Gloucestershire Hospitals NHS Foundation Trust

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS MEETING HELD IN PUBLIC**

**Thursday 12 September 2024 at 13:00 to 16:00**

**Museum of Gloucester, Brunswick Road, Gloucester, GL1 1HP**

**AGENDA**

| REF | ITEM | PURPOSE | REPORT | TIME |
|---|---|---|---|---|
| 1 | **Welcome, apologies for absence and quoracy check**[1] | Information | | 13:00 |
| 2 | **Declarations of interest** | Approval | | |
| 3 | **Minutes of previous meeting** | Approval | ENC 1 | |
| 4 | **Matters arising** | Assurance | ENC 2 | |
| 5 | **Patient Story** | Information | ENC 3 | 13:05 |
| 6 | **Public questions** | Information | | 13:20 |
| 7 | **Chair's Report**<br>*Deborah Evans, Trust Chair* | Information | | 13:25 |
| 8 | **Chief Executive's Report**<br>*Kevin McNamara, Chief Executive*<br>• People and Culture<br>• Operational Context<br>• Quailty and Performance<br>• Strategy<br>• Regulation<br>• Picture Archiving and Communication System (PACS) Update | Information | ENC 4 | 13:35 |
| 9 | **Strategic and Operational Risk**<br>*Kerry Rogers, Director of Integrated Governance* | Assurance | ENC 5 | 13:45 |
| **AUDIT AND ASSURANCE** | | | | |
| 10 | **Audit and Assurance Committee Report**<br>*John Cappock, Non-Executive Director* | Assurance | | 13:55 |
| **QUALITY AND PERFORMANCE** | | | | |
| 11 | **Maternity update**<br>*Lisa Stephens, Director of Midwifery*<br>*Christine Edwards, Clinical Lead, Obstetrics*<br>• Report to the Care Quality Commission - Section 31 Summary Report<br>• Perinatal Quality and Safety Report 2024/2025 Quarter 1 | Assurance | ENC 6 | 14:10 |

[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 |
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| **QUALITY AND PERFORMANCE** | | | | |
| 12 | **Quality and Performance Committee Report**<br>*Sam Foster, Non-Executive Director*<br>• Quality and Performance Committee Key Issues and Assurance Report, 24 July 2024 | Assurance | ENC 7 | 14:30 |
| 13 | **Engagement and Involvement Annual Review 2023-24 and Community Engagement Tracker**<br>*Juwairiyia Motala, Community Outreach Worker, and James Brown Director of Engagement, Involvement & Communications.* | Approval | ENC 8 | 14:40 |
| 14 | **Integrated Care Board sign off patient safety and quality of care in pressurised services**<br>*Al Sheward, Chief Operating Officer, Mark Pietroni, Medical Director & Director of Safety, Matt Holdaway, Director of Quality and Chief Nurse* | Assurance | ENC 9 | 14:50 |
| 15 | **Integrated Performance Report (Operational Performance)**<br>*Al Sheward, Chief Operating Officer, Mark Pietroni, Medical Director & Director of Safety, Matt Holdaway, Director of Quality and Chief Nurse and Karen Johnson, Director of Finance* | Assurance | ENC 10 | 15:00 |
| **PEOPLE AND ORGANISATIONAL DEVELOPMENT** | | | | |
| 16 | **People and Organisational Development Committee Report**<br>*Balvinder Heran, Non-Executive Director and Claire Radley, Director for People and Organisational Development*<br>• People and Organisational Development Committee Key Issues and Assurance Report, 28 May 2024<br>• People and Organisational Development Committee Performance Dashboard, July 2024 | Assurance | ENC 11 | 15:10 |
| ***Break*** | | | | 15:20 |
| **FINANCE AND RESOURCES** | | | | |
| 17 | **Finance and Resources Committee Report**<br>*Jaki Meekings-Davis, Non-Executive Director*<br>• Finance and Resources Committee Key Issues and Assurance Report, August 2024 | Assurance | ENC 12 | 15:40 |
| **STANDING ITEMS** | | | | |
| 18 | **Any other business and questions on consent items** | Information | | 15.50 |
| 19 | **Governor observations** | Information | | 15:55 |
| 20 | **Date and time of next meeting**<br>*Thursday 14 November 2024 at 13:00 (Lecture Hall, Redwood Education Centre)* | Information | | 16:00 |
| **Close by 16:00** | | | | |

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**Draft** Minutes of the Board of Directors' meeting held in Public.
Wednesday 11 July 2024, 13.00. p.m.
Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

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| **Present** | | |
| Deborah Evans | DE | Chair |
| Vareta Bryan | VB | Non-Executive Director |
| John Cappock | JC | Non-Executive Director |
| Sam Foster | SF | Non-Executive Director |
| Balvinder Heran | BH | Non-Executive Director |
| Marie-Annick Gournet | MAG | Non-Executive Director |
| Jaki Meekings-Davis | JMD | Non-Executive Director |
| Mike Napier | MN | Non-Executive Director |
| Sally Moyle | SM | Associate Non-Executive Director |
| Kaye Law-Fox | KF | Associate Non-Executive Director and Chair of GMS |
| Kevin McNamara | KM | Chief Executive Officer |
| Karen Johnson | KJ | Director of Finance |
| Professor Mark Pietroni | MP | Medical Director and Director of Safety and Deputy CEO |
| Al Sheward | AS | Chief Operating Officer |
| Matt Holdaway | MH | Chief Nurse and Director of Quality |
| Kerry Rogers | KR | Director of Integrated Governance |
| Ian Quinnell | IQ | Interim Director of Strategy and Transformation |
| Helen Ainsbury | HA | Interim Chief Digital and Information Officer |
| **Attending** | | |
| Deborah Tunnell | DT | Deputy Director for People and Organisational Development |
| James Brown | JB | Director of Engagement, Involvement and Communications |
| Lisa Stephens | LS | Director of Midwifery (Item 32/24) |
| Christine Edwards | TBC | Consultant, Obstetrics (Item 32/24) |
| Dr S Bhakthavalsala | SB | The Guardian of Safe Working Hours (GOSW) (item 36/24) |
| Michael Weaver | MW | Interim Trust Secretary (minutes) |
| **Apologies** | | |
| Claire Radley | CR | Director for People and Organisational Development |

| Ref. | Item |
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| **22/24** | **Chair's welcome and introduction** |
| | The Chair extended a warm welcome to all present. The meeting was declared quorate. |
| **23/24** | **Apologies for absence** |
| | Apologies for absence were received from Claire Radley, Director for People and Organisational Development. |
| **24/24** | **Declarations of interest** |
| | There were no interests declared other than those formerly recorded. |

| Ref. | Item |
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| **25/24** | **Minutes of previous meeting** |
| | With reference to Item 8/24 Kevin McNamara asked the Board to note matters reported by Matt Holdaway in relation to Maternity. With Reference to item 14/24 the three key initiatives to strengthen financial understanding in the coming year included identifying the drivers of the deficit, ensuring clarity with regards to demand and capacity modelling, and understanding of productivity. For Item 16/24 the Board discussed a range of measures to improve action in relation to Governance and the need to be proactive when following up on actions identified following external reviews.<br><br>**RESOLVED**: The Board **APPROVED** the minutes of the meeting held on 5 May 2024. |
| **26/24** | **Matters arising** |
| | The Chair noted one matter arising reported as closed. Professor Mark Pietroni received a copy of the Integrated Care Board's Corporate Risk Register and Board Assurance Framework. The Trust's Corporate Governance Team would review these documents to align the Trust's Board Assurance Framework and Trust Risk Register with system risk management practices.<br><br>**RESOLVED:** The Board **NOTED** the update on matters arising and **APPROVED** the CLOSED item. |
| **27/24** | **Public questions** |
| | The Chair noted that no questions from the public had been received prior to the meeting. |
| **28/24** | **Chair's Report** |
| | The Chair expressed their thanks to all colleagues who worked tirelessly during the recent period of industrial action, ensuring patient safety and minimising impacts. in June, the Chair attended the long service awards for Trust volunteers, celebrating their valuable contributions. Matt Bishop, a new local MP, serves as a governor of the trust, providing a beneficial connection. This morning, the Chair participated in the "Eight Perfect Days of Summer" program, aimed at improving urgent and emergency care. The discussions and teamwork were commendable, with a focus on Red and Green Days to maximise progress on diagnosis, treatment and timely discharge. The Trust has submitted its annual Fit and Proper Person Test declaration to NHS England, confirming compliance with the requirements for all directors and senior leaders. With much sadness, the Chair reported the passing of former trust chair Claire Chilvers. She was highly respected and will be missed. The Chair proposed sending a letter of condolence to her family on behalf of the trust.<br><br>**RESOLVED:** The Board **NOTED** the report. |
| **29/24** | **Chief Executive's Report** |
| | Following the UK Election on 4 July 2024, six new Members of Parliament were elected out of the seven Gloucestershire constituencies. Monthly meetings with MPs will continue, and initial contact has already been made. The Chief Executive has scheduled a meeting with Max Wilkinson, MP for Cheltenham, and would arrange meetings with all MPs in due course. Will Cleary Gray had been appointed as the Trust's Director of Improvement and Delivery, with the Chief Executive expressing gratitude to Ian Quinnell for serving as Interim Director of Strategy and Transformation. Will would join the Trust from an Integrated Care Board in South Yorkshire, where he led large, complex programs and began his career as a critical care nurse. |

| Ref. | Item |
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| **29/24** | **Chief Executive's Report** |
| | The Chief Executive also announced the appointment of Mike Gregson as the new Managing Director of Gloucestershire Managed Services and thanked Simon Wadley for his service as Interim Managing Director. Since the last Board meeting in May, the Chief Executive welcomed the first cohort of medical students from Three Counties Medical School and expressed gratitude to Sally Moyle for her support. The new students, many of whom had previously worked in various clinical roles within the Trust, provided positive feedback on the initiative, marking a significant achievement for the organisation. Towards the end of June, the Chief Executive re-signed the Armed Forces Covenant and met veterans and community groups supporting veterans and their families in areas such as homelessness, employment, and drug misuse. Reflecting on recent industrial action, he noted opportunities to improve operations at the "front door" and expressed optimism for a resolution. Following a CQC inspection of Maternity Services at Gloucestershire Royal Hospital on 26 March 2024, an enforcement notice issued on 9 May required enhanced reporting systems and monthly progress updates. The Chief Nurse for the Integrated Care Board established a fortnightly Quality Improvement Group with key stakeholders to oversee necessary improvements. The Trust initially engaged Maternity and Newborn Safety Investigations for an independent review of maternal deaths, but due to Maternity and Newborn Safety Investigations' new hosting by the Care Quality Commission, they lacked the legal basis to provide this service. The Trust then approached NHS England regional colleagues for expertise and asked a separate Local Maternity and Neonatal System in Hampshire to review neonatal deaths, which will begin shortly. The Gloucestershire health system conducted extensive public consultations from 2020 to 2023 for the Fit for the Future programme, aiming to strengthen eleven specialist services across Cheltenham General Hospital and Gloucestershire Royal Hospital. Eight of these service improvements have been completed, with the remaining three on track for completion in 2024/25. Professor Mark Pietroni confirmed the process of assurance around the centralisation of the Acute Medicine Take at Gloucestershire Royal Hospital. The Trust had consulted widely with clinicians across all specialities in Cheltenham and Gloucester and there is an extensive public and stakeholder communication plan in place. The Trust expects an update on the next steps of the Fit for the Future programme later this summer.<br><br>**RESOLVED:** The Board **NOTED** the report. |
| **29/24** | **Strategic and Operational Risk** |
| | Kerry Rogers, Director of Integrated Governance presented a report on the Board Assurance Framework and Trust Risk Register. While the Trust Risk Management Group functioned as intended the reporting process to Trust Leadership Team, the Board and its committees' needed refinement. The current Board Assurance Framework was functional but required improvement in order to be more efficient. Work was underway included updating the process for reporting and managing the Board Assurance Framework. Future reports should provide confidence in control measures to manage risks effectively. A new report format would be brough to the Board at its meeting in September.<br><br>**RESOLVED:** The Board **NOTED** the report. |

| Ref. | Item |
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| **30/24** | **Audit and Assurance Committee Report** |
| | John Cappock, Non-Executive Director presented reports from meetings held on 4 June, 20 June and 26 June 2024. At its meeting on 4 June there were no items rated red. Items rated red at meetings held on 20 and 26 June included the Head of Internal Audit Annual Opinion. Freedom to Speak Up and Consultant Job Planning. The Head of Internal Audit's annual opinion gave an overall statement of limited assurance due to financial outcomes, Care Quality Commission findings, limited assurance opinions on individual audits issued throughout the year, and some recent findings that showed a lack of evidence of improvement. However, it was rated amber due to sustained improvement in engagement and plans to address specific Care Quality Commission findings. Findings from the Freedom to Speak Up review aligned with the Freedom to Speak Up report presented to the Board on 9 May 2024, and actions were being addressed. A report on Consultant Job Planning was commissioned by management to obtain a candid assessment of the current position, resulting in a range of helpful recommendations, all of which were accepted. The Audit and Assurance Committee meetings on 20 and 26 June 2024 addressed several crucial areas. The Going Concern statement was endorsed, with the Committee concluding that the Trust is clearly a going concern, supported by the overall External Audit opinion and financial improvements. The Annual Governance Statement was approved, accurately reflecting the Trust's risk management and control effectiveness, despite significant issues noted. The Annual Report, reviewed in two iterations, was strengthened based on External Audit feedback and endorsed for Board approval. The Code of Governance requirements were confirmed as addressed, and the External Audit report's findings of significant control weaknesses were noted, with a commitment to a lessons learned approach. Finally, the Committee scrutinised and recommended the Annual Accounts for Board adoption.<br><br>**RESOLVED**: The Board **NOTED** the Audit and Assurance Committee report. |
| **31/24** | **Quality Account** |
| | The Quality Account 2023/2024 serves as the Trust's annual public report on service quality, fulfilling legal requirements and highlighting both past performance and future priorities. This year, key regulatory changes included removing the need for a Quality Report in the Annual Report. Integrated Care Boards have assumed responsibilities for the review and scrutiny of Quality Accounts. The Chair asked about the rationale behind selecting the Trust's quality priorities for 2024/25. These priorities were identified through an analysis of risks, incidents, and team feedback, focusing on at least three critical safety areas. The selection process involved a detailed decision-making approach with input from various stakeholders, as outlined in the 2023/24 Quality Account. To ensure accountability, progress towards these priorities will be tracked using clear indicators and metrics, with regular updates provided to the Quality and Performance Committee from the Quality Delivery Group the throughout the year.<br><br>**RESOLVED**: The Board **NOTED** the Quality Account 2023/2024. |
| **32/24** | **Maternity Update** |
| | **Care Quality Commission - Section 31 Summary Report** |
| | The Chair welcomed Lisa Stephens, Director of Midwifery, to the meeting. In response to the Care Quality Commission's (Section 31 letter, dated 9 May 2024, the Trust implemented immediate actions to mitigate risks in the Maternity Services at Gloucestershire Royal Hospital. |

| Ref. | Item |
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| 32/24 | **Maternity Update** |
| | **Care Quality Commission - Section 31 Summary Report** |
| | The Director of Midwifery, Deputy Director of Quality, and Director of Integrated Governance had been working on improving the approach to monitoring and assurance, particularly around Section 31, to reduce the volume of narrative information being submitted. The Care Quality Commission has emphasised the importance of understanding the methods behind Trust improvements, i.e. what, how and why, not just the outcomes. Over the past few months, significant progress had been made in changing how maternity services operated, with an emphasis on the focus, pace, and engagement of the multidisciplinary team working with the corporate executive team, even as data shifts were anticipated. Governance had been challenging due to competing timelines, with the CQC requiring detailed monthly reports for assurance. Al Sheward noted that the CQC had asked the Trust to establish an assurance process to audit the risk of Post Partum Haemorrhage. He questioned how the Trust could be assured that the audits had been conducted and suggested that assurance might come when the Trust could evidence that 100% of women had been assessed for Post Partum Haemorrhage. Matt Holdaway asked the Board to note that it had received papers submitted to the CQC at the end of May and highlighted that a subsequent submission was included in today's papers. The Trust met with each of the five workstream leads to request timelines for achieving full assurance and the Board would be provided with a more concise report at its September meeting, detailing progress across all workstreams. Kaye Law-Fox asked to know when the process for the Section 31 notice was expected to end. The endpoint would come when the Trust provides sufficient assurance for each of the five workstreams. However, the primary focus would be on ensuring the Trust demonstrates sustainable improvement, with particular emphasis on benefiting from the broader impact on team working. Vareta Bryan understood that getting the basics right was part of the process and ensuring their sustainability. Resourcing had been a key issue in balancing the needs for scrutiny and reporting while keeping services safe, but progress had been made, particularly in improving joint working across the multidisciplinary team, which provided assurance. Professor Mark Pietroni noted that the Trust had implemented a quality improvement methodology aimed at establishing lasting change. He observed that this approach may take longer to implement however it was designed to create enduring improvements.<br><br>**RESOLVED:** The Board **NOTED** the contents of the report and **RECEIVED ASSURANCE** that a robust improvement programme of work is underway. |
| | **Perinatal Quality and Safety Report Q4 2023-24** |
| | Lisa Stephens presented the Quarter 4 Perinatal Quality and Safety Report, which outlined locally and nationally agreed measures for monitoring maternity and neonatal safety, as per NHS England's guidelines. The report informed the Board of current and emerging safety concerns and provided insights across the multi-disciplinary maternity services team, also presented to the Local Maternity and Neonatal System. In March, the Trust implemented the Patient Safety Incident Reporting Framework altering the process for incident review and reporting. The stillbirth rate, previously raised as a concern, was validated for Q3 and Q4, showing rates of 3.5 and 3.6 per 1000 births, both below the national average of 4 per 1,000 births. During Q4, there were no maternal deaths, two new Serious Incidents, 27 new complaints, 823 Friends and Family Test (ratings with 83.9% positive responses, five stillbirths reviewed, and eight Serious Incidents, three of which met the Maternity and Neonatal Safety Improvement referral criteria. |

| Ref. | Item |
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| 32/24 | **Maternity Update** |
| | **Perinatal Quality and Safety Report Q4 2023-24** |
| | In February, a Safety Champion Walkabout highlighted staffing concerns. Following the Section 31 notice in May 2024, governance systems and data quality were reviewed to enhance assurance reporting, with progress reported Trust governance processes to the Board. Additionally, efforts were being made to improve the efficiency and quality of the Perinatal Mortality Review Tool (process, acknowledging that the current system was lengthy and required further review time. The Chair asked to know how the target figure of 2.5 per 1,000 births was determined. The Local Maternity and Neonatal System chose the 2.5 per 1,000 births target. Matt Holdaway suggested that there needed to be a greater focus on thoroughly reviewing cases and effectively embedding learning. He noted that the emphasis on data discussions had detracted from the more critical task of ensuring proper case referrals based on evidence. Sally Moyle inquired about the actions taken when the 90% training compliance target was missed and questioned how accountability was demonstrated when professional groups failed to meet this target. The team had tracked progress through a dashboard that separated professional groups, allowing for targeted support to those needing help with training. The shortfall in achieving 90% was attributed to a year-long projection that started at zero and gradually built up, rather than using a continuous assessment. The team anticipated reaching the required percentage by December, with continuous monitoring in place to address any challenges. Achieving the 90% target was essential for qualifying for the financial incentives offered through the Maternity Incentive Scheme, which aims to improve maternity safety within NHS Trusts. The dashboard facilitated a focused approach on different groups and types of training to close the gap effectively.<br><br>**RESOLVED:** The Board **NOTED** the risks highlighted around Perinatal Mortality Review Tool, data quality. The Board **NOTED** the ongoing improvement work with a quality Improvement focus. |
| | **Midwifery, Maternity and Neonatal Staffing Report for Quarter 4, 2023/2024** |
| | Lisa Stephens presented the Quarter 4 Midwifery, Maternity, and Neonatal Staffing Report, which highlighted improvements in workforce planning and safe staffing despite ongoing challenges, such as a 10% vacancy rate and a shortage of 51 whole-time equivalents. Appraisal rates had increased from 65% to 72%, and one-to-one care had improved from 98% to 99%. The service had made significant progress in reducing delays in labour and elective caesarean sections, upskilled Band 2 to Band 3 care assistants, and welcomed new obstetric consultants, splitting the rota to ensure 24/7 consultant availability. The Trust achieved 90% compliance with mandated consultant presence and revised the long-term locum onboarding process to better cover maternity leave. However, challenges persisted in neonatal anaesthetics due to nurse staffing issues, which affected compliance standards, and a plan was actioned to address these concerns. Kevin McNamara had suggested including staffing issues related to scanning in the report, despite these being part of a separate division. The Chair requested clarification on the specific clinical leadership responsibilities of the three new Consultant Obstetricians. Dr. Cornell was appointed labour ward and department lead, Dr. Gowda as a medicine consultant focusing on governance, and Dr. Kieran, who would join in September, as the maternal medicine lead. The Chair requested an update on the use of Entonox on the labour ward, including the status of the scavenging system and the cracking unit, noting that it was both a health and wellbeing issue as well as an environmental concern. |

| Ref. | Item |
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| **32/24** | **Maternity Update** |
| | The Trust's assessment revealed that while most rooms in the labour ward had acceptable rates of nitrous oxide, one room had not yet achieved the same assurance, and Entonox was not being used there. A temporary scavenger was put in place as part of an ongoing assessment to determine its appropriateness, with regular testing conducted to evaluate the suitability of these measures.<br><br>**RESOLVED:** The Board **NOTED** the contents of the report and the non-compliance with British Association of Perinatal Medicine (standards for neonatal nurse staffing. The Board **AGREED** the action plan developed to address these issues. The Board **NOTED** non-compliance with Royal College of Obstetricians and Gynaecologists audit standards and **AGREED** the action plan which will be monitored through the Maternity Delivery Group and Quality and Performance Committee |
| **33/24** | **Annual Medical Appraisal and Revalidation** |
| | The annual compliance report, required by NHS England, was presented for Board approval. It follows the NHS England template and focuses on the medical appraisal process mandated by the General Medical Council (This process ensures doctors are revalidated every five years. It includes annual appraisals, 360 reviews, Continuing Professional Development (returns, and patient feedback. The Associate Medical Director for Foundation Appraisal manages this with support from trained appraisers, mainly consultants. Governance is provided by the Revalidation Oversight Group chaired by Professor Mark Pietroni. This group meets twice a year and reports annually to NHS England. A recent inspection by the Regional Medical Director gave positive feedback with some recommendations. Five deputy responsible officers were appointed to assist with revalidations. However, the final responsibility remains with Dr Mark Pietroni, who is currently sharing the workload after the deputies completed their training. Kevin McNamara noted that certain aspects of the process required strengthening, particularly the connection between revalidation and employment, including line management. He emphasised the need to ensure that discussions about a doctor's performance, such as resource allocation, are well-aligned. While the paper focused on doctors, he stressed that the robustness of the process should extend to all staff.<br><br>**RESOLVED:** The Board **NOTED** the contents of the report and **APPROVED** it as an annual statement of compliance to be passed to NHS England. |
| **34/24** | **Quality and Performance Committee Report** |
| | Sam Foster, Non-Executive Director, presented reports from meetings on 29 May and 26 June 2024. The committee, with support from the Director of Integrated Governance, is improving its business processes. This includes the timely distribution of meeting papers and a clearer understanding of when sufficient assurance has been received from reports. Professor Mark Pietroni emphasised the need for Venous Thromboembolism (compliance with the National Institute for Health and Care Excellence (standard, which mandates that assessments be completed within 14 hours of admission, with attention given to both completion and timeliness. A new Venous Thromboembolism dashboard revealed that while 90% of assessments were completed, only 75% met the 14-hour requirement, and Professor Mark Pietroni expressed confidence in improving these figures, particularly in maternity services, with plans for a more detailed analysis in future reports. The committee discussed the challenges the Trust faced in achieving adequate patient flow within the hospitals. The focus had been on reducing the number of people classified as "No Criteria to Reside", where patients occupied hospital beds despite no longer needing acute care and requiring discharge or transfer. |

| Ref. | Item |
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| **34/24** | **Quality and Performance Committee Report** |
| | Gloucestershire had a disproportionate number of patients being discharged on Pathway 2, which was to a reablement bed, and which caused delays in the discharge process. The Integrated Care Board) Flow Director acknowledged that strategic conversations were ongoing but not fully developed, stressing the need for all system partners to respond uniformly to improve patient flow and reduce the number of patients classified as "No Criteria to Reside". The committee recognised that both cultural and operational improvements were necessary among all system partners, including the Trust, to address these challenges. The committee planned to receive a report on harm related to system delays, particularly those associated with patients classified as "No Criteria to Reside", at its meeting in September 2024.<br><br>R**ESOLVED:** The Board **NOTED** the update from the Quality and Performance Committee. |
| **35/24** | **Integrated Performance Report (IPR) (Operational Performance)** |
| | Al Sheward presented the Quality and Performance Report (and the operational performance section of the Integrated Performance Report (I) for June 2024. The Board was asked to note the following key points:<br><br>• Finance and Workforce Updates: The finance and workforce elements of the Integrated Performance Report were nearing completion, with the aim to include them in the August report, ahead of schedule.<br>• Emergency Care Performance: Significant work was being undertaken to improve emergency care, particularly regarding ambulance handovers and the overall performance of the Emergency Department (). Despite improvements, issues like the disconnect between non-criteria to reside (patients and ambulance delays remained.<br>• Elective Recovery and Referral to Treatment (): The Trust faced challenges with elective recovery plans, particularly regarding 52-week and 65-week RTT targets. However, there was positive news as the Trust reported zero 78-week breaches in June, marking a significant achievement.<br>• Cancer Services: Deep dives into cancer services, particularly urology and lower Gastrointestinal), had been conducted to address ongoing concerns. There is an emphasis on improving diagnostic times and addressing delays in areas like histopathology.<br>• Diagnostics: The Trust was working on an improvement plan for endoscopy and had engaged external support to address gaps in cardiology. Progress has been made in reducing wait times for diagnostics, although challenges remain in achieving optimal performance.<br>• Histopathology: Delays in histopathology are impacting cancer pathways, with manual processing contributing to extended wait times. The Trust is exploring digital solutions to expedite the process and reduce delays.<br><br>Kaye Law-Fox asked about the possibility of adding more detail to the expected recovery section, specifically outlining the actions needed to meet targets, such as a "route to green," and consistently showing the impact of underperformance across all services. It was noted that while the Trust was using the Integrated Performance Report as part of its performance assurance and accountability framework, additional work was needed. This included providing more training, help, and support for those contributing to the assurance reports. The Trust planned to continue working with teams to make reporting more concrete, focusing on the "when" and "how" rather than just a general overview. |

| Ref. | Item |
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| **35/24** | **Integrated Performance Report (IPR) (Operational Performance)** |
| | Kevin McNamara acknowledged the positive progress with "No Criteria to Reside" efforts whilst recognising that the system target is still some way off. Significant effort has been put into this work and should be a source of confidence for team across the system, however we need to continue to challenge ourselves where performance in below peers whether that is internal to the Trust or to the system. It was emphasised that, while not the only factor affecting flow through the hospital, this issue remained crucial for patient experience and outcomes and needed to be continually raised in system discussions. Matt Holdaway reported an increase in *Clostridioides difficile* (cases over recent months but remained optimistic that the Trust would stay below the annual threshold set by NHS England. Concerns were raised about the number of patient falls, which had not decreased as expected post-winter, despite efforts to mitigate harm related to staffing challenges. An in-depth report was scheduled for September to provide assurance to the Board. Postpartum haemorrhage continued to be a focus, with the "Reduce" project and other measures being implemented to improve outcomes.<br><br>**RESOLVED:** The Board **NOTED** the Integrated Performance Report for June 2024 |
| **36/24** | **Annual Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training** |
| | The Chair welcomed Dr Shyam Bhakthavalsala, the Guardian of Safe Working Hours to the meeting. Under the June doctors' contract, junior doctors filed 439 exception reports over the past year, with 22 highlighting immediate safety concerns, mostly due to excessive working hours in general medicine. Although the number of reports decreased from 480 to 130 compared to the previous year, the figures remained significant. The Trust compensated over £4,000 for extra hours worked but continued to face challenges like inadequate handover times and staffing gaps. Members of the Board emphasised the need to benchmark these figures against similar organisations and assess whether the exceptions pointed to systemic rota issues or typical workload challenges. They also noted problems with the process for signing off excess hours, suggesting further exploration by the People and Organisational Development Committee, including triangulation with an existing audit report, to address these concerns and ensure proper mitigation of any patient safety risks.<br><br>R**ESOLVED:** The Board **NOTED the** Annual Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training for assurance and information. |
| **37/24** | **People and Organisational Development Committee Report** |
| | Balvinder Heran, Non-Executive Director, presented a report from the meeting held on 28 May 2024. The committee received an update on the attraction strategy, which had been aligned with the Workforce Sustainability programme. Improvements were noted in the time to hire, with efforts focused on sustaining these gains and enhancing the applicant experience through improved online processes. The development of a marketing strategy and plan had progressed well, and the Employee Value Proposition was defined through a series of focus groups, providing meaningful and relevant insights. The report also addressed ongoing recruitment activities, such as careers fairs and digital efficiencies, as well as efforts to standardise rates for agency and bank staff to reduce competitiveness. |

| Ref. | Item |
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| **37/24** | **People and Organisational Development Committee Report** |
| | An in-depth review of attrition data revealed that many candidates had withdrawn from the recruitment process due to receiving other job offers, personal circumstances, or a loss of interest. To address this, reducing time-to-hire had been identified as a priority, with encouragement for managers to allow time off for interviews. The highest attrition rates were observed among administrative and clerical staff, largely due to career progression opportunities and competition from other sectors. While improvements were noted, the overall item remained rated Red due to ongoing challenges, and the committee requested further assurance on the impact of these improvements, particularly concerning BME staff members' application processes.<br><br>**RESOLVED: The** Board **NOTED** the update from the People and Organisational Development Committee and **AGREED** the Board would receive an updated People and Organisational Development Performance Dashboard at its meeting in September. |
| **38/24** | **Finance and Resources Committee Report** |
| | Karen Johnson, Director of Finance presented a report from the meeting held in June 2024 on behalf of Jaki Meekings-Davis, Non-Executive Director, who had left the meeting. The financial sustainability target for 2024/5 was a major challenge, with concerns about the heavy reliance on non-recurrent savings. The divisions and corporate areas were working hard, but meeting the £37.5 million target, which represented 5% of expenditure, was a significant concern. Challenges remain with the delivery of existing savings plans, for example, capacity issues within the procurement team, with recruitment efforts failing to fill critical gaps, making it an area which required urgent attention if we are to push further on savings opportunities in areas such as this. Lastly, the Integrated Care System (estates strategy had been discussed, focusing on the tension between the short time available to prepare the submission and ensure buy in. In addition, the system's financial deficit risk share approach, similar to last year, was also noted.<br><br>**RESOLVED:** The Board **NOTED** the Finance and Resources Committee Report for June 2024 |
| **39/24** | **Financial Performance Report** |
| | Karen Johnson presented the Financial Performance Report (Month 02 – Ended 31 May 2024). The Board was asked to note the following key points:<br><br>• The Trust reported a year-to-date deficit of £10.522 million, which was £898,000 worse than planned. This figure included adjustments for donated assets and the Salix grant.<br>• The Integrated Care System had reported a year-to-date deficit of £5.383 million, which was in line with the plan, with no organisations forecasting a deviation from their agreed breakeven positions by the year-end.<br>• Capital expenditure was £2.69 million, which was £722,000 behind the planned spend of £3.412 million. However, the Trust was still forecasting a breakeven outturn in line with the original plan.<br><br>The Trust faced pay pressures, initially exceeding workforce levels by 330 but reducing to 260 by month three, showing progress. The nursing team was commended for cost management and improved oversight, though industrial action added £500,000 to the medical workforce budget. Concerns were also raised about non-pay pressures in drugs and clinical supplies. Capital spending was slightly behind plan. The financial sustainability program highlighted a material shortfall in savings further. |

| Ref. | Item |
|---|---|
| **39/24** | **Financial Performance Report** |
| | The discussion noted that while activity levels had increased by 26% in month one compared to 2019/20, the associated costs did not decrease as expected, highlighting a key issue. This disconnect between higher productivity and static costs would be further addressed in reports to the Finance and Resources Committee.<br><br>**RESOLVED:** The Board **NOTED** for assurance the month two Finance Report. |
| **40/24** | **Any other business** |
| | Kevin McNamara reported that Amanda Pritchard, the Chief Executive of NHS England, had sent a letter to NHS Trusts in response to the Channel 4 Dispatches program. The programme had featured distressing undercover reports from Shrewsbury, particularly highlighting issues such as patients who were cared for in corridors. In her letter, Amanda Pritchard emphasised the need for Trusts to assure themselves of the quality and safety of their services, urging a thorough review of practices to ensure that similar problems were being addressed. She called for honesty in these assessments and encouraged organisations to take immediate action where necessary. The letter also prompted discussions on the broader issue of corridor care, which is a known challenge within the NHS. The Chair questioned how the Trust could ensure compassionate care in challenging environments. Kevin McNamara agreed, noting the importance of addressing cultural factors. |
| **41/24** | **Governor observations** |
| | Andrea Holder, Lead Governor, acknowledged the efforts of the Maternity team and their ongoing actions. Mike Ellis, Public Governor, appreciated the Integrated Performance Reports enhanced patient focus and the benefits it could bring. While he had concerns about the cessation of the acute medical take in Cheltenham, particularly for staff and residents, he was optimistic about the opportunity for Urology to use the space, believing it would improve cancer care and service delivery. He also highlighted the importance of resolving the bottleneck in histology reporting to ensure timely urology cancer diagnosis and treatment, reducing patient anxiety. |
| **21/24** | **Date and time of next meeting** |
| | Thursday 12 September 2024 at 13:00 (Museum of Gloucester, Gloucester) |

Gloucestershire Hospitals NHS Foundation Trust

**Report to the Meeting of the Gloucestershire Hospitals NHS Trust Board of Directors**

**12 September 2024**

# 526 voices - Experience of our patients as reported in the National Inpatient Survey

## Introduction

The purpose of this story is to bring to life the results of the National Inpatient Survey 2023 using the comments provided by patients as part of the survey. The story will demonstrate where as an organisation we have provided a positive experience for our patients and therefore where we can learn from good practice and highlight the areas where focused improvement is required.

Each month the majority (89.5% August 2024) of our inpatients (excluding daycase and assessment units) report through the FFT that they receive good care. This story aims to reflect these experiences too.

## Patient Background

This patient story is made up of the experiences of 526 patients that completed the National Inpatient Survey 2023. All of these patients stayed at least 24 hours and received either emergency or elective care in our hospitals during November 2023.

79% of these patients have a physical or mental health condition, disability or illness that has or is expected to last 12 months or more.

50% of these patients are women and 49% male with 64% aged 66 or over. 94% of these patients are white.

The experiences of these patients using the services in our organisation was ‘about the same’ compared to other Trusts. Meaning there is some really good practice and excellent care being delivered to some of our patients, while we have areas for improvement.

## Story Summary

### Admission to hospital

The story demonstrates that patients who access our inpatient services have a better experience of being admitted to hospital. We hear regularly of the frustration among patients having to wait prolonged periods on waiting lists, however, the story shows the importance of managing expectations in consultations.

There are positive comments regarding the use of Surgical Assessment Unit to reduce the wait in the Emergency Department. There are fewer positive comments regarding waiting in the Emergency Department for a bed and this is reflected, however, the FFT scores and feedback have been increasing with August score at 80.6%, the highest for more than a year.

**The hospital and ward - sleeping**
Patients reported difficulty sleeping on the ward with the majority of patients sleep being disturbed by other patients and the lighting in ward areas. Comparatively to other Trusts, we also need to improve how we explain to patients why we are moving them to another ward, particularly at night.

**The hospital and ward - Cleanliness**
Cleanliness of the ward is an area requiring improvement with patients reporting that they did not find their ward area as clean as we would want or compared to other Trusts. Improvements in cleaning audits and planned work this month to begin a programme to declutter ward areas should support an improvement in this.

**The hospital and ward – Care**
The story provides some examples of excellent care in relation to personal care and accessing medication. It also highlights the care received from both our doctors, nurses, allied health professionals and other healthcare professionals in ensuring our patients are treated with respect and dignity, have the worries and concerns addressed and made to feel comfortable and well cared for.

**The hospital and ward - Nutrition and hydration**

Nutrition and hydration experiences are mixed and the story reflects that. Being able to have food that met the dietary needs of our patients needs to be improved. The quality of the food is also reported as just below the national average. We are slightly above average in supporting our patients to drink. This area of improvement has been identified also through the Patient Led Assessments of the Care Environment (PLACE) and a Nutrition and Hydration quality improvement programme is underway.

**Leaving Hospital**

An area our patients report a less positive experience is at the end of their stay. Patients report a lack of involvement in decisions about going home both with themselves and their carers or family. Patients also note that they felt very rushed in the end after having waited for some hours to go home.

**Key Themes and Learning Points**

- The comments show that experiences are impacted by how the interactions we have with patients makes them feel.

- Management of patients' expectations, particularly relating to waiting.

- Ensure patients are involved in decisions about their care, including the provision of high quality, accessible information. This is necessary at all stages of a patient's journey with a particular focus required

- Provision for supporting our patients with their nutritional needs

- Cleanliness of ward or department requires improvement.

**Impact on Patient Care**

- Communication is a Safety Priority. Work has started to improve proactive communication with carers and families, following a review of experience themes
- Nutrition and hydration quality improvement work ongoing including 5 workstreams. Each question relating to nutrition and hydration within the survey has been assigned to each workstream for monitoring
- National Standards of Healthcare Cleanliness in place and a revised framework for cleaning standards and responsibility in place. In addition, de-cluttering project commencing in September 2024.
- Patient Led Assessments of the Care Environment (PLACE) will be taking place next month and a plan in place undertake a programme of 'PLACE lite' through the year to monitor response to PLACE action plan.

**Conclusion**

Members of the board are asked to note the number of patient voices that go into our patient surveys and the improvement response. Impact will be measured with the next survey which sill take place later this year and will again survey a cohort of our patients in our care during November 2024.

**Recommendations**

The Board are asked to note the story and the associated improvement work.

**Katherine Holland, Head of Patient Experience**
**September 2024**

# Chief Executive Report to the Board of Directors - Sept 2024

## 1. People and Culture

### 1.1 General Election

Since the last Council of Governors Meeting there has been a change of Government following the General Election. For Gloucestershire, there was also a change to the constituent boundaries with the creation of the cross-county boundary constituency of South Cotswolds (combined with parts of Wiltshire), which has increased our MPs from six to seven.

There were six new MPs elected for Gloucestershire, including Matt Bishop, who is one of our Governors and we look forward to working with them all and we have had contact from most already. The full list of MPs is below:

- Max Wilkinson – Cheltenham.
- Matt Bishop – Forest of Dean.
- Alex McIntyre – Gloucester.
- Sir Geoffrey Clifton-Brown – North Cotswolds.
- Dr Simon Opher – Stroud.
- Dr Roz Savage – South Cotswolds.
- Cameron Thomas – Tewkesbury.

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 Lord Darzi Review

The new Government announced on 11 July that Lord Ara Darzi would lead a rapid investigation and analysis of what the NHS does now and the scale of the challenges it faces.

Lord Darzi is a surgeon and innovator, independent peer and former health minister. He also led the NHS Next Stage review in 2007/08.

The investigation will consider the available data and intelligence in order to:

- Provide an independent and expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system.
- Ensure that a new 10-year plan for health focuses on these challenges.
- Stimulate and support an honest conversation with the public and staff about the level of improvement that is required, what is realistic and by when.

The analysis aims to shine a light on health inequalities and unwarranted variation in terms of demand for, access to, quality of and outcomes from NHS services across England.

It is expected that the independent investigation will report at some point in the autumn.

### 1.3 Industrial Action update - Junior Doctors

The British Medical Association's (BMA) Junior Doctors' Committee has agreed to put the latest Government pay rise before its members.

The latest offer is made up of a 4% backdated pay rise for 2023-24, on top of the existing increase worth an average of 9% for the last financial year. A further pay rise worth about 8% is being offered for 2024-25, as recommended by an independent pay review body.

That brings the total over the two years to roughly 22%, on average, for each junior doctor, with the lowest paid set to receive the largest increases.

If accepted, it would bring to an end a series of 11 separate periods of industrial action since March 2023.

### 1.4 Industrial Action update - GP services

GP services across England began collective action on Thursday 1 August for an indefinite period of time, and while there may be some disruption to services practices will remain open as usual and patients can make requests by phone, on-line or by walking in.

During collective action, practices are still required to be open between 08:00 and 18:30 Monday to Friday.

The nature of the action means that the impacts will vary at different GP practices and from area to area but could include GPs limiting the number of patient appointments per day.

NHS teams have worked hard to plan for disruption and to mitigate this where possible to ensure services continue to be provided for patients.

### 1.5 Agenda for Change

The Government announced in July the 2024/25 pay award for staff under the remits of the NHS Pay Review Body (NHS PRB).

With effect from 1 April 2024, a 5.5 per cent consolidated uplift for all Agenda for Change staff on NHS terms and conditions was approved.

Final details of the pay uplift such as when the backdated pay will be received are unclear at this stage.

Historically uplifts have been backdated and been paid in late summer or autumn. We are awaiting final details. We are also awaiting details on how it will be funded.

## 2. Operational context

### 2.1 Performance

**UEC**

Since July 8th (the first day of 8 Days of Summer), no patients have been boarded in ward corridors which is a significant achievement. We recognise that the boarding has impacted on the quality of patient and staff experience and several new processes, including the Integrated Flow Hub (IFH), have made a positive difference to flow across both hospitals. Building on the success of the 8 days of Summer working to identify those patients who

could leave the Trust by asking the Question – Home? Why not today? Resulted in the highest number of discharges we have seen for some time.

The Trust has set a No Criteria to Reside (NCTR) target of 105 by the end of August 2024 we currently work at around the 137 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, reduced delays for patients and reduced deconditioning hence why it is such a focus for us and the wider system.

Four-hour performance across the Trust improved in July to 63% from 58.6% in June. against a target of 78%. The four-hour performance in Minors improved to 71.6% in July compared to 66.7% in June.

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. We are closely monitoring the potential impact of the collective action taken by colleagues in General Practice.

Ambulance handover delays showed some signs of improvement in July. This is on the backdrop of an 6% increase in Ambulance arrivals across the Trust between June and July. The average handover time in July was 55mins. This compared favourably to the two previous months 78 mins and 76 mins respectively. Both CEO and COO have joined the SW Ambulance Hanover improvement programme. In some other parts of the country systems have moved to 45 minute handover deadlines before the crew leaves the patient in ED and this is something that we need to develop our thinking on.

**Elective Care**
Improvements with elective care were seen in July as we continue to reduce the number of patients waiting more than 65 weeks by the end of September. At the end of August there are 459 patients at risk of breaching 65 weeks at the end of September. Our plans will see this number significantly reduce in September. We do not plan to have more than 50 patients at the end of September (8 Spinal and 48 ENT). The Trust has not reported any patients waiting more than 78 weeks since June 2024.

**Cancer**
Current cancer data for July is being finalised. However, the following represents our position at 22nd August 2024.

| Standard – JULY 2024 | Total Seen | Breaches | Target | Performance |
|---|---|---|---|---|
| 2 Week Wait | 2,808 | 873 | 93% | 68.9% |
| Breast Symptomatic 2WW | 129 | 91 | 93% | 27.9% |
| 28 Day FDS | 2,617 | 567 | 75% | 78.3% |
| 31 Day Overall | 831 | 53 | 96% | 94.5% |
| 62 Day Overall | 354.5 | 134 | 85% | 62.2% |

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.

# 3. Quality & performance

## 3.1 NHSE's improvement teams offering support

NHSE National Team is providing additional support to the Trust ahead of winter 2024to help support ambulance offloads, ambulance handovers and waiting times in ED. The Trust is working with NHSE's Getting it Right First Time (GiRFT) and the Emergency Care Improvement Support Team (ECIST) as part of a targeted approach aimed at improving performance. It is planned to mobilise this work over the autumn. This will build on our existing approach through Working as One and the Clinical Vision of Flow (CVoF).

## 3.2 Right Care Right Person

Gloucestershire Police will be adopting Right Care Right Person (RCRP), which is an operational model that changes the way the emergency services respond to calls involving concerns about mental health.

Listening directly to the individuals who have experienced mental health crisis, it is known that police intervention can sometimes have a detrimental effect on patients who can feel they are being criminalised because of their health or social care issues.
The RCRP approach is solely about ensuring our communities receive an appropriate response from the individuals and agencies best equipped to support them.

It will not stop Gloucestershire Police immediate response to attend incidents where there is a threat to life. However, it will mean some changes to how the police respond if a patient has left an NHS premise or when individuals are brought to a place of safety (which could include an emergency department) if they require health support. The Trust are working with system partners to plan for the changes that are due to come into force at the end of September 2024.

## 3.3 High Intensity Use (HIU) Patients

The Trust continues to deliver a dedicated monthly MDT clinic focused on patients with High Intensity Use (HIU) of services, including ED. The clinic brings together a multidisciplinary team including a pain consultant, safeguarding coordinator, and mental health liaison, with the recent addition of an ICB-funded HIU Social Prescriber.

The HIU Clinic continues to demonstrate its value in providing comprehensive support to patients with complex needs and a recent case highlights the effectiveness of this approach. A young person, experiencing multiple health-related anxieties, was supported by the clinic. Complex factors including social isolation, domestic abuse, and cultural barriers were identified. The presence of a Muslim HIU Social Prescriber significantly enhanced engagement, enabling effective assessment and development of a comprehensive support plan.

This case demonstrates the crucial role of the HIU Clinic in addressing the multifaceted needs of vulnerable patients. The collaboration between medical, social, and mental health services is essential in achieving positive outcomes for individuals who may otherwise continue to have a poor experience and limited ongoing support.

### 3.4 Partnership with Kingfishers Treasure Seekers and Trauma-Informed Care Initiative

The Trust has launched two key initiatives aimed at enhancing support for vulnerable patients and staff within the Emergency Department (ED).

The first is a pilot project in collaboration with Kingfishers Treasure Seekers, a Gloucester-based charity supporting vulnerable patients. Two support workers from the charity are physically present in the ED from 6-11pm daily for a 10-week pilot, providing emotional and psychological support to distressed or vulnerable patients. Initial feedback from is extremely positive and the project not only benefits patients but also provides valuable support to staff and colleagues within the department.

The work with Kingfishers Treasure Seekers coincides with the launch of our Trauma-Informed Care (TIC) educational project.

Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.

It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and wellbeing.

Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?'.

This project, funded by Health Education England, aims to equip staff in unscheduled care with the knowledge and skills to deliver trauma-informed care. We are currently recruiting a Band 7 practitioner dedicated to leading this initiative and implementing TIC principles within the department.

### 3.5 Impact of Homelessness on Attendance and Admissions

The number of people experiencing homelessness nationally and locally has significantly increased, placing pressure on our services and the Trust's homeless team has been working to review the impact on hospital admissions, discharges, and readmissions.

In defining 'homelessness' the team focuses on individuals experiencing rough sleeping, those with no fixed abode, and those registered with the homeless healthcare team or residing in a homeless hostel. The trust team specialises in supporting homeless individuals with complex needs such as mental health, substance abuse, and exploitation.

The national housing and cost-of-living crises are driving the surge in homelessness. Research indicates that homeless individuals are disproportionately affected by health issues, with higher rates of emergency department attendance, hospital admissions, and length of stay.

To address this challenge, we implemented a strict 'no discharge to the street' policy, with exceptions for safety concerns. Our goal is to prevent unnecessary hospital admissions and readmissions through early intervention and support in the community.

Analysis of discharge data shows that the vast majority of patients are discharged promptly upon medical fitness. However, delays can occur in complex cases requiring specialist placements.

Despite the rising number of homeless individuals accessing our services, we have achieved a reduction in overall admissions and readmissions. This is a testament to the hard work of our teams, particularly in the emergency department and inpatient care.

To further improve our response, the team are developing standard operating procedures for managing homeless patients in the emergency department to ensure safe and timely discharges, early housing referrals, and personalised care plans for vulnerable individuals.

### 3.6 Post Graduate Doctors in Training

An independent review by NHS England South West Workforce Training and Education Quality team has found that the Trust has made 'significant improvements' in the way it delivers training and supports Post Graduate Doctors in Training (PGDiT) in our Emergency Departments.

The team carried out a repeat visit and assessed workforce, training and education quality for doctors in training during the review.

They concluded that significant quality improvements had been made against previously identified areas and that overall, the progress made means training is now of an 'acceptable quality overall' meaning no further visits would be required. The team did identify seven further action points but the panel was satisfied with the progress made and complimented the trainers, approach to training and commitment to learning and development. The panel also signalled some concerns particularly in relation to workforce pressures and volume of work, themes that are familiar with other EDs across the country.

## 4. Strategy

### 4.1 Centres of excellence

In July we centralised the Acute Medical Take at GRH as part of our vision *centres of excellence.* While there were teething issues the service reconfiguration was largely successfully.

The benefits of centralising the service, as set out in the wider Fit for the Future (FFTF) public consultation in 2020, include:

- Patients being seen more quickly by the most appropriate specialist teams.
- Patients experience more rapid diagnosis and shorter hospital stays.
- Improved patient flow, shorter patient waiting times, and faster ambulance handover times.
- Health outcomes and the overall patient experience should be improved.

In transferring the Acute Medical Take to GRH it has enabled the Trust to complete the establishment of an expanded HASU at CGH meaning more patients benefit from specialist care, a better patient experience and an improved environment for staff. This work has been completed. Meanwhile, more work is underway to develop the new stroke ward at Cheltenham.

The centralisation of the Acute Medical Take at GRH means that 10 of the 11 service reconfigurations across both sites set out in FFTF are now complete. Work continues on the remaining change, Image Guided Interventional Surgery (IGIS), which is due to be completed next year.

To support these improvements, the Trust secured more than £100m which has been invested in new buildings, state-of-the-art technology and equipment, new clinical practice, green initiatives, as well as digital care transformation across both sites.

