Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
10.15, Thursday 9 March 2023
Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			10.15
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 12 January 2023**	Approval	Enc 1	10.20
5	**Matters arising from Board meeting held on 12 January 2023**	Assurance		
6	**Patient Story** *Katherine Holland, Patient Experience Manager*	Information	Presentation	10.25
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	10.45
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	11.00
9	**Corporate Governance** *Kat Cleverley, Trust Secretary* • **Scheme of Delegation, Standing Financial Instructions, Standing Orders**	Approval	Enc 4	11.10
10	**Trust Risk Register** *Mark Pietroni, Medical Director*	Assurance	Enc 5	11.15
11	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director* • **Staff Survey Results** *Claire Radley, Director for People and Organisational Development*	Assurance	Enc 6 Presentation	11.20
12	**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 7	11.50
	Break (12.20-12.30)			
13	**Maternity Safer Staffing Report** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Enc 8	12.30
14	**Fit for the Future 2 Business Case** *Simon Lanceley, Director of Strategy and Transformation and Micky Griffith, Programme Director*	Approval	Enc 9	12.40
15	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director, and Karen Johnson, Director of Finance* • **Capital Plan 2023-24** • **Finance Strategy**	Assurance Approval Approval	Enc 10	12.50
16	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 11	13.20
17	**Any other business**		None	13.30
18	**Governor Observations**			
	Close by 13.35			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 12 January 2023, 10.15, Gloucester Guildhall			
Chair	Deborah Evans	DE	Chair
Present	Marie-Annick Gournet	MAG	Non-Executive Director
	Robert Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Kaye Law-Fox	KLF	Associate Non-Executive Director/Chair of GMS
	Deborah Lee	DL	Chief Executive Officer
	Alison Moon	AM	Non-Executive Director
	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
Attending	Abdul Arain	AA	Associate Specialist, Emergency Medicine (item 6 only)
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Katherine Holland	KH	Patient Experience Manager (item 6 only)
	Lisa Stephens	LS	Head of Midwifery (item 11 only)
	Jessica Wickett	JW	Senior PA, Emergency Medicine (item 6 only)
Observers	Three governors observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting. The NHS was under significant pressure; DE expressed her gratitude to all colleagues within the Trust for everything they did, and also to executive colleagues who had managed the recent industrial action. DE advised the Board that she had visited the Patient Advice and Liaison Service (PALS) yesterday and had witnessed a very positive, skilled team working alongside patients every day. DE had also visited the discharge lounge and could see what a great addition this would be for patients. The Trust had also performed very well in the recent National Maternity Users Survey, and congratulations were passed on to the team.
2	**Apologies for absence** Claire Feehily, Non-Executive Director, Mark Hutchinson, Executive Chief Digital and Information Officer, Sally Moyle, Associate Non-Executive Director, and Qadar Zada, Chief Operating Officer
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 8 December 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 8 December 2022** All matters arising were updated.
6	**Staff Story**

	AA and JW attended to present an initiative that they had implemented within their department. The Favourable Event Reporting Form (FERF) aimed to recognise good practice and positive events, with members of staff nominating their colleagues. A survey had been undertaken to measure the success of the project, and results indicated that staff really appreciated the feedback. Trainees had reported that it was the number one thing they liked about the department. AA noted that the project's success has been proven in the Emergency Department, and many other teams had expressed an interest in the initiative. Wellbeing and staff morale was more important than ever, and the system was already designed and tested, having now been run for five years. The Board was asked to consider rollout across the Trust to help create, support and promote a positive feedback culture and boost staff morale. Initial IT support would be required to implement the QR code system, and dedicated administrative support would be needed. AA and JW clarified that the system operated via mobile phones, noting that staff members tended to reflect and submit their nominations overnight. MN asked about the time commitment from the people administering the system; JW responded that some nominations were easier than others, with the most time-consuming activity being the searching of email addresses and line manager details. MP remarked that he had both sent and received FERF nominations and it was a very positive experience. CR noted that there was some work to do on the Trust's recognition and reward strategy, which this initiative could form part of. RG queried whether there was an element of novelty about the project that may have caused usage to reduce, and reflected on whether operational pressures had affected submissions. AA noted that there was high staff turnover and agency use which could impact the project, however feedback suggested that staff were regularly using the system and the number of FERFs had remained stable over time. The Board was supportive of the project, and thanked AA and JW for investing so much in their staff. CR would consider the initiative as part of the wider work on staff reward and recognition.
7	**Chief Executive's Briefing** DL briefed the Board as follows: • The Trust remained operationally challenged, with longer waiting times in emergency departments, a deterioration in ambulance handover and response times, and higher levels of patients being cared for in temporary settings. The position had been exacerbated by levels of acuity. • Despite the challenges, the Trust had not cancelled any cancer patients, and credit was due to the operational teams that had enabled this position. • The Trust had supported nursing colleagues during industrial action, whilst keeping the hospitals safe. The emergency departments had been significantly impacted by paramedic industrial action; however, planning had enabled staff to work collaboratively with ambulance colleagues to facilitate additional patient cohorts. Further industrial action was planned over the next few weeks. • The Trust's dedicated winter pressures ward had opened at Cheltenham General Hospital, and the Discharge Lounge at Gloucestershire Royal Hospital was now operational. • The Board was advised that the CQC improvement notice issued to radiology services following their inspection in November had been removed. • Operational Planning guidance for 2023/24 had been released and key metrics set out for trusts to achieve. • DL had appealed to local MPs in relation to the extension of staff benefits, including parking arrangements. The Board was pleased to note the positive maternity survey results, and passed on congratulations to the team.

8	**Board Assurance Framework** Executives had reviewed the risks on 12 December, and a summary of newly agreed risks was presented. KC advised that the new risks better reflected the Trust's current position and that they would be taken through Committees during January and February with a view to present the full BAF in March.
9	**Trust Risk Register** The Board received the report, noting that three new risks had been added, and one downgraded. AM questioned the risk related to lithium batteries and the wider concern around the poor installation work and sign off process. SL confirmed that this would form part of the rectification plan.
10	**Quality and Performance Committee Report** AM advised the Board of key issues discussed during December's meeting. A continually pressured position was seen, along with huge efforts to provide high quality reports which help the Committee to hold effective assurance discussions. A newly formatted Quality Performance Report had been received, with different metrics included. The Committee had welcomed the new report, and noted that the narrative was a work in progress. Concern remained around pre-empting and boarding patients, and the Committee considered the long-term goal for the process. The Committee had been advised that the Trust was not compliant against the Maternity Incentive Scheme for Year 3; the evidence was currently under review. The Annual Equality Report had been received, which was welcomed by the Committee and commended as a much-improved report; a number of improvements had been made during the year, which was encouraging. The Committee had particularly focused on the water safety briefing which had provided some assurances around active monitoring and engineering controls in place. **Quality and Performance Report** Other key points were highlighted as follows: • The CNO and COO had met with operational teams to discuss boarding, which was acknowledged as suboptimal care and not the standard that the Trust wanted to provide, however was a response to urgent and emergency care pressures affecting ambulance response times. The COO had made significant progress in strengthening operational teams. • There was an opportunity to achieve full compliance for Year 4 of the Maternity Incentive Scheme; the plan would be presented to the Board today. • There had been one MRSA infection recorded. • An increase in mixed sex accommodation breaches had been reported. • Further work was required to understand the apparent decrease in falls, which would be reported through the Committee. • PALS contacts related to boarding were now being reported. • An action plan associated with water safety was in place, and monitored through the Infection Prevention and Control team and Quality and Performance Committee. There was ongoing active monitoring of controls and actions. MP advised the Board of some concern related to the rising metrics around mortality data; potential coding issues were under review, and MP noted that patients staying longer in hospital meant they were more likely to die in hospital. However, this was not an acceptable explanation and advised that congestion with the Emergency Department was a key driver. The Board discussed the new Quality and Performance Report, noting that further work was required around the dashboard and associated narrative to ensure it was fully usable.
11	**Maternity Incentive Scheme**

	The Trust was not currently achieving all ten maternity safety actions, as assurance had not been provided to the Local Maternity and Neonatal System (LMNS) leads; three out of the ten actions were fully compliant. The Trust still had an opportunity to improve the position as submission was required on 2 February; the CQC section 29a warning notice and inadequate rating for maternity services would be declared as part of the submission. AM encouraged a review of the Year 3 self-assessment to look at areas where the Trust was not compliant to ensure a robust plan for future years. RG asked about the consequences related to submission of declaration that was not fully compliant. LS noted that the Trust may be identified as requiring additional support, and DL noted that there may be a financial impact. KJ queried whether there was enough time to turn some of the 'not met' areas into full compliance. The Board was advised that the information that was required to be reported to Board had been reported, however there were some non-compliance issues related to other areas that needed to be addressed. The team planned to provide further evidence to the LMNS over the next two weeks before submission to try to improve the position. The Board **approved** delegated authority to the CNO and CEO to sign the Board declaration form.
12	**Guardian of Safe Working Hours Quarterly Report** The Board received the report, which detailed activity during the period 1 July to 30 September 2022. The number of exception reports had increased during the quarter, which was thought to be driven by current NHS pressures. However, the number of exception reports had fallen compared with the same quarter in 2021. The key driver behind this was multifactorial, but the reduced compared with 2021 may be a positive consequence of increased expenditure on locum staff to support existing staff members. RG asked how likely it was that there were issues that did not get reported. MP advised that it was a self-reporting system and therefore likely, however the Trust encouraged a culture of reporting. AM asked about the number of General Medicine vacancies; MP replied that there may be an issue with how HR data was presented, however there was a high number of vacancies in this area. MP and the Board thanked Jess Gunn for her work as Guardian of Safe Working Hours.
13	**Finance and Digital Committee Report** RG advised that the key issue from both November and December's meetings was the Trust's challenged financial position. There was increased robustness of divisional monitoring against control totals, and the Committee continued to be assured by the understanding of the systemwide position that was evident in reports. A discussion had taken place around the need for systemwide change, and how small changes made within the Trust can only go so far. The capital programme was in a better position than last year, however challenges remained to ensure spend by the end of 2022-23; the Committee had been assured that the monitoring process was robust. The financial strategy had been received and was welcomed by the Committee; it was a work in progress, but was generally supported. The Committee had been assured by the progress of the digital programme. **Financial Performance Report** Other key points were highlighted as follows: • The Trust reported a year-to-date deficit of £4.9m, which was £3.3m adverse to plan. The Trust maintained the planned forecast breakeven position. • The system was required to breakeven for the year which, if achieved, would entitle the Trust to additional funds. The system was working closely to achieve breakeven. • Activity remained below 2019-20 levels, but was broadly similar to what had been reported throughout the year. • In month, divisions had remained in line with their forecast, which was positive. • Operational planning guidance for 2023-24 had been released just before Christmas and was being worked through.

	• An additional £2m capital funding had been granted since the release of the report. Challenges remained around ensuring spend by the end of the financial year.
14	**Audit and Assurance Committee Report** MN advised that external audit planning progress was going well. Some concern had been raised on the slippage of the Mental Health Act internal audit review, but the Committee had approved the change as it was scheduled for 2023-24. The Committee had been supportive of the HFMA financial sustainability audit self-assessment, which internal audit had endorsed.
15	**Estates and Facilities Committee Report** MN verbally updated the Board. November was the Committee's final meeting before responsibilities were absorbed into the newly established Finance and Resources Committee. Gloucestershire Managed Services (GMS) vacancies remained high, with significant turnover; retention was a key issue. There had been a particular trend around health and safety incidents, which had raised concern and required further scrutiny. Clarity on reporting of health and safety would be included as part of the governance review.
16	**Any other business** BH asked if there was a recognition scheme for corporate staff, similar to the Favourable Event Reporting Form (FERF) initiative. DL advised that the Trust held Going the Extra Mile (GEM) rewards, which were more formal and considered. The Board was advised that if the Trust adopted the FERF model, it would include corporate staff. DE noted that this was RG's final Board meeting, and thanked him for everything he had done as Non-Executive Director, Vice-Chair and the very important role he had played as Chair of Finance and Digital Committee. The Board congratulated RG on his tenure and wished him the best for the future.
17	**Governor Observations** AH gave credit to staff who continued to work so hard under such challenging circumstances. It was felt that the Maternity Incentive Scheme would be useful to receive at a governor session. ME had been impressed by the Staff Story and felt it was very positive that members of staff were putting such initiatives in place for their colleagues, and encouraged active expansion of this to support general staff morale.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Maternity Incentive Scheme	The Board approved delegated authority to the CNO and CEO to sign the declaration form.		
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. **Update January:** The Board was advised that the report would be developed and would be discussed at People and Organisational Development Committee for governance oversight, and Quality and Performance Committee and GMS Board for information.	MHo February 2023	In progress

Gloucestershire Hospitals
NHS Foundation Trust

CHIEF EXECUTIVE OFFICER'S REPORT
MARCH 2023

1 Operational Context

1.1 Whilst still operationally very challenging, the Trust has bounced back from the loss of performance experienced in late December and early January and continues on an upward trajectory to further improvement. This is very good news for our patients and staff, and is the result of continued excellent joint working by all partners in our health and social care system.

1.2 The Trust significantly improved Category 2 ambulance response and is now regularly achieving the (revised) national standard of 30m minutes and in the most recent 7 days, achieved a mean Cat 2 response time of 25 minutes. With a new emphasis on the 4 Hour A&E target, I am pleased to report that the Trust was the strongest performer in the South West in the most recently published data; this is a particularly important patient experience metric although we still fall short of the 76% standard and this remains a focus of the Urgent and Emergency Care Improvement Board. However, these improvements continue to come on the back of operational decisions that have undoubtedly impacted on the quality of care for patients and the experience of staff. We remain committed to improving flow through and hospitals and, in doing so, eliminate the need for patients to be delayed in our Emergency Department and pre-empted to our wards.

1.3 Of particular note, are the improvements achieved in supporting patients with No Criteria To Reside (NCTR) to be discharged home or to onward care. This is attributable to a system wide improvement initiative called *Flow Friday.* At the outset of this programme 6 weeks ago, the Trust had 65 patients who had waited more that 50 days to be discharged; we currently have 8. Of particular note, was the discharge of two young patients who had been in our care for more than 180 days; one of whom is now reunited with her young family. Our focus has now turned to those patients who have waited longer than 40 days. Finally, and very importantly, this work has had learning at the centre of its approach and has identified process issues and gaps in services, that we are now seeking to address with the aim of eliminating all 50+ day delays (other than when the patient's clinical condition dictates that they remain i.e. they have criteria to reside).

1.4 The Trust continues to perform well in respect of elective waiting times and is one of a handful of Trusts on track to meet the national target of having no patients waiting more than 78 weeks at the end of March. The very significant focus on cancer is beginning to bear fruit with reductions in the number of patients waiting more that 62 days for their first definitive treatment following GP referral, from 402 at the start of the calendar year to 264 as of yesterday. However, our goal remains to achieve the standard of 85% of patients being treated within 62 days; our operational plan submission will propose that we will achieve the standard by the end of May 2023. Very positively, every speciality is on track to achieve the two-week wait standard for the first time since before the pandemic – this is a hugely important milestone in supporting delivery of the 62-day target. Finally, the Trust remains the only Trust in the South West delivering the Faster Diagnosis Standard which is considered the crucial measure of a positive patient experience. None of this would be possible without the hard work and dedication of our staff; operational teams have been asked to ensure that staff are supported and engaged in providing additional capacity with the appropriate oversight

of total hours worked. Unfortunately, the industrial action proposed by junior doctors, is likely to lead to a deterioration in our elective performance and experience for our patients.

1.5 The sigh of relief was palpable at the decision of the Royal College of Nursing (RCN) to stand down their proposed industrial action; fingers crossed that the planned talks lead to a resolution of the dispute. However, the Trust remains in industrial action planning mode following the recent announcement form the British Medical Association (BMA) that its junior doctor members intend to strike for three days from the 13th to 15th March with no planned derogations. Similarly, the British Dental Association (BDA) is mirroring the BMA action and the Hospital Consultants and Specialists Association has confirmed it will extend its planned one-day strike to align with the three days of industrial action planned by the BMA and BDA. Planning is very well underway however, it is highly likely that much of the elective work planned to take place over this period, will not be able to proceed. Finally, the GMB Union and Unison continue their strike action which will impact services provided by the South West Ambulance Trust and, again, planning for this is well advanced and informed by the learning from previous industrial action involving ambulance services.

2 Key Highlights

2.1 On Thursday the 9th March, the national staff survey results will be published. The results remain under embargo until 9.30am on the day of publication however we will be taking the opportunity to share the results in our public board. Claire Radley, Director of People will describe the work already in hand, and planned for the future, to respond to the issues that are reflected in the survey results and that we have previously heard from the Care Quality Commission and others in relation to the culture in our organisation and the operational challenges staff experience. These findings are not new and serve to reiterate the importance of pursuing with rigour and pace the work in hand throughout the Trust and the need to be bolder and more innovative in our approach.

2.2 This month we celebrated NHS Overseas Workers' Day and the 70 nationalities who make up our diverse organisation; we also took the opportunity to welcome the recent arrival of 37 international nurses. Later this month we will be joining colleagues from across the Trust at four half day sessions, to be held at Kingsholme Rugby Ground to evaluate our Trust against the NHS Equality Delivery System (EDS22). EDS22 is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The latest version of the EDS was published in autumn 2022.

2.3 EDS22 provides a focus for organisations to assess the impact of discrimination, stress, and inequality on patients and staff; providing an opportunity for organisations to support a healthier and happier workforce, which in turn will increase the quality of patient care.

2.4 Each workshop will be taking place at Kingsholme Rugby stadium. They will be highly interactive, and hopefully fun and informative for you as well. The purpose of each workshop is to

- Work in partnership to complete a guided evaluation of the Trust's activities in relation to the following:
  - Colleague health and wellbeing
  - Support for colleagues who experience abuse, harassment, bullying and physical violence
- Help to craft and identify a new set of Equality Objectives, which will become the focus of our EDI activities over the next 4 years

2.5 In recognition of the value that staff have told us they place on the 50% food subsidy, free soup and porridge and free drinks we have taken the decision to continue this next year. This decision was heavily influenced by the Board's discussion of last month regarding our strategic priorities and risk appetite. Following representation by the Trust's Green Council, free drinks will only be provided to staff using reusable cups and we will no longer provide plastic bottled water given the availability of drinking water in all of our restaurants and cafes.

2.6 I am pleased to announce that following the final General Medical Council (GMC) inspection of the Three Counties Medical School, the school will take its first intake of students in September 2023. The Trust is a strategic partner in the initiative and we will take approximately 20 students on placement although the majority of their clinical practice will be in community services and primary care. This is one of a handful of post-graduate programmes, with many of the students already holding a first degree in a healthcare related subject. Although a different curriculum and model to Bristol Medical School, it is very much the intention to ensure these two programmes are integrated as much as possible.

2.7 Earlier this month I had an opportunity to join colleagues from the Bristol Medical School as part of their annual review of our Undergraduate Academy. Feedback from our learners was very positive and we hope to hold our position as the top academy in the Deanery for undergraduate medical students. Of particular note, was very positive feedback about the quality of clinical supervision and the pastoral support provided to students. This is testament to our Undergraduate Co-Deans Phil Davis and Su Jenkin, our Educational Supervisors and our Clinical Teaching Fellows, a role the Trust invested in five years ago which has been transformational with respect to student experience. Bristol Medical school standings in the Complete University Guide for student satisfaction survey has gone from 30/35 to joint second in the 2023 rankings and the Gloucestershire Academy has been a key contributor to these improved results.

2.8 This week the Executive Team has undertaken the four Quarterly Review meetings with our Clinical Divisions, which form a key part of our accountability framework. These meetings provide an opportunity for the Divisions to share their successes, escalate matters that require Executive input and to enable the Executive Team to gain assurance across the five domains set out in the Framework.

2.9 Despite the challenges, these were very positive meetings with evidence of the developing maturity and operational grip by the Divisional leadership teams. There remain a number of areas where Divisions are receiving enhanced support from the relevant Executive Director. All four Divisions are about to commence work with an external coach on team development and cross divisional working, linked

2.10 On Saturday 25th February, we said goodbye and thank you to our COVID Vaccination Team following the "retirement" of the JabVan. The team has done a phenomenal job since their inception in Redwood Education Centre in December 2020 and I'd like to extend my thanks to Lorna Herold and the whole JabVan Team for their huge contribution to the NHS vaccination campaign. This programme substantially altered the course of the pandemic and saved millions of lives globally and this team delivered just shy of 90,000 jabs as their contribution.

Deborah Lee
Chief Executive Officer
2nd March 2023

February 2023

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges							
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	Feb 2023	CNO/MD/COO	3x3=9	N/A	5x5=25
SR2	Failure to implement the quality governance framework	Dec 2022	Feb 2023	CNO/MD	3x4=12	N/A	4x4=16
2. We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people							
SR3	Inability to attract and recruit a compassionate, skilful and sustainable workforce	Mar 2022	Feb 2023	DOP	3x4=12	3x2=6	5x4=20
SR4	Failure to retain our workforce and create a positive working culture	Dec 2022	Feb 2023	DOP	3x4=12	N/A	5x4=20
3. Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other							
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	Jan 2023	MD/CNO	2x3=6	N/A	4x4=16
4. We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners							
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	Jan 2023	COO/DST	2x3=6	4x3=12	5x3=15
5. Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services							
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	Feb 2023	DST	1x3=3	3x3=9	3x3=9
SR8	Failure to ensure opportunities and capacity for staff to engage and participate	Jan 2023	Feb 2023	DOP	2x3=6	3x3=9	4x3=12
7. We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources							
SR9	Failure to deliver recurrent financial sustainability	July 2019	Dec 2022	DOF	4x3=12	4x4=16	5x4=20
8. We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact							
SR10	Inability to secure capital to reduce our estate backlog maintenance, support an annual refurbishment programme and replace clinical equipment within lifecycle	July 2019	Feb 2023	DST	4x3=12	4x4=16	4x4=16
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	Jan 2023	DST	3x3=9	3x3=9	3x3=9
9. We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care							

Board Assurance Framework Summary

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

Archived Risks (score of 4 and below)

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

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

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

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

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

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

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

Emergency Care Report:
• Friends and Family Test increased to 80% the highest score seen for 2 years
• Handover delays reduced from 194 delays over 4 hours w/c 2 Jan to 8 delays w/c 23 Jan
 	
Quality and Performance Report Feb 2023:
• Reduction in ED attendances from 19,175 Jan 2022 to 10,946 Jan 2023
	Emergency Care Report Feb 2023:
	• Escalation level for Jan 2023 BLACK
	• 4 hour performance at 60.11% (national target 76%)
	• Safety Checklist only 43% compliance
	  ○ NEWS2 scores recorded within 30min 54%
	  ○ NEWS2 compliance every 60 min 35%
	  ○ NEWS2 score recorded every 90 min 56%
	  ○ Refreshments offered within 2 hours 8%
	
	Quality and Performance Report Feb 2023 SPC Charts:
	• ED% of time to initial assessment under 15 min 46% (target 95%)
	• ED% total time in department – under 4 hours 60% (target 76%)
	• ED number of patients experiencing 12-hour trolley wait 1057 people (target = 0)
	
	QDG Exception Report Appendix 1 - Boarding of Patients on wards to relieve congestion
	
	Quality and Safety Risk Report: ED congestion leading to the increase in ED incidents
		• Planned Pilot system wide CQC Inspection of UEC Dec 2021 (report published March 2022)
		• Internal audit reviews 2022-2025

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Quality governance framework — February 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR2	**Failure to implement the quality governance framework**	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	A range of quality governance issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance Committee	CNO	SR1 SR3 SR4 SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	A refresh of the quality governance framework is in draft. 3 services (subcontracted service, maternity and surgery) have CQC Section 29A warning notices related to governance CCQ inadequate ratings for maternity and surgery Well led requires improvement score for Trust and a MUST DO action to improve governance	**2022/23 Q3** **3x4=12**	Implementation and embedding of the quality governance framework.	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee Report to Board • Trust Risk Register Report to Board • Quality and Performance Report (QPR) to Board • Quality and Performance Committee oversees progress of risks, safety, experience, access/performance and outcome improvement plans in areas where significant issues/concern highlighted • Key Issues and Assurance Report (KIAR) • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board • Monitoring of performance, access and quality metrics via Quality & Performance Report • Inspection and review by external bodies (including CQC inspections) reported through the Regulatory Report • Quality Strategy (insight, involve, improve) • Risk Management processes • Quality priorities and reporting through Quality Account • Improvement programmes • Executive Review process	• CQC Well-Led Report • Staff Survey Results • Quality governance processes •

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

• Implementation of Operational and Winter Plans • Annual Reports for key programmes (complaints, FTSU, equality, safeguarding, infection prevention and control)	

ACTIONS PLANNED

Action	Lead	Due date	Update
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CNO	Q1 2023/24	In progress and reviewed by Feb QDG
Work in progress for the closure of the CQC S29A warning notices	CNO	Overdue Q3 2022/23	Continue regular oversight meetings with CQC and ICS/LMNS. Regular oversight of risks and action plans.
Work to improve the ratings of the core services rated as inadequate to improve governance	CNO	Q2 2023/24	MDG and QDG have oversight of the CQC improvement plan for the S29a, Must do and Should do improvement action plans
Formal governance review, focusing on quality ward to Board processes	CNO/DOF/ Trust Sec	Dec 2023	Proposal agreed and start of review early March

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Learning from Deaths Report	• Cancer performance (haematology, urology and lower GI)	• Reporting to Q&P as per schedule • Internal audit reviews 2022-2025

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

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	**Inability to attract and recruit a skilful, compassionate workforce that is representative of the communities we serve.**	We have a compassionate, skilful and sustainable workforce, organised around the patient, which describes us as an outstanding employer who attracts the very best people.	Increased demand. Reduced pipeline locally and nationally to fill workforce gaps. Reduced training commissions. Hard to fill specialty posts across multiple professions on a national scale.	Reduced capacity to deliver key strategies, operational plan and high-quality services. Increased staff pressure. Increased reliance on temporary staffing. Reduced ability to recruit the best people due to deterioration in reputation.	People and Organisational Development Committee	Director for People & OD	SR1 SR4 SR5 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
5x4=20	The pandemic has had a significant impact on the NHS to recruit to its expanding workforce. On a platform of increased operational pressures, rapid demand, a competitive market place, reduced pipelines, challenged training places and funding, the risk to the Trust is significant for filling its workforce gaps and developing its services. Staff shortages and deteriorating staff experience will impact further on the Trust's ability to attract and recruit to the organisation.	**March 2024** **3x4=12**	A number of workforce plans focused on recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce	October 2022 January 2023	

CONTROLS/MITIGATIONS

- International recruitment pipeline
- UK RN graduate cohorts
- Increased apprenticeships, TNA Cohorts and student placement capacity
- Induction pilot of cohorts for HCA/HCSW
- Advanced Care and other alternative speciality roles
- Accreditation of Preceptorship module
- Formalised workforce Operational Plan submission 2022/2023 to NHSE, integrated with the ICS, with ongoing focus for 23/24
- Technology Enhanced Learning and Simulation Based Education
- NETS Group created to promote survey, to review and action results.
- AHP HCSW Associate Educator Post created with funding bid from NHSE for 9 months FT or 12 months PT

GAPS IN CONTROL

- Delays in time to hire
- No formalised marketing and attraction strategy / plan
- Inability to match recruitment needs (due to national and local shortages)
- High dependency on temporary staffing
- Poor establishment controls

ACTIONS PLANNED

Action	Lead	Due date	Update

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

Transactional recruitment review commenced in June 2022 as part of a formal transformation change programme	DDfP OD	Ongoing	Reporting into the Workforce Sustainability Programme Board, the focussed review continues with clear benefit realisation being evidenced.
Development of a marketing and strategy / plan	DDfP OD	Delayed until April 2023	This will be a work-stream within the Workforce Sustainability Programme and will include the procurement of an external marketing company to support the design and implementation of innovative and creative attraction solutions. The new role of Marketing & Attraction Lead has been put on hold whilst a non-pay investment bid is underway to support the delivery of the marketing and attraction strategy. Ambition is for go live to be from April 23/24.
Interventions and activities to deliver the workforce plan across the Trust	DDfP OD	Ongoing	Interventions and activities to deliver the workforce plan across the Trust continues. Increased overseas nurse recruitment has been agreed supported by NHSEI funding. The outcome of a further bid is awaited to secure further cohorts from April 2023. Fresh focus and attraction drive for UK based nurse graduates Further ICS collaborative recruitment event being held for Healthcare Assistants in February 2023.
Temporary staffing controls	DfPOD	Ongoing	This key workstream continues under the Workforce Sustainability Programme. Focus over the last quarter has been on improved grip and control with medical agency use in the division of Medicine, baselining non-clinical agency use ahead of migration to the Bank Service, a financial incentive framework for Bank workers supporting winter pressures, and the investment bid to build resilience within the Trust Staff Bank team.
Focussed planning of a Preceptorship Academy and commencement of a master accredited module	ADED	Ongoing	The first cohort of Preceptees have commenced on the Level 7 accredited Preceptorship Module. This is an attraction to newly qualified clinicians to the Trust. The Preceptorship Academy is launching, with branding and a SharePoint for Preceptees to access.
NETS (National Education and Training Survey) Group created	ADED	Ongoing	NETS Group (consisting of key stakeholders and influential roles) created prior to survey being launched to promote the completion of the survey, specifically targeting the new Student Forum and student reps. Results have been released, with the NETS Group meeting in March to analyse the results, and create proactive actions.
AHP HCSW Associate Educator Post created using BID funding from NHSE	ADED	Ongoing	Funding from NHSE for a fixed term AHP specific HCSW Associate Educator role, specifically aimed at the attraction to AHP HCSW posts for the Trust, working in collaboration with recruitment and the One Gloucestershire System. Focus will be on AHP HCSW development areas to support attraction and retention. This post will work alongside the HCSW Associate Educator focusing on nursing HCAs.
POSITIVE ASSURANCES		**NEGATIVE ASSURANCES**	**PLANNED ASSURANCE**

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

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

• Ability to offer flexible working arrangements • Flexibility with the targeted use of Bank incentives and Trust-wide reward • Extended funding into 23/24 on a number of initiatives • Improving vacancy and turnover performance seen in January 2023 data	• Diversity gaps in senior positions • Gender pay gap • Significant workforce gaps • Cost of living increases with AfC pay-scales not as competitive as some private sector roles • WRES and WDES indicator 2 (likelihood of appointment from shortlisting)	• Financial Sustainability Programme Board • Internal audit reviews 2022-25: - Workforce Planning - Cross health economy reviews - Equalities, Diversity and Inclusion - Recruitment and Selection

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR4: Workforce - Culture, Experience and Retention February 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**Failure to create a positive working culture and retain our staff.**	To transform the Trust as a place to work and receive care by building a fair and compassionate culture that allows everyone to thrive.	Staffing issues across multiple professions on national scale. Lack of resilience in staff teams. Increased pressure leading to high sickness and turnover levels.	Reduced capacity to deliver key strategies, operational plan and high-quality services. Increased staff pressure. Increased reliance on temporary staffing. Reduced ability to recruit the best people due to deterioration in reputation.	People and Organisational Development Committee	Director for People & OD	SR1 SR3 SR5 SR9

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

CONTROLS/MITIGATIONS

- Colleague Experience and Culture Programme:
  - Leadership and Team Working
  - Delivering transformational change and improvement
  - People policies, process and practice
  - 'Board to Ward' integrated quality and governance system
- Divisional colleague engagement plans
- Proactive Health and Wellbeing interventions
- Addressing HCSW remuneration T&Cs

GAPS IN CONTROL

- Increased staff sickness absence including the impact of Long Covid related illness
- Pace of operational performance recovery leading to staff burnout
- Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience
- Lack of time for staff to complete e-learning training

ACTIONS PLANNED

Action	Lead	Due date	Update
Leadership and Team Working Develop Specification for external OD support from funding bid to contract award	Head of L&OD	Feb 2023 to April 2023	Tender document near completion and on schedule for publication to selected procurement framework by end Feb 23

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

Delivering transformational change and improvement		Ongoing for next 6 months	Gold QI Improvement coach programme delivered to 25 staff 50 staff attend new Bronze programme
People policies, processes and practice • Schedule of policy reviews for Trust people policies • Supporting procedures that utilise the four-step model and tools within people processes and investigations • Established resources, advice and guidance to support line management practice	Quality Improvement & Safety Director	TBC	Full scoping of milestones to be programmed
Colleague communications and Engagement • Review and audit all internal communication channels completed • Review and engage services on Staff Survey results • Ongoing promotion of NQPS in Q4, 1, 2	DofComms	January - May 2023	Comms and Engagement plan for SEIP and staff survey results almost finalised. Webinars to be held 8th March (day before national publication) to share staff survey results with colleagues. 4-week schedule of engagement events thereafter. Recording of webinar will be shared on global on results launch day (9th March 2023). NQPS took place in January 2023. Results being analysed alongside staff survey results.
Establish a Trust wide Retention Group focussing on 2-3 core initiatives at a time, informed by expert exit data analysis	DfPOD	To commence April 2023	Delayed due to reduced capacity across the P&OD portfolio and ongoing operational pressures.
Wellbeing and support for the workforce	Head of L&OD	Ongoing	Half-price food and free drinks available from GHT food outlets until 31st March 2023, supporting staff wellbeing. Financial wellbeing support channels further promoted January 2023. Long-term funding and delivery options for Staff Psychology service being explored.
National Programme for B2-B3 HCSW Job profiles and pay drift. To include addressing GHT's legacy of varying pay and sick pay T&Cs for this staff group	DfPOD	Programme Delivery Group commencing February 2023	Financial impact for potential retrospective and prospective pay liabilities is going through internal Governance routes for approval February 2023
Becoming a Real Living Wage Employer (ICS collaboration)	DfPOD	Timescales not yet set	Early discussions being held with One Gloucestershire ICS partners

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

Cultural Awareness Pilot site for National Programme	ADED	Ongoing	EOI was submitted to be a pilot Trust for a new Cultural Awareness training package. As a Trust we have been chosen to provide a locally delivered days workshop for leaders from an IEN background and for line managers of IENS. This will feed into a Nationally delivered programme.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Ability to offer flexible working arrangements • Diversity Network with three sub-groups (ethnic minority; LGBTQ+, and disability). • Compassionate Behaviours Framework • Technology Enhanced Learning and Simulation Based Education • Divisional colleague engagement plans • Proactive Health and Wellbeing interventions	• Diversity gaps in senior positions • Gender pay gap • Cost of living increases • Exit interview trends • Inconsistent Pay T&Cs for HCSWs	• Colleague Experience and Culture Programme • Internal audit reviews 2022-25: - Cultural Maturity - Cross health economy reviews - Equalities, Diversity and Inclusion - Health and Wellbeing - Staff Engagement

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR5: Quality improvement methodologies — February 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	**Failure to implement effective improvement approaches as a core part of change management**	Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other	• No agreed approaches for continual and complex improvement (The GHNHST Way) • Lack of improvement capacity built into the Governance system • Limited formal planning and prioritisation processes for Quality improvement • Unclear Ward to Board quality governance arrangements	• Jump to solutions without engaging staff in process • Limited coordination of improvement at all levels • No drive for improvement and limited checks on process and engagement. • Too many priorities and adhoc activity without resource with poor outcomes • Inconsistent checks and balances to support improvement approaches in change management	Quality and Performance Committee	CNO	SR1 SR2 SR8

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	Staff and CQC feedback – too many initiatives Staff engagement scores Need to build a systematic improvement function at all levels Lack of capacity to support improvement	**Dec 2023** **2x3=6**	Implementation of Quality Governance arrangements Implementation of PSIRF Implementation of a prioritisation process for improvement activity from Ward to Board	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee Report to Board • Strategy and Transformation Board Report to Board • PSIRF implementation that requires a prioritised approach	• Quality governance arrangements • CQC Well-Led Report

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Feedback from staff on safety huddles	• CQC Well-Led Report	• Internal audit reviews 2022-25

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR6: Individual and organisational priorities not aligned — February 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR6	Individual and organisational priorities and resources are not aligned to deliver effective integrated care	We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	Individual organisations have their own strategy and priorities Budget allocation to organisations rather than priorities	• Lack of integration and system working • Wrong priorities and lack of single strategy for Gloucestershire • restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration	Quality and Performance	COO/DST	SR1 SR7

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	Jan 2024			
5x3=15	Development of an Integrated Gloucestershire system	3x3=9	3x3=9	2x3=6	Developed and embedded system working	Q2 2021/22	
						Q4 2021/22	

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

Action	Lead	Due date	Update

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

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place • Regular 'systemwide' planning meetings in place • KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established • GIRFT Report – Urology services have made significant improvements **Quality and Performance Report** – A high performer on elective recovery - continued to make significant progress on the number of patients on the waiting list. – A winter ward plan was in development, with 24-34 additional beds for this winter. – Cancer performance. – Plans in place to improve the two-week-wait pathway, – Marginal gains against the 62-day standard.	• Operational Plan 2022/23 not fully compliant • CQC Maternity Service report (inadequate rating) • CQC S29A Warning notice for maternity and Surgery **QPR metrics** Many access, performance and quality metrics triggering "red" and not meeting their performance targets.	• Operational Plan 2022/23 to be monitored delivery on formal basis from June 2022. • CQC Well Led Inspection (report due October 2022) • 'Flow' focussed strategy and delivery group planned • Internal audit reviews 2022-25: o Outpatient Clinic Management o Discharge Processes o Cultural Maturity o Clinical Programme Group o Patient Safety: Learning from Complaints/Incidents o Patient Deterioration o Equalities, Diversity and Inclusion o Infection Prevention and Control

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Community engagement and participation — February 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR7	**Failure to engage and ensure participation with public, patients and communities**	Patients, the public and communities tell us that they feel involved in the planning, design and evaluation of our services	Insufficient engagement and involvement approach, methodologies or timing.	Communities and external stakeholders feel uninformed	Quality and Performance / People and OD	DoST	SR1 SR6

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Jan 2023	Jan 2024			
3x3=9	External engagement has improved but requires a more systematic approach, including joined up working with partner organisations	**3x2=6**	**1x3**	• Impact mapping and metrics that show increase in public and community involvement. • Recruitment of 1000 people to Citizens Panel • 10% increase in membership, that reflects the diversity of local communities	Feb 2023 March 2022 Aug 2022 Nov 2022	**3x3=9** **3x3=9** **3x2=6** **3x2=6**

CONTROLS/MITIGATIONS

- Board approved Engagement and Involvement Strategy
- Annual Review of
- Quarterly Strategy and Engagement Governors Group
- Annual Members' Meeting
- Friends and Family Test
- Quarterly patient experience report to Quality and Performance Committee
- One Gloucestershire approach to public involvement
- Community Outreach Worker in post (funded by NHS Charities Together) to support seldom heard groups and identify gaps in engagement.
- Successful completion of two phases of Fit for the Future
- Programme to develop a 1000 strong ICS 'Citizens Panel' to support local community engagement

GAPS IN CONTROL

- Objective measurement of impact of public and patient engagement and involvement
- Resource gap for engaging, involving and growing Trust Membership.
- Engagement Tracker – mapping all activity and impact
- Engagement Toolkit – joint with ICS partners – to improve the quality and consistency of public/patient involvement.
- Revised CQC and NHS England approach in assessing community engagement

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of an engagement tracker – in part for NHS CT and also for publication	DEI&C	Dec 2022	Tracker in progress and 80% complete. Plan to publish as part of Annual Review in April 2023
Joint Engagement Toolkit (with ICS partners) – to improve the quality and consistency of public/patient involvement	DEI&C	Jan 2023	ICS Project Group to develop new toolkit, being led by Trust. Using best practice and mapping to the Trust Strategy and ICB '10 Steps to better engagement'.
Annual Members Meeting – community focused event	DEI&C/ Corp Gov	Oct 2023	Plan to host a large face-to-face event for AMM with community partners and aligned to the NHS75 celebrations.
Membership Strategy 2023-2025	Corp Gov	April 2023	Development of refreshed Membership Strategy – engagement workshop with Governors to help influence plan and approach.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Community engagement and participation February 2023

• Positive feedback from the Consultation Institute on Fit for the Future engagement and consultation programme • Progress demonstrated in publication of Engagement & Involvement Annual Review 2021/22 & 2022/23 • Level of engagement and involvement from Governors • Inclusion of patient and staff stories at Trust Board including bi-annual learning report • One Gloucestershire involvement group established – ensuring joined up priorities and work. • FFTF Phase 2 engagement programme completed	• Trust membership has reduced to below 2,000 with limited diversity • Opportunity to actively elect more divers Governors and grow membership • Friends and Family Test Scores have dipped, in particular ED and PALS calls have tripled in last 18 months from around 200+ per month to over 600.	Internal audit reviews 2022-25: • Patient Safety: Learning from Complaints/Incidents • Equalities, Diversity and Inclusion • ICS Citizens Panel

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

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

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

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Staff Experience Improvement Programme Board established • Board approved Engagement and Involvement Strategy – with key milestones for staff engagement • Monthly Team Brief to cascade key messages • NHS Staff Survey and NHS Quarterly Pulse Survey • Colleague Experience and Internal Communications Manager recruited. • Engagement and Involvement programme in place with local communities. • Leadership and Team Development presented to TLT and specification finalised ready to publish to marketplace for competition.	• Objective measurement of how well key messages are being cascaded to and understood by colleagues. • Resources to develop new approaches and tools to help reach and actively engage colleagues • Data analysis and insights to ensure the Trust understands the experience of colleagues and what matters most to them • Anonymous reporting tools/systems for staff to raise concerns • Ensuring 'people' are at the heart of our stories

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of Staff Experience Improvement Programme Board	Claire Radley	March 2024	Structured review and approach to culture and staff engagement, including Leadership and Teamwork; Restorative Just Principles and Practice; Colleague Communications and Engagement.
Review internal communications channels and opportunities for engagement. Team Brief now well established.	DEI&C	Feb 2023	Feedback on Team Brief cascade, review of communication channels aimed at colleagues who do not use email/digital systems regularly. Exploring face-to-face and virtual engagement events with leaders.
Development of Staff Survey engagement programme, including a review of engaging services and back to the floor programme.	DEI&C	Oct-Dec 2022	Working Group established and plan developed. Key interventions and resources developing to support all divisions.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Staff Experience Improvement Programme Board established • Review of Communications and Engagement – Our Brilliant Basics	• Identification of potential areas of improvement from staff survey results	Internal audit reviews 2022-25:

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

		• Staff Experience Improvement Programme Board review • Internal Communication and Engagement approaches • Cultural Maturity and managing incivility and discrimination • Staff Engagement • Recruitment and Retention

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR10: Financial sustainability — February 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR9	**Failure to deliver recurrent financial sustainability**	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources. We are a Trust with minimal backlog maintenance and fit for purpose equipment.	• The inability to deliver recurrent financial savings creating a financial gap. • Lack of financial accountability within the organisational culture. • Recruitment and retention challenges leading to high-cost temporary staffing. • Current economic crisis around cost of living, inflation and supply chain challenges. • External demands resulting is lack of flow of patients driving escalation costs and reducing productivity. • Conflict between clearing backlog demand v financial sustainability. • The level of resources to support the trust is not sufficient, including the need to maintain our buildings.	• The Trust and ICS continues to have an underlying financial baseline deficit which may grow in size. • Higher sustainability targets for the following year. • Creating an adverse impact on patient care outcomes. • Inability to deliver the current level of services. • Impact on future regulatory ratings and reputation; regulatory scrutiny/intervention leading to increased risk of reduced autonomy. • Prevention of investment to enhance services and inability to achieve the strategic objectives	Finance and Resources	DOF	SR1 SR3 SR4 SR6 SR10 SR14

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
5x4=20	• Although final plan for 22/23 showed a balanced position it included £19m of savings which are not materialising. Currently £4.8m gap. • Increase cost of temporary staffing due to workforce challenges. • The lack of flow in the hospital causing restrictions on elective recovery impacting on the ability to earn ERF. • Pressure on operational capacity, limiting the focus on how to drive out efficiencies whilst improving patient outcomes. • Productivity information is showing a reduction in activity but not a corresponding reduction in costs to match.	**Dec 2022**	**5x3=15**	• Everyone in the Trust (from Board to ward) understands and owns their element of responsibility around good stewardship of public money. • Full review of all revenue investments made during the pandemic to determine whether they are still to be supported or if financial commitment should be removed. • Continued monthly monitoring to understand the drivers of the deficit. • Drive the financial sustainability programme to start to see the recurrent benefits of financial improvement. • Targeted weekly financial oversight meetings in place for the two divisions who are experiencing adverse movement from budget. These meetings are chaired by the Chief of Service and Director of Finance is there to seek assurance. Early indications show an improved position but one that isn't at breakeven yet.	Aug 21	
		April 2023	**4x3=12**		April 21	
		June 2023	**4x3=12**		Sept 20	
					July 19	

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

			• Development of system transformation programmes to support longer term financial health • Development and acceptance of a financial recovery plan – showing clear executive leads.	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• PMO proactively supporting operational and corporate colleagues to generation and deliver future sustainable schemes using tools such as model hospital etc • Programme Delivery Group for financial sustainability • Pay Assurance Group (PAG) • ICS one savings programme to share ideas, resources and drive consistency • Monthly monitoring of the financial position • Controls around temporary staffing • Driving productivity through transformation programmes i.e., theatres and OP • Weekly financial recovery meetings in place with those adversely deviating from plan	• Finance strategy in draft and needs completing • Clear line of accountability with no accountability framework • Robust benefits identification, delivery and tracking across major projects • Controls on the approval of WLIs/overtime payments needs strengthening • Inability to generate ideas • Capacity issues to generate and implement ideas at pace i.e., RMN decision making thresholds

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of the financial sustainability team reporting within the strategy and transformation portfolio	DOF/ DOS	Feb 22 - Closed	This team has now moved across, training and development ongoing. Vacancies being filled by a combination of permanent and interim staff to get the governance and reporting in place by Mar 22. Detailed plans around deliverability of the financial sustainability programme will be in first draft by end of April.
Robust benefits identification, delivery and tracking across major projects	DOF/ DOS	Jun 22 – Closed	Capacity now in place to develop the process, format and framework around how we capture the benefits. This will be tested during the financial year and where necessary adapted to ensure the process is robust and effective.
Set up weekly meetings for those division that are showing financial pressure	CoS	Jun 22 – Closed	This has been set up and progress is good.
Trust wide communication is being developed and sent out to inform the organisation of the financial position to get the message understood	Comms	Jul 22	Initial comms going out in term briefs in July, Financial sustainability on the agenda for 100 leaders in July. Development of Trust wide workshops to gain more traction on ideas for medium term plan during the financial year.
Financial recovery plan (FRP) developed, drivers of the pressures understood and communicated to system and regulator partners	DOF	Aug 22 - closed	The first draft of the FRP in circulation with exec colleagues, divisional reps, ICB partners. More focus needed on generating more actions with clear expectations around accountability of delivery. Regular reporting to Finance and Digital
HFMA self-assessment tool completed ready for internal audit review	DOF	Sept 22 - Closed	HFMA self-assessment tool completed, final review taking place with final sign off by 30th Sept in preparation for internal audit review early Oct. Report presented to Audit Committee in November. Action plan now being addressed.

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

WTE growth from 19/20 actuals to 22/23 establishment understood and challenged	DOF	Oct 22	WTE growth will be presented to F&D in Sept with next steps clearly articulated.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22. • Continued the monitoring of financial sustainability • Move of financial sustainability to Strategy and Transformation to give focus on quality of service which should drive financial improvement • ERF monies being generated by Trust. • Improved and co-ordinated system working. • External Audit VFM report, Jun 22. • Development of productivity analysis at divisional level • Weekly reviews for those deviating from plan	• Temporary staff spend consistently above target. • Planned Trust and System underlying deficit moving into 22/23 a significant concern. • Continuing under-delivery of recurring efficiency programme. • ERF achievement for H2 is a cause for concern • Lack of benefit realisation on schemes that should be delivering financial improvement • No real consequences of financial deviation • No review on whether to continue to stop a project if overspending	• Internal Audits planned 2022-25: ○ Cross health economy reviews ○ Shared Services reviews ○ Risk Maturity ○ Data Quality ○ Budgetary Control ○ Charitable Funds ○ Payroll Overpayments • NHSE/I scrutiny of Trust/system finances. • ICS accountability and assurance on system wide transformational changes.

UPDATE

February 2023: Planned action due dates updated with a number of actions closed. HFMA self-assessment report presented to Audit and Assurance Committee.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR10: Inability to secure capital — February 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	**Inability to secure capital required to:** **i) make significant reduction in our estate backlog maintenance and critical infrastructure risks** **ii) support an annual theatre, and ward refurbishment programme** **iii) replace clinical equipment within lifecycle**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.	• National Capital Department Expenditure Limits (CDEL) • Age, condition and inefficiency of GHFT buildings & infrastructure • Previous equipment purchase profile resulting in peaks in end of life equipment • Scale of backlog maintenance: £72M of which £41M is Critical Infrastructure Risk (2021 6-facet survey)	• Unable to address backlog and critical infrastructure risks resulting in service interruptions impact on patient access, safety and quality • Poor quality theatre and ward environment impacting on patient outcomes & patient & colleague experience • Equipment failures leading to service interruptions impacting on patient access and diagnosis timescales	Finance and Resources Committee	DST	SR9 SR11

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Jan 2023	Jan 2024			
4x4=16	One Gloucestershire CDEL results in an annual capital budget of c£24M per year for GHFT. This is split across estates, digital and equipment. This allocation is insufficient to address the scale of backlog maintenance (£72M) risk within an appropriate timescale as well as a refurbishment, equipment replacement & digital programme.	**4x4=16**	**4x3=12**	• CDEL limits constrain the level of capital investment One Gloucestershire can commit to • Estate backlog maintenance schemes compete with other strategic and operational priorities, including strategic estate schemes, digital and equipment replacement • Equipment Managed Equipment Service (MES) procurement on hold as business case did not demonstrate value for money and impact of IFRS16 was unknown in 21/22. • ICS Partners have greater awareness of risk GHFT is carrying across estates in particular, which could lead to a change in CDEL allocation from 2023/24. • GHFT have a good track record of securing capital from NHSE schemes (UEC, TIF, CDC etc) and these schemes include backlog maintenance element.	Feb 2023 Sept 2022 July 2022 April 2022 April 2021 Oct 2020 June 2020	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Trust and ICS is sighted on the scale of estates backlog and Critical Infrastructure Risk • All NHSE/I capital bids include costs of address backlog maintenance risks in immediate and/or linked development areas • Improved risk reporting of estates risks through GMS, RMG, Committee & Board	• Lack of alternative routes to capital other than NHSE/I. • Lack of alternatives to a reliance on capital to address estate, refurbishment and digital investment due to Trust and ICS revenue position e.g. MES • Lack of a CDEL prioritisation process across the ICS that recognises the level of risk being carried by each organisation.

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

• Transition to longer term planning approach to develop a 3-5 year estates capital programme to provide assurance of when highest risks will be addressed • Exploring options to dispose of estate with capital receipt used to address backlog risks	• Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025.

ACTIONS PLANNED

Action	Lead	Due date	Update
Review equipment MES business case learning from how other Trusts/ ICSs have managed IFRS16	DoF/ DST	Q2 23/24	Project to be re-launched from April 2023. Will require project resource.
Improve awareness across ICS partners of level of risk GHFT is carrying across estate and equipment	DoF/ DST	From Q3 22/23	ICS capital group established with DoF and DST. Improved awareness of risk is already influence CDEL prioritisation decision making
Review scope, function, priorities and resourcing of ICS Estates Strategy Group	DST	Q1 23/24	Raise via ICS Strategic Executive
Develop library of estate capital schemes in anticipation of NHSE national programmes	DST	From Q2 22/23	Long-list developed. SOCs in place for GCI, DCC. Feasibility studies complete for Head & Neck & Breast. Further Feasibility studies planned
Explore partnership opportunities to develop GHFT estate and/or adjacent sites	DST/ GMS	From Q3 22/23	Opportunities in progress/ being explored with GCC and other potential partners.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I. Schemes include backlog maintenance element • PFI is being maintained to 'Condition B' in line with contract • New estate comes on line in 2023 (GSSD) providing good quality estate with reduced maintenance requirement. GSSD has addressed areas carrying backlog e.g. Gallery Wing, DSU at CGH. • Estate capital investment has been prioritised in 2023/24 at £14/£24M CDEL. • Recent investment in Radiology has reduced equipment risks (but resulting in lumpy replacement profile)	• Level of estate risk is increasing as reflected through risk scores • Unable to fund a ward refurbishment programme	Internal audit reviews 2023-25: • Environmental Sustainability • Estates Management

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR11: Sustainable healthcare — February 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR11	**Failure to meet statutory and regulatory standards and targets enroute to NHS becoming a net zero carbon footprint organisation by 2040**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.	Unable to meet our Green Plan objectives. Unable to secure or prioritise investment required to: • Retro-fit existing buildings and/ or construct new buildings to required EPC standard • Increase electrical infrastructure to support EV charging • Migrate from fossil fuel energy supplies • Unable to migrate 90% of vehicle fleet to low & ultra-low carbon emission engines by 2028	• Statutory and/or regulatory implications (as yet undefined) • Increase revenue cost of running inefficient estates and fleet using high-cost fossil fuel energy • Potential increase lifecycle cost of Hybrid/EV fleet • Potential impact on recruitment & retention • Reputational impact	Finance and Resources Committee	DoST	SR9 SR10

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Jan 2023	Jan 2024		Feb 2023	
3x3=9	• Scale of investment required to achieve required EPC ratings across GHFT estate • Electrical infrastructure investment required to stabilise and then increase capacity to support EVs	**3x3=9**	**3x3=9**	GHFT has been successful in securing external grants	Dec 2022	

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

ACTIONS PLANNED

Action	Lead	Due date	Update

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

Progress on delivery against GHFT Green Plan reported through F&R Committee	DST	From 2021	Process established. Last update in July 2022
Continue to research and respond to external grant applications	GMS (THu)	Ongoing	GHFT secured £11M from latest PSDS scheme
Establish EV Task & Finish Group	DST	Q4 2022/23	Term of Reference produced. Group to mobilise in Q1
Engage in ICS/ Gloucestershire County Sustainability groups to make linkages and pursue joint initiatives	GMS (JC)	Ongoing	GHFT/ GMS involved in EV strategy group to explore multi-partner options to support transition to EV across public sector organisations and shared use of infrastructure
Explore options within PFI contract to improve EPC ratings of PFI estate ahead of transfer to GHFT in 2035	DST	Q4 2022/23	Will form part of PFI contract review

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• SSD Programme progressing to plan at BREAM 'good' level • £13M (2021/22) and £11M (2022/23) of Public Sector Decarbonisation Scheme (PSDS) funding secured • GHFT declaration of Climate Emergency in 2020 resulting in Board approved Green Plan • ICS Green Plan defined as part of establishing NHS Gloucestershire ICS • Vital energy contract performance is demonstrating reducing emissions and returning power to national grid – enabler to achieving 80% reduction in carbon emissions between 2028 and 2032 • Response to local initiatives by GHFT colleagues e.g. Green Team competition, bids against £50k sustainability budget etc	• Electrical infrastructure capacity constraints • Unlikely to meet GHFT Green Plan objective to transition to electrical fleet by 2025 • Scale of estate challenge	Internal audit reviews 2023-2025: • Environmental Sustainability

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR12: Cyber security — January 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR12	**Failure to detect and control risks to cyber security**	We are digital hospital whose clinical and operational systems are protected from cyber-attacks and data breaches; through proactive monitoring and back-up systems.	• Cyber-attacks from organised groups targeting NHS • Malware attacks • Phishing attacks via emails to staff • Password access through data breaches • Physical breaches (equipment stolen on site) • Inadequate firewall protection and security updates • Location of Trust near to GCHQ	• Whole loss of systems and downtime – with inability to recover quickly • Demands for money to recover data (ransomware attacks) • Access to patient records and personal data that could be published • Access to VIP data and/or GCHQ staff as patients	Finance and Resources Committee	CDIO	SR9 SR13

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x3=12	The National Cyber Security Centre (NCSC) is clear that there are groups and individuals who want to target the NHS; and these are no longer carried out by isolated individuals, but are mounted by large and sophisticated criminal groups. Several high-profile public-sector organisations and NHS trusts have experienced breaches in the last two years and suffered cost and data losses – directly impacting patients/residents.	**Feb 2024** **3x3=9**		Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Cyber Security action plan in place, reviewed annually and gaps in security and investment identified • Monitoring systems in place and dedicated cyber security team • Backup systems and disaster recovery in place and regularly updated • Cyber security delivery workstreams – monitoring safety and access • Investment in cyber tools and software • Regular phishing tests and firewall tests (planned system hacks) • Regular security updates and patches	• Lack of in-house expertise in cyber security team • Inability to recruit specialist cyber staff because of cost (market forces) • Disaster recovery planning around support systems (out of IT control) not consistently in place

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

• Monthly reports to Digital Care Delivery Group, Finance & Resources cttee, ICS Digital Execs • NHS national monitoring (alerts) and NCSC alerts • Communications and engagement with users on prevention	

ACTIONS PLANNED

Action	Lead	Due date	Update
Completion of cyber security action plan	CDIO		Ongoing

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
Cyber Action Plan in place and regularly monitored/updated	Difficulty in recruiting enough experienced staff to support our cyber security needs	Internal Audits External Audit (annual) Monthly NHS reporting

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR13: Digital systems functionality — February 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR13	**Inability to maximise digital systems functionality and progress as a digital hospital**	We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care	• Inconsistency of approach and not following digital strategy • Implementing new systems without digital approval – that don't integrate with clinical record (EPR) • Lack of required investment in digital skills, resources and infrastructure • ICS wide strategy not aligning or in place to allow data sharing across system • Poor clinical and operational engagement in what is new developments or optimisations	• Reduced ability to innovate, use clinical intelligence and data effectively and plan. • Unable to reach Govt requirements to become a HIMSS level 6 organisation; impacting reputation as well as safety. • Inability to work effectively across the care system, providing poor joined-up care. • Inefficient operational practice and planning/flow. • Inefficient systems/poor data can contribute to clinical errors and poor safety • Unable to meet expectations of patients, commissioners and regulators.	Finance and Resources Committee	CDIO	SR9 SR12

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
3x4=12	The government requires that all hospitals reach a required digital standard of HIMSS level 6 to ensure safety and consistency across the NHS. Digital hospitals are safer hospitals, are better places to work and provide better patient care and outcomes. Improved data leads to better operational and clinical planning, as well as opportunities for innovation. The five-year strategy has seen the trust move from a digitally immature organisation to almost HIMSS level 5 and this must continue if we are going to reach our target of 2024.	**Feb 2024** **2x3=6**		Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record (Sunrise EPR) becomes single source of clinical information, implemented to HIMSS level 6- and five-year plan by 2024. • Joining Up Your Information (JUYI) implemented in partnership with external partners and available to access through EPR • Data Warehouse providing one version of the truth supporting clinical and operational dashboards used for planning across the ICS.	• ICS strategy implementation and plan not embedded/complete • Use of different systems across the ICS • Inability to integrate systems bought outside of digital remit (divisional) • Funding stability

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

• Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements • All projects must meet existing Digital Strategy and contribute to the journey to HIMSS level 6 • Implementations must provide significant patient care and/or safety benefits – and reduce risk • Optimisation of EPR for users as part of a continuous improvement, responding to clinical demand • Support wider organisational journey to outstanding	

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
	•	• Internal audit reviews 2022-25

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR14: Research — February 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR14	**Failure to enable research active departments that deliver high quality care**	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	• Lack of capacity within R&D department • Lack of willingness of departmental management to support research activities within their department • Financial approval of VCPs delayed by misunderstanding of research funding processes	• Disengagement of staff in research activities • Departure of research active staff to other more research active organisations • Unable to support staff to design, set up or deliver their research studies (own account & portfolio) • Lack of opportunity to secure additional funding for research and generate surplus for Trust • Higher turnover of staff leading to increased locum and bank staff → increased financial burden • Negative impact on reputation • Inability to secure university hospital status	People and Organisational Development	MD	SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
3x4=12		**Feb 2024** **2x3=6**		Risk entered Feb 2023

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Review of Research Office processes by new senior manager • Research office working with interested clinical teams to support them	• Mismatch between agreed commitment and investment activity.

ACTIONS PLANNED

Action	Lead	Due date	Update
Analyse results of clinical research survey for nurses	KG	April 2023	
Continuous Improvement projects in progress to streamline processes, releasing capacity	CS	Ongoing	Feb 2023: New
Review research sessions for clinical staff	CS	April 2023	
Ongoing discussions with finance	CS	Ongoing	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
Strong pipeline of research studies Engaged staff High engagement within Trust	Potential reduction in commercial income nationally Ongoing impact of pandemic	• Internal audit reviews

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	9 March 2023		
Title	Scheme of Delegation, Standing Financial Instructions, Standing Orders		
Author /Sponsoring Director/Presenter	Alex Gent, Head of Shared Services Kat Cleverley, Trust Secretary Steve Perkins, Director of Operational Finance Karen Johnson, Director of Finance		

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

Summary of Report

The Scheme of Delegation, Standing Financial Instructions and Standing Orders have been reviewed and updated. Key changes are highlighted as follows:

Tendering and Contract Procedure (SO8, SFI's & Scheme of Delegation Appendix 1)

The Trust has not amended the thresholds for tendering and contracts for 25 years and the threshold of £5,000 before quotations should be sought has not kept in line with inflation. A benchmarking exercise in 2022 identified that 70% of NHS Trusts have a threshold of £10,000 or above. Gloucestershire Health & Care NHSFT reviewed their threshold in 2022 in response to inflation and increased it from £16,000 to £18,000. It is recommended that the thresholds are increased to align with inflation, the current P2P authorisation limits and other NHS Trusts.

New Supplier Checks and Changes to Supplier Details (Scheme of Delegation and SFI's section 10 – Non-Pay Expenditure)

An Internal Audit review of Accounts Payable has identified that the Trust's Scheme of Delegation and SFIs do not specify the requirement for due diligence checks for new suppliers and changes to suppliers' details. Both documents have been updated to reflect this.

The Finance and Resources Committee received the documents and approved them in January 2023. They are presented to Board for ratification.

Recommendation

The Board is asked to:

- Approve the Scheme of Delegation
- Approve the Standing Financial Instructions
- Approve the Standing Orders

Enclosures

Scheme of Delegation, Standing Financial Instructions, Standing Orders

Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS

NHS FOUNDATION TRUST

SCHEDULE OF DECISIONS RESERVED TO THE BOARD AND THE SCHEME OF DELEGATION

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following January 2019 Audit and Assurance Committee feedback
1.0	Lukasz Bohdan	14-02-2019	Version approved by the Trust Board at its 14 February 2019 meeting with the exception of Section 3.2 'Estates Committee'
1.1	Cecilia Price & Lukasz Bohdan	31-05-2019	Amendments made following February 2019 Board feedback and changes to Committee ToRs
1.2	Lukasz Bohdan	Aug 2019	Version approved by the Trust Board at its June 2019 meeting
1.3	Lukasz Bohdan	Aug 2019	Amendments made to Director of Corporate Governance - August
1.4	Sim Forman	April 2020	Review
1.5	Karen Johnson, Steve Perkins, Kat Cleverley, Alex Gent	November 2022	Review

Contents

1 Introduction

1.1 Reservation of powers

Subject to a provision in the authorisation or the Constitution, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of Standing Order 5 or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit. The NHS Foundation Trust Code of Governance and the Code of Accountability requires the Board of Directors to draw up a schedule of decisions reserved to itself and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.2 Role of the Chief Executive

All powers of the Foundation Trust, which have not been retained as reserved by the Board of Directors or delegated to a Board committee or sub-committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those able to be delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

1.3 Caution of the use of delegated powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated power in a manner which could be a cause for public concern.

1.4 Absence of directors or officers to whom powers have been delegated

In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive.

1.5 Review and awareness of delegated powers

The Scheme of Delegation is reviewed annually. As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions and Standing Orders, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

2 Schedule of Decisions Reserved to the Board

REF[1]	Decisions reserved to the Board of Directors
	General Enabling Provision The Board of Directors may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
	Regulations and Control
	1 Approve Standing Orders (SOs) and Reservation of Powers to the Board.
	2 Suspend SOs, subject to SOs 3.30-3.34.
	3 Amend SOs, subject to SO 3.3.5.
	4 Approve Standing Financial Instructions (SFIs), including Financial Delegation Limits.
	5 Ratify the exercise of powers, which the Board has retained to itself, by the Chief Executive and the Chair in emergency, subject to SO 4.2.
SO 4.4 SO 5.5	6 Approve a scheme of delegation of executive powers from the Board of Directors to committees or sub-committees, which it has formally constituted, and authorise the delegation of a committee's executive powers to a sub-committee.
	7 Require and receive the declaration of Directors' interests that may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration in accordance paragraph 11 of the Constitution.
	8 Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on such reports.
	9 Confirm or otherwise the recommendations of the Trust's committees where the committees do not have executive powers.
	10 Establish terms of reference and reporting arrangements of all committees that are established by the Board of Directors.
SFI 17.1 SO 2.2	11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
C 19.1 SO 11.2	12 Authorise the use of the seal and agree a policy to define those documents that must be sealed.
	13 Ensure the quality and safety of healthcare services, education, training and research delivered by the NHS Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, the CQC, and other relevant NHS bodies.
	Appointments/ Dismissal
C 9.7	1 Appoint one of the independent Non-Executive Directors to be the Senior Independent Director in consultation with the Council of Governors.
	2 Approve the appointments to each of the committees, which it has formally constituted, and approve the terms of such appointments.
SO 5.6	
	3 Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
SFIs 9.1.3 & 9.1.4	4 Approve proposals of the Remuneration Committee regarding the remuneration and terms of service of Directors.
	Strategy, Plans and Budgets
SFI 1.3.1	1 Define the strategic aims and objectives of the Trust each year.

[1] Reference Key: Constitution (C), Standing Financial Instructions (SFIs), SFI Appendix (SFI A) and Standing Orders (SOs).

	2 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by NHS Improvement (Monitor).
SFI 20.1	3 Approve and monitor the Trust's risk management strategy.
	4 Approve the Trust's financial plan and annual budget.
SFI 4.1.5	5 Approve the Trust's capital programme.
	6 Approve annually the Trust's Operational Plan.
SFI 12.2.1	7 Approve Private Finance Initiative proposals (subject to any guidance issued by the Regulator).
	8 Approve the opening of bank or investment accounts.
SFI A1.5.2	9 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, over £5,000,000.
SFI A1.1.3	10 Approve capital expenditure, business cases and PFI schemes, including approval of variations, amounting to over £1,000,000.
SFI A1.1.3	11 Approve of increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves where the increase is >10% of the value in the agreed financial plan.
SFI A1.3	12 Approve purchase orders amounting to over £500,000.
SFI 8.5	13 Approve participation in a tendering exercise where retaining a service provided by the Trust amounts to over £50,000,000 and where acquiring a new service amounts to over £25,000,000.
SFI 2.1.1	14 Approve individual compensation payments.
SFI 10.1.1	15 Approve the level of non-pay expenditure on an annual basis.
SFI 11.1	16 Approve long term and short term borrowing facilities.
	Policy Determination 1 Determine insurance policy.
	Audit 1 To provide feedback to Governors to inform the appointment (and, where necessary, dismissal) of the External Auditor. 2 Approve the appointment (and where necessary, dismissal) of the Internal Auditors. 3 Receive reports of the Audit and Assurance Committee meetings, highlighting significant internal and external audit issues, and take appropriate action. 4 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice of the Audit and Assurance Committee where appropriate.
	Annual Reports and Accounts 1 Approve the Trust's Annual Report, the Quality Account and Annual Accounts.
	Monitoring 1 Receive Board Assurance Framework reports and reports from committees in respect of their exercise of powers delegated such as the Board of Directors sees fit. 2 Continuous appraisal of the affairs of the Trust by means of the provision of information to the Board as the Board may require from Directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS Improvement (Monitor) shall be reported, at least in summary, to the Board of Directors.

	3 Receive reports on all aspects of the Trust's performance, and particularly those covering performance against budget, financial plans, performance improvement plans, internal or national targets, and measures of activity and quality.
GMS Schedule of Matters Reserved and Delegated	**Matters concerning GMS** 1 Responsibilities of the Trust as shareholder of GMS as defined in company law. 2 Admission of additional shareholders for GMS. 3 Approval to issue any shares in GMS or grant any options or other right to subscribe for shares in GMS. 4 Approval to consolidate, sub-divide, convert, cancel, reduce, redesignate, purchase or redeem any share capital of GMS. 5 Approval of any change to the registered or trading name(s) of GMS, or to its brand. 6 Approval to change the location of GMS' registered office or its principal place of business. 7 Engage, carry on or establish any business outside of the United Kingdom or provide for the payment of any monies other than in good faith for the purposes of or in connection with the carrying on of such business outside of England and Wales. 8 Dissolution of GMS. 9 Approval and amendment of GMS' articles of association. 10 Appointment and removal of directors and the company secretary for GMS. 11 Appointment of a director to act as Chair of the GMS Board of Directors. 12 Approval of the terms and conditions of appointment for directors and the company secretary of GMS. 14 Approval of the GMS' schedule of matters reserved and delegated. 16 Approval of the membership and responsibilities of the Trust Estates and Facilities Committee. 24 Oversight and approval to issue, defend or settle any litigation, claim or other legal proceedings (other than actions to recover debts in the ordinary course of business) for fees and other costs in excess of £10,000. 30 Change the nature of GMS' business or commence any new business which is not ancillary or incidental to the business (otherwise than in accordance with approved business plan). 34 Approval to acquire or to dispose of assets with a value exceeding £1,000,000, ensuring financial viability. 35 Enter into a loan agreement with another lender, including any mortgage or other charge with a value exceeding £1,000,000. 36 Approval to create issue or allow to come into being any encumbrance over the whole or any part of the undertaking or assets of GMS (save for charges arising by operation of law in the ordinary course of business or under retention of title covenants with suppliers to GMS). 37 Approval to make any capital distributions or dividend distributions. 45 Enter into or to renew a contract or series of connected revenue or capital contracts within their financial allocation for any material for consideration payable being in excess of £5,0000,000; or consideration receivable represents on average in excess of £5,0000,000; per annum. 46 Approval of capital transactions or contracts not within the approved Trust capital plan for the year. 47 Providing parent company guarantees for new GMS contracts.

	51 Approval of staffing establishment and structure that could adversely affect services provided to a client or have significant impact on the staffing structure (e.g. redundancies). 52 Approval of changes to terms and conditions, excluding non-contractual policies, for employees who transfer from the Trust to GMS. 54 Approval of pension scheme arrangements for employees who transfer from the Trust to GMS.

3 Decisions/Duties delegated by the Board to Committees

3.1 Audit and Assurance Committee

The Audit and Assurance Committee will be responsible for the following:

- To consider the appointment of the external auditor, in line with the Code of Conduct for Foundation Trusts, and the audit fee. It is the role of the Council of Governors to appoint or remove the Trust's external auditor.
- To discuss with the external auditor before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the health economy and with the Trust's internal auditors.
- To review external audit reports, including value for money reports and annual audit letters, together with the management response.
- To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.
- To approve and review the internal audit programme in line with the Assurance Framework, consider the major findings of internal audit investigations and management's response, to receive and review the Head of Internal Audit opinion and ensure co-ordination between the internal and external auditors.
- To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- To prepare an Annual Report that sets out how the Committee has met its Terms of Reference.
- To offer assurance to the Board that the Trust has a robust Assurance Framework which is operating satisfactorily and which ensures that the same level of scrutiny is given to clinical risks as to strategic, financial and operational risks. This will be done through consideration of the annual report of the Quality Committee and an annual review of the Assurance Framework prior to the preparation of the Annual Governance Statement.
- To review the annual financial statements before submission to the Board, focusing particularly on changes in, and compliance with, accounting policies and practices; major judgemental areas; significant adjustments resulting from the audit.
- To review the adequacy of the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as requested by the Directorate of Counter Fraud Services; and to review any instances of fraud logged.
- To ensure that the Standing Financial Instructions (SFIs) and Standing Orders (SOs) are maintained and are kept up to date, with an annual review.
- To review any instances where the SFIs/SOs have been overruled by any individual within the Trust; or any occasions where SOs have been suspended at a meeting.
- To review any instances where the Chief Executive has waived competitive tendering or competitive quotation requirements, or has given approval to a tender invitation to a firm not on the approved list.
- To consider the Trust's Emergency Preparedness, Resilience and Response (EPRR) framework and provide assurance to the Board that it is fit for purpose.
- To consider any instances of Director's interests in any potential contracts.
- To review any changes to the internal controls within the Trust.

- To review any special payments made with respect to compensation for any losses.
- To consider other topics as defined by the Board from time to time.

Oversight of the Trust's subsidiaries' audit arrangements

- Gain assurance that any subsidiaries set up and owned by the Trust have appropriate and effective audit arrangements.
- Appoint or remove the external auditor for Gloucestershire Managed Services (GMS).
- Appoint or remove the internal auditor for GMS.
- Obtain assurance and approve the proposals for the acquisition or disposal of assets (GMS).
- Approve any change to GMS' accounting reference date.

GMS Schedule of Matters Reserved and Delegated:

31 Appointment or removal of the external auditor for GMS

32 Appointment or removal of any internal auditor for GMS

42 Approval of any change to GMS' accounting reference date

3.2 Finance and Resources Committee

The Finance and Resources Committee will:

To seek assurance on and be responsible for:

- Progress on the delivery of the Financial Strategy
- Progress on the delivery of the financial aspects of the Operational Plan
- Annual financial plans: revenue, budget, capital, working and associated targets for savings to ensure sustainability
- The Trust's financial plans over the short, medium and long term
- Cash flow status
- The availability of financial management information (to ensure a consistent approach to financial management)
- Sustainable service commissioning
- Review and maintain an overview of financial and service delivery agreements and key contractual arrangements
- Oversee the development, management and delivery of the Trust's annual capital programme
- Consider the effectiveness and alignment of key financial policies with the Trust's strategy
- To consider and recommend for approval by the Trust's Board of Directors any proposed changes to the Standing Financial Instructions
- Progress on the delivery of the Trust's Digital Strategy and aligned programmes
- The changes being brought about by the use of data, information, knowledge and technology within the Trust
- The opportunities and risks of the changes brought about by the Digital Strategy and the changing expectations of staff, stakeholders, patients, service users and the public

- That the risks associated with the adoption of digital technologies are understood, weighted against the benefits and mitigated as far as is possible
- That the Trust is supported by technology that is scalable, interoperable, flexible, fixable, resilient and fit for purpose
- That digital implementation and support structures are properly resourced, are embedded throughout the organisation and appropriately involve users and other stakeholders.
- Any other relevant matters as referred by the Board.
- Ensure that the Trust's Estates Strategy is aligned to and responds to the Trust's Clinical Strategy and other enabling strategies and operational plans.
- Ensure that the Trust's Estates Strategy takes account of and, where appropriate, is aligned to the Integrated Care System (ICS)'s estates strategy.
- Provide assurance and oversight of the delivery of the Trust's major capital schemes, defined as those in excess of £5m and any smaller scheme considered to be 'high risk' as determined by the Trust's Capital Control Group.
- Ensure that the estates maintenance and refurbishment programmes are aligned to Trust strategy and the risks and impact on service delivery are understood and actively managed.
- Maintain oversight of risks related to the estate and facilities function and provide assurance to the Board that risks are being comprehensibly assessed, controlled and mitigated effectively, including clarity with respect to ownership of risks between Trust and GMS
- Obtain assurance on the effectiveness of the corporate governance arrangements in respect of GMS, both within the Trust and within GMS, to ensure that they comply with regulatory requirements, adopt relevant good practice, and are effective.
- Obtain assurance on the effectiveness of the Trust's arrangements for managing its contract(s) with GMS, including the oversight of GMS' performance against key indicators or other measures of service delivery on an exceptions basis.
- Approve GMS' corporate strategy/strategic direction and obtain assurance that the corporate strategy for GMS addresses the Trust's requirements of GMS and is consistent with relevant Trust strategies.
- On behalf of the Board, review and approve the GMS Business Plan for each financial year, and any subsequent business cases for new or changed services, (even if they are outlined in the Plan) where the proposal's impact is deemed 'significant' , ensuring that they addresses the Trust's objectives so far as they are relevant to the business of GMS and any other content that the Committee requires.
- Subsequently obtain assurance from the Trust Executive Directors that delivery is in line with the GMS Plan. (*NB the delivery of the contracted service will be overseen by the Contract Management Board*). This assurance will also include financial performance, including the GMS contribution to the Trust's CIP plans (*NB This is more specific than the review of Group financial performance performed at the Finance and Digital Committee)*.Further, this assurance will also cover the realisation of the benefits set out in the March 2018 GMS business case).
- Exercise Trust's responsibilities as the GMS owner/shareholder, as set out in the *Schedule of matters reserved and delegated*.
- Advise and make recommendations to the Board as necessary on the exercise of its responsibilities and authority as shareholder/owner and client/customer of GMS.

GMS Schedule of Matters Reserved and Delegated

13 On behalf of the Trust's Board of Directors, authorise any conflicts of interests for any directors of the Trust who are also directors of GMS.

17 Approval of the responsibilities of the GMS Board of Directors.
22 Approval of arrangements to ensure compliance with regulatory requirements.
26 Approval of GMS' corporate strategy/strategic direction.
27 Approval of the annual business plan and annual budget for GMS (including objectives and any other strategic measures of performance), and any amendments to them as well as any subsequent business cases for new or changed services (even if they are outlined in the Plan) where the proposal's impact is deemed 'significant'
28 Approval of the financial plan and annual budget for GMS.
29 Approval for any of GMS' services to be sub-contracted to another provider.
30 Change the nature of GMS' business or commence any new business which is not ancillary or incidental to the business (otherwise than in accordance with approved business plan)
34 Approval to acquire or to dispose of assets with a value exceeding £20,000 and up to £1,000,000.
35 Enter into a loan agreement [with GMS on behalf of the Trust, including any mortgage or other charge
36 Enter into a loan agreement on behalf of GMS with another lender, including any mortgage or other charge with a value exceeding £20,000 and up to £1,000,000.
39 Acquisition of any interest or share capital in another body corporate.
40 Making any loan or granting credit, other than trade credit in the normal course of business on arm's length terms, or granting any guarantee or indemnity of the obligations of any person.
41 Approval of accounting and financial policies and procedures, subject to compliance with the approved budget and financial plan.
43 Approval to open or close any bank account for GMS.
45 Enter into or to renew a contract or series of connected revenue or capital contracts for any material for consideration payable being in excess of £250,000 and up to £5,0000,000; or consideration receivable represents on average in excess of £250,000 and up to £5,0000,000; per annum.
49 Obtain assurance that the findings and recommendations of GMS-related internal audit reports have been addressed by the GMS.
50 Approval of revenue transaction over £50,000 and not within the approved business plan for the year.

3.3 People and Organisational Development Committee

The People and Organisational Development Committee will:

- Obtain assurance that there are practices in place which ensure the sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention;
- Obtain assurance that the Trust attracts and retains a high performing workforce capable of delivering the Trust operational clinical strategies;
- Obtain assurance that the Trust implements effective and equitable reward packages that positively impact on performance and meet national and legislative parameters;
- Obtain assurance that strategic education issues and external relationships which impact on supply and engagement are included in Trust planning;
- Obtain assurance that the Trust delivers services which are fair and equitable promoting diversity and equality of opportunity;
- Obtain assurance that the Trust is driving improved employee engagement, ensuring appropriate mechanisms for the employee voice to ensure that rapid action is taken to improve staff experience.
- Obtain assurance that the research programme and governance framework is implemented and monitored.
- Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy;
- Agree annual objectives for Health and Safety;
- Agree (where necessary) People and Organisational Development reports prior to publication and review implications of national reports that have been published;
- Identify risks associated with People and Organisational Development issues ensuring ownership with mitigating actions, escalating to Trust Board as required;
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary;
- Consider and approve action plans, programmes of work and strategic objectives as a result of national audit related to protected characteristics and provide assurance to the Board on progress; and

Work with the Quality and Performance Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.

3.4 Quality and Performance Committee

The Quality and Performance Committee will:

- Monitor the Trust's arrangements to ensure its services are safe, effective, caring, responsive and well-led.

- Scrutinise the assessment of quality and performance risks identified in the Board Assurance Framework, ensuring there is sufficient assurance that these risks are adequately managed, including actions to eliminate gaps in controls.
- Review the arrangements in place to monitor compliance with key statutory requirements and guidance including, in particular, the Health and Social Care Act 2008 and associated regulations.
- Oversee the process by which quality and performance measures are developed and maintained and recommend to the Board the range of indicators that should be monitored.
- Monitor performance of the Trust's services against key quality and performance indicators, including clinical outcomes measures, as determined by the Board.
- Monitor arrangements to establish and maintain a culture that reflects the vision and values of the Trust, encouraging openness and transparency and promoting good quality care.
- Scrutinise the work of the relevant sub-committees through regular review of sub-committee reports.
- Regularly review the Trust's process of quality impact assessment of cost improvement plans (CIPs) and post-implementation reviews.
- Provide information as required to enable the Audit and Assurance Committee to discharge its duties in relation to internal control and risk management. The Chair of the Quality and Performance Committee shall be invited to attend the Audit and Assurance Committee annually, at the request of the Audit and Assurance Committee Chair, to assess the effectiveness of the relationship between the two committees.
- Report to the Audit and Assurance Committee once a year on the ways in which the Quality and Performance Committee has fulfilled its duties to assure the quality and safety of the Trust's services, including quality governance and audit.
- Where the Committee is concerned that identified risks have a material impact on the remit of either the Audit and Assurance Committee, the Finance and Resources Committee and the People and Organisational Development Committee to refer the details to the other relevant committees.
- Identify any gaps or weaknesses in the quality governance framework.
- Undertake thematic reviews of quality and performance topics identified for priority focus through the work of the Committee.
- Receive and scrutinise reports from the internal auditor relating to quality governance and other quality and performance matters.
- Recommend to the Audit and Assurance Committee areas of focus for the internal audit plan.
- Review the Trust's draft annual Quality Account prior to adoption by the Board.

3.5 Remuneration Committee

The Remuneration Committee will:

A. Appointments Role

- Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes.

- Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.
- Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

B. Remuneration Role

- Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process.
- Determine the remuneration and terms of service of Executive Directors.
- Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors.
- Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole).

Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.

4 Scheme of Delegation of Powers from the Constitution

Constitution Ref	Delegated to	Authorities/Duties Delegated
7.4.3 & 7.4.4 & 7.4.5	Trust Secretary	Make decisions regarding Members' and applicants' eligibility or disqualification.
7.7.9	Chair	Preside at the Annual Members' Meeting.
8.6.1	Chair	May veto the appointment of a Stakeholder Governor by serving notice in writing to the relevant sponsoring organisation where they believe that the appointment in question is unreasonable, irrational or otherwise inappropriate.
8.7.2	Trust Secretary	Ensure NHS Improvement (Monitor) is provided with details of the serving Lead Governor.
8.11.2	Trust Secretary	Request, where the vacancy arises amongst the appointed Governors, the appointing organisation appoints a replacement to hold office for the remainder of the term of office.
9.5	Chair	May exercise a second or casting vote where the number of votes for and against a motion is equal at a meeting of the Board of Directors.
17.5	Chair	Judge whether a transaction is "deemed to be high risk by its nature" or "of specific relevance to governor priorities".
Annex 2 3.4	Chair	Give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business of the meeting shall be conducted without interruption and disruption; exclude any member of the public or press from a meeting of the Council of Governors if they are interfering with, or preventing the proper conduct of the meeting.
Annex 2 3.7	Chair	Call a meeting of the Council of Governors at any time.
Annex 2 3.9	Chair	Serve notice of a Council of Governors meeting on governors.
Annex 2 3.17	Chair	Exercise a casting vote where the number of votes for and against a motion is equal at a meeting of the Council of Governors.
Annex 2 3.27	Chair	Decide questions of order, relevance, regularity and any other matters at a meeting of the Council of Governors.
Annex 2 3.33	Trust Secretary	Keep records of all written resolutions of any matter determined by the Council of Governors.
Annex 2 5.1.1 & 5.1.2	Governors	Declare any actual or potential conflict of interest.
Annex 2 5.1.3	Chair	Determine what action to take if a Governor has a conflict of interest.
Annex 2 5.3.1	Trust Secretary	Ensure a register of interests is established to record formally declarations of interests of Governors.

5 Scheme of Delegation of Powers from the Board Standing Orders (SOs)

SO Ref	Delegated to	Authorities/Duties Delegated
1.1	Chair	Be the final authority on the interpretation of the Standing Orders (on which they should be advised by the Chief Executive, Director of Finance and Trust Secretary).
3.4	Chair	Give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted.
3.7	Chair	Call a meeting of the Trust Board at any time.
3.9	Chair	Serve notice of the meeting of the Trust to every Director.
3.16 & 3.26	Chair	Exercise a casting vote where the number of votes for and against a motion is equal.
3.25	Chair	Decide questions of order, relevance, regularity and any other matters at the meeting of the Trust.
4.2	Chief Executive and Chair	Exercise the powers which the Board has retained to itself within the Standing Orders in emergency.
4.5	Chief Executive	Determine which functions they will perform personally and nominate officers to undertake the remaining functions for which they will still be accountable to the Board.
4.6	Trust Secretary	Prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendments agreed during the discussion; and periodically propose amendment to the Scheme of Delegation.
6.3.5	Chair	Determine what action to take if during the course of a meeting of the Board a Director has a conflict of interest.
6.13	Trust Secretary	Ensure a register of interests is established to record formally declarations of interests of Directors.
7.6	Directors, Governors and officers of the Trust	Disclose to the Chief Executive any relationship with a candidate for any staff appointment of whose candidature that Director or officer is aware.
7.6	Chief Executive	Report to the Trust any disclosure made by any Director, Governor and officer of the Trust concerning any relationship with a candidate of whose candidature that Director or officer is aware.
8.4	Director of Finance or nominated officer	Maintain a list of applicable exemptions from waivering competition.
8.5	Director of Finance	Waive competitive tendering/quotation procedures in specific circumstances as defined in SO 8.5.1-8.5.4.
8.6	Chief Executive and Director of Finance	Waive formal tendering procedures over £25,000 excluding VAT and under the thresholds of the EU Procurement Directives given specific circumstances as defined in SO 8.6.1-8.6.5.
8.16	Chief Executive or officer	Evaluate quotations and select the one which gives the best value for money.

	nominated by them	
8.18	Chief Executive	Ensure best value for money can be demonstrated for all services provided under contract or in-house.
8.19.1	Chief Executive	Demonstrate the use of private finance represents value for money and genuinely transfers risk to the private sector.
8.22 & 10.4	Chief Executive	Nominate an officer who shall oversee and manage each contract on behalf of the Trust.
8.22	Chief Executive	Nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and enter into contracts for the employment of agency staff or temporary staff.
8.23	Chief Executive	Nominate officers to assess the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.
8.23	Head of Shared Services or Head of Procurement	Peer review and confirm the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.
8.25	Chief Executive	Nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.
11.1 & 11.5	Trust Secretary	Keep the Common Seal of the Trust in a secure place and maintain a register of sealing.
11.3	Director of Finance	Approve and sign the sealing of any building, engineering, property or capital document.
11.3	Chief Executive	Authorise and countersign the sealing of any building, engineering, property or capital document.
11.4	Trust Secretary	Witness and attest to the affixing of the seal.
12.1	Chief Executive	Sign any documents where the signature will be a necessary step in legal proceedings involving the Trust.
12.2	Chief Executive	Sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.
13.1	Chief Executive	Ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions.
Annex A	Chief Executive	Perform tendering procedure as designated in Annex A of the SOs.

6 Scheme of Delegation of Powers from the Standing Financial Instructions (SFIs)

SFI Ref	Delegated to	Authorities/Duties Delegated
1 Introduction		
1.3.6 & 1.3.9	Chief Executive	Ensuring that all members of the Board, employees of the Trust and contractor are notified of and understand their responsibilities within SFIs.
1.3.7	Finance Director	1 Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

		2 Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; 3 Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; 4 Ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors; 5 Providing of financial advice to the Trust and its Directors and employees; 6 Designing, implementing and supervising of systems of internal financial control; and 7 Preparing and maintaining of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
1.3.8 & 1.3.9	All directors, staff and contractors	Security of Trust property; avoiding loss; exercising economy and efficiency in the use of resources; conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation; and reporting suspected theft or fraud to the Director of Finance.
2 Audit		
2.1.1	Audit and Assurance Committee	1 Overseeing Internal and External Audit services; 2 Reviewing systems of internal control and ensuring they are fit for purpose; 3 Monitoring compliance with Standing Orders and Standing Financial Instructions; and 4 Reviewing schedules of losses and compensations and making recommendations to the Board.
2.1.3	Director of Finance	Ensuring adequate internal audit service is provided
2.1.4	Audit and Assurance Committee	Making a recommendation to the Council of Governors to the appointment of external auditors; assessing the external (financial) auditors on an annual basis in terms of the quality of their work
2.2.1	Chief Executive / Director of Finance	Monitoring and ensuring compliance with the directions issued by the Secretary of State for Health and/or NHS Counter Fraud Authority on fraud, bribery and corruption.
2.2.4	Local Counter Fraud Specialist	Providing a written report at least annually on counter fraud work within the Trust.
2.2.5	All staff	Informing the Finance Director or Local Counter Fraud Specialist if they discover or suspect a loss of any kind
2.3.1	Director of Finance	1 Ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function; 2 Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

		3 In conjunction with the Counter Fraud and Security Management Service, deciding at what stage to involve the police in cases of misappropriation, and other irregularities; 4 Ensuring that an annual Internal Audit Report is prepared for the consideration of the Audit and Assurance Committee and the Board; 5 Ensuring that a three year strategic Internal Audit Plan is prepared for the consideration of the Audit and Assurance Committee and the Board; and 6 Ensuring that an annual Internal Audit Plan is produced for consideration by the Audit and Assurance Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year.
2.3.3	All staff	Notifying the Director of Finance or Local Counter Fraud Service whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature.
2.4.1	Director of Finance	Ensuring an Internal Audit function is in place and operates efficiently and effectively.
2.4.2	Internal Auditor	1 Providing assurances about the effectiveness of controls in place across all of the Trust's activities; 2 Reviewing the overall arrangements the Board itself has in place for securing adequate assurances and providing an opinion on those arrangements to support the Statement on Internal Control; and 3 Reviewing the way in which the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.
2.5.2	Council of Governors	Appointing (or removing) the external (financial) auditor on behalf of the Trust in accordance with the selection criteria in the Audit Code for NHS Foundation Trusts.
2.6.1	Chief Executive	Ensuring compliance with the Audit Code for NHS Foundation Trusts.
3 Financial Targets		
3.3	Chief Executive	Ensuring the Trust aims to maintain its financial viability and meets any specific financial targets set by the regulator; setting appropriate internal targets in order to ensure financial viability; signalling to the Finance and Digital Committee and the Board where the Trust's financial viability or key targets are at risk.
3.4	Director of Finance	1 Advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate; 2 Ensuring that adequate systems exist internally to monitor financial performance; 3 Managing the cash flow and external borrowings of the Trust; and 4 Providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.
4 Business Planning, Budgets and Budgetary Control		
4.1.1	Council of Governors	Providing the Board with its views on the Trust's forward plans for each financial year.

4.1.1	The Board	Consulting the Council of Governors on the Trust's forward plans for each financial year.
4.1.2	Chief Executive	Compiling and submitting to the Board and the Council of Governors an annual business plan which takes into account financial targets and forecast limits of available resources.
4.1.3	Chief Executive	Submitting the approved Business Plan to the Regulator as required.
4.1.4	Chief Executive	Ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.
4.1.5	Director of Finance	Preparing and submitting revenue and capital budgets for approval by the Board.
4.1.6	Director of Finance	Monitoring financial performance against budget and the Business Plan and report to the Board.
4.1.7	Budget holders	Providing information as required by the Director of Finance to enable budgets to be compiled and to explain variances.
4.1.8	Director of Finance	Ensuring adequate, on-going training is delivered to budget holders to help them manage their budgets successfully.
4.2.1	Director of Finance	Delegate the management of a budget to permit the performance of a defined range of activities.
4.2.1 & 4.3.2	Budget holders	The management of a budget to permit the performance of a defined range of activities.
4.3.1	Director of Finance	Devise and maintain systems of budgetary control including monthly financial reports to the Board containing sufficient information to ascertain financial performance.
4.3.3	Chief Executive	Ensuring the identification and implementation of cost improvements and income generation initiatives in accordance with the requirements of the annual Business Plan and agreed Control Total.
4.3.4	Director of Finance	Advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and also on the financial implications of future plans and developments proposed by the Trust.
4.5.1	Chief Executive	Providing the Regulator with the appropriate monitoring information.
4.5.2	Chief Executive	Ensuring the Trust contributes to standard national NHS data flows required for NHS policy development/ funding decisions as well as performance assessment by the Healthcare Commission.
5 Annual Accounts and Reports		
5.1	Director of Finance	1 Preparing annual accounts in accordance with the Regulator's Manual of Accounts and any other guidance from the same, the Trust's accounting policies and generally accepted accounting practice; 2 Preparing and submitting annual accounts to the Board and an audited summary of the Main Financial Statements to an Annual Members' Meeting convened by the Council of Governors, certified in accordance with current guidelines; and 3 Laying a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.

5.4.1	Trust Secretary	Preparing and submitting annual reports to the Board and an audited summary to an Annual Members' Meeting convened by the Council of Governors.
6 Bank Accounts		
6.1.1 & 6.4.1	Director of Finance	Managing and regularly reviewing the Trust's banking arrangements and advising the Trust on the provision of banking services and operation of accounts.
6.2.1	Director of Finance	Responsible for bank accounts; establishing separate bank accounts for the Trust's charitable funds; ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
6.3.1	Director of Finance	Preparing detailed instructions on the operation of bank accounts.
6.3.2	Director of Finance	Advising the Trust's bankers in writing of the conditions under which each account will be operated.
7 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments		
7.1.1	Director of Finance	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
7.1.3	Director of Finance	Banking of all monies received.
7.2.2	Director of Finance	Approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute.
7.3.1	Director of Finance	Take appropriate recovery action on all outstanding debts and provide the Finance and Digital Committee with a monthly analysis of debtors profiled by age and actions to recover.
7.4.1	Director of Finance	1 Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; 2 Ordering and securely controlling any such stationery; 3 Providing adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and 4 Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
8 NHS Contracts for the Provision of Services		
8.1	Chief Executive	Ensuring that the Trust enters into suitable legally binding contracts with NHS commissioners both for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator and also other healthcare services.
8.2	Chief Executive	Ensuring the Trust works will all partner agencies involved in both the delivery and the commissioning of the service required.
8.3	Director of Finance	Ensuring regular reports are provided to the Finance and Digital Committee and the Board detailing forecast/ budgeted and actual income from contracts with NHS commissioners, particularly highlighting the impact of differences between planned and actual numbers of patients treated and outline any action required to

		address such variances and periodically providing information on the impact of differences between the actual cost to the Trust of treating patients in individual service lines and the relevant national tariff.
9 Terms of Service and Payment of Directors and Employees		
9.1.2	Remuneration Committee	1 Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes; 2 Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future; 3 Appoint candidates to fill all the executive director positions on the Board; 4 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract; 5 Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process; 6 Determine the remuneration and terms of service of Executive Directors; 7 Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors; 8 Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole); and 9 Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.
9.1.3	Remuneration Committee	Send recommendations in report to the Board.
9.2.2	Vacancy Control Panel	Authorise changes to the funded establishment.
9.3.1	Vacancy Control Panel	Authorise changes in any aspect of remuneration, unless the changes are within the limit of the employee's approved budget and funded establishment.
9.3.1	Budget holders	Recruit to vacancies provided that this is within their approved budget and funded establishment.
9.4.1	Director of Finance	1 Specifying timetables for submission of properly authorised time records and other notifications; 2 Authorising the final determination of pay;

		3 Making payment on agreed dates; and 4 Agreeing method of payment.
9.4.2	Director of Finance	Issuing instructions regarding processing of payroll.
9.4.3	Nominated managers	1 Submitting time records, and other notifications in accordance with agreed timetables; 2 Completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and 3 Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.
9.4.4	Director of Finance	Ensuring the chosen method for providing the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.5.1	Director of People and OD	1 Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and 2 Dealing with variations to, or termination of, contracts of employment.
10 Non-pay Expenditure		
10.1.1	Chief Executive	Determine level of delegation to budget managers.
10.1.2	Director of Finance	Set out the list of managers who are authorised to place requisitions for the supply of goods and services; and the maximum level of each requisition and the system for authorisation above that level.
10.1.3	Director of Finance	Ensuring the Trust has clearly established arrangements for the purchase of goods and services.
10.1.4	Director of Finance	Ensuring the Trust makes optimum use of corporate, national or regional contracts for the acquisition of goods and services, in order to ensure best value for money.
10.2.1	Requisitioners	Obtain the best value of money for the Trust when choosing an item to be supplied, seeking the advice of the Procurement Shared Service.
10.2.2	Director of Finance	Paying accounts and claims promptly and paying contract invoices in accordance with contract terms or otherwise national guidance.
10.2.3	Director of Finance	1 Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; 2 Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; 3 Be responsible for the prompt payment of all properly authorised accounts and claims and for advising the Board on a monthly basis of performance against targets set under the Government's Better Payments Practice Code;

		4 Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. 5 Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, except in exceptional circumstances where prepayments are permitted. 6 Be responsible for ensuring due diligence checks are carried out on new or any changes made to existing supplier details before updating the finance system.
10.2.4	Budget holders	Ensuring all items due under a prepayment contract are received and informing the appropriate manager if problems are encountered.
10.2.4	Director of Finance	Be satisfied with the proposed arrangements for prepayments before contractual arrangements proceed.
10.2.6	Managers	Ensure full compliance with the guidance and limits specified by the Director of Finance concerning contracts and other commitments which may result in a liability.
10.2.7	Director of Finance	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the appropriate guidance.
11 Treasury Management		
11.1.2	Director of Finance	Advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health and report periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts,
11.1.3	Director of Finance	Make, or delegate an employee to make, any application for a loan, financing facility or overdraft.
11.1.4	Director of Finance	Prepare detailed procedural instructions concerning applications for loans, financing facilities and overdrafts.
11.1.5	Director of Finance	Authorise short term borrowing requirements.
11.2.2	Director of Finance	Advise the Board on investments and report periodically to the Board concerning the performance of investments held, other than short term temporary cash surpluses.
11.2.3	Director of Finance	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
11.3.1	Director of Finance	Manage and monitor the overall cash flow of the Trust and provide reports thereon to the Finance and Digital Committee and the Board.
12 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets		
12.1.1	Chief Executive	Ensure adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and ensure that the capital investment is not undertaken without consideration of the availability of resources to finance all revenue consequences, including capital charges.
12.1.2	Chief Executive	Ensure that for every capital expenditure proposal a business case is produced and the Director of Finance has certified to the costs

		and revenue consequences detailed in the business case which is approved by the Board subject to agreed delegated limits.
12.1.3	Director of Finance	Issue procedures for the management of capital schemes where the contracts stipulate stage payments; and issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
12.1.4	Chief Executive	Issue necessary authority to the manager responsible for any capital programme and a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.
12.1.5	Director of Finance	Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
12.2.1	Director of Finance	Demonstrate the use of private finance represents value for money and appropriately transfers significant risk to the private sector.
12.3.1	Responsible Officer	Maintain registers of assets and arrange a physical check of assets against the asset register to be conducted once every two years.
12.3.5	Director of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
12.4.1	Chief Executive	Control of fixed assets.
12.4.2	Director of Finance	Approve asset control procedures.
12.4.4	Directors and senior employees	Apply appropriate routine security practices in relation to NHS property.
13 Stores and Receipt of Goods		
13.2	Chief Executive	Delegate day-to-day responsibility for the control of stores of goods, subject to the responsibility of the Director of Finance for the systems of control.
13.3 & 13.7	Designated Manager / Pharmaceutical Officer	Define in writing the responsibility for security arrangements and the custody of keys for all stores and locations; be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles; and report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice.
13.4	Director of Finance	Set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
13.5	Director of Finance	Agree stocktaking arrangements.
13.8	Director of Finance	Identify those authorised to requisition and accept goods supplied via the NHS Supply Chain central warehouses.
14 Disposals and Condemnations, Losses and Special Payments		
14.1.2	Director of Finance	Prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.
14.1.4 & 14.1.5	Director of Finance	Authorise employees to condemn or otherwise all unserviceable articles; approve the form in which this is recorded; and take appropriate action if there is evidence of negligence.
14.1.4 & 14.1.5	All staff	If authorised by the Director of Finance, condemn or otherwise all unserviceable articles; record in a form approved by the Director of

		Finance; and report any evidence of negligence in use to the Director of Finance.
14.2.1	Director of Finance	Prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
14.2.2	All staff	Inform their head of department if they discover or suspect a loss of any kind, who must immediately inform the appropriate officer.
14.2.3	Director of Finance	Report losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, to the Audit and Assurance Committee.
14.2.4	Director of Finance	Take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
14.2.5	Director of Finance	Consider whether any insurance claim can be made for any loss.
14.2.6	Director of Finance	Maintain a Losses and Special payments Register.
15 Information Technology		
15.2	Director of Finance	Ensuring the accuracy and security of the computerised financial detail.
15.3	Director of Finance	Ensuring an appropriate Business Case is prepared and approved for a new financial system or significant amendment to a current financial system.
15.5	Director of Finance	Ensuring contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage.
16 Patients' Property		
16.2	Chief Executive	Ensuring patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.
16.3	Chief Operating Officer	Provide arrangements for the administration of patient property.
18 Acceptance of Gifts by Staff		
18.1	Director of Finance	Ensure staff are aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.
19 Retention of Documents		
19.1 & 19.3	Chief Executive	Maintaining archives for all documents required to be retained in accordance with Department of Health guidelines; instigating the destruction of these documents and maintaining a record of destroyed documents.
20 Risk Management & Insurance		
20.1	Chief Executive	Ensuring the Trust has a programme of risk management which is approved and monitored by the Board.
20.4	Director of Finance	Ensuring insurance arrangements exist where appropriate.

