Board of Directors

Thu 14 September 2023, 12:30 - 16:15

Room 10, Sandford Education Centre, Cheltenham General Hospital

Agenda

12:30 - 12:30 0 min

AGENDA

- 00 Public Board of Directors agenda, 14.09.2023v4.pdf (2 pages)

12:30 - 12:30 0 min

1. Chair’s Welcome and Introduction

12:30 - 12:30 0 min

2. Apologies for absence

12:30 - 12:30 0 min

3. Declarations of interest

12:30 - 12:30 0 min

4. Minutes of Board meeting held on 13 July 2023

- 01 Public Board of Directors minutes 13.07.2023.pdf (6 pages)

12:30 - 12:30 0 min

5. Matters arising

12:30 - 12:30 0 min

6. Staff Story

12:30 - 12:30 0 min

7. Chief Executive’s Briefing

- 07_CEO Report to Board of Directors_September 2023.pdf (7 pages)
- 07_Appendix - Executive Strategic Overview_Final.pdf (5 pages)

12:30 - 12:30 0 min

8. Board Assurance Framework

12:30 - 12:30 0 min

9. Trust Risk Register

- 09_Risk Register Report - Board September 2023.pdf (6 pages)
- 09_Trust Risk Register 7.9.23.pdf (6 pages)

12:30 - 12:30

10. Update on the PACs IT Issue

0 min

12:30 - 12:30
0 min

11. People and Organisational Development Committee Report

- 11_People and Organisational Development Committee KIAR June 2023.pdf (1 pages)

12:30 - 12:30
0 min

12. FTSU Update Report

- 12_FTSU Report.pdf (12 pages)

12:30 - 12:30
0 min

13. Engagement and Involvement Annual Review 2022-23

- 13_Coversheet - Engagement and Involvement Annual Review.pdf (2 pages)
- 13a_Engagement Involvement Update - Board Sept 2023.pdf (12 pages)
- 13b_Community Engagement and Involvement Tracker 1 April 2022 to 31 March 2023.pdf (19 pages)

12:30 - 12:30
0 min

14. Finance and Resources Committee Report

- 14a_Finance and Resources Committee KIAR_July.pdf (3 pages)
- 14b_Finance and Resources Committee KIAR_August.pdf (2 pages)
- 14b -2023- BOARD COVER SHEET - Finance Report M4.pdf (2 pages)
- 14b - M04 Financial Performance Report Trust Board.pdf (12 pages)

12:30 - 12:30
0 min

15. Quality and Performance Committee Report

- 15_Quality and Performance Committee KIAR 26.07.2023.pdf (2 pages)
- 15a - QPR_Jun23.pdf (51 pages)
- FINAL - Board Coversheet Maternity Staffing Aug 23.pdf (4 pages)
- Midwifery and maternity Staffing Report _Aug 23 FINAL.pdf (25 pages)

12:30 - 12:30
0 min

16. Organ Donation Annual Report

- 16_Organ and Tissue Donation Activities Report September 2023.pdf (2 pages)
- 16a_letter.pdf (1 pages)
- 16b_Summary report.pdf (3 pages)
- 16c_Detailed report.pdf (20 pages)
- 16d - Organ and Tissue Donation Board 2023.pdf (1 pages)

12:30 - 12:30
0 min

17. Audit and Assurance Committee Report

- 17_Audit and Assurance Committee KIAR 25.07.2023.pdf (2 pages)

12:30 - 12:30
0 min

18. GMS Governance Matters

- 18_GMS Governance Coversheet_RMs & ToR.pdf (2 pages)

18.1. Reserved Matters

- 18a_Schedule of Matters Reserved v5.0.pdf (4 pages)

18.2. Terms of Reference

18b_GMS Board Terms of Reference_Sept 2023.pdf (3 pages)

18.3. GMS Company Director number

18c_GMS Company Directors paper Sept 23.pdf (4 pages)

12:30 - 12:30
0 min

19. NHS England WT&E Provider Self-Assessment

12:30 - 12:30
0 min

20. EPRR Compliance

20_Board Coversheet EPRR Assurance Sep 2023. Final.pdf (3 pages)
20_GHNHSFT EPRR Board Report 2023-24. Final.pdf (9 pages)

12:30 - 12:30
0 min

21. Any other business

12:30 - 12:30
0 min

22. Governor Observations

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
12.30, Thursday 14 September 2023
Room 10, Sandford Education Centre, Cheltenham General Hospital
AGENDA

Ref	Item	Purpose	Report	Time
1	**Chair's Welcome and Introduction**			12.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 13 July 2023**	Approval	Yes	12.35
5	**Matters arising**	Assurance		
6	**Staff Story** *Claire Radley, Director for People and OD*	Information	Presentation	12.40
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive*	Information	Yes	13.00
8	**Board Assurance Framework** *Sim Foreman, Trust Secretary*	Review	Yes	13.15
9	**Trust Risk Register** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*	Assurance	Yes	13.25
10	**Update on the PACs IT Issue** *Helen Ainsbury, Interim Chief Digital Information Officer*	Assurance	No	13.35
11	**People and Organisational Development Committee Report** *Vareta Bryan, Non-Executive Director*	Assurance	Yes	13.50
12	**FTSU Update Report** *Claire Radley, Director for People and OD*	Assurance	Yes	14.05
13	**Engagement and Involvement Annual Review 2022-23** *James Brown, Director of Engagement, Involvement & Communications*	Assurance	Yes	14.30
	Break (14.20-14.30)			
14	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director, Karen Johnson, Director of Finance*	Assurance	Yes	14.45
15	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and David Coyle, Interim Chief Operating Officer* • **Maternity Staffing Report**	Assurance	Yes	15.00
16	**Organ Donation Annual Report** *Mark Haslam, Clinical Lead - Organ Donation*	Assurance	Yes	15.15
17	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Yes	15.25
18	**GMS Governance Matters** *Kaye Law-Fox, Chair Gloucestershire Managed Services (GMS)*: • **Reserved Matters** • **Terms of Reference** • **GMS Company Director number**	Approval	Yes	15.50
19	~~**NHS England WT&E Provider Self-Assessment** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*~~	~~Approval~~	~~Yes~~	16.05
20	**EPRR Compliance** *Dickie Head, Head of Emergency Preparedness, Resilience, Response, and Recovery*	Approval	Yes	16.20

21	**Any other business**	
22	**Governor Observations**	
Close by 16.30		

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 13 July 2023, 09.30, Bluecoat Room Gloucester Guildhall			
Chair	Deborah Evans	DE	Chair
Present	Vareta Bryan	VB	Non-Executive Director
	John Cappock	JC	Non-Executive Director
	David Coyle	DC	Interim Chief Operating Officer
	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director (via MS Teams)
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Kaye Law-Fox	KLF	GMS Chair/Associate Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Deputy CEO/Medical Director and Director of Safety
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Ian Quinnell	IQ	Interim Director of Strategy and Transformation
	Claire Radley	CR	Director for People and Organisational Development
Attending	Elinor Beattie	EB	Associate Medical Director (item 15 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)
	Terry Hull	TH	Strategic Asset Services Director
Observers	Three governors and three members of staff observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting, noting that this was the last Board meeting for both CF and KC. Both were thanked for contributions they had made to the Trust.
2	**Apologies for absence** Helen Ainsbury, Interim Chief Digital Information Officer, Deborah Lee, Chief Executive Officer, and Jaki Meekings-Davis, Non-Executive Director.
3	**Declarations of interest** CF declared an interest in item 9, as a patient on the ophthalmology waiting list.
4	**Minutes of Board meeting held on 11 May 2023** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 11 May 2023** All matters arising were updated.
6	**Patient Story** KH presented a story from a patient of the elderly care service. The patient had been admitted to the elderly care ward following a fall at home. A number of key themes were identified from the patient's story, including: the patient had lost hearing aids during admission, which AM reflected was frustrating and Quality and Performance Committee had oversight of the recently developed Patient Property Policy; the patient had also highlighted the

	number of staff changes that had occurred during her stay, noting that whilst all staff were very kind, there was a lot of conflicting information. The patient noted that she was lucky to have family who could advocate for her during her stay, and worried for others who would not have the same. KH advised the Board that the patient's experience would be used to inform the quality improvement work on discharge and patient flow, which was currently underway. MP added that patients would need to be included in the quality work to ensure they were at the heart of improvements. SM noted that workforce was a key issue. MH commented that staffing was a core part of improvement work; currently there are high vacancy rates and a large number of agency workers employed on the ward. Rapid change was needed for these patients who would also be preparing for social care.
7	**Chief Executive's Briefing** MP briefed the Board on the following: • There was slow but steady improvement in terms of overall operational context, with waiting list backlog and urgent and emergency care making significant improvement. • The Trust was preparing for industrial action, with arrangements in place. • A new Chief Executive Officer had been appointed. • The Trust was taking part in celebrations for NHS 75 and Windrush 75. CF queried the car parking permit situation, as this was a key issue for staff. MP advised that a new system had been developed to assess against fairer criteria, and changes were being made to charges for staff who were granted a permit at the request of staff: the increase in daily rates is balanced by the removal of a monthly permit fee.
8	**Board Assurance Framework** The Board received the BAF and discussed holding a strategic discussion on the risks which were increasing in score. A number of risks on the BAF were now 'red' and had increased in severity rather than reduced. Members of the Board commended the BAF, noting its importance in setting strategy and informing discussion on risk management.
9	**Trust Risk Register** A single score approach had been agreed and would be implemented to simplify the risk scoring process. A risk rationalisation exercise was underway, in particular for Digital, Workforce and GMS to consolidate and remove obsolete risks. Assurance against the water safety programme had been received, with good progress made in a number of areas. Recruitment remained a key challenge for the fire safety team; discussions were ongoing to review recruitment options.
10	**People and Organisational Development Committee Report** BH advised the Board that staff survey feedback remained a key issue, with critical pieces of work taking place to ensure sustainable, embedded culture change. The Committee had been pleased to note improvements in Freedom to Speak Up Guardian arrangements. CR added that the Committee meetings were a good example of where the BAF was being used effectively to inform conversations, reports and agendas, providing focus on the key workforce issues. Clear Freedom to Speak Up guidance from the National Guardians Office was being implemented, and the Trust was reviewing a more streamlined approach to reporting of cultural and other concerns to ensure clarity for staff wishing to raise an issue.

Unconfirmed

11	**Finance and Resources Committee Report** MN advised the Board that the concerning financial position had been a key area of discussion for the Committee in both June and May, along with some concerns around GMS compliance with fire safety. ***Finance Report*** Key points were noted as follows: • The Trust was reporting a year-to-date deficit of £5,165k which was £747k adverse to plan. • The Trust was reporting a year-to-date capital position of £7.3m against a planned spend of £10.1m. • A breakeven forecast outturn was reported in line with the plan, and had been reported to NHSE. KJ advised the Board of her concern in relation to the revenue position, which showed an adverse trend at month three. The causes for the revenue overspend were well understood, and intensive work was underway with the relevant divisions. The Committee meeting scheduled for August would review progress. Capital was in a good position, with a new governance process for business cases making a significant difference with added rigour. ***Digital Transformation Report*** The Board received the report for information. ***Community Diagnostic Centre Lease Agreement*** The Board received the report, noting that it had been approved by Finance and Resources Committee. The Board approved the Agreement for Lease with Gloucestershire County Council for the Community Diagnostics Centre project. ***Energy Performance Contract*** The Board received the report relating to a proposal to improve the quality and efficiency of the energy infrastructure at Gloucestershire Royal Hospital. The Board was reminded that Gloucestershire Hospitals NHS Foundation Trust (the **Trust**) had appointed Vital Energi Solutions Limited (**VE Solutions**) (formerly Vital Holdings Commercial ESCO Limited) (Company Number 07828647) to provide energy and energy management facilities at Cheltenham General Hospital and Gloucestershire Royal Hospital pursuant to an agreement dated 27 February 2014, which was subsequently amended and restated on 16 June 2017, further amended on 7 July 2021 and novated to the Gloucestershire Hospitals Subsidiary Company Limited (**GMS**) on 19 July 2021. Additional funding had been granted through the Public Sector Decarbonisation Scheme administered by Salix Finance Limited (on behalf of the Department for Energy Security and Net Zero), which would enable the Trust to procure additional energy savings measures at Gloucestershire Royal Hospital, to include, amongst other things, a new heat pump system, building façade systems and BEMS controls (**PSDS3a Project**). Following a competitive procurement process, utilising the framework process made available by the Carbon Energy Fund (**CEF**), VE Solutions had been appointed to deliver the PSDS3a Project. It was proposed that the Trust's wholly owned subsidiary, GMS, would enter into a new contract with VE Solutions, which utilised the CEF framework project agreement v6.09, for the financing, design, construction and installation, and the provision of certain services in connection with the PSDS3a Project (the **PSDS3a Project Agreement**) although it was recognised that Vital is not arranging third-party financing for the PSDS3 Project. It was noted that, in order to deliver the PSDS3a Project, the Trust must: 1. Approve GMS entering into the PSDS3a Project Agreement; 2. Enter into a Parent Company Guarantee between the Trust (acting as Guarantor) and VE Solutions (the **PCG**) in order to guarantee the covenant strength of GMS and GMS's obligations under the PSDS3a Project Agreement.

	In accordance with the Trust's standing orders/scheme of reservation and delegation and standing financial instructions, the Board approved the following recommendations: • the terms of, and transactions contemplated by, the PSDS3a Project Agreement and PCG be approved by the Trust; • (subject to such amendments as any of the Chief Executive, Director of Finance or Trust Secretary may in their absolute discretion deem necessary or desirable) the PCG be executed and entered into by the Trust as a deed under seal, and that appropriate entries be made as required in the Trust's register of sealings and that the same be delivered; • (subject to such amendments as the Chief Executive, Director of Finance or Trust Secretary may in their absolute discretion deem necessary or desirable) authority is provided by the Trust for GMS to execute and enter into the PSDS3a Project Agreement; • the sealing of the PCG is authorised by the Trust Board in accordance with 11.2 of the Trust's standing orders; • the PCG is approved by the Director of Finance and authorised by the Chief Executive in accordance with 11.3 of the Trust's standing orders; • the Director of Finance is authorised to sign and the Chief Executive to countersign the PCG in accordance with 11.3 of the Trust's standing orders; • the seal shall be affixed to the PCG in the presence of the Trust Secretary and will be attested by them in accordance with 11.4 of the Trust's standing orders; • the Chief Executive, Director of Finance or Trust Secretary shall be authorised to sign or execute on behalf of the Trust (subject to such amendments as the Chief Executive, Director of Finance or Trust Secretary may in their absolute discretion deem necessary or desirable) all other documents and do all other acts and things as they may consider necessary or desirable in connection with implementation of the PSDS3a Project; • the Chief Executive, Director of Finance or Trust Secretary be authorised to complete and sign a certificate of specimen signatures in the form appended to these minutes as Appendix 1, and that the same be delivered; and • any of the persons referred to in (2) above, the Board secretary or another relevant Trust Officer be authorised to deliver to VE Solutions a certified copy of the standing orders/scheme of reservation and delegation and standing financial instructions of the Trust. The Board agreed that the PCG, and each other document required to be executed or signed in connection with implementation of the PSDS3a Project, would (once amended as considered necessary by the Chief Executive, Director of Finance or Trust Secretary, delivered and completed) bind the Trust, VE Solutions and each other party to those agreements or other documents for the performance of the obligations stated in those agreements or other documents.
12	**Quality and Performance Committee Report** AM advised that there were some good signs of improvement in urgent and emergency care, cancer, boarding and electives. The Committee noted concerned about staffing levels. The Committee had received briefings on the water safety issue; a clear narrative on the root cause would be received, and on virtual wards, a national initiative which the Trust was a key part of. The Committee had also signed off the Quality Account for 2023/24. ***Quality and Performance Report*** Other key points were highlighted as follows: • The Trust remained committed to improving patient flow. Boarding of patients still happened on occasion, when appropriate. A clinical forum had been established with pharmacy staff. • A visiting programme for Non-Executive Directors and Governors was almost complete. • Friends and Family Test feedback was increasing each month.

Unconfirmed

13	**Perinatal Quality Surveillance and Safety Report (Quarter 4 2022/23)** The report provided comprehensive assurance to the Board that there was an effective system of clinical governance monitoring the safety of maternity services, with clear strategies for learning and improvement embedded. The report contained additional information to support the Trust in meeting the Maternity Incentive Scheme requirements for Year 4. This included reporting on all cases referred to Healthcare Service Investigation Branch (HSIB). The Board noted the current position for each of the safety actions, particularly noting that compliance for the Safety Champions and Ward to Board Reporting action had not been achieved despite intensive activity. An action plan had been developed and would be monitored by the Maternity Delivery Group and reported to Quality and Performance Committee for assurance.
14	**Annual Guardian of Safe Working Hours Report** The Board received the report, noting that here had been 475 exception reports raised during the period, no with no fines levied. The Board was advised that there was currently no Guardian in place; the Medical Director's office was responsible for the administration of the Guardian role in the interim. MP informed the Board that a new Guardian should be in place by August.
15	**Annual Medical Appraisal and Revalidation Report** An online medical appraisal system had been introduced in November 2022, which supported the new appraisal template and included additional sections to record educational and leadership activity. There was a plan to recruit and train eight new appraisers during 2023/24. The Board was advised that a visit from NHSE was planned to review the Trust's processes and policies; an external audit of appraisal and revalidation was also underway. The statement of compliance would be signed by the Chair and submitted to NHSE.
16	**Audit and Assurance Committee Report** CF advised the Board that engagement with internal audit reviews had been raised as a significant issue, however early indications from internal auditors showed a positive improvement and increased executive oversight. The Committee would also be monitoring the lessons learned process from this year's external audit.
17	**NHS Provider Licence Self-Certification** The Board **approved** the self-certification.
18	**CQC Statement of Purpose** The Board **approved** the addition of the Forest Dialysis Unit. The revised Statement of Purpose would be submitted to the CQC.
19	**Trust Seal Report** The Board received the report and endorsed the use of the Seal.
20	**Any other business** DE formally thanked RP for everything she had done for the Trust in her role as ANED, and wished her well for the future.
21	**Governor Observations** AH queried whether the experience of the patient discussed under item 6 was replicated across other areas of the organisation, and suggested that good practice was shared where patient experience was good. AH was pleased that the visiting programme for governors was being reintroduced, and suggested a development session

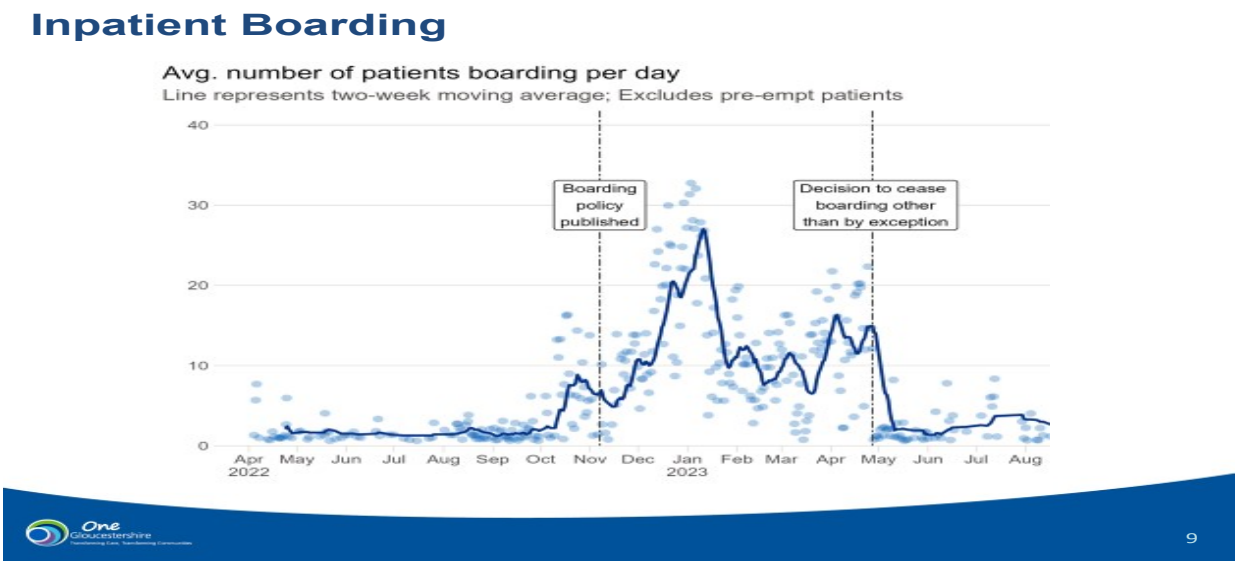
	for governors on the Board Assurance Framework. MP added that the patient story experience would link to the work of HealthWatch. PM noted that he had taken part in a Park Run event as part of the NHS75 celebrations, with CR and MH also joining.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Community Diagnostic Centre Lease Agreement	The Board approved the lease agreement.		
Energy Performance Contract	The Board approved the contract.		
NHS Provider Licence Self-Certification	The Board approved the self-certification.		
CQC Statement of Purpose	The Board approved the amended Statement of Purpose.		

CHIEF EXECUTIVE OFFICER'S REPORT TO THE BOARD OF DIRECTORS
SEPTEMBER 2023

1 Operational Context

1.1 The Trust continues on a positive trajectory in respect of operational performance with many of the longstanding performance concerns in urgent and emergency care continuing on a positive trend, including a significant reduction in the number of patients cared for in areas not designated for overnight care, including the Mayhill Day Surgery Unit and the permanent closure of all cohort areas in the GRH Emergency Department.



1.2 Inevitably, recent industrial action by medical colleagues has introduced a number of operational challenges but our teams and leaders have worked incredibly effectively to maintain safe care. Regrettably, due to high numbers of staff on leave and many staff, most notably consultant colleagues, experiencing significant fatigue we were unable to maintain the same levels of routine planned care as previously. During August we cancelled 571 patients awaiting outpatient appointments and a further 152 patients awaiting an operation. However, the cancellation of patients on a cancer pathway and those who would have waited more than 78 weeks have been kept to an absolute minimum.

1.3 Despite this backdrop, the Trust continues to perform well in respect of elective waiting times and Gloucestershire remains the only system in the South West achieving the national standard of no patients waiting more than 78 weeks. However, it is likely that next month, for the first time since February 2023, we will be reporting three 78-week breaches arising from cancellations related to industrial action. Whilst we continue to plan to achieve the 65-week maximum wait by March 2024 in light of the loss of activity, and predictions of strikes continuing, this now represents a key risk. Currently we have 659 patients waiting more than 65 weeks for treatment, an increase of 11% on the prior period.

1.4 In respect of diagnostic performance for CT / MRI / Ultrasound we are the top performing system nationally out of the 42 ICSs. Delays remain for patients accessing endoscopy and

echocardiography and oversight of their recovery plans remains through the Elective Recovery Board.

1.5 The very significant focus on cancer continues with small improvements continuing to be made. The 62 day waiting time standards remains the cause for most concern with the Trust continuing to meet the 2 week-wait and 28-day Faster Diagnosis Standard. The number of patients waiting more than 62 days for treatment following GP referral was 180 at the end of July, compared to 403 at the outset of the year. This represents 7.9% of the total cancer waiting list, an improvement from 14%, against a target of 6%.

1.6 As a Trust overall, at the end of June 68% of patients were treated within 62 days of referral against a standard of 85%; nationally the average stands at 59%. Urology and colorectal remain the specialities of most concern although we continue to make improvements.

1.7 The number of colorectal patients who have been treated within 62 days from referral has improved from 38.3% in January to 64.4% in July; the national average was 49%. Two factors account for 75% of the residual breaches – diagnostic delays relating to lack of endoscopy capacity and histopathology turnaround times; and patient complexity where an extended pathway is clinically indicated. Histopathology turnaround times to continue to improve and have gone from 30% within 10 days to 55% currently, with further improvement initiatives in hand. Endoscopy capacity has been increased through improved list utilisation from 74% to 86%. Other measures include mandatory qFIT testing (a screening test for bowel cancer) prior to GP referral to reduce the number of referrals necessary via the two-week pathway.

1.8 The number of urology patients who have been treated within 62 days has improved from 20.4% in January 2023 to 32.1% in June 2023; the national average was 42%. 65% of all breaches were attributable to delays in accessing a trans-perineal prostate biopsy (LATP) and 15% were attributable to patient complexity. A demand and capacity planning exercise has been undertaken and plans developed to ensure sufficient capacity to meet recurrent demand. This includes the expansion and development of the service footprint at CGH and an innovative initiative to train non-medical practitioners to undertake the biopsy. Whilst LATP capacity is the key issues that will address the bottleneck, other measures in hand include implementation of the *Best Practice Timed Pathway* for prostate cancer and a reduction in the time to first assessment from 14 days to 7 days.

2 Key Highlights

2.1 The nation has been horrified by the appalling and heinous crimes committed by Lucy Letby. Our thoughts are first and foremost with the families who have been directly affected by these crimes as well as ensuring staff and families in our care currently are appropriately supported. Whilst waiting for the Inquiry to shed light on the facts of the case and the implications for the NHS and wider, immediate reflections in the leadership team have commenced and Governors will be briefed fully as the NHS and Trust response evolves.

2.2 This month the Government announced a rationalisation in the number of Cancer Waiting Time Standards from the current nine to three that focus on diagnosis of cancer within 28 days, commencing treatment with 62 days of a referral and commencing treatment with 31 says after a decision to treat. Whilst these changes will not, of themselves, increase performance it will simplify both the reporting and monitoring of standards, brining a sharper focus on the interventions that have the greatest contribution to outcomes and patient experience.

2.3 We continue to make good progress on our buildings and service transformation programme and most notably our ward moves programme. We have now established our single, expanded Acute Medical Unit and early feedback indicates that our commitment to a different approach to engaging and involving staff in the ward moves programme has paid off. The impact on staff morale of working in a fit for purpose unit, with the opportunity to building a team for the future, is already very evident. Feedback from patients and staff from our new day surgery unit at Cheltenham General has been similarly positive.

2.4 As we plan for the next annual Staff Survey, progress continues across the Staff Experience Improvement Programme. Notably, The Wellbeing Collective (The Wellbeing Collective - Wellbeing Collective) have been procured to deliver the 3-year Team and Leadership Development Progamme. Their demonstrable success in working alongside organisations, including NHS, to achieve cultural and behavioural improvement is compelling, and aligned with our needs and cultural development principles. They have already begun the design phase, which will be based upon conversations with a range of staff, including members of the Board. A session will be planned for Board members later in Quarter 3 to share the output from the staff conversations, and roll-out of the Leader sessions will be in Quarter 4. Progress is also evident in the Freedom to Speak Up agenda, with an increase in reporting and process being brought into line with guidance from the National Guardian's Office. Following the Letby case, we have filmed a Vlog to raise awareness about the role of Freedom to Speak Up. A workshop to refine the Discrimination activity has brought focus to the two priority areas – the experience of internationally educated staff and ally-ship – which now has defined activity with a task and finish group working on the performance metrics. The Taskforce also continues to make significant progress across the four work streams: new starter packs; 24-hour food; reward and recognition; and 'just sort it' fund. All four groups are on target to deliver by December 2023, and several members of the group are now contributing to the other Staff Experience work streams.

2.5 Despite the challenges many of our staff face they continue to find time to be proud of their services and a number of teams have been shortlisted in recent weeks for national awards including the Health Service Journal Race Equality Award for the work we have done in partnership with Gloucestershire Health and Care Trust, sponsored by our hospitals' charity. The "Community Wellbeing: Reaching Out Together" project works with local communities that experience high levels of health inequalities to overcome barriers in accessing health services.

2.6 Within the first 12 months, almost 17,000 local people have been engaged by the community outreach team, including health and wellbeing checks, signposting services, providing information in a range of languages, identifying barriers in accessing care and helping to reduce emergency attendance. Nine outreach workers have been funded by the charity through the project, all from ethnic minority backgrounds who speak languages including Gujarati, Urdu, Malayalam, Tamil, Sinhala and Spanish allowing them to communicate and build strong links with the community in and around Gloucestershire. Particular recognition goes to colleague Juwairiyia Motala who has been instrumental in this success.

2.7 Congratulations also go the GloStars Team who have been shortlisted for two separate awards for their work supporting newly qualified nurses, many of whom were leaving their roles in their first year, before this programme was introduced. They have been shortlisted for the RCN Workforce Initiative of the Year and the Nursing Times Awards in the Staff Wellbeing Initiative category. Finally, congratulations to our Home Enteral Feeding Team, who not only won the

Trust Green Team Competition earlier this year but have also been shortlisted in the HSJ Sustainability Awards for their project to eliminate single use plastics from their service.

2.8 Sticking with the theme of success, I was absolutely delighted that this year we received a record number of nominations from colleagues and members of the public for this year's annual Staff Awards. More than 50 teams and individuals have been shortlisted for 14 different awards by a panel of judges which included members of the Board and our Council of Governors. Each and every shortlisted nomination was worthy of being a winner and as a panel member, we really had our work cut out. The awards ceremony is due to take place over two nights on 8th and 9th of November 2023, at Hatherley Manor. Following last year's success, the event will also be livestreamed to enable colleagues to join in the celebrations whether at work or at home.

2.9 We are gearing up for a slightly earlier launch of this year's National Staff Survey on September 20th. This will afford staff a little more time to submit their responses and we are hopeful of achieving our goal of more than 60% of staff submitting a response. We will be running drop in sessions around the organisation to enable staff who do not have easy access to emails to complete their survey and, reflecting last year's feedback from many staff who told us that they complete the survey in their own time, the survey provider will be issuing staff with a £5 voucher by way of a thank you.

2.10 Finally, I am delighted to announce that we have appointed a substantive Chief Operating Officer Alan Sheward. Al joins us from Great Western Hospital, Swindon where he is currently Deputy Chief Operating Officer and will take up post on the 11th December. Al brings a wealth of experience having undertaken both COO, Chief Nurse and Integrated Care System roles previously. Unfortunately, we were unable to appoint to the Director of Strategy and Transformation role and will be going back out to advert in early September. In the meantime, I am grateful to Ian Quinnell for agreeing to extend his period of acting up in to the role.

3. Reflections Post Letby

3.1 The nation has been horrified by the appalling and heinous crimes committed by neonatal nurse Lucy Letby. Our thoughts first and foremost, are with the families who have been directly affected by what the judge referred to as a "cruel, calculated and cynical campaign of child murder". Similarly, many of us have spent recent days reflecting on the potential widespread damage done to the relationship based on the trust between patients, families and healthcare professionals. As a senior manager, I have devoted considerable time to reflecting on the question "could this happen here?".

3.2 My immediate concerns have been the impact of these acts for colleagues working in out neonatal unit and the families and babies in their care. I visited the unit a few days after the full extent of what had happened came into the public domain, to try to better understand the impact on them and their families and, importantly, to gauge what additional support they may require. It was a sobering discussion to hear them describe their emotions which ranged from the very deep empathy that they are uniquely placed to feel, given the journeys they travel with parents, through to their anger that one individual has put at risk the basis of trust that underpins their relationships with families and each other. They are clearly a strong team, with strong leadership, supporting each other. I was reassured by the support available to them and the parents in the unit including the dedicated unit psychologist who joined me on my visit– this is a pilot post funded in response to the Ockenden Review which has more than proved its worth in the first few months it has been in place. I am also aware, however, that this kind of resource

is not typical and, as the ramifications of Letby begin to be felt beyond neonatal services, we will need to examine the way in which we support all staff.

3.3 One of themes that we explored as part of the visit, was the approach to families. Some colleagues expressed surprise that parents had not raised the issue, some describing it as "the elephant in the room". Others took comfort from this situation believing it was reflective of the confidence families have in the professionals looking after their babies. With input from the Maternity Voices Partnership, we have provided all parents on the unit with a letter stressing the importance we place on ensuring the safety and quality of our services, reassuring them about our outcomes and encouraging them to discuss any concerns they may have with a member of the team or the unit psychologist. Initial feedback is that this has been well-received.

3.4 One of the threads running through this case relates to the processes designed to support staff to raise their concerns. Following feedback through the annual Staff Survey and insights from the Care Quality Commission (CQC), both of whom reflected that staff did not always feel able or safe to speak up, we have considerably strengthened our approach in this regard. We are wholly committed to creating a culture where staff feel able to openly raise their concerns with the clear expectation that they will be listened to, their concerns taken seriously and acted upon when necessary. However, culture change takes time and with this context, we have paid considerable attention to ensuring all staff understand how they can raise their concerns confidentially through our Freedom To Speak Up (FSUP) routes. The following sets out some of the ways in which we have further strengthened our local FSUP approach and processes in the last year:

- The appointment of a full-time, experienced Lead Guardian with a track record of success in this area
- Ensuring staff are fully aware of the highly confidential nature of the service
- Creating a feedback and follow-up loop whereby the Guardian follows up and ensures that action has been taken and that the colleague raising the concern is satisfied their concern has been listened and responded to
- Ensuring staff are aware of the routes for escalation if they remain concerned that they have not been listened to and/or their concerns acted upon. This includes access to any leader in the organisation in order to effectively escalate, support to access a non-executive director of the Board and signposting to external speaking up resources.
- Targeted promotion and signposting of the service to groups who have used the service less frequently with investment into the Freedom to Speak up Team to address gaps.
- Tracking themes and trends, providing feedback at Board, Divisional and corporate levels with an emphasis on learning and improvement
- A monthly meeting between the Lead Guardian and Chief Executive to explore themes (not specifics) arising from those who have contacted the service the purpose being, should the FTSU Guardian meet barriers in the organisation around speaking up, these are addressed

3.5 Whilst creating an environment where staff feel able to speak up is an important theme arising from the situation, we must also acknowledge that staff in the service were raising their concerns but, based on the facts as they are currently understood, it appears that their concerns were not taken seriously and/or not acted upon by senior managers in the Trust. Potentially, therefore, not only has this case undermined the trust between patients and their care givers but between clinicians and senior managers.

3.6 This has prompted discussions as to whether senior managers are accountable in the same way as their clinical counterparts and whether they should be subject to regulation with a professional body. There is an important distinction to be drawn between regulation and

accountability. As an NHS Chief Executive Officer, I am accountable to the Board for my decisions and actions; beyond the Board, I am the accountable officer in respect of any adverse findings arising from the Care Quality Commission (CQC) and Health & Safety Executive (HSE) with the ultimate sanction of criminal proceedings being brought about. All Board Directors are bound by the Seven Nolan Principles of Public Life and required to be assessed and fulfil the requirements of the Fit and Proper Persons Test (FPPT), which have been recently strengthened following publication of the Kark Review.

3.7 However, this is not the same as regulation and many managers have welcomed the recent announcement by NHS England's Chief Executive to revisit again the question of regulation of NHS managers, particularly if this goes someway to restoring the loss of trust and confidence between NHS managers and their clinical colleagues. We also have an opportunity through our recent investment in a three-year programme to support multidisciplinary team, to ensure that as part of this work we recognise the value of healthy inter-professional relationships.

3.8 One of the important issues that the independent review will undoubtedly examine will be why there was not more awareness of and/or action taken, in response to the apparent marked increase in neonatal deaths at the Countess of Chester Hospital. For our own unit, the following opportunities to detect and investigate causes for concern are summarised below:

- Every neonatal death >22 weeks gestation is reviewed at the service line clinical governance meeting using the Perinatal Mortality Review Tool. The outputs from these individual reviews are reported to the Trust Hospital Mortality Group, Divisional Quality Board and onwards to the Quality & Performance Committee if concerns are identified.
- Any death or clinical incident where there are concerns about care, are immediately reviewed to ensure we do not miss the opportunity to establish early learning points and immediate actions we may wish to take. One of the issues that Letby gives rise to is the important of paying attention to "near misses" and untoward incidents.
- Every neonatal death >37 weeks is referred to the Healthcare Safety Investigation Branch (HSIB) for investigation and if not taken forward by HSIB (or parental consent not granted) are investigated under our own local Serious Incident Policy
- All neonatal deaths are reported to the Local Maternity and Neonatal System (LMNS) and reviewed in the ICB Perinatal Quality and Safety Group. The Gloucestershire Maternity and Neonatal Voices Partnership are members of the LMNS, representing the lay voice.
- All neonatal deaths are reported to and subject to scrutiny by the independent Gloucestershire Child Death Overview Panel overseen by the countywide Safeguarding Children's Partnership and are included in their Annual Report.
- All neonatal deaths are reported to the National Child Mortality Database which results in the collation of deaths throughout England (at unit level) and enables the monitoring of deaths in the context of national norms over a rolling four-year period. The latest report April 2019 to March 2023 demonstrates a mortality rate for Gloucestershire in line with national averages. This report is sent to every Integrated Care Board (ICB) and subject to scrutiny by the LMNS and Regional Team.
- In January 2021 MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) published its report *Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity.* The service has embraced the recommendations arising from this report including the implementation of the Perinatal Mortality Review Tool (PMRT).

3.9 Beyond neonates and children, we have similar processes using the national methodology of Structured Judgment Reviews (SJR) alongside the recent introduction of the Medical Examiner

role, whose responsibility it is to ensure that cause of death is accurately recorded and to identify any concerns that may have caused or contributed to a patient's death. Again, through our Hospital Mortality Group, we have the opportunity to review and scrutinise mortality at Trust and service line level.

3.10 Finally, there is a risk that as the pendulum swings to establishing additional systems of governance and scrutiny that aim to ensure such events could not happen again, that we lose sight of the importance of our overarching goal to ensure we become a learning organisation, with quality improvement at its heart. There is a risk of a tension between systems, processes and importantly cultures designed to enable staff to embrace reflection, curiosity and learning, and those designed with an emphasis to monitor, report and investigate. I am confident with the advent of changes such as the new Patient Safety Incident Response Framework (PSIRF) where the emphasis on learning is at the heart of this new methodology, our successful Gloucestershire Safety and Quality Improvement Academy alongside our ongoing review of our internal governance, that we can navigate these potential tensions and build a safety management system that brings the best of both worlds to ensure the very best outcomes for patients and families in our care.

Deborah Lee
Chief Executive Officer

1 September 2023

2023-24 Executive Team Strategic and Operational Priorities

Context:

In recognition of changes in the operational and economic environment in which we are working, from when the Trust Strategy was launched in April 2019, the Board Assurance Framework, Quality & Performance Report, Trust Risk Register and discussions with colleagues and partners have been used to identify three priority objectives for 2023/24 the last year of the Trust Strategy.

Fig1. From 10 to Three

These three strategic priorities result in seven key themes for 2023/24.

Fig2. Three & Seven

Priority 1: Flourishing Workforce

1. **Culture & Retention**
2. **Recruitment**
3. **How we Communicate, Engage & Involve Colleagues**

Priority 2: Care Delivery

4. **Urgent & Emergency Care**
5. **Cancer Care (62-day)**
6. **Elective Recovery**

Priority 3: Productivity & Sustainability

7. **Deliver our 2023-24 Productivity & Sustainability programme**

Executive Team Key Deliverable 2023-24

The three strategic priorities and seven themes have been used to define Executive Team Objectives for 2023/24; these are distinct from their personal objectives and capture the things that we all have significant contributions to make to ensure success.

Driving these priorities is the belief that this collection of deliverables has the most to contribute to improving outcomes and experience for patients; improved experience for colleagues who will become more engaged and feel more valued and experience lower levels of "moral injury" as a result of being able to deliver better quality care to their patients. Our aim is to see these improvements reflected in the proportions of staff who would recommend the Trust as a place to receive care or to work, with the aim of achieving the 2022/23 response rates on a journey to upper quartile performance.

Strategic Priority	Theme	Key Deliverables
Priority 1: Flourishing Workforce	1. Culture & Retention	To have reduced turnover to a maximum of 13% by March 2024 from peak of 14.91% in July 2022. To have reduced sickness absence to a maximum of 5% by March 2024 from peak of 6.12% in 2022. To conclude procurement of a provider and begin roll-out of the team and leadership development programme to line managers (phase 1) by Sept 2023. To have an agreed Vision and Strategy for Freedom to Speak Up by October 2023, including – - Refreshed approach to evaluating concerns raised and record keeping in line with national guidance. - Defined approach to continuous learning from concerns raised. - Refreshed policies and processes. - Development of Guardian values. - Mandatory training for all staff. Staff Experience Taskforce to have completed 4 short projects by December 2023 – - 'Just Sort It' fund - New starter packs - 24-hour food - Roll-out of FERF (staff recognition) Roll-out of Back to the Floor programme to all Trust Leadership Team members by December 2023. All executive team members engaged in Reciprocal Mentoring by December 2023, and wider roll-out to Trust Leadership Team by March 2024. To be in the top 5 most improved Trusts in the 2023 NHS Staff Survey
	2. Recruitment	To have reduced the vacancy rate to a maximum of 8% from peak of 11.61% in July 2022

	3.Staff Communication, engagement & Involvement	Staff Survey 2023 completion target of 60% Team Brief sent to 1800+ managers and senior staff Bi-Weekly Global Comms to be read by an average of 2,000 staff per week Transformed approach to staff communication, engagement and involvement in ward moves by July 2023 – - New Go/No Go criteria focused on staff experience - New intranet site detailing expectations - New guidance for managers

Strategic Priority	Theme	Key Deliverables
Priority 2: Care Delivery	1. Urgent & Emergency Care	To eliminate the routine cohorting and boarding of patients by the end of May 2023. Boarding will remain part of the Trusts escalation policy in the following scenarios • To enable the Emergency Department to release a queuing ambulance to respond to a Category One Call • To create a space in the resuscitation area to offload a critically ill patient • To prevent a four hour + ambulance handover delay
		To reduce and maintain ambulance handover delays to an average of 45 minutes by November 2023
		To reduce and maintain NCTR to a minimum of 160 by March 2024 with the aim of achieving the ICS stretch target of 140 by March 2024
		To reduce the delays for trauma surgery (all types including # Neck of Femur to ensure all patients are treated in line with the standards set from fracture to surgery
	2. Cancer Care (62 days)	To achieve and maintain all cancer standards, including 62 days by end of Quarter For no more than 6.5% of the cancer PTL to have waited more than 62 days for their first definitive treatment following GP referral

	3. Elective Recovery	To ensure no patients wait more than 78 weeks for admitted or non-admitted care and by March 2024 for this to be 65 weeks To ensure 99% of patients receive their diagnostic tests within 6 weeks of referral by end of June 2023 with exception of endoscopy and echocardiography To ensure echo and endoscopy achieve the standard by December 2023
	4. Ward Moves Programme	To successfully conclude the ward moves programme by w/c25 the December to include • Delivery of new Chedworth Day Surgery Unit (DSU) & 2 new theatres, at CGH • Opening of expanded Emergency Department and Acute Medical Unit at GRH • Establishment of COTE and Frailty Assessment Unit at GRH • Re-establish Vascular & Trauma bed-base at GRH • Right-size Surgical Assessment Unit (SAU) at GRH • Delivery of Interventional Guided Image Surgery Suite and relocation of Cath Labs • Acute Medical Take centralised to GRH ahead of Winter 2023/24 To conclude final 2023 ward move programme and then establish a 'move by exception only' for minimum of 12 months.
	5. Digital Programme	To deliver the "Big 5" Digital Programme by end of March 2024 - Maternity EPR – implementation of full electronic patient record, across all inpatient and community settings for ante-natal to post-natal. - Outpatient Journey – removing paper in outpatients for the first time but approaching with full OP journey, including; patient portal (pre and post appointment communication), and in clinic paperless order comms. - Electronic Prescribing & Medicines Management (EPMA) – Phase 2 – including scanning at the bed side, removing remaining paper, pharmacy app etc. - Cyber-Security – implement cyber-security action plan and new operating model. - Data Driven – EPR and systems optimisation Moving the digital programme to becoming more data driven decision making to improve

	6. Estates (other)	benefits realisation, clinical outcomes, safety focus, productivity etc.
		• Community Diagnostic Centre at Quayside open – January 2024 • GRH and CGH electrical infrastructure improvements (Year 2 of 5 year programme delivered) – March 2024 • New CGH Birthing Unit open (was Aveta) – April 2024
Priority 3: Productivity & Sustainability	7. Deliver our Productivity & Sustainability Programme	To achieve breakeven financial position
		To deliver £28.1m of financial sustainability savings £14.2m Divisional delivery (including £1.58m from corporate division) £12.4m Corporate and System Programmes £1.4M of system stretch to be delivered by GHFT
		To manage income and expenditure in line with budget to ensure we do not enter financial tiering and/or enhanced oversight
		To achieve agency cap of £13.5M To reduce medical agency spend by £3.3M by March 2024 from £5.9M in 22/23 To reduce nursing & AHP agency spend by £6.6M by March 2024 from £14.2M in 22/23 To reduce RMN usage (a subset of nursing & AHP figure above) by £1.6M by March 2024 from £3.6M in 22/23 To reduce non-clinical agency spend by £1.2M by March 2024 from £4.5M in 22/23
Priority 4: Good Governance	8. Strengthen our approach to corporate and clinical governance	Conclude and deliver key recommendations from Good Governance Institute Review by March 2024 Restructure and appoint to key roles in Corporate Governance Team by December 2023 Review and make recommendations for changes to the quality governance architecture of the organisation March 2024 Review and make recommendations for changes to strengthen the contractual and assurance frameworks between GMS and the Trust specifically in respect of HTM compliance March 2024

Report to Board of Directors

Date	14 September 2023
Title	Trust Risk Register
Author **Director/Sponsor**	Lee Troake, Head of Risk, Health & Safety Mark Pietroni, Medical Director and Director of Safety

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

Summary of Report

Purpose

The Trust Risk Register (TRR) enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. Following Risk Management Group on 16 August and 6 September 2023 the following changes were made to the Trust Risk Register.

Key issues to note

TRR updates:

- No new risks were proposed for approval onto the TRR
- No risks were proposed for approval with a TRR score to be held at divisional level
- One risk was downgraded from the TRR
- One risk was closed

For further details see enclosed report.

Transfer of Risks to DATIXCloud

It was noted by RMG that over 700 risks have been being quality assured during August before transfer to DATIXCloud at the start of September. Risks that are overdue a review, defunct, poor quality or with overdue actions will not be transferred until they are up to date. All owners were advised of the actions to take before the transfer period. Risks that remain on DATIXWeb following the transfer period from 7 September will no longer be accessible to owners to update.

Workforce Risks

As a result of a change in the Trust Risk Appetite earlier in 2023 which lowered the workforce threshold score from 15 to 10, there are approximately 50 risks currently awaiting review by the POD team with workforce scores of 10 or 12. This review was due for completion by the end of June 2023; however, slippage has led to

a revised completion date of the end of August 2023. This is a hard deadline as DATIX as risks will be transferred to DATIXCloud in September 2023.

Revised Risk Management Framework

The Risk Management Framework and associated documents are currently being realigned to the processes on DATIX Cloud. This will be sent to RMG for consultation in September.

Water Safety Risk

The RMG was assured that significant progress had been made and GMS was in a better position to ensure compliance. The Pseudomonas Action Plan contains 116 actions and is reviewed bi-weekly alternating between the Water Safety Group and the Pseudomonas Working Group. Evidence to support the progress or closure of each action is held online. The procurement of the Zetasafe software is ongoing with an intended completion date of September 2023.

Fire Safety Risk

GMS reported that the Trust would be compliant with HTM 05-01 regarding competent persons in fire safety by the end of September and this will mitigate risk C3900 on the risk register.

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

TRUST RISK REGISTER

BOARD REPORT- SEPTEMBER 2023

1.0 NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

None

2.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

None

3.0 INCREASE IN SCORE OF EXISTING TRR RISK

None

4.0 RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

D&S3558PharmEquip
Risk Lead: Amanda White
Executive Lead: Mark Pietroni

Reason for downgrade: A new Air Handling Unit has now been installed and commissioned, mitigating this risk. The risk remains open whilst minor issues remain following the installation.

Inherent Risk
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.
Cause
Breakdown of air handling unit (AHU). Pharmacy manufacturing air handling unit is 15+ years old, highlighted at inspection (previously and again in 2022) that it needs a replacement plan. Usual life for external AHU is 15 years, ours is now 18 years old. One aspect of air handling is temperature/humidity - We have been running on only one of the 2 chillers and breakdown frequency is increasing and becoming harder to resolve
Impact & Effect
Effect: • Would need to outsource all products usually prepared in-house to commercial provider or another licensed NHS unit. • At the present time capacity is not available within industry and this is not a reliable contingency.

• Temperature & humidity in the unit exceeding acceptable levels for drug storage and preparation Impact • Increased turnaround for treatments due to need to outsource because of prolonged closure of manufacturing unit impacting on ability to supply chemotherapy and parenteral nutrition to patients at CGH and GRH. • Delays in delivery of service due to increase rotation of staff out of clean rooms. • Increase risk of medication errors due to thermal discomfort of workforce • Potential loss of service as clean rooms too hot to prepare drugs • Financial loss of stock if max temps exceeded in storage areas • Risk of loss of Medicines and Healthcare products Regulatory Agency (MHRA) 'specials' license
Scoring
Safety C4 x L3 = 12 **reduced to C4 x L1 = 4**, Quality C3 x L4 = 12 **reduced to C3 x L1 = 3**, Statutory C4 x L3 = 12 **reduced to C4 x L1 = 4**
Evidence of scoring
• New AHU installed
Key Controls
• New AHU has been installed • 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.
Gaps in Controls
• The vinyl coverings to walls and ceilings have come away as a result of a leak in the ducting • BMS sensors issues. e.g., reduced shelf life of some products, increased monitoring
Actions
• Conform project satisfactory conclusion

5.0 RISKS CLOSED ON THE TRR

C3295COOCOVID
Operational Lead: Neil Hardy-Lofaro
Executive Sponsor: David Coyle

Reason for Closure: There are clear plans to deliver on 2WW and 62d cancer standards. No extension of current waits planned for specialties already compliant. BAF being completed to account for Elective Care 2023/24 priorities. Covid currently is not a significant factor in elective capacity.

Inherent Risk
The risk of patients experiencing harm through extended wait times for both diagnosis and treatment
Cause

As a consequence of the Covid-19 pandemic a high number of patients were cancelled (outpatient and inpatient) during the months of March, April and May. Whilst lockdown has been eased the ability to deliver services at pre-covid levels has not been achieved.

Impact & Effect

Effect: This results in an increasing backlog of patients for both outpatients and inpatients who experience delayed diagnosis and treatment.
Impact: Potential harm to patients, inequity in waiting times and patient complaints.

Scoring

Safety C4 xL3=12 **reduced to C3 x L3=9,** Quality, Reputational C3 x L3 = 9

Evidence of scoring

- 1 linked incident
- 3 linked risks
- Clinical Harm Reviews - Surgery Oct 2021 patients

Key Controls

Booking systems/processes:

- Two systems were implemented in response to the covid 19 pandemic.
- (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face-to-face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face.
- (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required).
- Both systems were operational from end March.

Activity:

- Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care.
- RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position.
- The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at specialty level to detail the volume completed

Gaps in Controls

- Delivery of RTT performance is reliant on (a) sufficient capacity being available and (b) efficient booking systems to ensure timely and chronological booking, maximising utilisation.
- At present, capacity has not returned to pre-covid levels and recovery and services are considering how capacity can be increased (both real and virtual). In addition, given the ongoing challenges with the CAS system, inconsistent RAG rating and Vetting, the ability to book efficiently is compromised.
- Capacity with beds impacting elective work to take place due to surge of C-19

Actions

- COVID T&F Group to develop Recovery Plan to minimise harm- closed 15/09/2022
- To resolve outstanding areas of concern- resolved 09/05/2022

6.0 OVERDUE REVIEWS OF TRR RISK

The following risks on the TRR are overdue for review.

Risk ref	Lead	Description	Review Date
C3034	MH	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability) and reduced patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	02/08/2023
S2424Th	MD	The risk to business interruption in theatres due to the failure of the ventilation to meet the statutory required number of air changes.	03/08/2023

Actions were assigned at RMG to ensure these risks were reviewed.

6.0 OVERDUE ACTIONS ON TRR RISKS

The following TRR risk have overdue actions. Those actions due in 2021 and 2022 are highlighted in red. Actions pre-June 2023 are in amber.

Risk action linked to:	Action Owner	Action Description	Due Date
S2424TH	KP	Review infections in Theatres	30/06/23
	DP	Provide comprehensive update on Theatre ventilation	28/04/23
S2976BIMA	RH	Develop escalation process for when Breast Radiologist is not available to provide service	29/07/22

Actions were assigned at RMG to ensure these actions were updated.