# 5 Regulation

## 5.1 CQC Inspection at Cheltenham General Hospital Site

An unannounced inspection in Cheltenham General Hospital (CGH) Medical Services, inclusive of Oncology, started on the 16th July with a night time visit. The inspection focused on the safe and responsive domains. On 18th July 2024 Inspectors arrived for a day time inspection. Interviews with Senior Leaders took place the week of the 5 August and data has been provided. See *here* for further information on CQC's New Approach to Assessment.

## 5.2 Adult Inpatient Survey

The CQC published its Adult Inpatient Survey last month (August). Overall, the Trust have seen a positive improvement in the results. Key highlights include 80% of respondents rated the overall patient experience at Cheltenham General and Gloucestershire Royal Hospitals positively at a rating of 7/10 or more, 98% of respondents said they were treated with respect and dignity and a further 98% of patients also said they had confidence and trust in doctors. Areas for improvement include the time patients can wait for admission (an area we know continues to be a challenge and is a significant focus for us as we work to reduce the waiting list), explanations given to patients if changing ward at night and the amount and level of patient involvement in relation to discussions concerning their discharge from hospital. We are continuing to review the findings to better understand how we can respond and work is ongoing to enhance patient experience. The results will come formally through the governance route to Q&P Committee.

## 5.2 Learning from our CQC inspections

The Chief Nurse and Director of Quality led a learning event on 21 June 2024 and the learning from each service was shared with clinicians across other services to ensure that we enable improvement in other areas of the organisation. This will be repeated every six months.

## 5.3 Independent Review of the Care Quality Commission

An independent review of the Care Quality Commission (CQC) has identified significant internal failings which is hampering its ability to identify poor performance at hospitals, care homes and GP practices.

The interim report, led by Dr Penny Dash, chair of the North West London Integrated Care Board, found inspection levels were still well below where they were pre-COVID, a lack of clinical expertise among inspectors, a lack of consistency in assessments and problems with CQC's IT system.

These failings mean the regulator is currently unable to consistently and effectively judge the quality of health and care services, including those in need of urgent improvement. The

report also found that social care providers are waiting too long for their registration and rating to be updated, with implications for local capacity.

The government has announced it will take steps to restore confidence in the effectiveness of health and social care regulation, including by increasing the level of oversight of CQC, ahead of a full report which will be published in the autumn.

This works forms part of the government's wider efforts to identify the challenges facing the NHS and take action to address them.

# 6 Picture Archiving and Communication System (PACS) Update

The Board will be aware of the ongoing issues the Trust has faced since the implementation of the Philips VUE Picture Archiving and Communication System (PACS) system in May 2023. At that time the Trust experienced significant disruption in terms of service delivery resulting in delays to patients and impact on staff. The Trust was hopeful remedial works undertaken by Philips and the Trust would mean those issues, whilst serious, would be short term and temporary.

Over the past 16 months, it is clear that the improvements we would reasonably expect from a supplier have not been delivered in a way that means we have a stable and consistent PACS system. The impact of this was shared with Board members in July in the form of a 'Staff Story'. The clear and visible impact on staff was evident because of the impact on their ability to care for patients who continue to experience delays in some high-risk specialities such as Breast screening.

The issues include:

- Delays to patient care resulting in impacts on waiting times.
- The frequency of down time and disruption resulting in reduced capacity and appointments;
- Experienced and dedicated staff leaving the service and the Trust due to the stress and anxiety caused by the instability of the system;
- Significant additional costs incurred through additional staffing and outsourcing as we seek to mitigate the impact of an unstable PACS system;

At time of writing this briefing, the testing of the new version of PACS and underlying infrastructure is progressing well and movement to the next stage of the programme is underway. Whist we are not expecting a perfect system, Philips consider that the most common causes of our outages are fixed in the latest version, so that moving into the Autumn we will have more stability.

However, it should be noted that there have been previous occasions where it has appeared positive progress is being made, only for instability to remain – hence the need for caution and continued focus on this issue. It should also be noted that we have spoken with other Trusts who have later versions of VUE PACS and while they are 'better' than ours they are by no means problem-free and we have to recognise that our staff may continue to have concerns about the effectiveness of the system. As such, there will be much work after moving to the new system to improve it for staff; staff who have had to endure such pressures over the last 16 months.

The Board should also be aware that as a result of the serious impact the instability caused by the Philips VUE system has had on the quality of care, our teams and operational delivery within the Trust over the last 16 months and that these issues have not been definitively resolved in that timeframe, we currently have limited confidence in Philips ability to deliver, too often, we are reliant on business continuity processes owing to the instability of the system. However, we continue to work closely in the hope that the latest version will resolve the issues we are experiencing.

At a corporate level, discussions have been ongoing with Philips regarding these issues and remedies that exist within the contract but without success. The Trust has incurred costs due to increased outsourcing to ensure continuity of the radiology service, and additional staffing costs which would not be necessary with a stable system. As we have failed to reach agreement with Philips and given the ongoing nature of the issues, I have taken the decision to trigger a clause in the contract which will move us to independent mediation. The expectation is that this will begin in October.

Finally, I would like to put on record my thanks and apologies to the teams who have been seeking to resolve these issues, and also the teams providing care who have been impacted to the extent they have been as a result of the instability of the system. Whilst we are not yet in a position we want to be, we are committed to reaching a position where we can resolve these issues for them and our patients.

**Kevin McNamara**
**Chief Executive**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

| Report to Board of Directors meeting held in Public | | | |
|---|---|---|---|
| **Agenda item:** | 9 | **Enclosure Number:** | 5 |
| **Date** | 12 September 2024 | | |
| **Title** | Strategic and Operational Risk | | |
| **Author / Sponsoring Director/ Presenter** | Lee Troake, Head of Risk and Safety and Michael Weaver, Interim Trust Board Secretary<br>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 | |

**Purpose of report**

The Strategic and Operational Risk Report enables the Board to have oversight of the Trust's risk profile and in particular, the Trust's Board Assurance Framework and Trust Risk Register.

**Strategic Risk and Board Assurance Framework**

The Board Assurance Framework is an essential strategic tool for NHS Trusts, designed to identify, manage, and mitigate strategic risks to ensure the delivery of safe, effective, and sustainable healthcare services. It highlights major risks that could impede the Trust's strategic objectives, offering a structured approach to risk management that aids in decision-making, strategic planning, and resource prioritisation. The Board Assurance Framework also enhances accountability, transparency, and compliance with NHS England and the Care Quality Commission, integrating risk management into the overall governance framework and promoting continuous improvement through regular reviews**.**

**Updates to the Trust's Board Assurance Framework**

The following items on the Trust's Board Assurance Framework have been updated since the last Board meeting in Public on 11 July 2024. The Trust Board Quality and Performance Committee received the following Board Assurance Framework Risks, SR2 Quality Governance and SR5 Quality Improvement Methodologies at its meeting on 24 July 2024.

**SR2: Failure to successfully embed the quality governance framework**

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

The Trust is undertaking several actions to improve its quality governance framework and address regulatory concerns, particularly in maternity and urgent care services. Key initiatives include reviewing and enhancing governance structures, as discussed in the December 2023 Board meeting, and aligning maternity services with the new Patient Safety Incident Response Framework.

**Updates to the Trust's Board Assurance Framework**

Following an inspection from the Care Quality Commission rapid improvement work is underway, including workshops on safety incident management and action planning. Additionally, efforts are focused on improving ratings for services deemed inadequate, with ongoing reviews of governance processes, compliance with mandatory training, and enhanced reporting structures from ward to board. These measures aim to strengthen overall governance, ensure regulatory compliance, and improve patient care outcomes.

**SR5 Quality Improvement Methodologies**

The Trust is reviewing its Quality Governance framework and implementing the Patient Safety Incident Response Framework (PSIRF), though progress is delayed, and resource challenges are prompting alternative approaches. Additionally, an A3 thinking approach for planning and monitoring improvements has been introduced, with key tools already added to the Quality Improvement resource toolkit.

The Trust Board Finance and Performance Committee received the following Board Assurance Framework Risk, SR09 Failure to deliver recurrent financial sustainability at its meeting on 29 August 2024.

**SR09 Failure to deliver recurrent financial sustainability**

- Current Risk Score: 5 x 5 = 25, Target Risk Score: 5 x 1 = 5

The Trust is developing a long-term financial plan, reviewing deficit drivers, and updating outdated policies, with ongoing communication to keep the organisation informed of financial challenges. Additionally, a national grip and control review is in progress, supported by secured resources, to address gaps in financial management throughout 2024/25. The Director of Operational Finance is leading the development of the Medium-Term Financial Plan, which will be presented at the next Committee meeting.

The Trust People and Organisation Development Committee received the following Board Assurance Framework Risk, SR17 Inability to attract a skillful, compassionate workforce that is representative of the communities we serve, at its meeting on 25 July 2024.

**SR17 Inability to attract a skillful, compassionate workforce that is representative of the communities we serve**

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

The Trust is transforming its recruitment process under the Workforce Sustainability Programme to improve efficiencies and experiences, with initiatives like TRAC Virtual Candidate Portal functionality rollout, integration of Occupational Health systems, and Trust-wide deployment of ID Verification Technology by August 2024. A marketing strategy is being developed, the Trust's website is being updated to promote job opportunities, and targeted recruitment advertising is ongoing. The non-clinical temporary staffing service launched in April 2024, showing a reduction in usage and costs, and a regional agency rate card is being implemented to ensure compliance with NHS caps. Additionally, a Workforce Controls Framework has been introduced to manage staffing and recruitment rigorously, with a workforce delivery plan being developed to support the 2024/25 Operating Plan. The committee noted the need for continuous monitoring and adjustment of these initiatives to ensure they meet the Trust's strategic goals and operational needs.

**Key issues to note with Trust Risk Register**

**Level of Risk and Risk Exposure**

Across all risk registers, 61% of risks are rated as high risk and a further 8% as extreme risk. In August the Trust exposure to risk increased by 3.1%.

**Trust risk register profile**

On the Trust risk register 59% of risks are rated as extreme and 41% rated as high risk. The Trust risk register profile is predominantly workforce risks, although the main recruitment risk, which previously scored a 20, is awaiting approval to downgrade to 16. This risk encompasses nursing recruitment for which there is already a separate risk that is pending a downgrade to 9. The main recruitment risk needs to be aligned to the nursing risk as well as the separate maternity recruitment risk and the 14 risks on the Trust risk register that relate to staffing.

The score on the main digital risk on the Trust risk register has been reduced but remains an extreme risk with a score of 15. A spotlight on the Picture archiving and communication system risks highlights the lack of timely escalation of these risks to the Trust Risk Management Group over a 12-month period. This is partially due to a lack of sponsor to bring the risk to the Trust Risk Management Group.

Similarly, a spotlight on the syringe pumps risk also indicates a breakdown in the sponsorship process and the failure of this risk to progress to to the Trust Risk Management Group for approval.

In both March and August, the value and success of the sponsorship process was challenged at Trust Leadership Team. Sponsorship was primarily introduced to prevent poor-quality risks being presented to Risk Management Group, but it has evolved into a system through which it is possible for a singular person to veto consideration of a risk by the Risk Management Group. It was agreed an alternative approach was required which will be considered and developed in the Autumn.

**Changes to the Trust risk register**

Risk #751 has been added to the Trust risk register and relates to a lack of a dedicated sonographer in Maternity and limited capacity amongst sonographers in D&S to support maternity scans within the required timeframes.

Risk #510 has been de-escalated from the TRR following a reduction of the score from 20 to 6. This was prompted by the largest of the modules (incidents) being transferred from DATIX web (old system) to DATIX Cloud (new system) in May.

Risk #436 was closed as a new air handling unit has been installed in the Chemistry laboratory, controlling ambient air temperature as required.

| System Performance Key Performance Indicators |
| --- |
| An overall level of Reasonable Assurance in relation to the Key Performance Indicators for risk management has been reported to the Audit and Assurance Committee. Whilst parts of the system can be assured, there is still limited assurance in relation to timely risk reviews and updating actions on risks and incidents. |
| **Risks or Concerns** |
| Risk in relation to the functionality of the risk and reporting functions on Cloud |
| **Recommendation** |
| Members of the Board are asked to **NOTE** the following:<br>• The strategic risks that could impede the Trust's strategic objectives.<br>• Items on the Board Assurance Framework updated since the previous Board meeting on 11 July 2024.<br>• Key issues to note with Trust Risk Register |
| **Enclosures** |
| • Board Assurance Framework Summary.<br>• Risk Management Report Board September 2024 |

## 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 | Failure to successfully embed the quality governance framework | Dec 2022 | July 2024 | July 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 | 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 | July 2024 | July 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 |

| 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 | Failure to deliver recurrent financial sustainability | July 2019 | August 2024 | August 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 | 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. | July 2019 | July 2024 | July 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 |

**Heat Map: Board Assurance Framework, Current Risk Ratings plotted**: The risks highlighted in **white** are discussed in the covering paper.

| | | Consequence | | | | |
|---|---|---|---|---|---|---|
| Likelihood | | 1 | 2 | 3 | 4 | 5 |
| | 5 | 5 Rating | 10 Rating | 15 Rating | 20 Rating | 25 Rating |
| | | | | | SR2 Quality Governance Framework<br>SR16 Culture and Retention<br>SR17 Recruitment and attraction | SR1 Urgent and Emergency Care<br>SR9 Recurrent financial sustainability |
| | 4 | 4 Rating | 8 Rating | 12 Rating | 16 Rating | 20 Rating |
| | | | | SR6 Deliver Integrated Care | SR5 Improvement and Change Management<br>SR10 Trust Estate | SR12 Cyber Security |
| | 3 | 3 Rating | 6 Rating | 9 Rating | 12 Rating | 15 Rating |
| | | | | SR11 Net-zero carbon organisation by 2040 | SR13 Digital systems functionality<br>SR14 Invest in research active departments | |
| | 2 | 2 Rating | 4 Rating | 6 Rating | 8 Rating | 10 Rating |
| | | | | SR7 Patient and Public Engagement | | |
| | 1 | 1 Rating | 2 Rating | 3 Rating | 4 Rating | 5 Rating |
| | | | | | | |

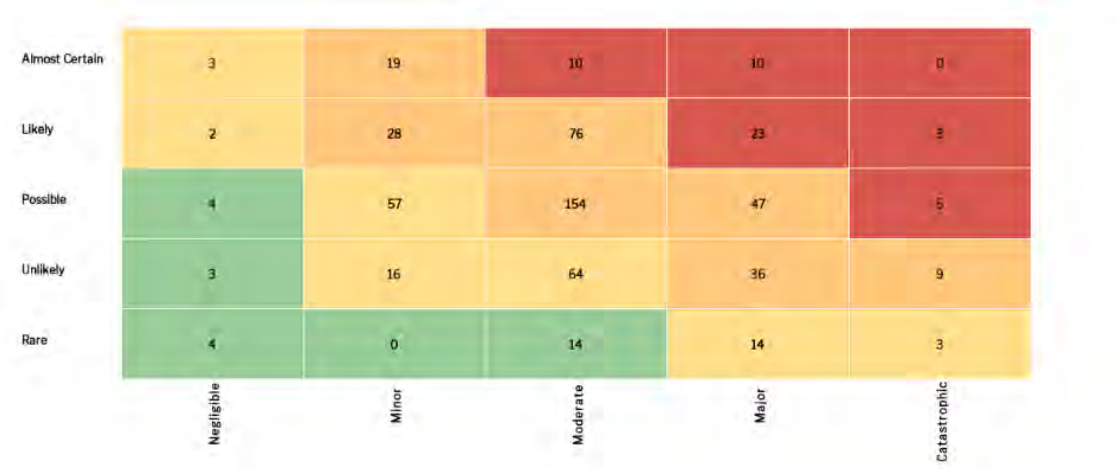
Gloucestershire Hospitals NHS Foundation Trust

# RISK MANAGEMENT REPORT – BOARD SEPTEMBER 2024

## SUMMARY

### Level of Organisational Risk

Across all registers there were 604 active risks as of 30 August 2024. Of these, 61% of risks are scored as high-risk and a further 8% are scored as extreme risk. This reflects a risk profile that is heavily weighted toward high risk and demonstrates the prevalence of day-to-day uncertainty at any one time.




### Risk Exposure Rate

In August the Trust experienced an increase in the risk exposure rate by 3.1%, with 24 new risks opening on the system. New risks allow for potential harm to be addressed before it materialises. However, they are driven by identified issues and reflect an increase in challenges faced within organisation.

## TRUST RISK REGISTER (TRR) OVERVIEW

### Risk Profile of the TRR

The risk profile of the Trust Risk Register (TRR) consists of 59% extreme risks (scoring 15+) and 41% high risks (scoring 10+).

Fourteen TRR risks impact on our workforce objective, nine of which are listed with workforce as the lead risk category. A further nine risks on the TRR are associated with safety, while six risks impact the quality of our services and are related to

staffing, high patient demand, clinical assessment and the Integrated Care Board (ICB).

Three TRR risks are identified as statutory risks including risk #426 – patient demand and overcrowding in Minors ED (score 20), and risk #266 poor flow in ED (score 16). The third statutory risk (#374) concerns the potential for prosecution due to the location of lithium batteries in non-rated fire compartments (score 15).

There are three business risks on the TRR, risk #534 which considers insufficient capital to address critical infrastructure required to support activities (score 16), risk #122 which relates to the potential for disruption following a cyber-attack (score 15) and risk #425 which concerns ageing ventilation in Theatres (score 16).

**Spotlight on Workforce risks**

Workforce risks have dominated the TRR for some time as extreme or very highly scored risks. They have accounted for the 3 of the top 4 risks on the TRR and 5 of the 11 risks scoring 16.

The three workforce risks scoring 20 were risks #79, #525 and #499. However, risk #79, which is the overarching Trust-wide risk for clinical recruitment including nursing, midwives, medical, dental and allied health professionals, has been under review by the Executive leads for Safety, Quality and People. This has recently resulted in a reduction of the score from 20 to 16 based on improvements in nursing recruitment in keys areas like COTE, Theatres, Upper GI, Oncology and Gastro. It has also been proposed that risk #79 is closed and a new more current risk is opened.

Risk #79, or the new risk proposed to replace it, will need to be aligned with risk #525 and risk #499 which are specific to recruitment in nursing and midwifery respectively. In late August, risk #525 (nursing) was reduced from a score of 20 to 9, this will go to the Risk Management Group (RMG) in September to approve a downgrade from the TRR. Risk #499 remains at a score of 20, and is being addressed by a maternity-specific recruitment and retention action plan, monitored at the Maternity Delivery Group (MDG).

The table below outlines the workforce risks on the TRR.

| Risk ID | Risk | Type | Subtype | Current likelihood | Current conse-quence | Current rating | Target rating | Oversight Committee |
|---|---|---|---|---|---|---|---|---|
| 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 | Recruitment and retention | 5 | 4 | Awaiting approval to downgrade to 16 | 12 | POD SLT, PODDG, PODC |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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 | Equality, Diversity and Inclusion | 4 | 4 | 16 | 6 | POD SLT, PODDG, PODC |
| 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 | Recruitment and retention | 4 | 4 | 16 | 6 | OHPCLI Board, PODDG, QDG, PODC & QPC |
| 281 | 3834 The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials Licence due to staff shortage. | Workforce | Staffing and competency | 4 | 4 | 16 | 1 | Medicines optimisatioCommittee, PODDG, PODC |
| 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 | Staffing and competency | 4 | 4 | 16 | 6 | QDG, QPC |
| 472 | 3743 The risk of failing to deliver the necessary support to the Haematology Laboratory due to insufficient staffing levels and lack of appropriate skill sets, leading to a delay to diagnosis or treatment within the clinical service | Workforce | Recruitment and retention | 4 | 3 | 12 | 4 | QDG, QPC |
| 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 | Recruitment and retention | 5 | 4 | 20 | 6 | Maternity Delivery Group, QDG, QPC |
| 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 | Staffing and competency | 4 | 4 | 16 | 4 | Theatres Collaboration Group |
| 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 | Recruitment and retention | 5 | 4 | Awaiting approval to downgrade to 9 | 9 | Vacancy Control Panel, Recruitment Strategy Group, PODDG, QDG, PODC & QPC |
| 609 | 2976 The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging. | Workforce | Recruitment and retention | 5 | 3 | 15 | 4 | Raditation Safety Committee, Screening Performance Committee, PODDG, QDG PODC, QDG |

**Spotlight on Digital TRR risks**

Risk #93 articulates the risk of identifying further cases of patient harm where results have not been acknowledged or actioned on Sunrise EPR. The risk arises from a lack of sign-off process when acknowledging and actioning a radiology or pathology report (score 12). Between 2021 and now, 4 deaths, 7 major harm incidents, 4 moderate harm incidents, 7 minor harm incidents and 37 no harm incidents have been identified as a result of not acknowledging or actioning radiology or pathology results. The Red Flag Working Group are developing a process for escalating unacknowledged or unactioned results, and a dashboard to monitor and respond to these pending a digital solution.

Risk #122 which articulates the risk of a cyber-attack, was recently reduced from a score of 20 to 15, to reflect work undertaken such as:

- An IT asset audit and the implementation of national standards for Data Security Protection
- Rationalisation of detection and preventing tooling
- Targeted monitoring and alerting across key systems and entry points and continued implementation of the Security Information and Event Management Solution (SIEM)
- A stocktake of end point users uploaded onto KACE and focus on the elimination of end-of-life operating systems

The Trust continues to work towards Cyber Essentials Plus and ISO 270001 certification in addition to robust disaster recovery planning.

| Risk ID | Risk | Type | Subtype | Current likelihood | Current consequence | Current rating | Target Rating | Oversight Committee |
|---|---|---|---|---|---|---|---|---|
| 93 | 3787 The risk of harm to patients due to clinical reports being lost and required clinical action omitted or delayed. | Safety | Electronic patient record | 3 | 4 | 12 | 6 | Clinical safety systems group, digital delivery group, Finance and Resources Committee |
| 122 | 3755 The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack | Business | Digital risk | 3 | 5 | 15 | 2 | Digital SLT, digital delivery group, Finance and Resources Committee |

## TRUST RISK REGISTER CHANGES

### NEW RISKS ON THE TRR

Risk #751 relates to a lack of a dedicated sonographer in Maternity and limited capacity amongst sonographers in D&S to support maternity. This risk was considered as part of the Intolerable Risk process in March 2024 but was not allocated funding. It is now part of the focus of CQC and will be managed and progressed via the MDG.

Risk Lead: Alex Holland / Executive Lead: Matt Holdaway

| **Inherent Risk** | | | |
|---|---|---|---|
| The risk of failure to provide a safe and high-quality maternity ultrasound service | | | |
| **Cause** | | | |
| Lack of scan capacity within Diagnostics and Specialities division, and limited power for W&C to change this. No current dedicated maternity scanning under direct employment/control of W&C. Increased requirements for scans to achieve compliance with national recommendations (SBLCB and MIS) | | | |
| **Effect** | | | |
| • Unable to achieve scan pathways compliant with Saving Babies Lives Care bundle version 3:<br>  ○ Unable to offer scans 3-4 weekly until delivery<br>  ○ Unable to implement uterine artery Doppler for all high-risk women<br>  ○ Unable to offer urgent scans for women presenting with RFMs (within 24 hours) or slowing growth – risk of poor outcomes and potential impact on place of birth for women<br>• Compliance with increased requirements for growth scans impacts on screening pathways and risks screening scans not being able to be reliably booked within gestational windows at times of peak capacity challenge<br>• Reputational and financial risk through adverse outcomes and inability to achieve MIS | | | |
| **Risk Category (domain)** | **Consequence** | **Likelihood** | **Rating** |
| Quality (staffing) | 4 | 4 | 16 |
| **Evidence of scoring** | | | |
| CQC report and interventions, missed / delayed scans | | | |
| **Controls** | | | |
| • Scan pathways individualised to start earlier for highest risk women in lieu of optimal uterine artery Doppler assessment service (growth scans for all eligible women are offered from 28 weeks in the Trust, rather than 32 weeks, and sometimes even earlier<br>• SFH measurement continues for women on USS pathway, in order to ensure late onset FGR not missed after scans cease at 36 weeks<br>• Plans in place to employ one dedicated maternity sonographer (midwife sonographer) with aim to try to fill gap in service for urgent/unscheduled growth scans for RFMs<br>• Project planned to assess current service and map against ideal service, | | | |

| |
|---|
| with options appraisal for various potential alternative service models<br>• Business case proposal<br>• Saving Babies Lives requirement mitigation |
| **Gaps in controls** |
| • One maternity-employed sonographer will not have sufficient impact on scan capacity to ensure that we are able to increase offer of scans until delivery for all women who need them<br>• Work required to evaluate level of service needed to achieve compliance with all national recommendations for maternity scans, with subsequent business case/options appraisal for how best to fill the gap between current service and optimal service. |
| **Actions** |
| • AH/LS/REJ meeting to discuss new post for midwife sonographer<br>• AH to look at service evaluation project for maternity scan service going forwards<br>• AH to explore options for locum sonography lists to fill gaps short-term |

**RISK SCORE CHANGES ON EXISTING TRR RISKS**

None

**DE-ESCALATION OF RISKS FROM THE TRR**

Risk #510 has been de-escalated from the TRR following a reduction of the score from 20 to 6. This was prompted by the largest of the modules (incidents) being transferred from DATIX web (old system) to DATIX Cloud (new system) in May. Incidents remaining open on web are being wound down in line with an agreed plan. With only the Alerts and Mortality modules left on web the level of risk posed by the use of this outdated system is now relatively low. The risk will be closed once the final modules go-live on the new system.

| **Inherent Risk** |
|---|
| 3084 The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems (DATIX web) for compliance, reporting, analysis and assurance. |
| **Cause** |
| Outdated DATIX web system used for Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints etc. across the Trust at all levels. Currently using an outdated version of DATIX which has functionality issues for example: Inability to integrate with new applications, poor integration between clinical systems, HR systems and business data. No analytics module, lack of basic automation/does not detect data discrepancies (i.e., score calculating etc<br>Poor audit trail in risk register module - no version control of scoring or lifecycle of the risk. Use of old computer language prompts for searching /unable to search using and/or/not-a standard feature of modern system. |
| **Effect** |

- Unable to confidently compile accurate data to support compliance, quality and safety improvement and assurance.
- Manual processes have to be used to cleanse, extract and manipulate data, increasing the risk of human error and different reporting mechanisms across the Trust.
- Lack of good governance around risk, safety and document control.
- Decision making and objective setting is influenced by risk data that lacks integrity. This may result in resources being misaligned to the risks.
- There may be missed opportunities or failure to address risks at early stage or mismanagement of risk exposing patients, visitors and staff.
- There is also an impact on productivity due to increased workloads / processing time required. This in turn increases the financial impact as more staff and times are used to support a resource intensive system.

| Risk Category (domain) | Previous Rating | New Score | | | |
|---|---|---|---|---|---|
| | | Consequence | Likelihood | Rating | Target |
| Quality (digital risk) | 20 | 3 | 2 | 6 | 3 |

**Evidence of scoring**

Score reduced as most modules have been transferred to Cloud. Main modules – risk, incidents and complaints now live on Cloud.

**Controls**

- Risks quality assured before transfer. Risk module moved to Cloud in Feb 2024
- Claims, PALS & Complaints live on Cloud. Incident Module moved to Cloud in May
- Risk Governance Process / Risk Management Group assurance
- Patient safety and H&S advisors monitoring the system daily
- Monthly performance reports to divisions identify process issues
- Risk management strategy in place
- Exec review data on performance / Divisional meetings on risk – quality boards
- Pod, Quality and digital delivery groups monitoring risk
- Bi-monthly training sessions on risk / DATIX project Manager / Project meetings weekly

**Gaps in controls**

Alerts Module & Mortality Reviews not yet implemented on Cloud

**Actions**

Remaining incidents being wound down / closed out on Web as per agreed process
Bi-weekly meetings to progress Alerts / Mortality module to implementation

**CLOSURE OF TRR RISKS**

Risk #436 was closed as a new air handling unit has been installed in the Chemistry laboratory, controlling ambient air temperature as required.

| **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 shutdown of all analytical equipment in the laboratory (Datixweb W112541 and W112544).<br>• 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.<br>• Breach of standards for ventilation - statutory intervention for failings in healthcare.<br>• 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).<br>• Frequent recalibration of equipment where the calibration is temperature sensitive and increased cost of additional calibration material and loss of staff time.<br>• Body deterioration during storage in mortuary.<br>• Impact on the quality of storage of blood components, results and turnaround times for a range of Haematology and Transfusion tests at Cheltenham General.<br>• Incorrect storage conditions for expensive blood products and reagents<br>• 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 |

**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

## HORIZON SCANNING - RISKS IN ESCALATION

This section of the report highlights key risks that are in escalation on the system due to the score meeting the TRR Appetite threshold. Risks in escalation require approval an executive (sponsor) to be referred to RMG and approved onto the TRR. Many of these risks have failed to progress to RMG for a decision. Two particular areas have been highlighted which featured in recent Board stories.

### Spotlight on PACS risks

Risk #577 – delayed diagnosis following Breast MRI and CT Staging scans due to the poor functionality of PACS was rated a 16 in February 2024. The risk lead was

required to approach an executive sponsor. The risk remained outstanding on the Surgical Divisional Quality Board risk paper from February onwards. The last documented review on 21 June 2024 states '*No improvement in PACS functionality…a significant risk to patients and staff. Some mitigation provided by employing extra staff to undertake imaging, to compensate'*. However, the risk was reduced from a score of 16 to 8 shortly after this on 11 July with the risk owner confirming that for patients whose radiology report had been delayed due to PACS, there was no 'demonstrable, disease-related harm'.

Risk #231, held by Radiology, is the risk of patient safety due to reduced performance of PACS/CRIS and was rated a 16 for Safety in August 2023. D&S Quality Board requested the owner obtain sponsorship in October 2023. In January, the score was changed from Safety (score 16) to a Workforce score of 20, after mitigations reduced the patient safety element of the risk. Consideration was given to the financial costs of £40,000 per month (outsourcing costs to mitigate PACS downtime). However, the Director for Finance advised that this was workforce risk due to the welfare implications for staff working with PACS. In May, a review noted the system was still down 3-4 times a week.

A story was presented at the last Board meeting on the significant issues with PACS, and its impact on staff wellbeing. At the PACs meeting in July, it was agreed both digital and radiology needed to provide input into this risk. At the August PACS meeting this had not been followed up and it was agreed a specific meeting was needed with digital. As yet, the risk has not been reviewed and a sponsor has not been secured after nearly a year scoring above the TRR threshold.

| Risk ID | Risk | Type | Subtype | Current likelihood | Current consequence | Current rating | Target Rating | Oversight Committee |
|---|---|---|---|---|---|---|---|---|
| 577 | 4068 The risk of delayed and poor reporting of Breast MRI and CT staging scans | Quality | Delayed diagnosis | 4 | 2 | 8 | 3 | Clinical safety systems group, digital delivery group, Finance and Resources Committee |
| 231 | 3486 The risk of compromised patient safety due to reduced performance of PACS/CRIS. | Workforce | Staffing | 5 | 4 | 20 | 2 | Digital SLT, digital delivery group, Finance and Resources Committee |

**Spotlight on Syringe Pump risk**

Risk #703 describes the risk of patient distress and poor symptom control (such as pain) during end-of-life (EOL) care due to a lack of syringe pumps. This risk was previously on the TRR in 2023 and was reduced after 50 syringe pumps were purchased and an action set for a tracker system to be introduced to prevent these being lost in the community or on wards. As the funding of the tracker system was not agreed and, over time, the pumps were not returned to the EOL team the risk re-materialised.

The issue of syringe pumps was discussed as part of a Patient Story at Board earlier in 2024 and the score was increased to 15 for quality. The executive sponsor approached in April to approve the escalation of the risk, requested the risk was downgraded as work was taking place to identify and procure a tracker system. The service line challenged the downgrade as at that time (April), funding had not been identified and the service was no closer to purchasing or implementing trackers.

A tracking system has since been identified and funding was approved in mid-May. However, the purchase stalled due to a query related to senior sign-off of the contracts. The risk has remained pending in escalation with no further confirmation of sponsorship or downgrade since April 2024.

| Risk ID | Risk | Type | Subtype | Current likelihood | Current consequence | Current rating | Target Rating | Oversight Committee |
|---|---|---|---|---|---|---|---|---|
| 703 | 2627 Risk of patient distress and poor symptoms control due to the lack of availability of syringe pumps for patients requiring symptom management | Quality | Equipment related | 5 | 3 | 15 | 4 | End of life quality group, Medical devices group, EOL Quality Board, QDG, QPC |

**Others risks in escalation**

There are over 40 risks scoring high enough to trigger the TRR threshold scores, majority of which were escalated on the system in February / March 2024 and have awaiting sponsorship. Without sponsorship by an executive a risk cannot progress to RMG for a broader discussion and approval onto the TRR. Common issues include:

- Confusion as to which executive should sponsor a risk
- Sponsor has not responded to sponsorship request
- Sponsor has declined sponsorship but the service line does not agree there is evidence to reduce the score
- Lack of time / opportunity for clinical staff to meet with executive sponsor
- Sponsor has requested amendments to a poor-quality risk but these have not been followed up by owner

Following a discussion at TLT, it was agreed the sponsorship process often hindered the flow of risks in moving up the register. Sponsorship was primarily introduced to address numerous poor-quality risks being presented to RMG but it has evolved into a system by which it is possible for a singular person to veto consideration of a risk by RMG. It was agreed an alternative approach was required which will be considered and developed in the Autumn.

## SYSTEM PERFORMANCE

An overall level of assurance in relation to the Key Performance Indicators (KPIs) for risk management has been reported to the Audit and Assurance Committee as follows:

| Assurance Level | Description |
|---|---|
| **Reasonable Assurance** | • Some medium risk rated weaknesses identified<br>• Isolated high risk rated weaknesses identified which is not systemic and / or has resolution in progress |

Whilst parts of the system can be assured, there is still limited assurance in relation to timely risk reviews and updating actions on risks and incidents.

## DATIX CLOUD

DATIX Cloud continues to have significant functionality issues. A director-to-director meeting took place in August in which DATIX agreed to implement a rapid response team to address issues.

## GMS COMPLIANCE REPORTING

In the absence of a suitable committee or group to monitor compliance within GMS, the RMG has received compliance reports from GMS since 2023 in response to concerns regarding water safety and fire safety. With the re-established Contract Management Group (CMG) now in place, compliance reports from GMS are reverted back to CMG. The RMG will continue to monitor GMS' performance in relation to the risk management process (e.g., KPIs).

## Appendix 1

## RISKS ABOVE 16 on the TRR

| Risk ID | Risk | Division | Type | Current likelihood | Current consequence | Current rating | Target 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 | Corporate | Workforce | 5 | 4 | Awaiting approval to downgrade to 16 | 12 |
| 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 | Corporate | Workforce | 4 | 4 | 16 | 6 |
| 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. | Diagnostics and Specialties | Workforce | 4 | 4 | 16 | 6 |
| 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. | Medical | Statutory | 4 | 4 | 16 | 6 |
| 281 | 3834 The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials Licence due to staff shortage. | Diagnostics and Specialties | Workforce | 4 | 4 | 16 | 1 |
| 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. | Surgical | Workforce | 4 | 4 | 16 | 6 |
| 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 | Corporate | Quality | 4 | 4 | 16 | 2 |
| 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. | Women's and Children's | Quality | 4 | 5 | 20 | 6 |
| 413 | 3767 The risk of harm to patients and staff due to being unable to discharge patients from the Trust | Corporate | Quality | 4 | 4 | 16 | 6 |
| 425 | 2424 The risk of increased financial impact on theatres and the trust due to ageing and ineffective air handling units | Surgical | Business | 4 | 4 | 16 | 6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 426 | 2268 The risk to patients within the Minors Area of the Emergency Department due to capacity and Overcrowding. | Medical | Statutory | 5 | 4 | 20 | 4 |
| 499 | 3536 The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays. | Women's and Children's | Workforce | 5 | 4 | 20 | 6 |
| 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 | Surgical | Workforce | 4 | 4 | 16 | 4 |
| 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 | Corporate | Workforce | 5 | 4 | Awaiting approval to downgrade to 9 | 9 |
| 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 | Corporate | Environmental | 4 | 4 | 16 | 6 |
| 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 Hospital | Surgical | Quality | 4 | 4 | 16 | 8 |

| Report to Board of Directors meeting held in Public | | | |
|---|---|---|---|
| **Agenda item:** | 11 | **Enclosure Number:** | 6 |
| **Date** | 12 September 2024 | | |
| **Title** | **Report to the Care Quality Commission - Section 31 Summary Report** | | |
| **Authors**<br><br>**Presenter** | Women's and Children's Division Director of Midwifery - Lisa Stephens<br>Women's and Children's Division Speciality Director - Christine Edwards<br>(Supported by Deputy Director of Quality - Suzie Cro)<br>**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 this coversheet 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. In summary, the CQC have received monthly reports, and all these reports have been provided to Board members in the virtual "Reading Room" (Board access only). A summary of the current progress has been provided at the end of this coversheet (see table).

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

As required by CQC, the enclosed Reports and the Maternity Dashboards were sent to the CQC on time. The next report will be prepared and sent to CQC on 30 September 2024. The Trust are also providing assurance externally to the ICB Quality Improvement Group (QIG) fortnightly and external stakeholders are present. A copy of the presentation has also been provided for information.

**Recommendation**

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

**Enclosures**

Reading Room (virtual board access only) – 28 June 2024 Report, 31 July 2024 Report, 30 August 2024 Report, latest Dashboard and 23 August 2024 QIG slides

**CQC S31 enforcement notice**

Table: Summary table of actions and within report dated 30 August 2024

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr>
<td>Work stream 1 – Postpartum Haemorrhage and Massive Obstetric Haemorrhage risk assessment and management</td>
<td>
Management<br><br>
– Launched Carbetocin 18 June 2024<br>
– Launched the Reduce Checklist on 1 July 2024 which supports clinicians to manage PPH.<br><br>
Risk assessments<br><br>
– The focus for the QI Team has been the intrapartum management and the baseline Reduce Checklist completion compliance is 91%.<br>
– Risk assessments at booking and 36/40 is being audited by Team Leads and then audit results added to the Production Boards for August and will be reported on in September.<br><br>
Target<br><br>
– The target is to have reduced the mean monthly PPH rate >1500ml to 30 per
</td>
<td>
CQUIMs – National Data published August 2024 (for June 2024)<br><br>
– The latest data has shown we have reduced our rates for PPH >1.5L to 36.0 per 1000 deliveries from 42.0 (National average at 30.0). This is a reduction of 6.0/1000 deliveries since April.<br><br>
<table>
<tr><th>CQUIMs Data</th><th>April 2024</th><th>May 2024</th><th>June 2024</th></tr>
<tr><td>National average</td><td>30.0</td><td>30.0</td><td>30.0</td></tr>
<tr><td>Trust data</td><td>42.0</td><td>38.0</td><td>36.0</td></tr>
</table>
<br>
Table: Intrapartum Reduce Checklist completion compliance<br><br>
<table>
<tr><th>Date</th><th>Number of women</th><th>August 2024</th></tr>
<tr><td>29-4 Aug</td><td>91</td><td>87.5%</td></tr>
<tr><td>5-11 Aug</td><td>92</td><td>94%</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>1000 deliveries by Jan 2025.<br><br>Governance<br><br>– The Labour Ward Forum have oversight of this improvement work and PPH outcome data. Escalation of issues will be to the new Maternity Oversight and Assurance Committee from 1 Sept.</td><td><table><tr><td>12-18 Aug</td><td>81</td><td>89%</td></tr><tr><td>19-25 Aug</td><td>79</td><td>95%</td></tr></table></td></tr>
<tr><td>Work stream 2 – Fetal monitoring peer reviews, accurate assessment and timely escalation of concerns</td><td>Monthly audits have been completed.<br><br>The rates have decreased across 4 metrics in July and so meeting the targets within the specified timeframes is currently at risk.<br><br>There is a meeting on 30 August to discuss the actions required to address some of the issues that are being noted in the QI work stream including the digital capture within Badgernet.<br><br>Targets<br><br>– To increase initial intrapartum risk assessment to 95% by 30 Sept 2024<br>– To increase hourly risk assessment to 85% by 30 Oct 2024<br>– To increase our hourly peer review rate</td><td>Table: Fetal monitoring audit results<br><br><table><tr><th>Issue</th><th>May 2024</th><th>June 2024</th><th>July 2024</th><th>Comparison to last month</th></tr><tr><td>Intrapartum risk assessment on admission</td><td>60%</td><td>95%</td><td>*90%</td><td>↓5%</td></tr><tr><td>Hourly risk assessment</td><td>80%</td><td>75%</td><td>**42%</td><td>↓33%</td></tr><tr><td>Hourly peer review</td><td>85%</td><td>75%</td><td>***70%</td><td>↓5%</td></tr><tr><td>Accurate assessment</td><td>67%</td><td>78%</td><td>92%</td><td>↑14%</td></tr><tr><td>Escalation</td><td>89%</td><td>84%</td><td>80%</td><td>↓4%</td></tr></table><br>*Even though we have seen a reduction in compliance this month, using our Production Board methodology (clinical teams owning their data), we are seeing teams responding to and making</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>to 85% during intrapartum care by 30 Oct 2024<br>– To increase the accurate interpretation of CTGs to 85% (escalated appropriately for their interpretation) by 30 Sept 2024<br>– 100% of CTGs escalated appropriately 30 Oct 2024</td><td>improvements contemporaneously. An audit was completed on 19 August showed 100% women had an initial risk assessment.<br>**There is no mandatory field to document type of fetal monitoring and so this can only be assessed by reviewing the clinical narrative. This has been escalated to Clevermed (digital supplier) for review.<br>***Hourly peer reviews have decreased because of the window for assessments has now reduced to 6 minutes in line with national requirements. Our SBL Midwife is in discussion with our peer Trusts to share best practice.</td></tr>
<tr><td>Work stream 3 – Temporary workforce (agency midwives) experience</td><td>– All current working Agency Midwives have had an induction to the unit.<br>– Clinical incidents related to Agency are being monitored and managed.<br><br>Target met as all Agency staff that have worked in the unit have had an induction.</td><td>Table: Induction completion rates<br><table><tr><th>Action</th><th>Number</th><th>%</th></tr><tr><td>Induction and checklist complete</td><td>16/16</td><td>100%</td></tr></table></td></tr>
<tr><td>Work stream 4 – Venous Thromboembolism risk assessments</td><td>– The focus has been improving the “on admission” risk assessments and the target has not been achieved for July and so there has been increased focus and further changes implemented and already in August we have seen an improvement up to 62%.<br>– The VTE risk assessment reminder is being added to the SBAR handover document (as this is completed as women</td><td>Table: VTE Risk assessment compliance<br><table><tr><th>Issue</th><th>May 2024</th><th>June 2024</th><th>July 2024</th><th>August 2024 (up to 28th Aug)</th></tr><tr><td>On admission</td><td>42%</td><td>57%</td><td>*52%</td><td>62%</td></tr></table></td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>transition through the service).<br><br>Target<br><br>– 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.</td><td>
<table>
<tr><td>(6 hrs)</td><td></td><td></td><td></td><td></td></tr>
<tr><td>On admission (24 hrs)</td><td>72%</td><td>84%</td><td>86%</td><td>87%</td></tr>
</table>
*Compliance for July has decreased. Due to clinical teams owning their data and instituting immediate actions compliance has increased to 62% during August, accepting that this is not a complete month.
</td></tr>
<tr><td>Work stream 5 - Maternal Obstetric Early Warning Scores (MOEWS) repeating observation when there is a trigger</td><td>The focus for the improvement work has been the “act on amber” early warning scores with repeat observations happening within 1 hour.<br><br>The target has been met for July and improvement actions are on-going to meet the next target.<br><br>Target<br><br>To increase compliance with acting on amber observations to 80% within 3 months (July), and 95% within 6 months (Oct).</td><td>Table: “Act on Amber” compliance<br><br>
<table>
<tr><th>Area</th><th>May 2024</th><th>June 2024</th><th>July 2024</th></tr>
<tr><td>Maternity Ward</td><td>63%</td><td>83%</td><td>86%</td></tr>
<tr><td>Delivery Suite</td><td>87%</td><td>90%</td><td>83%</td></tr>
<tr><td>Birth Unit GRH</td><td>75%</td><td>80%</td><td>100%</td></tr>
<tr><td>Stroud</td><td>No ambers</td><td>No ambers</td><td>No ambers</td></tr>
</table>
</td></tr>
</table>

| Report to Board of Directors meeting held in Public | | | |
|---|---|---|---|
| **Agenda item:** | 11 | **Enclosure Number:** | 6 |
| **Date** | 12 September 2024 | | |
| **Title** | Perinatal Quality and Safety Report 2024/2025 Quarter 1 | | |
| **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 August 2024 an extraordinary Quality and Performance Committee meeting was held. Delegated responsibility and reporting style was discussed. Safety Action 9 for Year 6 of Maternity Incentive Scheme states: *The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion*

QPC accepted the recommendation to act as an appropriate sub-committee and the board are invited to give QPC delegated authority regarding Maternity Incentive Scheme Y6.

In addition, a new style of reporting was agreed. Following the new Maternity Governance Structure being implemented in September and then into October, QPC will see a new style of reporting in October / November onwards.

The increased Stillbirth rate has led to the commencement of a Stillbirth review being undertaken by the Maternity Improvement Advisor. Part of this review includes a review of the PMRT process. The Q1 rate of 5.38 per 1000 births is above the Q3 Regional and National rate of 3.2. A theme has been associated with information to women around monitoring and responding to reduced fetal movements. Learning to staff and information to women is a focus of the department and the LMNS and MNVP have been involved in co-production of resources.

There were 3 Neonatal Deaths in Q1.

Compliance across professional groups for the MDT training ranges from 75% to 92%. Where rates have fallen below 90%, this is being reviewed by the Practice Development Team.

The Midwifery vacancy rate has increased to 13.07% and there were 31 obstetric middle grade rota gaps and 3 obstetric consultant rota gaps due to sickness/vacancy. These were covered by locum/existing

members of the obstetric team.

PSIRF was implemented in March 2024. During Q1 there were12 AER's and 5 PSII's. We have not agreed benchmarks as we transition to PSIRF. There were 4 new MNSI referrals. Historically MNSI referrals are in the region of 12 per annum.

In Q1 there were 16 new complaints. Main themes associated with communication and professionalism. The bi-monthly Maternity Patient Experience attended by matrons and the MNVP meeting continues with a focus on the CQC patient survey and complaints, and other feedback.

An external review by the LMNS of babies born at GRH less than 27 weeks gestation in Q1, however a review on the <27/40 deliveries is planned based on outlier status based on data from the regional network.

During June there were 19 term babies admitted to the neonatal intensive care unit. The majority of babies were admitted for respiratory reasons (12 babies). The current MIS year 6 safety action 3 no longer requires us to complete monthly audits of our term admissions, however we have made the decision to continue these MDT reviews at present to ensure our term admission are closely monitored and any learning is extracted and shared. There is a backlog of 66 cases which is being addressed by the ATAIN MDT team.

PMRT there are 3 cases awaiting review. Perinatal Governance Lead working on improving review processes in conjunction with the MIA.

**Risks or Concerns**

- Assurance around data quality on dashboard reporting with ongoing project
- Transition to PSIRF with previous concerns around maternity Governance
- Increased Stillbirth rate
- PMRT concerns with actions to improve process and quality of reporting and patient engagement

**Recommendation**

- Note the risks highlighted around PMRT
- Note the ongoing improvement work with a QI focus.
- Note the reviews underway
- Note that board are invited to give QPC delegated authority regarding Maternity Incentive Scheme Y6.