Appendix 1: Financial Delegation Limits

1.1 Revenue and Capital Expenditure (SFI Appendix 1.1.3)

Responsibility	**Board**	**Chief Executive, delegated to the Trust Leadership Team**
Approval of capital expenditure, business cases & PFI schemes, including approval of variations	>£1,000,000	<£1,000,000
Approval of increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves	If the increase is >10% of the value in the agreed financial plan	If the increase is equal to or >10% of the value in the agreed financial plan

1.1.1 Authorisation of Virement (SFI Appendix 1.1.4-1.1.5)

Executive Director	**Divisional Director**	**Budget holders**
<£100,000 between budgets with their control	<£25,000 within budgets in their control (but <£100,00 provided each of the three (four) DD's agree)	<£5,000 between budgets under their control (<£5,000 non-recurringly and <£1,000 recurringly between revenue budgets within their control)

1.2 Purchase Orders (SFI Appendix 1.3)

Expenditure range	**Authorised personnel**
Up to £1,000	Budget Holder
£1,000 to £10,000	Level 2 Approvers
£10,000 to £50,000	Level 3 Approvers
£50,000 to £100,000	Director of Operational Finance/Deputy Chief Executive Officer
£100,000 to £500,000	Director of Operational Finance/Deputy Chief Executive Officer
above £500,000	Chief Executive and Director of Finance

1.3 Tendering Limits (SFI Appendix 1.4)

Expenditure range	**Action required**
Up to £10,000	Single supplier or quotations via Procurement Shared Services
£10,001 to £50,000	Competitive quotations/tenders via Procurement Shared Services
£50,001 to UK Public Procurement Threshold	Formal tender procedure or further competition through an approved framework via Procurement Shared Service

Above UK Public Procurement Threshold	Formal tender procedure via Procurement Shared Services in accordance with UK Public Procurement Regulations or further competition through an approved framework.

1.4 Authorisation to enter into and sign Contracts for goods and services (SFI Appendix 1.5)

	Level 3/4 Budget Holders	Trust Leadership Team	Finance and Digital Committee	Trust Board
Total contract value (over the lifetime of the contract including permitted extensions)	0 - £250k	>£250k - £1m	>£1m - £5m	>£5m

a. Delegated authority limits associated with tendering (SFI 8.5)

	Director of Finance (in consultation with Chief Executive)	**Trust Leadership Team**	**Trust Board**
Decision not to bid	No limit	Not applicable	Not applicable
Total or annual value range where services are provided by the Trust and tender is to retain the current provision	0 - £10m	>£10m - £50m	>£50m
Total or annual value range where services are not currently provided by the Trust and tender is to acquire provision	0 - £5m	>£5m - £25m	>£25m

b. Charitable Funds (SFI Appendix 1.6)

Expenditure range	**Authorised personnel**
Up to £1,000	Fund holders (unless a lower limit is specified by the Chief Operating Officer and Deputy Chief Executive.)
£1,001 to £5,000	Chief Operating Officer and Deputy Chief Executive (who may delegate as he/she judges appropriate to senior managers)
Above £5,000	Charitable Funds Committee

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Standing Financial Instructions (SFIs)

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Foreword

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

1. The Gloucestershire Hospitals NHS Foundation Trust is a public benefit corporation which was established on 1st July 2004 under the Health & Social Care (Community Health & Standards) Act 2003 (subsequently consolidated into Chapter 5 of the National Health Service Act 2006). NHS Foundation Trusts are governed by a range of statutes, including the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) and the National Health Service Act 1977 (NHS Act 1977). The statutory functions conferred on the Trust are set out in the NHS & CC Act 1990 (Schedule 2), Chapter 5 of the National Health Service Act 2006 and the Trust's constitution.

2. As a public benefit corporation, the Trust has specific powers to do anything which appears to be necessary or desirable for the purposes of, or in connection with, its functions. In this respect it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

3. The Membership and Procedure Regulations 1990 (SI (1990)2024) require Trusts to adopt Standing Orders (SOs) for the regulation of their procedures and business whilst the "Directions on Financial Management in England" issued under HSG (96)12 in 1996, require Health Authorities to adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals. These Directions are not mandatory on NHS Foundation Trusts but are being observed, as far as they are relevant, as a matter of good practice.

4. In addition the Code of Accountability for NHS Boards (published by the Department of Health in April 1994, EL(94)40) requires Boards to draw up Standing Orders, a Schedule of Decisions reserved to the Board and Standing Financial Instructions. The Code also requires Boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives. Additionally, Boards will have drawn up locally generated rules and instructions, including financial procedural notes, for use within their organisation. Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

1. Introduction

1.1 General

1.1.1 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust and shall have effect as if incorporated in the Standing Orders (SOs) of the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.2 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the Trust's detailed corporate policy documents, financial procedures and any departmental procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance or delegated officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.4 The National Health Service Act 2006, The Health Act 2009 and the Foundation Trust's Constitution require that all the powers of the Foundation Trust are exercisable by the Board of Directors on its behalf. Standing Orders and the Reservation of Powers to the Board and Scheme of Delegation together with these Standing Financial Instructions and such other locally generated rules and instructions, including financial procedure notes, as may exist for use within the Foundation Trust provide a regulatory and business framework for the conduct of the Board of Directors. Collectively these documents must comprehensively cover all aspects of financial management and control. In effect, they set the business rules which Board members and officers must follow when taking action on behalf of the Board.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

a. "Trust" means the Gloucestershire Hospitals NHS Foundation Trust;

b. "Board" means the Board of Directors of the Trust as set out in the Constitution;

c. "Committee" means any committee established by the Council of Governors or the Board of Directors for the purposes of fulfilling its functions;

d. "Council of Governors" means the body of elected and appointed governors, authorised to be members of the Council of Governors and to act in accordance with the Constitution;

e. "Constitution" means the constitution, approved by the Independent Regulator, and which describes the operation of the Foundation Trust;

f. "Chief Executive" means the chief officer of the Trust;

g. "Director of Finance" means the chief financial officer of the Trust;

h. "2006 Act" refers to the National Health Service Act 2006;

i. "Authorisation agreement" refers to the document issued by the Regulator at the inception of the Trust authorising it to operate as a Foundation Trust in accordance with Chapter 5 of the National Health Service Act 2006;

j. "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

k. "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

l. “Funds held on trust” shall mean those funds which the Trust holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006, as amended. Such funds may or may not be charitable;

m. "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice;

n. “Mandatory services” are those services which the Regulator has deemed it compulsory that the Trust provides, as listed in the Authorisation agreement;

o. “Protected assets” refers to those assets of the Trust deemed by the Regulator to be essential to the provision of mandatory services (see above) and listed as such in the Authorisation agreement;

p. “Regulator” means the Independent Regulator for the purposes of the 2006 Act;

q. “Shared Services” means the Shared Services for Finance and Procurement, hosted by the Gloucestershire Hospitals NHS Foundation Trust;

r. "SFIs" means Standing Financial Instructions;

s. “SOs” means Standing Orders; and

t. “Virement” means the transfer of budgetary provision from one budget head to another.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a. formulating the financial strategy;

b. requiring the submission and approval of budgets;

c. defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d. defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the ’Reservation of Powers to the Board’ document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is accountable to the Board for ensuring that the Trust fulfils the functions and responsibilities set out in the Authorisation agreement within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust’s system of internal control.

1.3.5 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7 The Director of Finance is responsible for:

a. implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

b. maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c. ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and

d. ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors.

And, without prejudice to any other functions of Directors and employees to the Trust, the duties of the Director of Finance include:

e. the provision of financial advice to the Trust and its Directors and employees;

f. the design, implementation and supervision of systems of internal financial control; and

g. the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All directors and employees, singularly and collectively, are responsible for:

a. the security of the property of the Trust;

b. avoiding loss;

c. exercising economy and efficiency in the use of resources;

d. conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation; and

e. reporting suspected theft or fraud to the Director of Finance and/or Local Counter Fraud Service.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. Audit

2.1 Audit and Assurance Committee

2.1.1 In accordance with Schedule 7 (paragraph 23) of the 2006 Act and both the Trust's Constitution and Standing Orders, the Board shall formally establish an Audit and Assurance Committee of Non-Executive Directors to perform such monitoring, review and other functions as are appropriate. In particular the Audit and Assurance Committee will provide an independent and objective view of internal control by:

a. overseeing Internal and External Audit services;

b. review systems of internal control and ensure they are fit for purpose;

c. monitoring compliance with Standing Orders and Standing Financial Instructions; and

d. reviewing schedules of losses and compensations

2.1.2 Where the Audit and Assurance Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit and Assurance Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be brought to the attention of the Council of Governors and the Regulator.

2.1.3 It is the responsibility of the Director of Finance to ensure that an adequate internal audit service is provided and the Audit and Assurance Committee shall be involved in the selection process when an internal audit service provider is changed. This will likely involve a nominated member of the Audit and Assurance Committee being the Trust's representative on the Countywide selection panel (where the service is countywide).

2.1.4 The Audit and Assurance Committee is responsible for making a recommendation to the Council of Governors to the appointment of external auditors. The Committee has a responsibility for assessing the external (financial) auditors on an annual basis, in terms of the quality of their work.

2.2 Fraud and Corruption

2.2.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with directions issued by the Secretary of State for Health and/or NHS Counter Fraud Authority on fraud, bribery and corruption.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and guidance.

2.2.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff within the NHS Counter Fraud Authority in accordance with the NHS Counter Fraud Manual.

2.2.4 The local counter Fraud Specialist will provide a written report, at least annually on counter fraud work within the Trust.

2.2.5 Any employee discovering or suspecting a loss of any kind must either immediately inform the Finance Director, or inform the Local Counter Fraud Specialist who will then appropriately inform the Finance Director and/or Chief Executive.

2.3 Director of Finance

2.3.1 The Director of Finance is responsible for:

a. ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b. ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c. in conjunction with the Counter Fraud and Security Management Service, deciding at what stage to involve the police in cases of misappropriation, and other irregularities;

d. ensuring that an annual Internal Audit Report is prepared for the consideration of the Audit and Assurance Committee and the Board. The report must cover:

   i. a clear statement on the effectiveness of internal control, in accordance with current controls assurance guidance issued by the Department of Health including for example compliance with control criteria and standards,

   ii. major internal control weaknesses discovered,

   iii. progress on the implementation of internal audit recommendations,

   iv. progress against plan over the previous year;

e. ensuring that a three year strategic Internal Audit Plan is prepared for the consideration of the Audit and Assurance Committee and the Board; and

f. ensuring that an annual Internal Audit Plan is produced for consideration by the Audit and Assurance Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year.

2.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b. access at all reasonable times to any land, premises or employee of the Trust;

c. the production of any cash, stores or other property of the Trust under an employee's control; and

d. explanations concerning any matter under investigation.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance or Local Counter Fraud Service must be notified immediately.

2.4 Role of Internal Audit

2.4.1 In accordance with the requirements of the Accounting Officer Memorandum issued by the Regulator, the Trust is required to establish an Internal Audit function. It is the responsibility of the Director of Finance to ensure that this function is in place and operates efficiently and effectively.

2.4.2 Internal Audit will provide assurances about the effectiveness of controls in place across all of the Trust's activities. To fulfill this function, Internal Audit will review the overall arrangements the Board itself has in place for securing adequate assurances and provide an opinion on those arrangements to support the Statement on Internal Control (see Section 5.2). This will entail reviewing the way in which the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.

2.4.3 In addition Internal Audit will provide specific assurances on the areas covered in the Internal Audit Plan as approved by the Audit and Assurance Committee (see 2.3.1), and will work alongside other professionals wherever possible to advise on systems of control and assurance arrangements. This is a distinct role, which is quite different to reviewing and

commenting on the reliance of the assurances themselves, which is the responsibility of the Board.

2.4.4 The Head of Internal Audit will normally attend Audit and Assurance Committee meetings and has a right of access to all Audit and Assurance Committee members, the Chair and Chief Executive of the Trust.

2.4.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for Internal Audit shall be agreed between the Director of Finance, the Audit and Assurance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.5 External Audit

2.5.1 The Trust is required to have an external (financial) auditor and is to provide such information and facilities as are necessary for the auditor to fulfil their responsibilities under Chapter 5 of the 2006 Act.

2.5.2 Under Schedule 7 (paragraph 23) of the 2006 Act and the Trust's Constitution, it is the responsibility of the Council of Governors at a General Meeting to appoint (or remove) the external (financial) auditor on behalf of the Trust. As part of the appointment process, the Trust must ensure that the auditors meet the selection criteria set out in Appendix B of the Audit Code for NHS Foundation Trusts.

2.5.3 In accordance with the Audit Code for NHS Foundation Trusts, a market testing exercise will be undertaken as a minimum every 5 years.

2.5.4 The Council of Governors also has the power to appoint (and remove) any external auditor appointed to review and report on any other aspect of the Trust's affairs.

2.6 Audit Code

2.6.1 The Trust has a responsibility, under the terms of its Authorisation agreement, to comply with the Audit Code for NHS Foundation Trusts as approved by the Regulator. The Chief Executive has overall responsibility for ensuring compliance with the Code.

3. Financial Targets

3.1 The Trust is required to meet such financial targets as are specified by the Regulator, either under the terms of the initial Authorisation agreement or subsequently.

3.2 Whilst there is no specific target regulating overall revenue performance in Foundation Trusts (e.g. a requirement to break-even year on year), the Regulator has the power to intervene in the Trust's affairs and potentially to revoke its Authorisation agreement where financial viability is seriously compromised.

3.3 The Chief Executive has overall executive responsibility for the Trust's activities and in this capacity is responsible for ensuring that the Trust aims to maintain its financial viability and meets any specific financial targets set by the Regulator. In this capacity the Chief Executive is responsible for setting appropriate internal targets in order to ensure financial viability and for signalling to the Finance and Digital Committee and the Board where the Trust's financial viability or key targets are at risk.

3.4 The Director of Finance is responsible for:

a. advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate;

b. ensuring that adequate systems exist internally to monitor financial performance ;

c. managing the cashflow and external borrowings of the Trust; and

d. providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.

4. Business Planning, Budgets and Budgetary Control

4.1 Preparation and Approval of Business Plans and Budgets

4.1.1 Under the terms of Schedule 7 (paragraph 26) of the 2006 Act and its Constitution, the Trust is required to provide the Regulator with information concerning its forward plans for each financial year. In this respect, the Council of Governors is responsible for providing the Board with its views on those forward plans when they are being prepared and the Board correspondingly has a duty to consult them**.**

4.1.2 The Chief Executive will therefore compile and submit to the Board and the Council of Governors, an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

a. a statement of the significant assumptions on which the plan is based; and

b. details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.3 Once approved, the Chief Executive will be responsible for submitting the Business Plan as required to the Regulator.

4.1.4 The Chief Executive is also responsible for ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.

4.1.5 At the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit revenue and capital budgets for approval by the Board. Such budgets will:

a. be in accordance with the aims and objectives set out in the annual business plan;

b. accord with workload and manpower plans;

c.be produced following discussion with appropriate budget holders/managers;

d. be prepared within the limits of available and identified funds;

e. identify all sources of those funds; and

f. identify potential risks.

4.1.6 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

4.1.7 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and to explain variances.

4.1.8 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

4.2 Budgetary Delegation

4.2.1 The Director of Finance (on behalf of the Chief Executive) may delegate the management of a budget to permit the performance of a defined range of activities to relevant managers.

4.2.2 Expenditure authorised by the Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Director of Finance (on behalf of the Chief Executive).

4.2.5 The agreed budgetary delegation limits for the Trust are detailed in Appendix 1.

4.3 Budgetary Control and Reporting

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a. monthly financial reports to the Board in a form approved by the Board containing:
   i. income and expenditure to date showing trends and forecast year-end position;
   ii. explanations of any material variances from plan;
   iii. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
   iv. approved use of Reserves, both by the Chief Executive under delegated powers and via specific Board decisions; and
   v. capital expenditure to date versus plan.
   vi. projected outturn capital expenditure against plan;
   vii. explanations of any material variances from plan;
   viii. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

b. the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c. investigation and reporting of variances from financial, workload and manpower budgets;

d. monitoring of management action to correct variances; and

e. arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

a. any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

b. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

c. no permanent employees are appointed without the approval of an Executive Director other than those provided for in the authorised budgeted establishment.

4.3.3 The Chief Executive is responsible for ensuring the identification and implementation of cost improvements and income generation initiatives in accordance with the requirements of the annual Business Plan and agreed Control Total.

4.3.4 The Director of Finance is responsible for advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and will also advise on the financial implications of future plans and developments proposed by the Trust.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in section 12 of these SFIs). The delegation limits for capital expenditure are detailed in Appendix 1.

4.5 Performance Information and Monitoring Returns

4.5.1 The Chief Executive, on behalf of the Trust, is responsible for providing the Regulator with such information as is necessary to monitor compliance with the terms of the Authorisation agreement.

4.5.2 The Chief Executive, on behalf of the Trust, is also responsible for ensuring that the Trust contributes to standard national NHS data flows which are required for NHS policy development/ funding decisions as well as performance assessment by the Healthcare Commission.

5. Annual Accounts and Reports

5.1 In accordance with Schedule 7 (paragraph 25) of the 2006 Act and the Trust's Constitution, the Trust must keep accounts, and in respect of each financial year must prepare annual accounts, in such form as the Regulator may, with the approval of the Treasury, direct. These responsibilities will be carried out by the Director of Finance who, on behalf of the Trust, will:-

a. prepare annual accounts in accordance with the Regulator's Manual of Accounts and any other guidance from the same, the Trust's accounting policies and generally accepted accounting practice;

b. prepare and submit annual accounts to the Board and an audited summary of the Main Financial Statements to an Annual Members' Meeting convened by the Council of Governors, certified in accordance with current guidelines;

c. lay a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.

5.2 The annual accounts should, in accordance with the requirements set out in the Accounts Direction, include a Statement on Internal Control within the financial statements.

5.3 The Trust's annual accounts must be audited by the external (financial) auditor appointed by the Council of Governors and be presented at the Annual Members' Meeting referred to in 1 (b) above.

5.4 In accordance with Schedule 7 (paragraph 26) of the 2006 Act, the Trust will also prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's Annual Report Guidance for NHS Foundation Trusts and will include, inter alia:

a. information on the steps taken by the Trust to ensure that the actual membership of the various constituencies (public ,patients and staff) is representative of those eligible for such membership;

b. the Annual Accounts of the Trust in full or summary form;

c. details of relevant directorships and other significant interests held by Board members;

d. composition of the Audit and Assurance Committee and of the Remuneration Committee;

e. remuneration of the Chair, the Non-Executive Directors and Executive Directors, on the same basis as those specified in the Companies Act;

f. a statement of assurance by the Chief Executive in respect of organisational controls and risk management within the Trust (as per HSC 1999/123;

g. any other information required by the Regulator.

5.4.1 These responsibilities will be carried out by the Director of Corporate Governance who, on behalf of the Trust, will prepare and submit annual reports to the Board and an audited summary to an Annual Members' Meeting convened by the Council of Governors.

5.5 The Trust is to comply with any decision that the Regulator may make as to the form of the annual report, the timing of its submission and the period to which it relates.

6. Bank Accounts

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued by the Regulator.

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6.2 Bank Accounts

6.2.1 The Director of Finance is responsible for:

a. bank accounts

b. establishing separate bank accounts for the Trust's charitable funds;

c. ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

d. reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.2.2 No officer other than the Director of Finance will open any bank account in the name of the Trust (or constituent hospitals) or relating to any activities of the Trust/hospital, or issue instructions to the Trust's bankers.

6.2.3 No officer should disclose details of the Trust's bank accounts without the approval of the Director of Finance. This is to ensure that the risk of fraud and money laundering to the Trust's accounts is minimised

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

a. the conditions under which each bank account is to be operated;

b. the limit to be applied to any overdraft; and

c. those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.4 Tendering and Review

6.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business. Where appropriate the Trust will conduct such reviews/tendering exercises in conjunction with other NHS organisations in Gloucestershire.

7. Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 In this capacity, the Director of Finance will establish systems in order to ensure that timely and appropriate invoices are raised for income due under the terms of contracts with NHS commissioners (see Section 8).

7.1.3 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Trust will price its service contracts with NHS healthcare commissioners according to national tariffs published by the Department of Health. In areas where national tariff arrangements do not apply, the Trust will follow the Department of Health's guidance in the "Costing Manual" in costing/pricing NHS service contracts. The Director of Finance will ensure spend is in line with system allocations.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts and in this capacity is responsible for providing the Finance and Digital Committee with a monthly analysis of debtors profiled by age and actions to recover.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and Other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

a. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b. ordering and securely controlling any such stationery;

c. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d. prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8. NHS Contracts for the Provision of Services

8.1 The Chief Executive, as the accountable officer, is responsible for ensuring that the Trust enters into suitable legally binding contracts with NHS commissioners both for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator and also other healthcare services. In discharging this responsibility, the Chief Executive should ensure that these contracts take account of:-

a. the standards of healthcare quality expected, including those published by the Secretary of State under Section 46 of the Act and the Health Act 2006. ;

b. relevant National Service Frameworks and guidelines published by the National Institute for Health and Clinical Excellence;

c. service priorities contained within the Trust's Business Plan and agreed with healthcare commissioners;

d. national tariffs published by the Department of Health (see 7.2.1) or other agreed local pricing mechanisms where national tariffs do not (yet) apply;

e. the need to provide ancillary and other supporting services essential to the delivery of the healthcare involved;

f. the need to ensure the provision of reliable and on-going information on service cost, volume and quality;

g. previously agreed developments or investment plans.

8.2 A good contract for health care services will result from a dialogue between clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 The Director of Finance will need to ensure that regular reports are provided to the Finance and Digital Committee and the Board detailing forecast/ budgeted and actual income from contracts with NHS commissioners. This analysis will particularly highlight the impact of differences between planned and actual income and expenditure levels and outline any action required to address such variances. Periodically, at intervals to be agreed with the Board, the Chief Executive will also provide information on the impact of differences between the actual cost to the Trust of treating patients in individual service lines and the relevant national tariff.

8.4 Where the Trust participates in a tendering exercise (whether in competition with others or not) for a health related or non-clinical service, approval must be sought according to the delegated authority limits.

8.5 Delegated authority limits associated with tendering, in line with budget:

	Director of Finance (in consultation with Chief Executive)	Trust Leadership Team	Trust Board
Decision not to bid	No limit	No limit	Not applicable
Total or annual value range where services are provided by the Trust and tender is to	0 - £10m	>£10m - £50m	>£50m

retain the current provision			
Total or annual value range where services are not currently provided by the Trust and tender is to acquire provision	0 - £5m	>£5m - £25m	>£25m

8.6 No tender must be submitted without sign-off from the relevant authority.

9. Terms of Service and Payment of Directors and Employees

9.1 Remuneration Committee

9.1.1 In accordance with the requirements of the 2006 Act and Standing Orders, the Trust shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

a. Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes;
b. Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future;
c. Appoint candidates to fill all the executive director positions on the Board;
d. Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract;
e. Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process;
f. Determine the remuneration and terms of service of Executive Directors;
g. Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors;
h. Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole); and
i. Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.

9.1.3 The Committee shall advise the Board in writing as to the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board's meetings should record such decisions.

9.1.4 The Board will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

9.1.5 The Trust will remunerate the Chair and Non Executive Directors as determined by the Council of Governors.

9.2 Funded Establishment

9.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Vacancy Control Panel.

9.3 Staff Appointments

9.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a. unless authorised to do so by the Vacancy Control Panel; and

b. within the limit of their approved budget and funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

9.4 Processing of Payroll

9.4.1 The Director of Finance is responsible for:

a. specifying timetables for submission of properly authorised time records and other notifications;

b. the final determination of pay;

c. making payment on agreed dates; and

d. agreeing method of payment.

9.4.2 The Director of Finance will issue instructions regarding:

a. verification and documentation of data;

b. the timetable for receipt and preparation of payroll data and the payment of employees;

c. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d. security and confidentiality of payroll information;

e. checks to be applied to completed payroll before and after payment;

f. authority to release payroll data under the provisions of the Data Protection Act;

g. methods of payment available to various categories of employee;

h. procedures for payment by cheque, bank credit, or cash to employees;

i. procedures for the recall of cheques and bank credits;

j. pay advances and their recovery;

k. maintenance of regular and independent reconciliation of pay control accounts;

l. separation of duties of preparing records and handling cash; and

m. a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

a. submitting time records, and other notifications in accordance with agreed timetables;

b. completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and

c. submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable

arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to the Director People and OD for:

a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and dealing with variations to, or termination of, contracts of employment.

10. Non-pay Expenditure

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers (including the level of virement between one budget holder and another). The financial limits are laid out in the Scheme of Delegation.

10.1.2 The Director of Finance will set out:

a. the list of managers who are authorised to place requisitions for the supply of goods and services; and

b. the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Director of Finance will also be responsible for ensuring that the Trust has clearly established arrangements for the purchase of goods and services.

10.1.4 The Director of Finance will also be responsible for ensuring that the Trust makes optimum use of corporate, national or regional contracts for the acquisition of goods and services, in order to ensure best value for money.

10.1.5 The Director of Finance will also be responsible for ensuring that the Trust has robust due diligence checks in place to verify and validate new supplier and changes to existing supplier details.

10.2 Choice, Requisitioning, Ordering, Receipt and Payments for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust**,** i.e consideration of whole life costs and contribution to the achievement of other Trust objectives (e.g. safety, sustainability). In so doing, the advice of the Procurement Shared Service shall be sought. Requisitions must therefore be directed through the Trust's official contracts negotiated by or on behalf of the Trust, where available. Where such official contracts are not available, quotations or tenders must be obtained through the Procurement Shared Service via local, regional or national contracts, in accordance with Standing Orders. Only for exempt goods and services should a good or service be obtained without a purchase order.

10.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

10.2.3 The Director of Finance will:

a. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

b. prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

c. be responsible for the prompt payment of all properly authorised accounts and claims and for advising the Board on a monthly basis of performance against targets set under the Government's Better Payments Practice Code;

d. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i. A list of directors/employees (including specimens of their signatures) authorised to requisition, receipt and certify invoices for payment in respect of goods/services provided to the Trust where those goods or services are exempt from the P2P system of Procurement.

ii. Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment;
- correct treatment for VAT purposes.

iii. A timetable and system for submission to the Finance Shared Services Paymaster Services Manager of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv. Instructions to employees regarding the handling and payment of accounts within the Finance Shared Services.

e. be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a. the financial advantages outweigh the disadvantages (i.e., cashflows must be discounted to Net Present Value) and the intention is not to circumvent cash management arrangements;

b. the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

c. the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

d. the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate manager if problems are encountered.

10.2.5 Official Orders must:

a. be consecutively numbered;

b. be in a form approved by the Director of Finance;

c. state the Trust's terms and conditions of trade; and

d. only be issued to, and used by, the Procurement Shared Service.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a. all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Shared Service and the Director of Finance in advance of any commitment being made;

b. any contracts above specified thresholds are advertised, procured and awarded by the Procurement Shared Service in accordance with UK procurement legislation as amended and the principles of EU and WTO and GPA guidelines on public procurement and comply with current public procurement best practice and guidance;

c. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care and relevant regulatory bodies;

d. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

   ii. conventional hospitality, such as lunches in the course of working visits;

e. any gift, reward or benefit is recorded on the Trust's Hospitality Register;

f. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

g. all goods, services, or works are ordered on an official order except for purchases from petty cash and exempt expenditure agreed by the Director of Finance;

h. verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

i. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j. goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

k. changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

l. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

m. petty cash records are maintained in a form as determined by the Director of Finance.

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the appropriate guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Grants to Local Authorities and Voluntary Bodies

10.3.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 or section 64 of the Health Service and Public Health Act 1968 shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

11. Treasury Management

11.1 External Borrowing

11.1.1 As a Foundation Trust, the Trust has freedom to access capital (i.e. borrow externally) subject to the following:-

a. prohibition on the use of protected assets as security for borrowing; and

b. any additional degree of scrutiny required by financial institutions

11.1.2 The Director of Finance will advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts.

11.1.3 The Director of Finance will advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts

11.1.4 Any application for a loan, financing facility or overdraft will only be made by the Director of Finance or by an employee so delegated.

11.1.5 The Director of Finance must prepare detailed procedural instructions concerning applications for loans, financing facilities and overdrafts.

11.1.6 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance.

11.1.7 All long term borrowing must be consistent with the plans outlined in the current financial plan as reported to the Regulator.

11.2 Investments

11.2.1 Under the terms of the 2006 Act and its Constitution, the Trust may invest money (other than money held by it as a Trustee) for the purposes of or in connection with its functions. This may include investment by forming or participating in forming bodies corporate or by otherwise acquiring membership of bodies corporate.

11.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held, other than short term temporary cash surpluses.

11.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.2.4 In the case of temporary cash surpluses, these may only be held in such form and with such public or private sector organisations as are approved by the Board. In giving approval to the mechanisms for short term investment, the Board will take account of instructions or guidelines issued by the Regulator to Foundation Trusts.

11.2.5 For other longer term forms of investment, including those referred to in 11.2, the approval of the Board will be obtained before proceeding.

11.3 Cash Flow Monitoring

11.3.1 The Director of Finance is responsible for managing and monitoring the overall cash flow of the Trust and for providing reports thereon to the Finance and Digital Committee and the Board. These reports will include:-

a. a comparison of month end outturn with the plan (monthly); and

b. a rolling 12 month projection of month end cash balances (quarterly)

12. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

12.1 Capital Investment

12.1.1 The Chief Executive:

a. shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b. is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost ; and

c. shall ensure that the capital investment is not undertaken without consideration of the availability of resources to finance all revenue consequences, including capital charges.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

a. that a business case (in accordance with Monitor's guidance contained within Risk Evaluation for investment decisions by NHS Foundation Trusts) is produced setting out:

i. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

ii. appropriate project management and control arrangements.

b. that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case which is approved by the Board subject to agreed delegated limits.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Finance will issue procedures for their management, incorporating the recommendations of "Estatecode" and procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for the expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

a. specific authority to commit expenditure;

b. authority to proceed to tender; and

c. approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

12.1.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 Private Finance

12.2.1 When the Trust proposes to access finance under the Private Finance Initiative, the following procedures shall apply:

a. The Director of Finance shall demonstrate that the use of private finance represents value for money and appropriately transfers significant risk to the private sector;

b. Where the sum involved exceeds delegated limits, the business case must be referred to the Regulator; and

c. The proposal must be specifically agreed by the Board.

12.3 Asset Registers

12.3.1 The Responsible Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once every two years.

12.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be consistent with best practice.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b. stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c. lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be indexed to current values in accordance with best practice.

12.3.7 The value of each asset shall be depreciated using methods and rates as determined by the Director of Finance.

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a. recording managerial responsibility for each asset;

b. identification of additions and disposals;

c. identification of all repairs and maintenance expenses;

d. physical security of assets;

e. periodic verification of the existence of, condition of, and title to, assets recorded;

f. identification and reporting of all costs associated with the retention of an asset; and

g. reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13. Stores and Receipt of Goods

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a. kept to a minimum;

b. subjected to annual stocktake; and

c. valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 For goods supplied via the NHS Supply Chain central warehouses, the Director of Finance shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note.

14. Disposals and Condemnations, Losses and Special Payments

14.1 Disposals and Condemnations

14.1.1 Under the terms of the Authorisation agreement, the approval of the Regulator is required prior to the disposal of any protected assets (above any "de minimis" limit where specified). There are no external restrictions on the disposal of other assets provided that the proceeds are used to further the Trust's public interest objectives.

14.1.2 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. These procedures should take account of the requirements set out in (1) above.

14.1.3 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.4 All unserviceable articles shall be:

a. condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and

b. recorded in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

14.1.5 The Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

14.2 Losses and Special Payments

14.2.1 The Director of Finance shall prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police. The Director of Finance should comply with any requirements to report fraud as determined by the Regulator/Secretary of State.

14.2.3 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance (or the Local Counter Fraud Specialist on the Director's behalf) must notify the Audit and Assurance Committee which will consider approval of write off on behalf of the Board.

14.2.4 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.5 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.6 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15. Information Technology

15.1 The Trust, under the terms of its Authorisation agreement, is required to participate in the National Programme for Information Technology, in accordance with any guidance issued by the Regulator. This requirement extends to the Director of Finance in fulfilling their responsibilities for the computerised financial data of the Trust as set out below.

15.2 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;
b. ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
d. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

15.3 Where a new financial system or significant amendment to a current financial system is proposed, the Director of Finance will ensure that an appropriate Business Case is prepared and approved in advance at the appropriate level. The Director of Finance will also ensure that such systems are developed in a controlled manner, with appropriate project planning mechanisms, and are thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.4 In the case of new financial systems which are sponsored jointly by a number of healthcare or other organisations, including the Trust, the Director of Finance will seek to ensure that the same approval/ planning requirements as set out in paragraph 3 above are complied with and that the Trust is fully signed up to the development.

15.5 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.6 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.7 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy him/her self that:

15.7.1 systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

15.7.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

15.7.3 Director of Finance staff have access to such data; and

15.7.4 such computer audit reviews as are considered necessary are being carried out.

16. Patients' Property

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records; and
- the oral advice of administrative and nursing staff responsible for admissions;

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. The sole exception to this requirement is where patients are admitted in the circumstances outlined in paragraph 1 above.

16.3 The Chief Nurse must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to safeguard the interests of the patient.

16.4 Where good practice guidance (e.g. Department of Health instructions to non-Foundation Trusts) suggests the need to open separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. Funds Held on Trust (Charitable Funds)

17.1 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust (charitable funds) and define how those responsibilities are to be discharged. They explain that the trustee responsibilities must be discharged separately and full recognition given to the guidance and regulation as determined by the Charity Commission.

17.2 The Board, in its corporate trustee capacity, shall determine where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.3 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

18. Acceptance of Gifts by Staff

18.1 The Director of Finance shall ensure that all staff are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Standards of Business Conduct for NHS Staff.

19. Retention of Documents

19.1 The Chief Executive shall be responsible for defining retention periods in accordance with the relevant legislation and guidance and for maintaining archives for all documents required to be retained.

19.2 The documents held in archives shall be capable of retrieval by authorised persons.

19.3 Documents so held in accordance with HSC 1999/053 shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

20. Risk Management & Insurance

20.1 The Chief Executive shall ensure that the Trust has a risk management strategy, in accordance with current controls assurance guidance, which must be approved and monitored by the Board.

20.2 The programme of risk management shall include:

a. a process for identifying and quantifying risks and potential liabilities;

b. engendering among all levels of staff a positive attitude towards the control of risk;

c. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d. contingency plans to offset the impact of adverse events;

e. audit arrangements including; internal audit, clinical audit, health and safety review;

f. decision on which risks shall be insured; and

g. arrangements to review the risk management programme.

20.3 The existence, integration and evaluation of the above elements will provide the basis on which to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required in the Accounts Direction.

20.4 The Director of Finance shall ensure that insurance arrangements exist where appropriate. In this context, insurance will include any scheme administered by NHS Resolve (such as the risk pooling schemes) in addition to policies operated by commercial organisations. To this end, the Director of Finance shall:

a. be responsible for arranging all cover as may be determined by the Board;

b. be informed promptly of any event which may involve the Trust in a claim, or intended activity, which may involve a risk which has not already been covered; and

c. for any loss, consider whether a claim can be made against the appropriate insurance policy or scheme.

Appendix 1: Financial Delegation Limits

1. Revenue and Capital Expenditure

1.1 The Standing Financial Instructions require that revenue and capital budgets are prepared for approval by the Board on an annual basis. SFIs 4.2.5 and 4.4.1 specifically require that budgetary delegation limits are set.

1.2 At the start of each financial year the Board will,

(a) approve a financial plan for the year
(b) approve details of budgets ("Budget Book") to be delegated to budget holders
(c) approve levels for provisions and reserves identified in the financial plan. These will cover, inter alia, inflation, planned developments grouped by their nature, planned savings and a general contingency for unplanned developments and costs.

1.3 In accordance with SFIs 4.2.5 and 4.4.1 the Chief Executive may

(a) approve expenditure against provisions and reserves identified in the financial plan. All such approvals will
- be reported to the Board each month by the Finance Director as he monitors the position on all such provisions and reserves (both revenue and capital)
- be backed by documentary evidence signed by the Chief Executive and also by the Finance Director (who in signing is confirming that the expenditure is both appropriate and consistent with the Trust's financial plans and procedures).

Subject to the availability of funds a reserve for infrastructure, risk reduction, training, quality enhancement, etc. will be managed by the Main Board itself reflecting the subjectivity of prioritisation in this area

Capital business cases, for expenditure or asset disposal, over £1,000,000 require Board approval. (For disposals this is to be taken as the higher of book value and estimated sale proceeds)

(b) approve increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves. Any increases exceeding 10% must be submitted to the Board for approval (as well as the reporting and authorisation requirements in 1.3(a) above)

(c) seek in year variations from the Board to the limits on provisions and reserves

(d) vire expenditure between approved revenue budgets and between capital budgets and identify savings for re-allocation, provided that variations which involve a significant change in Trust policy or reduction in services to patients are presented to the Board for approval

(e) adjust approved budgets and development schemes for inflation, provided that additional costs can be met from the Inflation Reserve. It is expected that the Chief Executive will delegate this responsibility to the Finance Director, who will also adjust

budgets as appropriate for other events totally outside the control of managers, e.g. taxation changes

(f) exercise virement of the Trust's resources between years, after taking advice from the Finance Director.

1.4 In exercising these responsibilities the Chief Executive will delegate within agreed limits. For virement each Executive Director will be authorised to vire up to £100,000 between budgets within his or her control. Each Divisional Director will be authorised to vire up to £25,000 within budgets in his or her control but provided that the virement is agreed by each of the three (four) Divisional Directors that limit is increased to £100,000. Budget holders at the tier below Divisional Director level will be authorised to vire up to £5,000 between budgets under their control.

1.5 Individual budget holders will be authorised by the Directors to vire up to £5,000 non-recurringly and £1,000 recurringly between revenue budgets within their control.

1.6 In exercising the delegated powers outlined in paragraphs 1.3 to 1.6 above officers must liaise with the Director of Finance or his/her nominated representative to obtain advice and must ensure that full details are reported to him/her.

2. Revenue and Capital Income

2.1 Payment by Results, Patient Choice and competition from Independent Sector Providers mean that the Trust's income streams are less certain and more complex than in the past.

2.2 The Chief Executive will

(a) sign legally binding contracts with NHS commissioners and other funders
(b) ensure that the financial plan for the year reflects realistic income expectations and contains adequate flexibility
(c) organise clinical capacity and service delivery to optimum effect taking account of legally binding contracts, the Trust's commitment to its patients and its staff and the Trust's financial needs and opportunities
(d) report significant events and variations to the Board
(e) report systematically on patient activity against plan to the Board.

2.3 The Director of Finance will

(a) report to the Board on actual income against planned income
(b) identify the implications for provisions and reserves in year and for the Trust in future years.

2.4 Capital income from borrowing will be limited to the net sum necessary to fund schemes authorised in accordance with the Financial Plan and section (1) above. Schemes funded from separate capital allocations will only be approved if revenue costs are authorised in accordance with section (1).

2.5 The Trust will only borrow revenue or capital funds for its own needs unless specific Board approval has been given.

3. Purchase Orders

3.1 All purchase orders will be subject to the limits set below.

Upto £1,000	Budget Holder

£1,000 to £10,000	Level 2 Approvers
£10,000 to £50,000	Level 3 Approvers
£50,000 to £100,000	Chief Executive and Director of Finance
£100,000 to £500,000	Trust Leadership Team
£above £500,000	Board

Purchase order limits and authorisation apply to agreed goods and services that are exempt from P2P.

4. Tendering Limits

4.1 The following limits will apply

Expenditure Range	Action Required
up to £10,000	Single supplier or quotations via Procurement Shared Services
£10,001to £50,000	Competitive quotations/tenders via Procurement Shared Services
£50,001 to Public Procurement Threshold	Formal tender procedure or further competition through an approved framework via Procurement Shared Service
Above Public Procurement Threshold	Formal tender procedure via Procurement Shared Services in accordance with current UK Public Procurement legislation

5. Authorisation to enter into and sign Contracts for goods and services

5.1 Where the Trust intends to award or extend a contract, approval must be sought according to the delegated authority limits.

5.2 The delegated authority limits for contract approval are:

	Level 3 Budget Holders	Trust Leadership Team	Finance and Digital Committee	Trust Board
Total contract value (over the lifetime of the contract including permitted extensions)	0 - £250k	>£250k - £1m	>£1m - £5m	>£5m

5.3 Contract approvals must be submitted to all relevant groups depending upon value.

5.4 Contracts must be signed by an authoriser in accordance with 3.1 above.

6. Charitable Funds

6.1 The following limits will apply for authorisation of Charitable Funds expenditure

Expenditure Range	Responsibilities
up to £1,000	Fund holders (unless a lower limit is specified by the Chief Operating Officer and Deputy Chief Executive.)
£1,001 to £5,000	Chief Operating Officer and Deputy Chief Executive (who may delegate as he/she judges appropriate to senior managers)
Above £5,000	Charitable Funds Committee

N.B. all of the above limits (Sections 3, 4 and 5) are excluding VAT

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

STANDING ORDERS

STANDING ORDERS

Foreword

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. Standing Orders are part of its corporate governance arrangements.

The Standing Orders, Standing Financial Instructions and the "Schedule of decisions reserved to the Board and the Scheme of Delegation" provide a comprehensive business framework that can be applied to all activities. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

STANDING ORDERS

Contents

STANDING ORDERS
FOR THE REGULATION OF PROCEEDINGS AND BUSINESS OF THE BOARD OF DIRECTORS

1. Interpretation

1.1 Save as otherwise permitted by law, the Chair shall be the final authority on the interpretation of the Standing Orders (on which they should be advised by the Chief Executive and/or the Director of Corporate Governance).

1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts or the Trust Constitution shall have the same meaning in this interpretation.

2. The Trust

2.1 The Trust has the functions conferred on it by the NHS Act 2006 and by its Authorisation.

2.2 The Trust has resolved those certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Schedule of decisions reserved to the Board and the Scheme of Delegation" and have effect as if incorporated into the Standing Orders.

3. Meetings of the Board of Directors

3.1 **Admission of the Public and the Press** – subject to Standing Order (SO) 3.2 below, all meetings of the Board are to be open to members of the press and public.

3.2 The Board may resolve to exclude members of the press and/or public from any meeting or part of a meeting on the grounds:

3.2.1 That publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

3.2.2 The special reasons stated in the resolution and arising from the nature of the business of the proceedings.

3.3 The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting.

3.4 The Chair (or other person presiding under the provisions of SO 3.17) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business of the meeting shall be conducted without interruption and disruption. The Chair may exclude any member of the public or press from a meeting of the Board if they are interfering with, or preventing the proper conduct of the meeting.

3.5 Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.6 **Calling Meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine.

3.7 Meetings of the Board may only be called in accordance with this paragraph. The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.8 The Board may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. The Board shall agree a protocol to be applied in the case of such meetings.

3.9 **Notice of Meetings** - Before each meeting of the Board, a Notice of the Meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on their behalf, shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to them at least fourteen clear days before the meeting.

3.10 Subject to SO 3.12, lack of service of the notice on any Director shall not affect the validity of a meeting.

3.11 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.12 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or email.

3.13 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted (such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

3.14 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting, subject to Standing Order 3.9. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.15 Agendas will be sent to members six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

3.16 **Chair of Meeting** - The Chair, or in their absence, the Vice-Chair, shall preside at meetings of the Board and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

3.17 If the Chair and Vice-Chair are absent from a meeting of the Board, the Directors shall appoint another Non-Executive Director to preside over that meeting and they shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.18 **Notices of Motion** - A Director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This standing order shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.11.

3.19 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.20 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director(s) who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

3.21 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.22 Subject to SO 3.23, when a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

3.22.1 An amendment to the motion.
3.22.2 The adjournment of the discussion or the meeting.
3.22.3 That the meeting proceed to the next business.
3.22.4 The appointment of an ad hoc committee to deal with a specific item of business.
3.22.5 That the motion be now put.

3.22.6 A motion to exclude the public (including the press).

3.23 The motions specified in paragraphs 3.22.3 and 3.22.5 may only be put by a Director who has not previously taken part in the debate.

3.24 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.25 **Chair's Ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.26 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and members present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

3.27 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.28 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.29 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.30 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.31 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.32 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.33 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.34 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.35 **Joint Directors** - Where the office of a member of the Board is shared jointly by more than one person:

3.35.1 either or both of those persons may attend or take part in meetings of the Board:
3.35.2 if both are present at a meeting they should cast one vote if they agree:
3.35.3 in the case of disagreements no vote should be cast;

3.35.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.43 (Quorum).

3.36 **Suspension of Standing Orders** - Except where this would contravene any provision of the Constitution or any statutory provision or any direction made by NHS Improvement (Monitor), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

3.37 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.38 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

3.39 No formal business may be transacted while Standing Orders are suspended. Formal business shall include the proposal of motions and the determination of questions and resolutions, by voting or otherwise.

3.40 The Audit and Assurance Committee shall review every decision to suspend Standing Orders.

3.41 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

3.41.1 a notice of motion under Standing Order 3.18 has been given; and
3.41.2 no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and
3.41.3 at least two-thirds of the Directors are present; and
3.41.4 the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

3.42 **Record of Attendance** - The names and job titles of the Directors present at the meeting shall be recorded in the minutes.

3.43 **Quorum** - No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the Chair and Directors appointed (including at least one Executive Director and one Non-Executive Director) are present.

3.44 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.45 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 and 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.46 **Frequency –** The Trust shall hold meetings of the Board of Directors at least six times in each calendar year.

4. Arrangements for the Exercise of Functions by Delegation

4.1 Subject to a provision in the authorisation or the Constitution, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5 below or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders (SO 2.2) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

4.3 **E-Governance** – Where agreed by any of the office holders described in SO 4.2 decisions may also be made by way of a written resolution. In such cases the document or issue in need of review should be sent to Directors and the Board of Directors should have a specified number of days to register their approval via email or other means to the Director of Corporate Governance. The document should not require extensive discussion, although the Board of Directors may choose to ask specific questions to the document author. The email will need to clearly specify the approval that is sought. A document or issue will be considered approved when three-quarters of the Board of Directors has approved it. As in a Board meeting, the Chair shall have the casting vote in the event of an evenly split vote. Notice of all decisions taken by written resolution will be reported to the following formal Board or Committee meeting.

4.4 **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The Constitution and terms of reference of the committees and their specific executive powers shall be approved by the Board.

4.5 **Delegation to Officers: Schedule of decisions reserved to the Board and the Scheme of Delegation** - Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still be accountable to the Board.

4.6 The Director of Corporate Governance shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendments agreed during the discussion. The Director of Corporate Governance may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board as indicated above.

4.7 Nothing in the "Reservation of decisions to be reserved to the Board and the Scheme of Delegation" shall impair the discharge of the direct accountability to the Board of the Director of Finance or other Executive Directors to provide information and advise the Board in accordance with any statutory requirements.

5. Committees

5.1 **Appointment of Committees** - Subject to such directions as may be given by NHS Improvement (Monitor), the Trust may and, if directed by NHS Improvement (Monitor), shall appoint committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.

5.2 A committee appointed under SO 5.1 may, subject to such directions as may be given by NHS Improvement (Monitor) or the Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the Board committee (whether or not they include Directors of the Trust).

5.3 The Standing Orders of the Board as far as they are applicable shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board.

5.4 Each Board committee shall have such terms of reference and powers and be subject to such conditions as the Board shall decide. Each sub-committee shall have such terms of reference and powers and be subject to such conditions as the appointing committee shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

5.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State or NHS Improvement (Monitor) and where such appointments are to operate independently of the Trust, such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

5.8 Without prejudice to the formation of any other committees or sub-committees as the Board may see fit, the following committees shall be established by the Board:

a) Audit and Assurance Committee b) Remuneration Committee

5.9 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. Declarations of Interests and Register of Interests

6.1 Declaration of interests

6.2 Each Director shall comply with paragraph 11 of the Constitution regarding conflicts of interest.

6.3 Interests that are required to be declared by a Director in accordance with paragraph 11 of the Constitution are:

6.3.1 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in SOs 6.6 and 6.10 (subject to SO 6.7);

6.3.2 any actual or potential, direct or indirect, non-financial professional interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in SOs 6.8 and 6.10; and

6.3.3 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in SOs 6.9 and 6.10.

6.3.4 An interest must be declared under paragraph 11.3 of the Constitution to the Director of Corporate Governance at the time of the Director's appointment or as soon thereafter as the interest arises, and in any event within seven clear days of becoming aware of the existence of that interest.

6.3.5 If during the course of a meeting the Board, a Director has an interest of any sort in a matter which is the subject of consideration the Director concerned shall disclose the fact, and the Chair shall decide what action to take. This may include excluding the Director from the discussion of the matter in which the Director has an interest and/or prohibiting the governor from voting any such matter.

6.3.6 Subject to SO 6.3.4 if a Director has declared a financial interest in a matter (as described in SOs 6.6 and 6.7) they shall not take part in the discussion of that matter nor vote on any question with respect to that matter.

6.3.7 Any interest declared at a meeting of the Board and subsequent action taken should be recorded in the meeting minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

6.3.8 This SO 6 applies to a committee or sub-committee and to a joint committee or sub- committee as it applies to the Board and applies to a member of any such committee or sub-committee (whether or not they are also a member of the Trust) as it applies to a member of the Trust.

6.4 Nature of interests

6.5 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by NHS Improvement (Monitor).

6.6 A financial interest is where a Director may receive direct financial benefits (by either making a gain or avoiding a loss) as a consequence of a decision that the Board makes. This could include:

6.6.1 Directorships, including non-executive Directorships held in any other organisation

which is doing or is likely to be doing business with an organisation in receipt of NHS funding;

6.6.2 employment in an organisation which is doing or is likely to do business with an organisation in receipt of NHS funding; or

6.6.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing or is likely to do business with an organisation in receipt of NHS funding.

6.7 A Director shall not be treated as having a financial interest in any a matter by reason only:

6.7.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

6.7.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts;

6.7.3 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

6.7.4 of any remuneration or allowances payable to a Director in accordance with the Constitution.

6.8 A non-financial professional interest is where a Director may receive a non-financial professional benefit as a consequence of a decision that the Board makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a Director is:

6.8.1 an advocate for a particular group of patients;

6.8.2 a clinician with a special interest;

6.8.3 an active member of a particular specialist body; or

6.8.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

6.9 A non-financial personal interest is where a Director may benefit personally as a consequence of a decision that the Board makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where a Director is:

6.9.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

6.9.2 a member of a lobbying or pressure group with an interest in health and/or social care.

6.10 A Director will be treated as having an indirect financial interest, indirect non-financial professional interest or indirect non-financial personal interest where they have a close association with another individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a decision that the Director is involved in making. This includes material interests of:

6.10.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of the Director;

6.10.2 close friends and associates; and

6.10.3 business partners.

6.11 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

6.12 **Register of interests**

6.13 The Director of Corporate Governance will ensure that a register of interests is established to record formally declarations of interests of Directors.

6.14 Details of the register will be kept up to date and reviewed annually.

6.15 The register will be available to the public.

7. Standards of Business Conduct

7.1 **Policy** - Staff must comply with the national guidance contained in HSG(93)5 'Standards of Business Conduct for NHS staff'. The following provisions should be read in conjunction with this document.

7.2 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of Directors of the Trust, directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.3 A Director or Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4 Informal discussions outside appointments, panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 **Relatives of Directors, Governors or Officers** - Candidates for any staff appointment shall, when making application, disclose in writing whether they are related to any Director, Governor or the holder of any office in the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

7.6 The Directors, Governors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

7.7 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

7.8 Where the relationship of an officer or another Director to a Director or Governor is disclosed, the SO 6 shall apply.

8. Tendering and Contract Procedure

8.1 **Duty to comply with Standing Orders** - The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 3.39 (Suspension of SOs) is applied).

8.2 **Legislation Governing Public Procurement** - UK procurement legislation and any European Union retained procurement law for awarding all forms of contracts, including any advertising and award requirements, shall have effect as if incorporated in these Standing Orders.

8.3 The Trust shall comply as far as is practicable with the requirements of the NHS Executive "Capital Investment Manual". In the case of management consultancy contracts the Trust shall comply as far as is practicable with current NHSEI guidance on Consultancy Spending.

8.4 **Competition** - The Trust shall ensure that competitive tenders/quotations are invited, either directly or via a framework, for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals. Competitive quotations are not required for expenditure under £10,000but expenditure must not be disaggregated to avoid a competitive procurement process. The Director of Finance or nominated officer shall maintain a list of applicable exemptions from waivering competition.

8.5 Competitive tendering/quotation procedures may be waived, subject to prior review by Procurement and by the Director of Finance only where:

8.5.1 the estimated expenditure or income is above or is reasonably expected to be above £10,000 excluding VAT and does not, or is not reasonably expected to, exceed £50,000 excluding VAT and;

8.5.2 there is an urgent requirement and/or;

8.5.3 the goods, services or works are of a special characteristic that, in the opinion of the Chief Executive or the nominated officer, it is not possible or desirable to undertake a competitive process and/or;

8.5.4 where the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with.

8.6 Formal tendering procedures over £50,000 excluding VAT and under the thresholds of the UK Public Procurement Regulations, subject to prior review by Procurement, by the Director of Finance and the Chief Executive where:

8.6.1 the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

8.6.2 specialist expertise is required and is available from only one source; or

8.6.3 the task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

8.6.4 there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

8.6.5 Where provided for in the Capital Investment Manual.

8.7 The limited application of the waivering of these competition rules should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

8.8 Where it is decided that competitive tendering is not applicable and should be waived by virtue of SO 8.6.1 to 8.6.5, the fact of the waiver and the reasons should be documented and reported to the Audit and Assurance Committee in the Single Tender Action Report.

8.9 Except where SO 8.5 to 8.8, or a requirement under SO 8.2 applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.10 The Board shall ensure that the organisations invited to tender / quote for building and engineering works shall be those on an approved list in accordance with Annex A section 5. Where, in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

8.11 Tendering procedures are set out in Annex A.

8.12 **Quotations** - are required when the intended expenditure is reasonably expected to exceed £10,000excluding VAT but less than £50,000 excluding VAT.

8.13 Where quotations are required under SO 8.12 they should be sought from at least three firms/individuals as per Annex A based on specifications or terms of reference prepared by, or on behalf of, the Board.

8.14 Quotations should be in writing unless the Chief Executive or the nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

8.15 All quotations should be treated as confidential and should be retained for inspection for the period of the contract awarded.

8.16 The Chief Executive or the officer nominated by them should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

8.17 **Where tendering or competitive quotation is not required** - Where tenders or quotations are not required, because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Board.

8.18 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

8.19 **Private Finance** - When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

8.19.1 The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector. The proposal must be specifically agreed by the Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires.

8.19.2 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.20 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

a. these Standing Orders;
b. the Trust's SFIs;
c. Public Procurement Regulations and other statutory provisions;
d. any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants;
e. such of the NHS Standing Conditions of Contract as are applicable.
f. any framework agreement terms and conditions that apply to contracts made under frameworks, such as Crown Commercial Services (CCS).

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

8.21 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money.

8.22 **Personnel and Agency or Temporary Staff Contracts** - The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and to enter into contracts for the employment of agency staff or temporary staff. Agency & Temporary staff must be engaged in accordance with current NHS Agency Rules.

8.23 **Contracts for Services with Individuals or Personal Services Companies -** The Chief Executive shall nominate officers to assess the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.

8.24 **Healthcare Services Contracts** - Service contracts with NHS commissioners for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006.

8.25 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

8.26 **Cancellation of Contracts** - Except where specific provision is made in model Forms of Contracts or Standing Schedules of Conditions approved for use within the National Health Service and in accordance with Standing Orders 8.2 and 8.3 there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him/her or acting on his/her behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010 and other appropriate legislation.

8.27 **Determination of Contracts for Failure to Deliver Goods or Material** - There shall be inserted in every applicable written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other

event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials

exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.28 **Contracts Involving Funds Held on Trust** – As management processes overlap, the preceding requirements in respect of contracts equally apply to contracts involving funds held on trust.

8.29 All personnel involved in tendering and contracting activities must be aware of the Bribery Act 2010 and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to criminal proceedings being. All Trust staff involved in the tendering of a project shall complete the Conflicts of Interest Form.

8.30 **The Bribery Act (2010)** – Under the Bribery Act and the terms and conditions of an employee's contract, it is an offence for staff to accept any inducement or reward for:

8.30.1 doing, or refraining from doing anything in their official capacity; or
8.30.2 showing favour or disfavour to any person in their official capacity.

8.30.3 The Bribery Act 2010 replaces the fragmented and complex offences at common law and in the Prevention of Corruption Acts 1889-1916. This broadly defines the two sections below:

8.30.3.1 two general offences of bribery:

i. offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly;
ii. requesting or accepting a bribe either in exchange for acting improperly or where the request or acceptance is itself improper;

8.30.3.2 the corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

9. Disposals

9.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

c) items to be disposed of with an estimated sale value of less than £500, this figure to be reviewed annually; and

d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

10. In-House Services

10.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

10.1.1 Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

10.1.2 In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

10.1.3 Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £200,000, a Non-Executive Director should be a member of the evaluation team.

10.2 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

10.3 The evaluation group shall make recommendations to the Board.

10.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

11. Custody of Seal and Sealing of Documents

11.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Director of Corporate Governance in a secure place.

11.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers.

11.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating Division).

11.4 Where it is necessary that a document be sealed (in accordance with SO 11.6), the seal shall be affixed in the presence of the Director of Corporate Governance and will be attested by them.

11.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a register provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. The register of sealing shall be maintained by the Director of Corporate Governance. A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

11.6 **Sealing Policy** - The following contracts should have the seal applied:

11.6.1 All contracts for the purchase/lease of land and/or building;
11.6.2 All contracts for capital works exceeding £1,000,000;
11.6.3 Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the whole-life value exceeds or is expected to exceed £10,000,000, except for contracts within the Group; and
11.6.4 Any contract where the other party requests a seal.

12. **Signature of Documents**

12.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

12.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed), the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

13. Miscellaneous

13.1 **Directors acting as a corporate trustee** All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust. Directors acting on behalf of the Trust as a corporate trustee are acting as a quasi-trustee. Full recognition must be given to the guidance and regulation as determined by the Charity Commission Accountability for charitable funds held on trust is to the Charity Commission and to Monitor. Accountability for non- charitable funds held on trust is only NHS Improvement (Monitor).

13.2 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

13.3 **Documents having the standing of Standing Orders** - Standing Financial Instructions, "Schedule of decisions reserved to the Board and the Scheme of Delegation" and Board committee and sub-committee Terms of Reference shall have the effect as if incorporated into Standing Orders.

13.4 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

Annex A: Tendering Procedure

1 Invitation to Tender

1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted electronically, via the Trust E-Tendering system. Approval from the Head of Procurement must be obtained for exceptional circumstances where the E-Tendering system cannot be used. Where tenders are not submitted through the E-Tendering system, they must be submitted in a plain, sealed package bearing the word 'Tender' followed by the Tender Reference Number and the latest date and time for the receipt of such tender. A minimum of two people must open tenders. At least one person must not be involved in the tender process. Neither must be from the originating department.

1.2 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 1.3 and 1.4 below.

1.3

Every tender for building and engineering works, except for maintenance work only where Health Technical Memoranda (HTMs) guidance should be followed, shall use the appropriate Joint Contracts Tribunal (JCT) or NEC terms amended via Z clauses to comply with the Construction Act (as amended). JCT and NEC contracts to encompass, where relevant, Design Warranties, Collateral Warranties and third-party rights to mitigate project risk and protect the Trust. Tendering based on other forms of contract may be used only after prior consultation with the Shared Services Procurement Department.

1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Conditions of Contract, or other appropriate public sector Conditions that may apply. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

2 Receipt, Safe Custody and Record of Formal Tenders

2.1 Formal competitive tenders shall be submitted on the Trust's E-Tendering system or addressed to the Head of Procurement, Victoria Warehouse where approved in accordance with 1.1 above.

2.2 The date and time of receipt of each tender together with the details of the date, time and persons opening the documents will be recorded in the E-Tendering system.

2.3 Where tenders are received outside the E-Tendering system in accordance with 1.1, the Chief Executive shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.

3 Opening Formal Tenders

3.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two senior officers designated by the Chief Executive and not from the originating department.

3.2 A permanent record shall be maintained to show for each set of competitive tender

invitations despatched:

a) the names of firms/individuals invited;
b) the names of and the number of firms/individuals from which tenders have been received;
c) the total price(s) tendered;
d) closing date and time;
e) date and time of opening;
f) and the record shall be signed by the persons present at the opening, or recorded electronically in an E-Tendering system.

3.3 Where an electronic tendering package is used all actions by both procurement staff and suppliers are recorded within the system audit reports

3.4 Except as in Section 3.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.

3.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure Section 3.4 unreasonable.

4 Admissibility and Acceptance of Formal Tenders

4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

4.2 Tenders received after the due date and time (whether hard copy or via electronic means) may be considered only if the Chief Executive or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re- tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

4.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

4.4 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.

4.5 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his/her offer.

4.6 Necessary discussions with a tenderer of the contents of his/her tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

4.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under

consideration and while the tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

4.8 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

4.9 Should a request be made to the Board for acceptance of a tender that has not offered the most economically advantageous tender then the Board shall investigate and consider whether the request can be accepted or whether the tendering exercise should be completed again. Where the Board accepts that the reasons for accepting a tender that is not the most advantageous it shall document these reasons, together with any reference to risks to the Trust in accepting or rejecting the initial request.

4.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

4.11 All Tenders should be treated as confidential and should be retained for inspection for the period of the contract awarded. Successful tenders should be retained for six years after the expiry of the contract awarded.

5 Approved Firms for Building and Engineering Works

5.1 The Trust shall use suppliers on appropriate national frameworks for the provision of design, construction, and engineering works, from whom in the first instance proposals, quotations and tenders may be invited. For other services where tenders or quotations are required the Trust will use the processes established by the Procurement Shared Service.

5.2 The Chief Executive's prior approval shall be obtained where a firm not on an approved list is asked to tender and a report shall be submitted to the Audit and Assurance Committee on the reasons why the firm has been chosen.

5.3 Any Director may request a report on the financial standing of the favoured tenderer which will be carried out by an independent firm of financial advisers.

6 Conflicts of Interest

6.1 All Trust staff that are involved in a formal tender process shall sign a declaration of Conflict of Interest. Declarations should be retained with Tender records.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	10	Enclosure Number:	5
Date	9 March 2023		
Title	Trust Risk Register		
Author	Lee Troake, Head of Risk, Health & Safety		
Director/Sponsor	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 1 March 2023 the following changes were made to the Trust Risk Register.

Key issues to note

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- **C3941EFD**

Inherent Risk
The risk of severe patient harm due to an inadequate water safety programme at Cheltenham General hospital
Cause
There has been a break down in the water safety management programme
Impact & Effect
Effect • Positive Pseudomonas water outlets including showers and taps within augmented care wards across CGH Impact • Patients acquiring a Pseudomonas infection from positive water outlets and restricted access to water outlets including showers due to risk when used by vulnerable patient groups
Scoring
Safety C5 x L2= 10, Quality C3 x L3 = 9, Statutory C4xL3=12.
Evidence of scoring
• 1 linked incident • pseudomonas action plan Feb 2023
Key Controls
• Water safety group in place (monthly meetings) • Water safety Policy and GMS procedure Notes

- Risk assessments
- Water compliance group in place
- Comprehensive action plan has been developed to improve water management
- BI-weekly action plan review meeting

Gaps in Controls

- Water safety policy out of date and non-compliant
- Water safety plan not in place
- procedure notes not compliant with HMT04
- Flushing records incomplete
- Risk assessments not suitable and sufficient
- Actions following sampling non-compliant with guidance
- poor reporting by GMS to Water safety group
- Evidence of deviation from sampling procedure
- poor communication of positive results by GMS to IPCT and Trust / water safety group
- no electronic mechanism for procedure completion and notification of sampling

Actions

- Review of water safety policy and implementation of revised procedures
- Domestic Services staff to be trained in new cleaning methodology
- Flushing procedure note to be redeveloped and flushing implemented as per relevant standard
- Competency qualification required to appoint Deputy Responsible Person in CGH
- Implement all actions arising from SI investigation

- **S3481Obs**

Inherent Risk

The risk of severe harm to patients requiring emergency obstetric surgery caused by an inability to meet a minimum staffing requirements when opening a second obstetric theatre. The risk of harm to the wellbeing of staff when working outside minimum staffing requirements.

Cause

Currently, theatres in GRH are unable to provide a second team to open a second obstetric theatre between the hours of 16:00 – 08:00 due to inappropriate staffing levels. This is due to not only a rise in elective and emergency c-section's and the mis-alignment of colleagues working patterns that support these procedures, but the reconfiguration of the Trusts vascular service which has had an impact on the service.

Impact & Effect

Effect

- Patient delays in receiving emergency surgery
- Patients experience an increase in anxiety/stress to mothers and partners
- Staff inability to manage potential hemorrhage requiring hysterectomy in an emergency
- Staff clinical decision making altered by the availability of theatre
- Staff increase of stress/anxiety whilst at work
- Failure to meet NICE standards decision to delivery time
- Risk to delay, or not meeting staffing guidelines for other emergency surgeries as required, due to reallocation staffing to support obstetric emergency.
- Negative impact on other services e.g. perineal trauma

Impact

- Poor clinical outcome for mothers and babies including risk to life
- Poor clinical outcome for other emergency surgery
- Negative impact on staff health and wellbeing
- Increase risk of sick leave
- Increased risk of V&A due to anxiety levels
- Reputational Damage
- Risk of fines/prosecution
- Increased risk of sick pay and/or agency staff usage
- Recruitment / retention issues

Scoring

Safety C5 x L3 = 15, Quality and Workforce C4 x L4 = 16, Reputational C3 x L3 = 9

Evidence of scoring

- 98 Linked incidents
- Audit, Options Paper, SBAR, SOP

Key Controls

- If available the emergency team from theatres can attend (this prevents emergency surgery from taking place in theatres).
- Potentially second team from CGH to assist in main theatres to allow GRH theatre staff to attend obstetrics.
- Team assigned to emergency obstetric or main emergency theatre are shared out to obstetric theatres to cover roles in where possible and depending on skill mix.
- Pay bank staff to remain on shift to continue provision of elective work.
- Consider cancelling/delaying elective obstetric work to make provision for emergency obstetric surgery in discussion with obstetrician.
- Consider cancelling/delaying elective surgery work to make provision for emergency obstetric surgery in discussion with relevant surgical team and theatre management.

Gaps in Controls

- Emergency theatre team unable to attend due to clinical workload.
- Team from CGH only possibly available from 22.00 and could still be committed in theatres at CGH if available may take an hour to attend.
- Skill mix of theatre practitioners does not always allow for sharing of staff and results in theatres working below AFPP standards.
- Staff unable to cover bank shifts.

Actions

- 2nd Obstetric theatre paper Gateway to go to TLT on 18 April

RISK SCORE REDUCED FOR TRR RISK

- None

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

- None

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	Current Score	Current	Executive Lead title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
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	[illegible] E-learning package,Mandatory training Induction training,Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days Ward Based Simulation, system of electronic Vital Signs Acute Care Response Team Feedback to Ward teams, Following up DCC discharges on wards. Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients. Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient. ACRT are able to escalate to any department / specialist clinical team directly . ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors. ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	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
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews - Introduced "Review & Return" of ambulance arrivals to expedite diagnostics and reduce handover delays	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off. Progress VCPs for Flow Coordinator and ED Assistants Submit workforce paper to Exec COO Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners	Medical	Safety	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk	Medical Director	Divisional Board - Medical	Unscheduled Care Leaders Group		Quality and Performance Committee, Trust Leadership Team	31/01/2023	Barnes, Chester	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. Nearest resus trolly is in majors 3.Safety checklist completion is required before transfer to corridor and update throughout .Consultant cover 7/7 8- midnight and then on call (GRH) Escalation to silver/gold on call for extra help should the department require to overflow into another corridor outside of the ED environment .Daily audit by Nurse in Charge re suitability of suitable patients in corridor to ensure governance	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
C3963	Risk of increased harm, breach in regulations, distress and poor quality experience to patients, staff and visitors when boarding patients in wards.	Ward Boarding criteria in SOP to ensure unsuitable patients are not boarded. Risk Assessments completed for all wards . Consultation has taken place with wards. Weekly Boarding Meeting and Matrons Boarding group led by Director for Quality and Safety. Addendum produced for the ward evacuation plans to evacuate boarded patients first. Patient Experience issues to reported through datix and discussed at Safety huddles Procedures agreed such as - Allocate on Track in Pre-Empt space, Risk Assessment produced, EPR to be completed and accessible, Roles allocated for documentation completion. Patients nursed in corridor should be mobile and not require manual handling.Privacy screens used. Patients to be able to tolerate a mask in the corridor .Patients with COVID, C. Diff or Norovirus to be nursed within side room.Pressure relieving aids available from equipment library to reduce pressure sore risk. Staff support 2020 Hub available for staff who are affected by issues following boarding of patients . Trust communications team to create social media posts highlighting potential of corridor care . Trust letter prepared for all in-patients explaining need for corridor care and the expectation of move out of bay if required. Wards closed for infection control reasons are excluded from boarding of patients .Review of North Bristol Assessments / Guidance for boarding.Field added to datix to highlight boarding incidents. Communications via OpsMatron email. Escalation process for daily boarding issues Fire safety report/inspection completed in the Tower block. Beds will need to be by electrical socket to lower and raise. Bank and agency use to ensure ward working at establishment .Patients to be sent to appropriate specialty ward. Acuity and type of patient currently on ward assessed including enhanced care needs. Safe care completed to identify staffing numbers and acuity are correct and site/staffing matron aware. Matron undertaking ward rounds following 10am meeting each day to assess ward safety and patient experience. Patients who are corridor nursed to have News' score lower than 4 and not require oxygen or continuous cardiac monitoring. Patient medically fit for discharge to be in corridor care. Patients awaiting imminent discharge to be sat in day room to ensure bed space available for boarded patients . Full Handover of patient's needs to be undertaken on admission to ward or movement into corridor .ED staff to contact NIC mobile to hand over patient before transfer .Patient handover sheet to be completed if verbal handover not possible when on ward. Escalate to Matron/duty lead if patient acuity increases	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, Risk Management Group	Clinical Safety Effectiveness and Improvement Group, Emergency Care Operational Group, Fire Safety, GMS Health and Safety Committee, Health and Wellbeing Group, Patient Experience Group, Patient Flow Steering Group, Quality and Safety Systems Group, Staff Experience and		Emergency Care Board, Executive Management Team, Quality and Performance Committee, Trust Board, Trust Leadership Team	31/01/2023	Seaton, Andrew	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			28/02/2023	Johny, Asha	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	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 must complete. OD Specialists linked with divisions to provide more strategic and tailored support to these areas. Widening Participation Review held Oct 20 - Jun 21. Report published September 21	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	Corporate, Diagnostics and Specialties, Medical, Surgical,	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Staff Experience and Improvement		People and OD Committee	28/02/2023	Hopewell, Abigail	Trust Risk Register

	adversely impacts patient safety, job satisfaction, colleague wellbeing, and staff retention.	Widening Participation Review held Oct 20 - Jun 21. Report published September 21. EDI Team in place (EDI Lead, Coordinator, Administrator, Training Specialist) Colleague Wellbeing Psychology team fully established and offering training, 121s, group sessions to staff across the Trust. Focused on clinical areas. September 2022 A new Staff Experience Improvement Board has been established to address 3 key pillars of activity that relates to this risk: staff survey completion and priorities; restorative just and learning culture; behaviours and values.	2 x OD Specialists (fixed term) being recruited to offer additional support to a) maternity and b) junior nurse leadership development	Women's and Children's							Group					
			Staff Engagement and Internal Comms Manager being appointed to support internal communications effectiveness														
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	To review and update relevant retention policies	Medical, Surgical	Safety	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	01/03/2023	Holdaway, Matt	Trust Risk Register
			Set up career guidance clinics for nursing staff														
			Review and update GHT job opportunities website														
			Support staff wellbing and staff engagment														
			Assist with implementing RePAIR priorities for GHFT and the wider ICS														
			Devise an action plan for NHSi Retention programme - cohort 5														
			Trustwide support and Implementation of BAME agenda														
			Devise a strategy for international recruitment														
D&S2976BIMA	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Additional clinics covered by current staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee	06/03/2023	Hunt, Richard	Trust Risk Register
			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														
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service. Work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times) if the works carried out in CGH are not sufficient to mitigate heat gain. Autumn/winter 21/22 - Replaced window film in chem path lab and works completed in CGH lab, meaning BCP now robust. This summer (2022) will be the first opportunity to test this.	Develop draft business case for additional cooling	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	08/03/2023	Rees, Linford	Trust Risk Register
			Submit business case for additional cooling based on survey conducted by Capita														
			Rent portable A/C units for laboratory														
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	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Statutory	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		Fire Safety Committee Group, Risk Management Group, Trust Health and Safety Committee			Other	13/03/2023	Turner, Bernie	Trust Risk Register
			Identify any works required for alternative locations														
			Set up lessons learnt event														
			To sign off installation as required standard														
			To review usage and risk report to inform prioritisation														
			To roll-out new SVF process														
			To ascertain staff training requirements and roll-out														
			Fire team trainer to add information to mandatory training package														
			Rolling replacement programme for batteries														
			Check required on risk assessments														
			To broker discussions regarding funding impacts														
			Conclude RAG audit of areas across the Trust														
			Write risk assesment														
			Update busines case for Theatre refurb programme														
			Agree enhanced checking and verification of Theatre ventilation and engineering.														
			meet with Luke Harris to handover risk														
			implement quarterly theatre ventilation meetings with estates														
			gather finance data associated with loss of theatre activity to calculate financial risk														

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	investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan arrange replacement valve and acurator for air handling unit TH1 reinstate quarterly ventilation meetings	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - Surgery, Estates and Facilities Committee			Quality and Performance Committee, Trust Leadership Team	14/03/2023	Dobb, Michael	Trust Risk Register
C3876EOL	The risk of reduced quality of care for dying patients due being unable to discharge to a place of their choice and dying within hospital.	Follow up by staff to pursue suitable arrangements for patient choosing to EoL in community. Specialist Palliative Care working with individual cases with evidence, for these patients, they get home more quickly.	Map current process Upload sample CHC forms onto intranet site Solution for the digital storage and completion of national documents for application for CHC funding Develop a systemwide MDT to expediate EoL Discharges Obtain robust data set Flow chart for roles and responabilities for rapid discharge process Resource checklist for rapid discharge Develop outcome spreadsheet for rapid discharge MDT Regualr meeting with CHC leads	Ambulance Trust, Diagnostics and Specialties, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse and Executive Director for Quality	Quality Delivery Group	End of Life Quality Group		Trust Board	28/03/2023	White, Samantha	Trust Risk Register
C2628COO	The risk of poor patient experience and poorer outcomes where there is a breach of the 18 week wait from referral to treatment due to a backlog of patients.	Monitoring by clinical urgency and prioritisation is in place Additional capacity is being sought for each specialty Weekly review of PTL by the COO Monthly oversight by Improvement Board, led by CEO	1.RTT and TrakCare plans monitored through the delivery and assurance structures Formally review the Bed modelling and scenarios proposed as part of H2 submission.	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	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	30/03/2023	Zada, Qadar	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS 4. C.Diff reduction action plan in place	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Infection Control Committee			Quality and Performance Committee	31/03/2023	Bradley, Craig	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	31/03/2023	Bradley, Craig	Trust Risk Register

			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 #													
C1437POD	The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including; - Medical & Dental; Registered Nurses & Midwives and AHP professionals, thereby impacting on the delivery of the Trust's strategic objectives.	Trust Workforce Planning include as part of the Trust Business Planning Cycle template. Central workforce planning for the ICS is overseen by the ICS Workforce Steering Group Introduction of alternate/Advanced practice/new including Associate Specialists, Non- Medical Consultant, ACP, PA offering alternative solutions to medical gaps and increased AHP & Nursing development opportunities. Grow Our Own initiatives – wide range of apprenticeship schemes including at degree level to train our own Relaunch Launch of talent development system Ethical International Recruitment (IR) including Medical; Registered Nurses & midwives (first midwives being recruited 2022 via IR route) and AHP (including Radiographers) Expanded the number of staff on TNA cohorts Improved tracking of Nurse and HCA vacancies is now in place with Divisions, providing a more accurate view of our current position given the challenges reporting a vacancy position from the ledger. The Trust continues to implement alternative clinical roles such as: ACP's SAS Doctors re-opened Nurse Associates and Chief Nurse Fellows. Alongside ongoing professional pathway development and educational support. Focussed programme on attracting to A&C roles from the local market.	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	31/03/2023	Daniels, Shirley	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on the ward. the The risk of a prolonged inpatient stay whilst awaiting an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC and commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	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	31/03/2023	Freebrey, Clare	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Quality and Performance Committee, Trust Leadership Team	31/03/2023	Bradley, Craig	Trust Risk Register

			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														
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Patient flow and quality coordinator (band 7) allocated on a daily basis Daily staffing call and twice weekly staffing review between matrons and HoM Use of women and Children's pandemic staffing plan available for consultation to make decisions about service configuration and provision (closures of individual birth centres) Use of the escalation policy; include use of non clinical midwives and on-call community midwives to support the service; closing the unit to new admissions when required to ensure safety Senior Midwives on-call rota to provide out of hours leadership support plus on call Band 7 Rota to provide hands on support On-going staffing action plan including Staffing and recruitment action plan includes a rolling program of recruitment,proactive recruiting into 50% maternity leave Continuity midwives allocated intrapartum shifts since March 2022 BBA support withdrawn since September 2021 Planned homebirths on a case by case basis - letter sent to women to advise that homebirth service may not be supported Reduction of minimal staffing levels at Cheltenham birth unit to one midwife inline with Stroud model; followed by Temporary closure Short & long term sickness and absence management	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required. staff consultation on call enhancement discussion	Women's and Children's	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	31/03/2023	Stephens, Lisa	Trust Risk Register
D&S2404CHaem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place. No locums available (agency or NHS) for over 3 months Urgent and chemotherapy patients being prioritised for appointments Fixed term middle grade staff appointed and being trained to support consultant team Lack of capacity to accommodate even critical urgent and chemotherapy patients, now dependent on goodwill of staff to manage this workload. CEO agreement to use off-framework agency staff, however difficulty due to lack of locum availability, high rates and delay in HR response.VCP in place to advertise for consultant recruitment with additional incentive. Request support from Oncology to manage lymphoma workload (transferred from Oncology to Haematology mid 2020).	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	Divisional Board - D & S, People and OD Delivery Group, Quality Delivery Group	OHPCLI Board		People and OD Committee, Quality and Performance Committee	31/03/2023	Johny, Asha	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 -Monthly Divisional meetings, budget holder meetings and executive reviews. - Board and Associated sub committee reporting.	Development of Divisional Recovery Plan Performance Management of Delivery of Recovery Plans Financial Recovery Plan developed and reported to Finance & Digital Committee	Corporate	Finance	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Karen Johnson	Finance and Digital Committee			Executive Management Team, Finance and Digital Committee, Trust Board, Trust Leadership Team	31/03/2023	Johnson, Karen	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			03/04/2023	Brown, Sarah	Trust Risk Register

C3767COO	The risk of harm to patients and staff due to being unable to discharge patients from the Trust.	Clinical review and prioritisation Onward care team in place supporting discharge Prioritisation of end of life patients Currently GHT CHC process is reliant on ward staff to complete a number of the stages. OCT and SPC support where they are able, but there is not a constant provision of resource.	To resolve outstanding areas of concern	Ambulance Trust, Corporate, Diagnostics and Specialties, GP Services / NHS England, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	COO				Executive Management Team, Quality and Performance Committee	07/04/2023	Zada, Qadar	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the	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	10/04/2023	Zada, Qadar	Trust Risk Register
S3481Obs	The risk of severe harm to patients requiring emergency obstetric surgery caused by an inability to meet a minimum staffing requirements when opening a second obstetric theatre. The risk of harm to the wellbeing of staff when working outside minimum staffing requirements.	If available the emergency team from theatres can attend (this prevents emergency surgery from taking place in theatres). Potentially second team from CGH to assist in main theatres to allow GRH theatre staff to attend obstetrics. Team assigned to emergency obstetric or main emergency theatre are shared out to obstetric theatres to cover roles in where possible and depending on skill mix. Pay bank staff to remain on shift to continue provision of elective work. Consider cancelling/delaying elective obstetric work to make provision for emergency obstetric surgery in discussion with obstetrician. Consider cancelling/delaying elective surgery work to make provision for emergency obstetric surgery in discussion with relevant surgical team and theatre management.	ongoing audit recruitment of staff identify impact on other theatre staffing levels provide funding to allow recruitment of theatre staff Arrange meeting with Chief Midwife and BD 2nd Obstetric theatre paper Gateway to TLT by 18 April	Surgical, Women's and Children's	Quality	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		Divisional Board - Surgery	Theatres Collaborative			14/04/2023	Ball, Natalie	Trust Risk Register
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)10.0wte DSN funding in place to cover inpatient, outpatient, pump clinic and GDM. 3)Limited inpatients diabetes service available Monday - Friday provided by 1.5wte DISN, additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 5) Honorary contract for a diabetes nurse trainer in post, offering 0.2wte to the DSN team. This will add extra mentoring and training opportunity. 3.0 WTE Band 5 development role to be advertised and to grow our own specialist 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	17/04/2023	Mani, Vinod	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities.	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities 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)	Likely - Weekly (4)	12	8 -12 High 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 required standards of	Daily staffing review by matrons. A minimum of 2 midwives for all shift. However during a nightshift, if activity allows to reduce to 1 midwife at 02:00 Redeployment of staff where possible. Additional hours such as twilight shifts put out to staff as bank.	Address the safe staffing element audit acuity of unit and actual staffing within triage	Women's and Children's	Safety	Moderate (3)	Unlikely - Annually (2)	6	4 - 6 Moderate risk	Medical Director	Divisional Board - W & C, People and OD Delivery Group, Quality	Unscheduled Care Leaders Group		People and OD Committee, Quality and Performance	28/04/2023	Harris, Rachael	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 but overall with reduce departmental capacity creating delayed in patient access to treatment and breaches in CWT. Due to staff sickness levels increasing due to Covid and C19 isolation we have not always been able to run the other machines to 8pm and have had to reduce capacity further to 6.30pm. When there have been breakdowns, patients have been transferred to the closed machine temporarily without any delay. The working hours for Hereford have been brought in to 6pm, so that the machine can run with 4 staff. This will mean that ~8 patients per day from HFD will have to go to CGH instead which from previous experience is likely to cause patients distress. Patients are being prioritised on a clinical need basis by the Consultants for bookings and this has resulted in waiting lists and breaches as the referrals have continued to increase. The waiting list is being closely managed and Gloucester patients are being offer treatment on the Hereford machine if there are any slots on that unit. Tech Leads will be covering sickness as normal resulting in management tasks being left or delayed. Planning staff are working later shifts until 6pm so that they are available to help on the units to support in the evenings in the event of sickness, late patients etc. Research B6 radiographer has been redeployed to the treatment units to support. This has effected the numbers of Trials patients that can be recruited. nStudy leave has been curtailed for all staff, with the exception of Review, where the service requires this to go ahead due to staff leaving. Due to staff shortages we will continue to run a reduced on call service on Saturdays only. We will operate some Saturday working with Staff Bank volunteers where possible to attempt to catch up on palliative work where necessary. We have been running a reduced number of Review clinics, on Mondays and Thursdays only with adhoc cover for patients in between who need to be seen this will have a financial impact as these lost clinics cannot be billed for. It also has an effect on the Quality of care the patients will receive while on treatment Division have approved the over-recruitment of 8 Band 5s in June when the students qualify. Division have approved the over recruitment of 1 Band 7 post due to external interest in the post Division have approved an enhanced Bank payment to encourage staff to undertake other shifts if possible. Currently this only applied to full time	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 waiting list	Diagnostics and Specialties	Statutory	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Nurse & Director of Quality	Divisional Board - D & S	OHPCLI Board, Other	Divisional Quality Board	Other	02/05/2023	Moore, Bridget	Trust Risk Register

		Division have approved an enhanced Bank payment to encourage staff to undertake other shifts if possible. Currently this only applied to full time staff, but it is the part time staff who would be able to undertake Bank shifts so this needs to be reviewed. Staff will have to take paid overtime instead of toil as it is not possible to allow them to take back time. A paper was presented to PODG on 5.4.22 regarding recruitment and retention scheme A Banding review for therapeutic radiographers to bring them in line with National pay rates has been requested in the paper to PODG and DOAG Staff have been reminded of access to the Trust Hub for support and social events are being organised to try to maintain department unity and support. Mutual Aid has been sort with surrounding Radiotherapy department to limit the growth of the waiting list. 3 Departments have offered to take 1 patient/week each	Banding Review of Radiotherapy Staffing														
C3941EFD	The risk of severe patient harm due to an inadequate water safety programme at Cheltenham General hospital	- Water Safety Group in place (monthly meetings) - Water Safety Policy - approved and current - Annual water audit by external Authorised Engineer completed (November 2022) and actions added to action plan - SOP created for IPC actions post positive water results - GMS Procedure Notes - SOP created for management of positive results for GMS Estates team - SOP created for installation and management of filters, including tap replacement if tap will not take a filter - Water risk assessments review and update in progress - Compliance group in place (monthly meetings) - Bi-weekly action plan review meeting relating to all aspects of water safety (iterative as issues arise due to increased visibility and scrutiny) - Improved communication of positive results by GMS to IPCT and Trust/ Water Safety Group through creation and implementation of reporting SOP - Cleaning method statement for showers and bathrooms updated in line with national standards and signed off by IPC - Training designed and implemented for all domestic staff, focussing on augmented care areas as a priority - Process agreed regarding descaling, including tap replacement	review of water safety policy training records ensure flushing undertaken in each area To provide list of outlets Trust wide audit of outlets Formalised process to prioritise augmented care flushing To create staff engagement methods for water safety To use paraceti acid for drain cleaning across all augmented care areas To conclude water testing Avening ward Remove sensors Conclude risk assessment Rendcomb ward Complete evaluation of waterless bathing trial Review water tanks Review of birthing pool testing Purchase of water safety system	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Statutory	Major (4)	Possible - Monthly (3)	12	8 -12 High risk		Estates and Facilities Committee, Estates and Facilities Contract Management Group, Infection Control Committee	Water Action Group		GMS Board, Quality and Performance Committee, Trust Board	12/05/2023	Turner, Bernie	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start To update on IGIS 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	26/05/2023	Matthews, Kelly	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 Posters to set patient expectations of waiting times Recliner chairs available Exceptions made for carers to remain with waiting patients Additional space provided with trolley for use as assessment space when side rooms available ongoing recruitment and retention plan portable suction O2 cylinder availability All trolley spaces have access to a nurse call bell MSA mitigated with screens between trollies, waiting curtain tracking to be installed. Funding for 5A/SAU now reviewed and re-aligned from within division. Active recruitment on-going for RN's and HCA's.	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	31/05/2023	Jones, Lisa	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 some staff with medical conditions are unable to work reducing the staff pool.	Planned preventative maintenance by GMS Outsourcing for some products in place which would reduce impact somewhat - however this is not reliable due to external capacity limitations. Chiller has now broken down (16/06/22) - repaired late same day but not a permanent resolution GMS are checking the chiller each weekday morning and re-setting as necessary, however some days it trips several times a day resulting in temperatures up to 30degC in the cyto clean room and we have to contact GMS multiple times to request additional resets.	Liaise with GMS AHU motors report of AHU status check on chiller at weekends	Diagnostics and Specialties, Gloucestershire Managed Services	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		Divisional Board - D & S	Medicines Optimisation Committee		Cancer Services Management Board	02/06/2023	White, Amanda	Trust Risk Register
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Governance process. Reporting structure .Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new, overdue risks, partially completed risks, uncontrolled risks and overdue actions etc Risk Assessments, inspections and audits held by local departments Risk Management Framework in place.Risk Assessment policy in place Training on risk register. Risk Management group (ToR attached.Executive review meetings Patient safety group.H&S Divisional meetings.Trust H&S Committee People and OD delivery Group. People and OD delivery Committee Water action group.Infection Control Committee Access and egress group Quality delivery group Quality Performance Committee	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis test risk module Weekly meeting and action plan for DATIX Cloud	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	Divisional Board - Corporate / DOG, Finance and Digital Committee, Trust Health and Safety Committee	Quality and Safety Systems Group		Finance and Digital Committee, Quality and Performance Committee, Trust Leadership Team	06/06/2023	Troake, Lee	Trust Risk Register
	There is a risk the ICS/ Trust is unable to secure sufficient (CDEL) capital and/or secure additional borrowing, to address	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20								Capital Control Group, Digital Care Board, Divisional Board -	Capital					

F2895	secure additional borrowing, to address critical digital, estate or equipment risks and/or deliver key strategic schemes, resulting in interruption in clinical services impacting on patient care and outcomes and overall Trust performance.	3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation	escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Corporate, Gloucestershire Managed Services	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High Risk	Director of Finance	Corporate / DOG, Estates and Facilities Contract Management Group, Infrastructure Project Board	Capital Replacement Group, Medical Equipment Fund		Executive Management Team, Trust Leadership Team	30/06/2023	Johnson, Karen	Trust Risk Register

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 28 February 2023

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Staff Survey Results	The Committee discussed and reflected on the Staff Survey results from 2022. A number of actions were reviewed, including a personal letter to all staff from the CEO, engagement with all staff to find out the key things that would make a real difference and reflect on the metrics of recommending the Trust as a place to work and be treated, and a call to collectively work together to create a positive working culture.	A number of actions were explored by the Committee, and the Board would be discussing further in March.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Performance Dashboard	The report reflected performance against a range of People and OD metrics, providing assurance to the Committee across the core People Programmes: Workforce Sustainability, and Culture and Experience. Actions were highlighted to provide assurance to the Committee that a range of plans were in place to create a platform of high impact and sustainable transformation.	A report on the Trust's ambitions for nursing would be received in April. Clear alignment to the BAF was acknowledged.
Equality Report	The report highlighted the Trust's key achievements and progress made during 2021-22, with areas of particular positive progress highlighted. The team would continue to embed and realise improvements in the year ahead with a clear action plan. The report had been developed to become a more visually engaging document.	The newly formatted report was welcomed by the Committee. The Committee supported the publication of the report.
Gender Pay Gap Report	The mean gender pay for men in the Trust was 28.2% higher than for women (28.5% in 2021) which was a decrease of 0.3%. The median pay gap for men in the Trust was 21.7% higher than for women (23.4% in 2021) which was a decrease of 1.7%. The figures reflected the combined gender pay gap of both medical and non-medical staff.	Additional clarification on the data within the report would be provided, prior to publication of the report by the end of March.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
None.		

Items not Rated

Risk Register	ICS Update	Terms of Reference

Impact on Board Assurance Framework (BAF)

Two risks had been developed, one to focus on attraction and recruitment, and one to focus on culture and retention. The Committee welcomed the risks and agreed with the risk scores.

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

NHS
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KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 22 February 2023		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	***Pre-Empting and Boarding*** The increase in Emergency Department incidents continued to highlight system safety concerns. Boarding of patients continued in order to reduce the number of waiting ambulances. A significant reduction in handover delays had been seen in month. A rise in the number of incidents relating to boarding had been reported, with key outcomes and learning discussed at safety huddles. Main trends were identified in relation to criteria, handover and staffing. An audit had been undertaken and nursing handovers had been identified as a key issue.	In addition to existing work streams, a Quality Summit would be arranged for staff to discuss the organisation's plan for boarding and corridor care. A re-audit of handovers/documentation would be undertaken.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were highlighted as follows: • Increased incidents of pressure ulcers were mainly driven by reduced staffing. • Four-hour performance in ED had improved in January. • Areas of challenge were noted as Ophthalmology, Trauma and Orthopaedics and oral surgery. • Diagnostics were reporting some exceptional performance, although echocardiography and endoscopy remained challenging. • Cancer performance was stable, with recovery of the two-week-wait pathway achieved in February. However, urology and lower GI remained challenging. • Recovery of the 62-day backlog was expected to be achieved in June.	The Committee welcomed the improvements across a range of metrics, particularly cancer which had been an area of particular concern last month.
Maternity Safer Staffing Report	Midwifery Staffing remained a key risk on the Trust Risk Register. The evidence described in the report provided assurance that there were effective workforce planning tools utilised to review current establishments. The Committee noted the urgent action being taken to address staff shortages and the increased pressures on staff, which had been exacerbated by the Covid-19 pandemic.	Maternity staffing continued to be monitored by the Maternity Delivery Group. A twice-yearly report would be presented to the Committee.
Regulatory Update	The Committee noted the Prevention of Future Death Report that had been issued to the Trust by the Senior Coroner for Gloucestershire. The organisation had 56 days to respond; Quality Delivery Group had reviewed the report and the action plan would be reviewed by the Safety and Experience Review Group prior to submission. Action plans from recent CQC inspections continued to be reviewed and improvements made across the Trust.	A formal report describing the Trust's response to the Prevention of Future Death report would be received at the next Committee meeting.
Serious Incidents Report	There had been one Never Event reported since the last report related to a review of a decision made in February 2022 due to new evidence. No further investigation was needed as a thorough investigation was undertaken at the time. There had been seven new serious incidents reported, and no new Healthcare Safety Investigation Branch (HSIB) reports.	All serious incidents and Never Events were subject to serious incident investigation processes. Assurance of evidence of learning was required.
Trust Risk Register	One new risk had been added to the register related to the risk of reduced quality of care for dying patients due to being unable to discharge to a place of their choice. An improvement programme was in place to review simple discharges and a new programme board established to coordinate all discharge improvement activity.	A Review was agreed into the care pathway for patients who were nearing the end of life, both in admission and discharge terms.

Annual Complaints Report	A significant increase in the number of complaints received had been reported for 2021-22. Increased patient numbers and a reduced workforce, together with the need for clinical and nursing staff to manage competing clinical priorities had continued to adversely affect the Trust's ability to effectively and efficiently respond to complaints and implement improvement plans. The number of ward moves was noted by the Committee.	Clarity on ward moves would be provided to the Committee for assurance.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items not Rated		
System feedback	Terms of Reference	
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 during March.		

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 25 January 2023		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	***Cancer performance*** The Trust's cancer performance remained challenging, particularly in haematology, urology and lower GI. The number of patients was increasing, along with an increase in the backlog of patients on the 62-week wait pathway. The Trust had held a number of meetings with NHSEI to determine if there was anything more the Trust could do to improve the position. The number of patients on the 62-week wait pathway was decreasing, but there was further work to do to improve this. The Trust could potentially be moved into Tier 1 if significant improvement was not demonstrated, which would result in greater support and regular meetings with NHSEI.	The Committee received some assurance on the level of confidence to make significant improvements, however the position remained challenged. Pathway redesign was underway for urology and GI.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were highlighted as follows: • The Trust was currently achieving 2/10 of the safety actions for the Year 4 Maternity Incentive Scheme submission. • Women continued to receive good 1-1 support during labour. • There were challenges related to simple discharges and total numbers of patients which were impacting on overall performance. • Delayed transfers of care were a key area of concern. • An increase in mixed sex accommodation breaches had been reported, which was anticipated at times of pressure. • The emergency department had seen a very challenging December, with a decline in performance and the highest number of ambulance waits reported. The Committee noted signs of recovery in January. • In planned care, the Trust was performing well against the Referral to Treatment trajectory. • Falls data would be reviewed as it was not felt to be accurate. • Incidences of pressure ulcers had increased.	An extraordinary Board meeting had been arranged to sign off the Maternity Incentive Scheme submission, which was required by 2 February. Safety huddles were having a positive impact on staff during this challenging time.
Winter Plan Implementation	An overview on the strategy and scenario modelling was provided. A complex challenge was presented, with a number of objectives identified to achieve the overall plan.	An overview of the Trust's individual initiatives, and delivery as a system would be developed for discussion at Board.
Regulatory Update	The Committee noted the Inadequate rating following the inspection of the B-Braun subcontracted renal dialysis service, which had resulted in a section 29a warning notice related to deterioration of the estate.	A review of how CQC well-led actions were reported to committees would take place.
Serious Incidents Report	One Never Event had been reported, related to the misplacement of a nasogastric tube. Two serious incidents were reported. There had been no further Healthcare Safety Investigation Branch (HSIB) incidents.	All serious incidents and Never Events were subject to serious incident investigation processes.
Trust Risk Register	One new risk had been added to the register, and one downgraded. The register reflected a pressured system, with an increase in emergency department incidents continuing to highlight congestion	The Committee noted the reflection of a pressured system from the risks raised.

	and system safety. A final investigation report into the pseudomonas incident was due in mid-February.	Assurance was received that boarded patients received regular fire risk assessments, with all procedures updated and mitigated as much as possible.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Learning from Deaths Quarter 2 Report	All deaths were subject to a high-level review by the Bereavement team and Trust medical examiners. Families had the opportunity to feed back any comments on the quality of care received, which was collated as learning for the wards and end of life teams. Positive feedback rates had improved and was consistently at 85%.	The Committee was assured by the governance processes in place for reviewing deaths, and noted compliance with national guidance.
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 during January and February.		