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
WC3845Obs	Risk of first trimester screening offer being missed (if dating scan occurs after 14+1 weeks gestational window for screening), affecting patient pregnancy options and care pathway.	Support being offered by Quality Assurance and Imms team. USS manager has a staffing/workforce plan to address sonography workforce challenges Number of women who miss FTCS are being monitored and tracked to ensure	undertake review of ANSCO hours audit bookines review job plans create newsletter review of admin hours fetal medicine team meetings review booking system	Diagnostics and Specialties, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse	Divisional Board - W & C, Quality Delivery Group			Quality and Performance Committee	31/10/2023	Jorgensen, Trine	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	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 Develop action plan Quality Summit on corridor care	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 Improvement		Emergency Care Board, Quality and Performance Committee, Trust Board, Trust Leadership Team	09/10/2023	Cro, Suzie	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 Urgent and chemotherapy patients being prioritised for appointments Fixed term middle grade staff appointed and being trained to support consultant team 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 CEO agreement to use off-framework agency staff In March 2020 there was a redesign	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 Bespoke recruitment incentive	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	02/10/2023	Johny, Asha	Trust Risk Register
C1437POD	The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including Medical & Dental, Registered Nurses & Midwives and Allied Health 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 Alternate/Advanced practice/new including Associate Specialists, Non-Medical Consultant, ACP, PA offering alternative solutions to medical gaps	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	19/09/2023	Daniels, Shirley	Trust Risk Register
S2976BIMA	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	clinics covered by current staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting center widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee	12/10/2023	Hunt, Richard	Trust Risk Register
D&S3558PharmEquip	The risk of breakdown of air handling unit, due to age, leading to poorer patient outcomes for oncology and parenteral nutrition patients. The risk of loss of service and that that some staff with medical conditions are unable to work reducing the staff pool.	new AHU has been installed Outsourcing for some products in place which would reduce impact somewhat however this is not reliable due to external capacity limitations. GMS are checking the chiller each weekday morning and re-setting as	Liaise with GMS AHU motors report of AHU status check on chiller at weekends To confirm project satisfactory conclusion	Diagnostics and Specialties, Gloucestershire Managed Services	Safety	Major (4)	Rare - Less than annually (1)	4	4 - 6 Moderate risk		Divisional Board - D & S	Medicines Optimisation Committee		Cancer Services Management Board	31/10/2023	White, Amanda	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews - 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 Review risk, controls and supporting actions Speeding up waits to triage and to be seen and reducing ambulance handovers	Medical	Quality	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Divisional Board - Corporate / DOG, Divisional Board - Medical, People and OD Delivery Group, Quality Delivery Group, Trust Health and Safety Committee	Unscheduled Care Leaders Group		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	31/10/2023	Barnes, Chester	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	Provision of consultant for 1 day a week Increase in turn around time for film reporting	Consultant to start in July 2022 Bespoke recruitment incentive	Diagnostics and Specialties	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Medical Director	Divisional Board - D & S, Quality Delivery Group	OHPCLI Board		Quality and Performance Committee	09/10/2023	Johny, Asha	Trust Risk Register
C3930 S&T E&F	The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC	Some of the units are placed in fire-rated hazard rooms. Some of the units have a better level of installation.	To review hazard rooms with clinical teams and Fire team Identify any works required for alternative locations Set up lessons learnt event To sign off installation as required standard To review usage and risk report to inform prioritisation To roll-out new SVF process To ascertain staff training requirements and roll-out Fire team trainer to add information to mandatory training package	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Statutory	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		Fire Safety Committee Group, Risk Management Group, Trust Health and Safety Committee	Fire Safety		Other	05/12/2023	Turner, Bernie	Trust Risk Register

			Rolling replacement programme for batteries Check required on risk assessments To broker discussions regarding funding impacts Conclude RAG audit of areas across the Trust														
C3767COO	The risk of harm to patients and staff due to being unable to discharge patients from the Trust.	Clinical review and prioritisation Onward care team in place supporting discharge Prioritisation of end of life patients Currently GHT CHC process is reliant on ward staff to complete a number of the stages. OCT and SPC support where they are able, but there is not a constant provision of resource.	To resolve outstanding areas of concern	Ambulance Trust, Corporate, Diagnostics and Specialties, GP Services / NHS England, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	COO	Divisional Board - Corporate / DOG, Quality Delivery Group			Executive Management Team, Quality and Performance Committee	21/09/2023	Hardy-Lofaro, Neil	Trust Risk Register
C2669N	The risk of harm to patients as a result of inpatient falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention 5. Equipment to support post falls management 6. Acute Specialist Falls Nurse and therapist in post 7. Falls prevention champions on wards 8. Falls monitored and reported at the Quality and Performance Committee 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Little things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a Following presentation of W168912 N Jordan to attend ward to review completion of falls documentation and required management of patient following assessment by staff Following presenntation of W171436 to PHH N Jordan to forward information to purchase slippers for patients in ED W165353 Nadine Jordan to review with 9a x-ray identifying # and communication of #	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	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	30/11/2023	Bradley, Craig	Trust Risk Register
C1850NSafe	The risk of ineffective care, prolonged stay and harm of a child or young person (12-18yrs) with significant emotional dysregulation or mental health needs at Children's Inpatients	The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. All mental patients Risk assessed on	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	29/09/2023	Freebrey, Clare	Trust Risk Register
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, 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	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 Risk H&S team to quality assure all risks during August ready for transfer to DATIXCloud	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	06/11/2023	Troake, Lee	Trust Risk Register
			1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 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														

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), intentional rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on some wards where patients are at higher risk and dietician review available for those who are referred to be at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey once assessment suggests patient's skin may be at risk. 5. Weekly 'preventing harm hub' reviews Hospital Acquired Pressure Ulcers grade 3 and above. Ward team, patient safety team and tissue viability attending 6. annual foam mattress audit and replacement programme in place 7. Pressure Ulcer Prevention Steering Group and Plan	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 support to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed Bespoke training to DCC staff for categorisation of pressure ulcers Bespoke training to ward 4a to include 1st hour priorities produce training document on wound measurements for Rendcomb The provision of RCA support/training for TV issues to be take to pressure ulcer council Work with Knightsbridge to support staff TVN training Bespoke training in management of pressure ulcer [revention on ward 7a TVN to d/w TVN lead regarding use of share care pathway in regards to EPR Implement training programme in management of patient pressure ulcers in ED Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	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	30/11/2023	Bradley, Craig	Trust Risk Register
D&S2517PathEquip	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate). Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Estates and Strategy	Divisional Board - D & S, Quality Delivery Group	Pathology Management Board		Quality and Performance Committee	23/10/2023	Brown, Sarah	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Patient flow and quality coordinator (band 7) allocated on a daily basis	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required. staff consultation on call enhancement discussion	Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Interim Chief Nurse	Divisional Board - W & C, People and OD Delivery Group			People and OD Committee	31/10/2023	Stephens, Lisa	Trust Risk Register
M2268Emer	The risk of patient deterioration, harm and poor patient experience when care is provided in the corridor during times of overcrowding in ED	Patient to staff ratio 1:4 Clinically ready to proceed patients only to be moved to the corridor and those awaiting discharge . Clear criteria in place (recorded on escalation ambulance policy)to ensure only low risk patients are placed in corridor. Patients that have been identified as at risk of fall Risk of absconding / wandering should not be placed in the corridor. Patients with that cannot access the toilet facilities by chair or walking should not be placed in corridor.	Complete COC 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	06/11/2023	Allen, Samantha	Trust Risk Register
	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures	Temporary Staffing Service on site 7 days per week. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. Out of hours senior nurse covers Director of Nursing on call for support	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment							Divisional Board - Corporate /			People and OD Committee			

C3034N	with standard operating procedures (high reliability) and reduced patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	to all wards and departments and approval of agency staffing shifts. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 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. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to	Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSI Retention programme cohort 5 Trustwide support and implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director of Quality and Chief Nurse	DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		Quality and Performance Committee, Trust Leadership Team	02/08/2023	Holdaway, Matt	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 responsabilities for rapid discharge process Resource checklist for rapid discharge Develop outcome spreadsheet for rapid discharge MDT Regualr meeting with CHC leads Job description review Review new data around in-patient deaths who were coded as NCTR Monthly rapid discharge home to die meeting established	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		Quality and Performance Committee, Trust Board	09/10/2023	White, Samantha	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in a failure to recognise, plan and deliver appropriate urgent care needs.	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation system of electronic Vital Signs o Acute Care Response Team Feedback to Ward teams	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme Request addition to EPR observation chart to include patient voice of better/worse/the same, and edit section for escalation action	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Digital Care Board, Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Systems Safety Group, Resuscitation and Deteriorating Patient Group		Quality and Performance Committee, Trust Leadership Team	29/09/2023	Foo, Andrew	Trust Risk Register
C3941EFD	The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	- 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. Latest status is 11/18 completed actions with 2 awaiting approval, 3 in progress and 2 requiring further clarification. - Audit plan created for staff practices related to cleaning and disinfection, checklists and spot-checks introduced - SOP created for IPC actions post positive water results - Procedure Notes and Method Statements created covering procedures and practice for estates and domestics teams. Procedure Notes have all been reviewed by Authorising Engineer with systematic review for approval at Water Safety Group (for example, PN04-22 and PN04-03 coming to next WSG in May for sign off) - Capital team have undertaken training on Water Safety - SOP created for water samples typing, the management of positive results for GMS Estates and Apleona Estates	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 auemented 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 Agree and implement solutions for water temperature control D block	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Statutory	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director for Strategy and Transformation	Estates and Facilities Committee, Estates and Facilities Contract Management Group, Infection Control Committee, Trust Health and Safety Committee	Water Action Group		GMS Board, People and OD Committee, Quality and Performance Committee, Trust Board	30/09/2023	Turner, Bernie	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Clinical Chemistry Pathology laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months.	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - D & S, Estates and Facilities Committee, Quality Delivery Group	Pathology Management Board		Finance and Digital Committee, Quality and Performance Committee	11/10/2023	Rees, Linford	Trust Risk Register
C2803POD	The risk that staff morale, productivity and team cohesion are eroded by adverse workplace experiences and/or significant external events, which in turn adversely impacts patient safety, job satisfaction, colleague wellbeing, and staff retention.	Divisional staff survey action plans, monitored by Executive Reviews. Divisions are offered support by PACE. Trustwide staff survey action plan. Patient and Colleague Experience Group (PACE) - leading on the triangulation of experience data and delivery of compassionate culture work streams. 2020 Hub is staffed with 3.3 WTE staff to deliver a range of health-wellbeing support. EDI team established comprised of substantive roles (EDI Lead, EDI Coordinator, EDI Administrator) and fixed-term 18 months EDI Training Specialist. Colleague Wellbeing Psychology Lead in place, with 1.6 WTE Psychology Link Workers appointed for 23 months. 1 year fixed term 0.3 Resilience Trainer appointed. Compassionate Leadership training rolled out and all leaders/managers	Create Dashboard to underpin SPEIG work priority workstreams feeding into SPEIG Review Staff Survey results EDI/Cultural Improvement plans being devised in light of DWC and staff survey results Short, medium and long-term interventions being proposed to address health-wellbeing concerns 2 x OD Specialists (fixed term) being recruited to offer additional support to a) maternity and b) junior nurse leadership development Staff Engagement and Internal Comms Manager being appointed to support internal communications effectiveness	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Staff Experience and Improvement Group		People and OD Committee	01/09/2023	Hopewell, Abigail	Trust Risk Register

		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	To deliver the first year (phase 1) of the Teamwork/Leadership workstream as part of the Staff Experience Improvement Programme															
S2424Th	The risk to business interruption in theatres due to the failure of the ventilation to meet the statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place Competent external contractors used Prioritisation of patients in the event of theatre closure Review of infection data at T&O theatres infection control meeting	Write risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan arrange replacement valve and acurator for air handling unit TH1 reinstate quarterly ventilation meetings To provide comprehensive update on theatre ventilation Review of infections in Theatre 7	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - Surgery, Finance and Digital Committee			Quality and Performance Committee, Trust Leadership Team	03/08/2023	Dobb, Michael	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Plan to deliver national cleaning standards (NHSE 2021) 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	23/11/2023	Bradley, Craig	Trust Risk Register
M2613Card	The risk to patient safety as a result of laboratory failure due to ageing imaging equipment within the Cardiac Laboratories.	GE contract rolled to present day, we do have an external maintenance contract in place should issues arise. Lab 3 - Phillips Agito responsible for maintenance and contract in place. Any internal issues are escalated to domestic facilities Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting. C-arm in radiology	This has been worked up at part of STP reslace 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 ensure catheter labs open in December	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, Estates and Facilities Committee, Estates and Facilities Contract Management Group	Medical Devices Group, Medical Equipment Fund		Quality and Performance Committee, Trust Leadership Team	04/12/2023	Millward, Vicky	Trust Risk Register
M2815Stroke	The risk to patient safety due to delays in the acute stroke pathway for patients attending Gloucestershire Royal Hospital (GRH) Emergency Department.	Stroke patients attending GRH ED should be managed by ED/medical teams and offered thrombolysis/thrombectomy referrals if possible in GRH and then transfer to CGH HASU, unless felt more timely to transfer direct onto CGH. Monthly stroke breach meetings to review SSNAP data with feedback to ED. Regular feedback provided to ED and teaching of triage staff regarding pathway. Updating pathways and sharing via teaching to ED and medical staff. Specialist nurses when full complement provide 7/7 0700-2300 and can provide telephone support to GRH ED staff.	Increase pre alerts via SWAST to ED Increase pre alert from ED nurse to SSN Streamline process to request CT from ED Write business case to increase SSN service to 24/7 Recruitment to medical rota Change to medical rota to increase presence in HASU to 12 hours Please can you review and update risk and action Enhanced training for ED staff (nurses and doctors) re the stroke pathway and timelines to work to Stroke awareness training of ED triage nurses To work with ICB to improve patient awareness of stroke services not going to GRH Reducing ED pressures to allow staff to work safely and prioritise patients appropriately	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		Divisional Board - Medical, Emergency Care Delivery Group, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Quality and Performance Committee	27/09/2023	Hellier, Kate	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	onegoing 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, People and OD Delivery Group	Theatres Collaborative		Trust Board, People and OD Committee	09/10/2023	Ball, Natalie	Trust Risk Register

S3337	The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward	20 chairs and 2 side room capacity + swabbing room NEWS 2 taken by nursing team 4hrly at least Escalation via site to obtain inpatient bed SOP with criteria for admission Referral to Registrar/ ACRT if patients deteriorate whilst waiting for assessment Use of assessment rooms as side rooms for patients with gold approval only Staff visible within bay/ just outside of bay Trainee ACPs to review patients	Works to change colorectal office on 5a to bedded bay with bathroom works in orchard centre to allow relocation of colorectal office space on 5th floor escaltion via division tri to stop use of assessment rooms for inpatients 1-3 year strategy plan for SAU and 5th floor update SOP to reflect current situation recruitment drive for SAU	Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Surgery, Estates and Facilities Committee, Quality Delivery Group			Quality and Performance Committee	30/11/2023	Jones, Lisa	Trust Risk Register
S3968Oph	Risk of a delay to follow-up appointments leading to significant reduction of vision due to insufficient resources to correctly prioritise patients on the waiting list.	Funding has been allocated for immediate additional resources and for long term recruitment (failsafe officers) •Specialty tri are offering validator work as bank to existing staff within the department for an initial 8 week period For Red validated patients and DNBs, ensuring that these patients receive	GIRFT actions Contacting other Hospitals re Failsafe staffing Recruitment of additional Failsafe Officers Update the business case Inform elective care recovery board of the risk / situation	Surgical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Executive Director for Safety	Divisional Board - Surgery, Quality Delivery Group			Quality and Performance Committee	02/10/2023	Biston, Cathryn	Trust Risk Register
F2895	There is a risk the Integrated Care Board (ICS)/ Trust has insufficient capital due to the Capital departmental expenditure limit (CDEL) and/or is unable to 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	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	Capital Control Group, Digital Care Board, Divisional Board - Corporate / DOG, Estates and Facilities Contract Management Group, Infrastructure Project Board	Capital Replacement Group, Medical Equipment Fund		Executive Management Team, Trust Leadership Team	06/09/2023	Johnson, Karen	Trust Risk Register

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 27 June 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 Feedback	Following the publication of the staff survey results, a letter had been issued to all staff to ask for feedback on the one key change that staff want to see to improve their experience at the Trust. Key themes from the feedback received related to culture and line manager behaviour, and the boarding process.	A Staff Experience Taskforce had been established to review actions and projects that would lead to a positive change in culture and behaviour issues.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Performance Dashboard	Key points were highlighted as follows: • Key performance indicators now had targets in place. • Focused nursing recruitment had successfully secured funding to support the Trust with winter planning. • Bank and agency controls continued to be reviewed. • An effectiveness review was underway into the E-Rostering system. • Vacancy rates continued to be challenging across all roles.	A deep dive into attrition rates would be undertaken and an assurance report developed for the Committee meeting in September.
Freedom to Speak Up Report	An update on activity was provided, along with benchmarking data from the South West and national. During 2022/23, 98 staff accessed the FTSU process, which was lower than the South West average. Anonymous reporting at the Trust was higher than average. Key themes to concerns during the year related to poor behaviour, bullying, poor support and staff experience.	To fully analyse staff experience in the future, the team would share an anonymous survey for staff to fill in and report on the results, providing an opportunity to capture learning and improve the service.
Engagement and Involvement Annual Review	Over the last year, the Trust had been an active part of 58 groups and community events, reaching over 8,700 people, enabling the Trust to gain valuable insight into how access to services could be improved. The review also detailed information about the local communities and the challenges of health inequalities across the county.	Revised regulations from CQC and NHSE mean that People and Communities/Patient and Community Engagement would continue to be a key focus for the Trust. The review would be published on the Trust's website, alongside the Annual Report and Quality Account.
Equality Delivery System 22	The Trust was assessed against the EDS22 framework, which organisations completed on a system level. The Trust was rated against three domains (Commissioned or Provided Services; Workforce Health and Wellbeing; Inclusive Leadership) with an overall score of 11, which was a rating of "Developing".	The Trust's existing EDI action plan, along with recent WRES, WDES and Gender Pay Gap data would be reviewed at an EDI workshop scheduled for 6 July to determine next steps.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
None.		

Items not Rated

Risk Register	ICS Update	Audits

Impact on Board Assurance Framework (BAF)

SR3: continue to reflect actions and progress, including staff health and wellbeing and reflection of culturally specific training.
SR4: milestones to be included to reflect progress against a number of significant pieces of work, including the Staff Experience Taskforce. Consider inclusion of organisational risks associated with the transformational approach to co-design.

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	
Date	14 September 2023
Title	**Freedom to Speak Up Report**
Author /Sponsoring Director/Presenter	Louisa Hopkins - Lead Freedom to Speak Up Guardian Dr Claire Radley- Executive Lead for Freedom to Speak Up

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 report provides an update on the progress the Trust continues to make.

Including-

- Freedom To Speak Up Guardian assessment of the current position
- Review of concerns raised to Freedom to Speak Up (FTSU) service 2022- 23
- Regional work and local plans for improvement
- NGO Ambulance review gap analysis

Risks or implications

Freedom to Speak Up arrangements and learning are reviewed as part of the Well Led domain in CQC inspections.

The Trust is required to meet the following legal/regulatory requirements in relation to raising concerns:

- NHS contract (2016/17) requirement to nominate a Freedom to Speak Up Guardian.
- National NHS Freedom to Speak Up raising concerns policy (2022)
- NHS Constitution: The Francis Report emphasises the role of the NHS Constitution in helping to create a more open and transparent reporting culture in the NHS which focuses on driving up the quality and safety of patient care.

Staff have spoken up about concerns regarding discrimination.

The Raising Concerns Policy is currently under review.

Staff disclose to the Freedom to Speak up service protected characteristics of disability, pregnancy, maternity, religion, LGBTQ+ race and age.

Staff have shared patient safety concerns. Concerns are raised and responded to on a case by case basis.

Financial Implications

None

Approved by: Director of Finance / Director of Operational Finance	Date:

Recommendation

Discuss and note the Freedom to Speak Up update and support on going work to ensure an open and transparent culture of speaking up is achieved in the organisation.

Enclosures

Appendix 1 - Assessment of this organisation in response to the NGO's recommendations and work planned to address gaps identified.

Appendix 2 - Freedom to Speak Up Data 2022- 23

Purpose

This is the report of the Lead Freedom to Speak up Guardian providing an update on activity, bench marking where possible against South West and National data.

Background

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report 'The Freedom To Speak Up' (2015 www.freedomtospeakup.org.uk/the-report/). In this report, Sir Robert found that the culture in the NHS did not always encourage or support workers to raise concerns that they might have about quality and safety of care provided, potentially resulting in poor experiences and outcomes for patients and colleagues.

Concerns can be raised about anything that gets in the way of providing good care. When things go wrong, it is important to ensure that lessons are learnt and improvements made. Where there is the potential for something to go wrong, it is important that staff feel able to speak up so that potential harm is avoided.

Even when things are going well, but could be even better, staff should feel confident to make suggestions and that these would be taken on board. Speaking up is about all of these things.

Freedom to Speak up Guardians are employed to promote an open and transparent culture of speaking up and raising concerns. FTSUG provide impartial support to speaking up matters, monitoring and supporting any concerns of detriment or disadvantages behaviour toward staff as a result of speaking up. The FTSU Guardian values are Impartiality, Empathy, Courage and Learning.

The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC and NHSE.

The Trust has responded to data from the staff survey (please see data below) and CQC report April 2022 (https://api.cqc.org.uk/public/v1/reports/2a68a3e9-5335-4c90-8c07-ea5c55ec2370?20221129062700) citing a

lack of trust in the freedom to speak up system and a lack of action when concerns were raised.

The Trust has ensured a substantive post for Lead Freedom to Speak Up Guardian has been fulfilled as per National Guardians Office guidance for organisations. This post will enable the FTSU team to have the capacity to align with National Guidance and expectations. A gap analysis review is currently underway to ensure improvements are achieved.

Update on 2022- 23 FTSU activity:

Over this last year (between April 2022 and end of March 2023), 98 staff have accessed FTSU to raise concerns, which is lower than the South West average of medium size NHS FT (a medium sized Trust according to the NGO is 5000- 10000 staff). Please see graph A.

A dedicated Lead full-time Guardian is expected to increase trust and provision in the service and processes of FTSU. With more dedicated time to the role, it is expected that cases will increase. To date, compared with the same time period last year, cases have increased by 30% since the appointment of the new Lead FTSU Guardian.

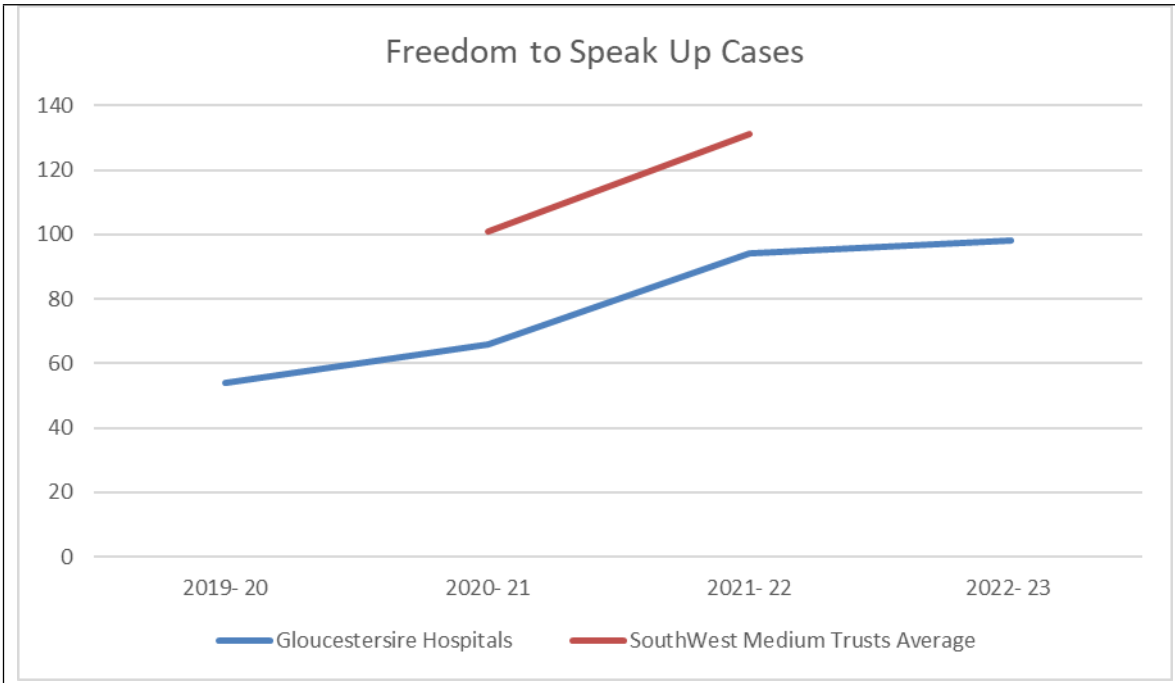
It is noted that anonymous reporting at Gloucestershire Hospitals is higher than the national average benchmark reported by the NGO. A high percentage of staff 34.6% accessed anonymous reporting compared with a 10.4 % national average. Anonymous reporting is welcomed and supported but can suggest staff feel a lack of trust in the organisation and fear of detriment, which triangulates with other data sources such as the CQC report (2022) and Staff Survey results. The stability of a Lead Guardian is expected to improve reporting to more open concerns and less anonymised concerns raised. The current anonymous reporting system is under review to ensure appropriate support is provided for staff going forward.

Staff have raised a range of concerns this last year. Concerns are reported by the Guardians as predominately behaviour, bullying concerns with themes of poor support and staff experience in speaking up leading staff to access the FTSU service. Learning has been achieved in a number of cases with the team reporting that the majority of staff voiced they would speak up again. Please see Appendix 3.

NGO 2022- 23 data is not available yet to benchmark against but we can report locally that patient safety concerns are 14.2% of 2022- 23 cases with behaviours, bullying and harassment accounting for 78.5% of cases.

Future reporting will be captured in accordance with the original National Guardians office categories of Systems and processes, Patient safety, Bullying and harassment, and Behaviours and culture in order to gain accurate bench marking comparisons. Cases that have an element of patient safety or worker safety will also be continued to be recorded.

To fully analyse staff experience in the future, the FTSU Team will share an anonymous survey for staff to fill in and report on the results as Yes, No or Maybe as per NGO data analysis and will give opportunity to capture the learning to improve the service.



Graph A

Local Work and improvements plans

Key performance indicators for assessment will be captured from the People Promise metrics from the staff survey, accessing data from Pulse surveys and assessing feedback data from the FTSU service beyond reporting a majority of answers.

An increase in concerns will indicate staff confidence in speaking up and accessing the FTSU service.

A decrease in anonymous reporting will be an on going measure of staff trusting the organisation and service with their concerns.

A baseline of the current metrics are included below for reference. As highlighted by National Guardian Dr Jayne Chidgey-Clark, the National picture also shows a decrease in confidence in speaking up and encourages organisations to view these results as wake up call to leaders at all levels, that Freedom to Speak Up is not just a 'nice to have' – it is essential for safe services. https://nationalguardian.org.uk/2023/03/10/response-to-nhs-staff-survey-results/

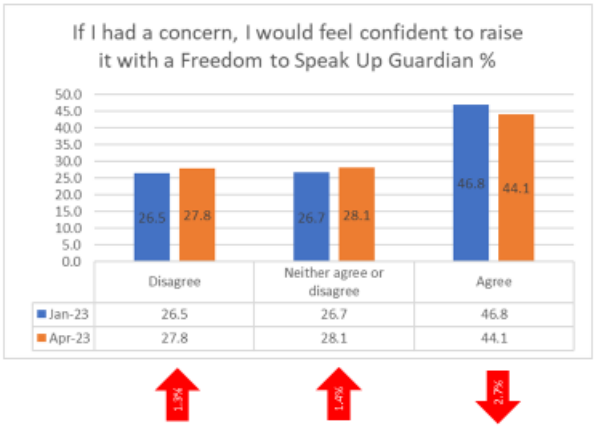
In 2022- 23, 6.1% of staff in the Trust who raised concerns considered they had experienced detriment as a result of speaking up. National Guidance is to record such experience as *'where disadvantageous and/or demeaning treatment as a result of speaking up is indicated.*' The last recorded data in relation to this from the NGO indicated a national average of 4.3%.

It is unclear what disadvantageous experiences staff in the Trust have had as a result of speaking up. Moving forward, any cases of disadvantageous treatment will be captured in case data and offered support and case review from The Lead Non Executive Director for Freedom to Speak Up as per guidance from The NGO.

Data from the most recent National and Pulse (quarterly) Trust survey is as follows -

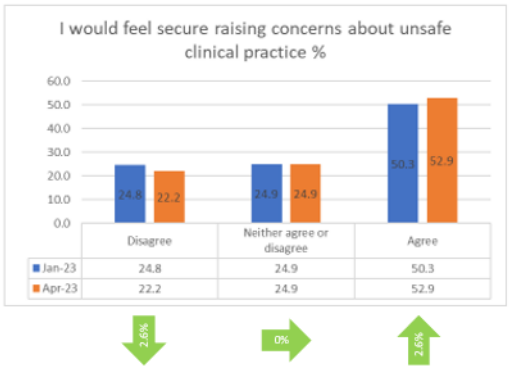
Raising concerns and speaking up

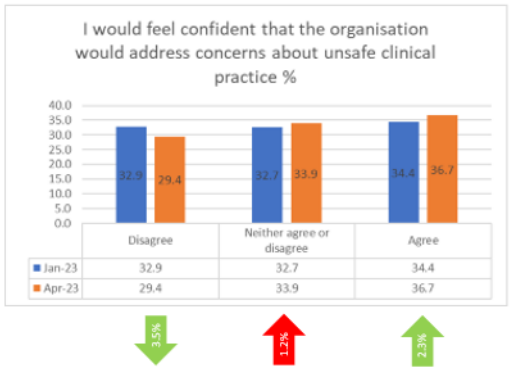
NHS
Gloucestershire Hospitals
NHS Foundation Trust



Raising concerns and speaking up

NHS
Gloucestershire Hospitals
NHS Foundation Trust

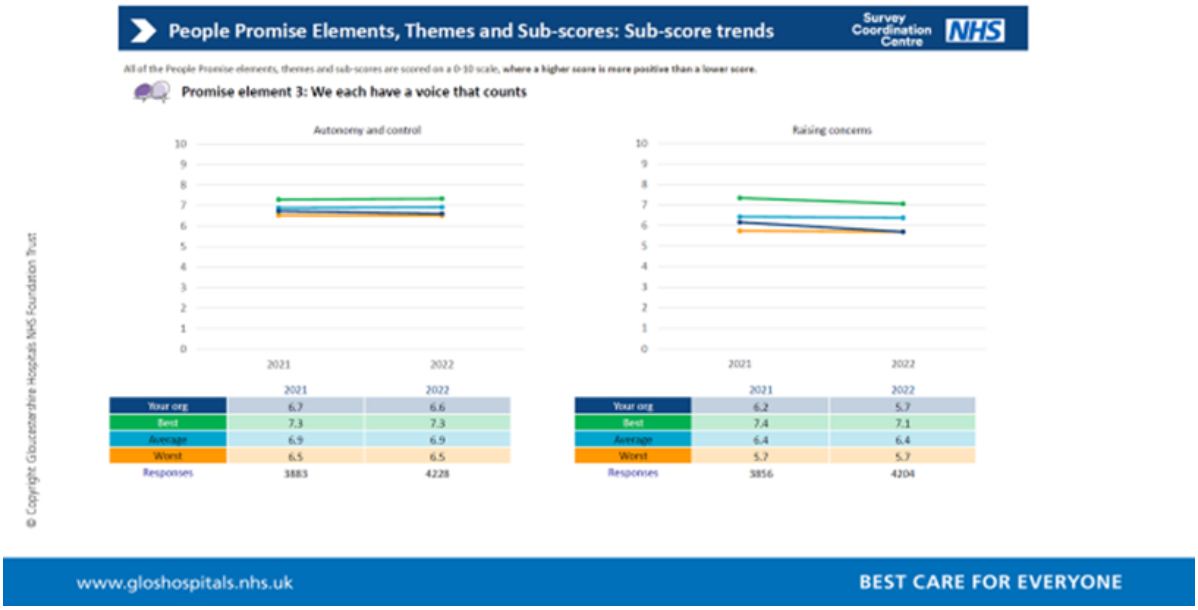




Raising Concerns and Speaking Up Metrics

NHS
Gloucestershire Hospitals
NHS Foundation Trust

People Promise 3 – We each have a voice that counts



www.gloshospitals.nhs.uk BEST CARE FOR EVERYONE

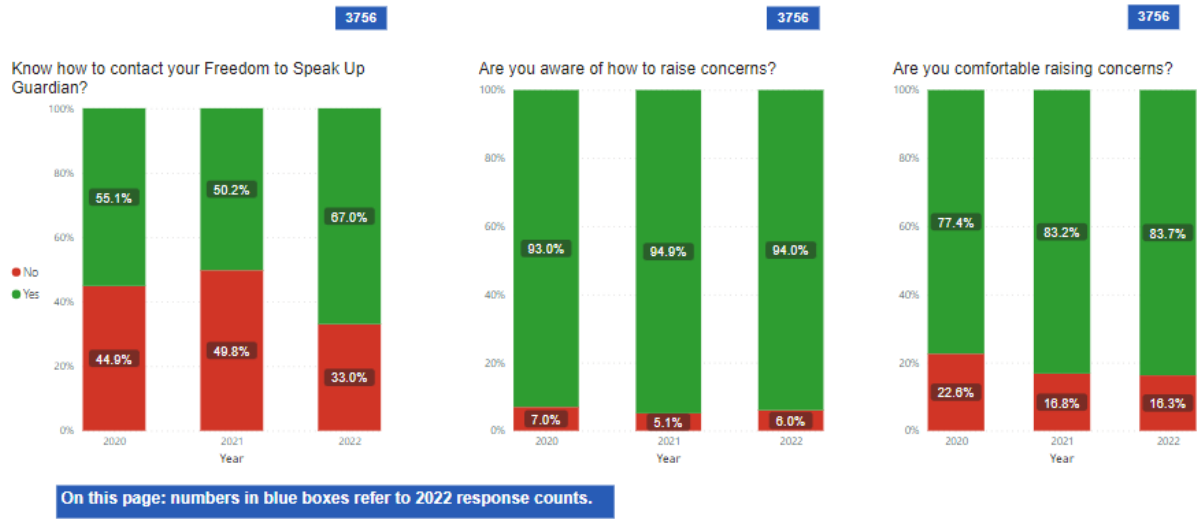
National and Regional Work:

The NGO has recently announced Suzanne McCarthy as new independent Chair of the NGO. The Accountability and Liaison Board seeks assurance and gives strategic advice to the National Guardian to promote her mission to make speaking up business as usual throughout healthcare.

Gloucestershire Hospitals Lead FTSU Guardian actively engages with the National Guardian's Office, acting as regional chair reporting to National Guardians Office when needed, completing data requirements and contributing to surveys.

The Lead FTSU Guardian provides ongoing mentorship to new and existing Guardians nationally.

Improvements have been made in bringing awareness to the FTSU Service as the following data from NHSE shows. In 2021 49.8% of learners in Gloucestershire reported they did not know how to contact their FTSU Guardian. This figure has now dropped to 33%.



	% learners who do **not** know
Gloucestershire Hospitals NHS Foundation Trust	33%

Learner groups	% learners who do **not** know
Medicine Postgraduate	23%
Nursing	23%
Allied Health Professional	71%
Midwifery	65%
Healthcare Science	17%
Dental Postgraduate	83%
Advanced Clinical Practice	20%
Medicine Undergraduate	75%
Health and Social Care	25%
Pharmacy	33%

This data has provided valuable insight into where to initiate raising further awareness of the FTSU service.

Conclusion and next steps:

The Freedom to Speak up Team is in a time of transition with a clear need to improve staff experience and trust within its service and proposes the following plans looking ahead:

- Continued attention over the next 6 months to review current practices and align with National Guidance including policy, protected time and support for the team
- Engage with staff and co create a strategy setting the tone for Freedom to Speak up over the next 3- 5 years, including seeking support from staff networks to ascertain barriers to speaking up
- Develop a champion network to ensure all staff have access to support in speaking up
- Address training needs in the organisation so that all staff have essential FTSU training accessible to them

In addition, a comms plan is needed and review of the differing services offering support to ensure Freedom To

Speak Up has a clear identity supported by the Trust.

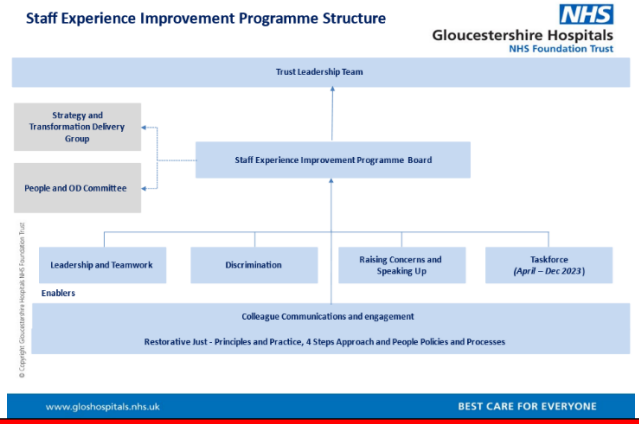
For example, there may be some confusion between the GLOSTAR support Guardians and Freedom to Speak Up Guardians. Both services offer sign posting and currently GLOSTAR have 150 guardians offering peer support. Terms of reference for the strategy engagement will seek to explore the differing support networks during engagement to eliminate any confusion of the services provided.

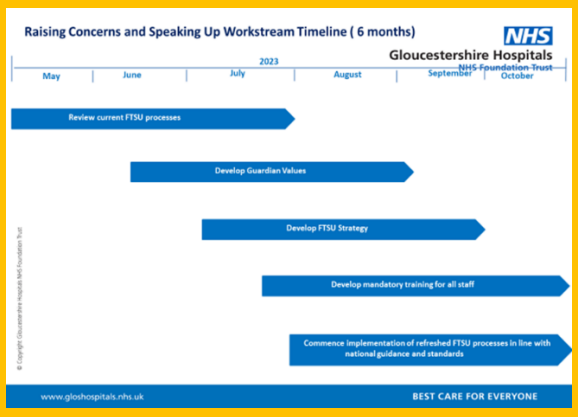
Finally, The National Guardian's Office carries out Speak Up reviews where it has information suggesting speaking up has not been handled following good practice.

Reviews seek to identify learning, recognise innovation and support improvement. Ambulance Trust review- *Listening to workers* recommends that all Organisations review the recommends against the current speaking up culture and provisions in their organisation.

Appendix 1 captures the assessment of this organisation in response to the NGO's recommendations and work planned to address gaps identified.

Appendix 1:

Recommendation taken from Ambulance Review Feb 2023 ***'Listening to workers'***	Review and action from Gloucestershire Hospitals FTSU Service
Recommendation 1: Review broader cultural matters	Cultural Review work is underway in Gloucestershire Hospital's NHS Foundation Trust Improvement programme in place focused on raising concerns 
Recommendation 2: Make speaking up business as usual This recommendation requires; • Mandate training on speaking up - in line with guidance from the National Guardian's Office - for all their workers, including volunteers, bank and agency staff, as well as senior leaders and board members.	• Training for all staff is highlighted and in the workplan as part of improvements to be made.
• Trust leadership (including managers, senior leaders and board members) to fully engage with Freedom to Speak Up, evidenced by board members undertaking development sessions	• New FTE Lead FTSU Guardian recruited and in post • Engagement for FTSU Strategy commencing June 2023 • Board development support planned for Quarter 3 with National Guardian Jayne Chidgey- Clark

	Work plan: • 
Embed speaking up into all aspects of the trusts' work by proactive engagement by leadership, managers and Freedom to Speak Up guardians across the trusts through regular communications.	• Open communication established with senior leaders and board. • Regular communication with Lead Exec and CEO in place. • Further work via Strategy engagement to help establish gap analysis for embedding FTSU
Trust leadership teams should identify the professional groups/areas within the trust that need support in implementing Freedom to Speak up by diagnosing root causes and putting in place a support mechanisms for managers and workers to feel psychologically safe when speaking up and reduce detriment.	• Comms plan in development • Engagement for strategy will include liaising with networks to provide gap analysis
Trust Boards to annually evaluate the effectiveness of speaking up arrangements; including effectiveness of facilitating all workers, including those from groups facing barriers to speaking up, being able to speak up about all types of issues and action being taken in response to speaking	• Board assessment Tool review due October 2023. Offer from National Guardian Jayne Chidgey-Clark to support board development. • Engagement for FTSU Strategy will provide insight and data regarding barriers to speaking up

Recommendation 4: Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers This recommendation requires all trusts to:	
• Meaningfully invest in the Freedom to Speak Up Guardian role. In discussion with their Freedom to Speak Up Guardian(s), leaders should identify the time and resources needed to meet the needs of workers in their organisation.	• FTSU FTE Lead Guardian in post Time and resources provided to the FTSU Guardian Further review is needed to understand the resources provided to the wider FTSU team.
• Create (if not already in place), maintain and regularly evaluate a network of Freedom to Speak Up Champions/Ambassadors to support raising awareness and promoting the value of speaking up, listening up and following up.	• Plans in place to develop FTSU Champion network November 2023 – awaiting new guidance from NGO due November 2023
• Provide emotional and psychological well-being support to Freedom to Speak Up Guardian(s). This support should reflect the challenges of the role and ensure the need for confidentiality. There should also be periodic check-ins with Freedom to Speak Up Guardian(s) about the effectiveness of this support.	• Supervision support currently being established for FTSU Team.

Appendix 2
Freedom to Speak Up Data 2022- 23

Concerns	End of Year 2019/20	End of Year 2020/21	End of Year 2021/22	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	End of Year 2022/23
Number of people raised directly with the Freedom to Speak Up Guardian	54	66	94	24 (including one team)	23 (including one team)	25 (Including one team	26	98
Number of issues raised anonymously	19	31	26	9	4	7	14	34
Nature of issue								
- Patient quality issues	*12	19	24	8	2	2	2	14
- Staff experience - unacceptable behaviour (bullying / harassment)	*42	78	101	22	22	13	20	77
- Worker Safety	--	--	--	3	4	1	1	9
Action	Yes	Yes	Yes	Yes	Yes	Yes	Yes	yes
Outside referral	0	0	0	0	0	0	0	0
Number of case where people indicate detriment	1	15	2	2	2	2	0	6
Of the people asked in this quarter who would speak up again	87%	The majority of individuals would speak up again.	The majority of individuals would speak up again.	The majority of individuals would speak up again.	The majority of individuals would speak up again.	The majority of individuals would speak up again.	The majority of individuals would speak up again.	The majority of individuals would speak up again.

Report to Board of Directors	
Date	14 September 2023
Title	**Engagement and Involvement Annual Review 2022-23 and Community Engagement Tracker**
Author /Sponsoring Director/Presenter	**Author:** Juwairiyia Motala, Community Outreach Worker, and James Brown Director of Engagement, Involvement & Communications. **Sponsors:** Dr Claire Radley, Director for People & OD

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

Summary of Report

Purpose

- To present to Board the final our Engagement and Involvement Annual Review 2022-23 and Community Engagement Tracker, which is a key milestone of our Engagement and Involvement Strategy.
- The Annual Review will be published to sit alongside our Annual Report and Quality Accounts.
- The review provides a summary, case studies and activities over the last year, as well as next steps.
- The review will also be used as part of the refreshed CQC framework and expected NHS England framework for community and public engagement.

Key issues to note

- The annual review is our third formal report on our engagement and involvement activity.
- The annual review sets out why engagement and involvement is important to the Trust and how we have worked with local people, community groups and partners over the last year.
- Over the last year the Trust has been an active part of 58 groups and community events, reaching over 8,700 people, enabling us to gain valuable insight into how we can improve access to services.
- The review sets out who our local communities are and the challenges of health inequalities across the county.
- Our commitment to engagement is a core element of the Care Quality Commission (CQC) well-led domain.

We have previously shared the draft annual review with CQC as part the Well-led review.

- The Trust has also developed its first Community Engagement Tracker, detailing the monthly activity undertaken – which also forms part of our reporting to NHS Charities Together.
- The CQC has significantly changed the focus of much of its regulatory framework, with a primary focus on 'people and communities' and assessing how NHS organisations involve, engage and listen to local people in improving services.
- In addition, it is expected that NHS England will relaunch the NHS Oversight Framework for Patient and Community Engagement, whereby individual organisations and systems are assessed and rated on the quality of the community and public engagement.

Strategy approval route:

- Strategy & Transformation Delivery Group – 1/6
- People & OD Committee – 6/6

Risks or Concerns

No risks on the Trust Risk Register relate specifically to Engagement, but good, effective engagement is included in the mitigating actions for a number of risks that sit at Divisional and programme level.

We have a legal obligation to engage and consult when it comes to service reconfiguration, Planning, assuring and delivering service change for patients (NHS England 2018). CQC well-led domain includes Key Lines Of Enquiry (KLOEs) on engagement.

Financial Implications

None

Approved by: **Director of Finance / Director of Operational Finance**	**Date:**

Recommendation

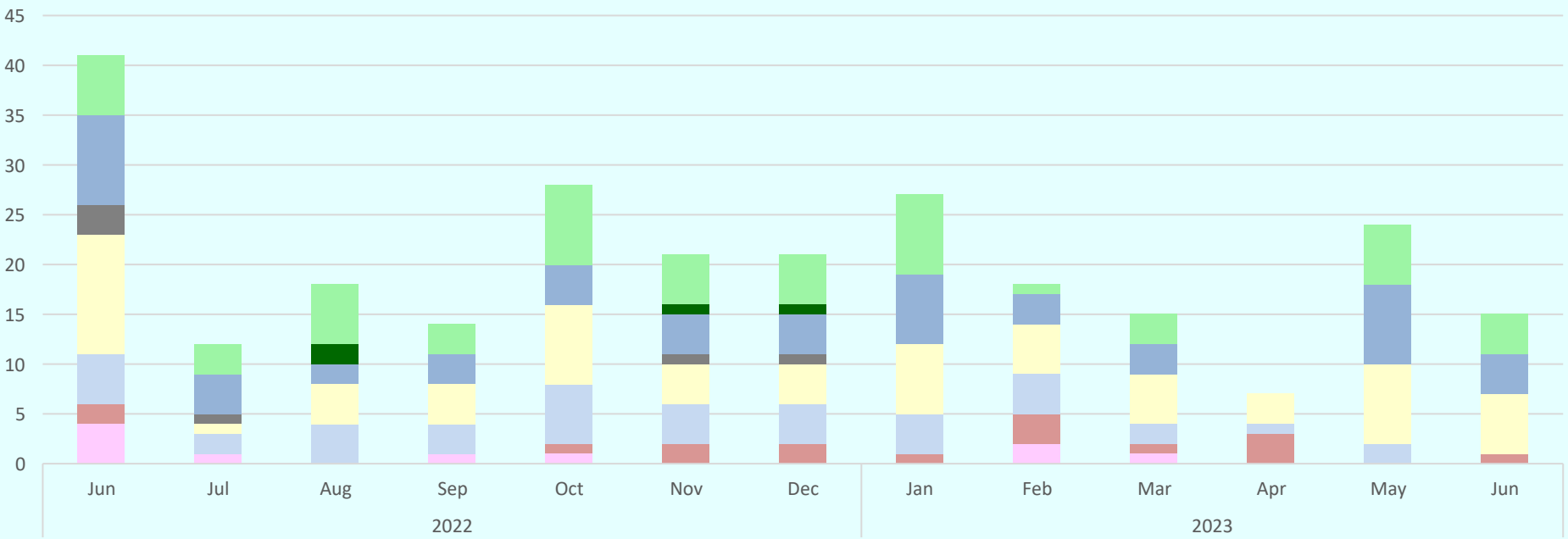
- That Board take note of the Engagement and Involvement Annual Review.
- Provide feedback and comments – and any areas for future development.

Enclosures

Engagement & Involvement Annual Review

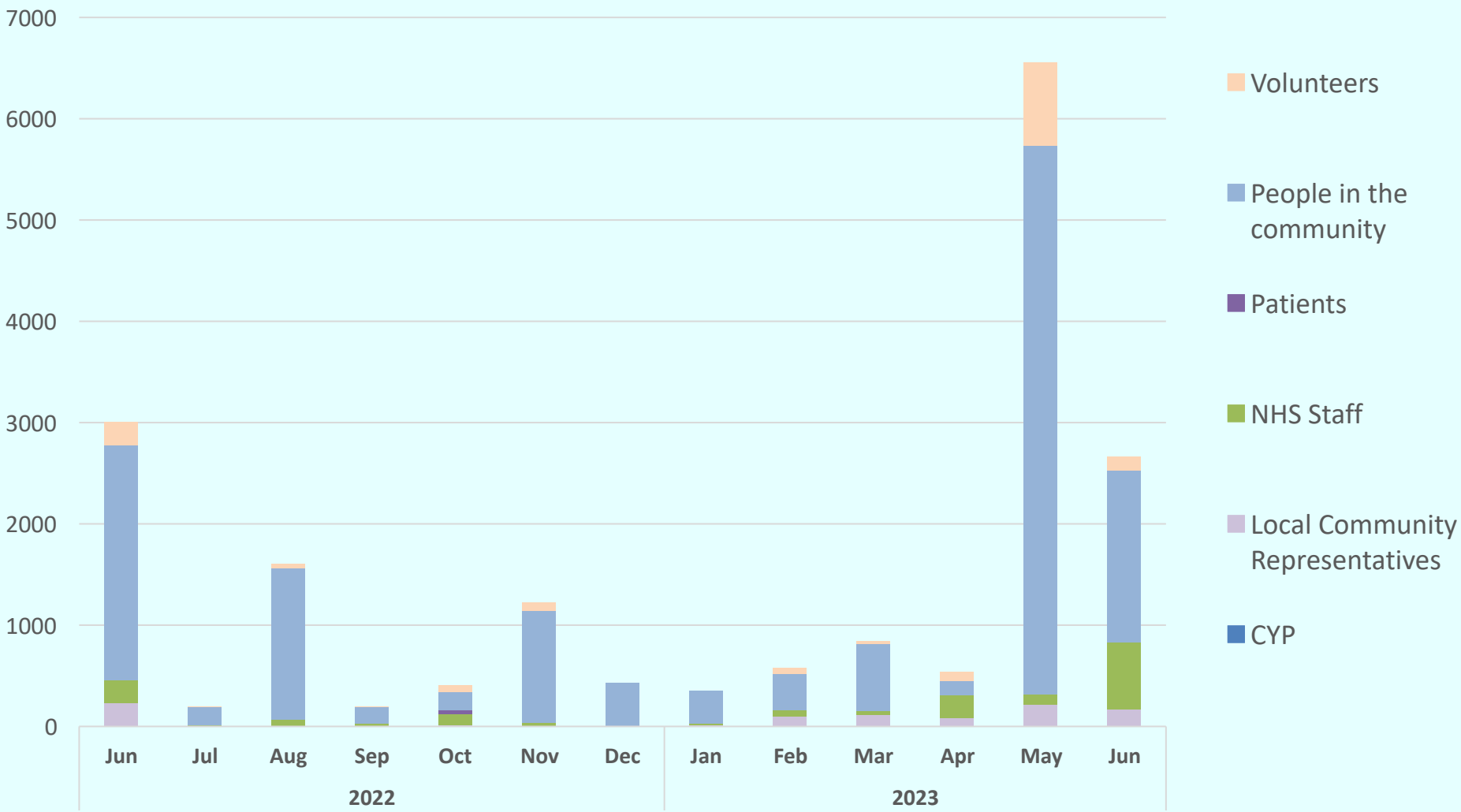
Our community engagement

Community Engagement Themes



- Awareness of specific pathways/conditins
- Collaborative work with other organisations
- Community Wellbeing/Social Prescribing
- Connecting with communities / building relationships with communities
- Formal consultation and engagement
- Patient access Improving the patient experience
- Patient communication and information

Community Involvement



Engagement & Involvement Strategy

Pillar	Year 1	Year 2	Year 3	Year 4	**Overall**
Our Service Users & Supporters					
Our Colleagues					
Our Partners					
Our Places & Communities					
Strategy					

Pillar - Our Service Users & Supporters

Domain	Milestone - Year 1	Year 2	Year 3	Year 4
Patient and carer involvement in service delivery, and service improvement and development	Establish a framework for involvement and engagement to support stakeholders and staff	Develop person-centred care charters with involvement of patients/carers	Evaluate quality of divisional decision-making and governance to assess how feedback from patients and service users has been captured and used	Patients and carers are involved in strategic planning, governance and in evaluating the Trust's performance and strategic progress
	Plan stakeholder engagement across all Journey to Outstanding enabling strategies		Increase feedback and response to surveys	
	Establish Engagement and Involvement tracker to monitor the activity and impact across services and programmes within the Trust	Embed use of patient and staff experience stories in divisional governance	Generate evidence on how engagement and involvement supports greater equality and inclusion for patients and colleagues	
	Establish annual impact report covering all engagement and involvement work			
Foundation Trust Membership	Develop new membership strategy and improve communication and engagement with Members	Maintain an accurate membership database which supports greater digital communication	Increase number of active members	Ensure the Trust membership is representative of the communities it serves in terms of disability, age, gender and ethnicity
	Promote the work of the Trust and Governors, encouraging greater attendance at Governor meetings and the Annual Members Meeting	Develop active two-way engagement between Members and Governors	Evaluate quality of member engagement	

Pillar - Our Colleagues

Domain	Milestone - Year 1	Year 2	Year 3	Year 4
Employee, volunteer and Governor engagement at all levels in the Trust	Establish an ongoing 'continuous listening' programme involving leaders at all levels	Ensure listening to staff and acting on feedback is reflected in divisional governance and is aligned to the staff related equality objectives	Strengthen pool of potential governor candidates - enhancing diversity and increase election turnout	Closure of the gaps outlined in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) - in line with the People and OD Strategy
	Undertake co-design programme to improve internal communications, establishing more tailored messaging and wider range of communication channels	Establish strategic programme for medical engagement, with programme support and co-ordination in place	Routinely triangulate colleague experience to identify areas of the Trust where more intensive support is required from People and OD team	
		Strengthen use of real-time experience data to influence priorities and action	Evaluate volunteer and governor experience through bespoke surveys and apply findings to support and development priorities	Be recognised as a Top 100 Employer for LGBT inclusion within the Stonewall Workplace Equality Index
Developing and supporting leaders and managers working at team, service and operational levels	Launch and deliver compassionate leadership training to strengthen the way in which leaders listen to and engage with colleagues	Build competency in listening to, giving and responding to feedback through leadership and management development programmes	Develop regular reporting of staff experience data into divisional and corporate governance, and agree actions required from leaders and managers	**Achieve higher staff engagement scores in the NHS staff survey, 7.6/10. Focus particularly on improving the scores relating to the opportunity staff have to contribute to improvements and Net Promoter**
	Review arrangements for briefing and cascading information to staff within each division	Use triangulation of staff experience data and themes to prioritise leadership development	Review governance arrangements within the Trust to ensure strong staff and patient representation	
Decision-making	Work in collaboration with the Pathways Programme to establish staff councils, across professional disciplines	Support leaders and managers to strengthen their approach to leading organisational change to better involve staff	Services have established staff Councils and achievements are widely shared	**Trust achieves accreditation for Pathways Programme**

Pillar - Our Partners

Domain	Milestone - Year 1	Year 2	Year 3	Year 4
Integrated Care System and Integrated Locality Partnerships	Develop programme to map system changes and plan joint approach to stakeholder engagement and ensuring consultation requirements are met	Establish and embed shared best practice model for engagement, involvement and consultation	Further integrate system level strategic and operational planning of engagement, involvement and communications activities	Ensure partnership approach to engaging stakeholders in reviewing/improving care pathways that span organisational boundaries
	Engagement and Involvement Impact Report developed and shared with partners	Ensure system and service leaders understand legal obligations for involvement and engagement	Improved partnership working and communications recognised by the CQC	Insights from patients and communities identify system as well as service priorities for improvement
	Stakeholder survey undertaken annually that invites partners to offer feedback on working with the Trust as a partner			
Academic and Education Partners	Ensure that we play a key role in the development of the Three Counties Medical school	Use engagement and involvement infrastructure to support increased patient and staff participation in research trials and the visibility and awareness of research activity across the organisation	Ensure that engagement supports the further development of a system wide research strategy	Increase the number of research collaborations with universities and commercial partners
	Ensure we have a strong voice in the development of Research 4Gloucestershire as the research arm of the Integrated Care System			
Clinical Networks, Alliances and Programme Groups	Influence the development of the clinical networks across the South West and the Midlands		Triangulation of system wide experience data and stakeholder insight and involvement shapes priorities for clinical collaboration and improvement across the One Gloucestershire Integrated Care System	
Hospitals Charity	Support the Trust Charity in enhancing the visibility of the brand and increase fundraising		Support further market and stakeholder research work to inform plans to increase fundraising	

Pillar - Our Places & Communities

Domain	Milestone - Year 1	Year 2	Year 3	Year 4
Healthwatch Gloucestershire	Develop proactive briefing programme whereby key stakeholders are kept informed on strategic programmes and developments – via GiG	Develop arrangements for joint projects on specific themes where strategic priorities are shared across the partnership		
Voluntary, Community and Social Enterprise Sector Involvement Network	Establish Involvement Network and regular programme of meetings, conversations and events	Agree role of the network in supporting the development of person-centred care charter	Share feedback and equality data routinely to prioritise where improvement is needed most in quality, access or experience for different groups or communities	Evaluate impact of the network to inform further development
	Map out our population and the communities we serve that we want to reach	Share annual impact report of Engagement and Involvement work	Collaborate on capacity building for engagement, involvement and improvement	Real-time experience and insight data is used to shape priorities for collaboration

Plans 2023-24

Finally.....


