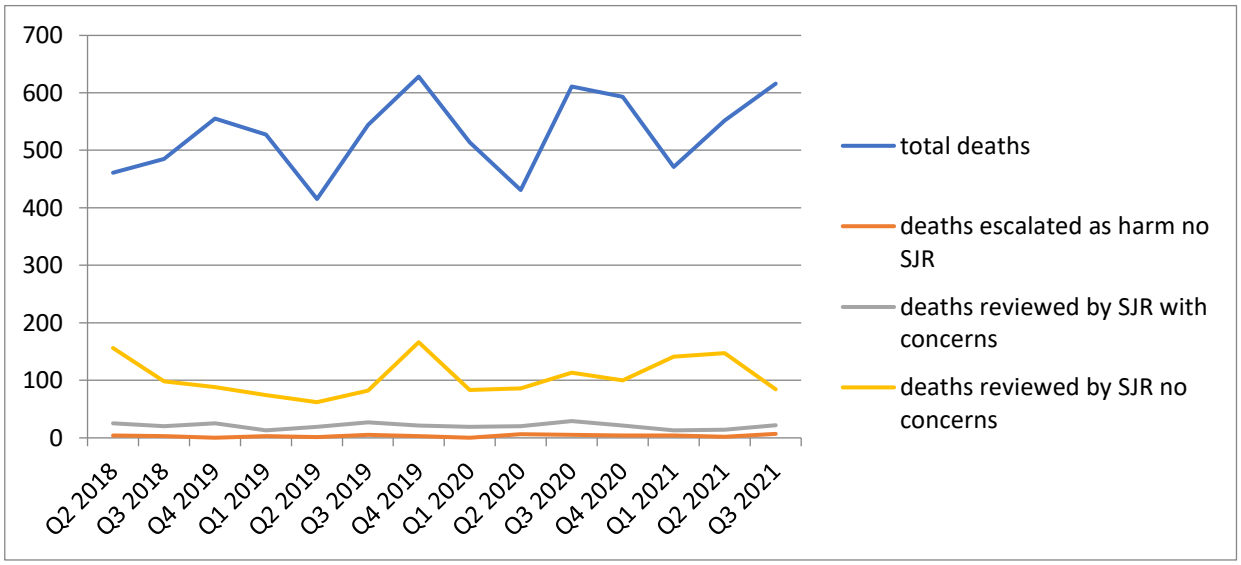
4. Structured Judgement Review Process

4.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They continue to ensure all deaths are recorded in real time.

4.2 Deaths identified for review (next page)

Mortality Quarterly Dashboard: Quarter 3 (Oct-Dec 2021 – Appendix 1)

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter
616	552	7	2	22	14	84	147	106 (17%)	157 (28%)	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1639	2150	13	15	49	89	372	382	409 (25%)	454 (21%)	1	1



Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
0	0	0	13	10	107	46	195	19	77	0	2

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
0	1	0	1	0	1	0	0	0	0

Problems identified in care and care record							
Problem in clinical monitoring		Problem in resuscitation following a cardiac or respiratory arrest		Other Problem		Quality of Patient Record Poor or very poor	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
0	1	0	0	0	2	0	1

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
59 (56%)	86 (53%)	**N/A**	4 (80%)	**58 (55%)**	54 (34%)	**32 (30%)**	16 (10%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
Measurement amended	Measurement amended	**6 (75%)**	9 (64%)	**129 (32%)**	305 (67%)	**50 (12%)**	6 (1%)

4.3 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach continues to embed within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty. Several areas are not performing sufficient reviews as they rely on the national triggers, this area needs a review and the identification of more relevant triggers.

4.4 The Performance against standard tables above illustrates the general performance with 56% is a slight increase from an average of around 53% which would reflect the continued heavy workload of clinicians when these reviews would be undertaken for this quarter.

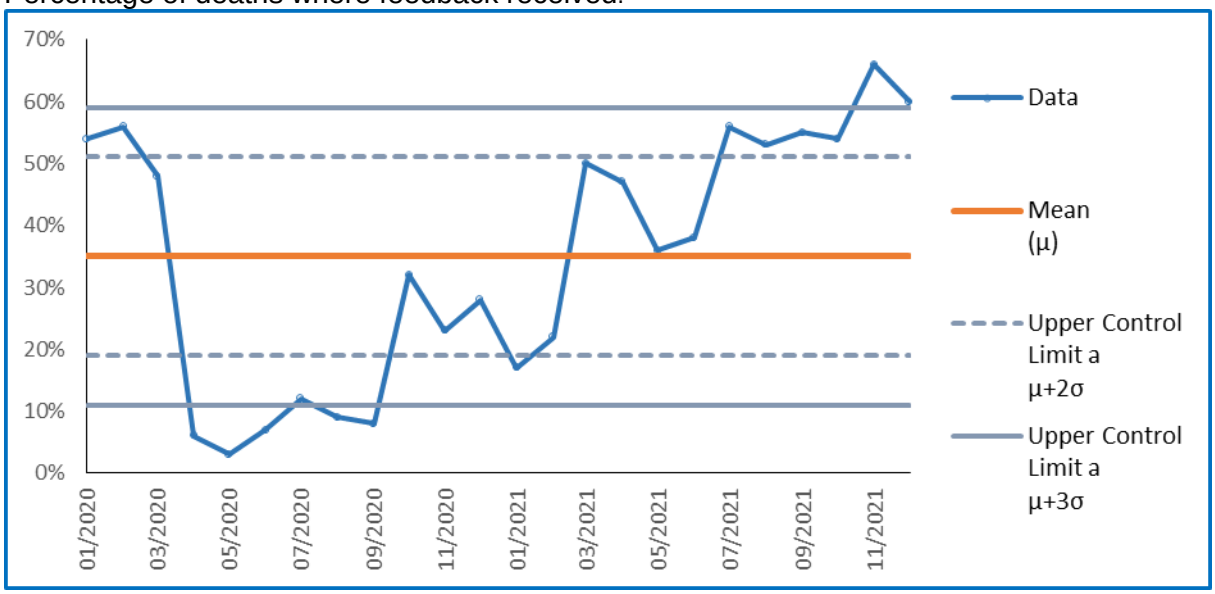
The one month reviews were originally put in place to capture any missed SI\DoC cases but it is rare that SJRs identified any new cases. HMG will continue to monitor the metric but place more emphasis on the reviews within three months.

5. Family Feedback from Bereavement team

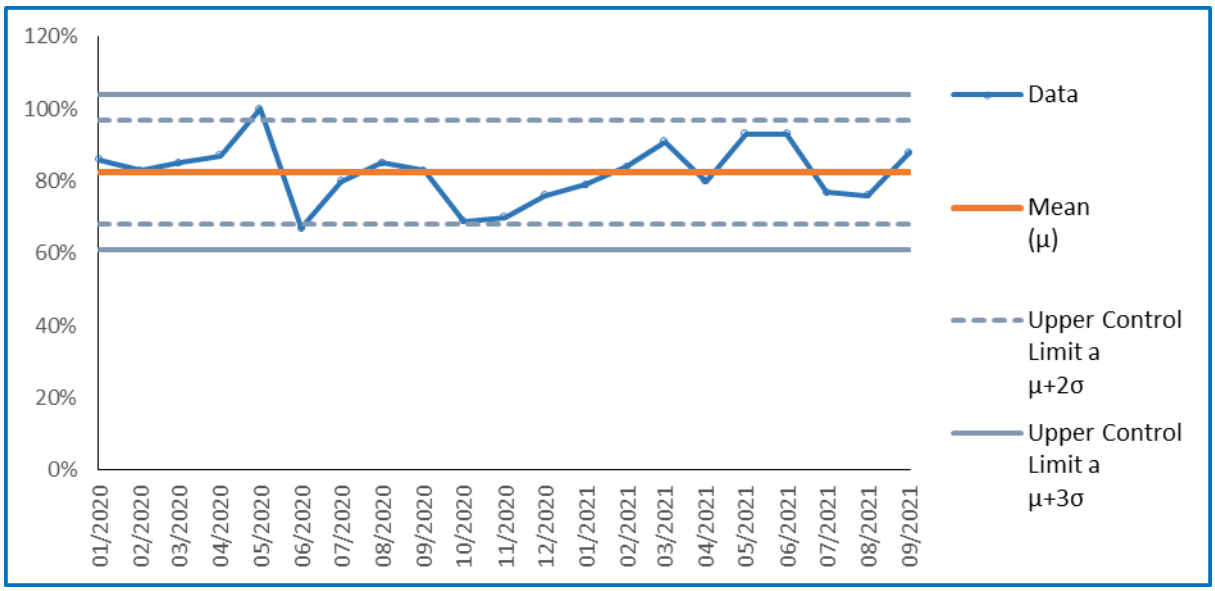
5.1 Following a review of family feedback mechanism with the End of life lead, a new set of indicators and themed reporting has been developed. The themed reporting is based on the national End of Life audit categories which allowed triangulation of feedback with the findings of the annual audit. These data will be presented at the End of meeting Life (as the expert group) as part of their meetings and inform discussion on assurance and improvement work with updates featuring in this report. Comments linked to the themed reporting can be seem in Appendix 4.