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 to Board of Directors			
Agenda item:	**12**	**Enclosure Number:**	**7**
Date	9 March 2023		
Title	Quality and Performance Report		
Author /Sponsoring Director/Presenter	Suzie Cro, Deputy Director of Quality and Programme Director for Nursing and Midwifery Excellence Matt Holdaway, Director of Quality and Chief Nurse, Qadar Zada, Chief Operating Officer, Qadar Zada, and Mark Pietroni, Director of Safety and Medical Director		

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

Summary of Report

Purpose

The 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.

Key points of note

New QPR Governance

In Summary

- The reporting period is for **January 2023**
- The narrative of the assurance discussions can be found in the **Key Issues Assurance Report** and in the **Quality and Performance Committee Report** presented to March's Board of Directors meeting.
- The QPR and the Assurance Reports from the Delivery Groups are now seen as 1 item on the Quality and Performance (Q&P) Committee agenda.
    - QPR **Executive Summary** – can be found on page 2
        - The **Access Dashboard** can be found on pages 5-6
        - There are **21 access** exception reports and the detail can be found on pages 7-27
        - The **Quality Dashboard** can be found on pages 28-29
        - There are **13 quality exception** reports and the detail can be found on pages 30-43
        - The **People and OD Dashboard** can be found on page 44

- There are 9 exception reports and the detail can be found on pages 45-52

- There is **still improvement work** to be done on checking that the metrics are the right ones and that they support oversight of the strategic objectives. Also, there is improvement work required for completion of metric exception reports and this will be completed for the April reporting period.

- The **Business Information (BI) Team** continue to provide excellent support for the production of the QPR.

- As part of our improvement plan, to improve (clinical) governance (CQC Must Do October 2022), a new **QPR Metrics Governance Steering Group** has been formed to support the improvement work for our reporting. Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables oversight that safe, effective patient care is delivered to a high standard. The steering group will review the QPR to ensure that it is: complete, accurate, relevant, up to date (timely) and free from duplication.

- 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. The steering group continue to work on improving exception report completion and that all exception reports are generated and any data anomalies are checked.

- If a new metric is required to be added to the report, or a metric 'retired', this will be approved by the Steering Group and reported into the **Quality Delivery Group.**

Conclusion

The Board are asked to note the new QPR Report, the 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).

Recommendation

The Board is asked to note the progress and receive the QPR noting that improvements are required to capture 100% exception report narrative.

Enclosures

QPR January 2023

NHS
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Quality and Performance Report
Statistical Process Control Reporting

Reporting Period January 2023

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. 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.

Elective Care
The RTT performance did not meet the national standard, although in January performance has regained the losses incurred in December Validation of the month-end position is ongoing and the finalised position is anticipated to be around 69.6% (up 3% on last month and back to levels experienced in November). Performance remains above the national average of approx 60%. The total incompletes has also increased in month with the January position anticipated to be around 70,800. This increase is due to December being an unusual month, in that there is typically around 3 weeks of Clock Starts, due to the Christmas/NY break, with a backlog and spike of referrals at the start of the year.

The number of patients waiting over 52 weeks has increased in month, moving from 1,485 in December to approximately 1,566 in January with an increase of around 80 in month. Again this has likely been influenced by continued operational pressures, high levels of covid and flu, but also 2 days of power outages and industrial action. The increase in 52 weeks has only been influenced by one specialty, with ENT having 102 additional 52 week breaches compared to December. Surgical Endoscopy made the greatest reduction with 28 less breaches in month. Most other specialties maintained a stable performance.

The number of patients over 78 weeks has increased by a further 5 in month with Januarys position likely to be a total of 42. The Trust continues to have zero 104w breaches and although risk does still exist this is now much reduced, with the longest waiting patient being 92 weeks (with plans in place).

Focus remains on achieving zero 78 weeks by 31st March recognising that the pressures over the past 2 months has placed increased challenge on achieving this. Currently there are a total of 124 patients at risk of breaching 78 weeks by 31st March. The risks include 71 daycases, 18 inpatients and 35 outpatients. Of the 89 admitted pathways currently, 61 have a TCI date prior to 31st March with the remaining undated. 15 of the 35 patients are currently unbooked or booked passed 31st March and efforts continue to date or bring forward. The 3 specialties with the highest number of risks include Oral Surgery, ENT and Surgical Endoscopy.

Cancer
December validated and submitted performance data showed the Trust met 1 out of 5 standards, only 5 of the standards are currently available to report for the QPR. The Trust met the 28 day faster diagnosis standard with a submitted position of 80.8%. 2ww performance continues to be impacted by lower GI, breast and urology capacity issues, this will be resolved by the February submission, with significant capacity added by the teams to the pathway to support compliance. 62 day standard performance for December was 71.6% which will rise following with the final submission. A review of November data has shown an improvement in the compliance from a submitted 3/10 metrics met to 6/10 metrics met standard, which will be reflected nationally in the resubmission. Overall performance is impacted by the waits for prostate biopsy and the subsequent outpatient capacity, diagnostic and elective capacity, waits for endoscopy procedures and delays to LGI first OPA. A focus on >62 day & >104 day numbers has resulted in a reduction in the overall figures. Tumour site specific recovery plans are in development and delivery, as are initiatives to reduce the overall size of the PTL. The performance, associated clinical risks and remedial actions are subject to weekly review

Quality metrics
The quality delivery group continues to be the group that reviews the performance of the data and the exceptions reports for each metric on the quality dashboard, ..

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

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23
All electives (including day cases)	4,817	5,086	6,022	5,020	5,821	5,624	5,669	6,193	6,253	6,190	6,222	147,676	5,887
Day cases	4,132	4,223	4,984	4,127	4,736	4,625	4,707	5,230	5,210	5,169	5,305	4,269	5,089
ED attendances	19,175	17,664	20,519	19,336	20,898	20,155	20,966	19,913	19,930	21,376	20,727	12,728	10,946
FUP outpatient attendances	35,108	32,901	38,503	32,464	37,828	34,567	33,690	35,317	35,480	35,654	38,356	30,825	37,328
GP referrals	9,424	9,674	10,590	9,402	10,682	10,363	10,237	11,019	10,517	10,834	10,739	8,568	10,478
New outpatient attendances	16,392	16,052	18,596	14,806	17,531	16,401	16,449	17,039	17,369	16,877	19,149	14,981	18,250
Non elective (Incl. Assessment)	5,290	4,627	5,258	4,801	5,419	5,242	5,266	5,157	5,220	5,655	5,663	5,205	4,942
Outpatient attendances	51,500	48,953	57,099	47,270	55,359	50,968	50,139	52,356	52,849	52,531	57,505	45,806	55,578

Guidance

Gloucestershire Hospitals
NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Cancer	Cancer - 2 week wait breast symptomatic referrals	≥ 93.0%	?	Jan-23	86.2%	
	Cancer - 28 day FDS (all routes)	≥ 75.0%	?	Jan-23	72.4%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	?	Jan-23	92.9%	L
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	P	Jan-23	98.6%	
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%	?	Jan-23	82.6%	L
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%	?	Jan-23	87.5%	L
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	?	Jan-23	57.7%	L
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	?	Jan-23	83.4%	
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%	?	Jan-23	54.4%	L
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	?	Jan-23	84.1%	L
	Number of patients waiting over 104 days with a TCI date	= 0	?	Jan-23	8	
	Number of patients waiting over 104 days without a TCI date	≤ 24	?	Jan-23	97	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	F	Jan-23	10.66%	
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	F	Jan-23	1,354	L
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	F	Dec-22	16.8%	L
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	F	Jan-23	23.72%	
	% of ambulance handovers < 15 minutes	No Target		Jan-23	19.57%	L
	% of ambulance handovers < 30 minutes	No Target		Jan-23	42.65%	
	% of ambulance handovers over 60 minutes	≤ 1.00%	F	Jan-23	38.31%	
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	F	Jan-23	46.4%	L

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	F	Jan-23	40.1%	
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%	F	Jan-23	60.04%	L
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	?	Jan-23	1,057	
	Number of ambulance handovers 30-60 minutes	↓ Lower		Jan-23	629	
	Number of ambulance handovers over 60 minutes	= 0	F	Jan-23	1,016	
Maternity	% of women booked by 12 weeks gestation	> 90.0%	?	Jan-23	86.9%	L
Operational Efficiency	% day cases of all electives	> 80.00%	?	Jan-23	86.44%	
	Average length of stay (spell)	≤ 5.06	?	Jan-23	7.42	H
	Cancelled operations re-admitted within 28 days	No Target		Jan-23	56.25%	
	Intra-session theatre utilisation rate	> 85.00%	?	Jan-23	86.34%	
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	?	Jan-23	3.03	
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	?	Jan-23	8.47	H
	Number of patients stable for discharge	≤ 70	F	Jan-23	231	H
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	?	Jan-23	205	L
	Urgent cancelled operations	↓ Lower		Jan-23	0	L
Outpatient	Did not attend (DNA) rates	≤ 7.60%	P	Jan-23	6.01%	
	Outpatient new to follow up ratio's	≤ 1.90	?	Jan-23	1.89	L
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	?	Dec-22	7.31%	L
Research	Research accruals	No Target		Aug-22	234	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	F	Jan-23	140	L

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No Target		Jan-23	8,086	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target		Jan-23	3,532	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0	?	Jan-23	1,565	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%	F	Jan-23	69.62%	H
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target		Jan-23	88.20%	H
	% patients receiving a swallow screen within 4 hours of arrival	No Target		Jan-23	90.20%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		Jan-23	88.2%	H
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%	?	Dec-22	92.7%	H
SUS	Percentage of records submitted nationally with valid GP code	≥ 99.0%	P	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%	?	Dec-22	38.46%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%	P	Dec-22	84.6%	L

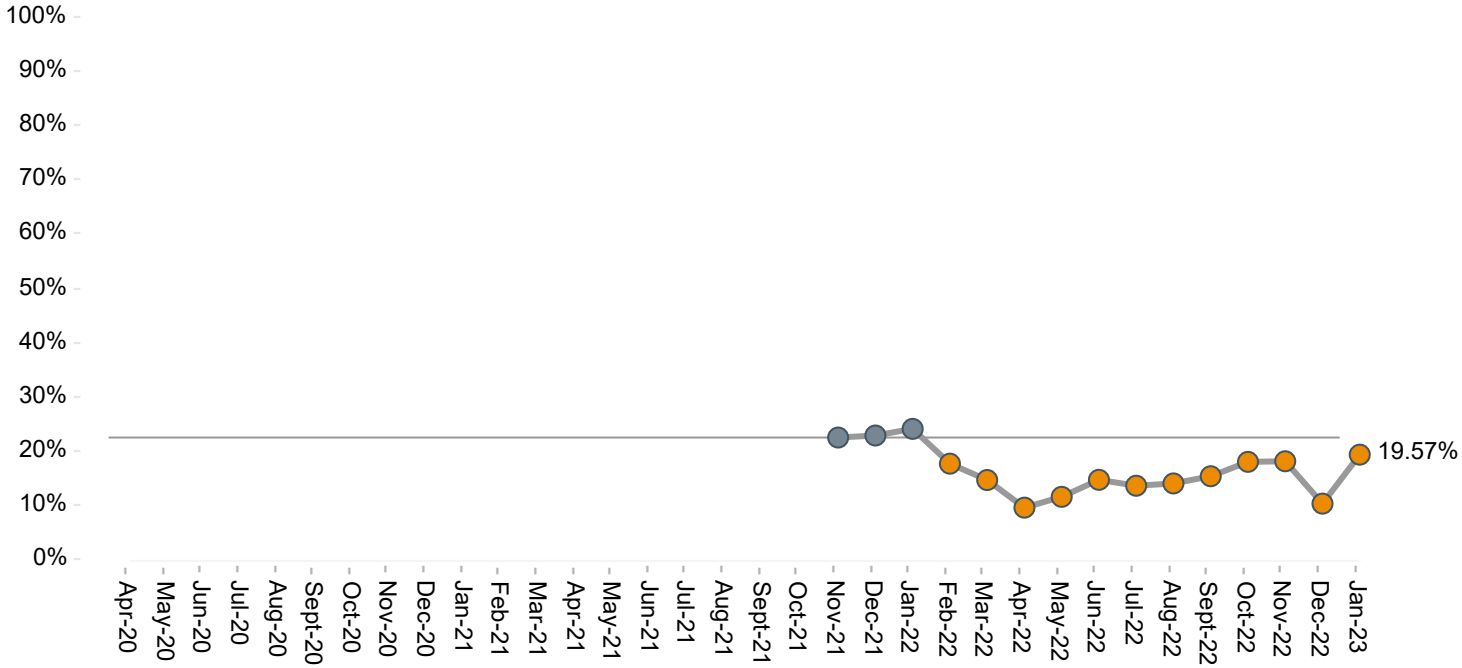
Access

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

Further reduction in the overall level of ambulance handovers was achieved in January. Discharge Lounge is having a positive impact; but the role of the Flow Co-ordinators and the opening of the CADU area will have a positive impact going forward.

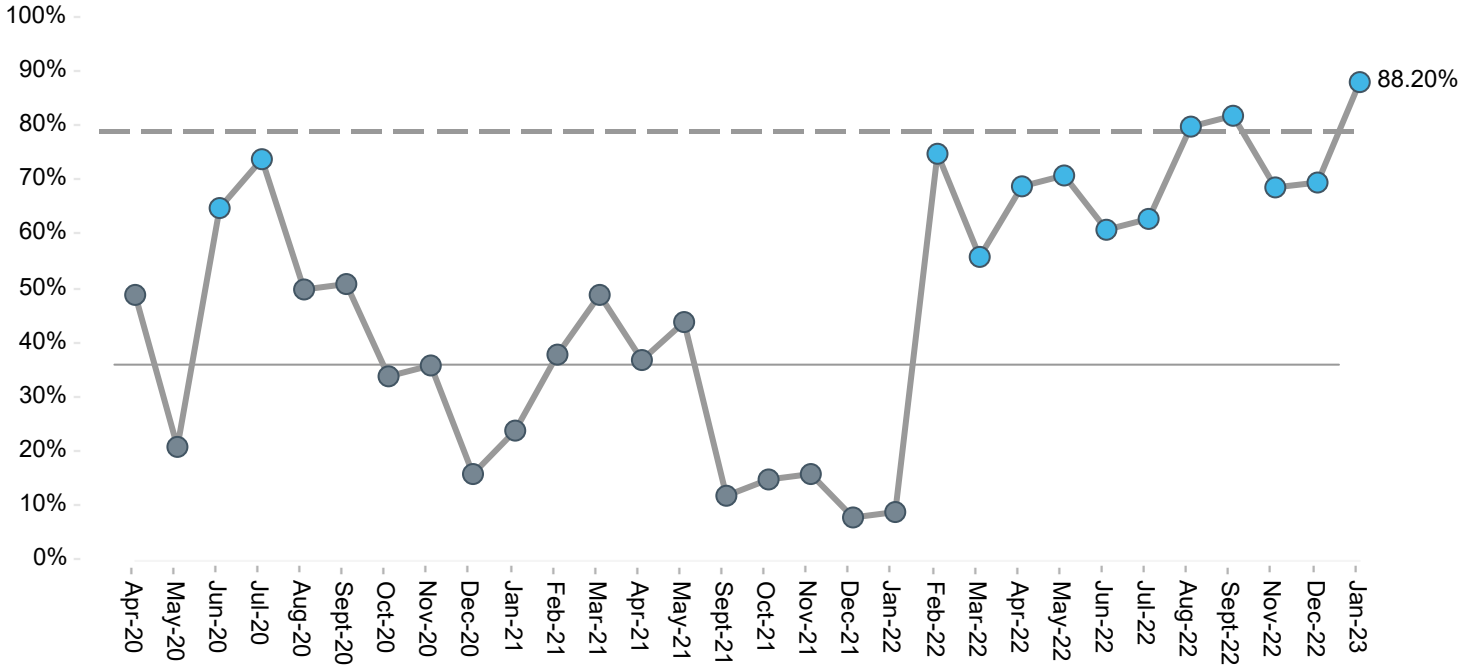
Access

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

[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

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

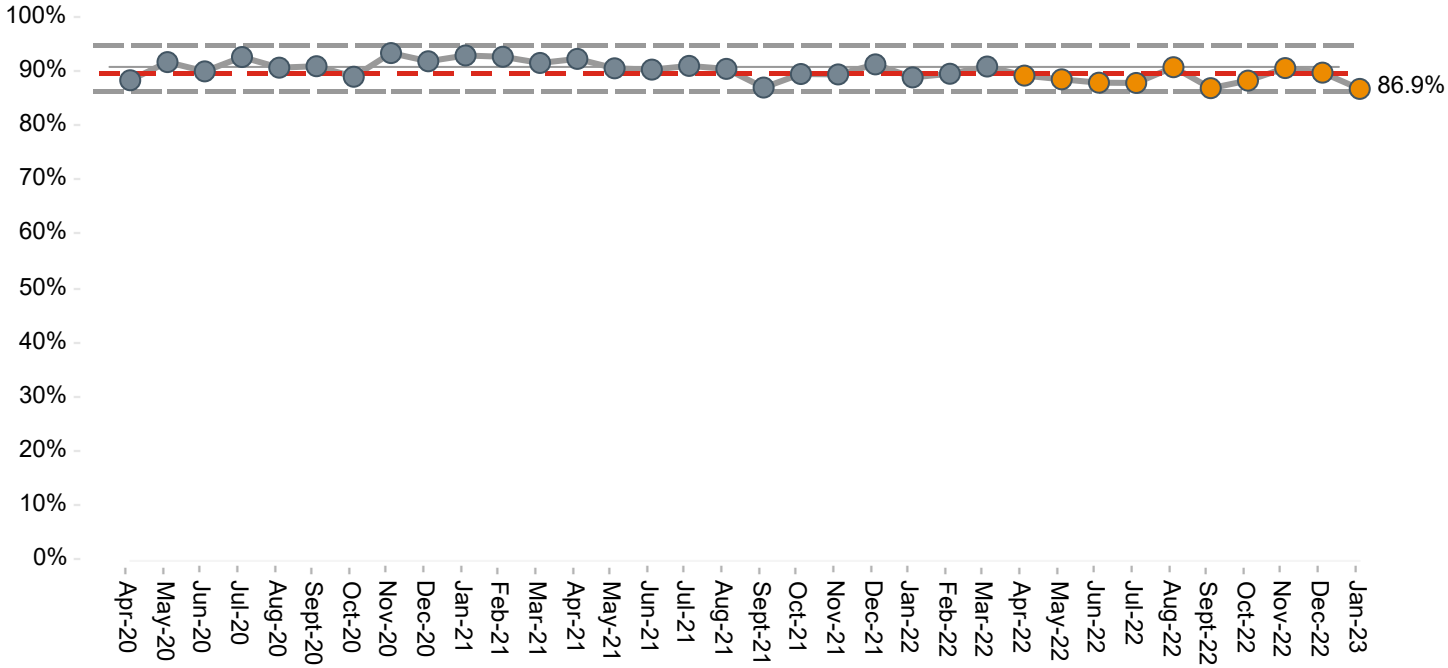
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[138] % of women booked by 12 weeks gestation

Target: > 90.0%



Data Observations

[2] SHIFT

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

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

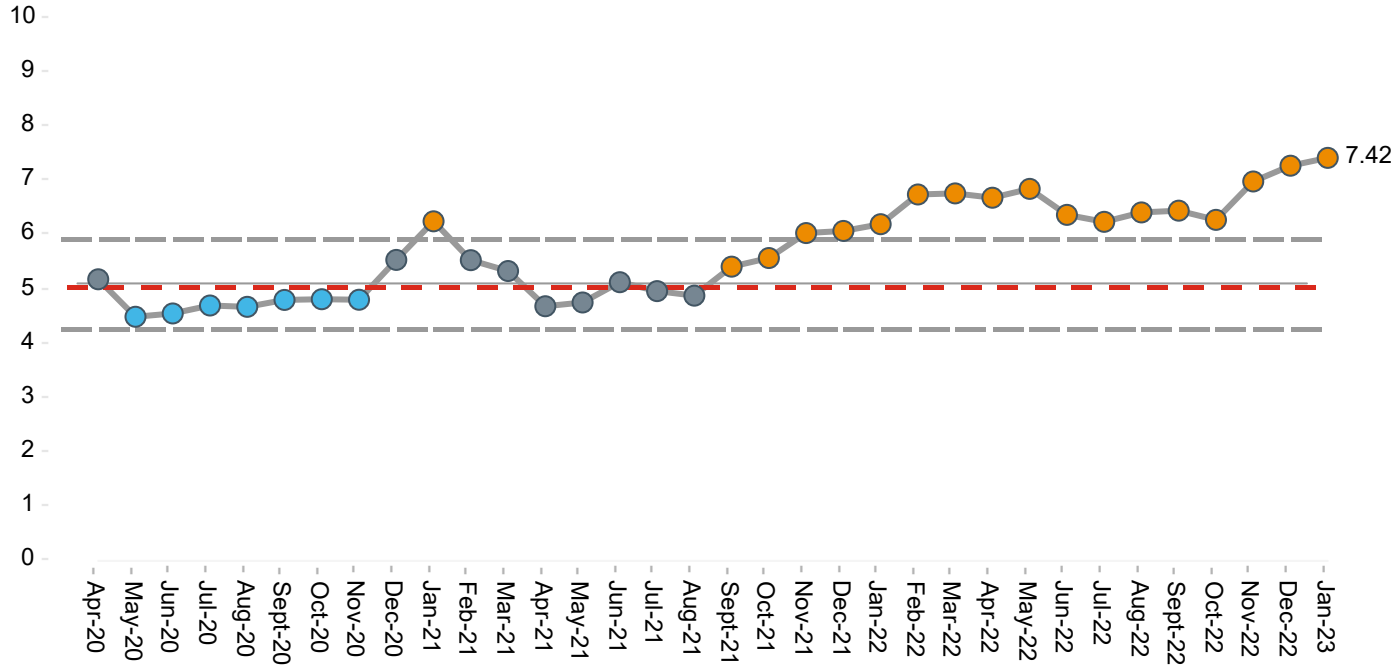
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[188] Average length of stay (spell)

- - - Target: ≤ 5.06



Commentary

Average Length of stay remains generally static for the period. Additional capacity made available in January did not have a significant impact. Focus remains on increasing volume of patients discharged with nCTR status. This stabilises the position, but does not significantly improve the performance of this metric. It is probable that this position will remain stable in the next reporting period.
Deputy Chief Operating Officer

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.

[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

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.

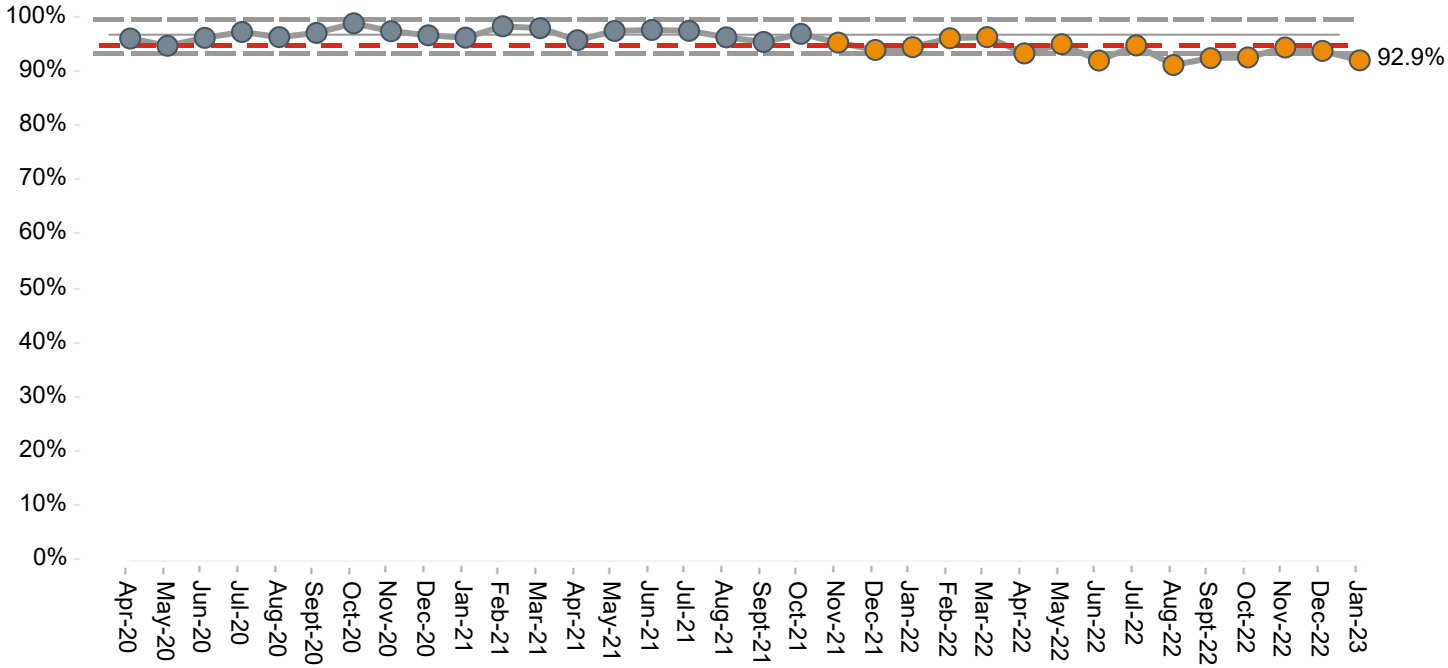
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 96.0%



Commentary

Unvalidated:
Standard = 96% | GHFT = 93.0%
Treated= 302,
Breaches=21
Number of Breaches for Specialities not achieving: Gynae = 3,
LGI=3, Urology=9, Lung =3 , Skin=2 : 11 breaches due to capacity both in surgery and radiotherapy
General Manager - Cancer

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.

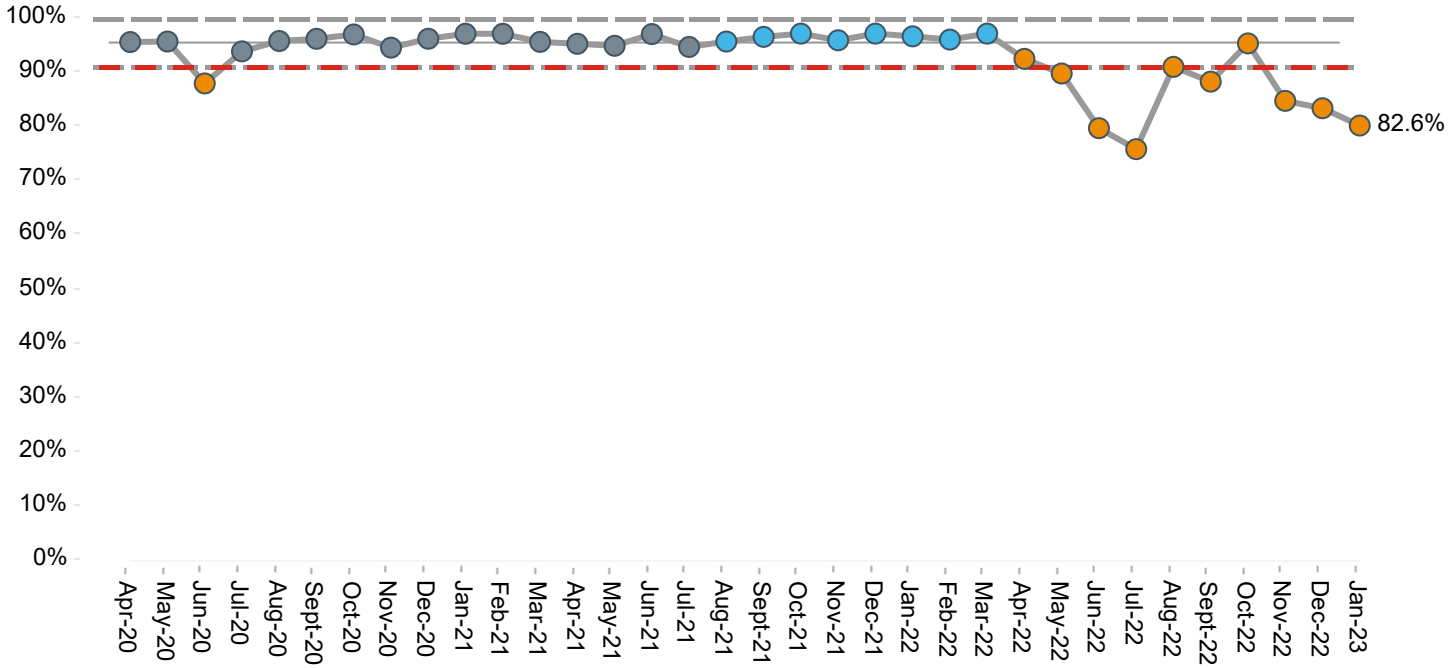
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 94.0%



Data Observations

[1] SINGLE POINT

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

[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

Unvalidated
Standard = 94%
GHFT = 84.5%
Treated =96
Breached =17
Performance impacted by focus of work on 62 PTL, leading to reduced numbers in cohort, expectation to have full data input by upload deadline
General Manager - Cancer

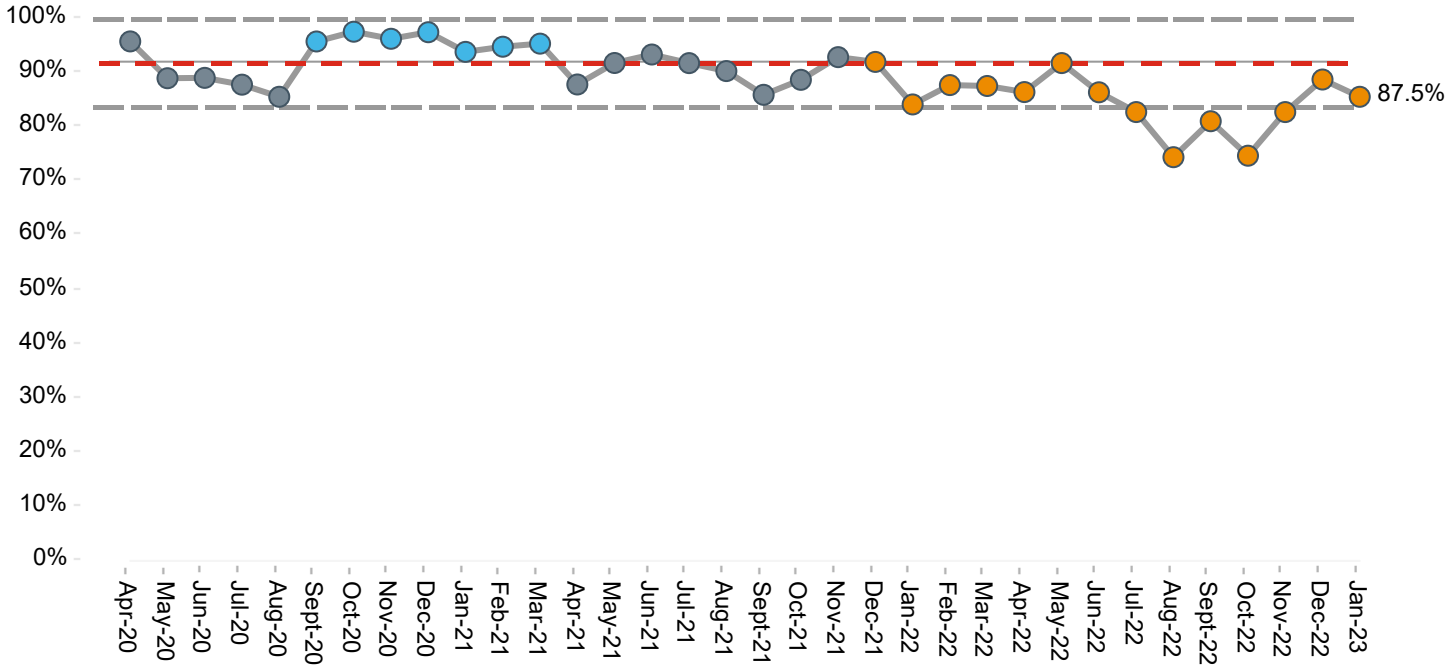
Access

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 = 93%
Treated = 64
Breaches = 7: Breast =2, gynae =2, Uro=1, skin=1, LGI = 1
General Manager - Cancer

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.

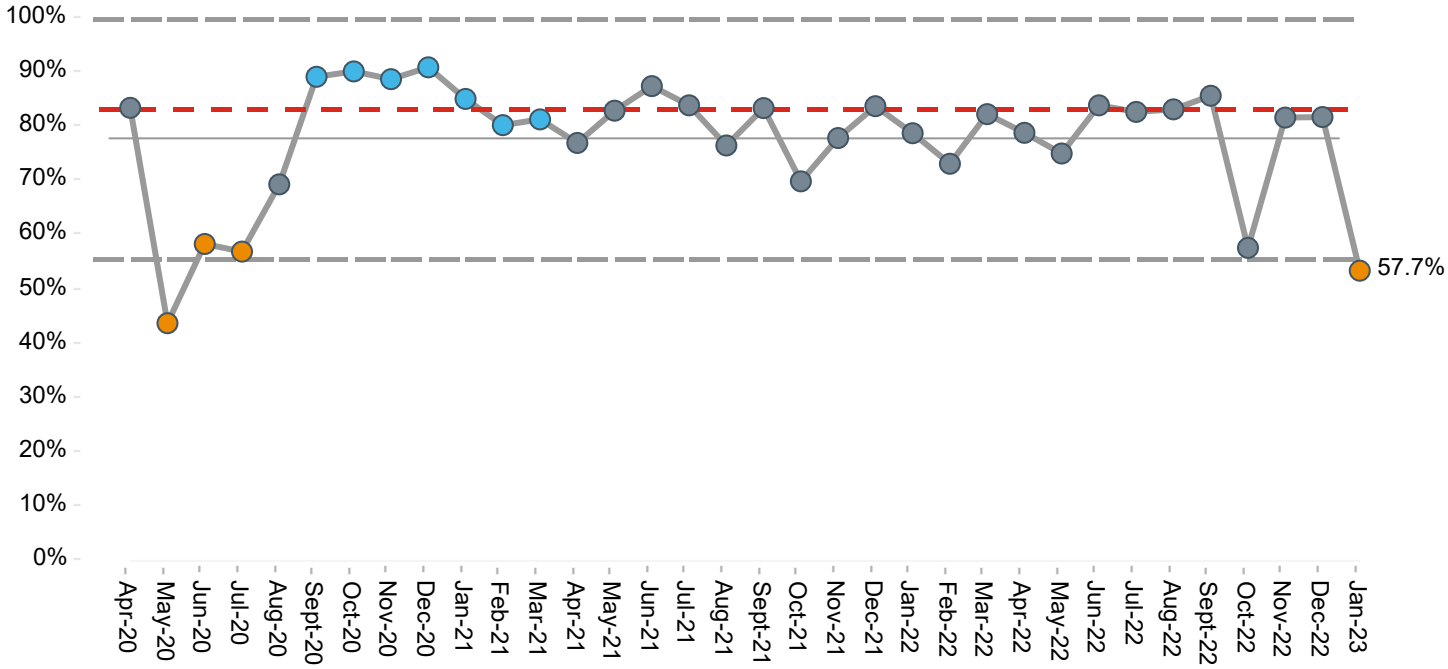
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[176] Cancer - 62 day referral to treatment (screenings)

Target: ≥ 90.0%



Commentary

Unvalidated position
Metric = 90%
GHFT = 58.5%
Accountable = 26.5
Breaches = 11 - Breast = 5 , LGI = 4 , Gynae =2
Elective capacity
inadequate = 8
Complex = 2
Pt choice = 1

General Manager - Cancer

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.

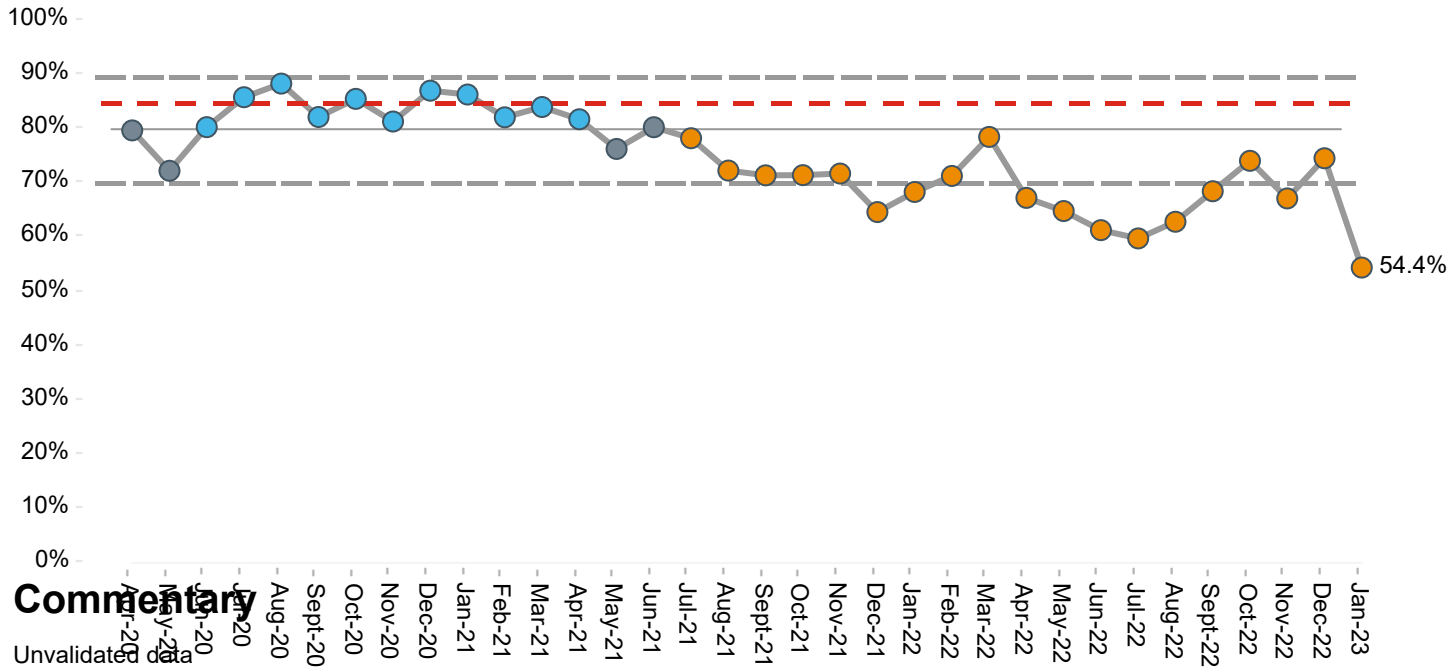
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 85.0%



Data Observations

[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

Unvalidated data
Standard = 85%
Treatments = 176 - expect this number to be greater than 250 as a validated position
Breaches 84;

Commentary

52.3% Specialities not meeting standard: Gynae=3.5, Haem=3, H&N=8.5, LGI=15.5, lung= 6, Skin=5, UGI=5.5, Urology=35

Breach reasons:
Admin delay: 1
Elective capacity inadequate: 29
Healthcare delay: 12
Medical delay: 3
Complex diagnostic pathway: 21
Un-validated: 5
Outpatient capacity inadequate : 13
PATIENT initiated (choice) : 3
covid: 1

General Manager - Cancer

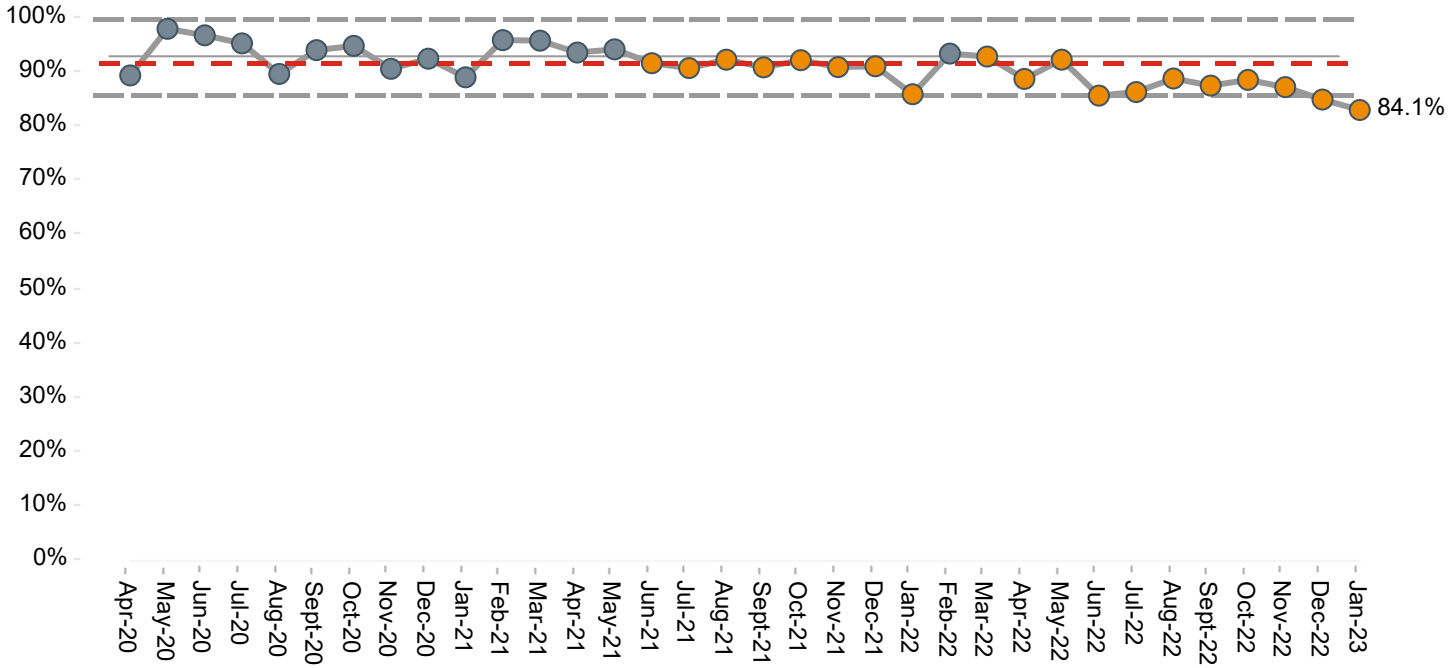
Access

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

[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

2ww Performance (unvalidated)
Standard = 93%
GHFT = 84.0%
DFS = 2304
Breaches: Total=368 - Not achieving Specialities: Lower GI=228, skin=45, Urology = 23, Breast=36, H&N=19, Haem=2 , NSS=1
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
Forward look to Feb, current performance 93.4%, with LGI the only speciality not meeting metric at 76% (63breaches)

General Manager - Cancer

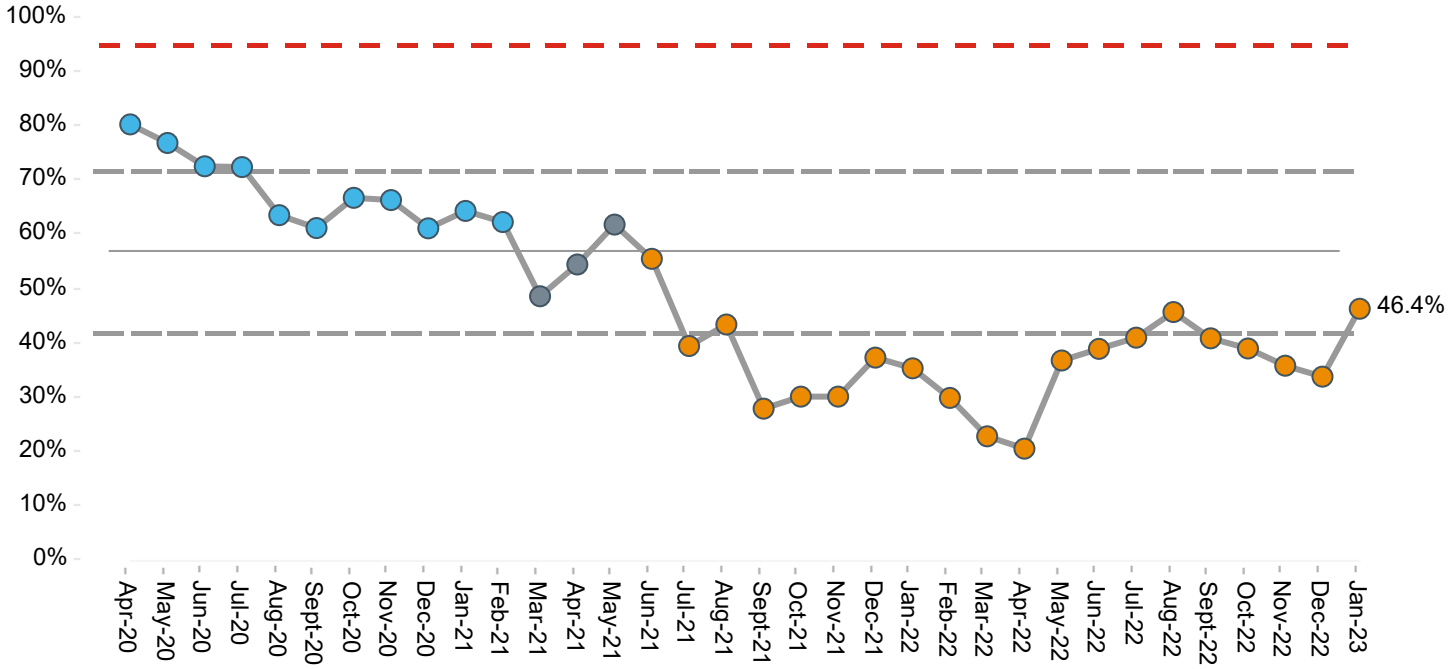
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 95.0%



Data Observations

[1] SINGLE POINT

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

[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

Time to triage reduced to 26 minutes (on average) in January. This represents the best monthly performance at the Trust since the first quarter or 2021/2.

General Manager of Unscheduled Care

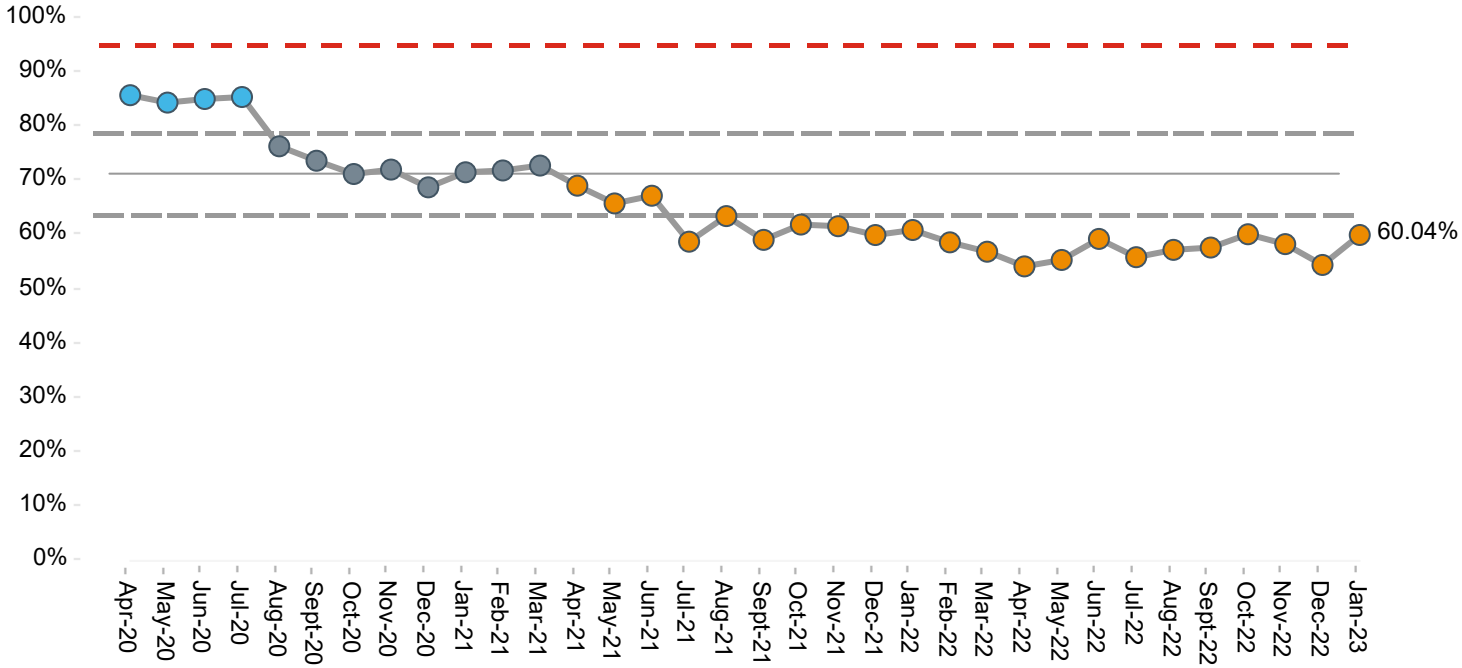
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 95.00%



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.

Commentary

4 hour performance improved to 60.3% in January (from 54.7% in December); this represents the (equal) best result in 2022/3 so far. Discharge Lounge will be starting to have an impact on decompressing ED. Once the Flow Co roles become established this will also work to improve the 4-hour performance ratio.

General Manager of Unscheduled Care

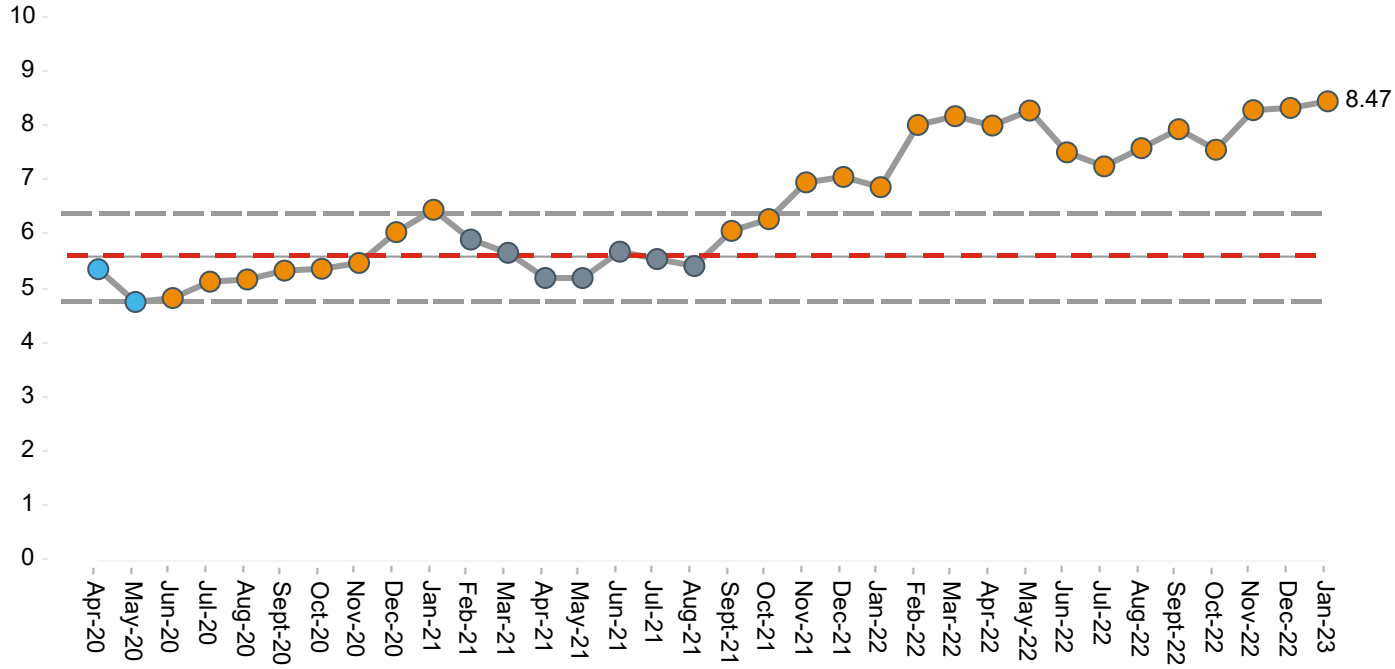
Access

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

Metric remains static for the period. Additional capacity made available in January did not have a significant impact. Focus remains on increasing volume of patients discharged with nCTR status. This stabilises the position; It is probable that this position will remain stable in the next reporting period. The is renewed focus on increasing the volume of patients discharged at less than 7 days LOS.
Deputy Chief Operating Officer

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.

[3] RUN

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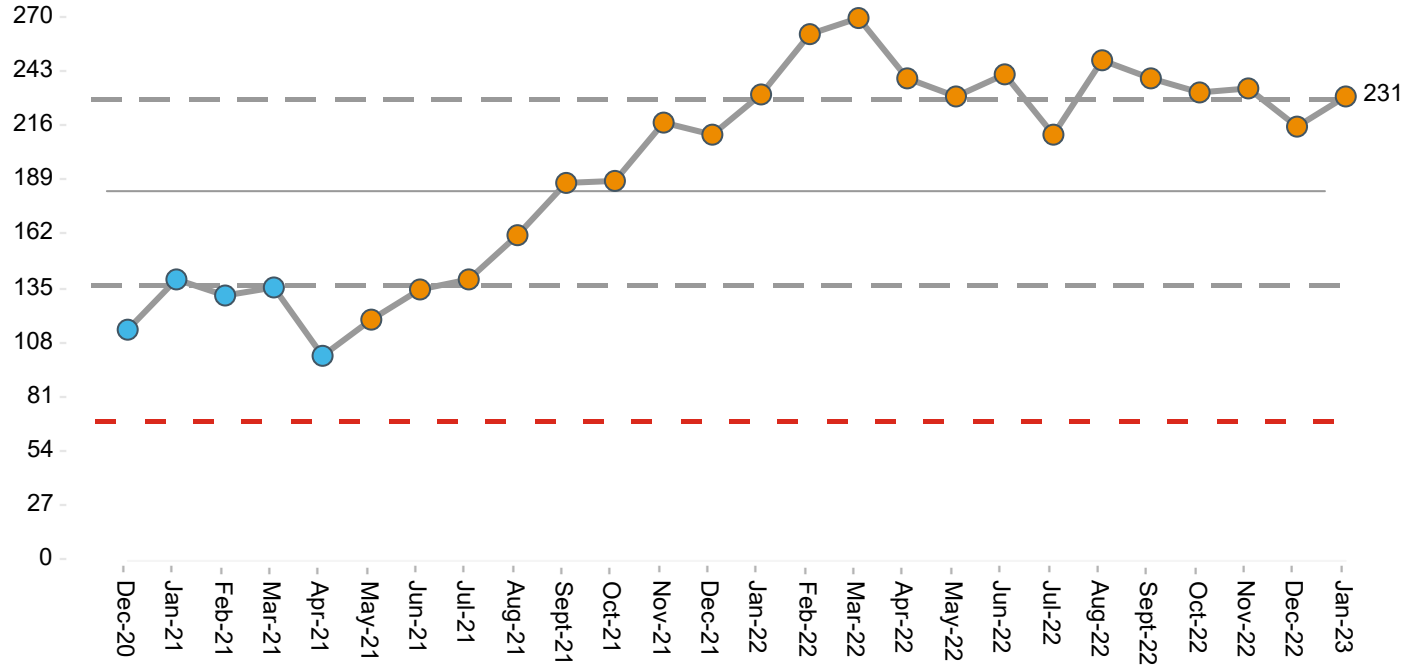
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[186] Number of patients stable for discharge

Target: ≤ 70



Data Observations

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Commentary

Ongoing issues with minimal improvements in the number of patients awaiting onward care. New national monies announced by government to support hospital discharge and social care. We should as a result see an improved picture moving forward.

Head of Therapy & OCT

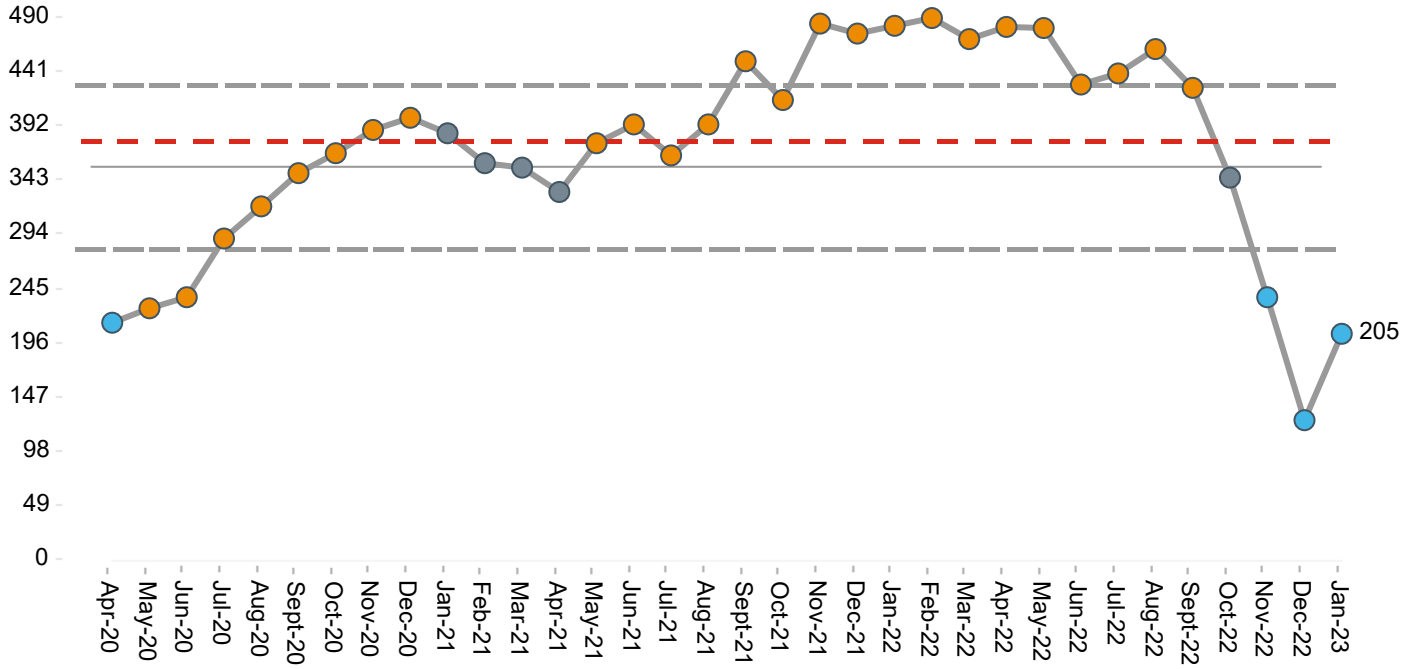
Access

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



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Commentary

DRAFT AS DATA QUALITY ISSUES January saw a significant deterioration in this metric. (Validation is underway) There is some seasonal effect demonstrated, but the availability of onward care destinations and low discharge volumes have contributed to this deterioration. Focus remains on securing additional non-hospital based care packages and ensuring patients are treated without the need for admission, initiatives are in place to support earlier discharges (Discharge Lounge and Early Meds for Earlier Beds, revised weekend arrangements) ensuring patients are discharged as quickly as possible on Pathways 0 and 1. It is predicted that the next period will be as challenging, but with a less acute deterioration.

Deputy Chief Operating Officer

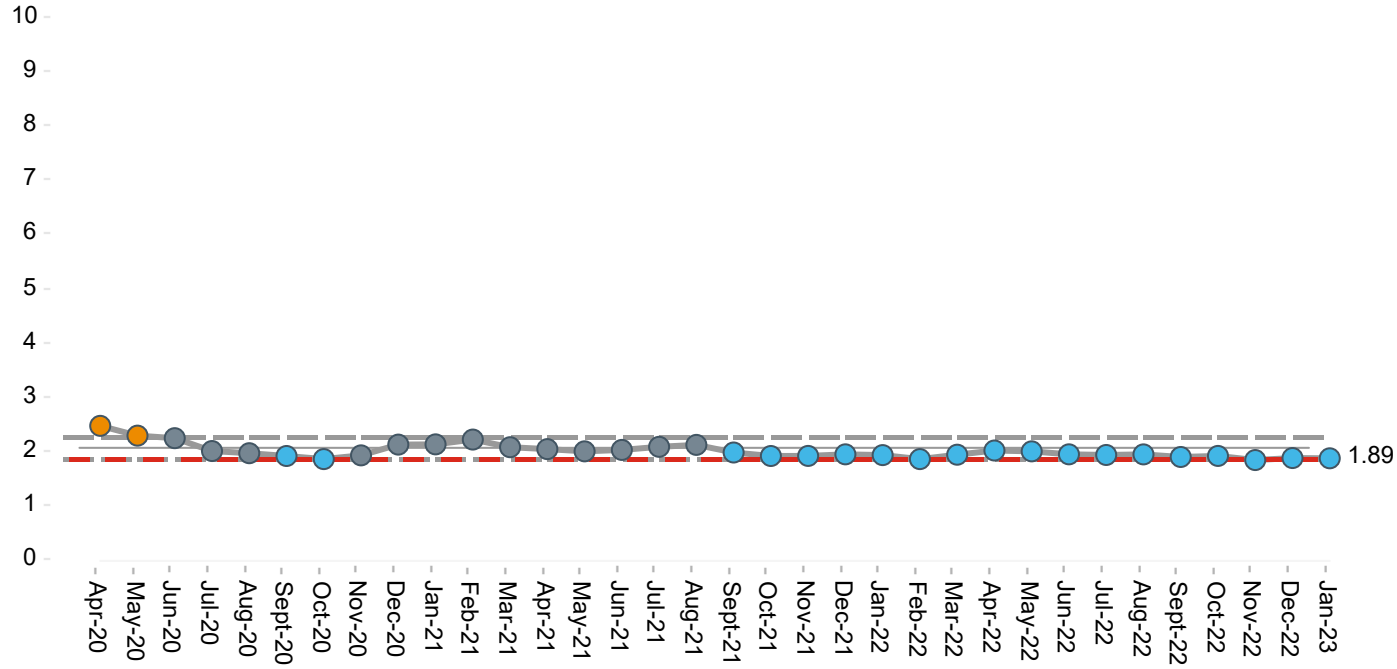
Access

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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[4] 2 OF 3

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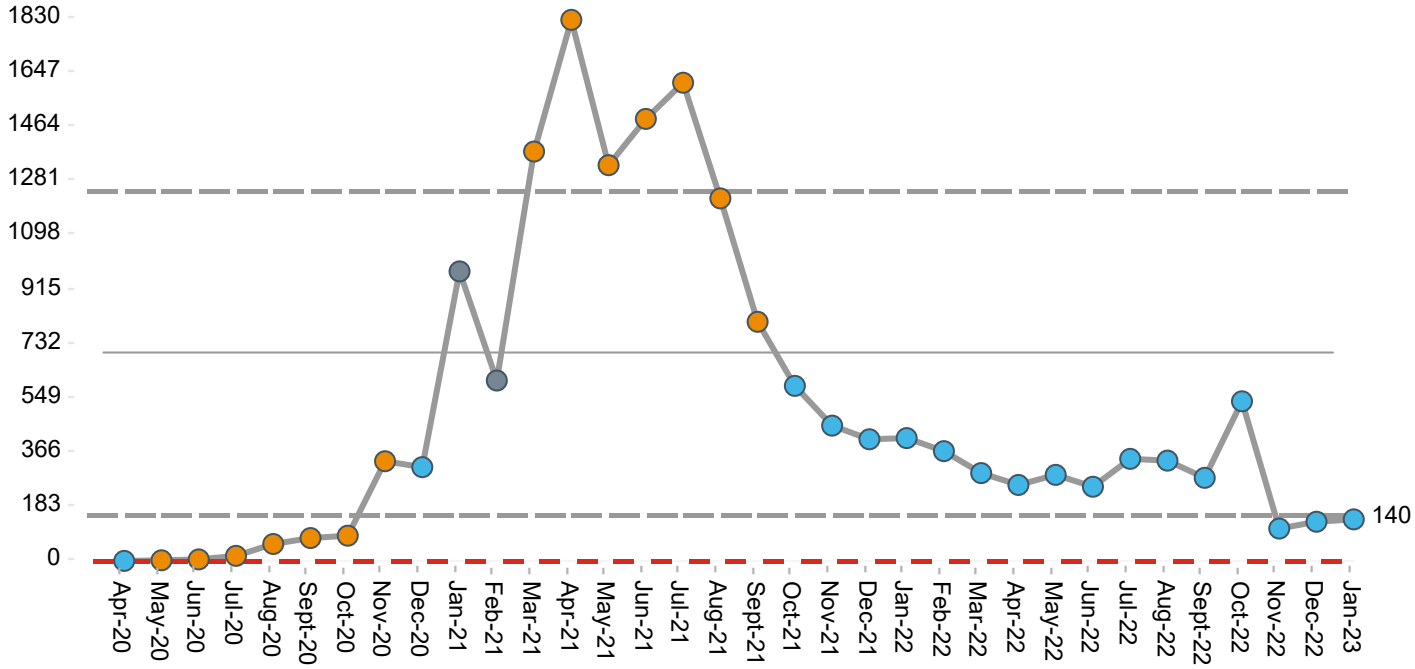
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Commentary

An increase of approximately 9 has been seen in month, which is the second consecutive month where an increase has been registered. Performance in both December and January have been influenced by exceptional operational pressures, high levels of covid and flu, industrial action and unforeseen events such as power outages.

Associate Director of Elective Care

Data Observations

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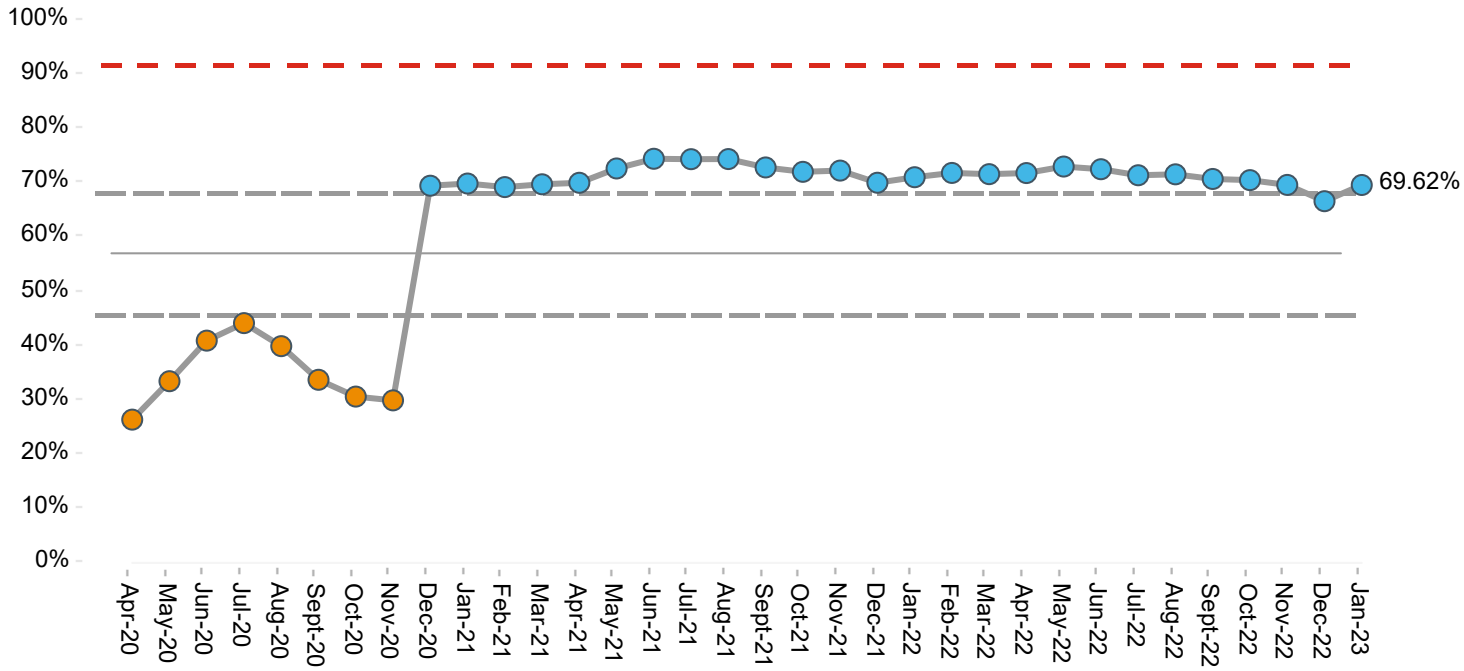
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 92.00%



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Commentary

See Planned Care Exception report for full details. RTT performance has recovered the drop in performance experienced in December, moving from 66.4% in December to a provisional 69.6% for January. This is back to similar levels achieved in November, and remains above the national average of circa 60%.

Associate Director of Elective Care

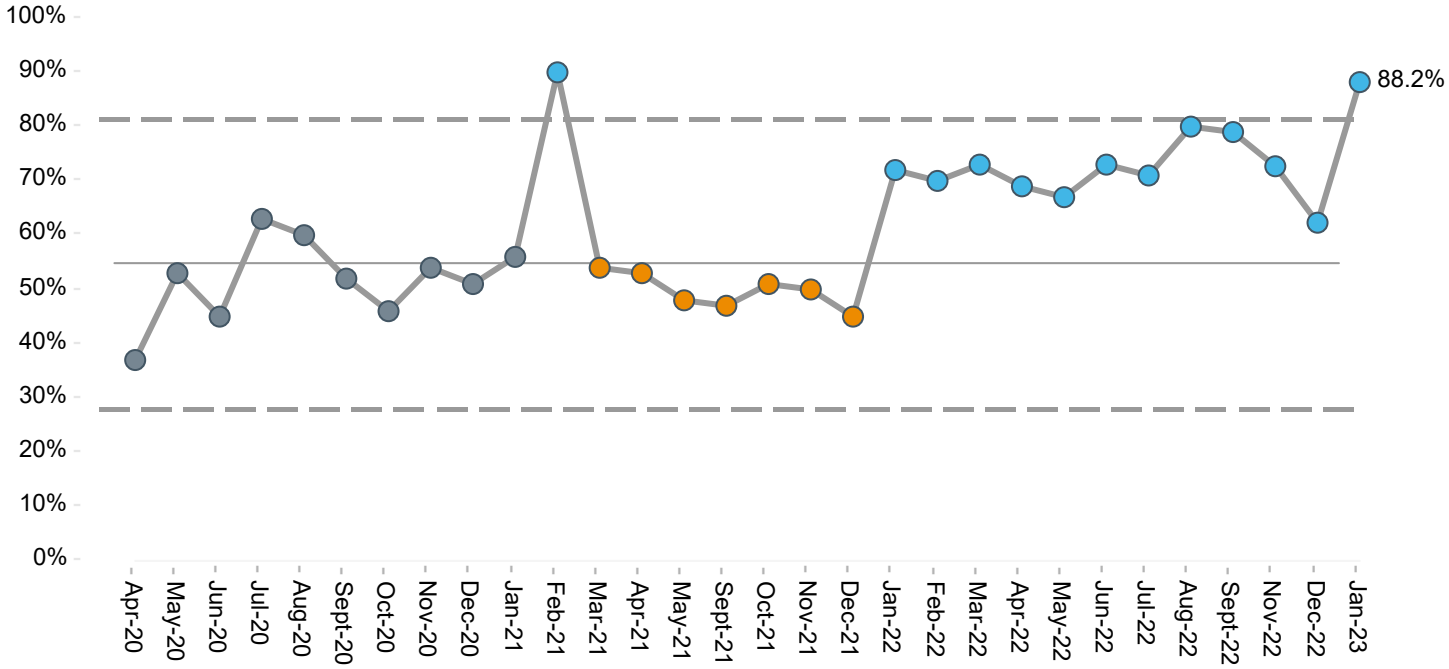
Access

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. Any impact on performance is driven by stroke attendances at GRH

General Manager - COTE, Neuro and Stroke

Data Observations

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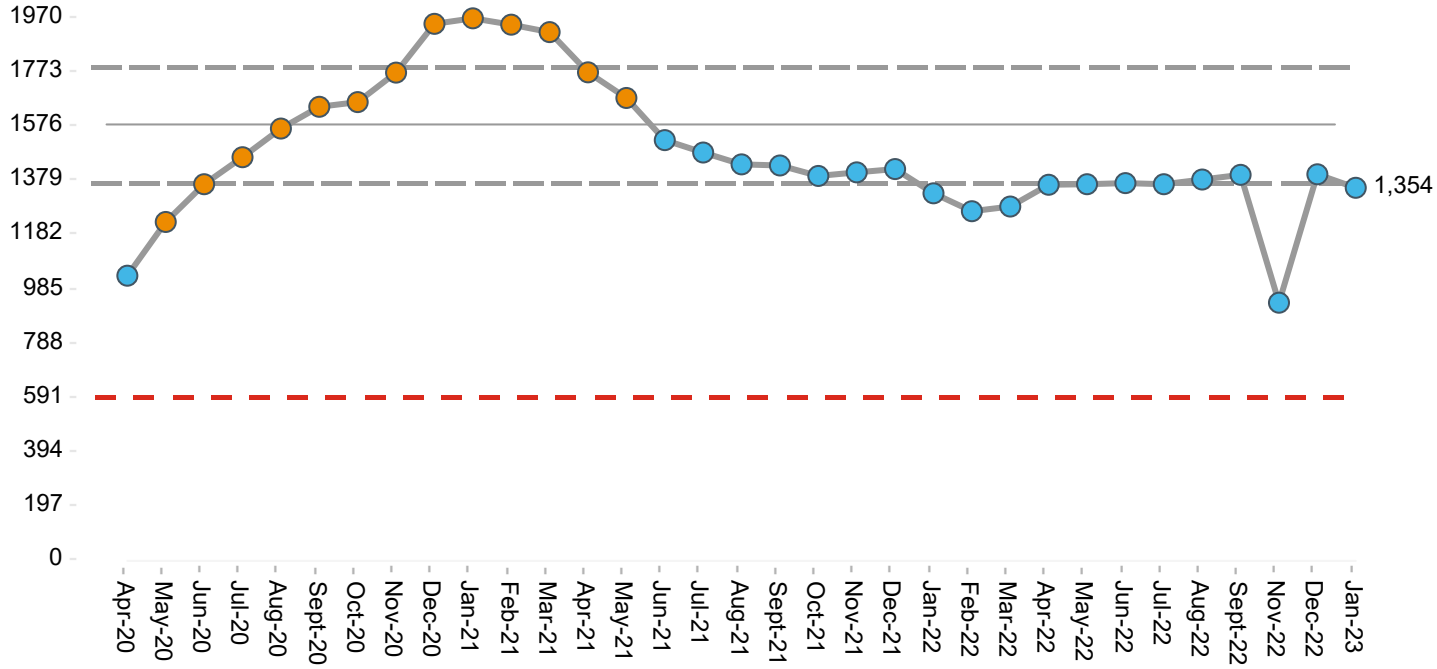
Access

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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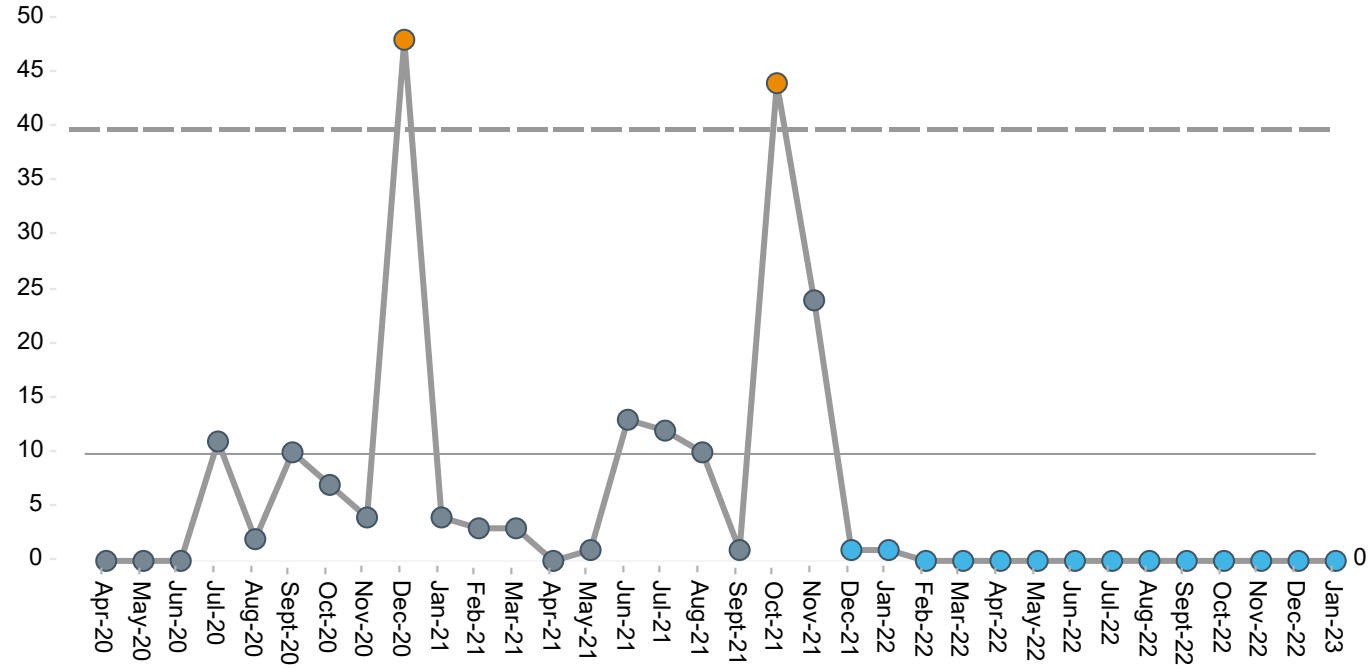
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[552] Urgent cancelled operations

- - - Target: ↓ Lower



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Commentary

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		Jan-23	80.8%	
	Inpatients % positive	No Target		Jan-23	90.8%	
	Maternity % positive	No Target		Jan-23	83.5%	
	Outpatients % positive	No Target		Jan-23	94.7%	
	Total % positive	No Target		Jan-23	92.2%	
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target		Jan-23	238	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target		Jan-23	704	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target		Jan-23	313	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target		Jan-23	335	
	Clostridium difficile - infection rate per 100,000 bed days	↓ Lower		Jan-23	38.5	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower		Jan-23	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7		Jan-23	10.5	
	Number of MSSA bacteraemia cases	≤ 8		Jan-23	3	
	Number of bed days lost due to infection control outbreaks	↓ Lower		Jan-23	62	
	Number of community-onset healthcare-associated Clostridioides difficile cases per month	≤ 5		Jan-23	5	
	Number of ecoli cases	No Target		Jan-23	4	
	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	≤ 5		Jan-23	6	
	Number of klebsiella cases	No Target		Jan-23	4	
	Number of pseudomona cases	No Target		Jan-23	0	
	Number of trust apportioned Clostridium difficile cases per month	< 10		Jan-23	11	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Infection Control	Number of trust apportioned MRSA bacteraemia	= 0		Jan-23	0	
Maternity	% PPH >1.5 litres	↓ Lower		Jan-23	3.4%	
	% breastfeeding (discharge to CMW)	= 0.0%		Jan-23	63.0%	
	% breastfeeding (initiation)	No Target		Jan-23	77.6%	
	% of women on a Continuity of Carer pathway	No Target		Jan-23	6.14%	
	% of women smoking at delivery	≤ 14.50%		Jan-23	9.19%	
	% of women that have an induced labour	≤ 30.00%		Jan-23	31.29%	
	% stillbirths as percentage of all pregnancies	< 0.52%		Jan-23	0.23%	
	Number of births less than 27 weeks	No Target		Jan-23	3	
	Number of births less than 34 weeks	No Target		Jan-23	10	
	Number of births less than 37 weeks	No Target		Jan-23	42	
	Number of maternal deaths	No Target		Jan-23	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target		Jan-23	1.3%	
	Total births	No Target		Jan-23	446	
Mortality	Number of deaths of patients with a learning disability	No Target		Jan-23	1	
	Number of inpatient deaths	No Target		Jan-23	206	
	Summary hospital mortality indicator (SHMI) - national data	No Target		Sept-22	0.000	
MSA	Number of breaches of mixed sex accommodation	≤ 10		Jan-23	60	
Patient Advice and Liaison Service (PA..	% of PALS concerns closed in 5 days	No Target		Jan-23	78%	
	Number of PALS concerns logged	↓ Lower		Jan-23	290	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Safety Incidents	Medication error resulting in low harm	↓ Lower	Jan-23	9	
	Medication error resulting in moderate harm	↓ Lower	Jan-23	1	
	Medication error resulting in severe harm	↓ Lower	Jan-23	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Jan-23	46	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Jan-23	0	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Jan-23	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Jan-23	14	
	Number of falls per 1,000 bed days	↓ Lower	Jan-23	6.80	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Jan-23	2	
	Number of patient safety incidents - severe harm (major/death)	No Target	Jan-23	9	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Jan-23	12	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Nov-22	70.74%	
	Number of DoLs applied for	No Target	Jan-23	90	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Jan-23	75	
	Total admissions aged 0-17 with DSH	↓ Lower	Jan-23	36	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Jan-23	11	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Jan-23	1	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Jan-23	0	
	Total number of maternity social concerns forms completed	No Target	Dec-22	73	
Serious Incidents	Number of never events reported	= 0	Jan-23	1	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Serious Incidents	Number of serious incidents reported	↓ Lower		Jan-23	4	
	Percentage of serious incident investigations completed within contract timescale	> 80%		Jan-23	10,000%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%		Jan-23	10,000.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target		Jan-23	53.4%	

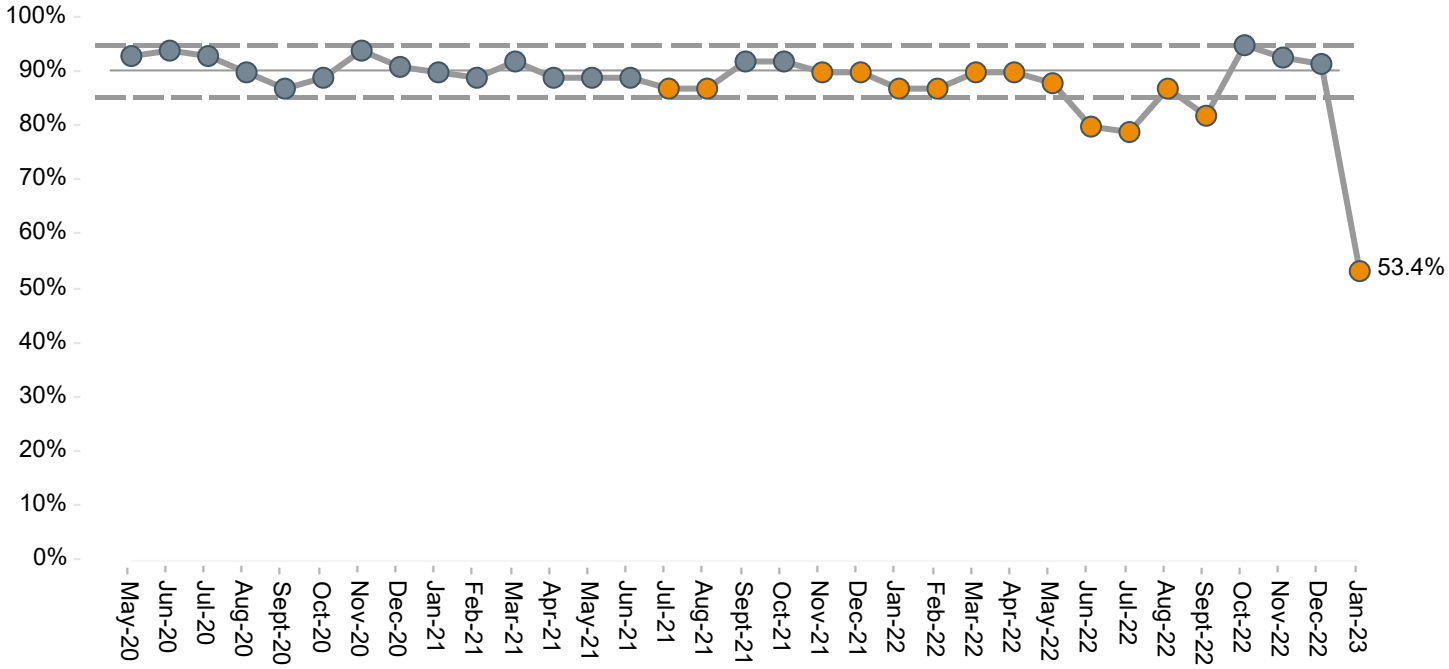
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



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Commentary

Quality Improvement & Safety Director

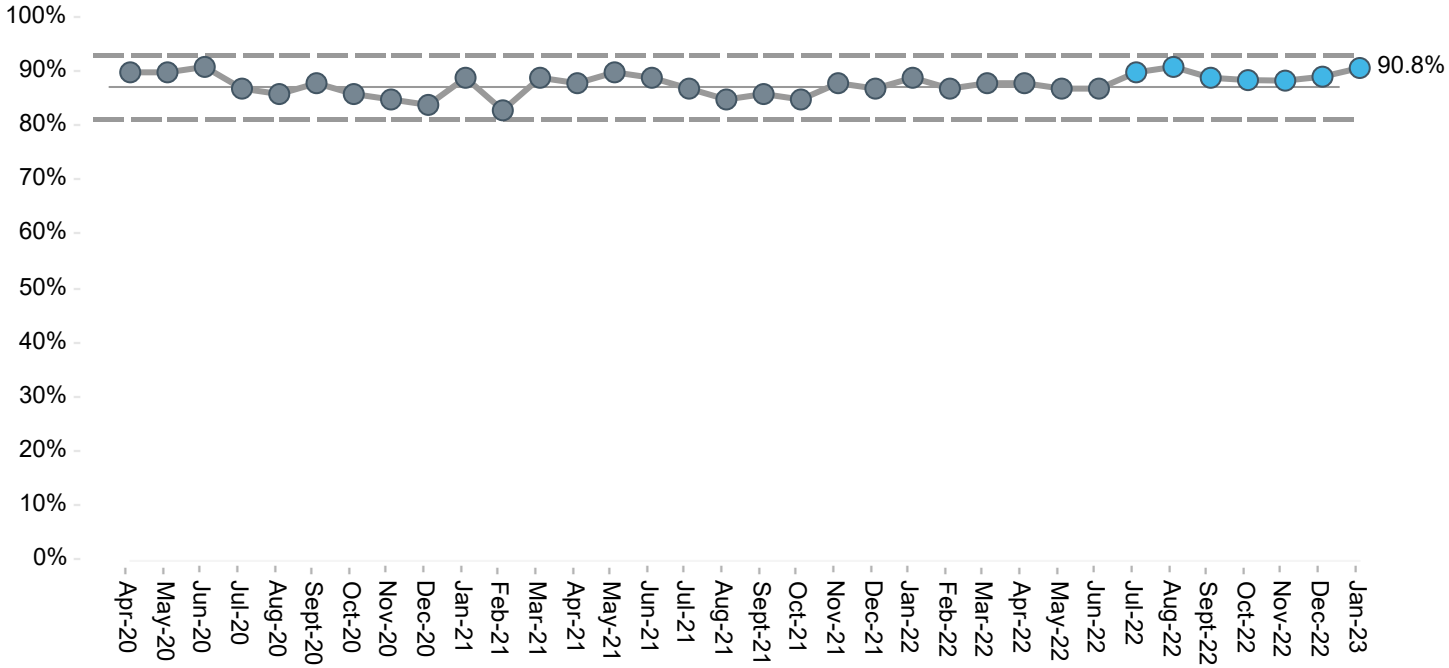
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[153] Inpatients % positive

- - - Target: No Target



Data Observations

[2] SHIFT

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Commentary

Inpatient % positive 90.8%

The current positive FFT score for Inpatient and Daycase is at 90.8%, an increase from 89.2% in December with the main themes emerging focussed on lack of staff to be able to provide basic care, communication, corridor care and the ward environment. These are reflective of the operational pressures currently facing the Trust and have been discussed at Quality Delivery Group.

Head of Quality

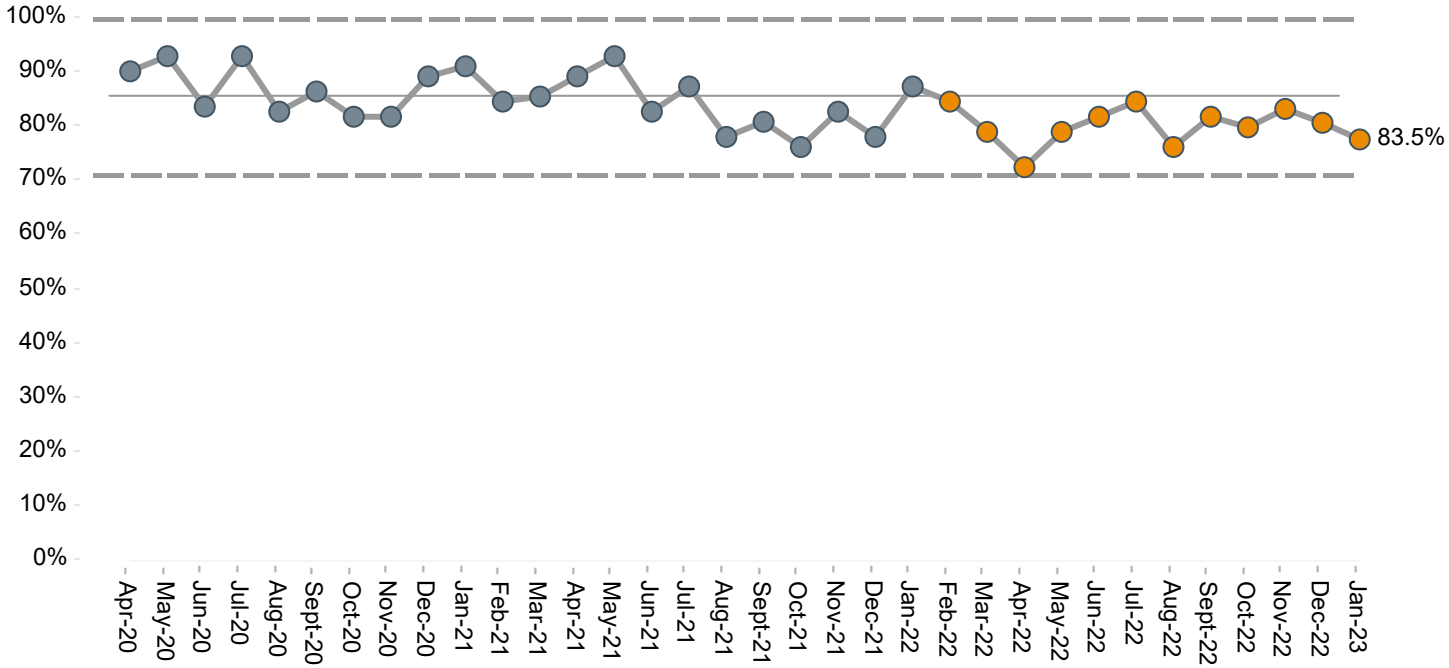
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[155] Maternity % positive

- - - Target: No Target



Data Observations

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Commentary

Maternity % positive 83.5%

The current positive FFT score for Maternity services is 83.5%, which is a decrease from December 2022 (86.8%). The division are working with the Maternity Voices Partnership to review feedback themes emerging from FFT and other sources, to put an improvement plan in place which is monitored in the division, and updates provided through to QDG and MDG. A workshop took place in November in partnership with the Maternity Voices Partnership to review priority areas for this improvement work, supported by a QI collaborative. Maternity Ward has been flagged as a priority and is in line with feedback. This work is being supported by the Patient Experience team.

Head of Quality

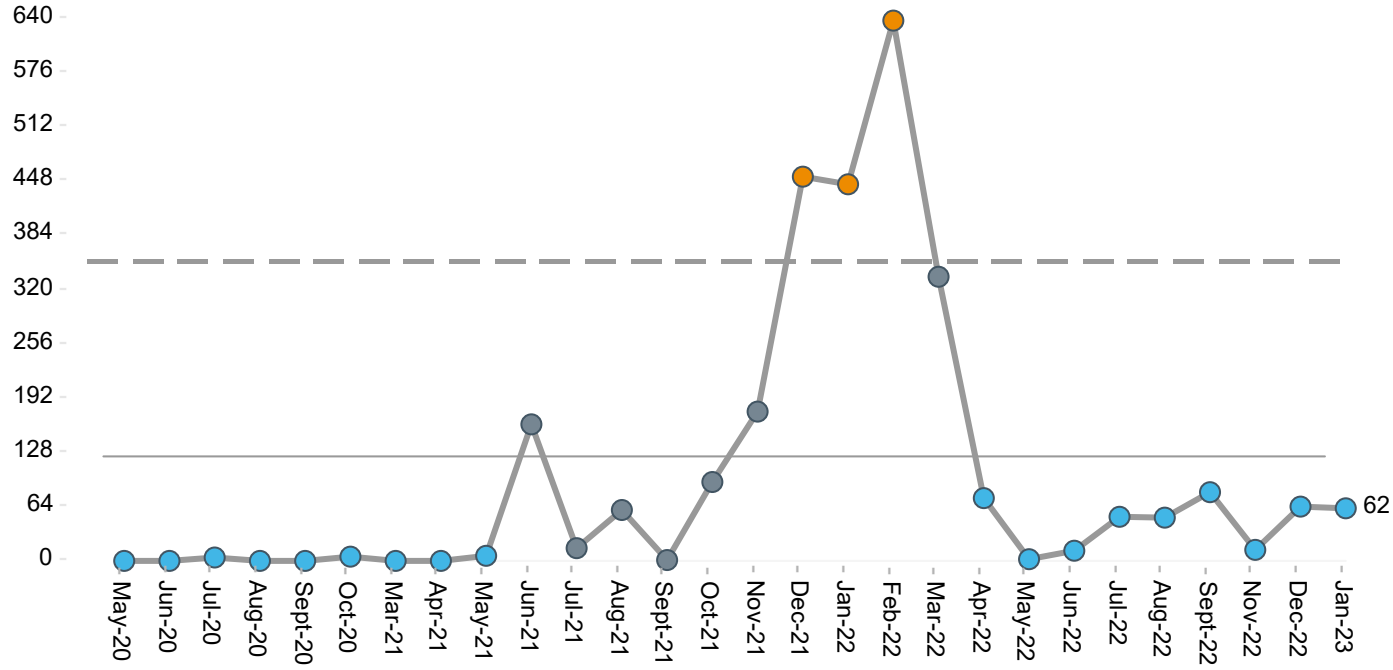
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



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Commentary

During January 62 bed days we lost due to outbreaks mostly associated with transmission of COVID-19 and Influenza A compared to 64 bed days in December 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. Emergency admission areas have access to point of care testing for Flu for all patients with symptoms on admission so to minimise transmission. Also, as much as reasonable possible respiratory and non-respiratory pathways were established in areas such as ED and cohort areas were created to overcome challenges with single room capacity. The number of Flu cases has significantly reduced but

Associate Chief Nurse, Director of Infection Prevention & Control

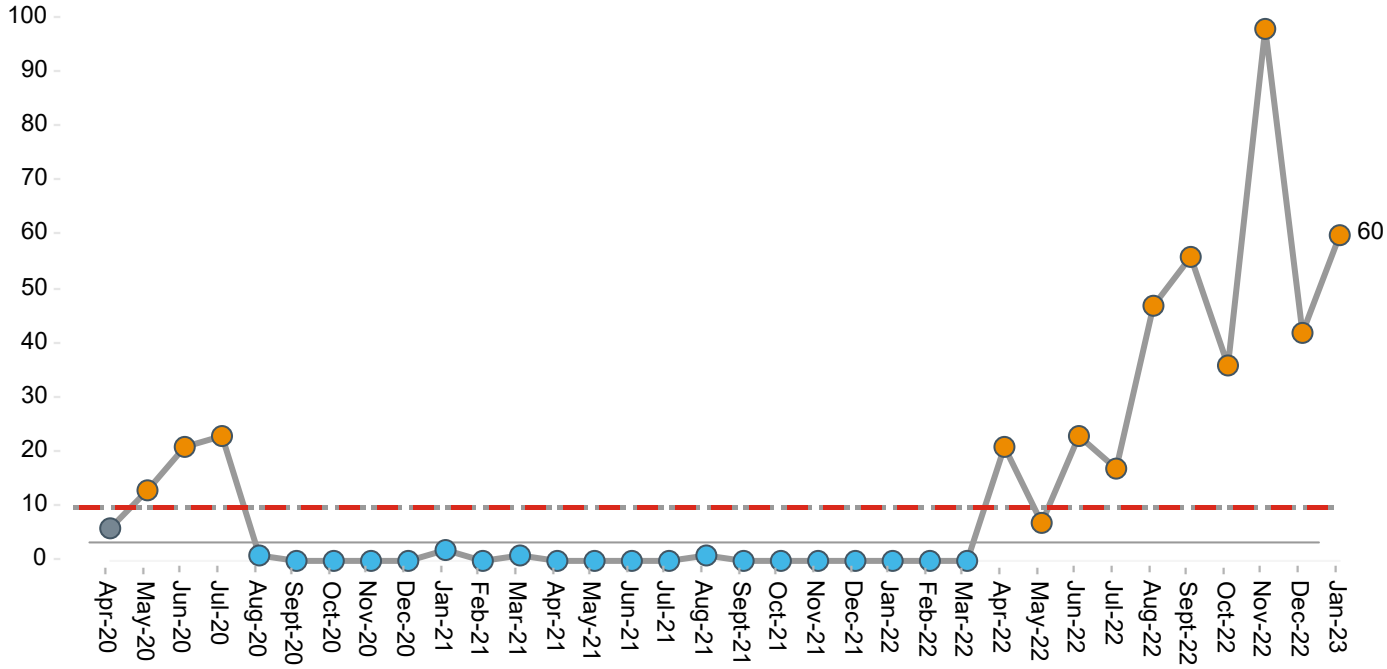
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[148] Number of breaches of mixed sex accommodation

- - - Target: ≤ 10



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Commentary

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

Associate Chief Nurse, Director of Infection Prevention & Control

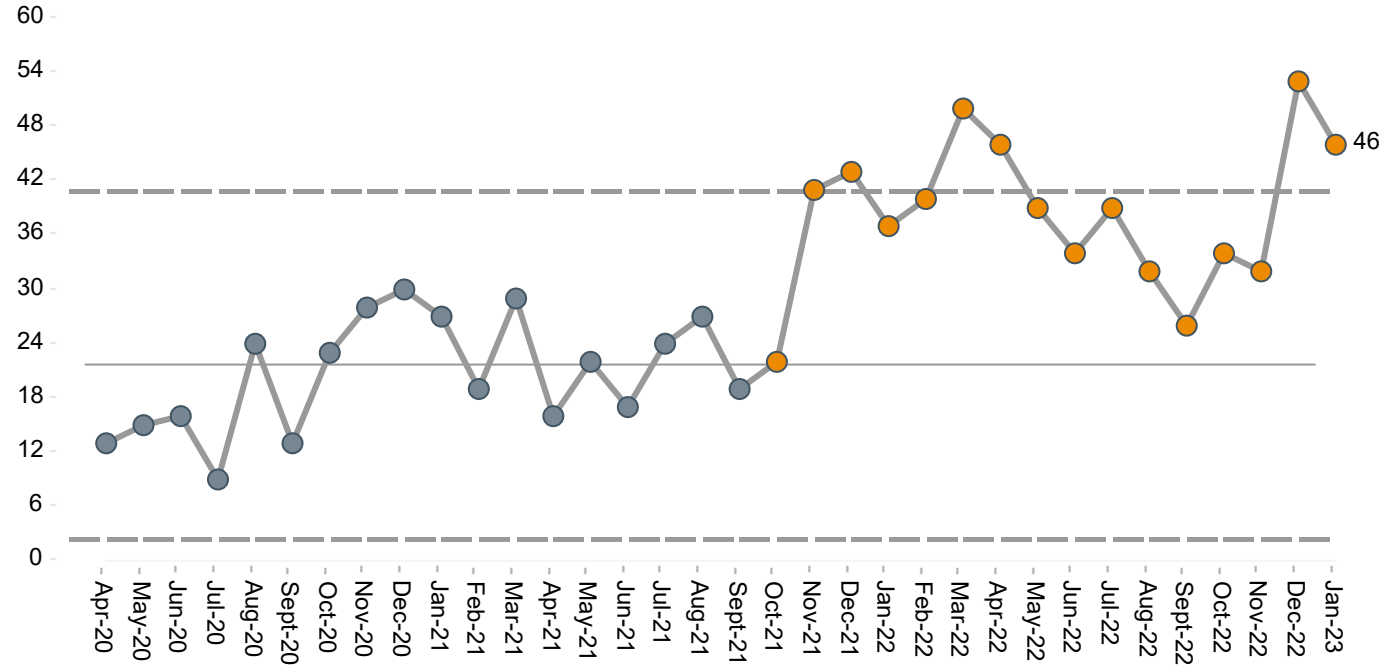
Quality

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

Category 2 pressure ulcers have increased over the winter period. Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning.