**Enclosures**

- 2024/25 Q1 PQS report

Gloucestershire Hospitals
NHS Foundation Trust

# Perinatal Quality and Safety
## Q1 Report 2024-2025

# Glossary

| Term | Description/Definition |
|---|---|
| AAR | After Action Review |
| 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 |
| PSII | Patient Safety Incident Investigation |
| PSIRF | Patient Safety Incident Review Framework |
| QS | Quality Summit |
| 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 2023* | Overall | Safe | Effective | Caring | Responsive | Well-Led |
|---|---|---|---|---|---|---|
| | Inadequate | Inadequate | Good | Good | Good | Inadequate |
| Maternity Safety Support Program: Yes. Commenced in September 2022 | | | | | | |
| * The Care Quality Commission have inspected Maternity Services 4 times since April 2022. On the Gloucestershire Royal Hospital Site, the service has been rated inadequate with overarching issues within the maternity governance system being highlighted at each inspection | | | | | | |
| After the latest inspection (March 2024) CQC issued an urgent notice of the decision to impose conditions on our registration for Maternity and Midwifery Services (9 May 2024). There are key workstreams associated with the improvement work | | | | | | |
| The improvement plan in response to the enforcement notice includes how we are going to improve Maternity Clinical Governance. We are providing monthly reports to the CQC and it is expected that this report is seen by Trust Board. | | | | | | |

| | Benchmark | | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AER (After Event Reviews) | | | | | | | | | | | 3 | 3 | 6 | 3 |
| PSII (Patient Safety Incident) | | | | | | | | | | | 0 | 0 | 4 | 1 |
| QS (Quality Summit) | | | | | | | | | | | 0 | 0 | 0 | 1 |
| New MNSI Referrals | | 0 | 2 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 4 | 0 |
| Number of complaints | | | | | | | | | | | | 5 | 9 | 1 |
| Number of positive FFT responses % | | | | | | | | | | | | 83.9 | 83 | 84.9 |

| | Benchmark | | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Direct Maternal Deaths | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Stillbirths (24 weeks gestation and above) | LMNS**<br>Target<br>Nat Av. 2021 | <=2.52<br><br>4.1 | 0.0 | 4.6* | 2.2 | 2.2 | 2.1 | 6.5 | 2.2 | 6.46 | 2.06 | 0.66 | 0.0 | 7.69 |
| Neonatal death rate per 1000 live births (>24/40) | LMNS **<br>Target<br>Nat Av. 2021 | <=0.89<br><br>2.7 | 0.0 | 0.0* | 2.2 | 0.0 | 2.1 | 0 | 0 | 0 | 0 | 2.2 | 0 | 2.6 |
| PeriPrem < 27 weeks gestation | | 0 | 2 | 1 | 1 | 2 | 0 | 0 | 0 | 1 | 3 | 0 | 0 | 0 |
| Avoiding Term Admissions into the Neonatal Unit (ATAIN) | | 5 | 4.6 | 2.2 | 3.3 | 2.8 | 3.5 | 3.9 | 3.5 | 3.2 | 3.9 | 2.9 | 2.1 | 4.9 |
| Coroner Regulation 28 made directly to the Trust | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Training compliance Mandatory update day**<br><br>Midwives | | 90% | 70 | 78 | 74 | 83 | 77 | 83 | 92 | 89 | 91 | 93 | 85 | 90 |
| MCA's/MSW's | | 90% | 72 | 72 | 57 | 65 | 85 | 89 | 85 | 91 | 84 | 92 | 85 | 88 |
| **PROMPT PART 1**<br><br>Midwives | | 90% | 84 | 84 | 83 | 90 | 90 | 97 | 97 | 96 | 93 | 98 | 92 | 96 |
| MCA's/MSW's | | 90% | 67 | 67 | 69 | 76 | 76 | 92 | 95 | 95 | 91 | 100 | 88 | 92 |
| Obstetricians | | 90% | 100 | 100 | 62 | 79 | 85 | 95 | 96 | 92 | 91 | 80 | 76 | 80 |
| Anaesthetics | | 90% | 66 | 66 | 60 | 93 | 93 | 91 | 87 | 81 | 83 | 90 | 85 | 84 |
| **PROMPT PART 2**<br><br>Midwives | | 90% | 88 | 88 | 84 | 89 | 89 | 95 | 94 | 94 | 90 | 98 | 92 | 91 |
| MCA's/MSW's | | 90% | 69 | 69 | 69 | 78 | 78 | 91 | 90 | 94 | 86 | 87 | 88 | 86 |

| | Benchmark | | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Obstetricians | | 90% | 100 | 100 | 62 | 79 | 79 | 91 | 70 | 72 | 86 | 75 | 72 | 73 |
| Anaesthetics | | 90% | 68 | 68 | 60 | 96 | 96 | 91 | 79 | 82 | 83 | 88 | 85 | 84 |
| **Fetal monitoring day**<br><br>Midwives | | 90% | 89 | 59 | 73 | 88 | | | | | 91 | 87 | 93 | 95 |
| Obstetricians | | 90% | 75 | 75 | 72 | 89 | 89 | 91 | 96 | 89 | 86 | 75 | 72 | 70 |
| **Middle grade rota gaps** - Obstetrics | | | 31 | 16 | 16 | 7 | 6 | 9 | 21 | 35 | 14 | 43 | 31 | 41 |
| **Consultant rota gaps** - Obstetrics | | | 0 | 0 | 2 | 3 | 2 | 6 | 2 | 0 | 2 | 3 | 3 | 0 |
| **Midwifery fill rate % - Days** | | | | | | | | | 87 | 97 | 89 | 91 | 85 | 89.5 |
| **Midwifery fill rate % - Nights** | | | | | | | | | 97 | 94 | 99 | 97 | 94 | 91.9 |
| **Midwifery vacancy rate %** | | TBC | 14.4 | 13.3 | 9.6 | 8.51 | 8.45 | 7.85 | 9.43 | 12.3 | 9.83 | 10.85 | 13.07 | 13.09 |
| Middle grade rota gaps - Neonates | | | | | | | | | | | | TBC | 2 | 0 |
| Consultant rota gaps - Neonates | | | | | | | | | | | | 0 | 0 | 0 |
| Neonatal nursing rota gaps (WTE) | | | | | | | | | | | | 7.4 | 7.4 | TBC |
| Themes from safety champion walkabouts | | | | | | | | | | | | TBC | / | 0 |

** LMNS target being reviewed at PQS

## Safety

### After Action Review (AER)

During Q1 there were 12 After Event Reviews (AER) held by the multi-disciplinary team.

Learning from these cases will be shared using a variety of methods and media, ensuring staff receive all information around how we can help to prevent reoccurrence, whilst deepening awareness of patient safety and quality concerns.

Ways of communicating to our teams include:

- Monthly Quality and Safety Newsletter
- Monday learning alert
- Closed practice development social media forum
- Mandatory study days
- Case examples during skills drills (where suitable)

Individual learning points have been addressed as immediate safety actions and urgent learning shared with the team.

| Incident number | Brief summary of the case | Learning identified |
|---|---|---|
| | Return to theatre for a deteriorating patient following emergency caesarean section, a concealed post-partum haemorrhage was found to be the cause | • Staff to consider escalation to the anaesthetic team as well as the obstetric team when there is a deteriorating mother<br>• Midwives to be reminded that high risk mothers must have 4 hourly observations overnight on the maternity ward<br>• Escalation to the on-call registrar/obstetric consultant must occur if the junior doctor is busy in theatre and an urgent review is required. The mother had a dropping haemoglobin but this was not escalated in a timely manner<br>• Clinicians reminded to document on Badgernet rather than paper when returning to theatre to aid ongoing care and decision making<br>• Staff to ensure management plans are clear and kept up to date to support staff with care planning and next steps |
| | Intrauterine death at 38 weeks and 5 days gestation | • Mother commenced on aspirin but was not high risk for fetal growth restriction or pre-eclampsia<br>• Differing opinion on management of mother's symphysis fundal height measurements towards the end of her pregnancy. Local policy not followed in regards to SFH above 90th centile<br>• Urinalysis not taken on a number of occasions in the community setting |

| | | |
|---|---|---|
| | | • No documented obstetric review prior to discharge home following birth of baby |
| | During an elective caesarean section, a woman suffered a cardiac arrest | There was no significant learning identified. Good quality care and a well-managed obstetric emergency were identified |
| 1360/1235 | Spontaneous labour at term, booked to birth at Stroud Maternity Unit. Transferred to GRH due to fetal heart concerns. The baby was born around 30 minutes after arrival and required resuscitation and admission to NNU. Initial CFM appeared to be normal and did not meet the threshold for therapeutic cooling. However, evolving due to evolving neurological concerns and CFM which became abnormal. An I MRI was performed on day 7, which was suggested hypoxic change. The case was therefore reported to MNSI. A repeat MRI was found to be normal with no signs of hypoxic change, which meant the resulted in the case being rejected by MNSI. | • Appropriate care during the antenatl and intrapartum periods<br>• Discussion to explore whether on admission transfer to theatre should have been expedited, MDT opinion felt the management in this case was appropriate. |
| 1620 | Miscarriage of a twin pregnancy at 17 weeks gestation. (Retrospective case review following debrief). The mother had a urinary tract infection treated prior to her booking appointment however a follow up mid-stream urine sample should be sent for MC & S to ensure the infection has resolved (there is a possible link with preterm birth and miscarriage with urinary tract infection during pregnancy). The pregnancy was complicated by vaginal bleeding, polyp removal and at 17 spontaneous rupture of membranes. The babies were born 5 days later | • A treated UTI at booked was not followed up with an MC&S, to ensure resolution of infection |
| 2095 | IOL at 38 weeks for obstetric cholestasis and subsequent CTG concerns resulted in an EMCS. The baby was born in poor condition with meconium-stained liquor. Following resuscitation, the baby was admitted to the NNU due to meconium aspiration and was subsequently transferred to a tertiary unit for cooling. MNSI investigation | The abnormal CTG was identified and escalated and the birth expedited promptly.<br>Learning:<br>• No urinalysis on admission for IOL.<br>• A raised BP on admission was not repeated an hour later as recommended (possibly due to transfer of mother to delivery suite)<br>• All abnormal CTG's should reviewed holistically face to face |
| 704 | An ELCS was planned due to a complicated pregnancy with degenerating fibroid. However, due to abdominal pain, the woman attended prior to the ELCS date and underwent an EMCS and myomectomy (due to suspicious looking fibroid). Total blood loss was 3400mls. Admitted to DCC for 6 days | Case demonstrated good practice and team working, and has been shared with the team via a TRIPLE sent via email and added to the Quality and Safety newsletter |
| | | |

| | | |
|---|---|---|
| W238514 | SVD following IOL for growth restricted baby. Baby born in good condition. At 3 days old the baby was admitted to Bristol PICU via HEMS following CPR by parents at home. Subdural and subarachnoid bleeds were diagnosed of an unknown cause. MNSI investigation | • Holistic assessment was not undertaken when parents raised concerns during a telephone call on day 3 regarding poor feeding and lack of micturition – missed opportunity to escalate to on-call neonatologist for advice/review: PD team to link with NN team to completed shared learning and teaching regarding at-risk neonates |
| 623 | A woman who was known to aim for a homebirth outside of guidance, gave birth at home and the baby was born with no signs of life. Despite resuscitation attempts the baby sadly died. MNSI investigation | To review current Birth Options process to ensure women are being given the correct information in order for them to make an informed choice |
| INC-2540 | A high-risk diabetic mother had a community midwife home visit at 35 weeks gestation for a routine antenatal check. The community midwife was unable to auscultate the fetal heart and the mother was referred into triage. On admission to GRH an ultrasound scan was undertaken by the obstetric consultant and it was confirmed that the baby had died. | No significant learning identified. Will be reviewed through the Perinatal Mortality Review Tool process, case to be included in the external stillbirth review |
| INC-3599 | Postnatal readmission via ambulance of a mother at 2 days postnatal with chest pain and shortness of breath. Known pre-eclamptic on anti-hypertensive medication. Mother admitted via ED and transferred to DCC with heart failure. The mother was discharged home following a 4 day stay. Likely diagnosis – acute pulmonary oedema and cardiomyopathy associated with pre-eclampsia. | • Mother booked late but no MSU sent<br>• Declined aspirin in pregnancy but unsure where the mother was given accurate information, as believed it was to help reduce risks associated with smoking (had previous PET)<br>• No evidence that the mother was offered an interpreter at each appointment<br>• Discharged home from the ward 1 day post caesarean section for pre-eclampsia (local guideline recommends 72 hour stay)<br>• No TTO anti-hypertensive medication given on discharge (out of hours), FP10 given but mother missed dose of labetalol |
| INC-3400 | Mother had an induction of labour for post-dates and large for gestational age baby. Developed sepsis during labour and had a pathological CTG. Baby born in good condition. IV antibiotics given. 500ml blood loss, IV oxytocin infusion running. Mother transferred to recovery. Midwife noted blood pressure drop in recovery and increased lochia, emergency bell called. Weighed blood loss 1800ml. MOH called placed and mother transferred back to theatre. Total blood loss 3800ml. HDU care provided. Mother discharged home on day 3. | • Mother requested further pain relief on the maternity ward and regular tightening's but a CTG was not offered<br>• Intrapartum observations do not flag possibility of sepsis (antenatal and postnatal observations tab asks if sepsis likely and will trigger considerations), has been referred to the digital team.<br>• Possibility of earlier antibiotics<br>• Cefuroxime and metronidazole given to mother however ceftriaxone and metronidazole advised for sepsis<br>• Yellow blood gas syringes not on trolleys in theatre<br>• Blood bank were not called immediately when MOH call placed (made within 10 minutes)<br>• Postnatal IV antibiotics prescribed once a day rather than 3 times a day (LASER to be produced on all learning points above and |

| | | |
|---|---|---|
| | | shared with all teams, will also be included in the newsletter) |

### Quality Summits:

A Quality Summit (QS) was held during June supported by the obstetric maternity improvement advisor (MIA). The review focused on a selection of our post-partum haemorrhage and massive obstetric haemorrhage cases over the past 8 months. The review was conducted to ensure all lessons learned and themes were identified, and to provide assurance on our current review processes. The QS did not identify any additional themes.

### Patient Safety Incident Investigation (PSII)

There was 1 new PSII reported within maternity during June. It was noted by both the transfusion lab and the maternity team that there had been a cluster of incidents involving Anti-D immunoglobulin. Whilst there were varying aspects to each of the incidents it was felt that a deep dive was required and the proposal was taken to Patient Safety Review Panel. A joint decision was made to conduct the review through a PSII under the new PSIRF framework.

### Maternity and Newborn Safety Investigations (MNSI)

There were 4 cases reported to MNSI during the quarter of May. Out of the 4 cases 3 were accepted and 1 was rejected by MNSI due to a normal MRI. The cases are detailed above in the AER section (cases 1360/1235, 2095, W238514 and 623).

## Quality

### Complaints

There was 16 complaints received for maternity during the quarter. A significant reduction on the previous quarter when 27 complaints were received.

| Complaint number | Complaint area | Theme of complaint |
|---|---|---|
| 671 | Delivery Suite | Dissatisfaction with child birth experience |
| 1205 | | Lack of adequate treatment and numerous mixed messages |
| 624 | Delivery Suite | Lack of proper communication with the patient. Consent not obtained before checking patient's dilatation as well as discussing issues with other members of staff. General lack of care and compassion. Delay in epidural. Lack of refreshments for relatives. Catheter not checked, shortage of pillow |
| 585 | Delivery Suite | Attitude of consultant, lack of dignity, patient did not give consent to be examined, lack of hygiene and infection control |
| 506 | ANC | Different interpretation of scan and test results. Attitude of medical staff. Mother made to go |

| | | |
|---|---|---|
| | | through emotional and mental health issues.<br>Communication breakdown |
| 317 | | Staffing levels and training levels of staff. Issues with new maternity system. Decision making re treatment. Poor communication. Poor nursing care. ITU - was care and treatment adequate? |
| 798 | Community | Communication by midwifes<br>SG concerns |
| 762 | Mat Ward/Delivery Suite | Lack of communication, concerns with care |
| 774 | Delivery Suite | Not listened to and poor labour experience |
| 899 | Maternity Ward | Delayed IOL, lack of communication, felt personal issues discussed in earshot of others |
| 896 | Maternity Ward | Attitude of staff |
| 1013 | Delivery Suite | Traumatic birth experience, lack of beds and pain management |
| 1122 | Maternity Ward | Poor communication regarding IOL, attitude of staff, poor level of care overall, rough handling when being supported with breast feeding |
| 1152 | Maternity Ward | Failure of staff to respond to call bell, staff attitude, traumatic birth experience |
| 1202 | Maternity Ward | Lack of communication and reassurance around breastfeeding support, medication error, staff attitude and found to be gossiping or on social media |
| 1511 | Delivery Suite | Poor attitude of the midwife<br>Unprofessionalism<br>Lack of communication |

The overarching theme highlighted throughout these complaints was a lack of, or breakdown in communication. The majority of the complainants have been offered, and have accepted a face-to-face meeting to discuss their concerns with the clinical leads. The remaining complainant will also be contacted and a meeting offered. Following the meetings, any learning identified will be shared with the teams and individuals where necessary. Complainants will be asked if we are able to share their anonymised patient story via the Quality and Safety newsletter. The learning around communication will feed into an overarching theme of the month.

## FFT

There were a number of concerns raised via our FFT feedback, which provides valuable insight into any emerging themes our service users may have. These concerns will be monitored and actioned monthly via Maternity Clinical Governance (MCG).

Themes during the quarter include:

- Triage – no room on delivery suite and mothers waiting in triage in pain and with a lack of privacy, lack of communication and information regarding planned caesarean section, no clear communication of management of pre-labour rupture of membranes
- Maternity Ward – medication issues, not enough staff, lack of support with breastfeeding, lack of communication, time taken to answer call bells

- Antenatal Clinic/Sonography – didn't feel listened to, lack of reassurance, scans felt rushed and lack of information provided

Maternity Department received approximately 1000 FFT responses during the quarter with an average of 83.4% sharing positive feedback, which is slightly lower than last quarters figure of 83.9%

From the feedback receive in latter part of the quarter:

GRH Birth Centre received 100% positive feedback with mothers reporting that they felt well supported and empowered.

Experiences are more challenging on the Delivery Suite, due to more complex births, staffing and resource pressures. While feedback was generally very positive, ratings were slightly poorer.

Maternity Ward feedback was more positive overall, while still receiving some comments about time taken to answer call bell there does seem to be some improvement in this area. Fewer comments about noise on the ward, however one concerned over safety with visitors on the ward. A few mentioning staff appearing to be stretched, delays at discharge. Some comments regarding conflicting advice given regarding infant feeding.

| | Very good | Good | Neither | Poor | Very poor | Dont know | Total Coun | Total Measure m-o-m |
|---|---|---|---|---|---|---|---|---|
| ⊞ Birth Unit GRH | 8 | 3 | | | | | 11 | 100.0% |
| ⊞ Delivery Suite GRH | 42 | 12 | 5 | 2 | | | 61 | 88.5% |
| ⊞ Home/Other | 1 | | 1 | | | | 2 | 50.0% |
| ⊞ Maternity Ward GRH | 29 | 22 | 11 | 4 | 2 | | 68 | 75.0% |
| ⊟ Outpatients | | | | | | | | |
| Midwife episode | 35 | 12 | 1 | | 2 | | 50 | 94.0% |
| Obstetrics | 16 | 5 | 3 | 1 | 1 | | 26 | 80.8% |
| Grand Total | 131 | 54 | 21 | 7 | 5 | | 218 | 84.9% |

# Morbidity and Mortality

## Direct Maternal Deaths

There were no direct maternal deaths during the month of June.

## Stillbirths (24 weeks and above)

There were 6 stillbirths during the quarter.

All stillbirths have been reported to MBRRACE within the recommended 7-day reporting period. All parents have been informed that a review will take place and their parents' perspectives have been sought. All PMRT reviews will have been commenced within the 2-month time frame as required by MIS year 6 standards and published within 6 months.

We have noted an increase in our stillbirth rate per 1000 births for the month of June. This has potentially been impacted by a lower birth rate in June at GHFT. There were 3

stillbirths during the month of June but a lower than usual number of total births. To provide a robust review and assurance process we have made the decision as a wider team to have an external review into the stillbirths that occurred at the Trust from the 1st August 2023 – 31st July 2024. This review will be supported by out midwifery MIA. In addition, all stillbirths at or above 24 weeks gestation from the 1st August will be reviewed at Patient Safety Review Panel, and reported for PSII.

The stillbirths for Q1 are as follows:

| Brief summary | Learning identified | Action required | Review process | Offered support via Maternity & Neonatal Independent Senior Advocate |
|---|---|---|---|---|
| 35-week intra-uterine death as described in AER section above | As per AER section above | | AER, PMRT, external review by MIA | Offered via PMRT process |
| Non-English-speaking mother newly arrived to the UK, late booker at 19 weeks gestation, contacted triage at 28+1 weeks gestation and reported absent fetal movements for 24 hours, out of area at the time, attended closest maternity unit where intra-uterine death was confirmed, travelled back to GRH for ongoing care | No evidence of an interpreter being offered at every appointment<br><br>No evidence that the Tommy's reduced fetal movements leaflet was accessed on the Badgernet app | All staff to be reminded that an interpreter must be offered to all women where English is not their primary language – to be shared on the monthly Quality and Safety newsletter<br><br>Review of Badgernet access and data underway to ascertain why leaflets are not being accessed<br><br>Display boards in the outpatient areas now contain the Tommy's information<br><br>Community midwives to continue to discuss fetal movements and direct to the Tommy's leaflet at antenatal appointments (available in | Datix review, PMRT and external review by MIA | Offered via PMRT process |

| | | | | |
|---|---|---|---|---|
| | | multiple languages)<br><br>QI project around translation & interpretation service<br><br>Risk to be added to risk register | | |
| Mother contacted triage at 27+2 weeks gestation with a history of no fetal movements felt for around a week (had previously contacted triage with reduced fetal movements a few weeks earlier and attended). On arrival to triage an intra-uterine death was confirmed | No evidence that the Tommy's reduced fetal movements leaflet was accessed on the Badgernet app | All staff to be reminded that an interpreter must be offered to all women where English is not their primary language – to be shared on the monthly Quality and Safety newsletter<br><br>Review of Badgernet access and data underway to ascertain why leaflets are not being accessed<br><br>Display boards in the outpatient areas now contain the Tommy's information<br><br>Community midwives to continue to discuss fetal movements and direct to the Tommy's leaflet at antenatal appointments (available in multiple languages)<br><br>QI project around translation & | Datix review, PMRT and external review by MIA | Offered via PMRT process |

| | | | | |
|---|---|---|---|---|
| | | interpretation service<br><br>Risk to be added to risk register | | |
| 35-week intra-uterine death as described in AER section above | See AER section above | | AER, PMRT, external review by MIA | Offered via PMRT process |
| Non-English-speaking mother newly arrived to the UK, late booker at 19 weeks gestation, contacted triage at 28+1 weeks gestation and reported absent fetal movements for 24 hours, out of area at the time, attended closest maternity unit where intra-uterine death was confirmed, travelled back to GRH for ongoing care | No evidence of an interpreter being offered at every appointment<br><br>No evidence that the Tommy's reduced fetal movements leaflet was accessed on the Badgernet app | All staff to be reminded that an interpreter must be offered to all women where English is not their primary language – to be shared on the monthly Quality and Safety newsletter<br><br>Review of Badgernet access and data underway to ascertain why leaflets are not being accessed<br><br>Display boards in the outpatient areas now contain the Tommy's information<br><br>Community midwives to continue to discuss fetal movements and direct to the Tommy's leaflet at antenatal appointments (available in multiple languages) | Datix review, PMRT and external review by MIA | Offered via PMRT process |
| Mother contacted triage at 27+2 weeks gestation with a history of no fetal movements felt for around a week (had previously contacted | No evidence that the Tommy's reduced fetal movements leaflet was accessed on the Badgernet app | As above | Datix review, PMRT and external review by MIA | Offered via PMRT process |

| | | | | |
|---|---|---|---|---|
| triage with reduced fetal movements a few weeks earlier and attended). On arrival to triage an intra-uterine death was confirmed | | | | |

## Neonatal Deaths

There were 3 neonatal deaths during the quarter:

| | **Brief summary of cases** |
|---|---|
| Apr | Out of area woman visiting area, presented in preterm labour in. 26+6 gestation. Baby transferred to original Trust and was discharged home but sadly died in April |
| May | A woman who was known to aim for a homebirth outside of guidance, gave birth at home and the baby was born with no signs of life. Despite resuscitation attempts the baby sadly died. MNSI investigation (as per AER above |
| Jun | 20 week medical termination of pregnancy - baby born with signs of life at birth |

## PeriPrem

There were no babies born during the quarter at less than 27 weeks gestation at Gloucester Royal Hospital.

It was highlighted by the LMNS following data sharing, that the PeriPrem rates at GRH were higher than similar level 2 Trusts in the South West region. For this reason, a review into babies born at less than 27 weeks gestation is planned and will be taken through Patient Safety Review Panel for consideration. This will be supported by the LMNS.

## Avoiding Term Admissions into the Neonatal Unit (ATAIN)

There were 42 term babies admitted to the neonatal unit during the quarter, giving an average figure of 3.3%. June saw an increase in admissions with 4.9%, which is just below the recommended national target of 5%.

Out of the 42, the predominant reason for admission is respiratory, followed by low cord gases

The low cord gases cases are to have an additional review by our fetal monitoring lead and currently sits as one of our patient safety priorities along with the current CQC section 31 workstreams on fetal monitoring.

The current MIS year 6 safety action 3 no longer requires us to complete monthly audits of our term admissions, however we have made the decision to continue these MDT reviews at present to ensure our term admission are closely monitored and any learning is extracted and shared.

# Training Compliance

## Midwives

Midwives mandatory training for the midwifery update day sits at 90% and the multi-disciplinary PROMPT training day sits at PROMPT parts 1 and 2 sit at 95% and 94% respectively for the quarter. The nationally recommended compliance figure for mandatory training is currently 90% and we are just achieving this within our midwifery cohort at present.

The Neonatal Life Support (NLS) training update is included within the midwifery update day.

The Fetal Monitoring update day compliance for midwives in Q1 was 92%

## MCA's/MSW's

Maternity Care Assistants and Maternity Support Workers Midwives mandatory training for sits at 88% and the multi-disciplinary PROMPT training day sits at PROMPT parts 1 and 2 sit at 93% and 87% respectively for the quarter

## Obstetrics

The multi-disciplinary PROMPT parts 1 and 2 training day compliance for the obstetrics is 79% and 73%

The Fetal Monitoring update day compliance for the obstetric team sits at 72%.
The obstetric training compliance has been escalated to the clinical and training leads for review and further plans have been put in place to increase compliance over the coming months to achieve the 90% recommended target.

## Anaesthetics

The multi-disciplinary PROMPT parts 1 and 2 training day compliance for anesthetics is 86% for both parts.

# Workforce

## Obstetrics

During Q1 there were 115 obstetric middle grade rota gaps. These gaps were as a result of industrial action, sickness and ongoing middle grade vacancy. The rota gaps were covered by a combination of locum clinicians, or the obstetric consultant team. There was no impact on the care provided

There were 3 obstetric consultant rota gaps during Q1, all of which were covered by locum existing members of the consultant body. There was no impact of patient care

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## Midwifery

The current midwifery vacancy rate has currently sits at 13.09, the highest rate within the quarter .

We currently have a rolling band 6 midwife vacancy out to advert and we continue to offer our students automatic posts on qualification. The wider marketing and comms team have increased their focus on the recruitment of midwives and this will be made available through social media platforms.

Our recruitment and retention team are working hard to support and listen to the needs of staff, and a new rotation plan has been designed to focus on staff satisfaction and patient safety. The team are currently scoping for the potential of team/self-rostering by the end of 2024 to support flexible working.

The midwifery fill rate for shits during June was 89.5% for days and 91.9% for nights. We will continue to monitor and report on this monthly. This is also included in the staffing report.

We continue to provide 100% in 1:1 care in labour, and achieve 100% compliance with the delivery suite coordinator being supernumerary.

## Neonatal

There were no rota gaps in the neonatal consultant or the tier 2 rotas for the month of June.

The neonatal nursing data for June is currently awaited.

## Safety Champions Walkabout

The safety champions walkabout occurs monthly in the clinical areas across Gloucester Royal Hospital, Stroud Maternity Unit, Cheltenham General Hospital. These walkabouts are supported by the executive and non-executive safety champions and are an opportunity to listen to staff concerns and experiences. Additional plans are now in place to extend the walkabouts to the community areas and to ensure a number of walkabouts are conducted out of hours for those staff members who work nights and weekends

The safety champions walkabout for June took place at Stroud Maternity Unit. No safety concerns were raised by staff.

## Maternity Incentive Scheme

The new NHS Resolution Maternity Incentive Scheme Year 6 guidance has now been published. The team will review the refreshed guidance, and this will be incorporated into

the existing processes from year 5 with any additions required. We will continue to report on progress monthly.

| Appendix 1 – MIS Year 6 progress | RAG Rating | Risk /Escalation |
|---|---|---|
| **1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 Dec 2023 to Nov 24 to required standard?** | | •Review of PMRT process and reporting commenced but compliant MIS |
| **2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** | | •Compliant – 98% July data – missing data for 12 patients, working on completion |
| **3. Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?**<br>**Drawing on insights from themes identified form any term admission to the NNU, undertake QI initiative to decrease admission/length of stay.** | | •New group formed meeting in Sept (Bi-monthly) Perinatal Operational Group (POG) Updated TC expansion action plan to be taken to Trust Board, commencing with MCG in September<br>•91 outstanding ATAIN reviews. Team to decide on process following new MIS guidance and implementation of PSIRF. Once determined- QI project to be registered by 30 Nov 2024 and updates to SC and LMNS. |
| **4. Can you demonstrate an effective system of clinical workforce planning to the required standard?** | | •Awaiting update from CE regarding consultant audits<br>•Compliant re monitor consultant attendance & lessons learned – evidence to be shared with Trust board /BSC/LMNS in bi-annual workforce paper<br>•Currently compliant regarding duty anaesthetist availability<br>•Currently compliant regarding Neonatal medical workforce<br>•Awaiting updated neonatal nursing retention and recruitment action plan- requested by end September to be added to bi-annual workforce paper. |
| **5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?** | | •Awaiting updated birth rate plus calculation- to be included in bi-annual workforce paper |

| MIS Safety Action | RAG Rating | Risk /Escalation |
|---|---|---|
| **6. Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?** | | •Targets to be agreed with LMNS, our compliance for MIS will be dependent on meeting these/ sufficient progress this year.<br>•See SBL exception report and proposed targets. |
| **7. Listen to women, parents and families using maternity and neonatal services and coproduce services with users.** | | •Regular monitoring of progress through experience meeting, reporting to safety champions through MDG and LMNS Board. |
| **8. Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?** | | •FM/PROMPT -Obstetric consultants 85% compliance – booked onto upcoming training<br>•New trainees require dates for training, 3 SHOs not currently attended training – last few months have been short of trainees, therefore difficult to fulfil training obligations. SA to explore if compliant due to previous Trust training and if not, if there is any locum funding available to release staff. |
| **9. Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?** | | •Awaiting confirmation if QPC is delegated committee and if so evidence of framework<br>•Claims scorecard to be added to PQS report- MCG 16/08/24<br>•BSC and quad meetings to be added to quad exception report/safety champion's paper<br>•Culture and improvement programme to be added quad exception report/PQS |
| **10. Have you reported 100% of qualifying cases to HSBI known as Maternity & Newborn Safety Investigations Special Health Authority (MNSI) from Oct 23 and to NHS Resolutions Early Notification (EN) scheme?** | | •To confirm with legal services completion of Claims reporting wizard |

| KEY ISSUES AND ASSURANCE REPORT<br>Quality and Performance Committee (QPC) 24h July 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** | Discussion at QPC was focused upon the maternity delivery group and the Regulatory report. The CNO gave assurance that progress of maternity-related actions in relation to CQC section 31 requirements were on track- timely responses had been submitted to the CQC, with positive feedback from a recent informal meeting.<br><br>Section 31 issues were rated amber in the Key Issues and Assurance Report (KIAR), while Section 29 work and the Maternity Incentive Scheme were rated red. Efforts were ongoing to improve the report with input from various stakeholders. Updates were awaited on the amber actions related to safeguarding Level 3 training.<br><br>The Trust Chair sought detail into the background that a review of cases of still birth was in progress – the CNO shared that whilst the still birth rate was within expected range – a lower local system rate had not been met. A recent increase in the rate was attributed to a drop in the birth rate, not an increase in stillbirths. However, the CNO was positive that utilising the Patient Safety Incident Response Framework (PSIRF) principles and conducting a retrospective review of stillbirths was a key line of enquiry that would be valuable for any learning and assurance for the Trust and wider system, | Ongoing strengthening of assurance reporting was noted to be in progress. |
| **Patient Experience Report &** | Patient-Led Assessments of the Care Environment (PLACE) revealed below-average scores in five out | |

| | | |
|---|---|---|
| **progress following Quality improvement summit:** | of eight criteria, including **cleanliness, food quality,** and **building maintenance.**<br><br>Actions are being taken to address these issues, particularly **food quality,** as part of the nutrition and hydration quality summit.<br><br>The committee noted that efforts were underway to analyse patient experience data with a focus on health inequalities, with a dashboard being developed in collaboration with BI. | The Trust Chief AHP presented progress following the Quality Improvement Summit in May 2024. The summit agreed the following themes and noted excellent multi-professional working to deliver:<br><br>• Reducing delays in food delivery from trolley to patient<br>• Improving the patient mealtime experience<br>• Enhancing the adult inpatient meal choice process<br>• Enhancing the children's inpatient meal choice process<br>• Improving patient hydration through Communication and Education<br><br>It was agreed that a further report would be presented to the Committee in November.<br><br>The committee will seek assurance relating to cleanliness via the IPC report<br><br>Improved analysis will be presented at a future QPC |
| **Patient Safety investigation and complaint report** | The committee continues to seek assurance regarding timeliness and **handling of complaints.** | It was reported that there had been a significant drop in complaint response rates from 25% to 9%, with targets set at 35 days for standard complaints and 65 days for complex complaints. A target of reaching a 60% response rate by June 2025 has been |

| | | |
|---|---|---|
| | | established this includes learning from how other organisations had made improvements to their complaints handling. The area of complaints has weekly oversight from the CMO- with a report due to QPC in September 2024. |
| | A National Patient Safety Alert related to **bed rails** was raised as not yet fully responded to despite discussions in various settings. there were ongoing concerns about the lack of a definitive solution. It was noted that mitigations are in place and that the H&S committee were also sighted on this issue due to it also being a matter of service/ contract management | It was agreed that this item would be placed on the agenda for the September committee to allow for a more thorough discussion. |
| **Items rated Amber** | | |
| **Item** | **Rationale for rating** | **Actions/Outcome** |
| **Quality and Performance report** | The overall system-wide **4-hour performance** target was 78% by year-end, with a trajectory slightly ahead despite challenges, particularly with ambulance handover times.<br><br>The **Elective 52-week position** was discussed. This showed a deviation from trajectory for December due to capacity issues, industrial action, and delayed Elective Recovery Fund ERF funding approvals. The goal was to eliminate **patients waiting over 65-weeks** by the end of September. Although the June stretch target was not met, progress was on track, with oral surgery, Ear, Nose, and Throat (ENT), and some trauma orthopaedic issues being the main concerns. Compared to other trusts in the Southwest, performance was strong, and for the first time in 12 months there were no **patients waiting over 78-weeks** in June.<br><br>Unvalidated performance for June was reported at 69.9%, with July expected to rise to the high 60s once validated. A robust recovery plan was in place to address diagnostic stages and breaches in Urology.<br><br>Since 8 July 2024, the trust had stopped **boarding** patients in line with NHS England's directive. Three patients who were boarded recently were quickly moved onto the ward. | .<br><br>The Trust chair welcomed the new style report, seeking strengthened internal governance regarding elective backlogs and the enhancement of system responsiveness through collaboration. The positive outcomes from the 8 Days of Summer improvement work were also noted. The COO acknowledged some inefficiencies of the Elective Recovery Fund (ERF) and reported that a strategic forum, supported by the ICB, was being established which looked to move to a more sustainable approach.<br><br>NB- The COO alerted the QPC to an NHSE letter that had just been received – "*Maintaining focus and oversight on quality of care and* |

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

| | | |
|---|---|---|
| | | *experience in pressurised services"* This letter had significant considerations for QPC and would be discussed internally with Executives and likely to be considered at September Trust Board |
| **Integrated Performance Report** | The COO re-raised the opportunities 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.** | Progress to be reported via IPR including an update on utilisation of virtual ward capacity. |
| **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 |
| **Patient Safety and Risk Assurance Report**<br><br>**Quality and Safety metrics** | **Falls** were raised as an area of focus by the CNO.<br><br>The improvement required regarding performance of closure **of serious incidents** was discussed, it was noted that Maternity related plans had been prioritised.<br><br>Outstanding serious incident action plans were reduced from 90 to approximately 30 due to weekly meetings with divisions. | A detailed report is expected at QPC in September<br><br>Delays in addressing overdue Serious Incidents were noted due to insufficient resources. Investigations were prioritised based on the incident's nature, patient and family engagement, and coroner involvement. Outstanding maternity Serious Incident (Sis) were being prioritised, and at was anticipated that all but one would be completed by the end of July. |
| **Infection Prevention and Control Annual Report** | The Committee noted that in 2023/2024 the trust had 2 cases of MRSA bacteraemia and 106 cases of C. difficile against an improvement objective of 97. The Trust continued to report outbreaks of COVID-19 resulting in bay and ward closures; there were, however, fewer outbreaks when compared to | |

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| | | |
|---|---|---|
| | 2022/23. The mild Influenza season saw a slow and steady increase in the number of cases, which were effectively managed.<br><br>March 2024 saw several Norovirus outbreaks leading to more than 100 beds being closed and a business continuity incident declared.<br><br>The serious incident involving the death of a patient following hospital acquisition of a Pseudomonas aeruginosa bacteraemia was discussed and the Committee noted the delivery and completion of the action plan. The annual audit completed by the Authorising Engineer for Water, which provided an assessment of the water safety programme demonstrated improved compliance compared to 2022 ( more detail below) | |
| **Quarterly Water Safety Update** | The Committee noted the background to the incident and the progress so far. There were 116 actions in the action plan, 89 were complete.<br><br>The Committee noted that GMS had commissioned an external provider, to update Legionella risk assessments; GRH had been completed and CGH reviews were in progress. Apleona area risk assessments were up to date and the annual audit completed by the Approved Engineer showed improvement.<br><br>Work was taking place following several Legionella positive results across Orchard Centre Community Diagnostic Centre and Stroud Maternity Hospital. A working group had been established to instigate the required remedial interventions. Affected outlets had been made safe with filters and isolation.<br><br>The Water Safety Group was receiving assurance of an effective water safety programme at both sites. Benchmarking of clinical surveillance also demonstrated Gloucestershire had the lowest rates of Pseudomonas and other waterborne bloodstream infections across the Southwest region. However, gaps in assurance in delivery of the water safety programme to the sites outside of the two main hospital buildings were noted. The Committee received the update and noted the contents of the report. | An estates terrier was being developed regarding water safety programme activities and was expected to report to Water Safety Group this month. |

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| Items Rated Green | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/Outcome** |
| **Learning from Deaths report Q3, October to December 2023** | The committee were provided with assurance of the governance systems in place for reviewing deaths and in addition demonstrated compliance with the National Guidance on Learning from Deaths.<br>The Committee noted: Summary Hospital-level Mortality Indicator (SHMI) for the Trust was "Higher than Expected" Hospital Mortality group in combination with Gloucestershire Mortality Group under the ICB had a workplan to investigate and improve data and care factors which have an impact on Summary Hospital-level Mortality Indicator (SHMI). Some of this sat within existing projects such as improving Patient Flow and Frailty. | |

| Items not Rated | |
|---|---|
| | |

**SYSTEM FEEDBACK** No further business to note, key issues picked up in various reports.

**Governor Observations**

Helen Bown commended the high-quality reports and discussions, highlighting the work on health inequalities and improvements in data cross-referencing. She emphasised the importance of sharing best practices across divisions. Andrea Holder requested to observe the August meeting on maternity and asked for the September nutrition steering group dates to be circulated. She also noted inconsistent food quality observed during Governor's walkabouts and sought further details on the DIPC comment about the impact of informing surgeons of their infection rates.

| 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 held in Public | | | |
|---|---|---|---|
| **Agenda item:** | 13 | **Enclosure Number:** | 9 |
| **Date** | 12 September 2024 | | |
| **Title** | Engagement and Involvement Annual Review 2023-24 and Community Engagement Tracker | | |
| **Author /Sponsoring Director/Presenter** | Juwairiyia Motala, Community Outreach Worker, and James Brown Director of Engagement, Involvement & Communications. | | |

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

**Summary of Report**

**Purpose**

- To present he final draft our Engagement and Involvement Annual Review 2022-23 and Community Engagement Tracker, which is a key milestone of our Engagement and Involvement Strategy.
- The Annual Review will be published to sit alongside our Annual Report and Quality Accounts.
- The review provides a summary, case studies and activities over the last year, as well as next steps.
- The review will also be used as part of the refreshed CQC framework and expected NHS England framework for community and public engagement.
- To present our first Inclusive Language Guide, co-designed with a wide range of staff and services and in partnership with Bradford District and Craven Health & Care Partnership.

**Key issues to note**

- The annual review is our fourth formal report on our engagement and involvement activity.
- The annual review sets out why engagement and involvement is important to the Trust and how we have worked with local people, community groups and partners over the last year.
- Over the last year the Trust has been an active part of 65 groups and community events, reaching over 13,000 people, enabling us to gain valuable insight into how we can improve access to services.
- The review sets out who our local communities are and the challenges of health inequalities across the county.
- Our commitment to engagement is a core element of the Care Quality Commission (CQC) well-led domain. We have previously shared the draft annual review with CQC as part the Well-led review.
- The Trust has continued to develop and improve the Community Engagement Tracker, detailing the monthly activity undertaken, themes and impact.
- The CQC has significantly changed the focus of much of its regulatory framework, with a primary focus on ‘people and communities’ and assessing how NHS organisations involve, engage and listen to local people in improving services.

**Summary of Report**

**Previous Publications:**

- Engagement and Involvement Annual Review 2020-21
- Engagement and Involvement Annual Review 2021-22
- Engagement and Involvement Annual Review 2022-2023
- Community Engagement and Involvement Tracker 2022-2023
- Engagement and Involvement Strategy 2019–2024

The Engagement and Involvement Review, Community Engagement and Involvement Tracker 2023-24 and Inclusive Language Guide have been reviewed via People & OD Group (10 July 2024) and People & OD Committee (25 July 2024) before progressing to Trust Board.

**Recommendation**

- To approve the Engagement and Involvement Annual Review and Tracker 2023-24 for publication.
- To note and provide feedback on the Inclusive Language Guide so it can be published and shared with staff and communities.
- Provide feedback and comments – and any areas for future development.

**Enclosures**

- Engagement and Involvement Review 2023-24
- Community Engagement and Involvement Tracker 2023-24
- Inclusive Language Guide

NHS
Gloucestershire Hospitals
NHS Foundation Trust

# Engagement and Involvement Review 2023 – 2024

## Building Bridges, Building Health:
## A Year of Engagement and Partnership

the **Best Care for Everyone**
care / listen / excel

# Welcome to our Engagement and Involvement Annual Review

**We are passionate about involving local people in designing, developing, and improving health care. Engagement is at the heart of the Trust's approach to building relationships with communities and hearing directly from patients, their families, and local people. We believe that this is a powerful way to improve access to services and achieve better outcomes and experience of care. We work in partnership with other organisations across Gloucestershire and under the umbrella of the One Gloucestershire "Working with People and Communities Strategy."**

Over the past year, we have undertaken a wide range of work including improving uptake rates in cervical screening in South Asian communities and improving the care of vulnerable and homeless people in our Emergency Departments.

Our Young Influencers provide a great example of how young people themselves can provide direct and actionable feedback on how services can be improved. They visited our Children's Emergency Department at Gloucestershire Royal Hospital and have made a set of observations to the department and patient experience team. They are also building a relationship with other community youth organisations to increase the reach of young voices being heard by the Trust.

We are grateful to the Gloucestershire Hospitals charity for providing start-up funding for our community outreach worker and having the confidence to allow us to prove its worth. With their support, we have now been able to extend our resources to fund a small core team of community support workers with a big reach.

**Bryony Armstong**

Public Governor for Cotswolds
Chair of GHFT Young Influencers Group

**Deborah Evans**

Trust chair

# Executive Summary

"Great things are not done by impulse, but by a series of small things brought together"

Vincent Van Gogh

**Our annual review celebrates not just some of our achievements, but the cornerstone of all our work – collaboration. We believe that building and maintaining strong relationships between our services and the communities we serve, improves the quality and access to health and care services.**

In 2023 we celebrated the 75 Windrush anniversary, many of whom dedicated their lives to building our communities and our health system. We also celebrated the NHS 75 anniversary, with a range of community and staff events to mark the occasion, and provided the opportunity to reflect on the incredible work that has been achieved together.

Working in partnership with our community isn't simply a box to tick; it's the key to unlocking better health outcomes. By understanding the needs for local people, we can transform our services and empower communities to focus on what matters most to them, helping to shape how healthcare is delivered for everyone.

This report explores our engagement and involvement work over the past year, outlining some of our achievements, our challenges and the future priorities the next 12 months. We have also continued to improve our Engagement and Involvement Tracker, providing a roadmap for how we work and demonstrating the impact it has had and how it has influenced how we work.

# Executive Summary

Although our work to strengthen how we involved communities began just before the pandemic, our biggest impact has been seen following the introduction of our community outreach project from early 2022, funded by NHS Charities Together. This has made a huge impact in how we can support and listen to so many local people and communities and transformed how we do this.

Our work has played a pivotal role in helping people who live in some of our under-served communities to access essential health and care support. This has been done in partnership with other local organisations and groups across Gloucestershire and we know it has improved the lives of many people, who may sometimes be at risk of not being picked up by health and care services.

We are also delighted this year that the Chair of our Young Influencers was elected to the Council of Governors and that the group has continued to develop and provide learning opportunities and improvement for key services, including the new Children's Emergency Department.

The Trust also hosted visits over the last 12 months, including the Prime Minister, Rishi Sunak, who visited our new Chedworth Surgical Unit and theatres at Cheltenham General Hospital and HRH Princess Royal Visit who visited the Stroud Maternity Unit. These visits provide an opportunity for staff and partners to proudly show the work they do and how they provide care for local people.

# Executive Summary

## Highlights of our engagement and involvement programme during 2023/24 include:

- Collaboration in partnership with ICB to film a Bowel Cancer Screening Film.
- Community Collaboration with Mindsong.
- Community-Led Health Research:
- Young Influencers
- Development of new Audio Guides in partnership with the Gloucestershire Sight Loss Council to improve navigation and access across our hospitals.
- Continued partnership with Inclusion Gloucestershire and Healthwatch Gloucestershire to focus on key issues that matter to local people and communities, ensuring greater collaboration;
- Continued to support and engage the 2,000 members of the Trust, with regular newsletters, public events, and Annual Members Meetings;

The Trust is part of the One Gloucestershire Partnership, which is made up of other health, social care and Voluntary and Community Sector (VCS) organisations. One Gloucestershire has a really important 'Memorandum of Understanding' with our VCS partners – reinforcing how we will all continue to work together for local people.

We want local people to help us design, develop and improve services by sharing their views and experiences and we believe the people we listen to and involve need to reflect the communities we serve. We know that many people are often not heard and to ensure our services meet the needs of everyone, we work creatively and accessibly to reach those whose voices are too often ignored or not sought.

The support of local people is crucial for the success of our work, and we are grateful for the valuable feedback, innovative ideas, and unique perspectives that help shape our services and how we work.

# Who we are and what we do

## We are an NHS Foundation Trust of over 9,000 staff, providing care for the population of Gloucestershire and neighbouring counties.

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. We also provide Maternity Services at Stroud Maternity Hospital and a range of outpatient clinics and some surgery services from community hospitals throughout Gloucestershire.

Gloucestershire Royal Hospital

Cheltenham General Hospital


Stroud Maternity Hospital







## Our visions and values

Our vision is to provide:

# the **Best Care for Everyone**

This is our guiding principle and shapes the way we work in partnership with our communities.

We care about what we do and believe our work matters to local people. We pride ourselves on our compassionate culture, which is underpinned by our three core values:

**caring**

We care for our patients and colleagues by showing respect and compassion

**listening**

We actively listen to better meet the needs of our patients and colleagues

**excelling**

We strive to excel through learning, and we expect our colleagues to do and be the best they can

# Our commitment to engagement and involvement

## Why is engagement and involvement important?

Our colleagues, patients and communities are at the heart our ambition to deliver the best care for everyone. By actively listening to those who use and care about our services, we can better understand diverse health and care needs and respond accordingly.

## What are we doing?

We are committed to embedding engagement and involvement throughout our hospitals.

Our goal is to ensure that the voices of patients, carers, and colleagues are continually heard and that they shape our decision-making process. We strive to make our organisation a great place to work and receive care.

## What will we achieve together?

**By working together, we can make better decisions and we will be able to:**

- Improve the quality of care and services;
- Improve patient safety;
- Improve colleague and patient experiences;
- Shape services around what local communities tell us that matter most to them;
- Attract, recruit and retain the best staff to the Trust;
- Support and celebrate the diversity of our local community in promoting healthy living

# An introduction to Gloucestershire

## Gloucestershire is a county of unparalleled beauty, boasting enchanting hamlets, picturesque towns, and stunning landscapes that include ancient forests, two iconic rivers, and three Areas of Outstanding Natural Beauty.

Beyond its natural splendour, Gloucestershire embraces a rich cultural diversity and history, blending rural and urban communities where over 100 languages are spoken. At Gloucestershire Hospitals NHS Foundation Trust, our team of over 9,000 colleagues represents more than 75 nationalities, fostering a dynamic blend of cultures and expertise that enhances the care we provide.

Collaborating closely with partners and local communities, the Trust is dedicated to enhancing health and well-being while ensuring equitable access to services. Recent census data highlights ongoing health and community challenges, which we are committed to addressing through collaborative partnerships.

# Key statistics on Gloucestershire

For more information on the health and wellbeing of Gloucestershire visit
https://www.gloucestershire.gov.uk/inform/

## Total population: 2021

**645,076**
people

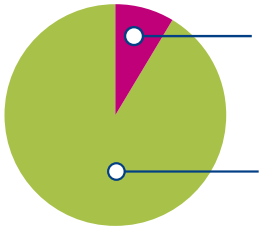
**49%**
male

**51%**
female

## Population distribution of Gloucestershire, 2021

| Gloucester | Tewkesbury | Cheltenham |
|---|---|---|
| 20% | 15% | 18% |
| **Forest of Dean** | **Stroud** | **Cotswolds & Tetbury** |
| 14% | 19% | 14% |

## Ethnic groups and language



**12.3%**
Of the population identify as 'ethnic minorities'

**87.7%**
Of the population identify as white British

**96%**
Of population chose English as main language

## Disability

**16.8%**
of the population are disabled under the Equality Act (2010)

**6.4%**
Of the population are not disabled but do have a long term physical or mental health condition(s)

**1 in 4**
People are classed as disabled in some LSOAs

## Diseases

Based on estimated projections

**By 2024**
there will be approximately
**11,000**
people aged 65+ living with dementia in Gloucestershire

# Key statistics on Gloucestershire

For more information on the health and wellbeing of Gloucestershire visit
https://www.gloucestershire.gov.uk/inform/

## Country of birth: Proportion of 2021 population


Europe (Non-UK)

90%

Africa

5%

Middle East and Asia

1.4%

The Americas and the Caribbean

2.3%

Antarctica, Oceania and other

0.9%

0.3%

**Poland**

Is the country where the highest number of non-UK people were born

**1 in 10**

People not born in the UK

**40%**

Increase in the non-UK born population between 2011-21

# Who do we engage and involve?

# Who do we engage and involve?

**Our Engagement and Involvement Strategy outlines how we want to engage and involve people in shaping our plans to improve services and listen to what matters to our communities.**

By continuing to build relationships and collaborative work with our partners we can coordinate services better, and plan care in a way that improves population health and reduces inequalities.

In Gloucestershire, we are now part of a new Integrated Care System, bringing together NHS organisations, councils, Healthwatch, charities and the community, voluntary and social enterprise sector (third sector) with the shared aim of improve the health and wellbeing of local people.

By continuing to build our relationship and work with our partners we can coordinate services better, and plan care in a way that improves population health and reduces inequalities between different groups.

The way in which we engage and involve people is at the heart of this work, and a cornerstone of this was in the codesigned ICS 'Working with People and Communities' strategy, which was further supported by the ground-breaking Memorandum of Understanding with VCS partners – cementing how we will all continue to work together for local people.