STAFF
AWARDS
2023
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Gloucester
HOSPITALS CHARITY


HSJ AWARDS 2023
In Partnership with:
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16 November 2023
We are proud to be shortlisted
NHS Race Equality Award
Award partner:
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Q
&
A

Involvement and Engagement Tracker

Gloucestershire Hospitals NHS Foundation Trust

It is really important that we are able to listen to colleagues, patients, local people and communities across Gloucestershire about their experiences of using our health and care services and to help shape improvements. Our involvement and engagement tracker records the level of activity and demonstrates how it has informed and influenced decision-making across the organisation.

Community Engagement and Involvement Activity – 1 April 2022 to 31 March 2023

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
Gloucester Feed the Hungry – 34 The Oxebode Gloucester	People in the community	Fortnightly (18 visits between May 2022 to January 2023)	50	How accessible are Trust Services/ health pathways for the homeless community?	Requested & shared information on Health and VCSE organisations and initiatives happening based on Community Outreach Worker knowledge	Increased planned care appointments. Support was offered to a young service user who was attending A&E to access a warm space & a drink. Signposted to Gloucestershire Nightstop Homeless charity. Support was given to a patient going for a hip replacement, as she was anxious about being away from home as Operation was in Oxford, chatted through ways to feel less isolated as will be away from family/friend's support. Network.	www.yourcircle.org.uk/Services/15188 Home - Gloucestershire Nightstop
Free study Club Friendship cafe	People in the community Volunteers	Fortnightly (40 sessions visits between May 2022 to January 2023)	12 – 20 people weekly	How can communities be supported to tackle cycles of poverty and increase educational attainment	More funding to support free study clubs	Provided funding to support activities that go in to running the free study club in Friendship café Provides a safe space outside of school, allowing young people to interact with peers and other individuals outside of the home and	Saturdays 10 –11 at friendship café youngthinkersgloucester

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
						getting more used to socialising in a post COVID setting.	
Diabetes (targeted more for middle aged people)	People in the community Patients	28/05/2022	20	What conditions would communities want further health education on	Diabetes	Helps those who may not have had access to a GP in the pandemic or are struggling for GP access currently to know the warning signs of diabetes which is more prevalent among core 20 groups	www.facebook.com/youngthinkersgloucester
BME Dementia Education & Information Event, Friendship Café, Gloucester.	NHS Staff & People in the community	08/06/2022	150	How accessible are Trust Services health pathways for the patients & carers suffering from Dementia?	Requested information on Health and VCSE organisations and initiatives happening based on community outreach worker knowledge.	Provided information to encourage access to early screening, addressed misconceptions and Increased confidence from people from ethnic minority backgrounds in our services.	Memory problems and dementia > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk) Dementia From the Inside by Jennifer Bute | Dementia Resources (3ndementiawg.org) Crossroads Gloucester Memory Café (crossroadsglos.org.uk)
Unreflected Reflections, Friendship Café, Gloucester.	NHS Staff & People in the community, Volunteers	13/06/2023	100	How accessible are Trust Services/health pathways for the members of the Ethnic Minority community?	Requested information on Health and VCSE organisations and initiatives happening based on community outreach worker knowledge	Provided ethnic minorities with information to encourage access to early interventions addressed misconceptions and Increased confidence from people from ethnic minority backgrounds in our services.	Unreflected Reflections - Voices Gloucester
Big Health & Well-Being Day, Plock Court, Gloucester	People in the Community NHS & Partner Organisations Staff & volunteers	17/06/2022	1500+	How accessible are Trust Services/ health pathways for the service users with additional needs?	Requested & shared information on Additional Accessibility Support & Voluntary Organisations. The event is aimed at helping people with learning disabilities with	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services	Big Health > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk) The aim of each Big Health Day is to:

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
					complex physical and emotional health needs, people with physical disabilities and sensory impairments, autistic people and anyone with mental health support needs to stay active and healthy.	Increased confidence from people from ethnic minority backgrounds	To deliver an inclusive event with the theme of staying healthy and active, meeting friends and having fun. To reduce health inequalities for people living with a learning disability, a physical disability and/or mental health problems and help people to help themselves, through activities outlined in our programme
Windrush Generation Event, All Nations Club, Gloucester	People in the Community & NHS Staff & Volunteers.	22/06/2023	200	Sharing & Celebration Event Voluntary Organisations & in collaboration with the Office of the Police and Crime Commissioner	The Sharing of Community stories, of the Windrush Generation who came to the U.K to join the NHS as Nurses.	Listening to Community Stories from NHS Staff and community members. Watched community documentary about the NHS Nurses who were from the Windrush Generation.	Lives of Colour: I-MMigrate Exhibition - The Museum of Gloucester Home | All Nations Community Centre (anccglos.com)
Skillzone, Community Safety Team Gloucestershire Fire and Rescue Service Tuffley Lane Tuffley Gloucester,	NHS Staff & Volunteers & People in the Community	22/06/2022	25	Information sharing event for Fire Safety Checks from the Complex Needs Officer & Safeguarding Coordinator Community Safety Team	Following patient discharge from acute care, what support is available in the home.	Encourage more appropriate use of VCSE services & support for hospital to home services.	We enable and support communities, individuals and stakeholders to be empowered, and take control of their health, wellbeing and care journey in a manner that best suits them. www.jigsawco-op.org.uk

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
				Gloucestershire Fire and Rescue Service			
Meet Little Amal by Invitation Cheltenham Community Event	People in the community	23/06/2022	250	How accessible are Trust Services/health pathways for the refugee community?	Requested information on Health and VCSE organisations and initiatives happening based on community outreach worker knowledge	Increased planned care appointments Increased confidence from people from ethnic minority backgrounds	www.walkwithamal.org
Prostate Cancer Awareness Event; All Nations Community Centre – Gloucester	NHS & Police Staff & People in the Community	22/06/2022	250	How accessible are Trust Services/health pathways for the members of the Ethnic Minority community?	Requested information on Health and VCSE organisations and initiatives happening based on community outreach worker knowledge	Provided ethnic minorities with information to encourage access to early screening, addressed misconceptions, and Increased confidence from people from ethnic minority backgrounds in our services.	Next event - 01/03/2023 5-7 pm All Nations Community Centre - Cancer Services from GHNHSFT. Cancer services videos YouTube: GHNHSFT Cancer services
Open Arms Artist Collective, Bethesda Methodist Church, Cheltenham	NHS Staff & Volunteers & People in the Community	30/06/2022	75	How accessible are Trust Services/health pathways for the patients & carers suffering from Dementia?	Requested information on Health and VCSE organisations and initiatives happening based on community outreach worker knowledge	Provided information to encourage access to early screening, addressed misconceptions, and Increased confidence from people from ethnic minority backgrounds in our services. Open Arms specialise in working with people living with dementia and their supporters/carers.	Open Arms Artist's Collective (openarmsartists.org.uk)
McMillan Information Hubb at Friendship Café, Gloucester	People in the Community	28/07/2023	50	How accessible are Trust Services/health pathways for the members of the Ethnic Minority community?	Addressing specific information leaflets to encourage dialogue surrounding barriers for people from ethnic minority backgrounds accessing these services including lack	Provided information to encourage access to early screening, addressed misconceptions and Increased confidence from people from ethnic minority backgrounds in our services.	The service offers support and information to anyone who has concerns about cancer, their relatives, friends and carers

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
					of knowledge process & support of Cancer Screening & Hospital pathways.		Macmillan Cancer Support Information Hub (gloshospitals.nhs.uk)
Jamaican Independence Day, Gloucester Park	People in the Community NHS & Partner Organisations Staff & volunteers	07/08/2023	1000	With the NHS Information Bus. How accessible are Trust Services/health pathways for the members of the Ethnic Minority community?	Addressing specific information leaflets to encourage dialogue surrounding barriers for people from ethnic minority backgrounds accessing these services Requested & shared information on Health and VCSE organisations and initiatives happening based on Community Outreach Worker knowledge	Provided ethnic minorities with information to encourage access to early screening, addressed misconceptions, and Increased confidence from people from ethnic minority backgrounds in our services.	Glosjam to celebrate 60 years of Jamaican independence this weekend - Gloucestershire Live You searched for 2023 events - Gloucester BID - Business Improvement District
St James Park Cultural Fete	People in the Community NHS & Partner Organisations Staff & volunteers	20/08/2022	500	With the NHS Information Bus. How accessible are Trust Services/health pathways for the members of the Ethnic Minority community	Addressing specific information leaflets to encourage dialogue surrounding barriers for people from ethnic minority backgrounds accessing these services Requested & shared information on Health and VCSE organisations and initiatives happening based on Community Outreach Worker knowledge	Provided ethnic minorities with information to encourage access to early screening, addressed misconceptions, and Increased confidence from people from ethnic minority backgrounds in our services. St James Park Cultural Fete is a fun-filled and free summer festival Its aims are to celebrate and enhance the life of our park and its community, by bringing communities together.	News | St. James's Place Charitable Foundation (sjpfoundation.co.uk)
McMillian Information Hub, Redwell	Local Community NHS & Partner Organisations	01/09/2022	100	Patient information sharing event.	Sharing information leaflets to encourage dialogue surrounding barriers for people from diverse/disadvantaged	Increased planned care appointments Reduction in emergency attendance	The service offers support and information to anyone who has concerns about cancer,

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
Centre, Matson	Staff & volunteers				backgrounds accessing these services Requested & shared information on Health and VCSE organisations and initiatives.	Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	their relatives, friends and carers Macmillan Cancer Support Information Hub (gloshospitals.nhs.uk)
75 Years My Story – Strike A Light, Gloucester	Local Community & others.	Fortnightly (8 visits between October 2022 to January 2023)	20	How accessible are Trust Services/health pathways for the members of the Ethnic Minority community especially when this is a community group within a community group.	Sharing information leaflets to encourage dialogue surrounding barriers for people from diverse/disadvantaged backgrounds accessing these services. Requested & shared information on Health and VCSE organisations and initiatives.	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds especially widowed women from minority backgrounds.	Since 2013, we've been working in Gloucester to create great cultural events and experiences that can bring communities together, make life vibrant and exciting – and change things for the better. In that time, we've learned loads about what works and what doesn't Strike A Light
Friendship Café Women's Walking Group, Stinchcombe Hill, Golf Course	Local Community	10/10/2022	40	How accessible are Trust Services/health pathways for the members of the Ethnic Minority community?	Sharing information leaflets to encourage dialogue surrounding barriers for people from diverse/disadvantaged backgrounds accessing these services Requested & shared information on Health and VCSE organisations and initiatives.	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	The Friendship Cafe | We provide youth & community-based activities
Music Works – BHM Event Gloucester	NHS & Partner Organisations Staff & volunteers	21/10/2022	150	Asked if people knew about Career & Volunteer opportunities	Requested information on career opportunities at GHFT.	Increased confidence from people from ethnic minority backgrounds on roles they may eligible for, how to find them and where to apply.	www.themusicworks.org.uk/about-us/what-we-do/

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
				within NHS Organisation & Local Authority Services?			
Stroud	Local Community	7/06/2022	100	Engaged to ask what the public thought of the proposed plans for FFTF2 - NHS Information Bus	FFTF Phase 2 – NHS Information Bus – Asking Members of the community to share feedback on Phase 2	50+ engagement events. 6 Facebook Live events Over 1,800 face-to-face conversations with public and staff Facebook info reached 64,500 individual people. Twitter info had over 55,000 impressions 200+ Fit for the Future 2 surveys complete	Fit for the Future: consultation on specialist hospital services is underway (gloshospitals.nhs.uk)
Cheltenham	Local Community	11/06/2022	100	Engaged to ask what the public thought of the proposed plans for FFTF2 - NHS Information Bus	FFTF Phase 2 – NHS Information Bus – Asking Members of the community to share feedback on Phase 2	50+ engagement events. 6 Facebook Live events Over 1,800 face-to-face conversations with public and staff Facebook info reached 64,500 individual people. Twitter info had over 55,000 impressions 200+ Fit for the Future 2 surveys complete	Fit for the Future: consultation on specialist hospital services is underway (gloshospitals.nhs.uk)
Bowel Cancel Screening event - awareness talk at Rosebank GP practice	People in the community Patients	12/06/22	15	What conditions would communities want further health education on	Conditions that are associated with stigma included Cancer	Helps those who may not have had access to a GP in the pandemic or are struggling for GP access currently to know the warning signs of diabetes which is more prevalent among over 80s and among particular minority groups	www.facebook.com/youngthinkersgloucester
Cirencester	Local Community	14/06/2022	150	Engaged to ask what the public thought of the proposed plans for FFTF2 - NHS Information Bus	FFTF Phase 2 – NHS Information Bus – Asking Members of the community to share feedback on Phase 2	50+ engagement events. 6 Facebook Live events Over 1,800 face-to-face conversations with public and staff Facebook info reached 64,500 individual people.	Fit for the Future: consultation on specialist hospital services is underway (gloshospitals.nhs.uk)

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
						Twitter info had over 55,000 impressions 200+ Fit for the Future 2 surveys complete	
Sahara Saheli Women's Group	Local Community	28/06/2022	20	Sharing Event Voluntary Organisations Discussion group about women's knowledge of the process & support of Cancer Screening & Hospital pathways.	There are specific barriers for South Asian women accessing these services including lack of knowledge process & support of Cancer Screening & Hospital pathways.	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Leaflets shared from McMillian Cancer Services. Focus Charity Cancer Services information shared. YouTube - Cancer Services
Open Arms Artist Collective (Dementia Support Group)	Volunteers People in the community NHs Staff	30/06/2022	40	How accessible are Trust Services/health pathways for Carers & Dementia Patients?	Requested & shared information on Dementia Support & Voluntary Organisations	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services	www.openarmsartists.org.uk/
Engagement with South Asian Community	People in the Community & NHS Staff & Volunteers.	27/07/2022	100	Navigating Mental Health Services	Difficulty accessing MH pathway, understanding support services available	Increased confidence from people from ethnic minority backgrounds. Encourage more appropriate use of VCSE services	Information sign-posting to Voluntary MH Organisations. Gloucestershire's Mental Health Services | Have Your Say Gloucestershire (engagementhq.com)
Anglo Asian Chinese Community	People in the Community & NHS Staff & Volunteers.	22/08/2022	15	How accessible are Trust Services/health pathways for the members of the	Requested information on Dementia Support & Voluntary Organisations	Increased planned care appointments Reduction in emergency attendance	The Anglo-Asian Cultural Centre | Buildings and Places (General) | Barton

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
				Ethnic Minority community?		Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	and Tredworth Community Heritage
Friendship Café – Youth Event	People in the Community	10/08/2022	45	Careers Opportunities in the NHS Information Event.	Sign-posting of Apprenticeship opportunities in NHS and voluntary organisations available.	Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Contact our team via - ghn-tr.apprenticeships@nhs.net to seek advice, information or guidance regarding Apprenticeships & Careers with our Trust
GL1 – Healthy Lifestyles	People in the Community & Patients	12/09/2022	30	How accessible are Trust Services/health pathways for the members of the Ethnic Minority community?	Requested information on Dementia Support & Voluntary Organisations Arranged for following to attend the Healthy Lifestyles Group	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	HLS Gloucestershire - Home (hlsglos.org)
Friendship Café	NHS & Police Staff with local Community Representatives Groups.	15/09/2022	15/20	Sharing Event Voluntary Organisations	The process to join Young Influencers & Trust Governor Membership.	Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Information Bus: NHS Gloucestershire ICB (nhsglos.nhs.uk) www.gloshospitals.nhs.uk/about-us/support-our-trust/our-youth-group/

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
CPR and first aid & cardiac teaching event (all ages)	People in the community Volunteers	16/09/2022	50	Do communities need CPR training	CPR training workshops	Early health intervention for chronic conditions - Hugely deprived area. these kids are first and second generation from non-English speaking families and the initiative gives them skills to get out of deprivation that they can pass on to younger students as they progress into later stages on	www.facebook.com/youngthinkersgloucester
Gallery ward 2 – GRH	Local Community Representatives & Voluntary Services	14/10/2022	15	Tour of new Gallery Ward 2 (Care of the Elderly)	Patient Care	Reduction in emergency attendance Increased planned care appointments	www.gms-facilities.co.uk/news/health-care-facilities-management-specialist-takes-on-management-of-new-4-5m-hospital-ward/
Cancer Awareness Talk	Patients & Volunteers	11/10/2022	50	Cancer Awareness Sessions delivered by GPs – Cancer Screening	Process Cancer Screening & Hospital pathways. Early Detection, the importance of early detection/screening	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Cancer awareness videos on YouTube: Cancer Services
NHS Careers Information Event. Friendship Café Gloucester	NHS Staff, Volunteers People in the community	27/10/2022	65	Careers Opportunities in the NHS	NHS Information Van – NHS Careers and Apprenticeships	Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Contact our team via – ghn-tr.apprenticeships@nhs.net to seek advice, information or guidance regarding Apprenticeships & Careers with our Trust

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
Mosque Visit	Volunteers People in the community	28/10/2022	20	Multi-Faith Community Event	How religious beliefs impact personalised care for patients.	Increased confidence from people from ethnic minority backgrounds	Mosque visits together with other Community Voluntary Organisations. Masjid-e-Noor Gloucester UK (masjidenoor.org.uk)
BME Mental Health Information Event. Friendship café	Patients, People in the Community	7/11/2022	70	Navigating Mental Health Services	Difficulty accessing MH pathway, understanding support services available	Increased confidence from people from ethnic minority backgrounds. Encourage more appropriate use of VCSE services Information sign-posting to Voluntary MH Organisations.	The Friendship Cafe | We provide youth & community-based activities Gloucestershire's Mental Health Services | Have Your Say Gloucestershire (engagementhq.com)
Gloucester Chinese Women's Guild	Patients, People in the Community	14/11/2022	35	Navigating Mental Health Services	Difficulty accessing MH pathway, understanding support services available	Increased confidence from people from ethnic minority backgrounds. Encourage more appropriate use of VCSE services Information sign-posting to Voluntary MH Organisations.	Gloucestershire Chinese Women's Guild 告羅士打郡華人婦女會 - Home (gcwg.org.uk) Gloucestershire's Mental Health Services | Have Your Say Gloucestershire (engagementhq.com)
National Inter-Faith Week (Week of 15th November)	Patients, People in the Community, NHS Staff & Other	15/11/2022	350	Multi-Faith Community Event This year for National Interfaith Week in Cheltenham we are Sharing our Spiritual Homes.	How religious beliefs impact personalised care for patients	Increased confidence from people from ethnic minority backgrounds Encourage more appropriate use of VCSE services Aim to deepen understanding of different faiths and to reflect on our own beliefs. Visits to Gas Green Baptist Church, St. Gregory's Roman Catholic Church, the Hindu	www.interfaithweek.org/

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
						Community Centre, the Kadampa Buddhist Centre, the local Bahai community, the Lower High Street Mosque and Cheltenham Orthodox Jewish Community.	
Gloucester Rugby Stadium	Patients, People in the Community, NHS Staff & Other	17/11/2022	285	How do religious beliefs impact personalised care for patients?	Patient sign-posting of health services and voluntary organisations available.	Increased confidence from people from ethnic minority backgrounds. Encourage more appropriate use of VCSE services	Gloucestershire VCS Alliance - Gloucestershire VCS Alliance (glosvcsalliance.org.uk)
Strike A Light – Hope Notes, Guildhall Gloucester	People in the Community & Other	10/11/2022	125	How accessible are Trust Services/health pathways for the refugee community?	Patient signposting of health services and voluntary organisations available.	Increased confidence from people from ethnic minority backgrounds. Encourage more appropriate use of VCSE services	Stories of Refuge Presentation https://strikealight.org.uk/2022/10/19/hope-notes/
Men's Walking & Well-Being Group- Friendship Café	NHS Staff, People in the Community, Patients	23/11/2022	6	Community Well-Being Activities for patients with LTC & carers Weekly Wednesday health support session for Local Men from ethnic minority backgrounds with LTC.	GHC Reaching Out Team offer support to patients living with LTC.	Increased confidence from people from ethnic minority backgrounds. Encourage more appropriate use of VCSE services .	GHC Reaching Out Team – Complex Care at Home Health Checks. Integrated Community Teams > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk)
Bangladeshi Women's Healthy Lifestyles Group	NHS Staff, People in the Community, Patients	27/11/2022	35	Community Well-Being advice for Community	Information Session on PALs service surrounding key areas of service offered. (Interpreter was used for the session)	Increased confidence from people from ethnic minority backgrounds. Provide advice about the NHS and support groups outside the NHS	Patient advice and support (gloshospitals.nhs.uk)
Community Engagement	People in the Community	22/11/2022	250	Cascade of NHS Job Vacancy	Shared NHS Vacancies being advertised through Community Groups for a fairer representation	Increased confidence from people from ethnic minority backgrounds.	The Friendship Cafe | We provide youth &

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
					from Diverse Minority Groups.	Encourage more appropriate use of VCSE services	community-based activities
Wilson Cheltenham Art Gallery & Museum	NHS Staff, People in The Community	13/12/2022	25	Community Well-Being Activities for patients.	Patient signposting of health services and voluntary organisations available.	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Gloucestershire events (soglos.com) Cheltenham Events 2023 | What's on in Cheltenham | Skiddle The Wilson – Cheltenham Art Gallery & Museum – The Wilson is Gloucestershire's premier art gallery and museum (cheltenhammuseum.org.uk)
Community Engagement Gloucester	Patient, People in the Community	28/12/2022	8	Community Well-Being advice for Community	Patient signposting of health services and voluntary organisations available.	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	NHS Organ Donation Support Organ donation (gloshospitals.nhs.uk) Home - NHS Organ Donation
Community Engagement Gloucestershire.	People in the Community & ICB Staff	21/12/2022	300+	Winter Campaign Information	Cascade Relevant UpToDate Health Information via social media/ WhatsApp to Community Groups. Advice for parents and carers about common winter illnesses in children that can be	Increased planned care appointments Reduction in emergency attendance Increased confidence from people from ethnic minority backgrounds	*www.nhsglos.nhs.uk/news/health-and-care-services-prepare-for-a-challenging-winter/* *www.nhsglos.nhs.uk/news/scarlet-fever-advice-for-parents-and-carers/*

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
					safely managed at home. It also includes the signs and symptoms of Strep A and Scarlet Fever.		
High Street, Cheltenham	Community (Turkish, Syrian, Polish & a few elderly	4/1/2023	25	Are Trust services accessible to members of ethnic & diverse minority groups?	Patient signposting of health services & local voluntary organisations is available	Increased planned care appointments	Burglary Prevention advice- Community Police Event Information Bus: NHS Gloucestershire ICB (nhsglos.nhs.uk)
Community Engagement	Local Community & Other	05/01/2023	200	Trust Membership Information We have around 2,000 members of our Trust. Read our Membership Strategy Join us today, it's quick, easy and its free.	Cascade of Information via Social Media platforms (and email)	Increased confidence from people from ethnic minority backgrounds	Join our Foundation Trust (gloshospitals.nhs.uk)
Oasis Centre, Cheltenham	CWR Awesome Women's Group	13/1/2023	15	How accessible are Trust Services/health pathways for the Refugee community?	Patient signposting of health services & local voluntary organisations available GARAS Welcome Cheltenham Refuge Program - Shared information about health services available, self-referral, and access to interpreters for appointments.	Increased confidence from people from ethnic minority backgrounds Encourage more appropriate use of VCSE services	www.garas.org.uk/

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
Masjid-e-Noor Mosque, Gloucester	NHS Staff & Partner Organisations	17/01/2023	25	How do religious beliefs impact personalised care for patients?	Multi-Faith Event – Staff learning about religious considerations linked to Bereavement/Birth/Religious Celebrations.	Increased confidence from people from ethnic minority backgrounds Encourage more appropriate use of VCSE services	http://gloucestermosquevisit.co.uk/guidance-notes-for-visitors/
Gloucester Chinese Women's Group, Gloucester	People in the Community & Others	23/01/2023	40	How do religious beliefs impact personalised care for patients?	Multi-Faith Event – Staff learning about religious considerations linked to Bereavement/Birth/Religious Celebrations Patient signposting of health services and voluntary organisations available.	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Integrated Community Teams > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk)
Masjid-Umar, Gloucester	People in the community NHS Staff	03/02/2023	60	GHC Reaching out Team Health Checks	Patient signposting of health services & local voluntary organisations available	Increased planned care appointments Reduction in emergency attendance Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	Integrated Community Teams > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk)
Arabic Gathering – Elmcroft Community Centre	People in the community NHS Staff	12/02/2023	80	How accessible are Trust Services/health pathways for the Refugee community?	Patient signposting of health services & local voluntary organisations available	Increased planned care appointments Reduction in emergency attendance	Contact ghn-tr.apprenticeships@nhs.net to seek advice, information or guidance regarding Apprenticeships & Careers with our Trust

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
					About career and apprenticeship opportunities available in the Trust	Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	HLS Gloucestershire - Home (hlsglos.org)
A Special Opening Ceremony to mark the Knife Angel's arrival. Gloucester Cathedral	NHS Staff Patients Volunteers People in the community Other	01/02/2023	150	The impact of Knife Crime in Gloucestershire on Acute services specifically A&E	Information sharing event to highlight youth crime in Gloucestershire., UpToDate MH support Information shared.	Reduction in emergency attendance Encourage more appropriate use of VCSE services	www.gloucesterbid.uk/knife-angel The Knife Angel | Gloucester Cathedral
Community Dementia Education & Information Event, Friendship Café, Gloucester	NHS Staff Patients Volunteers People in the community Other	15/02/2023	150	How accessible are Trust Services/health pathways for Carers & Dementia Patients?	Requested & shared information on Health and VCSE organisations and initiatives happening based on community outreach worker knowledge	Provided information to encourage access to early screening, addressed misconceptions and Increased confidence from people from ethnic minority backgrounds in our services.	Memory problems and dementia > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk) Dementia From the Inside by Jennifer Bute | Dementia Resources (3ndementiawg.org) Crossroads Gloucester Memory Café (crossroadsglos.org.uk)
On the Knife Edge, The Guildhall Gloucester.	Volunteers People in the community Other	22/02/2023	125	The impact of Knife Crime in Gloucestershire on Acute services specifically A&E	Information sharing event to highlight youth crime in Gloucestershire., UpToDate MH support Information shared.	Reduction in emergency attendance Encourage more appropriate use of VCSE services	The Knife Angel | Gloucester Cathedral "On a Knife Edge" - Live Performances about the impact of Knife Crime Tickets, Wed 22 Feb 2023 at 16:30 | Eventbrite

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
Bangladeshi Women's Healthy Lifestyles Group	NHS Staff Patients Volunteers People in the community Other	27/02/2023	30	Information Session on Diabetic Care surrounding key areas – Risk factors, Diabetic Reduction Course. Healthy Diet Family Education Groups.	There are specific barriers for South Asian women, especially due to language barriers accessing these services including lack of knowledge process & support of Diabetic care & Community Hospital pathways. (Interpreter was used for the session)	Provided information to encourage access to early screening, addressed misconceptions and Increased confidence from people from ethnic minority backgrounds in our services.	Community Diabetes Service > Glos Health & Care NHS Foundation Trust (ghc.nhs.uk)
Health Information Event – Prostrate Cancer Session	10 NHS Staff 10 Local Community Representatives 50 People in the community	1/03/2023	70	Process & Discussion of Prostate Cancer Screening & Hospital pathways.	Prostate cancer is the most common cancer in men in the UK. Although it affects all men, black men are 2-3 times more likely to develop this cancer than their white counterparts. The death rate is twice as high. Furthermore, black men are more likely to develop prostate cancer at a younger age. It is essential that black men know about their increased risk of prostate cancer.	Provided information to encourage access to early screening, addressed misconceptions and Increased confidence from people from ethnic minority backgrounds in our services.	NHS England » Time to talk about the prostate cancer risk in black men and what we can do about it
Careers day at Al Ashraf primary school	People in the community	06/03/23	100	How we can help empower young marginalised communities	To attend a careers fair	had a positive impact by inspiring the students and providing them with role models from their community.	www.facebook.com/youngthinkersgloucester
Bangladeshi Women's Healthy	5 NHS Staff 2 Local Community Representativ	06/03/2023	22	Information Session led by Hospital Clinical Staff on	Information & understanding of accessing Menopause health information	Provided information to encourage access to early screening, addressed misconceptions and Increased confidence from people	The menopause taboo for South Asian women | Stories (qvcuk.com)

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
Lifestyles Group	es 15 people in the Community			Understanding the Menopause surrounding key areas – Symptoms, HRT options. Healthy Diet Support Groups. & Education.	understanding GP support services available and the Hospital pathway for Genealogy (Interpreter was used for the session)	from ethnic minority backgrounds in our services.	Menopause - NHS (www.nhs.uk)
Friendship Café, Gloucester Exhibition – Threads the Red Dress	30 Local Community Representatives. 8 NHS Staff 150 People from the Community	14/03/2023	188	Refugee Story Sharing Event & Exhibition and Workshops for Women from Ethnic Minority Groups. An award winning global, collaborative embroidery project 2009 to 2023	Requested & shared information on Health and VCSE organisations and initiatives happening based on community outreach worker knowledge The Red Dress project, conceived by British artist Kirstie Macleod, provides an artistic platform for women around the world, many of whom are vulnerable and live in poverty, to tell their personal stories through embroidery.	Increased confidence from people from ethnic minority backgrounds Encourage more appropriate use of VCSE services	THREADS 2023: Launch of 'A Costume for Gloucester' project - Voices Gloucester The Red Dress reddressembroidery.com
Healthy Ramadan and diabetes webinar	People in the community Patients	15/03/23	20	What information people need to go into Ramadan healthier	Provided feedback on key topics	Ran webinar for community members	www.facebook.com/youngthinkersgloucester
Friendship Café Gloucester "Welcome Café "for Asylum Seekers	10 NHS Staff. 10 Local Community Representatives. 25 Asylum Seekers	16/03/2023	45	How accessible are Trust Services/health pathways for Asylum Seeker Patients?	Offered support & shared information on Health and VCSE organisations and initiatives happening based on community	Increased planned care appointments Reduction in emergency attendance	Migrant Health – Sirona care & health NHS services (sirona-cic.org.uk) GARAS

What / Where	Who	When	No of people	We asked (Activity)	You Said (Listened)	Impact (We did)	More information
					outreach worker knowledge	Encourage more appropriate use of VCSE services Increased confidence from people from ethnic minority backgrounds	
50 Plus Recruitment Event, The Guildhall Gloucester	10 NHS Staff 60 Local Community Representatives. 30 Volunteers 300 People from the Community	23/03/2023	400	Recruitment & Careers Opportunities within the Trust and Voluntary Services. 50Plus Choices is a fair for over 50s looking for new work and community opportunities.	The adult's recruitment team is attending the Department for Work and Pensions (DWP) recruitment event aimed at people aged over 50, at the Guildhall. The DWP has recently signed the Age-friendly Employer Pledge, a nationwide programme run by the Centre for Ageing Better to promote age inclusive working practices	The GNHSFT attended as part of the “The Age-friendly Employer Pledge” to encourage employers to: create an age-friendly culture hire age-positively be flexible about flexible working encourage career development at all ages ensure everyone has the health support they need We recognise the immense benefit that a multigenerational workforce brings and are delighted to support it.	. Over 50s Recruitment Event Gloucester Guildhall - 23 March 2023 - Adult Social Care Recruitment (gloucestershire.gov.uk)

KEY ISSUES AND ASSURANCE REPORT Finance and Resources Committee, 27 July 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**
None		
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
GMS Key Issues and Assurance Report	All KPIs not being met had been reviewed; plans and actions were in place for all areas. Work continued to close water related actions and cleaning standards were being met in high-risk areas. Recruitment and retention remained challenging.	There was additional focus on Recruitment and Retention and an update would be brought to this Committee in October
Financial Performance Report	At M3, the Trust was reporting a deficit of £7,831k; £884k adverse to plan. The drivers included industrial action. The Financial Sustainability Plan (FSP) target for the Trust was £34.7m. and year-to-date (YTD) the programme had delivered £6.5m of savings (£5.9m recurrent; £0.6m non-recurrent). The programme was slightly ahead of plan by £0.4m. Forecast outturn for 23/24 was £27.5m deficit unmitigated, reducing to £21.8m deficit after mitigations.	Work was taking place to understand and improve the position. 'Grip and control' meetings were taking place with the main focus was on emergency care, including temporary staffing. Conversations were taking place with NHSE.
Medium Term Financial Plan	NHSE required systems to produce a MTFP covering three years (with the first year being 2023/24). An initial plan was required in early September to show how systems would reach financial balance for 2024/25, a subsequent plan would be required later in the year to demonstrate how recurrent balance would be delivered. The Trust had built on the existing MTFP which showed an exit underlying position of £37m deficit and this was expected to grow to £69m. The Trust was modelling the impact of national tariff and inflation assumptions and the impact was c£20m per annum cost pressure (2.5% of annual spend). If no action was taken there would be an underlying deficit of £107m at the end of 2025/26. The Committee was concerned about the underlying financial balance.	Two workshops would be held in August to look at the underlying position and potential options; work was taking place across the Trust. An update to be provided to Board in September. As this was after the submission date to NHSE, a briefing would be shared in advance, along with an update to FRC in August. A Board meeting would be arranged if required.
Financial Sustainability Report	In M3, YTD performance was better than plan by £0.4m and for 23-24, green and amber rated scheme values were improving. The overall programme showed £10.9m of red schemes and although there had been an improvement there was still work to do.	Divisions were working on mitigations to assure delivery against plan. Focus continued around de-risking the 23/24 programme, and working with Trust and system partners to continue to find ways to generate efficiencies. A new governance process was being put into place.
Capital Programme Report	At M3, additional NHSE funding of £2.2m had been approved to support ERCP and CT Scanner projects. Expected in-year donations of £0.5m included in the Plan were yet to be secured, resulting in a current funded programme of £57.5m. YTD excluding IFRS16 capital, the Trust had goods delivered, works done or services received to the value of £10m, against a planned spend of £13.9m. This left £45.8m of non-IFRS16 capital to deliver in 23-24. In month, excluding IFRS16, the Trust	A graph comparing this year to last year would be provided in the next report. A 5-year plan would be provided at the August meeting.

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.

	delivered £2.7m against a forecast spend of £4.1m. An £8.0m increase in relation to IFRS16 capital had been reported within the forecast.	
Contract Management Group Overview Report	KPIs around the National Cleaning Standards and the Pseudomonas incident were noted. There were a number of outstanding actions related to the pseudomonas incident and work in progress was noted. Fire risk assessments had improved and a successful evacuation from theatres was noted. One health and safety incident was noted; no harm occurred.	KPIs were being progressed and were due to be signed off at the next Contract Management Group meeting.
GSSD Programme Status Update	At M24, the programme was forecast to overspend by £1.744M (4%) vs. programme budget of £44.5M, cost drivers behind this were noted.	An additional £1m was included within the 23/24 Estates Capital provision; mitigations for the remaining £744k were noted. Good engagement was taking place, digital schemes and areas of lower risk would be revisited, and it was anticipated that options would be available in the next two weeks. The overspend had been reported to the region.
Corporate Agency and Vacancy Review	Budget managers had reviewed establishment data, with a particular focus on any agency used and long-standing vacancies. This found that 19 (head count) admin & clerical and senior management agency staff were deployed at the Trust as at the end of June 2023, with potentially 7 agency staff due to leave during July; no other agency staff were due to commence a contract (as at the review date).	Further analysis of findings and a 'deep-dive' to designated areas would take place. The Committee received some assurance that there is a robust process in place for agency reviews. More work is required to understand the drivers and developing action plans to address the continued overspend on agency.
Estates Risk Register	There were 6 high scoring risks currently on the Risk Register. There were no new risks opened and no risks closed for this time period.	All risks now had a single domain reported on the register. The Trust's move to Cloud would be discussed to agree how that risk should be expressed.

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Reserved Matters	The Reserved Matters had been reviewed, streamlined and updated. This would give GMS authority to enter into contracts up to £1m. Strict governance arrangements would remain.	The Reserved Matters were APPROVED, subject to the addition that contracts must be made through a compliant route.
GMS Terms of Reference	The ToR for GMS would take affect from the start date of the newly appointed GMS Independent NEDs. The Quorum had been amended and named executives had been removed to allow for some flexibility.	The GMS Board Terms of Reference were APPROVED, with effect from the date of appointment of the three independent non-executive directors.

Items not Rated		
NHS England Productivity Tool and its use in GHFT	CGH Electrical Incident Update – item deferred to the next meeting	Sustainability Annual Report 2022-23
HFMA Internal Audit Follow-up	Annual Review of Estates Return Information Collection (ERIC)	

Business Cases and Investments			
Case	**Comments**	**Approval**	**Actions**
Orthotics Tender	A robust Mini-competition was undertaken. The outcome demonstrated best value to the Trust for the delivery of the proposed contract. The process was fully compliant with Public Contract Regulations (PCR 2015), met the needs of the service and represented value for money.	APPROVED	The committee APPROVED the award of the contract to Bidder 4.
Tower block wards 2023	GMS asked for approval to place an order with	APPROVED	The Committee gave APPROVAL for

Refurbishment	King Builders to enable the partial refurbishment of 6 wards in the GRH tower block in support of the Ward Moves programme.		an order to be placed with King Builders to enable the partial refurbishment of 6 wards in the GRH tower block in support of the Ward Moves programme. The value of the order was £463,896.38 plus 10% contingency = £510,000.
GRH ED CT Scanner Installation	Authorisation was requested for GMS to place an order with Canon Medical Systems Ltd. to enable the installation of the new CT scanner, funding for which was approved in the last month.	APPROVED	The Committee gave APPROVAL for an order to be placed with Canon Medical Systems to enable the installation of the new CT scanner. The value of the work was noted at £356,586 plus 20% contingency = £430,000 to enable the installation of the new CT scanner, funding for which was approved in the last month.
Impact on Board Assurance Framework (BAF)			
The Finance BAF was noted. The Estates BAF had been reviewed and updated and an updated version would be provided at the October meeting.			

KEY ISSUES AND ASSURANCE REPORT
Finance and Resources Committee, 24 August 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
Matters Arising – IT Technical Issue	A major IT incident had occurred the previous weekend, when servers across the Trust had gone down. This was due to a third party company undertaking an upgrade; a final patch update had caused corruption. There had been no access to systems and IT lost the ability to see the server estate.	There had been no harms as a result of the incident. The third party company had been unable to fix the issue and it was escalated. Root cause analysis was taking place and HA agreed to provide an update at the next meeting.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Financial Performance Report	At M4, the Trust was reporting a deficit of £7,550k; £1,731k adverse to plan. The drivers included industrial action. The Financial Sustainability Plan (FSP) target for the Trust was £34.7m. and year-to-date (YTD) the programme had delivered £8.5m of savings (£7m recurrent; £1.5m non-recurrent). The programme was slightly ahead of plan by £0.3m. Forecast outturn for 23/24 was £27.5m deficit unmitigated, reducing to £21.8m deficit after mitigations.	Actions were underway across the system to identify mitigations to offset these pressures. The Committee noted the seriousness of the position and received the contents of the report as a source of assurance that the financial position was understood.
Medium Term Financial Plan	The Committee received an update on the medium-term plan (MTFP) requirements set out by NHSE. The system was required to produce a MTFP covering three years (with the first year being 2023/24). The draft submission to show how systems would reach financial balance for 2024/25, needed to be made by 8 September. Following a review of the cost pressures and updates to tariff uplifts and the proposed medical pay award, the current position was an exit deficit of c£63m.	A further meeting to discuss the system position was taking place that afternoon. A subsequent plan would be required later in the year to demonstrate how recurrent balance would be delivered. The plan had been shared with system partners but they had not yet fed in. The Plan would be updated again and shared with Board before submission
Financial Sustainability Report	In M4, YTD performance was better than plan by £0.3m and for 23-24, green and amber rated scheme values were improving. The overall programme showed £11.3m of red schemes and a deterioration of £0.4M from month 3.	The Committee noted that the Efficiency Board continued to push the £14.2M programme and new governance process were being put into place for £12.4m programme. The first meeting of the Urgent Care Assurance Group was taking place that week and governance work was being worked through.
Capital Programme Report	At the end of July (M4), additional NHSE funding of £2.2m had been approved to support ERCP and CT Scanner projects. Expected in-year donations of £0.5m included in the Plan were yet to be secured, resulting in a current funded programme of £58m. Year to date, excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £12.8m, against a planned spend of £16.6m; a variance of £3.8m. This left £45.2m of non-IFRS 16 capital to deliver	The Committee noted the update and CM would check if the Capital Programme was included as a BAF risk.

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.

	in the remainder of 23-24.		
Items Rated Green			
Item	**Rationale for rating**	**Actions/Outcome**	
None			
Items not Rated			
None			
Business Cases and Investments			
Case	**Comments**	**Approval**	**Actions**
Student Accommodation Licences	Renewal of the accommodation contracts for medical student accommodation in Gloucester was required with external provider Studentdigs. The Accommodation was fully funded through MUT income from HEE associated with Institutional Agreement with University of Bristol that would run until at least 2028 in the current agreement term.	APPROVED	The Committee APPROVED the contracts at a cost of £919,836.48 in Yr1 academic year September 2023-June 2024 (split over financial years 23/24 June-March and 24/25 April-June) coming down in Value for Yr2 academic year to £818,352.48 + %rpi uplift (as variations for additional bedrooms at Roeuck/Brunswick cease).
Impact on Board Assurance Framework (BAF)			
The Finance BAF was noted.			

Report to Board

Agenda item:		Enclosure Number:	
Date	September 2023		
Title	M4 Financial Performance Report Month Ended 31st July 2023		
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 4.

Revenue

The Trust is reporting a year to date (YTD) deficit of £7.55m which is £1.7m adverse to plan. This is the position after adjusting for donated assets impact and Salix grant.
The ICS YTD deficit position of £9.5m which is £3.8m adverse to plan. This is the result of a £1.7m adverse to plan position from GHFT, a £0.07m YTD deficit position at GHC and a £2.1m deficit position at GICB.

Capital

The Trust is reporting a YTD position of £12.8m against a planned spend of £16.6m which is a variance of £3.8m. This excludes IFRS 16 capital. This leaves £45.2m of non-IFRS 16 capital to deliver in the remainder of 23-24.

The Trust is reporting a breakeven forecast outturn in line with the plan.

Recommendation

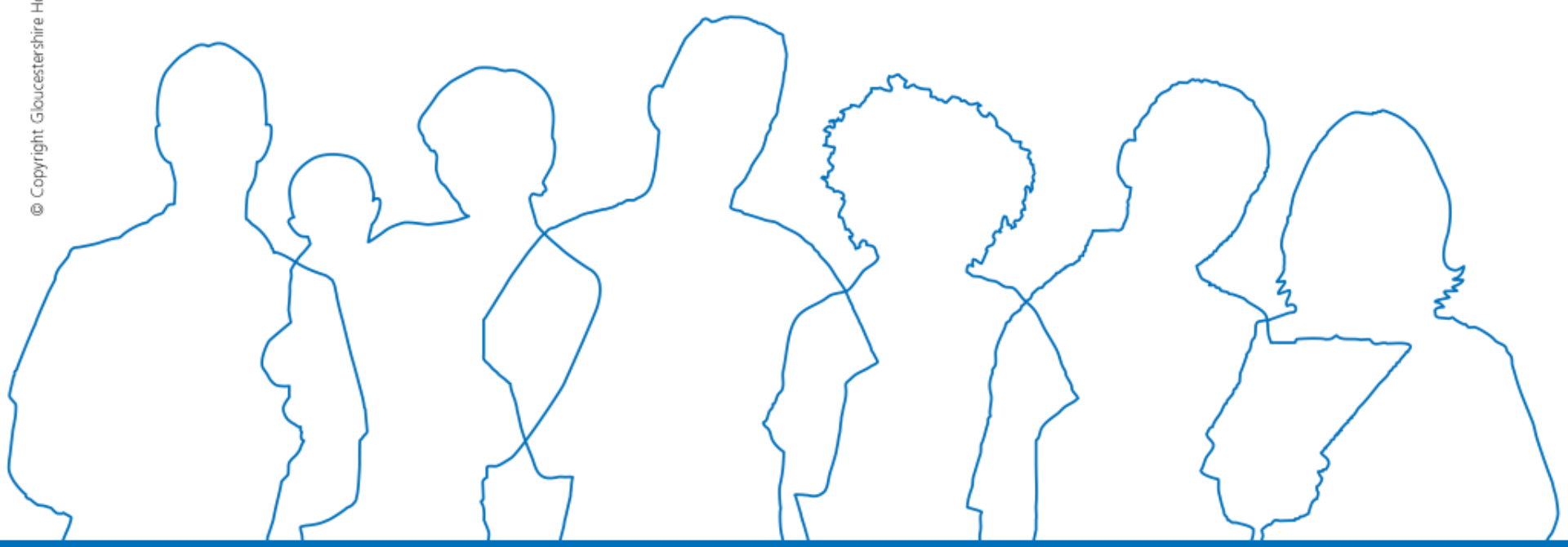
The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood.

Enclosures

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 31st July 2023



Gloucestershire Hospitals
NHS Foundation Trust

Revenue & Balance Sheet

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

System Overview

The ICS is required to breakeven for the year. At month 4, 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 £9.5m which is £3.8m adverse to plan. This is the result of a £1.7m adverse to plan position from GHFT, a £0.07m YTD deficit position at GHC and a £2.1m adverse variance at GICB due to prescribing cost pressures. Actions are underway across the system to identify mitigations to offset these pressures.

Month 4

M4 YTD Financial position is reporting a deficit of £7,550k which is £1,731k adverse to plan.

The position includes :

- Industrial Action costs £1,324k
- AfC Pay Award pressure £268k
- PFI indexation above planned inflation £248k
- Unscheduled Care pay pressures £4,900k
- Care of the Elderly, Neuro and Stroke pay pressures £1,200k
- Theatres and ophthalmology supplies £1,000k
- Energy pressures £370k
- Radiology outsourcing £403k
- Interest receivable and payable lower than plan £1,500k benefit
- Reserves £6,427k benefit
- Corporate underspends £67k benefit

The Financial Sustainability Plan (FSP) target for the Trust is £34.7M in 23/24 and year-to-date the programme has delivered £8.5M of savings (£7.0M recurrent; £1.5M non-recurrent). The programme overall is slightly ahead of plan by £0.3M. The level of red-rated schemes in the programme currently stands at £11.3M, and reducing this will be the focus of work over the coming months.

Month 4 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £7.55m deficit which is £1.73m adverse to plan		I&E Position YTD is £7.55m deficit which is £1.73m adverse against the plan of £5.82m deficit.
Income is £248m YTD which is £7.3m favourable to plan		M4 income position is £248m YTD which is £7.3m favourable to plan. This is driven by GMS reporting additional income due to pay award funding and capital margin. Most of the Trust income is covered by block contracts. The month 4 position reflects the blocking of ESRF and variable activity in line with NHSE guidance to reflect the impact of Industrial Action.
Pay costs are £157m YTD which is £8.7m adverse to plan		Pay costs are £157m YTD which is £8.7m adverse to plan. Pressures include Industrial Action costs and covering vacancies within ED, Acute Medicine, theatres and trauma.
Non Pay costs are £70.2m YTD which is £0.7m favourable to plan.		Non Pay costs (included non-operating costs) are £94.6m YTD which is £0.7m favourable to plan. This position includes overspends on clinical supplies within the Surgery Division, increased PFI costs due to indexation and pressures due to high energy costs. These are being offset by the release of reserves and underspends in corporate areas.
Delivery against Financial Sustainability Schemes		The Financial Sustainability Plan (FSP) target for the Trust is £34.7M. In Month 4, the Trust had planned efficiencies of £8.2M and achieved £8.5M.
The cash balance is 63.9m		Cash has increased by £6.1m due to receipt of capital funding.

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 4 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	8,200	8,500	300
Financial stability – variance from breakeven*	(5,819)	(7,550)	(1,731)
Agency spending against ledger budget	(3,449)	(6,966)	(3,517)
**adjusted position*			

The Trust is adverse to plan for Financial Stability and Agency Spending.
It is favourable to plan for Financial Efficiency. It is expected that this will deteriorate in future months because many FSP plans are phased to deliver in the latter part of the year and there remain high risk schemes totalling £11.3m.

M4 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of July 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 July the Group's consolidated position shows a deficit of £7.55m deficit which is £1.73m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 4 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	220,577	222,388	1,811			0	220,577	222,388	1,811
PP, Overseas and RTA Income	1,380	1,715	335			0	1,380	1,715	335
Other Income from Patient Activities	3,849	4,133	284			0	3,849	4,133	284
Operating Income	16,226	17,695	1,469	23,784	30,644	6,860	14,158	19,432	5,274
Total Income	**242,033**	**245,931**	**3,898**	**23,784**	**30,644**	**6,860**	**239,965**	**247,668**	**7,703**
Pay	(142,803)	(147,827)	(5,024)	(8,101)	(9,617)	(1,517)	(148,568)	(157,311)	(8,743)
Non-Pay	(98,447)	(100,908)	(2,462)	(14,853)	(20,354)	(5,501)	(90,386)	(92,488)	(2,102)
Total Expenditure	**(241,249)**	**(248,735)**	**(7,486)**	**(22,954)**	**(29,971)**	**(7,018)**	**(238,954)**	**(249,799)**	**(10,845)**
EBITDA	**783**	**(2,804)**	**(3,587)**	**830**	**673**	**(158)**	**1,010**	**(2,131)**	**(3,142)**
EBITDA %age	**0.3%**	**(1.1%)**	**(1.5%)**	**3.5%**	**2.2%**	**(1.3%)**	**0.4%**	**(0.9%)**	**(1.3%)**
Non-Operating Costs	(3,337)	(1,481)	1,856	(830)	(673)	158	(3,564)	(2,154)	1,410
Surplus / (Deficit)	**(2,554)**	**(4,285)**	**(1,731)**	**(0)**	**(0)**	**0**	**(2,554)**	**(4,285)**	**(1,731)**
Dontated Asset, Impairment & Salix Grant Adjustment	(3,265)	(3,265)	0	0	0	0	(3,265)	(3,265)	0
Adjusted Surplus / (Deficit)	**(5,819)**	**(7,550)**	**(1,731)**	**(0)**	**(0)**	**0**	**(5,819)**	**(7,550)**	**(1,731)**

* Trust position excludes £12m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £29m of inter-company transactions, including dividends

Balance Sheet

	Group Closing Balance 31st March 2023 £000	GROUP Balance as at M4 £000	B/S movements from 31st March 2023 £000
Non-Current Assests			
Intangible Assets	16,483	15,123	(1,360)
Property, Plant and Equipment	357,717	369,484	11,767
Trade and Other Receivables	3,901	3,858	(43)
Investment in GMS	0	0	0
Total Non-Current Assets	**378,101**	**388,465**	**10,364**
Current Assets			
Inventories	12,312	12,887	575
Trade and Other Receivables	46,622	28,487	(18,135)
Cash and Cash Equivalents	49,193	63,971	14,778
Total Current Assets	**108,127**	**105,345**	**(2,782)**
Current Liabilities			
Trade and Other Payables	(104,686)	(107,061)	(2,375)
Other Liabilities	(11,160)	(16,106)	(4,946)
Borrowings	(5,904)	(6,049)	(145)
Provisions	(7,929)	(7,901)	28
Total Current Liabilities	**(129,679)**	**(137,117)**	**(7,438)**
Net Current Assets	**(21,552)**	**(31,772)**	**(10,220)**
Non-Current Liabilities			
Other Liabilities	(7,603)	(5,336)	2,267
Borrowings	(41,793)	(48,160)	(6,367)
Provisions	(2,824)	(2,824)	0
Total Non-Current Liabilities	**(52,220)**	**(56,320)**	**(4,100)**
Total Assets Employed	304,329	300,373	(3,956)
Financed by Taxpayers Equity			
Public Dividend Capital	397,288	397,619	331
Equity	0	0	0
Reserves	28,113	28,113	(0)
Retained Earnings	(121,073)	(125,359)	(4,286)
Total Taxpayers' Equity	304,329	300,373	(3,956)

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M4 balance sheet and movements from the 2022/22 unaudited closing balance sheet.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

Funding

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m.

As at the end of July (M4), additional NHSE funding of £2.2m has been approved to support ERCP and CT Scanner projects. This brings the forecast programme funding (excluding IFRS 16) to £58.0m.

YTD Position

As of the end of July (M4), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £12.8m, against a planned spend of £16.6m, equating to a variance of £3.8m. This leaves £45.2m of non-IFRS 16 capital to deliver in the remainder of 23-24.

In month, excluding IFRS 16, the Trust delivered £2.8m against a forecast spend of £3.6m.

An £8.0m increase in relation to IFRS16 capital has been reported to NHSI in the M4 Provider Financial Return (PFR) as a result of the revised IFRS 16 assessments.

A number of cost risks have been flagged within the Estates capital programme. Further assessments on the cost implications, together with potential mitigations, are currently being undertaken by Estates and, at present, the forecast outturns on these projects remain in line with Plan.

23/24 Programme Funding Overview

Gloucestershire Hospitals NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m. As at the end of July (M4), additional NHSE funding of £2.2m has been approved to support ERCP and CT Scanner projects. This brings the forecast programme funding (excluding IFRS 16) to £58.0m.

