NHS
Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 11 July 2024 at 13:00

Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1	**Apologies for absence and quoracy check**[1]	Information		13:00
2	**Declarations of interest**	Approval		
3	**Minutes of previous meeting**	Approval	Yes	
4	**Matters arising**	Assurance	Yes	13:05
5	**Public questions**	Information		
6	**Chair's Report** *Deborah Evans, Trust Chair*	Information		13:15
7	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	Yes	13:30
8	**Strategic and Operational Risk** *Kerry Rogers, Director of Integrated Governance* • *Board Assurance Framework* • *Trust Risk Register*	Assurance	Yes	13:45
AUDIT AND ASSURANCE				
9	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Yes	13:55
QUALITY AND PERFORMANCE				
10	**Maternity update** *Lisa Stephens, Director of Midwifery* • *Report to the Care Quality Commission and Trust Board - Section 31 Summary Report* • *Perinatal Quality and Safety Report, Quarter 4 2023 - 2024* • *Midwifery, Maternity and Neonatal Staffing Report Q4 January 24 – March 24*	Assurance	Yes	14:05
11	**Quality Account** *Matt Holdaway, Director of Quality and Chief Nurse*	Information	Yes	14:25

[1] Standing Order 3.43 Quorum - No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the Chair and Directors appointed (including at least one Executive Director and one Non-Executive Director) are present. An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

REF	ITEM	PURPOSE	REPORT	TIME
QUALITY AND PERFORMANCE				
12	**Annual Medical Appraisal and Revalidation** *Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO*	Assurance	Yes	14:30
13	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Yes	14:40
14	**Integrated Performance Report (Operational Performance)** *Al Sheward, Chief Operating Officer, Mark Pietroni, Medical Director & Director of Safety and Matt Holdaway, Director of Quality and Chief Nurse*	Assurance	Yes	14:50
Break				15:00
PEOPLE AND ORGANISATIONAL DEVELOPMENT				
15	**Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training for April 2023 – March 2024.** *Dr Shyam Bhakthavalsala, Guardian of Safe Working* *Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO*	Assurance	Yes	15:10
16	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director* • ***PODC Dashboard***	Assurance	Yes	15:20
FINANCE AND RESOURCES				
17	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director*	Assurance	Yes	15:30
18	**Financial Performance Report** *Karen Johnson, Director of Finance*	Assurance	Yes	15:40
STANDING ITEMS				
19	**Any other business and questions on consent items**	Information		15:50
20	**Governor observations**	Information		15:55
21	**Date and time of next meeting** Thursday 12 September 2024 at 13:00 (Museum of Gloucester, Gloucester)	Information		16:00
Close by 16:00				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Draft Minutes of the Board of Directors' meeting held in Public.
Thursday 9 May 2024, 13.00
Room 3, Sandford Education Centre, Cheltenham General Hospital

Present	Deborah Evans	Chair
	Vareta Bryan	Non-Executive Director
	John Cappock	Non-Executive Director
	Sam Foster	Non-Executive Director
	Marie-Annick Gournet	Non-Executive Director
	Balvinder Heran	Non-Executive Director
	Mike Napier	Non-Executive Director
	Jaki Meekings-Davis	Non-Executive Director
	Prof. Sally Moyle	Associate Non-Executive Director
	Kaye Law-Fox	Associate Non-Executive Director and Chair of Gloucestershire Managed Services
	Kevin McNamara	Chief Executive Officer
	Karen Johnson	Director of Finance
	Dr Mark Pietroni	Medical Director and Director of Safety and Deputy Chief Executive Officer
	Al Sheward	Chief Operating Officer
	Matt Holdaway	Chief Nurse and Director of Quality
	Kerry Rogers	Director of Integrated Governance
	Helen Ainsbury	Interim Chief Digital and Information Officer
	Claire Radley	Director for People and Organisational Development
	Ian Quinnell	Interim Director of Strategy and Transformation
Attending	Sim Foreman	Interim Trust Secretary (Item 09/24)
	Michael Weaver	Interim Trust Secretary (minutes)
	Samantha White	Lead Nurse for Specialist Palliative and End of Life Care
	Helen Brain	Advanced Nurse Practitioner, Specialist Palliative Care
	Louisa Hopkins	Lead Freedom to Speak up Guardian (Item 12/24)
	Lisa Stephens	Director of Midwifery (item 15/24)
	James Brown	Director of Engagement, Involvement and Communications
Observers	One member of the public and six governors observed the meeting	
Apologies	None	

Ref.	Item
01/24	**Chair's welcome and introduction**
	The Chair extended a warm welcome to all attendees, with special acknowledgment to the new governors. While today's meeting is a meeting held in public, governors are encouraged to engage in more detailed discussions during Council of Governors sessions and other governance quality meetings. It was announced that this would be the final meeting for Sim Foreman, Interim Trust Secretary. The Chair expressed gratitude on behalf of the Board for his exceptional work and significant contributions to the work of the Trust.
02/24	**Apologies for absence**
	There were no apologies for absence.
03/24	**Declarations of interest**
	There were no interests declared other than those formerly recorded.
04/24	**Minutes of the previous meeting**
	With reference to Item 8, Chief Executive Officer's Report the Chair noted in the minutes the Trust had committed to undertake a review of all neonatal and maternal deaths over the past five years and that terms of reference were finalised for this work led by the Chief Nurse and Director of Midwifery. Kevin McNamara, Chief Executive Officer agreed to provide a further update under item 7, Chief Executive's Report. **RESOLVED**: The Board **APPROVED** the minutes of the meeting held on 14 March 2024.
05/24	**Matters arising**
	The Chair noted three matters arising reported as closed and one item reported as open. At its meeting on 14 March 2024 the Board noted concerns in relation to discrepancies between the Trust's Risk Register and risks reported on the NHS Gloucestershire Integrated Care Board (ICB). Dr Mark Pietroni, Medical Director and Director of Safety reported he had contacted the ICB and requested a copy of their risk register but had yet to receive a response. Dr Pietroni agreed to follow up on this matter. **RESOLVED:** The Board **NOTED** the update on matters arising and **APPROVED** the CLOSED items.

Ref.	Item
06/24	**Public Questions**
	The Chair noted receipt of two questions from Bren McInerney, a member of the public. One question concerned how the Trust ensures there is adequate investment and space for recognising and thanking staff in daily operations. Mr. McInerney also inquired about the impact measures in place to demonstrate this assurance, both internally and externally, and he will receive a written response. Claire Radley, Director for People and Organisational Development, provided a response, emphasising the Trust's commitment to recognising staff contributions. The Trust has implemented various recognition programs, including department-specific strategies, annual staff awards, and initiatives like complimentary tea and coffee for staff, with effectiveness measured through staff surveys and detailed committee reports. **RESOLVED:** The Board **NOTED** the update and actions related to public questions.
07/24	**Staff story**
	The Chair welcomed Samantha White, Lead Nurse for Specialist Palliative and End of Life Care, and Helen Brain, Advanced Nurse Practitioner, Specialist Palliative Care, to the meeting. Ms. White thanked the Board, noting that their presentation coincided with Dying Matters Week, highlighting the importance of discussing death, dying, and grief. The service aims to provide top-tier care for patients with complex needs, aligning with NHS England's recent paper on commissioning specialist palliative care services. Helen Brain emphasized the need for collaborative solutions to address increasing demand, staff well-being, moral distress, and burnout risks. The Chair and other board members acknowledged the valuable support provided by the Specialist Palliative Care service and stressed the need to address challenges such as medical device availability and meeting room provisions, suggesting a review by the Trust Leadership Team and reconfiguration of the End of Life Group. **RESOLVED:** The Board **NOTED** the staff story presented by Samantha White and Helen Brain and the action that would be taken by the Trusts End of Life Group and supported by Ian Quinnell, Interim Director of Strategy and Transformation.
08/24	**Chief Executive's Report**
	Kevin McNamara highlighted the following matters and updates from his report: • **Staff security and safety**: The Trust initiated a 12-week trial of body-worn cameras in the Emergency Department (ED) at Gloucestershire Royal Hospital on April 10, aiming to enhance security and safety amid rising incidents of abuse and aggression. The cameras, worn by key staff and the security response team, will be activated during incidents of abuse or violence, with strict controls in place to ensure compliance with data protection requirements, and an evaluation will be conducted at the trial's conclusion.

Ref.	Item
08/24	**Chief Executive's Report**
	• **The Sexual Safety Charter**: Prompted by a 2023 Royal College of Surgeons report highlighting high levels of workplace abuse and harassment, the Trust has committed to signing the Sexual Safety Charter by May 2024. They have established a Sexual Safety working group in line with the Safe Learning Environment Charter and are developing a Sexual Safety Policy. To ensure staff involvement and understanding, they are engaging through various channels to discuss survey results and action plans to prevent sexual harassment and violence. • **The Perfect 12 days of Spring:** At today's Board Strategy and Development meeting, the Board discussed the "Perfect Spring" initiative, where clinical teams audited and tested several systems to enhance patient flow and overall experience. Despite significant pressure, frontline staff participated actively, utilising daily huddles to set actions and review progress, supported by teams such as Business Intelligence and Quality Improvement. Key achievements included increased discharges, quicker patient assessments, and new facilities to streamline processes, with ongoing efforts planned over the next six months to further improve flow. • **CQC Report - Stroud Maternity Unit:** The Care Quality Commission (CQC) published a report on March 20 following their inspection of Stroud Maternity Unit in December 2023, rating it as 'Requires Improvement' primarily due to issues with safeguarding training compliance, medicine management, risk assessments, governance processes, and community engagement. However, the CQC noted strengths in infection control, teamwork, and staff training, with the unit implementing improvements in medication processes and data collection for place of birth assessments, aiming for an improved overall rating upon re-inspection. Matt Holdaway, Chief Nurse and Director of Quality highlighted the following matters in relation to the Maternal Deaths Review: • Following the Panorama program in January, discussions with the National Safety Inspectors (NSI) are progressing well. The Trust is finalising terms of reference for the Maternal Death Review, which will be presented to the Board at a future meeting. **RESOLVED:** The Board **NOTED** the report.
09/24	**Board Assurance Framework**
	Sim Foreman, Interim Trust Board Secretary highlighted the following items reported in the Trust Board Assurance Framework: • The Trust Board Secretary has responsibility for managing and maintaining the Board Assurance Framework. The Board Secretary meets with Executive Director leads on a regular basis in order to review and update strategic risks aligned to the organisation's strategic objectives.

Ref.	Item
09/24	**Board Assurance Framework**
	• The Risk Score for Risk SR9, Failure to deliver recurrent financial sustainability, has improved due to a better reported financial position. Karen Johnson, Director of Finance would be undertaking a further review in line with the new financial year. • Strategic Risk SR17, Inability to attract a skilful, compassionate workforce that is representative of the communities we serve, has been added to the Board Assurance Framework following a review of Strategic Risk SR16. • All 17 Strategic Risks will continue to be reviewed by the relevant Trust Board Committee. **RESOLVED**: The Board **NOTED** the Board Assurance Framework.
10/24	**Trust Risk Register**
	Dr Pietroni presented the Trust Risk Register Report for the last time, with Kerry Rogers, Director of Integrated Governance, taking over responsibility. Dr Mark Pietroni highlighted the following matters in relation to the Trust Risk Register. • The report included updates to the Trust Risk Register following the April 3, 2024, Risk Management Group meeting, highlighting key changes and performance against risk management KPIs; no new risks were introduced or closed. • Two risks were downgraded: one related to paused international nurse recruitment, and the other concerning the Clinical Chemistry Pathology laboratory service at Gloucestershire Royal Hospital, with new installations reducing the risk score. • The Trust's initiative to address overdue risks, led by the Medical Director, is showing positive results. • While the Trust performs well in recording controls and investigations, there is a need for improvement in learning from low-risk incidents and timely completion of actions. The Chair welcomed the reduction in risk rating for the Clinical Chemistry Pathology laboratory and agreed with Kevin McNamara that the Trust should align its "front door" and "back door" risks into a single flow risk for consistency. Sam Foster inquired about the inclusion of risk discussions in Division Performance Reviews, and it was noted that risks are managed through the Trust's Risk Management Group and included in executive review data packs, with ongoing efforts to reduce overdue risks and improve the risk management culture. **RESOLVED:** The Board **NOTED** and **RECEIVED** the Trust Risk Register.

Ref.	Item
People and Organisational Development	
11/24	**People and Organisational Development Committee Report**
	Balvinder Heran, Non-Executive Director presented reports from meetings held on 28 March 2024 and 25 April 2024. Matters discussed at the meeting held on the 28 March 2024 were as follows: Items rated red: • While recruitment and retention and recruitment attraction remains rated as red in terms of the level of assurance received from the Trust, the committee noted actions were underway and there was evidence of improvements being made across several key areas. Members of the committee are confident the level of assurance received from the Trust will be rated as amber. • The committee remains concerned around international nurses reporting bullying and harassment and the need for improved pastoral support in order to encourage people to feel safe to speak out. • The committee noted improvements in the objective structured clinical examination process. Changes to training had seen first time pass rate go from 17% to 65% but it was now reported to be in the mid 50s due to not having access to clinical areas for training, however this was being addressed. The committee expressed its thanks to Matt Holdaway and his team for all the work and support they had given in helping to improve the structured clinical examination process. • The time to hire continues to reduce and feedback from candidates continues to be positive. The committee would like to evidence that changes put in place are starting to become embedded in order to ensure sustainable improvements in performance. The committee would like to understand how these improvements are impacting on the work of the divisions. Items rated amber: • The People Performance Dashboard continues to improve in its clarity in its reporting. • Appraisal compliance remains an issue and work is underway to address the perception and prevalent culture that staff don't have time for appraisal and that it's viewed as a tick box exercise. • The committee is seeing less use of agency and more use of bank which is better from a cost and sustainability perspective. • Review of safeguarding training underway due to difficulties around clear understanding of what training is required across separate roles. Whilst this is a safety issue it was noted CQC (Care Quality Commission) reported good clinical practice. Committee noted safeguarding would be monitored through the Quality Delivery Group (QDG). • Security still remains a concern and the committee is expecting to receive a full report at a future meeting.

Ref.	Item
People and Organisational Development	
11/24	**People and Organisational Development Committee Report**
	• The two year plan for fire safety being drafted. The plan itself is commendable. However, what's causing significant concern across all areas of health and safety is the implementation of the plan. While having a plan is crucial, ensuring its implementation and long-term sustainability of the standards it sets is paramount. • The use of body worn cameras is welcomed, especially in high risk areas like the Emergency Department (ED) however staff working in those areas need support and training in de-escalation. • In terms of organisational readiness, the Trust was audited on board development, recruitment and workforce planning, Action plans will be reported to the committee. • There were no new emerging risks. Matters discussed at the meeting held on the 25 April 2024 were as follows: Items rated amber • The committee reviewed the draft Freedom to Speak Up (FTSU) report prior to going to Board. • The committee considered the report to be a fair and accurate reflection of where the Trust is, and the scale of the work needed to be completed. • Balvinder Heran thanked Louisa Hopkins and Claire Radley for the work they are doing in support of the People and Organisational Development Committee. The Chair thanked Balvinder Heran for her report and invited Claire Radley to present the People and Organisational Development Performance Dashboard for March 2024. The dashboard is continuously evolving, with data reported across a range of performance indicators. It was noted that turnover rates and vacancy rates are improving and there are ongoing efforts to develop performance trajectories for each performance indicator. R**ESOLVED:** The Board **RECEIVED** the update from the People and OD Committee.
12/24	**Freedom to Speak Up (FTSU) Guardian Update**
	The Chair welcomed Louisa Hopkins, Lead Freedom to Speak Up (FTSU) Guardian, to the meeting. Louisa provided an update on her first year, highlighting improvements in understanding and reporting staff experiences and the positive impact of the Trust's investment in the FTSU service. She emphasised the shift towards a more supportive, data-driven approach and discussed efforts to reduce anonymous reporting and foster an open culture, while addressing ongoing concerns about fear of speaking up and discrimination.

Ref.	Item
People and Organisational Development	
12/24	**Freedom to Speak Up (FTSU) Guardian Update**
	Looking forward, the focus will be on strengthening the fundamentals of the speaking up culture and ensuring all staff feel safe raising concerns. Louisa confirmed the Trust reported everything required to the National Guardians Office, and while the organisation could be more responsive, escalated matters were supported, with ongoing efforts to improve the reporting of patient safety concerns. **RESOLVED:** The Board **NOTED** and **RECEIVED** the Freedom to Speak Up (FTSU) Guardian Update.
Finance and resources	
13/24	**Finance and Resources Committee Report**
	Jaki Meekings-Davis, Non-Executive Director presented reports from meetings held in March and April 2024. Matters discussed at the meeting held in March 2024 were as follows: Items rated amber: The committee reviewed the Estates Risk Register, noting delivery risks and associated mitigation strategies. To further refine the Register and consider the 2024/25 capital program's impact, a Trust-wide Estates Risk workshop will be convened. Items rated green: • The committee received an update which focussed on the contractual relationship between the Trust and Gloucestershire Managed Services Limited (GMS). • The committee reviewed the KIAR (Key Information Assurance Report), noting ongoing work to address assurance gaps, risks, and the imminent formation of a new Medical Advisory Committee. Meanwhile, positive financial contributions from commercial activities, including revised payment rates for private patient insurers, are strengthening the Trust's finances. Matters discussed at the meeting held in April 2024 were as follows: Items rated amber: • Meeting NHS performance targets is challenging, with Urgent and Emergency Care Services currently rated as Amber. The Financial Plan projects a £41.6m deficit, factoring in a difficult-to-achieve £30.3m Financial Sustainability Plan, and meeting the workforce target of 8,083 whole-time equivalents requires major improvements in establishment controls. The committee supported the proposed submission of a £19.6m deficit plan, acknowledging the significant risk to its delivery, with the full submission due the week of May 2, 2024, delegated to the Trust Chair, Chief Executive, Chief Operating Officer, and Director of Finance.

Ref.	Item
Finance and resources	
13/24	**Finance and Resources Committee Report**
	• The Committee received assurance on a number of cyber security actions and the wider support to the ICS system provided by the Trust. • The committee noted progress with items rated green that included the Financial Performance Report 20223/24, Capital Plan 2023/24, Digital Transformation Report 2023/24, Information Governance Bi-Annual Report, Information Governance Bi-Annual Report and HIMSS/ENRAM Digital Maturity Level. The Chair thanked Jaki Meekings-Davis for her report. R**ESOLVED:** The Board **RECEIVED** the update from the Finance and Resources Committee.
14/24	**Financial Performance Report**
	Karen Johnson, Director of Finance reported in the Financial Performance Report for the Month ended 31 March 2024 and highlighted the following items: • The NHS Trust and its subsidiary company combined finances for March 2024 show a £536k deficit, exceeding budget. These are unaudited results and driven by pressures in urgent care and financial sustainability. Non-recurring income and one-time adjustments helped lessen the impact. • Despite strong revenue and capital spending performance, the Trust acknowledges upcoming challenges in the new year, including staff shortages and rising costs that exceed government funding. To address these, the Trust will prioritize updating its deficit report, analysing workforce impact on finances, and conducting a system-wide resource analysis to optimize allocation. • Karen Johnson expressed her thanks to colleagues and the delivery team for meeting the Capital Spend Target with only a £35k variance. Following Karen Johnson's presentation, the Chair invited board members' questions. Kevin McNamara proposed three key initiatives to strengthen financial transparency in the coming year. These include clarifying the Trust's current financial situation, analysing the impact of staffing and productivity on finances, and conducting a system-wide resource analysis to optimize allocation. Implementing these actions will provide a clearer picture of the Trust's financial health and inform future planning. R**ESOLVED:** The Board **RECEIVED** and **NOTED** the Financial Performance Report for the Month ended 31 March 2024.

Ref.	Item
Quality and Performance	
15/24	**Nurse Safer Staffing Report**
	Matt Holdaway, Chief Nurse and Director of Quality introduced the Nurse Safer Staffing Report. This report evaluates nurse staffing at Gloucestershire Hospitals against national safety guidelines and details the review process, findings, and necessary actions for adequate staffing in wards, assessment areas, and the Emergency Department. It supports the Ward Nursing Establishment review, approved by the Executive Directors in November 2023, aiming to provide a baseline following a series of ward moves between 2022-2024, with a request to increase the total establishment by 44.18 WTE. The report includes triangulation with nurse-sensitive indicators and data from the model health system, although temporary staffing is not covered. The Board was asked to note that no risks or concerns were detailed, and the Trust will work to strengthen compliance with national safety standards. The Board were asked to note the following key points: • Implement a Safer Staffing Policy: This ensures the right staff with the right skills are available at the right time. • Integrate the Safer Nursing Care Tool (SNCT) and professional judgment: Twice-yearly audits using SNCT will be conducted, combined with professional judgment and nurse-sensitive indicators. • Staff training for the first audit in March 2024 is underway. Recommendations for staffing adjustments will be presented to the board in September 2024, alongside a workforce review, to inform future planning. • Utilise the Red Flag System: As recommended by national guidelines, a standardized approach to reporting registered nurse shortages will be implemented. Red flags will be incorporated into daily staffing reviews and temporary staffing requests. R**ESOLVED:** The Board **RECEIVED** and **NOTED** the Nurse Safer Staffing Report and **APPROVED** the next steps.
16/24	**Maternity Update**
	The Chair welcomed Lisa Stephens, Director of Midwifery to the meeting. Lisa Stephens introduced the Midwifery, Maternity and Neonatal Staffing Report for Quarter 3, 2023/2024. The purpose of this report was 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. Lisa Stephens highlighted the following items for the period Quarter 3, October to December 2023. • Appraisal rates were 65% at the end of the quarter three and below target. Work with the organisational development lead is underway to improve appraisal process from staff feedback.

Ref.	Item
Quality and Performance	
16/24	**Maternity Update**
	Midwifery • Incident reporting on staffing, Red Flags and birth to midwife ratio illustrate a concerning picture within midwifery staffing. 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. • Safe staffing is informed by the acuity tool and reviewed every 4 hours. Mitigations are taken in line with the escalation policy. • An extensive midwifery staffing plan for 2023/24 has continued and is progressing with notable achievements. Obstetrics • Three new obstetric consultants have been appointed and will join the team in April, June and September. • Junior doctor industrial action has had a significant impact. However, all obstetric sessions, including planned caesarean section lists, antenatal clinics, foetal medicine and preterm birth clinics, have been staffed. • There remains one unfilled gap on the on-call rota, which will be covered internally. Neonatal and anaesthetic • Neonatal medical staffing and anaesthetic availability remain stable. • The Neonatal unit continues to be challenged around neonatal nurse staffing and therefore not compliant with British Association of Perinatal Medicine (BAPM) standards. A plan is being actioned with decreasing red rated items. The Chair invited board members' questions. Matt Holdaway asked Lisa Stephens to explain the use of agency staff in the service. To address staffing shortages, in Maternity Services the Trust has used more agency midwives. Initial uptake was good, but it highlighted the need for a better onboarding process and the need for ongoing reviews. The department is looking to reduce its reliance on agency staff. Ideally, the Trust will create a pool of known agency midwives for continued support when needed. Long-term solutions require a robust recruitment and retention plan focusing on converting temporary staff to permanent positions and attracting new hires. This addresses the root cause of staffing issues, with universities exploring ways to contribute to a stable midwifery workforce, including blended learning, increased annual intakes, and a midwifery apprenticeship program launching in September 2024. The Trust partners with Oxford Brookes for a BSN program starting in September and has secured funding for eight annual MSc spots at both universities. Despite current pressures, the service has seen a modest increase in its appraisal rate, supported by a part-time postholder developing a modified appraisal form.

Ref.	Item
Quality and Performance	
16/24	**Maternity Update**
	Senior teams monitor performance, providing targeted support to improve appraisal rates, particularly in high-pressure units, while maintaining 99.5% one-on-one care during labor, showcasing the team's dedication to safe, high-quality care. **RESOLVED:** The Board **RECEIVED** and **NOTED** ongoing risks workforce risks particularly in midwifery, obstetrics and neonatal nursing and **NOTED** the ongoing improvements and progress against action plans. **Perinatal Quality and Safety Report** The Perinatal Quality and Safety Report outlined measures to monitor maternity and neonatal safety, based on the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). It aimed to inform the Board of any present or emerging safety concerns, providing a 'ward-to-board' insight across the multi-disciplinary maternity services team, and is also presented to the Local Maternity and Neonatal System (LMNS). The Chair invited comments from the Board, and Sam Foster asked if the Trust plans to phase the categorisation of moderate harm incidents due to capacity issues in the Patient Safety Team. Kevin McNamara emphasised the importance of demonstrating learning from incidents and suggested not hesitating to commission external reviews, if necessary, also inquiring about the stillbirth rate trends. Lisa Stephens noted that internal reviews have been conducted on a cluster of stillbirth cases from March, and the findings will be incorporated into Trust processes, with future reports to include updates on stillbirth rates for more informed oversight. R**ESOLVED:** The Board **RECEIVED** and **NOTED** the risk highlighted including massive obstetric haemorrhage (MOH) rate and red rated CQC actions with subsequent plans. The Board **NOTED** the ongoing improvement work.
17/24	**Quality and Performance Committee Report**
	Sam Foster chaired her first Quality and Performance Committee (QPC) meeting on 27 March, where the discussion was open and productive, benefiting from the input of Trust Governors. The Good Governance Institute (GGI) review has initiated a reset, transitioning from QPR to IPR, with a proposal for a rolling programme of deep dives. Kerry Rogers, the new Director of Integrated Governance, has joined the Trust and is working with Sam Foster to identify and prioritise support areas, including the development of maternity services reporting. Matters discussed at the meeting held 24 April 2024 were as follows: Items rated red: • NHS England National Review of Paediatric Hearing Services. The Medical Director was not assured by the Trust's action plan and requested further action. A report will be brought back to QPC.

Ref.	Item
Quality and Performance	
17/24	**Quality and Performance Committee Report**
	• The committee discussed the timeliness and handling of patient complaints, an item the Chief Executive has raised as well. The committee asked to receive a detailed report on complaints management at its meeting in May. • A Never Event task and finish group had been established following two wrong side blocks in theatre. The committee were not assured that action had been taken to prevent recurrence given previous never events. • The Committee were informed that the water safety group are not assured that legionella assessment risks are being undertaken in a timely manner therefore risking missing the statutory requirement. The Executive were progressing actions to ensure oversight of improvements required. Items rated amber: • The Committee looked in more depth at the annual peer review of trauma units which the Board had discussed earlier at its meeting held in Private. While progress on the action plan was acknowledged, further assurance regarding its delivery was sought. • The Committee noted the need to refresh the Trust's Board Assurance Framework and Kerry Rogers would assist with reviewing and updating the Board Assurance Framework aligned to the Board workshops considering the next phase of the Trust's strategy. A recurring theme emerged from the Trusts "learning from deaths" discussion. There's a concern that crucial learnings from a range of reports aren't reaching frontline staff. This creates a gap between the information gathered and actionable knowledge. The Trust needs to ensure these learnings are documented effectively to bridge this gap and facilitate better knowledge transfer to frontline staff. R**ESOLVED:** The Board **RECEIVED** the update from the Quality and Performance Committee.
18/24	**Integrated Performance Report (Operational Performance)**
	Al Sheward presented the Quality and Performance Report (QPR) and the operational performance section of the Integrated Performance Report (IPR) for March 2024. The Board was asked to note the following key points: • The Trust's four-hour performance in Urgent and Emergency Care improved by 2%, reaching 58% compared to February's position. The Trust is set to agree on a target of 78% in the Operational Plan. • The Trust noted that timely handovers of patients from ambulances did not always result in improved Category 2 ambulance response times. This issue is being addressed with the Regional and National NHS England Teams.

Ref.	Item
18/24	**Integrated Performance Report (Operational Performance)**
	• The number of elective patients waiting over 52 weeks is expected to be around 2,890, with the main specialties contributing to this being Oral Surgery, Ear Nose and Throat, and Trauma and Orthopaedics. The Trust needs to clear these 2,890 patients waiting by March 2025. While progress is being made, there is a timing issue between the agreement and submission of the Operational Plan and the release of finances from the Elective Recovery Fund (ERF). In the first month of 2024/25, the Trust lost ERF activity due to a lack of confirmed direct funding, meaning those patients will now need to be treated in the remaining 11 months of the financial year. • The number of patients waiting over 65 weeks is expected to be 454. The Trust aims to have no patients waiting over 65 weeks by the end of September 2024. An internal stretch target has been set, primarily focusing on Head and Neck, Orthopaedics, and Cardiology. • The Trust aims to have no patients waiting over 78 weeks. At the end of March, there were 4 patients waiting over this period, and currently, there are 3 expected by the end of April. Al Sheward is working to ensure that patients are booked in the correct order, prioritizing those who have waited the longest. • National Cancer Surveillance recommends that no more than 6% of patients should be on waiting lists for over 62 days, but currently, 7.6% of patients exceed this wait time. The Trust team has reduced the backlog from 230 patients in February to 168 patients. The goal is to further reduce the backlog to approximately 150 patients. At the end of March, 66% of patients not in the backlog were seen within 62 days, compared to the national requirement of 85%. The Trust aims to meet the 85% target by March 2025, with ongoing improvements linked to specific specialties and Elective Recovery Fund (ERF) funding. • The Trust narrowly missed the Faster Diagnostics target of 74% by 0.8%. On July 31, the Trust also missed the 96th percentile by 0.1%. Improvements in colonoscopy and gastroscopy are crucial and will be examined in detail at the Trust Board Quality and Performance Committee meeting in June 2024. • Significant risks concerning Angiography were raised at the Trust Board Quality and Performance Committee, with over 500 patients waiting, many for more than 18 months. The Trust is seeking mutual aid from Oxford, Bristol, and Great Western to expedite patient treatment. • The Trust is making significant progress on the right to reside, although it has not yet reached its goal. Regarding no criteria to reside, the Chair requested future reports to include specific numbers along with percentages. The Chair also asked for a report on the target numbers the Trust is expected to achieve. During a recent visit to meet one of the Trust's Virtual Ward Clinicians, the Chair noted that the Trust has up to 200 virtual ward beds and raised questions about their use, growth, and relation to rapid response. The Chair was pleased with the targeted performance efforts to meet the operational plan standards.

Ref.	Item
Quality and Performance	
18/24	**Integrated Performance Report (Operational Performance)**
	Kaye Law-Fox suggested adapting the format of the Integrated Performance Report for maternity, including sections on Operational Performance, Care, Finance, and Workforce, balancing regulatory compliance with actionable information. The Chair invited Non-Executive Directors to contribute to the development of the Integrated Performance Report, which Trust teams find helpful for assuring the Board and Committees of Trust performance. Matt Holdaway commented on the report, highlighting a significant rise in bed days due to Norovirus and Covid outbreaks, and thanked the Infection Prevention and Control Team and site teams for their commendable work, suggesting their collaboration as a model for future outbreak management. **RESOLVED:** The Board **NOTED** the Integrated Performance Report (IPR) in conjunction with the Trust Quality and Performance Report (QPR). The Board **NOTED** progress being made to the development of an IPR in the coming weeks.
Quality and Performance	
18/24	**Consent items**
	Annual Equality Report 2022/2023. Claire Radley introduced the Annual Equality Report 2022/2023, which NHS Trusts are required to publish annually as part of the Public Sector Equality Duty. This report must be available for download on the Trust's website. The report highlights key achievements in 2022/23 and outlines plans for the upcoming year to foster a culture of ownership and shared responsibility for improving equality, diversity, and inclusion. Based on feedback from the Trust Board People and Organisational Development Committee, the Trust has maintained the same style and format for the Equality Report, emphasizing areas of progress. Due to unexpected team absence, the completion of the 2022/2023 report was delayed, but the 2023/2024 report is on track to be signed off by 14 November 2024. **RESOLVED: ACCEPTED** the 2022/23 Equality Report and **AUTHORISED** its publication on the Trust website **Health and Safety Executive – Letter of Contravention** The Health and Safety Executive carried out a statutory inspection over a three-day period in December 2023 and February 2024. The Trust received a Notice of Contravention Letter which informs an organisation that the Inspector suspects or has seen something that is a breach of a regulation. It requires the Trust to respond and to outline what it will do to resolve any concerns highlighted. A Notice of Contravention Letter is not an Improvement Notice, the latter being a formal ‘must improve’ approach with a strict deadline.

Ref.	Item
Quality and Performance	
18/24	**Consent items**
	The letter notes two material breaches: • Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) and 7 in relation to managing violence and aggression • Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) / The Manual Handling Operations Regulations 1992, Regulation 4 in relation to managing manual handling risks The Trust has developed a detailed action plan to address the inspector's concerns, including clear timelines and assigned responsibilities between departments. This action plan has been shared with key stakeholders such as the Trust Health and Safety Committee and will be submitted to the Health and Safety Executive (HSE) by May 31, 2024. Ian Quinnell suggested an independent review of security and manual handling to support the development of future training models, with the Chair noting that the action plan will be monitored through the Trust Health and Safety Committee and the People and Organisational Development Committee, and Kaye Law-Fox confirmed the full engagement and support of Gloucestershire Managed Services. R**ESOLVED:** The Board NOTED the report
19/24	**Any other business**
	There were no items of any other business.
20/24	**Governor observations**
	Andrea Holder, Public Governor for Tewkesbury, found the staff story very powerful and emotive, highlighting the need for restorative clinical supervision to reduce burnout and improve staff retention. She questioned the current implementation of clinical supervision and noted that while staff turnover is decreasing, there may still be areas with high turnover. She also inquired about the time it takes to advertise a post and its impact on hiring, as well as the scoring of clinical and financial risk. The Chair thanked Andrea Holder for her observations, noting that the matters raised would, where appropriate, be addressed outside the meeting.
21/24	**Date and time of next meeting**
	Thursday 11 July 2024 at 11:15 (Museum of Gloucester, Gloucester)
Meeting closed at 15.50	

Matters Arising – Trust Board of Directors meeting held in Public 9 May 2024

Gloucestershire Hospitals NHS Foundation Trust

Date /Ref.	Item	Agreed action	Lead(s)	Date due	*Update on Implementation of action as of 9 May 2024*	Status
14.03.24	Trust Risk Register	Check and cross reference the Trust Risk Register against the Integrate Care Board's risk register.	Kerry Rogers June 2024	June	*Dr Pietroni received a copy of the Integrated Care Board's Corporate Risk Register and Board Assurance Framework. The Trust's Corporate Governance Team will review these documents to ensure the Trusts Board Assurance Framework (BAF) and Trust Risk Register are aligned with system risk management practices.*	Closed

Chief Executive Report to the Board of Directors - July 2024

1. People and Culture

1.1 General Election

Since the last Board, a General Election has been called, and this will potentially mean a change of Government nationally, and also changes to some of our local MPs. There is also a change to the constituent boundaries with the creation of the cross-county boundary constituency of South Cotswolds, resulting in a major reconfiguration of the existing constituency of The Cotswolds, which would be renamed North Cotswolds. This will in effect mean an increase from six to seven MPs for Gloucestershire, with the new South Cotswold constituency combined with parts of Wiltshire.

There will likely be changes for the NHS, as there always are with any new parliament, and we will continue to work together with staff and our partners in improving what it is like to work in our Trust and to ensure we continue to deliver good quality care for our patients and communities.

1.2 New Appointments

Director of Improvement and Delivery

Following a recruitment process in June, the Trust has appointed Will Cleary-Gray as our new Director of Improvement and Delivery.

The role has been reshaped from the strategy, transformation and business development role, to emphasise the work we need to do on developing our approach to improvement, as well as the wider partnership/system agenda which will be important for the Trust in the years ahead.

Will started his NHS career as a Critical Care Nurse over 25 years ago and brings extensive experience in strategy, policy and COO roles at regional and national levels. Will is currently Executive Director of Strategy and Partnership for NHS South Yorkshire, a large, complex health system. Based on his experiences will give us a new perspective on some of the challenges and opportunities we face and make an important contribution to the wider Gloucestershire ICS agenda and will hopefully join the Trust in October.

My thanks to Ian Quinnell who has held the strategy and transformation brief since last summer and will continue to do so until Will's arrival. Ian's support has been hugely appreciated at a really important time for the Trust.

GMS Managing Director

Mike Gregson has been appointed as the Managing Director within GMS from 1 August. Mike is currently the Director of Governance and Change for GMS and has a career history of strategic leadership in the delivery of business improvement programmes.

Simon Wadley has been interim Managing Director for the last 18 months and will revert to his substantive role as Finance and Commercial Director within GMS and we are grateful for the leadership provided to GMS.

1.3 NHS Confederation

I attended the NHS Confederation in Manchester (12-13 June), and was delighted to spend time at our Health Innovation Lab exhibition stand, which was led by our Research Team. The work they are doing with staff and services across Gloucestershire, and in forging links with a wide range of partner organisations (including Leeds Teaching Hospitals NHS Trust) and medical technology companies in the UK and internationally is of real interest.

They have already begun work to develop several innovations, such as the Clarlite, which will enable surgeons to use LED lighting within a cavity, improving precision, the potential to reduce lighting costs and hopefully shortening operating times. Following an MoU signed with Whitespace Global (approved by CIRG in May) the Research Team are collaborating on a suite of AI products for the health industry. The first of these Tarqin (report writing) and Eamlie (corporate decision support making) will launch in September. In line with the Trust IP policy, we will be leading and benefiting financially from the commercialisation of these and further products.

I also listened to Amanda Pritchard's speech at the conference, and there were several important takeaways for the next couple of years ahead, from how organisations continue to improve and learn, how we strengthen and support leadership at all levels, and how we can make it easier and to nurture innovation in shaping care for the future.

These are important topics for us to engage in and as part of our forward plan for Board development we will be creating space for development discussions on topics like the commercial agenda, leadership & management development within the Trust and the use & adoption of a consistent methodology to drive improvement.

1.4 Three Counties Medical School

In early May, I was able to welcome the inaugural cohort of first-year medical students from the newly founded Three Counties Medical School (TCMS) based in Worcester. The students are placed on a variety of wards across the Trust and the idea is for them to become embedded with the teams over the next four weeks.

The new Three Counties Medical School (TCMS) will serve the three counties of Gloucestershire, Herefordshire and Worcestershire and will open this September. Recruitment is underway for its Education Site Director, which will act as the interface between Gloucestershire Hospitals and the University of Worcester Three Counties Medical School and be responsible for the delivery and quality of clinical education and training to medical students while on clinical placement.

1.5 Sexual Safety Charter - Update

We have been working hard with staff across the organisation with a focus on safety in the workplace and established a Sexual Safety working group earlier this year to help shape a new Sexual Safety Policy, that is being developed and refined through all the relevant governance routes, and review the Safe Learning Environment Charter (SLEC) the Trust is committed to supporting.

One of our commitments as part of our work around culture and improving staff experience, we have formally signed the NHS Sexual Safety Charter. The Charter requires every NHS organisation to commit to 10 principles and to implement the actions it sets out to improve safety at work. There is no place for unwanted, inappropriate or harmful sexualised behaviours within our Trust and we are committed to taking action to prevent and address this.

We will continue to work and engage staff so that anyone can be involved in how we implement the charters, prevent unwanted behaviour and measure and review results of the Staff Survey and NHS National Education and Training Survey (NETS).

1.6 Armed Forces Covenant

We have many staff working in our hospitals who have previously been members of the Armed Forces, have partners in the Armed Forces, or serve as Reservists

The last week of June marked Armed Forces Week, and as part of the celebrations I was delighted to re-sign the Armed Forces Covenant on behalf of the Trust. The Covenant pledges to honour and prevent disadvantage to the Armed Forces community – veterans, serving personnel, spouse or partner and children.

During the week, we hosted a breakfast drop-in at both hospitals for staff members who are veterans or still serving, and our Armed Forces Champions. We also has a number of displays, including the soldier silhouettes in the Atrium at Gloucestershire Royal Hospital and an information stand in our libraries.

1.7 Awards

Our Haematology Team received the Myeloma UK Clinical Service Excellence Programme (CSEP) Award on 12 June in recognition of their outstanding care and dedication to patients with myeloma, an incurable blood cancer that claims the lives of 3,000 people in the UK each year.

The service was praised for its efforts to improve patient's quality of life and commitment to providing compassionate care.

Myeloma is especially hard to spot as the symptoms are often vague and dismissed as ageing or other minor conditions and by the time many patients are diagnosed their cancer has often advanced and they require urgent treatment. This can significantly impact their chances of survival and quality of life.

Our Therapy Services has been shortlisted for two HSJ Patient Safety Awards for its 'Outpatient MSK Assessment and Advice Service'. There were over 400 entries and the team has been shortlisted for Patient Safety Pilot Project of the Year and Patient Safety in Elective Recovery Award.

The pilot 'MSK Assessment & Advice (A&A) Service aims to reduce the risks of long waits, aid elective recovery, and improve access to MSK Therapy by offering sooner, one-off, face-to-face appointments to patients waiting for a routine appointment. As a result of the pilot, evaluation demonstrated that serious pathologies were identified much sooner, and wait times and wait lists were reduced by more than half over 12 months, with patient satisfaction scores maintained at 96% positive.

Finally, our Quality Team has been shortlisted for an HSJ Patient Safety Award for the implementation of Martha's Rule (called Call 4 Concern) over the last year, under the Deteriorating Patients and Rapid Response Initiative of the Year category.

Congratulations to all our teams, and the winners will be announced during the HSJ Awards ceremony in Manchester on 16 September 2024.

2. Operational context

2.1 Performance

The Trust has set a No Criteria To Reside (NCTR) target of 105 by the end of July 2024 we currently work at around the 140 level which, despite progress, still has an impact on our ability to maintain flow and care for patients. There is a clear correlation between lower No Criteria To Reside and better flow and reduced delays for patients hence why it is such a focus for us and the wider system.

Four-hour performance across the Trust has remained relatively static at 58% over the last two months, against a target of 78%. The four-hour performance in Minors remains around 67% and majors 37.7% in May.

We have seen a steady increase in Minors in recent months which presents a challenge to us in terms of how we manage the capacity of the department. Part of the solution is system-based with regards to the need to ensure there are appropriate alternatives for Minors patients elsewhere in the system.

Ambulance handover delays have remained relatively stable across April and May at an average time of 76mins, and we had consecutive days in June below 40mins. There has been a gradual increase in handover times since January 2024. In May, the total number of handovers that were more than 60 mins was 1,071 which is a slight improvement on 1,131 in April 2024. Our recent audits with SWAST and community partners indicate that around 20% of patients conveyed by ambulance to our Emergency Departments could receive a different offer in the community if it was readily available.

To offer a fresh perspective and learning from other systems, in June we invited ECIST, the national Emergency Care Intensive Support Team to look at the internal processes we can control to seek to drive an improvement in the way we work and ultimately in the care we offer to patients. The visit helped bring some new ideas into the discussions which will be taken forward.

The number of patients waiting more than 78 weeks at the end of May was three patients, which consisted of two Oral Surgery; and one Cardiology. The Trust has a focus on predicting patients who may get to 78 weeks and combined with the review of patients at 65 weeks, will drive fewer patients getting to 65 weeks.

Cancer performance against the 28-day faster diagnosis target has started to improve with 75% of people in March receiving a diagnosis or all clear following a suspected cancer referral against the 75% target. To maintain this standard of 75% and achieve the new target of 77% Faster Diagnosis Standard (FDS), some planned actions include: a new escalation policy to support earlier identification of bottlenecks and concerns; Review of 2WW booking date and aim to bring this in line with seven days or less. Cancer performance is subject to a separate report elsewhere on the agenda.

The Trust acknowledges the size of the challenge and that many patients are still waiting longer than they would like. We recognise the impact this has on individuals and families and are working hard to improve this position for all concerned.

2.2 The 8 Days of Summer

In April, as part of the Clinical Vision of Flow (CVoF), the Trust ran a programme called the *Perfect 12 Days of Spring,* where clinical teams audited and tested several initiatives to help

improve flow across the system. Some of these were very successful and have continued to be embedded and other approaches helped to identify gaps that prevent the Trust from having the pace and capacity to see the patients who need to be in the right place, first time.

Following on from the success of the 12 Days of Spring, the Trust will be running the *8 Days of Summer* between 8-14 July, which will continue the focus on identifying good flow through the hospitals

The *8 Days of Summer programme* includes four clinically-led workstreams: Emergency Department; Same Day Emergency Care (SDEC) including assessment and short stay; Frailty; and Speciality Wards (where patients who need to be in a specialty bed to get care and treatment in a hospital, but where pathways such as hot clinics or virtual wards could offer an alternative).

Over the next six months, these workstreams will be working to improve flow, supported by staff from across the Trust.

The Perfect 8 Days of Summer will help to make space and capacity to see the patients who need us in the right place first time and this will help reduce ambulance waits, eliminate crowding in the EDs and SDECs, stop boarding, and improve the overall experience and outcomes for our patients and staff.

2.3 Industrial Action

On 29 May 2024 the British Medical Association (BMA) confirmed that junior doctors will take further industrial action from 7:00am on 27 June 2024 and ending 7:00am on 2 July 2024 as part of an ongoing dispute between junior doctors and the government.

In planning for the industrial action, Cheltenham's Emergency Department (ED) will temporarily switch to a Minor Injury and Illness Unit (MIIU) from 8am – 8pm, on Wednesday 26 June and close overnight from 8pm – 8am, until Tuesday 2 July when normal service provision will resume from 8am. Normal service means Cheltenham A&E will be consultant-led from 8am – 8pm and a MIIU, nurse-led service from 8pm – 8am.

These temporary changes will enable available emergency care staff to come together at Gloucester to keep services safe.

Patients who have a planned operation, outpatient clinic or procedure are being advised to attend as usual unless they hear from us directly to advise otherwise. However, we expect that over the five days around 60 inpatients will be cancelled and around 425 outpatient appointments.

In a further development, GPs across England are also voting on whether to start "work to rule" industrial action over a new pay contract and the British Medical Association opened the ballot on 16 June which will close on 29 June 2024.

While the result will not allow practice owners to initiate strikes, GPs could reduce appointments to the recognised safe working maximum level of 25 from August, limiting the number of patients they see each day.

3. Quality & performance

3.1 Martha's Rule and Call 4 Concern - Children Services

In March we updated on NHS England's phased of the introduction of Martha's Rule across the NHS from April 2024. In Gloucestershire, our programme is called Call 4 Concern and was introduced more than a year ago to ensure staff, patients, families or carers can call for help and advice from the Acute Care Response Team when they feel concerned about a worsening clinical condition.

Call 4 Concern has now been widely rolled out across the Trust and in June this extended to Children Services.

The safety of patients remains the main priority for the Trust and staff, and the successful implementation of Call 4 Concern (and Martha's Rule nationally) adds an important step in providing additional support and clinical reviews whenever they are needed.

The Trust has been awarded £80,000 NHSE funding to enable us to continue our improvement programme.

3.2 Enhancing SACT (chemotherapy) Outpatient Treatment

Cancer patients will now have more help available to try to prevent hair loss during their treatment with 4 new dual scalp cooling units funded by Cheltenham and Gloucester Hospitals Charity.

This was primarily funded by £70K of major gifts and grants, with support from funds raised by Mowgli Street Food, a restaurant based locally which has now raised over £32,000 for the charity.

Scalp cooling involves patients wearing a cold cap during treatment sessions such as chemotherapy to limit blood flow to the head, a method that can prevent drugs from reaching the hair and causing hair loss. The new machines can benefit two patients at the same time.

More than 5,000 people have chemotherapy and other treatments each year in the Gloucestershire Oncology Centre and the scalp cooling machines are in high demand from patients.

4. Strategy

4.1 Trust Strategy

In 2019 the Trust published its five-year Strategic Plan, called 'Our Journey to Outstanding' which will come to its conclusion this year. Over the last five years, the NHS and the hospitals have faced a significant number of challenges and changes, not least through the Pandemic, but also the impact of the cost-of-living crisis and changes across our communities. The Trust has also completed two public consultations as part of the Fit for the Future programme and through this work secured and invested over £100m in new building works and service improvements.

Work is now underway to involve staff, partners and communities in shaping a new Trust Strategy that will guide us and unite us in the work we do together every day.

We want the Trust to be a place that we are all proud to work for and where the care and compassion we provide patients is of the standard we would want to provide for our families.

The work to develop the new strategy has started and will be phased over the next six months, and will help bring together a wide range of views and voices and ensure ideas are reflected in the new strategy.

4.2 Centres of Excellence

The Gloucestershire health system undertook extensive public consultation in 2020 and again between 2022 and 2023 on shaping the future of our hospital services. This programme of work, called Fit for the Future (FFTF), focused on strengthening eleven specialist services across our two main hospital sites: Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). In doing so this would ensure that specialist care would be provided to more patients, waiting times would be lower, patient experience would be improved and patient outcomes would be better.

To date, eight of these eleven service improvements have been completed and we are well on track to complete the remaining three this year (2024/25).

The Trust is anticipating an update on the next steps of the Fit for the Future programme later this summer, following continued progress in realigning services to provide the best care at both of our hospitals and ensure many more patients have better outcomes, reduced waiting times, and a better experience.

5 Regulators

5.1 CQC Report - Children's Centre CQC Inspection September 2023

In September 2023 the Trust contacted the CQC and requested support and guidance about the provision of care for young people within the hospital, who should be placed in an appropriate placement setting for their needs.

The CQC responded to this request and carried out an unannounced focused inspection of the Children's Centre to look at the safety and quality of the service, specifically for young people with complex psychosocial needs.

The concerns raised to the CQC by the Trust related to the care of young people with complex psychosocial needs in our children's ward. We informed the CQC that we had patients who were ready for discharge, but sadly remained inappropriately placed at the hospital due to lack of capacity in more appropriate settings, with no clear discharge pathway.

We also raised the concern that to keep the patients and other children on the unit safe, the occasional use of physical restraint and administration of emergency sedation was required. This is distressing for everyone involved, and the Children's Centre was not the right setting to be providing the specialist care needed.

Following the inspection, the CQC raised several areas of improvement for the Trust:

- The privacy and dignity of young people receiving care could sometimes be compromised.
- Care plans and records did not always reflect national guidance.
- Staff had not completed all mandatory training.
- Concerns over the competencies of registered nurses supplied by an agency to provide specialist mental health care.

- The Trust's medicines policy and procedures around emergency sedation were not always followed.

However, the CQC noted that:

- Staff were responsive when caring for young people.
- Staff took time to interact with the young people in a respectful and considerate way outside of clinical interventions.

Following the CQC inspection, the team has strengthened processes around appropriate hospital admissions, administration of emergency sedation, reviewed mandatory training, and strengthened recruitment and use of Registered Mental Health Nurses.

The report is challenging and we recognise the patients at the heart of the Children's Centre inspection should not have been in our hospitals, which is why the Trust took the decision to proactively raise the safety concern and seek support from the CQC.

An action plan was submitted to the CQC on 20 June 2024.

5.2 CQC Report - Urgent and Emergency Care CQC Inspection December 2023

In December 2023 the CQC conducted unannounced focused inspections of Urgent and Emergency Care at Gloucestershire Royal Hospital.

The inspection looked specifically at the safety of the services following concerns raised to the CQC around cleanliness, however during the visit it was noted that the areas were clean. They also noted that there had been a small electrical fire in the department, but fire exits were blocked.

As a result, the CQC served a 29a Warning Notice on the service to make rapid and widespread improvements in fire safety to keep people safe, and the department was again rated as 'requires improvement'.

Key findings in the CQC Report:

- Staff were not following national regulations and guidance about fire safety.
- There were systems and processes in place to report and learn from incidents however local fire procedures were poor despite the recent fire in the department.
- Medical devices were not being tested in accordance with national regulations and guidance.

However, the CQC noted that:

- Although staff completion rates of infection prevention and control training were low, this improved in January 2024 following the inspection.

Since the inspection in December 2023, the Trust has completed several actions, including updating the fire plan and detailed planning for a full departmental fire evacuation for the new Emergency Department at Gloucestershire Royal Hospital. In addition, the services have completed refresher training for all designated fire wardens and increased mandatory training for fire safety for all staff across the department.

The Trust has reviewed and increased signage for fire exits and all fire exits are checked three times per shift and documented in shift reports. All Medical Devices will continue to be

regularly tested and a register maintained by the Patient Safety Lead within our Emergency Department.

The report has not yet been published by the CQC. We have invited CQC back in to view our improvements in the Emergency Department and they will be visiting us in July 2024.

5.3 Maternity Services CQC Inspection March 2024 – Section 31

The CQC visited Maternity Services at Gloucestershire Royal Hospital to carry out an inspection on 26 March 2024 and the report is expected in the summer. The initial feedback was that there were no immediate safety concerns and improvements had been made in the culture within the department. However, there was a need to strengthen reporting processes and evidence of learning.

On 9 May the CQC issued an enforcement notice, putting several reporting conditions in place to ensure focused attention and improved pace, including:

- Stronger systems to provide an up-to-date and overarching view of quality and safety across the maternity service;
- Systems and processes to identify and action timely identification and learning from incidents across all teams in the department.

These include immediate actions that the Trust is expected to take and the service is required to report progress to the CQC monthly. There will also be additional system oversight and coordination in place through this next period, so we can ensure that improvements that need to be made are embedded.

The service is also reviewing internal processes so there is an effective system of governance, aligned to Board reporting, to ensure improvements, including oversight of themes and trends from incidents and learning are acted upon and shared in a timely way. Our first report detailing our improvements has been submitted to CQC on 29 May 2024 and the second report is due on 28 June 2024. This process has been the subject of discussion at the most recent Quality and Performance sub-Committee.

At system level, the Chief Nurse for the ICB has established a fortnightly Quality Improvement Group with membership from ICB, Trust, LMNS, Maternity and Neonatal Voices Partnership, CQC, NHSE, and Maternity Improvement Advisor to bring together all the various stakeholders in this work to oversee the improvements required.

5.4 CQC Next steps

The Trust expects the CQC to re-inspect the services in the near future and will be working with colleagues and partners to ensure improvements are made. The Chief Nurse is hosting a learning event, enabling colleagues to support our response and learning across the Trust from our inspections, on 21 June 2024.

5.5 Independent thematic review – Maternity

The Trust had initially engaged with Maternity and Newborn Safety Investigations (MNSI), the national body for early investigating neonatal and maternal deaths in England, to establish an independent thematic review of maternal deaths. Unfortunately, representatives from MNSI contacted the Trust earlier this month to explain they are not able to undertake this review. Since becoming hosted by the Care Quality Commission, MNSI no longer have a legal basis to provide this type of work.

We have therefore approached NHSE regional colleagues to source expertise to undertake this important review on our behalf.

In addition, colleagues working in a separate LMNS in Hampshire have been approached to undertake a thematic review of neonatal deaths on our behalf. This review will begin shortly.

Kevin McNamara
Chief Executive

Report to Board of Directors meeting in Public

Agenda item:	8	Enclosure Number:	01

Date	Thursday 11 July 2024
Title	Board Assurance Franework
Author **Sponsoring Director/ Presenter**	Mike Weaver, Interim Company Secretary Kerry Rogers, Director of Integrated Governance

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

The Board Assurance Framework (BAF) is a crucial strategic tool for NHS Trusts, designed to ensure the delivery of safe, effective, and sustainable healthcare services by identifying, managing, and mitigating strategic risks in a structured and transparent manner. By highlighting major risks that could impede the Trust's strategic objectives, the BAF ensures these significant risks receive board-level attention. Through documenting and tracking risks, controls, and assurances, the BAF provides a clear understanding of risk mitigation measures and their effectiveness, thereby instilling confidence in the Trust's risk management processes.

The BAF supports decision-making by offering a structured approach to risk management, highlighting key risks and the status of mitigating actions to aid in strategic planning and resource prioritization. It enhances accountability and transparency by delineating risk management responsibilities within the Trust and regularly reporting risk information to the board and regulatory bodies. Additionally, the BAF ensures regulatory compliance with NHS England and the Care Quality Commission, and integrates risk management into the overall governance framework, promoting continuous improvement through regular reviews and updates.

Recent updates to the Gloucestershire Hospitals NHS Foundation Trust’s BAF include revisions to strategic risks such as the failure to embed the quality governance framework and financial sustainability issues. The Trust has developed a work plan addressing long-term operational and financial planning, though significant gaps remain, including the absence of a long-term financial sustainability plan and outdated policies. Moving forward, the BAF will be aligned with the Trust’s strategic objectives and regulatory requirements, integrated with other governance frameworks, and continuously updated to reflect changes and emerging risks, ensuring a cohesive approach to risk management.

Risks or Concerns

Risks reported on the Board Assuarnce Framework scored 20 and above:

- SR1 Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System
- SR2, Failure to successfully embed the quality governance framework
- SR9, Failure to deliver recurrent financial sustainability
- SR16, Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve. (Culture and Retention)
- SR17, Inability to attract a skilful, compassionate workforce that is representative of the communities we serve (Recruitment and attraction)
- SR12, Failure to detect and control risks to cyber security.

Financial Implications	
• SR9, Failure to deliver recurrent financial sustainability	
Approved by: Director of Integrated Governance	**Date: 4 July 2024**
Recommendation	
Members of the Board are asked to note the following: • The strategic risks that could impede the Trust's strategic objectives. • items on the Board Assurance Framework updated in June 2024 (SR2 and SR9).	
Enclosures	
• Board Assurance Framework Summary. • Board Assurance Framework Risk Summary SR2: Quality governance framework. • Board Assurance Framework Risk Summary SR9: Financial sustainability	

1. The Purpose of a Board Assurance Framework

1.1 The Board Assurance Framework (BAF) is a strategic tool essential for NHS Trusts to deliver safe, effective, and sustainable healthcare services. It achieves this by systematically identifying, managing, and mitigating strategic risks in a structured and transparent manner. The BAF helps identify major risks that could impede the Trust's strategic objectives, ensuring that these risks, which are broad in scope and significant in impact, receive board-level attention. By documenting and tracking risks, controls, and assurances, the BAF provides the board with a clear understanding of the measures in place to mitigate risks and the evidence supporting their effectiveness, thereby offering confidence in the Trust's risk management processes.

1.2 Moreover, the BAF supports decision-making by offering a structured approach to risk management, highlighting key risks and the status of mitigating actions to facilitate strategic planning and resource prioritization. It enhances accountability and transparency by clearly delineating risk management responsibilities within the Trust and regularly reporting risk information to the board and regulatory bodies. The BAF also ensures regulatory compliance by meeting requirements set by NHS England and the Care Quality Commission, and improves governance by integrating risk management into the overall governance framework, supporting continuous improvement through regular review and updates of risk information and controls

2. Updates to the Trust's Board Assuarnce Framework

2.1 The Board Assurance Framework (BAF) for Gloucestershire Hospitals NHS Foundation Trust outlines several strategic objectives aimed at ensuring excellence in healthcare delivery, workforce development, and financial sustainability.

2.2 The following items on the Trust's Board Assurance Framework (BAF) have been update in June 2024.

SR2: Failure to successfully embed the quality governance framework

- Current Risk Score: 5 x 4 = 20
- Previous Risk Score: 4 x 4 = 16
- Target Risk Score: 3 x 4 = 12

Planned Assurance

Reporting to Trust Board Quality and Performance Committee as per the planned meeting schedule and Internal Audit reviews 2022-2025

SR9: Failure to deliver recurrent financial sustainability

- Current Risk Score: 5 x 5 = 25
- Previous Risk Score: 5 x 1 = 5
- Target Risk Score: 1 x 3 = 3

Controls, mitigations and gaps in control

Changes in controls/mitigations include developing a workplan to look at developing a timeframe around engagement on the long- term operational and financial plan. The Trust faces significant control gaps, including the absence of a long-term financial sustainability plan, lack of staff awareness about the financial position, limited understanding of deficit drivers, an incomplete national grip and control assurance checklist, and outdated policies. These issues impede strategic financial management, adherence to best practices, and overall operational performance, necessitating immediate attention for long-term sustainability.

3. Next steps

3.1 When updating the Board Assurance Framework (BAF), it is essential to ensure alignment with the Trust's strategic objectives, thereby supporting the overall mission and goals. The BAF should be updated to reflect any changes in regulatory requirements, ensuring compliance with national standards and guidelines. Additionally, integrating the BAF with other governance frameworks and risk management processes within the Trust and the wider system will create a cohesive and comprehensive approach to risk management.

3.2 It is proposed that there is no fundamental review of the current strategic risk profile until such time as the Trust considers the next phase of its Strategy development which will in and of itself take account of current and emerging risk. It will mitigate some risks and no doubt will create others to the delivery of the strategy itself which will need to be identified, measured and mitigated accordingly. As the Strategy will be considered in this calendar year, it is expected the strategic risk environment will be reconsidered in unison.

3.3 In the interim period, the processes supporting updates to the BAF will continue with activity to support a stronger focus of committees on the assurances it shoud seek regarding the effectiveness of the control environment mitigating the risk from materialising or its impact should it be realised.

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
1.	**We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges**								
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	June 2024	June 2024	CNO/MD/COO	QPC	3x3=9	N/A	5x5=25
SR2[1]	Failure to successfully embed the quality governance framework	Dec 2022	June 2024	June 2024	CNO/MD	QPC	3x4=12	4x4=16	5x4=20
2.	**We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people**								
SR16	Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve. (Culture and Retention)	Feb 2024	May 2024	May 2024	DFP	PODC	3x4=12	N/A	5x4=20
SR17[2]	Inability to attract a skilful, compassionate workforce that is representative of the communities we serve (Recruitment and attraction)	May 2024	May 2024	May 2024	DFP	PODC	3x4=12	N/A	5x4=20
3.	**Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other**								
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	June 2024	June 2024	MD/CNO	QPC	2x3=6	N/A	4x4=16
4.	**We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners**								
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	Apr 2024	Apr 2024	COO/DST	QPC	2x3=6	N/A	4x3=12

[1] SR2 updated June 2024. SR1, SR2, SR5 and SR6 reported to QPC 26.06.24
[2] SR17 reported to PODC 28.05.24

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**								
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	May 2024	May 2024	DFP	PODC	1x3=3	3x3=9	3x2=6
7.	**We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources**								
SR9[3]	Failure to deliver recurrent financial sustainability	July 2019	Apr 2024	June 2024	DOF	FRC	2x4 = 8	5x1=5	5x5=25
8.	**We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact**								
SR10[4]	Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.	July 2019	Apr 2024	June 2024	DST	FRC	4x4=16	N/A	4x4=16
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	Apr 2024	June 2024	DST	FRC	3x3=9	N/A	3x3=9
9.	**We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care**								
SR12	Failure to detect and control risks to cyber security	Dec 2022	Apr 2024	June 2024	CDIO	FRC	5x3=15	N/A	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	Apr 2024	June 2024	CDIO	FRC	2x3=6	N/A	3x4=12
10.	**We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK**								
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	May 2024	May 2024	MD	CIRG	2x3=6	N/A	3x4=12

[3] SR9 updated Jube 2024
[4] SR10 reported to FRC 27.06.24 SR14 reported to CIRG 30.05.24

Board Assurance Framework Summary

Heat Map: Board Assurance Framework, Current Risk Score

		Consequence				
Likelihood		1	2	3	4	5
	5				SR2[5], SR12, SR16, SR17	SR1, SR9[6]
	4				SR5, SR6, SR10	
	3			SR11	SR13, SR14	
	2			SR7		
	1					

[5] SR2 Failure to successfully embed the quality governance framework updated Jube 2024.
[6] SR9 Failure to deliver recurrent financial sustainability updated June 2024.

Report to Board of Directors meeting in Public			
Date	11 July 2024		
Title	Trust Risk Register		
Author / Sponsoring Director/ Presenter	Lee Troake, Head of Risk and Safety Kerry Rogers, Director of Integrated Governance 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 3 July 2024 the following changes were made to the Trust Risk Register:

Key issues to note

TRR updates:

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

For further details see enclosed Trust Risk Report (Appendix 1) and Trust Risk Register Summary (Appendix 2).

Risk and Incident Performance Key Performance Indicators (KPIs)

Performance information across all risk registers was provided to RMG (see Appendix 3). Performance in the last reporting period against the current KPIs can be summarised as below:

- Trust performs well in relation to the following indicators for risk management:
  - Recording controls – all live risks had controls in place
  - Duty of Candours Investigations – at the end of June, 7 incidents were not fully
  - investigated within the 60 working day period of the current KPI (this KPI will be reviewed by patient safety under PSIRF)

Summary of Report

- Serious Incident (SI) investigations – at the end of June, 1 serious incident had not been fully investigated within the 60 working day period after being declared an SI or by the extension date agreed by the Integrated Care Board. This was within the KPI tolerance (this KPI will be reviewed by patient safety under PSIRF)
- Health & Safety harm related investigations – the Trust has performed well with all except 3 GMS incidents being closed without identifying the factors that can support learning.

- Performance requires improvement for the following indicators:

  - Risk reviews within the required frequency – performance has improved significantly between the end of March (226 overdue) and the end of April (144 overdue) but progress had not been made in May when 141 were overdue. In June this increased to 150 overdue. 42% of medical risks and 28% of Surgical risks were overdue, alongside 39% of corporate risks (NB: Corporate risk owners of these can be from any division but the risk is considered to be trust-wide). Over all registers across the Trust 29% were overdue
  - Recording actions on risks – improvement has been made since the last reporting period with all divisions, except W&C, reducing the number of risks that do not have active actions. However, there still remains 16% that do not have actions on the system. Two of these are Trust risks.
  - Investigation and learning from no/low harm incidents that are consider high risk events – 86 incidents remain unreviewed within a 7-day period. Of those that have been referred for investigation as high or extreme risk, 365 have not been fully investigated within a month of reporting (this has improved since last month)
  - Timely completion and sign-off of actions – all divisions required substantial improvement. 105 overdue actions remain open on web and 432 on Cloud related to risks. 31 actions are overdue on incidents on Cloud

Highest scoring and oldest risks on the TRR

Appendix 4 provides an overview of the highest scoring risks on the TRR and oldest risks on the TRR.

Datix Cloud

The expected update at the end of May (which has been delayed month on month) was due to fix a number of reporting and technical issues with the Cloud risk module. This was not successful and further issues have been noted with changes in registers not reflecting in the reporting side.

The functionality of the risk module on Cloud remains a major issue. The Trust will need to consider its position and what steps can be taken to ensure the supplier resolves issues that have been outstanding some time.

Risks or Concerns

Risk in relation to the functionality of the risk and reporting functions on Cloud

Recommendation
The Board is asked to NOTE the report
Enclosures
Appendices -1-4

BOARD

TRUST RISK REGISTER – JULY 2024

1.0 RISKS APPROVED ON TO THE TRUST RISK REGISTER (TRR)

None

2.0 INCREASED / REDUCED SCORE ON TRR RISK (NO MOVEMENT ON REGISTER)

None

3.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

None

4.0 DOWNGRADE OF TRUST LEVEL SCORE HELD AT DIVISIONAL RISK LEVELTO DIVISIONAL / SPECIALTY RISK REGISTER

Risk #452
Risk Lead: CB
Executive lead: MH

Scoring reduced Day Surgery unit not currently being used as an inpatient ward.

Inherent Risk
3709 The risk of harm to patients and poor-quality care when using Day Surgery Units as an inpatient ward
Cause
During periods of pressure on medical and surgical bed capacity, Mayhill Day Surgery unit is used as an inpatient escalation ward, and this is an increase in the frequency of use. At times the area is used not in accordance with the trust escalation process. Mayhill unit is not fit for purpose for inpatients. Further, day surgery does not have the correct staff ratio and scope of practice for inpatients as well as day surgery. Insufficient infrastructure to run unit as a proper ward when being kept open. Due to current Trauma pathway, trauma patients cannot go to 2A Annexe at a weekend and therefore Mayhill is kept open to accommodate.
Effect
• Often patients not appropriate for the ward - breaching SOP and action card • Receiving patients directly from ED with incidents of no clear plan for treatment • No establishment for staff at weekends so cost implication for temporary staffing • Normal staffing is appropriate for day case but inpatient ward is 24 hours • 15% of staff rota covered by bank and agency • Patients often waiting for nurse to provide basic care as insufficient staff for the acuity, missed intentional rounding daily. • No regular pharmacist for the ward - delays in obtaining medication

- No junior doctors based on unit
- No allocated medical consultants - patients not reviewed daily, sometimes several days before reviewed
- Enhanced care patients or wandering patients are at risk to abscond or entering theatres.
- Insufficient bedside lockers - drugs cannot be stored safely for patients without lockers
- Treatment room has insufficient storage space for an inpatient ward supplies and the locks are broken on the cabinets
- Fire risk assessment is only appropriate for a day surgery unit.
- Lack of facilities to support an inpatient evacuation
- Environment is not suitable for dementia patients with high level confusion and anxiety
- Patients with falls risks - uneven floor, unable to 1:1 patient with high falls risk
- Male and Female patients sharing sleeping areas and have to use same access routes whilst patients not in their day clothes
- Only 1 patient bathroom, one shower room for all patients - shared by all patients and mixed sex
- When housing inpatients Mayhill day surgery is in regular breach of the mixed gender accommodation policy
- Insufficient stock levels for an inpatient ward - daily chasing of materials management for supplies
- Delays in prescribing / Broad medication storage compromised
- Patients going to theatre at risk of not having a space to come back to post operatively delaying discharge from recovery, knock on effect to the whole of theatre flow.
- Lack of clarity regarding escalation of issues
- Sharing therapy resources - delays getting patients assessed
- No allocated OCT which means there is a delay in getting patients discharged
- Electrical sockets, regularly tripping causing operational pressures
- Unfunded domestic services as funded for opening hours.
- Cleaning of equipment not being done by bank and agency staff and due to high proportion of temporary staff unit falling below target levels
- No catering facilities / No storage for mobility equipment
- No curtains on the ward which causes difficulties with patients sleeping and temperature in the summer months
- Impact of staff wellbeing
- At times the trust escalation policy is not followed during extreme pressure
- Patients may deteriorate without medical review
- Delay of receiving support when clinical emergency due to geographical distance from main ward areas
- Quality of care is reduced due to staffing issues
- Patients left waiting for medication
- Patient's dignity not preserved
- Substandard nutrition levels for patients due to limited menu that is repeated daily
- Increase in falls, pressure ulcers and other general injuries
- Patients bed bathed as unable to access suitable bathroom facilities
- Potential unauthorised access to medicines. POPAM storage monitoring noticeably shows area non-compliant.
- Confirmed cases of infection / Dirty equipment
- Impact on elective patients arriving for day surgery as this leads to increased numbers in the waiting area means breaches of privacy and dignity.
- Increase in complaints and impact to Friends and Family feedback with more negative feedback.

- Staff have left the team as a direct result of being expected to care for patients outside of their scope of practice
- Sickness levels amongst staff have been elevated as a direct result of being exposed to this environment
- Loss of capacity as a day surgery units effects utilisation of theatre lists, under filled, and theatre flow reduced.
- Patients may have to sit in areas for long periods of time.

Risk Category (domain)	Previous Score	New Score		
		Consequence	Likelihood	Rating
Safety	3 x 4 =12	2	2	4

Evidence of scoring

Ward is not currently used as an inpatient ward for overnight stays. Team are following SOP for admission to Mayhill.

Controls

- Bank and Agency staff are being used to cover rota gaps
- Staff are escalating issues to materials management for supplies
- Staff escalating issues with domestic and catering cover to relevant services
- Escalating to speciality teams any concerns re inpatients
- SOP written and approved clarifying admission criteria to Mayhill – additional action card for escalation use
- Reporting via datix the use of Mayhill as escalation area
- Reporting via datix mixed sex breach on Mayhill due to use as an escalation area
- Reporting via datix inappropriate patients not meeting admission criteria
- Fire evacuation plans

Gaps in controls

Gaps below only exist if / when ward is used in escalation:

- 15% of staff rota covered by bank and agency
- Lack of funding/establishment for appropriate staffing levels
- 1/3 of patients not appropriate for the ward
- Lack of fire safety compliance as an inpatient area - compliant for day case
- Lack of agreed doctor/junior doctor/nurse and HCA requirements when agreed to open in escalation
- Failure to meet basic ward provisions
- Failure to meet drug safety requirements
- Failure to meet mixed gender accommodation policy
- Lack of agreed provisions around therapy assessment and treatment plans
- Failure to meet nutritional requirements of patients
- Failure to meet minimum requirements for space between patients - unable to have chair and locker by bed

Actions

- Review service hours of Mayhill – completed 23/05/2024
- Review and implement escalation policy – completed 23/05/2024

Risk #437

Risk Lead: SJ
Executive lead: MH

Scoring reduced due to improved compliance of twice daily check of Controlled Drugs (CD) in GRH. CGH continue to develop CD checking of drugs prior to staff leaving shift.

Inherent Risk

3908 The risk of safe storage and monitoring of controlled drugs within the emergency department				
Cause				
Areas within department not carrying out routine CD checks due to unawareness of checks daily or acuity of patient. Workload pressures in resus leads to drugs not being signed out correctly				
Effect				
• CD book balance incorrect • Potential for missing CDs to go unnoticed • Failure to follow POPAM • CD's left unattended				
Risk Category (domain)	**Previous Score**	**Consequence**	**Likelihood**	**Rating**
Statutory	15	3	4	12
Evidence of scoring				
Audit completed. Scoring reduced due to improved compliance of twice daily check of Controlled Drugs (CD) in GRH. CGH continue to develop CD checking of drugs prior to staff leaving shift.				
Controls				
• POPAM Guidance - storage and administration • Routine TWICE DAILY checks - 9@9 - signed for to accept compliance by -coordinator in area • Double signing in CD books for checking Daily • Medicines management e-learning • POPAM audit • Compliance audit - looking at 9@9 and compare with CD book checks - 20 random dates				
Gaps in controls				
• Departments not compliant with checks/POPAM • Three monthly review as per policy by pharmacy • Process for NIC to be following up when signed for but not compliant with person taking accountability through supportive conversation				
Actions				
CD drugs to be checked twice daily and missing FP10's followed up. Completed 20/03/2024				

5.0 DOWNGRADE OF TRR RISK TO DIVISIONAL / SPECIALTY RISK REGISTER

None

6.0 CLOSURE OF RISKS ON TRR

#436
Risk Lead: SB
Executive lead: IQ

Chemistry is now complete but risk still remains in Microbiology and Haematology. A new risk to be raise to cover these areas.

Inherent Risk

2517 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

Cause

Temperature control across the Pathology laboratories is inadequate affecting Histopathology, Mortuary and Stores, Microbiology, but especially Clinical Chemistry and Haematology and Transfusion. Air conditioning systems at Cheltenham are not fit for purpose nor are cooling systems in Gloucester. This used to be a problem only in summer but is now all year with temperatures uniformly over 25 degrees in Chemistry and over 30 degrees reached in parts of the Chemistry laboratory in winter. The ventilation does not meet the requirements of HTM03-01 Specialist Ventilation for Healthcare.

Effect

- Ambient air temperatures are not maintained within acceptable range of 20-25 degrees therefore is not suitable for reagents and analysers. Room temperatures frequently reach level of 30 degrees or more during the summer. Summer 2019 temperatures reached 34 degrees in Chemistry in Gloucester. A temperature of 35 degrees results in complete shut down of all analytical equipment in the laboratory (Datixweb W112541 and W112544).
- Potential for loss of ability to process Pathology, especially Clinical Chemistry samples on one side of the county. Delayed turnaround times, inability to support A&E waiting times, and various urgent clinical pathways; affecting patient safety. Temporary withdrawal of part of the repertoire of tests across all laboratories. Risk of reporting incorrect results leading to misdiagnosis and patient harm.
- Breach of standards for ventilation - statutory intervention for failings in healthcare.
- Prolonged turnaround times due to transporting tests off site, reorganising the location of reagents to preserve stability (£100k of reagent in use at any one time in Chemistry alone, similar in other labs).
- Frequent recalibration of equipment where the calibration is temperature sensitive and increased cost of additional calibration material and loss of staff time.
- Body deterioration during storage in mortuary.
- Impact on the quality of storage of blood components, results and turnaround times for a range of Haematology and Transfusion tests at Cheltenham General.
- Incorrect storage conditions for expensive blood products and reagents
- Increased workload when aliquots have to be made and frozen until the equipment can function again.
- Uncomfortable and hot working conditions for staff - greater than 30 degrees.
- Loss of UKAS accreditation for all laboratories if not resolved. Likely impact on other accreditation and licencing bodies - HTA, HSE, HFEA.
- Loss of income from clinical trials, screening programs and private hospitals if UKAS accreditation lost.

Risk Category (domain)	Consequence	Likelihood	Rating
Quality	5	2	10

Evidence of scoring

Controls

- 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
- Labs at CGH works completed
- Microbiology and Haematology remains on capital 5 year programme

Gaps in controls

Microbiology and Haematology only:

- Current ventilation systems do not perform adequately when the external air temperature rises.
- Temporary air conditioning units do not provide sufficient cooling.
- Air conditioning units blow cold air onto sensitive equipment resulting in fluctuations in operating temperature that requires recalibration. Need to move A/C or add deflectors to divert the air flow.
- If work is transferred to Bristol this will compromise their capacity and adversely affect turnaround times for laboratory services

Actions

- Update air conditioning Units in GRH Labs- 31/3/23 by Terry Hull - CGH complete. GRH phase 1 complete. Remaining areas, awaiting funding award

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
79	1437 The risk of being unable to recruit 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	Workforce	PH	12/03/2012	8	5	4	20	20/06/2022	↑	30/06/2024
83	3550 The risk of physical or psychological harm to patients, relatives, public and staff during incidents involving challenging, aggressive, abusive, threatening and offensive behaviour or physical violence.	Safety	LT	18/06/2021	10	4	3	12	01/03/2024	↑	30/06/2024
93	The risk of harm to patients due to clinical reports being lost and required clinical action omitted or delayed.	Safety	KH	24/05/2022	15	3	4	12	02/05/2024	↓	18/09/2024
96	3826 Risk of delays in managing formal employee relations cases due to limited investigating officer capacity.	Workforce	JT	17/06/2022	12	4	3	12	11/09/2023		14/06/2024

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
122	3755 The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack	Business	TT	11/09/2023	20	3	5	15	10/05/2024	↓	31/07/2024
141	4007 The risk that substantive non-medical staff are not fully compliant with their appraisal requirements and they receive a low-quality appraisal experience	Workforce	AH	20/02/2023	16	4	3	12	13/11/2023	↓	02/08/2024
143	1850 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 Gloucestershire Royal Hospital.	Safety	CF	16/01/2014	9	3	3	9	23/05/2024		24/08/2024
154	4009 The risk of colleagues identifying with certain minority protected characteristics (EM, Disabled and LGBTQ+) continuing to report a worse experience and higher levels of discrimination, leading to low morale, poor health and wellbeing, and which	Workforce	MS	20/02/2023	16	4	3	12	10/01/2024	↓	31/07/2024

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
160	1945 The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls.	Safety	CB	19/08/2014	9	4	3	12	12/09/2023	↑	31/07/2024
161	2667 The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	Safety	CB	05/02/2018	16	3	4	12	02/01/2024	↓	15/07/2024
233	2669 The risk of harm to patients as a result of inpatient falls	Safety	CB	06/02/2018	15	3	4	12	02/01/2024	↓	31/07/2024
236	2803 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	Workforce	AH	16/10/2018	4	4	4	16	14/09/2023	↑	02/08/2024
264	2404 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.	Workforce	AJ	02/12/2016	9	4	4	16	14/09/2023	↑	19/07/2024

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
266	3682 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.	Statutory	EW	22/11/2021	15	4	4	16	14/09/2023	↑	31/08/2024
281	3834 The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials Licence due to staff shortage.	Workforce	MP	15/09/2023	12	4	4	16	30/10/2023	↑	30/08/2024
333	3968 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.	Workforce	CB	14/12/2022	9	4	4	16	20/05/2024	↑	31/07/2024
348	3963 Risk of increased harm, breach in regulations, distress and poor quality experience to patients, staff and visitors when boarding patients in wards.	Quality	DT	18/09/2023	15	5	3	15	18/09/2023		16/08/2024
355	3941 The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	Safety	BT	01/11/2022	15	2	5	10	11/10/2023	↓	30/04/2024

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
374	3930 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	Statutory	BT	17/10/2022	10	3	5	15	18/09/2023	↑	07/05/2024
385	3876 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	Quality	SW	05/08/2022	16	4	4	16	18/09/2023		08/07/2024
409	3845 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.	Quality	TJ	04/07/2022	8	4	5	20	01/06/2024	↑	30/08/2024
413	3767 The risk of harm to patients and staff due to being unable to discharge patients from the Trust	Quality	DT	18/03/2022	16	4	4	16	02/01/2024		12/08/2024
425	2424 The risk to business interruption in theatres due to the failure of the ventilation to meet the statutory required number of air changes	Business	MD	16/01/2017	4	4	4	16	02/01/2024	↑	22/07/2024

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
426	2268 The risk of patient within the Minors Area of the Emergency Department due to capacity and Overcrowding.	Statutory	SJ	29/09/2015	16	5	4	20	29/03/2024	↑	31/08/2024
443	2815 The risk to patient safety due to delays in the acute stroke pathway for patients attending Gloucestershire Royal Hospital (GRH) Emergency Department.	Safety	KH	30/10/2018	16	2	4	8	23/04/2024	↓	28/06/2024
472	3743 The risk of failing to deliver the necessary support to the Laboratory due to insufficient staffing levels and lack of appropriate skill sets, leading to a delay to diagnosis or treatment within the clinical service and harm to the patient.	Workforce	AJ	07/02/2022	15	4	3	12	19/09/2023	↓	19/07/2024
499	3536 The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Workforce	LS	20/05/2021	15	5	4	20	01/07/2022	↑	31/07/2024

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
507	3481 The risk of severe harm to patients requiring emergency obstetric surgery caused by an inability to meet a minimum staffing requirement when opening a second obstetric theatre. The risk of harm to the wellbeing of staff when working outside mini	Workforce	NB	02/03/2021	9	4	4	16	19/09/2023	↑	19/06/2024
510	3084 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.	Quality	LT	21/11/2019	20	2	4	8	03/07/2024	↓	31/10/2024
525	3034 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	Workforce	MH	27/08/2019	20	5	4	20	20/09/2023		30/04/2024

Appendix 2 - Trust Risk Register Summary

NHS Gloucestershire Hospitals NHS Foundation Trust

Risk ID	Risk	Type	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Current rating date	Movement	Next Review Date
534	2895 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/o	Environment	KJ	05/03/2019	8	4	4	16	20/09/2023	↑	31/08/2024
538	2819 The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of the early warning scoring system which may result in a failure to recognise, plan and deliver appropriate urgent care needs.	Safety	AF	06/11/2018	8	2	5	10	20/09/2023	↑	09/07/2024
609	2976 The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Workforce	RH	09/07/2019	15	5	3	15	28/02/2024		30/04/2024
764	S2045 The risk of reduced quality of care in the fractured neck of femur pathway due to lack of resources and theatre capacity leading to poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal Hos	Quality	SW	18/06/2020	6	4	4	16	19/02/2024	↑	31/07/2024

NHS
Gloucestershire Hospitals
NHS Foundation Trust

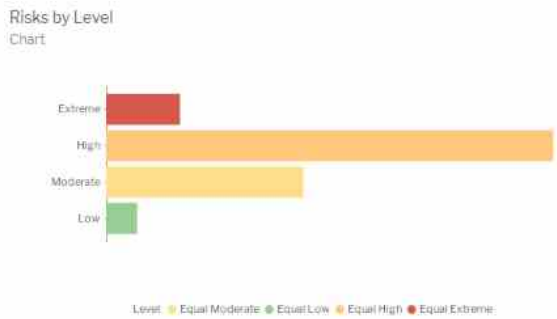
Risk Assurance Dashboard & KPIs

Lee Troake

July 2024

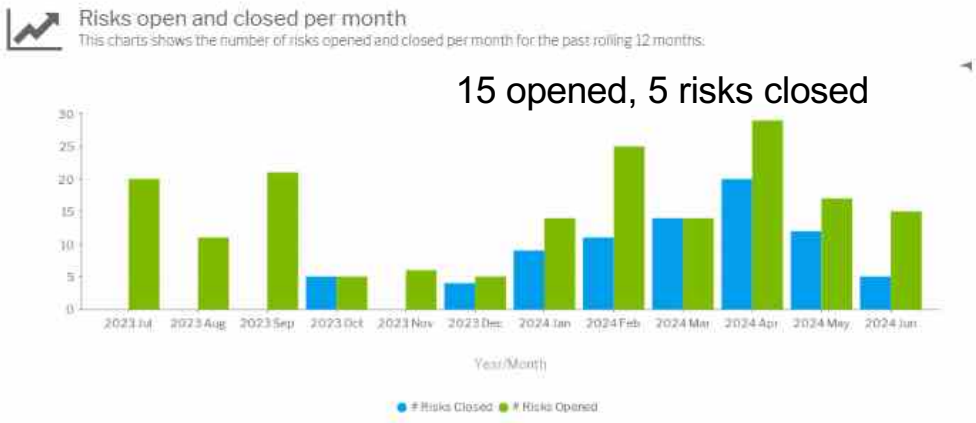
the Best Care for Everyone
care / listen / excel

Dashboard All Registers



Level	# Risks
Low	24
Moderate	152
High	345
Extreme	57

Risk Exposure Rate	1.7% increased exposure in June



Objective	# Risks
Care without boundaries	105
Centres of Excellence	117
Compassionate workforce	103
Digital future	73
Driving research	13
Effective estate	92
Financial balance	48
Involved people	21
Outstanding care	300
Quality improvement	216

No. of risks impacting achievement of organisational objectives

Dashboard All Registers – score changes

- Risk score changes following review
  - score increased – 8
  - score decreased - 11 (3 met the target score)

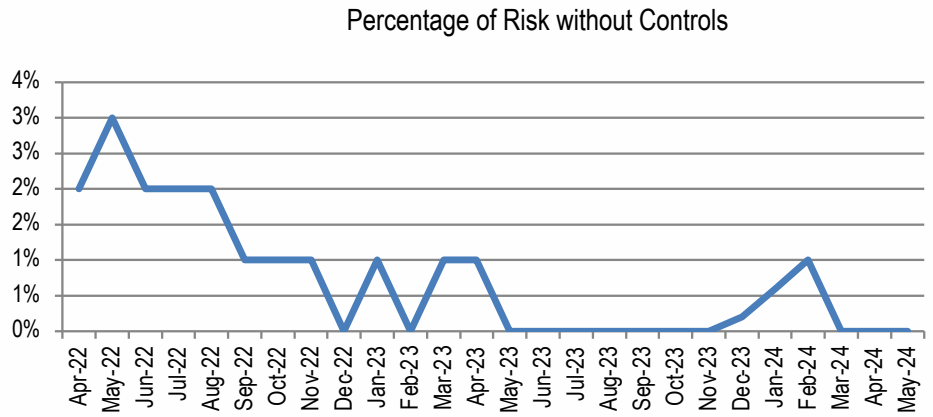
- Risks accepted for escalation to higher register or de-escalation to lower register in last month
  - Escalated - ?
  - De-escalated - ?

