Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
10.30, Thursday 12 January 2023
The Blue Coat Room, Guildhall, Gloucester
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			10.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 8 December 2022**	Approval	Enc 1	10.35
5	**Matters arising from Board meeting held on 8 December 2022**	Assurance		
6	**Staff Story** *Abdul Arain, Associate Specialist Emergency Department*	Information	Presentation	10.40
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	11.00
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	11.15
9	**Trust Risk Register** *Mark Pietroni, Medical Director*	Assurance	Enc 4	11.20
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*	Assurance	Enc 5	11.30
	Break (11.50-12.00)			
11	**Maternity Incentive Scheme** *Lisa Stephens, Head of Midwifery*	Assurance	Enc 6	12.00
12	**Guardian of Safe Working Hours Quarterly Report** *Jess Gunn, Guardian of Safe Working Hours*	Assurance	Enc 7	12.15
14	**Finance and Digital Committee Report** *Robert Graves, Non-Executive Director, Karen Johnson, Director of Finance and Mark Hutchinson, Executive Chief Digital and Information Officer*	Assurance	Enc 8	12.25
15	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 9	12.45
16	**Estates and Facilities Committee Report** *Mike Napier, Non-Executive Director*	Assurance	Verbal	12.55
17	**Any other business**		None	13.05
18	**Governor Observations**			
	Close by 13.15			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 8 December 2022, 09.00, Sandford Education Centre			
Chair	Deborah Evans	DE	Chair
Present	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Robert Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director (joined the meeting virtually)
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Deborah Lee	DL	Chief Executive Officer
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People and Organisational Development
	Qadar Zada	QZ	Chief Operating Officer
Attending	Pat Blackwood	PB	Corporate Governance Officer
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Lisa Evans	LE	Assistant Trust Secretary
Observers	One governor observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting.
2	**Apologies for absence** Mark Hutchinson, Executive Chief Digital and Information Officer
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 10 November 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 10 November 2022** All matters arising were noted.
6	**Chief Executive's Briefing** DL briefed the Board on current challenging operational pressures, with a significant increase in paediatric attendances reported due to anxiety around strep A infections. The communications team was reviewing messaging in relation to this to ensure optimal information was available. MH advised the Board of the busy operational period and plans in place to manage planned industrial action. The Board was informed that Trust leaders were working closely with the corporate nursing team for the two days of industrial action. The Trust was taking a collaborative approach with unions to ensure minimal disruption to normal services.

Unconfirmed

7	**Board Assurance Framework** The Board received the BAF for information, noting that a full review would be undertaken by executives on 12 December to ensure that the risks were accurate and reflected the current position of the Trust.
8	**GMS and Trust governance arrangements** The Board had considered refreshed governance arrangements between the Trust and Gloucestershire Managed Services (GMS) during the development session in November. The three key areas of governance discussed with the aim of realising the vision for GMS were: to strengthen working relationships between the Trust and GMS; to strengthen Trust and GMS contributions to the success of the subsidiary company model; and to consider Trust nominations to the GMS Board of Directors. Recommendations for the change in governance arrangements had been supported, and were set out in detail in the report for formal approval. MN encouraged the Trust and GMS to ensure that Reserved Matters were robust, and to consider whether the evolvement of the ICB could potentially impact on the model. DL reflected that KC would ensure that reports and decisions would be planned and scheduled as much as possible with regards to Reserved Matters, and to ensure that business decisions were made in a timely way. The Board formally **approved** the twelve recommendations set out in the report.
9	**Any other business** None.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
GMS and Trust Governance Arrangements	The Board approved the twelve recommendations within the report.		
Estates and Facilities Committee Report	A report would be prepared to detail the progress of violence and aggression workstreams to Quality and Performance Committee and Board of Directors.	MHo Nov 22-Jan 23	In progress

Gloucestershire Hospitals
NHS Foundation Trust

CHIEF EXECUTIVE OFFICER'S REPORT
JANUARY 2023

1 Operational Context

1.1 Consistent with the national picture, the Trust has experienced an unprecedented period of operational challenge which has manifested in longer waiting times in our emergency departments, a deterioration in ambulance handover times and ambulance community response times and higher levels of patients being cared for in temporary settings. This position has been exacerbated by the acuity of patients being admitted which means that length of stay is extended, and therefore daily discharges lower and the opportunity to divert people away from the front door reduced.

1.2 The system and Trust response has been exceptional and testimony to this is the fact that Gloucestershire was the final system to declare OPEL Level 4 (a measure of whole system pressure). That said, the pressure upon staff throughout the system has been extreme and considerable focus is being placed on how we can support staff given the likelihood of these conditions persisting. This includes reviewing the models that served us well during the early phases of the pandemic, such as the Psychology Link Worker model and TRIM Practitioner support.

1.3 Despite these challenges, and at odds with many systems, the Trust has not cancelled any cancer patient due to operational pressures in the last month. Huge credit is due to the operational teams that have enabled us to hold this position, along with the leadership from Qadar Zada, Chief Operating Officer. In light of concerns expressed by the Care Quality Commission, significant scrutiny continues on the use of theatre recovery and, to date, no elective patient has been cared for in theatre recovery overnight.

2 Key Highlights

2.1 During the national Royal College of Nursing (RCN) strikes of 15th and 20th December, 527 Trust employees took part in industrial action over the two days. We were pleased to be able to support staff to exercise their right to strike, whilst keeping our hospitals safe. We worked closely with RCN colleagues and teams across the Trust whilst also responding to some additional challenges including heavy snowfall and the burst water pipes affecting Gloucestershire!

2.2 Our services, particularly our Emergency Departments, were also significantly impacted by strike action from paramedics who are members of GMB and Unison, on 21st December. Our planning ensured that teams worked hard across divisions and with South West Ambulance Trust (SWAST) colleagues to facilitate additional cohorting of patients at ED. Patients were triaged as quickly as possible and focused discharges ensured as many people as possible were home in time for Christmas.

2.3 Further industrial action is currently set to take place over the coming weeks (11th and 23rd of January for paramedics) and planning is active including reviewing and responding to the insights from previous strikes. The national RCN industrial action planned for the 18th and 19th of January will not affect our Trust, this time. At the time of writing, the outcome of the ballot

for industrial action amongst members of the Hospital Consultants and Specialists Association is awaited, whereas the ballot of midwives did not meet the threshold for industrial action. The vast majority of the members of the Chartered Society of Physiotherapists supported strike action although dates for industrial action have yet to be confirmed. Finally, the British Medical Association (BMA) has signalled their intention to ballot members in respect of proposed industrial action on the 9th January.

2.4 This month saw the opening of two new services, which were a central part of our Winter Plan. On the 29th December we opened our first dedicated winter pressures ward, on Prescott ward at Cheltenham General. This ward is intended to "flex" to provide additional and much needed capacity during winter and to be utilised in quieter periods as a "decant" ward to enable decoration and refurbishment of wards that would otherwise result in loss of beds.

2.5 On Tuesday 3rd January we opened the long-awaited Discharge Lounge at Gloucestershire Royal. This modular build, which was enabled following the Trust's successful bid against national capital for initiatives aimed at reducing ambulance handover delays, can accommodate 29 patients awaiting discharge from GRH, including patients in beds and trolleys. The evidence is compelling with respect to the impact on flow and ED congestion, if a patient's planned discharge from the ward can be affected even a few hours sooner. All wards are being asked to identify patients suitable for early transfer to the lounge, the night before.

2.6 I am pleased to report that the Care Quality Commission Improvement Notice issued in November following their inspection of radiotherapy services has been removed. Overall, the inspection was very positive but nevertheless it is good to have achieved compliance with all requirements, so quickly after the initial inspection.

2.7 On the 23rd December 2022, NHS England published the 2023/24 priorities and operational planning guidance. The guidance lays out "three key tasks" for the NHS and describes the immediate priority to be, to recover core services and productivity; secondly, as we recover, to make progress in delivering the key ambitions set out in the *NHS Long Term Plan*; and thirdly, to continue to transform the NHS for the future.

2.8 Within these broad headings are some clear measures by which success will be judged; the following are the key metrics against which acute trust performance will be judged:

- Improving ambulance response times to an average of 30 minutes for Category 2 calls, with an expectation of achieving pre-pandemic response times and/or the existing national standard of 18 minutes. Gloucestershire's performance for December was 122 minutes, a deterioration on performance in November of 42 minutes.
- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 – the current standard is 95%. The Trusts performance for December was 54%.
- Eliminate waits of over 65 weeks for elective care by March 2024 – currently the Trust has 356 patients waiting more than 65 weeks against a SW region system average of 2,859 and within a range of 356 to 8,510
- Increase the percentage of patients that receive a diagnostic test within 6 weeks – the Trust currently achieves this standard

- Meet the cancer *Faster Diagnosis Standard* by March 2024 so that 75% of patients referred with suspected cancer are diagnosed or have cancer ruled out within 28 days of referral - the Trust currently meets this standard
- Increase fill rates against funded establishments in midwifery services whilst continuing to make progress towards the national ambition to reduce stillbirth, neonatal and maternal mortality, and serious intrapartum brain injury

2.9 In addition to these sector specific measures, all organisations are expected to contribute to the delivery of a net system financial position for 2023/24 in the context of 2% pay inflation (additional funding is expected, if awards agreed as part of the Pay Review Body settlements, are in excess of net 2%) and 5.5% non-pay inflation. Inherent in this is an expectation that efficiency of 2.2% will be demonstrated alongside increased productivity, including a reduction in agency spend to no more than 3.7% of the total pay bill.

Deborah Lee
Chief Executive Officer
5th January 2023

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	8	Enclosure Number:	3
Date	12 January 2023		
Title	Board Assurance Framework		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

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

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

Executives reviewed the full BAF on 12 December 2022 and agreed a set of risks that reflect the current position of the Trust and the key challenges impacting on strategic objectives. The BAF summary is attached here, with the full risks currently in development for discussion and review at relevant Committees during January and February, with the aim to present the full BAF to Board in March.

The Board is presented with the summary of the new risks that will form the Board Assurance Framework.

Recommendation

The Board is asked to note the new risks, and to continue to support the development of the BAF.

Enclosures

- Board Assurance Framework summary January 2023

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges							
SR1	Inability to ensure adequate workforce availability	Nov 2022	Jan 2023	DOP	3x4=12	3x2=6	5x4=20
SR2	Failure to effectively manage urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	Jan 2023	CNO/MD			
SR3	Failure to implement the quality governance framework	Dec 2022	Jan 2023	CNO			
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							
SR4	Inability to recruit a compassionate, skilful and sustainable workforce	Dec 2022	Jan 2023	DOP			
SR5	Failure to retain our workforce and create a positive working culture	Dec 2022	Jan 2023	DOP			
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							
SR6	Failure to implement effective quality improvement methodologies	Dec 2022	Jan 2023	MD			
SR7	Inability to fully implement and deliver effective change models	Dec 2022	Jan 2023	MD			
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							
SR8	Inability to ensure sufficient capacity to enable time and capability to deliver	Dec 2022	Jan 2023	COO			
5. Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services							
SR9	Failure to raise awareness and ensure engagement with public, patients and staff	Dec 2022	Jan 2023	DST			
7. We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources							
SR11	Failure to deliver value for money in a sustainable way	July 2019	Jan 2023	DOF	4x3=12	4x4=16	5x4=20
8. We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact							
SR12	Inability to access capital required to i) make any significant reduction in our estate backlog maintenance and critical infrastructure risk ii) replace equipment within lifecycle	July 2019	Sept 2022	DST	4x3=12	4x4=16	4x4=16
SR13	Failure to develop, implement and maintain sustainable healthcare practices	Dec 2022	Jan 2023	DST			
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							
SR14	Failure to detect and contain risks to cyber security	Dec 2022	Jan 2023	CDIO			
SR15	Inability to maximise system functionality	Dec 2022	Jan 2023	CDIO			

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							
SR16	Failure to enable research active departments that deliver high quality care	Dec 2022	Jan 2023	MD			
SR17	Failure to maximise current capacity	Dec 2022	Jan 2023	MD			
SR18	Inability to achieve sufficient financial investment to enable research	Dec 2022	Jan 2023	MD			

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	
SR10	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.

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Report to Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	12 January 2023		
Title	Trust Risk Register		
Author **Director/Sponsor**	Lee Troake, Head of Risk, Health and Safety Mark Pietroni, Medical Director and Director of Safety		

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

Summary of Report

Purpose

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

Following Risk Management Group on 8 December 2022 and 4 January 2023 the following changes were made to the Trust Risk Register.

Key issues to note

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- **S3337**- The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward

  Scores: Quality C4 xL4 = 16, Statutory C4 x L3 = 12, Workforce C3 x L3 = 9, Finance C3 x L3 = 9, Reputational C2 x L3 = 6, Safety C3 x L2 = 6

  Risk Cause: Lack of beds within hospital to move patients from SAU onto wards within 4 hours, once decision to admit made, thereby creating mixed sex breaches. Inadequate patient beds in SAU to meet demand for patients to transfer in to, currently 22 EGS beds predicted requirement is 48. Current SAU footprint is not adequate for the number of patients attending, unit seeing an average of 902 patients per month. This is an increase from 400 when it opened in 2018. Lack of medical staff to review patients when required in theatre/ ED etc. No bedhead services in SAU area or area used for assessment when side rooms not available

- **C3963** - Risk of increased harm, breach of regulations, distress and poor-quality experience to patients, staff and visitors when boarding patients in wards.

  Scores: Quality C3 x L5 = 15, Workforce C4 x L3=12, Statutory C3 x L4=12, Safety C3 x L2= 6, Reputational C2 x L3 = 6, Finance C3 x L2 = 6

  Risk Cause: High demand and overcrowding in the Emergency Departments at GRH and CGH led to ambulance off loading delays and patients remaining ED for many hours. This significantly increased

the risk of patient deterioration in ambulances and in ED, staff burn out or error and the availability of ambulances in the community to attend critically ill patients. Boarding and cohorting were initially introduced in ED to assist with the release of ambulances. However, CQC intervened due to the risks associated with ED corridor care. Boarding of patients in wards is now used as part of a wider a solution to balance and spread the risk across the hospital.

- **C3930S&T E&F** - The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC

  Scores: Statutory C5 x L3 = 15, Safety C5 x L2 = 10, Reputational C3 x L3= 9, Business C3 x L3 = 9

  Risk Cause: Lithium batteries are safe providing certain criteria has been met regarding their installation, use and maintenance. The batteries burn at very high temperatures and are very difficult to put out, (there is one extinguisher on the market at present but this causes asphyxiation so not appropriate for hospital use). The battery chargers have been placed in main corridor routes and next to hazards.

  The installation of some of the battery chargers was of poor quality, lacking appropriate trunking/protective covers for the wiring. There is also a lack of plug sockets for the units. The batteries have a life span of 1000 charges after which they should be replaced. There is a report that states how many times the batteries have been used, as well as an indicator if there is a problem on the battery itself.

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL/SPECIALTY RISK REGISTER

The following risk was discussed for downgrade. It has been reviewed by the surgical team and Surgical Quality Board based on the data collated by the Business Intelligence (BI) Unit which indicated a reduction in the number of patients remaining in recovery beyond 4 hours. Before downgrade is approved, the risk owner and Divisional Director of Quality and Nursing will meet with BI to reconcile the difference between the data graphs shown to RMG and the DATIX incidents.

- **S2715** - The risk to quality of care of patients remaining in recovery when they are either fit for discharge and require ward-based care or require care on DCC

  Scores: Quality downgraded from C3 x L5 = 15 to C2 x L3 = 6
  Safety downgraded from C2 x L4= 8 to C2 x L2 = 4
  Workforce downgraded from C3 x L4 = 12 to C2 x L2 = 4
  Statutory downgraded from C3 x L4 =12 to C2 x L3 = 6
  Business downgraded form C2 x L4 = 8 to C1x L1= 1

- **Risk Cause**: Lack of inpatient beds leading to patients who require ward-based care remaining in Recovery where the appropriate facilities for their inpatient care are not available.

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

Recommendation
The Board is asked to note the report.
Enclosures
Trust Risk Register

TLT Report

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
C3963	Risk of increased harm, breach in regulations, distress and poor quality experience to patients, staff and visitors when boarding patients in wards.	Ward Boarding criteria in SOP to ensure unsuitable patients are not boarded Risk Assessments completed for all wards Consultation has taken place with wards	weekly boarding meetings being held- end date to be reviewed in April 2023 simple discharge group to be commenced and discharge processes to be reviewed	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk		Divisional Board - Corporate / DOG, Divisional Board - D & S, Divisional Board - Medical, Divisional Board - Surgery, Divisional Board - W & C, Emergency Care Delivery Group, Quality Delivery Group,	Clinical Safety Effectiveness and Improvement Group, Emergency Care Operational Group, Fire Safety, GMS Health and Safety Committee, Health and Wellbeing Group, Patient Experience Group, Patient Flow		Emergency Care Board, Executive Management Team, Quality and Performance Committee, Trust Board, Trust Leadership Team	31/01/2023	Seaton, Andrew	Trust Risk Register
D&S2404CHaem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	Divisional Board - D & S, People and OD Delivery Group, Quality Delivery Group	OHPCLI Board		People and OD Committee, Quality and Performance Committee	13/08/2022	Johny, Asha	Trust Risk Register
C1437POD	The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including; - Medical & Dental; Registered Nurses & Midwives and AHP professionals, thereby impacting on the delivery of the Trust's strategic objectives.	Trust Workforce Planning include as part of the Trust Business Planning Cycle template. Central workforce planning for the ICS is overseen by the ICS Workforce Steering Group Introduction of alternate/Advanced practice/new including Associate Specialists, Non- Medical Consultant, ACP, PA offering alternative solutions	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
D&S2976BIMA	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Reallocate clinical sessions by current staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting center widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee	22/08/2022	Hunt, Richard	Trust Risk Register
D&S3558PharmEquip	The risk of breakdown of air handling unit (due to age)leading to poorer patient outcomes for oncology and parenteral nutrition patients. The risk of loss of service and that that	Planned preventative maintenance by GMS Outsourcing for some products in place which would reduce impact somewhat however this is not reliable due to	Liaise with GMS AHU motors report of AHU status Check on chiller at weekends	Diagnostics and Specialties, Gloucestershire Managed Services	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		Divisional Board - D & S	Medicines Optimisation Committee		Cancer Services Management Board	28/02/2023	White, Amanda	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off. Progress VCPs for Flow Coordinator and ED Assistants Submit workforce paper to Exec COO Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners	Medical	Safety	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk	Medical Director	Divisional Board - Medical	Unscheduled Care Leaders Group		Quality and Performance Committee, Trust Leadership Team	31/01/2023	Barnes, Chester	Trust Risk Register
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 specialities 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow up plan 3. Additional provision for capacity in key specialilities to support f/u clearance of backlog To resolve outstanding areas of concern Establish a risk review meeting	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	28/04/2023	Zada, Qadar	Trust Risk Register
WC3685OBS	The risk of delayed review, identification and treatment for pregnant women attending triage, in addition inability to adequately meet	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	28/02/2023	Harris, Rachael	Trust Risk Register
D&S3743CHaem	The risk of failing to deliver the necessary support to the Laboratory due to insufficient staffing levels and lack of appropriate skill sets, leading to a delay to diagnosis or treatment within the clinical service and harm to the patient.	Provision of consultant for 1 day a week Increase in turn around time for film reporting Communication of reduced resource to all involved Recruitment process	Consultant to start in July 2022	Diagnostics and Specialties	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Medical Director		OHPCLI Board			30/11/2022	Johny, Asha	Trust Risk Register
C3930 S&T E&F	The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC	Some of the units are placed in fire-rated hazard rooms. Some of the units have a better level of installation.	To review hazard rooms with clinical teams and Fire team Identify any works required for alternative locations Set up lessons learnt event To sign off installation as required standard To review usage and risk report to inform prioritisation To roll-out new SVF process To ascertain staff training requirements and roll-out Fire team trainer to add information to mandatory training package	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Statutory	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk		Risk Management Group, Trust Health and Safety Committee			Other	16/01/2023	Turner, Bernie	Trust Risk Register

			Rolling replacement programme for batteries Check required on risk assessments To broker discussions regarding funding impacts Conclude RAG audit of areas across the Trust														
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	31/03/2023	Zada, Qadar	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Little things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a Following presentation of W168912 N Jordan to attend ward to review completion of falls documentation and required management of patient following assessment by staff Following presenntation of W171436 to PHH N Jordan to forward information to purchase slippers for patients in ED W165353 Nadine Jordan to review with 9a x-ray identifying # and communication of #	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	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	31/12/2022	Bradley, Craig	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's	Develop Intensive intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Divisional Board - W & C, Quality Delivery Group, Safeguarding Strategic Group	Safeguarding Adults Operational Group, Safeguarding Children Operational Group / Board		Quality and Performance Committee, Trust Board, Trust Leadership Team	30/03/2023	Freebrey, Clare	Trust Risk Register
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints,	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new, overdue risks, partially completed risks, uncontrolled risks and overdue actions etc	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis test risk module Weekly meeting and action plan for DATIX Cloud	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	Divisional Board - Corporate / DOG, Finance and Digital Committee, Trust Health and Safety Committee	Quality and Safety Systems Group		Finance and Digital Committee, Quality and Performance Committee, Trust Leadership Team	12/01/2023	Troake, Lee	Trust Risk Register
		1. Evidence based working practices including, but not limited to; Nursing	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														

C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and suppt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed Bespoke training to DCC staff for categorisation of pressure ulcers Bespoke training to ward 4a to include 1st hour priorities produce training document on wound measurements for Rendcomb The provision of RCA support/training for TV issues to be take to pressure ulcer council Work with Knightsbridge to support staff TVN training Bespoke training in management of pressure ulcer [revention on ward 7a TVN to d/w TVN lead regarding use of share care pathway in regards to EPR. Implement training programme in management of patient pressure ulcers in ED Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR	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	31/12/2022	Bradley, Craig	Trust Risk Register
D&S2517PathEquip	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate). Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Estates and Strategy	Divisional Board - D & S	Pathology Management Board			31/01/2023	Brown, Sarah	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Patient flow and quality coordinator (band 7) allocated on a daily basis	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required. staff consultation on call enhancement discussion	Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Interim Chief Nurse	Divisional Board - W & C, People and OD Delivery Group			People and OD Committee	31/01/2023	Stephens, Lisa	Trust Risk Register
M2268Emer	The risk of patient deterioration, harm and poor patient experience when care is provided in the corridor during times of overcrowding in ED	Patient to staff ratio 1:4 Clinically ready to proceed patients only to be moved to the corridor and those awaiting discharge . Clear criteria in place (recorded on escalation ambulance policy)to ensure only low risk patients are placed in corridor. Patients that have been identified as at risk of fall Risk of absconding / wandering should not be placed in the corridor. Patients with that cannot access the toilet facilities by chair or walking should not be placed in corridor.	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR audit form fo NIC re patients suitability Fire risk assessment Risk assessment of corridor care Review of SOP and escalation policy	Medical	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse & Director of Quality	Divisional Board - Medical, Emergency Care Delivery Group, Quality Delivery Group, Trust Health and Safety Committee	Emergency Care Operational Group, Patient Experience Group, Resuscitation and Deteriorating Patient Group		Emergency Care Board, Quality and Performance Committee, Trust Leadership Team	31/01/2023	Forrest, Matthew	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across	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	Medical, Surgical	Safety	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	30/09/2022	Holdaway, Matt	Trust Risk Register

		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	Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment														
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	20/02/2023	Zada, Qadar	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 speciality 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	20/02/2023	Zada, Qadar	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package 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	13/08/2022	Foo, Andrew	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	14/12/2022	Rees, Linford	Trust Risk Register
C2803POD	The risk that staff morale, productivity and team cohesion are eroded by adverse workplace experiences and/or significant external events, which in turn adversely impacts patient safety, job satisfaction, colleague wellbeing, and staff retention.	Divisional staff survey action plans, monitored by Executive Reviews. Divisions are offered support by PACE. Trustwide staff survey action plan. Patient and Colleague Experience Group (PACE) - leading on the triangulation of experience data and delivery of compassionate culture work streams. 2020 Hub is staffed with 3.3 WTE staff to deliver a range of health-wellbeing support. EDI team established comprised of substantive roles (EDI Lead, EDI Coordinator, EDI Administrator) and fixed-term 18 months EDI Training Specialist. Colleague Wellbeing Psychology Lead in place, with 1.6 WTE Psychology Link Workers appointed for 23 months. 1 year fixed term 0.3 Resilience Trainer appointed. Compassionate Leadership training rolled out and all leaders/managers	Create Dashboard to underpin SPEIG work priority workstreams feeding into SPEIG Review Staff Survey results EDI/Cultural Improvement plans being devised in light of DWC and staff survey results Short, medium and long-term interventions being proposed to address health-wellbeing concerns 2 x OD Specialists (fixed term) being recruited to offer additional support to a) maternity and b) junior nurse leadership development Staff Engagement and Internal Comms Manager being appointed to support internal communications effectiveness	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Staff Experience and Improvement Group		People and OD Committee	30/12/2022	Hopewell, Abigail	Trust Risk Register
F3806	The risk that the organisation is not able to manage resources within delegated budgets.	The controls that are in place to prevent the risk materialising are -sustainability programme Annual budget planning - Monthly System review and NHSEI Returns -Monthly Management Accounts including detailed forecasts	Development of Divisional Recovery Plan Performance Management of Delivery of Recovery Plans Financial Recovery Plan developed and reported to Finance & Digital Committee	Corporate	Finance	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Karen Johnson	Finance and Digital Committee			Executive Management Team, Finance and Digital Committee, Trust Board, Trust Leadership Team	18/11/2022	Johnson, Karen	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Write risk assesment Update busines case for Theatre refurb proaramme 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 budeet 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	31/10/2022	Dobb, Michael	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS 4. C.Diff reduction action plan in place	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Infection Control Committee			Quality and Performance Committee	17/02/2023	Bradley, Craig	Trust Risk Register
	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs	This has been worked up at part of STP reolace bid. Submission of cardiac cath lab case Procure Mobile cath lab								Capital Control Group, Centre						

M2613Card	equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	2021 to CQC. Again Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	Project manager to resolve concerns regarding other departments phasing of moves to enable works to start To update on IGIS programme	Gloucestershire Managed Services, Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board - Medical	Medical Devices Group, Medical Equipment Fund		Service Review Meetings	20/01/2023	Matthews, Kelly	Trust Risk Register
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DISN commenced March 2021, funded by CCG for 12 month and a further one in June 2021 . 4) 0.77 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding 5) 3 WTE 12 month fixed term dedicated inpatients diabetes nurses	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR New Elearning module in progress to complete bimonthly audit into inpatient care for diabetes Recruitment events and Staff development opurtunity to be a DSN	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Chief Nurse and Director of Quality	Divisional Board - Medical, People and OD Delivery Group, Quality Delivery Group	Medical Workforce Productivity Board, Medicines Optimisation Committee, Patient Experience Group		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	10/02/2023	Mani, Vinod	Trust Risk Register
S2715	The risk to quality of care of patients remaining in recovery when they are either fit for discharge and require ward-based care or require care on DCC.	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 Use of overnight recovery prohibited by Trust following CQC ruling Recovery asked to contact Silver Command when site are seeking to keep a patient in recovery overnight as of October 2022.	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 followine surgery review of establishment as part of staffing risks	Surgical	Quality	Minor (2)	Possible - Monthly (3)	6	4 - 6 Moderate 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	31/01/2023	Ball, Natalie	Trust Risk Register
S3337	The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward	20 chairs and 2 side room capacity + swabbing room NEWS 2 taken by nursing team 4hrly at least Escalation via site to obtain inpatient bed SOP with criteria for admission Referral to Registrar/ ACRT if patients deteriorate whilst waiting for assessment Use of assessment rooms as side rooms for patients with gold approval only Staff visible within bay/ just outside of bay Trainee ACPs to review patients	Works to change colorectal office on 5a to bedded bay with bathroom works in orchard centre to allow relocation of colorectal office space on 5th floor escaltion via division tri to stop use of assessment rooms for inpatients 1-3 year strategy plan for SAU and 5th floor update SOP to reflect current situation recruitment drive for SAU	Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Surgery, Estates and Facilities Committee, Quality Delivery Group			Quality and Performance Committee	12/12/2022	Jones, Lisa	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 be working 8-6.30 shifts. This allows the maximum capacity with 3 machines	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 stfafing in order to support recovery of waitine list Banding Review of Radiotherapy Staffing	Diagnostics and Specialties	Statutory	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	31/01/2023	Moore, Bridget	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	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	31/03/2023	Lanceley, Simon	Trust Risk Register

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 21 December 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**
Quality and Performance Report	***Urgent and Emergency Care*** An update on Pre-empting and Boarding procedures at the Trust was received, highlighting issues and actions related to safety, patient experience, ambulance handovers, length of stay, and Category 2 ambulance response times. Pre-empted and boarded patients were subject to regular and continued fire risk assessments, with evacuation procedures and plans regularly reviewed.	The team would continue to monitor data and hold weekly action plan review meetings and daily safety huddles to closely monitor the ongoing situation. Key metrics and trends would be shared with the Committee from January onwards.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	The Committee received a newly formatted report which included new metrics, access and quality dashboards which enabled the team to capture data on multiple levels and automated information, allowing for greater efficiency and control. The following key points were highlighted: • Work continued to address the must dos/should dos from the CQC section 29a notice in maternity. • Maternity advisors had rated the Trust as non-compliant for Year 3 of the Maternity Incentive Scheme, whereas the Trust had self - assessed as compliant; a review of evidence would be undertaken to ensure full compliance for future years. • PALS contacts continued to be high, with 65% closed within five days. • Positive Friends and Family Test feedback remained at 86%, with improvement in feedback ratings reported in inpatients, maternity and unscheduled care. • A new tool for ward accreditation was being piloted and would be rolled out to other divisions. • A deep dive into cancer performance had taken place to improve achievement of the 62-day standard. Robust plans were now being developed for colorectal, haematology and urology. • The Trust was performing well in relation to elective care, with 52-week waits remaining stable. • The Trust had increased focus on simple discharges, with a quality improvement approach utilised to streamline processes with a view to make permanent changes, including such initiatives as the Discharge Lounge.	Additional work on the reformatted Quality and Performance Report would take place to improve the narrative. A detailed update on cancer performance and assurance on recovery would be received in February/March. Evidence would be compiled to support compliance against Year 3 Maternity Incentive Scheme.
Water Safety Briefing	An initial assessment had confirmed that the engineering controls in place were expected to control the pseudomonas bacteria, in line with national guidance. A thorough review of best practice had been undertaken, with some actions arising. A key concern related to cleaning standards, particularly the cleaning of filters/drains/showers, which was being discussed with GMS and the Infection Prevention and Control team.	The Committee expressed concern that patients remained on the affected ward, however some assurance was provided that an active dynamic risk assessment was underway, along with active water monitoring.
Serious Incidents Report	No further Never Events had been reported; seven new serious incidents and one Healthcare Safety Investigation Branch (HSIB) case had been reported.	A recovery plan had been submitted for consideration to increase capacity within the

	Current staffing vacancies, sickness and increase in activity meant that progress had been slower than standards required, however all cases were reviewed and prioritised and initial letters to complainants detailed delays.	team, however the Committee noted that a key post in the complaints team had now been recruited to.
Trust Risk Register	One new risk had been added to the risk register, related to the quality of continued poor patient experience on the Surgical Assessment Unit (SAU) for patients requiring admission to a ward.	The Committee requested assurance around patient experience in the Trust's current environment and how this was tested, i.e., through governor walkabouts/FFT data/other proactive steps to ensure optimal patient experience.
Getting it Right First Time Report	There had been no deep dive visits undertaken during the previous six months, however a number were planned to anaesthetics, cardiology and ophthalmology. The main focus of the team continued to be the High Volume Low Cost programme, which aimed to reduce waits for planned surgical activity by improving utilisation and streamlining pathways.	The team was reviewing its governance procedures and leadership model.
Quarterly Patient Experience Report	Patients reported an overall positive experience of the Trust's services, though there were a number of areas identified where improvements were required, particularly around wait times and communication in unscheduled care and inpatient settings.	Divisional teams would lead improvement work supported by the patient experience team, which would be reported through to Quality Delivery Group.
Winter Plan	The Committee received the report for information, noting that a review of the deployment of an additional £6m resource awarded to the ICB was underway.	None.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Update	The Committee received a thorough written report outlining progress against CQC action plans.	The Committee would continue to receive regular updates.
Annual Equality Report	The report highlighted a number of improvements that had been made following conversations with the community, including the development of patient booklets and easy read leaflets, a systemwide improvement programme for carers, a community engagement event for the Whole Person Care Strategy, and growth and engagement with the Young Influencers Group. Other initiatives focused on health inequalities, Changing Place facilities, hearing loss improvement workstreams, and further work into veteran awareness.	Reporting of the Equality Delivery System 22 (EDS22) would be monitored through Quality Delivery Group.
Draft ICS Strategy	The Strategy had been discussed at Board of Directors in December.	The Committee supported the publication of the Strategy on 31 December.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		
Executives had fully reviewed BAF risks on 12 December; new risks would fully reflect the current situation of the Trust and would be presented to the Committee in the new year.		