To support the way in which we work, 'Get Involved in Gloucestershire' was established and is an online participation platform for people to share views, experiences and ideas about local health and care services.

We remain committed to work in partnership to make it easier for people to share their experiences and enable a wide range of approaches to ensure we can listen to the voices from our vibrant and diverse communities.

# Who we engage

**The diagram details our stakeholders**

# Who do we engage and involve?

## Our partnership with the Voluntary, Community and Social Enterprise Sector (VCSE) and Healthwatch helps provide vital insight and reach into groups with particular needs across our communities so that our services are accessible and responsive to all.

We are continually strengthening how we can engage and involve local people to ensure what matters to them is used to influence decision making.

There are lots of ways people presently share their experiences and are actively involved and engaged in shaping local health services in Gloucestershire, including:

Elected and appointed Governors

Trust Membership

Get Involved in Gloucestershire
getinvolved.glos.nhs.uk/

Gloucestershire Voluntary and Community Sector Alliance

Young Influencers
www.gloshospitals.nhs.uk/about-us/support-our-trust/our-youth-group/

Online patient experience websites, including NHS Choices and Care Opinion
www.careopinion.org.uk/services/rte

NHS Friends and Family Test questions
www.gloshospitals.nhs.uk/contact-us/friends-and-family-test/

Patient Advice and Liaison Service
www.gloshospitals.nhs.uk/contact-us/patient-advice-and-support/

Directly with our complaints, concerns and customer service team

Healthwatch Gloucestershire
www.healthwatchgloucestershire.co.uk

Engagement on social media

Patient Stories

Through engagement activities and events

Attendance at Trust Board and Annual Members Meeting

Participation in our Fit for the Future engagement
https://getinvolved.glos.nhs.uk/fit-for-the-future-2

We recognise that there is more we can do to increase opportunities for meaningful involvement and to ensure this reflects the diverse communities we serve. We continue to learn so we can be more innovative, and resourceful in how we engage people to improve experience for both patients and colleagues.

# The impact of involvement and engagement over the last year.

The Trust is directly involved in a wide range of projects in partnership with local communities and the impact of this work has been mapped with the introduction of our Community Engagement Tracker. Outlined below are just some of the highlights from the last year and the full scope is available in our Engagement Tracker.

# Community Engagement Tracker

**The Team uses the Community Engagement Tracker, which is designed to systematically track and analyse community interactions to improve services and foster meaningful relationships with stakeholders, facilitating data-driven decision-making and evaluating engagement efforts.**

It focuses on directing community members to Voluntary, Community, and Social Enterprise (VCSE) groups, building local relationships, and enhancing healthcare services based on community feedback.

Between April 2023 and March 2024, The Community Engagement Team engaged with over 13,000 people, which was achieved by being involved with and attended 70 community group events and activities. This work has helped in increase access to VCSE services, improved access and attendance to health appointments, and improved access to healthcare information. Success is measured through engagement metrics and data analysis, and the insights directly help to change how our services work, ensuring the understand what matters to local people and communities.

Our improvement comes from regularly reviewing the feedback and supporting communities, all aligned with the Trust values to ensure meaningful engagement and quality improvement across the Trust.

Find out more here: ( LINK TO TRACKER TO BE ADDED)

# **Voices of Our Community:** A Look Back at the Stories that Define Us

## Refugees and Asylum Seekers Group

**A Syrian woman who came to the UK as a refugee with her young family shared her deeply personal and challenging experience. During her labour, she struggled without a close family member or interpreter present. From her previous experiences with her two older children, she anticipated complications, but she was unable to communicate this to the maternity staff. The medical team, unaware of the issues she foresaw, did not initially address her concerns.**

Eventually, she received emergency treatment, but only after considerable distress and effort to make her voice heard. Despite her attempts, she felt unheard and unsupported during this critical time. With support from the Trust Community Engagement Team, her experience was brought to the attention of the Director for Safety and Medical Director, the Deputy Chief Executive, and the Chief of Service for Women's and Children's. They escalated her concerns, ensuring that her experience was acknowledged and would inform future practices.

Her story has since become an essential part of ongoing training packages and will be included in the review of patient translation and interpreter services. She was finally listened to and supported, and the right method to communicate with her was established. Her primary wish is that no other mother-to-be experiences the frustration and fear she felt during her labour and subsequent birth. She wanted her lived experience to be shared and understood. Additionally, she was supported in accessing specialized perinatal care, ensuring her needs were met during this vulnerable period.

*Her story has since become an essential part of ongoing training packages and will be included in the review of patient translation and interpreter services.*

### Voices in our community: Stories

# Attending - Emma Will Sewing Studio Well-Being Group

## The Trust Community Engagement Team participated in Community Engagement sessions with the Gynaecological Screening Nurses to understand the cultural barriers and data related to cervical screening.

The Trust Community Engagement Team worked with women from the local South Asian communities, explaining the cervical screening procedure and exploring the cultural barriers to accessing screening. One significant barrier is the emphasis on modesty, integral to many cultural and religious practices, which encourages women to dress modestly and avoid exposing private areas.

Additionally, there is a prevalent myth and taboo surrounding the HPV virus and its link to cervical cancer. Since HPV is a sexually transmitted virus, some cultures view the screening as an accusation of promiscuity. Furthermore, in many cultures and religions, a young woman's virginity is highly valued, and there is a misconception that cervical screening might affect this.

We also engaged with influential community members and local religious leaders from the mosque to understand their perspectives and seek their support in encouraging women to access screening. The religious leaders had in-depth discussions with our clinical team and were supportive, recognising that screening is part of maintaining one's health and well-being, which is highly regarded.

Despite these efforts, barriers still exist. However, progress is being made. For instance, six women have now accessed screening interventions. One man, who thanked me, shared that he now understands the importance of cervical screening. His wife of 20 years had never been screened, but with his support, she attended.

He also mentioned that being able to discuss these issues openly has given him the confidence to talk to his five sisters and two teenage daughters about puberty and HPV prevention. Coming from a Bangladeshi background where these topics are often considered taboo, this represents a significant shift.

### Voices in our community: Stories

# South Asian Community Arts Group

## Working in Collaboration with Strike A Light (who are Strike a Light) to host a celebration to celebrate the 75 years of the South Asian Community, through music and art  in August 2022

South Asian Heritage Month seeks to commemorate, mark and celebrate South Asian cultures, histories, and communities. The month seeks to understand the diverse heritage and cultures that continue to link the UK with South Asia.

The Trust Community Engagement Team supported young widowed women in the local community who have tragically lost their husbands to short-term illnesses, they have heard heartfelt testimonials about the excellent care provided by the Trust and staff. During the celebration of South Asian Heritage Month's 75th anniversary, we utilised art therapy as a means to address grief and navigate the intricacies of culture.

These women grapple with internal family expectations and the daunting task of becoming the primary breadwinners, often without prior work experience. It's important to note that for many of these women, English is not their first language.

Find out more here: bit.ly/3X5Pv26

> *The month seeks to understand the diverse heritage and cultures that continue to link the UK with South Asia*

**Voices in our community: Stories**

1. Refugees and Asylum Seekers Group
2. Attending: Emma Will Sewing Studio Wellbeing Group
3. South Asian Community Arts Group
4. Attending: Jamaica Day
5. Attending: South Asian Mens Health and Wellbeing Group
6. Attending: Chinese New Year Celebrations

# Attending - Jamaica Day


## The Community Engagement Team participated in the Jamaica Day event on August 6th, 2023.

During the event, a young teenage boy approached us on the NHS bus a refugee from Syria, wanted to discuss a sensitive ongoing issue he was facing at home. His parents were struggling to adapt to Western teenage norms, keeping him confined at home, monitoring his activities, and expressing frustration over his friendships with non-cultural peers. Their fear of losing control had escalated to angry outbursts and threats of violence.

These behaviours stemmed from their cultural beliefs where parental consent and approval were paramount, contrasting with their son's desire for autonomy. Recognising this as a safeguarding concern, the Trust Community Engagement Team contacted a member of the Police Better Together Team who were also present at the event, they supported the boy's decision to open up and requested the Community Engagement team's continued presence.

Later, the Community Engagement Team facilitated a discussion involving the young boy's parents regarding the father's mental health symptoms. They guided accessing mental health services through the Locality Inclusion Lead at Gloucester Health and Care Trust.

Additionally, they encouraged them to connect with the School Support worker for a referral to the Positive Parenting Program offered by Gloucestershire County Council. This collaborative effort underscored the impact of coordinated support across different teams and systems.

*This collaborative effort underscored the impact of coordinated support across different teams and systems*

# Attending – South Asian Mens Health and Well-Being Group

**The Trust Community Engagement Team had the privilege of meeting an elderly gentleman who has been a local community champion throughout his life and who kindly introduced the team to two more friends of his, with whom he has regular interactions. During our conversation, they candidly discussed the challenges they face due to long-term health conditions, which significantly affect their daily lives.**

These complications often necessitate the presence of a family member to provide care and assistance. They opened up about the profound sense of isolation and frustration that accompanies their inability to venture out independently, constantly relying on someone to accompany them. Perhaps most importantly, they shared their deep longing for a more vibrant social life.

Listening to their heartfelt stories and recognizing their desire for continued support, the Trust Community Engagement Team took the initiative to arrange a meeting with various NHS teams, including the Reaching Out Team for Ethnic Minorities. Fortunately, one of the team members expressed a willingness to provide these men with weekly support in diverse settings, particularly during outings and activities aimed at enhancing their well-being and mental health.

This collective effort gave rise to what is now known as the South Asian Men's Group, or SAM's. Moreover, the group has received valuable support from the Health Education Forum teams of the Adult Social Care Engagement Team for Gloucestershire County Council as well as the participation of Gloucestershire Health and Care Mental Health Services, who have contributed by sharing essential service information.

The SAM's group now convenes weekly, offering its members the invaluable opportunity to come together and bolster each other's health and well-being. This supportive environment is made possible through the dedicated assistance of the Complex Care at Home Reaching Out Team.


# Attending – Chinese New Year Celebrations

**During the Chinese New Year celebrations to which the Community Engagement Team had been invited, the team had the opportunity to connect with a gentleman who possessed a strong command of the English language.**

He opened up to the team about the challenges he had been grappling with ever since he assumed the role of the sole caregiver for his ailing wife. His struggles were multifaceted, encompassing not only the profound emotional difficulty of witnessing his wife's cancer diagnosis rapidly deteriorate but also the practical challenges associated with hospital appointments and caring for their two children.

Recognising the importance of providing him with the right support, The Community Engagement Team guided him towards the Cancer Support Services, including the Focus team, and explained the various support groups available, such as those offered by McMillan and Maggie. Additionally also suggested that he get in touch with the Carers Hub, assuring him that they could accommodate his language needs and provide invaluable assistance.

The conversation extended to delve into the intricacies of cultural complexities and the community's reactions, which weighed heavily on his mind.

He confided in the team about his family's disappointment, as they believed that he and his wife had deviated from traditional Eastern health teachings by adopting Western cultural norms and lifestyle choices. They saw the cancer diagnosis as a direct consequence of this departure from the traditional holistic path to well-being.

In response, The Community Engagement Team shared information about an alternative support group offered by the South Gloucestershire Council – the Chinese Lantern Project helpline, of which he was unaware.

Since our initial conversation, the Community Engagement Team has had the privilege of meeting with this gentleman again, and are pleased to report that he is now in a significantly improved emotional state. His wife has completed her chemotherapy treatment, and as a family, they have chosen to integrate holistic healing into their approach to well-being.

They have also enrolled their two children in a local language school, ensuring they can communicate effectively with their grandparents who plan to visit next summer. This newfound optimism for the future, combined with enhanced support, has made managing his relationship with his own family more manageable for him.

## Voices in our community: Stories

# Case Studies

## The impact and outcomes

1. Co-designing Hospital Audio Guides
2. Community-Led Health Research Initiatives Submergence Project
3. Diabetes UK Community-Led Health Research Initiatives
4. Mindsong 2023
5. NHS and Community Iftars
6. Breast and Cervical Screening Uptake in South Asian Communities:
7. Bowel Cancer Screening Film
8. Celebrating Windrush75 and NHS75
9. Royal Visit to Stroud Maternity
10. Young Influencers
11. Apprenticeships and Careers Engagement
12. Young Thinkers Gloucester
13. Co-designing our Membership Strategy

# 1. Co-designing Hospital Audio Guides



## Brief Description

Navigating a busy hospital environment can be challenging for anyone, but for those who are blind and visually impaired, it can be particularly difficult. Lack of accessibility can create anxiety, restrict independence, and impact on access to some health services. In addition, over the last few years, Gloucestershire Royal Hospital and Cheltenham General Hospital have undergone significant transformation and improvement works, and these changes add further challenges for people.

## Who did we speak to?

The Trust worked in partnership with Gloucestershire Sight Loss Council and staff within our ophthalmology and eye services, and the Emergency Departments, to understand how people access services and how they can be improved for those with sight loss. The aim was to create hospital audio guides for key services across Cheltenham General Hospital and Gloucestershire Royal Hospital.

## What and how did we ask?

We worked with Gloucestershire Sight Loss Council over several days to walk a number of routes across both sites, with the aim of understanding how to navigate hospital services if you have sight loss or visual impairment. The work ensured we identified immediate issues that may impact on access, further development work and to develop the script to be turned into the audio guides.

## What did we do?

The team from the Sight Loss Council provided written guides for both sites, and these were then combined with Artificial Intelligence (AI) voice-over technology (elevenlabs.io), to create the audio guides, which enabled rapid development and testing and significantly reducing costs. A total of 12 new guides were created and enable people to access the Emergency Departments on both hospital sites, as well as Ophthalmology and Eye Screening services. The guides are available on the hospital website and can be accessed from smartphones and tablets, and is believed to be the one of the first NHS navigation audio tools ever developed.

## What did people tell us?

Our hospitals can be difficult to navigate for many people and the development of audio guides provides clear, step-by-step instructions, allowing blind and visually impaired people to navigate hospitals independently and with confidence, ensuring that are able to find their way to appointments and services and reducing anxiety. These initial audio maps focus on eye services and the Emergency Departments and we hope to build a larger library in the coming months.


Find out more here:
www.gloshospitals.nhs.uk/your-visit/visitors-and-carers/hospital-audio-guides/

# 2. Community-Led Health Research Initiatives Submergence Project



## Brief Description

The Submergence Project, funded by a grant from Innovate UK, introduced a transformative immersive light experience at Cheltenham and Gloucester Hospitals. This initiative, a collaboration with Squidsoup—an international group of artists and technologists—features a large, immersive, walkthrough experience called Submergence. This installation, which used LED lights that emit patterns in sync with sound, aimed to create a calming environment, reduce stress, and potentially shorten hospital stays for patients.

The primary goal of the Submergence Project is to enhance the mental and emotional well-being of patients during waiting times. By pioneering immersive art installations in the Oncology and Children's centers at Gloucestershire's two main hospitals, the project seeks to improve patient experiences and explore future applications of immersive technologies within clinical settings. The success of this research will support a bid for a larger project, potentially bringing similar installations to hospitals nationwide.

## Who did we speak to?

As part of this project, we undertook a pioneering community-led health research initiative in collaboration with NHS Charities, Gloucestershire Health and Care NHS Foundation Trust (GHT), and community groups such as Sahara Saheli Women's group and South Asian Elderly Women Group at Friendship Café, among others. The goal was to gather valuable feedback from minority groups who often face barriers to participation in research initiatives.

## What and how did we ask?

Our engagement strategy involved inviting members of these community groups to experience the light installation firsthand at CGH and provide feedback. This approach was crucial to ensuring inclusivity in our data collection efforts, reaching marginalized groups who might not typically have access to such research opportunities.

## What did we do?

We conducted in-person visits to these community groups, discussing the Submergence Project and extending invitations to visit CGH for the installation experience. Feedback forms were tailored to accommodate language and accessibility needs, ensuring that everyone could express their thoughts effectively.

The response from participants was overwhelmingly positive. They expressed pride in being included in this research initiative and emphasized the importance of such opportunities for their communities. The desire for more involvement in future research projects was a common sentiment among attendees.

## What did people tell us?

In response to this feedback, we are actively collaborating with research partners to develop additional opportunities for community engagement and participation. This includes exploring future projects that build on the success of the Submergence Project and continue to prioritise inclusivity in health research.

The Submergence Project not only brought innovative art into our hospitals but also set a precedent for community-led health research. By engaging with diverse community groups, we have not only gathered valuable insights but have also paved the way for more inclusive and meaningful research practices in the future.

This report underscores our commitment to fostering community engagement and ensuring that our research initiatives reflect the needs and perspectives of all individuals in our community. We look forward to building on these efforts and continuing to champion inclusivity in healthcare research and innovation.

Find out more here:

Submergence Charity news

Submergence BBC Points West

# 3. Diabetes UK Community-Led Health Research Initiatives



## Brief Description

The trust partnered with local communities, the Trust Research team and Diabetes UK to advance health research, especially in diabetes care.

Diabetes UK, the largest charitable funder of diabetes research in the UK, is dedicated to achieving breakthroughs in diabetes care, treatment, and prevention. They advocate for and support everyone affected by or at risk of diabetes, offering essential information, advice, and support to help individuals manage their condition. Additionally, Diabetes UK fosters community support and has developed a national programme to help high-risk patients lose weight and become more active.

The trust prioritises community involvement and feedback, focusing on collaborations with local groups to drive meaningful improvements in healthcare delivery and outcomes. A key focus of the study is diabetic retinopathy, a condition where diabetes can damage the retina, potentially leading to permanent sight loss. In England, all individuals with diabetes aged 12 and older are invited to a screening program where retinal images are taken to detect early signs of the disease. This process currently requires eye drops to dilate the pupils for high-quality images.

Participants are also asked to provide feedback on the Plain English Summary and the patient information sheet, ensuring that study materials are clear and accessible.

## Who Did We Speak To?

We engaged with various local community groups and individuals, including the All-Nations Community Centre, Ebony Carers, SAM's (South Asian Men's Group), and community members with diabetes. Recruitment was facilitated through community links and radio outreach.

## What and how did we ask?

Our engagement targeted individuals and groups affected by diabetes, particularly from Asian and Afro-Caribbean backgrounds, to ensure research relevance and impact within diverse communities.

Engagement was conducted through platforms such as Facebook, GFM Radio, and WhatsApp messaging, seeking feedback on research proposals and materials.


## What did we do?

We held focus groups, utilised social media platforms, and collaborated with local radio for community outreach and feedback.

We initiated the CONCORDIA study in collaboration with Diabetes UK, Professor Peter Scanlon, and local community groups, focusing on using advanced imaging technology for diabetes-related eye screenings.

Patient feedback guided the development of study materials, protocols, and patient leaflets, ensuring culturally relevant and patient-centered research practices.

## What Did People Tell Us?

Participants emphasised the importance of improving diabetes-related eye screenings by minimising discomfort associated with traditional methods.

Community members highlighted the significance of culturally sensitive healthcare solutions and improved patient experiences.

1. Co-designing Hospital Audio Guides
2. Community-Led Health Research Initiatives Submergence Project
3. Diabetes UK Community-Led Health Research Initiatives

# 4. Mindsong 2023

5. NHS and Community Iftars
6. Breast and Cervical Screening Uptake in South Asian Communities:
7. Bowel Cancer Screening Film
8. Celebrating Windrush75 and NHS75
9. Royal Visit to Stroud Maternity
10. Young Influencers
11. Apprenticeships and Careers Engagement
12. Young Thinkers Gloucester
13. Co-designing our Membership Strategy

## Brief Description

In collaboration with Mindsong, a Gloucestershire charity dedicated to supporting individuals with dementia through music and song, we engaged with diverse community groups to better understand the significance of music and sound in their lives and the positive impacts on memory.

Mindsong assists individuals with dementia and memory loss, employing various techniques including music therapy. They aim to facilitate and enrich the lives of those affected by dementia and their caregivers.

## Who did we speak to?

We directly interacted with community groups, particularly the South Asian Elderly Women Group and Gloucester Chinese Women's Guild, to explore their perceptions of music and memory. Mindsong's data revealed limited involvement and uptake from minority communities, prompting this initiative.

## What and how did we ask?

Community feedback emphasised the importance of culturally and religiously sensitive playlists that resonate with childhood memories. Participants expressed a desire to incorporate music from their cultural and religious heritage into their playlists.

## What did we do?

As a follow-up to these insights, we intend to collaborate with Mindsong in the summer of 2024 to develop a Community Playlist. This project will involve working closely with diverse community groups to curate a playlist that reflects their unique backgrounds and musical preferences.

## What did people tell us?

The final outcome of this collaboration will be a community-inspired video playlist, showcasing the diversity and richness of musical heritage within our local communities. The video will be accessible through the link:
GHT and Mindsong.

This initiative aims to foster inclusivity and appreciation for the role of music in supporting individuals with dementia across culturally diverse communities.

Find out more here:
bit.ly/3SQxFgT

1. Co-designing Hospital Audio Guides
2. Community-Led Health Research Initiatives Submergence Project
3. Diabetes UK Community-Led Health Research Initiatives
4. Mindsong 2023

# 5. NHS and Community Iftars

6. Breast and Cervical Screening Uptake in South Asian Communities:
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13. Co-designing our Membership Strategy

## Brief Description

The Trust organised the first NHS Iftar events at Gloucestershire Hospitals Trust to allow staff and colleagues to come together to celebrate and experience the breaking of the fast. This initiative aimed to provide NHS staff with an opportunity to learn about Ramadan and Eid-Ul-Fitr celebrations, fostering a deeper understanding and appreciation of these cultural events.

Iftar is the evening meal Muslims enjoy to break their fast during Ramadan, the holy month of fasting in Islam. It's a significant daily event where Muslims gather with family and friends at sunset after the Maghrib prayer. Traditionally, Iftar starts with dates and water. Fasting from dawn to sunset during Ramadan fosters self-discipline, empathy, and spiritual reflection.

Iftar gatherings are communal, often hosted by mosques and community centers to promote fellowship and provide for those in need. Sharing Iftar is considered a charitable act (sadaqah) in Islam, embodying a blend of religious practice, social tradition, and cultural celebration that strengthens bonds and encourages spiritual growth.

## Who did we speak to?

We were asked by our staff and our One Gloucestershire colleagues, to provide our staff across the county with an opportunity to learn about Ramadan and Eid-Ul-Fitr celebrations

We organised NHS Iftar events across organisations which were multifaceted, focusing on promoting inclusivity, enhancing cultural competence, and fostering a sense of community among staff.

## What and how did we ask?

An open QandA session was held, encouraging attendees to ask questions and engage in discussions in a safe and respectful environment.

Testimonials and positive feedback were received from attendees, highlighting the impact and value of the events.

We also produced Communications to Share Across the Trust/ICS: Communications were developed and disseminated across the Trust and Integrated Care System (ICS) to share the experiences and outcomes of the Iftar events.

## What did we do?

The event aimed to be inclusive, welcoming all staff members regardless of their religious or cultural backgrounds. It was meticulously planned to ensure maximum participation, accommodating the diverse working schedules of our staff.

Our talented chefs from Gloucester Managed Services prepared traditional Iftar meals, creating an authentic experience for everyone present. During the event, staff members openly shared their personal stories and experiences related to Ramadan and Eid, fostering deeper connections and mutual understanding among colleagues.

We also had guest speakers who provided insightful perspectives on the significance of Ramadan and Eid-Ul-Fitr, enhancing the overall learning experience. The program included moments for congregational prayers and a call to prayer, allowing Muslim staff to practice their faith while offering non-Muslim colleagues an opportunity to observe and learn. The events were highly attended, with over 800 staff members participating, indicating significant interest and engagement across the organisation.

## What did people tell us?

The NHS Iftar events are part of the Trust's approach to ensuring an inclusive, culturally competent, and cohesive workplace. These events have not only enhanced understanding and appreciation of different religious traditions but have also strengthened the sense of community and collaboration among staff.

The initiative promoted collaboration with colleagues across the different NHS organisation,  and strengthened relationships among staff from different departments and areas of the Trust.

The events sparked ongoing conversations about cultural diversity and inclusivity, contributing to a more inclusive organisational culture.

Find out more here:
https://intranet.gloshospitals.nhs.uk/news/ramadan-2024/

# 6. Breast and Cervical Screening Uptake in South Asian Communities:



## Brief Description

In our ongoing commitment to breast and Cervical cancer awareness The Trust wanted to work with local South Asian Communities to support the uptake of Breast cancer and cervical screening. This was led by the Community Engagement and Involvement Manager , who brought women from specific communities together and hosted discussion sessions to understand what matters most to them when responding to the invitation for screenings.

This initiative aims to engage with diverse communities and gain insights into the barriers and preventive measures surrounding breast cancer screening, particularly among women aged 50 and over within local communities.

## Who did we speak to?

This initiative was carried out as data highlighted stark disparity in screening rates among women from Ethnic Minorities aged 50 and above also from a series of regular meetings and collaborations with local community groups.

The Trust worked very closely with groups and individuals from the South Asian Community, as well as health and care professionals who work closely with these communities. The discussion sessions were held in collaboration with community organisations, and aimed to listen to the experiences and barriers individuals faced in accessing cervical screening. Tackling inequalities in outcomes, experience and access

## What and how did we ask?

During the discussion sessions, participants shared their knowledge of breast and cervical cancer and the importance of screening. The sessions also explored the barriers that South Asian women face in accessing cervical screening, including cultural and language barriers. Participants were encouraged to share their personal experiences with screening and any concerns they may have.

## What did we do?

The Trust worked with community organisations and religious experts to:

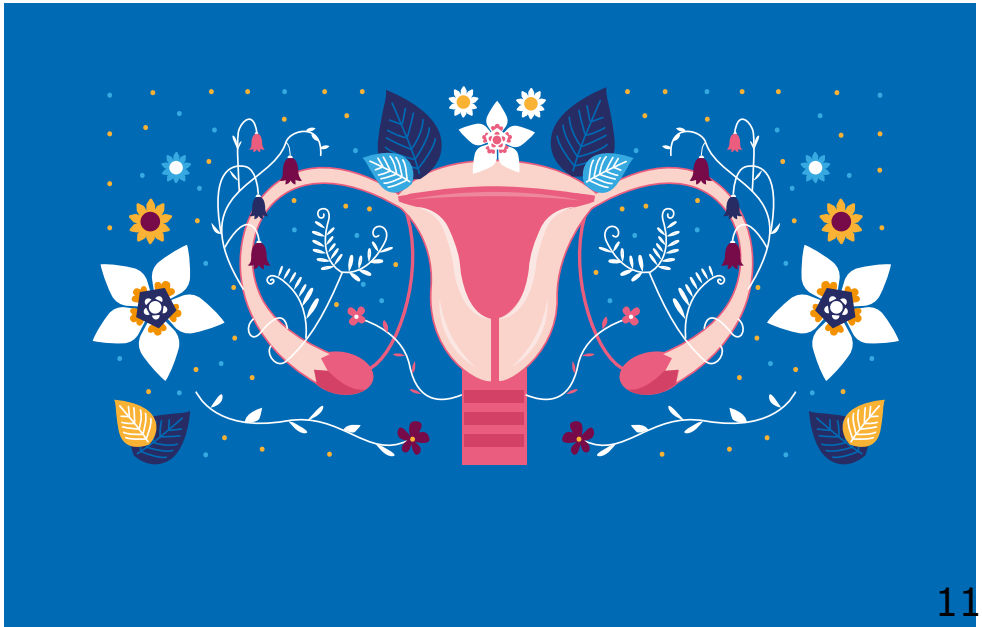
- Breast Cancer Awareness Bus Tour, conducted in collaboration with the ICB (International Cancer Board)
- deliver culturally sensitive information and education about cervical screening
- promote the importance of regular screening
- address concerns and misconceptions

## What did people tell us?

The coordinator of the Gloucestershire Action for Refugees and Asylum Seekers group reached out to me. She expressed her concerns about a group of Afghan refugees comprising nine women, all aged 50 or older, who were completely unaware of breast cancer screening. In response, the Trust promptly connected with our ICS partners and successfully arranged for this group to be included in our bus tour.

Participants expressed concerns about the lack of awareness and education about cervical screening in the South Asian community. Many cited cultural barriers, such as stigma and shame around discussing sexual health, as well as practical barriers and a lack of understanding about the screening process.

Participants also expressed a desire for more culturally sensitive education and information about cervical screening, as well as greater access to screening services in community settings.



# 7. Bowel Cancer Screening Film



## Brief Description

To enhance cancer screening uptake among diverse communities, the Trust partnered with healthcare providers to engage with these communities. We hosted discussion sessions to understand their priorities and responses to screening invitations.

In collaboration with NHS Gloucestershire Integrated Care Board and Reddoor Film and Media, we reached out to the Gloucestershire community to create a bowel cancer screening awareness film.

A 60-second film was produced to encourage bowel screening uptake. It was showcased on large screens at Gloucester Quays and shall be used at local community venues for bowel cancer awareness events. The film featured local people speaking in various languages, urging everyone to take the test, emphasising that early treatment can save lives.

## Who Did We Speak To?

The Trust engaged with individuals and groups from diverse communities, alongside health and care professionals serving these communities.

We focused on improving screening uptake in areas with historically low participation. The film's key message was:
"If you receive a kit, don't ignore it. It could save your life!"

Languages featured included:

- Gujarati
- Punjabi
- Urdu
- Bangladeshi
- Arabic
- Sylheti
- Hindi
- Cantonese
- Polish
- Filipino
- Romanian
- Spanish
- Portuguese

## What and How Did We Ask?

We explored the cultural and language barriers that people from diverse communities face. Participants discussed their personal experiences and concerns about screening.

## What Did We Do?

The Trust partnered with community organisations and leaders to:

- We recruited volunteers to promote the screening programme in their native languages. Collaborating with local faith and community leaders, and individuals who had completed the screening test, we ensured the film reflected Gloucestershire's rich diversity
- Deliver culturally sensitive information and education about the bowel cancer screening programme.
- Promote regular screening through the awareness film, particularly during Bowel Cancer Awareness Month in April.
- Improve screening uptake in low-participation areas.
- Address concerns and misconceptions.

## What Did People Tell Us?

Participants highlighted a lack of awareness and education within diverse communities. They noted cultural barriers such as stigma and shame around discussing personal health, practical obstacles, and a general lack of understanding about the screening process. There was a strong call for more culturally sensitive education, better access to screening services, and more community-based information.

1. Co-designing Hospital Audio Guides
2. Community-Led Health Research Initiatives Submergence Project
3. Diabetes UK Community-Led Health Research Initiatives
4. Mindsong 2023
5. NHS and Community Iftars
6. Breast and Cervical Screening Uptake in South Asian Communities:
7. Bowel Cancer Screening Film

# 8. Celebrating Windrush75 and NHS75

9. Royal Visit to Stroud Maternity
10. Young Influencers
11. Apprenticeships and Careers Engagement
12. Young Thinkers Gloucester
13. Co-designing our Membership Strategy

## Brief Description

The summer of 2023 marked two important milestone anniversaries: the 75 anniversary of Windrush (June 22) and the 75 anniversary of the NHS (July 5).

The Trust worked with local health and care partners and community groups to plan and deliver two joined-up and very special events, making the anniversaries with staff and local people.

### Windrush 75:

> On 22June, 1948, HMT Empire Windrush arrived in the UK, bringing over 1,000 passengers from the West Indies, many of whom were former service personnel. This marked the beginning of post-war immigration, with numerous passengers taking up roles in the NHS, which began just two weeks later. The 'Windrush Generation' refers to those who migrated from Caribbean countries to Britain between 1948 and 1971, following an invitation from the UK government to help rebuild the country after WWII.
> We celebrate their immense contribution to British culture and daily life.

### NHS75:

> 5 July 2023, marked 75 years since the NHS was founded, representing the countries first universal health system available to all, free at the point of delivery, now treating over a million every day.

## What Did We Do?

The Trust worked with a wide range of community groups, staff, NHS organisations, the Heritage Hub, and local people to bring to life several events and activities to mark the two milestones.

To commemorate the 75th anniversary of Windrush a Windrush flag was raised at Gloucestershire Royal Hospital, followed by cake, refreshments, and entertainment from MusicWorks.

To mark the NHS 75 anniversary staff and patients were able to enjoy themed menus across a week, reflecting meals served over the 75 years of the NHS, and special cakes were given to all staff across both sites on July 5.

## Gloucester Cathedral Event:

On Thursday, July 6 2023 , NHS staff from across Gloucestershire gathered at Gloucester Cathedral for a service led by health and community leaders. The event, included Evensong with songs and readings reflecting health and healing. Following Evensong, NHS leaders and community partners reflected on the contributions of the county's dedicated health and care professionals.

The event also featured an NHS75 Exhibition showcasing images and items from the local NHS and Windrush.

## Art Exhibition

As part of the NHS75 celebrations, we partnered with NHS Gloucestershire to host a special community art exhibition in the Cloister of the Cathedral. The exhibition featured inspiring artwork created during sessions aimed at boosting mental and physical wellbeing. It highlights the work of the Gloucestershire Creative Health Consortium's partners, who tackle a wide range of health issues creatively, with many sessions funded by the NHS.

The exhibition included artwork from various organisations, Adult Education in Gloucestershire participants, and images from Gloucestershire Archives showcasing moments in the NHS's history.

A poignant new sculpture, 'The Hand that Cared,' by Deborah Harrison, will also be on display. This sculpture honours Fannie Storr, a Senior Nurse and the first Director of Nursing Education in Gloucestershire, who devoted her life to caring for others and died during the COVID-19 pandemic.

## NHS75 Park-run

On July 8, thousands of runners participated in special Parkrun events across the county, with participation awards handed out. The NHS teamed up with parkrun UK to encourage NHS staff, volunteers, and local communities to 'parkrun for the NHS.'

## Planting 75 Trees

As part of the green commitment, the Trust planted 75 trees at Gloucestershire Royal and Cheltenham General Hospitals with staff from across the organisation helping to plant them

## Heritage Hub

The Gloucestershire Heritage Hub helped to research the history and timeline of health and the birth of the NHS in the county, thanks to their volunteers. This included archiving a number of key items and artefacts from the hospitals. The volunteers mapped out the rich history of health and care in Gloucestershire, from Edward Jenner to the birth of the NHS and its evolution in the county, including primary, community, hospital, and ambulance services. The Trust's Medical Photography team also catalogued hundreds of photos, creating a digital archive, which were displayed at the Cathedral exhibition and available online at the Heritage Hub. A series of special films highlighting the changes in the NHS in Gloucestershire over the past 75 years and its significance to the local community will be shared on social media throughout the week, featuring staff, partner organizations, and members of the public

Find out more here:

- Gloucestershire celebrates 75 years of the NHS
- NHS 75 Community Art Exhibition - Gloucester Cathedral
- The Hand that Cared - Gloucester Cathedral

# 9. Royal Visit to Stroud Maternity



## Brief Description

On Friday 22 March 2024, HRH The Princess Royal, Patron of Stroud Hospital League of Friends, visited Stroud Maternity Unit to meet the mothers, babies and staff who benefit from the League's support. The League of Friends has been a dedicated supporter of Stroud Maternity for decades, funding refurbishment projects and additional equipment and since 2017, support from the League has extended to free singing and yoga for mothers and babies at the unit.

The royal visit was a very special day for our staff, volunteers, mums and families and a memory they will cherish for years to come.

Find out more here:
HRH Visit to Stroud

# 10. Young Influencers



## Brief Description

As a Trust, we acknowledge the significance of involving young people to ensure their voices are heard in our decision-making process. Since rebranding last year, the Young Influencers group has launched a new webpage and produced new promotional materials. They continue to meet monthly face to face or via teams to provide meaningful feedback and improve service provision across the Trust.

## Who did we speak to?

The Young Influencers Group comprises individuals aged 14 to 22 years who are dedicated to enhancing the experiences of young people accessing the hospital.

## What and how did we ask?

We held a focus group with Young Influencers to identify what matters to young people in relation to health and what outcomes they wish to achieve this year. The focus group identified AandE as an area of interest, as well as the desire for opportunities to provide feedback on services across the hospital and to reach more young people in the wider community.

## What did we do?

We concentrated on promoting the Young Influencers Group internally and encouraging various departments within the Trust to utilise the group for feedback and service improvements. The Young Influencers conducted a 15-Step Challenge review in the Children's Emergency Department and are developing an information leaflet for young people accessing ED. The Young Influencers input on the Call for Concern poster led to significant enhancements, and they have since been asked to provide feedback on the 'Language That Cares' leaflet as well as in the Trust recovery departments.

To engage more children and young people in the broader community, the Young Influencers will attend the No Child Left Behind family event in Cheltenham. They are also collaborating with the Trust's digital team to create a video for use in schools, aiming to spark interest in the hospital's work.

## What did people tell us?

Members of the Young Influencers Group have highlighted the importance of having a voice and influencing Trust services. Departments have been keen to involve the Young Influencers for feedback and to identify potential opportunities for service improvement.

Find out more here:
Young Influencers

1. Co-designing Hospital Audio Guides
2. Community-Led Health Research Initiatives Submergence Project
3. Diabetes UK Community-Led Health Research Initiatives
4. Mindsong 2023
5. NHS and Community Iftars
6. Breast and Cervical Screening Uptake in South Asian Communities:
7. Bowel Cancer Screening Film
8. Celebrating Windrush75 and NHS75
9. Royal Visit to Stroud Maternity
10. Young Influencers

# 11. Apprenticeships and Careers Engagement

12. Young Thinkers Gloucester
13. Co-designing our Membership Strategy

## Brief Description

The apprenticeships and careers engagement supports the Trust's aim to increase the promotion of apprenticeships and career opportunities, build connections with young people, attract new talent, and inspire our future workforce.
The team link in with the ICB with regards to widening participation and apprenticeships within our communities, with further development opportunities for young people including hosting T Level industry placements, Experience within the workplace and work experience, QandA sessions, and taster sessions.
Working with the "We Want You" project team on careers engagement and Widening participation.

## Who did we involve and why?

Over the last year, we engaged with over 34 local schools, colleges, and alternative providers to target students between the age of 10 – 21 to promote NHS apprenticeships, career opportunities, and experiences in the workplace.  We supported National Apprenticeship Week, T Level Thursday, and National Healthcare Science Week with events for our existing staff as well as community engagement. The NHS has signed up to the Care Leavers Covenant to help support this group into work within the NHS.

## What and how did we ask?

The Apprenticeships Team provided a single point of contact for career leads, students, parents and other members of the community to discuss apprenticeships and career opportunities within the NHS.

- Virtual Engagement Events – Career Awareness QandA sessions to highlight Careers within our Trust and widen participation for our local community to speak with NHS professionals about their roles and how they could find out more about career pathways.
- Face to Face Engagement Events – Attendance at local career events in schools and colleges and alternative providers (e.g. Young Gloucestershire) to inspire the future workforce via representation from our Career Role Models (for which we have 234 currently representing our Trust).
- Social Media – regular content via X and Instagram to promote apprenticeships and career opportunities within the Trust and NHS.
- Healthcare Science Awareness - Event held at University of Gloucestershire for Year 9s and above
- Visit with Healthcare Scientist to local Primary school and competition for winners to return to Hospital site for tour and talk to Healthcare Scientists and use our VR Escape room
- Created 3 Podcasts for National Apprenticeship week – 1. General Information 2. A Parents Perspective 3. Ella's story (a care leaver)
- Ella's Story Podcast on youtube
  www.youtube.com/watch?v=7xol0YDs9Kc

## What did people tell us?

The engagement has helped build knowledge and relationships between the NHS, ICS, and local schools/colleges, promoting and recruiting students into apprenticeships and future careers within the NHS.

- Helped break down some barriers for young people applying for vacancies, providing support on how to apply, access to IT equipment, and how to write and submit an application

The We Want You project showcased a drama production about apprenticeships and routes into the NHS and Social Care to schools around the county.

## We Want You Project

Engaging young people with the We Want You project | NHS Employers

- Strengthening work experience opportunities across the ICB, moving toward a process across the One Gloucestershire system

Find out more here:
Apprenticeships

# 12. Young Thinkers Gloucester



## Brief Description

We are proud to support Young Thinkers Gloucester (YTG), an established third-sector organisation led by two local doctors. YTG provides a free weekly study club for children in the Barton and Tredworth area and organises health and education events for the community.

The Trust has provided funding to YTG through NHS Charities Together, promoting healthy lifestyles and health equality. This support has enabled YTG to offer health information sessions on important topics such as diabetes, bowel cancer, CPR training, early intervention, and healthy lifestyles.

YTG has launched a new podcast series featuring special guests and covering diverse topics such as diabetes management, dementia awareness, and youth mentoring. You can find their podcast on the Young Thinkers Gloucester YouTube channel:

https://youtube.com/@youngthinkersgloucester

## Who Did We Speak To?

The Trust has been in contact with Young Thinkers Gloucester to discuss ongoing support, collaboration, and ways to maximise positive community impact.

## What and How Did We Ask?

The Trust inquired about YTG's plans for this year's education sessions and how we could support their community efforts. We provided the necessary funding to assist these initiatives.

## What did we do?

The Trust's funding has helped YTG continue their:

- Free study club at Friendship Cafe
- CPR and first aid and cardiac teaching events for all ages
- Diabetes awareness sessions
- Bowel cancer screening guidance for young people
- Healthy Ramadan and diabetes webinar

The YTG team expressed their gratitude for the Trust's ongoing support and funding, which has enabled them to continue their vital work educating young people on various topics. They emphasised the importance of community engagement and education in positively impacting health outcomes.

Find out more here:
www.facebook.com/youngthinkersgloucester/

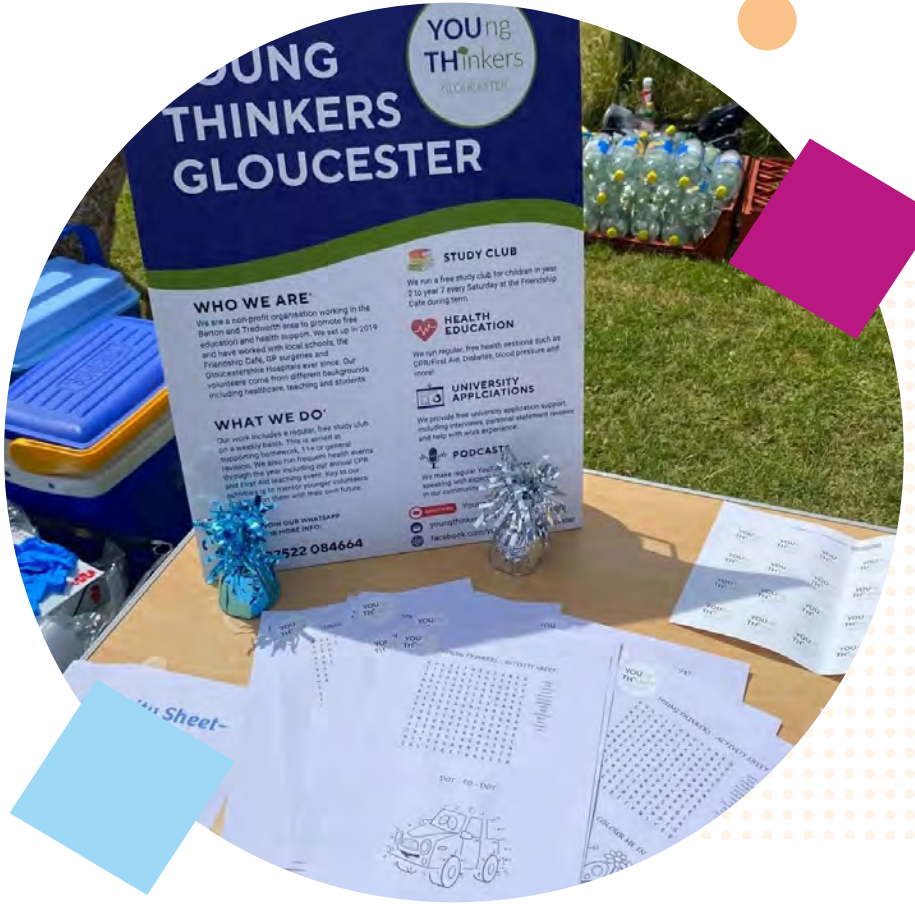



Image sourced: Young Thinkers Gloucester Facebook

1. Co-designing Hospital Audio Guides
2. Community-Led Health Research Initiatives Submergence Project
3. Diabetes UK Community-Led Health Research Initiatives
4. Mindsong 2023
5. NHS and Community Iftars
6. Breast and Cervical Screening Uptake in South Asian Communities:
7. Bowel Cancer Screening Film
8. Celebrating Windrush75 and NHS75
9. Royal Visit to Stroud Maternity
10. Young Influencers
11. Apprenticeships and Careers Engagement
12. Young Thinkers Gloucester

# 13.Co-designing our Membership Strategy

## Brief Description

As a Foundation Trust we are accountable to our local communities, our patients and staff, and enables us to listen to what matters most to people in our decision-making.

We do this by encouraging people to become a Trust 'member' which provides a range of benefits, but importantly ensures that people have a say in how services will be designed and delivered. In addition, members can elect Trust Governors, who perform a vital role in holding non-executive Board members to account for the performance of the Board. Members can stand for election to become a Governor.

It is important that we have an involved, informed, and representative membership, ensuring we continue to listen and respond to the needs of the community in delivering the best care and services.

In 2023 we refreshed our Membership Strategy by co-designing it with members, our Council of Governors, local communities and staff.

## Who did we speak to?

Our strategy was codesigned with Governors and Trust staff who were part of a workshops and was also shaped through engagement with members of the public at events over the summer and our Young Influencers Group. We reached out to our 2,000 members to ask them what mattered most to them and get their input into co-designing a new strategy.

## What and how did we ask?

We held several co-design workshops with staff, our Governors, Board and Young Influencers, as well as working with members and the public at events over the summer in 2023. We also used our regular Members newsletter and community engagement to directly get views from members and the public, to understand what we could do to strengthen our approach to membership.

## What did we do?

The membership strategy was shared in a draft version and key questions were asked, have continued to provide regular newsletters to our members, covering a range of topics such as new services, developments within the Trust, and patient stories. We have also made changes to the Annual Members Meeting, such as inviting guest speakers to talk about important healthcare issues and providing opportunities for members to ask questions and provide feedback.

## What did people tell us?

Our members, governors, staff, and community groups highlighted four key areas for the Trust to focus on within the strategy. It was also recommended that the strategy should be simpler to implement and be for a two-year period, to ensure pace in delivering against the priorities.

Through the co-design of our strategy, four core aims emerged:

1. Develop a membership that is representative of our diverse communities;
2. Support the Council of Governors to be reflective and representative of our diverse communities;
3. To improve the quality of engagement and communication with members;
4. To keep accurate and informative databases of members and tools to engage with people.

Work is now well underway in delivering the strategy and we are grateful to those people who provided their views and ideas to shape the way in which we work together.

Find out more here:
Membership Strategy 2024 - 2026

# Other ways we involve and engage

# Other ways we involve and engage

**Over the last year we have continued to strengthen and develop the range of ways we are able to engage and work with local people and colleagues. As an NHS organisation we also have a number of established approaches to ensure the voice of local communities are represented.**

We have continued to build our joint-working with our NHS and voluntary partners across Gloucestershire. There is a clear benefit to local people in health and social care working together on engagement and involvement opportunities, helping us to have more meaningful conversations and ensuring our voluntary and community sector have an active role.

## Get Involved Gloucestershire

In 2021 NHS partners launched 'Get Involved in Gloucestershire' which is an online participation space for people to can share views, experiences and ideas about local health and care services.

The new digital platform will be a central point for the NHS and local people to find out and directly get involved in shaping local services. The experiences shared through the platform will help inform and influence the decisions local NHS organisations make.

Further information about Get Involved in Gloucestershire and free registration can be found here:
https://getinvolved.glos.nhs.uk/

# Other ways we involve and engage

## Governors

An important way local people can directly get involved with the Trust is as Member and staff through our Council of Governors. We have 22 public, staff and appointed governors who represent the views and interests of Trust members and the local community, to ensure our Trust reflects the needs of local people.

Our governors ensure we listen to the views of patients and people who live locally, along with our staff and other interested parties. They hold us accountable and ensure we can make improvements to our services, and the information we provide.

The Council of Governors meet six times a year to provide feedback on developments and decisions at our hospitals. These meetings are open to the public, who are welcome to attend.

Further information about Governors can be found here:

www.gloshospitals.nhs.uk/about-us/governors

## Members

As a Foundation Trust, we are accountable to local people and we actively promote the benefits of becoming a member and how to stand for election as a governor.

Members are our staff, our patients and members of the public who either have a general interest in healthcare or are interested about a specific condition or speciality. Members are regularly invited to get actively involved with the Trust to develop services which will best suit the needs of local people.

For more information and to become a member visit:

https://www.gloshospitals.nhs.uk/about-us/support-our-trust/join-our-foundation-trust/

# Other ways we involve and engage

## Patient Experience

Our patient experience matters to us. Our Trust's strategy has a commitment to create a culture where patients really are at the heart of everything we do and that a patient centred care is embedded across the Trust.

We know from international evidence that outstanding patient experience improves patient safety and clinical effectiveness and also improve the experience of NHS colleagues.

As a Trust we produce an Annual Patient Experience Report which focuses on all our patient experience initiatives, including Friends and Family, compliments, comments and complaints and projects that have happened across the organisation this year.  This can be read at:

https://www.gloshospitals.nhs.uk/about-us/reports-and-publications/reports/

## People's Panel

As part of our One Gloucestershire approach to involvement, have supported the recruitment of more than 1000 local residents to join a People's Panel. The Panel is made up of individuals, whose anonymous feedback will be used at a county and a more local level to shape health and care services and support. The Panel includes people who live in priority areas of the county, the Core20, where under served communities experience greater health inequalities than elsewhere in Gloucestershire.

## Insight Hub

We are supporting the development of an online space, a 'library', where all qualitative Insight (reported feedback from local people and communities) can be kept together in one place. Its purpose will be to assist One Gloucestershire partners to access current Insight from across the areas with the aim of avoiding duplication and involvement fatigue.