Trust wide

Percentage of deaths where feedback received.

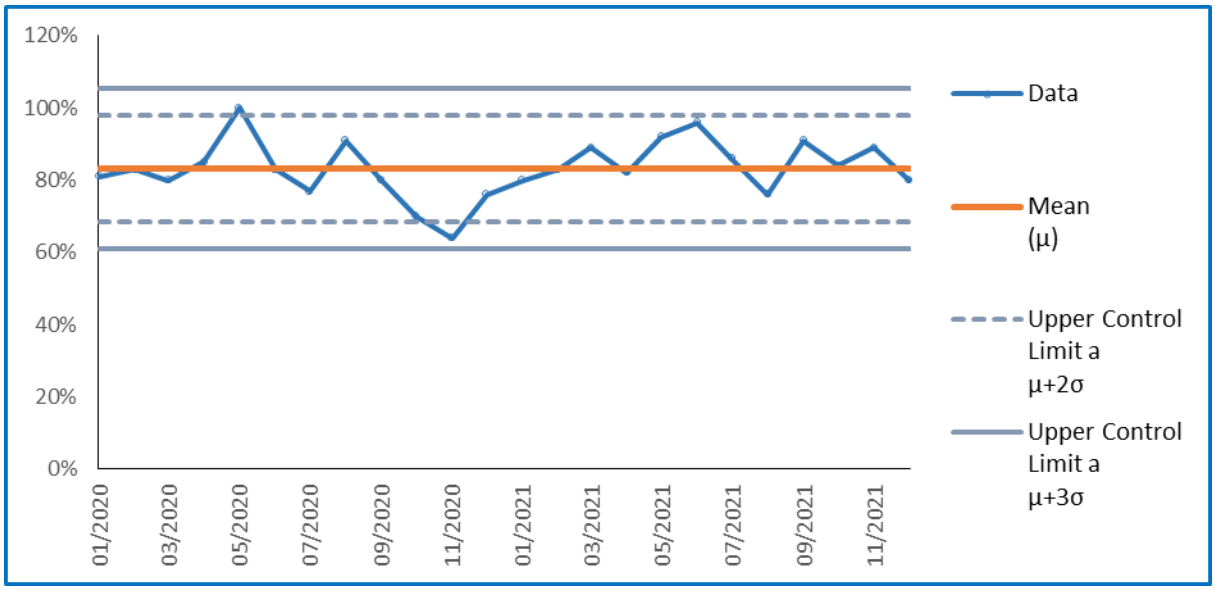


Percentage of positive feedback received



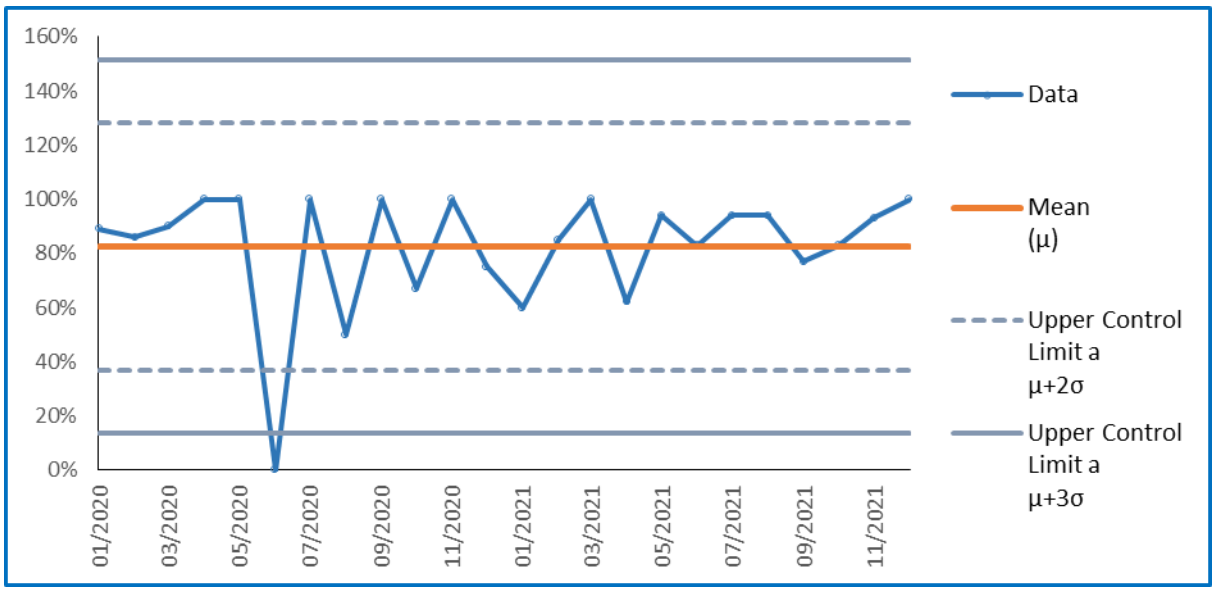
Medical Division

Percentage of positive feedback received



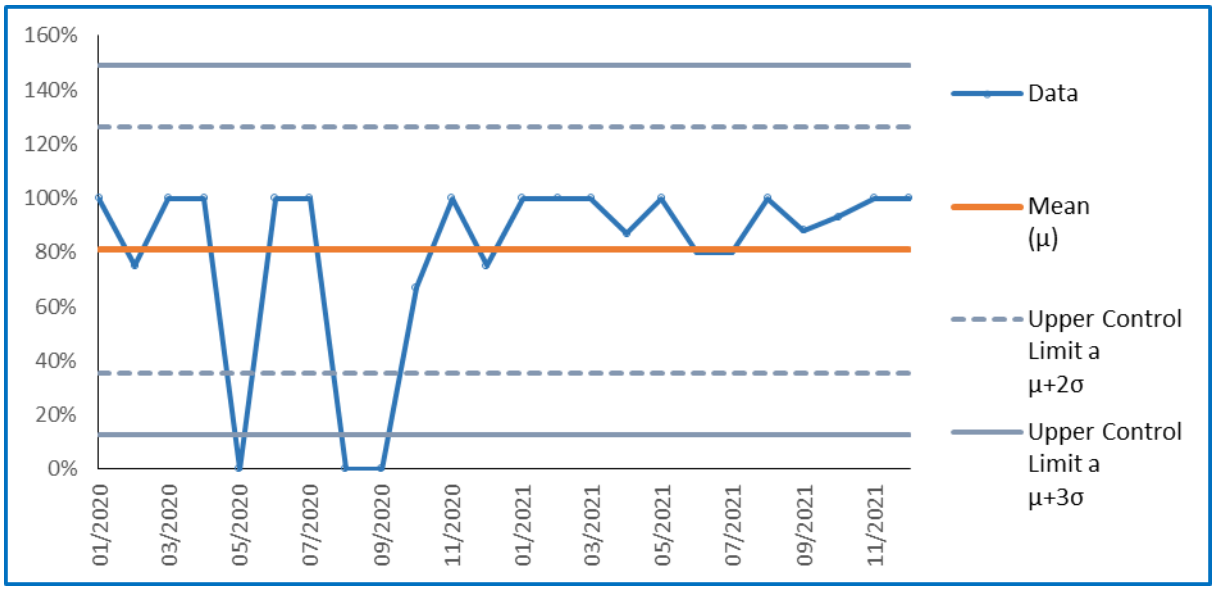
Surgical Division

Percentage of positive feedback received



Diagnostics and Specialties Division

Percentage of positive feedback received



5.2 Conclusion

There has been continued improvement in positive feedback from November 2020 to March 2021 and now is showing normal variation with a mean of 82% has been maintained.

Thematic review will feature in the End of Life committee with future recommendations or actions highlighted in this report.

6. Learning from Deaths

6.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through the speciality and divisional processes, this approach although improving is still inconsistent.

All specialties now receive monthly individual monthly data on SJR performance.

6.2 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some common themes continue to be identified which are in common with known areas of quality, as in previous months these are in particular the complex management of the deteriorating patient and resuscitation decisions on admission. (Appendix 3)

6.3 Serious incidents that result in death all have action plans. A summary of the individual closed actions plans and learning in the past 3 months is attached for information (Appendix 2).