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

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 23 November 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**
Quality and Performance Report	***Urgent and Emergency Care*** Challenges in urgent care continued. Significant progress had been achieved with ambulance handovers, although further improvement was required in line with Cat2 response, consistency between CGH and GRH, and further work around discharge and flow. The team would move into the new built ED which would help to enhance morale in the team. Boarding and pre-empting of patients continued in response to the national requirement to rapidly improve ambulance handover times. Assurance was provided to the Committee that processes had been robustly set out and challenged to ensure the best care possible for patients under the current circumstances.	Direct and indirect consequences of boarding and pre-empting would be considered and included in future reports. The Committee requested additional assurance around security of patients' property whilst boarding.
Trust Risk Register	No new risks had been agreed, and no risks had been changed. An action plan regarding the pseudomonas incident raised concern as it contained a number of incomplete actions and safety related plans that the Committee queried as to why they were not already in place. The investigation was ongoing and would include these points, with a particular focus on cleaning standards.	A briefing and action plan around water safety would be brought to the Committee for assurance.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	The following key points were highlighted: • A challenge remained within two key areas of diagnostics, endoscopy and echocardiography. Recovery plans were in place for both areas. • A renewed focus on cancer performance was being undertaken as recovery pace was behind plan. • Elective recovery was making good progress despite issues in specific areas. • Theatre productivity would be an area of focus in the coming months. • The Aveta birth unit remained closed due to staffing challenges and postnatal beds in Stroud remained closed with weekly review. • The quarterly Patient Experience Report showed that 89% of patients would recommend the Trust's services. • The PALS and complaints teams continued to operate under pressure, and a review was underway to consider integration of both teams. • A volunteer recruitment programme would be re-established. • The development and implementation of Patient Safety Partners was supported, in line with the new Patient Safety National Standards. • Mortality data was rising, with no local factors identified. Alerts were investigated through the usual processes, however concern remained with delay-related harm.	A review of the suite of metrics around safeguarding would take place to ensure that systems and processes were appropriate for patients with learning disabilities. The Mortality Group would provide further updates and assurance on Trust data.
Winter Plan	The Committee was assured by the process of developing the comprehensive Winter Plan, which included lessons learned from	Assurance was sought and provided on aspects of the winter

	the previous year and addressed portering and back-office functions. Whilst there was confidence in the plan, significant challenges were recognised around stranded and super-stranded patients, boarding and pre-empting, and complex needs pathways.	plan under Trust control, noting wider system contribution and leadership needed for the plan to be achieved. A heatmap would be developed to clarify pre-empting and boarding standard operating procedures and associated risk assessments.
Serious Incidents Report	No further Never Events had been reported; the Committee noted that it had been twelve months since a Never Event was declared in theatres. Three new serious incidents had been reported. Additional work to improve accessibility for patients with learning difficulties was underway.	An update on mislaid gynaecology samples would be provided at the next meeting. An update on accessibility would be included in the next scheduled safeguarding report.
Annual Clinical Improvement, Audit and GSQIA Report	Assurance was provided on the oversight of the Clinical Effectiveness and Quality Improvement function, including the Gloucestershire Safety and Improvement Academy future plans and training.	Additional work on divisional quality management plans, governance and reporting would take place to improve organisational understanding and championing.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Update	The Committee received a thorough written report outlining progress against CQC action plans.	The Committee would continue to receive regular updates.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		
Executives would review the BAF in December to ensure it was reflective of the Trust's current position.		

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors			
Agenda item:	**10**	**Enclosure Number:**	**05c**
Date	12 January 2023		
Title	Quality and Performance Report (QPR) – November 2022		
Author /Sponsoring Director/Presenter	Authors: Deputy Director of Quality and Programme Director for Nursing and Midwifery Excellence Suzie Cro, Director of Quality Improvement and Safety – Andrew Seaton Presenting directors: Director of Quality and Chief Nurse, Matt Holdaway, Chief Operating Officer, Qadar Zada, and Director of Safety and Medical Director, Mark Pietroni		

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

Summary of Report

Purpose

The purpose of this report is to provide an update on the programme of work that has been progressing to improve the Quality and Performance Report and to provide a first version of the new report for the Committee to review.

Key points of note

- New QPR
- This new reporting has gone live during a very operationally challenging time for the Trust.
- The QPR, Dashboard and Metric Reports can now be found here.
- We are now capable of capturing data at multiple levels in the organisational hierarchy (Trust wide, Site, Division, Ward, Specialty).
- The Business Information (BI) Team have supported the programme, the implementation and have provided a reporting guide.

QPR Report Production

- Going forward it will be the Directors' responsibility, supported by their deputies, to keep the data owners up to date, to chase non-completion and to chase completion of exception reports.
- To support this an automated reminder will be sent to data entry owners from the 1st of the month to submit their metric results.
- The QPR Initial Baseline Report will be available on 8th of every month for use at the Delivery Group meetings
- All reporting metric values and exception reports must be submitted before midnight on the 14th of the

month for the final version for the month to be published for Q&P Committee and Board.

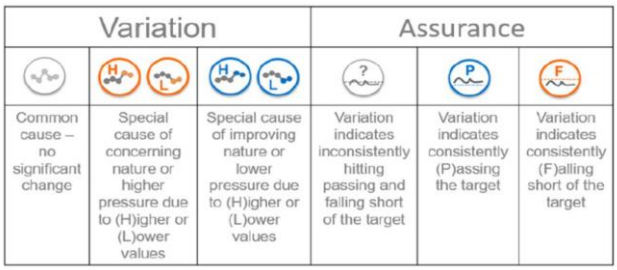
New QPR Governance

- If a new metric is required to be added to the report, or a metric retired, this will be approved by the Quality Metric Review Meeting that will report into the **Quality Delivery Group.**

Monitoring performance at Q&P Committee

- The QPR and the Assurance Reports from the Delivery Groups should be seen as 1 item on the Q&P and Board agendas.
- The Exception Reports within the QPR can be used to provide more information.
- The Delivery Group Exception Reports will provide the narrative for the analysis, improvement programmes/actions.
- The Dashboards (Access and Quality) are to be used to inform the assurance discussions.

Picture: Dashboard key



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

Orange icons indicate that you would expect to **consistently miss a target**

Blue icons indicate that you would expect to **consistently achieve a target**

Grey icons indicate that **sometimes the target will be achieved and sometimes it will be missed**

<u>Access Dashboard</u>

The Access Dashboard shows the most recent performance of metrics in the Access category. Exception reports will be shown within the QPR report. The Planned Care Delivery Group, Cancer Delivery Group and Emergency Care Delivery Group Exception Reports will provide the narrative for the committee to review with the access dashboard.

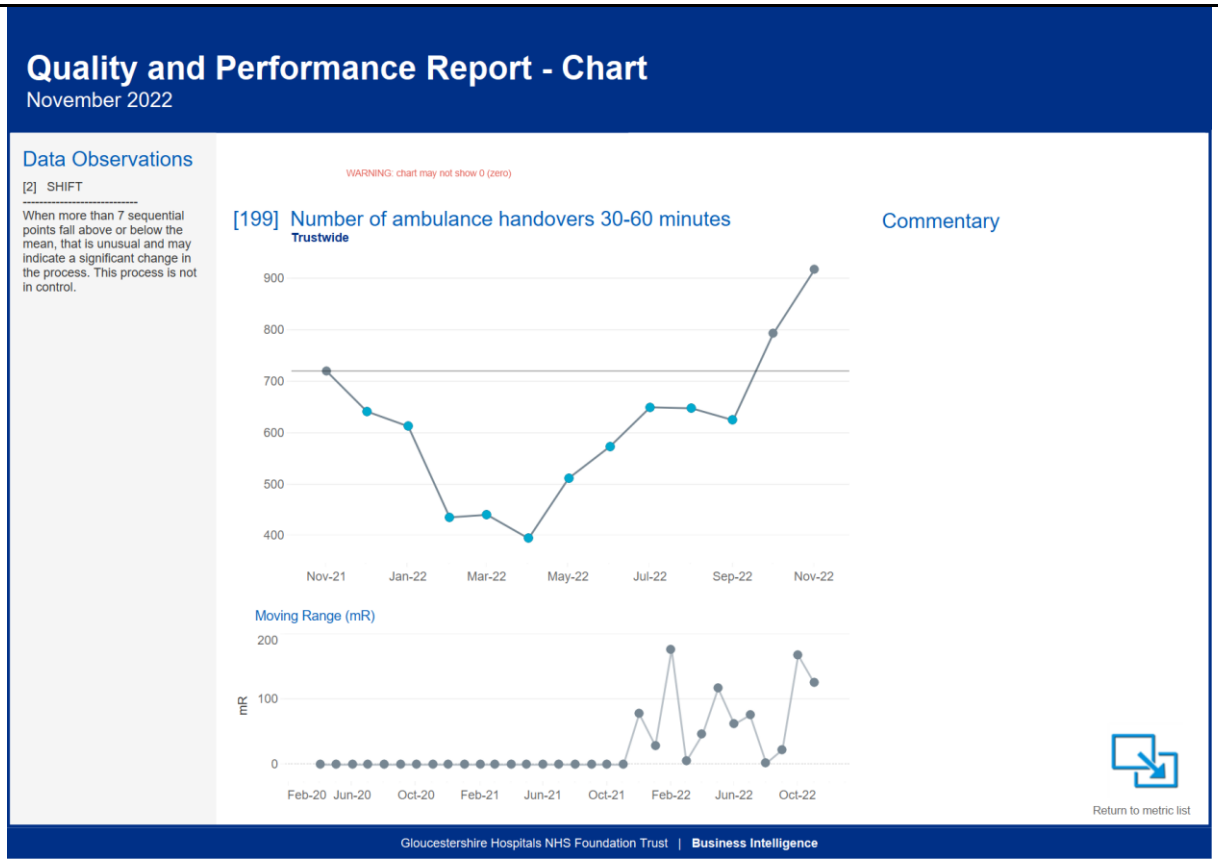
Picture: Access dashboard within new QPR

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Cancer	Cancer - 2 week wait breast symptomatic referrals	≥ 93.0%		Nov-22	96.0%	
	Cancer - 28 day FDS (all routes)	≥ 75.0%		Nov-22	80.1%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%		Nov-22	93.9%	
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%		Nov-22	100.0%	
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%		Nov-22	84.3%	
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%		Nov-22	85.9%	
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%		Nov-22	87.8%	
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%		Nov-22	57.8%	
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%		Nov-22	61.1%	
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%		Nov-22	88.1%	
	Number of patients waiting over 104 days with a TCI date	= 0		Nov-22	1,538,433	
	Number of patients waiting over 104 days without a TCI date	≤ 24		Nov-22	1,197	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%		Nov-22	16.05%	
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600		Nov-22	937	
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%		Oct-22	56.2%	
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%		Nov-22	29.61%	
	% of ambulance handovers < 15 minutes	No Target		Nov-22	18.35%	
	% of ambulance handovers < 30 minutes	No Target		Nov-22	44.10%	
	% of ambulance handovers over 60 minutes	≤ 1.00%		Nov-22	30.90%	
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%		Nov-22	36.0%	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%		Nov-22	28.7%	
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%		Nov-22	58.36%	
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0		Nov-22	967	
	Number of ambulance handovers 30-60 minutes	↓ Lower		Nov-22	918	
	Number of ambulance handovers over 60 minutes	= 0		Nov-22	958	
Maternity	% of women booked by 12 weeks gestation	> 90.0%		Nov-22	90.5%	
Operational Efficiency	% day cases of all electives	> 80.00%		Nov-22	85.21%	
	Average length of stay (spell)	≤ 5.06		Nov-22	7.02	
	Cancelled operations re-admitted within 28 days	No Target		Nov-22	75.47%	
	Intra-session theatre utilisation rate	> 85.00%		Nov-22	88.69%	
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40		Nov-22	2.66	
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65		Nov-22	8.31	
	Number of patients stable for discharge	≤ 70		Nov-22	235	
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380		Nov-22	513	
	Urgent cancelled operations	↓ Lower		Nov-22	0	
Outpatient	Did not attend (DNA) rates	≤ 7.60%		Nov-22	6.19%	
	Outpatient new to follow up ratio's	≤ 1.90		Nov-22	1.86	
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%		Oct-22	7.17%	
Research	Research accruals	No Target		Aug-22	234	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower		Nov-22	122	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No Target		Nov-22	6,819	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target		Nov-22	2,650	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0		Nov-22	1,317	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%		Nov-22	31.81%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target		Nov-22	68.80%	
	% patients receiving a swallow screen within 4 hours of arrival	No Target		Nov-22	68.20%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		Nov-22	72.7%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%		Nov-22	96.1%	
SUS	Percentage of records submitted nationally with valid GP code	≥ 99.0%		Mar-21	100.0%	
	Percentage of records submitted nationally with valid NHS number	≥ 99.0%		Mar-21	99.0%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%		Nov-22	29.17%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%		Nov-22	91.7%	

Picture: Example of 1 metric as it can be viewed on the digital platform (please note commentary not yet completed)



Quality dashboard

The Quality Dashboard shows the most recent performance of metrics in the Quality category. Exception reports will be shown within the QPR report. The Quality Delivery Group and Maternity Delivery Group Exception Reports will provide the narrative for the committee to review with the quality dashboard.

Picture: New Quality Dashboard

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Friends & Family Test	ED % positive	No Target	Nov-22	70.7%	
	Inpatients % positive	No Target	Nov-22	88.5%	
	Maternity % positive	No Target	Nov-22	89.6%	
	Outpatients % positive	No Target	Nov-22	93.3%	
	Total % positive	No Target	Nov-22	88.6%	
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Nov-22	159	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Nov-22	237	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Nov-22	149	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Nov-22	92	
	Clostridium difficile - infection rate per 100,000 bed days	↓ Lower	Nov-22	28.1	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Nov-22	3.1	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Nov-22	3.1	
	Number of MSSA bacteraemia cases	≤ 8	Nov-22	1	
	Number of bed days lost due to infection control outbreaks	↓ Lower	Nov-22	13	
	Number of community-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	Nov-22	1	
	Number of ecoli cases	No Target	Nov-22	8	
	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	Nov-22	8	
	Number of klebsiella cases	No Target	Nov-22	1	
	Number of pseudomona cases	No Target	Nov-22	2	
	Number of trust apportioned Clostridium difficile cases per month	< 10	Nov-22	9	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned MRSA bacteraemia	= 0	Nov-22	1	
Maternity	% PPH >1.5 litres	↓ Lower	Nov-22	3.8%	
	% breastfeeding (discharge to CMW)	= 0.0%	Nov-22	63.8%	
	% breastfeeding (initiation)	No Target	Nov-22	79.4%	
	% of women on a Continuity of Carer pathway	No Target	Nov-22	11.17%	
	% of women smoking at delivery	≤ 14.50%	Nov-22	10.07%	
	% of women that have an induced labour	≤ 30.00%	Nov-22	31.10%	
	% stillbirths as percentage of all pregnancies	< 0.52%	Nov-22	0.00%	
	Number of births less than 27 weeks	No Target	Nov-22	3	
	Number of births less than 34 weeks	No Target	Nov-22	133	
	Number of births less than 37 weeks	No Target	Nov-22	38	
	Number of maternal deaths	No Target	Nov-22	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Nov-22	1.8%	
	Total births	No Target	Nov-22	455	
Mortality	Hospital standardised mortality ratio (HSMR)	↓ Lower	Aug-22	113.0	
	Hospital standardised mortality ratio (HSMR) - weekend	↓ Lower	Aug-22	105.0	
	Number of deaths of patients with a learning disability	No Target	Nov-22	3	
	Number of inpatient deaths	No Target	Nov-22	164	
	Summary hospital mortality indicator (SHMI) - national data	No Target	Sep-22	1.0	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Nov-22	98	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Advice and Liaison Service (PA..	% of PALS concerns closed in 5 days	No Target	Nov-22	65%	
	Number of PALS concerns logged	↓ Lower	Nov-22	299	
Patient Safety Incidents	Medication error resulting in low harm	↓ Lower	Nov-22	4	
	Medication error resulting in moderate harm	↓ Lower	Nov-22	1	
	Medication error resulting in severe harm	↓ Lower	Nov-22	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Nov-22	32	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Nov-22	0	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Nov-22	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Nov-22	13	
	Number of falls per 1,000 bed days	↓ Lower	Nov-22	5.00	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Nov-22	5	
	Number of patient safety incidents - severe harm (major/death)	No Target	Nov-22	5	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Nov-22	9	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Nov-22	70.74%	
	Number of DoLs applied for	No Target	Nov-22	86	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Nov-22	111	
	Total admissions aged 0-17 with DSH	↓ Lower	Nov-22	46	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Nov-22	18	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Nov-22	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Nov-22	0	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Safeguarding	Total number of maternity social concerns forms completed	No Target	Nov-22	83	
Serious Incidents	Number of never events reported	= 0	Nov-22	0	
	Number of serious incidents reported	↓ Lower	Nov-22	5	
	Percentage of serious incident investigations completed within contract timescale	> 80%	Nov-22	100%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%	Nov-22	100.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Nov-22	92.7%	

Conclusion

The Board is asked to note the new QPR Report, the proposed governance for new metrics, the access and quality dashboards, the plan for the exception reporting by the Delivery Groups to cover the narrative (with more detail being available within the QPR). As this is the first version improvements to the report are required and will be seen in the next iteration.

Recommendation
The Board is asked to note the progress and receive the first report noting that improvements are required.
Enclosures
QPR November 2022 – Dashboard

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period November 2022

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.

For cancer, performance data showed the Trust met 3 out of 9 standards. The Trust met 2ww breast symptomatic, 31 day subsequent treatment (SACT and Radiotherapy). 2ww performance continues to be impacted by lower GI capacity issues. 62 day standard performance for October was 70.3% which will rise following final submission. Performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity. >62 day and >104 day numbers are currently static but GHFT is regionally in one of the best positions in terms of >62 day backlogs although more work required to bring >104 days down further.

For elective care, the RTT performance did not meet the national standard, and in November performance dipped slightly for the third successive month. Although validation of the month-end position is ongoing, the finalised position is anticipated to be around 69.8% (down 0.6% in month). Although a reduction, performance is still considered to be stable and significantly above the national average of approx 59%. The total incompletes has reduced in month, which is the first time in several months where a reduction has been observed. The unconfirmed November position is expected to be around 65,500 (compared to 66,102 last month). This decrease was particularly noted in patients under 18 weeks (hence the slight deterioration in RTT performance).

The number of patients waiting over 52 weeks has increased in month, reducing from 1,189 in October to approximately 1,276 in November. The three specialties contributing to this increase being Surgical Endoscopy (+42), Oral Surgery (+33) & ENT (+18). The number of patients over 78 weeks has remained the same as last month with a total of 33. The main specialties affected being ENT (8),Oral Surgery (5) and Clinical Haematology (4). The Trusts continues to have zero 104w breaches, noting that risks still does exist with a small number of patients having TCIs close to this limit.

Divisions have made progress in the creation of speciality patient leaflets associated with the 'My Planned Care' project. This national initiative seeks to support patients who are waiting for certain procedures, which may have been delayed during the pandemic, and encourages them to take an active interest in their personal wellbeing and health.

Communication with patients is continuing via the Elective Care Hub, with focus having now turned to patients on a follow up waiting list, and intermittent reviews of patients on an RTT pathway. Further promotion of ECH contact line is due to take place at the request of the ICB, thereby allowing GPs to more readily divert calls to the team.

Directors Operational Assurance Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

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

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
All electives (including day cases)	5,499	4,943	4,817	5,086	6,022	5,020	5,821	5,624	5,662	6,184	6,249	6,182	6,175
Day cases	4,540	3,942	4,132	4,223	4,984	4,127	4,736	4,625	4,700	5,223	5,206	5,160	5,262
ED attendances	20,093	18,388	19,175	17,664	20,519	19,336	20,898	20,155	20,966	19,913	19,930	21,376	20,727
FUP outpatient attendances	37,926	32,314	35,107	32,898	38,497	32,463	37,825	34,567	33,677	35,304	35,463	35,631	38,248
GP referrals	9,802	8,148	9,393	9,630	10,554	9,404	10,653	10,364	10,212	10,998	10,509	10,823	10,691
New outpatient attendances	18,146	15,181	16,392	16,050	18,596	14,805	17,528	16,395	16,448	17,036	17,366	16,867	19,108
Non elective (Incl. Assessment)	5,665	5,258	5,290	4,627	5,258	4,801	5,419	5,242	5,265	5,157	5,221	5,654	5,663
Outpatient attendances	56,072	47,495	51,499	48,948	57,093	47,268	55,353	50,962	50,125	52,340	52,829	52,498	57,356

Guidance

Gloucestershire Hospitals
NHS Foundation Trust

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

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
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- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

Source: NHSI Making Data Count

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Cancer	Cancer - 2 week wait breast symptomatic referrals	≥ 93.0%	Nov-22	96.0%	
	Cancer - 28 day FDS (all routes)	≥ 75.0%	Nov-22	79.9%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	Nov-22	94.5%	
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	Nov-22	100.0%	
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%	Nov-22	87.2%	
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%	Nov-22	83.8%	
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	Nov-22	88.2%	
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	Nov-22	60.3%	
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%	Nov-22	61.0%	
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	Nov-22	88.1%	
	Number of patients waiting over 104 days with a TCI date	= 0	Nov-22	1,538,433	
	Number of patients waiting over 104 days without a TCI date	≤ 24	Nov-22	1,197	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	Nov-22	16.05%	
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	Nov-22	937	
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	Oct-22	56.2%	
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	Nov-22	29.61%	
	% of ambulance handovers < 15 minutes	No Target	Nov-22	18.35%	
	% of ambulance handovers < 30 minutes	No Target	Nov-22	44.10%	
	% of ambulance handovers over 60 minutes	≤ 1.00%	Nov-22	30.90%	
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	Nov-22	36.0%	
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	Nov-22	28.7%	
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%	Nov-22	58.36%	
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	Nov-22	967	
	Number of ambulance handovers 30-60 minutes	↓ Lower	Nov-22	918	
	Number of ambulance handovers over 60 minutes	= 0	Nov-22	958	
Maternity	% of women booked by 12 weeks gestation	> 90.0%	Nov-22	90.3%	
Operational Efficiency	% day cases of all electives	> 80.00%	Nov-22	85.21%	
	Average length of stay (spell)	≤ 5.06	Nov-22	7.02	
	Cancelled operations re-admitted within 28 days	No Target	Nov-22	75.47%	
	Intra-session theatre utilisation rate	> 85.00%	Nov-22	88.69%	
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	Nov-22	2.66	
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	Nov-22	8.30	
	Number of patients stable for discharge	≤ 70	Nov-22	235	
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	Nov-22	513	
	Urgent cancelled operations	↓ Lower	Nov-22	0	
Outpatient	Did not attend (DNA) rates	≤ 7.60%	Nov-22	6.20%	
	Outpatient new to follow up ratio's	≤ 1.90	Nov-22	1.86	
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	Oct-22	7.17%	
Research	Research accruals	No Target	Aug-22	234	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	Nov-22	122	

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Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No Target	Nov-22	6,819	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target	Nov-22	2,650	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0	Nov-22	1,267	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%	Nov-22	31.81%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target	Nov-22	68.80%	
	% patients receiving a swallow screen within 4 hours of arrival	No Target	Nov-22	68.20%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target	Nov-22	72.7%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%	Nov-22	96.1%	
SUS	Percentage of records submitted nationally with valid GP code	≥ 99.0%	Mar-21	100.0%	
	Percentage of records submitted nationally with valid NHS number	≥ 99.0%	Mar-21	99.0%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%	Nov-22	29.17%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%	Nov-22	91.7%	

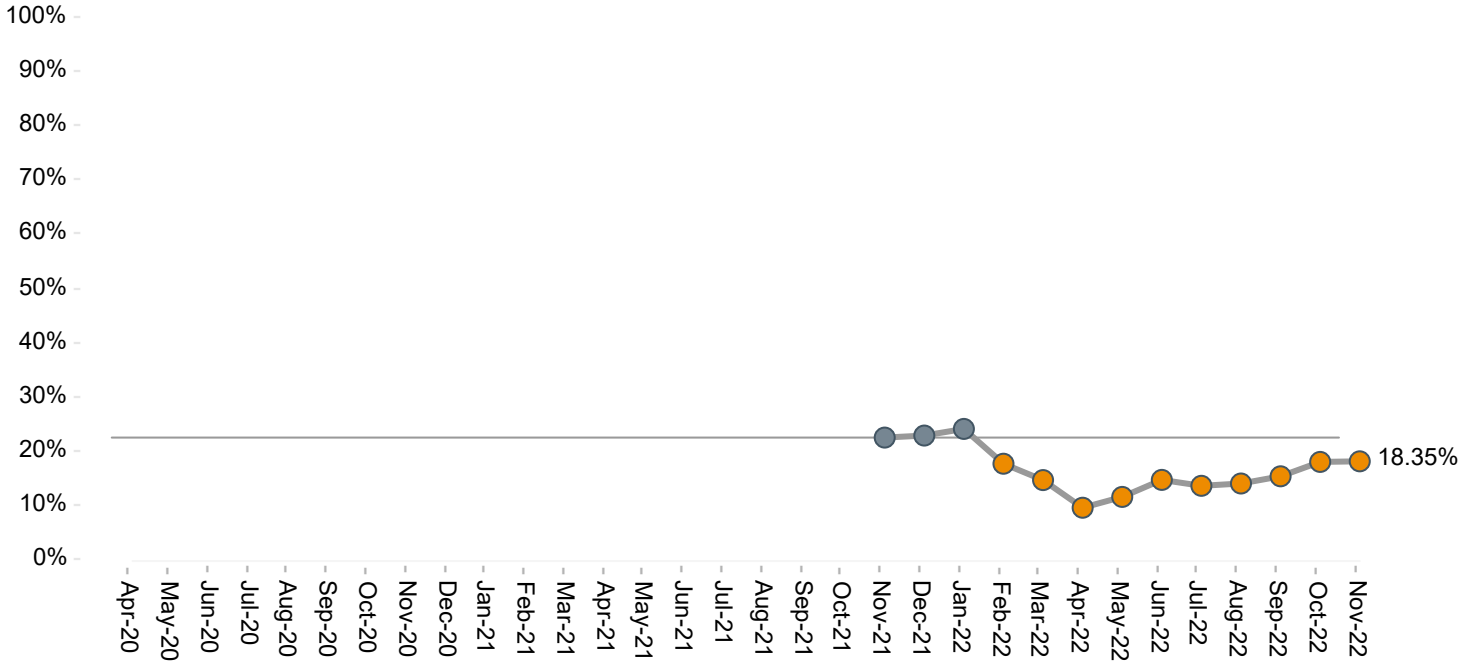
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[594] % of ambulance handovers < 15 minutes

- - - Target: No Target



Data Observations

[2] SHIFT

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

Commentary

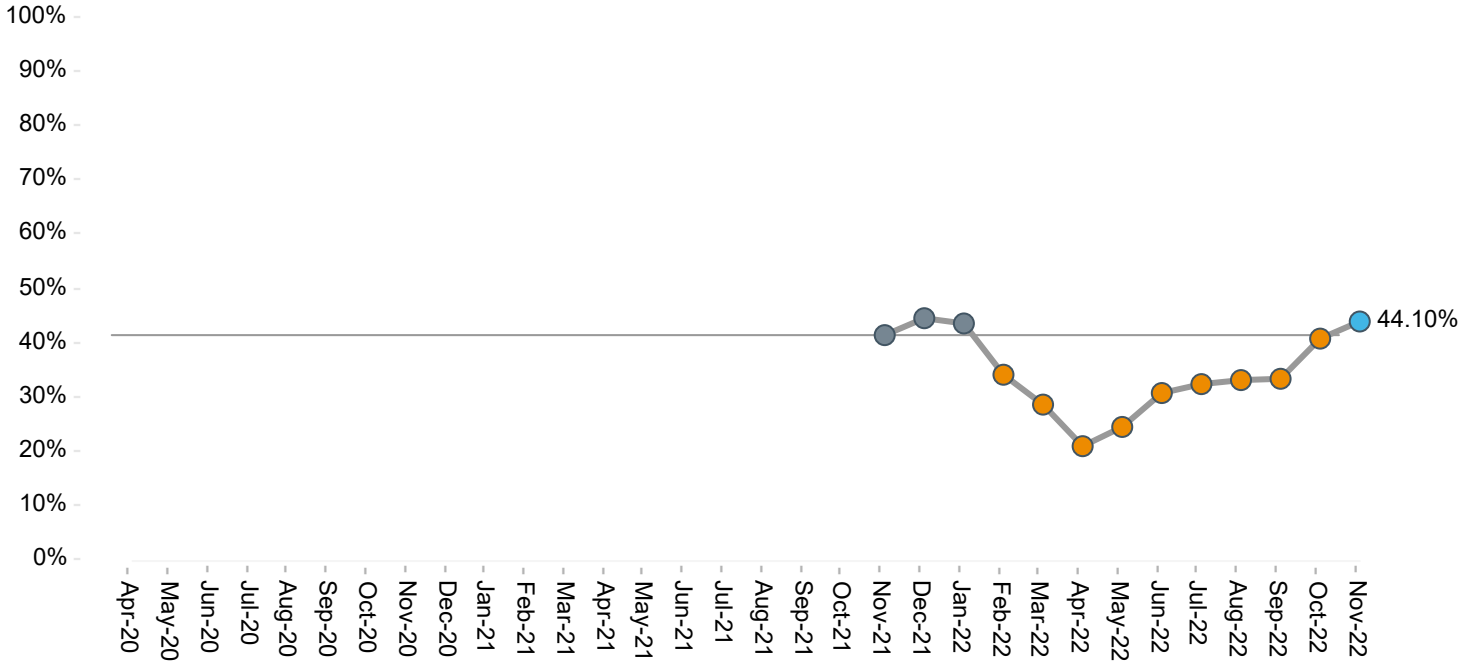
This has remained constant in terms of proportion between October and November at just below 20% of total.

Access

SPC - Special Cause Variation

[595] % of ambulance handovers < 30 minutes

- - - Target: No Target



Data Observations

[2] SHIFT

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[3] RUN

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

Commentary

Performance improved in November, increasing to nearly 45% - from 42.1% in October.