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

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

Associate Chief Nurse, Director of Infection Prevention & Control

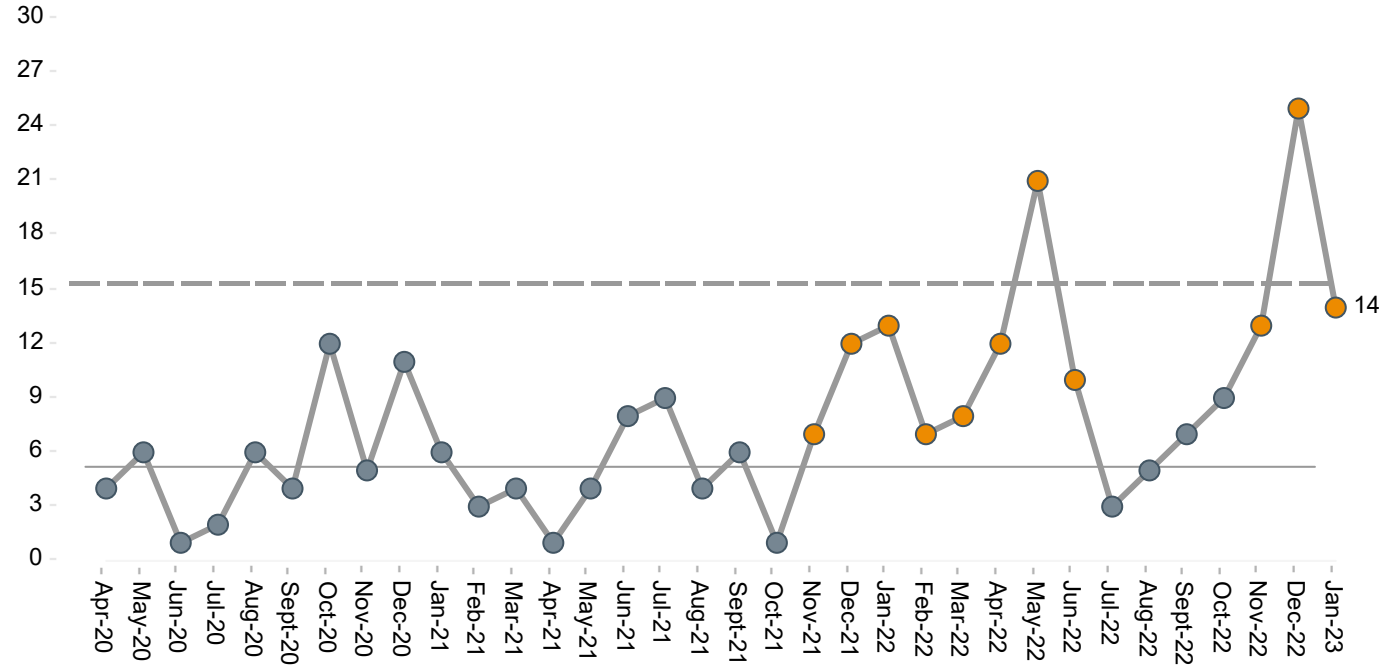
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



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Commentary

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

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

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

Associate Chief Nurse, Director of Infection Prevention & Control

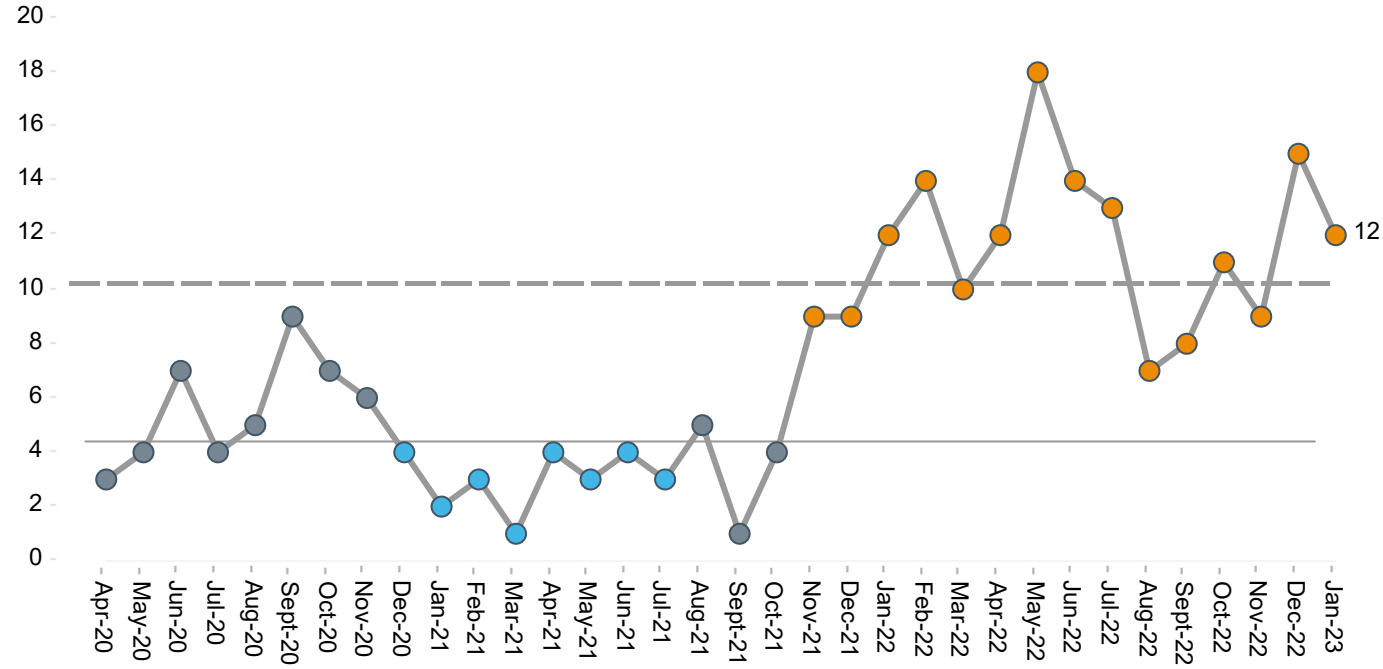
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Data Observations

[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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[4] 2 OF 3

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Commentary

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

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

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

Associate Chief Nurse, Director of Infection Prevention & Control

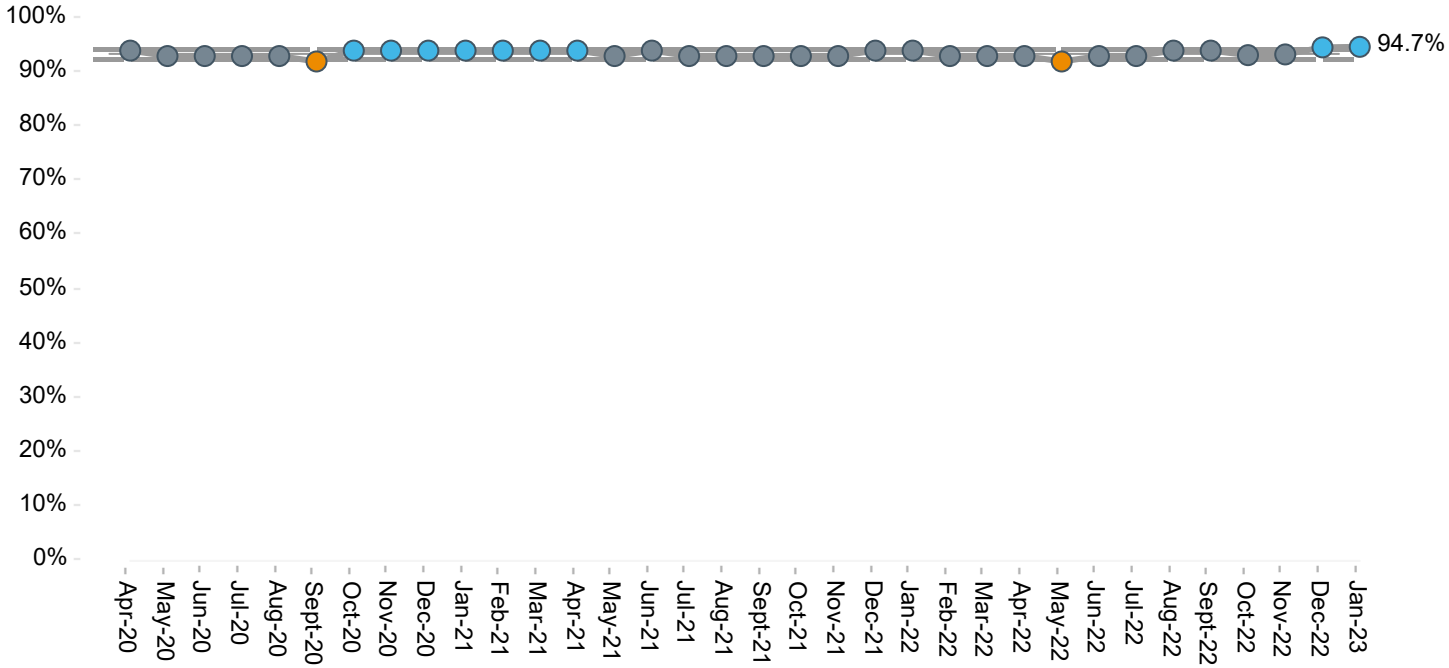
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[291] Outpatients % positive

- - - Target: No Target



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Commentary

Outpatient % positive 94.7%

The current positive FFT score for Outpatients is 94.7%, a slight increase from 94.6% in December. The main themes emerging focussed on waits for appointments, waits in the outpatient departments and appointments feeling rushed. There were comments relating to not feeling listened to by clinical staff.

Head of Quality

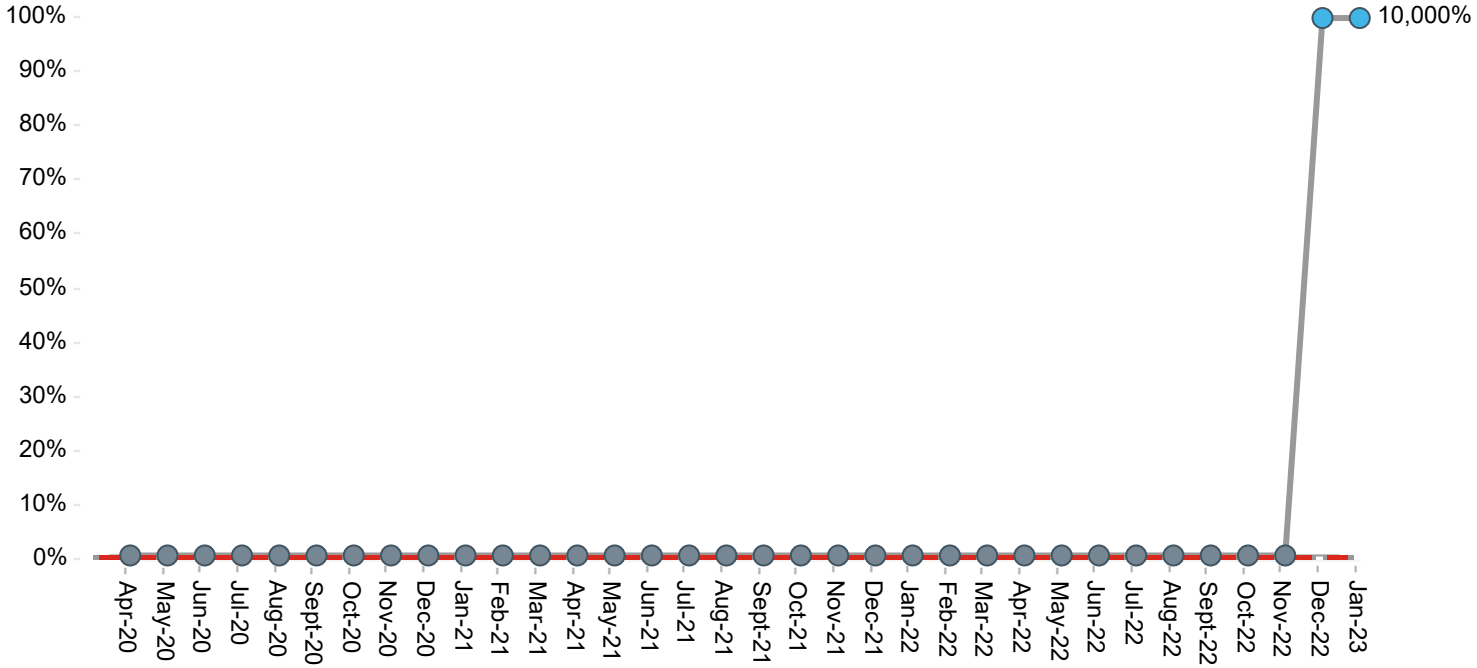
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[105] Percentage of serious incident investigations completed within contract timescale

Target: > 80%



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Commentary

All investigations are either within the standard investigation time or have a formal extension requested

Quality Improvement & Safety Director

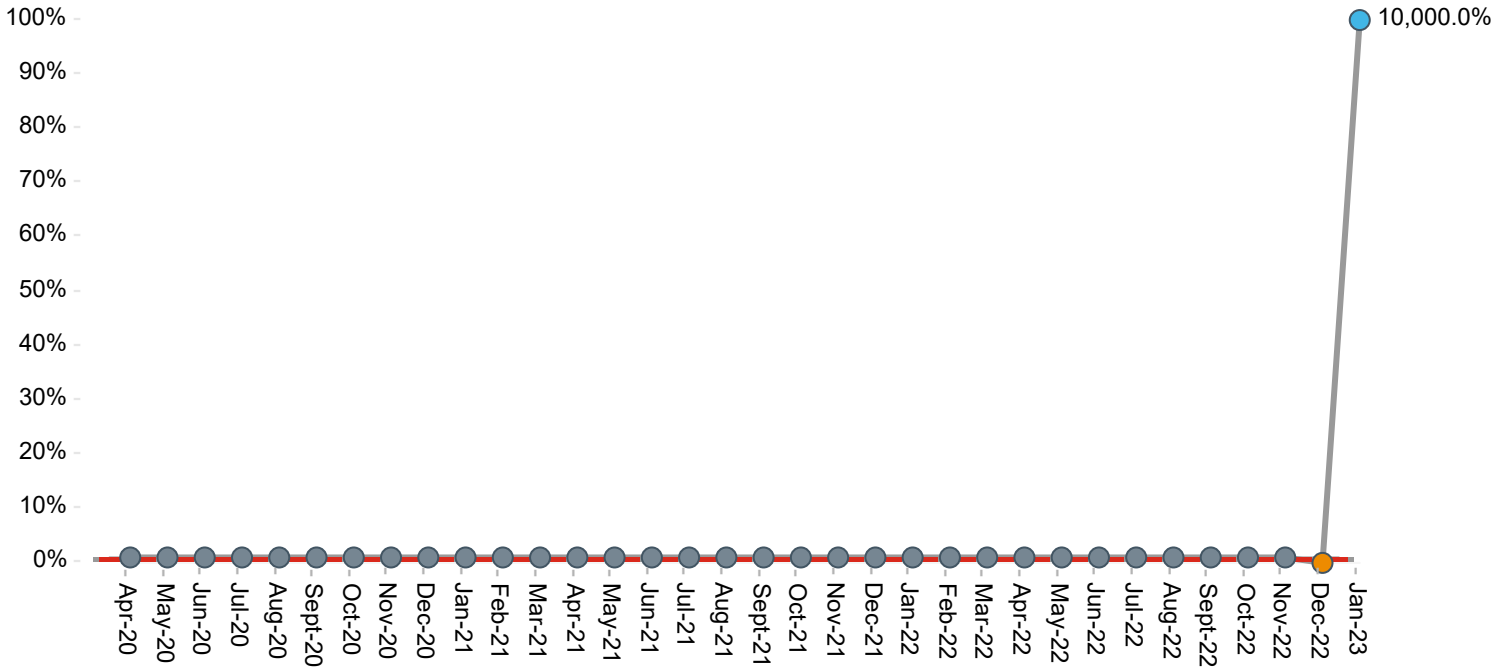
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[104] Serious incidents - 72 hour report completed within contract timescale

- - - Target: > 90.0%



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Commentary

Data in this field is still not accurate, almost all 72hr reports are sent to the ICB on time

Quality Improvement & Safety Director

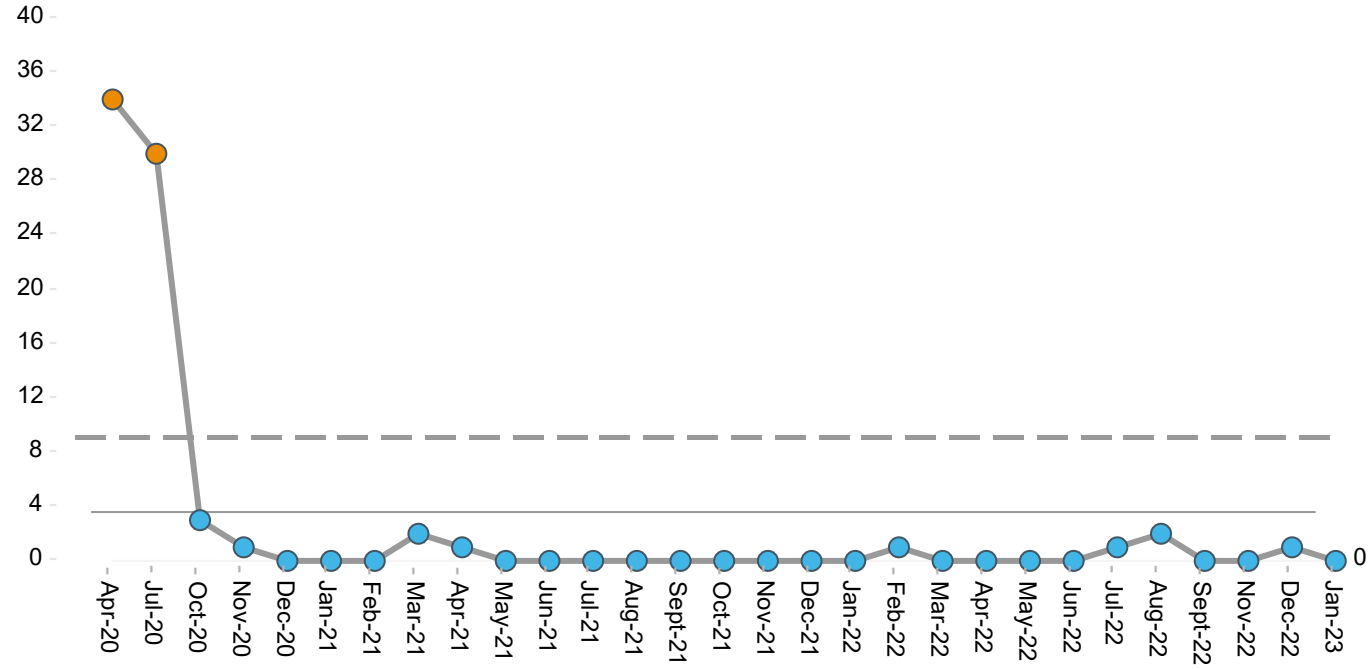
Quality

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

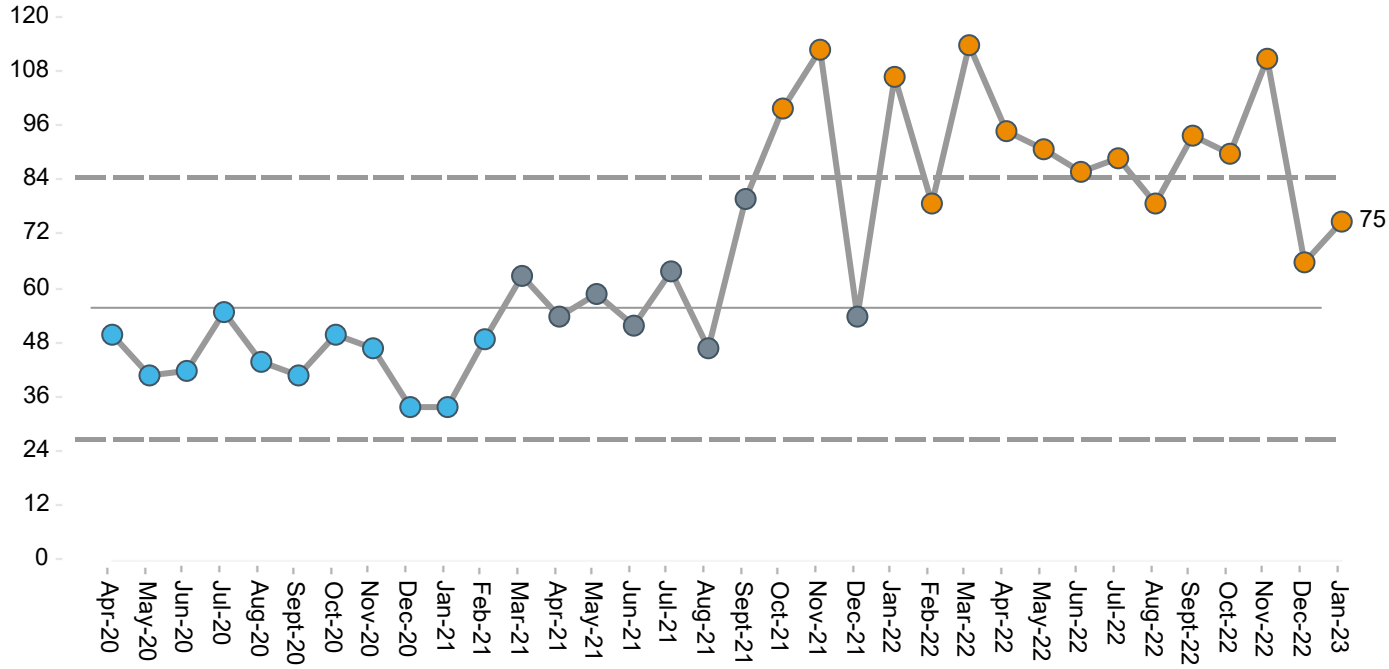
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



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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%	?	Jan-23	86%	L
	Trust total % overall appraisal completion	≥ 90.0%	F	Jan-23	78.0%	L
Safe Nurse Staffing	% registered nurse day	≥ 90.00%	?	Jan-23	96.35%	
	% registered nurse night	≥ 90.00%	?	Jan-23	101.59%	
	% unregistered care staff day	≥ 90.00%	?	Jan-23	96.51%	L
	% unregistered care staff night	≥ 90.00%	P	Jan-23	116.56%	
	Care hours per patient day HCA	≥ 3.0	P	Jan-23	3.5	
	Care hours per patient day RN	≥ 5.0	?	Jan-23	5.2	
	Care hours per patient day total	≥ 8.0	?	Jan-23	8.7	
	Overall % of nursing shifts filled with substantive staff	≥ 75.00%	P	Jan-23	98.21%	
Vacancy and WTE	% total vacancy rate	↓ Lower		Jan-23	8.64%	H
	% vacancy rate for doctors	↓ Lower		Jan-23	3.69%	
	% vacancy rate for registered nurses	↓ Lower		Jan-23	11.76%	H
	Leavers FTE	No Target		Jan-23	62.93	
	Staff in post FTE	No Target		Jan-23	6,943.46	
	Starters FTE	No Target		Jan-23	97.93	
	Vacancy FTE	No Target		Jan-23	657.13	
Workforce Expenditure and Efficiency	% sickness rate	≤ 4.1%	?	Jan-23	5.7%	H
	% turnover	≤ 1,260.0%	P	Jan-23	14.2%	H
	% turnover rate for nursing	≤ 12.60%	P	Jan-23	11.76%	H

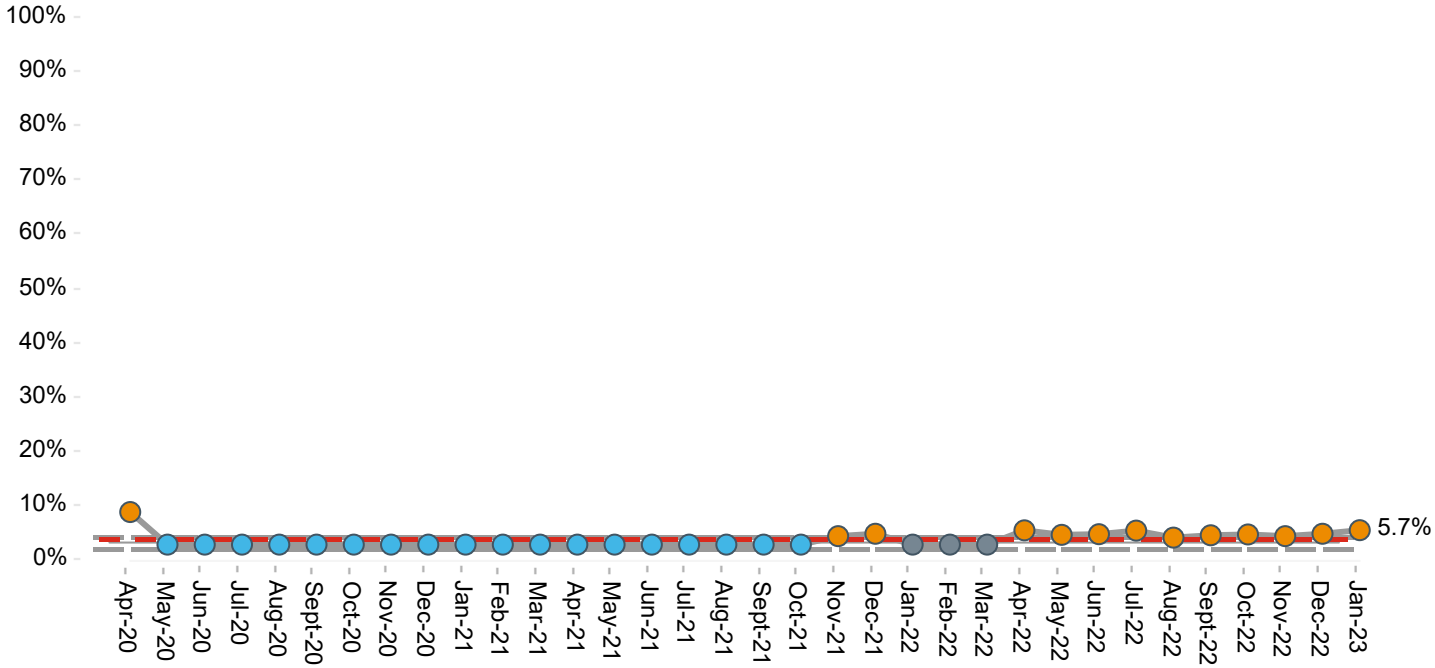
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[201] % sickness rate

Target: ≤ 4.1%



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Commentary

Senior HR Business Partner

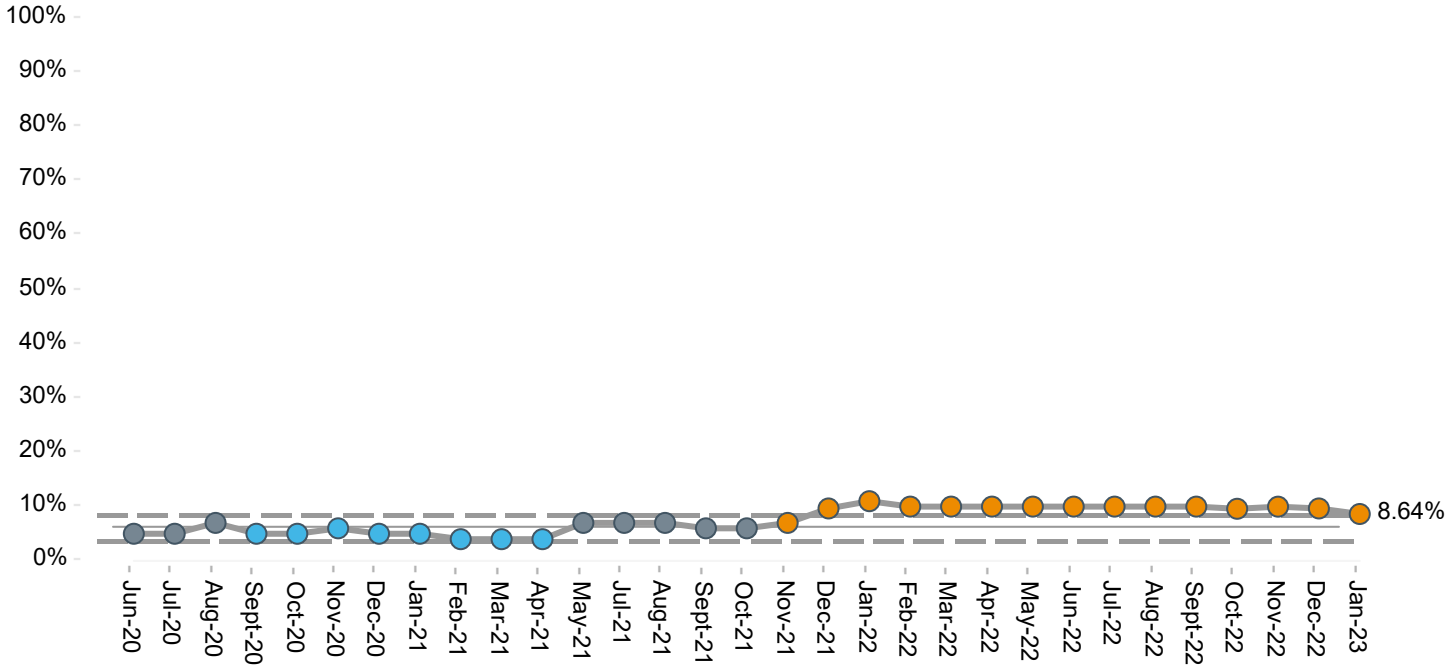
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[498] % total vacancy rate

Target: ↓ Lower



Commentary

Senior HR Business Partner

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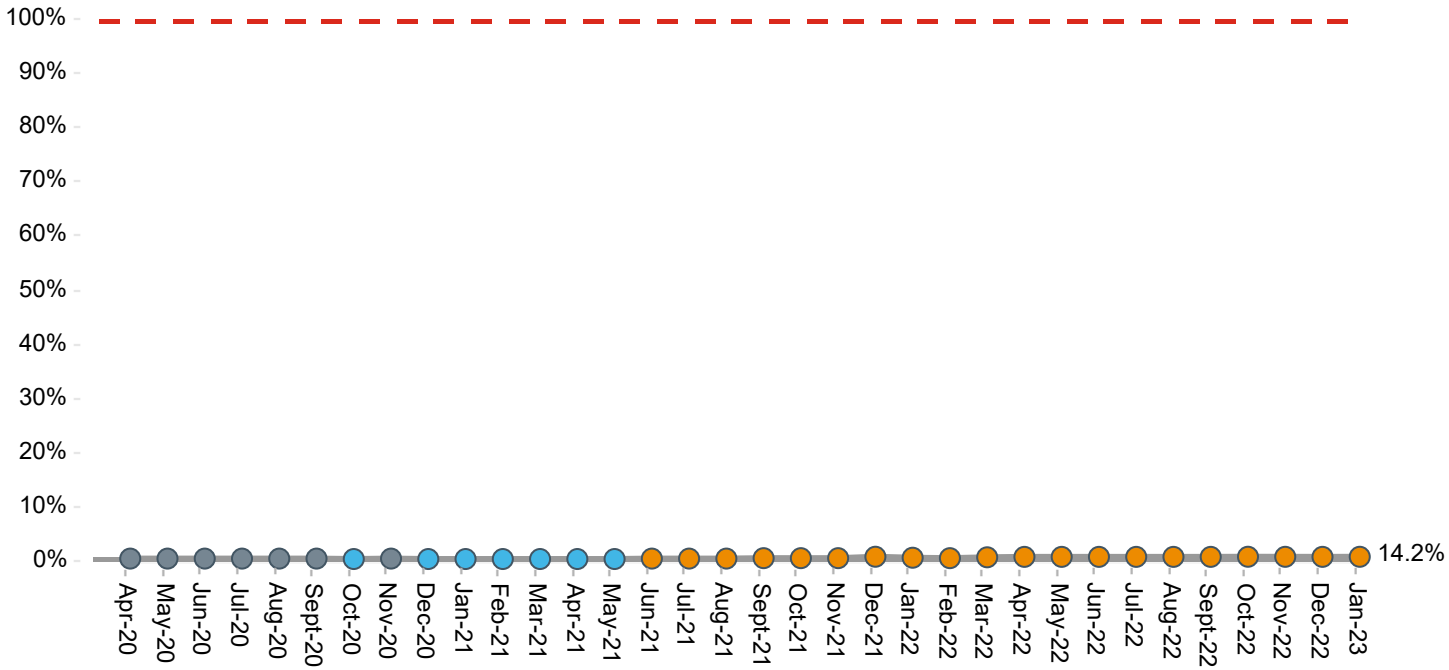
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[213] % turnover

Target: ≤ 1,260.0%



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Commentary

Senior HR Business Partner

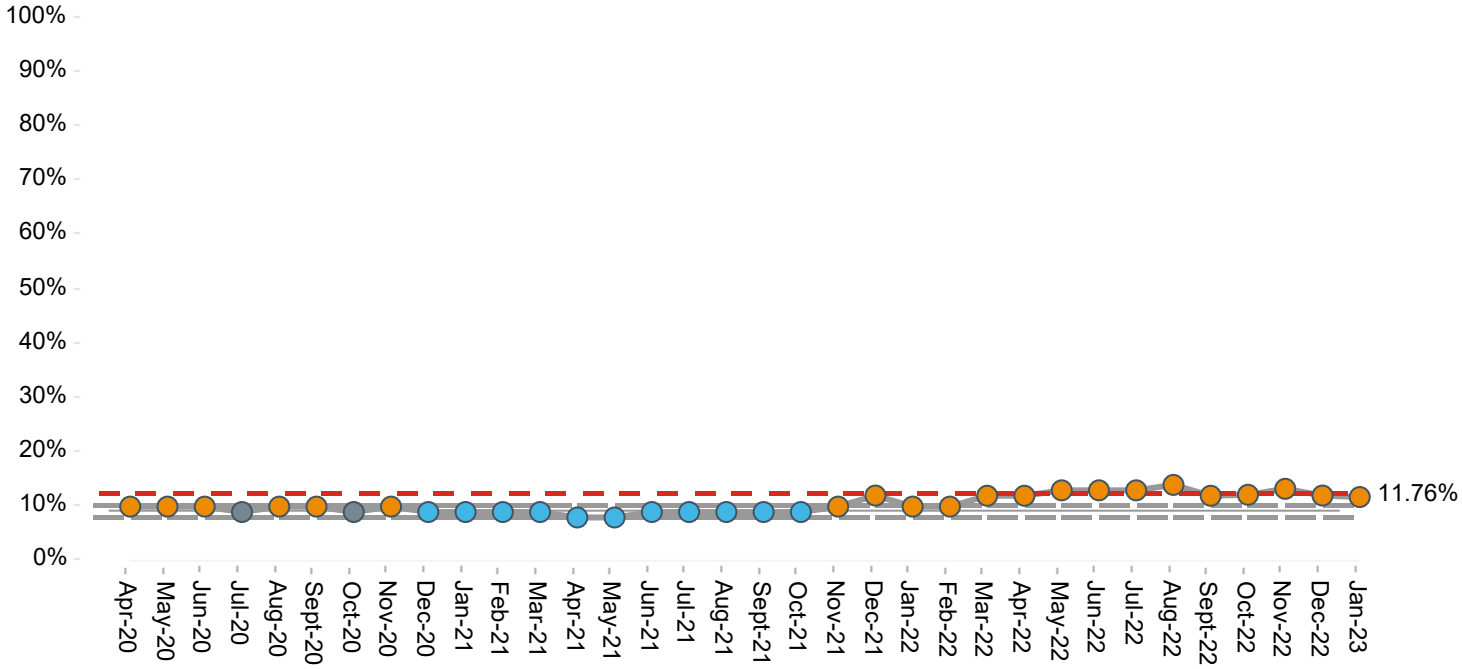
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[497] % turnover rate for nursing

Target: ≤ 12.60%



Commentary

Senior HR Business Partner

Data Observations

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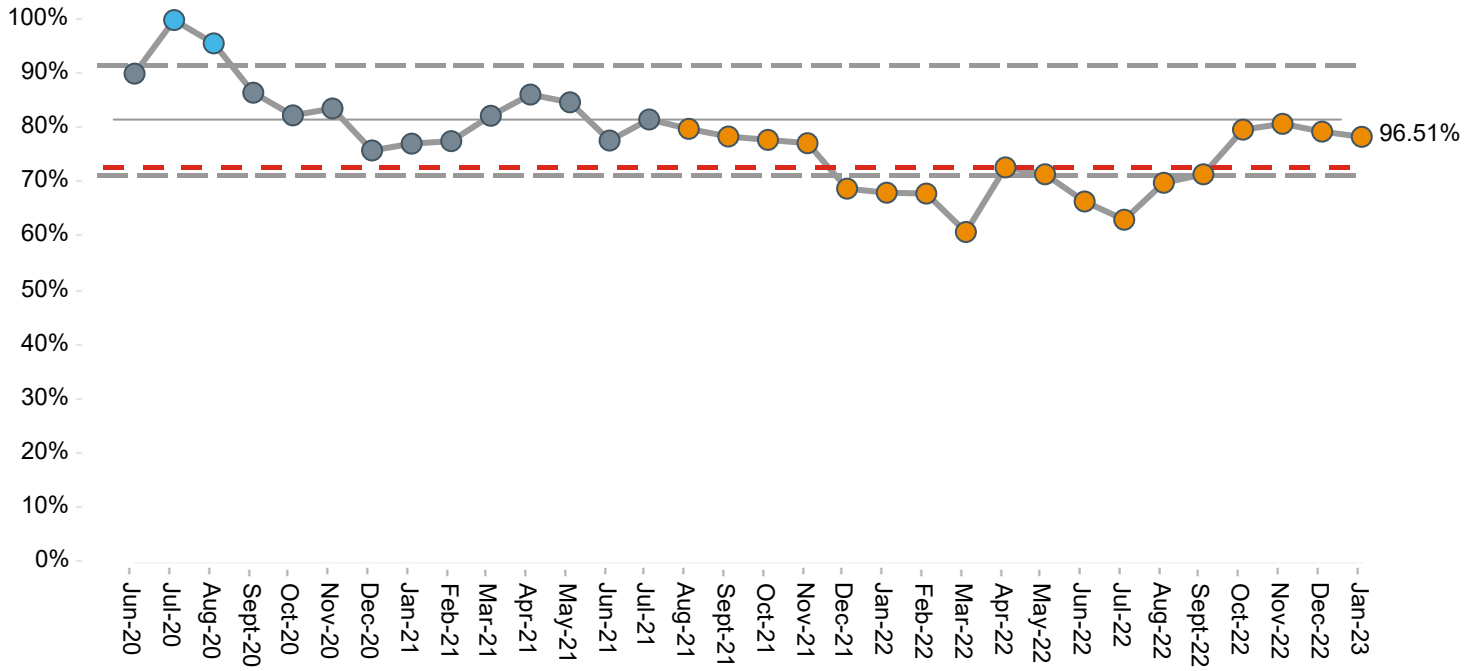
People & OD

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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[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.

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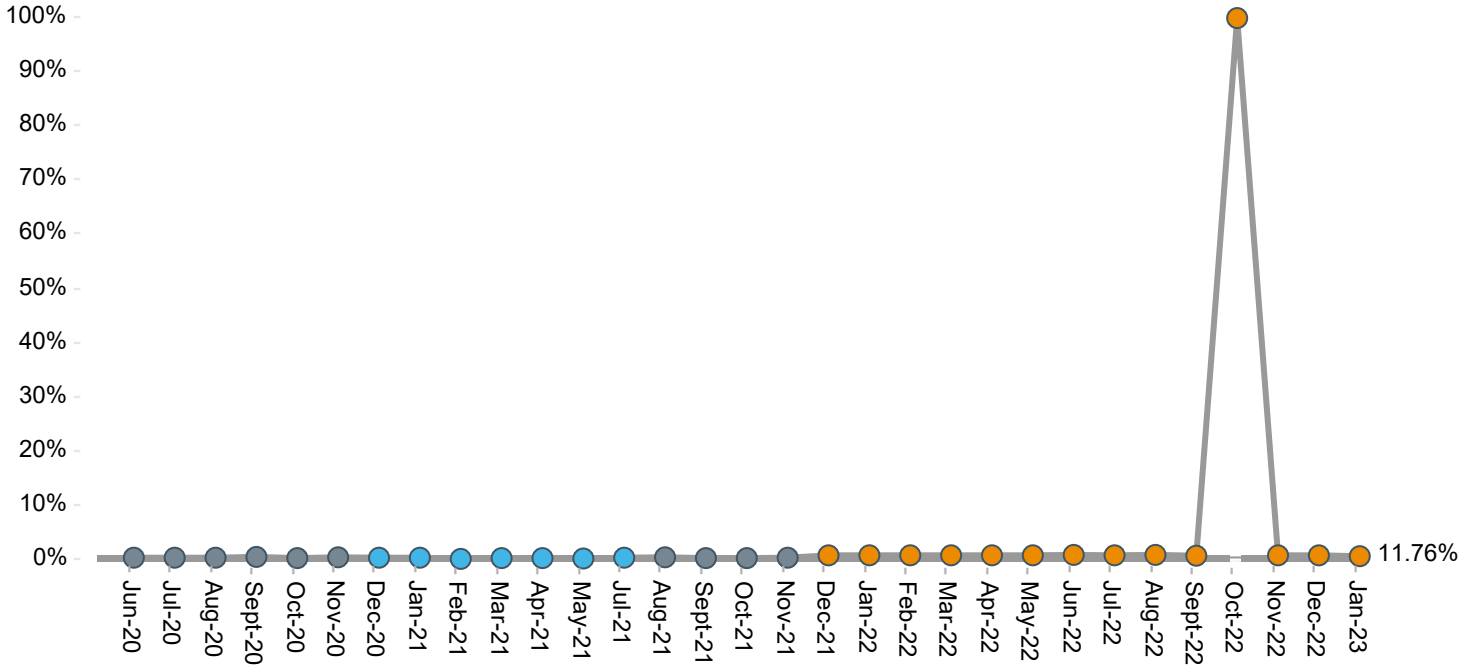
People & OD

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

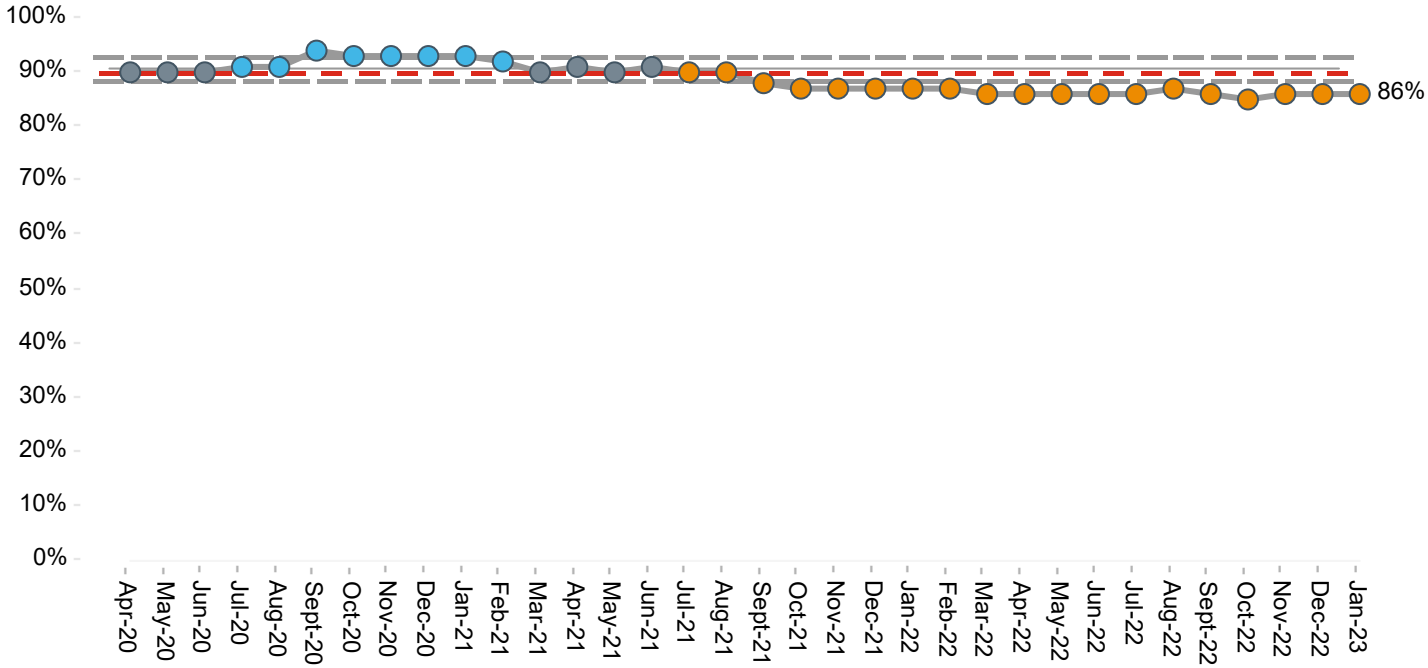
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[214] Trust total % mandatory training compliance

- - - Target: ≥ 90%



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Commentary

Training for the Trust is still below the target compliance. Currently Non- Division is lowest in compliance at 79% the highest is Corporate at 91%. The lowest compliance for Subject is Safeguarding across all Divisions. Digital Education is working with the Safeguarding subject matter expert as to the process to complete all elements of the training and how this can be worked on collaboratively within the system. Compliance for Stat/Man training is on the risk register. Meetings are booked to discuss specifically the Medical and Dental staffing group.

Deputy Director of People and Organisational Development

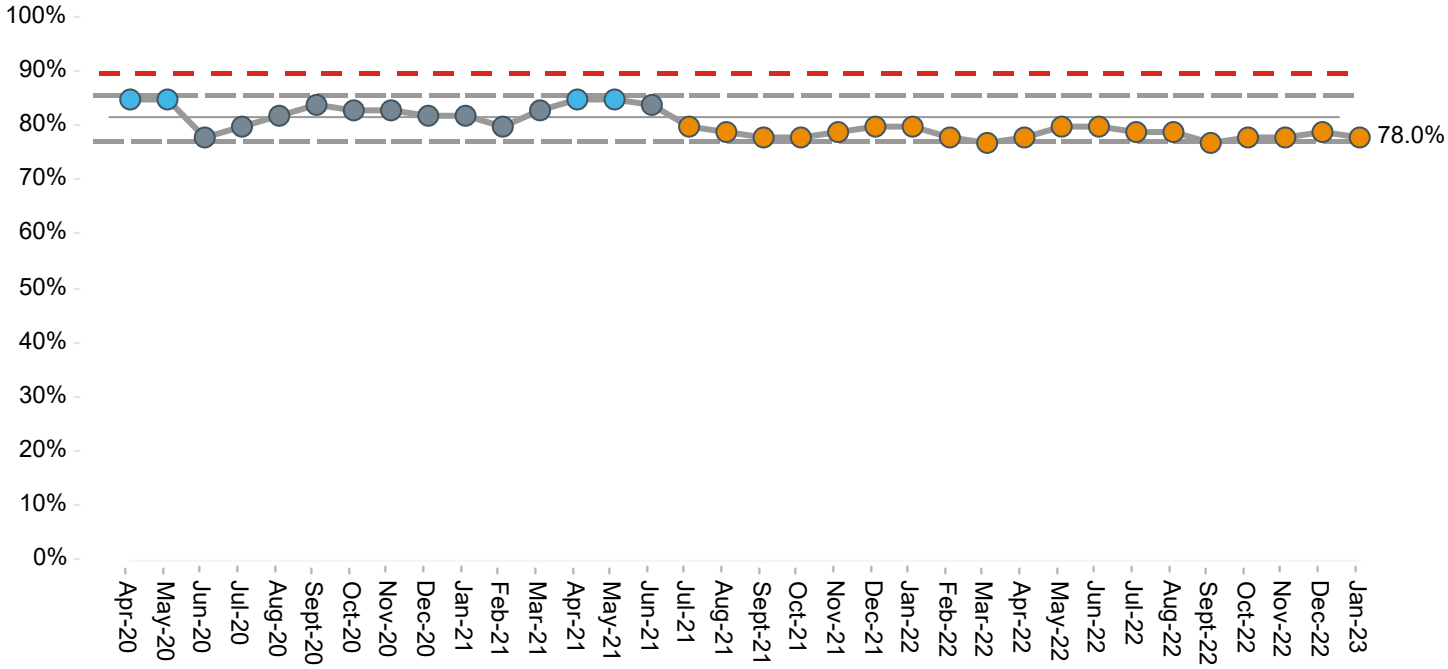
People & OD

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[221] Trust total % overall appraisal completion

Target: ≥ 90.0%



Commentary

Appraisal completion for the Trust is still below the target compliance (78% vs. 90% target). Currently Non- Division is lowest in compliance at 47% the highest is both Medicine and Surgery at 83%.
Compliance for appraisals is being added to the risk register.
Further discussions will be held at divisional and Trust levels during the Spring following the forthcoming publication of the 2022 staff survey results which will give further insight into colleague's experience of appraisal frequency and effectiveness.

Data Observations

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Report to Trust Board of Directors			
Agenda item:	**13**	**Enclosure Number:**	**8**
Date	9 March 2023		
Title	Maternity Safer Staffing Report		
Author /Sponsoring Director/Presenter	Lisa Stephens, Interim Director of Midwifery Matt Holdaway, Chief Nurse and Director of Quality		

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

Summary of Report

Purpose

The purpose of this report is to provide assurance to the Trust Board that there is an effective system of maternity workforce planning and an effective system for the monitoring of safe staffing levels. This midwifery staffing oversight reports staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period. This report covers the period July - December 2022.

The Covid-19 pandemic has increased staff related absences and has provided further complexity to the Maternity Service provision. CQC carried out an unannounced focused inspection rated the service as inadequate and one of the issues identified was that there was not always having enough staff to care for women and keep them safe and a section 29A warning notice was issued (May 2022).

Key issues to note

Obstetric medical workforce

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

Anaesthetic medical workforce

- The Trust meets the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation (1.7.2.1) as a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times.

Neonatal medical workforce

- The Trust met the BAPM national standards for junior medical staffing (NHSR Maternity Incentive Scheme Safety Action 4 (2022).

Neonatal nursing workforce

- The neonatal unit meets the service specifications for neonatal nursing standards. A Speciality Specific Nursing CRG workforce staffing tool calculation was completed on the 14/03/2022. The neonatal unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines.

Midwifery workforce

- The most recent completed Birthrate plus report was completed in 2019. There has been further uplift in the establishment in response to Ockendon funding associated with clinical workforce. The **BirthRate plus** (BR+) full review of midwifery staffing has been completed and the report is anticipated in February 2023. If the funded establishment is not compliant with the BR+ report, the Head of Midwifery, with the Divisional Director of Operations, will complete an action plan and this will be presented to the Trust Board.

- Midwifery staffing is on the **Trust risk register** with a score of 20 for safety.

- The **Midwifery Coordinator on delivery suite has supernumerary status** to ensure there is an oversight of all birth activity within the service. There were 3 occasions when this status was not maintained. Because this occurred in 3 months where this was a one-off event (August, September and December 2022), and that it was not recurrent (i.e.: occurs on a regular basis and more than once a week) the Trust is able to report compliance with this standard

- CQC carried out an unannounced focused inspection **rated the service as inadequate** and one of the issues identified was that there was not always having enough staff to care for women and keep them safe and a section 29A warning notice was issued (May 2022).

- The **midwife to birth ratio** has fluctuated during the 6-month period. The average was: 1:29 (best practice 1:28). Compliance with the accepted ratio of 1:28 was not achieved during July, August and September which was associated with high levels of midwifery sickness and vacancies. The midwife to birth ratio continues to be monitored and reported to the Chief Nurse monthly via the Maternity Delivery Group.

- The ratio of midwife to mother **1:1 care in labour** is monitored and reported monthly. Data Is acquired from Trakcare and discrepancies are analysed by the Digital Midwife. An action plan specifically related to 1:1 care in labour was implemented following the Section 29a and is monitored by the Divisional Tri. The average of: 1:1 Care in labour compliance is 97% based on Trakcare data which provides a service wide overview. There is an action plan (CQC S29A plan which the Maternity Delivery Group have oversight of).

- **Shift fill rate** was monitored during the 6-month period. It was suboptimal (<85%) during the months July, August and September and improved of during the following 3 months. The improvement was associated with new starters commencing in post and increased uptake of bank.

- There is a daily touchpoint by Matrons/**Flow Midwife** and Head of Midwifery to review and plan forecasted staffing and activity. Mitigation around red flags associated with staffing are addressed by this team or by the Band 7 CDS coordinator and Senior Midwife Manager on Call out of hours.

- The percentage of **specialist midwives** employed is 11.82 % of the total midwifery workforce establishment which are not included in the direct care numbers (meets the standard which is advised at 8-10%).

<u>Midwifery Continuity of care</u>

- Following the NHSE recommendation on staffing issued on the 1st of April, a commitment was made at Directors Operational Group (DOAG) in July 2022 to ensure the correct midwifery workforce in place before moving forward with further Continuity roll out. Three teams were launched in April 2021 and due to recruitment and retention issues this has now reduced to currently two teams providing care in this way. This has remained unchanged during July – December 2022

<u>Red Flags are incidences of possible concern with staffing</u>

- The most frequent staffing Red Flag was associated with delays in Induction of labour (IOL). There was a range of between 9 and 20 delays in starting and a range of 47 – 86 delays in continuing IOL episodes based on monthly data from July – December 2022. CQC flagged this as an issue for the service in the S29a warning notice and there is a Quality Improvement (QI) project underway to support learning and improvement.

Conclusion

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

Recommendation

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

Enclosures

Maternity Safer Staffing Report

Gloucestershire Hospitals
NHS Foundation Trust

QUALITY AND PERFORMANCE COMMITTEE 22 February 2023

BOARD 9 March 2023

MATERNITY STAFFING REPORT

1. Purpose of Report

1.1. The purpose of this report is to provide assurance to the Trust Board that there is an effective system of maternity workforce planning and an effective system for the monitoring of maternity safe staffing levels.
1.2. This report covers the period July 2022 to December 2022.
1.3. Our focus was to ensure women, babies and their families receive the maternity care they need, including care in all:

- maternity services (for example, pre-conception, antenatal, intrapartum and postnatal services, clinics, home visits and maternity units)
- settings where maternity care is provided (for example, home, community, free-standing and alongside midwifery-led units, hospitals including obstetric units, day assessment units, and fetal and maternal medicine services).

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

2. Executive Summary

2.1. An **unannounced focused inspection by the CQC** to Maternity Services in April 2022 has led to an overall **inadequate rating** of the service in July 2022. The rating was influenced by their findings that the service did not always have enough staff to care for women and keep them safe. Actions against the CQC action plan are reported monthly by the service at Maternity Delivery Group and the Quality and Performance Committee (Q&P).
2.2. Midwifery Staffing has remained critical with vacancies during this period in the region of 17 - 28 whole time equivalents (WTE). Absence related to sickness and maternity leave rates remains high, with variation in temporary fill. Midwifery staffing remains on the **Trust Risk Register** with a score of 20 for safety. Controls are in place to mitigate the risk and a staffing improvement plan is being enacted with oversight of the plan at the Executive led Maternity Delivery Group (MDG) supported by the Deputy Director of Quality.
2.3. Currently a **BirthRate plus** (BR+) full review of midwifery staffing has been completed. The final paper is due in early Feb 2023. Delays to the report was related to workforce data quality, however the final recommended establishment figure is anticipated imminently.
2.4. An extensive midwifery staffing plan for 2022 was developed and is progressing with **notable achievements** of:

- Successful recruitment to Senior roles of Band 8 and above:
    - Recruitment and Retention Project Manager who will commence in January 2023.
    - Consultant Midwife commences in March 2023
    - Lead Midwife (Healthy Lifestyles and Tobacco Dependency) commences in May 2023.
- Organisational Development Lead has launched Band 7 Leadership Programme with cohort 1 of 4 commencing in January 2023.
- Increased conversion rate from post offer to joining trust from 25% in 2021 to 81% in period March 22- December 22.
- Commencement and uptake of midwifery incentives to support staffing during summer months and festive season.
- Two Return to Practice and two International recruitment midwives commenced in this period.
- Two GHNHSFT Registered Nurses have been offered places on the University of Worcester MSc RM programme (Shortened – 2 years) to commence in March 2023.
- Midwifery Wellbeing Evaluation project with Psychologist ongoing
- The maternity service is required to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period. Below is a summary table of our progress against the Maternity Incentive Scheme Standards 4 and 5.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Table1: Summary of Maternity Workforce position in relation to Maternity Incentive Scheme standards

Professional group	Current position	RAG rating
Midwifery Workforce	**Midwifery workforce** <u>Midwifery workforce review</u> – The most recent completed Birthrate plus report was completed in 2019. There has been further uplift in the establishment in response to Ockendon funding associated with clinical workforce.The **BirthRate plus** (BR+) full review of midwifery staffing has been completed and the report is anticipated in February 2023. If the funded establishment is not compliant with the BR+ report, the	New Birth rate plus report awaited

Professional group	Current position	RAG rating
	Head of Midwifery, with the Divisional Director of Operations, will complete an action plan and this will be presented to the Trust Board. <u>Risk Register entry</u> – Midwifery staffing is on the **Trust risk register** with a score of 20 for safety. <u>Planned to actual staffing ratios</u> – The **midwife to birth ratio** has fluctuated during the 6-month period. The average was: 1:29 (best practice 1:28). Compliance with the accepted ratio of 1:28 was not achieved during July, August and September which was associated with high levels of midwifery sickness and absence. The midwife to birth ratio continues to be monitored and reported to the Chief Nurse monthly via the Maternity Delivery Group. – The ratio of midwife to mother **1:1 care in labour** is monitored and reported monthly. Data Is acquired from Trakcare and discrepancies are analysed by the Digital Midwife. An action plan specifically related to 1:1 care in labour was implemented following the Section 29a and is monitored by the Divisional Tri. The average of: 1:1 Care in labour compliance is 97% based on Trakcare data which provides a service wide overview. – There is a daily touchpoint by Band 8 of the Day and **Flow Midwife** with remainder of senior midwifery team opting in if staffing is sub-optimal to review and plan forecasted staffing and activity. Mitigation around red flags associated with staffing are addressed by this team or by the Band 7 CDS coordinator and Senior Midwife Manager on Call out of hours. Further metrics around Maternity OPEL to be identified and benchmarked	

Professional group	Current position	RAG rating
	– Typical escalation and mitigation include: o Redeploying staff o Utilisation of on-call staff o Reviewing and temporarily pausing elective activity o Closure of units or whole unit closure – The percentage of **specialist midwives** employed is 11.82 % of the total midwifery workforce establishment which are not included in the direct care numbers (meets the standard which is advised at 8-10%). <u>Midwifery Continuity of care</u> – Following the NHSE recommendation on staffing issued on the 1st of April, a commitment was made at Directors Operational Group (DOAG) in July 2022 to ensure the correct midwifery workforce in place before moving forward with further Continuity roll out. Three teams were launched in April 2021 and due to recruitment and retention issues this has now reduced to currently two teams providing care in this way. This has remained unchanged during July – December 2022 <u>Red Flags are incidences of possible concern with staffing</u> – Red flags as outlined by NICE (2015) Safer Midwifery Staffing are captured via BR+. Red flags are monitored daily and high incidences reported at the monthly MDG. – The most frequent staffing Red Flag was associated with delays in Induction of labour (IOL). There was a range of between 9 and 20 delays in starting and a range of 47 – 86 delays in continuing IOL episodes based on monthly data from July – December 2022. CQC flagged this as an issue for the service in the S29a warning notice and now there is a Quality Improvement (QI) project underway to support learning and improvement.	

Professional group	Current position	RAG rating
	– The Midwifery Coordinator has supernumerary status and there were 3 occasions when this status was not maintained. Because these were 3 months where this was a one-off event, and that it was not recurrent (i.e.: occurs on a regular basis and more than once a week) the Trust is able to report compliance	
Obstetric Medical Workforce	The maternity service acknowledges and commits to incorporating the principle outlined in the RCOG document "Roles and Responsibilities of Consultants" into the service. A Gap analysis is in progress and has been discussed at the consultant meetings. The consultants are fully engaged with the report and are prioritising the improvement plan. The work so far has been presented at the Patient Safety Meeting. Priorities will be confirmed by the end of December. There are 13 consultant obstetricians, who are resident on call from 0830-2100 Monday – Friday; 0830- 1430, 2000 – 2130 at weekends (provide 77.5 hours/week direct cover), and then on call cover overnight. Audits monitoring compliance with consultant attendance have commenced. In the most recent audit (Q2 2022 – June – Sept) the consultant was present in 87.5% (14 out of 16) of the 16 cases). There was also 1 case where the (87.5%) consultant was on the other theatre overnight. Where the consultant should be present unless the registrar has been signed off as competent, they were present in 90.5% (43 of 45 cases) where information was available. Further work is needed to gain high quality data collection for this audit. A Monthly data collection to record of the competencies of the most senior registrar on duty that night is in progress following daily assessment completed by Band 7 Co-Ordinator / obstetric team to enable audit. Action plan for non -compliance reported to Maternity Safety Group presented by	Standard met

Professional group	Current position	RAG rating
	Speciality Director (SD).	
Anaesthetic Medical Workforce	To meet the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation (1.7.2.1) a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times.	Standard met
Neonatal Medical workforce	The Neonatal SD has confirmed that the Trust did meet the British Association of Perinatal Medicine (BAPM) national standards in full for consultants until November 2022 when there was a change in the standards. Recruitment to cover the gap has commenced. The trust is complaint against BPAM standards for junior medical neonatal staffing and this is what is measured for MIS Scheme.	Standard met
Neonatal nurse workforce	The neonatal unit meets the service specifications for neonatal nursing standards. A Speciality Specific Nursing CRG workforce staffing tool calculation was completed in August 2022 The neonatal unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines.	Standard met

3. Background

3.1. The National Quality Board (NQB) standards for nursing and midwifery (2018) provide the guidelines for NHS providers and this paper describes the Trust's approach to meeting those expectations/ standards. the NQB standards demand a triangulated approach to staffing decisions with 3 expectations around Right Staff, Right Skills, Right Place and Time

3.2. The publication of a range of highly critical reports surrounding maternity units including the Ockendon Final Report (2022), Report of the Morecambe Bay investigation (2015), Cwm Taf Morgannwg (2017), Shrewsbury and Telford (2020) East Kent (2022) have contributed to the high profile afforded to maternity safety and quality. Findings from Nottingham will add to the picture on maternity. A combined delivery plan is awaited from NHSE

3.3. NICE guidance - Safe midwifery staffing for maternity settings published in 2015

identified recommendations surrounding organisational requirements, setting the midwifery establishment, assessing the difference in number and skill mix of midwives, and monitoring and evaluating midwifery staffing requirements.

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

3.5. Midwifery Staffing expectations include the following:

- Deliver all pre-conception, antenatal, intrapartum and postnatal care needed by women and babies
- Provide midwifery staff to cover all the midwifery roles needed for each maternity service, including co-ordination and oversight of each service
- Allow for locally agreed midwifery skill mixes (for example, specialist and consultant midwives and practice development midwives)
- Provide a woman in established labour with supportive one-to-one care
- Provide midwife to birth ratios as per Birthrate plus
- Allow for planned and unplanned leave
- Time for professional midwifery advocate role
- Ability to deal with fluctuations in demand
- Ensure professional support and leadership for clinical teams (Midwifery, Obstetric Neonatal, anaesthetic) in and out of hours

OBSTETRIC MEDICAL WORKFORCE

4. Obstetric medical workforce

4.1. The medical Obstetric team currently comprises: -

- 13 consultant obstetricians, who are resident on call from 0830-2100 Monday – Friday; 0830- 1430, 2000 – 2130 at weekends (77.5 hours/week), and then on call overnight.
- 24-hour Registrar presence for obstetrics, supported by a registrar for gynaecology, with 12.5-hour shifts
- 24 hour SHO presence – 0830-1700 for obstetrics, 1700-0830 and weekends for both obstetrics and gynaecology
- A Registrar for the elective caesarean section list, 5 days a week, from 0830-1700; supported by the Gynaecology consultant
- 13 weekly Consultant run antenatal clinics across the county, including specialist clinics for:
    - Maternal medicine
    - Perinatal mental health
    - Substance misuse and blood borne viruses

- Teenage pregnancies
- High BMI
- Preterm birth prevention
- Diabetic medicine

- There are 6 consultant fetal medicine sessions per week, across both sites
- The number of consultant antenatal clinics has recently increased with plans to introduce a further additional weekly clinic.
- An Obstetrician, Matron and Head of Midwifery facilitate a weekly MDT 'Birth options' Huddle which signposts subsequent clinic appointments with the woman and most appropriate professional to lead the discussion

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

Picture: Roles and responsibilities of an O&G Consultant

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

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

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

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

4.5. Audits monitoring compliance with consultant attendance have commenced. In the most recent audit (Q2 2022: June – Sept) the consultant was present in 87.5% (14 out of the 16 cases). There was also 1 case where the consultant was in the other theatre overnight. Where the consultant should be present unless the registrar has been signed off as competent, they were present in 90.5% (43 of 45 cases) where information was available. Further work is needed to gain high quality data collection for this audit.

4.6. A Monthly data collection to record of the competencies of the most senior registrar on duty that night is in progress following daily assessment completed by Band 7 Co-Ordinator / obstetric team to enable audit. Action plan for non -compliance reported to Maternity Safety Group presented by Speciality Director (SD).

4.7. The audits will be reviewed by the Board Maternity Safety Champions.

OBSTETRIC ANAESTHETIC MEDICAL WORKFORCE

5. Obstetric anaesthetic medical cover

5.1. The obstetric anaesthetist is a member of the delivery unit team. Approximately 60 per cent of women require anaesthetic intervention around the time of delivery of their baby. The Royal College of Anaesthetists published updated guidelines on Staffing requirements in February 2022, Guidelines for the Provision of Anaesthesia Services

for an Obstetric Population.

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

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

5.4. In units offering a 24-hour regional anaesthesia service, the duty anaesthetist should be resident on the hospital site where the regional anaesthesia is provided (not at a nearby hospital). The service is fully compliant with this standard.

5.5. As a basic minimum for any obstetric unit, a consultant or other autonomously practicing anaesthetist should be allocated to ensure senior cover for the full daytime working week; that is, ensuring that Monday to Friday morning and afternoon sessions are staffed. The Service is fully compliant with this standard.

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

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

5.8. A cross divisional group are considering solutions to provide a second theatre team to maternity out of hours and a paper has been prepared and shared for further discussion. This relates to Risk Register entry WC3583 which currently scores 9 for safety. Combined with two other Risk Register entries (WC3481Obs and S3621TH) Maternity theatre, it is felt that this would result in a combined risk score of 15

5.9. The duty anaesthetist has a clear line of communication to the supervising consultant at all times

5.10. The anaesthetist who is on duty for delivery suite attends the MDT handover (Safety Huddle) and ward round alongside the Obstetric Consultant, Obstetric Registrar and Band 7 Delivery Suite Co-ordinator. Evidence of compliance for this requirement is kept on delivery suite. Should the duty anaesthetist be attending a woman (in theatre

or delivery room) when the round takes place the Obstetric Registrar will hand over any relevant information as soon as the anaesthetist is available to facilitate the sharing of the existing workload/potential patients. There is an ongoing audit of anaesthetic presence on MDT handovers and ward rounds, indicating excellent compliance at the 8:30am handover and ward round, but we are currently failing the standards at the evening 8:30pm handover and ward round due to the duty anaesthetist being clinically engaged during that time (theatre work or siting an epidural).

5.11. Additional consultant programmed activities are allocated for:

- elective caesarean deliveries – service fully compliant
- antenatal anaesthetic clinics – service fully compliant

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

5.13. In busy units, increased levels of consultant or other autonomously practicing anaesthetist cover may be necessary and should reflect the level of consultant obstetrician staffing in the unit. This may involve extending the working day to include senior presence into the evening session and/or increasing numbers of autonomously practicing anaesthetists. A cross divisional MDT working group have completed an Obstetric SBAR paper to support extension of maternity theatre hours from 4pm to 6pm Monday to Friday.

5.14. In addition, there is a cross divisional MDT subgroup that are looking at the feasibility of an additional out of hours' maternity theatre team

5.15. **In summary**, to meet the NHSR MIS Standards (Oct 2022) GHT can confirm that there is a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. There is a clear guideline on when escalation to the on-call consultant should happen. Where there is a need for a second obstetric anaesthetist (between 18:00 and 08:00), the senior resident on call registrar will immediately attend. If the senior resident on call registrar is engaged in care with other non-obstetric patient, he/she will attend as soon as they are able to delegate care of their non-obstetric patients. (ACSA standard 1.7.2.1).

NEONATAL MEDICAL WORKFORCE

6. Neonatal Medical Workforce

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

6.2. Daily ward rounds. Resident 09.00-17.00 weekdays and 09.00-14.00 weekends
- 24 hr tier 2 resident cover
- 24 hr tier 1 resident cover, with additional 2 tier 1s 09.00-17.00

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

6.4. The Trust did meet the BAPM national standards in full for consultant cover until November 2022 when there was a change in the standards. Recruitment to cover the gap has commenced.

NEONATAL NURSING WORKFORCE

7. Neonatal Nursing Workforce

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

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

7.3. The unit is funded for 11 WTE neonatal nurses (inclusive of Nursery nurses registered nurses without the Qualification in specialty) on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).

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

7.5. Staffing was reviewed as part of the SW Neonatal Network and Gloucester was awarded £115,092 to enhance nursing care as part of Getting It Right First Time (GIRFT)

7.6. This funding has been allocated to additional nursing posts (Band 5/6). These have been filled.

7.7. This took place on the 24th of May 2022 and there is an associated action plan in progress

7.8. The Unit has been challenged in relation to nurse staffing due to high numbers of maternity leave (11 members of staff) and 5 on long term sick.

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

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

MIDWIFERY STAFFING

8. Right staff - evidence based midwifery workforce planning

8.1. There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group

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

8.3. Currently a BR+ review is being undertaken and the report is due in February 2022. There have been significant delays due to issues associated with data quality for the assessment, and the results are now anticipated in Autumn 2022. Once the results have been received an action plan will be drawn up and this will be presented to Divisional Board with any issues/concerns escalated. To meet the NHSR Maternity Incentive Scheme Safety Action 5 this report and action plan must be presented to the Trust Board when completed.

8.4. As recommended, there are currently 11.82 % of specialist midwives and midwives in managerial positions employed and this accounts for 8-10% of the establishment, which are not included in clinical numbers, as recommended by BR+ (NHSR Maternity Incentive Scheme Safety Action 5). The table below is a breakdown of the various managerial and specialist midwives total. The In-post total exceeds funded establishment as there has been significant external funding sought with fixed term posts for specialist posts arising from drivers such as Ockendon and national midwifery staffing situation.

	Band	**Funded establishment**	**WTE in post July 22**	**WTE in post – Dec 22**
Managerial Position	8	6	6.8 (1 WTE Long term sick)	5.8 WTE (1 WTE LTS)
Specialist Midwives	6/7	15.71	22.63	21.65

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

Table 4: Funded midwifery clinical establishment July 22 *(Source: ESR)*

	Band	**Funded establishment**	**WTE in post – July 22**	**WTE in post – Dec 22**
Team Leaders	7	22.16	26.22	25.36
Clinical Midwives	5/6	218.25	185.46	198.55
Total		**240.41**	**211.68**	**223.91**

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

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

8.8. The publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust on 10 December 2020 described immediate and essential actions (IEAs).To reduce variation in experience and outcomes for women and their families across England, NHS England and Improvement invested money to support the system to address all 7 IEAs consistently and to bring sustained improvement in our maternity services. The midwifery element of this funding was offered to increase the Band 5/6 midwifery workforce establishment nationally by 1200 FTE midwives in 2021/22. Locally the additional posts have been recruited to with the exception of the Bereavement midwife Band 7 which is to be advertised in early 2023 to strengthen the current Bereavement team.

8.9. New positions funded by NHSE/I funding have been recruited to including the Recruitment and Retention Project Manager which has a nominal budget to support midwifery wellbeing. This is a fixed term post with consideration to be given to permanent positions

8.10. A dedicated Professional Midwifery Advocate (PMA) role for new starters has been commenced with leadership from the Head of Midwifery via the PMA Lead

8.11. A Consultant Midwife recruitment has been completed with the successful applicant joining in March 2023. A Lead Midwife for Tobacco Dependency will join in May 2023.

Table 5: Funded midwifery specialist and management posts July 2022 *(Source: ESR)*

Role	Band	Funded	WTE Post July 22	WTE Post Dec 22
Director of Midwifery	9	1.0		0
Chief Midwife/DDQN	8D	1.0	1.0	
Head of Midwifery/DDQN (Gynae)	8C	1.0	1.0	1.0
Consultant Midwife(vacant)	8B	0.6	0	0*
Lead Midwife (Healthy Lifestyles & TDD)	8A	0.6	0	0*
Midwifery Matrons	8A	3.0	3.8	3.8
Governance Lead	8A	1.0	1.0	1.0
Specialist Midwives	6/7	19.96	22.62	21.62
	Total	26.56		

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

Table 6: Specialist midwifery roles *(Source: Payroll Data)*

Specialist Role - Band 6 & Band 7
Perinatal Mortality Review Midwife
Risk support midwife
TRIM practitioner
A/N Screening Advisors
Practice Facilitator
Safeguarding
Practice Facilitator - community
Frenulotomy
Breast Feeding Support
Digital Midwife
Risk Management Midwife
MSW / Apprenticeship Project
Better Births
Substance misuse/Teen preg
Practice Development Midwife
Infant Feeding Advisor
IR practice educator
Professional Midwifery Advocate Lead
International Recruitment Midwife / Recruitement and Retention Midwife
Perinatal mental health
Fetal Monitoring Midwife
Contraception Lead Midwife

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

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

8.14. The publication of the final Ockendon report in March 2022 highlighted 15 Immediate Safety Actions of which Workforce planning and sustainability and Safe Staffing were included.

8.15. A Gap analysis against the 15 IEA's was conducted to provide an initial rapid review and reported to Q&P on the 27th of April with the following breakdown of actions related to Safe Staffing Levels which is one of the four key pillars:

Table 7: Ockendon IEA's mapping

IEA	Actions	Met	Partially met	Not Met	More Info	N/A
1. Workforce planning and sustainability	11	0	5	3	1	2
2. Safe staffing	10	4	1	4		1

8.16. Whilst work is ongoing, capturing of the further work on the actions associated with Ockendon is planned with further mapping and revised gap analysis due at the end of February 2022. This will be presented in the next paper

8.17. Shortly after the publication of the final report, NHSE issued a clear directive to trusts on Midwifery Continuity of Carer (MCOC). In response to this we immediately risk assessed our midwifery staffing position. Our position is therefore unchanged with only two MCOC teams continuing presently. The service has committed to review this once midwifery staffing is at an acceptable level

9. Right skills – midwifery attraction, recruitment and retention

Midwifery establishment versus actual staffing levels

9.1. The maternity service has effective strategies to attract, recruit, retain and develop our staff, as well as managing and planning for predicted loss of staff to avoid over reliance on temporary staff. This is essential as there is limited access to agency midwives in Gloucestershire

9.2. In anticipation of annual leave disproportionate to the agreed 17% due to excessive sickness, maternity leave and vacancies an incentive proposal was presented to Pay Assurance Group (PAG). These incentives were extended again in November 2022. The extended incentives within service budget included – Enhanced Bank pay rate until 31st March 2023, Temporary Standby rotas for unsocial hours between from July until end of March 2022, and a Golden Welcome for new starters. Additional incentives include enhanced bank rates for community and unit on call staff called in during escalation

9.3. The Mandatory training for midwives which consists of 3 days plus e learning for midwives requires more than the Trust uplift of 21% and needs to be reviewed in line with Ockenden requirement on training and education. This will be reviewed to establish if an uplift is required following receipt of the Birthrate plus report and the finalisation of the maternity TNA. From January 2023, all Midwives will be eligible to use 36 hours per annum to complete mandatory training to increase compliance in this area.

9.4. A systematic, evidence-based process to calculate midwifery staffing establishment was completed in 2019. Our current assessment meets the 2019 Birth Rate plus assessment in addition to recommendations arising from Ockendon and Midwifery Continuity of Carer establishment setting.

9.5. Due to ongoing Acuity and activity changes a refreshed assessment has been undertaken. This Birth rate plus assessment was commenced in 2022 and we are awaiting the final outcome. There has been a delay in the final outcome assessment as due to various data recording sources we do not believe that all data submitted is an accurate review of the service requirements. The Head of Midwifery is in further

discussion with Business Information as well as the Birth Rate Plus team to expedite a more accurate report which is anticipated in February 2023.

9.6. The Trust board have therefore been updated and informed that the evidence around midwifery staffing budget reflects establishment as calculated by Birthrate plus report in 2019.

9.7. The Midwifery Coordinator on delivery suite has supernumerary status and there were 3 occasions when this status was not maintained. Because these were 3 months where this was a one-off event (August, September and December), and that it was not recurrent (i.e.: occurs on a regular basis and more than once a week) the Trust is able to report compliance

Table: Supernumerary Status of Delivery Suite Co-ordinator Source: BR+ Acuity tool

Month	Co-ordinator not supernumerary
July 2022	**0**
Aug 2022	**1**
Sep 2022	**1**
Oct 2022	**0**
Nov 2022	**0**
Dec 2022	**1**

9.8. Planned versus actual midwifery staffing is calculated monthly. The following table outlines percentage fill rates for the clinical areas (in-patient and community) month by month.

Table: Registered Midwives – Clinical Establishment fill rate (source: ESR/Health Roster

Month	Fill rate – percentage
Jul 2022	**81**
Aug 2022	**74**
Sep 2022	**82**

Oct 2022	**87**
Nov 2022	**85**
Dec 2022	**86**

9.9. Fill rates decreased in July - September 2022 for a number of reasons; Covid related absence, maternity leave, peak annual leave time and long-term sickness. This is monitored on a daily basis and staff are redeployed across the service based on activity and the acuity.

9.10. There were a number of new starters in September and October 2022 which following a period of preceptorship contributed to the improved fill rates

9.11. When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are prioritized maintained
- Activate the on-call midwives from the community to support labour ward
- Request additional support from the unit on call/Flow Midwife and Band 8 of the Day

9.12. All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

9.13. In addition, a significant number of temporary staff have been used across the service to increase fill rates cover maternity leave and long and short-term sickness. Enhanced bank pay has strengthened bank uptake.

9.14. The action plan to support achieving 1:1 care in labour was received by Board in November. Our current data is showing 97% compliance (100% is the expected standard). The Maternity Digital Team are working with Business Information Team to review every care episode with non-compliance and make data corrections (for example some elective CS episodes are non-compliant and this is corrected as they were not usually labouring as booked for an operative procedure). After the data correction, the Team have been running the reports again. The focus for the improvement plan is getting this right at the outset.

9.15. Midwifery staffing remains as a risk on the Trust Risk Register scoring 20 for safety (WC35360bs). Due to midwifery staffing issues, the decision was made with Board agreement to consolidate care provision. This has meant the Cheltenham Aveta Birth Unit has remained temporarily closed to intrapartum care. There is a plan to review this at the beginning of the New Year. Postnatal Beds at Stroud have also been temporarily closed and will be reviewed by mid-January 2023.

Recruitment and Retention Team

9.16. Appointments have been made following successful bids to NHSE monies to develop a team dedicated to supporting new starters and ongoing support for retaining midwives within the service. These include appointment to the Recruitment & Retention project manager to support activity and reporting around Midwifery Workforce. The post holder commences in January 2023.

Vacancies

9.17. There are currently 18.04 WTE vacancies in the clinical workforce funded establishment.

9.18. In the past year, significant attrition has arisen from newly qualified appointees withdrawing from accepted posts prior to commencing employment with a conversion rate of 25%. To address this the HOM has negotiated a 'golden Welcome' package for new starters comprising New Starters from August until end of Mar 2022:

- £1000 (untaxed paid in two instalments) for staff who commence with us
- 1 year subscription to midwifery professional e-journal
- 1 year annual NMC registration fee

9.19. A regular Band 5/6 advert has seen significant interest with the recent appointment of a number of both experienced and newly registered midwifery staff. The R&R team are linking with all midwives who have accepted posts to maintain communication, outlining their role and significant support and offer the 'Golden Welcome'

9.20. In the period, July – December 2022 18 Band 5 and Band 6 Midwives have joined the trust having accepted the 'Golden Welcome'. This presents an increased conversion rate from post offer to joining trust from 25% in 2021 to 81% in period March 22-December 22

9.21. Significant work has also been undertaken in the recruitment of Band 7 roles within the service with the creation of several new roles. Band 7 managers will commence the Band 7 Leadership programme led by our Organisational Development lead for midwifery in January 2023. This is the first of 4 cohorts with the programme to be completed in July 2023

Turnover, absence and sickness

9.22. Currently there are 21.28 WTE shortage of midwifery staff due to turnover, maternity leave, and sickness absence.

Table 8: Staffing leave/ absence and secondment *(Source: Health-Roster)*

	Sickness & Absence WTE	**Maternity Leave WTE**
Jul-22	26.88	17.47

Aug-22	20.58	17.99
Sep-22	20.22	17.73
Oct-22	15.27	15.56
Nov-22	23.35	13.83
Dec-22	24.2	10.14

9.23. Peaks associated with absence were notable in July and November. This coincided with increase in Covid rates amongst midwifery staff and their families. In addition, general sickness and absence associated with mental health and anxiety were noted. Maternity leave has been consistently above 10 WTE with a peak in August of 17.99 WTE. To offset the shortfall arising from vacancies and absence, enhanced bank rates have been offered to registered midwives and this will continue until 31st March 2023.

9.24. Temporary staffing fill has included both agency and bank. Whilst fill rate has varied between 9 and 20 WTE, it has not met the demands associated with midwifery absence and the vacancy rate.

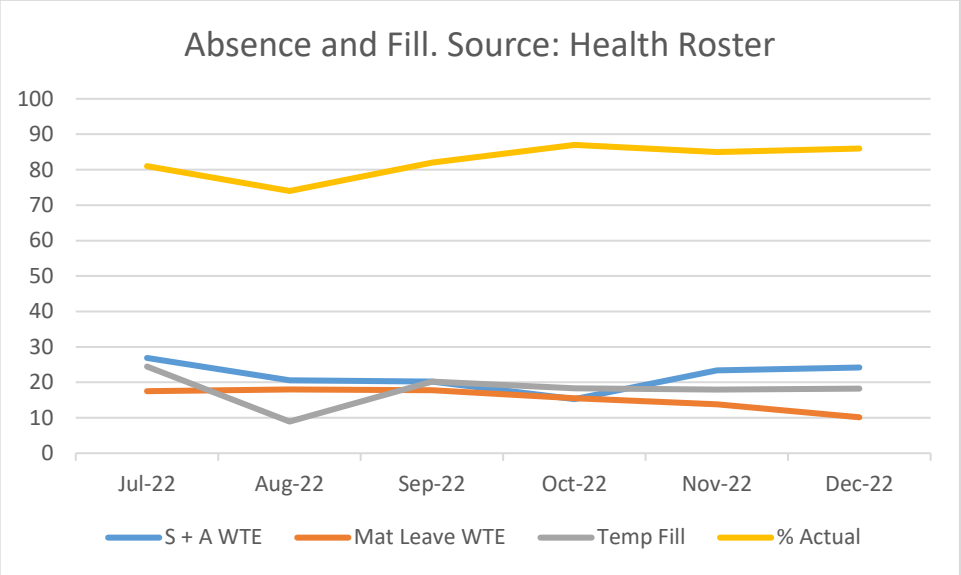
9.25. The use of Bank nurses has been well received supporting midwives on the maternity ward and on delivery suite to care for high risk surgical and medical patients and fixed term roles for Band 5 nurses within maternity are being considered. A Band 7 midwife has been appointed to oversee the Governance associated with the commencement of these RN posts to support the team on the maternity ward

9.26. Registered Nurses on the Maternity ward are to be offered a 12-month fixed term post as a pipeline for the Shortened Midwifery programme. The opportunity to work within maternity strengthens their application for the MSc programme.

9.27. Two registered nurses from GHNHSFT the commence the MSc programme in March 2022. They have been offered a secondment and course fees funded by HEE.

9.28. Eight HEE funded places have been applied for March 2024

Graph – Midwifery Absence and Fill rates:



9.29. In response to the poor staffing rates, actions within the service have included closure or reconfiguration of elements of the maternity service

The timeline of significant closure below is aligned with midwifery workforce reduction:

Dates	Duration	Area	Midwifery staffing absence - WTE	Rationale
8/12/21 – 7/02/22	62 days	Cheltenham Birth Centre	Vacancies: 24.4 Absence: 48.84 **Total: 73.24**	Due to increased demand for maternity services combined with staffing challenges including colleagues having to isolate due to COVID-19 and general staff sickness
17/03/22 – 28/03/22	11 days	Gloucester Birth Unit	Vacancies: 24.4 Absence: 49.09 **Total: 73.24**	Due to increased demand for maternity services combined with staffing challenges including colleagues having to isolate due to COVID-19 and general staff sickness
05/04/22 – 25/04/22	20 days	Stroud Maternity Unit	Vacancies: 17.9 Absence: 36.12 **Total: 54.02**	acing unprecedented staffing challenges in our maternity service. The ongoing and significant sickness rates, including Covid have continued to worse Staffing the service remains a challenge and we agreed a blended approach to support the Maternity Service including support of acute service by community and continuity midwifery teams
05/04/22 - present	Ongoing currently 10 months	Cheltenham Birth Centre	**Range: 14.9 – 27.9** *April 22:* Vacancies: 17.9 Absence: 36.12	**05/04/22 – as above** **25/04/22 -** Due to a reduction in sickness we are in the position today to announce a staged approach to reopening our MLUS. Cheltenham to remain closed **24/06/22 -** to extend the temporary closure of the Cheltenham Aveta into the Autumn. Birth Unit to maintain staff staffing levels across wider maternity services.

			Total: 54.02 *November 22:* Vacancies: 17.71 Absence: 37.18 **Total: 54.89**	23/09/22 despite very positive recruitment numbers coming online in the next month, sickness, other forms of leave absence and retirement will continue to have a significant impact on the overall numbers. Confirmed ongoing closure into the Autumn due to Midwifery staffing. No plan to reopen prior to February 2023, with review w/c 09 01 23 11/01/23 Ongoing staffing challenges despite new starters – to extend closure until March 2023
14/07/22	6.5 hours	Whole Maternity Service Closure	Vacancies: 12.81 Absence: 44.35 **Total: 57.16**	Extremely high level of activity led to service closure
01/10/22 - present	Ongoing – currently 3 months	Stroud postnatal beds	Vacancies: 17.81 Absence: 30.83 **Total: 48.64**	01 10 22 Initial closure due to service wide staffing pressure whilst considering recommendation from MSIP team Nov 22 Ongoing closure of postnatal beds to facilitate 1:1 care in labour

9.30. A number of new and ongoing actions are presented monthly to the Maternity Delivery Group and those for period June – December 2022 listed below:

a. A Daily Head of Midwifery and Matron Staffing touchpoint has now become an opt-in meeting as day to day staffing has become more settled
b. Band 8 of the Day now embedded within the service who has overall responsibility for service wide staffing, acuity and associated actions, escalating to the Head of Midwifery if required
c. Band 7 Midwifery Managers from the in-hospital service cover the 'Flow & Quality midwife' Rota. The Flow and Quality Midwife role maintains quality standards through effective staff deployment, activity and service oversight on a daily basis of the maternity service. The Flow and Quality Midwife, under the leadership and support of the Band 8 of the Day is available to provide professional leadership, guidance, development and support for midwives and support staff ensuring the provision of excellent care with compassion. The local Maternity OPEL tool is completed daily by the Flow midwife to assess staffing and communicate activity across maternity and the wider trust. This post has been funded to provide a 24/7 rota which is being recruited to currently.
d. Use of the escalation policy; which includes the use of specialist midwives to support the clinical service, on-call midwives being called in (hospital and community) and a review of all urgent/non-urgent clinical activity.
e. A reduced Senior Midwives on-call rota with increase seniority to enhance out of hours' leadership support, including linking with Trust Site support
f. Bleep system for new starters to bleep for support from PDM or R&R team

<u>Temporary workforce (Agency and Bank)</u>

9.31. The maternity service continues to use limited selected agency midwifery and nursing bank to fill shifts where there are shortages of staff. A bespoke nursing bank pool is being developed for the maternity ward. Enhanced bank rates have increased fill rates.

9.32. However, even with agency and bank usage in every month there remains high levels of unfilled shifts

	Unfilled Midwifery Shifts
Jul-22	70-90
Aug-22	70-90
Sep-22	70-90
Oct-22	94
Nov-22	88
Dec-22	88

Midwifery leadership

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

9.34. In addition, the central delivery suite is funded to have a supernumerary Band 7 shift coordinator allocated to each shift to provide professional leadership, clinical expertise and will have responsibility for the shift; this individual should have detailed knowledge of activity on the delivery suite supplemented by an awareness of activity within the inpatient areas and pending admissions from outpatient and triage areas. The Band 7 Flow and Quality Midwife role has been introduced. This 'helicopter view' is essential for overall assessment of the acuity and to support staff redeployment when required.

9.35. The newly established 'Flow and Quality' Midwife role is embedding. This is a Band 7 midwife who supports the 'Band 8 of the day' and Delivery Suite co-ordinator to manage flow associated with staffing and activity throughout the service. Currently covering Monday to Friday. The impact of the role has been very positive with funding now secured thought Ockendon funding to enable recruitment to support a 24/7 rota

9.36. The Band 7 CDS co-ordinator is supported 24 hours a day, 7 days a week either by the "Band 8 of the day" or the Senior Midwife on call. The shift coordinator is responsible for liaising with all areas to ensure safe and effective use of resources to ensure safe delivery of care at all times.

9.37. The responsibility for addressing known midwifery staffing shortfalls rests with the Senior Band 7 who has responsibility for managing the area. When staffing shortages remain an issue on a day to day basis this is escalated to the "Band 7 Flow & Quality Midwife" or "Band 8 of the day".

9.38. Further actions in response to staffing shortfall over the past 6 months have been a feature of managing the service based on midwifery availability.

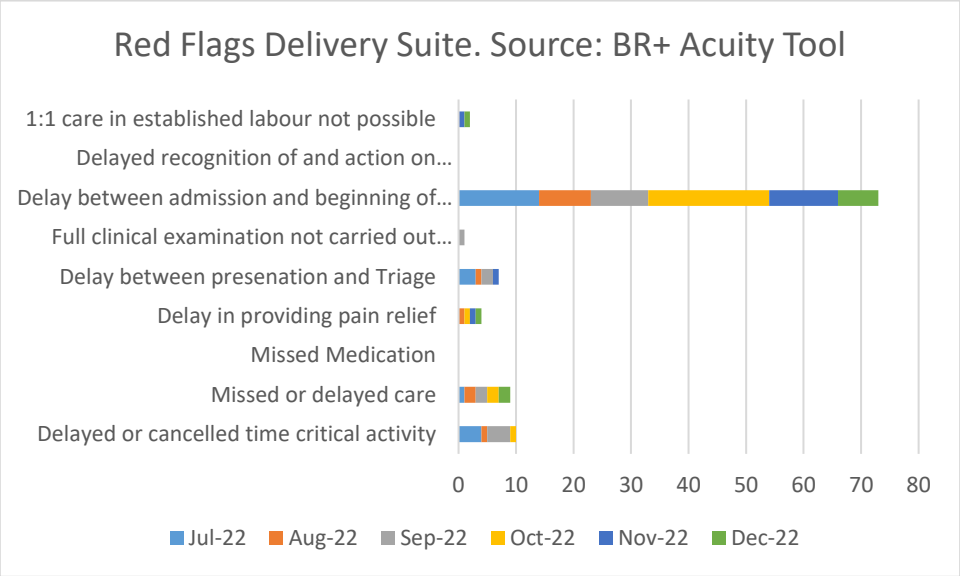
9.39. The Band 7 team are fully recruited to, however additional funding for the flow roles and bereavement midwife means that new opportunities are currently reflected as vacancies. These roles are likely to attract candidates both external and internal to the organisation.

Safer Midwifery Staffing

9.40. Ongoing monitoring of safety metrics and data

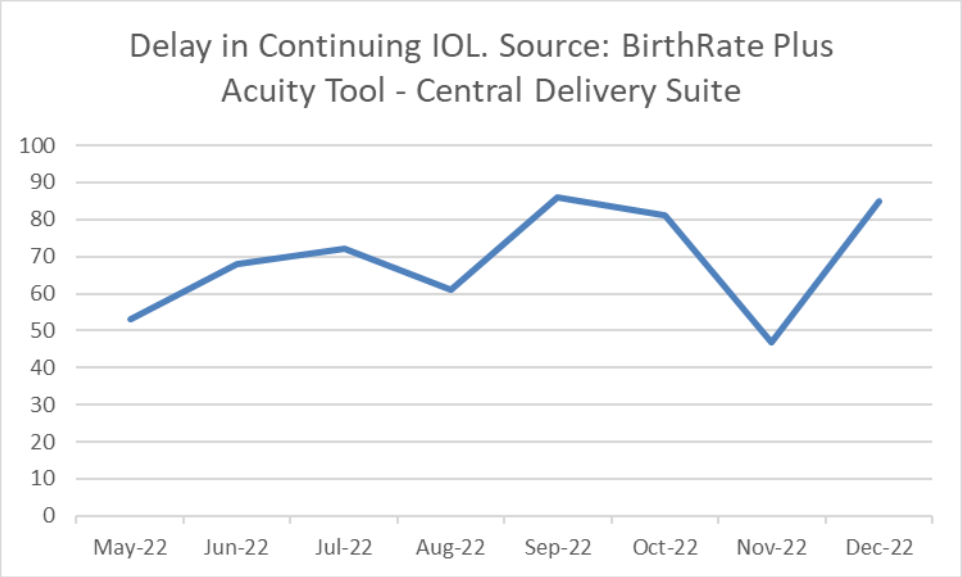
- Safe midwifery staffing is monitored by the completion of the Birthrate Plus acuity tool (4 hourly), daily staffing safety huddles, monitoring of the midwife to birth ratio and monitoring of red flags as per NICE Guidance (NICE NG4, 2021).
- We use the Birthrate+ Acuity tool which monitors compliance with supernumerary labour ward co-ordinator status and provision of 1:1 care in labour.

Table 9: BR+ Review of Red Flags July - Dec 2022 *(Source: Birthrate plus)*



9.41. There was one reported episode in November and December where 1:1 care in labour was not possible on CDS. This source is Birthrate plus and is considered in light of data from Trac which is 97% compliance. The most frequent Red Flag was associated with delays in Induction of labour on Central Delivery Suite. There was a range of between 9 and 20 episodes a month where there was a delay between admission and commencement of Induction of labour.

9.42. Continuing IOL is also monitored. During the period of June – December 2022 there was a range of 47 – 86 episodes.



9.43. There is a Quality improvement project underway. This has commenced with a tracker to obtain realtime data to support analysis.

9.44. 1:1 care in labour is monitored at Quality & Performance and reported monthly. Data Is acquired from Trakcare and discrepancies are analysed by the Digital Midwife. An action plan specifically related to 1:1 care in labour was implemented following the Section 29a and is monitored by the Divisional Tri.