The current forecast programme can be divided into the following components; Operational System Capital (£25.9m), National Programme (£22.6m), STP Capital – GSSD (£0.6m), IFRIC 12 (£1.1m), Government Grant (£6.7m) and Donations (£1.1m)

The breakdown of secured funding is shown below.

in £000's

		Plan	Forecast	Variance	Secured
DIGITAL	Digital	5,700	5,700	0	5,700
MEDICAL EQUIPMENT	Medical Equipment	5,996	5,981	15	5,981
ESTATES	Estates	14,192	14,207	(15)	14,207
Total Charge against Capital Allocation (excluding impact of IFRS 16)		**25,888**	**25,888**	**(0)**	**25,888**
RIGHT OF USE ASSET	Right Of Use Asset	1,478	1,478	0	1,478
Total Charge against Capital Allocation (including impact of IFRS 16)		**27,366**	**27,366**	**(0)**	**27,366**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Image Sharing	326	174	152	174
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	iRefer	0	152	(152)	152
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Digital Pathology	115	115	0	115
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Equipment 22/23	451	451	0	451
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Enabling works	4,185	4,185	0	4,185
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Digital	2,540	2,540	0	2,540
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	5th Orthopaedic Theatre	8,703	8,703	0	8,703
NAT PROG: RIGHT OF USE ASSET: NEW	Leases: Community Diagnostic Centre	4,098	4,098	0	4,098
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	CT Scanner	0	954	(954)	954
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	Endoscopic Retrograde Cholangiopancreatography (ERCP)	0	1,251	(1,251)	1,251
STP PROGRAMME: GSSD	Gloucestershire Hospitals Strategic Site Development	561	561	0	561
IFRIC 12	PFI Lifecycle	1,126	1,126	0	1,126
DONATIONS VIA CHARITABLE FUNDS	Gamma Camera	514	514	0	514
DONATIONS VIA CHARITABLE FUNDS	Jet Ventilator	61	61	0	61
DONATIONS VIA CHARITABLE FUNDS	Other potential charitable donations	500	500	0	0
GRANT	PSDS 3a Salix (Grant Funded)	6,724	6,724	0	6,724
Total Additional Capital		**29,904**	**32,109**	**(2,205)**	**31,609**
Gross Capital Funding Total (including IFRS 16)		**57,270**	**59,475**	**(2,205)**	**58,975**
Exluding IFRS16		(1,478)	(1,478)	0	(1,478)
Gross Capital Funding Total (excluding IFRS 16)		**55,792**	**57,997**	**(2,205)**	**57,497**

23/24 Programme Spend Overview

Gloucestershire Hospitals NHS Foundation Trust

As of the end of July (M4), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £12.8m, against a planned spend of £16.6m, equating to a variance of £3.8m. This leaves £45.2m of non-IFRS 16 capital to deliver in the remainder of 23-24.

In month, excluding IFRS 16, the Trust delivered £2.8m against a forecast spend of £3.6m.

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	505	332	173	940	1,011	(71)
MEDICAL EQUIPMENT	47	186	(139)	390	220	170
ESTATES	1,745	1,815	(71)	6,062	5,964	98
22/23 VAT RECLAIMS	0	(593)	593	0	(593)	593
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**2,296**	**1,739**	**557**	**7,392**	**6,602**	**790**
RIGHT OF USE ASSET	76	59	17	347	59	288
Total Charge against Capital Allocation (including impact of IFRS 16)	**2,372**	**1,798**	**574**	**7,739**	**6,661**	**1,078**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	23	26	(2)	294	24	270
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	685	472	214	2,837	1,295	1,542
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	60	174	(114)	2,077	412	1,665
NAT PROG: RIGHT OF USE ASSET: NEW	0	0	0	0	0	0
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	0	0	0	0	0	0
STP PROGRAMME: GSSD	0	0	0	447	561	(114)
IFRIC 12	94	94	0	375	375	0
DONATIONS VIA CHARITABLE FUNDS	0	0	0	0	0	0
GRANT	403	306	97	3,194	3,494	(300)
Gross Capital Spend Total	**3,639**	**2,869**	**769**	**16,963**	**12,823**	**4,140**
Excluding IFRS16	(76)	(59)	(17)	(347)	(59)	(288)
Gross Capital Spend Total (excluding IFRS 16)	**3,563**	**2,811**	**752**	**16,616**	**12,764**	**3,852**

A number of cost risks have been flagged within the Estates capital programme. Further assessments on the cost implications, together with potential mitigations, are currently being undertaken by Estates and, at present, the forecast outturns on these projects remain in line with Plan.

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a deficit of £7,552k which is £1,733k adverse to plan.
- Note the Trust balance sheet position as of the end of July 2023.
- Note the Trust capital position as of the end of July 2023.

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:	**September 2023**

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 26 July 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**
None.		
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were noted: • Challenges related to maternity staffing continued, resulting in unit closures. The Committee was given assurance that safety and quality of care had not been compromised. • The maternity patient safety champion pathway had been finalised. • A deep dive into maternity governance was planned and would be undertaken by the maternity improvement advisor. • There were currently 2745 patients on the 52 week wait list, which was anticipated to increase due to industrial action. • Planning for further industrial action was underway. • Increased demand for cancer services was reported, with continued challenges in urology and lower GI. • There had been an 8.2% increase in emergency attendance in comparison to last year; however there had been increased efficiencies with ambulance handovers. Improvements were being made to complex discharge pathways. • VTE risk assessments were noted to be at 69% and confidence of assurance processes questioned. ***Maternal Death Review*** An internally generated review of deaths since 2018 had been undertaken to ensure all learning had been identified and implemented. A key theme related to the disparity in the number of black and Asian women affected, which was in line with the national trend. Health inequalities work was underway to make significant improvements in feedback and the establishment of a new EDI and public health interest post within maternity services.	Patient communication during industrial action would be reviewed to ensure it was as effective as possible. The VTE digital risk assessment process would be reviewed. The MBRRACE gap analysis full report and recommendations would be brought to the 9%Committee.
Learning From Deaths Report	The report provided assurance on the systems in place for reviewing deaths and demonstrating compliance with national guidance. Further improvements were being made to raise awareness of translation services available for families.	Assurance was provided that data had been extensively reviewed by the Hospital Mortality Group, however there was some concern about the SHMI indicator which was under review.
Trust Risk Register	A new risk had been reported related to delayed follow-up ophthalmology appointments. Additional assurance was needed on water safety procedures to ensure delivery. Challenges to the delivery of the next phase of the Patient Safety Incident Response Framework (PSIRF) were noted.	The Committee requested additional assurance on the management of emerging risks, capacity to manage water safety processes, and capacity to implement the next phase of PSIRF.

Serious Incidents Report	No new never events were reported. Six new serious incidents had been reported, with testicular torsion cases under investigation as a one system investigation.	A forward plan following the testicular torsion case investigation would be brought to the Committee for assurance.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Prevention of Future Deaths Report	A report was received. The Committee noted the process and took assurance from the early identification of harm and management of concerns.	None.
Infection Control Annual Report	The report provided performance and activity information for 2022/23. A number of highlights were noted by the Committee.	More detailed Information on orthopaedics and maternity services progress with surgical site infections would be included in the next quarterly report.
Annual Patient Experience Report	A report was provided for assurance on three critical areas: improving the experience of care, using insight and feedback, and co-production.	Communication and relationship building between divisions, PALS and the patient experience team would continue to be improved to ensure information is shared and used across the Trust.
Getting it Right First Time (GIRFT)	A national reset of the GIRFT framework had initiated a number of review requests, which the team was completing. A clinical lead had not yet been appointed.	Review to include what GIRFT could add in terms of Opthalmology backlog improvements.
Regulatory Report	The process for reporting was clear.	Positive improvement trajectories in maternity services were noted.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		
SR1 Urgent and Emergency Care: Reflection of Newton work to be included, and ensure target risk scores were appropriately realistic. Recent improvements in urgent and emergency care, winter planning, and industrial action would be reflected. *SR2 Quality governance framework:* the report from the last CQC visit would be reflected, along with the impact of reducing boarding. *SR6 Individual and organisational priorities*: Scoring would be reviewed to reflect Newton work.		

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.

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period June 2023

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

In June, the Trust continued to make progress on improving access targets. There are plans in place for the management of the impact of continued Industrial Action. We remain focussed on maintaining quality, delivering our clinical priorities which includes cancer performance and reducing our long waiting patients.

ELECTIVE CARE
The Trust has again ACHIEVED zero 78 week and zero 104 week breaches in June. RTT performance has dipped very slightly in-month. The part-validated position for June is 67.7% compared to last month's finalised position of 68.4%. Validation will continue until the submission on the 19th. Performance remains above the national average of approx. 58%. Total incompletes have increased again in month and is estimated to be around 76,500, compared to 75,053 last month. Patients waiting over 52 weeks continue to increase, with a trend of 2-300 increase per month, associated with IA and previous bank holidays. June is estimated to be around 2,750 (compared to 2,496 at the end of May). With 7 days in Industrial Action scheduled in July a further increase is anticipated. There are 17 (78wk breach) risks remaining for July (@7/7/23) and 151 risks for August, and given the increasing trend of patients waiting 52 weeks further challenges are anticipated.

DIAGNOSTICS
DM01 breach performance for June is anticipated to be around 14.8% (compared to 14.4% last month). Although the percentage remains largely unchanged, the number of breaches has increased by 230 and the total waiting list by approx. 1,300. Echo's have reduced by approx. 50 breaches in-month, however Endoscopy modalities have increased further, with 981 breaches compared to 743 last month.

URGENT & EMERGENCY CARE
The Trust saw a further increase in ED attendances in June. It was only a marginal increase in June (compared with May) however the level of attendances was just over 9% higher than across the year 2022/3. Disappointingly, four-hour compliance has fallen in June; reflective of increased footfall and (possibly) some impact of the IAs. The level of twelve-hour compliance, on the other hand, has improved for the sixth month in succession. Since December 2022, performance against this metric has improved from 83.0% to 86.4%; we continue to look to improve performance in this area and implemented an updated process to increase the number of referrals (as opposed to DTAs) during the second half of June. Number of hours lost to ambulance delays has increased slightly during the month, however, this is still at ~ 75% of the level delivered in 2022/3. SDEC attendances have increased by 7.5% in June (compared with May) with significant growth in both news and follow-ups.

CANCER PERFORMANCE
Unvalidated performance shows overall delivery of 5 against the 10 national operational standards. The Trust MET the 2WW Standard with performance of 95.7% in June. Whilst not meeting the standard, LGI has shown improvements over the last 4 reported months and these improvements are forecasted to continue. The Trust MET the 2WW standard for breast symptomatic with performance of 100%. The Trust CONTINUED TO MEET 28d FDS standard in June with a performance of 80.3% and continues to be one of the highest performing Trusts in the SW ICS against the FDS standard. The Trust DID NOT meet the 31d FDT standard in June with data showing performance of 92.7%. The Trust DID NOT meet the 62d Standard at 65.8% for June while we continue to work to reduce and clear our backlog, treating our longest waiting patients. 17 of the patients treated in June were historic patients. Daily validation of future 62-day breaches is now firmly in place within Cancer Services. The Trust back-log is continually reducing with an end of June reportable position of 162, and steps have been taken to minimise 'tip ins'. Of the GHFT backlog, Colorectal and Urology due to complex pathways and diagnostic capacity. Cancer services are working closely with these specialties to support recovery of performance.

The Quality Delivery Group monitor and review all the exception reports generated for the quality metrics and this is reported in the Quality Delivery Exception Rep..

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

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
All electives (including day cases)	5,625	5,672	6,198	6,257	6,196	6,236	5,097	5,932	5,781	6,556	5,085	6,165	6,164
Day cases	4,626	4,711	5,235	5,214	5,178	5,317	4,284	5,133	4,935	5,655	4,346	5,270	5,252
ED attendances	12,092	12,596	11,915	11,888	12,630	12,290	12,726	10,947	10,706	12,511	11,616	12,990	13,170
FUP outpatient attendances	34,614	33,716	35,380	35,535	35,721	38,426	30,887	37,456	33,671	38,575	30,870	34,983	36,724
GP referrals	10,371	10,181	11,008	10,524	10,806	10,734	8,569	10,484	9,774	11,924	9,334	10,614	11,140
New outpatient attendances	16,447	16,466	17,048	17,382	16,898	19,162	15,009	18,302	16,881	18,775	14,821	17,195	18,168
Non elective (Incl. Assessment)	5,240	5,266	5,158	5,221	5,656	5,664	5,282	5,238	5,013	5,697	5,276	5,510	5,456
Outpatient attendances	51,061	50,182	52,428	52,917	52,619	57,588	45,896	55,758	50,552	57,350	45,691	52,178	54,892

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%	?	Jun-23	100.0%	H
	Cancer - 28 day FDS (all routes)	≥ 75.0%	?	Jun-23	80.7%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	?	Jun-23	92.9%	L
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	P	Jun-23	98.9%	L
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%	?	Jun-23	99.4%	
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%	?	Jun-23	72.4%	L
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	?	Jun-23	51.1%	L
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	?	Jun-23	83.0%	
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%	F	Jun-23	66.5%	
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	?	Jun-23	95.7%	H
	Number of patients waiting over 104 days with a TCI date	No Target		Jun-23	10	
	Number of patients waiting over 104 days without a TCI date	No Target		Jun-23	25	L
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	F	Jun-23	14.84%	L
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	F	Jun-23	1,068	L
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	F	Jun-23	95.3%	H
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	F	Jun-23	22.18%	
	% of ambulance handovers < 15 minutes	No Target		Jun-23	27.60%	H
	% of ambulance handovers < 30 minutes	No Target		Jun-23	53.44%	H
	% of ambulance handovers over 60 minutes	≤ 1.00%	F	Jun-23	29.35%	L
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	F	Jun-23	43.8%	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	F	Jun-23	35.4%	H
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%	F	Jun-23	59.50%	
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	F	Jun-23	987	
	Number of ambulance handovers 30-60 minutes	↓ Lower		Jun-23	709	
	Number of ambulance handovers over 60 minutes	= 0	F	Jun-23	938	
Maternity	% of women booked by 12 weeks gestation	> 90.0%	?	Jun-23	92.6%	
Operational Efficiency	% day cases of all electives	> 80.00%	?	Jun-23	85.20%	H
	Average length of stay (spell)	≤ 5.06	F	Jun-23	8.17	H
	Cancelled operations re-admitted within 28 days	No Target		Jun-23	88.89%	
	Intra-session theatre utilisation rate	> 85.00%	?	Jun-23	88.66%	
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	P	Jun-23	3.09	H
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	F	Jun-23	9.38	H
	Number of patients stable for discharge	≤ 70	F	Jun-23	176	
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	F	Jun-23	643	H
	Urgent cancelled operations	↓ Lower		Jun-23	0	L
Outpatient	Did not attend (DNA) rates	≤ 7.60%	P	Jun-23	6.58%	
	Outpatient new to follow up ratio's	≤ 1.90	?	Jun-23	1.92	L
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	?	May-23	8.13%	
Research	Research accruals	No Target		Feb-23	141	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	F	Jun-23	133	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		Jun-23	9,882	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target		Jun-23	5,071	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0		Jun-23	2,745	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%		Jun-23	68.14%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target		Jun-23	74.50%	
	% patients receiving a swallow screen within 4 hours of arrival	No Target		Jun-23	75.50%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		Jun-23	72.2%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%		Dec-22	92.7%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%		Jun-23	66.67%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%		Jun-23	66.7%	

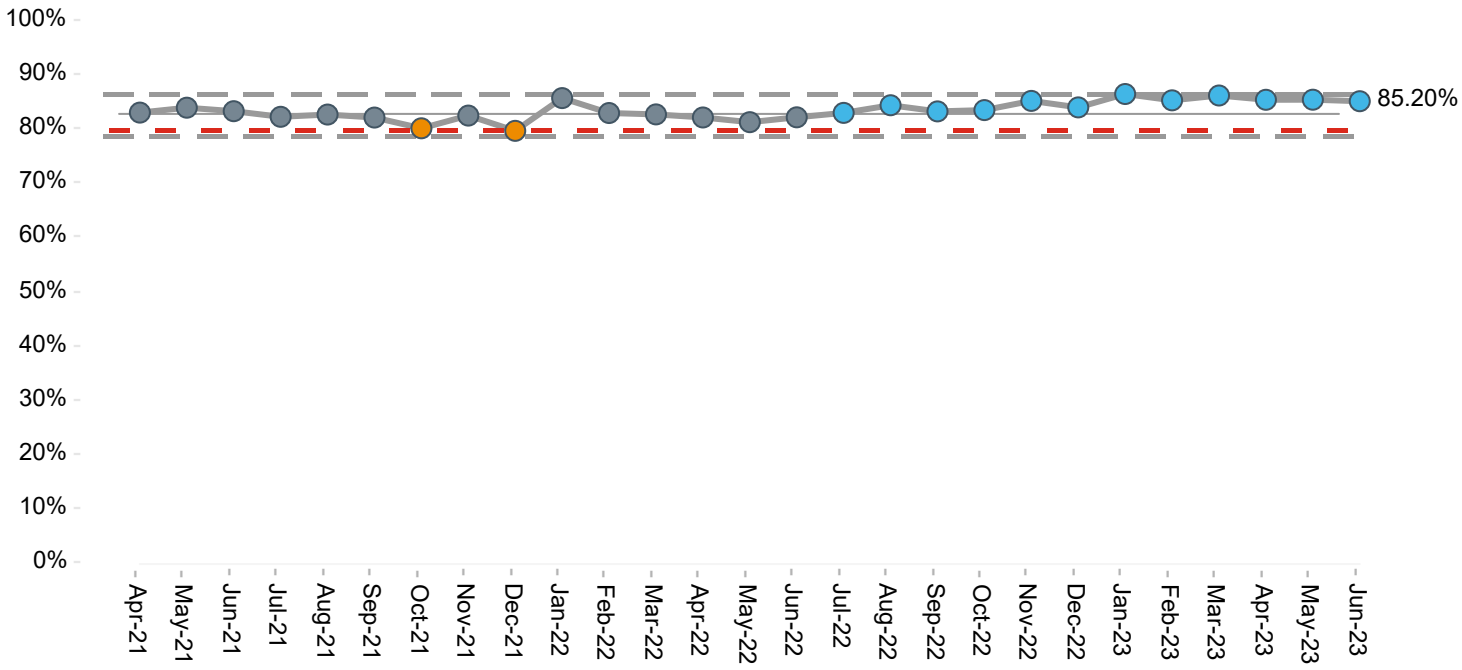
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[487] % day cases of all electives

Target: > 80.00%



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

Daycase rate of 79.4% has been achieved for May 2023.
Divisional Director - Surgery

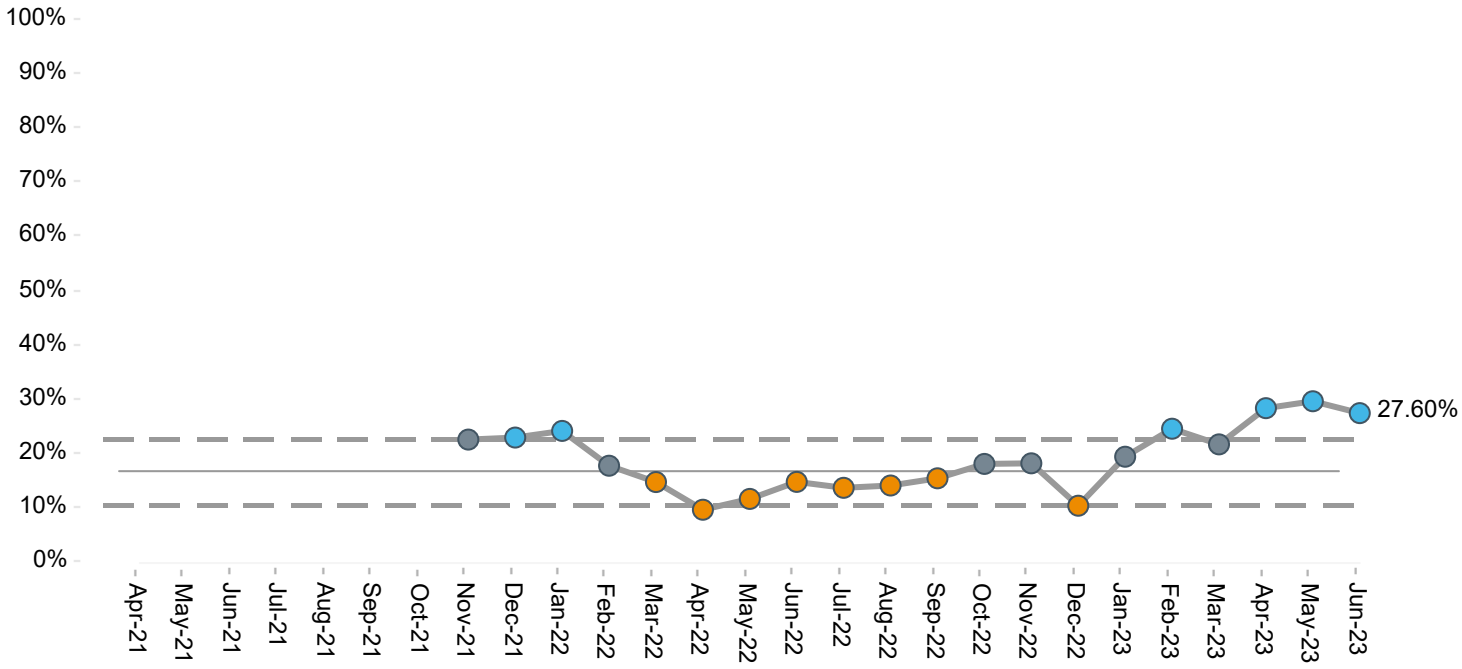
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[594] % of ambulance handovers < 15 minutes

- - - Target: No Target



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

The level of ambulance handover delays has increased slightly in June. It remains well below the average level achieved last year.

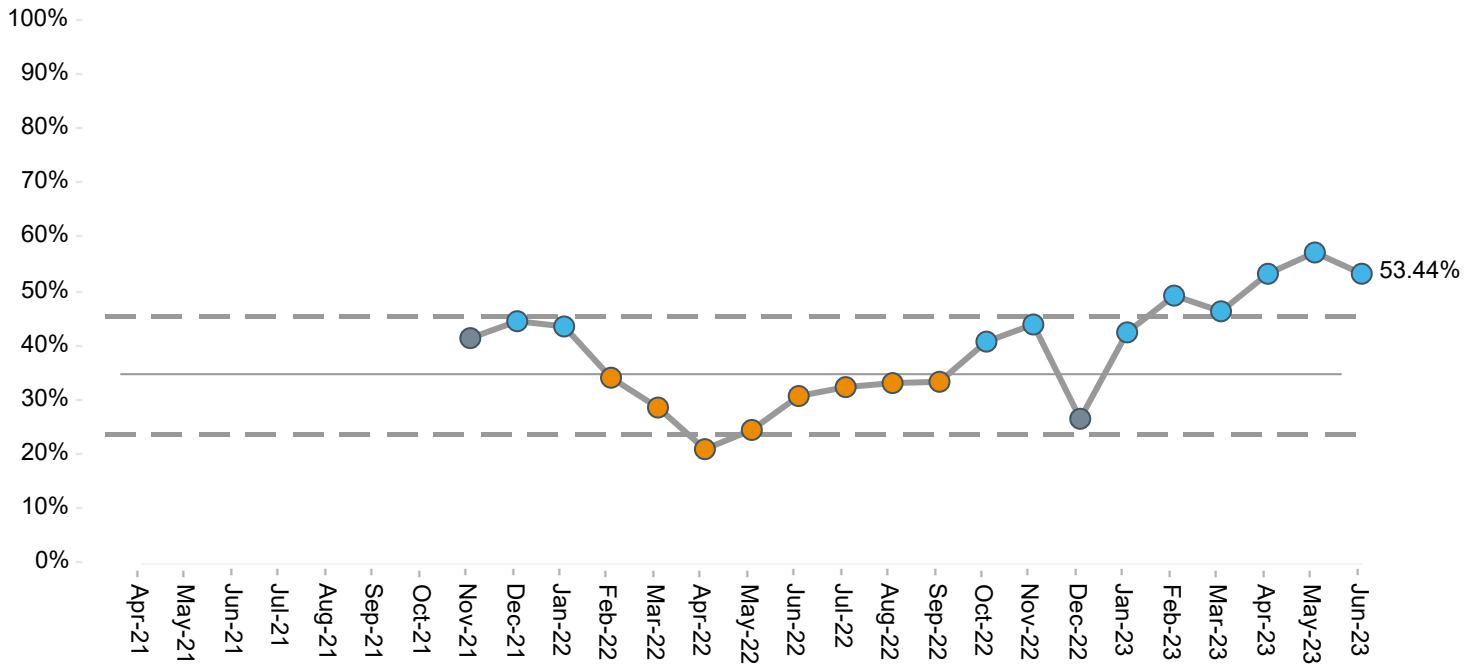
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[595] % of ambulance handovers < 30 minutes

- - - Target: No Target



Commentary

The level of ambulance handover delays has increased in June. It remains well below the level achieved in 2022/3.

Data Observations

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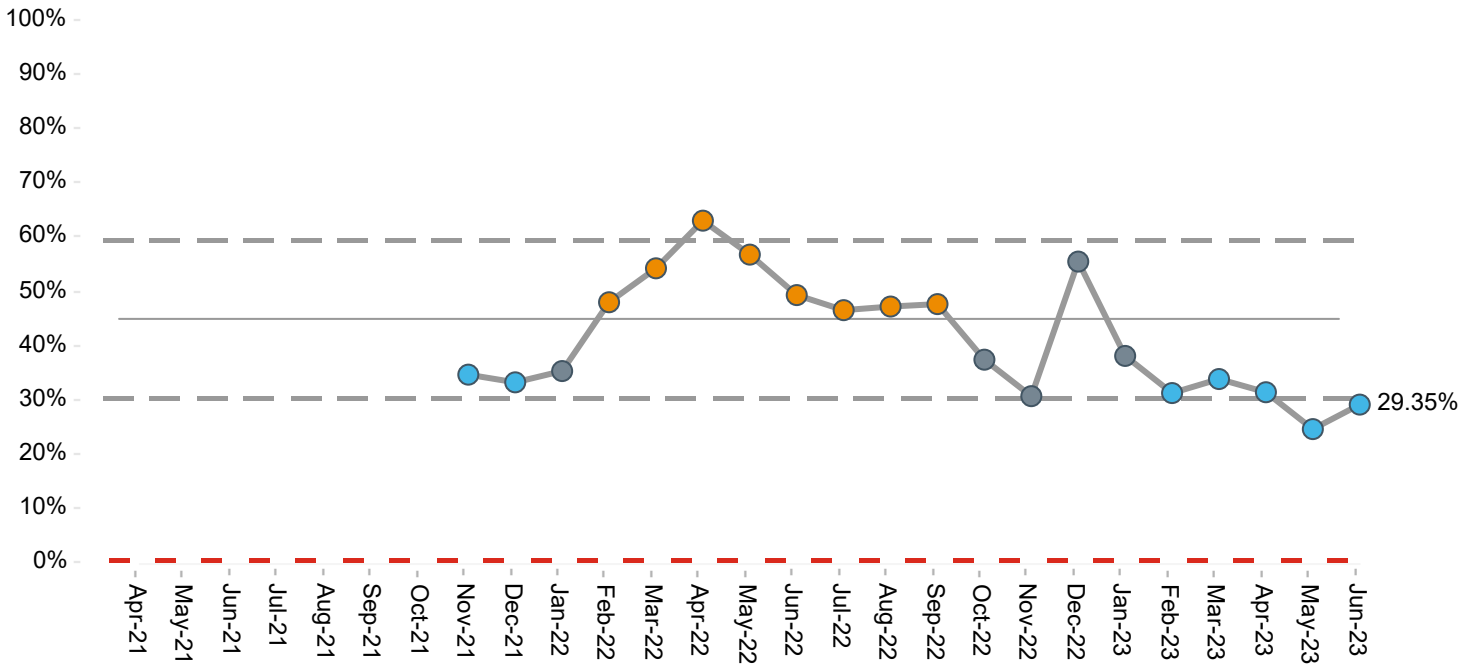
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[482] % of ambulance handovers over 60 minutes

Target: ≤ 1.00%



Commentary

The total hours lost to ambulance handovers has increased by 13% in June. Much of this is reflective of the fact that there was a significant increase in the number of handovers of more than an hour (which increased more rapidly that footfall).

Data Observations

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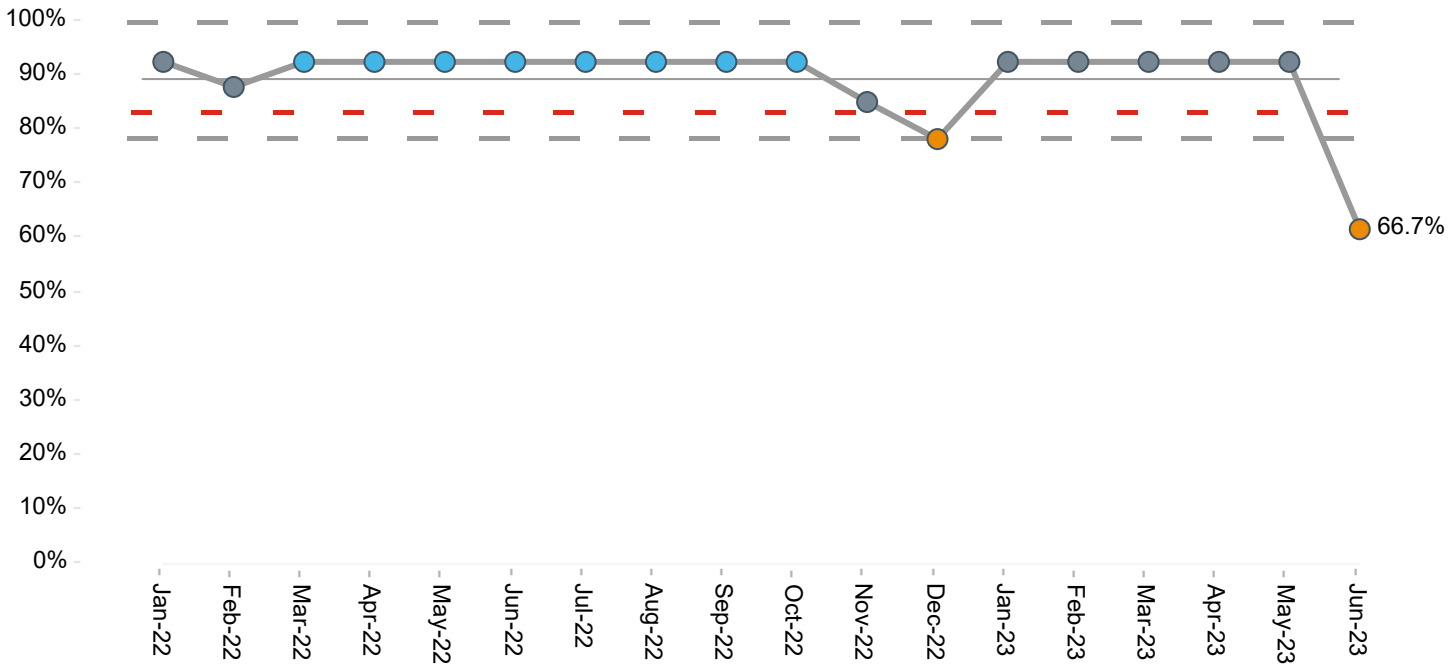
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 90.0%



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Commentary

% of fracture neck of femur patients being treated within 36 hours performance remains under the national target. Key elements that have contributed to the decline in the pathway are; lack of available trauma beds (2A is set to return to T&O between Oct '23 and Feb '24). Additional Trauma list capacity will be created at GRH from Oct '23 once more elective orthopaedic work is repatriated to CGH when Chedworth Day Case Theatres open, this will provide additional NOF capacity on lists at GRH. The service also continue to review local recovery actions.

General Manager – Trauma & Orthopaedics

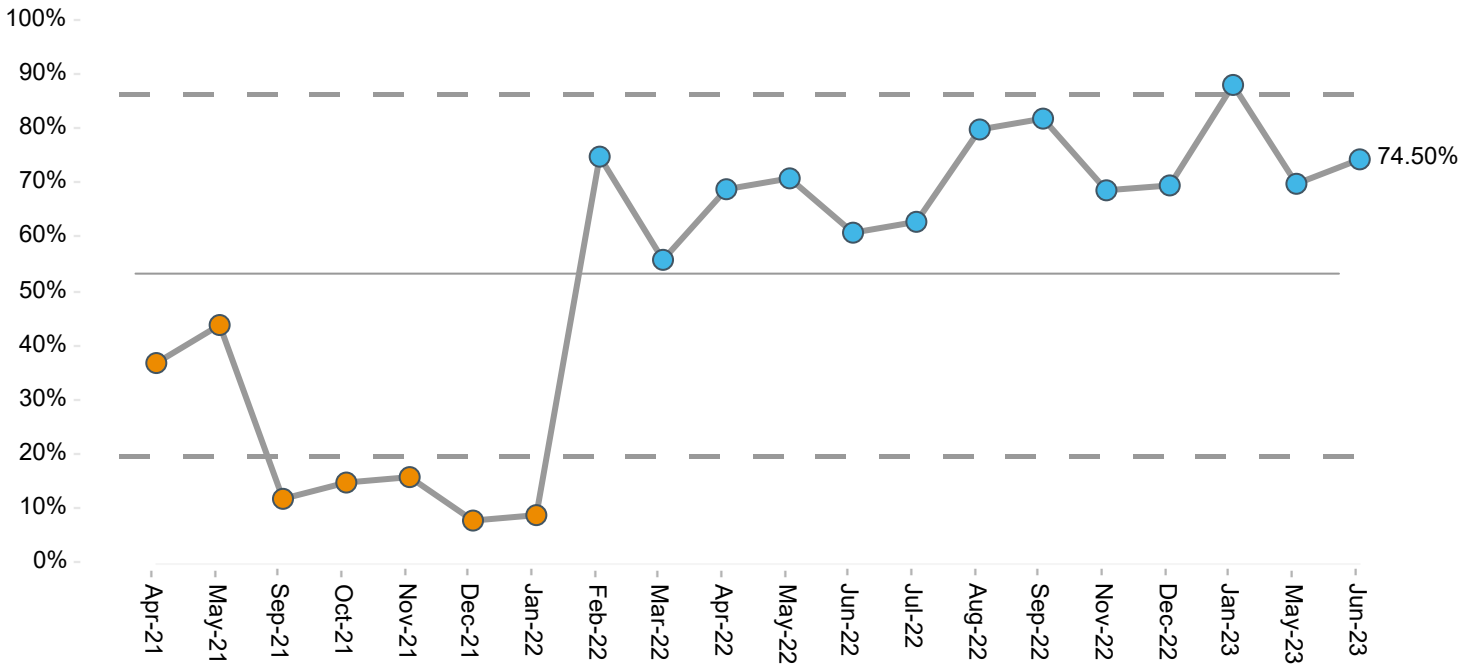
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



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Commentary

The direct to CT stroke pathway has significantly improved access to the stroke unit in 4hrs. This is not always possible within 4 hours for stroke patients that are in GRH. The stroke team are aware of the stroke outlier and offer support as they can to the team treating them and the site team prioritise the stroke outlier for the next available stroke ringfence bed.

General Manager - COTE, Neuro and Stroke

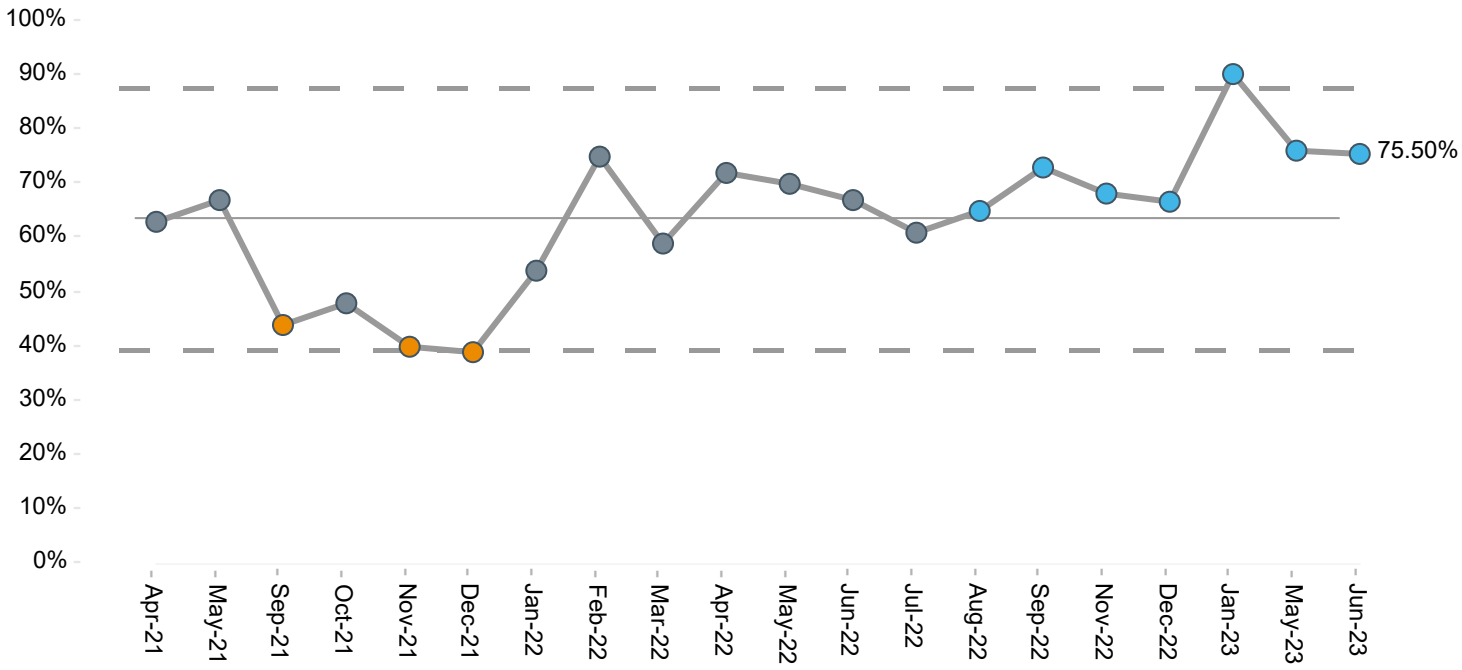
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[474] % patients receiving a swallow screen within 4 hours of arrival

- - - Target: No Target



Data Observations

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Commentary

Staffing within the SALT team has improved which has been reflected in the improved performance
General Manager - COTE, Neuro and Stroke

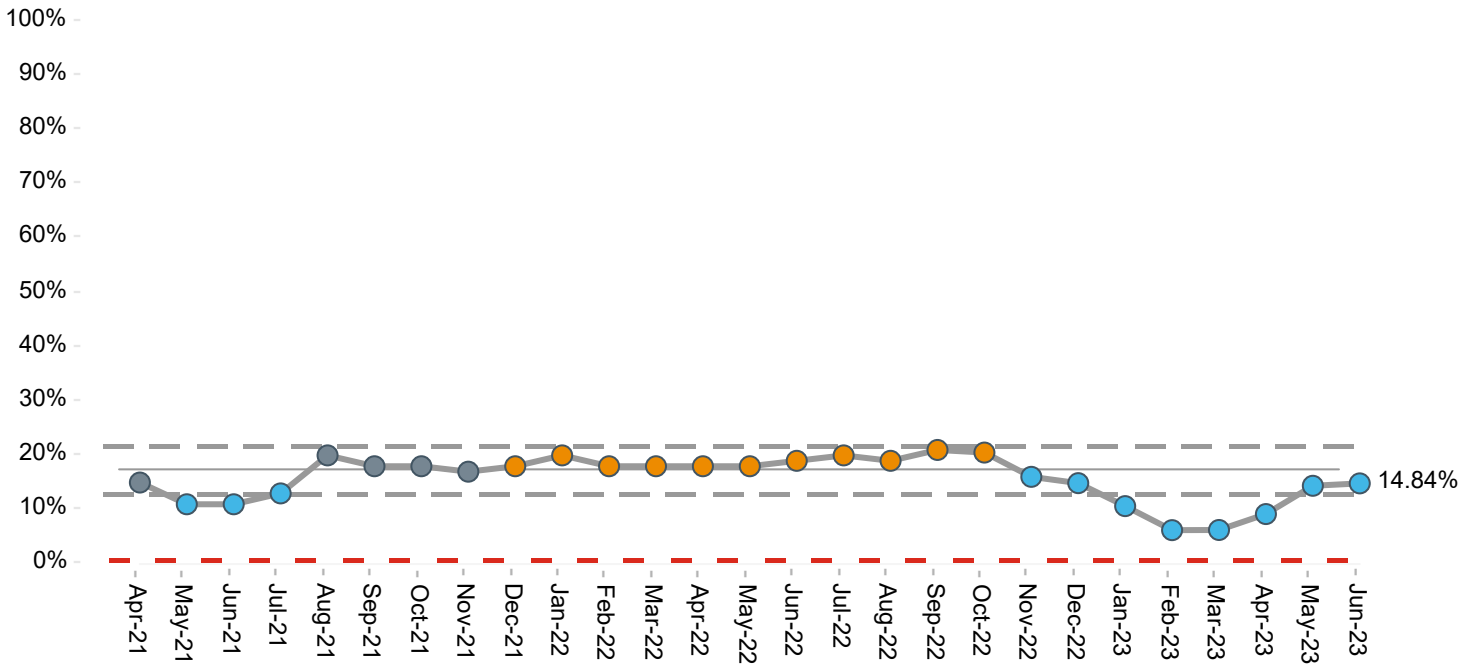
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[183] % waiting for diagnostics 6 week wait and over (15 key tests)

Target: ≤ 1.00%



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Commentary

The validated diagnostic DM01 performance for May remains similar to last month from a percentage perspective. However, the number of breaches has increased by 230 and the total waiting list by approx. 1,300. Echo's have reduced by approx. 50 breaches in-month, but Endoscopy modalities have increased further, with 981 breaches compared to 743 last month.

Associate Director of Elective Care

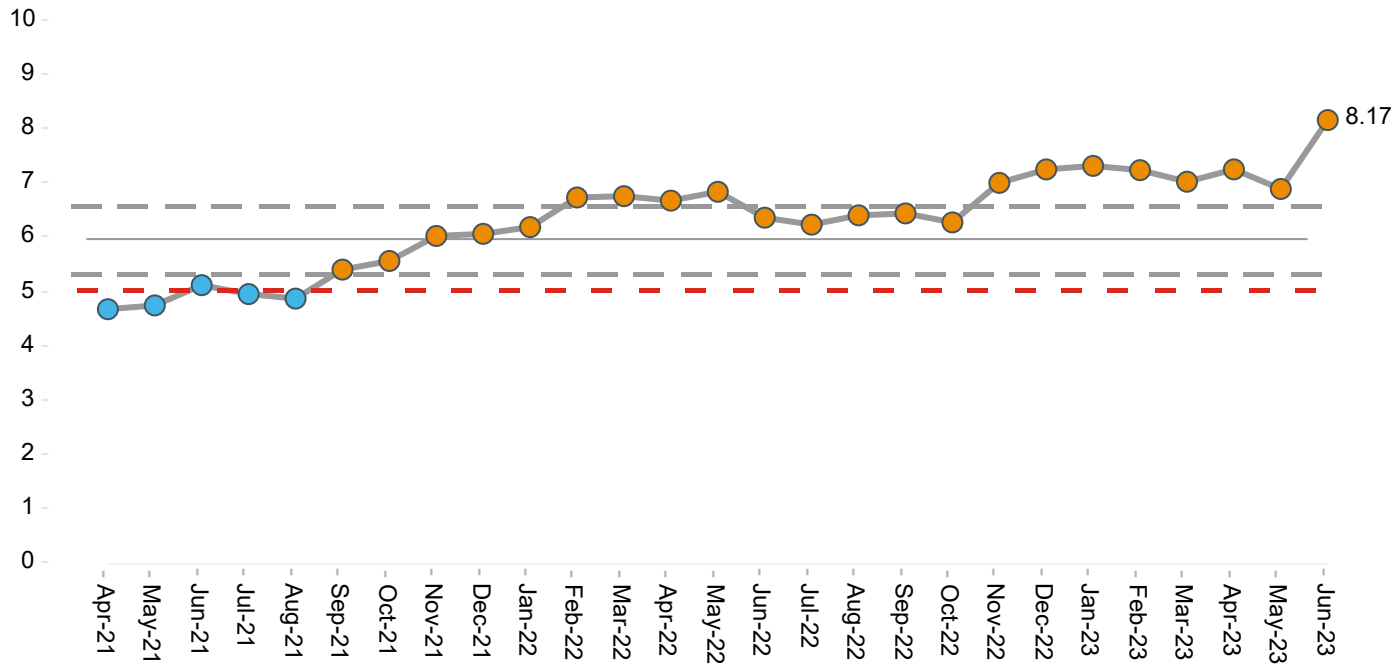
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[188] Average length of stay (spell)

Target: ≤ 5.06



Commentary

Data shows a recovery in average length of stay to now 6.94days. This remains well above the figures of pre pandemic, but is in keeping with the national picture around increase complexity and dependency of patients admitted to hospital post COVID. Work continuing to address both the long length of stay with weekly 21+ day reviews and a system wide SBAR for super stranded nCTR patients. In addition to this work, short stay patients are also a focus, with improvements seen within the less than 24hrs LOS group. The aim as we realise the benefit of our new AMU unit, it expand this focus onto the <72hrs group as well.

Deputy Chief Operating Officer

Data Observations

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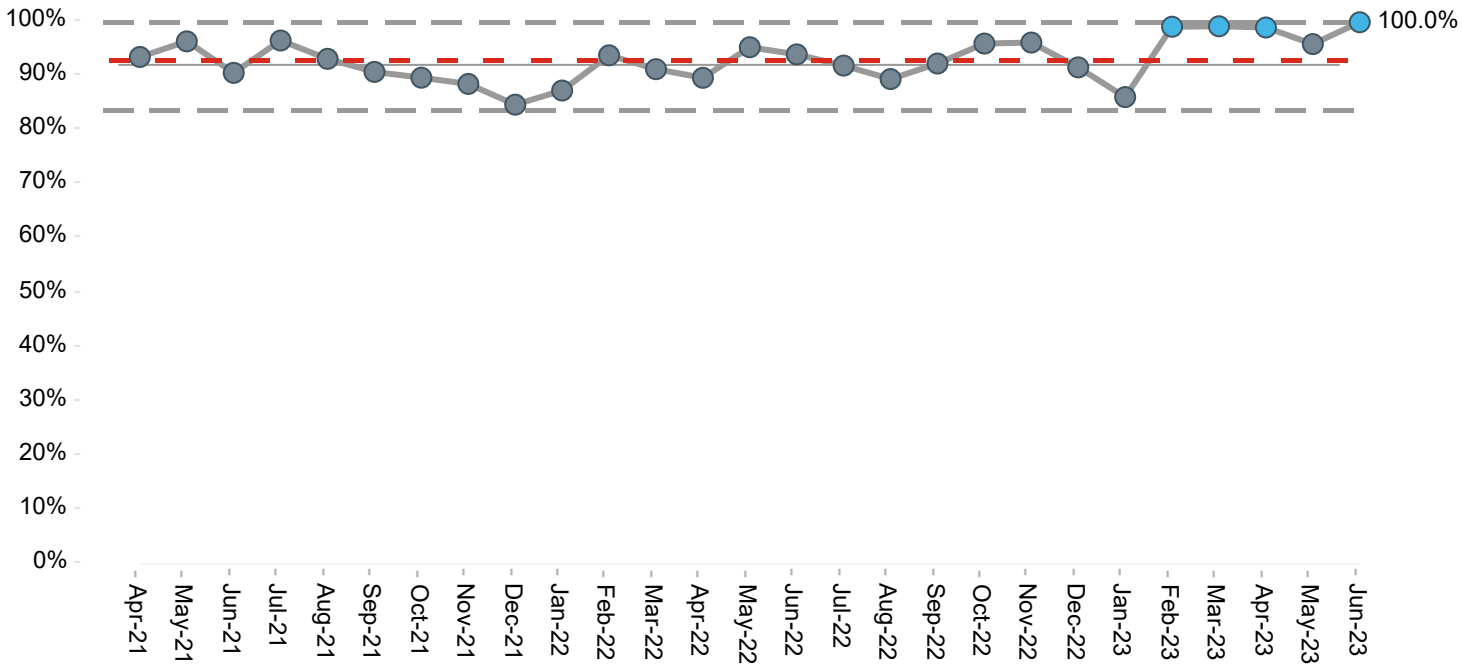
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[170] Cancer - 2 week wait breast symptomatic referrals

Target: ≥ 93.0%



Data Observations

[4] 2 OF 3

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Commentary

Unvalidated June performance of 100% - Continuing to maintain performance since Feb-23

Divisional Director of Operations

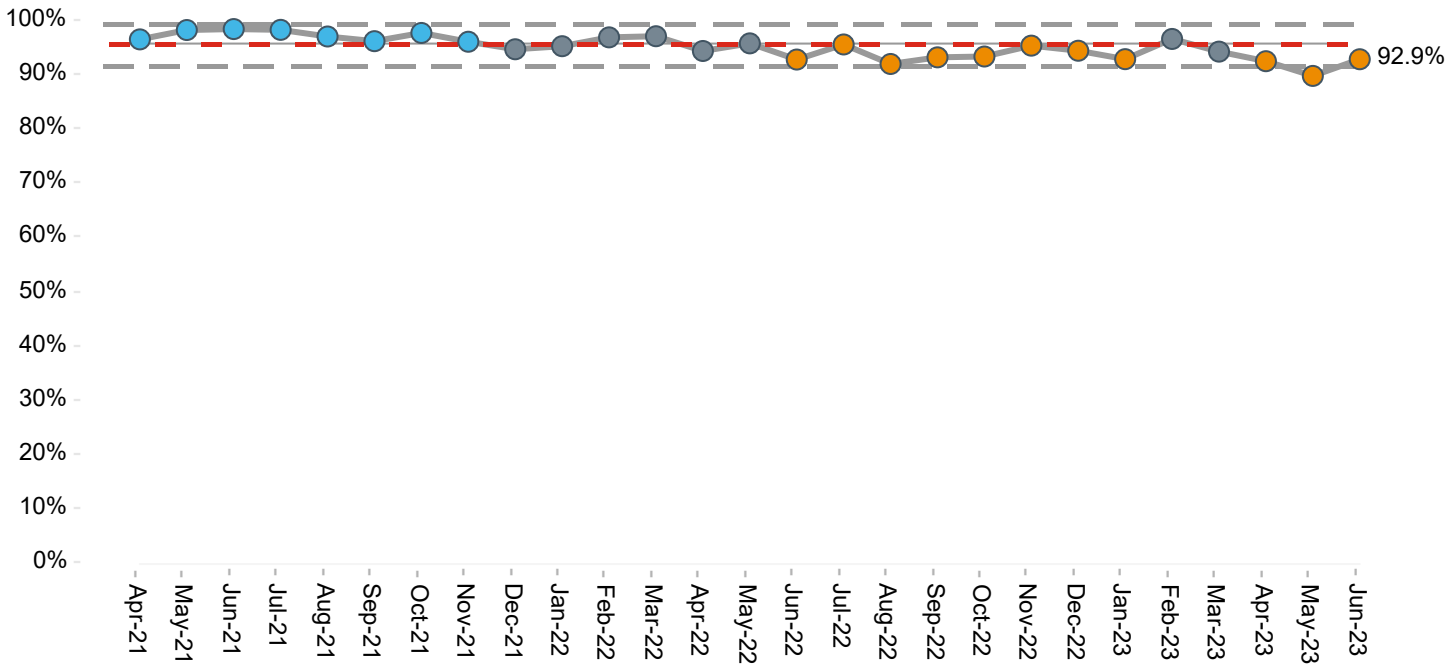
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 96.0%



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Commentary

Unvalidated June performance of 92.9% with 22 out of 312 patients breaching. An analysis is underway of each breach to look at themes which caused delay, and actions plans to be created with specialties to mitigate this and increase performance.
A 31 day pathway training and
education package will also be cascaded to the multi-disciplinary team to ensure understanding of the issues and help to encourage timely escalation
Divisional Director of Operations

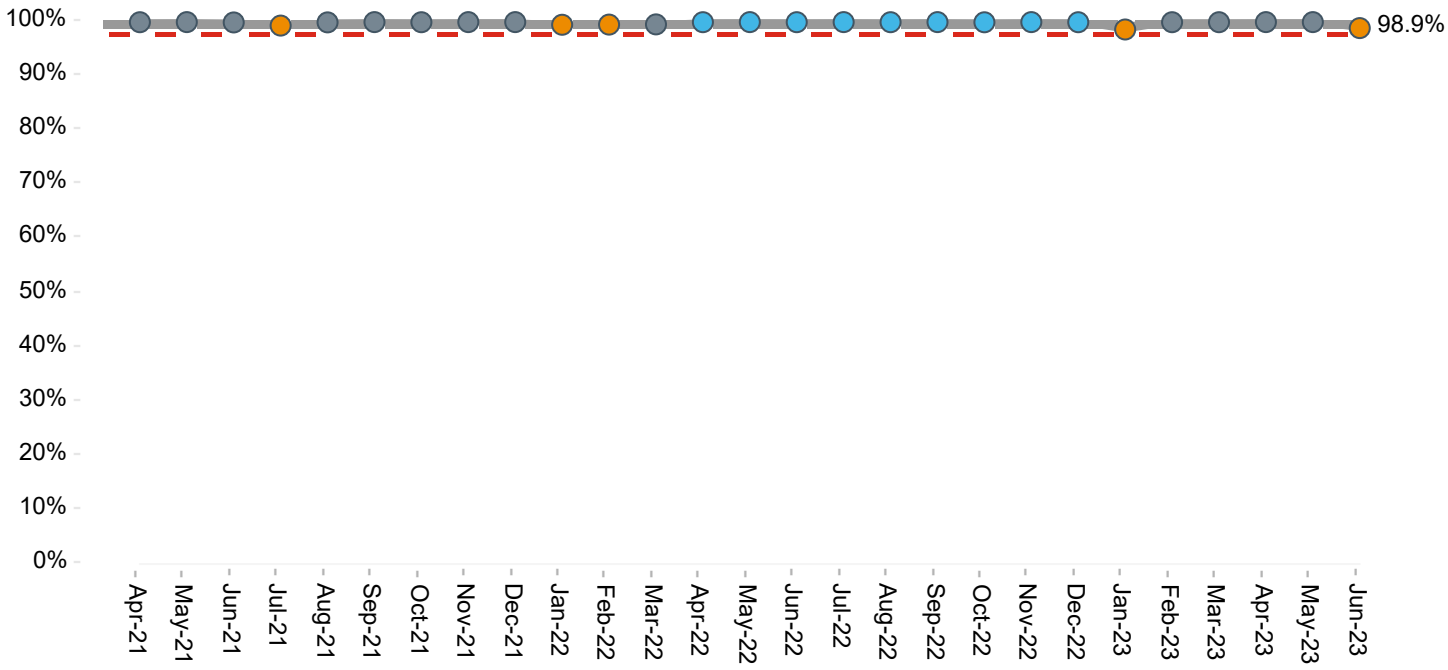
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 98.0%



Data Observations

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[2] SHIFT

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Commentary

Achievement of 31day subsequent treatment anti-cancer drugs at 99.3%
Divisional Director of Operations

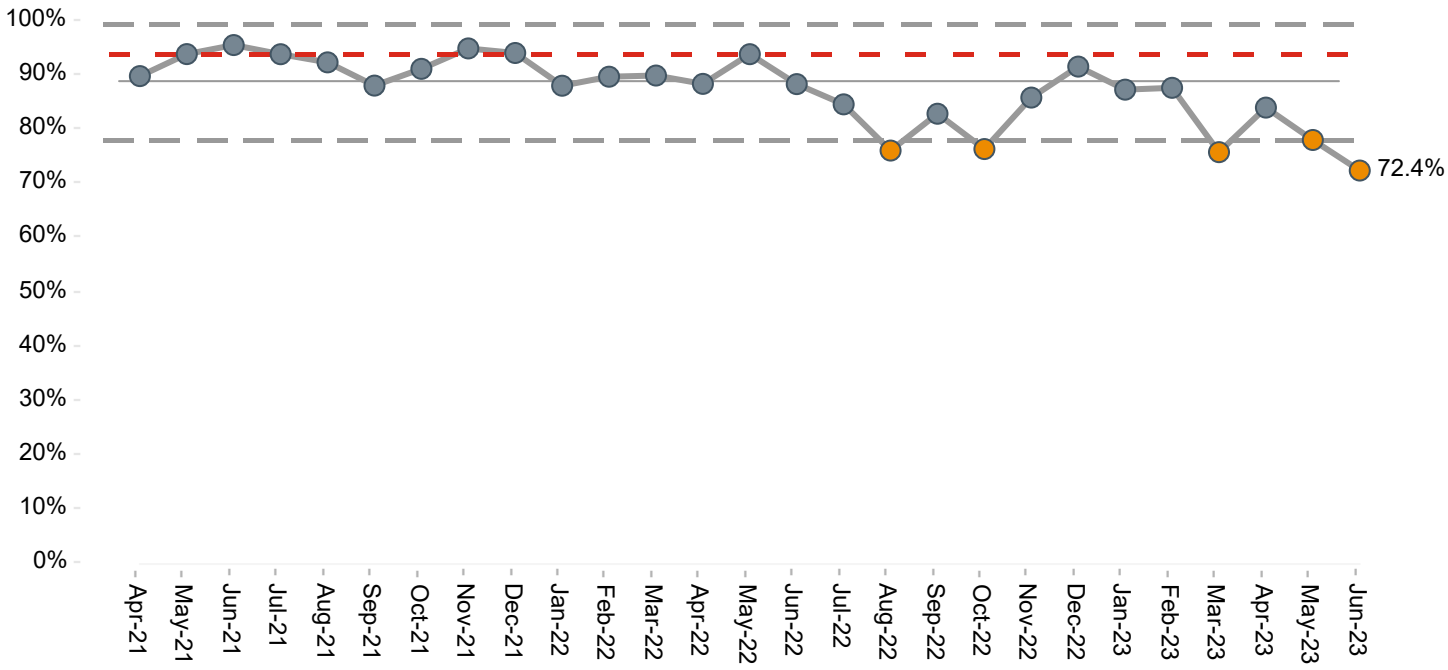
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

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.