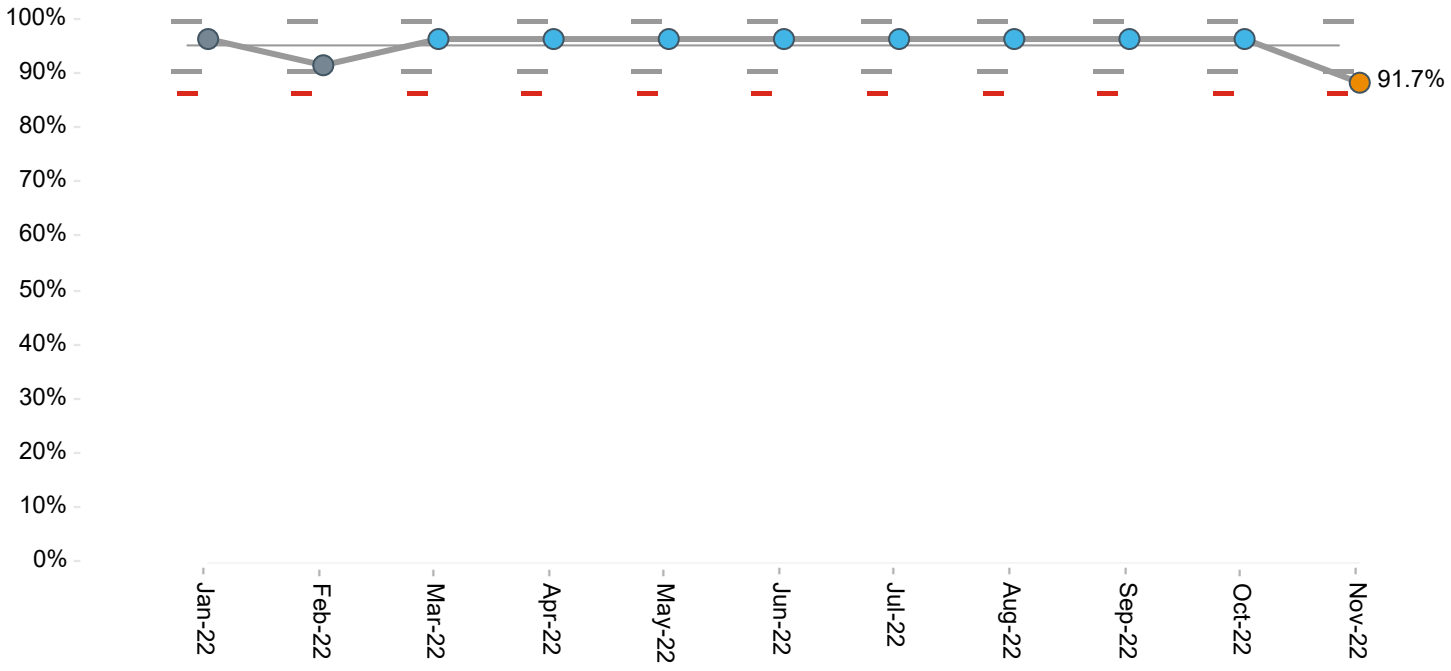
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[139] % of fracture neck of femur patients treated within 36 hours

Target: ≥ 90.0%



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

General Manager – Trauma & Orthopaedics

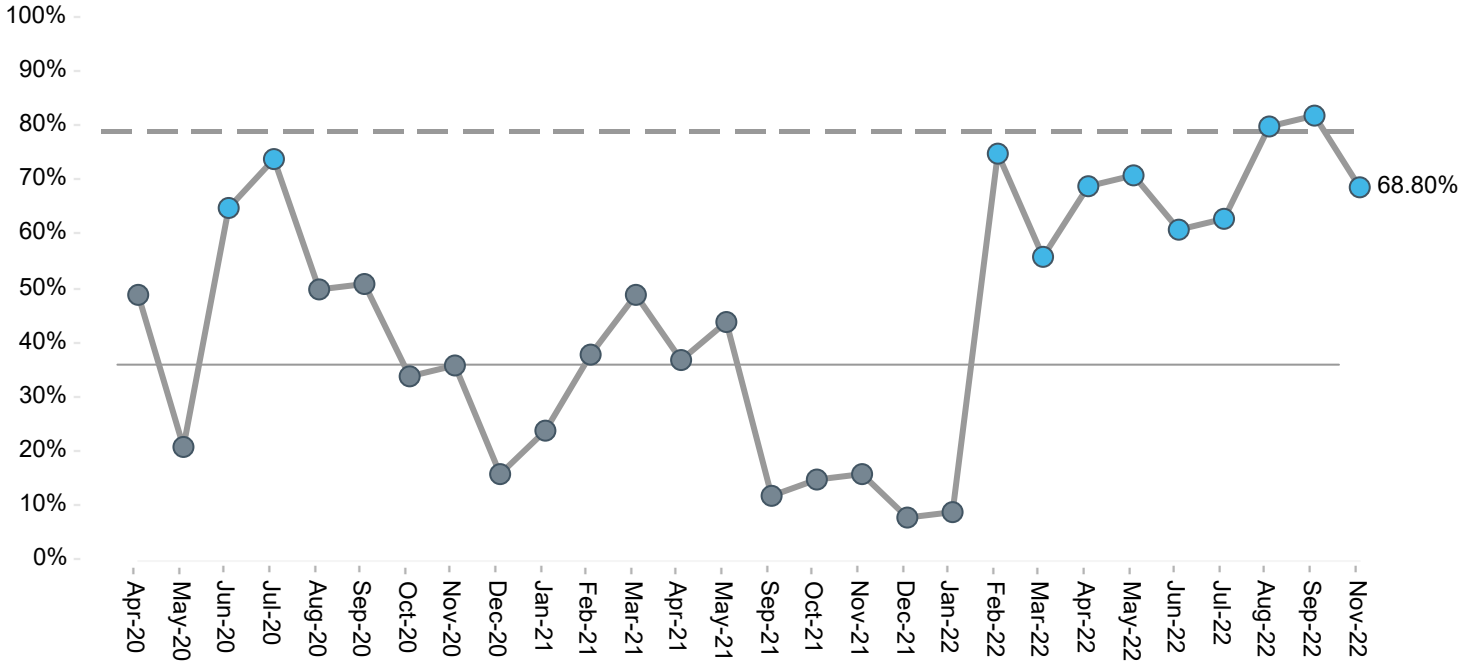
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

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[4] 2 OF 3

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

Commentary

There has been a sustained improvement in this metric since the Direct to CT stroke pathway has been implemented. Strokes that present to GRH ED drive this percentage down and work is ongoing with ED to improve this.

General Manager - COTE, Neuro and Stroke

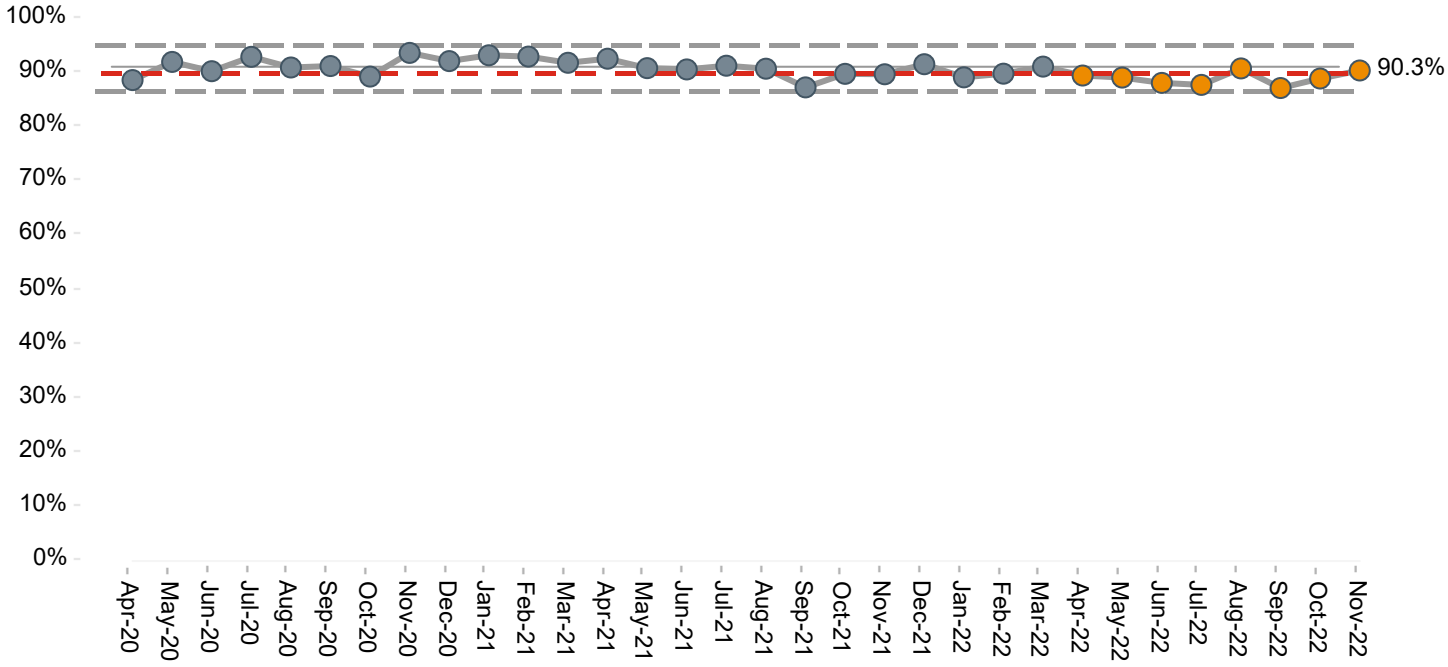
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[138] % of women booked by 12 weeks gestation

Target: > 90.0%



Data Observations

[2] SHIFT

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Commentary

The service have met target for November at 90.3%. However, it still remains that staff shortages are potentially having an impact. It is also possible that there is an element of late data entry impacting on this metric. The service are going to look into specific areas to identify if any one area has a worse rate than another, enabling them to target support where it is needed.

Divisional Director of Quality and Nursing and Chief Midwife

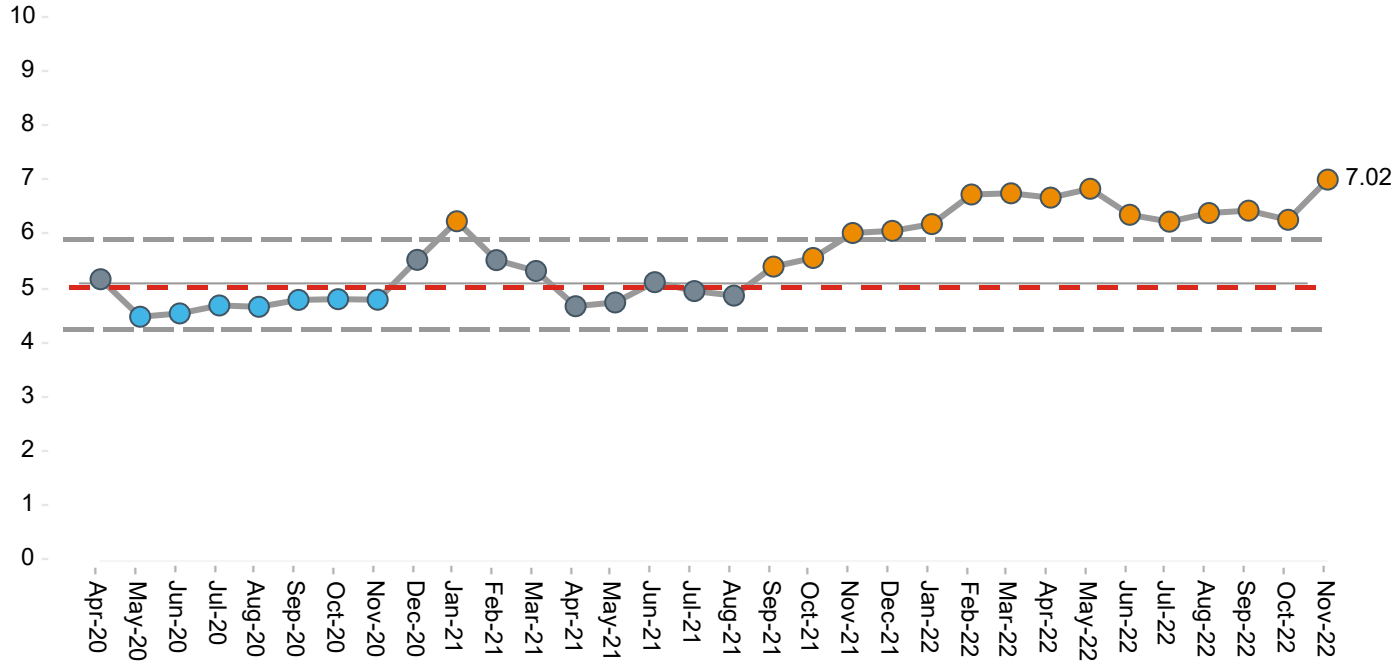
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[188] Average length of stay (spell)

- - - Target: ≤ 5.06



Commentary

Deputy Chief Operating Officer

Data Observations

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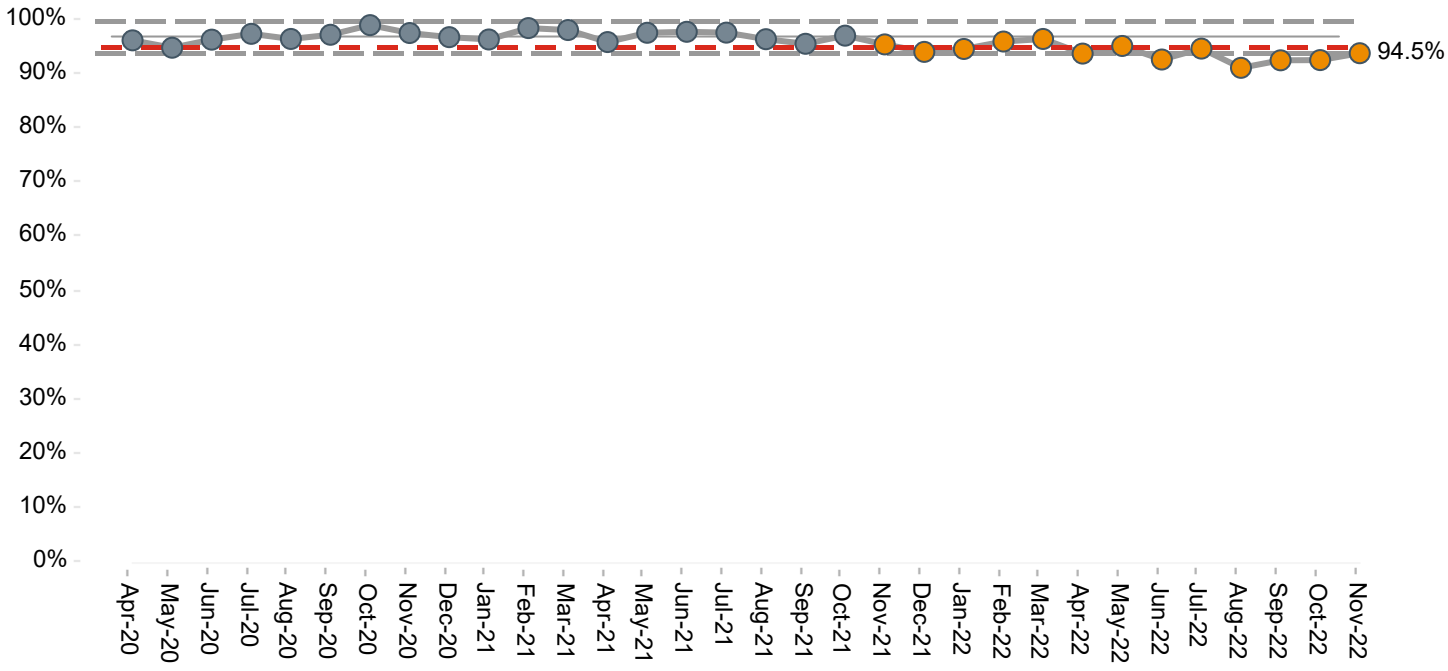
Access

SPC - Special Cause Variation

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

- - - Target: ≥ 96.0%



Data Observations

[1] SINGLE POINT

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Commentary

Standard = 96% | GHFT = 93.4% [Treated= 317, Breaches=21, Uro=8, Breast = 4, Lung = 4] : 11 breaches due to capacity, 5 breaches related to radiotherapy staffing issues/Linac(s) switch off due to roof leak. 1 breach related to consultant sickness (covid).

General Manager - Cancer

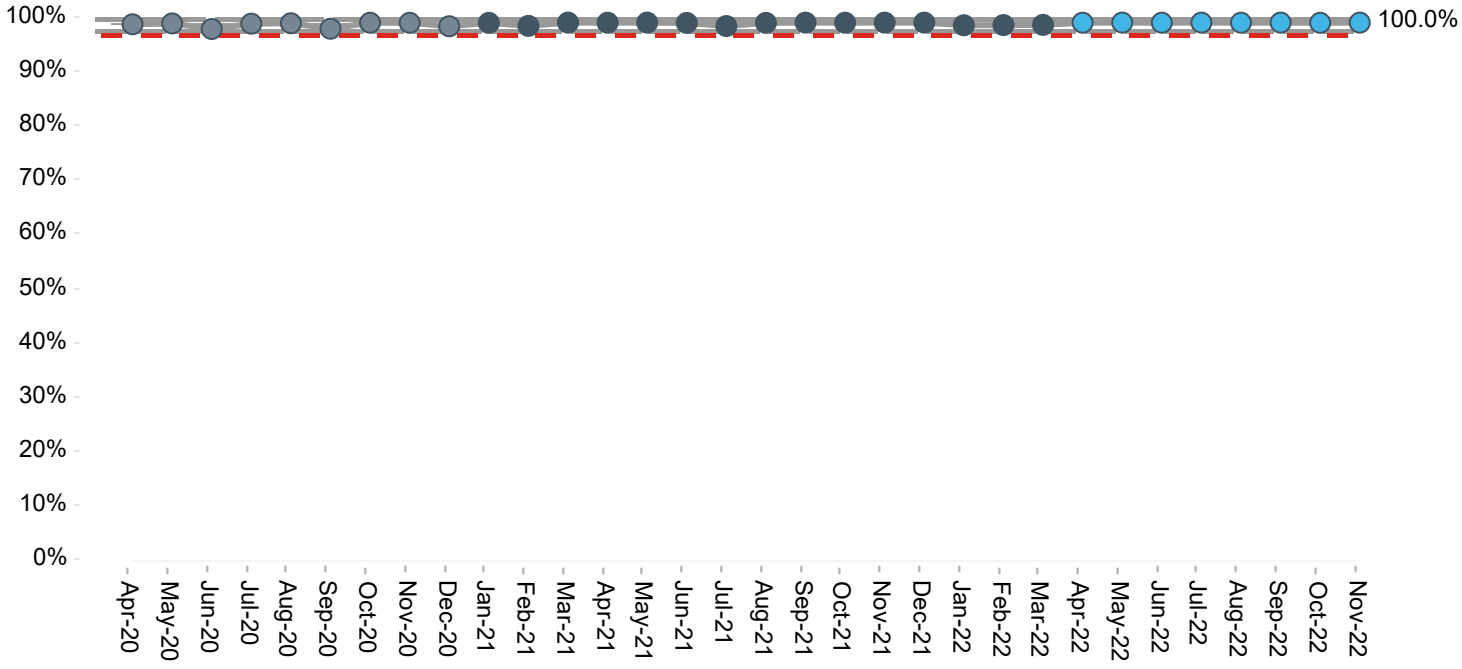
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 98.0%



Data Observations

[2] SHIFT

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[5] UNDER-STRATIFICATION

When 15 or more sequential points fall within +/- 1sigma from the mean this is an indication of under-stratification. The control chart may be looking at too broad a time range and may need to be broken up into smaller time period segments.

Commentary

31 day subs chemotherapy performance (unvalidated)
Standard = 98%
GHFT = 100%
General Manager - Cancer

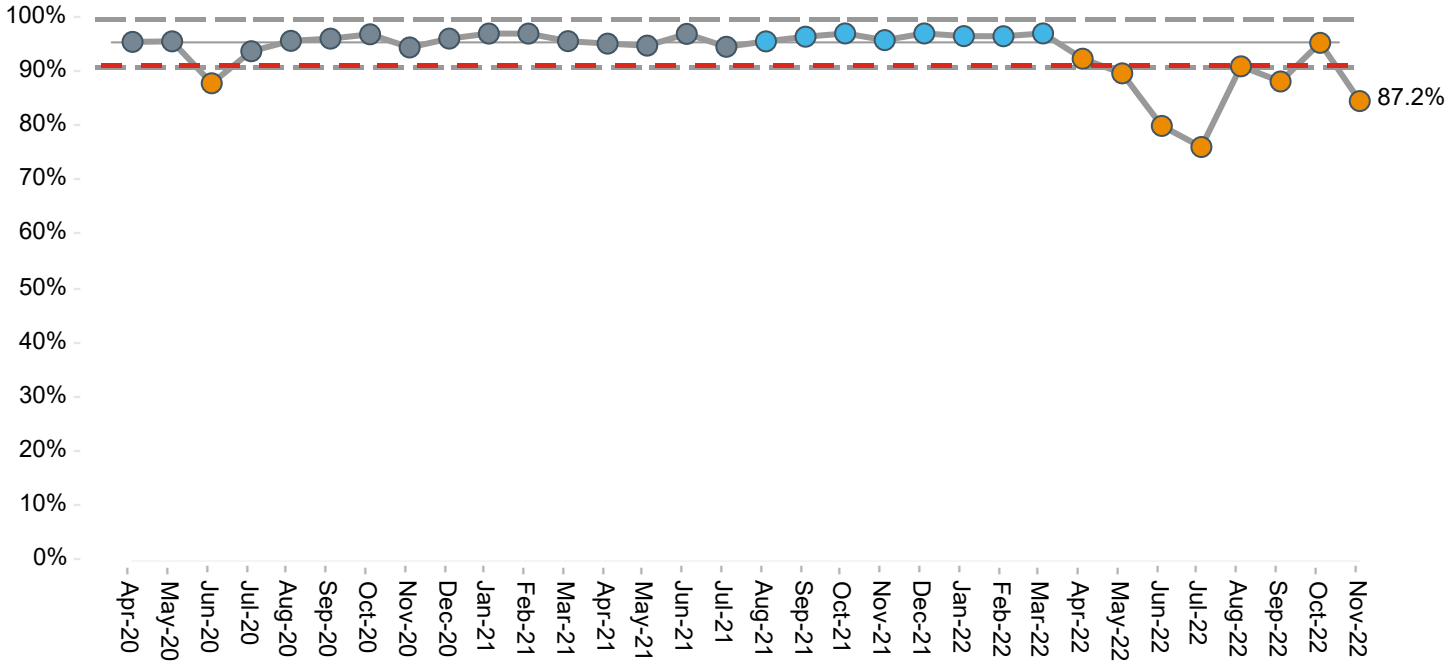
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[174] Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)

- - - Target: ≥ 94.0%



Data Observations

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Commentary

Performance impacted by known radiographer staffing issues (Trust risk). Some of the locums recruited to vacancies have now left which has meant staffing issues have returned (less acute than in spring 22). Radiotherapy department also has a roof leak that has required 1 or 2 linacs to be switched off during periods of rain. This has impacted on timely treatment.

General Manager - Cancer

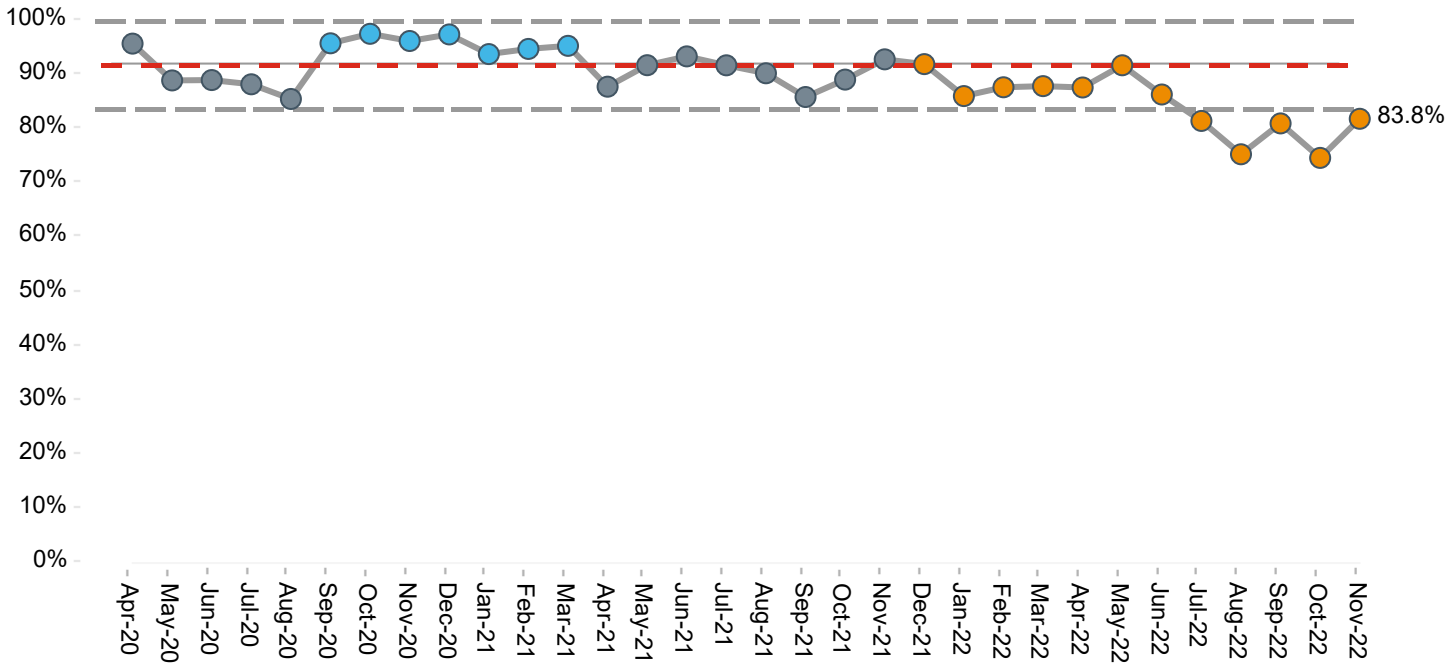
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 94.0%



Commentary

31 day subs surgery performance (unvalidated)
Standard = 94%
GHFT = 85.3%
Treated = 75 Breaches = 11 Uro 8, Breast = 3

All
breaches related to theatre capacity
General Manager - Cancer

Data Observations

[1] SINGLE POINT

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[2] SHIFT

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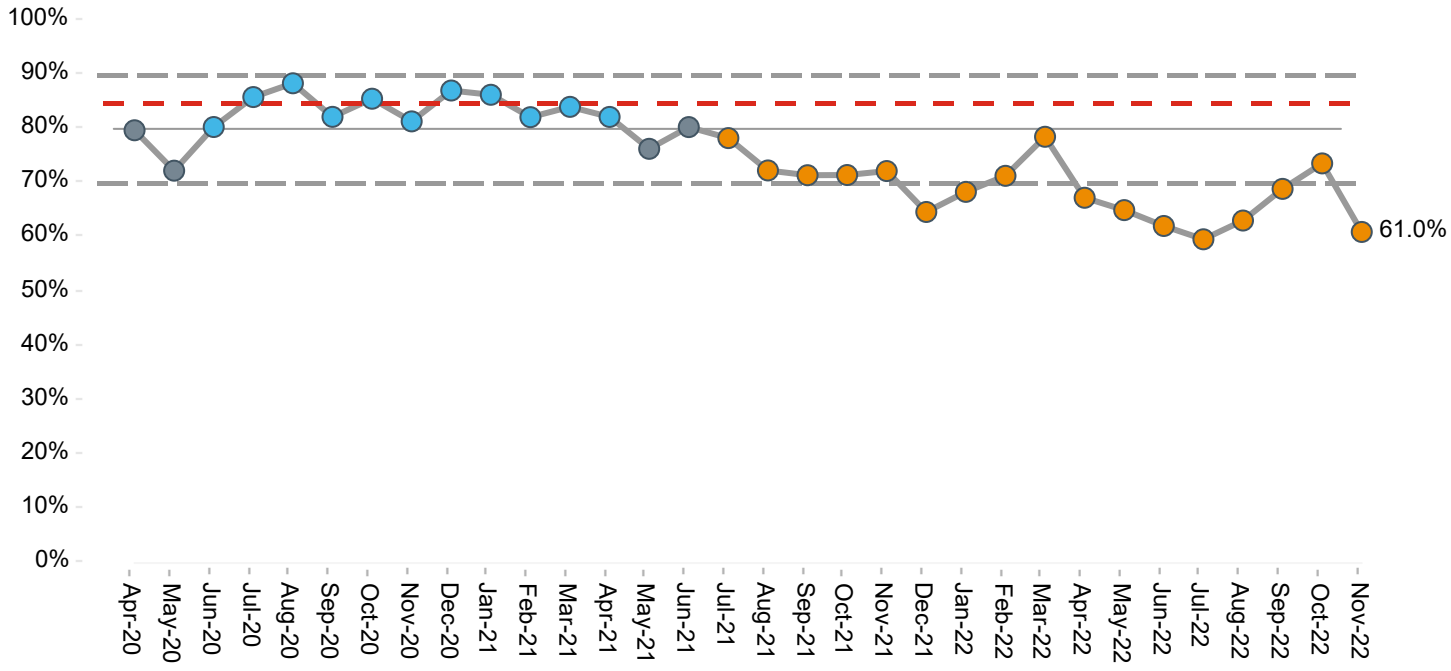
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 85.0%



Data Observations

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Commentary

Treatments = 189, Breaches 80.5 | Urology = 36.5 LGI=16 | Breast = 7 | Skin = 5 . Breach reasons [Elective capacity inadequate: 25 | Complex diagnostic pathway: 23.5 | Health Care Provider initiated delay: 8 | Un-validated: 7 | Outpatient capacity inadequate : 5]
PATIENT initiated (choice) : 4 | Treatment delayed for medical reasons: 2 | Patient choice 1st O/P Appoint: 2
Administrative delay:
2 | Other reason (not listed): 1 | Patient Did Not Attend (no advance notice): 1
Grand Total 80.5

General Manager - Cancer

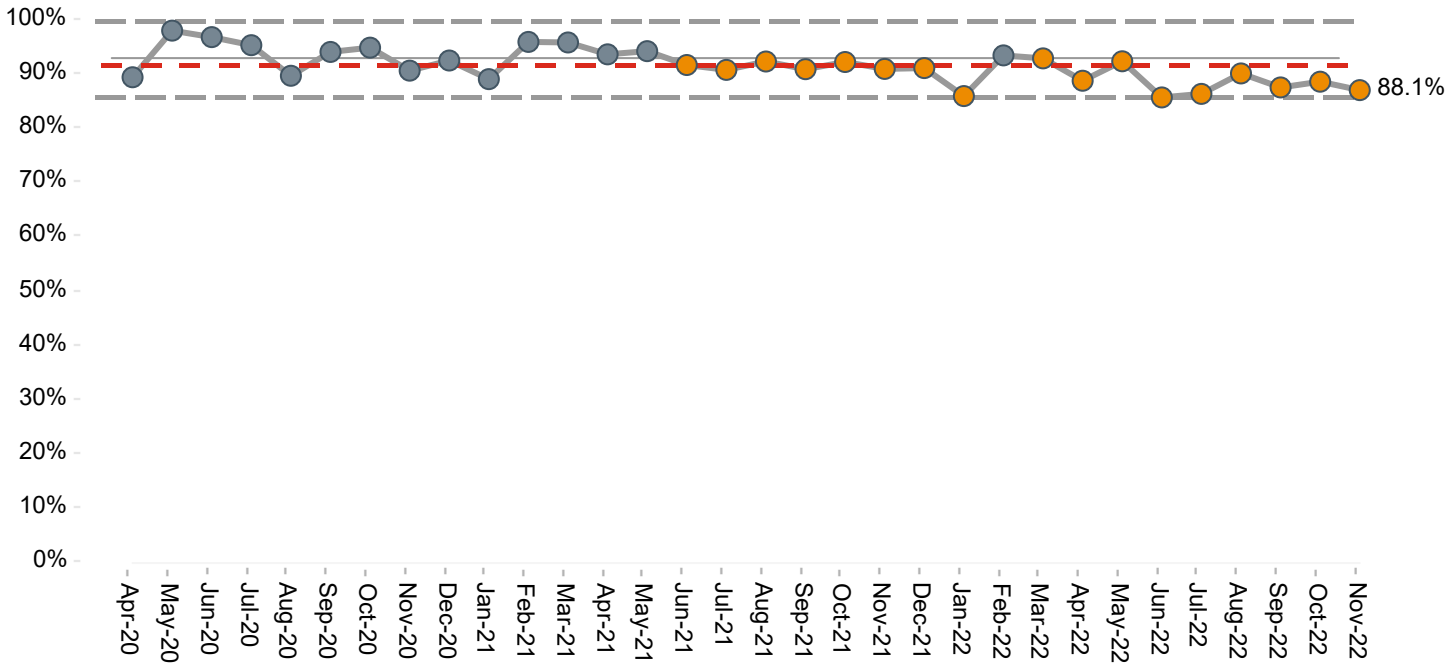
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 93.0%