Risk ID	Risk	Risk Register	Service level 3	Date opened	Status	Initial rating	Previous Rating	Previous Rating Date	Current rating	Current rating date	Movement	Movement (number)
520	2811 The risk of compromised patient safety is increased due to delayed care, diagnosis, treatment caused by multifactorial delays within the mental health pathway for at risk patients whilst in the Emergency Department.	Medical Divisional Risk Register	Emergency Department	20/09/2023	Active	12	3	08/05/2024 1:17 PM	12	14/06/2024	↑	9
54	2800 The risk of prolonged safe holding as part of the V&A response for a patient where emergency sedation is not appropriate or has not taken effect.	Corporate Specialty Risk Register	Safeguarding	12/10/2018	Active	6	6	09/09/2023 8:59 AM	9	04/06/2024	↑	3
229	3467 The risk to patient safety due to the demand for ultrasound being higher than the current capacity.	Diagnostics and Specialties Specialty Risk Register	Radiology	15/02/2021	Active	6	6	14/09/2023 9:24 AM	9	18/06/2024	↑	3
551	4081 The risk of increased patient harm owing to inability to given timely advice via telephone advice line and undertake follow up appointments within timescale	Medical Divisional Risk Register	Rheumatology	19/07/2023	Active	9	9	20/09/2023 1:57 PM	12	18/06/2024	↑	3
668	1748 The risk of statutory intervention for non- delivery of national access standards in relation to cancer.	Corporate Specialty Risk Register	Chief Operating Officer Department	21/09/2012	Active	6	6	15/11/2023 12:05 PM	9	23/06/2024	↑	3
783	The safety risk of loss of clinical information due to the inaccessibility of the PASS system for Familial Hypercholesterolemia patients	Medical New Risk	Diabetology	22/03/2024	Active	6	6	22/03/2024 9:15 AM	9	26/06/2024	↑	3
837	The risk of reduced accuracy when assessing Blood pressure in pregnancy	Women's and Children's New Risk	Maternity	05/06/2024	Active	6	6	05/06/2024 11:29 AM	9	17/06/2024	↑	3
78	3475 The risk of harm to patients, staff and the public if the Trust is unable to respond appropriately to a chemical, biological, radiological and nuclear materials and agents and explosions (CBRNe) incident.	Corporate Divisional Risk Register	Chief Operating Officer Department	25/02/2021	Active	8	8	11/09/2023 10:31 AM	9	19/06/2024	↑	1

Risk ID	Risk	Risk Register	Service level 3	Date opened	Status	Initial rating	Previous Rating	Previous Rating Date	Current rating	Current rating date	Movement	Movement (number)	Reached Target
799	The risk of not being able to access NHSE allocated Bowel Cancer Residual Monies will directly impact the success of the Endoscopy Service Recovery and Improvement Programme Plan and sustainability of the service	Medical New Risk	Endoscopy	11/04/2024	Active	16	16	11/04/2024 12:20 PM	8	11/06/2024	↓	-8	No
448	4032 The risk of increased patient harm and reduction in quality of service as no staffing available to provide regular clinical review of medication for Multiple Sclerosis patients	Medical Divisional Risk Register	Neurology	19/04/2023	Closed	9	9	19/09/2023 9:39 AM	2	20/06/2024	↓	-7	Yes
186	2826 The risk of staff being unable to access a workstation and complete work and delay in contact/ reviewing patients resulting in late delivery of key objectives and low staff morale and decreased recruitment/retention rates.	Diagnostics and Specialties Divisional Risk Register	Dietetics	21/11/2018	Active	15	15	13/09/2023 1:19 PM	9	19/06/2024	↓	-6	No
265	2353, The risk to patient safety for inpatients with Diabetes whom will not receive the diabetes specialist nursing input with skills to support and optimise diabetic management and overall sub-optimal care provision	Medical Divisional Risk Register	Diabetology	07/07/2016	Active	12	12	14/09/2023 2:23 PM	6	18/06/2024	↓	-6	Yes
424	3650 The risk of harm and poor quality experience for patients nursed on Gutting ward due to a mixed bed base and three unfunded escalation beds	Medical Divisional Risk Register	Care of the Elderly	28/10/2021	Closed	9	9	18/09/2023 2:08 PM	4	20/06/2024	↓	-5	Yes
64	3286 The risk of Emergency Preparedness Resilience and Response (EPRR) shortfalls during a incident due to the Trust Incident Coordination Centre (ICC) not meeting the national recommendations and the requirements of Civil Contingencies Act (CCA) 200	Corporate Divisional Risk Register	Emergency Planning, Resilience, Response & Recovery	13/07/2020	Active	8	8	10/09/2023 11:25 AM	4	19/06/2024	↓	-4	No
142	3706, Risk of inability to provide out of hours stroke service due to financial pressures	Medical Divisional Risk Register	Stroke	14/12/2021	Active	12	12	12/09/2023 11:11 AM	9	12/06/2024	↓	-3	No
672	4115 the risk to quality of care for head and neck patients receiving timely diagnosis, treatment and management of the cancer pathway	Surgical Divisional Risk Register	Ear Nose and Throat	21/11/2023	Active	12	12	21/11/2023 11:18 AM	9	03/06/2024	↓	-3	No
682	4108 The risk of insufficient capacity to assess patients for systemic anticancer treatment (SACT)	Diagnostics and Specialties Divisional Risk Register	Oncology	24/10/2023	Active	9	12	10/05/2024 1:55 PM	9	19/06/2024	↓	-3	No
841	The Risk a patient does not get a procedure due to the lack of IR Consultant Radiologists	Diagnostics and Specialties New Risk	Radiology	11/06/2024	Active	15	15	11/06/2024 11:38 AM	12	11/06/2024	↓	-3	No
786	The risk of no PAC's support out of hours	Diagnostics and Specialties New Risk	Radiology	26/03/2024	Active	9	12	11/06/2024 12:33 PM	9	11/06/2024	↓	-3	No

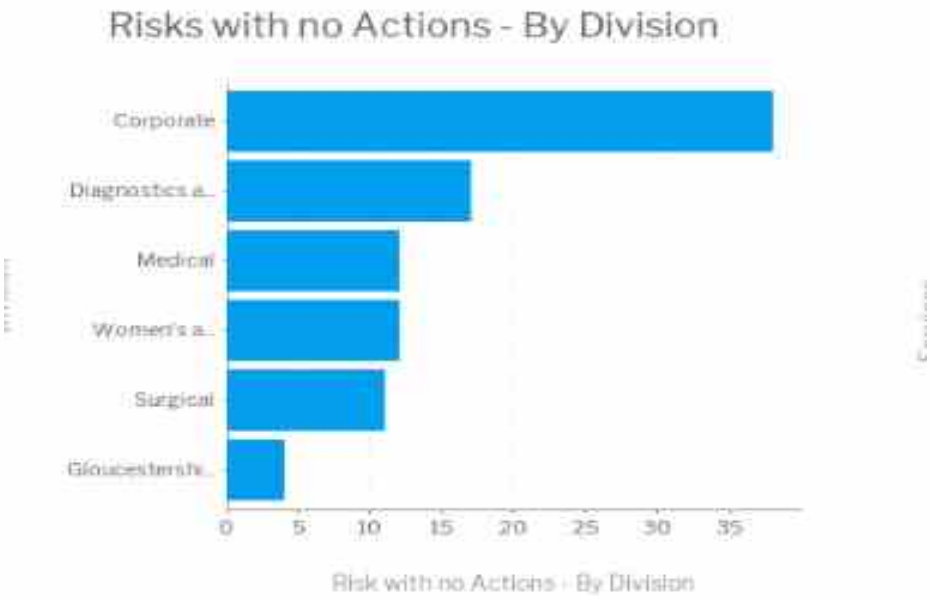
Dashboard – Risks with no Controls

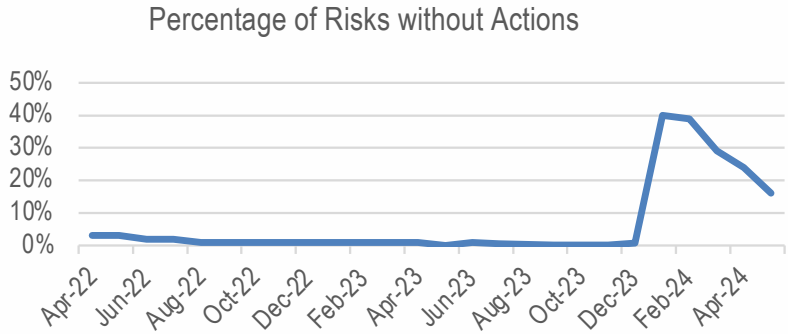
	No controls	Total no. of risks	% No controls
Corporate	0	151	0%
Medical	0	92	0%
Surgical	0	100	0%
D&S	0	147	0%
W&C	0	42	0%
GMS	0	34	0%
Trust	0	566	0%



Dashboard – Risk with no actions

132 risks with no actions (excluding new risks)

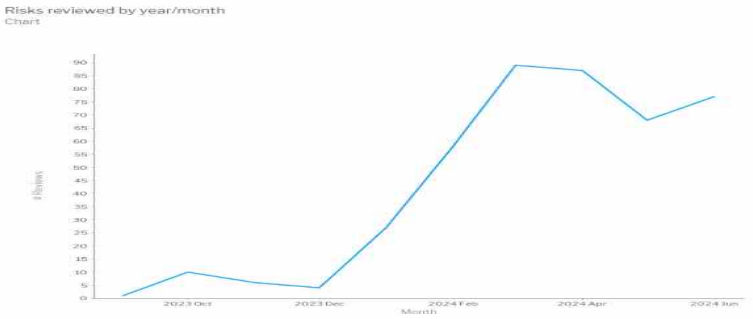




	No actions	Total no. of risks	% with no actions	Change since last month
Corporate	38	151	25%	⬌
Medical	12	92	13%	↓
Surgical	11	100	11%	⬌
D&S	17	147	12%	↓
W&C	12	42	28%	↑
GMS	4	34	12%	↓
Trust	94	566	16%	↓

Dashboard – Risk Reviews

- Risk reviews – No. of risks reviewed per month



Month	# Risks reviewed	# Reviews
2023 Sep	1	1
2023 Oct	10	10
2023 Nov	6	6
2023 Dec	4	4
2024 Jan	27	27
2024 Feb	58	58
2024 Mar	83	89
2024 Apr	82	87
2024 May	68	68
2024 Jun	71	77
	410	427

Risk owners with number of risks overdue . Full list in Appendix 1

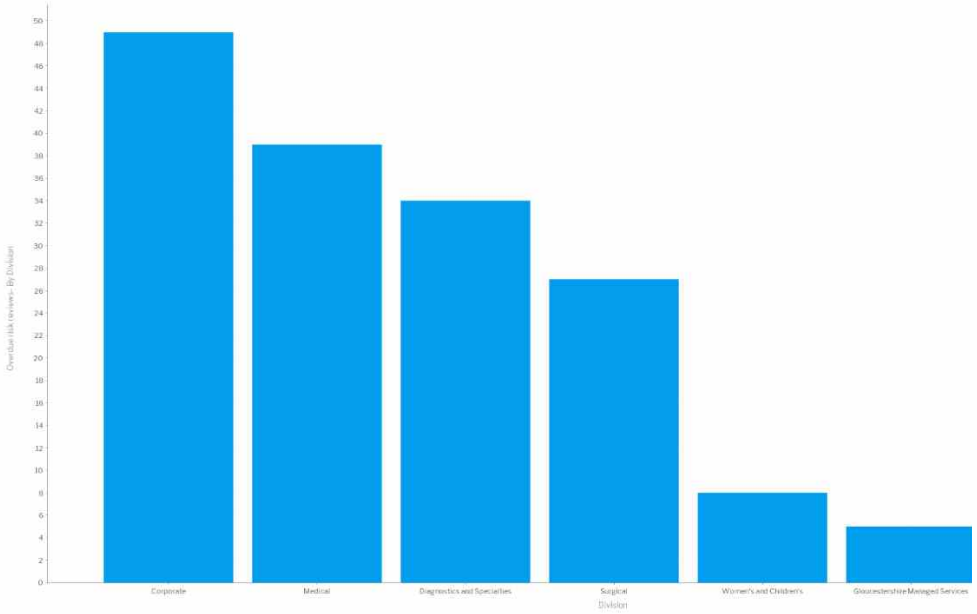
Risk owner	# Overdue risks
BT	11
SB	7
SJ	7
AE	5
CF	6
LR	5
BF	4
AH	4
DP	4
DC	4
EW	4

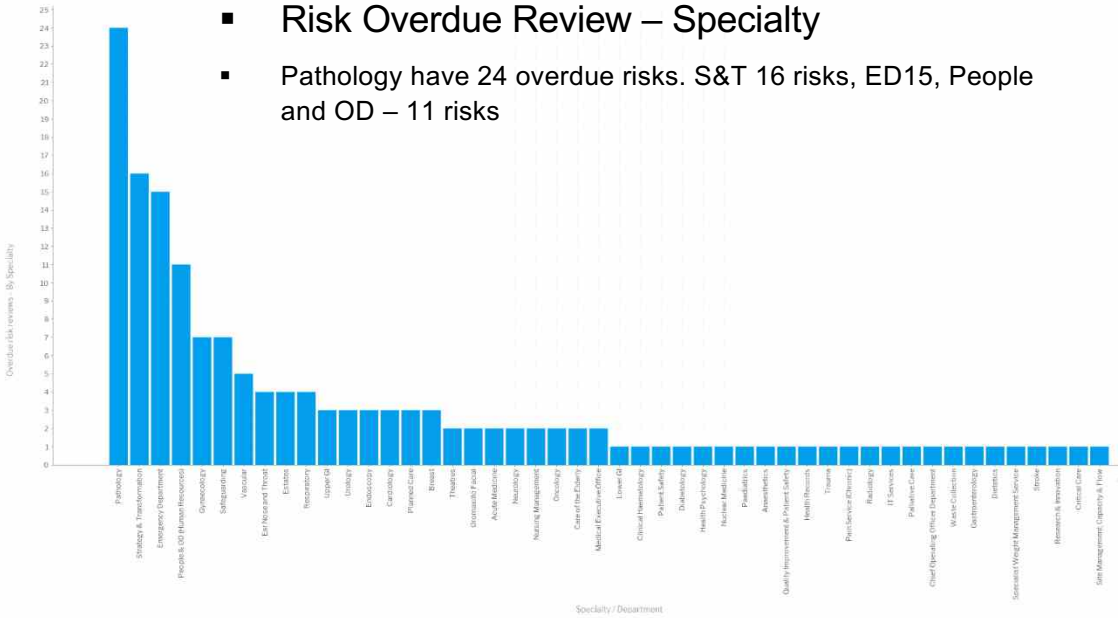
- Risk Overdue Review – No. of risks overdue

	Not reviewed	Total no. of risks	% not reviewed	Change since last month
Corporate	49	127	39%	↑
Medical	39	91	42%	↑
Surgical	27	96	28%	↑
D&S	34	150	22%	↑
W&C	8	41	20%	↑
GMS	5	36	14%	↓
Trust	162	541	29%	↑

Dashboard – Risk Reviews

- Risk Overdue Review – Division





- Risk Overdue Review – Specialty
- Pathology have 24 overdue risks. S&T 16 risks, ED15, People and OD – 11 risks

Dashboard – No or minor harm incidents

- Initial review

The incidents not review on web are all patient incidents

	Not reviewed in 7 days	Total no. reported in 7 days period	%Total not reviewed in 7 days	Change since last month
Corporate	6	2	300%	↑
Medical	8	48	16%	↑
Surgical	42	31	135%	↑
D&S	22	8	275%	↑
W&C	0	19	0%	↔
GMS	8	7	114%	↑
Trust	86	115	75%	↓

- Investigation – high or extreme risk incidents

Agreed for investigation due to an identified high / extreme risk which remain open beyond the prescribed investigation period, (excluding bereavement incidents and incidents that are deemed the responsibility of partner organisations).

	Not Investigated in 30 days	Total no. reported in 12 months	%	Change since last month
Corporate	28	`189	15%	↑
Medical	114	1842	6%	↓
Surgical	85	1629	5%	↓
D&S	71	568	12.5%	↑
W&C	33	438	7.5%	↓
GMS	34	321	10.5%	↑
Trust	365	4987	7%	↓

Dashboard – Moderate harm incidents

- Initial Review of Moderate harms

	Not reviewed in 7 days	Total no. reported in 7 days	%	Change since last month
Corporate	0	2	0%	⇔
Medical	0	8	0%	⇔
Surgical	8	8	100%	⇔
D&S	0	2	0%	⇔
W&C	2	9	8%	↑
GMS	1	1	100%	⇔
Trust	11	30	37%	↓

- Investigation of Priority Category Incidents

Priority categories for moderate+ harms that are not declared a DOC or SI are: Care, monitoring and review incidents, Diagnosis and assessment incidents, Falls, Hospital acquired pressure ulcers, Maternity foetal incidents / Maternity maternal incidents & Medication incidents

	Not Investigated in 60 days	Total no. reported in last 12 months	%	Change since last month
Corporate	0	2	0%	⇔
Medical	3	10	30%	↑
Surgical	5	25	20%	↑
D&S	3	9	33%	↑
W&C	9	91	10%	↑
GMS	0	3	0%	⇔
Trust	20	140	14%	↑

Dashboard – Duty of Candor

- Duty of Candor

Any DOC that was declared more than 60 working-days ago will have exceeded the investigation deadline. The data below shows DOCs that have exceeded the deadline in comparison to the number declared in a rolling 12-month period. See Appendix 1 for details

	Not Investigated in 60 days	Total no. reported in last 12 months	%	Change since last month
Corporate	0	0	0%	⇔
Medical	3	60	5%	↓
Surgical	3	15	20%	↑
D&S	0	5	0%	⇔
W&C	0	5	0%	⇔
GMS	1	1	100%	⇔
Trust	7	86	8%	⇔

Dashboard – Serious Incidents

- Serious Incidents

Timeframe: 60-working day (12 weeks) investigation following declaration, unless an extension is granted. The data below shows SIs investigations that have exceeded that date in comparison to the number declared in a rolling 12 months period. This excludes completed investigations, that are open pending the completion of the action plan. See Appendix 1

	Not investigated by deadline	Total no. reported in the last 12 months	%	Change since last month
Corporate	0	0	0%	⇔
Medical	0	13	0%	↓
Surgical	0	4	0%	⇔
D&S	0	1	0%	⇔
W&C	1	17	5%	⇔
GMS	0	0	0%	⇔
Trust	1	35	3%	↓

Dashboard – Health and Safety Incidents

- Contributory Factors

Contributory factors play a key role in identifying the cause and ultimately the learning from an adverse event. These help to identify the underlying issues that have led to the harm event. See Appendix 1

	No contributory factors	Total no. closed in last month	%	Change since last month
Corporate	0	7	0%	⇔
Medical	0	72	0%	⇔
Surgical	0	13	0%	⇔
D&S	0	13	0%	⇔
W&C	0	0	0%	⇔
GMS	3	12	25%	↓
Trust	2	117	2%	↓

Dashboard – Actions (on Web)

- Overdue actions on risk – all closed

	No. overdue	Total open	% overdue	Change since last month
Corporate	0			
Medical	0			
Surgical	0			
D&S	0			
W&C	0			
GMS	0			
Trust	0			

- Overdue actions on incidents

	No. overdue	Total open	% overdue	Change since last month
Corporate	24	31	77%	↓
Medical	39	51	76%	↑
Surgical	13	26	50%	↓
D&S	13	20	65%	↓
W&C	12	55	22%	↓
GMS	4	4	100%	↔
Trust	105	187	56%	↓

Dashboard – Actions (on Cloud)

- Overdue actions on risk

	No. overdue	Total open	% overdue	Change since last month
Corporate	126	223	56%	↑
Medical	79	117	68%	↑
Surgical	110	146	73%	↑
D&S	54	139	39%	↑
W&C	18	45	40%	↑
GMS	45	65	69%	↑
Trust	432	735	58%	↑

- Overdue actions on Incidents

	No. overdue	Total open	% overdue	Change since last month
Corporate	3	3	100%	↔
Medical	12	20	60%	↓
Surgical	6	12	50%	↔
D&S	3	4	75%	↑
W&C	6	20	30%	↔
GMS	1	1	100%	↑
Trust	31	60	52%	↓

Proposed Quality check KPI

- Quality Assurance Criteria - **Risk # 160**

Risk description: Defines the risk, not an issue. Description correlates with the main type (domain) of the risk

- Description describes risk moderate harm due to lack of controls to prevent pressure ulcers. However, incidents indicated this already occurs. Query whether risk is now increased incidence of harm?

Cause: Defines the issues that may lead to the risk materialising

- Correctly refers to medical factors such as loss of mobility / sensation / circulatory factors etc. as well as lack of controls within care e.g., risk assessment, use of aids, failure to reposition etc.

Effect: Defines what will happen if the risk materialises e.g., the consequences for patients, public, staff & organisation. Considers factors like harm, operational impact, statutory breaches, financial implications

- Identifies severe harm and avoidable harm, increased length of stay / morbidity / infection / pain / deconditioning. Also reflections regulatory intervention and claims. Could include impact of flow where stay is lengthened

Proposed Quality check KPI

- Quality Assurance Criteria - **Risk # 160**

Risk Rating: Score correlate with factors identified in the effect score, professional judgement and / or evidence of incidents. Is supported by evidence / professional judgement on probability of risk. Takes account of current controls and gaps that impact how well the risk is controlled at present. Supporting evidence attached the risk where available

- Rating is 12. No data linked to risk in Cloud to support the score.

Controls: Factors already in place (not planned) to prevent the risk materialising or reduce the severity of the consequence if is does materialise

- Identifies some good controls e.g., nutritional assistants, pressure relieving equipment, harm hub, mattress audit, TV nurses, steering group and plan

Gaps: Factors which increase the chance of the risk materialising or increase the severity of the consequence if is does materialise (not actions)

- Gaps not that pressure ulcer equipment is not available in timely manner – insufficient quantities and staff spend time locating it. Insufficient funding for trust-wide replacement of mattresses / cushions and insufficient nutrient nurses
- No reference to the other aspects identified in the cause such as lack of risks assessment, failure to reposition patient

Proposed Quality check KPI

- Quality Assurance Criteria - **Risk # 160**

Actions: Action plan in place to address identified gaps in controls

- No actions listed on the risk. No action plan attached to the risk. Bed replacement programme may be a solution to the availability of a mattress but not referenced on risk
- Risk has been open since 2014 and has been on TRR for much of that time – have previous actions failed to help to reduce it?

Reviewed every 3 months

- Last reviewed on 18 March 2024 and review date set to 30 June 2024 – should be reviewed every 3 months minimum e.g., by 18 June 2024

APPENDIX 4 – TRUST BOARD IN PUBLIC

TRUST RISK REGISTER – HIGHEST SCORING RISKS & OLDEST RISKS

JULY 2024

1. Highest scoring risks

The following 5 risks score 20 on the Trust Risk Register (TRR):

Risk ID	Risk	Risk Register	Type	Subtype	Current rating
79	1437 The risk of being unable to recruit 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 Risk Register	Workforce	Recruitment and retention	20
409	3845 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.	Trust Risk Register	Quality	Clinical assessment	20
426	2268 The risk of patient within the Minors Area of the Emergency Department due to capacity and Overcrowding.	Trust Risk Register	Statutory	Integrated care board risk	20
499	3536 The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Trust Risk Register	Workforce	Recruitment and retention	20
525	3034 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	Trust Risk Register	Workforce	Recruitment and retention	20

#79 Recruitment (20)

This risk was opened in 2012 with a score of 12 and was originally designed to cover both recruitment and retention. It briefly reduced to a score of 6 in December 2017 following a number of recruitment programmes that year, before the score was raised to 8 in July 2018 by the Recruitment and Retention Steering Group. Funding for 100 overseas nurses was secured in 2021, with the first cohort arriving in the Spring of that year. Despite successfully attracting overseas staff, the turnover rate for staff remained high and continued funding was sort in 2021 to maintain Healthcare Assistants.

As the vacancy rate increased into 10.97% in June 2022, the risk was raised to its current score of 20. Key initiatives included the recruitment of a further 170 overseas nurses in 2023, a Nursing Associate and Trainee Nursing Associate programme was implemented and a collaborative recruitment campaign was run One Gloucestershire ICS. In addition, recruitment drives and incentives were developed for specialty areas such as Radiographers, General Medicine (grade 7) and Anaesthetists. By March 2023 the vacancy rate had reduced to 7.58%.

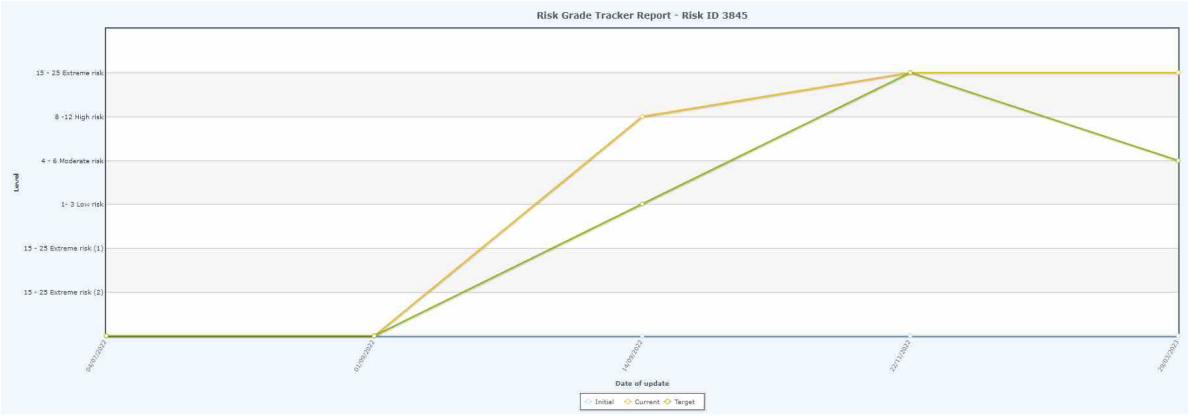
In late 2023, the risk was split into two risks – one for recruitment and one for retention. This is to reflect the different controls required to attract new staff and to retain existing staff. The

People and OD workstream have retained the score of 20 on what is now a recruitment only risk. However, following a review of the revised scope of the risk by the Corporate Divisional Board, the score is yet to be agreed as a 20. It was noted that nursing recruitment issues in COTE, Theatres, Upper GI, Oncology and Gastro which are identified as the key areas, would not attract a score C4 x L5 = 20. There is also a need for alignment as this risk reflect the recruitment position for nursing and midwives, which are covered in more specific risks (risk #499 and #525)

Risk grade tracker Risk #79 (previously 1437): Current score (orange), Target score (green)

#409 First trimester scans (20)

This risk was opened in July 2022 with a score of 12 and was increased to 16 in November 2022 following NHSE identifying a number of missed scans and a recommendation that this was treated as a Serious Incident due to the failure to meet the contract for screening. An action plan was required to addressed the delayed and missed scans. In June 2024 the score was increased to 20 due to a lack of scanning capacity, late bookings and language barriers increasing the risk. There is now a full action plan in progress which is anticipated to take 18 months to complete. The Trust is working with the NSHE Improvement team on this plan alongside the Screening service as it covers several divisions.



Risk grade tracker Risk #409 (previously 3845): Current score (orange), Target score (green)

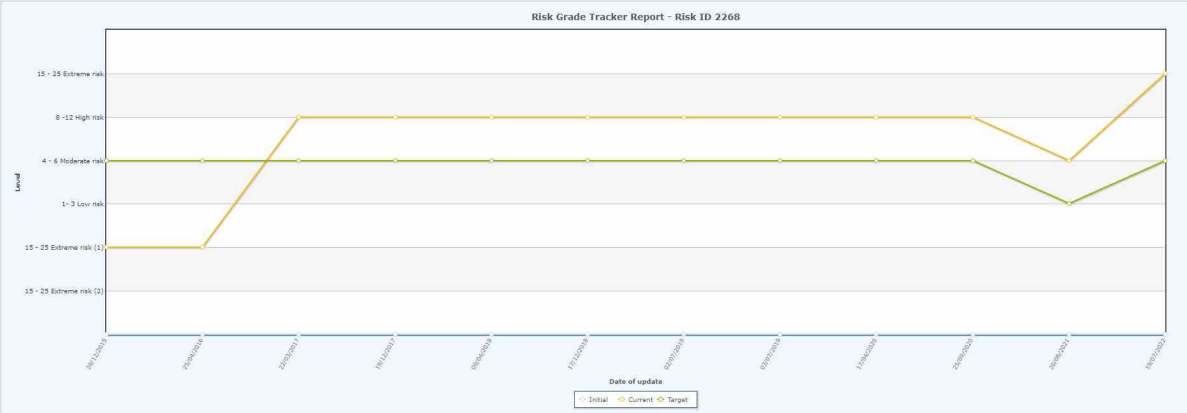
#426 Minors ED overcrowding (20)

Opened with a score of 15 in December 2015, which was reduced to 12 in December 2017 following the relocation of ACUA to Cardiology to improve flow and reduce overcrowding. As this had an impact, the risk was reduced to 8 in April 2018. Operational pressures and increased corridor care over the winter led to an increased score to 12 in December 2018.

In April 2020 as the COVID-19 pandemic took hold and lockdowns began, the admission numbers via the Emergency Department (ED) reduced which in turn reduced corridor care. The risk was aligned with a reduction in score to 9. As lockdowns were lifted and admissions increased, the score was revised back up to 12 in September 2020.

By June 2021 corridor care in ED had been stopped which reduced overcrowding. As result the score was lowered to 6 and consideration was given to closing the risk. However, by July 2022, all Trusts had been directed by NHS England to reduce ambulance wait times for clinical handover and offloading patients. This was particularly over the summer months with patients waiting outside in ambulances in hot weather and the ambulance service missing target response times for priority calls. This required a move back to corridor care and increased overcrowding. The score was escalated to 16.

Since that time the new ED footprint has been opened providing additional space for patients. Whilst this has had an impact on majors, there is still significant overcrowding has in minor injuries which has been linked to high demand and low staffing resources. This resulted in the score increasing to 20 in March 2024.



Risk grade tracker Risk #426 (previously 2268: Current score (orange), Target score (green)

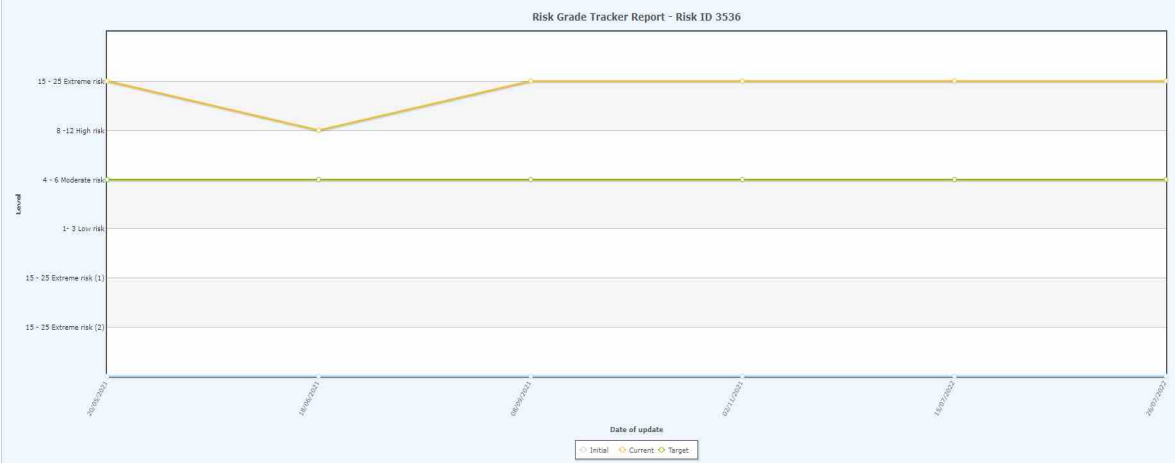
#499 Insufficient Midwives (20)

This risk was opened in May 2021 with a score of 20, which was reduced to 16 and then 15 within a month following the approval of bank shift financial incentives for Bands 5, 6 and 7 for the next 3 months. The score was reduced to 12 in June 2021 to reflect the maternity staff action / escalation plan which had been implemented and that monthly birth rate / acuity reports were being closely monitored. However, it was increased to 16 in September 2021, as the 3-month financial incentives came to an end, the home birth service had been closed

to support the main Central Delivery Suite, midwife-led units had been closed and some births moved elsewhere. Although 28 vacancies had been filled by this time, a further 9 were left and in November 2021 the score was increased to 15 as the escalation plan continued.

Staffing issues continued in 2022, including a higher attrition rate for new starters, and with no further financial incentives approved. In July 2022 the score was increased to 20 to reflect this and has remained at this score since. Significant recruitment and retention (R&R) continued through 2023. The R&R plan anticipated joiners September 2023 to January 2024 of 28 WTE. However, the vacancy rate over the summer 2023 was at its highest at 14.9%. This is now reducing month by month.

A bi-annual paper is sent to Board and monthly paper to Maternity Delivery Group outlining the workforce status. A perinatal workforce strategy has been launched.



Risk grade tracker Risk #499 (previously 3536: Current score (orange), Target score (green)

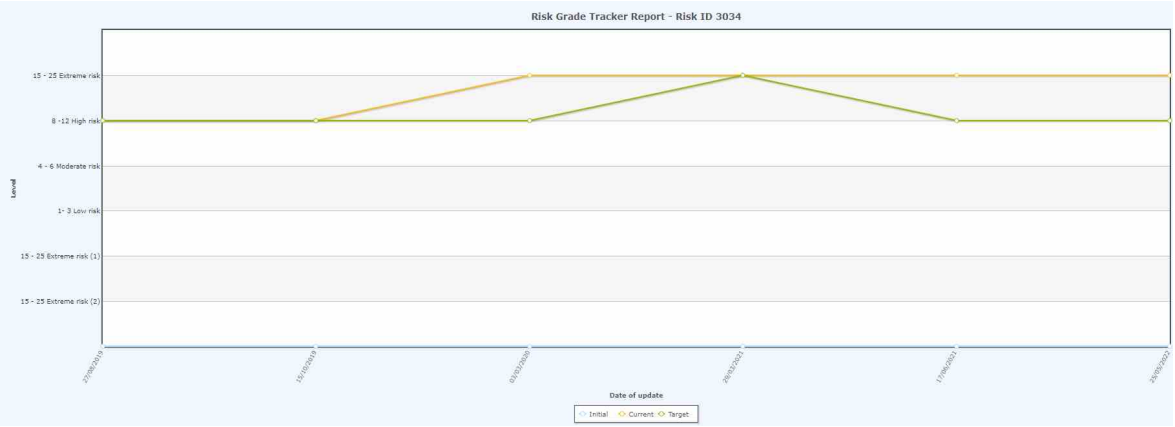
#525 Nursing Vacancies (20)

Opened in 2019 with a score of 12. In March 2020 it was rated 15, following a discussion at Quality Performance Committee. In April 2020 a discussion agreed that this risk and risk #79 (1437) overlapped and should be merged. This did not take place, and there is not audit trail in the notes to indicate why this did not go ahead. In May 2020 the score was increased to 20, although there are no notes to support the reason for the increase. This may be a reflection of two similar risks remaining on the register and only one being updated more thoroughly. An action plan in June 2020 highlighted the need for a dedicated resource for marketing and promotion of nursing jobs.

By June 2021 vacancy rates were noted as high and the 60:40 ratio of register nurses (RNs) to HCAs recommended in the Workforce Standards had not been achieved. Figures indicated an under establishment of RNs. A Safer Staffing review was implemented. Winter pressures, with increased demand and acuity of patients led to a plan for winter incentives in 2021.

By March 2022, there were 340 RN vacancies and in May 2022, the risk score was increased to 20 to reflect this. A further safer staffing paper was presented to the Quality

Performance Committee in May 2023 due to the continued shortfall in nursing across the Trust.



Risk grade tracker Risk #525 (previously 3034): Current score (orange), Target score (green)

2. Oldest risks

The following risks are the oldest risks on the Trust Risk Register:

#79 Recruitment (2012)

See update in section 1 above.

#143 Children's Inpatient – Lack of Mental Health Support in Acute Care Setting (2014)

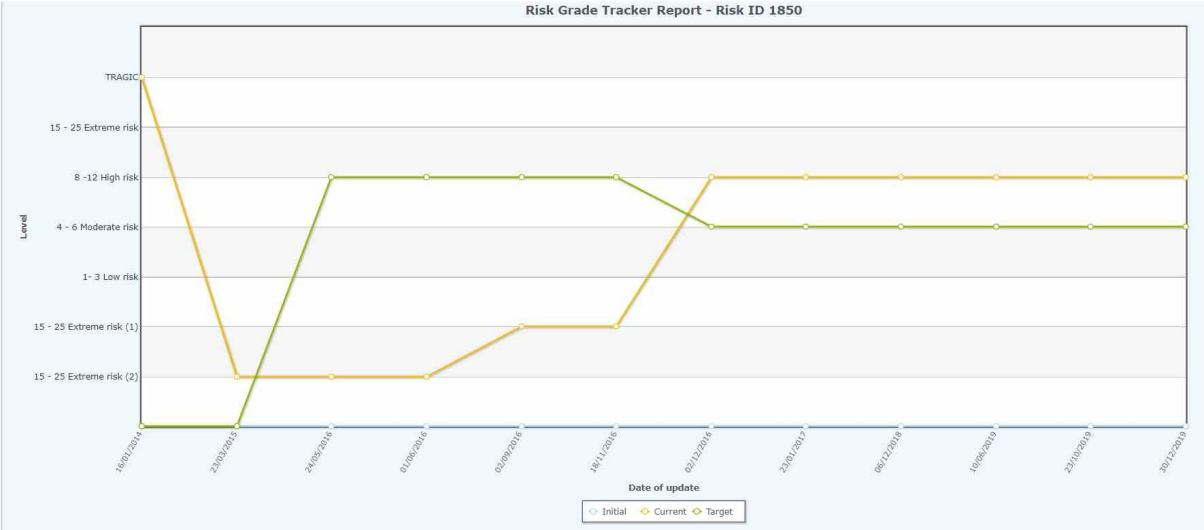
This risk was opened in 2014, with a score of 20 it remained at this until it was reduced in quick succession to 15, then 12, then 9 in September 2016, December 2016 and January 2017 respectively. There ae no notes on the risk to support this reduction.

In April 2019, it was recognised that patients with no medical needs were experiencing prolonged admissions in Children's Inpatients (CIP) due to a lack of suitable places to discharge them. An increased number of children presenting at ED with deliberate self-harm and overdose, coupled with a reduction in mental health support for Children and Young People, increased the risk and in October 2019 the score was increased to 12 and remained at this score for the next 4 ½ years. Frequent incidents of violence towards staff involving children with complex mental health needs were noted over this period.

Whilst the Children's inpatients ward has a number of 'safer' rooms, these do not meet the needs of complex children. Acute staff skill sets do not support complex mental health needs either. Additional costs related to the need for Registered Mental Health Nurses (RMNs) to provide 1:1 care have been incurred.

The pandemic exacerbated this situation as more children presented with mental health needs that could not be met by an Acute Trust. In July 2020, five patients exhibiting violence and aggression and /or with complex feeding needs that required restraint, were cared for simultaneously in CIP, causing significant distress to staff and patients as the Trust does not have the staff, competencies or facilities to offer the high level / intense care needed for this number of complex patients.

An ICB approach has been developed but a national lack of Tier 4 beds prevents the safe discharge of these patients to suitable accommodation. The Trust took a robust approach to ensure children who did not medical care were not incorrectly admitted to CIP. The risk was very recently re-scored to a 9 and is pending de-escalation. However, the evidence to support the reduced score has not yet been presented.



Risk grade tracker Risk #143 (previously 1850): Current score (orange), Target score (green)

#160 Pressure Ulcers (2014)

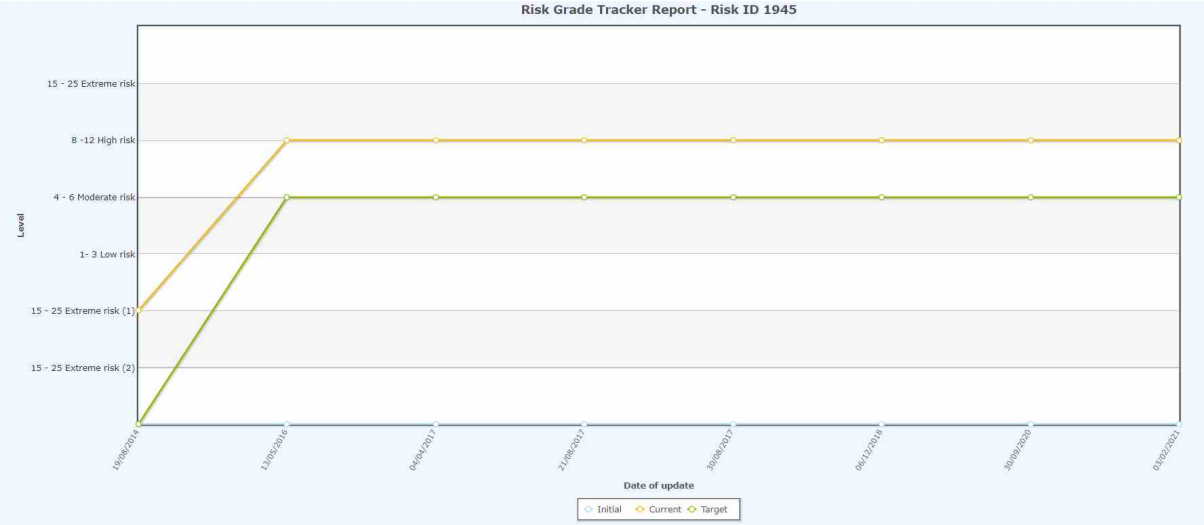
This risk was opened in 2014, with a score of 16, it was reduced to 8 in May 2016 although the notes indicate that grade 3 and 4 pressure ulcers were still being investigated.

The risk was mitigated through education and the provision of pressure relieving equipment and a standardised investigation process was applied to incidents. However, the number of incidents in 2017 led to an increase in to 12 in August of that year and an action plan was developed. In 2018 additional pressure relieving equipment was introduced and the Preventing Harm Hub began weekly reviews on incidents. By September 2020 the frequency of grade 3 harm incidents had reduced and the score was lowered to 9.

In February 2021 the score was increased to 12 again following the impact of the pandemic on patient demand and the lower staff to patient ratio (which led to less repositing of patients). It has remained at that score since.

The risk was reviewed by RMG on 3 July 2024 due to the length of time is has been on the Trust Risk Register and has remained at a static score. This is part of a quality assurance process. It was agreed the risk score required a more in-depth review as the static score

would indicated that none of the actions on the comprehensive pressure ulcer actions plan have had an impact on the risk level in the last 3 years (which is unlikely to be the case). However, it was noted that pressure ulcers had increased recently.



Risk grade tracker Risk #160 (previously 1945): Current score (orange), Target score (green)

#426 Overcrowding in minors ED (2015)

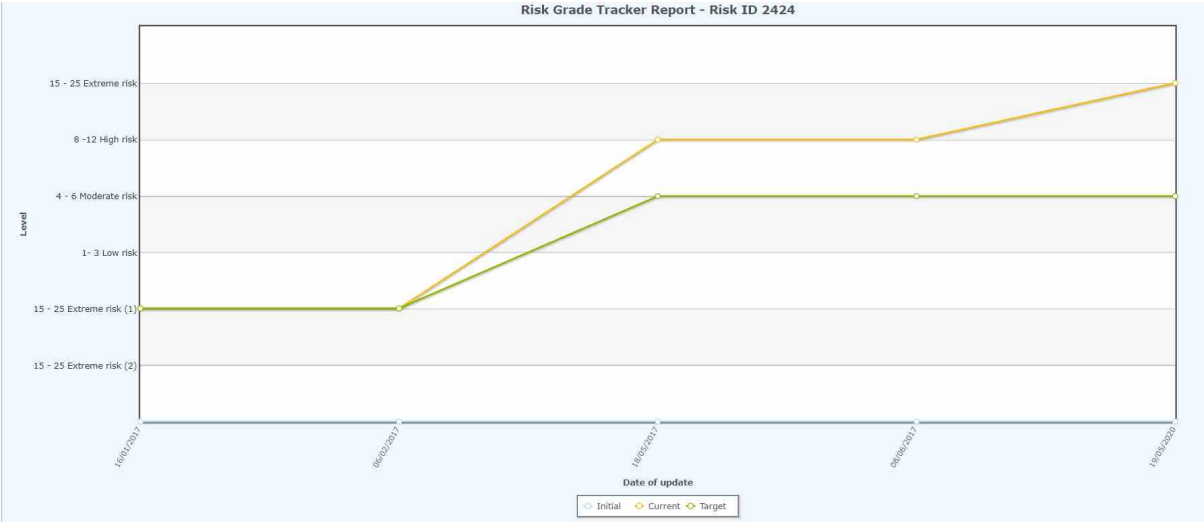
See update in section 1 above.

#425 Ageing and Ineffective Ventilation in Theatres (2017)

Opened in January 2017 with an initial score of 16, this risk it was reduced in May 2017 to 12 by the divisional board. There are few progress notes on the risk until April 2019 when it was recorded that ventilation units were being checked every 4 weeks by an external company and there was a potential opportunity to do some work in the summer when the decant theatre became available for a short period.

A year later, the next note indicates that the time required to shut down a theatre to progress works is extensive and funding need to be agreed as this was not part of the capital plan. The score was increased to 16 in May 2020 and has remained at this level.

Ventilation audits completed by GMS in 2023 show up to 17 ventilation units noted as performing poorly. Five were to be given priority - SSD in GRH, DCC GRH and CGH, Rendcomb side rooms. £400K was available at that time but this only covered one unit. Theatres confirmed that over performing (too many air changes) occurs which causes issues for patient (e.g., being too cool) and causes doors to open and close due to the pressure (infection control risk). Two new air handling units were delivered for Theatres 3 and 4.



Risk grade tracker Risk #425 (previously 2424): Current score (orange), Target score (green)

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – MEETINGS 20 and 26 JUNE 2024

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 both meetings are available. Business transacted in both meetings related to the year end processes and endorsing a range of official statutory reports for approval by the full Board of Directors at it's special meeting on 26th June. This suite of reports has represented a very significant effort by a number of teams and colleagues from across the Trust and I would wish to record my thanks to all for their contribution.

Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
	There were NO items rated as RED	

Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Going Concern statement	In light of the overall External Audit opinion, content of the Annual Report and the Head of Internal Audit opinion previously report, I have opted to score all component parts of the various submissions as amber, although this particular element could have been considered as green.	The Committee considered the three available scenarios and concluded that the Trust is clearly a going concern and that it is appropriate for the accounts to be prepared on this basis.
Annual Governance Statement	The AGS reflected an accurate portrait of our work as a Trust in assuring the effectiveness of controls and management of risk and reflects significant control issues uncovered during the year and the remedial actions being taken to address these	The Committee noted and endorsed the limited assurance opinion expressed and considered it a fair assessment
Annual Report	Two iterations of the Annual Report were considered by the Committee. The first iteration was presented on 19th June prior to feedback from the External Auditors. This version provided a very fair assessment and a candid reflection of the challenging year that the Trust has faced on a number of fronts, reflected in the various improvement plans. The second iteration was presented on 26th June and had been strengthened further to reflect Audit findings	The Committee noted and endorsed for approval by the Board the tenor and message of the revised Annual Report.
Code of Governance requirements	The Code of Governance requirements were presented to the Committee for scrutiny. All elements of the requirements appeared to have been considered and appropriately reflected in the various submissions.	The Committee noted and confirmed that the various requirements had been addressed.

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.

Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
External Audit report	The Audit opinion reflected significant weaknesses in the control environment and reflected the themes detailed within the Head of Internal audit annual opinion. The External auditor also highlighted some lessons learned for future iterations of Audit Planning.	The Committee noted the audit findings and endorsed the lessons learned approach including input from Deloitte colleagues, the CFO and Director of Integrated Governance.
Annual Accounts	The Committee received the annual accounts and scrutinised the output.	The Committee scrutinised, noted and endorsed the Annual Accounts and recommended them for adoption by the Board.
Items Rated Green		
Items not Rated		
N/A		
Impact on Board Assurance Framework (BAF)		
None noted.		

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

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – 4 JUNE 2024

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
	There were NO items rated as RED	

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit	**Head of Internal Audit annual opinion** – Limited assurance opinion from the Head of internal Audit for a variety of reasons including financial outcome, range of CQC findings and extent of limited assurance opinions issued during the year, some findings reported to late in the financial year to be able to evidence improvement. Rated as amber as although a difficult read, there has been sustained improvement in engagement and plans are in place to address the specific CQC findings	Continued sustained performance needed, progress in follow ups against various limited assurance items and progress against the various CQC findings
	Freedom to speak up – Design moderate, effectiveness limited. A very helpful review following the first year of operation. Findings in line with the FTSU recent report to Board and findings and actions are being addressed	Build on good progress to date.
	Divisional Governance (Medicine) Design moderate and effectiveness limited. Helpful recommendations currently being implemented	Implement agreed recommendations
	Consultant job planning – Overall limited assurance assessment for design and operational effectiveness. Report was commissioned by Management to obtain candid assessment of current position with a range of helpful recommendations, all of which were accepted by management. Noted as particularly important given the range of Consultant appointments currently being recruited and the importance of ensuring that this expensive and influential resource is aligned culturally with the Trust direction of travel and best supported to enable them to succeed	Evidence of implementation and improved performance as a result.
	GMS assurance mapping – This report was originally commissioned by the previous CEO in light of concerns. It has helpfully supported work commissioned by the incoming CEO and the full suite of recommendations, which are in line with the other work stream will be considered by the full Board in July.	Consider as part of overall Board discussion on GMS in July and follow up on implementation of agreed recommendations and way forward
	Payroll additions – Overall limited assurance for design and limited for effectiveness. As per the previous report, this was commissioned by	Needs to be a fundamental plank of revised governance

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.

	Management to obtain candid assessment of current position with a range of helpful recommendations, all of which were accepted by management. Extent of local arrangements surprising and indicative of some historic governance gaps.	arrangements and supporting CEO doing the basics brilliantly mantra. F&R will oversee enhancements and Audit will follow up per agreed time line.
	Follow up report – Generally looking far better and clearly a lot of work has gone in to get us to this point. Recognition of the impact of some long standing outstanding actions on the annual internal audit opinion.	Good sustained progress and delivery of the annual plan. However, this needs to be sustained for the full performance year to avoid a further limited assurance
External Audit	Interim pre year end audit is progressing well. Good cooperation and work between Trust team and external audit. Detailed year end plan submitted. Rated amber pending delivery of year end process. Head of Internal Audit opinion has potential to impact year end processes.	Good plan which now needs to be seen actioned and is being kept under review by the Committee.
Gloucestershire Managed Services (GMS)	A number of audit recommendations where further progress is needed. Annual plan discussed and endorsed.	
Board Assurance Framework (BAF) and Risk Register	Board Assurance Framework and Risk register position noted. Concern around Datix noted and extent of areas showing high and fairly long-term risk scores. Committee keep to see a Board Development session on long term areas of concern to assess and learn from these	

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
High quality papers - circulated well in advance of the meeting which made prep easier		
Follow up actions between meetings – Very good progress		
Good focus on non-traditional audit Committee areas, with focus on patient added value		
Matters arising. All outstanding matters were closed off.		
Counter Fraud report – Excellent, clear digestible report. Good progress reported against various ongoing cases. Evidence of added value particularly around input to raising fraud awareness across a range of staff groups. **Annual counter fraud opinion rated GREEN for the year**. This contrasts with the head of internal audit opinion but has been robustly tested and stands up to scrutiny.		
Single tender actions report - one retrospective tender, total value of £455K, all with accompanying justifications		
Losses and compensations – No ex – gratia payments made and approved write off of invoice totalling £4K.		
Use of Seal – four uses noted, all in order		

Items not Rated			
N/A			

Investments			
Case	**Comments**	**Approval**	**Actions**
N/A			

Impact on Board Assurance Framework (BAF)
None noted.

Report to Board of Directors meeting in Public			
Agenda item:	**10**	**Enclosure Number:**	
Date	July 2024		
Title	Report to the Care Quality Commission and Trust Board - Section 31 Summary Report		
Authors	Women's and Children's Division Director of Midwifery - Lisa Stephens Women's and Children's Division Speciality Director - Christine Edwards Women's and Children's Division Director of Operations – Becky Hughes Women's and Children's Division Chief of Service – Simon Pirie (Supported by Deputy Director of Quality - Suzie Cro)		
Presenter	Director of Quality and Chief Nurse – Matt Holdaway		

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

Summary of Report

The purpose of the report is to summarise the key steps taken to eliminate immediate risk with respect to each point in the CQC Section 31 letter dated 9 May 2024. Clinical Teams have been set up to lead the improvement work and they are undergoing quality improvement training as they improve the services. There is an improvement programme for Governance in Maternity being led by the Director of Integrated Governance, the Director for Safety and Medical Director and the Director of Quality and Chief Nurse.

In summary, the CQC have imposed the following conditions in Maternity and the service have taken the actions to improve compliance. The following table provides a high-level summary of the actions and next steps, and this is contemporary and includes information up until the end of June 2024.

Table: CQC issue with current update 28 June 2024

Issue	**Immediate actions to end of June 2024**
Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **continually risk assess and manage the risk of post-partum haemorrhage (PPH) and potential major obstetric haemorrhage (MOH**).	• Review of data to understand where the improvement needs to be focused • Launch of the use of Carbetocin to assist with the prevention of haemorrhage at Caesarean section (18 June 2024) • Training to support launch of a checklist to support management of PPH/MOH (1 July 2024) **Next steps** • Audit to be completed of risk assessment compliance and Reduce checklist compliance

Summary of Report

Issue	Immediate actions to end of June 2024
Ensure maternity staff at Gloucestershire Royal Hospital complete **hourly peer reviews (also known as 'fresh eyes')** during intrapartum care in line with national guidance.	• Policy rewritten and was launched Jan 2024. • Audit is underway and is awaiting finalisation of the data at a multidisciplinary meeting. • The results will enable the QI Team to write a focused QI aim statement. **Next steps** • Develop QI aim statement and actions once audit complete.
Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **interpret fetal monitoring traces accurately** and **escalate** in line with Trust guidance to ensure all women and birthing people and their babies are cared for in a safe and effective manner in line with national guidance.	• Case reviews are underway to audit interpretation and escalation. **Next steps** • Develop QI aim statement and actions once audit complete.
Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **complete and escalate maternity early obstetric warning score (MEOWS) charts** in line with national guidance during intrapartum and postnatal care.	• Weekly audits have continued with the Maternity Ward now having achieved 100% compliance for completion and escalation of observations since Feb 2024. **Next steps** • Focused work continues within the birthing areas to improve their rates.
Implement an effective system for ensuring staff **complete venous thromboembolism (VTE) risk assessments**.	• Risk assessments at booking and in the postnatal period are at 97% and 100% respectively. **Next steps** • The focus for the QI Team has been to improve risk assessment completion for women on admission as this rate is 35%. • Collect data for outcomes for deep vein thrombosis (DVT) and pulmonary embolism (PE).
Implement an effective system for ensuring **agency midwifery staff have a comprehensive induction to the unit, are able to access the maternity electronic records (BadgerNet) system and Trust policies as well as enter and exit the unit without delay**.	• A new induction pack has been launched and the Flow Midwife "meets and greets" every agency Midwife. • Agency staff now have access cards (1 July 2024). • Agency Midwives can access Maternity and Trust policies and the BadgerNet system. **Next steps** • Audit every Agency Midwife has had meet and greet and feels supported.

Summary of Report

Issue	Immediate actions to end of June 2024
Improvement of **Maternity Governance**	• 2 workshops have been held focusing on safety incident reporting and audit and clinical effectiveness. • Learning event for the Trust held led by the Chief Nurse and Quality Team to share the learning across the organisation. **Next steps** • 3rd workshop planned for 12 July focusing on Safety Reporting and Investigations (PSIRF).

As required by CQC, the enclosed Report and the Maternity Dashboard were sent to the CQC within 21 days of the enforcement notice (dated 9 May 2024). The next report was sent to CQC on 28 June 2024 and this latest report will be reviewed in detail by the Quality and Performance Committee in July 2024. The Trust are also providing assurance externally to the ICB Quality Improvement Group (QIG) and external stakeholders are present. A copy of the last presentation (abridged to cover the CQC S31 issues has been provided to Board members for information (appendix 1).

Recommendation

The Board is asked to note the contents of the report and receive assurance that a robust improvement programme of work is underway.

Enclosures

- Report to the Care Quality Commission and Trust Board - Section 31 Summary Report dated 28 May 2024
- Appendix 1 Abridged presentation provided to the ICB Quality Improvement Group (QIG) 28 June 2024

Gloucestershire Hospitals
NHS Foundation Trust

Report to the Care Quality Commission and Trust Board

Section 31 Summary Report

28 May 2024 version 3

Care Quality Commission (CQC) Section 31 Report

1. Purpose of the report

1.1. The purpose of this report is to summarise the steps taken to eliminate immediate risk with respect to each point in the Section 31 letter dated 9 May 2024. It also provides an outline of the detailed plans we have put in place to ensure sustained improvement and how we are working towards compliance in the areas highlighted in the enforcement notice. We are also planning to ensure continuous improvement in the culture of safety and learning through programmes of work across audit, safety incident identification and management, risk management, stakeholder engagement, integrated governance processes and speaking up, and as relevant to the S31 we have highlighted some of our organisational responses below.

1.2. The CQC has requested sight of reports written to provide assurance to the senior leadership and/or Board of Directors and as our first meeting of the Quality and Performance Committee (Q&PC) is this month, this report has also been written to provide assurance to the Trust Board through the scrutiny of the Q&PC regarding the Maternity Service's current compliance with the conditions and plans and progress towards full compliance.

1.3. In summary, the CQC have imposed the following conditions in Maternity and the service must:

- Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **continually risk assess and manage the risk of post-partum haemorrhage (PPH) and potential major obstetric haemorrhage (MOH**).
- Ensure maternity staff at Gloucestershire Royal Hospital complete **hourly peer reviews (also known as 'fresh eyes')** during intrapartum care in line with national guidance.
- Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **interpret fetal monitoring traces accurately** and **escalate** in line with Trust guidance to ensure all women and birthing people and their babies are cared for in a safe and effective manner in line with national guidance.
- Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **complete and escalate maternity early obstetric warning score (MEOWS) charts** in line with national guidance during intrapartum and postnatal care.
- Implement an effective system for ensuring staff **complete venous thromboembolism (VTE) risk assessments**.
- Implement an effective system for ensuring **agency midwifery staff have a comprehensive induction to the unit, are able to access the maternity electronic records system and Trust policies as well as enter and exit the unit without delay**.

1.4. This CQC Section 31 Report and the Maternity Dashboard will be sent to the CQC within 21 days of the enforcement notice (dated 9 May 2024) and then an update will be provided monthly thereafter.

1.5. This is an outline of the reporting schedule for the next 6 months:

- 29 May 2024
- 28 June 2024
- 31 July 2024
- 30 August 2024
- 27 September 2024
- 30 October 2024

Table: Summary of the issues

Overarching theme	Headline issue	Specific issues identified in S31
Clinical governance Risk Audits Learning culture and improvement Experience (staff and patients) Data – themes and trends from safety (maternal morbidity and mortality) Safety – immediate learning from incidents shared with staff in a timely way	Postpartum haemorrhage and Massive Obstetric Haemorrhage	– Risk assessment and management of PPH/MOH – Clinical incident management (W227314, W227347, W227802) – Audits, themes and trends – Data (ITU admissions and 3rd / 4th degree tears) – Learning and Improvement
	Fetal monitoring	- Peer reviews - Accurate interpretation of electronic fetal monitoring, - Escalation of concerns - Audits and themes and trends - Clinical incident management (MI-033153) – Learning and Improvement
	Temporary workforce (agency)	– Induction – Support – Access to the unit – Access to Trust Policies – Access to the electronic patient record (BadgerNet) – Access blood test results system – Monitoring agency performance – Monitoring safety through clinical incidents
	Maternal Venous Thromboembolism (VTE)	– Risk assessments – Acting on audit results, risk identification and assessment – Audit plans

		– Learning and improvement
	Maternal Obstetric Early Warning Scores	– Staff acting on triggers and repeating observations – Acting on audit results, risk identification and assessment – Learning and improvement

2. Executive Summary

2.1. Immediate actions

2.2. The Trust has responded to the issues outlined within the CQC Section 31 letter and has taken immediate steps to improve Maternity Services in order to ensure women, birthing people and their families receive care of an appropriate standard and are not at risk.

2.3. We have a new Director of Integrated Governance who, with the Chief Nurse and Director of Quality and the Medical Director and Director of Safety, will lead a review of the Maternity Service governance processes and systems to identify areas for further improvement and to identify developments to the governance architecture that scrutinise and monitor sustained quality improvement.

2.4. The Maternity Service will use quality improvement as our systematic approach to improving the maternity services and the quality of care and outcomes for women, babies and their families. Our approach, that we need to embed, is now based on iterative change, continuous testing and measurement, and **empowerment of frontline teams**.

2.5. We have immediately set up 5 key improvement work streams led by clinical teams and they are enacting the changes and improvements that will keep mothers, babies and birthing people safe.

- Work stream 1 – Postpartum Haemorrhage and Massive Obstetric Haemorrhage risk assessment and management
- Work stream 2 – Fetal monitoring peer reviews, accurate assessment and timely escalation of concerns
- Work stream 3 – Temporary workforce (agency midwives) experience
- Work stream 4 – Venous Thromboembolism risk assessments
- Work stream 5 - Maternal Obstetric Early Warning Scores (MOEWS) escalation

2.6. Each Team is already working with clinical staff in all the clinical areas. The clinical leads are widening their membership so that staff at all levels are involved.

2.7. We have briefed staff so that they understand what the issues are and they can take steps themselves to make improvements on an individual level.

2.8. We have developed a detailed communications plan to communicate with service users to ensure they feel safe and know how to raise concerns.

2.9. We are seeking the help of the Maternity and Neonatal Voices Partnership to make sure there is a current service user working with each of the improvement work streams so we stay close to the service user voice and collaborate in our improvement efforts.

2.10. We are working with the Freedom to Speak Up Guardian to implement a series of planned surgeries as part of plans to encourage a culture of speaking up and as a way of understanding if our improvement activity is delivering the intended outcomes.

We will also encourage staff to speak up about mistakes and ensure they feel safe to do so.

2.11. We are working with corporate teams to ensure improvement activity is aligned with Trust activities in areas such as Quality Improvement, Patient Safety Incident Response and associated learning. Business Intelligence and Performance, HR recruitment support, Audit and Clinical Effectiveness and Corporate Governance thereby increasing capacity to deliver and monitor sustained improvement.

2.12. Each Work stream has a quality improvement plan that sits within a plan on a page. To wrap around the work streams we have a programme of work that has been developed to improve the services' governance systems and processes.

2.13. Learning and improvement

2.14. The service has started to develop and embed a systematic approach to improvement.

2.15. The improvement capability will be enabled across the service.

2.16. All teams will be able to access in-house expertise for support to improve and they will be able to access analytical experts to support their specific improvement projects.

2.17. We will build appropriate strategy, governance, oversight, evaluation and accountability to ensure the improvement projects are taken forward effectively. This will incorporate learning from patient safety events and feedback.

2.18. Our plans to improve services will take into account the resources required to deliver them.

3. Background

3.1. Since 2022, the Maternity Service at Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Royal Hospital site has been inspected by the Care Quality Commission a total of 3 times.

3.2. There has been an additional inspection of the Stroud Maternity Unit and this site was rated as Requires Improvement in March 2024.

Table: Overview of inspection activity since April 2022

Dates	CQC reference	Regulatory activity at Gloucestershire Royal Site
April 2022	RGP1-13228561189 Section 29a	Following an inspection of maternity at Gloucestershire Royal Hospital (GRH) in the Trust was issued with a section 29a warning notice. **Issues** - lack of risk assessments to the health and safety of service users, - lack of sufficient staffing to support safe care, and - ineffective governance systems to learn from incidents.
April 2023	RGP1-17411267474 Section 29a	Following an inspection in maternity at GRH in the Trust was issued with a section 29a warning notice **Issues** - staff compliance with safeguarding training,

		- timeliness of incident investigation, - ensuring improvements are made to ensure the safety of the service.
26 March 2024	AP2076	The CQC carried out an onsite inspection of the maternity service. As part of the assessment process CQC requested data in relation to learning from incidents, governance, audit and safeguarding. CQC requested this data on 4 April 2024 and the Trust returned it by 17/18 April 2024.
1 May 2024	DMR-000000001390	CQC sent the Trust a letter detailing possible urgent enforcement action under Section 31 of the Health and Social Care Act. The Trust responded to the letter as per request.
9 May 2024	RGP1-19322356327	Under Section 31 of the Health and Social Care Act 2008 the Trust were served with a notice to impose conditions on our registration. This urgent action was taken as CQC believe "a person will or may be exposed to the risk of harm if they do not do so". Within 21 days of the notice and monthly thereafter the Trust must provide 1. An updated action plan with clear details of progress on all conditions 2. All reports to provide assurance to the senior leadership team and/or Trust Board to demonstrate compliance with the conditions 3. The Trust maternity dashboard

4. Well led - our leadership approach to the S31 (quality improvement (QI) clinical governance and programme management)

4.1. Situation

4.2. The CQC enforcement letter was received by the Chief Executive Officer on the day of Trust Board and so the Board were briefed in private session.

4.3. The Maternity Service has many significant challenges and so a decision was made by the Executive Lead for the Maternity Service (Chief Nurse and Director of Quality) with the Women's and Children's Senior Leadership Team (Chief of Service, Director of Midwifery and Director of Operations) and the Maternity Speciality Team (Head of Midwifery, Speciality Director and Deputy Director of Operations), to adopt a different approach for resolving the issues raised by the CQC Section 31 enforcement notice.

4.4. A decision was made that they would use quality improvement methods alongside a co-ordinated programme approach including our Corporate Specialist Teams for Quality (safety, risk, QI, experience and clinical effectiveness).

4.5. For clarity, our quality improvement approach with the Gloucestershire Safety and Quality Improvement Academy, is based on a systematic approach to improving services and the quality of care and outcomes for patients based on **iterative change**, **continuous testing and measurement**, and **empowerment** of frontline teams.

4.6. We recognised that quality improvement methods require a fundamental change to how the maternity service works, and we needed to ensure that staff are engaged with and actively involved in developing a shared vision of the new approach.

4.7. Quality improvement approaches require us to have a very different leadership style: we as leaders needed to commit to a shift from 'problem-solving' to being **enablers of change.**

4.8. To note when we are using the term "Change ideas" this is the terminology being used for the specified practical changes/actions the project teams have made/ are making that will alter the processes in the secondary drivers. Implementing the change ideas enables improvement to the processes to be realised through measurement of the data.

4.9. In order to successfully embed quality improvement approaches, we needed to develop a new approach to leadership that moved away from top-down solutions to recognising that frontline teams, service users and carers are often best placed to develop solutions.

4.10. We also recognised that we needed to bring about transformational change to the service and would link this work with the Maternity Transformation Programme.

4.11. The Medical Director and Director for Safety is working with all services through the Safety and Clinical Effectiveness Teams to implement 'The NHS Patient Safety Strategy' and have developed our local Patient Safety Incident Response Framework and so it was very important, as part of responding to Section 31, we connected this work too.

4.12. We recognise the need to implement stronger, independent oversight of sustained improvement and the role of the Quality and Performance Committee and that of the Board of Directors will be strengthened as will operational leadership oversight of the Executive team. Data will be triangulated with clinical insight, observation and feedback from staff and service users to gain robust assurance.

4.13. We also recognise the importance of an active approach to learning from other Trusts and have begun a series of meetings to deliver a structured approach to organisational learning.

4.14. Immediate actions

4.15. One of our immediate actions was to set up a small team to co-ordinate and connect the actions required for the CQC Section 31 with the wider Maternity Transformation Programme. Also, we have engaged and involved the wider team within the Trust who had skills to support the improvement work.

4.16. A "Section 31 Programme Office" was set up and this is led by the Maternity Assurance Programme Manager, the Deputy Director of Operations and the Deputy Director of Quality reporting to the Women's and Children's Divisional Senior Leadership Team and the Executive Lead for Maternity - Chief Nurse and Director of Quality.

4.17. With the Programme Manager, we agreed that our key enablers for embedding a culture of quality improvement included:
- developing and maintaining a new approach to leadership;
- allocating adequate time and resources for improvement;
- ensuring there is effective patient engagement and co-production;
- maintaining staff engagement

4.18. Next step was to engage the services of a trained Executive Coach, and the Deputy Director of Quality fulfilled this role.

4.19. We have involved our Corporate Quality Teams
- Associate Director of Safety (Investigations and Family Support) - to support our approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improvement patient safety.
- Associate Director of Patient Safety (Improvement & Human Factors) and Patient Safety Specialist to support QI and human factors approach to the work
- Clinical effectiveness and Quality Improvement Manager – to support QI training, audit and clinical effectiveness elements of the programme.
- Head of Patient Experience - to support the co-design and patient experience elements of the improvement programmes.

4.20. Next, we set up a series of facilitated workshops

13 May 2024 Workshop 1 – rapid improvement event
Aim - to test the idea of developing a shared vision for QI and agree first steps with clinical leads identified

16 May 2024 Workshop 2
Aim - to share progress of the development of the GSQIA “QI Plans on a Page” to date

20 May 2024 Workshop 3
Aim - to host a GSQIA “Quality Improvement Clinic” to provide information and resources to the clinical leads to develop their knowledge of quality improvement

4.21. In the background to the Quality Improvement approach we have a programme office running using the MSP Framework (the drivers for this being good programme principles, good governance and transformational flow).

4.22. <u>The next table outlines our Immediate actions to improve services</u>

Immediate actions	**Who**	**Date for completion**
9 May 2024 briefing to private Trust Board	CEO	Complete
9 May 2024 Senior Leadership huddle to plan approach and next steps with the S31	Chief Nurse and Director of Quality with Women and	Complete

Immediate actions	Who	Date for completion
	Children's Division CoS and Maternity Senior Leadership Team	
9 May 2024 Section 31 Programme Office Set up	Deputy Director of Quality, Maternity Assurance Programme Manager and the Deputy Director of Operations	Complete
9 May 2024 Engage Executive Coach (Deputy Director of Quality) to facilitate workshops	Chief Nurse and Director of Quality	Complete
9 May 2024 Invite ICB and LMNS to the workshops to work alongside	Maternity Assurance Programme Manager	Complete
Development of a S31 communications plan for staff and families (supported by Director of Engagement, Involvement and Communications) Communications to the public (link)	Chief of Service, Director of Midwifery and Director of Operations	Plan complete and being enacted
On behalf of the Chief Nurse plan, set up and facilitate 3 workshops 13 May 16 May 20 May Each session included learning reflection – what have we learnt and what are we learning?	Deputy Director of Quality / Maternity Assurance Programme Manager	Complete
Check in meeting with CQC to describe our QI approach 13 May 2024	Director of Midwifery	Complete
Learning from excellence meeting with Royal United Hospitals Bath	Chief Nurse	Complete
Learning from an organisation with a maternity service with a CQC S31	Chief Nurse	Complete
Plan for the resources required to invest in an educational infrastructure that means staff can be trained in the GSQIA tools and techniques.	Director of Midwifery / Specialty Director	7 June 2024
Set up external reporting arrangements to the ICB - Quality Improvement Group (QIG) first meeting 17 May 2024 (fortnightly	ICB colleagues	Complete

Immediate actions	Who	Date for completion
meetings to provide assurance on S31 progress). CEO, Chief Nurse and Director for Integrated Governance to be in attendance with the Maternity Team.		
Agree and confirm internal reporting for S31 Report and check and challenge on progress Executive Led Maternity Delivery Group (invite Director of Integrated Governance and Medical Director and Director of Safety) Next meeting 12 June 2024	Director of Midwifery (on behalf of the Chief Nurse)	Complete
Set up meeting to review audit plan and clinical effectiveness work stream reporting to Chief Nurse/ Medical Director and Director of Safety	Maternity Assurance Programme Manager	Complete
Set up safety review of S31 issues and PSIRF implementation work stream reporting to Medical Director and Director of Safety & Chief Nurse	Associate Director of Safety and Perinatal Clinical Governance Team	Complete
Initial Safety Review complete of 4 cases within the S31 letter to be reported to Medical Director and Director of Safety	Associate Director of Safety	28 May 2024
Review and make a plan for work stream Teams to undertake quality improvement training and to participate in quality improvement activities Bronze Training part 1 - 7 June 2024 Bronze Training part 2 - 21 June 2024 Bespoke Silver Training - 12 July – 5 Dec 2024 The last hour of the session will be the clinical Teams presenting progress with the Director for Integrated Governance, Chief Nurse and Medical Director present to hear progress and provide support to clinical teams. Maternity staff invited.	Deputy Director of Quality/ Deputy Director of Operations / Quality Improvement and Effectiveness Team	Complete
Identify Board level “buddies” for each QI work stream	Chief Nurse	3 June 2024
Set up data work stream with the aim to review and improve ward to Board reporting with the Maternity Dashboard to include	Deputy Director of Operations	Complete

Immediate actions	Who	Date for completion
- Suite of Maternity metrics to be reported to Trust Board as part of the Integrated Performance Report - Stretch targets for the QI projects as better data becomes available		
Chief Nurse led Learning Summit for CQC S31 so we can share and learn with our Divisional colleagues booked for 21 June 2024	Deputy Director of Quality	Complete
This CQC S31 report to be received for assurance by Quality and Performance Committee (sub board) 29 May 2024	Medical Director (on behalf of the Chief Nurse)	28 May 2024
Set up Maternity Governance Review meeting 7 June 2024 Maternity Team, Director for Integrated Governance, Medical Director and Director of Safety & Chief Nurse	Maternity Assurance Programme Manager	Complete

4.23. The next steps of our plan will be developed once the first report has been sent to the CQC and the Governance Review Workshop has taken place.

4.24. The Governance Review Workshop will develop the short, medium and long term plans for Governance within Maternity and will be supported by our new Director for Integrated Governance as they will provide “fresh eyes” and support for the ongoing improvement required.

5. Issue – Safety and effectiveness of Postpartum haemorrhage (PPH) and Massive Obstetric Haemorrhage (MOH) risk assessments and management

Issues in summary

Postpartum haemorrhage and Massive Obstetric Haemorrhage	– Risk assessment and management of PPH/MOH – Clinical incident management (W227314, W227347, W227802) – Audits, themes and trends – Data (ITU admissions and 3rd / 4th degree tears) – Learning and Improvement

5.1. Issues that CQC identified

5.2. The maternity service missed opportunities for sharing immediate learning in relation to:

- The quality of multiprofessional team working in theatres (W227347),
- Delays to transfer from a homebirth to the unit when retained placenta had been identified (W227314)
- The PPH risk score being calculated in the antenatal period (W227802)

5.3. The Major Obstetric Haemorrhage rates continued to be high. It was noted in the Maternity Clinical Governance minutes *"There have been 10 MOH 2000ml-2999ml between 04/02 and 11/03 these have been added to the spread sheet and are awaiting review".* There was no evidence of the actions being taken to reduce rates.

5.4. Background

5.5. In October 2023, a "PPH Sprint" was undertaken including the NHS England Maternity Improvement Advisors (MIAs), Midwives and Obstetricians. Sprints are a quality improvement methodology to tackle problems that staff are facing in their daily work lives. The Sprint is an intense day team work where the staff come together to find solutions and to test ideas with each other.

5.6. The key findings were identified following a thorough review of cases.

5.7. The first 24 sets of notes there were themes identified around:

- The risk assessment was completed and then staff did not then follow correct pathway for the risk identified which should have been "usual" active management or higher level treatment with the PPH Bundle (as described in Trust Policy).
- intrapartum management, specifically around prolonged second stage in low-risk women
- Escalation of care – buzzer being pulled only when estimated blood loss (EBL) greater than 1000ml

Then once it was felt that the themes were saturated a further set of 60 notes were reviewed (at this stage the MIAs advised to only collect data relevant for learning and improvement)

- Through these next cases there was a continued theme that demonstrated that staff did not know when to use of higher level PPH bundle versus when to use active management.
- At times the risk assessment was not completed when there was an opportunity to do so.
- There was a continued theme that there was late escalation with high levels of blood loss before the emergency buzzer was pulled,
- Also, there was late escalation when the estimated blood loss reached the level of an MOH and so the emergency call was delayed.

5.8. In response to this "PPH Sprint" there were focused change ideas implemented. In January 2024, there was focused teaching about weighing blood loss. The themes of this "PPH Sprint" were included within the Prompt PPH/MOH training. Another change idea, due to the continued issues identified in recognition of PPH and MOH, was to implement Obs Cymru, a checklist for the prevention and management of PPH. At the time of the CQC inspection this checklist had not been implemented as there were ongoing discussions with the multidisciplinary team.

5.9. Immediate actions in response to the S31

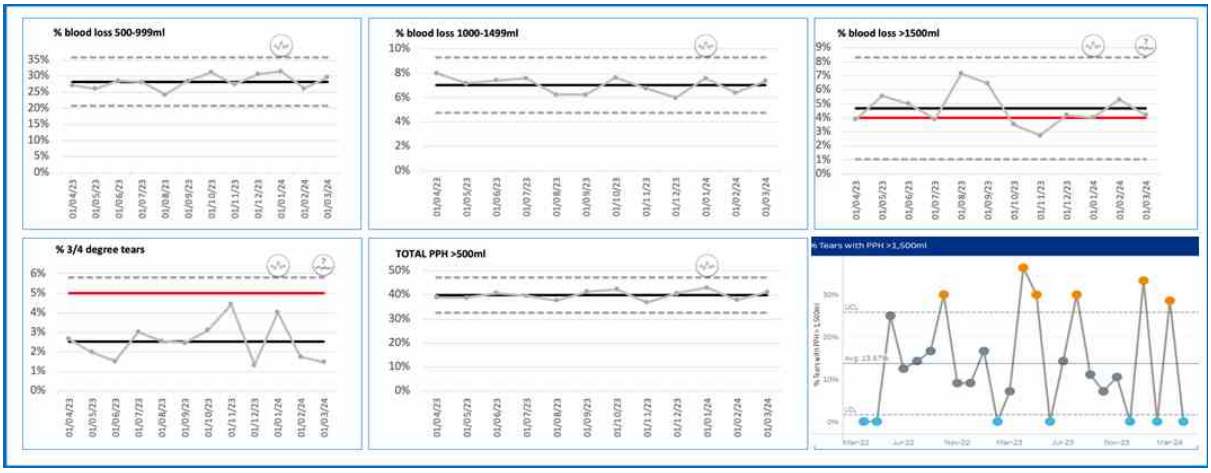
5.10. We recognise that we should have acted more swiftly to share the learning from the incidents identified by CQC. We will build this in as part of the QI improvement programmes and we will implement the change ideas from the "PPH Sprint" at pace.
5.11. Our continued approach has been based on the empowerment of frontline teams.
5.12. On the 13 May 2024, the team leads were identified for the PPH/MOH work stream and the CQC section 31 letter with the issues was shared.
5.13. The Team Leads are a Consultant Obstetrician (Labour Ward Lead), Labour Ward Matron and the 2 Obstetric Anaesthetic Leads. The Team was tasked with completing a plan on a page (appendix 1).
5.14. On 16 May 2024, the Team Leads presented the first draft of their QI Plans on a page (action plans) to the wider team (this included the Safety Team, the Quality Team and the Clinical Effectiveness and Quality Improvement Team). All the Teams identified that they would benefit from further QI support with their plan.
5.15. On 20 May 2024, we ran a QI clinic and each team had an opportunity to work with a trained Quality Improvement Facilitator.
5.16. The PPH/MOH team has identified SMART aims.

SMART Aim

1. To reduce the rate of PPH >500ml from 41% to below the national average of 25% births over a 6-month period
2. To reduce our mean monthly MOH (1500ml) from 5% to 3% in 6 months

5.17. They have identified a suite of metrics (including risk assessment completion and use of proformas within the management of PPH/MOH as well as monitoring mandatory PROMPT training compliance) that they will monitor whilst they implemented changes to see if the changes resulted in an improvement.

Source: BadgerNet standard reports. GHNHSFT rates vs. all other centres using BadgerNet (labelled National)	**Latest Month % April 2024**	**National Rates % April 2024**	**6 monthly rolling average/1000 births**
PPH Total >500mls-999mls	26.7%	29.5%	40.3%
PPH > 1000mls	9.6	11.5%	
MOH >1500mls	2.9%	2.8%	4%



5.18. The clinical team have identified and prioritised their change ideas

5.19. The immediate suite of actions for this team have been identified are all within the QI plan on a page and for ease of reference they are listed here.

Immediate actions	**Who**	**When is progress going to be checked and issues escalated**
Implement the ObsCymru Checklist	Team PPH/MOH	7 June 2024
Trial Carbotocin for women undergoing Caesarean Section	Team PPH/MOH	7 June 2024
Use BadgerNet to prompt medical review, use Badgernet to prompt calling a Consultant	Team PPH/MOH	7 June 2024
Join the current risk assessment with the ObsCymru Checklist Stage 0	Team PPH/MOH	7 June 2024
Review case notes with the NHSE MIA Team	Team PPH/MOH	10 June 2024
Implement plan for sharing learning (team talk in MDT handover, email, lunchtime teaching, mandatory skills drills training, **simulation training**, coffee and chats, Practice development team involvement)	Team PPH/MOH	7 June 2024

5.20. The QI plan includes the next set of change ideas to be implemented, which will be the short, medium and long term plans as the Team work through their improvement plan and implement their change ideas and they will measure whether the change has had the desired impact.

6. Issue – Fetal monitoring peer reviews, accurate assessment and timely escalation of concerns

Issues

Fetal monitoring	- Peer reviews - Accurate interpretation of electronic fetal monitoring, - Escalation of concerns - Audits and themes and trends - Clinical incident management (MI- 033153) - Learning and Improvement

6.1. Situation

6.2. CQC reviewed the Maternity Service fetal monitoring audit for September 2023 to March 2024. There was no evidence of review of the accuracy of cardiotocography (CTG) interpretation, classification and whether staff followed escalation processes effectively when fetal distress was identified.

6.3. The Maternity Service provided evidence of audits of 20 notes completed every other month in relation to the escalation of CTG traces. However, this audit did not include any information on whether traces were categorised in line with Trust guidance so did not demonstrate the Trust had effective oversight.

6.4. CQC considered that there is an ongoing risk to service users that fetal monitoring is not being completed in line with national guidance - NICE guideline NG229 Fetal monitoring in labour, published December 2022. If fetal monitoring is not completed and escalated effectively there is an increased of adverse perinatal outcomes such as neonatal cerebral palsy, hypoxic-ischemic encephalopathy, or stillbirth.

6.5. We reviewed the Maternity and Newborn Safety Investigation (MNSI) MI-033153 final report March 2024 and noted it made the following safety recommendation in relation to fetal monitoring: There was no evidence the service had implemented the recommendations from this safety investigation.

6.6. Background

6.7. The fetal monitoring policy was rewritten in line with national guidance (NICE 2022 and the fetal physiology guideline). It was approved and ratified through an MDT guideline committee before being published in April 2024.

6.8. A monthly fetal monitoring audit was in place to assess the compliance of hourly peer reviews and risk assessment, focusing on the recommendations from saving babies lives. The audit pathway was revisited and improved in February 2024 to capture CTG interpretation in relation to poor outcomes and suboptimal care. This included appropriate escalation and if appropriate action was taken in response to the escalation.

6.9. The MNSI (MI-033153) report was received by the Trust on 18th March 2024. A multi-disciplinary action planning meeting took place on 12th April 2024. An action plan has been designed. This was due to be presented at the Trust Safety Experience Review Group (SERG) on 1 May 2024. The presentation did not go ahead due to the

Maternity Team's response to Section 31 CQC intent communication. This action plan will be presented to SERG on 6th June 2024. The learning and improvement actions continue to be implemented.

6.10. Our immediate actions in response to the S31

6.11. Our approach has been based on the empowerment of frontline teams.
6.12. On the 13 May 2024, the team leads were identified for the Fetal Monitoring work stream and the CQC section 31 letter with the fetal monitoring issues was shared.
6.13. The Team Leads are a Consultant Obstetrician (Fetal Monitoring Lead), Labour Ward Matron. They will expand their QI Team once the audit results are known.
6.14. The Team were tasked with completing a plan on a page (appendix 2).
6.15. On 16 May 2024, the Team Leads presented the first draft of their QI Plans on a page (action plans) to the wider team (this included the Safety Team, the Quality Team and the Clinical Effectiveness and Quality Improvement Team). All the Teams identified that they would benefit from further QI support with their plan.
6.16. On 20 May 2024, we ran a QI clinic and each team had an opportunity to work with a trained Quality Improvement Facilitator.
6.17. The Fetal Monitoring team identified a SMART aim:

SMART AIM
To confirm through audit within one month that staff are identifying and escalating fetal compromise effectively and addressing any issues found, sharing learning and providing assurance.

6.18. **Measurement plan**

6.19. MDT audits set up and April audit being undertaken.
6.20. Review of HSIB/MNSI cases to identify any issues with fetal monitoring effectiveness.

6.21. **Measures and Data Collection**

- Compliance with FM risk assessment at onset of labour
- Compliance with hourly peer review and risk assessment
- Audit of effective fetal monitoring and categorisation, escalation and review
- Datix investigation for all babies born with Apgars below 7 at 5 minutes of age, born with a cord PH of 7.10 or below and/or a base excess of equal to or more than -12 or where a poor outcome was present

Immediate actions	**Who**	**When is progress going to be checked and issues escalated**
Review Trust processes for MNSI (MI-033153) case	Associate Director of Safety Investigations and Family Support	COMPLETE

Immediate actions	Who	When is progress going to be checked and issues escalated
Present MNSI case action plan to the Trust Safety and Experience Review Group 6 June 2024	Maternity Safety Team	7 June 2024
MDT audits have already been set up and April audit is now being undertaken.	Team Fetal Monitoring	7 June 2024
Review of HSIB cases to identify any issues with fetal monitoring effectiveness.	Team Fetal Monitoring	7 June 2024
Audit data to be reviewed in an MDT monthly meeting-There are cases that require an MDT discussion to ensure that accurate CTG categorisation was made this will ensure that the data is accurate and will finalise the monthly audit	Team Fetal Monitoring	7 June 2024
Improvements to the audit inclusion criteria; this will include data from all MNSI and Attain cases, current Datix for Apgar's of equal to or less than 7 at 5 minutes of age, updated Datix criteria to be implemented for babies born with a cord PH of 7.10 or below and/or a base excess of equal to or more than -12.	Team Fetal Monitoring	7 June 2024
Improve fetal monitoring team representation at key meetings, such as ATAIN and SI's, to access immediate learning, safety action and enable timely implementation to individuals and teams.	Team Fetal Monitoring	7 June 2024
Disseminate learning in a timely fashion through: • Continue attendance at national network • Annual mandatory fetal monitoring training day and competency assessment. Continue to develop lunchtime learning and make available on Teams to make the training accessible for staff who can use some	Team Fetal Monitoring	7 June 2024

Immediate actions	Who	When is progress going to be checked and issues escalated
of their allocated CPD annual training hours. • Individual learning (one to one's) • Team talk, words of the week, PDM social media group and to consider other forms such as, an intranet page, email bulletins, newsletters, posters. • Ad hoc teaching on shift and monthly governance newsletter to include fetal monitoring updates. • Create bitesize training sessions on relevant topics identified from learning trends and staff feedback such as antenatal and computerised CTG's.		

6.22. The QI plan includes the next set of change ideas to be implemented which will be the short, medium and long term plans as the Team receives the audit results and then will work through their improvement plan and implement their change ideas dependant on the findings.

7. Issue – Temporary workforce (agency midwives) experience

Issues

Temporary workforce (agency)	– Induction – Support – Access to the unit – Access to Trust Policies – Access to BadgerNet – Access blood test results system – Monitoring agency performance – Monitoring safety and incidents

7.1. Situation

7.2. During the CQC onsite inspection on 26 March 2024 CQC spoke with one bank nurse and one agency midwife. Both these staff told CQC that they did not find the induction adequate. Senior staff told us they had withdrawn their agency induction pack for review despite the increased use of agency midwives. The Agency Midwives told CQC they have issues getting swipe cards at short notice, but longer-term agency midwives would get one.

7.3. Three agency midwives raised concerns with CQC in February 2024 (CQC reference CAS-247054-T9G8K9) about lack of support from senior midwives to the agency

midwives who were unfamiliar with the unit and not being familiar with the maternity records system, among other concerns.

7.4. A recent complaint received by CQC in April 2024 (CQC reference CAS- 348931-X3B9H2) in relation to the care received by Service User A describes how half the midwives who looked after her were agency midwives, and they were unfamiliar with the electronic records system used and the policies and procedures used at the Trust.

7.5. Background

7.6. Risk 499 (3536) “The risk of not having sufficient midwifery staff on duty to provide quality care ensuring safety and avoidable harm including treatment delays” was added to the risk register in May 2021. To mitigate this risk the service has needed to use a temporary staffing solution to ensure that shifts are filled and that there are enough midwives on duty to provide care to mothers and babies.

7.7. The service had an induction pack and because of service changes temporarily withdrew this to update the content.

7.8. Immediate actions

7.9. The Trust was concerned to hear that Agency Midwives, and women cared for by Agency Midwives, did not feel supported and so have initiated an immediate response to the concerns raised.

7.10. Our approach has been based on the empowerment of frontline teams.

7.11. On the 13 May 2024, team leads were identified for the Temporary Workforce work stream and the CQC section 31 letter was shared.

7.12. The Team Leads are the Head of Midwifery, the Lead Nurse for Accreditation and Regulation, a Matron and the Maternity Recruitment and Retention Project Lead.

7.13. The Team were tasked with completing a plan on a page (appendix 3).

7.14. On 16 May 2024, the Team Leads presented the first draft of their QI Plans on a page (action plans) to the wider team (this included the Safety Team, the Quality Team and the Clinical Effectiveness and Quality Improvement Team). All the Teams identified that they would benefit from further QI support with their plan.

7.15. On 20 May 2024, we ran a QI clinic and each team had an opportunity to work with a trained Quality Improvement Facilitator.

7.16. The Temporary Workforce Improvement Team identified a SMART aim:

To improve the orientation, induction and access experience of Agency Midwives with the Flow Midwife holding a meet and greet, to organise access and talk through induction pack, and this being documented (target 100% by the end of June 2024).

7.17. Outcome measure

- Agency staff satisfaction levels, through short survey undertaken in June 2024 and repeated in Sept 2024. Satisfaction of midwives, patients and families through feedback from Maternity and Neonatal Voices Partnership (MNVP) and Complaints Team

7.18. Process Measures

- Audit of checklist being completed

- Audit Badgernet access (time taken to enable this e.g. < 1 hour
- Audit access to Trust Policy

7.19. Balancing Measures

- Number of Datix submissions by agency staff & review acuity tool

Table: immediate actions

Immediate actions	Who	When is progress going to be checked and issues escalated
Induction pack – information revised and issued to all clinical areas and agency for agency midwives to receive before shift. Checklist devised and implemented for agency midwives to sign at start of shift Update communicated to all key parties	Head of Midwifery and Team	7 June 2024
Access to relevant areas – contact details included in revised induction pack. Process for issuing swipe cards benchmarked with other Trusts	Head of Midwifery and Team	7 June 2024
Badgernet access – all clinical Band 7 midwives now have the correct access to be able to create a Badgernet login for Agency midwives	Head of Midwifery and Team	7 June 2024
Policy access – details included in induction pack and access assessed through checklist	Head of Midwifery and Team	7 June 2024
Evidence – Datix relating to agency midwives audited	Head of Midwifery and Team	7 June 2024
Agency Midwife Checklist to be completed at the beginning of each shift by Flow midwife, ensuring they have Badgernet & policy access, contact numbers for areas and have been orientated. This informs an action card relating to Trust Policy	Head of Midwifery and Team	7 June 2024

7.20. The QI plan includes the next set of change ideas to be implemented which will be the short, medium and long term plans as the Team receives data and the team will work through their improvement plan and implement their change ideas dependant on the findings. These are listed on the Driver Diagram with the prioritisation of the change ideas.

8. CQC Section 31 Issue – Venous thromboembolism (VTE) risk assessments

Issues

Maternal Venous Thromboembolism (VTE)	– Risk assessments – Acting on audit results, risk identification – Audit plans – Learning and improvement

8.1. Situation

8.2. CQC identified that there is an ongoing risk service users are not receiving VTE risk assessment in line with national guidance. Women should have a venous thromboembolism (VTE) risk assessment performed during their pregnancy in line with RCOG Green-top Guideline No. 37a.

8.3. Background

8.4. Carrying out risk assessments reduces the risk of venous thromboembolism during pregnancy and the puerperium. All women should undergo a documented assessment of risk factors for VTE in early pregnancy. Risk assessments should be repeated if the woman is admitted to hospital for any reason or develop other concurrent problems. Risk assessments should be repeated again intrapartum or immediately postpartum.

8.5. While **rare** in the United Kingdom (UK), venous thrombosis and VTE is the leading direct cause of death of pregnant women and pregnant people during pregnancy or up to 6 weeks after the end of pregnancy. Pregnant women and pregnant people who develop a VTE must undergo additional treatment and this can cause distress and anxiety at a time when they may already feel vulnerable.

8.6. The evidence about risk factors and the occurrence of VTE in pregnancy and the first 6 weeks after giving birth is imprecise. In addition, while there are recommendations for prescribing of medication to thin the blood if a pregnant woman/pregnant person is identified as being at risk, the preventative and treatment dose(s) have not been formally tested in clinical trials. Research studies are ongoing to address identified knowledge gaps within the evidence base. Safety risks have also been reported in research literature and are reiterated in national reports which make recommendations to improve care during pregnancy and in the first 6 weeks after birth.

8.7. Immediate actions

8.8. The Trust recognises that it should have taken earlier action in response to the audit results and has now taken immediate actions.

8.9. In response to this section 31 enforcement notice we have identified 2 clinical leads (matron and Consultant Obstetrician) to commence a quality improvement project to improve compliance of completing risk assessments.

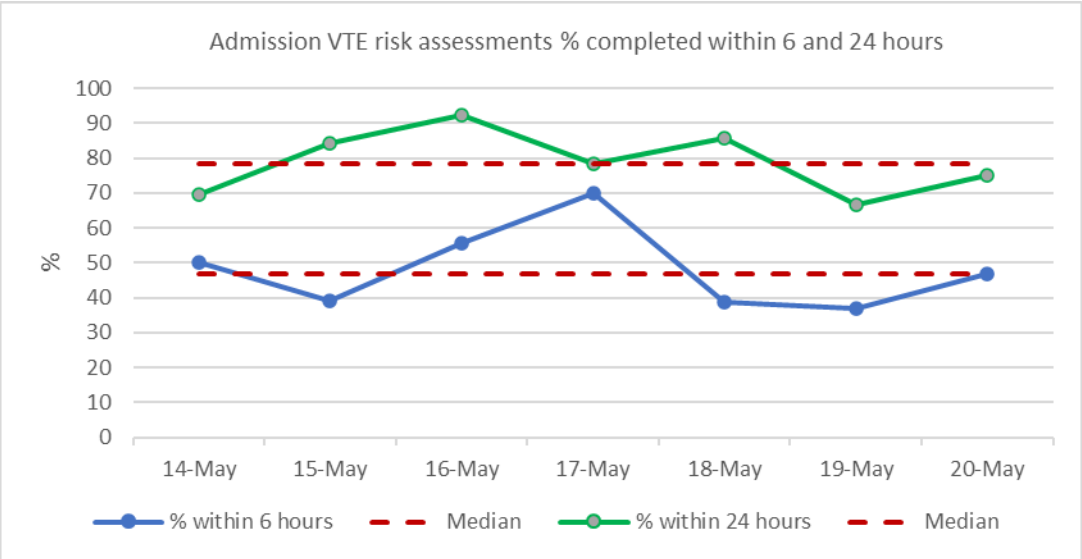
8.10. Our approach has been based on the empowerment of frontline teams.

8.11. On the 13 May 2024, team leads were identified for the VTE Risk Assessment work stream and the CQC section 31 letter was shared.

8.12. The Team Leads are a Consultant Obstetrician and a Matron.
8.13. The Team was tasked with completing a plan on a page (appendix 4).
8.14. On 16 May 2024, the Team Leads presented the first draft of their QI Plans on a page (action plans) to the wider team (this included the Safety Team, the Quality Team and the Clinical Effectiveness and Quality Improvement Team). All the Teams identified that they would benefit from further QI support with their plan.
8.15. On 20 May 2024, we ran a QI clinic and each team had an opportunity to work with a trained Quality Improvement Facilitator.
8.16. The VTE Improvement Team identified a SMART aim:

> For admission VTE risk assessment to be completed within 6 hours of admission 70% by 31 July, 80% by 31 August and >95% by 30 November 2024.

8.17. Our current data tells us that VTE risk assessment at booking was over 97% and post-delivery over 99%, and that the “on admission” risk assessment was recognised as the main issue.
8.18. Themes and trends for non-compliance to be monitored by team leads to ensure understanding of barriers to completion. Such as, daily run chart of admission VTE.



Immediate actions	**Who**	**When is progress going to be checked and issues escalated**
Manual audit to assess current compliance.	VTE Team	7 June 2024
Communications to staff to increase compliance: message to doctors, added to team talk to ward, CDS and GBU, meeting with lead midwives on ward, CDS and GBU to show them how to access information on	VTE Team	7 June 2024

Immediate actions	Who	When is progress going to be checked and issues escalated
patients VTE assessment status, posters on the ward, box with reminder and TEDS/ Tape measures for easy access		
Added to ward and Community production boards to ensure remains a priority for area leaders.	VTE Team	7 June 2024
VTE work stream to review local guideline, audit criteria. Review BadgerNet risk assessment.	VTE Team	7 June 2024
Medical Director & Director for Safety to chair the VTE Committee -executive oversight for VTE	MD,DoS	28 May 2024

8.19. The QI plan includes the next set of change ideas to be implemented which will be the short, medium and long term plans as the Team receives data and the team will l work through their improvement plan and implement their change ideas dependant on the findings. These are listed on the PDSA chart and the Driver Diagram with the prioritisation of the change ideas.

9. Issue- Maternal Obstetric Early Warning Scores (MOEWS) escalation

9.1. Situation

9.2. CQC reviewed the MOEWS action log and inspection evidence request. They found improvements to ‘act on amber’ (repeating observations within an hour where indicated) had not been embedded. Compliance was consistently below 60% from data they reviewed between August 2023 to January 2024 and while performance had improved in February 2024 (90% compliance) and March 2024 (67% compliance) this improvement was not sustained.