Commentary

Unvalidated June performance of 51.1% with 21 out of 79 patients breaching. An analysis is underway of each breach to look at themes which caused delay, and identify demand and capacity issues

Divisional Director of Operations

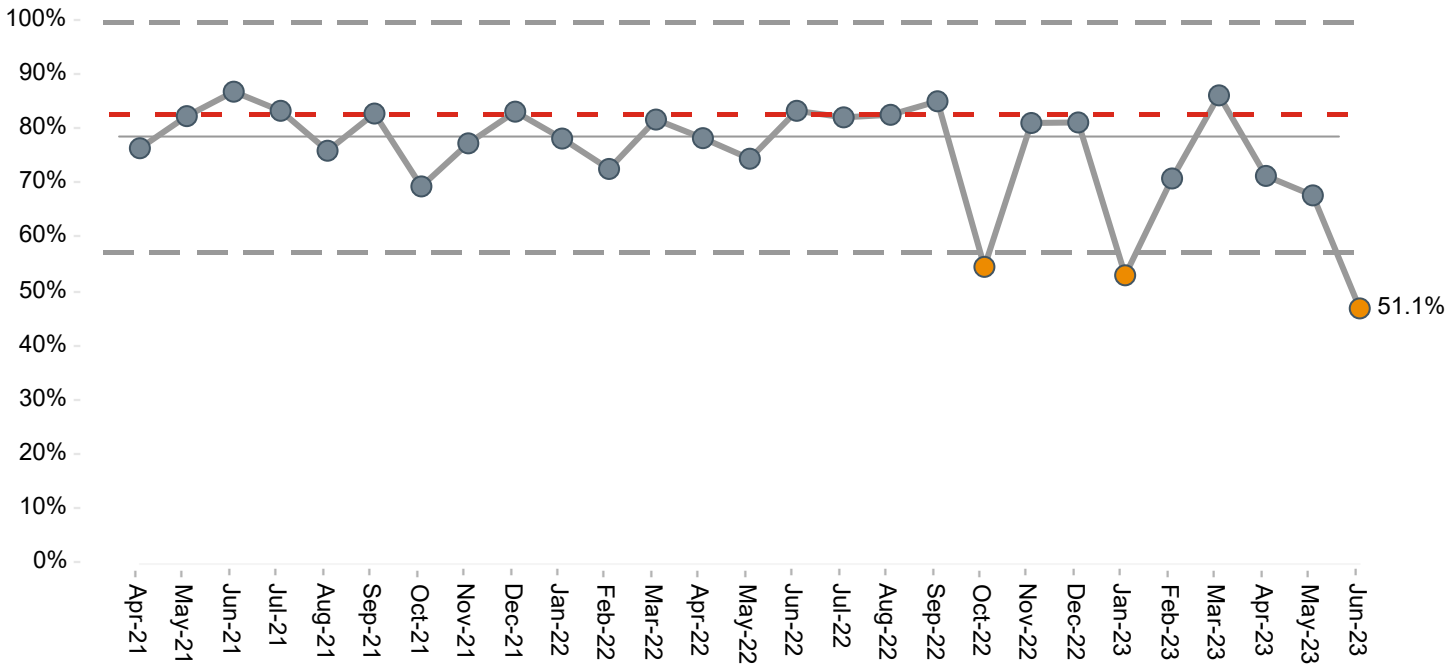
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[176] Cancer - 62 day referral to treatment (screenings)

Target: ≥ 90.0%



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.

Commentary

Unvalidated June performance of 51.5% with 14 out of 29 patients breaching 62 days. Concerns raised in local performance meetings on delays with referrals into the system and cancer services to review data and issues raised

Divisional Director of Operations

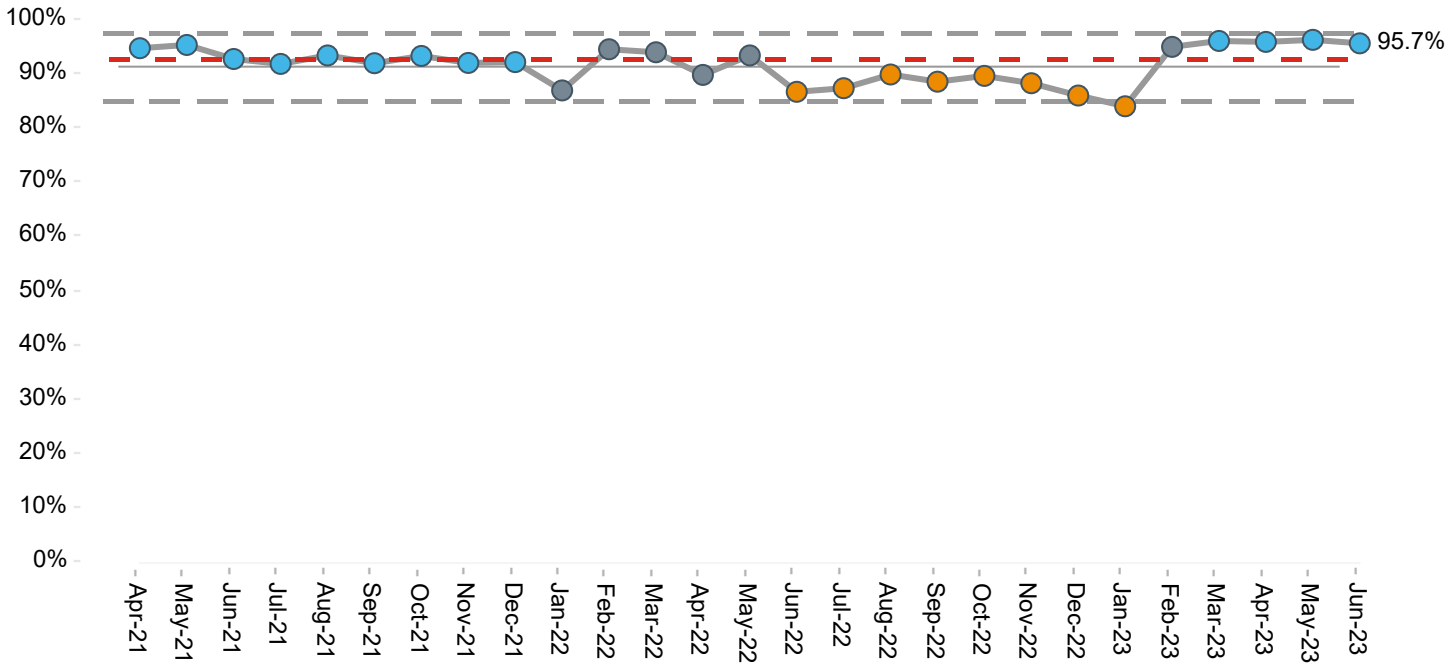
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 93.0%



Commentary

Un-validated June performance of 95.7%. Maintained achievement of performance since Feb-23, with all specialties continuing to work on maintaining14 day target, and reducing polling days moving forward

Divisional Director of Operations

Data Observations

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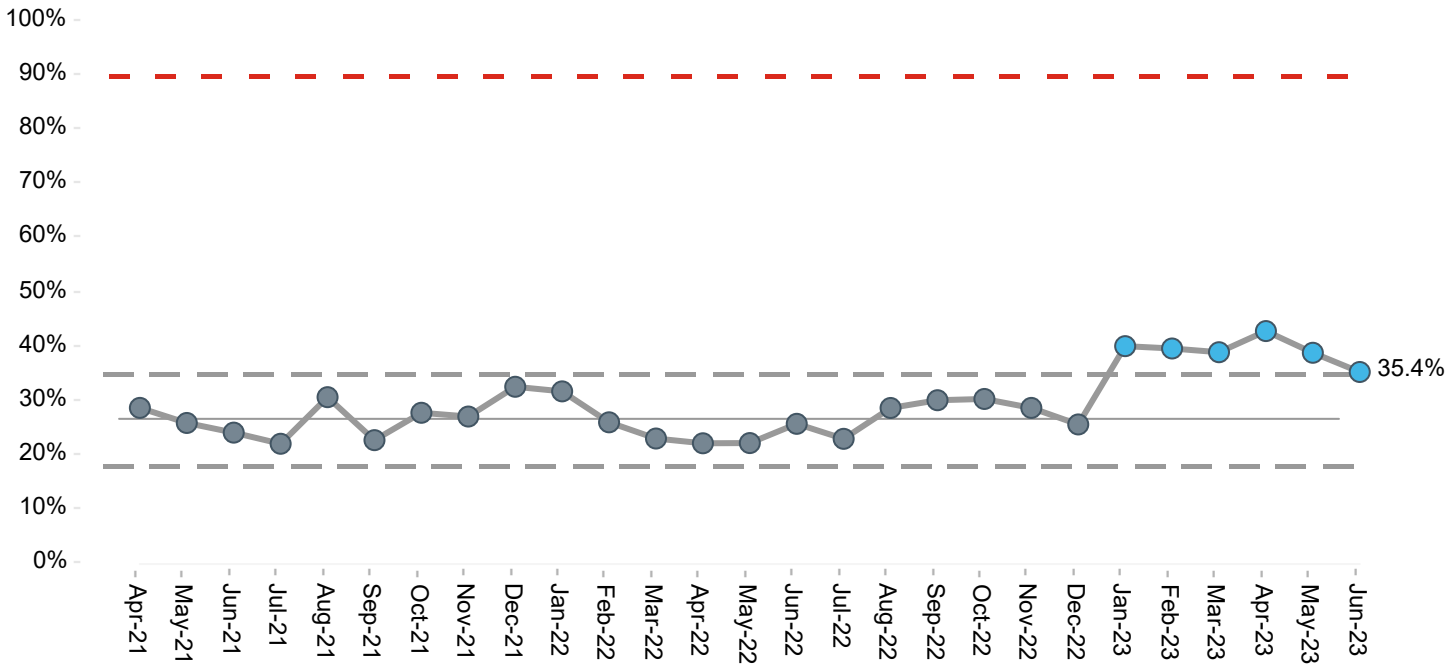
Access

SPC - Special Cause Variation

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

Target: ≥ 90.0%



Data Observations

[1] SINGLE POINT

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Commentary

Despite the higher footfall in the department and the impact of IAs, average time to start of treatment was retained well within the average of 125 minutes achieved in 2022/3. There was, however, a small deterioration in performance in the month.

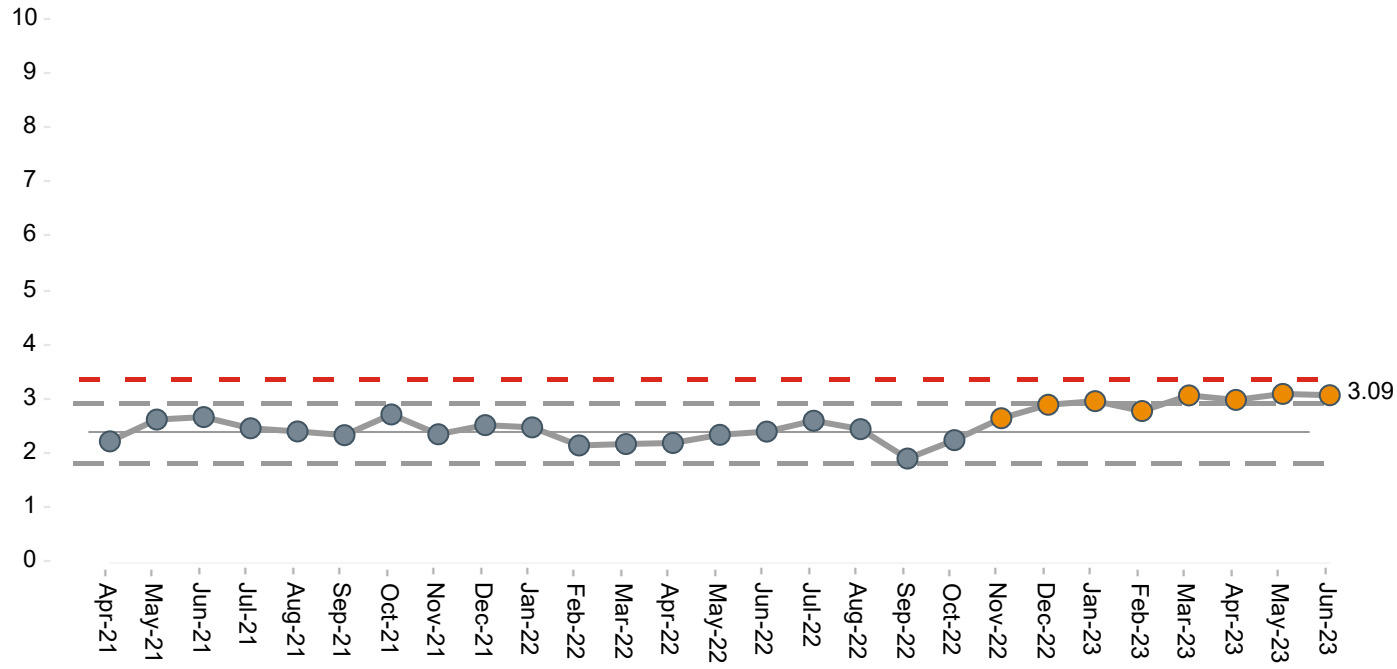
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 3.40



Commentary

Despite a small reduction in performance against the target, the overall average of 3.14days remains well below the standard set of 3.4. There are no concerns with this patient pathway, with the small variance attributable to a number of complex patients having planned admissions.

Deputy Chief Operating Officer

Data Observations

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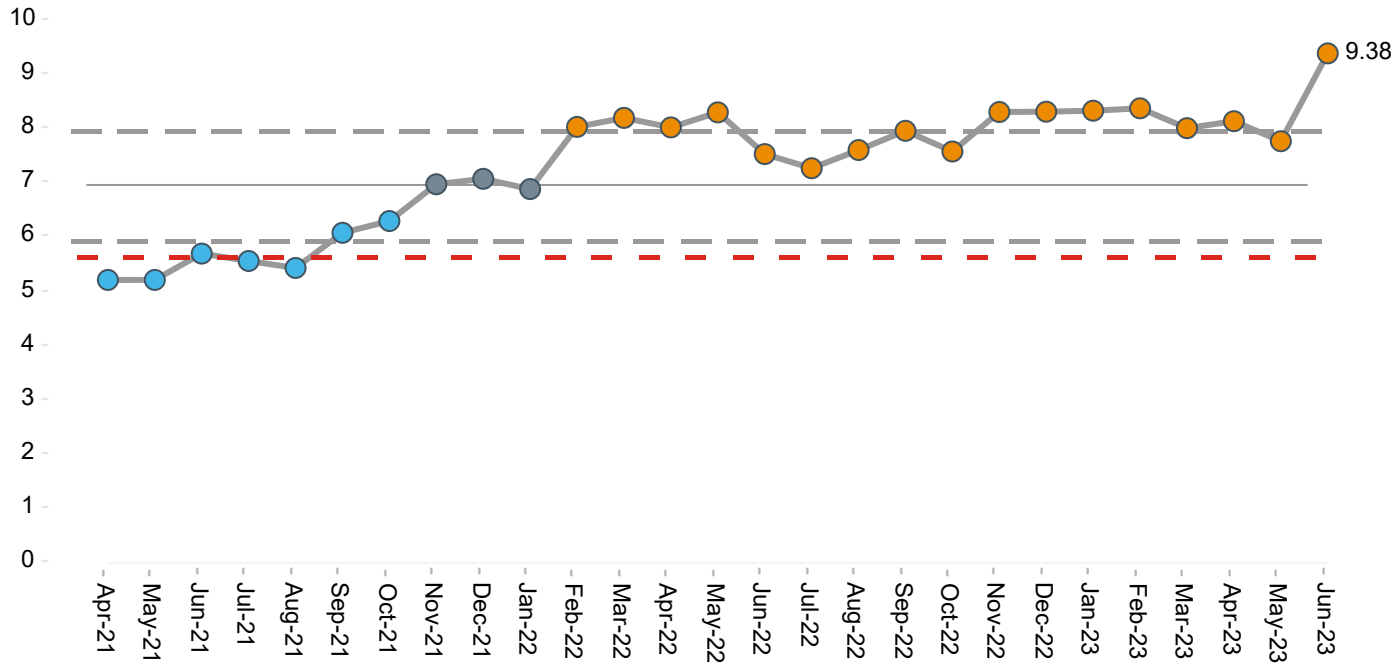
Access

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



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Commentary

The overall LOS has reduced in the main due to improvements within the emergency pathways. Average LOS is now 7.82 days, with a downward trajectory. There are multiple workstreams to support this continued improvement, with the aim to hit below 7days as an average overall.
Deputy Chief Operating Officer

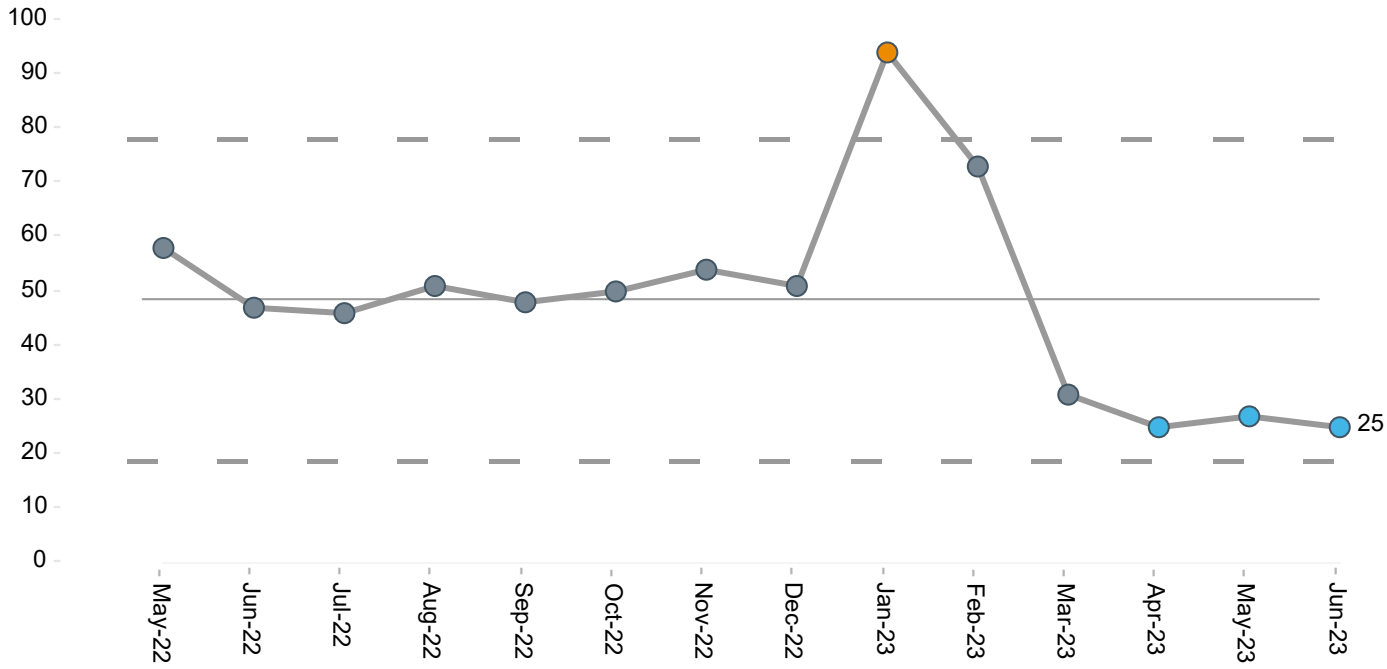
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[608] Number of patients waiting over 104 days without a TCI date

- - - Target: No Target



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Commentary

Reduction in the number of patients without at TCI date as Cancer Services continues to validate daily and work with the services on ensuring all backlog patients have agreed and proactive next steps

General Manager - Cancer

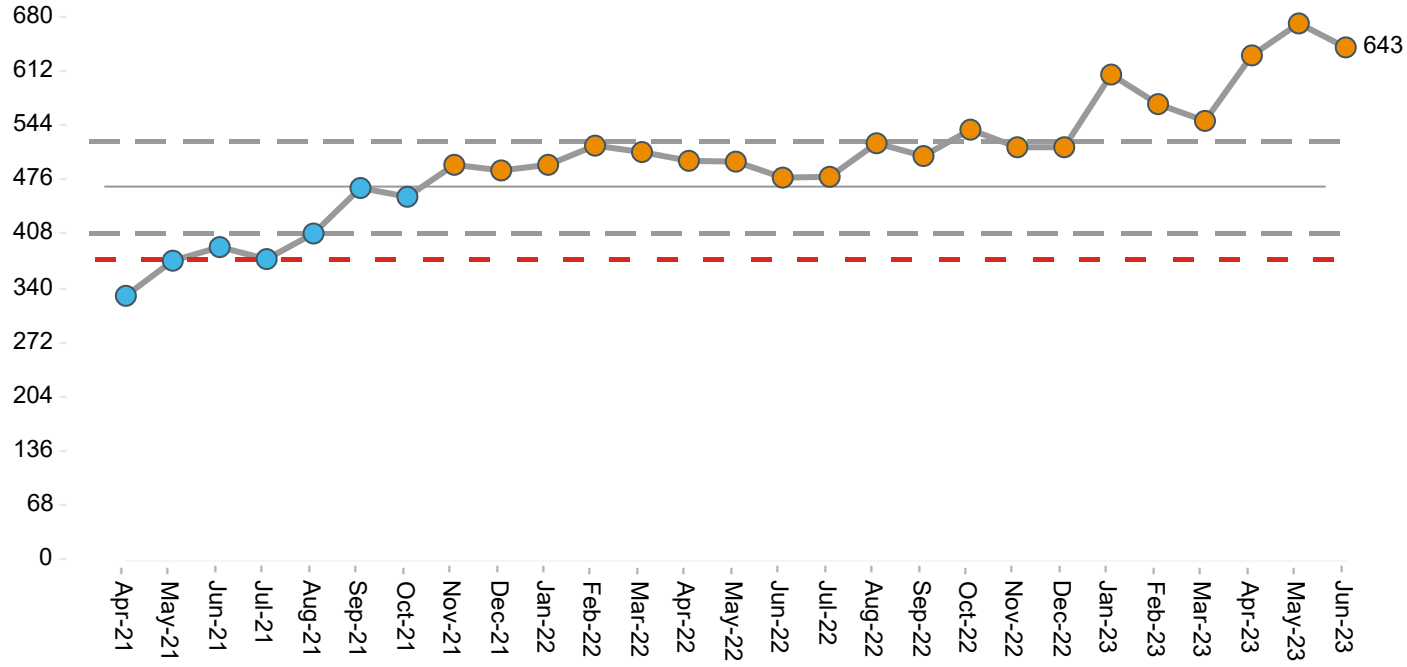
Access

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

The in month performance has seen a noted improvement, but this remains the main area of focus due to the still high number of patients stranded over 7 days. Continued work with and pressure on our partners to improve the current median waits for pathway 1-3 patients, along with internal review of decision making and driving patients into pathway 0. This is currently challenged due to significant resource issues within Therapy, the main staff group which enables the reablement and resolution of issues to enable simple discharges.

Deputy Chief Operating Officer

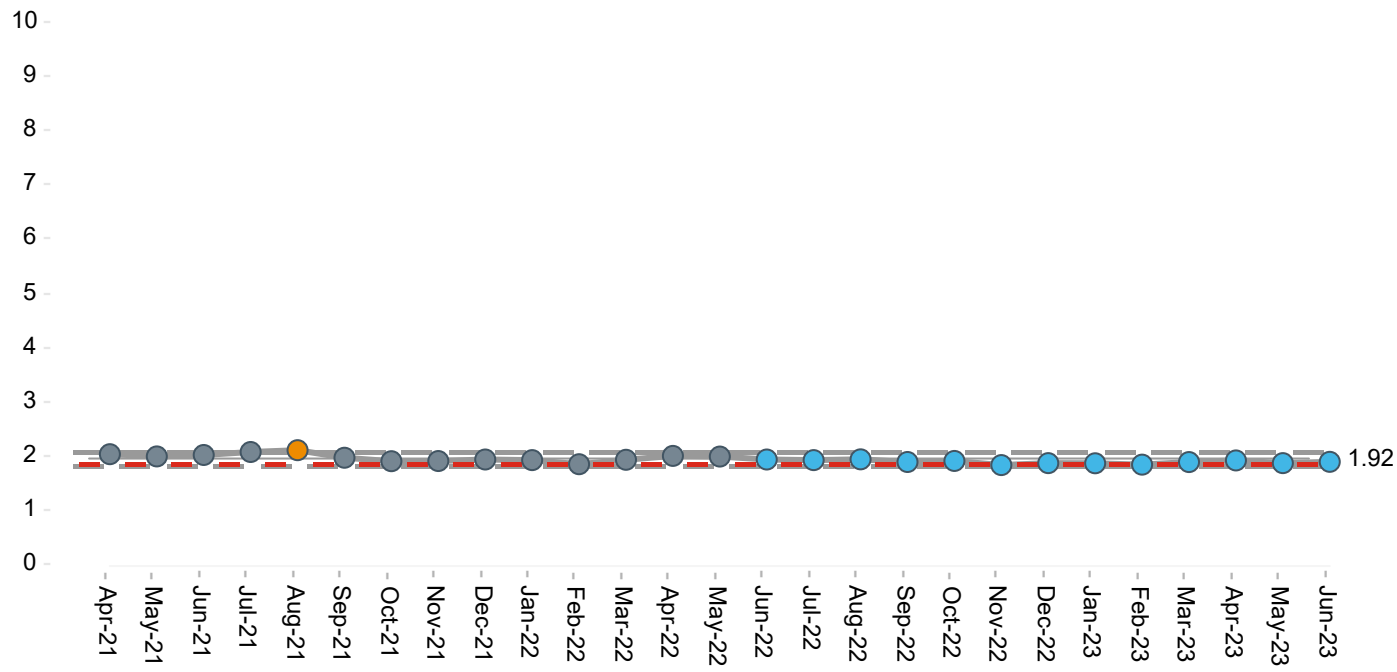
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[490] Outpatient new to follow up ratio's

- - - Target: ≤ 1.90



Commentary

Associate Director of Elective Care

Data Observations

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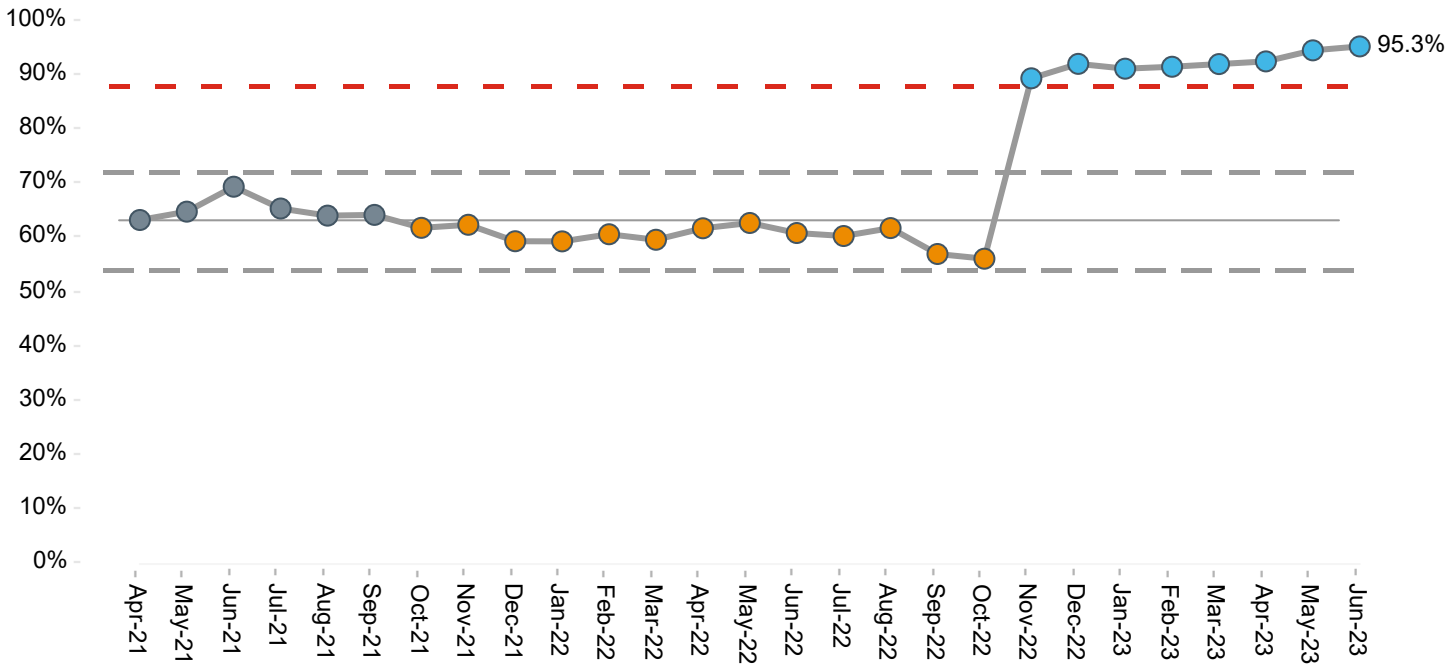
Access

SPC - Special Cause Variation

[301] Patient discharge summaries sent to GP within 24 hours

Target: ≥ 88.0%



Commentary

Medical Director

Data Observations

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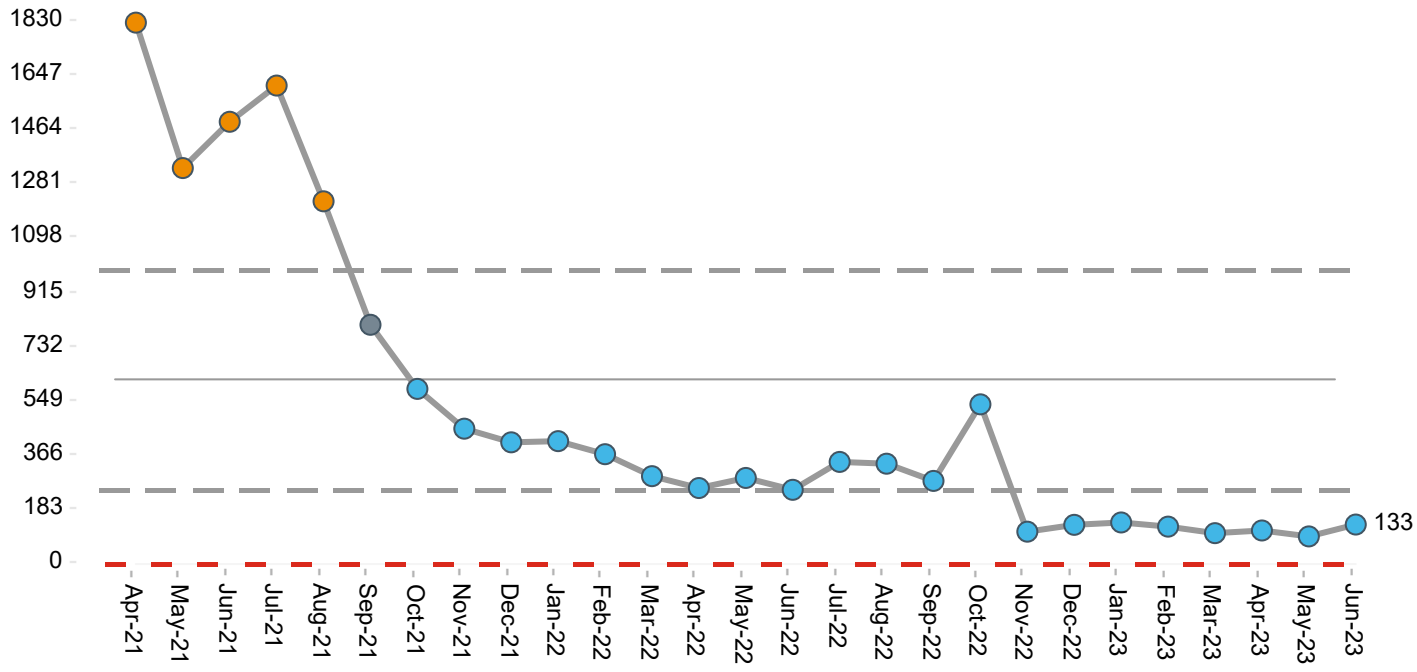
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



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

The 70+ week category has seen a notable increase in month moving from 93 in May to an estimated 136 for June. With the continual increase in 52 weeks this now demonstrates the follow through into this category and the increased risk to 78 week achievement.

Associate Director of Elective Care

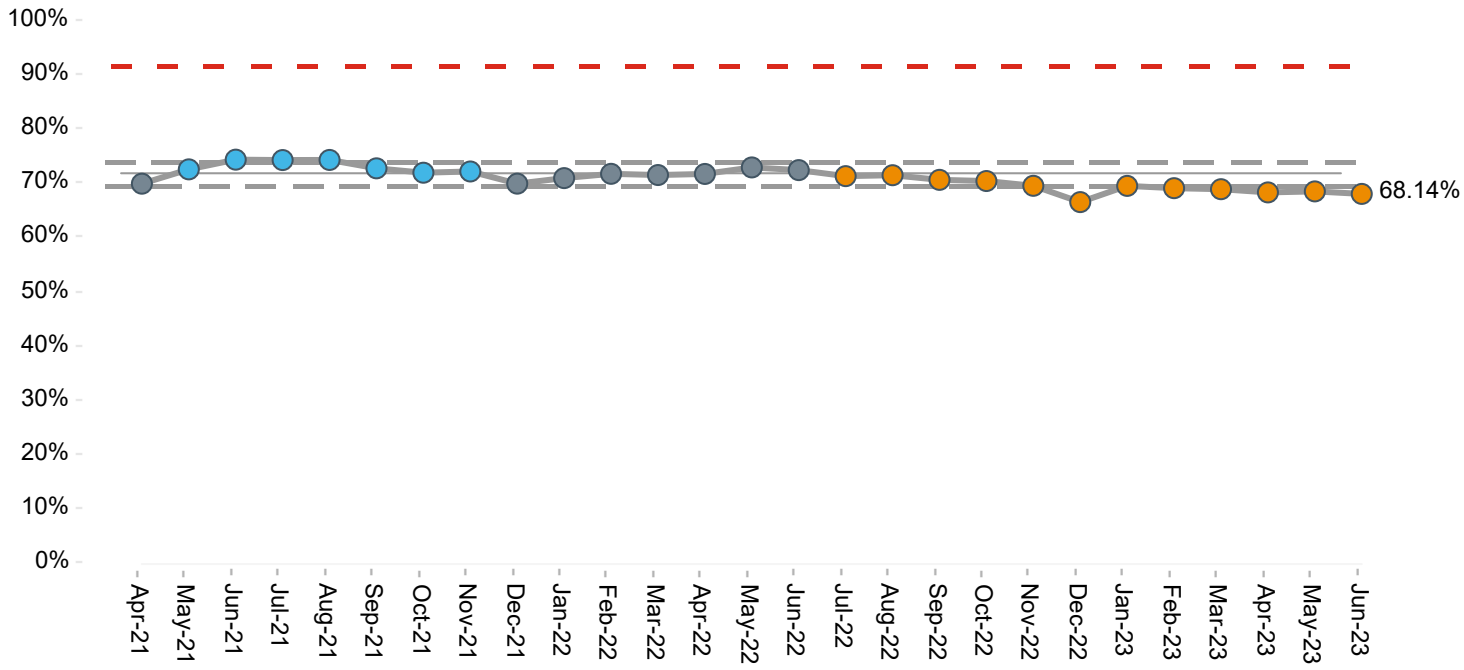
Access

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 remains relatively stable with a current part-validated performance of 68.01%, compared to last months finalised position of 68.6%. Nationally GHFT still remains in a favourable position.

Associate Director of Elective Care

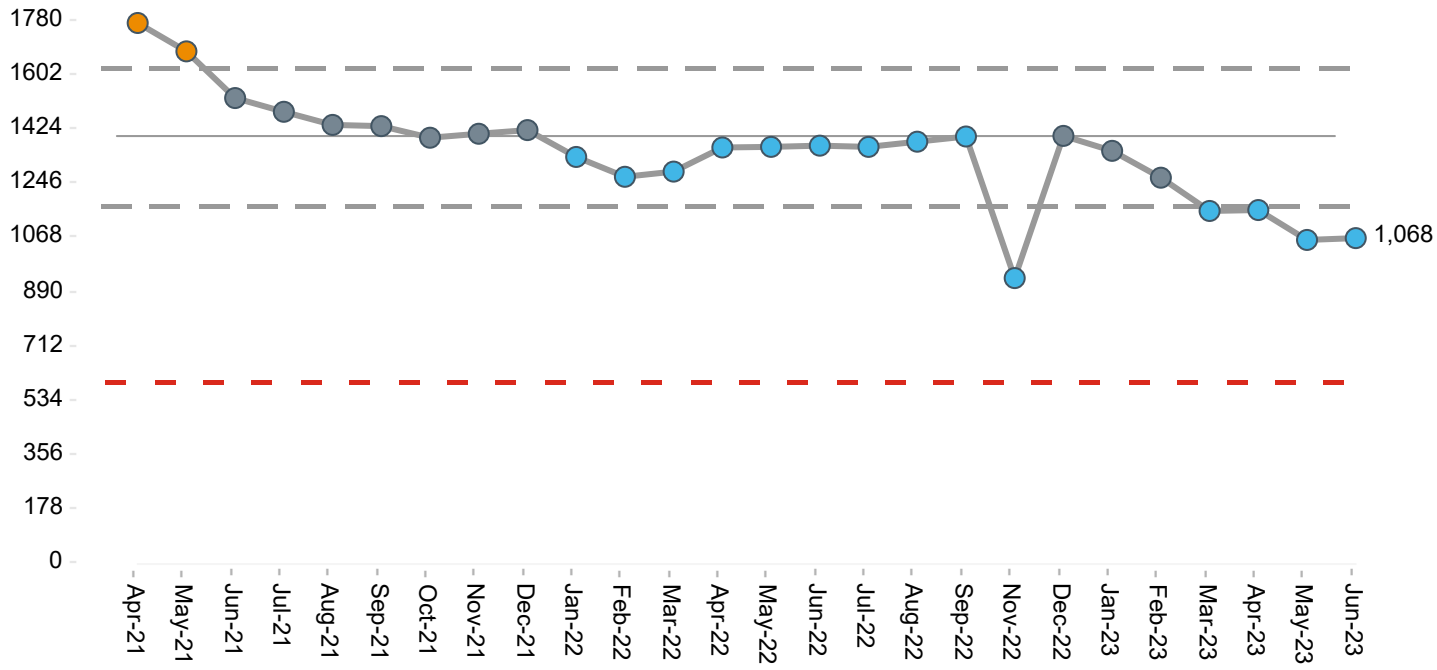
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 600



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Commentary

The number of planned / surveillance patients waiting is increasing. This has been impacted by the recent increased focus of meeting cancer targets, along with doctors strikes and bank holidays, however the biggest factor is the fact that the Gastrenterology establishment is not sufficient enough to meet increasing demand. Demand and capacity modelling is currently underway to identify the staffing requirement which will be developed into a business case. This will support the current development of an ICB Diagnostics workforce plan. Weekly meetings in place to monitor the situation. Also in support 2 fellows are due to start in August / September. There is also a visiting consultant who is with us over the next 2 months whose main focus is DM01 and Surveillance patients. A meeting with the Regional Diagnostic Lead has taken place and further action planning is being developed.

General Manager of Endoscopy

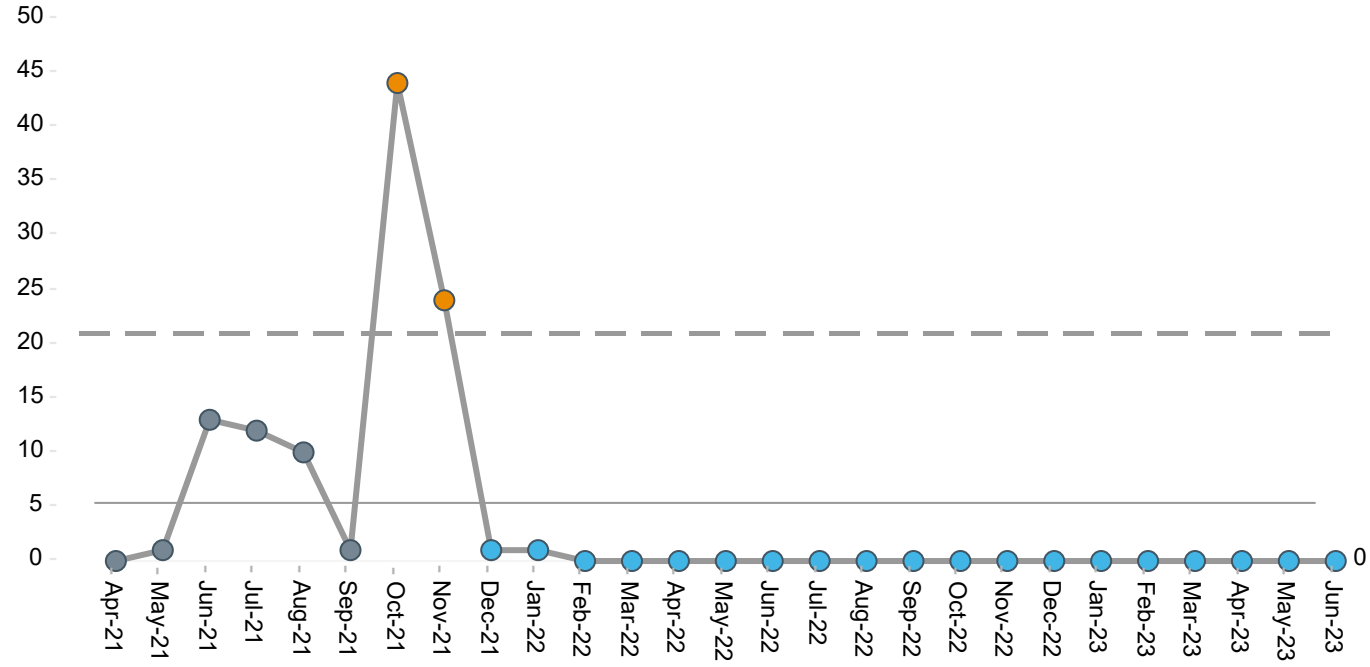
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[552] Urgent cancelled operations

- - - Target: ↓ Lower



Data Observations

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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		Jun-23	77.7%	
	Inpatients % positive	No Target		Jun-23	91.9%	
	Maternity % positive	No Target		Jun-23	71.4%	
	Outpatients % positive	No Target		Jun-23	94.2%	
	Total % positive	No Target		Jun-23	91.8%	
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower		Jun-23	19.8	
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target		Jun-23	58	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target		Jun-23	188	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target		Jun-23	95	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target		Jun-23	75	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower		Jun-23	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7		Jun-23	4.0	
	Number of E. coli bacteraemia cases	No Target		Jun-23	4	
	Number of Klebsiella bacteraemia cases	No Target		Jun-23	4	
	Number of MSSA bacteraemia cases	≤ 8		Jun-23	1	
	Number of Pseudomonas bacteraemia cases	No Target		Jun-23	0	
	Number of bed days lost due to infection outbreaks	↓ Lower		Jun-23	17	
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5		Jun-23	2	
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5		Jun-23	3	
	Number of trust apportioned C. difficile cases per month	< 10		Jun-23	5	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Infection Control	Number of trust apportioned MRSA bacteraemia	= 0		Jun-23	0	
Maternity	% PPH >1.5 litres	↓ Lower		Jun-23	6.6%	
	% breastfeeding (discharge to CMW)	= 0.0%		Jun-23	49.5%	
	% breastfeeding (initiation)	No Target		Jun-23	71.4%	
	% of women smoking at delivery	≤ 14.50%		Jun-23	8.32%	
	% of women that have an induced labour	≤ 30.00%		Jun-23	24.18%	
	% stillbirths as percentage of all pregnancies	< 0.52%		Jun-23	0.00%	
	Number of births less than 27 weeks	No Target		May-23	1	
	Number of births less than 34 weeks	No Target		Jun-23	2	
	Number of births less than 37 weeks	No Target		Jun-23	12	
	Number of maternal deaths	No Target		Jun-23	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target		Jun-23	3.2%	
	Total births	No Target		Jun-23	93	
Mortality	Number of deaths of patients with a learning disability	No Target		Jun-23	0	
	Number of inpatient deaths	No Target		Jun-23	139	
	Summary hospital mortality indicator (SHMI) - national data	No Target		Apr-23	1.104	
MSA	Number of breaches of mixed sex accommodation	≤ 10		Jun-23	44	
Operational Efficiency	Daily Average of Boarded Patients	No Target		Jun-23	10	
Patient Advice and Liaison Service (PA..	% of PALS concerns closed in 5 days	No Target		Jun-23	73%	
	Number of PALS concerns logged	↓ Lower		Jun-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	Jun-23	18	
	Medication error resulting in moderate harm	↓ Lower	Jun-23	2	
	Medication error resulting in severe harm	↓ Lower	Jun-23	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Jun-23	38	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Jun-23	0	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Jun-23	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Jun-23	15	
	Number of falls per 1,000 bed days	↓ Lower	Jun-23	6.10	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Jun-23	4	
	Number of patient safety incidents - severe harm (major/death)	No Target	Jun-23	8	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Jun-23	15	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Jun-23	66.50%	
	Number of DoLs applied for	No Target	Jun-23	93	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Jun-23	92	
	Total admissions aged 0-17 with DSH	↓ Lower	Jun-23	30	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Jun-23	5	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Jun-23	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Jun-23	0	
	Total number of maternity social concerns forms completed	No Target	Jun-23	81	
Serious Incidents	Number of never events reported	= 0	Jun-23	0	
Serious Incidents	Number of serious incidents reported	↓ Lower	Jun-23	9	
	Percentage of serious incident investigations completed within contract timescale	> 80%	Jun-23	100%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%	Jun-23	77.8%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Jun-23	69.5%	

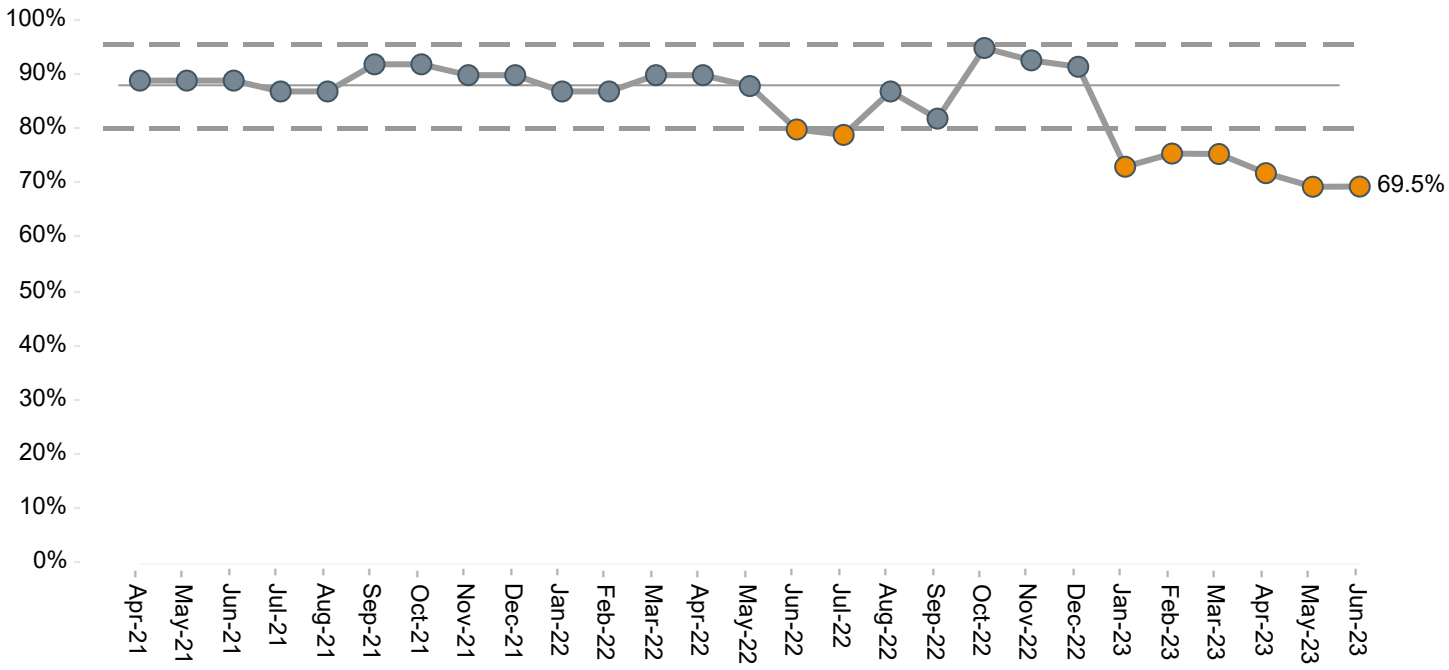
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[125] % of adult inpatients who have received a VTE risk assessment

- - - Target: No Target



Data Observations

[1] SINGLE POINT

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Commentary

awaiting metric validation and handover from AS

Quality Improvement & Safety Director

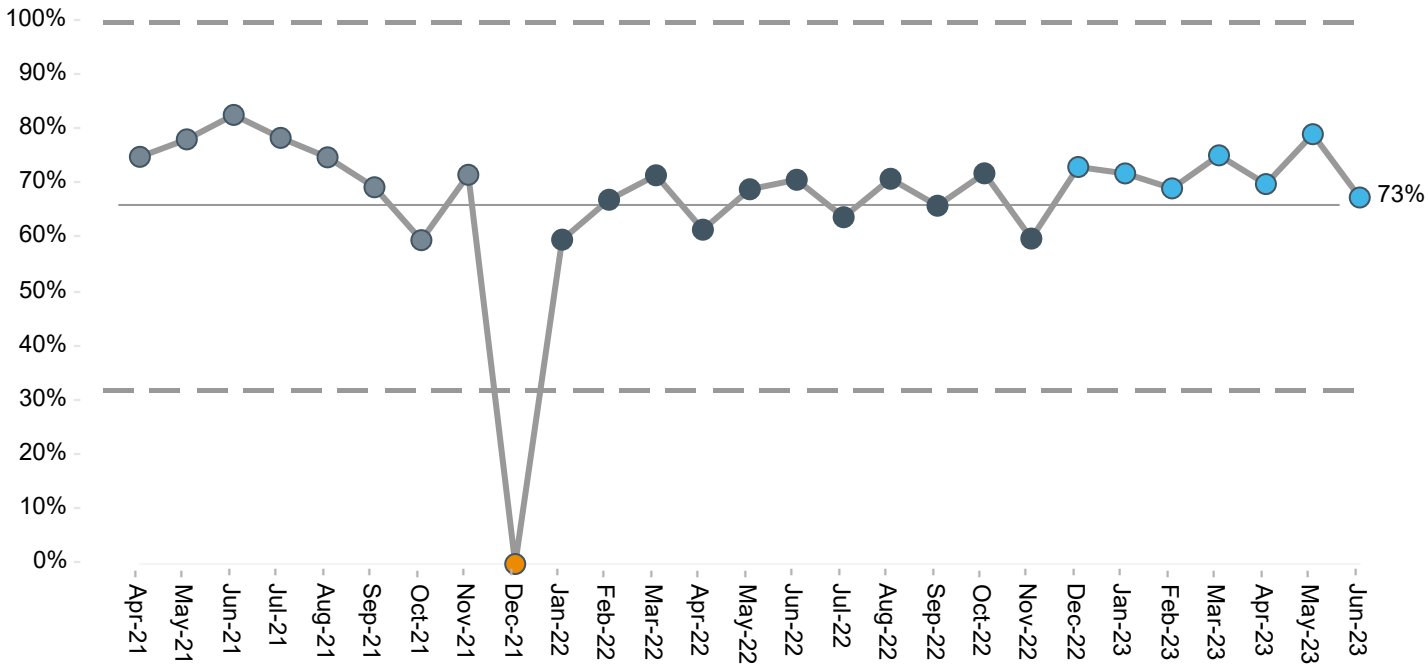
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[569] % of PALS concerns closed in 5 days

Target: No Target



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[5] UNDER-STRATIFICATION

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

Commentary

The % of PALS Concerns closed within 5 working days is 73%, a slight decrease from 86% in May. The number of new concerns received in June is down slightly. The improved position is due to the slight reduction in number of concerns received in the month. Complexity of cases remains high and this is seen in the number of issues within each concerns.