Data Observations

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[4] 2 OF 3

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Commentary

2ww Performance (unvalidated)
Standard = 93%
GHFT = 89.7%
DFS = 2688 Breaches 312, Lower GI=184, Skin = 38, Urology = 27

9 out
of 12 specialties met target this month. Capacity issues remain in Lower GI surgery and endoscopy. Plans in place to increase capacity and engaging ICB in respect to qFIT being a mandatory requirement on 2ww form

General Manager - Cancer

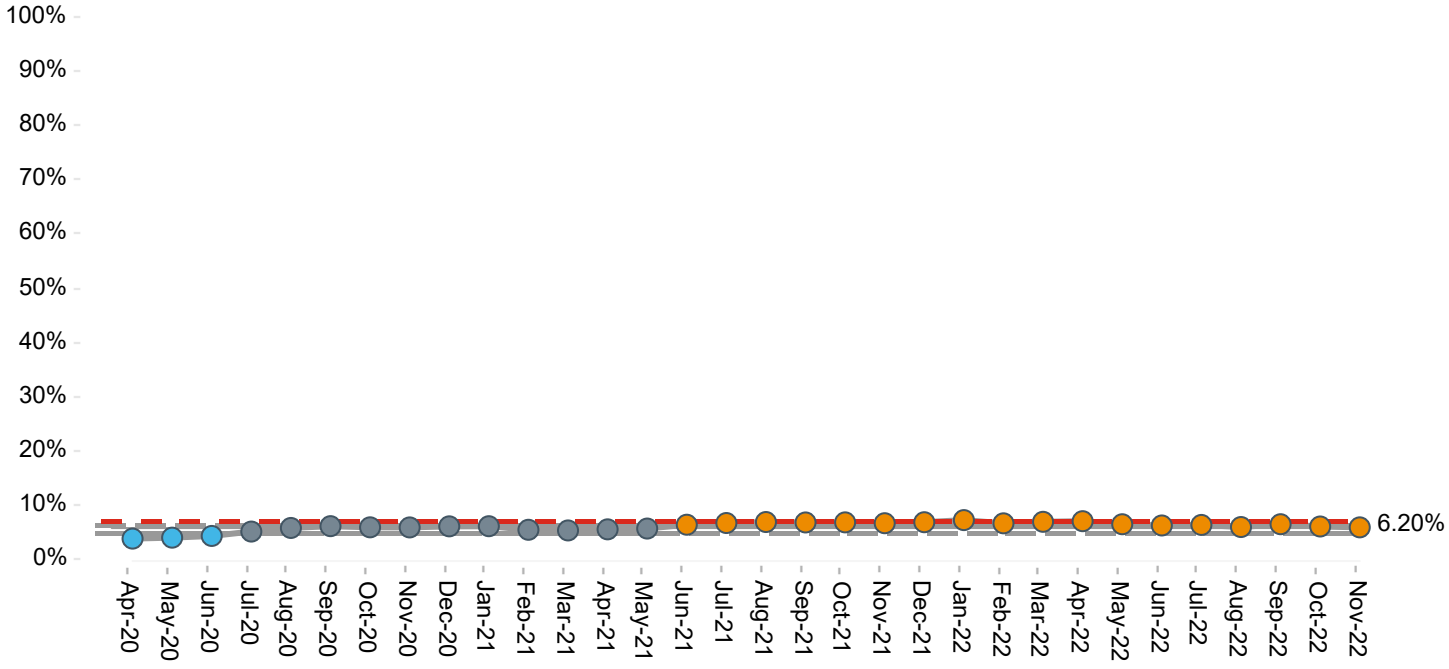
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[491] Did not attend (DNA) rates

Target: ≤ 7.60%



Commentary

Associate Director of Elective Care

Data Observations

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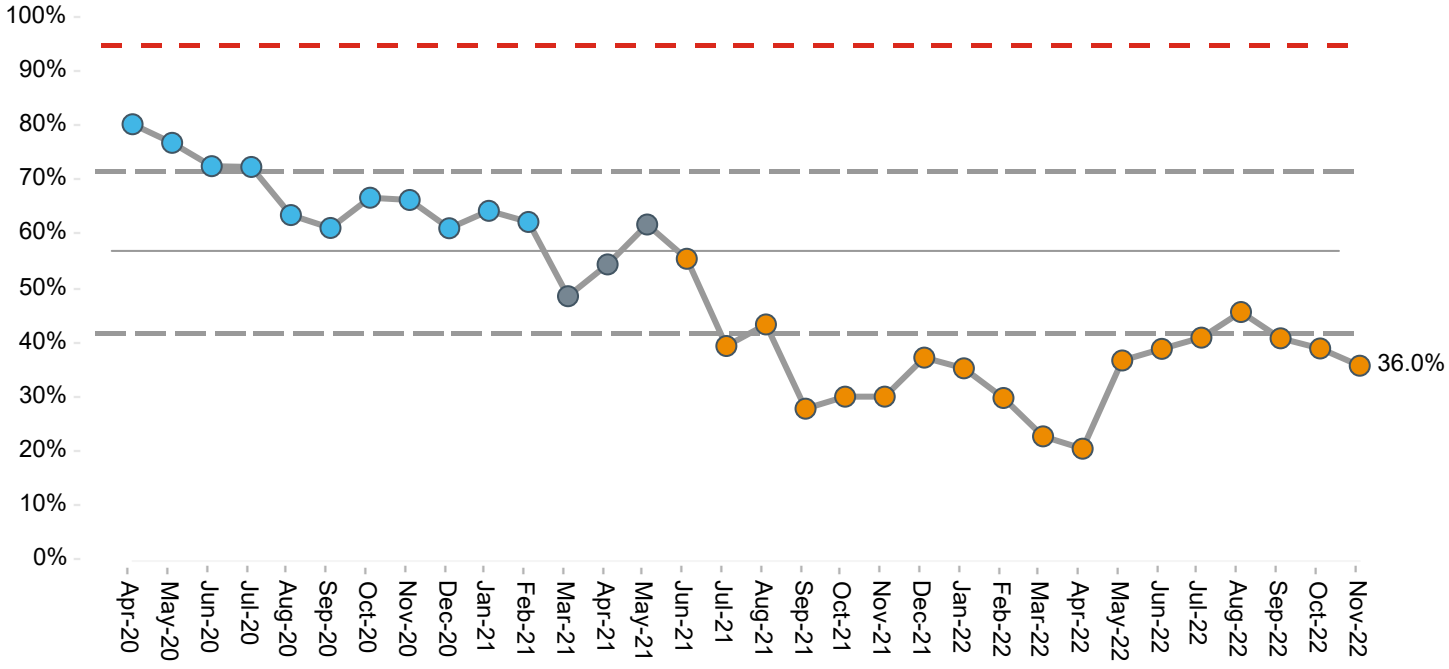
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[195] ED: % of time to initial assessment - under 15 minutes

Target: ≥ 95.0%



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Commentary

Performance has deteriorated (slightly) for the third successive month - the proportion now sits well below 40%.
General Manager of Unscheduled Care

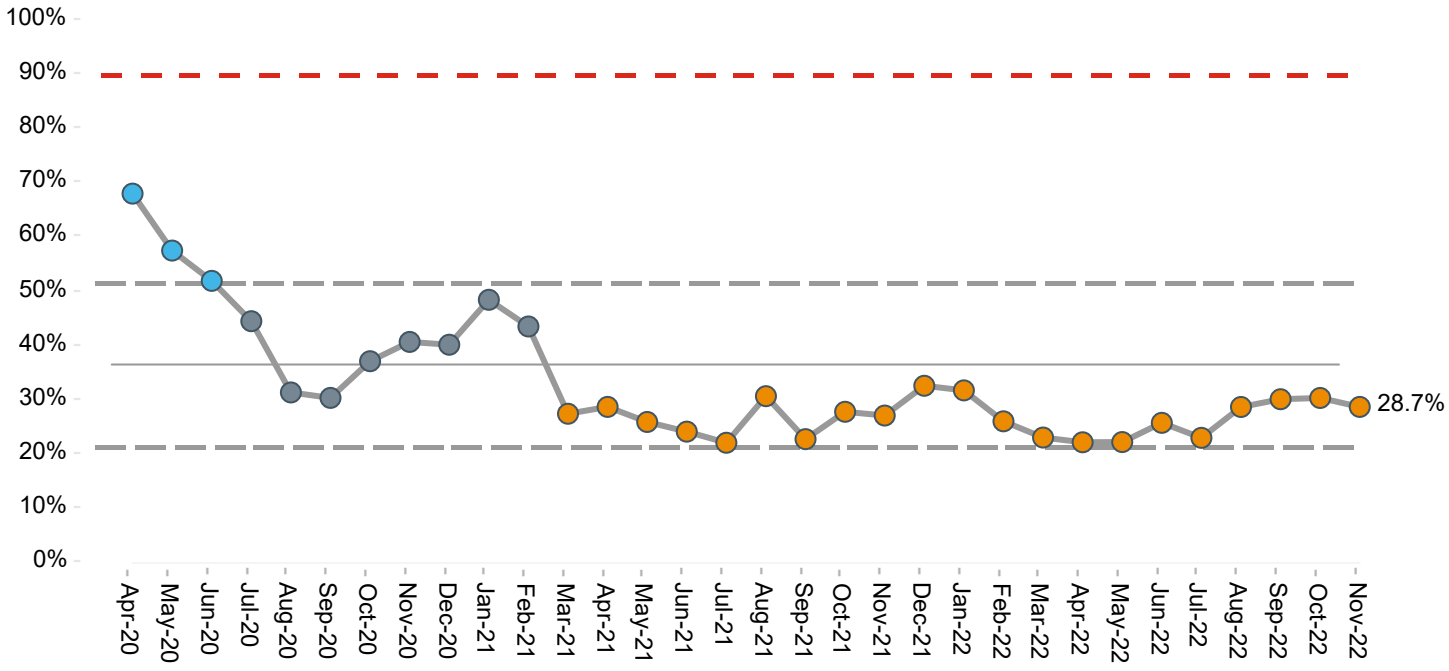
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 90.0%



Commentary

Performance for the month of November remains consistent at around a third of total patients.

Data Observations

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[4] 2 OF 3

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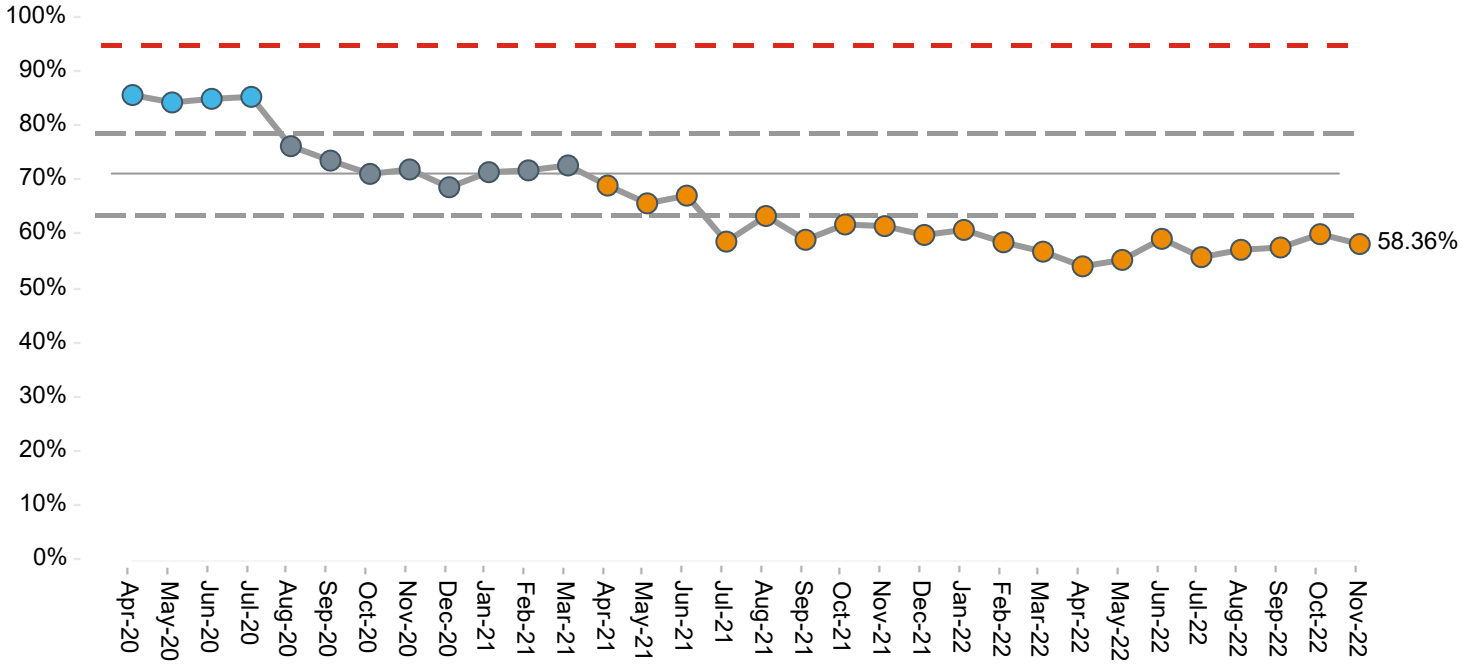
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[191] ED: % total time in department - under 4 hours (type 1)

Target: ≥ 95.00%



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Commentary

Flow coordinator posts have been recruited and are expected to start in the department from the beginning of January 2023. This, allied to other initiatives such as the implementation of an extended (29 bay) discharge lounge, are expected to improve performance against this metric in the new year.

General Manager of Unscheduled Care

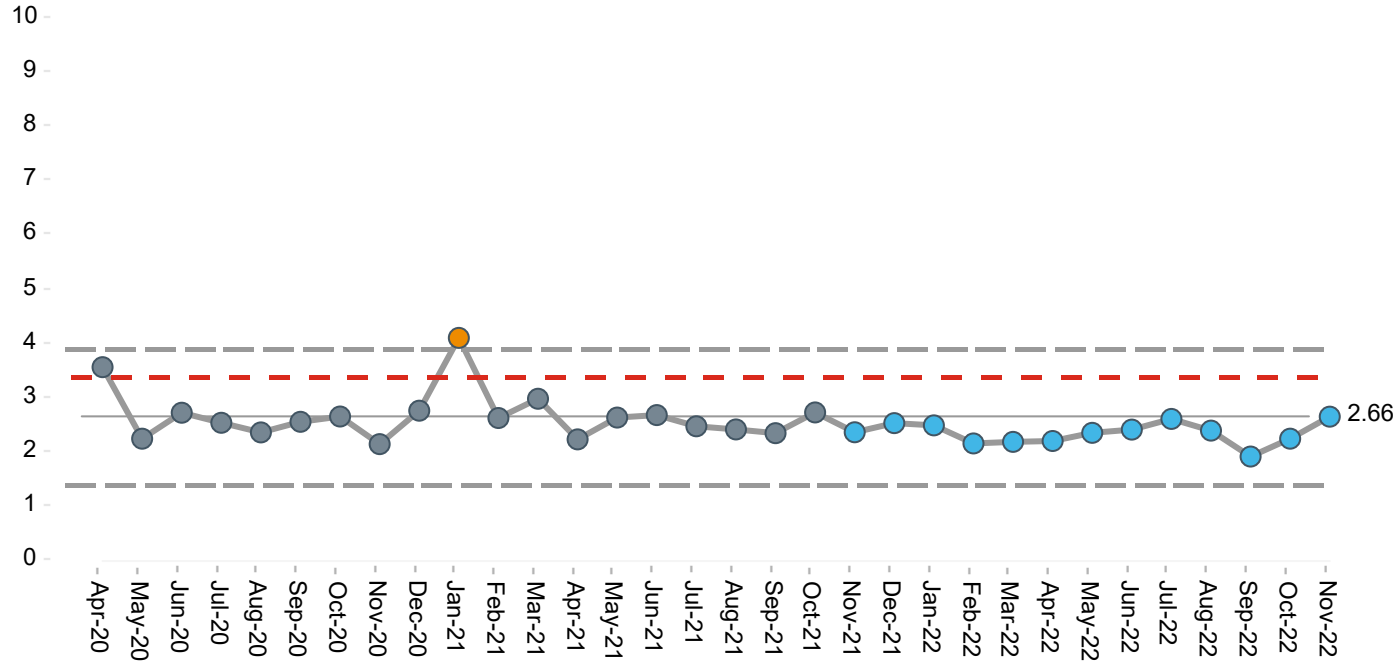
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 3.40



Data Observations

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Commentary

Deputy Chief Operating Officer

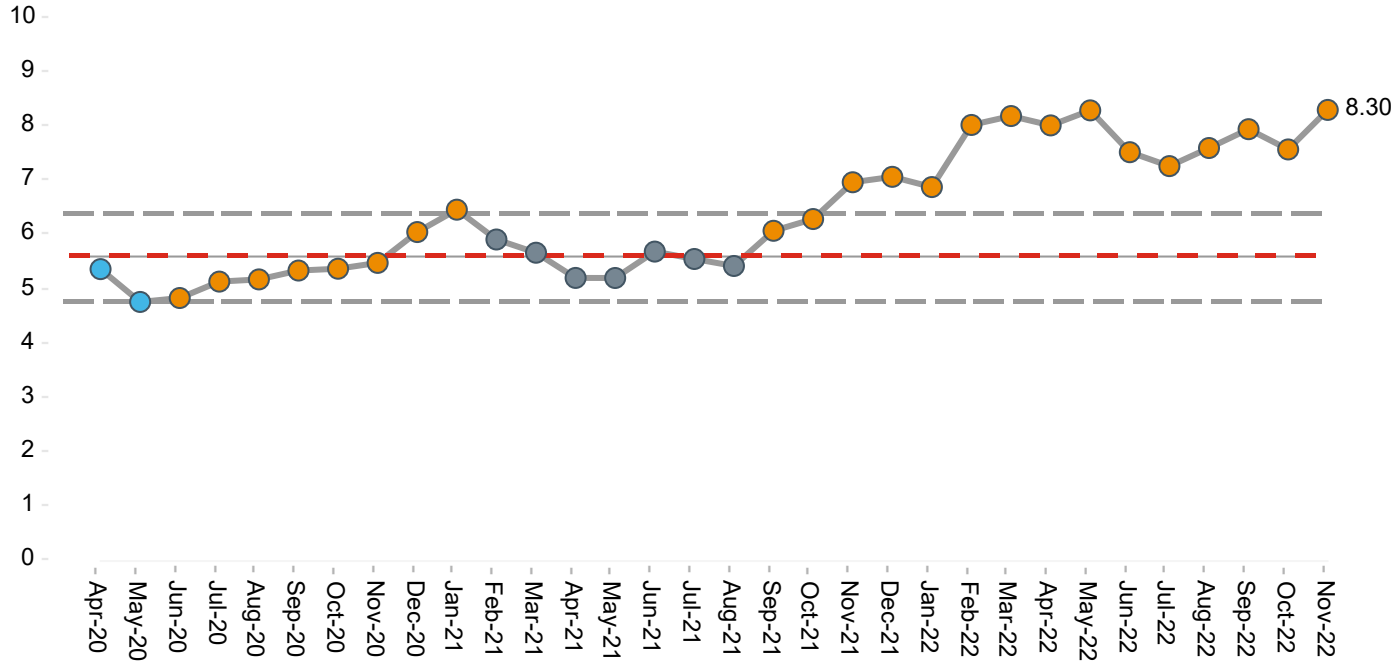
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 5.65



Commentary

This Metric is linked directly to the increased number of patients waiting over 21day without (nCTR) No Criteria to reside Status. This metric and trend is unlikely to change significantly in the next Quarter.

Deputy Chief Operating Officer

Data Observations

[1] SINGLE POINT

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[3] RUN

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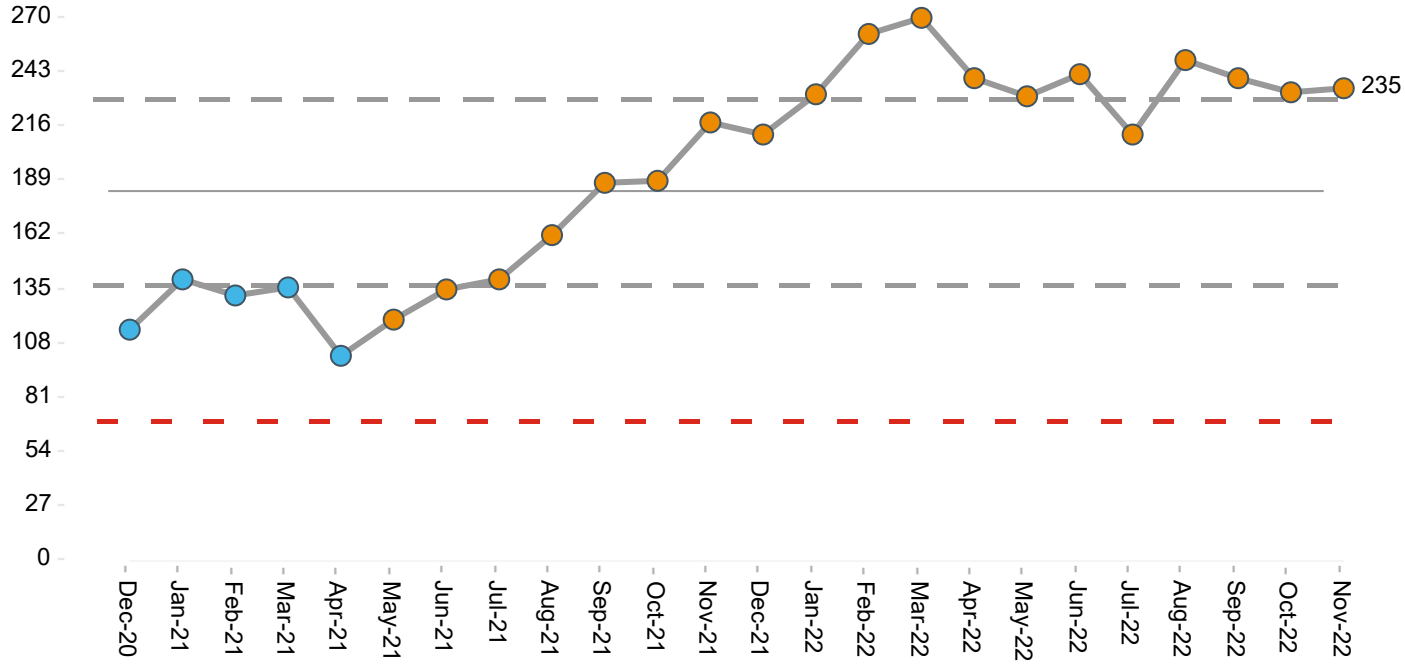
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[186] Number of patients stable for discharge

Target: ≤ 70



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[3] RUN

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Commentary

Our nCTR numbers have shown a notable increase. Multiple conversations with system partners as to actions required to reduce this number.
Head of Therapy & OCT

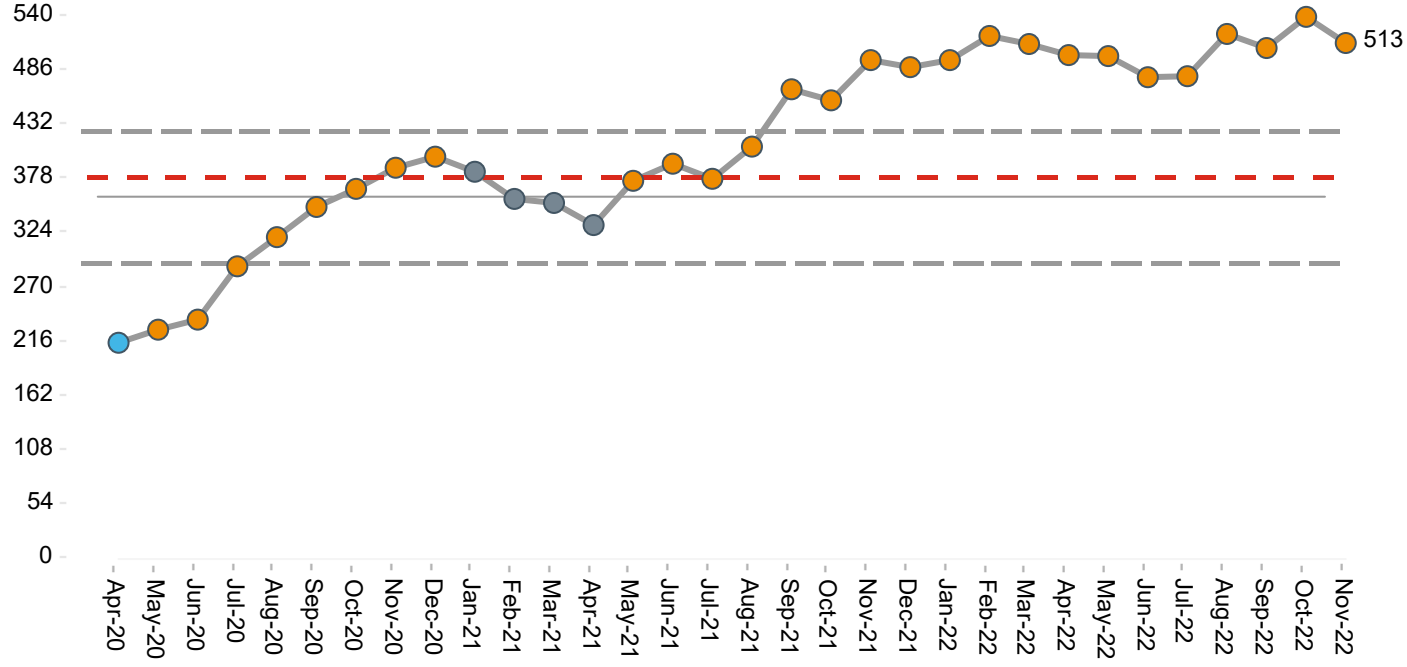
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 380



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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[3] RUN

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Commentary

The patients with nCTR remains above the intended trajectory. There has been a slow but determined increase of the 21+ day figures and the long waiters of over 75+ days. This represents a significant clinical risk and in contributing negative to other metrics such as ED Performance. 'Sloman' plan is monitored monthly across the ICB and Region.

Deputy Chief Operating Officer

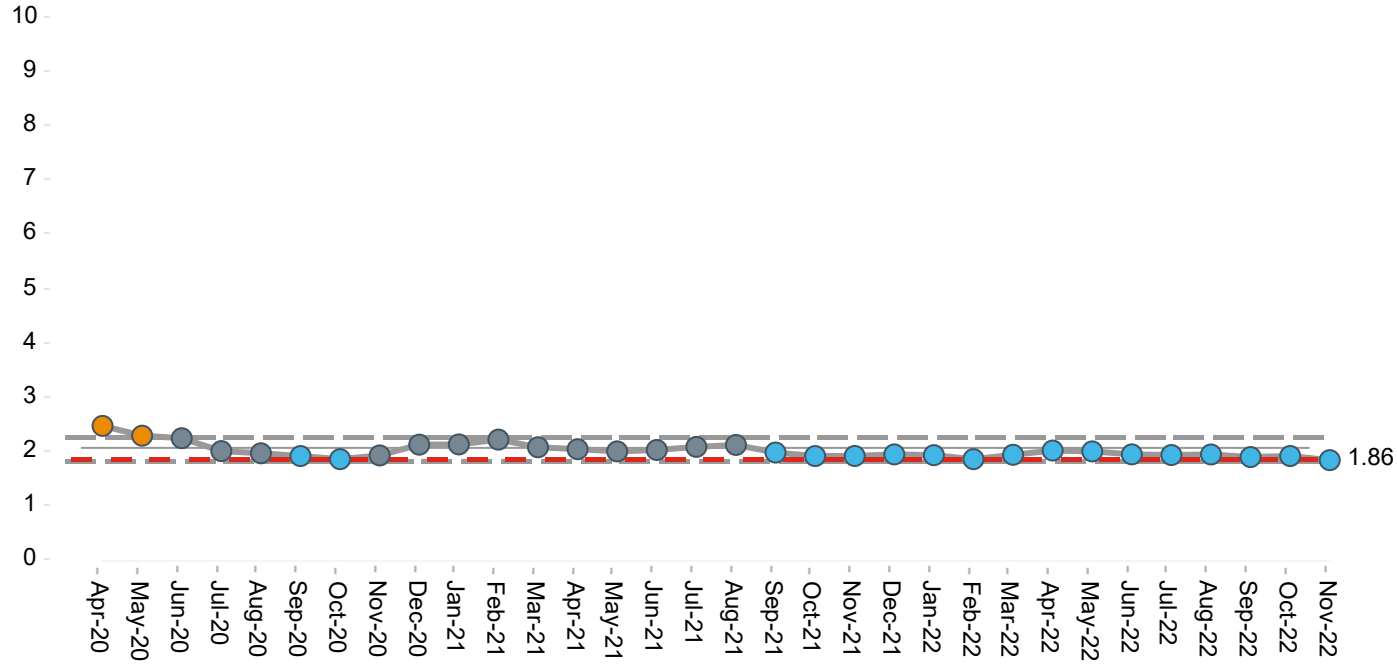
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[490] Outpatient new to follow up ratio's

Target: ≤ 1.90



Commentary

Associate Director of Elective Care

Data Observations

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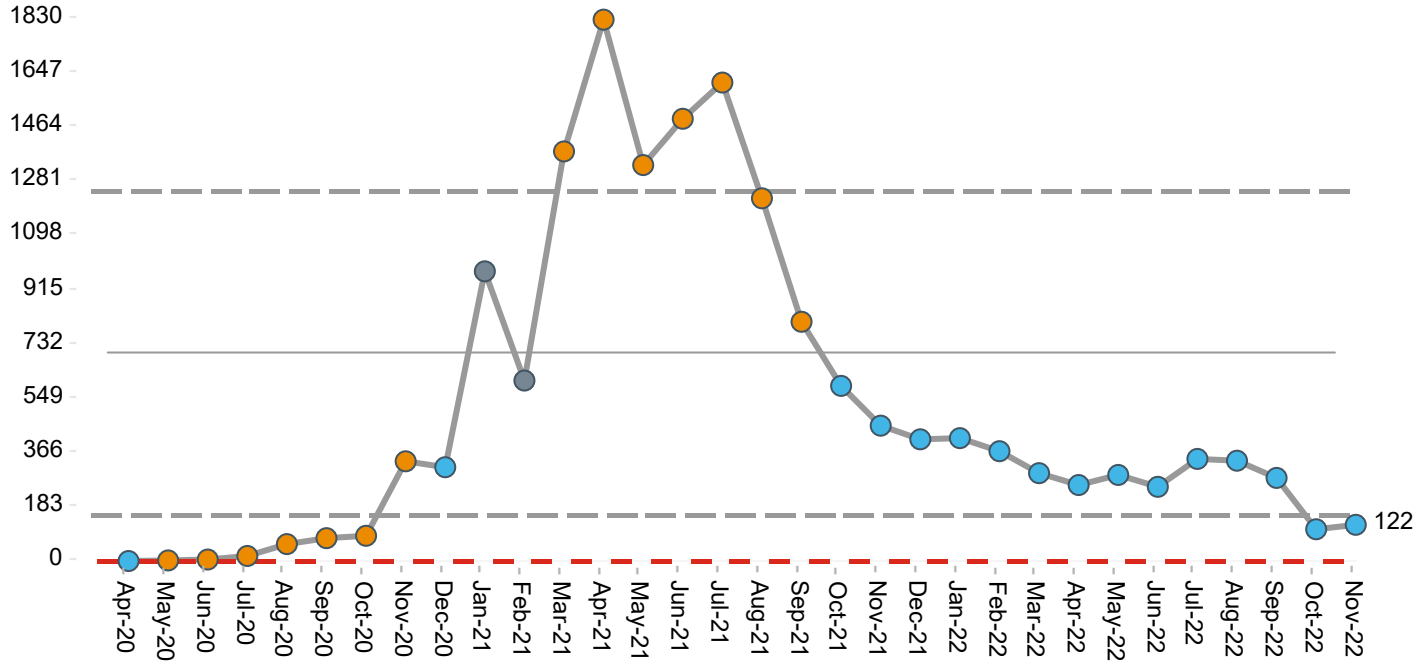
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ↓ Lower



Commentary

Marginal reductions in this cohort of patients are being made. Although reported as 122, this is expected to be around 105 in the validated position.