# Other ways we involve and engage

## Patient and colleague stories

Patient and colleague stories are regularly presented at the beginning of Trust Board meeting. The stories provide an example of the lived experience of patients and colleagues to highlight examples of excellence and where there are areas for improvement.

https://www.gloshospitals.nhs.uk/about-us/our-board/board-papers/

## 6.8 Our Annual Members Meeting

Our Annual Members Meeting is where the Trust shares key highlights and achievements, and reflect on the previous year's performance, and where we share some future developments planned for the year ahead.

You can watch Annual Members Meeting again at:

YouTube GlosHospitalsNHS

## Healthwatch Gloucestershire

The Trust works closely with Healthwatch Gloucestershire (HWG) and they are actively involved in our work and plans, including attendance at Trust Board, Partnership Involvement Network and a number of service projects, including the Covid vaccination programme.

More information about Healthwatch can be found here:

www.healthwatchgloucestershire.co.uk/

## Maternity Voices Partnership

Gloucestershire Maternity Voices Partnership is made up of volunteers who represent the voice of women and families from all communities and cultures to inform improvements in local maternity care. The partnership is directly involved with the Trust's Maternity and Midwifery services and provides an important independent voice in shaping our services.

https://getinvolved.glos.nhs.uk/gloucestershire-maternity-voices-partnership

# Other ways we involve and engage

## Social Media

Social media continues to evolve and can bring closer involvement and engagement with a wider range of people than traditional approaches alone. The Trust has evolved its engagement and involvement, embracing face-to-face activity with social media, with a far wider reach. This includes our Facebook Live events, live streaming QandA sessions with staff, and listening to individuals' experiences of services.

We have several social media channels that anyone can follow and these are outlined below:

Twitter:
www.twitter.com/gloshospitals

Facebook:
https://www.facebook.com/gloshospitalsNHS

YouTube:
www.youtube.com/c/GlosHospitalsNHS

LinkedIn:
https://www.linkedin.com/company/gloucestershire-hospitals-nhs-foundation-trust/

# What will we be doing this year?

# What will we be doing this year?

## Over the past year, we have developed an engagement plan to ensure we are able to attend as many key local events and celebrations, as well as being invited to support community programmes.

We will continue to explore new ways to connect with our communities to help gain a deeper understanding of priorities, ensuring what we all do remains responsive to local needs

# What will we be doing this year?

## Key priorities over the next year include:

1. Co-design a new Engagement and Involvement Strategy
2. Co-design the new Trust strategic plan
3. Inclusive Language Guide
4. Introduce a new digital patient portal PEP, improving access to appointments, health records,
5. Support and work with the Patient Experience Team Accessible Information Standards (AIS),
6. Support the Trust Charity 'Lions at Large' project with the Pride of Gloucestershire Trail taking place in the summer of 2025 to fundraise for new cancer care facilities in Cheltenham.
7. Reframe – Diverse Images for Healthcare Project with Medical Photography.
8. Maintain our partnership with Youth Thinkers Gloucester, supporting some of the most deprived areas and engaging communities on health issues;
9. We will continue to focus on health equity and work towards ensuring all communities have access to the right care, at the right time, in the right ways.

**If you want to find out more about the activities mentioned above, make sure you join the 'Get Involved in Gloucestershire' https://getinvolved.glos.nhs.uk platform where you can also share your views, experiences and ideas about local health and care services across the county.**

# Summary

## Individually, we are one drop. Together, we are an ocean

Ryunosuke Satoro

Meaningful community engagement and involvement is at the heart of what we do. In a year in which we celebrated and reflected on 75 years of dedication and care of those who have work with and within the NHS, as well as the Windrush generations who shaped our communities and services, it is absolutely clear that it is together where we can make such a huge difference in the lives and wellbeing of each other.

Through working together, in meaningful partnerships with local people and community groups, we gain invaluable insights into specific health needs, challenges, and barriers that impact on accessing services and health and wellbeing. This deeper understanding enables us to develop culturally sensitive and impactful partnerships and improve access to services.

Over the last year we have continued to make good progress in several areas, including permanent recruitment to our Community Engagement and Involvement Team, who lead on building relationships with a range of partners, communities and seldom heard groups. Our Young Influencer group now has a direct role on the Council of Governors, including the election of a Governor, and they have led several projects to support services.

We have also continued to develop our “Centres of Excellence” at Cheltenham General Hospital and Gloucestershire Royal Hospital and over the last year there has been several exciting building works completed, including the opening of the new Chedworth Surgical suite in Cheltenham, the upgrade of the new Emergency Department in Gloucester, and the new Cardiology Cath Labs in Gloucester, all helping to improve access and service quality at our hospitals.

Our partnerships and relationships with local community groups, voluntary organisations and service providers has meant we have continued to reach more people across the county and help improve access to our hospitals. The impact of what we do together ensures we make it easier for people to share their experiences and to help understand what matters most to them.

# Summary

## Thank you

We have also continued to improve and develop the way in which we engage and involved people, from attendance at numerous events and groups, to strengthening the quality of  live streaming and digital tools. We've incorporated this to our engagement activities, with a mix of virtual, digital, and face to face events to enhance our outreach and involvement.

Ultimately, our community engagement and involvement work are essential for creating a health and care services that are patient-centred, equitable, and effective. By working together, we can improve health outcomes, reduce healthcare costs, and create healthier and more connected communities.

As we move forward, we remain committed to involving people in shaping better health and care services. We want to strengthen our work and demonstrate the positive impact of engaging with communities and stakeholders. We will continue to work together to meet new challenges as the needs of our local population evolve.

We would like to thank all the individuals, partners and organisations who have taken part in our involvement and engagement activities during the year. Our aim is to put the voices of local people and communities at the centre of health and care decision-making in Gloucestershire.

Gloucestershire Hospitals
NHS Foundation Trust

# Involvement and Engagement Tracker
# 1 April 2023 to 31 March 2024

## Community Engagement & Involvement: Purpose

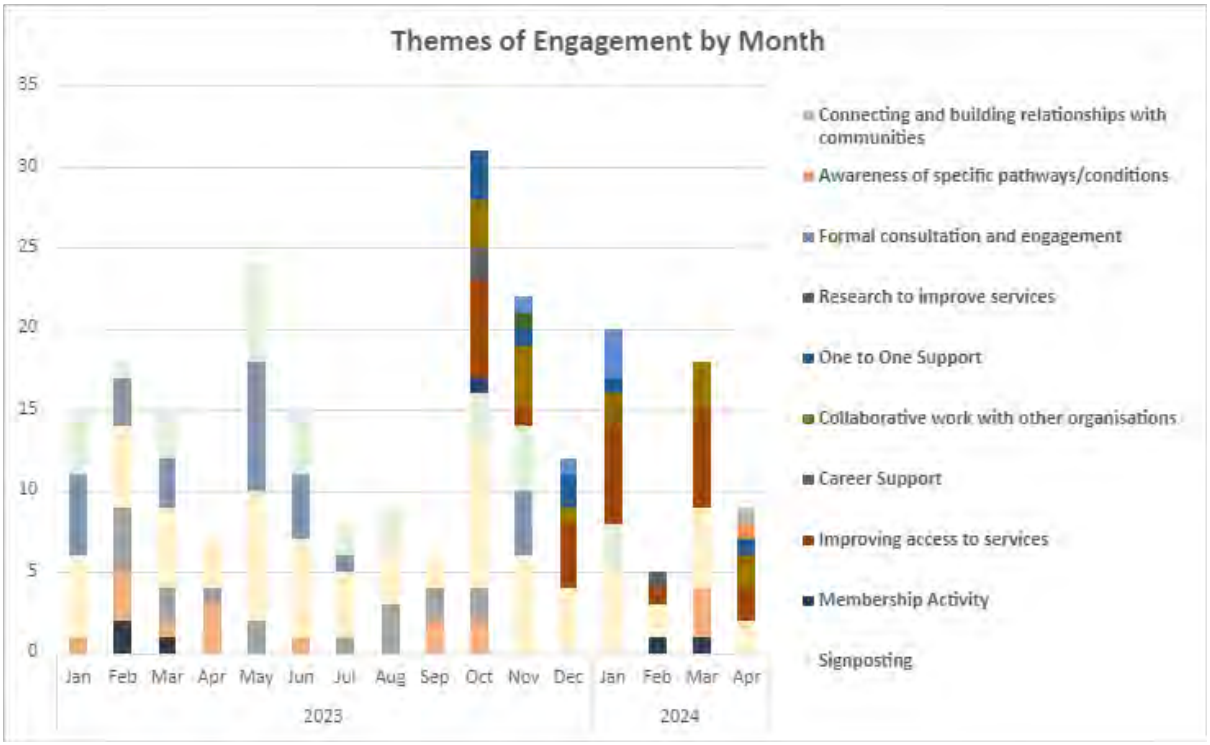
Listening to colleagues, patients, and local communities across Gloucestershire about their experiences with health and care services is vital for shaping improvements. Our Community Engagement Tracker records the level of engagement and demonstrates how it informs and influences decision-making across the organisation.

## Engagement and Involvement Overview

In the past 12 months, we engaged with 16,000 people by visiting 65 community groups and events. Through these interactions, we gained insights into what matters most to our communities, with a key focus on improving access and information.

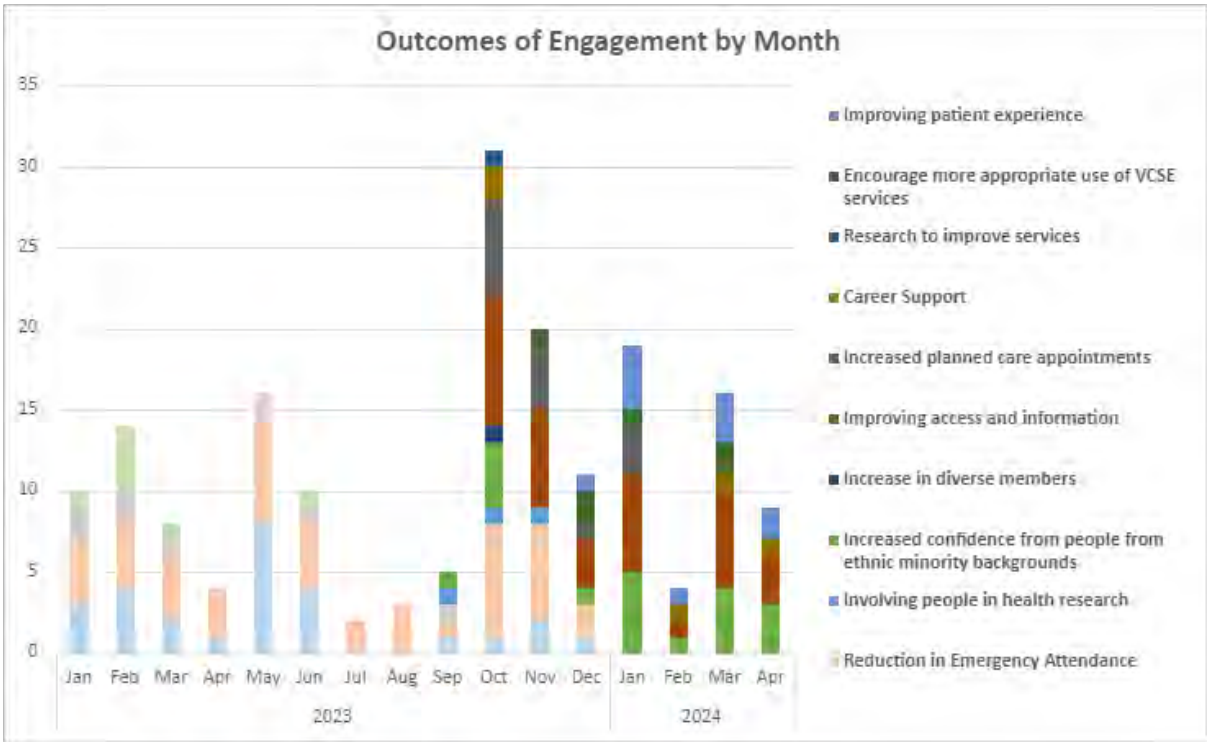
## Themes of Engagement by Month

The themes of engagement by month focus on three key areas: Signposting to VCSE Groups, which involves directing community members to Voluntary, Community, and Social Enterprise (VCSE) groups for relevant services; Building Relationships, which entails establishing and maintaining connections with local communities; and Service Improvement Research, which gathers insights from the community to enhance healthcare services based on their feedback.



## Outcomes of Engagement by Month

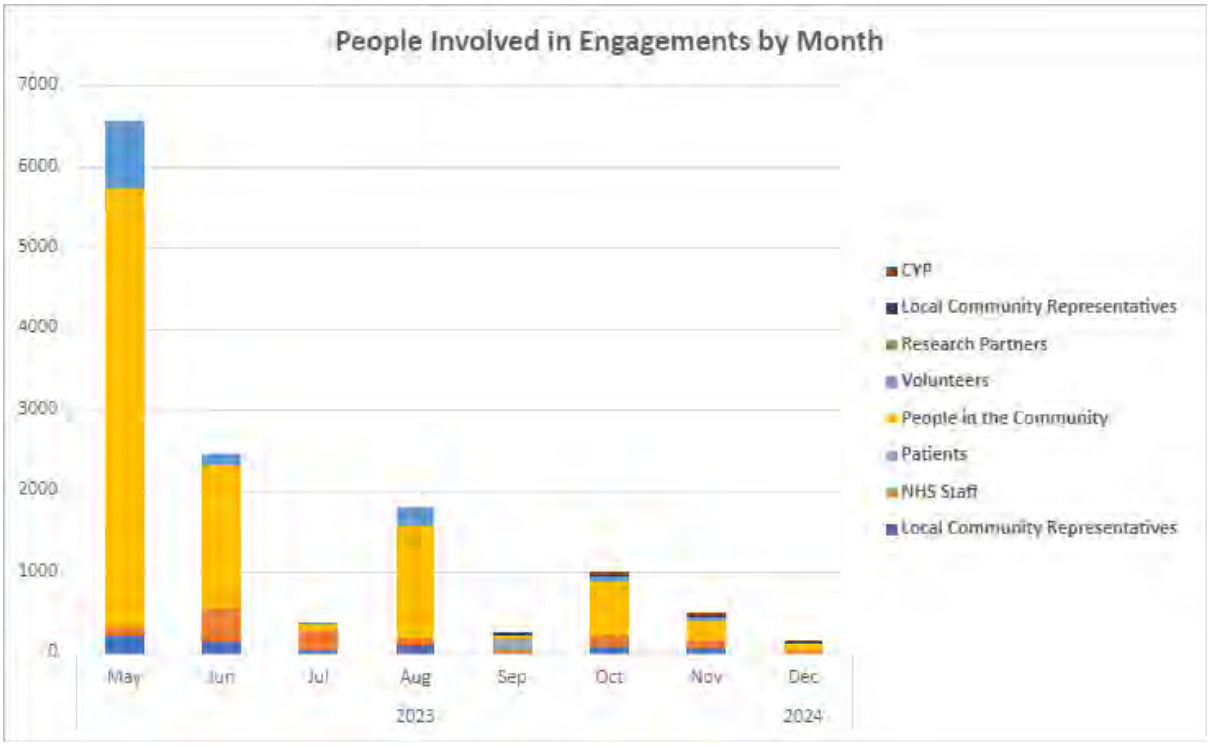
Between April 2023 and March 2024, engagement activities included interacting with 13,000 individuals and participating in 70 community group events. These efforts led to several positive outcomes: increased use of VCSE services, a rise in scheduled healthcare appointments, improved access to and clarity of healthcare information, and enhanced overall patient experience.




## People Involved in Engagement by Month

Measuring success involves tracking engagement metrics, such as the number of interactions, feedback received, and participation in community events. The Involvement & Engagement Tracker is used to monitor performance, identify areas for improvement, and make informed decisions.

Our data provides valuable insights and trends from our engagement helping us plan how we work and identify what matters to local communities. The community feedback is then able to be applied to shape service improvements and our strategic planning.




The Involvement and Engagement Tracker builds on inclusivity and diversity by collecting demographic data on age, disability, gender, sexuality, ethnicity, religion, and transgender identity to understand their impact on diverse groups and identify any gaps.

Targeted engagement ensures that underrepresented groups are involved, giving all community voices a platform. Continuous improvement is achieved through regular review and feedback from engagement activities to identify common themes and inform future service development.

To find read the Engagement out the impact of our work please read the Engagement & Involvement Review for 2023/2024

NHS
Gloucestershire Hospitals
NHS Foundation Trust

# Inclusive Language Guide

Your reference guide

the **Best Care for Everyone**
care / listen / excel

# Introduction

**There is power in words and language.**

At Gloucestershire Hospitals NHS Foundation Trust, the language and words we use must reflect our values, and beliefs and work as a system.

Language and the way we communicate are important aspects of building trust and connection, helping to empower and include people if we get it right.
In line with our wider place-based values, this guide is intended to be people-centred, highlighting inclusive leadership, and compassion, and creating supportive environments where everyone feels they belong.

# Our overarching principles

If you don't have time to read all of this guide, please read and apply the principles listed below.

1. **Keep it simple: use clear, concise language with no jargon.**
2. **Centred around audience: consider what words and phrases include and exclude groups and individuals?**
3. **Identify the purpose: consider the type of communication. Is it text, verbal, video etc. think about the context in which you are using these words.**
4. **Be accountable: language evolves, it's not static which means you won't always get it right. When you don't, apologise and take action to make it right.**
5. **Respect privacy: we all have the right to privacy and confidentiality and there will be some occasions where people do not want to or feel safe to disclose their protected characteristics.**

*"Diversity is you because you are unique. Inclusion is accepting you because you matter."*

**Furkan Karayel**, 2021, Inclusive Intelligence: How to be a Role Model for Diversity and Inclusion in the Workplace

**Inclusive language teaches us to value other people for who they are. To be sensitive and respectful towards other people. It is about being aware of the language we use and the impact it may have on others, rather than just using a list of acceptable words.**

Language matters, but we also recognise that it is complex and ever-changing. There is a wealth of information out there that can advise us on the right language to use but it can be overwhelming and difficult to know where to start.

This guide is designed as a starting point and an at-a-glance resource for colleagues, and we intend to build on it following feedback from you – the people using it or those who have helped contribute to its development.

It has not been designed to cover everything.

This guide was co-designed with partners, representatives and allies from across Bradford District and Craven who specialise in race, gender, LGBTQ+ and disability. It has also been reviewed by the Equality, Diversity and Inclusion Council at Gloucestershire Hospitals NHS Foundation Trust.

The guide will be reviewed and updated on a six-month basis.

If you have any recommendations for the update, please email:
**ghn-tr.inclusionnetwork@nhs.net**

# Considering intersectionality

Important

When using this guide, it is crucial to remember that discrimination is complex and multifaceted. Many individuals and groups face overlapping forms of racism, sexism, heterosexism, ageism, and classism, among other factors.

## Intersectionality

Intersectionality is a concept that helps us understand how different aspects of a person's identity combine to create unique experiences of discrimination and privilege. It acknowledges that everyone has their own unique experiences of oppression, and we must consider all the factors that can marginalise people—such as gender, race, class, sexual orientation, and physical ability.

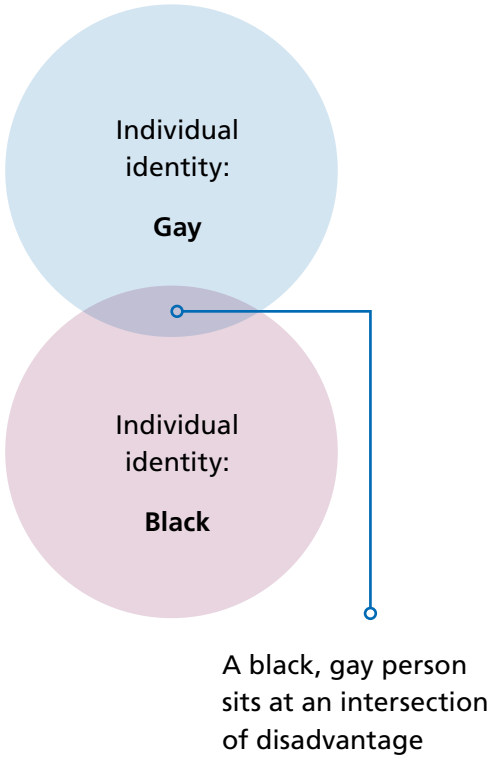
Historically, individuals who are Black have faced discrimination due to their race, and those who are gay have faced discrimination due to their sexuality. Therefore, a Black gay person faces discrimination on two fronts, placing them at an intersection of disadvantage.

In essence, intersectionality recognises that people have multiple identities that are inherently interconnected.

It is a critical concept for understanding how individuals face unique challenges at the intersections of these identities.

Crenshaw, who coined the term, defines intersectionality as "a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that are not understood within conventional ways of thinking."

It is important to be aware of intersectionality to understand how it shapes experiences and social inequalities. When writing about intersectionality, the language and information used should be carefully considered to avoid exacerbating stereotypes.



# Considering intersectionality

**Example**

**In healthcare black women are 4 x more likely than white women to die in pregnancy or childbirth because of the lack of access, structural racism and implicit bias they face as women and as black women.**

**When presenting this information, in some cases, and in mainstream media, the reason for this statistic is omitted.**

By just stating 'black women are 4x more likely than white women to die in pregnancy or childbirth' and not providing information on why this is, stereotypes are reinforced as people may misinterpret the information to believe that black women are more likely to die in pregnancy or childbirth because they are black.

Important

Communicators must always give relevant context when it comes to instances when there are overlapping factors at play to avoid exacerbating stereotypes.

# Disability and language

(including mental and physical health)

# Disability and language

Many of us know and work with colleagues who have visible disabilities or long-term conditions. However, many conditions are hidden and can affect a person's thinking, emotions, or physical abilities, including their mental health.

It's important to respect the diversity and individuality of people with disabilities, long-term conditions, and mental health conditions by using language that acknowledges their capabilities and contributions.

There are several ways we can do this.

# Talking about disability

The word ‘disability’ should not be avoided; we can use it accurately when needed. To be accurate, we must understand that disabilities, long-term conditions, physical impairments, and mental health conditions are common in our workplaces and communities. According to the Equality Act, a disability is a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on a person’s ability to do normal daily activities.

However, many people prefer the social model of disability, which states that people are disabled by structures, environments, and social systems – not by their bodies or minds. We should be clear about a person’s disability, and if we are unsure, we should ask them what language they prefer.

It’s also important to note that many people may not see themselves as disabled but rather as having a long-term condition. Colleagues with neurodiverse conditions like dyslexia, ADHD, or autism might not consider themselves disabled but instead focus on the strengths these conditions give them. Different neurodivergent people may feel differently about whether neurodivergence is a disability, so it’s important to be open to learning.

In general, it is okay to refer to someone who is neurodivergent as disabled if it is part of their identity. For example, a person with an autism diagnosis might prefer to be called an ‘autistic person’ rather than a ‘person with autism’ because it is a core part of who they are, not something separate from them.

# Make communications accessible

Under the Equality Act public bodies have a statutory duty to provide content in an accessible format.

In the NHS, for example, there is an Accessible Information Standard that NHS organisations providing care must follow. Inaccessible content can result in being fined, but more importantly, it means that colleagues and members of the public accessing our communications and messages are excluded and unable to understand them.

Making sure our language is accessible includes using simple and concise words, using Alternative Text on images, using colours that contrast each other, making hyperlinks accessible, using captions on videos and using accessible font. If you are creating documents and content on Microsoft, there is a built-in 'Check Accessibility' function which can support you with this. Another example is using OpenDyslexic font, which is designed to increase readability for readers with dyslexia. You can find more information about how to make content accessible in the 'Further reading and support' section of this guide.

# Avoid the 'hero narrative'

Also known as 'inspiration porn', a term coined by Stella Young. While some people do refer to their long-term conditions as superpowers, for many people having a disability or being neurodivergent is not something that is inspirational or a 'brave struggle', it is simply a normal way of living. For many people, their conditions give them other strengths.

Using inclusive language includes swapping terms like 'suffers from autism' to 'living with autism' and avoiding battle terminology like 'fighting multiple sclerosis (MS)' and replacing with 'living with MS or 'diagnosed with MS'. Individuals with disabilities or health conditions are capable and equal members of society, avoid using language that patronises or undermines them.

**If you're unsure about which language you should be using when it comes to disability, seek help or ask how a person would like to be referred.**

# Person-first language

When talking about a specific person many people living with long-term conditions or disabilities prefer person-first language which emphasises the person and not their disability or mental health condition.

This avoids reducing someone to just their disability.

For example:

- **Luc is a person with disabilities.**
- **Saadia, a person who is Deaf.**
- **They have hypermobility.**

However, if a person identifies more with the social model of disability mentioned earlier in this document, they would prefer to be referred to as 'a disabled person' – someone who is disabled by a world that is not equipped to allow them to participate and thrive. Our guidance here would be to listen to how people talk about their disability themselves and take your cue from them.





# Avoid ableist language

Ableism is a form of discrimination and is based on the notion that people with disabilities need 'fixing'. Using ableist language means to describe something using a term/ phrase or word that have negative connotations relating to physical or mental disabilities.

There are many phrases that are inappropriate, outdated and should not be used. For example:

- ✗ They are such a spazz/ spastic
- ✗ Mentally retarded

Here are some examples demonstrating how to change your language to be as inclusive as possible:

| Instead of saying: | Trying saying this: |
|---|---|
| ✗ The blind leading the blind | ✓ They don't seem to know what they are doing |
| ✗ Confined to a wheelchair | ✓ She uses a wheelchair for mobility |
| ✗ They are deaf to reason | ✓ They are unresponsive to reason |

# Gender and language

# Gender and Language

**When it comes to gender and language it is important to use words that do not discriminate against a particular sex or gender identity and instead promote gender equality. This can be somewhat difficult when living in a society that still has work to do on eradicating gender biases.**

**We all have unconscious bias and our views, choices and decisions are influenced by this. However, using gender-inclusive language helps us move towards a more equitable society, where diverse teams with a range of viewpoints and opinions perform better.**

# Stereotypes and generalisations

Avoid assuming gender based on appearance or making generalisations. When we use sweeping statements or stereotypes, we reinforce the notion that certain traits, behaviours, and roles are appropriate or expected for individuals based on their gender.
This can widen gender inequalities.

As a general rule of thumb, we should avoid using masculine or feminine language. For example, using "they" as a singular pronoun rather than 'he' or 'she'.

**If you're unsure about which language you should be using when it comes to gender, seek help or ask how a person would like to be referred.**

# Intersectionality

As mentioned in the introduction of this document, gender stereotypes intersect with other forms of discrimination, such as race, sexuality, and disability. This is something to be aware of as one person may be facing discrimination and disadvantage on more than one front.

# Relevance

In many situations, defining or highlighting a person's gender is simply not relevant in our communications.

This can be done using the strategies mentioned in the 'stereotypes and generalisations' section and also using a passive voice or removing gendered words or loaded terms.

# Gender and gender identity

# Gender and gender identity

**Gender refers to our internal sense of who we are and how we see and describe ourselves, this is our gender identity.**

**Sex refers to physical and biological elements for an individual, whereas gender, also referred to as gender identity, is how an individual identifies with their gender, whether male, female or non-binary, which may or may not correspond to their sex assigned at birth.**

**Gender is broader than just male or female. Someone may see themselves as a man, a woman, non-binary (neither) or gender fluid (not having a fixed gender).**

| | |
|---|---|
| Born gender | An individual's 'born gender' is the gender assigned to them at birth. This would be male, female, or intersex if physical characteristics that were both male and female were present. |
| **Gender-neutral pronouns** | Pronouns are words we use to refer to an individual's gender in conversation, for example, 'he' or 'she'. Some people may prefer gender-neutral pronouns if their gender identity is not 'male' or 'female'.<br><br>A gender-neutral person may go by 'they/them' pronouns. |

Important

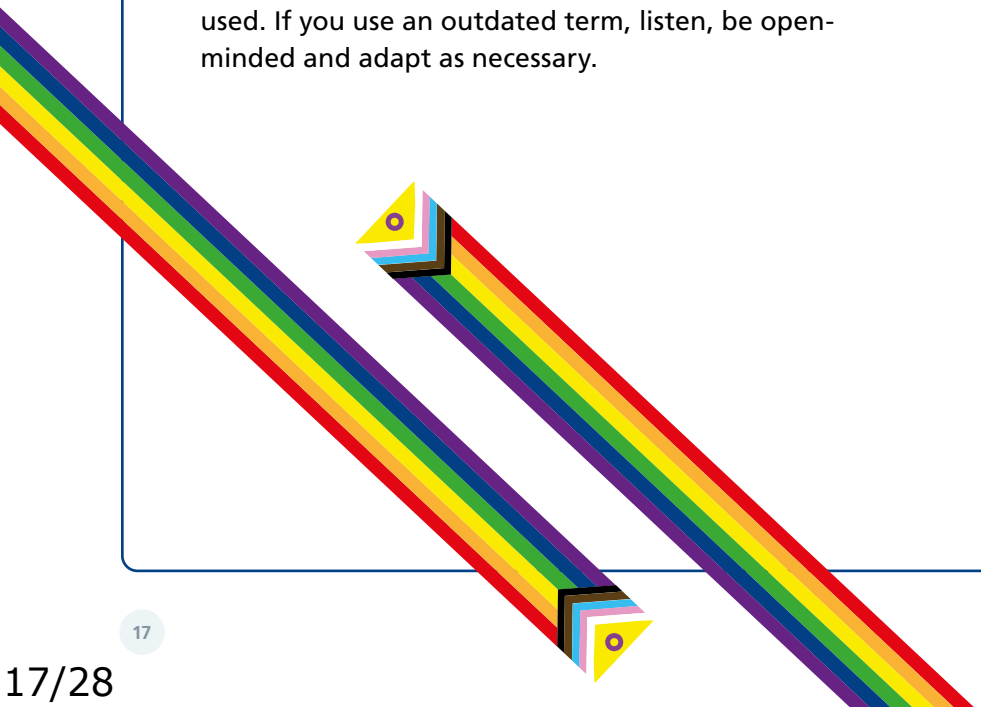
**If you are unsure of what pronouns to use for an individual, you can politely ask.**

You can include your pronouns on your email signature and/or name badge is you are comfortable as a way of showing support to the trans and non-binary community.

# LGBTQ+ language

By using inclusive LGBTQ+ language we show respect and recognition for a community which has faced and continues to face discrimination locally, in the UK and around the world. It demonstrates that we are allies with the LGBTQ+ community and helps to create an environment of acceptance, where people feel valued and seen for who they are.

Language is fluid and ever-changing with the LGBTQ+ landscape, so it is important to educate yourself and stay updated with new terms, and language that is no longer used. If you use an outdated term, listen, be open-minded and adapt as necessary.



# LGBT+ versus LGBTQ+

LGBT+ is an umbrella term for the lesbian, gay, bisexual and transgender community. The plus (+) represents the multiple ways that people within this community can identify or describe themselves in terms of their gender identity or sexual orientation.

As familiarity and awareness around the range of terms people from the LGBT+ community use to identify their sexual orientation and / or gender identity has grown, other versions of the LGBT+ initialism/abbreviation has become more common.

The most common alternative to LGBT+ in the UK is LGBTQ+. This stands for lesbian, gay, bisexual, transgender and ‘queer’ and /or ‘questioning’.

Questioning is where a person is taking time to understand their sexual orientation and or gender identity.

# Be accurate

Just like when using language around race and ethnicity, it is important to use accurate and respectful terms. This helps to educate others and challenges stereotypes. Refrain from making assumptions about someone's sexual orientation or gender identity based on appearance or any other factor. This is known as 'misgendering' and can cause distress and hurt. Remember that LGBTQ+ individuals are diverse and may have different experiences and identities.

Your approach should be led by how an individual or group wants to be referred to. If you are unsure of this, simply ask how an individual would like to be referred to or use their name and gender-neutral pronouns such as 'they' rather than binary terms like 'he' or 'she', 'ladies and gentlemen' or 'men and women'.

For an example of an inclusive greeting at an event, it would be better to start with 'good evening everyone".

# Pronouns

Pronouns are important and should not be assumed. For transgender people, using the wrong pronoun can be uncomfortable and painful. They may prefer to be referred to as they/them unless they have stated otherwise. To reduce discomfort and promote inclusivity, we should move towards using gender-neutral language and terms.

Supporting the LGBTQ+ community can be as simple as sharing and explaining our pronoun preferences. Many people are now adding their pronouns to social media profiles or email signatures to normalise the process of stating one's gender. This is one of the easiest ways to be an LGBTQ+ ally.

Additionally, it is crucial to refer to a person by the name they have given you and not use their 'deadname'. To deadname is to call someone by a name they no longer use, such as a name a transgender person had before transitioning. This can feel invalidating.

Being respectful of people's pronouns and gender identities is essential. If you are unsure of someone's pronouns and it is not appropriate to ask, using 'they/them' pronouns can help ensure comfort and respect.

# The use of ‘queer’

Some people in the LGBTQ+ community prefer to call themselves ‘queer’ because they don’t want to use a specific label like ‘lesbian’, ‘gay’, or ‘trans’. However, because ‘queer’ was used as an insult in the past, some people might still find it offensive. It’s important to ask individuals what terms they prefer.

Many in the LGBTQ+ community have taken back the word ‘queer’ and use it with pride. But because of its history as a slur, some people, especially older generations, may feel unsure or uncomfortable using it. This shows how language can change over time. The best advice is to use the term ‘queer’ only if the person uses it to describe themselves.

# Privacy

We all have the right to privacy and confidentiality and there will be some occasions when people do not want to or feel safe to disclose their gender identity.

It is not always appropriate to ask a person about their sexual orientation or gender identity – read the room and think about the situation you are in.

# LGBTQ+ inclusive communications

We should consider the LGBTQ+ community in our communications to ensure they are included. This could include removing titles such as ‘Mr, Ms, Mr and Mrs’ for communications, removing gender boxes on forms where it is unnecessary, avoiding heteronormativity (the idea that everyone is or should be heterosexual) and making sure the community is visibly included in materials.

By including and having representatives from the LGBTQ+ community involved in the communications we produce we will ensure they are more inclusive. Listen to the community, hear their stories and reflect it back in the communications we create. When collecting equality monitoring data, we need to ensure we are reflective of gender-neural terms.

# Race and language

# Race and language

**When it comes to race, ethnicity and language, the words we use will often depend on the context in which we are using them and which community or group we are referring to.**

By using the correct language when it comes to race, we can avoid furthering racial prejudice and discrimination and move towards equality. As with any other groups that may share some commonality, it is important to avoid generalisation or homogenising a group. It is important to note that it is not always appropriate to mention a community's or a person's race or ethnicity, so think about when and whether it is necessary to mention it.

| | |
|---|---|
| **Race** | Race focuses on physical appearance, primarily skin colour and bone structure. |
| **Ethnicity** | Ethnicity refers to our cultural identification in international law and how this is articulated. A group of people with related traits in culture, faith, food, language and heritage could belong to a similar ethnic group. |
| **Heritage** | Heritage refers to an individual's ancestors and what they identified with.<br><br>For instance, someone born in Ireland to parents from Nigeria could say they have African heritage. They may not share the ethnicity (perhaps they can't speak a Nigerian language) and may be Irish in terms of nationality |
| **Nationality** | Nationality refers to the place where someone was born and or holds citizenship.<br><br>Where you live and your ethnicity can also influence your nationality. |

# The use of ‘BAME’

**The term "BAME" (Black, Asian, and Minority Ethnic) centres whiteness by referring only to non-white groups, thereby excluding white minority ethnic groups. It is widely regarded as a lazy classification that lumps together many diverse ethnicities without consideration of their unique identities and experiences.**

Instead of using "BAME," strive to be accurate and specific about the group you are referring to. Take the time to understand how the person or group you are talking to prefers to be identified. Ask yourself how they self-identify.

When discussing racial or ethnic groups, ensure that the terms you use accurately reflect those groups. Avoid using broad umbrella terms unnecessarily, as they do not represent a single homogenous ethnic group. Always seek more detailed data and insights to better recognize, understand, and reflect the experiences of different minoritised ethnic groups.

Commit to continuous education, listening, and learning, as language is always evolving. Respect people’s preferences and allow options for self-description when asking survey questions.

# The use of the term “person of colour “

When using the term “person of colour,” it is crucial to consider individual preferences, as identity is deeply personal and varies. The term “people of colour” can be contentious; some feel it reinforces a hegemonic “whiteness” and creates an “other” category. Alternative terms like “racialised minority” or “racially minoritised” can also be met with criticism for being unfamiliar or overly focused on race. While some younger individuals find “people of colour” acceptable, others, particularly in the UK, view it negatively due to its similarity to the offensive term “coloured” and its American origin.

**Always listen, educate yourself, and ask politely if unsure about the appropriate terminology. Learn from mistakes, apologise if you cause offence and strive to improve.**

# Ethnic minority, ethnic diversity or global majority?

While the term ‘ethnic minority’ is still widely used and accepted in Gloucestershire the terms ‘ethnically diverse’, ‘ethnic diversity’ and ‘diverse ethnic communities’ (as used by the ICB) are our preferred phrases of use within a health and care setting. However, we are aware that key partners in the county are using other terms, including ‘global majority’.

Global majority is a collective term that refers to people who are Black, Asian, Brown, dual-heritage, indigenous to the global south, and or have been traditionally referred to as 'ethnic minorities'. Globally, these groups currently represent approximately eighty per cent (80%) of the world's population making them the global majority, not a minority.

# Person-first language

When talking about a specific person it is important to use person-first language which emphasises the person and not their ethnicity. This avoids reducing someone to just their ethnicity. For example:

- **‘A person from the Irish Traveller community’**
  rather than **‘an Irish Traveller’**

- **A person from the South Asian community’**
  rather than **‘a South Asian person’**

- **‘A person from the Caribbean community**
  rather than **‘a Caribbean person’**

# Stereotypes and generalisations

It is important to avoid the use of broad terms, generalisations and stereotypes when talking about race and ethnicity. There are many nuances between and within communities which should be acknowledged.

Be as specific as possible and avoid placing people in broad categories, which sound like microaggressions

Examples of microaggression:

- If someone says to an Ethnic Minority person that they are **'surprised at how well-spoken'** they are.
- Asking a gay/lesbian couple **"Who's the man/woman' in the relationship?"**
- Saying to a disabled person **'you people are so inspiring'.**

# If we get it wrong

Language is always evolving which means that we are likely to get the language we use around race and ethnicity wrong at some point. That's okay and will help us learn. In the UK and around the world, racism is still present, and we have been raised in a society where racist language is used. Often, we have unconscious bias or use language that is not inclusive and can be harmful.

If you get it wrong or are corrected on your use of language, acknowledge it, apologise and take action to make it right. This may be as simple as switching to the term you have been asked to use. If you haven't been corrected, be open and respectful and have a conversation with the person who has highlighted your language to decide which term would be more inclusive. Avoid over-apologising and instead, focus on learning from feedback and from positive examples of inclusive communication from wider industries.

**If you're unsure about which language you should be using when it comes to race, seek help or ask how a person would like to be referred to as or which ethnicity they identify with.**

*"When designing experiences, I pay extra attention to the words I use, ensuring they are not ableist. For example, we often see buttons that say "watch," "read," and "see," which implies that everyone can see or listen. I started swapping them for "explore," "discover," and "learn more." It's also important to use pictures and illustrations that represent folks from various communities, including people with disabilities."*

---

**Max Masure**, 2022, You don't Suck, Overcoming Imposter Syndrome

# Further reading and support

## Please see below a list of further reading and support around inclusive language

- Inclusive language glossary, In Communities
- Communications and engagement toolkit to be used when communicating with socio-economically deprived areas, by NHS England
- How to talk about the building blocks of health, The Health Foundation toolkit
- Bias-free language and intersectionality, APA style
- Inclusive Language Guide, Oxfam
- How to write in plain English The Plain English Campaign
- EDI Guides, Chartered Institute of Public Relations
- Include guidance on the Equality Act 2010
- Accessible Information Standard Statement
- Inclusive language NHS inform

**Throughout this guide, we have taken reference from:**

Humber and North Yorkshire Health and Care Partnership's Inclusive Language Guidance

Bradford District and Craven Health and Care Partnership's Inclusive Language Guide

NHS
Gloucestershire Hospitals
NHS Foundation Trust

the **Best Care for Everyone**
care / listen / excel

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

CC:
- Local authority chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2024

Dear colleagues,

**Action required: Maintaining focus and oversight on quality of care and experience in pressurised services**

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

**Sarah-Jane Marsh**

National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer

NHS England

**Dr Emily Lawson DBE**

Chief Operating Officer

NHS England

**Professor Sir Stephen Powis**

National Medical Director

NHS England

**Dame Ruth May**

Chief Nursing Officer

England

| Report to Board of Directors meeting in Public | | | |
|---|---|---|---|
| **Date** | | 12th September 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

**IPR**

This new Integrated approach offers a targeted update on key metrics providing the committee an update on the current performance; the actions taken to correct or mitigate the position and an assessment on a return to compliance assessment.

Performance

Please note that as usual the Cancer related data is a validated position from the previous month.
Please note that there is a governance/assurance cycle error with this data (UEC) being included for relevance but has not been through the UEC > DOAG > TLT > route this will be corrected for September Q&P. Further development is planned of this report for the next reporting cycle, to include other domains and associated metrics.

Quality Metrics

The performance of the quality metrics is monitored at the Quality Delivery Group and for maternity the Maternity Delivery Group. Of note:

- Pressure ulcers and falls are 2 of the Trust's safety priorities and improvement work, using PSIRF methods, is being implemented for oversight/thematic reviews after a safety incident is reported.
- Boarding is no longer happening (corridor care with no bed space) but pre empting (bed space imminently available (4 hours)) continues when needed in times of escalation and only for short periods.
- We continue to have rates above national average for Postpartum haemorrhage >1.5L. 2 change ideas have been implemented to improve this outcome (Carbetocin and a check list) and we await August's data to see if these make an impact on outcomes. Monitoring the detection and escalation of deterioration for women and babies remains another of our Trust's Safety Priorities.
- The combined FFT score remains stable however there was a decline in the maternity FFT score of 7% ↓ in maternity.

Finance

The revenue financial position shows that on a year-to-date basis the Trust is c£0.6m adverse to plan due to the impact of industrial action.

## Risks or Concerns

Continued non-compliance against Cancer performance indicators; Continued non-compliance against UEC standards; UEC governance remains 'out of sync' but will be corrected in August so that true assurance and escalation can be confirmed;

There are a number of challenges within the financial position which are being reviewed with actions developed to resolve. Most significantly will be the delivery of the financial sustainability programme which includes a number of system led high risk schemes. Against the two other strategic oversight framework metrics for finance (agency spend as a % of pay and delivery of savings) the Trust is showing compliance.

## Financial Implications

**N/A**

| **Approved by:** | **Date:** |
|---|---|
| **Chief Operating Officer** | **05/09/2024** |

## Recommendation

To NOTE the contents of the IPR and associated metrics

## Enclosures

IPR Power Point Presentation

# Integrated Performance Report (IPR)

**July 2024**

- Operational Performance
- Quality & Safety
- Use of Resources
- Workforce

# SPC Chart Guidance

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

**How to interpret variation results:**

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

**How to interpret assurance results:**

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

- 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.

# Operational Performance Metrics

# Single Oversight Framework

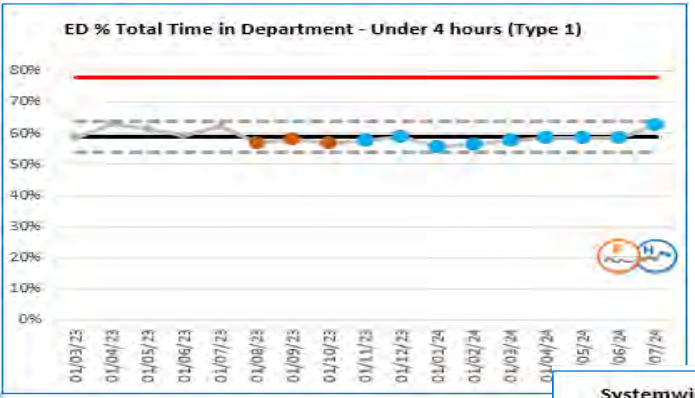
| | | | Target | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality of Care, Access & Outcomes | Elective Care | Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment | | | | | | | | | | | | | |
| | | 52ww | *0 by Sept 24* | 2738 | 2883 | 2825 | 2633 | | | | | | | | |
| | | 78ww | *0* | 3 | 3 | 0 | 1 | | | | | | | | |
| | | 104ww | *0* | 0 | 0 | 0 | 0 | | | | | | | | |
| | | Total elective activity undertaken compared with 2019/20 baseline | | 115% | 110% | 105% | 107% | | | | | | | | |
| | | Total diagnostic activity undertaken compared with 2019/20 baseline | | 145% | 135% | 150% | 135% | | | | | | | | |
| | Cancer | Total patients waiting over 62 days to begin cancer treatment compared with baseline | *No Target* | 159 | 203 | 217 | 201 | | | | | | | | |
| | | Proportion of patients meeting the faster cancer diagnosis standard | *80%* | 75.6% | 79.2% | 76.7% | 78.3% | | | | | | | | |
| | | Total patients treated for cancer compared with the same point in 2019/20 | *No Target* | 335 | 341 | 284 | 314 | | | | | | | | |
| | Outpatient | Outpatient follow-up activity levels compared with 2019/20 baseline | | 47,649 | 46,941 | 44,041 | 48,666 | | | | | | | | |
| | Urgent Care | Proportion of ambulance arrivals delayed over 30 minutes | | 59.7% | 57.6% | 60.2% | 51.9% | | | | | | | | |
| | | Proportion of patients spending more than 12 hours in an emergency department | | 13.9% | 13.0% | 12.8% | 11.0% | | | | | | | | |
| | Primary Care | Proportion of patients discharged from hospital to their usual place of residence | *No Target* | 97.46% | 97.16% | 97.37% | 97.22% | | | | | | | | |
| | Safe Care | Summary Hospital -level Mortality Indicator | *No Target* | No Data | No Data | No Data | No Data | | | | | | | | |
| | | Clostridium difficile infection rate per 100,000 bed days | *No Target* | 50.3 | 31.4 | 44.5 | 30.8 | | | | | | | | |
| | | E. coli bloodstream infection rate per 100,000 bed days | *No Target* | 36.6 | 31.4 | 22.3 | 26.4 | | | | | | | | |

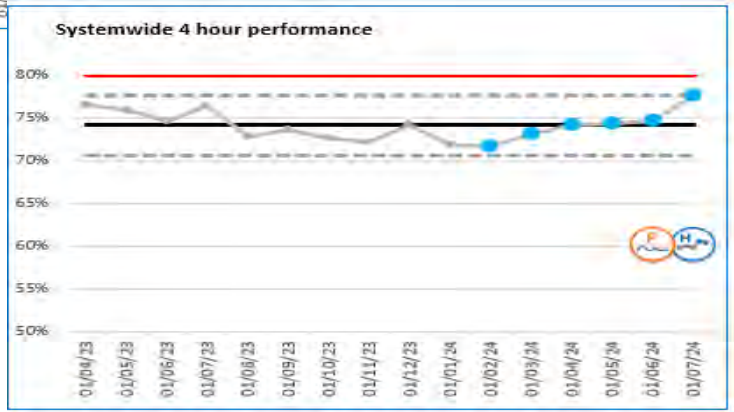
# Watch Measures

| | | | Target | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Watch Measures** | Diagnostics | **Compliant Diagnostic Modalities** | | | | | | | | | | | | | |
| | | Barium Enema Performance | *95%* | 100% | 100% | 100% | 100% | | | | | | | | |
| | | Computed Tomography Performance | *95%* | 100% | 99% | 100% | 100% | | | | | | | | |
| | | DEXA Scan Performance | *95%* | 100% | 100% | 100% | 100% | | | | | | | | |
| | | Non-obstetric Ultrasound Perrformance | *95%* | 97% | 96% | 99% | 97% | | | | | | | | |
| | | Severe Harm from Patient Medication Errors | *0* | 0 | 0 | 0 | 0 | | | | | | | | |

# UEC: Seen within 4 hours

(Standard: a min of 78% of patients seen within 4 hrs in March 25)



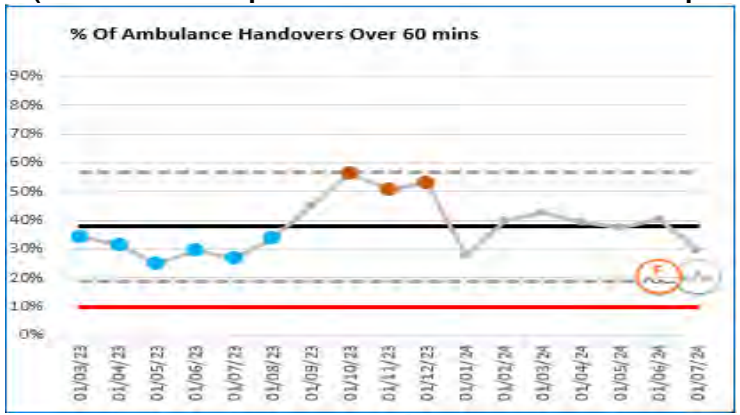

**Commentary:**
Four-hour performance has remained broadly consistent over the last three months with compliance levels at 58.6%. This masks a small improvement in the level of compliance in Minors (non-admitted pathway patients, which is slightly up from 66.9% to 67.2%) Majors (admitted pathway)

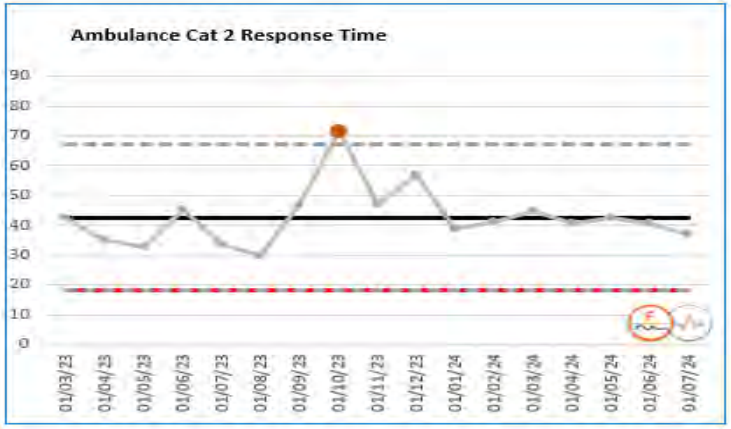
**Planned Actions:**
The Eight Days of Summer initiative presents an opportunity for the clinical and operations teams to undertake a re-set. Across the first eleven days of July we've seen an improvement to 62.7% compliance overall (including 72.6% in Minors). This has entailed operational leads working much more closely with teams on the shop floor; the challenge is going to be maintaining this progress.