This metric is monitored at QDG through the Patient Experience Report.

Head of Quality

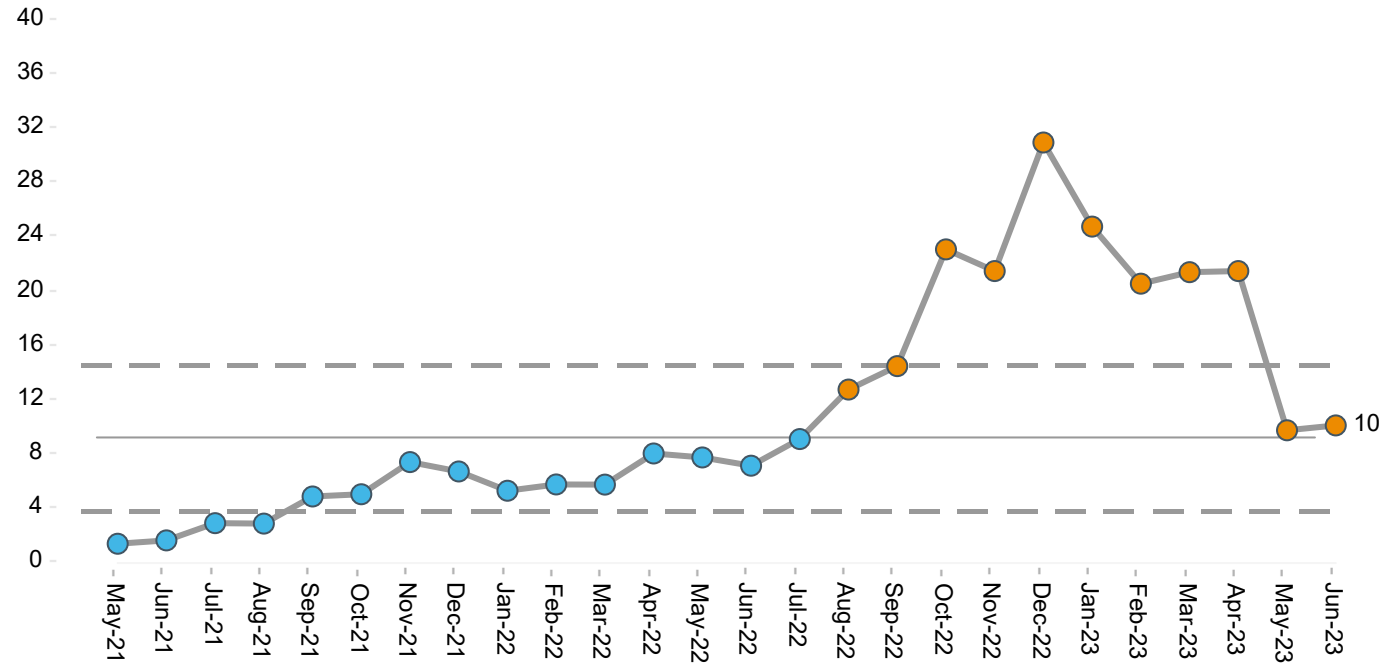
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[607] Daily Average of Boarded Patients

- - - Target: No Target



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Commentary

Director of Operations for Hospital Flow

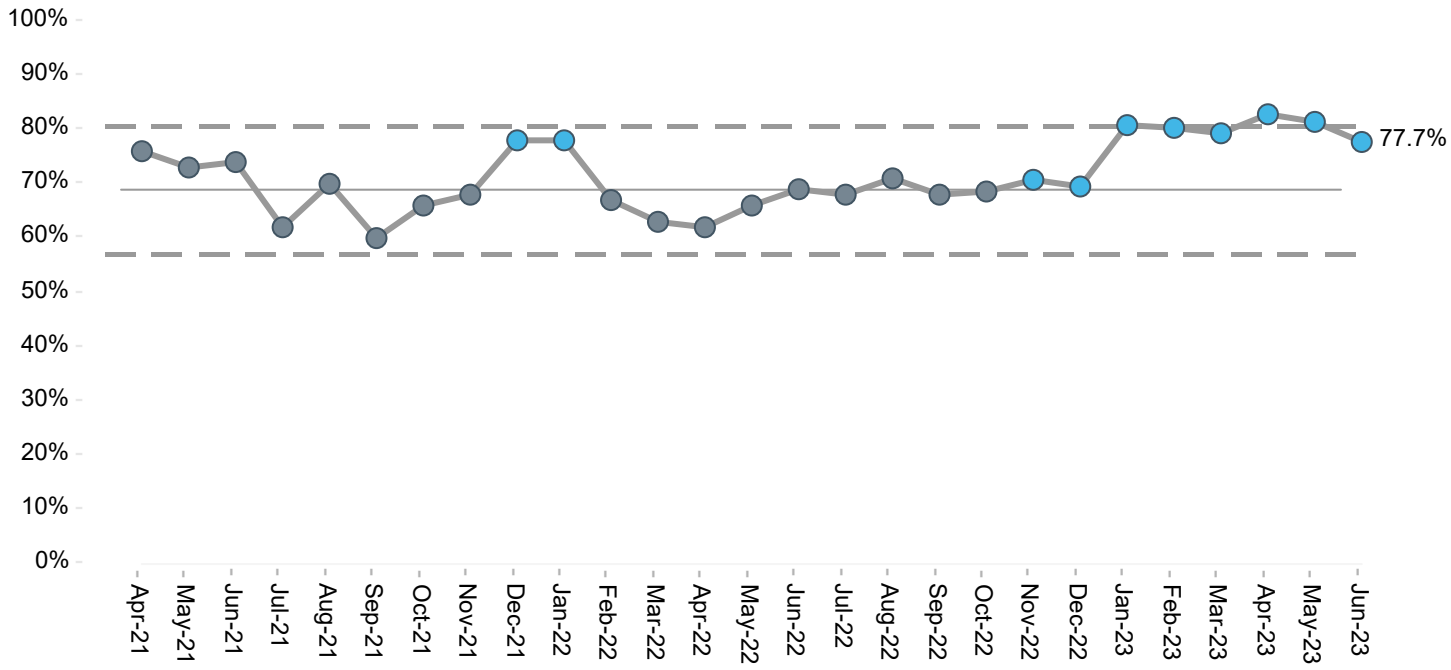
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[154] ED % positive

Target: No Target



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Commentary

The current positive FFT score for ED is at 77.7% across both sites, a decrease from 81.4% in May 2023.

Despite this decrease the score
remains above the average for the eighth month. The score reflects the increased operational pressures facing the department.

The main
theme remains focused on wait times and the information provided while waiting. The team receive and review reports on the feedback weekly, both FFT and PALS, and are supporting real time improvement in response to any emerging themes. This approach has seen the department maintain above average scores .

Updates and monitoring is through to QDG.

Head of Quality

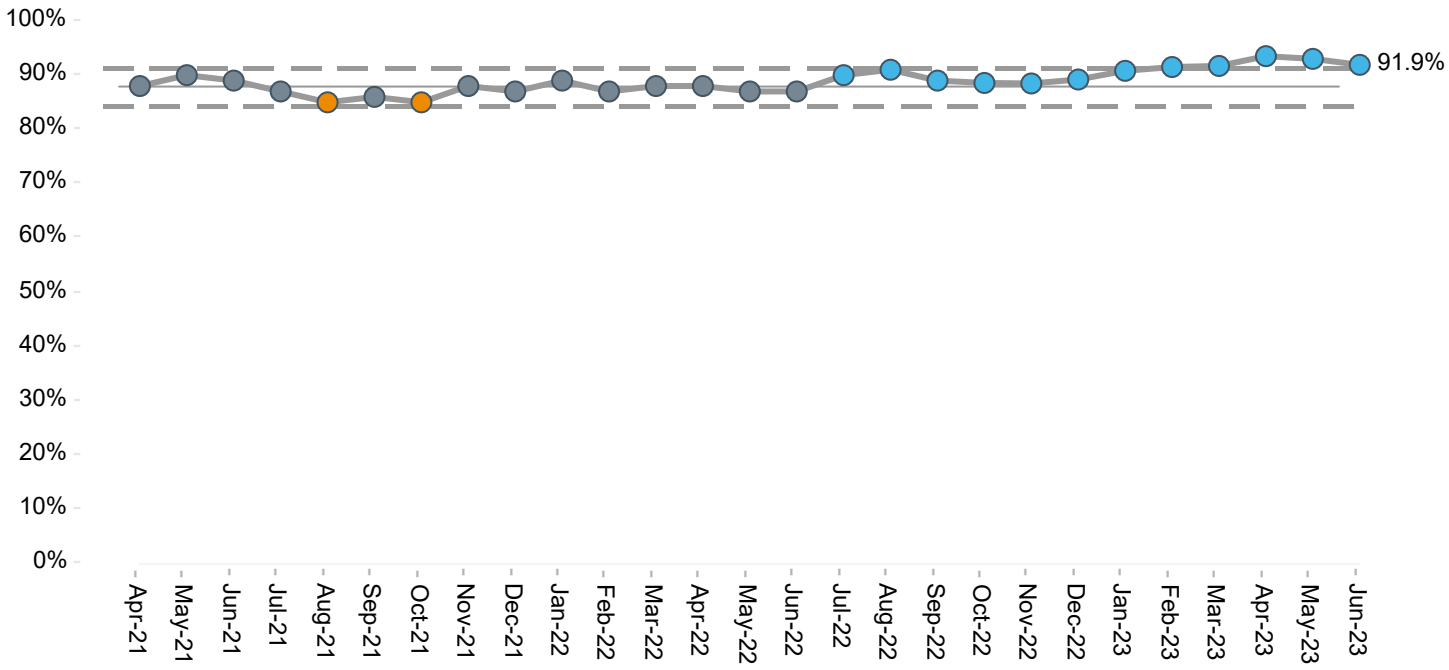
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[153] Inpatients % positive

- - - Target: No Target



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Commentary

Inpatient % positive 91.9%

The current positive FFT score for Inpatient and Daycase is at 91.9%, a decrease from 93.0% in May. The twelfth month of the score above the average of 87% and the fifth month above the upper control limit.

There is not one thing driving
this, however, we have seen an increasing trend in the concerns and comments relating to the organisation and management of our services and the impact of this on communication and basic patient care. Patients report that staff are overall kind and caring with acknowledgement that there are significant pressures due to staffing and resources.

Updates and monitoring will be reported through
Quality Delivery Group via divisional reports and the Patient Experience Report.

Head of Quality

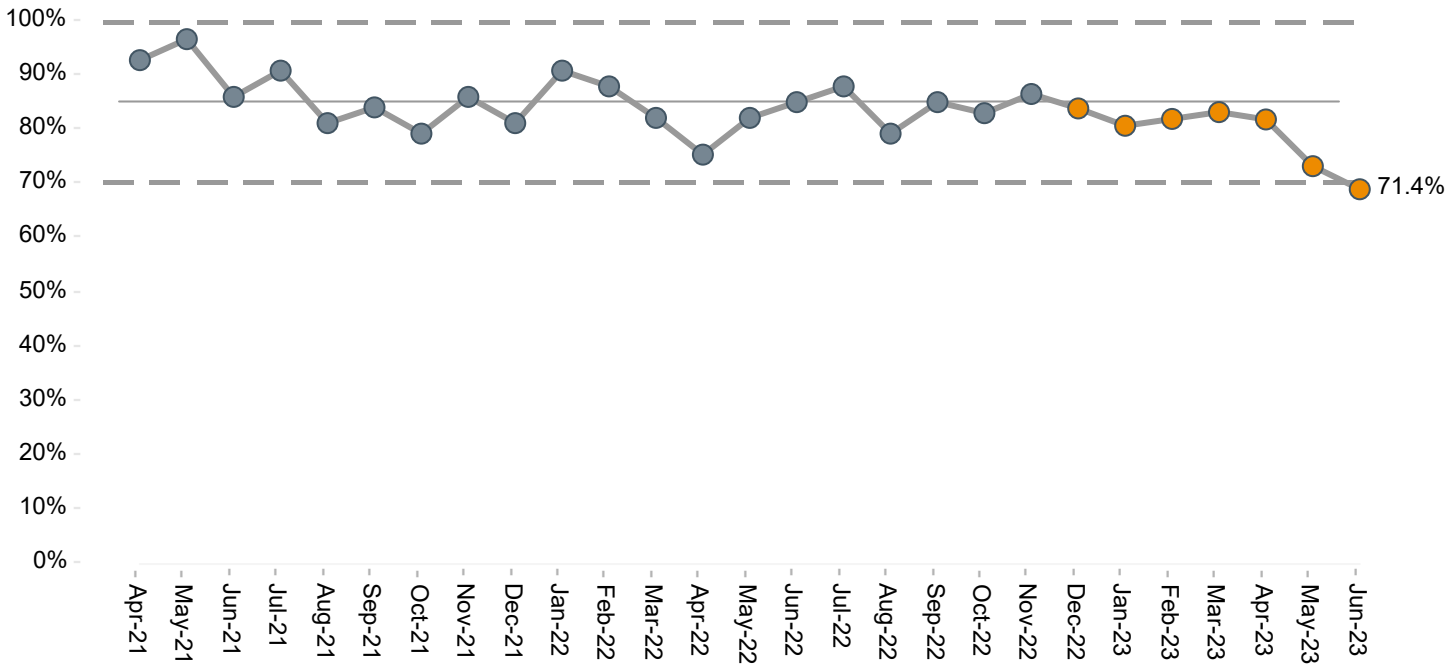
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[155] Maternity % positive

- - - Target: No Target



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Commentary

Maternity % positive 71.4%

The current positive FFT score for Maternity services is 71.4%, which is a decrease from May 2023 (75.8%).
The positive score is now below the lower control level and has been below the average for seven months.

The reduction in score is
mostly due to a lower score for delivery suite/ birth. The score for the maternity ward remains lower than the birth touchpoint but the division are focusing on improvements on the Maternity Ward as identified as part of collaborative working event and continues in line with feedback. The division are also exploring how experience data is reviewed and acted on to enable learning and improvement. This work is being supported by the Patient Experience team.

Head of Quality

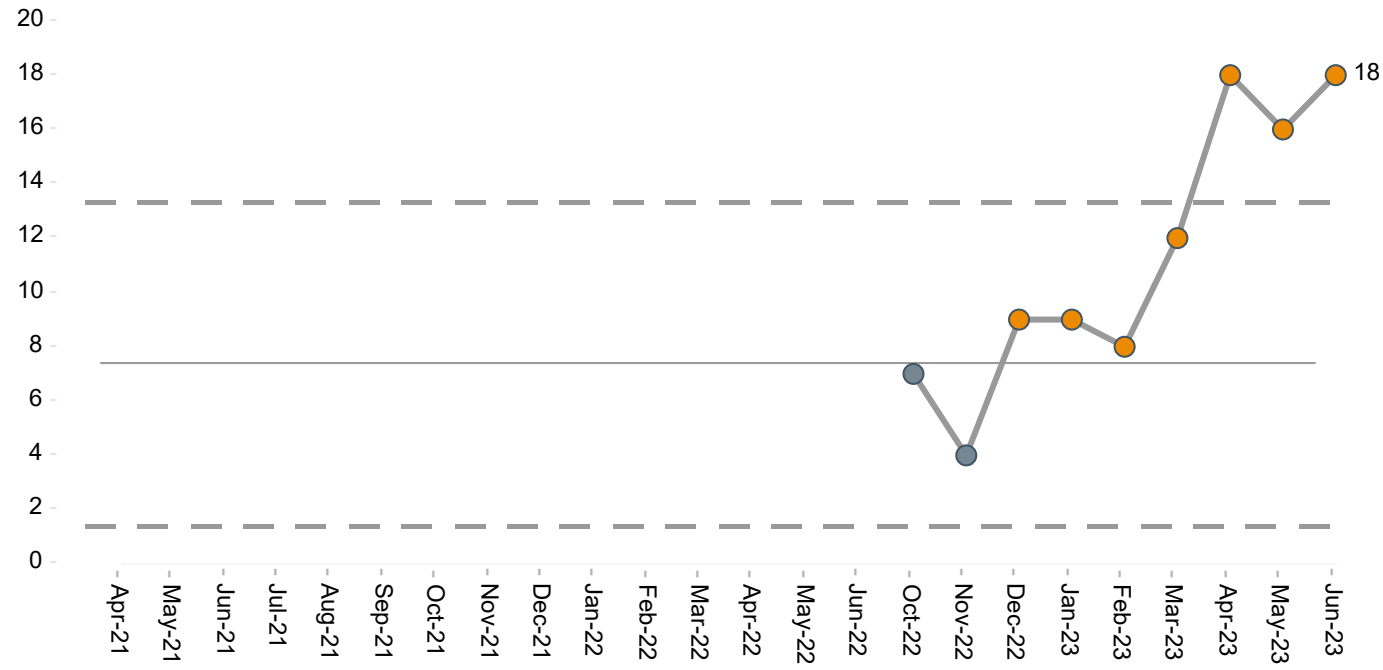
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[460] Medication error resulting in low harm

- - - Target: ↓ Lower



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Commentary

Quality Improvement & Safety Director

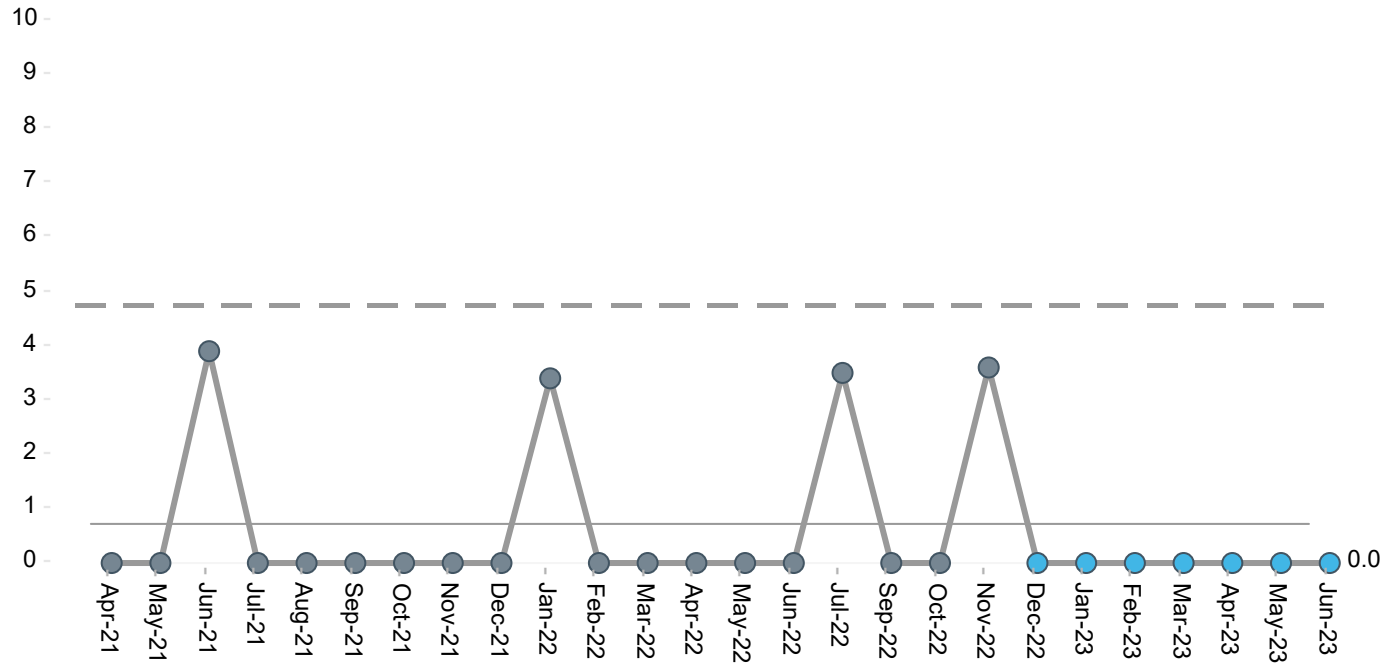
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Data Observations

[2] SHIFT

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Commentary

There have been no MRSA bacteraemia cases in June 2023; we continue to have a zero tolerance approach to MRSA BSI and reduction of Gram positive bacteraemias continues to be a focus of the IPC annual programme for 2023/24 with a particular focus on device related causes and high risk populations.

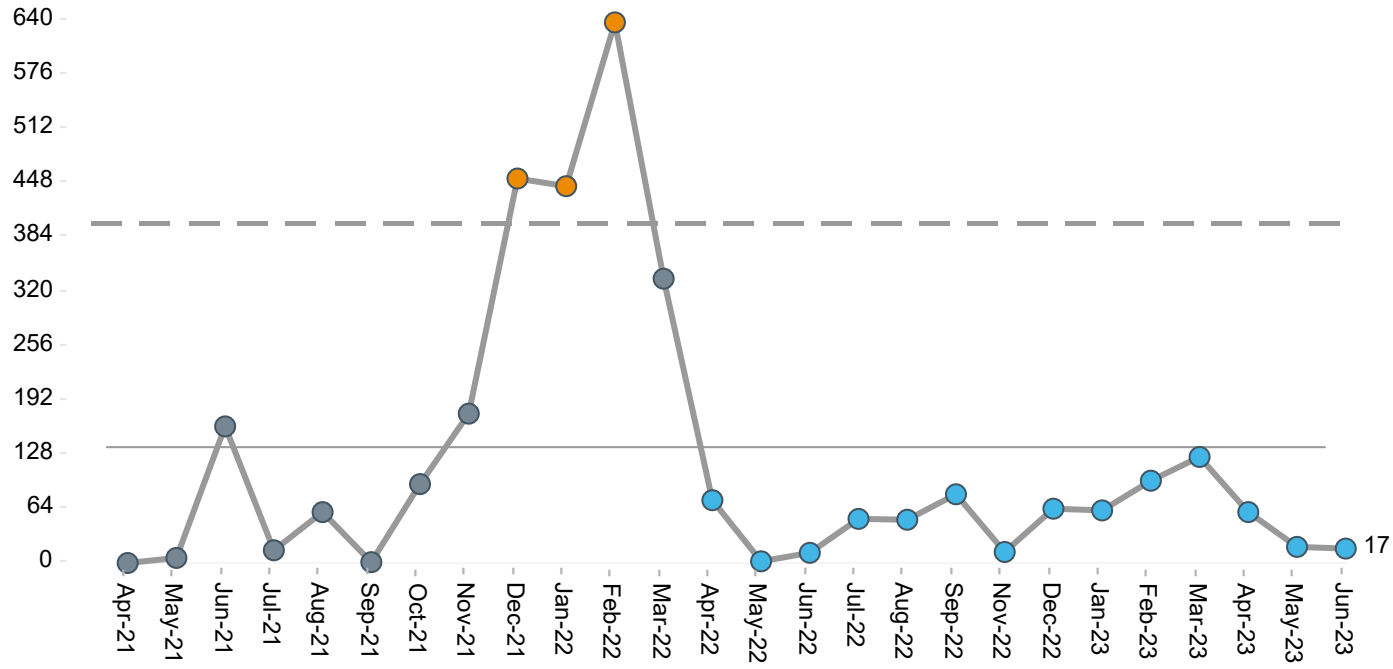
Director of Infection Prevention & Control

Quality

SPC - Special Cause Variation

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

- - - Target: ↓ Lower



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Commentary

During June 2023, 18 bed days were lost due to outbreaks associated with transmission of COVID-19. 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 cleaning. With COVID-19 testing changes as per national guidance the number of outbreaks associated with COVID-19 is likely to reduce further.

Director of Infection Prevention & Control

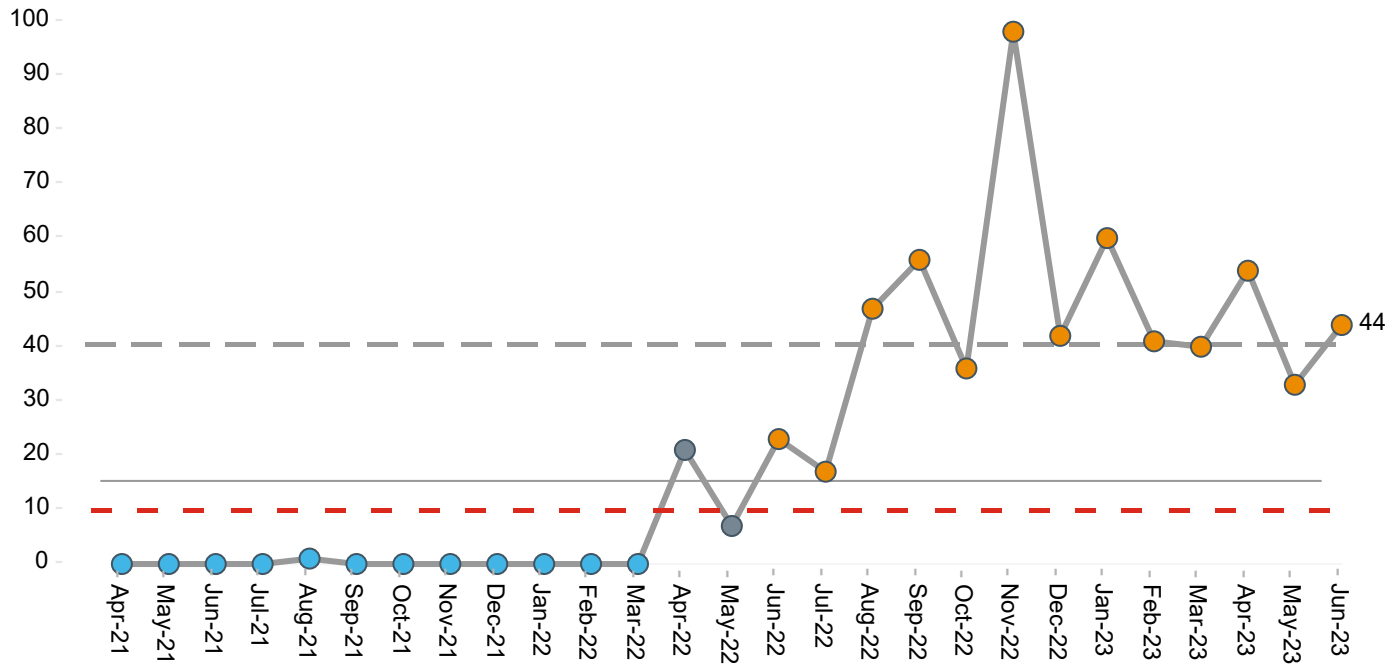
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[148] Number of breaches of mixed sex accommodation

Target: ≤ 10



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[4] 2 OF 3

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Commentary

Mixed-sex accommodation breaches are recorded manually each day. These are due to operational pressures when patients can be placed into wards from assessment areas and recovery within a 4-hour window. Breaches for clinical reasons are reported to the Gold director on-call and action is taken to resolve the issue as soon as possible.

Deputy Chief Nurse

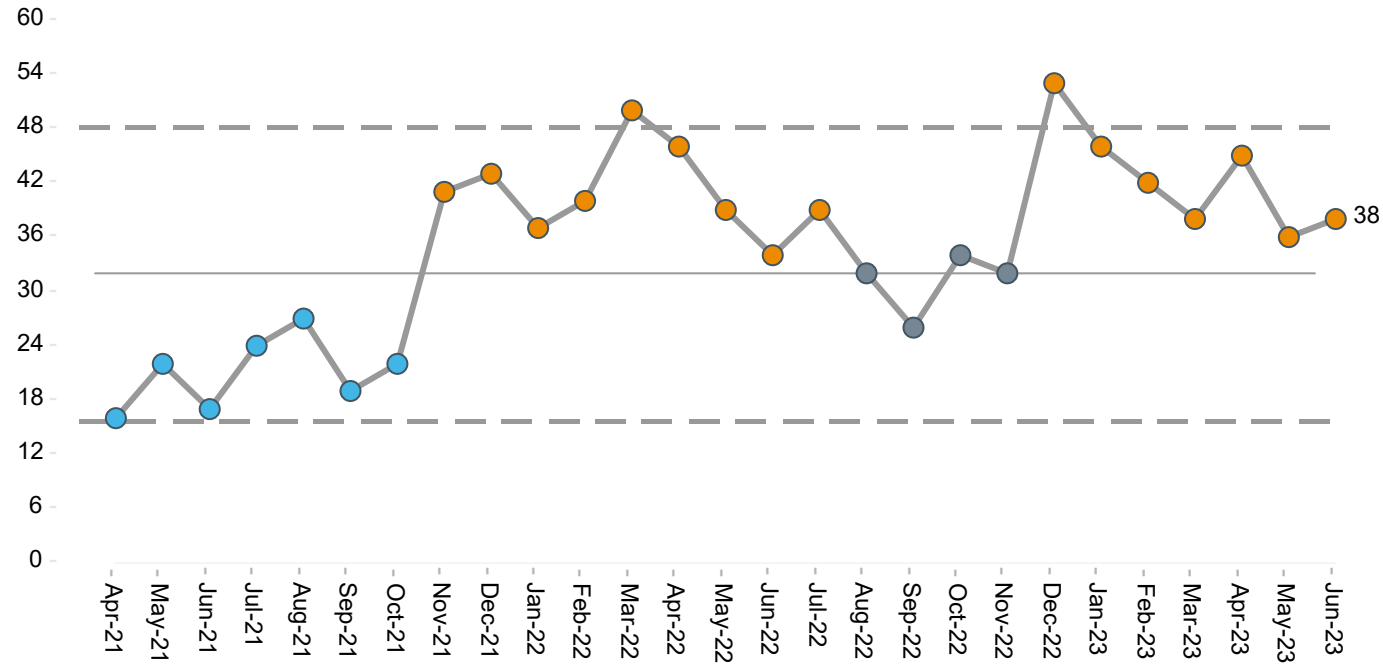
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Commentary

There were 38 category 2 pressure ulcers acquired in hospital during June 2023. Risk factors are not enough care hours available per patient, prolonged periods of immobility in the ED and periods waiting in hospital corridors.
Deputy Chief Nurse

Data Observations

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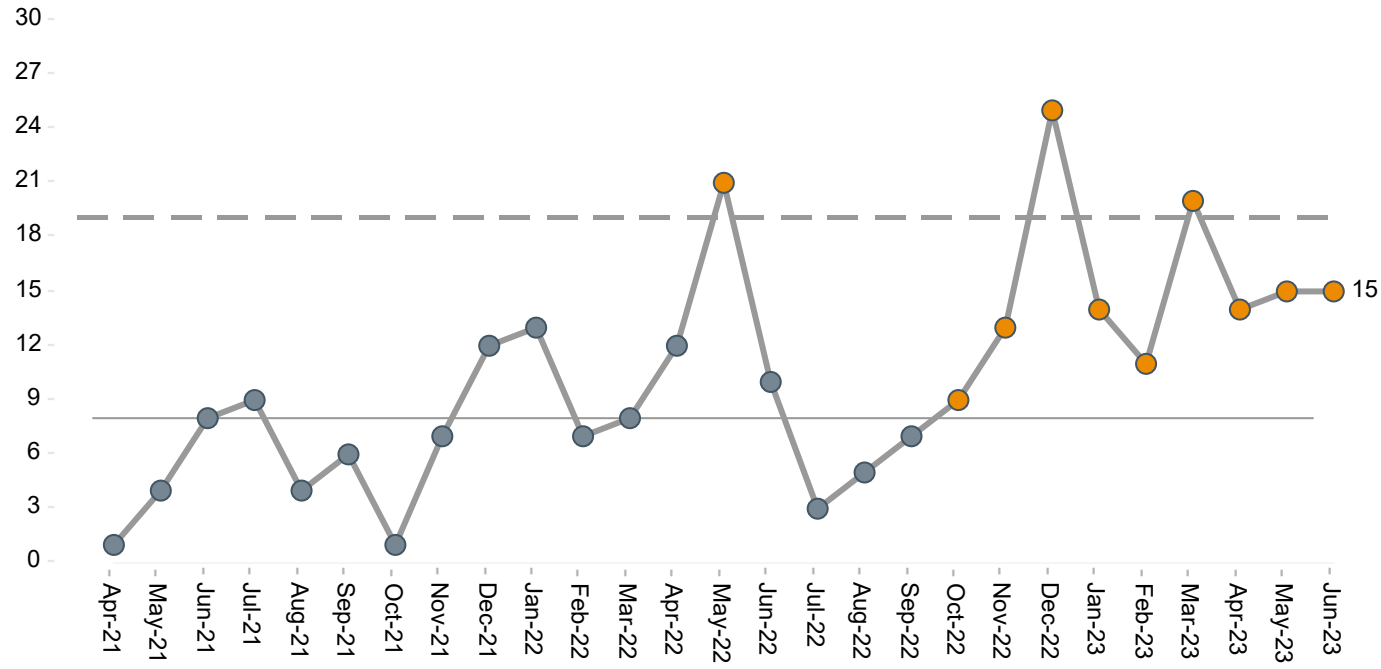
Quality

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

There were 15 deep tissue injuries acquired in hospital during June 2023. Each of these are reviewed with the ward team as part of the Preventing Harm Hub. Risk factors include not enough care hours available per patient, prolonged immobility in the ED and periods spent in hospital corridors.

Deputy Chief Nurse

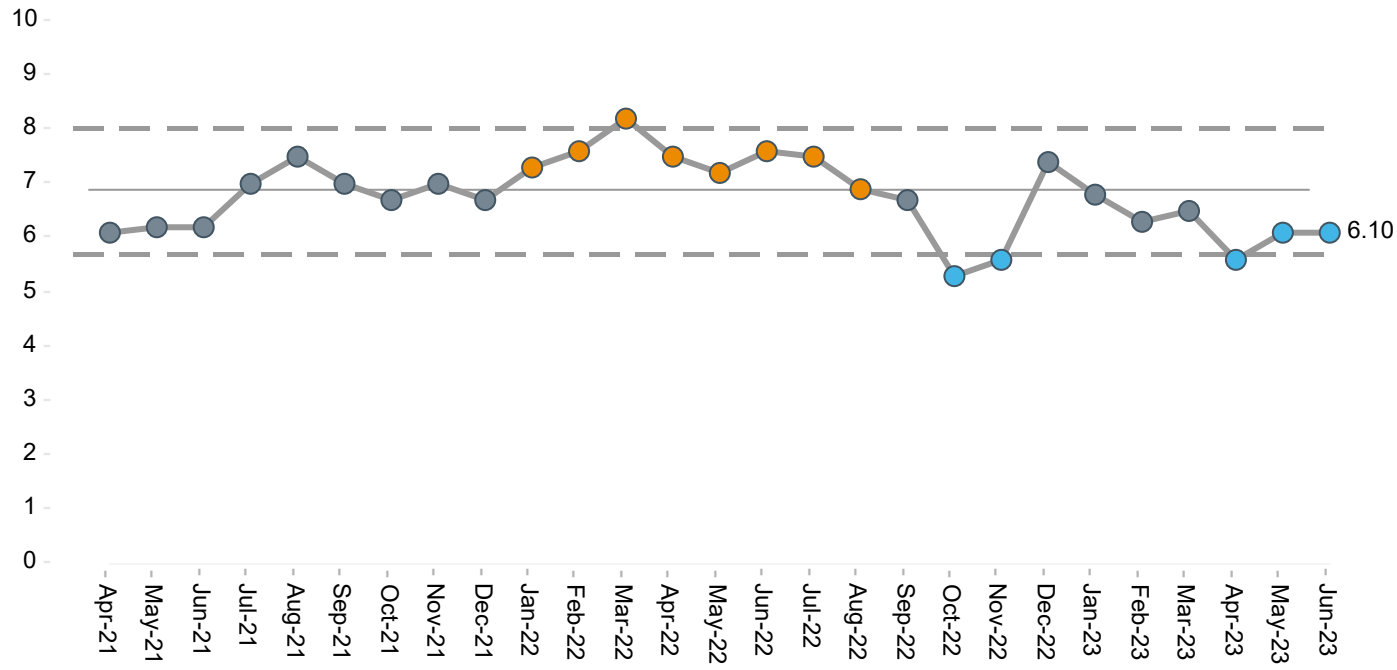
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Commentary

Falls per 1000 bed days remained at a rate of 6.1, the same as the previous month. The rate in June 2022 was 7.6.
Deputy Chief Nurse

Data Observations

[1] SINGLE POINT

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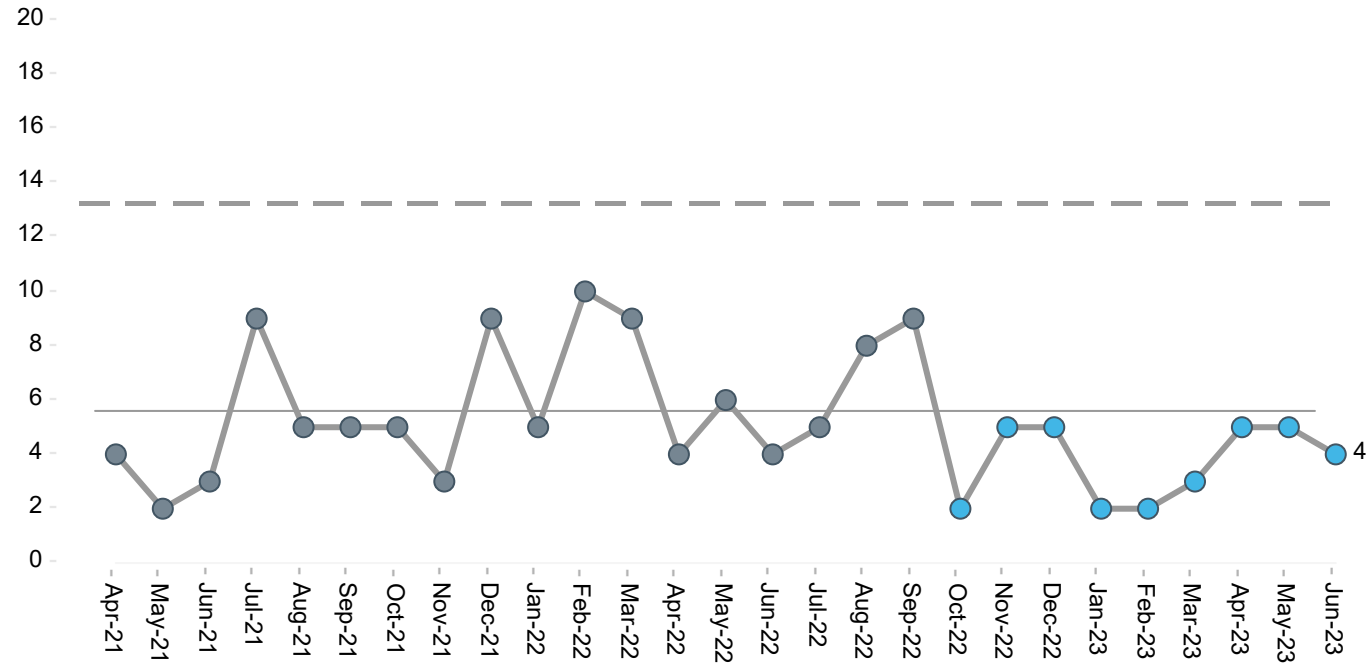
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[113] Number of falls resulting in harm (moderate/severe)

- - - Target: ↓ Lower



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

There were 4 falls resulting in harm during June. All falls with harm are reviewed with the ward team by a specialist falls practitioner and the patient safety investigation team.

Deputy Chief Nurse

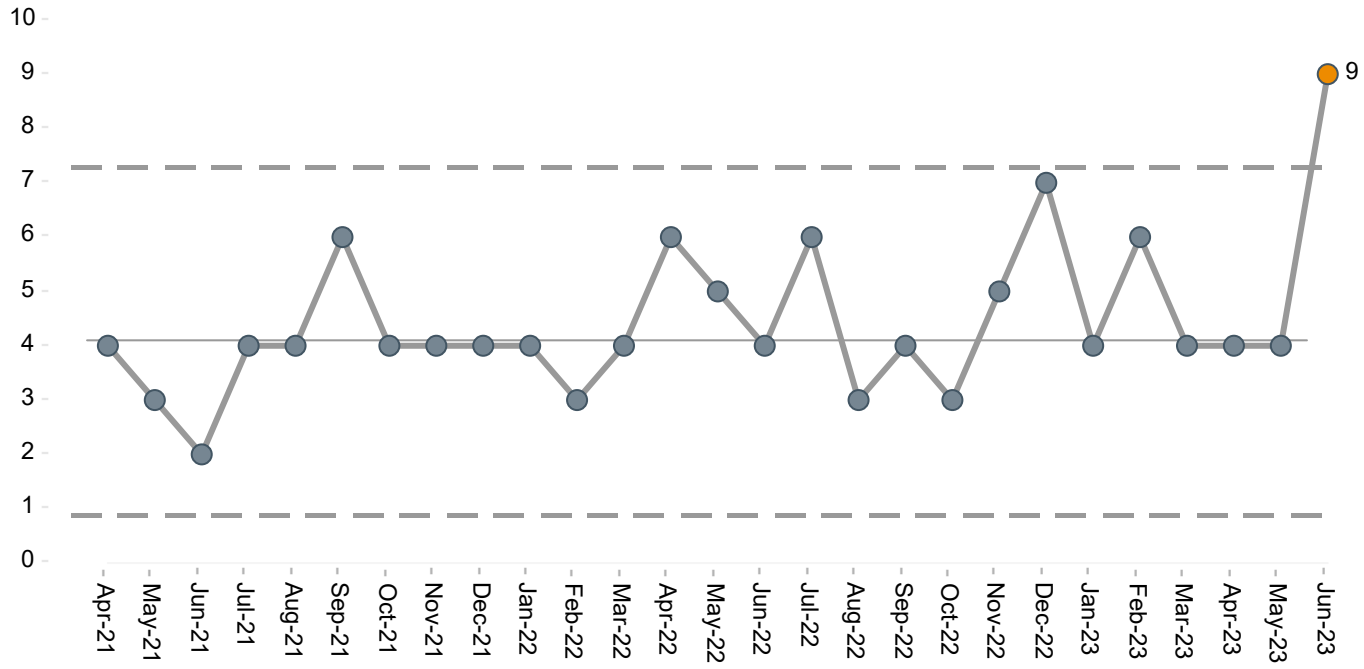
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[103] Number of serious incidents reported

- - - 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.

Commentary

Quality Improvement & Safety Director

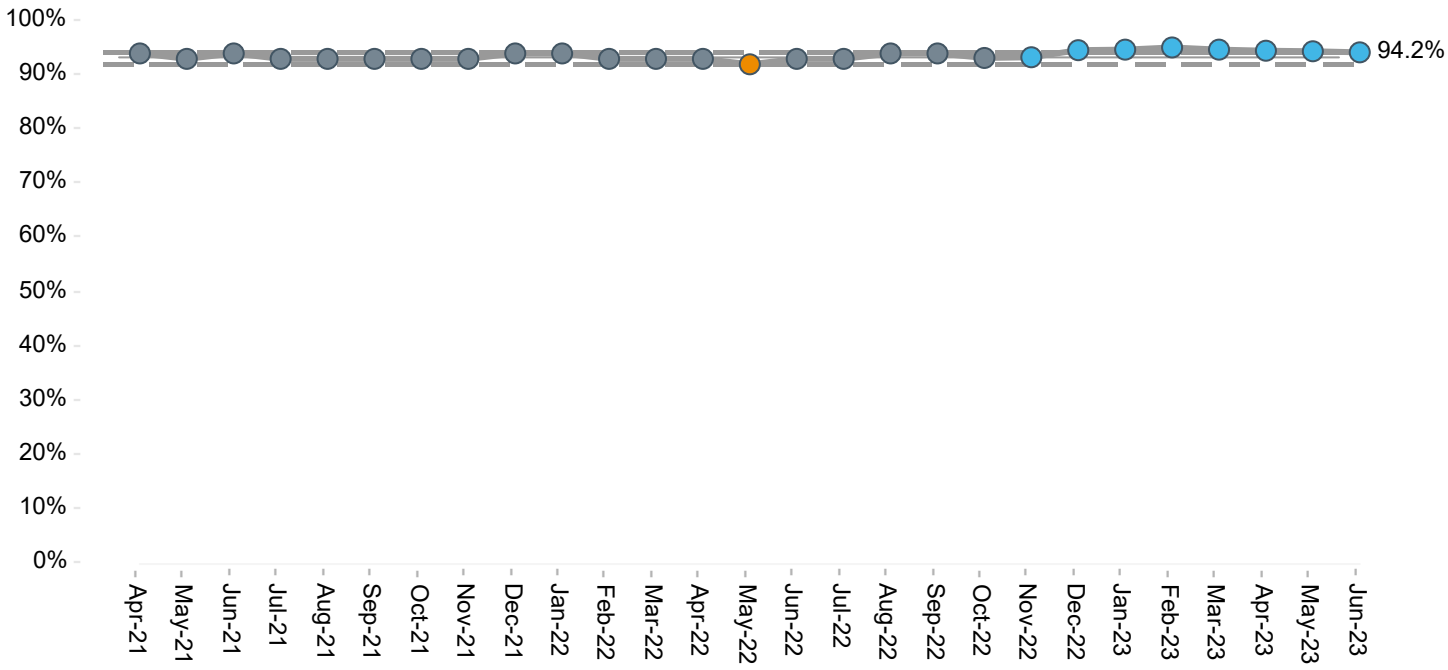
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[291] Outpatients % positive

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

Outpatient % positive 94.2%

The current positive FFT score for Outpatients is 94.2%, a slight decrease from 94.4% in May. This is the eighth month the positive score has been above average, however, this is the fourth month we have seen a decline albeit slight. Comments remain overall positive with many saying 'thank you'. The main themes on areas for improvement continue to be on waits for appointments, waits in the outpatient departments and appointments feeling rushed.

Head of Quality

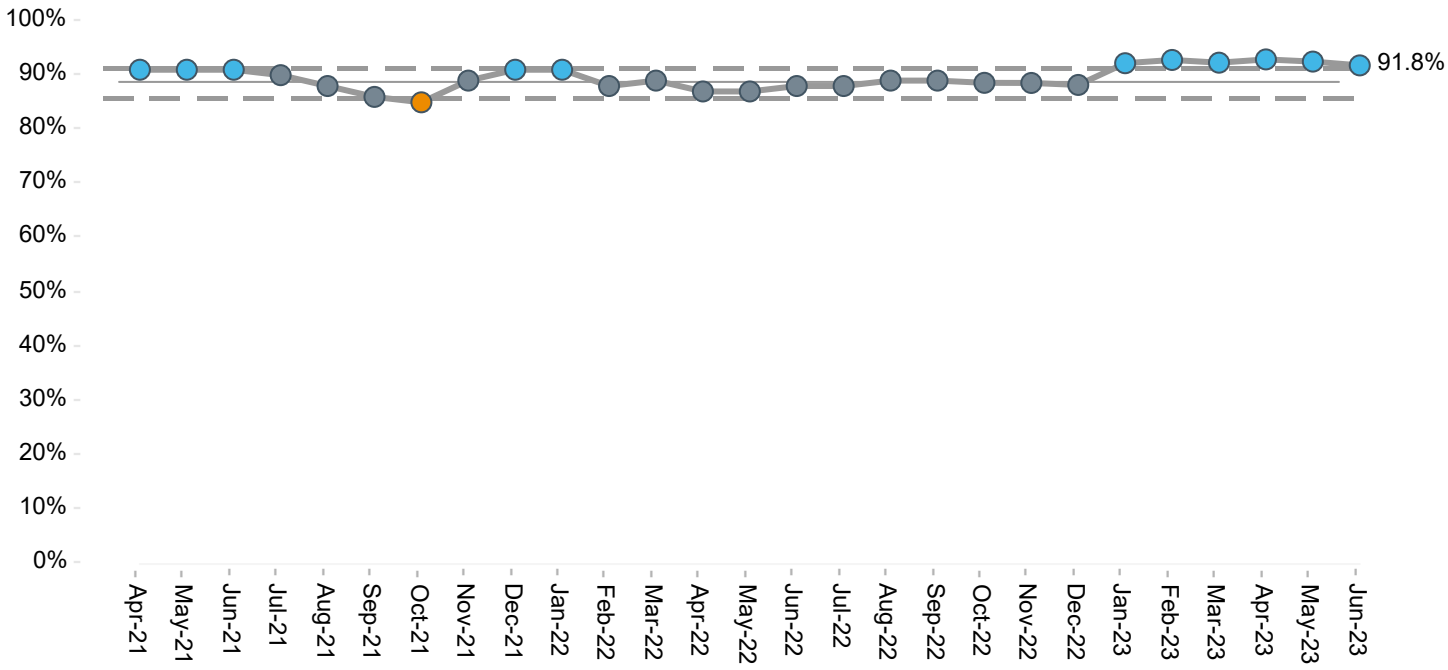
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[156] Total % positive

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.

[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

The overall Trust FFT positive score has seen a slight decrease this month to 91.8% compared to 94.4% in May.

Our overall score sees us
maintain our position above the upper control limit for the sixth month running despite a reduction in all care types.

Divisions
provide updates through QDG each quarter on improvement plans happening within their areas, and the patient experience team have amended the current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans. Further improvements will continue to be identified.

Head of Quality

Report to Trust Board of Directors			
Agenda item:		**Enclosure Number:**	
Date	September 2023		
Title	**Maternity Safer Staffing Report** (Jan – June 2023)		
Author /Sponsoring Director/Presenter	Director of Midwifery - Lisa Stephens Chief Nurse - Matt Holdaway		

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

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 January to June 2023. This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 5.

The Covid-19 pandemic and the national pressures on maternity services 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 and monitored at Maternity Delivery Group. Trusts should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. This will be confirmed in the next Maternity Staffing paper.

- The trust has implemented the RCOG monitoring and effectiveness tool for all future long-term locums contained within the RCOG Guidance on the engagement of long-term locums in the maternity care, and a 6- month audit is underway commencing in May 2023. This will be reported to MDG with relevant recommendations in November 2023.

- The trust has completed a Compensatory Rest SOP which is going through Guidelines processes.

The Obstetric Job plan reflects the requirement to enable compensatory rest and an agreed monitoring process is being formulated. Currently, job plans ensure that there are no direct clinical commitments scheduled on the rest day. An audit is to be undertaken to provide assurance on compliance commencing in July for Quarter 1. This will be reported to MDG in September 2023. This will be repeated again for Quarter 2. Any action plan arising from the audit will be shared with the Safety Champions and LMNS

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). There are gaps within the rotas due to sickness absence and maternity leave, however these gaps are filled largely by internal locums. The LMNS have been informed of these standards being met through the SW NICU/LNU Medical Workforce Stocktake.

Neonatal nursing workforce

- The Unit remains challenged in relation to nurse staffing 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.
- A GIRFT deep dive visit in May 2022 identified that Neonatal Qualification in Speciality rates of 63% was below national recommendation of 70%
- A review is underway to review neonatal workforce. If an action plan is required, this will be shared with the LMNS and Safety Champions and monitored via MDG

Midwifery workforce

- Midwifery Staffing has remained critical with vacancies during this period in the region of 17 – 35 whole time equivalents (WTE). The vacancy rate in June 2023 was 14.41%. 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)

- A **BirthRate plus** (BR+) full review of midwifery staffing has been completed. The recommended total workforce requirement (Band 3 – Band 9) to provide total clinical specialist and management is 274.15 WTE to compare with 278.62 resulting in an overall positive variance of 4.47 WTE. The service and the LMNS are supportive of no change to funded establishment during this period of national and local drivers and the minimal uplift of 21% which is low in comparison with other trusts.

- The **Midwifery Coordinator on delivery suite has supernumerary status** to ensure there is an oversight of all birth activity within the service. There were no occasions when this status was not maintained.

- The **midwife to birth** ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. Compliance with the BR+ ratio of 1:24.4 was not achieved during May and June 2023 which was associated with high levels of vacancies and decreasing bank fill. 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 until 7th of June, and then Badgernet. The average of: 1:1 Care in labour compliance remains at 97%. 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 February 2023 and improved slightly during the following 3 months. Fill rate is generally less at night than during the day. The Head of Midwifery is working with matrons on staffing KPI's to address this.

- 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 **Midwifery Managers and specialist midwives** employed is 13.19% % of the total midwifery workforce establishment which are not included in the direct care numbers (meets the standard which is advised at 8-10%). However the emphasis on midwifery leadership and specialism posts has arisen post national reports.

Midwifery Continuity of care

- 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

Red Flags are incidences of possible concern with staffing

- The most frequent staffing Red Flag and clinical actions was associated with delays in Induction of labour (IOL). There was a range of between 8 and 22 delays in starting and a range of 51 – 122 delays in continuing IOL episodes based on monthly data from Jan to June 2023. 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 and the quality of care as evident by Midwifery Staffing Quality indicators.