9.3. Background

9.4. Maternity Obstetric Early Warning Scores are clinical prediction models that use measured vital signs (temperature, heart rate, respiratory rate, systolic blood pressure, level of consciousness, oxygen saturation and temperature) to monitor women’s health during their hospital stay. The model identifies the likelihood of patients deteriorating. When a patient shows signs of deterioration, the MOEWS triggers a warning (amber score) so that an action can be taken and/or care can be escalated. Modified Obstetric Early Warning Scores (MOEWS) are used only for our maternity population.

9.5. Maternity Early Warning Score MEWS or MOEWS are widely used throughout hospitals in the UK to highlight when additional care is needed to protect the health of

the expectant mother and baby. The majority of MEWS have been developed by clinical consensus.

9.6. Immediate actions taken

9.7. The Trust recognises that it should have taken earlier action in response to the audit results and has now taken immediate actions.
9.8. In response to this section 31 enforcement notice we have identified 2 clinical leads (matron and Consultant Obstetrician) to commence a quality improvement project to improve compliance of completing risk assessments and escalation accordingly.
9.9. Our approach has been based on the empowerment of frontline teams.
9.10. On the 13 May 2024, team leads were identified for the MOEWS improvement work stream and the CQC section 31 letter was shared.
9.11. The Team Leads are a Consultant Obstetrician and a Matron.
9.12. The Team was tasked with completing a plan on a page (appendix 5).
9.13. On 16 May 2024, the Team Leads presented the first draft of their QI Plans on a page (action plans) to the wider team (this included the Safety Team, the Quality Team and the Clinical Effectiveness and Quality Improvement Team). All the Teams identified that they would benefit from further QI support with their plan.
9.14. On 20 May 2024, we ran a QI clinic and each team had an opportunity to work with a trained Quality Improvement Facilitator.
9.15. The MOEWS Improvement Team identified a SMART aim

To increase compliance with acting on amber observations to 80% within 3 months (July), and 95% within 6 months (Oct).

9.16. The Team have carried out an initial literature research and found a study published on 15 May 2024 which they will share with the overarching improvement group.

Gerry S, Bedford J, Redfern OC*, et al* Development of a national maternity early warning score: centile based score development and Delphi informed escalation pathways *BMJ Medicine* 2024;**3:**e000748. doi: 10.1136/bmjmed-2023-000748. Link https://bmjmedicine.bmj.com/content/3/1/e000748 WHAT IS ALREADY KNOWN ON THIS TOPIC • Maternal early warning scores (MEWS) are widely used to help identify physiological deterioration during pregnancy • Most MEWS were not developed based on evidence based research WHAT THIS STUDY ADDS • A new national MEWS was developed, based on the results of a large prospective study

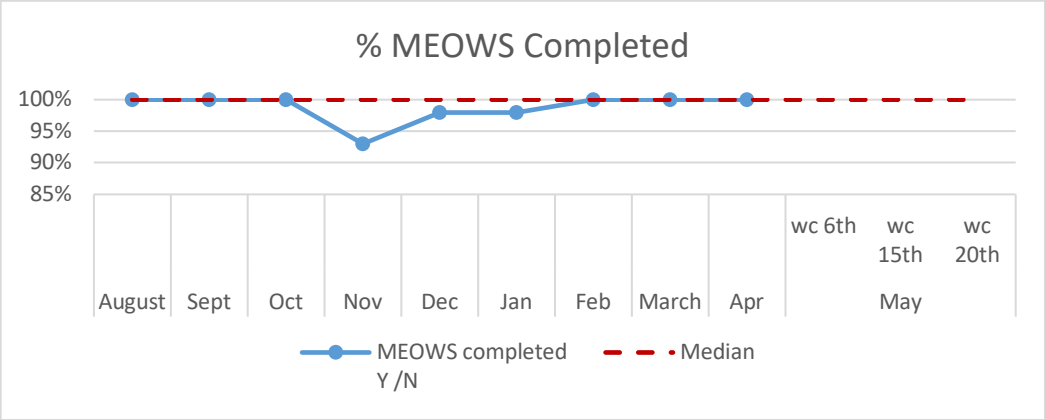
- Compared with other commonly used MEWS, the new national MEWS showed a more manageable alert rate in a healthy population
- How well the tool predicts adverse outcomes, however, was not assessed

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE, OR POLICY

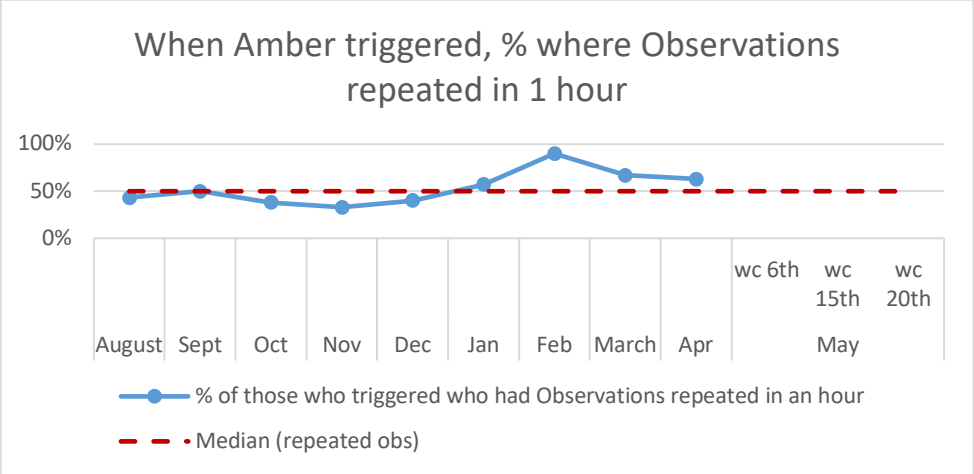
- The new national MEWS is programmed for implementation across the English NHS
- The effects of consistency, a reduced alert rate in a healthy population, and Delphi based escalation protocol will be monitored
- The MEWS and escalation pathways could be translated to other healthcare systems with a few modifications

9.17. The leads have already contacted the National Team, to find out when the National MEWS charts are being rolled out in Gloucestershire and the current plan is to role this out for Trusts with digital systems in 2026. The new chart has been rolled out in 16 paper based Trusts already.

9.18. The MOEWS Team have reviewed compliance of undertaking MEOWs, ensuring all parameters are completed and that the MEOWs are completed within relevant time frames are 100%.



9.19. Results of the audit highlight that staff are not acting on observations that trigger amber as per policy and so are not potentially recognising the deteriorating patient. Immediate action was taken to address the issue concerning thermometers and a new cleaning process has been implemented, the success of which will be monitored via the audit programme.



9.20. Themes from the audit include; agency and student midwives not following policy, thermometers not being cleaned correctly and so providing false readings that are then not acted on. A survey on the ward identified trigger fatigue, confirmation bias and lack of alerts on BadgerNet system.

Immediate actions	**Who**	**When is progress going to be checked and issues escalated**
MEOWS display board up and discussed daily	MOEWS Team	7 June 2024
Continue to audit act on amber compliance All bands to be involved with audit	MOEWS Team	7 June 2024
Visual prompts displayed on computers	MOEWS Team	7 June 2024
Education from PD, CIPP, PROMPT	MOEWS Team	7 June 2024
Team talk	MOEWS Team	7 June 2024
Trolley teaching	MOEWS Team	7 June 2024
Celebrate compliance	MOEWS Team	7 June 2024
Check where we are with National MEWS	MOEWS Team	7 June 2024

9.21. The QI plan includes the next set of change ideas to be implemented which will be the short, medium and long term plans as the Team receives data and the team will work through their improvement plan and implement their change ideas dependant on the findings. These are listed on the PDSA chart and the Driver Diagram with the prioritisation of the change ideas.

10. Conclusion

10.1. The Trust recognises the importance of ensuring a structured approach to quality and safety assurance and management, and that insights gained from incidents, audit activity, service user voice/feedback and regulatory inspections are important

indicators of quality and safety improvement opportunities and the need for urgent and effective action.

10.2. Immediate action has been taken to protect people who use our services from harm, and the risk of harm, and to ensure women receive care of an appropriate standard and assessments of the effectiveness of these actions will be monitored through oversight of the QI workstreams. Reviews of the incidents commented on specifically by the CQC have recently been reported to the Medical Director & Director for Safety for executive review.

10.3. The next meeting to review the QI work streams is the 7 June 2024 and the next steps to improve the governance systems within the service is the 7 June 2024.

10.4. The role of the Board of Directors and its Quality and Performance Committee and that of the Executive in overseeing assurance of intended improvements and operational delivery of the action/QI plans respectively will be strengthened and reporting requirements will be implemented from June to include the role of audit and clinical effectiveness.

10.5. The Trust's transition to PSIRF is also recognised as an opportunity to further develop systems and processes that are consistent thereby strengthening the support available from the corporate safety team. It also provides an opportunity to use alternative approaches (SWARM (Hot debrief), AAR (cold debrief) and Quality Summits and will support identification and sharing of learning. This work will be integrated accordingly into our QI approach consistent with development of the Framework across the Trust.

10.6. Finally, equal importance has been attached to the service user voice and the voices of staff and so we will be working to ensure that this feedback is actively encouraged and listened to and integrated into our assurances that risks to quality and safety are reliably understood, managed and mitigated with effective controls.

11. Recommendation

11.1. The CQC are asked to note the contents of the report and be assured that the Trust are committed to delivery of this improvement plan.

Authors:
Women's and Children's Division Director of Midwifery - Lisa Stephens
Women's and Children's Division Speciality Director - Christine Edwards
Women's and Children's Division Director of Operations – Becky Hughes
(Supported by Deputy Director of Quality - Suzie Cro)

Sponsors:
Women and Children's Division Chief of Service - Simon Pirie
Director of Quality and Chief Nurse – Matt Holdaway
Deputy CEO, Director of Safety and Medical Director – Mark Pietroni
CEO – Kevin McNamara

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Improvement Group

28 June 2024

(Abridged version for Trust Board 11 July 2024)

the Best Care for Everyone
care / listen / excel

Purpose

- Keeping mothers, babies, birthing people and families safe whilst they are in our care is our priority with this improvement work.
- The purpose of this presentation is to provide an update on the pace of progress for members of the Quality Improvement Group.

QI work streams

- We have provided the current data for **May 2024** (and up until 23 June where this is available).
- We have highlighted the key actions taken up to 23 June 2024.
- We have then provided the next steps for each work stream.

High level summary of key actions

Since the last QIG

- Increased practice development team presence in clinical teaching and clinical review meetings (26 June)
- Learning posters have been circulated regularly (staff getting regular updates)
- Carbetocin commenced at CS – now monitoring CS PPH rates (18 Jun 2024)
- Intermittent auscultation audit themes acted upon with posters, Birth Centre Leads Meeting, Champions identified. Repeat Rapid audit commenced (24 June 2024)
- Agency Swipe card process agreed and signed off. Commenced (28 June 24)
- Commenced planning for Facebook live session for women on PPH
- Trolley teaching on PPH and REDUCE- so far 85 clinical staff taught – Midwives, Obstetricians, Student midwives, Anaesthetists, Theatre Practitioners (ready for launch on 1 July 2024)

High level summary of key actions

Since the last QIG

- CQC 31 updates provided at Patient Safety Champion Meeting (23 May)
- Continued with our meetings/huddles/reminders/communications (as per communications plan and rhythm of the day as presented at last QIG)
- QI Teams have completed Bronze GSQIA training (14 June)
- QI teams have provided an update on progress on their QI work with the Specialty Director, Chief of Service, Director of Midwifery, Chief Nurse and Medical Director present. This enabled the leads to escalate any concerns (14 June).
- Held a Maternity Governance workshop - PSIRF and Maternity (20 June)
- Held a Trust wide learning event to share learning across the Trust (21 June)
- Presented progress to Trust Quality and Performance Committee (sub board) (26 June)
- Updated on all the programmes within this slide deck (26 June)
- NED and Exec lead Board Safety Champion walkabout in Stroud with Perinatal Governance Lead and DoM – Spoke with staff about unit improvement work (19 June 2024)

Multidisciplinary QI workstream groups

The energy as we launched the groups was very positive. We encouraged colleagues to contribute to these projects as we will be using their output to make improvements to the way we work.

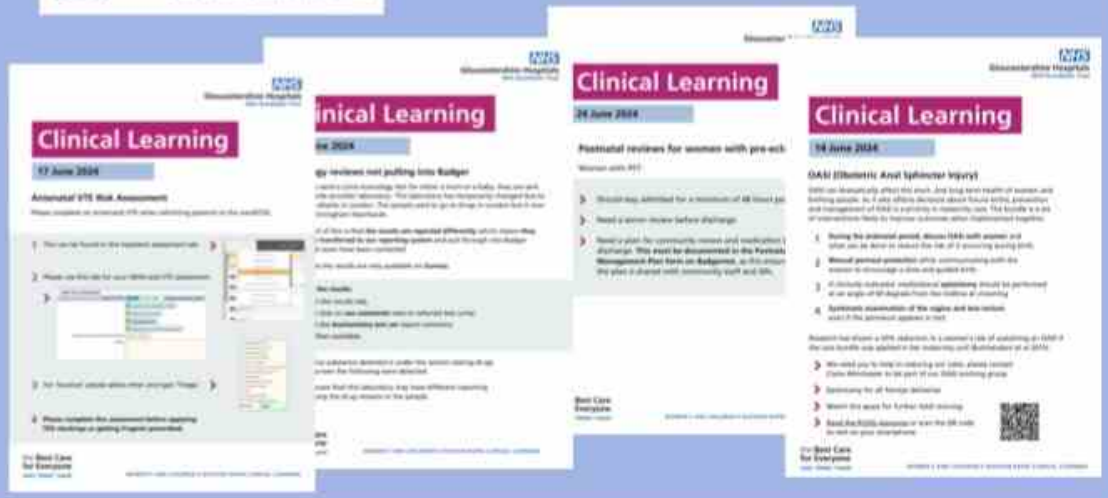
Colleagues can find out more about the groups on the Intranet.

We have introduced a new Rapid and Weekly Clinical Learning system

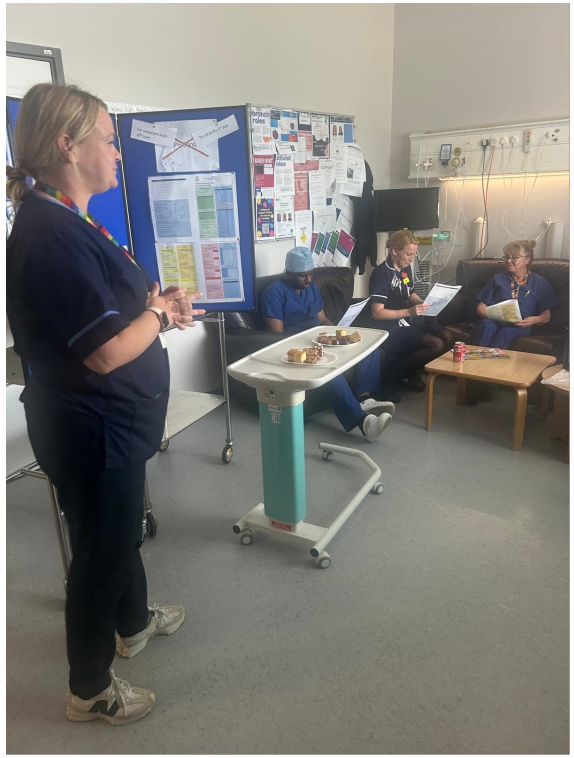
and a fortnightly update from the Head of Midwifery.

Your
Midwifery Staff Update
from Joanne Cowan, Head of Midwifery

Rapid Clinical Learning goes out to all maternity staff by date and is added to the Intranet.



Clinical teaching / Trolley Teach



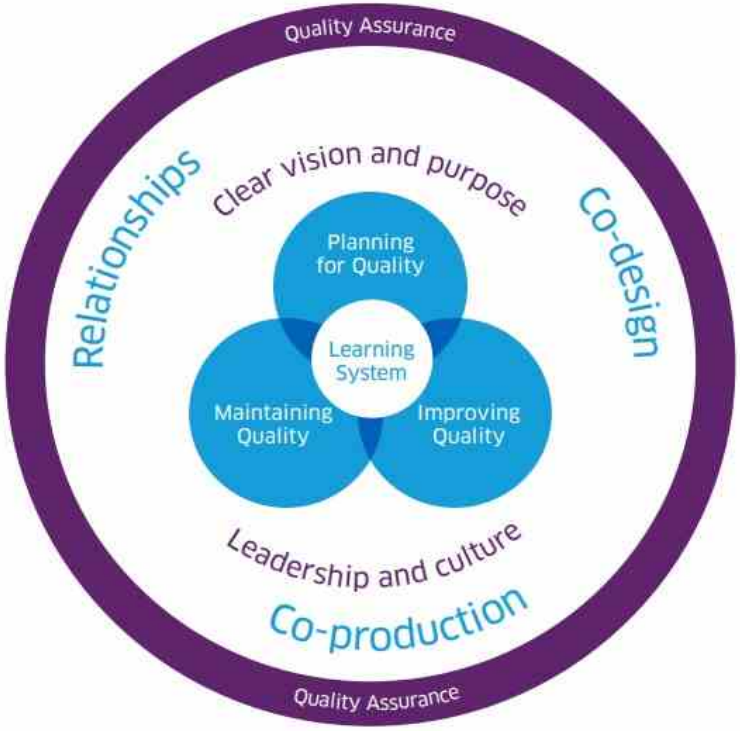
Learning journey to date

- We are learning that if we focus on continuous learning and improvement that this has improved staff morale.
- We have shared our actions and results to date with clinical teams through the clinical QI leads and through centralised communications from our communication specialist.
- We now have a really good understanding of how to make improvements happen in a structured way and can wrap around expert QI training, advice and support for teams.
- We are developing our Quality Management System within our Maternity Governance workshops and have a clear idea about what that looks like and how we make that happen.
- Women and their families are involved in developing and evaluating our improvement initiatives.
- We have developed processes to ensure learning happens when things don't go as planned (clinical incidents) we are using our PSIRF tools (swarms, after action reviews) to inform our improvement work streams
- We have supported staff to prioritise this work and to develop their QI skills.
- We are developing our strategy for how we develop these capabilities beyond this S31 period so this is our way of working.
- We are developing strong external relationship with stakeholders to support us in our improvement journey by reporting on our successes and also sharing where things aren't going as planned.
- Our approach to disseminating learning is focused on Messages from QI teams, Weekly updates from Incidences reviewed, Sharing MNSI learning, Monthly Quality & Safety Newsletter

Maternity Governance Improvement

Chief Nurse and Director of Quality – Matt Holdaway
Director for Integrated Governance – Kerry Rogers
Medical Director and Director of Safety – Mark Pietroni
Deputy Director of Quality - Suzie Cro
Maternity Senior Leadership and Governance Teams
ICB & LMNS

Goal – Development of robust Maternity Quality Management System (QMS)



S31 Immediate actions

Date	Action
9 May 2024	Letter - CQC served a Section 31 notice on the service
13, 16 and 20 May	Develop clinically led 7 CQC S31 work streams- PPH/MOH, fetal monitoring, MOEWs, VTE, agency midwives, dashboard and governance (
17 May 2024	QIG 1
20-28 May 2024	Set up QIG improvement work streams in same way as S31 (antenatal screening and antenatal scanning) plans on a page and teams to join Bronze QI training
28 May 2024	Summary Report submitted to the CQC (report 1)
31 May 2024	QIG 2
20 May – 23 June 2024	Clinical teams working on improvements with communications plan (feedback loop with staff) Meeting with MNVP chair to outline QI Workstreams – Teams encouraged to engage
7 June 2024 2-4pm	Bronze QI training session 1 for maternity clinical teams
7 June 2024 2-4pm	Maternity Governance Work shop (clinical effectiveness deep dive VTE) Chief Nurse and Director of Integrated Governance with Maternity Senior Leadership Team and ICB/ LMNS
7 June 2024 4-5pm	Clinical teams feedback to Executives, LMNS and Maternity Senior Leadership Team

S31 Governance Actions complete

Date	Actions completed
13 June 2024 1pm	Feedback from CQC (approach and first report)
14 June 2024	QIG 3 (Presentation)
20 June 2024 – 1-3pm	Maternity Governance deep dive – clinical incident reporting (PSIRF implementation)
20 June 2024 3-4pm	Feedback from CQC (post QIG)
14 June 2024	Bronze QI straining session 2 – bronze complete
17 June 2024	Freedom to Speak Up Guardian walkabout complete
28 June 2024	QIG 4 (Report)
28 June 2024	Next CQC summary Report (monthly thereafter)

S31 Governance Actions complete

What	By who	By when
Daily MDT review of incidences commenced (update on next slide)	Maternity Governance Team	Complete
New process around learning from incidences commenced	Maternity Governance Team	Complete
Facilitated co-design governance workshop - QI within a Quality Management System (QMS) - Deep dive into clinical effectiveness and audit function within maternity (ward to Board) using VTE as a worked example - Review of **maternity priorities** within the Maternity Transformation Programme STOP, START, CONTINUE	Senior leaders	Completed 7 June 2024

S31 Governance Actions complete

What	By who	By when
Facilitated **co-design** governance workshop - Deep dive into safety (ward to Board/ internal/external reporting) using PPH/MOH as a worked example - Continue review of maternity priorities within the Maternity Transformation Programme	Medical Director Senior Maternity Leadership Team (LMNS ICB)	Complete 20 June 2024
- Feedback (QIG and S31 Report) to Quality and Performance Committee (sub board)	Chief Nurse	26 June 2024
- MDT review of incidences now 3 times per week with planned review in Autumn	SD/DoM	1 Sep 2024
- Governance architecture meeting held	MIA/Corporate Gov/CN/DOM/CoS/Quality	24 June 2024
- Deputy Chief Nurse and Director of Corp Governance now attend MDG	Dep CN / DCG	12 June 2024

Next steps for Governance July 2024

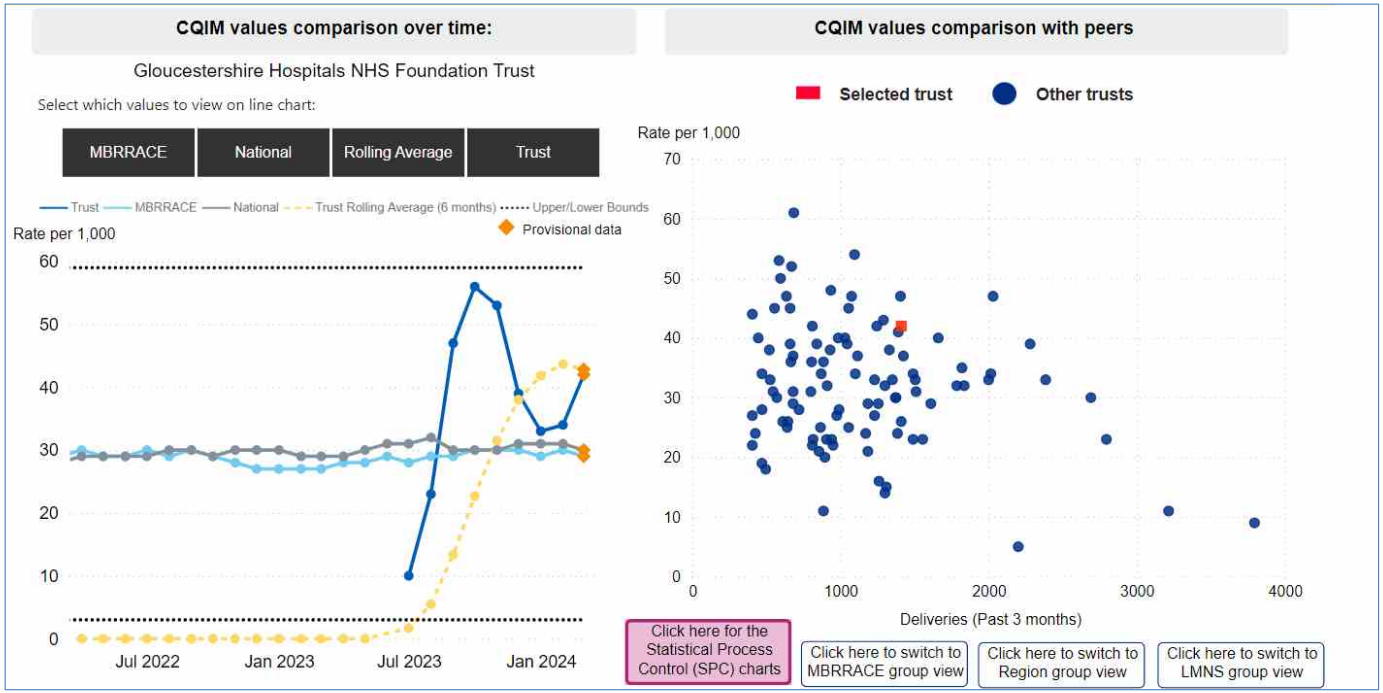
Date	Actions
28 June 2024	Present to QIG
28 June 2024	Report to CQC
11 July 2024	Trust Board of Directors
12 July 2024 9-11:30	Maternity Governance deep dive – PPH/ MOH (continued) Presentation on Maternity PSIRF by DoM/Perinatal Gov Lead/Obs Gov lead to Trust & LMNS
12 July – 6 Dec 2-4pm	Silver QI training commences (monthly sessions) Last hour is feedback session with Executives and Maternity Senior Leadership Team (4-5pm)
July – Dec 2024	Continue fortnightly QI huddles to hear progress, escalations and to review trends in data
12 July 2024	QIG 5 (presentation)
6 December 2024	Silver QI graduation (all QIG members to be invited)

Reducing the rates of postpartum haemorrhage

Team PPH

Clemmie Skilton – Education and Training Lead
Victoria Cordell – Consultant Obstetrician
Rachael Harris - Matron
Jo Collins – Anaesthetist

PPH > 1.5L National data



Data extracted from national maternity dashboard (11th June 2024).

Latest data is provisional for March 2024.

GHNHSFT have been submitting data nationally following implementation of Maternity EPR (BadgerNet). Prior to BadgerNet go-live in June 2023 data was not submitted.

There are currently 10 data points, these are mapped on the left chart along with a rolling 6 month average. National and MBRACE group comparators are presented as 3 year trends.

Right hand graph shows correlation between number of deliveries in the last three months and the rate of PPH at all trusts nationally.

This shows a rate of 42 per 1,000 deliveries (red square).

Following receipt of the S31 letter, the Maternity team have been conducting a review of PPH data submitted national. There are some variations in definitions which are being explored by GHFTs BI and data management teams.

Trust PPH data

Data extracted from GHNHSFT Maternal Morbidity & Mortality dashboard (11th June 2024).

Latest data is for May 2024.

Data for last 12 months is now viewable on the GHNHSFT Maternal Morbidity and Mortality dashboard. Data for PPH has been broken down into the following categories to support the on-going QI project:

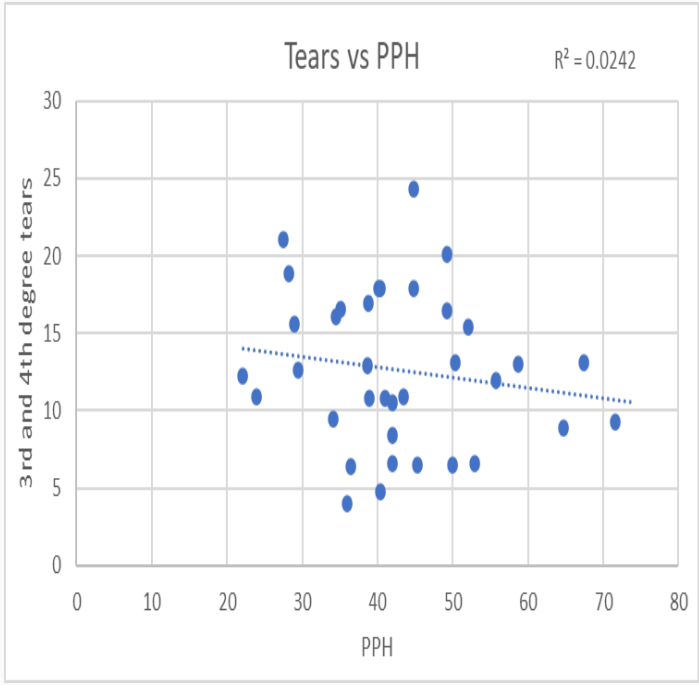
- PPH 500-1000ml (top left)
- PPH 100-1500ml (top right)
- PPH 1500ml+ (bottom left)
- PPH 3000ml+ (bottom right)

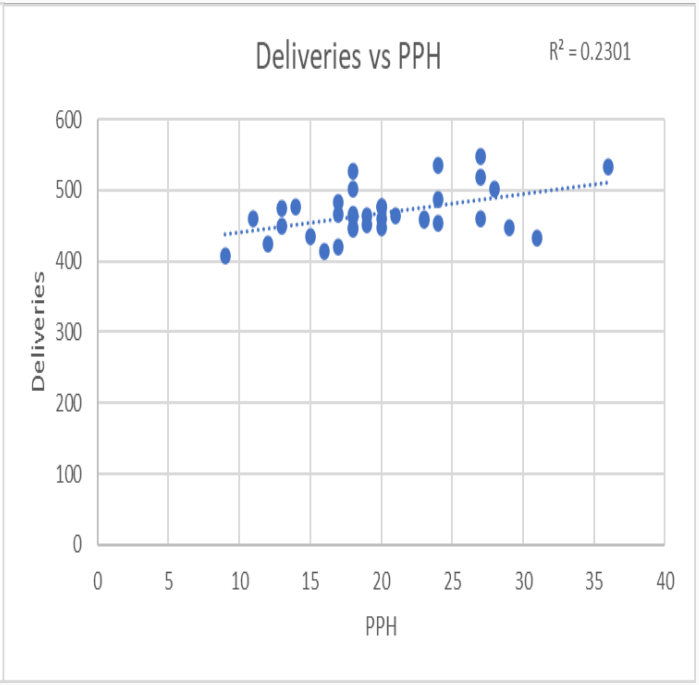
All are expressed as rates per 1,000 deliveries to allow for greater comparison with national and peer group benchmarks.

SPC charts enable the service to track trends in data. The data is live within our BI reporting hub and includes additional functionality.

PPH Trust data

- Impact of 3rd/4th degree tears as a risk indicator for PPH there is no statistical association between PPH and 3rd/4th degree tear





PPH risk assessments compliance

- PPH Risk assessment: Improving compliance on Badgernet PPH Risk Assessment tools
- Risk assessment should be completed for all women:
  - By community midwives:
    - at booking and
    - 36 weeks (this will facilitate place of birth discussions)
  - By triage/ ward staff:
    - On admission
  - By CDS team:
    - currently at onset of labour - this assessment will be changing soon

NOTE: This data is not available from Badgernet and needs to be manually audited and the plan for this is to audit after implementation of Reduce checklist (OBS Cymru)

Actions taken

What	By who	By when
9 May 2024 CQC S31 letter requesting response	Senior Leadership Team	Complete – iterative plan developed
13 2024 May QI Teams formed	Senior Leadership Team	Complete
Team PPH formed and QI plan on a page developed	Team PPH	16 May 2024
Bronze QI training for team members	Team PPH	7 June session 1 complete 14 June session 2 complete
Review case notes with NHSE MIA Team (PPH sprint)	Team PPH	Completed 10 June 2024
Write training package for trolley teaching	Team PPH	For launch 18 June 2024. Teaching started as planned 18 June. 12-2 daily.
Launch Carbetocin drug at CS	Team PPH	18 June 2024 started

Actions taken

What	By who	By when
Prepare to implement OBS Cymru checklist (policy changes, SOPs, digital system updates)	Team PPH	For launch 1 July 2024
Communications to staff	Team PPH	Ongoing
Understand data - monthly review	Team PPH	Ongoing
Completion of Risk Assessment for PPH checked at ward round twice daily	Delivery Suite Consultant	Ongoing
Implement teaching for Carbetocin for launch 18 June	Team PPH	Completed 12 June 2024
Registrar teaching	Team PPH	Circulated 21 June 2024
Create PPH champion Team	Team PPH	Completed 10 June 2024
Present QI progress at Labour Ward Forum	Team PPH	Completed 14 June 2024
Create SOP for OBS Cymru for launch 1 July 2024	Team PPH	Completed 12 June 2024

Actions taken

What	By who	By when
Launch Carbetocin use at CS and then monitor rates	Team PPH	18 June 2024 launched
Daily trolley teaching for checklist sessions start (9/10 sessions, 85 staff to date)	Team PPH	Commenced 18 June
OBS Cymru checklist prepare for launch 1 July 2024	Team PPH	1 July 2024 written and MDT reviewed
Implementing PSIRF Methodology for Clinical incident reporting (swarm, after action review, cluster review)	Team PPH	Continue
Maternity Governance Training Session Patient Safety Incident Response Framework (PSIRF) in Maternity facilitated by Dr Charlie Candish Associate Medical Director (Safety) and Associate Director of Safety Investigation and Family Support Medial Director and Director for Safety	Senior Leadership Team and Team PPH (LMNS and ICB colleagues)	20 June 2024
Meeting with Lead for Obs Cymru regarding plan, including paper tool v digital entry	Team PPH Obs MIA	26 June 2024
MNVP linking with Team PPH on a Facebook live session	MNVP Chair/Team PPH	July 2024
Cluster review of cases completed with report submitted. Recommendations actioned	Team PPH/DOM/SD	26 June 2024

Next steps

What	By who	By when
Deliver QI communications plan	Team PPH with Comms specialist	Continue
OBS Cymru (REDUCE) checklist launch 1 July 2024	Team PPH	1 July 2024
PSIRF Methodology for Clinical incident reporting being implemented (swarm/hot debrief, cold debrief/ after action review, cluster reviews)	Team PPH	Continue
Maternity Governance Training Session (2nd Session) Patient Safety Incident Response Framework (PSIRF) in Maternity facilitated by Dr Charlie Candish Associate Medical Director (Safety) and Associate Director of Safety Investigation and Family Support	Senior Leadership Team and Team PPH (LMNS and ICB colleagues)	12 July 2024
Recommendations from meeting with Obs Cymru team to be presented at next Badgernet Clinical Design Authority meeting	DoM	16 July 2024
Recommendation from PPH cluster review: monthly reviews (3 per month) to prospectively identify themes after the REDUCE changes have been implemented	Team PPH/Maternity Governance	July 2024

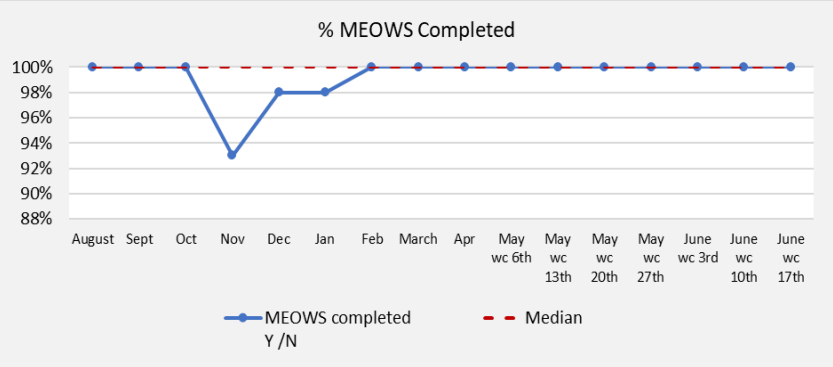
Modified Obstetric Early Warning System (MOEWS)

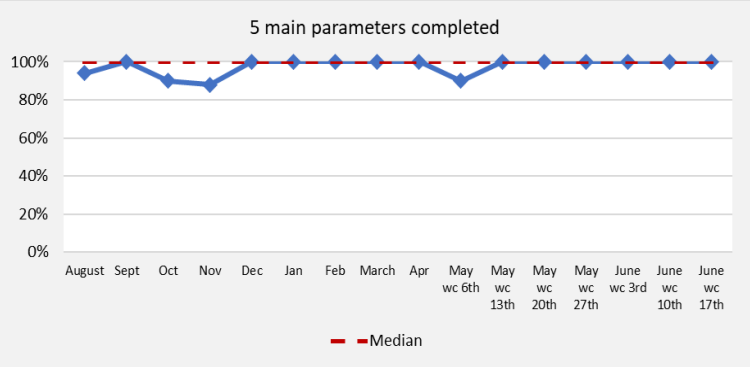
Team MOEWS

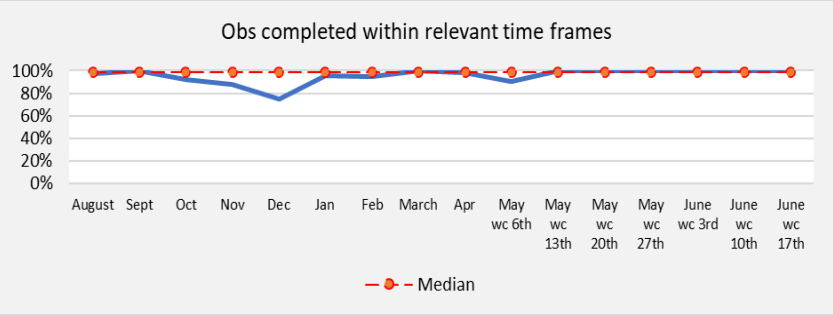
Sharan Athwal– Consultant Obstetrician
Kat Lilly- Matron

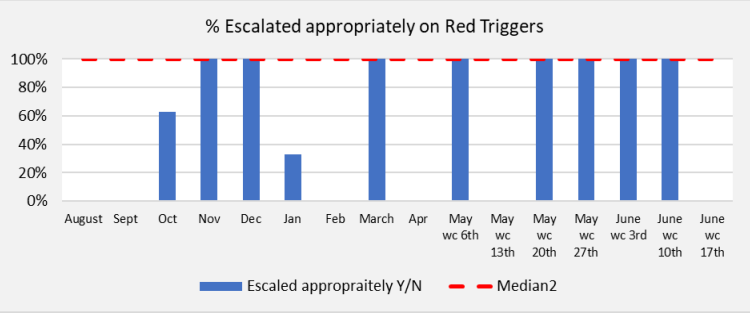
MOEWS data

Maternity Ward MOEWS data included up to 23 June 2024





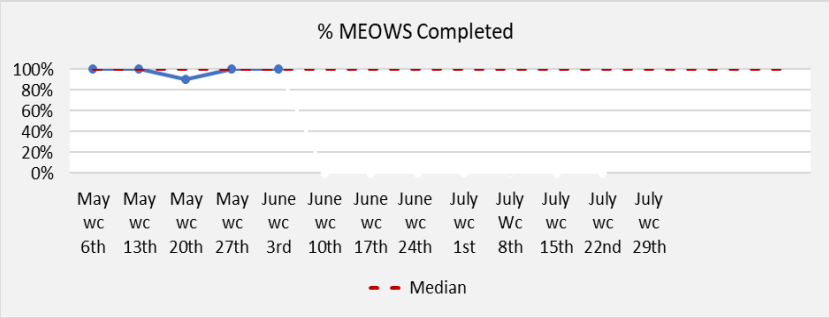


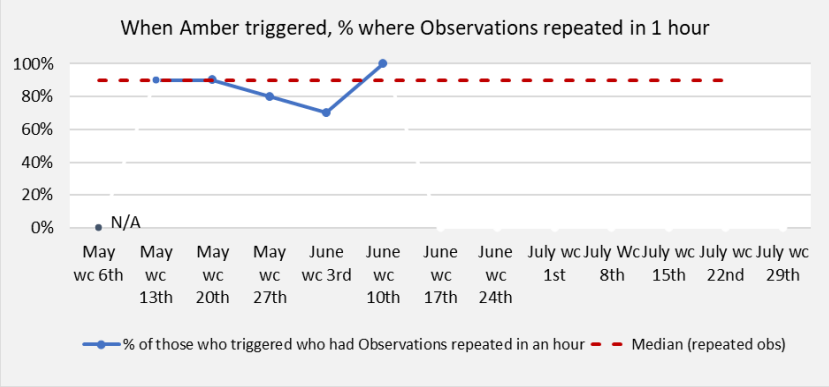


MOEWS – Display Boards

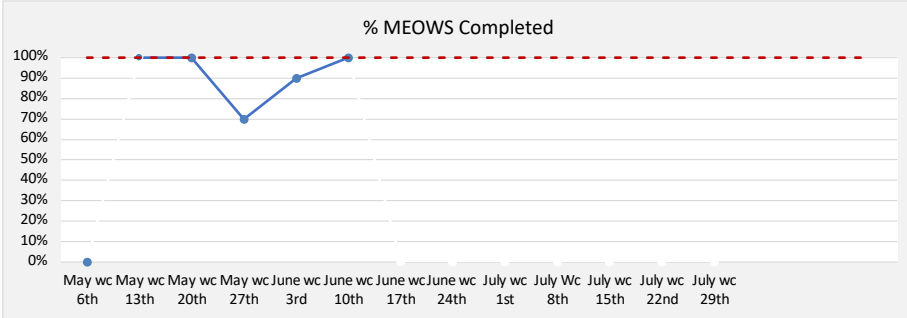
MOEWS data (June 2024 data being collated)

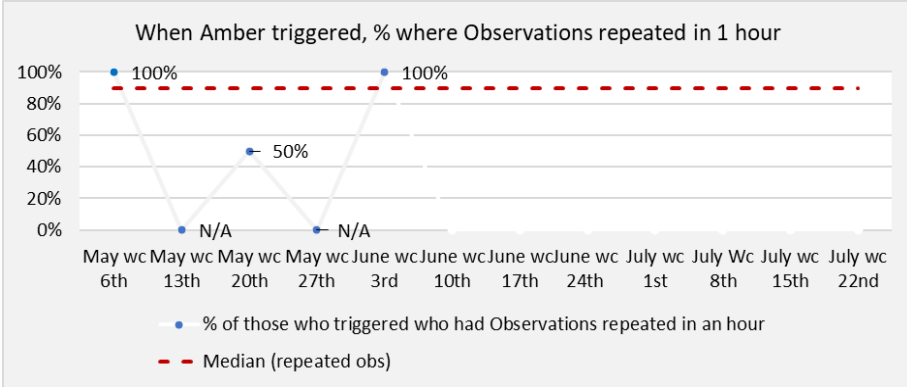
Delivery Suite MOEWS





Birth Unit MOEWS





Actions taken

What	By who	By when
MOEWS display board up and discussed daily	Team MOEWS	Complete 7 June
Continue to audit act on amber compliance with all colleagues involved	Team MOEWS	Continue until compliance 95%
Visual prompts displayed on computers	Team MOEWS	Complete reminders on computers
Education from PD, CIPP, PROMPT	Team MOEWS	Complete as part of Maternity Training
Team talk	Team MOEWS	Complete as updates daily
Celebrate compliance	Team MOEWS	Complete
Check national roll out MEWs	Team MOEWS	Complete (roll out 2026)

Next steps

What	By who	By when
Deliver QI communications plan	Team MOEWS with Comms specialist	Continue
Trolley Teach to commence	Team MOEWS	1st July 2024
Deeper dive into intrapartum data (to be completed by leads in the next 2 weeks).	Team MOEWS	30 June 2024
Discuss implementation of Martha's Rule for maternity service (Trust have obtained NHSE pilot monies)	Team MOEWS	1st July 2024
Continue with current weekly audits (June data to be available early July to be presented by leads at next QI meeting after 12 July 2024)	Team MOEWS	12 July 2024

Fetal monitoring – peer reviews, interpretation and escalation of CTGs

Team Fetal Monitoring

Rebecca Evans Jones - Consultant Obstetrician
Rachael Harris – Matron
Sasha Wainfur – B7 FM Lead

Actions taken

What	By who	By when
Review Trust processes for MNSI (MI-033153) case and learning disseminated	Associate Director of Safety Investigations and Family Support	Complete Case received 10 March, MDT action plan developed, update on progress and assurance at SERG on 6 June 2024
Present MNSI case action plan to the Trust Safety and Experience Review Group (SERG) 6 June 2024	Patient Safety Team	Complete
Review of HSIB cases to identify any issues with fetal monitoring effectiveness	Team Fetal Monitoring	5 Cases completed 21st June 2024

Actions taken

What	By who	By when
Improvements to the audit inclusion criteria and audit tool	Fetal Monitoring Team	New audit complete from midwifery perspective awaiting further Consultant input
Improve fetal monitoring team representation at key meetings	Team Fetal Monitoring	Complete (consultant or midwife)
CTG audit data reviewed with Consultant Lead	Team Fetal Monitoring	Partial - needs 2nd meeting

Antenatal and Intrapartum Peer Review

A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigge r to provide a holistic review earlier (SBLCB v3, 2023)

CARES	
Care of Woman	Coping/Mobility/Fluid Balance/Nutrition/Bladder care
Analgesia	Woman confirms current method is effective and/or happy to continue
Review	Partogram review/Progress/MEOWS/Contractions– effectiveness and frequency/Liquor colour/Ability to perform IA/Woman understands plan of care and happy to continue
Escalation	Concerns identified/Deviations from normality or original plan of care
Staff Wellbeing	Break/Any concerns/Up-to-date documentation/Support

Actions taken

What	By who	By when
Disseminate learning in a timely fashion through: • Attendance at national network • Annual mandatory fetal monitoring training day and competency assessment. • Lunchtime learning • Individual learning (one to one's) • Team talk • Words of the week, • PDM social media group - Ad hoc teaching on shift - Newsletters to include fetal monitoring updates. - Bitesize training sessions on relevant topics identified from learning trends and staff feedback such as antenatal and computerised CTG's.	Team Fetal Monitoring	Continuous

Next steps

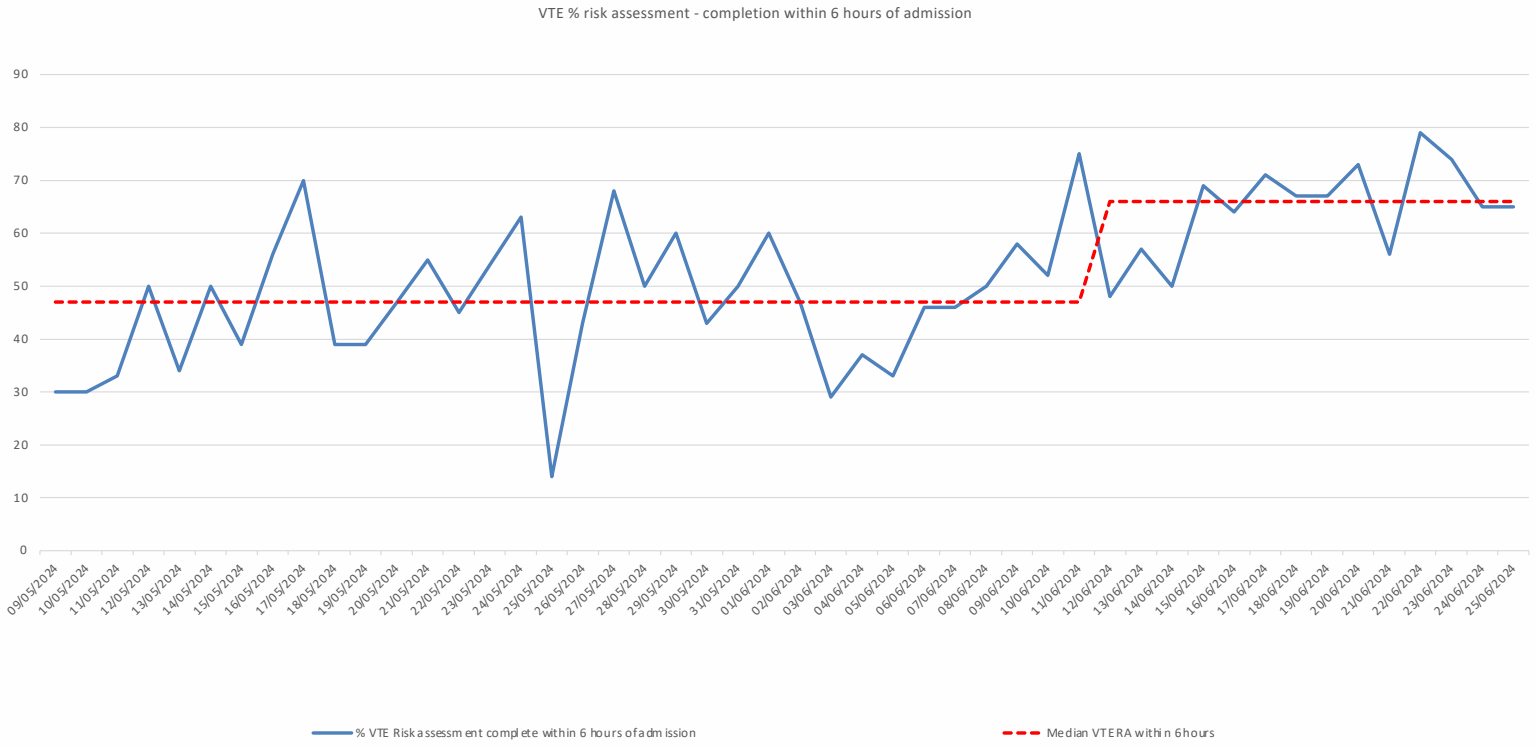
What	By who	By when
Deliver QI communications and learning plan	Team Fetal Monitoring	Continue
New lead being progressed to complete audit	SD/DoM	8th July 2024
Individual learning for cases shared – Midwifery and Obstetric	Team Fetal Monitoring	1 July 2024
Audit actions identified after MDT meeting – individual & team learning, Birth Centre IA champions, Posters	Team Fetal Monitoring	21 June 2024
Importance of documenting cord gases and agreeing Apgar scores with neonatal Team (adding to Team Talk)	Team Fetal Monitoring	8th July 2024
Produce LASER for specific case (oxytocin 2nd stage)	Fetal Monitoring Consultant	8th July 2024
Improving the hourly reviews to (within 10 min of the hour)	Fetal Monitoring Midwife	1st July 2024
Fetal Monitoring lead to link with IOW lead re Badger audit of Fresh Eyes	Fetal Monitoring Midwife	6th July 2024
Review Agency Midwife local training regarding Fetal Monitoring	Fetal Monitoring Midwife	13th July 2024
Lead rapid IA audit in Birth Centers	Consultant Midwife	24th July 2024

Reducing the risk of venous thromboembolism

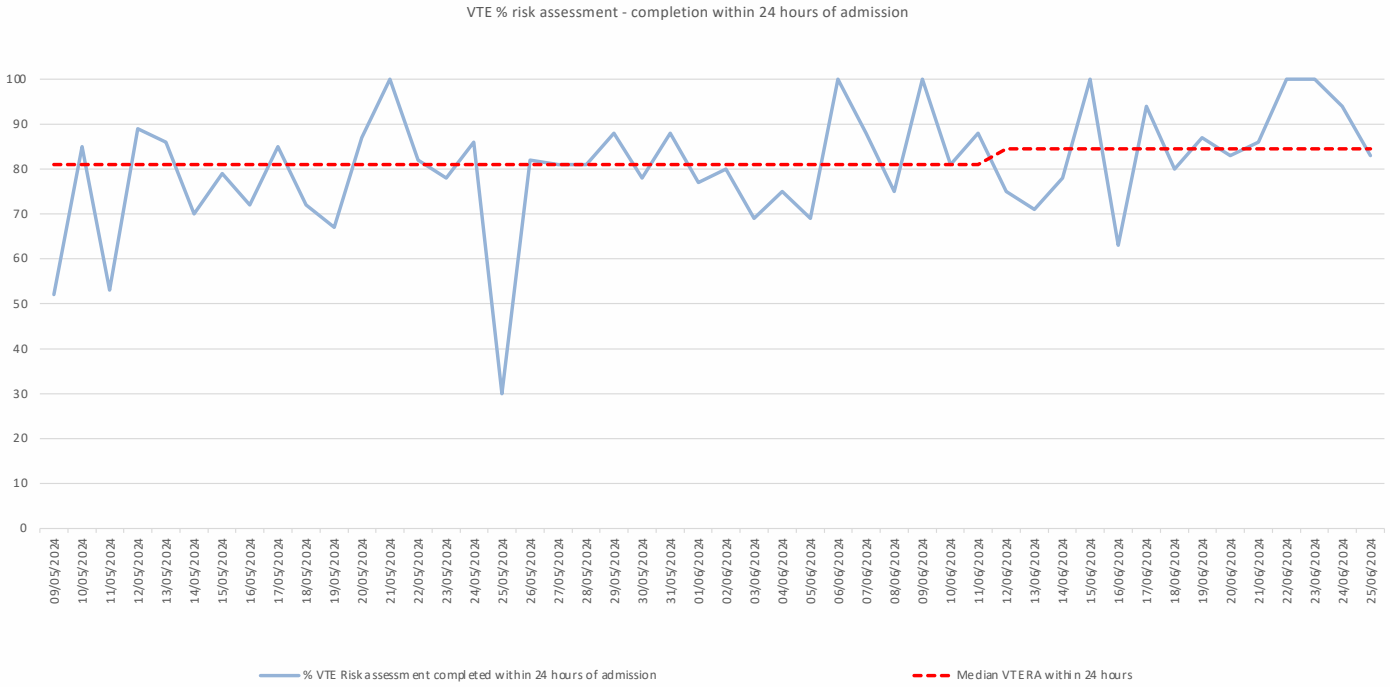
Team VTE

Jothi Doraiswamy– Consultant Obstetrician
Trine Jorgensen - Matron

VTE data (within 6 hours)



VTE data (24 hours)



‘Think VTE’ – in clinical areas

Actions taken

What	By who	By when
Audit complete	Team VTE	Completed
Review Badgernet documentation	Team VTE	Completed
Request changes to BadgerNet	Team VTE	Completed
Learning on completion of risk assessment has been sent to PDM for dissemination. Reminder to complete and escalate if at risk.	Team VTE	Completed
Completion of Risk Assessment for VTE checked at ward round twice daily	Delivery Suite Consultants	Ongoing
Attend Bronze QI training (Bronze 2)	Team VTE	Complete
Practice Development to do micro teach	PDM	13th June

Next steps

What	By who	By when
Deliver QI communications plan	Team VTE with Comms specialist	Continue
Deliver improvement actions in response to audit - Midwives to complete risk assessments and flag - Medical staff to prescribe thromboprophylaxis	Team VTE	Review 1 July
Review further diagnostic data for DVT and thrombosis with Business Information	Team VTE	1 July
Continue with learning feedback loops with colleagues	Team VTE	Continue
Attendance at next Trust VTE Improvement Group (Led by Trust Medical Director)	Team VTE	July 2024
Review EPR function on patient admission	Perinatal Quad	July 2024
Complete Audit on compliance with treatment options post VTE Risk Assessment	Team VTE	27 July 2024

Agency Midwives

Team Agency

Joanne Cowan– Head of Midwifery
Rowan Roberts – Workforce PMO

Actions taken

What	By who	By when
The **induction** pack has been reviewed and is being handed out.	Agency Improvement Team	Complete
The checklist has been developed to make sure that the Flow Midwife meets with every Agency Midwife to assure they have access required and do a “meet and greet” to ensure that they feel **supported**.	Agency Improvement Team	Complete
Access Cards will now be provided (see next steps)	Agency Improvement Team	Complete
Access to digital systems has improved (BadgerNet)	Agency Improvement Team	Complete

Actions taken

What	By who	By when
Survey handed out for Agency Staff	Agency Improvement Team	Complete
Weekly review of **clinical incidents** that relate to Agency Staff for May 2024 reported by exception within staffing report at MDG (and will be completed monthly)	Agency Improvement Team	Complete
Escalate Access cards for Executive decision	Agency Improvement Team	1 July 2024

Next steps

What	By who	By when
Audit Flow Midwife checklists are being completed and compliance will be audited last week in June 2024	Agency Improvement Team	30 June 2024
Access to digital systems Blood tests request made to EPR digital team Policies – advice from Trust Policy Group (TPAG)	Agency Improvement Team	1 July 2024
Access swipe cards made available to every agency midwife on a shift by shift basis	Flow midwife	28 July 2024

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Thank you

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Report to Board of Directors meeting in Public			
Agenda item:	**10**	**Enclosure Number:**	
Date	11 July 2024		
Title	Midwifery, Maternity and Neonatal Staffing Report Q4 January 24 – March 24		
Author /Sponsoring Director/Presenter	Lisa Stephens- Director of Midwifery / Matt Holdaway – Chief Nurse and Director of Quality		

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

Summary of Report

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. The report covers the period January to March 2024.

During the quarter:

- Appraisal rates have improved from 65% to 72% at the end of the quarter but remain below the target. Working with the Divisional organisational development lead to improve appraisal rates continue

Midwifery

- Midwifery Staffing challenges continue. Initiatives to enhance recruitment and retention continue to be actioned
- The vacancy rate has fallen slightly to 24.26 WTE (9.83%), however there is a combined high shortage rate of 51.15 WTE at the end of Q4
- There were no occasions when supernumery status of the co-ordinator was reported to be compromised.
- One- to-one care in labour has improved to 99% with an ongoing action plan.
- An extensive midwifery staffing plan for 2023/24 has continued and is progressing with notable achievements.
- Staff red flags show persistent delays with Induction of labours and Elective Caesarion Sections
- The forthcoming Trust change uplift Band 2 Maternity Care Assistants to Band 3 requires a programme to upskill. Band 3 upskilled Maternity Support Workers can offset the midwifery establishment 90/10

Obstetrics

- 3 new obstetric consultants have been appointed and will join the team in April, June and September.
- This will enable a complete split of the gynae and obstetric on-call rota so that there will always be an obstetric and a gynaecology consultant available.
- The increase in obstetric workforce will also enable more of the SPA roles to be undertaken so job planning is currently underway and will inform remaining shortfalls in the obstetric team.
- Junior doctor industrial action has had a significant impact. However, all obstetric sessions, including planned caesarean section lists, antenatal clinics, fetal medicine and preterm birth clinics, have been staffed.
- The findings of the Roles and Responsibilities of the consultant obstetrician audit show an improvement with the many challenges with collecting audit data
- The consultant was present in 90% of situations where they MUST attend; the remaining 2 situations were mitigated for.
- There is documented compliance in 100% of 'should attend' situations, and a significant number where presence was not mandated but the consultant attended anyway
- The trust have not been able to demonstrate compliance for long term locums onboarding process. This has now been updated via a new onboarding tool and will be monitored

Neonatal and anaesthetic

- The Neonatal unit continues to be challenged around neonatal nurse staffing and therefore not compliant with BAPM standards. A plan is being actioned with zero red rated items.
- Neonatal medical staffing and anaesthetic availability remain stable.

Risks or Concerns

- Midwifery staffing remains on the risk register due to:
  - Workforce vacancies and turnover rate
  - Low morale associated with poor staffing levels
  - Level and pace of change
  - Not achieving 100% compliance with 1:1 care in labour – there is an ongoing action plan in place that has trust sign off.
  - Community on-call utilisation for escalation.
- The increased workload in both obstetrics and gynaecology has made it untenable for one consultant to be responsible for both services.
- Neonatal nursing staffing not achieving BAPM standards.

Recommendation

- Note the ongoing workforce risks particularly in midwifery, obstetrics and neonatal nursing.
- Note the ongoing improvements and progress against action plans.

Enclosures

- Midwifery and maternity staffing report Q4 July 2024

QUARTERLY MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT

Quarter 4 2023/24

QUALITY AND PERFORMANCE COMMITTEE – 26 June 2024

BOARD – 12 July 2024

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 March 2024 (quarter 4). Our focus is to ensure women, babies and their families receive the maternity care they need, including care in all:

- maternity services (for example, 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 Incentive Scheme (MIS), a separate paper is now provided which also includes staffing data on other key staffing groups, obstetricians, and anaesthetics.

2.4 Midwifery Staffing expectations include the following:

- Deliver all 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 one-to-one care by a midwife
- 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 23.5-36.85 whole time equivalents (WTE). The vacancy rate in March 2024 was 9.83 %. Absence related to sickness and maternity leave rates remains high, with variation in temporary fill. Midwifery staffing remains on the **Trust Risk Register** with a score of 20 for safety. Controls are in place to mitigate the risk and a staffing improvement plan is being enacted with oversight of the plan at the Executive led Maternity Delivery Group (MDG) supported by the Deputy Director of Quality.

3.4 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. A review of the uplift for midwives is under review with the Local Neonatal and Maternity System.

3.5 An extensive midwifery staffing plan for 2023/24 has continued and is progressing with **notable achievements** of:

- Establishment and commencement of full senior midwifery leadership team Band 8s - July 2023
- Recruited to substantive Director of Midwifery (DoM) post in this quarter
- Recruitment for other senior roles based on Maternity Incentive Scheme Action Plan for year 3 & 4 has been progressed with an Education and Training Midwife (8A) as well as the Perinatal Quality & Governance Lead (8B) appointed. Appointments for the Patient Safety Midwives' roles have also been made (Band 7s) with two Band 6 roles advertised currently
- Incentivised shifts continued and waiting approval for summer months
- Introduction of retire and return scheme with no on call commitment
- Staff listening and update events held routinely each month
- Ten International recruitment midwives recruited (5 working clinically, 3 awaiting PIN and 2 in training)
- Increased uptake of Registered Nurses additionally to those contracted on both Maternity Ward and on Delivery Suite
- 33 new midwifery starters since September.
- Celebration of International Day of the Midwife Friday 3 May 2024 which was received positively by staff.
- Series of podcasts produced and will be available on Maternity Intranet Pages
- On call consultation being planned. Other models also being explored DoM/ Head of Midwifery (HoM)
- Commencement of long-line agency midwife, currently finding work positive and enjoying her shifts.

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
- Not achieving 100% compliance with 1:1 care in labour – there is an ongoing action plan in place that has trust sign off- currently 99% this quarter
- Community on-call utilisation for escalation.

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 against staffing establishment.

4.2 This review recommended a birth to midwife ratio of 1:24.4 births across the Trust, (1 midwife: 24.4 births across the acute and community service).

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. This will be changing with the upcoming Trust change for all band 2 Heath Care and Maternity Care Support Workers to be uplifted from a band 2 to band 3. This change is planned for quarter 1, 24/25. Only Band 3 Maternity Support Workers can offset the midwifery establishment with a 90/10 for postnatal skill mix. A programme to support upskill for MCA's has commenced.

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. This has been reviewed, and a provisional plan made for opening with the newbuild in the Autumn 2024 – this plan remains under review at present regarding a potential new build / refurbishment of current facilities. Postnatal beds at Stroud remain closed temporarily however the midwifery lead unit remains open to birthing people 24 hours a day.

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 March 2024 there was combined **51.55 WTE** shortage of midwifery staff due to vacancies, maternity leave, and sickness absence, a slight increase from December at 49.22 WTE.

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

Month	**May 2023**	**Jun 2023**	**July 2023**	**Aug 2023**	**Sept 2023**	**Oct 2023**
Combined shortfall (WTE)	56.44	57.81	63.57	62.38	52.25	51.34
	Nov 2023	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 2024**	**Apr 2024**
	52.2	49.22	54.34	61.52	51.15	55.19

5.4 The **vacancy of 24.26 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.

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 and recent Care Quality Commission ratings as inadequate. This emphasis on robust midwifery leadership will continue to support the Maternity Improvement plan.

5.5 The table below is a breakdown of the various managerial and specialist midwives' total. The in-post total exceeds funded establishment as there has been significant external funding sought with fixed term posts for specialist posts arising from drivers such as Ockendon, Maternity Incentive Scheme and local and national Maternity Improvement programmes.

Table: Managerial and Specialist Posts (WTE) Source: ESR

	Band	Funded establishment				WTE in Post			
		June 23	Sep 23	Dec 23	Mar 24	Jun 23	Sep 23	Dec 23	Mar 24
Managerial Position	8/9	9.2	9.2	9.2	9.2	10.2	10.2	10.2	10.2
Specialist Midwives	6/7	17.07	17.67	21.86	25.24	20.35	25.32	27.2	25.82

Table: Combined Funded midwifery establishment March 24 (Source: ESR)

		Funded Establishment			WTE in post		
	Band	**Sep 23**	**Dec 23**	**Mar 24**	**Sep 23**	**Dec 23**	**Mar 24**
Team Leaders	7	20.34	22.98	25.68	24.8	28.84	29.44
Clinical Midwives	5/6	223.79	223.79	221.09	195.83	198.57	193.07
Total		**244.13**	**246,77**	**246.77**	**220.13**	**227.41**	**222.51**

5.6 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.

Table: Managerial and Specialist establishment by post March 24 (Source: ESR)

		Funded			WTE in post		
Role	**Band**	**Sep 23**	**Dec 23**	**Mar 24**	**Sep 23**	**Dec 23**	**Mar 24**
Director of Midwifery	9	1.0	1.0	1.0	1.0	1.0	1.0
Head of Midwifery	8C	1.0	1.0	1.0	1.0	1.0	1.0
Deputy Head of Midwifery *(Interim)*	8B	0	0	0.8	0	0	0.8
Consultant Midwife	8B	0.6	0.6	0.6	0.6	0.6	0.6
Lead Midwife (Healthy Lifestyles & TDD)	8A	0.6	0.6	0.6	0.6	0.6	0.6
Midwifery Matrons	8A	5.2	5.2	5.2	5.2	5.2	5.2
Safeguarding Midwife	8A	0.8	0.8	0.8	0.8	0.8	0.8
Governance Lead	8A	1.0	1.0	1.0	1.0	1.0	1.0
Specialist Midwives	6/7	17.07*	17.67	21.86	20.35	25.32	27.2
	Total	27.27	27.87	32.86	30.55	35.52	38.2

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 December 2023 and April 24. The extended incentives within service budget included – Enhanced Bank pay rate Temporary Standby rotas for unsocial hours, and a Golden Welcome (not this one) 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 24.26 WTE (March 2024) vacancies in the clinical workforce funded establishment.

6.4 A regular Band 5/6 advert has seen significant interest with the 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 offer support.

6.5 In the period, Jan – March 2024 10 new Midwives have joined the trust.

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

Month	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Starter number	3	0	1	2	0	15
	Oct 23	**Nov 23**	**Dec 23**	**Jan 23**	**Feb 24**	**Mar 24**
	0	3	1	4	0	6

6.6 Higher than average levels of turnover and slow recruitment over Q1 and into Q2 led to the high vacancy rate, however this has slightly fallen by the end of Q3.

7 Turnover, absence and sickness

7.1 Currently there are 51.15 WTE (Mar 24) shortage of midwifery staff due to turnover, maternity leave, and sickness absence.

Table 8: Staffing absence and secondment Jan-Mar 24 (Source: Health-Roster)

Month/Yr	WTE			
	Sickness	Maternity Leave	Vacancy	Total
Jan 24	17.42	13.66	23.26	54.34
Feb 24	17.37	13.77	30.38	61.52
Mar 24	4.88	12.02	24.26	51.15

7.2 It is notable that the peak associated with absence in March 2022 was a

combined rate of 77.82 WTE, one year later, the same combination fell to 53.69 in March 2023. The same reduction was not seen in 23/4, however vacancy rates, sickness and maternity leave are starting to settle with some small fluctuation with combined absence now 51.15 WTE (March 24).

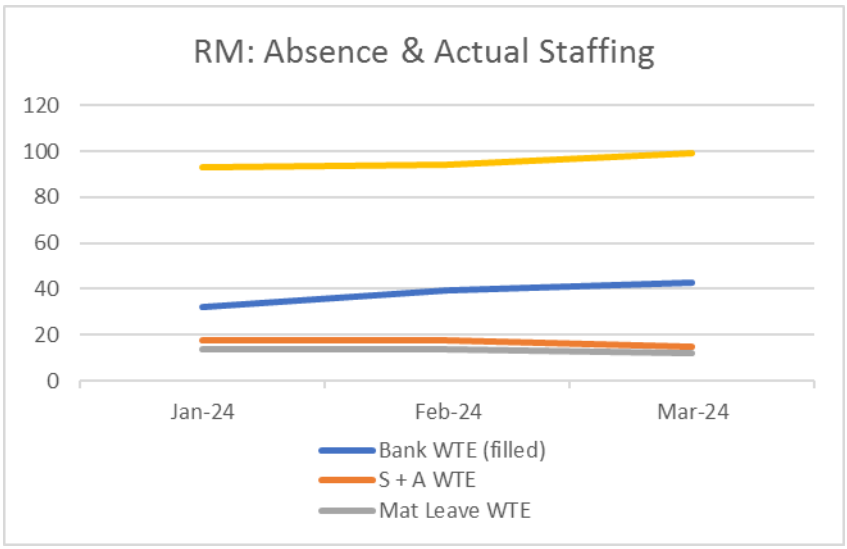
7.3 Temporary staffing fill has included both agency and bank. Whilst fill rate has varied between 31.9 and 43 WTE, it has enhanced safer staffing. This is based on improvements in 1:1 care, feedback from staff, and daily assessment at the flow and quality call

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 now in place with more posts being advertised.

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

7.6 Eight HEE funded places have been acquired for March 2024 and communication about recruitment to these places are in progress. Currently five RN's are in post on fixed term contracts on maternity ward with another 1.0 going out for a recovery nurse on Central Delivery Suite.

Graph – Midwifery Absence and Fill rates Jan -Mar 24 (Source R&R database)



7.7 In response to the poor staffing rates, actions within the service have previously included closure or reconfiguration of elements of the maternity service. This has improved throughout Q4 with no full-service closures required, but occasional relocation of the GBU has continued albeit much less frequently.

8.0 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.

8.3 The Band 7 Flow and Quality Midwife role is now embedded. This 'helicopter view' is essential for overall assessment of the acuity and to support staff redeployment when required 24/7. This Band 7 midwife supports the 'Band 8 of the day' and Delivery Suite co-ordinator to manage flow associated with staffing and activity throughout the service in and out of hours.

8.4 The Band 7 Flow & Quality midwife is supported 24 hours a day, 7 days a week either by the "Band 8 of the day" or the Senior Midwife on call. They are 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 CDS team are recruited to, however current scoping is underway to establish where funding lies for each post, with the intention to develop a band 7 CDS ward manager post from existing vacancy.

9.0 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 has been developed and is monitored.

9.4 The Midwifery Workforce Improvement plan was reviewed and expanded in July 2023 resulting in a total of 49 actions with progress against them as below:

Workforce Action plan	March 2023	July 2023	Dec 2023	March 2024
Closed	3	23	32	33
Overdue	1	6	1	0
In Progress	15	7	1	0
Complete	7	12	16	16
Total number of elements	**26**	**48**	**48**	**49**

9.5 Significant progress has been notable around preceptorship programme, midwifery landing internet page, regular Infographic updates to staff, leaver and stay data.

9.6 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 the form of a daily (Mon-Fri) Flow and Quality touchpoint call. 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 of labour huddles support clinical decision making for the team when faced with high levels of acuity.

10.0 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.

10.01 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. This remains an ongoing issue, and has been escalated through to the Quadrumvirate.

Table – All staff Mandatory Training Compliance Jan – March 2024 Source: Education

Mandatory Day	Overall Compliance		
	Jan	**Feb**	**March**
Maternity Mandatory Day (Midwives & MCA's Only)	89%	85%	84%
PROMPT Part 1 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	96%	92%	91%
PROMPT Part 2 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	86%	79%	83%
Fetal Monitoring (Midwives & Obstetricians)	96%	89%	86%

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

10.3 Appraisal rates, are a CQC 'must do '. A plan was put in place with additional

Table: Appraisal Compliance rates Oct 23 -March 24 Source: OD team

Month	Appraisal compliance %
Oct 23	66%
Nov 23	63%
Dec 23	65%
Jan 24	69%

Feb 24	70%
March 24	72%

The progress in completion rates for maternity has increased over the past 6 months and although this progress has been slow teams are continuing to prioritise appraisals despite heavy workloads and staff vacancies.

10.4 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 have completed 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

11.0 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 however summer staffing saw a decline as low as 84%. This is monitored on a daily basis and staff are redeployed across the service based on activity and the acuity.

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

Table: Maternity Service Fill rate (Day/Night) Source: Health Roster

	Day qualified %	**Night qualified %**
Jan 24	87%	97%

Feb 24	97%	94%
Mar 24	89%	99%

11.2 Fill rates have started to stabilise at more sustainable levels. The fluctuations in this quarter have been for several reasons, including school and public holidays, 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 has improved these.

11.3 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.

12.0 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: 1 WTE to 24.4 births

Table: Midwife to Birth ratio

Month	Midwife to Birth Ratio
Jan 24	1:25
Feb 24	1:26
Mar 24	1:26

13.0 Specialist Midwives

13.1 Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. The current percentage for GHNHSFT is calculated to be 9.35.

13.2 Some new posts have been recruited to following the BR+ review and there are additional posts that are being recruited to following MiS and additional fundings allocated such as LMNS.

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

- Perinatal Mental Health Team
- Vulnerable Women's Team
- Safeguarding Team
- 2 Patient Safety Midwives
- Recruitment and Retention Midwife
- Digital Midwife – this team expanded for support with new EPR
- Screening Midwife
- 2 Bereavement midwives
- Contraception Midwife
- Audit & Guidelines Midwife
- Practice Development Midwives
- MSW Project Midwife
- Fetal Monitoring Midwife
- Infant Feeding Support
- Frenulotomy Midwife
- Practice Facilitators (Delivery Suite/Community)
- Specialist Midwife: Preterm Birth/Complex Pregnancies
- Quality Midwife: PMRT/HSIB/Audit and Guidelines
- Specialist Midwife: Treating Tobacco Dependency
- Saving Babies Lives lead midwife

New posts:

- *Band 6 Digital midwife – appointed now*
- *Patient safety midwife – currently being advertised*

14.0 Birth Rate Plus Live Acuity Tool

14.1 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.

14.2 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.

14.3 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 coordinator. 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.

14.4 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.

14.5 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

14.6 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. Birthrate Plus acuity tool for the maternity ward was launched in January 2024 with support of their matron.

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 – Dec 23. This illustrates complexity in caseloads

Table: Staffing levels meeting acuity Apr – Mar 24 Source: Birthrate plus

Month	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Staffing levels met acuity	53%	34%	38%	41%	48%	42%
	Oct 23	**Nov 23**	**Dec 23**	**Jan 24**	**Feb 24**	**Mar 24**
	48%	47%	51%	68%	52%	63%

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

16.0 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 (band 7 or above) available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward and across the service.

16.2 There were no occasions when supernumery status of the co-ordinator was reported to be compromised during the 3-month period:

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

	Number of days per month	Number of shifts per month	Compliance
Jan 24	31	62	100%
Feb 24	29	58	100%
Mar 24	31	62	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.

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.

17.0 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: Care in labour compliance – all areas

Month	1:1 care in labour compliance
Jan 24	99%
Feb 24	99%
Mar 24	99%
YTD	**98%**

17.4 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.

18.0 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 following tables demonstrate red flag events on CDS during the reporting period:

Chart: Number and percentage of Red Flags recorded on Central Delivery Suite Jan 24-March24 inclusive –Source: BR+ Acuity Tool

RF1	Delayed or cancelled time critical activity Delay with EL LSCS list Delay in transferring women to Delivery Suite who are under going IOL	15	31%
RF2	Missed or delayed care (for example, delay of 60 minutes for suturing) Delay in third degree tears and MRP going to theatre Preterm women not receiving magnesium sulphate, three hours prior to birth	2	4%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) Delay in establishing sliding scale insulin Delay in administration of antibiotics e.g. woman being treated for sepsis	0	0%
RF4	Delay in providing pain relief Midwife not available to provide 1:1 care for woman requesting an epidural	1	2%
RF5	Delay between presentation and triage Delay of more than 15 minutes	1	2%
RF6	Full clinical examination not carried out when presenting in labour Exception, if woman presents in advanced labour	0	0%
RF7	Delay between admission for induction and beginning of process For women who are high risk and the IOL process is commencing on the Delivery Suite	29	60%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) Staff not acting on MEOWS scores appropriately	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
	Total	48	

Download

[redacted]

18.2 During the months of Jan – March 24 there were 48 red flags submitted via the birth rate acuity tool. This tool is completed 4 hourly on the central delivery suite to add staffing and identify complexities. The main group related to the delay in induction of labour. There were no red flags for women not receiving one to one care in labour.

Staff continue to incidents via datix. All incidents are reviewed at the maternity flow and quality meeting daily, except weekends when they are reviewed on a Monday. The aim is to identify those that need a full MDT review. Recognising that this is a midwifery meeting there are plans to review this process with the aim to having a daily MDT meeting in the next quarter.

Table : All datix staffing incidences by month/ source Jan -March 2024

	Jan 24	*Feb 24*	*March 24*
Central delivery Suite	69	47	64
Community Midwifery	6	3	5
Maternity Ward	29	31	36
Triage	10	33	22
Total	114	114	127

18.2. MNSI (Maternity and Safety Investigation programme, formally the Healthcare Safety Investigation Branch / HSIB) referrals are monitored via the maternity dashboard. During the quarter 4 period there were no referrals. This is monitored via the Quality and Safety Divisional Group and Maternity Clinical Governance.

Month	**Jan 24**	**Feb 24**	**March 24**
MNSI referral number	0	0	0

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

18.3 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.

18.4 The existing MCoC service delivery model and business plan are 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.

19.0 Obstetric staffing

19.1 The obstetric consultant team and maternity senior management team 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 Trust compliance has been audited for the period covering the 7th June to the 6th July 2023. The aim of the audit is to assess local compliance against RCOG standards for situations where the consultant must attend. The audit identifies compliance against the following situations:

1. Situations where consultant presence is mandated
2. Situations where the consultant should attend, if the registrar is not signed off as competent.

19.4 The audit was repeated for 2024 over the period most 1-29th February 2024 and concluded:

> The findings of this audit show an improvement with the many challenges with collecting the data needed to evidence compliance with the recommendations.
>
> There has been a significant improvement in the completion of the daily collection tool since it has become incorporated into the twice daily 'Board round'.
>
> The consultant was present in 90% (18/20) of situations where they MUST attend; the remaining 2 situations were mitigated for.
>
> There is documented compliance in 100% of 'should attend' situations, and a significant number where presence was not mandated but the consultant attended anyway
>
> The trial of completing the revised 'mandatory/should attend' paper proforma at the handover at the Board round at the end of each shift, proposed following the previous audit, has proved to be very successful

19.5 Data collection was challenging as the audit timescale co-incided with the launch of the BadgerNet Maternity EPR. An action plan is included as an appendix to the audit. The findings have been circulated to Maternity Delivery Group and Safety Champions Meeting. Any recommendations following the audit will be monitored.

19.6 The Trust has implemented the RCOG guidance on the engagement of short-term locums in maternity care. An audit of short-term locum doctors working within the Obstetrics & Gynaecology service on tier 2 or 3 (middle grade) rotas for the period February – August 2023 demonstrates 100% compliance with the criteria contained within the guidance.

19.7 The Trust has implemented the RCOG guidance on engagement of long-term locums in maternity care.

19.8 Following an audit of long-term locums working within the Obstetrics & Gynaecology service for the period February – August 2023, the Trust has been unable to demonstrate full compliance with guidance.

19.9 During this time period, the Trust employed one long-term locum, a locum Consultant. An audit of the recruitment process for this individual has shown that the RCOG monitoring and effectiveness tool was not completed as part of the recruitment process.

19.10 As a result, an action plan to review and update the recruitment and onboarding process for all long-term locums working within maternity care has been developed. The recruitment and onboarding process now includes completion of the RCOG monitoring and effectiveness tool.

19.11 The Trust will undertake further audits covering the period September 2023 – March 2024 to provide assurance and evidence of improved compliance. Findings will be presented at Maternity Delivery Group and Safety Champions Meeting and any recommendations following the audit monitored.

19.12 The Trust has implemented the RCOG guidance on compensatory rest to ensure that all consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest.

19.13 The Trust has an agreed standard operating procedure in place to support the provision of compensatory rest as recommended by the RCOG.

19.14 The job plans of the Obstetric Consultant Team reflect the requirement for compensatory rest with job plans arranged to allow for a day off following a Monday-Friday on-call and provision for any direct clinical care (DCC) activity following a Sunday or Bank Holiday to be either cancelled / covered by another member of the Consultant Team.

19.15 An audit of the Obstetric Consultant on-call rota for October 2023 demonstrated that all Consultants working non-resident on-call out of hours were able to take the required amount of compensatory rest in the period immediately following their on-call.

20 Anaesthetic staffing

20.1 There is no update to Anaesthetic staffing from the previous paper as fully compliant. 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 Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

20.3 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.

20.4 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.

20.5 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).

20.6 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.

	Q1 23/24	**Q2 23/24**	**Q3 23/24**	**Jan 24**	**Feb 24**	**March 24**
% compliance	100%	100%	100%	100%	100%	100%

20.7 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).

21.0 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.

21.2 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.

21.3 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.

21.4 Although staffing numbers are currently compliant, at least one of the ANNPs working on a tier 1 medical rota is set to retire in the next year. Previous attempts to recruit a further ANNP was unsuccessful due to lack of applicants. A business case for ANNP succession planning has been submitted, but not approved.

22 Neonatal nursing staffing – awaiting update for quarter 4

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 10 neonatal nurses and 1 nursery nurse 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 15.05 WTE 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 slightly decrease from its current level of 9.6 WTE (Q3) to 7.5 WTE. 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.

22.9 An action plan has been developed to provide oversight of all activity relating to recruitment and retention on the Neonatal Unit.

Table: Neonatal Workforce action plan update

Neonatal Workforce Action plan	**Dec 23**	**Mar 24**
Closed	36	47
Overdue	7	0
In Progress	12	13
Complete	28	23
Total number of elements	**83**	**83**

22.10 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.

22.11 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.

22.12 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.

22.13 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.

22.14 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.

23.0 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 and ongoing national maternity scrutiny.

23.2 Incident reporting on staffing, Red Flags and birth to midwife ratio illustrate a concerning picture within midwifery staffing. 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.

23.4 Whilst the audit of short-term locum doctors demonstrates 100% compliance with the criteria contained within the guidance, the trust has been unable to demonstrate full compliance with guidance on long term locum. An action plan has been developed.

23.5 The Neonatal unit continues to be challenged around neonatal nurse staffing. An action plan has been developed which will be monitored in MDG

24.0 Recommendations

24.1 It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes non-compliance with BAPM standards for both neonatal nurse staffing and agree to the action plan

24.2 It is recommended that formally record to the Trust Board minutes non-compliance with RCOG audits and to note that an action plan has been developed and monitored through MDG.

Please note results from the Consultants Audit, point 19.4, was added following the Maternity Delivery Group on 12/6/24. This was discussed at the meeting and Chairs approval was sought in retrospect.

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Report to Board of Directors meeting in Public

Agenda item:	10	Enclosure Number:	
Date	11th July 2024		
Title	Perinatal Quality and Safety Report Q4 2023-24		
Author /Sponsoring Director/Presenter	Lisa Stephens- Director of Midwifery / Matt Holdaway- Chief Nurse / Director of Quality		

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

Summary of Report

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the GHNHSFT Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward-to-board' insight across the multi-disciplinary, multi-professional maternity services team. This is also presented to the LMNS.

In March we commenced the Patient Safety Incident Reporting Framework (PSIRF) which will alter the way we review and report our incidents going forward.

Stillbirth rate has been raised as a concern by the LMNS. Data from October to March (Q3 & Q4) has now been validated excluding those babies who have died as result of medical termination of pregnancy. This is due to a EPR data extraction issue and is currently being reviewed in its entirety for previous quarters and other perinatal mortality indicators. The current national benchmarking figure for stillbirths is 4.1 per 1000 births, and Trust Validated data confirmed that Q3 and Q4 Stillbirth rate is below current national benchmark rates (3.5 and 3.6 per 1000 births). Discussions with the LMNS continue to validate their data sources and confirm any associated actions.

Highlighted data from the PQS report during Q4:

- No maternal deaths were reported
- 2 new Serious Incidences reported – ATAIN review (cleft palate) and 2.7Litre Massive Obstetric Haemorrhage
- No new MNSI referrals. During Q5 there where 5 open MNSI cases undergoing investigation
- 27 new complaints. Main themes associated with communication and concerns with care
- There were 823 ratings through FFT with 83.9% positive responses
- 5 still births at 24/40 gestation or above. All have had an initial review, with all scheduled or have had MDT review via PMRT process

Summary of Report

- There were 3 additional cases reported to MBRRACE as late fetal losses above 22 weeks gestation
- A cluster review to identify any immediate learning was initiated. Immediate learning has been actioned.
- No neonatal death
- 8 Serious incidents were reported, of these 3 incidents met criteria for MNSI referral.
- Periprem – there were 4 babies born at GRH less than 27 weeks gestation
- During Q4 there were 44 term babies admitted to the neonatal intensive care unit. The majority of babies were admitted for respiratory reasons (38 babies). All of these cases have undergone a multi-disciplinary review process in line with MIS safety action 3 requirements. Any learning has been shared with the teams via individual Datix review and monitoring processes.
- PMRT – 8 cases this quarter with care grading confirmed or awaiting review

Safety Champion Walkabout conducted in February with themes around staffing discussed

To note, in May 2024 (Q1 24/5), following the S31 warning issue notice we are reviewing our Governance Systems and Data quality to enhance our assurance reporting. The progress associated with this is reported to QIG and via our Regulation Report to Trust Board

Massive Obstetric Haemorrhage rates continue to be monitored. QI project commenced in Q1 (2024/5). Cluster review completed with themes associated with risk assessment completion and escalation. However, the initial review indicated that appropriately actioned indicating that staff were aware of level of clinical risk. A subsequent review is being presented at MDG on 10th July 2024.

Risks or Concerns

- Assurance around data quality on dashboard reporting with ongoing project
- Transition to PSIRF with previous concerns around maternity Governance
- PMRT process is lengthy. Team identifying ways to have more timely review

Recommendation

- Note the risks highlighted around PMRT, data quality
- Note the ongoing improvement work with a QI focus.

Enclosures

- Q4 PQS report

Gloucestershire Hospitals
NHS Foundation Trust

Perinatal Quality and Safety Report Quarter 4 2023 - 2024

Glossary

Term	Description/Definition
AFE	Amniotic Fluid Embolism
ATAIN	Avoiding Term Admissions to Neonatal Units
CGH	Cheltenham General Hospital
CQC	Care quality Commission; The independent regulator of health and social care in England
ELCS	Elective Caesarean Section
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GRH	Gloucestershire Royal Hospital
HSIB	Health Safety Investigation Branch
MIS	Maternity Incentive Scheme
MNSI	Maternity Neonatal Safety Investigations (Formerly HSIB)
NHS	National Health Service
PET	Pre-eclampsia Toxaemia
PQS	Perinatal Quality and Safety
SBL/SBLCB	Saving Babies Lives Care Bundle
TC	Transitional Care
Trust	Means Gloucestershire Hospitals NHS Foundation Trust

Introduction

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the LMNS Board and GHNHSFT Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward-to-board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflections actions in line with Ockenden and progress made in response to any identified concerns at provider level. The report will also provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the clinical quality assurance group.

Work has been undertaken during the month to remodel the monthly Perinatal Quality and Safety Report to provide enhanced signposting, benchmarking and compliance status, thus enabling greater visibility of concerns affecting the Division.

The report has been divided into:

- Safety
- Quality
- Morbidity and Mortality
- Training Compliance
- Workforce
- Maternity Incentive Scheme

Monthly Dashboard

CQC Maternity Ratings 2022*	Overall	Safe	Effective	Caring	Responsive	Well-Led
	Inadequate	Inadequate	Good	Good	Good	Inadequate
Maternity Safety Support Program: Yes						
*Previous ratings were not all updating during this inspection. The maternity rating for safe and well-led went down to inadequate. The previous rating for effective, caring and response remained as good. Overall the Trust was rated as inadequate						

	Benchmark		April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
AER (After Event Reviews)														3
PSII (Patient Safety Incident)														0
QS (Quality Summit)														0
New SI's (Prior to PSIRF)			0	0	0	0	0	3	3	2	3	1	1	
New MNSI Referrals		0	0	4	1	2	1	1	1	1	1	0	0	0
Number of complaints														5

	Benchmark		April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of positive FFT responses %														83.9 in Q4
Direct Maternal Deaths		0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths (24 weeks gestation and above)	LMNS Target Nat Av. 2021	<=2.52 4.1	4.7	5.9	2.1	0.0	4.6*	2.2	2.0	2.1	6.5	2.2	6.46	2.06
Neonatal death rate per 1000 live births (>24/40)	LMNS Target Nat Av. 2021	<=0.89 2.7	0.0	0.0	0.0	0.0	0.0*	2.2	0.0	2.1	0	0	0	0
PeriPrem < 27 weeks gestation		0	1	1	0	2	1	1	2	0	0	0	1	3
Avoiding Term Admissions into the Neonatal Unit (ATAIN)		5	2.6	3.9	3.9	4.6	2.2	3.3	2.8	3.5	3.9	3.5	3.2	3.9
Coroner Regulation 28 made directly to the Trust		0	0	0	0	0	0	0	0	0	0	0	0	0
Midwives Mandatory Day		90%	85	75	84	78	78	74	77	83	92	89	91	90
MCA's/MSW's Mandatory Day		90%	72	65	71	72	72	57	61	65	78	78	78	78
Midwives PROMPT part 1		90%	80	85	84	84	84	83	84	90	97	97	96	93
MCA's/MSW's PROMPT part 1		90%	75	75	68	67	67	69	76	76	92	95	95	91
Obstetricians PROMPT part 1		90%	61	90	100	100	100	62	79	79	91	95	72	86
Anaesthetics PROMPT part 1		90%	58	61	69	66	66	60	93	93	91	87	81	83

	Benchmark		April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Midwives PROMPT part 2		90%	84	84	94	88	88	84	89	89	95	94	94	90
MCA's/MSW's PROMPT part 2		90%	74	68	75	69	69	69	78	78	91	90	94	86
Obstetricians PROMPT part 2		90%	67	98	100	100	100	62	79	79	91	70	72	86
Anaesthetics PROMPT part 2		90%	58	61	69	68	68	60	96	96	91	79	82	83
Midwives Fetal Monitoring		90%	83	86	96	89	59	73	88	88	90	95	91	91
Obstetricians Fetal Monitoring		90%	46	82	74	75	75	72	89	89	91	96	89	86
Middle grade rota gaps - Obstetrics				49	39	31	16	16	7	6	9	21	35	14
Consultant rota gaps - Obstetrics				4	0	0	0	2	3	2	6	2	0	2
Midwifery fill rate % (Day)				95	90	82	78	78	87	90	88	87	97	89
Midwifery fill rate % (Night)				91	85	80	77	76	86	93	89	97	94	99
Midwifery vacancy rate %		TBC		13.9	14.9	14.4	13.3	9.6	8.51	8.45	7.85	9.43	12.3	9.83

Safety

Serious Incidents

There were 2 new serious incidents reported during Q4. In March 2024 we commenced the new Patient Safety Incident Reporting Framework (PSIRF) which will alter the way we review and report our incidents going forward.

Incident No.	Incident Date	Incident detail
W216028/ W216091	July 2023	ATAIN review cleft palate – diagnosed Pierre Robin – emergency tracheostomy due to unstable airway

The above incident from July 2023 underwent ATAIN review in September 2023, which did not reveal any acts or omissions from a maternity perspective. However, review of USS images revealed facial anomalies, which although not routinely examined as part of FASP, are evident. For this reason, the incident was revisited by Maternity, deemed an SI and was presented to the panel on 19th February. Although the incident currently sits within Obstetrics, the investigation is to be carried out by the Trust Patient Safety Team as it spans both USS and Neonatology. As such, upon completion of the review, any subsequent action plan will be jointly owned by D&S & Neonatology.

Incident No.	Incident Date	Incident detail
W233220	February 2023	2.7L Massive Obstetric Haemorrhage, DCC admission – Possible Amniotic Fluid Embolism (desaturated in theatre)
Immediate Safety Actions: Problem: Delay in the administration of oxytocin infusion Actions: • Availability of infusion to be mentioned when undertaking the WHO checklist on arrival to theatre • Explore with Pharmacy the possibility of providing prepared oxytocin infusions • Commence trial of Carbetocin		

Maternity and Newborn Safety Investigations (MNSI)

There were no new referrals made to MNSI during quarter 4

There was 1 case reported in December 2023 involving a baby transferred for therapeutic cooling. The MRI was subsequently normal for this baby and MNSI rejected the case in January 2024.

During Q4 there were 5 open MNSI cases undergoing investigation, with an additional case completed in March. The final report was received by the Trust and has subsequently been shared with the family and an action plan formulated.