**Expected recovery:**
Target for system-wide performance for the year is 78% - at this current level (July) performance is at 77.6% so this is ahead of the trajectory we've set ourselves; also need to ensure we can maintain progress beyond the conclusion of the current initiative. The centralisation of the Acute Medical take will present an clear opportunity to pull more patients out of the ED stream, at increased pace

# UEC: Average Handover Time

(Standard: Improve Cat 2 ambulance response time to an avg of 30 min across 24/25)



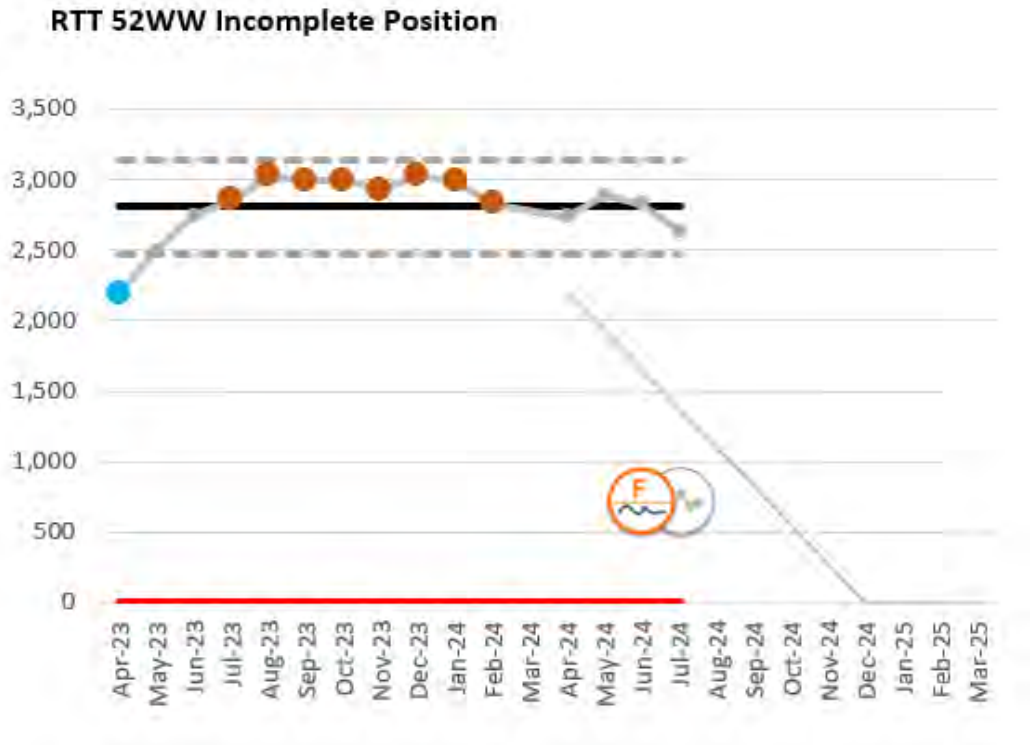

**Commentary:**
The performance on ambulance handovers has remained static with roughly 40% at more than 60 minutes. Whilst this represents a significant improvement compared with the Oct-Dec 2023 performance has plateaued in the last few months.

**Planned Actions:**
The space and focus afforded by the Eight Days of Summer initiative has enabled the team to re-look at the work in this area. Work to strengthen processes at the front door is underway as we look to focus on maintaining performance in early July - where we've seen five days where average ambulance times have been below 40 minutes and seven days where less than 64 hours have been lost to ambulance delays. Findings from the 6A audit will be used to set next actions and effect recovery. There have been significant improvements in very long offload times which correlate to improved focus and escalation.

**Expected recovery:**
Looking to continue to reduce average handover times to between 20 & 30 minutes.

# Elective: 52 Week Wait

(Standard (Local): *Eliminate all over 52ww by September 2024)*



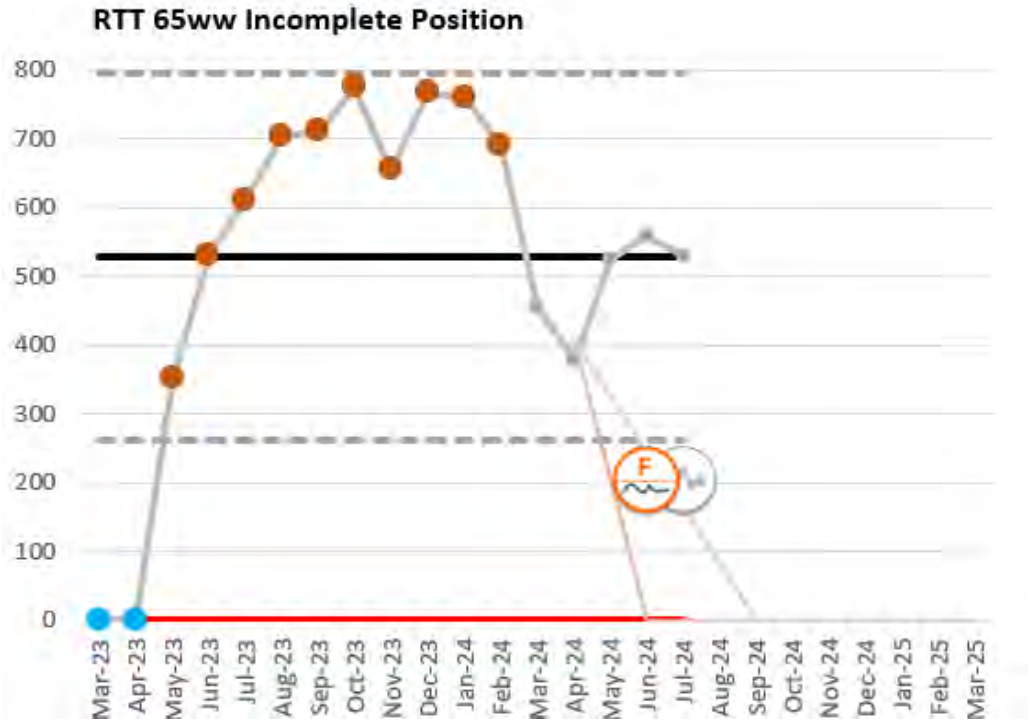

**Commentary:**
The July position is currently unconfirmed, with 2,633 patients breaching this standard. This is compared to 2,816 in June. This reduction is largely attributable to 2 specialties – Oral Surgery (-126) and T&O (-75). Some specialties have increased slightly with the 3 predominant specialties being; Urology (+36); Spines (+22) and Bariatric surgery (+21). ENT remained largely unchanged with +4.

**Planned Actions:**
With pay rates having been agreed respective services are moving forward with additional activity as part of the first round of ERF schemes. The most significant being in ENT with 9 dates confirmed. Spinal and Oral are continuing to use additional IS capacity.

**Expected recovery:**
Performance will improve with the mobilisation of ERF schemes.

# Elective: 65 Week Wait

(Standard: *Eliminate waits of over 65ww by Sept 2024 (national target), local stretch to eliminate over 65ww by June 24)*



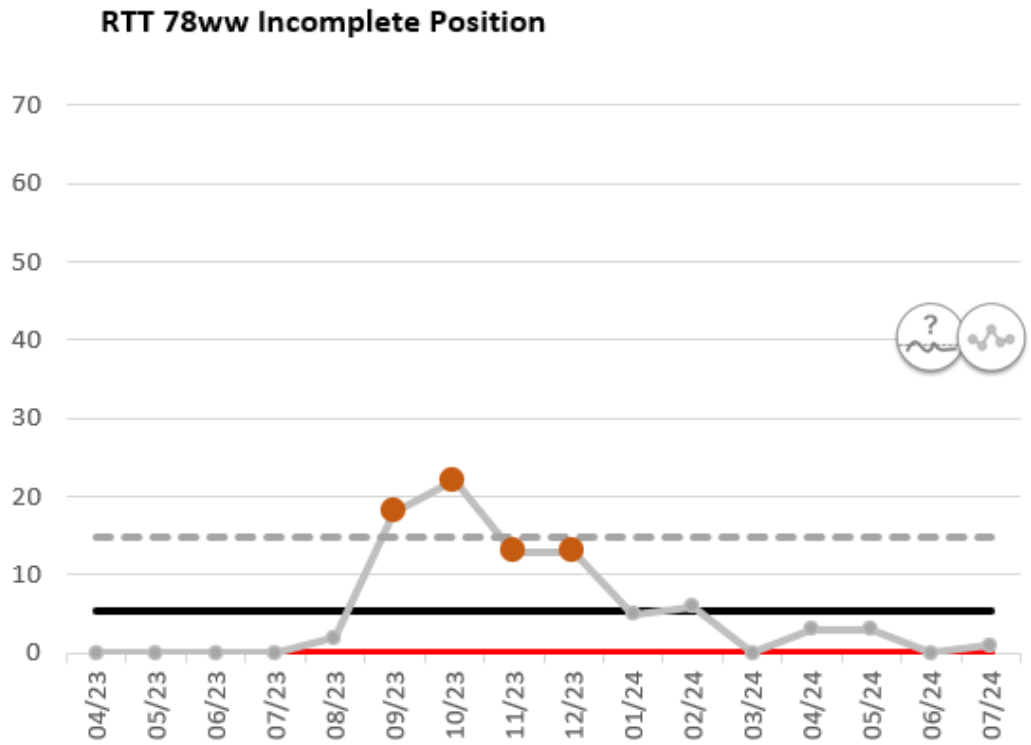

**Commentary:**
The number of patients waiting over 65 weeks has improved in month but only slightly, with an unsubmitted position of 523. The most challenged areas continue to be ENT (329); Oral Surgery (124) ); Spines/T&O (34) and Cardiology (22). These 4 specialities represent 97% of the breaches. Minimal gains have been made during July.

**Planned Actions:**
Majority of services are on track to deliver zero breaches with the exception of the 4 specialties cited above. Although additional activity is planned, this will still likely result in a shortfall. Additional activity is therefore being sought.

**Expected recovery:**
Performance remains significantly off track for reasons previously explained. Achievement of this target will be dependent on the mobilisation of additional schemes.

# Elective: 78 Week Wait

(Standard: *Eliminate all over 78ww by March 2024*)




**Comments**
Unfortunately during July, one 78 week breach occurred which related to Oral Surgery. Although a RCA has been completed and it is acknowledged that some opportunities to reduce the pathway were missed, the primary factor remains the exceptionally long wait to 1st appointment which was 400+ days.

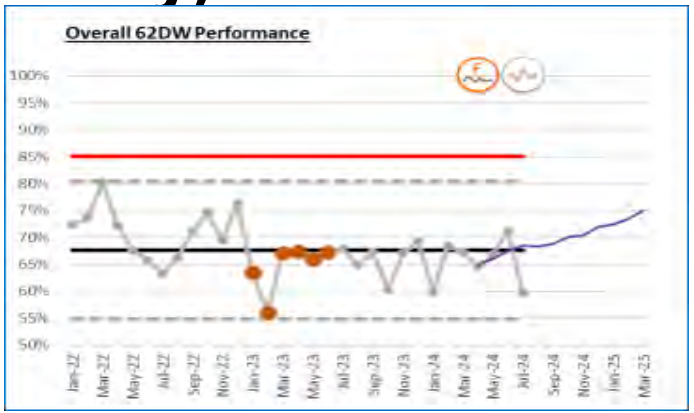
Although risks do exist for August the numbers remain low and a zero position should be achieved, noting that more challenges often exist during summer holidays due to patient availability.

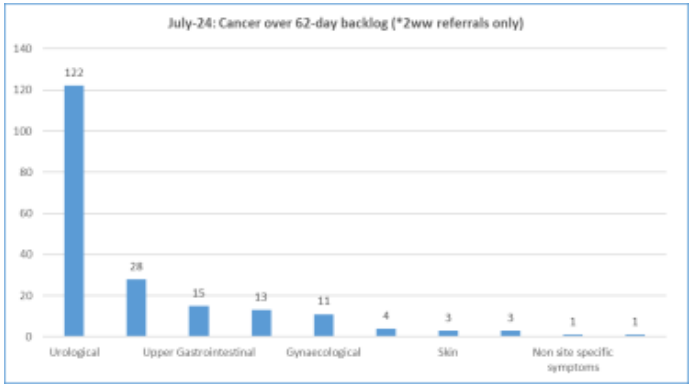
**Planned Actions:**
Full mobilisation of ERF schemes remains critical to delivery, but as above, long term success is dependent on sufficient recurrent new capacity to allow the reduction of wait times to 1st appointment.

**Expected recovery:**
All 78ww are to be eliminated.

# Cancer: % Patients seen within 62 Days (with trajectory)

*Standard: 85%*



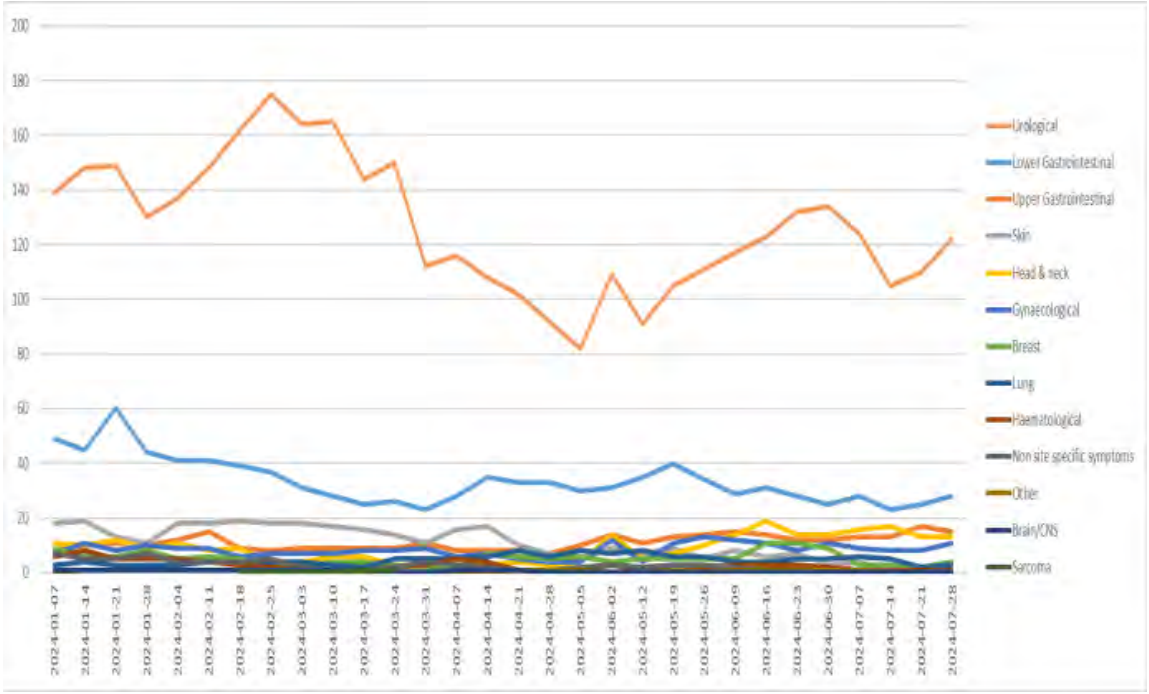




**Commentary:**
Unvalidated 62 Day standard for July is currently at 61.1% and we will miss this target
This is on slightly belwo our recovery trajectory for 24/25 however we are aware that due to focussing on treating some of our longer patients and significantly reducing our backlog we may see a reduction over the next month
62 Day reportable backlog is 205 as of 12/08.

**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 6% 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 62 Day Backlog Position



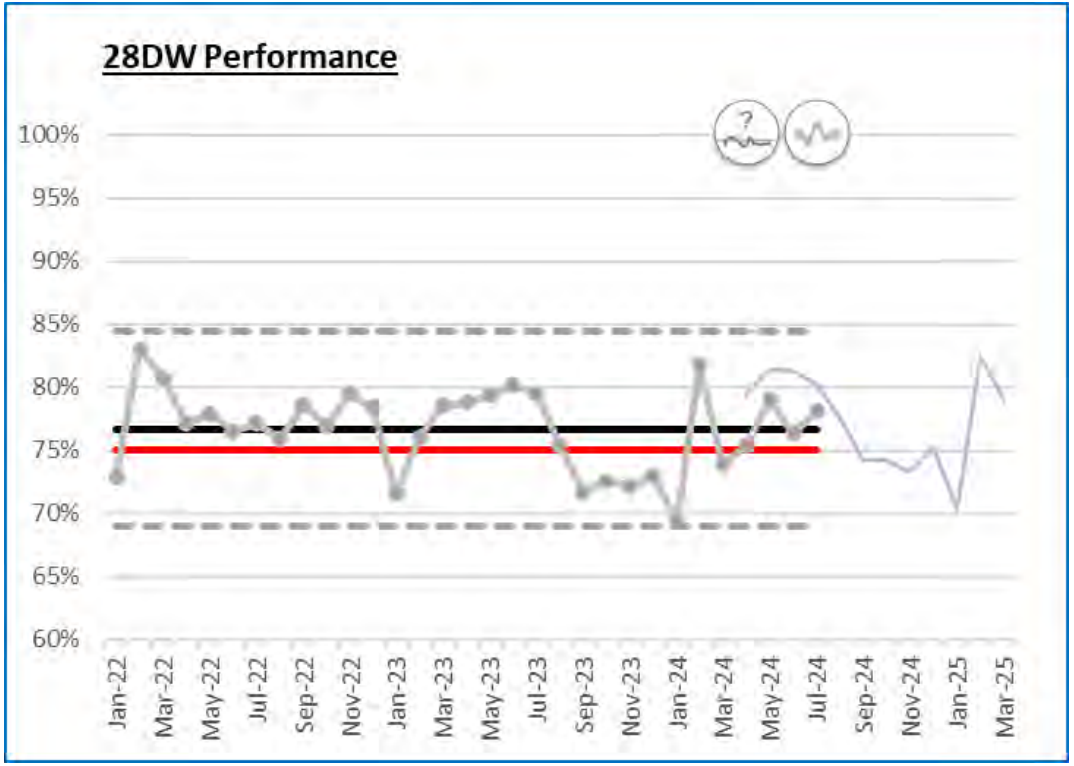

**Commentary:**
62 Day reportable backlog is 205 as of 12/08/24
The majority of this cohort is held by Urology as demonstrated by the graph – This is due to delays in the diagnostic phase of this pathway, with many patients waiting after day 62
for diagnostic results or testing

**Planned Actions:**
**Implementation of "Day 0" pathway**
analysis and new escalation policy to be devised with timelines supporting treatment or discharge before day 62
Focus on specialty level recovery and diagnostic pathways, especially within Urology

**Expected recovery:**
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 7% 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 Diagnoses Standard (FDS) % with trajectory

*Standard (75%): Improve performance against the 28 day FDS to 77% by March 2025 towards the 80% ambition by March 2026*




**Commentary:**
Unvalidated 28 Day standard for July is currently at 78.4% and we are expected to meet this target.

**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 BTP 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.**

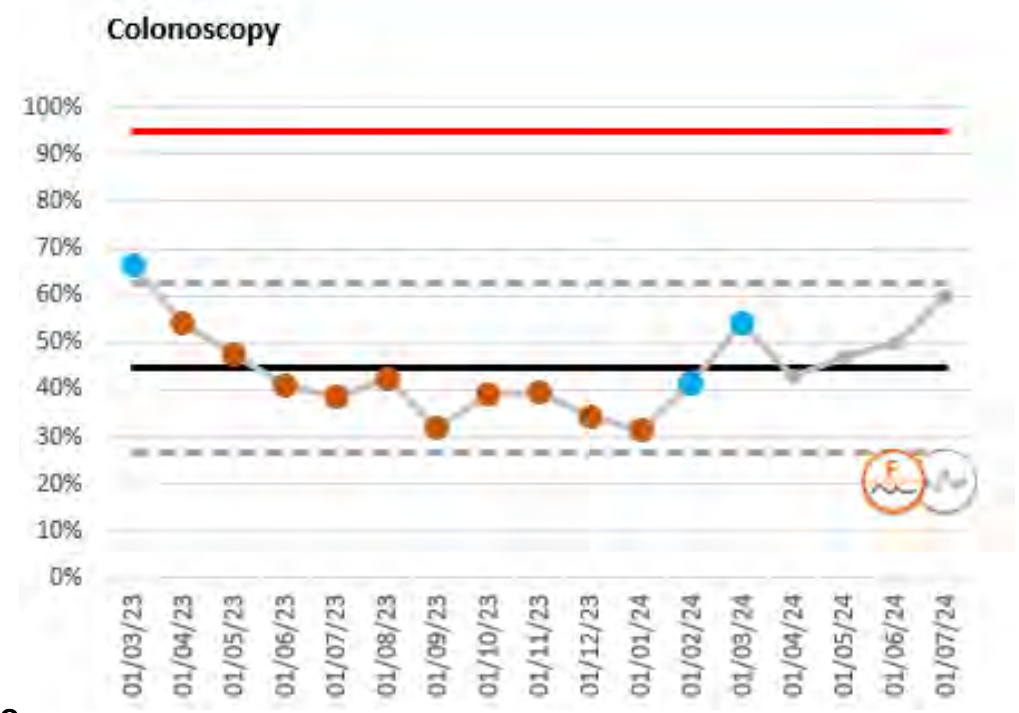
# Cancer Waiting Times Performance for the last 3 months

*Please Note – July is unvalidated*

| CWT Standards | Two week wait | | | 28 Day FDS | | | 31 Day Treatment | | | 62 Day Treatment | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | May-24 | Jun-24 | Jul-24 | May-24 | Jun-24 | Jul-24 | May-24 | Jun-24 | Jul-24 | May-24 | Jun-24 | Jul-24 |
| Acute leukaemia | | | | | | | | | | 100.0% | | |
| Brain/CNS | 100.0% | 100.0% | 100.0% | 72.7% | 88.9% | 88.9% | 100.0% | 90.9% | 100.0% | | | |
| Breast | 8.1% | 5.8% | 15.6% | 86.7% | 86.6% | 86.9% | 99.3% | 96.5% | 97.7% | 88.9% | 88.8% | 94.4% |
| Gynaecological | 93.0% | 97.4% | 98.9% | 66.3% | 67.8% | 73.6% | 100.0% | 96.4% | 98.2% | 81.0% | 48.5% | 75.8% |
| Haematological | 76.5% | 84.6% | 95.2% | 33.3% | 28.6% | 19.0% | 100.0% | 98.6% | 100.0% | 55.6% | 77.3% | 44.4% |
| Head & neck | 71.1% | 90.0% | 93.7% | 71.6% | 68.2% | 71.1% | 95.8% | 97.4% | 95.0% | 80.0% | 50.0% | 54.8% |
| Lower GI | 60.9% | 59.2% | 60.9% | 79.1% | 76.0% | 76.8% | 95.3% | 94.3% | 96.3% | 55.7% | 67.0% | 58.1% |
| Lung | 100.0% | 100.0% | 98.0% | 91.7% | 92.0% | 93.3% | 94.2% | 97.9% | 92.6% | 76.0% | 83.9% | 66.1% |
| Other | | | | | | | 100.0% | 100.0% | 92.3% | 54.5% | 100.0% | 100.0% |
| Sarcomas | | | | | | | 100.0% | 100.0% | | 0.0% | | |
| Skin | 94.1% | 80.7% | 75.1% | 91.8% | 75.6% | 78.8% | 97.7% | 93.9% | 87.5% | 87.6% | 98.0% | 86.2% |
| Non site specific symptoms | 96.9% | 84.8% | 90.0% | 52.8% | 50.0% | 57.9% | | | | | | |
| Testicular | 100.0% | 100.0% | 92.3% | 100.0% | 84.6% | 100.0% | | | | 90.0% | 100.0% | |
| Upper GI | 99.2% | 97.9% | 98.8% | 92.6% | 91.0% | 94.2% | 98.5% | 100.0% | 100.0% | 80.0% | 75.0% | 77.3% |
| Urological | 93.2% | 89.6% | 88.3% | 54.7% | 42.0% | 36.1% | 84.3% | 85.6% | 87.9% | 32.0% | 36.6% | 21.1% |
| Trust Total | 69.3% | 68.8% | 68.9% | 78.5% | 75.4% | 77.3% | 95.2% | 94.4% | 94.8% | 66.8% | 71.2% | 59.7% |

# 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%)*



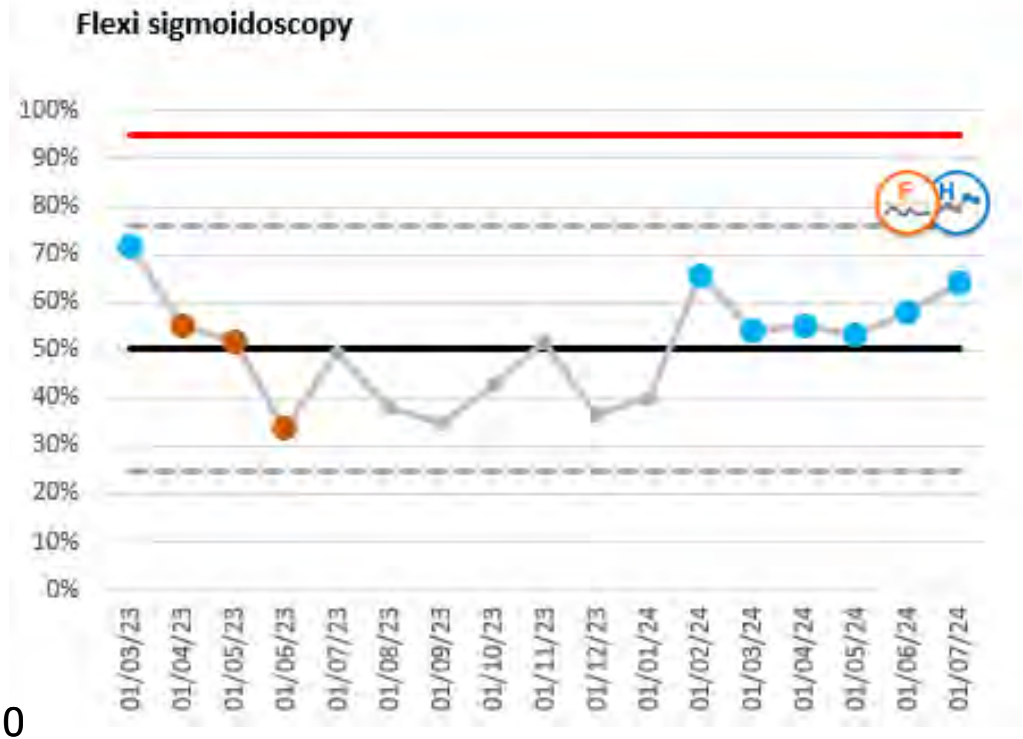

**Commentary:**
Colonoscopy DM01 performance improved again in June to 50% compared to 54% in May. Overall DM01 performance in June was 39% which was an improvement on the May position of 41.3% (Target 5%). For May to June overall >6week endoscopy waitlist continued to reduce from : 660 (-58) and >26week to 14 (-99) and June to July : 526 (-132) and >26week to 11 (-3)

**Planned Actions:**
(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

**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%)*



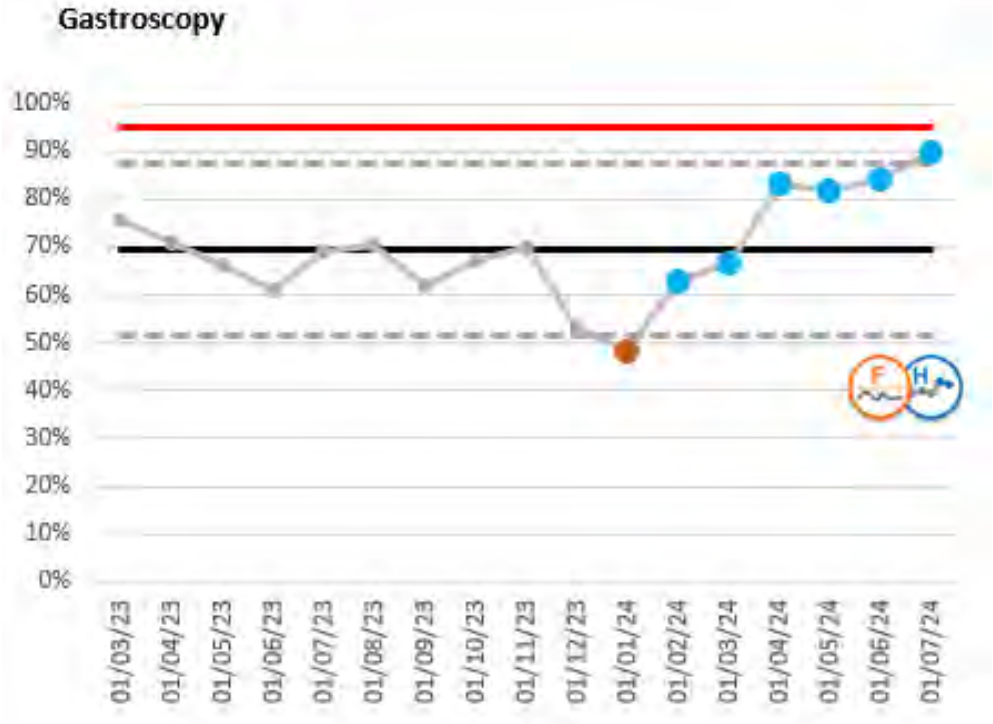

**Commentary:**
Flexi DM01 performance improved slightly again in June to 42% from 46% in May. Overall DM01 performance in June was 39% which was an improvement on the May position of 41.3% (Target 5%). (Target 5%). For May to June overall >6week endoscopy waitlist continued to reduce from : 660 (-58) and >26week to 14 (-99) and June to July : 526 (-132) and >26week to 11 (-3)

**Planned Actions:**
(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

**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%)*



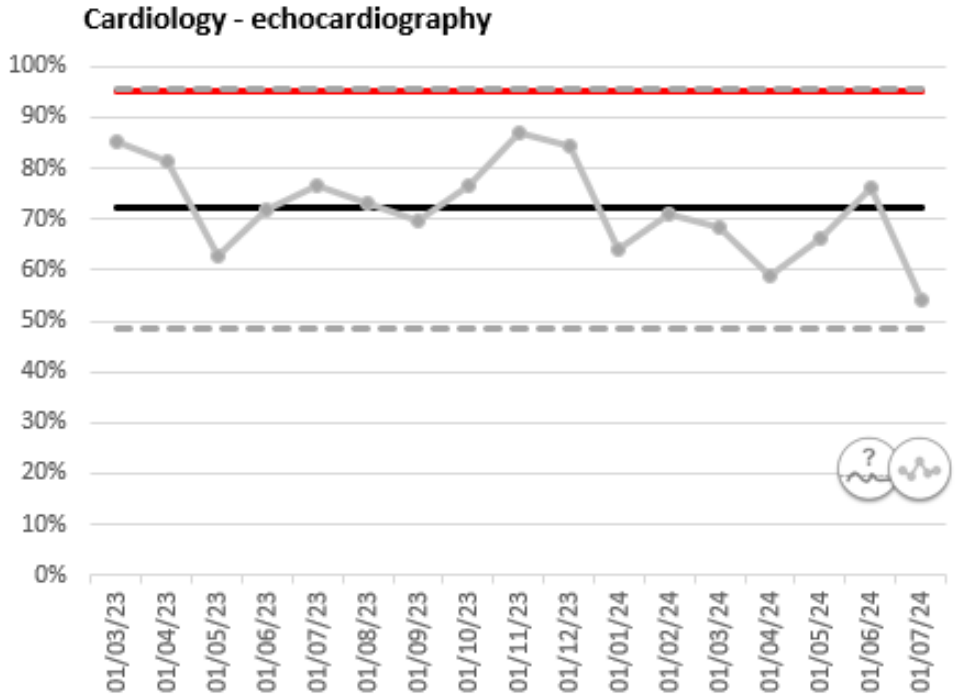

**Commentary:**
Gastroscopy DM01 performance improved slightly in June with 16% compared to 17% in May. Overall DM01 performance in June was 39% which was an improvement on the May position of 41.3% (Target 5%). For May to June overall >6week endoscopy waitlist continued to reduce from : 660 (-58) and >26week to 14 (-99) and June to July : 526 (-132) and >26week to 11 (-3)

**Planned Actions:**
(ERF) Increased locum lists by 2 per week focussing on 2WW & STT
(ERF) Visiting consultant started 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

**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%)

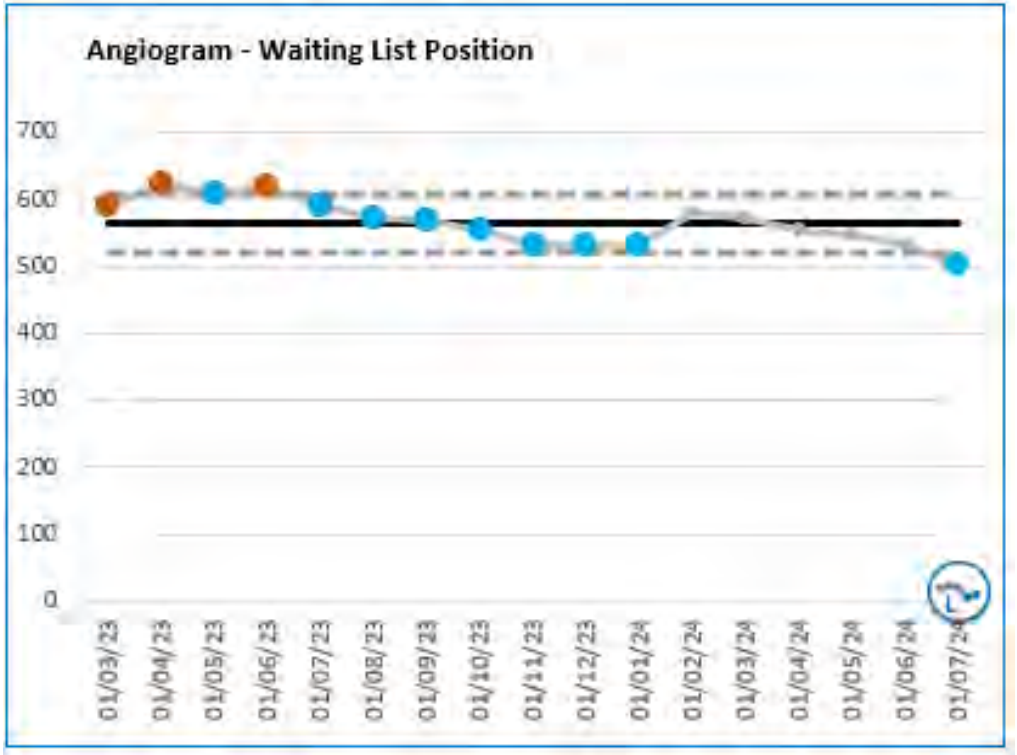



**Commentary:**
Current drivers relate to workforce challenges, referral reviews, demand & capacity, oversight of processes and IP demand. As per last month the national shortage of echo physiologists making recruitment significantly harder than in other areas.

**Planned Actions:**
Additional clinics being undertaken to support specific cohorts of patients. Introduction of portable hand held echo scanners for inpatient (Aug 24) will reduce impact on OP list. Continued recruitment efforts to fill vacancies with either substantive and agency.

**Expected recovery:**
Trajectory to be completed and taken through Planned Care Improvement Board.

# Angiogram - Waiting List Position



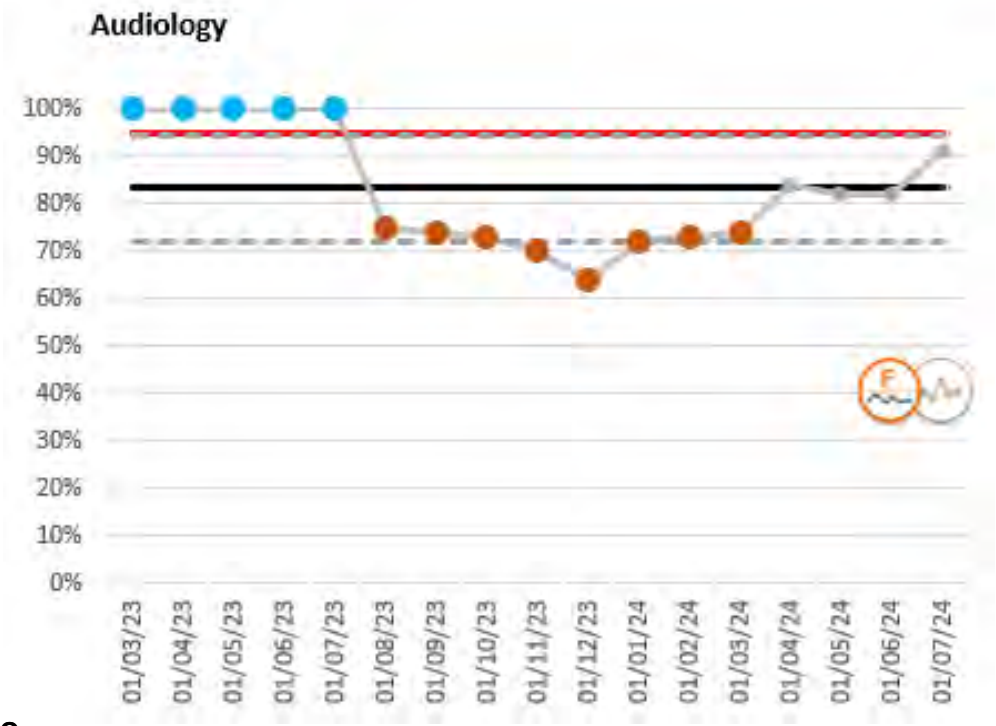

**Commentary:**
Small reduction in waiting list numbers to 550 patients which continues a downward trend. This is reflective of the new estate being more reliable and improved radiographer cover

**Planned Actions:**
Additional weekend activity using our own staff and estate. This is funded via ERF and a paper to approve enhanced rates currently with PAG committee. Potential weekend activity from end July. Also scoping sending activity to GWH, BHI and JR2. GWH offered support pending their internal PSR process completion. Utilisation of 3rd cath lab to reduce backlog when it becomes operational due Dec24/Jan25.

**Expected recovery:**
Waitlist to be halved by March 2025 and cleared by Sept 2025

# 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. The service are completing a workforce review to identify efficiencies and additional capacity.

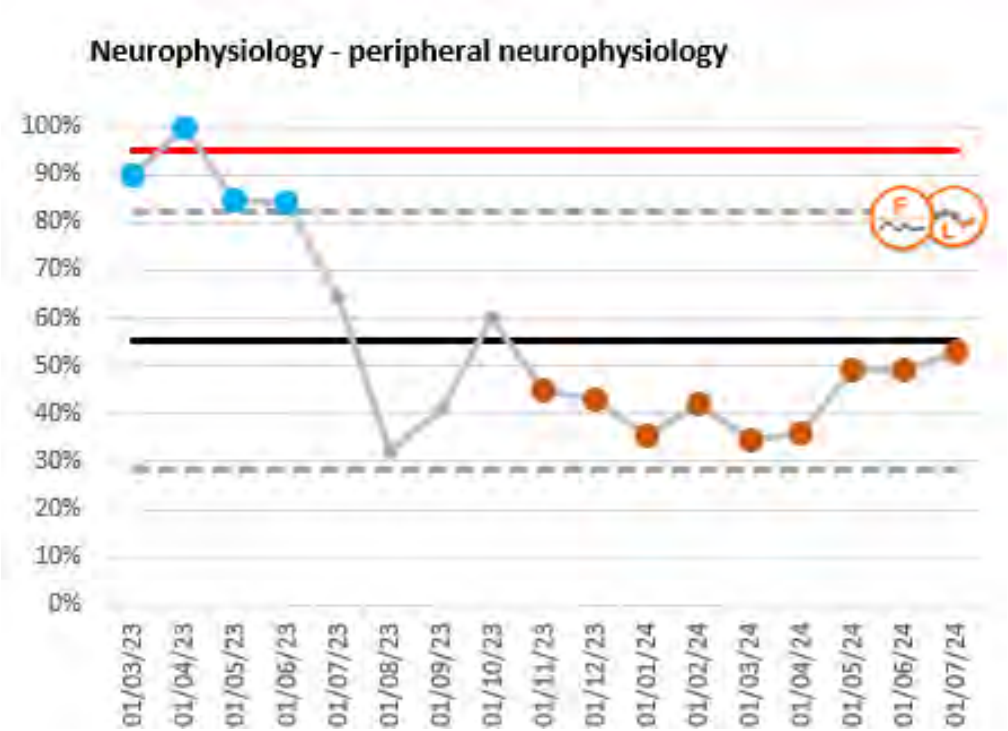
Targeted recruitment support will be undertaken, recognising the national shortage of audiologists.

**Expected recovery:**

Dependent on above actions, which are 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%)

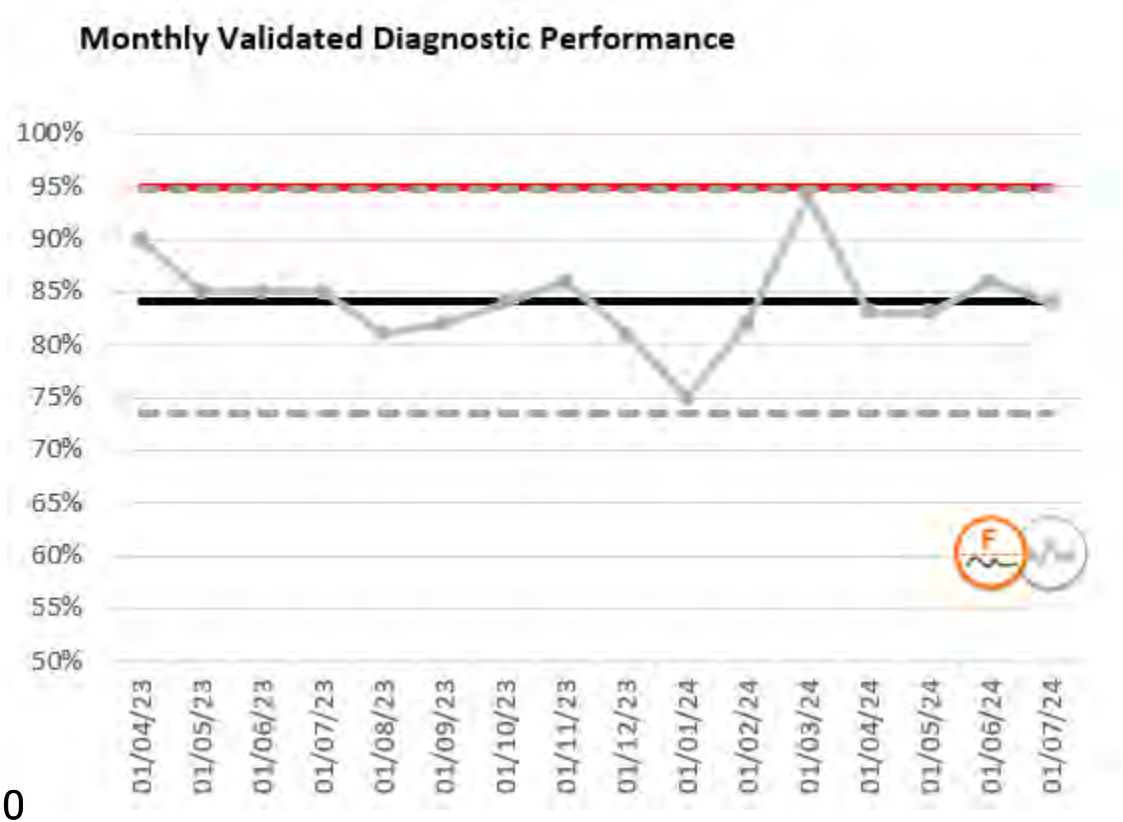



**Commentary:**
There has been continued reduction in waitlist over 6weeks from 360 to 318
patients. The longest waiting patient has remained static at 20 weeks

**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 (part time hours)
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:**

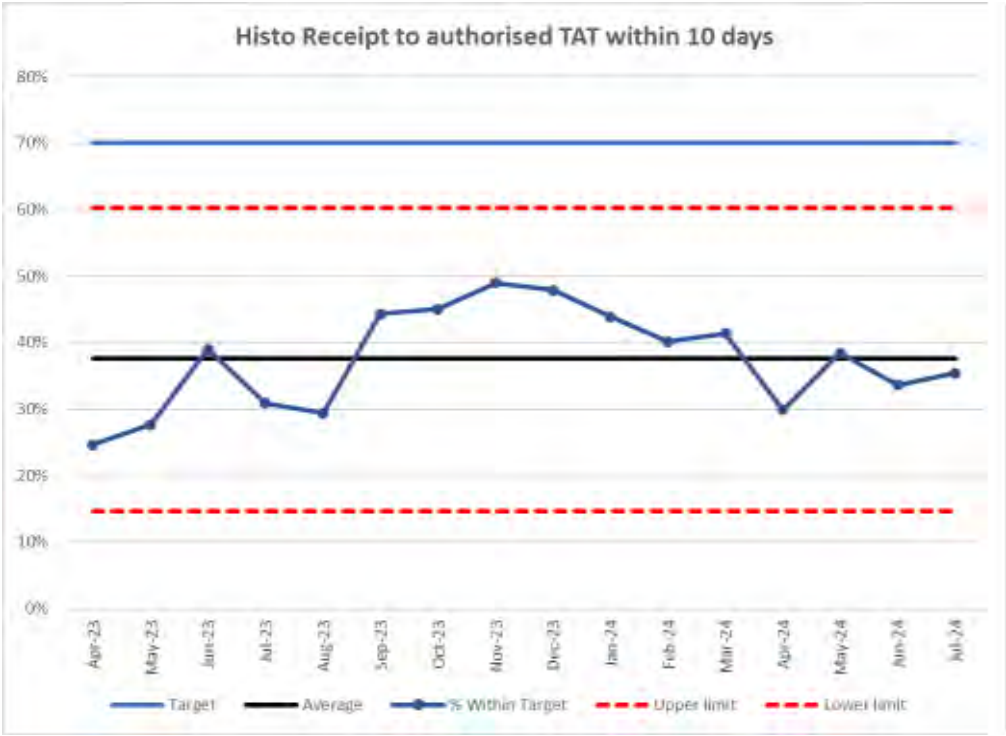
Cumulative delivery of the actions described in earlier slides will positively influence an improving position.

**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*

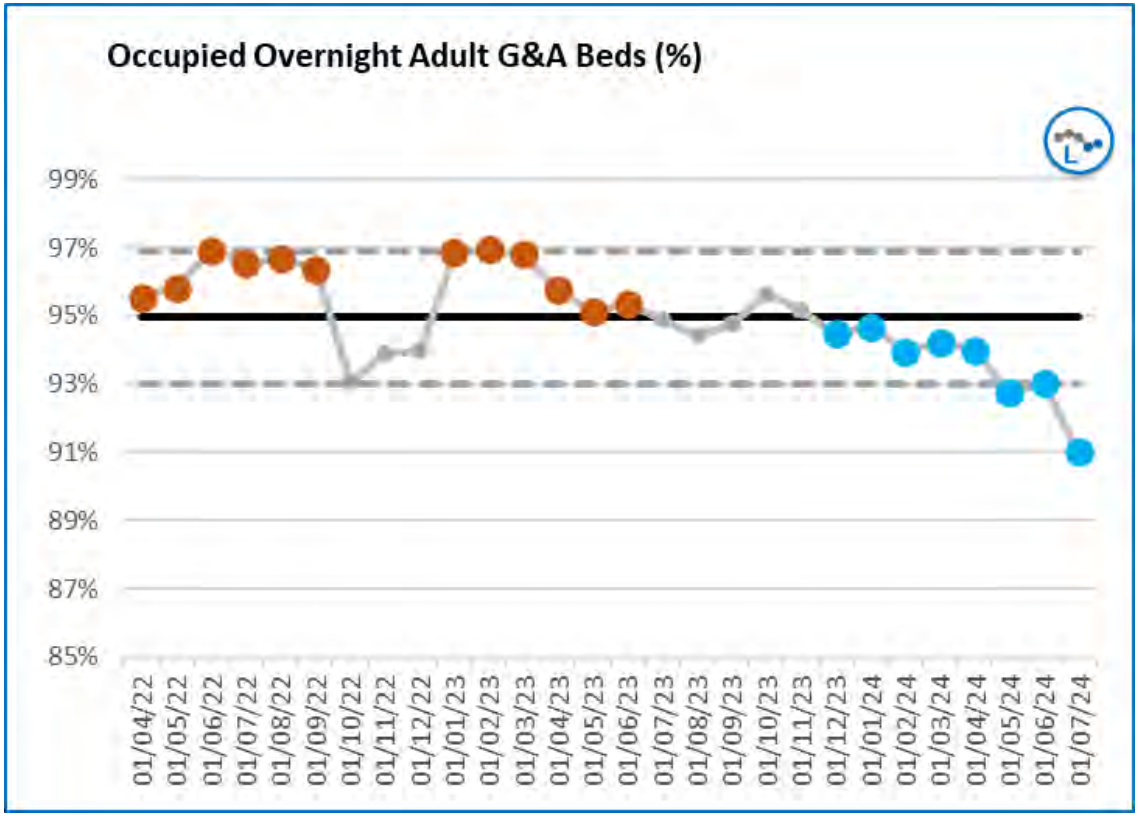



**Commentary:**
There is a national shortage of Histopathologists and this comes at a time of a 30% increase in Histopathology requests. The department has old, end of life equipment which is becoming increasingly unreliable. The Department is reliant on outsourcing and locum reporting. Performance improved slightly in July. There is a focus on ensuring that specimens contributing to Cancer diagnostics are prioritised.