Recommendation

The Board to note the contents of the report on Maternity Workforce planning to the required MIS standard

Where audits have commenced an update will be provided in the next paper

Due to the intensive requirements to achieve compliance with MIS year 5 a follow up Quarter 2 paper will be presented to board in November 2023

Enclosures
Maternity Safer Staffing Report

BI-ANNUAL MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT

QUALITY AND PERFORMANCE COMMITTEE 13 September 2023

BOARD 14th September 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 safe staffing levels.

1.2. This report covers the period January to June 2023. Our focus is to ensure women, babies and their families receive the maternity care they need, including care in all:

- maternity services (for example, pre-conception, antenatal, intrapartum and postnatal services, clinics, home visits and maternity units)
- settings where maternity care is provided (for example, home, community, free-standing and alongside midwifery-led units, hospitals including obstetric units, day assessment units, and fetal and maternal medicine services).

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

2. Background

2.1. It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

2.2. Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

2.3. Previously midwifery staffing data has been included in the nurse staffing paper, however since 2022, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

2.4. 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)

- 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

3. Executive Summary

3.1. This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 5.

3.2. 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).

3.3. Midwifery Staffing has remained critical with vacancies during this period in the region of 17 – 35 whole time equivalents (WTE). The vacancy rate in June 2023 was 14.41%. 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).

3.4. A **BirthRate plus** (BR+) full review of midwifery staffing has been completed. The final paper has been received. The recommended total workforce requirement (Band 3 – Band 9) to provide total clinical specialist and management is 274.15 WTE to compare with local establishment of 278.62 resulting in an overall positive variance of 4.47 WTE. The service and the LMNS are supportive of no change to funded establishment during this period of national and local drivers and the minimal uplift of 21% which is low in comparison with other trusts.

3.5. An extensive midwifery staffing plan for 2022/23 has continued and is progressing with **notable achievements** of:

- Successful recruitment to Senior roles of Band 8 and above:
- New EPR System commenced in June 2023
- Perinatal Workforce Strategy completed and launched
- Full complement of Matron team appointed – with full team in post in July 2023
- Full funded implementation of the flow role with 24/7 cover. There are still gaps in rota as new Band 7's are appointed
- Consultant midwife commenced
- Lead Midwife (Healthy Lifestyles and Tobacco Dependency) commenced

- Organisational Development Lead has launched and the 4 cohorts programmes concluded in June 2023 Evaluation has been very positive.
- Commencement
- Two Return to Practice and two International recruitment midwives commenced in this period.
- Two GHNHSFT Registered Nurses have been commenced places on the University of Worcester MSc RM programme (Shortened – 2 years) in March 2023, with a further 8 HEE funded places for the next academic year
- Midwifery Wellbeing Evaluation project with Psychologist ongoing

3.6. Midwifery staffing remains on the risk register with RISKS:

- Workforce Vacancies and turnover rate
- Low morale associated with poor staffing levels
- Level and pace of change
- Anticipated low uptake of midwifery incentives to support staffing fill rates during summer months despite incentives
- Not achieving 100% compliance with 1:1 care in labour – there is an ongoing action plan in place that has trust sign off.

4. Birthrate Plus Workforce Planning

4.1. A formal Birth Rate Plus assessment was completed in January 2023, which reviewed the acuity of women who used maternity services, at GHNHSFT.

4.2. This review recommended a birth to midwife ratio of 24.4:1 births across the Trust.

4.3. NICE (2017) recommend that an assessment is carried out every three years. The recommended total workforce requirement (Band 3 – Band 9) to provide total clinical specialist and management is 274.15 WTE to compare with 278.62 resulting in an overall positive variance of 4.47 WTE. The service and the LMNS are supportive of no change to funded establishment during this period of national and local drivers and the minimal uplift of 21% which is low in comparison with other trusts.

4.4. The service does employ a significant number of Band 2 maternity care assistants. Only Band 3 Maternity Support Workers can offset the midwifery establishment with a 90/10 for postnatal skill mix. This will be adjusted during the period where Band 3's complete the MSW programme and the trust focus on Band 2 roles.

5. Midwifery Staffing

5.1. 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 in October 2023. Postnatal Beds at Stroud have also been temporarily closed and will be reviewed in October 2023.

5.2. There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group

5.3. During June 2023 there was combined **57.81 WTE** shortage of midwifery staff due to vacancies, maternity leave, and sickness absence.

Table: Combined Midwifery Shortfall (WTE) Source: Maternity Workforce PMO

Month (2023)	Jan	Feb	Mar	Apr	May	Jun
Combined shortfall (WTE)	44.26	35.74	53.69	51.76	56.44	57.81

5.4. The **vacancy of 35.41 WTE is multifactorial** due to resignations associated with retirement, dissatisfaction with midwifery, internal and external promotion or movement into non-clinical post and health related reasons as well as an increase in establishment associated with Ockendon clinical funding. In addition, some long-term sick is converting to leavers as illustrated in the reducing sickness rate. It is noted that many staff are opting to reduce hours or resign, whilst converting to Bank contract.

5.5. There are currently 13.19% of Midwifery Managers and specialist midwives and midwives employed and this exceeds the BR+ recommendation of 8-10%. However, the emphasis on midwifery leadership and specialism posts has arisen post national reports.

5.6. 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, Maternity Incentive Scheme and local and national Maternity Improvement programmes.

Table: Managerial and Specialist posts (WTE) Source: Maternity Workforce PMO

	Band	**Funded establishment**		**WTE in Post**		
		Dec 22	**June 23**	**July 22**	**Dec 22**	**June 23**
Managerial Position	8/9	6	9.2	6.8* (*1 WTE LTS)	5.8*	10.2*
Specialist Midwives	6/7	15.71	17.07	22.63	21.65	20.35

5.7. Below is the breakdown of the midwifery clinical establishment

Table: Funded midwifery clinical establishment June 23 (Source: ESR)

		Funded Establishment		**WTE in post**		
	Band	**Dec 22**	**June 23**	**July 22**	**Dec 22**	**June 23**
Team Leaders	7	22.16	27.52	26.22	25.36	25.80
Clinical Midwives	5/6	218.25	218.25	185.46	198.55	184.55
	Total	**240.41**	**245.77**	**211.68**	**223.91**	**210.35**

5.8. 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.

5.9. Some new posts have been recruited to following the BR+ review and there are additional posts that are being recruited to.

Specialist midwife posts in Band 6 and Band 7 in GHNHSFT include:

- Perinatal Mental Health Team
- Vulnerable Women's Team
- Safeguarding Team
- Risk Management Midwife
- Recruitment and Retention Midwife
- Digital Midwife – this team expanded in preparation for Go Live in June 23
- Screening Midwife
- Bereavement midwife
- Contraception Midwife
- Audit & Guidelines Midwife
- Practice Development Midwife
- MSW Project Midwife
- Fetal Monitoring Midwife
- Infant Feeding Support
- Frenulotomy Midwife
- Practice Facilitators (Delivery Suite/Community)

New posts being recruited to:

Specialist Midwife: Preterm Birth/Complex Pregnancies
Quality Midwife: PMRT/HSIB/Audit and Guidelines

5.10.

Table: Band 8/9 Midwifery Posts June 23 (Source: ESR)

		Funded		WTE in post		
Role	**Band**	**Dec 22**	**June 23**	**July 22**	**Dec 22**	**June 23**
Director of Midwifery	9	1.0	1.0		0	1
Head of Midwifery	8C	1.0	1.0	1.0	1.0	1
Consultant Midwife	8B	0.6	0.6	0	0	0.6
Lead Midwife (Healthy Lifestyles & TDD)	8A	0.6	0.6	0	0	0.6
Midwifery Matrons	8A	3.0	5.2	3.8	3.8	5.2
Safeguarding Midwife	8A	0.4	0.8	0.4	0.4	0.8
Governance Lead	8A	1.0	1.0	1.0	1.0	1.0
Specialist Midwives	6/7	19.96	17.07*	22.62	21.62	20.35

6. Midwifery Recruitment and Retention

6.1. The maternity service has a range of 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

6.2. 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 May 2023. The extended incentives within service budget included – Enhanced Bank pay rate Temporary Standby rotas for unsocial hours, and a Golden Welcome for new starters. Additional incentives include enhanced bank rates for community and unit on call staff called in during escalation

6.3. There are currently 35.39 WTE (June 2023) vacancies in the clinical workforce funded establishment.

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

6.5. In the period, Jan – June 2023 11 new Midwives have joined the trust having accepted the 'Golden Welcome'.

Table: New Starters – headcount (Source: R&R New Starter Tracker)

Month	Jan	Feb	Mar	April	May	June
Starter number	0	5	2	3	0	1

6.6. Higher than average levels of turnover and slow recruitment over Q1 and Q2 have led to the high vacancy rate

7 Turnover, absence and sickness

7.1. Currently there are 44.26 WTE shortage of midwifery staff due to turnover, maternity leave, and sickness absence.

Table: Staffing leave/ absence and secondment Jan – June 23*
***(Source: Health-Roster)** * March 22 included as comparator*

Month/Yr	WTE			
	Sickness	**Maternity Leave**	**Vacancy**	**Total**
Mar 22*	**35.13**	**13.96**	**28.73**	**77.82**
Jan-23	16.15	10.15	17.61	43.91
Feb-23	20.23	7.75	25.76	53.74
Mar-23	15.42	8.60	29.67	53.69
Apr-23	14.71	9.20	26.96	50.87
May-23	16.51	9.57	29.36	55.44
Jun-23	12.29	10.11	35.39	57.79

7.2. It is notable that the peak associated with absence in March 2022 led to a combined rate of 77.82 WTE. Whilst vacancy rates have increased, sickness and maternity leave is settling.

7.3. 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 however it has enhanced safer staffing.

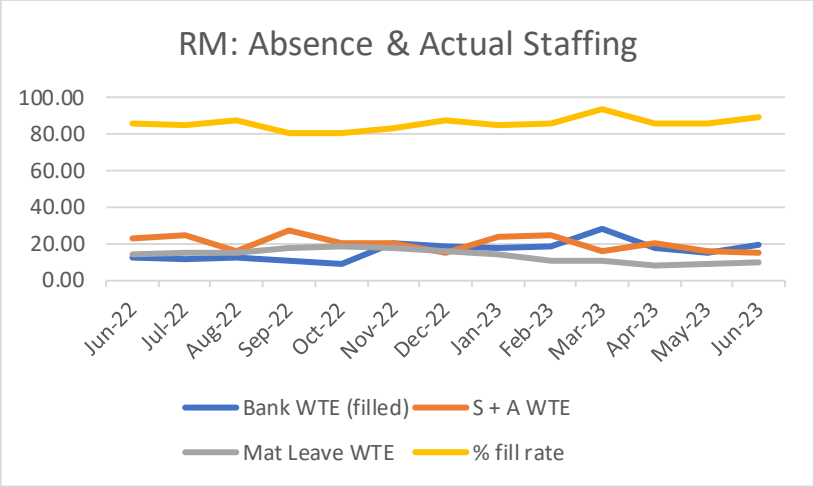
7.4. The use of Bank nurses has been well received supporting midwives on the maternity ward and on delivery suite to care for high risk surgical and medical patients and fixed term roles for Band 5 nurses within maternity are being considered. A Band 7 midwife has been appointed to oversee the Governance associated with the commencement of these RN posts to support the team on the maternity ward. Four fixed term Registered Nurse posts have been accepted.

7.5. The opportunity to work within maternity strengthens their application for the MSc programme.

7.6. Two registered nurses from GHNHSFT have commenced the MSc programme in March 2023. They have been offered a secondment and course fees funded by HEE.

7.7. Eight HEE funded places have been acquired for March 2024 and communication about recruitment to these places are in progress

Graph – Midwifery Absence and Fill rates Jan – June 23:



7.8. In response to the poor staffing rates, actions within the service have included closure or reconfiguration of elements of the maternity service

8 Midwifery leadership

8.1. 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.

8.2. 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.

8.3. 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

8.4. 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.

8.5. 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".

8.6. Further actions in response to staffing shortfall over the past 6 months have been a feature of managing the service based on midwifery availability.

8.7. 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.

9. Escalation and Trust risk register entry

9.1. 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.

9.2. 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.

9.3. The risk associated with midwifery staffing (**W&C3536OBS)** remains on the Trust Risk Register (score:20). An improvement action plan was developed.

9.4. This has now been followed by a prospective Midwifery Workforce Improvement plan which outlines actions associated with:

- Improved Recruitment process
- Recruitment and Retention lead posts
- Reduction of turnover rate
- International recruitment
- Improving quality of workforce data

Workforce Action plan	October 22	March 23	July 2023
Closed	0	3	
Overdue	16	1	
In Progress	10	15	
Complete	1	7	
Total number of elements	**26**	**26**	**26**

9.5. 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 continues 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. Similarly the introduction of twice daily MDT induction huddle supports clinical decision making for the team when faced with high levels of acuity.

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.

Table 12 – Mandatory Training Compliance – All Staff groups: Jan – June 23
(Source: Local Training Data)

MEASURE	Jan	Feb	Mar	Apr	May	Jun
Elearning Compliance	82%	80%	80%	79%	80%	79%
PROMPT Training - part 1	53%	61%	68%	-	74%	81%
PROMPT Training - part 2	57%	66%	72%	-	81%	89%

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

10.4. During 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 was put in place with additional training dates so that compliance can be met by end of December 2023. This forms part of the CQC 'Must Do's'

Table: Appraisal Compliance rates Jan - June 2023

Month	Appraisal compliance %
Jan 23	75%
Feb 23	74%
Mar 23	75%
Apr 23	79%
May 23	76%
June 23	73%

10.5. The progress in completion rates for maternity has continued reflecting the effort and focus by our staff and managers, completion rates maintained with an average of 75% The completion rates fell slightly short of the 80% hoped for by this stage. There is still some way to go to reach or exceed 90% completion and the forthcoming summer months where staffing is anticipated to be challenging there is a risk associated with compliance.

10.6. The Organisational Development Lead post which commenced in August 2022 is supporting the overall compliance with appraisals.

10.7. 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

includes:

- 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

11. Planned Versus Actual Midwifery Staffing Levels

11.1. Fill rate is calculated monthly. The following table outlines percentage fill rates for the clinical areas (in-patient and community) month by month. The midwifery fill rate is RAG rated and illustrates actual staffing with consideration of absence and agency and bank shifts. Enhancement and incentives for Bank and standby continue with acknowledgement of the longer-term impact upon the health and wellbeing of the midwifery workforce. In addition, a growing picture where staff are converting from contract to Bank only posts. Fill rates have been stable since October 2022. This is monitored on a daily basis and staff are redeployed across the service based on activity and the acuity.

Table: Registered Midwives – Clinical Establishment fill rate (source: ESR/Health Roster)

Month	Fill rate - percentage
Jan-23	94
Feb-23	85
Mar-23	86
Apr-23	89
May-23	89
Jun-23	87

The following table outlines percentage fill rates for the inpatient areas by month.

Table: Maternity Service Fill rate Jan – June 2023 Source: Bank office

	Day qualified %	Night qualified %
Jan-23	96%	88%
Feb-23	94%	91%
Mar-23	94%	86%
Apr-23	97%	86%
May-	95%	91%

23		
Jun-23	90%	85%

11.2. Fill rates have dropped particularly in the night for several reasons during school holidays and because of short term sickness, maternity leave, and long-term sickness. This is monitored daily, and staff redeployed based on the acuity. There have been several new starters recently which will improve these in Quarter 3.

11.3. Fill rate is generally less at night than during the day. The Head of Midwifery is working with matrons on staffing KPI's to address this.

11.4. In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness. Over the past 2 years an extensive ongoing Midwifery Workforce Action plan has been implemented.

12. Birth to Midwife Ratio

12.1. The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. This has now been added to the maternity dashboard so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio.

12.2. The Birthrate plus report published in Feb 2023 highlighted the local overall birth to midwife ratio based on casemix, taking into account the variation in complexity within obstetric led and midwifery led settings. This was calculated at: 24.4 births to 1 wte

Table: Midwife to Birth ratio (BR+ overall local ratio 24.4:1)

Month	Midwife to Birth Ratio
Jan 2023	1:24
Feb 2023	1:23
Mar 2023	1:22
Apr 2023	1:23
May 2023	1:28
June 2023	1:26

13. Birth Rate Plus Live Acuity Tool

13.1. The Birth Rate Plus (BR+) Live Acuity Tool was introduced a number of years ago in the Central Delivery Suite and more latterly in the alongside Birth centre (Gloucester birth unit). The tool is not utilised in the standalone birth centres. The tool has been purchased for use in the Maternity Ward (Antenatal and postnatal

inpatient area), however the BR+ team are updating the tool so it has not yet been implemented.

13.2. The BR+ tool enables midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

13.3. The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

13.4. This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

13.5. The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity. The following mitigations 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 maintained.
- Activate the on-call midwives from the community to support labour ward.
- Request additional support from the on-call midwifery manager.
- Review birth unit activity

13.6. All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

15. Clinical Activity and Staffing

15.1. Acuity is assessed by four hourly recording of staffing and clinical activity is undertaken via the Birthrate Plus Acuity tool on both Gloucester Birth Unit and Central Delivery Suite. The confidence factor related to the Gloucester birth unit data remains consistently low and this will be prioritised by the Matron responsible for this area once in post. All Birthrate plus data within this report therefore only relates to Central Delivery Suite data.

15.2. Despite a very favourable birth to midwife ratio associated with lower than monthly average birth-rates, the incidences of acuity exceeding staffing levels illustrate a variable trend when there are 3 or more midwives short on Central Delivery Suite during the period of January 23 – June 23. This illustrates complexity in caseloads

Table: Staffing levels meeting acuity Jan – June 23 Source: Birthrate plus

Month	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Staffing levels met acuity	57%	49%	67%	53%	34%	38%

Charts: Monthly Acuity by RAG status (Source: BirthRate Plus Acuity Tool – CDS)

16. Supernumerary Labour Co-ordinator

16.1. Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

16.2. There were no occasions when supernumery status of the co-ordinator was reported to be compromised during the 6 month period:

Table: Compliance with *Supernumery Status of Delivery Suite Co-ordinator*
Source: BR+ Acuity tool

	Number of days per month	Number of shifts per month	Compliance
Jan 2023	31	62	100%
Feb 2023	28	56	100%
Mar 2023	31	62	100%
April 2023	30	60	100%
May 2023	31	62	100%
June 2023	30	60	100%

16.3. Confidence factor in the inputting of the data into the BR+ tool is continuously reviewed by the senior midwifery team and reported to the Maternity Delivery Group. There were 2 months during the 6-month reporting period where confidence factor was < 80% (February 2023: 75.00% and May 2023: 79.57%).

16.4. Work is in progress by the Band 8 of the day and flow midwife continue to support data quality during periods of high acuity.

17. One to One in Established Labour

17.1. Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

17.2. If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

17.3. The following table outlines compliance by Month for the whole service.

Table: 1:1 Care in labour compliance – all areas (Source: Trakcare and Badgernet from 7th June 2023)

Month	1:1 care in labour compliance
Jan 2023	96%
Feb 2023	95%
Mar 2023	96%
Apr 2023	98%
May 2023	96%
Jun 23	98%
YTD	**97%**

Table 1:1 Care in labour compliance – each areas (Source: Trakcare and Badgernet from 7th June 2023)

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Central Delivery Suite	96%	96%	98%	98%	97%	98%
Gloucester Birth Centre	98%	93%	98%	97%	91%	96%
Aveta Birth Centre	Closed	Closed	Closed	Closed	Closed	Closed
Stroud Maternity Unit	100%	100%	88%	100%	88%	100%

This continues to be monitored via the CQC action plan and remains below 100%. The 1:1 care in labour action plan has now been enhanced to increase focused work and communication by the clinical Maternity Patient Safety Champions. In addition, data quality is anticipated to be enhanced with the implementation of a new EPR system.

18. Red Flag Incidents

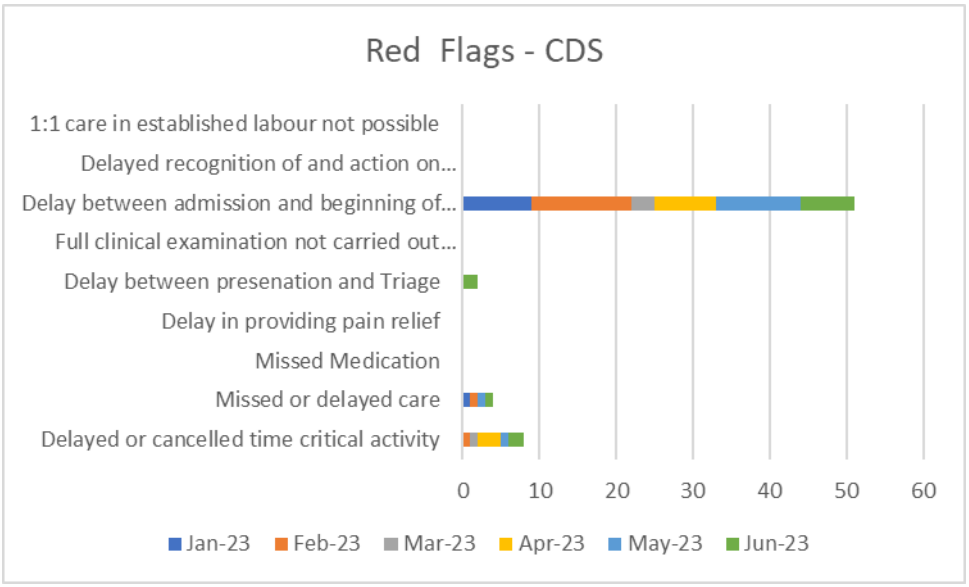
Safer Midwifery Staffing

18.1. 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).
- The Birthrate+ Acuity tool monitors compliance with supernumerary labour ward co-ordinator status and provision of 1:1 care in labour.
- Red flags are highlighted with a monthly breakdown below
- A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

- The most frequent staffing clinical actions was associated with delays in Induction of labour (IOL). There was a range of between 8 and 22 delays in starting and a range of 51 – 122 delays in continuing IOL episodes based on monthly data from Jan to June 2023. 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.
- The following tables demonstrate red flag events on CDS during the reporting period:

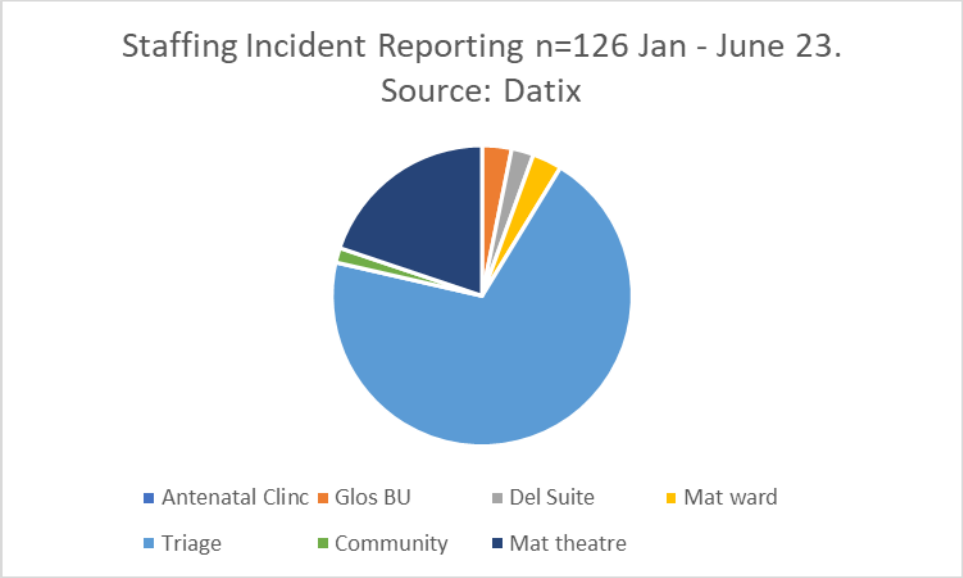
Chart: Red Flags recorded on Central Delivery Suite Jan – June 23 Source: BR+ Acuity Tool



-

18.2. During the months of January to June there were 126 Datix incidences reported related to midwifery staffing, an increase from 88. The majority of these related to insufficient staffing in Maternity Triage. The largest reporting area was Triage particularly in relation to breeches of primary assessment time.

Graph: Incidences associated with staffing Source: BR+ Acuity Tool



18.3. HSIB referrals are monitored via the maternity dashboard. During the period of January 23– June 2023 the HSIB referrals fluctuated, with a total of 5 cases. This is monitored via the Quality and Safety Divisional Group and Maternity Clinical Governance

Month	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23
HSIB referral number	0	0	0	0	4	1

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

18.4. 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.

18.5. 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. Three teams were rolled out. One has since paused and the remaining two continue to provide care in the MCoC model

19. Obstetric staffing

19.1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. This includes obstetric staffing on the labour ward and any rota gaps.

19.2. Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

19.3. An audit has been commenced with the findings being presented at Maternity Delivery Group and Safety Champions Meeting. Any recommendations following the audit will be monitored.

19.4. Trusts should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. This will be confirmed in the next Maternity Staffing paper.

19.5. Currently there is one long term locum employed by the trust. We have implemented the RCOG monitoring and effectiveness tool for all future long-term locums contained within the RCOG Guidance on the engagement of long-term locums in the maternity care, and a 6- month audit is underway commencing in May 2023. This will be reported to MDG with relevant recommendations in November 2023.

19.6. Trusts should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

19.7. The trust has completed a Compensatory Rest SOP which is going through Guidelines processes. The Obstetric Job plan reflects the requirement to enable compensatory rest and an agreed monitoring process is being formulated. Currently, job plans ensure that there are no direct clinical commitments scheduled on the rest day. An audit is to be undertaken to provide assurance on compliance commencing in July for Quarter 1. This will be reported to MDG in September 2023. This will be repeated again for Quarter 2. Any action plan arising from the audit will be shared with the Safety Champions and LMNS>

20. Anaesthetic staffing

20.1. For safety action 4 of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.

20.2. For safety action 4 of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.

20.3. Where the duty anaesthetist has other responsibilities, they should be abldelegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

20.4. The obstetric anaesthetist is a member of the delivery unit team. Approximately 60 per cent of women require anaesthetic intervention around the time of delivery of their baby. The staffing of anaesthetics for maternity services is allocated according to the RCoA GPAS 2023 and ACSA standard 1.7.2.1.

20.5. 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.

20.6. 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).

20.7. The duty anaesthetist has a clear line of communication to the supervising consultant at all times

The following demonstrates compliance with this standard by month.

	Jan 23	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**
% compliance	100%	100%	100%	100%	100%	100%

20.8. In summary, to meet the NHSR MIS Standards (2021) GHT can confirm that there is a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. (RCoA GPAS 2023 and ACSA standard 1.7.2.1).

21. Neonatal medical staffing

21.1. To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

21.1. The Neonatal Unit are budget compliant with meeting the Local Neonatal Units Standards of Tier 1 and Tier 2 separate rotas for the junior medical workforce to meet BAPM requirements.

21.2. There are gaps within the rotas due to sickness absence and maternity leave, however these gaps are filled largely by internal locums. The LMNS have been informed of these standards being met through the SW NICU/LNU Medical Workforce Stocktake.

22. Neonatal nursing staffing

22.1. To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

22.2. The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN)

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

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

22.5. The unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPM guidelines. Unit activity for Jan to June 23 has varied from 55% to 91% cot occupancy (monthly averages – staffing funded figures are based on an average of 80% occupancy). Fluctuating activity makes staffing consistently to BAPM standards for ratios of nurses to babies, alongside the necessity to adhere to differing ratios for acuity of NNU patients challenging (nurse:pt ratio of 1:1 for ITU, 1:2 for HDU, 1:4 for Special Care/Transitional Care). This is addressed by trying to flex nurses off days/nights with less activity/acuity (whilst maintaining a safe minimum staffing level to cope with anything that may present) and onto busier days, using annual leave flexibly, flexing admin, teaching and study time. This often relies on the goodwill of staff to change shifts/take leave at short notice however.

22.6. The unit funding for nursing staff also covers provision of outreach support to ex-NNU patients on home oxygen (19 babies as of June 2023), providing developmental assessment in follow up clinics, weekly ROP clinic support, providing senior Education nurse to maternity PROMPT training monthly and staffing a Palivizumab clinic through the winter months.

22.7. The Unit had a GIRFT deep dive visit on 24th May 2022. At that point in time Neonatal Qualification in Speciality (QIS) rates were at 63% which is below national recommendation of 70%. In January to June 2023 QIS rates averaged 65%. This remains below national recommendations but will improve to 68% in September presuming satisfactory completion of the course by this year's cohort of two attendees and no other changes to workforce. The QIS course runs annually, four places for September/December 2023 have been funded by the ODN and members of staff identified to fill these which will improve QIS rates but not until course completion in the summer of 2024. The only other way to improve QIS compliance is to recruit in staff who already have the qualification however there is a small pool of such staff nationally and they are not traditionally a very mobile workforce.

22.8. The Unit remains challenged in relation to nurse staffing. August 2023 nurse staffing figures demonstrate a gap of 18 WTE (or 26%) comprised largely of maternity leave, long term sickness absence, a small number of vacancies and a small number of staff appointed but not yet in post. Maternity leave is predicted to rise from its current level of 6.2 WTE (August 2023) to a peak of 9.6 WTE (Oct/Nov/Dec 2023). The impact is roughly equally spread across both QIS and non-QIS nursing staff. Actions to mitigate have included attempts to boost the neonatal nurse bank through targeted recruitment adverts, liaison with DCC to identify any staff with transferable skills willing to take on bank, efforts to boost support services (admin and clerical roles, housekeeping, Band 4 nursery nurses) to reduce non-nursing tasks being carried out by nursing staff, and liaison with bank office to source and manage temporary staffing options to fill gaps. An action plan is being developed to provide oversight of all activity relating to recruitment and retention on the Unit.

22.9. Escalation plans have been instigated when activity increases/staffing is impaired to support nursing which has included utilising all nursing time into clinical shifts (cancelling/postponing study leave/admin time/teaching days), flexing staff on and off shifts to match demand and booking of bank/agency nurses.

22.10. Agency and bank are utilised if required however there is a very limited pool of bank/agency staff with neonatal skills, especially so if QIS cover is needed, and these staff tend to be employed with the higher agencies and are consequently more expensive.

22.11. Staffing is regularly reviewed with the South West Neonatal Network and Gloucester was awarded £52,600 from June 2023 for nurse quality roles (Education and Governance) to bring the unit closer to recommended staffing numbers in these areas. Whilst these posts have been filled they have been so from existing staffing pool.

22.12. 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 BAPM guidance and recorded on Badger which is also reviewed by the team locally as well as the Neonatal network.

22.13. A review is underway to review medical and nursing workforce. The outcome of this may lead to an action plan. Once completed this will be shared with the LMNS and Safety Champions and monitored via MDG.

23. Conclusions

23.1. 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.

23.2 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 overall. 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.

23.3 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.

23.4 Due to the intensive requirements to achieve compliance with MIS year 5 a follow up Quarter 2 paper will be presented to board in November 2023

24. Recommendations

22.1 It is recommended that:

- The Board to note the contents of the report on Maternity Workforce planning to the required MIS standard
- Where audits have commenced an update will be provided in the next paper
- The next Maternity Staffing paper will be presented within 3 months rather than 6 monthly, which will outline progress on Quarter 2

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Report to Committee/Board of Directors	
Date	14 September 2023
Title	Organ and Tissue Donation Activities Report
Author /Sponsoring Director/Presenter	Dr M Pietroni, Medical Director Dr Mark Haslam, Clinical Lead Organ and Tissue Donation

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

Summary of Report

To update the Board in respect of organ and tissue donation activities.

Key issues/highlights

- The NHSBT report documents ongoing success of Trust processes to identify potential organ and tissue donors, make a timely referral and to provide support for clinical teams and families by specialist nurses.
- In 2022/2023 the Trust facilitated 6 solid organ donors resulting in 16 patients receiving a lifesaving or transforming transplant.
- 118 corneas were received by NHSBT Eye Banks from our Trust.
- Of 43 patients who met organ donation referral criteria, 42 were referred (98%). UK referral rate 94%.
- Nine families were approached to discuss organ donation, all were supported in person by a specialist nurse (UK 93%)
- Consent rate from families approached was 66% (UK 61%).
- Consistent results over time (referral rates for DBD 100% and DCD 99% over 5 years), change in culture maintained (referral rate 2012/13 50%).
- GHNHSFT upgraded to a Level 2 centre in 2023.
- NHSBT National Awards - multiple nominations and award winner “Exceptional Committee”
- Invited to participate in SIGNET trial, first patient recruited.
- Co-hosted NHSBT vs England and Wales Transplant Team cricket match in partnership with Stagecoach.

Implications and Future Action Required

1. Targeting 100% referral and in person specialist nurse involvement
2. Training/education for junior doctors and nursing team.
3. Continued expansion of tissue donation services.
4. Work in partnership with local businesses and the wider community (Go Volunteer Glos)

Risks or Concerns

Recommendation

The Board is asked to receive this report as a source of assurance regarding the quality of organ and tissue donation activities in the Trust.

Enclosures

- Letter dated May 2023 from Anthony Clarkson, Director of Organ and Tissue Donation and Transplantation, NHS Blood and Transplant
- Summary Report - Actual and Potential Deceased Organ Donation, 1 April 2022 - 31 March 2023
- Detailed Report - Actual and Potential Deceased Organ Donation, 1 April 2022 - 31 March 2023

NHS
Blood and Transplant

www.nhsbt.nhs.uk

May 2023

Dear Ms Lee and Dr Pietroni,

We continue to see improvements in the number of donors and transplants. In 2022/23 1429 deceased donors proceeded to donation and 3575 patients received a transplant across the UK. We still have a long way to go to return to pre-pandemic activity levels, but we're confident we can get there with your Trust's help. Please accept our recognition and thanks for the effort of your staff as we look to recover further.

This letter explains how your Trust contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - 2022/23

From 8 consented donors, Gloucestershire Hospitals NHS Foundation Trust facilitated 6 actual solid organ donors resulting in 16 patients receiving a transplant during the time period. Additionally, 118 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - 2022/23

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation.

- Your Trust referred 87 patients to NHSBT's Organ Donation Services Team; 42 met the referral criteria and were included in the UK Potential Donor Audit. There was a further 1 audited patient that was not referred.
- A Specialist Nurse was present for 9 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.

Up to date Trust metrics are always available via our Power BI reports found here: https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.

Deemed Consent Legislation - England

On 20 May 2020 the Organ Donation (Deemed Consent) Act 2019, known as Max and Keira's Law, came into force in England. The societal ambition is that the new law will help save and improve even more lives moving forward. In England, during 2022/23, there were 519 occasions when consent was deemed from 935 occasions where deemed consent applied.

Why it matters

In 2022/23, 299 people benefited from a solid organ transplant in the South West. However sadly, 27 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Actual and Potential Deceased Organ Donation 1 April 2022 - 31 March 2023

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2022/23, from 8 consented donors the Trust facilitated 6 actual solid organ donors resulting in 16 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

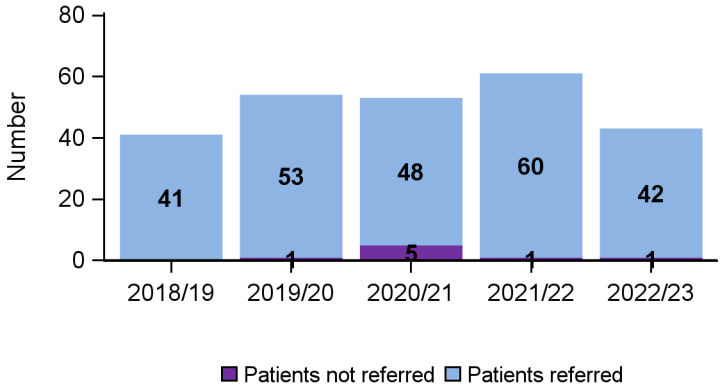
In addition to the 6 proceeding donors there were 2 consented donors that did not proceed.

Best quality of care in organ donation

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

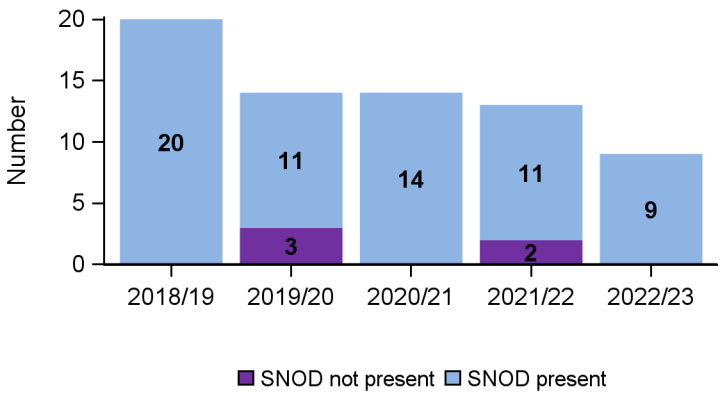


The Trust referred 42 potential organ donors during 2022/23. There was 1 occasion where a potential organ donor was not referred.

Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



A SNOD was present for 9 organ donation discussions with families during 2022/23. There were no occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2022 - 31 March 2023		
Deceased donors	117	1,429
Transplants from deceased donors	299	3,589
Deaths on the transplant list	27	441
As at 31 March 2023		
Active transplant list	499	6,959
Number of NHS ODR opt-in registrations (% registered)**	2,920,580 (53%)	28,567,574 (44%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.47 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers comparison with UK data, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	4	1980	40	5307	43	6910
Referred to Organ Donation Service	4	1965	39	4886	42	6482
Referral rate %		*99%*		*92%*		*94%*
Neurological death tested	4	1556				
Testing rate %		*79%*				
Eligible donors[2]	3	1439	26	3467	29	4906
Family approached	3	1244	6	1691	9	2935
Family approached and SNOD present	3	1190	6	1526	9	2716
% of approaches where SNOD present		*96%*		*90%*		*93%*
Consent ascertained	2	846	3	959	5	1805
Consent rate %		*68%*		*57%*		*61%*
- Expressed opt in	2	476	1	578	3	1054
- Expressed opt in %		*95%*		*84%*		*89%*
- Deemed Consent	0	284	2	306	2	590
- Deemed Consent %		*63%*		*52%*		*57%*
- Other*	0	86	0	74	0	160
- Other %*		*60%*		*38%*		*47%*
Actual donors (PDA data)	2	783	3	636	5	1419
% of consented donors that became actual donors		*93%*		*66%*		*79%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2022 - 31 March 2023

Gloucestershire Hospitals NHS Foundation Trust

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Trust metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2023 based on data meeting PDA criteria reported at 9 May 2023.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2022 and 31 March 2023, Gloucestershire Hospitals NHS Foundation Trust had 6 deceased solid organ donors, resulting in 16 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2021/22. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

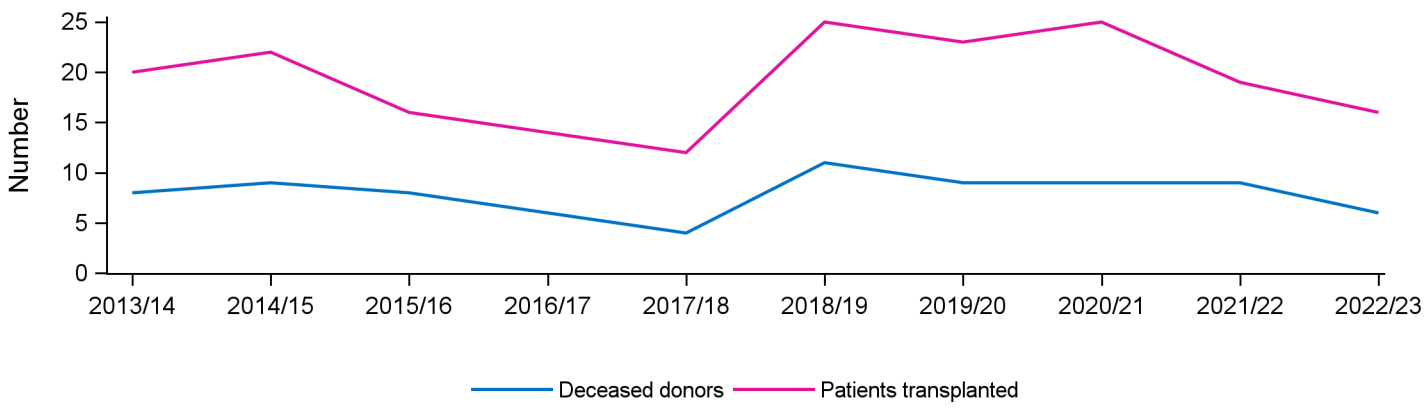
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Trust		UK	
DBD	3	(5)	7	(13)	3.0	(3.0)	3.5	(3.4)
DCD	3	(4)	9	(6)	3.3	(2.0)	2.9	(2.7)
DBD and DCD	6	(9)	16	(19)	3.2	(2.6)	3.2	(3.1)

In addition to the 6 proceeding donors there were 2 additional consented donors that did not proceed, all where DCD donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	4	(9)	0	(0)	3	(3)	0	(0)	0	(2)	0	(0)
DCD	6	(6)	0	(0)	2	(0)	0	(0)	2	(0)	0	(0)
DBD and DCD	10	(15)	0	(0)	5	(3)	0	(0)	2	(2)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2013 - 31 March 2023



2. Key Numbers in Potential for Organ Donation

A summary of the key numbers on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents key numbers in potential donation activity for Gloucestershire Hospitals NHS Foundation Trust. This data is presented in Table 2.1 along with UK comparison data. Your Trust has been categorised as a level 3 Trust and therefore percentages in this section are only presented on a national level. A comparison between different level Trusts is available in the Additional Data and Figures section.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2021/22 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Table 2.1 Key numbers comparison with national rates, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	4	1980	40	5307	43	6910
Referred to Organ Donation Service	4	1965	39	4886	42	6482
Referral rate %		*99%*		*92%*		*94%*
Neurological death tested	4	1556				
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Eligible donors[2]	3	1439	26	3467	29	4906
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% of approaches where SNOD present		*96%*		*90%*		*93%*
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Actual donors (PDA data)	2	783	3	636	5	1419
% of consented donors that became actual donors		*93%*		*66%*		*79%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2018 - 31 March 2023

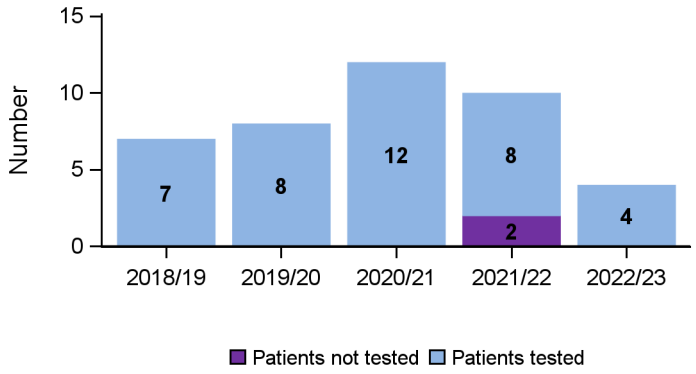


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2022 - 31 March 2023

	Trust	UK
Biochemical/endocrine abnormality	-	29
Clinical reason/Clinician's decision	-	62
Continuing effects of sedatives	-	6
Family declined donation	-	28
Family pressure not to test	-	48
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	43
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	-	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	8
Treatment withdrawn	-	18
Unknown	-	3
Total	**-**	**424**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2018 - 31 March 2023

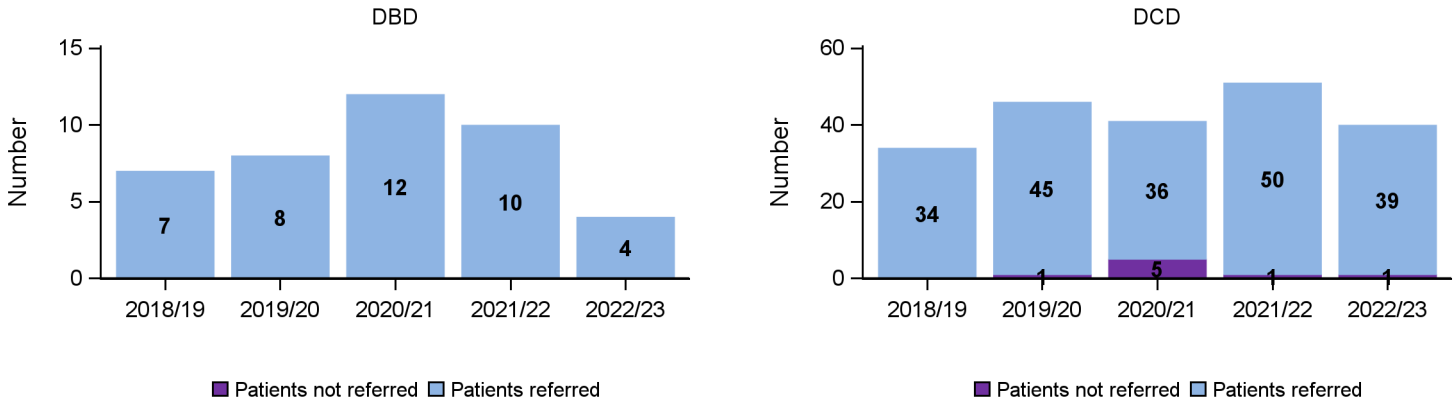


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Family declined donation following decision to remove treatment	-	1	-	15
Family declined donation prior to neurological testing	-	1	-	1
Medical contraindications	-	-	-	28
Not identified as potential donor/organ donation not considered	-	6	1	271
Other	-	-	-	27
Patient had previously expressed a wish not to donate	-	-	-	3
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	1	-	2
Thought to be medically unsuitable	-	1	-	53
Uncontrolled death pre referral trigger	-	5	-	16
Total	**-**	**15**	**1**	**421**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2022/23 there were 13 potential donors in your Trust with an ACI reported, 0 DBD and 13 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

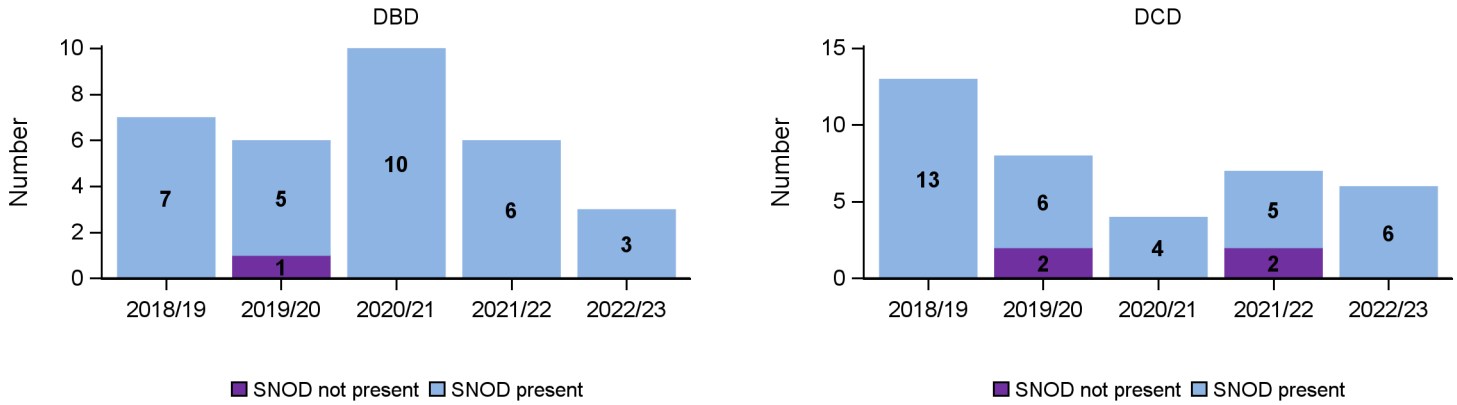
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2022/23, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 31% and 19%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 61%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2018 - 31 March 2023



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2023]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2023]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2023]

3.5 Consent

In 2022/23 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2018 - 31 March 2023

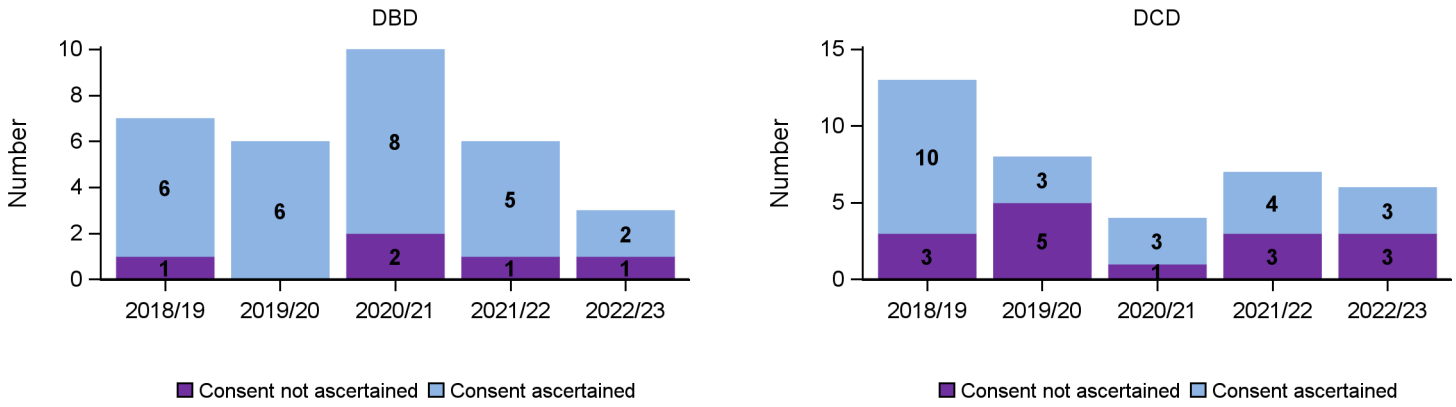


Table 3.3 Reasons given why consent was not ascertained, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	UK	Trust	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	2	-	1
Family concerned other people may disapprove/be offended	-	1	-	2
Family concerned that organs may not be transplantable	-	1	1	7
Family did not believe in donation	-	4	-	12
Family did not want surgery to the body	-	38	-	51
Family divided over the decision	-	21	-	18
Family felt it was against their religious/cultural beliefs	-	40	-	24
Family felt patient had suffered enough	-	22	-	62
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	20	-	13
Family felt the length of time for the donation process was too long	-	17	1	126
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	2	-	16
Family were not sure whether the patient would have agreed to donation	-	44	-	90
Other	-	22	-	73
Patient had previously expressed a wish not to donate	1	121	1	175
Patient had registered a decision to Opt Out	-	22	-	31
Strong refusal - probing not appropriate	-	17	-	31
Total	**1**	**398**	**3**	**732**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	10	-	8
Clinical - Cardiac arrest during referral	-	2	-	-
Clinical - Considered high risk donor	-	7	-	8
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	6	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	10	-	51
Clinical - Organs deemed medically unsuitable on surgical inspection	-	7	-	3
Clinical - Other	-	3	-	10
Clinical - PTA post WLST	-	-	-	165
Clinical - Patient actively dying	-	4	-	19
Clinical - Patient asystolic	-	1	-	-
Clinical - Patient's general medical condition	-	2	-	3
Clinical - Positive virology	-	1	-	3
Clinical - Predicted PTA therefore not attended	-	-	-	3
Consent / Auth - Coroner/Procurator fiscal refusal	-	5	-	10
Consent / Auth - NOK withdraw consent / authorisation	-	5	-	24
Logistical - Other	-	-	-	3
Total	**-**	**63**	**-**	**323**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 4.1 and 4.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 4.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Cheltenham, Cheltenham General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	1	1	-	1	-	0	0	0	0	-	0	-	0
Gloucester, Gloucestershire Royal Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	3	3	-	3	-	3	3	3	3	-	2	-	2

Table 4.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Cheltenham, Cheltenham General Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	10	10	100	10	8	2	2	-	2	-	2
Gloucester, Gloucestershire Royal Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	30	29	97	29	18	4	4	-	1	-	1

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Gloucestershire Hospitals NHS Foundation Trust in 2022/23 there were 0 such patients. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

A summary of key numbers for Emergency Departments

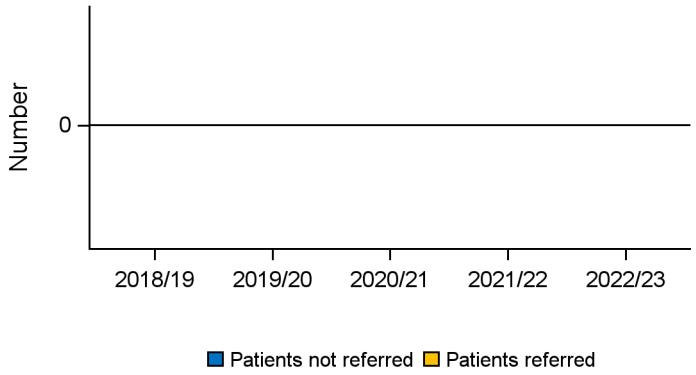
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

5.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

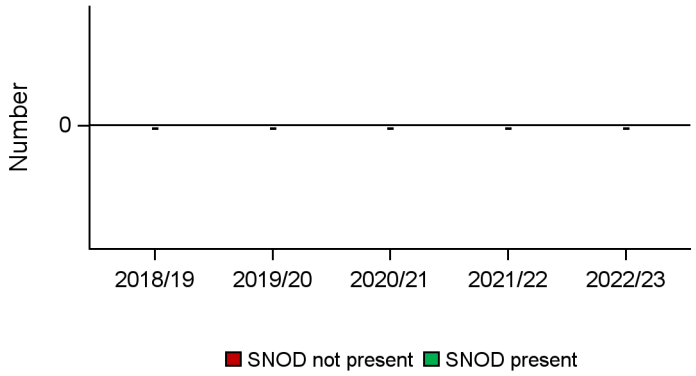
Figure 5.1 Number of patients meeting referral criteria that died in the ED, 1 April 2018 - 31 March 2023



5.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 5.2 Number of families approached in ED by SNOD presence, 1 April 2018 - 31 March 2023



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2023]

6. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

6.1 Supplementary Regional data

Table 6.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2022 - 31 March 2023		
Deceased donors	117	1,429
Transplants from deceased donors	299	3,589
Deaths on the transplant list	27	441
As at 31 March 2023		
Active transplant list	499	6,959
Number of NHS ODR opt-in registrations (% registered)**	2,920,580 (53%)	28,567,574 (44%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.47 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

6.2 Trust/Board Level Benchmarking

Gloucestershire Hospitals NHS Foundation Trust has been categorised as a level 3 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 6.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 6.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 6.3 and 6.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 6.3 National DBD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	4	4	-	4	-	3	3	3	3	-	2	-	2
Level 1	1133	896	79	1124	99	879	831	714	677	95	474	66	438
Level 2	441	340	77	439	100	331	307	267	259	97	182	68	171
Level 3	287	229	80	283	99	224	216	188	184	98	135	72	124
Level 4	119	91	76	119	100	90	85	75	70	93	55	73	50

Table 6.4 National DCD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	40	39	98	39	26	6	6	-	3	-	3
Level 1	2564	2370	92	2464	1772	941	856	91	537	57	369
Level 2	1346	1239	92	1313	841	373	333	89	209	56	132
Level 3	979	910	93	944	571	269	241	90	155	58	97
Level 4	418	367	88	408	283	108	96	89	58	54	38

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key numbers in potential for organ donation	
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Appendix A.1 gives a fuller explanation of terms used.

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 PDA data by hospital and unit	
Table 4.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 4.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

5 Emergency department data	
Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 5.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

6 Additional data and figures	
Table 6.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 6.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 6.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 6.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.

Organ and Tissue Donation GHNHSFT

Consistent performance

DBD 100%, DCD 99% referral rates over the last 5 years

Cultural change delivered - referral rate 2012/13 50%

Highlights

100% Specialist nurse support for donor families

16 transplant recipients

Upgraded to Level 2 center

Invited to join SIGNET Trial

National Pilot for Tissue Donation

National Award winning ODC “Exceptional Committee”

Community and corporate engagement program

Hosted NHSBT vs England and Wales Transplant Team cricket match

SIGNET Statins for Improving orGaN outcomE in Transplantation

NHS Blood and Transplant

Yes I donate ORGAN DONATION

NHS Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit and Assurance Committee, 25 July 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
External Audit Progress Report	The annual report and accounts had been finalised and submitted. There remained some Value for Money work to review, however the audit would be certified as fully completed by the end of the week. GMS audit continued, with financial statement process and accounts review outstanding. There had been a delay in charity audit work due to capacity issues in the Deloitte team.	A lessons learned process would be undertaken to develop a detailed audit plan with clear timescales and outcomes.
Risk Assurance Report	The risk management process was discussed in detail, particularly the algorithm and process used to ensure emerging risks were flagged to Committees, and streamline the number of risks raised at Board level to key risks with appropriate qualitative information. The implementation of the Patient Safety Incident Response Framework would strengthen the overall process.	A GMS risk assurance system was under review to ensure compliance with the ten HTM standards.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit	***Progress Report*** The Committee noted that the Workforce Planning internal audit review was in draft. Reviews into Payroll, Allied Health Professionals, and divisional governance would be scheduled in. ***Follow Up Report*** Six recommendations remained overdue, reflecting a significant improvement in closure of outstanding follow ups. A new process had been established with increased executive oversight and management of follow up recommendations by the Trust Secretary.	The Committee was assured by the improvement in engagement with internal audit, and was encouraged by the process in place to ensure this continued.
GMS Report	The 2022/23 audit was ongoing, with no material concerns raised, although progress and completion remained unclear. An internal audit review on Staff Engagement was currently in draft and awaiting management response.	Internal auditors had been engaged in a best practice modelling piece for GMS governance; this would be shared with the Board of Directors as part of August's development session.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
Counter Fraud Report	Key points were noted: • The annual report for 22/23 showed an overall green rating, with an amber rating for conflicts of interest and gifts and hospitality, and a red rating for fraud, bribery and corruption risk assessment. • Improvements on risk assessments were noted, and it was anticipated this would be rating amber during 23/24. • The Trust induction process would incorporate information on secondary employment to ensure new staff were aware of the implications. ***Declarations of Interest Process*** Assurance was provided on the plan to increase compliance with declaration of interest processes throughout the organisation, including increased use of ESR, appraisals and revalidation processes	Internal recruitment controls would be reviewed following themes identified on recent investigations into the use of fake references.

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.

	to ensure all interests, secondary employment, private practice and gifts and hospitality were recorded and regularly updated. A counter fraud exercise would be undertaken in September to determine current compliance.	The Committee was pleased to note the progress made on the DOI process.
Losses and Compensations Report	The Committee noted ex-gratia payments totalling £4,233.97 and approved the write off of 143 invoices. Six ex-gratia payments had been made to patients for property lost on wards.	None.
Single Tender Actions Report	Four waivers were processed during the reporting period, with a value of £25,000. The total value of single tender actions was £384,219.	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
No significant changes noted.		

NHS
Gloucestershire
Managed Services

Report to Trust Board of Directors	
Date	14 September 2023
Title	GMS Board Governance
Author / Sponsoring Director/ Presenter	Kaye Law-Fox, Chair Gloucestershire Managed Services (GMS)

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

Summary of Report

Two governance papers are presented to Trust Board and are recommended for approval.

1. **GMS Schedule of Matters Reserved and Delegated** (RMs) – This enclosure proposes revisions to the matters reserved and delegated approved by Trust Board in January 2023 and Finance and Resources Committee in March 2023.

   The opportunity has been taken to review, streamline and update the RMs, as well as to propose revisions based on GMS status as a limited company, the Companies Act (2006) and Trust and GMS operational delivery requirements.

2. **GMS Board Terms of Reference** (ToR) – This enclosure proposes revisions to the GMS Board Terms of Reference following the Trust Board approval of the replacement of Trust appointed non-executive directors with independent on-executive directors (NEDs) in December 2022. Three independent NEDs were recruited in July 2023. Role titles and number of GMS executive company directors on the GMS Board have also been amended.

3. Approval was given to these two governance papers by
   - GMS Board of Directors on 25 July 2023
   - Trust Finance and Resources Committee on 27 July 2023

Recommendation

1. **Approve** the revised GMS Schedule of Matters Reserved and Delegated.
2. **Approve** the revised GMS Board Terms of Reference.

Source(s) of Assurance Evidence (confidence RAG)	**R**	**A**	**G**
• Trust Board Minutes 8 December 2022			✓
• Companies Act (2006)			✓
• GMS Standing Financial Instructions			✓
• GMS Articles of Association			✓

Enclosures			
• GMS Schedule of Matters Reserved and Delegated v5.0 • GMS Board Terms of Reference Sept 2023			
Route TO this Board of Directors			**Date**
GMS Board approved	25.07.23	Trust Board	
GMS iMD		Trust Finance and Resources Committee	27.07.23
GMS SLT		Trust Leadership with GMS relationship	
GMS Departments		Contract Management Group	

GLOUCESTERSHIRE HOSPITALS SUBSIDIARY COMPANY LIMITED (TRADING AS GLOUCESTERSHIRE MANAGED SERVICES, GMS)

SCHEDULE OF MATTERS RESERVED AND DELEGATED

This document defines the authority reserved and delegated in respect of Gloucestershire Hospitals Subsidiary Company Limited (Company Number 11124256) trading as Gloucestershire Managed Service (GMS), a wholly owned subsidiary of Gloucestershire Hospitals NHS Foundation Trust (Trust). The document has effect as if incorporated into the constitutions of the Trust and GMS.

The Trust and GMS agree that when exercising the authority defined in this document, they will consult each other on all material matters[1].

Any proposals considered by the Finance and Resources or Group Audit and Assurance Committees must first be approved by the GMS Board of Directors.

Any proposals considered by the Trust's Board of Directors must first be approved by the Finance and Resources or Group Audit and Assurance Committees, and the GMS Board of Directors.

RM No.	Description	Trust Board of Directors	Trust Finance and Resources Committee	Group Audit and Assurance Committee	GMS Board of Directors
	Governance, company law and other legal and regulatory matters				
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	●			
13.	Approval of the GMS' scheme of matters reserved and delegated	●			
14.	Approval of authority delegated to Chair, Managing Director, and other members of the GMS Board of Directors and to any Committees established by it				●
15.	Approval of the membership and responsibilities of the Trust Finance and Resources Committee	●			
16.	Approval of the responsibilities of the GMS Board of Directors as expressed in the GMS Board Terms of Reference		●		
17.	Establishment of any Committees of the GMS Board of Directors, and approval of their membership, responsibilities, and authority				●
18.	Approval of the responsibilities of members of the GMS Board of Directors and all managers				●
19.	Approval of risk management arrangements for GMS				●
20.	Approval of governance policies for GMS				●
21.	Approval of GMS arrangements to ensure compliance with regulatory requirements		● (on behalf of Trust)		● (on behalf of GMS)
22.	Ensure GMS compliance with the health and safety legal and regulatory requirements		● (on behalf of Trust)		● (on behalf of GMS)
23.	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) including fees	● (for fees and costs exceeding £50,000)			● (for fees and costs not exceeding £50,000)
	Planning and control				
24.	Oversee the development of the GMS corporate plan, annual business plan, annual budget, and strategies for GMS				●
25.	Approval of GMS' corporate strategy / strategic direction		●		

[1] See Appendix 1

RM No.	Description	Trust Board of Directors	Trust Finance and Resources Committee	Group Audit and Assurance Committee	GMS Board of Directors
26.	Approval of the annual business plan and annual budget for GMS (including, objectives, any other strategic measures of performance), and any amendments to them, as well as any subsequent business cases for new or changed services) where the proposal's impact is deemed significant*		●		
27.	Approval for any of GMS' services to be sub-contracted to another provider		●		
28.	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) which substantially differs from the purpose of the OHFA	● (new)	●		
	Financial matters and internal control				
29.	Appointment or removal of the external auditor for GMS			●	
30.	Appointment or removal of any internal auditor for GMS			●	
31.	Approval of statutory accounts and the company's annual report				●
32.	Approval to acquire or to dispose of assets	● (with a value exceeding £1,000,000)	● (with a value exceeding £500,000 and up to £1,000,000)		● (with a value not exceeding £500,000)
33.	Enter into a loan agreement with GMS on behalf of the Trust, including any mortgage or other charge		●		● (on behalf of GMS)
34.	Enter into a loan agreement with another lender, on behalf of GMS, including any mortgage or other charge	● (with a value exceeding £1,000,000)	● (with a value exceeding £20,000 and up to £1,000,000)		● (with a value not exceeding £20,000)
35.	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)	●			
36.	Approval to make any capital distributions or dividend distributions	●			
37.	Acquisition of any interest or share capital in another body corporate		●		
38.	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				●
39.	Approval of accounting and financial policies and procedures, subject to compliance with the approved budget and financial plan				●
40.	Approval of any change to GMS' accounting reference date			●	
41.	Approval to open or close any bank account for GMS				●
42.	Approval of insurance policies and any associated arrangements				●
43.	GMS to enter into or to renew a contract or series of connected revenue or capital contracts, through a compliant route to market, for any material for consideration payable	●(being in excess of £5,000,000)	● (being in excess of £1,000,000 and up to £5,000,000)		● (being below or equal to £1,000,000)
44.	Approval of capital transactions or contracts not within the approved Trust capital plan for the year	●	●		
45.	Providing parent company guarantees for new GMS contracts	●			
46.	Ensure that the findings and recommendations of GMS-sponsored internal audit reports have been addressed by the GMS Board				●
47.	Obtain assurance that the findings and recommendations of GMS' internal audit reports have been addressed by GMS			●	
48.	Approval of revenue transactions not within the approved business plan for the year		● (above £250,000)		● (not exceeding £250,000)
	Resourcing				
49.	Approval of staffing establishment and structure that could adversely affect services provided to the Trust or have significant impact on the staffing structure not within the approved plan for the year (e.g., redundancies)*		●		●
50.	Approval of changes to terms and conditions, (excluding non-contractual policies), for employees who transfer from the Trust to GMS	●			

RM No.	Description	Trust Board of Directors	Trust Finance and Resources Committee	Group Audit and Assurance Committee	GMS Board of Directors
51.	Approval of changes to terms and conditions, (excluding non-contractual policies), for employees who transfer from the Trust to GMS	●			
52.	Approval of terms and conditions for individuals appointed by GMS (not transferring from the Trust)				●
53.	Approval of pension scheme arrangements for employees who transfer from the Trust to GMS	●			
54.	Approval of pension scheme arrangements for individuals appointed by GMS (not transferring from the Trust)				●
	Other matters				
55.	Approval of operational policies				●
56.	Approval of employment policies				●
57.	Approval of communications with stakeholders				●

Appendix 1 – Definitions related to GMS Reserved Matters and escalation process

Material Matters

The Trust's Standing Orders (SO6.5) state that "*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)".* NHS Monitor is now NHSI, however, the document can no longer be found online.

NHS Improvement has produced specific guidance for Trust to use when considering changes to a subsidiary. https://improvement.nhs.uk/documents/3509/Addendum_to_transactions_guidance_FINAL_CORRECTED.pdf However, the document can no longer be found online.

Determining Materiality

Should the Trust or GMS determine that a matter or proposal is deemed as material the Trust and GMS Company Secretary will contact the following individuals, or their appointed deputies to reach agreement:

Trust: Trust's Lead Executive for Estates

GMS: GMS Managing Director

Should it not be possible to reach agreement the matter will be judged by the Chair of the Finance and Resources Committee and the GMS Chair

Significant

* With regard to the approval of GMS business cases (matter 26) by the Finance and Resources Committee, and "*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)*" (matter 49) by the Trust Board, the Trust will seek approval only where the potential impact is deemed as significant. Significant in this context means:

- Proposals which might result in the risks to the Trust which would be assessed as: having a score of 12 and above for the safety domain, and 15 and above for all the other domains; and/or having a catastrophic consequence of regardless of the domain; and/or adversely affect the delivery of the Trust's strategic objectives
- Proposals with value equal to or above 10% of the GMS turnover (before the proposed change)
- Proposals which affect 5% or more of the GMS workforce (before the proposed change) and/or affect the GMS posts that have been defined as business critical.

The decision on whether a proposal triggers the above criteria in relation to RM26 and RM49 will be judged by the Finance and Resources Committee Chair and the GMS Chair.

This Schedule of Matters Reserved and Delegated shall be reviewed at least annually. Any review of this document shall adopt the change control procedure defined in the Operational Agreement between the Trust and GMS.

Version Control			
Version	**Author**	**Date**	**Changes**
1.0	DAC Beachcroft	08-03-2018	Version approved by Trust Board as part of SubCo Business Case
2.0	Lukasz Bohdan	09-10-2018	Version reflecting changes which came into force on 30 September 2018
2.1	Lukasz Bohdan	08-03-2019	Amendments made following Board, GMS Committee Chair and CEO feedback; for discussion at 11 March 2019 GMS Committee
2.2 and 2.3	Lukasz Bohdan	03-05-2019	Amendments made following Trust/ GMS Committee workshop and subsequent feedback
2.4	Lukasz Bohdan	22-08-2019	Amendments made to reflect changes agreed at the May GMS Committee and June 2019 Trust Board (Scheme of Delegation)
3.0	Sim Foreman	11 February 2021	Amendments APPROVED by Trust Board in February 2021. Ratified by GMB Board on 23 February 2021.
4.0	Kat Cleverley	26 January 2023 09 March 2023	Amendments APPROVED by Finance & Resources Committee on 26 January 2023 and Trust Board on 9 March 2023. Amendments not taken to GMS Board.
5.0	KC / KLF / JMD	25 July 2023 27 July 2023 14 Sept 2023	Amendments approved by the GMS Board of Directors Amendments approved by the Trust Finance and Resources Committee Amendments approved by the Board of Directors of Gloucestershire Hospitals NHS Foundation Trust

NHS
Gloucestershire
Managed Services

GLOUCESTERSHIRE HOSPITALS SUBSIDIARY COMPANY LIMITED
BOARD OF DIRECTORS
TERMS OF REFERENCE

Chair	Independent Non-Executive Director
Frequency of Meetings	10 x per annum
Quorum	Three members (including one executive and two independent non-executive directors)
Approval	July 2023
Review date	July 2024

Purpose of Board of Directors

The Board of Directors ("the Board") is established as the principal forum through which the directors of Gloucestershire Hospitals Subsidiary Company Limited (SubCo), trading as Gloucestershire Managed Services (GMS) will fulfil their responsibilities as defined in company law and in the governance arrangements agreed between GMS and its sole shareholder, Gloucestershire Hospitals NHS Foundation Trust (the Trust).

Responsibilities

The Board shall:

Governance and company law matters

- Provide advice, information and recommendations as required to the Trust's board of directors and the Finance and Resources Committee to enable them to fulfil their responsibilities as defined in their terms of reference and the Schedule.
- Approve any responsibilities and authority delegated to the Chair, Managing Director, directors, or managers of GMS.
- Establish committees of the Board where necessary and approve their responsibilities, authority, and membership.
- Approve risk management arrangements for GMS, consulting as necessary with the Finance and Resources Committee in respect of risks for the Trust.
- Approve any necessary governance policies for GMS.
- Ensure that GMS is compliant with all relevant legal and regulatory requirements and consult as necessary with the Finance and Resources Committee such that it may fulfil its responsibilities in this respect as defined in the Schedule of Matters Reserved agreed between GMS and the Trust (the Schedule).

Legal and regulatory compliance

- Approve the issuing, defence, or settlement of and litigation or other legal proceedings as defined in the Schedule.
- Monitor GMS's compliance with all relevant regulatory requirements and require that action is taken to address any non-compliance.
- Where necessary to ensure compliance with regulatory requirements, agree with the Finance and Resources Committee any action which must be taken jointly by the Trust and GMS.

Strategy, Planning and Control

- Through discussion with the Finance and Resources Committee develop any corporate strategy which the Trust requires for GMS and present it for assurance by the Finance and Resources Committee.
- Oversee the development of, and recommend for approval in accordance with the Schedule, the following:
    - The corporate and annual business plans, and strategies for GMS, and any amendments to them.
    - Proposals for any change to the nature of GMS's business which is not ancillary or incidental to the business; and

- Proposals for any of GMS' services to be sub-contracted to another provider.

- Monitor delivery of objectives in any strategy and the business plan to ensure that they are delivered as required.
- Monitor GMS's performance to ensure that it provides its services in accordance with its agreement(s) with the Trust, including by reference to relevant key performance indicators or other measures.

Risk management

- Ensure that GMS has in place appropriate risk management arrangements, including a risk register.
- Review regularly the risks which are relevant to GMS and the management of them by directors and senior managers.
- Where necessary to manage any joint risks, agree with the Finance and Resources Committee any action which must be taken jointly by the Trust and GMS.

Financial matters and internal control

- Consult with the Group Audit and Assurance Committee as necessary to enable it to approve the appointment or removal of the external and internal auditors for GMS.
- Consider and approve the statutory accounts and annual report for GMS.
- Monitor the systems of internal controls and risk management framework for GMS, including by considering reports from the internal auditor, or other source of external validation, and ensure agreed recommendations are delivered.
- Approve the acquisition or disposal of assets as defined in the Schedule.
- Approve any loan agreement with the Trust or another lender, including any mortgage or other charge, as defined in the Schedule.
- Oversee the development of a financial plan for GMS, ensuring that it is consistent with Trust's financial objectives, and recommend it for approval by the Finance and Resources Committee.
- Develop a budget for each financial year, ensuring that it is consistent with the strategy, annual business plan and any financial plan for GMS, and recommend it for approval by the Finance and Resources Committee.
- Monitor GMS's performance against any financial plan and the annual budget to ensure that they are delivered.
- Ensure that GMS has in place, and approve, appropriate insurance policies and associated arrangements.
- Ensure that GMS has in place, and approve, appropriate accounting policies and procedures. Approve the accounting reference date. Make recommendations to the Finance and Resources Committee to open or close any bank account.
- Approve proposals for GMS to enter into a contract or series of connected capital and revenue contracts for any material matter(s) as defined in the Schedule.
- Approve revenue transactions not within the approved business plan as defined in the Schedule.

Resourcing

- Approve the appointment of professional advisors or consultants required by GMS with fees or other costs in excess of the threshold defined in the Schedule.
- Approve or recommend for approval, as defined in the Schedule, staffing establishment and structure that could adversely affect services provided to a client or have significant impact on the staffing structure not within the approved plan for the year.
- Develop and recommend for approval by the Trust's board of directors any proposals for changes to the terms and conditions, including pension arrangements, of staff who transfer from the Trust.

- Approve the terms and conditions, including pension arrangements, for staff appointed by GMS (who do not transfer from the Trust).
- Approve any significant contractual employment issues (e.g., redundancy business cases and termination payments) or non- standard contractual arrangements.

Other matters

- Ensure that GMS has in place, and approve, appropriate policies.
- Ensure that GMS has in place, and approve, appropriate employment policies, and pay frameworks.
- Monitor and approve GMS's communication with, and accountability to, stakeholders
- Approve Terms of Reference for any Committee or Group reporting into this Board, including approval of any matters delegated to any Committee or Group.

GMS Board accountability arrangements

- Agree with the Finance and Resources Committee the arrangements through which the Board will give account to that committee, including the information which the Finance and Resources Committee requires in order to exercise its responsibilities as defined in these TOR.

Membership

The Board shall comprise:

- Four Independent Non-executive Directors (one of whom shall be the Chair and one the Vice-Chair)
- Three Executive Directors

The quorum for meetings will be three members with at least two Independent Non-Executive Director and one Executive Director.

The GMS Heads of Service shall normally attend Board meetings (as attendees) to contribute to discussions, but they shall not form part of the quorum or have any decision-making authority.

The Board may decide that any other person must attend one or all of its meetings to contribute to discussions, but no such person shall form part of the quorum and or have decision-making authority.

Accountability and reporting

After each of its meetings the Board shall report to the Finance and Resources Committee such issues as it considers should be brought to that committee's attention or require a decision, including on the matters in respect of which authority is reserved to the Finance and Resources Committee or the Trust's board of directors (as defined in the Schedule).

Reporting to this Board will be:

- GMS Remuneration Committee
- Any other GMS Committee or Group established by this Board

Conduct of business and administrative matters

The proceedings of the Board shall be in accordance with GMS's Articles of Association, these Terms of Reference and the Schedule of Matters Reserved and Delegated (the Schedule) agreed between GMS and the Trust. Where there is any inconsistency between these Terms of Reference and the Articles of Association, the Articles of Association shall prevail.

Review

These Terms of Reference will be reviewed at least annually. Any review of these Terms of Reference shall adopt the change control procedure defined in the Operational Agreement between the Trust and GMS.

Report to Trust Board of Directors	
Date	14 September 2023
Title	GMS Company Directors
Author /Sponsoring Director/Presenter	Kaye Law-Fox

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

Background

In December 2022 Trust Board approved a suite of governance changes relating to GMS, specifically, Trust relinquished its two direct nominations to GMS Board, and approved their replacement with two independent non-executive directors. From 1st August 2023, GMS Board of Directors comprises four independent NEDs, one of whom is Chair, and two role specific executive directors. Reserved Matters apply.

RM10 Appointment and removal of directors and the company secretary for GMS.

RM12 Approval of the terms and conditions of employment for directors and the company secretary of GMS.

Consideration

The substantive GMS Managing Director resigned on 10th August 2023 and a recruitment process will commence in September, taking up to ten months' to fill the substantive role (depending on the circumstances of the appointee).

The GMS Finance and Commercial Director has been Interim Managing Director since 24th November 2022 and is currently the only executive company director at GMS Board.

Two executive (Managing Director and Finance and Commercial Director), and four independent non-executive directors are company directors listed at Companies House. The proposal to increase the number of executive company directors to three is made to

1. provide executive support to the Interim Managing Director (until the substantive Managing Director post is filled), thereafter
2. provide greater executive contribution and accountability at GMS Board and to the Trust Group
3. provide greater balance of influence on decision making between executive and non-executive directors.

Within its current organisation structure, GMS has one substantive director post and two fixed term Directors. The substantive post is Strategic Assets Director, held by Terry Hull. Should the Strategic Assets Director be appointed as an interim or permanent change, there would be some re-fashioning of

responsibilities and pay to reflect the change in accountability, and the Interim Managing Director will undertake this. Approval of this proposal would also support the Strategic Assets Director's personal development plan and the GMS business plan; additionally supporting stability in the senior leadership team and demonstrate career progression from within.

Approval of the Strategic Assets Director on an interim basis would allow for flexibility by the substantive Managing Director in relation to the eventual shape of their senior leadership team.

GMS Governance Rules, Matters Reserved and Delegated, and Terms of Reference

Four company documents relate to the appointment of GMS company directors. GMS Standing Financial Instructions are silent on this point. The hierarchy of extant documents relating to this recommendation are

1. GMS Articles of Association (governing rules)
2. GMS Standing Orders (underpin the Articles and are also rules)
3. Scheme of Matters Reserved and Delegated
4. GMS Board ToR

The requirements of each have been considered by the GMS Company Secretary and are satisfied. Appendix 1 provides detailed assessment of requirement and how they are satisfied.

Options

1. Approve an additional executive company director to the GMS Board of Directors.
2. Approve the role of Director of Strategic Assets Director as the additional executive company director[1] on an interim basis, and for up to six months post appointment of the substantive GMS Managing Director.
3. Approve the role of Director of Strategic Assets Director as the additional executive company director[1] on a permanent basis.
4. Update GMS company documentation in the routine cycle of review[2]

Risks or Concerns

The concern is that to remain at a ratio of 2:1 will restrict effective executive challenge and therefore influence on the business by executive company directors, and potentially ownership of decisions by the business.

Recommendation

It is recommended that Trust Board, in its role as shareholding parent company, **approve** options

1. Approve an additional executive company director to the GMS Board of Directors, and
2. Approve the role of Director of Strategic Assets Director as the additional executive company director[1] on an interim basis, and for up to six months post appointment of the substantive GMS

[1] on satisfactory completion of the Fit and Proper Persons, Declaration of Interest and Director Qualifications requirements

[2] GMS Standing Orders provisions that
13.4 Conflict between Standing Orders and Articles of Association / Scheme of matters reserved and delegated – Should these Standing Orders conflict with Articles of Association / Scheme of matters reserved and delegated, the latter will take precedence.

Managing Director.

3. Update GMS company documentation in the routine cycle of review[2]

Enclosures

APPENDIX 1 - Satisfaction of the requirements of GMS company documentation

APPENDIX 1

SATISFACTION OF THE REQUIREMENTS OF GMS COMPANY DOCUMENTATION

1. GMS Articles of Association

s.17 Methods of Appointing Directors

s. 17.1 Any person who is willing to act as a director, and is permitted by law to do so, may be appointed to be a director.

s.17.1.1 by ordinary resolution; or

s.17.1.2 by a decision of the directors (with the prior consent of the holders of a majority of the shares).

These requirements are met by and satisfactory completion, prior to appointment, of the Fit and Proper Persons Test, Declaration of Interest and Director Qualifications requirements, and Trust Board approval in accordance with Matters Reserved and Delegated (RMs)10, 12.

2. GMS Standing Orders

s.2 GMS

s.2.3 Composition of GMS – in accordance with the Constitution the composition of the Board of GMS shall be as per the Articles of Association and the GMS Board Terms of Reference.

The requirements of the GMS Articles of Association are met, as para 1 above, and GMS Board Terms of Reference are met as para 4 below.

s. 2.4 Appointment of the GMS Directors – GMS Directors, including the Chair, are appointed and removed by the Trust Board.

This requirement is satisfied by seeking Trust Board approval in accordance with RM10.

3. Scheme of Matters Reserved and Delegated

The following Matters reserved to Trust Board are applicable

RM10. Appointment and removal of directors and the company secretary for GMS

RM12. Approval of the terms and conditions of appointment for directors and the company secretary of GMS.

Satisfied via approval of this paper.

RM19. Approval of the responsibilities of members of the GMS Board of Directors and all managers.

Satisfied via GMS Board.

4 GMS Board Terms of Reference

GMS Board Terms of Reference approved at GMS Board on 11 July 2023 and FRC on 27 July 2023.

Membership

The Board shall comprise:

- *Four Independent Non-executive Directors (one of whom shall be the Chair and one the Vice-Chair)*
- *Three Executive Directors*

Report to Board of Directors				
Date	14 September 2023			
Title	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST EPRR ASSURANCE REPORT 2023-24			
Author /Sponsoring Director/Presenter	Author: Dickie Head, Head of EPRR Sponsor: Neil Hardy-Lofaro, DCOO Presenter: David Coyle, COO			
Purpose of Report		Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**		
Regulatory requirement		**To highlight an emerging risk or issue**		
To canvas opinion		**For information**		
To provide advice		**To highlight patient or staff experience**		

Summary of Report

Purpose

To provide assurance to Trust Board with regard to the Trust's performance in achieving the set Core Standards for Emergency Preparedness, Resilience and Response (EPRR). The Deep Dive sits separate to the assurance process so does not affect our formal status. As it focusses on training and exercising data sets are still changing and therefore these will be inserted prior to submission to board.

Key issues to note

1. To comply with NHSE/I Assurance there is a requirement to submit a report covering EPRR to the Board. The attached report at Appendix 1 fulfils that requirement and provides an overview to DOAG as to the state of EPRR.

2. The process for 2023-24 returns to the standard EPRR Toolkit. The number of Core Standards has increased to 73. These changes were revealed in May 23 and therefore a number of Core Standards that were rated Compliant are now rated Partially Compliant as there has been insufficient time to address the changes.

3. Core Standards and Deep Dive are found in Appendix 1.

4. **The Trust self-assesses that:**
   a. **The Trust self-assesses that 67 Core Standards out of 73 are Fully Compliant and 6 are Partially Compliant - a 92% compliancy level.**
   b. **Therefore, the Trust self-assesses that it has achieved Substantially Compliant status for 2023-24**.

Overview

5. **Impact of Industrial Action.** The effect that prolonged Industrial Action since late Nov 22 has had on conducting planning, training and exercising cannot be underestimated. EPRR has had a coordinating role throughout the period focusing mainly through the pan-Trust Industrial Action Working Group in the planning phases and then the Incident Management Team during the execution. The impact has been three-fold. The EPRR team has been unable to revise and review a number of standing plans and SOPs; planned EPRR activity has had to be cancelled on a number of occasions at short notice; and the

availability of staff across the Trust to conduct EPRR training has also been severely limited by the frequency of industrial action.

6. The overall awareness, relevance and application of EPRR good practice continues to increase and improve across the Trust. The Trust has continued to build on this step-change in the practical application of EPRR working practice continues to strive to ensure such lessons are embedded through a combination of a set of Trust-wide common processes and procedures; a high tempo of EPRR Assurance and associated meetings; a stronger process for debriefing incidents; and a continued focus on key priorities across the Trust.

Priorities

7. **EPRR priorities.** In Nov 21 the COO and Head of EPRR developed a set of priorities that took into account assessed gaps in EPRR. The priorities are below with a brief assessment of progress made.

- **Fire:** From Sep 22 – Sep 23 the Trust has seen training sessions covering Fire Drills; Fire Evacuations; Fire Warden Training; Table Top Exercises; and Fire Walks. Fire Warden training has continued to be implemented Trust-wide.vAll Fire Risk Assessments have been completed by GMS Fire Team. These are significant achievements under challenging staffing circumstances.

- **Chemical Biological Radiological Nuclear explosive (CBRNe).** There has been a significant improvement in the Trust's CBRNe position. Following the previous year's concept development, the Trust now finds itself in an increasingly strong position. Now that a good level of basic training has been achieved, we will be able to develop incident response training at Level 3 to senior staff. The excellent working relationship between ED and Trust Lead for CBRNe has been instrumental in delivering this improvement.

- **Lockdown.** Lockdown Action Cards are now in place across the Trust. While the Trust is well practiced in the process of local reactive lockdowns often for security reasons, the opportunity to rehearse a deliberate Lockdown has remained extremely challenging due to Industrial Action. An exercise was conducted for the first time in 3 years on 16 Aug 22 as last year's report was published, and lessons identified have been implemented. However, this area remains an area of concern and will remain a focus for EPRR as we transition in to Winter 23-24.

- **Incident Control Centre (ICC) / GOLD / Silver On-Call Training.** ICC formally checked on frequent basis. There has been a significant increase and professionalisation of On Call Training (GOLD and SILVER) with significant assistance of ICB.

- **Digital Contingency.** Continued improvement in Business Continuity Planning and disaster recovery processes. Active involvement in exercises including an ICS wide cyber incident exercise.

- **Adverse Weather.** Previously Winter Readiness and now expanded to cover all Adverse Weather-related issues. Significant improvements in response to hot weather.

8. **Conclusions**

This reporting period continued on from another tough year. There was a brief period in Autumn 22 where, aside from preparing for Winter there was a sense of the Trust having the opportunity to begin the process of reviewing EPRR areas that had been neglected during COVID19. However, Industrial Action has impacted significantly on the ability of the Trust to conduct EPRR training and exercises and reviews of complex plans.

9. **Implications and Future Action Required**

a. Should Industrial Action continue in to the Winter consideration must be given as to mitigating further

the impact on EPRR outputs.

b. The Trust will revise and develop the EPPR Strategy and Plan.

c. Priorities will continue to be reassessed. It is likely that Digital Contingency will move up.

d. Assurance processes are now well established within the Trust however it is in the more formal areas of Business Continuity that gaps must be addressed.

e. The CBRNe capability is improving – momentum must be maintained.

Risks or Concerns

1. The impact of Industrial Action on standard EPRR activity has been significant. Should Industrial Action continue through the Winter of 23-24 significant prioritisation of EPRR activity may be required ahead of other clinical or administrative activity.

2. Digital Contingency is complex and with ever increasing impact. The Trust will review Digital Resilience across the whole Trust, not just within the Digital Team.

Financial Implications

None at present

Approved by: **Director of Finance / Director of Operational Finance**	**Date:**

Recommendation

Board accepts the report for Assurance purposes.

Enclosures

1. 20230901 GHNHSFT EPRR Report 2023-24

2. Appendix 1 GHFT Core Standards Master as at 20230901

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
EPRR REPORT 2023-24 TO BOARD

EPRR/Assurance/2023-24/GHNHSFT Response

As at 1 Sep 2023

References:

A. Emergency Preparedness, Resilience, and Response Annual Assurance Process for 2022/23 - dated 23 May 202
B. NHS core standards for emergency preparedness, resilience, and response guidance dated May 23

Introduction

1. In line with Ref A Gloucestershire Hospitals NHS Foundation Trust (GHFT) is mandated to submit an annual Emergency Preparedness, Resilience and Response (EPRR) assurance return to the NHS Gloucestershire Integrated Care Board (ICB). Ref B is the recently updated NHS Core Standards for EPRR.

2. The process for 2023-24 continues the standard process using the EPRR Toolkit.

3. In contrast to last year the number of Core Standards has increased to 73 while a number of Core Standards have been merged. These changes were revealed in May 23 and therefore a number of Core Standards that were rated Compliant are now rated Partially Compliant as there has been insufficient time to address the changes. The Deep Dive, which sits separate to the assurance process, has focused on Training and Exercising. The detail covering the Core Standards and Deep Dive are found in Appendix 1.

4. To comply with NHSE Assurance there is a requirement to submit a report covering EPRR to the Board. This report fulfils that requirement.

5. While NHSE Assurance is a critical element of EPRR output, the report also covers other elements that are fundamental to an efficient and safe Trust but sit outside the confines of the Assurance Toolkit.

6. The EPRR team consists of Head of EPRR; the EPRR Manager; and the Trust CBRNe Lead (0.6 WTE)

NHSE Annual Assurance Compliance 2023-24

7. The Trust has strived to continue to update and revise policies, procedures, training, action plans and action cards. However, this has been heavily impacted by planning and executing plans to mitigate the impact of the extended periods of Industrial Action the NHS has faced from late Nov 22. The Trust has focused on key risks in priority areas, while also reacting to challenges and incidents throughout the year. While internal auditing has understandably been challenging, it is assessed that this has been mitigated by the Trust regularly using internal and external EPRR networks on a weekly, daily and even hourly basis, as well as the frequent implementation of EPRR plans due to incidents throughout the reporting period.

8. The Trust self-assesses that it is Partially Compliant in six Core Standards laid out in Table 1 below. The Trust assesses all other Core Standards as Fully Compliant. Those that have seen a change from Partially Compliant to Fully Compliant are also listed below.

9. **The Trust self-assesses that:**

   a. **67 Core Standards out of 73 are Fully Compliant and 6 are Partially Compliant - a 92% compliancy level.**

   b. **Therefore, the Trust has achieved Substantially Compliant status for 2023-24.**

Partially Compliant Core Standards 2023-24

a.	b.	c.		d.
No.	**Core Standard**	**Comment and Next Steps**	**Status 22-23**	**Status 23-24**
CS16	Evacuation and Shelter	Not assessed as Core Standard in previous year: • Deep Dive 2022 assessed Partially Compliant • Plan needs review against current guidance • May 2023 Fire Awareness Month 195 Fire Evac executed	NOT ASSESSED	PARTIALLY COMPLIANT
CS 46	Business Impact Analysis/Assessment (BIA)	The formal use of Business Impact Analysis/Assessment has not been a regular process across the Trust. The intent is to introduce the concept following a review of how best to integrate this into our present processes	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS49	Data Protection and Security Toolkit	This is a remit laid on all Trust members to complete. Digital have a plan in place to ensure increased compliance.	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS50	BCMS monitoring and evaluation	No formal audit has taken place- a new requirement – hence a drop to Partially Compliant. An audit team will be brought in during 23-24.	FULLY COMPLIANT	PARTIALLY COMPLIANT
CS51	BC Audit	While the Trust assesses being mostly compliant in this core standard due to the large amount of internal auditing that has taken place within divisions, no independent external audit has taken place, hence a Partially Compliant assessment. An independent audit will be implemented and aligned with our own internal audit programme, which will also be revised.	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS60	Decontamination Capability Availability 24/7	There have been significant improvements in this area with Level 1 and Level 2 training reaching 54% and 39% respectively. We are now embarking on a series of Level 3 Incident Coordination Training which will allow us to rate ourselves as Fully Compliant	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
Core Standards that have moved from Partially Compliant to Fully Compliant in last 12 months				
CS22	EPRR Training	More frequent and more formal provision in place	PARTIALLY COMPLIANT	FULLY COMPLIANT

CS23	EPRR Testing and Exercising Programme	More frequent and more formal provision in place	PARTIALLY COMPLIANT	FULLY COMPLIANT
CS58	Specialist advice for Hazmat/CBRN exposure	A revised CBRNe plan was brought in to place last year. At one stage there were very high completion rates of Level 1 training – over 75% - across ED. However, a combination of high staff turnover which has reduced the pool of trained staff and the challenge of training in a period of extraordinary staff pressures has resulted in a drop in capability. A revitalised approach has been adopted from July 22 onwards with an uptick in those attending Level 2 training, and with Level 1 integrated in to onboarding of staff in to the department. A Core Team of trained CBRNe responders are still held as a reserve to reinforce ED staff in the case of an extended incident. These are now categorised as a Special Operations Response Team (SORT).	PARTIALLY COMPLIANT	FULLY COMPLIANT

Table 1

Overview

10. **Impact of Industrial Action.** The effect that prolonged Industrial Action since late Nov 22 has had on conducting planning, training and exercising cannot be underestimated. The nature of relatively short notice strikes and of planning and mitigating risk in previously unexplored territory has been challenging. EPRR has had a coordinating role throughout the period focusing mainly through the pan-Trust Industrial Action Working Group in the planning phases and then the Incident Management Team during the execution. The main impact has essentially been three-fold. The EPRR team has been unable to revise and review a number of standing plans and SOPs; planned EPRR activity has had to be cancelled on a number of occasions at short notice; and the availability of staff across the Trust to conduct EPRR training has also been severely limited by the frequency of industrial action. In order to illustrate the overall effect Diagram 1 and Table 2 below give an overview of industrial action up to Jul 23.

Overview of Industrial Activity Nov 22 – Aug 23

24 Separate IA events
50 Days affected by IA
Approx 131 days of planning and preparation
44 Trust Industrial Action WG meetings
50 days when Incident Management Team / Incident Control Centre activated
120 IMT Meetings
4 distinct and major planning challenges: SWAST; RCN; Jnr Drs; Consultants
Span of planning – approx. 21 Trust elements
43 Formal Returns
32 activations of Reporting Mechanism
1 x Formal Structured Debrief

Table 2

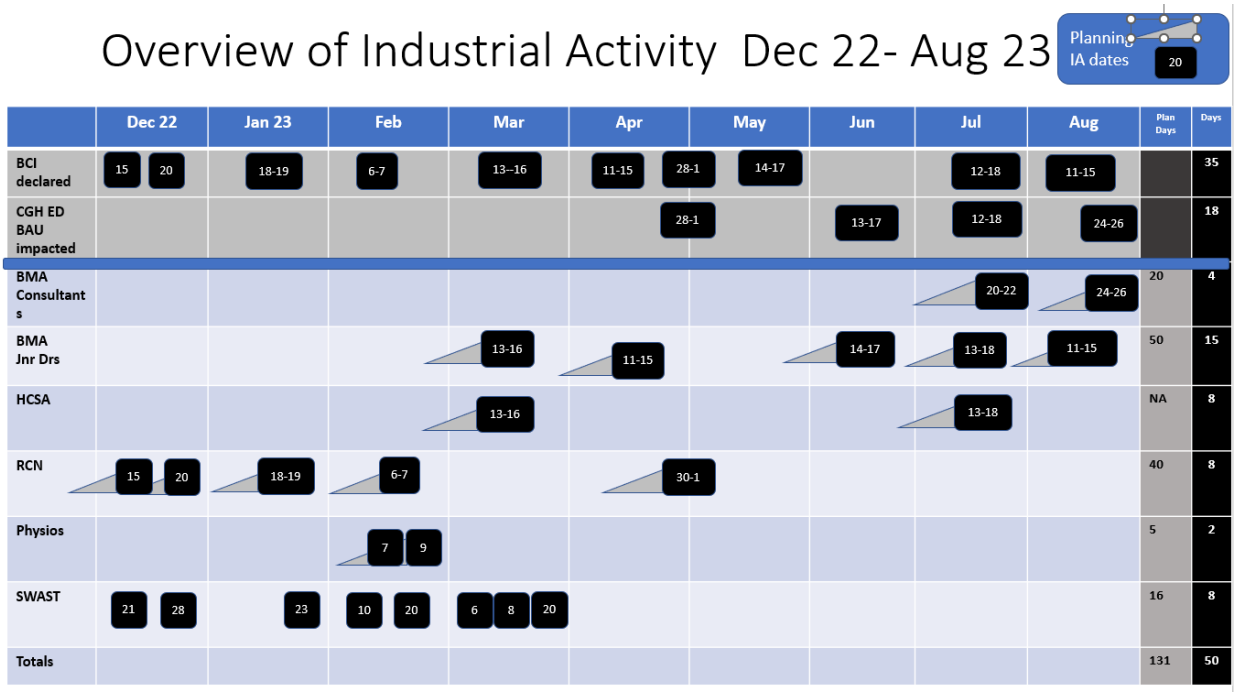


Diagram 1

11. However, the overall awareness, relevance and application of EPRR good practice continues to increase and improve across the Trust. Indeed, the pan-Trust planning processes that have been implemented during this period are now regarded as standard practice and have led to an increasingly efficient and robust approach. This approach was begun during the COVID19 pandemic and we have continued to build on this step-change in the practical application of EPRR working practices. The Trust continues to see a rise in the awareness and application of EPRR. The Trust has strived to ensure such lessons are embedded through a combination of a set of common processes and procedures; a high tempo of EPRR Assurance and associated meetings; and a stronger process for debriefing incidents.

Incidents, Annual Programme, Plan, and Priorities

12. **EPRR priorities.** The EPRR priorities first developed in 2020 are reassessed on annual basis and were reviewed in Nov 22 and refined to adjust Winter Readiness to Adverse Weather to ensure hot weather preparations were included. The priorities are below with a brief assessment of progress made.

a. **Fire**: Through the continued close working of the EPRR Assurance Group with the GMS Fire Team progress continues in this challenging domain. The gaps in the GMS Fire Team continue to impact on Risk. From Nov 22 – Aug 23 the Trust has seen: 2569 staff receiving training from the GMS Fire Team broken down as:

- Fire Drills: 1231
- Evac Drill: 351
- Table Top Fire Drill Exercises: 308
- Table Top Evac Training Exercises: 343
- Fire Warden Training: 336
- All Fire Risk Assessments have been completed by GMS Fire Team – with actions now being followed up by individual wards.

b. **Chemical Biological Radiological Nuclear explosive (CBRNe) Aim: Establish a SWAST compliant CBRNe/Special Operations Response Team (SORT) team and rota:**

i. There has been a significant improvement in the Trust's CBRNe position. Following the previous year's concept development, the Trust now finds itself in an increasingly strong position whereby it is regularly training staff and steadily building up capability. At present we have 54% (94 personnel) of all ED staff trained across both sites in Level 1 (Awareness) which is a good standard although the aspiration is to reach beyond 80%. 39% (61 personnel) of ED staff are trained in Level 2 (Suits and Tents) and 3 staff are trained in Level 3 (Incident Response). This last is now able to be developed given that we have reached a good level of basic training. The Trust also has taken the unusual step in ensuring ED Receptionists are trained as they are critical in early identification of an incident with presently 57% of this grouping trained. Finally, additional resilience has been added to the system by training 60% of Portering Staff in how to erect the Decontamination Tent.

ii. The creation of a bespoke Decontamination Room which is planned to be fitted out by Nov 23 as part of the Emergency Department new build has greatly enhanced not only the reaction time but also the resilience and capability of the Trust's CBRNe response.

c. **Lockdown: Establish and Exercise Trust-wide and Local Lockdown Plan.** Lockdown Action Cards are now in place across the Trust. While the Trust is well practiced in the process of local reactive lockdowns often for security reasons, the opportunity to rehearse a deliberate Lockdown has remained extremely challenging due to Industrial Action. An exercise was conducted for the first time in 3 years on 16 Aug 22 as last year's report was published, and lessons identified have been implemented. However, this area remains an area of concern and will remain a focus for EPRR as we transition in to Winter 23-24.

d. **Incident Control Centre (ICC) & GOLD/SILVER On-Call Training** With the GRH ICC now well established, subject to routine inspection and, when required, activated (as has been twice for precautionary reasons during recent incidents) - the Trust is assured of a robust capability. The intent to set up a second ICC on the CGH site remains.

e. With the requirement to meet Minimum Occupational Standards for On Call Managers now in place the provision of formal training by ICB has been most welcome. This is putting senior staff in a stronger position to react to challenging scenarios. GOLD and SILVER staff continue to receive a formal induction from the EPRR team that covers the key aspects of SILVER and GOLD responsibilities as well as the use of the ICC and the Virtual On-Call Dashboard. In addition, an external training programme is now in place for members of BRONZE (Site), SILVER and GOLD that has delivered Major Incident Training; Applied Suicide Intervention Skills Training; Joint Emergency Services Interoperability Programme training; Principles of Health Command training; MAGICLite training (Strategic level training for GOLD); CBRNe Awareness training; Structured Debrief training; and Strategic Leadership in Crisis and Emergency training. These courses have been delivered to a spread of senior staff and are recorded by the EPRR Manager.

f. The Trust Incident Management Team (IMT), which has been running since the beginning of the COVID19 pandemic, is still functioning. It has been frequently expanded to cover the frequent periods of Industrial Action.

g. **Digital** The reporting period has seen continued focus by the Digital team on Business Continuity Planning. There has been significant increased clinical reliance on the availability of the Trusts EPR due to the implementation of the Electronic Prescribing and Medicines Administration (EDMA). During the lead up to EPMA go live the existing EPR BCP was updated and tested with all Business Continuity devices on the wards, printers PCS and UPS checked and updated. In February a real live scenario was experienced within the trust due to an interruption to the power supply which resulted in the BCP plans for the wards and departments use of both EPR and wider digital systems being tested. Following the incident, a number of lessons learnt have been included in an action plan to ensure the continuing improvement of business continuity arrangements. Internally the Digital team has continued to run a number of workshops in order to review and strengthen their own business continuity and disaster recovery processes, including a refresh of the digital major incident process as well as participating in an ICS wide cyber incident response exercise organised by the cyber security team and supported by the NHS England south west cyber security lead.

h. **Adverse Weather**. Following July 22's significant heatwaves considerable work has gone in to preparing for future such events. There is an element of resilience and forward planning that has not been present before, as well as daily horizon scanning for high temperatures, as well as a better operational awareness of the need to mitigate heat. The Heat plan has been revised and Action Cards reviewed and disseminated. A reserve of air-cooling units is now available on site and able to be deployed rapidly.

Internal Assurance and Audit Processes

13. Industrial Action has presented challenges for internal assurance and auditing. Despite this the EPRR Assurance Group has maintained a high tempo of activity conducting formal fortnightly meetings, and connecting informally on a daily basis. EPRR leads and their deputies at Deputy Divisional Level have continued to lead the way ensuring key activity has continued. Internal audits have been conducted either within their own teams or when possible across Divisions providing objectivity.

Governance

14. EPRR governance continues to be delivered by a series of Committees and Working Groups including:
    a. EPRR Assurance Meeting
    b. Fire Safety Management Committee
    c. Security Management Group
    d. EPRR Group

    The frequency at which these groups meet brings an ability to horizon scan and respond to arising issues often before they become significant challenges. The EPRR Assurance Meeting is regarded as the 'battle-winner' in delivering EPRR outputs.

15. The above groups escalate issues and risks in to the rest of the Trust governance framework on a regular basis including:

a. Exception reports from the Security and Fire groups to the Health and Safety Committee.
b. Risks reviewed regularly and escalated to Risk Management Group
c. EPRR Report to Trust Board through DOAG, Trust Leadership Team, Audit and Assurance Committee, Board
d. NHSE EPRR Assurance through DOAG, Trust Leadership Team, Audit and Assurance Committee, Board.

Business Continuity

16. Maintaining Business Continuity has been a challenge throughout this period. Systems have been stress tested on a routine basis and improvements have been introduced when required. However, there is no doubt that the formal processes in this arena require more work and resource hence why the Trust has self-assessed that 3 Core Standards in this arena are assessed as Partially Compliant.

Linkages and Collaborative Working

17. The Trust's EPRR team has continued to develop and build networks across Gloucestershire and the South West. Relationships with the ICB remain strong, open, and transparent. The Trust EPRR team feels well supported by a forward thinking NHSE SW EPRR team. Relationships in the Local Resilience Forum and Local Health Resilience Partnership are possible, well rehearsed with both formal and less formal meetings at 100% attendance. Internal linkages remain active and continue to develop with a focus on ensuring GMS and Appleona are linked in to Trust operational processes.

Learning from Incidents

18. During the reporting period, during which the Trust has fluctuated in and out of 'incident' due to Industrial Action there have also been other significant incidents of a varying nature ranging from power outages, interruptions to essential support systems, extreme weather, and security incidents. Where appropriate a process is now in place for turning Lessons Identified in to Lessons Learned through the newly adopted Structured Debrief Process. The EPRR team has conducted training in this approach and will ensure it continues as a Trust-wide policy when ensuring learning from significant incidents. The recent declaration of a Major Incident due to Digital issues on 20-21 Aug 23 is now subject to a series of Structured Debriefs with an initial report from Head of EPRR to DOAG by early Oct 23. While the response by staff to challenging circumstances was good there are significant lessons to be learnt regarding processes, equipment, and communications systems.

Planning

19. While revision of plans has been difficult, a number have been addressed, including the Heat plan. Work has begun on reviewing the Major Incident Plan with initial progress made - however this has been interrupted by Industrial Action.

Training, Testing, and Exercising.

20. There has been a welcome increase in exercises being conducted in the wider health and Emergency Services environment. The exercise the Trust has run or been involved in have included:

- Sep 22: Internal Mass Casualty exercise 23 Sep – focussing on theatres response to Mass Casualty incident
- 1 Nov 23 - Ex PLUTO - to build a shared understanding of the implications for local
- multi agency partner organisations in responding to an outbreak of exotic notifiable disease in animals (including birds)
- 14-18 Nov 22 Ex ARCTIC WILLOW – UK Health Security Agency led distributed National Exercise exploring the health response to multiple, concurrent operational and winter pressures in England, and the interdependencies with Local Resilience Forum (LRF) partners in responding to these pressures.
- 9 Mar 23 – Ex MIGHTY OAK - South West NHS Mass Casualty Scenario aiming to assess the effectiveness of the Casualty Distribution Plan and wider Major Incident and Mass Casualty response.
- *Planned: Ex CALCARIA PREPARE – Sep 23 TBC – Low level CBRNe Exercise focussed on GRH and CGH EDs*

Horizon Scanning

21. The Trust continues to horizon scan across a wide spectrum for threats or challenges including adverse weather; travel restrictions including strikes.

Statutory Inquiry

22. The Trust has a team that remains in readiness for any taskings regarding the Statutory Inquiry. At present the impact of the inquiry has been limited. A Trust COVID19 Tool remains ready to be used that has collated data and decision making. Dir of Finance is the project lead with Head of EPRR in support.

Next Steps and Summary

23. This reporting period continued on from an extraordinarily yet another tough year. There was a brief period in Autumn 22 where, aside from preparing for Winter there was a sense of the Trust having the opportunity to begin the process of reviewing areas that had been neglected during COVID19. However, the very significant impact of industrial action has impacted significantly on the ability of the Trust to conduct EPRR training and exercises. Despite this it has been encouraging to see how much activity has still been able to take place in certain areas.

24. However, and yet again, the quid pro quo is that the Trust is regularly solving significant and new challenges at speed. The frequent (almost continuous) activation of the Industrial Action WG in the planning phase, and the subsequent activation of a large Incident Management Team during the execution phase of Industrial Action has resulted in an even larger layer of senior and mid-level staff who are experienced planners, able to anticipate and mitigate risk. While this ensures a strong element of resilience in the Trust there is also a downside. In last year's report it was assessed that while we were 'perhaps a little tired, we remain match fit'. There is now a sense that we are seeing the signs of fatigue. While all strive to maintain a high level of professionalism and rigour there is an increased risk that mistakes could be made – this is countered through a rigorous planning and execution process.

25. The Trust continues to remains in a sound position in terms of being able to react to EPRR challenges. While the Trust has become increasingly efficient and experienced in mitigating the effects of Industrial Action the time energy and effort involved must not be underestimated. It is increasingly clear the continued impact of mitigating immediate risk is beginning to impact the important tasks of training, and reviewing and updating plans. In order to counteract this the main effort of the EPRR team and the wider Trust as we move in to Autumn 23 will be to focus on essential plans and ensure they have been reviewed thoroughly and in preparation for what no doubt will be a tough Winter 23-24.

Dickie Head

Head of Emergency Preparedness, Resilience and Response GHNHSFT

Appendix 1. NHSE/I Assurance Toolkit 2023-24