Quality

Complaints

There were 27 new complaints received within maternity for quarter 4. The main themes associated with our complaints include:

- Patients/mothers not feeling listened to
- Issues and concerns with clinical care provided
- Lack of communication/information provided by staff
- Staff attitude

A new system for managing complaints in maternity will be introduced, focusing on resolution for patients/parents, initiating contact as soon as possible on receiving the complaint and offering a face-to-face meeting or a telephone consultation if they wish. The maternity patient safety team will be welcoming 2 new members of the team and plans are in place for a daily walk-around on the maternity ward to check in with patients/parents to ensure they are happy with their care, address any issues at the time and arrange a debrief if required. This will aim to reduce the number of complaints received, but also ensure patients/parents feel listened to and steps taken to support them with any queries or concerns they may have. Learning from complaints will be shared with the wider team via a new Quality and Safety newsletter, and with complainants' consent, patient stories will be shared.

Friends and Family Testing

During Quarter 4 the Trust received 823 ratings for maternity through the friends and family testing service. Of the 823 responses, 83.9% were positive. Positive feedback for was received for theatre, delivery suite, and obstetric and midwifery outpatients. The main area of concern reported by service users accessing maternity care was the maternity ward. Specific concerns included staffing and its subsequent impact on the time taken to answer call bells, missed observations and missed medications.

The feedback will be provided to the leads for the individual areas to manage and address, and general feedback and learning will be provided to staff, including both positive feedback and concerns highlighted, via the monthly Quality and Safety newsletter for the Women and Children's Division.

Morbidity and Mortality

Direct Maternal Deaths

There were no direct maternal deaths during Q4.

Stillbirths

Stillbirth data from October to March (Q3 & Q4) has now been validated excluding those babies who have died as result of medical termination of pregnancy. This is due to a Badgernet (EPR) data extraction issue and is currently being reviewed in its entirety for previous quarters and other perinatal mortality indicators. The current national benchmarking figure for stillbirths is 4.1 per 1000 births.

Table: Validated data for Quarter 3 and Quarter 4:

Quarter 23/24	GHT SB rate per 1000 births	Current National Benchmark
Q3	3.5	4.1
Q4	3.6	

There were 5 stillbirths at 24 weeks gestation or above during Q4. All 5 cases have had an initial Datix review and have either had or are scheduled to have a multi-disciplinary review with external panel members via the perinatal mortality review tool (PMRT) process. The Perinatal Mortality Review Tool (PMRT) process is a robust multi-disciplinary review including external panel members for scrutiny. The PMRT review process includes any baby at or over 22 weeks gestation, up to 28 days of life, who have died. Currently we have a slight backlog of cases, however we have requested additional ad hoc meetings to ensure these cases are reviewed timely, and in line with the MIS recommendations.

There were an additional 3 cases reported to MBRRACE as late fetal losses above 22 weeks gestation. They have been included in the table below. These 3 cases were included in a cluster review of the perinatal losses during February. The cluster review was undertaken to ensure our data was accurate, all losses had been identified and any immediate learning reviewed and actioned.

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required standard:

a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. Trust compliance: All eligible perinatal deaths from 8th December 2023 to 31st March 2024 notified to MBRRACE-UK within 7 working days **(Trust compliance 100%)**

b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards. Trust Compliance: All parents given the opportunity to provide their feedback/questions from 8th December 2023 to 31st March 2024 **(100% compliance)**

c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023;

- 95% of reviews should be started within two months of the death **(Trust Compliance 100%)**
- a minimum of 60% of multi-disciplinary reviews should be completed and published within six months **(Trust compliance: no cases eligible for this standard from 8th December 2023 to 31st March 2024)**

d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust on an ongoing basis for all deaths from 8th December 2023. Trust Compliance: Bi monthly reports submitted for Dec 23 & Jan 24 and Feb & March 24 **(Trust compliance 100%)**

PMRT care grading for stillbirth (split into care leading up the death of the baby and care following the confirmation of the baby's death)

A. No issues with care identified

B. Care issues that would have made no difference to the outcome

C. Care issues which may have made a different to the outcome

D. Care issues which were likely to have made a difference to the outcome

Gestation & diagnosis	Review process	Learning identified	Action required/taken	PMRT grading of care
24+3 weeks, severe early onset fetal growth restriction, monitored under Fetal Medicine Unit, attended for ultrasound scan and no fetal heartbeat seen	Initial Datix review Perinatal Mortality Review Tool process	Urinalysis not taken at any point during pregnancy Aspirin risk assessment not completed in full with outcome during booking	Learning regarding urinalysis has been shared to the wider clinical team Feedback provided to community leads regarding aspirin and PD team to launch themed learning around aspirin Local aspirin leaflet to be completed LASER to address all areas of learning for this case	Grading of care to be confirmed

		No screening bloods taken following confirmation of stillbirth Minimal postnatal care visits (day 4 and 14)	To be included on Bereavement midwives learning and feedback for the Quality and Safety newsletter for May postnatal care and taking of screening bloods following confirmation of loss Audit to be completed on bereavement checklists for Q1 to assess if screening bloods taken and feed back to governance lead Bereavement midwives have linked with community midwifery team and shared learning regarding visits postnatally. To monitor closely and Datix any missed visits	
24+2, attended routine community midwife appointment and midwife unable to auscultate fetal heart, intra uterine death confirmed following transfer to GRH	Initial Datix review Perinatal Mortality Review Tool process	Urinalysis not taken at every antenatal contact Minimal postnatal care visits (day 4 and 14)	Learning regarding urinalysis has been shared to the wider clinical team Bereavement midwives have linked with community midwifery team and shared learning regarding visits postnatally. To monitor closely and Datix any missed visits	B leading up to the death of the baby B care of the mother following the confirmation of death of the baby
36+6, attended triage with reduced fetal movements, intra uterine death confirmed	Initial Datix review Perinatal Mortality Review Tool process	No CO screening at booking SFH shows likely slowed growth at 35+6	Learning to be shared on the Quality and Safety newsletter Action on growth to feed into wider workstream on scanning including review of current guidance All incidents related to growth to be linked to ongoing workstream	Awaiting PMRT review
34+2, attended triage with reduced fetal movements since the previous evening, intra uterine death confirmed	Initial Datix review Perinatal Mortality Review Tool process	Care appropriate and no learning identified	No actions required	Awaiting PMRT review
38+6, attended routine community midwife and unable to auscultate the fetal heart, referred to triage and intra uterine death confirmed on USS	Initial Datix review After Event Review Perinatal Mortality Review Tool process	Urinalysis not taken on a number of occasions in the community setting No documented obstetric review prior to discharge home Mother commenced on aspirin when low risk FGR/PET	Learning shared on Quality and Safety newsletter Feedback provided to community leads regarding aspirin and PD team to launch themed learning around aspirin	Awaiting PMRT review
23+4, late fetal loss, presented to	Initial Datix review	Contacted triage the following day with	Learning to be shared to triage team	B leading up to the death of the baby

triage with cramping and abdominal pain	Included in February cluster review Perinatal Mortality Review Tool process	abdominal and back pain, advised to take analgesia and stay at home. Called again 2 hours later with worsening pain and admitted, IUD confirmed Mother contacted triage regarding abdominal pain, no documentation of discussion and minimal information on Badgernet Second triage call mother reported reduced fetal movements and cramping, triage assessment did not mention cramping and not discussed/assessed on admission	Scoping for individualised training for telephone triage – to be led by triage lead midwife	B care of the mother following the confirmation of death of the baby
23+1, attended for cervical length scan and baby had died	Initial Datix review Included in February cluster review Perinatal Mortality Review Tool process	Postnatal check only completed on day 2 and 14	Bereavement midwives leading piece of work around postnatal care of bereaved women, comms has been sent to community leads to disseminate, for individualised care	Awaiting PMRT review
23+4, attended for fetal heart auscultation but unable to find fetal heartbeat, transferred to GRH where ultrasound scan confirmed the baby had died	Initial Datix review Included in February cluster review Perinatal Mortality Review Tool process	Faulty doppler, unable to auscultate, reported good fetal movements, not followed up for 2 days, unable to auscultate fetal heart and IUD diagnosed	Has already been actioned with individual feedback, clinicians to ensure equipment in working order prior to clinics/visits	Awaiting PMRT review

Neonatal Deaths

There were no neonatal deaths during the months of January, February and March.

PERIPrem

PERIPrem, or Perinatal Excellence to Reduce Injury in Premature Birth is a unique perinatal care bundle of 11 interventions that demonstrate a significant impact on brain injury and mortality rates amongst babies born prematurely. A key, and potentially the most challenging element to the PERIPrem care bundle is birth in the right place. This applies to extreme preterm infants under 27 weeks gestation, under 800g or under 28 weeks if a multiple birth. We continue to monitor and audit our PERIPrem babies to ensure that all efforts were made to safely transfer mothers at high risk of preterm birth. During Q4 there were 4 babies born at Gloucester Royal Hospital at less than 27 weeks gestation.

Gestation	Singleton/Multiple pregnancy	Was a tertiary unit contacted?	Reason for no transfer	Case reviewed by MDT
26+6	Singleton	No	Rapid labour	Yes
24+6	Singleton	Yes – discussion with Sonar	In advanced labour when admitted to GRH	Yes
26+5	Multiple (twins)	Yes – would not accept in utero as in active labour	Admitted in active labour with bulging membranes	Yes

Avoiding Term Admissions into the Neonatal Unit (ATAIN)

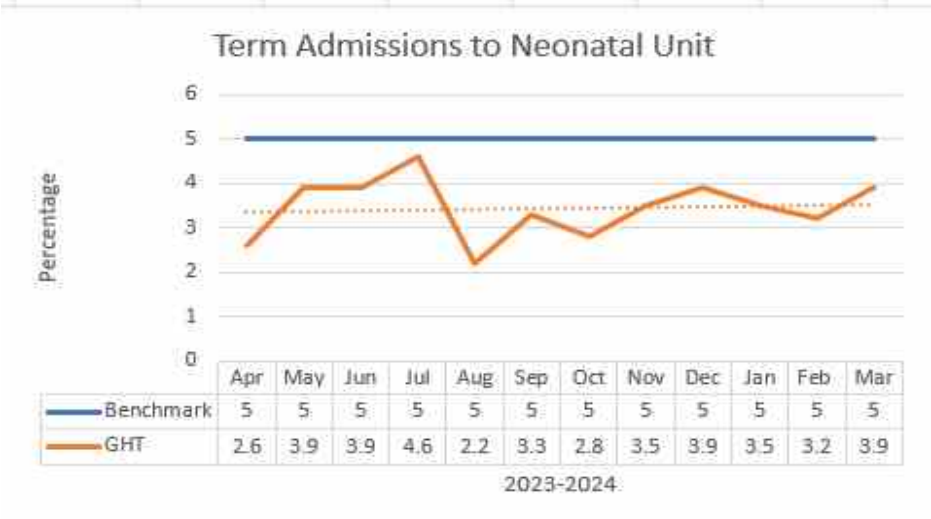
There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals

The Trust is working towards providing a transitional care (TC) pathway for babies from 34 weeks and above in alignment with the BAPM framework.

During Q4 there were 44 term babies admitted to the neonatal intensive care unit. The majority of babies were admitted for respiratory reasons (38 babies). All of these cases have undergone a multi-disciplinary review process in line with MIS safety action 3 requirements. Any learning has been shared with the teams via individual Datix review and monitoring processes.

Across January there were 2 babies admitted to NICU for low cord gases and cerebral function monitoring (CFM) was completed. The CFM was normal and there were no ongoing concerns. These babies did not fit criteria to be reported to MNSI. There was 1 additional baby that had low tone post birth and required a brief period of resuscitation. The baby was transferred to NICU for ongoing monitoring but was discharged home the following day with no concerns.

We continue to sit under the national benchmarked figure for our term admissions to the neonatal unit.



Training Compliance

The table below displays the mandatory training compliance across the multi-disciplinary team. The target rate is 90% compliance in line with MIS safety action 8. Any drop in compliance is escalated through the practice development team within maternity.

	Overall Compliance		
	Jan	**Feb**	**March**
Maternity Mandatory Day (Midwives & MCA's Only)	89%	85%	84%
PROMPT Part 1 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	96%	92%	91%
PROMPT Part 2 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	86%	79%	83%
Fetal Monitoring (Midwives & Obstetricians)	96%	89%	88.5%

Workforce

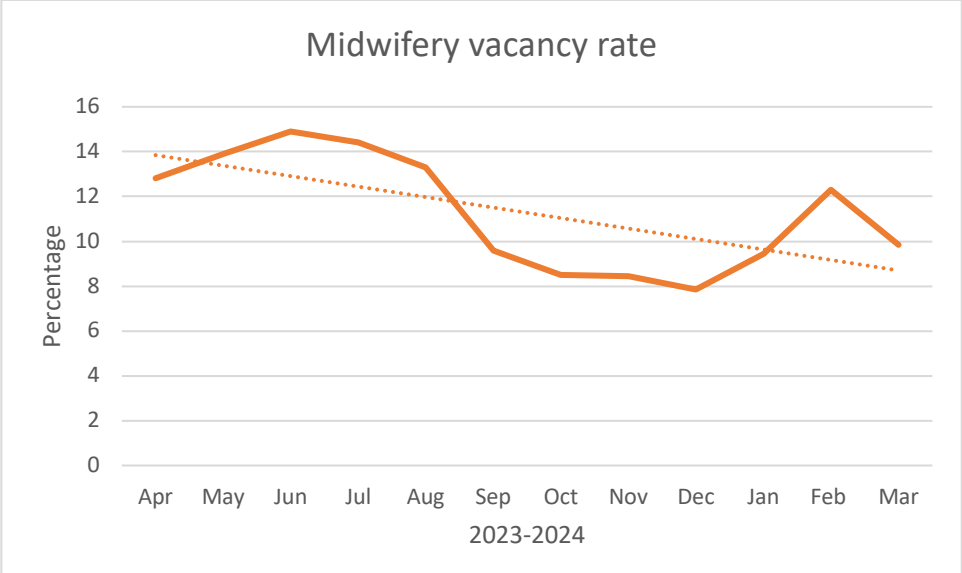
Obstetrics

During Q4 there were 77 rota gaps for obstetric middle grades. A number of gaps were as a result of industrial action. All rota gaps were covered by locum members of staff.

There were 4 obstetric consultant rota gaps across Q4 and these were also covered by locum staff.

Midwifery

At the end of Q4 our midwifery vacancy rate was 9.83%. Although midwifery workforce remains challenging in terms of staffing, March saw a reduction in the vacancy rate to 9.83%, which is the result of our ongoing recruitment drive, and saw 6 new starters joining the Trust in March. Retention focus is ongoing and will include a review of future bank enhancement arrangements and plans to support summer staffing.



Culture Survey

Our new communication and engagement lead, is in post and part of her initial work has included comms on our recent CQC inspection. Staff have reported 'they feel included in the ongoing CQC work and that communications are sufficient'. Monthly all-staff feedback sessions have been established and improvements made on 'you said, we did' type feedback from safety champions walk arounds.

A review of office space has commenced to improve team working. Some of the senior leadership team and the antenatal clinic team have visited the Royal United Hospitals Bath NHS Foundation Trust to gather ideas from what works well there and share learning.

Multiple workshops have been facilitated and successfully involved the MDT in our current priorities, establishing QI projects and undertaking QI training. We have also held workshops

to establish PSIRF within maternity, with a final workshop for PSIRF on 12th July. We also plan to hold an MDT review of our governance structure.

Following on from the NHSE culture programme, we have commissioned Matt Crosby to support the wider maternity leadership team with the development of ongoing response to staff feedback.

Safety Champions

The safety champion walkabouts continue in the clinical areas with plans to schedule out of hours walkabouts, and visits to the community hubs. This will ensure all of our staff groups have an opportunity to meet the safety champion team and build on psychological safety in their areas.

*See below communication to staff following the February safety champions walkabout.

Gloucestershire Hospitals
NHS Foundation Trust

Safety Champion Walk About 22/02/24

Page 1 of 2

Gloucester Birth Unit 22/02/24

Present

- Lisa Stephens – Director of Midwifery
- Matt Holdaway – Chief Nurse
- Charlotte Wakefield – Midwife safety champion

We had a positive and insightful discussion with Emily Bridges (Birth Unit Lead Midwife) and Louise Hockin (flow and quality midwife), and other members of the core birth unit team.

What we noticed

- Welcoming, warm atmosphere
- Safe clinical space
- The team were caring for two women at the time of the walk about, it felt peaceful and calm.

Points shared in discussion

- Staffing a common safety theme. Issue raised that staff are leaving substantive posts in favour of bank contracts
- Inconsistency with the quality of work from a couple of individual agency midwives. This was raised with senior staff in a timely and appropriate way
- Safer process for the use of medications now in place – no longer taking multiple different medications into rooms in the same packaging (syntometrine/oxytocin) in line with CQC recommendations. Each medication is taken when required from the clinical room
- Positive feedback for the now established flow team, with staff feeling safer and supported. Particularly knowing that the flow midwife has oversite of the whole unit. Community leads to be included which will allow for escalation planning in such a way that supports the unit and the community equally.
- The delay in growth scans meaning that midwifery led women awaiting a scan are going into labour and therefore do not meet the criteria for MLC.

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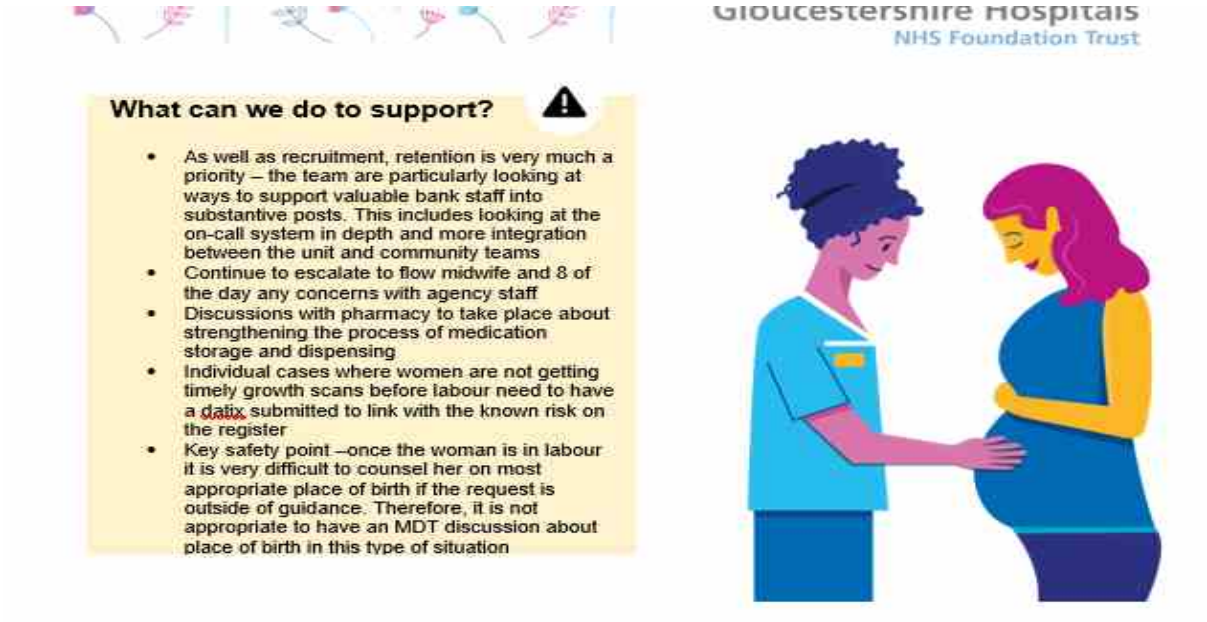

Maternity Incentive Scheme

Details of the Y6 scheme are awaited and are anticipated at the beginning of April.

Saving Babies Lives Care Bundle Version 3:

A project initiation document has been created by the lead midwife for SBLCB. This document details the project plan timeline and audit plan. This document has been circulated separately to this report, but will follow the same governance reporting pathway.

The Project deliverable is the full implementation of the Saving babies lives care bundle version 3. This includes all 6 elements and 71 interventions of SBLCB-v3

Interventions that were fully implemented for MIS year 5 require ongoing surveillance and a full review in order to ensure future compliance targets and agreed action plans have been achieved and evidence required for year 6 MIS submission is captured and signed off by the LMNS/ICB and Trust board. This ensures the bundle is fully imbedded at GHT and demonstrates the Trusts commitment to ensuring the standards set by SBL are regularly reviewed and delivered.

Please note the SBLCB is a living document and compliance will fluctuate despite ongoing monitoring and surveillance. The project will be complete once the Trust and LMNS/ICB agree all interventions are fully implemented, however it is likely interventions will be amended or added to for MIS year 6 the publication of which is outside the control of this project. Therefore, the scope of this project will need to allow flexibility and movement in objectives and the Trust must understand that ongoing work is required to maintain the full implementation of the care bundle

Report to Board of Directors meeting in Public

Agenda item:	11	Enclosure Number:	01

Date	Thursday 11 July 2024
Title	Quality Account 2023/2024
Author / Sponsoring Director/ Presenter	Deputy Director of Quality, Suzie Cro Head of Quality – Debra Ritsperis Director of Quality and Chief Nurse, Matt Holdaway

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

Purpose

Our Quality Account has been provided to Board members for information. A summary of the quality indicators can be found on page 22 of the enclosed report.

Background

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts.

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

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

Guidance

There is no guidance this year from NHS England (last guidance January 2023 (link).
The processes for producing Quality Accounts remain the same as previous years, with the following exceptions to NHS providers:

- NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. NHS foundation trusts will continue to produce a separate Quality Account for 2022-23.

Summary of Report

- There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS foundation trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.

- Integrated care boards (ICBs) have assumed responsibilities for the review and scrutiny of Quality Accounts. ICBs must clarify with providers where they are expected to send their Quality Account. Our Account will be sent to the ICB Chief Nurse and then will be presented to Quality Committees.

Production Timeline

Date	Requirement
1 April 2024	Request all sections to be completed
24 April 2024	Draft account shared with Quality and Performance Committee members to for assurance and to enable comment prior to final report being produced.
15 May 2024	Sent to HOSC, Health Watch and ICB for comments after QDG approval 3/3 Statements received and added
11 June 2024	QDG received FINAL draft account
18 June 2024	Trust Leadership Team received final draft account for approval
30 June 2024	Publication on Trust website
12 July 2024	Trust Board to receive for information

Publishing requirements for the 2023/24 Account

The NHS.uk website no longer allows NHS organisations to upload reports. Therefore, just as last year, we were asked to:

- Upload our Quality Account to an appropriate page on our organisation's website (so that it is clearly visible and easily accessed by members of the public).
- Forward the link of the webpage to the following email addresses:
  NHS providers – quality-accounts@nhs.net

Our Quality Priorities for 2024/25

- We must identify at least three priorities and we have chosen to report on our safety priorities
- We have indicated in our 2023/24 Quality Account how our priorities were decided and who was involved in the decision-making process.
- QDG will receive a plan and updates as to how we are to achieve this improvement over 2024/25
- We will measure our improvement through clear indicators/metrics.
- Our governance arrangements for the Quality Account is that QDG will receive regular progress reports throughout the year.

Summary of Report
Our Quality Strategy describes our processes for delivering the Trust's strategic objectives for Quality and provides the framework for deciding on our priorities. 
Recommendation
Board members are asked to receive the Quality Account for information
Enclosures
Quality Account 2023/24

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Quality Account 2023–2024

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Our Quality Account 2023/24

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

Table of Contents

Part 1

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

Welcome to our 2023-2024 Quality Account, which demonstrates our commitment to providing the best possible care to our patients and their families. This report reviews the quality of care we have provided over the past 12 months and shares our priorities for the year ahead for improving the safety, outcomes and experience of our staff and patients.

Our achievements are all thanks to the commitment, adaptability and professionalism shown by our staff across the Trust. Over the past year, our teams made significant progress delivering our key quality priorities for our patients as we have continued our recovery from the Covid-19 pandemic, in the face of strong headwinds from increased demand, industrial action, and financial pressures. Despite the many challenges, we have achieved a huge amount.

The year just gone 2023/24

Month	Key event
April 2023	- The year started with news that Deborah Lee would be standing down from her role as Chief Executive of the Trust after seven years in post and would like to thank Deborah for her service to the Trust and people of Gloucestershire. - The **Care Quality Commission (CQC)** were on site and revisited our Surgery and Maternity Services. - We are starting the year with patients in **non-designated bed spaces** and so we held a Quality Summit, with clinical colleagues, to develop a plan for reducing and, ultimately, eliminating the need to care for patients in corridors on our wards and care for patients in areas not intended for this purpose, including day surgery and Emergency Department cohort areas. - Our journey commenced on the national, NHS England (NHSE) sponsored, "**Worries and Concerns"** quality improvement collaborative. This programme of work was designed to ensure that patient and family concerns are central to the management of acute illness and deterioration. We are going to be testing and implementing methods for patients, families and carers to escalate their concerns about deterioration and to input their views about their illness into the health record.
May 2023	– The Trust has strengthened its approach to accountability, challenge and staff support through the appointment of a dedicated lead for **Freedom to Speak Up** (FTSU). There are a number of teams across the Trust who have 'Guardians' so plans are now in place to ensure clarity between the roles they all play. – NHS Resolution publish the year 5 **Maternity Incentive Scheme** (MIS) guidance. This is a financial incentive program designed to enhance maternity safety within our service. It rewards Trusts that can

Month	Key event
	demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns.
June 2023	- Teams have worked incredibly hard to minimise the loss of elective activity associated with **industrial action**. However, thanks to the efforts of our administrative teams, 90% of these patients have been re-booked. - The **Armed Forces Covenant** was re-signed by the Chief Executive and work commenced to capture Armed Forces Serving personnel and families onto our patients' digital record. - Launch of '**PALS champions'** an initiative to support our ward clerk team to be able to provide advice to our patients, carers and visitors.
July 2023	- On Wednesday 5 July 2023, the **NHS celebrated 75 years of service** and our Trust played its part, along with system partners, in marking this significant milestone. A wide range of activities were planned throughout the week as we came together with our community to mark the occasion. - We continue delivering our **cultural improvement plan** with great work being done with good engagement with a significant number of colleagues who have joined a dedicated Taskforce. - National **Urgent and Emergency Care (UEC22) Patient Experience** survey results published, overall experience 'about the same' as other Trusts. - National **Cancer Patient Experience** (CPES22) survey results published, achieved 'above expected' in 9 questions.
August 2023	- Our **Maternity service** continues on the improvement phase of Maternity Safety Support Programme (MSSP). System and Regional input being provided to support increasing pace of change. The MSSP team are providing support to undertake thematic analysis of cases relating to massive obstetric haemorrhage. - **Industrial Action** has been ever present throughout the year, and there has been a total of 17 separate periods of action by different health staff since December 2022, affecting on our hospitals, our staff and our patients. As part of our planning, we had to temporarily close Cheltenham's ED for extended periods and pause some planned care and outpatient appointments, although we worked hard to minimise disruption for patients receiving cancer care, and for those who have been on the waiting list a long time. We hope that positive progress will be successful this year in resolving the issues nationally. - In Cheltenham, two new theatres and the new Chedworth Surgical Unit opened providing dedicated day surgery facilities. The state-of-the-art facilities will be used for urology, Gastrointestinal (GI) and orthopaedic surgery bringing the total number of theatres on the Cheltenham site to 14 and together this will help us treat up to 2,500 more day-surgery patients per year.

Month	Key event
September 2023	- The **Care Quality Commission (CQC)** were on site and visited our Children and Young People's Services for an unannounced focused inspection. - The "**Slipper Trial**" on Woodmancote Ward started and this initiative reduced falls from an average of 11 falls per month to 6 during period of trial (19/09/23 – 19/11/23). - **National Inpatient (IP22) Survey** results published, overall experience 'about the same' as other Trusts. Areas requiring improvement continue to be around discharge.
October 2023	- Through our **Health Inequalities** Improvement Programme "Tackling Tobacco Dependency", our percentage (%) compliance of recorded smoking status on admission has been sustained at greater than 80% and this has been supported by changes to the digital systems. This enabled better oversight of patients so that interventions can be targeted.
November 2023	- **CQC** published inspection reports with improved position for surgery and Trust remaining with a "requires improvement" rating. Maternity were rated "inadequate" and were served with a continued section 29a warning notice. This was to ensure safeguarding training level 3 was provided for all staff and incidents to be investigated in a timely way so learning can be shared quickly to reduce the risk of it happening again. This is a repeat of part of the warning notice issued following the inspection in April 2022. - This month we were delighted to see an early evaluation of **stroke services** following their centralisation at Cheltenham General. Since then the team has improved access to imaging within an hour (gold standard care) from 54% to 74% (52 minutes median time to 11 minutes) and 71% of patients were admitted to a specialist stroke unit within four hours of a stroke being confirmed compared to just 32% previously (383 minutes median to 15 minutes). We know from the evidence that achieving these care goals significantly reduces both mortality and morbidity from stroke and we are now **rated 'B' overall in the Sentinel Stroke National Audit Programme** from a previous rating of 'E' - Our Learning from Deaths Report was presented at Trust Board and the **Standardised Hospital Mortality Index** (SHMI) data was starting to improve, although there appeared to be greater potential for harm at weekends with work underway to understand the differences to improve flow, visibility and access at weekends. There was also a need to ensure that data captured reflected those patients with dementia, as failure to do so made it appear patients were in better health then they actually were and leads to a potential overstatement of mortality measures. Three new projects had been initiated to improve communications related to **end-of-life care**.

Month	Key event
	- Received more than 10,000 responses to the **Friends and Family Test** in one month thanks to further expansion of the survey into areas not previously covered
December 2023	- The **Care Quality Commission (CQC)** were on site and visited our Emergency Department at Gloucester Royal Hospital for a focused unannounced inspection. - The new **Emergency Department** (ED) at Gloucestershire Royal Hospital is now fully operational, which includes a new Minors and the new Children's department opens in January. This significantly larger footprint will enable us to support patients when they are acutely unwell.
January 2024	- In January 2024, Kevin McNamara joined the Trust as our **new CEO,** having previously led Great Western Hospitals NHS Foundation Trust and with over 20 years in the NHS in a number of senior roles. - 29 January 2024 **BBC Panorama** documentary was broadcast. The documentary explored the challenges nationally in **maternity**, with a specific focus on our Trust's maternity services. It includes the tragic deaths of two babies and a mother and interviews midwives and families. We released a statement which you can read and since April 2020 we have invested an additional £1.8 million to increase Maternity staffing, including obstetricians, consultants, administration support and the number of Midwives working in the department has increased from 242.99 (2020) to 263.77 (December 2023). - In January 2024 the **Preventing Deconditioning Project**, funded by £15,000 from the Gloucestershire Integrated Care Board (ICB) commenced in the emergency department to facilitate all eligible patients to sit out of bed/trolley. The project will roll out through February with nursing and AHP leadership support in AMU, Courtyard, Frailty Assessment Unit, Cardiology, to become Trust wide. - Our **Patient Safety Incident Review Framework (PSIRF) Plan and Policy** were approved on 24th January by Trust Board, and these were then ratified by the Gloucestershire Integrated Board on 15 February. We will be transitioning into new ways of working from 1st March 2024.
February 2024	- We have submitted to our declaration to NHS Resolution that we are fully **compliant with all 10 Maternity Incentive Scheme (Year 5) safety actions**, In January we presented evidence for each safety standard to the Trust Board. - The head of the NHS has announced the rollout of 'Martha's Rule' in hospitals across England from April, enabling patients and families to seek an urgent review if their condition deteriorates and we will be continuing with our "Worries and Concerns" project and implementing the 3 Martha's Rule standards.
March 2024	- The Trust received a visit in March 2024 from HRH The Princess Royal, who met staff and mothers, babies and families at the maternity unit at Stroud Hospital. The royal visit was organised by Stroud

Month	Key event
	Hospitals League of Friends who have been a dedicated supporter of Stroud Maternity for decades, funding refurbishment projects and equipment. - CQC published an inspection report for our Stroud Maternity Unit and rated the service as requires improvement. - On 2 March 2024, we received a letter giving us an overview and guidance for the NHS Resolution Maternity Incentive Scheme for year 6 which will be fully published in April 2024. - Our CQC national maternity survey results were published and we have about the same scores (when compared to other maternity services) for "labour and birth", "staff caring for you" and for "care in hospital after the birth". We will respond to the results and will continue our patient experience improvement work. - On 7 March 2024 our local our local Staff Survey results were published and we had a slight percentage increase in questions related to **speaking up "**we each have a voice that counts: Raising concerns". - Our Patient Safety Incident Review Framework (PSIRF) Plan and Policy go live as we transition into a new way of working. - Introduction of '**Your chance to say thank you'** pilot enabling patients and staff a quick method to say 'thank you' to a member of staff or department. This is a collaborative project between the PALS and ward clerk management team

To improve patient outcomes and experience we must continue to maintain our collective focus on the overall quality and safety of our services, based on the national approach set out in A shared commitment to quality and The NHS Patient Safety Strategy. This includes applying the Patient Safety Incident Response Framework (PSIRF) in the development and maintenance of patient safety incident response policies and plans.

The Year Ahead

The outlook for 2024/25 is equally challenging and we will continue to make important progress on things that matter to our Gloucestershire community, our staff and our patients. We will need to keep a relentless focus on improvement, fewer delays and unnecessary processes so that we can provide the best care for our patients.

This year we will consult again on developing our **new Quality Strategy** for 2025-2029, this will outline our ambition to improve the care we provide. It will set out our aims to deliver the Best Care for our patients, improve the experience of our staff and volunteers, improve the health of our population, and ensure value for money through improvement and efficiency. As part of that journey we will complete the NHS IMPACT self-assessment and use this to create a shared, measurable plan for embedding improvement, systematically using improvement as the approach to deliver key priorities.

To improve patient outcome and experience we must continue to focus on the overall quality and safety of our services. In line with the NHS Operating Plan 2024/25 we will continue to implement the Patient Safety Incident Response Framework and our key **Safety Priorities**

will be our Quality Priorities for 2024/25. In addition to the safety priorities we will continue with our journey and focus on deterioration and with this we will be scoping implementing Martha's Rule.

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

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

Kevin McNamara
Chief Executive Officer

Parts 2 and 3

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into parts:

- Part 2
    - Part 2.1
        - 2.1.1 What our priorities for 2024/25 are
        - 2.1.2 How well we have done in 2023/24
    - Part 2.2: Statements of assurance from the Board
    - Part 2.3: Reporting against core indicators
- Part 3: The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2

Part 2.1

2.1.1 Our priorities for 2024/25

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

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

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

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

Patient Safety Incident Response Plan (PSIRP)
For next year, we have chosen to focus on our Patient Safety Incident Response Plan (PSIRP) as this sets out how Gloucestershire Hospitals NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Data Sources
Data sources were identified by the Patient Safety Incident Response Framework (PSIRF) working group based on those which would provide insight into our patient safety incident profile. Using these sources, data representing the preceding 12 months (June 2022 – May 2023) was reviewed, as the preceding years were impacted by the COVID-19 pandemic and were therefore potentially not representative of the ongoing safety profile of the organisation. It is intended that a small-scale data review will occur again 18 months after publication to cover the data period June 2022 - May 2024, to validate the selection of safety priorities with a larger data set and a full data review occurring, every four years. At this time, the PSIRP will be updated as necessary, to ensure that it continually reflects the organisation as it changes.

- The data sources used to identify our initial safety priorities include:

- Patient safety incidents,
- Risks and their controls,
- Claims
- Complaints
- Staff survey
- Inquests
- Freedom to Speak Up themes
- Patient Advisory & Liaison (PALs) themes
- Friends and Family Test (FFT) themes

Stakeholder Engagement

An initial list of potential safety priorities was identified by comparing the themes contained within these data sets and identifying areas of commonality. Whilst consideration was given to the frequently occurring outcomes, the focus was largely on the underlying issues and factors that appeared to contribute to different safety incidents and other forms of unwanted outcomes. This list was initially reviewed by the PSIRF working group, which consisted of members of the patient safety, risk and quality teams from across the Trust. This initial review identified a list of potential safety priorities, which were then shared with staff Trust wide through a Quarterly Pulse Survey. Through this survey, staff members were able to comment on the proposed priorities by answering the following question:

Figure 1: Quarterly Pulse Survey Question

As part of the development of our Patient Safety Incident Response Plan, a review of our data has highlighted the following themes from safety incidents, risks and patient feedback. Which of these do you believe should be included as Trust Safety Priorities for the coming year? (Choose up to 3)

▪ Staffing

▪ Culture (i.e., Our organisational behaviours, values and normal practices)

▪ How we introduce and use digital systems in our clinical and administration processes

▪ Environment design and facilities

▪ Falls

▪ Pressure Ulcers

What else would you include that is not listed above and why?

Using the feedback from the survey, supplemented by an additional review of emerging risks the safety priorities listed below were agreed.

Due to ongoing improvement work within the maternity department, this supplemental review

included further consideration of any trends which highlighted the necessity for maternity specific safety priorities, which were not already encompassed by the identified Trust-wide safety priorities. This additional review concluded that whilst the majority of the Trust-wide safety priorities were equally relevant to maternity, an additional safety priority related to the recognition and escalation of deterioration within pregnancy, should be considered. This was subsequently added to the priorities listed below.

Our patient safety incident response plan: local focus

Patient Safety Incident type or issue	Description	Planned response and anticipated improvement route
Staffing	Risks and incidents where inadequate numbers of staff or skill mix have been identified.	Trends identified and incidents reviewed and used to inform the workforce sustainability work stream of the people and organisational development strategy.
Culture	Risks or incidents where team / department or organisational culture is impacting on behaviours, standards or safe delivery of services/ care.	Trends identified and incidents reviewed and used to inform the staff experience work stream of the people and organisational development strategy.
Digital Systems	Risks and incidents related to the introduction and use of digital clinical systems.	Trends identified and incidents reviewed by the clinical systems safety group. Emerging risks/ issues identified for Quality Summits and inform ongoing improvement efforts
Flow and discharge	Risks and incidents related to impeded patient flow from assessment to discharge, including delays to discharge, excluding clinical complications.	Trends identified and incidents reviewed and used to inform the discharge improvement programme and the urgent and emergency care work stream. Emerging risks/ issues identified for Quality Summits and inform ongoing improvement efforts
Communication	Risks and incidents that relate to communication between staff and	Trend analysis used to inform quality improvement efforts

Patient Safety Incident type or issue	Description	Planned response and anticipated improvement route
	patients and their families	
Patient Falls	Patient fall	Incidents reviewed and trends identified Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at falls learning hub. Learning, trends and annual audit used to inform improvement programme. Annual quality summit.
Pressure Ulcers	Hospital acquired pressure ulcers	Incidents reviewed and trends identified. Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at pressure ulcer learning hub. Learning & trends used to inform improvement programme. Annual quality summit.
Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery	Risks and incidents where delays in recognition and/or escalation of deterioration during pregnancy and/or delivery have or could have affected the safe care and outcome for mother or baby.	Trends identified and incidents reviewed by the maternity governance team; Individual incidents that meet national (mandated) criteria for PSII to be referred to MNSI and Patient Safety Review Panel. Emerging risks/ issues that do not meet criteria for referral to MNSI or Patient Safety Review Panel to be identified for Quality Summits and inform ongoing improvement efforts.

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

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

Health Inequalities

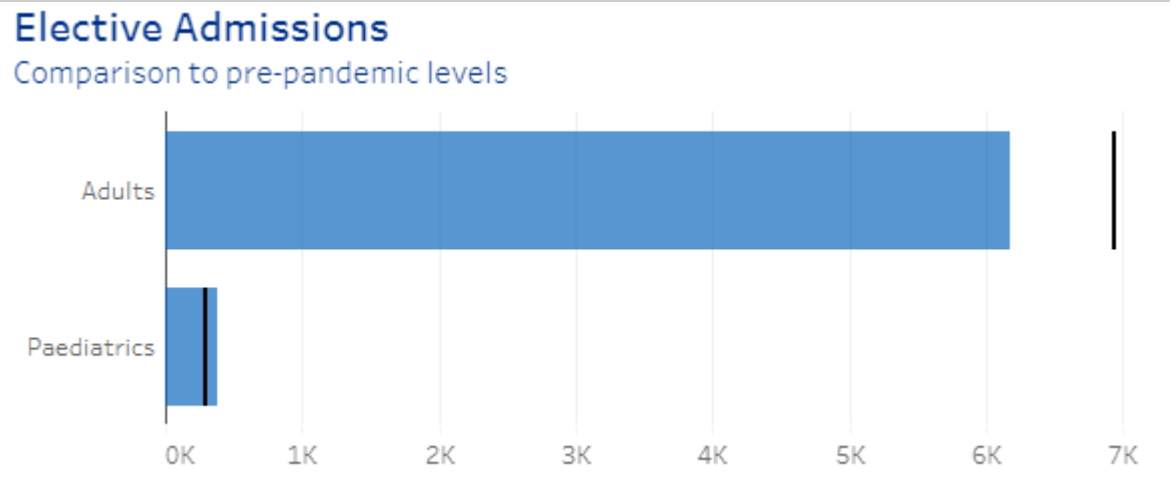
Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can affect both our physical and mental health and wellbeing. Health inequalities can stem from barriers individuals experience when accessing healthcare services, or poor experiences of healthcare that deter individuals from future engagement. These scenarios can contribute to delayed healthcare access and poorer outcomes as a result.

Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs. NHS England's Healthcare Inequalities Improvement Programme's vision is for the NHS to deliver "exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes". Good quality, robust data enables the NHS to understand more about the populations we serve. It enables NHS bodies to identify groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and deliver targeted action to reduce healthcare inequalities.

Elective Recovery

- Over the last 12 months, **children's elective services at the trust are treating a similar number of patients compared to pre-pandemic levels** (financial year 2019/20). In April of this year, 382 children had some form of elective procedure or surgery carried out compared to 283 in April 2019
- However, **delivering elective adult services at pre-pandemic levels has been much more challenging**, with the trust consistently performing fewer procedures last year compared to 2019/20
- However, **all demographics within Gloucestershire have been affected equally**. There is no difference due to age, gender, ethnicity or deprivation. All available evidence points to patients being treated in order of clinical urgency. This would suggest the **downturn in activity is due to capacity constraints, rather than any particularly group taking priority**, either consciously or unconsciously.

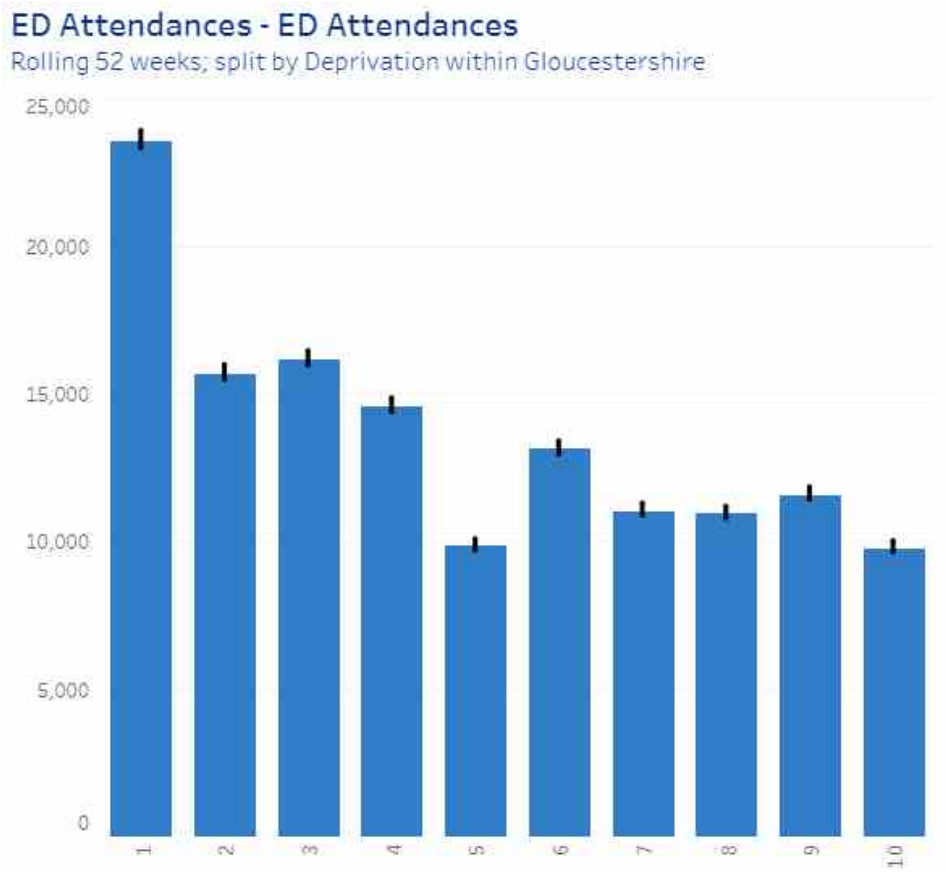
Figure 1. Elective admissions in April 2024 compared to pre-pandemic levels



Emergency Care

- Across all sectors of our hospital, **demand for services correlates with deprivation** i.e., people living in the most deprived parts of the county are much more likely to require hospital care.
- This is most pronounced for our emergency services; people living in the top 10% most deprived areas are **1.5x more likely to attend A&E** and **1.3x more likely to be have an emergency admission**, compared to people living the next 10%.
- This is true for both adults and children.

Figure 2. Number of attendances to A&E in the last 12 months, split by deprivation (1 = most deprived, 10 = least deprived)



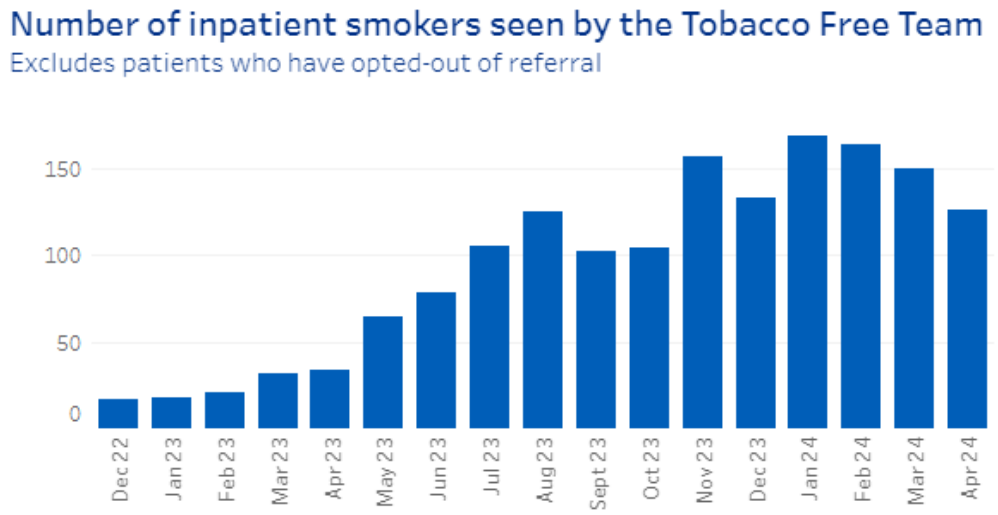
Smoking Cessation

- Smoking cessation sits across all the domains of the Core20Plus5 adult framework.
- Since December 2022, the trust has employed tobacco treatment advisors to offer support to patients on wards on an opt-out referral, to support them to give up smoking by providing them with evidence based bedside interventions and Nicotine Replacement Therapy. We also follow up, and referral to community service for onward support.
- As of June 2023, we offer this service across our Gloucester and Cheltenham sites, and **60% of all smokers who were inpatients on our wards were offered support from one of our advisors.**
- The service is also available to all trust staff who would like support in stopping smoking.
- We have also vastly improved how we record a patient's smoking status when they visit one of our wards, through a combination of better use of technology and offering

training to staff. Over the last 6 months, **99% of patients were asked about their smoking status on admission.**

- Provide **Very Brief Advice (VBA) training** to staff to improve their knowledge and confidence around smoking.

Figure 3. Number of smokers offered support to stop smoking in hospital, per month



Children's Oral Health

- Over the last 12 months, 74 tooth extractions were carried out due to tooth decay in children aged 10 and under
- We found **no differences due to age, gender or ethnicity**
- However, we found that **children living in the most deprived part of the county are much likely to require a tooth extraction due to tooth decay** e.g., places like Cinderford, Coleford, and Newnham in the Forest of Dean, Matson in Gloucester, as well as parts of Stonehouse in Stroud.

Deprivation

- The English indices of multiple deprivation measure relative deprivation in small areas of England called lower-layer super output areas (LSOA). The index of multiple deprivation (IMD) is the most widely used
- These measures can be used to compare regions to one another to determine whether they are more or less deprived than one another, relative to the rest of England
- Locally we also look at comparing how deprived an area is to the rest of Gloucestershire

Why do we use deprivation relative to Gloucestershire?

- While comparisons of deprivation to England as a whole are useful, it is also useful to consider deprivation relative to other parts of Gloucestershire. For example, an area may not be considered particularly deprived when compared to other parts of England, but may still have worse outcomes and less access to services compared to other parts of the county. Therefore, if when we are evaluating whether there are

inequalities present in our community, we need to consider this alongside a local picture as well as a national one.

- Deprivation is made of 7 domains:
    - **Income** – measures the proportion of the population experiencing deprivation relating to low income
    - **Employment** – proportion of working age people involuntarily excluded from the labour market
    - **Education** – measures the lack of attainment and skills in the local population
    - **Health** – measures the risk of premature death and the impairment on quality of life due to poor physical or mental health
    - **Crime** – measures the risk of personal and material victimisation
    - **Barriers to Housing & Services** – measures the physical and financial accessibility of housing and local service
    - **Living Environment** – measures the quality of both 'indoor' and 'outdoor' local environment

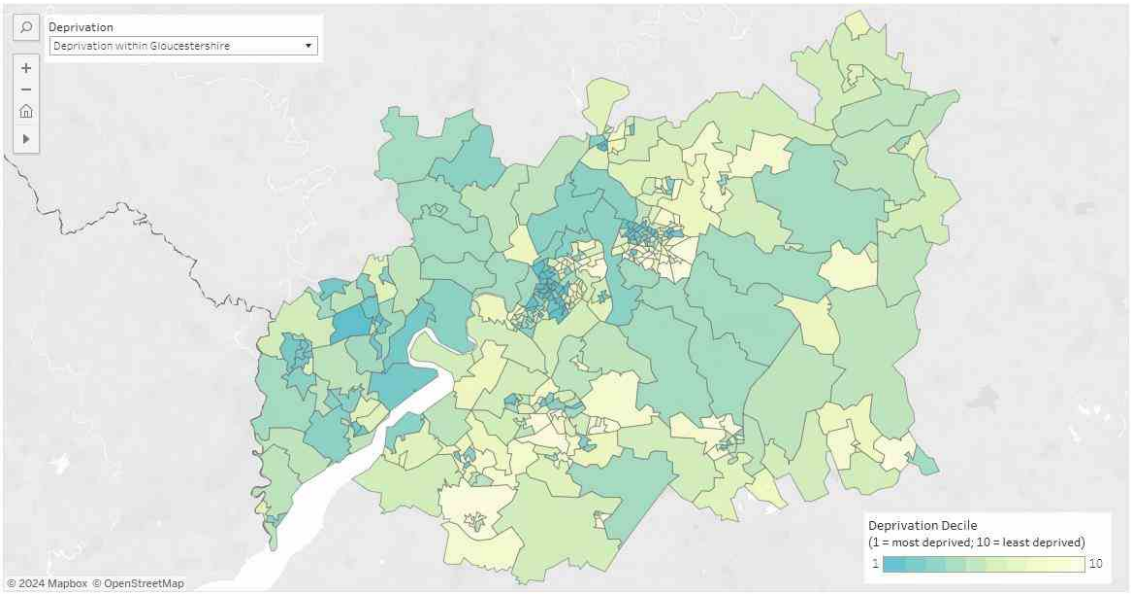


Figure 4. Deprivation compared to the rest of Gloucestershire (1 = most deprived; 10 = least deprived)

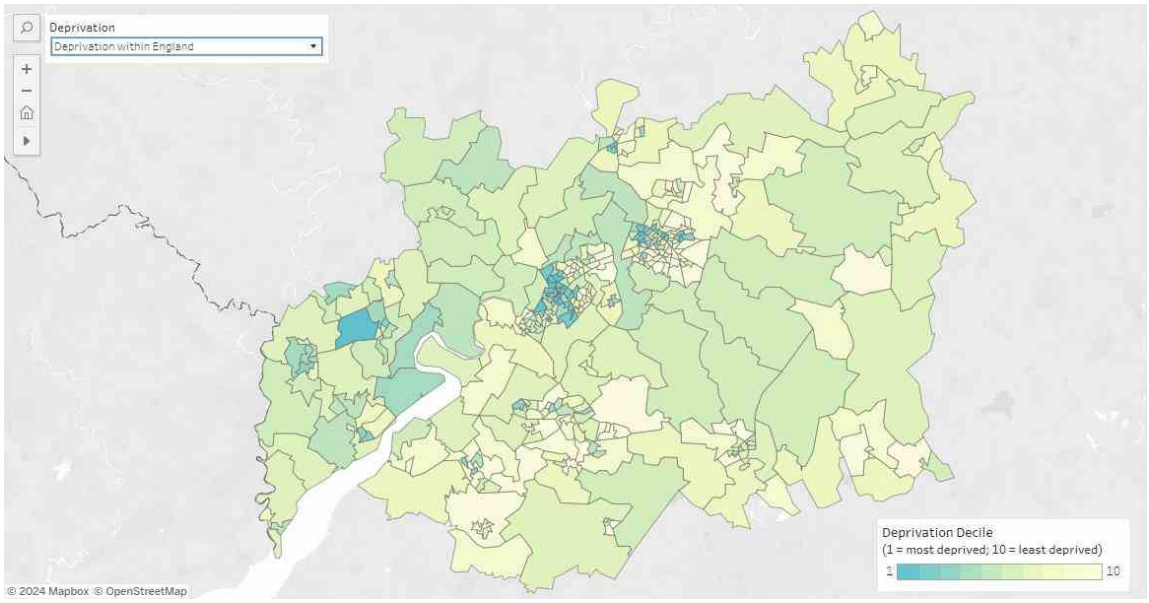


Figure 5. Deprivation compared to the rest of England (1 = most deprived; 10 = least deprived)

Areas of improvement for 2024/25:

A key priority for the trust in the upcoming year is to develop a Health inequalities strategy/plan. This will act as a framework for delivery of health inequalities activity within the trust.

Data Quality

- Ethnicity is one area where our data capture is poor in regards to data quality. As a Trust, we are **expected to record ethnicity for 95% of patients**, but we are below this for inpatients, outpatients and waiting lists. **Only 90% of patients on our waiting lists have their ethnicity recorded**. While we have not encountered any observable differences due to ethnicity, this may be to certain groups being missed in our data capture. We can't assume we are providing an equitable service if we are not recording ethnicity consistently. Therefore, an ambition to improve data quality in the upcoming year should be prioritised.
- Further understanding of those patients that are waiting on the waiting list for a long period of time.
- Data capture for protected characteristics in all indicators could be improved.
- Work with patient experience team to further understand the experiences of patients accessing hospital services.
- Work with services to further understand patient demographics specific to their area and identify areas of improvement.
- Ensure services are aware of the translation and interpretation service.
- Consideration to the **accessibility of information**, services and support, and digital inclusion for patients; by applying the Core20Plus5 framework, digital inclusion framework, inclusion health framework.
- EHIA can support and inform actions to support and reduce healthcare inequalities, therefore implement a proactive approach to ensure that any policies, programmes, proposals or initiatives meet the necessary Equality Act duties.

- In order to improve the access, experience and outcomes of our patients improve partnership working with VCSE, local government and anyone else involved in the care of our patients.
- Workforce- consider health inequalities within the staff population and provide improvement suggestions for staff wellbeing.

1.1 A summary position for our priorities for improving quality 2023/24

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
1.	To improve maternity safety/ experience	The priority for 2023/24 will be focused on delivering the 10 safety standards within the NHS Resolution **Maternity Incentive Scheme (MIS)**.	At the beginning of the year new safety standards were published and by February 2024 we have submitted a position of achieving 10/10.
2.	To improve emergency department (ED) care safety/ experience	One of our programmes of work we have chosen to report on will be delivering the Commissioning for Quality and Innovation indicator (CQUIN 05) "**Identification and response to frailty in emergency departments".**	Our aim was to achieve 30% by the end of the year. Our starting position at quarter 1 was 29% and we finished the year with a slightly decreased position of 27%. Operational pressures impacting on the ability to complete assessments.
3.	To improve adult inpatient safety/ experience	Our adult inpatient Friends and Family feedback tells us that patients do not like to be cared for **in non-designated bed spaces**, including boarding, and therefore our focus will be on monitoring and then reducing/eliminating our use of escalation beds.	We started the year with an average of 20 patients a day in non-designated bed spaces and finished the year with a decrease to 8. Our plan is to reduce this to zero but operational pressures continue to impact on the flow of patients through the hospital.
4.	To improve experience of discharge	In order to release beds for waiting patients we will have an improvement programme focused on our **discharge lounge** (this is a change from simple discharges).	We started the year with an average of 15 patients per month attending the Discharge Lounge and by March 2024 this has **increased** to 19. We will continue to improve the number of patients using this facility.
5.	To enhance and improve our safety culture	To enhance and improve our safety culture we will be implementing the **National Patient Safety and Incident Response Framework (PSIRF)** which will bring a	Our 2023 Staff Survey scores, for the raising concerns questions, have **increased** by an average of 1%.

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
		change to our safety investigation work and we will be **focusing on staff being able to raise their concerns (Staff Survey questions 20a, 20b, 25e, 25f.**	
6.	To improve our prevention of harm (pressure ulcers and falls)	The priority for 2023/24 will be to improve our risk assessment, prevention and management of harm in relation to **pressure ulcers and falls.** This will include the delivery of the CQUIN (CQUIN12) assessment and documentation of pressure ulcer risk assessments.	At the beginning of the year our compliance rates were 62% (aim 85%) and by the end of the year our position was 64.25%. There was a 2% improvement and this work will continue as this is a safety priority next year.
7.	To improve our care for patients whose condition deteriorates	We are one of 7 Trusts who have been chosen by NHS England to implement improvement work in the area of including patients/carers and their families in identifying deterioration – our "**Worries and Concerns Programme**" of improvement work. Alongside this programme, we have reviewed the CQUIN07 recording of and response to NEWS2 scores for unplanned critical care admissions.	Our aim was that we would be achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration. We started the year with 32% compliance and ended the year with improved scores of 52% - this was an improvement of 20%.
8.	To improve mental health care for our patients coming to our acute hospital	We will be continuing the implementation of the Trust's Mental Health Strategy – **Whole Person Care Strategy**.	We have improved our systems for requests for enhanced care professionals reducing spend for temporary (agency) Registered Mental Health Nurses.
9.	To improve our care for patients with diabetes	Our focus will be on carrying out improvement work in response to the national **diabetes** audit findings.	We have focused our improvement efforts on improvement identified by national audits and GIRFT data.
10.	To reduce health inequalities	We will continue to deliver the Core20Plus5 health inequalities programme	We began the year with % compliance rates of recorded smoking status

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
		focused on **tackling tobacco dependency** for colleagues, inpatients and in maternity.	on admission at 75% and by April we have increased this to 86%.
11.	Surgical experience	Our focus will be delivering on the Commissioning for Quality and Innovation Indicator (CQUIN 02) **supporting patients to drink, eat and mobilise (DrEaMing) after surgery.**	We started the year with overall compliance rates of 90% and at the end of the year we had made an improvement and scores were at 95%.
12.	Equality, diversity and inclusion – equality priorities	The Patient Experience Team will be enabling the delivery of **2 equality priorities** by improving our translation and interpretation services and focusing on the accessibility of our services.	As part of the Equality Delivery System Gloucestershire Integrated Care Board in conjunction with Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust along with system partners have rated Gloucestershire for domain one of the EDS as 2 – achieving activity. This is a maintained position from previous year.
13.	Commissioning for Quality and Innovation (CQUINs)	We will be focused on delivering our 5 CQUINs – **CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery** (TARGET - 80% of patients within 24hrs) – **CQUIN04:** Prompt switching of intravenous to oral antibiotic (TARGET 40% of fewer) – **CQUIN05: Identification and response to frailty in emergency departments**	See CQUIN results for each programme within the report.

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
		(TARGET 30% receiving clinical frailty assessment) – **CQUIN07: Recording of and response to NEWS2 score for unplanned critical care** (TARGET 30% having timely response Early Warning Score (EWS) 5-6 60-minute response and EWS 7+ response time 30 min) – **CQUIN12: Assessment and documentation of pressure ulcer risk assessments (**Target: 70% to 85%).	
14.	Caring for people at the end of their lives	We will support the improvement of our compliance with national guidance on care at the end of life (One Chance to Get It Right, NICE guidelines and the Quality Standards for end of life care).	At the start of the year we used the feather icon (signifying end of life) 31 times and at the end of the year increased this to 42.

1. Quality priority - To improve maternity safety/ experience

To improve maternity safety/ experience	The priority for 2023/24 will be focused on delivering the 10 safety standards within the NHS Resolution **Maternity Incentive Scheme (MIS)** for year five.

Background

The priority for 2023/24 was focused on delivering the 10 safety standards within the NHS Resolution **Maternity Incentive Scheme (MIS) for year five**. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Specifically, Safety action 7 has a focus on patient experience and requires the service to listen to women, parents and families using maternity and neonatal service and co-produce services with users. We have worked collaboratively with Gloucestershire Maternity and Neonatal Voices (GMNVP) to develop our priorities to improve the experiences of our maternity service. These are now reviewed and monitored at our Maternity and Neonatal Experience Group.

How we have performed 2022/23

The Maternity Service were able to report that they were compliant with ten out of ten standards and submitted this return to NHS Resolution in February 2024.

Table: Summary of Safety Action Compliance (link)

Safety Action	Description	Compliance
Safety Action 1	Are you using the National Perinatal Mortality Review Tool to 8 review perinatal deaths to the required standard?	Compliant
Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Compliant
Safety Action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the	Compliant

Safety Action	Description	Compliance
	recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?	
Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant
Safety Action 5	Can you demonstrate an effective system of midwifery 37 workforce planning to the required standard?	Compliant
Safety Action 6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Compliant
Safety Action 7	Can you demonstrate you listen to women, parents and families using maternity and neonatal services and coproduce services with users?	Compliant
Safety Action 8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Compliant
Safety Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant
Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Compliant
Overall		**10/10 Compliant**

The Maternity Service awaits confirmation of their position by NHSR and this should be received in April 2024.

Plans for improvement 2024/25

The plan for 2024/2025 will be to implement year 6 of the Maternity Incentive Scheme but this will not be reported in the account as we will focus on the Patient Safety Priority - **Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery**.

2. Quality priority - To improve emergency department (ED) care safety/ experience

To improve emergency department (ED) care safety/ experience	One of our programmes of work we have chosen to report on will be delivering the Commissioning for Quality and Innovation indicator (CQUIN 05) "**Identification and response to frailty in emergency departments".**

Background

Although important before, it is now even more of a priority for hospital teams to develop and adapt their services for vulnerable adults, such as older people living with frailty. This requires early and appropriate assessment to identify those who need hospital admission and those whose needs may best be met by Same Day Emergency Care Services (SDEC).

Frailty is an important marker of adverse outcomes for older people accessing emergency care. Identifying the most at risk older people in Emergency Departments (EDs) may help guide clinical practice, and service improvement in emergency care. If frailty identification is to be used to direct patients towards an appropriate clinical response, it is logical for the process to start at the beginning of the patient's urgent care episode. For example, delays in identifying and managing delirium (a hyper-acute manifestation of frailty) are associated with increased patient harm. Earlier identification and management of frailty syndromes, such as delirium, has the potential to improve outcomes.

In 2023/24, we took part in the Commissioning for Quality and Innovation (CQUIN) with the ambition of achieving 30% of patients of our patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

Table: CQUIN goals

CQUIN05: Identification and response to frailty in emergency departments	
Applicability: Acute CQUIN goal: 10% to 30% Supporting ref: SDEC guide to frailty – Link	There are well-evidenced links between frailty and adverse health outcomes including deconditioning, malnutrition and irreversible cognitive decline which may all lead to increased health and care requirements. Early identification of frailty can mitigate some of these risks. Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) was asked to provide acute frailty services for at least 70 hours a week. Patients with grades of frailty (clinical frailty score (CFS) 6 or above) should be assessed for frailty associated syndromes via a comprehensive geriatric assessment and/or be referred to the acute frailty service.

How we have performed 2023/24

There is a growing awareness that the identification of frailty in the urgent care context is important, allowing a population at high risk of harm and resource use to be flagged for focussed interventions.

Frail older people usually present with a range of issues, not just medical, and require a thorough, multidisciplinary management plan. Isolated medical interventions cannot alone optimise outcomes for these people – a more holistic, multidimensional care model is required. Comprehensive geriatric assessment (CGA) is a structure for the thorough assessment and management of a person's medical, psychological, functional, social and environmental circumstances and needs. It improves patient and service outcomes, and increases the likelihood that patients survive and are back home 3 to 12 months after discharge.

Description

We took part in in the CQUIN with the ambition of achieving 30% of patients of our patients aged 65 and over attending the emergency department (ED) or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

Table: CQUIN results

Quarter (Q)	Denominator	Numerator	Results	Narrative
Q1 report	99	28/99	29%	Where screened, 8 patients were found to have a frailty score of 6+. 7 of these had a CGA initiated, and 1/6 were appropriately referred to the acute frailty service. GSQIA Silver course underway focussing primarily on ensuring patients 65yrs+ have a frailty assessment score documented.
Q2 report	80	9/80	11.3%	15% (12) had a frailty score documented Of these patients, who had a score, three had a score of 6+. None of the three had a Comprehensive Geriatric Assessment (CGA) or referral to Acute Frailty Service (AFS) completed (remaining 9 appropriately scored and not referred).

Quarter (Q)	Denominator	Numerator	Results	Narrative
Q3 report	97	23/97	24%	Overall compliance 24% (23/97) 27% (26) had a frailty score documented, and of these x8 had a score of 6+. 5 of these (62.5%) had a CGA completed. 2/8 were not applicable for referral to acute frailty, so 4/6 were referred.
Q4 report				Overall compliance 26% (26/100) 27% (27) of patients had a frailty score documented, and of these x11 had a score of 6+. 100% (11) of these had a CGA completed and x 7 (64%) were referred to the acute frailty service

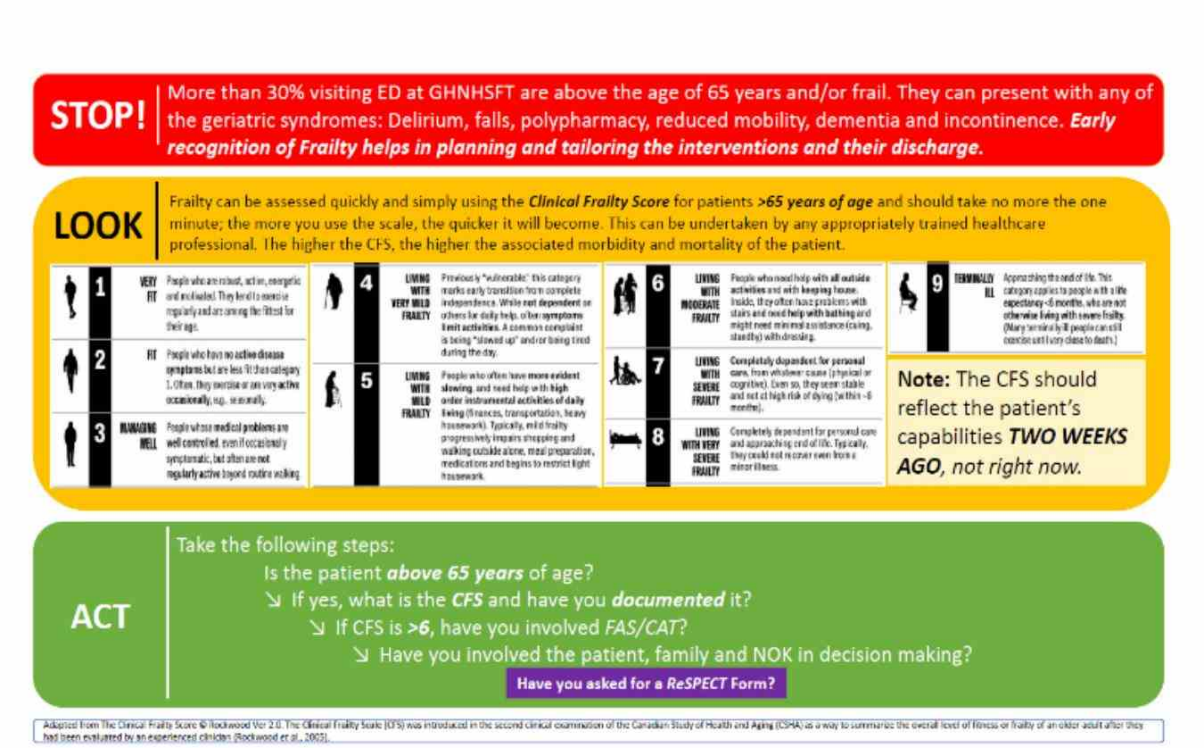
Commentary on the data

- Frailty is an important marker of adverse outcomes for older people accessing emergency care.
- The advantages of identifying frailty in the ED include prompting a more holistic clinical assessment, influencing clinical decision-making, guide disposition decisions and service design.

Following discussions with key stakeholders. **p**lan, **d**o, **s**tudy, **a**ct (PDSA) cycles are focussing on targeted education of staff through teaching sessions and the creation of a visual prompt (see below NB – draft copy, awaiting further changes to align with ED messaging), and changes to the electronic documentation of frailty score at triage. Currently frailty score is a non-mandatory field resulting in poor compliance with completion. The hope is it can be made a 'significant field' with the additional evidence of initiation of a comprehensive geriatric assessment (CGA) where appropriate and/or referral to the acute frailty service, however this requires further discussion to ensure there are no difficulties created where patients attend via other routes.

One of the improvement initiatives was to create a poster which flags to our colleagues when to consider completing the frailty assessment.

Chart: Improvement initiative used to improve recognition and completion of scores



Adapted from The Clinical Frailty Score © Rockwood Ver 2.0. The Clinical Frailty Scale (CFS) was introduced in the second clinical examination of the Canadian Study of Health and Aging (CSHA) as a way to summarize the overall level of fitness or frailty of an older adult after they had been evaluated by an experienced clinician (Rockwood et al., 2005).

Plans for improvement 2024/25

Identifying that a patient is living with frailty is as important as identifying illness severity. Both contribute to immediate and longer-term patient experience and outcomes. There will be a frailty work stream with the 'clinical vision of flow' work and there has been some scoping for 2 Silver QI projects looking at frailty scoring, including in and out-patients. We will continue this work in 2024/25 and we will be reporting on this in the Quality Account.

3. Quality priority - To improve adult inpatient safety/ experience

To improve adult inpatient safety/ experience	Our adult inpatient Friends and Family feedback tells us that patients do not like to be cared for **in non-designated bed spaces**, including boarding, and therefore our focus will be on monitoring and then reducing/eliminating our use of escalation beds.

Background

Boarding is the term used when placing a patient in an undesignated bed space usually in a corridor on a ward. In October 2022, the Trust implemented boarding to reduce ambulance handover delays. This had been trialled at North Bristol NHS Trust in August 2022 and the change involved moving patients from the Emergency Department (ED) to hospital ward corridors irrespective of bed availability. NHS England encouraged Trusts to implement this model. The Royal College of Emergency Medicine recommended boarding in response to a full Emergency Department. Our adult inpatient Friends and Family feedback told us that patients did not like to be cared for **in non-designated bed spaces**, including boarding, and so our focus has been on reducing/eliminating our use of these non-designated bed spaces.

How we have performed 2023/24

Patients are best served by being taken to their speciality ward into a designated bed space. Moving patients to corridors inside already full wards enables us to take new emergencies patients and this must be done with care, caution and with safety in mind. Crowding in the emergency department is associated with increased mortality and poor patient and staff experience. Delayed off-loading of patients from emergency ambulances has a consequent issue of reduced ability to attend further emergency calls. Emergency departments can become crowded for many reasons, but a lack of inpatient bed capacity and the resulting “exit block” from the department is one of the key factors. Our ED tends to start fill up from mid-morning, but often inpatient beds often become available late in the afternoon or early evening. This was one of the reasons for us to create our discharge lounge as this was to enable wards to take ED patients earlier and patients who were to be discharged had their care in the lounge area.

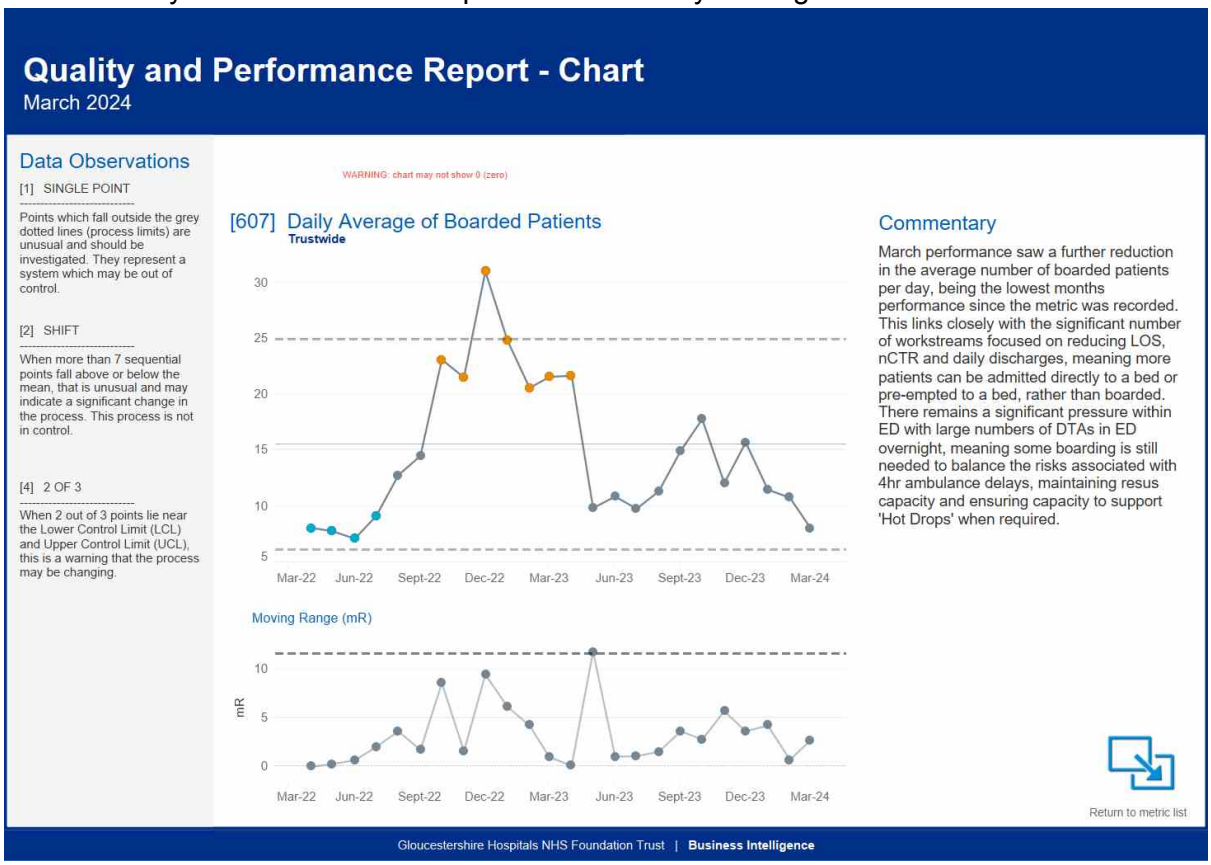
Our ED is often “boarding” patients who need to be admitted and this in turn is congesting the department and maximising staff demand, impeding the care of newly arriving emergency patients. To mitigate this situation, using the Trust Escalation Policy, specified wards take admissions to undesignated bed spaces in their corridors. The patients need to meet certain criteria in order to be boarded and one benefit is that they have the right specialised staff caring for them. The action of boarding in corridors does then lead to further issues as we might have decompressed ED in the short term but the long-term issue is that the wards have more patients to care for and can pay less attention to focusing on enabling discharges to happen.

Through our detailed analysis of our data it shows us that boarding has not had the impact on flow it was assumed that it would although there are occasions when it has positively

impacted on the risk profile of ED and/or the community when in extremis. This is probably due to the impact it has on the ability to ‘pre-empt’. Effectively filling our hospitals and reducing, rather than increasing flow. There are occasions when the organisation works outside of policy which increases the risk of regulatory enforcements. There may be a place for boarding in our escalation process, but the current triggers are not appropriate, this will be rectified as current escalations and triggers are reviewed.

In March 2024, our data performance saw a further reduction in the daily average number of boarded patients per day. The figures for March recorded that there were the lowest number of patients, 8, since the metric was recorded. This reduction also aligns with the number of comments we received in our friends and family test data relating to experiences of boarding. This improvement links closely with the significant number of work streams focused on reducing length of stay, reducing the number of patients with no criteria to reside and increasing the number of daily discharges. These improvement programmes mean that more patients can be admitted directly to a bed, rather than being boarded in an undesignated bed space. Unfortunately, there remains significant pressure within the Emergency Department, with large numbers of patients with a decision to admit waiting for a bed in the Emergency Department overnight, meaning that some patients will need to be boarded to balance the risks associated with greater than 4-hour ambulance delays, maintaining resuscitation bay capacity and ensuring there is capacity to support emergency ‘hot drops’ when required.

Chart: Quality and Performance Report – Chart - Daily Average of Boarded Patients



Plans for improvement 2024/25

Our analysis has demonstrated that moving patients to already full wards does not ultimately improve flow through the hospital. Our focus must be on enabling our patients to discharged to their homes in a timely way and to utilise our beds effectively. This metric will continue to have oversight from the Board as will be reported within the Quality and Performance Report and the improvement focus will be moved to enabling timely and **effective discharges as we will focus on the Patient Safety Priority – flow and discharges.**

4. Quality priority - To improve experience of discharge

To improve experience of discharge	In order to release beds for waiting patients we will have an improvement programme focused on "**simple" discharges**. N.B., We have amended this priority to the use of discharge lounge as simple discharge programme was delayed in implementation and starts 2024/25

Background

Our Discharge Lounge

To improve the patient experience of flow through the hospital and discharge home or to another care setting, a new £1.5m discharge lounge opened in February 2023, accommodating 29 patients, with room for 5 beds and 4 reclining chairs. Use of the discharge lounge frees up hospital beds as early as possible, helping to reduce the length of time that patients wait in the emergency department or are required to wait for a bed on the wards.

How we have performed 2023/24

A series of quality improvement initiatives have seen improved use of the discharge lounge from both the ward and emergency departments, to improve flow through the hospital. This means patients can be accommodated on the appropriate specialty ward and ambulance handover delays are minimised for patients awaiting admission to the emergency department.

The discharge lounge is open from 7:00am-7.30pm, and has aimed to accommodate at least 10 patients by 10:00am. Patients are able to access food and beverages, their medicines and a range of books, magazines or television channels while they await their transport. Situated at the rear of the hospital the discharge lounge offers easy and accessible access for transport collection.

The ward use of the discharge lounge has steadily increased throughout 2023-4, from a weekly average of 45 patients being discharged through the lounge in March 2023 to a high of 157 patients being discharged through the lounge in the peak of winter, in January 2024. The discharge lounge chart below also demonstrates an increase of patients per day, including over the weekend, as we aim to increase the number of patients who can be discharged over the weekend.

Chart: Discharge Lounge Data 31 March 2024

Continuous monitoring and reporting of the use of the discharge lounge on out Business Intelligence Hub permits continuous improvement in identifying times or days that use of the discharge lounge could enhance overall patient experience.
The medical division has established discharge co-ordinator roles to help ward staff facilitate complex discharges.

Emergency Department has enhanced its use of the discharge lounge throughout 2023/2024 from a daily average of 1-2 patients to a daily average of 4 patients. The weekly average of emergency department patients using the discharge lounge rose from 6 patients in June 2023 up to 30 patients in the peak of winter in February 2024. Each emergency department patient discharged through the lounge frees up a bed or chair for a waiting patient or ambulance to offload. We have added some specific questions to the friends and family test and early data shows that 80% of patients using the lounge felt their experience was very good or good.

Plans for improvement 2024/25

- We will continue to maximise the use of the Discharge lounge by the wards and emergency department by analysing and reporting the metrics to look for opportunities to grow.
- We will listen to feedback from patients on their experiences of the discharge lounge in order to improve, through continued use of specific questions on the friend and family test
- We will continue to monitor and improve our patients awaiting a discharge summary when this causes delays to discharge

- We will continue to monitor our potential patients eligible for the discharge lounge to understand and alleviate any blockages to smooth flow for patients.
- The improvement focus **will focus on the Patient Safety Priority – flow and discharges.**

5. Quality priority - To enhance and improve our safety culture

To enhance and improve our safety culture	To enhance and improve our safety culture we will be implementing the **National Patient Safety and Incident Response Framework (PSIRF)** which will bring a change to our safety investigation work and we will be **focusing on staff being able to raise their concerns (Staff Survey questions Q20a, Q20b, Q25e, Q25f).**

Staff Survey https://cms.nhsstaffsurveys.com/app/reports/2023/RTE-benchmark-2023.pdf

Background

Improving our safety culture remains a priority in line with the implementation of the National Patient Safety Strategy and Patient Safety Incident Response Framework (PSIRF). On the 16 August 2022, the PSIRF was published. PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents (unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patient) for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (2015) and makes no distinction between 'Patient Safety Incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS and is a key part of the NHS patient safety strategy.

PSIRF is not an investigation framework that prescribes what to investigate, instead it supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute healthcare providers.

Organisations are expected to transition to PSIRF within 12 months, completing by Spring 2024.

How we have performed 2023/24

Introduction of the Patient Safety Incident Response Framework (PSIRF)
The Trust transitioned from the Serious Incident (SI) framework to the PSIRF on the 01 March 2024. An implementation plan has been produced and has been shared with the wider patient safety team at a team briefing held on the 4 March 2024. A task and finish group is being established to coordinate the process development and testing that is required to support the transition.

PSIRF has introduced new training obligations, which vary by role. Individuals are currently being directed to undertake training which is of limited availability, but free of charge, through the Health Services Safety Investigations Body (HSSIB) or attend the online learning that was procured by the Integrated Care Board (ICB). Whilst other avenues are being pursued to fulfil this training obligation, there may be a requirement to arrange the necessary training through an external training provider at a cost.

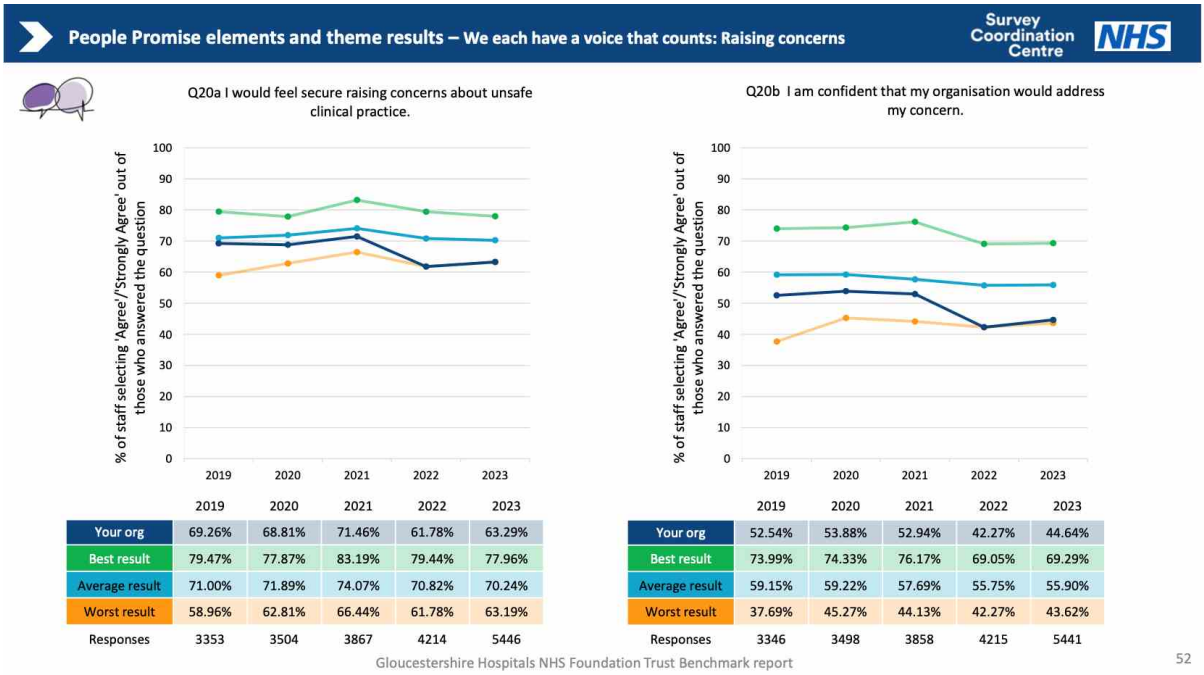
National Patient Safety Training
Level 1 national patient safety training was launched on the 20 February 2024 and is now available to all staff through the Electronic Staff Record (ESR). 22% of staff completed the training in the first two weeks.

Introduction of the Learn from Patient Safety Events (LFPSE) and Datix Cloud (DCIQ) Incident Reporting
Implementation may be impacted due to a previous shortage of end user testing and the requirement from the Information Governance team to complete a further data protection impact assessment (DPIA). The target implementation date of the module at the start of April 2024 is currently at risk, due to these two issues, which we continue to try and progress.

Safety culture and raising concerns
In our Quality Strategy, we stated that we would use our Staff Survey questions to monitor the safety culture within the Trust. This year the raising concerns culture metrics have improved across all 4 questions by an average of 1% (see charts for **Staff Survey questions Q20a, Q20b, Q25e, Q25f).**

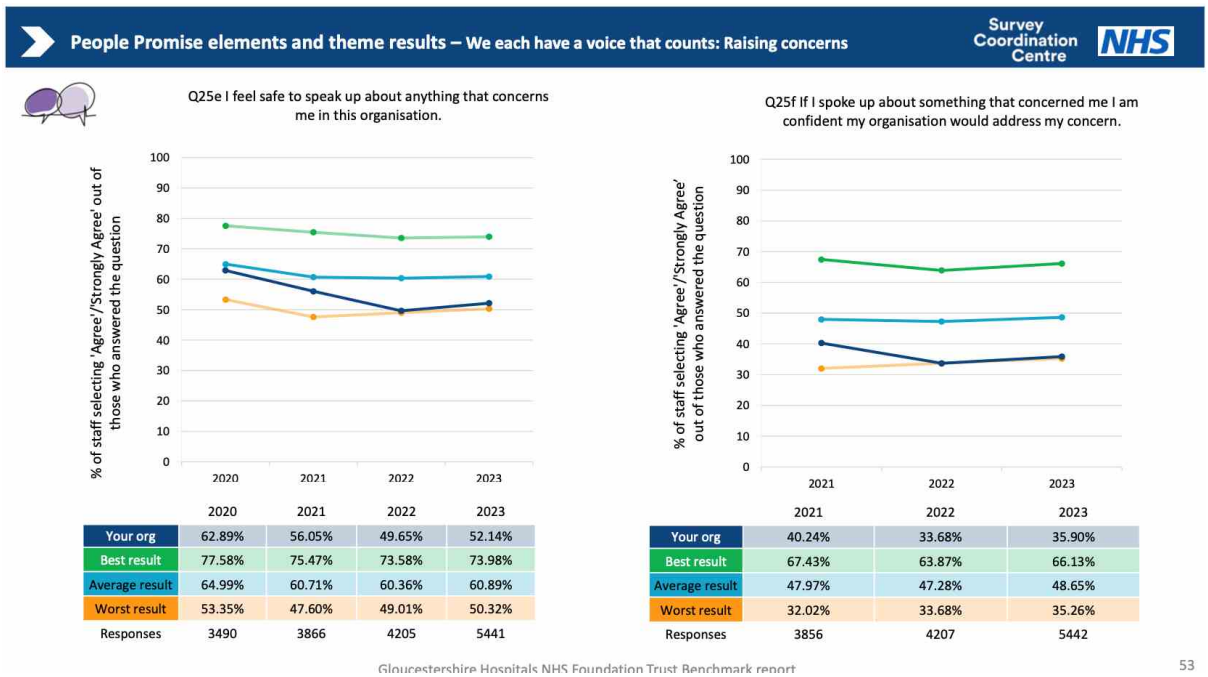
Questions
I would feel secure raising concerns about clinical practice
I am confident my organisation would address the concerns
I feel safe to speak up about anything that concerns me in this organisation
If I spoke up about something that concerned me I am confident that my organisation would address my concerns.

Graphs: Gloucestershire Hospitals NHS Foundation Trust NHS Staff Survey Benchmark Report 2023 (link)



	2019	2020	2021	2022	2023
Your org	69.26%	68.81%	71.46%	61.78%	63.29%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	3353	3504	3867	4214	5446

	2019	2020	2021	2022	2023
Your org	52.54%	53.88%	52.94%	42.27%	44.64%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	3346	3498	3858	4215	5441



	2020	2021	2022	2023
Your org	62.89%	56.05%	49.65%	52.14%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	3490	3866	4205	5441

	2021	2022	2023
Your org	40.24%	33.68%	35.90%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	3856	4207	5442

Plans for improvement 2024/25

The Safety Priorities laid out in this Quality Account will become our priorities for 2024/25 and we will continue to monitor this via our executive led Quality Delivery Group.

6. *Quality priority - To improve our prevention of harm (a) pressure ulcers and b) falls)*

To improve our prevention of harm (pressure ulcers and falls)	The priority for 2023/24 will be to improve our risk assessment, prevention and management of harm in relation to a) **pressure ulcers and b) falls.** This will include the delivery of the CQUIN (CQUIN 12) assessment and documentation of pressure ulcer risk assessments.

Pressure ulcer prevention

Background

a) Pressure ulcer prevention

In 2023/24, we took part in the Commissioning for Quality and Innovation (CQUIN 12) the assessment and documentation of pressure ulcer risk. NICE clinical guideline CG179 sets out best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently re-published National Pressure Injury Advisory Panel (NPIAP).

The aim of this improvement programme was to reduce the risks to our patients (1945 pressure ulcers and 3963 boarding of patients) and that is if the pressure ulcer risk assessment tool is not completed and patients deemed at risk of developing pressure ulcers do not have an adequate pressure ulcer prevention plan, patients will be at risk of developing pressure damage. All patients must have a pressure ulcer risk assessment (Waterlow) completed within 6 hours of admission and if they are at risk a plan for prevention must also be completed within 24 hours of that admission. There are obstacles within the SSKIN (**s**urface, **s**kin inspection, **k**eep moving, **i**ncontinence, **n**utrition and hydration (SSKIN)) bundle don't allow appropriate information to be documented. There are risks when patients are boarded that skin inspection cannot be facilitated.

How we have performed 2023/4

For CQUIN12, assessment and documentation of pressure ulcer risk, our aim was to be achieving 85% of patients having a pressure ulcer risk assessment (PURAT) by the end of March 2024.

Overall there was good compliance with the completion of the risk assessment tool within the specified time frame (6 hrs) however if patients are at risk of pressure damage then often compliance with completing the full risk assessment plan within 24 hours of admission is poor and this impacted on our overall compliance.

For quarter 4 our current data from business intelligence (BI) was an overall compliance of 64%.