Associate Director of Elective Care

Data Observations

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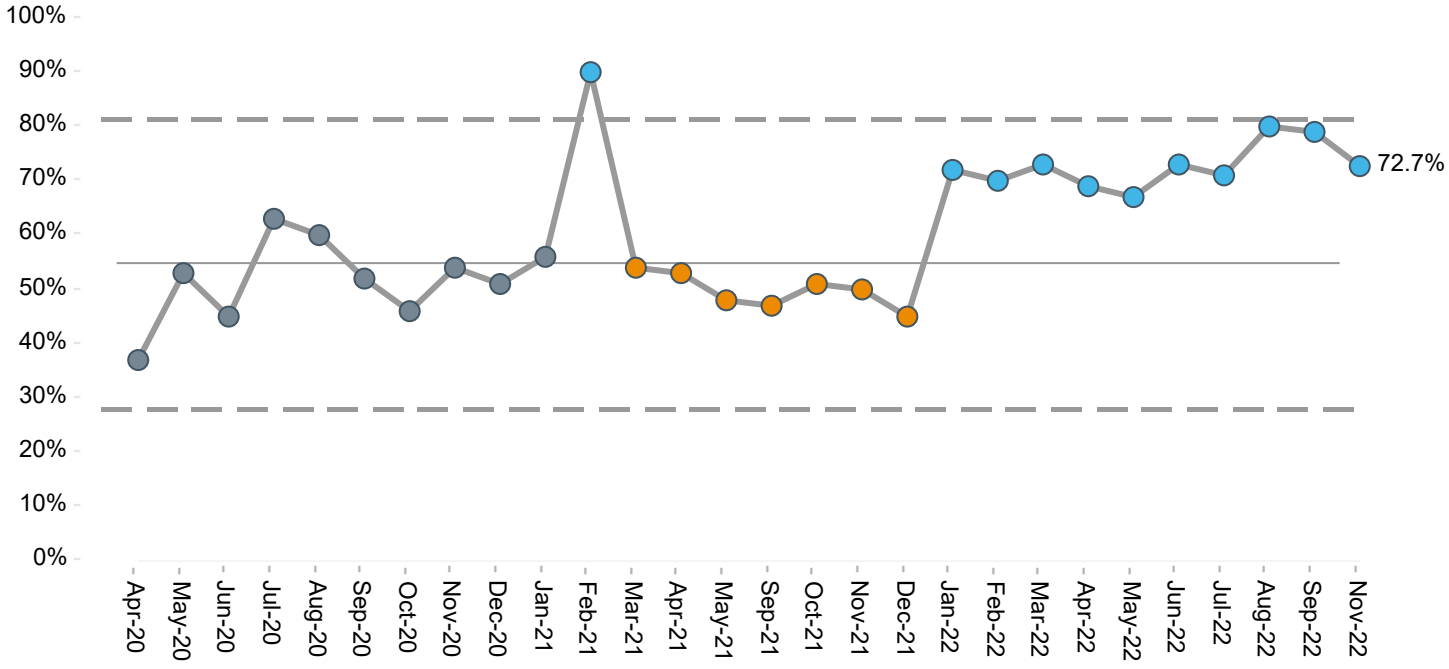
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[142] Stroke care: percentage of patients receiving brain imaging within 1 hour

- - - Target: No Target



Commentary

There has been a sustained improvement in this metric since the start of the direct to CT stroke pathway has been formed.
General Manager - COTE, Neuro and Stroke

Data Observations

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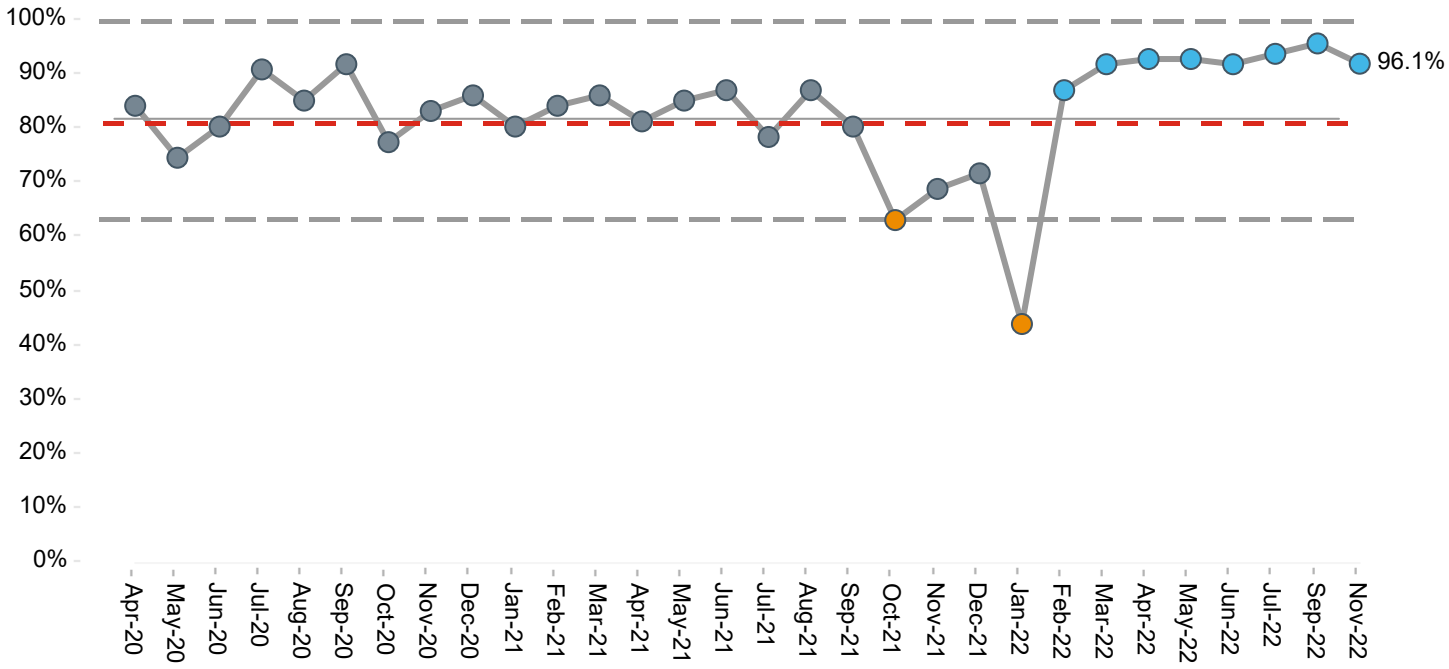
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[143] Stroke care: percentage of patients spending 90%+ time on stroke unit

Target: ≥ 85.0%



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Commentary

The stroke direct admit pathway has seen sustained improvements in this metric since the pathway was implemented.
General Manager - COTE, Neuro and Stroke

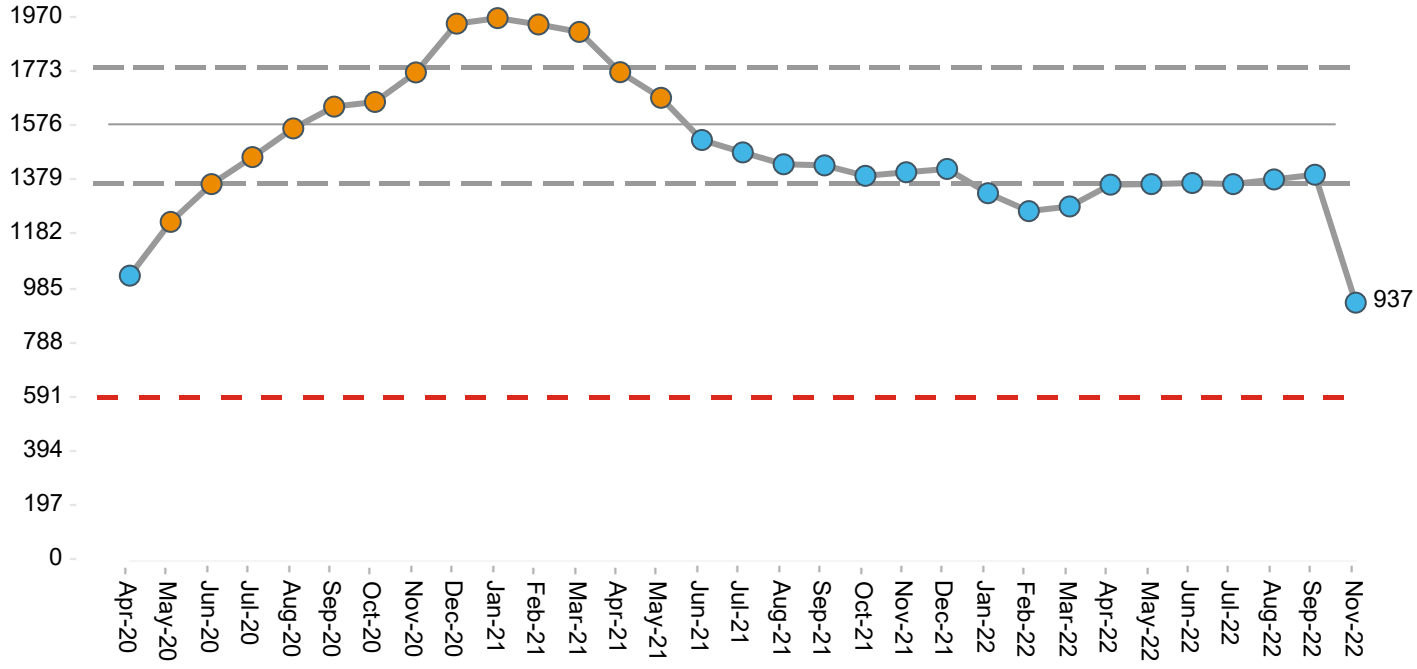
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 600



Commentary

General Manager of Endoscopy

Data Observations

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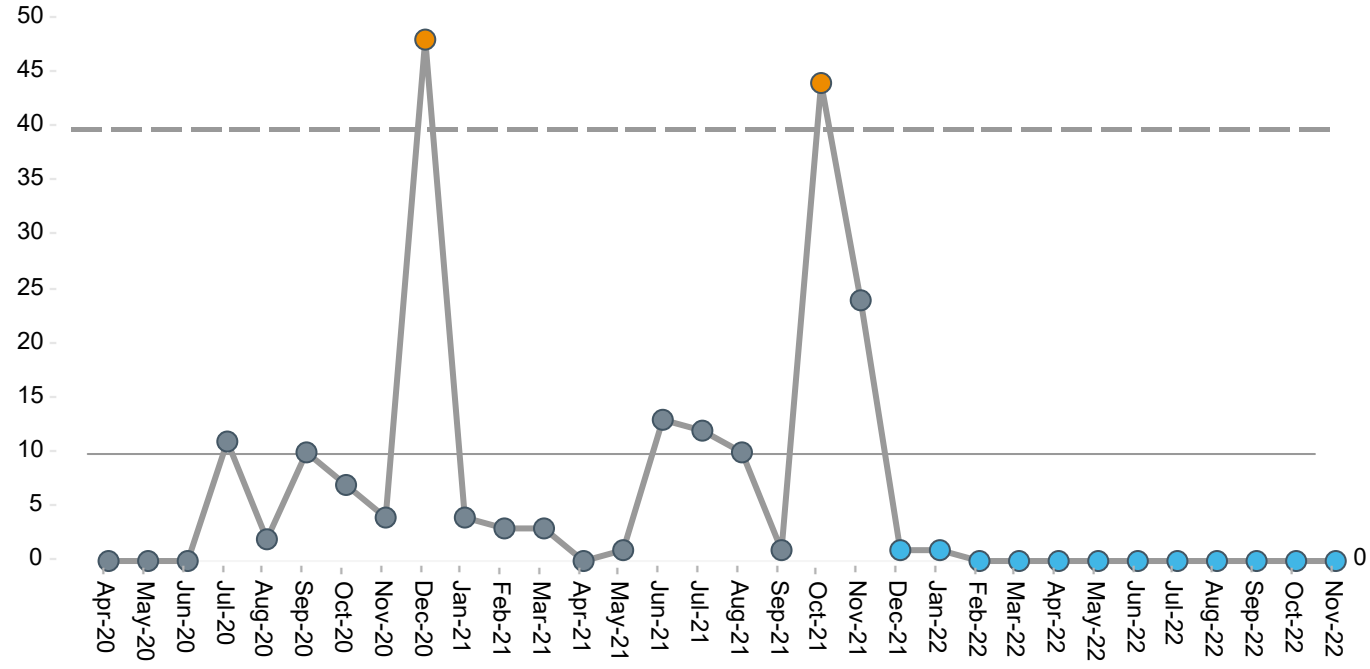
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[552] Urgent cancelled operations

- - - Target: ↓ Lower



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Commentary

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Not given

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Friends & Family Test	ED % positive	No Target	Nov-22	70.7%	
	Inpatients % positive	No Target	Nov-22	88.5%	
	Maternity % positive	No Target	Nov-22	89.6%	
	Outpatients % positive	No Target	Nov-22	93.3%	
	Total % positive	No Target	Nov-22	88.6%	
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Nov-22	162	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Nov-22	237	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Nov-22	150	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Nov-22	94	
	Clostridium difficile - infection rate per 100,000 bed days	↓ Lower	Nov-22	28.1	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Nov-22	3.1	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Nov-22	3.1	
	Number of MSSA bacteraemia cases	≤ 8	Nov-22	1	
	Number of bed days lost due to infection control outbreaks	↓ Lower	Nov-22	13	
	Number of community-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	Nov-22	1	
	Number of ecoli cases	No Target	Nov-22	8	
	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	Nov-22	8	
	Number of klebsiella cases	No Target	Nov-22	1	
	Number of pseudomona cases	No Target	Nov-22	2	
	Number of trust apportioned Clostridium difficile cases per month	< 10	Nov-22	9	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned MRSA bacteraemia	= 0	Nov-22	1	
Maternity	% PPH >1.5 litres	↓ Lower	Nov-22	3.8%	
	% breastfeeding (discharge to CMW)	= 0.0%	Nov-22	63.8%	
	% breastfeeding (initiation)	No Target	Nov-22	79.4%	
	% of women on a Continuity of Carer pathway	No Target	Nov-22	11.15%	
	% of women smoking at delivery	≤ 14.50%	Nov-22	10.07%	
	% of women that have an induced labour	≤ 30.00%	Nov-22	31.10%	
	% stillbirths as percentage of all pregnancies	< 0.52%	Nov-22	0.00%	
	Number of births less than 27 weeks	No Target	Nov-22	3	
	Number of births less than 34 weeks	No Target	Nov-22	133	
	Number of births less than 37 weeks	No Target	Nov-22	38	
	Number of maternal deaths	No Target	Nov-22	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Nov-22	1.8%	
	Total births	No Target	Nov-22	455	
Mortality	Hospital standardised mortality ratio (HSMR)	↓ Lower	Aug-22	113.0	
	Hospital standardised mortality ratio (HSMR) - weekend	↓ Lower	Aug-22	105.0	
	Number of deaths of patients with a learning disability	No Target	Nov-22	3	
	Number of inpatient deaths	No Target	Nov-22	164	
	Summary hospital mortality indicator (SHMI) - national data	No Target	Sep-22	1.0	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Nov-22	98	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Advice and Liaison Service (PA..	% of PALS concerns closed in 5 days	No Target	Nov-22	65%	
	Number of PALS concerns logged	↓ Lower	Nov-22	299	
Patient Safety Incidents	Medication error resulting in low harm	↓ Lower	Nov-22	4	
	Medication error resulting in moderate harm	↓ Lower	Nov-22	1	
	Medication error resulting in severe harm	↓ Lower	Nov-22	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Nov-22	32	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Nov-22	0	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Nov-22	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Nov-22	13	
	Number of falls per 1,000 bed days	↓ Lower	Nov-22	5.00	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Nov-22	5	
	Number of patient safety incidents - severe harm (major/death)	No Target	Nov-22	5	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Nov-22	9	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Nov-22	70.74%	
	Number of DoLs applied for	No Target	Nov-22	86	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Nov-22	111	
	Total admissions aged 0-17 with DSH	↓ Lower	Nov-22	46	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Nov-22	18	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Nov-22	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Nov-22	0	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Safeguarding	Total number of maternity social concerns forms completed	No Target	Nov-22	83	
Serious Incidents	Number of never events reported	= 0	Nov-22	0	
	Number of serious incidents reported	↓ Lower	Nov-22	5	
	Percentage of serious incident investigations completed within contract timescale	> 80%	Nov-22	100%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%	Nov-22	100.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Nov-22	92.7%	

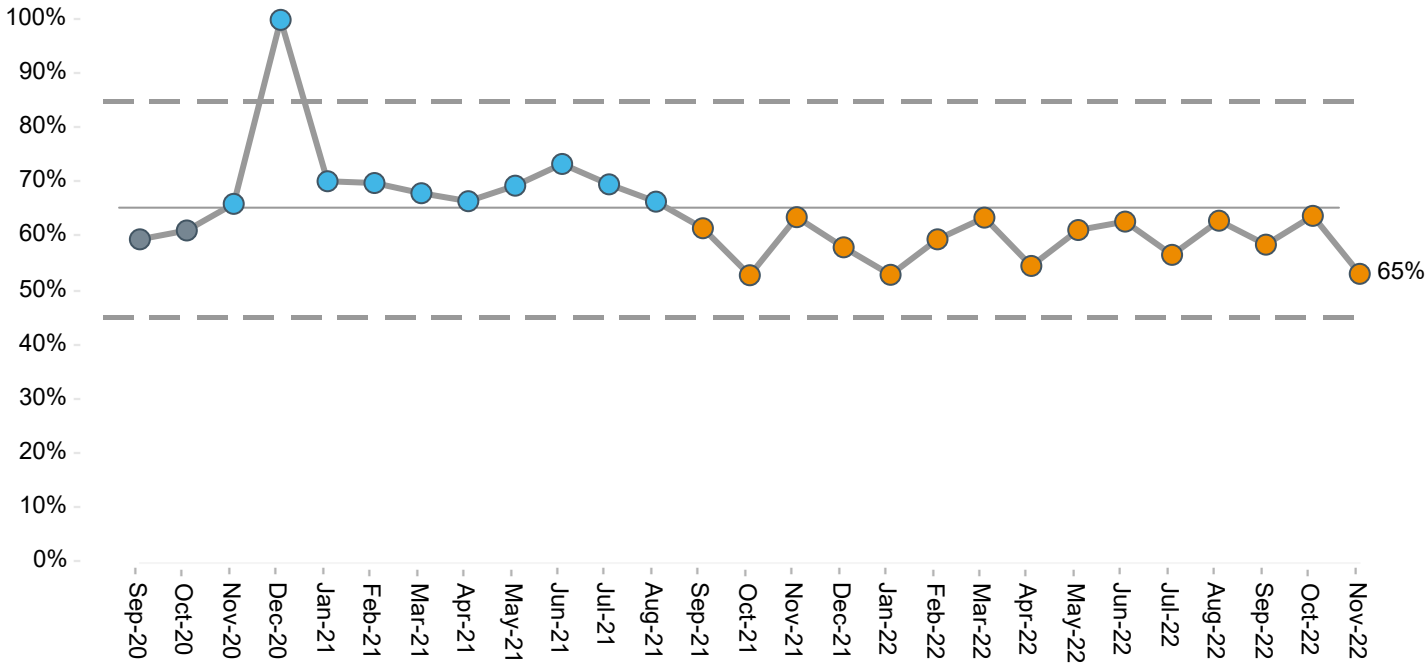
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[569] % of PALS concerns closed in 5 days

- - - Target: No Target



Data Observations

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Commentary

Head of Quality

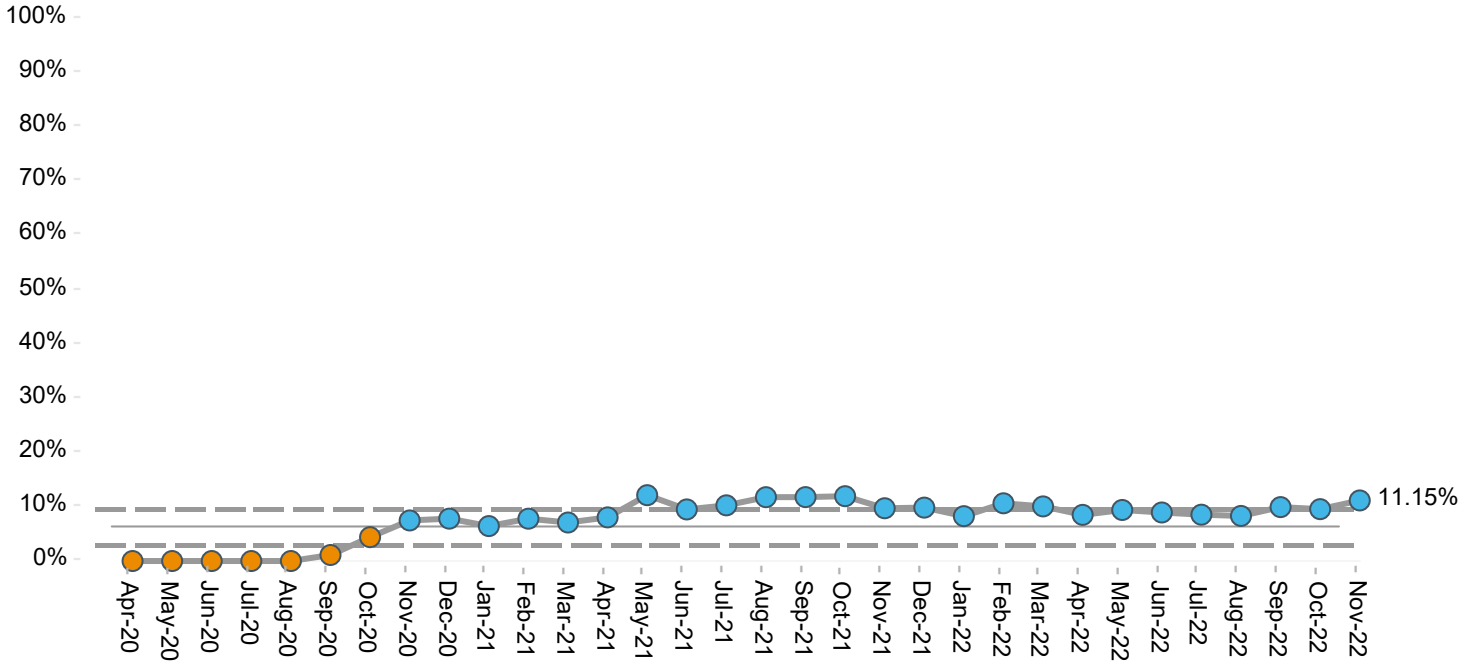
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[555] % of women on a Continuity of Carer pathway

- - - Target: No Target



Commentary

Due to a shortage of midwives, National targets for this metric have been removed for the foreseeable future.
Divisional Director of Quality and Nursing and Chief Midwife

Data Observations

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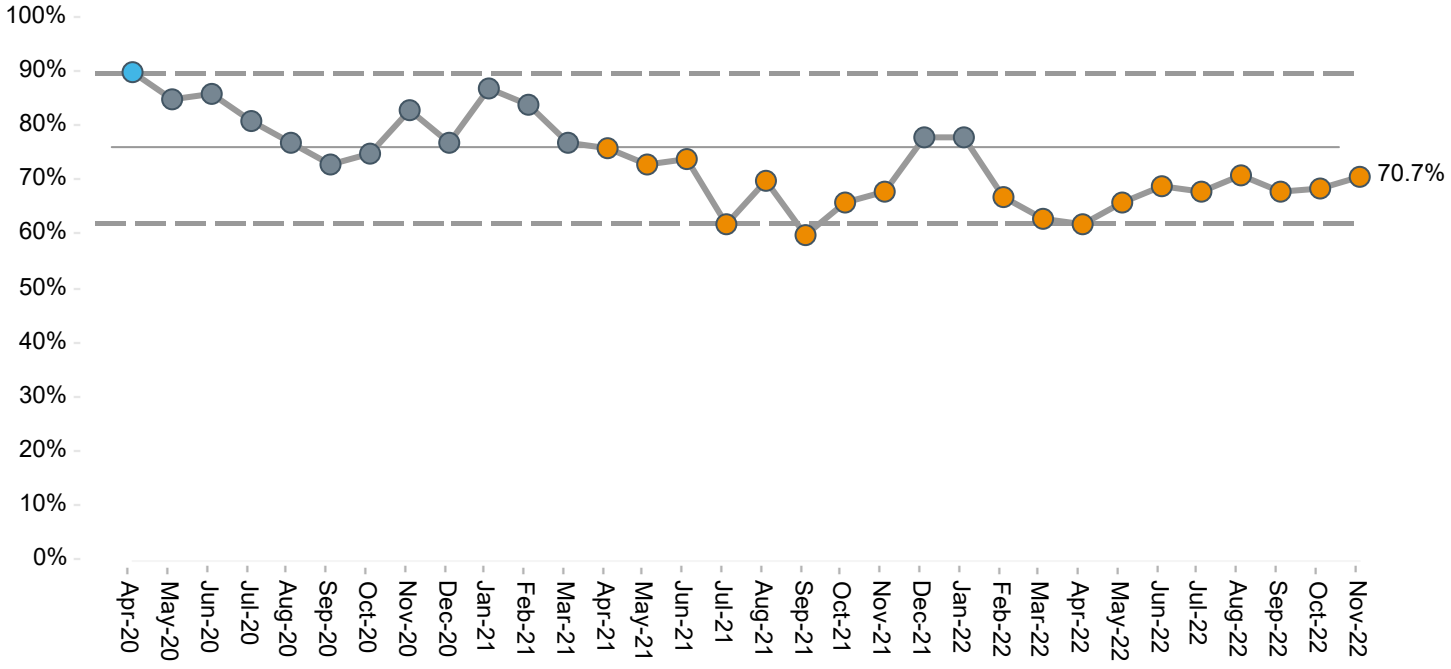
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[154] ED % positive

Target: No Target



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Commentary

Head of Quality

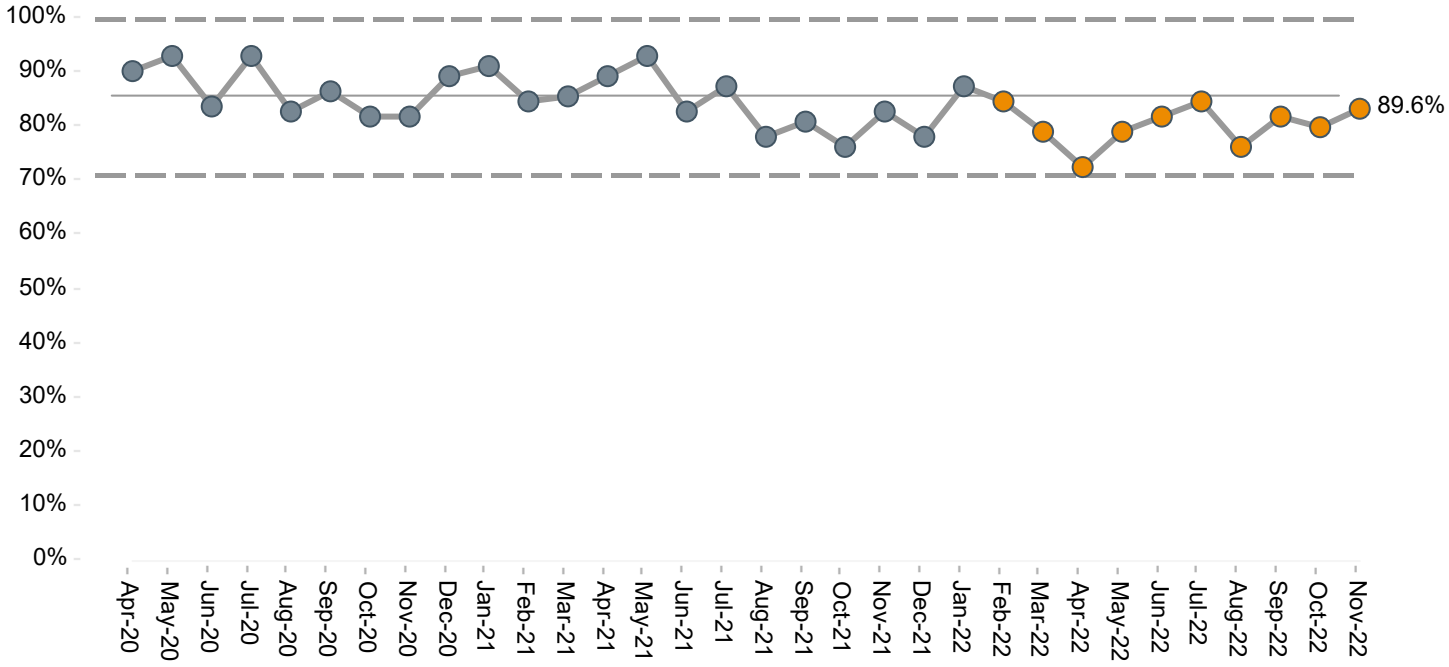
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[155] Maternity % positive

- - - Target: No Target



Data Observations

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Commentary

Head of Quality

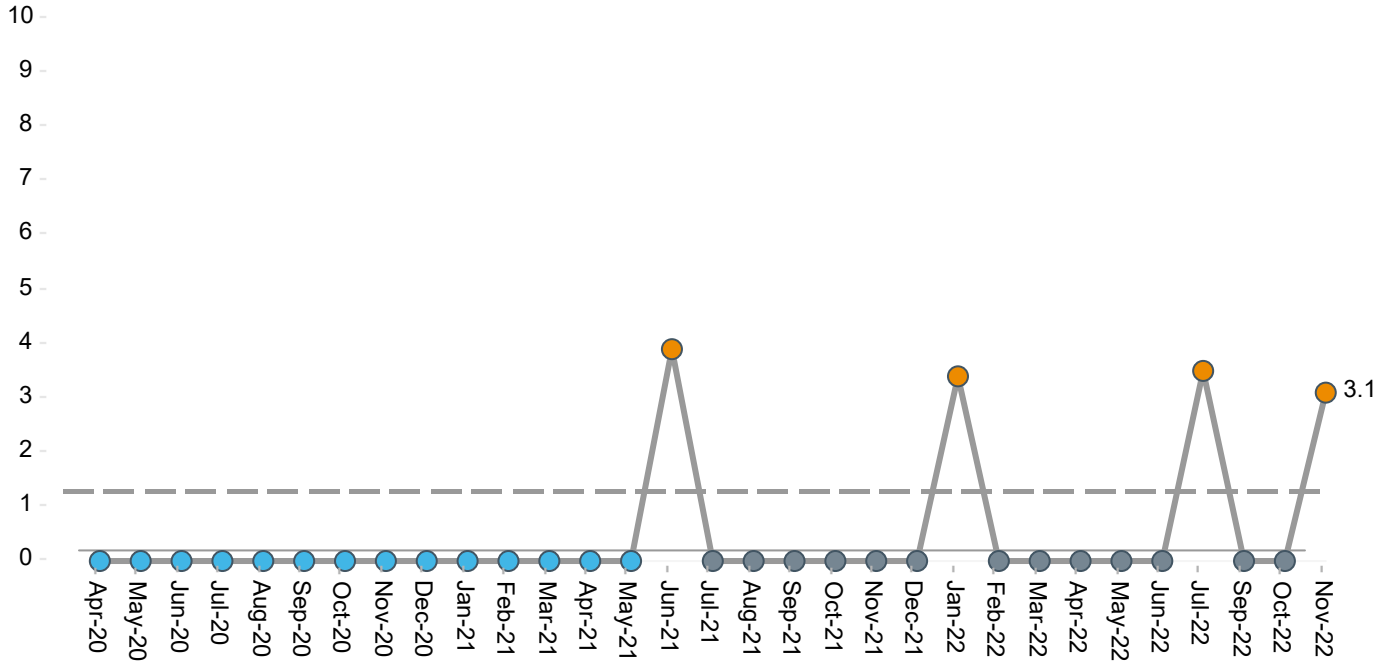
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[445] MRSA bacteraemia - infection rate per 100,000 bed days