Table 10: 1:1 Care in labour compliance *(Source: Trakcare)*

Month	1:1 care in labour compliance
July 2022	96%
Aug 2022	96%
Sep 2022	98%
Oct 2022	98%
Nov 2022	98%
Dec 2022	97%

9.45. Accepted midwife to birth ratio is 1:28. Midwife to birth ratio has been calculated monthly to provide actual ratio based on: Establishment – vacancies – absence (Sickness & absence + mat leave) + Temporary Staffing = Actual Midwife. The (Monthly Births x 12)/ Monthly Actual Midwife = comparative monthly figure to illustrate fluctuations in ratio as presented below. The data is presented following alignment of locally held data.

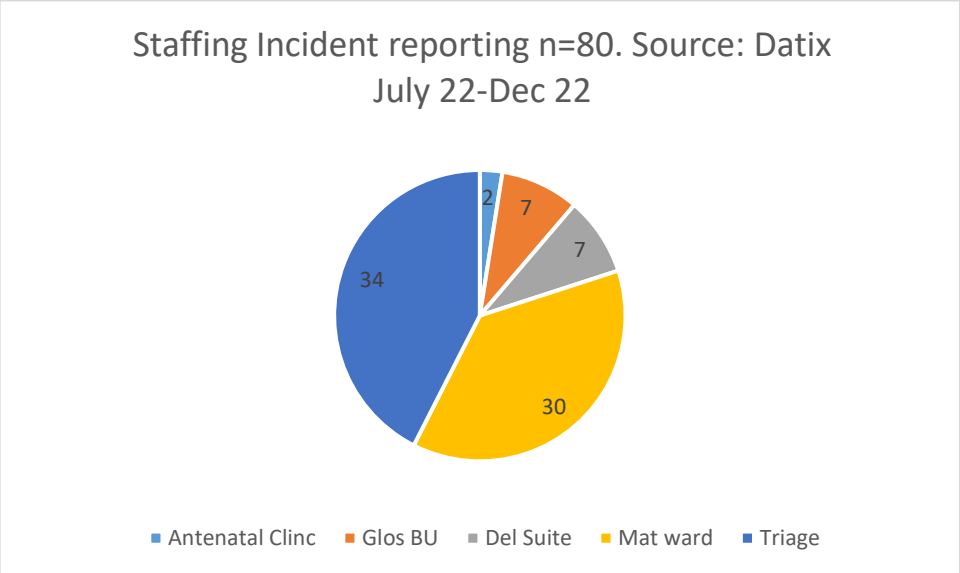
Table 11: Midwife to Birth Ratio *(Source: ESR/Health Roster)*

Month	Midwife to Birth Ratio
Jul 2022	1:29
Aug 2022	1:32
Sep 2022	1:31
Oct 2022	1:27
Nov 2022	1:27
Dec 2022	1:26

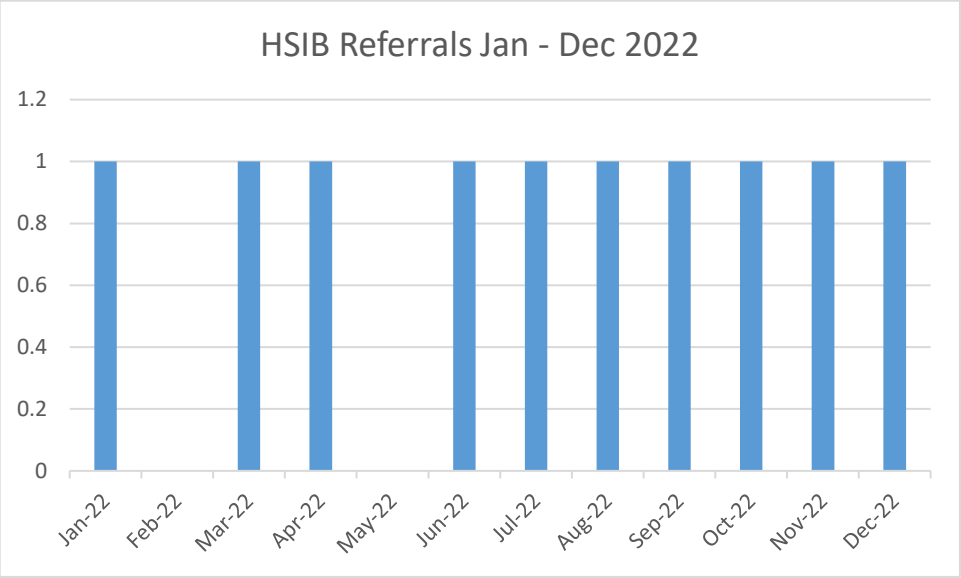
This is monitored via the Divisional Dashboard at the Maternity Clinical Governance Meeting and Divisional Board. The table above illustrates an improved Midwife to Birth ratio in February, April, and June. This is associated with a reduction in sickness and absence rates within midwifery.

9.46. During the months of July to December there were 80 Datix incidences reported related to midwifery staffing, an increase from 75. The majority of these related to insufficient staffing in Maternity Triage. This relates to Risk Register entry number WC3685Obs. The largest reporting area was Triage particularly in relation to breeches of primary assessment time.

Graph: Incidences associated with staffing



9.47. HSIB referrals are monitored via the maternity dashboard. During the period of January 22– December 2022 the HSIB referrals did not exceed 1 per month, with a total of 10 cases. Not all referred cases were accepted by HSIB. No parental consent is one reason they would not accept.



Escalation and Trust risk register entry

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

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

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

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

- Retention lead posts
- Midwifery development and leadership
- Emotional wellbeing project
- Development of Maternity Support Worker role

9.52. Day to day management of the suboptimal staffing is being managed by increased, visible midwifery leadership in key areas. A daily and weekly service wide overview of staffing has been implemented to enable oversight and planning ahead for staffing issues. In addition, responsive Multidisciplinary Huddles which includes the Service Tri are conducted on CDS during periods of significant activity.

10. Right skills – mandatory training, development and education

10.1. Our staffing establishments take account of the need to enable clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students. The CQC 29a warning notice was received in June 2022 in response to not complying with legal requirements on minimum staffing

10.2. The service has identified the need to expand Administrative and clerical roles to release midwifery time. A paper has been submitted to the clinical safety group.

10.3. In the past year, due to the pandemic and surges of Covid-19 mandatory and non-mandatory training has been either cancelled or staff asked to attend clinical areas and rebook onto other dates which has impacted on our mandatory training compliance rates. **Mandatory training compliance has decreased from 81% in December 2021** (Trust target 90% compliance). Significant work is underway to increase MDT compliance with mandatory training across all staff groups to achieve 90% by the 31st December 2022. The 90% compliance is a Maternity Incentive Team requirement for all staff.

Table 12 – Mandatory Training Compliance – All Staff groups – Dec 2022 *(Source: Local Training Data)*

Training Detail	Midwives	Consultant Obstetricians	Consultant Anaesthetists	Junior Obstetricians	Junior Anaesthetist
Mandatory Midwives Day	91%	NA	NA	NA	
PROMPT	93%	74%	93%	90%	95%
Fetal Monitoring	95%	92%	NA	93%	NA

10.4. A recovery plan has put in place with additional training dates and compliance for MIS standards was met in December 2022

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

10.6. Over the last few months due to the pandemic and surges of Covid-19 **appraisal rates had decreased from 68% in December 2021 to 60% in July 2022** (Trust target 90%

compliance). A recovery plan is being put in place with additional training dates so that compliance can be met by end of December 2022. This forms part of the CQC 'Must Do's'

Table: Appraisal Compliance rates July – Dec 2023

Month	Appraisal compliance %
July 2022	60%
Aug 2022	60%
Sep 2022	62%
Oct 2022	66%
Nov 2022	70%
Dec 2022	75%

10.7. The progress in completion rates for maternity has continued reflecting the effort and focus by our staff and managers, completion rates increasing from 70% to 75% over December. The completion rates fell slightly short of the 80% hoped for by the end of the year but demonstrate sustained improvement. There is still some way to go to reach or exceed 90% completion it remains clear that the direction of travel and momentum is positive and the service is on track to meet the CQC expectations and our aspirations.

10.8. The appointment of the Organisational Development Lead post which commenced in August 2022 is supporting the overall compliance with appraisals.

10.9. The maternity service analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework. The maternity service Practice Development team will complete a Training Needs Analysis exercise to ensure that all six core modules of the Core Competency Framework are included in our unit training programme over the next 3 years (NHSR, MIS safety action 8). The training plan will include;

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

This Training schedule has been completed in readiness for January 2023 commencement. The training and education policy is being reviewed and updated for completion in February 2023

11. Conclusions

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

11.2. Incident reporting on staffing, Red Flags and birth to midwife ratio illustrate a concerning picture within midwifery staffing. HSIB referrals have decreased in this 6-month period. Initiatives to enhance recruitment and retention are being actioned and it is anticipated that the next 6 months will see an improved recruitment picture. Attrition continues to be of significant concern and actions to address this are ongoing.

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

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NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	14	Enclosure Number:	9
Date	9 March 2023		
Title	Fit for the Future Phase 2 Decision Making Business Case (DMBC)		
Author **Sponsoring Director**	Micky Griffith, Programme Director, Fit for the Future Simon Lanceley, Director of Strategy & Transformation		

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 Decision Making Business Case (DMBC) is to present the case for change and secure Board approval for the reconfiguration of five specialist hospital services as part of the continued implementation of our *Centres of Excellence* Clinical Strategy.

Context

- Fit for the Future (FFTF) is part of our Integrated Care System (ICS) response to the NHS Long Term Plan. The programme is implementing our *Centres of Excellence* vision, providing a greater separation of emergency and planned care across Gloucestershire Royal Hospital and Cheltenham General Hospital.
- The FFTF Phase 1 DMBC was approved in March 2021 and five of the seven reconfigurations have now been implemented. None of the services in scope of Phase 1, their costs or benefits are part of the approval resolutions contained within this Phase 2 DMBC.
- FFTF Phase 2 builds on the learning from Phase 1, and the case has been developed to meet the requirements set out in the NHS England (NHSE) Planning, assuring and delivering service change for patients (March 2018) and Addendum (May 2022), and in accordance with the South West Clinical Senate review process. Full appendices are included for completeness.

Key points to note

The services in scope of Phase 2 are:

- Benign Gynaecology*
- Diabetes and Endocrinology*
- Non-interventional Cardiology
- Respiratory*
- Stroke*
- *Five of these services are operating in the preferred configuration as Temporary Service Changes as agreed with Gloucestershire Health Overview and Scrutiny Committee.

- The case sets out the rationale for proceeding with five resolutions in the context of the outcome, findings and feedback received from:
    - The public, patient and staff involvement process (May- July 2022);
    - The South West Clinical Review Panel (Aug 2022);
    - Gloucestershire Health Overview and Scrutiny Committee (October 2022), and;
    - NHS England South West Regional Team (October 2022).
- A full Integrated Impact Assessment has been completed for the proposed service reconfigurations, comprising Equality Impact Assessment, Health inequalities impact assessment and a Health impact assessment.
- The only additional financial investment required to implement FFTF Phase 2 relates to the establishment of a Respiratory High Care unit at Gloucestershire Royal Hospital, which requires a revenue investment of £274,000 and a capital investment of £21,000.
- Full appendices are included for completeness.
- Should the recommendations be approved by Trust Board, the DMBC will proceed to NHS Gloucestershire Integrated Care Board on 29th March for decision.

Recommendation

The Board is asked to approve the following Programme recommendations as defined in the Decision Making Business Case:

- **Resolution #1**: To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2**: To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #3**: To centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Resolution #4a**: To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b**: To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.
- **Resolution #5**: To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.

Enclosures

FFTF2 DMBC v1.1

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Phase 2 Decision-making Business Case

Version 1.1

March 2023

Work in Progress – subject to decision-making

Fit for the Future 2

Developing specialist health services in Gloucestershire

Contents

Document Control

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1.1	01/03/23	Micky Griffith	Incorporate SRO comments/amends

Document Distribution:

Forum/Audience	Date	v#	Comments
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Publication onto Get Involved in Gloucestershire website	01/04/23		

[1] See section 2.6 for document iterations.

1 Executive Summary

1.1 Strategic Statement

We, the health and social care organisations in Gloucestershire have committed to working together as an Integrated Care System (ICS) to improve the health of local people through supporting them to take more control of their own health, with a greater focus on prevention and self-care (people looking after themselves when they can), and ensuring we deliver the right care, in the right place at the right time. Fit for the Future is a key enabler to our right care, right place, right time objective.

Prioritising Self Care and Prevention means that we are using our data to understand the health needs of local people and working to improve long term health and wellbeing. Health and wellbeing are influenced by more than just health services, so as an ICS we work as an active partner in the public sector to improve health through better housing, better education, better employment, better transport and keeping people safe.

Evidence and experience tell us that people can find it harder to improve their own health or to access our services when they have other challenges in their lives. These include living with deprivation, disability, or a mental health condition. Our commitment is that we will ensure our services are easier to access for people with health inequalities, both ensuring our services recognise and deliver parity of esteem for mental health and provide additional support when people need it.

Delivering the right care in the right place at the right time means that when care can be delivered at home or close to home, it will be. When people need to come to a centre to get care, our aim is to minimise the distance needed to travel to get there, as it can be hard to get around our county particularly with a long-term health condition.

Sometimes however, we will need to prioritise achieving a better health outcome over trying to minimise travel for people. Health care for some conditions is increasingly high tech and needs highly trained staff and expensive equipment to keep pace with the best in the world. When specialist care is needed our aim is to increasingly deliver this through *Centres of Excellence*, that separate emergency and planned care and centralise services where we can consolidate skills and equipment to provide the very best care.

The NHS is going through the most challenging period of its 75-year history to date. Gloucestershire's health and care system, like other parts of the country, is in the process of recovering from the pressures that the COVID pandemic placed on our services, staff and local communities. There are also the added challenges of recent industrial action and a rise in seasonal illness.

Living within our means to make the best use of every Gloucestershire pound means a commitment to work together to put the patient first in everything we do, developing our workforce, and streamlining our services and organisations where possible to ensure everything we deliver is as efficient as it can possibly be.

We know we still have a long way to go, but we believe that the proposals in this second phase of Fit for the Future (FFTF2) will help us to keep moving in the right direction. We are confident that our plans for service development, including some that are temporary service changes made in response to the pandemic, will deliver benefits in the long-term.

1.2 Why we think that change is needed

Our strategic statement set out above is a summary of our ICS strategic response to the triple challenges facing health and care services delivery as described in the NHS Five Year Forward view, the health and wellbeing gap, the care and quality gap and the finance and efficiency gap.

The Fit for the Future (FFTF) Programme and *Centres of Excellence* approach described in this document are specifically looking to address issues and risks arising from the historic configuration of hospital services across Cheltenham General Hospital (CGH) and Gloucestershire Royal hospital (GRH), part of Gloucestershire Hospitals NHS Foundation Trust and located eight miles apart.

Since merging to form a single Trust in 2002, a number of services have now been centralised including those in the first phase of FFTF[2], paediatrics ophthalmology, oncology and urology. For a number of other specialties, the FFTF programme is seeking to address issues and risks arising from continuing to deliver services across both sites. These include pressures on workforce, quality and safety as resources become ever more stretched to cope with increasing demand. At times, this means services can be compromised in terms of their potential to develop the same standard of specialist care across both sites. We believe reconfiguring some of our services more efficiently across the two sites to improve clinical linkages between services will deliver improvements against the care and quality gap.

We aim to address the health and wellbeing gap by increasing the quality and health outcomes that our hospital services deliver, increasing the specialist services offer in our county and supporting the identified health needs of our population.

1.3 Proposals

It is the Programme's recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the NHS Gloucestershire Integrated Care Board (GICB) that the following resolutions should be considered for agreement and approval, considering all the evidence that has been made available, on the basis that they represent the most appropriate option to address the case for change.

- **Resolution #1**: To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2**: To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #3**: To centralise Non-Interventional Cardiology inpatient beds[3] at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Resolution #4a**: To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b**: To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.

[2] Details in section 3.5

[3] Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

- **Resolution #5**: To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.

This Decision-Making Business Case (DMBC) sets out the rationale for proceeding with these resolutions in the context of the extensive work that has been undertaken through the Fit for the Future Programme. This includes consideration of the outcome, findings and feedback

- The public, patient and staff involvement process (May- July 2022);
- The South West Clinical Review Panel (Aug 2022);
- Gloucestershire Health Overview and Scrutiny Committee (October 2022), and;
- NHS England South West Regional Team (October 2022).

This DMBC has been drafted on the basis of decisions taken by the Board of Gloucestershire Hospitals NHS Foundation Trust (November 2022) and the NHS Gloucestershire Integrated Care Board (November 2022).

Details of the patient, staff, efficiency, and effectiveness benefits of each resolution can be found in the individual service sections, which directly or indirectly support our ICS objectives set out in our response to the NHS Long-Term Plan including:

- Ensuring people with specialist health conditions can access outstanding hospital care
- Delivering high quality, joined up services with the right care, staff skills and equipment in the right place
- Delivering care that is fit for the future through the development of outstanding specialist hospital care in the future across the CGH and GRH sites
- Developing and supporting our workforce and meeting the challenge of recruiting and keeping enough staff with the right skills and expertise.

1.4 Decision-making business case structure

Fit for the Future (FFTF) Phase 2 builds on the learning from Phase 1, and this document is designed to meet the requirements set out in the NHS England (NHSE) *Planning, assuring and delivering service change for patients (March 2018)* and *Addendum (May 2022),* and in accordance with the South West Clinical Senate review process.

- **Section 2** sets out the purpose and scope of this Decision-making Business Case (DMBC) and the process we are undertaking.
- **Section 3** introduces our system, our challenges and our Integrated Delivery Plan priorities including FFTF.
- **Section 4** describes our FFTF2 public, patient and staff engagement activities and includes feedback from our engagement survey.
- **Section 5** provides information affecting all of the service change proposals including the options appraisal process, overall bed impact, and requirements relating to inter-hospital site ambulance transfers.
- **Sections 6 to 10** present detailed information on the five FFTF2 service proposals including the current service model, the case for change, preferred option evaluation, clinical evidence, benefits; workforce, “blue light” impact, responses to Clinical Senate review, engagement themes and responses.

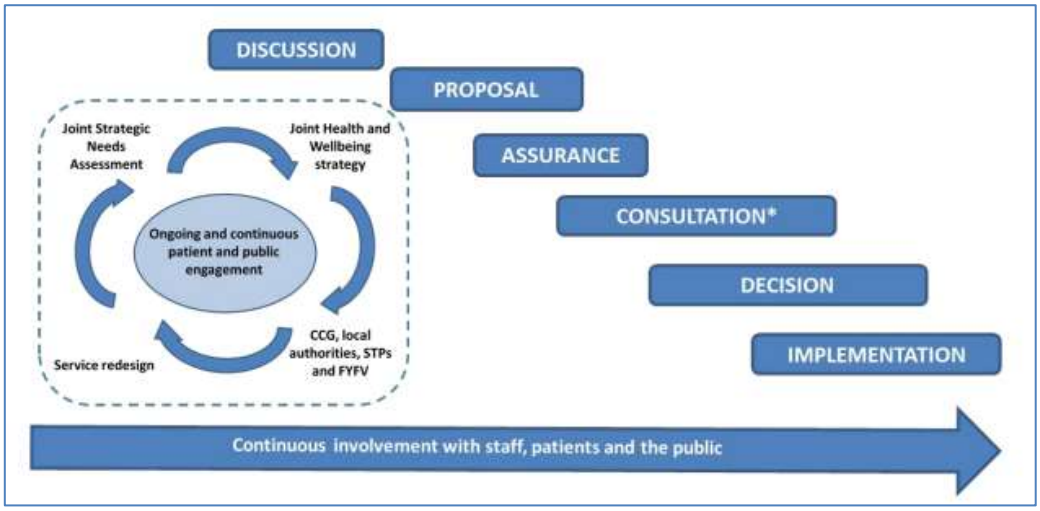
- **Section 11** describes our approach to integrated impact assessment and a summary of Equality Impact, Health Inequalities Impact and Health Impact assessments.
- **Section 12** provides the economic and financial analysis.
- **Section 13** provides details of our internal and external governance and decision-making processes.
- **Section 14** sets out the resolutions to be approved.
- **Section 15** provides our implementation structure and high-level schedule.

2 Purpose of the document

2.1 The process we are undertaking

As with all service reconfiguration programmes, we have worked closely with NHS England (NHSE) through the regional office and are guided by the *Planning, assuring, and delivering service change for patients (March 2018)* and *Addendum (May 2022)*[4]. This guidance is designed to be used by those considering, and involved in, substantial service change to navigate a clear path from inception to implementation. It supports commissioners and providers to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.

Service change has several phases from setting the strategic context to implementation. A summary of these (from the guidance), is set out below:



2.2 Single-step business case

As noted in the guidance[3], public consultation may not be required in every case and the decision about whether public consultation is required should be made considering the views of the local authority.

The ICB is therefore able to depart from the NHSE Guidance provided it has good reason to do so. When deciding if consultation would be required for FFTF2, the ICB considered the following factors:

- The extensive amount of engagement that had already been carried out and the positive response to the proposals.
- The ICB had produced an Output of Engagement report of the kind that would normally be produced following public consultation
- The Output of Engagement Report was considered by the Health Overview and Scrutiny Committee (HOSC) in October 2022; The committee discussed next steps and considered whether further public involvement would provide additional information, such as alternatives or impacts, that could influence decision making. The committee did not raise any concerns with the engagement undertaken to date and the approach suggested by the ICB, and requested that updates be brought to

[4] NHS England » Planning, assuring and delivering service change for patients

future meetings of the committee regarding the implementation of Fit for the Future 2 service changes

- Discussions had taken place with the SW Regional NHSE team, and NHSE were content that no further public involvement (including consultation) was expected. This would also mean that NHSE Stage 2 assurance process was not required.
- Of the five FFTF services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes and have been well publicised.
- It was also relevant that ICBs must be mindful of the cost of undertaking public consultation, when resources are stretched, and it is incumbent on public bodies to manage resources efficiently and effectively.

The subject of further FFTF2 public involvement, including consultation, was discussed at the ICB public meeting on 30/11/22 (having previously been considered by the GHNHSFT Board on 10/11/22). Details of the papers and minutes of the meeting can be found at Board Meetings : NHS Gloucestershire ICB (nhsglos.nhs.uk).

On the basis of the particular facts and circumstances stated above, and in full understanding of its duties, the ICB Board took a formal view that there should be no further public involvement in Phase 2 of the FFTF programme. The Board agreed that next steps should be taken to bring a decision-making Business Case (DMBC) to the March 2023 Board meeting.

In the light of this decision there is not a requirement for a Pre-Consultation Business Case (PCBC) to be approved by the ICB and therefore as we now have a single-step business case process, for the benefit of decision-makers and for completeness, some information usually included within a PCBC is contained within this DMBC.

2.3 Purpose and scope of DMBC

This Decision Making business case (DMBC) is concerned with the configuration of hospital services across Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), specifically between Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

This DMBC is based on the evidence compiled in the business case submitted to the South West Clinical Senate (and copied to NHSE), feedback from FFTF2 public, patient and staff engagement and includes the outputs from the engagement report[5] and seeks to ensure that progress to decision-making and implementation is fully informed by detailed analysis of outcomes.

The DMBC will present and summarise the extensive work completed to date, with the following purposes in mind:

- To present our response to the FFTF2 engagement and involvement;
- To demonstrate that options, benefits, and impact on service users have been considered, and;
- To confirm the recommendations for service change in order to enable decision- makers to determine if these proposals should be implemented

[5] The full FFTF2 Output of Engagement Report can be found in Appendix 1

2.4 Intended audiences and their decision-making roles

This DMBC is written by the Gloucestershire Fit for the Future Programme for the following audiences:

- The NHS Gloucestershire Integrated Care Board (GICB) which will decide whether the proposed service changes should be implemented based on the evidence presented. The ICB is the legally accountable Authority so has final responsibility for approving next steps.
- The Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) who will confirm organisational level support for the proposed changes to clinical services including formal approval of the case in terms of finance, workforce, and implementation plans.
- NHS England and Improvement (NHSE&I) who have undertaken a Stage 1 review of FFTF2, received the pre-consultation business case submitted to the South West Clinical Senate and confirmed that a Stage 2 assurance process was not required[6].
- The Gloucestershire Health Overview and Scrutiny committee (HOSC) who will continue to scrutinise the proposals in line with their responsibilities.

For the purposes of transparency, the final version of this DMBC will be made available publicly, but the document is not written with a public audience in mind.

2.5 Document Status

This document has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

Until published as part of publicly available Board papers, this is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act, the parties should discuss the potential impact of releasing such information as is requested.

The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services.

[6] See section 2.2

2.6 Document Iteration

This document has been developed through an iterative process designed to meet the needs of the various stages of internal and external assurance. The table below presents both the document types and the approval/ review forum to date; culminating in a DMBC:

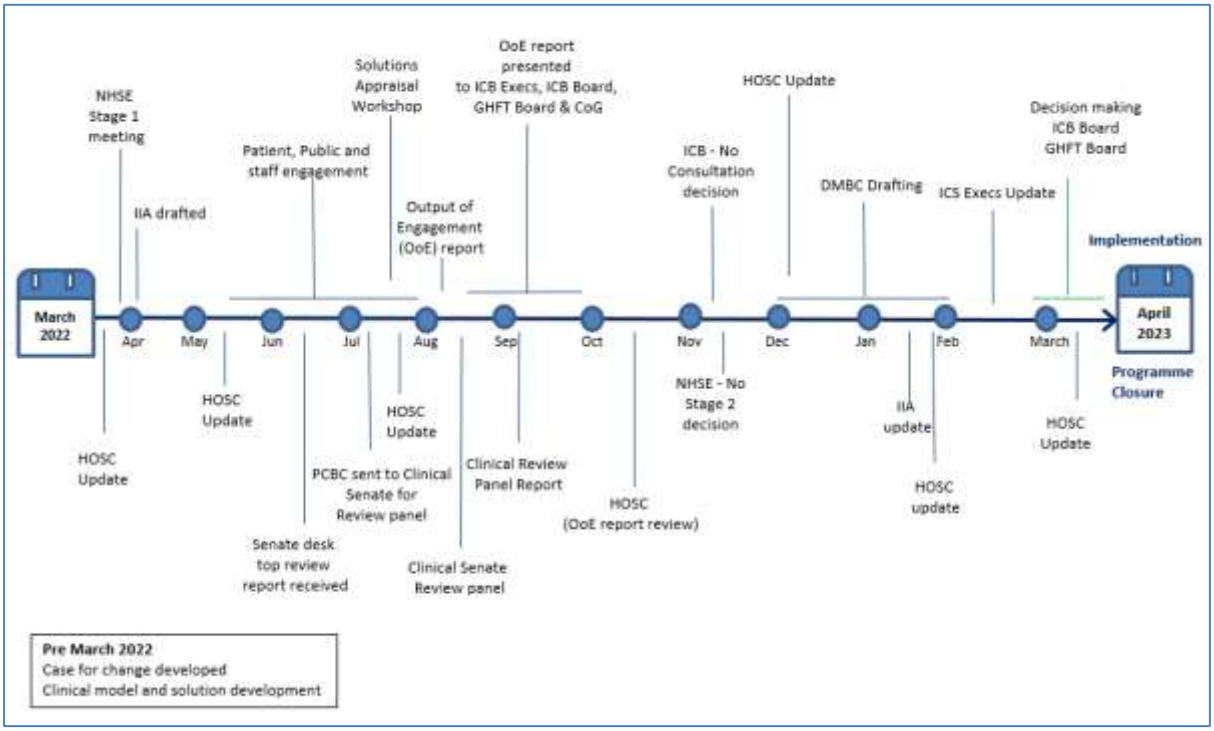
Forum/Audience	Date	Document name and version
NHSE	31/03/22	Glos. ICS Stage 1 Information (v1.2)
GHNHSFT Council of Governors	23/03/22	Glos. ICS Stage 1 Information (v1.2)
ICS Lay & NED Network	12/04/22	Glos. ICS Stage 1 Information (v1.2)
GHNHSFT Board	14/04/22	Glos. ICS Stage 1 Information (v1.2)
GCCG Governing Body	21/04/22	Glos. ICS Stage 1 Information (v1.2)
ICS Executives	05/05/22	Glos. ICS Stage 1 Information (v1.2)
HOSC	17/05/22	FFTF2 Information (v1.3)
South West Clinical Senate (Desk-Top Review)	19/05/22	FFTF2 Information (v1.4)
South West Clinical Senate (Clinical Review Panel)	28/07/22	FFTF2 Pre-Consultation Business Case[7] (v1.6)
GHNHSFT Board	09/03/23	FFTF2 DMBC (v1.1)
Gloucestershire ICB	29/03/23	FFTF2 DMBC (v tbc)

In addition to the above, the FFTF2 Output of Engagement Report (Appendix 1) was reviewed and discussed at the following meetings and published on the ICS Get Involved in Gloucestershire website:

Forum/Audience	Date	v#
Integrated Care System Strategic Directors	18/08/22	1.2
GHNHSFT Board	08/09/22	1.2
GHNHSFT Council of Governors	22/09/22	1.2
NHS Gloucestershire Integrated Care Board	28/09/22	1.2
HOSC	18/10/22	1.3

[7] The decision not to consult was taken after the Clinical Review Panel (see section 2.1)

2.7 FFTF2 Programme Timeline



Key Points

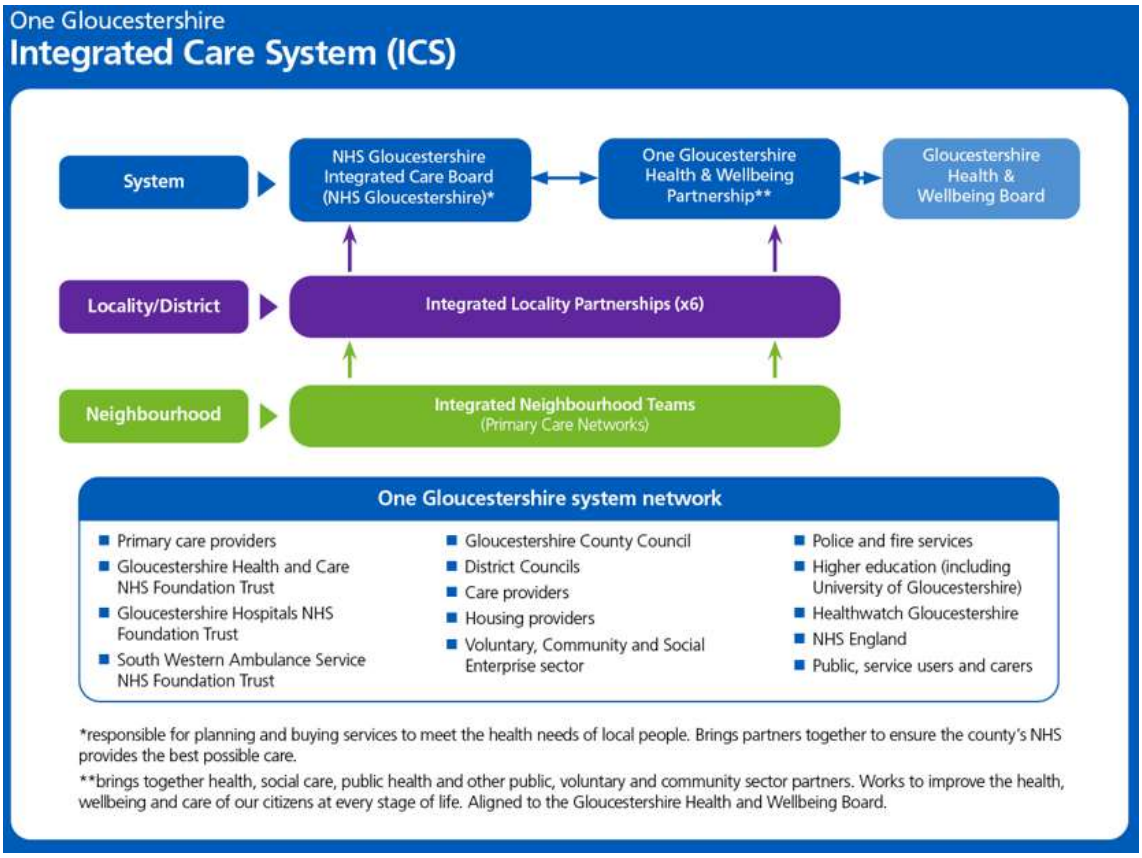
- **Our proposals are guided and informed by the NHSE** *Planning, assuring and delivering service change for patients (March 2018)* **and** *Addendum (May 2022)*
- **Following discussion with NHSE and HOSC, the decision was taken to undertake a single-step business case process and move to decision-making (DMBC) following extensive public, patient and staff involvement.**
- **Due to the single-step business case process this DMBC includes information that would usually be included in a Pre-Consultation Business Case.**
- **This DMBC includes information previously submitted to the South West Clinical Senate for review and contains Senate feedback.**

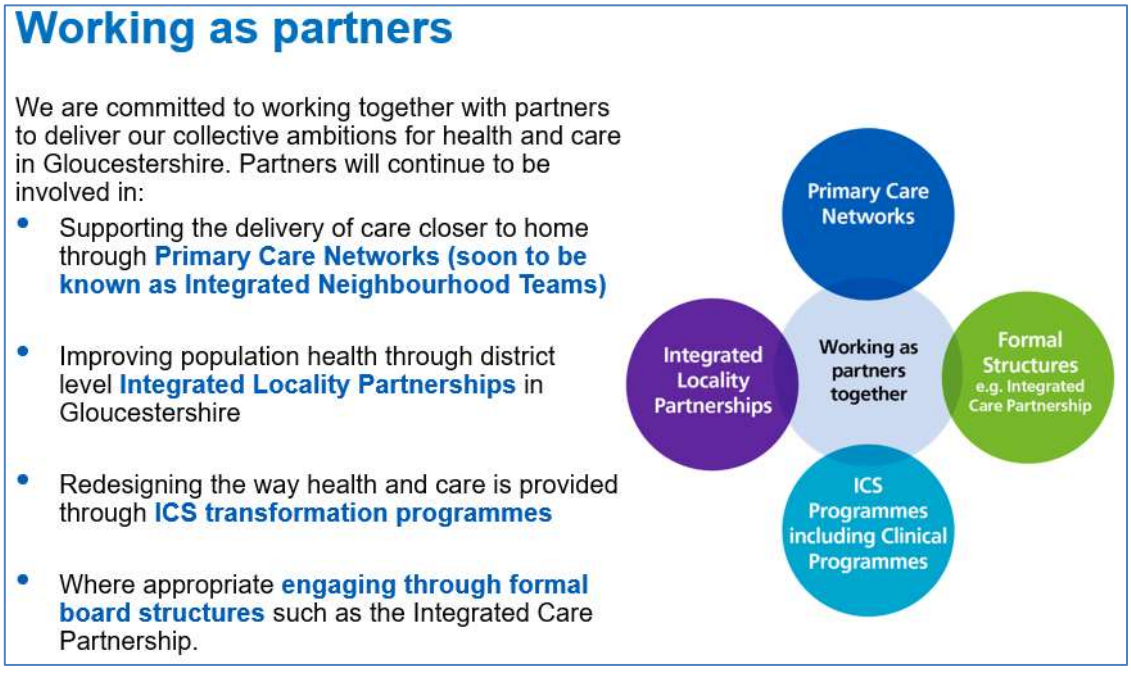
3 Introduction to the System

3.1 One Gloucestershire Integrated Care System

Our One Gloucestershire Integrated Care System (ICS) is a partnership that brings together NHS, social care, public health and other public, voluntary and community sector organisations, which became a legal entity on 01/07/22.

Our NHS Gloucestershire Integrated Care Board (NHS Gloucestershire) is responsible for planning and buying services to meet the health needs of local people. It also brings partners together to ensure the county's NHS provides the best possible care. It works alongside our One Gloucestershire Health and Wellbeing Partnership - ensuring a joined-up approach across the NHS, public health, social care and the wider public, voluntary and community sector.

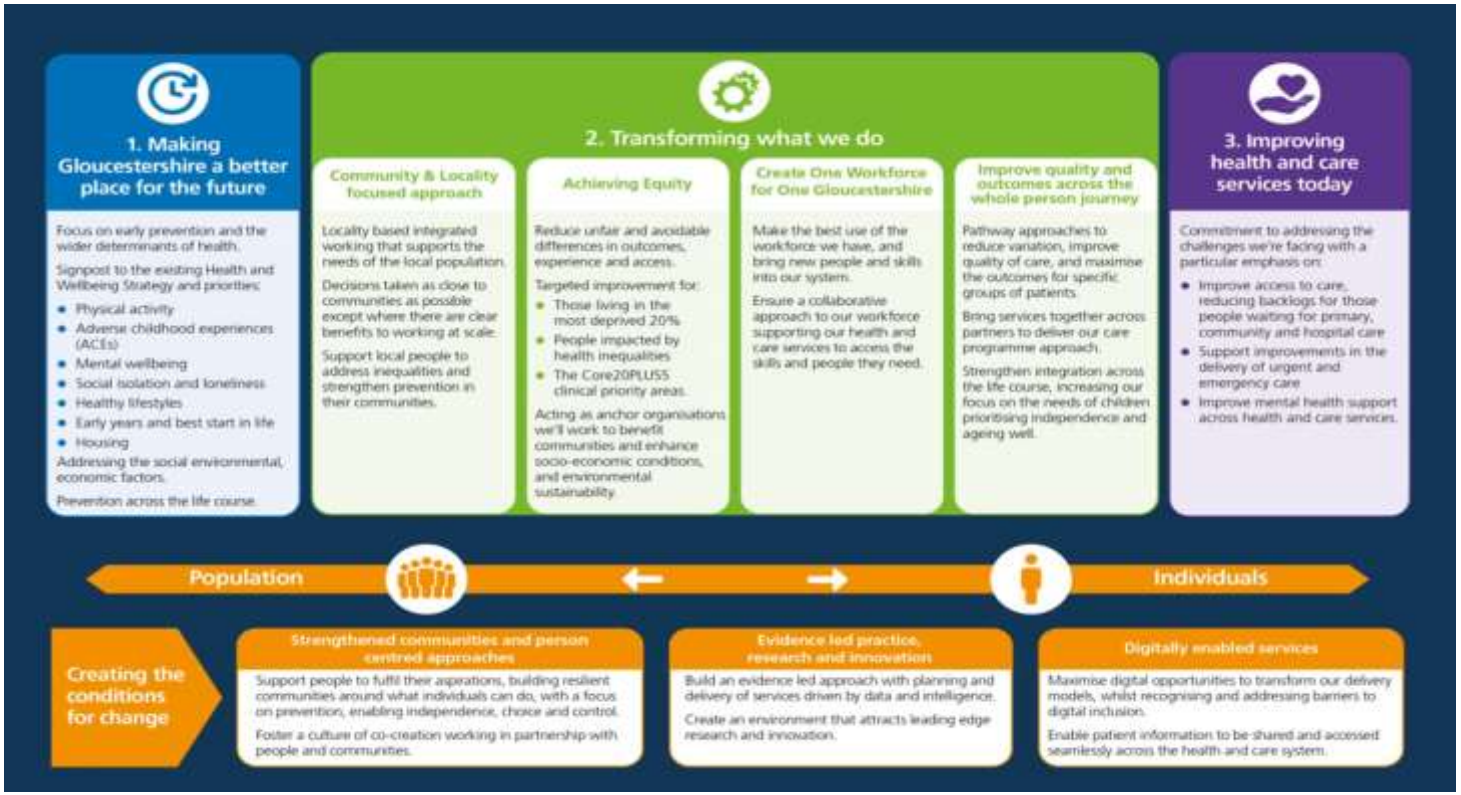




We know that by working together we can build a healthier Gloucestershire; supporting people to live well and providing high-quality joined-up care when people need it. We are ambitious for our county. We want to work with our communities, to improve health and wellbeing.

3.1.1 *One Gloucestershire Integrated Delivery Plan*

Our Integrated Delivery Plan sets out our priority programmes and the activities that we will be seeking to deliver as partners across the health and social care system in Gloucestershire. The plan has been formed from delivery plans that have been developed for each of our Integrated Care System transformation programmes, setting out objectives for the future[8]. These plans have been worked up with partner organisations and reflect a shared commitment to delivery for the years ahead.



[8] Further details can be found at Our priorities in Gloucestershire : NHS Gloucestershire ICB (nhsglos.nhs.uk)

3.1.2 *ICSClinical Programme Groups*

The ICS Clinical Programme Groups (CPGs) are well established in a number of disease areas, working with system partners and lay representatives to ensure optimal clinical pathways for the people of Gloucestershire.

The aim of the programme is to deliver whole pathway transformation across key clinical programme areas, utilising a structured 'Clinical Programmes Approach' based on the principles of improvement science. A fundamental priority is to deliver the best value healthcare for our population.

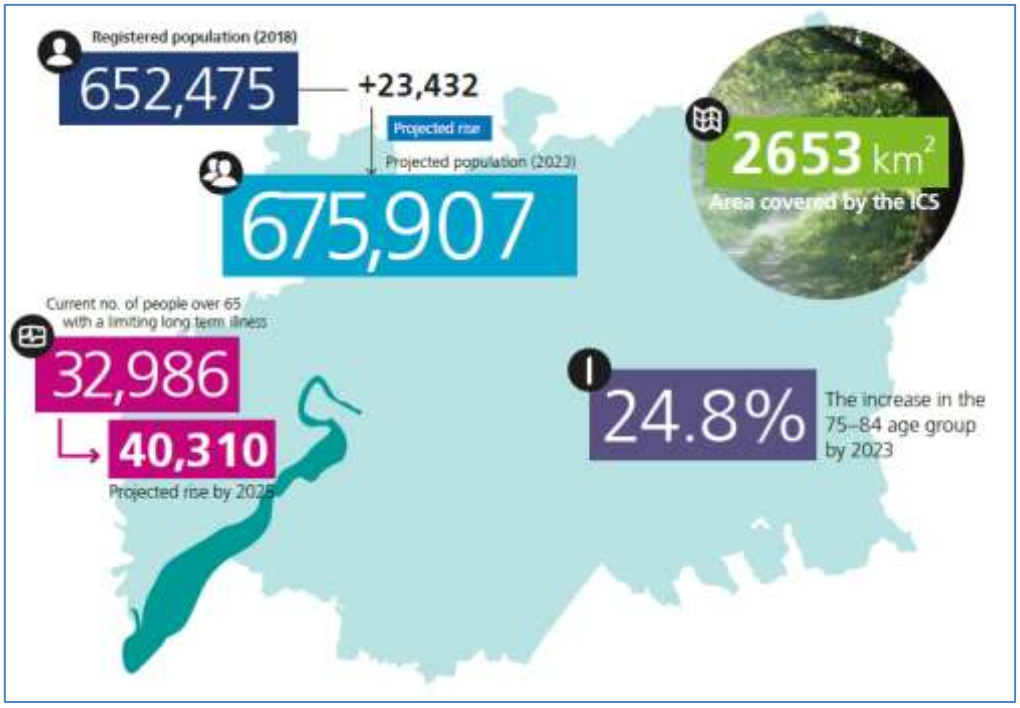
The programme takes a pro-active approach to preventing disease, diagnosing and treating and managing the condition from its early stages. We build on the strong foundations of the clinical programme approach to deliver truly integrated care- both within physical and mental health; challenging system partners to remove barriers to care delivery and reduce the health inequality gap.

We work with all partners to ensure that the clinical programme approach is contributing to eradicating health inequalities, through analysis of data and proactive engagement with service users and the communities we serve through prevention, early diagnosis and timely access to support throughout their lives and be supported at their most vulnerable times to access personalised care, including end of life.

As part of a collaboration between our priority programmes, CPGs and FFTF came together to set up and support service Task and Finish groups in 2021, covering stroke and frailty.

3.2 Local Health Context

The FFTF programme undertakes an integrated impact assessment (see section 11), for the individual services in scope, however, a summary of countywide demographic information is provided below.



The health of people in Gloucestershire is generally better than the England average. Gloucestershire is one of the 20% least deprived counties/unitary authorities in England, however about 12.6% (13,320) children live in low income families. Life expectancy for both

men and women is higher than the England average although it is 8.4 years lower for men and 5.4 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

Gloucestershire has a lower proportion of 0-19-year olds and 20-64-year olds when compared to the national figure, whilst the proportion of people aged 65+ exceeds the national figure. As is the case in many parts of the UK, the number of older people in the county has steadily increased over the last 10 years. Projections suggest this trend will continue, with the number of people aged 65+ projected to increase by 77,000 or 59.4% between 2016 and 2041.

According to the 2011 Census [9]16.7% of Gloucestershire residents reported having a long-term limiting health problem; this was below the national figure. As age increases the proportion of respondents reporting a limiting long-term health problem increases. Given the ageing population, the number of people with a limiting long-term health problem is likely to increase in the future.

The three leading causes of death for our population are cancer (27.9%), cardiovascular disease (26.8%) and respiratory disease (14.2%). Age is the leading risk; however, the burden of disease in these categories is associated with four additional key risk factors: poor diet, physical inactivity, smoking and excess alcohol consumption.

Poor mental and emotional wellbeing also have a key part to play. Gloucestershire is broadly in line with national and regional benchmarks for alcohol related admissions to hospital, levels of physical activity and adult excess weight, although some districts have worse rates than the county as a whole, notably in the west of the county in the Forest of Dean, Gloucester and Tewkesbury. Smoking rates in Gloucestershire are steadily declining and are lower than comparators.

Our ageing population, changing patterns of disease (more people living with multiple long-term conditions) and rising public and patient expectations mean that fundamental changes are required to the way in which care is delivered in our county. We will more fully involve individuals in their own health and care by making shared decision-making a reality by intensively training our clinicians to give people the support and information they need for effective self-management and involving their families and carers to support them in making the changes needed to keep healthy. There is clear evidence that most people want to be more involved in their own health and that, when they are, decisions are better, health outcomes improve, and resources are allocated more efficiently.

3.2.1 *Population and Demand Growth*

Our assessment of the impact of population growth uses 2018 subnational population projections from the Office of National Statistics (ONS). We have reviewed the age-group, gender, and locality profiles of patients for each of the proposals in scope and applied the appropriate growth rates to our baseline activity to assess the impact of cumulative growth for the period 2022 to 2031.

The management of growth demand is a consistent and ongoing objective within the ICS to ensure that hospital appointments and admissions are appropriate as well as the year-on-year efficiencies within GHNHSFT to deliver productivity improvements.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID)

[9] See section 0 for rationale regarding use of 2021 census

pandemic. As with all systems, the past 36 months (since March 2020), has seen a significant change in the demand distribution and commensurate use of resources; for example, when comparing 2019 with 2021 we have seen a >25% reduction in average surgical bed numbers used (and a reduction as a proportion of total) and a 50% increase in number of beds occupied by Medically Fit for Discharge/ Not Meeting the Criteria to Reside (MFFD/NMCTR).

Given the multi-factorial nature of current resource demands, including COVID, elective recovery, continuing Urgent & Emergency Care demand, and uncertainty as to their impacts, this DMBC has not attempted to inflate resource demand (including bed demand and capacity, see section 5.7), based on an unmitigated position. Our modelling takes account of the last three years, our pre-COVID demand and our plans for the future.

If these proposals are approved and the programme shifts to implementation over the coming years, decisions will take account of the position at the time, and the developing recovery paradigm.

Our proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE, excluded these impacts from our baseline data, staffing models, resource requirements and finances.

3.2.2 *Joint Strategic Needs Assessment & Joint Health and Wellbeing Strategy*

The Gloucestershire Joint Health and Wellbeing Strategy 2019-2030[10] (JHWS) sets out the plans to address our seven Health and Wellbeing Board priorities:

- Physical activity
- Adverse childhood experiences (ACEs)
- Mental wellbeing
- Social isolation and loneliness
- Healthy lifestyles
- Early years and best start in life
- Housing

As an ICS we recognise that our JHWS is intrinsically linked to our response to the NHS Long-Term Plan (LTP) and the services included within this document should not be seen in isolation from all the other developments that support the delivery of our JHWS and address the issues and challenges identified in our Joint Strategic Needs Assessment 2017 (JSNA)[11] . Our JSNA does highlight that Gloucestershire has an ageing population, with a higher and growing number and proportion of older people and this is developed as part of our Case for Change

3.3 Local Providers Context

The One Gloucestershire ICS structure is presented in section 3.1 and includes the following organisations, NHS Gloucestershire Integrated Care Board, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire County Council, South Western Ambulance Service Foundation Trust and Gloucestershire Health and Care Services NHS Foundation Trust.

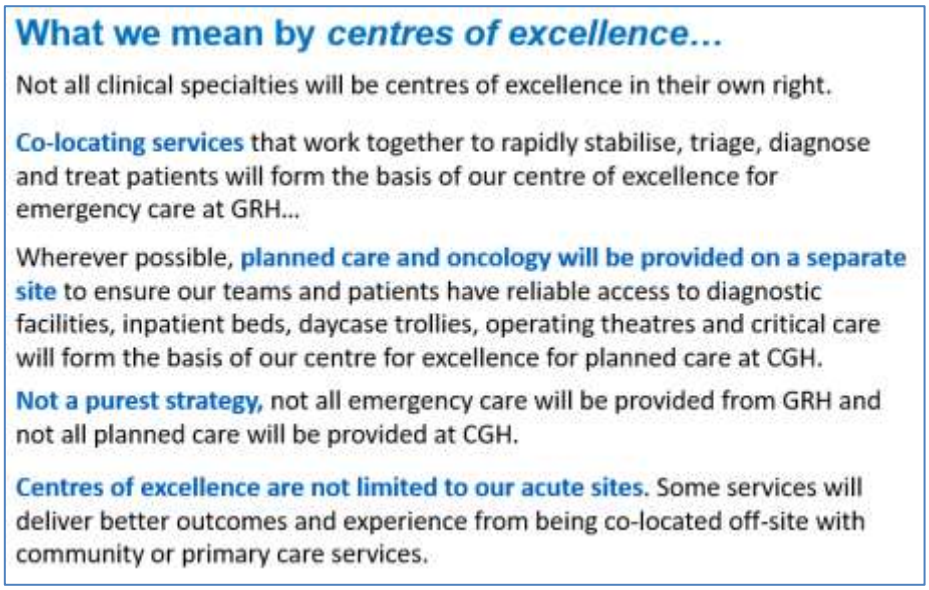
[10] Gloucestershire Joint Health and Wellbeing Strategy 2019-2030 can be found in Appendix 2

[11] Gloucestershire Joint Strategic Needs Assessment (2017) can be found in Appendix 3

3.4 Introduction to the Fit for the Future Programme

As part of our response to the NHS Long Term Plan and commitment to the public in Gloucestershire, when patients require specialist care, we believe they should receive treatment in centres with the right specialist staff, skills and equipment by delivering care that is fit for the future.

Our FFTF Programme includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospital sites. Our *Centres of Excellence* vision for the future configuration of specialist hospital services with GRH focussing more (but not exclusively) on emergency care, paediatrics, and obstetrics and CGH focussing more (but not exclusively) on planned care and oncology. Across the UK and the world, it is recognised that an element of separation between planned and emergency care services can improve care for everyone.



3.4.1 *National drivers/context*

This section sets out the national context in which this FFTF2 business case has been developed.

The *Centres of Excellence* programme envisions that some specialties will have a greater separation of urgent care and planned care to improve availability of beds, access to appropriate senior staff, ensure fewer cancelled operations and improve waiting times. The benefits of separating planned and unplanned activity are cited by a number of sources.

The Royal College of Surgeons of England (RCS) recommends separating planned surgical admissions from emergency admissions (ideally on a single site), suggesting that this can result in earlier investigation, definitive treatment and better continuity of care, as well as reducing hospital-acquired infections and length of stay (particularly medical emergencies) wherever possible.[12] The King's Fund also states that professional guidance, as well as the available research evidence, support the separation of planned from emergency surgery (either geographically or through the provision of dedicated facilities and staff).

The NHS Long Term Plan[13] states that separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing emergency care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. NHS England has confirmed that it will continue to support hospitals that wish to pursue this model.

The NHS England Transforming Urgent and Emergency Care Services in England guide for local health and social care communities (2015) states that:

- Getting patients to definitive, specialist hospital care can be more important to outcomes than getting them to the nearest hospital for certain conditions, such as stroke, major trauma and heart attacks.
- In an emergency, patients should be seen by a senior clinical decision maker as soon as possible. This improves outcomes and reduces length of stay, hospitalisation rates and cost.
- Acute assessment units (which co-ordinate tests and input from the different hospital specialist teams) enhance patient safety, improve outcomes and reduce length of stay.

3.5 Fit for the Future: Phase 1

FFTF Phase 1 completed its Stage 2 review in September 2020 and the Decision-Making Business Case (DMBC) was approved in March 2021. The reconfigurations agreed in Phase 1 are presented overleaf, including their implementation status which is linked to GHNHSFTs Strategic Site Development (SSD) programme. This has allowed us to phase the implementation of the proposals contained within FFTF, ensuring that the necessary facilities and infrastructure are in place to support the reconfiguration of services.

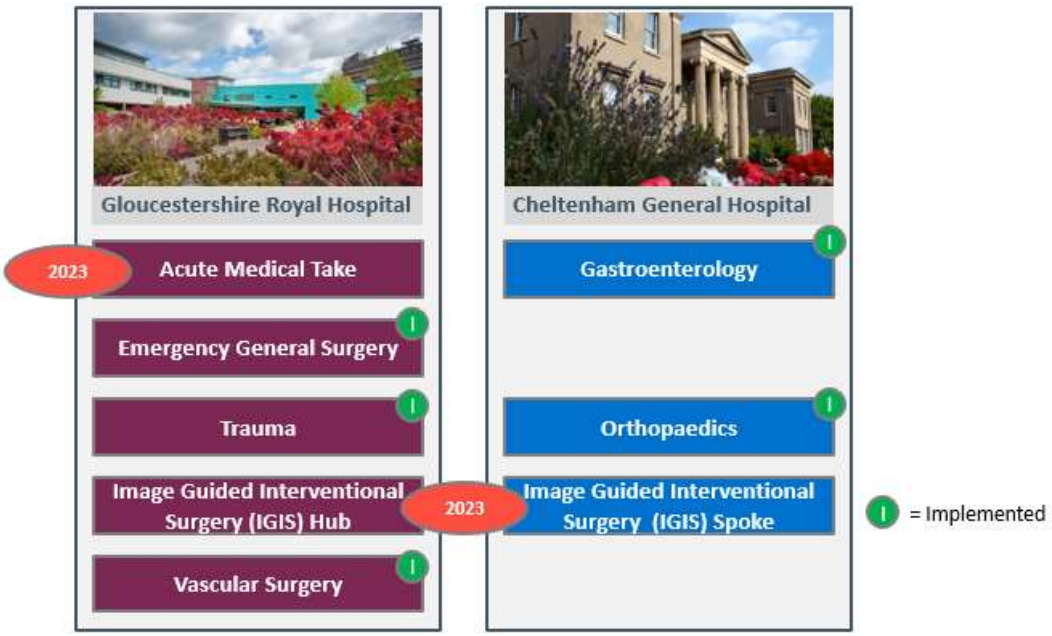
[12] RCS referenced in King's Fund (2014) https://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/elective-surgical

[13] NHS (2019) https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

The SSD programme includes two additional theatres and a Day Surgery Unit at CGH; the new facilities will improve patient experience, reduce waiting lists and result in fewer operations being cancelled. GRH will benefit from an improved Emergency Department and acute medical care facilities designed to speed up diagnosis, assessment and treatment. There will be a redesigned outpatients and fracture clinic accommodation for orthopaedic outpatients, additional x-ray capacity and a programme of ward refurbishment. The current timescales (subject to change) for completion of key GSSD developments are:

- GRH Gallery wing – creation of additional inpatient ward facilities -– Completed
- CGH Day case unit - April 2023
- GRH Catheter Labs - September 23
- CGH Theatres - October 2023
- GRH Expanded Emergency Department (ED)
    - Phase 2A (New Minors/Fractures) and 2B (Majors) – Completed
    - Phase 5b (Existing ED refurbishment) –June 2023.
- GRH Acute Medical Unit
    - AMU 2 (single side room with ensuite) –February 2023
    - AMU 1 (x15 bed spaces) –May 2023.

FFTF Phase 1 Service re-configurations



The benefits to services included in Phase 1 were designed to:

- Improve health outcomes for patients
- Make sure patients are always assessed by the right hospital specialist (e.g., doctor) with timely decisions about their treatment and care
- Ensure there are always safe staffing levels, including senior doctors available 24/7 and teams have the best equipment and facilities
- Reduce waiting times and limit the number of operations that are cancelled
- Support joint working between services to reduce the number of hospital visits people have to make

- Create flagship centres for research, training and learning - attracting and keeping the best staff in Gloucestershire
- Deliver more specialist services in Gloucestershire to enable people to receive care locally rather than travelling to Bristol, Birmingham and Oxford as they do now.

For the services implemented we are delivering many of the benefits described in our FFTF1 DMBC; details can be found in Appendix 4b. We continue to work on the realisation of the FFTF1 benefits and these will be added to as we implement the remaining FFTF1 service reconfigurations in 2023.

All our Phase 1 documents (including the DMBC) can be found at Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

With these Phase 1 changes agreed and the principle of a greater separation of emergency and planned care established, the programme developed Phase 2 reconfigurations that fit with this model, which are subject of this decision-making business case.

3.5.1 *Planned General Surgery*

The only FFTF Phase 1 service not covered above is Planned General Surgery. Prior to the DMBC approval process, GHNHSFT Trust Leadership Team (TLT) explored in detail the configuration options for Lower GI (colorectal) surgery, and it was evident as a result of the debate, which considered feedback received during FFTF1 public engagement and consultation, that there was an alternative, potentially even better option, that includes the best elements from the two options presented during consultation and notably the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. Since then, significant work has been undertaken and further proposals presented, and decisions made, by TLT (November 2022). The latest position is that the division are developing a decision-making business case to cover the following:

1. The creation of dedicated Gastrointestinal day surgery lists at CGH.
2. The creation of specialised centres at CGH for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer.
3. Co-location of all resectional Upper Gastrointestinal Surgery at GRH
4. Co-location of all Colorectal resectional surgery at GRH.

The benefits of this proposal include greater numbers of patients within the Centres of Excellence model making use of the new Day Surgery unit in Cheltenham, reduction of cancellation for bed pressures- especially when the new theatres are completed in 2023 and the creation of highly specialised units to maximise efficient theatre lists and reduce cancellation.

It should be noted that there are no dependencies between this last remaining FFTF Phase 1 service change and our proposals in FFTF Phase 2.

3.6 Fit for the Future: Phase 2

'Fit for the Future - 2' is not only about the continued development of the '*Centres of Excellence*' approach and how we organise specialist hospital care at CGH and GRH, in some cases it's also about how we can improve the wider journey of care (pathway) for the person who needs services or support.

The services we focus on in FFTF2 are:

- Benign Gynaecology *[14]
- Diabetes and Endocrinology *
- Non-interventional Cardiology
- Respiratory *
- Stroke *

Each of the services will be covered in detail in their individual sections. In developing our FFTF2 programme we sought to look at the whole pathway for some services rather than a focus only GHNHSFT services, as was the case in FFTF1.

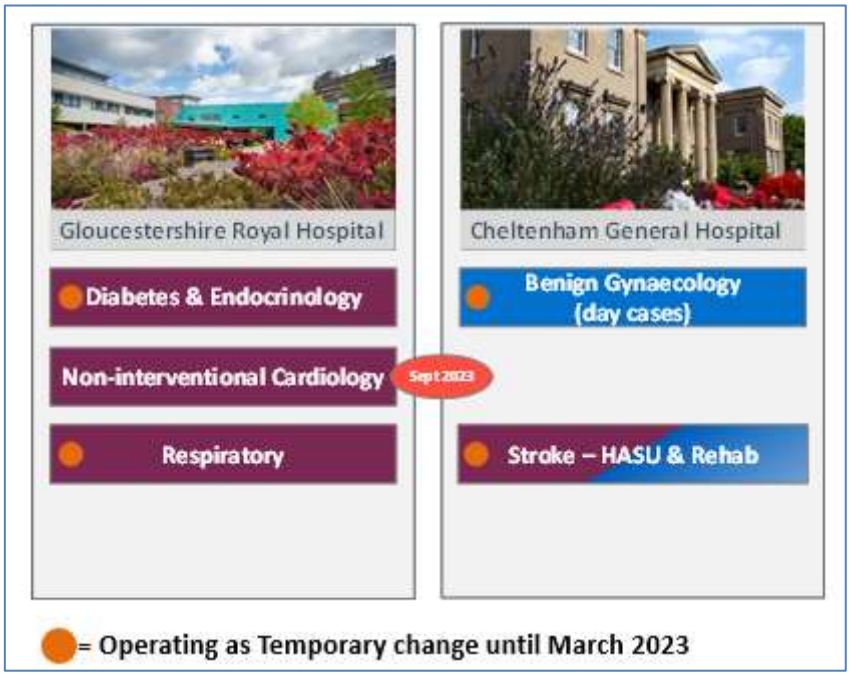
When we are looking at how, when and where we support, or provide healthcare to someone, there are a number of things we need to think about:

How we can provide the very best care for people at each stage of their illness or injury i.e., very specialist care for people when they are very unwell, rehabilitation support for people to help them recover and regain their independence, e.g., from an operation or other treatment and - in many cases - follow up care and support over the longer term

Opportunities to join up care (integration) - improve communication and make care simpler and smoother across services and communities. This could be:

- between related services in a hospital
- between GP surgeries and community or hospital services
- between health and social care services and;
- between the NHS, social care and other key community partners, e.g., local councils, voluntary and community groups and others.

How we tackle health inequalities, i.e., ensure that we improve health outcomes for everyone - regardless of where they live in the county and their social, environmental or economic circumstances.



[14] *Currently subject to Temporary Service Change (for details see individual service sections)

One of the services included in our FFTF2 engagement (see section 4), was Frailty/Care of The Elderly as we wanted to take the opportunity to hear from the public, patients and staff about their experiences of current services. However, the potential developments and improvements to the frailty pathway would not be subject to the statutory duty requirements co-ordinated by the FFTF Programme. For this reason, Frailty/Care of The Elderly is not included in this DMBC.

The only other temporary service change not covered in FFTF2 is the re-location of the Medical Day Unit at CGH. It was not part of our FFTF2 engagement and is being managed as a separate process.

It is also important to state what Fit for the Future 2 (FFTF2) is not about. It is not about:

- Saving money. The priority is quality of care and health outcomes
- FFTF1 - the public consultation in 2020, past decisions and the service changes that are now being implemented
- The Accident and Emergency Department in Cheltenham, which remains a 24-hour A&E (nurse led service overnight 8pm to 8am).

Key Points

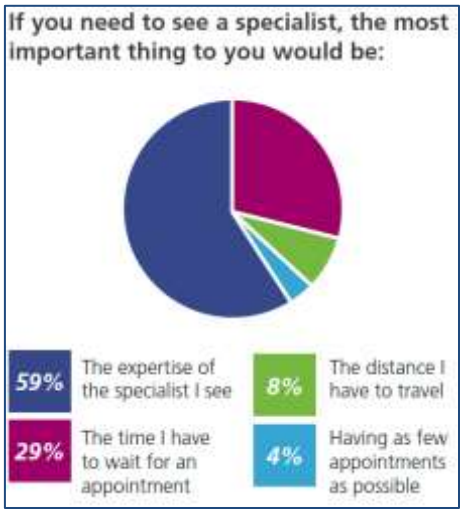
- **Fit for the Future (FFTF) is a key element of our ICS Integrated Delivery Plan**
- **FFTF links with our ICS Clinical Programme Groups to deliver whole pathway transformation.**
- **FFTF is part of our response to the NHS Long Term Plan delivering our Centres of Excellence vision for the future configuration of specialist hospital services at GRH and CGH.**
- **The FFTF Programme has two phases (FFTF 1 & 2), working closely with the GHNHSFT Strategic Site Development, to deliver benefits to our population.**

4 Public, Patient and Staff Engagement

In this section we seek to demonstrate that the Fit for the Future2 (FFTF2) programme has built on the extensive engagement and consultation activities for FFTF Phase 1, which clearly identified that there is high recognition of *Centres of Excellence* amongst those responding to our surveys. In addition, many respondents to our FFTF1 Consultation felt that the centralising of services would optimise care quality, increase staff retention and learning for staff which would result in reduced waiting times and cancellations.

Furthermore, as part of developing our local plans for Gloucestershire over the last few years, we have been asking staff, patients, carers, public and community partners, what matters to them about local health and care services

- 69% of respondents agreed we should bring some specialist hospital services together in one place
- A significant proportion felt the expertise of the specialist was more important than distance to travel (see opposite).



It is our contention that FFTF2 has engaged inclusively[15], innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services. In doing so we believe we have met the requirements of NHSE Guidance:

- Robust public involvement;
- To be proactive to local populations;
- To be accessible and convenient;
- To consider different information and communication needs, and;
- To involve clinicians.

Our learning from the Phase 1 consultation highlighted the benefits of new channels of communication with the public (as a result of COVID restrictions), and our engagement for Phase 2 included blended approach of face to face and virtual.

The FFTF2 public and staff engagement programme started in May 2022 (until 31/07/22), to seek views on the future provision of specialist hospital care in Gloucestershire. The full Output of Engagement report can be found in Appendix 1, and details all the engagement activities, full demographic analysis of survey respondents and all quantitative data. As stated in section 0 the report has been widely shared and formally reviewed by NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), NHSE and Gloucestershire Health Overview and Scrutiny Committee (HOSC).

A brief summary is presented in this section.

[15] See Appendix 1 OoE - section 5.5 Engaging people with protected characteristics and others identified in the Integrated Impact Analysis and individual service IIAs (Appendix 13)

4.1 Engagement Materials

The engagement programme produced and utilised the following:

Engagement Booklet (Long)	Engagement Booklet (Short)
Engagement Booklet (Easy Read)	Display materials
An Engagement questionnaire/survey (online and hard copy)	Range of videos (with local clinicians explaining each of the service proposals)
Frequently asked questions	

4.2 Engagement activities

A range of communications channels have been used including:

Gloucestershire Hospitals: Facebook Live (@GlosHospitals)	Targeted engagement to address the homogeneity of participants
'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform	GHNHSFT staff FFTF2 events plus presentations and awareness raising at team, divisional and Trust-wide meetings
NHS Information Bus Tour	Public events
A phased communication campaign for GHNHSFT staff using existing channels (CEO briefing etc.), weekly FFTF2 service focus emails, posters across both hospital sites, booklet drops to teams and Q&A sessions.	Presentations to Integrated Locality Partnerships; ILPs are operational and strategic partnership of senior leaders of providers and local government, supporting integration at PCN level
Healthwatch Gloucestershire	Presentations to local councillors
Presentations to PCN clinical leads	Media releases and stakeholder briefings
Media (print and social) advertising	

4.2.1 *Staff Communication and Engagement*

Details of staff engagement activities referred to above are provided in Appendix 1 and feedback themes from staff are included in both this section and in the individual service sections.

It is important to note that, following feedback from staff during FFTF1 we adapted our survey categorisation nomenclature and also enhanced and improved our staff engagement campaign for FFTF2. We had a very good response from staff to our survey, at 43% respondents (i.e., excluding those not completing or "preferring not to say").

Informal feedback from staff has been that FFTF2 staff engagement was better than FFTF1.

4.3 Quantitative Analysis

Full details are in the individual service sections (6-10) and indicate a strong level of support for all service ideas, summarised in the table below:

Service	Support	Oppose
Benign Gynaecology	92%	8%
Diabetes and Endocrinology	98%	2%
Non-interventional Cardiology	99%	1%
Respiratory	97%	3%
Stroke	84%	16%

4.4 Qualitative Analysis - Engagement feedback themes

Details of the responses and themes is provided for each of the services in sections, however, a number of themes were consistent across all services; these included:

4.4.1.1 Public and Patients themes

- Support for Centres of Excellence approach
- Travel and Transport
- Car parking
- Ward environment

4.4.1.2 Staff themes

- Benefits of the Centres of Excellence approach
- Travel and Transport
- Car parking for patients
- Health inequalities
- Interdependencies with other clinical services
- Improved integration with primary and community services

4.5 Other Stakeholders

4.5.1 *Neighbouring ICBs and Health Boards*

The FFTF Programme team have been in contact with neighbouring ICBs at the start of our engagement to encourage them and their residents to participate. We have shared information on the programme scope, exchanging of activity information and agreements to build relationships and share information as the preferred option(s) are finalised.

The overall activity numbers for FFTF2 are considerably lower than FFTF1 and the impact on patients registered outside Glos. is similarly reduced. We also look at patients per practice and have contacted the practices direct (those >4). This is summarised in the table below.

ICB and Health Boards	Activity	Practices >4
Aneurin Bevan University Health Board	65	3
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board	16	13
NHS Coventry and Warwickshire Integrated Care Board	2	1
NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	6	2
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	29	24
NHS Herefordshire and Worcestershire Integrated Care Board	200	41

4.5.2 *Health Overview and Scrutiny Committee*

Throughout both the Fit for the Future Programmes regular updates on the FFTF programme and engagement have been provided to the Gloucestershire Health Overview and Scrutiny Committee (HOSC), with the Output of Engagement report will be presented and discussed with members in October 2022.

4.5.3 *MPs*

The ICS Executives are in regular communication with local MPs, and this has included proposals within scope of the Fit for the Future Programme.

Key Points

- **Fit for the Future 2 (FFTF2) built on the extensive engagement and consultation activities for FFTF Phase 1**
- **FFTF2 has engaged inclusively, innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services.**
- **Engagement responses indicate strong support for our proposals.**

5 Information for all FFTF2 Service Proposals

As described in Section 3.6 there are five services in scope for Fit for the Future (FFTF) Phase 2 and, whilst all are aligned to our strategy, the drivers for change vary across each service.

This section provides information on aspects common to all proposals whilst the following sections provide information for each individual service change proposal, covering:

- The "current state" service model
- Clinical engagement
- Case for change, the problem we are seeking to address
- Clinical evidence
- Our preferred option for "future state" and the work done to assess
- Benefits
- Interdependencies
- Workforce
- Learning from temporary service change period (where applicable)
- South West Clinical Senate review
- Engagement feedback
- Addressing themes from engagement.

5.1 South West Clinical Senate Review

The FFTF programme has worked closely with the South West Clinical Senate through Phases 1 and 2 and greatly values the Senate's input to provide an independent clinical review of large-scale service changes, to ensure there is a clear clinical basis underpinning any proposals for reconfiguration. The senate also check whether proposals for large scale service change meet the Department of Health's tests for service change, particularly the clinical model and the evidence base (and the bed test where relevant).

Details of the Senate Clinical Review Panel (including the full report) would usually be contained with a PCBC but, as detailed in section 2.2, we are using a single-step business case and therefore have included both the report and a summary in the DMBC.

5.1.1 *Senate Review Process*

The review is undertaken in two stages:

1. **Stage 1 Sense-Check /Desktop Review by Senate**: completed via desktop by a small (4-6) 'virtual' panel of Senate Clinicians. The Desktop Review Report (received 28/06/22) raised a number of questions and details of these and our responses are presented in the relevant service sections (0 - 0).
2. **Clinical Review Panel** (10/08/22): This brings together a panel of out of area clinicians relevant to the service areas and our clinical leads for the proposed models to present the model of care, followed by questions and discussion with the panel. The Clinical Review Report (received 15/09/22), is in Appendix 5, a brief summary is provided in the section below, and our comments are presented in the relevant service sections.

5.1.2 *Clinical Review Panel summary*

Full details can be found in the report and those specific to each service are contained in the relevant sections, however there were a number of general findings:

The Panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.

- The Panel did not have any concerns about the proposals from an access, equality, or diversity perspective.
- Some of the proposed service changes were introduced as temporary measures as part of the response to the COVID pandemic and the Trust has had the opportunity to learn from this.
- Some of the proposed service changes have impacts outside the services included in the scope and these have been considered alongside the specific proposals.
- The panel was reassured that the Trust has ensured that all specialities providing specialty medical consultation services at CGH have included this work in consultant job planning. The panel believes that it is essential that this continues in the future.

The panel report also included specific points that would need to be factored into the implementation plans, for both Phase 1 and Phase 2 of the FFTF Programme. Details can be found in the report (Appendix 5) but can be summarised as:

- The management and monitoring of inter-site ambulance transfers (see section 5.6)
- Preparations for the centralisation of the acute medical take to GRH including medical cover at CGH, SWASFT protocols and acuity of Emergency Department walk-in patients (see section 15)
- Workforce (see section 5.4)
- Bed modelling (see section 5.7)
- Stroke (see section 10), and
- Communication (see section 15.4)

5.2 Options Evaluation Process

5.2.1 *A structured process was used to identify options*

The Fit for the Future Programme has, from the outset, had a clear process in place to develop its clinical models through a combination of innovative ways to involve local people and staff (from a survey and 'drop in' events, independently facilitated workshops, an engagement hearing, and culminating in an inclusive and transparent solutions appraisal process), a clear governance structure and agreed and delivered outputs.

The process was initially developed as part of Phase 1; details are available in the Phase 1 Pre-Consultation Business Case (Fit for the Future | Get Involved In Gloucestershire (glos.nhs.uk) and has been adapted for Phase 2. This is a two-stage process using hurdle/ essential criteria to a long-list and then desirable criteria to the medium/short-list to identify the preferred option. In a summary our process involves:

- **Building a clear Case for Change** - This involved describing the local population's health and care needs now and into the future, setting out how services are currently provided and highlighting the challenges faced by current health and care services now and in the future as they seek to meet the needs of our local population.
- **Defining evaluation criteria**, against which different *Centres of Excellence* models for the future have been assessed. These were heavily shaped by feedback from the pre-consultation engagement phase.
- **Developing best practice care pathways and models of care**. This first involved drawing on local, national and international exemplars.

- The **shortlisted options** have been evaluated against the agreed criteria; detailed in individual service sections.
- The **preferred options** have been tested for safety, feasibility and viability both internally (by the ICS and organisational governance) and review by the South West Clinical Senate and NHSE.

5.2.2 *Hurdle Criteria*

Hurdle criteria are applied by the individual services (with support from the FFTF programme team) at a dedicated service meetings and confirmed by the relevant Divisional meeting. The criteria were developed in Phase 1 following engagement feedback and are:

- Address the issues identified in the Case for Change
- Supports the delivery of high-quality care across Gloucestershire, ensuring provision of a clinically safe service.
- Achievable and able to be delivered in a timely and sustainable way.
- Affordable and offers best value for money, making the most of the Gloucestershire pound
- Supports sustainable ways of working and facilitates both recruitment and retention of our workforce.

5.2.3 *Desirable Criteria*

There are a number of domains (each with a sub-set of questions), including:

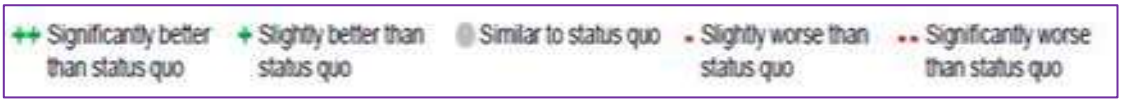
Quality of care (10 questions)
This section included questions to evaluate clinical effectiveness, patient outcomes, patient and carer experience, continuity of care, the quality of the care environment, self-care, patient transfers, travel time impact and the management of risk.
Access to care (10 questions)
This section included questions to evaluate the impact on patient choice, simplifying the offer to patients, travel burden for patients, carers and families, waiting times, supporting the use of new technology to improve access, improving or maintaining service operating hours and locations, impact on equality and health inequalities and accounting for future changes in population size and demographics.
Deliverability (8 questions)
This section included questions to evaluate the expected time to deliver, meeting the relevant national, regional or local delivery timescales, access to the required staffing capacity and capability, support services, premises/estates and technology to be successfully implemented.
Workforce (12 questions)
This section included questions to evaluate the impact on workforce capacity / resilience, optimising the efficient and effective use of clinical staff, cross-organisational working across the patient pathway, flexible deployment of staff and the development of innovative staffing models, staff health and wellbeing, recruitment and retention, maintaining or improving the availability of trainers, enabling staff to maintain or enhance their capabilities/ competencies, the travel burden for staff and clinical supervision.

Strategic fit (2 questions)
This section included questions to evaluate compatibility with the One Gloucestershire vision and the NHS Long Term Plan
Acceptability (1 question)
This question seeks to evaluate if the model has satisfactorily considered the FFTF engagement feedback.

5.2.4 *Assessment Process*

The process used by the FFTF programme is to arrange workshops, both in person and virtual (as requested by our FFTF Lay Reference Group), consisting of clinical and operational staff from each service, members of the public, stakeholders, GPs and organisational and system leadership.

The proposals are assessed using the desirable criteria and the assessment method we use is to compare proposals to the status quo and record if:



Scorers were provided in advance with a range of information for each of the services being evaluated including:

- Service description
- Service Change Proposal
- Case for Change
- Impact summary
- Evidence to support scoring – description of “what would be better” and “what would be worse” for every question
- Clinical Senate Desk-top Review feedback
- Integrated Impact Assessment including travel impact analysis

The scoring is normally a two stage process:

1. **Online questionnaire**: all the information is sent in advance and scorers complete individual assessments (including comments), of the solutions/models they had been allocated, prior to the workshop.
2. **Workshop consensus**: in-person workshops are held with each table reviewing a number of service proposals where:
    - scorers were given copies of their assessments
    - facilitators share the online results for each question
    - A discussion takes place referencing the workshop information and comments
    - A consensus score and any comments are agreed and recorded

Unfortunately, due to the ongoing system pressures, rising COVID and the heatwave in mid-July (when events had been booked 10 weeks in advance for clinical colleagues), GHNHSFT declared a Business Continuity Incident (BCI) on one of the workshop dates. Given the notice requirements for clinical staff and the deadline for clinical senate submission, in

agreement with NHSE, for two of the service change proposals we reverted to using the on-line responses from scorers and these have been reviewed and summarised by the FFTF Programme Director for inclusion in the relevant service sections.

The overall status is presented below:

Stroke	Evaluated in virtual workshop and consensus scores agreed
Respiratory	Evaluated in virtual workshop and consensus scores agreed
Diabetes and Endocrinology	Evaluated in virtual workshop and consensus scores agreed
Non-interventional Cardiology	Evaluated individually online and reviewed/ summarised by Programme Director
Benign Gynaecology	Evaluated individually online and reviewed/ summarised by Programme Director

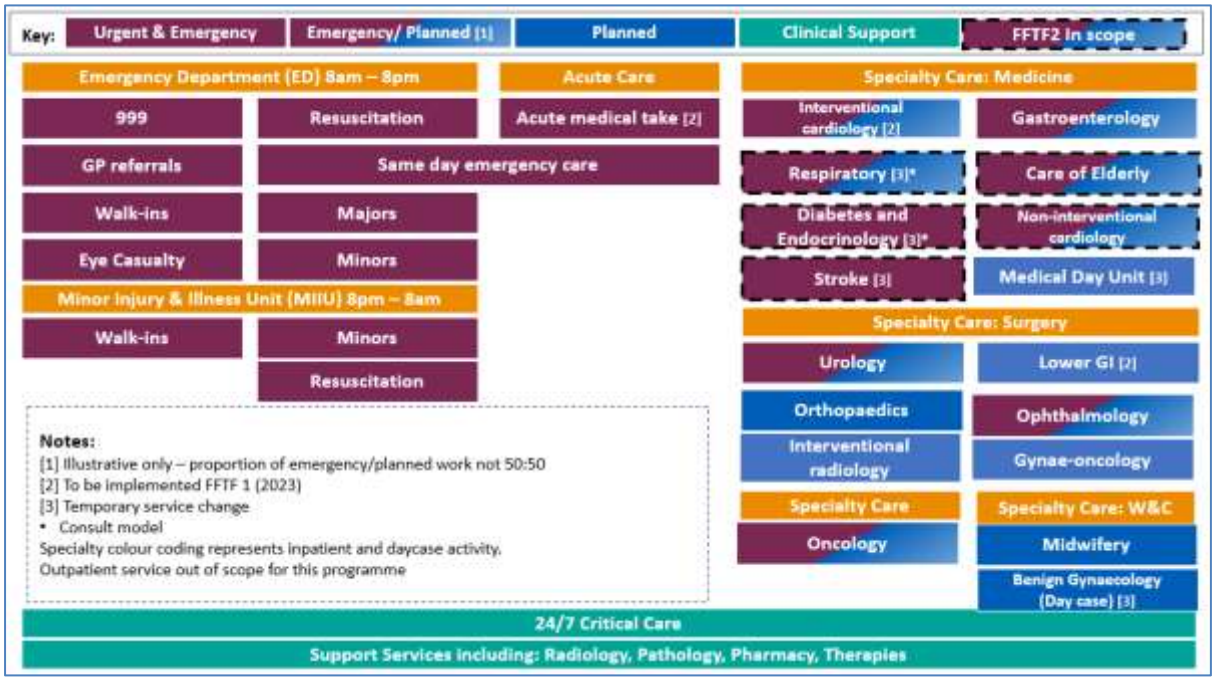
5.3 GHNHSFT Service locations

For context and completeness, we have included a summary of the "current state" and "future state" services at each site. This is, however, made complex as we need to take account of:

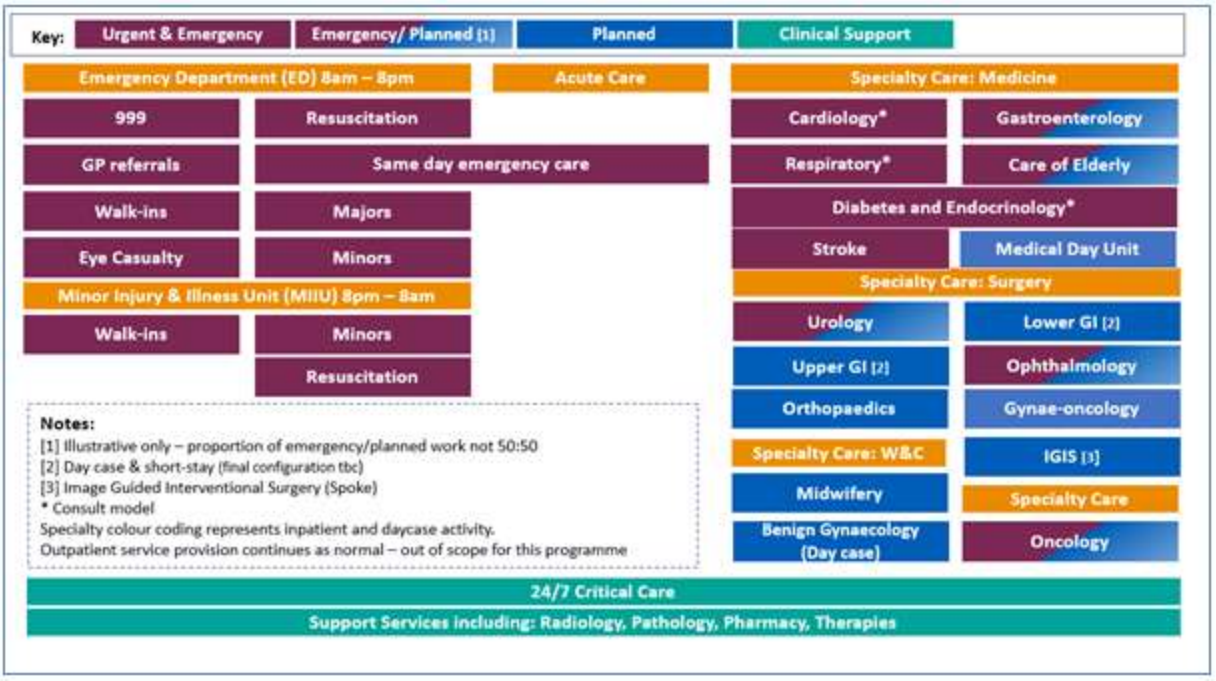
- FFTF1 services that are to be implemented in 2023
- FFTF2 services that are operating as temporary service changes.

The schematics below represent the "current state" location of services as of February 2023 and the "future state" when FFTF1 and FFTF 2 services are implemented.

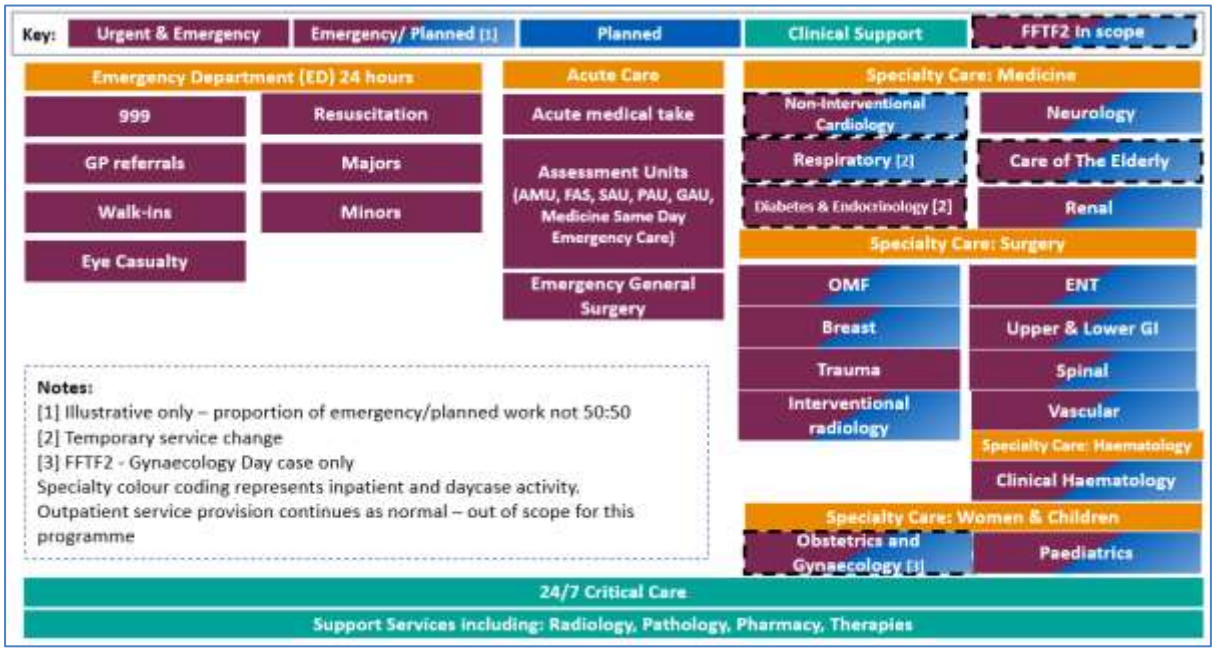
5.3.1 *Cheltenham General Hospital (CGH) current state*



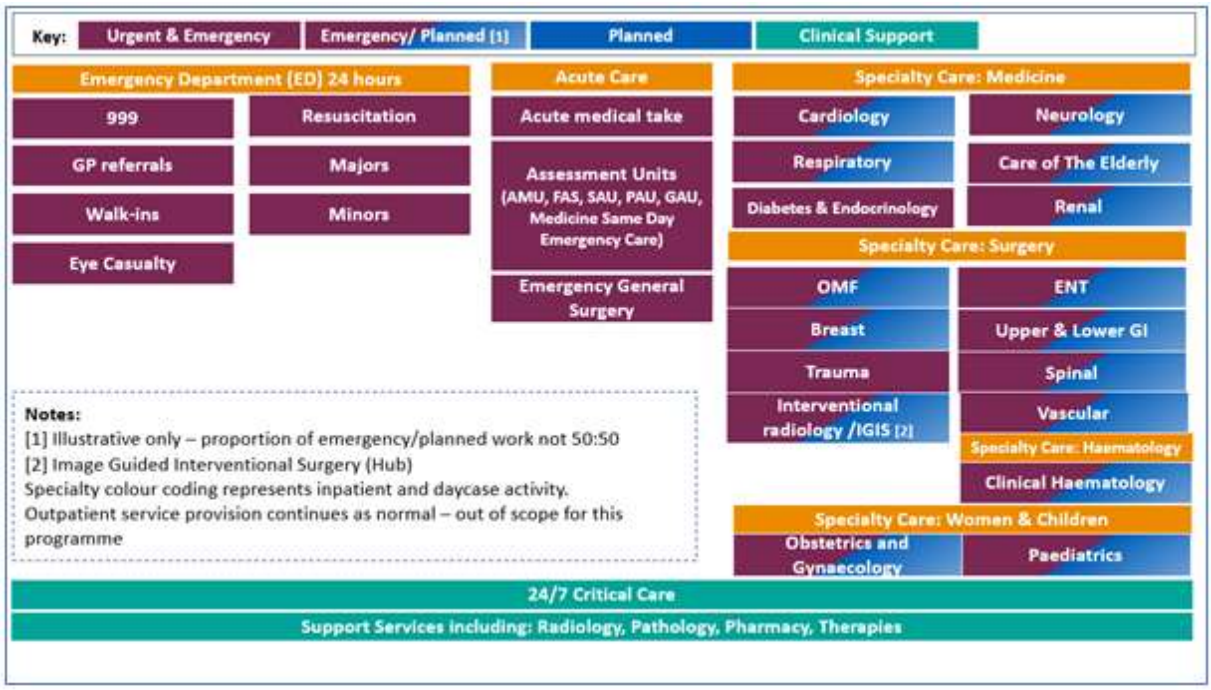
5.3.2 *Cheltenham General Hospital (CGH) future state*



5.3.3 *Gloucestershire Royal Hospital (GRH) current state*



5.3.4 *Gloucestershire Royal Hospital (GRH) future state*



5.4 Workforce

The ICS partners, as sponsors of this DMBC, are fully cognisant of the indispensable role that our staff have in the delivery of the proposed changes. GHNHSFTs People and Organisational Development Strategy sets out the trusts' direction of travel to 2024 in terms of its staff and is centred around the ethos of *"Caring for those who Care".* The NHS Long Term Plan sets out how we will transform models of care over a 5 year period with the People Plan 2020/2021[16] setting out the workforce transformation needed to deliver 21st century care including an initiative to "release time to care", all linked to the NHS Long Term Plan. Great emphasis is also placed on staff development, health and wellbeing and work life balance including a far more flexible approach to working patterns etc.

We are committed to supporting and developing our staff and fully endorse the NHS Long Term Plan ethos of ensuring we have "*…enough people with the right skills and experience so that staff have the time they need to care for patients well"* **(NHS long Term Plan).** All of this has underpinned our approach in respect of the workforce plans for Centres of Excellence.

We recognise that changes to location and ways of working can have a positive and negative impact on job satisfaction, morale, retention and travel time and cost. Staff affected will include those working directly in the services in scope and there may be some changes for staff working in support services.

Defining the long term configuration, co-location with other clinical services and supporting estate and equipment investment will help to improve recruitment and retention in services in scope. A change in site will also have a differential impact on staff with some colleagues seeing an increase in travel time and costs and some seeing a reduction.

[16] NHS people has been further prioritised in the national planning guidance for 2021/22 and 2022/23, and work continues to develop for the longer term

5.4.1 *Staff Engagement if a decision is made to implement proposed models*

As indicated in the section above, of the five services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes (some since June 2020 and others from Feb 2022). Staff working arrangements have been agreed and put in place. If a decision is made to approve the proposals in this DMBC, in addition to the staff engagement detailed in section 4, further staff engagement will be undertaken for all services, either confirming the current locations and working arrangements (four services) or the proposed service change (1 service); the methodology is described below.

Managers will use team and one to one meetings to understand individual and team preferences on location or specialty. Staff wishing to remain within their current Division, e.g., Surgery, Medicine etc., will be accommodated and, wherever possible, within their current specific speciality. The objective will be to accommodate preferences wherever possible, i.e., stay on the same ward or site, stay together as a team or stay with the specialty (so move with the service) and this will be achieved through vacancy management which will form part of any implementation plan.

As staff are required to work across sites, relocation is not anticipated to be a contractual issue, but we recognise that there may be individual needs or concerns which will need to be accommodated and these will be raised with the HR Advisory and HR Business Partner (HRBP) team to resolve, e.g., travel issues and child care.

A staff briefing document will be provided to Managers to support these conversations and ensure consistency of message and will be sent to Staff Side for review. Feedback on the proposals will be captured on a standard form. A Frequently asked questions (FAQs) will also be provided.

Our approach is to encourage staff to talk to their line manager throughout the process to discuss individual issues or circumstances and if further support is required staff can seek advice from the HR Advisory Service, staff side representative or for staff wellbeing and psychological support through the GHNHSFT 2020 Hub.

To support the process, we will ensure regular communication between each affected HRBP with oversight by the Director of People and OD. This will ensure that we have early sight of any issues including if the messaging has been adequate and consistent and if there are any issues to implementation. Any inconsistencies or areas of concern will be escalated to the Divisional Tri and relevant HRBP and the team will be proactive in meeting colleagues and staff groups where necessary.

5.4.2 *Workforce PlanningApproach*

The FFTF Programme, working with HR, clinical and operational colleagues, uses a workforce planning approach to model the workforce requirements of service change proposals. This was followed for FFTF1, where there were significant workforce changes and has been used proportionately for FFTF2, in recognition of the significantly smaller scale of workforce changes.

Critical to workforce planning is identifying demand and capacity and this has been central to the work underpinning this DMBC. Workforce planning is an essential element of any Business Planning Cycle and as such a crucial building block in the Operational planning for FFTF and establishing Centres of Excellence. In line with NHS directorate and Trust guidance the overall test is that we comply with the Safer Staffing requirements as detailed in National Quality Board (NQB) guidelines.

Ratio of staff to patients

When considering ratio of staff to patients a number of the NHS related recognised measuring tools were applied dependent upon speciality/professional staff group/expertise etc. GHNHSFT has an established process in terms of review of nursing (both registered and unregistered) that is undertaken annually with a bi annual review. In addition, an essential component of workforce planning is the "do ability" factor including:

- Application of uplift to ensure adequate cover for absence such as annual leave and training
- Legal compliance such as working time directive
- Rotas particularly in relation to sustainability of a rota

5.4.3 *Recruitment and Retention*

A key theme for the public, and core to our Case for Change, is the impact of proposed changes on clinical staff numbers, recruitment and retention and examples of our workforce challenges are detailed in the individual service sections, noting the scale of recruitment for Phase 2 is only 3.5 FTE, linked to Respiratory High Care (section 9).

The development and appraisal of our proposals have included the requirement to support sustainable ways of working and facilitate both recruitment and retention of our workforce.

If proposals are approved a planned phased approach to recruitment will be applied; with identified sources of pipeline and any marketing/advertising identified and planned. In terms of *best for patient and best for staff* having substantive staff in place is best all-round and therefore any required recruitment will be structured in such a way to minimise the use of locum/agency/bank.

In the FFTF2 service specific sections we detail how each proposed new clinical option will positively impact our workforce challenges including centralisation of services to avoid splitting resources across two hospital sites which we believe contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention and efficient use of resources.

5.4.4 *Training çincluding new roles/ways of woļ ƛ ƴ Ǝ Ω NJ Ŝ I· t ƛ Ǝ ƴ Ƴ Ŝ ƴ ű ž upskilling*

We are committed to providing training, development and support to our staff. Any change in job role/area or working conditions such as equipment etc. would be identified and individual and personalised skills analysis work undertaken to identify skills and any gaps/upskilling required.

Where specialities are centralised on a particular site this will enhance the training and support offered to staff. It will also form closer working relationship and peer support which is a positive. For mentors this will prove invaluable in terms of easier access to those they are mentoring and vice versa.

5.4.4.1 Developing Advanced Clinical Practitioner roles

At GHNHSFT there has, for many years been opportunities for advanced level working with Consultant Nurses in Vascular, Trauma and Orthopaedics, Oncology, and Neurology and a Consultant Physiotherapist in MSK and a new appointment Consultant Paramedic in Emergency Department. There have previously been many Nursing, Therapy and Pharmacy Staff undertaking a variety of roles extending their scope of practice with variation in titles and educational pathways. However, since development of a GHNHSFT shared decision-

making council in December 2020 to discuss and debate further there resulted in successful completion of a Trust Policy in Advanced Practice first version September 2021. The Policy aligned to Health Education England definitions and education and supervision guidance has allowed scoping. A new One Gloucestershire Advanced Practice Lead Role from April 2022 drives a current workplan to formalise and develop the Advanced Clinical Practitioners (ACP) role within a safely governed framework.

Health Education England published the first Multi-Professional Framework for Advanced Practice in 2017. Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Master's level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.

The benefits of this structure are that there is a defined level of practice within clinical professions such as nursing, pharmacy, paramedics and occupational therapy. This level of practice is designed to transform and modernise pathways of care, enabling the safe and effective sharing of skills across traditional professional boundaries.

Advanced clinical practitioners (ACPs) are healthcare professionals, educated to Master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for. ACPs are deployed across all healthcare settings and work at a level of advanced clinical practice that pulls together the four ACP pillars of clinical practice, leadership and management, education and research.

A definition of ACP, its underpinning standards and governance, can be found in the Multi-professional framework for advanced clinical practice in England. The framework ensures there is national consistency in the level of practice across multi-professional roles that is clearly understood by the public, advanced clinical practitioners, their colleagues, education providers and employers.

The roles undertaken by advanced clinical practitioners are determined by the needs of the employer aligned to strategic workforce plans. Currently at GHNHSFT there are small number of stablished ACP roles aligning to HEE definition but there are developing teams of ACPs, Acute Response Team, also teams are currently being developed in ED, Critical Care, Same Day Emergency Care (SDEC), General Surgery, Respiratory and Neonatal Medicine

The NHS Long-Term Plan highlights how advanced clinical practice is central to helping transform service delivery and better meet local health needs by providing enhanced capacity, capability, productivity and efficiency within multi-professional teams. We have a dedicated One Gloucestershire Advanced Practice Lead Role since April 2021 reporting to system workforce leads. The role supported by SW Faculty Health Education England supports a drive in development and implementation of safely governed trainee and established roles. A unified framework for role development, progression, education pathways and supervision aligned to HEE guidance is being developed GHNHSFT to inform multi professional clinical, operational and education leads.

5.4.5 *Staff Support through change*

As indicated, of the five services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes (some since June 2020 and others from Feb 2022).

However, if the proposals are supported, confirmation that four of the changes are to become permanent and the one remaining service change will still have an impact on

individuals and groups of staff. A significant element of Managing Change is to support those individuals who are both directly and indirectly affected, one of the main being communication and underlining the need for staff involvement. This is an inclusive process not exclusive.

To support the process, we will ensure regular communication between each affected service line team, Chief Nurse and HRBP with overall oversight by the Director for People and OD. This will ensure that we have early sight of any issues including if the messaging has been adequate and consistent and if there are any issues to implementation. Any inconsistencies or areas of concern will be escalated to the Divisional Tri and relevant HRBP and the team will be proactive in meeting colleagues and staff groups where necessary. Any such change would be undertaken in line with the relevant HR policies.

How change affects individuals can differ greatly and that is why in line with our trust ethos of *Caring for those Care* individual personal needs will be considered. Whilst our underling needs must be to ensure we are able to meet the needs of the service in terms of patient safety and patients we will also balance this with the needs of our staff.

Through staff engagement we will identify individual wants and needs, managing this in line with our trust policies and procedures which are aimed to resolve matters wherever possible by consent.

Staff will be afforded support, and this will be made available and tapered to individual needs. This will also include confidential support links such as 2020 Staff Advise and Support Hub; Working Well (colloquially referred to as Occupational Health) and Staff Support.