Deaths by Special Type –	Jan-Mar 2021		Apr-Jun 21		Jul-Sept 21		Oct-Dec 2021		Jan-Mar 2022	
Type	*Number*		*Number*		*Number*		*Number*		*Number*	
Maternal Deaths (MBRRACE)	1		0		0		1		0	
Coroner Inquests with SI	3		1		4		1		2	
Serious Incident Deaths	6		6		8		2		4	
Learning Difficulties Mortality Review (Inpatient deaths)	3		6		8		6		3	
Perinatal Mortality	Neonatal <8 days	4 (but only 1 at GRH)	Neonatal <8 days	2	Neonatal <8 days	4 (only 1 at GRH)	Neonatal < 8 days	4 (but only 1 at GRH)	Neonatal < 8 days	4 (3 at GRH)
	Still birth	5	Stillbirth >24/40	3	Stillbirth >24/40	2	Still Birth	1	Still Birth	5

6.4 LeDeR

During Q1 and Q2 to date in 2021 we had a slightly higher than usual numbers of LD deaths, but this has not been the case in Q3

LeDeR reviewers are regularly attending GHFT to review notes and QA meetings occur every month. There is a backlog of reviews on deaths occurring since April, but the presentation order of reviews at LeDeR is not under the control of GHFT

Generally in-hospital care is thorough and considered good. There are two main areas for collaborative work:

a) Improving oral hygiene
b) Improving identification of need for modified diet and fluids in first 48 hours of admission

6.5. Monthly updates are provided to QDG from the Safeguarding lead on LeDeR, action is taken forwards on the Safeguarding meeting. The latest update report on LeDeR can be seen in appendix 6

7. Mortality Dashboard (Appendices)

7.1 The Trust reporting requirements can be found below:

Appendix 1
a) SJR dashboard & Divisional Performance

Appendix 2
a) Summary reports from Serious Incidents (For Q&PC only)

Appendix 3
a) Example of learning from SJRs (For Q&PC only)

Appendix 4
a) Mortality indicators – Dr Foster report

Appendix 5
a) Themed feedback

Appendix 6
b) LeDeR report

8. Conclusions

8.1 All deaths are reviewed within the Trust via the bereavement and the Medical Examiner approach.

8.2 There is good progress on local learning from problems in care and ensuring these are being reflected on within specialties. Identified themes through specialty & divisional learning

8.3 Timeliness and completion rate have shown continual improvement with a small increase in quarter for SJRs, general workload is still impacting on consistency of approach across the Trust.

8.4 Family feedback shows good satisfaction, analysis is reported under the national end of life clinical audit themes and will be interpreted by the End of life group to identify areas for improvement.

8.5 Mortality indicators across most parameters are showing normal variation with and without COVID.

9. Recommendations

9.1 The Committee is asked to note the Learning from Deaths Quarterly Report and approve in advance of it going to Trust Main Board.

Author: Andrew Seaton, Quality Improvement and Safety Director

Presenter: Dr Alex D'AGAPEYEFF , Interim Director for Safety & Medical Director

May 2022

Gloucestershire Hospitals NHS Foundation Trust

Appendix 1

Mortality Quarterly Dashboard: Quarter 2 (Oct-Dec 2021)

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
105	75	**0**	0	**1**	3	**19**	9	**20**	10 (10%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
247	340	**2**	6	**5**	24	**37**	91	**40**	104 (31%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology (% of total death)**	**Deaths investigated as serious or moderate harm incidents. Following SJR**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	27	**0**	3 (11%)	0	0	0
T&O	24	**0**	6 (25%)	0	0	1
Upper GI	6	**0**	2 (33%)	0	0	0
Lower GI	34	**0**	6 (18%)	0	0	0
Vascular	7	0	3 (43%)	0	0	0
Urology	5	**0**	0 (0%)	N/A	N/A	N/A
Breast	0	N/A	0 (0%)	N/A	N/A	N/A
ENT	2	**0**	0 (0%)	N/A	N/A	N/A

OMF	0	N/A	N/A	N/A	N/A	N/A
Ophthalmology	0	**N/A**	N/A	N/A	N/A	N/A

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
5 (25%)	4 (44%)	**N/A**	N/A	**7 (35%)**	4 (40%)	**12 (60%)**	4 (40%)
This Year (YTD)	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
Measurement amended	Measurement amended	**N/A**	2 (0%)	**14 (35%)**	83 (73%)	**18 (45%)**	0

Reason for SJR not being undertaken	**This Quarter**	**Last Quarter**
Notes unavailability	**0**	**0**

Gloucestershire Hospitals NHS Foundation Trust

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
476	446	**0**	2	**20**	11	**65**	135	**85**	144 (32%)	**0**	1
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1298	1633	**2**	8	**43**	61	**330**	275	**363**	330 (20%)	**1**	1

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Acute medicine	**101**	0	6 (6%)	**0**	**0**	**1**
Cardiology	**20**	0	5 (25%)	**0**	**0**	**0**
Emergency Department	**57**	0	55 (96%)	**0**	**0**	**15**
Gastroenterology	**11**	0	2 (18%)	**0**	**0**	**0**
Neurology	**6**	0	0 (0%)	**0**	**0**	**0**
Renal	**43**	0	4 (9%)	**0**	**0**	**0**
Respiratory	**81**	0	7 (9%)	**0**	**0**	**0**

Rheumatology	**0**	0	N/A	**0**	**0**	**0**
Stroke	**24**	0	1 (4%)	**0**	**0**	**0**
COTE	**120**	0	7 (6%)	**0**	**0**	**2**
Diabetology	**16**	0	1 (6%)	**0**	**0**	**0**
Endoscopy	**0**	0	N/A	**0**	**0**	**0**

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
54	80 (54%)	**N/A**	4 (80%)	**50 (59%)**	48 (33%)	**20 (24%)**	10 (7%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
Measurement amended	Measurement amended	**6 (75%)**	4 (44%)	**112 (31%)**	311 (94%)	**30 (8%)**	6 (2%)

Reason for SJR not being undertaken	**This Quarter**	**Last Quarter**
Notes unavailability	**0**	**0**

Gloucestershire Hospitals
NHS Foundation Trust

Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
28	29	**0**	0	**0**	0	**2**	2	**3 (11%)**	2 (7%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
57	72	**1**	0	**0**	4	**4**	14	**5 (9%)**	18 (25%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Oncology	**24**	**0**	**1 (4%)**	**0**	**0**	**0**
Clinical haematology	**4**	**0**	**1 (25%)**	**0**	**0**	**0**

Performance against standards for review			
Deaths reviewed within 3 months of request (% of total requiring review)	**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**	**Completion of Key Learning Message (% of total requiring review)**	**Deaths selected for review but not reviewed to date (% of total requiring review)**

This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter
0 (0%)	1 (33%)	**N/A**	N/A	**1 (33%)**	1 (33%)	**0 (0%)**	2 (100%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
Measurement amended	Measurement amended	**N/A**	2 (100%)	**2 (40%)**	14 (78%)	**2 (40%)**	0 (0%)

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Gloucestershire Hospitals NHS Foundation Trust

Maternity and Gynaecology

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of in hospital deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
3	0	**0**	0	**0**	0	**0**	0	1	0	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
3	2	**0**	1	**0**	0	**0**	0	1	0 (0%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Gynaecology	**3**	**0**	**0**	**N/A**	**N/A**	**N/A**
Maternity	**0**	**0**	**0**	**N/A**	**N/A**	**N/A**

Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
N/A	1 (100%)	**N/A**	N/A	**N/A**	1 (100%)	**0**	0

This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
Measurement amended	Measurement amended	**N/A**	**N/A**	**1 (100%)**	N/A	**0**	0

Appendix 5

Themes of Feedback (Oct-Dec 2021)

Communication with the dying person

There were no comments directly relating to communication with the dying person.

Communication with families and others

Where communication was mentioned it was mostly a negative comment. Themes related to difficulties caused by visiting restrictions, inability to get through on phone, notification of death/impending death, lack of communication specifically from Drs, lack of notification of transfers and a lack of explanation about decisions and management at the end of life.

“Family felt that it was difficult to get good information about what was going on and this was exacerbated because of the covid visiting restrictions.”

“Answering of telephone very poor, tried to get through to ward one day, not picked up, tried for over 2 hrs.”

“wife was upset that despite being 1st NOK contact she was not told of husband's death and was told by daughter in law”

“Family said they were not informed of the death. Only when they phoned to find out how patient was were they then told he had died”

“Family felt that staff didn't portray the urgency if the situation. Sad that they hadn't been able to see her”

Needs of families and others

There were mainly positive comments regarding the care shown to families. Specific mention was given to respecting privacy and access to side rooms.

“Staff on the ward deserve a medal. So kind and so considerate.”

There was only one negative comment regarding lack of compassion and kindness

“felt very alone approaching the end of her husband's life, she felt the ward lacked compassion and kindness and was left alone for 2 hours.”

Individualised plan of care

The majority of comments are not specific to plans of care. There were 5 individual negative comments re pain relief/sedation and feeding.

“poor pain control. Had to keep asking for pain relief”

“Son would have liked syringe driver to have been started earlier. Dad was very agitated so would have preferred him to be sedated.”

“Family felt disappointed that her pain relief took too long to get under control.”

“issues regarding patient being offered regular solids despite 'fluids only' sign above head

Families and others experience of care

The vast majority of comments related to experience of care were positive:

“Husband said - We couldn't think more highly of staff at the hospital. The Queen wouldn't have got better service.”

“Can't fault anyone - lovely people, truly appreciate everything during difficult times.”

“Wonderful care - went above and beyond. Nurses treated Mum like she was the only patient they'd ever treated”

“"The care was outstanding, I have never witnessed such dedication and devoted care by ALL the staff”

Negative comments included concerns re staffing, patients nursed in corridor, multiple ward moves, in hospital falls, failed discharges resulting in readmission and not being listened to by staff

“Daughter wished she had not brought mum into hospital - could have cared for her just as well at home. Mum was in corridor for 7 hours by the toilet”, “no doctors available over weekend, no CT scans, no pharmacy. Despite loveliness of staff no drs meant mum was neglected.”