- - - Target: ↓ Lower



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Commentary

During November 2022 there was one hospital onset health care associated MRSA bacteraemia. The total annual number of hospital onset MRSA bacteraemias is two. A post infection review has been completed and a wider system meeting was held to review the patients pathway involving stakeholders across the ICS. Areas for learning related to antibiotic prescribing in the community to ensure MRSA cover and ensuring timely and prompt commencement of decolonisation has been identified and will be addressed as an ICS in targeted actions for improvement to ensure lessons are learnt

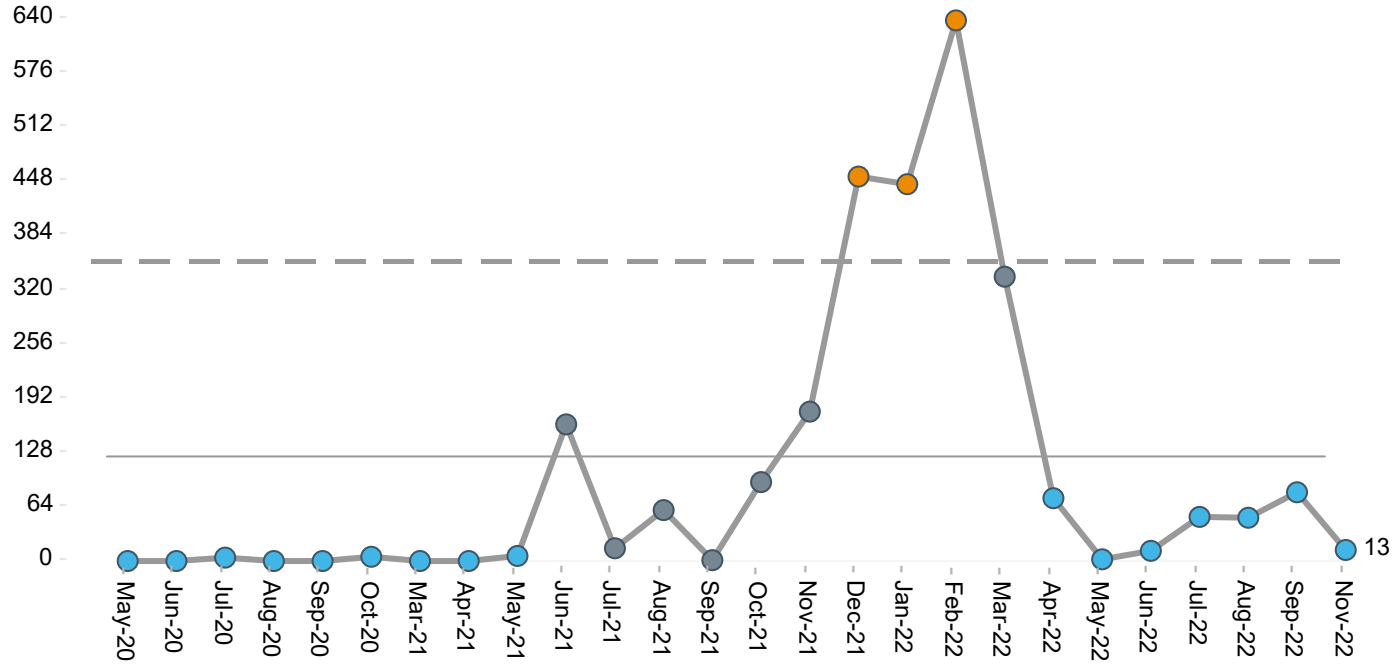
Associate Chief Nurse, Director of Infection Prevention & Control

Quality

SPC - Special Cause Variation

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

- - - Target: ↓ Lower



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Commentary

During November, 13 bed days we lost due to outbreaks mostly associated with transmission of COVID-19 compared to 23 bed days in October 2022. The IPCT reviewed all outbreak affected areas and supported use of empty beds where possible for patients who were deemed safe to use them this significantly reduced the number of empty beds in closed areas. The IPCT continued to also support with ensuring implementation of effective IPC practices to minimise risk of transmission including use of single room isolation, testing and use of PPE

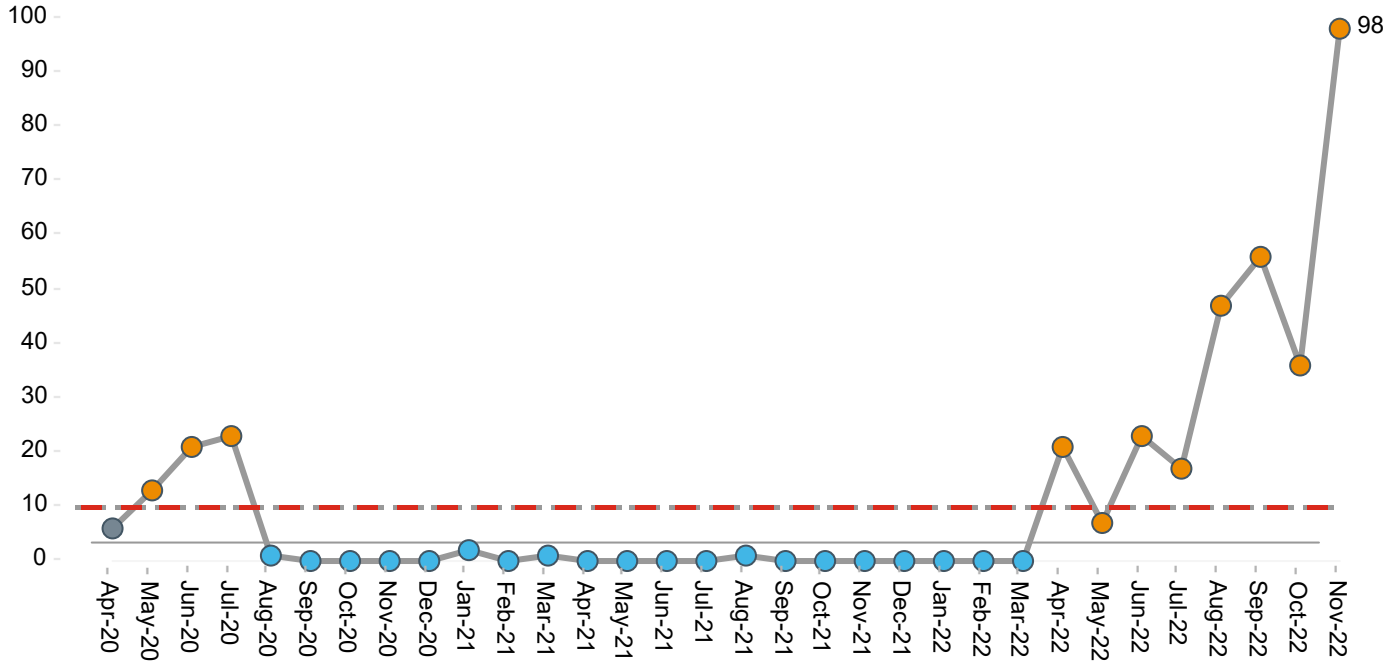
Associate Chief Nurse, Director of Infection Prevention & Control

Quality

SPC - Special Cause Variation

[148] Number of breaches of mixed sex accommodation

- - - Target: ≤ 10



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Commentary

Associate Chief Nurse, Director of Infection Prevention & Control

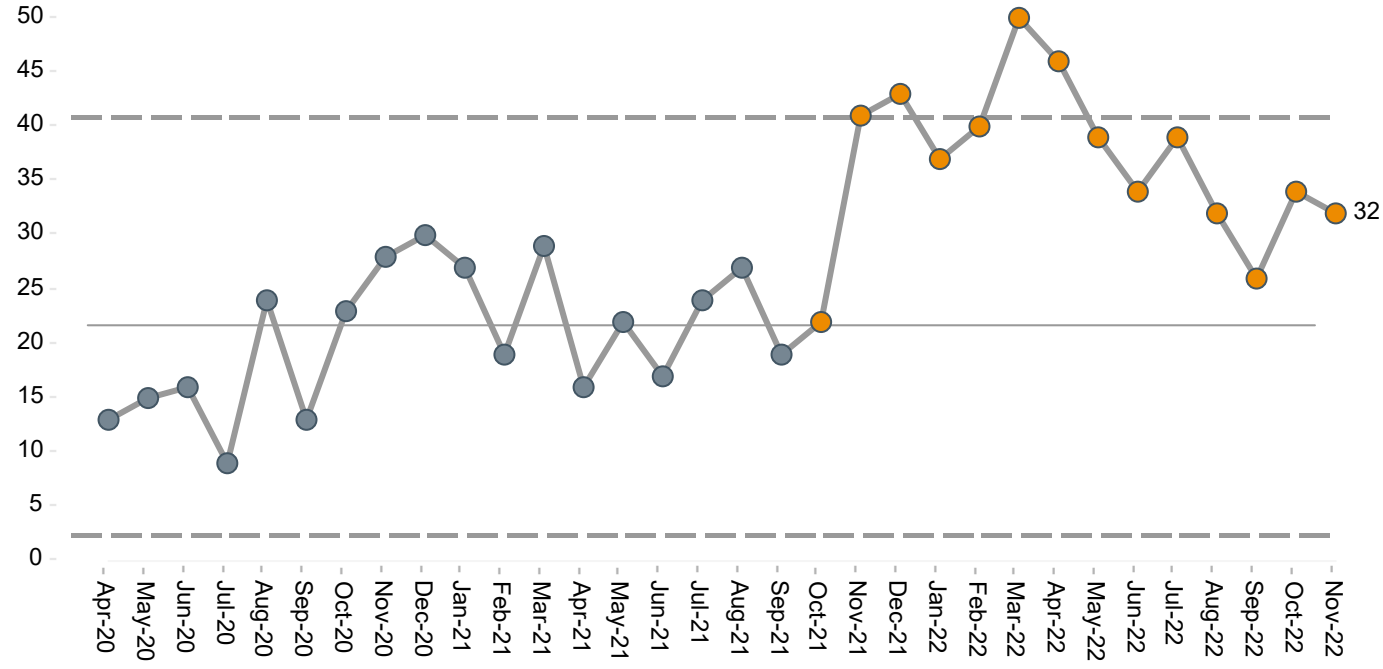
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[266] Number of category 2 pressure ulcers acquired as in-patient

- - - Target: ↓ Lower



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Commentary

Associate Chief Nurse, Director of Infection Prevention & Control

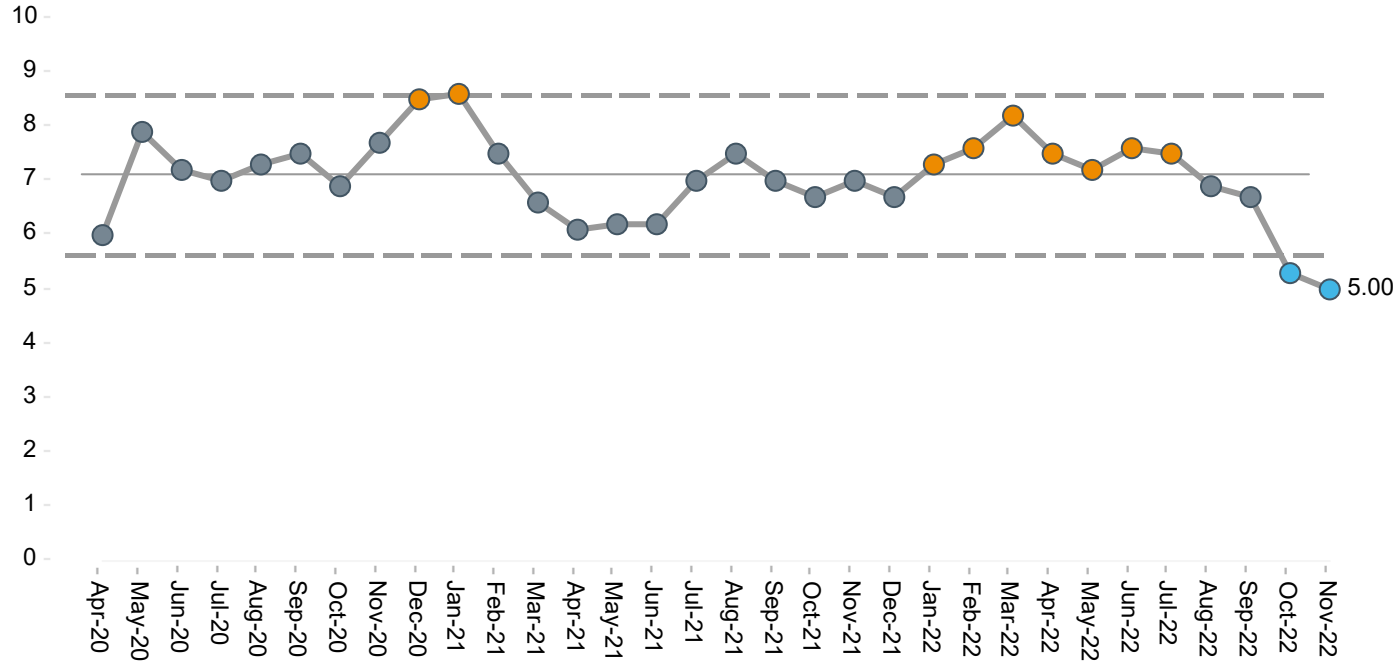
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[112] Number of falls per 1,000 bed days

Target: ↓ Lower



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Commentary

Associate Chief Nurse, Director of Infection Prevention & Control

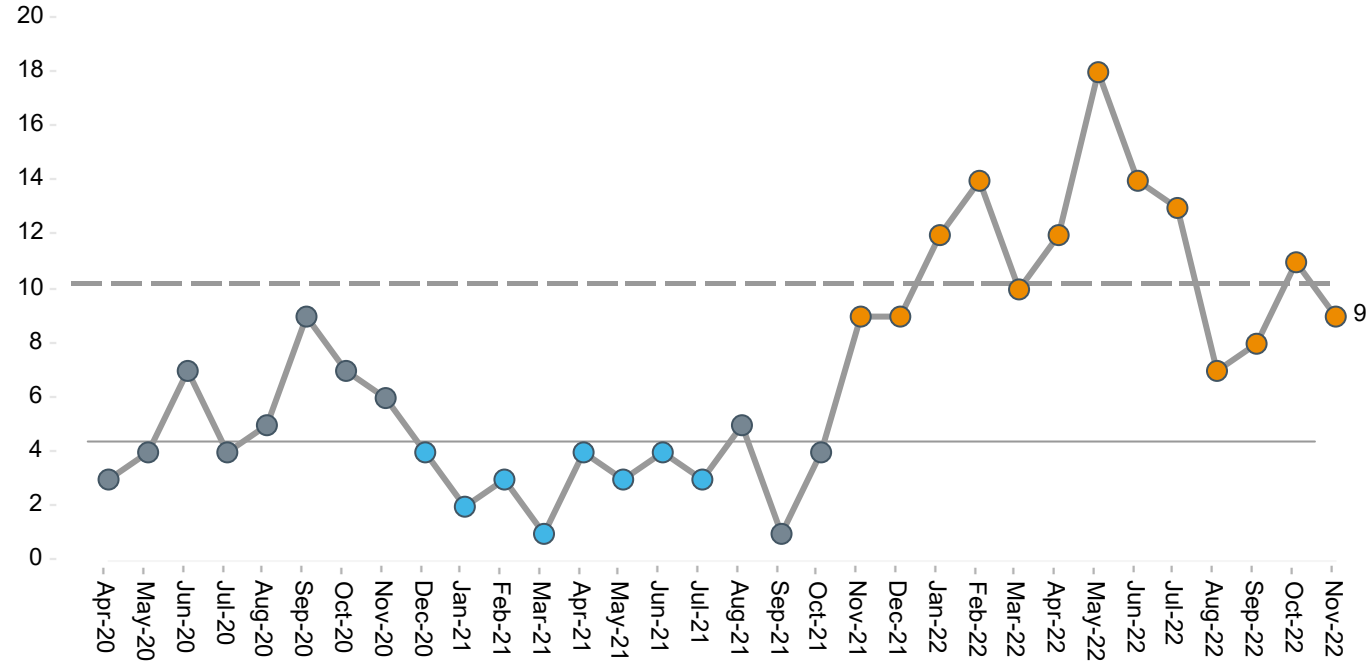
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Commentary

Associate Chief Nurse, Director of Infection Prevention & Control

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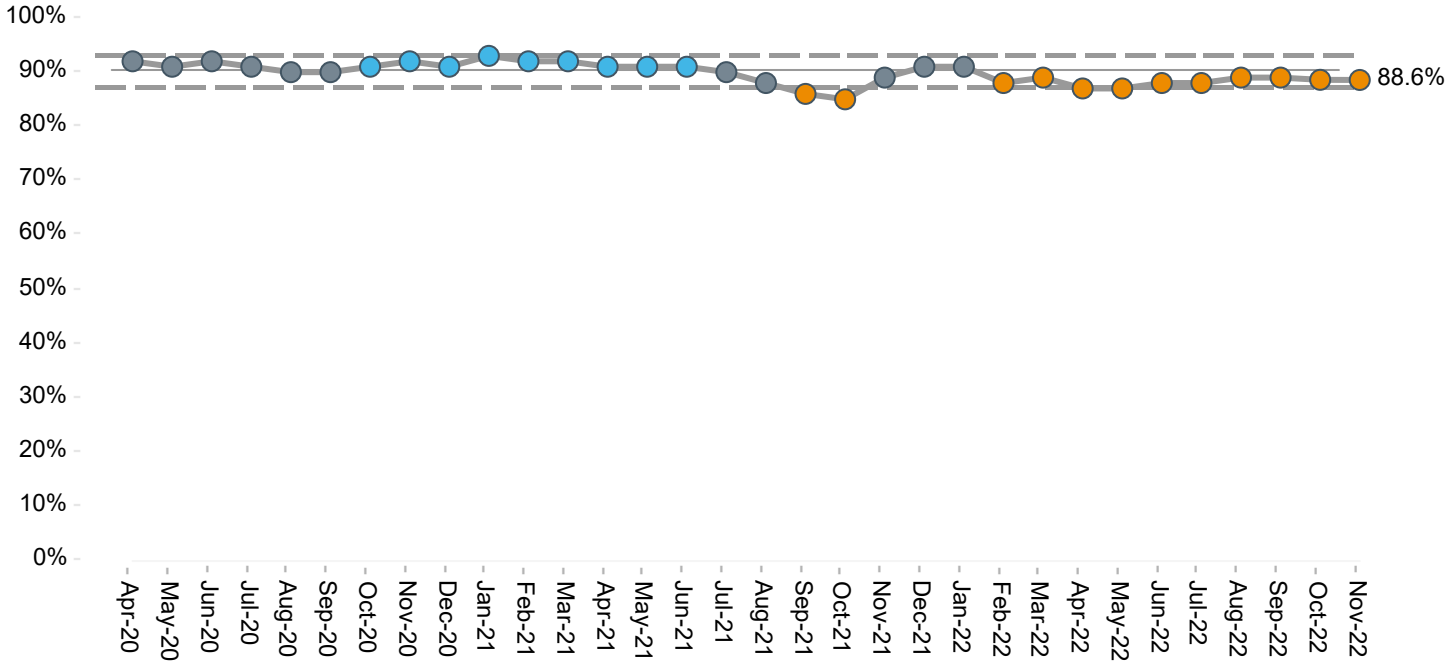
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[156] Total % positive

Target: No Target



Commentary

Head of Quality

Data Observations

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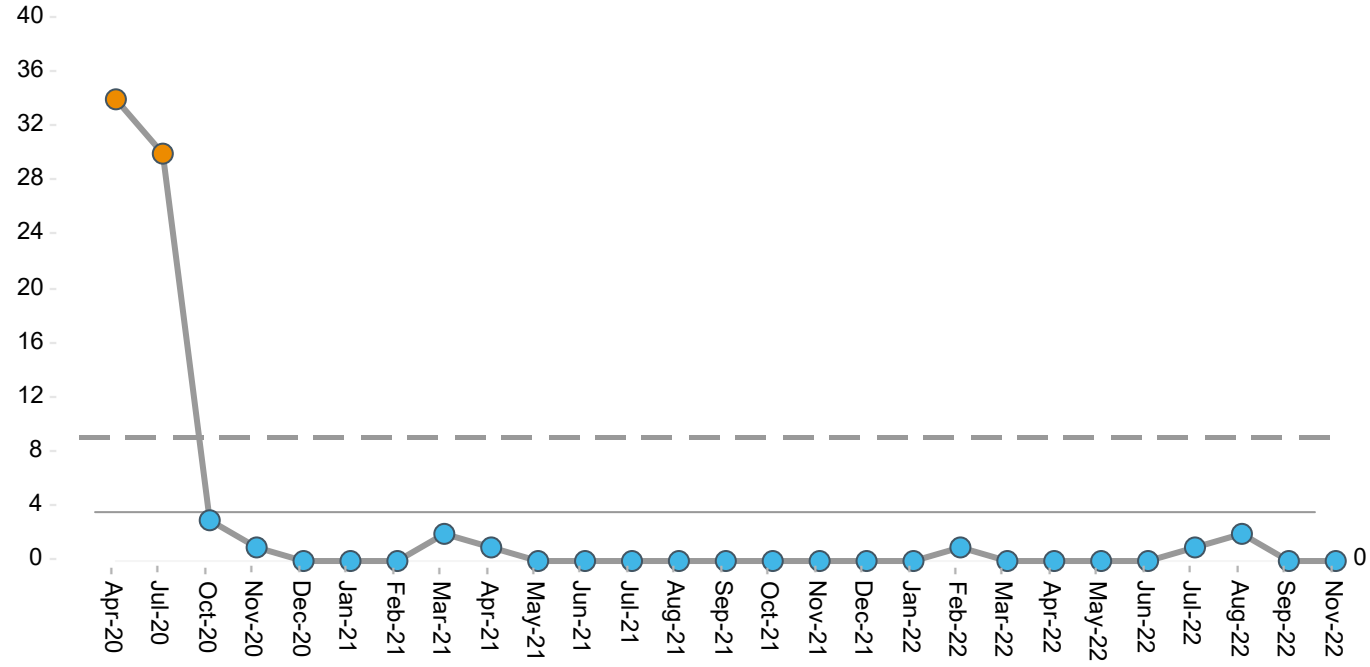
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[548] Total attendances for infants aged < 6 months, other serious injury

- - - Target: ↓ Lower



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Commentary

Deputy Director of Quality and Deputy Chief Nurse

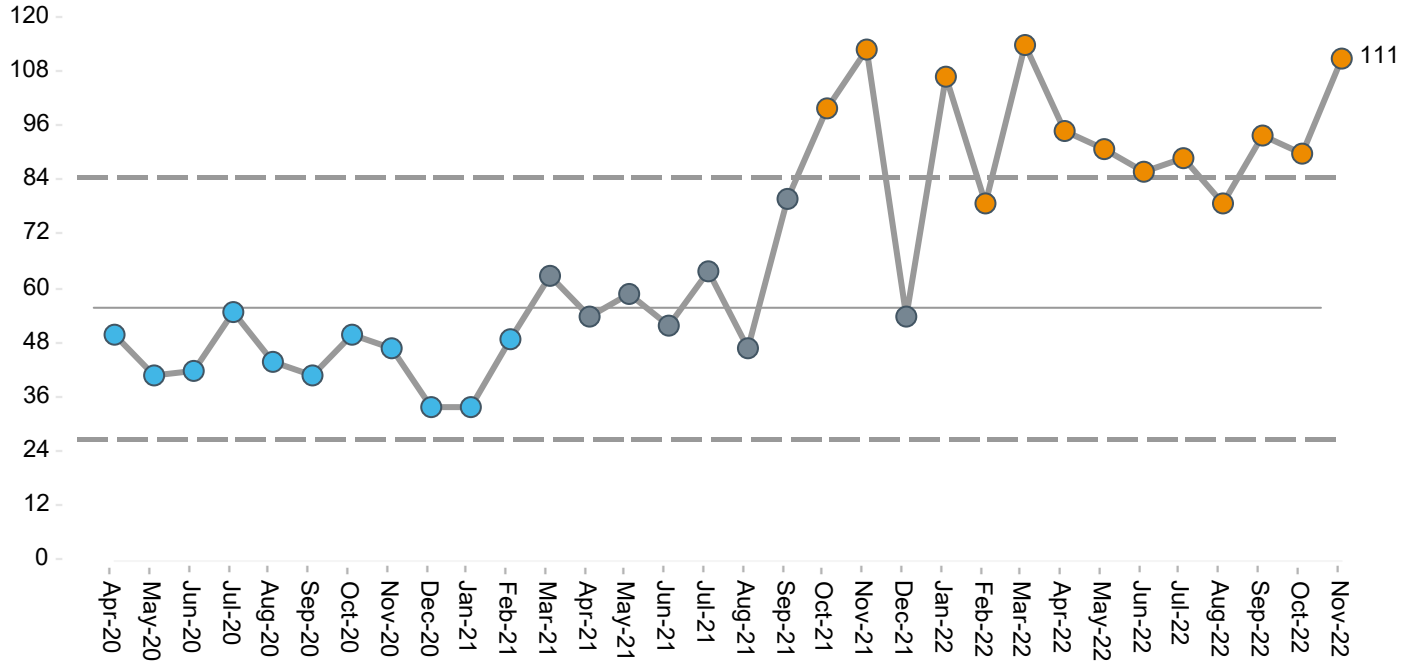
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[550] Total ED attendances aged 0-18 with DSH

- - - Target: ↓ Lower



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

[4] 2 OF 3

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

Commentary

Deputy Director of Quality and Deputy Chief Nurse

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Finance	NHSI Financial Risk Rating	No Target	Oct-22	34	

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Exception reports are shown on the following pages.

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Appraisal and Mandatory Training	Trust total % mandatory training compliance	≥ 90%	?	Nov-22	86%	L
	Trust total % overall appraisal completion	≥ 90.0%	F	Nov-22	78.0%	L
Safe Nurse Staffing	% registered nurse day	≥ 90.00%	?	Nov-22	97.34%	
	% registered nurse night	≥ 90.00%	?	Nov-22	102.93%	
	% unregistered care staff day	≥ 90.00%	?	Nov-22	99.45%	L
	% unregistered care staff night	≥ 90.00%	P	Nov-22	116.24%	
	Care hours per patient day HCA	≥ 3.0	P	Nov-22	3.6	L
	Care hours per patient day RN	≥ 5.0	?	Nov-22	5.4	
	Care hours per patient day total	≥ 8.0	?	Nov-22	8.9	
	Overall % of nursing shifts filled with substantive staff	≥ 75.00%	P	Nov-22	99.30%	
Vacancy and WTE	% total vacancy rate	↓ Lower		Nov-22	9.99%	H
	% vacancy rate for doctors	↓ Lower		Nov-22	3.97%	
	% vacancy rate for registered nurses	↓ Lower		Nov-22	13.94%	H
	Leavers FTE	No Target		Nov-22	50.80	
	Staff in post FTE	No Target		Nov-22	6,036.81	
	Starters FTE	No Target		Nov-22	69.09	
	Vacancy FTE	No Target		Nov-22	761.80	
Workforce Expenditure and Efficiency	% sickness rate	≤ 4.1%	?	Nov-22	5.6%	H
	% turnover	≤ 1,260.0%	P	Nov-22	14.1%	H
	% turnover rate for nursing	≤ 12.60%	P	Nov-22	13.28%	H

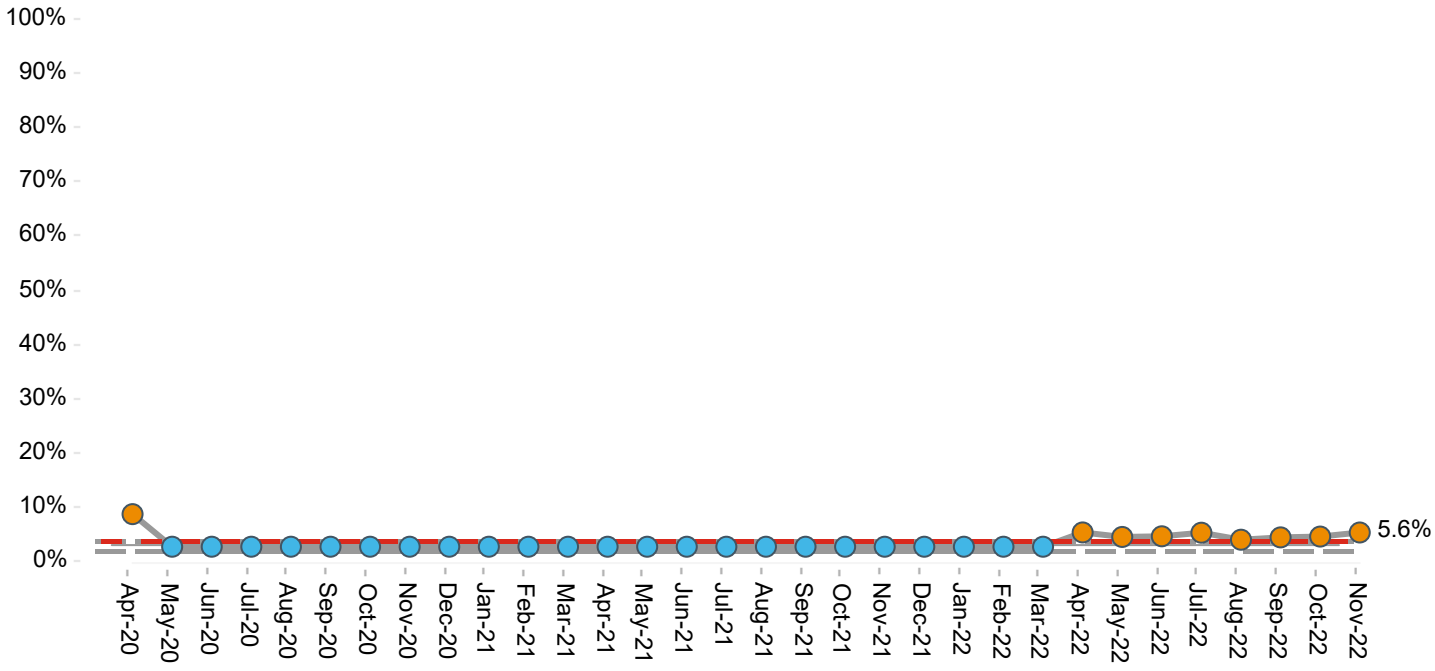
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[201] % sickness rate

Target: ≤ 4.1%



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Commentary

Senior HR Business Partner

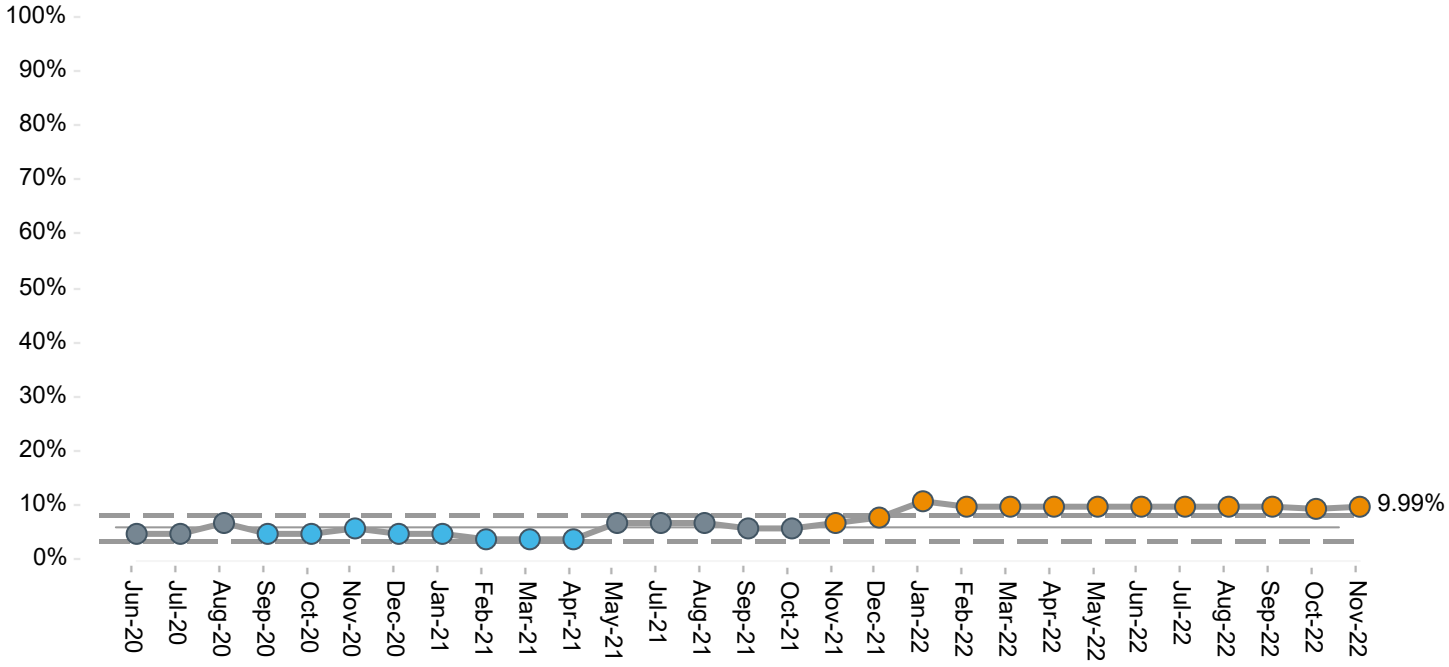
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[498] % total vacancy rate

- - - Target: ↓ Lower



Commentary

Senior HR Business Partner

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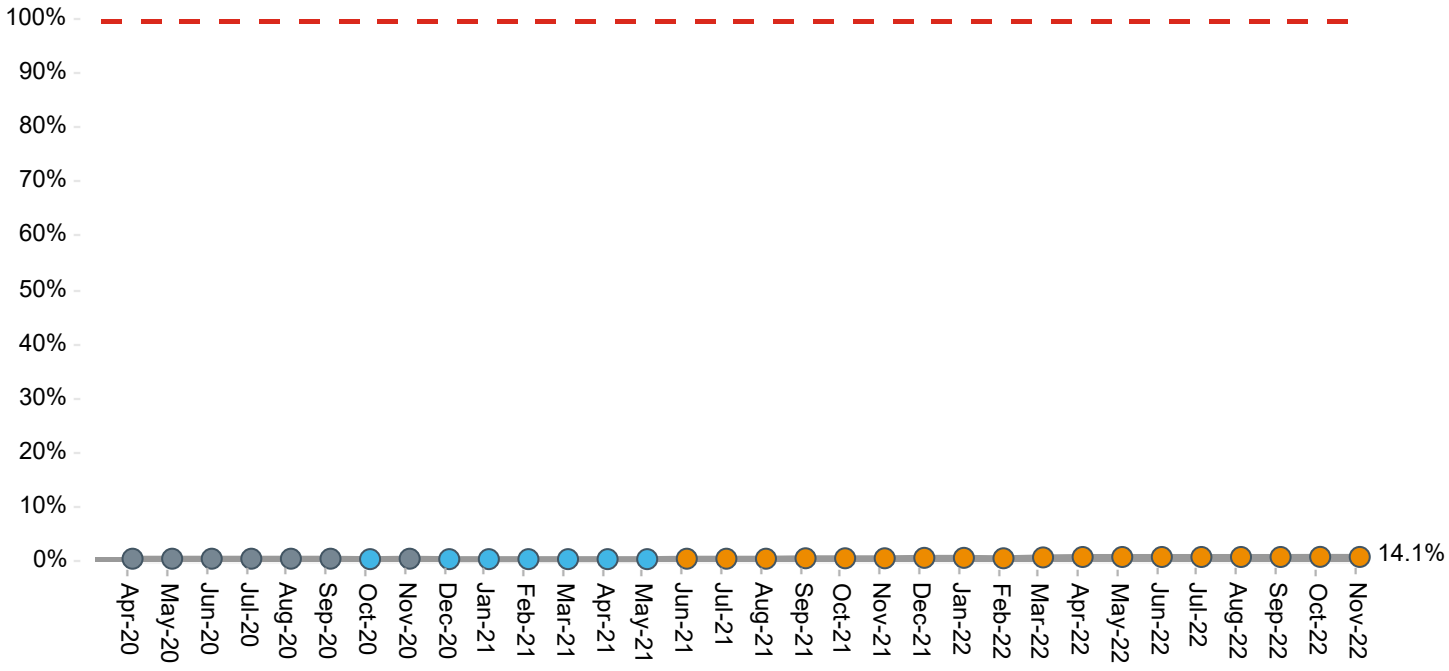
People & OD

SPC - Special Cause Variation

[213] % turnover

Target: ≤ 1,260.0%



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Commentary

Senior HR Business Partner

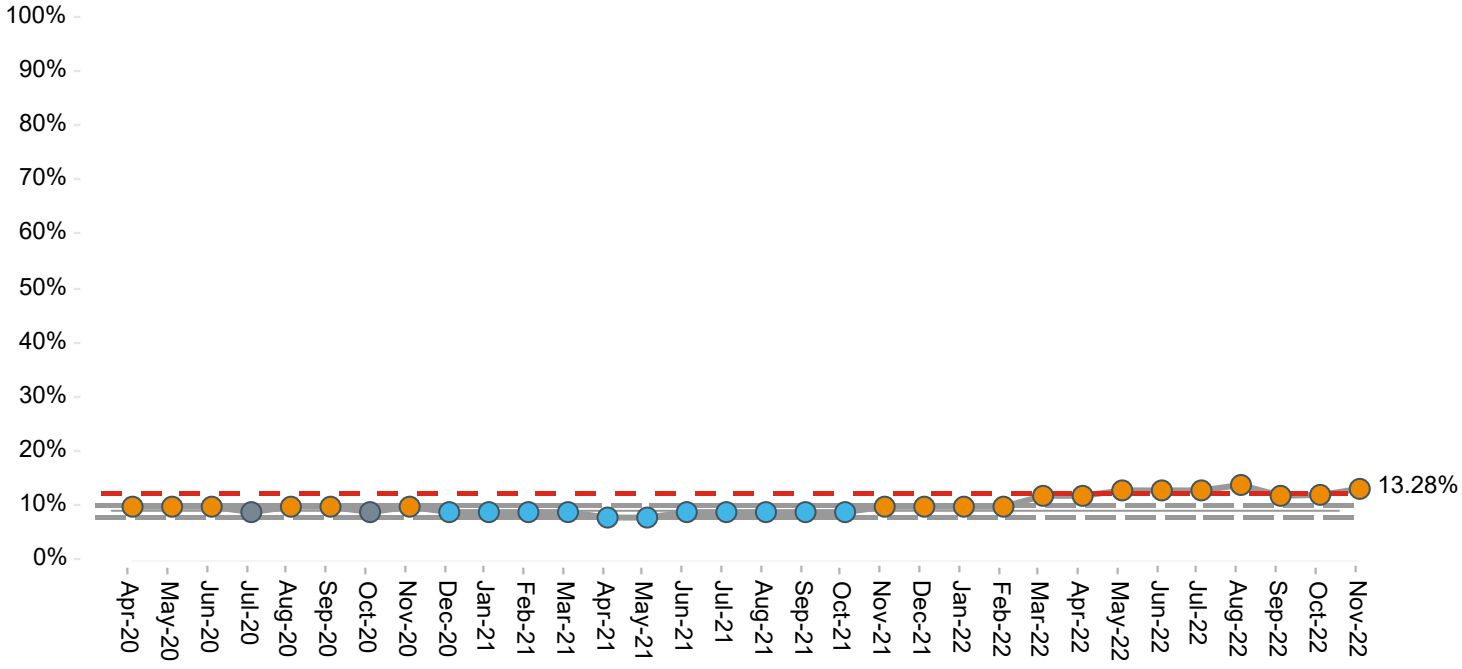
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[497] % turnover rate for nursing

Target: ≤ 12.60%



Commentary

Senior HR Business Partner

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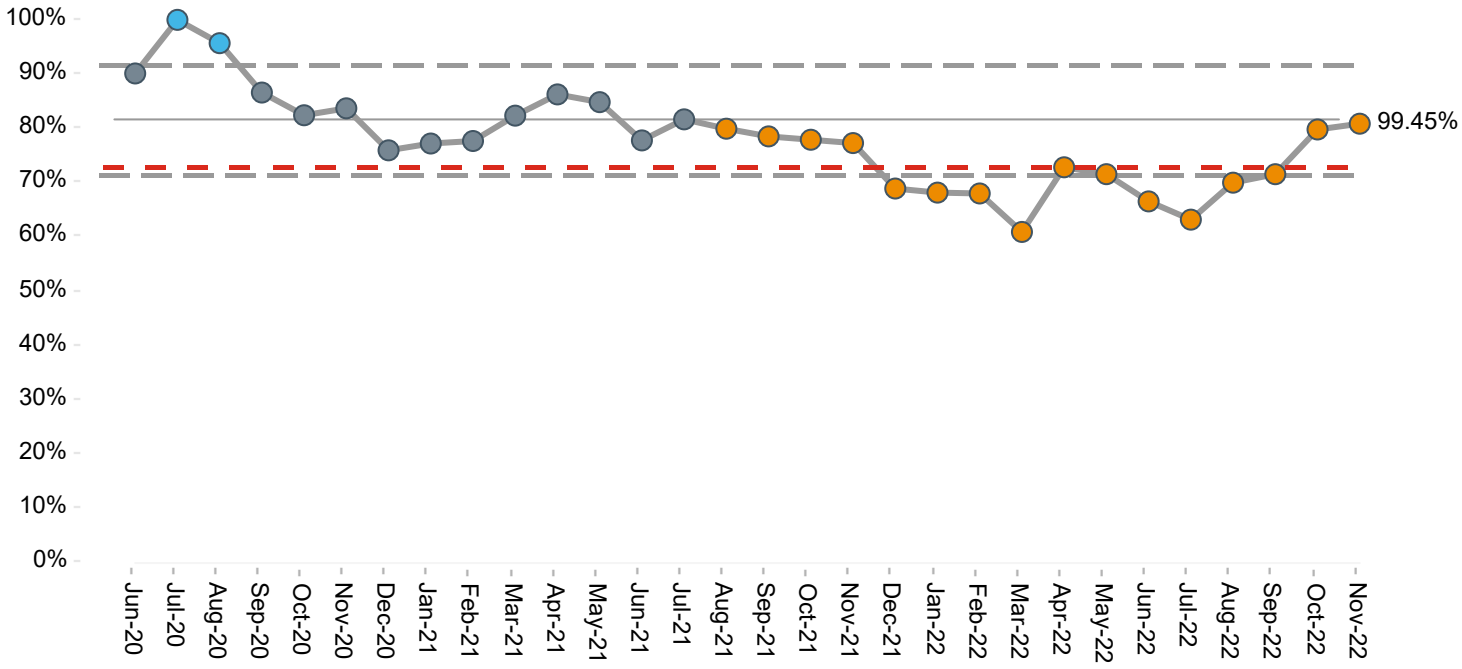
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[510] % unregistered care staff day

Target: ≥ 90.00%



Commentary

Deputy Director of Quality and Deputy Chief Nurse

Data Observations

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[3] RUN

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

[4] 2 OF 3

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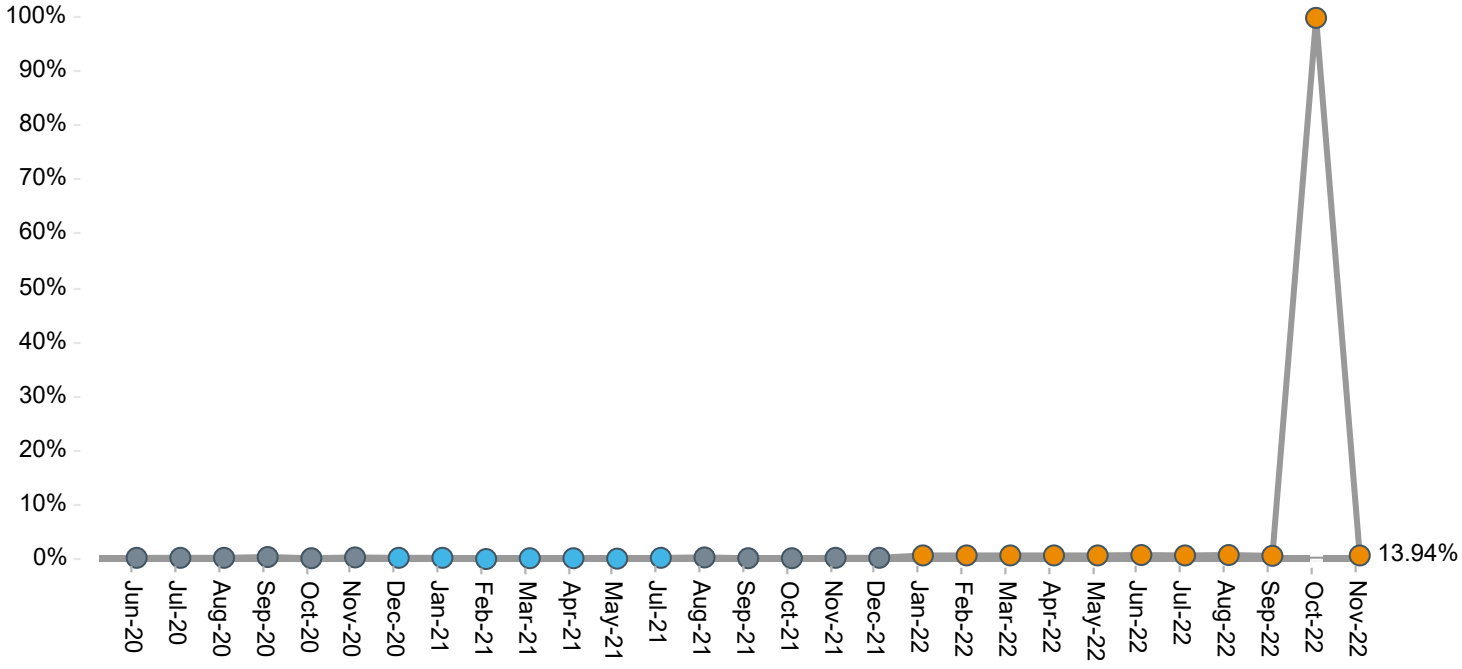
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[500] % vacancy rate for registered nurses

- - - Target: ↓ Lower



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Commentary

Senior HR Business Partner

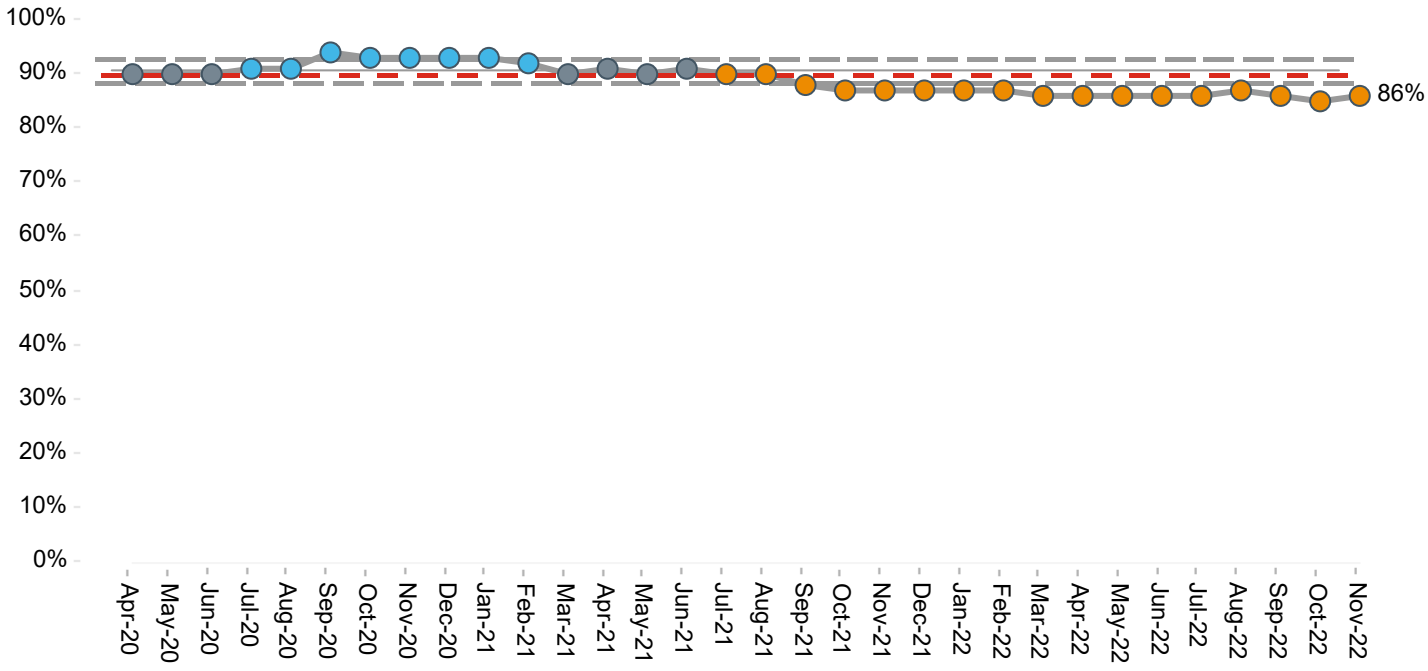
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[214] Trust total % mandatory training compliance

Target: ≥ 90%



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Commentary

• Trust total % mandatory training compliance: Mandatory training compliance remains below the 90% target and has remained at approx 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 such as Medical Staff -training grades and Bank staff, and specific topics such as IG and Safeguarding leads.

Deputy Director of People and Organisational Development

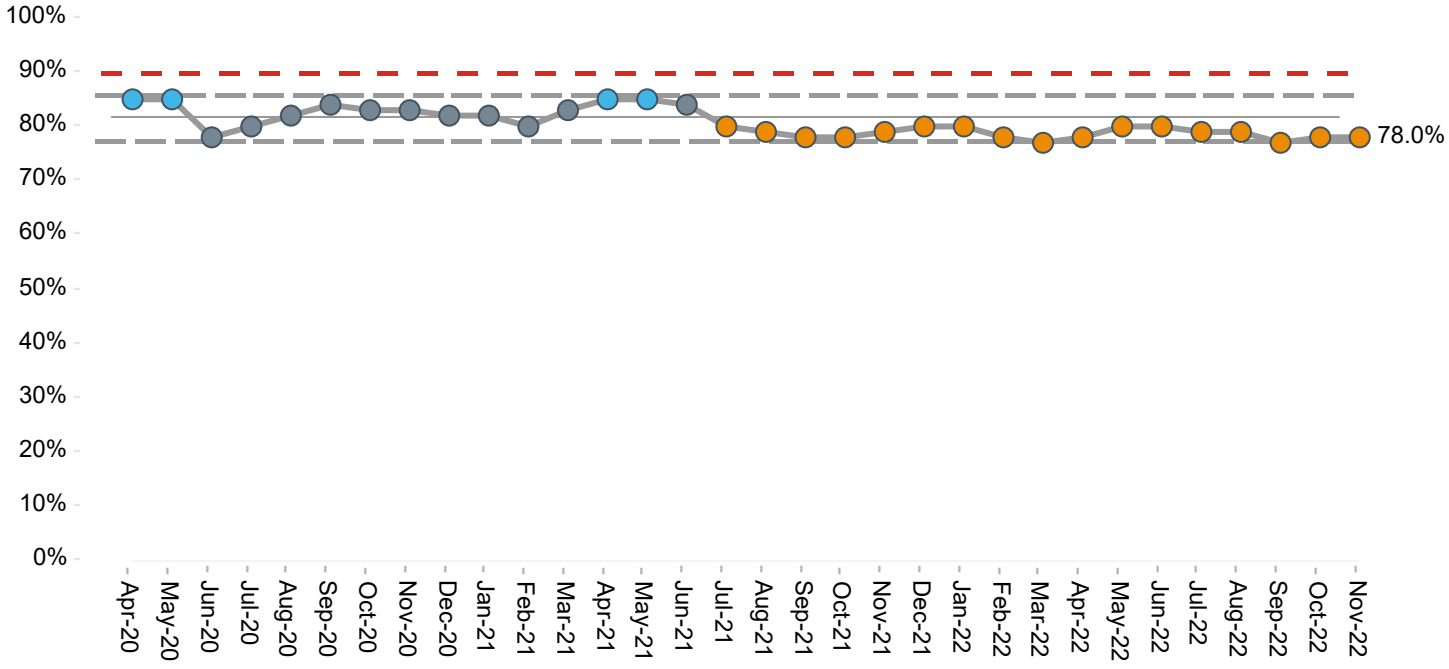
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[221] Trust total % overall appraisal completion

Target: ≥ 90.0%



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Commentary

• Trust total % overall appraisal completion: The Trust appraisal rate continues to fall below the trust target of 90% and remains at 78%. Medicine (85%), Surgery (82%) and D&S (75%) and Women & Children (75%) Divisions have the highest compliance rates. The lowest Divisional Appraisal rates are Corporate (71%) and non-division at 53%. Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Appraisals come under Leadership and Organisational Development.
Deputy Director of People and Organisational Development

Gloucestershire Hospitals NHS Foundation Trust

Maternity Incentive Scheme Year 4

Board Update – 12 January 2023

Head of Midwifery - Lisa Stephens
Specialty Director Obstetrics – Dr Christine Edwards
Executive Director and Board Maternity and Neonatal Safety Champion– Matt Holdaway

(Supported by Deputy Director of Quality – Suzie Cro)

Overview of our maternity services

Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Hospitals Foundation NHS Trust provides a large maternity service for the county in which circa 6000 babies are delivered each year.

- The maternity service comprises
  - Community midwifery service with home birth service
  - Continuity of Carer Teams
  - Maternity Advice Line (hosted at SWAST)
  - Obstetric antenatal clinics (Gloucester, Stroud and Cheltenham)
  - Maternity Day Assessment
  - Maternity Triage
  - Delivery suite based at Gloucestershire Royal Hospital with Obstetric Theatres
  - Three midwifery led birth units, one co-located at Gloucestershire Royal and two stand alone units at Cheltenham and Stroud
- Overall the CQC have rated the maternity service as inadequate (last inspected April 2022) and there is a section 29A warning notice in place for which there is a improvement plan in place.

Current position and plan

Gloucestershire Hospitals NHS Foundation Trust

Position

- Currently **we are not** achieving all ten maternity safety actions as we have not been able to provide the assurance required to the Local Maternity Neonatal System Leads (currently we are agreed that 3 out of 10 are fully compliant).
- The LMNS Leads still need to check 2 standards.
- We still have an **opportunity** to improve the position as the Trust must submit our completed declaration form by 2nd February 2022.
- We currently have a CQC section 29a warning notice and an inadequate rating for the maternity service which we will declare.

Plan

- Our plan is to provide **further evidence** to the LMNS over the next 2 weeks before submitting our declaration (it is unlikely that we will meet all 10 safety actions and will need to provide an action plan).

Request to the Board

Gloucestershire Hospitals
NHS Foundation Trust

Request to the Board

- The Board must be satisfied that the evidence provided demonstrates compliance and so we are asking the Board to give delegated authority to the Director of Quality and Chief Nurse to agree the position with the LMNS Leads before the CEO signs the declaration form.
- The Board declaration form needs to be signed by the CEO and so we are asking the Board to give permission to the CEO to sign the declaration prior to the submission.
- Trusts that do not achieve all 10 safety actions may be eligible for a small amount of funding to support progress and so we are asking the Board to support our action plan (which will be signed off by the Director of Quality and Chief Nurse) which will be submitted together with the declaration form by 2 February 2022.

Current position

Gloucestershire Hospitals
NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	9	1	0	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	No	9	3	1	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	No	13	5	0	0	1
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No	6	2	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	3	0	0	0	0

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?	No	0	0	0	0	30
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	No	6	1	0	0	0
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Yes	18	0	0	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	No	0	0	0	0	25
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	Yes	8	0	0	0	0

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	12	Enclosure Number:	7
Date	12 January 2023		
Title	Guardian of Safe Working Hours Quarterly Report		
Author /Sponsoring Director/Presenter	Dr Jess Gunn, Guardian for Safe Working Mark Pietroni, Medical Director and Director of Safety		

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

Summary of Report

Purpose

This report covers the period 1st July 2022 to 30th September 2022

Key issues to note

There were 98 exception reports logged.

There were no fines levied.

43 Datix reports were submitted during this quarter, relating to medical staff shortages

The total expenditure on agency and bank locum cover, across all specialties', over the last quarter was: £9,682,037.00

A further £429.49 was paid to junior doctors as a result of a total of additional hours worked and 5.15 hours were allocated as TOIL.

Conclusions

The number of exception reports has increased this quarter, likely as a direct result of current NHS pressures. However, the number of exception reports has fallen compared with the same quarter in 2021. The cause of this is likely multifactorial but the reduction compared with 2021 may be a positive consequence of increasing expenditure on locum staff to support existing staff members.

Recommendation

The Board should be assured that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

Enclosures

Guardian of Safe Working Hours Quarterly Report

Quarterly Guardian Report on Safe Working Hours for Doctors and Dentists in Training

For Presentation to the Main Board

1. Executive Summary

1.1 This report covers the period of 1.07.22 – 30.09.22. There were 98 exception reports logged.

1.2 During this period, 0 fines were levied.

2. Introduction

2.1 Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hour's limits. The Terms and conditions have been updated in 2019, with further requirements being monitored.

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

High level data	
Number of doctors / dentists in training (total):	417
No. of trust doctors	70
Total Junior doctors	487
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors: (first/additional trainees to maximum 0.5 SPA)	0.25/0.125 PAs

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2& GPT**	**IMT & ST3-8**	**Additional training and trust grade vacancies**
ED	0	0	3	0	**3x trust doctor ST1 grade**
Oncology	0	0	1	0	**1x trust doctor ST1 grade**
T&O	0	0	1	0	**1 x Trust Dr (ST1) + Information from HR: 'Waiting for department to advise Workforce Establishment numbers outstanding'**
Surgery	0	0	0	1	**1x ST6 upper GI** **Anaesthetics- Information from HR: 'Waiting for necessary Workforce reports – With Trust/Remedium recruitment numbers are unclear'**
General Medicine	u/a	u/a	u/a	u/a	**Information from HR: 'Waiting necessary Workforce reports – With Trust recruitment/Remedium recruitment numbers are unclear'**
Paeds	0	0	1	0	**1x trust doctor**
Cardiology	0	0	0	0	**No outstanding recruitment**

(vacant training grade post to which tabulated numerical value corresponds)*

Total Junior Doctor Vacancies – currently unable to provide absolute number due to missing data.

4. Locum Bookings

4.1 Data from finance team and HR:

The total expenditure on agency and bank locum cover, across all specialties', over the last quarter was: £9,682,037.00

The breakdown of this locum expenditure over the last quarter, according to department, is as follows:

		July	August	September
Medicine	Agency	912,075	1,186.338	1,509.817
	Bank	520,071	400,432	538,848
Surgery	Agency	548,633	573,992	803,571
	Bank	244,681	229,027	286,464
Diagnostics & Specialist	Agency	218,712	247,023	344,286
	Bank	57,972	24,597	31,160
Womens & Childrens	Agency	202,109	246,130	301,085
	Bank	77,128	78,951	98,935

5 Additional Costs

5.1 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £429.49 (70.25 additional hours worked.)

Total number of hours given as TOIL as result of exception reporting of additional hours worked: 5.15 hrs

5. Exception Reports

	Exceptions Raised		
Specialty	**Working Hours**	**Educational Opportunities**	**Service Support Available**
General/GI Surgery	6	7	3
Urology	0		0
Trauma/ Ortho	0		0
ENT	9		2
MaxFax	0		0
Ophthalmology	0	0	0
Orthogeriatrics	0	0	0
General Medicine	50 (+ 2 ISCs)	2	8
Geriatric Medicine	2	0	0
Neurology	0	0	0
Cardiology	1	1	0
Respiratory	2	0	0
Gastro	0	0	0
Renal	1	0	0
Endocrine	0	0	0
Acute medicine/ ACUA	1	0	0
Emergency Department	0	0	0
Obstetrics and Gynaecology	0	0	0
Paediatrics	2	0	0
Psychiatry	0	0	0
Anaesthetics	0	0	0
Oncology	0	0	0
Haematology	0	0	0
GP	0	0	0
Other	**1**	**0**	**0**
Total	**75**	**10**	**13**

6. Fines this Quarter

6.1 This quarter there have been no fines levied.

7. Issues Arising

7.1 There were 2 reports listed as ‘immediate safety concern’. The nature of these concerns related to workload and reported lack of medical staff/ junior doctors on the ‘oncall’ medical team. This was the result of both anticipated staff shortage (ie known rota gaps) and unplanned/ unexpected staff absence due to sickness.

Further information was obtained about the nature of these events and subsequent to this, at the time of writing, no further ISC reports or concerns about ongoing or unresolved issues have been received.

8. Actions Taken to Resolve Issues

8.1 As above.

9. Correlations to Clinical Incident Reporting

9.1 There were 43 datices submitted over the last quarter, from medical, paediatric and surgical specialties, directly relating to medical/ doctor staff shortages.

The reported consequences of these staff shortages include:

- Lack of junior doctors to support consultants doing ward rounds, and review in patients out of hours, with a consequent delay in undertaking ‘jobs’ required to progress patient care, including requesting tests, prescribing discharge medications, writing discharge summaries and liaising with other specialties and patients’ relatives. This has a detrimental effect on patient ‘flow’ through the hospital and a significantly negative effect on patient experience.

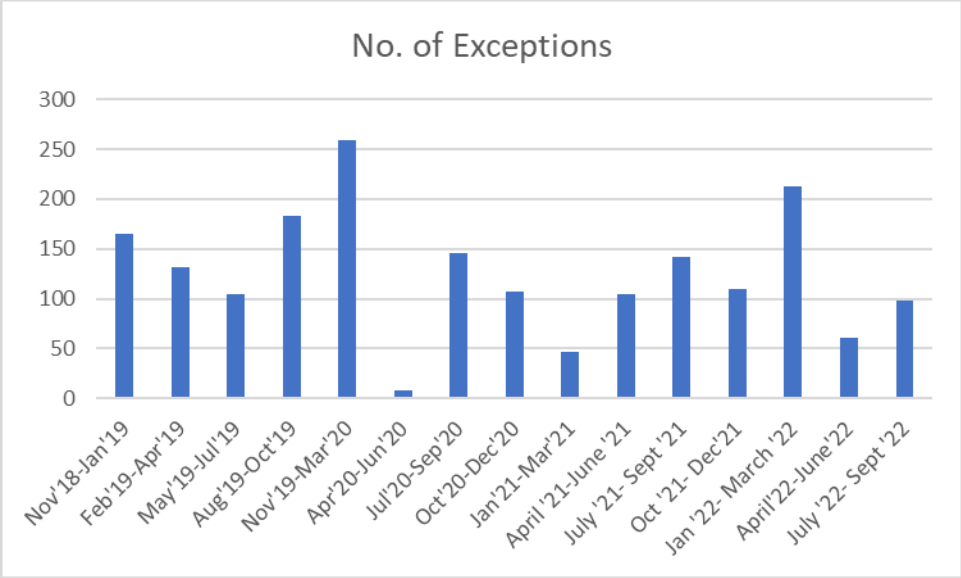
- Delays in patients being seen and assessed when presenting to ED, SDEC, SAU etc with consequent impact on patient care, patient experience and flow through the hospital.

98% of these datices concluded that the actual level of harm arising from these events was ‘none-no harm caused’ with the remaining 2% categorized as ‘moderate (short term) harm’. However, 9% of these scenarios were recognised as having a high risk rating and 5% a moderate risk rating. At the time of writing 86% of these events did not have a risk rating ascribed to them.

10. Junior Doctors Forum

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

11. Trajectory of exception reports



This graph shows the number of exception reports per quarter.

12. Summary

11.1 A total of 98 exception reports have been made from the beginning of July 2022 until the end of September 2022. No fines were levied.

The overall rate of exception reports has fallen and is lower than the same quarter in 2021. This may be a positive consequence of spending on staff members through bank and agency to support the work of existing staff.

Author: **Dr Jess Gunn, Guardian of Safe Working Hours**

Presenting Director: **Prof Mark Pietroni**

Date 03.01.2023

Recommendation

- ☐ To endorse
- ☐ To approve

Appendices

Link to rota rules factsheet:
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20August%202016%20v2.pdf

Link to exception reporting flow chart (safe working hours):
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Safe%20working%20flow%20chart.pdf

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 22 December 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
Financial Performance Report	Key points were highlighted as follows: • The Trust had reported a deficit position of £4.9m which was £3.3m adverse to plan. The Trust continued to see the same key drivers to the position that had been reported to the Committee throughout the year. • The in-month position reported a £5.8m surplus which was £5.6m favourable to plan. • The financial position continued to be pressured. Regular meetings were continuing with Surgery and Medicine, with support from finance, HR and procurement to manage the financial position.	The Committee remained concerned about the financial position, but noted that divisions would be held to their forecast variance from December; this would be the control total against which divisions would be monitored for the remainder of the year. The Committee was assured that all divisions had signed up to their control totals and had full ownership.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Financial Sustainability Report	The Plan target for the Trust was £19m, with £4.2m currently unidentified. This meant that the efficiency requirement would increase as the year progressed. The month 8 forecast position reported an improved position, driven by non-recurrent actions taken within the Corporate division and a small improvement in the Medicines Optimisation Programme within Surgery.	Discussions would take place at ICB to consider further systemwide efficiencies across shared services.
Capital Programme Report	The Trust submitted a gross capital expenditure plan of £67.1m for the 22-23 financial year. To date, there had been £11.8m of additional capital approved, totalling £78.9m. As of the end of November (M8), the Trust had goods delivered, works done or services received to the value of £28.4m, which was £4.1m behind plan.	Discussions continued with regard to the 23/24 capital plan, which was currently a pressure for the Trust and system. Whilst the pressure had been reduced, further work was required to ensure a balanced position.
Financial Strategy	The Five Year Financial Strategy was provided for feedback; the Committee was supportive of the draft, and encouraged additional information around productivity to be included.	The Committee was encouraged by the strategy, and noted that it would be presented for ratification at March's Board of Directors meeting. The Strategy would also be shared with the ICB.
Digital Transformation Report	An update was provided on the four key work areas: Electronic Patient Record; Clinical Systems Optimisation; Infrastructure and Cyber; and Business Intelligence. The Committee was advised that electronic prescribing had been successfully deployed across the Trust and was now in use for all Cheltenham adult inpatients, theatres and Emergency Department, and all Gloucester adult inpatients, theatres and Emergency Department. Positive feedback had been received from staff on the digital change support provided during rollout. ***Digital Funding*** Additional funding had been granted to upgrade Trust hardware. There was a planned internal audit review next year to revisit actions from the previous audit.	The Committee congratulated the team for the successful rollout of the electronic prescribing system.
Cyber Security	Work progressed at pace on the agreed cyber audit action plan,	Cyber security continued to be

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.

Report	focusing on reducing risk and system updates.	highlighted as a key risk to the Trust. This would be reflected in the BAF.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items not Rated		
Finance and Resources Committee Terms of Reference	Digital Risk Register	Finance Systems Upgrade
ICS Update		

Investments			
Case	**Comments**	**Approval**	**Actions**

Impact on Board Assurance Framework (BAF)
Executives had fully reviewed BAF risks on 12 December; new risks would fully reflect the current situation of the Trust and would be presented to the Committee in the new year.

KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 24 November 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
Financial Performance Report	Key points were noted as follows: • The Trust reported a £10.7m deficit, which was £8.9m adverse to plan. The Trust continued to see the same key drivers to the position that had been reported to the Committee throughout the year. • The in-month position was a £180k surplus, in line with plan. • The run rate had reduced and was £600k more favourable than expected, however this had been achieved through the release of GenMed provision. • There had been a significant deterioration of the performance of the Medicine division, with work ongoing to understand the position and the mitigations that could be put in place to address. This was highlighted to the Committee as an area of particular concern, as the position was not sustainable and further divisional support was required. The Committee noted that a review of the approach to divisional meetings and executive reviews was underway to protect staff time and ensure that meetings were effective and adding value.	The Committee was concerned about the financial performance of the Medicine division, but noted the change of approach and additional actions in place.
Financial Recovery Plan	In response to an unmitigated forecast outturn deficit position of £24.4m in month five, a recovery plan was created to achieve a balanced financial position for the Trust. A number of actions continued and had resulted in an improved position, however there remained a significant deficit to address.	The Financial Recovery Plan would continue to be reviewed and implemented with a further update at December's meeting. The Committee noted the mitigated position of £9.9m, which was an improvement of £3.7m from the previous month.
Medium Term Financial Plan	The plan highlighted the Trust's underlying recurrent sustainability challenge of c£69m as at the end of 2022-23. A number of national planning assumptions were unknown, with internal assumptions utilised to populate the presented model. All key NHS partners within the ICS were developing a Plan to collate a five-year position for the local system.	The Committee welcomed the report as a roadmap and looked forward to the next iteration. Further details would be available during December, along with an understanding of the underlying position of the system.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Digital Transformation Report	Four key work areas were set out in the newly formatted report: Electronic Patient Record; Clinical Systems Optimisation; Infrastructure and Cyber; Business Intelligence. The Committee particularly noted cyber risks as a key threat to the organisation.	A cyber security BAF risk would be developed. The Committee noted the successful EPMA rollout.
Financial Sustainability	In month, the gap of the full £13.2m target had reduced by £0.8m, driven by non-recurrent actions taken by the Women's and Children's and Diagnostics and Specialties divisions. Additional mitigations to further close the savings gap were in	Systemwide opportunities would be incorporated into future reports. The work that Newton had completed would be showcased at a future

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.

	place and additional productivity work ongoing to address.	Committee meeting.
Capital Programme Report	The Trust had submitted a capital expenditure plan of £67.1m, with an additional £3.8m approved, resulting in a total of £70.9m. As at the end of October, the Trust had goods delivered, works done or services received to the value of £20.5m; £8.1m behind plan.	There was some concern noted around the number of new projects and the capacity of the organisation to manage deliverability.
Oversight Framework	The Trust was currently in segment 3, due to urgent and emergency care (including ambulance handover delays, and emergency department 12-hour waits), quality (including maternity safety support programme, and the CQC Requires Improvement rating).	None.

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

Items not Rated		
Finance and Resources Committee Terms of Reference	Digital Risk Register	Budget Setting Methodology

Investments			
Case	**Comments**	**Approval**	**Actions**
Vascular Theatre Business Case	None.	Approved.	None.

Impact on Board Assurance Framework (BAF)
Executive review of BAF risks to take place on 12 December. Cyber security BAF risk would be developed.

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	14	Enclosure Number:	8c
Date	12 January 2023		
Title	M8 Financial Performance Report		
Author /Sponsoring Director/Presenter	Hollie Day, Caroline Parker, Craig Marshall Karen Johnson		

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

Summary of Report

Purpose

This purpose of this report is to present the financial position of the Trust at Month 8.

Month 8 overview

- The Trust is reporting a year-to-date deficit of £4.9m deficit which is £3.3m adverse to plan. This includes one-off benefits of £12m, of which £8m were released in Month 8.
- The Trust is maintaining the planned forecast breakeven position.
- The ICS is required to breakeven for the year. At month 8, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan, however there are risks in these forecasts.
- The ICS year-to-date (YTD) deficit position of £3.3m is £2m adverse to plan and is the result of a £3.2m adverse to plan position from GHFT, and a £1.2m YTD surplus position at GHC.

Capital

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m.

As of the end of November (M8), the Trust had goods delivered, works done or services received to the value of £28.4m, £4.1m behind plan.

Next Steps

The financial position at month 8 continues to be pressured. Regular meetings with the Surgery and Medicine Divisions will continue and these meetings will provide support from finance, HR and PMO to the divisions to help manage the financial position.

Focus now turns to the forecast position for the year. From December divisions will be held to their forecast variance and this will be the control total against which they will be monitored for the remainder of the financial year.

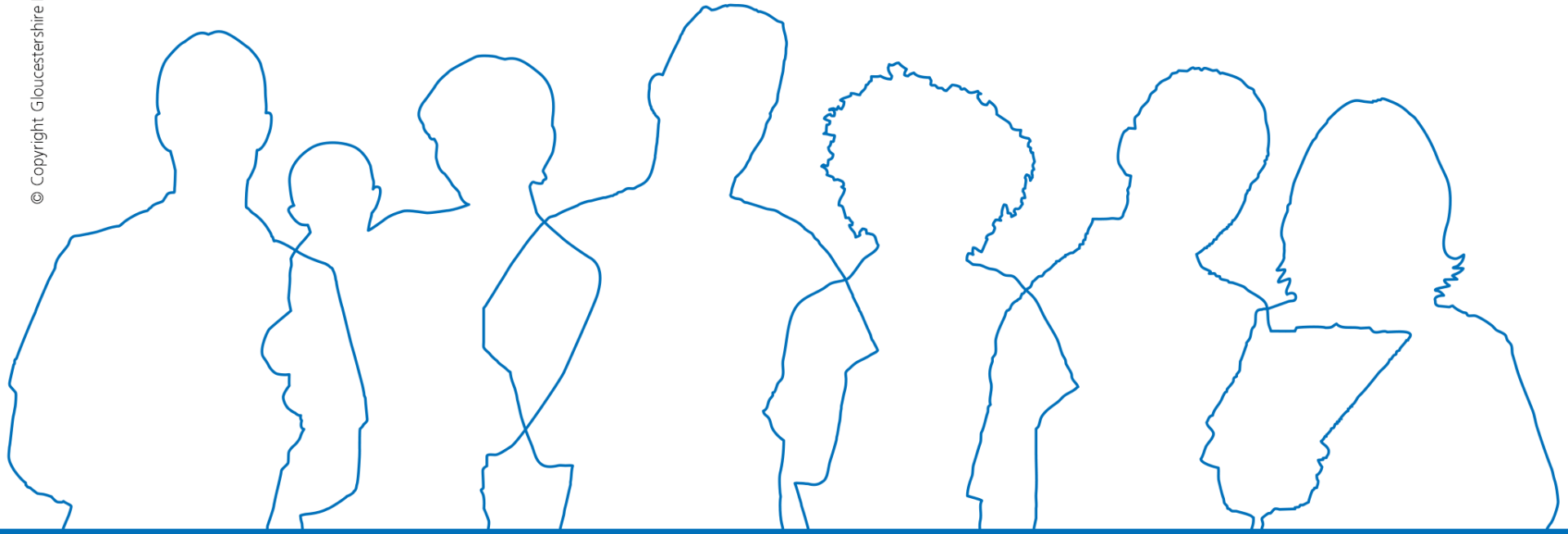
Conclusions

The Trust is reporting a year-to-date deficit of £4.9m which is £3.3m adverse to plan. The Financial Recovery Plan is being implemented and reviewed with updates reported to Finance and Digital Committee.
Recommendation
The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood.
Enclosures
Financial Performance Report Month 8

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 30th November 2022



Revenue & Balance Sheet

Director of Finance Summary

System Overview

The ICS is required to breakeven for the year. At month 8, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan.

The ICS year-to-date (YTD) deficit position of £3.3m which is £2m adverse to plan. This is the result of a £3.2m adverse to plan position from GHFT, and a £1.2m YTD surplus position at GHC.

Month 8

M8 Financial position is reporting a deficit of £4.9m which is £3.3m adverse to plan (£3.2m after adjusting for donated assets). The in month position is £5.8m surplus which is £5.6m favourable to plan. The deficit is driven by :

- Underperformance on out of county contracts of £2m and underperformance on pass-through drugs & devices overhead income £1m
- Divisional pay pressures of £5.8m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands. Of this, £3m is for RMNs and escalation.
- Pay Award pressure of £1m
- Non pay pressures within divisions of £4.6m net due to clinical supplies, outsourcing and laboratory reagent costs.
- Additional income (mainly Covid out of envelope and prior year releases) in divisional positions £2.5m
- Financial Sustainability pressure of £3m
- GMS energy inflation pressure of £1m
- Corporate areas are £1.6m net underspent YTD. The position includes an accrual of £1m for digital costs which assumes that the budget will be fully spent by the end of the year.
- Non recurrent benefits of £12m including release of Gen Med VAT provision for service and capital of £4.4m relating to prior year and M1-7. Also includes 100% release of the health & well being day accrual £2.8 and release of Spec Comm ESRF costs £2.1m

The Financial Sustainability Plan (FSP) target for the Trust is £19m, of which £4.2m remains unidentified, meaning the efficiency requirement will become higher as the year progresses. The M8 forecasted position represents an improvement over the M7 full year forecast of £0.6M, driven by £0.5M non-recurrent actions taken within Corporate division and a small improvement in the medicines optimisation programme within surgery. The M8 YTD position includes FSP delivery of £10.0m against a target of £11.5m which is an under-delivery of £1.5M.

Director of Finance Summary

Total activity in M8 was 96% of the same period in 19/20. Day cases and outpatient activity has increased from prior month, whilst Inpatient, ED attendances and Non Elective activity has reduced.

The financial position remains under significant pressure despite releasing £8m of non recurrent benefits into M8. These are one-off mitigations that had been identified as part of the Financial Recovery Plan. The release of these benefits means that the run rate improved by £5.8m and is £7.4m better than forecast (pre-mitigations). Divisional positions have remained broadly in line with forecast for the month with the exception of pass-through drugs costs which have increased.

Month 8 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £4.9m deficit		M8 Financial position is reporting a deficit of £4.9m which is £3.3m adverse to plan.
Income is £452m YTD which is £5m adverse to plan		M8 overall income position is reporting £452m income which is £5m adverse to plan. The income variance is driven by income plan shortfall of £5.9m (which is offset by provision released against non pay), underperformance of activity on out of ICS contracts c£2m and less than expected pass through drugs c£2.8m which sees a corresponding underspend in divisional expenditure budgets.
Pay costs are £287m YTD which is £4.2m adverse to plan		Pay costs are £287m YTD which is £4.2m adverse to plan. The YTD position includes a one off benefit of c£2.8m. Without this pay would be overspent by £7m YTD driven by pay award pressure of £1m and the use of temporary staffing in both Medicine and Surgery Divisions for Nursing and Medical staff. The month 8 position (excluding one off benefit) includes Substantive staff underspend of £32.8m offset by overspends in Agency (£13.7m) and Bank/Locum (£23.8m). The total contracted vacancies in month 8 are 718 WTE.
Non Pay costs are £170.3m YTD which is £6m favourable to plan. This includes Non-Operating Costs.		**Non Pay costs (including non-operating costs) are £170.3m YTD which is £6m favourable to plan.** The YTD position includes a one off benefit of c£9.3m and the release of a provision to offset the income shortfall of £5.9m. Without this non pay would be overspent by £9m YTD. The main drivers of the non pay overspends include inflation £1.2m, supplies & services £4m, and FSP shortfall £3m.
Delivery against Financial Sustainability Schemes		Total efficiencies for the Trust are £19m which consist of £4.2m Covid reduction, £1.6m GMS savings and £13.2m Trust wide efficiencies. At month 8, £10m efficiencies have been delivered YTD. Forecast delivery is £14.8m which is a shortfall of £4.2m due to unidentified schemes.
The cash balance is £65.2m		Cash has reduced by £13m due to last month including the receipt of quarterly payment in advance from HEE.

Oversight Framework – Financial Matrix

Gloucestershire Hospitals
NHS Foundation Trust

The purpose of the NHS Oversight Framework is to:

- ensure the alignment of priorities across the NHS and with wider system partners
- identify where ICBs and/or NHS providers may benefit from, or require, support
- provide an objective basis for decisions about when and how NHS England will intervene.

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

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

The Financial Matrix used by the Trust to monitor the Finance and Use of Resources for Month 8 YTD position is below. The System is also required to monitor against these metrics plus achievement of Mental Health Standard.

Group Position	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Financial efficiency – variance from efficiency plan	11,500	10,000	(1,500)
Financial stability – variance from breakeven*	(1,631)	(4,972)	(3,341)
Agency spending	(3,091)	(16,772)	(13,681)
before donated assets adjustment			

The Trust is adverse to plan against each metric. The Financial Recovery Plan was developed and is being acted upon to improve the position although an adverse position is forecast to continue for the remainder of 2022/23.

M8 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of November 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 November the Group's consolidated position shows a deficit of £4.9m which is £3.3m adverse to plan (before donated asset adjustment).

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 8 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	420,331	410,489	(9,842)			0	420,331	410,489	(9,842)
PP, Overseas and RTA Income	4,261	3,175	(1,086)			0	4,261	3,175	(1,086)
Other Income from Patient Activities	8,335	8,060	(275)			0	8,335	8,060	(275)
Operating Income	25,520	28,007	2,487	40,821	39,300	(1,521)	24,405	30,517	6,111
Total Income	**458,447**	**449,731**	**(8,716)**	**40,821**	**39,300**	**(1,521)**	**457,332**	**452,240**	**(5,092)**
Pay	(268,428)	(271,938)	(3,509)	(14,462)	(15,182)	(721)	(282,702)	(286,932)	(4,230)
Non-Pay	(184,629)	(177,237)	7,387	(24,536)	(23,100)	1,436	(167,419)	(163,733)	3,686
Total Expenditure	**(453,058)**	**(449,175)**	**3,878**	**(38,998)**	**(38,283)**	**715**	**(450,120)**	**(450,664)**	**(544)**
EBITDA	**5,389**	**556**	**(4,838)**	**1,823**	**1,018**	**(805)**	**7,212**	**1,576**	**(5,636)**
EBITDA %age	**1.2%**	**0.1%**	**(1.1%)**	**4.5%**	**2.6%**	**(1.9%)**	**1.6%**	**0.3%**	**(1.2%)**
Non-Operating Costs	(7,021)	(5,531)	1,494	(1,823)	(1,018)	805	(8,843)	(6,548)	2,295
Surplus / (Deficit)	**(1,631)**	**(4,975)**	**(3,344)**	**(0)**	**0**	**0**	**(1,631)**	**(4,972)**	**(3,341)**
Dontated Asset Adjustment	258	400	142				258	400	142
Adjusted Surplus / (Deficit)	**(1,373)**	**(4,575)**	**(3,202)**	**(0)**	**0**	**0**	**(1,373)**	**(4,572)**	**(3,199)**

* Trust position excludes £26.8m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £36.7m of inter-company transactions, including dividends

Balance Sheet

Gloucestershire Hospitals
NHS Foundation Trust

	Group Closing Balance 31st March 2022 £000	GROUP Balance as at M8 £000	B/S movements from 31st March 2022 £000
Non-Current Assests			
Intangible Assets	13,760	11,959	(1,801)
Property, Plant and Equipment	304,585	341,926	37,341
Trade and Other Receivables	4,414	4,327	(87)
Investment in GMS	0	0	0
Total Non-Current Assets	**322,759**	**358,212**	**35,453**
Current Assets			
Inventories	9,370	10,660	1,290
Trade and Other Receivables	26,360	21,028	(5,332)
Cash and Cash Equivalents	71,530	69,813	(1,717)
Total Current Assets	**107,260**	**101,501**	**(5,759)**
Current Liabilities			
Trade and Other Payables	(80,104)	(92,221)	(12,117)
Other Liabilities	(14,401)	(6,197)	8,204
Borrowings	(3,626)	(3,752)	(126)
Provisions	(24,089)	(16,225)	7,864
Total Current Liabilities	**(122,220)**	**(118,395)**	**3,825**
Net Current Assets	**(14,960)**	**(16,894)**	**(1,934)**
Non-Current Liabilities			
Other Liabilities	(5,971)	(5,609)	362
Borrowings	(34,064)	(57,354)	(23,290)
Provisions	(3,600)	(3,600)	0
Total Non-Current Liabilities	**(43,635)**	**(66,563)**	**(22,928)**
Total Assets Employed	**264,164**	**274,755**	**10,591**
Financed by Taxpayers Equity			
Public Dividend Capital	361,345	376,908	15,563
Equity	0	0	0
Reserves	19,823	19,823	0
Retained Earnings	(117,004)	(121,976)	(4,972)
Total Taxpayers' Equity	**264,164**	**274,755**	**10,591**

The table shows the M8 balance sheet and movements from the 2021-22 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. To date, there has been £11.8m of additional capital approved bringing this up to £78.9m

YTD Position

As of the end of November (M8), the Trust had goods delivered, works done or services received to the value of £28.4m, £4.1m behind plan.

A breakeven forecast outturn has been reported to NHSI in the M8 Provider Financial Return (PFR).

22/23 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. To date, there has been £11.8m of additional capital approved bringing this up to £78.9m.

The current agreed programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£11.9m), Right of Use Assets (£15.4m), IFRIC 12 (£0.8m), Government Grant (£3.2m) and Donations (£1.3m)

There have been funding awards that are nearing full approval that is not currently reflected in the position that will be added to the reported position when full approval is gained. These include National Programme funding for a Digital Pathology Interface (£122k) and a 5th Orthopaedic Theatre at CGH (£2m).

The breakdown of additional funding that has been secured since the plan and those known funds that have yet to be secured are shown below.

Additional Funding Secured in year	£000's in 22/23
MRI Acceleration Software Upgrade	165
Diagnostic Digital Capability Programme - Pathology and Imaging	755
Cyber 22/23 – Firewalls	99
Front Line Digitisation - 2nd Tranche 2223	2,200
PSDS 3a Salix	3,241
Paediatric MH UEC	362
Discharge waiting area GRH	1,500
Avening & Prescott wards refurb CGH	1,572
Community Diagnostic Centre	1,941
Total Additional Funding Secured in year	**11,835**

Known funding bid submissions - unsecured at M8	£000's in 22/23
Digital Pathology Interface	122
5th Orthopaedic Theatre at CGH	2,000
Total unsecured in 22/23	**2,122**

22/23 Programme Spend Overview

Gloucestershire Hospitals NHS Foundation Trust

As of the end of November (M8), the Trust had goods delivered, works done or services received to the value of £28.4m, £4.1m behind 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**	**Allocation**	**Actual**	**Variance**
Medical Equipment	Operational System Capital	54	41	13	1,554	1,241	313	2,223	2,228	(5)
Digital	Operational System Capital	175	631	(455)	3,318	2,718	600	5,634	5,429	205
Estates	Operational System Capital	1,951	511	1,440	6,154	2,463	3,691	16,548	17,179	(631)
IDG Contingency	Operational System Capital	0	0	0	0	0	0	609	609	0
National Programme - Digital	National Programme	282	282	1	1,534	1,776	(242)	6,569	6,568	1
National Programme - Non Digital	National Programme	0	1,566	(1,566)	0	1,585	(1,585)	3,434	2,976	458
National Programme - CDC	National Programme	0	0	0	0	0	0	1,941	1,941	(0)
STP Programme - GSSD	STP Capital - GSSD	1,235	2,966	(1,731)	18,941	16,254	2,688	21,280	21,281	(1)
Donations Via Charitable Funds	Donations via Charitable Funds	60	0	60	391	0	391	1,281	781	500
Grant	Grant	0	355	(355)	0	355	(355)	3,241	3,241	0
IFRIC 12	IFRIC 12	68	68	0	545	544	1	817	817	0
Right of Use Asset	Right of use assets adjustment	0	1,414	(1,414)	0	1,414	(1,414)	15,355	15,355	0
Gross Capital Expenditure		**3,826**	**7,833**	**(4,007)**	**32,437**	**28,350**	**4,087**	**78,931**	**78,404**	**527**
Less Donations and Grants Received	Donations via Charitable Funds	(60)	(355)	295	(391)	(355)	(36)	(4,522)	(4,022)	(500)
Less PFI Capital (IFRIC12)	IFRIC 12	(68)	(68)	(0)	(545)	(544)	(1)	(817)	(817)	(0)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Operational System Capital	27	27	0	212	212	0	318	318	0
Total Capital Departmental Expenditure Limit (CDEL)		**3,724**	**7,436**	**(3,712)**	**31,713**	**27,663**	**4,051**	**73,910**	**73,883**	**27**

The main contributors for being behind plan are;

The **Gloucestershire Hospitals Strategic Site Development** project - reported previously the difference is to begin to recover from November which can be seen by the high in-month spend and is backed up by the contractor's most recent forecast spend profile.

The **Estates programme** - both IGIS and theatres refurbishment projects experienced delays compared to the original plan. Costs for these projects are now being incurred with the revised spend trajectory included within the forecast.

- The IGIS delay is primarily driven by a delayed start of the Kier construction works package. Works had been expected to start on 5th September but have now been delayed to 5th December in response to a clash of crane access and phasing interactions with the GSSD project.
- The theatre's refurbishment project experienced delays in the design and awarding of the contract. The programme is on course to deliver the full £2.4m in 22/23 with the remainder in early 23/24

A breakeven forecast outturn has been reported to NHSI in the M8 Provider Financial Return. Although there are concerns about slippage materialising and further funding awards that will increase the back-ended nature of the programme and concerns about deliverability and risk.

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Committee is asked to:

- Note the Trust is reporting a year to date deficit of £4.9m which is £3.3m adverse to plan.
- Note the Trust balance sheet position as of the end of November 2022.
- Note the Trust capital position as of the end of November 2022.
- Note the next steps.

Authors:	**Hollie Day – Associate Director of Financial Management** **Caroline Parker - Head of Financial Services** **Craig Marshall – Project Accountant**
Presenting Director:	**Karen Johnson – Director of Finance**
Date:	**January 2022**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	**14**	**Enclosure Number:**	**8d**
Date	12 January 2023		
Title	Digital Transformation Report		
Author /Sponsoring Director/Presenter	Anna Morton, Programme Director - Digital Mark Hutchinson, Executive Chief Digital & Information Officer		

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

Summary of Report

This paper provides an update on projects being delivered and overseen by the Digital Transformation Office. It brings together the previous 'project update' and 'EPR update' reports into one paper and includes reporting in line with the four main work areas:

- Electronic Patient Record (Sunrise EPR)
- Clinical Systems Optimisation
- Infrastructure and Cyber
- Business Intelligence

The importance of improving GHFT's digital maturity in line with our five-year strategy has been realised throughout the transformation programme. 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 Transformation Report

PUBLIC BOARD OF DIRECTORS – JANUARY 2023

DIGITAL TRANSFORMATION REPORT

1. Executive Summary

This paper provides the Finance & Digital Committee with updates on projects being delivered and overseen by the Digital Transformation Office. This now also includes EPR programmes. The projects are categorised as four digital delivery areas:

- Electronic Patient Record (Sunrise EPR)
- Clinical Systems Optimisation
- Infrastructure & Cyber
- Business Intelligence

This work plan continues to deliver 55 projects, as well as all the crucial, ongoing, BAU operations of the Digital and IT shared service departments, against the agreed delivery plan for 2022/23. This delivery is managed despite a high vacancy factor, with 74 vacancies against CIO, and 18 against CITS. Of these vacancies, 95% have VCPs instigated and logged and recruitment is underway.

1.1 Highlights this period

Electronic Prescribing

ePMA went live as planned across the Trust and is now in use for all Cheltenham adult inpatients, as well as theatres and ED and all Gloucester adult inpatients, as well as theatres and ED. The digital change support has been positively received by staff.

All prescribing, reviewing and administering of medications in these areas is now happening on Sunrise EPR.

This impacts all registered nurses, AHPs, pharmacists and clinicians working on these wards/areas and the Trust has moved to:

- electronic prescribing of medicines;
- electronic administration record;
- electronic pharmacy clinical check (validation);
- an improved medicine management process by interfacing with the pharmacy stock control system (EMIS);
- an electronic Discharge Note (eDN) including discharge medications;
- a new discharge summary module in EPR (no longer in TrakCare).

ICE OpenNet

ICE OpenNet has been deployed successfully, providing clinicians with enhanced access to the patient's diagnostic journey and improving efficiency.

2. RAG Status Updates

The reports below provide more detail on the status of projects within the Programme of Work categories.

The current status of projects:

EPR	Clinical Systems Optimisation	Infrastructure and Cyber	Business Intelligence
8	15	23	9

Complete or in closure	On Hold	Red Rated	Amber Rated	Green Rated	Discovery Phase
13	5	1	19	11	7

Red	Significant issues with the project – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the project performance, project is close to tolerance level
Green	Project is on track
Blue	Complete & Closed (or In Closure)

Since the last report one project has been completed and closed. The project closed is:

- ICE OpenNet

3. Conclusion

There are a significant number of digital projects underway across the organisation, all supporting the organisation's commitment to reaching HIMSS Level 6; as well as increasing efficiency, realising quality benefits and improving patient safety and care.

All of our programmes underpin our commitment to using Sunrise EPR to transform the way that we deliver care and make the most of the clinical and operation intelligence it now provides.

- Ends -

NHS
Gloucestershire Hospitals
NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit and Assurance Committee, 22 November 2022

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
None.		

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit Progress Report	The Committee discussed the recommendation that the Mental Health Act review was removed from this year's plan and carried out in 2023-24, with scoping work into the Advanced Health Practitioners review brought forward. The Committee was concerned with the change in plan but noted the significant operational pressure of the mental health team. Two audits had been completed since the last Committee meeting, and planning and fieldwork had commenced in another four areas. ***Follow up Report*** Three recommendations had been completed, with four overdue following no response, and progress made on six other recommendations. The Committee was advised that 89% of all 2019-20 recommendations had been completed, 100% of 2020-21 recommendations complete, and 48% of 2021-22 completed. The Committee discussed asset management and the need to ensure there was a viable tracking system to monitor small value assets once they had left the organisation. ***Risk Maturity Assessment*** The review identified a number of areas of good practice, including clear corporate objectives which linked to the strategic objectives in the Board Assurance Framework, and a well-embedded risk management process. Areas for improvement included enhancing job descriptions, ensuring robust appraisal processes, and reviewing divisional analysis of risk registers, formulation of risks and timescales. The review highlighted discrepancies in levels of detail recorded and recommended enhancement and harmonisation and uniformity of recording. Another recommendation was made in relation to considering the Trust's risk appetite statement, which was last refreshed in 2020.	The 2023-24 internal audit programme would be reviewed to consider the best plan to reduce slippage and embed an early flagging system to alert auditors and the Trust to any issues that might cause delay. Additional assurance would be sought through Quality and Performance Committee to identify any other factors that may be affecting engagement with internal audit. A discussion would take place with Executives to agree the change to the audit plan. The Trust was currently reviewing its risk management processes and registers to ensure efficiency and consistency.
HFMA Financial Sustainability Audit	The Trust had been able to demonstrate good compliance against the set questions within the assessment for 49 out of the 57 questions where the Trust had initially scored itself a 4 or 5. However, further testing identified six questions where evidence did not support the rating and required further development to ensure systems and processes were improved, or additional evidence provided.	The action plan would be incorporated into business as usual.
Counter Fraud Report	Key points were noted as follows: • The Trust was reviewing its faster payment scheme to ensure processes were secure against potential cyber security threats. • Four investigations were ongoing; the Committee noted the outcomes of the investigations that had been closed.	None.
Risk Assurance Report	In September, two risks had been added to the Trust's risk register; one risk had been downgraded to a divisional risk, and one risk had been closed. There had been no Risk Management Group in October, and no changes made to the register at November's meeting.	Executives would discuss the elements of the rollout and implementation of the Datix project to ensure future

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 expressed some concern in relation to the risks that reflected a stressed operational environment, with a particular increase in Emergency Department reporting, staffing issues and lack of resilience. The Trust was currently reviewing measures it could put in place to address the risks. Consideration would be given to which level of risk score should be reviewed at Trust level as part of the work to ensure risk management processes were as efficient as possible.	projects are managed effectively.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
External Audit Progress Report	The Committee was advised that planning for the 2022-23 audit was underway, with dates being finalised.	The plan for 2022-23 audit would be presented in January, along with a lessons learned report into the audit for 2021-22.
Losses and Compensations Report	The Committee noted 12 ex-gratia payments totalling £5,584.20 and approved the write-off of 374 invoices with a total credit value of £15,821.77.	None.
Single Tender Actions Report	Nine waivers had been processed within the reporting period, with a value of over £25k. Three retrospective waivers had been reported which were all with the same company; the Committee noted that this had been rectified. Training sessions had been held to ensure there would be no further incidences.	Director of Finance to clarify the total amount spent on the three retrospective waivers.
GMS Report	The Committee received GMS' annual accounts for information and noted the successful implementation of the Micad system upgrade. The Health and Safety Executive was expected in relation to the pseudomonas incident.	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
Risk rationalisation continued, with good progress being made. An executive session was planned in December for a full review. Consider Sustainability and whether this could be a separate risk, or strengthened within the Estates risks.		