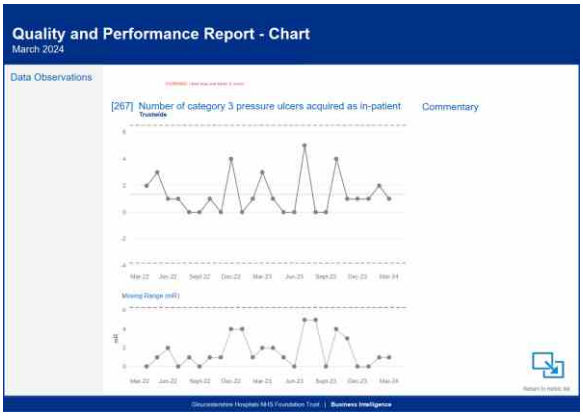
Table: Percentage of completed risk assessment by quarter

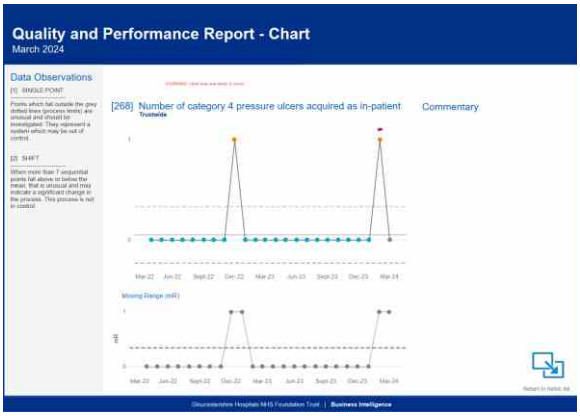
CQUIN measurement	Q1	Q2	Q3	Q4
Compliance with completion of: pressure ulcer risk assessment and actions	62%	61.66% 4801/7786 pts	60.35% 4670/7737	64.25%

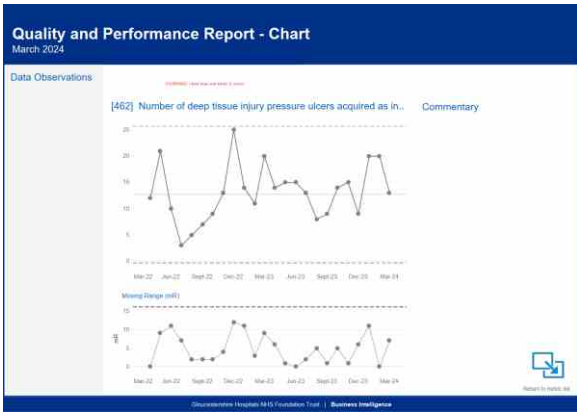
Over this year, we have:

- Improved our recording of data via the dashboard.
- A Silver Quality Improvement (QI) project underway which is focused on understanding the barriers to completion of PURAT.
- Developed our electronic patient record (EPR) to facilitate high quality pressure ulcer prevention care plans.
- Developed a programme of pressure ulcer prevention (PUP) simulation to facilitate high quality education to staff in the prevention of pressure injuries.
- Re introduced the Pressure Ulcer Steering Group (bi monthly meetings).
- Raised awareness of our programme of work on the “International Stop the Pressure” day in November 2023 and by holding conversations about Pressure Ulcer Preventions (PUP).

Chart: Pressure ulcer outcome data







Plans for improvement 2024/25

We will:

- Continue to analyse our data to understand our issues and to make improvements to preventing pressure ulcers

- Analyse our data from the Silver QI project (this was a questionnaire developed and sent to staff in order to understand current knowledge and key challenges at ward level).

- Implement further EPR changes, key changes were completed in January 2024 including extra opportunities for staff to document their pressure ulcer prevention care.

- Continue to implement PUP simulation, pilot undertaken now implemented and dates integrated into tissue viability (TV) training and the evaluation will be ongoing.

- Collaborate with Gloucestershire Health and Care Trust (GHC) and the Gloucestershire Integrated Care Board (ICB) to share information and ideas in our pressure ulcer prevention PUP.

- The improvement focus will be **on the Patient Safety Priority – pressure ulcer prevention.**

Falls prevention

Background

b) Falls prevention

In 2023/24, we took forward the recommendations made by the NHSE Team when they visited the Trust and the National Audit of Inpatient Falls (NAIF) recommendations. Our overall aim of our improvement programme was to reduce inpatient falls and falls with harm.

How we have performed 2023/4

This year we have focused on supporting our training program and falls link education days for falls prevention. We have improved and made changes to the current electronic Patient Record (EPR) documentation. Finally, we have supported changes with the Patient Safety Incident Review Framework (PSIRF) for investigating falls with harm.

Achievements

- Patients who repeatedly fall continue to be reviewed with prevention strategies developed by the specialist team with the ward teams (212 people in total).

- We have improved our falls prevention training which is now a whole day a month and 248 staff members have attended this year.

- We have provided “Falls Link Education” days (there was a total of 4 session this year).SEP These days have been very well received. Each day looks at an aspect of falls and we hold collaborative conversations to listen to each other’s ideas to make prevention improvement. The subjects we have covered this year have been “Vision and falls”, “Dementia and falls”, “Medications and falls and “The Fear of Falling”.

- The Falls Steering Group was reinstated and will continue quarterly in 2024.

- The specialist team have provided education on our Preceptorship Programme (224 staff have received education).

- The “Slipper Trial” on Woodmancote Ward reduced falls from an average of 11 falls per month to 6 during period of trial (19/09/23 – 19/11/23).

Chart: Falls outcome data

Plans for improvement 2024/25

We will:

- Learn from our project on Woodmancote Ward and procure slippers for other areas.

- Complete a silver QI project to improve the calculation of lying/standing blood pressure BP to ensure that a condition called orthostatic hypotension is recognised and managed accordingly. The Falls Team are currently working with Ward 4b, 7b and the Stroke Unit.

- Commence investigating falls under the new Patient Safety Incident Framework (PSIRF) from 1 March 2024. The process is well underway in how we investigate falls under PSIRF. We will also capture the learning from non-injurious falls.

- Continue to improve wording of electronic patient record documentation and also for bedrails to improve accuracy of assessment.

- Improve the documentation of the medical/nursing assessment post fall to replace ‘blue sticker’ in paper notes. The new nursing and medical post falls form will be added to our electronic patient record. The nursing assessment is a new addition, meaning that the whole post falls audit initial assessment and plan are all in one place.

- The improvement focus will be **on the Patient Safety Priority – falls prevention.**

7. Quality priority - To improve our care for patients whose condition deteriorates

To improve our care for patients whose condition deteriorates	We are one of 7 Trusts who have been chosen by NHS England to implement improvement work in the area of including patients/carers and their families in identifying deterioration – our "**Worries and Concerns Programme**" of improvement work.

Background

The Worries and Concerns programme of work to detect and facilitate escalation of patient concerns about clinical deterioration began in Jan 2023, through sponsorship from NHS England as one of 7 NHS Trusts to be supported. This pre-dated the work on Martha's Rule, which honours Martha Mills, who lost her life to undetected clinical deterioration after her parents repeatedly tried to escalate their concerns over Martha's clinical deterioration.

The Worries and Concerns Project has been consumed into Martha's Rule, which is now a requirement from NHS England that all acute NHS Trusts should have:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition. This is Martha's Rule.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

CQUIN07: Recording of and appropriate response to NEWS2 score for unplanned critical care admissions

As part of this programme we have reviewed the CQUIN data - CQUIN07: recording of and appropriate response to NEWS2 score for unplanned critical care admissions. The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration and ensuring a timely response, the importance of which has been emphasised during the pandemic. This CQUIN measure incentivises adherence to evidence-based steps in the identification, recording and timely response to deterioration, which will reduce the rate of preventable deaths and ICU admissions in England. The goal was to achieve 10-30%.

Progress made in 2023/2024

We are making a cultural change to see patients as partners in their care. We are encouraging staff to ask patients how they are feeling about their illness/wellness trajectory every time staff undertake clinical observations. Research in the paediatric space suggests the more we ask patients their opinion about their illness/wellness perspective, the more confident they will feel about raising concerns.

Aim 1 of the project is to provide a 24-hour rapid response service for clinical deterioration on receipt of a patient or carer concern. Patient and carer escalation of concerns had been happening on an informal basis for those patients particularly at risk, for example step-down from critical care, patients with learning difficulty and those with fractured ribs. In preparation to widen participation to all acute adult in-patients the staff, patient and family information was tested and adapted in two acute clinical areas. The staff escalation process remained unchanged. The patient escalation was through a mobile telephone number to call or text. Capturing the learning of the pilot sites, the project was rolled out to all acute adult inpatient areas with a series of launch days. The paediatric department are piloting the normal systems of escalation through their clinical matrons during the day, Monday to Friday, which is successful could be piloted in neonates and maternity.

AIM 2 of the project is where patients and carers can record their concerns in the clinical notes and this has been established in the acute adult areas by an addition to the NEWS chart after the NEWS score calculation. Stakeholder engagement and education has commenced on this new action and sustainment activities have been rolled out through our Basic Life Support training, News policy and clinical skills training for our healthcare assistants, Nursing associates and Registered Nurses. Business intelligence metrics have been set up to record the nurse and patient concern elements of the NEWS chart being recorded to identify areas of good practice and areas that need support.

Ongoing work with the Business Intelligence team have facilitated a ward/department compliance with routine and enhanced observations which are reaching on average an 80% compliance rate. Further work is in development to measure the metrics of a NEWS2 score within an hour of arrival or handover on a ward, and whether the observations are completed in a timely manner depending on the NEWS2 score. The number of patients scoring NEWS 2 of 5 or more are identified, facilitating easy identification of clinical episodes where an audit of escalation measures can be made.

We have re-drafted the NEWS2 Policy around the expectations of NEWS2 recording and escalation actions expected on the NEWS2 score. This will form part of the deteriorating patient policy with policies on Paediatric early warning scores and Maternity Early Warning Scores. Recognising that the scores, plus clinician concern, plus patient concern is the best indication of potential acute clinical deterioration.

We have published a Blog on our journey so far with the BMJ on-line here: Empowering patients and families to escalate worries and concerns. - Evidence-Based Nursing blog (bmj.com)

To assist other Trusts aspiring to follow our journey. We have briefed the Governors and had launch days in both Gloucester and Cheltenham where we have explained the project to patients and staff during our ward walks for e\ach site. The picture below is the launch day in Gloucester supported by the Acute Care Response Team and Governors.

CQUIN 07: results

Our aim was that we would be achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes. Our ambition was to have 30% compliance with all actions documents and we started the year well with 32% compliance. We have ended the year with 54% compliance.

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	32%	42%	*13%	**54%**

*NB – small sample this quarter. Data collection is very time consuming and 17 cases were found to be not applicable to the audit. Multiple items are required to be present per case for it to be deemed compliant.

Improvements for 2024/2025

- Publication of the NEWS2 Policy to incorporate the Worries and Concerns Project
- Publication of the Deteriorating Patient Policy to include actions for acute adult, child, neonates and maternity
- Nomination for the Health Service Journal Patient Safety Awards under the Deteriorating Patient Category
- Application to NHS England for further support to develop the Worries and Concerns Project in Paediatrics and Neonates

- Publication of our lessons learnt so far in support of other Trusts wishing to implement a similar patient record and escalation of clinical concerns process.

8. Quality priority - To improve mental health care for our patients coming to our acute hospital

To improve mental health care for our patients coming to our acute hospital	We will be continuing the implementation of the Trust's Mental Health Strategy – **Whole Person Care Strategy**.

Background

Analysis of the reported violence and aggression incidents in the Trust, of which there are over 1000 per year, identified boredom and the lack of structure and meaningful activity as a contributing factor. Nursing teams were focussed on supporting patients with their activities of daily living and essential clinical care and therapy teams were focussed on rehabilitation. There was a gap in provision of policy advice and guidance on how to manage patients who may become confused, distressed, aggressive or at risk of self-harm. A multi-disciplinary cross-Trust collaboration revised the enhanced care policy to provide a robust risk assessment and intervention guide for adult and paediatric patients. The enhanced care policy forms part of the Trust's Whole Person Care Strategy To improve mental health care for patients coming into our hospital.

How we have performed 2023/24

The enhanced care policy was approved in September 2023 and was launched with a series of half-day workshops provided by the safeguarding team. The robust risk assessments have been well-received by staff as they risk assess and grade the clinical issues, falls risk, aggressive behaviour and risk of absconding and or self-harm, and thus the level of enhanced care required to mitigate the risk. The enhanced care is graded from ward care, to intermittent extra care, to within sight or continuous one to one. Observations have indicated staff have been empowered to apply the minimum level of enhanced care required to mitigate the risk, with growing confidence in using the tool. Patients have enjoyed more freedom when those who require to be in sight of a nurse to be cared for in a bay together, to give the freedom of movement within the bay area.

Interventions suggested as the risk of confusion, absconding or aggression increases includes patient engagement activities, inviting family and friend visits, bed or sensor alarms and medication reviews. The majority of patient interventions in enhanced care can be managed by our healthcare support worker teams. Where there is the highest risk of harm or absconding or there are statutory reasons to detain or treat a patient under the Mental Health Act, then a Registered Mental Health Nurse will provide the enhanced care.

An action card, published with the revised enhanced care policy provide direction and guidance for enhanced care provision, to include a structured plan for the day, clinical observations, and links to the 'This is Me' document, health passport, high intensity user plan or play therapy activities leads to a much-improved patient experience.

The clarification of the risk assessment matrix and recommendations for enhanced care activities have enabled the minimum restrictions to be placed on patients, with more healthcare support workers managing the enhanced care, rather than defaulting to request a

Registered Mental Health Nurse. A consequence of this improved patient experience has been a cost saving of @ £400,000 per month in nursing bank and agency shifts.

An external provider has continued to provide safe-hold and enhanced care training for all staff.

A review of nursing time allocated to each ward area has been undertaken with the NHS Safer Nursing Care Tool, to ensure baseline care needs are met, and ward leaders have been trained to escalate increased care needs requiring additional nursing support through the Safe Care platform.

Plans for improvement 2024/25

- A pilot project for 12 months will see a Band 7 Enhanced Care Lead appointed to facilitate a substantive enhanced care team of Registered Mental Healthcare Nurses and Healthcare Support Workers, to prevent reliance on nursing bank and agency staff.
- A security consultant will be appointed to review the safe-hold, restraint and enhanced care training and make recommendations for future training.
- The training contract will be tendered to facilitate the appropriate training competencies.
- A trial of activity co-ordinators will be conducted by the occupational therapy teams to provide meaningful and structured activities for patients at risk of mental deterioration.

9. Quality priority - To improve our care for people with diabetes

	To improve our care for patients with diabetes	Our focus will be on carrying out improvement work in response to the national **diabetes** audit findings (children and adults).

Background

To improve the safety, care and experience for the patient with diabetes, accurate insulin administrations are paramount to maintain healthy blood sugar levels. The aim for 2023/2024 was to look at clinical incidents relating to diabetic inpatients and adopt the learning into practice.

How have we performed in 2023/2024?

Getting it Right First Time (GIRFT)

The latest Getting It Right First Time (GIRFT) report feedback for Trust highlights that the Trust's multi-disciplinary foot care service (MDFS) is considered to be good. The Trust is performing better on access to and training on diabetes technologies. There is ongoing planning for continued improvement on this. The inpatient outreach service provision is below expected standards and the service was currently not able to provide 7-day week cover due to resourcing issues (inability to recruit).

National Diabetes Inpatient Safety Audit (NDISA)

The Trust introduced insulin prescribing on the electronic patient record (EPR), as of early December 2023, and as a result there are less insulin related clinical incidents occurring. The national audit recommendations in2023/24 were all at ICB and Commissioner level and primary care, these include ongoing planning for technologies and type 2 diabetes.

For the past 3 years, there have been approximately 100 insulin incidents reported onto the Trust Datix system. The main reason for incidents is missed insulin doses, at approximately 80% of all incidents. There were a small number of wrong prescription doses, time or insulin types, patients using insulin pens with expired drugs in or more than one insulin paper chart in use.

Throughout 2023/2024 we have focussed on moving the regular insulin prescription chart onto the electronic prescribing system on the patient's electronic records. This work is now complete and all routine prescriptions and administrations of insulin for adult inpatients are recorded electronically. Our Business Intelligence Team can now design reports to build a baseline measure for missed doses of insulin. We wanted to provide staff with the opportunity to learn and master the electronic prescribing and administering of routine insulins, prior to undertaking any additional quality improvement work. Also, for any quality improvement work to focus on the electronic prescribing system for future capability, not the insulin paper charts.

It is important to note the Trust guidelines, prescription and management for patients who are seriously unwell with diabetic ketoacidosis or may require a variable dose rate of insulin infusions are still managed on paper prescriptions. In the fullness of time, we hope all insulin

administration will be recorded electronically, but this is being carefully managed by the electronic prescribing team, because incorrect insulin administration can easily result in harm.

Plans for 2024/2025

- We will start to learn from the feedback from electronic prescribing and administration.
- We will actively measure missed doses of insulin, which we expect to decrease
- We will start to make plans for further movement of insulin prescription onto electronic patient records.

10. Quality priority - To reduce health inequalities

To reduce health inequalities	We will continue to deliver the Core20Plus5 health inequalities programme focused on **tackling tobacco dependency** for colleagues, inpatients and in maternity.

Background

The NHS Long Term Plan set out clear commitments for NHS action to improve prevention by tackling avoidable illness, as the demand for NHS services continues to grow. Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health, but reduce health inequalities and also decrease demand on services by reducing the number of smoking related admissions and readmissions. The Global Burden of Disease (GBD) ranks tobacco as the top modifiable risk factor that drives deaths and disability, with 96,058 avoidable deaths associated with its use in England in 2019 (GBD, 2019).

Tobacco dependency affects almost all patient pathways – both surgical and medical – from pregnancy and neonates through to children and adults. Latest figures record

- 13.9% of adults,
- 9% of 11-15 year olds, and
- 9.6% of pregnant women (at the point of delivery) in England **still smoke tobacco**

(ONS, 2020; NHSD, 2020; NHSD, 2021).

Smoking tobacco is linked to just over 500,000 hospital admissions each year, with smokers being 36% more likely to be admitted to hospital than non-smokers. Smoking tobacco is linked to over 100 different conditions, including at least 15 different types of cancer, 9 mental health conditions and numerous respiratory, cardiovascular and other disorders (RCP, 2018). Tobacco dependence treatment is effective and improves the health and wellbeing of the person smoking and their family, as well as saving them money.

Smoking is also the single greatest modifiable risk factor for poor outcomes in pregnancy, with nearly 1 in 10 women still smoking when their baby is born. The harms associated with smoking relate, not only to the mother, but also to the unborn child, where we see a doubling of the likelihood of stillbirth and tripling of the likelihood of sudden infant death. We also see smoking rates concentrated among pregnant women from poorer backgrounds, with women from the poorest 10% of the population six times more likely to smoke than those from the most affluent 10%. Continuing to implement the NHS England Saving Babies Lives Care Bundle version 2 (SBLCBv2) is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of still births by bringing together 4 elements of care with reducing smoking in pregnancy being one of the four.

How we have performed 2023/24

Adult Inpatient Programme Update

It is well established that effectively treating tobacco dependent smokers attending hospitals requires provision of very brief advice, the offer of evidence-based pharmacotherapies and interventions, and referral to specialist tobacco dependency service.

Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health, but reduce health inequalities and also decrease demand on services by reducing the number of smoking related admissions and readmissions. The recommended acute inpatient pathway is underpinned by published evidence on the Ottawa Model for Smoking Cessation and based on work undertaken in Greater Manchester as part of the CURE model. We are pleased to offer this to adult inpatients admitted to our Hospitals.

Every patient admitted to Gloucestershire Hospitals NHS Foundation Trust (GHT) who smoke is offered NHS funded tobacco treatment, all inpatients are:

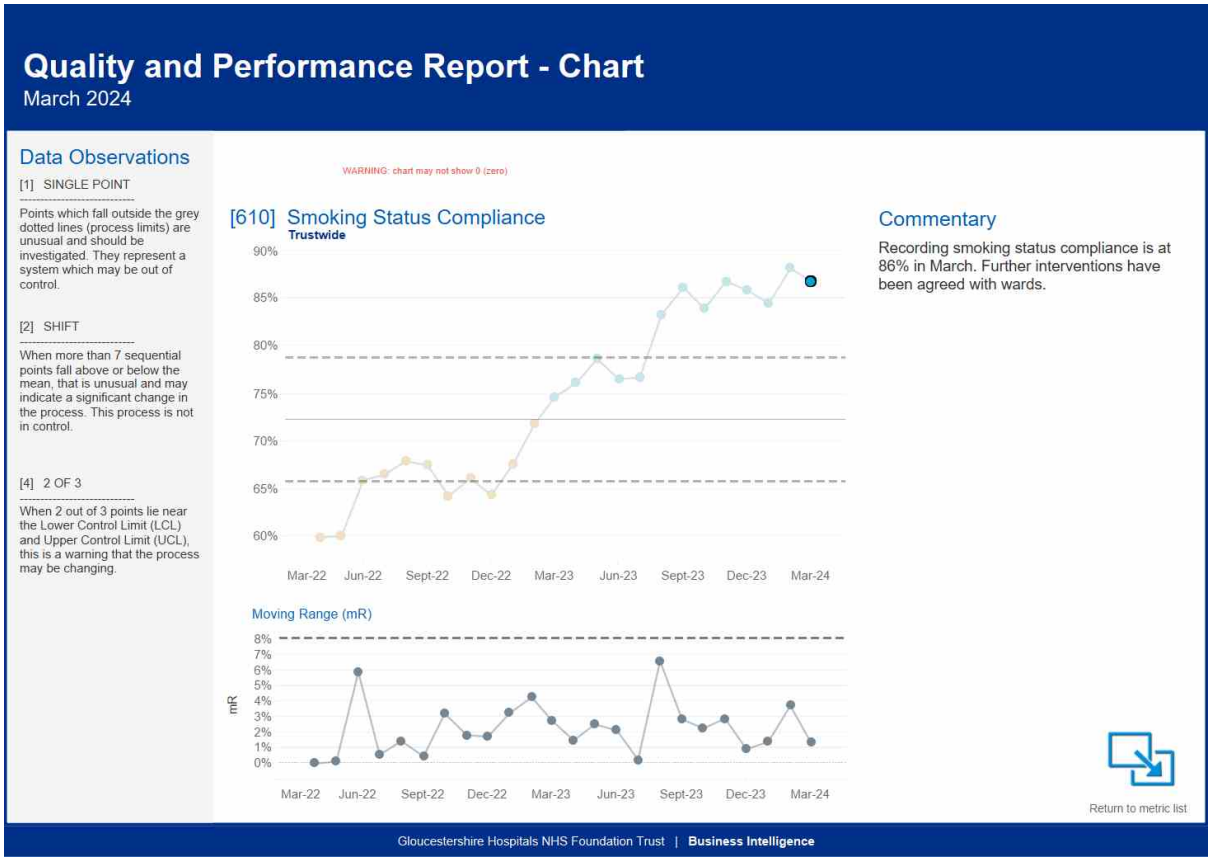
1. Screened for smoking status
2. Be on an opt-out referral pathway to a tobacco treatment advisor
3. Provided with personalised behavioural support and Nicotine Replacement Therapy (NRT)
4. Provided with a discharge package including continued smoking support by the community team.

We have been routinely collecting adult smoking status data since November 2022 and have created an internal Tableau dashboard that identifies all smokers and their location within the hospital (Adults - % compliance on recorded smoking status (Smoking Status | GHNHSFT BI Hub (glos.nhs.uk)).

Table: % compliance on recorded smoking status (adults)

Adult services	% compliance on recorded smoking status average
Trust compliance at end of year	82%

Graph: % compliance on recorded smoking status (adults) on admission documentation



Following a QI approach the Tobacco Free Team rolled out ward by ward on the inpatient wards, providing Very Brief Advice (VBA) training for staff to build staff confidence, subsequently the compliance of recording smoking status increased. This was further enhanced by making smoking status a significant field on EPR. A Trust wide communications campaign helped to embed this further. Although the Trust wide compliance is at 82% it is important to note some wards are achieving 100% compliance every month.

In the next table, we have summarised our key achievements over the last year and our plans for improving our service in 2024/25 will also start to take place.

Table: Key achievements over for the Adult Inpatient Programme over 2023/24 and Plans for improvement 2024/25

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
Leadership and Co-Ordination/ Project team	• Head of Health Inequalities and Healthy Hospitals • Health Improvement Manager • 2 x Tobacco Treatment Advisors • Clinical Lead • Deputy Director of Quality	• Recruit Tobacco free champions/ ambassadors on wards

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	• Senior BI analyst • Pharmacist • Communications lead	
Data Collection and Monitoring	• The Electronic Patient Record (EPR) amended to support the relevant recording of smoking status as a **significant** field • NHS England data submission requirements have been updated. • BI have created and improved our daily Tableau smoking data dashboard and national metrics are included.	• Synthesise data to identify areas of improvement • Using the QI methodology embark on a silver QI project to identify improvements and efficiencies in the pathway.
Governance and reporting	• An internal programme Board has been set up and are meeting monthly. • Leads attend the Integrated Care Board (ICB) Tackling Tobacco Dependency Steering group meeting. • NHS England assurance meetings monthly • Updated NG209 • Programme reports into QDG • NHSE monthly tobacco treatment submissions	• Complete Service review evaluation • Sustainability of service when the funding from ICB finishes • Identify support for staff
Training and Development	• Advisors have attended specialised training programme. • Very Brief Advice training has been provided for all inpatient wards, this is being regularly topped up by the team to ensure coverage of new staff. • Developing bespoke training for tobacco-free champions/ambassadors.	• Increase the uptake of Very Brief Advice training on wards • Offer VBA training online for staff working evenings • Scope out support required for Paediatrics • Identify support required for outpatients

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	• Tobacco free team participated in bespoke Quality Improvement (QI) support from British Thoracic Society for 6 months. • Team completed GSQIA Silver QI project to increase the compliance of smoking status recording across the Trust.	
Identification and Referral Pathways	• Follow up calls upon discharge • Patients are referred to community provider upon discharge for onward care.	• Establish relationships with new community provider to support patients when discharged from hospital. • Identify further referral pathways as appropriate for patients e.g. Mental health
Treating tobacco Interventions	• Evidence based interventions offered across both sites • Pharmacotherapy – Nicotine Replacement Therapy (NRT) is available on all inpatient wards. • New anti-smoking drug Cytisiene has been approved on Trust formulary. • Patients will be supplied with NRT upon discharge	• Pharmacotherapy- increase number of patients that are being offered NRT on arrival • Trial prescribing Cystisiene on respiratory unit
Communication and Engagement	• There have been Trust wide communications about the programme. • Smoke free policies have been updated. • The TTD Team are attending regular ward rounds and board rounds with identified wards.	• Continue to support national campaigns: • No Smoking Day • Mental Health Awareness week • World No Tobacco Day • Love your Lungs week • Stoptober • Lung cancer awareness month

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	• New signage and posters have been created for teams to download • Team have carried out Trolley dash in both sites • Team paraphernalia produced • No smoking day stall in Atrium	• New Year Quit Attempts

Maternity Programme Update 2023/24:

We have been continuing to support pregnant smokers to quit by implementing the NICE clinical effectiveness guidance (NICE guideline NG 209 Tobacco: preventing uptake, promoting quitting and treating dependence) and the NHS England Saving Babies' Lives Care Bundle (version 3). The care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice and the first element is around reducing smoking in pregnancy as this element provides a framework to reducing smoking in pregnancy by following NICE guidance.

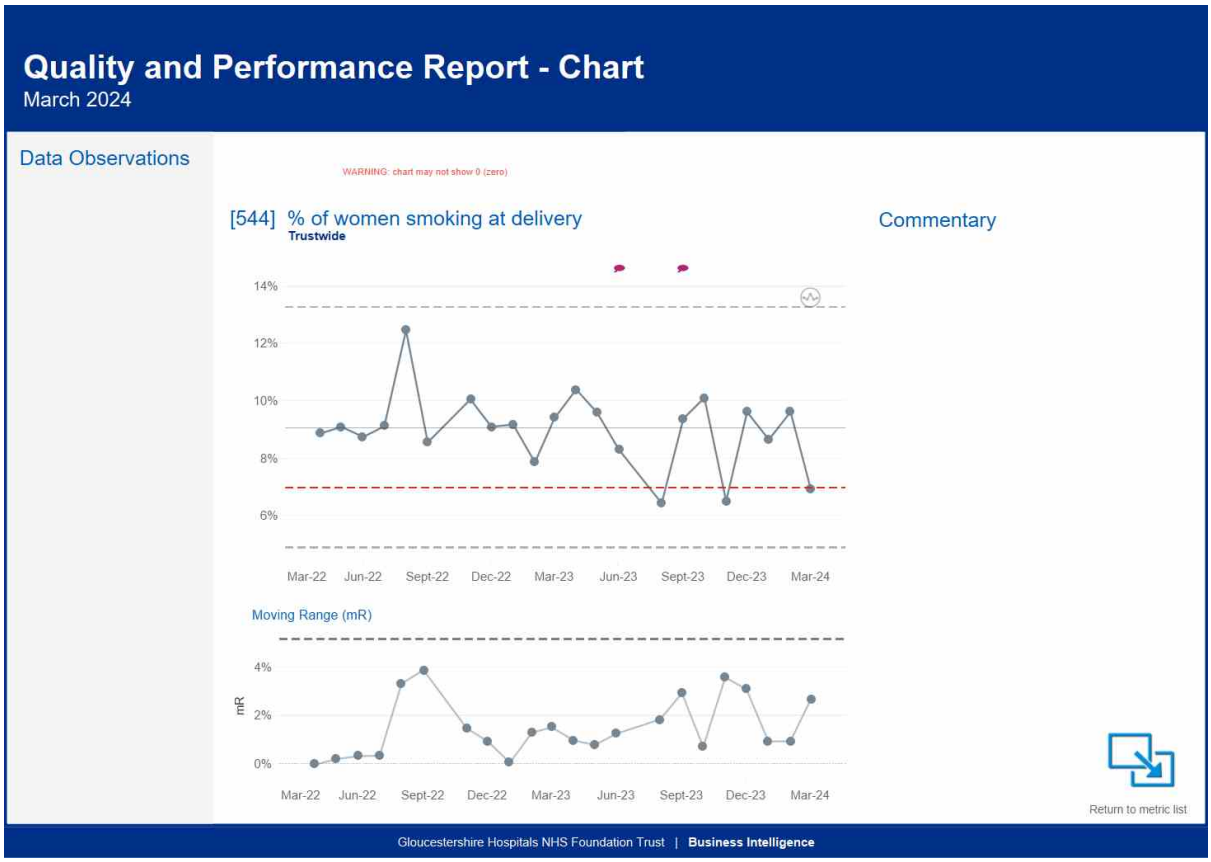
Reducing smoking in pregnancy will be achieved by offering carbon monoxide (CO) testing for all women at every antenatal contact throughout pregnancy, to identify smokers or those exposed to tobacco smoke and offer them a referral for support from a trained stop smoking advisor.

The interventions we have put in place are:

- CO testing should be offered to all pregnant women at every antenatal contact appointment, with the outcome recorded on the electronic maternity information system.
- Referral for those with elevated levels (4ppm or above) for support from a trained stop smoking specialist, based on an opt-out system. Referral pathway must include feedback and follow up processes.
- Referral to an in-house maternity treating tobacco dependency (TTD) team as recommended in SBLCB v3 available for residents of Gloucester City as part of a quality improvement programme initiative.
- All relevant maternity staff should receive training on the use of the CO monitor and having a brief and have meaningful conversations utilising very brief advice (VBA) techniques with the pregnant person.
- A range of treatments and support options are being procured to enhance the engagement with the in-house maternity TTD quit programme including GHT outpatient direct supply of nicotine replacement products (NRT), National 'swop to stop' interventions including e cigarettes and vaping alternatives and participation in the National financial incentive scheme.

The table below highlights are data for the 2022/23 year and now for 2023/24

Table: % of women smoking at delivery



	2022/23	2023/24
Indicator	**Data**	**Data**
Number of women smoking at booking	**594**	**434**
% women smoking at booking	**11.0**	**8.1 %** ***This cohort is not the same cohort as the data set for % women smoking at delivery***
Number of women smoking at delivery	**514**	**406**
% women smoking at delivery	***9.5***	***8.9 %*** ***This cohort is not the same cohort as the data set for % women smoking at booking***
Number of women smoking at booking	**654**	**N/A**

	2022/23	2023/24
Indicator	**Data**	**Data**
% women smoking at booking	***10.0%***	***N/A*** ***This data set is incomplete due to suspension in recording during the transition from Trakcare to Badgernet***
CO Monitoring at booking %	***93.2***	***85.1 %***
Number of women booking where CO reading >4ppm	**288**	**345**
% of women booking where CO reading >4ppm	***4.4%***	***6.4 %***
Number declining CO Monitoring at booking	**703**	**9**
Number of current smokers accepting referral to Smoking Cessation	**482**	**302**
% of current smokers who accepted referral to Smoking Cessation	***74.0***	***69.6 %***
% of current smokers who declined referral to Smoking Cessation	***23.5***	***20.3 %***
% of current smokers who were asked to be referred to Smoking Cessation	***97.5***	***89.9 %***
Healthy Lifestyles Smoking Referrals	**639**	**339**
HLS Referrals Declined, No response or blank	**314**	**156**

Table: Key achievements for the Maternity Programme over for 2023/24 and Plans for improvement 2024/25

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
Leadership and Co-Ordination	• Band 8a Lead Midwife Tackling Tobacco Dependency (TTD) • Appointed Maternity Support Workers (MSW) to be Smoke-free Advisors.	• A Band 8a Lead Midwife Tackling Tobacco Dependency (TTD) leads on a Quality Service Improvement and Redesign (QSIR) Programme developing an in-house maternity TTD team • 2 WTE Maternity Support Workers (MSW) have been recruited and given specialist training as TTD Advisors to support pregnant

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
		people and their partners on smoking cessation programmes in Gloucester City. • A Band 7 Specialist Midwife for TTD and a Band 6 QI project support Midwife lead the TTD team. • The National Lead & Lead for Greater Manchester Smoke-free programme provides monthly coaching on the project implementation strategy.
Planning and Commissioning	• TTD pathway in maternity services will be included in the Integrated Care Board (ICB) Maternity Services specification. • Areas with highest Smoking at Time of Delivery (SATOD) rates have been identified and linked to areas of highest deprivation in Gloucester and Forest of Dean (FoD). • Incentives and vaping are being explored with ICB TTD Steering group.	• TTD pathway in maternity services are included in the Integrated Care Board (ICB) Maternity Services specification. • Areas with highest Smoking at Time of Delivery (SATOD) rates have been identified and linked to areas of highest deprivation in Gloucester and Forest of Dean (FoD). The in-house maternity TTD are piloting the service in Gloucester City with an ambition to roll out to the area of the second highest rates of deprivation in the FoD after 1 year. • The National Financial Incentives Scheme and Swop to Stop vaping interventions are being pursued through the QI project and LMNS TTD team.
Data Collection and Monitoring	• Data was monitored by the service on a on monthly dashboard against a planned trajectory for improvement. • An audit was completed and action plan developed to review compliance for CO monitoring at 36 weeks.	• A digitalised maternity information system, Badgernet, has been introduced across the maternity service, launched in June 2023. The in-house TTD team coordinate all referrals and appointments through Badgernet. • In addition, an NHS supported software package from DCRS digital services is being procured to support the TTD caseload management for the in-house

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
		team and contribute to the production of high quality data to support the project evaluation. • Data has been mapped against the external provider for community TTD support, Healthy Lifestyles, and a data collection tool devised to support co production of TTD data that aligns across the 2 TTD services. • Data continues to be monitored by the service on a on monthly maternity assurance dashboard against a planned trajectory for improvement. • An audit of all SBL v3 element 1 recommendations has been carried out in response to the Maternity Incentive Scheme requirements and an action plan developed to improve carbon monoxide screening, staff training in skills for giving very brief advice (VBA) to increase the number of opt out referrals made.
Training and Development	• Training and development provided for Consultant Lead and for Lead Midwife. • Training has been identified for the MSW Smoke-free Advisors. • Very Brief Advice (VBA) training and e-learning training was put in place.	• Training and development provided for the Specialist and Project Support Midwife to enable them to provide service user support on quit programmes in addition to project and team leadership skills. • Training has been provided for the MSW TTD Advisors. • Smoke Free Pregnancy and Very Brief Advice (VBA) mandatory face to face training and an e-learning module training has been developed for all members of the MDT in maternity care.
Identification and Referral Pathways	• The maternity service is working with Healthy Life Styles (HLSs) to review current pathway and HLS's Health	• The TTD in pregnancy Trust policy has been updated and 4 new pathways created for CO screening, antenatal and postnatal

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	Advisors now attending the Antenatal Clinic at Gloucester Royal Hospital (GRH).	referrals for TTD support and referral for raised CO screening results in non-smokers. These have been ratified. • Standard operating procedures (SOP) for the TTD Advisors role and NRT outpatient supply have been created and ratified.
Stop Smoking Interventions	• Research into the evidence for vaping, as an alternative to Nicotine Replacement Therapy (NRT), is being currently reviewed.	• Antenatal smokers and their significant other person are offered face to face behavioural support and a range of NRT products provided through a voucher pad system. • An outpatient supply of NRT products is being organised within the Antenatal Clinic at GHFT to enable direct supply of products and early intervention • The National Financial Incentives Scheme and Swop to Stop vaping interventions are being pursued through the QI project and LMNS TTD team.
Communication and Engagement	• Midwives survey on knowledge of TTD pathway results presented to Local Maternity and Neonatal System (LMNS).	• The Lead Midwife for TTD has engaged in an MVNP live event on social media, updated Trust and Maternity webpages and produced educational cards with a QR code for service users and staff. • Preparations are underway for National No Smoking Day in March 2024 and activities include production of a lived experience video of a current quit programme participant. • Discussions are in progress regarding carrying out further behavioural insights focus group work with social researchers to gain an understanding of strategies required to optimise engagement with a diverse community in the most

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
		disadvantaged areas of Gloucestershire.

11. Quality priority - Surgical experience

	Surgical experience	Our focus will be delivering on the Commissioning for Quality and Innovation Indicator (CQUIN 02) **supporting patients to drink, eat and mobilise (DrEaMing) after surgery.**

Background

Getting it Right First Time (GIRFT) has supported a Commissioning for Quality and Innovation (CQUIN) indicator measuring whether patients are supported to drink, eat and start being mobile after surgery. This original CQUIN for 2022/23 has now been updated and published for 2023/24.

Ensuring that patients drink, eat and mobilise ('DrEaM') as soon as possible after surgery is an element of the NHS's enhanced recovery programme that helps to prevent post-operative blood clots and respiratory complications and that should result in an average 37.5% reduction in length of stay for patients who "DrEaM" in the first 24 hours after surgery. This indicator was updated for 2023/24 to include a more comprehensive range of procedures and to ensure that the thresholds continue to be stretching, but achievable.

This year we have been encouraged to ensure that 80% of all in patients undergoing major surgery are supported to DrEaM within 24 hours of surgery.

DrEaMing is supported by the Perioperative Quality Improvement Programme, as well as the relevant Royal Colleges, and was highlighted in the GIRFT national report for anaesthesia and perioperative medicine. The new indicator applies to surgery delivered from 1st April 2023.

How we have performed 2023/24

We are developing a culture of enhanced recovery in our departments and enhanced recovery targets have been embedded in our protocols. Empowering the multidisciplinary team to deliver care in line with the enhanced recovery ethos. The national goal for the CQUIN was 70% to 80% and we have performed above that figure at 95% in quarter 3.

Table: CQUIN results for each quarter

Measure	Q1	Q2	Q3	Q4
Overall compliance	90%	96%	95%	95%
The patient was supported to drink	99/99	97/97	98/98	92/92
The patient was supported to eat	86/87	88/88	90/90	81/89
The patient was supported to mobilise	88/98	93/98	92/97	91/95

Plans for improvement 2024/25

We are waiting to hear nationally if CQUINS will continue. The plan for the improvement work is that it will become part of our processes and will not be reported in our Quality Account next year as we will report on the Safety Priorities.

12. Quality priority - Equality, diversity and inclusion – equality priorities

	Equality, diversity and inclusion – equality priorities	The Patient Experience Team will be enabling the delivery of **2 equality priorities** by improving our translation and interpretation services and focusing on the accessibility of our maternity and cancer services.

Background

The Equality Delivery System (EDS) was first launched for the NHS in 2011 and is a system that helps NHS organisations improve the services they provide for their local communities. The main purpose of the EDS is to review and improve our performance for people with characteristics protected by the Equality Act 2010.
The nine Protected Characteristics are:

- Age
- Disability
- Gender reassignment
- *Marriage and civil partnership
- Pregnancy and maternity (and paternity)
- Race
- Religion or belief
- Sex
- Sexual orientation

How we have performed 2023/24

This year we have continued to work across Gloucestershire to revisit our EDS progress from 2022/23 for Cancer Services and Translation & Interpretation Services and we have also included Maternity Services.

EDS is an improvement tool to review and improve our approach in addressing inequalities in health access, experience, impact and outcomes. It is driven by data, evidence, engagement and insight.

For the EDS, for each service area, we were required to test four outcomes:
• 1A: Patients (service users) have required levels of access to the service
• 1B: Individual patients (service user's) health needs are met
• 1C: When patients (service users) use the service, they are free from harm
• 1D: Patients (service users) report positive experiences of the service

We have collated information to support this assessment from NHS Gloucestershire ICB, Gloucestershire Health & Care NHSFT and Gloucestershire Hospitals NHSFT. The evidence gathered includes statistical data, policies, strategies, working protocols and procedures, service specifications and health inequalities action plans. The evidence has been discussed with the ICB Working with People and Communities Advisory Group and Maternity and

Neonatal Voices Partnership representatives, who gave valuable insight into our self-assessment and made recommendations regarding ratings for each of the four outcomes.

Each outcome was scored based on the evidence provided. Once each outcome has a score, they are added together to gain domain ratings. Using the middle score out of the three services from Domain 1, domain scores are then added together to provide the overall score, or the EDS organisation rating. Ratings in accordance to scores are below.

The scoring system allows us to identify gaps and areas requiring action.

Table: EDS scoring

Undeveloped activity – **organisations score 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score 2** for each outcome	Those who score **between 22 and 30,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score 3** for most outcomes	Those who score **31 and above,** adding all outcome scores in all domains, are rated **Excelling**

Table: Gloucestershire scores for domain 1

Our assessment rating

There is a range of scores across the different services, but when combined they equate to the following:

Outcome 1A – Achieving activity = Score 2
Outcome 1B – Achieving activity = Score 2
Outcome 1C – Achieving activity = Score 2
Outcome 1D – Achieving activity = Score 2

Overall Rating for Domain 1: Commissioned or Provided services is Achieving Activity (score 8 out of possible 12)

Narrative

Outcome 1A: Patients (service users) have required levels of access to the service

Cancer services:

- There is good provision of cancer services across primary care, acute and community services.
- A place-based population health approach is being taken through Integrated Locality Partnership and Primary Care Networks.
- Our Integrated Care Strategy focuses on understanding our communities and achieving equity through a range of targeted improvement for those living in our most deprived areas of the county.

- There is ongoing work to improve data coverage and links across all health data sets, to improve the data completeness. Analysis by some protected characteristics remains challenging due to the incompleteness of data.
- The Gloucestershire ICS Cancer Programme oversees much of the work to increase early diagnosis rates and ensure identification of, and reduction in, inequalities

Translation and Interpretation (T&I) Services:
- Each NHS organisation in One Gloucestershire commissions Translation & Interpretation (T&I) Services, which are available to patients' attending appointments in Primary Care, Acute and Community Services.
- We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners.
- This will enable:
    - Continuity of interpreter (where preferred)
    - Improved access to services • Collection of robust feedback from people in our communities
    - Improved staff training
- Our work with Gloucestershire Deaf Association has provided a better understanding of the number of British Sign Language users accessing health care in the county.
- We are working with voluntary sector partners to raise awareness of the Accessible Information Standard (2016) and develop mechanisms to ensure compliance across our system.

Maternity Services:
- The Local Maternity and Neonatal System (LMNS) Board has regular oversight of and monitors the national local maternity services dashboard. This brings together information from different data sources to track, benchmark and improve the quality of maternity services in Gloucestershire. Maternity services, including Delivery Suite, Birthing Units, Community Midwives and Perinatal Mental Health Services are delivered in a number of locations in Gloucestershire.
- Our data shows that 21.3% of maternity bookings are for women from ethnic minority communities. This is higher than the ethnic minority population in Gloucestershire, which according to the 2021 Census is 17.7%, for women of child-bearing age. 23.9% of all bookings are from women who live in the most deprived areas (IMD Deciles 1&2) of Gloucestershire. 14.7% of these women are booked with the Continuity of Carer team/pathway.

Outcome 1B: Individual patients (service user's) health needs are met
Cancer Services:
System-wide work to deliver the Cancer Operational Planning guidance 2023/24 has contributed to local action, including:
- Faster diagnosis and operational improvement; e.g. Targeted focus on inequalities in prostate cancer aimed at increasing engagement in men over 45 from a black ethnic background, with family history of prostate cancer.
- Early Diagnosis: NHS Cancer Screening - Working to identify the population groups with low screening uptake locally e.g. Actively developing opportunities to improve screening uptake in women from South Asian communities and in areas of deprivation.

- Improving access to screening for people with Learning Disabilities and Autism by having a dedicated cancer screening support nurse. Primary Care Direct Enhanced Service and Quality Improvement Projects respond to local needs and challenges.

Translation and Interpretation (T&I) Services:
- Access to the T&I services available across One Gloucestershire services 24/7, 365 days.
- Policies and procedures in place to ensure staff are able to access T&I support.
- Reasonable adjustments made e.g. longer appointments, mobility, support for hearing and sight impairments.
- New service specification for spoken language will: - support requests for continuity of interpreter across organisations - enable service improvement (re T&I) based on feedback from patients
- Accessible Information Standard: Working in partnership with VCS organisations to support awareness raising of communication needs for people with a disability, sensory or cognitive impairment.

Maternity Services:
The Local Maternity and Neonatal System (LMNS) has developed an Equity and Equality action plan, in collaboration with the Maternity and Neonatal Voices Partnership (MNVP). This 5-year plan sets out initiatives which include:
- 2 Midwifery Continuity of Carer (MCoC) teams have been established to provide support in areas of high deprivation and ethnic minority communities.
- A Perinatal Emotional Health and Wellbeing pilot funded by the ICB and delivered by The Nelson Trust supports women with low/moderate perinatal mental health needs, and can support with issues around accommodation, drug and alcohol misuse and domestic abuse.
- Perinatal Equity and Equality Action Plan developed with a focus on mothers from more deprived areas and ethnic minorities, young mothers and Traveller communities
- A young mums' support group is delivered by Forest Voluntary Action Forum (FVAF), who has identified the needs of the young people and encourages social inclusion, helps build confidence, learn new skills and increase parenting social circles.

Outcome 1C: When patients (service users) use the service, they are free from harm
Cancer Services:
- Gloucestershire residents are able to access reasonably high quality, safe healthcare. The Care Quality Commission has rated both main providers as ‘Good’. In Primary Care settings, residents can also access good quality GP services, most of which are rated as either ‘Good’ or ‘Outstanding’.
- System Safety Group established to oversee the implementation of Patient Safety Incident Response Framework (PSIRF) at system level.
- Patient safety policies and procedures in place with all providers: additional needs are supported by LD Liaison Nurse Service; Admiral nurse for inpatients with dementia diagnosis; Transgender policy.
- Embedded through Professional Registration, Staff training, Risk Assessments, Information Governance, DATIX reporting, Freedom to Speak Up Guardians, Duty of Candour.

Translation & Interpretation Services:

- Policies and procedures are in place to ensure NHS providers are compliant with contractual safety requirements – these are generic for all patients.
- DATIX reporting reviewed and actioned.
- Freedom to Speak Up Guardians, who support staff to speak up on issues relating to patient safety and the quality of care; staff experience and learning/improvement.
- One Gloucestershire Quality Framework, Quality Strategy, Whistleblowing Policy support patient safety.

Maternity Services:

- Local Maternity and Neonatal System receive regular updates on quality and safety, including the quarterly Perinatal Quality Surveillance and Safety Report.
- Maternity and Neonatal safety champions in post and meet bi-monthly, undertaking walkabouts of key areas of focus. They provide visible leadership and promote safe, personalised care, share learning and best practice from national research, local investigations and initiatives.
- DATIX reporting – a daily review of all incidents rated moderate harm+ takes place to ensure we are responding to any potential safety concerns in a timely way. In addition, the introduction of hot and cold de-brief post incident to support staff health and wellbeing
- We have strengthened the quality and safety reporting both internally and externally to support an increase in learning from our incidents and patient feedback.

Outcome 1D: Patients (service users) report positive experiences of the service
Cancer Services:

- Working with people and communities Strategy: NHS Gloucestershire's system-wide approach ensures proactive engagement across diverse communities.
- Patient experience information gathered through engagement is reported back to service leads and system partners.
- Patient Experience data is gathered, monitored and acted upon: - National cancer survey – high levels of satisfaction reported, although limited analysis by protected characteristics possible due to small numbers involved - Patient experience data gathered via Friends and Family Test (FFT) – demographic data capture extended to provide greater breakdown of ethnicity; disability; carer
- Working closely with ICB Insights Manager to build relationships with local communities and groups, including plans for engagement work and cultural competency training for staff supporting events.
- Targeted campaigns include:
    - Prostate cancer risk and awareness event with the African Caribbean Community.
    - Breast Cancer Awareness Events utilising the Information Bus to target deprived communities, ethnic minority communities (prevalence of late stage diagnosis), the homeless community and the LGBT+ community.
    - Bartongate Children's Centre event
    - female Afghani refugees, with support from GARAS.
    - All Nations Health and Wellbeing event attended by Prostate and Breast Nurses.

- General awareness, risks and prevention with Nepalese soldiers

Translation & Interpretation Services:

– We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners.

This will enable:

- Continuity of interpreter (where preferred)
- Improved access to services - Collection of robust feedback from people in our communities
- Opportunity to promote service to local communities
- Improved staff training
- Gloucestershire Health and Care NHSFT are in the process of introducing a QR code, so that when an appointment has taken place, the Deaf client will receive a text so they can send back some feedback.
- Working with Inclusion Gloucestershire, Gloucestershire Hospitals NHSFT have reviewed patient information leaflets and agreed which should be translated into Easy Read. Information to support patients in Shared Decision Making has been included on the back of each leaflet.

Plans for improvement 2024/25

Our EDS improvement programme will be reported on in our Trust Equality Report.

– Further data analysis is underway for cancer services to improve identification of variation and link further datasets to improve data quality.
– Work to provide consistency and clarity of the maternity offer for labour and delivery.
– Further improvements are made to equality data recording, in order to achieve consistency.
– Establish mechanisms for gathering patient experience of translation and interpretation services and explore innovation in improving access and visibility of the service.
– Review compliance with the Accessible Information Standard providing and evaluating the impact of additional training and support for staff.

13. Quality priority - Commissioning for Quality and Innovation (CQUINs)

1.	Commissioning for Quality and Innovation (CQUINs)	We will be focused on delivering our CQUINs

Background

The Commissioning for Quality and Innovation (CQUIN) scheme provides a framework to support improvement in the quality of services. The Trust requirement is to undertake and report on all applicable CQUINs in 23/24, with our 'top 5' (based on preference and priorities) being linked to the financial incentive part of the CQUIN.

Support remains available to all CQUIN teams via the Clinical Effectiveness Improvement (CEI) team and through the GSQIA Silver process where beneficial.

For information, the full CQUIN specifications details for 2023/24 can be found here.

How we have performed 2023/24

Our quarter 4 results have been uploaded to the National portal / emailed to the national teams as required.

With Gloucestershire Integrated Care Board, we have agreed our top 5 CQUINs for 2023/24 were:

- CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery
- CQUIN04: Prompt switching of intravenous to oral antimicrobial treatment
- CQUIN05: Identification and response to frailty in emergency departments
- CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions
- CQUIN12: Assessment and documentation of pressure ulcer risk.

Table: CQUIN results by quarter

CQUIN	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
CQUIN 01: Staff flu vaccination rate	Not applicable	31.8%	56.6%	57.5%
CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	90%	96%	95%	95%

CQUIN	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CQUIN04: Compliance with timed diagnostic pathways for cancer services	Nul return	Nul return	Nul return	Nul return
CQUIN04: Prompt switching of intravenous to oral antimicrobial treatment	18%	29%	28%	21%
CQUIN05: Identification and response to frailty in emergency departments	29%	11.3%	24%	27%
CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	0.56%	1.09%	Not yet available	Not yet available
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	32%	42%	13%	54%
CQUIN08 Achievement of revascularisation standards for lower limb ischaemia	Normal submission to National Vascular Registry			
CQUIN10: Treatment of non-small-cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	100%	66.7%	50%	100%
CQUIN11: Improving the quality of shared decision-making conversations	This has been added to our Friends and Family Test data			

CQUIN	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CQUIN12: Assessment and documentation of pressure ulcer risk	62%	61.6%	60.3%	64.25%

Plans for improvement 2024/25

CQUINs are to be paused next year, with NHS England publishing non-mandatory indicators for Trusts to follow if they wish. Proposal to follow/report on these indicators will be only if they align with Patient Safety Incident Framework (PSIRF) Safety Priorities or other priorities.

14. Quality priority - Caring for people at the end of their lives

2	Caring for people at the end of their lives	We will support the improvement of our compliance with national guidance on care at the end of life (One Chance to Get It Right, NICE guidelines and the Quality Standards for end of life care). (NB The NACEL Audit is paused in 2023.)

Background

We have continued our work to improve people's experience of care in the last few days and hours of life. We have more than 2000 inpatients who die each year in hospital. Following the NICE Guidance 31 we have focussed on communicating respectfully and involving them and the people important to them in decisions about maintaining comfort and dignity. Our approach helps patients manage common symptoms whilst minimising side effects from drugs and maintaining comfort and hydration.

The identification of dying requires senior decision making and a multidisciplinary approach, together with robust and compassionate communication with the patients and those important to them. An individualised plan of care is developed and delivered to provide the best possible experience at this challenging time as illustrated in the report "More care, less pathway" (2013 More Care, Less Pathway (publishing.service.gov.uk)).
The Trust provides good EOL care (CQC 2018) and uses enablers to support this such as the Shared Care Plan and the SWAN model of care, and metrics to monitor the delivery of this care such as those generated by the National Audit for Care at the End of Life (NACEL). Practice is largely in line with other Trusts.

How we have performed 2023/24

Since the transition to the electronic patient record system, the use of the shared care plan has fallen as the system does not facilitate sharing the same as the paper form. We will work on how we will improve our use of the shared care plan because we know it enables a more comprehensive package of support for each patient and is a marker of good practice. In the interim we are using the SWAN feather symbol for the identification of dying and measure the patients on our electronic patient records system and we measure the prescribing of Glycopyrronium which is one of the anticipatory medications prescribed to support care of our dying patients.

We have improved the quality and quantity of our syringe pump training for nursing staff by developing and recording our syringe pump competencies on our Trust training register. A "train the trainer" model of teaching delivery has been commenced, with assured training from the specialist palliative care team. This will involve a combination of ad-hoc, bedside training as well as monthly training sessions for those clinical areas who do not have a nominated trainer. Registered nurses who work on wards who care for the dying, require a 50% competency upload by the end of 2024, increasing to 75% in 2025. This has been added into the ACE ward accreditation.

The competency report is also being refined and an aim for Q4 to see the output of above. We are measuring our 2023/4 performance, quarterly by:

	Q1	Q2	Q3	Q4
Number of adult deaths	475	447	481	514
% for whom feather icon used	31	33	38	42
Median / mean time (days) between feather icon application and death occurring	2.0 / 3.6	2.0 / 5.0	2.0 / 3.3	2.0/4.2
% for whom Glycopyrronium prescribed	77	79	81	82
Mean / median time (days) between Glycopyrronium prescription and death occurring	3.0 / 4.8	3.0 / 3.2	2.0 / 4.4	2.0/4.5
% Eligible nurses with syringe pump competency **	Not available	6.1%	Not available	17%

The proportion for whom the feather icon was placed on the tracking board has shown an increasing trend. This is a consequence of changes in EPR enabling more clinicians to apply the icon and is also due to Trust Wide Dying Matters Week comms, Grand Round, junior doctor teaching, the End-of-Life Care Leaders and PURPLE pilot and informal encouragement of use from the Palliative Care Team.

The proportion of patients who are prescribed Glycopyrronium remains high and demonstrates a similar trend which is encouraging as it suggests that the majority of dying is identified and *just in case* medicines are prescribed.

The PURPLE pilot project which is using a quality improvement approach to identify patients who are sick enough to die and to ensure appropriate management plans are in place is an initiative which aims to support appropriate and timely identification of dying. This project is now piloted over 4 wards.

The End-of-Life Care Leader project is now running with 31 junior doctors having attended an introduction session. Part of their role is to support the development and sharing of best practice through targeted QI initiatives and role modelling on their wards.

SWAN ambassadors are currently provided with an annual update and work is ongoing to ensure there is representation from all wards. The model of more frequent meetings / an end of life council proved unsuccessful as staff struggled to be released from clinical duties. The EOL council remains an aspiration as part of Pathway to Excellence.
Monitoring is undertaken via the End-of-Life Delivery Group which is now meeting monthly and where discussions are currently taking place as to the best ways for divisions to report issues and progress.

Plans for improvement 2024/25

We would like to develop an electronic version of the shared care plan to enhance communication with the patient and carers.

We will monitor registered nurses who work on wards who care for the dying, requiring a 50% competency upload by the end of 2024, increasing to 75% in 2025.
We would like to deliver a systematic and comprehensive approach for delivering and recording attendance for all staff for End-of-Life training.
Statistical analysis on the timing of anticipatory medicines being prescribed, the SWAN feather icon being applied and the patient dying, to identify meaningful improvement.

References:

- NICE Quality Standard Overview | Care of dying adults in the last days of life | Guidance | NICE
- Ambitions for palliative and end of life care ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

Health services

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgery services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provides services at the satellite oncology centre in Hereford County hospital.

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist healthcare for a population of more than 650,000 people. Our hospitals are district general hospitals with a great tradition of providing high quality hospital services; some specialist departments are concentrated at either Cheltenham General or Gloucestershire Royal Hospitals, so that we can make the best use of the expertise and specialist equipment needed.

Our Trust employs around 8000 staff. Our success depends on the commitment and dedication of our colleagues. Many of our staff are world leaders in the fields of healthcare, teaching and research and we aim to recruit and retain the best staff possible. Our patients are cared for by more than 2,390 registered nurses and midwives, 905 Healthcare Assistants and 992 medical staff. 257 Healthcare Scientists and 527 Allied Health Professionals. In addition, our estates are looked after by 763 NHS Gloucestershire Managed Services staff,

Further details, including our organisational chart can be found on our website
The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgery services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provides services at the satellite oncology centre in Hereford County hospital.

https://www.gloshospitals.nhs.uk/about-us/our-trust/who-we-are-and-what-we-do/

Information on participation in clinical audit

From 1 April 2023 to 31 March 2024, 47 national clinical audits and 4 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 98% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals

NHS Foundation Trust was eligible to participate in during 2023/24 are as follows:

	Eligible	Participated	Status
Case Mix Programme (CMP)	Y	Y	Ongoing
Elective Surgery (National PROMs Programme)	Y	Y	Paused
Emergency Medicine QIPS (RCEM) – Care of Older People	N	N	N/A (deferred)
Emergency Medicine QIPS (RCEM) – Mental health (self-harm)	Y	Y	Ongoing
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Y	Y	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	Y	Y	Ongoing
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	Y	N (due to closure of registry)	Closing
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Y	Y	Ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	Y	Y	Ongoing
Muscle Invasive Bladder Cancer Audit	Y	Y	Closed
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP)- Adult asthma secondary care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP)- Paediatric asthma secondary care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP)- Chronic Obstructive Pulmonary Disease	Y	Y	Ongoing

	Eligible	Participated	Status
(COPD) Secondary Care			
National Audit of Breast Cancer in Older People (NABCOP)	Y	Y	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	Complete
National Audit of Dementia (NAD)	Y	Y	Ongoing
National Bariatric Surgery Registry (NBSR)	Y	Y	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Y	Y	Ongoing
National Child Mortality Database	Y	Y	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	Ongoing
National Joint Registry (NJR)	Y	Y	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing
National Neonatal Audit Programme (NNAP)	Y	Y	Ongoing
National Ophthalmology Audit (NOD)	Y	Y	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	Ongoing
National Perinatal Mortality Review Tool	Y	Y	Ongoing
National Prostate Cancer Audit	Y	Y	Ongoing
National Vascular Registry	Y	Y	Ongoing
Perioperative Quality Improvement Programme	Y	Y	Ongoing
National Acute Kidney Injury Audit	Y	Y	Ongoing
UK Renal Registry Chronic Kidney Disease registry	Y	Y	Ongoing
Adult Respiratory Support Audit	Y	Y	Ongoing
Smoking Cessation Audit- Maternity and Mental Health Service	Y (but data collection deferred)	N/A	NYR
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	Ongoing
Serious Hazards of Transfusion UK (SHOT) - National Haemovigilance Scheme	Y	Y	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y	Y	Ongoing
The Trauma Audit and Research Network (TARN)	Y	Y	Ongoing

	Eligible	Participated	Status
UK Cystic Fibrosis Registry	Y	Y	Ongoing
National Parkinson's Audit	Y	Y	Ongoing

Ongoing – relates to continuous data collection, please note
NYR – data collection has not yet started
PTP – plan to participate in the next round

The reports of the above national clinical audits were reviewed (or will be reviewed once available) by the provider in 2023/24.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Case Mix Programme (CMP)	The CMP is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland. ICNARC report on COVID-19 in critical care: 2023 This report presents analyses of data on patients critically ill with confirmed COVID-19, admitted up to 31 March 2023 from critical care units participating in the Case Mix Programme and increasing numbers of surge/other areas providing critical care.
Elective Surgery (National PROMs Programme)	GNHFT participated in reporting to this audit in 2023. The most recent data available for PROMs is “Finalised Patient Reported Outcome Measures (PROMs) in England for Hip and Knee Replacement Procedures (April 2021 to March 2022). Published July 2023. Changes were made by NHS Digital to the linking of data fields from Hospital Episode Statistics (HES) and Patient Reported Outcome Measures. Due to this reporting has been paused, with no current timeframe for publication of results.
Emergency Medicine QIPS (RCEM) – Care of Older People	GNHFT participated in reporting to this audit in 2021/2. The Trust is not participating in this QIP at present due to departmental priorities. Other Trust based Care of the Elderly QIPS are ongoing including improving documentation of Clinical Frailty Scores.
Emergency Medicine QIPS (RCEM) – Mental health (self-harm)	This QIP tracks the current performance in EDs against clinical standards in individual departments and nationally on a real-time basis over a 2-year period. This includes; - ED Mental Health Triage process - Observation of patients at risk of further self-harm or absconding - ED clinician assessment

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	The Trust continues participate in this QIP, to identify scope for improvement work and monitor real time change. Epilepsy12 has the continuing aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. Epilepsy12 seeks to help improve the standard of care for children and young people with epilepsies. Data is collected and processed relating to the delivery of patient care and the organisation and structure of services. This information is used by the audit to highlight areas where services are doing well, and also to identify areas in which they need to improve. The Trust has ensured participation in Cohort 5 of data collection and will review the next publication to identify any scope for quality improvements.
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	The National Audit of Inpatient Falls (NAIF) audits the delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards in England and Wales. NAIF reviews the care the patient has received before their fall as well as the post fall care. From 2025 the audit will also look for evidence of examination for other injuries for patients who are found to have a fracture, or other serious injury which is recommended by NICE clinical guideline CG161 and quality standard QS86. The Trust Falls Prevention team provide ongoing and regular training for all members of the multidisciplinary health care team with the aim of keeping staff competent and confident to carry out assessments, including the correct and appropriate management of post falls assessments, thereby identifying risk factors and ensure action is taken to address these risks. This includes high quality multi-factorial falls risk assessments (MFRA) for patients over 65 and other inpatients who may be at risk. Current QIs in progress include the improvement of calculation of lying down blood pressures, with training led by Clinical Nurse Educators and Falls Link Nurses. A Post Fall Assessment document is being integrated into EPR to improve documentation of post fall checks and requirements for administration of analgesia.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	The National Hip Fracture Database (NHFD) was established to measure quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform. The Trust uploads data from all hip fracture cases admitted to GRH. These data are analysed locally and discussed at monthly governance meetings. NHFD provides 3 monthly update reports allowing us to benchmark our Trust against other hospitals, these reports are also discussed at governance meetings. Improvement work continues around consolidation and embedding of previous years' actions, together with looking at additional theatre availability.
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	The IBD Registry is closing current activities by **Easter 2024**, and is in discussions through **Spring 2024** about possible transition to an NHS organisation. The Trust has not participated in the latest rounds of data collection.
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	LeDeR summarises the lives and deaths of people with a learning disability and autistic people who died in England. It aims to; - Improve care for people with a learning disability and autistic people. - Reduce health inequalities for people with a learning disability and autistic people. - Prevent people with a learning disability and autistic people from early deaths. This year's report found that nationally there has been gentle but continuous improvement in the median age of death for people with a learning disability in 2022. There was a drop in the number of avoidable deaths since 2021 – 42% of deaths were deemed "avoidable" in 2022 compared to 50% in 2021. For most of 2023/2024 the LeDeR Quality Assurance panel were reviewing deaths which occurred in 2022/2023. Of the 28 deaths which occurred that year in either inpatients or shortly after discharge, to die at home or in a community hospital, 25 were graded at least 'Satisfactory', but 6 were graded 'excellent'. The Trust has not seen any in-hospital death graded 'excellent' before, so this was a major achievement. It has taken a lot of years of dedication by many professionals and families to achieve this.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	A single grade is given across primary care, secondary care and social care so these high gradings are a tribute to the efforts of everyone in all three areas of health and social care. Even where the grade allocated was 'Satisfactory' the deficit was not within hospital care. Only one death was graded 'Inadequate'. No death was graded less than Inadequate and 2 deaths have yet to be graded. In response to issues that have arisen in LeDeR reviews, minor modifications have been made to the alerts placed on Trakcare for Learning Disability patients, and the LD liaison nurses have adopted a more structured approach to their visits to in-patients, which has reduced the frequency of many of the concerns. The Maternal, Newborn and Infant Clinical Outcome Review Programme includes surveillance data on women in the UK who died during or up to one year after pregnancy between *January to December 2021. This year themed reports have been published on;* - A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death. - A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death. - Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth. - Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes The Trust continues to participate in MBRRACE-UK data reporting and reviews the recommendations at the Maternity Clinical Governance meeting to identify any action plans including quality improvement work. Report findings are shared on the MDT PROMPT study day to ensure National learning is shared amongst the team. Improvements in Health inequalities is a key focus in the Trust's maternal death action plan.
Muscle Invasive Bladder Cancer Audit	This BAUS snapshot audit was launched in January 2022. National and local results were published in August. Presentation of these results took place in September at a local audit meeting. Currently our time to cystectomy is better than the national average/MITRE data. However, there are gains to be made in

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit	time to TURBT, and subsequent time to restaging TURBT. One delay in this pathway is the need for repeating the pre-assessment clinic before each operation, which often is unnecessary If patients are having similar operations in a short period of time – we are looking at bypassing the need for a second pre-assessment prior to restaging TURBT. NDISA reviews inpatient service provision in England and Wales. Service provision is assessed against recommendations in the 2020 Diabetes Getting It Right First Time (GIRFT) report. The rates and risk factors are reviewed for serious diabetes-specific inpatient harms that can occur to inpatients with diabetes in acute hospitals in England. The Trust continues to submit to NDSIA Harms on harms that are reported, errors are discussed by the Diabetes Team. It is recognised that staff shortages have impacted the ability to meet all GIRFT recommendations. The Trust has introduced insulin prescribing on EPR, as of early December 2023, as a result there are less insulin related incidents occurring.
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	NPID is a work stream of the National Diabetes Audit (NDA) and measures the quality of pre-gestational diabetes care against NICE guideline-based criteria and the outcomes of pre-gestational diabetic pregnancy. It focuses on key areas of preparing women with diabetes for pregnancy and taking appropriate steps to minimise adverse outcomes to the mother. The Trust continues to participate with ongoing data collection. Data is published nationally and reviewed at the annual Diabetes in Pregnancy conference.
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	NDA provides a view of diabetes care in England and Wales. It measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. This supports Trusts to Identify and share best practice and identify gaps or shortfalls that are priorities for improvement. The Trust has continued to participate in the NDA. Reports and Trust data are reviewed at Diabetes Team Operational Meetings and the Gloucestershire Diabetes Clinical Program Group. Improvements have been made and are ongoing for access to and training on diabetes technologies. Ongoing planning is in progress for management of Type2 Diabetes.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Respiratory Audit Programme (NRAP) - Adult asthma secondary care	NRAP's adult asthma secondary care work stream includes a continuous clinical audit of people admitted to hospital with asthma attacks, and a snapshot audit of the organisation and resourcing of care. The audit is continuous and collects information on adults admitted to hospital in England and Wales with asthma attacks. Snapshot organisational audits collect information on how services are organised and what resources are available to them at a given point in time. The Trust continues to participate in this audit, combining data for both sites. The data is used to identify improvement priorities which can drive improvements to care.
National Respiratory Audit Programme (NRAP)- Children and young people's asthma secondary care asthma secondary care	NRAP's children and young people's asthma secondary care work stream includes a continuous clinical audit of people admitted to hospital paediatric services in England and Wales with asthma attacks, and a snapshot audit of the organisation and resourcing of care. This audit aims to collect information on children and young people aged 1-18 years, admitted to hospital paediatric services with an asthma attack in England and Wales. Data is measured against key performance indicators recommended by NRAP to support good practice in the delivery of acute asthma care. The Trust has completed data for the organisational audit for this year. Outcomes from previous years' reports include staff working with CYP and families continuing to be appropriately trained to explain the risk of asthma exacerbations linked to smoking and indoor air quality and making referrals to smoking cessation specialist services. A formal transition service is in place for from child to adult asthma services. The Paediatric Respiratory service is reviewing options to meet recommendations on dedicated in-patient time for asthma.
National Respiratory Audit Programme (NRAP - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	NRAP's COPD secondary care work stream includes a continuous clinical audit of people admitted to hospital with flare-ups of COPD, and a snapshot audit of the organisation and resourcing of care. Data is measured against the key performance indicators recommended by NRAP to support good practice in the delivery of acute asthma and COPD secondary care. The Trust are continuing to undertake the NRAP organisational audit. The business intelligence spreadsheets tracking admissions is supporting accuracy of data and the identification of patients with COPD.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Audit of Breast Cancer in Older People (NABCOP)	NABCOP is a national clinical audit run by the Association of Breast Surgery (ABS) and the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England (RCS). The aim of NABCOP is to support NHS providers to improve the quality of hospital care for older patients with breast cancer by publishing information about the care provided by all NHS hospitals that deliver breast cancer care in England and Wales, and looking at the care received by patients with breast cancer and their outcomes. The NABCOP audit pulls the anonymised data it requires automatically. The Trust reviews cases and reports at specialist departmental meetings. The NABCOP Patient information sheet for >70s is now used within clinics.
National Audit of Care at the End of Life (NACEL)	NACEL is designed to measure the experience of care at the end of life for dying people and those important to them, and to provide audit outputs which enable stakeholders to identify areas for service improvement. GHT took part in the 2022 round of the audit, the most recent publication was shared at Quality Delivery Group, Trust Mortality Group and End of life Delivery Group. An action plan has been developed and is overseen by the End of Life Delivery Group.
National Audit of Dementia (NAD)	The National Audit of Dementia (NAD) audit relates to the quality of care received by people with dementia in general hospitals. The latest NAD report has been reviewed by the Trust's Dementia Delivery Group and an action plan is in place to include; - Widening opportunities for patient engagement - Improved EPR capture of Dementia and Delirium - Increased levels of Datix reporting with refined reporting of falls, pressure ulcers, violence and aggression and complaints - Review and development of current Dementia training - Initiative for ensuring Trust hospitals are Dementia Friendly environments.
National Bowel Cancer Audit (NBOCA)	The annual report was published in January 2023 and discussed at the Upper GI clinical governance meeting in February 2023. Discussion of results has highlighted areas for work over the coming 12 months, looking at: Ileostomy closure, adjuvant chemo and laparoscopy rates.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Bariatric Surgery Registry (NBSR)	The State of the Nation Report was published in early 2024 and was reviewed at the Colorectal Governance Meetings. NBOCA has also been discussed in several CRUM Meetings due to concerns regarding the accuracy of the data. The National Bariatric Surgery Registry is the result of a collaboration between ALSGBI (Association of Laparoscopic Surgeons of Great Britain and Ireland), AUGIS (Association of Upper Gastrointestinal Surgery), BOMSS (British Obesity & Metabolic Surgery Society) and Dendrite Clinical Systems. The key objective of the registry is to accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include reportage on weight loss, co-morbidity and improvement of quality of life. All cases performed in Gloucester are submitted to NBSR. These are then reported on the NBSR Website. The results are presented at the SQAG (Surgical Quality Assurance Group) Meeting and at the Upper GI Surgical Governance Meeting.
National Cardiac Arrest Audit (NCAA)	We subscribe to The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland. It is a joint initiative between the Resuscitation Council (UK) and ICNARC. The aims of the audit are to: improve patient outcomes; decrease incidence of avoidable cardiac arrests; decrease incidence of inappropriate resuscitation as well as to promote adoption and compliance with evidence-based practice. All NCAA reports are reviewed as a department as well as quarterly at the Deteriorating Patient & Resuscitation Committee. The reports are also available on the Deteriorating Patient & Resuscitation Committee shared drive so that they can be accessed and be reviewed by appropriate clinicians with access. We also publish the Audit data within the department newsletter issued across the Trust as well as being accessible on the Intranet, staff notice boards, and shared with department heads for dissemination. The Trust continues to share the results at Induction sessions and Mandatory updates. Any inappropriate

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	CPR attempts are highlighted and reviewed, and if appropriate, simulated to help focus teaching and lessons learned. The NACRM report details activity in cardiac rhythm management device and ablation procedures for England & Wales and covers data from April 2021- March 2022. On a national scale, following a 17% drop in therapeutic implants in 20/21, there was an 11% increase in activity in 21/22, but overall activity was still 7.7% lower than pre-pandemic levels. Ablation rates have improved nationally, but remain 11% down from 19/20. Use of leadless pacemakers increased. Trust reports are reviewed at the Arrhythmia Group meeting and with the clinical lead and pacing operators, where Trust data and scope for quality improvements are reviewed alongside national recommendations from the audit.
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	This year's report covers April 2022 to March 2023. Total PCI procedures increased nationally over this period. The number of primary PCIs for patients with ST-elevation myocardial infarction (STEMI) returned to pre-pandemic levels and PCI for other acute coronary syndromes almost did so. Elective PCI numbers were lower. The report focuses on several specific quality improvement metrics derived from national and/or international standards and guidelines. The Trust meets recommendations substantially, specifically in the use of adjunctive imaging in LMS intervention and use of newer antiplatelet agents in the STEMI setting. Day case PCI for elective work is the default as was recognised by the GIRFT report in March 2023 and rates for the unit (87.4%) continue to be well above the national average of 71%, improving access to PCI for local population without impacting IP patient care/bed use. Recommended antiplatelet drug use in STEMI cases is higher at 76.8% than national average of 40%. 30day mortality at 1.71% is lower than national average for matched activity/volume.
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	This report summarises the care provided within hospitals in England, Wales and Northern Ireland people who suffered a heart attack during 2021/22. Quality of care is assessed against a set of quality improvement (QI) metrics derived from national and/ or international standards and guidelines. These cover patients diagnosed with higher-risk ST-segment elevation myocardial infarction (STEMI) heart attacks and those with non-ST-segment elevation myocardial infarction (NSTEMI) heart attacks.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	The Trust has used QI methodology to improve data completeness for MINAP and continues to do the primary PCI timings. Cardiology is now on one site at GRH and will certainly have a positive impact on the service. This report summarises selected key findings from the National Heart Failure Audit (NHFA), part of the National Cardiac Audit Programme (NCAP) and covers the period of 2021/22. It deals with a specific and crucial phase in the disease trajectory of patients admitted to hospital with heart failure in England and Wales. There is a particular focus on a set of quality improvement metrics, based on standards and guidelines, which aim to drive up standards of care during an acute admission to achieve better patient outcomes. The Trust has continued to participate in this audit and recent initiatives include; - Initiation of a pilot 1 year project for a nurse-led inpatient heart failure service in GRH - Work towards establishing a 'Virtual ward' to manage ambulatory heart failure patients within a virtual environment at home rather than in hospital
National Child Mortality Database	NCMD aims to understand patterns and trends in child deaths where an event before, or around, the time of birth had a significant impact on life, and the risk of dying in childhood. Over the past 12 months this has included thematic reports on infection related deaths of children and young people and death due to traumatic incidents. The Trust continues to participate in the NCDM and reviews local data at Perinatal and Paediatric Clinical Governance meetings, which, by also reviewing national or local recommendations, identifies action plans and quality improvement work. The Trust also works closely with the ICB in these respects.
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIAA assesses the provision of care and the impact of that care on outcomes for people with Early Inflammatory Arthritis in England and Wales. NEIAA determines whether the care provided is consistent with current recommended best practice defined by NICE QS 33. The audit assesses seven key metrics of care for people with new symptoms of suspected inflammatory arthritis attending rheumatology services. The Trust continues to participate in the audit and reviews the report and local data at the departmental governance meeting. The Trust is identified as an outlier for Quality Standard 2 and is

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	working towards improving data capture to support potential quality improvements for the referral and assessment pathways. NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high-quality comparative data from all providers of emergency laparotomy.
National Emergency Laparotomy Audit (NELA)	NELA is carried out by the National Institute of Academic Anaesthesia's Health Services Research Centre (HSRC) on behalf of the Royal College of Anaesthetists (RCoA), in conjunction with surgical and other key stakeholders. The most recent report was published February 2023. This was discussed at the NELA MDT and an action plan set. Data continues to be uploaded to the NELA website, with quarterly joint surgical and anaesthetic NELA meetings to review results.
National Joint Registry (NJR)	The National Joint Registry (NJR) collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery. The results of the NJR are shared with the Medical Director and Chief Executive, and are discussed at hip and knee MDT meetings amongst all hip and knee surgeons. Individual reports are used as part of the appraisal process. 22/23 info Gloucestershire Hospitals has been found to have a revision rate for primary hip replacements over the last 5 years to be above that which is expected based on national data. A review of cases has been registered with the clinical effectiveness team to analyse the factors relating to these revisions, with a view to undertaking a Quality Improvement project if required following this diagnostic phase of the project.
National Lung Cancer Audit (NLCA)	Most recent report not reviewed yet. The National Lung Cancer Audit (NLCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works with a number of specialists to collect hospital and healthcare information and report on how well people with lung cancer are being diagnosed and treated in hospitals across England, Wales, (and more recently) Jersey and Guernsey. The most recent publication was included in last year’s quality account, and the next report is due. Outcomes will be reviewed at the Lung AGM and appropriate specialty and governance meetings. Quality improvement projects to improve our service

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Maternity and Perinatal Audit (NMPA)	and pathways are ongoing. To be reviewed on 14/5/24. The National Maternity and Perinatal Audit (NMPA) is a large-scale project established to provide data and information to those working in and using maternity services. It helps us understand the maternity journey by bringing together information about maternity care and information about hospital admissions. The NMPA aims to cover 2019-2023 data in their next publication. The Trust continues to participate in the NMPA and reviews reports alongside local data to highlight areas of potential service improvement.
National Neonatal Audit Programme (NNAP)	NNAP assesses whether babies admitted to neonatal units receive consistent high-quality care. This includes measuring key outcomes of neonatal care, measures of optimal perinatal care, maternal breastmilk feeding, parental partnership, neonatal nurse staffing levels, and other important care processes. Trust data is submitted nationally and reviewed quarterly, alongside recommendations from the report to identify any scope for local quality improvement work. Current QIs include; - improving timely administration of full course of antenatal steroids, and administration of magnesium sulphate. - Increased capacity for undertaking 2 year developmental assessments
National Ophthalmology Audit (NOD)	The National Ophthalmology Database Audit (NODA) is the latest dataset to be published on the National Clinical Audit Benchmarking (NCAB) website. This data was updated on NCAB on 03/11/2023. This Audit looked at Risk-adjusted posterior capsule rupture rate where GNHFT sits, 'Within Expected Range' and Risk-adjusted Visual Acuity Loss where GHNHSFT sits as, 'Better Than Expected'.
National Paediatric Diabetes Audit (NPDA)	The NPDA measures effectiveness of diabetes care received by the children and young people with diabetes against NICE guidelines. This includes treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes related complications including acute hospital admissions. Ongoing Trust based QIs include; a new telephone advice sheet and inpatient guidelines for management of patients admitted to the ward, improving foot checks during annual review clinics, encouraging patients to send an early morning urine sample to the

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	lab and visits if patients do not attend or cancel annual review appointments. A GSQIA Silver project is in progress looking at preparing 14-16 years' olds with diabetes to transition to adult services with a view to increase confidence in self-management.
National Parkinson's Audit	The National Parkinson's Audit provides data about the state of Parkinson's services across the UK, which inform priorities and help drive service improvement and measure change. The audit uses evidence-based clinical guidelines as the basis for measuring the quality of care in the outpatient setting. Trust data reports on Neurology, COTE and Physiotherapy have been reviewed as part of a planned collaborative approach to identify quality improvement initiatives. A Training programme and educational pathways are in progress to upskill staff in providing care for patients with Parkinson's. This has included initiatives for earlier referral and resources from the Parkinson's Excellence Network, such as the 'Get in on Time' campaign to ensure patients receive timely medication.
National Perinatal Mortality Review Tool	The PMRT supports objective, robust and standardised local reviews of care when babies die. This includes baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths and neonatal deaths. It helps to ensure local and national learning results improve care, reduce safety-related adverse events, and prevent future baby deaths. The main focus of this year's report is 'quality' in terms of parent engagement, the review process, and subsequent actions plans. The Trust continues to participate in PMRT data reporting and inputs all stillbirths and early neonatal deaths. All parental feedback is gathered using locally adapted PMRT parental engagement materials and is shared and discussed monthly. Local PMRT summary reports are completed and shared with the Trust Board. Actions are reviewed at monthly PMRT meetings.
National Prostate Cancer Audit	The National Prostate Cancer Audit (NPCA) is a national clinical audit assessing the process and outcome measures from all aspects of the care pathway for men newly diagnosed with prostate cancer in England and Wales. The findings help to define new standards and help NHS hospitals to improve the care they provide to patients with prostate cancer. The Trust submits data for NPCA and reviews the reports at the appropriate specialty and governance meetings when they are

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	released. Trust specific results are freely available on the NPCA website providing clear data for patients. Improvements made during 2020/21 have been maintained with results showing GHT is within the recognised 'normal' limits for emergency readmissions and genitourinary complications requiring intervention. The National Cancer Audit Collaborating Centre (NATCAN) published a State of the Nation report from the National Oesophago-Gastric Cancer Audit (NOGCA) on the care received by people with oesophago-gastric cancer in January 2024.
National Oesophago-gastric Cancer Audit	Previous Audit review: Specific recommendations received from publication around the nutritional status and dietetic support for patients. A second specialist cancer support dietician was employed in August 22 and all patients undergoing curative surgery for OG cancer now have access to specialist dietetic support before, during and after surgery in our trust. Plans are in place to develop a nutritional database to allow submission of these results increasing completeness of the NOGCA data set.
National Vascular Registry	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions (Patent outcomes (mortality and revision rate) within expected boundaries). National Vascular Registry Sate of the Nation report reviewed in Sept 23, at the Vascular department away day.
Perioperative Quality Improvement Programme	GNHFT continue to participate in reporting to this registry in 2023/4. The Perioperative Quality Improvement Programme (PQIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery. The ambition is to deliver real benefits to patients by supporting clinicians in using data to improve patient outcomes across the UK, reducing variation in processes of care and supporting implementation of best practice. This work links to the DrEaMing CQUIN (**Dr**inking, **Ea**ting, **M**obilis**ing**) the Trust participated in during 22/23 (and continues into 23/24) where the provision of fluids, food and mobilisation within 24 hours of surgery are assessed. Excellent results were found from this CQUIN.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Acute Kidney Injury Audit	Acute kidney injury (AKI) is a sudden deterioration of kidney function, and is associated with about 100,000 deaths every year in hospital in the UK. The audit has objectives; - To demonstrate the impact of AKI on the English population, through analysis of the AKI rate and outcomes at the level of the Integrated Care Boards. - To show the different demographics and outcomes of various groups of people with AKI, but in particular, people who are entirely cared for in the community versus those who are admitted to hospital with their AKI, or develop it during their stay. The Trust continues to participate and registry data is used for quality assurance and feeds in to other audit and quality improvement activity along with the UK Renal Registry annual report.
UK Renal Registry Chronic Kidney Disease registry	The UK Renal Registry (UKRR) collects and reports data annually on approximately 70,000 patients with Chronic Kidney Disease (CKD) (including people pre-KRT and on KRT) at each of the UK's adult and paediatric kidney centres. The data is analysed against the UK Kidney Association's guidelines The Trust continues to submit data, with a quarterly annual validation and query resolution. Registry data is used for quality assurance and feeds in to other audit and quality improvement activity and is discussed in other meetings, such as GIRFT, regional Kidney Quality Improvement Partnership and the renal regional network.
Adult Respiratory Support Audit	The Adult Respiratory Support Audit captured data as an on patients outside critical care that have required respiratory monitoring or intervention (i.e. either admitted to an acute respiratory support unit or treated in another ward setting with NIV/CPAP/HFNO), with a view to better understanding variations in clinical practice and outcome.
Smoking Cessation Audit-Maternity and Mental Health Service	This audit was cancelled by the British Thoracic Society.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) measures how well stroke care is being delivered in in England, Wales and Northern Ireland. The clinical audit measures the processes of care provided to stroke patients in inpatient and community settings against evidence-based standards. The organisational audits measure the structure of stroke services in acute hospital settings and community settings. The Trust SSNAP data is reviewed on a regular basis by ED, radiology, stroke nurses, consultants and the wider stroke team. Trust Improvements include: 1. Improved GRH pathway to reduce delays and missed thrombolysis/thrombectomy 2. Improved access to CT/CT angiograms and MRI scans to improve time to diagnosis, especially valuable for stroke mimics. Further work is underway to provide access to MRI 7 days a week. 3. DIDO pilot project launched Jan-April 2024 with SWAST to reduce delays to transfer to Southmead for thrombectomy patients. 4. Reduction in vacancies in therapy for Physio, OT, SALT and psychology 5. Pilot of Activity coordinator roles on Woodmancote ward to improve wellbeing and rehab of ward patients 6. Launch of Community Neuro Rehab team to increase community therapy offer and improve access to stroke Early Supported Discharge team 7. Work with ward nurses to improve training and management of continence and low mood/anxiety 8. Move of HASU into a dedicated ward with therapy room and co-located ambulatory area for SDEC reviews 9. Discussions with ICB regarding resource for the TIA service due to significant increased demands for TIA clinics.
Serious Hazards of Transfusion UK (SHOT) - National Haemovigilance Scheme	SHOT is the UK's independent, professionally-led haemovigilance scheme. Since 1996 SHOT has been collecting and analysing anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom. The SHOT report was published in July 2022 and circulated to members of the Hospital Transfusion Committee. It was presented at the October HTC meeting.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Society for Acute Medicine Benchmarking Audit (SAMBA)	GAP analysis resulted in review of the following areas to ensure compliance: • storage processes, • SOP • planning and delivery of staff training/retraining • removal/restocking of expired components from storage locations. SAMBA provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 22nd June 2023. Maintaining and improving the quality of care provided to patients within acute medicine services is vital, but presents an ongoing challenge given the continual pressures felt across the urgent and emergency care system. The Trust has continued to participate in SAMBA, the insights gained through SAMBA are used to improve the care provided for acute medical patients. This has included; - Increased AMU PTWR in ED by using 2 AMU consultants as well as regular involvement of front door specialists as a result of re-structuring consultant PTWR rota - Electronic PCR and e- prescribing - 2 more acute consultants employed in 2023 (LTFT so 1.5 total WTE) - New medical assessment zone in the AMU which opened March and has improved flow from GP admissions to reduce numbers in ED
The Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured, with reports being reviewed every two months within the Major Trauma meeting. We excel in obtaining timely scans of our trauma patients on their arrival in the Emergency Department, but have faced a number of challenges over the past couple of years with our mortality rates and senior decision-makers seeing patients within target time. To tackle this there has been an integrated approach with close co-operation with our colleagues in the trauma network. 22/23 info

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
UK Cystic Fibrosis Registry	Having moved into the new ED at GRH, we have already implemented a number of initiatives and are embarking on a deep dive of our data. The UK Cystic Fibrosis report is aimed at anyone who is interested in the health, care, and outcomes of people with cystic fibrosis (CF) in the UK. It has the purposes of; - helping people with CF and their families understand CF and make informed decisions - giving clinical teams the evidence they need to improve the quality of care - Monitoring the safety and effectiveness of new treatments for cystic fibrosis - Providing data for research to find the best ways to treat cystic fibrosis - Helping commissioners provide funding to NHS CF centres that is proportionate to the severity of their patients' condition There two patients under care of the Trust that have now completed the study, out of 3 current patients. The annual CF Registry Conference in October is attended by the Trust. The annual report provides regional feedback and highlights opportunity for quality initiatives.

The reports of 182 local clinical audits and Quality Improvement projects were registered in 2023/24 and these are reviewed and actioned locally. In addition, 22 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2023/24. Some examples of actions associated with audits and completed QI projects are as follows:

Aim: To Improve the documentation of Post Return of Spontaneous Circulation (ROSC) following cardiac arrest by 30%
Changes: Creation of a post resuscitation care bundle with related awareness and teaching sessions.
Results: Initial good response with completion, ED staff were engaging and had good understanding of post ROSC care. When the ROSC care bundle was used, it provided a cohesive template for documentation.
Next steps: Roll out onto wards/clinical areas for all CA, have a digital version on EPR with post ROSC care listed to aid documentation compliance increase.
Aim: To improve the self-reported quality of sleep of awake patients in critical care to an average

of 7/10 on the sleep quality scale
Changes: This project focussed on tests of change related to music/audio therapy for sleep, which supported other projects that also looked at sleep quality/delirium such as the use of light therapy and sleep bundle, alongside the rehabilitation pathway.
Results: Median score of 7/10 achieved.
Next steps: Share learning within the trust and also to the southwest network.
Aim: 50% increase in the number of patients receiving iron transfusions in anaemic colorectal patients undergoing elective resection surgery over a 3-month period
Changes: Creation of an endoscopy checklist, creation of a central pathway by which to identify and transfuse patients with pre-op IDA, raising awareness amongst staff on how to use it
Results: 75% referred via 2WW colorectal clinic or endoscopy, 100% received IV iron transfusions pre-operatively, Median 29.5 days between initial Hb check and IV iron
Next steps: Implementation of pre-operative anaemia protocol across all surgical specialties
Aim: To improve storage to eliminate confusion and reduce wrong implant selection, increasing the percentage of staff who find the storage room clear and easy to use to 100% within 12 months
Changes: Surveys to staff and review of storage options. New purchase of storage and testing of clear labelling options
Results: Clarity of labelling and storage has promoted confidence in selection. Sharing of information and collaborative working across site has been beneficial to both areas. A delay in the roll out at GRH allowed for a smoother transition as the adopted tests of change from CGH could be easily imbedded into GRH
Next steps: Additional of information on stock levels

Participation in clinical research

Research and Innovation

Research and innovation (R&I) are recognised as important pillars in enabling the NHS to provide quality care for its patients. Research active organisations are known to provide better care for patients and more stimulating environments for staff to work in. We need to ensure that
R&I are integral to the day-to-day business of the Trust as they provide the organisation, its patients and its staff with access to new drugs, devices and developments in the delivery of care that they would otherwise have to wait for.

In 2023/2024, the R&I team have supported a significant increase in research activity almost doubling the number of open studies from 53 last year to 100; 21% of which are commercial studies. We have recruited 1522* patients into studies this year in spite of a change in study portfolio and a reduction in high recruiting trials from 6 to 2. We are regularly approached to act as a site for commercial studies with 398 expressions of interest (EOIs) sent to the team this year. Not all studies are suitable for the Trust's population but we managed to convert 93 of these EOIs into future studies. This activity has been achieved against a backdrop of a major reorganisation and staffing issues in the team.

We also have exciting new developments in our medical technology partnerships and these innovations will be led by focussing on understanding and addressing the most critical challenges the NHS faces. In particular, tackling the issues the impact on patient experience, resource allocation and health outcomes. Although these projects are at an early stage, we anticipate being able to report that a number of these projects will be up and running in the next six months.

*this figure is likely to increase as data are uploaded by contract research companies

Care Quality Commission

As a healthcare provider, we hold registration with the Care Quality Commission (CQC). CQC monitor, inspect and regulate our services. This section outlines any breaches to those obligations and provides assurance that improvement action plans have been put in place to enable us to meet the requirements.

Inspections

Like last year, the year started in April 2023 with unannounced inspection in our core services of Maternity and Surgery. This inspection activity was followed with inspections in Children's and Young People's Service, the Emergency Department and then Stroud Maternity.

The ratings for the Trust are as follows:

- The overall rating for the Trust remains as "**Requires Improvement**".

Core services

- Maternity at Gloucestershire Royal site was again rated as "Inadequate" after the report was published in November 2023.
- Surgery remain as "Inadequate" as the service was unrated at the inspection in November 2023.
- For the Children and Young People's Service inspection we are still awaiting our report.
- For the Gloucestershire Royal Emergency Department inspection, we are still awaiting the report.
- The Stroud Maternity Service was rated as "Requires Improvement" and the report was published 20 March 2024.

Table: Summary of inspection activity and reports received

Inspection	Dates	Reports published and link	Rating	Must Do / Should do actions
Well Led	13 & 14 July 2022	7 October 2022 Report	Requires Improvement **No change in rating over 2023/24**	7 Must do 1 Should do
Core Service – Maternity (Unannounced	25 April 2023	10 November 2023	Inadequate	S29a 2 actions 1 Must do

Inspection	Dates	Reports published and link	Rating	Must Do / Should do actions
focused Inspection) **Section 29a Warning Notice**		GRH link here		4 Should dos
Core Service - Surgery (Unannounced inspection)	25 & 26 April 2023	10 November 2023 CGH link here GRH link here	Unrated – previous rating inadequate	3 Must do 2 Should do
Children and Young People Services (GRH) (Unannounced)	20 September 2023			Report awaited
Emergency Department (GRH) (Unannounced)	13 December 2023			Report awaited
Maternity Stroud (Announced)	12 December 2023	Report published 20 March 2024	Requires Improvement	6 Must Do 4 Should Do
Maternity (GRH) (Unannounced)	26 March 2024			Awaiting report Currently collating data for return.

Improvement plans are in place for all “Must do” and “Should do” issues and these are monitored through the Divisions and the Quality Delivery Group.

Warning and improvement notices

In 2023/24 published in the inspection report, the Trust was served with 1 section 29a warning notices where significant improvement was required.

Core Service area	Inspection date	Issues	Action
Maternity GRH	25 April 2023	Level 3 safeguarding training not at compliance level and clinical incidents not reviewed within 30 days	The safeguarding training plan has been updated and L3 training rates have increased across the professional groups. New processes are being put in place for review of clinical incidents with low risk ones being closed within 30 days.

CQC new assessment framework

CQC's new assessment framework applies to providers, local authorities and integrated care systems. Their 5 key questions and ratings (outstanding, good, requires improvement and inadequate) are still central to their approach. All inspections in 2024 will be carried out in the new framework.

Information governance Incidents

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

Nine incidents have been reported to the ICO during the 2023/24 reporting period. This compares to 15 reported in the previous period.

Table: Summary of incidents reported to the Information Commissioner

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
April 2023	Gynaecology patient list was found by patient in her maternity notes - these are a set of health records taken home by maternity patients.	10	Letters sent to all 10 patients 21/09/23
	Lessons learnt – Management of handover sheets under review to ensure data minimisation requirement adhered to		
June 2023	Audio recording from a family complaint meeting (run time 1hr 10mins) copied to an additional complainant via the AMS portal, in error.	1	Patient contacted by IG team via email
	Lessons learnt – Human error, staff reminded to double check recipients prior to file transfer		
June 2023	A sanctions letter relating to unacceptable conduct by a patient was sent to an unrelated person of same name.	1	Contacted by service
	Lessons learnt – human error, staff reminded to double check recipients prior to sending communication		
July 2023	Data relating to one patient included in error in another patient's report. Data integrity breach due to report with incorrect data being used to support referral / application process with partner organisations. Error compounded when apology made as details of root cause shared with the complainant, including the fact that the incorrect data was from another patient with the same name and going through the same application process, therefore putting the second patient's confidentiality at risk	2	Patient contacted Trust to report integrity breach

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
	Lessons learnt – under investigation		
July 2023	Patient record reported by member of the public to have been inappropriately accessed and information shared via a WhatsApp group	4	Under investigation
	Lessons learnt – under investigation		
Oct 2023	A letter that was written to update a patients GP on their condition and progression of their cancer treatment was sent to another patient in error	1	Awaiting confirmation from service
	Lessons learnt – under investigation		
Nov 2023	Disciplinary details relating to a member of staff, documented as part of a People & OD investigation report, shared in error as part of another member of staff investigation panel process. The section of the report had previously been agreed to be redacted as containing third party PID. A copy of a report with the section not redacted has been shared in error to another member of staff, their representative and the investigation panel	1	Staff member contacted by IG team via email
	Lessons learnt – under investigation		
Nov 2023	A copy of a patient's discharge summary has been shared in error with another patient on discharge	1	Awaiting confirmation from service
	Lessons learnt – under investigation		
Jan 2024	A printed sheet detailing patient identifiers and clinical details for a MDT meeting found in a public place	11	Awaiting confirmation from service
	Lessons learnt – under investigation		

All of the above incidents have been now been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence, and requiring no further action, unless new matters came to light. In the case of breaches by staff we are also requested to report the outcome of disciplinary action when concluded so that ICO can further consider the issue of criminal liability under s170 Data Protection Act 2018 for unauthorised access or disclosure.

Table: Summary of confidentiality incidents internally reported 2023/24

Summary of confidentiality incidents internally reported 2023/24	
Reportable breaches	(detailed above) 9
Number of confirmed non-reportable breaches	195
Number of no breach / Near miss incidents.	272
Total number of confidentiality incidents internally reported	476

A large number of the 272 no breach/near miss reported incidents (169) relate to lost Smartcards which are disabled when reported as missing.

The effectiveness and capacity of these systems has been routinely monitored by our Trust's Digital and Information Service governance group, Digital Care Delivery Group. A performance Summary is presented to our and Finance and Resources Committee twice a year.

Learning from deaths

During 2023/ 2024 there were 3326 Gloucestershire Hospitals NHS Foundation Trust patients who died. This comprised the following number of adults in hospital deaths which occurred in each quarter of that reporting period:

Q1 – 814

Q2 – 788

Q3 – 885

Q4 - 859

Due to the time required for SJR review the following figures are not complete as Q4 will be outstanding until June/July 2024.

Total Number of Gloucestershire Hospitals NHS Foundation Trust patients who died up to Q4 is 2487

Of these 2487 deaths 338 have been triggered for an investigation by structured judgement review (SJR).

Of these 2487deaths 7 have been reviewed by other means (harm review/ investigation, PIR, complaint)

Of these 338 SJRs carried out, 1 has been identified that the cause of death is judged to be more likely than no to have been due to problems in the care provided to the patient

1. The percentage of deaths which were selected for SJR=14%
2. The percentage of deaths which have been reviewed as an SJR=66% (Q4 deaths may not have been completed due to 4-month time lag for review)

1. The percentage of deaths reviewed by other means =0.28%
2. Out of all 338 SJRs conducted (in respect of deaths occurring up to 31/12/2023 and as at 07/04/24), the percentage of deaths identified as having sub-optimal care as a contributing factor to the death = 5.6%

Therefore, out of the total number of deaths reported across the Trust, the percentage of deaths for which sub-optimal care was a contributing factor (in respect of deaths occurring up to 31/12/2023 and as at 07/04/24) = 5.6%.

Statement from NHS doctors in training rota gaps

Context and Background
Rota gaps significantly impact not only the doctors in training—who may face longer hours and additional responsibilities—but also patient safety and the quality of care delivered. Addressing this issue is crucial to ensure that doctors in training maintain a safe and sustainable workload.

The prevalence of training rota gaps varies by specialty, with medicine experiencing notably larger gaps compared to other specialties within our trust.

Monitoring, Delivery, and Assurance
The Guardian of Safe Working has been providing quarterly reports on rota gaps across specialties to the Trust Board, along with exception reports.

Quality Panel (QP) Reports
Annual reports from South West Health Education England, through the Quality Panel, offer feedback from NHSE-appointed trainees concerning rota gaps and workload.

National Training Survey
This survey provides a nationwide overview of workload and rota design, encompassing feedback from both NHSE-appointed trainees and locally employed doctors.

Rota Gaps Mitigation Strategies for 2024/25
Efforts to mitigate rota gaps include discussions with rota gap leads across all specialties and the implementation of several strategies:
- Utilisation of advanced practice roles, utilising agenda for change staff.
- Recruitment of international medical graduates (IMGs).
- Expansion of Physician Associate (PA) roles across all specialties.
- Employment of locally employed doctors (LEDs).

Challenges for 2024/25
- A significant increase in less than full-time (LTFT) applications, leading to fewer whole-time equivalent staff despite stable or increased staff numbers.
- High rates of maternity leave.
- Trainees requiring amended duties or coming off on-calls.
- Misallocation of doctors under incorrect cost codes, especially in medicine.
- Communication breakdowns between rota/department leads, medical staffing, and finance departments.
- Issues with community placements and GP supervision due to part-time GPs, practice mergers, and retirements.

Next Steps for 2024/25
- Continued focus on integrating LEDs and IMGs into the workforce.
- Assess where long standing gaps rotas and build a case for IMG/LED permanent back fill
- NHSE Education & Training continue to adjust the number of trainees to balance the workload

- A coordinated effort involving medical staffing, finance, rota leads, and Postgraduate Medical Education (PGME) to proactively address rota gaps.
- Expansion of roles for Advanced Care Practitioners (ACPs), Physician Associates and Advanced Nurse Practitioners (ANPs) to move towards a self-sustaining workforce in critical departments.

Summary
In summary, our trust is implementing a comprehensive range of measures to address training rota gaps, aiming to ensure that doctors in training can continue to provide high-quality patient care. However, the increasing trend in LTFT applications requires urgent and coordinated workforce planning to manage the widening gaps effectively.

Bibliography:
[1] https://nhsproviders.org/news-blogs/news/workforce-strategy-vital-to-tackle-demoralising-rota-gaps
[2] https://www.rcplondon.ac.uk/news/trainees-are-under-pressure-fill-rota-gaps-which-leads-patient-safety-concerns-regular-basis
[3] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis

Veteran Aware Hospital

Background

Gloucestershire Hospitals NHSFT was re-accredited as a Veteran Aware hospital in August 2022, recognising the work and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community. A 1-year in assurance visit was conducted by the Veterans Covenant Healthcare Alliance in November 2023.

Performance 2023/24

This year saw the appointment of a new Armed Forces Lead and the two Armed Forces Advocates complete their 2-year secondment for the research study into Veterans in Acute Care Setting research project funded by the Armed Forces Covenant and Chester University. 171 Veterans had their service and clinical details entered into the study, which was in line with the other 16 NHS Trusts. We await the publication of the study next year. Early indications identify veterans in acute care as mainly male, 75 years of age with multiple morbidities.

The Veteran Aware work has focussed on improving the quality of the patient experience by filtering the results from the Friend and Family test for Veterans and Armed Forces personnel. The results demonstrated a 2% average below the Trust average of 90%, but given the small numbers of Veterans and Armed Forces personnel, this was not statistically significant. New Veterans and Armed Forces ward posters were distributed to wards to encourage patients to advise us of their Veteran or Armed Forces status. New patient information leaflets have been produced to advise staff and patients of the NHS approved pathways for mental health, physical health, homelessness and the judicial system, as well as the main charities that provide emotional and practical support to Veterans, Armed Forces personnel and their families. Banner scrolls are on display in out-patient departments across the Trust to encourage patients to advise us of their Armed Forces status.
The patient administration system has been amended to capture all Veteran, Armed Forces serving personnel and their immediate partner/spouse and child/dependents, in order the Trust can understand the Armed Forces demographic and ensure no-one is disadvantaged in healthcare. There were 1213 veterans registered in the adult acute in-patient electronic records for the year 2023-2024. The capture rate of Armed Forces personnel in acute care remained steady at 80%. The average length of stay for Armed Forces patients at 7, 14 and 21 days was the same as for non-Armed Forces patients.

Trust induction training has been updated to advise that the Patient Advisory and Liaison Service team have been trained by the NHS Armed Forces Network, as Service Champions, and will be the first point of contact for a Veteran or Armed Forces patient need. NHS e-learning for Veteran Aware responsibilities has been requested on all staff training, to comply with the Armed Forces covenant.

The Trust has continued to support training and development of employees from the Defence Medical Services in placements in the emergency department and critical care clinical areas. The Trust also supports visits to Open Days from the 243 Multi Role Medical Regiment (previously Field Hospital) from Bristol and engages with them over the annual NHS-Military Challenge.

The Armed Forces Lead continues to represent the Trust on the Gloucester County Council Armed Forces Network forum, with other Health and Social Care organisations. The Trust celebrated Armed Forces week by the Chief Executive re-signing the Armed Forces Covenant. Remembrance Day was commemorated by ornamental displays in the Atrium and a service of remembrance in both the Gloucester and Cheltenham hospitals.

Improvements for 2024/2025

- Re-establishment of the Armed Forces Council to embed the Veteran Aware work throughout the Trust
- Embed the Step-Into-Health programme to actively encourage Armed Forces leavers into the NHS
- Analysis of the Patient Administration System data to capture patients in paediatrics and maternity, where there are known health inequalities for Armed Forces serving personnel
- Publication of the Veteran Aware Policy
- Preparation for re-accreditation for the Gold Employer Recognition Scheme, due to be re-accredited in 2025.

Freedom to Speak Up

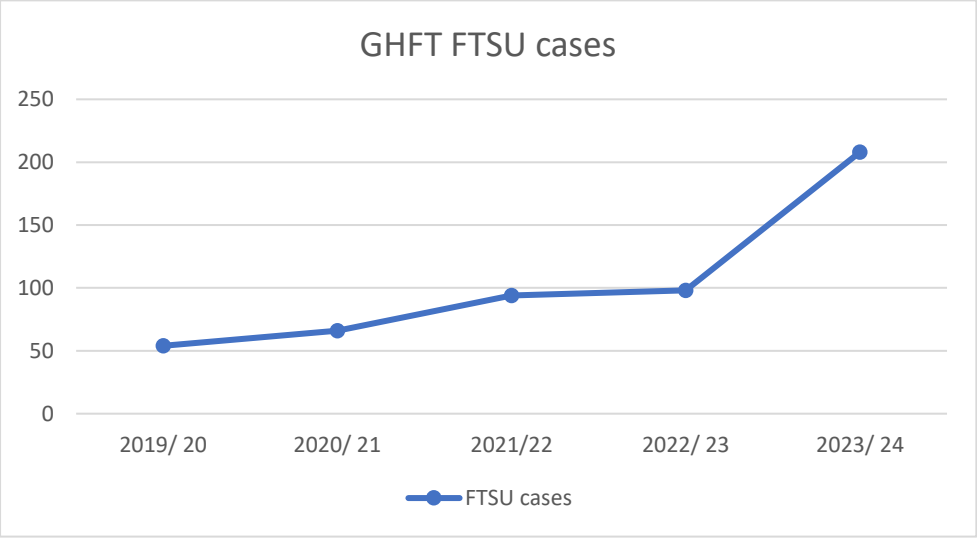
Our Trust is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life and in all of its practices. The Trust recognises that those who work for our organisation are in the best position to recognise when something is going seriously wrong within it, and may want to voice concerns.

The Trust has invested in the Freedom to Speak Up Service this year with a new WTE Lead Freedom to Speak Up (FTSU) Guardian to further develop the service and an additional 0.4WTE FTSU Guardian. This is to ensure all staff have access to safe speaking up in the Trust. Guardians have access to any leader in the organisation to raise and escalate issues and also access external speaking up routes if barriers are met in the organisation. There has been a fresh focus in the FTSU function to align the FTSU service with National Guardians Office (NGO) guidance values, training and data collection.

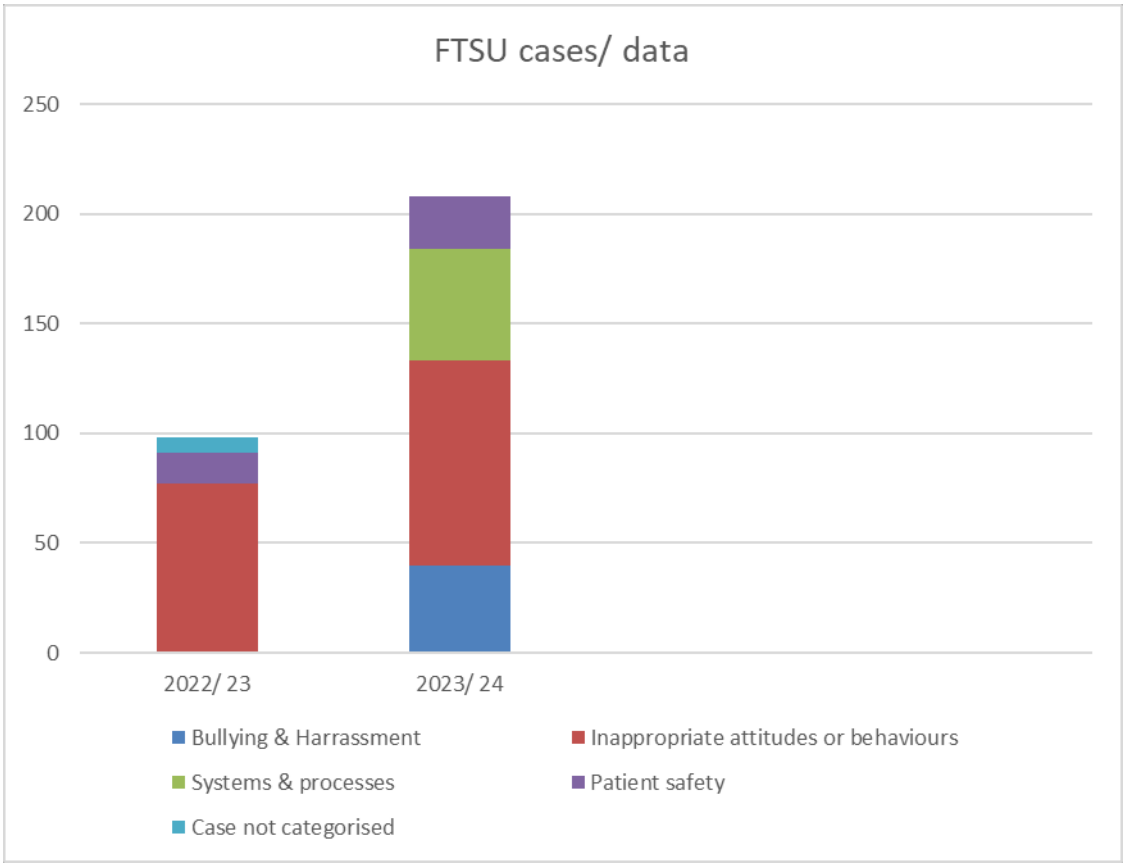
Trust Data

At our Trust, In the year 2023/ 24 208 staff spoke up in comparison to 98 staff last year.

Graph: Total number of cases per year

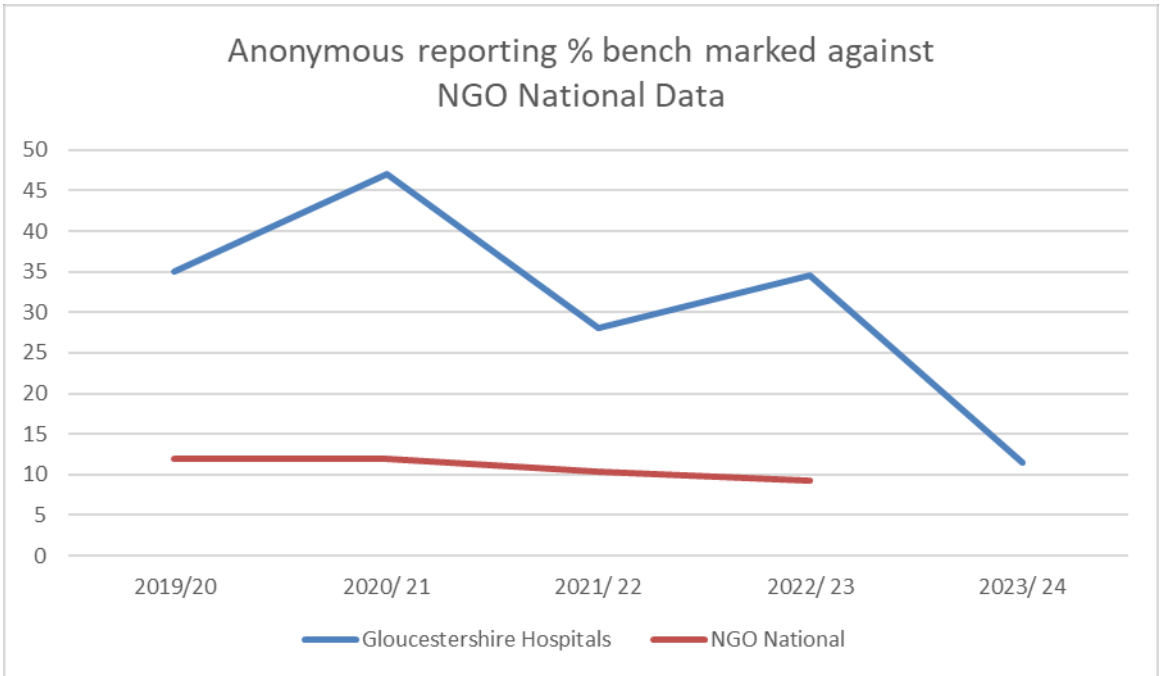


Staff have spoken up about a variety of concerns but inappropriate attitudes or behaviours (previously captured as behaviours), remain the organisations highest reason for contacting FTSU with nearly half of all total cases. Themes have been captured in the FTSU service as fear of speaking up; discrimination; poor experience as new starters; poor experience as a disabled person requiring reasonable adjustments; nepotism in recruitment and general poor behaviours witnessed or experienced in the organisation.



It has been noted that anonymous reporting at Gloucestershire Hospitals has been higher than the national average sitting at 34.5% last year.
The graph below shows the anonymous reporting trends bench marked with National Data over the last 5 years.

Graph: Anonymous reporting % benchmarked against National Guardian Office data



Anonymous reporting is highlighted by the National Guardians Office as an indicator of staff potentially feeling a lack of trust in the organisation and fear of detriment. As expected, the stability of a Lead Guardian with protected time has decreased anonymous reporting to more open concerns and less anonymised concerns raised.

Freedom to Speak Up is designed to support staff have a voice in the organisation where there are barriers to speaking up. The FTSU service has focused on case management this last year to provide staff with an excellent speaking up experience, where speak up, listen up and follow up is supported by the organisation. With anonymous reporting reducing, there is evidence to suggest that trust is gaining in the service and the organisation is more trusted by staff to respond to their concerns.

Cases have increased and the organisation has responded by supporting the recruitment of a new 0.4 WTE FTSUG to support the need of growing a dedicated FTSU team with protected time.

There is genuine support from senior leaders to respond to cases and support staff speaking up. With the continued alignment with the National Guardians Office and communicating those processes to staff through training and education, it is hoped FTSU will continue to develop into a valued and trusted service by staff to further impact speaking up being ‘business as usual’ in the organisation.

Data quality

Data quality (DQ): relevance of data quality and action to improve data quality
Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is: -
1. Complete
2. Accurate
3. Relevant
4. Up to date (timely)
5. Free from duplication (for example, where two or more difference records exist for the same patient)

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

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- We regularly send data submissions to secondary users service (SUS) and via these submissions we receive DQ reports back. Based on SUS DQ reports we action all red and amber items highlighted in report to improve data quality.
- In data published for the period April 2023 to March 2024, the percentage of records which included a valid patient NHS number was:
    - 99.8% for admitted patient care (national average: 99.7%)
    - 100% for outpatient care (national average: 99.8%)
    - 99.2% for accident and emergency care (national average: 98.9%)
- The percentage of published data which included the patient's valid GP practice code was:
    - 99.9% for admitted patient care (national average: 99.3%)
    - 99.9% for outpatient care (national average: 98.6%)
    - 98.8% for accident and emergency care (national average: 99.4%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as: -
    - Outpatients including attendances,
    - Outcomes, invalid procedures
    - Inpatients including missing data such as NHS numbers, theatre episodes
    - Critical care including missing data, invalid Healthcare Resource Groups

- A&E including missing NHS numbers,
- Invalid GP practice codes
- Waiting list including duplicate entries, same day admission

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

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

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

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

Part 2.3 Reporting against core indications

Reporting Against Core Indicators

Domain	Indicator	Year	Trust
Domain 1 – Preventing people from dying prematurely	Most recent value of the Summary Hospital Level Indicator SHMI for trust	2023/24	1.1349
Domain 3 – Helping people to recover from episodes of ill health or following injury.	Percentage of Patients 0-15 Readmitted to hospital within 30 days of being discharged	2023/24	12.90%
Domain 4 – Ensuring people have a positive experience of care.	Staff who would recommend the trust to their family or friends	2023/24	46%
	Patients who rate the quality of their care as positive or extremely positive	2023/24	91.90%
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	Patients admitted to hospital who were risk assessed for venous thromboembolism	2023/24	69.86%
	Rate of C. difficile infection	2023/24	36
	Patient safety incidents and the percentage that resulted in severe harm or death	2023/24	88

Patient Reported Outcomes Measures (PROMs)

Below is from the national website for period April 21 – March 22 (this is the most up to data finalised data).

	EQ-5D		EQ VAS		Oxford Score	
	Trust %	*England %*	*Trust %*	*England %*	*Trust %*	*England %*
Total Hip	87.10%	89.50%	76.10%	69.80%	100%	96.90%
Total Knee	78.50%	82.10%	60.30%	61.20%	98.60%	94.80%

Quality and Performance Report

The Board see a monthly Quality and Performance Report and below are our quality and performance metrics that we have chosen to report on. Link to Board reporting (here).

Quality Dashboard

NHS 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	Mar-24	76.8%	
	Inpatients % positive	No Target	Mar-24	93.5%	
	Maternity % positive	No Target	Mar-24	81.4%	
	Outpatients % positive	No Target	Mar-24	94.3%	
	Total % positive	No Target	Mar-24	92.2%	
Health Inequalities	Smoking Status Compliance	No Target	Mar-24	87%	
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower	Mar-24	40.8	
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Mar-24	27	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Mar-24	193	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Mar-24	43	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Mar-24	129	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Mar-24	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Mar-24	9.1	
	Number of E. coli bacteraemia cases	No Target	Mar-24	4	
	Number of Klebsiella bacteraemia cases	No Target	Mar-24	1	
	Number of MSSA bacteraemia cases	≤ 8	Mar-24	5	
	Number of Pseudomonas bacteraemia cases	No Target	Mar-24	0	
	Number of bed days lost due to infection outbreaks	↓ Lower	Mar-24	292	
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5	Mar-24	3	
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5	Mar-24	5	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned C. difficile cases per month	< 10	Mar-24	8	
	Number of trust apportioned MRSA bacteraemia	= 0	Mar-24	0	
Maternity	% PPH >1.5 litres	< 2.00%	Mar-24	5.45%	
	% breastfeeding (discharge to CMW)	= 0.0%	Mar-24	0.4%	
	% breastfeeding (initiation)	≥ 81.00%	Mar-24	74.42%	
	% of women smoking at delivery	< 7.00%	Mar-24	6.93%	
	% of women that have an induced labour	≤ 33.00%	Mar-24	25.79%	
	% stillbirths as percentage of all pregnancies	< 0.200%	Mar-24	0.412%	
	Number of births less than 27 weeks	No Target	Mar-24	5	
	Number of births less than 34 weeks	No Target	Mar-24	15	
	Number of births less than 37 weeks	No Target	Mar-24	49	
	Number of maternal deaths	No Target	Mar-24	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Mar-24	2.1%	
	Total births	No Target	Mar-24	487	
Mortality	Number of deaths of patients with a learning disability	No Target	Mar-24	2	
	Number of inpatient deaths	No Target	Mar-24	162	
	Summary hospital mortality indicator (SHMI) - national data	No Target	Nov-23	1.135	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Mar-24	9	
Operational Efficiency	Daily Average of Boarded Patients	No Target	Mar-24	8	
Patient Advice and ..	% of PALS concerns closed in 5 days	No Target	Mar-24	75%	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Advice and ..	Number of PALS concerns logged	↓ Lower	Mar-24	257	
Patient Safety Incidents	Medication error resulting in moderate harm	↓ Lower	Mar-24	2	
	Medication error resulting in severe harm	↓ Lower	Mar-24	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	36	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	1	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Mar-24	13	
	Number of falls per 1,000 bed days	↓ Lower	Mar-24	6.90	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Mar-24	3	
	Number of patient safety incidents - severe harm (major/death)	No Targe	Mar-24	13	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Mar-24	5	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Targe	Oct-23	58.08%	
	Number of DoLs applied for	No Targe	Mar-24	128	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Mar-24	89	
	Total admissions aged 0-17 with DSH	↓ Lower	Mar-24	23	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Dec-23	9	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Jan-24	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Aug-23	0	
	Total number of maternity social concerns forms completed	No Targe	Mar-24	61	
Serious Incidents	Number of never events reported	= 0	Mar-24	0	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Mar-24	69.9%	

Part 3: Other information

Annex 1: Statements from Healthwatch, Integrated Care Board and Health Overview and Scrutiny Committee

NHS Gloucestershire Integrates Care Board (ICB) response to Quality Account:

Thank you for giving NHS Gloucestershire ICB an opportunity to comment on your quality account. During 2023/24 a significant amount of improvement work has been in progress and it's good to see the results really making a difference to the lives of the people of Gloucestershire who find themselves in need of specialist healthcare.

The 'Slipper Trial' has demonstrated how small changes can positively influence outcomes for those experiencing frailty and we welcome the roll out of this across other areas in the coming year. Ensuring greater compliance with gold standard stroke care by improving timely access is a huge improvement for local people.

The implementation of the 'Worries and Concerns' pilot during 2023/24 is commendable, this supports families to raise live concerns if they feel their loved one is clinically deteriorating. This will now become Martha's Rule which is a requirement for all acute Trusts and the ICB will continue to support the Trust to ensure all families have a voice.
Although the Trust has delivered the quality objective requirements regarding maternity services, as outlined in the maternity incentive scheme (MIS), there continues to be a focus on improving care and experience for those who use these services. There is still work to do to ensure consistent improvements are embedded within the service and this will be a focus within the ICB throughout 2024/25.

We were pleased that the Trust was able to make the switch from the Serious Incident Framework to the new Patient Safety Incident Response Framework (PSIRF). The Trust has recognised that this is a significant cultural leap and embedding will take time.
In March 2024, the ICB ratified the Trusts' plans and supports their PSIRF ambitions focusing on staffing, culture, digital and communications, as well as the more traditional focuses on falls, pressure ulcers, flow and discharge and delay related harm. We have a good working relationship with the Trust and are working at a system level to embed the new ways of working and ensuring the focus is on learning from all adverse events.

The ICB will fully support the delivery and oversight of the quality objectives for 2024/25 in order to continually drive forward high quality, safe services for patients across Gloucestershire.

Marie Crofts,
Chief Nursing Officer,
NHS Glos ICB

Received 3 June 2024

Statement received from Healthwatch Gloucestershire 31 May 2024

31.05.2024

Statement from Healthwatch Gloucestershire

Thank you for sharing the Quality Accounts for Gloucestershire Hospitals NHS Foundation Trust for 23/24.

Healthwatch Gloucestershire congratulate the Trust on their achievements last year. We are pleased to see that identifying those living with frailty remains a priority for the coming year and note the pilots undertaken last year in relation to falls prevention and preventing deconditioning in ED. We are also pleased to see that there is an emphasis on patient safety and providing opportunities for patient and staff voices to be heard and acted upon through the appointment of a dedicated lead for Freedom To Speak Up, the launch of a PALS champion and the PSIRF plan that went live in March.

This continues to be a challenging time, with services still recovering from the impact of Covid, a nationwide shortage of certain key workers and the ongoing industrial action throughout the year having an impact on service delivery. We recognise the pro-active steps taken by the Trust and their staff in response to this to ensure essential services were able to continue and the loss of elective activity kept to a minimum.

We also acknowledge the action taken and action planned for improvements in response to the CQC inspections of Maternity services, Children's services and the Emergency Department at Gloucester Royal Hospital.

We understand that new initiatives and action plans require monitoring and evaluation, and Healthwatch Gloucestershire values the strong connections we have with the Trust to be able to share public feedback, provide insight and make recommendations for improvement. We are pleased to have one of our Board members as a Governor for the Trust who has also been able to observe the Quality and Performance Committee. Our volunteers took part in PLACE visits last year and Healthwatch Gloucestershire were also grateful to be supported by the Trust to visit their Urgent and Emergency Care services in December. This enabled us to observe and speak to people directly about the quality of care they were receiving which has been shared with the Trust.

We welcome Kevin McNamara as the new CEO and the new senior staff in the leadership team being established. We look forward to continuing to work together with the Trust in the coming year.

Statement from Gloucestershire Health Overview and Scrutiny Committee

Chair of the Gloucestershire Health Overview and Scrutiny Committee, provided a statement dated 24 June 2024

Thank you for your invitation to comment on the Gloucestershire Hospitals NHS Foundation Trust Annual Report (Quality Account) 2023/24. In what has been a challenging year, I can confirm that the Gloucestershire Health Overview and Scrutiny Committee will continue to support the Trust when considering any issues and concerns that impact on the delivery of services provided by Gloucestershire Hospitals. As in previous years, the Gloucestershire Health Overview and Scrutiny Committee value and appreciate the often innovative and lifesaving work which the staff employed by the Trust carry out on a daily basis. The Committee welcomes the co-operation of Trust staff as we continue to look at issues around system flow, ambulance discharge times, waiting times and CQC reports.

Annex 2: Statement of director's responsibilities for the quality report

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance
- detailed requirements for quality reports 2022/23
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to March 2024 (link)
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from Gloucestershire Integrated Care System 3 June 2024
    - feedback from Healthwatch Gloucestershire dated 31 May 2024
    - feedback from the Health Overview and Scrutiny Committee 24 June 2024
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2022/23 (Link to latest published report)
    - the 2021 National Patient Survey published by CQC September 2022 (Link)
    - the 2023 national staff survey published Jan 2024 (Benchmark report (Link)
    - CQC inspection reports (RTE inspection Reports Link)

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

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

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

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

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

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

By order of the board

Deborah Evans
Chair

Chief Executive
Kevin McNamara

Report to Board of Directors meeting in Public

Agenda item:	12	Enclosure Number:	01

Date	11 July 2024
Title	Designated Body Annual Board Report and Statement of Compliance
Author / Sponsoring Director/ Presenter	Dr Kate Tredgett/Professor Mark Pietroni

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*
Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Risks or Concerns

No concerns.

The Trust has a legal duty to deliver an Appraisal and Revalidation function. It is the way the Trust and the GMC is assured that doctors remain up to date. Failure to deliver an appropriate process puts the quality of care at risk.

Financial Implications

The Appraisal and Revalidation function is paid for by the Trust and constitutes part of the cost of employment of doctors. No additional or unexpected funding concerns in this financial year.

Recommendation

To note the contents of the report and approve it as an annual statement of compliance to be passed to NHSE.

Professor Mark Pietroni,
Director for Safety and Medical Director, Deputy Chief Executive
3 July 2024

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

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Section 1 – Qualitative/narrative
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Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of

Gloucestershire Hospitals NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Ensure that regular meetings of the Revalidation Organisational Group continue.
Comments:	Prof. Mark Pietroni is the Responsible Officer. Over the 23/24 period one of the 3 trained deputy ROs, Dr Raghuram stepped down. In addition, the deputy RO and AMD with responsibility for appraisal and revalidation Dr Elinor Beattie stepped down at the end of March 2024. 4 new deputy ROs will be undergoing training in 24/25 – Dr K Tredgett, Dr N Peter, Dr C. Fowler and Dr C Candish. Dr Kate Tredgett started as AMD with responsibility for appraisal and revalidation at the start of April 2024 Revalidation Oversight Group (ROG) continues twice yearly.
Action for next year:	Action for next year: Ensure new deputy ROs complete training

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Recruitment and training of additional appraisers.
Comments:	5 new appraisers have been appointed and are undergoing training in 24/25
Action for next year:	Despite the recruitment, there remains a gap between the numbers of appraisers and the appraisals required. A further round of recruitment will take place end of 2024 / early 2025

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	We have now moved to an online system for storing this information for senior medical staff.
Comments:	Comments: Online system embedded and the Revalidation and Appraisal Team oversee the records of all prescribed connections to us as a Designated Body
Action for next year:	Continue current process

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Ensure that the Appraisal and Revalidation Policy is ratified and available on the trust intranet site.
Comments:	The Policy has completed the ratification process and is available on the Trust Intranet. It will be reviewed in January 2025.
Action for next year:	Review policy as per review schedule

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To respond to any recommendations arising from the visit and audit, and formulate an action plan as required.
Comments:	High Level RO visit took place in August 2023 and Appraisal and Revalidation Audit reported in September 2023. Actions being addressed and are referred to where relevant in this report
Action for next year:	Actions for next year: Complete and close all actions from audit and HLRO visit

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Continue to support locum and short term placement doctors with their appraisal and revalidation needs.
Comments:	There is a shortened clinical fellow appraisal form to record meetings with educational or clinical supervisors. Good communication is maintained with other employing organisations.
Action for next year	Continue

1B – Appraisal

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

Action from last year:	Continue to develop the L2P platform following feedback from all users. Work with the education team to ensure that reports are accurate and timely
Comments:	Appraisees are now able to download their own mandatory training reports. Complaints reports (the availability of these was raised in both the audit and HLRO visit report) are now automatically uploaded onto L2P by the appraisal team and all appraisees are emailed a report with regard to Serious Untoward Incidents. Appraisees must have met with their Speciality Director and a Form A is completed which also contributes to the appraisal evidence and discussion.

Action for next year:	Continue to ensure all supporting information is consistently included in all appraisals.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	No actions required
Comments:	There were 3 unauthorised missed appraisals in 23/24. These are discussed at ROG with recorded actions to address in each case.
Action for next year:	Continue to be rigorous in addressing this

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Ensure this policy is kept up to date by annual review.
Comments:	The policy has been updated and was issued in January 2024. It will be reviewed in January 2025
Action for next year:	Review Revalidation and Appraisal Policy in January 2025

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Further recruitment and training to replace a number of retiring appraisers this year.
Comments:	Our appointed appraisers currently undertake 10 appraisals per year. A further 5 appraisers have been appointed and are undergoing training. Despite the recruitment, there remains a gap between the numbers of

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	appraisers and the appraisals required. A further round of recruitment will take place end of 2024 / early 2025. Appraiser support groups continue twice yearly. An action from the HLRO visit was to consider reviewing appointment and retention of 'retired appraiser workforce' and to undertake a review of low scoring appraisers. Appraiser reviews take place in Autumn and these actions will be progressed then.
Action for next year:	Appraiser reviews to take place as per annual cycle in Autumn 2024

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Ongoing review
Comments:	As mentioned above, appraiser support groups continue. We continue to use the EXCELLENCE scoring tool to peer review our appraisal summaries. All appraisers receive an individual feedback report and they are required to reflect on this before their annual meeting with the Appraisal Lead
Action for next year:	Appraiser support groups to be consistently face to face.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Ensure that the ROG meetings and regular team meetings continue and develop the L2P reporting system to allow updates to be shared.
Comments:	ROG meetings currently taking place twice yearly and face to face. The Revalidation and Appraisal Team meet weekly to ensure all issues are rapidly addressed and there is regular dialogue between the team and the RO.
Action for next year:	Confirm frequency of ROG meetings and run meetings accordingly. Continue to used L2P system for reporting.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Continue to review our processes in light of an online appraisal system and GMC/NHSE requirements
Comments:	System in place. As documented in 1Ai above there have been changes to the deputy ROs. Training and embedding of new deputy ROs in supporting this process will take place over 24/25
Action for next year:	Complete training of new deputy ROs and deputy ROs to be contributing to the process

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No changes required
Comments:	All revalidation recommendations are made in a timely manner, with doctors notified of their outcome. Should a deferral or non-engagement be appropriate, then contact is made by the Medical Director
Action for next year:	No changes required

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	No action required
Comments:	The revalidation and appraisal process is fully embedded within the Trust. The organisation will be participating in a pilot project exploring

	how evidence generated by the National Consultant Information Portal (NCIP) can be fed into and complement the appraisal process. This will be for urological surgeons in the first instance. There is also often active inclusion of other national registry outcomes by individual clinicians (eg NJR for T&O surgeons) into the appraisal process
Action for next year:	Continue current process. Participate in the NCIP pilot project

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	No further action required
Comments:	The process is embedded within the Trust. Policies are in place which provide the performance management framework to be followed should there be conduct or performance concerns raised. These policies include Revalidation and Appraisal, Maintaining High Professional Standards, Performance Management, Disciplinary Performance / conduct matters being formally managed are monitored in accordance with policy requirement with RO / NED oversight. restrictions / exclusions / suspensions are reported monthly through the Procedural Oversight Report submitted to the Private Board
Action for next year:	No action required

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	No action identified
Comments:	L2P system established and user friendly. Information such as around complaints is uploaded into the system for each doctor. Doctors are able to access their own record of mandatory training.
Action for next year:	Continue

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	No action identified
Comments:	Policies are in place within the Trust which provide adequate processes to be followed should there be concerns raised and against any licensed practitioner (as described in 2Dii above) These are reviewed to ensure they meet the necessary requirement. These are reviewed to ensure they meet the necessary requirements.
Action for next year:	No additional action required

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	As outlined last year, all processes are managed by Human Resources following strict policies that are in place and relevant notification given to appropriate people/groups within the trust. Last years action was for ongoing review to ensure that all necessary processes are followed and further consideration of protected characteristics recording to ensure these are reviewed as part of the annual board report
Comments:	As described in 1Dii above, medical cases are regularly reviewed with the Medical Director and HR. Formal care work is monitored in accordance with policy requirements and reported through the Procedural Oversight Report submitted to the Private Board monthly. There is requirement to provide Workforce Race and Disability Equality Standard reports to Board.
Action for next year:	No additional action required

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	A review of process to be undertaken to ensure that relevant information is transferred through the MPIT process for all new connected doctors to our trust
Comments:	There are no concerns around this process.
Action for next year:	Need to review to be discussed at ROG December 2024

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	All staff undertake Equality and Diversity Training as part of their statutory training via the Core Skills Framework. This is also supported by the trusts Equality and Diversity policy.
Comments:	The Equality and Diversity Steering group oversee the Trust Equality and Diversity agenda and Equality Diversity and Inclusion policy. Equality and Diversity e-learning is a mandatory requirement for all staff.
Action for next year:	Ongoing work through the Equality and Diversity Steering Group

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Domain not included last year

Comments:	Senior leadership meetings and engagements events with staff were implemented following the CQC reports Action plans in place.
Action for next year:	Continue current approach

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Domain not included in last year's report
Comments:	New Good Medical Practice guidance published by CQC in January 2024. L2P platform amended to take account of this in appraisals and appraisers updated of these platform changes at appraiser support groups
Action for next year:	Invite GMC to present guidance at appraiser support groups to update appraisers and support their review of this in the appraisal process

1E – Employment Checks

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

Action from last year:	All checks are undertaken against national NHS Pre-Employment Check Standards as per NHS Employers guidance. This meets the 6 checks that is required from identification, references through to Right to Work
Comments:	This is regularly reviewed and changes made to process if notice provided by NHS Employers
Action for next year:	No further action, continue current process

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Domain not included last year
Comments:	New Associate Medical Director appointed to lead on Quality and Safety. Daily Safety Huddles implemeted across both sites to learn lessons from any “near-miss” cases, Trust adopting the Patient Safety Incident Response Framework (PSIRF)with a focus on compassionate engagement and learning. Daily Safety Huddles implemeted across both sites to learn lessons from any “near-miss” cases
Action for next year:	Continue this work

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Domain not included last year
Comments:	Associate Medical Director appointed this year with responsibility for engagement, development and inclusion. There is ongoing work from the inclusion network. The Trust has commissioned the Wellbeing Collective, who will work with different service lines to further strengthen the promotion of these values across the organisation. We have a dedicated EDI Steering Group which reports to the People and OD committee
Action for next year:	Develop and embed role and associated work streams

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Domain not included last year
Comments:	Guidance for staff on intranet Raising concerns (gloshospitals.nhs.uk) and ongoing work Trustwide around this including Freedom to Speak Up Guardians. We have appointed a new Lead for our Freedom to Speak Up Guardians
Action for next year:	Continue

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Domain not included last year
Comments:	Signposting through appraisal process, DATIX process and daily incident response safety huddles.
Action for next year:	Continue

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Domain not included last year
Comments:	See above 1Fii.
Action for next year:	Develop and embed AMD role and associated work streams

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Domain not included last year
Comments:	HLRO visit took place this year. See above. Attendance by RO and / or deputies routinely as SW RO network meetings. We regularly meet with clinical leaders across the organisation through the Speciality Directors Forum.
Action for next year:	To continue as currently

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	738

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	592
Total number of appraisals approved missed	26
Total number of unapproved missed	3

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	103
Total number of late recommendations	0
Total number of positive recommendations	103
Total number of deferrals made	10
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	10

2D – Governance

Total number of trained case investigators	20
Total number of trained case managers	20
Total number of new concerns registered	2
Total number of concerns processes completed	n/a
Longest duration of concerns process of those open on 31 March	10 mths

Median duration of concerns processes closed	n/a
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	1

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	676
Number of new employment checks completed before commencement of employment	4056

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	n/a
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	n/a

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The online medical appraisal system introduced in November 2022 in now embedded. There has been a visit the Higher Level RO and team from NHS England to review our processes and policies, and an external audit of appraisal and revalidation is underway. Actions are being addressed At the end of 23/24 there has been a change in some of the deputy ROs, with new ROs undergoing training in 24/25. There is a new associate medical director for revalidation and appraisal who started in April 24. These roles will embed over 24/25 5 new appraisers have been recruited and will be trained and will start to appraise in 24/25 Appraiser Support and quality assurance continues
Actions still outstanding

MPIT process not formally reviewed – plan in place to revisit
Current issues
See general review above
Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
A round of appraiser recruitment will take place end of 2024 / early 2025 Complete and close all actions from audit and HLRO visit Continue to ensure all supporting information is consistently included in all appraisals. Review Revalidation and Appraisal Policy in January 2025 Appraiser reviews to take place as per annual cycle in Autumn 2024 Appraiser support groups to be consistently face to face. Confirm frequency of ROG meetings and run meetings accordingly Complete training of new deputy ROs Participate in NCIP pilot Consider need for MPIT review at ROG Organisation to continue to benefit from the work of the Ongoing work through the Equality and Diversity Group Invite GMC to present new GMP guidance at appraiser support groups to update appraisers and support their review of this in the appraisal process Develop and embed the role and associated work streams of the Associate Medical Director appointed this year with responsibility for engagement, development and inclusion

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Achievements – Positive feedback from audit and HLRO visit. Successful appointment of new associate medical directors who will support the RO role. Appointment of new appraisers. Embedded L2P system which is supporting to process Challenges – To ensure adequate numbers of appraisers to undertake the appraisals of our connected doctors Aspirations – To continue to develop the appraisal and revalidation process through the ongoing development of our appraisers to consistently provide helpful and supportive and developmental appraisals for our connected doctors, complemented by development of increasingly rigorous data and supporting information eg as is being explored through the NCIP pilot

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) 26th June 2024		
The Committee fulfilled its role as defined within its terms of reference, noting that they remained under review following Good Governance Institute (GGI) review. 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**
Maternity Services	The Chair of QPC along with the Director of integrated governance and the CNO met with Trust colleagues support shaping of reporting to enable stronger assurance – a full cycle of business is required to enable benefits to be realised. Current high areas of risk are as follows: - Ultrasound scanning. - First trimester screening - Post partum haemorrhage. - Complaints - Second obstetric theatre The CNO reported the CQC had served a notice, under **Section 31** of the Health and Social Care Act 2008, with the decision to impose conditions on our registration as a provider. The concern related to Maternity Services and the Trust's response, and delivery of required actions was included in committee papers and discussions. It was reported that there had been 2 referrals to MNSI in May (Updates on current HSIB investigations were provided)	Trust team continue to consider options to strengthen assurance reporting The CNO is planning to develop a KIAR to summarise work undertaken at service level. CNO agreed to work with Corporate Governance to agree a forward plan of reporting to QPC with an aim that we receive internal assurance in advance of external bodies where possible. Smaller sub – group of QPC to meet in August to track oversight and support. Due to no committee in August – a KIAR will be submitted to QPC in September recording this meeting. The NED Maternity Board Safety Champion (who is new in the role) had visited the maternity service and was progressing several opportunities to deliver this key role.
Patient Safety investigation and complaint report	QPC had sought assurance the previous month regarding timeliness and **handling of complaints –** this had also been identified by the CEO as an area requiring grip and delivery Request that a detailed report on complaints to come back to the May Committee for assurance. The improvement required regarding performance of closure **of serious incidents** was discussed, it was noted that Maternity related plans had been prioritised.	The Annual Patient experience report was deferred to next month due to some confusion with uploading paper - this will be first on the QPC agenda next month (July) for discussion The area of complaints has weekly oversight from the CMO- with a report due to QPC in September 2024.

Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance report	The CMO sheared the analysis of **VTE compliance** against the NICE standard that assessment should be completed within 14 hours of admission as there was a need for both completion and timeliness. It was noted that previous data held was not comparable to the dashboard. The Committee noted that New VTE dashboard showed a snapshot compliance of completing VTE stood at 90%. However, completion within 14hrs (NICE guidelines) was at 75%. Both numbers would be included once the dashboard went live and included in future IPR's. The CMO reported that he was confident there would be an improvement with a specific focus on maternity services. The CMO reported on the Mortality – SHMI National Data, which showed an increase over the last 3 months. The Hospital Mortality Group was reviewing and an action plan to address clinical and coding issues, and will provide an update report to QPC	. Update to QPC as per forward planner
Integrated Performance Report	The Committee noted that four-hour emergency care standard performance remained broadly unchanged in May at 58.5% compared to 58.8% in April. This was against a standard of 78%, and whilst ambulance handovers remained an area of focus, No Criteria to reside performance had not improved in previous weeks which was critical in allowing the Trust to reinstate flow. Cancer: 62-day standard was currently off trajectory. The faster diagnosis was being achieved and there was a plan to deliver the 52-week standard by October. Deterioration against the Elective: 65-week standard was noted and there were 3 patients waiting over 78 weeks; patient unavailability (with unreasonable notice) had had a bearing on this.	Progress to be reported via IPR including an update on utilisation of virtual ward capacity. Progress to be reported via IPR

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
	Eve Olivant, Director of Flow (ICB) delivered a presentation to QPC on system flow – it was reported that the key work being undertaken was around system governance and escalation when adequate flow could not be achieved. The Trust Chair sought assurance on the system wide plan and how the Committee could get assurance on system partner plans that contributed to the delivery of a reduction in No Criteria to Reside (NC2R)". The COO noted that Gloucestershire had a disproportionate number of people leaving the Hospitals on pathway 2. The CEO asked what was needed to drive this conversation. The ICB flow director reported that the strategic conversation was developing but was not yet where it needed to be. There was more work to do to ensure that all partners responded at the same rate and that the responses provided additional capacity. There was acknowledgement that all system partners including the Trust had cultural and operational process improvement work to achieve better flow. The COO raised the opportunity to consider system delay related harm It was acknowledged that a previous Quality Summit had not achieved what was intended – The Trust QPC was planning to receive a planned delay related harm report in September – it was proposed that a system delayed replated harm report would be prepared – this was agreed with the ICB flow director.	CNO to escalate to the System Quality Committee to progress a system level risk register that includes system delay related harm.
Board Assurance Framework	The Director of Integrated Assurance reported the current Board Assurance Framework was a 'work in progress'. A board strategy session was planned to enable a whole board discussion with our new Director of Strategy.	The committee noted with the CEO that the totality of several of the risk areas was not routinely discussed at ICB level in addition, the ICB Board are not routinely reviewing system flow metrics – CEO to discuss with ICB colleagues at next ICB Board

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Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Patient Safety and Risk Assurance Report	It was reported that one national patient safety alert remained overdue. This related to medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. An update related to the actions taken because of the audit findings, remained pending. There had been 0 Never Events reported since the last report.	Updates to be provided as part of QPC Action log
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
	An NHS Review of Paediatric Hearing Services had initially rated the service as Red – serious risk. The CMO had overseen progressing an action plan and progress was being made- It was recognised that there was external desire to encourage the service to progress accreditation – this was discussed is a wider strategic conversation to be had as it was not only this service that accreditation / or not needed consideration.	
Integrated performance report	The Committee noted that the new Integrated approach offered a targeted update on key metrics and provided an update on the current performance; the actions taken to correct or mitigate the position and an assessment on a return to compliance assessment. The committee welcomed the opportunity to receive an updated forward plan to prevent multiple requests to grow the IPR beyond a reasonable size.	Committee to continue to support iterative nature of IPR under leadership of Executive team
SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.		

GOVERNOR OBSERVATION

Maggie Powell noted the complexity of external demands and the work required to complete reports for regulators. Maggie was reassured that colleagues still remembered that there were patients behind the data. Andrea Holder noted the huge amounts of data being worked through. She noted the evolving system wide work and reported that she was discussing issues with Lead Governors at Gloucestershire Health and Care and Southwest Ambulance Trusts.

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H1/H2= first/second half of the financial year
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Investments			
Case	**Comments**	**Approval**	**Actions**
Impact on Board Assurance Framework (BAF)			
All strategic risks discussed. Challenge given on current and target risk scores			

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

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) 29th May 2024		
The Committee fulfilled its role as defined within its terms of reference, noting that they remained under review following Good Governance Institute (GGI) review. 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**
Maternity Services	There was a large suite of papers submitted to QPC regarding **Maternity services** – The committee spent some time discussing the Section 31 received on May 1st, and the improvement work underway, however it was felt the level of internal assurance needed to be urgently strengthened to enable the Trust to provide assurance externally on this key patient safety area	Trust team to consider options to strengthen assurance reporting opportunities. The Chair of QPC along with the NED Board Maternity Safety champion to meet with the Director of governance, executives, and service team to support shaping of reporting to enable stronger assurance.
Patient Safety investigation and complaint report	QPC had sought assurance the previous month regarding timeliness and **handling of complaints –** this had also been noted as an area requiring grip and delivery by the CEO. Request that a detailed report on complaints to come back to the May Committee for assurance. The performance regarding **closure of serious incidents** was discussed alongside the capacity of the team. It was noted that resources had been insufficient to maintain activity with delays and extensions being requested Alternative models working were being developed in response.	The Trust Chair noted the workforce constraints but was concerned about the numbers of overdue complaints with 203/420 over 3 months old. The Trust Chair noted the efforts of the team however was concerned by the delays. The Director of Governance was asked to support, and the Committee agreed to receive a plan and trajectory to come back in 3 months' time.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance report	The CMO raised that he was undertaking some analysis of VTE compliance against the NICE standard that assessment should be completed within 14 hours of admission as there was a need for both completion and timeliness. It was noted that assurance with VTE completion in maternity is part of the Trust's Section 31 response.	The CMO committed to bring back a more detailed analysis of Trust VTE performance against NICE guidance.

Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
	Harm from falls and pressure ulcers were discussed as requiring more prominence as proxy markers of quality.	The improvement programme that is underway would be added to the forward plan.
Integrated Performance Report	DM01 and **Endoscopy** Improvement Plan: The COO provided the committee with an update On the Endoscopy Programme Plan In addition, a letter had been sent to the JAG (Joint Advisory Group) accreditation team to provide assurance on the plans in place to respond to the recommendations made by NHSE and to address the findings of the Four eyes work. **Angiography:** QPC were made aware that the wait for angiography was approx. 18 months. The reasons for this related to estate reliability, priority cases and workforce. The move of the service from CGH to GRH whilst initially increase the waitlist the committee were assured that the mitigation of risk of estate reliability would have a positive impact on the position, and continued improvement work in other areas was underway. However, we were unlikely to see a significant improvement in Cardiology Waiting times for Angiography until Q3/4 A deterioration in **ambulance handover times** for patients being offloaded in 30 minutes was noted, there was no significant deterioration in numbers waiting over 4 hours. The Trust Chair sought assurance on the system wide plan and how the Committee could get assurance on system partner plans that contributed to the delivery of a reduction in “no criteria to reside (NC2R)”.	Progress to be reported via IPR Progress to be reported via IPR Eve Olivant, Director of Flow (ICB) invite to attend the next meeting to present the system plan
Regulatory Report	The QPC were updated that the **CQC Section 29a** (Childrens services) had been withdrawn by the CQC. The CQC accepted that the Trust had invited the CQC in due to Trust concerns about children who required care in a more appropriate setting. The Trust recognised that there are areas for internal improvements also.	

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	Improvement work was continuing following the **NHSE Annual Peer Review of Trauma Units** and Trauma Centres, the update report was noted. An NHS Review of **Paediatric Hearing Services** had rated the service as Red – serious risk. An action plan was in place and progress was being made. **Major Trauma Diagnostic Report & Recovery Plan:** The service team attended QPC and reported that Gloucestershire Royal Hospital was the busiest Trauma Unit in the Severn Major Trauma Network. Since 2021 there had been a serious concern placed on the trust by the Network based upon the Major Trauma Outcomes (01/01/2021 to 31/12/22). The Committee noted that since June 2023 the Trust had not had access to the Trauma Audit and Research Network (TARN) data and the service were not able to evidence improvements at this time. Data collection was anticipated to resume in Q1 2024. There was significant work taking place to make improvements, including around time to repatriate from major trauma centres. Work was taking place to improve education, staffing and documentation / evidence. A trauma lead was due to be allocated in the department. The team updated that recruitment of 8 International Medical Graduates had been successful. QPC noted the cautious optimism with regard to the recovery plan and commended Dr Emma Colley (ED Consultant and ED Trauma Lead) for her work.	Future progress to come back to QPC The Committee would receive a more detailed update of the position at the June meeting. The next report would come to the Committee in September when it was hoped that data would be available to validate assumptions.
Board Assurance Framework	Noted that the BAF requires a review as some areas out of date	Plans for Executive team to work with new Director of Integrated Governance to refresh
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Patient Safety and Risk Assurance Report	Patient Safety Incident Response Framework (PSIRF) There had been 0 Never Events reported since the last report There had been 0 referrals to HSIB in March.	PSIRF roll out plans on track

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Quality Delivery Group	The Committee noted that the Trust had been an early adopter of Martha's Rule. The CMO this was being positively received by staff and patients and there was a plan to roll out into adult wards.	
Guardian of Safe Working	The CMO reported that a total of 271 exception reports had been raised between -1 April 2023 and 31 December 2023. No fines had been levied during that period. The overall rate of exception reports has dropped slightly compared to the same period in 2022/2023, though more incidents had been graded as 'immediate safety concern'. These would continue to be monitored and ongoing discussions were taking place with relevant specialties around how trainees could be supported. The CMO reported that a spike normally took place in August when new F1s began in their roles, however this spike had been lower than in previous years. Immediate safety concerns were raised with the supervisor and if not resolved were escalated to the CMO	

Items not Rated	

SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.

GOVERNOR OBSERVATION – Helen Bown reported that she was encouraged by the ambition to improve system working and noted that deep dives were producing some interesting pieces of work. Maggie Powell added that the impact of fresh eyes on this work was positive. The requirements of the regulators were noted.

Investments

Case	Comments	Approval	Actions

Impact on Board Assurance Framework (BAF)

All strategic risks discussed. Challenge given on current and target risk scores

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

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Report to Board of Directors meeting in Public

Date	**11th July 2024**
Title	Integrated Performance Report **(IPR)**
Author / Sponsoring Director/ Presenter	Chief Operating Officer

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

This is the 3rd Integrated Performance Report (IPR) since its introduction in April 2024. There are a few areas of note.

Operational Performance

- The operational elements will be refined to remove indicators to a watch list where achievement has been sustained for 3 reporting periods.
- This month sees the introduction of the Care and Quality elements.
- Both finance and workforce elements will be added in July/Aug 2024.

There are a number of areas of note.
Out of the core performance standards covering RTT, Cancer and DM01, the Trust did not achieve.

- 52 weeks is not on trajectory in month.
- 65 weeks was not achieved in month.
- The Trust will be reporting 3 X 78-week waiters for May and 1 X 78 week waits for June
- 62 Day cancer target for May will not be achieved.
- 28 day faster diagnostic standard will be achieved.
- Recovery plans are required for all DMO1 performance measures involving Endoscopy. This forms part of the endoscopy recovery plan.
- A key risk is for Histopathology results. This requires support from Digital and Workforce colleagues.

Care & Safety

There are a number of areas to note

- There has been an increase in the number of C.Diff cases, although the trust remains on track to limit the number of cases below the threshold assigned by NHSE per annum
- Falls remains a concern as rates have not reduced following winter. Work is underway to understand the drivers of this with a report coming to QP committee in September
- Postpartum Haemorrhage continues to be an area of focus, all aspects of the Reduce Project have now been rolled out, along with the introduction of a new drug at caesarean section.
- SHMI has risen and there is a clear action plan to address the main drivers both inside and outside the Trust
- VTE reporting is being updated in the next report to address the narrative comments.

Risks or Concerns

Risks are identified with some key performance indicators. Especially those related to our longest waiting patients.

Financial Implications	
Elective Recovery Fund was achieved in April and May 2024.	
Approved by: Director of Operations, Chief Nurse and Medical Director.	**Date: 08th July 2024**
Recommendation	
Enclosures	
IPR Power Point Presentation.	

Integrated Performance Report (IPR)

June 2024

SPC Chart Guidance

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**

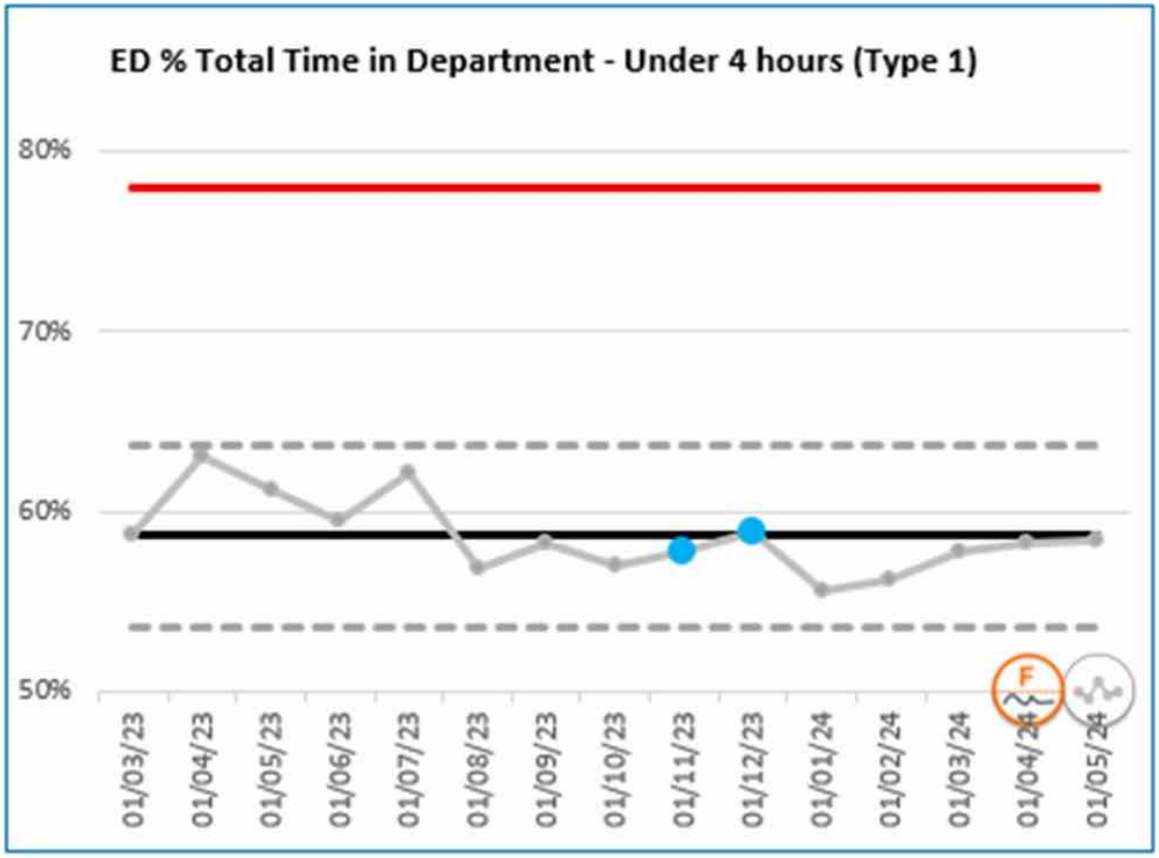
How to interpret assurance results:

- 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**

- The **red lines** on the charts show the **target** for that performance metric.
- The **black lines** on the charts show the **mean** for that performance metric.

UEC: Seen within 4 hours

(Standard: a min of 78% of patients seen within 4 hrs in March 25)



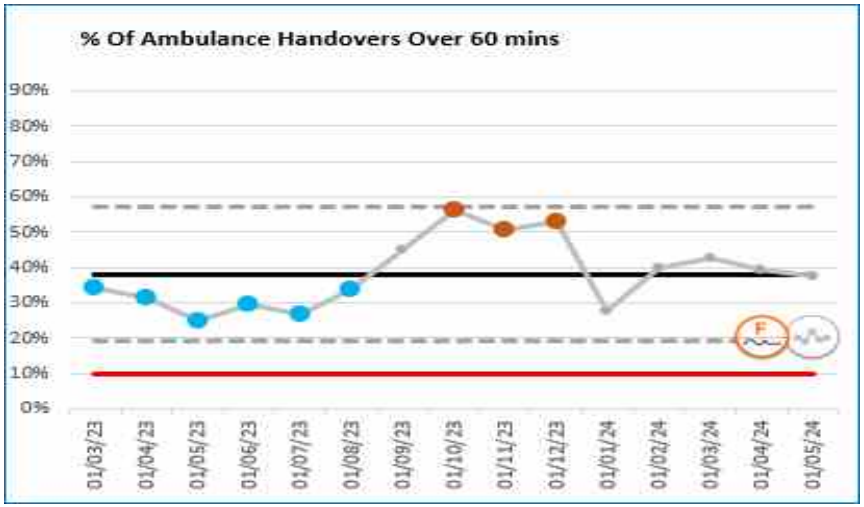
Commentary:
Four-hour performance remained broadly unchanged in May at 58.5% compared to a 58.8% in April. Whilst there has not been a deterioration in the performance there hasn't been a step change to meet the operational standard in the direction of the trajectory that is required.

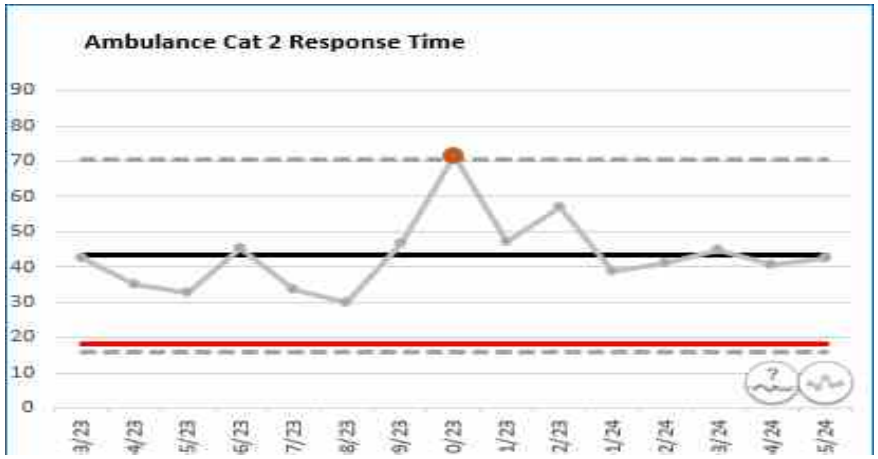
Planned Actions:
A UEC improvement plan has been developed with a focus on short, medium and long term actions. A number of schemes have been developed that are looking to improve elements aligned to the national operational standards around ambulance handover, 4 hour performance. Specific work is being planned in relation to the minors non admitted patients. ECIST have been invited are providing support including a visit in June

Expected recovery:
The trajectory submitted as part of the 24/25 operational planning aimed for a position of 60.5% in May 2024 – the aim for June is 61.1%. Twice daily meetings in place to support improved flow and achieve trajectory

UEC: Average Handover Time

(Standard: Improve Cat 2 ambulance response time to an avg of 30 min across 24/25)





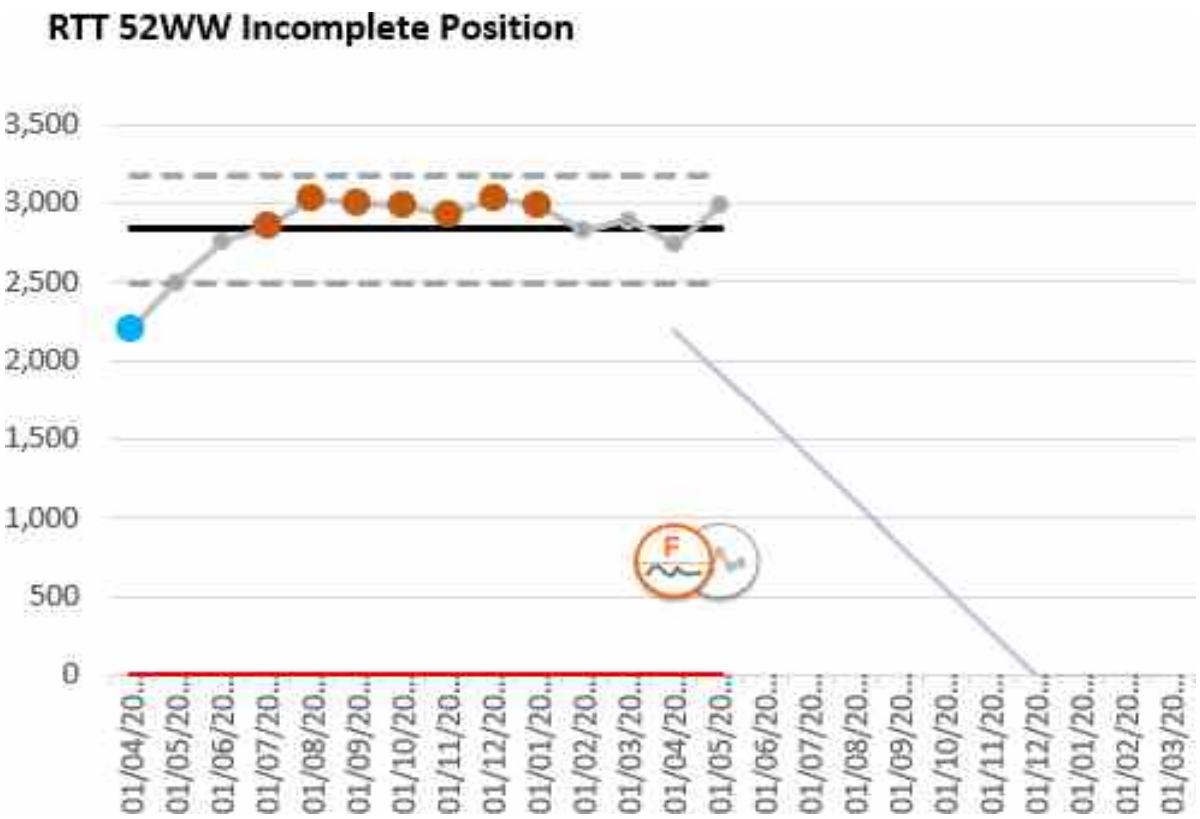
Commentary:
The percentage of ambulance handover delays over 60 mins reduced during May to 37% from April's position of 40%.

Planned Actions:
Continued focus on the work around the Pitstop processes and embedding the Red to Green work that the team have developed. We have also invited ECIST in to work with us and review processes. 6A audit has identified opportunities for system partners to consider, and have demostrated the opportunity presented by earlier access to alternative pathways and expertise. This would partially mitigate the clusters first thing in the morning, and at shift change

Expected recovery:
Ambulance handover performance has remained at roughly the same level as in April; with the implementation of actions as per the performance improvement plan and work through the 8 days of Summer we intend to see an improvement in the performance.

Elective: 52 Week Wait

(Standard (Local): *Eliminate all over 52ww by September 2024)*



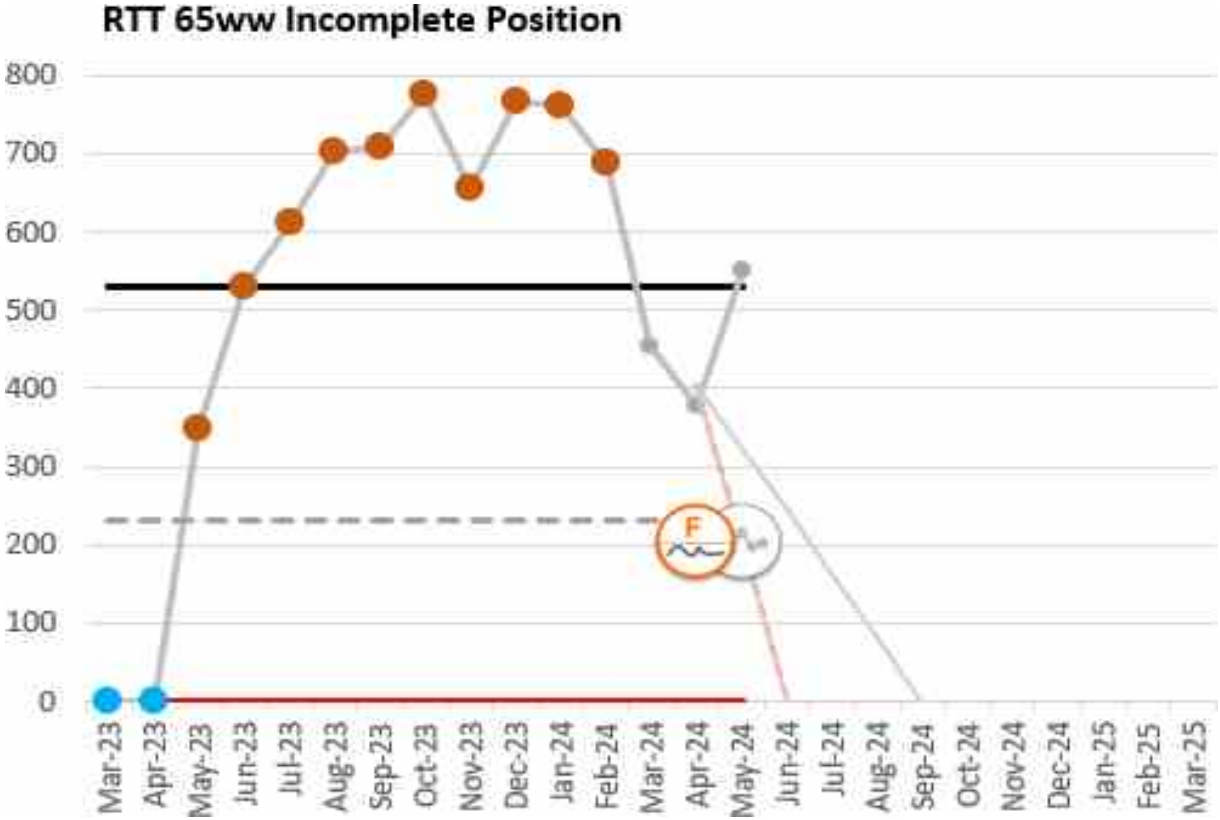
Commentary:
The May position is currently unconfirmed, the month-end submission is expected to increase with a forecast around 2,900 (compared to 2,738 last month). The number of breaches in the most challenged services of Oral Surgery and ENT, have increased (from 1,914 breaches las month to 2,019). Other key specialties contributing to this position are T&O/spines and Cardiology.

Planned Actions:
Delivery of the 2024/25 operational plan will be reliant on sufficient resources and supported with ERF funding, in a timely manner, together with avoidance of lost capacity through Industrial Action.

Expected recovery:
The trajectory submitted as part of the 24/25 operational plan showed the volume of over 52 ww gradually reduce over the coming months, subject to ERF funding/delivery and IA

Elective: 65 Week Wait

(Standard: *Eliminate waits of over 65ww by Sept 2024 (national target), local stretch to eliminate over 65ww by June 24)*



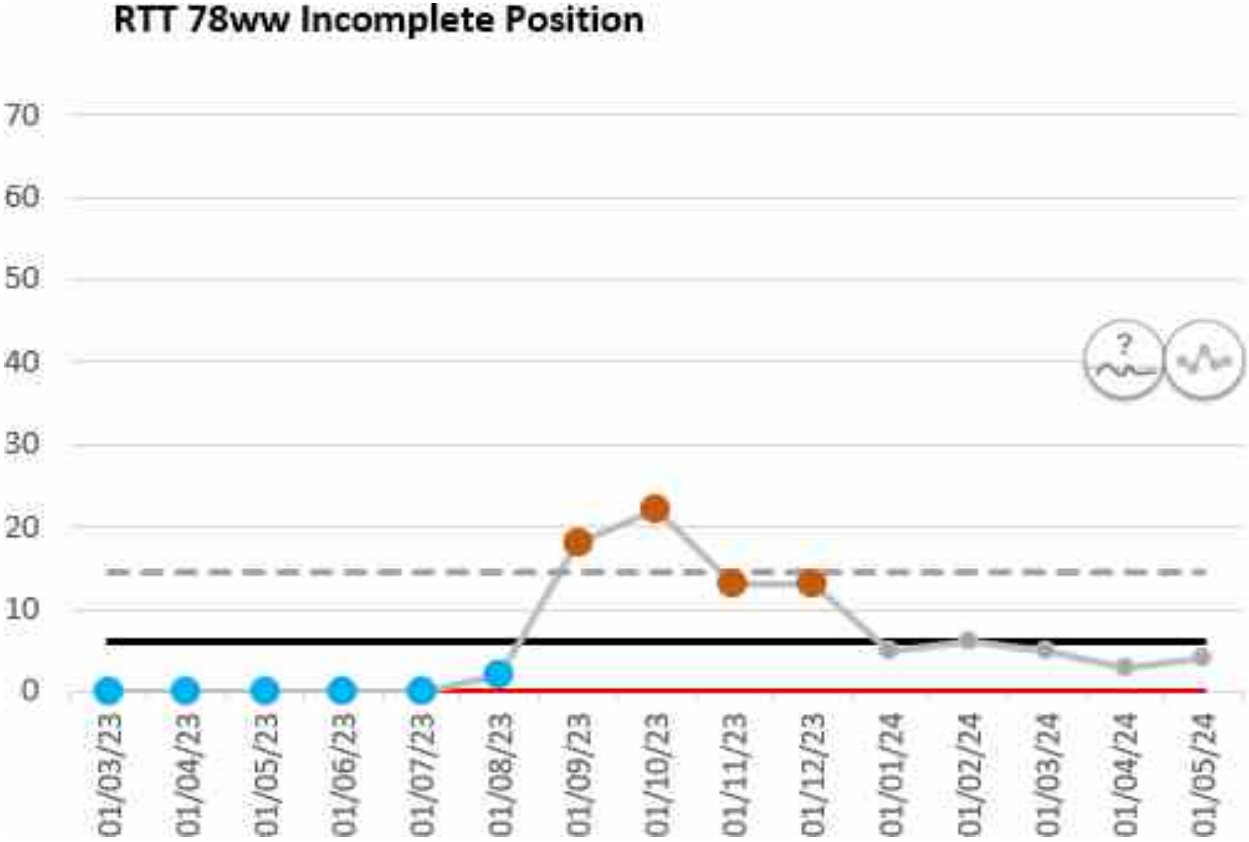
Commentary:
At the time of producing the report the number of patients waiting over 65 weeks has increased significantly with an anticipated position around 525 (compared to 379 last month). As above, Oral Surgery and ENT have the greatest volume with 447 (308 last month). T&O/spines then have 33.

Planned Actions:
A service by service line review of ability to deliver against the 65 week target continues through the Elective Care Improvement Board. Delivery will be subject to implementation of agreed ERF schemes and avoidance of lost capacity through Industrial Action.

Expected recovery:
With this increase together with planned Industrial Action at the end of the month and ERF schemes not fully mobilised, the internal target is unachievable by June month-end .

Elective: 78 Week Wait

(Standard: *Eliminate all over 78ww by March 2024)*



Comments
The number of patients waiting >78 weeks at the end of May was 3 – the same as April. These consisted of 2 x Oral Surgery and 1 Cardiology patient.

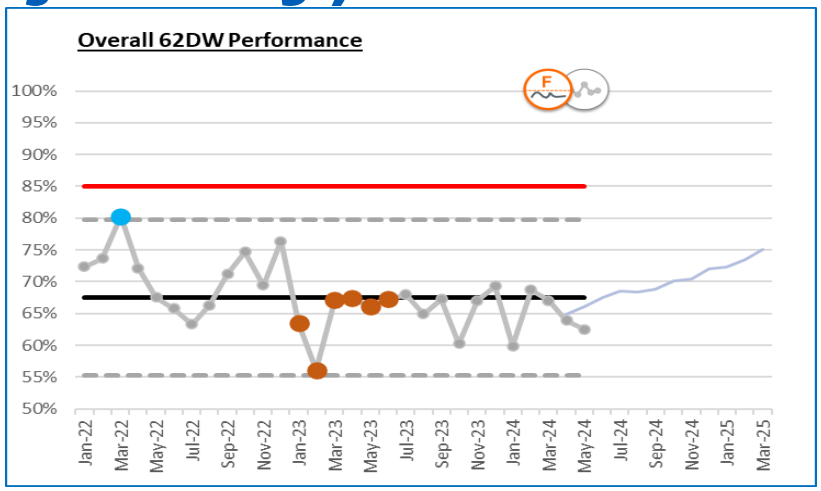
The June month-end forecast will potentially see similar numbers, subject to IA planning. Although each patient continues to be tracked closely, patient unavailability (with unreasonable notice) is having a bearing, together with the risk of reduced capacity due to IA.

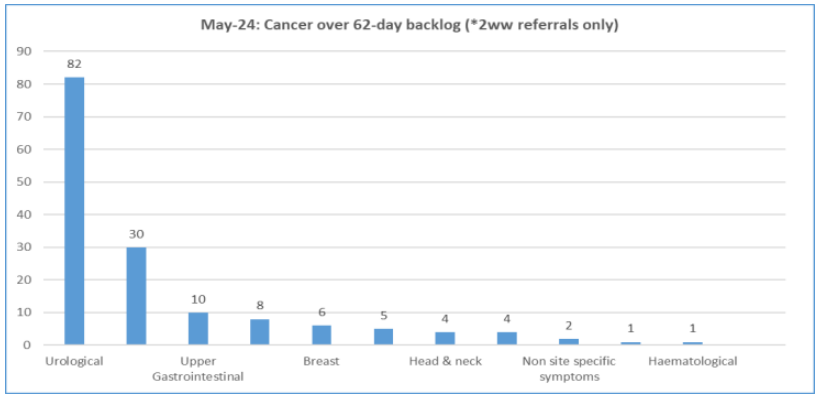
Planned Actions:
Mobilisation of ERF schemes critical to delivery, with many schemes still awaiting operationalising. There is a daily review of long waiting patients, a focussed review of administrative and management actions and some additional BI support being launched in the next period

Expected recovery:
All 78ww are to be eliminated by the end of March 24.

Cancer: % Patients seen within 62 Days (with trajectory)

Standard: 85%





Commentary:

Unvalidated 62 Day standard for May is currently at 65.5% and we will miss this target

This is on track for our recovery trajectory for 24/25 however we are aware that due to focussing on treating some of our longer patients and significantly reducing our backlog we may see a reduction over the next month

62 Day reportable backlog is 210 as of 10/06.

Planned Actions:

Focus on specialty level recovery and diagnostic pathways :Urology improvement plan agreed by Trust to support additional LATP and treatment capacity. Local LGI recovery plan being developed with focus on minimising patient delays. Radiology project manager in place to review TATs and improvement plans for diagnostic testing; Review of access policy to support operational decision making and mitigating and performance risk . Review of Cancer Alliance funding for 24/25 with focus on operational delivery against this standard

Expected recovery:

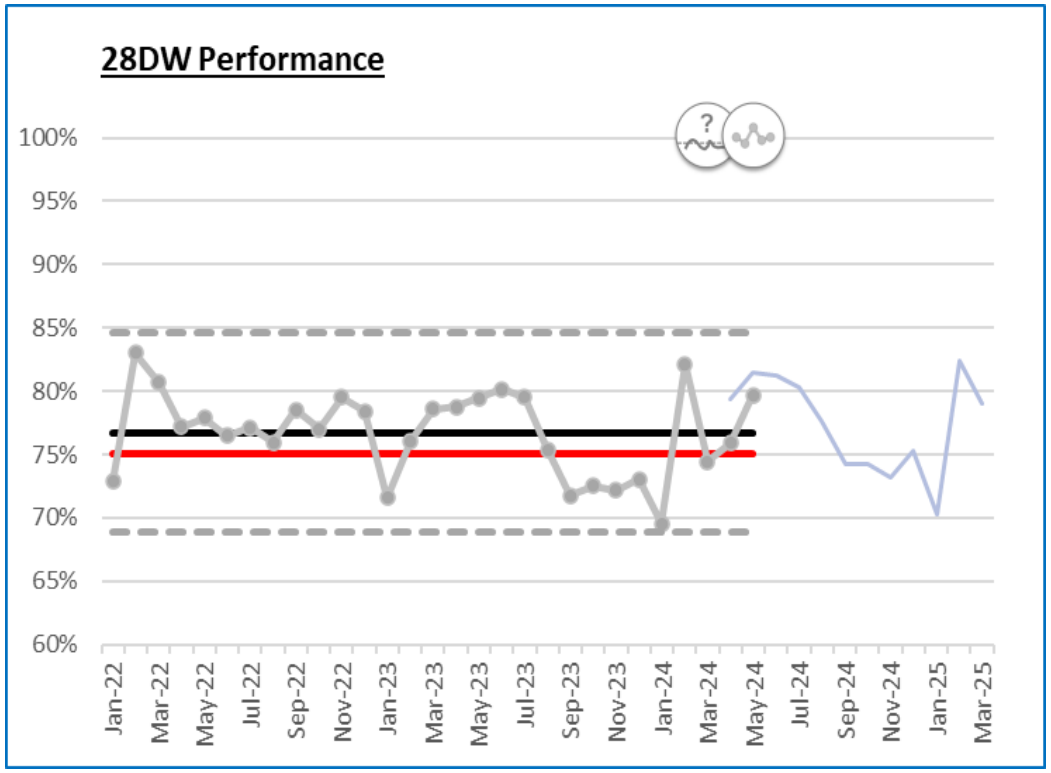
Trajectory has been submitted to ICB for recovery of 62Day at a sustained position of 75% by March-25

Sustained backlog recovery of no more than 6% of our PTL expected March-25

Current backlog of patients waiting longer than 62 days is currently at 8.5% of our PTL size. As good practice, a manageable backlog size should be no more than 5-6% of the PTL and our aim by (date to be agreed) is to sustain a maximum of 6% backlog moving forward

Cancer: Faster Diagnosis Standard (FDS) %

Standard: *Improve performance against the 28 day FDS to 77% by March 2025 towards the 80% ambition by March 2025*



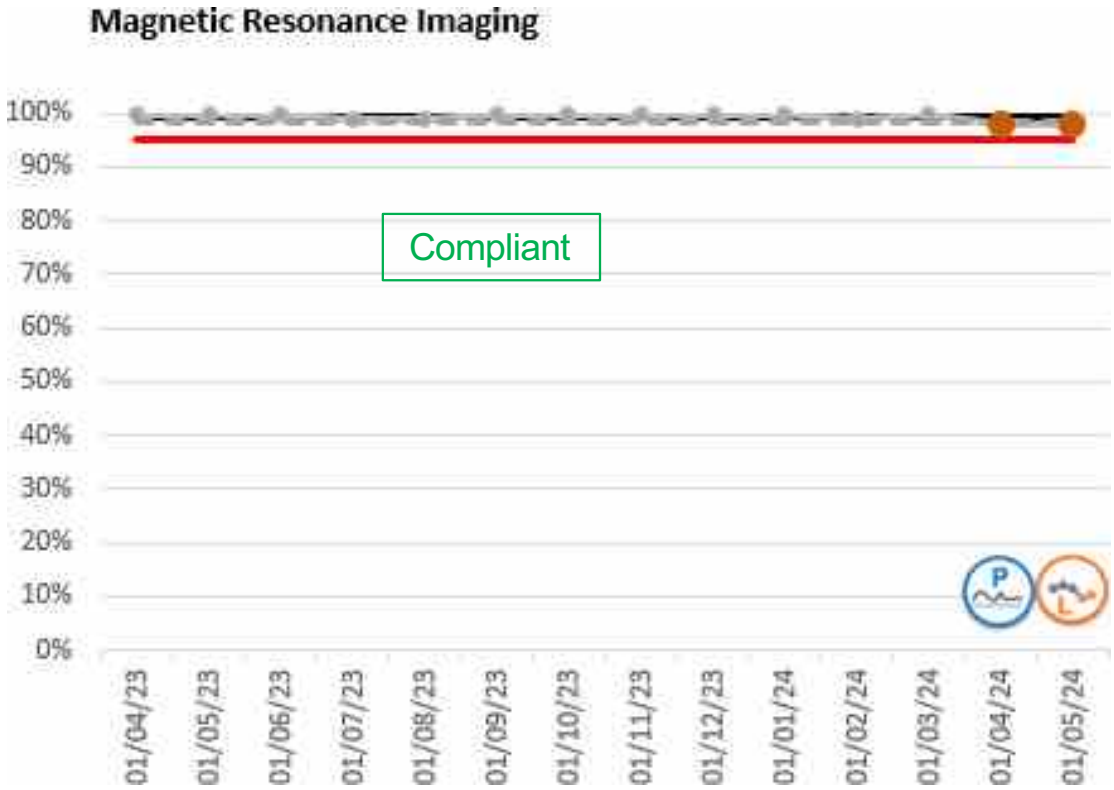
Commentary:
Unvalidated 28 Day standard for May is currently at 79.3% and we are expected to meet this target
However please note that although overall we are meeting the FDS target, only 46% of patients who had a confirmed diagnosis were informed before Day 28

Planned Actions:
In order to maintain this standard of 75% and achieve the new target of 77% FDS, some of the planned actions include :
Focus on BPTP implementation on key specialties
New Escalation policy to support earlier identification of bottlenecks and concerns
Review of 2WW booking date and aim to bring this in line with 7 days or less
Review of non-cancer and cancer FDS to look at opportunities to improve FDS for cancer patients

Expected recovery:
Recovery and sustained achievement of the FDS standard is expected by March-25, however is dependent on all services which support the cancer pathways supporting the actions agreed

Diagnostics: MRI

*(*Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



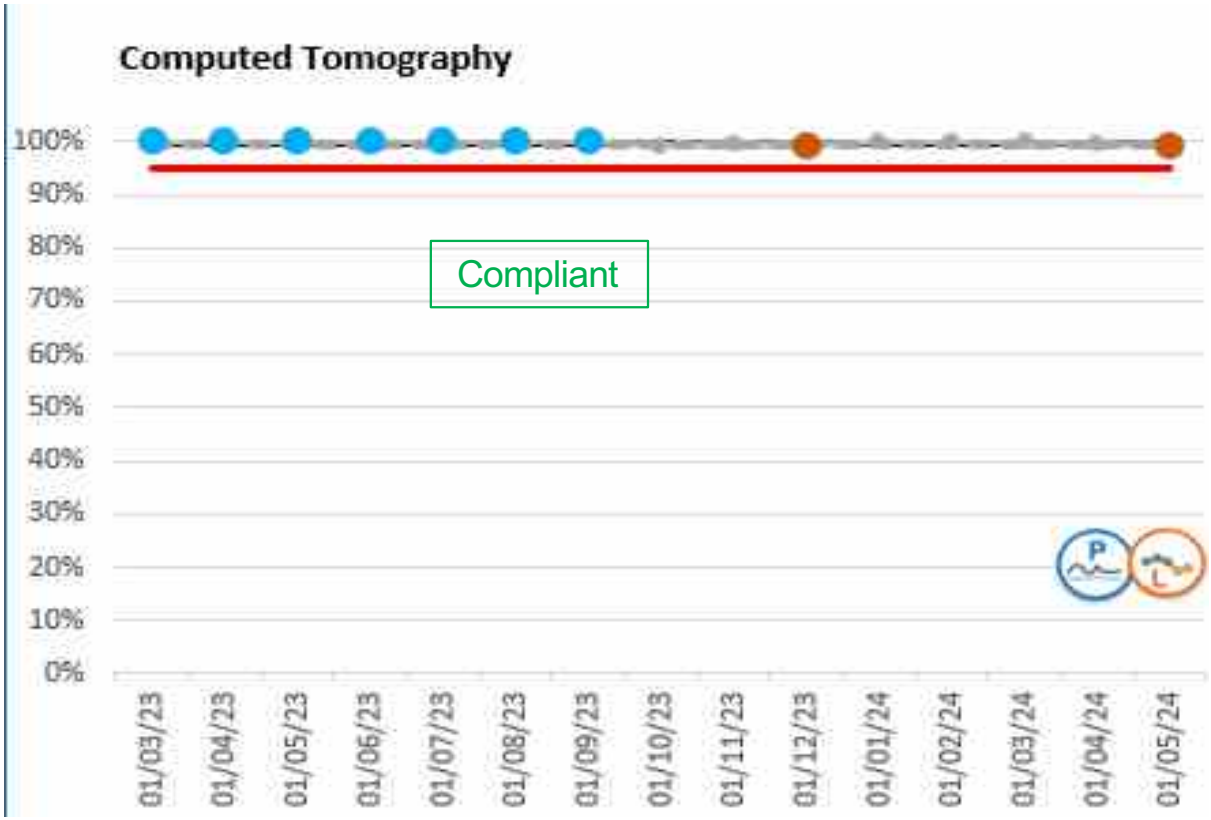
Commentary:
31 breaches are in Paediatric GA MRI, caused by high demand in anaesthetics. All other areas of MRI are fully compliant.

Planned Actions:
Paediatrics Service are writing a business case to support an increase in anaesthetic capacity.

Expected recovery:
D&S MRI have capacity to accommodate Paediatric demand. Once additional anaesthetic capacity is identified standard expected to be compliant.

Diagnostics: CT

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*



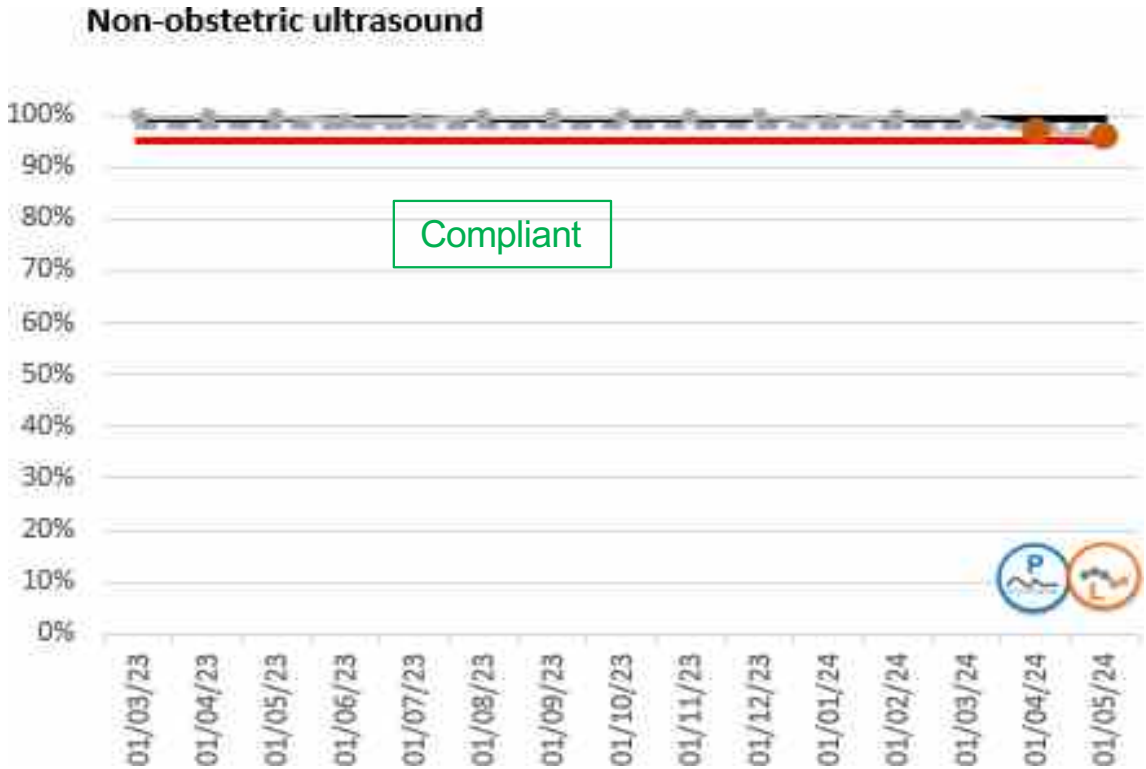
Commentary:
12 breaches in May, due to multiple equipment failures.

Planned Actions:
No additional planned actions required at present.

Expected recovery:
Expect maintain 95%.

Diagnostics: Ultrasound

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*



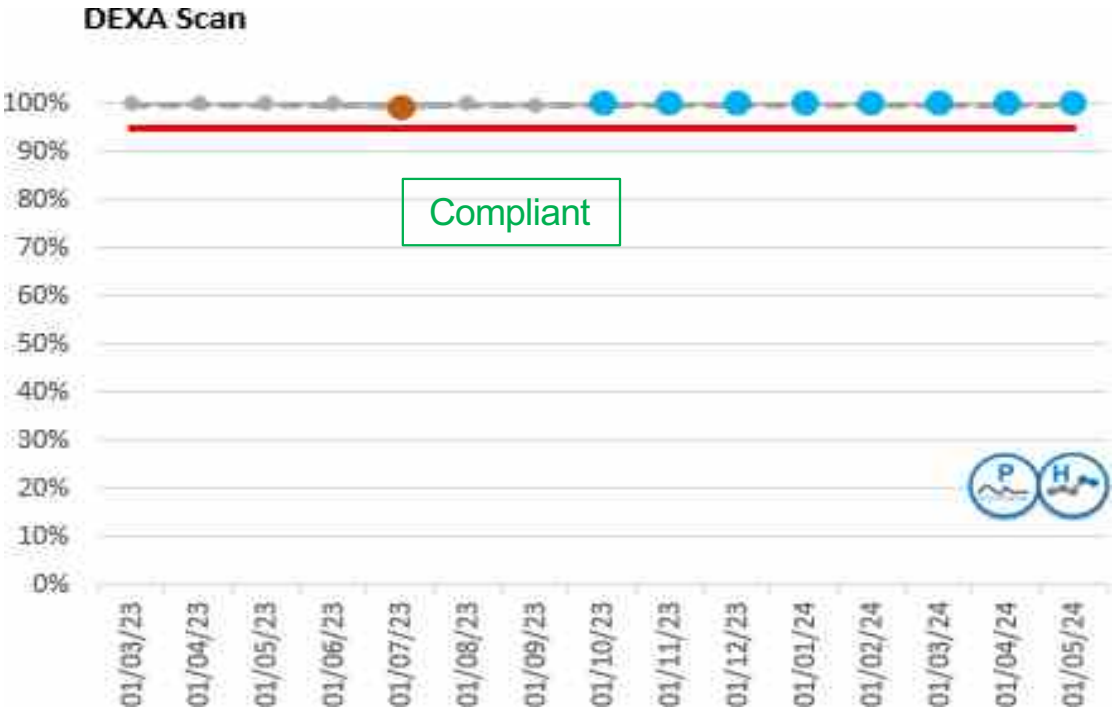
Commentary:
164 breaches in May.
7WTE vacancies in Sonographer line, and difficult to recruit due to national shortage.
Additional obstetric ultrasound activity impacting on NOUS.

Planned Actions:
Action plan in place as knock on effect may reach into June. Working with recruitment team and increasing agency request.

Expected recovery:
End of July for recovery

Diagnostics: DEXA

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



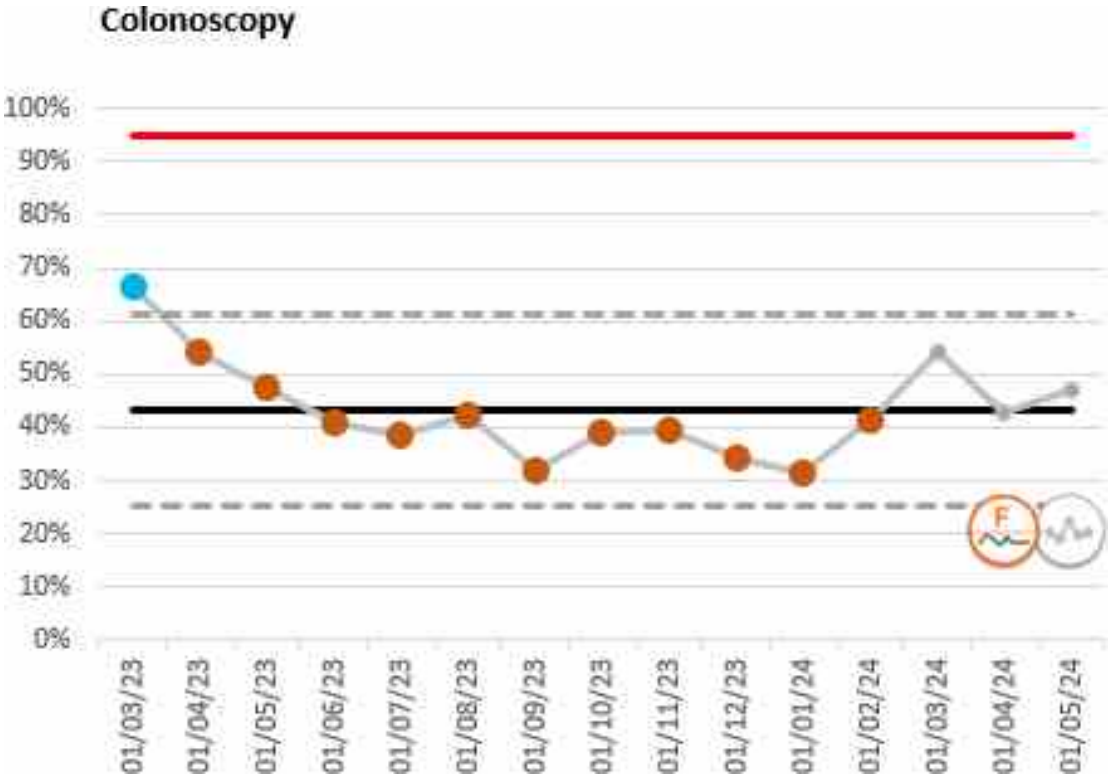
Commentary:
No breaches in DEXA

Planned Actions:
No additional actions required at present.

Expected recovery:
Not Applicable

Diagnostics: Colonoscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



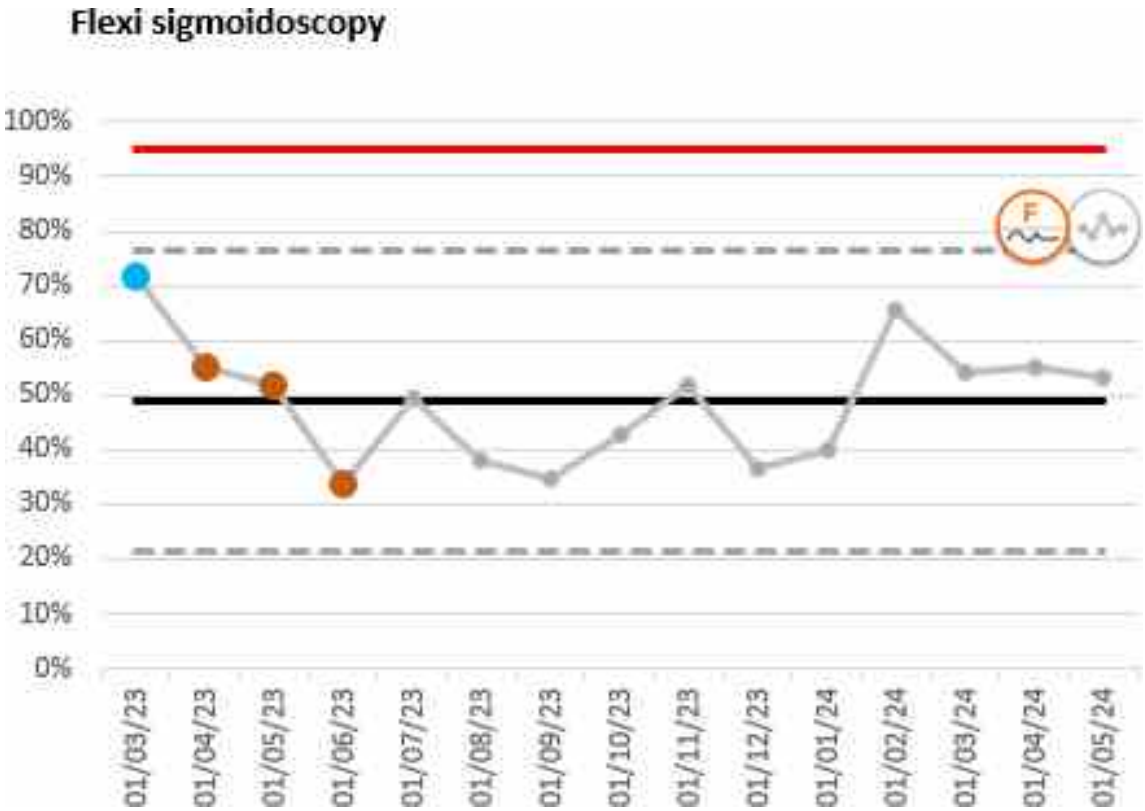
Commentary:
Colonoscopy DM01 performance improved slightly at 54% compared to 56% in April (Target 5%). Colonoscopy waiting list increased slightly: Surgery list cancellation due to sickness, half term and CE injury (895 May compared to 892 April).

Planned Actions:
Continue to utilise funds to back fill in-week lists, estimated to run out end of June.
(ERF) Increased locum lists by 2 per week focussing on 2WW & STT
(ERF) Visiting consultant to start 24th June (6 lists per week)
(ERF) Interview for Fixed Term consultant 25th June (Start October with 5 lists per week)
Deliver on the Endoscopy Recovery and Improvement Programme Plan including development of 3-5-10 year strategy
Implementation of TNE service started 10th June and expected to delivery 5 lists per week which will release OGD theatre capacity that can be utilised for colonoscopies

Expected recovery:
Expected DM01 and surveillance recovery by March 25

Diagnostics: Flexi Sigmoidoscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



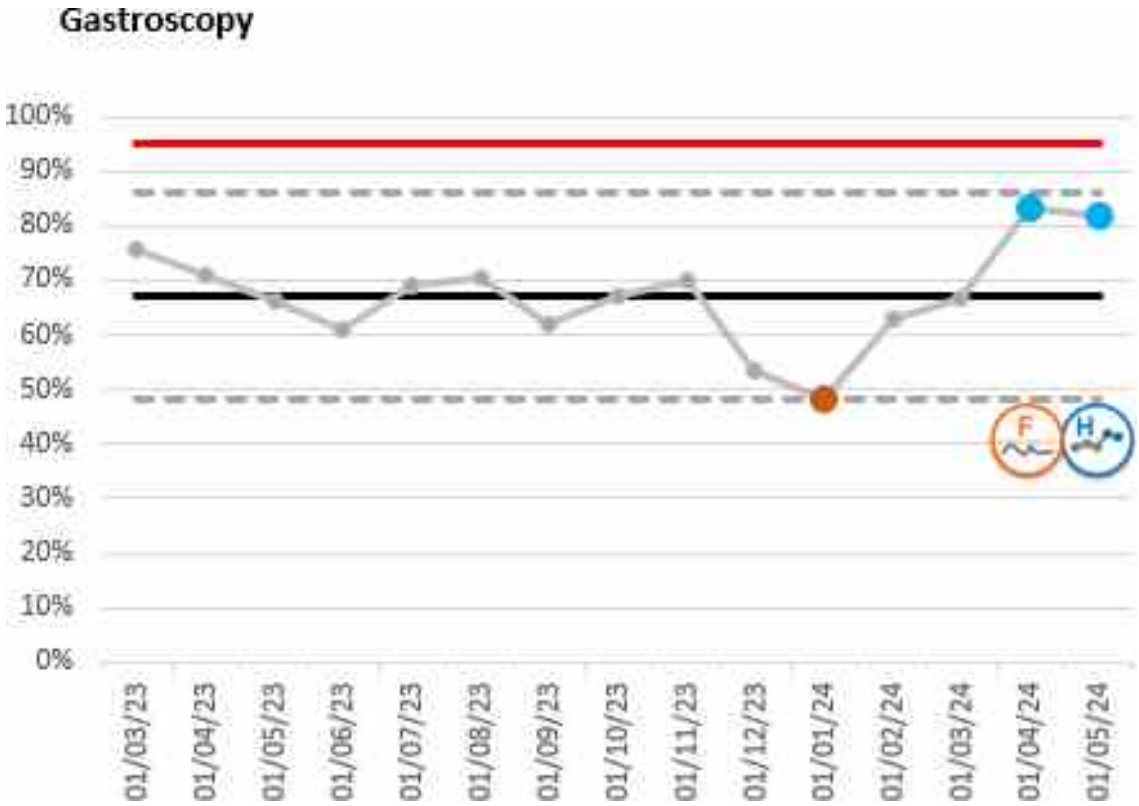
Commentary:
Flexi DM01 performance declined slightly at 45% compared to 46% in April (Target 5%). Colonoscopy waiting list increased slightly: Surgery list cancellation due to sickness, half term and CE injury (895 May compared to 892 April).

Planned Actions:
Continue to utilise funds to back fill in-week lists, estimated to run out end of June.
(ERF) Increased locum lists by 2 per week focussing on 2WW & STT
(ERF) Visiting consultant to start 24th June (6 lists per week)
(ERF) Interview for Fixed Term consultant 25th June (Start October with 5 lists per week)
Deliver on the Endoscopy Recovery and Improvement Programme Plan including development of 3-5-10 year strategy
Implementation of TNE service started 10th June and expected to delivery 5 lists per week which will release OGD theatre capacity that can be utilised for colonoscopies

Expected recovery:
Expected DM01 and surveillance recovery by March 25

Diagnostics: Gastroscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



Commentary:
Gastroscopy DM01 performance remained static in May at 17% (Target 5%). Colonoscopy waiting list increased slightly: Surgery list cancellation due to sickness, half term and CE injury (895 May compared to 892 April).

Planned Actions:
Continue to utilise funds to back fill in-week lists, estimated to run out end of June.

(ERF) Increased locum lists by 2 per week focussing on 2WW & STT

(ERF) Visiting consultant to start 24th June (6 lists per week)

(ERF) Interview for Fixed Term consultant 25th June (Start October with 5 lists per week)

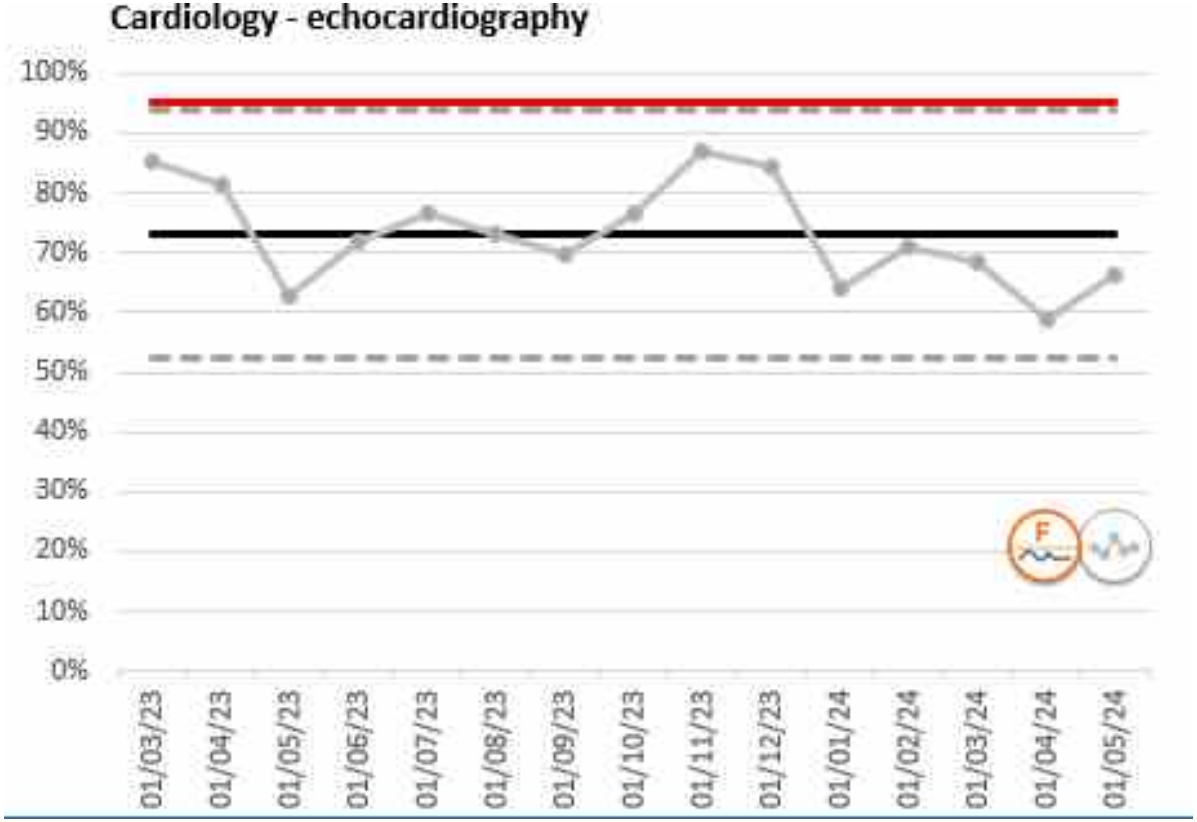
Deliver on the Endoscopy Recovery and Improvement Programme Plan including development of 3-5-10 year strategy

Implementation of TNE service started 10th June and expected to delivery 5 lists per week which will release OGD theatre capacity that can be utilised for colonoscopies

Expected recovery:
Expected DM01 and surveillance recovery by March 25

Diagnostics: Echocardiography

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)



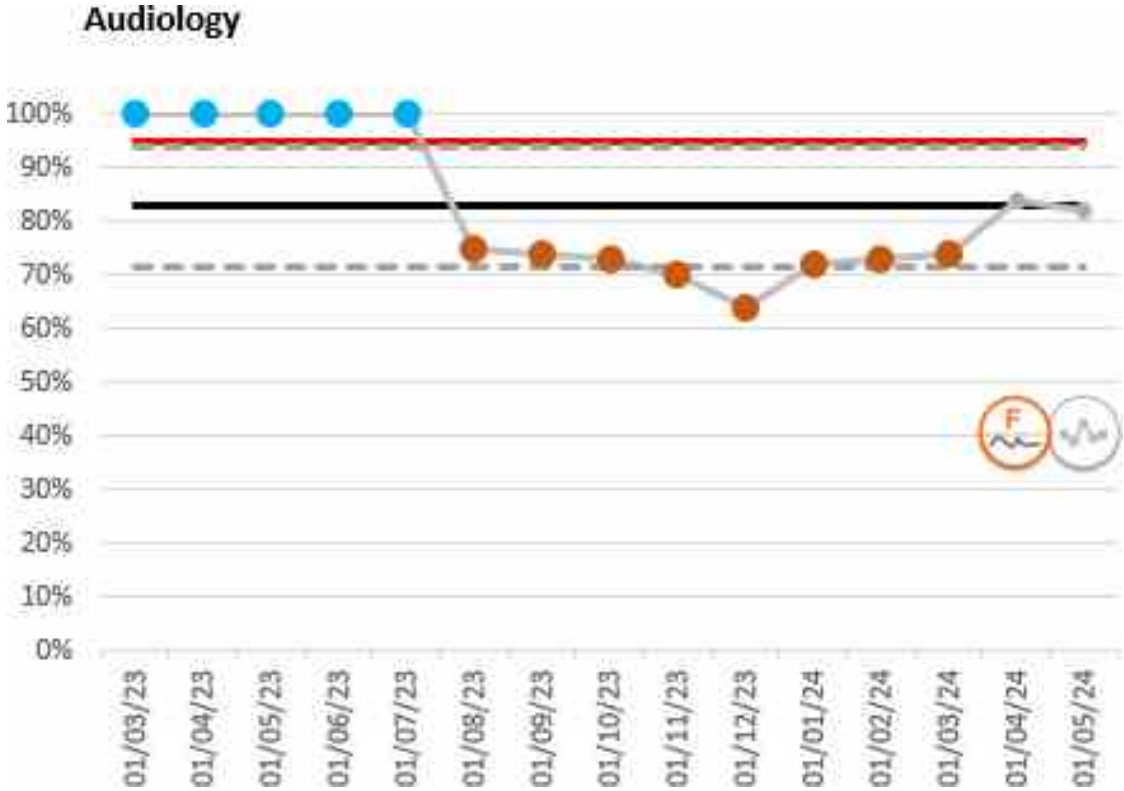
Commentary:
During April 2024 there were 498 breaches. Current drivers relate to workforce challenges, referral reviews, demand & capacity, oversight of processes and IP demand. As per last month the national shortage of echo physiologists making recruitment significantly harder than in other areas.

Planned Actions:
Additional clinics being undertaken to support specific cohorts of patients. Action plan has been developed to address the above issues. In addition to a deep dive being carried out in Echocardiography.

Expected recovery:
Trajectory to be completed and taken through Elective Recovery Improvement Board.

Diagnostics: Audiology

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)



Commentary:

The Change in DM01 Reporting definitions commenced in August 2023 which affected historic 100% . DM01 Compliant reporting has now been fully applied and reflected.

Planned Actions:

Additional activity continues to support the recovery of this service. This will continue. Targetted recruitment support will be undertaken, recognising the national shortage of audiologists.

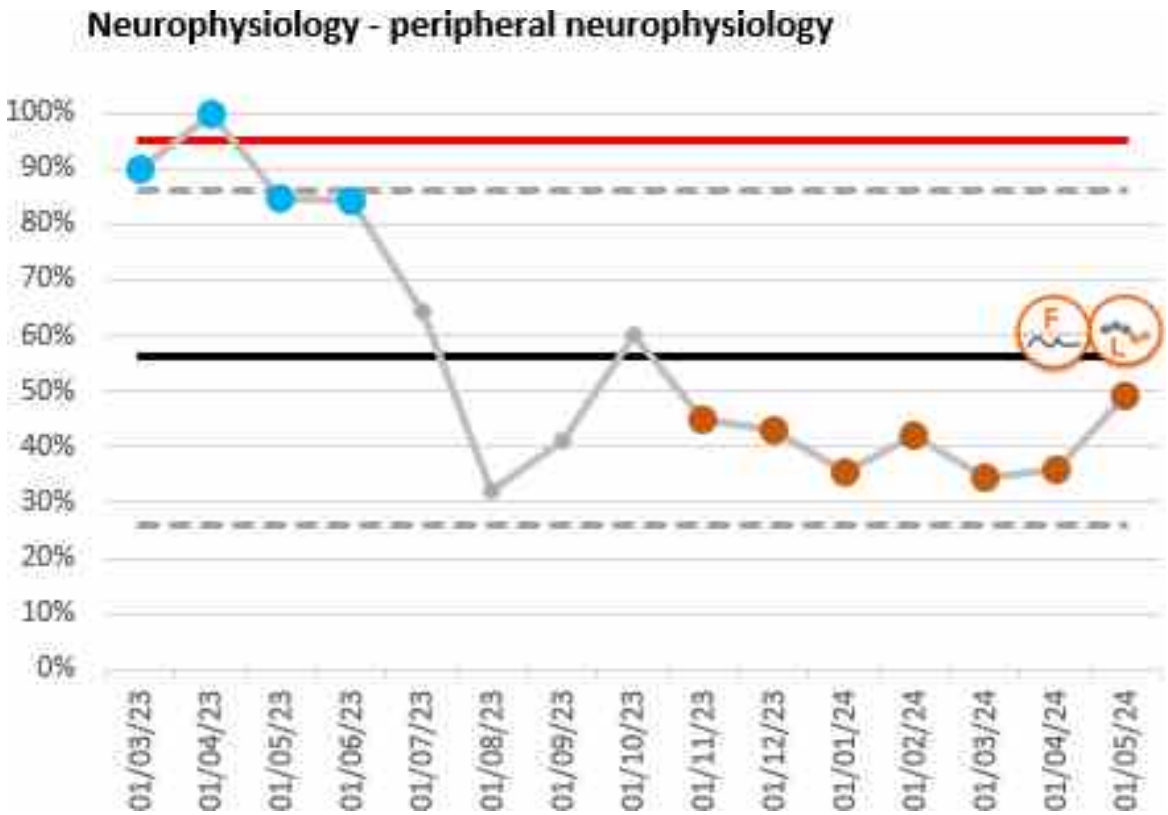
Continual review of process efficiencies for ENT clinical cover to ensure audiologists are utilised appropriately, to maximise the improvement required,

Expected recovery:

Dependent on above action plan, which is being managed in conjunction with focus on paediatric audiology. Predicted recovery for March 2025.

Diagnostics: Neurophysiology

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)

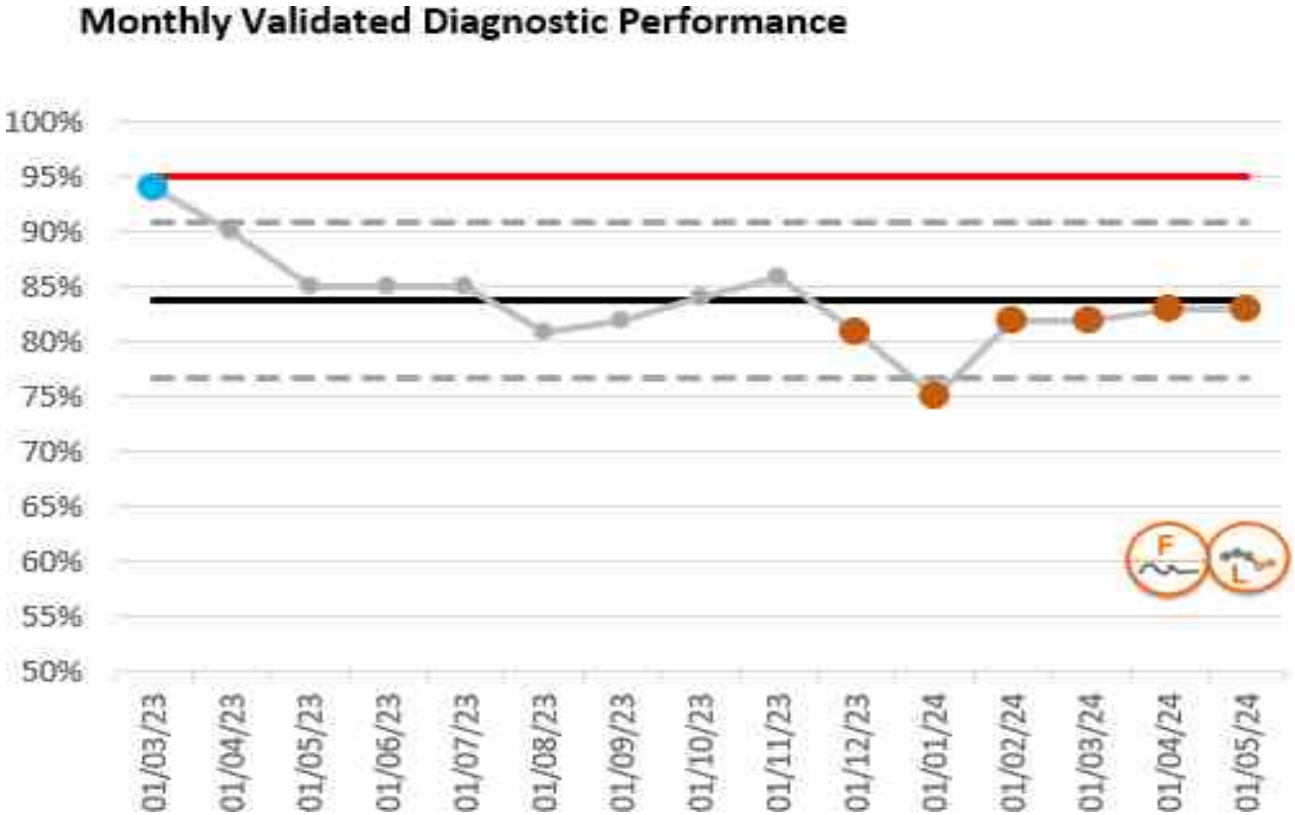


Commentary:
There has been a reduction in the number of weeks that the longest waiting patients are experiencing and is now at 19 weeks. We have 360 patients waiting over 6weeks and that has reduced by 40 patients.

Planned Actions:
2 x B7 Neurophysiologists recruited and will start in September 2024
Recruiting apprentice (sept 24)
Member of staff returning from Maternity leave due to return July 24
New GP referral form live
Administrative validation in place
Aim to develop education programme for GP's and trainees

Expected recovery:
Initial step change anticipated in September 2024

Diagnostics: Performance Trend



Commentary:

Despite strong delivery in the Imaging Modalities the Trust remains in a non-compliant position overall.

Planned Actions:

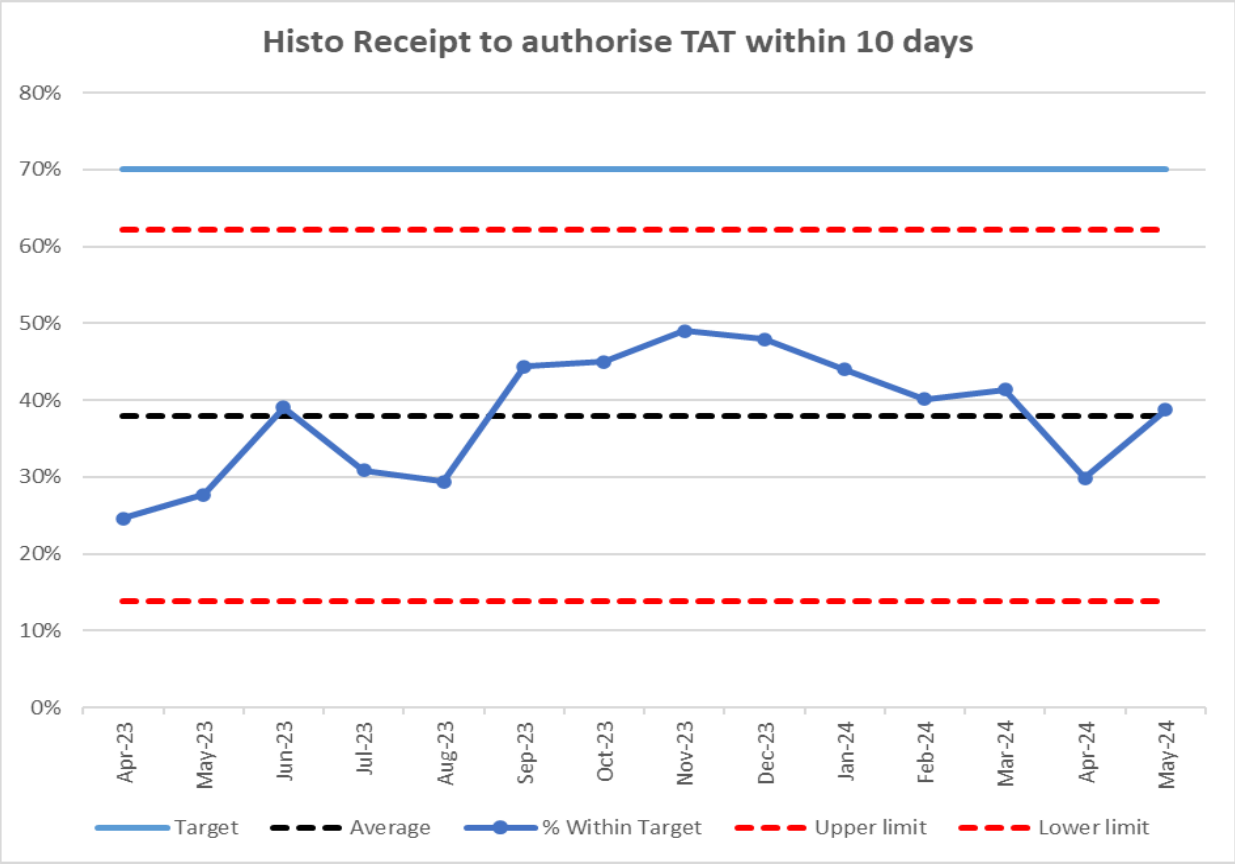
Cumulative delivery of the actions described in earlier slides will positively influence an improving position.

Expected recovery:

It is unlikely that full compliance will return until the end of 2024/25, however there will be a continued improvement towards compliance

Diagnostics: Histopathology 10-day reporting

Standard: Delivering 70% turnaround times



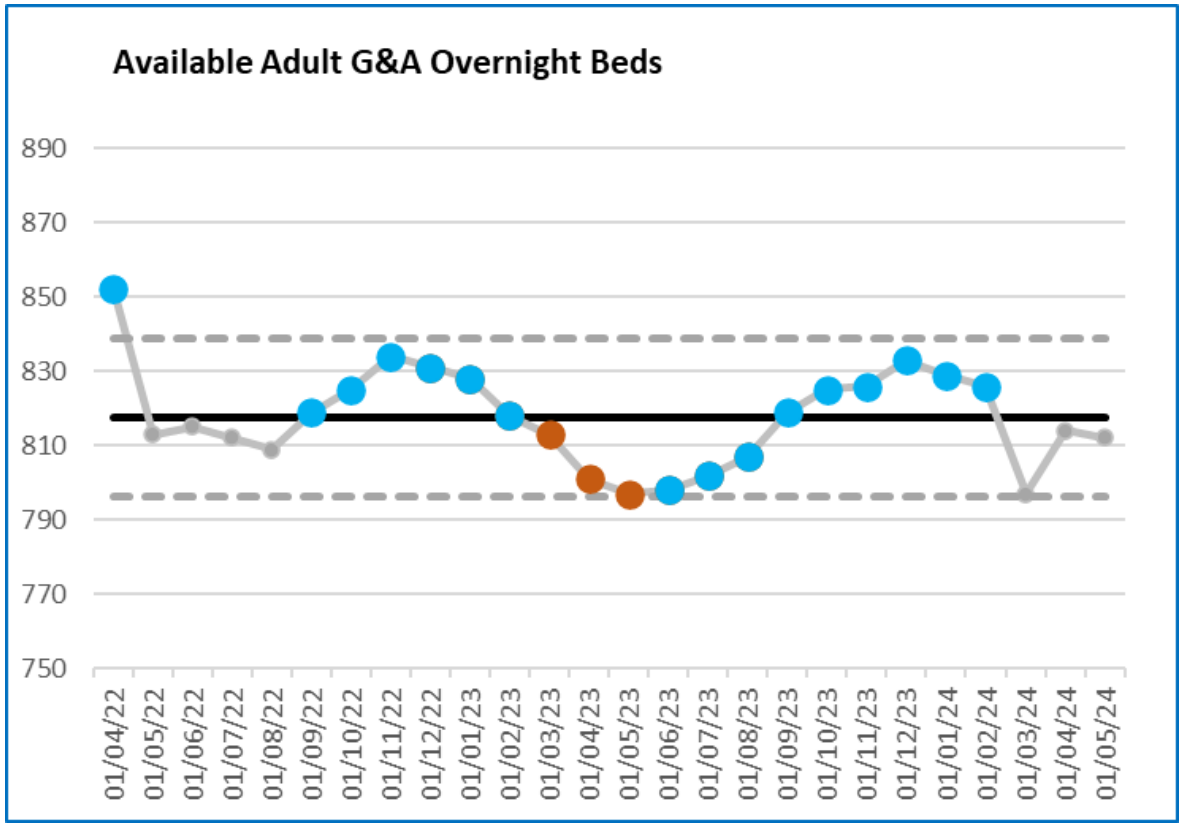
Commentary:
There is a national shortage of Histopathologists and this comes at a time of a 30% increase in Histopathology requests. The department has old, end of life equipment which is becoming increasingly unreliable. The Department is reliant on outsourcing and locum reporting. Performance fell in April as the department lost a very experienced Histopathologist at the end of March. This was in addition to major equipment failure which caused delays to multiple specimens

Planned Actions:
We are increasing capacity for Scientist dissection. This together with new tissue processors will increase capacity and efficiency.
The department is implementing Digital Pathology and this will improve efficiency around reporting.
Recruitment of new Histopathologists is also ongoing
Trial of six day working to increase capacity

Expected recovery:
Dependent on recruitment and procurement of new equipment

General & Acute Beds: Available Overnight

Standard: maintain acute G&A beds as a minimum at the level funded and agreed through operating plans in 2023/24

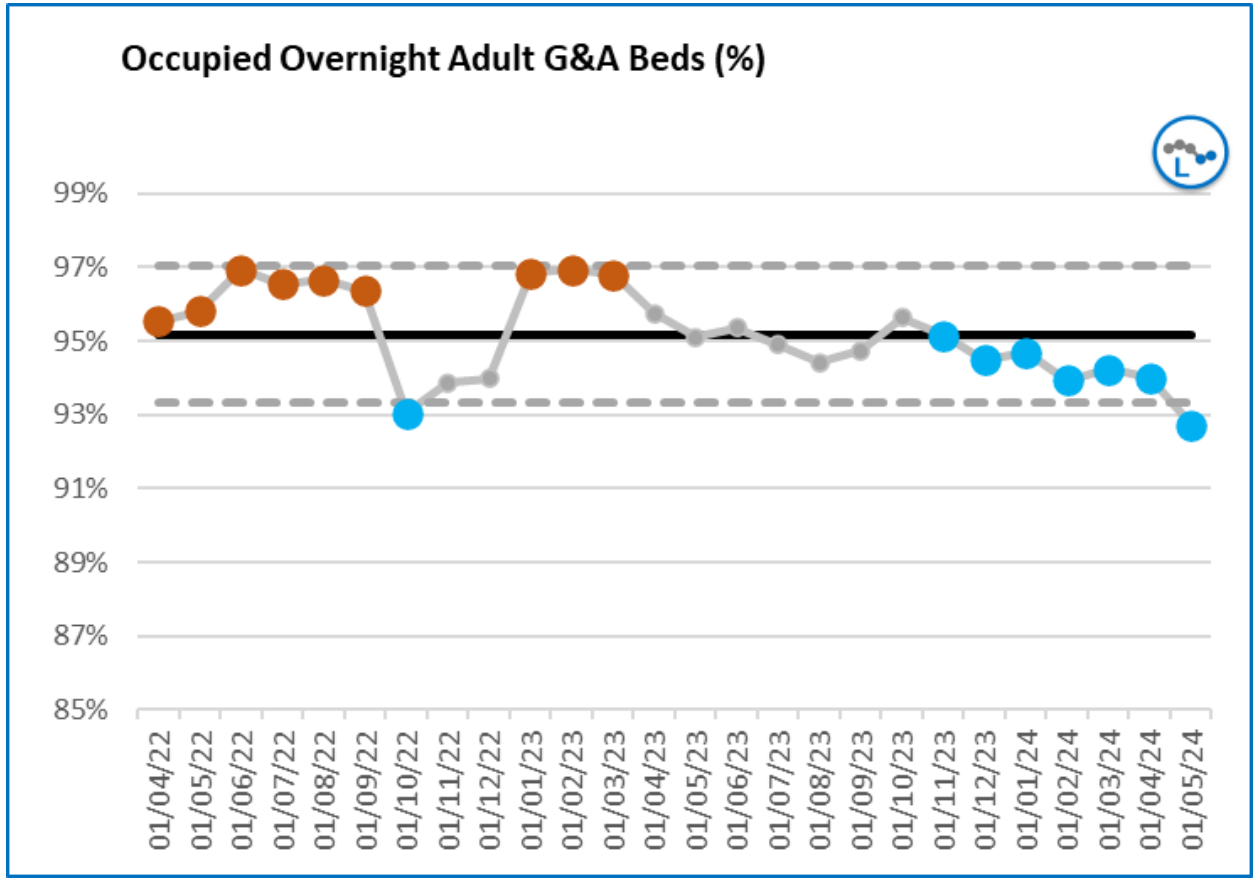


Commentary:
Data within this metric still relates to prior to making recent changes to the governance around our bed stock.

Planned Actions:
A bed base reconciliation process has now taken place, which has confirmed our bed stock and ensured all reports have been rectified against that number. Alongside this we have introduced a new governance process for any changes to our bed stock to ensure understanding and awareness across the various teams.

Expected recovery:
In terms of accuracy of data, this will be evident within the April data set. In terms of bed stock availability, this is dependent on multiple factors such as Infection outbreaks or estates work. What we do now have is much better understanding of impact and recover timelines within each episode. There are currently no issues affecting our bed stock

General & Acute Beds: Occupied

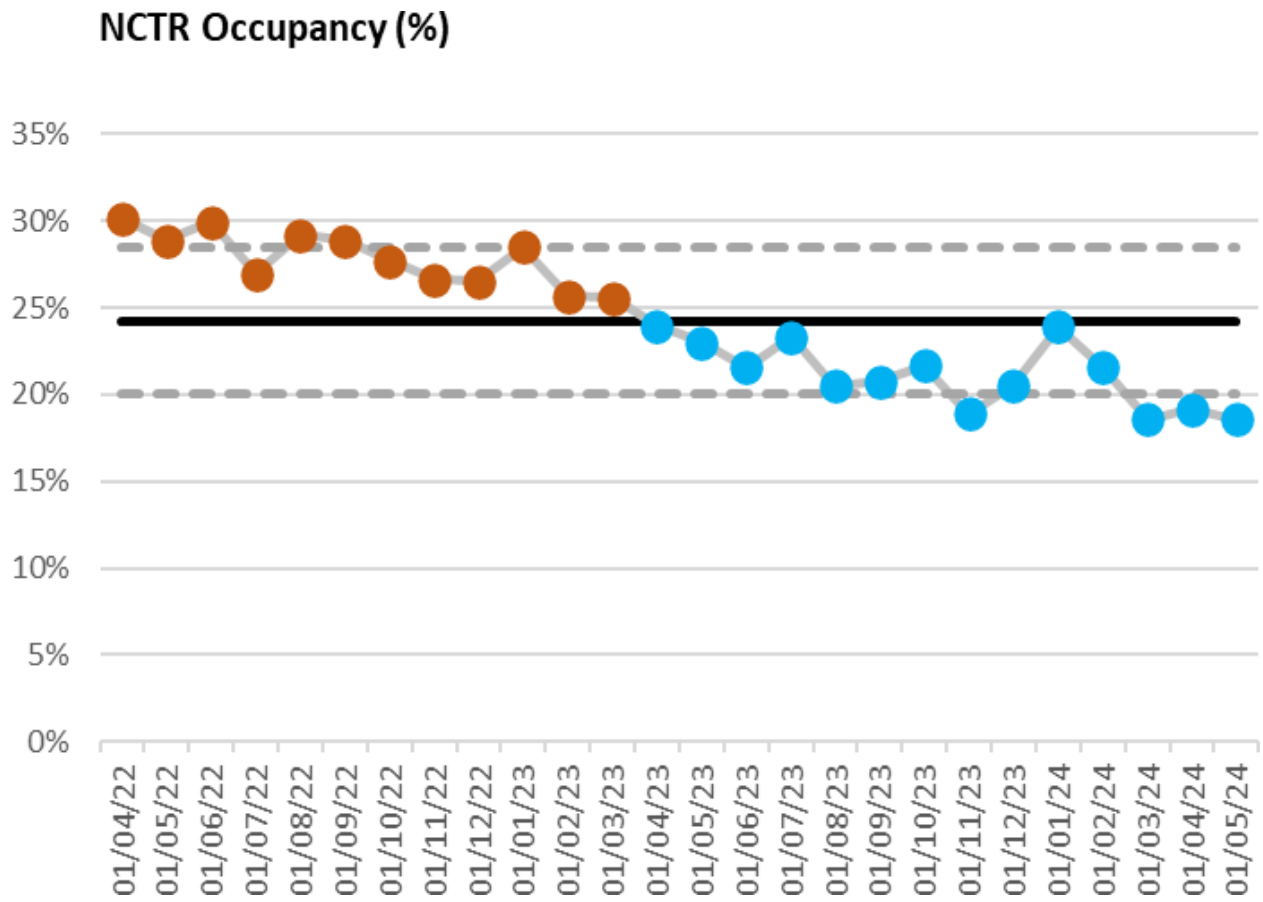


Commentary:
This data has still got limitations linked to issues we have been resolving through within our bed stock reconciliation. Our lower occupancy is driven through bed utilisation within our elective orthopaedic wards predominantly.

Planned Actions:
As part of our bed stock reconciliation, the surgical division is considering the elective orthopaedic beds and how best to capture and manage these beds. This has been taken through the new governance process for agreement and ratification.

Expected recovery:
The accuracy and validity of data will continue be improved.

General & Acute Beds: % Beds Occupied with NCTR

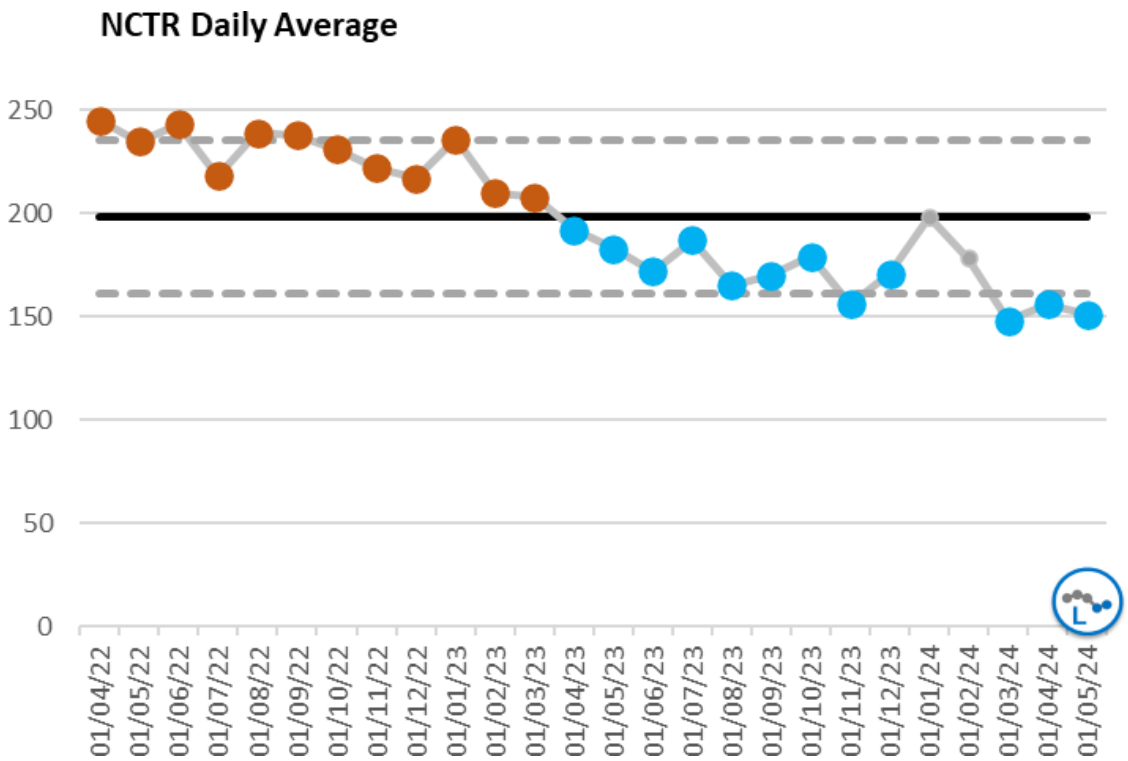


Commentary:
Overall the no criteria to reside numbers continue to show a positive downward trend. However this recovery is variable and subject to external influences such as P1,2 and 3 discharges.

Planned Actions:
Multiple actions in train as part of the development of the Intergrated Flow Hub, WasO programme and challenge within the wider ICS. This covers a range of internal actions around process improvement and driving 21+ day reviews, to driving flow within P1 & P2 predominantly, aiming for same day/next day discharges. These actions are regularly reviewed at Strategic Escalation Group with system partners. Breaking the Cycle event planned across the system as part fo the 8 Days of Summer event in July

Expected recovery:
In line with planning for 24/25, the expectation is that the nCTR number is less than 80 by the end of the year, being maintained through our winter months. This is currently at risk.

General & Acute Beds: Daily Average Occupied with NCTR



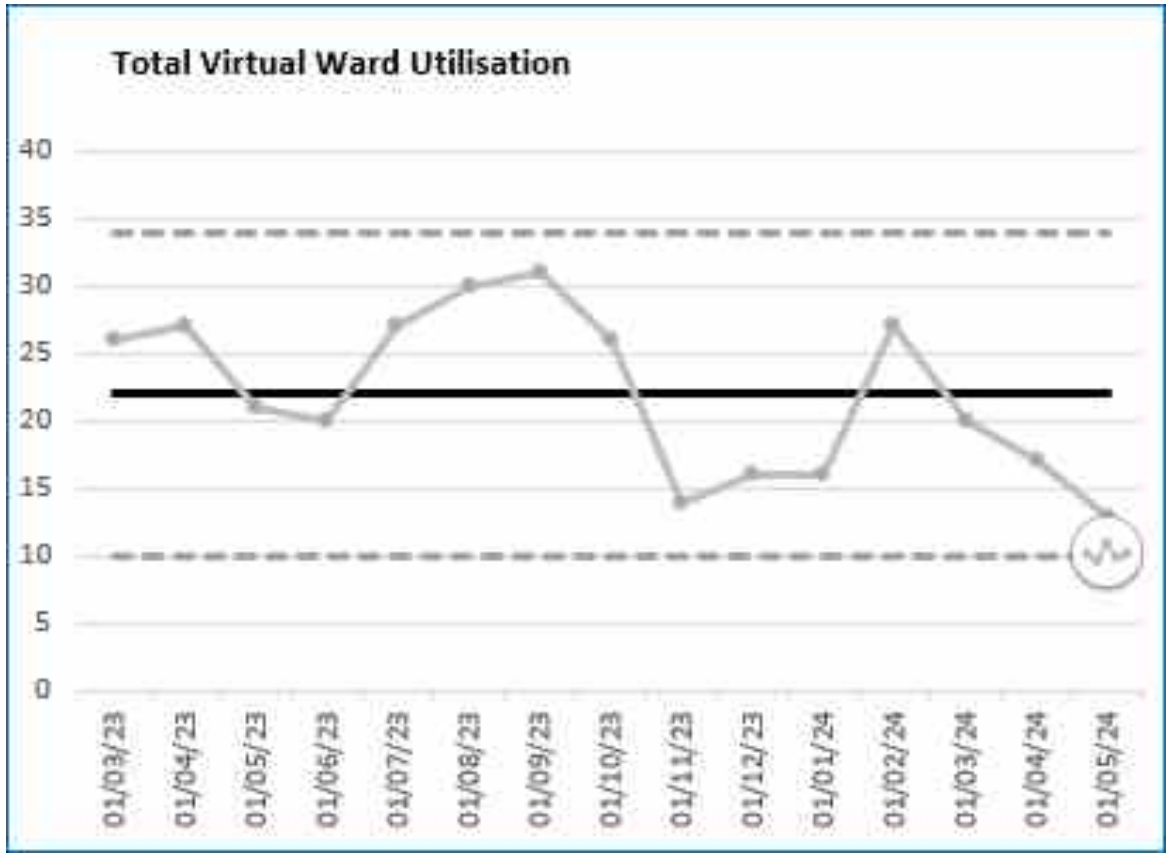
Commentary:
Overall the nCTR numbers continue to show a positive downward trend.

Planned Actions:
Continue focus on simple discharges P0 and conversions from P1 to P0. Establish links and relationships with CVoF Programme;

Expected recovery:
Continure to report an improving trajectory of nCTR patients in the Acute Hospital bed base.

Virtual Wards: Utilisation

Standard: 80%



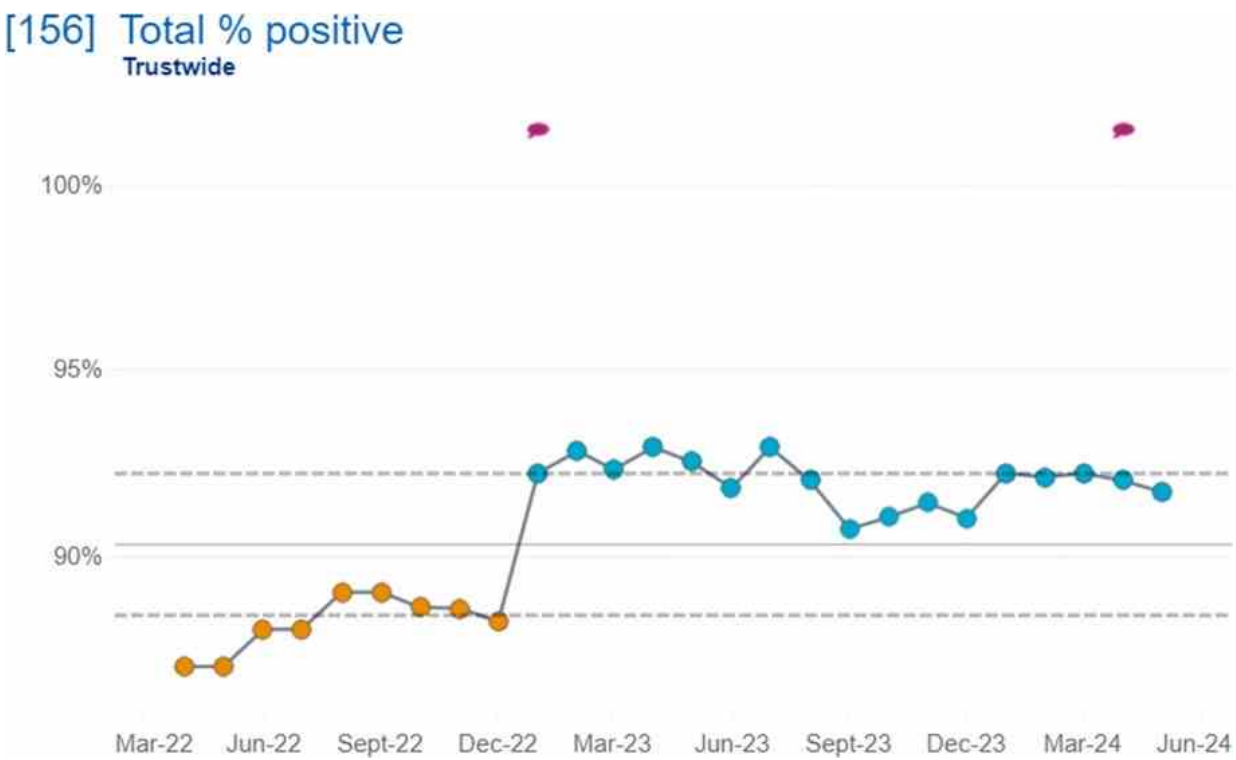
Commentary:
Reporting based on snapshot data (fortnightly national reporting). Gloucestershire systemwide occupancy remains above 80% since Jan 24. The GHFT led respiratory, frailty and surgical virtual wards are at an earlier stage of development. Activities to maximise utilisation are focussed on these wards. The virtual ward medical hub, went live May 2024, is a key enabler by providing 12-hour support 7 days a week.

Planned Actions:
The Virtual Ward Programme continues to support the growth in capacity and occupancy across pathways. In July this will be further enhanced by the acute medicine VR going live. Programme activities include enhancing the confidence with clinical teams, increasing referral routes and operational hours, as well as embedding virtual wards within the system flow processes.

Expected recovery:
The Virtual Wards Programme delivery plan will continue the development and growth of virtual wards across Q1 and Q2 with an intent to consistently achieve 80% occupancy ahead of winter 24/25.

Quality & Safety Metrics

Quality of Care: FFT Positive Response



Commentary:
The overall Trust FFT positive score has dropped slightly this month to 91.7% compared to 92% in April 2024. There has been a reduction in scores from inpatients, outpatients and the emergency department. There was a slight increase in the score for Maternity services. Delays in appointments and feeling dismissed are themes from outpatients.

Planned Actions:
To review who we are not hearing from including those patients experiencing a health inequality or fall into a protected characteristic group. Also look to further expand the accessibility of the survey.

Expected recovery:
To continue to see a high number of responses and expand the areas covered by the FFT. Unless there is a significant improvement in individual care types this score will remain static

PALS

Commentary:
Number and complexity of PALS cases has increased, this has been compounded by sickness in the team. Target is 75% concerns closed in 5 days, the team have achieved this.

Planned Actions:
PALS team continue to provide a responsive service through email, phone and face to face. The team continue to build relationships with teams within the Trust to support swift responses to patients, carers, family and visitors.

The further training of ward clerk champions across both sites will enable earlier de-escalation of issues to support a reduction of enquiries and concerns.

Expected recovery:
The expected return of a member of staff in June 2024, regular review of process, contacts and improvement work to improve experience and reduce concerns

Patient Care: Mixed Sex Breaches

Commentary:
Mixed sex accomodation breaches are monitored daily by the Clinical Site Team and reported to the Deputy Chief Nurse. These are mostly linked to issues with patient flow, where patients cannot move to their next step within 4 hours.

Planned Actions:
Conitnue reporting and seeking approval
Focus from Site Team to correct MSA breaches is effective.

Expected recovery:
Minimal breaches are expected with a sustained and improved patient flow position.

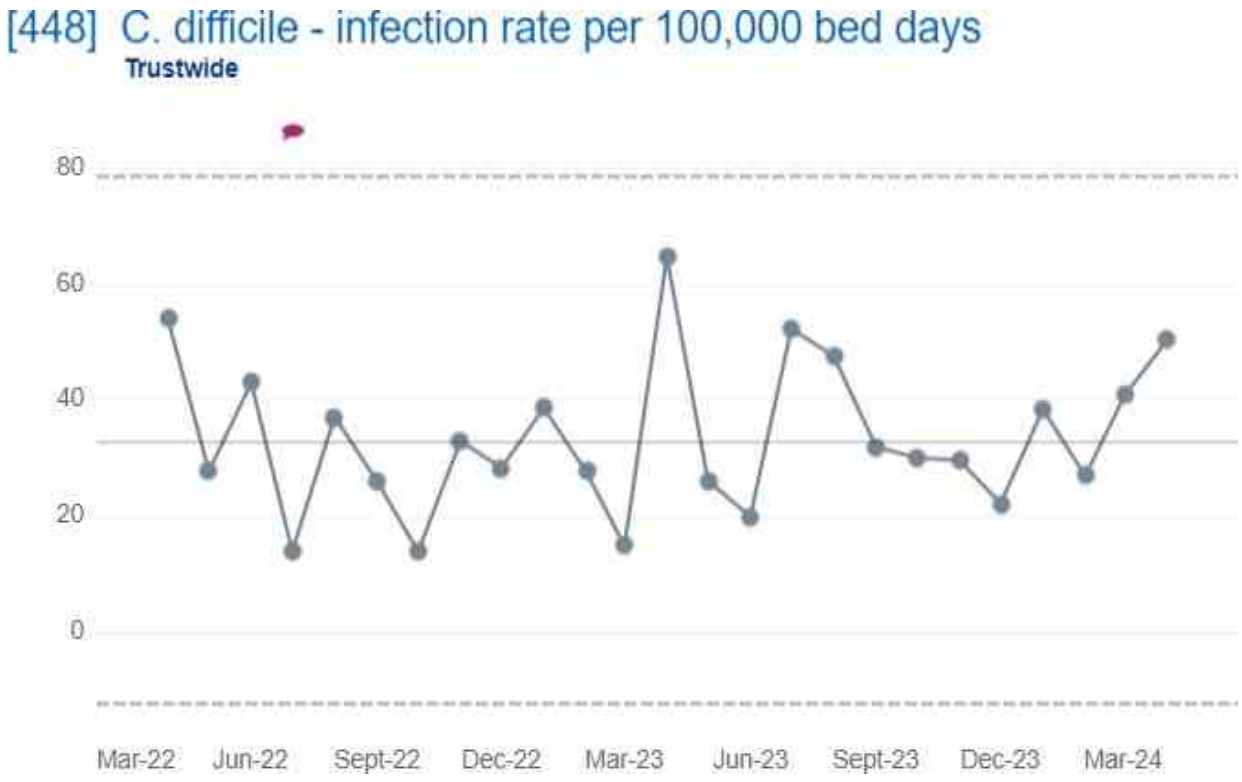
Patient Care: Boarded Patients

Commentary:
Work continues to progress boarding in a downward trajectory and balance the risk of ambulance handover-delays and beds closed due to infection control measures. Fortnightly safety huddles monitor risks and incidents and promote learning for a better patient experience.

Planned Actions:
A system-wide working group 'Working as One' continue with their action plan to address system issues.

Expected recovery:
The aim is to cease boarding by end July 2024

Infection Control: *C. diff*



Commentary:

The annual *C. difficile* limit for 2023/24 set by NHS England was 97 cases apportioned to the Trust, during 2023-2024 there were 106 cases, which meant the Trust breached the annual threshold. The annual CDI threshold for 2024/25 set by NHS England has not yet been published. From April 1st 2024, we have had 18 trust apportioned cases of *C. difficile.* Nationally and across the South-West region there has been an increase in the number of *C. difficile* cases.

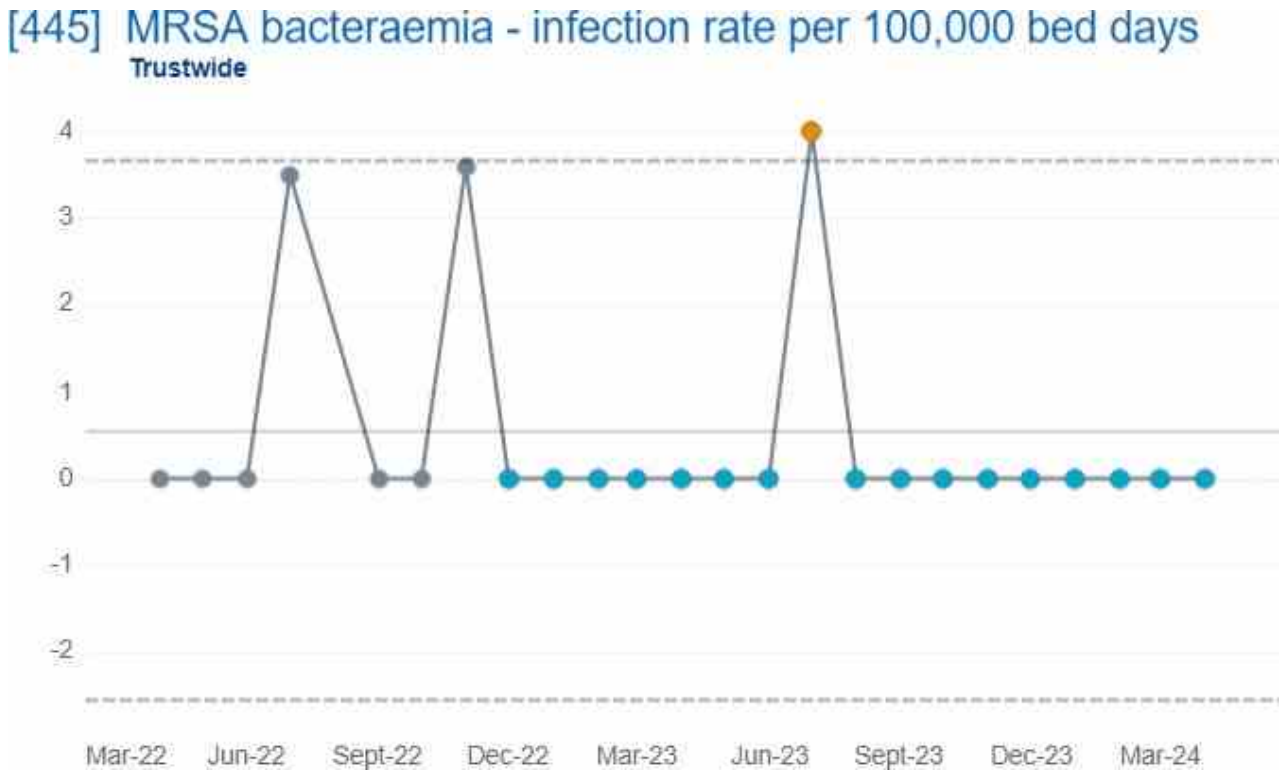
Planned Actions:

The Trust *C. difficile* reduction plan for 2024/2025 focuses on actions to address cleaning; equipment and environment (delivery of National standards of Cleanliness), antimicrobial stewardship, timeliness of stool sampling, prompt isolation of patients and optimising management of patients with *C. difficile.* Activity against this reduction plan is monitored by the Infection Control Committee. The Trust also chairs and supports a system wide *C. difficile* infection improvement group (CDIGG) which delivers system wide CDI actions to prevent CDI infections and recurrences for all patients across Gloucestershire. This activity is reported and monitored by the ICS IPC and ICS AMS groups which reports to the ICS Infection Prevention Management Group.

Expected recovery:

With implementation of the Trust and system wide improvement plans we aim to see a reduction in *C. difficile* cases compared to 2023/2024 rates therefore below 106 cases and 36.00 infections per 100,000 bed days). We also aim to either come below or meet the annual *C. difficile* threshold set by NHSE once these are published.

Infection Control: MRSA



Commentary:
The Trust has not had a MRSA bacteraemia case apportioned to the trust for 5 months. This includes any case defined as hospital onset (any case identified after day 1 of admission) or health care associated, whereby a patient has had healthcare within 4 weeks of their bacteraemia.

Planned Actions:
The Trust has a comprehensive MRSA screening programme, with the IPCT carrying out regular compliance audits which are fed into monthly meetings with DDQNs and ICC. All MRSA bacteraemias are investigated by the IPCT to support remedial action and learning. The Trust chair and supports a system wide Gram positive blood steam infection (BSI) improvement group, which focuses on reducing rates of both MRSA and MSSA BSIs, with a particular focus on reducing BSI risk factors and causes including invasive device care and management and skin and soft tissue infections. The IPCT also engage with the regional BSI improvement group

Expected recovery:
We continue to have and maintain a zero-tolerance approach to MRSA bacteraemias in line with national improvement thresholds.

Safety Priority: Patient Falls

Commentary:
Falls per 1000 bed days shows that the rate grew between October 23 and Mar 24. The rate is dependent on how many patients are occupying beds but does not reflect that fact the number of falls reported, takes into account patients who are repeat fallers, who despite review and appropriate interventions in place, will continue to fall due to pre-existing medical conditions/behaviours. This also does not take into account the acuity of the patients, enhanced care not provided, levels of staffing and unsafe environment

Planned Actions:
Continue with current falls plan, including training, reviewing of patients, improvement work in areas that are a cause for concern

Expected recovery:
It is difficult to predict a recovery due to the many exacerbators of falls such as acuity and dependency of patients and

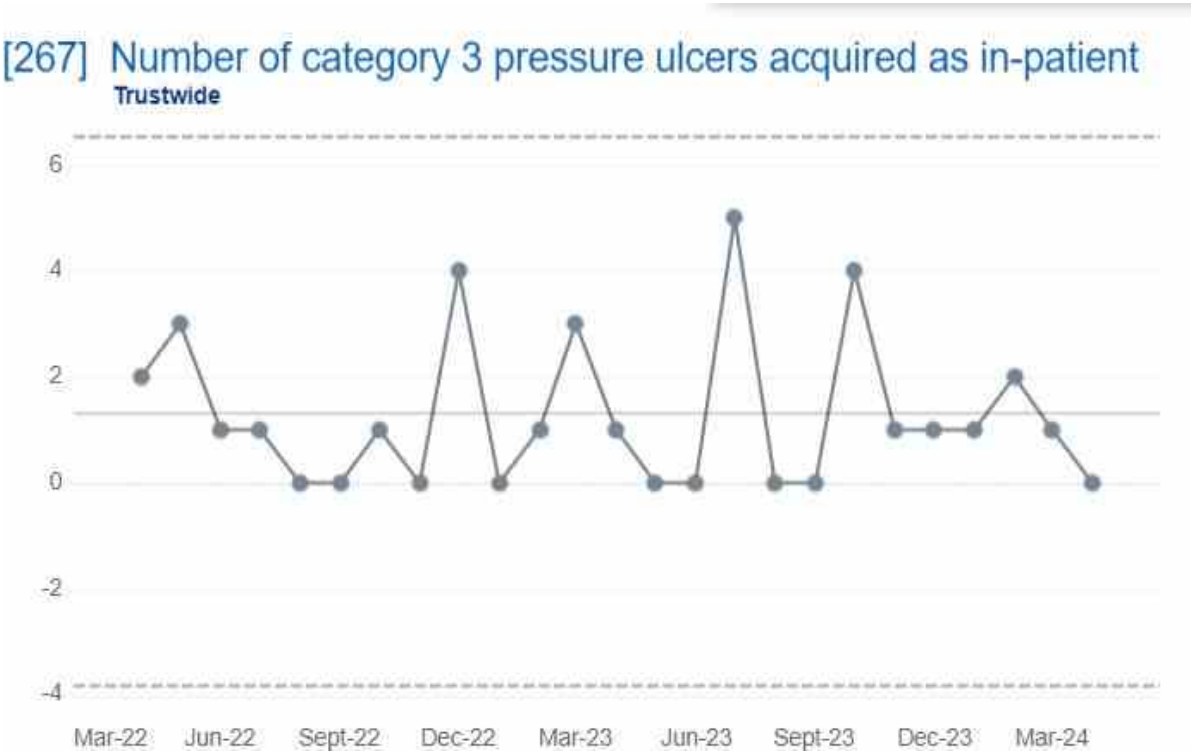
Safety Priority: Pressure Ulcers Cat2

Commentary:
All pressure ulcers continue to be a patient safety concern. Contributing factors include prolonged immobility in the **pre-hospital and emergency care stage** of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated by more patients on a ward than the staffing model accommodates, or gaps in staffing. Intentional-rounding mitigates some risk.

Planned Actions:
Improvement focus is on specialist review of all hospital acquired category 2 pressure ulcers and above. This gives assurance to the conformation of the category and allows for rapid intervention advice.
Specialist equipment for prevention of pressure ulcers has been procured and is available in the equipment library in both Gloucester and Cheltenham Sites.
The Tissue Viability Team deliver comprehensive simulated training in the prevention of pressure ulcers monthly at a variety of locations.

Expected recovery:
Implementing lessons learned can contribute to the downward trajectory of factors within our control

Safety Priority: Pressure Ulcers Cat3



Commentary:
All pressure ulcers continue to be a patient safety concern. Contributing factors include prolonged immobility in the **pre-hospital and emergency care stage** of admission and lack of repositioning. Intentional-rounding mitigates some risk.

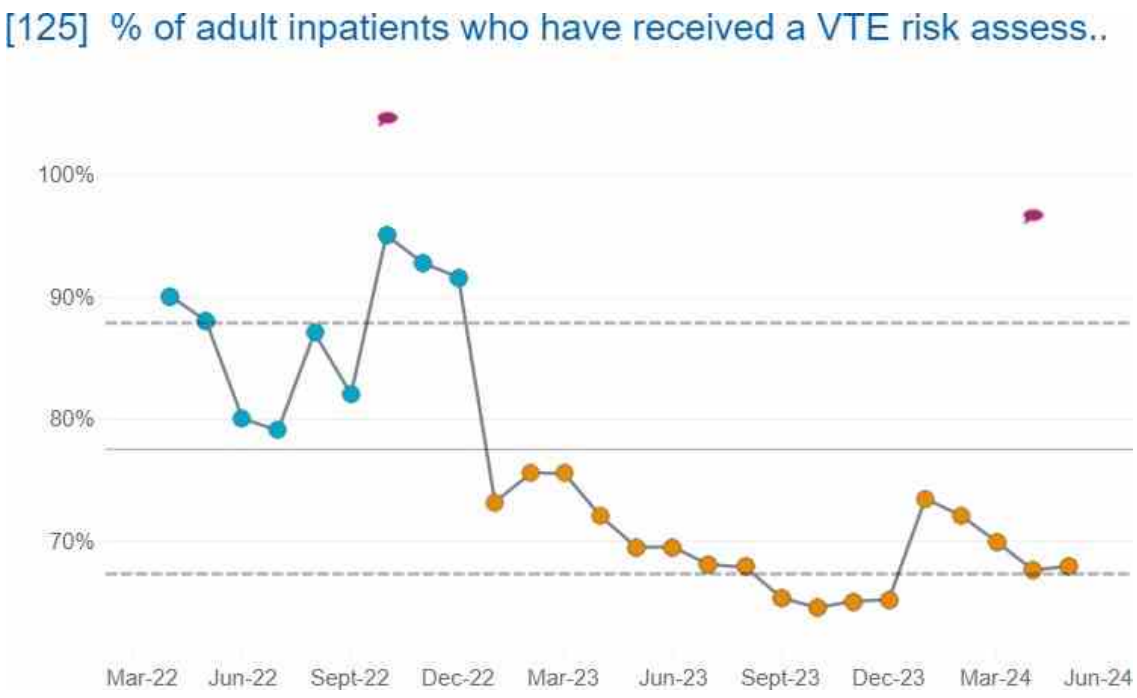
Planned Actions:
Improvement focus is on specialist review of all hospital acquired category 2 pressure ulcers and above. This gives assurance to the conformation of the category and allows for rapid intervention advice.

Specialist equipment for prevention of pressure ulcers has been procured and is available in the equipment library in both Gloucester and Cheltenham Sites.

The Tissue Viability Team deliver comprehensive simulated training in the prevention of pressure ulcers monthly at a variety of locations.

Expected recovery:
Implementing lessons learned can contribute to the downward trajectory of factors within our control

Patient VTE Risk Assessment



Commentary

- New VTE dashboard showed a snapshot compliance of completing VTE 90%. H0wever completing within 14hrs (NICE guidelines) is only 75%. Both numbers will be included once the dashboard goes live. The compliance of reassessment (if stay longer than 72hrs) is very low, however we are to concentrate getting the first VTE assessment being over 95%. Medical Division compliance very good; Surgical division less so.

Planned actions

- MD to continue to chair VTE group until improvement sustained
- Surgical Division developing a plan to improve compliance
- Maternity compliance very poor <65%. QI project re VTE assessment as part of CQC response to report to VTE group. Immediate improvement to 85% completion within 24 hrs and 75% within 6 hrs.
- DVT policy to review in July

Expected recovery

- Maternity recovery target: for admission VTE risk assessment to be completed 80% within 6 hours by 20/08/24 and >95% by 20/11/24
- Surgery tbc at next VTE group

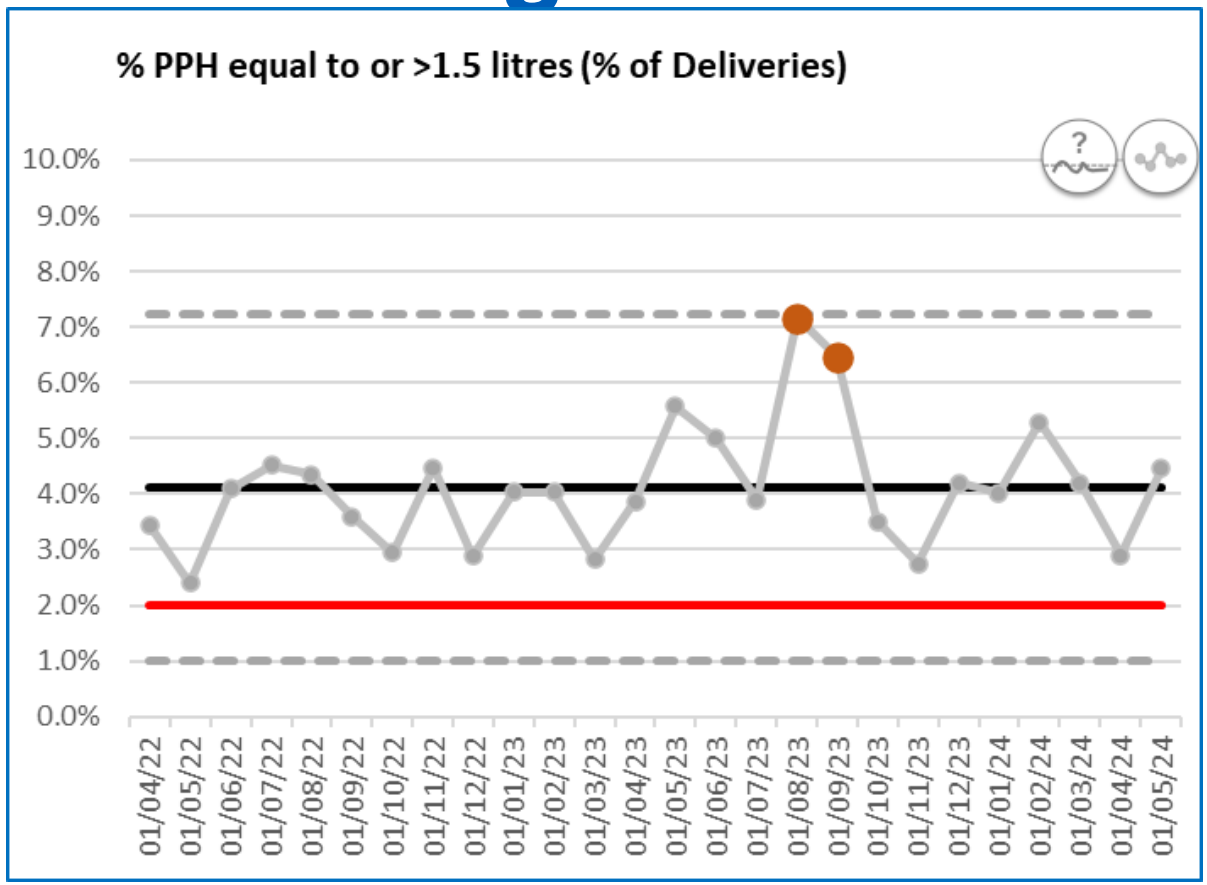
Patient Smoking Cessation

Commentary:
All patients admitted to hospital should be asked about their smoking status and this should be recorded on their clinical notes and referred to the Tobacco Free Team. Smoking should be treated like any other addiction, patients should be offered NRT upon admission.
Currently there is long term sickness in the team that is impacting on delivery.

Planned Actions:
VBA training sessions planned in GRH wards.
Trust wide comms reminder to record smoking status.
Contingency plan of recruiting advisors on Bank shifts.
Silver QI currently in process.

Expected recovery:
The tobacco free team will continue to deliver interventions on the wards.

Maternity Care: Postpartum Hemorrhage



Commentary:
Latest data is provisional for March 2024. There is a concern over maternal obstetric haemorrhage (MOH), noting that the % of births with MOH between April 2023 to Jan 24 has fluctuated from 2.5% to 6.7%, with an average of 4.5%, against the ambition of <2%. GHNHSFT have been submitting data nationally following implementation of Maternity EPR (BadgerNet). Prior to BadgerNet go-live in June 2023 data was not submitted. Data for last 12 months is now viewable on the GHNHSFT Maternal Morbidity and Mortality dashboard. The national data held indicates that the result in March is within the upper and lower bounds, however the increased rate locally necessitates a locally driven QI project

Planned Actions: Data for last 12 months is now viewable on the GHNHSFT Maternal Morbidity and Mortality dashboard. The QI project team are leading on the implementation of a new drug (Carbetocin) at Caesarean Section and a PPH Checklist - The Reduce Project

Expected recovery: Oversight and actions associated with QI methodology

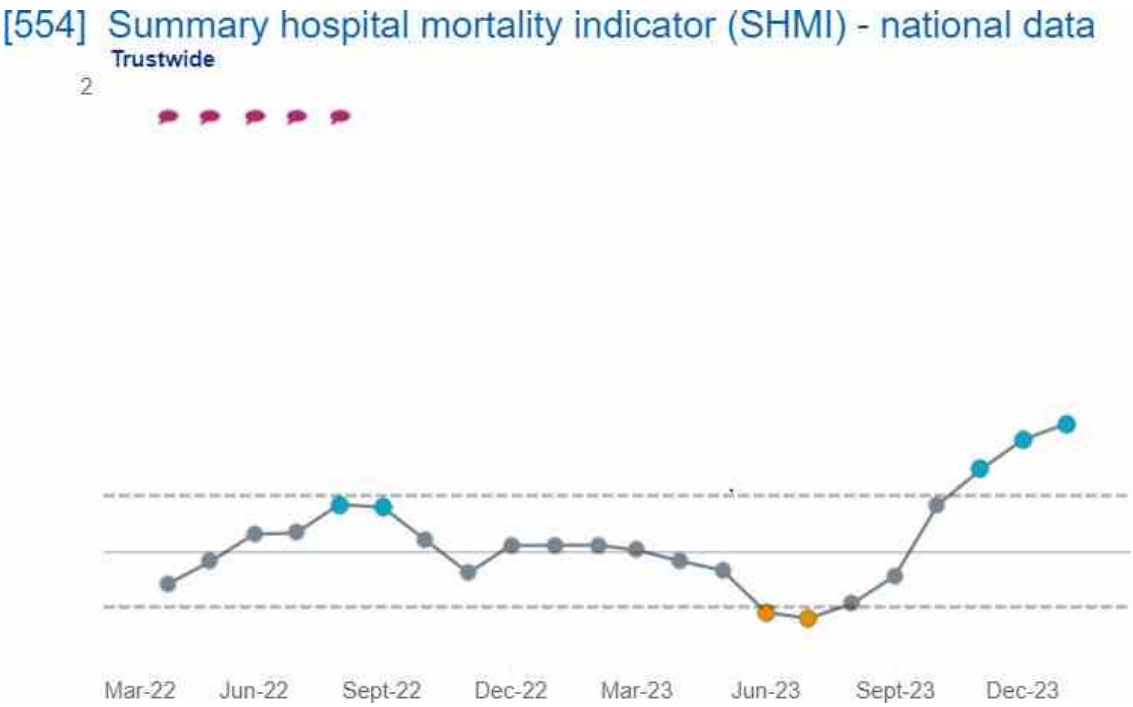
Patient Harm: Medication

Commentary:
Daily reporting of incidents with harm at the Incident Response Safety Huddle to identify immediate learning.

Planned Actions:
Maintenance of medication error surveillance and action on issues identified and learning.

Expected recovery:
N/A

Mortality – SHMI National Data



Commentary:

Increasing SHMI (NHS Digital) over last 3 months Hospital Mortality Group monthly, reviewing action plan to address clinical/coding issues

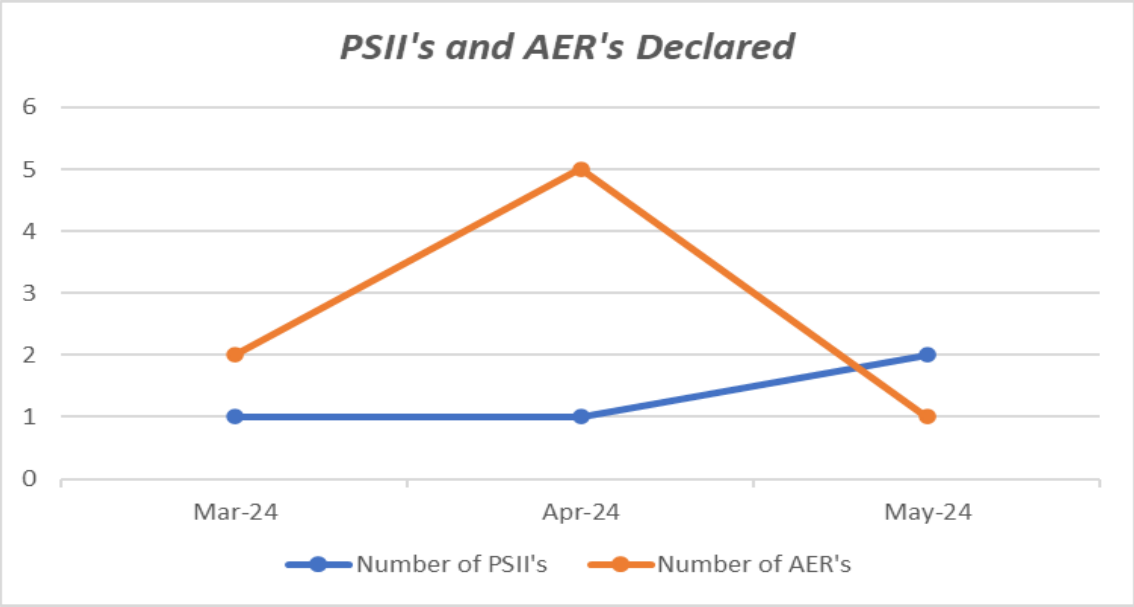
Planned Actions:

Primary Diagnosis coding work
Dementia coding work
Clinical Audits to review care/comorbidities/coding in:
- COPD
- Septicaemia

Weekend/weekday ICB Clinical Audit
Delay Related data shared with GHT/ICB and to link with Clinical Vision of Flow work
Neck of Femur Action Plan

Expected recovery:
SHMI is a 12 months rolling data metric and these actions will therefore take3-6 months before an improvement is seen.

PSII and AER



Commentary:

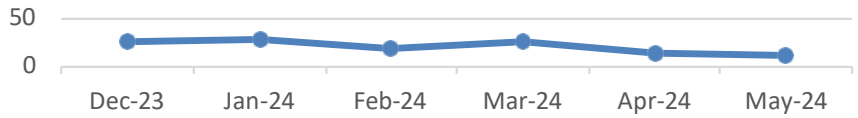
PSII – Patient Safety Incident Investigation. Declared when a problem in care is considered to have contributed to death, or a safety concern is such that a detailed systems approach investigation is indicated

AER – After Event Review. Declared when there is potential for a Duty of Candour disclosure and/or there is a need for further information to inform action/learning to reduce the risk of recurrence

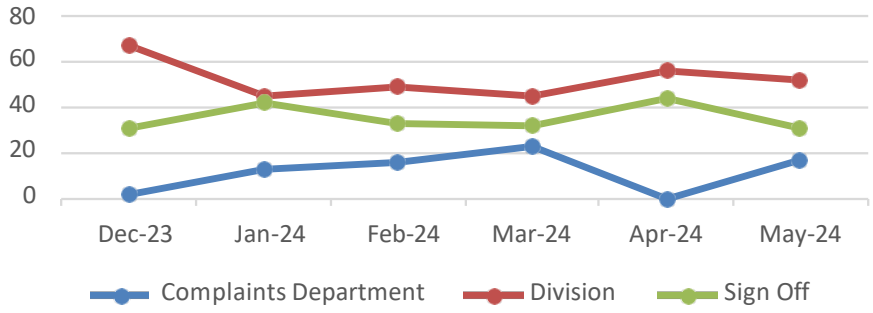
Complaints

Standard: Increase the percentage response rate to 60% by June 2025

Percentage of Complaints Closed within agreed (35 or 65 days) timeframes



Contributing Factors for Delay



Commentary:

Ability to provide responses is adversely affected by the number of complaints received, delayed responses from clinical teams, delays to sign off and workforce issues in the complaint department.

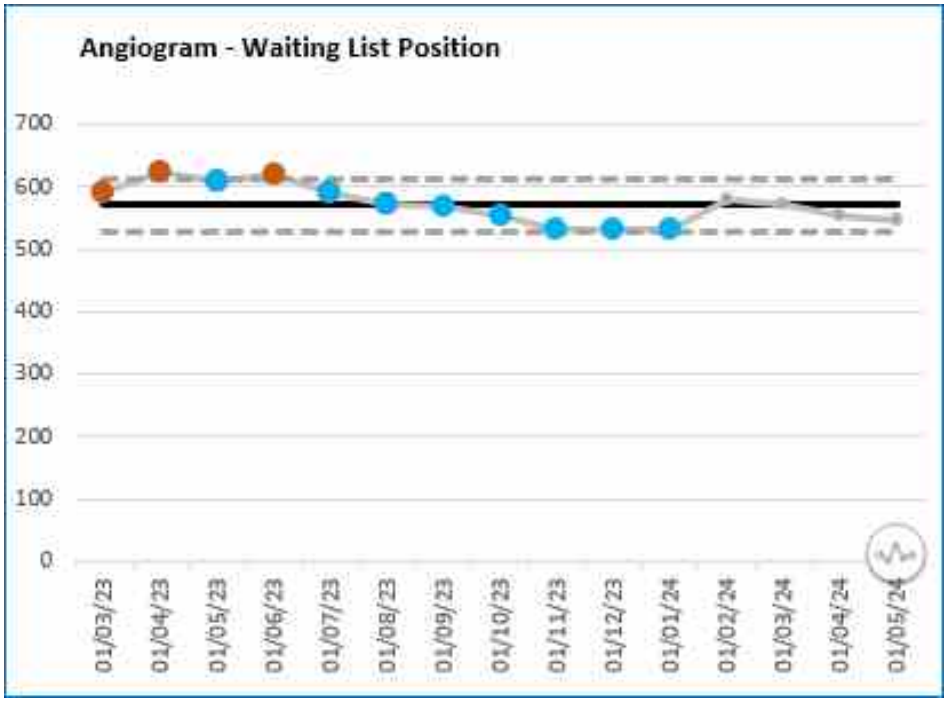
Planned Actions:

- 3 x weekly triage meeting
- Early local resolution meetings/clinical debrief
- Continued collaboration with PALs; enabling immediate resolution of concerns
- Increased oversight/accountability of Divisional Leadership teams
- Refine escalation process for delayed responses
- Use of standardised responses for known
- Executive Director and CEO support with chasing delayed responses

Expected recovery:

Recovery will be adversely affected by the resignation of two B3 Complaint Administrators in May 2024.

Angiogram - Waiting List Position



Commentary:
Daily reporting of incidents with harm at the Incident Response Safety Huddle to identify immediate learning.

Planned Actions:
Maintenance of medication error surveillance and action on issues identified and learning.

Expected recovery:
N/A

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NHS Foundation Trust

Report to Board of Directors meeting in Public

Agenda item:	15	Enclosure Number:	
Date	2 July 2024		
Title	Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training for April 2023 – March 2024.)		
Author **Director/Presenter**	Dr Shyam Bhakthavalsala, Guardian of Safe Working Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO		

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

1. A total of 439 exception reports have been raised from the beginning of April 2023 to the end of March 2024.
2. No fines have been levied during that period.
3. The overall rate of exception reports has dropped slightly, though there has been a larger number of reported ISCs. No broad themes have been identified among these.
4. A total of £4029.80 was paid to junior doctors because of exception reporting of additional hours worked,
5. In addition, 28 hours have been given as time off in lieu due to additional hours worked and reported to GOSW.
6. A new Guardian of Safe Working has been in post from September 2023.

Recommendation

That the Board notes the report for assurance and information.

Enclosures

Annual Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training.

Annual Report of the Guardian of Safe Working Hours (GOS for Doctors and Dentists in Training

For Presentation to Public Board
Thursday, July 11th, 2024

1. Executive Summary

1.1 This annual report covers the period of 1st April 2023 to 31st March 2024.

1.2 During this period, there were 439 exception reports logged, 22 of which have been reported as an immediate safety concern. Most exception reports are related to extended working hours and have been closed with additional payment or time off in lieu.

1.3 0 fines were levied.

2. Introduction

2.1 Under the 2016 Terms and Conditions of Service (TCS) for Junior Doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the Board of compliance with safe working hours' limits. The Terms and Conditions have been updated in 2019, with further requirements being monitored.

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

High level data

Number of doctors / dentists in training (total): OBJ	412
No. of trust doctors	125
Total Junior doctors	537
Amount of time available in job plan for GOSW: OBJ	1PA
Allocated administrative support: OBJ	4Hrs
Amount of job-planned time for educational supervisors:	0.25/0.125 PAs

(first/additional trainees to maximum 0.5 SPA)

3. Junior Doctor Vacancies

Department	**Additional training and trust grade vacancies**
ED	**3x ST1/2** **8X Trust Registrar** **1 Chief Reg**
T&O	**2x Trust Dr (ST3) 1 x St3**
Surgery	1 x StR 1 Upper GI & Colorectal Surgery 1 Chief Reg
General Medicine	**1x Cardiology St1/2** **1x Cardiology Clinical Fellow** **1 x Registrar COTE/Stroke** **1 Trust Reg Respiratory** **6 Trust StR 3 Acute** **2 Trust StR 1 Acute** **1 F1 Acute** **2 F2 Acute** **9 Undergraduate Fellows** **1 Chief Reg**
Women's & Children's	**2 x St1 Paediatrics** **1 StR 1 obs & gynae**

(Based on data available in April 2024)

4. Medical Agency and Bank for Junior Doctors

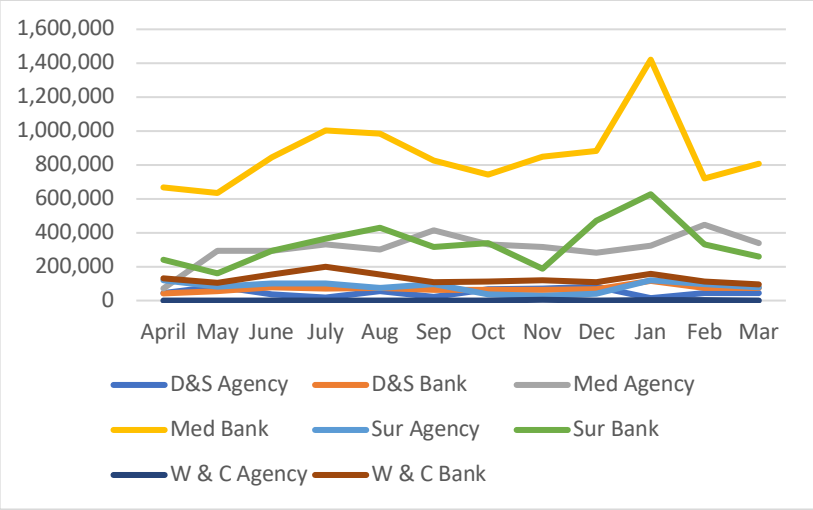
4.1 This data is supplied by Finance.

4.2 The total expenditure on agency and bank locum cover, across all divisions, over this period was £22,119,620. This also includes the cost of covering junior doctor industrial action.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Monthly breakdown of medical agency and Bank Spend by Division

Month	Type	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
D&S	Agency	43,800	83,610	37,590	17,950	56,741	21,643	66,264	70,913	83,142	14,309	42,540	42,562	581,063
D&S	Bank	41,951	54,885	77,634	71,698	75,634	61,694	63,925	63,287	68,477	115,928	72,764	76,297	844,176
Med	Agency	71,076	294,259	294,166	330,036	302,465	412,511	329,980	317,080	283,512	323,051	447,043	339,860	3,745,039
Med	Bank	666,053	634,423	845,739	1,004,270	985,180	824,713	742,273	849,849	884,193	1,421,134	721,139	807,725	10,386,693
Sur	Agency	119,172	81,835	101,591	101,393	74,611	97,285	35,861	27,921	42,121	119,797	95,397	78,502	975,484
Sur	Bank	240,682	160,447	294,114	365,772	430,273	315,783	336,941	186,230	472,570	627,222	331,748	257,834	4,019,614
W & C	Agency	0	0	0	0	0	0	0	4,675	0	976	3,356	0	9,007
W & C	Bank	130,276	105,813	152,029	199,243	155,072	107,392	111,188	121,405	109,847	157,332	113,647	95,303	1,558,545
TOTAL	Agency	234,048	459,704	433,346	449,379	433,817	531,438	432,105	420,590	408,774	458,132	588,336	460,924	5,310,593
TOTAL	Bank	1,078,962	955,568	1,369,516	1,640,984	1,646,159	1,309,582	1,254,327	1,220,771	1,535,086	2,321,616	1,239,298	1,237,159	16,809,027
TOTAL	Agency	1,313,009	1,415,272	1,802,863	2,090,363	2,079,976	1,841,020	1,686,432	1,641,360	1,943,860	2,779,748	1,827,634	1,698,083	22,119,620



Total Locum Expenditure during the period April '23 - Dec '23

Division		TOTAL
D&S	Agency	581,063
	Bank	844,176
Med	Agency	3,745,039
	Bank	10,386,693
Sur	Agency	975,484
	Bank	4,019,614
W & C	Agency	9,007
	Bank	1,558,545

TOTAL	Agency	5,310,593
TOTAL	Bank	16,809,027
TOTAL	Agency + Bank	22,119,620

5. Additional Cost

5.1 A total of £4,029.80 was paid to junior doctors because of exception reporting of additional hours worked in the last year.

5.2 A total of 28 hours was given as time off in lieu as a result of exception reporting of additional hours worked.

6. Exception Reports

6.1 A total of 439 exceptions have been reported during the period April '23 - March '24 including 22 exceptions reported as immediate safety concern. This contrasts with 475 reports with 10 ISCs for the previous year.

6.2 The following exception reports were raised across specialties:

Exceptions Raised				
Specialty	***Working Hours***	***Educational Opportunities***	***Service Support Available***	***Of which, no. of ISCs***
A&E	18	0	1	
General Medicine	250	14	11	13
General Surgery	60	10	12	5
Anaesthetics	1	0	0	
Obstetrics & Gynaecology	2	0	0	1
Paediatrics	13	0	1	2
ENT	17	0	0	0
Oncology	17	0	0	0
Ophthalmology	2	0	0	0
Orthopaedics	4	2	0	0
SUB-TOTALS	**384**	**26**	**25**	**22**
TOTAL EXCEPTION REPORTS inc. ISCs = 439				

7. Fines Levied

7.1 For the period 1 April 2023 to 30 March 2024, no fines have been levied.

8. Issues Arising

8.1 There were 22 ERs with immediate safety concerns, 9 of which related to hours or pattern and 12 relating to service support, including inadequate time for handover. There does not appear to be a recurring pattern and on a positive note, no ISCs have been reported in the last month.

9. Actions Taken to Resolve Issues

9.1 A new Guardian of Safe Working has been appointed from 01/09/2023 with 1 PA time allocation. The post remained unoccupied between April '23 to September '23, with most of the duties

being carried out by the Medical Director's office. It was decided that the Medical Director's office would continue to undertake necessary data collection and support for preparing board reports, allowing the Guardian to focus on issues being raised through Exception Reports and follow up liaison with Junior Doctors. However, this has not happened yet due to vacancies in the Medical Director's office. With the appointment of the new Governance lead, it is hoped that more support will be available for the role of GOSW.

9.2 As GOSW, I would follow up all exception reports raised as an immediate safety concern with a view to escalating to the medical director's office where necessary. I would also review exception reports to identify themes and patterns and those which appear stalling at the local level. Trainees can also contact me by email if they feel their concerns have not been addressed. Any exception reports relating to education matters are referred to the Director of Medical Education, Dr Preetham Boddana, for oversight or follow up when necessary..

9.4 Administrative support for the Guardian of Safety Work Hours has been minimal and finding information outside of the 'Allocate' reporting system particularly challenging, presumably due to staff shortages in medical staffing.

10. Post Graduate Doctors Forum

10.1 The Postgraduate Doctor's forum (previously Junior doctors forum) is expected to meet every other month and is a useful forum for juniors to raise any issue of concern and keep informed of current business issues within the Trust. Though there had been a gap in these meetings, they have now resumed regularly and are well attended.

10.2 As GOSW, I would attend these meetings whenever possible. I would also get regular updates from PGDF chair and would discuss any concerns as appropriate.

10.3 There were unspent monies raised previously through GOSW fines – these are now being utilized for purchasing new furniture and coffee pods for the doctor's mess as well as paying for selfcare and preventing burnout webinars that juniors can access.

11. Summary

11.1 439 exception reports have been raised from the beginning of April 2023 to the end of March 2024.

11.2 No fines have been levied during that period.

11.3 The overall rate of exception reports has dropped slightly, though there has been a larger number of reported ISCs. No specific themes or patterns have been identified on further review.

11.4 A total of £4029.80 was paid to junior doctors because of exception reporting of additional hours worked in the las year.

11.5 In addition 28 hours have been given as time off in lieu due to additional hours worked and reported to GOSW.

11.6 A new Guardian of Safe Working has been in post from September 2023.

Author: **Dr Shyam Bhakthavalsala, Guardian of Safe Working**

Presenting Director: **Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO**

Date: **09.11.2023**

Recommendation
For assurance
To approve

Appendices:
Link to Rota rules factsheet:
Rota rules at a glance | NHS Employers

Link to exception reporting flow chart (safe working hours):
Safe-working-flow-chart-orange (nhsemployers.org)

NHS
Gloucestershire Hospitals
NHS Foundation Trust

People and Organisational Development Performance Dashboard

May 2024

Deborah Tunnell
Deputy Director for People & Organisational Development

the Best Care for Everyone
care / listen / excel

Executive Summary

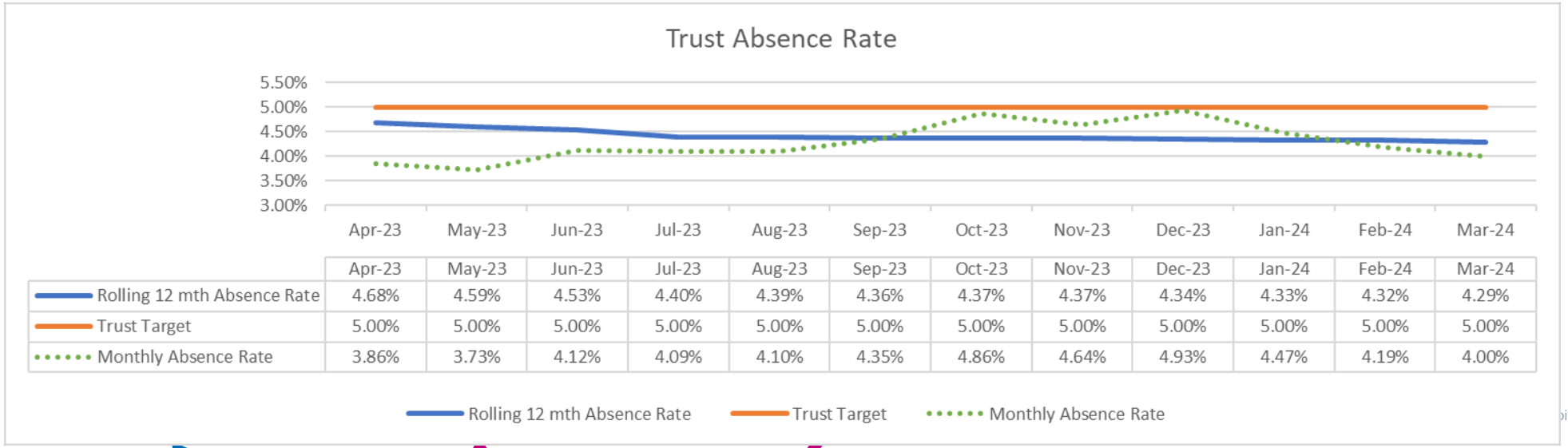
Performance Indicator	Target	April-23	May-23	June-23	July-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan 24	Feb 24	Mar 24
Turnover	**13%**	13.05%	12.62%	12.23%	12.12%	11.65%	11.56%	11.38%	11.37%	11.27%	11.06%	10.82%	10.93%
Vacancy	**8%**	7.61%	7.67%	7.40%	7.05%	7.05%	6.31%	6.43%	5.86%	6.54%	6.90%	6.65%	6.59%
Sickness	**5%**	4.67%	4.58%	4.52%	4.40%	4.27%	4.34%	4.36%	4.36%	4.34%	4.33%	4.32%	4.29%
Appraisal	**90%**	81%	80%	80%	79%	79%	79%	79%	79%	80%	79%	79%	78%
Essential Training	**90%**	87%	88%	88%	87%	87%	87%	86%	86%	85%	85%	86%	85%
Agency (FTE & % of establishment)	**2%**	144 (1.9%)	144 (1.9%)	176 (2.3%)	177 (2.2%)	167 (2.1%)	160 (2.1%)	122 (1.6%)	111 (1.4%)	104 (1.3%)	119 (1.5%)	132 (1.7%)	132 (1.7%)
Bank (FTE & % of establishment)	**6.5%**	745 (9.8%)	674 (8.8%)	643 (8.4%)	670 (8.4%)	714 (9.2%)	697 (9.0%)	650 (8.4%)	689 (8.8%)	679 (8.7%)	667 (8.4%)	742 (9.3%)	736 (9.3%)

■ **Red:** (10% over target) | ■ **Amber:** (within 10% of target) | ■ **Green:** (achieved/better than target)

Absence: Sickness (BAF SR16 Workforce - Culture, Experience and Retention)

Key Points to note
Sickness absence has seen a 0.03% decrease from Feb 24 to Mar 24 at 4.32%
March 2024 is the twelfth consecutive month when sickness absence has been recorded below the Trust target of 5%.
March 2024 sickness absence is currently 0.71% under the Trust target.

Improvement actions	Due Date	RAG
The Sickness Absence project under the Workforce Sustainability Programme has not progressed due to the Lead leaving post. The HR Operations Manager will pick up and progress, identifying with stakeholders the priorities and specific areas of focus.	May 2024	
The People Advisory Team have additional training in the use of ESR scheduled for 8th May. HR Operations Manager will ensue that all team members are confident and proactive in using ESR and supporting managers with Data led discussions.	May 2024	
A Sickness Management workshop delivered to the Medicine Division manager by the HR Operations Manager.	April 2024	

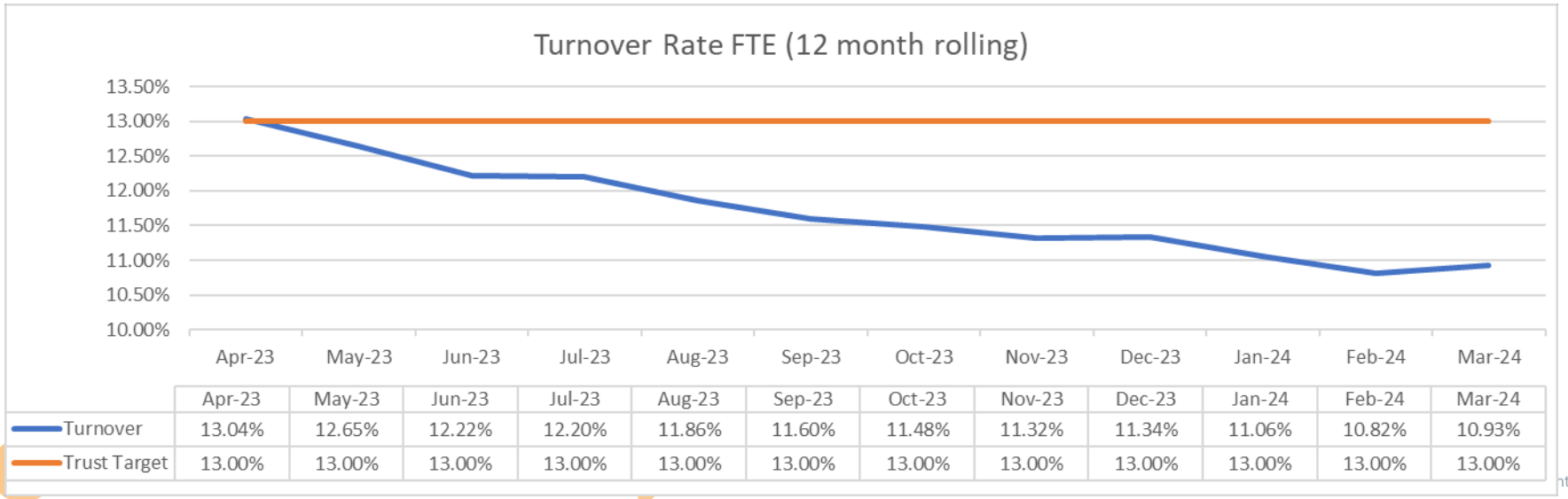


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Rolling 12 mth Absence Rate	4.68%	4.59%	4.53%	4.40%	4.39%	4.36%	4.37%	4.37%	4.34%	4.33%	4.32%	4.29%
Trust Target	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Monthly Absence Rate	3.86%	3.73%	4.12%	4.09%	4.10%	4.35%	4.86%	4.64%	4.93%	4.47%	4.19%	4.00%

Turnover (BAF SR16 Workforce - Culture, Experience and Retention)

Key Points to note
Staff trnover has seen a 0.11% increase from Feb 24 to Mar 24, with 10.93% recorded in Mar 24.
January 2024 is the first month to see a slight increase in turnover since Apr 23 but the twelfth consecutive month when turnover has remained under the Trust target of 13%.
March 2024 Turnover is currently 2.07% under the Trust target.

Improvement Actions	Due Date	RAG
The Staff Experience Improvement Programme continues with its focus across the three core workstreams, each with defined action target dates.	Ongoing	
The Retention Group is making progress with three projects: Improving the exit process, Flexible retirement policy and transition from substantive to bank. A dedicated Exit/leavers page has been published on the intranet as a one-stop shop for all papers/materials relating to leavers.	Ongoing	
The People Promise Partner has been appointed and is scheduled to commence in post May 2024	May 2024	



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Turnover	13.04%	12.65%	12.22%	12.20%	11.86%	11.60%	11.48%	11.32%	11.34%	11.06%	10.82%	10.93%
Trust Target	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%

Statutory & Mandatory Training (BAF SR16 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

	Compliance (See Notes)	
	29-Feb	31-Mar
CSTF Statutory and Mandatory Training Competencies		
GHT Total Compliance	86%	85%
Breakdown by Division		
Corporate	91%	90%
Diagnostics & Specialty	88%	87%
Medicine	86%	86%
Non-Division	82%	82%
Surgery	84%	83%
Womens & Children	80%	80%
Breakdown by Training Competency		
318|LOCAL|Moving and Handling Level 2 (2yr)|	85%	85%
318|LOCAL|Safeguarding Adults Level 2|	43%	46%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	92%	91%
NHS|CSTF|Fire Safety - 1 Year|	89%	88%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	92%	91%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	97%	97%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	85%	84%
NHS|CSTF|Information Governance and Data Security - 1 Year|	89%	87%
NHS|CSTF|Moving and Handling - Level 1 - 2 Years|	88%	87%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	93%	93%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year| *	86%	84%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	90%	89%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	89%	89%
NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	87%	87%

Key Points to note

The Trust's overall compliance has decreased by 1% from Feb 24 at 85%.

No Division has seen an improvement from Feb 24 to Mar 24. Corporate Services, Diagnostics and Surgery divisions have seen a decrease from Feb 24 to Mar 24.

Safeguarding Adults L2 and Information Governance remain non compliant.

Improvement Actions	Due Date	RAG
Head of Corporate Learning & Development has commenced a full Stat/Man review, working with stakeholders to review the numbers of programmes, relevancy and ability to undertake the requirements	August 2024	
NHS England Statutory and Mandatory Training Programme requires NHS Trusts to ensure 11 core subjects are fully aligned to the latest Core Skills Training Programme	June 2024	
NHS England Statutory and Mandatory Training Programme requires NHS Trusts to fully implement the free e-Learning for healthcare training packages including the shorter e-Assessments for all Core Skills Training	October 2024	
A review of the current content of Safeguarding is being undertaken, including the way it is reported across the higher levels (L2 & L3). The Safeguarding SME is also identifying whether there is an appetite to develop an ICB/ICS wide safeguarding training offering	April 2024	

Appraisal (BAF SR16 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

	Compliance	
	29 Feb	**31 Mar**
GHT Total	**79%**	**78%**
Breakdown by Division		
Corporate	74%	74%
Diagnostics & Specialty	75%	74%
Medicine	83%	83%
Non-Division	83%	88%
Surgery	83%	81%
Womens & Children	74%	76%
Breakdown by Staff Group		
Add Prof Scientific and Technical	59%	60%
Additional Clinical Services	83%	82%
Administrative and Clerical	73%	71%
Allied Health Professionals	75%	76%
Estates and Ancillary	76%	75%
Healthcare Scientists	78%	76%
Medical Staff - Consultants	88%	93%
Medical Staff - SAS Senior	76%	74%
Nursing and Midwifery Registered	82%	81%

Key Points to note
The Trust has seen a 1% decrease in overall compliance at 78% in Mar 24
With the exception of W&C and Non Div who has seen a 2% & 5% increase in compliance respectively, all other Divisions have not seen an increase in compliance from Feb to Mar 24.
Apart from two groups, all staff groups saw an decrease in compliance from Feb 24 to Mar 24. Medical Consultants saw the greatest increase of 5%.
Healthcare Scientists & SAS Senior Doctors have seen the greatest decrease in compliance of 2% from Feb 24 to Mar 24. Allied Health Professionals are the only staff group to have seen an increase (1%) from Feb 24 to Mar 24.

Improvement Actions	Due Date	RAG
Review and rewrite of non-medical appraisal policy, procedures and paperwork is underway. Project plan updated. Planned launch now early July 2024	July 2024	
Review of training support for appraisers and appraisees to be developed, alongside refreshed policy and paperwork	June 2024	
New draft paperwork being tested with sample of stakeholders in Trust. Feedback window extended to accommodate Easter and sickness absence in team. Now being pulled back on track and expected to fall in line with expected launch early July.	July 2024	

Health and Safety BAF SR16 Workforce - Culture, Experience and Retention)

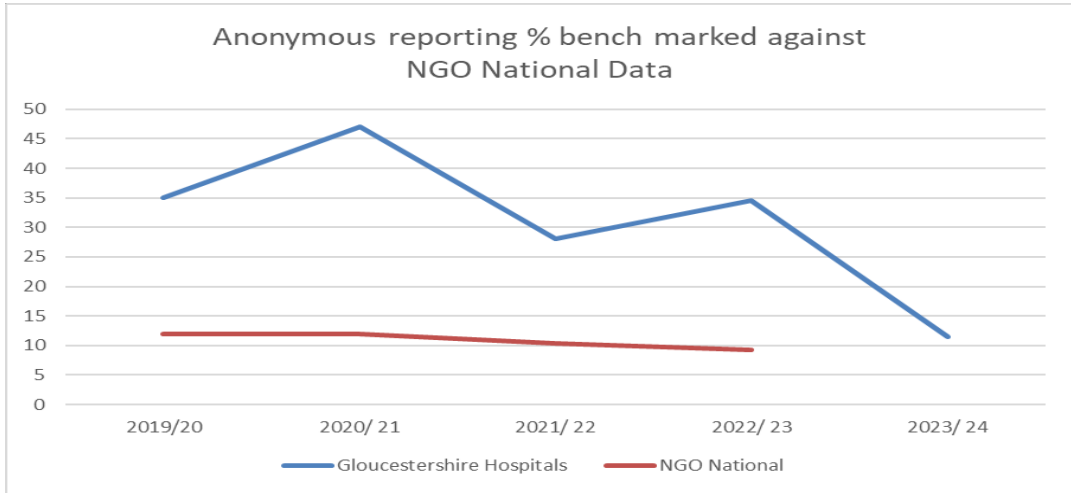
Key Points to note
The Trust was issued with a Notice of Contravention (NoC) letter on 4 April 2024
An NoC informs an organisation that the Inspector suspects or has seen something that is a breach of a regulation. It requires the Trust to respond and to outline what it will do to resolve any concerns highlighted. An NoC is not an Improvement Notice, the latter being a formal 'must improve' approach with a strict deadline.
The letter notes two material breaches: Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) and 7 in relation to managing violence and aggression Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) / The Manual Handling Operations Regulations 1992, Regulation 4 in relation to managing manual handling risks
Five key actions are required in order to achieve compliance by 31 May 2024

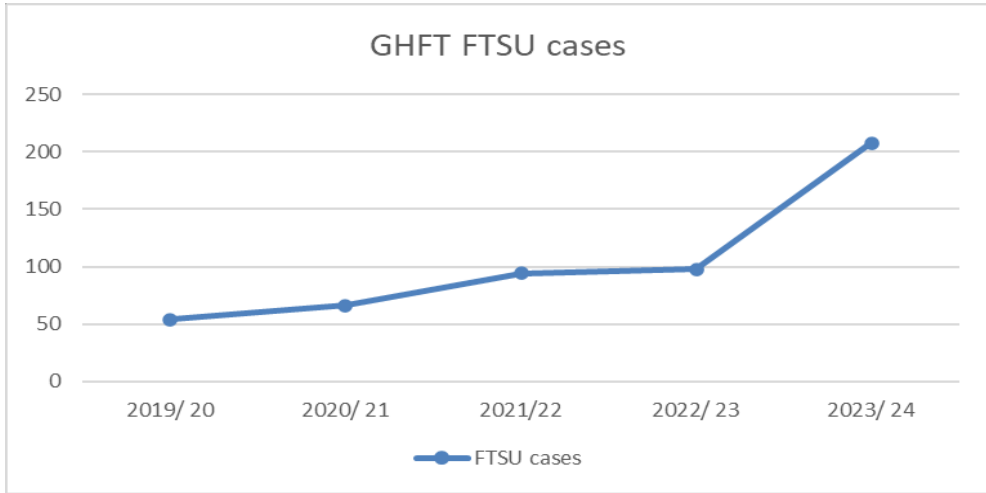
Improvement Actions	Due Date	RAG
Develop an action plan in response to the HSE NoC and set up a monitoring group to progress the actions by the 31 May 2024	April 2024	
HSE action plan - action owners to progress their actions in a timely manner	May 2024	
Ventilation issues relating to Entonox will be raised at the Ventilation Group. The report has been drafted and will be submitted to the next Group.	May 2024	
Formalin Investigations - these are now complete and the final reports are being prepared for circulation.	May 2024	
Fire safety - extraordinary meeting. This took place in April 2024. Further work is required by the Associate Director of Estates to prepare a costed action plan for consideration. This was also discussed at TLT in April 2024.	May 2024	

Freedom to Speak Up (BAF SR16 Workforce - Culture, Experience and Retention)

Key Points to note
FTSU had a total of 208 cases this last year in comparison with 98 last year. Anonymous reporting has seen an over reduction with comparisons with national reporting seen below. 62 cases remain open to date.
Overall case data for last year is now available with inappropriate and poor behaviours absorbing nearly half of all cases.
Themes have been captured in the FTSU service as fear of speaking up; discrimination; poor experience as new starters; poor experience as a disabled person requiring reasonable adjustments; nepotism in recruitment and general poor behaviours witnessed or experienced in the organisation.

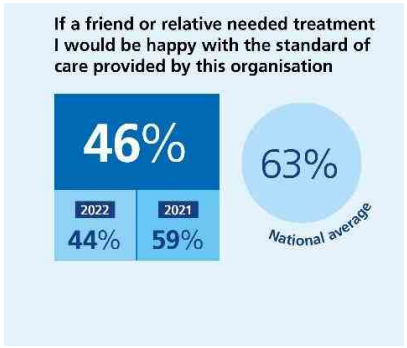
Improvement Actions	Date Due	RAG
A 0.4 WTE FTSU Guardian has been appointed on 23 month fixed term	Achieved	
Review of patient safety concerns raised to FTSU. Terms of Reference set Jan 2024	In progress, due Q1	
Development of FTSU Champion network	July 2024	





Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)

Staff Survey 2023 Net Promoter Scores

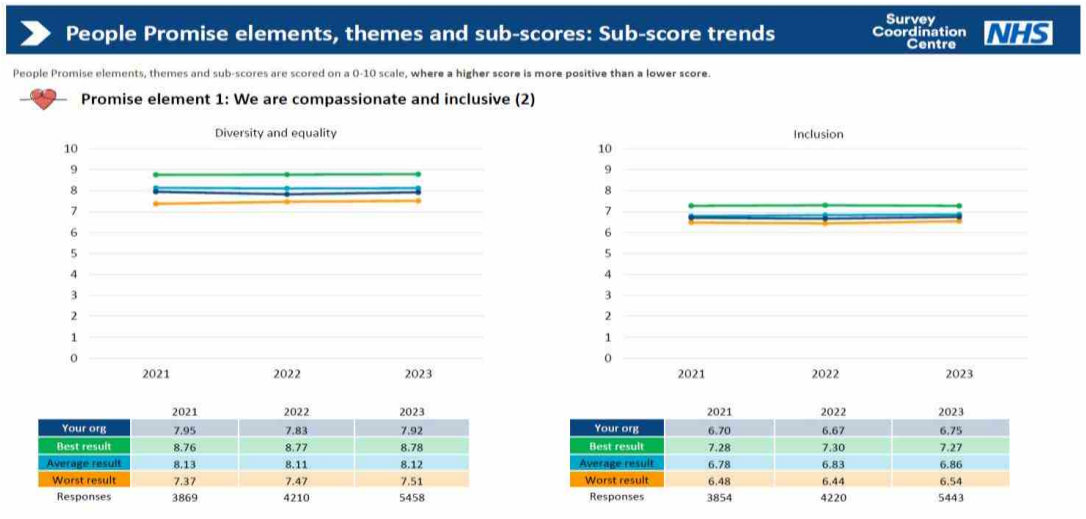


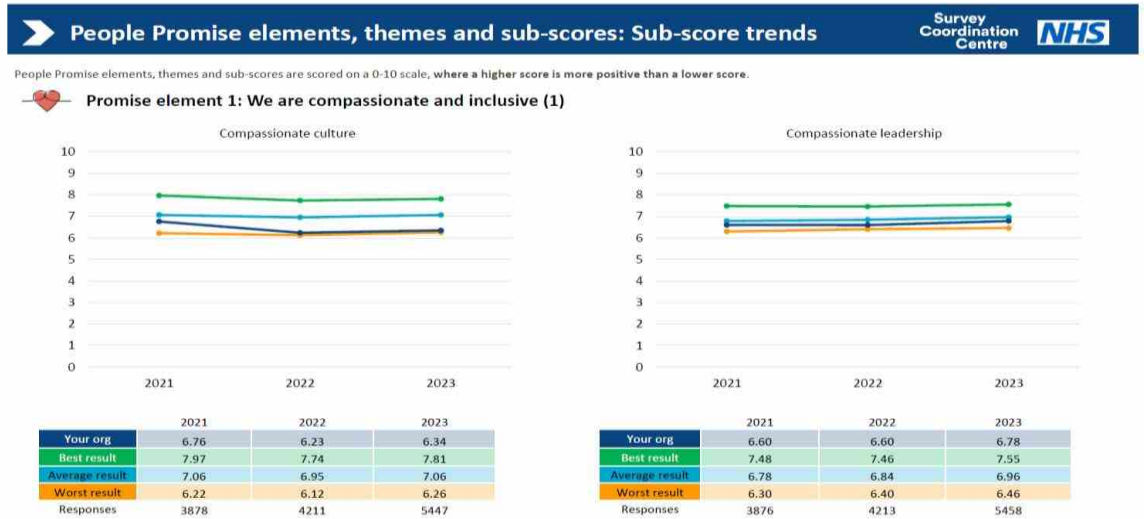
Key Points to note

The 2023 staff survey results show that more staff are recommending our Trust as a place to work and as a place to receive care compared to 2022:
Would you recommend this organisation as a place to work? 46% (up from 43% in 2022).
If a friend or relative needed treatment would be happy with the standard of care? 46% (up from 44% in 2022).

Our 2023 results are still below the national average for compassionate culture and compassionate leadership and Diversity, Equality and Inclusion, however small improvements can bee seen from the 2022 results.

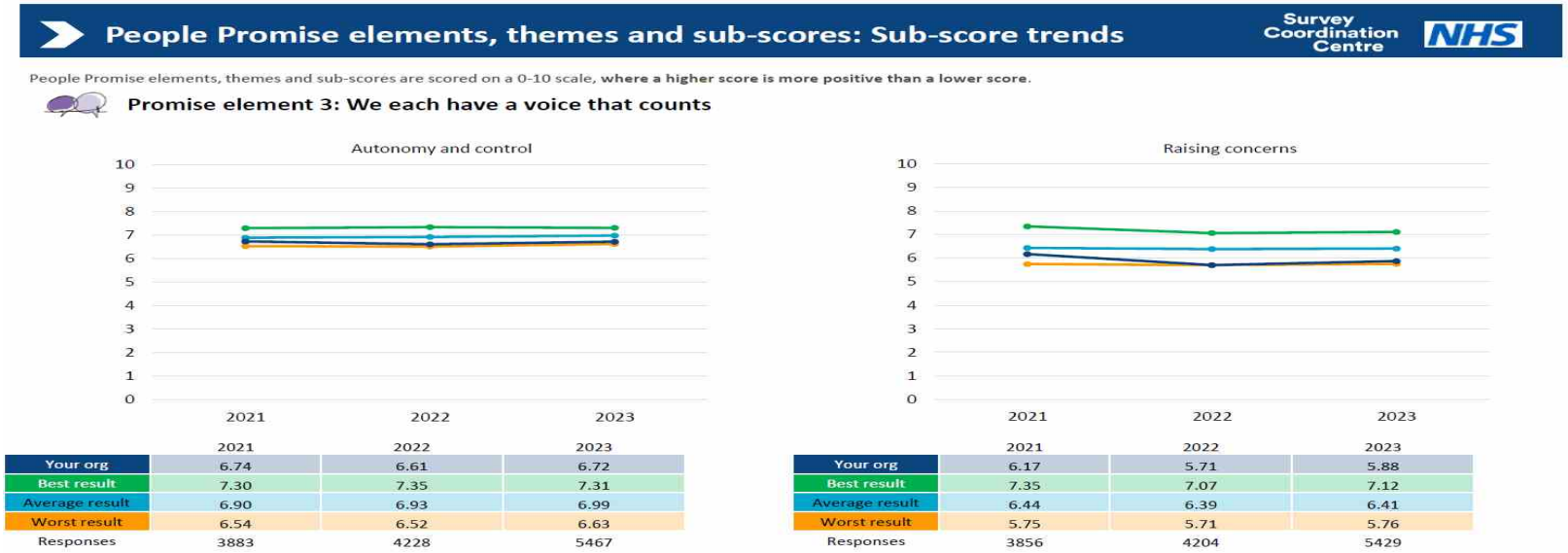
People Promise element 1: We are compassionate and inclusive





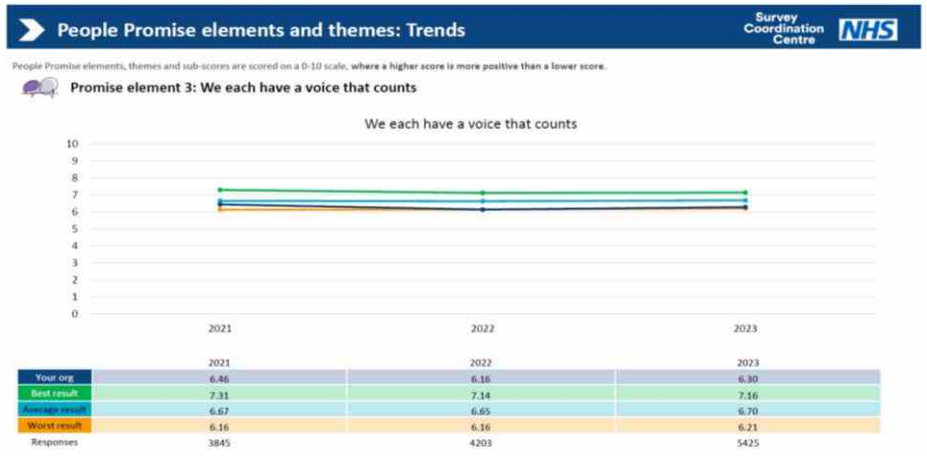
Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)

People Promise element 3: We each have a voice that counts



	2021	2022	2023
Your org	6.74	6.61	6.72
Best result	7.30	7.35	7.31
Average result	6.90	6.93	6.99
Worst result	6.54	6.52	6.63
Responses	3883	4228	5467

	2021	2022	2023
Your org	6.17	5.71	5.88
Best result	7.35	7.07	7.12
Average result	6.44	6.39	6.41
Worst result	5.75	5.71	5.76
Responses	3856	4204	5429



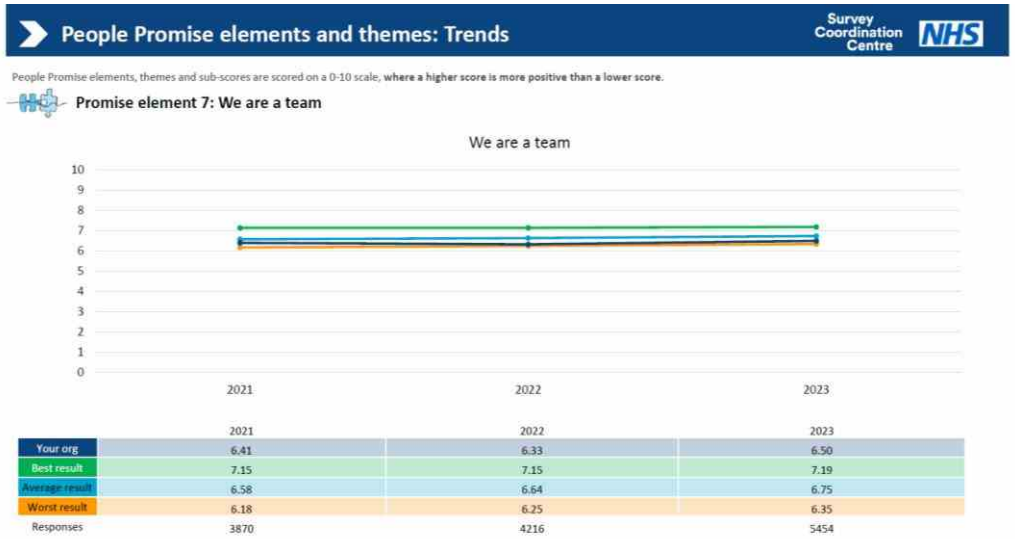
	2021	2022	2023
Your org	6.46	6.16	6.30
Best result	7.31	7.14	7.16
Average result	6.67	6.65	6.70
Worst result	6.16	6.16	6.21
Responses	3845	4203	5425

Key Points to note

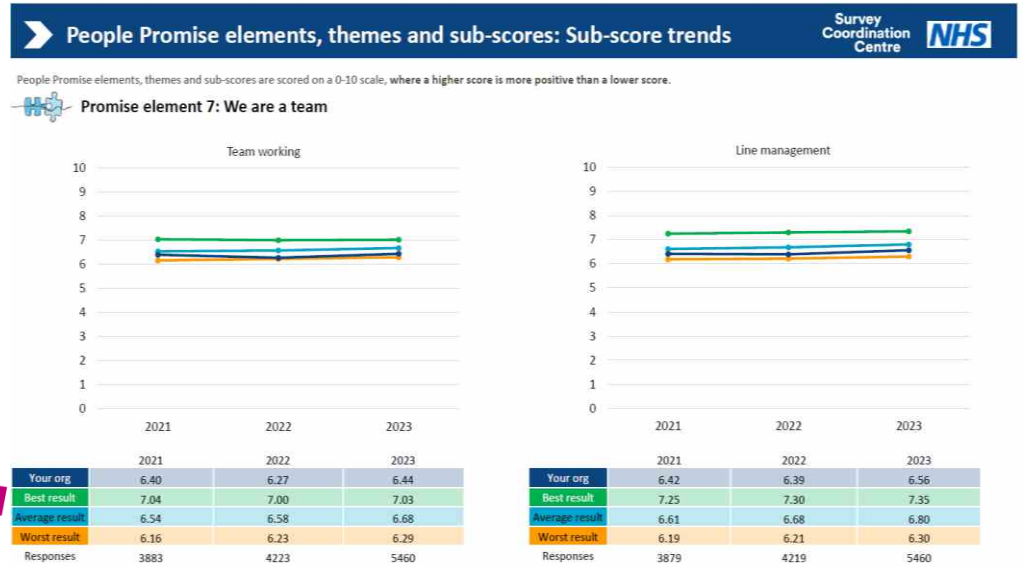
The results evidence an improvement in 12 months indicating that the refresh of the Freedom to Speak Up service has been effective. However, the results are still below the national average.

Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)

People Promise element 7: We are a team



	2021	2022	2023
Your org	6.41	6.33	6.50
Best result	7.15	7.15	7.19
Average result	6.58	6.64	6.75
Worst result	6.18	6.25	6.35
Responses	3870	4216	5454



	2021	2022	2023
Your org	6.40	6.27	6.44
Best result	7.04	7.00	7.03
Average result	6.54	6.58	6.68
Worst result	6.16	6.23	6.29
Responses	3883	4223	5460

	2021	2022	2023
Your org	6.42	6.39	6.56
Best result	7.25	7.30	7.35
Average result	6.61	6.68	6.80
Worst result	6.19	6.21	6.30
Responses	3879	4219	5460

Key Points to note

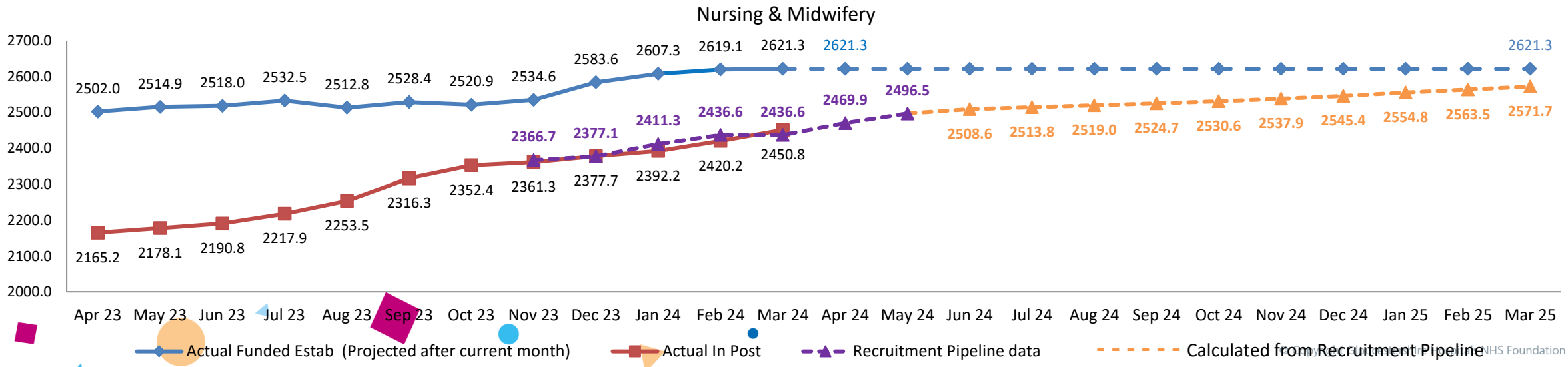
All three of the themes within this people promise element have positively improved and are only marginally below the national average scores.

Improvement Actions	Due Date	RAG
A relaunch of the Staff Experience Improvement Programme for 24/25 will be presented to the May Trust Leadership Team meeting.	May 24	
The Leadership and Teamwork workstream has commenced delivery of the development programme with The Wellbeing Collective with planning for waves 2 and 3 well underway.	Ongoing until 2026	
The Anti-Discrimination workstream continues to review the most appropriate reporting platform and is considering whether it should include other requirements to centralise the reporting of all inappropriate behaviours, not just discrimination	Ongoing for 24/25	
The Taskforce has formally completed but some of the projects are still underway to completion. The new starter packs have been created and will be distributed to new starters from 1st May. Research into the most appropriate 24/7 food provision is still progressing.	July 2024	
The Speaking Up workstream is ready to progress into the next phase of strategic deliverables now that a Freedom to Speak Up Guardian has been appointed to offer more casework support and a Project Manager has been assigned to support the workstream.	Ongoing for 24/25	
The Restorative Just and Learning Culture workstream has a workshop planned on 21st May to agree actions to launch this approach into the organisation	Ongoing for 24/25	

Recruitment Pipeline (BAF SR17 Workforce - Recruitment & Attraction)

Key Points to Note
We continue to see a steady increase in Nursing and Midwifery numbers, closing the gap to funded establishment. As at March 2024, the difference stands at 170.5 WTE.
Future projections of starters & leavers remains positive, with the position at the end of 2024 showing a vacancy gap of 79.9 WTE
Although NHSE funding has now ceased for Trusts to support international recruitment, we remain focussed on domestic opportunities to support future recruitment

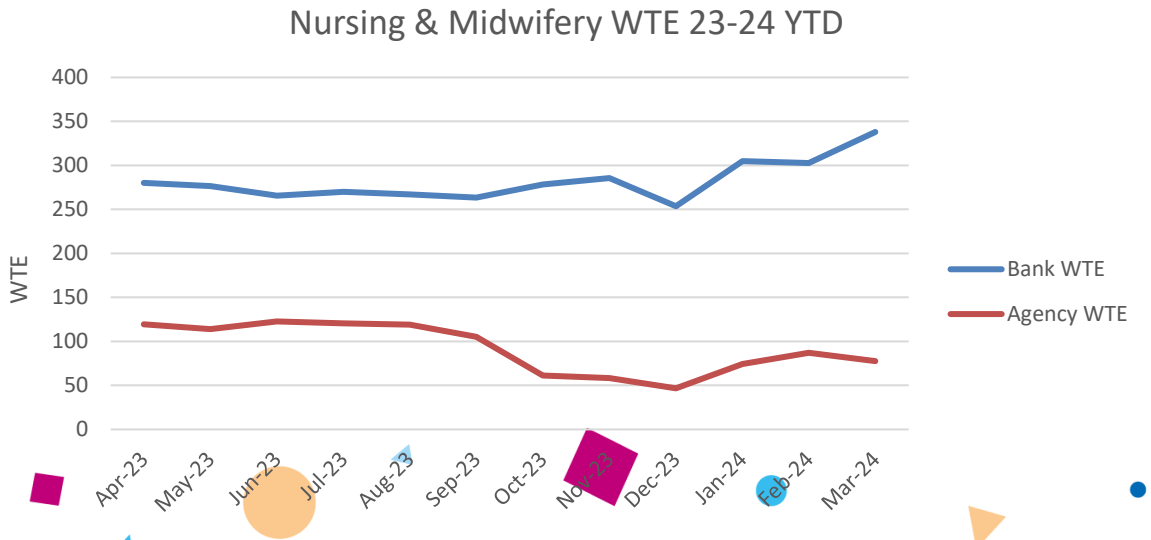
Improvement Actions	Date Due	RAG
The Nursing, Midwifery and AHP Careers Fair took place on Saturday 20th April 2024, which attracted over 160 attendees, looking for current and future opportunities to join our Trust	April 2024	
We have now successfully onboarded all International Educated Nurses, who have since undertaken and passed their OSCE exams, allowing them to obtain there NMC registration, which improves our nursing 'actual' totals.	April 2024	
Circa 50 Newly Qualified Nurses are currently in the process of being onboarded to join us in July/August 2024, after leaving University	Summer 2024	

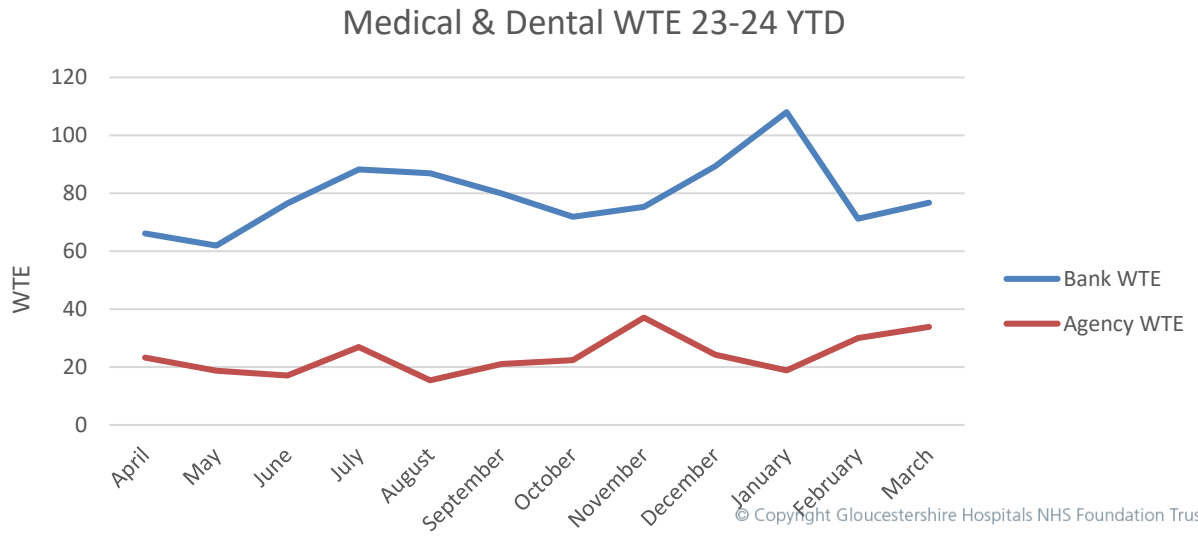


Bank and Agency (BAF SR17 Workforce - Recruitment & Attraction)

Key Points to Note
Bank spend for Medics in M12 - £1,357,224 (increase from M11) Agency spend for Medics in M12 - £451,863 (decrease from M11)
Bank spend for Nursing & Midwifery in M12 - £2,505,324 (decrease from M11) Agency spend for Nursing & Midwifery in M12 - £612,184 (decrease from M11)
Locum bank WTE and spend continues to increase, however this should improve following the implementation of a pan-Trust grip & control group in May.
Nursing bank WTE has increased throughout the winter, possibly as a result of supporting medical industrial action. Nursing agency WTE has seen a decrease of up to half throughout the year, largely as a result of HealthRoster system changes.

Improvement Actions	Date Due	RAG
All bank and agency bookings for non-clinical staff are now centralised through the Bank Service and recorded on HealthRoster. Usage will be reported to NHSE in May.	1st April 2024	
Removal of the local medical locum bank enhancements is under discussion and review by the pan Trust medical grip and control group	April 2024	
Medical agency rates are under discussion and review with the SW temporary staffing collaboration.	May 2024	
The regional agency rate card for Nursing is to be fully implemented. The Trust must be NHSE cap compliant for 95% of it's agency usage.	1st July 2024	

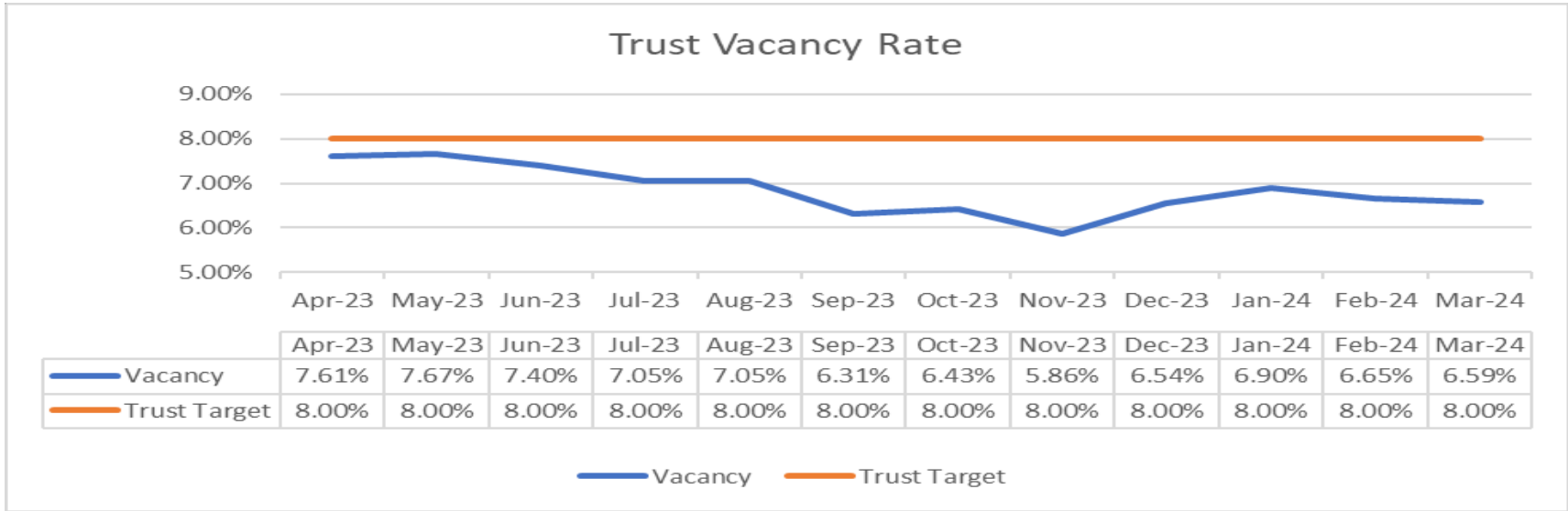




Vacancies (BAF SR17 Workforce - Recruitment & Attraction)

Key Points to note
The Trust vacancies for March 2024 are 0.73% from the lowest recorded vacancies in the last 12 month period (November 2023).
March 2024 has seen a 0.06% decrease from the previous month.
In March 2024, the Vacancy is 1.41% under the Trust target.

Improvement Actions	Date Due	RAG
We are still seeing a strong performance in the overall Trust vacancy rate with progress in Time to Hire and retention of staff.	Ongoing focus	
Hard to fill recruitment drives in areas such as Dietetics and Vascular Consultants has produced successful outcomes. We will be reviewing these activities to draw conclusion on the Welcome Incentives offered and if these were one of the factors for successful recruitment.	June 2024	
The Trust's new Marketing and Attraction brand through the design of an Employee Value Proposition, continues to develop, but with a slight delay seen with launch. Full comms and engagement plan has been drafted.	June 2024	



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Vacancy	7.61%	7.67%	7.40%	7.05%	7.05%	6.31%	6.43%	5.86%	6.54%	6.90%	6.65%	6.59%
Trust Target	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%

Time to Hire (BAF SR17 Workforce - Recruitment & Attraction)

Key Points to note
Time to Hire sees a further reduction in March 2024, down to 43.4 working days. This continues our success in driving down the time for new starters to join us and improves the experience of new staff joining our organisation.
We have seen positive process changes in chasing outstanding information from both New Starters and Recruiting Managers, which is contributing to the current success in our Time to Hire KPIs.

Improvement Actions	Date Due	RAG
Rollout of TRAC VCP to Corporate and Surgical Division remains on target which will see the final divisions moved to this process	May 2024	
As we move towards e-solutions to support recruitment, we will be launching ID Verification Technology for new starters to complete their identification checks remotely, which in turn will help with Time to Hire reduction.	May 2024	
Occupational Health checks to be integrated in to TRAC recruitment system in Summer 2024, with training and roll-out planned thereafter.	September 2024	

Month	Actual	Target
Apr-23	46.1	49.0
May-23	55.9	49.0
Jun-23	52.1	49.0
Jul-23	55.0	49.0
Aug-23	55.1	49.0
Sep-23	55.4	49.0
Oct-23	52.5	49.0
Nov-23	47.2	49.0
Dec-23	46.6	49.0
Jan-24	51.7	49.0
Feb-24	49.2	49.0
Mar-24	43.4	49.0

Attrition (BAF SR17 Workforce - Recruitment & Attraction)

Key Points to note
The highest attrition rate during recruitment is still being seen at the Interview Process stage, with the main reason given by candidates as having received another job offer and decided to withdraw from GHFT.
Of the 164 withdrawing at interview stage, 43 (26.2%) have indicated that they have been made another job offer, supporting previous information that applicants are applying for multiple roles.
The Admin and Clerical staff group still remain with the highest attrition through the recruitment process
Overall, 223 candidates withdrew their applications during the recruitment stages shown below in March 2024

Improvement Actions	Date Due	RAG
We continue to monitor attrition data through the recruitment process to provide further understanding regarding reasons of withdrawal.	Ongoing monitoring	

	Additional Clinical Services	Additional Professional Scientific and Technical	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Nursing and Midwifery Registered	Grand Total
Interview	38	1	82	11	2	5	25	164
Longlisting	12	1	10		4	2	8	37
Offer	6	1	3			1	4	15
Shortlisting			1	1			1	3
Starting			2	1			1	4
Grand Total	**56**	**3**	**98**	**13**	**6**	**8**	**39**	**223**

Key:

RAG Rating	RAG Definition
Blue	Completed
Green	On track to be delivered within planned timeframes
Amber	Delays to delivery within planned timeframes
Red	Risk to achievement

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 28th May 2024

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
Recruitment and Attraction	• Update received on attraction strategy. Framework aligned with the Workforce Sustainability programme, interventions and enabling workstreams. Committee noted improvements in the time to hire and confidence that these will be sustained along with changes to client applicant experience (enhanced online processes). • Development of the marketing strategy and plan progressing well. • Employee Value Proposition (EVP) defined through a series of focus groups, ensuring it was meaningful and relevant and feedback, was seen as valuable and offered new perspectives. **Quarterly recruitment update** • Update on work around ongoing recruitment activities (careers fair, and digital efficiencies), standardising rates for agency and bank staff, reducing competitiveness and move towards standard rate cards. • Workforce planning focused on monitoring and managing workforce growth. • **Attrition in the Recruitment Process for A&C Staff** • Update on in-depth review of attrition data provided to better understand why candidates were withdrawing during the recruitment process. Overall evidence confirmed many applicants apply for multiple jobs simultaneously and primary reason for withdrawal was due to receiving another job offer. Others included personal circumstances, inability to attend interviews, and loss of interest. • To improve candidate retention, reducing time-to-hire was a priority, encouraging managers to allow time off for interviews. • Highest attrition rate was among administrative and clerical staff, due to career progression opportunities.	This item remained RED. Whilst assurance was provided on projects showing improvements across several key areas, issues set out leave the overall item RED. Presentation on the Employee Value Proposition was to come to the July People and OD Committee Further assurance requested around improvement in time to hire and its impact on BME staff members application process – PODC to receive update at future meeting. Committee acknowledged the hard work and was assured with updates provided. PoDC to receive update on any impacts on BME staff.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Culture, experience, and retention	• Staff Experience Improvement programme showed progression, with various workstreams focused on leadership and anti-discrimination. Over the next 12 months, these initiatives would continue, including integrating restorative justice and learning enablers into the anti-discrimination workstream.	Committee questioned level of confidence to meet the extended deadline of October for the restorative culture initiative and received assurance levels of confidence had raised dramatically following the first meeting; time

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.

	• Challenges in discrimination reporting were noted, primarily due to confidentiality concerns. New methods were being sought to ensure confidential but not anonymous reporting, enabling data collection and staff support. Divisions to take ownership of discrimination issues in the workplace. FTSU seeing a high volume of cases being managed and a new associate guardian joining the team to bring more support and to allow others to use more strategic thinking. • A champion network to launch July 2024 to enhance guardianship structure. The task force had completed its work, other activities to be integrated into regular business operations. • The restorative culture initiative had been delayed, with the timeline extended to October 2024;	frames were in place and there was confidence that these would be met.
EDI Development Plan	Update provided on progress with the plan	
People Performance Dashboard	• Increase use of bank was rated red and matched previous trends and reflected impact of industrial action with a continued focus on managing bank and agency, temporary staffing to be maintained until acceptable levels could be sustained. **Appraisal project** • A sample set of paperwork being tested to develop the policy documents was on track to launch in July 2024. A trust-wide rollout included targeted marketing and training for areas that had low appraisal completion and groups in with lower compliance rates. Additional support would be offered to managers and teams in these areas. Assurance regarding the essential training.	A report to come to PoDC on impact of changes on compliance rates with expectation these would increase and time allowed for completion of necessary training.
Health and Safety	• Letter of contravention received requiring action to be taken. It was less severe than an improvement notice in terms of legal consequences, but failure to comply could result in a notice for prosecution from the Health and Safety Executive. • Some points had been challenged and addressed in the response. • Points, particularly around security, were valid and the security review paper was work in progress. • An action plan, consisting of 51 actions, went to the HSC in mid-May. acknowledged not all actions could be completed by their deadline and decision on whether further monitoring would remain in place until action plan was fully implemented. To be confirmed.	PoDC to be kept updated on key health and safety issues at each meeting.
Items not Rated		
Risk Register • No new emerging risks. • No closed risks to report.		

KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – JUNE 2024

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Financial Sustainability Plan (FSP) Report Month 2	Performance at month 2 was behind plan by £2m - £1.4m of savings have been delivered. The target for the year has been increased to £37m as part of delivering a breakeven position across the ICS. This is equivalent to c5% of revenue expenditure and a sizeable challenge. At £18m too large a proportion of plans are either unidentified or of a non-recurrent nature – thereby ensuring that the problem recurs in following years. . A more comprehensive analysis of requirements and confidence in achieving them will be available by Month 3.	Efficiency Board established and continues to refine ways of working. A focus on recovering all possible income is gaining traction. The national toolkit for improving "grip and control" is in the process of being tailored to the Trust before implementation.
	.	
Financial Performance Report Month 2	The Month 2 financial position was an adverse variance of c£0.9m against a deficit plan of £10.5m mainly due to nursing costs and slippage on financial sustainability schemes. At a system level the month 2 position is a £5.8m deficit in line with projections. Delivery of Financial Sustainability Plans and control of establishment and staffing costs are key to delivery of financial targets and any overspend will impact on levels of working capital. There have been some sizable positives in terms of establishment control/headcount reductions, however medical staffing costs rose as a consequence of covering vacancies and the impact of industrial action. Workforce colleagues will be providing a detailed report on workforce controls, impacts and next steps to the next committee.	Approval of a business case to ease medical staffing pressures in Emergency and AMU settings. Roll out of the Accountability Framework. Update on workforce controls to next meeting.

Item	Rationale for rating	Actions/Outcome
Digital Transformation Report	39 projects are scheduled for delivery during the year. A challenging agenda in an area of difficulty in terms of securing adequate numbers of experienced staff.	Continue to monitor delivery.

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.

	Outpatient transformation schemes, particularly the introduction of the Patient Engagement Portal, have been more successful than anticipated but remain to be fully implemented. The transition to digital records involves precision in coding if income levels are to match the costs of providing services. A number of initiatives are underway. The Committee received an update re cyber security and supply chain vulnerabilities in the light of recent incident in London.	Approval of a £0.5m business case for a better coding initiative. Report including learning to be produced for September meeting,
Capital Programme Report Month 2	Total allocation is £43.5m with an additional allocation of £4.2m agreed with the system for backlog and MRI scanner replacement. At month 2 spend was £2.7m against a budget of £3.5m, a variance of £750k. There is currently a breakeven position against funds expected by the end of the year. Source of funding for additional expenditure currently unclear.	Continued monitoring against spend targets and system wide management of cash.
Productivity Deep Dive Bi- Annual Procurement Assurance Report	Current productivity versus 2019/20 is -15% using PBR to value activity –pace of improvement is planned to increase during 2024/25. New national data just been received and is under interpretation – this will inform future reporting. The Theatre Improvement programme to month 2 saw a 80.5% rate and progress towards the target of 85% continues. Positive feedback from Patient Engagement Portal with improved DNA (did not attend) rates, reduced postage costs and uptake higher than anticipated. Overall a positive performance in a challenging period with significant new legislation and requirements needing to be incorporated into working procedures. Persistent problems in recruitment and retention in the team indicate that staffing levels and grades may be out of kilter with the market – thereby increasing risk of delivery of an essential service.	Update against target available in Month 3. Focus on theatres in Community Hospitals where utilisation is low. Focus on coding and specialty level productivity workshops. Review to be undertaken, report back to September meeting.

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Annual Governance Report - Digital	Positive story of development of Divisional Digital and Information Groups, clinical ownership and improved project governance.	Annual report
Annual debtors	Assurance re performance of the function, including comparative information from other Trusts	Explore private hospitals practice re: payment
Update on GMS strategic review	Positive reports of consultation and consensus re next steps.	Board debate July
Strategic Review		

Items not Rated			
System Financial Risk Share			Approved
ICS Infrastructure Strategy			
Items Referred from Audit and Assurance Cttee Estates and Facilities Contract Management Group Terms of Reference Commercial and Innovations Group KIAR			

Investments
No Business Cases considered at this meeting

Case	Comments	Approval	Actions

Impact on Board Assurance Framework (BAF)

SR12 : Cyber Security : risk assessment reduced to 15 in light of current level of confidence following extensive preparatory works and appointments to key posts during 23/24.

SR 9 : Failure to deliver recurrent financial sustainability – updated assessment in light of latest information, longer term perspective including cashflow and system risk share arrangements. A risk score of 25 agreed pending production of a longer term financial plan in Q2.

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

SR 10 : Condition of the estate – NOW RETITLED – The risk to patient safety, quality of care, reputational damage and contractual penalties as a result of the areas of poor estate and the scale of backlog maintenance – noted this more precise definition and continued risk score of 16.

SR 13 - Digital Systems Functionality – no changes recommended.

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

Report to Board				
Date	11 July 2024			
Title	**Financial Performance Report (Month 02 – Ended 31 May 2024)**			
Author /Sponsoring Director/Presenter	Hollie Day, Caroline Parker, Craig Marshall, Simon Williams Karen Johnson			
Purpose of Report		Tick all that apply ✓		
To provide assurance		✓	To obtain approval	
Regulatory requirement			To highlight an emerging risk or issue	
To canvas opinion			For information	
To provide advice			To highlight patient or staff experience	

Summary of Report

Purpose

This purpose of this report is to present the financial position of the Trust at Month 2.

Revenue

The Trust is reporting a year to date deficit of £10,522k which is £898k adverse to plan. This is the position after adjusting for donated assets impact and Salix grant.

The Integrated Care System year to date position is £5,383k deficit which is in line with plan. No organisations are forecasting deviation from their agreed breakeven positions at year end.

Capital

At Month 2, the Trust had goods delivered, works done or services received to the value of £2,690k against a planned spend of £3,412k which is £722k behind the original plan. The Trust is forecasting a breakeven forecast outturn in line with 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

Finance report

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Finance Report M2 2024/25

Presenter: Karen Johnson, Director of Finance

Authors:
Hollie Day – Associate Director of Financial Management
Caroline Parker - Head of Financial Services
Craig Marshall - Project Accountant
Simon Williams - Associate Director of Income & Contracting

the Best Care for Everyone
care / listen / excel

Revenue Position

Monthly I&E

System Overview

Gloucestershire Integrated Care System (ICS) is reporting a YTD deficit of £5.383m in M2. This is in line with plan. No organisations are forecasting deviation from their agreed breakeven positions at year end.

GHFT Overview - Month 2

M2 YTD Financial position is reporting a deficit of £10,522k which is £898k adverse to plan. The position includes :

- Financial Sustainability (FSP) pressures
- Pressures within the Medicine division due to unfunded enhanced care, supernumerary, vacancy cover & sickness.
- Underspends within Corporate areas
- Underspends within the other clinical divisions
- Reserves offsetting the position
- Donated assets and IFRIC 12 adjustment

Consolidated Group Summary

Month 2 Financial Position	M02 Plan £000s	M02 Actuals £000s	M02 Variance £000s	M02 Cumulative Plan £000s	M02 Cumulative Actuals £000s	M02 Cumulative Variance £000s
SLA & Commissioning Income	56,326	55,149	(1,176)	109,996	109,422	(574)
PP, Overseas and RTA Income	433	523	90	858	973	115
Other Income from Patient Activities	1,145	1,653	508	2,449	3,194	745
Operating Income	(1,763)	3,371	5,134	9,894	9,787	(107)
Total Income	**56,140**	**60,696**	**4,555**	**123,197**	**123,376**	**179**
Pay						
Substantive	(37,738)	(35,518)	2,219	(79,414)	(72,298)	7,116
Bank	(187)	(2,435)	(2,248)	(414)	(5,521)	(5,107)
Agency	(1,043)	(1,306)	(263)	(2,215)	(2,485)	(270)
Locum	(319)	(1,167)	(848)	(629)	(2,239)	(1,611)
Total Pay	**(39,287)**	**(40,427)**	**(1,140)**	**(82,671)**	**(82,543)**	**128**
Non Pay						
Drugs	(7,715)	(8,567)	(852)	(15,422)	(17,360)	(1,938)
Clinical Supplies	(3,800)	(4,332)	(532)	(7,667)	(8,969)	(1,302)
Other Non-Pay	(8,606)	(12,834)	(4,228)	(25,469)	(24,884)	584
Total Non Pay	**(20,120)**	**(25,733)**	**(5,613)**	**(48,558)**	**(51,213)**	**(2,656)**
Total Expenditure	**(59,408)**	**(66,160)**	**(6,753)**	**(131,229)**	**(133,756)**	**(2,527)**
EBITDA	**(3,267)**	**(5,465)**	**(2,197)**	**(8,032)**	**(10,380)**	**(2,348)**
EBITDA %age	**(5.8%)**	**-9.0%**	**3.2%**	**(6.5%)**	**-8.4%**	**1.9%**
Non-Operating Costs	(894)	(103)	791	(1,788)	(1,195)	593
Surplus / (Deficit)	**(4,161)**	**(5,568)**	**(1,406)**	**(9,820)**	**(11,575)**	**(1,755)**
Dontated Asset, Impairment & Salix Grant Adjustment	98	98	0	196	1,053	857
Adjusted Surplus / (Deficit)	**(4,063)**	**(5,470)**	**(1,406)**	**(9,624)**	**(10,522)**	**(898)**

* Trust position excludes £7.3m of Hosted Services income and costs. This relates to GP Trainees
** Group position excludes £10.2m of inter-company transactions, including dividends

Pay – key issues

Pay costs are £82.5m which is £0.1m favourable to plan and includes:

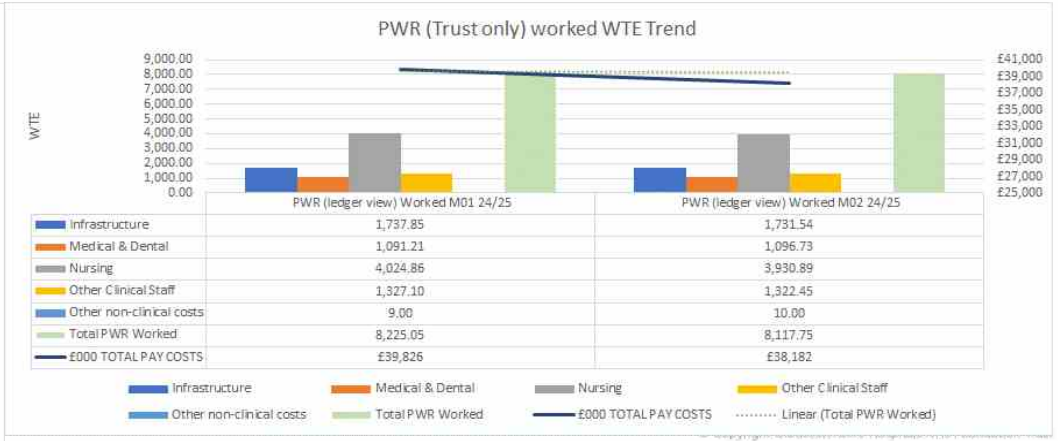
- £2.5m underspend in reserves for legacy FSP funding that is offsetting non pay pressures within the divisions. Excluding reserves, **the underlying pay overspend is £2.4m.**
- Nursing pressures due to enhanced care, supernumerary staff and sickness.
- Medical staffing pressures due to consultant cover and pressures ED & AMU.

The WTE Worked position at M2 24/25 is 8,873.91 for the Group (8,117.75 for the Trust) which is 154.14 above funded levels, mainly driven by nursing. This is an improvement of 112.42WTE from prior month, with a 93.97WTE reduction in nursing, particularly bank.

The table on the right shows the Trust position (excludes GMS) and compares WTE worked against pay costs.

Both WTE and costs have reduced compared to prior month which reflects the impact of tighter grip and control measures particularly in nursing. Medical staff, however, have increased in month due to temporary staff covering consultant shifts.

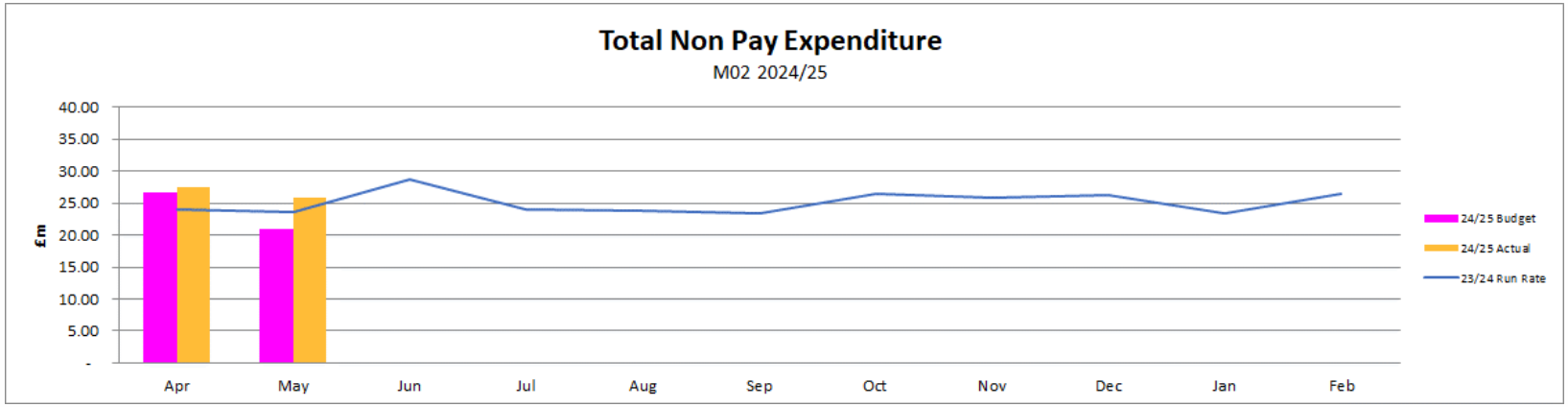
Workforce colleagues are preparing an update on the Workforce Controls Framework which will be presented to Finance & Resources Committee in July.



	PWR (ledger view) Worked M01 24/25	PWR (ledger view) Worked M02 24/25
Infrastructure	1,737.85	1,731.54
Medical & Dental	1,091.21	1,096.73
Nursing	4,024.86	3,930.89
Other Clinical Staff	1,327.10	1,322.45
Other non-clinical costs	9.00	10.00
Total PWR Worked	8,225.05	8,117.75
£000 TOTAL PAY COSTS	£39,826	£38,182

Non pay – key issues

- Non Pay costs (including non-operating costs) are £52.4m which is £2m adverse to plan.
- This position includes the impact of legacy FSP which is funded in reserves but held against pay as mentioned in previous slide. This will be realigned for month 3.
- The underlying non pay underspend is £0.4m.



Oversight framework summary

The Financial Matrix used by the Trust to monitor the Finance and Use of Resources for Month 02 YTD position is below.

The System is also required to monitor against these metrics plus achievement of Mental Health Standard.

The Trust is adverse to plan for all metrics

Group Position	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Financial efficiency – variance from efficiency plan	3,418	1,403	(2,015)
Financial stability – variance from breakeven*	(9,624)	(10,522)	(898)
Agency spending against NHSE cap 3.2%	(2,526)	(2,485)	42
adjusted position			

Focus on Agency spend:

Agency spend is under significant scrutiny nationally, at system level and internally.

NHS England has capped agency spend at 3.2% of pay bill. For GHFT this is £15.158m (£1.26m per month).

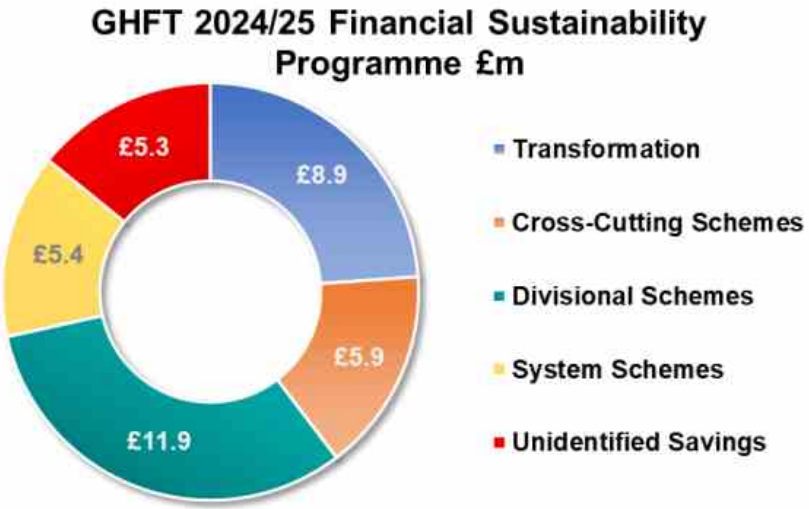
- M2 agency cost is £1.179m and has reduced from prior month by £126k and WTE has reduced by 3.76. Spend is below NHSE cap in month and YTD.
- When compared against M7 23/24 (reference point used by NHS England), costs have reduced by £171k and WTE has reduced by 27.94.

Income - performance

Commissioner	YTD Position (£000) M2	Adjusted YTD Position (£000) M2	M2 Plan (£000)	YTD vs Plan VAR	Drug var	Device var	API Var	*API Var (specialised delegation)*	*API Var (Non specialised delegation)*
NHS Gloucestershire ICB	81,961	**81,961**	80,349	1,612	0	0	1,612	*0*	*1,612*
Other English ICBs	6,286	**6,286**	4,543	1,743	3	2	1,738	*1,875*	*-137*
NHS England	22,295	**22,295**	24,424	-2,129	478	-117	-2,490	*-1,875*	*-615*
Wales	1,311	**1,311**	1,140	171	40	4	128	*0*	*128*
Local Authority	175	**175**	175	0	0	0	0	*0*	*0*
Total	**112,029**	**112,029**	**110,631**	**1,398**	**521**	**-111**	**988**	***0***	***988***
Less GICB (assume block)	-1,612	-1,612	0	-1,612	0	0	-1,612	*0*	*-1,612*
Variance excluding GICB (API)	110,417	110,417	110,631	-214	521	-111	-624	*0*	*-624*

- Activity is reported in arrears and the month 2 position is informed from month 1 information.
- The initial view does suggest that the overall commissioning income is running at a surplus of £1.4m. However contained within that is the performance on pass through drugs and devices which once taken out reduces the surplus to £988k. A further adjustment to allow for the funding from GICB to be recognised as fixed and the overall performance becomes negative at £624k.
- The relative performance of H&W ICB and NHSE Spec Comm should be noted. The specialised income has been devolved to H&W but not the activity plan. This is creating a false picture with both organisations and is something being worked on with NHSE.
- These figures do not include an additional amount of £291k for the consultants' pay award which will be included in future reporting.
- At this stage of the year there are no contract variations to report.

Financial Sustainability Programme 2024/25



- GHFT's initial savings target was £26.7M, which left Gloucestershire Integrated Care System a deficit position.
- In order comply with NHS England's request to achieve a balanced plan, all system partners, including GHFT, have agreed to find further efficiencies.
- This means GHFT's Sustainability Programme is now £37.4M, which represents approx. 5% of Trust spend.
- To ensure no one part of the Trust is unfairly disadvantaged by this increased efficiency ask, it has been apportioned on the basis of controllable spend, with provisions made to protect services such as Maternity

- Due to the stretches required to reach a balanced plan, there are £5.3M worth of savings still to be identified.
- The Trust is actively working through all opportunities available and these go through the various internal governance before being accepted into the programme.
    - The programme is supported by benchmarking and 'opportunity' tools gathered from various horizon-scanning platforms.
    - These platforms include Model Hospital, Model Health, NHS Futures Platform, One NHS Finance and the Efficiency Exchange.
    - These opportunities have been presented to divisions and they are currently working through areas showing opportunities
    - This will be enacted through a programme management approach with timelines and milestones

Capital Position

Monthly Capital Position

As of the end of May (M2), the Trust had goods delivered, works done or services received to the value of £2.7m, against a planned spend of £3.5m, equating to a variance of £0.75m behind the original plan.

	Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
DIGITAL	699	227	472	893	615	278
MEDICAL EQUIPMENT	31	7	24	186	45	140
ESTATES	962	554	407	1,728	1,789	(61)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**1,691**	**788**	**903**	**2,807**	**2,449**	**357**
RIGHT OF USE ASSET	204	53	151	476	91	385
Total Charge against Capital Allocation (including impact of IFRS 16)	**1,895**	**841**	**1,054**	**3,283**	**2,540**	**742**
NAT PROGRAMME, GRANTS, DONATIONS & OTHER	101	120	(20)	201	196	5
Gross Capital Spend Total	**1,996**	**961**	**1,034**	**3,484**	**2,736**	**747**
Less Donations and Grants Received	0	(3)	3	0	(3)	3
Less PFI Capital (IFRIC12)	(50)	(50)	0	(100)	(100)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	28	28	0	28	57	(28)
Total Capital Departmental Expenditure Limit (CDEL)	**1,974**	**936**	**1,038**	**3,412**	**2,690**	**722**

Forecast Capital Position

The Trust originally submitted a gross capital expenditure plan for the 24/25 financial year totalling £43.0m. To date, a further £0.5m of National Programme funding has been approved bringing the current allocation for 24/25 to £43.5m.

An additional allocation of Operational System Capital of £4.2m has been agreed with the System in June towards Estate's backlog projects (£2.4m) and a replacement MRI scanner at CGH (£1.8m). This additional allocation was included in a revised Financial Planning Return submission on 12th June which brings the total capital allocation for 24/25 up to £47.7m.

The plan incorporated year to date actuals as a Month 2 with the opportunity to reprofile the remaining months spend. The Trust will report against this resubmitted Plan position from Month 3.

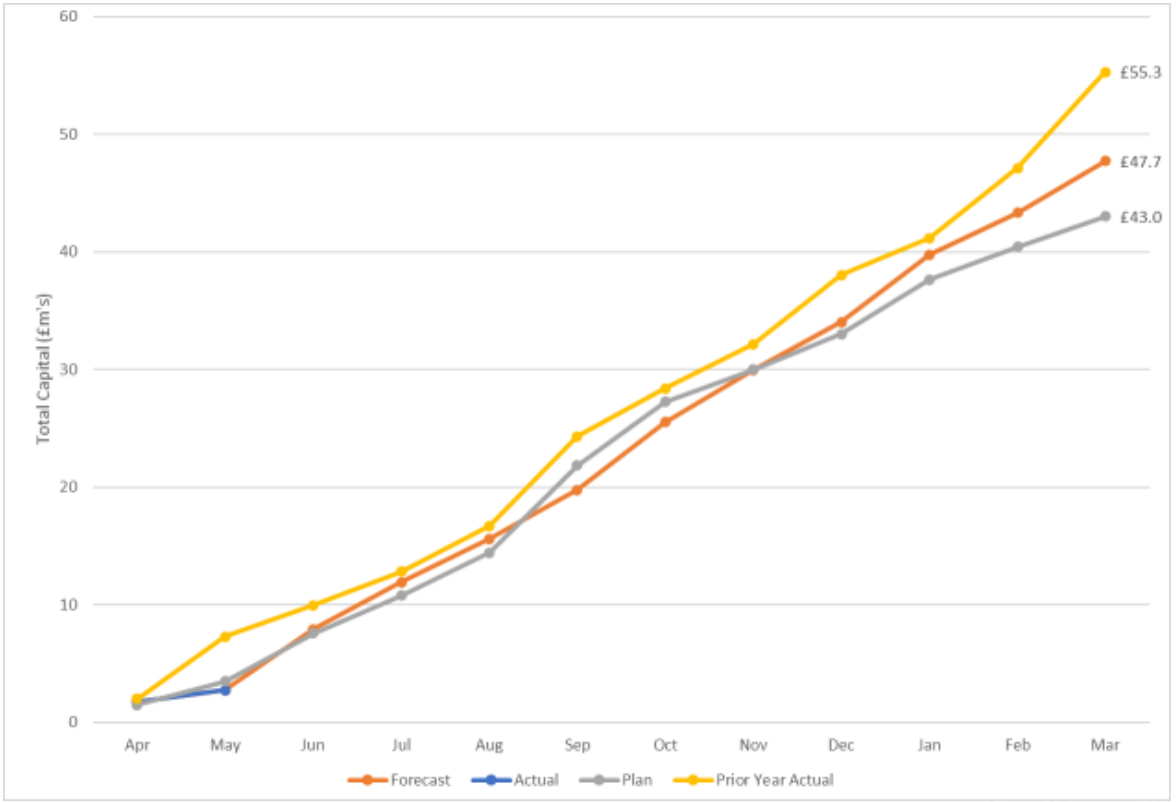
The Trust is currently reporting a breakeven forecast outturn in line with the plan.

	Current Allocation £000's	Forecast £000's	Variance
DIGITAL	7,020	7,020	0
MEDICAL EQUIPMENT	7,627	7,627	0
ESTATES	17,196	17,196	0
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**31,843**	**31,843**	**0**
RIGHT OF USE ASSET	7,413	7,413	0
Total Charge against Capital Allocation (including impact of IFRS 16)	**39,255**	**39,255**	**0**
NAT PROGRAMME, GRANTS, DONATIONS & OTHER	4,265	4,265	0
Gross Capital Spend Total	**43,520**	**43,520**	**0**
Less Donations and Grants Received	(1,499)	(1,499)	0
Less PFI Capital (IFRIC12)	(599)	(599)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	341	341	0
Total Capital Departmental Expenditure Limit (CDEL)	**41,763**	**41,763**	**0**

Capital trend analysis

The graph to the right shows the current trajectory of spend against plan and the actual delivery of spend that was incurred in 2023/24.

Whilst the trend in spend profiles between each year will be specific to the individual projects so comparison is somewhat limited but the graph does give an indication of how the current year is progressing in relation to intentions and in comparison to last year.



Balance Sheet

Balance sheet

	Group Closing Balance 31st March 2024 £000	Trust Balance as at M2 £000	GMS Balance as at M2 £000	GROUP Balance as at M2 £000	B/S movements from 31st March 2024 £000
Non-Current Assests					
Intangible Assets	15,221	14,419		14,419	(802)
Property, Plant and Equipment	367,742	365,615	32	365,647	(2,095)
Trade and Other Receivables	3,424	3,403		3,403	(21)
Investment in GMS	0	600		0	0
Total Non-Current Assets	**386,387**	**384,037**	**32**	**383,469**	**(2,918)**
Current Assets					
Inventories	12,505	11,880	768	12,648	143
Trade and Other Receivables	27,812	31,439	2,861	31,085	3,273
Cash and Cash Equivalents	57,741	39,309	8,031	47,340	(10,401)
Total Current Assets	**98,058**	**82,628**	**11,660**	**91,073**	**(6,985)**
Current Liabilities					
Trade and Other Payables	(96,750)	(83,055)	(11,092)	(90,932)	5,818
Other Liabilities	(15,373)	(24,398)		(24,398)	(9,025)
Borrowings	(8,356)	(10,520)		(10,520)	(2,164)
Provisions	(4,001)	(3,909)		(3,909)	92
Total Current Liabilities	**(124,480)**	**(121,882)**	**(11,092)**	**(129,759)**	**(5,279)**
Net Current Assets	**(26,422)**	**(39,254)**	**568**	**(38,686)**	**(12,264)**
Non-Current Liabilities					
Other Liabilities	(6,313)	(4,836)		(4,836)	1,477
Borrowings	(57,034)	(54,799)		(54,799)	2,235
Provisions	(3,299)	(3,404)		(3,404)	(105)
Total Non-Current Liabilities	**(66,646)**	**(63,039)**	**0**	**(63,039)**	**3,607**
Total Assets Employed	293,319	281,744	600	281,744	(11,575)
Financed by Taxpayers Equity					
Public Dividend Capital	407,649	407,649		407,649	0
Equity	0		600	0	0
Reserves	32,180	32,180		32,180	0
Retained Earnings	(146,510)	(158,085)		(158,085)	(11,575)
Total Taxpayers' Equity	293,319	281,744	600	281,744	(11,575)

Cash Flow Forecast

	Opening Balance	Receipts	Payments	Closing Balance
Apr 24	55,176	77,849	(73,661)	59,364
May 24	59,364	64,554	(84,609)	39,309
Jun 24	39,309	61,687	(66,944)	34,052
Jul 24	34,052	88,812	(68,970)	53,893
Aug 24	53,893	69,452	(65,948)	57,397
Sep 24	57,397	64,599	(76,281)	45,715
Oct 24	45,715	84,986	(76,145)	54,556
Nov 24	54,556	67,141	(76,354)	45,344
Dec 24	45,344	63,963	(71,094)	38,213
Jan 25	38,213	68,108	(77,260)	29,062
Feb 25	29,062	74,364	(63,460)	39,966
Mar 25	39,966	65,930	(81,439)	24,457
Apr 25	24,457	76,597	(69,932)	31,122
May 25	31,122	67,108	(61,895)	36,334
Jun 25	36,334	64,376	(70,748)	29,962
Jul 25	29,962	80,163	(66,424)	43,701

- The cashflow reflects the Trust position.
- The table is for an 18 month period and is based on the assumption that income and expenditure will be at similar levels from April 2025 onwards.
- It is currently assumed that financial sustainability target identified in the plan is achieved
- Income levels are based on the June planning submission and assumes that there will be a catch up payment in July of the revised income plans.
- Trust holds 28 days operating cash (c£2.1m per day) at the end of April – at the end of March 2025 this would be equivalent to just under 12 days.

Risks

- Risks to the Income & Expenditure (revenue) position
- Risks to Capital

Risks to the I&E (revenue) position

Risks

- Financial Sustainability Programme (FSP) does not deliver recurrent efficiencies
- Pay award exceeds funded levels
- Non pay inflation exceeds funded levels
- Industrial action impact on costs, activity and income
- Cost pressures identified through the planning phase which have not been able to be mitigated
- The impact of risks outlined above lead to a cash shortfall in the Trust

Mitigations

- Non recurrent efficiencies to close FSP gap
- Additional funding from NHSE for inflation
- Additional funding from NHSE for industrial action

Risks to the Capital position

Risks

- Projects not completing on time
- Projects Overspending
- Emerging unfunded risks (e.g. urgent backlog, failing equipment
- Any delayed response to the receipting of orders for goods received or works done will mean that the reported expenditure position will be understated.
- The IFRS16 plan was based on assumptions including that a new contract will be entered for the same length. Any changes to this will impact on the IFRS16 charge
- Additional right-of-use assets are entered into without appropriate capital governance approval.

Mitigations

- Bringing forward of future years schemes
- Reprioritisation of capital programme
- Value Engineering and Scope Control
- Appropriate scrutiny of projects prior to approval
- Initiating post project evaluations for future learning
- Monitoring and challenge of project progress through sub groups, groups and committee
- Approach the system to see if there is ability to fund from system held IFRS16 contingency.
- Controls, training and processes for IFRS16 put in place

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Thank you

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