5.4.6 *Staff Travel*

Remodelling of services across our two main hospital sites will ultimately have an impact on staff travel to and from work. Staff will experience

- No change as a result of reconfiguration.
- Positive change resulting in shorter travel times.
- Negative change resulting in increased travel time to get to and from their work place.

As described above, as most staff are required to work across sites within their service line relocation is not anticipated to be a contractual issue, but we recognise that there may be individual needs or concerns and our programme of staff engagement will provide opportunities for these to be addressed.

5.5 Impact of Changes on Junior Doctor Rotas and Training

5.5.1 *Engagement with the Deanery*

Historically, the main concern from trainees was a significant imbalance between CGH and GRH in workload and opportunity. This meant less than ideal training experience for trainees on either side – too much emergency work in GRH to get to clinics and too little experience in CGH for the number of trainees placed there. Part of the aim of reconfiguration is to better manage the emergency workload and even-out the opportunities for specialist trainee experience. The Medical Clinical Tutor and Deanery Representative have been in contact with the training Programme Director for Medicine to discuss how we are responding to the concerns raised. Further work is ongoing with the Director of Medical Education, Training programme directors and Clinical Tutors to review the training opportunities that the future configuration of services and will provide. This will

then be shared and discussed with the Programme Directors and Heads of School for Medicine.

The main upcoming change in postgraduate medical education is expansion of foundation trainee numbers over the next 3 years. Currently programmes are being designed to considering where trainees will be placed.

5.5.2 *General advice from the Deanery:*

It is important to maintain foundation trainee post numbers across the trust and all the work schedules for posts affected will be reviewed to ensure suitable learning opportunities are still open to them. The learning objectives for foundation doctors are set through a national curriculum, overseen by the UK foundation programme office and the GMC, and include:

- Foundation year 1 doctors require immediately available support from people with the skills to manage problems they might face (so that could be the Acute Care Response Team or DCC team).
- There is no precise specification for particular hours of the day or night, but posts should provide opportunities for experience to achieve the learning outcomes.
- Foundation year 1 doctors require immediately available support from people with the skills to manage patient care. F2s take on more responsibility for leading and managing patient care but still need to be able to access support for problems they might face (so that could be the Acute Care Response Team or Dept. of Critical Care team).
- There is no rule that requires training to be provided on one site. Many trainees will need to work at several sites to achieve their learning outcomes. Moving between sites should be justified on training grounds rather than service grounds and doctors in training must have induction to all areas and appropriate clinical supervision at all times. If doctors need to move sites during a shift, we need to think about how they will do that safely (and return back afterwards) and without interrupting continuity of patient care.
- Training posts must allow trainees to achieve the learning outcomes set in their curriculum. Colleges may set expectations for proportions of elective/emergency work, but this isn't universal across programmes and will be a guide.
- The risk of prioritising service over training is the withdrawal of training posts and loss of trainees.

Details of the trainee posts affected by FFTF Phase 2 changes are presented overleaf and the impact of FFTF2 planned and proposed service changes on Out of hours Doctor rotas in Appendix 6.

	FY1Trainees	SHO (FY2, CT1 & 2)	ST3 and above
Cardiology, Diabetes & Endocrinology. Respiratory & Stroke.	Rotas for foundation doctors are largely unchanged with foundation doctors working with their allocated teams during the day. Out of hours rotas were altered 2 years ago to enable cross site working which will continue which gives access to the advantages that each site offers. However, there will be greater numbers working in GRH.	With these services co-located the SHOs will have greater access to registrar support; this should improve learning opportunities and training. Rotas for out of hours shifts are worked at both sites which is unchanged, however more shifts will be at GRH.	With these services co-located the Registrars will have greater access to consultant support; this should improve learning opportunities and training. Out of hours rotas are unchanged.
Gynaecology Surgery (Day-Case only)	All foundation doctors will remain at GRH- training will be unchanged	All SHO doctors will remain at GRH- training will be unchanged	Registrars who are assisting surgical day case lists will travel from GRH to CGH. However, the inconvenience of the short journey will be offset by the reduction in cancelled lists; therefore, offering improved training opportunities.

5.6 Inter-site Ambulance Transfers

The Trust and the ICB have contracts in place with independent providers to deliver patient transfers by ambulance. The transfers include transporting patients from the GRH to Hartpury Suite (Cath Lab) at CGH, supporting patient discharge to their place of residence or to other providers and transferring patients between the two hospital sites.

As part of FFTF Phase 1, work was carried out to identify the inter hospital demand to support the centralisation of emergency general surgery and the acute medical take at GRH, and the transfer of vascular services and interventional cardiology services to GRH. This work has been updated to reflect the current experience during the temporary service changes and the proposed service changes within FFTF Phase 2, i.e., the centralisation of respiratory, cardiology, diabetes and endocrinology services at GRH and the centralisation of stroke services at CGH.

Examples of patient cohorts used in our activity modelling include the following:

Stroke	• Patient attending ED at GRH who were transferred to the stroke ward at CGH • Patients on a stroke ward at CGH transferred to another specialty ward at GRH • Patients transferred from an inpatient ward at GRH to a stroke ward at CGH
Respiratory	• Patient attending CGH ED and admitted to respiratory ward at GRH
Cardiology	• Patient attending ED who were admitted to a cardiology ward at CGH and GRH
Diabetes	• Patient attending ED at CGH who were transferred to GRH

It is estimated that the service changes set out in FFTF Phase 1 and 2 equate to approximately 10 patient transfers per day. This assessment has been based on activity data showing the number of patients attending the Emergency Departments at CGH and GRH who are then transferred to the other hospital site for admission and inpatient transfers between the two hospitals. We have also included an assessment of the number of walk-in patients attending the ED at CGH who are then admitted to a cardiology ward. For comparison we have also reviewed the patient transfer activity during COVID, when there were a substantial number of service moves across the two sites. This shows that at its peak there were on average 16 transfers a day.

The Trust is currently exploring, with advice from the ICB, how best to meet this future demand, recognising that some of the service moves have either already been formally completed or have temporarily moved in response to COVID (and are therefore in our current activity). It is anticipated that we will utilise the funding approved in the FFTF1 DMBC invest in provision of a further ambulance for inter hospital transfers only, that the crew will be trained to paramedic standard, the service will operate 7 days a week. In addition, it is proposed to provide a budget to cover ad-hoc transfers, which will be an expansion of the current ambulance transfer availability.

These proposals for inter-site ambulance transfers are planned on the basis of the current demands being placed on SWASFT and the impact of demand and hand-over delays on current response times. However, further work will be required to develop SOPs with SWASFT and GHNHSFT colleagues (where these are not currently in place), to confirm the precise response on the basis of each specific patient cohort and the clinical decision-making.

The South West Clinical Senate panel report included specific points regarding inter-site transfers that would need to be factored into the implementation plans, for both Phase 1 and Phase 2 of the FFTF Programme. These are listed below and will be picked up as part of the Cross Division Task and Finish Group (section 15.3.1):

- The Panel recommended that the Trust monitors the time taken and impact of transferring patients in both directions between sites when clinically necessary.
- The Panel recommended that the expected patient flows between the hospitals should be modelled and included in the proposals
- The Panel recommended that there should be a programme in place to review all inpatient transfers so that learning is captured, to help minimise the number of avoidable transfers.

- The Panel recommended that there should be central coordination of this service to ensure that journeys in both directions are used optimally and that empty return journeys are minimised.

5.7 Bed Demand and Capacity Modelling

5.7.1 *Approach*

As part of Phase 2 we undertook a full refresh of our bed demand and capacity modelling and this was combined with an extensive engagement process across GHNHSFT including clinical teams, operational Directors, Divisional Boards, our Clinical Advisory Group, a dedicated Cross-Divisional working group and senior Executives. A specific Decisions Summit was convened to discuss and agree bed numbers and ward allocations. This initially confirmed the vast majority of ward allocations, and these were presented to the South West Clinical Senate in August 2022. Subsequently, as part of the system operational planning cycle a further revalidation process has been undertaken by operational teams, as well as triangulation with BI reporting to assure alignment.

Appendix 7 presents full details by ward and service of the 2019/20 baseline, the proposed individual service and ward changes (both FFTF and non-FFTF) and the expected future state once all moves are completed.

A short summary of the key elements from the bed modelling are provided in the sub-sections below.

5.7.2 *Bed Capacity/ Availability*

Separate to the FFTF programme there have been a number of developments at GHNHSFT (see Appendix 7), affecting the numbers of beds (i.e. capacity), these include the impact of:

- Strategic Site Development
- An increase in Assessment Units
- Other operational changes

5.7.2.1 GHNHSFT Strategic Site Development (SSD) Programme

As part of the Trust's strategic site development (SSD) programme changes at GRH include the extension of the Same Day Emergency Care (SDEC) area, which provides an improved same day emergency care provision, the extension of the Acute Medical Assessment Unit, which will increase the bed space by 16 beds and enable the centralisation of acute medicine at GRH along with improved Mental Health provision and the conversion of non-clinical space within Gallery Wing to create a new 24-bed ward.

5.7.2.2 Assessment Units

A significant factor affecting both bed demand and capacity is the increasing move towards provision of Assessment Units. These units all have a similar function, providing timely care for patients with a fast-track through to the specialist team and quicker treatment. They all reduce attendances to ED and will work more closely with GPs and paramedics using Cinapsis to bypass ED, where clinically appropriate.

Our plans are to extend and expand the use of Assessment Units and the details, including context, performance and proposals, for each are provided in Appendix 7 and include:

- **GRH**: Surgical Assessment Unit (SAU) and Vascular Assessment Unit (VAU)
- **GRH**: Frailty Assessment Service /Unit (FAS/FAU)
- **GRH**: Gynaecology Assessment Unit (GAU)

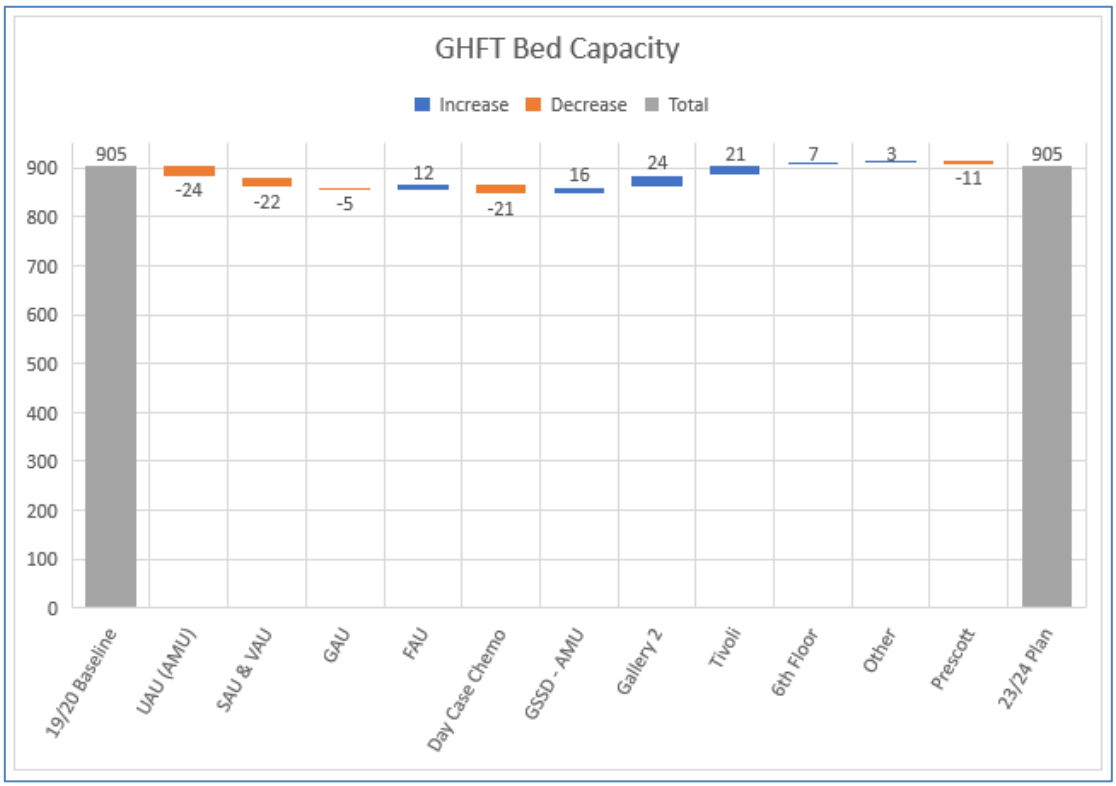
- **CGH**: Urology Assessment Unit (UAU)

5.7.2.3 Operational Changes

These include:

- **CGH**: Day Case Chemotherapy - provision of Systemic Anti-Cancer Therapy (SACT)
- **GRH**: 6th Floor Developments
- **CGH**: Hazelton/Tivoli Ward
- **CGH**: Prescott from 35 to 24 beds. The use of the ward is currently being reviewed (a process which is not part of FFTF).
- **GRH & CGH**: There are a small number of bed reductions due to either IPC, patient experience or previous unfunded escalation capacity that have been removed from the bed capacity stock modelled.

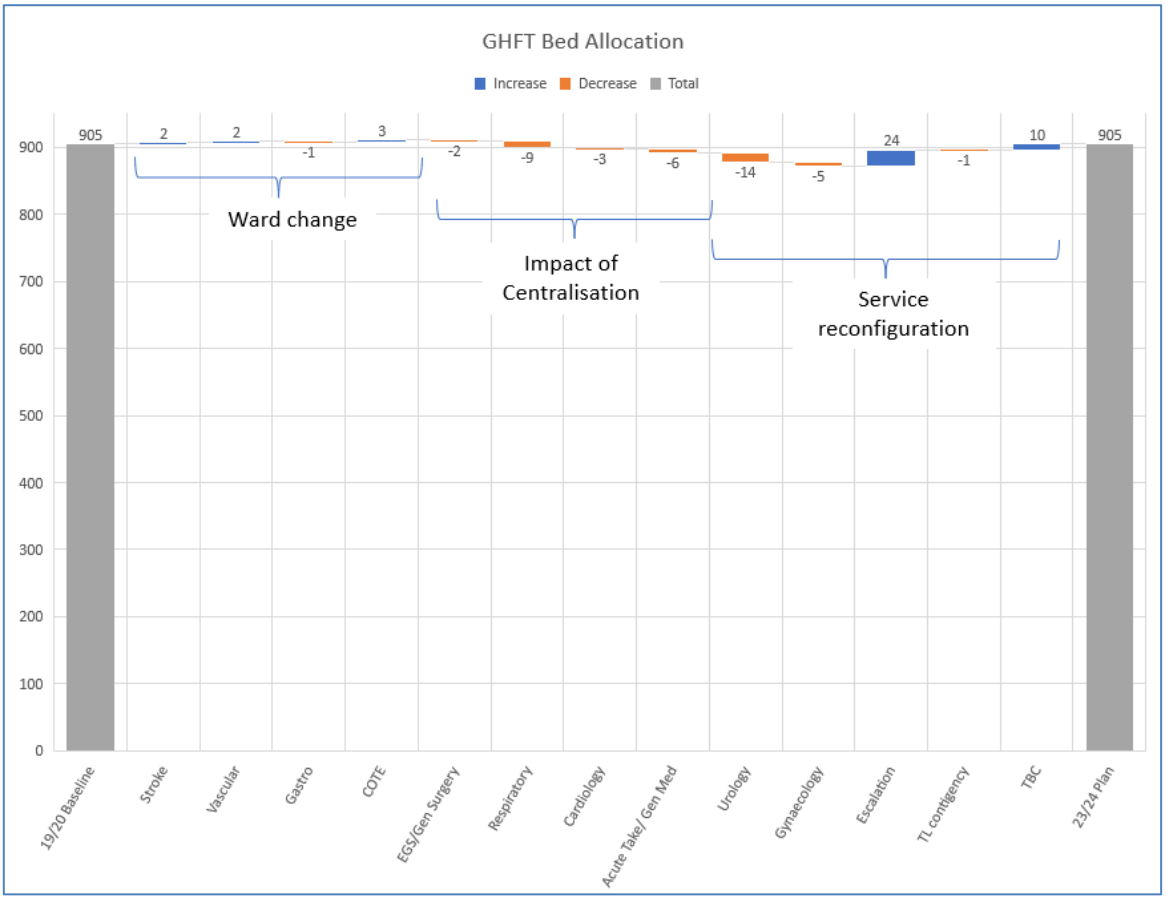
The overall impact of the above changes on bed capacity for the Trust as a whole is presented in the below.



5.7.3 *Bed Demand Impacts and Capacity Allocations*

Once the bed capacity has been determined, the bed modelling process then seeks to allocate the available capacity to the individual services/ specialities to ensure that the FFTF proposals can be accommodated on the two sites. This process takes account of the previous/ current demand and factors in any changes such as:

- FFTF1 & 2 Centralisation impacts – including efficiency improvements that result in a reduction in beds required e.g. reduced length of stay.
- Service reconfigurations – a change in the way services are operated.
- Ward changes - A small number of bed changes result from the allocation of different services to different wards.



It should be noted that Stroke and Vascular were already centralised prior to being relocated as part of FFTF.

5.7.4 *Department of Critical Care (DCC)*

5.7.4.1 Background

Implementing service change proposals in Phase 1 and Phase 2 of FFTF has an impact on the capacity requirements of the Trust's two DCC units, particularly the timing of the centralisation of acute medical take to GRH, planned for September 2023 when the GSSD new build is completed. Overall, there will be a shift in DCC activity from CGH to GRH.

As with acute bed modelling (section 5.7.1), the past 36 months (since March 2020), has seen a significant change in the demand distribution and commensurate use of DCC beds on both GRH and CGH, due to both COVID patients and reductions in elective activity. This makes DCC modelling complex, so to take account of these exceptional circumstances we have used a range of information and data to inform our DCC demand and capacity modelling.

A full refresh of the DCC bed model has been undertaken for the years 2018-2021, split by specialty capturing the daily average (from the 4 hourly census), patient activity, new admissions and bed days per admission. This is used to calculate an average bed demand per specialty per month.

The detailed paper outlining the work the DCC, Divisional, Business Intelligence and FFTF Programme teams have undertaken to model the impact of all the proposed changes, identify the scale of the capacity challenge and describe and appraise a range of mitigations can be found in Appendix 8.

A brief summary of the mitigations and impact is presented overleaf.

5.7.4.2 GRH DCC Potential Mitigations

Transfer from DCC at GRH to DCC at CGH of patients who are likely to stay on DCC for two weeks or above.

This is undertaken for clinical reasons; the CGH DCC is less busy and able to offer a better patient experience and access to rehabilitation. The clinical team has established a consultant led retrieval service, which is able to provide a transfer service with very low risk of harm. This process is already in place but could be expanded. The number of additional patients who could be effectively transferred would be 3 a month (as assessed by clinical teams) these patients would stay an average of 10 days each. Giving a monthly mitigation of one bed GRH. This initiative has already been started and is reflected in some of recent modelling. However, there may be capacity to increase this if services are able to continue their review at the CGH site. There is an estimation that to extend this model might gain 0.5 of a bed at GRH.

Respiratory High Care

The creation of a dedicated High care Unit within the respiratory wards will decrease the number of patients into DCC. The BI team have produced a report showing GRH DCC Admissions 01/01/2017 to 31/01/2020 with Primary or Secondary Reason for Admission System = Respiratory showing:

- Advanced Respiratory Days = Number of days receiving advanced respiratory care i.e., mechanical ventilation; and
- Basic Respiratory Days = Number of days receiving basic respiratory care i.e., CPAP, Non-Invasive Ventilation (NIV), NHFO etc

From this report it has been calculated that 990 bed days on DCC for patients who received NIV alone in a 3-year period would be saved. An average of 330 bed days a year, one bed if spread out over the year. This could be higher as the calculations do not include the time on NIV for patients who were also ventilated but these numbers are smaller.

Respiratory patients are more likely to be unwell during the winter months. Although the numbers have been averaged over a year, the greatest impact on DCC at GRH will be in the winter; which is when the demand is highest and therefore this option would be highly effective; numbers range from 0-7 patients. A very effective temporary Respiratory High Care was set up for COVID patients. However, the patients for whom the new service is designed were not included in the trial and so would give greater DCC capacity.

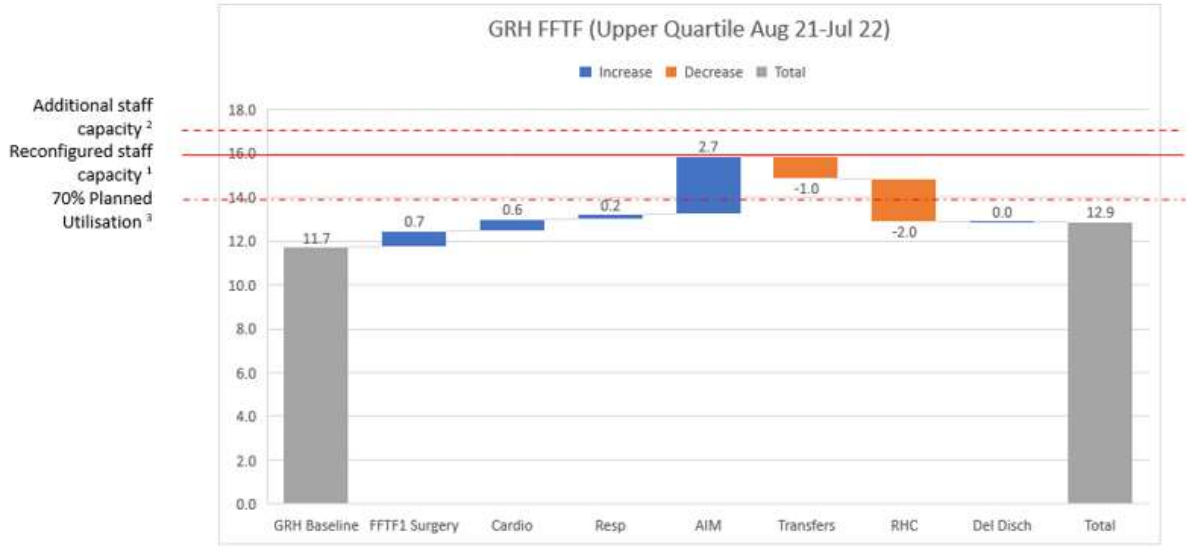
Reduce delayed discharges

Analysis shows that on average roughly 2 beds are taken up by patients that shouldn't be in DCC. This increases to 3 beds during peak hours (10-5). However, it should be noted that this is a long-term issue resulting in the difficulty of discharging patients from hospital who although medically fit have further social and care needs, resulting in the inability to discharge patients from DCC to the ward. Work would be required across the integrated healthcare sector to reduce the number of patients without criteria to reside before any impact on DCC could be anticipated; **this has therefore not been included as a mitigation.**

Other mitigations are included in Appendix 8.

An extract of the analysis presented in Appendix 8 representing the current best estimate of activity and mitigations is presented overleaf. A key set of performance metrics have been agreed and will be monitored by the Cross Division Task and Finish Group (see section 15.3.1).

Mitigated demand at GRH using upper quartile activity for all services (including baseline) combined (excluding delayed discharge mitigation)



#1: Reconfigured staff capacity excl. contingency staffing #2: Additional staff capacity excl. contingency staffing

#3: DCC planning preference is for 70% planned bed utilisation. Note: activity presented includes both planned and unplanned

As stated in the FFTF1 DMBC this will be a key stop / go decision point for the implementation programme to confirm at the point that the Acute Take is scheduled to centralise.

Key Points

- **The South West Clinical Senate panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.**
- **The FFTF programme has developed an inclusive and transparent options appraisal process**
- **The crucial role of our staff is highlighted and our plans for staff engagement and support through change are presented along with the anticipated benefits of these proposals for recruitment and retention.**
- **The impact of our proposals on Inter-site ambulance transfers are understood and plans in place to manage and mitigate.**
- **A comprehensive bed demand and capacity modelling process has been undertaken to support these proposals.**

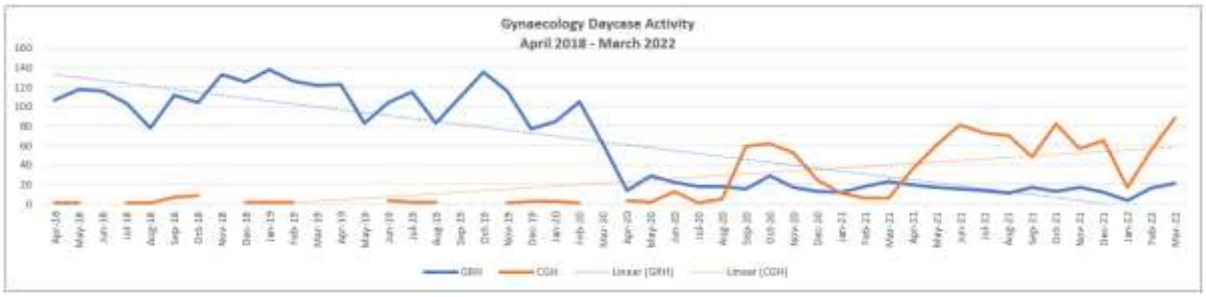
6 Benign Gynaecology

6.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

Until the beginning of 2020, the majority of Gynaecology Day case operations were carried out at Gloucestershire Royal Hospital (GRH). However, during the COVID pandemic, the proportion of Gynaecology Day case surgeries carried out at Cheltenham General Hospital (CGH) significantly increased to facilitate our response to the pandemic.

The graph below evidences this shift[17] and hence our decision to include the service in our FFTF2 programme.



Outpatient appointments are provided at both acute hospital sites (Cheltenham and Gloucester), in the community and virtually when appropriate.

6.2 Activity

For the period Oct 2020 – Sept 2021 there were a total of 1143 Benign Gynaecology elective patients of which 512 were Day cases; of these 468 (90%) attended CGH and 44 (10%) at GRH.

6.3 Clinical Engagement

The clinical and operational teams were involved in the relocation of day cases to CGH during the pandemic and the discussions regarding the future proportions of activity to be undertaken at each site. The gynaecology team participated in the public, staff and patient engagement and the options appraisal process in July 2022.

6.4 Case for change: the problem we are seeking to address

When Benign Gynaecology Day case surgery was predominantly delivered at GRH there could be bed availability issues at times due to high numbers of emergency patients, resulting in patient cancellation because the day unit was required for emergency inpatients. As Benign Gynaecological day case surgery is not classed as urgent or related to cancer, the risk of cancellation is relatively high. Although the vast majority of this work may not be classed as clinically urgent; for many of the patients the symptoms experienced are unpleasant and affect the quality of their lives.

[17] During 2020/21 129 day-cases were undertaken at either the Nuffield or Winfield Hospitals, this was a temporary arrangement to enable surgery to continue during the worst of the COVID 19 pandemic

Whilst a transfer of these cases to CGH does not guarantee that cancellation is avoided (there are still bed pressures when demand is extremely high) there is evidence of a significant lower level (a reduction of up to 50%) of cancellation.

This move would also align with the Centre of Excellence strategy for CGH to become the centre for Elective work. As part of Gloucestershire Strategic Site Development (GSSD) at CGH GHNHSFT are developing two new theatres and a new ring-fenced Chedworth Day Surgery Unit. The Day Surgery Unit is expected to be completed by April 2023 and the two new theatres by October 2023, subject to construction timelines.

In summary the new unit will provide:

- A waiting area and reception
- 27 individual pre-operative pods to prepare patients for surgery (they are designed so that the doors can accommodate a trolley if necessary but not a bed- thus ensuring that the unit cannot be affected by bed pressures)
- A treatment room used initially for pain procedures and Lithotripsy but with the ability to extend this.
- A fifteen bedded post operative area for day surgery patients
- A discharge lounge.

This cohort of Benign Gynaecology patients would greatly benefit from this environment which offers individual cubicles, providing privacy and dignity and, due to the design, are ring-fenced for elective surgery.

6.5 Clinical Evidence

This type of surgery can safely be undertaken at either site as both CGH and GRH have all the support services that are required. It is for operational capacity/ efficiency and patient experience benefits that the proposed change is being undertaken.

6.6 How was preferred option evaluated?

The Gynaecology Service developed a list of options with support from the FFTF Programme Team. Given the nature of the service and proposals, there were only two options, deliver the service at GRH only or the current proposal; to maintain the majority of Benign Gynaecology Day Cases at CGH. As described in section 5.2, the next step was the application of the FFTF desirable criteria. As previously described, due to the ongoing system pressures, rising COVID and the heatwave in mid-July (when events had been booked 10 weeks in advance for clinical colleagues), GHNHSFT declared a Business Continuity Incident (BCI) on the day of one of the workshops. Given the notice requirements for clinical staff and the deadline for clinical senate submission, in agreement with NHSE, we have reverted to using the on-line responses from scorers and these have been reviewed and summarised by the FFTF Programme Director for inclusion in this section.

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was *reverting back* to the original configurations, i.e., reversing the current temporary service change.

	Revert Benign Gynaecology Day Cases from the majority at CGH back to all at GRH	
Quality	**Scores**	Similar to slightly worse than status quo
	Comments	• If care reverts back to GRH there is a higher chance that you will have a mix of patients on a ward due to urgent care pressures and this may impact on the quality of care for patients. • New day surgery unit is completed and open, there will be a better patient experience in terms of the environment and the impact that has on privacy and dignity.
Access	**Scores**	Similar to slightly worse than status quo
	Comments	• 17% of patients are negatively affected but this is for a single day as day-case. Option for some patients in East to continue to be treated at GRH. • If service moves back to GRH there is a higher likelihood of cancellation therefore increasing waiting times for the patients. • Less cancellations = more capacity
Workforce	**Scores**	Similar to slightly worse than status quo
	Comments	• No difference as status quo but new DSU will improve working environment. • A dedicated unit should aid recruitment and training. • Potential for GRH urgent care pressures to impact on availability of trainers. • Resources used are the same for the same activity • Now that staff are settled in CGH moving back to GRH will be more disruptive.
Deliverability	**Scores**	Similar to significantly worse than status quo
	Comments	• Change has been made so resource would be required to re-schedule all activity back to GRH • Better to stay at CGH and use the new day unit than to be shoehorned back into an already crowded GRH.
Strategic Fit	**Scores**	Similar to slightly worse than status quo
	Comments	• reverting elective activity to GRH is not aligned with CoEx strategy. • New DSU will improve environment for patients. Public will soon accept the distinction between the 2 main hospitals CGH = Planned & GRH = Emergency
Acceptability	**Scores**	Slightly worse than status quo
	Comments	• 95% of respondents support the proposals. This includes staff

Based on the above assessment, the preferred option it to maintain the majority of Benign Gynaecology Day Cases at CGH.

There is minimal impact on pathways. Referral into the service would stay the same and the out-patient clinic appointments will continue at the same venues that they have always been.

The only change is the hospital site, with patients discharged the same day. If follow up clinics or therapy is required post operatively, this can be carried out at a site closest to the patient's home, this would not change because the site for surgery has changed. It is not the intention to bring all day-case gynaecology to CGH; a smaller number will remain at GRH to offer choice and to achieve maximum theatre list efficiency. A small number of day-cases are also undertaken at Stroud Hospital, there are no plans to change this.

There will be no change to outpatient clinic provision which will continue to be provided at both Acute Trust and Community Hospital sites.

6.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Reduction in cancelations	Since moving the majority of Day Cases to CGH the cancelation rate has fallen by half (Oct 2020 to Sept 2021 @2.46% compared with Feb 2019 to Jan 2020 @4.75%)
Improved Patient experience	Chedworth Day Surgery Unit is expected to be completed by April 2023, providing individual pre-operative pods, which provide privacy and dignity for patients as they prepare for surgery, and a post operative bedded area.

6.8 Benefits including clinical outcomes

Potential Benefits

- Although initially a short-term COVID enabling move, the relocation to CGH has been beneficial as there are significant bed pressures on the GRH site. In addition, with fewer cancellations this proposal will provide better care for patients and enable quicker elective recovery post COVID.
- Fewer patient cancellations because the new day case unit at CGH would be dedicated to planned surgery and would not be used for emergency inpatients
- Access to the new Surgical Admissions and day case unit at CGH once complete in April 2023. The innovative unit will have individual rooms to prepare for surgery providing high levels of privacy and dignity for patients
- Individual rooms are beneficial to those with disabilities and special needs as well as carers who are so essential to the care of those with dementia and learning disabilities
- It would allow a higher number of operations to take place and would enable women/people with Gynaecological conditions, that may have gone undiagnosed to undergo surgery sooner, allowing for quicker post pandemic recovery for the service
- This change would fit with the strategic vision for Centres of Excellence with a greater focus on planned care (non-emergency services) at CGH
- Whilst a transfer of these cases to CGH does not guarantee that cancellation is avoided (there are still bed pressures when demand is extremely high) there is a significant lower level of cancellation (reduced by half).

Potential drawbacks

- 18% of patients would have longer to travel[18] to CGH for day case surgery. Those affected would only need to make the extended journey on one occasion - on the day of surgery.
- This potential inconvenience for some patients should be considered alongside the potential reduction in rates of cancellation which could represent a greater stress and inconvenience to patients

6.9 Interdependencies

There are no specific interdependencies (over and above Business as Usual), related to the location of this service at CGH.

6.10 Workforce

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

6.11 "Blue light" ambulance travel impact

These proposals relate to Day cases and therefore there is no "Blue light" ambulance travel impact

6.12 Learning from Temporary Service Change Period

This Benign Gynaecology Day case proposal has been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

6.13 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel supported the proposals for benign gynaecology services.
- The Panel noted that in many Trusts Advanced Nurse (Clinical) Practitioners (ANP/ACP) and Nurse Consultants now carry out much of the ambulatory care in gynaecology, including hysteroscopy, cystoscopy, and colposcopy and recommended that Gloucestershire explores these working practices to assist with capacity and workforce issues. Please see section 5.4.4.1 for details of the development of ACPs.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

6.14 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme

6.14.1 *Quantitative Survey responses*

The proposal we engaged on was to continue to deliver the majority of Benign Gynaecology Day case surgery at Cheltenham General Hospital.

[18] Details of the methodology can be found in section 11.5

- **92%** of *all* respondents either **strongly supported** or **supported** the idea
- **96%** of *staff* respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	28%	45%	39%	16%	84%
A community partner	4%	50%	50%	0%	100%
A member of the public	37%	39%	56%	5%	95%
An employee working in health or social care	27%	33%	63%	4%	96%
Prefer not to say	5%	50%	33%	17%	83%
Grand Total	**100%**	**40%**	**52%**	**8%**	**92%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 6.15.

6.14.2 *Qualitative Responses Public and Patient themes*

Theme	Survey comment examples
Reduced cancellations	• It releases women from worry over a long period of time. • Fewer cancellations and shorter waiting
New Day Case unit at CGH	• The day case unit at CGH will be good for this, and having it at a site where there is less likely to be cancellations is good • Privacy and lack of fear of constant cancellation are far more important than the inconvenience of a longer journey • Individual rooms especially for those with disabilities etc.
Centres of Excellence	• If the intention is to make Cheltenham the main day-case site, then it would seem an appropriate to relocate this service to Cheltenham. • The case makes sense • Excellent plan benefits outweigh drawbacks
Travel	• Useful to centralise system but transport will always be a problem if you expect day cases to arrive by 7.30am • I find it incredibly difficult to get to Cheltenham general and I am fit and well with my own transport. GRH is far easier to get to it's all about not having the choice
Patient experience	• Women need to feel they are being seen speedily, by a professional who will listen and expedite treatment, in the near future. • Expertise in one place. Better services. Better access to services.

6.14.3 *Qualitative ResponsesStaff themes*

Theme	Survey comment examples
Clinical considerations	• Sensible if the procedure is minor and doesn't involve complications, consideration needs to be given to more complex patients with additional needs, who may require inpatient care. minor surgery suitable for CGH • For day case procedures not expecting overnight stays, I feel this appropriate
New Day Case unit at CGH	• Exciting to be having treatment in the new Day unit being built in CGH rather than the very tired unit in GRH
Reduced cancellations	• Reductions in cancellations are a necessity • Get operations done when no beds • Sounds like a robust plan to consolidate services on a single site and reduce the impact of bed availability on cancellations
Car Parking	• More car parking for our patients is needed

6.15 Addressing themes from engagement feedback

Feedback received and FFTF2 response
New Day Case unit at CGH
It is welcomed that both staff and the public see the benefits from undertaking Benign Gynaecology Day cases at the new Chedworth Day Surgery Unit (opening April 2023)
Reduced cancellations
The negative impact of cancellations on this cohort of patients is recognised by both staff and the public and the positive impact that the reduction in cancellations will have if these proposals are confirmed.
Travel
The negative impact of increased travel, particularly for patients travelling from the Forest of Dean to CGH is clearly recognised. Analysis has indicated that ~ 18% of patients will be negatively impacted, with 82% neutral or positive. For this cohort the impact is only for one day and as it is not the intention to bring all day-case gynaecology to CGH, a smaller number will remain at GRH to offer choice based on circumstances. Finally, if follow up clinics or therapy is required post operatively, this can be carried out at a site closest to the patient's home.

Key Points

- **This service change proposal delivers the case for change through reductions in cancellations and improved patient experience.**
- **The new Chedworth Day Case unit has individual pre-operative pods, which provide privacy and dignity for patients as they prepare for surgery.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This proposal is currently implemented as a temporary service change**

7 Diabetes and Endocrinology

7.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

The Diabetes and Endocrinology (D&E) Service provides outpatient and inpatient services for the population of Gloucestershire at both Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH). In addition, the service provides non-Covid related clinics for Diabetes patients at The Vale, North Cotswold and The Dilke community hospitals, with D&E clinics being held at Tewkesbury and Cirencester community hospitals.

There are a small number of diabetes and endocrinology patients admitted directly to the specialty beds, primarily for management following an acute diabetic or endocrine episode. Most of the inpatients cared for by the D&E Service are General Medicine patients. Whilst up to 20% (National Diabetes Inpatient data) of the Trusts inpatients are estimated to have diabetes, this is usually not the primary reason for patients to be admitted. These patients may not necessarily need to be a on a specialist diabetes and endocrinology ward, but they may need clinical support from the D&E service.

The current service includes:

- Inpatient beds: 14 dedicated inpatient beds on Ward 9B at GRH for patients admitted via AMU.
- At CGH, the service is currently providing support to other hospital in-patients who happen to have diabetes.
- Outpatient services: General diabetes, insulin pumps, joint Renal clinics, general Endocrine, joint pituitary/neurosurgery, young adult diabetes, diabetes- podiatry clinics, antenatal clinics, lipid services

The service has 4.8 WTE consultants working across both sites. The service currently has 1.77 Band 6 WTE inpatient specialist nurses and 2.0 Band 5 WTE inpatient nurses.

The current inpatient pathway within the service for both sites is summarised below and can be found in Appendix 9:

- Patient presents at ED
- Patient admitted either direct to ward or for medical assessment (AMU or ACUC)
- Patient referred to D&E team for triage and admitted to ward (if not already) under care of D&E

Before the COVID pandemic, there were 26 beds across both GRH (14 beds) and CGH (12 beds). However, these beds were also used for General Medicine patients. It is estimated that the service requires 14 - 18 dedicated Diabetes and Endocrinology beds, with the remaining beds being used by General Medicine patients who are supported by the Diabetes and Endocrinology Team.

We have a traffic light system to prioritise admissions to the D&E ward. The highest priority would be a patient who is admitted with the diabetic or endocrine emergency; the next priority would be a patient who has a general medical problem but also has diabetes that might be slightly complex. Then a patient who has a general medical problem or straightforward diabetes condition and finally, a general medical patient who doesn't have diabetes or endocrine problems.

7.2 Activity

The total number of admissions for the service between February 2019 and January 2020 were 786 patients, with 45% of patients (357 patients) being admitted to CGH and 55% of patients (429 patients) being admitted to GRH.

7.3 Clinical Engagement

In order to develop the medium list of options for the service, a hurdle criteria workshop was held with clinical colleagues within the Diabetes and Endocrinology service and also clinical colleagues from services who work closely with Diabetes and Endocrinology. The workshop provided clinical staff members an opportunity to discuss the long list of options and decide on the medium list to take out to public and staff engagement. Furthermore, the medium list of options was shared at the Medicine Divisional Board for approval and sign off.

In addition to the hurdle criteria workshop, regular updates are provided to the Diabetes and Endocrinology Clinical Programme Group on the progress of the business case, including the options taken forward for public and staff engagement.

7.4 Case for change: the problem we are seeking to address

There is a small specialist team for diabetes and endocrine services, spread across multiple sites which has an impact on service delivery including:

- Disruption to services, caused by staff absence and sickness with staff spread too thinly across both sites.
- Increasing difficulties in providing:
    - Specialist diabetes and endocrinology inpatient service on both sites
    - A quick response to referrals from other departments within one (1) working day which delays patients transition into diabetes and endocrinology services; causing patients to stay in hospital for longer than they need to.
    - Regular daily visits to admission wards on both sites as well as Renal and Vascular wards who both receive a number of Diabetic and Endocrine patients.
    - Timely support to Emergency Departments

COVID has created additional pressure on Diabetes and Endocrinology services. It has aggravated pre-existing diabetes in some patients and has also triggered diabetes for some patients as a result of the virus or its treatment.

The Getting It Right First Time (GIRFT) report, which is a national programme designed to improve the treatment and care of patients through in-depth reviews of services, identified staffing levels as an issue for the D&E service in GHFT. This was particularly around providing In-patient diabetic nurses 7 days a week.

In order to address this, the service is in the process of establishing a dedicated Diabetic Inpatient Nurse Team for patients with a secondary diagnosis of Diabetes. This team will work across both sites and will provide additional support. The dedicated Diabetic Inpatient Nurse Team at GRH will assist the service in addressing the recommended action, as per the 2019 GIRFT report.

The main aim is to ensure that patients from across our county experience diabetic and endocrine services that are comparable to those areas at the leading edge of care, treatment, and outcomes.

7.5 Clinical Evidence

Studies suggest that type 1 and type 2 diabetes inpatients who are cared for by specialist diabetes nurses are likely to have a reduced length of stay, compared to patients who are cared for by general health care professionals (SIGN (2017) Management of diabetes: a national clinical guideline. SIGN 116.) Therefore, by consolidating the service at GRH, this would facilitate the service's ability to prioritise type 1 and type 2 diabetic patients who are cared for under other specialties but who will also require specialist diabetes nursing input.

National evidence (Lancet, NHS England and Diabetes UK) has shown that COVID infection, in people with or without previously recognised diabetes, increases the risk of the emergency states of hyperglycaemia with ketones, Diabetic KetoAcidosis (DKA) and Hyperosmolar Hyperglycaemic State (HHS). Nationally, emergency admissions for DKA were 6% higher in the first wave of the pandemic compared to previous years and 7% higher in the second wave of the pandemic compared to previous years.

During COVID the Diabetes and Endocrinology service experienced an increase in ward referrals. In January 2021 there were 181 ward referrals for diabetic and endocrine patients, the majority of which were related to COVID and the use of Dexamethasone (a drug used for the treatment of severe cases of COVID and other serious infections).

Furthermore, recent research from a London NHS Trust suggested that 12% individuals (all who had type 2 diabetes and 4 of 5 who had COVID) died during their admission with DKA, compared with 2.3% pre-pandemic. Those who died had significant comorbidities or multiorgan failure at admission and were not deemed appropriate for intensive care or ventilatory support (American Diabetes Association). Thus, reflecting the importance of the Diabetes and Endocrinology service being able to support the management of patients admitted with COVID or who are recovering from COVID.

Therefore, by consolidating the service at GRH it will enable the service to support the management of patients admitted to GRH with COVID and patients recovering from COVID, through the centralisation of a dedicated diabetic and endocrine bed base at GRH, which is aligned to the Trusts policy of utilising GRH as the 'red site' for COVID patients.

In September 2019 the National Diabetes Inpatient Audit (NaDIA) was conducted in acute hospitals across England. NaDIA 2019 was a repeat of the 2010 to 2013 and 2015 to 2017 annual audits. There was no 2014 audit and NaDIA 2018 covered the hospital characteristics only.

In 2019 NADIA data reflected that GHNHSFT were in:

- The lowest quartile for average diabetes specialist nursing hours per patient.
- The second lowest quartile for average diabetes consultant hours per week per patient.
- The highest quartile for percentage of emergency admissions.
- The highest quartile for Medication, Prescription and Insulin errors.

The above NADIA data for GHNHSFT highlights areas for inpatient care which could be improved through the consolidation of the service's staff onto one site.

The Diabetes is Serious Report released in April 2022 suggests that:

- People in most deprived areas of Gloucestershire struggle the most with managing their condition (55% of patients in the most deprived areas and 37% of patients in the least deprived areas)

- Almost one third of inpatients across England with diabetes have a medication error during their hospital stay, due to lack of knowledge around diabetes from other non-specialist colleagues (NaDIA 2019).

The recommendation from the report is for ICSs to continue to invest in and support the development of specialist inpatient teams so that all hospitals can ensure minimum standards of care and people with diabetes are safe in hospital.

In respect of NICE guidance our proposals deliver the following:

- Service providers (hospitals) ensure that adults with type 1 diabetes in hospital receive advice from a multidisciplinary team with expertise in diabetes.
- Healthcare professionals (members of the multidisciplinary team) ensure that they provide advice to adults with type 1 diabetes who are in hospital and enable them to continue to administer their own insulin if they are willing and able and it is safe for them to do so.
- Adults with type 1 diabetes who go into hospital if they are ill or need an operation get advice from a team of specialists in diabetes, who will respect their expertise in managing their own diabetes. They are supported to carry on injecting their own insulin if they want to and can do so safely, although sometimes intravenous insulin will be needed instead (for example, if they cannot eat or are having an operation that affects blood glucose levels).

7.6 How was preferred option evaluated?

Hurdle criteria have been applied to the a long-list[19] with representation from Diabetes and Endocrinology, Inpatient Therapy, Pharmacy, the wider Medical Division and Vascular to assess a long list of options for the service and to better understand clinical adjacencies.

This session provided a recommended medium list of options including Option 1a – Current Service Model Split Site D&E and Gen Med Cover, Option 2a – Consolidation of IP beds to GRH, D&E and Gen Med Cover and also Option 2b – Consolidation of IP beds to GRH with no Gen Med Cover. However, Option 2b was ruled out by the medical division as it would not be feasible to remove General Medical cover. Therefore, it was agreed that Option 1a and Option 2a would be worked up for public engagement.

As described in section 5.2, the next step was the application of the FFTF desirable criteria.

[19] The long-list and hurdle assessment can be found in Appendix 9

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was *reverting back* to the original configurations, i.e., reversing the current temporary service change.

		Revert the dedicated Diabetes and Endocrinology Inpatient Beds from a centralised model at GRH to a split site model at GRH and CGH
Quality	**Scores**	Worse than status quo
	Comments	• Co-location better for providing the service • Always a consultant at CGH to support inpatient referrals. • Single site improves continuity of care, plus teaching. • Diabetes work with a large number of teams. Broadly makes sense to have IP in the larger of the two hospitals. • Having more D&E on one site would support the emergency care pathway. • Single site supports better training opportunities and safer working environment with better staff cover.
Access	**Scores**	Broadly similar to status quo
	Comments	• Looking at health inequalities - greater proportion of people with diabetes in Gloucester and the West of county. • Approx. 10% negative travel impact. • Making sure that barriers are removed for people impacted by travel - this is a system responsibility.
Workforce	**Scores**	Significantly worse than status quo
	Comments	• Staff survey results - current model working well. • Better for staff recruitment, especially specialist staff. • Dedicated IP service is sustainable, means IP team better able to support other specialties. • Flexibility greater on one ward. • Supports further innovative models in areas of professional practice.
Deliverability	**Scores**	Significantly worse than status quo
	Comments	• Changes already happened. • As renal and vascular ward at GRH this will be better for centralisation.
Strategic Fit	**Scores**	Slightly worse than status quo
	Comments	• slightly worse as not supporting Centres of Excellence strategy
Acceptability	**Scores**	Slightly worse than status quo
	Comments	• 98% of respondents support the proposals. • Important to have a very positive comms plan and also be willing to support those who may have negative consequences.

Based on the above assessment, the preferred option it to maintain the current consolidation of dedicated the Diabetes and Endocrinology Inpatient beds at GRH with a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

7.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Disruption to services, caused by staff absence and sickness	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will enable the service to provide a more resilient staffing model. Also support the retention and in-house development of specialist Nursing staff, better for specialist SPR training and also Nurse training, and facilitate better consultant job planning.
Provide a response to referrals from other departments within one (1) working day	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will enable a consultant to cover inpatient work at GRH (currently 1-2 consultants at GRH + 1 consultant at CGH), which would allow the additional consultant to prioritise inpatient referrals from other wards. The consultant based at CGH would be able to prioritise inpatient referrals to support the 1 working day e-referral target, as opposed to waiting to see these patients post ward round and afternoon clinics. This would allow for a proactive service for patients, as opposed to the current reactive service.
Provide regular daily visits to admission wards on both sites as well as Renal and Vascular wards	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will provide increased Consultant capacity
Timely support to Emergency Departments	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will provide increased Consultant capacity. Potential for acute medicine SDEC in-reach service, would be better able to cover ED/SDEC, if centralised at GRH.

7.8 Benefits including clinical outcomes

Potential Benefits

- Minimising the disruption to services caused by staff absence and sickness
- Ensuring safe and consistent staffing levels, including senior doctors - 24 hours a day - leading to safer care and shorter hospital stays
- More specialists in one place resulting in timely assessment and decision making from senior professionals when patients arrive at hospital - leading to prompt diagnosis, treatment and timely recovery
- Diabetes and Endocrine consultants would be better able to coordinate inpatient work on the improved specialist ward

- Consultants would be better able to prioritise inpatient referrals from other wards and support a timely response to inpatients from other specialties (service areas) within one (1) working day. This in turn would help patients to leave hospital sooner after care
- Supporting joint working between care professionals; including links to related wards, facilities and equipment to avoid the need for multiple visits and hospital stays
- Creating better training and learning opportunities for nurses - the majority of consultants would be on one site to help develop their skills and knowledge in this area. Improving the service's ability to develop their own Diabetes and Endocrine nurses in-house could limit future shortages of specialist nurses. Studies suggest that type 1 and type 2 diabetes inpatients who are cared for by specialist diabetes nurses are likely to have a reduced length of stay in hospital, compared to patients who are cared for by general health care professionals.

Potential drawbacks

- The proposal would increase travel times for some patients and relatives/carers in the east of the county who previously would have travelled to CGH for inpatient care and now need to attend GRH.
- The overall impact is <10% of diabetes and endocrinology patients[20], families and carers are negatively affected by centralising at GRH

7.9 Interdependencies

Diabetic and Endocrinology Services has links with the Vascular Services, Complex Foot Clinics and Obstetrics – Gestational Diabetes.

It is not anticipated that the clinical links with Vascular, Renal, Neurosurgery or Complex Foot Clinics will be adversely impacted by these proposals vascular inpatients services are at GRH and Complex Foot Clinics are outpatient based, which will remain unchanged under this proposal.

For Obstetrics Gestational Diabetes, inpatients high risk clinics are already held at GRH where the Women's Centre is located. The Gestational Diabetes education groups at CGH will continue and remain unchanged.

It is not anticipated that either proposal will have a negative impact upon Imaging services as all services are provided on both sites. In addition, it is not anticipated that there will be significant impacts for Oncology or Therapy Services.

7.10 Workforce

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

The staff benefits of the preferred option are listed in section above and include better in-house training provision for specialist nurses, workload efficiencies would support consultants to prioritise inpatient referrals from other wards and help the service to make the best use of the staffing resource it currently has.

[20] Details of the methodology can be found in section 11.5

The services nursing staff have previously been required to work cross site, which will remain unchanged.

7.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact.

In respect of diabetes and endocrinology patients the numbers are

- 239 ambulance admissions to GRH - < 5 patients per week (Feb 2019 and Jan 2020)
- 63 ambulance admissions to CGH - ~ 1 patient per week (Feb 2019 and Jan 2020)

There is also some cross-over of D&E patients captured in the "blue light" activity analysis for the Acute Medical take in FFTF1. Furthermore, the cost of separate analysis for D&E only was over £4,500 (£70 per patient record).

Based on the factors above, the decision was taken not to model separate D&E "blue light" activity in FFTF2.

In respect of any emergency inter-site transfers, please see section 5.6.

7.12 Standard Operating Procedures (SOPs)

A SOP is currently in development

7.13 Learning from Temporary Service Change Period

This diabetes and endocrinology proposal has been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

In addition, COVID has created additional pressure on Diabetes and Endocrinology services. It has aggravated pre-existing diabetes in some people and has also triggered diabetes for some patients as a result of the virus or its treatment. This factor supports our proposals to improve the efficiency and effectiveness of the diabetes and endocrinology service by centralising the dedicated inpatient beds on the GRH site.

7.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel agreed that the move would strengthen links with vascular surgery, renal medicine and maternity services and that this would be advantageous for people with diabetes.
- The Panel was reassured that there will be sufficient specialist input available at CGH for the management of in-patients there with diabetes or other endocrine conditions.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

7.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

7.15.1 *Quantitative Survey responses*

The proposal we engaged on was to continue to centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.

- **98%** of all respondents either **strongly supported** or **supported** the ideas
- **100%** of staff respondents either **strongly supported** or **supported** the ideas

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	26%	57%	36%	7%	93%
A community partner	4%	50%	50%	0%	100%
A member of the public	38%	44%	56%	0%	100%
An employee working in health or social care	28%	42%	58%	0%	100%
Prefer not to say	5%	40%	60%	0%	100%
Grand Total	**100%**	**47%**	**51%**	**2%**	**98%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 7.16.

7.15.2 *Qualitative ResponsesPublic andPatient themes*

Theme	Survey comment examples
Innovation	• I think it's good to centralise a specialty in one place however I do think that you need make more use of technology, e.g., virtual monitoring • Self-help, education and support for new patients and healthy eating should be part of any new service approach • Train other NHS staff (Drs, nurses, AHPs & dietitians) to enable triage process. These trained staff can refer on &/or discuss directly (phone/email) with specialist diabetes personnel to determine care plan.
Clinical considerations	• A protocol for treating Addisons Crisis and patients being “red flagged” for urgent treatment • More support needed for long-term diabetics. • I think life style is very important and self-control of healthy eating is a better option than reliance on medication. Healthy exercise is also vital. • The staff need to be trained and competent, to deal with patients who have complex needs.

Theme	Survey comment examples
Centres of Excellence	• This seems to be the most efficient way to organise services, but continued support to patients with diabetes or endocrine conditions located on other wards is essential. • The case made is good • The Centres of Excellence approach should bring patient benefits
Travel	• Having the team under one roof is a good thing, but the transport problem is still there. • The benefits are partially outweighed by transport for some people • I believe there should be inpatient beds available at both Gloucester and Cheltenham sites.
Patient experience	• Would just like any services focusing on patient care.

7.15.3 *Qualitative ResponsesStaff themes*

Theme	Survey comment examples
Clinical considerations	• It has several linkages to acute specialties that it should remain at GRH. • Centralising service will improve outcomes, patient care and experience.
Integration	• It is important to integrate care for people with diabetes • Diabetes specialists/teams in the community to offer specialist care. • Patient education is really important especially in the community or primary care • I am concerned that reconfiguration discussions which are 'site centric' overlook the overwhelming need to move diabetes services into the community to point of near exclusivity.
Workforce	• There are not enough Diabetic Community Nurses to cover the whole county. • The Diabetes team is extremely small and therefore centralising services to GRH site makes sense
Car Parking	• Parking needs to be improved massively.

7.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
A protocol for treating Addisons Crisis
There are protocols available on the Trust's intranet for treating Addisonian crisis. The previous Trakcare system has an icon available to all patients with specific healthcare needs, of which steroid dependency is one of them. Whenever a patient is started on replacement steroids the icon will be allocated to them on Trakcare. There have been some issues pulling this through onto the new EPR system, but this is being addressed currently.

Feedback received and FFTF2 response
Diabetes specialists/teams in the community to offer specialist care
Confirm that community D&E outpatient clinics will not be impacted. Although this particular proposal focuses on inpatient care, The Hospital Trust does work in collaboration with Gloucestershire Health and Care to share information and projects being worked on in health care settings across Gloucestershire. ICS Diabetes and Endocrinology Integration Model Project aims to develop a single point of access to manage patients in the community who may not need to go into Acute Trust. Type 2 diabetic patients would be included within the scope of this project, with the objective being that the vast majority of these patients would be seen in a community clinic by default. In order to facilitate this, the ICS have recruited a community Diabetic consultant. CCG Virtual Ward Round Project - The virtual ward project is currently being scoped out by the ICS and focuses upon Diabetic and Endocrine patients who are discharged from the Hospital to reduce readmissions.
Patient education is really important especially in the community or primary care
The ICS run various patient education programs of people with newly diagnosed type 2 diabetes and for people who are starting on insulin. There are also a number of courses covering diet and lifestyle to assist in the prevention of the development of type 2 diabetes. In terms of type 1 diabetes, we do a lot of one-to-one work and also offer a number of options on learning to carbohydrate count, these are mainly online based.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 4% of patients will be negatively impacted, with 96% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.
Train other NHS staff (Drs, nurses, AHPs, dietitians) to enable triage process.
The future plan is to have two Diabetes link nurses for each ward and ED areas. In addition, there will be updated training every 2 months for healthcare professionals. There is currently and diabetes e-learning available online for staff, which is currently being considered to become mandatory training for all medical staff members. Furthermore, the service already RAG rates patients to determine which inpatients do need to be seen by the specialist team.

Key Points

- **This service change proposal delivers the case for change through an improved staffing model.**
- **This service change proposal delivers a range of patient and staff benefits.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This proposal is currently implemented as a temporary service change.**

8 Non-interventional Cardiology

8.1 The 'current state' service model

The cardiology services currently operate at both Gloucestershire Royal (GRH) and Cheltenham General Hospitals (CGH) with 21 inpatient beds at CGH and 25 at GRH. The service runs outpatient clinics at CGH, GRH and several other community hospitals in the county.

Diagnosis may include the use of X-ray, MRI, ultrasound scans and CT scans. For some patients the service also undertakes interventional cardiology within the cardiac catheter labs to perform surgery. Procedures are undertaken as day cases or inpatients.

The cardiology service is staffed by 6 HCA's (3.55 WTE), 26 registered nurses (RN) band 5-7 (26.48 WTE) and 14 consultants (12 WTE and 2 part time P/T).

Patient Pathway

Non-interventional cardiac admissions include pathways such as Heart Failure, endocarditis, and cardioversions. These pathways are replicated on both acute hospital sites. A typical patient pathway would be:

- Patient presents to ED (GRH / CGH)
- Initial emergency diagnostics undertaken
- Routed to Same-Day-Emergency-Care / diagnosed with primary cardiac condition
- Patient admitted to cardiac ward
- Further specialist cardiac diagnostics undertaken
- Patients are then likely to follow one or more of the following paths
    - Non-interventional treatment such as IV antibiotics given
    - Patients may then be discharged if stabilised, or
    - If intervention is not deemed urgent, patients may be discharged home to attend follow up as an outpatient or be admitted for a planned surgical intervention.

8.2 Activity

The total number of admissions for cardiology (both interventional and non-interventional for the period Jan-Dec 2021 was 3,475.

8.3 Clinical Engagement

Clinical engagement has included regular discussions with clinical and operational leads in cardiology regarding development of options and case for change. The clinical and operational cardiac team developed a long list of options based on their developed Case for Change, then used the FFTF hurdle criteria to review this list and refine down to a medium list of options.

'Medical Triumvirate' senior leaders reviewed hurdle process whereby options are reduced from an initial long list to a medium list. Wider clinical engagement was achieved through monthly reporting to the Image Guided Interventional Surgery (IGIS) Programme Board, including clinical representation from Cardiology, Interventional Radiology and Vascular services.

The medium list was also shared for comment with clinical and operational representation for all services through presentation to the GHNHSFT Strategy & Transformation Delivery Group.

8.4 Case for change: the problem we are seeking to address

Before describing our ideas for FFTF2, it's helpful to summarise recent developments in cardiology services that were agreed as part of FFTF1.

These included the centralisation of interventional cardiology, the relocation of the two cardiac catheter labs to GRH and the creation of an Image Guided Interventional Surgery (IGIS) hub at GRH and a spoke service for planned care at CGH; due to be completed in 2023/24. As part of these changes 13 inpatient beds will move from CGH to GRH.

The centralisation of interventional cardiology and the relocation of the cardiac catheter labs to GRH does present an opportunity to explore how we could potentially reorganise the remaining eight cardiology inpatient beds at CGH.

The problems we are seeking to address include;

- The challenges with patient pathways and identifying those patients requiring intervention at the point of admission. Also, for patients whose care pathway changes during their inpatient stay.
- Better use of the staff groups with significant shortages, such as radiographers, physiologists and specialist nurses.
- The need to improve Out of Hours Care for cardiac patients.

The patients that could be affected by these proposals are those not requiring cardiac intervention who would currently be admitted or transferred to the eight cardiology beds at CGH.

8.5 Clinical Evidence

The Cardiology GIRFT Programme National Specialty Report (Feb 2021) highlighted the need to review the ways cardiac services are delivered and included the following:

- Prevention, diagnosis and management of cardiovascular disease forms a key part of the NHS England and NHS Improvement (NHSE/I) Long Term Plan.
- The falling CVD mortality rate has been the biggest contributor to increased life expectancy for men and women within the UK. However, demographic shifts within our society mean that CVD-related mortality is increasing.
- To address this, we need to review the ways cardiac services are delivered and who is delivering them, to ensure both that patients are getting the care they need and that services are fit for the future.
- The best way to deliver equity of access to appropriate services and expertise, match demand to capacity and make the most efficient use of resources.
- Cardiology beds should be co-located and in hospitals with a cath or pacing lab there should be ring-fenced beds, trolleys or chairs.
- Multidisciplinary meetings are an essential part of cardiology treatment pathways and a core function of the heart team.

8.6 How was preferred option evaluated?

The Cardiology Service developed a long-list of options with support from the FFTF Programme Team. Hurdle criteria have been applied to the long-list of options[21]. Where any option has failed any of the criteria, it was been removed from the longlist. As described

[21] The long-list and hurdle assessment can be found in Appendix 10a

in section 5.2, the next step was the application of the FFTF desirable criteria.

		Centralise Non-Interventional Cardiology inpatient beds at GRH. Consult service at CGH.
Quality	**Scores**	Slightly to significantly better than status quo
	Comments	• Improved OOH care and ensures all cardiac patients are located on same site as interventional facilities. • Impact on those walking into CGH ED. • Inter-site transfers for cath labs cease • Should improve continuity of care through services and clinicians being on one site reducing need for moves
Access	**Scores**	Broadly similar to status quo
	Comments	• Patients will still present to their nearest ED. • Approx. 10% negative travel impact. • Improved utilisation of cath labs • Improved efficiency through centralisation could be used to create capacity.
Workforce	**Scores**	Significantly better than status quo
	Comments	• Single site allows improved staff cover and resilience. Only 1 x OOH consultant needed. • Single site provision allows for more efficient deployment of nursing staff. • Improved rota and cover arrangements. If rotas are more easily filled, then staff resilience will be improved. • Middle grade doctors will benefit from more access to senior colleagues. • Trainees will see a higher number of cases with standardised care.
Deliverability	**Scores**	Similar or slightly better than status quo
	Comments	• Implementation of non-interventional cardiology could be aligned with operationalising of interventional cardiology, part of IGIS FFTF Phase 1 proposals. • Clinical staff within the service are well engaged and supportive of the preferred solution. • Suitable location for the service identified at GRH.
Strategic Fit	**Scores**	Slightly to significantly better than status quo
	Comments	• Consolidating cardiology services are expected to achieve improved outcomes of care, reduced LoS and more timely and responsive intervention when required. • Improvement for inpatients and carers accessing specialist support, information and guidance from a strengthened team on site
Acceptability	**Scores**	Significantly better than status quo
	Comments	• 98% of respondents support the proposals. • Important to address the issues raised by the 2%. A change management programme of working with colleagues and professional partners along with a proactive communications campaign.

Based on the above assessment, the preferred option is to centralise Non-Interventional Cardiology inpatient beds at GRH and provide a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

8.7 How does this address the case for change?

Reason for change	How preferred option addresses this
The challenges with patient pathways and identifying those patients requiring intervention at the point of admission	Centralising all cardiology inpatient beds (interventional and non-interventional) at GRH would ensure patients were able to access the appropriate services once diagnosis was confirmed.
Improved out of hours care for patients	One consultant on call can attend to patients with greater efficiency when they are located on a single site.
Better use of the staff groups with significant shortages	Increased clinical presence for more ward rounds and consequently more efficient patient management. Length of stay reduction in transfer between sites, continuity of care with single consultant, increased efficiency of cath labs (delays caused from site transfers)

8.8 Benefits including clinical outcomes

Potential Benefits

- Looking ahead to the implementation of the FFTF1 IGIS model and the centralisation of interventional cardiology at GRH, the cardiology service believes it can provide a more efficient, more responsive and safer service by consolidating inpatient beds at GRH and providing a fully centralised cardiology inpatient service.
- Reduce length of stay for patients.
- Increased clinical presence for more ward rounds and consequently more efficient patient management. Length of stay reduction in transfer between sites, continuity of care with single consultant, increased efficiency of cath labs (delays caused from site transfers).
- Improved out of hours care for patients. One consultant on call can attend to patients with greater efficiency when they are located on a single site. Travelling cross sites can incur delays due to travel.
- Improved staff cover and improved staff resilience for sickness and absence
- Improved cross specialty working, i.e., how cardiology teams work with other acute specialties (service areas)
- Provide enhanced training for junior and middle grade doctors with regular access to the full clinical team
- Ensure that patients requiring regular Electrocardiogram (ECGs) receive this treatment in a timely way
- Ensure staff resilience for the future of the service through centralisation and by cross training a number of clinical members of staff; specifically nursing staff.
- Prevent the need for patient transfer which has cost implications. Transfer costs include both the ambulance cost but also for some patients the cost of a nurse

chaperone.) This is on the risk register. M2174CARD (score of 8) – risk to patient safety due to inability to treat patients whilst transferring between sites.

Potential drawbacks

- Friends or family travelling from the east of the county visiting a patient receiving non-interventional cardiology inpatient care at GRH would have to travel further.
- Approximately 10% of patients, families/carers[22] are negatively affected by centralising services on GRH.

8.9 Interdependencies

These include:

FFTF1 Implementation - As detailed in section 8.4 there are clear interdependencies with the centralisation of interventional cardiology, the relocation of the two cardiac catheter labs to GRH and the creation of an IGIS hub at GRH and a spoke service for planned care at CGH; due to be completed in September 2023.

Acute medical take – Impact of the centralisation of the acute medical take in September 2023.

Dept. Critical Care at GRH – the centralisation of cardiology will increase DCC demand at GRH.

8.10 Workforce

The cardiology service is staffed by 6 HCA's (3.55 WTE), 26 registered nurses (RN) band 5-7 (26.48 WTE) and 14 consultants (12 WTE and 2 part time P/T).

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

The staff benefits of the preferred option are listed above and include better training, workload efficiencies and help the service to make the best use of the staffing resource it currently has.

8.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact.

As part of FFTF1 we modelled the "blue light ambulance travel impact for interventional cardiology and we do not anticipate any requirement for non-interventional cardiology.

In respect of any emergency inter-site transfers, please see section 5.6.

8.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 10b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

8.13 Learning from Temporary Service Change Period

Cardiology services (interventional and non-interventional) have not been subject to any temporary service changes made in response to the pandemic.

[22] Details of the methodology can be found in section 11.5

8.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The panel agreed that the move of non-interventional cardiology in-patient services to the same site as the interventional service (i.e. at GRH) was advantageous.
- The Panel noted that routine echocardiograms performed by physiologists are not available at weekends at either GRH or CGH. They were reassured that when clinically necessary, echocardiograms can be performed by an on-call consultant cardiologist; however, recognising that the provision of echocardiograms is essential to an acute cardiology service and to other service such as critical care and stroke, the Panel recommends that, if possible, steps are taken to address this issue.

In response the clinical teams have indicated that we rarely need access to immediate echo for stroke patients but have good access weekdays and link with the cardiologists at the weekend if required.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

8.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

8.15.1 *Quantitative Survey responses*

The proposal we engaged on was to centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.

- **99%** of all respondents excluding staff either **strongly supported** or **supported** the ideas
- **97%** of staff respondents either **strongly supported** or **supported** the ideas

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	14%	50%	50%	0%	100%
A community partner	4%	33%	67%	0%	100%
A member of the public	42%	49%	51%	0%	100%
An employee working in health or social care	37%	45%	52%	3%	97%
Prefer not to say	4%	33%	67%	0%	100%
Grand Total	**100%**	**47%**	**52%**	**1%**	**99%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented overleaf, with our response in section 8.16.

8.15.2 *Qualitative Responses Public and Patient themes*

Theme	Survey comment examples
Innovation	• Use of technology to reduce referral times, e.g., patient/ GP/ specialist video calls and portable ultrasound and ECG equipment that can be used to provide diagnostic information to specialists
Clinical considerations	• How will patients with other medical issues who also have a need for non-interventional cardiology be treated in CGH? • It seems to make sense to consolidate cardiology beds in one site (GRH). Would be great for additional funding for MRI, CT, as well as services related to heart failure and genetic heart conditions. • Reduce length of stays. All different specialists under one roof, better for care and training, more likely to get correct specialist.
Centres of Excellence	• I can see the logic in moving the remaining non-interventional beds to be under the care of the centralised inpatient cardiology team. • Concentrating expertise in one hospital is important. • Objectively - absolutely right to optimise cardiac services in one place. Hard sell for past patients who have been treated successfully in Cheltenham, but this should be pushed forward.
Travel	• Transport over the county is appalling • Makes sense but it is the traveling that could be a problem for those without their own
Patient experience	• My first symptoms were over 65 years ago, and I am truly grateful for the NHS support I had since! I still enjoy life.

8.15.3 *Qualitative Responses Staff themes*

Theme	Survey comment examples
Clinical considerations	• Best located where support services are • Agree cardiology inpatient provisions should be based at GRH • Centralising services on the GRH site will be of great benefit to ongoing cardiac care/services hopefully reduce waiting times for interventions, improving patient outcomes and LoS in the long term and decreasing the need for transfers out of county. • Better pathway to interventional investigations
Interdependencies	• Cardiology should be on the same site as Vascular Services • Cardiology should be based on the site with greatest cover from Vascular and Interventional Radiology • I am concerned that this good work in centralising specialist services will be overly reliant on Ambulance Service performance.
Travel	• Travel may cause a difficulty for some people; however, the benefits appear to outweigh the negatives.

8.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
Co-location of all cardiology services (FFTF1 and FFTF2)
It is welcomed that both staff and the public see the benefits from centralising all cardiology inpatient services at GRH
Co-location of cardiology with vascular
It is welcomed that staff see the benefits from centralising all cardiology inpatient services at GRH which will be co-located with vascular services.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 10% of patients will be negatively impacted, with 90% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**

9 Respiratory

9.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

Our respiratory services provide a patient centred service for all ages of patients, presenting with respiratory related issues. The team consists of medical, nursing, therapy and support staff. The Consultant led Outpatient Clinics/Services are provided at both acute hospital sites plus seven locations in the community. These services are used for general respiratory conditions and also suspected cancer and sleep disorders. As part of the investigation patients may be referred for further screening. This could be arranged for the same day or as a separate appointment for another service for example an X-Ray, a CT scan, a blood test, lung function tests, a sleep study, an allergy skin prick test or a bronchoscopy, all of which will be undertaken as an Outpatients appointment.

Prior to the temporary COVID service changes (see below), specialist respiratory inpatient beds were provided on both hospital sites. At CGH they were located on Knightsbridge Ward (12 beds) and on Avening Ward (21 beds). At GRH they were located on Ward 8b (33 beds). A total of 66 beds. There were over 11,000 hospital admissions per year, with an average length of stay of 5.1 days; 77% of the admissions were to GRH and 23% to CGH (Feb 2019 to Jan 2020).

In June 2020, GHNHSFT implemented a number of temporary service changes as part of the Integrated Care System (ICS) response to the COVID Pandemic. The changes were implemented to reduce the number of emergency routes into hospital and to free-up additional capacity on the GRH site to create a 'red' emergency care COVID controlled site with patients managed through three emergency admission pathways: confirmed COVID, suspected COVID and confirmed non-COVID.

As part of these changes, GRH became the site for emergency admissions for patients in acute respiratory failure and a COVID Respiratory High Care (RHC) unit was created on one of the wards at GRH, where patients receive advanced respiratory support via non-invasive ventilation (NIV) or nasal high flow oxygen with full cardio-respiratory monitoring. This relieved the demand on the intensive care unit.

Under the temporary service changes, the improvements in efficiency and reduction in outliers ensure that the respiratory specialty inpatient beds, including High Care, can be located on Ward 8a and 8B (58 beds) at GRH. Currently, approximately 92% of patients are admitted to GRH and 8% admitted to CGH.

Current patient pathway

For patients attending ED a referral is made to the respiratory team for a respiratory assessment, either by an ED consultant or by the acute take physician. The patient is assessed and depending on the outcome, they are admitted to a respiratory bed, referred to another specialty or discharged.

The respiratory team provide a consultation service to other specialties (service areas) at CGH for patients who may require a specialist respiratory assessment or treatment.

Clinical protocols are in place to support the early recognition of and transfer of deteriorating patients at CGH and the management of patients in CGH needing advanced respiratory support.

9.2 Activity

From Feb 2019 to Jan 2020 there were 11,384 admissions, with an average length of stay of 5.1 days; 77% of the admissions were to GRH and 23% of these admissions were to CGH.

A comparison has been made of activity over a three-month period (July – Sept 2021) against the FFTF baseline year 2019/20, with the same time period in 2021. During this period there were 2210 admissions in 2019/20 compared to 2421 admissions in 2021, showing a 10% increase in admissions.

In 2021 approximately 92% of patients were admitted to GRH and 8% were admitted to CGH, which reflects the temporary centralisation of respiratory specialty beds at GRH. Also, during this period 146 patients were cared for within COVID respiratory high care beds.

9.3 Clinical Engagement

The clinical team developed a long list of options and used the FFTF hurdle criteria to review this list and develop a medium list of options. The medium list, together with the case for change was presented to the Medical Division Board, which was approved. The Trust has also presented the case for change and the medium list of options to the Respiratory Clinical Programme Group (CPG). The CPG has also supported the case for change and the medium list of options.

9.4 Case for change: the problem we are seeking to address

The proposals are concerned with centralisation of respiratory inpatient beds and the provision of the respiratory high care service taking into consideration a number of factors, including:

- Workforce challenges;
- Benefits of a Respiratory High Care Unit (RHC)[23];
- Improvements to multi-disciplinary team working, and;
- Interdependencies related to the centralisation of the acute medical take to GRH in Sept 2023 (FFTF1).

Workforce challenges

- Make more efficient and effective use of the specialist team
- Need to cover gaps in establishment, medical staff rotas and staff absences.
- Need to improve staff recruitment and retention
- Need to improve junior doctor training and improved training for nursing and therapy staff
- To provide resource support towards the development of a Respiratory High Care unit

[23] Also known as Respiratory Support Units (RSU)

Respiratory High Care (RHC)

- A Respiratory High Care Unit is a dedicated area of enhanced care that enables a higher level of monitoring and respiratory intervention than would be expected for a standard ward environment.
- Currently there isn't a dedicated area for patients requiring non-invasive ventilation (NIV) on the Respiratory wards and there are no central monitoring facilities. This makes it difficult to co-ordinate and safely manage the care for patients receiving NIV.
- The service does not have the necessary support from Advanced Care Practitioners and physiotherapists to be able to deliver high quality care. The lack of facilities and dedicated skilled resource means that the service is limited in its ability offer NIV to patients who would benefit from this service.
- Evidence has shown that patients requiring NIV can be managed within a Respiratory High Care facility, avoiding the need for admission to DCC[24]
- RHC delivers Improved clinical outcomes, specifically improved mortality rates.

Improved multi-disciplinary team working

- Desire to improved multi-disciplinary team working
- Support the implementation of new ACP roles

Support the Centralised Acute Medical Take

- Acute respiratory patients represent a significant proportion of the acute medical take, including many of the sickest patients who often require immediate care on a specialist unit
- There is a need to ensure that the respiratory service has the on-site staff and bed capacity to support the acute medical take.

Compliance with National Recommendations

- Nationally the British Thoracic Society, the Intensive Care Society and the Getting It Right First Time (GIRFT) programme recommend the development and implementation of RHC/ RSU

9.5 Clinical Evidence

The new national report for respiratory medicine published in Sept 2021, by the Getting It Right First Time (GIRFT) programme, outlined how more patients' lives could be saved if all acute trusts could establish a dedicated NIV unit. The report highlighted a gap in provision of NIV. GIRFT recommends a series of actions to help all trusts work towards a dedicated NIV service to help improve outcomes for patients. These include measures to identify the right patients for treatment and starting more treatment at the right time. These units emerged as a key response to the pandemic, delivering improved outcomes for patients and allowing respiratory support for patients outside of intensive care, freeing critical care capacity for those patients who needed invasive ventilation. GIRFT aligns with the British Thoracic Society (BTS) in recommending RSUs in all NHS hospitals.

[24] The intensive care at GHNHSFT is known as Dept. of Critical Care (DCC)

The British Thoracic Society and Intensive Care Society[25] provides guidance on the development and implementation of Respiratory Support Units, setting out the following recommendations:

- Acute NIV should be offered to all patients who meet evidence-based criteria. Hospitals must ensure there is adequate capacity to provide NIV to all eligible patients.
- Acute NIV should only be carried out in specified clinical areas designated for the delivery of acute NIV.
- All staff who prescribe, initiate or make changes to acute NIV treatment should have evidence of training and maintenance of competencies appropriate for their role.

9.6 How was the preferred option evaluated?

Hurdle criteria have been applied across all options[26]. Where any option has failed any of the criteria, it has been removed from the longlist. Whilst the medium-term trajectory of this, and potential future, pandemics is uncertain, the capability to establish a COVID controlled respiratory ward at short notice, is a key part of our response, particularly as we learn more about how the longer-term pattern of these diseases in our communities emerge. The lessons learned regarding the benefits of high care for other (non-COVID) respiratory patients in our hospitals is another factor in developing this important service.

Due to the specialist staffing, equipment and infection control measures already installed at GRH, there is no realistic CGH location for high care in the short to medium term.

As described in section 5.2, the next step was the application of the FFTF desirable criteria.

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was *reverting back* to the original configurations, i.e., reversing the current temporary service change.

The scorecard from the solutions appraisal process is presented overleaf.

The Trust is currently collaborating with the West of England Academic Health Science Network (AHSN) on implementing an NIV care bundle with ongoing data monitoring, audit and evaluation. Data monitoring would include:

- Numbers of patients receiving RHC on the ward
- Mortality rates in comparison with other Trusts providing RHC
- Early discharges
- Length of stay
- Number of admissions to DCC compared to current position
- Avoidance of readmissions

The outputs will be reviewed as part of the monthly service line review process within the Medical Division.

[25] *British Thoracic Society and Intensive Care Society. Respiratory Support Units: Guidance on development and implementation - June 2021, ISSN 2040-2023, British Thoracic Society Reports, Vol 12, Issue 3, June 2021*

[26] The long-list and hurdle assessment can be found in Appendix 11a

Revert the Respiratory Inpatient Beds from a centralised model at GRH (with High Care) to a split site model at GRH and CGH (without High Care).		
Quality	**Scores**	Similar to significantly worse than status quo
	Comments	• When Acute take at GRH more patients would require transfer if revert back. • Most patients will be directed to correct site pre arrival but some 'walk in patients' to CGH may require transfer. • Time to start NIV is important so a reduction in transfer will optimise start time. • Average of 7mins increase in "blue light" does not have clinical impact.
Access	**Scores**	Similar to status quo
	Comments	• Little effect on patient travel- maybe more on family • Same staffing hours but centralisation gives slightly more clinical time. • Respiratory disease often associated with deprivation therefore proposal to collocate at GRH has a positive impact. • Distribution of beds better matched to caseload. • Increased resilience from centralisation to offer Resp. High care
Workforce	**Scores**	Slightly to significantly worse than status quo
	Comments	• Team building positive in last 2 years during move. • Overall time allocated Consultant ward consultation remains the same but beneficial for nursing staff and other members of the team. • Significant impact on nursing team when cross site changes are made. • Centralisation means trainees have an opportunity to see a greater number of conditions plus high care. • Recruitment is easier as roles more attractive. Retention of staff felt to be a major factor
Deliverability	**Scores**	Significantly worse than status quo
	Comments	• If move back significant interruption to other services. • This would affect staff groups, specialist nurses & therapists. • If move back will be without Respiratory High Care. • Dependencies with Acute Take and possibly other services, e.g., cardiology.
Strategic Fit	**Scores**	Significantly worse than status quo
	Comments	• Current configuration in line with clinical strategy • Respiratory high care is nationally recognised as a standard of care and reversing model would prevent delivery of respiratory high care facilities
Acceptability	**Scores**	Significantly worse than status quo
	Comments	• 96% of respondents support the proposals.

Based on the above assessment, the preferred option it to maintain the Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital with a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

9.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Workforce Challenges	Centralisation allows more efficient staffing of the wards, making it easier to cover gaps in establishment, medical staff rotas and staff absences With the specialist staff in one place, it is easier to co-ordinate care, provide training and improve staff recruitment and retention. Centralisation provides the medical and nursing resource to support the development of a Respiratory High Care unit
Respiratory High Care	Our proposed option would enable us to develop a dedicated enhanced Respiratory High Care area, within one of the respiratory wards with central monitoring facilities. Other than a centralised respiratory service at GRH, there is no realistic alternative location for Respiratory High Care in the short to medium term.
Improved multi-disciplinary team working	Centralisation supports improved multi-disciplinary team working as evidenced by processes for joint working e.g. ward/board rounds, MDT meetings, joint care plans etc Centralisation also supports the implementation of new ACP roles
Support the Centralised Acute Medical Take to GRH	When Cheltenham acute medical take moves to Gloucester there should be less respiratory patients coming through. The risk of the patient in Cheltenham who becomes sick with a respiratory complaint will be lower and a patient on a surgical ward becoming unwell could be seen. Acute respiratory patients represent a significant proportion of the acute medical take, including many of the sickest patients who often require immediate care on a specialist unit.
Compliance with National Recommendations	Other than a centralised respiratory service at GRH, there is no realistic alternative location for Respiratory High Care in the short to medium term.

9.8 Benefits including clinical outcomes

Potential Benefits

- The provision of a respiratory high care unit will enable the service to comply with National Quality Standards for acute non-invasive ventilation (NIV) in adults[27] and compliance with recommendations of both the British Thoracic Society and Intensive Care Society and GIRFT for respiratory high care units[28].
- The provision of a respiratory high care unit will improve capacity to deliver NIV care in a ward setting. Experience during COVID showed that an 11 bed RHC unit increased capacity to provide NIV in a ward area by 50%, compared to current provision.
- Provide more timely care. Experience during COVID showed that patients could be admitted direct from ED to the RHC Unit.
- Improve clinical outcomes:
    - Reduce mortality rates. Patients with acute respiratory failure requiring NIV have a 25% inpatient mortality, with national audit showing significantly worse outcomes in patients receiving NIV outside designated high care areas.
    - Improve recovery – reducing the need for oxygen at home
- Decrease Length of Stay through additional prescribing and specialist input throughout the Respiratory unit.
- Reduce re-admission rates, through the provision of timely care.
- Reduction in admissions of respiratory patients to DCC and the ability to step down Respiratory patients in an appropriate timeframe. Admissions are seasonal, at its peak it is anticipated that the provision of a RHC Unit would avoid 7 admissions to DCC a month
- Having the specialty respiratory beds in one place makes it easier to staff the wards and makes more efficient use of the specialist team. With the specialist staff in one place, it is also easier to co-ordinate care, provide training and improve staff recruitment and retention.
- Improved cross specialty working, i.e., how respiratory teams work with other acute specialties (service areas).

Potential drawbacks

- The centralisation of specialist respiratory beds at GRH will impact some patient and carer travel times
- The overall impact is <10% of respiratory patients[29], families and carers are negatively affected by centralising at GRH
- Additional investment will be required to deliver the new high care service on a permanent basis, but evidence shows that this service increases capacity to provide NIV on the ward, improves the quality of care and patient outcomes, including reducing mortality and reducing the number of respiratory admissions to intensive care.

[27] *Davies M, Allen M, Bentley A, et al. British Thoracic Society Quality Standards for acute non-invasive ventilation in adults. BMJ Open Resp Res 2018;5:e000283. doi:10.1136/ bmjresp-2018-000283*

[28] *Guidance on development and implementation - June 2021, ISSN 2040-2023, British Thoracic Society Reports, Vol 12, Issue 3, June 2021*

[29] Details of the methodology can be found in section 11.5

9.9 Interdependencies

There is a key dependency with the acute medical take. The preferred option would support the planned centralisation of the acute medical take. Respiratory patients form a significant proportion of the acute medical take and are some of the highest acuity patients within the medical take, who require prompt transfer and treatment on specialist respiratory ward areas.

Details of the interdependencies between respiratory high care and DCC can be found in section 5.7.4.

9.10 Workforce

The only staffing changes that are being considered relate to the development of the Respiratory High Care service and include 2 x Advanced Clinical Practitioners and 1.5 x Band 7 physiotherapists. The medical and nursing support can be provided within existing establishments.

The workforce benefits of co-location are detailed in the sections above.

9.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for Respiratory are as follows:

- The respiratory emergency patients were diverted to GRH in the model; the C2 mean increases in Gloucestershire CCG by 32 seconds.
- The performance impacts are generally larger than the HASU impacts, though are small in the context of the overall performance.
- The average utilisation of ambulances across SWAST increases by 0.1 percentage points to 68.6%. The increase in travel time to hospital is 6m 26s on average across the 1.5% of transported patients in Gloucestershire CCG who are affected.
- The total time from time of call to handover at hospital increases by 5m19s on average for respiratory patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- An increase of 28 ambulance hours per week is required to mitigate the performance degradation.

9.11.1 *2019/20 Arrival to Handover Modelling*

- SWAST has experienced increased handover delays in 2021/22 compared to previous years.
- The base position, respiratory emergency modelling scenarios were re-run with 2019/20 handover delays to quantify the effect of longer handover times on response performance.
- In respiratory emergency, the impacts on performance with 2019/20 handover delays are of a similar magnitude to that with 2021 handover delays. With 2019/20 handover delays the mean response time impacts are generally smaller, but the 90th percentile impacts are generally larger.

- The C1 impacts are smaller, potentially as due to the lower strain placed on resources by reduced handover delays, the highest acuity category is protected.

In respect of any emergency inter-site transfers, please see section 5.6.

9.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 11b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

9.13 Learning from Temporary Service Change Period

These respiratory proposals have been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

Of particular importance was the development of our COVID respiratory high care service. There is a need to develop a respiratory high care service to improve the quality of service for the local population of Gloucestershire; including patient outcomes, continuity of care, patient experience and reductions in mortality.

9.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel believed that the proposals would deliver clear benefits for respiratory patients.
- The panel believed that the development of a Respiratory High Care Unit (RHCU) is an important advance that would have benefits for patients and is likely to have a positive impact on workforce recruitment and development. However, the panel did not think the development of this unit would have the proposed impact on future critical care bed requirement as many patients are currently receiving respiratory support on the respiratory wards.
- The Panel agreed that the proposals resulted in good training opportunities for respiratory registrars working at CGH during the daytime.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

9.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

9.15.1 *Quantitative Survey responses*

The proposal we engaged on was to continue to centralise Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.

- **97%** of all respondents either **strongly supported** or **supported** the idea
- **100%** of staff respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	64%	0%	0%	100%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	43%	41%	51%	5%	3%	92%
An employee working in health or social care	34%	48%	52%	0%	0%	100%
Prefer not to say	6%	40%	60%	0%	0%	100%
Grand Total	**100%**	**44%**	**53%**	**2%**	**1%**	**97%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 9.16.

9.15.2 *Qualitative ResponsesPublic andPatient themes*

Theme	Survey comment examples
Innovation	• More opportunities for self-referral and annual pulmonary rehab
Clinical considerations	• Need to ensure that patients on these wards with other health conditions receive good support from other specialties. • If the last 2.5 years has shown this to work and be beneficial, that's a pretty compelling 'inadvertent pilot'!! • Review by same practitioners maintain continuity of care. This gives the patient confidence in their care.
Ward environment	• On the whole this idea should be supported however the wards in Gloucester Hospital are poorly ventilated and understaffed.
Integration	• Lack of community support is a huge problem • Putting respiratory professionals in GP clinics/hubs rather than only in GRH • Community involvement may be needed, and it is important to introduce them as soon as possible, to maintain quality care.
Travel	• Makes good sense and has been 'trialled' through the pandemic, again we need to acknowledge limited resources, and the distance is manageable but could be costly for some.

9.15.3 *Qualitative ResponsesStaff themes*

Theme	Survey comment examples
Clinical considerations	• Anyone with a diagnosis of acute respiratory illness having access to relevant teams to avoid A&E attendance, perhaps contact through the direct admission pathway to avoid the emergency department. • Patient transfers from CGH. • Respiratory is a service that has worked well being centralised to GRH site • It seems to make sense to consolidate beds in one site especially with more consultant emergency cover should the patient become acutely unwell
High Care	• Respiratory high care service is a needed service to be able to meet the requirements of acutely unwell respiratory patients. • Evidence from COVID suggests a higher level of respiratory care needed.
Workforce	• The proposal is exciting, there needs to be consideration of the workforce resource required outside of medics and nursing. • The Respiratory service at the Trust is exceptionally well lead and proactive in its outlook and approach.
Integration	• There is further work to be done with improving integration of services across the ICS with further investment for managing respiratory conditions and access to services such as pulmonary rehabilitation and care/support in the community. • Curious as to why some respiratory services couldn't be offered at community level.

9.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
Respiratory High Care
The business case includes on average 11 respiratory high care monitored beds – demand is highly variable. Extra beds are to have monitors in the side rooms for times of high demand of infection control needs. Additional resources required to develop this service are 2 x Advanced Clinical Practitioners and 1.5 x band 7 physiotherapists. The medical and nursing support can be provided within existing establishments.
Patients who come in for surgery may develop other problems that need respiratory help
This would be covered by the consultant based at Cheltenham, very sick patients could be looked after in intensive care.
Patients needing transfer
At the point that the ED team think that the patient needs to be admitted they would put them on the Acute take list, arrangements would then be made to transfer the patient (via a Trust inter-site ambulance) to Gloucester. The patient would be taken directly to the Acute Medical Unit, avoiding the ED.

Feedback received and FFTF2 response
Community support
Cheltenham outpatient clinics will not be changed. We are also developing an Acute Respiratory Infection Virtual Ward. This model will be aimed at patients who would otherwise have been admitted to hospital on a <5 Length of Stay (LoS) bed stays and have a News2 score of <4. This model also supports patients being discharged from hospital to the care of this ward who would otherwise have had to remain in hospital longer.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 9% of patients will be negatively impacted, with 91% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits, including the significant patient outcomes resulting from the establishment of a Respiratory High Care Unit.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **The centralisation of Respiratory in-patient beds is currently implemented as a temporary service change.**

10 Stroke

10.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change" model.

The specialist stroke pathway in Gloucestershire is delivered jointly by Gloucestershire Hospitals NHS FT (GHNHSFT) and Gloucestershire Health and Care NHS FT (GHCFT). The stroke service consists of medical, nursing, therapy and support staff and cares for patients of all ages that present with stroke and/ or Transient Ischaemic Attack (TIA).

The GHNHSFT stroke service manages the largest number of stroke patients in the South West. It is a well-established service with well-developed links to the regional tertiary stroke centre at North Bristol Trust (NBT).

The Gloucestershire stroke pathway comprises the following:

Service	Provider	Pre-COVID location	Current Location
Hyper Acute Stroke Unit (HASU)	GHNHSFT	GRH	CGH[30]
Acute stroke Unit (ASU)	GHNHSFT	GRH	CGH[31]
Community Stroke Rehabilitation unit	GHCFT	The Vale Community Hospital	
Early Supported Discharge (ESD)	GHCFT	Domiciliary / Patient's Home	

Currently (Feb 2023), HASU has 10 beds on the Acute Care Unit and the ASU is located on Woodmancote Ward with 32 beds. Outpatient services are located at CGH and include new and follow up clinics and a transient ischaemic attack clinic. The Stroke service have a funded establishment of six consultants. Details of future bed requirements are provided in section 5.7.

The FFTF2 changes only relate to the location of the HASU and the ASU provided by the Hospitals Trust and do not include any change to the core elements of the Gloucestershire stroke pathway listed above.

Current patient pathway

There is an agreed protocol with South West Ambulance Services Foundation Trust (SWASFT) to take all stroke/query stroke patients direct to CGH.

- SWASFT/GP call via CINAPSIS
- The patient is accepted by the stroke team
- The patient arrives at CGH and is taken directly for a CT scan (no contact with the Emergency Department at CGH)
- The patient is swabbed for COVID. (If a patient requires admission and is negative the patient is admitted to a bed on ACUC. If positive the patient is admitted to Knightsbridge ward.)

[30] Relocated in February 2022 (temporary until March 2023). Split site model Jun 2020 to Jan 2022.

[31] Relocated in June 2020 (temporary until March 2023)

- Depending on their condition, following their stay on HASU, patients are either transferred to the ASU (~50%) to continue their inpatient treatment and care, transferred to another service provider or able to return home with on-going community support where needed.

If patients with stroke symptoms 'walk in' at the CGH Emergency Department, the stroke team are alerted, the patient is assessed and if appropriate, they are admitted.

If a patient with stroke symptoms 'walks in' at GRH Emergency Department, they receive a priority assessment and there is immediate communication with the stroke team. If appropriate the patient is transferred to CGH for rapid stroke assessment.

There is a consult model in place for GRH, which means that stroke staff will provide advice and support to other specialties (service areas) on the GRH site.

Prior to the relocation of the HASU to CGH the Trust discussed the proposal with the national Getting It Right First Time (GIRFT) clinical lead for stroke services and has been advised that a similar model is currently being used at East Kent Hospitals with direct admissions to a planned care site. Feedback on the proposed model has been positive and supportive.

10.2 Activity

The pathway schematic (Appendix 12a) details the flow and numbers of patients for the period Jun 20- May 21. In summary:

- ~ 1000 strokes including stroke admissions and existing inpatients experiencing a stroke
- ~50% of stroke admissions are transferred to ASU
- A significant proportion of stroke admissions (~30%) are discharged to usual place of residence from HASU

10.3 Clinical Engagement

A Task and Finish group, as a sub-group of the Circulatory CPG, was established to undertake a diagnostic review of current service configuration and with the aim of developing a service model and configuration for the stroke services in Gloucestershire, which will maintain and enhance service performance as measured by the SSNAP[32] indicators.

The scope of this review included the optimal number of beds, the longer-term preferred staffing models for each element of the pathway (including opportunities and benefits of enabling staff to work across the whole pathway) and options[33] for improving the non-bedded element (Community Rehabilitation etc.).

Membership of this group included clinical and management representatives from GHNHSFT and GHCFT, CCG commissioning leads, Stroke Association and lay representation.

[32] Sentinel Stroke National Audit Programme

[33] This is subject to a separate Business Case process and outside the scope of FFTF2

10.4 Case for change: the problem we are seeking to address

The FFTF2 proposals are concerned with location of the HASU and ASU taking into consideration a number of factors, including:

- Benefits of co-location including workforce
- Removal of stroke from the ED pathway improving outcomes and mitigating ED demand
- Site bed capacity constraints
- Ward environment available at each site

Workforce

Nationally there is a shortage of stroke doctors. The Trust has attempted to recruit to these posts substantively, but this has been difficult as, across the country, Trusts are chasing a limited workforce pool. Strenuous efforts have also been made to backfill these posts, including locum/off framework agency staff. Despite these efforts it has proved difficult to cover these vacancies.

In addition, a combination of planned and unplanned staff changes means the number of stroke medical and nursing staff has reduced. This position made it difficult to provide safe and sustainable staffing levels on stroke wards under the post-COVID split site configuration at GRH and CGH, and to continue to provide outpatient services on both sites.

Given the above position the Trust identified the stroke staffing levels as an intolerable risk (number ID 3706) and, following detailed assessment of the options to reconfigure the service to make the best use of available staff, it determined that centralising stroke services onto one site would help mitigate this risk; the Trust moved HASU to CGH in Feb 2022.

This change has enabled staff covering all stroke areas (stroke doctors, nurses and therapists) to be on same site, so more able to cross cover each other.

ASU Ward Environment

Operating the ASU at CGH has highlighted a number of staff and patient benefits. Feedback from staff and patients is that Woodmancote is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement.

Removal of stroke from the ED pathway

GRH and CGH Emergency Departments (EDs) are facing increasing demand due to delayed presentations from the pandemic, continued COVID demand, difficulties in patients accessing other services, difficulties in discharging patients who are medically fit, all of which affects to overall patient flow from the ED and delays in ambulance handovers. This can lead to delays in stroke patients being seen by the correct team impacting the ability to meet national standards for stroke care, for example time to CT scan carrying out thrombolysis[34] and admission to a dedicated stroke ward within 4 hours. The timely administration of tPA/ thrombolysis saves lives and because tPA restores blood flow by dissolving the clots in a blood vessel, it may limit the damage from a stroke and protect

[34] The medicine itself is called alteplase, or recombinant tissue plasminogen activator (rt-PA). The process of giving this medicine is known as thrombolysis.

against quality of life impacts, like mobility loss or speech difficulties. More benefits can be found in section 10.8).

In its pre-Pandemic configuration (with both HASU and ASU at GRH) the stroke service was rated C (on a scale of A to E), and initially, in its temporary configuration the service was rated B. However, the split site model and system pressures during winter 21/22 resulted in a rating fall to D.

The creation of a direct admit pathway, avoiding the need for patients to be seen in ED has improved the Trust's performance against national SSNAP targets on the time taken to receive a CT scan, to be assessed, to receive thrombolysis and be admitted to a stroke ward. Following the relocation of HASU to CGH the Trust SSNAP scores have improved (to either C or B in the quarters since Mar 2022).

In addition, relocating the HASU to CGH and revising the admission pathway has reduced pressure in GRH ED and GRH cardiology ward/medical bed base. The direct patient pathway to stroke team, that avoids ED, has reduced pressure in GRH and CGH ED.

10.5 Clinical Evidence

There has been strong evidence for many years that treatment at specialised stroke units, offering rapid access to the range of appropriate assessments and multidisciplinary expertise and intervention, is associated with lower mortality and lower rates of post-hospital disability[35].

Our current pathway (and proposals) is following NICE guidance (NG128, QS2 and CG 162) and the removal of stroke from the ED pathway is enabling direct to CT, earlier Alteplase (we are starting bolus in CT), a more protected bed capacity and so better access to specialist stroke unit.

As stated in section 10.1 the FFTF2 changes only relate to the location of the HASU and the Acute Stroke Unit ASU provided by the Hospitals Trust and do not include any change to the core elements of the Gloucestershire stroke pathway, which are aligned with best practice[36], that is:

- **Hyper-acute care** typically covers the first 72 hours after admission. Every patient with acute stroke should gain rapid access to a stroke unit (<4 hours) and receive an early multidisciplinary assessment.
- **Acute stroke car**e immediately follows the hyper-acute phase, usually 72 hours after admission. Acute stroke care services provide continuous specialist input, with daily multidisciplinary care and continued access to stroke trained consultant care, physiological monitoring and urgent imaging as required.
- **Inpatient rehabilitation** is an essential bridge for many stroke survivors between acute stroke care and post-discharge integrated community rehabilitation. Its key outcomes overlap with those for acute stroke care, community rehabilitation and life after stroke.
- **Early Supported Discharge** facilitates early transfer of care to a community setting, where rehabilitation continues at the same intensity and with the same expertise as in the inpatient setting.

[35] Stroke: GIRFT Programme National Specialty Report (April 2022)

[36] National Stroke Service Model (May 2021)

10.6 How was preferred option evaluated?

The T&F Group applied hurdle criteria to the long-list (of 256 possible permutations)[37]. This process was undertaken prior to the decision to relocate HASU to CGH (Feb 2022) and before the decision to separate the non-bedded developments into a separate business case process outside of FFTF2. Taking these factors into account, particularly the learning over the past two years that it is more effective to manage and deliver a quality service if both units are on the same site, the medium-list became #3.

As described in section 5.2, the next step was the application of the FFTF desirable criteria. Our solutions appraisal exercise is designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in the case of stroke was *reverting back* to the original configurations, i.e., reversing the current temporary service change.

The scorecard from the solutions appraisal process is presented overleaf.

[37] The long-list and original hurdle assessment can be found in Appendix 12a

	Revert Hyper-Acute Stroke Unit and Acute Stroke Unit from CGH and back to GRH	
Quality	Scores	Worse than status quo
	Comments	• Key benefit of current model is direct admitted pathway. • SSNAP from Feb access to CT and HASU beds has improved. • Woodmancote purpose built as an acute unit. • CGH gives more opportunity to provide the number of beds required. • Some feedback from vascular but view not essential to have co-location. • No significant "Blue Light" impact
Access	Scores	Broadly similar to status quo
	Comments	• Cinapsis significantly improved • Overall public transport options for services moving to CGH generally worse. • Access to HASU is better on CGH site as well as Woodmancote as less bed pressures and ability to reduce LOS
Workforce	Scores	Similar or slightly worse than status quo
	Comments	• Move positively received by staff. • Issue moving Woodmancote back for rehab colleagues, thrive in a rehab environment. • Better space for training • Woodmancote better environment to develop skills and deliver care
Deliverability	Scores	Worse than status quo
	Comments	• Should not underestimate the space needed, which would be a challenge to provide on the GRH site. • Better access to CT and MRI at CGH.
Strategic Fit	Scores	Similar than status quo
	Comments	• Purist planned and emergency site split - slightly worse. • Innovative model not accepted "norm" but other sites in England
Acceptability	Scores	Similar than status quo
	Comments	• Comments from vascular. Concerns re pathway, but this would not materially change. • 82% of respondents support the proposals

Based on the above assessment, the preferred option it to maintain the Hyper Acute Stroke Unit (HASU) and Acute stroke ward (ASU) at Cheltenham General Hospital.

There will continue to be a choice of outpatient appointments at CGH and virtually when appropriate.

10.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Improved rehabilitation ward environment	Woodmancote at CGH is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward at GRH, as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement.
Removal of stroke from the ED pathway	Our current pathway (and proposals) is following NICE guidance (NG128, QS2 and CG 162) and the removal of stroke from the ED pathway is enabling direct to CT, earlier Alteplase (we are starting bolus in CT.
Site bed capacity constraints	The relocation of both HASU and ASU to CGH has created an opportunity for a more protected stroke bed capacity than was achieved on our emergency site (GRH)
Workforce	The co-location of HASU and ASU are essential to mitigating our workforce requirements and risks. The proposal delivers this.

10.8 Benefits including clinical outcomes

Potential Benefits

- Direct admit stroke pathway (avoiding ED) which improves performance against four of ten SSNAP domains, i.e., Domain 1 -time to scan, Domain 2 – admission to a stroke Unit, Domain 3 proportion of patients receiving thrombolysis and timescale and Domain 4 – specialist assessment and timescale.

Overall thrombolysis/ tPA effectiveness:

- 1 in 3 get better
- 1 in 10 get significantly better incl complete recovery
- 1 in 33 get worse including bleeding and/or death
- Every 15 minute delay in re-perfusing an ischaemic stroke equates to 1 extra year of disability

- Both inpatient units are on the same site - which supports a seamless service and means that patients can access the right specialist staff at the right time
- The co-location of HASU and ASU provides improved staff cover and improved staff resilience for sickness and absence
- The ASU would continue to use the specialist Woodmancote Ward and would not need to share space with HASU. This environment is more spacious, it has hoists and provides an area for therapy services. It is also a better and quieter environment for patients receiving rehabilitation care. The quality of this environment is better than the original space available at GRH

- When compared to a split site option it reduces the need to transfer patients receiving inpatient stroke care[38]
- There would not be the same challenges on bed availability as there would be on the GRH site.
- Reduced pressure in GRH ED and GRH cardiology ward/medical bed base
- Better training of stroke ward juniors
- TIA clinic could be run from Ambulatory Emergency Care Unit (AEC) at CGH – enabling faster access to specialist opinion, ability to train acute medical juniors in stroke.
- Reduced pressure on GRH CT/MRI.

Potential drawbacks

- There will be travel impact for some patients previously attending GRH who will now attend CGH. The overall impact is 15% of HASU and 17% of ASU stroke patients / families/ carers are negatively affected by centralising at CGH[39]
- There are a number of non-stroke conditions that can present with similar clinical features to stroke and TIA (these patients are known as stroke mimics). These may be taken to CGH and then, once identified, are either managed by the stroke team at CGH or may be required to be transferred to GRH.
- Likewise, there may be patients that develop a stroke whilst an inpatient at GRH and may need to be transferred stroke unit. However, this position would be similar if the stroke service was to revert to being centralised at GRH.
- Whilst the clinical evidence for consolidating stroke services onto a single site (now CGH) shows improved patient outcomes, clinical protocols are in place for any suspected stroke patient presenting at GRH, including advice and support and safe transfer from GRH to CGH.

10.9 Interdependencies with other services

There are a number of interdependencies of operating the HASU at CGH (our planned site), these including medical cover at CGH once the Acute Medical Take (ACUC) moves to GRH (September 2023). Full details of rotas are provided in Appendix 6.

10.10 Workforce

The Stroke service have a funded establishment of 6 consultants.

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

[38] There would still be occasions where a patient may 'walk in' at the GRH Emergency Department and would need to be transferred to CGH or an inpatient at GRH has a stroke, while under the care of another service area (specialty) and, based on their clinical needs, it is decided to transfer them to CGH.

[39] Details of the methodology can be found in section 11.5

10.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for HASU are as follows:

- The impact to response performance of making the proposed changes are generally small, at 18 seconds for both the C2 mean and C2 90th percentile in Gloucestershire CCG.
- Average ambulance utilisation across the model increases by 0.1 percentage points; this is expected as despite travel time to CGH being 3m 37s longer on average, only 1.2% of transported patients in Gloucestershire CCG are affected by the change.
- The total time from time of call to handover at hospital increases by 7m24s for HASU patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- A series of simulation runs were then carried out, adding additional ambulance deployments at Staverton to identify the additional resources required to mitigate the performance impacts.
- An additional 14 ambulance hours per week at Staverton are needed to restore performance, delivered through the extension of shifts. In terms of scale, this is approximately 10% of the overall additional ambulance hours required for FFTF1.

10.11.1 *2019/20 Arrival to Handover Modelling*

- SWAST has experienced increased handover delays in 2021/22 compared to previous years.
- The base position, HASU modelling scenarios were re-run with 2019/20 handover delays to quantify the effect of longer handover times on response performance.
- In HASU, the impacts on performance with 2019/20 handover delays are of a similar magnitude to that with 2021 handover delays. With 2019/20 handover delays the mean response time impacts are generally smaller, but the 90th percentile impacts are generally larger.
- The C1 impacts are smaller, potentially as due to the lower strain placed on resources by reduced handover delays, the highest acuity category is protected.

In respect of any emergency inter-site transfers, please see section 5.6.

10.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 12b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

10.13 Learning from Temporary Service Change Period

These stroke proposals have been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

10.14 South West Clinical Senate Review

The clinical panel made the following comments:

- Whilst most stroke services are co-located with the acute medical take, the Panel believed that the proposals would deliver clear benefits for stroke patients but that there are also some possible disbenefits including for those presenting to GRH who will need to be transferred to CGH for management and rehabilitation and may experience delays in their early management.
- Integration of the ASU and HASU on the same site at CGH in purpose-built accommodation is advantageous for both patients and staff.
- "Direct to CT" pathways will save valuable time in assessing and managing people with a stroke brought to hospital by ambulance.
- It would be preferable for stroke mimic patients to be cared for at GRH under other acute medicine pathways, instead of in the Stroke Unit at CGH, but this may not always be possible, and bed and workforce planning must allow for the continuing management of stroke mimics at CGH.
- The Panel observed that the imaging support at CGH is currently unable to identify late presenting patients who may be suitable for thrombectomy using CT Perfusion Imaging in line with NICE Guidance NG128 and the national optimal stroke imaging pathway. The Panel recommended that this is addressed as soon as possible.

In respect of the point raised above, the clinical teams have indicated the following:

- We are aware of the benefits of CT perfusion scanning and are working with our radiology department to look at how to progress this within GHNHST. This will require training of radiographers and radiologists, which does not have an immediate solution, but we know this is an aim.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

10.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

10.15.1 *Quantitative Survey responses*

The proposal we engaged on is that both the Hyper Acute Stroke Unit and Acute Stroke Unit remain permanently at CGH and the way that patients currently access the service remains the same. The learning over the past two years is that it's easier to manage and deliver a quality service if both units are on the same site (CGH).

- **84%** of all respondents excluding staff either **strongly supported** or **supported** the idea
- **73%** of staff respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	46%	9%	9%	82%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	44%	51%	47%	0%	2%	98%
An employee working in health or social care	35%	36%	37%	0%	27%	73%
Prefer not to say	5%	20%	20%	0%	60%	40%
Grand Total	**100%**	**43%**	**41%**	**1%**	**15%**	**84%**

It should be noted that the ideas for stroke received the highest proportion of opposition from survey respondents compared to other services, particularly from staff concerned with the location of stroke at the non-emergency site. Concerns were raised especially regarding co-location with vascular surgery and cardiology. All survey comments were reviewed by the Stroke team and a response is provided in section 10.16. Meetings between the two services have also been undertaken.

All survey respondents were asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 10.16.

10.15.2 *Qualitative Responses Public and Patient themes*

Theme	Survey comment examples
Interdependencies	• Getting a stroke patient to one of these units within the critical 4 hours is another matter given the current demand for ambulances.
Clinical considerations	• I'm very unsure about this. No mention made of thrombectomy • I am concerned that, with the often time critical nature of strokes, the move of in-patient stroke to CGH might lengthen the time before a patient received a necessary thrombolytic agent. • The issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. • Why would you have Stroke based at Cheltenham General when cardiac, interventional radiology and vascular services are all at Gloucestershire Royal Hospital • Happy that CGH has control of stroke admissions. I agree with potential benefits.
Benefits	• Excellent - good analysis of potential drawback • Streamline to get the best optimal service. The better and sooner we treat stroke, the way better the outcomes for patients and their long-term outlook.
Ward environment	• It makes sense to have both the HASU and ASU on the same site, but also that they are separated so as to have the ASU in the quieter area.

Theme	Survey comment examples
	• Vital to have prompt effective assessment and treatment. Good to have a therapy areas on Woodmancote Ward.
Inter-site transfers	• There will still be transfers required, but there would be anyway if it was all located at GRH. However, as ever the issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. • Same site for both makes sense and if transport between the 2 hospitals if needed is in place, that should cover the unusual cases

10.15.3 *Qualitative ResponsesStaff themes*

Theme	Survey comment examples
Clinical considerations	• The purpose-built ward at CGH is suitable • I share the concern about receiving the correct treatment, diagnosis and transfers to Cheltenham. • The new model for HASU works well having limited beds and a focus on patients being moved on quickly
Interdependencies	• Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site. • Acute stroke is an emergency service, and it should be based at a site where there is 24 hour ED • What happens to overnight Strokes when ACUC moves to GRH, and the medical cover goes with it? • Removing the service from the main ED and delaying crucial intervention such as thrombolysis.
Workforce	• It has hugely helped with staffing and team moral being on the same site. • I point out that, especially for understaffed therapy teams, HASU and ASU being on the same site saves huge amounts of resources as the therapists can help out on each ward depending on staffing and patient demands. • I would also say that the service should have more funding for therapists and assistants and would benefit from an activities coordinator, social work support and complex discharge coordinator
Ward environment	• The current HASU ward is not fit for purpose • Larger clinical area for HASU - more room for beginning rehabilitation of patients • Woodmancote is more modern, lighter and purpose built for Stroke rehabilitation. • Woodmancote is well suited to the therapy needs of patients considering the track hoists and large therapy room and Cheltenham hospital is a good environment for these patients with nice outdoor areas that can be accessed.

Theme	Survey comment examples
Health inequalities	• Stroke services should be at biggest acute hospital in the city where socioeconomic circumstances make stroke most common

10.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site.
There is currently no interventional radiology input from Gloucester or Cheltenham. The interventional radiology for strokes is carried out at Southmead and there is no intention that that will change. If, and when, GHNHSFT starts providing thrombectomy for strokes, we will revisit our service configurations, but currently and the for the next few years, this is not an issue. The vascular issue is around access to carotid dopplers and carotid endarterectomy for the high TIAs. Surgery is not performed on the same day and best practice is within seven days. The vascular unit at GRH includes patients from Swindon which is acceptable. Cardiology input is for telemetry and tapes and echoes. We will continue to have cardiac investigations on both sites. Furthermore, echoes are never immediate to help guide next steps of treatment. It's not emergency care. We rarely share stroke patients with cardiology. We may occasionally ask for advice on rhythm disturbance, but we have not had a patient that suddenly had a heart attack and needed resuscitating.
Medical cover at CGH
Out of hours there is 24/7 medical registrar cover at CGH. This registrar provides cover for the acute take as well as supporting the stroke service. Once the acute take centralises at GRH the responsibilities of this post will reduce. The medical registrar works closely with the specialist nurses and the Advanced Care Response Team. There is a Consultant Specialist regional on call rota for thrombolysis/thrombectomy queries. At weekends there is a Stroke Consultant on site at GRH from 8am – 12.00.
Strokes at GRH
If a patient with stroke symptoms 'walks in' at GRH Emergency Department, they receive a priority assessment and there is immediate communication with the stroke team. If appropriate the patient is transferred to CGH for rapid stroke assessment. There is a consult model in place for GRH, which means that stroke staff will provide advice and support to other specialties (service areas) on the GRH site. There is now an agreed protocol for managing COVID positive stroke patients in CGH.
Ambulance travel times
As with FFTF1, the FFTF2 programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for HASU are as follows:

- The impact to response performance of making the proposed changes are generally small, at 18 seconds for both the C2 mean and C2 90th percentile in Gloucestershire CCG.
- Average ambulance utilisation across the model increases by 0.1 percentage points; this is expected as despite travel time to CGH being 3m 37s longer on average, only 1.2% of transported patients in NHS Gloucestershire are affected by the change.
- The total time from time of call to handover at hospital increases by 7m24s for HASU patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- A series of simulation runs were then carried out, adding additional ambulance deployments at Staverton to identify the additional resources required to mitigate the performance impacts.
- An additional 14 ambulance hours per week at Staverton are needed to restore performance, delivered through the extension of shifts. In terms of scale, this is approximately 10% of the overall additional ambulance hours required for FFTF1.

Ward environment

As part of proposed moves for Cardiology in May 23, the HASU will be able to relocate into the Cardiology ward at CGH, which will provide 21 beds. This ward looks out on to a courtyard garden providing better space for recovery. It will also provide better space for therapy services. Cheltenham has better car parking access for wheelchair users.

Travel and Transport

The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 15% of patients will be negatively impacted, with 85% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Inter-site transfers

The Trust currently has a contract with an independent company to provide patient transfers by ambulance. The transfers include transporting patients from the GRH to Hartpury Suite (Cath Lab) at CGH, supporting patient discharge to their place of residence or to other providers and transferring patients between the two hospital sites. As part of FFTF Phase 1, work was carried out to identify the inter hospital demand to support the centralisation of emergency general surgery and the acute medical take at GRH, and the transfer of vascular services and interventional cardiology services to GRH. This work has been updated to reflect the current experience during the temporary service changes and the proposed service changes within FFTF Phase 2, i.e., the centralisation of respiratory, cardiology, diabetes and endocrinology services at GRH and the centralisation of stroke services at CGH.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits and supports improvements in SSNAP performance.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This service change proposal is currently implemented as a temporary service change.**

11 Integrated Impact Assessment (IIA)

An integrated impact assessment supports decision making by evaluating the impact of a proposal, informing public debate and supporting decision makers to meet their Public Sector Equality Duty (see section 13.3), and their duty to reduce inequalities.

In relation to equality, these responsibilities include assessing and considering the potential impact which the proposed service relocation could have on people with characteristics that have been given protection under the Equality Act, especially in relation to their health outcomes and the experiences of patients, communities and the workforce. With reference to health and health inequalities, the responsibilities include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

The assessment uses techniques such as evidenced based research, engagement and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services. The aim of the assessment is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative impacts of the proposed change. The Fit for the Future (FFTF) programme undertakes the following process to develop its IIA.

1. Undertake a baseline IIA for each service based on the proposals, clinical evidence and potential outcomes prior to the engagement process and include recommendations based on the evidence review to inform an action plan.
2. Update the baseline IIA following public involvement to take account of feedback from the public, patients, staff and stakeholders. The IIA report contains evidence that decision-making arrangements will pay due regard to equalities and inequalities issues and the Brown principles[40].

A full IIA for each service is provided in the relevant appendices (13a-e), which includes all data and evidence-based review. The FFTF IIA uses data and analysis provided by the Office of National Statistics (ONS) to help us understand impacts on those affected by potential change. These IIA's use data from the 2011 Census as this is the most recent Census data that has been robustly analysed by the ONS, who provide a statistical commentary which we have used to help us with our assessments of impact. The IIA's also contain data from GHFT detailing admissions to hospital by protected characteristic and location which helps us analyse impacts of change.

The most recent census also took place in 2021 and the ONS is currently in the process of releasing data, analysis and commentary, however, this is not available for this DMBC as the ONS release schedule is currently planned for:

- Early 2023 - Phase 2: Multivariant data releases and statistical commentary
- Spring 2023 – Phase 3: Alternative population base analysis (workplace etc) and statistical commentary
- Summer 2023 – Phase 4: Comparable data released and statistical commentary

As soon as more data is available it will be used in future IIA's.

[40] [40] R. (Brown) v. Secretary of State for Work and Pensions [2008] EWHC 3158 at paras 90-96.

The FFTF IIA is made up of 3 chapters:

- Equality Impact Assessment
- Health inequalities impact assessment
- Health impact assessment

The proposals presented in the FFTF2 engagement for all groups were found to be either neutral impact, significant positive impact/moderate adverse impact, or significant positive impact.

Our approach to the engagement targeted all groups, ensuring proactive engagement amongst older and disabled residents more likely to be service users and ensuring opportunities for people to have their say were provided in both urban and rural venues through the extensive use of the NHS Information Bus and Get Involved in Gloucestershire (GiG) engagement website.

11.1 IIA Summary

As stated above full IIAs for each service is provided in the relevant appendices, however, the impact assessment for services consolidating on either the CGH or GRH site is often similar including:

- Centralisation of services can improve patient outcomes, continuity of care, length of stay, patient experience and reduces mortality particularly beneficial to patients with protected characteristics including those with long term conditions or co-morbidities which are prevalent in patients with disabilities and those over 65.
- Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services to GRH might have a greater positive impact on these communities
- On the basis that there is a higher proportion of the population in the Gloucester district who are living in deprivation (25%) and who suffer from Type 2 Diabetes (6.8%) there is a potential that patients who access the service from Gloucester will be positively impacted by a movement of services to GRH
- The re-location of services from GRH to CGH will impact some patient and carer travel times either positively or negatively (see individual service sections for service impacts)
- There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely based on a person's sex.
- There is currently limited data to determine any impact of the changes for women during pregnancy.
- There is currently limited data to ascertain any impact of the changes for those who are from any particular marital status.
- According to the Stonewall survey, 13% of LGBTQ+ people have experienced some form of unequal treatment from healthcare staff because they are LGBTQ+
- There is currently limited data to ascertain any impact of the changes for those who are from any particular religious background.
- There is limited evidence regarding the impact to those who have undergone gender reassignment, however, impacts may mirror those of sexual orientation.

- Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes.
- Consolidation of the inpatient bed base should provide shorter lengths of stay, faster diagnostics and minimised waiting times which will help carers who have to attend hospital regularly.
- Services centralising at GRH will be located nearer to the highest proportion of homeless people in Gloucestershire. Homeless people are more likely to have long term conditions and multiple conditions which means consolidating and co-locating services will provide support for more complex needs such as these.
- Mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. Relocation of services may therefore be beneficial to this group.
- GHNHSFT admission data demonstrates that more people attend GRH than CGH with mental health related issues. Relocating services to GRH may therefore be beneficial to this cohort.
- The consolidation of relevant specialist services improves training and enhanced understanding of patient conditions, leading to better clinical outcomes and improving access to services with fewer cancellations
- Feedback from staff and patients suggests public transport and parking can be a challenge at both sites.
- Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access.

11.2 Equality Impact assessment

Equality impact assessment (EIA) is a tool which identifies and assesses impacts on a range of affected groups of people with characteristics protected under the Equality Act 2010, namely: age; gender, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race and ethnicity; religion and belief; and sexual orientation.

The aim of an EIA is to establish the differential impact of a policy, such as in this case the development of centres of excellence and the proposed relocation or centralisation of services within Gloucestershire, on these groups. It also considers the potential measures which could reduce any negative impacts, especially in relation to health outcomes and the experiences of patients, carers, communities and the workforce. It also seeks to identify opportunities to better promote equality and good relations.

A full EIA for each service is provided in the relevant appendices (13a-e), which includes all data and evidence-based review. The impacts for each EIA domain are presented below; the key indicates the nature of the impact. This key is used throughout this section.

Key	Description
Significant Positive Impact	The positive impact is significant despite small adverse impacts
Significant Positive Impact Moderate Adverse Impact	The positive impacts outweigh the adverse impacts, however the adverse impacts have been identified and recommendations made to mitigate against these
Significant Adverse Impact	The adverse impact is significant and despite positive impacts it is not clear that the adverse impacts are outweighed by the positive impacts
Neutral Impact (no significant change)	No significant change identified for this cohort

Equality Impact Assessment – Summary of Impact by Service Proposal

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Protected Characteristics	Age	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Disability	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Pregnancy	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Marital Status	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Ethnicity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Religion	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender reassignment	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

11.3 Health Inequalities Impact Assessment

The Health Inequalities Impact Assessment identifies and assesses health inequalities and the impact of the proposed changes for the local community. The aims of a health inequalities impact assessment include identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

Unlike the protected characteristics listed in the Equality Act 2010, there are no specific groups identified in Section 14T of the NHS Act 2006 in relation to the duty to reduce health inequalities. However, research has identified that a range of groups and communities are at greater risk of poorer access to health care and poorer health outcomes[41]. Groups other than those that have protected characteristics as defined in the Equality Act 2010 who face health inequalities include Looked after and accommodated children and young people, carers (paid/unpaid & family members), homeless people or those who experience

[41] https://www.england.nhs.uk/wp-content/uploads/2019/01/ehia-long-term-plan.pdf

homelessness, people with addictions and substance misuse problems, on low incomes, living in deprived areas or remote locations, and those with enduring mental ill health.

A full Health Inequalities Impact Assessment (HIIA) for each service is provided in the relevant appendices, which includes all data and evidence-based review. The impacts for each HIIA domain are presented below; the key indicates the nature of the impact; see key description used above.

Health Inequalities Impact Assessment – Summary of Impact by Service Proposal

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Health Inequalities	Deprivation	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Looked After Children (LAC)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)
	Carers and unpaid carers	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact
	Homelessness	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact
	Substance Abuse	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Mental Health	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	People Living in rural and remote areas	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Neutral Impact (No Significant Change)	Significant Positive Impact

11.4 Health Impact Assessment

The Health Impact Assessment (HIA) identifies and assesses health outcomes, service impacts and workforce impact of the proposed changes for the local community. The aims of a health impact assessment include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

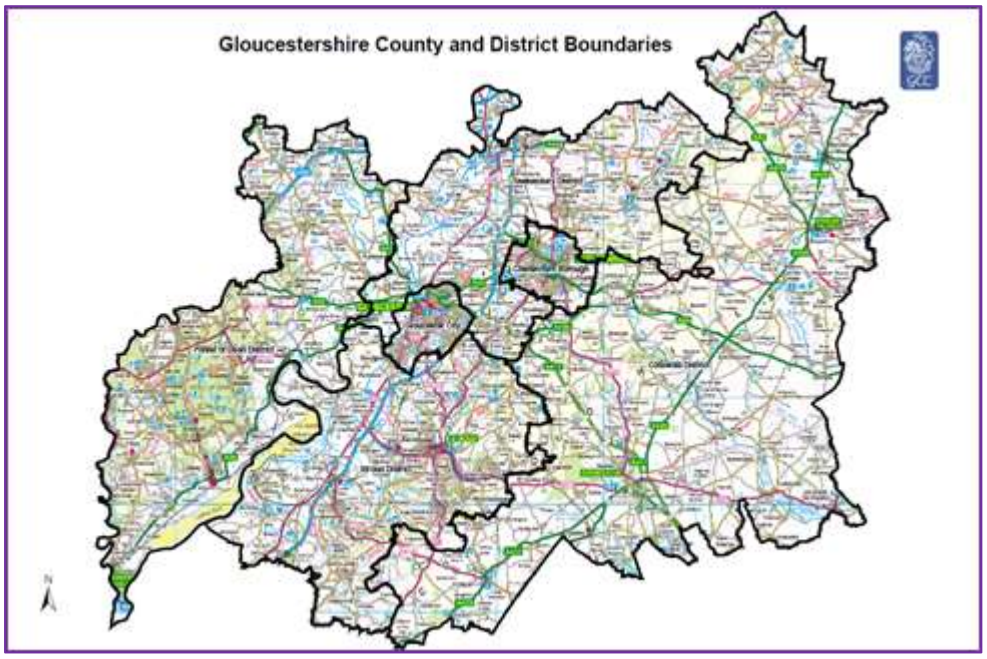
A full Health Impact Assessment (HIA) for each service is provided in the relevant appendices, which includes all data and evidence-based review. The impacts for each HIA domain are presented overleaf; the key indicates the nature of the impact; see key description used above.

Health Inequalities Impact Assessment – Summary of Impact by Service Proposal

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Health Impact	Cardiovascular Disease	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Diabetes Mellitus	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Falls among the elderly	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Overweight and Obesity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

11.5 Patient and Carer Travel

All of the proposed changes involve services being centralised (or consolidated) on one or other of GHNHSFT two main hospital sites, Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH), which are 8 miles apart.



Locality Populations	
Cheltenham	117,090
Gloucester	129,285
Tewkesbury	92,599
Cotswolds	89,022
Stroud	119,019
Forest of Dean	86,543

We fully recognise and appreciate that behind every number is a patient and family/carer and that the day to day impact on them will vary dependent on a range of factors including access to car travel, public transport availability and accessibility and differential impact related to protected characteristics.

We have undertaken detailed analysis using anonymised activity for the FFTF2 services to assess the impact of our proposals on patients. Using the postcodes in our baseline activity we worked with the NHS South, Central and West Commissioning Support Unit (SCW CSU) to create spatial maps for each service proposal. The analysis was completed for:

- Travel by car (peak)
- Travel by car (off peak)
- Travel by public transport

As the data was anonymised and we therefore do not have access to the specific mode of transport used by patients who currently access services, we have used the following methodology to calculate the impact for each model:

Step 1. For all modes of travel (assuming all patients were to access using this mode), calculate the numbers of patients for each service, for each of the following categories

a. Positive impact (decrease 20+ minutes)
b. Neutral impact (+/- 20 minutes)
c. Negative impact (increase 20+ minutes)

Step 2. For each service identify the locality within Gloucestershire where the largest number of negatively impacted patients reside.

Step 3. Using ONS car ownership data for the relevant locality, calculate the potential number of patients for each service who could be users of public transport (This is likely to overstate the use of public transport as many non-car owners will use other means to get to hospital).

Step 4. For each service proposal assess if time of day (peak or off-peak) can be estimated e.g., if emergency (distributed across 24 hrs) or Day-case (2 cohorts a.m. peak and p.m. off-peak).

Step 5. Using the data from Step 1 calculate the number of patients for each proposal that will be travelling by car (peak and off-peak) and by public transport.

Step 6. Using the data from Step 1 and 5 calculate the number of patients for each proposal who are negatively or positively affected and deduct from the total to find those where the impact is neutral.

The details of the annual travel impact (for peak / off-peak car and for public transport) is provided for each service in the respective service sections above with a more detailed breakdown in the service IIAs (Appendices 13a-e); a summary of impacts is tabled below:

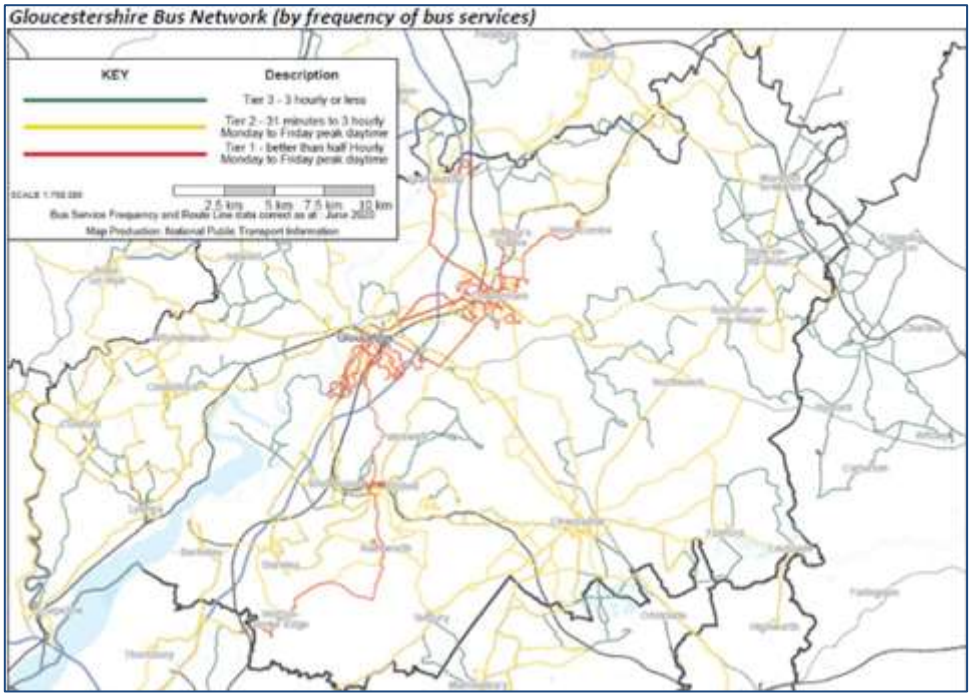
Service	Positive Impact (Decrease 20+ mins)	Neutral Impact (+/- 20mins)	Negative Impact (Increase 20+ mins)
Stroke			
-Hyper-Acute Stroke Unit (all patients)	9.7%	75.2%	15.1%
-Acute Stroke Unit (50% patients[42])	11.0%	72.1%	16.9%
Respiratory	2.0%	89.5%	8.5%
Diabetes and Endocrinology	4.9%	90.9%	4.2%
Non-interventional Cardiology	15.3%	74.7%	10%
Benign Gynaecology	8.6%	73.7%	17.8%

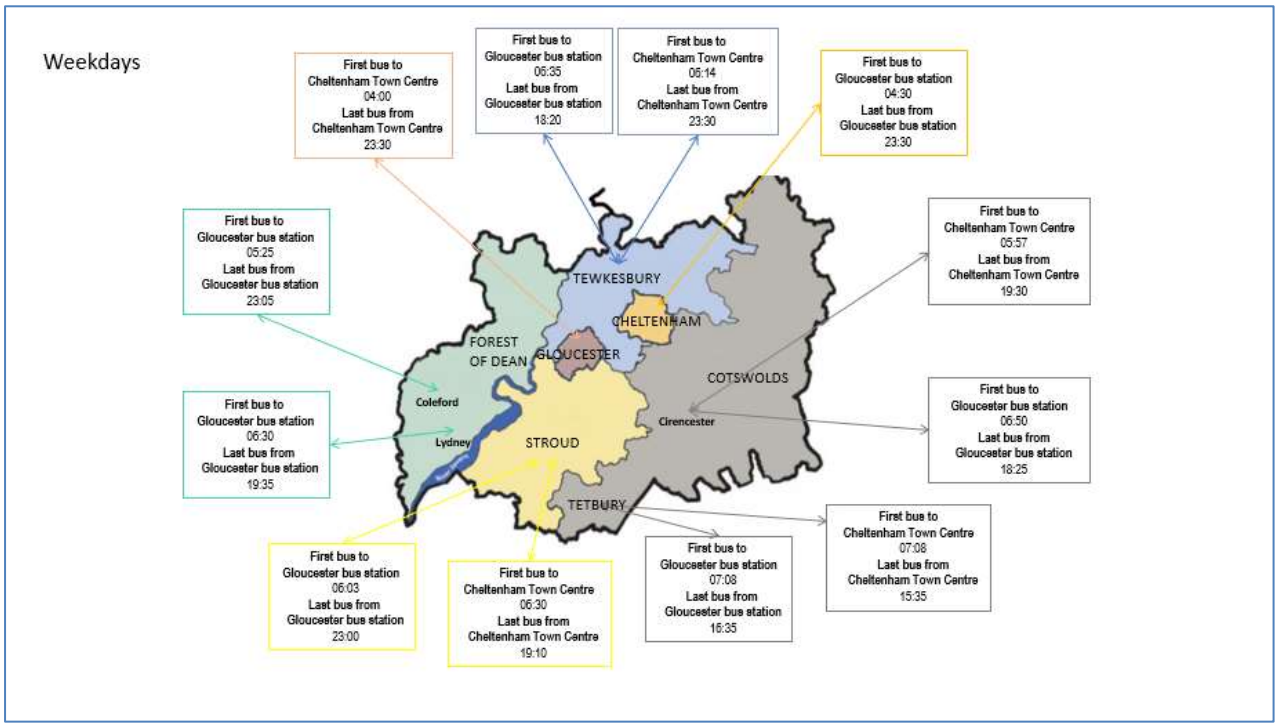
[42] The other 50% are discharged

11.6 Public transport services to GRH and CGH

Gloucestershire County Council (GCC) leads the Local Transport Plan which has public transport as one of its key themes. Although public transport has been identified as an issue there a range of services in place and proposals to improve access summarised below:

- GCC spend approx. £2.5 million a year on subsidised bus routes across the county. This remains a significant investment in public transport especially as in recent years some Councils have dramatically scaled back their funding.
- The Local Transport Plan is currently being refreshed up until 2041 which will set out strategic ambition for bus travel this sets out a commitment to making GP surgeries accessible with 45 minutes.
- The average journey time by train between Cheltenham Spa and Gloucester is 10 minutes. On an average weekday, there are 60 trains travelling between Cheltenham Spa and Gloucester.
- GCC provides £0.5 million per year in annual grants to support community transport providers, as this is an important provider of transport for vulnerable people. Dial-A-Ride is a bookable door-to-door transport service for those people who do not have their own transport and are unable to use public transport. The following community and Voluntary transport providers operate in Gloucestershire:
    - Connexions – county wide
    - Lydney Dial-A-Ride
    - Cotswold Friends
    - Newent Dial-A-Ride (Shepard House).
- Non-Emergency Patient Service exists for people who are eligible. These services provide free transport to and from hospital.
- GCC is progressing the Thinktravel Total Transport portal which will bring community, voluntary and public transport together under one platform, making accessible transport available to a wider audience who may not previously have considered these options as a travel choice.
- GHNHSFT works closely with a range of partners on transport planning services including GCC.
- GCC currently operates three Park & Ride facilities.
- The 99 bus service connects GRH, Gloucester Bus station, Arle Court Park and Ride, Cheltenham Town Centre and CGH.
- The bus network does have key routes linking Gloucester, Cheltenham and key towns, with services running on a regular basis during peak hours (see maps overleaf).





Weekday bus services (first and last) to Gloucester and Cheltenham

Further information is available in the following appendices:

- Appendix 14a Travel Impact travel analysis includes spatial maps and impact activity (by locality) for each mode of travel for each FFTF2 service proposal.
- Appendix 14b public travel info includes information on bus, train, dial-a-ride services available for each locality to access CGH and GRH.

11.7 Car Parking

On the GRH site there are a total of 11 car parks providing 1,854 car parking spaces, of which 532 are public, 1208 staff and 87 spaces available for blue badge holders (DDA). On

the CGH site there are a total of 11 car parks providing 741 car parking spaces, of which 192 public, 437 staff and 40 Oncology patient car parking spaces with 56 spaces for blue badge holders.

Prior to COVID GHNHSFT initiated a full review of staff travel and car parking in line with NHS car parking management guidance to identify best practice in car park management and sustainable transport; including:

- Working with patients and staff to make sure that users can get to the site as safely and conveniently as possible;
- Solutions should also be economically viable;
- Travel plan should reduce environmental impact of staff commuting to work;
- Charges should be reasonable for the area;
- Concessions should be available for certain groups of users;
- Other concession, for example for volunteers or staff who car share should be considered locally; and
- Priority for staff parking should be based on need.

The review was paused at the start of the pandemic and has recently been re-started.

The public and staff have the option of using the 99 bus that operates between the two hospital sites. It runs Monday to Friday from 06:20 (first bus) to 20:05 (last departure[43]), every half an hour and takes 30 minutes. It is free to GHNHSFT staff on production of an ID badge. The bus also stops at other stops between the hospitals with a fee of £1.00 payable at Gloucester Road, Cheltenham, Cheltenham Road and Longlevens. The bus service also collects passengers from the Arle Court Park and Ride in Cheltenham. The cost for this is £1.00 on production of ID badge and the cost for parking your car there is free. Staff impacted by changes may choose to use this service if their base changes from one site to another, but consideration needs to be given to the increase in their daily journey time as a result.

11.8 Carbon Impact

We have estimated the carbon impact using the following methodology:

- Using our travel impact analysis to determine number of patients positively and negatively impacted.
- Using travel time as a proxy for travel distance calculated the net impact (difference between positively and negatively affected)
- Using the 8 mile distance between GRH and CGH calculated the carbon impact

An assessment of the travel impacts on carbon footprint of the proposed changes can be found in Appendix 14c; the overall impact is +1.35 metric tonnes of CO^2.

We recognise this analysis does not report any other environmental impacts but as the level of activity and therefore resource use is the same as the baseline, travel is the single largest change.

[43] Up until March 2023 when the current extended service trial ends (19:05 is the non-trial last departure).

Key Points

- **Equality Impact Assessments (for groups with protected characteristics) have been completed for all service change proposals.**
- **Health Inequalities Assessments (for groups and communities that are at greater risk of poorer access to health care and poorer health outcomes) have been completed for all service change proposals.**
- **Health Impact Assessments (for groups and communities that have specific health needs and are at greater risk of poorer access to health care and poorer health outcomes) have been completed for all service change proposals.**
- **Impact is predominantly positive or neutral with no significant adverse impacts.**
- **Patient and carer travel impact modelling has been undertaken.**

12 Economic and Financial Analysis

12.1 Introduction

The economic and financial analysis has been developed by the Fit for the Future Programme team working with GHNHSFT clinical divisions, reporting to the GHNHSFT Director of Finance, and in collaboration with the Gloucestershire Integrated Care System Resources Steering Group (RSG) which comprises Directors of Finance from ICB, GHNHSFT, and GHCFT. Prior to the decision to stand-down the NHSE Stage 2 process, the programme also engaged with NHSE Finance colleagues.

The programme team included GHNHSFT Finance team, information analysts, a Senior HR Business Partner for Workforce Transformation, as well as the FFTF Programme Director and Programme Managers.

12.2 Methodology

The methodology used for FFTF1 was repeated for FFTF2 and was based on the following principles:

- Identification of the relevant clinical divisions / service areas for solutions in scope
- Identification of the appropriate baseline for activity, workforce and finance
- Identification of shifts of activity for each of the proposed solutions
- "Bottom up" impact assessment for each service proposal to identify changes in workforce or other resource requirements
- Robust "Confirm and Challenge" process to ensure any staffing or resource requirements were essential
- Identification of financial impact (income and expenditure, both recurrent and non-recurrent) of proposed changes
- Combine proposed changes with baseline to determine finance for each service area
- Review of Downside Risk.

As stated in section 3.6, four of the five FFTF2 service change proposals are currently already in place under Temporary Service Change arrangements, some since June 2020 and one (stroke HASU) since Feb 2022. The additional resource requirements are significantly less than those identified in FFTF1 (see section 12.7) and are presented in the sub-sections below:

12.2.1 *Growth*

Our assessment of the impact of population growth uses 2018 subnational population projections from the Office of National Statistics (ONS). The management of growth demand is a consistent and ongoing objective within the ICS to ensure that hospital appointments and admissions are appropriate as well as the year-on-year efficiencies within GHNHSFT to deliver productivity improvements.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID-19) pandemic. Our proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE&I, excluded impact of COVID-19 from our baseline data, staffing models, resource requirements and finances.

Given the multi-factorial nature of COVID-19 effects and uncertainty as to their impacts, the DMBC has not attempted to inflate resource demand (e.g. bed numbers) based on an

unmitigated position. If these proposals are approved and the programme shifts to implementation, decisions will take account of the position at the time, and the developing pandemic recovery paradigm.

12.3 Workforce

Any additional workforce requirements were presented in the individual service sections (6 to 10), and are summarised in the table below:

Service	Additional Workforce
Benign Gynaecology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.
Diabetes and Endocrinology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.
Non-interventional Cardiology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals
Respiratory	The only staffing changes that are being considered relate to the development of the Respiratory High Care service
Stroke	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

12.3.1 *Respiratory High Care service*

Centralising respiratory beds at Gloucestershire Royal Hospital, provides the flexibility and capacity to support the development of a respiratory high care unit. With additional investment in providing 2 x Advanced Clinical Practitioners and 1.5 x Band 7 physiotherapists, the Respiratory service can provide an 11 bedded high care unit. The medical and nursing support can be provided within existing establishments.

12.4 Financial Impact

As stated above the only anticipated additional resources for the delivery of FFTF2 relate to the establishment of a Respiratory High Care unit, which requires a revenue investment of £274,000 and a capital investment of £21,000

Workforce

The recurrent revenue cost of the additional FTE includes pay, staff non-pay and on-costs:

Role	FTE	£ Revenue)
ACP Grade 8A	2	£148,210
Band 7 Physio	1.5	£82,575
Total	**3.5**	**£230,785**

Equipment and Set-up Costs

The equipment and set-up costs are:

Item	£ (Revenue)	£ (Capital)
Monitoring Equipment - £17,000 Monitoring Installation - £4,000		21,000
IT Project Management (6mths)	18,000	
5-year Maintenance Contract	22,540	
Equipment depreciation (per year for 10 years)	£1,700	
PDC cost of capital @3.5%	£565	
Total	**£42,805**	**£21,000**

The ICB is currently following up funding opportunities through Additional Capacity Investment with NHSE.

12.5 Phasing

Subject to DMBC resolution approval and recruitment, the phasing profile of the costs identified above would be as follows for 2023/24 year and then £59,391 per quarter going forward:

Respiratory High Care	FTE	Total	2023/2024			
			Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
Revenue						
ACP Grade 8A	**2**	£148,210		£37,053	£37,053	£37,053
Band 7 Physio	**1.5**	£82,575		£20,644	£20,644	£20,644
IT Project Management (6mths)		£18,000	£12,000	£6,000		
5-year Maintenance Contract		22,540	£1,127	£1,127	£1,127	£1,127
Depreciation		£1,700	£425	£425	£425	£425
Cost of capital		£565	£141	£141	£141	£142
Total (Revenue)	**3.5**	**£273,590**	**£13,693**	**£65,390**	**£59,390**	**£59,391**
Capital						
Monitoring Equipment & Installation		£21,000	£21,000			
Total (Capital)		**£21,000**	**£21,000**			

12.6 Downside risks

There is one implementation risk (section 15.6), that may result in finanical risk if unmitigated.

Implementation Risk	Comment	£
DCC Capacity at GRH if planned mitigations are insufficient to managed demand	Additional staffing cost (Appendix 8) This risk is managed by the Cross Division Task and Finish group (section 15.3.1)	£403,356

There were a number of Downside Risks associated with FFTF1 and these have been assessed in respect of FFTF2 services:

FFTF1 Downside Risk	FFTF2 Update
Inability to achieve repatriated income	There are no assumptions in FFTF2 for repatriated income.
Impact of Inter-site Ambulance Transfers	These have been refreshed for FFTF2 services and are within the funds approved in the FFTF1 DMBC
SWASFT Conveyances to GWH	These have been monitored and have not increased as a result of FFTF changes.
Activity shift to GWH	These have been monitored and have not increased as a result of FFTF changes.

12.7 FFTF 1 Finance Update

This DMBC is concerned only with the proposals for service change within Phase 2 of the FFTF Programme; these are:

- Benign Gynaecology *[44]
- Diabetes and Endocrinology *
- Non-interventional Cardiology
- Respiratory *
- Stroke *

The DMBC for FFTF1 was approved in March 2021 and none of the services in Phase 1, their costs or benefits are part of the approval resolutions contained within this DMBC (section 14).

As stated at the start of this section, the FFTF Programme has worked closely with RSG and was requested to include updates/refresh on FFTF1 benefits and costs. These have been presented at:

- ICB Board (Jan 23);

[44] *Currently subject to Temporary Service Change (for details see individual service sections)

- Resources Steering Group (Jan 23);
- ICS Strategic Executives (Feb 23);
- GHNHSFT Finance & Resources Committee (Feb 23), and;
- GHNHSFT Board briefing session (Feb 23).

A copy of the information shared can be found in Appendix 4b, and the original FFTF1 DMBC can be found at Fit for the Future | Get Involved In Gloucestershire (glos.nhs.uk).

A summary of the refresh can be found in the table below:

Service Area	Type	Original FYE (Mar 2021)	Refresh FYE (Feb 2023)
Emergency General Surgery	**Investment**	£137,000	£81,872
	NCRB[45]	£314,382	£379,797
Planned General Surgery	**Investment**	£112,000	£140,612
	NCRB	£216,731	£216,731
Vascular Surgery	**Investment**	£0	£0
	NCRB	£0	£44,640
IGIS	**Income**	£463,600	£518,660
	Investment	£559,135	£723,072
	CRB[46]	£27,000	£27,000
	NCRB	£142,147	£142,147
Acute Care Response Team	**Investment**	£397,000	£522,169
Acute Medical Take	**Income**	-£250,000	£0
	Investment	£349,456	£277,000
	CRB	£187,606	£187,606
	NCRB	£144,147	£144,147
Total	**Investment**	£1,804,591	£1,744,725
	Benefits CRB	£678,206	£733,266
	Benefits NCRB	£817,407	£927,462
	Net excl. NCRB	-£1,126,385	-£1,011,459
	Net incl. NCRB	-£308,978	-£83,997

The refreshed benefit position reduces Phase 1 net investment by £100,000 to £1M. This is further reduced to £84k when Non Cash Releasing Benefits (NCRB) are included.

Key Points

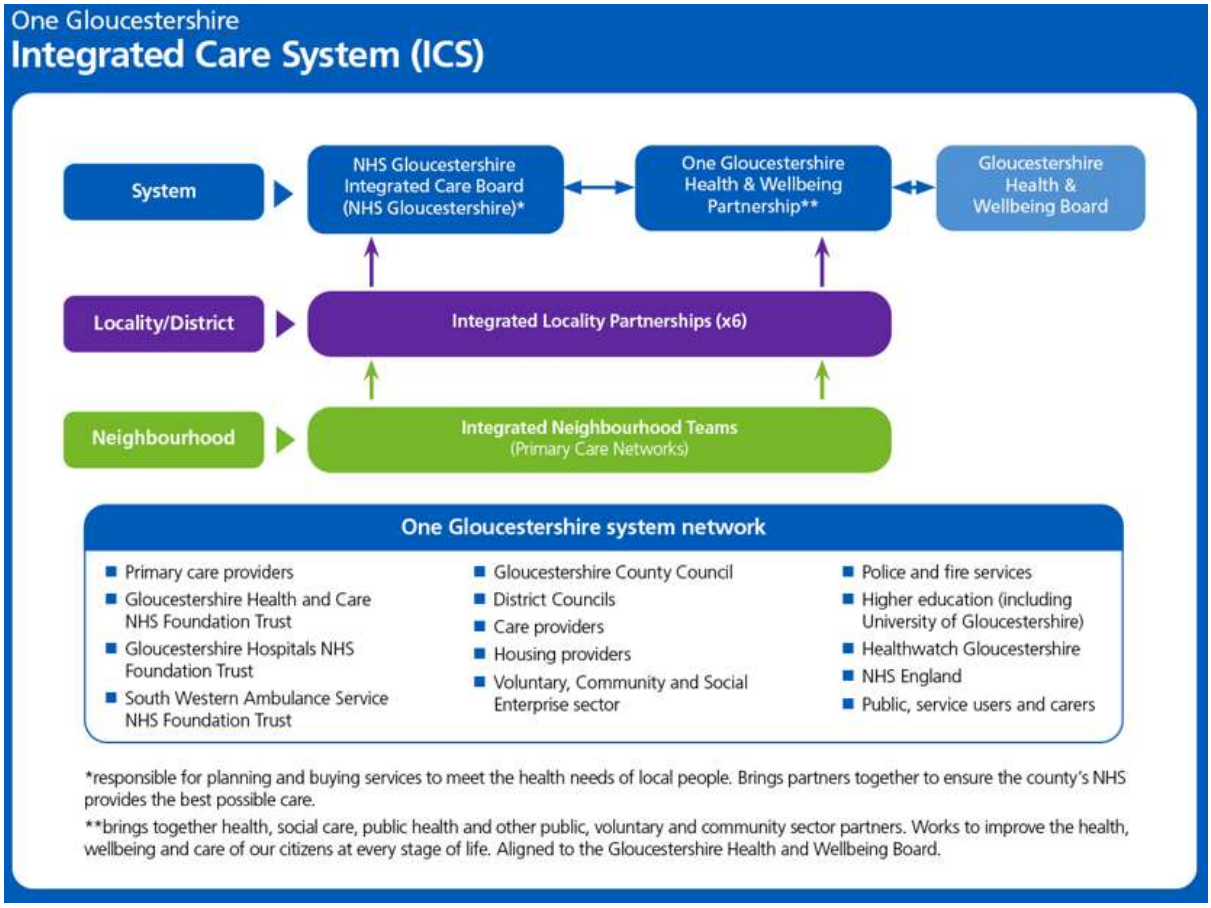
- **Four of the five FFTF2 service change proposals are currently already in place under Temporary Service Change arrangements.**
- **The additional resource requirements (<£300,00), are significantly less than those identified in FFTF1 and relate only to Respiratory High Care (RHC) Unit.**
- **Funding is being sourced to support the establishment of RHC Unit.**
- **For context, update information is provided on FFTF1 finances.**

[45] Non-Cash Releasing Benefits

[46] Cash Releasing Benefits

13 Governance and Decision making

A short introduction to One Gloucestershire Integrated Care System is provided in section 3 (and schematic presented below). We have a strong commitment from all of our system partners to move forwards with this new way of working and believe it will be pivotal to support us to deliver against our challenging performance, financial and delivery objectives more quickly, as embodied by the scale of our Fit for the Future Phase One (FFTF1) implementation and our Fit for the Future Phase Two (FFTF2) proposals for change set out in this document.



13.1 Internal Assurance

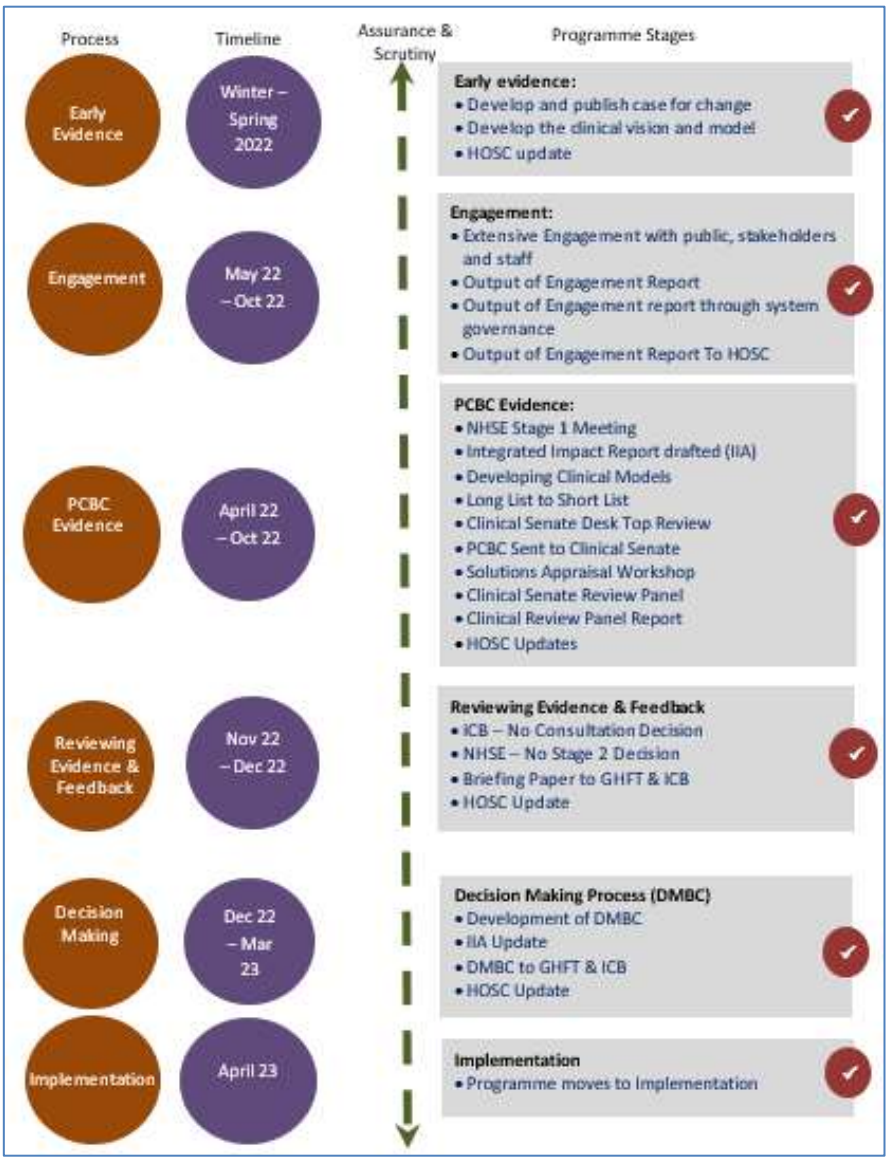
As presented in section 3.1.1 FFTF is a priority programme within our ICS Integrated Delivery Plan, that we will be seeking to deliver as partners across the health and social care system in Gloucestershire. These plans have been worked up with partner organisations and reflect a shared commitment to delivery for the year ahead.

The FFTF programme is embedded into both system and GHNHSFT governance structures. Regular reports have been taken to the NHS Gloucestershire ICB and ICB Strategy Executives GHNHSFT Trust Board and the ICS Resource Steering Group (RSG), as well as system and Board sub-committees.

The programme management arrangements are overseen through the programme Senior Responsible Officers (held jointly by both ICB and GHNHSFT Directors), the ICS Programme Development Group (PDG) including oversight of the Programme Director, the Programme

Managers Group, FFTF Communications and Engagement and activity and financial modelling. Investment is provided by the system to ensure that there are central programme resources in place to ensure delivery of programme objectives.

This DMBC is the result of years of evidence development, assurance and review of proposals to deliver an option that addresses our case for change and delivers our clinical model. The process is summarised below

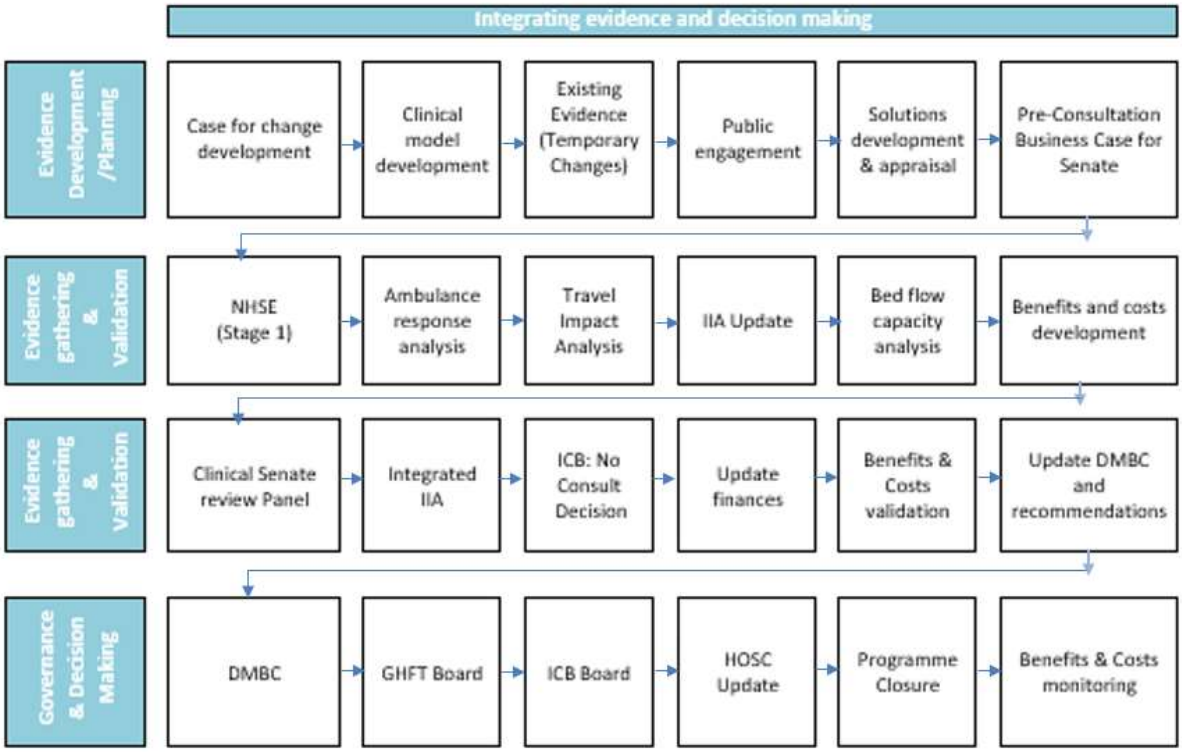


13.1.1 *Process for decision making*

As set out in the national guidance on service change in the NHS the ICB's statutory responsibilities includes their duty to lead involvement on any planned service change in their local systems. In this case, NHS Gloucestershire ICB leads on behalf of the One Gloucestershire Integrated Care System (ICS).

The decision-makers in this regard will be the Board of Gloucestershire Hospitals NHS Foundation Trust and the of Board NHS Gloucestershire ICB.

The process of evidence gathering, validation and decision-making is provided overleaf:



13.2 External Assurance

13.2.1 *South West Clinical Senate review*

Details of the independent clinical review undertaken by the South West Clinical Senate are provided in section 5.1 and the full report of the Clinical Review Panel (CRP) can be found in Appendix 5. The service specific comments can be found in the individual service sections and titled *South West Clinical Senate Review* and our responses to the Desk-top review can be found in Appendix 17.

13.2.2 *NHS England assurance process*

NHS England has been continuously involved in the Fit for the Future Programme and assured FFTF1 at our Stage 2 review in September 2020 and the FFTF2 proposals completed their Stage 1 assessment in March 2022. As detailed in section 2, following discussions with the SW Regional NHSE team and the decision by the ICB Board that there should be no further public involvement in Phase 2 of the FFTF programme, NHSE were content and confirmed that a Stage 2 assurance process was not required; therefore the FFTF2 proposals would not be subject to the government's four tests and NHSE's test for proposed bed closures (where appropriate) i.e. the "5 Tests".

Notwithstanding the above, the FFTF Senior Responsible Officers believe it would provide additional assurance for decision-makers on the robustness of these FFTF2 proposals for an assessment against the "5 Tests" to be included in the DMBC; details are provided in the sections below. Furthermore, the FFTF Programme has used the NHSE Stage 2 Key Lines of Enquiry (KLOE) as a reference document.

13.2.3 *Test #1: Strong public and patient engagement.*

The FFTF Programme has a strong track record in public engagement and involvement, and Section 4 details our FFTF2 engagement including both our activities and the feedback received. FFTF2 engagement built on the extensive engagement and consultation activities

of FFTF Phase 1, which clearly identified that there is high recognition of Centres of Excellence approach amongst those responding to our surveys.

The comprehensive Output of Engagement Report can be found in Appendix 1 and was reviewed by NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), NHSE and our local HOSC.

13.2.4 *Test #2: Consistency with current and prospective need for patient choice.*

Our solutions appraisal criteria for preferred options always includes a specific assessment of the impact on patient choice i.e. "*What is the likelihood of this option meeting the requirements of the NHS Constitution and The NHS Choice Framework*".

When considering the impact on patient choice it should be noted that:

- None of the proposed solutions/models will withdraw the number of specialties provided by GHNHSFT.
- There would continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.
- For FFTF2 services the potential changes relate to the centralisation of services either on the Gloucester or Cheltenham sites (previous centralisation has resulted in improved outcomes for patients).
- Four of the five FFTF2 service proposals relate to emergency pathways (not elective) where, in accordance with the NHS Choice Framework, patients may not have a choice.
- Whilst the number of sites where patients can choose to have their operation may change, the two hospital sites are only 8 miles apart and we believe that when the impact of the changes is assessed the improved patient outcomes will outweigh the reduction in choice regarding inpatient locations.

13.2.5 *Test #3: Clear, clinical evidence base.*

Details of the current service, proposed changes, clinical evidence and impacts can be found in the individual service sections. Details of the independent clinical review undertaken by the South West Clinical Senate are provided in section 5.1 and the full report of the Clinical Review Panel (CRP) can be found in Appendix 5.

Overall, the Panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.

13.2.6 *Test #4: Support for proposals from clinical commissioners.*

Prior to July 2022, the NHS Gloucestershire CCG undertook a lead role in the FFTF Programme working closely with ICS partners and this role is now the responsibility of the NHS Gloucestershire ICB. In respect of Test#4, the FFTF Programme provides regular updates to ICS, GHNHSFT internal governance forums and the proposals contained within this DMBC will be required to be approved by the NHS Gloucestershire ICB.

Details of our FFTF2 engagement with all of our neighbouring ICBs and Health Boards can be found in section 4.5.1. We have shared information on the programme scope, exchanging of activity information and agreements to build relationships and share information as the preferred option(s) were finalised.

13.2.7 *Test #5: Bed modelling*

There are no planned reductions in beds available at GHNHSFT as a result of any of the Fit for the Future proposed changes. Full details of our bed demand and capacity modelling can be found in section 5.7.

13.3 Public sector equality duty (PSED)

The Equality Act 2010 requires the ICB, in the exercise of its functions, to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In order to advance equality of opportunity, decision-makers should have due regard in particular to the need to:

- Remove or minimise the disadvantage suffered by persons who share relevant protected characteristics;
- Take steps to meet the needs of those who share such characteristics, and;
- Encourage participation of those who share such characteristics.

The requirements of the Equality Act 2010 also mean that the ICB should ensure that service design and communications should be appropriate and accessible to meet the needs of diverse communities

The requirements of the Public Sector Equality Duties are integral to the Fit for the Future approach. To inform the programme there has been extensive engagement and communications activity seeking to gather the views of seldom heard groups.

Furthermore, our solutions appraisal criteria included a specific assessment of the impact of solutions on accessibility to services and the Public Sector Equality Duty; namely "*What is the likelihood of this option having a positive impact on equality and health inequalities*?"

13.4 Information Governance (IG) issues and privacy impact assessment

Following specialist IG advice, the Data Protection Impact Assessment (DPIA) has been drafted on the basis that the current phase of the FFTF Programme is focusing on a DMBC, and there should be no change to any patient pathways and patient data flows. At no time will any patient identifiable data be held by the programme. The data that will be held by the programme during the next phase are as follows –

- Project Management documentation
- Programme Governance documentation
- Involvement documentation and feedback

The current DPIA is presented in Appendix 15 and will be adapted for each the phase of the programme, including implementation.

It should be noted that all the proposals that form part of this DMBC are not intended to change the provider of the services nor are there changes to clinical systems or record-keeping specific to the FFTF Programme; any changes would be subject to a separate DPIA process.

The DPIA describes:

- the data, data flows, and retention period
- any data protection and privacy risks identified
- the risk management measures agreed

Key Points

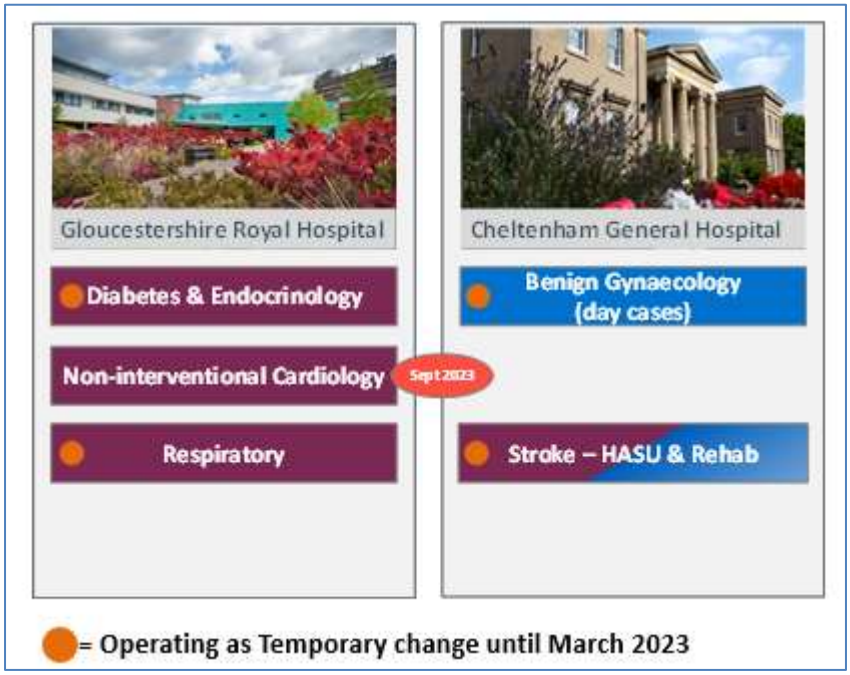
- **The FFTF programme is embedded into both system and GHNHSFT governance structures.**
- **NHS Gloucestershire ICB leads on behalf of the One Gloucestershire Integrated Care System (ICS).**
- **FFTF2 proposals have been subject to independent clinical review by the South West Clinical Senate**

14 Recommendation

14.1 Resolutions to be agreed

It is the Programme's recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the NHS Gloucestershire Integrated Care Board (GICB) that the following resolutions should be considered for agreement and approval, considering all the evidence that has been made available, on the basis that they represent the most appropriate option to address the case for change.

- **Resolution #1**: To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2**: To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #3**: To centralise Non-Interventional Cardiology inpatient beds[47] at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Resolution #4a**: To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b**: To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.
- **Resolution #5**: To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.



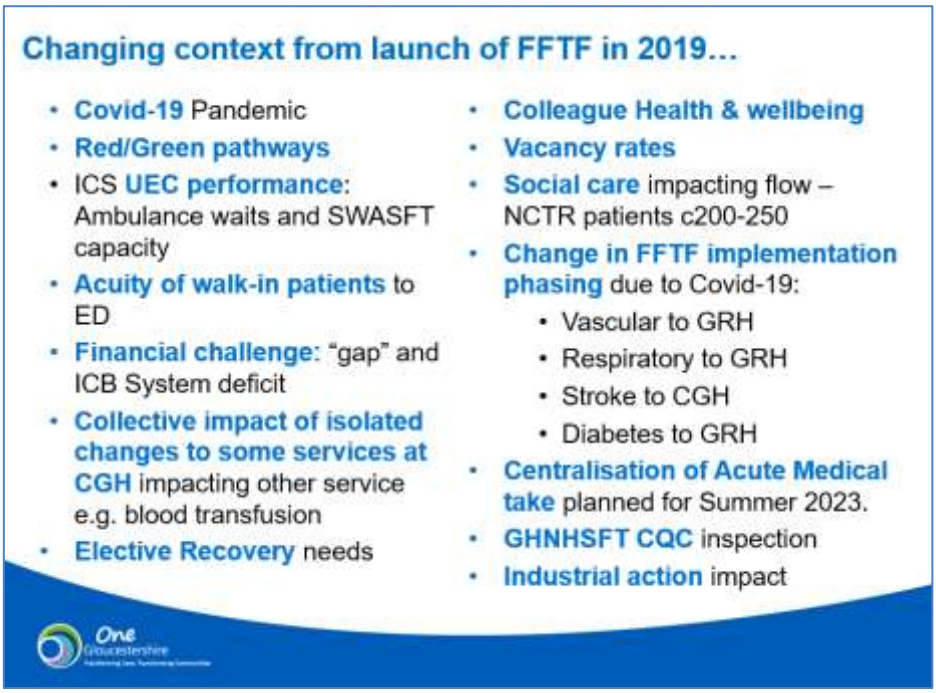
[47] Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

15 Implementation

15.1 Introduction

Our *Fit for the Future Programme,* which incorporates *Centres of Excellence,* is a large scale, long-term change programme which is being delivered through a number of phases over a number of years. Furthermore, the implementation of services within FFTF1 and FFTF2 have and will not be implemented sequentially as, in some cases, we needed to align with the implementation of the GHNHSFTs strategic site development (SSD) programme. This has had to be combined with the phased implementation of FFTF1, in some cases accelerated by the need to respond to the early stages of the COVID pandemic and the development of our FFTF2 programme, which includes a number of services that are subject to temporary service change, having also relocated in response to COVID and other pressures.

The implementation context/ landscape has also changed since the start of the FFTF Programme, which has added additional pressures and challenges that need to be considered and managed by the implementation teams; these are well understood by anyone working in the NHS for the last 36 months and are summarised below:



15.2 Implementation Phasing

The factors listed above have created a level of complexity that needs to be carefully presented to ensure all those involved in assessing these proposals are assured. For completeness we have included both FFTF1 and FFT2 services and these are summarised below:

- **FFTF Phase 1 services – formally implemented following decision-making**: these were services that were in place in March 2021, such as the Trauma and Orthopaedics, Gastroenterology, Emergency General Surgery and Vascular Surgery.
- **FFTF Phase 1 services - Implemented following completion of other enabling workstreams:** these are services that require enabling work to be completed, for

example, estates work, recruitment and training, procurement and installation of equipment. This includes IGIS and Acute Medicine.

- **FFTF Phase 2 services - Temporary service changes formally implemented following decision-making**: these are services that are currently in place (March 2023), including Stroke, Benign Gynaecology, Diabetes and Endocrinology and Respiratory.
- **FFTF Phase 2 services - Implemented following completion of other enabling workstreams:** these are services that require enabling work to be completed and include Non-Interventional Cardiology.

The table below presents a summary of each service and its actual or indicative implementation status.

FFTF Phase	FFTF service	Actual implementation date	Formal or planned implementation date
FFTF1	Trauma at GRH and Orthopaedics at CGH	October 2017	March 2022
FFTF1	Gastroenterology at CGH	November 2018	March 2022
FFTF1	Emergency General Surgery at GRH	April 2020	March 2022
FFTF1	Vascular Surgery at GRH	June 2020	March 2022
FFTF2	ASU at CGH [1] HASU at CGH [1]	June 2020 February 2022	March 2023[2]
FFTF2	Respiratory at GRH [1]	June 2020	March 2023[2]
FFTF2	Benign Gynaecology at CGH [1]	June 2020	March 2023[2]
FFTF2	Diabetes & Endocrinology at GRH [1]	September 2021	March 2023[2]
FFTF1	Acute Medicine (Acute Medical Take) at GRH	-	September 2023
FFTF1	Image Guided Interventional Surgery 'Hub' at GRH and a 'Spoke' at CGH (including interventional Cardiology)	-	September 2023
FFTF2	Non – Interventional Cardiology at GRH	-	September 2023[2]
FFTF1	Elective General Surgery at GRH and CGH	-	October 2023

[1] Subject to Temporary Service Change (for details see individual service sections).
[2] Subject to approval.

15.3 Governance arrangements for implementation

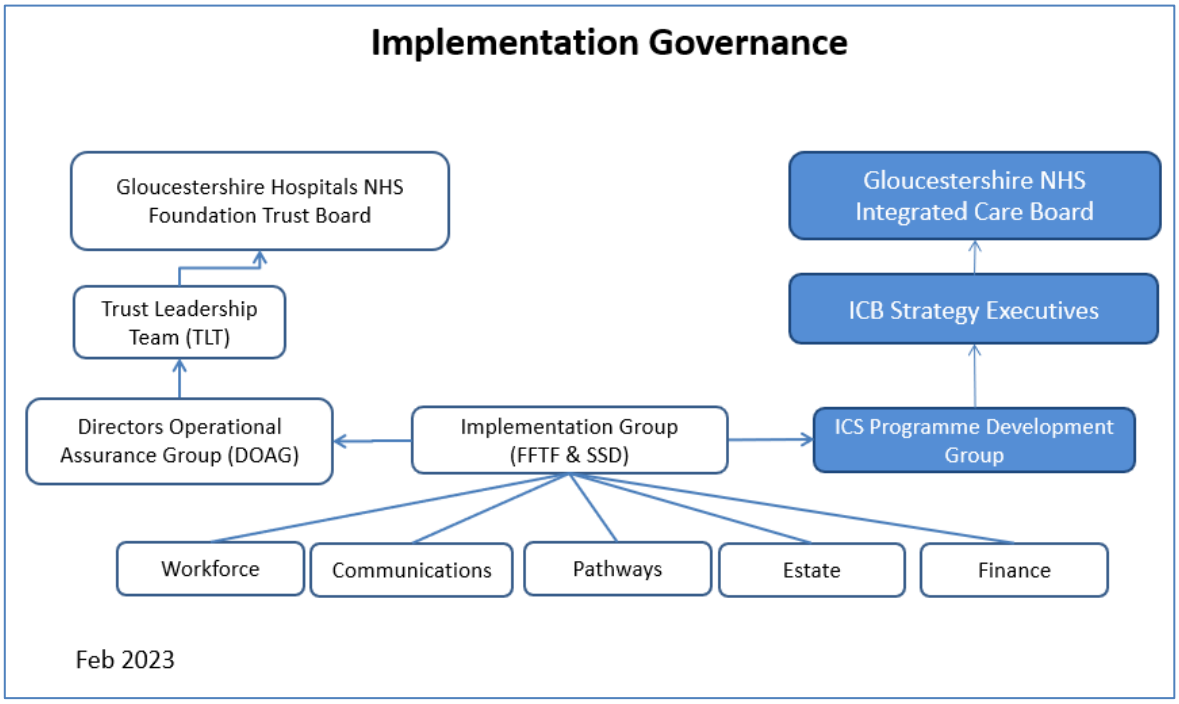
Formal governance arrangements are required to steer and govern the process of service reconfiguration and development of the FFTF programme; to deliver this we have a dedicated FFTF Implementation Group, that is implementing FFTF1 and will be responsible for implementing FFTF2.

In order to oversee the implementation of Phase 1 FFTF GHNHSFT established a working sub-group of the Directors Operational Assurance Group (DOAG). This subgroup was titled

'Phase 1 Implementation Group[48]', it meets monthly, is chaired by the Deputy COO, with representation from Deputy Divisional Directors of Operations and is tasked with overseeing the implementation of GSSD (Gloucestershire Strategic Site Development) and Phase 1 FFTF; including any interactions between the programmes or with wider strategies and changes being implemented in the Trust. The Phase 1 Implementation Group reports monthly to DOAG; DOAG has a direct reporting line to TLT (Trust Leadership Team) and then Main Board.

A number of workstreams will lead on both the planning and development required to support FFTF2 changes to service provision, as well as the transactional processes of change. Governance arrangements will have clear links within the wider Gloucestershire ICS and individual organisational governance structures to ensure that implementation plans across all areas are aligned.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting risk are maintained.



15.3.1 *Cross Division Task and Finish Group*

As part of the implementation planning, particularly focused on the centralisation of the Acute Take in September 2023, GHNHSFT have established the Cross Division Task and Finish group, chaired by the Medical Director. The group's objectives include:

- To consider the FFTF service moves and agree what clinical and support services and processes need to be in place, to ensure the delivery of sustainable services at CGH and GRH.
- To develop *go/no-go* criteria for the centralisation of the acute take to GRH.
- To produce a paper for DOAG setting out recommendations including go/no-go criteria, to confirm the date for centralisation of the acute take.

[48] Subject to DMBC approval the group will be re-named FFTF Implementation Group and cover FFTF 1 & 2.

- Area of scope include:
    - Engagement and communications
    - Patient pathways/operational policies/SOPs[49]
    - Clinical standards/protocols
    - Medical Cover arrangements
    - Medical Training
    - Clinical Support Services
    - Inter site ambulance transfers
    - SWASFT protocols
    - Acuity of Emergency Department walk-in patients
- As detailed in section 5.7.4 the group have agreed DCC metrics to monitor the impact of the current mitigations to assess the confidence that the demand at GRH DCC can be met.

15.4 Communication and engagement plan

One Gloucestershire partners will formally publish the Fit for the Future 2 Decision Making Business Case (DMBC) ahead of the GHNHSFT Board meeting 9th March 2023 and the NHS Gloucestershire Integrated Care Board meeting on 29th March 2023.

The aim of the communications and engagement plan (Appendix 16) is to ensure staff, community partners, the public and media receive information on the outcome of the decision-making process and next steps in a timely and appropriate way.

There are a number of communication and engagement objectives, including:

- To provide clear, consistent and accurate information
- To support the NHS to communicate the outcome and the changes
- To ensure relevant audiences receive the information in the right order e.g. staff first
- To ensure effective media and social media arrangements are in place.

The communications and engagement plan includes a number of key stakeholders that need to be engaged and supported as decisions are made and communicated.

The communication plan will consider the South West Clinical Senate Panel recommendation that the ICB should develop a communications strategy that informs patients about the location of specialist medical services such as cardiology and stroke and encourages patients to present to the most appropriate hospital.

The communication plan will also include the request by the HOSC that updates be brought to future meetings of the committee regarding the implementation of Fit for the Future 2 service changes.

[49] Standard Operating Procedures

15.5 Benefits Realisation

Details of the benefits are provided in Appendix 4a and 4b[50], including benefits realised for FFTF2 services already in place through temporary service change. Benefits will be continuously developed and monitored as part of the implementation programme; a summary is provided below:

	Benefits
Improved patient outcomes	• Ensuring safe and consistent staffing levels • Reduction in surgical cancellations. • Better coordination of inpatient work • Provide regular daily visits to admission wards on both sites • Improved rehabilitation ward environment • Removal of stroke from the ED pathway • Improve the quality of care provided for respiratory patients • Improved out of hours care for patients • Reduction of mortality due to Respiratory High Care
Improved patient experience	• The provision of a protected dedicated day case unit • Improved rehabilitation ward environment • Improve bed capacity constraints • Improved Patient experience • Prevent the need for patient transfer
Improved staff experience	• Easier to staff the wards • Better use of the staff groups with significant shortages • Improved staff cover and improved staff resilience for sickness and absence. • Provide enhanced training for junior and middle grade doctors with regular access to the full clinical team
Improved staff recruitment and retention	• Improved training • With the specialist staff in one place, it is also easier to co-ordinate care, provide training and improve staff recruitment and retention
Improved efficiency and effectiveness (cash releasing and growth avoidance/non-cash releasing)	• More efficient use of the specialist team • Inpatient bed number reduction. • Reduce length of stay for patients. • Prevent the need for patient transfer

The FFTF Implementation Group will work with the clinical divisions to ensure the identified benefits are delivered. The ICS Programme Development Group will link these benefits with the wider system in support of the delivery of our Operational Plan.

[50] Appendix 4b also includes FFTF1 benefits realisation to date.

15.6 Implementation Risks

The FFTF programme risk register hold risks associated with the DMBC assurance process only[51]. Implementation risks are part of the risk management function of the FFTF Implementation Group post decision-making. When assessing implementation risk, it should be noted that four of the five FFTF2 services are already in place through temporary service changes.

The risks regarding DCC are held on Divisional and, where appropriate, GHNHSFT Risk Registers.

The high level risks specifically associated with FFTF2 implementation but excluding GHNHSFT service Business as Usual (BAU) risks, are listed below.

FFTF service	Implementation Risks
Stroke Currently located at CGH as Temporary Service Change	• Completion of FFTF1 & 2 implementation to allow ward moves at CGH
Respiratory Currently located at GRH as Temporary Service Change	• Funding for Respiratory High Care (RHC) Unit • Impact on DCC capacity at GRH if RHC Unit not implemented
Diabetes & Endocrinology Currently located at GRH as Temporary Service Change	• None identified
Benign Gynaecology Currently located at CGH as Temporary Service Change	• Benefits accruing from Chedworth Day Surgery Unit if delays in completion of construction
Non – Interventional Cardiology	• Bed reduction resulting from planned benefits is not realised leading to bed pressures and outliers on other wards • Alignment of FFTF2 implementation with FFTF1 IGIS enabling works • DCC capacity at GRH

[51] Available on request

15.7 Outline programme implementation plan

As summarised in the introduction to this section, the implementation of the recommendations contained within this DMBC will be completed in stages over the next 12 months (on the basis that resolutions are approved in March 2023).

15.7.1 *FFTF2Formally implemented following decision making*

- **Resolution #1**: To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2**: To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #4a**: To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b**: To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.
- **Resolution #5**: To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.

15.7.2 *FFTF2 Implemented following completion of enabling workstreams*

- **Resolution #3**: To centralise Non-Interventional Cardiology inpatient beds[52] at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.

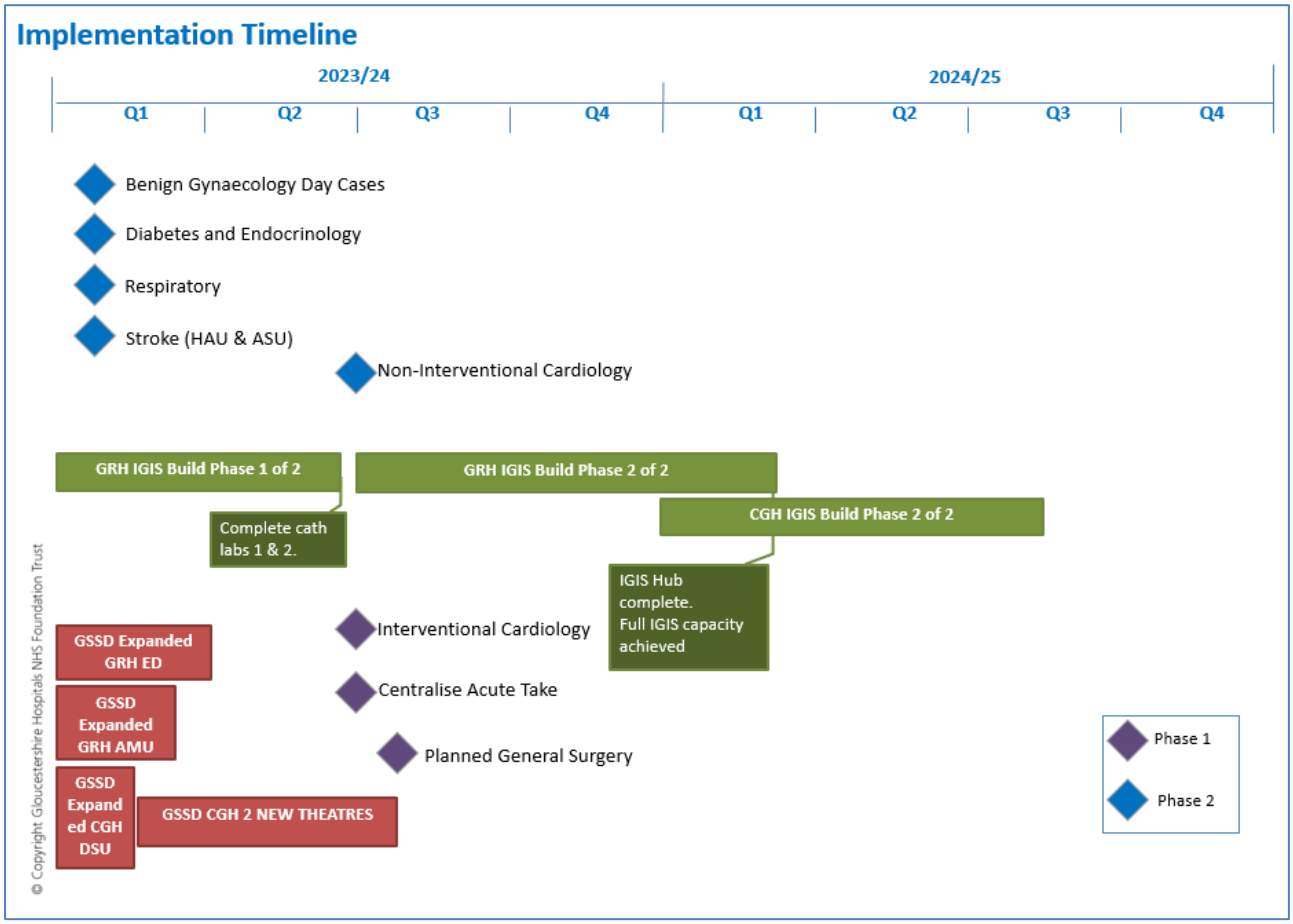
Implementation is dependent on a number of enabling workstreams, including:

- Changes to the Trust estate – delivered through the Trust Strategic Site Development Programme;
- Workforce – recruitment and training to support new models of care;
- Procurement and installation of new equipment – new Cardiac Cath Labs, additional Interventional Radiology equipment; and,

15.7.3 *Implementation timetable*

A Gantt chart outlining the high-level implementation milestones described above can be found overleaf.

[52] Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.



Key Points

- **Four of the five FFTF2 proposals are currently implemented as temporary service changes.**
- **One of the five FFTF2 proposals requires completion of enabling work prior to implementation.**
- **The dedicated FFTF Implementation Group, implementing FFTF1, will be responsible for implementing FFTF2.**

16 Appendices

Appendix 1: FFTF2 Output of Engagement Report

See separate document

Appendix 2: Gloucestershire Joint Health and Wellbeing Strategy 2019-2030

See separate document

Appendix 3: Gloucestershire Joint Strategic Needs Assessment (2017)

See separate document

Appendix 4a: FFTF2 Benefits Realisation

See separate document

Appendix 4b: FFTF1 & 2 Benefits and Costs

See separate document

Appendix 5: South West Clinical Senate Review Panel Report

See separate document

Appendix 6: Out-of-Hours Doctor Rotas

See separate document

Appendix 7: Bed Modelling Paper v1.5

See separate document

Appendix 8: DCC Capacity v4

See separate document

Appendix 9 Diabetes & Endocrinology Supporting Documentation

See separate document

Appendix 10a Non-interventional Cardiology Supporting Documentation

Appendix 10b Non-interventional Cardiology Opinion SOP

See separate documents

Appendix 11a Respiratory Supporting Documentation

Appendix 11b Respiratory SOP

See separate documents

Appendix 12a Stroke Supporting Documentation

Appendix 12b Stroke Pathway SOP

See separate documents

Appendix 13a: Benign Gynaecology IIA

Appendix 13b: Diabetes & Endocrinology IIA

Appendix 13c Non-interventional Cardiology: IIA

Appendix 13d: Respiratory IIA

Appendix 13e: Stroke IIA

See separate documents

Appendix 14a: Travel Impact Analysis

Appendix 14b: Public Travel Information

Appendix 14c: Carbon Footprint

See separate documents

Appendix 15: Data Protection Impact Assessment (DPIA)

See separate document

Appendix 16: DMBC Communications Plan v3

See separate document

Appendix 17: South West Clinical Senate -Desk-top review and responses

See separate document

Appendix 18: Glossary

See overleaf

Appendix 18: Glossary

Acute Medical Take	The Acute Medicine team coordinates initial medical care for patients referred to them by a GP or the Emergency Departments and decides on whether they need a hospital stay (also referred to as 'the acute medical take')
A&E	Accident and Emergency department (also known as Emergency Department (ED)
Acute Care Response Team (ACRT)	The ACRT includes technicians, nurse practitioners and advanced nurse practitioners who cover 24/7 both Cheltenham and Gloucester and respond to referrals for unwell and deteriorating patients across all adult wards and departments.
Acute Medical Unit (AMU)	Provides rapid assessment, diagnosis and treatment of patients with urgent medical and surgical conditions.
Acute Stroke Unit (ASU)	Acute stroke care services provide continuous specialist input, with daily multidisciplinary care and continued access to stroke trained consultant care, physiological monitoring and urgent imaging as required.
A d d i s o n ' s c r	A life-threatening situation that results in low blood pressure, low blood levels of sugar and high blood levels of potassium
Benign Gynaecology	The medical speciality (area) dealing with the health of the female reproductive system and benign means non-cancerous.
British Geriatric Society:	The professional body of specialists in the healthcare of older people in the United Kingdom
British Thoracic Society (BTS)	A registered charity that aims to improve standards of care for people who have respiratory diseases and to support and develop those who provide that care
Centres of Excellence (CoEx)	The development of the two main hospital sites. Part of the Fit for the Future Programme
CGH	Cheltenham General Hospital
CINAPSIS	A referral system that makes it easy for clinicians to communicate between healthcare organisations
Comprehensive Geriatric Assessment (CGA)	A multidisciplinary assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socioenvironmental circumstances
Community Stroke Rehabilitation unit	Inpatient ward which is dedicated to patients who would benefit from specialist stroke rehabilitation following acute medical treatment
COTE	Care of the Elderly
COVID/ Coronavirus	COVID is a new illness that affects lungs and airways. It is caused by a virus called coronavirus.
CT Scan	A procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body
CPAP	Continuous positive airway pressure (CPAP) therapy is a common treatment for obstructive sleep apnoea.

Department of Critical Care (DCC)	A special ward in Gloucester that cares for people who are critically ill, in an unstable condition, or need close monitoring after surgery
Diabetes and Endocrinology (D&E)	Diabetes is a serious condition where a person's blood glucose (sugar) levels are too high as a result of their body being unable to produce enough insulin or being unable to produce any insulin at all. Endocrine conditions are where a person's endocrine system (that produces the body's hormones) does not work correctly, causing hormonal imbalances in the body.
Diabetic KetoAcidosis (DKA)	A serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones
Decision-Making Business Case (DMBC)	Prepared following consultation, to support in making a final decision on service change. It will consider all the responses to the consultation
DOAG	GHNHSFT Directors Operational Assurance Group
Early Supported Discharge (ESD)	Facilitates early transfer of care to a community setting, where rehabilitation continues at the same intensity and with the same expertise as in the inpatient setting
ED	Emergency Department
EGS	Emergency General Surgery
EPR	Electronic Patient Record
Frailty Assessment Service/Frailty Assessment Unit (FAS/FAU)	Works with community services to provide specialist assessment and support for older people who attend the Emergency Department with signs of frailty
Clinical Programme Groups (CPGs)	Supports the delivery of the whole pathway transformation across key clinical programme areas in Gloucestershire.
Gloucestershire Clinical Commissioning Group GCCG/CCG	CCGs are the GP-led bodies responsible for planning and investing in many local health and care services, including the majority of hospital care and stroke services.
Gloucestershire Health & Care NHS Foundation Trust (GHCFT)	Formed in 2019 by the merger of 2gether Trust and Gloucestershire Care Services to provide joined up physical health, mental health and learning disability services
Gloucestershire County Council (GCC)	Responsible for a large number of services, including education, health and transport.
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)	Provides a wide range of specialist acute services
Gloucestershire Strategic Site Development (GSSD) (SSD)	A £39.5M Programme to improve acute care facilities at Gloucester Royal and day surgery and theatre capacity at Cheltenham General
GI	Gastrointestinal (a planned gastrointestinal service is sometimes referred to as upper GI and a planned colorectal service is sometimes referred to as lower GI).
GIRFT	A national programme designed to improve the treatment and care of patients through in-depth reviews of services.

GRH	Gloucestershire Royal Hospital
GAU	Gynaecology Assessment Unit
Hyper acute stroke unit (HASU)	Provides the initial investigation, treatment and care immediately following a stroke
Health overview and scrutiny committee HOSC	A committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and, if necessary, challenging health plans.
Homeward Assessment Team (HAT)	A multi-disciplinary team who assesses and supports people to leave hospital after treatment
Hot and Cold Split	Emergency Care (Hot) and Planned Care (Cold)
IPC	Infection Prevention and Control
Image Guided Interventional Surgery (IGIS)	Surgical procedures where the surgeon uses tracked instruments in conjunction with live images to guide the procedure
Integrated Impact Assessment (IIA)	The purpose of the Integrated Impact Assessment is to explore the potential positive and negative consequences of the proposals. It includes a Health Impact Assessment (HIA), Travel and Access Impact Assessment, Equality Impact Assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and Sustainability Impact Assessment.
Integrated Locality Partnerships (ILPs)	Partnerships made up of senior leaders of health and social care providers and local government.
Intensive Care Society	Representative body and Charity for all intensive care professionals and patients across the UK
Inpatient (IP)	A person who stays one or more nights in a hospital in order to receive medical care or treatment
Joint Strategic Needs Assessment (JSNA)	Looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
Joint Health and Wellbeing Strategy (JHWS)	The Local Authority and Clinical Commissioning Group (CCG) work together to understand the health and wellbeing needs of their local community and agree joint priorities for addressing these needs to improve health and wellbeing outcomes and reduce inequalities.
Length of Stay (LoS)	The amount of time someone has to stay in hospital for care, treatment, and recovery.
MOFD	Medically Optimised for Discharge, an intensive therapy ward working with patients to focus on improving their capacity in order to facilitate timely discharge.
MFFD/NMCTR	Medically fit for discharge/not meeting the criteria to reside

NaDIA	National Diabetes Inpatient Audit provides a comprehensive view of diabetes care in England and Wales
Non-invasive ventilation (NIV)	The use of breathing support administered through a face mask, nasal mask, or a helmet
NHS Long Term Plan (LTP)	Sets out priorities for the NHS over the next ten years
NHSE	NHS Improvement became part of NHS England in July 2022
NHS South, Central and West Commissioning Support Unit (SCW CSU)	An NHS organisation providing support and transformation services to health and care systems
Operational Research in Health (ORH)	A management consultancy that uses advanced Operational Research techniques to support resource planning in the public sector.
One Gloucestershire Integrated Care System (ICS)	The working name given to the partnership between the county's NHS and care organisations to work in partnership in improving health and care, to help keep people healthy, support active communities and ensure high quality, joined-up care when needed in Gloucestershire
Office of National Statistics (ONS)	The UK's largest independent producer of official statistics and the recognised national statistical institute of the UK
Pre-Consultation Business Case (PCBC)	The document which presents the business case for any changes to services on which the CCGs agree to consult. It shows that CCGs have properly considered the options, undertaken pre-consultation engagement, submitted to the required scrutiny, and met the four tests and three conditions required by the Secretary of State.
PCI	Primary Percutaneous Coronary Intervention. A coronary angioplasty is a procedure used to widen blocked or narrowed coronary arteries
Primary Care Network (PCN)	Groups of GP practices working closely together - along with other healthcare staff and organisations - providing integrated services to the local population
Royal College of Surgeons of England (RCS)	An independent professional body and registered charity that promotes and advances standards of surgical care for patients
Respiratory High Care (RHC) or Support Unit (RSU)	An area of enhanced care that enables a higher level of monitoring and respiratory intervention than would be expected for a routine ward environment
Same Day Emergency Care (SDEC) (SDEC)	This unit provides same day assessments and treatment; without being admitted into hospital overnight
SAU	Surgical Assessment Unit
South West Clinical Senate	Established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders

South West Ambulance Service Foundation Trust (SWASFT)	Provides a wide range of emergency and urgent care services across South West England
SSNAP	Sentinel Stroke National Audit Programme - An audit tool for collecting patient data
Task & Finish Group (T&F)	A time limited group set up as an action sub-group of a larger committee or meeting with the aim of a delivering a specified objective
TrakCare	The electronic patient management system used across NHS
Transient ischemic attack (TIA)	A temporary period of symptoms similar to those of a stroke. A TIA usually lasts only a few minutes and doesn't cause permanent damage
TLT	GHNHSFT Trust Leadership Team
T h e K Fund g ' s	An English health charity that shapes health and social care policy and practice and provides NHS leadership development
UAU	Urology Assessment Unit
VAU	Vascular Assessment Unit
VCSE	Voluntary Care Sector Enterprise

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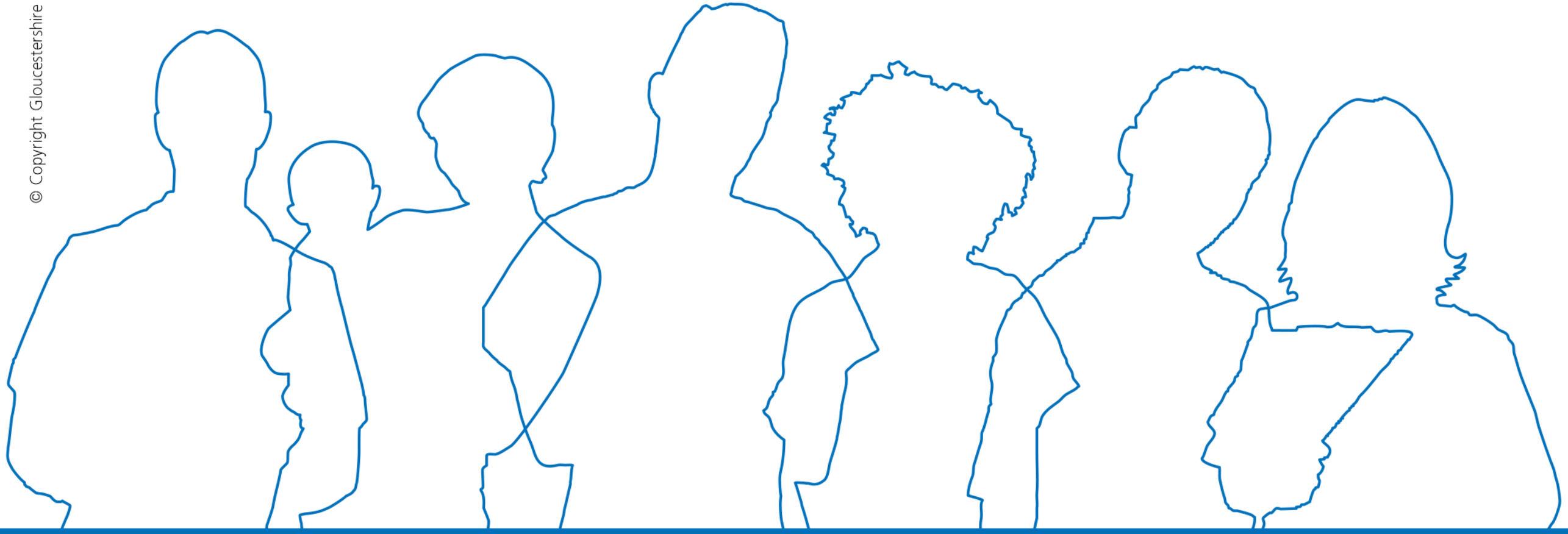
Fit for the Future – Phase 2
Decision Making Business Case: Overview

GHNHSFT Trust Board
9th March 2023



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NHS Foundation Trust

Purpose…

To present the case for change and secure Board approval for the reconfiguration of five specialist hospital services as part of the continued implementation of our *Centres of Excellence* Clinical Strategy.

Cheltenham General as *centre of excellence* for planned care & oncology

Gloucestershire Royal as a *centre of excellence* for emergency care

Centres of Excellence Clinical Strategy:

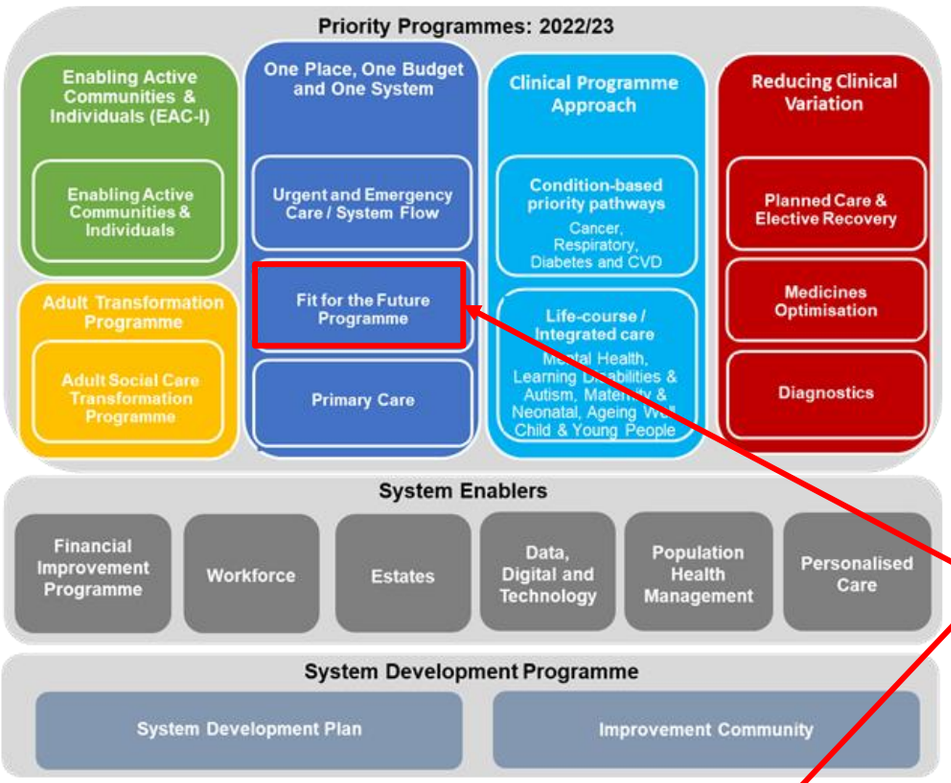
A single, specialist hospital for Gloucestershire operating out of two campuses, one in Cheltenham and one in Gloucester.

All the specialist care and expertise you need will be right on hand whether you are coming to us for planned surgery, or in an emergency.

Context: Trust & ICS Strategic Objectives

Gloucestershire Hospitals
NHS Foundation Trust

ICS Integrated Delivery Plan:



Centres of Excellence informed by:

NHS Long Term Plan	Kings Fund	Royal College of Surgeons of England	Royal College of Physicians
Transforming Urgent and Emergency Care Services in England,	NHS England & Improvement	Royal College of Emergency Medicine	NICE Guidance
South West Clinical Senate	Getting It Right First Time (GIRFT)	Staff co-design & engagement	Provision of Vascular Services
Co-design & feedback from public	Nuffield Trust	Provision of Interventional Radiology Services	Citizens' Jury

GHFT Strategic Objectives 2019 - 2024

Outstanding care	Compassionate workforce	Quality improvement	Care without boundaries	Involved people
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	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	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	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	Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

Centres of Excellence	Financial balance	Effective estate	Digital future	Driving research
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 the county	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI *Outstanding* rating for Use of Resources	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	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	We are research active, providing innovative and groundbreaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Gloucestershire Hospitals
NHS Foundation Trust

Context: FFTF Phase 1

Phase 1: Approved March 2021

Gloucestershire Royal Hospital

- Summer 2023 — Acute Medical Take
- Emergency General Surgery (I)
- Trauma (I)
- Phased from Sept 23 — Image Guided Interventional Surgery (IGIS) Hub
- Vascular Surgery (I)

Cheltenham General Hospital

- Gastroenterology (I)
- Orthopaedics (I)
- Image Guided Interventional Surgery (IGIS) Spoke

Phase 2: Scope of this DMBC

Gloucestershire Royal Hospital

- Diabetes & Endocrinology
- Non-interventional Cardiology — Sept 2023
- Respiratory

Cheltenham General Hospital

- Benign Gynaecology (day cases)
- Stroke – HASU & Rehab

(I) = Implemented

● = Operating as Temporary change until March 2023

Gloucestershire Hospitals
NHS Foundation Trust

Phase 2: Decision Making Business Case (DMBC)

Contents

Section 4: Public, Patient & Staff Engagement

Gloucestershire Hospitals NHS Foundation Trust

- **50+ engagement events**
- **3,000 Engagement booklets** distributed
- **6 Facebook Live** events
- Over **1,800 face-to-face conversations** with public and staff
- **200+ surveys** completed
- NHS **Information Bus Tour**
- Internal **GHFT communication** campaign
- **Presentations** to Primary Care Networks, Integrated Locality Partnerships, Clinical Programme Groups, Health Overview & Scrutiny Committee and local councillors.
- **Outcome of Engagement report** received by Trust Board in September 22.

FFTF Phase		Support	Oppose
Phase 2 *engagement* **N=100**	Stroke to CGH	**84%**	16%
	Benign Gynaecology to CGH	**92%**	8%
	Respiratory to GRH	**97%**	3%
	Diabetes to GRH	**98%**	2%
	Cardiology to GRH	**99%**	1%

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NHS Foundation Trust

Sections 6 to 10: Service Proposals

Gloucestershire Royal Hospital

- Diabetes & Endocrinology
- Non-interventional Cardiology
- Respiratory

Cheltenham General Hospital

- Benign Gynaecology (day cases)
- Stroke – HASU & Rehab

Sept 2023

= Operating as Temporary change until March 2023

Provided for each service:

- The "current state" service model
- Clinical engagement
- Case for change
- Clinical evidence
- Our preferred option for "future state" and the work done to assess
- Benefits
- Interdependencies
- Workforce
- Learning from temporary service change period (where applicable)
- South West Clinical Senate review
- Engagement feedback
- Addressing themes from engagement.

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Section 11:Integrated Impact Assessment (IIA)

Equality Impact Assessment:

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Protected Charictaristics	Age	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Disability	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Pregnancy	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Marital Status	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Ethnicity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Religion	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender reassignment	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

Impact is predominantly positive or neutral with no significant adverse impacts.

Health inequalities impact assessment:

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Health Inequalities	Deprivation	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Looked After Children (LAC)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)
	Carers and unpaid carers	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact
	Homelessness	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact
	Substance Abuse	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Mental Health	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	People Living in rural and remote areas	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Neutral Impact (No Significant Change)	Significant Positive Impact

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Health Impact	Cardiovascular Disease	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Diabetes Mellitus	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Falls among the elderly	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Overweight and Obesity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

Health impact assessment:

Section 12: Economic & Financial Analysis

Proposal: Create an 11 bed Respiratory High Care (RHC) Unit, providing advanced respiratory support, including non-invasive ventilation (NIV) for patients within the respiratory bed base at GRH.

Cost: **£274k Revenue (FYE) & £21k Capital**.

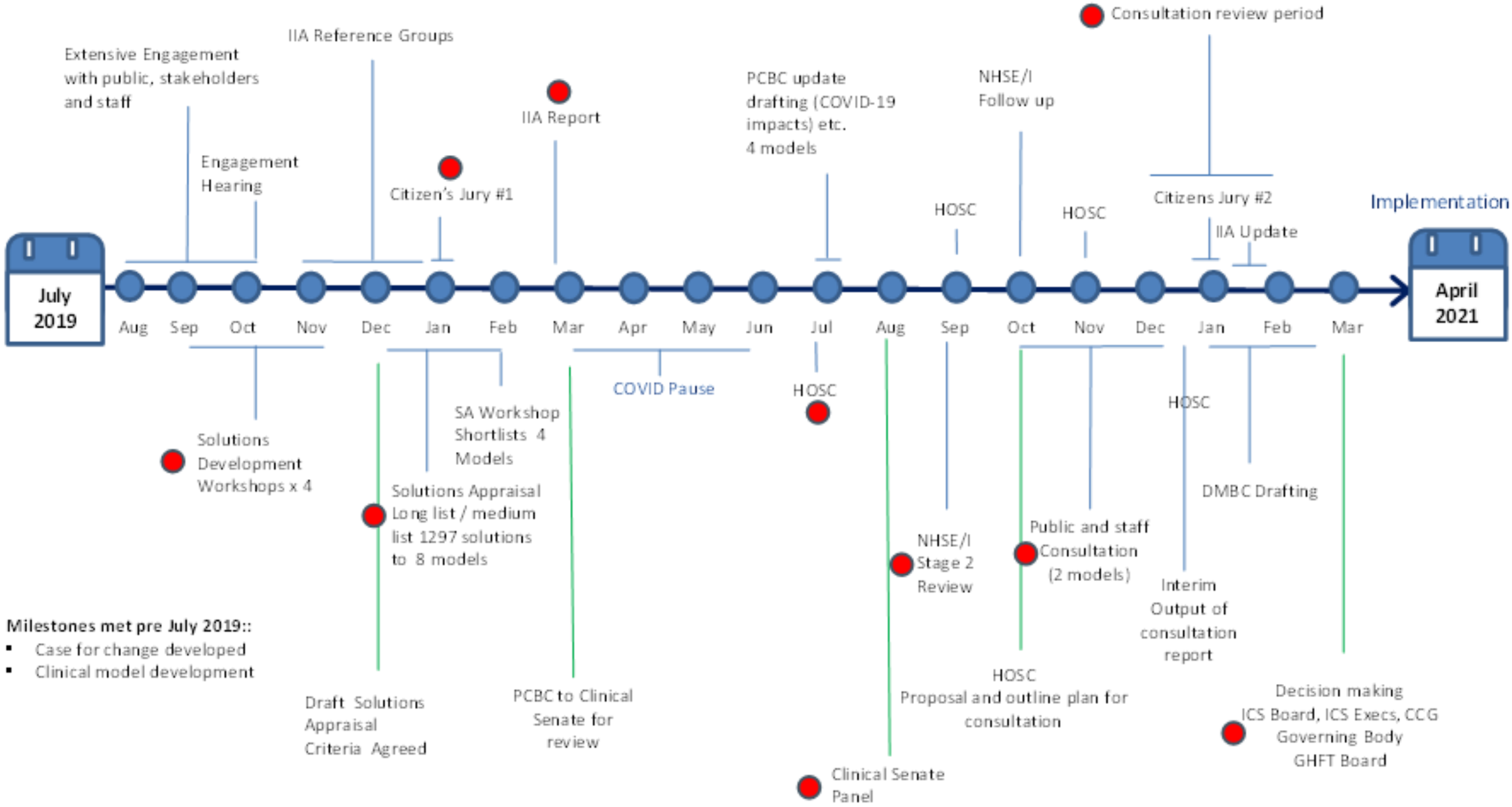
Context:

- ***National Best Practice***:
  - **GIRFT** –recommends establishing a dedicated non-invasive ventilation (NIV) service to improve outcomes of care
  - **British Thoracic Society and Intensive Care Society** recommends the establishment of Respiratory Support Units.
- ***COVID experience*** - Established RHC during COVID and managed around 270 patients with acute respiratory failure during this period, avoiding admission to DCC
- ***Staff costs*** - Medical and nursing staff costs included within current budget

Benefits:

- Aligns with national best practice guidance
- Improves patient outcomes – inc. reducing mortality and greater continuity of care
- Reduces GRH DCC bed demand (range of 1 to 7 beds with greater impact over Winter), **a key enabler for centralisation of Acute Medical Take.**

Section 13: Governance & Decision Making



Section 13: Governance & Decision Making

Following feedback from:

- **Public & colleague engagement**
- **Gloucestershire Health Overview & Scrutiny Committee (HOSC)**
- **South West Clinical Senate**
- **NHS England**
- **GHFT Trust Board**
- **Our legal partner,**

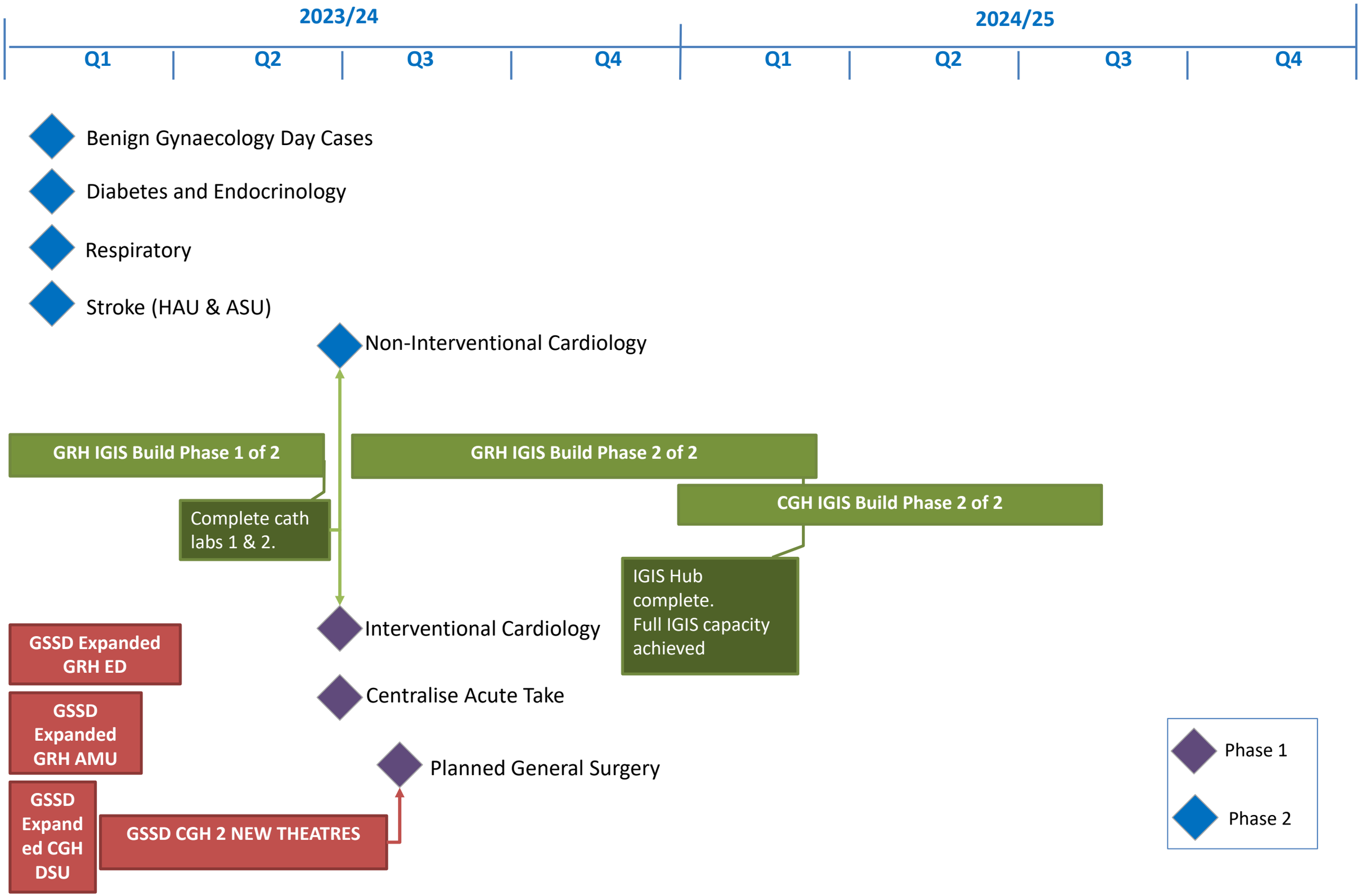
On 30th November, **Gloucestershire Integrated Care Board (ICB)** approved the recommendation that *no further public involvement is required on the proposals within FFTF Phase 2 and the programme should proceed to Decision Making Business Case (DMBC) stage.*

Section 14: Recommendation

Gloucestershire Hospitals
NHS Foundation Trust

- **Resolution #1:** To locate the majority of **Benign Gynaecology** Day Cases at **Cheltenham General Hospital (CGH)**.
- **Resolution #2:** To centralise the dedicated **Diabetes and Endocrinology Inpatient beds** at **Gloucestershire Royal Hospital (GRH)** and provide a **Diabetes and Endocrinology Consult service** at **CGH**.
- **Resolution #3:** To centralise **Non-Interventional Cardiology inpatient beds** at **GRH** and provide a **Cardiology Consult service** at **CGH**.
- **Resolution #4a:** To centralise **Respiratory Inpatient beds** at **GRH** and provide a **Respiratory Consult service** at **CGH**.
- **Resolution #4b:** To establish a **Respiratory High Care unit** at **GRH**.
- **Resolution #5:** To locate the **Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU)** at **CGH**.

Section 15: Implementation



Work in Progress: FFTF Phase 2 proposals subject to Decision Making Business Case

Cheltenham General Hospital

Centre of Excellence for Planned Care & Oncology

Gloucestershire Hospitals NHS Foundation Trust

Emergency Department:

- 999
- Resuscitation
- GP referrals
- Same day emergency care (SDEC)
- Walk-in
- Majors
- Minors

Consultant led: 8am to 8pm
Nurse led: 8pm to 8am

Acute Care

- Acute Medical Take
- Emergency General Surgery (EGS)

Medicine

- Interventional Cardiology
- Medical Cardiology
- Respiratory
- Care of Elderly
- Diabetes and Endocrinology
- Gastroenterology
- Stroke – Hyper Acute
- Stroke - Rehab

Surgery

- Urology
- Planned Upper GI & Colorectal – DC & SS
- Vascular
- Ophthalmology
- Orthopaedics

Diagnostic & Specialties

- Interventional radiology
- Oncology

Women & Children

- Benign Gynaecology
- Gynae oncology
- Midwifery

Key:

- Urgent & Emergency
- Emergency/ Planned
- Planned
- Clinical Support
- Illustrative only – proportion not 50:50
- Centralised/ moved to **GRH**
- Centralised/ moved to **CGH**
- TBC: DMBC to Board in May 2023

24/7 Critical Care

Support Services : Radiology, Pathology, Pharmacy, Therapies ++

Gloucestershire Royal Hospital
Centre of Excellence for Emergency Care…

Gloucestershire Hospitals
NHS Foundation Trust

Emergency Department:

- 999
- GP referrals
- Walk-in
- Resuscitation
- Same day emergency care (SDEC)
- Majors
- Minors

Acute Care

- Acute Medical Take
- Emergency General Surgery

Medicine

- Cardiology
- Neurology
- Respiratory
- Care of The Elderly
- Diabetes & Endocrinology
- Renal
- Stroke
- Gastroenterology

Surgery

- OMF
- ENT
- Orthopaedics
- Vascular
- Trauma
- Upper GI & Colorectal

Diagnostic & Specialties

- Interventional radiology
- Clinical Haematology

Women & Children

- Obstetrics and Gynaecology
- Paediatrics
- Gynaecology (benign daycase)

Key:

- Urgent & Emergency
- Emergency/ Planned
- Planned
- Clinical Support
- Illustrative only – proportion not 50:50
- Centralised/ moved to **CGH**
- Centralised/ moved to **GRH**

24/7 Critical Care

Support Services : Radiology, Pathology, Pharmacy, Therapies ++

NHS
Gloucestershire Hospitals
NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance and Resources Committee, 23 February 2023

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Financial Performance Report	Key points were noted as follows: • The financial position at M10 continued to highlight a significant challenge; the actions proposed by divisions as part of their forecasts were not generating a significant reduction in spend. • The M10 financial position was a deficit of £8.4m which was £7m adverse to plan (£7.6m after adjusting for donated assets). The in-month position was £0.5m surplus which was £0.6m favourable to plan. • Divisional pay pressures of a £7.5m pay overspend due to the use of temporary staff to cover vacancies.	The Committee was concerned about the Trust's spend and how it would be brought under control. Some assurance was provided that overspends were partially offset by underspends and non-recurrent funds. The Committee would regularly receive an Annual Debtors Report.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Financial Sustainability Report	The Financial Sustainability Programme (FSP) gap, before addition of recovery actions, was £3.2m; this was projected to reduce to £1.9m, with additional forecasted recovery actions. The gap to the full year target of £13.2m had reduced by £0.5m.	Work continued to drive forward and stretch the identified divisional and cross-cutting workstreams and to generate new schemes to ensure a successful Financial Sustainability Plan. Weekly meetings continued to take place, within the Medical and Surgical Divisional Tri, to provide additional rigour around Financial Recovery. A revised governance and reporting structure for the FSP continued to be developed.
Capital Programme Report	Key points were noted as follows: • The Trust had submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. • There had been £13.3m of additional capital approved and a reduction in expected in-year donations of £0.5m, bringing this up to £64.7m. • At the end of January (M10), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £38.5m, leaving £26.2m of non-IFRS 16 capital to deliver in the remaining 2 months of the financial year.	A balanced draft capital plan for 23/24 had been issued, with a full draft plan submitted to the Committee in February before submission to NHSE. The Committee agreed that a five-year plan would support improvements. A process for Business Case approvals was being developed and an assessment of the Capital Programme would be scheduled after year end.
Operational Planning	The Committee received a progress update on 2023/24 Operational Planning process and assumptions. The RAG rating for activity and performance standards, items that needed further work (awareness/ escalation), key risks and next steps were noted. Work continued around the draft submission due to go to NHSE on 23 February, with a focus on activity and performance trajectories.	Colleagues continued to review and refine planning assumptions for Urgent and Emergency Care (UEC) and system flow ambitions including additional UEC submissions required by NHSE. The recovery narrative was being finalised to reflect key decisions and meetings were taking place to ensure assumptions and delivery activities were captured on system and organisational delivery plans.
Planning and Budget Setting	The Committee noted the current medium-term plan and 2023/24 budget setting updates. In January an underlying recurrent sustainability challenge of c£58.6m was reported. Updates from local discussions that had informed budget setting had now been	Discussions continued to understand options to manage or mitigate the pressures. Budget sign off continued to be progressed

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.

	incorporated, these updates gave the Trust an underlying recurrent deficit position of c£58.1m. Based on the operational planning guidance, and the under-delivery of 2022/23 schemes, the Trust had a target of c4% (£26.6m) of sustainability requirements. Even if this was achieved the Trust would still deliver a material deficit in 2023/24 due to underlying issues and identified additional developments.	with budget holders and was currently complete, excluding sustainability requirements and developments. The Programme Management Office continued to work with operational and corporate colleagues to identify and implement sustainability schemes for 2023/24.
Digital Transformation Report	Four key work areas were set out: Electronic Patient Record; Clinical Systems Optimisation; Infrastructure and Cyber; Business Intelligence. The Committee particularly noted cyber risks as a key threat to the organisation. The Information and Coding update was also noted.	The Cyber Security BAF was being finalised.
Healthcare Support Workers Banding	The Band 2-3 Health Care Support Worker (HCSW) pay drift issue and the national campaign driven by UNISON through the Regional Social Partnership Forums to re-band HCSW roles at Band 3 was discussed. The potential financial impact of prospective costs, and the retrospective backpay provision was noted.	The Committee endorsed the approach.

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

Items not Rated		
Procurement Bi-Annual Contract Forward Look	Legal Case with HMRC	FFTF Phase 2 Business Case
Digital Clinical Systems Report	Digital Risk Register	

Investments			
Case	**Comments**	**Approval**	**Actions**
Community Diagnostic Centre (CDC) Risk and Authority to Contract	The Committee supported the placement of orders with Gloucestershire County Council (GCC) for advanced enabling works ahead of the signing of the Agreement for Lease for the CDC project. Costs and risks involved were noted.	Approved.	An MoU would be put in place, which would provide some documentary evidence of both sides' commitment to the scheme.
Electrical Resilience – HV Generator Replacement	The Committee was asked to approve the placement of an order with Cummins Inc. for the purchase of 2 Nr. HV Generators required as part of the 23/24 Electrical Resilience capital programme.	Approved.	The Committee agreed that a single system approach was required and an assessment of potential benefits would be brought to the Committee.
WMB Warehouse Lease Extension	The Committee was asked to support the lease continuation.	Approved.	None.

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 during March.

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance and Resources Committee, 26 January 2023

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Financial Performance Report	Key points were noted as follows: • The financial position at M9 continued to highlight a significant challenge; the actions proposed by divisions as part of their forecasts were not generating a significant reduction in spend. • The M9 financial position was a deficit of £7.9m which was £6.4m adverse to plan (£6.6m after adjusting for donated assets). The in-month position was £3m surplus which was £3m favourable to plan.	The Committee was concerned about the Trust's spend and how it would be brought under control. Some assurance was provided that there was added rigour to divisional processes. Corporate areas were releasing underspend, however medicine remained challenged and needed to be addressed.
Contract Management Group Exception Report	Areas of concern including the recent Business Continuity Incidents involving floods at GRH and an electrical outage at CGH were noted. The Committee expressed concern about a recent unsuccessful Fire Evacuation practice.	A review of the Business Continuity Incidents had taken place and would be considered in contract management discussions. The Fire Evacuation was a concern and required senior ownership.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Financial Sustainability Report	The Financial Sustainability Programme (FSP) gap, before addition of recovery actions, was £3.7m; this was projected to reduce to £2.4m, with additional forecasted recovery actions. The gap to the full year target of £13.2m had reduced by £0.5m.	Work continued to drive forward and stretch the identified divisional and cross-cutting workstreams and to generate new schemes to ensure a successful Financial Sustainability Plan. Weekly meetings continued to take place, within the Medical and Surgical Divisional Tri, to provide additional rigour around Financial Recovery.
Capital Programme Report	Key points were noted as follows: • The Trust had submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. • There had been £13.3m of additional capital approved and a reduction in expected in-year donations of £0.5m, bringing this up to £64.5m. • At the end of December (M9), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £32.4m, leaving £32m of non-IFRS 16 capital to deliver in the remaining 3 months of the financial year.	A balanced draft capital plan for 23/24 and had been issued, with a full draft plan submitted to the Committee in February before submission to NHSE. Positive conversations were taking place with GMS colleagues and itemised work plans were being sought from some areas.
Operational Planning	A summary of the 2023/24 Operational Planning Guidance, issued by NHS England on 23 December, was received. The Committee noted the governance process, roles and responsibilities and timeline, and was supportive of the general approach. There were some challenges to achieving the objectives which required further planning.	A task and finish group would be established to ensure that any gaps in performance in the most challenging areas were mitigated using expertise from a range of disciplines. Authority would be delegated to FRC to approve the plan.
Costing Strategy	The draft Five-Year costing strategy was received, with particular attention paid to weaknesses and threats to the achievement of the strategy.	The Trust was slightly ahead of many other Trusts. Engagement and collaborative working continued at pace.
Five-Year Medium-Term Plan	The medium-term financial plan (MTFP) presented to the committee in November highlighted that the Trust had an underlying recurrent sustainability challenge of c£69m. The	Discussions were ongoing with operational teams to validate the level of resource requested, and to understand options to

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.

	Trust had a target of c6.4% (or £31.7m) of sustainability requirements and even if this was delivered the Trust would still deliver a material deficit in 2023/24. There were significant financial pressures and intolerable risks this year.	manage or mitigate the pressures. Budget sign off continued to be progressed with budget holders and the Programme Management Office continued to work with operational and corporate colleagues to identify and implement sustainability schemes for 2023/24.
GMS Managing Director's Report	The Committee noted that the domestic service had been unable to recruit and retain the required number of employees to deliver the current National Cleaning Standards recovery action plan. Operationally, turnover was greater than recruitment, despite some early success.	A new recovery plan would be developed and discussed to ensure a realistic target.

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

Items not Rated		
Commercial and Innovation Review Group Update	Estates Risk Report	

Investments			
Case	**Comments**	**Approval**	**Actions**
None			

Impact on Board Assurance Framework (BAF)
Executives had fully reviewed the BAF on 12 December. The Finance risk had been updated; particular consideration would be paid as to whether capital programme spend needed to be a separate risk or strengthened under Estates or Finance.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	15	Enclosure Number:	10
Date	9 March 2023		
Title	M10 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 10.

Month 10 overview

- The Trust is reporting a year-to-date deficit of £8.4m deficit which is £7m adverse to plan (£7.6m after adjusting for donated assets). This includes one-off benefits of £12.3m.
- The Trust is maintaining the planned forecast breakeven position.
- The ICS is required to breakeven for the year. At month 10, 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 £7.5m is £7.1m adverse to plan and is the result of a £7.6m adverse to plan position from GHFT, a £0.64m YTD surplus position at GHC and a £0.22m deficit at GICB.

Capital

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

As of the end of January (M10), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £38.5m, leaving £26.2m of non-IFRS 16 capital to deliver in the remaining 2 months of the financial year.

Next Steps

The financial position at month 10 continues to be pressured. As the Trust continues to experience winter pressures and further risks emerge, divisions need to continue to monitor their positions against forecast positions and identify mitigations where necessary.

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 10

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 31st January 2023

Revenue & Balance Sheet

Director of Finance Summary

System Overview

The ICS is required to breakeven for the year. At month 10, 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 £7.5m which is £7.1m adverse to plan. This is the result of a £7.6m adverse to plan position from GHFT, a £0.64m YTD surplus position at GHC and a £0.22m deficit at GICB.

Month 10

M10 Financial position is reporting a deficit of £8.4m which is £7m adverse to plan (£7.6m after adjusting for donated assets). The in month position is £0.5m deficit which is £0.6m adverse to plan. The deficit is driven by :

- Underperformance on out of county contracts of £2.1m
- Underperformance on pass-through drugs & devices overhead income £1.2m (net) and shortfall against income plan £1.4m (net).
- Divisional pay pressures of £7.5m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands.
- Non pay pressures within divisions of £4.7m net due to clinical supplies, outsourcing and laboratory reagent costs.
- Financial Sustainability pressure of £3.2m
- GMS inflation pressure of £1m
- Pay award pressure £1m

The drivers of the deficit are partially offset by:

- Corporate net underspends of £3m.
- Non recurrent benefits of £12.3m 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 £2.8m and release of Spec Comm ESRF costs £2.7m

The Financial Sustainability Plan (FSP) target for the Trust is £19m, of which £3.2m remains unidentified. The M10 forecasted position has improved by £0.5m driven mainly by £0.2m non-recurrent actions taken within Corporate division and £0.2m non-recurrent pay improvement within D&S.

The M10 YTD position includes FSP delivery of £13.4m against a target of £15.1m which is an under-delivery of £1.7M.

Director of Finance Summary

Total activity in M10 was 95% of the same period in 19/20. Day case and outpatient activity has increased from December. ED attendances, non elective and inpatients have reduced.

The financial position continues to be in deficit. The M10 position was £0.113m better than forecast due primarily to corporate underspends offsetting divisional positions. Divisional positions were higher than forecast due to ERF costs being incurred (matched with income) and a theatre stock adjustment. The Trust overall run rate improved compared to last month due to technical adjustments made in the prior month. This has not impacted the overall forecast.

Month 10 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £8.4m deficit (before donated assets adjustment)		M10 Financial position is reporting a deficit of £8.4m which is £7m adverse to plan (£7.6m after adjusting for donated assets).
Income is £565m YTD which is £7.9m adverse to plan		M10 overall income position is reporting £565m income which is £7.9m adverse to plan. The income variance is driven by income plan shortfall of £7.4m (which is offset by provision released against non pay), underperformance of activity on out of ICS contracts c£2.1m and less than expected pass through drugs c£3.7m which sees a corresponding underspend in divisional expenditure budgets.
Pay costs are £357m YTD which is £3.4m adverse to plan		Pay costs are £357m YTD which is £3.4m adverse to plan. The YTD position includes a one off benefit of c3m. Without this pay would be overspent by £6.4m YTD driven by the use of temporary staffing in both Medicine and Surgery Divisions for Nursing and Medical staff. The month 10 position (excluding one off benefit) includes Substantive staff underspend of £43m offset by overspends in Agency (£16.6m) and Bank/Locum (£29m). The total contracted vacancies in month 10 are 745 WTE.
Non Pay costs are £217m YTD which is £4.3m favourable to plan. This includes Non-Operating Costs.		Non Pay costs (including non-operating costs) are £217m YTD which is £4.3m favourable to plan. The YTD position includes a one off benefit of c£9m and the release of a provision to offset the income shortfall of £6m. Without this non pay would be overspent by £11m YTD. The main drivers of the non pay overspends include inflation £1m, supplies & services £3m, and FSP shortfall £3m.
Delivery against Financial Sustainability Schemes		Total efficiencies for the Trust are £19m. At month 10, £13.4m efficiencies have been delivered YTD. Forecast delivery is £15.8m which is a shortfall of £3.2m due to unidentified schemes.
The cash balance is £53.5m		Cash has reduced by £1m due to payment of creditors and capital additions.

Oversight Framework – Financial Matrix

Gloucestershire Hospitals
NHS Foundation Trust

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

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

The Financial Matrix used by the Trust to monitor the Finance and Use of Resources for Month 10 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	15,100	13,400	(1,700)
Financial stability – variance from breakeven*	(1,341)	(8,394)	(7,052)
Agency spending	(3,925)	(20,530)	(16,605)
**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.

M10 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of January 2023 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.

In January the Group's consolidated position shows a deficit of £8.4m which is £7m adverse to plan (before donated asset adjustment).

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 10 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	526,041	512,686	(13,354)			0	526,041	512,686	(13,354)
PP, Overseas and RTA Income	5,332	4,250	(1,082)			0	5,332	4,250	(1,082)
Other Income from Patient Activities	10,209	10,008	(202)			0	10,209	10,008	(202)
Operating Income	32,070	34,422	2,352	51,577	53,430	1,853	31,301	38,015	6,714
Total Income	**573,652**	**561,366**	**(12,286)**	**51,577**	**53,430**	**1,853**	**572,883**	**564,959**	**(7,924)**
Pay	(335,420)	(338,034)	(2,614)	(18,166)	(18,977)	(812)	(353,358)	(356,784)	(3,425)
Non-Pay	(230,471)	(224,807)	5,660	(31,223)	(33,574)	(2,351)	(209,574)	(208,767)	808
Total Expenditure	**(565,891)**	**(562,840)**	**3,046**	**(49,388)**	**(52,551)**	**(3,163)**	**(562,933)**	**(565,551)**	**(2,618)**
EBITDA	**7,761**	**(1,474)**	**(9,240)**	**2,189**	**879**	**(1,310)**	**9,950**	**(592)**	**(10,542)**
EBITDA %age	**1.4%**	**(0.3%)**	**(1.6%)**	**4.2%**	**1.6%**	**(2.6%)**	**1.7%**	**(0.1%)**	**(1.8%)**
Non-Operating Costs	(9,103)	(6,922)	2,185	(2,189)	(879)	1,310	(11,291)	(7,802)	3,490
Surplus / (Deficit)	**(1,341)**	**(8,397)**	**(7,055)**	**0**	**(0)**	**(0)**	**(1,341)**	**(8,394)**	**(7,052)**
Dontated Asset Adjustment	370	(131)	(501)				370	(131)	(501)
Adjusted Surplus / (Deficit)	**(971)**	**(8,528)**	**(7,556)**	**0**	**(0)**	**(0)**	**(971)**	**(8,525)**	**(7,553)**

* Trust position excludes £33.5m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £49.8m of inter-company transactions, including dividends

Balance Sheet

	Group Closing Balance 31st March 2022 £000	GROUP Balance as at M10 £000	B/S movements from 31st March 2022 £000
Non-Current Assests			
Intangible Assets	13,760	11,252	(2,508)
Property, Plant and Equipment	304,585	347,093	42,508
Trade and Other Receivables	4,414	4,306	(108)
Investment in GMS	0	0	0
Total Non-Current Assets	**322,759**	**362,651**	**39,892**
Current Assets			
Inventories	9,370	10,393	1,023
Trade and Other Receivables	26,360	20,920	(5,440)
Cash and Cash Equivalents	71,530	53,481	(18,049)
Total Current Assets	**107,260**	**84,794**	**(22,466)**
Current Liabilities			
Trade and Other Payables	(80,104)	(76,941)	3,163
Other Liabilities	(14,401)	(13,536)	865
Borrowings	(3,626)	(3,891)	(265)
Provisions	(24,089)	(16,816)	7,273
Total Current Liabilities	**(122,220)**	**(111,184)**	**11,036**
Net Current Assets	**(14,960)**	**(26,390)**	**(11,430)**
Non-Current Liabilities			
Other Liabilities	(5,971)	(5,517)	454
Borrowings	(34,064)	(54,404)	(20,340)
Provisions	(3,600)	(3,600)	0
Total Non-Current Liabilities	**(43,635)**	**(63,521)**	**(19,886)**
Total Assets Employed	**264,164**	**272,740**	**8,576**
Financed by Taxpayers Equity			
Public Dividend Capital	361,345	378,314	16,969
Equity	0	0	0
Reserves	19,823	19,823	0
Retained Earnings	(117,004)	(125,397)	(8,393)
Total Taxpayers' Equity	**264,164**	**272,740**	**8,576**

Gloucestershire Hospitals
NHS Foundation Trust

The table shows the M10 balance sheet and movements from the 2021-22 closing balance sheet.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

Funding

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

To date, there has been £13.5m of additional capital approved and a reduction in expected in-year donations of £0.5m, bringing the programme up to £64.7m.

YTD Position

As of the end of January (M10), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £38.5m, leaving £26.2m of non-IFRS 16 capital to deliver in the remaining 2 months of the financial year.

A breakeven forecast outturn has been reported to NHSI in the M10 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, of which £15.4m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £51.7m.

To date, there has been £13.5m of additional capital approved and a reduction in expected in-year donations of £0.5m, bringing the programme up to £64.7m

The current agreed programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£13.6m), IFRIC 12 (£0.8m), Government Grant (£3.2m) and Donations (£0.8m)

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

		Plan	Secured	Variance
DIGITAL	Digital	5,634	5,634	0
MEDICAL EQUIPMENT	Medical Equipment	2,223	2,223	0
ESTATES	Estates	16,548	16,548	0
IDG CONTINGENCY	IDG Contingency	609	609	0
RIGHT OF USE ASSET	Right Of Use Asset	15,355	4,000	11,355
Total Charge against Capital Allocation (including impact of IFR		**40,369**	**29,014**	**11,355**
NATIONAL PROGRAMME - DIGITAL	Front Line Digitisation	3,300	3,300	0
NATIONAL PROGRAMME - DIGITAL	MRI Acceleration Software Upgrade		165	(165)
NATIONAL PROGRAMME - DIGITAL	Image Sharing		30	(30)
NATIONAL PROGRAMME - DIGITAL	Irefer		37	(37)
NATIONAL PROGRAMME - DIGITAL	Home Reporting - Radiology Workstations		300	(300)
NATIONAL PROGRAMME - DIGITAL	Digital Pathology		262	(262)
NATIONAL PROGRAMME - DIGITAL	Lims & Interoperability - Sample Tracking Zebra Printers		126	(126)
NATIONAL PROGRAMME - DIGITAL	Cyber 22/23 – Firewalls	50	99	(50)
NATIONAL PROGRAMME - DIGITAL	Front Line Digitisation - 2nd Tranche 2223		2,200	(2,200)
NATIONAL PROGRAMME - NON DIGITAL	Paediatric MH UEC		362	(362)
NATIONAL PROGRAMME - NON DIGITAL	Discharge waiting area GRH		1,500	(1,500)
NATIONAL PROGRAMME - NON DIGITAL	Avening & Prescott wards refurb CGH		1,572	(1,572)
NATIONAL PROGRAMME - NON DIGITAL	TIF 5th Orthopaedic Theatre		1,465	(1,465)
NATIONAL PROGRAMME - CDC	Community Diagnostic Equipment 22/23		463	(463)
NATIONAL PROGRAMME - CDC	Community Diagnostic Centre Enabling works		1,261	(1,261)
NATIONAL PROGRAMME - CDC	Community Diagnostic Centre Digital		217	(217)
NATIONAL PROGRAMME - NON DIGITAL	1 x Siemens Stereo to improve image reading outcomes and activity		84	(84)
NATIONAL PROGRAMME - NON DIGITAL	Endoscopy Early Drawdown		173	(173)
STP PROGRAMME - GSSD	STP Programme - GSSD	21,280	21,280	0
IFRIC 12	IFRIC 12	817	817	0
DONATIONS VIA CHARITABLE FUNDS	Donations Via Charitable Funds	1,281	781	500
GRANT	Grant		3,241	(3,241)
Total Additional Capital		**26,728**	**39,735**	**(13,007)**
Gross Capital Funding Total		**67,096**	**68,749**	**(1,652)**
Excluding IFRS16		(15,355)	(4,000)	(11,355)
Gross Capital Funding Total excluding IFRS 16		**51,742**	**64,749**	**(13,007)**

22/23 Programme Spend Overview

Gloucestershire Hospitals
NHS Foundation Trust

As of the end of January (M10), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £38.5m, leaving £26.2m of non-IFRS 16 capital to deliver in the remaining 2 months of the financial year.

Excluding IFRS 16, the Trust delivered £6.2m in the month against a previously forecast spend of £6.9m, equating to a £0.7m adverse variance.

in £000's	In Month			Year to Date		
	Last Forecast for this Month £000's	In Month Actual £000's	Variance to Last Month Forecast £000's	Plan £000's	Actual £000's	Variance to Plan £000's
DIGITAL	771	631	140	4,645	3,896	750
MEDICAL EQUIPMENT	226	84	142	1,668	1,539	128
ESTATES	2,641	2,740	(99)	10,658	6,291	4,367
IDG CONTINGENCY	0	0	0	338	0	338
RIGHT OF USE ASSET	0	2	(2)	0	1,006	(1,006)
Total Charge against Capital Allocation (including impact of IFRS 16)	**3,638**	**3,458**	**180**	**17,309**	**12,732**	**4,577**
NATIONAL PROGRAMME - DIGITAL	375	259	116	2,814	1,895	918
NATIONAL PROGRAMME - NON DIGITAL	568	229	339	0	2,439	(2,439)
NATIONAL PROGRAMME - CDC	326	174	152	0	355	(355)
STP PROGRAMME - GSSD	1,532	1,535	(2)	21,280	20,242	1,038
IFRIC 12	68	68	0	681	680	1
DONATIONS VIA CHARITABLE FUNDS	75	54	21	166	54	112
GRANT	357	379	(22)	0	1,136	(1,136)
Gross Capital Funding Total	**6,940**	**6,156**	**784**	**42,249**	**39,534**	**2,716**

A breakeven forecast outturn has been reported to NHSI in the M10 Provider Financial Return (PFR) albeit the latest internal forecasts are showing a projected outturn of £1m under allocation. This is primarily driven by the IGIS project. Any slippage now becomes a real risk to our year-end position. The programme continues to be monitored and mitigations explored for potential slippage that may materialise.

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £8.4m which is £7.0m adverse to plan (£7.6m after adjusting for donated assets).
- Note the Trust balance sheet position as of the end of January 2023.
- Note the Trust capital position as of the end of January 2023.
- 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:	**March 2023**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	**15**	**Enclosure Number:**	**10**
Date	9 March 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 & 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 MAIN TRUST BOARD – MARCH 2023

DIGITAL TRANSFORMATION REPORT

1. Executive Summary

This paper provides the Board 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 workplan continues to deliver 57 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.

Next year's programme of work is currently being finalised and will be shared next month demonstrating alignment to the rationalised Trust strategic priorities.

1.1 Highlights this period

Digital Programme 2023/24
The definition of the programme of work for EPR for 2023/24 is progressing and will be detailed and shared with the organisation upon confirmation of the capital programme and finalisation of project documentation. Project briefs are being scoped for all main projects. The prioritised programme of work aligns to the Trust's rationalised strategic priorities, whilst also supporting the Trust's digital agenda. The programme takes into account new project requests from clinical staff across the Trust.

TrakCare Upgrade
The TrakCare upgrade that took place from Saturday evening, 4th February, into Sunday morning, 5th February, was completed successfully.

The system was off-line for 9 hours 30 minutes - this was 30 minutes less than was anticipated, with all users brought back on-line at 03.30hrs.

During the downtime, the Trust switched access to TrakCare from Internet Explorer to Microsoft Edge. This has impacted some of our users as they log-in to TrakCare for the first time in the weeks ahead. The team is working to ensure everyone has access.

EPR

ePMA (Electronic Prescribing and Medicines Administration)
As planned; the first drop of significant optimisation for ePMA was delivered on 17th January and improves a number of areas, most notably the discharge process. The second drop of changes is planned for 2nd February. This drop will further improve the discharge process, deliver a number of order sets for clinicians to allow for speedier ordering of medications for patients, updated functionality for medication within clerking documents, and additional clinical summary views for all staff relating to medications.

LTSS (Long-Term Stay Score)
The launch of LTSS risk assessment is being planned for February. Go-live planning and support is currently in development. Risk scores will be released into ED documentation in EPR, allowing clinical staff the visibility of a patient's risk of a long stay should they be admitted. The assessment of usage, benefit and optimisation is planned to be owned by the Urgent and Emergency Care Board and updates will be reported into this forum.

Virtual Wards
A frailty virtual ward is in the early days of roll-out. This ward allows teams to ensure that suitable patients can be discharged from the hospital, but still monitored on EPR remotely. The team are carrying out PDSA cycles to optimise the service. The solution in use by frailty is similar to the one utilised to great success by the Respiratory team for tracking COVID patients as they are discharged from the Trust. There are plans for similar functionality to be rolled-out to a surgical SAU virtual ward model too.

Internal Referrals in EPR
Work is progressing to ensure that internal referrals to medical teams are available in EPR by the end of March 2023. This will progress into a stage of testing the referrals internally in the next reporting period.

EPR Clinical Design Authority
The existing EPR Clinical Strategy and EPR Clinical Documentation workstreams are being changed into a more fit-for-purpose EPR Clinical Design Authority, which will launch at the end of February. This group will be responsible for reviewing change requests, new project requests and in making key design decisions throughout all EPR projects. This will ensure that plans and changes to the system are aligned with clinical, operational and digital priorities, as well as ensure greater support for adoption of changes and new developments in EPR. It is vital that all divisions and clinical specialties have representation at this group as it will dictate the development of EPR moving forward.

PACS

We are replacing IntelliSpace PACS with VUE PACS. The new PACS (Picture Archiving and Communication System) aims to improve performance. There is a like for like replacement, but launching of images via EPR will be quicker and performance of loading complex images will improve. Reporting will be done in PACS instead of CRIS for Radiologists. This predominantly impacts colleagues who currently view radiology images through Sunrise EPR and IntelliSpace PACS.

Cyber
Risks within the programme are reviewed with the Cyber Security team at an operational level, as part of a rolling programme of cyber risk mitigation working group meetings with representation from the IT operational teams and Cyber Security team. Controls currently under improvement following the latest GHT and ICB meetings include a programme of enrolling users to use MFA on NHSmail - with a specific focus on rolling-out to Finance Services teams to counter fraud.

Engagement and training compliance figures at the 8-week point are currently a focus of review as part of an action plan to increase Trust-wide compliance with the 95% annual training requirement. The current status of the GHT DSPT version 4 submission remains as "Approaching Standards", as a result of the Trust not yet achieving 95% of staff having completed their IG refresher training. In line with NHS digital process, a high-level action plan has been submitted with progress being monitored through DCDG.

The ICB run monthly induction sessions with sections included on IG and cyber security. The ICB is also currently not achieving compliance with the 95% of all staff having had annual refresher training.

In addition to the mandatory data security awareness training, GHC have followed-up a recent phishing campaign with a requirement for those staff identified as having fallen for the simulated phishing email, or as identified as having been subject of a real phishing issue to undertake additional cyber e-learning. To date a total of 512 GCH staff have been directed to complete this additional learning. This approach is under review for GHT and the ICB.

The Cyber team now communicates cyber threat instances and vulnerabilities more proactively using TopDesk (the service desk management tool) to log actions required of the operational teams, to provide a more complete report. This recently introduced process for IT security triage continues, ensuring that vulnerabilities requiring action are logged by the security team to highlight requirement to operational teams and to quantify the resource required to remediate. A weekly review of the triage list prioritises tickets for GHT and ICB/GP. A similar approach is in place, adapting existing process to enable similar triage for GHC. To facilitate this, a member of the security team now attends the weekly GHC review meeting.

Information Governance
Analysis of the new starter compliance supports recommendation and illustrates that as at the end of December, 25% of new starters from October failed to complete the training in the two-month grace period given to complete adding to the rolling monthly challenge and increasing the risk to the organisation.

So far, 13 incidents have been reported to the ICO during the 2022/2023 financial year reporting period to date. Additionally, 32 confidentiality incidents have been reported on the Trust internal Datix incident reporting system during December 2022.

CDIO Risk
Key issues to note:

- There are 62 Digital risks currently on the Risk Register.
- Three risks awaiting confirmation for re-submission for entry to the Corporate Risk Register.
- Two risks proposed for increase in score.
- Two new risks are under review.

As at the end of January, all but four of the Digital risks have been reviewed within their review date as per policy. Those that are remaining will be carried over and reviewed in February.

In conclusion, controls and actions are in place to monitor Digital risks.

2. RAG Status

The current status of projects within the Programme of Work categories:

EPR	Clinical Systems Optimisation	Infrastructure & Cyber	Business Intelligence
8	15	25	9

Complete or in closure	On Hold	Red Rated	Amber Rated	Green Rated	Discovery Phase
15	1	5	20	10	6

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, the following projects have been completed and closed:

- Quality Performance Reporting on Tableau

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 -

Gloucestershire Hospitals
NHS Foundation Trust

23/24
Draft Capital Plan

2324 Draft Capital Plan

Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

The Trust now have a balanced draft capital plan for 23/24 totalling £56.5m capital spend, £48.0m that will score against CDEL.

2324 Draft Capital Plan

Gloucestershire Hospitals
NHS Foundation Trust

23/24 Capital Programme

The Trust has formulated a balanced, prioritised capital plan for 23/24 totalling £56.5m. (See next slide) The current agreed programme can be divided into the following components;

Operational System Capital (£25.9m) – This is largely made of a core operational capital allocation of £24.4m. There is also a possibility that the system will have an uplift to their operational capital allocation depending on achieving a surplus, breakeven or an agreed deficit target. It has been agreed by the system that the majority of this uplift would be earmarked for high-priority backlog maintenance within GHFT and therefore an additional £1.5m has been added to the operational system capital in the draft plan.

Right of Use Asset (£5.6m) – This is the right-of-use asset that is estimated to be entered in 23/24. The Trust gets given CDEL for Those that would have been operating lease previously (£1.5m). Even though the CDC lease (£4.1m) would have been classified as a finance lease under the old accounting standard, Trusts are being given the CDEL cover for these. Ordinarily, anything that would have been a finance lease would have had to have been funded from the Trust's operational system capital.

National Programme (£15.6m) – This comprises three multi-year nationally approved programme allocations that had been approved in 22/23 but were planned for delivery and funding in 23/24.

IFRIC 12 (£1.1m) – This is capitalised Lifecycle on the PFI building, calculated from the PFI financial model, billed through the unitary payment. This does not impact CDEL but the PFI residual interest of £0.3m does count.

STP PDC (£0.6m) – Final PDC funding of the GSSD programme from the national STP programme allocation.

Government Grant (£6.7m) – This is the continuation of the Salix grant that the Trust was successfully awarded in 2022. This does not impact CDEL.

Donations (£1.0m) – This comprises c£0.5m for the Gamma Camera purchase which the charity has successfully raised the required funds but is dependent on the IGIS programme for delivery and funding to be provided. There is also another £0.5m that has been added as an estimate of other charitable donations that might be known. This does not impact CDEL

Refinements to the plan will be carried out before the final submission in April

2324 Draft Capital Plan

Draft 23/24 Capital Programme - Detail

Programme Area	Capital Scheme	Capital Framework Area	23/24 Planned Allocatio
OPERATIONAL CAPITAL: DIGITAL	Clinical Systems - Clinical System Consolidation (I/faces)	DIGITAL	500
OPERATIONAL CAPITAL: DIGITAL	Infrastructure & Cyber - End User Hardware refresh	DIGITAL	1,250
OPERATIONAL CAPITAL: DIGITAL	Infrastructure & Cyber - Data Centre Hardware Refresh	DIGITAL	300
OPERATIONAL CAPITAL: DIGITAL	Infrastructure & Cyber - Network Refresh	DIGITAL	150
OPERATIONAL CAPITAL: DIGITAL	Infrastructure & Cyber - Legacy Infrastructure	DIGITAL	500
OPERATIONAL CAPITAL: DIGITAL	Infrastructure & Cyber - VDI GHT Desktop v2	DIGITAL	120
OPERATIONAL CAPITAL: DIGITAL	EPR - EPMA Expansion	DIGITAL	450
OPERATIONAL CAPITAL: DIGITAL	EPR - Order Comms Expansion	DIGITAL	400
OPERATIONAL CAPITAL: DIGITAL	EPR - Clin Docs Expansion	DIGITAL	180
OPERATIONAL CAPITAL: DIGITAL	EPR - Closed Loop Process	DIGITAL	300
OPERATIONAL CAPITAL: DIGITAL	BI - TrakCare upgrade / patches	DIGITAL	400
OPERATIONAL CAPITAL: DIGITAL	BI - Data Warehouse	DIGITAL	150
OPERATIONAL CAPITAL: DIGITAL	New Finance System	DIGITAL	1,000
OPERATIONAL CAPITAL: DIGITAL	Digital Schemes	DIGITAL	0
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	Finance Lease Buyouts / Extensions	MEDICAL EQUIPMENT	465
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	MEF Contingency (Medical Equipment Replacements)	MEDICAL EQUIPMENT	1,000
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	Various Theatre Equipment	MEDICAL EQUIPMENT	315
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	Ultrasound replacement	MEDICAL EQUIPMENT	295
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	Image intensifiers	MEDICAL EQUIPMENT	330
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	IR room 8 (IGIS)	MEDICAL EQUIPMENT	1,511
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	3rd Cath Lab - Cardiology (IGIS)	MEDICAL EQUIPMENT	1,500
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	Pharmacy manufacturing Unit, modernise obsolete PMU	MEDICAL EQUIPMENT	380
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	HEE Capital Items	MEDICAL EQUIPMENT	200
OPERATIONAL CAPITAL: ESTATES	Fit for the Future (IGIS)	ESTATES	3,439
OPERATIONAL CAPITAL: ESTATES	Electrical Infrastructure	ESTATES	2,540
OPERATIONAL CAPITAL: ESTATES	Backlog Maintenance - Significant and high risk (CIR)	ESTATES	2,039
OPERATIONAL CAPITAL: ESTATES	Backlog Maintenance - Moderate and low risk	ESTATES	874
OPERATIONAL CAPITAL: ESTATES	Backlog - Theatres Refurbishment	ESTATES	1,800
OPERATIONAL CAPITAL: ESTATES	Gloucestershire Hospitals Strategic Site Development (Operati	ESTATES	3,500
OPERATIONAL CAPITAL: ESTATES	Ward and Theatre Refurbishments	ESTATES	0
IDG CONTINGENCY	IDG Contingency	CORPORATE/VARIOUS	0
RIGHT OF USE ASSET: NEW	Leases: Community Diagnostic Centre	RIGHT OF USE ASSET	4,098
RIGHT OF USE ASSET: NEW	Leases: Other - including investment property	RIGHT OF USE ASSET	886
RIGHT OF USE ASSET: NEW	Leases: Fleet, Vehicles & Transport	RIGHT OF USE ASSET	157
RIGHT OF USE ASSET: NEW	Leases: Equipment - clinical diagnostics	RIGHT OF USE ASSET	82
RIGHT OF USE ASSET: LEASE REMEASUREMENT	Leases Remeasurement: Other - Thirlestaine Court	RIGHT OF USE ASSET	29
RIGHT OF USE ASSET: LEASE REMEASUREMENT	Leases Remeasurement: Other - Stroud Maternity	RIGHT OF USE ASSET	58
RIGHT OF USE ASSET: LEASE REMEASUREMENT	Leases Remeasurement: Other - Cirencester Theatres	RIGHT OF USE ASSET	266
			0
Total Charge against Capital Allocation (including impact of IFRS 16)			**31,464**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Image Sharing	DIGITAL	174
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Digital Pathology	DIGITAL	115
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Equipment 22/23	MEDICAL EQUIPMENT	451
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Enabling works	ESTATES	4,185
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Digital	DIGITAL	2,540
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	5th Orthopaedic Theatre	ESTATES	8,170
STP PROGRAMME: GSSD	Gloucestershire Hospitals Strategic Site Development	ESTATES	561
IFRIC 12	PFI Lifecycle	CORPORATE/VARIOUS	1,126
DONATIONS VIA CHARITABLE FUNDS	Gamma Camera	MEDICAL EQUIPMENT	514
DONATIONS VIA CHARITABLE FUNDS	Other potential charitable donations	CORPORATE/VARIOUS	500
GRANT	PSDS 3a Salix (Grant Funded)	ESTATES	6,724
			0
Sub Total (for when filtered)			**56,524**
Gross Capital Expenditure Total			**56,524**
Less Donations and Grants Received	Less Donations and Grants Received		(7,738)
Less PFI Capital (IFRIC12)	Less PFI Capital (IFRIC12)		(1,126)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)		330
Total Capital Departmental Expenditure Limit (CDEL)			**47,989**

Gloucestershire Hospitals
NHS Foundation Trust

Draft 23/24 Capital Programme - Summary

in £000's	23/24 Planned Allocation
OPERATIONAL CAPITAL: DIGITAL	5,700
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	5,996
OPERATIONAL CAPITAL: ESTATES	14,192
IDG CONTINGENCY	0
RIGHT OF USE ASSET: NEW	5,223
RIGHT OF USE ASSET: LEASE REMEASUREMENT	353
Total Charge against Capital Allocation (including impact of IFRS 16)	**31,464**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	289
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	7,176
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	8,170
STP PROGRAMME: GSSD	561
IFRIC 12	1,126
DONATIONS VIA CHARITABLE FUNDS	1,014
GRANT	6,724
Gross Capital Funding Total	**56,524**
Less Donations and Grants Received	(7,738)
Less PFI Capital (IFRIC12)	(1,126)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	330
Total Capital Departmental Expenditure Limit (CDEL)	**47,989**

Gloucestershire Hospitals
NHS Foundation Trust

24/25 and beyond

The Trust is also required to submit a plan for 24/25. The Trust is still yet to conclude what this looks like but has agreed on the draft plan to submit a high-level plan as below. This is based on an operational capital allocation of £24.4m and includes already approved national programme PDC and Salix Grant.

It is planned to work on the detail to refine this ahead of the final submission in April.

There are also plans for 25/26 to 27/28 that are to be submitted but the intention is to leave at a high level for both draft and final plan submissions.

Programme Area	Capital Scheme	Capital Framework Area	Current Planned Allocation 2425 £000's
OPERATIONAL CAPITAL: DIGITAL	Digital Schemes	DIGITAL	5,000
OPERATIONAL CAPITAL: MEDICAL EQUIPMENT	MEF Contingency (Medical Equipment Replacements)	MEDICAL EQUIPMENT	5,000
OPERATIONAL CAPITAL: ESTATES	Backlog Maintenance - Significant and high risk (CIR)	ESTATES	5,600
OPERATIONAL CAPITAL: ESTATES	Backlog Maintenance - Moderate and low risk	ESTATES	2,400
OPERATIONAL CAPITAL: ESTATES	Ward and Theatre Refurbishments	ESTATES	6,000
IDG CONTINGENCY	IDG Contingency	CORPORATE/VARIOUS	404
Total Charge against Capital Allocation (including impact of IFRS 16)			**24,404**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Image Sharing	DIGITAL	203
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Digital Pathology	DIGITAL	122
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Digital	DIGITAL	1,312
IFRIC 12	PFI Lifecycle	CORPORATE/VARIOUS	599
GRANT	PSDS 3a Salix (Grant Funded)	ESTATES	999
Sub Total (for when filtered)			**27,639**
Gross Capital Expenditure Total			**27,639**
Less Donations and Grants Received	Less Donations and Grants Received		(999)
Less PFI Capital (IFRIC12)	Less PFI Capital (IFRIC12)		(599)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)		341
Total Capital Departmental Expenditure Limit (CDEL)			**26,382**

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- To approve the draft 23/24 and 24/25 capital plans as part of the draft planning return submission to NHSIE.

Authors:	**Craig Marshall, Project Accountant**
Presenting Director:	**Karen Johnson, Director of Finance**
Board Date:	**March 2023**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	15	Enclosure Number:	10
Date	9 March 2023		
Title	Finance Strategy		
Author /Sponsoring Director/Presenter	Karen Johnson, Director of Finance		

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

Summary of Report

Purpose

The purpose of this report is to obtain Board approval for the draft Five Year Finance Strategy Update.

The draft has already been discussed and updated for feedback from Finance and Resources Committee in December 2022 and Trust Leadership Team in January 2023.

A copy was also circulated to the Integrated Care Board for feedback from the wider system.

Recommendation

The Board is asked to approve the draft Five Year Finance Strategy Update for internal and external publication.

Enclosures

Five Year Finance Strategy Update

NHS
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NHS Foundation Trust

Finance Strategy

the **Best Care for Everyone**
care / listen / excel

Foreword

As a Trust we are on a five year strategic journey to being outstanding – one of the key pillars underpinning this is financial sustainability.

We are updating this Financial Strategy in 2022: year 3 of the 5 years. Finance in the NHS has been challenging for many years and will continue to be and we have seen this reflected within our own Trust's financial position over past financial years.

To address this challenge, we have developed our financial strategy to outline how we will be a financially literate organisation. This will ensure that staff who have budgetary responsibility have had training and are provided with tools to support their financial understanding and monitoring, enabling them to make the best decisions for their patients and teams.

The most important task that we all need to be involved in for long-term financial sustainability is investing in transforming patient care, using a Systems Thinking approach. This approach finds points of leverage where application of a relatively small amount of resources would make the largest difference to people's health and reduce net overall lifetime resources needed. We need to focus on prevention, self-management and home care, which are usually much lower-cost options and prevent the need for a hospital visit in the first place. Using highly effective clinical and back office digital systems will give us the basis we need for these improvements.

We will teach our budget holders and business partners about Systems Thinking and points of leverage, so that they can work together to identify transformation opportunities and create the necessary business cases to support their successful delivery.

We will also continue to use national productivity programmes and tools to identify unwarranted variation. This will support our teams and support functions in identifying and implementing efficiency improvements that we can make within the Trust and across the Integrated Care System (ICS).

We will continue to work with ICS partners, and others, through our Resources Steering Group (RSG), to explore alternative routes to capital and investment. This will support us in providing an infrastructure that matches our ambition to deliver Best Care for Everyone.

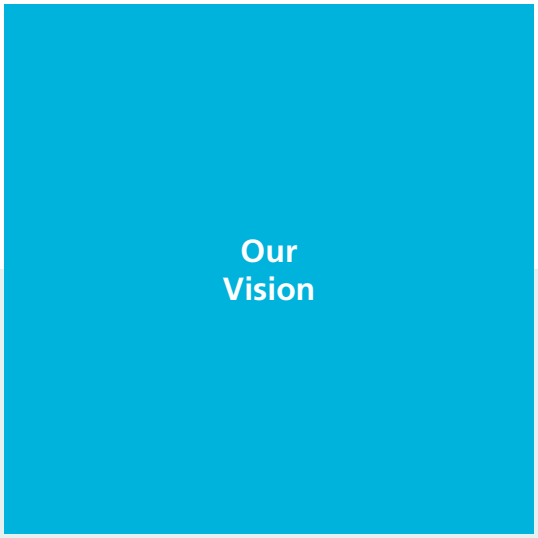
Partnership working across our ICS will help support addressing the challenges faced in Gloucestershire, yet that is only one part of the solution for the Trust. Through developing new systems, increasing engagement, and supporting budget holders to have greater understanding and confidence, we can help ensure that the whole Trust is in a position where it is able to help ensure that we are financially sustainable and able to meet the challenges ahead.

Karen Johnson
Director of Finance

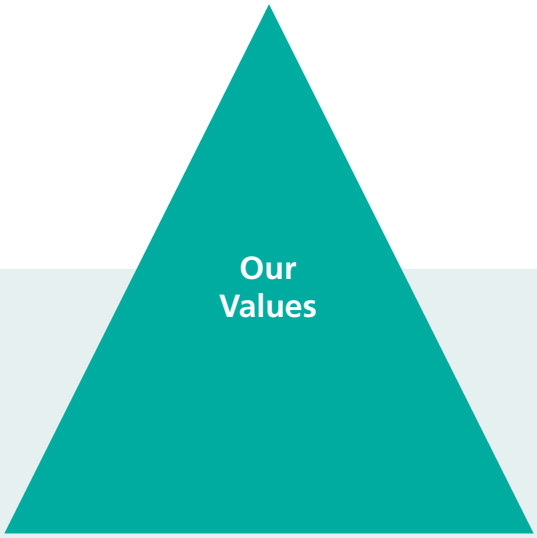
Our Trust's overall strategic objectives 2019–2024

Our purpose, vision and values

To improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day



Best Care for Everyone



Caring, Listening, Excelling

Our Trust's overall strategic objectives 2019–2024

We all want to achieve the strategic objectives of our Trust and the wider health and social care system which we are part of.

We are here to deliver the best possible care to patients within the budget available from taxpayers. As a Finance function, this is where we fit in.

Where patients do appropriately need our care, we want to make things run smoothly, with facilities and digital systems designed to meet patients' needs to a high quality and cost effectively. Patients themselves want to be diagnosed and treated quickly and accurately too.

Yet, in many cases, care can be better delivered by other organisations or self-management rather than NHS acute trusts, and we are increasingly recognising this.

For example, when a patient is ready to be discharged from hospital, yet has to stay in hospital longer while homecare is arranged. Similarly the old adage of "Prevention is better than cure".

Prevention and self-management, wherever possible, are better for the patient and much more cost effective when looking at each patient's lifetime use of health services.

Overall objective of our healthcare system

To deliver longer life in good health

The need for financial sustainability

Funding within the NHS continues to be an ongoing challenge.

Funding within the NHS continues to be an ongoing challenge for organisations due to an ageing population causing increasing demand, with a lack of home care to enable timely hospital discharges, as well as increasing costs of goods and staff.

When compared with the national funding formula, Gloucestershire is above its target allocation.

Through a process called convergence it will be at its target allocation, compared to other NHS areas, by 2024/25. So this NHS internal issue has now been resolved. Yet the other cost pressures remain, and given a population over 65 years old (which is above the England average) this presents an additional challenge when looking at resource consumption.

Gloucestershire ICB total funding	2022/2023	2023/2024	2024/2025
Core allocation / £millions	986	1,039	1,068
Distance from target %	1.55%	0.81%	0.01%
Average spend per head £: Gloucestershire	1,459	1,527	1,560
Average spend per head £: England	1,570	1,643	1,670
Target / £millions	971	1,031	1,068
Over funding / £millions	15	8	0

Age group	Population 2019	Spend / £'000s 2018/19	Spend per head / £
0–19	142,506	61,530	432
20–64	357,054	328,257	919
65+	137,510	345,336	2,511
	637,070	**735,122**	**1,154**
65–75	73,800	115,357	1,563
75–84	45,378	126,371	2,785
85+	18,332	103,609	5,652
	137,510	**345,336**	**2,511**

The need for financial sustainability (continued)

Why is this important?

This funding is used to support many different areas of health care within Gloucestershire.

We have a population that is growing and ageing, above England average rates. As we grow older, healthcare utilisation increases with age.

Looking at our spend per person by age category we can see this marked increase in cost with age. Nearly half of NHS funding is spent on people over 65. Now, many more people have dementia too, which requires more expensive care.

Over time this increase in an over 65 population will present additional financial challenges to our local health economy. This increased resource consumption means that as a local system we will need to make savings in order to ensure that the funding received covers the costs incurred.

Our Trust has seen a significant financial challenge over the last few financial years with an increasing underlying deficit position that is not sustainable.

Cost is not directly linked to activity as we are currently paid on a block grant basis rather than Payment By Results, which complicates matters.

Whilst we often say that an increasingly elderly population is driving health costs up, the full story is more subtle than that. In many cases, it is being able to maintain people longer in ill health that is pushing up costs, as many chronic diseases have an impact in later life when the impacts of decades of unhealthy life styles catch up on people.

Then, coincidentally, because nothing is done to change that dynamic, an increasingly aging population drives up health costs – yet the driver is not just age but the lack of ill health prevention strategies.

Prevention and self-management strategies are often not primarily clinically driven, as they will have to come from changes in social, work and public health policies.

Clinicians have an important role to play in providing data about clinical outcomes, and working with patients, system partners and others, to ensure that effective prevention and self-management strategies are put in place and appropriate resources allocated.

With the backdrop of population growth and changing needs, a system wide approach is needed to find solutions to deliver health and care in the most sustainable way.

Systems Thinking and finding points of leverage to reduce overall lifetime resources needed per patient, while not affecting quality of care, is our preferred approach.

PESTLE analysis

When considering the future position of our financial sustainability there are a number of external factors that we need to consider which could impact the Trust and its costs:

P	**Political**	Impact of Brexit, COVID-19 and war in Ukraine on inflation, staff availability, goods and services availability Campaign groups and impact on service redesign (e.g. Fit For The Future) Comprehensive spending reviews and political priorities Non NHS commissioning and any qualified provider contracting
E	**Economic**	Level of continued investment in the NHS Changes in the VAT regime Risk of increased patients with poor health outcomes due to economic downturn from COVID-19 Payment By Results and future funding models
S	**Social**	Lack of heating at home due to utilities costs inflation causing more A&E attendances Availability of staffing – staff leaving health and social care, especially post COVID-19 and with salaries not keeping pace with inflation, nurses using foodbanks due to less financial support from DWP for part timers and impact of student loan repayments
T	**Technological**	New drugs/devices/treatments Changes in how we work and deliver care (increased use of remote solutions) Automated intelligence opportunities
L	**Legal**	Changes to legislation including Brexit, VAT, new Public Procurement Bill Challenges to how we provide services/ redesign
E	**Environmental**	Carbon reduction and impact on old estates (with potential benefits from a new estate) Climate crisis New ways of working Impact on services and costs from pandemics

Three paths to financial sustainability

In general, there are three things that we can do to make the organisation financially sustainable.

Three paths to financial sustainability

Increase income

Longer term, we do need increased income to cope with an ageing population. Yet, at the moment, the highest priority area for extra income in health and social care is in social care.

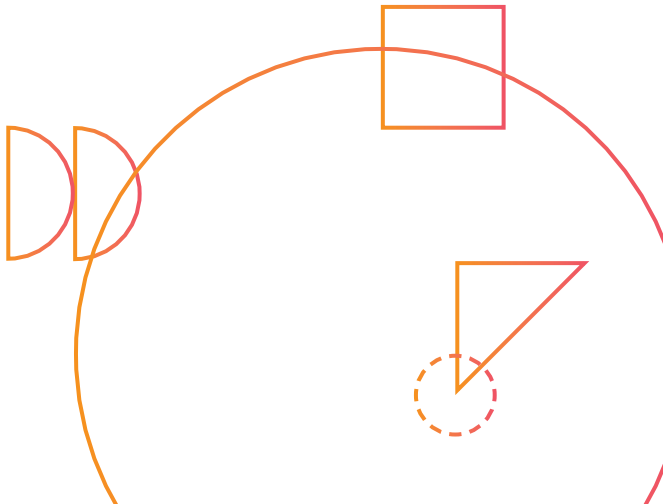
There is a shortage of funding for homecare and care homes, because these areas have suffered significant funding cuts (whilst NHS funding was generally protected) and also because there is much higher demand.

This extra demand is both because of the ageing population, and also because the NHS has been so effective at treating diseases like cancer that many more people now survive longer and develop dementia, which requires more social care.

What this means is that many of our hospital beds are full of people who are well enough to leave hospital, yet are waiting for homecare or a care home place. This stops us treating other patients and fills up A&E.

A hospital bed is more expensive per day than homecare or a care home place. So, to overcome this, we must let social care have as much funding as possible. This will free up our bed spaces in the hospitals and allow us to treat more patients.

Private patient income, commercial income and research and development are areas where there is an opportunity to increase income. We can explore these areas more and are doing so.



Three paths to financial sustainability

Reduce unnecessary day-to-day spend, where quality of patient care can be maintained

This is essential for the Trust to continue to look at and hold budget holders to account.

Usually savings are relatively small in each team, yet added up across the Trust they could come to a significant total.

The new finance system will help the finance team and budget holders to more easily identify spend by adding better descriptions on management accounts reports, drill down to the underlying paperwork, and create new reports which show patterns in spend. This will help everyone to better understand the current spend and any cost savings that could be made.

For example, temporary staff could be replaced by permanent staff, who tend to cost less. Ad hoc spend with several suppliers could be put together and retendered as one contract, to achieve savings.

The new finance system will also allow new controls to be put in place to flag overspends as they happen. For example, if a purchase order is over budget, the new system will be able to flag this to the requisitioner and budget holder. This means budget holders will be aware of overspends straight away, rather than finding out later.

Transparency will help us all to ensure we are making the most of our funding so that we can provide care to as many patients as possible.

Three paths to financial sustainability

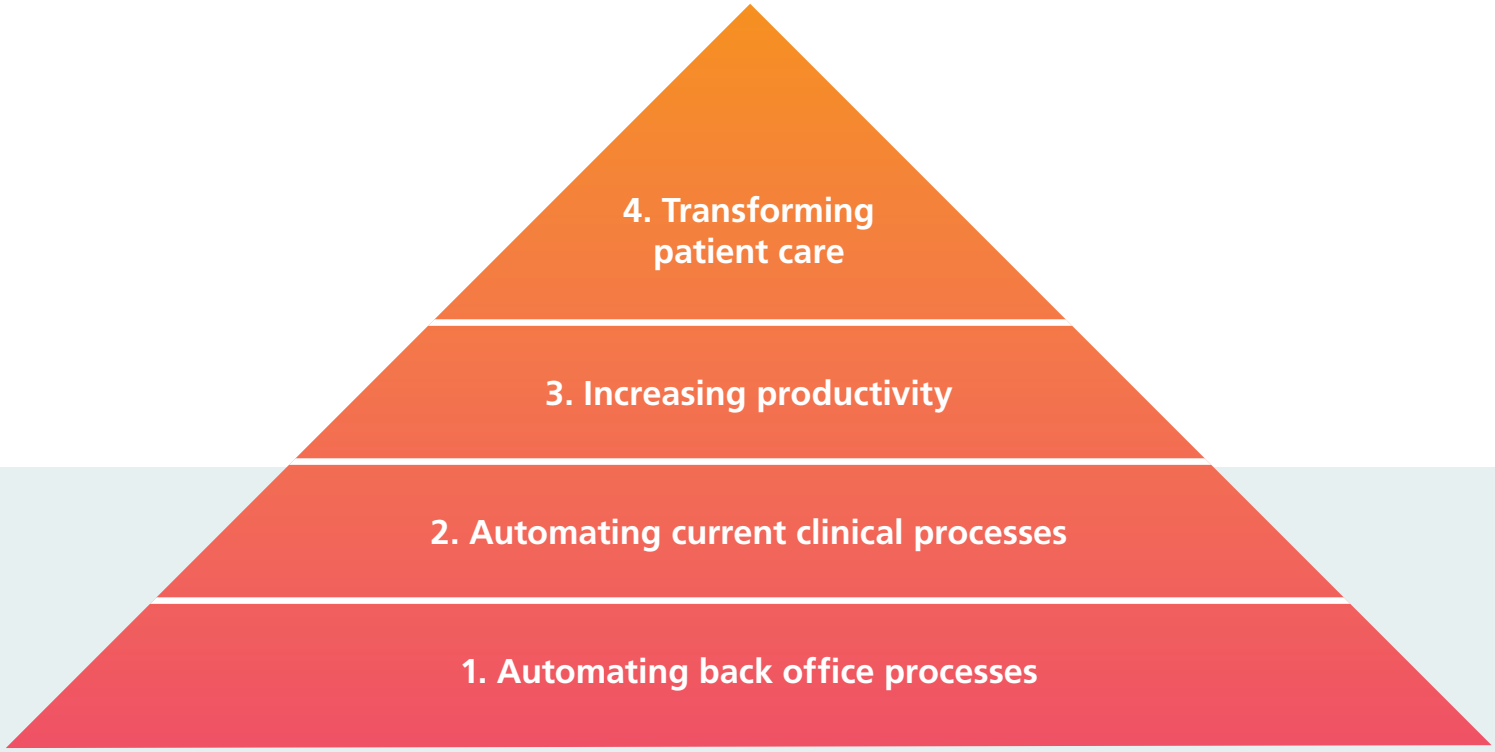
Make new investments which reduce future spend

This is the area most likely to result in the largest financial benefits for the Trust longer term.

There are some innovations now available, particularly in digital and estates, which can result in significant cost savings.

There are four levels of innovation and we need to work our way up the pyramid below.

Our aim is to reach the place where we are actively focusing on transforming patient care, at the top of the pyramid, so that fewer people need a hospital appointment or stay in the first place.



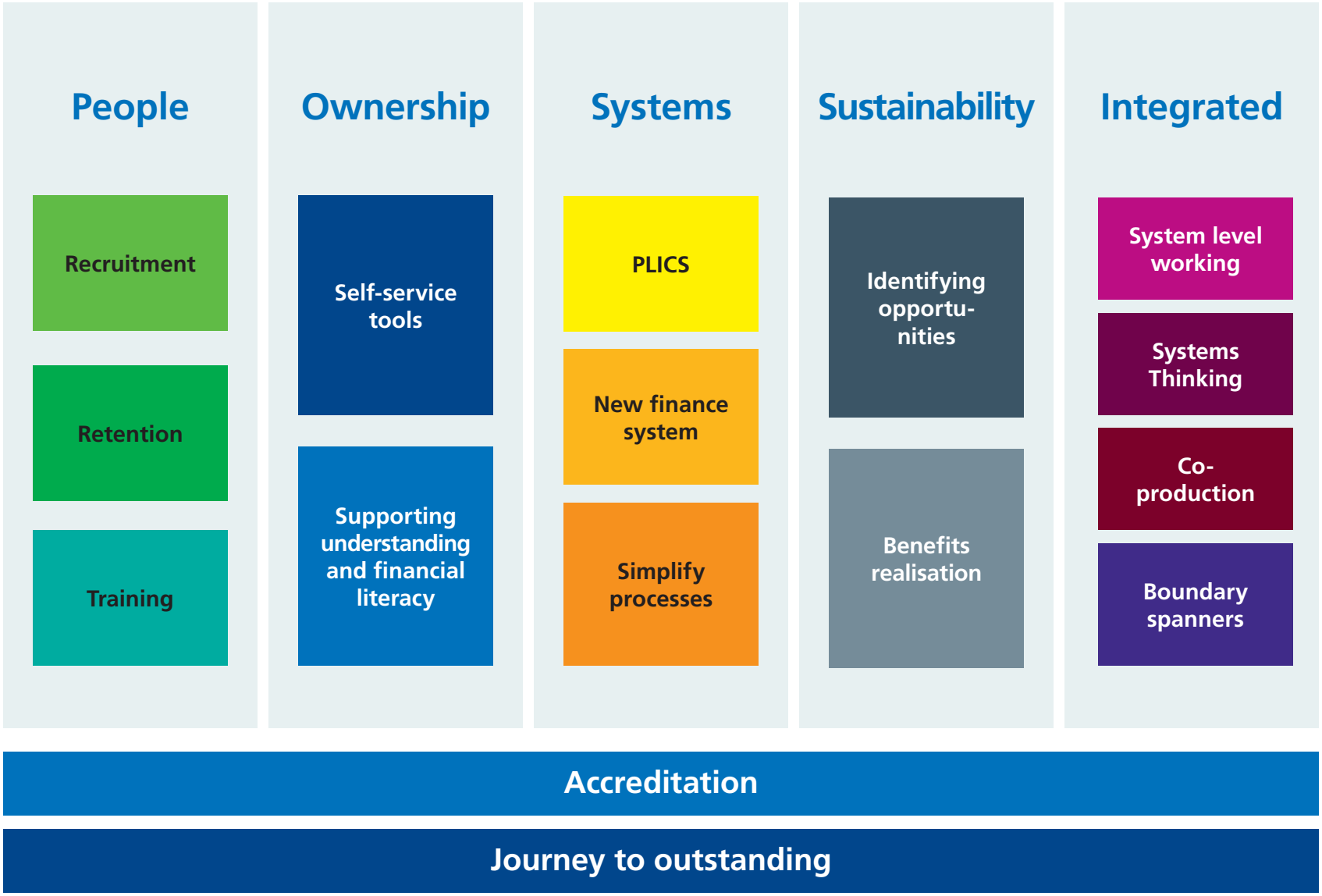
Key initiatives and milestones

Key initiatives	2023 milestones	2024 milestones	By end of 2024
New finance system	New finance system specified, tendered for, supplier agreed and implementation planned	New finance system initial implementation and roll out with full budget holder self service dashboard for finance data e.g. drilldown to purchase orders and invoices	Finance system reviewed, refined and developed further. For example indirect costs could be charged in the management accounts (in line with costing rules) in order to reconcile total cost of each service.
Productivity dashboard	Productivity dashboard including finance, HR and patient database information combined. Planning and beta testing with old finance system data.	Productivity dashboard developed for new finance system. GHNHSFT view developed and rolled out first, then ICS wide view developed.	Transparency for system users has been achieved and data is easily accessible for decision support.
Training	New mandatory finance training designed and rolled out to requisitioners and budget holders	Mandatory finance training continues	All requisitioners and budget holders are trained, understand their role and how to use the system
Systems Thinking	Finance team trained in Systems Thinking	Systems Thinking fully in use and new plans developed to implement it each year	All budget holders and their managers can use Systems Thinking in their work

How do we deliver financial sustainability?

Delivering financial sustainability for our Trust requires partnership working – both internally and with our partners within our Integrated Care System.

Within our trust we have identified five key pillars to support us on our journey to sustainability which we intend to develop upon.



How do we deliver financial sustainability?

People

The finance directorate focuses on more than just income and expenditure.

It is an essential support service that assists all clinical and non clinical teams in understanding the costs, identifying income and efficiency opportunities available, and implementing these opportunities, in order to ensure that we have a sustainable and financially-viable Trust.

Because of this, we need to ensure that we have a high performing team in place, to support our operational colleagues on the financial sustainability journey.

When opportunities arise within the team, we follow the Trust's leadership recruitment toolkit, focussing on values based recruitment, welcoming applications from all backgrounds. This helps ensure that we recruit qualified and knowledgeable staff who are able to inspire colleagues to achieve transformational change.

A commitment to continuous learning and development support is essential – we want our team to learn and be supported to help grow both them and the knowledge of the department which can benefit the wider Trust. In particular, we will learn about new concepts such as Systems Thinking, so that we can work with budget holders to identify transformational change opportunities, create business cases, and successfully implement the changes. We will reduce the current barriers to change and create more impetus and buy-in.

Working with ICS colleagues, we will look for opportunities to share learning, retain colleagues and offer varied experiences, whilst supporting new ways of working.

How do we deliver financial sustainability?

Ownership

Using resources to best value is not the sole responsibility of the finance team – it is something that every one of our colleagues across the Trust is involved in.

Our improvement programme, Count Me In, aims to help staff gain a better understanding of NHS finances and highlight the role everyone has to play in financial sustainability.

Finance training

Finance training is available to all staff within the organisation. The department runs the following sessions:

- Financial Awareness Session
- Foundation Finance Training
- HFMA e-Learning

Trust Induction

Finance have a presence at Trust induction and welcome all new staff to the Trust.

As part of the induction process, staff are shown a Finance engagement video outlining key teams and their roles in finance and procurement.

E-learning

We offer flexible and free CPD accredited e-learning to all staff within the organisation to raise financial awareness.

Our e-learning modules, called Take 5, are informal, interactive, and enable colleagues to complete them at their own pace.

How do we deliver financial sustainability?

Ownership (continued)

The key aims of the Count Me In programme are to:

- enable financial sustainability and support the delivery of outstanding patient care
- increase the financial awareness and accountability of all colleagues in our Trust
- improve our financial systems and processes
- take pride in our work and be a highly functioning department
- network countywide, regionally and nationally to learn best practice and support each other
- become an outstanding finance function by achieving the highest level of Future Focused Finance Towards Excellence accreditation
- be supported at all levels to support our journey to outstanding

Some of the ways the finance function is supporting sharing the message of financial awareness with colleagues are through training, induction and e-learning.

But we want to go further.

If we introduce a new finance and procurement system so that budget holders and service managers are empowered to access and understand financial analysis and information of relevance to them via the cloud 24/7, then we create capacity to add value from the time we spend with budget holders.

We can introduce greater automation, for example automated exchange of invoices with suppliers' finance systems, and automated accrual of purchase orders which have been delivered but not yet been invoiced by suppliers. With greater automation will come greater accuracy and less staff time spent on basic transactions.

This means the finance team can focus less on number crunching, and more on strategic conversations with budget holders, the Executive Team and the ICS, which lead to improved effectiveness within the budget the Trust has available now, and better patient care.

We can also better forecast and make the case for the appropriate funding we and other Trusts need for the future, with an ageing population, helping national policy makers to understand and respond to NHS cost pressures.

In addition to freeing up capacity to support change, self service solutions will also support budget holders in decision making, and understanding the impact of these, as well as providing real time information.

We intend to expand our online offering. A recent budget holder survey highlighted that colleagues have welcomed the online offering that we have provided and would like to continue with online (both live and pre-recorded sessions). Topic areas requested that we will be exploring are:

- Reviewing operational effectiveness
- Reviewing financial sustainability
- Service redesign
- Forecasting
- Profitability and return on investment
- Budgeting
- Reading a budget statement

We want to make our core finance training mandatory for requisitioners and budget holders.

How do we deliver financial sustainability?

Systems

We want to enhance our service offer to our stakeholders we support through the provision of high quality financial analysis and information.

This means we need to review our current systems, consider their interoperability and their access options so that we can have 24/7 systems available which reduce the level of manual intervention needed. Where possible we will look at:

- Systems that offer real time information, moving away from system overnight refreshes or in arrears reporting
- Systems that offer the opportunity to triangulate finance with workforce and activity to ensure we have "one version of the truth"

Ledger

The current ledger system has been in place for over 20 years. The finance team has already worked with stakeholders to identify that a new system is needed. Over the next 12 months we will work to procure the system. We will go through a tender process to identify the best supplier and develop a plan to implement the new system.

Self service

As described earlier we want to allow budget holders to be able to access analysis and information to them to create capacity to support them in other areas.

To do this we need to put into a place a self service system which provides reporting and transaction access on demand. A very basic initial budget holder dashboard has been rolled out, yet for full functionality we need the new finance system in place which will allow flexible combining, slicing and dicing, and drill down to invoices, purchases orders etc.

We will develop this over time with budget holders to ensure it is useable, relevant, understandable and adds new features to support needs.

Automation

We want to make purchasing as easy as possible for users (within appropriate buying and delegation limits).

We want to embrace automation where possible and facilitate paperless processes and electronic workflows that maintain good audit trails of decisions made and money spent. This also applies to the financial feeder systems which add data into our ledger, some of which currently require manual intervention.

Patient Level Information Costing Systems (PLICS)

To support the identification and delivery of efficiency opportunities we need to be able to clearly report the linkages between activity and costs at a patient level. We are able to produce high level information which can be reported at budget holder level.

This will be rolled out in a phased approach alongside core costing business-as-usual of analysis including compliance to the national costing standards for the annual mandated cost collection and service engagement.

How do we deliver financial sustainability?

(Financial) Sustainability

Our ICS has a significant financial challenge, as described earlier, when looking at its demographic and funding profile.

With financial challenges continuing across the NHS, financial sustainability initiatives form a part of the core activities need across health care in order to operate within available resources.

The level of opportunity for transactional sustainability and improvements has reduced year on year by the changes already delivered and, just like other organisations, we will need to be looking to deliver larger scale transformational schemes in tandem with traditional in year 'transactional' schemes to address the current system challenges and create a longer term sustainable future in parallel.

Financial sustainability schemes can fall into three types:

- Income generating
- Cash releasing (a reduction in the amount of money currently spent)
- Cost avoidance (mitigating the need to invest further)

The finance directorate benefits from the Project Management Office (PMO) in the Strategy and Transformation division which assists divisions with the identification, tracking and reporting of sustainability schemes.

In addition there are many resources and programmes available that staff are encouraged to engage with, such as Get It Right First Time (GIRFT), Model Hospital and NHS Benchmarking, PLICS etc.

By developing systems and increasing financial awareness and ownership across the organisation we intend to be able to identify and deliver a greater level of financial sustainability.

Over time we hope to see a shift towards a greater level of recurrent savings which will support our long term aim of being a financially sustainable Trust.

Financial sustainability in the use of resources is not limited to identifying ways to reduce or avoid costs.

We must also review investments made to ensure that they have delivered the benefits that we have intended.

Where they haven't we will need to identify corrective actions or look to disinvest and learn lessons for future initiatives.

How do we deliver financial sustainability?

Integrated

Collaborative working across our ICS is essential to ensure that end to end pathway transformation can occur to support financial sustainability and realise better outcomes for patients.

To support that the organisations in the ICS have a shared vision in respect to the financial principles and approaches to be taken which will support this:

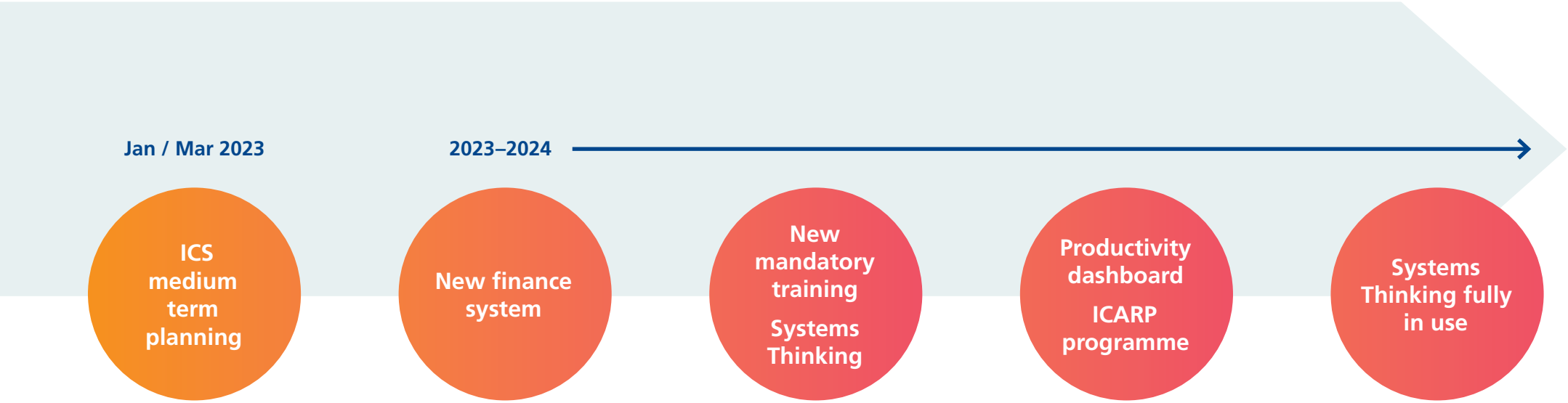
- The ICS vision, priorities and Long Term Plan will be central to financial decision making, contracts and planning to ensure that the wider system impact is considered and affordable, at all times taking into account NHS England and other regulatory recommendation and direction.
- Financial position and risks for the system and each organisation are owned by all Gloucestershire NHS partners and the focus will be on resolving the current and long term overall system position before looking at organisational positions. Actions taken will consider effects on service delivery, financial consequences and non-financial impacts for both short-and long-term timescales.
- Collaborative and proactive working across organisations will be in place to achieve the best outcomes for the Gloucestershire population to deliver the best value and maximise the best use of assets across the system.
- Deliverability, delivering value and benefits realisation form part of the decision making process for investments and will be part of a continuous process to maximise quality and value for money.
- System partners will be open and transparent and plan on a joint and consistent basis
- The system will balance Business As Usual and delivering the strategic plan including identifying solutions to sustainability issues.
- The system will develop mechanisms to continue to take forward allocative efficiency.
- The system will adopt an open and collaborative approach to the identification of opportunities. This will be based on a system wide analysis of areas of opportunity developed using a combination of benchmarking and productivity information including finance, workforce, quality & outcome metrics and activity data, showing how baseline productivity could be improved.
- Resources will be reviewed to ensure their best application and look to identify if they should be re-shaped or de-prioritised before investing in additional opportunities, which may require pump priming, and be linked to clear benefits.
- The contracting approach will focus on delivering the best value from the system's resources including maximising income in to the system. Each stage must be as straightforward as possible to add value to the system.

How we will measure success

We want to ensure that over time the actions identified under our 4 key enabling pillars are successful. As a team we are developing a range of success measures to help us track this success, with example measures including:

People	Ownership	Systems	Sustainability	Integrated
Team sickness and turnover rates remain below peer and national averages	Annual delivery of planned financial position	New ledger system which supports improved reporting and leads to the release of time across all staff who use it (in turn supporting better outcomes for patients)	Increasing levels of sustainability delivery with recurrent benefits seen (either productivity based or cash releasing)	The ICS delivers a financial position of breakeven or better continually
Ratio of qualified to unqualified staff (where appropriate) benchmarks above average levels with other organisations	The Trust continually delivers financial position of breakeven or better	New PLICS reporting tool to support the increasing identification of benefits from clincial redesign	As a Trust and ICS be rated as outstanding for the use of resources assessment	As a Trust and ICS be rated as outstanding for the use of resources assessment
Recruitment to match Trust diversity levels	Development of online tutorials to support financial understanding	Budget holders to access online real-time reporting	Increasing levels of delivered efficiency programmes on an ICS basis	Increasing levels of delivered efficiency programmes on an ICS basis
Improved staff survey results for the finance directorate, leading to increased performance and retention	Finance training to be included in mandatory training	Interoperable systems that combine finance, workforce and activity information	Increased active engagement across the Trust to benchmarking	Increased active engagement across the Trust to benchmarking

Timeline for change



Integrated Care System medium term financial plan and medium term sustainability programme

New finance system with full budget holder self service dashboard

New mandatory training designed and rolled out to requisitioners, budget holders

Finance team trained in Systems Thinking

Productivity dashboard including finance, HR and patient database information combined. GHNHSFT view, then ICS view developed.

ICARP programme

Systems Thinking fully in use and new plans developed to implement it each year

Gloucestershire Hospitals
NHS Foundation Trust

Finance Strategy

V2, February 2023

KEY ISSUES AND ASSURANCE REPORT
Audit and Assurance Committee, 24 January 2023

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Risk Assurance Report	A significant number of red rated risks were highlighted; the Committee raised concern about the ability of the Trust to achieve its key performance indicators against some of the risks if they continued to be red-rated.	A full review of risk, including KPIs and alignment to quality governance processes, would be produced for March.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit Progress Report	The outpatient clinic management review was making progress; however, delays had occurred when requesting information from the business intelligence team. The Committee was advised that the Head of Internal Audit Opinion would seek assurance from engagement in reviews and follow ups, and improvement in recommendation completions would be required. ***Follow up Report*** The Committee received a summary of completed and overdue recommendations. Fifteen recommendations had been made from 2022-23 audit reports; one recommendation related to risk maturity had been completed, with one due and one in progress. Twelve remaining recommendations were not yet due. ***Charitable Funds Review*** The review rated Design Opinion and Design Effectiveness as Moderate. Two medium priority recommendations had been made related to regular fund activity review to ensure that inactive funds were identified and appropriately managed, and assignment of funds to a delegated budget holder and fund advisors. One low priority recommendation had been made related to the need to update all policies and procedures in line with the charity's restructure and rebrand. The Charitable Funds handbook should also be updated as part of this. ***Draft Internal Audit Plan 2023-24*** The draft audit plan was received for information.	The Trust would consider its approach to cost improvement and efficiency as part of the HFMA self-assessment, and how sustainable processes would be embedded. Audit plans would be reviewed in line with strategic BAF risks.
HFMA Financial Sustainability Audit	An action plan identified from the self-assessment was received, with progress noted. Future iterations of the report would consider a review of action completion dates and RAG-rating.	The Committee acknowledged the progress made. Regular reporting would be scheduled twice yearly for oversight.
Counter Fraud Report	The Committee considered the oversight of GMS single tender waivers and requested a report for the next meeting. A covid-19 spend review had highlighted a favourable position for the Trust, when benchmarked against other organisations.	The FDC for GMS would produce a report on GMS single tender waivers in March.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
External Audit Progress Report	The plan for 2023-24 would focus on revenue recognition, property valuation, capital expenditure, and accruals. A mandated review of management override of controls would be included, along with Value for Money. Early work into VFM would begin in March.	None.

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

	Lessons Learned Report There had been a much-improved position last year, however there were still improvement opportunities to make the year-end process more efficient. These would be adapted into the process for this year.	
Losses and Compensations Report	The Committee noted 11 ex-gratia payments totalling £3,393 and approved the write-off of 86 invoices with a total credit value of £26,739.	Assurance was requested on the progress and impact of the Patient Property Policy.
Single Tender Actions Report	Six waivers had been processed within the reporting period, with a value of over £25,000.	None.
GMS Report	The Committee received the report, particularly noting that GMS was working with the Trust and auditors on interim audit. Planned audits for 23-24 included Data Quality, Materials Management, and Staff Engagement. Fifteen insurance claims were currently in process.	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
Executives had reviewed the risks on 12 December and agreed a set of new risks that reflected the Trust's current position. Each risk was being developed by executives for discussion and review at January and February committee meetings. A new BAF was due for presentation at March's Board.		