**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
Further trial of six day working to increase capacity is being considered

**Expected recovery:**
Next quarter actions to be focussed on recovery but is dependent on recruitment and procurement of new equipment

# General & Acute Beds: Occupied

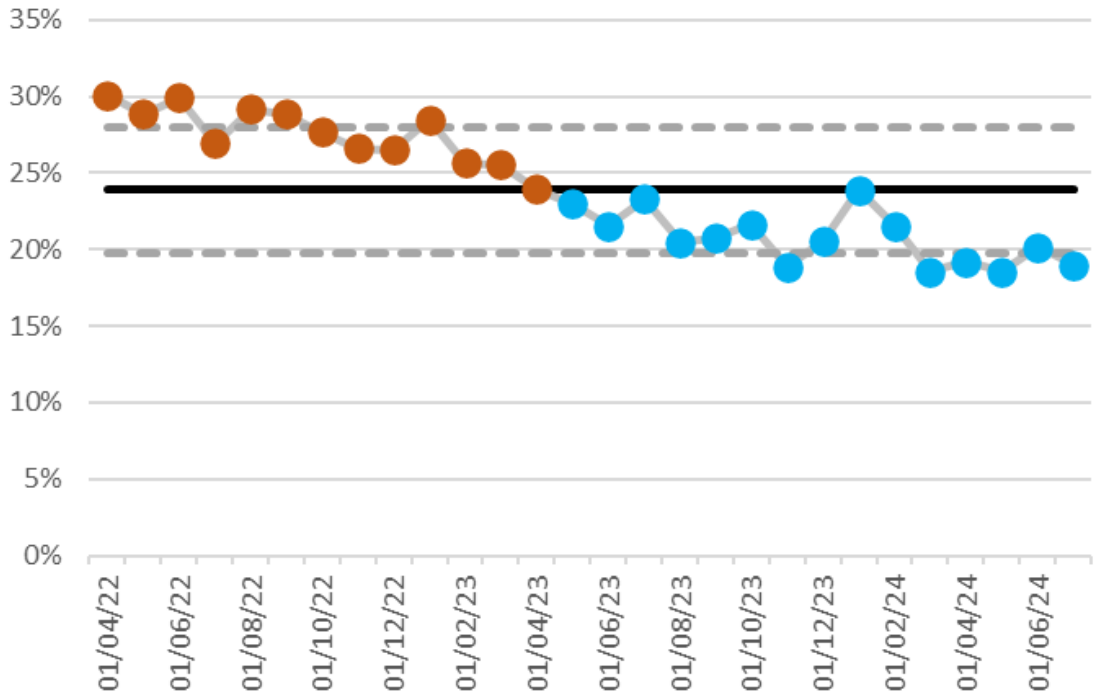



**Commentary:**
Overall occupancy percentage driven by elective pathways and bed capacity within elective orthopaedics and oncology in the main. Our lower occupancy at midnight has been achieved through improvements in mutiple areas of flow and discharge, meaning we have not required to board or use escalation areas in over 1 month. This combined with generally higher levels of discharges across P0-3, means we have empty beds going into the night to manage attendance and demand out of hours.

**Planned Actions:**
Multiple planned actions in place broadly covered across UEC, flow/LOS, discharge and nCTR improvement plans being managed through the CVOF and WasO programmes.

**Expected recovery:**
Continued improvements in performance and bed capacity to support flow 7 days a week.

# General & Acute Beds: % Beds Occupied with NCTR




**Commentary:**

NCTR LOS has seen significant imporvements with a significant reduction in the median wait across all pathways. However linked to improved internal processes, the overall number and percentage is still above that of the operational plan. Improvement shows an overall downward trend and is expected to continue with work across the system on discharge pathways, especially pathway 1.

**Planned Actions:**

NCTR improvement plan part of UECIB and the WasO metrics.

The Intergrated Flow Hub is in continued development and is currently focused on improved digital processes to reduce process delays alongside driving increased pathway 1 decisions to improve patient outcomes.

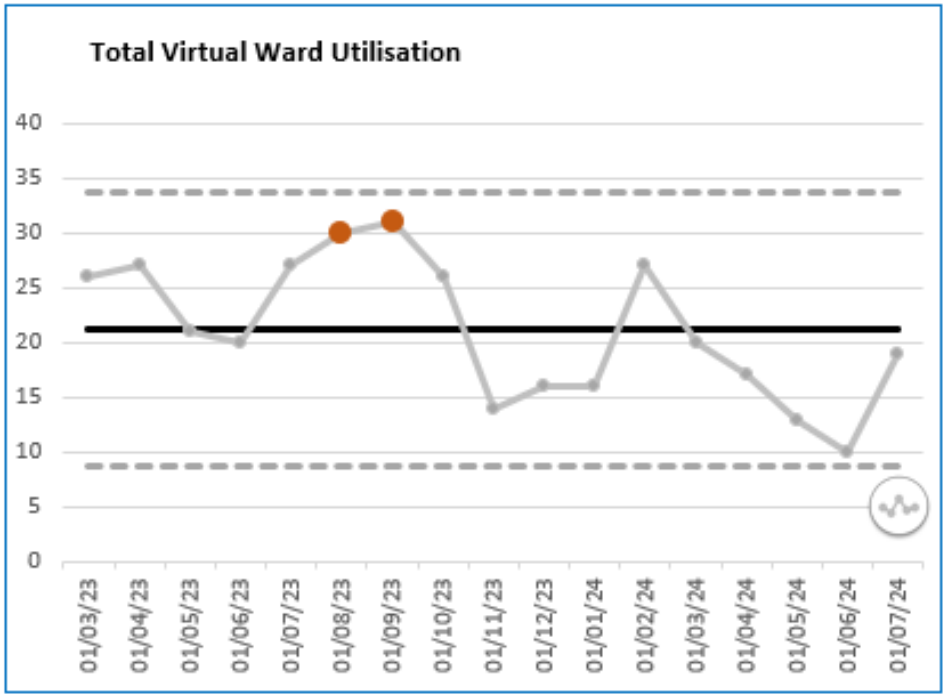
Focused work alongside system partners to improve the pathway 1 availability to enable same day/next day discharges.

**Expected recovery:**

In line with planning for 24/25, the expectation is that the nCTR number is less than 85 by the end of the year, being maintained through our winter months. This is currently at risk with the figure sitting 10-15 above the plan.

# Virtual Wards: Utilisation

*Standard: 80%*



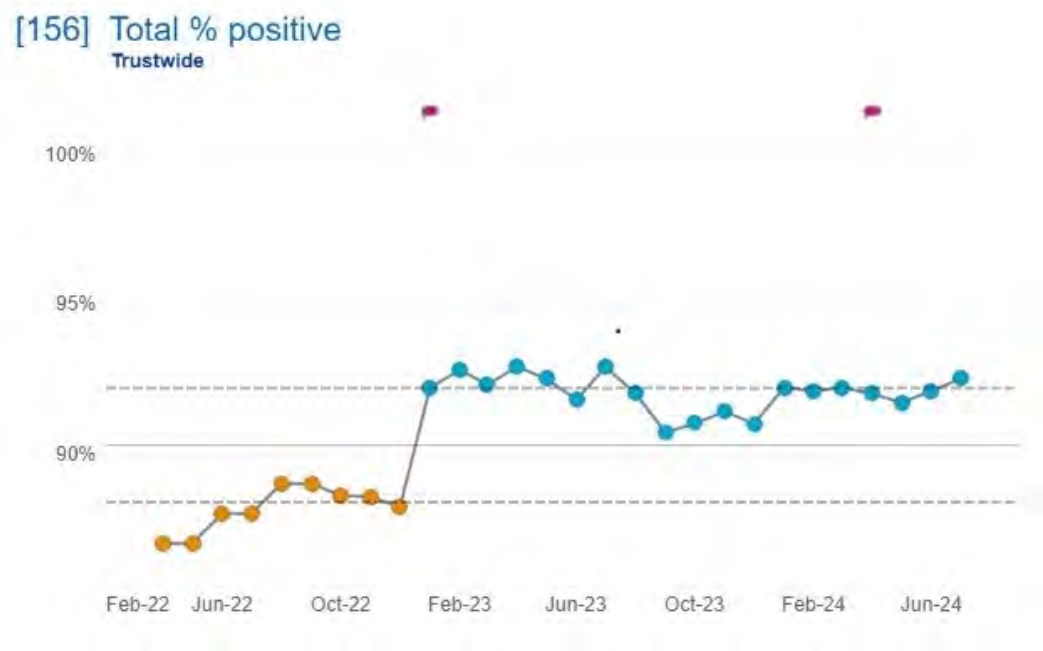

**Commentary:**
Reporting based on snapshot data (fortnightly national reporting). Gloucestershire systemwide occupancy remains above 80% since Jan 24. The GHFT led respiratory, frailty and surgical virtual wards are at an earlier stage of development. Activities to maximise utilisation are focussed 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 increased slightly this month to 92.5% . There has been an increase in scores from inpatients 93.9% and emergency departments (ED) 79.2% but a reduction in maternity services to 75.2%. Delays in appointments and feeling dismissed continue to be themes from outpatients. Positive action in ED at GRH in response to feedback through environmental improvements have supported improved experience.

**Planned Actions:**
To work further with divisions to support improvements to experience. Implementation of safety priority for communication will support.

**Expected recovery:**
Increase in overall score is impacted most by dips in positive score within outpatients and ED although all care types impact. We would look to remain at the upper control where possible.

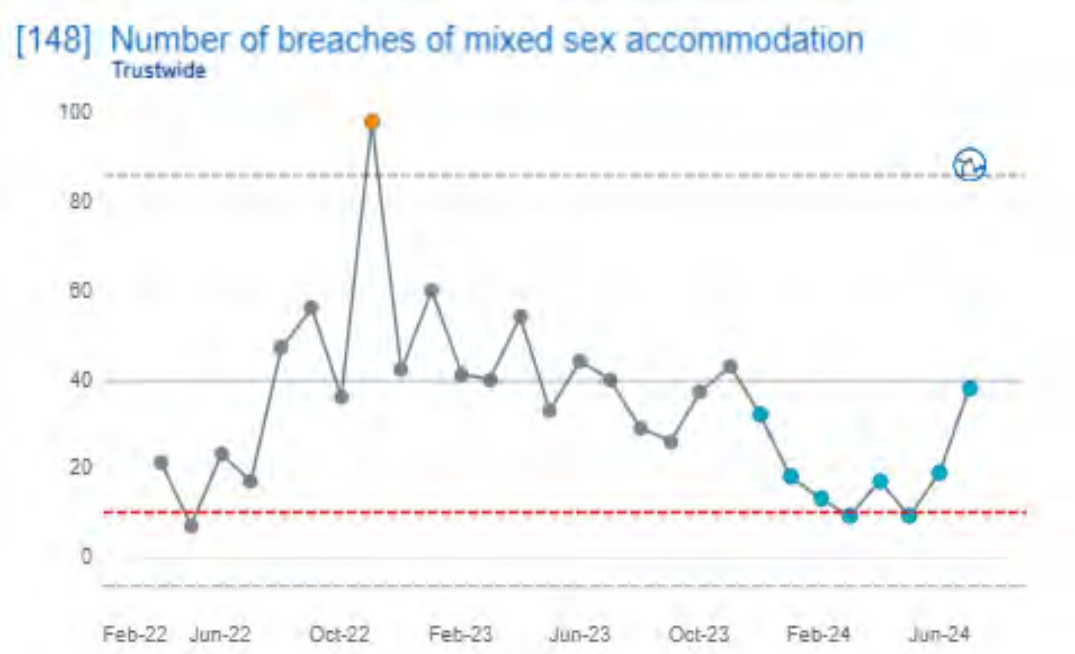
# PALS


**Commentary:**
PALS team have increased the number of concerns closed in 5 working days to 80% and are above target (75%). This is despite of a year-on-year increase in concerns compounded by increase in complexity.

**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.
Increased accessibility of PALS to support more drop in availability.

**Expected recovery:**
Review of processes following the implementation of Datix cloud to enhance reporting. Would hope to see a further increase in the coming months to then see a slight decline as we move further into winter.

# Patient Care: Mixed Sex Breaches

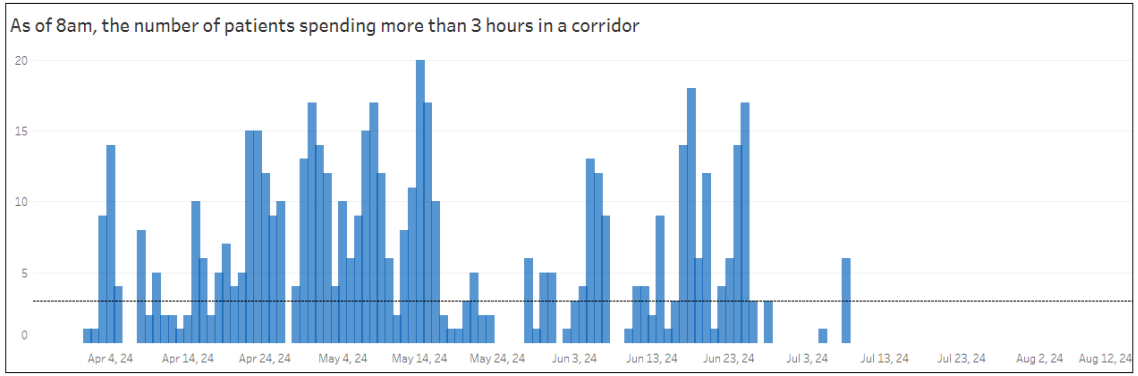


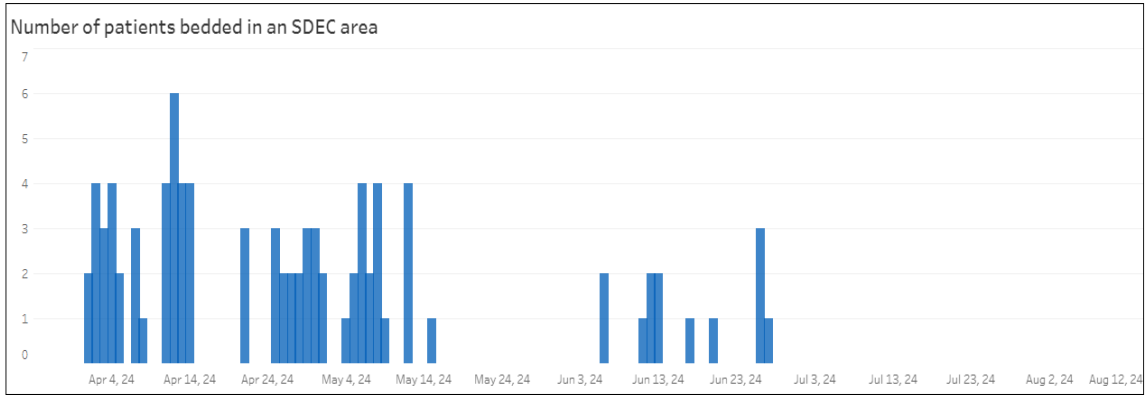

**Commentary:**
As part of reduced use of escalation areas and improved flow, we have also seen a sustained improvement in mixed sex breaches. The only area we have had any mixed sex breaches in the past month have been in DCC and ability to move into a bed within the 4hr timelines to avoid being classified as a breach.

**Planned Actions:**
Joint work to be undertake between DCC and Site management to consider the process and timeliness of moving ward level patients out of DCC

**Expected recovery:**
Further reduction of unjustified mix sex breaches.

# Patient Care: Boarded Patients



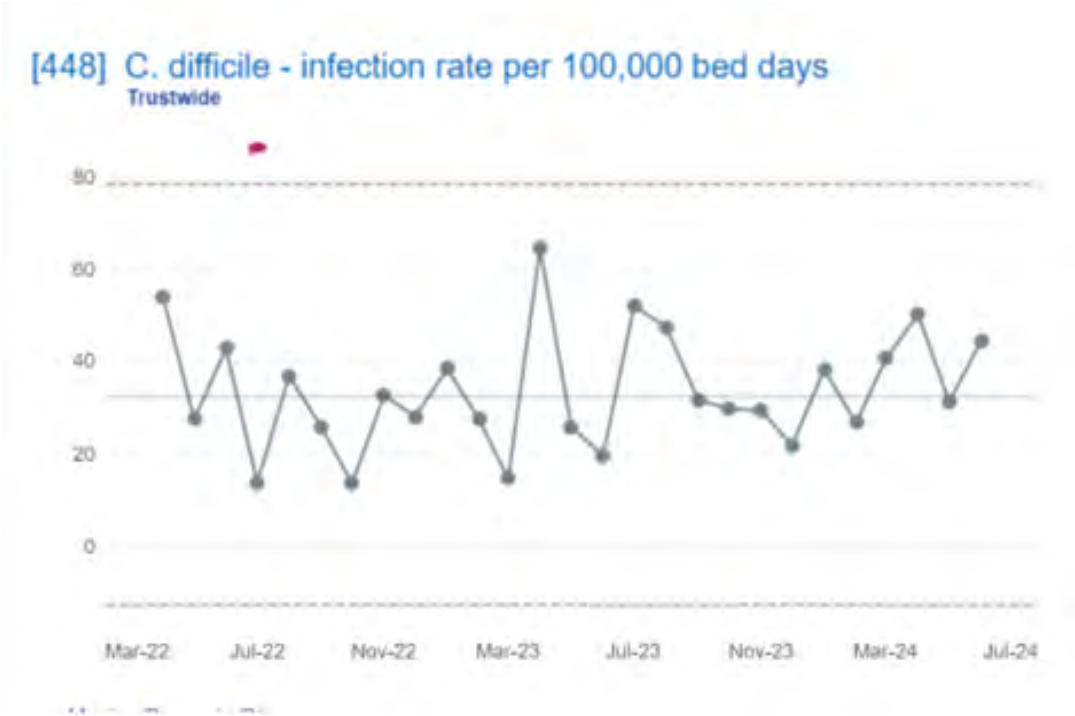




**Commentary:**
The improved performances across the board relating to flow has meant that we have not required to board for over the past month, alongside not needing to use any SDEC areas as escalation beds.

**Planned Actions:**
Boarding has been stopped as a result.
Escalation policy in the process of being ratified through TLT outlining when we would consider pre-empting to wards, but only once certain actions have been undertaken.

**Expected recovery:**
No more boarding or use of SDEC areas outside of agreed escalation policy when in extremis.

# Infection Control: *C. diff*

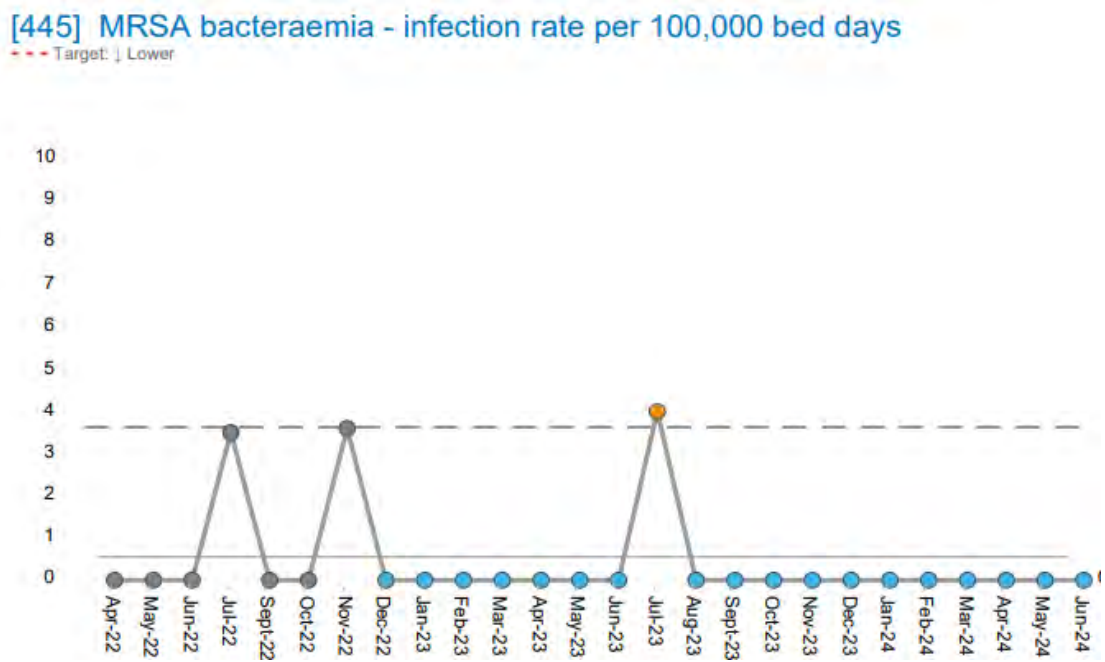



**Commentary:**
The annual *C. difficile* limit for 2023/24 set by NHS England was 97 cases apportioned to the Trust, during 2023-2024 there were 106 cases, which meant the Trust breached the annual threshold. The annual CDI threshold for 2024/25 set by NHS England has not yet been published. From April 1st 2024, we have had 35 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, especially men in the community, where there has been a significant increase this year. This activity is reported and monitored by the ICS IPC and ICS AMS groups which reports to the ICS Infection Prevention Management Group. The Trust also support work in the regional Southwest CDI collaborative.

**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

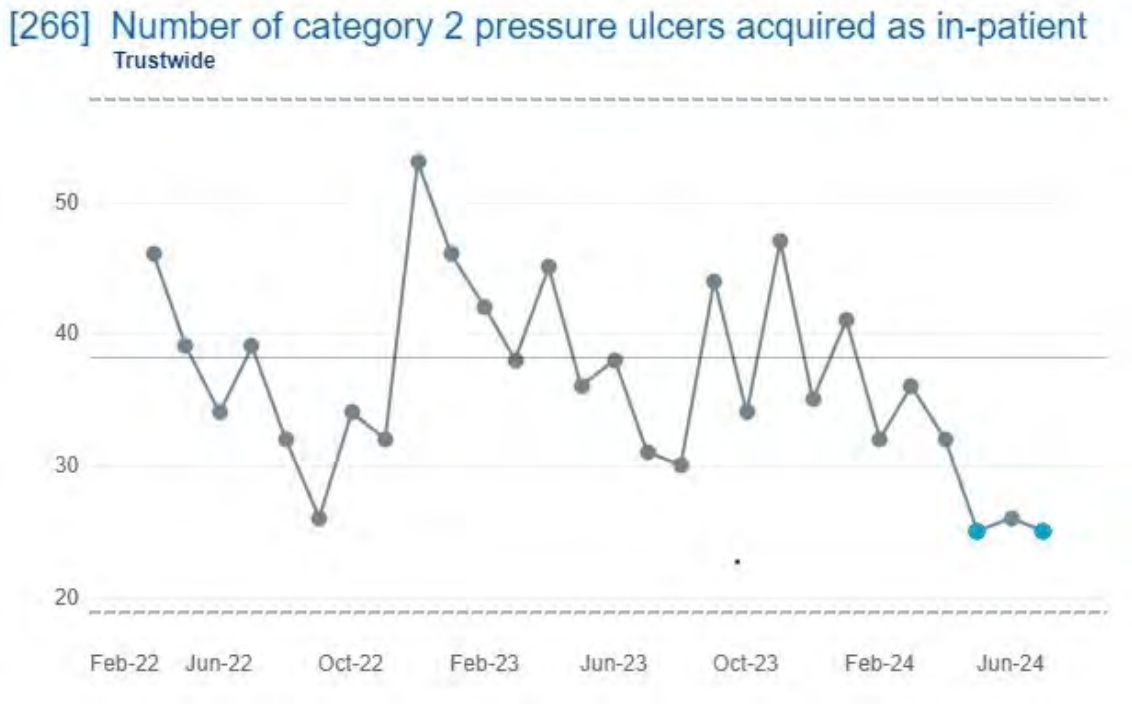



**Commentary:**
The Trust has not had a MRSA bacteraemia case apportioned to the trust for 7 months.

**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: Pressure Ulcers Cat2

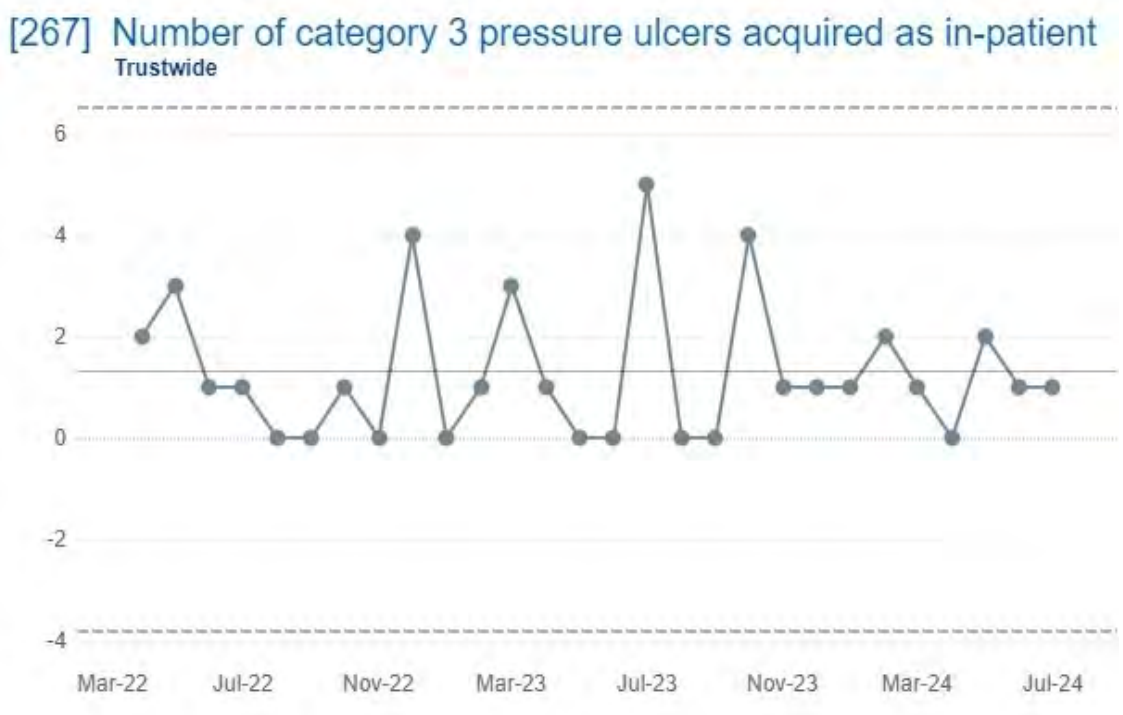



**Commentary:**
All pressure ulcers continue to be a patient safety concern. Contributing factors include prolonged immobility in the **pre-hospital and emergency care stage** of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated 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

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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.

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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

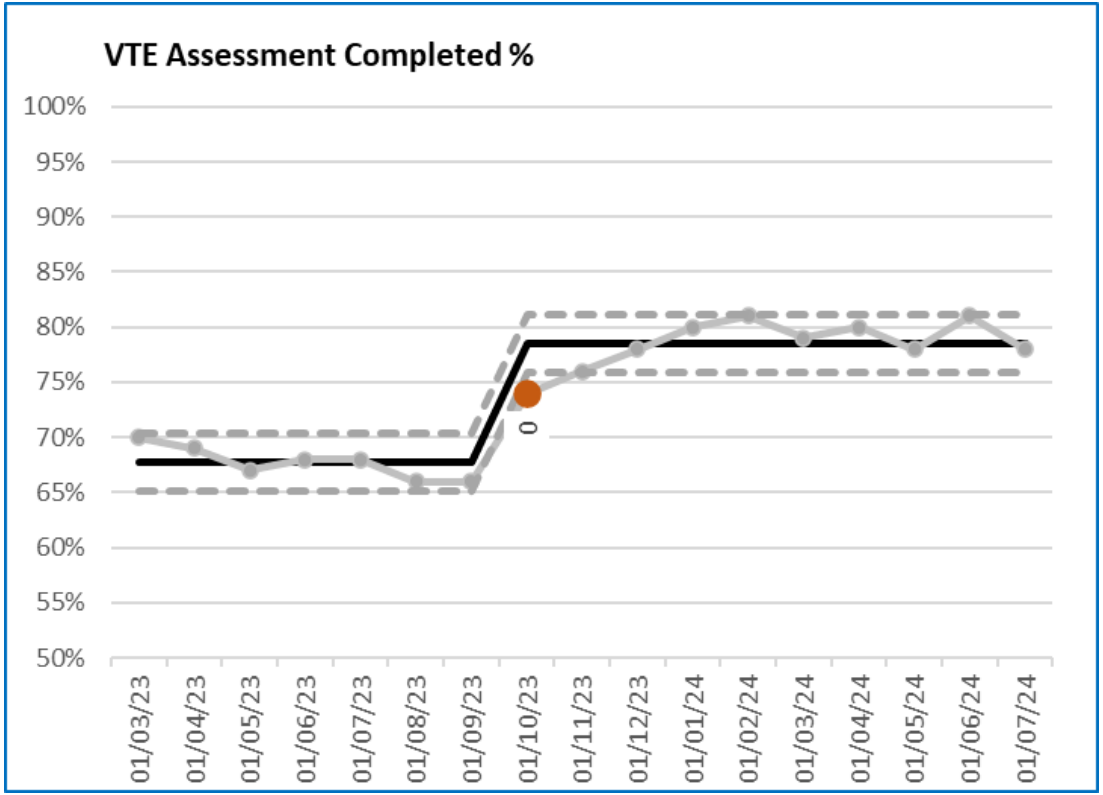
# Safety Priority: Patient Falls


**Commentary:**
Falls per 1000 days reducing slightly over past 2 months. The rate of falls is linked closely to acuity of patients and availability of nursing staff. All patients over 65 or at risk of falls have an assessment on admission to guide falls prevention strategies.

**Planned Actions:**
A comprehensive training package has been launched by the Falls Team and is being very well attended, this is a key focus for us.

**Expected recovery:**
The rate of falls will continue to fluctuate with us aiming for a rate below 6 per 1,000 bed days.

# Patient VTE Risk Assessment




**Commentary**

- Snapshot compliance (c90%) is much higher than of within 14hrs (NICE guidelines) is only 75%. Focus is on improving snapshot compliance first. There is considerable variation across Divisions - Medical Division compliance very good; Surgical division less so related to Day Case surgery.

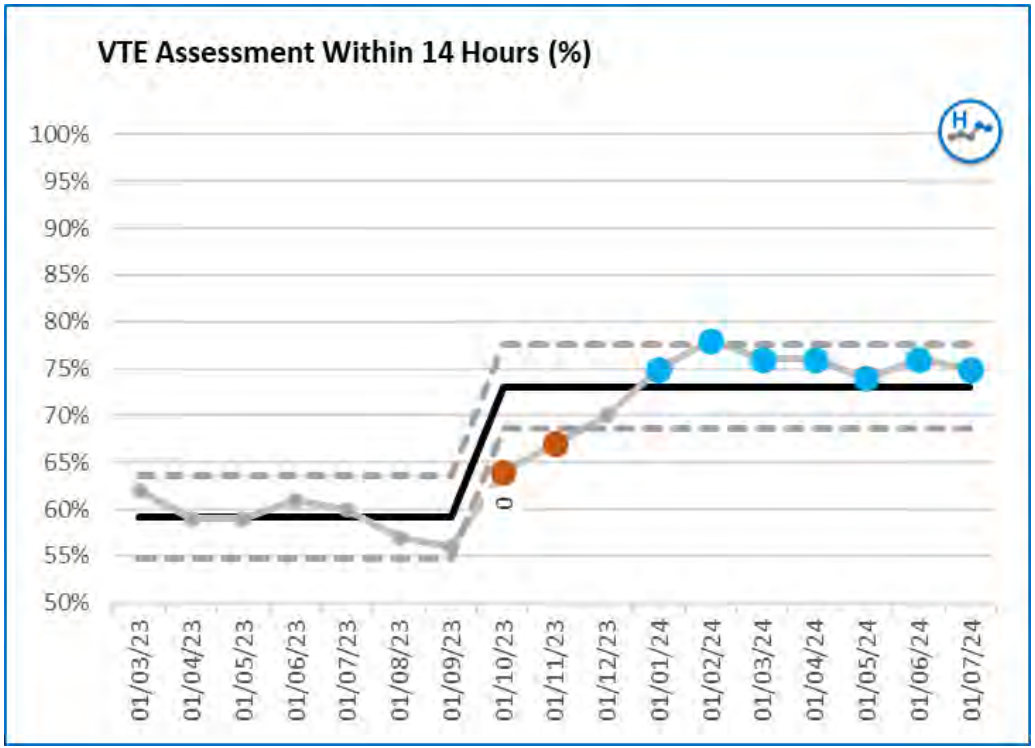
**Planned actions**

- MD to continue to chair VTE group until improvement sustained
- Surgical Division to present improvement plan to next VTE committee
- Maternity QI project in underway using different targets to Trust targets. VTE committee and Maternity QIP have agreed to use same targets as per NICE guidance. Significant improvement in compliance as a result.
- VTE committee has agreed metrics to be aligned with EPR – due in next report

**Expected recovery**

- Maternity recovery target: to meet Trust target re snapshot compliance within 3 months
- Surgery targets to be confirmed at next VTE Committee

# Patient VTE Risk Assessment Within 14 Hours

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**Expected recovery**

- Maternity recovery target: to meet Trust target re snapshot compliance within 3 months
- Surgery targets to be confirmed at next VTE Committee

# Patient Smoking Cessation


**Commentary:**
All patients admitted to hospital should be asked about their smoking status by the clinical and admitting teams; 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 of interventions.

**Planned Actions:**
VBA training sessions planned in GRH wards.
Trust wide communications reminder to record smoking status.
Contingency plan of recruiting advisors on Bank shifts.

**Expected recovery:**
The tobacco free team will continue to deliver interventions on the wards.

# Maternity Care: Postpartum Hemorrhage >= 1,500 ml


**Commentary:**
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 June is within the upper and lower quartiles but we remain above national average ( average = 30.0 per 1000 deliveries).

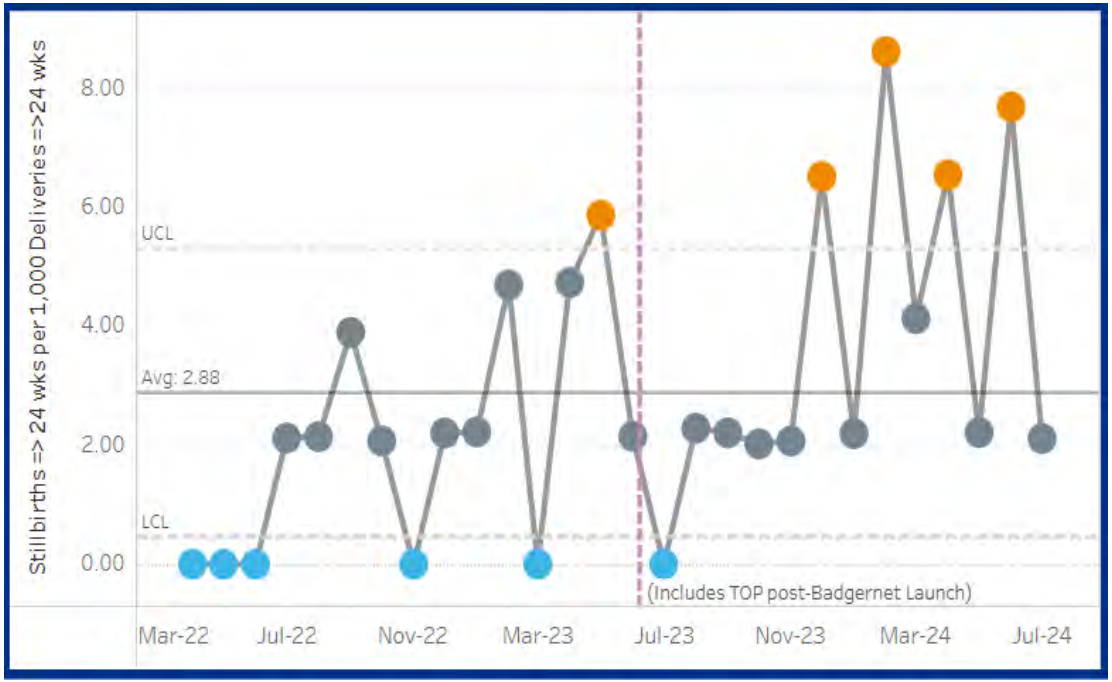
We have a **CQC S31 enforcement notice** that includes our oversight of the improvement programme for this metric.

**Planned Actions**: Carbetocin (medication to reduce blood loss post c/s) commenced on 17th June. REDUCE Risk assessment and Checklist commenced 1st July and it is expected to see improved outcomes for August. There is a clinical Team (Consultant and Midwife) leading the improvement work for PPH.

**Expected recovery**: The QI aim is to be at national average by Jan 2025. Oversight and actions associated with QI methodology is reported to the **Maternity Delivery Group**. The service are implementing PSIRF methodology for oversight of the cases reported as safety incidents.

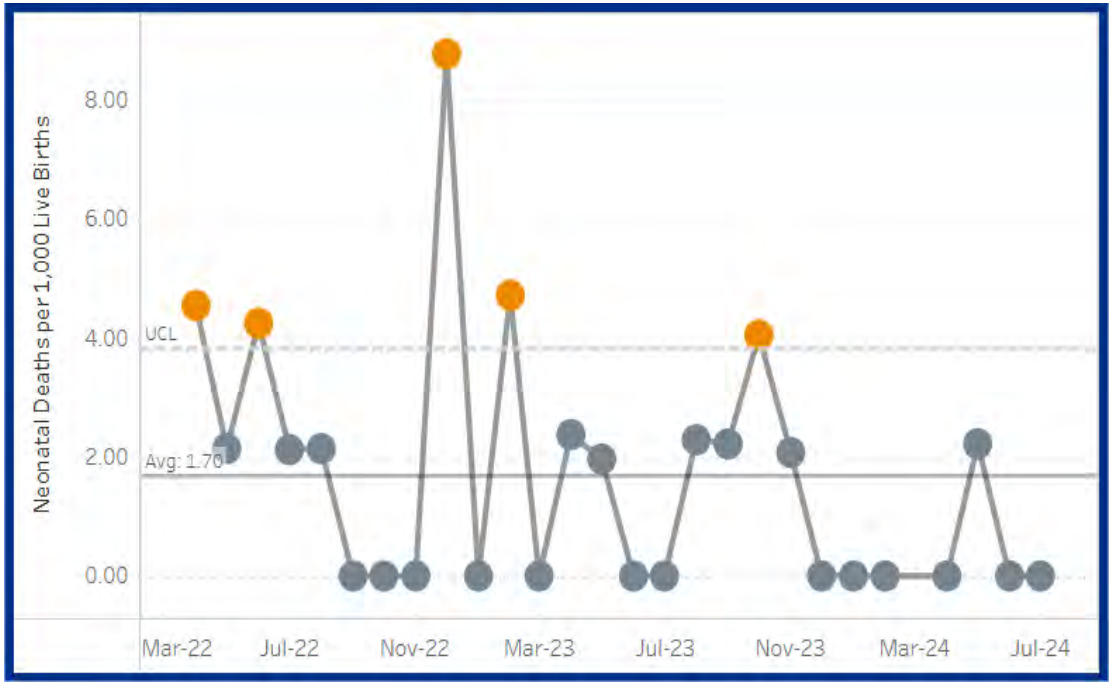
Detection and escalation of maternal and fetal deterioration is one of the areas of improvement for the Trust's **Safety Priorities.**

# Maternity Care: Stillbirths



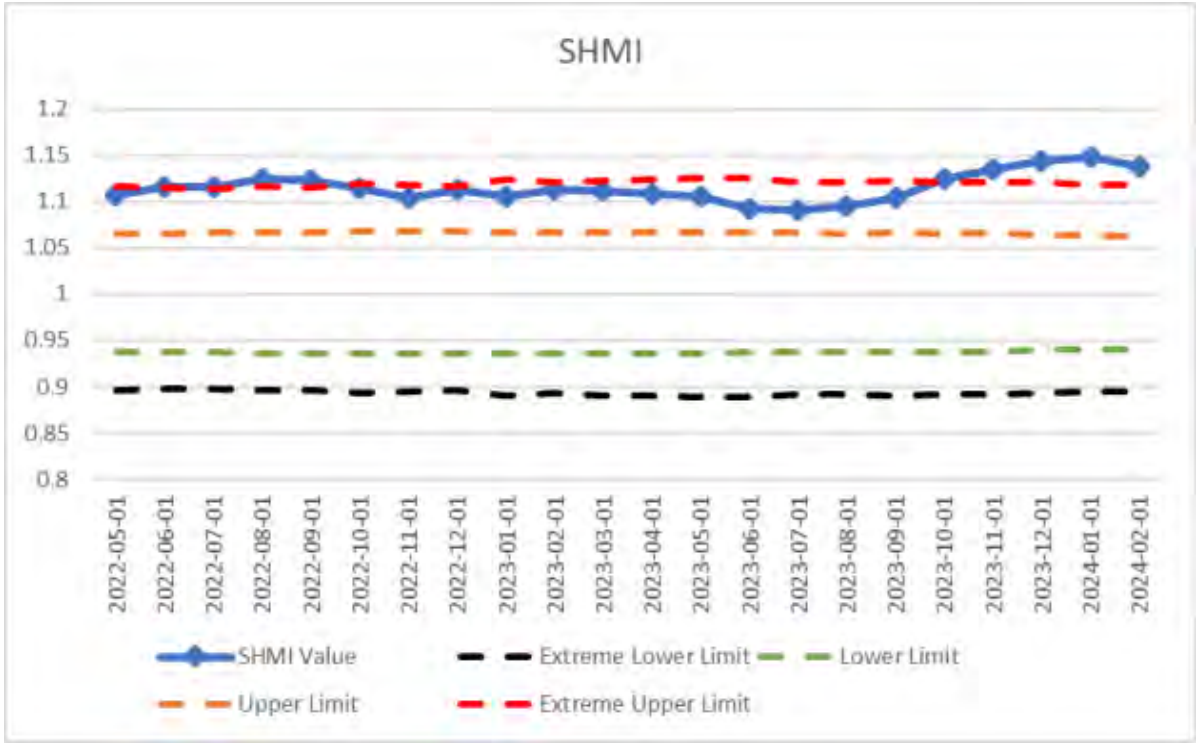

**Commentary:**

# Maternity & Neonatal : Neonatal Deaths >22 Weeks




**Commentary:**

# Mortality – SHMI National Data



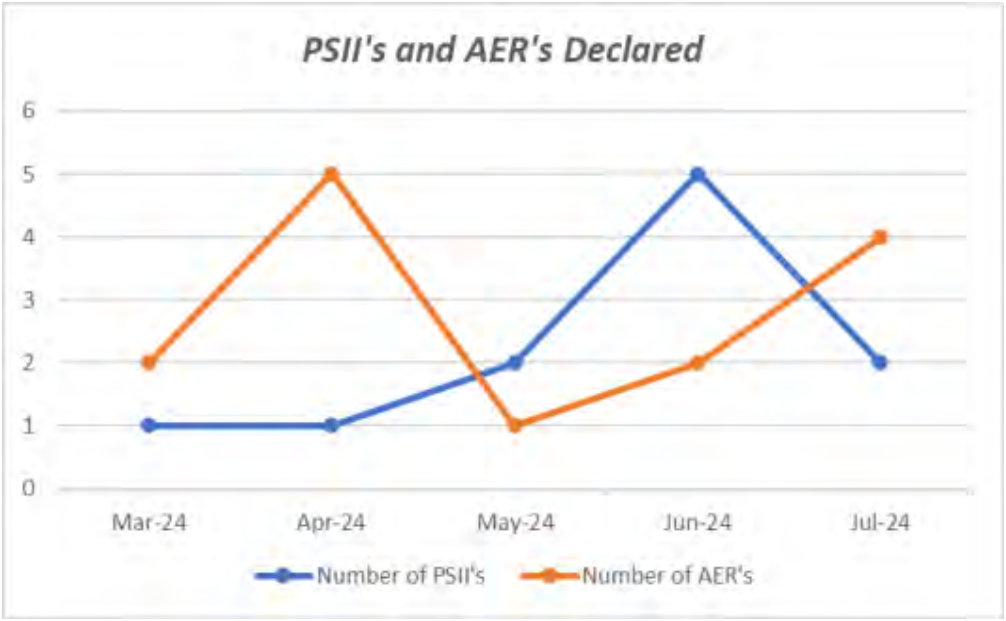

**Commentary:**
Increasing SHMI (NHS Digital) over last 3 months
Hospital Mortality Group monthly, reviewing action plan to address clinical/coding issues

**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



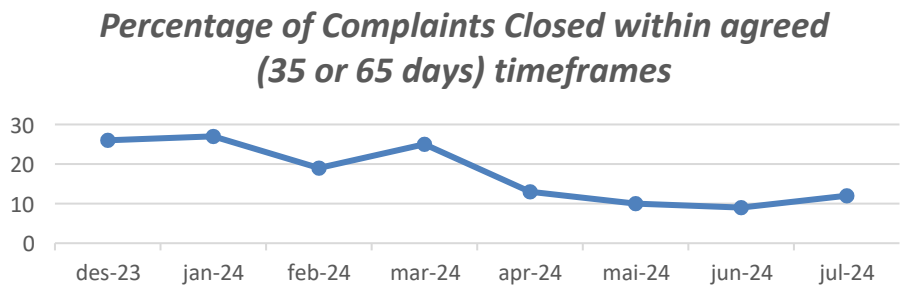

**Commentary:**

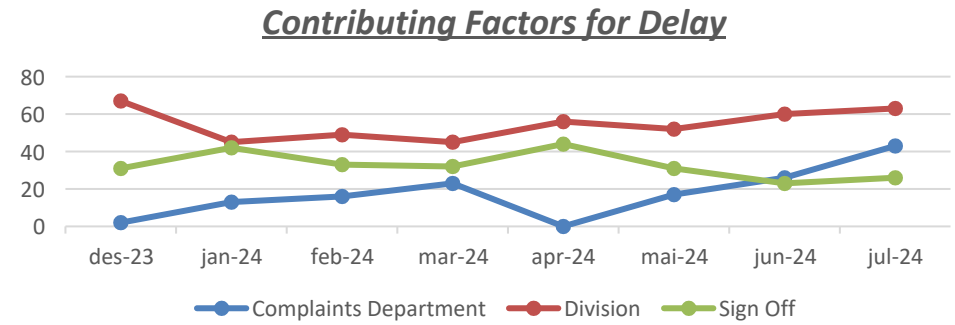
PSII – Patient Safety Incident Investigation. Declared when a problem in care is considered to have contributed to death, or a safety concern is such that a detailed systems approach investigation is indicated

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




**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.

# Use of Resources Metrics

# Financial metrics

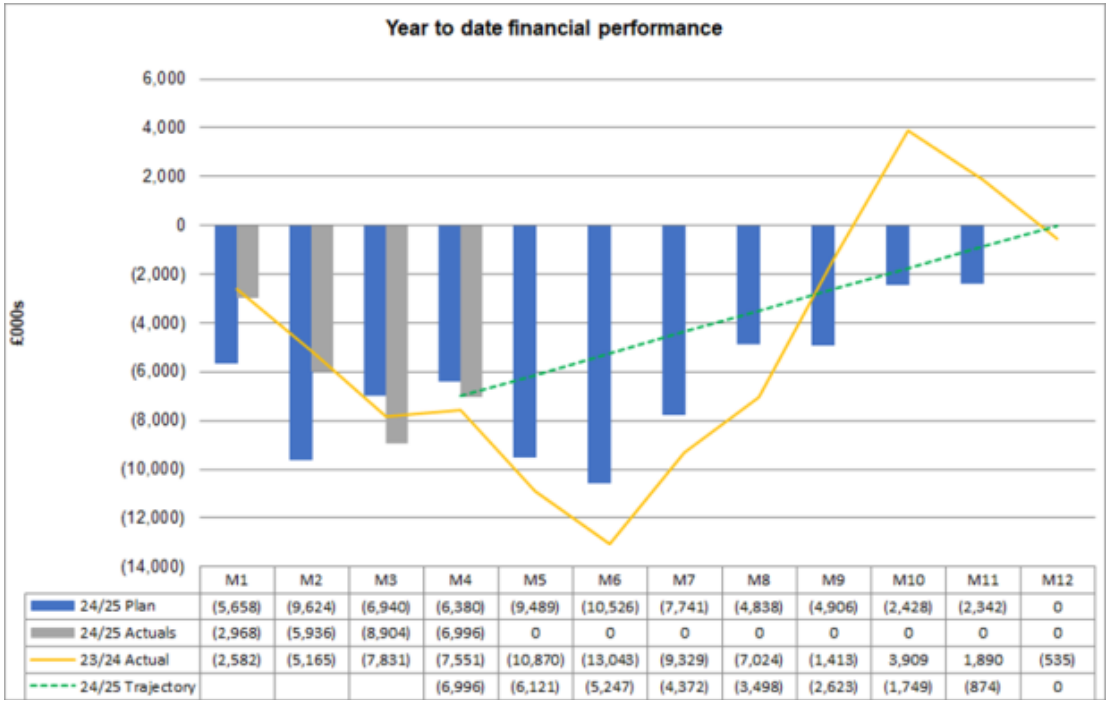
NHS England measure the Trust for FSP delivery, variance from breakeven and agency spend as a % of paybill.

Internally we are including other metrics for review.