“He said that the sense that he wasn't being taken notice of left him feeling uncomfortable and insecure about leaving his dad in the hospital. He felt that they were "indifferent about Dad"”

“concerned regarding low numbers of staff considering the level of care needed”

“Few issues at beginning of stay moved wards 9A,8A then 7A. “Dying person” was blind and team didn't appreciate that.”

“unhappy that trust were still trying to discharge patient to Dilke just hours before his death.”

“She felt left unattended most of the time. Not allowed to stay and care for her dad, despite having carer status.”

Hospital Mortality Group **Appendix 6**
11th May 2022

Learning Disability Deaths Report (LeDeR)

1. Purpose of Report

1. Quarterly update on in-hospital Learning Disability deaths

2. Executive Summary

1. On average there are 1 – 2 deaths per month of a person with a Learning Disability. These are all reported to LeDeR

2. During 2021/2022 deaths were weighted away from Q4; there is no obvious reason for this

3. LeDeR reviewers regularly attend GHFT to review notes and now need accompanying as notes are predominantly on Sunrise so they need assistance with finding the information they are looking for.

4. Quality Assurance meetings occur every month. The backlog of reviews on deaths occurring since April 2021 is reducing, but the presentation order of reviews at LeDeR is not under the control of GHFT and deaths in the community also have to be reviewed

5. The new LeDeR grading system is the reverse of the previous system so to avoid confusion we are using words and describing 'good' care or 'poor' care.

3. Activity and Performance

1. There were 23 confirmed deaths of inpatients with learning disabilities in 2021/2022. This within normal variation.

2. For comparison:

Quarter	Total number of LD deaths	Number of COVID deaths within total	LeDeR QAs concluded for in-hospital deaths
1 2021/2022	6	0	3
2 2021/2022	8	0	5
3 2021/2022	6	2	4
4 2021/2022	3	1	1
1 2022/2023 (to date)	3	0	0

3.3 Deaths in people with a learning disability usually occur chronologically earlier than those of the general population. Given that people with Profound Multiple Learning Disabilities (PMLD) and Severe Learning

Disabilities usually have significant physical health problems, it is not surprising that these people die before their 30th birthday. Typically they will have a cardiac arrest and not respond to any resuscitation measures. This is a very small number of the LD deaths each year. Those with Moderate Learning Disabilities also have physical health problems which mean that they will not live to their 70th birthday, but in Gloucestershire we see many of this group living until well beyond their 60th birthday. Those with Mild Learning Disabilities have fewer physical health problems and we are undertaking many LeDeR reviews of people in their late 70s and 80s who have lived long, happy lives and follow the same frailty pathway to death that the general population follows. Thus, many of the issues raised in LeDeR reviews are common to other elderly people who do not have a Learning Disability and LeDeR reviewers have had to adjust to the normalities of the frailty pathway.

3.4 Notable causes of death

a) Aspiration pneumonia – found to be linked to poor oral hygiene, so we are linking up with other related projects within and outside the hospital to promote better oral hygiene. 'I don't want to clean my teeth' is not considered an acceptable choice any longer.
b) Sepsis – in common with many of the general population sometimes the source is clear and at others it is not.
c) Bowel perforation – on average 1 person per quarter dies of a perforated bowel. These deaths have been reviewed in great detail and, given the difficulty of diagnosis, this is considered reasonable. Certainly the 4 deaths from this cause could not have been prevented.
d) Status epilepticus – this is not unexpected, given the number of people with a learning disability who also have epilepsy, however, one of these deaths had to go to Serious Incident investigation which revealed that GHFT had two separate and conflicting Status Epilepticus guidelines, neither of which the reviewing consultant agreed with. There were other findings in this investigation of note, particularly the need to call earlier for anaesthetic assistance and some user difficulties with EPR. This will not be the only death to have been impacted by these issues, but is potentially the only death which has been so thoroughly reviewed.
e) There have been 3 deaths of a person with a Learning disability from COVID during 2021/2022, which is considerably better than 7 deaths the previous year.
f) Unusually, 1 person died as a result of a dissecting aortic aneurysm, but given that this was a man over 60, this would be on the list of diagnoses to exclude in the general population.

4. Summary

4.1 National agreement on reviewing the deaths of people over 18 years with a diagnosis of autism has begun, but that was only 2 of the 23 deaths in 2021/2022.

4.2 Generally in-hospital care is thorough and considered good. There are two main areas for collaborative work:
a) Improving oral hygiene
b) Improving identification of need for modified diet and fluids in first 48 hours of admission

Author: Jeanette Welsh, Lead for Safeguarding Adults

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	10	Enclosure Number:	9
Date	14 July 22		
Title	Journey to Outstanding Visits Report		
Author /Sponsoring Director/Presenter	Matt Holdaway, Director for 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

To provide assurance of senior management engagement with wards and departments and Board visibility.

Key Issues to Note

There have been 9 visits completed from April 22 to June 22. The aim has been to increase the rate of bookings to 8 a month depending on the impact of COVID and availability lead directors. Most visits that were cancelled have been re-arranged and were due to work pressures either operational or at department level. Prior to each visit the areas are contacted to check the current position. The main trend within the recorded notes relates to concerns about staffing levels, skills mix including medical and therapy staffing and the delays and process for recruitment and impact of issues arising from the unscheduled care pathway.

Conclusion

Although there is considerable workload pressure the visits will continue to be planned with a final check on the day to assess the department's workload.

Recommendation

To RECEIVE the report as a source of assurance of leadership visibility and engagement with staff

Enclosures

- Journey to Outstanding Feedback Report

Gloucestershire Hospitals
NHS Foundation Trust

BOARD – JULY 2022
FEEDBACK FROM OUR JOURNEY TO OUTSTANDING (J2O) VISIT

1. Introduction

This paper provides an update on the J2O visits completed from April – June 2022, during this time 17 visits were booked with 9 taking place.

2. Background

The purpose of the visit is for Executive and Non-Executive Directors to engage directly with colleagues and discuss issues associated with our journey to outstanding. The visits also support the Boards desire to achieve ward/department to Board reporting and is a key part of the Care Quality Commission Well Led domain.

The visit is designed to enables colleagues to share what is going well, what barriers there are to success and any key safety concerns affecting both staff and patients from a safety and experience view point.

In addition, the visits provide an opportunity for Board members to 'test' the delivery of strategy within the organisation and to actively receive feedback from colleagues.

3. Actions from Visits

Following the visit, notes from the visit are shared with the visiting executive and the team for accuracy checking. Once an approved set of notes have been agreed, these will be sent to the visiting team manager, the divisional risk/governance manager and the Divisional Director of Quality and Nursing.

Immediate actions relating to safety should be escalated to the Divisional Director of Quality and Nursing for resolution. The Quality Improvement and Safety Director will follow up with the visiting team manager three months following the visit to review actions.

4. Visits Completed

Knightsbridge, West Block OPD, Ward 3b, Ward, 2a, Orthopaedic Theatres, Guiting, Ward 6b, Ward 8b and 5a.

5. Summary

Of the 17 visits booked from 1st April 2022 to 30th June 2022 7 have taken place on the first date arranged. The completion and approval of meeting notes are confirmed with the visiting executive within four weeks of the meeting. The aim is to return to seven to eight visits a month, increasingly these will become face to face, unless a team specifically requests a virtual meeting to support wider participation.

To give more opportunity for involvement of NEDs the following approaches have been tested, where possible:

1. Planned visits three months in advance to allow NEDs to plan better.
2. Shared J2O visit date table, keeping it updated (on MS Teams file share) so that as NEDs accept, others can see what is available. This would enable NEDs to review should their diaries change, and fill any gaps.

6. Summary of Main Themes from all visits

Themes include:

- Staffing pressures due to sickness
- Time lag between staff leaving and recruitment
- Redeployment/Staff moves to other areas
- Multiple outliers, lack of capacity in community
- Staff experiencing V&A
- Lack of space on ward and to store equipment
- Impact of Flow

7. Planned Visits for July 22

Planned visits	Virtual – On site	Date	Lead
Kemerton	On site	12.07.22	Karen Johnson
NICU	On site	14.07.22	Andrew Seaton
4b	On site	20.07.22	Matt Holdaway
Prescott	On site	28.07.22	Mark Pietroni

8. Conclusion

In conclusion, this brief paper provides an updated on the J2O visits arranged in the last three months across the organisation. Of the 17 arranged 9 were completed. These are mainly being cancelled because of clinical priorities on the day.

Andrew Seaton - Quality Improvement & Safety Director
July 2022

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	11	Enclosure Number:	10
Date	14 July 2022		
Title	Annual Appraisal and Revalidation Report		
Author /Sponsoring Director/Presenter	Sponsor: Alex d'Agapeyeff, Interim Medical Director Presenter: Elinor Beattie, Associate Medical Director		

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

Summary of Report

Key points:

There have been no significant changes to our processes in the last year, but the Board is asked to note:

1. Online system to support appraisal and revalidation has been approved and is currently at implementation stage, hoping to go live in the Autumn
2. Recruitment and training of 8 new appraisers this year
3. Team expanded to merge job planning role with appraisal and revalidation.
4. Appraiser Support and peer review of appraisal summaries have continued
5. Centralisation of the Appraisal budget leading to more transparency in the funding allocation

Recommendation

The Board is asked to review the content of this report and to confirm that this organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Enclosures

- Annual Board Report and Statement of Compliance

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

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

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Gloucestershire Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Not required this year, but our audit figures are included in this report Action from last year: To reduce the number of unapproved or late appraisals. Comments: Since appraisals restarted last year we have continued to provide timely appraisals for the senior medical staff. The number of unapproved or late appraisals is similar to pre Covid levels Action for next year: Continue to adapt our appraisal processes to comply with GMC requirements. Procurement process for a software package to support appraisal and revalidation is currently underway.

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

Yes – A D'Agapeyeff as Acting MD is RO at present Three trained deputy ROs – E Beattie, A Raghuram Ensure that regular meetings of the Revalidation Organisational Group continue.

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

Yes Action from last year: To recruit and train more appraisers to ensure that the trust is not relying on zero hours appraisers to complete the required number of appraisals. Comments: A further 8 new appraisers have been appointed and trained. They are starting appraisals in June 22. The appraisal budget has now been centralised and sits within the Medical Director's portfolio. Action for next year: No further recruitment planned at present

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

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

Action for next year: We are hoping to move to an online system to record and oversee the appraisal and revalidation process

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

Action from last year: Appraisal and Revalidation for Senior Medical Staff policy was last reviewed in 2018, and is due for review in January 2022. As it is likely we will have a new system for recording appraisals, it is appropriate to wait until then to rewrite the trust policy.

Comments: Not updated as we were expecting to move to a web based system to support appraisal and revalidation. If this is to be delayed further policy will be reviewed.

Action for next year: Review and revise policy

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Actions from last year: Arrange through the Appraisal Leads Network

Comments: No peer review has taken place this year. This is in line with other organisations and it is recognised that this has not been possible due to the pandemic. RO and Appraisal Leads meetings have continued throughout and sharing of best practice and challenges has continued

Action for next year: Remain compliant with regional and national appraisal policy and peer review as directed.

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

Action from last year: Ongoing review of processes to support locum or short term placement doctors.

Comments: We have continued to support these doctors with their appraisal and revalidation needs and a tutor has been appointed to oversee this staff group. There is a shortened clinical fellow appraisal form to record meetings with educational or clinical supervisors. Good communication with other employing organisations.

Action for next year: Continue as above

Section 2 – Effective Appraisal

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

Action from last year: All senior medical staff have a full annual appraisal using the MAG form which supports the GMC requirements. This appraisal is carried out by a trained appraiser from a different speciality. To support this, the doctor is required to meet with their speciality director beforehand to ensure there are no outstanding governance issues or concerns, and to highlight any areas of excellence/commendation. Information about complaints and SIs is provided centrally to the appraisee.

Comments: We have offered the Appraisal 2020 template to staff this year which focuses on support and wellbeing. Appraisers have been trained to use this form and are aware of the services available to staff who need to access them. This includes the 2020 Hub and if required, the national service Practitioner Health

Action for next year: Continue to adapt our appraisal process in light of GMC guidance and move to an online system to support this.

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

Action from last year: N/A

Comments:

Action for next year:

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

Action from last year: This policy is due for review in January 2022 and will be updated to take account of the changes to the GMC appraisal template and the process changes that will be required for an online system.

Comments: See above

Action for next year: Review and rewrite policy

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

Action from last year: Reduce reliance on Zero Hours appraisers Comments: We have recruited and trained 8 new appraisers which has increased our number to 40. Action for next year: Further recruitment and training to replace a number of retiring appraisers this year.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

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

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

Action from last year: The reintroduction of quarterly Revalidation Team meetings. These were held virtually due to the pandemic but have restarted and will continue. Board reporting was also suspended last year but we have remained compliant throughout. Action for next year: Ensure that the ROG meetings and regular team meetings are quorate and arranged in good time to allow attendance.

Section 3 – Recommendations to the GMC

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

Action from last year: None

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: We have an embedded process for reviewing the appraisal history of all doctors due for revalidation and timely recommendations are made by the RO or his deputy. This has continued, taking into account a large number of deferred revalidation and missed appraisal with no ongoing concerns.

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

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

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

Comments: This process will remain in place

Action for next year: No further changes required

Section 4 – Medical governance

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

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

Comments: The revalidation and appraisal process is fully embedded within the Trust. This includes a pre appraisal meeting with the speciality director with a focus on medical governance. This information is available to the appraiser to direct discussion at appraisal

Action for next year: No further action to be taken

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

Action from last year: Employee Relations system in place to manage conduct issues relating to all staff. Doctors are also able to receive details of complaints or serious incidents that they have been involved in for review at appraisal

Comments: This process is fully embedded within the trust

Action for next year: No further action required

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

Action from last year: Robust policies are in place within the Trust which provide adequate processes to be followed should there be concerns raised and against any licensed practitioner

Comments: These remain in place and constantly reviewed to ensure they meet the necessary requirements

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

Action from last year: All processes would be managed by Human Resources following strict policies that are in place and relevant notification given to appropriate people/groups within the trust

Comments: Ongoing review to ensure that all necessary processes are followed.

Action for next year: Further consideration of protected characteristics recording to ensure that these are reviewed as part of the annual board report

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

Action from last year: A review of process to ensure the transfer of information between revalidation officers via the Medical Practice Information Transfer (MPIT) form for those doctors that move to us and also where known connections to other organisations exist

Comments: The review highlighted some inconsistencies with the transfer of information for new doctors connected to our Trust

Action for next year: A full review of process to be undertaken to ensure that relevant information is transferred through the MPIT process for all new connected doctors to our trust

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

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

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

Action from last year: All staff undertake Equality and Diversity Training as part of their statutory training via the Core Skills Framework. This is also supported by the trusts Equality and Diversity policy.

Comments: The Trust has taken great strides in Equality and Diversity through a Diversity Network and being active in all aspects of Equality.

Action for next year: Ongoing work through the Equality and Diversity Group

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: All checks are undertaken against national NHS Pre-Employment Check Standards as per NHS Employers guidance. This meets the 6 checks that is required from identification, references through to Right to Work

Comments: This is regularly reviewed and changes made to process if notice provided by NHS Employers

Action for next year: No further action

Section 6 – Summary of comments, and overall conclusion

There have been no significant changes to our processes in the last year, but the Board is asked to note:

1. Online system to support appraisal and revalidation has been approved and is currently at implementation stage, hoping to go live in the Autumn
2. Recruitment and training of 8 new appraisers this year
3. Team expanded to merge job planning role with appraisal and revalidation.
4. Appraiser Support and peer review of appraisal summaries have continued
5. Centralisation of the Appraisal budget leading to more transparency in the funding allocation.

Name of Organisation: Gloucestershire Hospitals NHS Foundation Trust

Total number of appraisals which were due to take place 21/22 appraisal year - 560

Total number of appraisals which took place - 540

Total number of appraisals recorded as approved missed – 17

Total number of unapproved missed appraisals - 3

Do you offer your doctors the input light appraisal template? – Yes

Section 7 – Statement of Compliance:

The Board of Gloucestershire Hospitals NHS Foundation has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

Gloucestershire Hospitals NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed: _ _ _ _ _ _ _ _ _ _ _

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

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

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 30 June 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	Key points were noted as follows: • The Trust had initially submitted an overall plan for 2022-23 with a forecast outturn deficit position of £9.2m. The system was required to breakeven for the year, which had been reflected in the revised plan that the Trust had submitted in June. • The Trust reported a year-to-date deficit of £6.5m which was £3.7m away from plan. Key drivers related to temporary staffing in Medicine and Surgery for vacancies and unscheduled care positions within Nursing and Medical staff. Work continued with colleagues to review and agree overall divisional forecasts. The key risk related to the continuation of the current run rate, which would significantly affect the Trust's planned position. • Efficiencies for the Trust totalled £18.8m, with £12.9m of schemes monitored through Project Management Office. Unidentified schemes are currently contributing £1.5m to the deficit position. • The Operational Plan had been resubmitted and showed a deterioration of activity in Months 1 and 2. The Committee acknowledged the challenging situation, and was advised that the Trust was likely to come under scrutiny following Quarter 1.	Additional information on system finances and productivity would be incorporated into reporting from July. An update on the £2.7m of prior month accruals and charges would be provided in July.
Capital Programme Report	The Trust had submitted a capital expenditure plan of £67.1m for 2022-23. No new funding allocations had been agreed within the first two months of the year. At the end of May, the Trust had goods delivered, works done or services received to the value of £6.3m, which was £0.1m ahead of plan. A breakeven forecast outturn had been reported to NHSEI. There were some pressures within the Estates programme which were currently being reviewed; the Committee would receive further information once implications were known and fully understood. The Committee noted that the bid for the Community Diagnostic Centre had been resubmitted following feedback from the regional team around value for money.	Outputs from the recent capital programme questionnaire would be shared with the Committee.
Financial Sustainability Report	The Committee noted an increase in the financial sustainability plan target from £12.9m to £13.2m, the additional of which was the Trust's contribution towards a balanced system plan. Across the programme for 2022-23, savings of £10.2m had been identified and profiled against workstreams and divisional programmes; plans were in development to determine how the savings would be achieved.	The Financial Sustainability Plan would be presented in July. A regional productivity tool to demonstrate improvements in spend and activity would be incorporated into regular reporting.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
Digital and EPR Programme Report	The Committee noted that further improvements to clinical documentation went live on Sunrise EPR at the end of May, with one final optimisation drop due to take place. The electronic prescribing and medicines administration project was progressing well.	The Committee supported the EPR major project roadmap and digital work plan for 2022-23.

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

	The Committee was assured that action plans following the cyber security internal audit review had progressed, with the majority of urgent projects now completed. The Committee noted that Tap and Go was currently being launched in clinical areas.	

Items not Rated			
Risk Register	ICS Update	Digital Project Prioritisation	

Investments			
Case	**Comments**	**Approval**	**Actions**
Interventional Consumables Contract Recommendation	The Committee ratified the award of the contract for Rhythm Management and Interventional Cardiology via the Peninsula Purchasing and Supply Alliance (PPSA).	Ratified	Concerns around the timings of the process would be outlined in a letter to PPSA from RG and KJ.
TIF Orthopaedic Theatre	The Trust had been successful in progressing through the stages to bid for capital monies to build a fifth elective orthopaedic theatre in Cheltenham. The final stage of the bidding process was submission of the business case for national consideration.	Approved	The business case would progress to the ICB for final approval.

Impact on Board Assurance Framework (BAF)
Additional detail on risk rationalisation and analysis would be reflected in July's Committees for assurance.

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	12	Enclosure Number:	12
Date	14 July 2022		
Title	M2 Financial Performance Report		
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 2 to the Trust Board.

Key issues to note

- The ICS system are required to breakeven for the year and in June the Trust resubmitted a plan which will has a breakeven position for the year.
- the Trust is reporting a year to date deficit of £6.5m deficit which is £3.7m adverse to plan. (April Planning scenario)
- the Trust is working with Divisions to agree overall forecasts.
- the Trust capital position is £0.1m ahead of plan.

Month 2 overview

The ICS system are required to breakeven for the year and in June the Trust resubmitted a plan which will has a breakeven position for the year.

M2 Financial position (based on the April planning scenario) is reporting a deficit of £6.5m which is £3.7m 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 RMN support.

Total efficiencies for the Trust are £18.7m with unidentified schemes within reserves contributing £1.5m to the deficit position.

Work is continuing with operational colleagues to review and agree overall Divisional Forecast. Currently if the run rate continues, the Trust and system will be significantly off plan.

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 May (M2), the Trust had goods delivered, works done or services received to the value of £6.3m, £0.1m ahead plan.

Next Steps

The financial position at month 2 is highlighting a significant challenge which needs to be responded to. Weekly recover meetings are now in place with the divisions under financial pressure to ensure the right level of support is available. Actions have taken place which have helped reduce the run rate position from month 1 however this isn't sufficient to close the gap and more work is needed.

Conclusions

The Trust is reporting a year to date deficit of £6.5m deficit which is £3.7m adverse to plan (April planning scenario). If run rate continues the Trust will be significantly off plan. Forecasts are being reviewed 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 31st May 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.

The ICS system are required to breakeven for the year and in June the Trust resubmitted a plan which will has a breakeven position for the year. The revised breakeven plan for the year is based will be achieved by receiving additional ICS income (£7.2m), further one off technical opportunities on expenditure (£1.2m) and additional sustainability schemes requirement of c£0.3m. This position will be reflected from month 3 reporting onwards.

Month 2

M2 Financial position (based on the April planning scenario) is reporting a deficit of £6.5m which is £3.7m 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 RMN cover.

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.
At month 2, of the £12.9m schemes monitored through the PMO, c£4.1m efficiencies have been allocated out to divisions with the remaining £8.8m efficiencies held in reserves and awaiting identification. Unidentified schemes within reserves are contributing £1.5m to the deficit position.

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)
-Following detailed review of all divisions, there is a potential of £2.7m one off prior year benefit than can be used to mitigate position

Director of Finance Summary

Forecast Outturn

Work is continuing with operational colleagues to review and agree overall Divisional Forecast.

Currently if the run rate continues, the Trust will be significantly off plan. A summary of Quarter 1 position is forecasting to be £1.3m adverse to **original deficit plan**. This includes

- YTD underspend for Corporate underspends is not available
- Release of 50% Health and Wellbeing annual leave days accrual and release of £2.7m one off prior year benefits.
- Continuation of current divisional performance and the non delivery of sustainability savings.

Quarter 1 Potential Forecast	Variance £000s
Month 2 Deficit Variance to Plan	(3,742)
Corporate Planned Spend	(673)
50% Health Wellbeing released	1,350
One off Prior Year Benefit	2,768
	(297)
Continuation of Operational Divisional Month 2 Variance	(325)
Non Delivery of Sustainability continues monthly	(725)
Quarter 1 Position (Deficit to Original Plan Deficit)	**(1,347)**

Month 2 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £3.7m deficit		M2 Financial position is reporting a deficit of £6.5m which is £3.7m adverse to plan.
Income is £110.7m YTD which is £0.8m adverse to plan		M2 overall income position is reporting £110.7m income which is £0.8m adverse to plan. The SLA and commissioning income is showing a adverse position of £991k which relates to lower than anticipated pass through drugs funding however the associated assumed costs are also lower. The position also includes out of area commissioner (Hereford and Worcester) income risk due to activity. The RTA income for month 2 is favourable to plan (£100k) offset with pressure on Private Patients (£461k). Other operating favourable position includes HEE income which is above plan (£471k)
Pay costs are £70.7m YTD which is £0.4m adverse to plan		M2 Pay costs are £70.7m which is £0.4m 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 month 2 position includes Substantive staff underspend of £8.1m offset by overspends in Agency (£3.1m) and Bank (£4.3m) The total contracted vacancies in month 2 are 830 WTE.
Non Pay costs are £45.0m YTD which is £3.1m adverse to plan		M2 Non Pay costs are £45.0m. The other main drivers of the non pay overspends are establishment costs(£694k), Education and Training costs (£367k) supplies and services (£1.3m) offset by underspend on transport costs (£114k) Drugs costs are favourable to plan at £374k.
Total Financial Sustainability schemes need to be allocated out to Divisions		At month 2, of the £12.9m schemes monitored through the PMO, c£4.1m efficiencies have been allocated out to divisions with the remaining £8.8m efficiencies held in reserves and awaiting identification. Unidentified schemes within reserves are contributing £1.5m to the deficit position.
The cash balance is £79.9m		Increase in cash is reflected in the increase of accruals and provisions.

M2 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of May 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 May the Group's consolidated position shows a £6.5m deficit which is £3.7m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 2 Financial Position	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	101,784	100,793	(991)			0	101,784	100,793	(991)
PP, Overseas and RTA Income	1,008	721	(287)			0	1,008	721	(287)
Other Income from Patient Activities	1,696	1,547	(149)			0	1,696	1,547	(149)
Operating Income	6,255	6,852	597	10,756	8,628	(2,128)	7,047	7,664	617
Total Income	**110,742**	**109,912**	**(830)**	**10,756**	**8,628**	**(2,128)**	**111,535**	**110,724**	**(811)**
Pay	(66,834)	(67,189)	(355)	(3,547)	(3,584)	(36)	(70,381)	(70,773)	(391)
Non-Pay	(45,120)	(48,129)	(3,009)	(6,686)	(4,707)	1,980	(41,843)	(45,019)	(3,176)
Total Expenditure	**(111,954)**	**(115,318)**	**(3,363)**	**(10,234)**	**(8,291)**	**1,943**	**(112,225)**	**(115,792)**	**(3,567)**
EBITDA	**(1,212)**	**(5,406)**	**(4,193)**	**522**	**338**	**(185)**	**(690)**	**(5,068)**	**(4,378)**
EBITDA %age	**-1.1%**	**(4.9%)**	**(3.8%)**	**4.9%**	**3.9%**	**(0.9%)**	**-0.6%**	**(4.6%)**	**(4.0%)**
Non-Operating Costs	(1,579)	(1,127)	451	(522)	(338)	185	(2,100)	(1,465)	635
Surplus / (Deficit)	**(2,790)**	**(6,533)**	**(3,743)**	**(0)**	**(0)**	**(0)**	**(2,790)**	**(6,533)**	**(3,743)**
Fixed Asset Impairments	0	0	0					0	0
Surplus / (Deficit) after Impairments	**(2,790)**	**(6,533)**	**(3,743)**	**(0)**	**(0)**	**(0)**	**(2,790)**	**(6,533)**	**(3,743)**

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

** Group position excludes £8.0m of inter-company transactions, including dividends

Balance Sheet

Gloucestershire Hospitals
NHS Foundation Trust

	Closing Balance 31st March 2022 £000	GROUP Balance as at M2 £000	B/S movements from 31st March 2022 £000
Non-Current Assests			
Intangible Assets	13,760	13,345	(415)
Property, Plant and Equipment	304,585	333,294	28,709
Trade and Other Receivables	4,414	4,392	(22)
Total Non-Current Assets	**322,759**	**351,031**	**28,272**
Current Assets			
Inventories	9,370	9,584	214
Trade and Other Receivables	26,360	23,727	(2,633)
Cash and Cash Equivalents	71,530	79,922	8,392
Total Current Assets	**107,260**	**113,233**	**5,973**
Current Liabilities			
Trade and Other Payables	(80,104)	(91,164)	(11,060)
Other Liabilities	(14,401)	(17,056)	(2,655)
Borrowings	(3,626)	(3,766)	(140)
Provisions	(24,089)	(26,797)	(2,708)
Total Current Liabilities	**(122,220)**	**(138,783)**	**(16,563)**
Net Current Assets	**(14,960)**	**(25,550)**	**(10,590)**
Non-Current Liabilities			
Other Liabilities	(5,971)	(5,880)	91
Borrowings	(34,064)	(60,480)	(26,416)
Provisions	(3,600)	(1,489)	2,111
Total Non-Current Liabilities	**(43,635)**	**(67,849)**	**(24,214)**
Total Assets Employed	**264,164**	**257,632**	**(6,532)**
Financed by Taxpayers Equity			
Public Dividend Capital	361,345	361,345	0
Reserves	19,823	19,823	0
Retained Earnings	(117,004)	(123,536)	(6,532)
Total Taxpayers' Equity	**264,164**	**257,632**	**(6,532)**

The table shows the M2 balance sheet and movements from the 2021-23 closing balance sheet.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

Funding
The Trust submitted a gross capital expenditure plan for the 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 May (M2), the Trust had goods delivered, works done or services received to the value of £6.3m, £0.1m ahead plan.

A breakeven forecast outturn has been reported to NHSI in the M2 Provider Financial Return (PFR).

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 May (M2), the Trust had goods delivered, works done or services received to the value of £6.3m, £0.1m 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	123	39	83	568	461	106	1,894	1,894	0
Digital	Operational System Capital	317	283	33	633	902	(269)	5,709	5,709	0
Estates	Operational System Capital	224	113	110	252	140	112	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	36	22	115	221	(106)	3,350	3,350	0
STP Programme - GSSD	STP Capital - GSSD	2,095	2,257	(162)	4,490	4,477	13	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	136	136	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		**2,883**	**2,797**	**87**	**6,194**	**6,338**	**(145)**	**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)	(136)	(136)	(0)	(817)	(817)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Operational System Capital	27	27	0	53	53	0	318	318	0
Total Capital Departmental Expenditure Limit (CDEL)		**2,842**	**2,755**	**87**	**6,111**	**6,255**	**(145)**	**65,316**	**65,316**	**0**

All slippage commitments from the previous year have been agreed to be covered by 22/23 programme allocations. At the time of writing there are some pressures materialising within the Estates programme which are being worked through and will be reported back once the implications are known.

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £6.5m deficit which is £3.7m adverse to plan.
- Note the Trust is working with Divisions to agree forecasts. The trust will be resubmitting an updated Year breakeven forecast plan.
- Note the assumptions around potential mitigations and next steps including the delivery of sustainability schemes.
- 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:	**July 2022**

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	12	Enclosure Number:	13
Date	14 July 2022		
Title	Digital and EPR Programme Report		
Author /Sponsoring Director/Presenter	Nicola Davies, Digital Engagement and Change Mark Hutchinson, Executive Chief Digital and 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:

- Further improvements to clinical documentation went live on Sunrise EPR at the end of May, supported by the EPR team on wards. One final optimisation drop is due to take place.
- Electronic prescribing and medicines administration (ePMA) project is progressing.
- Action plans following Cyber Security internal audit have progressed with the majority of urgent projects now complete and an update provided in this report.
- Tap & Go is being rolled-out in clinical areas; further update in the report.
- The EPR major project roadmap for 2022/23 is included in the report.
- The digital work plan for 2022/23 is also included in the report.

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

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. The programme plan below details the EPR functionality planned for 2022/3.

Our digital journey »»

EPR Key Projects

NHS Gloucestershire Hospitals NHS Foundation Trust

Sunrise EPR Project	Impacts/In Scope
ePMA (electronic prescribing & medicines admin)	Replace current yellow drug chart
Inpatient Electronic Discharge summaries	Adult inpatient areas
Blood Transfusion onto EPR (resulting)	Blood transfusion users
E-referral Rollout/expansion	Existing EPR users - phased
Paper-lite Outpatients - phased	Outpatients
NHS at Home	Pre and Post admission
Clinical Documentation Expansion	Existing users
Pre-Assessment Clinic Process / Documentation	Surgical
Sunrise Mobile	Existing users

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2.1 Clinical documentation on EPR

A further optimisation drop (sprint 4) went live on Wednesday 25th May, with improvements made to medical take lists in adult inpatient areas as well as speciality referral documentation in ED. Floor walking and ward round support was provided during the first week, with training videos and guides to support.

Sunrise EPR 'Take Lists by Speciality' have now been introduced following feedback and input from medical colleagues in particular, along with insight and testing from a range of specialities. The configuration was developed in house and is unique to Gloucestershire.

As part of this, improvements were made first in ED;

- additional tab ‘Specialty Referral’ is now completed to ensure a patient appears on the speciality take list.
- Options include; request for review; request for admission and discharge from ED

In Adult inpatients, speciality take lists have now been pushed out to every clinical user. This means clinicians now have only one Take List and patients will remain on this list until they are discharged from EPR. The list includes attendance source and whether or not the patient has been clerked or reviewed by a senior clinician. None of this functionality replaces the current bleep process, but provides assurance for clinicians and a single place to view essential patient information.

The final sprint will include nursing documentation and flowsheets, as well as final optimisations for doctors. The team is also working closely with surgical teams to make improvements.

2.2 Tap and Go

Following an initial rollout to EPR users in Emergency Departments in July 2021, the demand for ‘Tap & Go’ functionality has increased. This functionality allows clinicians to tap in and out of devices using their smartcards, with their ‘desktop’ following them as they move around clinical areas. This saves significant time logging in and out and ensures that Sunrise EPR opens up exactly where they left off.

A full rollout is planned for 2022/23 now funding has been secured. Starting first in acute medical wards, Tap & Go then launched in the Tower for testing on two wards before being rolled out further. It is now available throughout the Tower at GRH and in adult inpatient wards in CGH. The project is ahead of schedule and a full closure report will be submitted to Digital Care Delivery Group once it is complete. Clinicians have described this programme as ‘transformative’ to the way they work.

2.3 EPR Programme RAG Status Updates

The highlight reports provide more detail on the status of live EPR projects. This update is correct as reported to the EPR Programme Delivery Group.

- Preparation continuing for implementation of Phase 1 of the Clinical Data Storage Platform (Onbase).
- Work is progressing to deliver ePMA, with configuration and build continuing, together with unit testing and work to determine the finalised scope.
- Preparation for the TrakCare upgrade in July is on target, comms and business continuity assurance is starting.
- Transfusion Medicine (blood transfusion results into EPR) testing is continuing.
- The implementation of Pre-Assessment Digital Workflows has been delayed, but the intention is to proceed with a two-phase delivery.
- EPR continuous improvement is continuing with a structured development and delivery cycle, reporting to EPR PDG.

Activity Planned for Next Period:

- ePMA resourcing constraints will be resolved, moving the project back to GREEN status.
- The ePMA drug catalogue build will complete.
- The ePMA unit testing will continue.
- Work towards delivering the Clinical Data Storage Platform will continue, with the data load proceeding and the first phase of the project will progress to completion.
- Planning and work will continue for the TrakCare Upgrade, achieving operational readiness and moving 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, with a two-phase delivery to enable early realisation of benefits whilst outstanding issues are resolved.
- Project documentation sign off for the new Maternity system will continue.

2.4 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.

2.5 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.

3. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Transformation Office (DTO). A separate report has been submitted to Finance & Digital Committee, providing additional detail on projects as requested at a previous meeting. Once discussed this will form the basis of project reporting in the future.

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	5	1	0	4	8

Since the last report no project has been completed and closed and three projects have gone into closure.

3.1 Key Projects Updates

This update is correct as reported to the DTO Team Meeting on Wednesday 25th May.

Key issues to note:

- The Data Centre Refurbishment project remains in closure, with handover documentation awaiting approval.
- The Tableau Visualisation and Reporting Platform Phase 1 project is in closure.
- The Mindray Patient Monitoring in Cardiology project has moved into closure.
- The GHT Office 365 Transition and Change (Office 2016) has moved into closure, with any remaining work to be picked up as BAU activity.
- The CVIS project UAT has completed successfully and a cutover date has been set.
- The project to deliver a new Appraisal & Re-validation System (Phase 1 - Procurement) is now progressing.
- A project to optimise internal and external WiFi at GRH and CGH sites has commenced.
- A project to improve cyber security through the deployment of ISE Security and Policy Management (802.1x) for the GHT wired network estate has commenced.

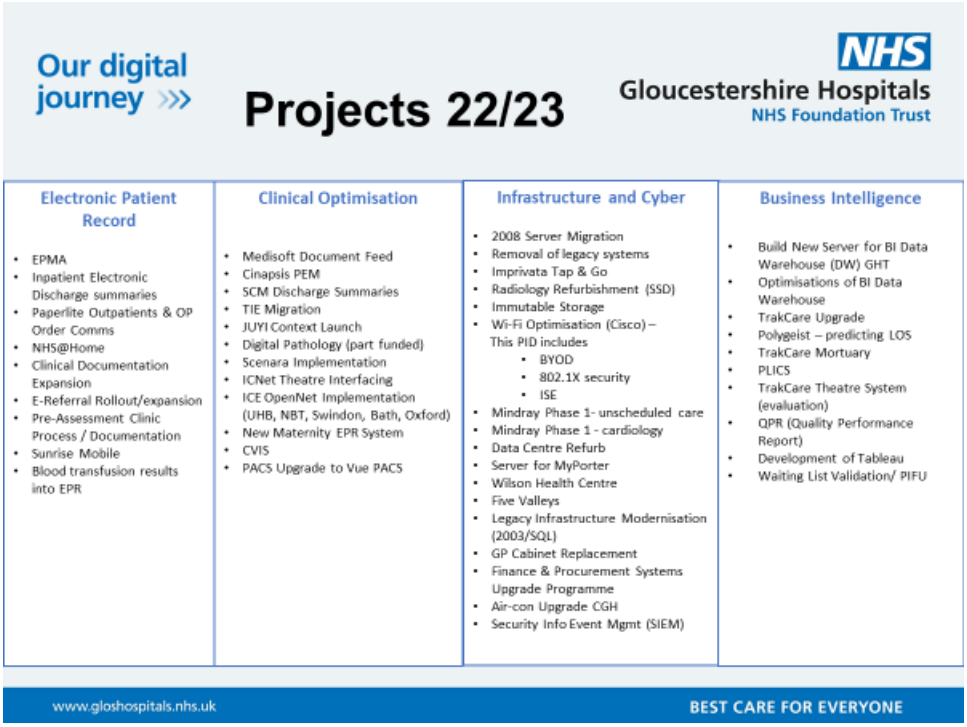
Projects in Closure/Handover to BAU

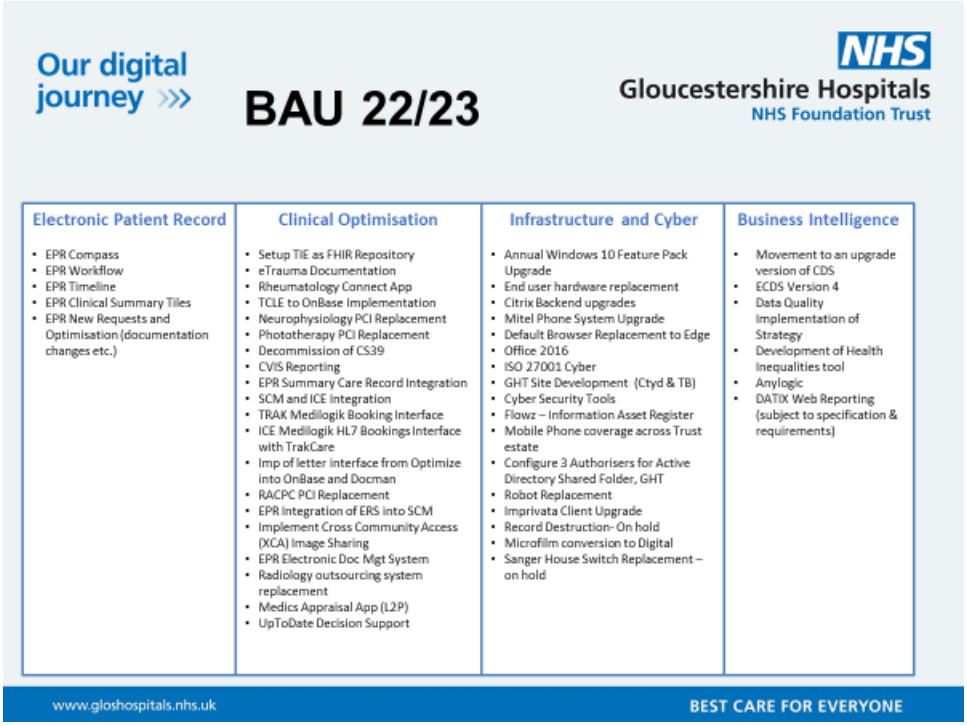
- Data Centre Refurbishment
- Tableau Visualisation and Reporting Platform Phase 1
- Mindray Patient Monitoring in Cardiology
- Install Infrastructure for NEW Portering System (MyPorter)
- GHT Office 365 Transition and Change (Office 2016)

3.2 Programme for 2022/23

The digital work programme for 2022/23 is being shared across the organisation.

A summary of the project and business as usual (BAU) workplans are below. Divisions are being asked to review the plan and flag any significant programmes of work that are missing from this priority list, noting that additional projects will require both funding and resource.





4. 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).

5. Cyber Security

This update provides assurance on cyber security actions and support provided to GHT, CCG and GHC as part of the wider service level agreement in CITS. A monthly overview summary report is provided to ICS Digital Execs and GHT's Digital Care Delivery Group. It covers:

- Current picture (latest position)
- Cyber security monthly incident report
- Cyber performance indicators and risk
- Cyber related projects programme

More detailed operational reporting, including analysis of threats and issues, is discussed at the Cyber Security Operational Group. Key highlights this month:

- The team continuous to work to the agreed cyber audit action plan, reducing risk and updating systems, work is progressing at pace.
- A new process for reporting cyber concerns has been agreed, where tickets created by the security team, for action by other operational teams can be triaged, prioritised and assigned.
- Windows 10 upgrade is underway and being rolled out across organisations during May and June. The plan for completion has been approved by region and is being closely monitored.
- With GHT Office 2016 rollout is now complete with some residual devices being followed up as part of project closure
- Improvement noted against national average comparison within March Windows Exposure Score and Server Exposure Score (MDE) KPI.

Conclusion

It is more important than ever to monitor and manage cyber risks across the NHS. A significant amount of work is underway to reduce the Gloucestershire healthcare community's vulnerability to attack and protect its assets.

-Ends-

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 28 June 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

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Workforce Transformation Programmes	The Committee was encouraged by the structure of the Staff Experience Programme, which focused on three key projects; Staff Survey, Restorative Just and Learning Culture, and Trust Values. A number of activities had taken place to enable the programme launch, including introduction meeting with programme leads, workshops, planning sessions and an established programme structure. The Workforce Sustainability Programme structure was presented, and the Committee supported the focus on four key workstreams: transactional recruitment, e-rostering, temporary staffing controls, and sustainable workforce.	The Committee was supportive of the new approach, and agreed that the Compassionate Leadership Programme should be paused to focus on the values framework.
Performance Dashboard	The Committee received a new style dashboard which reflected performance across a range of operational measures identified within the People and OD Strategy. The Trust used the key measures to benchmark to Model Hospital and University and Teaching peer rates.	Exit interview information would be included in the dashboard for additional scrutiny on why people leave the organisation. The dashboard would continue to be developed to establish a robust tool which effectively measured and monitored performance.
Research and University Hospitals Progress	The Committee received an update on key achievements and was pleased with the progress being made towards University Hospitals status.	None.
People and OD Strategy Report	The Committee received an update on progress against milestones for key initiatives. The Trust was looking to review the Strategy against new People Plan guidance, to ensure incorporation of the four key pillars: Looking after our people; Belonging in the NHS; New ways of working and delivering care; and Growing for the future.	A full review of actions would be undertaken to ensure they were in line with future plans.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
None.		

Items not Rated

Risk Register	ICS Update		

Impact on Board Assurance Framework (BAF)

The Committee approved the risk score and recommended to Board. The Committee discussed further refinement to the risk, including the reasons for gaps in control, i.e. why there are delays in time to hire. The risk would be refined to explain how the organisation becomes an employer of choice.

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.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	14	Enclosure Number:	15
Date	14 July 2022		
Title	Provider Licence Self-Certification		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

The Trust is required to self-certify on an annual basis the status of compliance with licensing conditions as part of the Foundation Trust Provider License. The NHS System Oversight Framework bases its oversight on the NHS provider licence. Foundation trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

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

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

Recommendation

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

Enclosures

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

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

Self-Certification Template - Condition FT4

Gloucestershire Hospitals NHS Foundation Trust

Insert name of organisation

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

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

These self-certifications are set out in this template.

How to use this template

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

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | 2021-22 | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

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

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

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

Signature _____ **Signature** _____

Name _____ **Name** _____

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

A _____ Please Respond

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | Please Respond

Certification on training of governors (FTs only)

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

Training of Governors

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

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

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

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

A

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

Self-Certification Template - Conditions G6 and CoS7

Gloucestershire Hospitals NHS Foundation Trust *Insert name of organisation*

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

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

These self-certifications are set out in this template.

How to use this template

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

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2021-22 | Please complete the explanatory information in cell

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

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

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

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

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

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

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

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

The Trust reported as an individual organisation and as a system during 2021-22. The Trust delivered a year-end surplus of £516k, which was in line with plan. The overall year-end system position was a surplus of £6.8m. The Trust also delivered an overspend against its capital programme of £326k. A financial and operational plan had been developed to support the delivery of services. For 2022-23, the Trust is working with partners in the system to plan for the next financial year and determine the system position. The Trust is managing any potential significant variance during the first few months of the year by working closely with Divisions.

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

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

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