Currently the Trust is showing an adverse position for the last three months related to the overall in year revenue position – further detail is on the next slides

| Metric | | Month 1 | | | Month 2 | | | Month 3 | | | Month 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Plan | Actual | Var | Plan | Actual | Var | Plan | Actual | Var | Plan | Actual | Var |
| Revenue (deficit)/surplus | Ytd £'000s | -5,561 | -6,007 | -446 | -9,624 | -10,522 | -898 | -6,940 | -8,905 | -1,965 | -6,380 | -6,996 | -616 |
| | Forecast £'000s | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Capital vs budget plan | Ytd £'000s | 1,513 | 1,753 | 240 | 2,689 | 2,689 | 0 | 7,699 | 4,041 | -3,658 | 11,943 | 5,661 | -6,282 |
| | Forecast £'000s | 45,972 | 45,972 | 0 | 45,972 | 45,972 | 0 | 45,972 | 45,972 | 0 | 45,972 | 45,972 | 0 |
| FSP | Ytd £'000s | | | 0 | 3,418 | 1,403 | -2,015 | 4,793 | 5,473 | 680 | 6,778 | 9,610 | 2,832 |
| | Forecast £'000s | 37,389 | 37,389 | 0 | 37,389 | 37,389 | 0 | 37,389 | 32,091 | -5,298 | 37,389 | 37,389 | 0 |
| Nos days operating cash | | 5 | 28 | 23 | 5 | 23 | 18 | 5 | 16 | 11 | 5 | 24 | 19 |
| BPP - nos invoices paid in 30 days | | 95% | 98% | 3% | 95% | 99% | 4% | 95% | 99% | 4% | 95% | 99% | 4% |
| Agency spend as % of pay | | 3.2% | 3% | -0.2% | 3.2% | 3% | -0.2% | 3.2% | 3% | -0.2% | 3.2% | 3% | -0.2% |

# M03 Financial Position (Trust)




| | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 24/25 Plan | (5,658) | (9,624) | (6,940) | (6,380) | (9,489) | (10,526) | (7,741) | (4,838) | (4,906) | (2,428) | (2,342) | 0 |
| 24/25 Actuals | (2,968) | (5,936) | (8,904) | (6,996) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 23/24 Actual | (2,582) | (5,165) | (7,831) | (7,551) | (10,870) | (13,043) | (9,329) | (7,024) | (1,413) | 3,909 | 1,890 | (535) |
| 24/25 Trajectory | | | | (6,996) | (6,121) | (5,247) | (4,372) | (3,498) | (2,623) | (1,749) | (874) | 0 |

**Commentary:**

M04 financial position is reporting an adverse variance of £616k against a deficit plan of £6,380k

**Planned Actions:**

- Recurrent financial sustainability opportunities continue to be explored.
- A detailed Brilliant Basics toolkit has been developed which is aligned to the NHSE Financial Play Book.
- Medicine mandated support is in place.
- Workforce controls have been implemented and being monitored.
- Financial Improvement Board meets fortnightly and is chaired by CEO.

**Expected recovery:**

The current forecast position for Trust and ICS is breakeven which is in line with plan. There are risks to delivering a breakeven position which are being managed across the system.

# M03 Financial Position (Trust)

| Summary I&E Position (Trust only) | Current Month Budget £000 | Current Month Actual £000 | Current Month Variance £000 | YTD Budget £000 | YTD Actual £000 | YTD Variance £000 | YTD variance excl NR benefit £000 |
|---|---|---|---|---|---|---|---|
| Income | (66,390) | (68,201) | (1,811) | (255,568) | (257,427) | (1,859) | *(703)* |
| Pay | 38,861 | 38,066 | (795) | 154,682 | 154,824 | 143 | *1,478* |
| Non Pay | 26,969 | 27,530 | 561 | 107,267 | 110,495 | 3,229 | *3,649* |
| **(Surplus)/Deficit** | **(560)** | **(2,606)** | **(2,046)** | **6,380** | **7,893** | **1,513** | ***4,424*** |
| | | | | | | | |
| **Donated Assets/Grants/IFRIC 12 Adj** | | **697** | **697** | | **(897)** | **(897)** | ***(897)*** |
| | | | | | | | |
| **Adjusted (surplus)/deficit** | **(560)** | **(1,909)** | **(1,349)** | **6,380** | **6,996** | **616** | ***3,527*** |

**Headlines**

The headline drivers of the YTD overspend are:

Non recurrent benefits of **£2.9m** released to support position.

Industrial Action costs of **£0.626m** for M3 and M4.

Pay overspend of £142k.

The overspend is £1.48m excluding non recurrent benefits, including IA.

Non pay overspend of £3.2m

Overspend excluding non recurrent pharmacy stock benefit is £3.6m. This is before adjusting for IFRIC 12 which is £0.897m. Non pay overspend is driven by passthrough drugs and clinical supplies.

Income overperformance of £1.9m

The overperformance excluding non recurrent benefits of £1.2m is £0.7m.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

# Thank you

**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 | **Workforce Sustainability –Oversight Framework:**<br>Increase of 918.81 whole-time equivalents compared to 2019/20, driven by planned developments and efforts to fill vacancies resulting in an annual pay cost increase of over £32 million.<br>Framework integrated into the governance process to oversee workforce levels and growth but no timeline provided to Committee.<br>When implemented, it would ensure that any workforce-related decisions considered the financial impact on the organisation and would apply to all staff groups, roles, and professions across the Trust.<br>Workforce sustainability and oversight plan had developed and be used as a tool for monitoring and reporting on various interventions and work streams with efforts focused enabling operations. | Committee to receive the workforce sustainability and oversight plan in November with a progress update against actions. |

**Items rated Amber**

| Item | Rationale for rating | Actions/Outcome |
|---|---|---|
| Board Assurance Framework Risk SR16: Restorative and Just Culture | Workshops conducted, working group established and funding secured for training related to Mersey Care. Some progress made but overall timeline remained impacted by the initial delay in starting this work stream.<br>Anti-Discrimination –facing delays along with need to increase staff confidence in reporting discriminatory behaviour. Staff able to use Datix system, but it lacked confidentiality especially when the alleged perpetrator was the individual's line manager or colleague who may automatically receive the report. New Trust-held reporting form being developed to address this issue, with process mapping planned throughout August 2024. | Committee to receive assurance on how delays were going to be minimised and when appropriate systems for reporting securely would be in place |
| SR17 | Being reviewed. | The Chair requested that due dates be added into the Board Assurance Framework. |
| Culture, experience, and retention | **Employer Value Proposition Strategy and Concept**<br>Core focus of the new branding was to promote pride in the services and care provided to patients, while also reflecting the values outlined in the NHS People Promise and the Trust's ambitions.<br>A review of existing recruitment assets was found to be inconsistent and lacking a clear message as to why | Whilst committee were assured of progress and update on progress of roll out requested in November |

| 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. |

| | | |
|---|---|---|
| | candidates would choose to work at Gloucestershire Hospitals. Recruitment was ad hoc across social media, with no structured approach. The team had conducted research and workshops, engaging a diverse group of staff. The feedback was instrumental in developing the new strategy.<br><br>Development phase is underway starting with development of a new recruitment website, to better communicate the reasons to join the Trust and showcase the cultural and organisational achievements.<br><br>Staff engagement took place and new strapline, logo and visual identity were developed. Vision to foster a culture within the hospitals, where everyone felt listened to and valued. A new style for the website and an intranet page would be set up with endorsement from the CEO. | |
| **Workforce Disability Equality Standard / Workforce Race and Equality Standard Submission** | The committee approved the Workforce Disability Equality Standard / Workforce Race and Equality Standard report.<br><br>Visible improvement in 7 out of the 10 metrics, with 3 were showing worse reporting. Trust Equality, Diversity, and Inclusion development plan created to address outstanding actions related to the Workforce Race Equality Standard.<br><br>Listening events organised in respect of staff experiences of harassment, bullying or abuse from patients, multiple, particularly for internationally educated colleagues.<br><br>Data at a divisional level now accessible, allowing for more targeted action plans. | Committee to receive updates on plans to ensure national standards would be met, and impact of changes to ensure greater accountability at divisional level. |
| **International Educated Nurse Experience** | Trust had successfully integrated 750 internationally educated nurses into the organisation, with 135 of these professionals joining between April 2023, and March 2024.<br><br>Improvements were outlined to the Committee.<br><br>Query around what training was provided to the hosting wards/teams that were receiving the internationally recruited staff members, actions to support colleagues who did not pass the objective structured clinical examinations and percentage of individuals recruited that stayed in the Trust.<br><br>Confirmed pass rates for examinations had varied across cohorts. Highest first-time pass rate achieved was around 69-70%, but the valuable clinical space had been repurposed for operational needs, leading to fluctuations in pass rates.<br><br>Committee were reassured the organisation supported individuals who did not pass on their first attempt by allowing them to retake the exam up to 3 times. One case where an individual did not pass on the third | |

| | | |
|---|---|---|
| | attempt and was offered a substantive contract as a healthcare support worker, enabling the individual to remain employed before reapplying. | |
| People Performance Dashboard | Report was a slightly out of date due to the timing of Committee but going forward would be part of the integrated performance report (IPR) to be reported through this group and Board.<br><br>Significant changes to reporting taking place which would be tested in August and format to be amended to align with the content in the Integrated Performance Report. | |
| Health and Safety | **Health & Safety Update:**<br><br>Committee noted the Health and Safety Executive (HSE) inspections at Cheltenham and Gloucester sites (arrangements for managing violence and aggression, manual handling practices) - HSE would not be taking any further action against the Trust but requested updates on new arrangements implemented, particularly concerning our violence and aggression (VNA) strategies.<br><br>Updated report, on security, and violence and aggression aspects would be presented to next PoDC.<br><br>Noted whilst the People and OD Committee had overall responsibility for Health and Safety, relevant technical leads were not present, to advise the committee but it was confirmed that wider issues had been discussed at Quality and Performance Committee.<br><br>Pseudomonas action plan - 89 out of 116 actions completed. ZetaSafe software for monitoring water management services was pending at Cheltenham General Hospital due to challenges in integrating outlets into the system with reporting expected in July 2024. Annual reviews of Pseudomonas risk assessments in augmented care areas conducted.<br><br>Concerns with GMS regarding water safety, specifically the lack of timely reviews and updates to Legionella risk assessments. GMS had hired a consultant to update the assessments for the remaining areas in GRH and CGG and comprehensive risk assessments to be completed by the consultant, with priority given to areas currently under interim assessment.<br><br>Health and Safety Committee confirmed Fire Safety risk assessments were up to date and compliant, but concerns remain about the difficulty in monitoring actions without a digital system and the need for a suitable workable digital solution were urgent.<br><br>COO expressed concerns to the Trust Leadership Team about non-compliance in evacuation and shelter training lack of recent or historical training records and current sessions not capturing all staff, particularly those on | PoDC to be kept updated on key health and safety issues at each meeting.<br><br>Committee to receive updated report on security, V&A at next meeting.<br><br>Updates on all high-risk areas to be reported to next PoDC with action plans and timescales. |

| | | |
|---|---|---|
| | night shifts or days off. Fire Safety Group to confirm minimum attendance requirement for compliance and new areas must receive training within 6 months of handover.<br><br>Health and Safety Plan for 2024-2026 developed and agreed by Health and Safety Committee. | |

**Items not Rated**

**Risk Register**

- No new emerging risks.
- No closed risks to report.

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# People & Organisational Development Committee Performance Dashboard

**July 2024**

**Deborah Tunnell**
**Deputy Director for People & Organisational Development**

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# Executive Summary

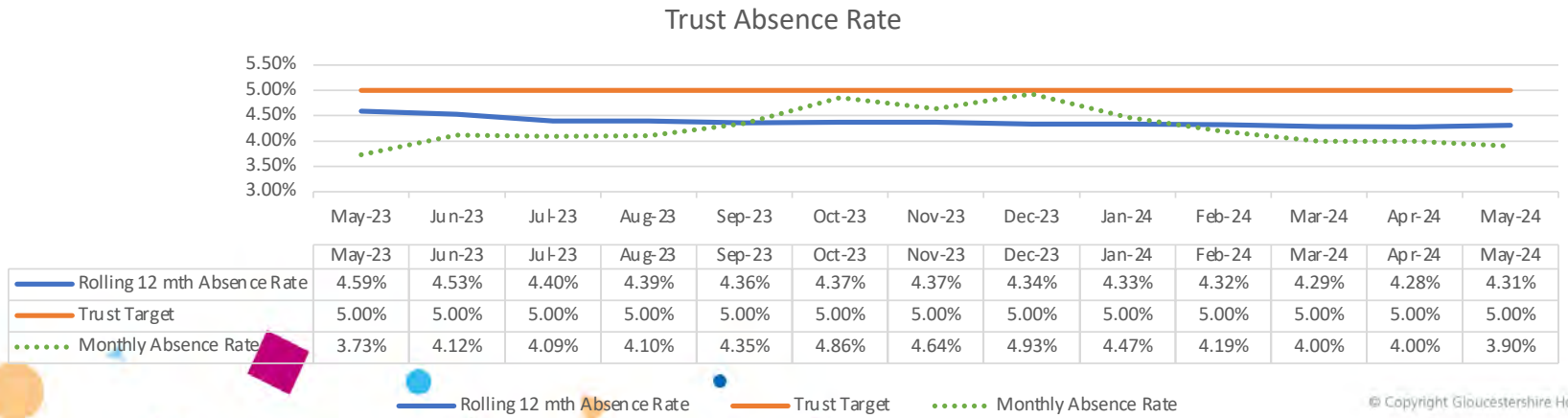
| Performance Indicator | Target | June-23 | July-23 | Aug-23 | Sept-23 | Oct-23 | Nov-23 | Dec-23 | Jan 24 | Feb 24 | Mar 24 | Apr 24 | May 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Turnover** | **13%** | 12.23% | 12.12% | 11.65% | 11.56% | 11.38% | 11.37% | 11.27% | 11.06% | 10.82% | 10.93% | 10.58% | 10.35% |
| **Vacancy** | **8%** | 7.40% | 7.05% | 7.05% | 6.31% | 6.43% | 5.86% | 6.54% | 6.90% | 6.65% | 6.59% | 6.11% | 6% |
| **Sickness** | **5%** | 4.52% | 4.40% | 4.27% | 4.34% | 4.36% | 4.36% | 4.34% | 4.33% | 4.32% | 4.29% | 4.28% | 4.31% |
| **Appraisal** | **90%** | 80% | 79% | 79% | 79% | 79% | 79% | 80% | 79% | 79% | 78% | 80% | 80% |
| **Essential Training** | **90%** | 88% | 87% | 87% | 87% | 86% | 86% | 85% | 85% | 86% | 85% | 86% | 86% |
| **Agency** (FTE & % of establishment) | **2%** | 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%) | 98 (1.2%) | 94 (1.2%) |
| **Bank** (FTE & % of establishment) | **6.5%** | 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%) | 686 (8.7%) | 599 (7.6%) |

**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 |
|---|
| Although the monthly sickness absence rate for May (3.90%) has decreased by 0.10% since Apr, the 12 month rolling sickness absence rate has seen a 0.03% increase from Apr 24 (4.28%) to May 24 at 4.31% |
| The 12 month rolling sickness rate as at May 2024 is the first month since Oct 23 when sickness absence has been recorded as higher than the previous month. |
| The 12 month rolling sickness absence as at May 2024 is currently 0.69% under the Trust target. |

| Improvement actions | Due Date | RAG |
|---|---|---|
| A number of Divisions are participating in Sickness Management workshops. HR Operations Manager to review content and support consistent delivery via People Advisory Team. | June 2024 | |
| Additional training on ESR use for the People Advisory team has been completed. HR Operations Manager will support People Advisory Team with consistency of data input. HR Administrator now producing and sharing costs of sickness absence via HR Advisors and HRBP's to further support sickness absence management. | August 2024 | |
| HR Operations Manager and People Advisory team have developed actions points following a team workshop in June to review all elements of the sickness management process including policy/data/ recording/letters/templates/Working Well support with actions/amendments to be shared with AD HR and Resourcing. | August 2024 | |

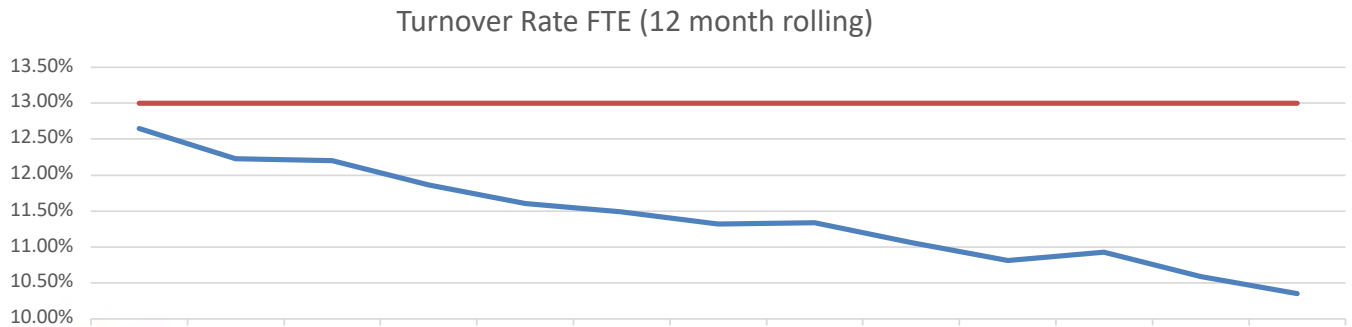



| | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rolling 12 mth Absence Rate | 4.59% | 4.53% | 4.40% | 4.39% | 4.36% | 4.37% | 4.37% | 4.34% | 4.33% | 4.32% | 4.29% | 4.28% | 4.31% |
| 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% | 5.00% |
| Monthly Absence Rate | 3.73% | 4.12% | 4.09% | 4.10% | 4.35% | 4.86% | 4.64% | 4.93% | 4.47% | 4.19% | 4.00% | 4.00% | 3.90% |

# Turnover (BAF SR16 Workforce - Culture, Experience and Retention)

| Key Points to note |
|---|
| Staff turnover has seen a 0.23% decrease from April 24 to May 24, with 10.35% recorded in April 24. |
| Following a minor increase in March 24, Turnover has returned to a downward trend. |
| May 2024 Turnover is currently 2.65% 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 | |
| Retention Group – scheduling launch of ESR Exit Questionnaire in July which will enable better recording and reporting of the reasons people leave the Trust. This will be supported by launch of updated leaver/exit guidelines, checklists, process maps. | July 2024 | |
| People Promise Partner has commenced in post and is leading the submission of initial self-assessment /benchmarking data to NHS England | June 2024 | |




| | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Turnover | 12.58% | 12.22% | 12.20% | 11.86% | 11.60% | 11.48% | 11.32% | 11.34% | 11.06% | 10.82% | 10.93% | 10.59% | 10.35% |
| 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% | 13.00% |

# Statutory & Mandatory Training (BAF SR16 Workforce - Culture, Experience and Retention)

**KPI - 90% compliance target**

**Breakdown by Division**

| | 31-May | 30-Apr | 31-Mar |
|---|---|---|---|
| **GHT Total** | **86%** | **86%** | **85%** |
| Corporate | 91% | 91% | 90% |
| Diagnostics & Specialty | 88% | 88% | 87% |
| Medicine | 87% | 87% | 86% |
| Non-Division | 87% | 86% | 82% |
| Surgery | 85% | 84% | 83% |
| Womens & Children | 81% | 80% | 80% |

**Breakdown by Training Competency**

| | 31-May | 30-Apr | 31-Mar |
|---|---|---|---|
| 318\|LOCAL\|Moving and Handling Level 2 (2yr)\| | 86% | 85% | 85% |
| 318\|LOCAL\|Safeguarding Adults Level 2\| (combined with Level 3 until April) | 55% | 47% | 46% |
| 318\|LOCAL\|Safeguarding Adults Level 3\| | 47% | n/a | n/a |
| NHS\|CSTF\|Equality, Diversity and Human Rights - 3 Years\| | 92% | 91% | 91% |
| NHS\|CSTF\|Fire Safety - 1 Year\| | 90% | 89% | 88% |
| NHS\|CSTF\|Health, Safety and Welfare - 3 Years\| | 91% | 91% | 91% |
| NHS\|CSTF\|Infection Prevention and Control - Level 1 - 3 Years\| | 97% | 97% | 97% |
| NHS\|CSTF\|Infection Prevention and Control - Level 2 - 1 Year\| | 86% | 85% | 84% |
| NHS\|CSTF\|Information Governance and Data Security - 1 Year\| | 88% | 88% | 87% |
| NHS\|CSTF\|Moving and Handling - Level 1 - 2 Years\| | 87% | 87% | 87% |
| NHS\|CSTF\|NHS Conflict Resolution (England) - 3 Years\| | 94% | 93% | 93% |
| NHS\|CSTF\|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year\| | 86% | 85% | 84% |
| NHS\|CSTF\|Safeguarding Adults - Level 1 - 3 Years\| | 91% | 90% | 89% |
| NHS\|CSTF\|Safeguarding Children (Version 2) - Level 1 - 3 Years\| | 89% | 89% | 89% |
| NHS\|CSTF\|Safeguarding Children (Version 2) - Level 2 - 3 Years\| | 87% | 87% | 87% |

**Breakdown by Staff Group**

| | 31-May | 30-Apr | 31-Mar |
|---|---|---|---|
| Add Prof Scientific and Technical | 84% | 84% | 83% |
| Additional Clinical Services | 90% | 89% | 88% |
| Administrative and Clerical | 94% | 93% | 92% |
| Allied Health Professionals | 87% | 87% | 86% |
| Estates and Ancillary | 88% | 87% | 88% |
| Healthcare Scientists | 88% | 86% | 88% |
| Medical Staff - Consultants | 79% | 79% | 79% |
| Medical Staff - SAS Senior | 76% | 75% | 75% |
| Medical Staff - Training Grades | 57% | 56% | 56% |
| Nursing and Midwifery Registered | 88% | 87% | 86% |

**Compliance Rate Highlight key** Less than 70% | 70%-89% | 90% and above

(Information Governance only) Less than 95% | 95% and above

## Key Points to note

The Trust's overall compliance has remained consistent from April to May at 86%.

No Division has seen a decrease from April to May. Corporate, D&S and Medicine have remained consistent. Non Division, Surgery and W&C divisions have seen an increase of 1%.

Safeguarding L2 has seen the greatest increase of 8% from Apr to May. Six of the competencies have seen a 1% increase from Apr to May, with the remaining seven remaining consistent from the previous month.

| Improvement Actions | Due Date | RAG |
|---|---|---|
| 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 | Oct 2024 | |
| Head of Corporate Learning & Development has commenced a review of the reporting process for Statutory & Mandatory Training compliance leading to a proposal for improved governance routes and defined roles & responsibilities | July 2024 | |

# Appraisal (BAF SR16 Workforce - Culture, Experience and Retention)

**KPI - 90% compliance target**

| | 31-May | 30-Apr | 31-Mar |
|---|---|---|---|
| **GHT Total** | **80%** | **80%** | **78%** |
| **Breakdown by Division** | | | |
| Corporate | 71% | 73% | 74% |
| Diagnostics & Specialty | 77% | 76% | 74% |
| Medicine | 85% | 84% | 83% |
| Non-Division | 65% | 88% | 88% |
| Surgery | 84% | 83% | 81% |
| Womens & Children | 81% | 79% | 76% |

**Breakdown by Staff Group**

| | | | |
|---|---|---|---|
| Add Prof Scientific and Technical | 66% | 63% | 60% |
| Additional Clinical Services | 85% | 84% | 82% |
| Administrative and Clerical | 71% | 72% | 71% |
| Allied Health Professionals | 74% | 75% | 76% |
| Estates and Ancillary | 65% | 73% | 75% |
| Healthcare Scientists | 81% | 78% | 76% |
| Medical Staff - Consultants | 91% | 92% | 93% |
| Medical Staff - SAS Senior | 76% | 72% | 74% |
| Nursing and Midwifery Registered | 85% | 84% | 81% |

Compliance rate highlight key — Less than 70% — 70%-89% — 90% and above

| Key Points to note |
|---|
| The Trust has remained consistent in overall compliance at 80% from April to May. |
| Non Division has seen a 23% decrease and from April to May. Medicine, Surgery and D&S have all seen a 1% increase, and W&C a 2% increase from the previous month. Corporate has seen a slight decrease of 2%. |
| Medical – SAS has seen the greatest increase of 4%, closely followed by AddProfSciTech and Healthcare Scientists who has seen a 3% increase from the previous month. |
| Estates & Ancillary has seen the greatest decrease of 8%, with AHP being the only other group seeing a decrease of 1% from April to May. |

| Improvement Actions | Due Date | RAG |
|---|---|---|
| Non-Medical Appraisal policy and paperwork have been written and now going through Governance process for approval with planned launch mid-July 2024 | July 2024 | |
| Training materials being updated and developed to support launch. Areas with low SS scores and compliance have been identified to target as part of launch | July 2024 | |

## Health and Safety (BAF SR16 Workforce - Culture, Experience and Retention)

| Key Points to note |
|---|
| The HSE have accepted our action plan in response to their inspection and do not seek to take any further action. |
| Serious V&A incident occurred on 4b. Patient unexpectedly exhibiting delusional behaviour and attacked a staff member with broken glass. Injuries to hand(s) required stitches. Reported as RIDDOR. Further incident with different patient who lacked capacity – patient attempted to strangle staff member. |
| Security Report draft received. Trust requires amendments to the report. Awaiting final report. |
| Listeria Alert – two patients at other Trust died from Listeria following the consumption of sandwiches that matched a batch that were sample in April and which tested positive. The supplier, Real Wraps, were not shut down and continued to supply the NHS, including GMS outlets at our Trust. |
| Legionella – CDC building. This was detected in the water supply. |
| Exposure to Entonox remains an issue in Maternity and Endoscopy where ventilation does not meet the required standard |
| 10th floor leaking roof cannot be resolved due to the presence of the crane for the works. |

| Improvement Actions | Due Date | RAG |
|---|---|---|
| Robust action plan submitted to the HSE in response to the HSE NoC. Action plan has been accepted. HSE awaiting the Security Review report | May 2024 | |
| HSE action plan – action owners to progress their actions in a timely manner | July 2024 | |
| Ventilation issues in Endoscopy have been raised with Associate Director for Estates – agreed to provide an Authorised Engineer to review | May 2024 | |
| Listeria - Inpatient areas where sandwiches were supplied have been identified and goods removed. All fridges were checked. Communication to staff to check staff fridges. | June 2024 | |
| Legionella meeting called. Immediate actions put in place to provided bottled water to clinics. Filters added to taps and further investigation to establish cause. To be led by water safety Group | June 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 | |
| 10th floor action plan in progress. Awaiting decision on windows | July 2024 | |

# Freedom to Speak Up (BAF SR16 Workforce - Culture, Experience and Retention)

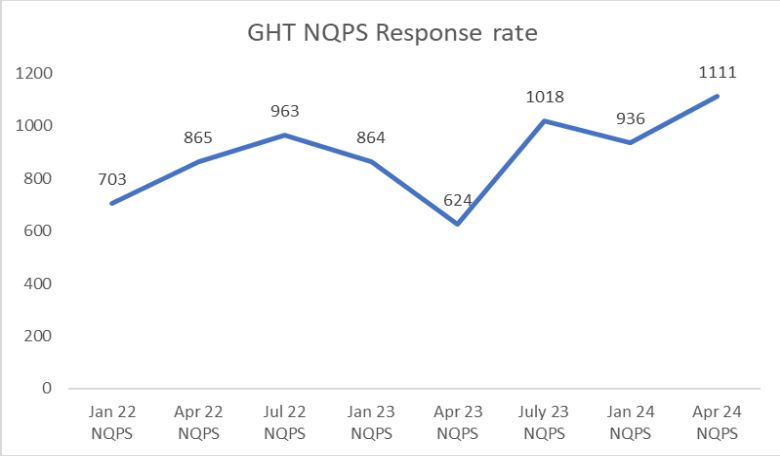
| Key Points to note |
|---|
| At the end of 2023/24, FTSU has supported 208 staff speak up in the organisation with over half of cases relating to staff behaviours and the impact of poor behaviours. . |
| FTSU anonymous reporting has reduced to 11.5% bringing it more in line with National data of 9.3% |
| The external FTSU audit has been completed with improvements set for the next year. |
| Work has begun to recruit champions into the champion network. |
| New FTSU Guardian started in post June 2024. |

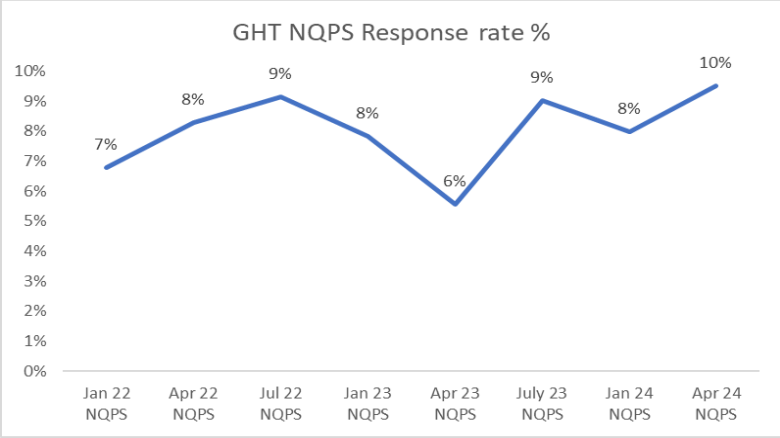
| Improvement Actions | Date Due | RAG |
|---|---|---|
| Review of patient safety concerns raised to FTSU. Terms of Reference set Jan 2024 | End of Q1 | |
| Launch of FTSU champions | July 2024 | |

Freedom to Speak Up Guardian
www.nationalguardian.org.uk

Your voice matters

# Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)




| Key Points to note |
| --- |
| April 2024 has seen the highest number of responses to the NQPS since it started however, when compared to the increase in headcount across the organisation the increase in response percentage is not significant. |
| April 2024 has seen the highest % response rate of the workforce since the NQPS started.<br><br>Workforce numbers include GMS & Bank staff as the NQPS is open to all. |

# Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)

**Key Points to note**

All NQPS questions that align to the Staff Experience Improvement Programme have statistically significantly improved from April 23 to April 24 demonstrating that the programme is having a positive impact

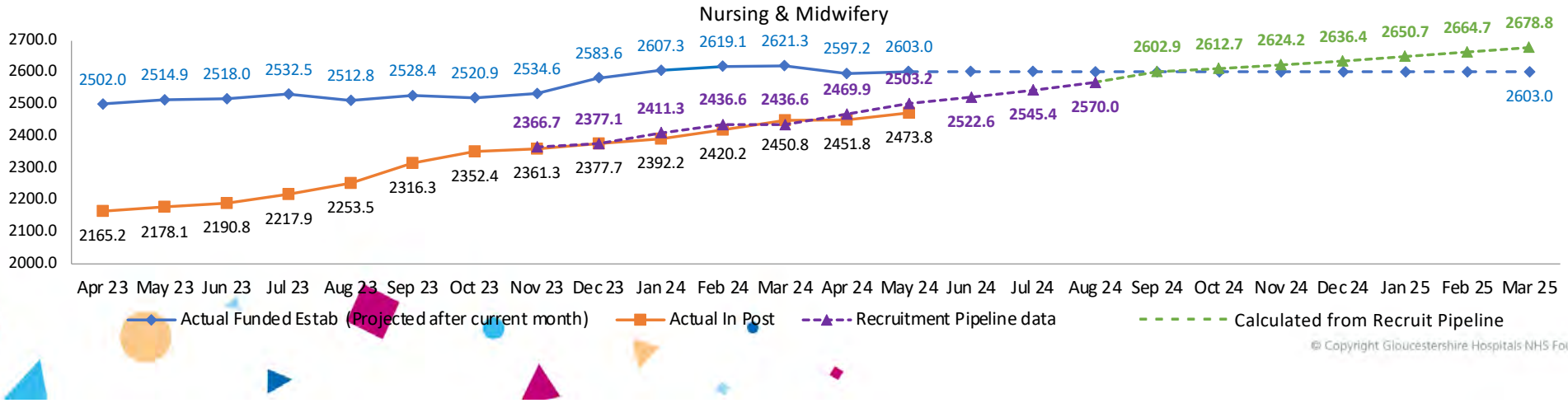
| Workstream | Statement | NQPS April 2024 | NQPS Jan 2024 | Increase or decrease (-) since Jan 24 | NQPS April 2023 | Increase or decrease (-) since April 23 |
|---|---|---|---|---|---|---|
| Teamwork and leadership | In my team disagreements are dealt with constructively | 47.9% | 45.1% | 2.8% | 41.7% | 6.2% |
| | Teams within this organisation work well together to achieve their objectives | 39.6% | 37.5% | 2.1% | 30.1% | 9.5% |
| | My immediate manager asks for my opinion before making decisions that affect my work | 50.7% | 49.0% | 1.6% | 42.0% | 8.7% |
| | My immediate manager takes a positive interest in my health and wellbeing | 62.8% | 62.4% | 0.4% | 55.0% | 7.8% |
| Anti-Discrimination | I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas etc.) | 63.8% | 58.1% | 5.7% | 46.0% | 17.8% |
| | The people I work with are polite and treat each other with respect | 65.8% | 63.0% | 2.8% | 59.3% | 6.5% |
| | In the last 3 months have you personally experienced discrimination at work from your manager/team leader or other colleagues? (No) | 87.8% | 85.3% | 2.6% | 83.8% | 4.0% |
| | In the last 3 months have you personally experienced harassment, bullying or abuse at work from your manager/team leader or other colleagues? (No) | 85.8% | 85.3% | 0.5% | 78.4% | 7.4% |
| Building a safe speaking up culture | I would feel secure raising concerns about unsafe clinical practice | 58.4% | 54.1% | 4.3% | 52.9% | 5.5% |
| | I would feel confident that the organisation would address concerns about unsafe clinical practice | 46.9% | 42.0% | 4.9% | 36.7% | 10.2% |
| | If I had a concern, I would feel confident to raise it with a Freedom to Speak Up Guardian | 55.2% | 52.6% | 2.5% | 44.1% | 11.1% |

| Improvement Actions | Due Date | RAG |
|---|---|---|
| **Leadership and Teamwork**<br>• 33 hours of ALS delivered, with 63 leaders<br>• 12 hours of leader workshops delivered, with 33 leaders<br>• 13 hours of team sessions delivered | | |
| **Anti-Discrimination**<br>EDI intranet is being finalised with the comms team and is on track to be delivered by the end of May 24.<br>Following the tackling bad behaviours workshop and RJC workstream launch meeting, the scope of this workstream has become clearer. Programme documentation has been updated to reflect the commencement of the RJC workstream. The deliverables are; develop EDI Intranet presence; develop and implement an appropriate reporting tool and process for discrimination; EDI team to develop and implement an EDI service action plan using the overarching EDI development plan. | | |
| **Speaking Up**<br>External audit now complete, some of these actions will form part of the workstream action plan<br>FTSU Guardian recruited – start date June 2024 | | |
| **Restorative Just and Learning Culture**<br>Full project plan is in development.<br>TLT asked to note their responsibilities for implementing this approach | | |
| **People Promise Exemplar Programme**<br>The People Promise Partner commenced in post on 29th May.<br>The self assessment is almost complete which will inform the priorities we need to address, this in turn will identify the initiatives taken forward | | |
| **Taskforce – New Starter Packs and 24/7 Hot Food**<br>Distribution of packs went live Monday 3rd June.<br>Email will be sent to all new starters at the end of the first month to obtain feedback from new colleagues regarding their welcome pack | | |

# Recruitment Pipeline (BAF SR17 Workforce - Recruitment & Attraction)

| Key Points to Note |
|---|
| A continued increase in Nursing and Midwifery numbers, sees the Trust closing the gap to funded establishment. As at May 2024, the difference stands at 129.2 WTE. |
| Future projections of starters & leavers will mean that in September 2024 our projected recruitment pipeline will hit the Trust's funded establishment |
| Ongoing support of our Newly Qualified Registered nurses remain a focus to ensure they are all onboarded post graduation (summer 2024). Current challenges exist to place into teams/divisions. |

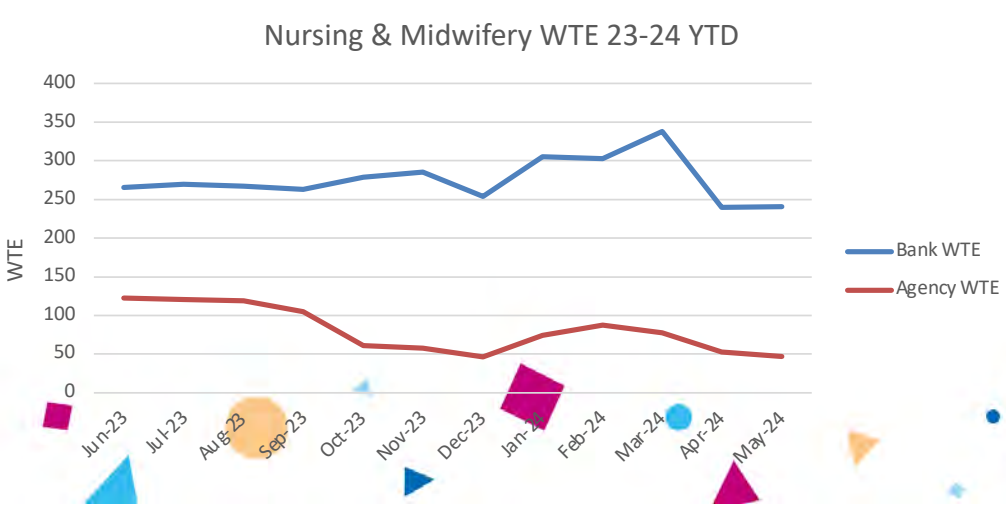
| Improvement Actions | Date Due | RAG |
|---|---|---|
| Currently supporting Midwifery with recruitment needs including hard to fill roles. Development of a creative brand awareness video, followed by 3 month social media campaign, to support the current recruitment needs. | September 2024 | |
| A focus on Childrens Nursing is in discussion with the team, where gaps exist in establishment. This will be supported with a bespoke campaign to attract new colleagues in to the Trust. | September 2024 | |
| Due to the focus on Midwifery and Childrens Nursing, a showcase event is planned for October with support from the Women's and Childrens Division to promote career opportunities. | October 2024 | |

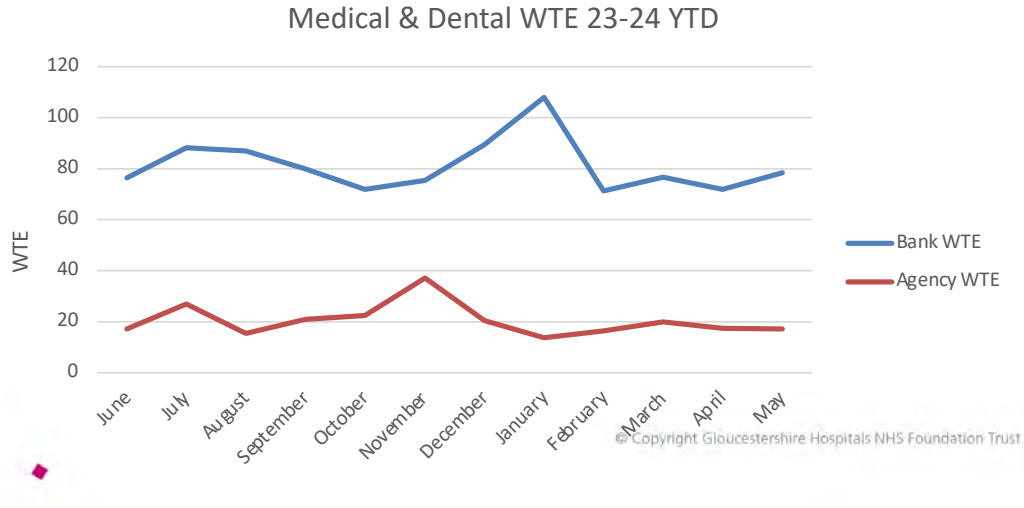


# Bank and Agency WTE (BAF SR17 Workforce - Recruitment & Attraction)

| Key Points to Note |
|---|
| Bank spend for Medics in M02 - £1.1m (increase from M01)<br>Agency spend for Medics in M02 - £657k (increase from M01) |
| Bank spend for Nursing & Midwifery in M02 - £2.07m (increase from M01)<br>Agency spend for Nursing & Midwifery in M02 - £429k (increase from M01) |
| The Medical Grip & Control meetings have gained traction and now include representation from all Divisions. Initial aims and actions involve a review of the locum break policy and locum enhancements. |
| The Nursing Agency Reduction meetings continue to monitor temporary staffing usage through Optima reports, including scrutinising all additional and optional shifts utilised on a weekly basis.<br>NHSE mandate for all off-framework usage to cease from 1st July 2024. |

| Improvement Actions | Date Due | RAG |
|---|---|---|
| Non-clinical temporary staffing usage reported to NHSE in May for the first time. Next steps is to upload pay rates in to the roster system for improved reporting on spend. | 1st August 2024 | |
| Two locum medics papers have been prepared and presented to PAG. Both papers include options for approving before progressing to DOAG and potentially TLT.<br>• A review of locum enhancements – applying standard approach across the board.<br>• A review of the locum breaks process – and evidence to show how much in paid breaks the trust it paying. | 1st August 2024 | |
| The Trust must be NHSE cap compliant for 95% of it's agency usage and have no off-framework agency usage after 1st July. | 1st July 2024 | |

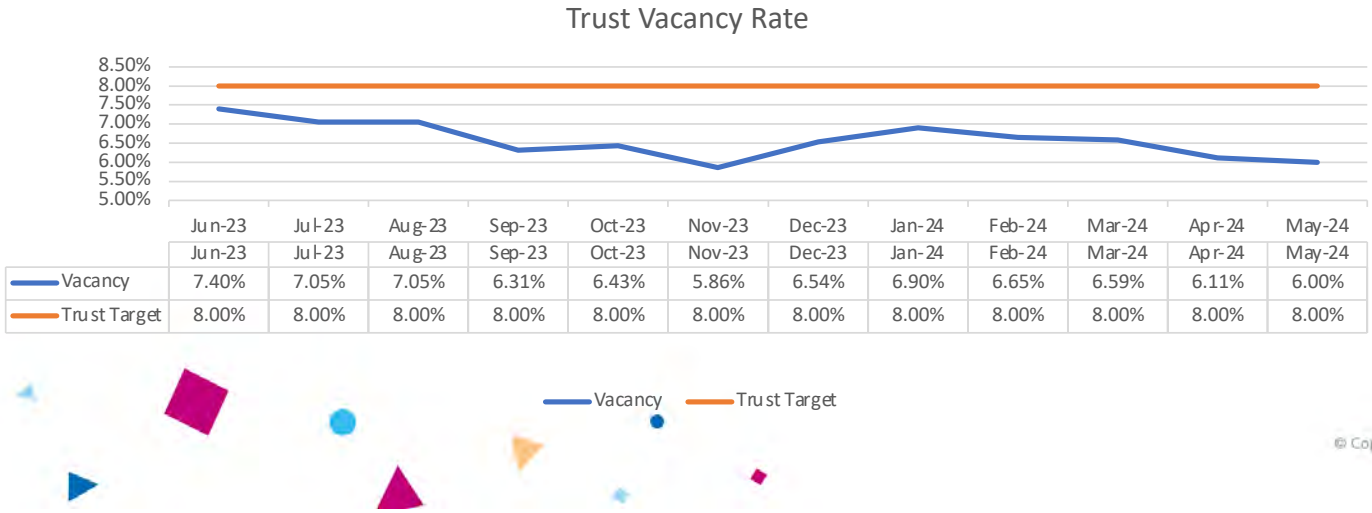


# Vacancies (BAF SR17 Workforce - Recruitment & Attraction)

| Key Points to note |
|---|
| The Trust vacancies for May 2024 are only 0.14% from the lowest recorded vacancies in the last 12 month period (November 2023 5.86%). |
| May 2024 has seen a 0.11% decrease from the previous month. |
| In May 2024, the Vacancy is 2% under the Trust target. |

| Improvement Actions | Date Due | RAG |
|---|---|---|
| A continued strong performance in the overall Trust vacancy rate with progress in Time to Hire and retention of staff. | Ongoing focus | |
| A new monthly, division focussed, Hard to Fill meeting set up to collate information and collaborate on areas that have challenges to recruit. | July 2024 | |
| The Trust's new recruitment brand and proposition through the design of an Employer Value Proposition (EVP), will launch internally July 2024, with the external launch, along with a new recruitment website to follow thereafter. | July 2024 | |

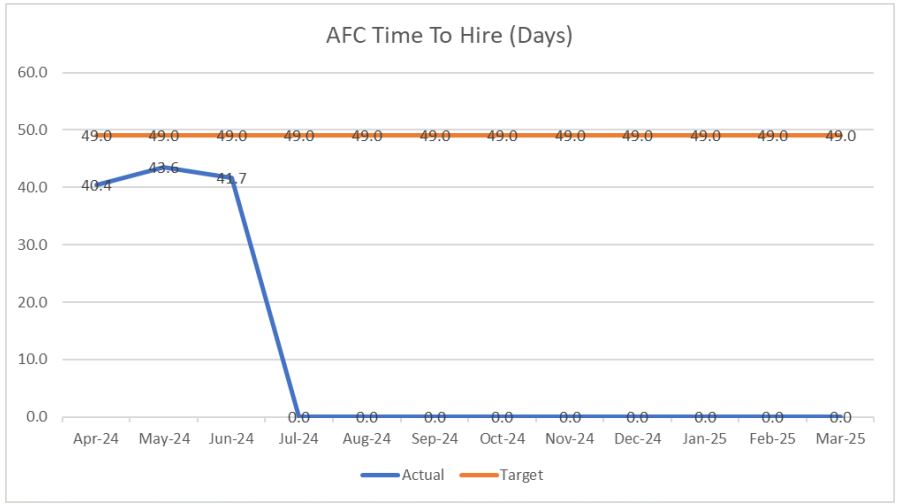



| | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 |
| Vacancy | 7.40% | 7.05% | 7.05% | 6.31% | 6.43% | 5.86% | 6.54% | 6.90% | 6.65% | 6.59% | 6.11% | 6.00% |
| 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 |
|---|
| We still remain under the target of 49 days for Time to Hire with the Trust average in June at 41.7 days. Although we saw a slight increase compared to April, it is predicted with further efficiencies to come in ID Verification Technology (IDVT) and OH integration, will see further reductions. |
| Challenges still exist with chasing recruiting managers for shortlisting, updating interview outcomes and additional VCP approval; which is being monitored and support provided. |

| Improvement Actions | Date Due | RAG |
|---|---|---|
| Rollout of TRAC VCP to Corporate delayed to include the new Workforce Controls process. | May 2024 | |
| IDVT rolled out to Medical Staffing as trial with Doctors. Initial testing completed with full rollout to General Recruitment in July 2024. Initial results have seen ID checks completed in 24 hours. | 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-24 | 40.4 | 49.0 |
| May-24 | 43.6 | 49.0 |
| Jun-24 | 41.7 | 49.0 |
| Jul-24 | 0.0 | 49.0 |
| Aug-24 | 0.0 | 49.0 |
| Sep-24 | 0.0 | 49.0 |
| Oct-24 | 0.0 | 49.0 |
| Nov-24 | 0.0 | 49.0 |
| Dec-24 | 0.0 | 49.0 |
| Jan-25 | 0.0 | 49.0 |
| Feb-25 | 0.0 | 49.0 |
| Mar-25 | 0.0 | 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 141 withdrawing at interview stage, 30 (21.2%) 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 the highest attrition through the recruitment process |
| Overall, 237 candidates withdrew their applications during the recruitment stages shown below in May 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** | 20 | 2 | 76 | 12 | 8 | 1 | 22 | 141 |
| **Longlisting** | 31 | | 28 | 6 | 4 | 2 | 7 | 78 |
| **Offer** | 1 | | 3 | | | 1 | 1 | 6 |
| **Shortlisting** | 2 | | 8 | | | | 2 | 12 |
| **Grand Total** | **54** | **2** | **115** | **18** | **12** | **4** | **32** | **237** |

Gloucestershire Hospitals NHS Foundation Trust

## 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
# FINANCE AND RESOURCES COMMITTEE – AUGUST 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 Report - Month 4 | Performance at month 4 was ahead of plan by £2.8m, with £9.6m of savings delivered. To date £15.4m of the annual target of £37m of plans are either unidentified or of a non-recurrent nature.<br><br>Positive progress at system level – particularly the productivity agenda. | Financial Improvement Board (new title) will receive a timetable for delivery in August.<br><br>Full plan for delivery to next meeting.<br><br>Quarterly update in future. |
| Financial Performance Report - Month 4 | The Month 4 financial position was an adverse variance of £616k against a deficit plan of £6.9m. Whole time equivalent numbers continued to reduce but remained above the baseline target. Other staffing pressures and supply increases accounted for the remainder of the deficit. | The Committee noted the position and received the report as a source of assurance that the financial position was understood. |
| Capital Programme Report - Month 4 | At month 4 spend was £6.3m behind plan – expenditure of £6.8m against a plan of £13.1m. A deep dive review of capital schemes was underway and would be reported to the next meeting.<br><br>A number of IFRS 16 contracts were under review.<br><br>A breakeven position is forecast for the year after a number of within budget virements had been agreed by the Capital Delivery Group. | Outcome of deep dive review to next meeting.<br><br>The committee received the report as evidence of assurance of the position and delegated authority to the Director of Finance to approve the Cobalt MRI services contract in consultation with the Committee Chair or Vice Chair. |

**Items rated Amber**

| Item | Rationale for rating | Actions/Outcome |
|---|---|---|
| GMS Business Plan 2024/25 | The Business Plan had been through a number of Trust and GMS groups prior to submission to this committee and reflected the outcomes of the recent review of GMS. There was an increased clarity around targets, responsibilities for delivery and forecast dividend. The plan reflected the new organisational structure and strengthened governance arrangements.<br><br>The Committee noted that at the end of Q1, GMS was £40k behind the planned dividend of £495k. | The Committee approved the GMS Business Plan and the budget proposal and noted that the additional funds related to the GMS Review were separate to these figures. |

| 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 Green | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/Outcome** |
| National Cost Collection 2024 Submission | The Committee reviewed the submission and was assured regarding the content. | The Committee reviewed and approved the National Cost Collection output and would provide assurance to the Board that the submission for 2024 had been completed. |
| **Items not Rated** | | |
| None | | |
| **Investments** | | |
| **Case** | **Approval** | |
| Cardiac MRI Business Case | The Committee APPROVED the Gloucestershire Cardiac MRI (cMRI) service Business Case. | |
| IGIS position update | The Committee APPROVED:<br>• An uplift in the value of the framework contact award to Kier to comply with procurement requirements of £2,506,733<br>• An increase in the purchase order to Kier for agreed variations of £1,703,047 plus ability to raise further purchase orders up to a maximum of £2,506,733<br>• Deferral of Cheltenham General Hospital Phase 2 works to 25/26, pending prioritisation of the overall programme, to suit funding envelope and pre-commitment of the capital programme to support its delivery. | |
| **Impact on Board Assurance Framework (BAF)** | | |
| SR 9: Failure to deliver recurrent financial sustainability – work to update the Medium-Term Financial Plan was underway and would be presented to the next meeting. | | |

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund