GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 14 November 2024 at 13:00 to 16:00

Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

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** *Deborah Evans, Trust Chair*	Information	ENC 4	13:25
8	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	ENC 5	13:35
GOVERNANCE AND ASSURANCE				
9	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	ENC 7	13:45
10	**Strategic and Operational Risk** *Kerry Rogers, Director of Integrated Governance*	Assurance	ENC 6	13:55
11	**National Health Service Provider Licence** *Kerry Rogers, Director of Integrated Governance*	Assurance	ENC 8	14:10
MATERNITY SERVICES TRANSFORMATION				
12	**Report to the Care Quality Commission - Section 31 Summary Report** *Lisa Stephens, Director of Midwifery and Dr Christine Edwards, Consultant, Obstetrics*	Assurance	ENC 9	14:15
REF	**ITEM**	**PURPOSE**	**REPORT**	**TIME**
INTEGRATED QUALITY AND PERFORMANCE REPORTING				
13	**Integrated Performance Report (Operational Performance)** *Al Sheward, Chief Operating Officer, Prof Mark Pietroni, Medical Director & Director of Safety and Matt Holdaway, Director of Quality and Chief Nurse*	Assurance	ENC 11	14:40

[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.

14	**Quality and Performance Committee Key Issues and Assurance Report** *Sam Foster, Non-Executive Director*	Assurance	ENC 12	
	Winter Plan *Al Sheward, Chief Operating Officer*	Approval	ENC 13	
	Learning from Deaths Report *Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO*	Approval	ENC 14	
PEOPLE AND ORGANISATIONAL DEVELOPMENT				
15	**People and Organisational Development Committee Key Issues and Assurance Report** *Balvinder Heran, Non-Executive Director*	Approval	ENC 15	15:10
	Workplace Race Equality Standard / Workforce Disability Equality Standard (WRES/WDES) Submission *Claire Radley, Director for People and Organisational Development*	Assurance	ENC 16	
	Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training, 1 January to 30 June 2024 *Dr Shyam Bhakthavalsala, Guardian of Safe Working* *Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO*	Approval	ENC 17	
FINANCE AND RESOURCES				
16	**Finance and Resources Committee Key Issues and Assurance Report** *Jaki Meekings-Davis, Non-Executive Director*	Approval	ENC 18	15:20
	Emergency Planning Response and Resilience (EPRR) *Al Sheward, Chief Operating Officer*	Approval	ENC 19	
STANDING ITEMS				
17	**Any other business and questions on consent items**	Information		15:40
18	**Governor observations**	Information		
19	**Date and time of next meeting** *Thursday 16 January 2025, 09.00 to 12.00 Venue to be confirmed.*	Information		
Close by 16:00				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Draft Minutes of the Board of Directors' meeting held in Public.
Thursday 12 September 2024, 11.15am
Museum of Gloucester, Brunswick Road, Gloucester, GL1 1HP

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
Claire Radley	CR	Director for People and Organisational Development
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
Attending		
Sian Batchelor	SB	
James Brown	JB	Director of Engagement, Involvement and Communications
Mike Ellis	ME	Public Governor (Cheltenham)
Lisa Evans	LE	Deputy Trust Secretary
Katherine Holland	KH	Head of Patient Experience
Bren McInnerney	BM	Member of the Public
Juwairiyia Motala	JM	Community Engagement and Involvement Manager
Susan Mountcastle	SM	Public Governor (Forest of Dean)
Apologies		
Helen Ainsbury	HA	Chief Digital & Information Officer (Interim)
Andrea Holder	AH	Lead Governor and Public Governor (Tewkesbury)

Ref.	**Item**
43/24	**Chair's welcome and introduction**
	The Chair extended a warm welcome to all present. The meeting was declared quorate.
44/24	**Apologies for absence**
	Apologies for absence were noted as above.
45/24	**Declarations of interest**
	There were no declarations of interests.
Ref.	**Item**

46/24	**Minutes of previous meeting**
	RESOLVED: The Board **APPROVED** the minutes of the meeting held on 11 July 2024.
47/24	**Matters arising**
	RESOLVED: The Board **NOTED** the update on matters arising and **APPROVED** the CLOSED item.
48/24	**Patient Story**
	Katherine Holland presented the results of the National Inpatient Survey 2023. The story demonstrated where the Trust had provided a positive experience for patients and where we could learn from good practice. It highlighted areas where focused improvement was required. Katherine reported that each month the majority (89.5% August 2024) of inpatients reported through the Friends and Family Test that they had received good care. The update included the experiences of the 526 patients that completed the National Inpatient Survey 2023. The Board noted that all of those patients stayed at least 24 hours and received either emergency or elective care during November 2023. Board members noted that the experiences of the patients using Trust services was 'about the same' compared to other Trusts. There was some really good practice and excellent care being delivered to some of our patients, with some areas for improvement noted. The following key themes and learning points were noted: • experiences were impacted by how the interactions with patients made them feel • management of patients' expectations, particularly relating to waiting was important • there was a need to ensure patients were involved in decisions about their care, including the provision of high quality, accessible information. This was necessary at all stages of a patient's journey. • provision for supporting patients with their nutritional needs was required. • cleanliness of ward or department required improvement. The Board are NOTED the story and the associated improvement work. Impact would be measured with the next survey.
49/24	**Public questions**
	The Chair noted that a question had been received from a member of the public which requested permission to distribute leaflets at the Trust Annual Members Meeting and Annual General Meeting the following month. The Board noted that this had been declined.
50/24	**Chair's Report**

	The Chair reported on the activities she had undertaken since the last meeting. This included: • A chairs visit had taken place which focussed on alternatives to conveyance to the Emergency Department. The chairs of Gloucestershire Health and Care, Integrated Care Board and a non-executive director and the medical director of South West Ambulance Trust were involved Community based admissions avoidance services such as Rapid Response and the Virtual Wards at Gloucestershire Health and Care and the integrated flow hub and virtual wards at the Trust were included • The Chair had attended a NED/Governor Visit to the Human Resources Department with the lead governor. Many of the team attended and achievements including a reduction in time to hire to 47 days, and financial savings through e-rostering were noted. The Trust was a pilot site for a new mandatory training offer, that would mean that staff could take their NHS training record to any NHS Trust. The Chair welcomed the publication of the Darzi report. It provided an appraisal of the whole NHS system and addressed the key issues affecting organisations. It included submissions from across the NHS and input from other groups.
51/24	**Chief Executive's Report**
	Kevin McNamara reported on the Lord Darzi Review which was published that day. Data and intelligence had been considered and the review provided an understanding of the current performance of the NHS across England and the challenges facing the healthcare system. Key headlines included the level of capital investment, which was a significant issue for this Trust. The report also discussed productivity and the Board noted that additional investment would not come without requirements on the Trust. Kevin noted that the report would feed into the 10 year plan for Health and any spending reviews. The Darzi report would ensure that a new plan was focussed on the challenges and would open a conversation about expectations and improvement required, considering what was realistic. Communication would go out to Trust staff that week. Work had begun to develop a new Trust Strategy, with an aim to publish by the end of the financial year. Positive movement around the Junior doctor's industrial action was noted. The outcome was likely to be known the following month. Potential collective action in primary care was noted. The Board noted that an article in the Health Service Journal had indicated that 19 trusts required support around ambulance handovers, including this Trust. Support had been offered in 2 of the 6 key areas and Kevin reported that he had expressed interest. The Trust's own survey work had shown that 1 in 5 ambulances could go elsewhere, those alternatives were being highlighted and flow was also being worked on. Kevin updated the Board following a staff story at the July Board meeting around the implementation of the PACS Digital System in May 2023. Challenges were noted, including delays to patient care and increased downtime. He thanked the teams who were managing this and some progress was noted. Kevin McNamara reported that issues had been escalated to the National and European division of Phillips.

	Claire Radley updated the Board on the National Quarterly Pulse Survey results. Significant improvements were being seen, particularly around recommending this Trust as a place to work or receive care.
52/24	**Strategic and Operational Risk**
	Kerry Rogers presented the Strategic and Operational Risk Report which provided oversight of the Trust's risk profile and in particular, the Trust's Board Assurance Framework and Trust Risk Register. The Board noted the role of the Board Committees in undertaking deep dives. Kerry reported the need to focus on effectiveness of the controls; there was more work to do, to improve how the Trust Leadership Team received an aggregated sense of the operational risk profile. There was ongoing work with teams to change reporting structures, which had started with Trust Leadership Team. The Risk Management Group's role in escalating concerns was noted. The Board received updates to the Board Assurance Framework, and Kerry Rogers reported that this document was improving. The Risk Management report was noted, Kerry reported that the PACs risk had been reviewed and there were lessons learned which would be considered in detail. The Datix Cloud risk had been de-escalated from the Trust Risk Register following a reduction of the scoring; further discussions were taking place with Helen Ainsbury, Chief Digital Officer. With the establishment of the Contract Management Group, there was growing confidence in GMS Compliance reporting and management of risk was moving to Business as Usual. John Cappock welcomed the challenge at the Trust Leadership Team around executive sponsorship of risk and noted that an alternative approach was to be developed. Risk scores were discussed. The scoring for Net Zero was considered to be low; Ian Quinnell confirmed that the Annual Sustainability Report was scheduled to go through the governance process in the autumn. **RESOLVED:** The Board **NOTED** the report.
53/24	**Audit and Assurance Committee Report**
	John Cappock, Chair of the Audit and Assurance Committee, reported that the Committee had met earlier that week on the 10 September. He noted that the audit opinion this year described the Trust as having limited assurance, although there was positive feedback received from the auditors. The trust management needed to improve responsiveness to findings in audit reports going forward. The Committee had received good quality papers in advance of the meeting and there was good progress being made on follow up actions. The meeting had received updates from the Internal and External Auditors and a report from the Internal Auditors on the Mental Capacity Act would be brought to the next meeting. A report was received from Counter Fraud was welcomed. An update on Gloucestershire Managed Services was received and the challenges facing the subsidiary were noted. The Brilliant Basics report was received; this piece of work would be the joint responsibility of the Audit and Assurance and the Finance and Resources Committees. The Losses and Compensations Report was received and the impact of small losses was discussed. **RESOLVED**: The Board **NOTED** the Audit and Assurance Committee report.
54/24	**Maternity Update**
	Care Quality Commission - Section 31 Summary Report

	Lisa Stephens, updated the Board on the key steps taken to eliminate immediate risk with respect to each point in the CQC Section 31 letter dated 9 May 2024. The Board noted that the CQC had received monthly reports, which were made available to the Board members. The summary of the current progress was noted. Lisa reported that Clinical Teams had been set up to lead improvement work and were undergoing quality improvement training. An improvement programme for Governance in Maternity was being led by the Director of Integrated Governance, the Director for Safety and Medical Director and the Director of Quality and Chief Nurse. The next report would be sent to CQC on 30 September 2024, assurance was also being provided to the Integrated Care Board, Quality Improvement Group fortnightly. Engagement was taking place with colleagues around 3 neonatal deaths in quarter 1, Lisa reported that she was not expecting any issues with achieving the required standards. Four new Maternity Neonatal Safety Investigations were reported during the quarter, this was being monitored closely. Information was being triangulated and a review was being carried out of into babies born at less than 27 weeks gestation, following data sharing it appeared that this Trust may be an outlier. The perinatal review process was to be reviewed. **RESOLVED:** The Board noted the report and contents of the table, and was assured that a robust improvement programme of work was underway.
55/24	**Maternity Update**
	Perinatal Quality and Safety Report Q4 2023-24
	Lisa Stephens outlined 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 report informed the 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 report was also presented to the Local Maternity and Neonatal System. The Board noted that a Quality and Performance Committee Maternity Meeting took place in August to discuss reporting processes. A new style of report would be taken to the Committee from October. Matt Holdaway noted that local teams had reported an increase in still births. The increased rate had led to the commencement of a Stillbirth review being undertaken by the Maternity Improvement Advisor. The Chair added that the Trust could not know if the increase represented any trend or was due to small number variation. There was further work to do and a report would be taken to the Quality and Performance Committee. Lisa Stephens reported that work was being done to improve the interpretating service and a pocket guide was also being produced. **RESOLVED:** The Board **NOTED** the risks highlighted around Post-Mastectomy Radiotherapy, the ongoing improvement work with a Quality Improvement focus and the reviews underway. The Board agreed that the Quality and Performance Committee be given delegated authority regarding Maternity Incentive Scheme Y6.
56/24	**Quality and Performance Committee Report**

	Sam Foster, presented report for the meeting held on 24 July 2024. Sam highlighted the red rated areas considered by the committee. These included the Maternity Services, and the Patient Experience Report, which had noted that the Patient Led Assessment of the Care Environment had revealed below average scores in 5 out of 8 criteria, including cleanliness, food, quality and building maintenance. 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 Business Intelligence colleagues. Another red area was the Patient Safety Investigation and complaints report. The committee continued to seek assurance regarding timeliness and handling of complaints but was confident this was being addressed. **RESOLVED:** The Committee **NOTED** the Quality and Performance Committee KIAR.
57/24	**Engagement and Involvement Annual Review - 2023-24 and Community Engagement Tracker**
	James Brown and Juwairiyia Motola presented the final draft of the Trust's Engagement and Involvement Annual Review 2022-23 and Community Engagement Tracker, which was a key milestone of the Engagement and Involvement Strategy. The Board noted that the Annual Review would be published to sit alongside the Annual Report and Quality Accounts. The review provided a summary, case studies and activities over the last year, as well as next steps. It would also be used as part of the refreshed CQC framework and expected NHS England framework for community and public engagement. The Trust's first Inclusive Language Guide was received. The Board noted the following key points: • Over the last year the Trust had been an active part of 65 groups and community events, reaching over 13,000 people, enabling us to gain valuable insight into how we could improve access to services. • The review set out who our local communities were and the challenges of health inequalities across the county. • The Trust continued to develop and improve the Community Engagement Tracker, detailing the monthly activity undertaken, themes and impact. • The work of the Trust's Young Influencers was noted. Juwairiyia reported that the Integrated Care Board was now leading on some of this work. The CQC had significantly changed the focus of much of its regulatory framework, with a primary focus on 'people and communities' and assessing how NHS organisations involved, engage and listen to local people in improving services. James Brown reported that a good discussion had taken place at Council of Governors that week. It was noted that James had agreed that lessons learned following the Panorama report would be included in the final report. **RESOLVED:** The Board APPROVED the Engagement and Involvement Annual Review and Tracker 2023-24 for publication. The Board NOTED the additional section to be added. The Board NOTED the Inclusive Language Guide to be published and shared with staff and communities.
58/24	**Integrated Care Board sign off patient safety and quality of care in pressurised services**
	The Board had received a letter from NHS England, Action required: Maintaining focus and oversight on quality of care and experience in pressurised services. The requirements of the letter were noted. This had followed a Channel 4 documentary on corridor care. Matt Holdaway reported that actions were being taken internally and the rapid cessation of corridor care was set out. The Board noted that no patients had been

	boarded in corridors or other non-established areas since July and Matt was now made aware of all patients boarded in non-designated areas. In future people would only be cared for in corridors as a last resort and only when the Trust was in Opel 4 with full system wide escalation. The next area of focus was around patients receiving care in inappropriate areas of the Emergency Department. The better care fund would be used and discussions were taking place with community colleagues. Seven day Audits were being carried out, along with Non-Executive Safety walk arounds. The Chair asked if the Urgent and Emergency Care recovery plan reflected the Winter Plan and what needed to happen to ensure that there was no corridor care over the winter. The Board noted that 20% of patients conveyed by ambulance did not need to come to the Trust if there were alternatives available. Al reported that the Winter Plan needed to be part of the existing structure rather than additional beds, he noted that the Urgent and Emergency Care Improvement Plan was looking at pathways. The role of the system in reducing pressures was noted. Al added that this Trust had a responsibility to help the South West Ambulance Trust but the Ambulance Trust was also being asked to help; there was a 6 week challenge in place to look at how people could be cared for in their own community. There was a focus on flow, better decision making around discharges and planning. The response to the letter from the Integrated Care Board would come to the next Board meeting in November. **RESOLVED:** The Board NOTED the letter received from NHS England and the work taking place to address the issues raised.
59/24	**Integrated Performance Report (Operational Performance)**
	Al Sheward presented the Quality and Performance Report (and the operational performance section of the Integrated Performance Report) for June 2024. The Board noted that workforce metrics would be included in next month's oversight framework. The Board noted the following key points: • Cancer related data was a validated position from the previous month. This was included for information but had not been through the full governance route on this occasion. This would be corrected for the September Quality and Performance Committee. Further development of this report was taking place. • Pressure ulcers and falls were 2 of the Trust's safety priorities and improvement work, using Patient Safety Incident Response Framework methods, was being implemented for oversight/thematic reviews after a safety incident was reported. • Boarding was no longer happening (corridor care with no bed space) but pre-empting (bed space imminently available (4 hours)) continued when needed in times of escalation and only for short periods. • The Trust continued to have rates above national average for Postpartum haemorrhage >1.5L. Two changes had been implemented to improve this outcome (Carbetocin and a check list) and August's data was awaited to determine if this had made an impact on outcomes. Monitoring the detection and escalation of deterioration for women and babies remained a priority for the Trust. • The combined Friends and Family Test score remained stable however there was a decline in the maternity score.

	• Karen Johnson reported that the revenue financial position showed that on a year-to-date basis the Trust was c£0.6m adverse to plan due to the impact of industrial action. Capital spend was seeing an underspend particularly in the International Financial Reporting Standard 16 (IFR16), which related to lease accounting. Financial Sustainability was on track but the Board noted that it was becoming more difficult to find savings. Agency spend was below the nationally defined upper limit however the cap was likely to reduce. The drivers of non-pay were being investigated. Al Sheward reported that this had been a busy month for system performance. For Urgent and Emergency Care: Seen within 4 hours, performance stood at 77.6% which was ahead of the trajectory. The Board noted that work streams to support this were in place. Ambulance handovers required improvement. The Trust remained an outlier and a trial looking at work in this area and to strengthen processes was taking place. Work was also taking place to reduce waiting times for elective performance. The Trust was one of the highest performing Trusts in the South West for 65 week waits. Cancer performance was noted and the key cancer standards were discussed. Challenges in the 2 week waits were noted. Quality improvement work was happening and patients were receiving treatment more quickly and the backlog was also being reduced. Performance trends in other areas was discussed. Al reported that a review found that current ways of working were not effective and a review of booking systems was taking place, education and training would be considered. Mixed Sex breaches had risen, this was associated mainly with the department of critical care, where exceptional circumstances were applied. A revision of processes was taking place and clear communications would be provided. The Board noted that while patient falls continued to reduce this was not at the same rate seen previously. A report would be taken to the next Quality and Performance Committee meeting. Professor Pietroni reported that Venous Thromboembolism assessments remained static and NHS guidelines were not being met; planned actions were outlined. Increasing Summary Hospital Mortality Indicators were noted over last 3 months; Hospital Mortality Group monthly, was reviewing this and an action plan to address clinical/coding issues was in place. **RESOLVED:** The Board **NOTED** the Integrated Performance Report for September 2024
Ref.	**Item**
58/24	**People and Organisational Development Committee Key Issues and Assurance Report**
	Balvinder Heran, Non-Executive Director, presented a report from the meeting held on 28 July 2024. The committee received an update on Workforce Sustainability and noted an increase in Whole-Time equivalents, creating a pressure on the budget. The Board assurance framework highlighted concerns including Datix not being confidential; a new reporting process was being developed. An update on the Employer Value Proposition strategy and Concept was received, a focus on branding and identity was noted. Time to recruit and time to hire had reduced. The Workforce Disability Equality Standard / Workforce Race and Equality Standard Submission was approved; improvements were noted however three metrics showed a worse position. Staff harassment remained a concern. 135 of internationally educated

	nurses joined the Trust between April 2023, and March 2024. The Health and Safety report was received. The Board noted that the People Dashboard would be included in the next Integrated Performance Report. **RESOLVED: The** Board **NOTED** the update from the People and Organisational Development Committee.
59/24	**People and Organisational Development Committee Performance Dashboard**
	The People and Organisational Development Performance Dashboard was noted.
60/24	**Finance and Resources Committee Key Issues and Assurance Report**
	Jaki Meekings-Davis, Non-Executive Director, presented the Key Issues and Assurance Report from the August meeting. The financial sustainability target for 2024/5 was a major challenge, £15.4m of the £37m target remained unidentified or non-recurrent. The month 4 position was an adverse variance of £616k against a deficit of £6.9m. Month 4 spend was £6.3m behind plan against a plan of £13.3m The GMS Business plan was received and the Committee was pleased to note the new organisational structure and robust governance arrangements in place. Two business cases were approved. **RESOLVED:** The Board **NOTED** the Finance and Resources Committee Report for August 2024
61/24	**Any other business**
	Kevin McNamara reported that a debate was to take place at Westminster regarding Maternity Services in Gloucestershire. This had been initiated by Alex McIntyre, MP for Gloucester. Kevin thanked Ian Quinnell for acting as Director for Strategy and Engagement while the permanent position was determined. The Board noted that Will Cleary-Gray would be joining the Board as Director of Improvement Delivery at the next meeting.
62/24	**Governor observations**
	Mike Ellis noted the interesting patient story. He discussed the difficulty sleeping on some wards and noted that nutrition was an area of focus for Governors. He noted the update on complaints and suggested that an update for Governors would be useful. Susan Mountcastle said that she was interested to hear that alternatives to admission at this Trust were being explored with system partners.
63/24	**Date and time of next meeting**
	Thursday 14 November 2024 at 13:00 (Lecture Hall, Redwood Education Centre)

Report to Board of Directors	
Date	14 November 2024
Title	Patient Story - Life with a Urinary Catheter
Author /Sponsoring Director/Presenter	**Authors and Presenters –** Katherine Holland, Head of Patient Experience Andy, Patient Kerry Holden, Deputy Director – Infection, Prevention and Control **Sponsoring Director -** Matt Holdaway, Director of Quality and Chief Nurse

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

Patient stories provide details and insights into experiences of illness and care. Stories can inspire and support organisations to reflect and learn. They can also act as a reminder of compassionate care. Stories can enable organisations to also improve the quality of care and effectiveness of systems.

Story summary

Andy shares his story of living with a urinary catheter following cancer treatment including his experience of receiving emergency support when he has had complications with his catheter. He also shares the impact having a catheter has had on his life. Andy describes not always feeling listened to when he has sought help. He also describes how he feels health care professionals have a lack of knowledge of how to manage and support patients with catheters.

Key themes and learning

There are several points where learning can be taken including:

- Not feeling listened to
- Staff not able to always support due to a lack of knowledge or experience
- Importance of compassionate care

Andy's story will be shared as part of a Urinary Catheter Quality Summit scheduled 11

November 2024 that is being led by Kerry Holden, Deputy Director – Infection, Prevention and Control and supported by stakeholders across One Gloucestershire Integrated Care System (ICS). During this Summit, projects will be scoped to improve the quality of how we support patients with urinary catheters.

Conclusion

Andy's story has enabled us to hear the impact of having a urinary catheter and how we can improve the experiences of patients in the future that either already have a catheter inserted or may do.

Having stories is a key part of Quality Summits they enable staff to reflect, learn, identify and prioritise quality improvement projects.

Risks or Concerns

Recommendation

The Trust Board are asked to note the experience shared, the impact, the learning and the planned next steps.

Enclosures

Gloucestershire Hospitals
NHS Foundation Trust

Chairs Report to Trust Board - November 2024

1. Purpose

This brief report summarises my activities as Chair of the Trust, and also highlights the work of my fellow non-executive directors and our governors. It is intended to increase visibility of our work rather than be a comprehensive account.

I have previously given an oral report, so the format and content of this report will be reviewed and amended on the basis of feedback.

2. The role of Non-Executive Directors and Governors

Every NHS Trust is required to be governed by a Board with a majority of non-executive members, and as a Foundation Trust, these are appointed with advice from our governing body. The role of non-executives is to contribute to the development of the strategy for the Trust, to ensure that sound governance and assurance is in place and to ensure that the Trust is accountable to the public, and our funders, the government for the range, quality, safety and responsiveness of the services we provide.

Our governing body consists of local governors elected from Trust membership, stakeholder governors drawn from local organisations and staff governors who are colleagues who work for our Trust. Together they provide rich feedback on patient, carer, public and colleague experience. We value our governors greatly and these reports will include examples of their work as well as ours

3. Quality, safety and patient experience

One of the principal committees which feeds into our Board is Quality and Performance committee which is chaired by Sam Foster, meets monthly and covers patient safety, quality of care, patient experience and performance of services, including waiting times.

Over the past few months the Trust has been undertaking “PLACE” assessments across Cheltenham General Hospital, Gloucestershire Royal Hospital and our maternity service at Stroud Community Hospital.

These assessments are led by our Governors supported by volunteers from Healthwatch Gloucestershire, our own volunteers and other members of our local community. We welcomed 22 Patient Assessors in total.

PLACE has included assessments of:

- 20 inpatient wards including Paediatrics and Maternity
- 8 outpatient areas including Orthotics and Thirlestaine Breast Screening Centre
- 8 food tasting in inpatient areas

- 2 Emergency departments
- Internal, communal areas including toilets and lifts
- External areas including accessibility of entrances, signage and grounds

PLACE is an assessment of the environment including cleanliness, condition and appearance of our hospitals, food quality, accessibility including for patients with a disability and those patients with dementia.

The results of PLACE are expected late 2024, however, some actions have already started in response to some of the observations made by assessors.

Non-Executive Directors are invited to the regular graduation events of Gloucestershire Quality Improvement Academy where we hear presentations from clinical colleague on their improvement projects. This time I was accompanied by John Cappock. The topics were:

- Timeliness of antibiotics for suspected sepsis in our Emergency Department
- Blood pressure measurements in falls prevention
- Skin care in the radiotherapy department
- Treatment of chest pain in Same Day Emergency Care department
- Improving extubating (removing breathing tubes) in patients in Critical Care.

4. Governance and Assurance

This is a major role for Non-Executive directors all of whom chair or serve on Trust Committees as well as attending Board meetings. Our key Committees are Finance and Resources, Quality and Performance, People and Organisational Development and Audit and Assurance. We also have a Charitable Funds Committee chaired by Marie Annick Gournet. Our wholly owned subsidiary Gloucestershire Managed Services which provides estates and facilities is supported by a Board, chaired by Kaye Law Fox.

NHS England wrote to all NHS Organisations at the end of June 2024 asking Boards to maintain focus and oversight on quality of care and experience in pressurised services and avoid “corridor care” wherever possible. They asked that Non-Executive Directors should undertake safety walkabouts , ask patients about their experiences and report them back to the Board. We already have a programme of joint visits between Governors and Non-Executive Directors. I also have my own programme of visits which will include pressurised services on both our hospital sites between now and Christmas. Sam Foster our Chair of Quality and Performance who is a former Director of Nursing has scheduled monthly visits in the calendar year 2025. We are reflecting on how best to report at Board level.

5. Visits and ambassadorial roles

Since the last Board meeting my visits have included:

- The public launch of the Big Space Cancer Appeal, with colleagues Marie Annick Gournet and Vareta Bryan plus various fund-raising events
- A visit to the University of Worcester with our CEO hosted by Sally Moyle
- The official opening of Chedworth day surgery unit with our Chief Executive
- A development session of the OneGloucestershire Integrated Care Partnership

- Co-hosting a visit from the Health Overview and Scrutiny Committee to our cancer centre
- A visit to Pamington ward at Cheltenham General to look at plans to expand our cancer day treatments
- Shadowing our volunteer who works on ward 7A at Gloucestershire Royal

6. Contributing to our OneGloucestershire Integrated Care system

As our Integrated Care system only comprises one Acute Trust, one community and mental health services Trust, primary care and a close working relationship with County Council colleagues, there is a significant involvement of our Non-Executive Directors in its governance and assurance processes.

We serve on all the ICB committees which are People and Organisational Development (Deborah Evans) System Audit Committee (John Cappock or a member of the Audit Committee, currently Marie Annick Gournet) System Quality Committee (Sam Foster) System Resources Committee (Jaki Meekings- Davis)

All non-executive Directors are invited to an ICS Non-Executive Director online meeting, currently co-chaired by Vareta Bryan. Vareta also serves on an ICS network called Volunteering for Health.

As chair of the Trust, I am a non-voting partner on the Integrated Care Board attending monthly Board meetings, circa 6 development sessions a year and ad hoc Remuneration Committee meetings.

Deborah Evans
Chair

October 2024

Chief Executive Report to the Board of Directors - November 2024

1. People and Culture

1.1 Chief Digital Information Officer

Following a competitive appointment process held in October, Lee Pester has been appointed as Chief Digital Information Officer (CDIO) for our Trust. Lee brings with him a significant amount of experience and will join us from his current role as CDIO at Plymouth Hospitals in early 2025.

I am grateful to Helen Ainsbury, who has been our interim Chief Digital and Information Officer since April 2023, during what has been a very busy time in the digital space. Helen will be supporting a smooth transition to Lee over the coming months.

1.2 Developing the 10-Year Health Plan

On 21 October 2024, the Department of Health and Social Care launched a period of engagement to inform the 10-Year Health Plan. This engagement follows the publication of Lord Darzi's Independent Investigation of the NHS in September.

Members of the public, as well as health and care professionals, are being invited to share their experiences, views and ideas for the future of the NHS using the online platform Change.NHS.uk, which will be live until the start of next year, and available via the NHS App.

The 10-Year Health Plan will be published in spring 2025 and will be underpinned by three key shifts required in the NHS - hospital to community, analogue to digital, and sickness to prevention.

The Trust and local system will submit suggestions as part of the process and will encourage staff, patients and local communities to also share views and ideas. This will also be reviewed as part of our future strategic planning to ensure they are aligned and continue to address the priorities of our local communities.

1.3 HOSC Visit to Cheltenham Cancer Centre

In October seven Councillors from the Health Overview Scrutiny Committee (HOSC) visited the regional cancer centre at Cheltenham General Hospital to understand how the services operate and the plans to improve facilities through the Big Space Cancer appeal.

As part of the visit, the Councillors were able to hear directly from the clinical and support teams as well as see several patient services and the current estate that hosts the cancer centre.

The Cancer Centre provides facilities used for the non-surgical treatment of cancer patients for Gloucestershire and the surrounding areas, including Radiotherapy and SACT (Systemic Anti Cancer treatment). The catchment area for patients seen and treated includes all of

Gloucestershire, patients from Herefordshire and Powys, as well as some patients from the bordering counties to Gloucestershire – which is approximately one million people.

The workload of the Oncology department has been growing annually and in 2023/24 there were 4773 new patient registrations in Oncology and there were 25,498 SACT treatments delivered and the total number of Oncology appointments in 2023/24 was 70,407. Radiotherapy treated 2,972 patients during the same time period which equates to 32,607 treatments.

As well as the outpatient departments, the Regional Cancer Centre houses the Oncology & Haematology inpatient wards and Acute Haematology Oncology Unit (AHOU). There are 40 inpatient beds split between Lilleybrook and Rendcomb wards, the AHOU is situated on Lilleybrook ward and provides a 24/7 non-elective assessment and admission pathway for patients being treated by Oncology.

1.4 Big Space Cancer Appeal

The Trust's charity has formally launched is public phase of the Big Space Cancer Appeal. To date almost £8.5m out of £17.5m has already been raised for the appeal including an incredible £2 million donation from the Summerfield Charitable Trust as well as a host of individual donations, fundraising challenges and business support.

Our Regional Cancer Centre in Cheltenham has been providing specialist cancer care for people for more than 60 years. The current building was opened 25 years ago and has served us well. This has enabled hundreds of thousands of local people to receive simply the best care there is to offer in the UK. However, as a consequence of the phenomenal developments in cancer diagnosis, treatment, support and research we have outgrown our buildings.

Every day, our teams meet patients face-to-face, often for very challenging and difficult conversations. This often takes place in windowless rooms that don't have the space for family members to be there for support. The rooms are small and cramped – and open out onto a noisy, busy waiting area, with no space to sit, reflect and recover.

The environment makes an enormous difference. All research and evidence show that when we provide a bright, spacious healing environment – the experience of patients and families is substantially improved. We also know that the speed of recovery will be improved by these improvements.

This is why the charity in partnership with the Trust has launched the appeal, to help build new facilities which put the patient experience first at every step, creating a centre of excellence in Cheltenham which matches clinical expertise with a nurturing and therapeutic environment.

The appeal will make a lasting difference for the growing local population and our NHS staff. For more information visit: The Big Space Cancer Appeal

1.5 Postgraduate Medical Education Conference

In early October I was delighted to attend and talk at the annual Postgraduate Medical Education Conference at the Racecourse, joined by our consultants, SAS doctors and trainees.

The conference was a great opportunity to connect into the important issue of training and education and the critical part it plays not just in meeting the demands we see today but ensuring we can continue to meet the demands of the future.

1.6 Sexual misconduct at work

The 2023/24 NHS staff survey for England showed that one in eight workers – around 58,000 – had reported experiencing unwanted sexual behaviour last year, while one in 26 reported experiencing similar harassment from a work colleague.

A new framework issued to all Trusts in October outlines how NHS staff should recognise, report, and act on instances of sexual misconduct in the workplace. Material has been shared with all Trusts for use, including a recommended policy, guidance for reporting and investigating reports of sexual misconduct, and suggested communications and training materials.

The national policy has been developed in partnership with staff who have lived experience, trade unions, colleagues in the voluntary, community and social enterprise sector, academics experts and system leaders. It also builds on the launch of the NHS Sexual Safety Charter, which our Trust has signed up to, and is actively working to implement all ten principles to tackle unwanted, inappropriate or harmful sexual behaviour in the workplace.

The new policy covers sexual misconduct connected to work or the workplace, which can include many things, such as:

- sexual comments or jokes
- unwanted touching or kissing
- showing sexual pictures
- staring at someone in a sexual way
- asking personal questions about someone's sex life
- sexual assault or rape

Incidents of sexual misconduct taking place on NHS premises or elsewhere, such as virtual or physical environments that may not always be designated workplaces, are all included under this guidance.

The Trust has a Sexual Safety Task and Finish Group, which is developing an implementation plan. A full revision of our Grievance, Disciplinary and Mutual Respect policies is also underway, and the new principles for responding to sexual misconduct are being integrated. The development has senior-level oversight, led by Claire Radley, Director for People and OD.

1.7 Agenda for Change – Pay Award

The Government announced in July 2024 A consolidated 5.5% pay award for staff on Agenda for Change (AfC) terms under the remits of the NHS Pay Review Body (NHS PRB).

This increase has been in October 2024 pay packets, with back pay from April 2024 included. Royal College of Nursing (RCN) confirm members have rejected the 5.5% reject pay award: Members of the RCN have voted to reject the UK government's NHS pay award for 2024/25 in England. Two-thirds of nursing staff voted against the current year's pay award.

The pay award has been applied to all agenda for change roles, including Nurses, despite the rejection vote. Gloucestershire Managed Services staff will also receive the pay award.

2. Operational context

2.1 Performance

Urgent and Emergency Care

Since the start of July 2024 (the first day of 8 Days of Summer), almost no patients have been placed onto a ward corridor as part of our escalation process for managing hospital flow, continuing to be a significant achievement and overall improvement for patient and staff experience. We have an ongoing programme of work focused on further improvements in reducing our length of stay (LOS), improving our discharges and reducing delay-related harm. With key areas of focus on our Integrated Flow Hub (IFH), 21-day LOS, pathway 0 discharges, weekend discharges and our nCTR recovery plan, the combined result is a significant improvement in our hospital flow across both sites.

Since the beginning of this financial year, we have seen an average daily discharge of 118 build to 131 patients per day by the end of September. Building on the success of our previous improvement weeks, we have the next ‘8 days of Autumn’ planned for the week commencing 4 of November, where we have a strong focus on our EPR processes and optimisations to further improve efficiencies within patient care, alongside ensuring patient are in the right care setting for their needs (Right Care, Right Place).

No Criteria to Reside (nCTR) continues to fluctuate, with current figures of 120 nCTR across our two hospitals, although we did hit a new low of 105 recently, our systems goal remains at 87. There have also been improvements within the median average wait to be discharged when waiting for a pathway 1-3, with the median wait across all pathways having reduced to 5 days as of the end of September, reduced down from 7 in May 2024.

Further work is required to achieve the targeted 87 patients and patients ideally leaving on the same or next day of being declared nCTR, with the current level of nCTR being above the agreed level of patients at this point in the year, as outlined and agreed within the system operation plan. There is a clear correlation between lower nCTR and better flow, reduced delays for patients and reduced deconditioning hence why it is such a focus for us and the wider system.

Alongside this we also have dedicated improvement programmes focused on our front door pathways, aimed at improved outcomes and experiences for patients accessing these areas. This includes a rapid improvement offer from NHS England and a regional SWAST improvement programme where we are a leading site for a 45-minute ambulance handover workstream, alongside our own Clinical Vision of Flow and UEC improvement plan.

The past month has seen a significant increase in demand across our various admission pathways, especially our new direct attend pathway via our new Acute Medical Zone (MAZ). This provides a direct route for GPs to access support from our acute medics via Cinapsis, with a now dedicated area to bring those patients not suitable for our Same Day Emergency Care (SDEC) area in to be assessed, without having to go through ED.

As a result of this increased demand, where we are currently seeing an average 15 more admissions per day so far in October, with this trend starting to build from the middle of September, causing some deterioration in front door performance. As a result the month of August saw a 4hr performance of 62.9% overall, reducing slightly to 61.2% in September.

This trend of a stronger performance in August, followed by a slight dip in September was mirrored in our Minors performance which sustained a 71.6% performance in August, before dipping to 69.3% in September. However, an area of improvement that has continued to slowly climb, is our 12hr performance where 89.5% and 89% performance in August and September denote an ongoing gradual improvement from the 86% we started at this financial year.

Ambulance handover delays remain both a key measure and an area of improvement focus. Throughout August and September, we averaged around 95 ambulances per day, with a significant proportion of that arriving out-of-hours. Overall admissions were down in August, which alongside a month-on-month improving daily average total and pathway 0 discharge profile, enabled us to achieve an average ambulance handover of 49mins for August.

September saw a return to higher daily admissions, with handover times correspondingly dropping slightly to 57mins. Outside of the internal improvement work highlighted above, we have also been engaging with the system improvement schemes as part of the Working as One programme and the soon-to-be-launched new integrated urgent care service (IUCS).

The expectation of the launch of the IUCS is a more robust and complete urgent community response and alternative pathway to ED. This will not only help with hopefully a reduction in ambulance conveyance but will significantly improve the OOH pathways, reducing pressure on our Minors department, where we see a significant pressure land in the early evening, tending to be where we see a significant drop in our 4hr performance for minors patients affecting the overall average.

Elective Care
Specialties have continued to accelerate delivery of reducing the number of patients waiting more than 65 weeks. The organisation ended September with only 55 patients outstanding treatment by month end, having started the month with a total risk of 459 patients requiring expedited appointments.

The month end October position currently sits at a risk profile of 10-15 patients, and we begin November with 360 patients requiring treatment or discharge by month end to reach the national target. The trust has not reported any patients waiting more than 78 weeks at month end since June 2024.

3. Quality & performance

3.1 Stroud Post-Natal Beds

On 16 September the Trust met with Dr Simon Opher, MP for Stroud and members from the Stroud League of Friends to explore options to expand peer support group provision.

The Trust has given its commitment to provide safe maternity care across services in Gloucestershire, and our Aveta Birth Unit in Cheltenham and Post-natal beds in Stroud remains temporarily closed. The Trust remains committed to the reopening of the Aveta Birth Unit when it is safe to do so and confirmed at health overview and scrutiny committee in October that it would be the first priority.

Stroud Maternity Hospital remains open for labour and birth and the community midwifery service is unchanged.

No decisions have been taken about the postnatal beds and the Trust is working in partnership with the Stroud League of Friends and other community partners on ideas to develop services and support within that space.

The Local Maternity and Neonatal System (LMNS) will be carrying out a health needs assessment over the coming months on maternity provision.

There are plans to meet with partners and key individuals from the community in Stroud at the end of November as the focus is to be clear on the future of the hospital as a place to give birth and receive high-quality midwifery care and support.

4. Strategy

4.1 Trust Strategy

Work has been progressing well to involve staff, partners and communities in shaping a new Trust Strategy that will set out our future direction and the work we do together every day.

Over the last few weeks, 30 different workshops have been held with a wide range of services, and so far more than 400 staff have been involved in sharing their experiences and their ambitions for the new strategy. Work has also begun with community partners, to help reach local people and communities and ensure their views are also included.

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

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

5 Regulation

5.1 CQC Chief Executive announced

The Care Quality Commission confirmed the appointment of Sir Julian Hartley a its new chief executive in October. Ian Trenholm stood down as CQC chief executive at the end of June 2024 after six years in post.

Sir Julian has been the Chief Executive of NHS Providers since February 2023, prior to which he was Chief Executive of several organisations, most recently ten years as Chief Executive of Leeds Teaching Hospitals.

5.2 Review into the operational effectiveness of the Care Quality Commission

In October the Government published the full review into the CQC. The review found significant failings in the internal workings of CQC, leading to a loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improve quality - and a direct impact on the capacity and

capability of both the social care and the healthcare sectors to deliver much-needed improvements in care.

The conclusions of the review summarised 10 key topics and noted several key areas of concern, including:

- a backlog in new registrations of health and care providers
- delays in re-inspecting after a 'requires improvement' or 'inadequate' rating
- increasing age of ratings
- significant challenges with the provider portal and regulatory platform
- delays in producing reports and poor-quality reports
- concerns around the single assessment framework (SAF) and its application
- lack of clarity regarding how ratings are calculated and concerning use of the outcome of previous inspections

The review made a number of recommendations that aim to restore confidence and credibility and support improvements in health and social care:

- rapidly improve operational performance, fix the provider portal and regulatory platform, and improve the quality of reports
- rebuild expertise and relationships with providers
- review the SAF to make it fit for purpose with clear descriptors and a far greater focus on effectiveness, outcomes and use of resources
- clarify how ratings are calculated and make the results more transparent
- continue to evolve and improve local authority assessments
- formally pause ICS assessments

The full report is available on the government website here:
Review into the operational effectiveness of the Care Quality Commission

5.3 CQC Inspections

No new inspections have taken place since the last report. The last unannounced inspection took place on 16th July—18th July 2024 at Cheltenham General Hospital (CGH) Medical Services, including Oncology, and we now await the inspection report.

At present, the CQC has not confirmed when it will share the outcome of that inspection with the Trust.

5.4 Delayed reports

We are still waiting for the CQC inspection reports for the unannounced inspections of the Emergency Department at Gloucestershire Royal Hospital (GRH) (December 2023) and the GRH Maternity Service (March 2024).

We have followed these up recently with the CQC, but there is still no confirmation of when these will be published.

Kevin McNamara
Chief Executive

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – SEPTEMBER 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. The Committee indulged the Chair in treating the last round of meetings, approving a/cs and reports to close out 2023/24 as the end of term and using this September meeting effectively as a start of a new term. The Committee reflected on the limited assurance in the annual head of internal audit opinion. The reasons for these have been well rehearsed and it was agreed that a high priority for the remainder of this year is to do better in our responsiveness, remaining on top of recommendations and agreed time scales and aiming to get back to a moderate level of assurance as a minimum outcome of the 2024/25 annual head of internal audit assurance opinion. The Committee received encouraging messaging on these themes from the internal audit representatives but we need to ensure that remain consistent in our delivery against management actions and show similar vigilance against follow up actions.

Items rated Red

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

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit	**Medical Recruitment** – Design moderate, effectiveness moderate. A very helpful review with effective management responses. Rated as amber given that the moderate opinions are below the highest rating of substantial	Ensure delivery against agreed outcomes.
	Mental capacity Act audit – Overall limited assurance assessment for design and operational effectiveness. Report was deferred as there was insufficient time to agree management actions following receipt of the report. The report will be finalised and circulated to Committee members and discussed at the December meeting of the Committee If necessary any urgent matters will be discussed in a forthcoming NED meeting prior to the December meeting. vel and best supported to enable them to succeed.	Will be revisited in the December meeting and fall back arrangements made in case of urgent actions
	Follow up report – Generally looking far better and clearly a lot of work has gone in to get us to this point. Recognition of the impact of some long standing outstanding actions on the annual internal audit opinion.	Good sustained progress and delivery of the annual plan. However, this needs to be sustained for the full performance year to avoid a further limited assurance
Board Assurance Framework (BAF) and Risk Register	**Risk register** position noted. Concern around Datix noted and extent of areas showing high and fairly long-term risk scores. Committee keen to see a Board Development session on long term areas of concern to assess and learn from these. Committee also noted the work ongoing around sponsorship of risk and welcomed the candid approach to these	Committee will receive an update on proposed revised ways of working at its next meeting.

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

Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
External Audit	The report confirmed the closure of the 2023/24 work in respect of the Trust. Charity and GMS audits are ongoing and will be reported in due course. Focus of external audit discussion was around the proposal to make some revisions to the year end process to more effectively align work with Audit committee dates to ensure that the Committee can provide assurance, challenge, advice and input at appropriate times.	Complete work in respect of Charity and GMS
Gloucestershire Managed Services	The Committee received an audit on capital procurement. The report was limited by design and effectiveness and was a challenging read. The GMS management confirmed the value of the report in surfacing issues and this was reflected in the management responses which were welcomed by the Committee.	Deliver against the agreed management actions
Contractual matters	Committee discussed future arrangements in respect of internal and external audit providers and endorsed the recommendations which were subsequently approved by Council of Governors.	Implement actions approved by Council of Governors.

Items Rated Green
Item
High quality papers - circulated well in advance of the meeting which made prep easier
Follow up actions between meetings – Very good progress
Good focus on non-traditional audit Committee areas, with focus on patient added value
Matters arising. All outstanding matters were closed off.
Counter Fraud report – Excellent, clear digestible report. Good progress reported against various ongoing cases. Evidence of added value particularly around input to raising fraud awareness across a range of staff groups..
Quality Account – excellent report which was received and endorsed by the Committe
Brilliant Basics and National Recovery Support Finance Playbook – report noted
Single tender actions report - one retrospective tender, total value of £160K, all with accompanying justifications
Losses and compensations – No ex – gratia payments made and approved write off of invoice totalling £28K.

Items not Rated
N/A

Report to Board of Directors			
Agenda item:	10	**Enclosure Number:**	6
Date	14 November 2024		
Title	Strategic and Operational Risk		
Authors/ Sponsoring Director/ Presenter	Lee Troake, Head of Risk and Safety and Michael Weaver, Interim Trust Board Secretary Kerry Rogers, Director of Integrated Governance		

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

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**.**

Update on Strategic Risks - Quality and Performance Committee[1]

SR2 Quality Governance

- 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. In July 2024, the Trust Leadership Team held an Away Day dedicated to developing clinical governance systems. The Clinical and Corporate Divisions reviewed and refined their reporting structures. Safety governance work is ongoing, with the Patient Safety Incident Response Framework actively implemented and regularly reported to the Quality Delivery Group. New complaints management processes have been designed and are set for implementation within the next month. Integrated Performance Reporting is now fully established.

SR5 Quality Improvement Methodologies

- Current Risk Score: 4 x 4 = 16, Target Risk Score: 2 x 3 = 6

Strategic Risk 5 outlines the Trust's challenges in embedding systematic quality improvement. Key issues include limited improvement capacity, inconsistent planning, and governance gaps from ward to board, with feedback highlighting the need for structured change.

[1] Matters reported to meetings held on 25 September and 30 October 2024

Update on Strategic Risks - Quality and Performance Committee

Current control measures involve regular reporting and a phased approach to implementing the Patient Safety Incident Response Framework. Planned actions include a governance framework review, progressing Patient Safety Incident Response Framework implementation with alternative working models due to resource limits, and adopting the "A3 thinking" model for structured planning. Assurance indicators reveal positive feedback from safety huddles, but staff surveys and a Care Quality Commission report highlight areas needing improvement.

Update on Strategic Risks - Finance and Performance Committee[2]

SR9 Failure to deliver recurrent financial sustainability

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

The Trust's financial sustainability remains challenging with a current risk score of 25, compounded by growing reliance on non-recurrent funding. The Trust is making progress on its medium-term financial plan and addressing staffing overages, with two divisions tasked to submit improvement plans soon. Collaborative discussions with the Integrated Care Board and commissioners aim to better balance recurrent and non-recurrent income to mitigate the deficit. Members of the Finance and Resources committee highlighted the importance of independent assurance on financial controls and saw the development of the medium-term plan as a constructive step toward achieving financial stability.

SR10 Risk to patient safety, quality of care, reputation, and financial penalties due to poor estate conditions and backlog maintenance

- Current Risk Score: 4 x 4 = 16, Target Risk Score: 4 x 4 = 16

Risk SR10 highlights the need for essential upgrades to estate conditions to protect patient safety, care quality, and the Trust's reputation, with an £86 million maintenance backlog, of which £57 million represents critical needs. The Trust has secured a £17 million capital allocation for 2024/25, which, while not covering all necessary upgrades, allows prioritisation of the most urgent areas. Despite national funding limits (CDEL) constraining the pace of improvement, the Trust is actively exploring partnerships, lease and disposal options, and conducting feasibility studies to optimise available capital. These efforts reflect a proactive approach to addressing estate challenges, maximising resources, and positioning the Trust to secure additional support from NHS funding where possible.

SR11 Meeting Statutory and Regulatory Standards on the Path to Net-Zero Carbon by 2040

- Current Risk Score: 3 x 4 = 12, Target Risk Score: 3 x 3 = 9

SR11 underscores the Trust's strong commitment to achieving a net-zero carbon footprint by 2040. Although funding constraints pose challenges for essential projects like updating buildings for energy efficiency and expanding infrastructure for electric vehicles, the Trust has successfully secured substantial external funding, including £13 million from the Public Sector Decarbonisation Scheme. Planned actions are advancing, with a focus on prioritising the electric vehicle strategy, fostering partnerships within the Integrated Care System, and re-launching the Green Plan in 2024 to enhance staff engagement and awareness. While efforts continue to strengthen senior leadership support and address infrastructure capacity, these proactive measures highlight the Trust's dedication to sustainable healthcare and its resilience in adapting to new funding models for long-term planning.

[2] Matters reported to meetings held on 26 September and 31 October 2024

Update on Strategic Risks - Finance and Performance Committee

SR12 Failure to detect and control risks to cyber security

- Current Risk Score: 3 x 5 = 15, Target Risk Score: 3 x 4 = 12

SR12 highlights the cyber security risks currently facing the Trust as a digital healthcare organisation. Key threats include malware, phishing, and potential physical breaches, with the National Cyber Security Centre emphasising the increasing sophistication of cyber-attacks on the NHS. To address these risks, the Trust has implemented a comprehensive cyber security action plan, which strengthens monitoring, incorporates regular testing, and includes an upgraded Security Incident and Event Management system. Notable improvements include a fully staffed cyber security team, an asset register for devices, and proactive partnerships within the regional healthcare network to enhance response capabilities. Future actions focus on retiring outdated software, expanding device monitoring, and refining third-party supplier management to mitigate potential vulnerabilities.

SR13 Inability to optimise digital systems functionality and progress as a digital hospital

- Current Risk Score: 3 x 4 = 12, Target Risk Score: 2 x 3 = 6

SR13 highlights the Trust's commitment to optimising digital systems for safe, responsive, and joined-up care. Key initiatives include expanding the use of the electronic patient record system, enhancing clinical data accessibility, and improving digital governance across clinical divisions. The Trust has launched a range of digital programmes, such as advanced electronic prescribing, a patient engagement portal, and stabilisation of critical systems, with notable successes in areas like ophthalmology and paediatrics. Future actions focus on completing these digital advancements, refining system integration, and addressing infrastructure needs, aiming to enhance operational efficiency, improve patient experiences, and strengthen system resilience.

Update on Strategic Risks - People and Organisational Development Committee

SR16 Culture, Experience and Retention

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

SR16 outlines the Trust's proactive approach to improving workforce culture, experience, and retention. Key initiatives include a comprehensive Staff Experience Improvement Programme, which focuses on leadership development, team working, anti-discrimination efforts, and wellbeing support. The Trust has strengthened its approach to health and wellbeing with new initiatives like a Wellbeing Nurse and a Wellbeing Champion Network and has implemented flexible working policies to enhance retention. Additionally, the Equality, Diversity, and Inclusion Development Plan aims to improve inclusivity through targeted recruitment, discrimination reporting tools, and cultural competence training. The Trust's ongoing commitment to fostering a positive, supportive environment is reflected in these structured plans, aimed at building resilience, reducing turnover, and enhancing overall staff satisfaction and engagement.

Trust Risk Register Update

Purpose

The Risk Management Report provides oversight of our Trust risks, risks in escalation and emerging high risks.

Trust Risks Update

A positive update has been reported on the first trimester screening (FTS) risk, with a significant improvement in compliance with the FTS guidance. This risk, previously scoring 20, will now be taken forward through the governance process for downgrading.
An existing risk relating to the lack of an electronic system (Order Comms) to request and track pathology and radiology results has been accepted on to the TRR due to the impact manual requesting and monitoring has on the workforce.

Risks in Escalation

A risk relating to insufficient radiologists which is driven by both a national radiologist shortage and local staffing pressures will be escalated to Risk Management Group (RMG) shortly for consideration. A further risk which identifies in sufficient consultant radiologists is also in escalation.
A staffing risk in relation to the Minor Injuries Unit in CGH has scored highly for some time but has yet to be escalated by the division.

Emerging High Risks

Emerging high risks in October include:

- Women presenting with persistent reduced foetal movements from 28 weeks, not having an ultrasound scan with liquor volume and umbilical dopplers within 24hrs or next working day as per the guidance
- Shortage of trained anaesthetic practitioners (Nurses, Operating Department Practitioners OPDS)
- A lack of access to emergency urology theatres

Sponsorship of Risks

A new process for quality assuring risks was agreed at RMG on 6 November to replace the existing exec sponsorship process which has not been working effectively for some time.

Risk and Incident KPIs

Proposed new incident KPIs were received from Patient Safety in October as part of the transition to PSIRF. The RMG agreed it was not in a position to accept the proposed KPIs until reassurance on the process for managing untracked incidents was in place.

Policy Management

The Risk Management Group is increasingly concerned that the Trust is operating with a significant number of out-of-date policies. A meeting will take place between the Medical Director and the Policy Team leads to consider next steps to address

Risk System Performance
An overall level of **Reasonable Assurance** in relation to the Key Performance Indicators (KPIs) 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** Policy management – the Trust continues to operate with a significant number of out-of-date policies
Recommendation
Members of the Board are asked to **NOTE** the following: • The strategic risks that could impede the Trust's strategic objectives. • Items on the Board Assurance Framework reported to Trust Board Committees • Key issues to note with Trust Risk Register
Enclosures
• Board Assurance Framework Summary. • Risk Management Report Board September 2024 • Risk Management Report, Trust Risk Register risks scoring over 16+

Gloucestershire Hospitals NHS Foundation Trust

RISK MANAGEMENT REPORT – BOARD

November 2024

1. TRUST RISK REGISTER (TRR) UPDATE

1.1 Maternity risk of first trimester screening (risk #409)

The maternity risk of first trimester screening (FTS) being missed is one of three extreme rated risks on the register. Initially, adopted onto the TRR in September 2023, work has been undertaken to address the risk, overseen by the Maternity Delivery Group. The Service is now fully recruited to, including appointing a pre-term and complex pregnancy midwife, and has moved 80% of referrals to an electronic system, reducing the previous risks associated with paper-based referrals. Fetal medicine meetings take place monthly to manage risks and issues and women who miss FTS are tracked so that subsequent screening opportunities are offered. The service had previously been missing 10-15 FTS a month, now reduced to only 1-2. With a significant improvement in compliance, the risk has been reduced and will be taken through the governance route for downgrading on the risk register.

1.2 Lack of Order Comms (risk #397)

This risk identifies the impact on clinical staff who spend unnecessary time looking for pathology and radiology results where there is no electronic system to request results. In some areas there is a lack of electronic audit trail to show when samples were requested, by whom, which tests were requested, whether or not they have been received in the lab, and what stage testing/approval is at. Reliance in placed on spreadsheets of results and manual checking and clinicians are unable to electronically acknowledge or show that it has (or not) been actioned. Clinicians are also unable to search for unactioned results for themselves or others. The risk was recently added to the TRR after meeting the threshold for a workforce risk.

Order Comms, an electronic requesting system, has been rolled out in some areas of the Trust. In mitigation of this risk, Order Comms is due to be rolled out in Outpatients by December 2024. However, Histopathology is more complex as it requires an update to TCLE (TrakCare Lab Enterprise) before Order Comms can be installed.

Details of all risks scoring on the Trust Risk Register are provided in Appendix 1.

2. RISKS IN ESCALATION

2.1 Insufficient Radiologists (risk #135)

This existing risk, which has been on the register since 2015 was first escalated in 2023 and approved by the D&S divisional board in March 2024. It was first presented to an exec sponsor in May 2024, and was referred onto another exec in June who required amendments to the risk. These were not made by the division until October 2024.

The risk identifies delays in patient pathways due to a local and national shortage in radiologists (estimated national shortage of 45% by 2027). This includes a local reported shortfall in radiologists to provide robust weekend and evening cover. A lack of comparative recruitment package to other South West Trusts is sighted as a barrier to recruitment in GHNHSFT.

The shortage has resulted in delays to issuing reports for acute imaging to ED and inpatient wards for cancer patients and routine imaging. The risk reports this issue is intensified by a 100% increase in cross-sectional imaging activity from ED and 40% increase from GPs over 4 years, which has not been matched by an increased workforce establishment.

In response, the Service is prioritising reporting, monitoring turn-around times, and utilising outsourcing companies as well as insourcing (WLI) to increase capacity. However, it is noted that outsourcing companies are reducing the capacity on offer and a limited outsourcing budget prevents additional outsourcing being a viable option to address the increase in activity.

2.2 Insufficient consultant radiologists (risk #841)

Opened in June 2024, this risk identifies that elective and acute care procedures across both sites are delivered by only 5.7 WTE consultants. This will reduce to 5 WTE by the end of 2024. The service provides specialist reporting for vascular, abdominal and cancer imaging, acute general reporting, and radiology and operative support to multidisciplinary meetings.

The IR consultants deliver approx. 85hrs per week of programmed operating / procedural care in addition to a 1 in 7 day on-call provision. The Imaged Guided Interventional Surgery (IGIS) hub which will bring interventional radiology (IR), vascular surgery and interventional cardiology into one hub to offer less invasive procedures and lower hospital admission times, will increase capacity. Full utilisation of the IGIS footprint across both sites requires sufficient consultant workforce for 160hrs IR operating per week, plus further CT-guided IR procedural lists as well as support to the hybrid theatre for complex endovascular cases and to urology surgical lists.

In the last 12 months, 288 hours of staff annual leave which was covered through displacing other DCC and SPA activity and through goodwill arrangements. There were 33 days of complete or partial room closures due to a lack of staffing cover.

Risk mitigation includes a VCP submitted for agency staff, prioritising cover for the IR lab, an active recruitment drive and consideration of fixed term locums. The service is developing a business case around the increased workload and new IR labs

coming online in the next 6 weeks. There is also a plan to review the delivery model in line with the acute take reconfigurations, the on-call arrangements and the scope of the service to identify areas for temporary withdrawal or reduction of activity.

2.3 Staffing in ED, CGH (risk #411)

This existing risk was first escalated in 2023 and approved by the Medical divisional board in November 2023. The division has yet to discuss this risk with an exec lead.

The risk concerns patients with major injuries or critical illness are remaining in ED CGH beyond 20:00 hours or may still present there after this time, when it changes from a type 1 ED to a Minor Injuries Unit (MIU - between 20:00 and 08:00). The staff rely on SWAST to transfer patients to GRH by ambulance. The risk notes the potential for harm due to delays in care.

Steps already taken to mitigate this risk include early identification of patients requiring admission and transport, use of the public website and external signage to publicise ED hours, 111 informed to direct patients appropriately, clinical hand overs, appropriate nursing levels and consultant cover until 10pm to manage patients presenting before 8pm who remain in the department at the switch over to MIU. Given the last update to the risk was July, it is not clear whether this risk is up to date.

3. EMERGING (NEW) POTENTIALLY HIGH RISKS

3.1 Pregnant women with reduced foetal movement (Risk #922)

This highlights the risk of women presenting with persistent reduced foetal movements from 28 weeks, not having an ultrasound scan with liquor volume and umbilical dopplers within 24hrs or next working day as per the guidance. The median (middle) wait time for women in the last 12 months is 7 days and a mean wait time is 10 days.

The risk is reported to be caused by capacity issues within the sonography department. Training for a midwife sonographer is approximately 15 months and enhanced bank and locum rates are not attractive to staff.

The risk outlines that staff cannot escalate urgent scans for women with persistent reduced movements over other urgent growth scan requests. They are allocated on a first come first served basis rather than priority rated. This is exacerbated by scanning slots being allocated by non-clinical booking staff without clinical context of urgency. A QI projected has been registered to review options for improving the service.

3.2 Shortage of trained anaesthetic practitioners (Nurses, Operating Department Practitioners OPDS)

Since 2018 Theatres have relied on agency staff to fill gaps in rosters, with longline agency used for several years. This risk is associated with a re-negotiation of agency rates across the South West that has resulted in all agency staff cancelling their booked shifts. Lists remain uncovered without agency or bank staff and Theatres report being unable to fulfil their recovery plan due to lack of suitable resources and staff turnover at 13.34.

Internationally recognised and Health and Care Professions Council (HCPC) registered staff have been recruited but require training due to their different skills sets; a 6–9-month nurse training programme.

The initial score of the risk is 20, although this is yet to be agreed through the governance route. Actions identified include, creating a staff bank pool for Theatres, an Anaesthetic Practitioner shortfall SOP, identifying a barometer for acceptable workforce gaps and a review of new staff supernumerary period.

3.3 Delay and mismanagement of emergency urology cases (risk #933)

This risk reports a lack of access to emergency urology theatres which are only available between the hours of 6 and 8 pm (if theatres are not overrunning from the day). The risk is noted to be exacerbated by reduced anaesthetic cover support in CGH out of hours due to an increased need at GRH. Outcomes may include delayed management of acutely unwell urology patients, cancellation of elective 2ww patients, urgent and non-urgent cases and increased length of stay affecting hospital flow. This risk was opened on 18 October and has yet to be scoped out in terms of controls, gaps and actions but has an initial score of 15.

4. SPONSORSHIP OF RISKS

A new process for quality assuring risks was agreed at RMG on 6 November to replace the existing exec sponsorship process which has not been working effectively for some time.

The new process requires divisional Boards, or the Senior Leaders in the corporate division, to carry out a quality check based on an agreed criteria before a risk can be presented to RMG to consider inclusion on the TRR. Once embedded, this should ensure better quality and well-evidenced risks are presented to RMG. This process will be implemented with immediate effect for risks coming to RMG from December 2024 onwards.

5. RISK AND INCIDENT KPIS

Proposed new incident KPIs were received from Patient Safety in October as part of the transition to PSIRF. RMG requested a direct comparison between the existing and new KPIs to better understand the impact of the proposed changes. A worked comparison presented at RMG on 6 November, highlighted the need for a robust process to be in place to manage the closure or progress of incidents that would not

be tracked under the proposed KPIs. For example, the 1740 no or minor harm incidents currently open on the system. Concern was raised that CQC had already asked for this level of data for maternity and had criticised the Trust based on 400+ incidents open at that time.

The RMG agreed it was not in a position to accept the proposed KPIs until reassurance on the process for untracked incidents was in place.

6. POLICY MANAGEMENT

The RMG is increasingly concerned that the Trust is operating with a significant number of out-of-date policies which could lead to either harm, regulatory intervention, non-compliance with current or reputational damage. RMG agreed the need for a proportionate response to the issue due to the known lack of capacity to review and update polices within all divisions.

A meeting will take place between the Medical Director and the Policy Team leads to consider next steps to address this issue.

7. SYSTEM PERFORMANCE

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

Assurance Level	Description
Reasonable Assurance	• Some medium risk rated weaknesses identified • 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. RMG agreed the disparity between resources and approach in divisions needs review in order to shape an agreed strategy to improve performance.

Appendix 1

TRR RISKS 16+

Risk ID	Risk	Division	Type	Current likelihood	Current consequence	Current rating	Target rating
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 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
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 overcrowding and staffing	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.	Surgical	Workforce	4	4	16	4
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	Corporate	Business	4	4	16	6

751	The risk of failure to provide a safe and high-quality maternity ultrasound service	Women's and Children's	Quality	4	4	16	3
764	S2045 The risk of reduced quality of care in the fractured neck of femur (NOF) 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 Roy	Surgical	Quality	4	4	16	8
14							

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	October 2024	October 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	September 2024	September 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	October 2024	October 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	October 2024	October 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	October 2024	October 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	October 2024	October 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	October 2024	October 2024	CDIO	FRC	5x3=15	N/A	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	October 2024	October 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 SR16 Culture and Retention SR17 Recruitment and attraction	SR1 Urgent and Emergency Care SR9 Recurrent financial sustainability
	4	4 Rating	8 Rating	12 Rating	16 Rating	20 Rating
				SR6 Deliver Integrated Care	SR5 Improvement and Change Management SR10 Trust Estate	
	3	3 Rating	6 Rating	9 Rating	12 Rating	15 Rating
					SR11 Net-zero carbon organisation by 2040 SR13 Digital systems functionality SR14 Invest in research active departments	SR12 Cyber Security
	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

Report to Board of Directors meeting held in Public			
Agenda item:	11	**Enclosure Number:**	8
Date	14 November 2024		
Title	NHS England self-certification of compliance with the NHS Provider Licence in 2023-24		
Author **Sponsoring Director / Presenter**	Michael Weaver, Interim Trust Board Secretary Kerry Rogers, Director of Integrated Governance		

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

Purpose of report

The updated NHS provider licence, effective from April 2023, mandates that healthcare providers meet rigorous conditions aimed at enhancing patient services and addressing contemporary challenges such as climate change and system integration. This updated framework ensures that NHS Trusts and Foundation Trusts operate consistently within national legislative and regulatory standards. The Trust fulfils these requirements through annual self-certification, verifying that Board members adhere to the "Fit and Proper Person Test" (FPPT), thereby reinforcing governance integrity. A robust governance framework, supported by dedicated committees on quality, workforce, finance, and operational performance, equips the Board to manage risks proactively and uphold high standards of quality and safety.

Environmental sustainability is integral to the Trust's objectives, with its Green Plan targeting net-zero emissions by 2040. Key initiatives, including energy-efficient infrastructure enhancements, biodiversity projects, and sustainable waste management, underscore the Trust's commitment to environmental stewardship. Financial oversight is also prioritised, with the Finance and Resources Committee focused on resource management, monitoring financial pressures, and controlling operational expenses, particularly staffing costs. These strategies affirm the Trust's dedication to delivering high-quality, sustainable healthcare that aligns with NHS and governmental priorities. The Trust confirms compliance with all licence requirements, as detailed in the report, and provides evidence to support its adherence to NHS Acts, the NHS Constitution, and governance standards, ensuring a well-led organisation.

Recommendations

To agree:

i. That the Trust meets the requirements of General Conditions G3 and G5 of the NHS Provider Licence.

ii. That the Trust meets the requirements detailed in conditions NHS1 and NHS2.

1. Introduction

1.1 The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

1.2 In October 2022 NHS England proposed changes to the NHS provider licence; these changes were designed to support the development of effective system working, enhance NHS England oversight of key services provided by the independent sector and help address climate change. A number of technical changes were also proposed to align the licence with the regulatory framework and reduce burden.

1.3 The modifications reflect existing statutory and policy requirements and so build coherence across national legislative, policy and regulatory frameworks. The updated licence conditions were published on 31 March 2023, the modified NHS Provider Licence came into effect on 1 April 2023 and are now applicable for all NHS Trusts and Foundation Trusts.

1.4 Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

- Fit and proper persons as governors and directors
- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution; and
- Complied with governance arrangements

1.5 NHS providers need to self-certify the General and Trust conditions after the financial year end.

2. Condition G3 – Fit and Proper Persons as Governors and Directors

2.1 Paragraph 1 of licence condition GE states:

1. *The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:*

   a. *a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.*

   b. *a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986).*

   c. *a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it.*

   d. *a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.*

2.2 Paragraphs 2 and 3 of licence condition G3 state the following:

> *2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.*
>
> *3. For the purposes of paragraph 2, a person is not fit and proper if that person is:*
>
> *a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or*
>
> *b. an organisation which is a body corporate, or a body corporate with a parent body corporate:*
>
> *i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a).*
>
> *ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986.*

2.3 NHS England has developed a Fit and Proper Person Test Framework in response to recommendations made by Tom Kark KC in his 2019 review of the Fit and Proper Person Test (the Kark Review). The Kark Review was commissioned by the government in July 2018 to review the scope, operation and purpose of the FPPT as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2.4 The Trust Annual Report and Accounts 2023/2024 outlines that all directors within the Trust have confirmed their compliance with the "Fit and Proper Person Test" as stipulated by the NHS Foundation Trust's License and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This compliance ensures that each director meets the regulatory standards required to hold their position, contributing to the integrity and governance quality of the Trust

2.5 All Executive and Non-Executive Director appointments are subject to relevant checks of qualification, professional registration (where required), references and induction arrangements. Annual reviews are in place (both individual and collective).

2.6 Governors submit a FPPT declaration on appointment/election.

3. Condition G5 – Systems for compliance with Licence conditions and related obligations

3.1 Condition G5 requires licensees to take all reasonable precautions against the risk of failure to comply with the licence conditions, including:

- *the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and*
- *regular review of whether those processes and systems have been implemented and of their effectiveness.*

3.2 Paragraphs 1 and 2 of licence condition G5 state:

1. *The Licensee shall take all reasonable precautions against the risk of failure to comply with:*
   a. *the Conditions of this Licence,*
   b. *any requirements imposed on it under the NHS Acts, and*
   c. *the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.*
2. *Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:*
   a. *The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and*
   b. *regular review of whether those processes and systems have been implemented and of their effectiveness.*

3.3 In 2023/24, the Trust maintained an integrated governance framework, delegating various assurance functions to dedicated committees responsible for governance, quality, workforce, finance, and operational performance. This structure allows the Board to focus on the most significant risks and set strategic directions based on comprehensive oversight of quality and control measures within the Trust.

3.4 Key components of this governance approach include regular reports from Committee Chairs, who provide Key Issues and Assurance Reports (KIAR) to the Board. These reports highlight areas requiring immediate attention, provide a low assurance rating where necessary, and ensure that the Board Assurance Framework (BAF) reflects the Trust's evolving priorities and external conditions.

3.5 Throughout 2023/24, efforts were directed at enhancing the Integrated Performance Report to deliver a consolidated summary of critical metrics across quality, people, operations, and finance, further aiding Board oversight.

4. Trust conditions – NHS1 and NHS2

4.1 NHS1 (Information to update the register) Condition sets the obligations of NHS FTs to make available to NHSE written and electronic copies of the following:

a. the current version of Licensee's constitution.
b. the Licensee's most recently published annual accounts and any report of the auditor on them, and
c. the Licensee's most recently published annual report

4.2 NHS2 Condition outlines the governance arrangements that the Licensee must adhere to, including, but not limited to, ensuring good corporate governance, addressing climate change and achieving net zero emissions, following NHS England guidance on digital maturity, fulfilling the duty to operate efficiently, economically, and effectively, and maintaining sufficient capability at Board level to provide effective organisational leadership in the quality of care delivered.

4.3 The Board is required to review annually their systems and processes in order to ensure good governance. There is no set approach for how NHS England expect this to be evidenced but would normally include a review of the effectiveness of board and committee structures, reporting lines and performance and risk management systems.

4.4 The Board evaluates the effectiveness of its Committees, including those involving Governors, through several mechanisms. Each Committee provides regular Key Issues and Assurance Reports (KIAR) that are reviewed by the Board. These reports focus on issues requiring escalation and offer assurance on actions that aim to improve governance. Furthermore, the Board Assurance Framework (BAF) serves as a structured tool to identify and manage strategic risks, helping ensure committees' activities align with the Trust's strategic goals. The Trust's annual report includes insights on committee performance and any gaps identified in effectiveness, promoting transparency in governance.

4.5 The Trust's annual report provides several key areas where evidence of compliance with regulatory requirements and internal governance standards is presented:

i. Care Quality Commission (CQC) Compliance: The Trust is broadly compliant with CQC registration standards; however, certain areas, notably Maternity and Urgent and Emergency Care Services, have received warning notices. These notices have led to targeted quality improvement actions, with oversight by the Integrated Care Board, aimed at enhancing safety and service quality. In May 2024, the Trust received an enforcement notice from the CQC, which imposed specific reporting and operational conditions to drive improvements in quality and safety, particularly within maternity services. Key requirements of this enforcement action include:

- **Enhanced Quality Oversight**: Implementation of systems to provide a comprehensive and up-to-date overview of service quality and safety across all areas.
- **Incident Learning Processes**: Strengthening processes to ensure prompt identification of incidents and fostering a culture of learning across teams.

Furthermore, the conditions stipulate monthly progress reporting to the CQC, ensuring that these improvements are consistently monitored and embedded within the Trust's governance framework. This level of regulatory oversight highlights the Trust's dedication to adhering to standards that enhance patient safety and quality of care.

ii. **Workforce Compliance**: Regular reporting on workforce metrics, including vacancy rates, staff turnover, and mandatory training completion, is overseen by the People and Organisational Development Committee, alongside the Quality and Performance Committee. This oversight ensures alignment with Health and Social Care Act requirements for sufficient and qualified staffing.

iii. **Internal Audit and Governance**: The Trust's governance structure includes an annual internal audit plan managed by the Audit and Assurance Committee. This plan focuses on internal control risks and other compliance-related issues, ensuring that the Trust meets statutory and regulatory obligations.

iv. **Board Assurance Framework (BAF)**: The BAF provides a structured approach for the Board to monitor and manage risks that could impact strategic objectives. This framework is part of the Trust's compliance with NHS Foundation Trust License Condition 4.

These mechanisms and processes collectively support the Trust's compliance efforts and provide the Board with assurances regarding governance, safety, and regulatory standards.

4.6 The Trusts Annual Report and Accounts 2023/2024 include a separate section for the Annual Governance Statement (AGS) as well as detailed information on risk management (per the Trust's Risk Management Policy). Risks to compliance and mitigations in place are detailed within the Annual Governance Statement Section of the Annual Report and Accounts. A draft of the Annual Report was submitted to the Audit and Assurance Committee and a final report with external auditors' comments was circulated to the Trust Board in advance of the Audit and Assurance Committee in June at which the Annual Report and Accounts 2023/24 were approved.

4.7 The Trust's plans for achieving net zero carbon emissions are detailed in their Green Plan, targeting a net-zero footprint by 2040 for emissions under their direct control. The Trust has implemented various initiatives, including:

i. **Infrastructure Upgrades**: Projects under the Public Sector Decarbonisation Scheme, such as roof insulation, installation of an air source heat pump, and façade replacements, aim to reduce emissions significantly, estimated to save 1,389 tonnes of CO_2 annually upon completion.
ii. **Green Space Initiatives**: Efforts to enhance biodiversity include tree planting, creating wildflower gardens, and establishing rain gardens to improve air quality and community engagement.
iii. **Operational Changes**: Adjustments such as introducing hybrid pool vehicles, shifting clinical waste processing methods, and expanding shuttle services reduce reliance on carbon-heavy options, thereby improving air quality and reducing traffic congestion.
iv. **Sustainable Waste Management**: Initiatives include anaerobic digestion for food waste to create fertilizers and energy, which saved around 1.6 tonnes of carbon dioxide equivalent, marking a substantial environmental improvement.

These steps reflect the Trust's commitment to sustainability, aligning with NHS and governmental environmental goals to progressively reduce carbon emissions.

4.8 The Finance and Resources Committee, plays a key role in overseeing the Trust's financial performance. Its main responsibilities include:

i. **Resource Management**: The committee ensures effective management and utilisation of the Trust's financial resources. This includes oversight of financial controls, the Estates Strategy, and the performance of Gloucestershire Managed Services (GMS), the Trust's subsidiary.

ii. **Operational and Financial Reporting**: The committee receives regular updates from sub-committees and groups focused on operational performance, financial sustainability, and the implementation of capital projects. This enables continuous monitoring and adjustment to ensure financial goals and operational requirements are met.

iii. **Investment Approvals and Strategy Implementation**: The committee reviews and approves business cases for major investments, ensuring the anticipated benefits of these investments are realised. This also includes biannual reports on procurement, as well as areas like cyber security and information governance, which are crucial to maintaining financial and operational resilience.

iv. **Managing Financial Pressures**: The committee closely monitors financial pressures affecting the Trust, such as recruitment challenges, temporary staffing costs, and increased expenses linked to industrial actions. Strategic actions are taken to address these pressures, including reviewing expenditure at operational and system levels to identify cost-saving opportunities.

These responsibilities highlight the committee's essential role in securing the Trust's financial health and sustainability, while supporting the operational capacity necessary to deliver high-quality healthcare services.

5. Conclusion

5.1 In conclusion, the Trust is committed to upholding high standards in compliance, governance, and sustainability, with clear plans to drive further improvements. The recent updates to the NHS provider licence offer an opportunity for the Trust to deepen system integration and step up climate initiatives, ensuring it remains aligned with national priorities.

5.2 To enhance its governance framework, the Trust will continue to refine the Board Assurance Framework and strengthen the alignment of committee activities with its strategic objectives. By enhancing the clarity and consistency of Key Issues and Assurance Reports (KIAR) across committees, the Trust can foster more effective risk management and oversight.

5.3 In Maternity and Urgent and Emergency Care Services, the Trust is actively addressing quality improvements in response to previous CQC warning notices. Strengthening quality oversight and refining incident learning processes will help these areas meet regulatory standards and enhance patient safety.

5.4 The Trust's Green Plan, targeting net-zero emissions by 2040, provides a robust foundation for sustainability. By expanding green initiatives in waste management and energy efficiency across all operational areas, the Trust can accelerate its environmental progress.

5.5 The Finance and Resources Committee remains dedicated to effective resource management and financial sustainability. Additional focus on workforce planning and managing staffing costs will further strengthen financial resilience. Through these focused improvements, the Trust aims to enhance its services, governance, and environmental contributions, delivering even better outcomes for patients and the community.

Recommendations

To agree:

i. That the Trust meets the requirements of General Conditions G3 and G5 of the NHS Provider Licence.

ii. That the Trust meets the requirements detailed in conditions NHS1 and NHS2.

Report to Trust Board of Directors				
Date	14 November 2024			
Title	**Report to the Care Quality Commission - Section 31 Summary Report**			
Authors **Presenter**	Women's and Children's Division Director of Midwifery - Lisa Stephens Women's and Children's Division Speciality Director – Chris Edwards (Supported by Deputy Director of Quality - Suzie Cro) **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).

In May 2024, Maternity Clinical Teams were set up to lead the improvement work and they have been undergoing quality improvement (QI) training as they improve the issues within the service. The last QI training session was in October and the Teams are preparing their projects for the GSQIA graduation ceremony. The ceremony will be held in February 2025. The teams are all making progress with their improvement projects and will continue to report on a monthly basis to the Chief Nurse and Medical Director. There is an improvement programme for Governance in Maternity and phase 1 of the new structures have been implemented (there will be 4 clinically led Meetings – Antenatal, Intrapartum, Postnatal and Midwifery Led).

As required by CQC, the enclosed Reports and the Maternity Dashboards were sent to the CQC by the deadlines. The next report will be prepared and sent to CQC on 29 November 2024. The Trust are also providing assurance externally to the ICB Quality Improvement Group (QIG) fortnightly and external stakeholders are present (NHSE regional and national teams). A copy of the presentation provided to the last Group (1 November 2024) 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 (board access only)

- 30 September 2024 CQC S31 Report
- 30 October 2024 CQC S31 Report
- 1 November 2024 ICB QIG Presentation (for information)
- Coversheet for new Maternity Dashboard highlights (as provided to CQC)

CQC S31 enforcement notice

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

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr>
<td>Work stream 1 – Postpartum Haemorrhage (PPH) and Massive Obstetric Haemorrhage (MOH) risk assessment and management</td>
<td>
Management

– Carbetocin launched 18 June 2024 and audit showed 100% women received this drug.
– Reduce Checklist being used in practice since 1 July 2024 and audit demonstrate 93% women have had checklist completed.
– PPH Guideline has been updated (M1042).

Target

– The target is to have reduced the mean monthly PPH rate >1500ml to 31 per 1000 deliveries by Jan 2025 (in line with national average). When using the national data our rolling 6-month average is 39.3 per 1000 deliveries.

Governance
</td>
<td>
CQUIMs – National Data published 20 September 2024 (for July 2024).

– The latest national data has shown increased rates for PPH >1.5L to 41.0 per 1000 deliveries.

NB: The national data and the Trust data are aggregated slightly differently and there is a note to explain this within the main report at paragraph 3.12, page 14).

<table>
<tr><th>CQUIMs

Data</th><th>April

2024</th><th>May

2024</th><th>June

2024</th><th>July

2024</th><th>Aug

2024</th></tr>
<tr><td>National average</td><td>30.0</td><td>30.0</td><td>30.0</td><td>31.0</td><td>31.0</td></tr>
<tr><td>Trust data</td><td>42.0</td><td>38.0</td><td>36.0</td><td>37.0</td><td>41.0</td></tr>
</table>

The Trust data for September 2024 shows an increase in the PPH rate >1500ml to 38.29 per 1000 deliveries which is within standard deviation.
</td>
</tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>– In the new governance structure the Intrapartum Forum have oversight of this improvement work and PPH outcome data. Escalation of issues will be to the new Maternity Oversight and Assurance Committee.
– The PPH Team are monitoring safety incidents at the 3 times weekly MDT meeting and looking for trends/themes/ areas for improvement.</td><td>
<table>
<tr><th>Trust data</th><th>April 2024</th><th>May 2024</th><th>June 2024</th><th>July 2024</th><th>Aug 2024</th><th>Sept 2024</th></tr>
<tr><td>Trust data</td><td>29.02</td><td>44.64</td><td>52.08</td><td>44.97</td><td>17.78</td><td>38.29</td></tr>
</table>

The Reduce Checklist is being consistently used in practice and so now analysis will begin for the cases reported as safety incidents.

Table: Risk assessment compliance
<table>
<tr><th>Date</th><th>% completion</th></tr>
<tr><td>Sept</td><td>93%</td></tr>
</table>
</td></tr>
<tr><td>Work stream 2 – Fetal monitoring peer reviews, accurate assessment and timely escalation of concerns</td><td>The % compliance rates have increased across 3 metrics and decreased across 2 in September and focused improvement work continues.

Targets

– To increase initial intrapartum risk assessment to 95% by 31 December 2024 (updated).
– To increase hourly risk assessment to 85% by 30 Oct 2024
– To increase our hourly peer review rate</td><td>Table: Fetal monitoring audit results
<table>
<tr><th>Issue</th><th>May 2024</th><th>June 2024</th><th>July 2024</th><th>Aug 2024</th><th>Sept 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>95%</td><td>85%</td><td>↓10%</td></tr>
<tr><td>Hourly risk assessment</td><td>80%</td><td>75%</td><td>42%</td><td>65%</td><td>85%</td><td>↑20%</td></tr>
</table>
</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
– To increase the accurate interpretation of CTGs to 85% (escalated appropriately for their interpretation) by 31 December 2024 (updated).

Governance

– In the new governance structure the Intrapartum Forum will have oversight of this improvement work. Escalation of issues will be to the new Maternity Oversight and Assurance Committee.</td><td>
<table>
<tr><td>Hourly peer review</td><td>85%</td><td>75%</td><td>70%</td><td>65%</td><td>*85%</td><td>↑20%</td></tr>
<tr><td>Accurate assessment</td><td>67%</td><td>78%</td><td>92%</td><td>85%</td><td>90%</td><td>↑5%</td></tr>
<tr><td>Escalation</td><td>89%</td><td>84%</td><td>80%</td><td>92%</td><td>85%</td><td>↓7%</td></tr>
</table>
*window of 15 minutes has now been agreed as no target set by NHSR for Maternity Incentive Scheme.
</td></tr>
<tr><td>Work stream 3 – Temporary workforce (agency midwives) experience</td><td>– HSIB have produced a Safety Report about Agency working and so the Team have benchmarked against this report and the findings presented to the Maternity Delivery Group.

Governance

– In the new governance structure the Workforce Meeting will have oversight of the temporary workforce. Escalation of issues will be to the new Maternity Oversight and Assurance Committee.</td><td>– All current working Agency Midwives have had an induction to the unit.
– Clinical incidents related to Agency are being monitored and managed.

This target has been met and so no new data provided.

Table: Induction completion rates August 2024
<table>
<tr><th>Action</th><th>Number</th><th>%</th></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>– Temporary workforce will be included within the Perinatal Workforce Report (required to meet NHSR Maternity Incentive Scheme Standards).
– The Trust Temporary Staffing Policy describes expected standards for the managers and staff (B7020).

Target met as all Agency staff that have worked in the unit have had an induction. There has been a large reduction in the usage of agency for September and this will be reported on in the next workforce report.</td><td><table><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 for September has been improving the “on admission” risk assessments within 14 hours.
– The next VTE prophylaxis audit is in progress and data is being finalised within a report.

Target – updated

– For admission VTE risk assessments to be completed within 14 hours of admission by >95% by 30 November 2024.</td><td>Table: VTE Risk assessment compliance
<table><tr><th>Issue</th><th>May 2024</th><th>June 2024</th><th>July 2024</th><th>Aug 2024</th><th>Sept</th></tr><tr><td>On admission (14hrs)</td><td></td><td></td><td></td><td></td><td>*75%</td></tr><tr><td>On admission (6 hrs)</td><td>42%</td><td>57%</td><td>52%</td><td>62%</td><td>Discontinued metric</td></tr><tr><td>On admission (24 hrs)</td><td>72%</td><td>84%</td><td>86%</td><td>87%</td><td>Discontinued metric</td></tr></table></td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>Governance

– In the new governance structure the Postnatal Forum will have oversight of VTE risk assessment. Escalation of issues will be to the new Maternity Oversight and Assurance Committee.
– There is a Policy for Management of Venous Thromboembolic Disorders (M2014).
– Team VTE attend the Trust-wide VTE Improvement Group chaired by the Medical Director.</td><td>*The data is now for a full 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.

The target has been met for September and the Team are in discussion and developing a plan for the audits and future governance/oversight arrangements.

Target

To increase compliance with acting on amber</td><td>Table: “Act on Amber” compliance

<table><tr><th>Area</th><th>May 2024</th><th>June 2024</th><th>July 2024</th><th>Aug 2024</th><th>Sept 2024</th></tr><tr><td>Maternity Ward</td><td>63%</td><td>83%</td><td>86%</td><td>94%</td><td>*89%</td></tr><tr><td>Delivery Suite</td><td>87%</td><td>90%</td><td>83%</td><td>100%</td><td>100%</td></tr><tr><td>Birth Unit GRH</td><td>75%</td><td>80%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Stroud</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>No ambers</td></tr></table>*This month saw a decrease in the rate and this was due to new</td></tr>
</table>

Issue	Actions	Data
	observations to 80% within 3 months (July), and 95% within 6 months (Oct). **Governance** – In the new governance structure the Postnatal Forum will have oversight. Escalation of issues will be to the new Maternity Oversight and Assurance Committee.	student midwives and so teaching has begun in the University.

Report to Board of Directors meeting in Public			
Date	07 November 2024		
Title	Integrated Performance Report (IPR) Reporting **September** Data		
Author /Sponsoring Director/Presenter	- Chief Operating Officer - Director of Quality and Chief Nurse - Director of Safety and Medical Director - Director of People - Director of Finance.		
Purpose of Report	Tick all that apply □		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement	✓	**To highlight an emerging risk or issue**	✓
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Integrated Performance Report

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

Performance

- **The 4-hour emergency care standard** was not achieved in September. 62.9% of patients were seen, treated and discharged within 4 hours, a small decrease in performance compared to August 2024. However, a marked improvement has been observed in October. The system performance was also not achieved.
- **Ambulance Handover Times** – September saw a worsening position for Ambulance Handover Times. 30% of patients waited more than 60 mins to be taken off an ambulance. This corresponds to the system Cat 2 response time.
- **Referral to Treatment** – The number of patients waiting >52 weeks has seen a significant reduction. This is linked to the work undertaken to address patients waiting >65 weeks. The number of patients waiting >52 weeks at the end of September was 48. This has reduced to 8 in October. The Trust plans to declare no patients waiting >65 weeks at the end of November.
- **Cancer -** The validated 62-day position for September is 64.4%. This is slightly below our recovery trajectory. The Faster Diagnostic Standard was also not achieved with a performance in September of 71.0% against the target of 75%. The 31-day standard was also not achieved with a September performance of 92.4% against a target of 96%.
- **DM01 –** The final validated position for September was 18.01% against a target of 15%.

Quality & Safety metrics

- Governance – the Quality Delivery Group has oversight of all metrics and improvement programmes related to the IPR. The detail and narrative for each quality metric is provided within the report with only headlines in this summary.

Experience

- The Friends and Family Test data showed a slight decrease in the number of people rating their care good or excellent. A thematic review of current comments is underway. The largest decreases in scores are within maternity and the emergency departments. Most of the negative comments in maternity relate to care on the maternity ward and for the

emergency department the commonest reason for poor a poor rating is the negative experience of long waits.
- The Patient Advice and Liaison Team have seen an increase in the number of concerns closed in 5 working days.
- Mixed sex breaches – as part of the reduced use of escalation areas and improved flow we have seen a sustained improvement.

Safety
- 33 Patient Safety Incident have required review through Patient Safety Incident Investigation (PSII) or After Event Review (AER) since the Trust transitioned to Patient Safety Investigation Framework (PSIRF).
- In response to the Trust's Summary Hospital- Level Mortality Indicator (SHMI) data the Integrated Care Board (ICB) have set up a Quality Improvement Group so that key stakeholders can provide support and oversight of the actions being taken to make improvements.
- The Trust has identified 8 safety priorities that are being closely monitored (falls and pressure ulcers are 2 outcome metrics we are monitoring and we have developed PSIRF related improvement actions).

Clinical effectiveness
- VTE risk assessment in maternity is now being measured to the NICE standard of 14 hours of admission. The Trust VTE group is led by the Medical Director and the group review rates within all services. Each service that is not at the required target has improvement actions agreed at the meeting which will then be implemented.
- Postpartum haemorrhage rates are still above national average and there is improvement work ongoing to improve how we manage cases.

Workforce

The workforce section complies with the requirements of the Single Oversight Framework in terms of staff engagement and the demographics of staff in leadership roles. It reflects a number of 'watch' metrics with annual targets where movement on a monthly basis will not be seen. However, underpinning these are 'driver' metrics which reflect activities and interventions that aim to move the dial of change and improvement to meet the associated targets.

Workforce performance metrics reflect where there has been deterioration in performance. This being seen in Appraisal, Statutory / Mandatory training and Bank use in this month's reporting. The supportive narrative reflects the areas/services which are contributing to this performance position together with the recovery actions in train to realise improved performance against target.

Finance

At the end of September 2024 (M6) the Trust reported a ytd deficit of £8.9m which is £1.6m favorable to plan due to the timing of transactions. At an ICS level the M6 position has reported a ytd deficit of c£8.7m with the system, and individual NHS partners, continuing to forecast breakeven financial positions by the end of the financial year.

The Trust is currently experiencing pressures against its financial position linked to the delivery of financial sustainability plans, workforce costs, non-pass-through drug costs and from clinical supplies and services. We continue to work with system partners to develop and implement mitigations to this position.

Against the national use of resource metrics, the Trust is currently delivering to the agency as % of pay target and the ytd delivery of sustainability schemes. As we have a ytd deficit we have not met the revenue financial balance requirement.

Capital spend continues to forecast full year utilization of available resources – there is an in-year underspend linked to the revision of some schemes and from the application of lease costs associated with IFRS16.	
Risks or Concerns	
Financial Implications	
N/A	
Approved by: **Chief Operating Officer**	**Date:**
Recommendation	
To NOTE the contents of the IPR and associated metrics	
Enclosures	
IPR Power Point Presentation	

Integrated Performance Report (IPR)

September 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

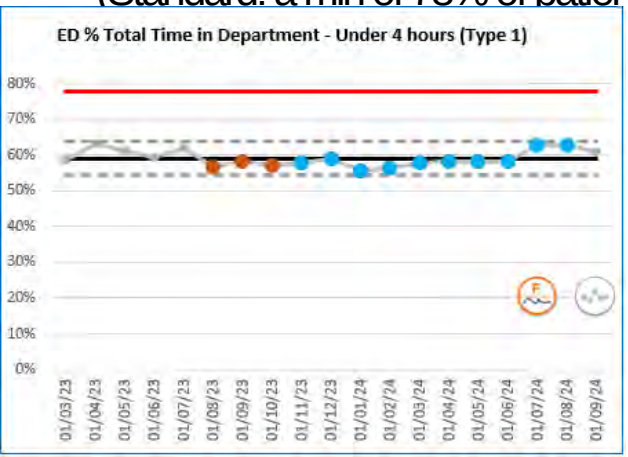
			Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality of Care, Access & Outcomes	Elective Care	Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment													
		52ww	*0 by Sept 24*	2738	2883	2825	2633	2580	1760						
		78ww	*0*	3	3	0	1	1	0						
		104ww	*0*	0	0	0	0	0	0						
		Total elective activity undertaken compared with 2019/20 baseline		115%	110%	105%	108%	110%	111%						
		Total diagnostic activity undertaken compared with 2019/20 baseline		145%	135%	150%	135%	147%	136%						
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	*No Target*	159	203	217	201	188	197						
		Proportion of patients meeting the faster cancer diagnosis standard	*75%*	74.9%	77.6%	74.4%	76.3%	72.2%	72.1%						
		Total patients treated for cancer compared with the same point in 2019/20	*No Target*	335	341	284	314	301	266						
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		117.3%	111.3%	104.4%	109.0%	110.1%	113.8%						
	Urgent Care	Proportion of ambulance arrivals delayed over 30 minutes		59.7%	57.6%	60.2%	51.9%	47.0%							
		Proportion of patients spending more than 12 hours in an emergency department		13.9%	13.0%	12.8%	11.0%	10.7%							
	Primary Care	Proportion of patients discharged from hospital to their usual place of residence	*No Target*	97.46%	97.16%	97.37%	97.23%	97.47%							
	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	59.1							
		E. coli bloodstream infection rate per 100,000 bed days	*No Target*	36.6	31.4	22.3	26.4	27.3							

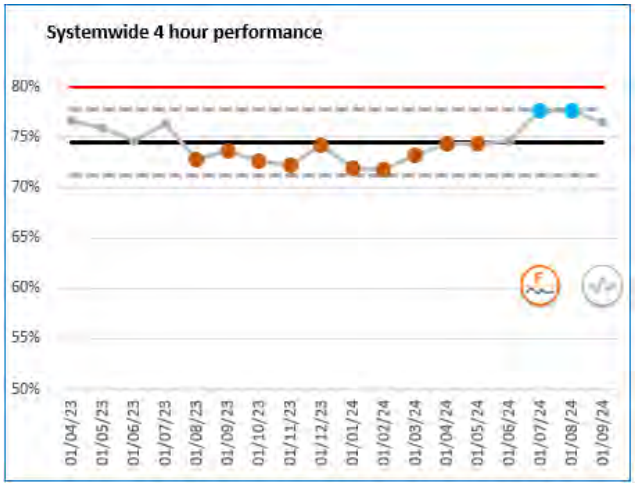
Watch Measures

	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
Compliant Diagnostic Modalities													
Barium Enema Performance	*95%*	100%	100%	100%	100%	100%	100%						
Computed Tomography Performance	*95%*	100%	99%	100%	100%	100%	100%						
DEXA Scan Performance	*95%*	100%	100%	100%	100%	100%	100%						
Non-obstetric Ultrasound Performance	*95%*	97%	96%	99%	97%	97%	95%						
Severe Harm from Patient Medication Errors	*0*	0	0	0	1	0	0						

UEC: Seen within 4 hours

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





Commentary:
There was a decrease in performance during September compared to the previous month of 63%. 62.9% was recorded as the 4 hours position for August 2024. Noted that the second half of the month saw the position deteriorate although no significant increases in attendances.

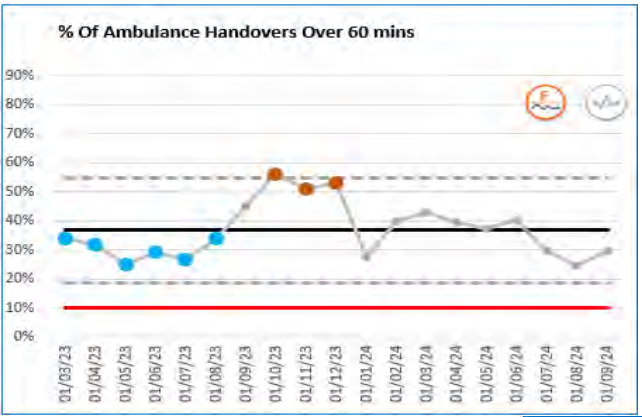
Planned Actions:

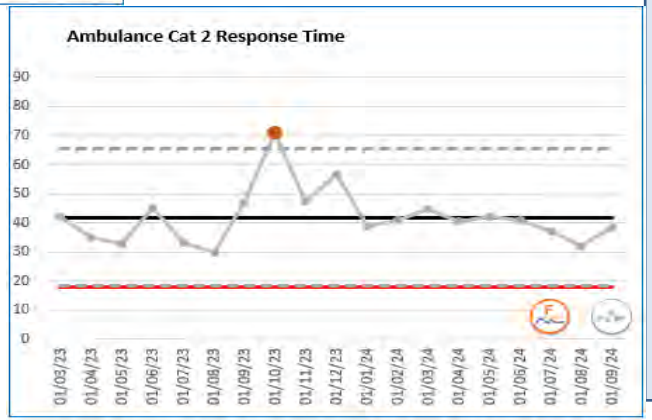
- ED daily huddles have been run throughout August, this has provided senior leadership and site support to drive escalations within the department. These will continue to be refined through September to ensure that escalations are made in a timely way with learning captured.
- Specialty pathway access is a continued focus of the UEC Improvement Board with a range of workstreams in place as per the CVOF work.
- There will be a Criteria to Admit review scheduled in September to look at admissions from the department.

Expected recovery:
The ambition is to recovery the trajectory position based on the work as per the performance improvement plan, CVOF and ECIST support.

UEC: Average Handover Time

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





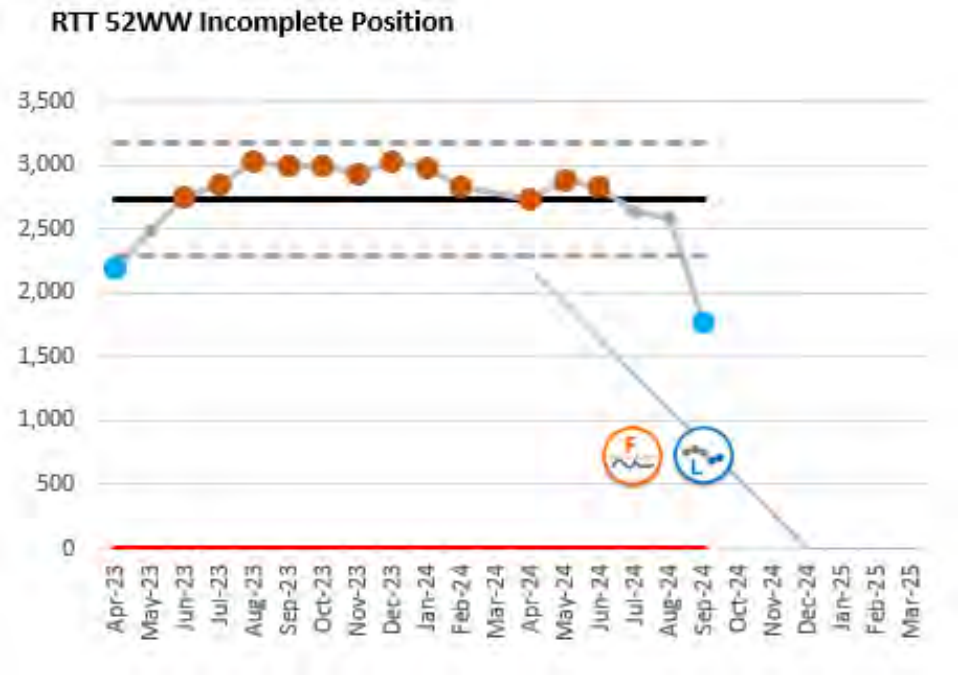
Commentary:
There was an improved performance during August, however, this deteriorated slightly in September. 30% of ambulance handovers took more than 60mins against the target of no more than 10% of patients. This was also matched with a worsening position of Cat 2 response times.

Planned Actions:
The ECIST Paramedic has visited the department and made some recommendations to the Team. These outputs will form part of the CVoF and ECIST RIO work. The Team will undertake a 'red-pen' and a table top exercise in readiness for the W45 pilot which will seek to reduce ambulance delays

Expected recovery:
There will be continued focus through September with key stakeholders to address daily issues which impact handovers. Internal focus on work with Acute Medicine colleagues, ECIST support and system to drive improvements over the next 12 weeks.

Elective: 52 Week Wait

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



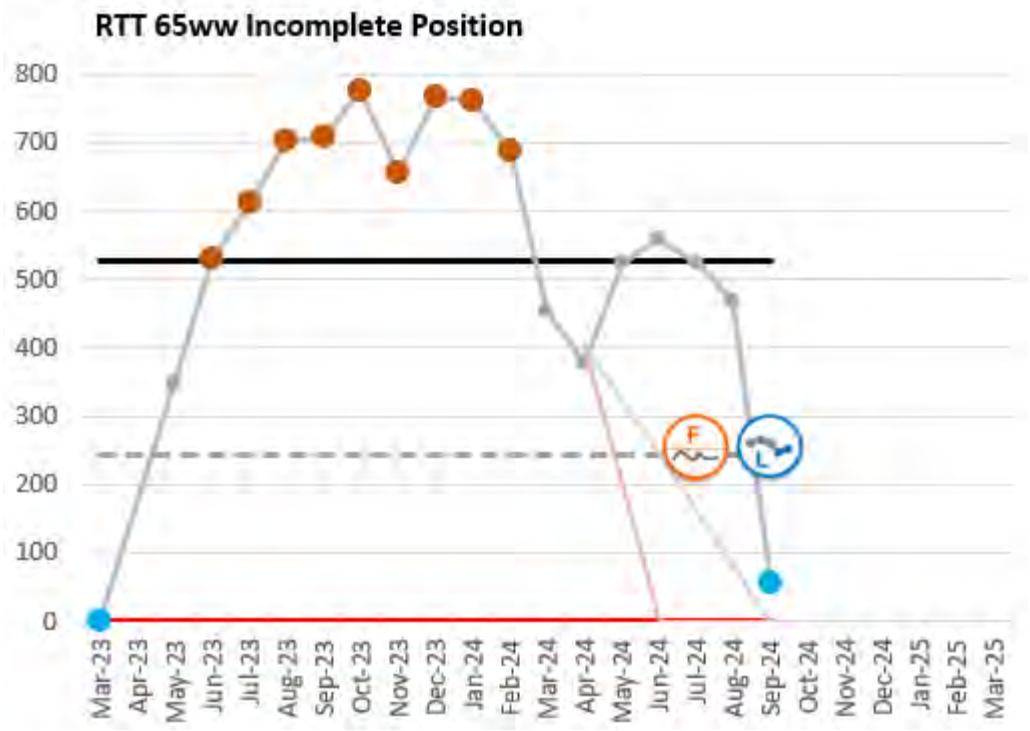
Commentary:
The September month-end position is currently unsubmitted, however this is likely to be finalised around 1,743. This is a significant reduction on the August position of 2,509. This reduction of 766 is largely attributable to immense effort in attempting to clear all 65 week waits by month-end. The notable reductions being made in ENT (-313); Oral Surgery (-222); T&O/Spines (-104) and Cardiology (-50)

Planned Actions:
ERF schemes continue to be undertaken with the additional capacity offering the ability to reduce treatment times further. Continued focus and scrutiny exists through the various weekly meetings, the PAAF, and support from the validation team/ ECH.

Expected recovery:
Performance will continue to improve with ERF schemes in place.

Elective: 65 Week Wait

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



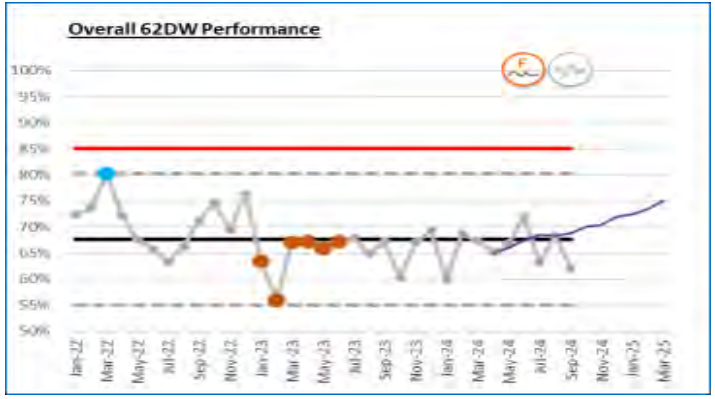
Commentary:
Agreement was reached with NHSE to allow a tolerance of 50 breaches at September month-end. The finalised position being 55. This is a remarkable achievement given the August month-end position was 441.
The 55 breaches related to Oral Surgery (26), ENT (24), Cardiology (4) and Spinal Surgery (1).

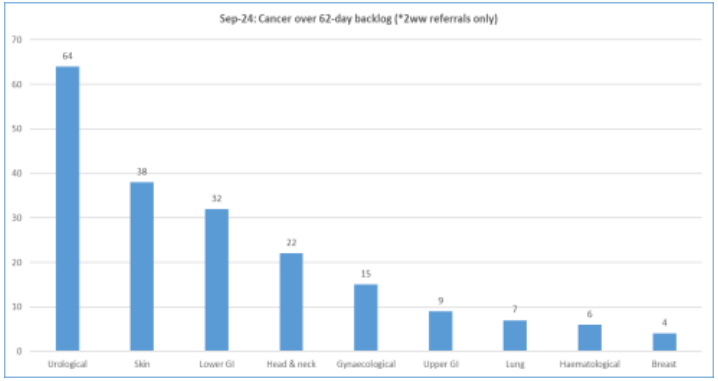
Planned Actions:
ERF schemes continue to be undertaken with the additional capacity offering the ability to reduce treatment times further. Continued focus and scrutiny exists through the various weekly meetings, the PAAF, and support from the validation team/ ECH.

Expected recovery:
Performance has recovered significantly in the past month. As such the starting position for October is much improved, endeavouring to achieve zero breaches by month-end.

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

Standard: 85%



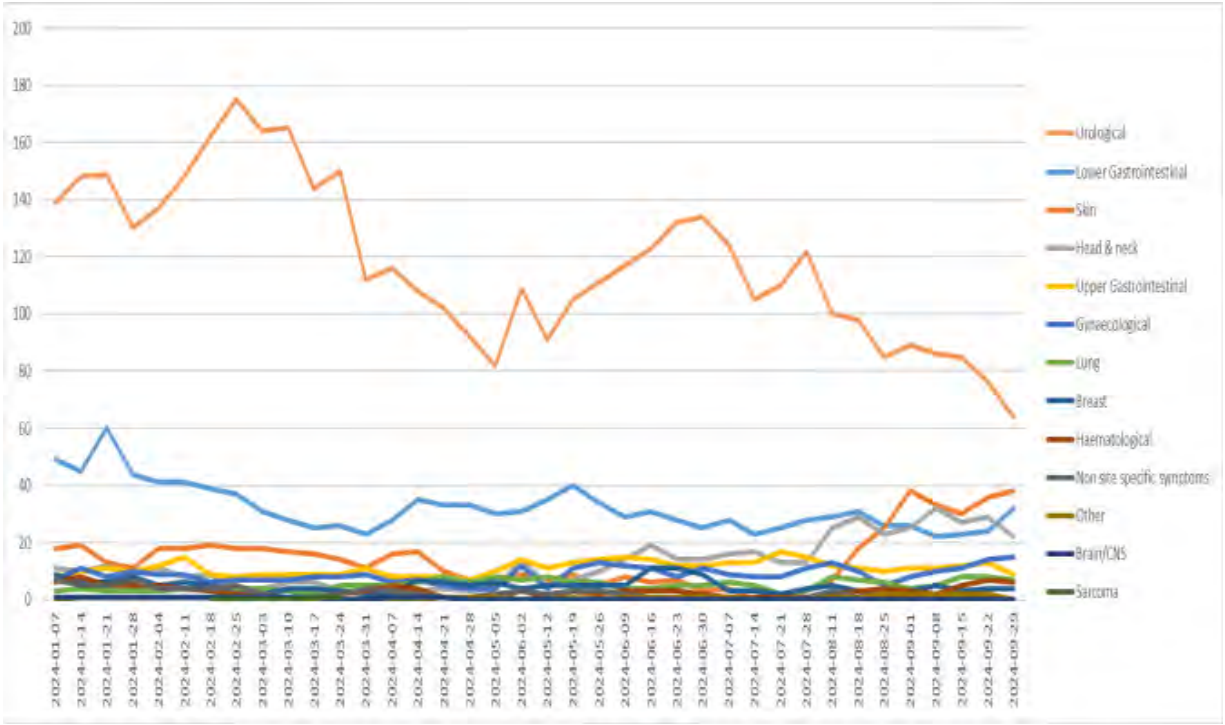


Commentary:
Unvalidated 62 Day standard for Sep is currently at 62.2% and we will miss this target
This is slightly below our recovery trajectory for 24/25 however we are aware that due to focussing on treating some of our longer patients and significantly reducing our backlog we may see a reduction over the next month

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



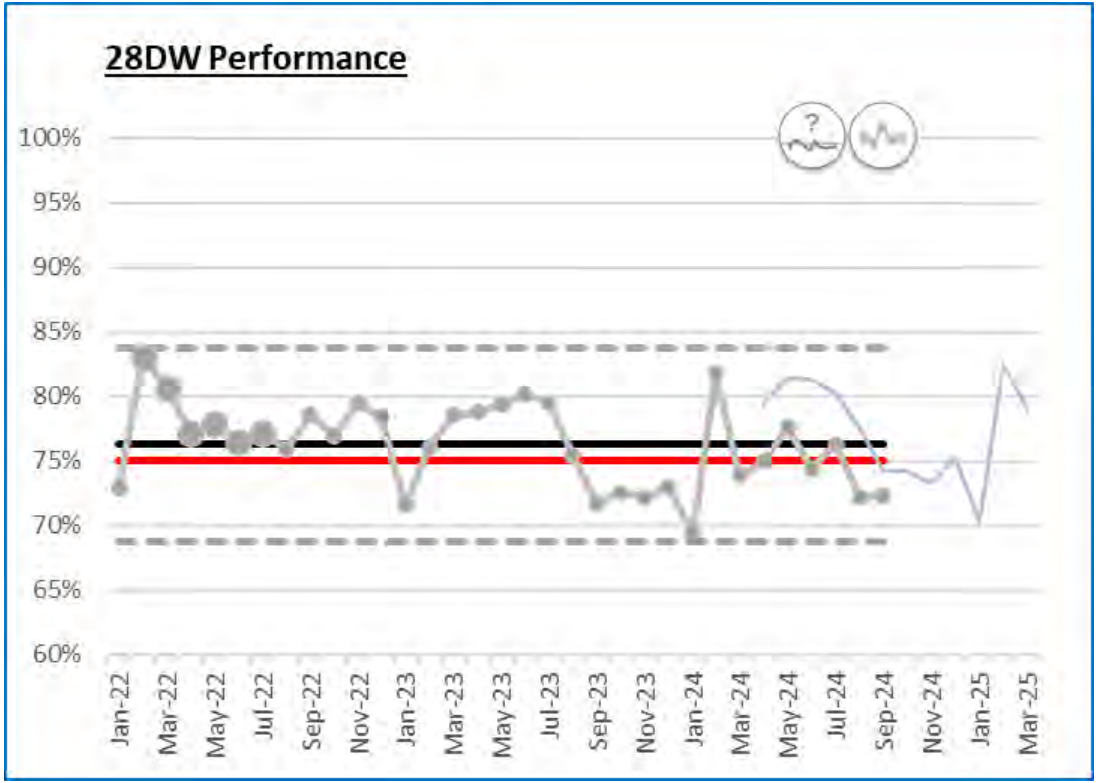
Commentary:
62 Day reportable backlog is 197 as of 29/09.
The majority of this cohort is held by Urology as demonstrated by the graph however it had decreased over the past few weeks – The overall delays for Urology are due to the diagnostic phase of this pathway, with many patients waiting after day 62
for diagnostic results or testing, however great improvements have been made to support additional capacity
Due to the delays and constraints within Skin and their Minor Ops Capacity, we have seen a dramatic increase in their backlog

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 August is currently at 72.3% and we are unlikely to meet this target, even with validation. Skin FDS performance has dropped dramatically (65.7%) and this has had a knock-on impact overall Trust FDS performance

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.
Skin FDS recovery trajectory in progress however is dependent on procurement support

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.

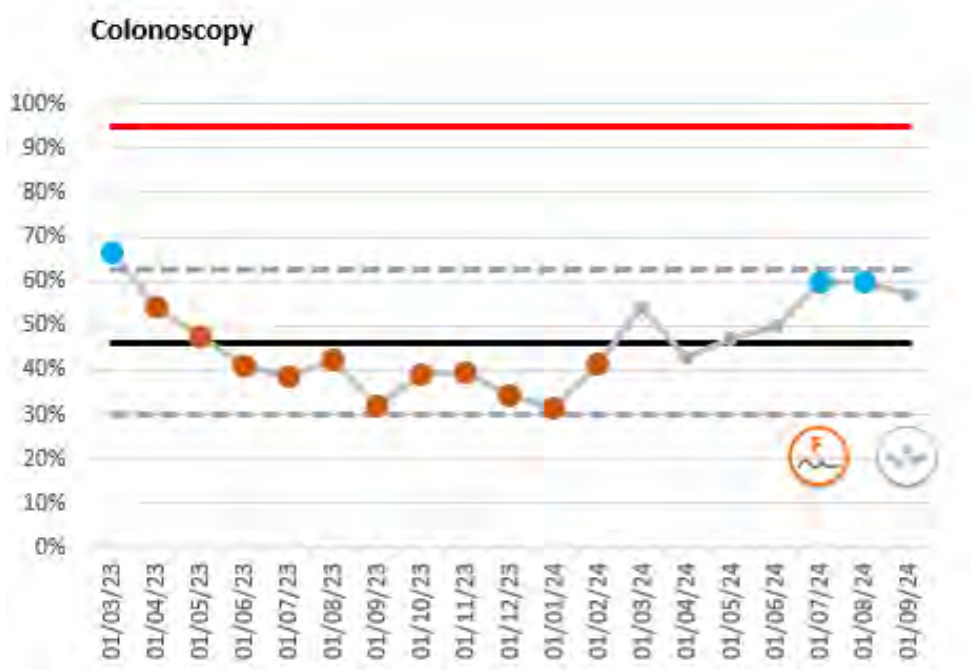
Cancer Waiting Times Performance for the last 3 months

Please Note – September is unvalidated

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Jul-24	Aug-24	Sep-24	Jul-24	Aug-24	Sep-24	Jul-24	Aug-24	Sep-24	Jul-24	Aug-24	Sep-24
Acute leukaemia												
Brain/CNS	100.0%	100.0%	100.0%	81.8%	80.0%	100.0%	87.5%	100.0%	100.0%			
Breast	15.6%	9.5%	15.1%	87.0%	87.5%	85.6%	98.1%	98.0%	98.2%	92.7%	90.7%	94.7%
Gynaecological	98.9%	97.4%	94.4%	73.6%	74.2%	72.5%	98.5%	95.7%	75.6%	73.7%	79.5%	53.6%
Haematological	95.2%	100.0%	100.0%	19.0%	29.4%	23.1%	98.3%	98.6%	100.0%	44.4%	76.9%	50.0%
Head & neck	93.7%	92.5%	87.0%	70.3%	69.7%	62.8%	93.2%	100.0%	100.0%	51.5%	73.9%	61.5%
Lower GI	61.3%	59.3%	79.4%	75.5%	75.2%	79.8%	95.1%	100.0%	87.7%	64.7%	87.1%	62.1%
Lung	98.0%	100.0%	100.0%	92.7%	90.2%	100.0%	93.8%	91.4%	81.8%	68.3%	85.4%	40.4%
Other							100.0%	100.0%	88.9%	100.0%	72.7%	72.7%
Sarcomas							100.0%	100.0%				
Skin	74.9%	83.8%	69.7%	74.5%	61.0%	48.8%	93.3%	95.3%	93.5%	92.6%	89.7%	80.0%
Non site specific symptoms	90.5%	50.0%	89.7%	59.0%	37.5%	43.2%						
Testicular	92.3%	100.0%	100.0%	85.7%	87.5%	66.7%					75.0%	
Upper GI	98.8%	99.6%	99.6%	90.2%	90.9%	94.7%	98.0%	100.0%	97.5%	77.8%	84.2%	82.0%
Urological	88.6%	94.9%	94.6%	42.0%	43.3%	41.1%	91.6%	95.5%	76.2%	27.8%	26.3%	34.1%
Trust Total	69.0%	74.5%	70.5%	75.4%	71.4%	71.0%	95.3%	97.1%	90.4%	63.1%	68.3%	62.2%

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 deteriorated in August. However, the number of patients waiting over 40wks continue to decrease. There has been a focus at reducing waits for 2WW/STT which is now booking at day 14. This has impacted our DM01 performance. Colons have reduced more than OGD and Flexisyg as they are more complex procedures.

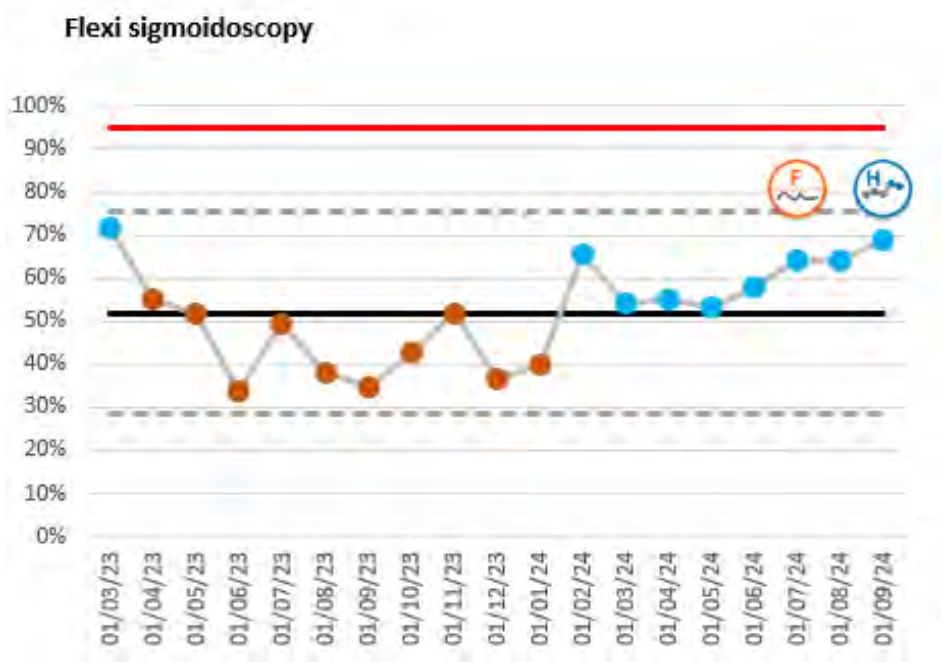
Planned Actions:
ERF scheme – consultant started this week with 5 lists per week.

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 2025

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:
Flexisyg DM01 performance improved in August. There has been a focus at reducing waits for 2WW/STT which is now booking at day 14 and despite this flexisyg DM01 has improved. This is in part to these being less complex procedures.

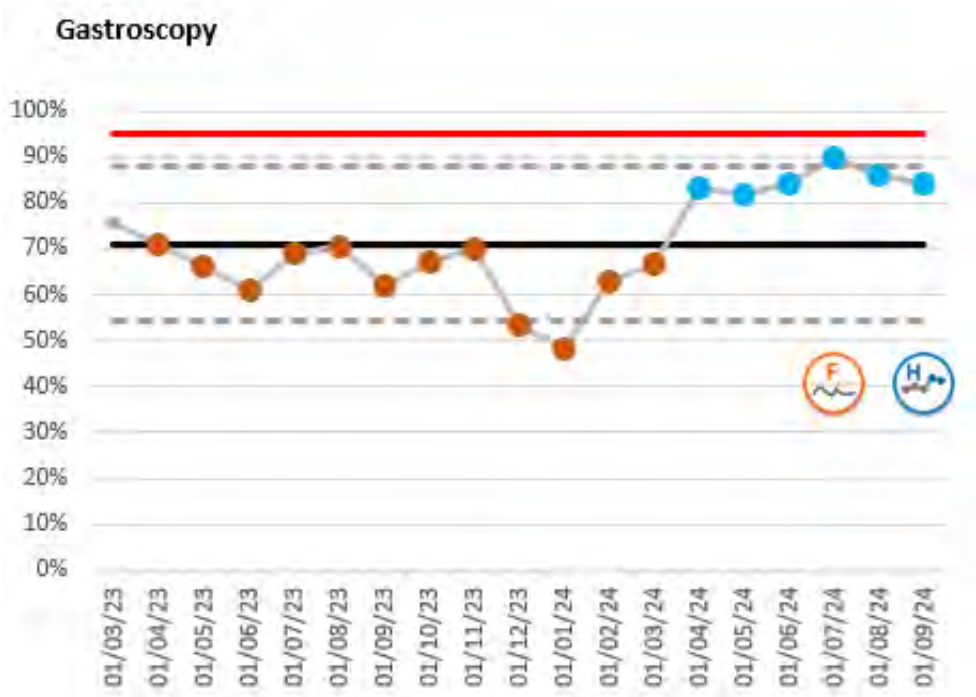
Planned Actions:
ERF scheme – consultant started this week with 5 lists per week.

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 2025

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 performance and waitlist size plateaued in Aug. However, the number of patients waiting over 40wks has reduced.

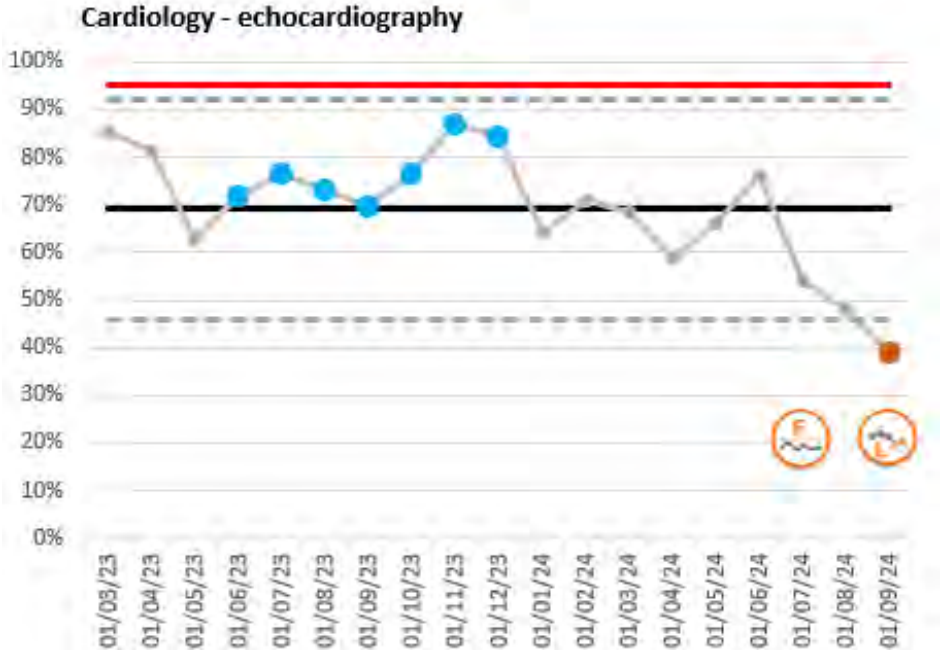
Planned Actions:
ERF scheme – consultant started this week with 5 lists per week.

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 2025

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.

Planned Actions:

ISCV – dedicated reporting system for the physiology and clinical team. Will support with improving the reporting speed for the physiologists.

ECHO support worker – 1 x WTE Band 3 to be recruited to. IP review identified a gap in the IP process which would support the recruitment to this role. Benchmarking identifies the success of the role in other Trusts.

Open Access to ECHO by the GP – discussions with the ICB have commenced.

2nd Room available at CDC

Vetting process of referrals to be improved – new criteria being written

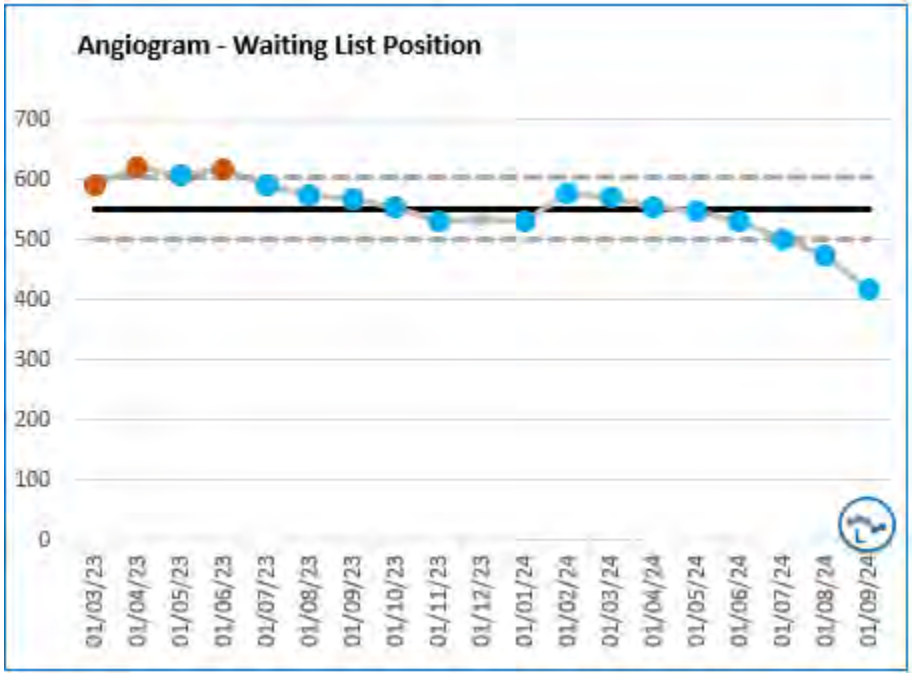
•Staff returned from maternity increase activity by 25 slots per week.

•Change to staff rotas – providing additional slots – up to 30 per month

Expected recovery:

Trajectory to recover DM01 by May 25

Angiogram - Waiting List Position



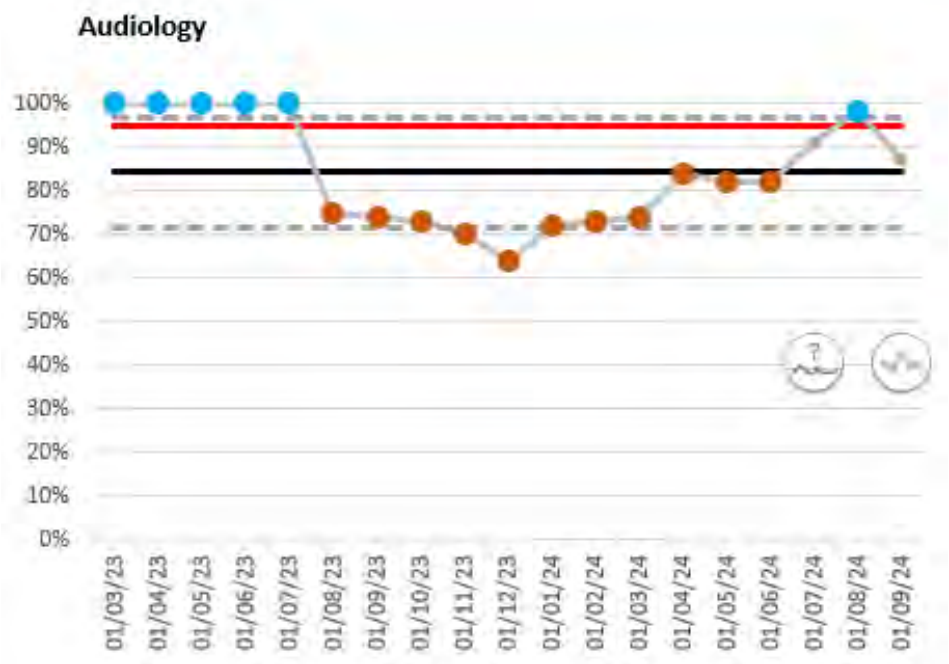
Commentary:
Reduction in waiting list numbers continue to just over 400patients. This is reflective of the new estate being more reliable,
improved radiographer cover and the start of additional weekend activity.

Planned Actions:
Additional weekend activity using our own staff and estate. This is funded via ERF and weekend activity started on the 7th Sept 2024.
Utilisation of 3rd cath lab
to reduce backlog when it becomes operational due Jan 25.

Expected recovery:
Waitlist to be halved by March 2025 and cleared by Oct 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.

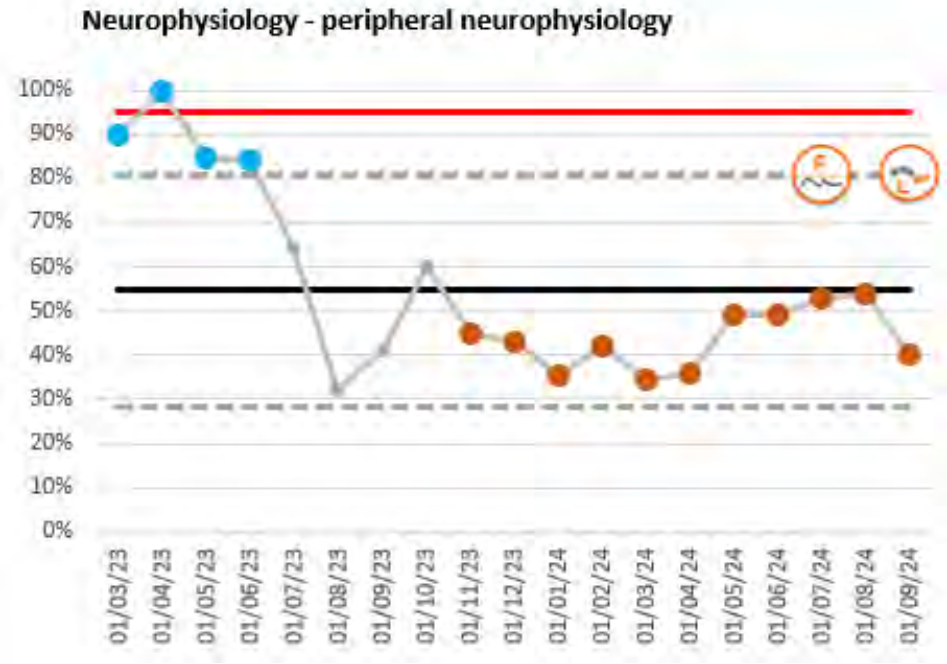
In August 2024, the service is now demonstrating DM01 compliance, recovering backlogs and a large improvement in position from December 2023. The position has deteriorated slightly in September due to Audiology's support with delivering an additional 1000 appointments from Aug-Sept 24 to support ENT 65-week recovery.

Planned Actions:
Additional audiology activity continues to support the recovery of DM01 in conjunction with supporting ENT recovery. The service are completing a workforce review to identify efficiencies and additional capacity.

Validation exercise underway to support redirection of ENT patients direct to audiology to ensure efficiency of patient pathways which may have a minimal impact on DM01 compliance.

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%)

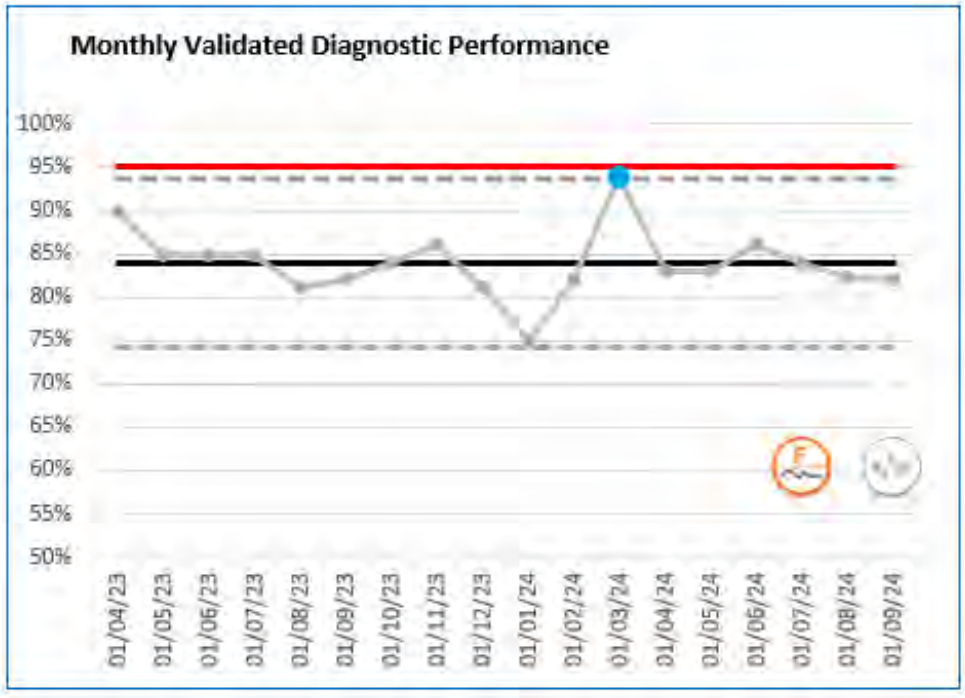


Commentary:
There has been continued reduction in waitlist over 6weeks and steady improvement in performance since March 24. However, September saw a decrease in performance due to leave, sickness and skill mix.
The longest waiting patient has remained static around 20 weeks.

Planned Actions:
2 x B7 Neurophysiologists recruited and started in September 2024. They both require some training in NCS procedures which is limiting their impact on DM01.
Recruiting apprentice (sept 24)
New GP referral form live and embedded
Aim to develop education programme for GP's and trainees
Fully validated position for Oct 24

Expected recovery:
Initial step change anticipated in September 2024 in line with recruitment.

Diagnostics: Performance Trend



Commentary:
The trust aggregate performance position demonstrates a deterioration of 3.58% Q1 2024-25 to Q2 YTD across the 14 diagnostic modalities overall. In M6 the total breach position (unvalidated is 24.28%), the worst performance this year.

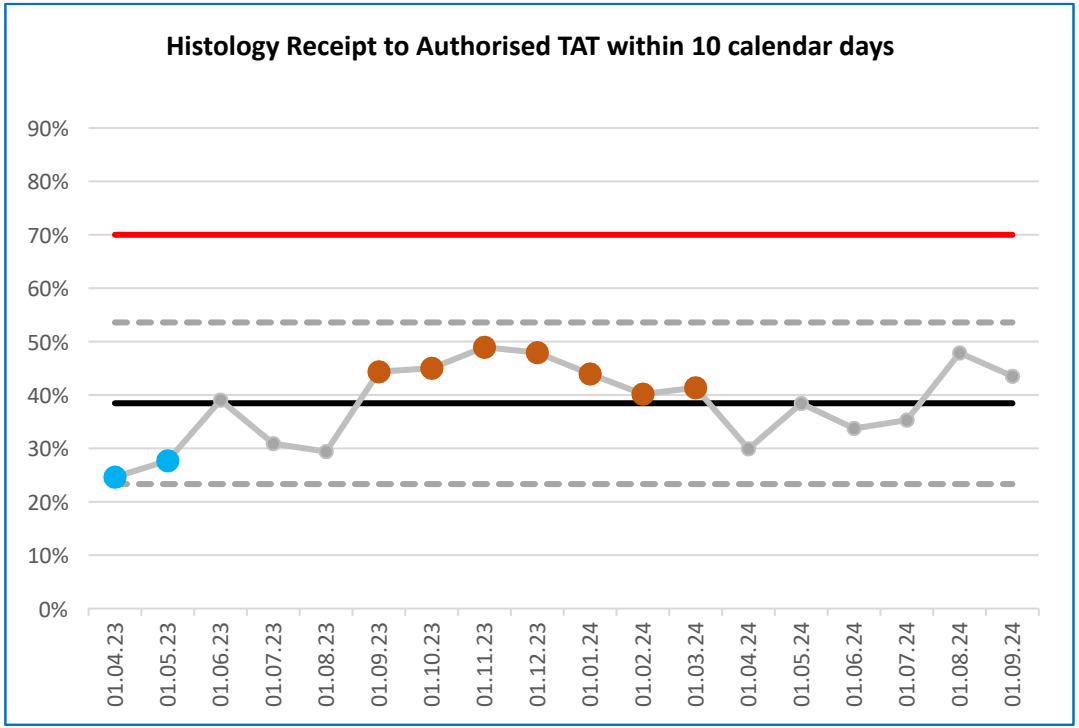
Specific acknowledgement should be given to the accelerated recovery of Urodynamics that has improved by 11.16% from August to September 2024. A significant deterioration in Echo (9.54%) and Neurophysiology (13.63%) are the largest deteriorations in M6 from M5.

Planned Actions:
Recovery in the three most challenged modalities (Cystoscopy, Echo and Urodynamics) will be delivered through specific recovery plans.

Expected recovery:
Trajectory currently sits between 16-20% breach performance however Neurophysiology requires an immediate Medicine exception report.

Diagnostics: Histopathology 10-day reporting

Standard: Delivering 70% turnaround times

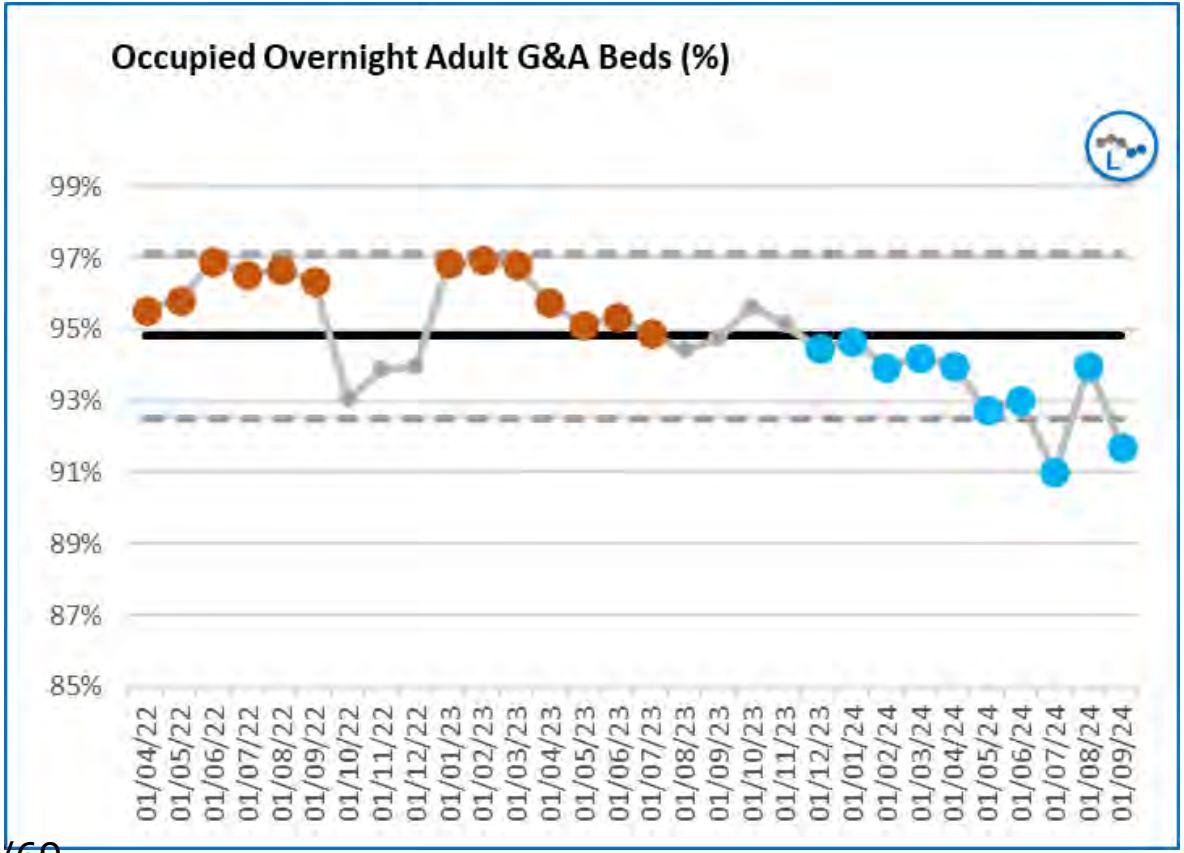


Commentary:
There is a national shortage of Histopathologists and this comes at a time of a 30% increase in Histopathology requests. There are currently three vacancies within the consultant body. The department has old, end of life equipment which is becoming increasingly unreliable causing delays in processing. The Department is reliant on outsourcing and locum reporting to cover the consultant vacancies. There is a focus on ensuring that specimens contributing to Cancer diagnostics are prioritised.

Planned Actions:
We are increasing capacity for Scientist dissection. New tissue processors are being purchased as the funding has been released.
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 of additional staff. Delivery of the new equipment is scheduled for the end of October

General & Acute Beds: Occupied

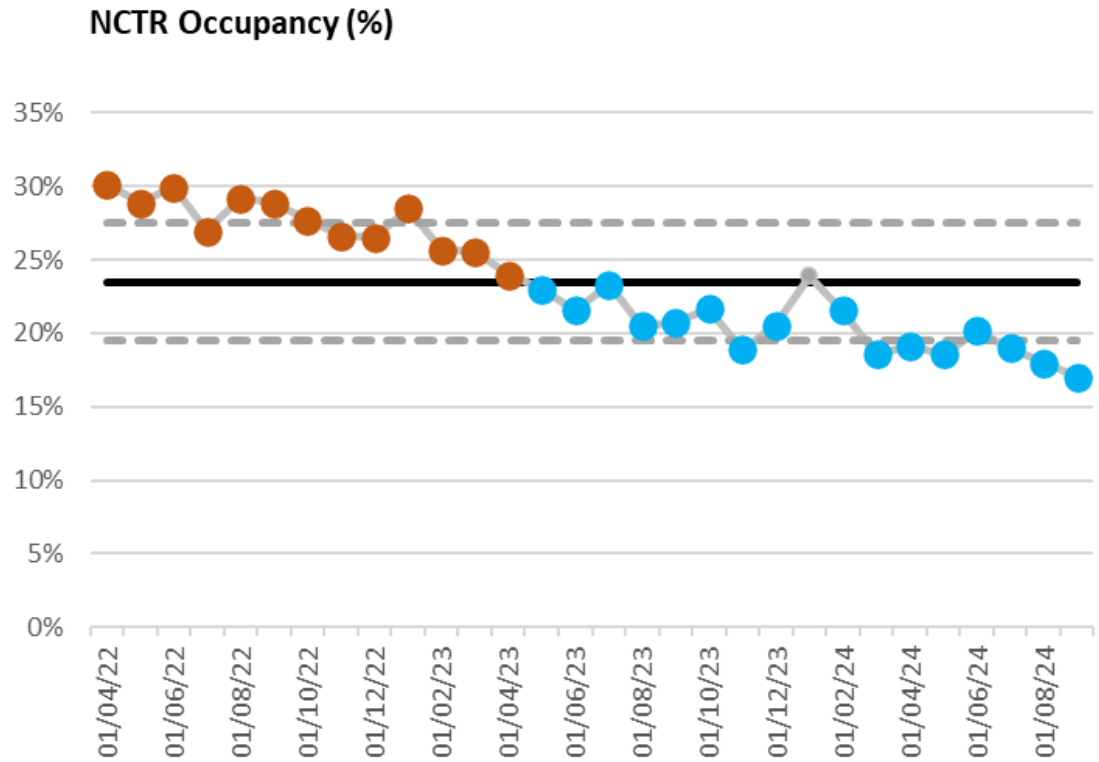


Commentary:
Overall occupancy percentage driven by elective pathways and bed capacity within elective orthopaedics and oncology in the main. Our lower occupancy at midnight has been achieved through improvements in multiple areas of flow and discharge, meaning we have not required to board or use escalation areas since the beginning of July. 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. ECIST Rapid Improvement Offer will help shape and deliver further initiatives focussed on improving flow and ensuring appropriate use of our Bed base

Expected recovery:
Some changes expected in line with work and consideration around the allocation of elective orthopaedic wards to day case and inpatient beds. This will make the bed base more accurate to what is available to the UEC pathways.

General & Acute Beds: % Beds Occupied with NCTR



Commentary:
NCTR LOS has seen significant improvements with a significant reduction in the median wait across all pathways. However the overall number and percentage is still above that of the operational plan.

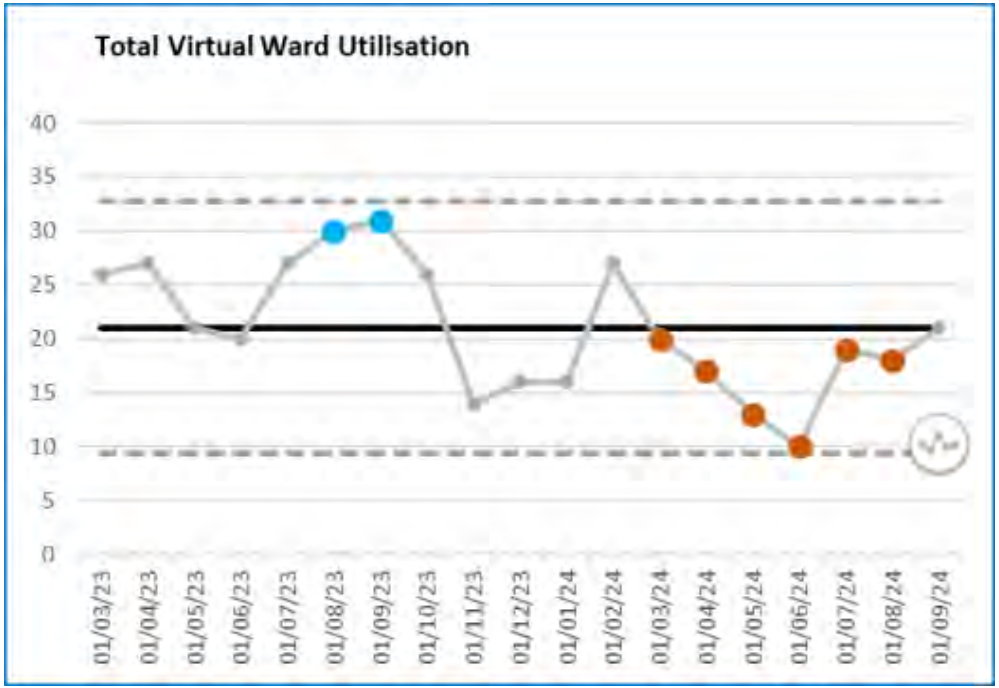
In line with planning for 24/25, the expectation is that the nCTR number is less than 87 by the end of the year, being maintained through our winter months. This is currently at risk with the figure sitting 30-35 above the plan. At time of report nCTR numbers remains at 120

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. Focus internally around driving down any internal delays with agreement to move back to referring 48hrs pre nCTR. To be launched as part of Autumn reset week.
Focused work alongside system partners to improve the pathway 1 availability to enable same day/next day discharges.
Expected recovery:
Expected to reach 100 pre Christmas with aim to further achieve and reach the pre set 87.

Virtual Wards: Utilisation

Standard: 80%



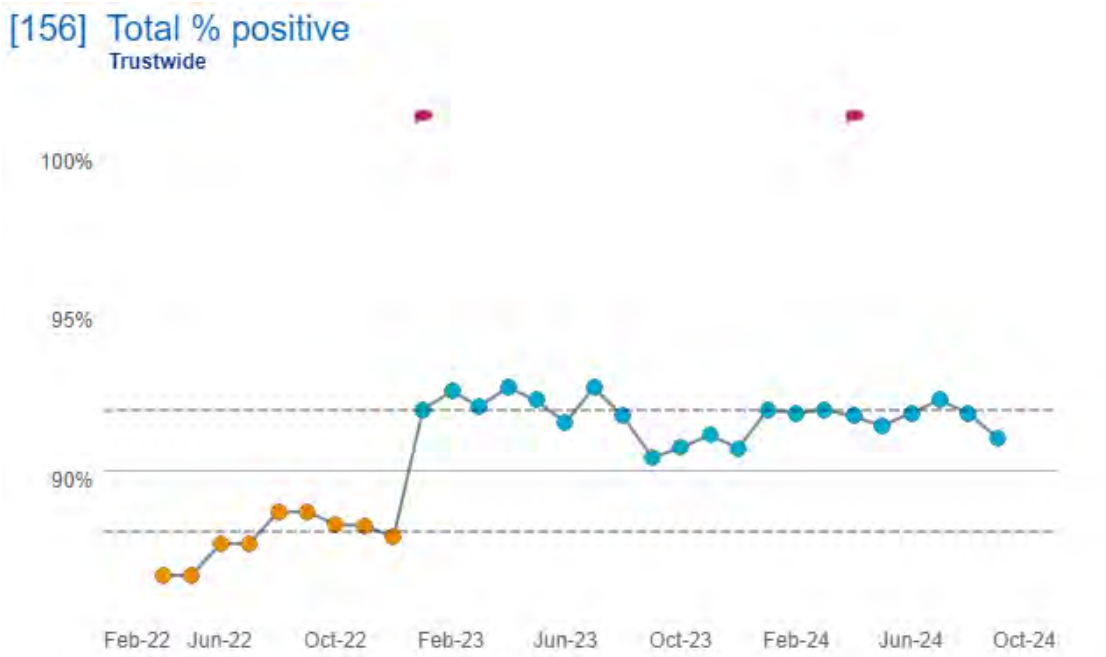
Commentary:
Reporting based on snapshot data (fortnightly national reporting). Gloucestershire systemwide occupancy remains above 80% since Jan 24. The GHFT led respiratory, frailty and surgical virtual wards are at an earlier stage of development. Activities to maximise utilisation are focussed on these wards.

Planned Actions:
The Virtual Ward Programme continues to support the growth in capacity and occupancy across pathways. July saw the launch of the Acute Medicine VR environment. 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. There is improved engagement at the Bed and Site Safety meetings with capacity being identified.

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 FFT score has reduced once again in September to 91.3% from 92.1% in August. This is as a result of a decrease in score for all care types, with the largest drops within ED and Maternity. Although disappointing, this direction of travel is in line with previous years' for this time of year. An increase in attendances and challenges with flow during September will have impacted experiences.

Planned Actions:
For divisions to review their data and identify learning and improvement opportunities. Further analysis required of the free text comments to better understand emerging or existing themes.

Expected recovery:
If data follows a similar pattern to previous years, we would expect to see our results largely plateau over the challenging winter months.

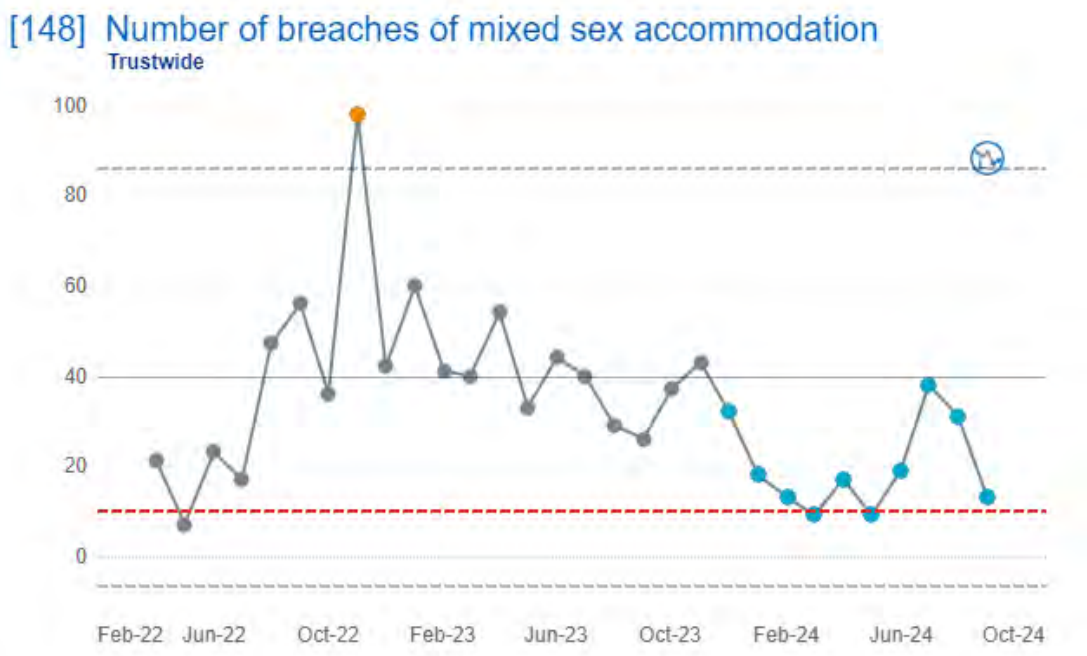
PALS

Commentary:
PALS team have seen an increase in the number of concerns closed in 5 working days to 78% and above target (75%). The workforce in the team has stabilised a little during September. We have also amended how we calculate this metric to be more representative of the closure rate.

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 expect to see only a slightly improved position as we usually see an increase in concerns over the winter months.

Patient Care: Mixed Sex Breaches

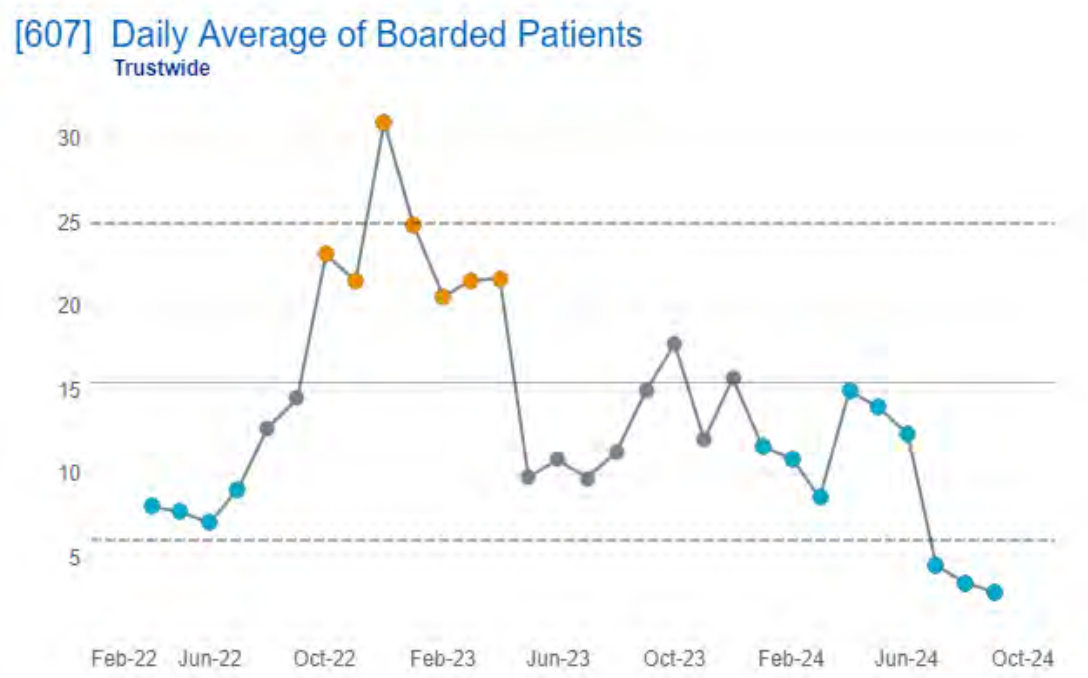


Commentary:
As part of reduced use of escalation areas and improved flow, we have also seen a sustained improvement in mixed sex breaches. Mixed sex breaches are seen in Critical Care due to the inability to move into ward beds within the 4hr timelines.

Planned Actions:
New Critical Care process introduced to support more accurate capturing of timelines for transfer off, which will help reduce mix sex breaches whereby the transfer off is around the 4-6hr mark.

Expected recovery:
Further reduction of unjustified mix sex breaches outside of clinical need.

Patient Care: Boarded Patients

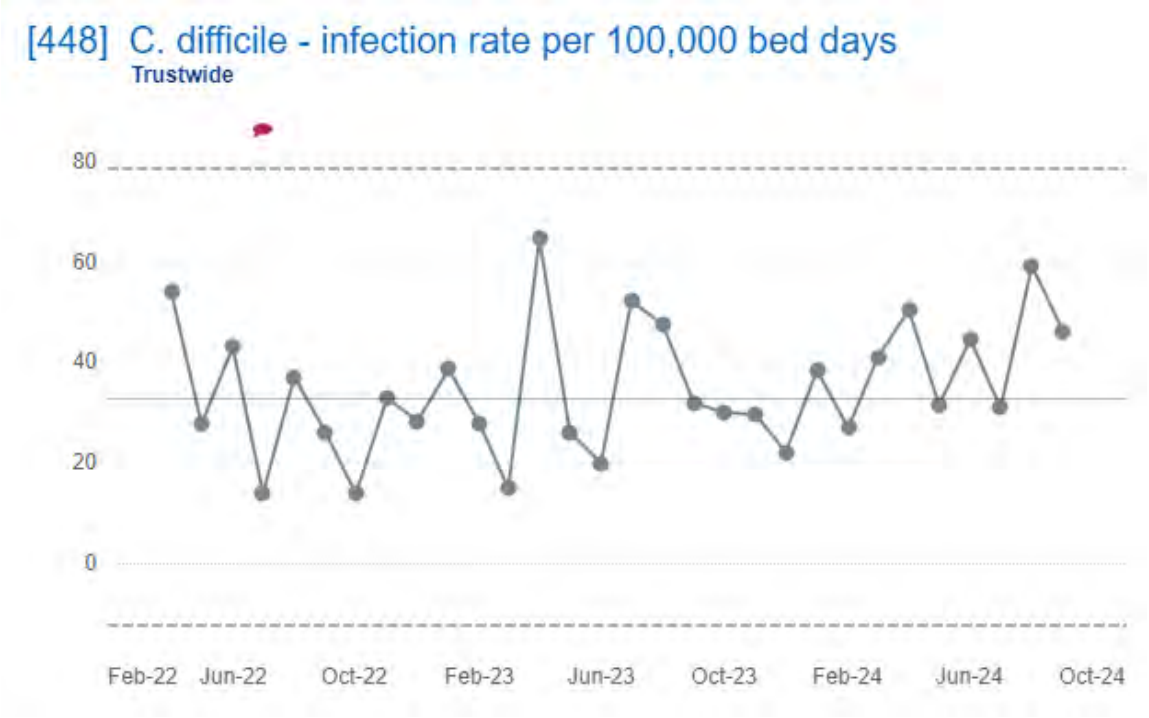


Commentary:
There has been a significant reduction in patients placed in corridors since early July 2024. 8 incidents of patients being in placed in a corridor were reported via Datix during September 2024, 14 episodes of escalation beds being used, mostly in the Frailty Assessment Unit and 9 occurrences of inpatients being placed in SDEC waiting areas, mostly Gynae Assessment Unit.

Planned Actions:
Commitment to not use corridors routinely to care for patients has been made by the Executive Tri. Escalation Policy is being completed that will only support the use of corridors in a critical incident.

Expected recovery:
Sustained reduction in the use of corridors to provide care.

Infection Control: *C. difficile*



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 is 104 cases. From April 1st 2024, we have had 58 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; especially in men living the community.

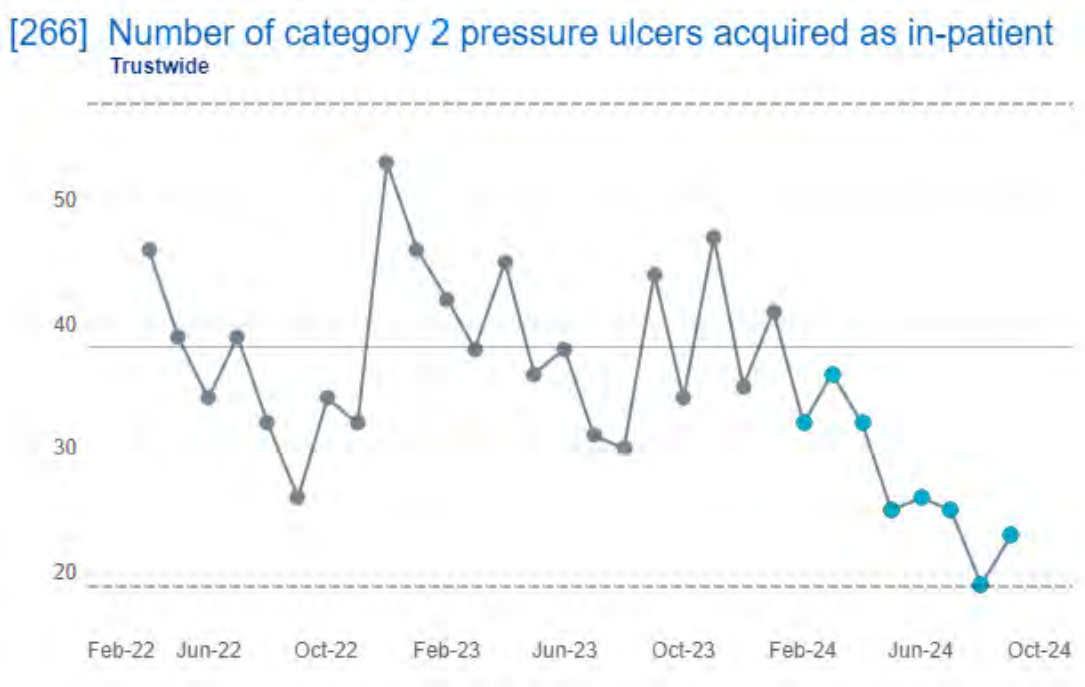
Planned Actions:

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 (CDIIG) 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 ad undertaking a review of men awaiting urological procedures as this seems to be a current risk factor across the SW; we now have data locally for this and are reviewing within the CDIIG group

Expected recovery:

With implementation of the Trust and system wide improvement plans we aim to see a 10% reduction in *C. difficile* cases rates compared to 2023/2024, when we had 36 infections per 100,000 bed days. We also aim to either come below or meet the annual *C. difficile* threshold set by NHSE (104 cases)

Safety Priority: Pressure Ulcers Cat 2

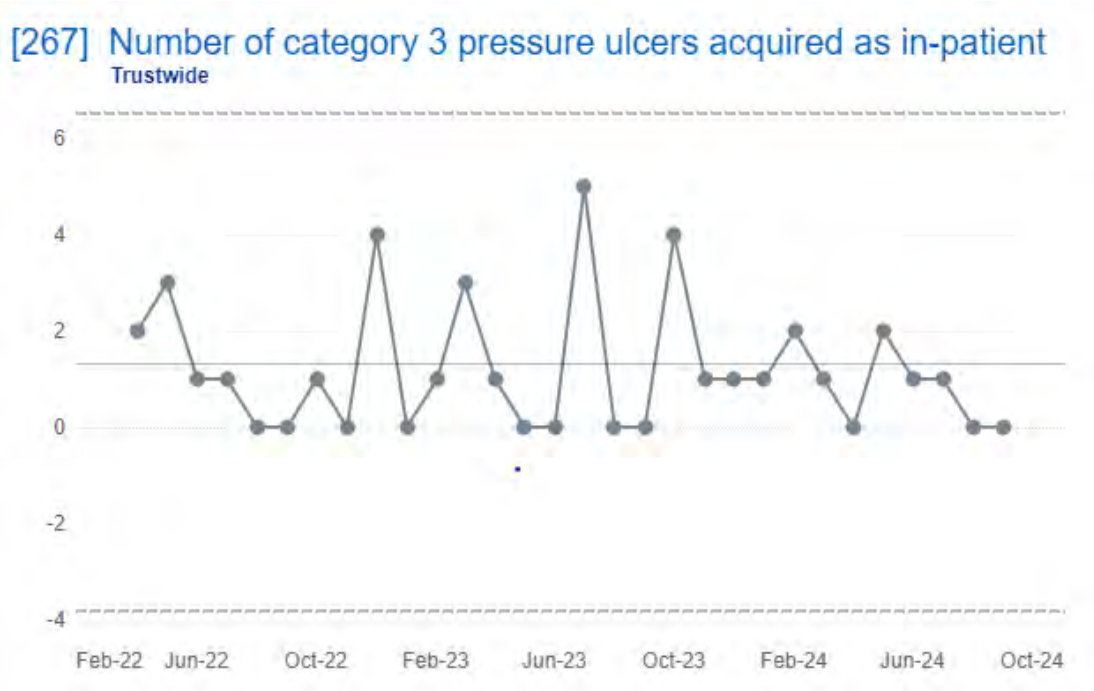


Commentary:
Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated by more patients on a ward than the staffing model accommodates, or gaps in staffing. The reduced count over the past 4 reporting periods is possibly a result of reduced corridor usage.

Planned Actions:
Improvement focus is on specialist review of all hospital acquired category 2 pressure ulcers and above. Specialist equipment for prevention of pressure ulcers has been procured and is available in the equipment library in both hospitals.
The Tissue Viability Team are investigating the significant reduction to provide assurance that this is not a reporting issue.

Expected recovery:
Implementing lessons learned can contribute to the downward trajectory of factors within our control

Safety Priority: Pressure Ulcers Cat 3

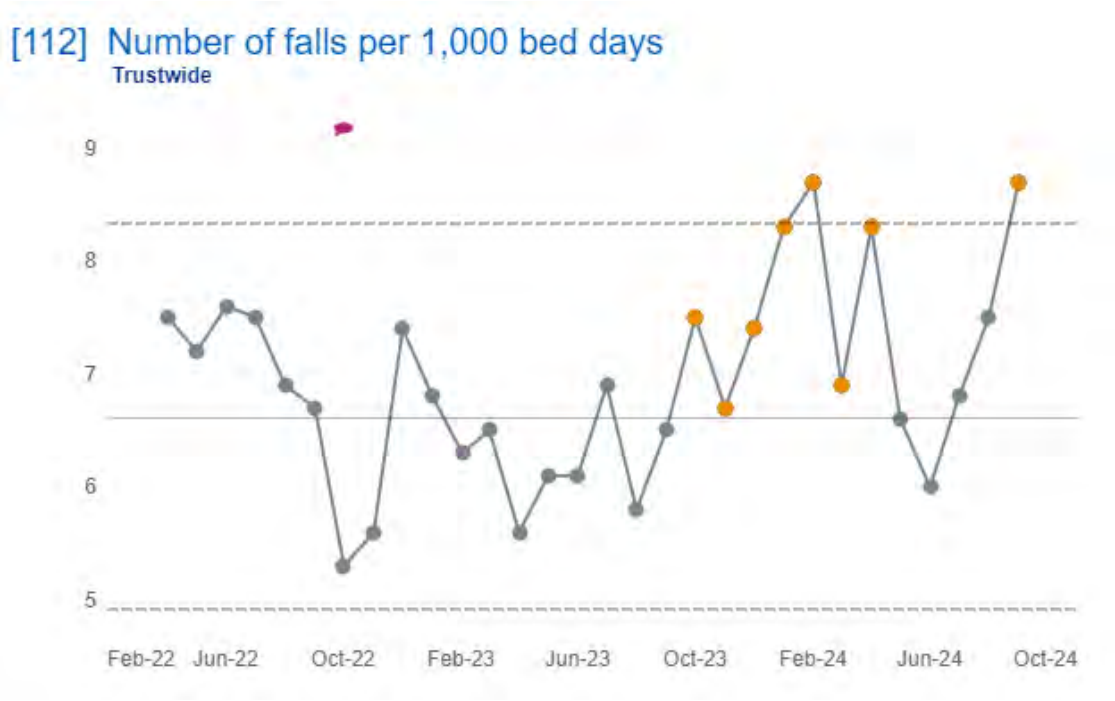


Commentary:
Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated by more patients on a ward than the staffing model accommodates, or gaps in staffing.

Planned Actions:
Improvement focus is on specialist review of all hospital acquired category 3 pressure ulcers. Specialist equipment for prevention of pressure ulcers has been procured by individual wards. 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

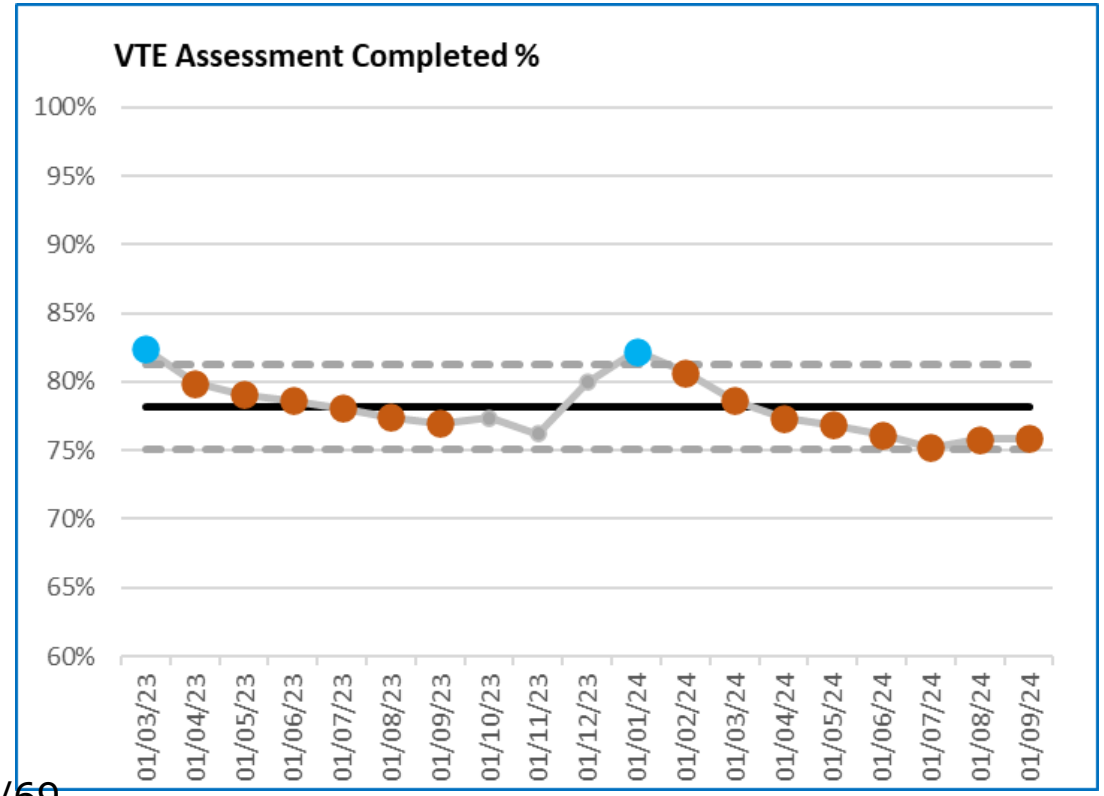


Commentary:
Falls per 1000 days had an increase in the autumn of 2023, this correlates with a focus on enhanced care usage and a reduction of that provision. The rate of falls is linked closely to acuity of patients and availability of nursing staff. All patients over 65 or at risk of falls have an assessment 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



Deep Dive at VTE Committee on 22/10/24

Data:

- VTE Dashboard to replace all other data used in the Trust. Confirmed data feeds in to IPR
- Maternity data still managed separately as link to Badgernet in progress

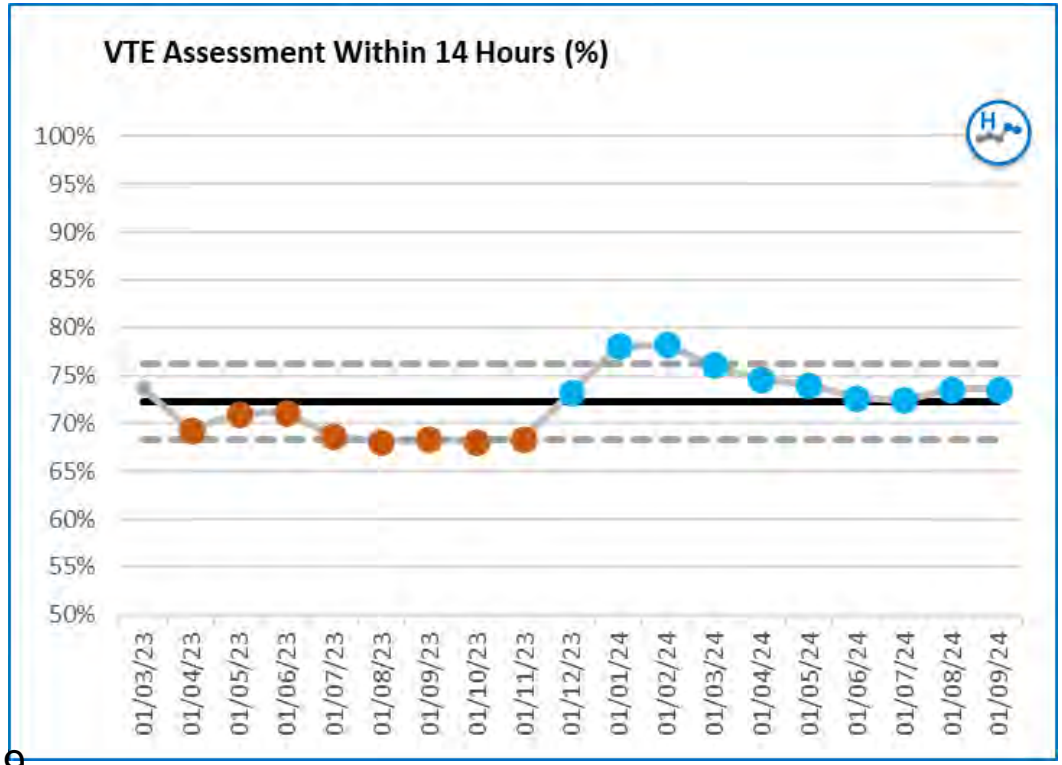
Trust:

- When LOS>36 hrs excluded Trust is achieving 96%; 92% at >24 hrs LOS
- Main issue with assessment within 14hrs is short stay (surgical) patients
- Surgery have assigned Dep CoS and Dep DDQN to lead. Areas of focus:
- Data quality: Assessment Units (ENT, T&O) and discharge summaries
- Documenting TED Stockings – EPR change request to a task from a prescription
- PDSA being developed
- Prescription of dalteparin when required has fallen from 95% - 85% over the last year

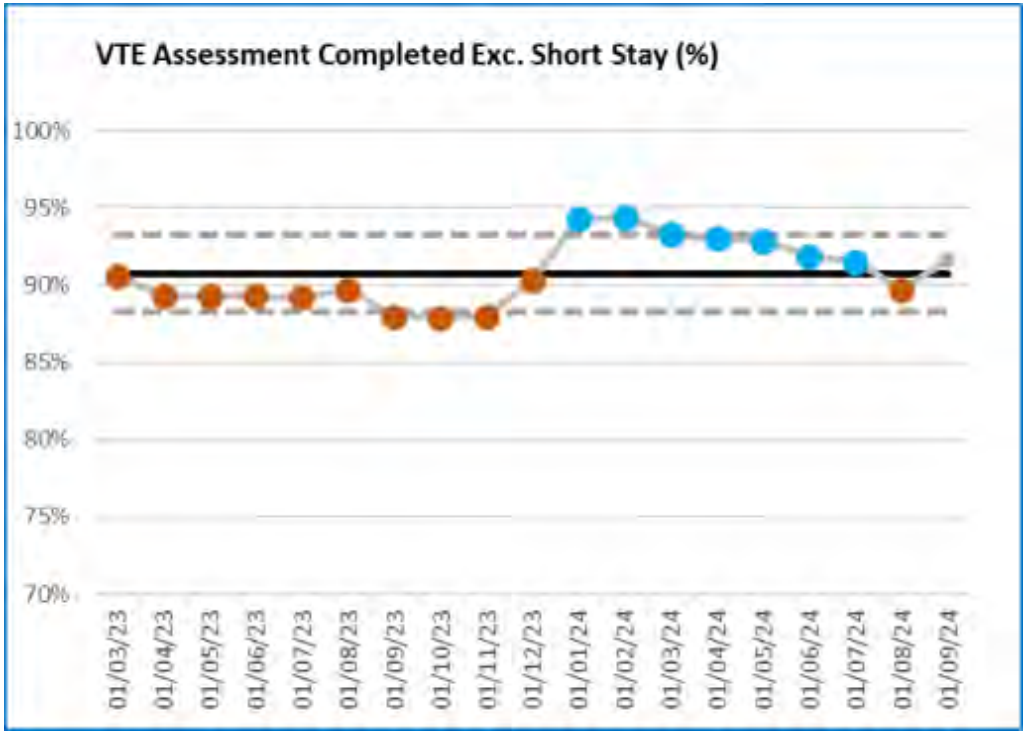
Maternity:

- Aligned targets to the rest of the Trust
- Changes in process includes clarity of responsibility (ward) and routine reminder via SBAR
- Achieving 80% assessment within 14 hrs (from 60%) and on track to achieve 95% by end Nov
- Reporting bi-weekly via CQC/QIG process

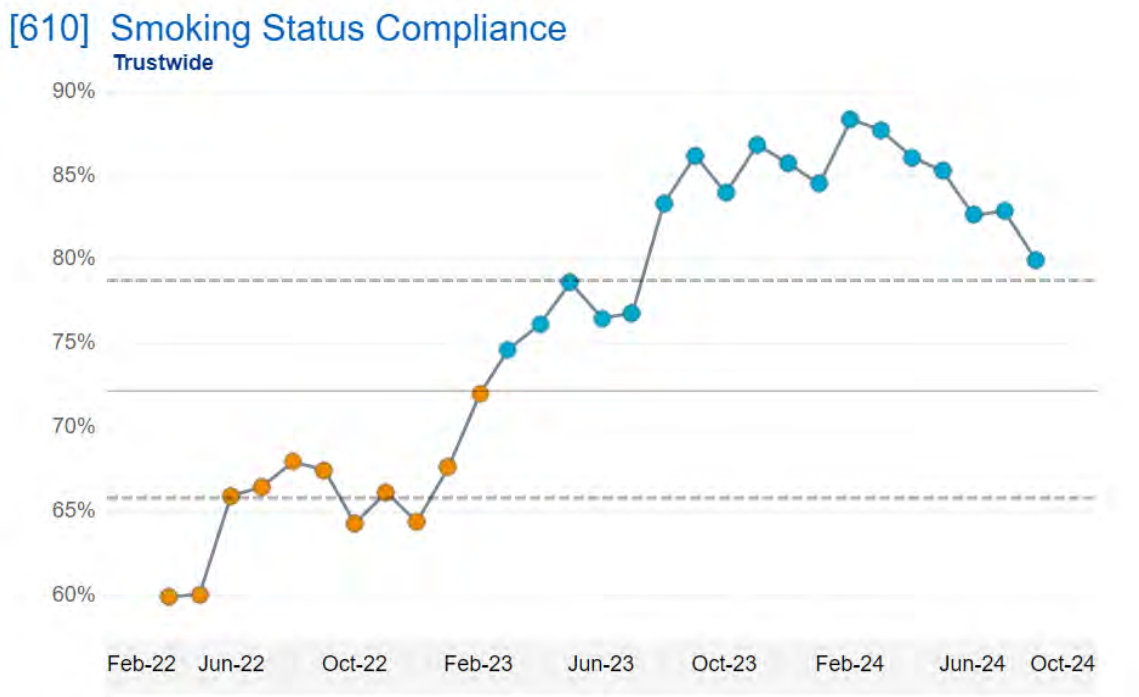
Patient VTE Risk Assessment Within 14 Hours



Patient VTE Risk Assessment Excluding Short Stay



Patient Smoking Cessation

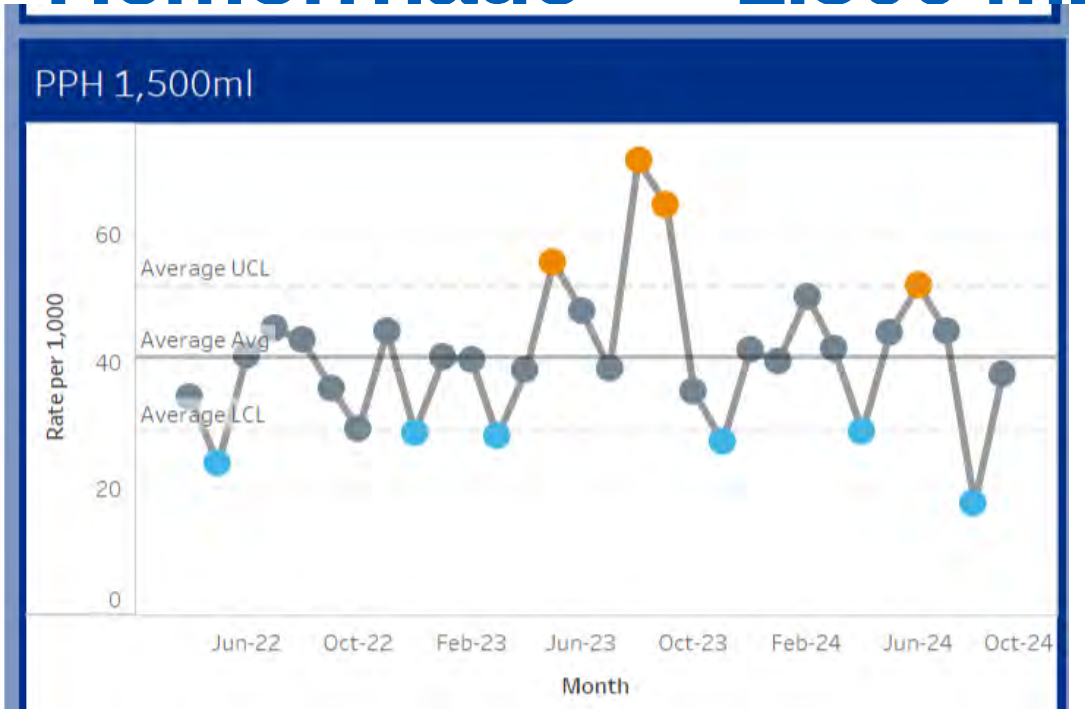


Commentary:
All patients admitted to hospital should be asked about their smoking status by the clinical and admitting teams; this should be recorded on their clinical notes and referred to the Tobacco Free Team.
Smoking should be treated like any other addiction, patients should be offered NRT upon admission.
Currently there is long term sickness and 1 vacancy within the team that is impacting on delivery of interventions.

Planned Actions:
Trust wide communications reminder to record smoking status.
Recruited advisors on Bank shifts.
Recruitment commenced for vacancy.

Expected recovery:
The tobacco free team will continue to deliver interventions on the wards.

Maternity Care: Postpartum Hemorrhage >= 1.500 ml



Commentary:
Detection and escalation of maternal and fatal deterioration is one of the areas of improvement for the Trust's **Safety Priorities.**

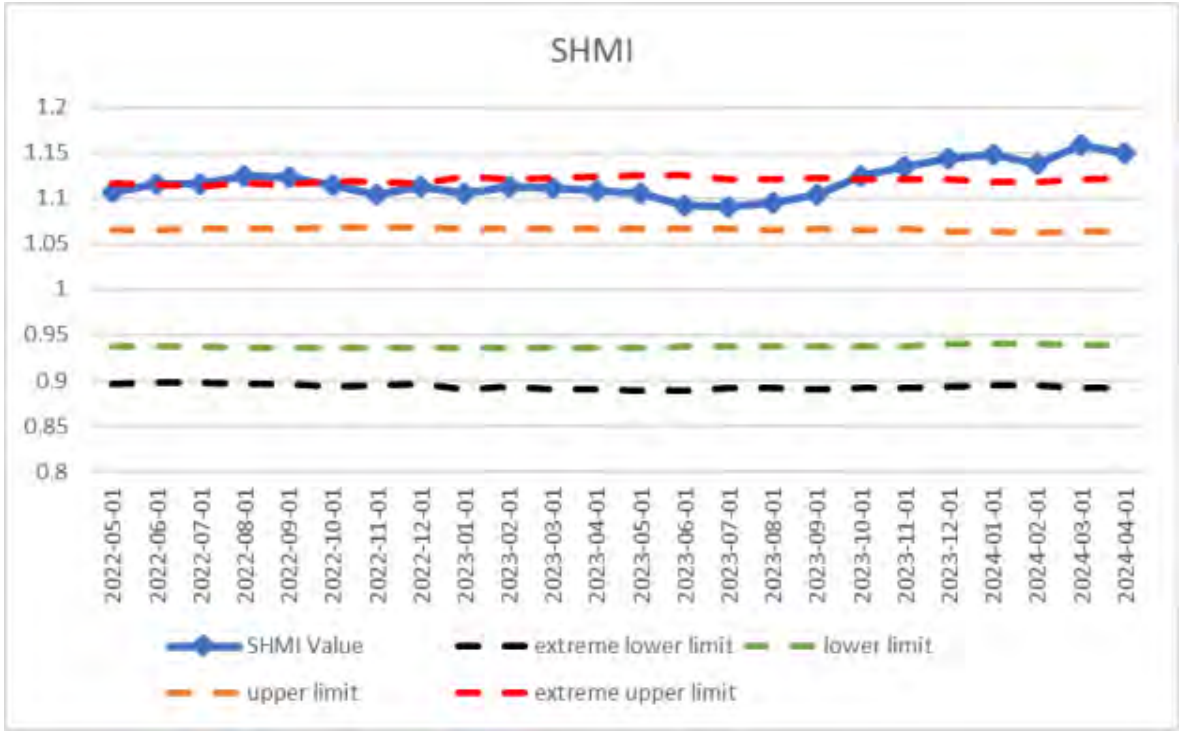
The PPH rate has increased this month to 38 per 1000 deliveries (national average 31) from a rate of 17 per 1000 deliveries last month. The PPH improvement team continue to analyse safety incidents on a weekly basis to target their improvement actions as the focus is to learn when cases happen to see how we can improve the management of incidences.

We have a **CQC S31 enforcement notice** that includes our oversight of the improvement programme for this metric. Key focus has been on the commencement of Carbetocin for all C/S and the implementation of a REDUCE proforma and risk assessment.

Planned Actions: to continue to audit risk assessment compliance and to analyse safety incidents to learn about where improvements can be made.

Expected recovery: The QI aim is to be at national average rates by Jan 2025. Oversight and actions associated with the QI work is reported to the **Maternity Delivery Group**.

Mortality – SHMI National Data



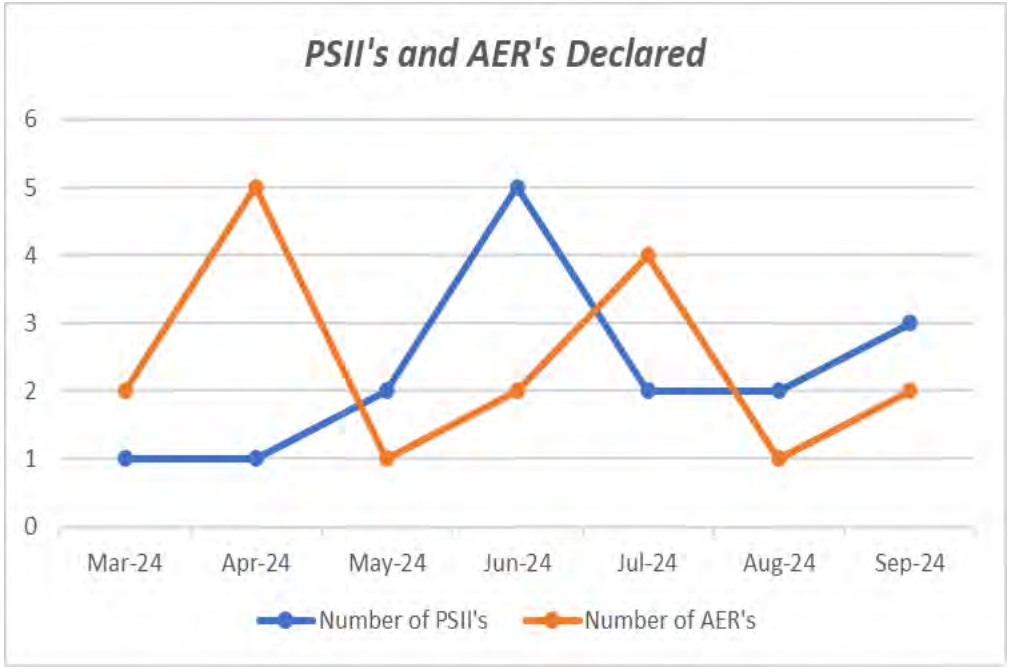
Commentary:
Latest SHMI (NHS Digital) = 1.15

Actions:
Quality Improvement Group meeting monthly chaired by ICB CMO with Regional NHSE involvement:

Primary Diagnosis/Charlson scoring coding work
Correction of incorrect data upload (leading to fewer expected deaths for GHT, therefore increasing SHMI)
Dementia coding work
Clinical Audits to review COPD and Septicaemia complete
Weekend/weekday ICB Clinical Audit ongoing
Delay Related Harm data reviewed for Jan-Jun24 with reduction in excess mortality associated with ED waits>8 hours.

Expected recovery:
SHMI is a 12 months rolling data metric and these actions will therefore take at least 3-6 months before an improvement is seen.

PSII and AER



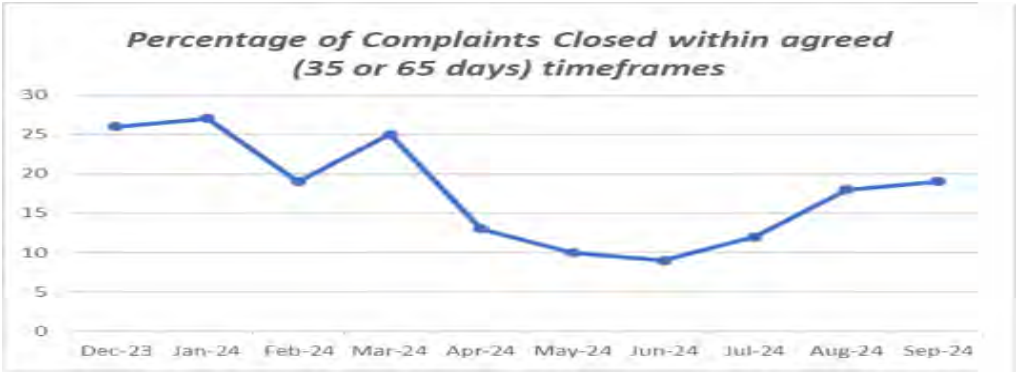
Commentary:

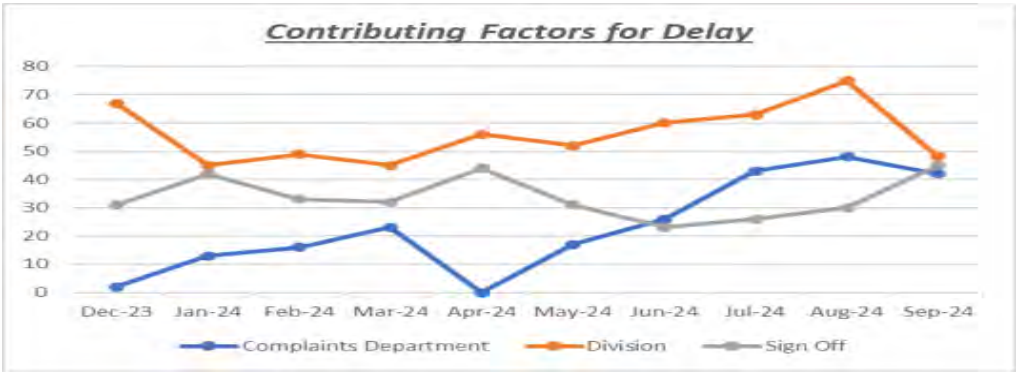
PSII – Patient Safety Incident Investigation. Declared when a problem in care is considered to have contributed to death, or a safety concern is such that a detailed systems approach investigation is indicated

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

33 Patient Safety Incidents have required review through PSII or AER, since the Trust transitioned to PSIRF in March 24; an average of 4.7 per month.

Complaints Standard: Increase the percentage response rate to 60 % by Jan 2025





Commentary:
Ability to meet response times continues to be adversely affected by the number of complaints received, delayed responses from clinical teams, delays to sign off and workforce issues in the complaint department. Whilst the response rate has improved, it remains inadequate.

Actions:

- Increased oversight/accountability of Divisional Leadership teams; chasing and clearing
- X 3 workshops with Complaint Dept
- QI approach to review of Complaint Process incorporating; design of new SOP for complaint management and proposals for focussed project group to clear backlog (out for consultation)
- Successful recruitment into 2 x Vacant WTE B3 Admin posts. Start dates – October/November 2024

Expected recovery:
Current actions in place are providing a month on month improvement in response rates. A significant improvement is expected once the backlog is cleared.

Use of Resources Metrics

Financial Metrics

Metric		Month 1			Month 2			Month 3			Month 4			Month 5			Month 6		
		Plan	Actual	Var	Plan	Actual	Var	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	-9,489	-9,192	297	-10,526	-8,907	1,619
	Forecast £'000s	0	0	0	0	0	0	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	15,428	7,254	-8,174	19,153	11,023	-8,130
	Forecast £'000s	45,972	45,972	0	45,972	45,972	0	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	8,863	11,236	2,373	11,476	14,332	2,856
	Forecast £'000s	37,389	37,389	0	37,389	37,389	0	37,389	32,091	-5,298	37,389	37,389	0	37,389	37,389	0	37,389	37,389	0
Nos days operating cash		5	28	23	5	23	18	5	16	11	5	24	19	5	27	22	5	25	20
BPP - nos invoices paid in 30 days		95%	98%	3%	95%	99%	4%	95%	99%	4%	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%	3.2%	3%	-0.2%	3.2%	2.9%	-0.3%

Key Messages

NHS England measure the Trust for FSP delivery, variance from breakeven (revenue I&E position) and agency spend as a % of pay bill. Internally we are including other metrics for review.

- Revenue I&E position is £8.9m deficit YTD against a plan of £10.5m. This is £1.6m favourable to plan and £0.7m better than forecast. The Trust has been in a deficit position for the last three months and further detail is on the next slides.
- FSP delivery is £14.3m YTD against a plan of £11.4m. This is £2.9 favourable to plan.
- Agency spend is 2.9% of total pay bill which is 0.3% better than the NHSE target of 3.2%.
- Capital spend is £11m YTD against a plan of £19m. Spend is behind plan by £8.1m. Spend has been behind plan for the past three months and further detail is on the next slides.

M06 Financial Position (ICS)

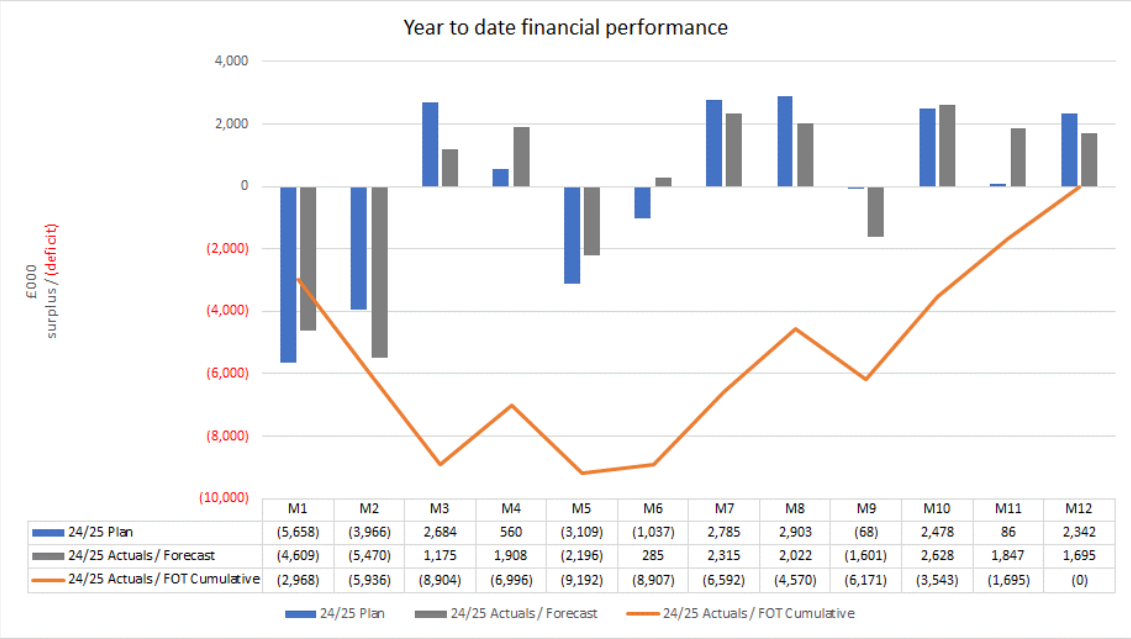
Glos ICS	YTD Plan £000	YTD Actual £000	YTD Variance £000
GHC	244	252	9
GHT	-10,526	-8,907	1,619
ICB	-	-	-
System position	-10,282	-8,655	1,628

Commentary

Gloucestershire Integrated Care System (ICS) is reporting a YTD deficit of £8.655m against a deficit plan of £10.282m. This is £1.6m favourable to plan.

The ICS continues to submit a breakeven forecast for 2024/25 to NHS England but there is a level of risk within that which is being managed across the system.

M06 Financial Position (Group)



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
24/25 Plan	(5,658)	(3,966)	2,684	560	(3,109)	(1,037)	2,785	2,903	(68)	2,478	86	2,342
24/25 Actuals / Forecast	(4,609)	(5,470)	1,175	1,908	(2,196)	285	2,315	2,022	(1,601)	2,628	1,847	1,695
24/25 Actuals / FOT Cumulative	(2,968)	(5,936)	(8,904)	(6,996)	(9,192)	(8,907)	(6,592)	(4,570)	(6,171)	(3,543)	(1,695)	(0)

Commentary

M06 financial position is £8.9m deficit YTD against a plan of £10.5m. This is £1.6m favourable to plan and £0.7m better than forecast.

Planned Actions:

- Recurrent financial sustainability opportunities continue to be explored.
- Non Pay Oversight Group being launched 15th October.
- Workforce controls continue to be monitored through Workforce Impact Group chaired by Execs.
- Financial Improvement Board continues to meet monthly chaired by CEO.

Expected Recovery:

The current forecast position for the Trust and ICS remains breakeven which is in line with plan. This requires a significant improvement in run rate which is demonstrated in the graph. The risks to delivering the plan are being managed across the system.

M06 Financial Position

Summary I&E Position (Group)	YTD Plan £000	YTD Actual £000	YTD Variance £000
Income	(375,830)	(391,059)	(15,229)
Pay	242,344	243,338	994
Non Pay	144,012	156,795	12,783
Total	10,526	9,074	(1,452)
Donated Assets/Grants/IFRIC 12 Adj	0	(167)	(167)
Adjusted (surplus)/deficit	**10,526**	**8,907**	**(1,619)**

Summary I&E Position (Trust only)	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(382,431)	(388,292)	(5,861)
Pay	233,204	229,626	(3,577)
Non Pay	159,752	167,743	7,990
Total	**10,526**	**9,074**	**(1,452)**
Donated Assets/Grants/IFRIC 12 Adj		**(167)**	**(167)**
Adjusted (surplus)/deficit	**10,526**	**8,907**	**(1,619)**

Headlines

The headline drivers of the YTD position are:

YTD position is £1.6m favourable to plan. This is driven by one-off FSP schemes delivering ahead of plan.

The Group position includes GMS and is compared to the original plan submitted in June 24. This is what is reported to NHSE. There are large variances against income, pay and non pay due to the various funding received (and associated costs) since the plan was submitted. These include consultant pay award funding, depreciation funding and ERF.

The Trust position reflects performance against working budgets which have been adjusted for service changes and funding changes. It is the Trust position that we monitor ourselves against internally. The headline drivers are:

Income overperformance of £5.8m. Overperformance includes £1.9m pass through drugs overperformance. There is also £1.8m underperformance on out of area elective activity which are on API contracts. (H&W is c.£1m and NHSE Spec Comm is c.£0.8m).

Pay underspend of £3.6m. Underspend includes £2.8m non recurrent benefit of HCSW.

Non pay overspend of £7.9m. Overspend includes £2.2m passthrough drugs and £2.2m FSP target that is held in non pay but being delivered against pay (HCSW).

M06 Pay

	YTD Budget	YTD Actual	YTD Variance		Variance excl NR
Pay M6 YTD	£000	£000	£000		£000
Infrastructure	37,372	36,670	(701)		(701)
Medical & Dental	68,441	69,646	1,205		1,205
Nursing	92,449	90,031	(2,419)		339
Other Clinical Staff	34,757	32,639	(2,118)		(2,118)
Total (excl reserves)	233,019	228,986	(4,033)		(1,275)
Reserves (FSP & other staff)	1,467	490	(977)		(977)
Divisions (FSP target)	(1,283)	150	1,433		1,433
TOTAL	233,204	229,626	(3,577)		(819)

Headlines

Pay is £3.6m YTD underspent. This includes the benefit of £0.868m HCSW rebanding underspend relating to M1 to M5. It also include the release of HCSW accrual of £1.8m. Without these non recurrent benefits, pay would be £0.8m underspent.

- Medical staffing overspend of £1.2m including industrial action costs of £616k.
- Nursing underspend of £2.4m which includes HCSW adj. Without this, nursing is £0.3m overspent YTD.
- Infrastructure £0.7m underspent, mainly within corporate areas.
- Other clinical staff £2.1m underspent, of which £1.75m is in D&S. £0.4m is in Surgery.
- Other staff £0.4m overspent. This is where FSP negative budget is held. £1.4m of YTD variance is FSP in divisions, (£0.97m) FSP in reserves due to slippage in cost pressures and HRI.

M06 WTE Position (draft)

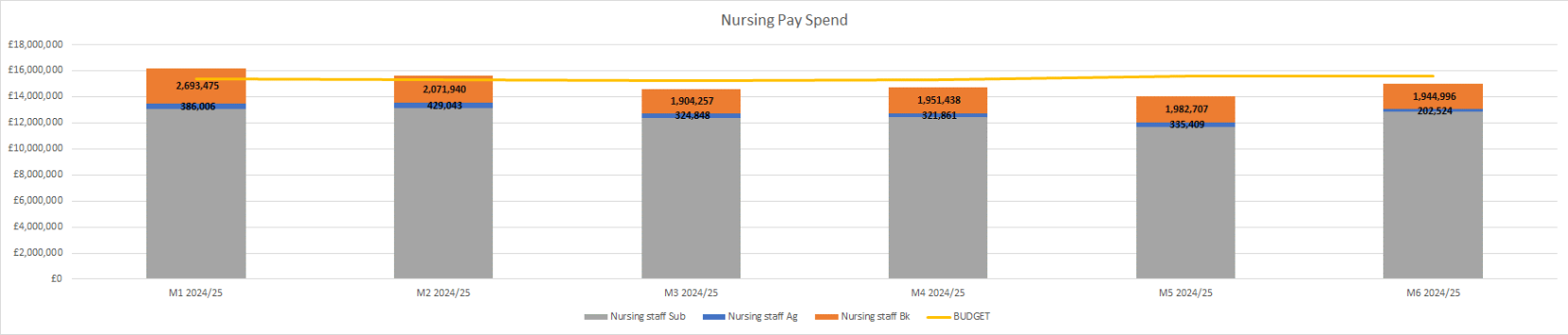
At the time of writing, full PWR including GMS is not available

Workforce Group	M6 Funded WTE	PWR Worked M07 23/24	PWR Worked M05 24/25	PWR Worked M06 24/25	Month 5 2425 to month 6 2425 movement WTE	Movement from M7 23/24	Funded WTE vs PWR WTE
Infrastructure costs	1,794.93	1,698.18	1,740.47	1,742.50	2.03	44.32	-52.43
Medical & Dental Staff	1,134.59	1,112.11	1,299.15	1,149.94	-149.21	37.83	15.35
Nursing staff	3,777.78	3,913.09	3,933.91	3,917.59	-16.32	4.50	139.81
Other Clinical Staff	1,428.25	1,324.14	1,338.32	1,384.78	46.46	60.64	-43.47
Total Trust before adj	8,135.55	8,047.52	8,311.85	8,194.81	-117.04	147.29	59.26

Headlines

- The M6 worked WTE is 147.29 higher than M7 23/24.
- The M6 worked WTE is 59.26 higher than funded levels.
- The M6 worked WTE is 117.04 WTE lower than prior month.
- Medical & Dental WTE has reduced by 149.21 (prior month contained junior/resident doctor rotation)
- Nursing WTE has reduced by 16.32.
  - This includes a reduction in D&S of 33.2 due to recoding to Other Clinical staff. There have been increases in Medicine 11.38 and Surgery 12.82.
- Other clinical staff has increased by 46.46wte, of which 33.2 is due to recoding from nursing. The remainder is within Surgery, D&S and Corporate

M06 Nursing Pay

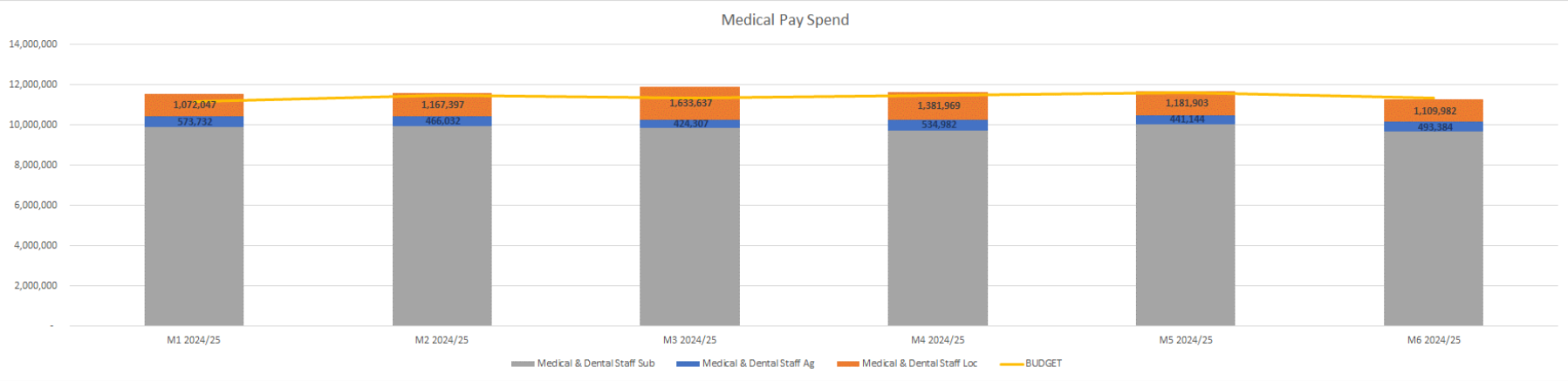


Headlines

Nursing budgets are £2.4m underspent YTD. This includes the benefit of £1.8m from releasing HCSW recognition payment accrual which is not needed and slippage in rebanding of £0.868m. Without these benefits, **pay is £0.3m overspent YTD.**

- M6 spend is £306k lower than prior month (excluding HCSW adj). Prior month contained £157k bank holiday enhancements. The remainder is £149k reduction across all divisions.
- Worked WTE (PWR) has reduced from M5 to M6 by 16.32WTE
  - This includes a reduction in D&S of 33.2 due to recoding to Other Clinical staff. There have been increases in Medicine 11.38 and Surgery 12.82.
- Nursing agency spend has reduced by £133k from M5 to M6 (£335k to £203k).
- Nursing agency WTE has reduced by 15.03wte from M5 to M6.
  - This includes a reduction in D&S of 33.2 due to recoding to Other Clinical staff. There have been increases in Medicine 11.38 and Surgery 12.82.

M06 Medical Pay



Headlines

Medical staffing budgets are £1.2m overspent YTD. This includes industrial action costs of £616k.

- In M6, medical budgets are £84k underspent.
- Spend has reduced by £413k in month. Within this movement, there has been a reduction of £216k within Surgery (mainly WLI and locum) and £106k reduction in D&S (WLI and vacancy cover).
- Medical agency spend has increased by £52k from M5 to M6 (£441k to £492k). However locum spend has reduced by £72k.

M06 Non Pay

Non Pay	YTD Variance £000 Divisions	Corporate	Reserves/ Central	FSP (pay offsetting non pay)	Total
YTD Variance	11,180	-637	-2,553		7,990
Adjusted items and passthrough:					
IFRIC12 & donated assets		-167			-167
Pass through drugs and devices	4,423	0	-2,205		2,219
FSP non pay pressure that is covered by HCSW NR benefit (pay)				2,668	2,668
YTD Variance excl adjusted items and pass through	6,757	-470	-348	-2,668	3,271

Headlines

M6 YTD non pay position is overspent by £7.9m

This reduces to £3.2m after removing:

- IFRIC12 & donated assets
- costs of passthrough drugs & devices that are matched by income
- FSP target that is held in non pay but being delivered against pay for HCSW non recurrent benefit.

The £3.2m is split by:

- Divisional pressures £6.7m.
  - This is partly offset by the £2.6m NR HCSW FSP delivery held in pay.
- Corporate underspend £0.47m
- Reserves underspend £0.3m

M06 Income

Income	YTD Budget £000	YTD Actual £000	YTD Variance £000
HEE Income	(7,643)	(9,344)	(1,701)
Other Income from Patient Activities	(5,442)	(10,799)	(5,356)
Other operating income	(15,649)	(13,550)	2,099
PP Overseas and RTA Income	(2,922)	(3,098)	(177)
SLA & Commissioning Income	(350,775)	(351,501)	(726)
Total Income	(382,431)	(388,292)	(5,861)

Headlines

M6 YTD income position is £5.8m favourable to plan. This is driven by:

- HEE income £1.7m which offsets costs within divisions

- Non Recurrent income & balance sheet releases:
  - Funding repayment £0.8m
  - Depreciation funding £1.8m
  - Spec comm bowel scope £0.5m

These NR items offset £2.099m FSP target

- CDC and Cancer funding £1.5m above budget

- SLA & Commissioning Income
  - IA funding £0.6m
  - Pass through drugs overperformance £1.9m.
  - Underperformance on out of area elective activity which is an API contract. This is £1.8m of which H&W is c.£1m and NHSE Spec Comm is c.£0.8m.

M06 Capital Position

in £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	2,995	2,953	42	7,020	7,020	0
MEDICAL EQUIPMENT	1,696	614	1,082	8,953	8,953	0
ESTATES	8,174	5,267	2,907	20,080	20,157	(77)
NBV OF ASSET DISPOSALS	0	(77)	77	0	(77)	77
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**12,865**	**8,757**	**4,108**	**36,052**	**36,052**	**0**
RIGHT OF USE ASSET	5,169	1,523	3,646	7,412	7,412	(0)
Total Charge against Capital Allocation (including impact of IFRS 16)	**18,033**	**10,280**	**7,753**	**43,464**	**43,464**	**0**
NAT PROGRAMME, GRANTS, DONATIONS & OTHER	2,500	1,937	563	4,623	4,623	0
Gross Capital Spend Total	**20,533**	**12,217**	**8,317**	**48,088**	**48,088**	**0**

Gross Capital Spend Total	**20,533**	**12,217**	**8,317**	**48,088**	**48,088**	**0**
Less Donations and Grants Received	(1,250)	(1,065)	(185)	(1,499)	(1,499)	0
Less PFI Capital (IFRIC12)	(300)	(300)	(1)	(600)	(600)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res Interest)	170	171	(1)	341	341	0
Total Capital Departmental Expenditure Limit (CDEL)	**19,153**	**11,023**	**8,130**	**46,330**	**46,330**	**0**

Note:

The total capital allocation increased in month by £0.4m following an award of national programme PDC for a histopathology scanner and advancement in the rollout of digital histopathology within the Trust and Network.

Headlines

The headline drivers of the YTD position being £8.1m behind plan are:

Right of Use Assets (£3.6m) driven by two contracts

• CT/MRI Services (£2.0m) The length of the agreed contract variation was much shorter (9months instead of the assumed 3years) this is due to a decision to undertake a review into our service provision over the coming months which will dictate the terms of any future contract

• Cirencester Lease (£1.1m) Continued delays in entering a new agreement with GHC to continue to use Cirencester Theatres. Operational need specified now initiating talks with GHC to prepare terms and calculate budgetary impact.

Operational Capital

• IGIS (£1.6m) - Delays in project and revised timetable agreed. IR Room and 3rd Cath Lab equipment expected to be delivered at the end of October which will close this gap.

• Other Estates projects (£1.3m) - A number of estates projects slipping for various reasons. A detailed forecast and deep dive being undertaken in October to firm up forecast position and identify/agree mitigations.

• Medical Equipment Replacements (£1.0m) Allocation of budget and delivery of equipment slower than estimated. Expected to recover in the coming months.

Cash Flow

	Apr-24 £'000	May-24 £'000	Jun-24 £'000	Jul-24 £'000	Aug-24 £'000	Sep-24 £'000	Oct-24 £'000	Nov-24 £'000	Dec-24 £'000	Jan-25 £'000	Feb-25 £'000	Mar-25 £'000	Apr-25 £'000	May-25 £'000	Jun-25 £'000	Jul-25 £'000	Aug-25 £'000	Sep-25 £'000	Oct-25 £'000
Opening Balance	**55,176**	**59,364**	**39,309**	**32,237**	**40,838**	**46,441**	**42,946**	**63,792**	**53,409**	**44,660**	**33,958**	**41,514**	**29,919**	**32,796**	**32,381**	**20,084**	**27,859**	**24,240**	**15,537**
Receipts																			
SLA Income	56,603	56,604	53,597	58,941	70,953	62,151	65,944	54,913	57,308	60,756	58,169	59,832	57,088	59,311	57,211	61,107	57,058	58,584	61,890
Other NHS	17,271	2,650	3,025	14,209	4,254	1,963	22,719	2,662	2,615	3,056	10,503	2,447	15,847	2,400	3,125	12,821	2,215	2,015	19,313
Other Non-NHS	2,924	1,941	1,723	1,677	1,487	2,366	2,133	1,559	1,427	1,827	2,012	2,953	2,611	2,039	1,596	2,394	1,934	1,868	2,121
VAT	1,051	3,358	2,455	4,210	2,709	3,080	2,135	2,479	3,095	3,019	2,431	2,214	2,051	2,358	2,444	2,841	3,218	2,166	1,935
Total Receipts	**77,849**	**64,554**	**60,801**	**79,036**	**79,403**	**69,963**	**92,931**	**61,613**	**64,446**	**68,658**	**73,116**	**67,447**	**77,597**	**66,108**	**64,376**	**79,163**	**64,424**	**64,634**	**85,258**
Payments																			
Payroll - Direct payments	-23,625	-23,934	-25,273	-24,715	-24,750	-23,999	-30,723	-26,410	-26,386	-26,205	-26,281	-28,950	-25,944	-25,879	-26,521	-26,054	-26,015	-26,064	-26,061
Payroll - On costs	-18,111	-16,960	-17,234	-18,108	-17,474	-17,195	-18,085	-18,069	-18,064	-18,050	-18,111	-18,065	-18,091	-16,946	-18,069	-18,549	-18,045	-18,045	-18,085
Payables	-31,926	-43,714	-25,366	-27,612	-31,576	-26,746	-23,277	-27,518	-28,745	-35,105	-21,168	-27,527	-30,685	-23,697	-32,083	-26,785	-23,984	-24,186	-34,022
Loan Principle & Interest	0	0	0	0	0	-1,215	0	0	0	0	0	-1,186	0	0	0	0	0	-1,215	0
PDC Payments	0	0	0	0	0	-4,304	0	0	0	0	0	-3,312	0	0	0	0	0	-3,828	0
Total Payments	**-73,661**	**-84,609**	**-67,873**	**-70,435**	**-73,801**	**-73,458**	**-72,085**	**-71,996**	**-73,194**	**-79,360**	**-65,560**	**-79,041**	**-74,720**	**-66,523**	**-76,674**	**-71,387**	**-68,044**	**-73,338**	**-78,168**
Net Cashflow	**4,188**	**-20,055**	**-7,072**	**8,601**	**5,603**	**-3,495**	**20,846**	**-10,384**	**-8,748**	**-10,702**	**7,555**	**-11,594**	**2,876**	**-414**	**-12,297**	**7,775**	**-3,619**	**-8,704**	**7,090**
Closing Balance	**59,364**	**39,309**	**32,237**	**40,838**	**46,441**	**42,946**	**63,792**	**53,409**	**44,660**	**33,958**	**41,514**	**29,919**	**32,796**	**32,381**	**20,084**	**27,859**	**24,240**	**15,537**	**22,627**

Headlines

- The cashflow reflects the Trust position.
- The table is for an 18 month period and is based on the assumption that income and expenditure will be at similar levels from April 2025 onwards.
- It is currently assumed that financial sustainability target identified in the plan is achieved
- Trust holds 28 days operating cash (c£2.1m per day) at the end of April – at the end of March 2025 this would be equivalent to just over 14 days.

Workforce

Staff in Senior Leadership Roles (watch metric)

Proportion of staff in senior leadership roles who are BME	Target (by March 2025)	No. BME Staff March 2023	No. BME Staff March 2024	No. BME Staff Aug 2024
Trust Wide Total (B8a - VSM)	69	35	44	41
Band Specific				
B8a	41	24	32	30
B8b	17	3	7	5
B8c	7	5	4	6
B8d	4	2	1	0
B9	2	0	0	0
VSM	2	1	0	0

Proportion of staff in senior leadership roles who are female	Mar-21	Mar-22	Mar-23	Mar-24
Trust Wide Total (B8a - VSM)	233	248	273	327
Band Specific				
B8a	143	156	168	209
B8b	47	49	56	68
B8c	16	21	22	20
B8d	12	12	11	13
B9	5	2	4	7
VSM	10	8	12	10

Model employer WRES

Staff Engagement (watch metric)

		2019	2020	2021	2022	2023
	Benchmark group - median result	GHT	GHT	GHT	GHT	GHT
Staff engagement score	6.91	6.87	6.9	6.6	6.32	6.45
Does your organisation act fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability of age?	55.89%	55.57%	53.72%	53.19%	48.97%	51.38%

Staff Survey Bullying and Harassment (watch metric)

Staff survey bullying and harassment score	Benchmark group median result	2019	2020	2021	2022	2023
In the last 12 months how many times have you personally experienced harassment, bulling or abuse at work from patients/service users, their relatives or other members of the public? % of staff saying they experienced at least one incident of harassment, bullying or abuse	24.76%	28.53%	26.97%	30.05%	28.63%	25.82%
In the last 12 months how many times have you personally experienced harassment, bulling or abuse at work form managers? % of staff saying they experienced at least one incident of harassment, bullying or abuse	10.37%	12.94%	12.58%	12.98%	13.64%	10.42%
In the last 12 months how many times have you personally experienced harassment, bulling or abuse at work from other colleagues? % of staff saying they experienced at least one incident of harassment, bullying or abuse	18.72%	19.68%	20.23%	21.98%	22.35%	19.43%
The last time you experienced harassment, bulling or abuse at work, did you or a colleague report it? % of staff saying they, or a colleague, reported it, out of those who answered the question excluding those who selected "Don't know" or "Not applicable"	49.85%	42.15%	42.01%	43.32%	46.92%	46.38%

Staff Perception of Leadership Culture (watch metric)

Aggregate score for NHS staff survey questions that measure perception of leadership culture	Benchmark group - median result	2021	2022	2023
PP4 - We are compassionate and inclusive	7.24	7	6.83	6.95
Compassionate culture sub-score	7.06	6.76	6.23	6.34
Compassionate leadership sub-score	6.96	6.6	6.0	6.78
Diversity and equality sub-score	8.12	7.95	7.83	7.91
Inclusion sub-score	6.86	6.7	6.67	6.75

NQPS Job Perception – 3 monthly watch

NQPS CORE	Jan-22	Apr-22	Jul-22	Jan-23	Apr-23	Jul-23	Jan-24	Apr-24	Jul-24
I look forward to going to work	43.00%	36.00%	39.50%	33.80%	37.70%	39.60%	44.00%	46.90%	47.00%
I am enthusiastic about my job	55.00%	50.00%	53.00%	49.90%	52.70%	56.30%	56.60%	58.50%	61.50%
Time passes quickly when I am working	69.00%	71.00%	67.00%	64.80%	63.90%	64.30%	62.80%	65.60%	66.00%
There are frequent opportunities for me to show initiative in my role	58.00%	53.00%	55.00%	55.10%	55.10%	56.80%	55.40%	60.20%	63.00%
I am able to make suggestions to improve the work of my team/department	59.00%	56.00%	53.00%	54.70%	54.20%	56.40%	55.60%	59.50%	62.10%

Commentary:
Since July 2023, the Trust has seen a significant improvement in all but one (time passing quickly) core NQPS questions.

The highest increase since July 2023 includes staff recommending the organisation as a place to work which has risen from 33.7% to 44.6%.

Several questions still report lower than scores in January 2022 when the NQPS was launched – but all have shown an increase in the last 3 months (April 24 to July 24)

Planned Actions:

Expected Recovery:

NQPS Job Perception cont. 3 monthly watch

NQPS CORE	Jan-22	Apr-22	Jul-22	Jan-23	Apr-23	Jul-23	Jan-24	Apr-24	Jul-24
I am able to make improvements happen in my area of work	46.00%	39.00%	39.00%	39.20%	43.60%	42.30%	43.10%	46.70%	48.90%
Care of patients/service users is my organisation's top priority	68.00%	57.00%	56.00%	51.10%	50.90%	51.60%	56.60%	57.90%	60.10%
I would recommend my organisation as a place to work	46.00%	38.00%	34.00%	28.00%	30.80%	33.70%	39.80%	42.20%	44.60%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	54.00%	38.00%	41.00%	31.30%	32.90%	37.80%	41.00%	43.40%	44.00%

Commentary:
Since July 2023, the Trust has seen a significant improvement in all but one (time passing quickly) core NQPS questions.

The highest increase since July 2023 includes staff recommending the organisation as a place to work which has risen from 33.7% to 44.6%.

Several questions still report lower than scores in January 2022 when the NQPS was launched – but all have shown an increase in the last 3 months (April 24 to July 24)

Planned Actions:

Expected Recovery:

NQPS Workstream Metrics 3 monthly watch

Workstream	NQPS SEIP	Apr-23	Jul-23	Jan-24	Apr-24	Jul-24
Teamwork and Leadership	In my team disagreements are dealt with constructively	41.70%	44.00%	45.30%	48.60%	50.40%
	Teams within this organisation work well together to achieve their objectives	30.10%	30.70%	37.30%	39.70%	41.20%
	My immediate manager asks for my opinion before making decisions that affect my work	42.00%	48.60%	49.40%	51.30%	51.30%
Anti-Discrimination	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas etc.)	46.00%	53.10%	58.10%	64.30%	65.10%
	The people I work with are polite and treat each other with respect	60.00%	62.70%	62.80%	66.10%	69.40%
	In the last 3 months have you personally experienced discrimination at work from your manager/team leader or other colleagues? (No)	84.00%	85.60%	85.20%	87.90%	88.10%
	In the last 3 months have you personally experienced harassment, bullying or abuse at work from your manager/team leader or other colleagues? (No)	78.50%	82.90%	85.20%	85.90%	86.10%

Commentary:
Linked to the Staff Experience Improvement Programme (SEIP), the workstream metrics indicate significant improvement in most areas since they were first added to the NQPS in April 2023. Highlights include, a 12% increase in staff feeling that the organisation respects individual differences and an 8% increase in staff feeling confident to raise a concern with a FTSU guardian if they had one since July 2023.

Planned Actions:

Expected Recovery:

NQPS Workstream Metrics cont 3 monthly watch

Workstream	NQPS SEIP	Apr-23	Jul-23	Jan-24	Apr-24	Jul-24
Building a safe speaking up culture	I would feel secure raising concerns about unsafe clinical practice	52.90%	56.80%	54.00%	59.00%	62.70%
	I would feel confident that the organisation would address concerns about unsafe clinical practice	36.90%	42.40%	41.70%	47.20%	47.20%
	If I had a concern, I would feel confident to raise it with a Freedom to Speak Up Guardian	43.70%	50.90%	52.30%	56.10%	58.90%
Wellbeing	My immediate manager takes a positive interest in my health and wellbeing	55.30%	59.60%	62.60%	63.50%	62.90%
	My organisation takes positive action on health and well-being	-	-	-	-	47.90%

Commentary:
Linked to the Staff Experience Improvement Programme (SEIP), the workstream metrics indicate significant improvement in most areas since they were first added to the NQPS in April 2023. Highlights include, a 12% increase in staff feeling that the organisation respects individual differences and an 8% increase in staff feeling confident to raise a concern with a FTSU guardian if they had one since July 2023.

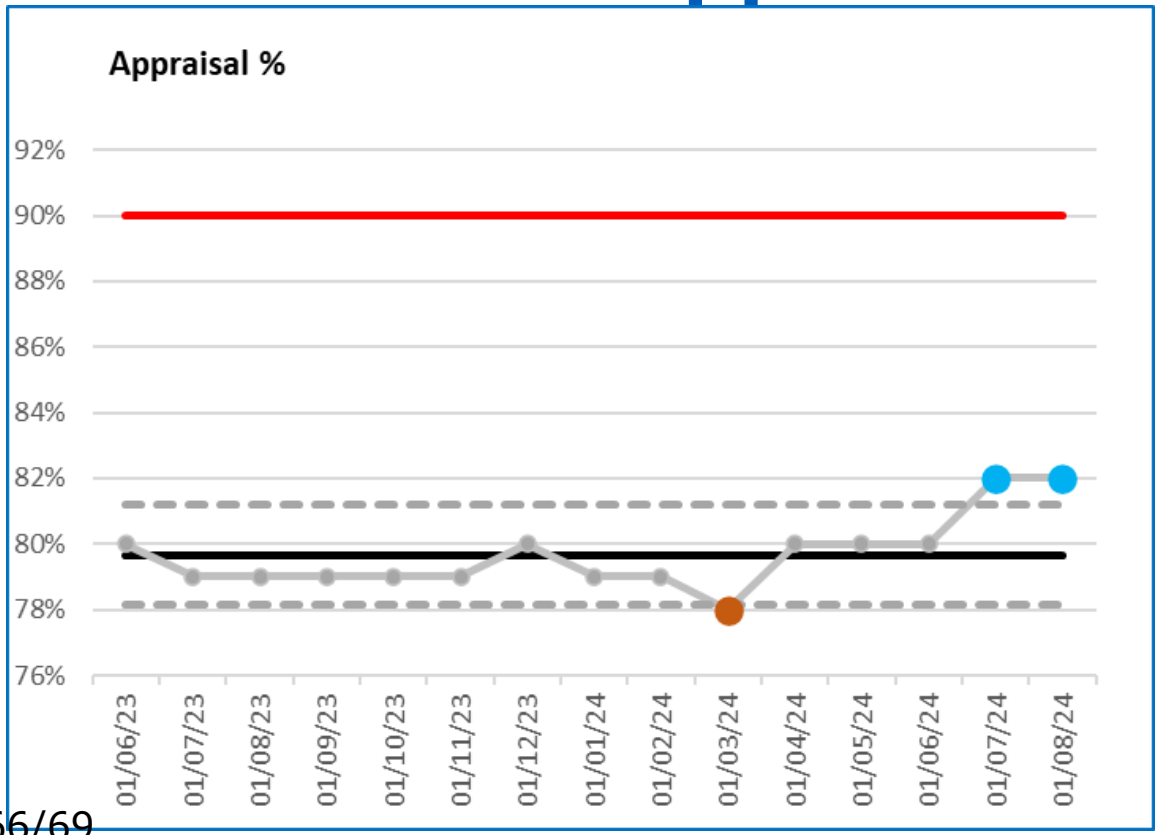
Planned Actions:

Expected Recovery:

Workforce Performance Indicators

Performance Indicator	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Turnover	13%	11.56%	11.38%	11.37%	11.27%	11.06%	10.82%	10.93%	10.58%	10.35%	10.55%	9.95%	9.94%
Vacancy	8%	6.31%	6.43%	5.86%	6.54%	6.90%	6.65%	6.59%	6.11%	6%	6.82%	7.24%	7.43%
Sickness	5%	4.34%	4.36%	4.36%	4.34%	4.33%	4.32%	4.29%	4.28%	4.31%	4.32%	4.35%	4.34%
Appraisal	90%	79%	79%	79%	80%	79%	79%	78%	80%	80%	80%	82%	82%
Essential Training	90%	87%	86%	86%	85%	85%	86%	85%	86%	86%	87%	87%	88%
Agency	2%	2.1%	1.6%	1.4%	-1.3%	1.5%	1.7%	1.7%	1.2%	1.2%	1.2%	1.1%	1.1%
Bank	6.50%	9.0%	8.4%	8.8%	8.7%	8.4%	9.3%	9.3%	8.7%	7.6%	7.4%	7.6%	7.4%

Workforce – Appraisal



Commentary:

- The Trust has seen a step back of 1% in overall compliance at 81% from 82% in the previous 2 months.
- Medicine has remained consistent at 85% in line with previous months. W&C remain consistent at 80%. D&S have improved by 1% from the previous month with Surgery seeing a decrease of 3% to 85%
- Estates and ancillary saw an increase of 6% to 75% lifting them into amber.

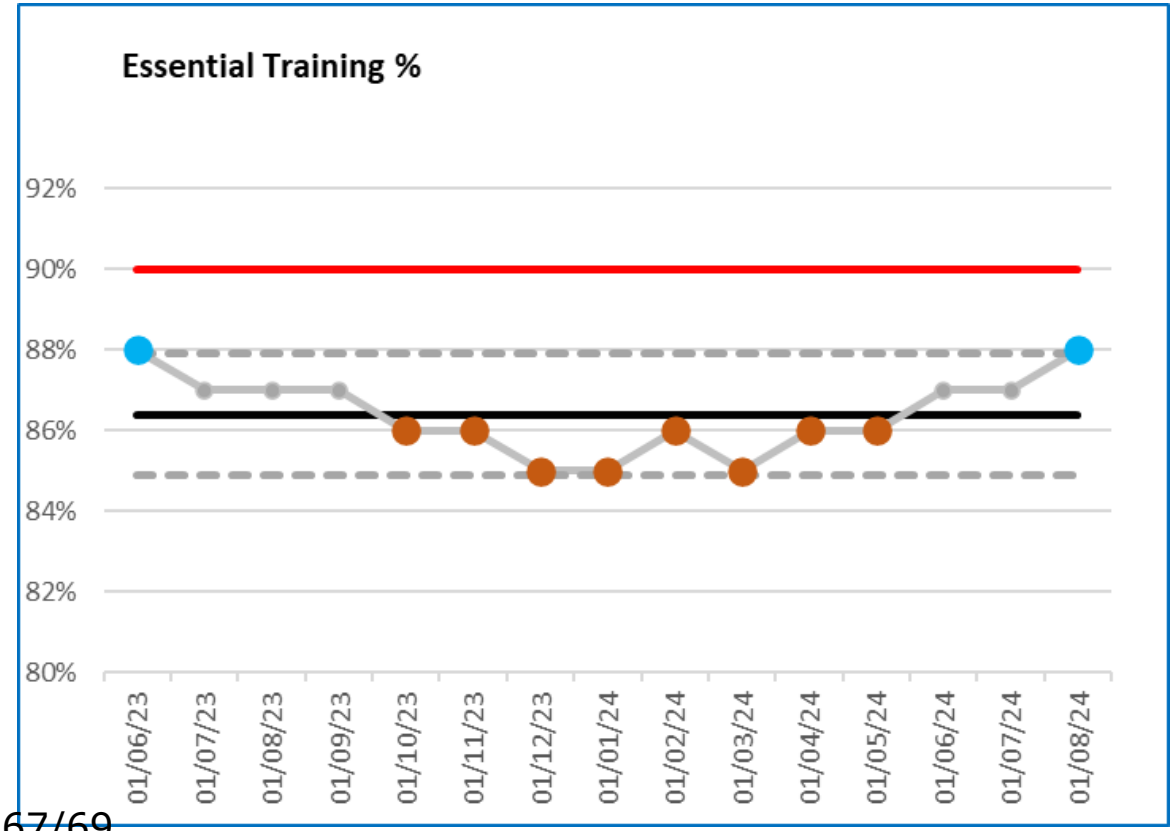
Planned Actions:

- Better understanding of the reasons for the Add prof scientific/ tech group lower compliance compared to other staff groups. Is this a recording or appraisals issue, investigation starting.
- Appraisal format (Inc. paperwork) back to review with new iteration discussed with user focus group. ELD to be consulted .

Expected Recovery:

- Jan 2025

Workforce – Essential Training



Commentary:

- The Trust's overall compliance has risen by 1% to 88% between July and September.
- All subjects have either risen or remained consistent apart from Moving and Handling L2 which has seen a drop of 1% in September.
- Medicine, Surgery and Non-Division have all seen a increase in compliance since July.
- Safeguarding continues to recover with an increase of 6% compliance since July.

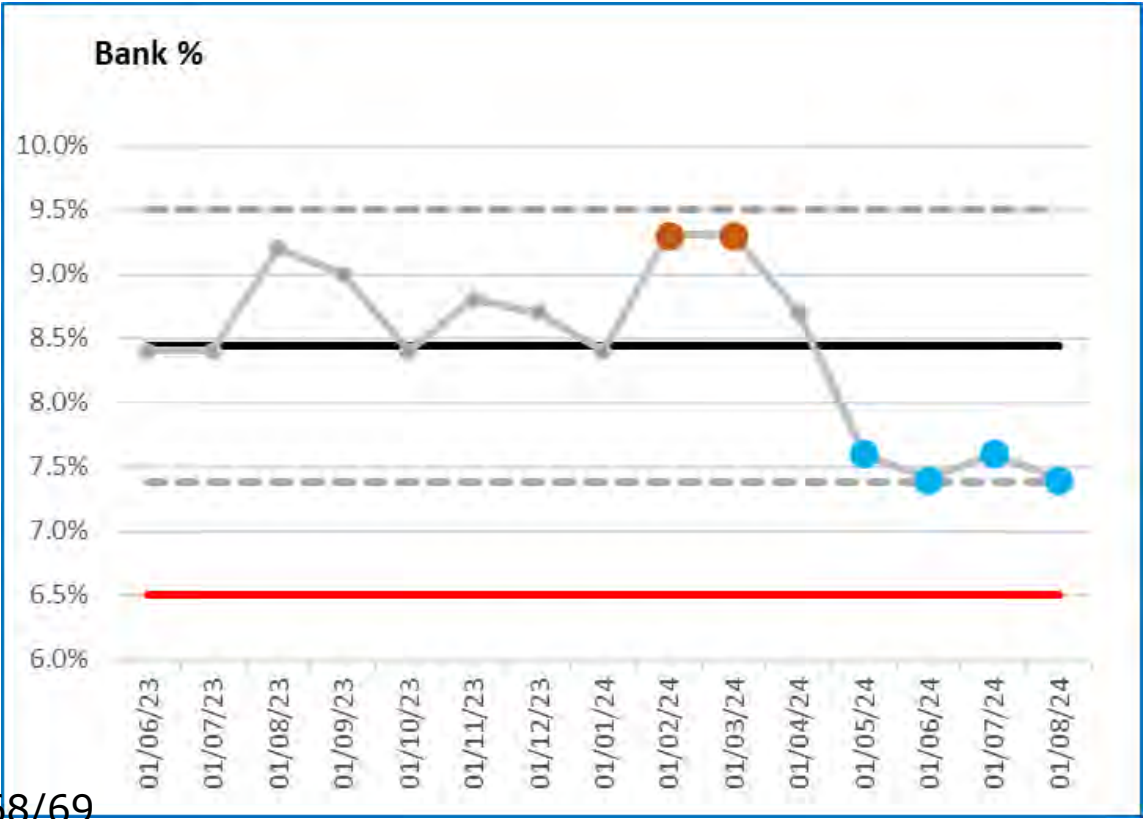
Planned Actions:

- We continue the move of the 11 core subjects across to the national content offerings, due for completion by the end of Oct24, enabling increased passporting of the training between all NHS Organisations
- The updated Safeguarding Adults training is due for release at the end of October / Start of November, this will simplify the process of completing the training requirement.
- Commencement of a Stat/Man oversight group.
- We have started work reviewing the Doctors Stat/Man requirements, supported by Dr Kate Tredgett.

Expected Recovery:

- 2025 due to the national work

Workforce – Bank



Commentary

- The vast reduction in bank WTE has continued in this month.
- In comparison to M11/12 of 2023/24 financial year, there has been a drop of over 140 WTE used in this month.
- This drop has been maintained for 4 consecutive months, showing it was not an out layer or random event.
- This reduction was achieved by close monitoring of requests for extra staff and a total review of all rosters.

Planned Actions:

Continued scrutiny of bank and agency use through Grip & Control meetings, along with regular Roster Reviews for Nursing & Midwifery (N&M).
Regional rate cards are in development for bank staff. The rates agreed could result in a positive or negative impact on bank fill in the Trust. GHFT are involved in the groups driving this development, so will endeavour to ensure the resultant rates are best placed to help the trust achieve its strategic goals.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Thank you

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) 25TH September 24		
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**
Maternity Services	Maternity services were identified as needing **continued oversight.** The committee proposed deep dives into maternity to ensure thorough review and sustained improvements. The CNO shared that a deep dive into **still birth rates** utilising the Patient Safety Incident Response Framework (PSIRF) principles and conducting a retrospective review of stillbirths was in progress to ensure that robust learning and assurance for the Trust and wider system was understood.	Ongoing strengthening of assurance reporting was noted to be in progress.
Patient Safety investigation and complaint report	The committee continues to seek assurance regarding timeliness and **handling of complaints.** Response rates improved from 9% in June to 18% in August but remain inadequate. Actions taken included enhanced oversight from Divisional Leadership teams, workshops with the Complaints Department, and the development of a new Standard Operating Procedure for complaint management, which establishes resolution timelines. Recruitment efforts have also filled two Band 3 administrative posts, effective October and November 2024.	QPC will receive an update following TLT agreed complaints handling improvement plan
National Patient Safety Alert	One overdue alert, National Patient Safety Agency Alert 2023/010, concerned risks associated with medical equipment. The Health and Safety Committee supported reducing the maintenance interval, but funding sources remained undetermined. An update on risk assessments related to **beds and bed rails** was outstanding, delaying closure of the alert.	It was agreed that this item would be followed up as an action for November committee as progress was not yet delivered.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Integrated Performance report	The committee acknowledged ongoing non-compliance in **cancer performance indicators** and **urgent/emergency care** standards. However, it was anticipated that the implementation of the Winter Plan, Emergency Care Intensive Support Team (ECIST Rapid Improvement Offer (RIO), Southwest Discharge focus workshops, and continues	. Planned deep dives would be presented to QPC as per forward plan.

	focus as part of the Clinical Vision of Flow (CVoF) would lead to improvement in future reporting periods. Concerns were raised about the monthly monitoring of **Venous Thromboembolism assessments.** The COO highlighted the Oversight Framework, identifying two red flags and one amber flag related to the **Faster Diagnostic Standard**. Current data showed a reduction in patients waiting over 52 weeks to approximately 1,800, a notable improvement since August, driven by Elective Recovery Fund initiatives. The goal remains to eliminate patients waiting longer than 52 weeks by March 2025.	The CMO planned to update QPC progress at the October meeting regarding the timeline for the delivery of improvements. Planned deep dives would be presented to QPC as per forward plan.
Quarterly Cancer Performance Report **Faster Diagnostic Standard**	QPC received the report that showing an anticipated **62-day cancer performance** of 67% for August, which fell short of the trajectory agreed upon with the Integrated Care Board (ICB) and NHS England (NHSE). The backlog at that time related predominantly in the urology service with a noted increase in skin services. A recovery plan was put in place with the objective of exceeding 77% performance in the coming months. The **Faster Diagnostic Standard** was reported as off track for the first time in six months, largely due to capacity issues in skin services. This was expected to impact the backlog and 62-day performance through September and potentially October. Deep dives into urology and haematology performance were planned to address ongoing challenges.	Quarterly reports would update QPC as per forward plan.
Integrated Performance Report	**System Flow &Urgent and Emergency Care (UEC) Update** ICB colleagues presented QPC the Integrated Care System (ICS) Urgent and Emergency Care governance, escalation, and reporting plans, which aim to improve oversight and system flow. This included a review of the Non-Conveyance to Treatment Rate improvement trajectory,	

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

	assessing the effectiveness of strategies to meet set goals. The committee discussed the delivery of the 2024 Operational Pressures Escalation Levels framework, developed in response to NHS England's letter on **"Improving Quality in Pressurised Services."** The committee noted the progress in implementing this framework, which is designed to address system pressures and enhance operational performance. **Urgent and Emergency Care Flow and Improvement Update** A significant i**mprovement in ambulance handover times** was reported, with offload delays at this time averaging in single figures, down from three to four days. Lost hours due to delays reduced from approximately 1,000 per month to just over 500, effectively halving the lost time. However, further work was noted as required to reach the target of a maximum offload wait of 45 minutes. There was also discussion of the **Non-Conveyance to Treatment Rate** situation, with 50% of ambulance arrivals being discharged from the Emergency Department (ED). Of these, 20% were identified as needing community-based services, and another 20% were offloaded from ambulances to the minor's waiting area. Further discussion was had regarding the stubborn **non-criteria to Reside (NC2R) position,** with 140 patients awaiting discharge, 121 of whom were ready but awaiting brokerage arrangements. The committee remained concerned about achieving the winter target of 85-87 NC2R patients and focused on improving earlier discharge decision-making. The committee agreed that The newly established Integrated Flow Hub, which facilitates discharge decisions within three hours during working hours, was highlighted as a key development. Ongoing work is required to improve capacity in Pathways 1 and 2. The committee reviewed NHS England's winter letter, which focused on the second year of the	Planned deep dives would be presented to QPC as per forward plan. The COO would address this matter with the CEO and Deputy CEO of the Integrated Care Board (ICB), which would require escalation through the system's Chief Executives.

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Winter Planning and Harm Prevention	Urgent and Emergency Care recovery plan. Building on last winter's lessons, plans include the continuation of the Kingfisher pilot in the Emergency Department, aimed at improving patient experience and mental health support. There was a detailed discussion on the system's approach to reviewing complex care of long-stay patients. Concerns were raised about delays in discharging patients who no longer meet the criteria to reside, which can result in harm. Moving towards a true discharge-to-assess model was discussed as critical for improving patient flow and reducing harm from prolonged hospital stays. The committee acknowledged the efforts made to address system-wide issues, particularly concerning access to primary care and community services, which significantly impact patient access to emergency care. Concerns were raised regarding workforce availability and the funding necessary for additional community service capacity. Plans for increased weekend General Practitioner capacity were discussed, with access to primary care identified as a critical factor in preventing emergency department visits.	This was agreed as an ongoing wider system discussion via the ICB for feedback at future QPC meetings. The committee also discussed the integration of multidisciplinary team reviews with broader quality governance structures, including the review of all deaths of patients classified as no longer meeting criteria to reside. The committee discussed future touchpoints for winter planning, agreeing that this would be a recurring feature in upcoming Quality and Performance Committee meetings. It was decided to include a dataset related to the clinical vision and flow in the Integrated Performance Report for light-touch monitoring. The committee noted the contents of the draft Winter Plan, agreed on the next steps, and approved the Board timetable
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 ICB Board

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Maternity Delivery Group	The exception report highlighted the need for improved oversight of the Saving Babies' Lives initiative. A positive trend was noted in postpartum haemorrhage rates, currently at 17 cases per thousand, compared to the national rate of 30. Over the past five months, there were zero cases of three-litre blood loss in three months	Update to be given to QPC at the next meeting
Patient Safety and Risk Assurance Report	The improvement required regarding performance of closure **of serious incidents** was discussed, it was noted that Maternity related plans had been prioritised. .	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.
Diagnostic Performance	The committee discussed actions being taken to address the persistent non-compliance in cystoscopy, echocardiography, and urodynamics. The response highlighted ongoing recruitment efforts for physiologists in echocardiography and process improvements in cystoscopy. It was also noted that with increased support with sonographers to Maternity, it was likely the Adult Cardiac ECHO list would not be in a position to recover until recruitment had taken place.	A specific timeline for compliance was requested, and there was agreement to provide an update at the next meeting
Delay Related Harm Report	The committee reviewed data presented to the Trust Board on 24 May, indicating increased excess mortality for patients who waited over eight hours in the emergency department before admission. Updated mortality data from January to June 2024 showed a significant reduction in excess deaths from July to December 2023. At Gloucestershire Royal Hospital, excess deaths decreased from 179.3 to 37.6, while Cheltenham General Hospital saw an increase from 9.7 to 22.9. Notably, there was a marked reduction in Standardised Mortality Ratio and excess deaths among patients aged 80 and over, attributed to enhanced frailty pathways. Despite a decrease in patients waiting over eight hours, numbers remained high,	The committee emphasised the importance of eliminating delays in Accident and Emergency, considering various patient flows. Accurate coding was deemed essential to reflect case complexity and avoid inflating the Summary Hospital-level Mortality Indicator. The next update is scheduled for March 2025, which will include data from July to December 2024 and assess the effect of centralisation on the Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator for

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	warranting ongoing monitoring. Improvements in Accident and Emergency congestion was noted, particularly a decline in Delayed Transfers of Care and the lowest number of patients classified as "No Criteria to Reside" since pre-pandemic times. The committee identified a significant impact on the Summary Hospital-level Mortality Indicator, primarily due to emergency admissions waiting more than eight hours. Coding issues in the Acute Medical Unit were highlighted, with a review undertaken to address inaccuracies that could inflate Summary Hospital-level Mortality Indicator. Many patients spent over eight hours in Accident & Emergency but were not counted as admissions upon discharge. This exclusion raised concerns about delay-related harm in non-admitted patients. A focus was placed on developing a quality improvement approach within the Accident and Emergency team to address this issue. The committee acknowledged the need for clarity in data inclusion, especially regarding pathways for patients in Accident and Emergency. There was variability in patient conditions that complicated the categorisation of non-admitted patients. The ongoing interest in addressing delay-related harm remained strong, with discussions escalated through governance channels to the Integrated Care Board.	Gloucestershire Royal Hospital and Cheltenham General Hospital.
Quality and Safety metrics: Falls update Report	The falls team collaborated with the patient safety team to align the management of injurious falls with the Patient Safety Incident Response Framework, identified as a trust priority. The annual inpatient falls rate was reported at 6.83 falls per 1,000 bed days, reflecting a 2% year-on-year increase that was not statistically significant (p-value 0.51). This rise correlated with changes in the deployment of Health Care Support Workers.	The committee acknowledged the impressive output from the small falls team and the importance of linking divisional actions to governance through monthly reviews. Plans for a quality summit on falls in November were confirmed to identify underlying issues and develop proactive improvement strategies. The need to enhance governance and

	A slight increase in falls with harm was noted, rising from 0.147 to 0.178 per 1,000 bed days, also not statistically significant (p-value 0.33). The committee was tasked with tracking falls with harm rates and continuing improvement initiatives. Gaps in updating falls risk assessments within four hours of a fall and on admission were identified, prompting a focused education and training programme.	prioritise patient safety was reiterated.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Endoscopy Services	It was reported that the backlog in endoscopy services has been cleared, and performance was at 87.9% utilisation. All patients from 2023 or earlier have been seen, signalling significant operational improvements. Projections suggest a 50-60% increase in activity due to upcoming changes in bowel cancer screening tests, which will necessitate proposals for seven-day working to enhance capacity and sustainability.	A recovery and improvement programme has been initiated for the Endoscopy Service, driven by recommendations from NHS England and NHS Improvement following declining performance. The key challenges include demand and capacity management, staffing shortages, digital optimisation, funding limitations, and infrastructure inadequacies. The Faecal Immunochemical Test (FIT) for bowel cancer screening, expected to be introduced in 2026, will likely increase activity significantly. A comprehensive strategy aligning with broader business plans is necessary to address these challenges.
Organ Donation Report	The committee reviewed the Trust's annual data in preparation for the board presentation, noting risks from recent changes and recognised the expertise and input of the team. The committee also discussed the SCORE project, aimed at scheduling overnight organ retrievals for daytime transplants and the implications of the relocation of acute stroke services to Cheltenham that may impact on theatre availability.	The committee will monitor logistical challenges and provide updates as needed, acknowledging current performance and potential issues in the organ donation process.
Items not Rated		
SYSTEM FEEDBACK	No further business to note, key issues picked up in various reports.	

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Governor Observations

Governor Bown praised the quality of the papers and broader staff involvement, enhancing patient experience. She noted the innovative use of the Operational Pressures Escalation Level as a cross-agency tool, while Lead Governor Holder inquired about its connection to winter pressures. The extensive information from subcommittees was acknowledged.

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 Confidential Board of Directors			
Date	14 November 2024		
Title	The Trust Winter Plan 2024/25 (FINAL DRAFT)		
Author /Sponsoring Director/Presenter	Al Sheward, 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

The Winter Plan 2024/25 sets out a coherent and comprehensive review of the Trusts intended response this winter. This document sets out the key learning from Winter 2023/24, the shape and architecture of the document based on available guidance and planning information at time of writing.

NHSE guidance is expected in the next month or so; The ICS Winter Plan is under development; and specific data items usually included from WHO and Epidemiological journals is due later in September. These are therefore not included in this version. There are also specific outcomes and measurables being developed for cases requiring investment should 'Winter monies' be forthcoming; These will be available as appendices in due course,

Our key areas of focus are to

- Continue to do what we are doing but better.
- Support local teams to manage their local demands using the Clinical Vision of Flow (CVOF)
- Work with system partners to address the number of patients who no longer have Criteria to Reside. We will also work with the system to deliver the Integrated Urgent Care offer (due Nov 2024).
- Support better cover of medical staff to the out of hours period.

Risks or Concerns

National Guidance on winter planning priorities have not yet been published so assumptions have been made; There is no additional funding sources available at this time.

Financial Implications

Financial investment requests may be forthcoming but as yet these would be unfunded.

Approved by: A W Sheward	**Date: Oct 2024**

Recommendation

To NOTE the contents and narrative.

Enclosures

Gloucestershire Hospitals
NHS Foundation Trust

WINTER 2024/25.
A new approach

Executive Lead
Al Sheward, Chief Operating Officer

Active Period
November 2024 to April 2025

Foreward

Winter is not an emergency or considered an unusual event but is recognised as a period of increased pressure due to demand in the clinical acuity of the patients and the capacity demands on resources within the Trust. Winter 2024/25 will undoubtedly present further challenges to the Trust and the wider system at a time when we are already under considerable pressure.

July 2024 saw a change in Government, but no change in the focus on the provision and delivery of services across the NHS. Whilst some economic conditions have improved, and public sector pay deals are being offered, there remains continued uncertainty posed by Covid-19, Influenza, and continued incidence of Norovirus this winter, will continue to present challenges.

Our services have been impacted by further waves of Covid-19, and another variant could increase demand and exacerbate an already pressured system which is responding to the usual increase in respiratory presentation alongside the slips, trips, and falls associated with the winter period.

- The prevailing guidance set out by the new Government will likely be updated, but based on the NHSE Correspondence of the 27th March 2024, the Trust has been provided clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by Industrial action
- The 3 key priorities are to achieve Financial Balance, Protect Patient Safety, and Prioritise Emergency Performance and Capacity, whilst protecting urgent care, high priority Elective and Cancer Care
- Systems are being requested to agree the actions required to deliver on the priorities for the remainder of the year.

The plan is intended to describe the priorities for the next few months, together with actions that have already been taken to build resilience ahead of winter, as well as provide the opportunity for further actions to be developed as we understand the likely impact of this year's winter season.

We will work across five key 'C' themes this year; Care, Confidence, Collaboration, Capability and Capacity. There is a need to control the use of resources, focusing on being efficient caring, maximising productivity and minimising unnecessary spend and wastage.

Last winter was a challenging period for the NHS not helped by spikes in the incidence of COVID 19. Thanks to the huge efforts of frontline staff, patients continued to receive safe care during this period. Despite the seasonal changes it is clear that the system remains under pressure, and in order to meet the challenges of this winter we need to learn from the experiences of last year and that is why we have undertaken some analysis to develop a likely scenario for this winter.

The priorities within this plan are:

1. The reduction of overcrowding in ED through the appropriate and timely streaming of patients
2. Implementation of the national discharge guidance to enable a sustained reduction of Delayed Transfers of Care and patients that are medically optimised for discharge referred to as No Criteria to Reside (nCTR)
3. Implementation of the identified schemes may promote discharge and reduce admissions to achieve reduced bed occupancy levels, this will improve flow
4. Reducing the variation in practice across ward areas and increasing standardization of process and promotion of high standards for our patients and each other.
5. Reforming and redesigning the wider Urgent and Emergency Care system led by the Clinical Vision of Flow programme
6. Further implementation and expansion of Same Day Emergency Care pathways following the centralisation of the acute medical take at Gloucestershire Royal Hospital in July 2024.
7. Further Expansion of clinical 'Assessment' services across the surgical specialties offered by the Trust;
8. The reduction and avoidance of admissions through the better use of services within the community, primary care, NHS111 and other ambulatory services for patients
9. Building upon the already established system wide working with partners across Gloucestershire.
10. To maintain a dynamic and agile capacity to respond quickly to changes in circumstance, priority and environment.

We continue to develop this plan and agree system wide actions that will support Winter, and I want to take this opportunity to thank colleagues who have played a part in developing this plan, and who will contribute additional time to managing our patients over the winter.

We are committed to the delivery of high quality, safe care and as such propose to enter into a 'Winter Covenant' across the Trust where every department is focused on the patient, and each other at the most challenging period.

We recognise the impact that the aftermath of Pandemic has had on our colleagues across the health and social care system and we know that this year we will receive the same good will, compassion and caring response from our colleagues. We know that our patients, rightly, expect the best quality care when unwell and we will do all we can to live up to these expectations.

Al Sheward

Chief Operating Officer

Executive Lead for Emergency Planning, Readiness and Resilience

Executive Summary

This year's Winter Plan has been formulated against the backdrop of a challenging winter due to a number of issues including; an increasing demand for Emergency Care, the possibility of further industrial action, potential spikes in COVID-19 and associated variants, the uncertainty of increased incidences of Influenza, Norovirus and RSV, and the need to reduce our elective backlogs.

Our plan seeks to support a whole system response, working in collaboration with system partners to deliver the core objectives as set out by NHSE/NHSI in response to the challenges faced by the NHS this winter period.

We will work across five key 'C' themes this year; Care, Confidence, Collaboration, Capability and Capacity. There is a need to control the use of resources, focusing on being efficient caring, maximising productivity and minimising unnecessary spend and wastage.

This structured approach to our winter plan builds on existing pathways, seeks to support individuals in their communities and manage our front door through innovative proactive models of care. This will enable those accessing emergency care to be seen more quickly, by the right specialists in the right department, alongside more structured discharge pathways for the more vulnerable such as those presenting with mental health issues or frailty conditions.

Our plan sets out how we will effectively manage the demand over the winter period will be riant on capability and capacity of our systems, process and staff, and not be reliant on the 'traditional' physical bed/ward solution. Key objectives this winter are to keep patients well and safe through managing ambulance offloads in a timely manner, prevent unnecessary admissions and make sure we do everything possible to avoid any delays when it comes to safely discharging patients, and creating capacity and flow across the system.

A number of solutions and proposals, across a range of services, may require specific and targeted investment prior to implementation in order to support care across the organisation this winter. It is recognised that there are lessons to be learnt from last year by continuing what went well, in addition to looking at new innovative ways of working and doing things differently. Schemes identified will require organisational support, investment in time and a willingness to find new ways of delivering safe, effective care in the context of an uncertain and pressured environment.

Finally, our colleagues are without doubt our most valued resource and we recognise that the last few years have been an extraordinarily challenging time, and continue to be so. Within the plan a range of initiatives have been identified, which are ongoing in order to support our staff. With staff safety and wellbeing in mind, we are committed to ensuring all staff have the opportunity to have their Flu and Covid vaccinations, protecting themselves, their families, our patients and communities.

The challenges ahead

NHS England have identified a number of core priorities objectives to increase capacity and operational resilience in emergency care ahead of winter 2024/25. Any initiatives that are undertaken by the Trust to increase capacity to see patients more quickly, but not be reliant on admitting capacity and build additional operational resilience within our services where applicable are directly aligned to these core objectives.

Our challenges include:

- Demand and capacity for the Emergency Department impacting on 4-hour performance. ED attendances have increased to levels seen in 2018/19 (pre-pandemic levels).
- The availability of specialist and general mental health care specialists to support the vulnerable patients in the Emergency Units and inpatient wards, especially the high levels of patients presenting with eating disorders, many into paediatrics.
- The impact, and continued risk of collective action within Primary care is likely to alter normal behaviour and patterns of referral and attendance;
- Patients classed as having no Criteria to reside (nCTR) are leading to delays in discharges and associated constraints on flow through the system. The system has reduced the numbers of patients to around 140, but numbers remain higher than our plan.
- Ring fenced capacity for infectious diseases patients, need to respond to the spikes in Covid-19 in a dynamic, and patient focussed way; responding to the more traditional norovirus and influenza events to minimize the risk of bed closures will also be important.
- Realising the benefits of Ward reconfigurations, new service locations, new pathways and the centralisation of the Acute medical take have all been completed this Summer, so the potential of these opportunities must be seized and exploited. and have taken place, in order to create a unique opportunity to continue to deliver uninterrupted elective recovery whilst providing additional winter capacity.
- This process continues, which will support the investment in Same Day Emergency care pathways and clinical assessment space, virtual ward environments.
- The associated clinical and nursing workforce demand, availability and cost pressures.
- Delivering care in safe and appropriate clinical environments, whilst maintaining minimal risks pre and post hospital environments. The need to maintain a ZERO tolerance for Boarding, outside the declaration of a critical or major incident, is a key safety and quality measure.
- The operational impact of the continued development of our Estate, cannot be underestimated; continued collaboration with colleagues from GMS will be essential and is aimed at delivery of improvements with as minimal impact on patient care and performance as possible.

Aims of our Winter Plan – building across the 5 'C's

System wide approach. To ensure that our Winter plan compliments the broader system plan, ensuring an integrated approach to caring for our patients. Working with partners in Primary care, private and commercial organisations, our neighbouring acute Trusts, South West Ambulance Service Trust (SWAST) we seek to provide a high quality and impactful response to meet the needs of our communities.

Working as One. To collaborate, develop and implement strategies across the system facilitated and informed by our Newton partners.

Delivering quality care. We will focus on delivering the best possible care, safety and experience for all of our patients by being patient focused, responsive, respectful, responsible and ambitious.

Looking after our colleagues. Recognising that the delivery of safe and effective care is dependent on the skills, dedication and availability of our staff, we will continue to keep our staff safe and supported through a range of measures.

Resilient workforce plans. We will utilise effective rostering and planning of leave across the winter period to provide service and system resilience to mitigate known risks in a planned way. Consultant Job Plans will be confirmed and deliver a consistent response. The use of agency locums, bank shifts and other compensatory capacity for our substantive staff will be considered, but must be complimentary to business-as-usual planning and effective use of resources, and considerate of the financial challenges and priorities ensuring excellent stewardship of finite resources.

Avoiding unnecessary attendances. Recognising that there is a marked increase in demand, resulting in longer waiting times to access care, in our Emergency departments we are further

developing alternative pathways. This includes plans to extended the use of Advice & Guidance to clinically advise and make best use of community and Same Day Emergency Care (SDEC) resources.

Reducing Conveyances. With access and education, awareness and better communication we seek to reduce the numbers of patients being brought into our ED who receive the lowest levels of intervention, which could better be delivered in the home.

Admissions avoidance. The main principle is right patients in the right place at the right time. A range of winter schemes identified will support this principle, for example we will aim for senior decision makers from relevant specialties to be available when reviewing patients within the emergency department.

Acute Medical Take. The acute medical take as has been centralized on the GRH site since July 2024 and has allowed more responsive and focused care and treatment to be delivered, whilst reducing the number of admissions, length of stay and delay across these pathways. The quality and safety benefits of this continue to be realized.

Maintaining elective care capacity. The winter period is also an extremely challenging time to effectively manage elective patients and there continues to be a pressure in delivering the elective recovery trajectory and recovery from the impact of Industrial action earlier in the year, with a risk of further IA at the time of writing. There remains the need to protect and focus Cancer Pathway diagnostics and treatments.

We remain committed to maintaining elective capacity, and with a clear focus on protecting where possible Cancer treatments, we continue to support and protect surgical activity to achieve reduced waiting times for our patients; to adapt to the priorities of the new UK Government which will seek to prioritise access standards and reduce waiting lists. Orthopaedic elective surgery and Daycase facilities will be ringfenced.

Focus on Cancer Service Delivery. Continue to deliver Cancer Surgery and maintain elective activity to eliminate the numbers of patients waiting over 65 weeks.

Develop alternative Pathways to Inpatient Admission. Learning from issues that arose during winter last year, further ward reconfiguration has taken place. The aim of the reconfiguration was to improve flow, support offloading of Ambulances, creating improved patients and working environments, and promoting Same Day Emergency Care (SDEC) pathways. Increase ‘virtual’ ward capacity and capability to keep patients out of hospital wherever possible.

The Surgical Assessment and Virtual Ward capacity ensures capacity which will turnover Emergency and unscheduled demand. This example has allowed for the expansion in similar specialty based services which will need to be maintained. We will build on the success of the Trauma Assessment Unit (TAU) and Head and Neck (HaNSU) assessment services, and deliver a Urology Assessment Unit (UAU) based at Cheltenham General Hospital.

Prioritise access for the acutely unwell patient. When admission is the only option, the continued provision of ringfenced capacity such a hip fracture (#NOF) beds to ensure that there is capacity for both emergency and planned Trauma patients, respiratory patients, Critical care, gynaecology emergencies and frailty patients will be maintained, along side the protection of assessment capacity from being used by inpatients.

Promote timely discharge from Hospital and early flow. The Discharge Lounge will increase hours during winter and the benefits will be expanded to allow for the piloting of a lounge model on the Cheltenham Hospital site also.

Stop corridor care. The use of non-ward based care for inpatients has stopped; therefore all departments, professions and services are prioritising practice, protocols and initiatives which deliver flow earlier in the day, consistently and constantly, noting the entire patients patient pathway from attendance to discharge. This will be a 'last resort action' in the most extreme of circumstances only.

How will this be delivered ?

In April 2024, the Trust launched the **Clinical Vision of Flow (CVoF) Programme**. Co-chaired by the Deputy Medical Director, Deputy Director of Nursing and Quality and Deputy Chief Operating Officer.

This Trustwide continuous improvement programme is supporting the changes in practice, behaviour and culture at ward level, embedding the behaviours and procedures needed to support flow; the clinical leaders across the organisation intend to maximise the daily discharge potential, earlier in the day, and across the weekend.

In order to achieve this, we will focus on; planning discharge from admission and at daily board rounds, reviewing short stay pathways, enhancing therapy services and criteria led discharges. To re-invigorate Red to Green processes at ward level and continue to promote greater volumes of Pathway 0 discharges, earlier in the day and throughout the weekend. Four workstreams supporting Emergency Care, Short-stay and Assessment, Sick Specialties and Frailty have ambitious delivery programmes.

Complementing the Working as One programme which supports cross ICS working and changes we are confident that continued focus on these actions will achieve those objective set out above; reduce the need to resort to unpalatable and inefficient solutions of the past which expend physical bed-based, resource intense and 'quality-lite' time for our staff and patients, in an stressed financial environment.

Resource allocation and investment.

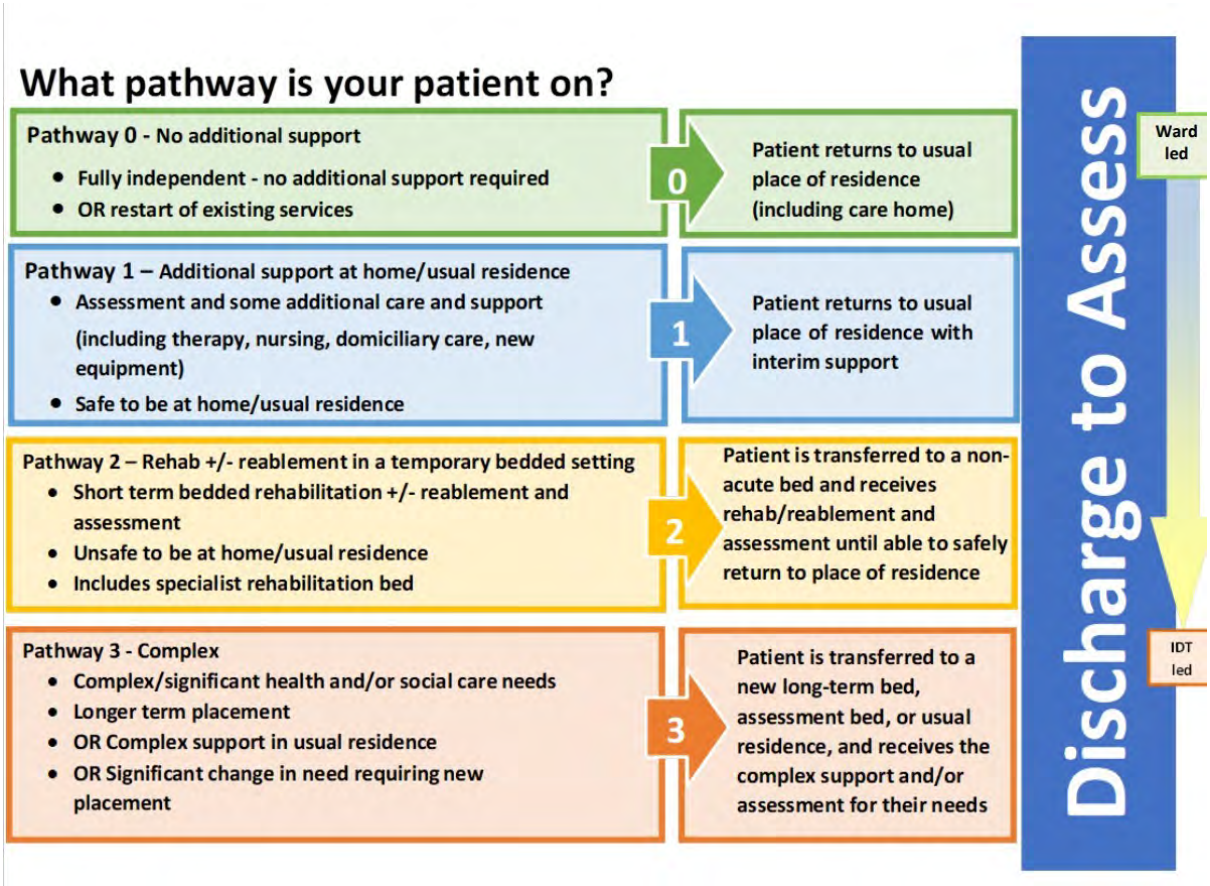
Investment has been allocated to create a new dedicated discharge waiting area. The aim of this initiative is to improve patient experience and facilitate the early discharge of patients from ward areas in order to aid flow across the Trust.

Working with system partners, and key stakeholders, we will create a clear plan and trajectory of improvement to reduce the number of stranded and super stranded patients.

We also recognise the need to maintain a continuous flow, with the early identification of suitable patients for our partners to plan and respond to. We will link in with our charitable and voluntary sector services to support discharges alongside maximising the use of the Discharge to Assess and Home First pathways where person centered assessments are completed in a home environment.

The development and use of the Virtual Ward environment intended to keep patients at home, with remote monitoring and the ability for rapid assessment which also help increase the available of acute beds in the acute sites.

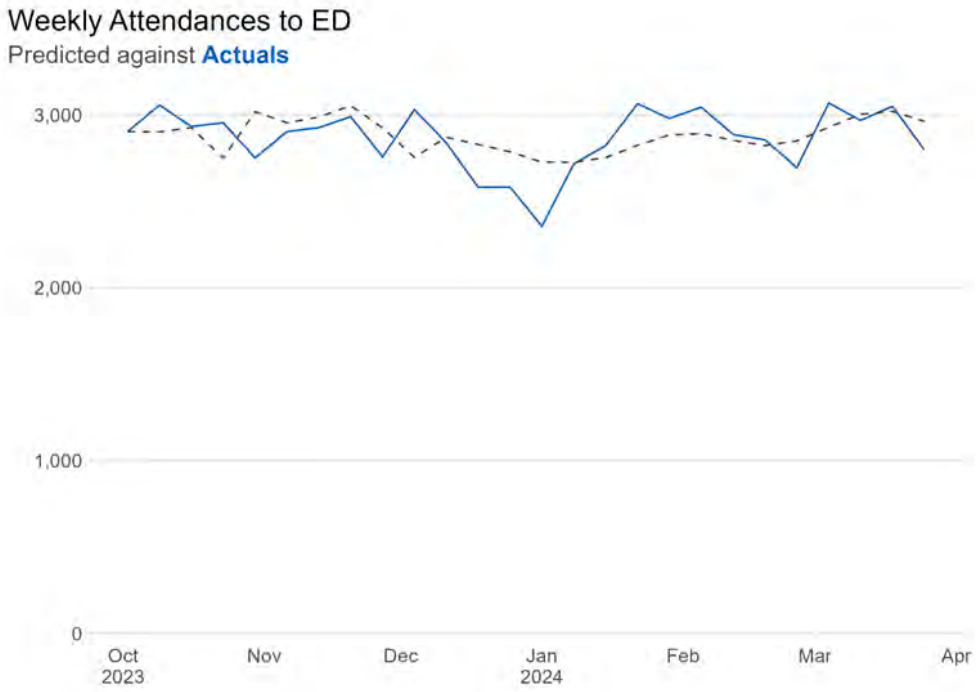
The figure below describes the pathways to discharge, and it is imperative to improve the 'local' knowledge base for everyone involved in promoting discharge, including medics, AHPs, Nursing and Operational Managers. Mutual and respectful challenge will be encouraged.



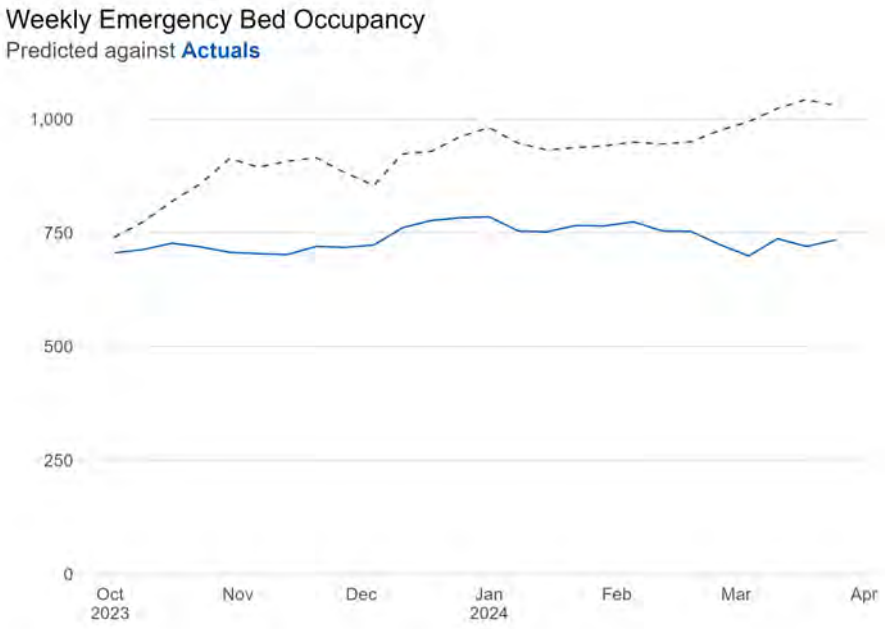
We recognise the need for increased discipline in managing patient pathways, and that better patient and carer engagement is needed to manage expectations and support shared decision making. Consideration needs to be given to reviewing policies and procedures that support choice to ensure they are compliant with latest guidance, legislation and local objectives.

A Review of Winter 2023/24 – shaping our Clinical Vision of Flow

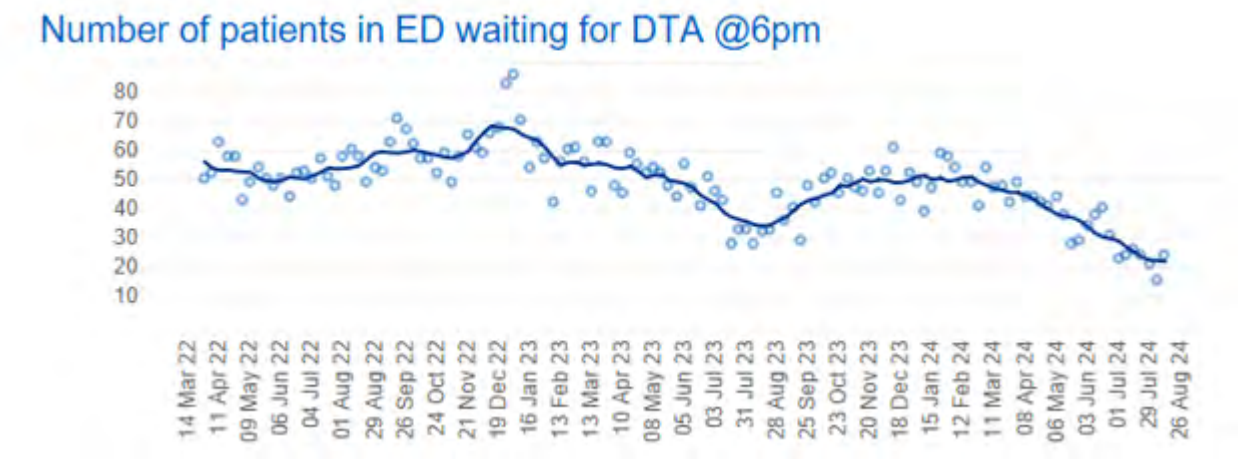
Christmas and New Year period saw fewer attendances than expected, however late January and early part of February saw greater attendances than expected. However, across the whole of the Winter season our predicted activity was broadly accurate with an overall variance within 18 attendances per day (+/- 3.3%)



Weekly Bed occupancy was below prediction, which demonstrated that the greater volume of patients were able to be treated and discharged by ED without requiring admission.

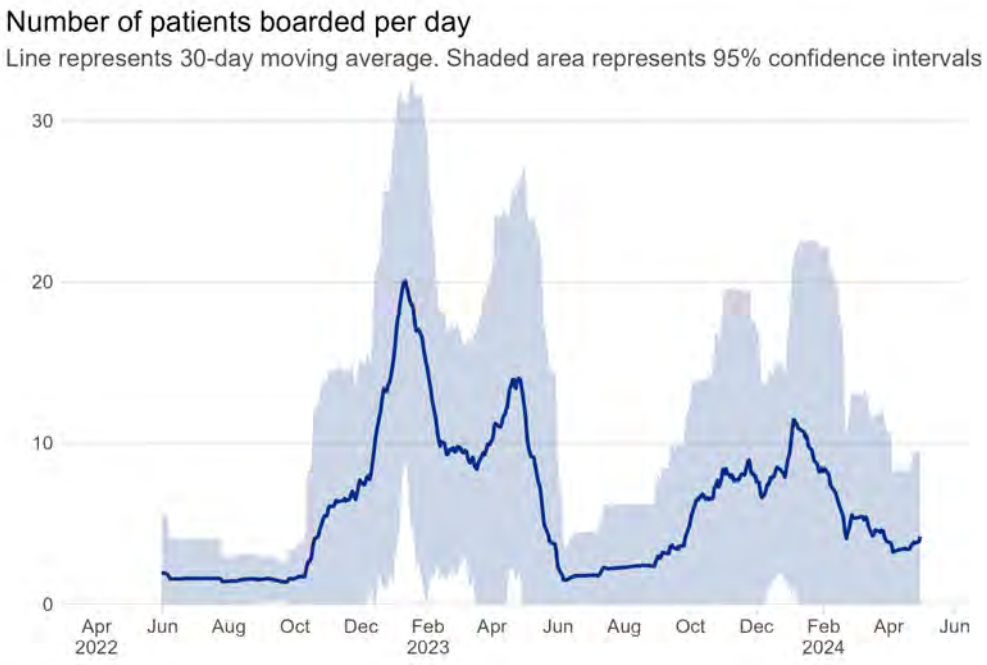


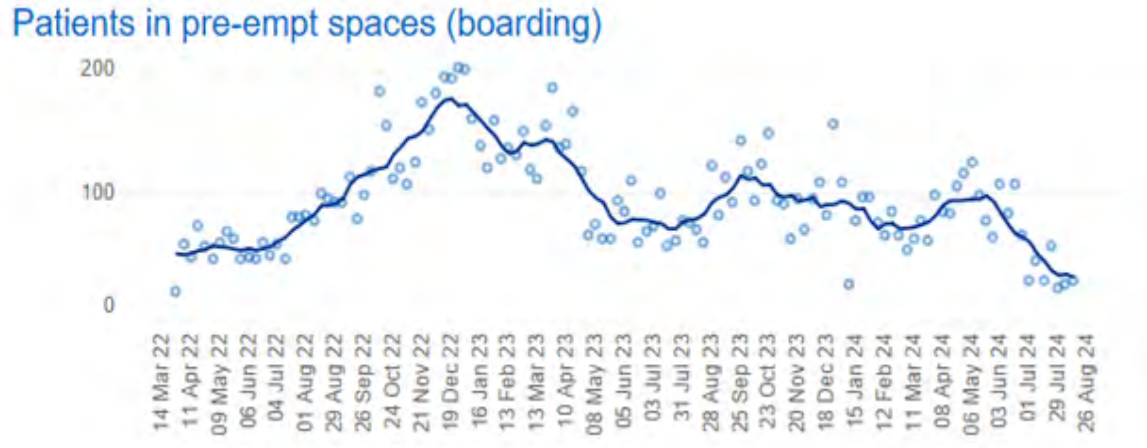
The Trust has worked hard on reducing the numbers of Decisions to Admit (DTAs) and increasing the numbers of referrals to specialties, increasing use of SDEC and Assessment Pathways, virtual ward environments and streaming initiatives. Our plan requires this to be further enhanced. Average DTAs in the department is falling consistently.



Last Winter saw a significant and consistent reliance on non-ward based care and corridor care to assist with the management of flow and Ambulance offload times and CAT2 performance.

A comprehensive and focussed action plan has been in place for several month which has focused on weaning the organisation away from Boarding and Pre-empting of patients. The safety, quality and experiential risks to patients and staff cannot be underestimated. Following the “8 Days of Summer” initiative the Trust has invested in initiatives and practice to increase flow and turnover allowing a cessation of all corridor-based care.



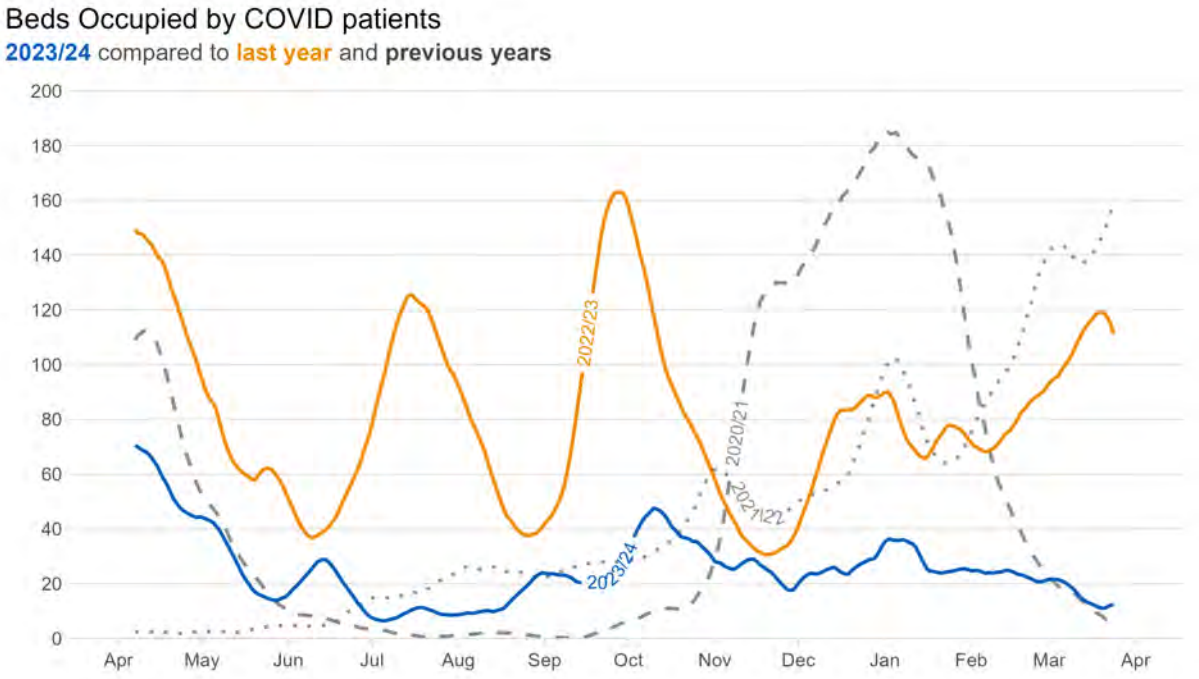


The revised Trust Escalation and Flow Policy (Oct 2024) will confirm that corridor-based care will not feature but be reserved only to events such as Critical or Major Incident declaration. This requires all the contributary initiatives and practice already introduced to be continued and enhanced. This will build both Confidence and Capacity.

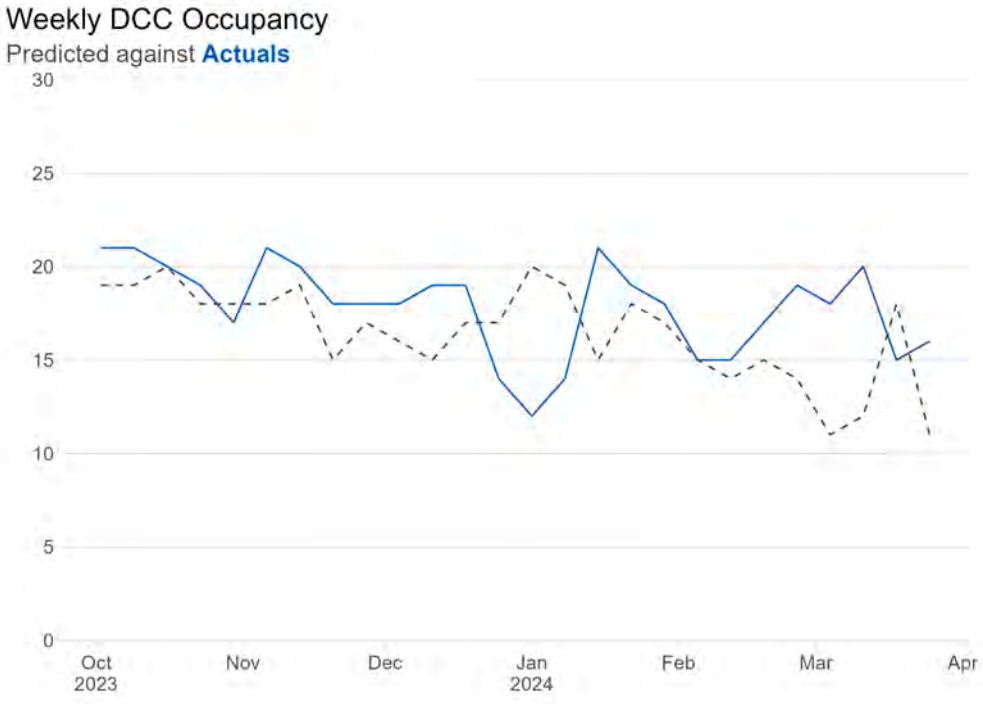
Collaboration across the ICS has seen positive movement in the reduction of our longest waiting patients which has allowed us to continue to reduce the overall burden on the Hospital sites, and improved our confidence for this winter's plan;

Other Key Highlights

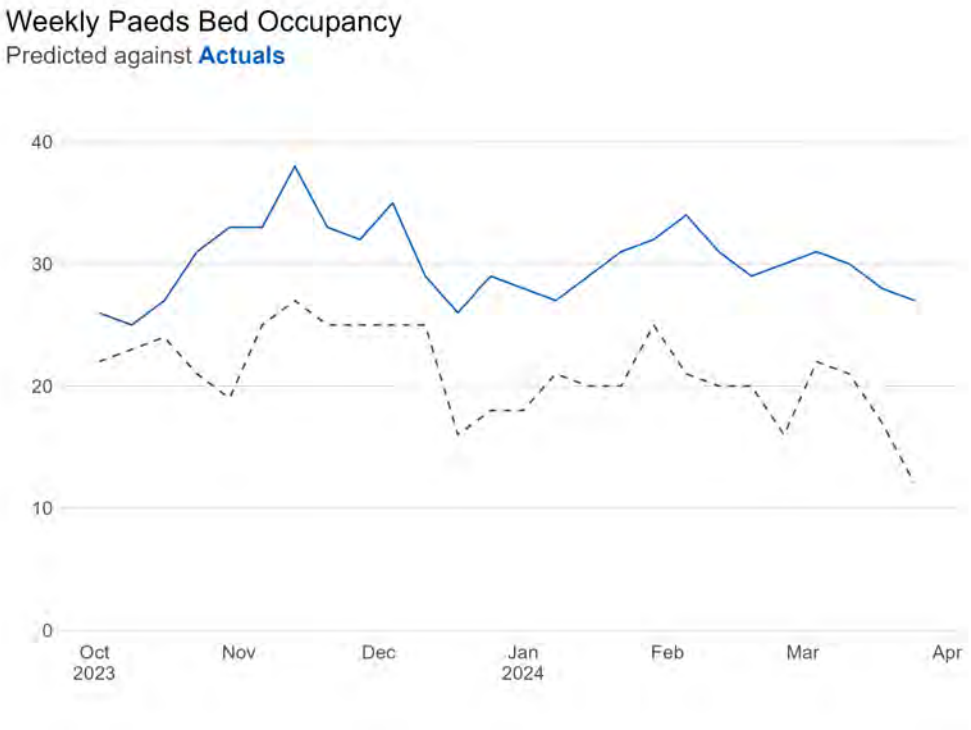
Significant less impact from COVID-19 than previous years was experienced. A dynamic and iterative approach mitigated its impact throughout the year.



Critical Care occupancy was broadly consistent with that predicted.



Paediatric Occupancy exceeded that predicted, with some complex and long stay patients with complex Mental Health input, feeding regimes and a lack of alternative capacity. This has proven to be experienced outside of winter and close working with GCC and GHC colleagues continues for this cohort of patients.



Therefore our key planning assumptions can be summarised as follows:

	Assumption
ED Baseline	Trend of last 5 years + growth
Emergency Occupancy	95%
Elective Occupancy	95%
Paeds and DCC beds	Ringfenced and cannot be used for medical outlier
NCTR	In-line with operational plan
Flu	Modelled from recent flu season in Australia (yet to be published)
COVID / RSV / Norovirus	Assume similar level as last winter, with far less pressure due to COVID

This position is at August based on the best available validated data and published guidance. The impact of continued Industrial and collective actions, in the absence of a formal settlements with the BMA Junior Doctors and GPs is as yet unknown.

HM Government and DoHSC priorities are also anticipated in the coming months but broadly are expected to require continued focus on Cancer Performance, Elective waiting list reduction and Emergency access in a financially constrained environment.

Specific initiatives over the last three Winter period have failed to effectively reduce the number of attendances to the Trusts Emergency Departments. These are multi-factorial but do demonstrate the need to focus on reducing the number of avoidable attendances, conveyances and increasing access to alternatives for our communities across Gloucestershire.

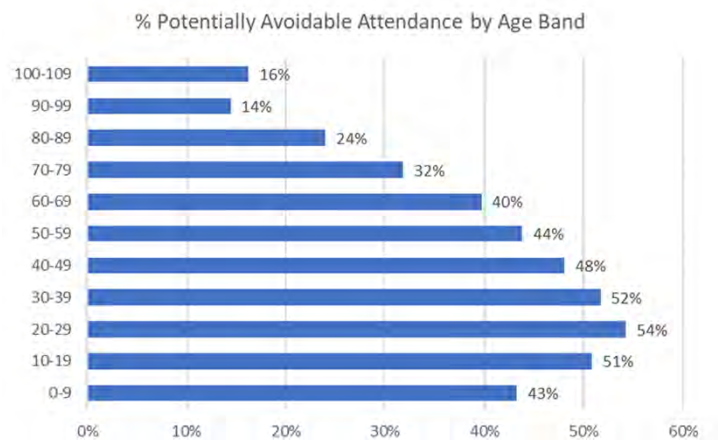
Winter Periods from 2021/22 to 2023/24

Year	Potentially Avoidable	Total ED Attendances	% Of Which Are PA	Average PA Attends per day
Winter 2021/22	27,761	70,258	39.5%	152
Winter 2022/23	30,954	71,773	43.1%	169
Winter 2023/24	32,229	74,942	43.0%	176

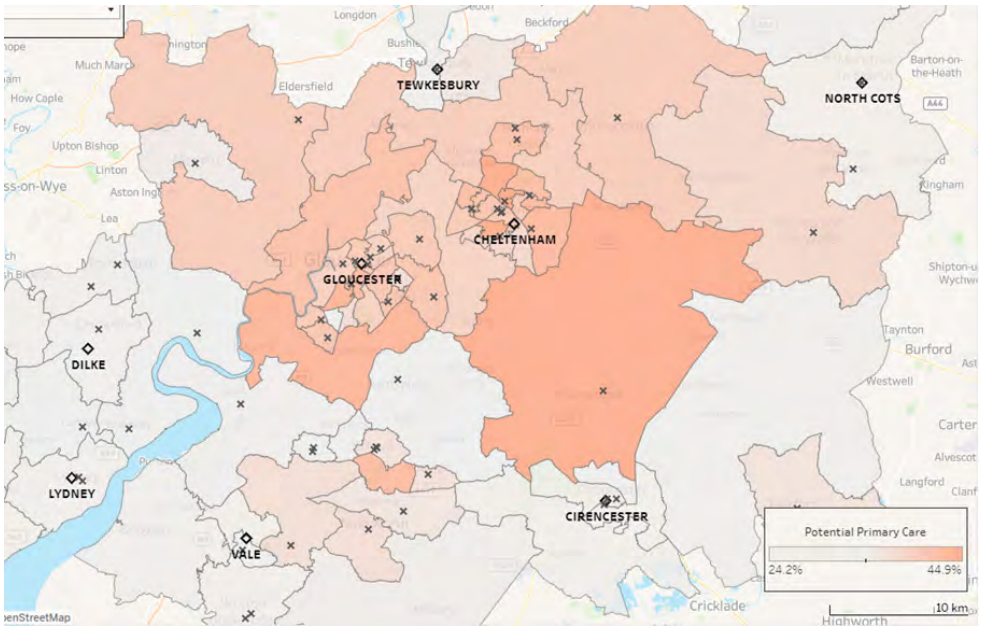
Continued collaboration with SWAST and access to community-based services are already a key priority for the UEC Improvement Board, Working as One and Clinical Vision of Flow programmes and pilots for improving streaming initiatives. Interfaces with the new NHS111 and OOHs providers will launch in November.

Priorities for joint planning with ICS colleagues will focus on avoidable attendances; access to alternatives; increasing registrations with GP and communications with the population. Working parties for Urinary Conditions and Catheter care, Falls, Community Assessment Team and Alcohol Detox (SIWA) support are underway to support the education and development of services to better support patients in the community, and avoid the traditional attendance into the ED.

Changing behaviour of our patients and communities is key to our success but this is not event-based and required co-ordinated and collaborative approaches. Our data indicates that the majority of avoidable attendances to ED are made by patients younger than 50.

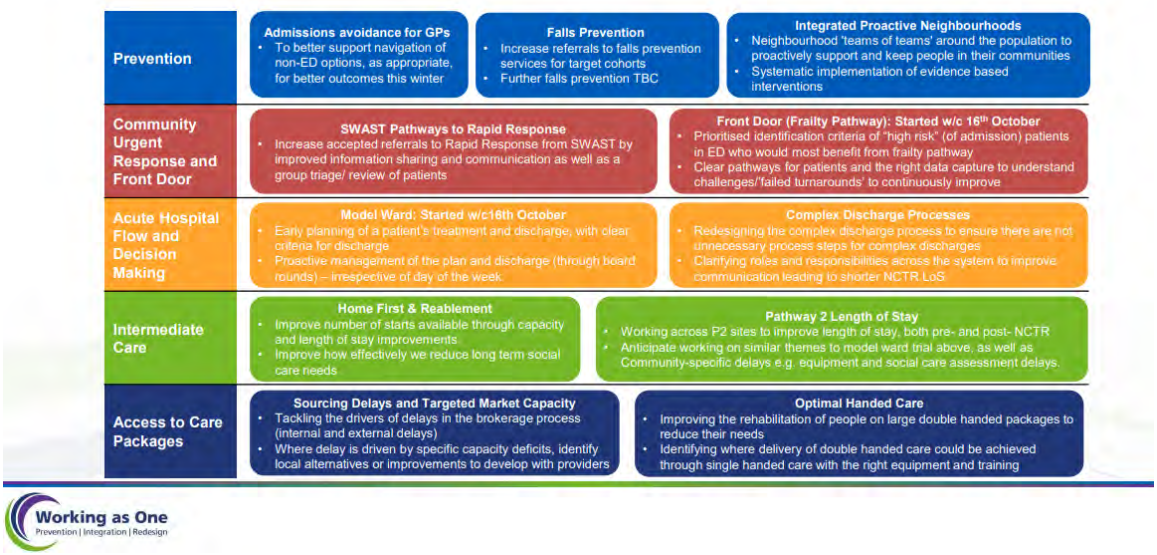


Geographically, there are more opportunities to access health care advice and treatments in the surrounding areas, with the highest avoidable attendance numbers experienced closer to hospital-based services.



Overall, 36% of the avoidable attendances had no diagnosis recorded or recorded as "no abnormality detected" which does suggest the need to improve coding compliance. With those patients where a diagnosis was recorded the most frequent diagnoses were sprains, respiratory infections, gastroenteritis and tonsilitis. 81% of avoidable attendances has no further treatment recorded or advice and guidance only.

We need to improve the use of the technology and tools provided within the Hospital and tap into the communication opportunities provided to the ICS to assist in reducing footfall to the hospitals sites, and directing more people to alternatives such as community based MIIUs, pharmacies, dentists and online advice.



We have established greater collaboration across the ICB including the establishment of the Integrated Flow Hub which has brought together colleagues from the Trust, ICS, GHC, GCC and social services, Brokerage and Working as One where conversations have delivered reductions in referral time, length of stay and increased the numbers of patients discharged for P1, 2 and 3 pathways. It has supported the reduction in the numbers of patients without having a criteria to reside (nCTR) and is well on track to hit the target of 95 at the end of this year. These achievements promote the "can do" belief of the system as a whole.

In spite of the threat of 'collective action' by GPs in England, the system will continue to promote deliver a number of initiatives being undertaken in primary and social care, including the voluntary enterprise sector. Some of these include;

- GP practice appointments available for NHS 111 to book directly into
- More GP services available on Saturday afternoons across the county
- Provision of COVID-19 booster and flu vaccination programmes
- Focus by Social Care on a 'Home First' approach to discharges
- The voluntary sector will identify more key 'Community Anchor' organisations who will play a co- ordinating role as safe havens for citizens this winter

Supporting Initiatives

To make the best use of resources available it is imperative that we put in place as many mitigating actions and processes as is possible. This section sets out our usual business continuity processes, and internal plans.

Business Continuity and Command and Control models will be refreshed allowing focus on Flow to be maintained, whilst dealing with more immediate and emergency situations.

This will see the development of a responsive and reactive operations HUB coordinating, EPPR, ICT, GMS and Apleona and other support services responses This will allow the Integrated Flow Hub and Site to work across the system partners and clinical divisions and maintain focus. It will complement the Integrated Flow Hub and the Bed Management and Site hub, effectively driving and co-ordinated expertise, prioritisation and resource to minimise and mitigate the impact of winter challenges.

Business continuity will be enhanced with the introduction of iResponse. The development of action cards focused on departmental and role response is an important winter mitigation as it enables the seamless continuum of service delivery regardless of the challenges we face. Rapid access to the most up to date guidance and prirotisation guidance rather than reliance on the less effective Policy data base where information is buried;

Severe weather Response: Building on the Summer Plan for a second year we have in place well-rehearsed severe weather plans that include processes already identified. In addition, the Emergency Preparedness, Resilience, Response, and Recovery (EPRR) team will be conducting continuous anticipatory severe weather horizon scanning with the Met office so that wards and services can proactively plan for snow, flooding and other potential events.

The Trust participates in receiving UKHSA Adverse Weather and Health Plan throughout the summer and this national initiative is continuing throughout the Winter. Risks and associated mitigating actions are discussed at the Site Safety Meetings daily.

Service supply interruptions: for instances when critical supplies are affected e.g., fuel there is a process in place to rapidly meet with operational managers, risk assess and put in place Business Continuity Plans at pace with in a coordinated approach. Any residual risk or areas of concern can then be escalated to senior management for oversight and support.

Industrial Action: The Trust experienced increasingly significant impacts of Industrial action throughout the year and it is hoped that a National deal can be agreed shortly. Whilst the risk has reduced since the General Election, there remains a residual risk of continued Collective Action in Primary care, and a risk of continual challenge in an economically challenged environment, including civil disturbance.

Collective Action: GPs and Primary care, following a national ballot, have commenced actions short of withdraw of labour; The impact of this has yet to be felt directly by Acute sector service providers, but the Trust are managing and planning responses to mitigate any impact as much as possible;

Escalation: We have a well-established Patient Flow and Escalation Policy which complies with national requirements and links to the systems' OPEL tool. This is due for revision in October 2024 when the latest OPEL Framework is published. We plan, as part of a system wide review to review our internal actions against the revised OPEL framework to ensure consistency of response, language and process, as outlined in the latest publication.

The policy enables us to:

- Recognise early pressure within the acute trust utilising SHREWD data, the Emergency Department's (ED) hourly board round and live ED metrics.

- Ensure patients requiring assessment/admission are seen in the most appropriate area, by the most appropriate resource, at the right time to treat the patient's presenting condition in a safe, effective and appropriate clinical pathway.
- Ensure patient expectations are met in line with national performance standards
- Define the process by which GHFT capacity will be managed during times of surges in activity and/or demand for inpatient beds. This includes maintaining focus on quality, safety and patient experience when the Trust is in escalation.
- Ensures consistency of approach for capacity escalation issues and processes
- Clarifies the roles and responsibilities of all parties involved in 'Capacity and Flow' in GHFT, this includes: the Clinical Divisions, support services and Site Management Teams; Duty Managers; On-Call Managers; On-Call Nursing Directors and On-Call Directors.
- We have in place, or in development, a suite of tools that will increase our effectiveness in managing bed flow at times of escalation/de-escalation.

Additional Transport to support Discharges – in times of escalation local taxi services can provide some additional journey's home for patients discharged from the ED or wards who are without funds and without recourse to true hospital transport. This enables a safe discharge and return home rather than risk extended waits or social admission.

The re-tendering for transport services, ensuring value for money is underway, and will re-patriate contract responsibility from the ICS to the Trust who can shape its delivery to meet the needs of the Trust more precisely. This will require a review of the volume of services to patients, which currently are very high with few controls.

The development of a Business care for a Managed bed and mattress service will be delivered to mitigate the loss of equipment, delays and sub-optimal equipment to patients and the staff caring for them will be reduced.

Volunteers in the Emergency Department – this expanding role and group of volunteers support patient well-being in ED by checking on patients, providing refreshments or blankets and being a listening ear if required.

Use of Volunteers to support medication and equipment delivery will be expanded. This will allow patients to go home in the knowledge that any outstanding medications or small equipment will be delivered that day.

Weekend assessment and discharge team (WAD) at GRH expanded to CGH – recognising that system flow is significantly more challenged at weekends, compared to weekdays, which then impacts on Monday and Tuesday activity a WAD team was trialled at GRH and has become a business-as-usual approach. There will be a fixed term appointment to support consistency and flexibility throughout the season, supporting both sites and assisting in the teaching and education of medical teams promoting early and planned discharges across the weekend.

Senior Operational Support at weekends – providing operational drive and focus across the whole weekend to support escalation, discharges and 'pipeline' actions to drive continuous flow 7 days a week. To activate 'wicked weekend' activities and 'Recovery sprints' when required.

The Trust has a range of interventions in process, plans and responses to be considered to address the problem of supporting Ambulance Offloads. These include:

- Delivery of Ambulance Handover Improvement Plan
- Hourly daytime huddles with Site, ED and SWAST
- Platinum-level (Exec Tri) support for management of decreasing tolerance for offload delays
- Agreed SOPs with ambulance service.
- ZERO Tolerance for 4 hour offload delays and a return to expected standards of 15 minutes
- Ceasing the boarding and Pre-empting of patients; focusing on discharge promoting activities, Criteria to Admit and Conveyance management in accordance with the revised Trust policies
- Ongoing review of triage processes, linked with the winter scheme enhancing front door capacity.
- Clinical review by the nurse coordinator for patients on trolleys who may be fit to sit.
- Continue handover escalation for those actions and patients delayed over 30 minutes.
- Further development of Safety Huddles in the ED department for effective and focussed escalations and feedback from Divisional Managers of the Day
- Delivery of Divisional and cross-divisional huddles facilitated by the Response Hubs as needed.
- Delivery of the national Internal Professional Standards and supported by breach analysis to inform future actions. Effective escalation management.

Specialty in reach to ED – Where possible and appropriate, we will aim for the Specialty in reach and input into ED to be provided by a Registrar rather than Surgical House Officer (SHO), unless a decision can be made appropriately by SHO.

Promote the development of initiatives such as Criteria to Admit and Next steps promotion as supported by the CVOF Programme.

Greater use of EPR Support for Discharge - The weekend handover to be shared on EPR for weekend team. This would support planned weekend discharges and Nurse Led Discharge process

These will be promoted and monitored via the refocussed Urgent and Emergency Care Improvement Board (UECIB) which incorporates the assurance required of the CVOF Programme.

Additional winter initiatives that expand our services

This section outlines some of the additional initiatives that the Trust has, or is, working up for implementation this winter. These initiatives do not require funding or funding has already been approved, and are therefore classed as improvement schemes/business as usual;

Supporting advice & guidance for Winter – increasing capacity and operational hours across the surgical Division over winter to be able to respond effectively to primary acre and Paramedics optimising the ability to avoid ED attendances and acute admissions through diverting patients to an alternative setting;

Expanding Surgical SDEC facilities within existing footprint – creating senior decision- making capacity later in the day to enable later return patient appointments, prevent unwarranted admissions and release middle of the day capacity to focus on ED referrals (matching its peak activity).

Speciality Review outside ED - This will consolidate Assessment unit models such as HaNSU (Head and Neck) and the delivery of a Urology Assessment Unit (UAU) at CGH;

Increase in ECHO activity and SDEC-like Cardiology (Pilot) - Conversion of outpatient sessions to inpatient sessions, which will create capacity for discharge dependent ECHOs to take place.

Additional 'Hot Clinic' slots a week – Hot clinic capacity has been increased to release capacity to ED by streaming urgent GP referrals.

Delivery of 7 Days of Autumn to include ward reset and 'Breaking the cycle' Methodology with system support for w/c 4th November 2024

Early Seasonal Planning for Christmas and New year from the period 16th December 2024 to 20th January 2025 incorporating Recovery.

Patient Experience and Colleague Well-being

With significant pressures on the NHS, and the system as whole, we recognise the need to underpin our Winter Resilience Plan with a clear focus on patient experience and staff wellbeing.

Patient experience

It is of utmost importance that we maintain a focus on patient experience, especially with increased demand and new models of working, to ensure that we hear the patient voice in order to address any issues in a timely fashion.

Focus on ability to stream to alternatives, were clinically indicated, preventing waiting time and improving experience. Building confidence in non-hospital facilities and better managing expectations of patients.

Reducing time spent in the department with no active management; Speciality assessment in the Speciality where possible; focus on 12 hour maximum stay; development of 'CDU type' model of care to allow patients to complete their diagnostic and treatment in a step-down facility (e.g. 2nd Troponin test result; endoscopy)

Proactive pull model to the 'Paediatric Assessment Unit' for appropriate patients when capacity allows to continue

There is a recruitment programme underway to attract rotational staff and a bespoke training programme to improve specific knowledge and skills.

Discharges

To enhance patient experience, we are developing a new volunteer discharge support role to trial over winter that will support quicker discharges by helping patients pack their belongings, call relatives and

potentially collect TTO's. This is currently being worked up as a scheme with an associated NHS England funding bid being submitted.

Monitoring patient experience

Utilising the learning from Friends and Family Test (FFT) enhanced monitoring has commenced and this is facilitated via the Quality and Delivery Group and Quality and Performance committee. There will be a focus on supporting teams to understand their data and develop effective action plans. This will enable us to proactively support areas with specific challenges to address which are often linked to pressures in demand, workforce or a combination of factors. This is now led by an ED Patient Experience Lead now receives the FFT data on a weekly basis

This was put in place to ensure that any emerging trends seen coming can be addressed in a timely fashion, and the ED Patient Experience Lead works closely with the Patient Experience Team to ensure clear communication and documentation of all plans put in place to address to enable monitoring and improvement process are clear.

Colleague Health and Wellbeing

Our colleagues are without doubt our most valued resource and we recognise that the last two years have been an extraordinarily challenging time, and continue to be so. In recognition of this it is important that we all play our part in looking after each other.

Maintaining good habits:

Despite the day-to-day operational pressures it is important that we maintain excellent discipline in all activities that impact on colleague well-being. These measures include;

- Proactively enabling breaks, ensuring annual leave is taken evenly across the year to support health and well-being; enabling training and education throughout period of stress; reducing the impact of surge by better prediction, planning and response.
- Reducing the care of patients in corridors by focussing on capacity creating flow activities.
- Completing the improvements to the working environment (IGIS, 3rd Cath Lab, Move of HASU and opening of UAU, not opening more inpatient capacity at short notice)
- Better matching staff levels to demand profiles (specifically realising the revised rotas for Medical Staff in ED following reinvestment in the team; centralisation of acute medical take on the GRH site since July 2024)
- Following up on periods of sickness, as per policy, to understand what support might be required for colleagues.
- Adhering to Infection Prevention and Control policies to look after each other, our patients and families, with healthy and respectful challenge.
- Recognising the contribution everyone makes to the environment in which we work.

Looking after our colleagues:

We are committed to continued training and development of colleagues, reducing the instances of cancellation and promoting at workplace training where the practical training comes to the workplace for pragmatic and practical applications.

- Learning from 'events' to be better shared with colleagues.
- We are working as a system to understand where there are workforce challenges and joined up strategies to address theses to prevent competing markets.
- Promoting compassionate leadership work already underway including the respectful resolution programme and a cultural barometer pilot,
- Continuation of the already well-established colleague wellbeing offer, including ongoing support from the Hospital charity that incorporates:
- 2020 Wellbeing Hub open 8am – 5pm Monday to Friday, providing practical support for mental, financial and physical health needs with links to numerous charitable and support organisations.
- IRSH (Incident Response Safety Huddle) has proven successful in prioritising safety and learning from incidents relating to patients safety that a more staff focussed approach will be considered, which reflects the need for confidence and discretion in the workplace,
- Continued use of the 24/7 Employee Assistance Programme, operated through Vivup providing telephone support and counselling.
- Psychology Link Worker support offering 1:1 support, team support, training and decompression activity. This is often provided within the team environment and has been particularly valuable since the start of the Covid pandemic.
- The active Peer Support Network of 24 colleagues across the Trust (accessed through the 2020Hub).
- Increasing the number of TRiM trained managers (10) and trained TRiM practitioners (51) providing support to keep colleagues functioning after potentially traumatic events, by providing support and education to those who require it. TRiM aims to identify those who are at risk of experiencing greater levels of psychological distress after potentially traumatising events and ensure they are signposted to professional sources of help.
- The completion / delivery of staff rooms and spaces upgrade projects.

Collaborative Working across professional and organisation boundaries

As already described, we have identified a number of schemes that will require a partnership approach; some of these are of significant impact from a GHFT perspective and others are cross-cutting priorities that will support whole system resilience over winter and improve the experience of our patients and visitors. For clarity the schemes are set out below to reflect their impact on our winter resilience including:

- Develop sub-acute pathways (including frailty) with direct access from Primary care and SWAST to GHC but that includes a step up/down model with the acute.
- Revise the Mental Health support in ED
- Review ED Triggers and associated escalation/response.
- Increase in Commissioned Supra-Regional bed capacity e.g., Neuro-rehab, Brain injury rehab, eating disorders etc.
- Develop and agree a 'Winter Covenant' across the system (See Appendix 1)

- Review roles and Responsibilities for BRONZE-SILVER-GOLD managers and conversations and planning for weekends and seasonal events.
- Review and agree daily, weekly and monthly business rhythms for the system. Our organisational agility will allow us to respond to the priorities and challenged presented by system partners and agencies with whom we work.
- Liaison and communications are already established with SWAST and will be further enhanced with the Fire Service and Police Services in Gloucestershire, who are also required to respond dynamically to the needs of the communities in Gloucestershire and more widely.

We will jointly commit to :

- Review Inclement Weather policy and procedures;
- Seasonal Influenza and Immunisation plans, Infection Prevention and Control Policies
- Norovirus plan
- Respiratory Plan
- Business Continuity plans
- Information Sharing Protocols with systems partners such as SWAST
- Major and Significant incident response plan
- Cold Weather Plans
- Promote continued co-ordination and collaboration with our Local Resilience Partnerships;

The benefit of these internal and collective system actions will create a new forecast for the overall bed demand required to operate safely over the winter period. We will use this to generate a graphical representation of the way in which bed demand is predicted to increase and fall over the period. Critically this projection will include the phased realisation of benefits from the improvement work as it moves to full year effect.

This modelled demand will then be used to inform and agree a viable and deliverable operational plan for managing acute bed stock through the winter period and, more specifically, identify times when the Acute Trust would need to consider scaling down elective work to increase additional inpatient capacity to safely manage demand across the Gloucestershire communities.

Communication

Central to this successful approach is to use targeted, consistent and timely messaging across all media and platforms. The Impact of getting this right cannot be underestimated and we will be working across the system using the expertise at hand to access as wide a section of our community as possible.

Key operational leaders will work with the trust Communications department to release key messages for the public to promote “choose well messages” and for staff around areas of transformation work that is taking place. This communication will be based on a range of methods including internal and external communications.

The Trust is also part of a number of UEC and system flow joint working groups as part of the wider ICS to provide a ‘winter communications’ campaign which focuses on appropriate use of services, redirection from ED and keeping well in winter.

How will we know if our plan is working ?

Our approach this year has been design a plan with the clinical divisions and support services. Each division has contributed to the plan, and as already described is supported by the Clinical Vision of Flow Programme.

The "Clinical Vision of Flow Programme" (CVOF) is a quality improvement initiative focused removing delay related harm and improving flow.

The Programme Vision is to provide:

The best care for everyone:

At Gloucestershire Hospitals, we envision flow where every patient's journey is efficient, seamless, and centred on what's right for them. We are committed to swiftly connecting our patients with the right clinical team and ensuring admission only when truly essential. Together, we strive to navigate each step effectively, reducing delay-related harm and allowing our patients to quickly get back to the comforts of their own homes or wherever their next step may be.

Pride in what we do for our patients and each other is a key feature of the care we provide.

AIMS of the CVoF Programme:

The CVOF Programme has identified 12 priority aims, with ambitious targets to be met by 2024-2026:

- Eliminate ambulance handover delays over 15 minutes – by March 25 (this is a stretch target)
- 95% 4hr standard for patients waiting in ED by April 2025
- Zero patients waiting over 8 hours in ED by April 25
- No patients staying in assessment areas for more than 2 midnights by April 25
- 100% P0 go home same day as made NCTR by Dec 24 (unless clinical deterioration occurs)
- 98% P1 and P2 to leave same day/next day of submission to IFH by April 2025 (to be inc for all WS)
- Excess deaths over 8 hrs will be zero by Oct 2025
- 95% of patients access the correct specialty bed on the day they need it by April 25
- 1 empty bed in every ward with no corridor care or use of non-designates bed spaces by Oct 24. 2 empty beds in every ward with no corridor care or use of non-designated bed spaces by April 25
- No more than 5% of patients move wards more than twice during their hospital stay (excluding ED) by April 25 (unless a clinical reason)
- 95% of patients with capacity to know the answers to 4 Questions (measured by pt survey) by Sept 25. 50% by Dec 24 – suggest similar version for ED and SDECs
- Over 75% of staff would recommend GHFT as a place to work by April 26 - Increase by 10% by the next staff survey April 25

Measures of success

Each of the 4 workstreams will managed a ranger of initiatives and projects designed to positively impact our delivery throughout the year. Using data and intelligence available from ourselves and our colleagues in the BI team we will received regular updates on how our actions and plans are affecting the services we deliver to our patients and community.

We will assure ourselves, the Trust Board and regulators via the UECIB and Board Committees regularly using the Clinical Vision of Flow Dashboard | GHNHSFT BI Hub (glos.nhs.uk)

Supported by Internal Professional Standards, the ED for example with be required to ensure that there is effective communication and escalation to ensure it can meet its own remit and operational standards as set out below:

The Emergency Department should primarily be accessed for serious and life-threatening conditions and therefore all patients will spend as little time as possible within the Emergency Department and in any event will not spend more than 12-hours waiting wherever possible.

- All patients will undergo triage within 15 minutes of attending ED.
- All patients in Emergency Department requiring assessment or admission will be 'pulled' into the appropriate short stay areas or specialty bed.
- The Trust and all System Partners will adopt the Actions set out in the NHS Discharge Guidance (Aug 20)
- All patients will be assessed where required by an appropriate decision maker working to a service agreed care pathway.
- All specialties will review all emergency patients daily – 7 days a week – and continue a multi professional Board and Ward round approach to be completed each morning based on clinical need.

The Trust, in accordance with national best practice, which is recognised by the appropriate Royal Colleges, will embrace the principles of SAFER as a mechanism for optimising Patient Flow:

- Senior Review (S) – All patients will have a senior review before midday.
- All patients (A) – Will have expected discharge date and clinical criteria for discharge.
- Flow (F) – Commencing at the earliest opportunity, first patients by 10am.
- Early discharge (E) – 33% of patients discharged before midday.
- Review (R) – Multi-disciplinary team reviews of patients with extended length of stay.

- The afternoon Board Rounds will focus the identification of definite discharges for the following morning with patients moving by 12pm.
- All appropriate patients will be discharged via the Discharge Waiting Area. These patients will be, wherever clinically appropriate, moved to discharge Waiting Area between the hours of 07:00am - 21:00pm (This allows for timely closure). A 'golden patient' will be identified daily, in advance by each ward with the aim being to move this patient to the discharge lounge no later than 10:00am the following day.
- Specialties will provide appropriate in-reach to admission areas to: Provide specialist support in inpatient management Ensure appropriate patients are identified and rapidly moved to specialty wards
- Discharge/early supported discharge is expedited by specialist opinion/community management

These organisational standards set out the minimum rules of engagement, but our ability to exceed their delivery and set ambition is not limited.

GOVERNANCE

Internal Reporting and Assurance

Executive Reviews will continue throughout the period and are aimed at focussing on the delivery of key metrics, measures of quality and safety and to request and agree levels of operational and financial support as needed.

UECIB will provide the assurance from the Divisions on actions and escalations and ensure that risks are dynamically assessed and reflected on the Risk Register and via the Board Assurance Framework (BAF)

In line with reporting of the constitutional standards the winter plan will be strategically reviewed at Quality and Performance Committee. The operational and tactical reviews generated above will drive the narrative that supports the discussion but the winter plan will not be reported separately to avoid duplication of existing Quality and Performance Committee reports.

The focus of discussion at each of the above meeting will be the development of actions and plans to recover the expected trajectory and Trust position if required.

External reporting

Early reporting of data that indicates emerging problems, is seen as a key element in the effective management of winter. At our three times daily Site Safety meetings we will critically review and undertake dynamic actions to correct deviation from our measures. This will require Organisation-wide engagement and action. The actions and plans outlined and being developed should focus on maintenance and achievement rather than remedial actions.

We will continue to contribute to the daily system-wide conversations in accordance with the prevailing OPEL framework, and raise additional support requirements at the Tactical (TEG) and Strategic Escalation (SEG) groups which site across the whole ICS and incorporate SWAST.

Trusts are required to provide SITREPs based on the following reporting requirements;

- Temporary A&E closures;
- A&E diverts;
- Ambulance handover delays over 30 minutes;
- Trolley-waits of over 12 hours;
- Cancelled elective operations;
- Urgent operations cancelled in the previous 24 hours and those operations cancelled for the second or subsequent time in the previous 24 hours;
- Availability of critical care, paediatric intensive care and neonatal intensive care beds;
- Non clinical critical care transfers out of an approved group and within approved critical care transfer group (including paediatric and neonatal);
- Bed stock numbers (including escalation, numbers closed, those unavailable due to delayed transfers of care etc.);
- Details of actions being taken if trust considers that it is experiencing serious operational problems.
- COVID & RSV related reporting returns are expected as is the case at present.

This Plan sets out the Principles and process for the delivery of a safe and responsive service portfolio to our patients. It will be subject to revision as National priorities are confirmed, sources of funding and support are confirmed and risks assessed; The principles herein will be delivered in accordance with Trust Escalation and Flow Policy, focussed on patient safety and service quality and financial control and governance.

A Covenant for Winter

The delivery of the plan must be agile and dynamic, responsive and patient focussed, and consistent with the Trusts Aims and Objectives. Promoting a covenant as the Acute provider we will :

- Maintain and monitor performance using Internal Professional Standards across all specialties.
- Re-mobilise 111 appointment system through Urgent Care to reduce inappropriate attendances and decompress waiting rooms supporting social distancing requirements
- Ensure patients are diverted to Same Day Emergency Care (SDEC) areas wherever possible through ED to decompress ED and ensure patients are seen in the right place at the right time by the right clinician.
- Maintain screening at the front door of the hospital to manage infection control with entries to Covid secure areas (RED ED) with assessment such as temperatures being taken on arrival and maintaining pathways which protect and control our patients, staff and contractors from Infections such as Covid, Flu and Norovirus
- Rapid offloading and assessment of SWAST conveyed patients to reduce the length of time in ED, including RATA and achievement of the 15 minute standard.
- There will be ZERO tolerance of offload delays exceeding 2 hours.
- Maintain 7+ day patient Length of Stay reviews throughout winter across all adult wards to reduce LOS
- Engage and actively participate in communications across the system in a positive and action-orientated way.
- Continue to build on better identification of EOL undertaking advanced care planning and identifying patients who are sick enough to die facilitating rapid discharge where appropriate led through the Trusts Palliative care team
- Provide live and close monitoring of site activity and performance responding and mobilising escalation in a safe and timely manner through Senior Site Practitioners overseen by the Silver On-call managers.
- Ensure robust pathway for patients identified as EOL to access supported pathways into the community
- Utilise OPEL Framework and Full Capacity Protocol supported Action Cards for all key clinicians and managers

- Maintain early discharge planning to maintain timely discharge. Discharge Lounge will develop and publish INCLUSION criteria so that only a few patients will NOT be able to access the facility.
- Create and maintain a clear pathway for care home patients delivering effective communication and rapid discharge of patients back to their usual place of residence.
- Ensure Mental Capacity Assessments and Best Interest Decisions are still undertaking in line with legal requirements, even in the context of rapid decision making and discharge.
- Maintain the Single Point of Access (SPA) providing direct access to community health and social care discharge pathways through a robust D2A model.
- Embed updated process and escalation routes for the undertaking of CHC and Care Act assessments to maintain flow and capacity through the pathway and within the 6-week funding period managed through weekly MDTs to allow early discussion post discharge of all patient's assessment pathway

September 2024

Appendices

Identified problem	Policy/Process
Adverse Weather Control Room Lead Roles and Responsibilities	 AC_Control_Room_Lead_.docx
Transportation of staff	   AC_Transport_Lead_. Framework_LRF.docx Access_to_4x4_Cell_ XX Access to 4x4 docx Advers Weather.docx
Pathology transport	 AC_Pathology_Transport_.docx
Colleague support	   Accommodation_Guidance_CGH_and_GRH_ AC_Staff_Linen_Staying_on_Site.docx AC_Food_Voucher_.docx

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board

Agenda item:		Enclosure Number:	
Date	14 November 2024		
Title	Learning from Deaths report (Q4, Jan to March 2024)		
Author /Sponsoring Director/Presenter	Sponsor: Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO Author: Jo Mason-Higgins, Acting Associate Director of Safety (Investigation and Family Support) Charlie Candish, Associate Medical Director (Safety)		

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

Summary of Report

To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

Key issues to note

1. All deaths are reviewed within the Trust via the independent Medical Examiner Service.
2. Learning from serious incidents is monitored through SERG, summaries are found in Appendix 2 (for QPC only).
3. There is good local learning from problems in care and ensuring these are being reflected within specialties. The need for the outcome of SJR reviews to be reflected in Trust-wide improvement programmes and (PSIRF safety priorities) is recognised.
4. Timeliness and completion rate of SJR, whilst improving in Q4 of 2023/2024 is of concern. A review (utilising a QI approach) of SJR process, compliance and outcomes is being considered.
5. It is clear that the positive feedback is consistently high regarding the care provided with the care experience being identified as positive as well as our staff being kind and helpful. There was also a negative trend relating to communication next steps in general. A review of the Trust's process for feeding back (to families) findings of SJR is being considered. It is recognised that proactive feedback may improve experience and reduce concerns and complaints.
6. Hospital crude mortality remains low/falling, but SHMI has risen. The cause of this is multifactorial and both coding and care issues are under investigation, including the following:

- Primary diagnosis coding
- Charlson comorbidity scoring
- Dementia coding
- Fractured Neck of femur pathway improvement
- Clinical audits in septicaemia, COPD, weekend admissions

- Delay related harm data review

The SHMI action plan is being monitored by a Quality Improvement Group, chaired by the ICB CMO, with representation from Regional NHSE. Progress will be reported in each Learning from Deaths report.

Recommendation

The report is provided to board for assurance.

Enclosures

Quality and Performance -Learning from deaths – Q4 January 2024-March 2024

QUALITY & PERFORMANCE COMMITTEE –October 2024

LEARNING FROM DEATHS REPORT – Q4, January to March 2024

1. **Aim**

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 This report covers the period January to March 2024 and is an update from the previous report.

2. Learning From Deaths

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties.

c. Serious incident review and implementation of action plans. (Appendix 1 for Q&PC only).

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports and national audits.

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. Death's that trigger a Structured Judgment review are entered on to the Datix system to support the SJR process.

2.3 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through individual speciality and divisional processes. The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some themes continue to be identified which are in common with known areas of quality

2.4 All specialties receive individual monthly data on SJR performance and report to HMG on a rolling basis where performance is reviewed. Most SJRs are undertaken within 2 months.

2.5 All families are given the opportunity to provide feedback to the bereavement team on the quality of care. Feedback from bereaved families is largely positive.

2.6 The family feedback analysis from Bereavement is analysed through to the End of Life meeting and triangulated with the national end of life survey data.

2.7 A structured judgment review was undertaken on 67% of death's (requiring review) within this reporting period. Performance and feedback of learning is presented to HMG on a rolling basis from Divisions and examples of this can be seen in Appendix 2 (Q&PC only). Themed issues are being tracked in nine areas over time through datix reporting.

2.8 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups. Summary reports on closed action plans are included in the report. (Appendix 1).

2.9 Deaths outside the SJR process are included in the table below:

Deaths by Special Type	Jan-March 2022	April-June 2022	Jul-Sept 2022	Oct-Dec 2022	Jan-March 2023	April-June 2023	July -Sept 23	Oct-Dec 23	Jan to March 24
Maternal Deaths (MBBRACE)	0	0	2	1	0	0	0	0	0
Serious Incident Deaths ***Figures represent date investigation complete rather than date SI declared**	4	7	9	7	6	*1	*9		
Learning Difficulties Mortality Review (inpatient deaths)	3	9	8	7	6	5	5	4	6

	Jan -Mar 22	Apr-Jun 22	Jul-Sep 22	Oct -Dec 22	Jan -Mar 23	Apr-Jun 23	Jul-Sep 23	Oct-Dec 23	Jan-Mar 24
SB >24 wks	5	0	4	2	3	6	1	5	5
NND >24 wks Born at GRH/Died GRH	2	2	1	0	0	0	2	1	1
NND <24 wks Born at GRH/Died GRH	1*	3*	3*	4*	2*	0	1*	3	0
	0								
NND >24 wks Born & Died Elsewhere	0	0	1	1	2	0	1	0	0
NND <24 wks Born & Died Elsewhere	0	0	0	0	0	0	1	0	0

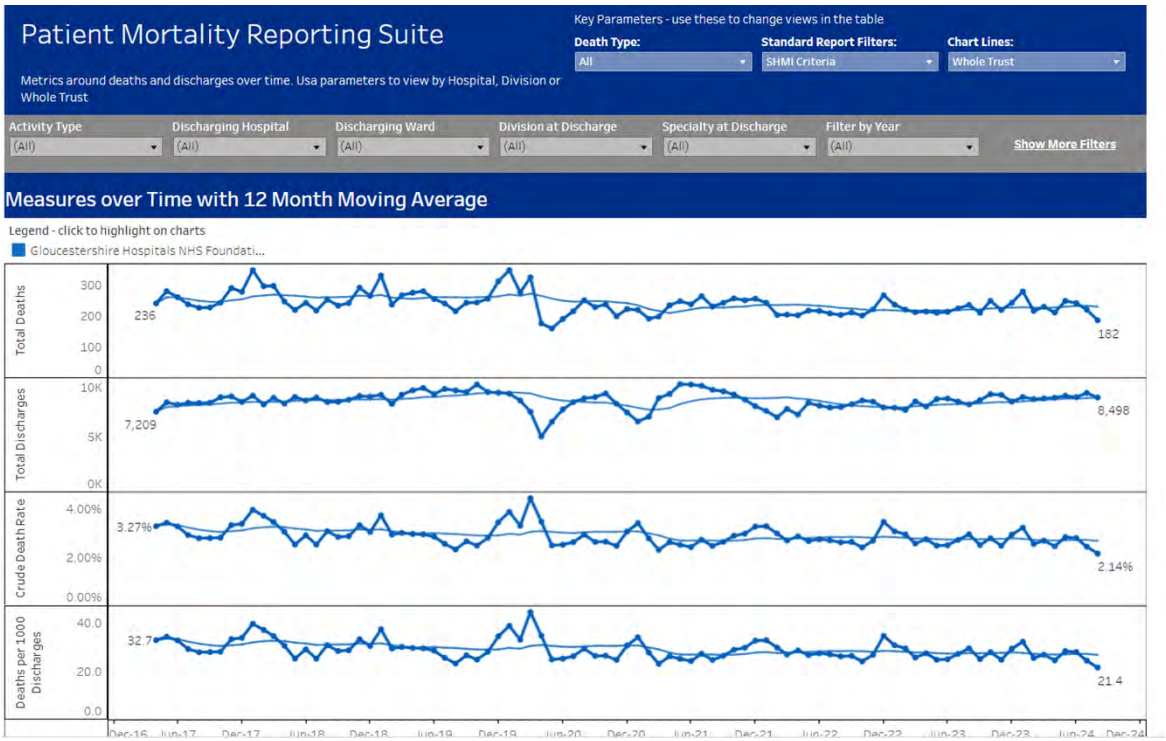
NND >24 wks Born GRH & Died Elsewhere	0	1	0	1	0	0	0	1	1
NND <24 wks Born GRH & Died Elsewhere	0	0	0	0	0	1	1	0	0

Post Neonatal death								1**	1

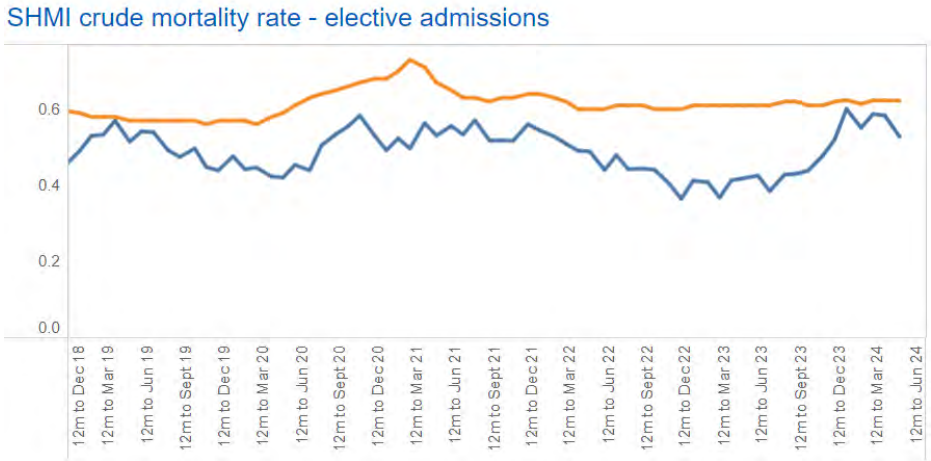
3. Mortality Data

3.1 Crude Hospital Mortality:

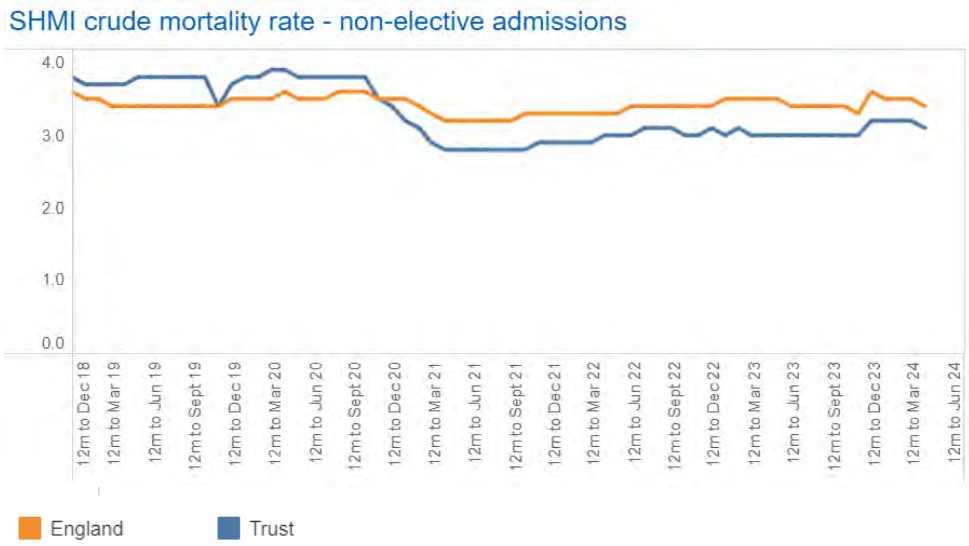
Hospital mortality (deaths per spell, 12m average) continues to fall (BI data):



The hospital mortality rate for elective admissions is 0.5%, with the national average, 0.6%:



The hospital mortality rate for non-elective admissions is 3.1%, with the national average, 3.4%:



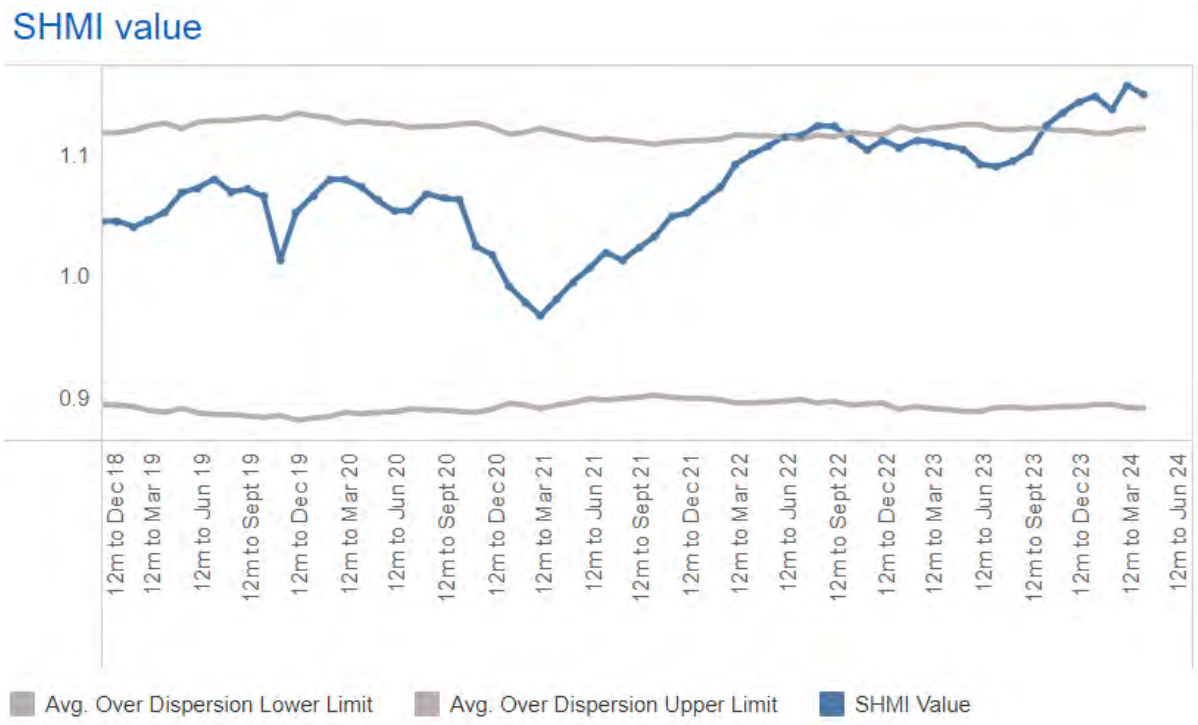
3.2 SHMI

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation, or within 30 days of discharge and the number that would be expected to die based on patient characteristics including diagnosis, age, sex, type of admission, and coded co-morbidities. It covers all non-specialist acute trusts.

Data presented here is from the NHS Digital publication date of 12/9/24, covering the period **May 23-April 24**. It therefore covers Q4 and is the latest reported data set.
The current SHMI is **1.15**, with 2855 observed deaths and 2485 expected deaths based on current coding.

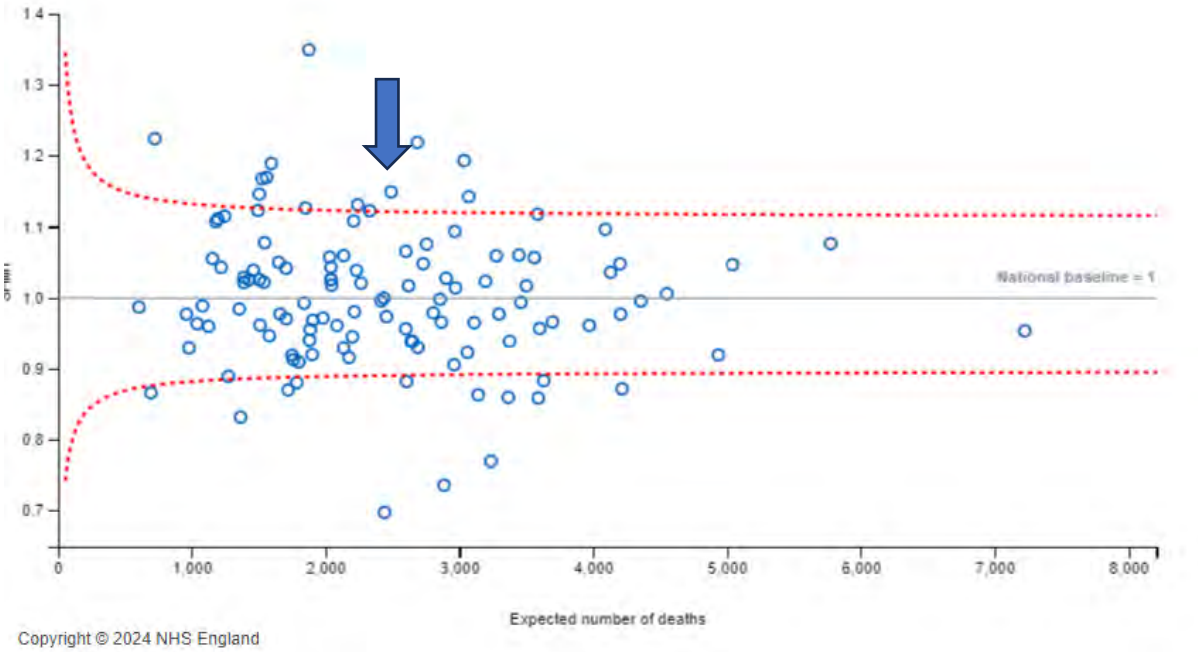
This SHMI level has been rising, despite the above static/falling hospital crude mortality (deaths per spell).

SHMI is the preferred mortality metric over HSMR



3.3 National Picture:

This SHMI level is more than one standard deviation above expected and therefore considered an outlier, along with 15 other organizations:



Important points to note are:

1. **Site:**

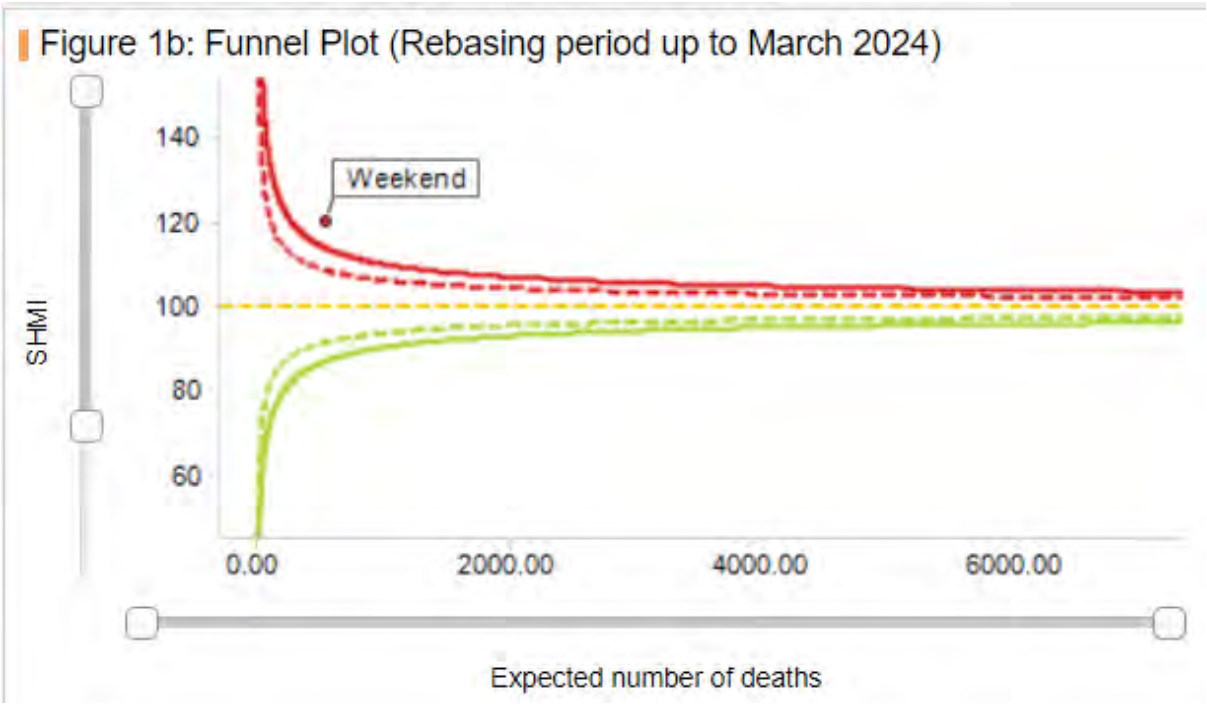
The SHMI level is higher for Cheltenham General (**1.18**) than Gloucestershire Royal (**1.14**), and is likely to reflect the change in patient cohorts/flows in the two sites:

Site level breakdown (official statistics in development)

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
RTE03	Gloucestershire Royal Hospital	85515	2075	1,825.00	1.14	As expected SHMI
RTE01	Cheltenham General Hospital	15775	780	660.00	1.18	Higher than expected SHMI

2. **Weekend/Weekday variation:**

SHMI is higher for those patients admitted at a weekend (**1.20**), and is the focus of an ICB led system wide clinical audit.



3. In/Out of Hospital

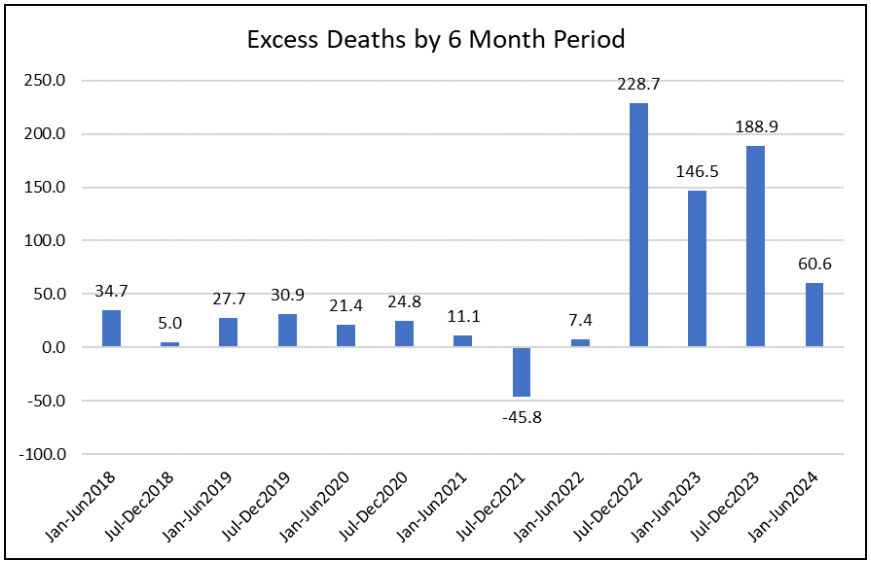
The SHMI for in hospital death is within the expected range at 1.08 (HED data). The SHMI for out of hospital death is above the expected range at 1.30 (HED data)

65% of deaths occurred within hospital (national average 69%), 35% of deaths occurred outside of hospital (national average 31%).

This could represent improved discharge planning for patients towards the end of life. This is under further investigation and review.

4. Delay Related Harm:

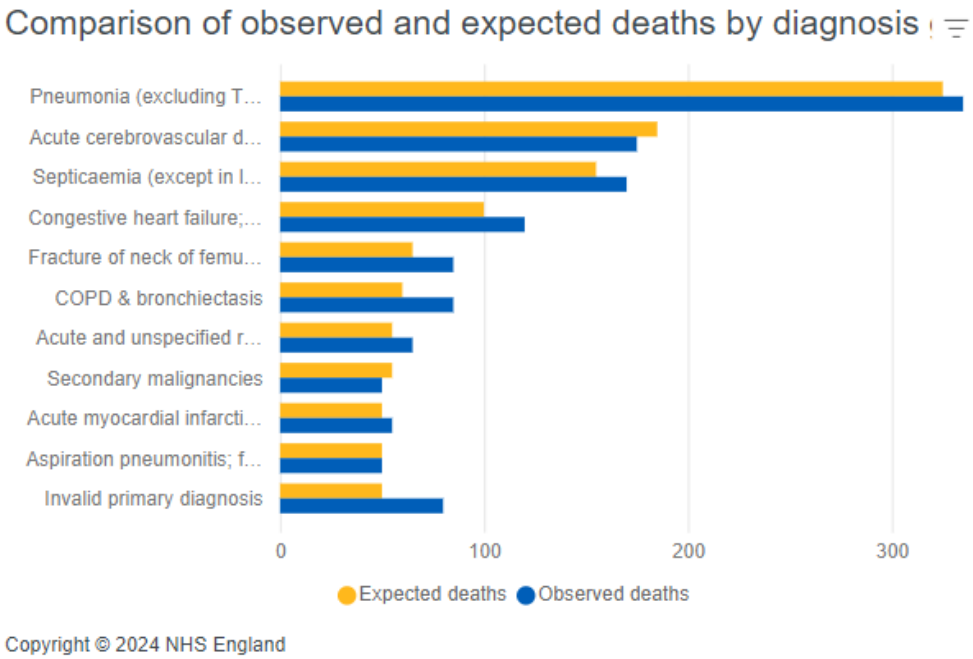
Data reporting increased mortality from ED delays has been published nationally. GHT data analysis has replicated this. Further analysis of data from Jan-Jun24 has shown a significant reduction in this excess mortality due to improving flow within the hospital, as reported to Quality and Performance committee Sept 24. This improvement is likely to lower SHMI in the coming months.



This reduction is more noticeable for Gloucestershire Royal Hospital.

5. Diagnostic groups:

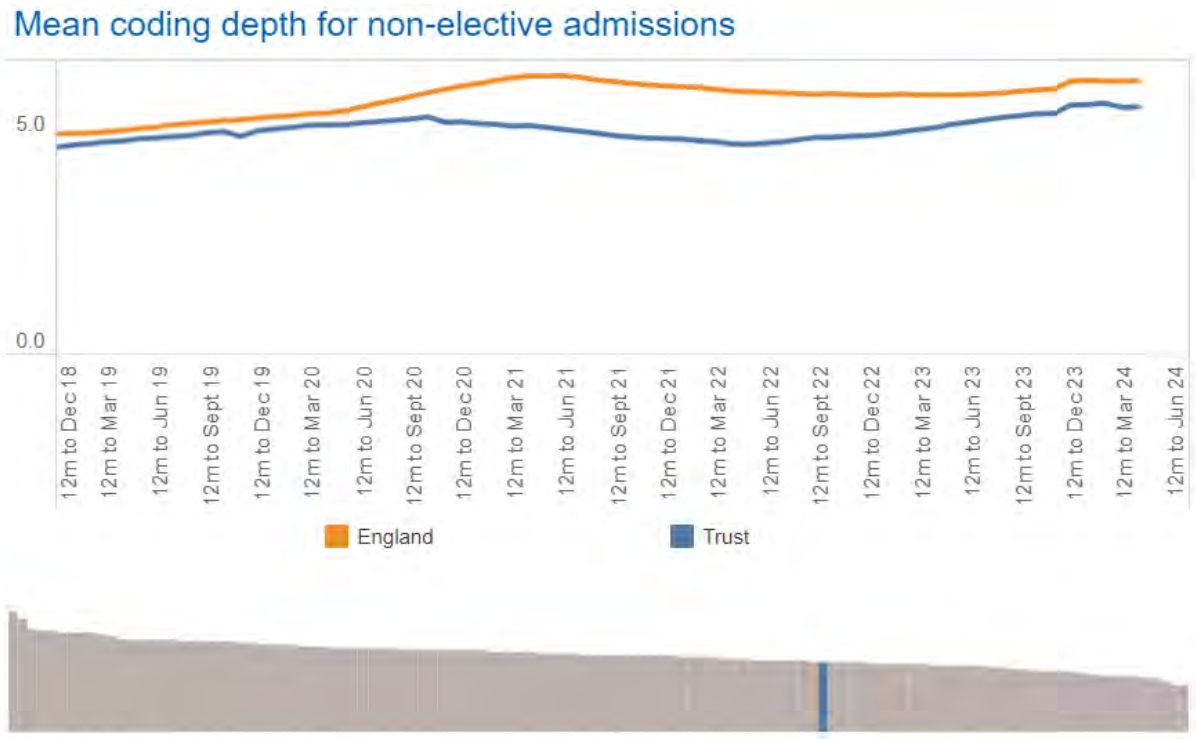
Observed and expected deaths are grouped by primary diagnosis which guides clinical audits to review the care of different cohorts of patients.



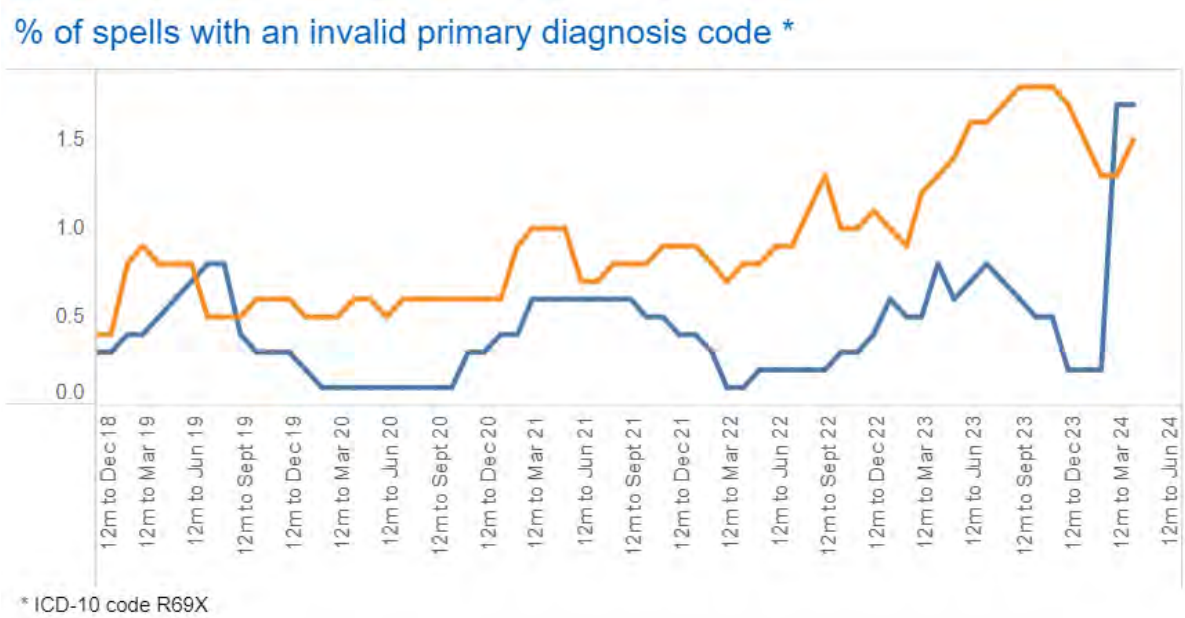
COPD and sepsis clinical audits have shown appropriate care, with high risk, co-morbid patients. Improving care of fracture neck of femur patients with decreased time to theatre is ongoing.

6. Coding:

Appropriate coding of all admissions is essential to estimate the correct risk of a patient dying, and therefore the "expected" deaths. Co-morbidity scoring is via the Charlson scoring system. Depth of coding is currently lower than the national average. A quality improvement project is underway to improve co-morbidity capture, and in particular decrease the number of patients inappropriately coded as "Charlson Zero".



A data upload issue has occurred where an increased number of patients were not allocated a "primary diagnosis" (and therefore correct risk of dying), but were assigned the code R69X. This code is attached to a lower risk of death and therefore lowers the "expected" deaths for GHT. This has increased the SHMI.



The BI unit is working with our data partners to re-submit this data.

Summary:

Hospital crude mortality remains low/falling, but SHMI has risen. The cause of this is multifactorial and both coding and care issues are under investigation, including the following:

- Primary diagnosis coding
- Charlson comorbidity scoring
- Dementia coding
- Fractured Neck of femur pathway improvement
- Clinical audits in septicaemia, COPD, weekend admissions
- Delay related harm data review

This SHMI action plan is being monitored by a Quality Improvement Group, chaired by the ICB CMO, with representation from Regional NHSE. Progress will be reported in each Learning from Deaths report.

4. Structured Judgement Review Process

4.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They continue to ensure all deaths are recorded in real time.

4.2 Deaths identified for review (next page)

Mortality Quarterly Dashboard: Quarter 4 (January – March 2024)

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
563	526	**1**	2	**21**	31	**85**	77	121(21.4%)	125(23.7%)	**1**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2091	**1528*[1]**	**9**	19	**122**	77	**341**	408	407 (19.4%)		**2**	4

***[1] Data was originally reported using Datix but all deaths no longer reported on datix therefore the BI Mortality Dashboard now being used for Total Number of Adult Deaths.**

Assessment Scores

Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
1	1	**4**	15	**14**	56	**30**	141	**28**	98	**1**	2

0

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control	Problem related to operation/ invasive procedure		
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
3	**10**	**0**	**1**	**1**	**3**	**0**	**0**	**0**	**1**

Problems identified in care and care record							
Problem in clinical monitoring		**Problem in resuscitation following a cardiac or respiratory arrest**		**Other Problem**		**Quality of Patient Record Poor or very poor**	
This Quarter	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**
2	**6**	**0**	**0**	**0**	**4**	**0**	**1**

System Indicators

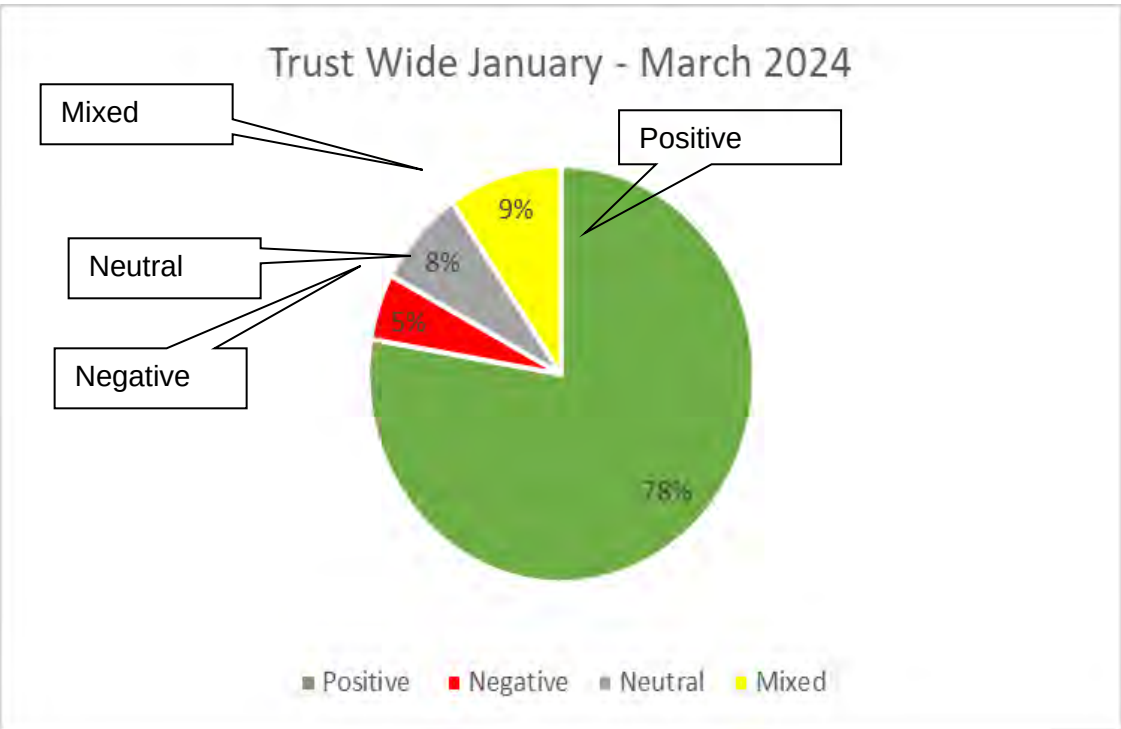
Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
50 (67%)	**46 (45%)**	**2 (100%)**	**1 (100%)**	**52 (49%)**	**55 (54%)**	**54 (50%)**	**37 (34%)**
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
176 (40%)	327(66%)	**9 (69%)**	14 (66%)	**232 (53%)**	194 (36%)	**255 (58%)**	29 (5%)

4.3 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach continues to embed within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

4.4 The Performance against standard tables above illustrates that 67% of deaths (requiring review) were reviewed within 3 months in the reporting period, representing an increase on the 45% in the previous quarter. The annual (2023/2024) percentage of death's reviewed within 3 months is 40% compared to 66% in the previous year (2022/2023).

5. Family Feedback from Bereavement team

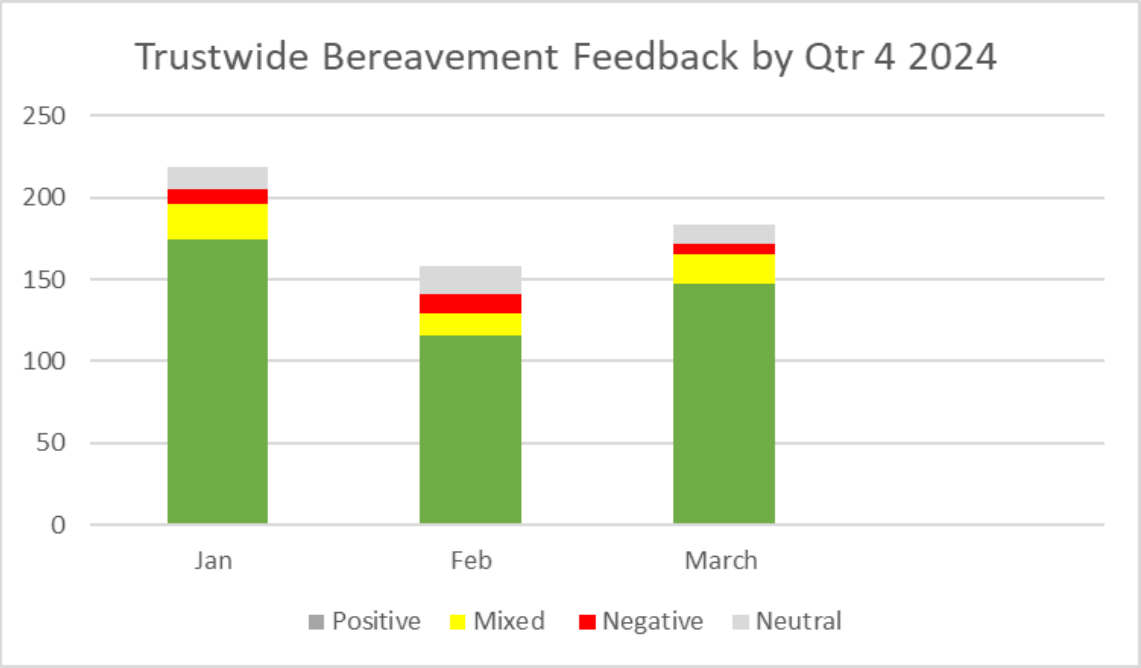
5.1 The following summarises the category of family feedback in the period 1st January 2024 to 31st March 2024 as captured by the bereavement team:



5.2 Themes of Feedback Qtr. 4 Jan – March 24

The Bereavement Feedback has been reviewed and the first draft will be submitted to the Trust Mortality Committee in October 24.

5.3 Numbers of Feedback received by month (all deaths where feedback received)



5.4 Top Bereavement Feedback Trends by Specialty

5.4.1 Medicine Top 5 Specialties Positive and Negative Trends

Acute

Positive Trends	Negative Trends
5 clinicians, palliative care and bereavement named in the positive feedback	None
Good Care provided	
Kind and Helpful staff	
Good Communication	
Bereavement office support	

CoTE

Positive Trends	Negative Trends
Kind and Helpful staff	None
6 clinicians named in positive feedback	

ED

Positive Trends	Negative Trends
6 clinicians named in the positive feedback	None
Good Care provided	
Kind and Helpful staff	

Respiratory

Positive Trends	Negative Trends
2 Clinicians named in positive feedback and a member of the Chaplaincy Service was named twice.	None
Good Care provided	
Kind and Helpful staff	

Renal

Positive Trends	Negative Trends
1 clinician named in positive feedback	None
Good Care provided	
Kind and Helpful staff	

5.4.2 Surgical Top 4 Specialties Positive and Negative Trends

Surgical (Ward 5a, Dixton, Tivoli)

Positive Trends	Negative Trends
16 clinicians, the mortuary and palliative care named in positive feedback	Communication
Good Care provided	
Kind and Helpful staff	

Trauma & Orthopaedics

Positive Trends	Negative Trends
1 HCA named in positive feedback	Communication
Good Care provided	
Kind and Helpful staff	

ENT

Positive Trends	Negative Trends
Good Care provided	None

Vascular

Positive Trends	Negative Trends
1 clinician named in positive feedback	None

5.4.3 D&S Specialty Positive and Negative Trends

Oncology

Positive Trends	Negative Trends
Good Care provided	
Kind and Helpful staff	

5.4.4 W&C Specialty Positive and Negative Trends

Gynaecology
No trends identified

5.5 Family Feedback Conclusion

The feedback has been combined for the Jan – March 2024 period of the Learning from Death's report. It is clear that the positive feedback is consistently high regarding the care provided with the care experience being identified as positive as well as our staff being kind and helpful. There was also a negative trend relating to communication next steps in general.

6. LeDeR Report

On average there are 1 – 2 deaths per month of a person with a Learning Disability. These are all reported to LeDeR. The Learning Disability Team also contribute time to assisting reviewers with interpretation of notes of people who had been in hospital, but died elsewhere.

LeDeR reviews usually do not reach the QA panel until at least 6 months after the person has died, as it takes that long for the reviewers to be able to interview family and carers and to review professionals' notes and then write their report.

Feedback on deaths of people with LD or autism will therefore not reach staff involved for at least 6 months. Even then, feedback can only be shared if family have given permission for this, and whether they give this consent or not is variable.

All 2022/2023 deaths have been reviewed. The vast majority were graded 'met expected good practice'. 6 deaths were rated 'excellent' representing a significant achievement given that this score requires care across, primary care, secondary care, community healthcare (where involved) and social care to have met the required standard. One

death was scored 'inadequate' and related to a patient whose care spanned across a number of health and social care partners.

All Q1 (of 2023/2024) deaths have been reviewed – all at least 'satisfactory', with one graded as excellent'. Two Q2 (of 2023/2024) deaths have been reviewed so far. Both graded 'excellent'. One Q3 (of 2023/2024) death has been reviewed, so far and graded as Good care, meeting expected good practice. 6 deaths for Q4 of 2023/2024 were reported and awaiting review.

7. Conclusions

7.1 All deaths are reviewed within the Trust via the independent Medical Examiner Service.

7.2 There is good local learning from problems in care and ensuring these are being reflected within specialties. The need for the outcome of SJR reviews to be reflected in Trust-wide improvement programmes and (PSIRF safety priorities) is recognised.

7.3 Learning from serious incidents is monitored through SERG, summaries are found in Appendix 1 (for QPC only).

7.4 Timeliness and completion rate of SJR, whilst improving in Q4 of 2023/2024 is of concern. A review (utilising a QI approach) of SJR process, compliance and outcomes is being considered.

7.5 It is clear that the positive feedback is consistently high regarding the care provided with the care experience being identified as positive as well as our staff being kind and helpful. There was also a negative trend relating to communication next steps in general. A review of the Trust's process for feeding back (to families) findings of SJR is being considered. It is recognised that proactive feedback may improve experience and reduce concerns and complaints.

7.6 Hospital crude mortality remains low/falling, but SHMI has risen. The cause of this is multifactorial and both coding and care issues are under investigation, including the following:

- Primary diagnosis coding
- Charlson comorbidity scoring
- Dementia coding
- Fractured Neck of femur pathway improvement
- Clinical audits in septicaemia, COPD, weekend admissions
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This SHMI action plan is being monitored by a Quality Improvement Group, chaired by the ICB CMO, with representation from Regional NHSE. Progress will be reported in each Learning from Deaths report.

8. Recommendations

The Committee is asked to note the Learning from Deaths Quarterly Report and approve in advance of it going to Trust Main Board.

Authors: Jo Mason-Higgins, Acting Associate Director of Safety (Investigation and Family Support)
Charlie Candish, Associate Medical Director (Safety)

Presenter/s: Charlie Candish, Associate Medical Director (Safety)
Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO

Report to Board of Directors

Date	14 November 2024
Title	WRES/WDES Report and Action Plans
Author / Sponsoring Director/ Presenter	Author: Maria Smith, Associate Director of Education, Learning and Culture Sponsor: Dr Claire Radley, Director for People and OD

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

The Workforce Race Equality Standard (WRES) report for the year 2022/2023 and the Workforce Disability Equality Standard (WDES) report 2022/2023, provides a comprehensive overview of our Trusts commitment to Equality, Diversity and Inclusion with regards to Racial and Disability Equality, by following a framework to collect and analyse data on workforce racial and disability inclusion and colleague experiences, identifying actions to address any disparities identified.

The Workforce Race Equality Standard

NHS organisations use nine metrics to compare the experiences of BME and white staff. This report presents data for these nine key WRES metrics, detailing the actions taken in 2023 and those planned for 2024/25. The actions are based on areas identified for further development, informed by the WRES metrics, the action plan, and the staff survey. Metrics 5 to 8 specifically come from the 2023 staff survey results.

Summary

Over the past 12 months, the Trust has made significant efforts to improve various indicators. As a result, we have made improvements in **6 out of the 9** indicators since 2022, demonstrating that our initiatives are yielding positive outcomes and that the Trust is making progress in several areas. While these advancements are encouraging, it is evident that further efforts are required. Importantly, the Trust still falls below the National Average on the majority of indicators.

Non-clinical,

- BME representation increased from 135 to 191 (1.3%), while White representation increased from 1358 to 1628 but decreased by 2%.
- Colleagues with unknown/null ethnicity rose from 115 to 154 (0.8%). I

Clinical,

- BME representation grew from 1074 to 1280 (3.4%),
- White representation fell from 3793 to 3590 (4.6%),
- Unknown/null ethnicity rose from 667 to 749 (12.1%).
- The number of BME senior leaders (8a+) increased from 30 to 41, representing a 0.8% decrease, with the highest representation in Band 8a, rising from 23 to 30, but showing a 0.1% decrease.

The number of BME Total Board members decreased by 4.9% from 3 in 2023 to 2

***Each division has received its respective data. Divisions are tasked with developing their action plans and presenting to EDISG, PODG, and PODC*.**

Workforce Disability Equality Standard

The WDES, an annual requirement, evaluates the Trust's performance across ten indicators (with two indicators having subcategories, totalling 14 metrics). Our performance in 2023/24 can be summarised as follows:

Summary

The Trust has implemented numerous initiatives and projects to improve its indicators, resulting in improvements in **7 out of 10** metrics. Although some changes are minor, they demonstrate that the Trust is making progress in several areas, which is encouraging. However, it is clear that much more work is needed, as the Trust still performs below the National Average on all metrics.

Non-Clinical –

- The number of staff declaring a disability increased from 72 in 2023 to 110 in 2024, reflecting a 1.1% rise.
- Non-disabled staff also increased from 794 to 1041, marking a 3.4% increase.
- Meanwhile, the number of unknown/null staff grew from 742 in 2023 to 822 in 2024, which equates to a 4.4% decrease.

Clinical –

- The number of staff declaring a disability rose from 152 in 2023 to 175 in 2024, a modest 0.3% increase. Non-disabled staff increased from 2703 to 2967, a 3.3% rise.
- The number of unknown/null staff decreased from 2602 in 2023 to 2477 in 2024, a 3.6% decrease.
- Representation of staff declaring a disability in senior pay bands 8C, 8D, 9, and VSM increased by 3.4%.
- The highest representation is in pay bands 1, 2, 3, and 4, with 4.7% (138) of staff in these

bands declaring a disability.

There has been no change in representation of disabled total board members from 2023 to 2024.

Both the WRES and WDES reports serve as vital tools in evaluating our Trusts progress in promoting racial and disability equality, while also guiding future actions and initiatives with clear benchmarking against other organisations.

Risks or Concerns

C4009POD
C4010POD

Financial Implications

Whilst funding has been identified for the overarching cultural programme, specific activity and investment is required for progression of the EDI agenda. Some funds have been ring-fenced for the remainder of 24/25, but further funding will be required in the future.

Approved by: Director for People and OD	**Date: 06/11/23**

Recommendation

Board to note the Trust's WRES and WDES data and plans.

Enclosures

WRES 23/24 Report
WRES 23/24 Action Plan
WDES 23/24 Report
WDES 23/24 Action Plan

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Workforce Race Equality Standard 2023–2024

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Contents

1.0 Executive Summary

The Workforce Race Equality Standard (WRES) was introduced in 2015, with the first report produced in 2016. It was designed to demonstrate progress against nine key indicators, which focus on addressing inequality and unfair treatment at work for Black and Minority Ethnic (BME) staff. This allows the Trust to track progress over the years and identify areas that require improvement and make necessary changes.

Over the last 12 months the Trust has undertaken a vast amount of work to improve on indicators. As such, we have seen improvements since 2022 in 6 of the 9 indicators, which shows the work being completed has been paying off, and the Trust is on a positive trajectory in some areas. Although this is positive, it is clear that much more work is needed. Notably, the Trust continues to perform worse than the National Average on most indicators.

Key findings include:

- 20% of the Trusts staff are BME, which is an increase of 1.9% from 2023.
- The number of BME senior leaders (Band 8a+) has increased from 30 to 41, this equates to a very small percentage decrease (0.8%)
- The likelihood of White staff being appointed from shortlisting compared to BME staff has remained largely the same (1.46 in 2023 compared to 1.57 in 2024).
- The relative likelihood of White or BME staff entering the formal disciplinary process has become more equal, however with White staff remaining more likely than BME staff.
- The relative likelihood of BME staff accessing non-mandatory training and CPD continues to be higher than White staff, and has seen an increase from 0.78 to 0.81.
- There was an increase (of 0.53%) in BME staff experiencing harassment, bullying or abuse from patients, relatives or the public. White staff reported a 2.01% decrease.
- Both BME and White staff reported a decrease in experiencing harassment, bullying or abuse from other staff since the 2022 staff survey.
- 5.94% more BME staff believe the Trust provides equal opportunities for career progression or promotion (going from 41.14% to 47.08%) along with 1.52% more White staff.
- There has been a decrease in BME Board members from 3 to 0, which equates to 16.7%.

2.0 Introduction

Welcome to the 2024 Workforce Race Equality Standard (WRES) Report. This report enables the Trust to publish data on the employment experiences of our Black and Minority Ethnic (BME) staff compared to those of our white staff.

The WRES was introduced in 2015 to demonstrate progress in ensuring that colleagues from BME backgrounds have equal access to opportunities and receive fair treatment in the workplace.

Nine measures (metrics) allow NHS organisations to compare the experiences of BME and white staff. This report includes data for the nine key WRES metrics and outlines the actions taken during 2023 as well as those planned for 2024/25. These actions are based on areas identified for further development, informed by the WRES metrics, action plan, and staff survey. Metrics 5 to 8 are derived from the staff survey results for 2023.

At Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), as of 31st March 2024, our Electronic Staff Records (ESR) data shows the following:

Workforce Data	2023/24 Headcount	2024%	2022/23 Headcount	2023%	% Difference
Total Workforce	8699		8097		
BME staff	1741	20%	1466	18.1%	Increase of 1.9% compared to the 2023 data.
White staff	5916	68%	5730	70.8%	Decrease of 2.8% compared to the 2023 data.
Ethnicity Unknown	1042	12%	901	11.1%	Increase of 0.9% compared to the 2023 data.

Aims

- Compare the workplace and career experiences of the Trust's Ethnic Minority (EM) and white staff, using data drawn from the WRES reporting in 2024.
- Present high-level findings and analysis of the WRES metrics data.
- Highlight trends in NHS staff survey data published for the year 2024.
- Suggest actions to improve the experiences of Ethnic Minority staff for each metric.
- Raise awareness of race equality within the Trust's workforce and outline some of the challenges that EM staff collectively experience at work.

WRES Metrics

WRES Metric	White, BME & Ethnicity unknown or Null
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2	Relative likelihood of staff being appointed from shortlisting across all posts

3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4	Relative likelihood of staff accessing non-mandatory training and CPD
9	Percentage difference between the organisations' Board voting membership and its overall workforce

3.0 Data and Summary of Progress

3.1 Workforce Indicators

Percentages presented are rounded to the nearest whole number.
Highlighted in green are where there have been percentage increases in disability representation, and red where there have been percentage decreases.

Indicator	2022/2023				2023/2024			
1. Percentage of staffs in Bands	Non-Clinical							
	Band	**White 2023**	**BME 2023**	**Ethnicity Unknown/Null 2023**	**Band**	**White 2024**	**BME 2024**	**Ethnicity Unknown/Null 2024**
	Under Band 1	71% (10)	14% (2)	14% (2)	Under Band 1	62% (8)	8% (1)	31% (4)
	Band 1	100% (4)	0% (0)	0% (0)	Band 1	100% (2)	0% (0)	0% (0)
	Band 2	81% (177)	10% (22)	9% (20)	Band 2	84% (373)	9% (39)	8% (34)
	Band 3	86% (469)	8% (43)	6% (32)	Band 3	84% (482)	9% (54)	7% (39)
	Band 4	84% (231)	7% (19)	9% (25)	Band 4	85% (252)	9% (26)	6% (19)
	Band 5	86% (143)	8% (14)	6% (10)	Band 5	78% (141)	13% (23)	9% (16)
	Band 6	79% (135)	13% (22)	9% (15)	Band 6	76% (145)	16% (30)	8% (15)
	Band 7	91% (72)	4% (3)	5% (4)	Band 7	85% (83)	7% (7)	8% (8)
	Band 8a	84% (46)	9% (5)	7% (4)	Band 8a	84% (58)	7% (5)	9% (6)
	Band 8b	92% (35)	5% (2)	3% (1)	Band 8b	87% (40)	9% (4)	4% (2)
	Band 8c	91% (19)	5% (1)	5% (1)	Band 8c	86% (19)	5% (1)	9% (2)
	Band 8d	83% (10)	8% (1)	8% (1)	Band 8d	83% (10)	8% (1)	8(1)
	Band 9	100% (2)	0% (0)	0% (0)	Band 9	75% (3)	0% (0)	25% (1)
	VSM	83% (5)	17% (1)	0% (0)	VSM	63% (12)	0% (0)	37% (7)

Clinical							
Band	**White 2023**	**BME 2023**	**Ethnicity Unknown/ Null 2023**	**Band**	**White 2024**	**BME 2024**	**Ethnicity Unknown/Null 2024**
Under Band 1	48% (23)	10% (5)	42% (20)	Under Band 1	57% (8)	14% (2)	29% (4)
Band 1	0% (0)	0% (0)	0% (0)	Band 1	0% (0)	0% (0)	0% (0)
Band 2	70% (811)	19% (223)	11% (128)	Band 2	63% (616)	25% (243)	13% (126)
Band 3	80% (262)	15% (50)	5% (17)	Band 3	78% (251)	15% (47)	8% (25)
Band 4	58% (217)	6% (22)	37% (138)	Band 4	74% (220)	10% (30)	16% (47)
Band 5	51% (781)	32% (494)	17% (261)	Band 5	43% (780)	33% (607)	24% (431)
Band 6	79% (987)	16% (193)	5% (63)	Band 6	74% (890)	21% (248)	6% (71)
Band 7	85% (509)	10% (62)	5% (30)	Band 7	84% (559)	11% (73)	5% (34)
Band 8a	85% (138)	11% (18)	4% (7)	Band 8a	85% (183)	12% (25)	4% (8)
Band 8b	96% (44)	2% (1)	2% (1)	Band 8b	95% (58)	2% (1)	3% (2)
Band 8c	64% (9)	29% (4)	7% (1)	Band 8c	74% (14)	21% (4)	5% (1)
Band 8d	83% (5)	17% (1)	0% (0)	Band 8d	100% (7)	0% (0)	0% (0)
Band 9	80% (4)	0% (0)	20% (1)	Band 9	100% (4)	0% (0)	0% (0)
VSM	75% (3)	25% (1)	0 (0%)	VSM	0% (0)	0% (0)	0% (0)
Of which Medical and Dental							
Consultants	73% (325)	21% (95)	5% (23)	Consultants	72% (333)	22% (100)	7% (32)
Non-consultant Career Grades	35% (64)	44% (81)	22% (39)	Non-consultant Career Grade	100% (3)	0% (0)	0% (0)
Trainee Grades	45% (278)	46% (280)	9% (57)	Trainee Grades	58% (309)	23% (120)	19% (100)

Non-Clinical

BME representation has increased from 135 to 191, which equates to a 1.3% increase.
White representation has increased in numbers from 1358 to 1628, however this equates to a 2% decrease.
Colleagues declaring Unknown ethnicity/Null has increased from 115 to 154, which equates to a small 0.8% increase.

Clinical

BME representation has increased from 1074 to 1280, which equates to a 3.4% increase.
White representation decreased from 3793 to 3590, which equates to a 4.6% decrease.
Colleagues declaring Unknown ethnicity/Null has increased from 667 to 749, which equates to a 12.1% increase.

The number of BME senior leaders (8a+) has increased from 30 to 41, however this equates to a small decrease 0.8%. The highest representation is in Band 8a, which saw an increase from 23 to 30 BME leaders, however this equates to a 0.1% decrease.

Band	Total BME representation in Band 8a+	
B8a	30	Increase of 7 since 2023, however this equates to a 0.1% decrease
B8b	5	Increase of 2 since 2023, which equates to a 1.1% increase
B8c	5	Remained the same as 2023
8d	1	Decrease of 1 since 2023, which equates to a 5.8% decrease
B9	0	Remained the same as 2023
VSM	0	Decrease of 2 since 2023, which equates to a 20% decrease

3.2 Relative Likelihood Indicators

Indicator	Data Item	White	BME	Ethnicity Unknown/ Null
2. Relative likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants	4742	3487	398
	Number appointed from shortlisting	1237	579	386
	Relative likelihood of appointment from shortlisting	16.60%	26.09%	71.86%
	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	1.57		

A figure above 1 indicates that White staff are more likely to be appointed from shortlisting compared to BME staff.

The relative likelihood of White staff being appointed from shortlisting compared to BME staff has increased by 0.11 from the previous year.

Indicator	Data Item	White	BME	Ethnicity Unknown/ Null
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	Number of staff entering the formal disciplinary process	46	12	10
	Likelihood of staff entering the formal disciplinary process	0.78%	0.69%	0.96%
	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	0.88		

A figure above 1 indicates that BME staff are more likely than White staff to enter the formal disciplinary process.

White staff are more likely than BME staff to enter the formal disciplinary process, however this likelihood has decreased from since 2023 (0.58 in 2023 to 0.88 in 2024, with a figure closer to 1 meaning this is becoming more equal.

Indicator	Data Item	White	BME	Ethnicity Unknown/ Null
4. Relative likelihood of staff accessing non-mandatory training and CPD	Number of staff accessing non-mandatory training and CPD	4244	1536	1036
	Likelihood of staff accessing non-mandatory training and CPD	71.74%	88.23%	99.42%
	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.81		

BME staff are more likely to access non – mandatory training and Continued Professional Development compared to White staff.

The relative likelihood of BME staff accessing non-mandatory training and CPD has marginally increased from 0.78 to 0.81.

3.3 Staff Survey Indicators

Indicator		2022	2023
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28.38%	26.37%
	BME	31.92%	32.45%

In 2023, 0.53% more BME staff have experienced harassment, bullying or abuse from patients, relatives or the public compared to 2022. Results decreased for White staff by 2.01%.

Indicator		2022	2023
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	25.92%	23.78%
	BME	34.03%	30.17%

Both BME staff and White staff experienced less harassment, bullying or abuse from staff compared to 2022 (3.86% and 2.14% respectively).

Indicator		2022	2023
7. Percentage believing that trust provides equal opportunities for career progression or promotion	White	50.93%	52.45%
	BME	41.14%	47.08%

5.94% more BME staff believe that the Trust provides equal opportunities for career progression or promotion, along with a 1.52% increase in White staff, since 2022.

Indicator		2022	2023
	White	7.76%	6.82%
	BME	23.80%	19.01%

8. Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months			

BME staff are much more likely to experience discrimination from managers, team leaders or other colleagues, than White staff. However, the number of BME staff experiencing this has decreased by 4.79% since 2022. There has also been a 0.94% decrease for White staff.

3.4 Board Indicator

Indicator	Data Item	White	BME	Ethnicity Unknown/Null
9. Percentage difference between the organisations' Board voting membership and its overall workforce	Total Board Members:	71% (6)	12% (0)	18% (1)
	Of which: voting Board members	86% (6)	0% (0)	14% (1)

There has been a decrease of 4.9% of BME Total Board members from 2023, going from 3 to 2.

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Workforce Race Equality Standard

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WORKFORCE RACE EQUALITY STANDARD – WRES – ACTION PLAN 2024/2025

The actions outlined in the Workforce Race Equality Standard (WRES) are intricately woven into our Equality, Diversity, and Inclusion (EDI) Development Plan, reflecting the Trust's commitment to fostering a diverse and inclusive workplace. The EDI Development Plan integrates the 8 Trust Actions mandated by the WRES, which include improving board representation, supporting career progression, and enhancing equality data reporting. Each action aligns with our EDI Development Plan and, EDI High Impact Actions. These measures seamlessly integrate with our 3 priorities: Recruitment and EDI principles, Anti –Discrimination and Allyship –Leadership Practices. By embedding the WRES actions into our EDI Development Plan, we aim to drive meaningful change, address inequalities, and create an environment where diversity is celebrated and everyone can thrive.

Indicator	Actions delivered in 23/24 and planned 24/25
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	**Delivered 23/24** • We have concluded an updated analysis identifying areas of racial disparity, along with associated trends and recommendations for achieving Model Employer parity targets by 2028. • As part of the 'Workforce Sustainability Programme', a staff retention group was established. This group focused on three main areas: Exit/Leavers, Retirement Policy, and Transitioning substantive leavers to the bank. The Exit/Leavers Project specifically addressed the Exit Process, Exit Questionnaire/Interview procedures, and the compilation/reporting of exit data **Planned 24/25** • We will be creating a Cultural Awareness training programme with the aim of adopting a model for organisation-wide implementation across the Trust. This training will specifically focus on supporting managers, particularly those who work with internationally educated colleagues. **EDI Trust Action 3 EDI Training** • All members of the Board and Executive team will be required to set SMART objectives related to Equality, Diversity, and Inclusion (EDI), which will be evaluated during their annual performance review. **EDI Trust Action 1 Board Requirements** • In 2023, recruited an EDI Project Officer to provide administrative assistance and pastoral support for the Inclusion International Educated Nurses, Midwives and Allied Health Professionals. **EDI Trust Action 4 EDI Service**
2. Relative likelihood of staff being appointed from shortlisting across all posts.	**Delivered 23/24** • For all interviews at Band 8a and above, it is mandatory to include an Inclusion Champion to ensure fairness and transparency. The Inclusion Champion plays a critical role in overseeing the interview process, ensuring that it is conducted impartially and equitably. • In certain areas, candidates are given interview questions in advance to ensure transparency and fairness in the interview process **Planned 24/25**

Indicator	Actions delivered in 23/24 and planned 24/25
	• As part of our ongoing initiatives, we will continuously review, update, and implement the necessary training and support for managers in writing job descriptions and person specifications to ensure they are free from bias. **EDI Trust Action 5 Recruitment Principles** • Data from WRES and WDES will be collected by division. Each divisional lead will be required to develop action plans specific to their division based on this data. **EDI Trust Action 8 Divisional EDI Actions** • To support staff development opportunities, we will be organising 'Interviewing Impact workshops' aimed at providing support and guidance to our staff. These workshops will focus on refining interview skills and techniques, empowering staff to effectively showcase their capabilities for career progression within the organisation. **EDI Trust Action 3 EDI Training and Action 5 Recruitment EDI Principles**
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	**Delivered 23/24** • We launched a Trust-wide Staff Experience Improvement Programme led by the Director for People. This will incorporate Just and Restorative culture principles as part of the planned implementation. • We will continue to develop and implement the planned Staff Experience Improvement Programme which includes workstreams focused on the following: o Discrimination o Teamwork and leadership development o Speaking and Raising Concerns • The Trust has recruited a Lead Speak Up Guardian to enhance our commitment to fostering a transparent and supportive workplace. Additionally, we have appointed a part-time Associate Guardian to further support this initiative **Planned 24/25** • We will continue with our Trust-wide Staff Experience Improvement Programme. This ongoing initiative will integrate principles of Just and Restorative culture into its planned implementation. **EDI Trust Action 6 Staff Experience Improvement Programme** • As part of our ongoing initiatives, we plan to update our Inclusion network intranet page. This update will include information on protected characteristics and discrimination, alongside signposts directing staff to available support resources. **EDI Trust Action 4 EDI Service**
4. Relative likelihood of staff accessing non-mandatory training and CPD	**Delivered 23/24** We commissioned a leadership development programme aimed at Speciality Directors and aspiring Consultant leaders. We took positive action when advertising and asked the provider to include content preparing colleagues from diverse backgrounds to apply for leadership roles in the future. **Planned 24/25** • We aim to increase the promotion of training and development opportunities tailored specifically for our ethnic minority groups. **EDI Trust Action EDI Training**

Indicator	Actions delivered in 23/24 and planned 24/25
5. Q14a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. 6. Q14 b/c. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	**Delivered 23/24** • We have continued to develop and implement the planned Staff Experience Improvement Programme which includes workstreams focused on the following: o Anti-Discrimination o Teamwork and leadership development o Speaking and Raising Concerns • As part of the Teamwork and Leadership Development workstream specific deliverables include: o Workshops for leaders and teams across the Trust which include reflection and skills development on responding to inappropriate behaviours and building psychological safety o Executive and senior leadership workshops – 1 event half a day o Action Learning Sets for leaders which will have a specific focus on team culture • In October, a listening event was organised for Ethnic Minority colleagues, providing them with an opportunity to engage in discussions with senior members of both the Trust and the Royal College of Nursing. **Planned 24/25** • Continuing As part of the Teamwork and Leadership Development workstream specific deliverables include: **EDI Trust Action 6 Staff Experience Improvement Programme** o Workshops for leaders and teams across the Trust which include reflection and skills development on responding to inappropriate behaviours and building psychological safety o Executive and senior leadership workshops – 1 event half a day o Action Learning Sets for leaders which will have a specific focus on team culture • This year, we will be hosting a listening event for International Educated Nurses, offering them a platform to engage in conversations with senior members of the Trust and the Royal College of Nursing. **EDI Trust Action 2 Internationally Educated Colleagues and Trust Action 4 EDI Service** • For 2024/2025, we will commission the delivery of another cohort of the Inclusion Allies training programme in collaboration with One Gloucestershire system partners. This system-wide initiative was not delivered in 2023/2024.**EDI Action 3 EDI Training.**
7. Q15 Percentage believing that trust provides equal opportunities for career progression or promotion.	• **Delivered 23/4** • We developed the Reciprocal Mentoring Programme, initially involving Trust Executives paired with colleagues from minority protected characteristics. The second iteration expanded to a system-wide initiative, including colleagues from all protected characteristics. Plans are in place for a 3rd Cohort. • We launched a new leadership development pathway to make it clearer as to the available routes for development for leaders, managers and supervisors including those who aspire to get into a management role • **Planned 24/25**

Indicator	Actions delivered in 23/24 and planned 24/25
	• As part of our collaborative efforts within the system, we intend to sustain our Reciprocal Mentoring Programme. This initiative will be extended to include all Staff with a protected characteristic**. EDI Trust Action 3 EDI Training** • We will integrate Equality, Diversity, and Inclusion (EDI) principles into the recruitment process as part of the Trust's broader EDI Development Plan. **EDI Trust Action 5 Recruitment Principles** • We will Conduct a comprehensive review of current recruitment policies and procedures. **EDI Trust Action 5 Recruitment Principles** • We have conducted a review of the Interview Inclusion Champion role to assess whether the current process is effective. The results will be presented to the Recruitment Team and the Equality, Diversity, and Inclusion Steering Group (EDISG), followed by a discussion to determine necessary actions for improvement. **EDI Trust Action 5 Recruitment Principles** • We are developing a Cultural Awareness training programme aimed at organization-wide implementation across the Trust. This training will specifically support managers, particularly those working with internationally educated colleagues. Although the cultural awareness 'train the trainer' sessions were not accomplished in 2023/2024 due to capacity constraints, these issues have been resolved for 2024/2025. **EDI Trust Action 3: EDI Training**. • To support staff development opportunities, we will be organising 'Interviewing with Impact' workshops. These sessions are designed to provide support and guidance, focusing on refining interview skills and techniques. Staff will receive instant feedback during the workshops, empowering them to effectively showcase their capabilities for career progression .**EDI Trust Action 3 EDI Training** • We have completed the Trusts first Ethnicity Pay Gap. We will analyse the data and create improvement plans, to narrow the gap. **EDI Trust Action 4 EDI Service** • The Staff Experience Improvement Programme's Discrimination Workstream has been actively enhancing discrimination reporting through Datix improvements, promotion, and data analysis. It has engaged divisional leaders, promoted the Mutual Respect Policy, and provided a dedicated landing page for staff engagement. The workstream has also supported colleagues reporting discrimination, collaborated with the International Educated Nurses (IEN) Council, and leveraged the Inclusion Network. **EDI Trust Action 6 Staff Experience Improvement Programme** • We are reviewing an updated, appraisal document to ensure it promotes inclusivity and encourages colleagues to outline their plans for advancing the inclusion agenda for both patients and staff. **EDI Trust Action 3 EDI Training and Trust Action 8 Divisional EDI Actions**
8. Q15b In the last 12 months have you personally experienced discrimination at work from any of the following?	**Delivered 23/24** • As part of the Anti-Discrimination workstream, we have outlined specific deliverables. o We are simplifying and actively promoting a mechanism for reporting discrimination within the Trust, ensuring clarity on how instances of discrimination are addressed.

Indicator	Actions delivered in 23/24 and planned 24/25
b) Manager/ team leader or other colleagues	o The ongoing collaboration with staff inclusion networks will result in the co-production of a Discrimination Action Plan. o A review of the Mutual Respect policy is underway to incorporate detailed instructions on responding to incidents of discrimination. • As part of the Teamwork and Leadership Development workstream specific deliverables include: o Workshops for leaders and teams across the Trust which include reflection and skills development on responding to inappropriate behaviours and building psychological safety o Executive and senior leadership workshops o Action Learning Sets for leaders which will have a specific focus on team culture **Planned 24/25** • We have three Co-Chairs of the Ethnic Minority Network who are actively collaborating to instigate change and cultivate a safe environment for staff to voice their concerns. **EDI Trust Action 4 EDI Service** • We have EDI Drop-in Clinics for staff, clinics aim to provide a confidential and safe setting for staff to address any EDI-related experiences, offer support and guidance, and exchange positive experiences and ideas. **EDI Trust Action 4 EDI Service** • We are developing a Cultural Awareness training programme aimed at organization-wide implementation across the Trust. This training will specifically support managers, particularly those working with internationally educated colleagues. Although the cultural awareness 'train the trainer' sessions were not accomplished in 2023/2024 due to capacity constraints, these issues have been resolved for 2024/2025. This initiative aligns with EDI Trust Action 3: EDI Training. **EDI Trust Action 3 EDI Training** • For 2024/2025, we will commission the delivery of another cohort of the Inclusion Allies training programme in collaboration with One Gloucestershire system partners. This system-wide initiative was not delivered in 2023/2024. **EDI Trust Action 4 EDI Service**
9. Percentage difference between the organisations' Board voting membership and its overall workforce	**Delivered 23/24** • We developed the Reciprocal mentoring programme involving Executives who will be buddied with colleagues from minority protected characteristics to include all protected characteristics, not just ethnic minorities **Planned 24/25** • Within our One Gloucestershire Systems framework, we are planning to launch our third system-wide Reciprocal Mentoring Programme specifically for staff with protected characteristics. This initiative aims to foster mutual learning and support between mentors and mentees, enhancing understanding and collaboration across different levels of the organisation. **EDI Trust Action 3 EDI Training**

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Workforce Disability Equality Standard Report 2023–2024

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Contents

1.0 Executive Summary

The Workforce Disability Equality Standard (WDES) came into force in 2019. Its purpose is to enable NHS organisations to compare the workplace experiences of disabled and non-disabled staff against 10 metrics. This allows action plans to be created and monitored year on year with the aim of demonstrating progress against the indicators, and identifying areas of improvement relating to the Trusts culture, and to address inequality and unfair treatment at work.

In the 2023-24-year, Gloucestershire Hospitals NHS Foundation Trust has pushed forwards with many initiatives and projects aimed at improving on indicators. As such, we have seen improvements on 7 of the 10 metrics. Although some of these changes are small, it does show that the Trust is moving in the right direction in a number of areas which is positive. However, it is clear that much more work is needed. Notably, the Trust continues to perform worse than the National Average on all metrics.

Key findings include:

- 3.57% of the Trusts staff have declared a disability, which is an increase of 0.63% from 2023.
- The number of senior leaders declaring a disability (AfC Pay band grouping 8C+) has increased by 3, which equates to a 3.4% increase.
- The likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff has seen a very small decrease, from 1.39 in 2023 to 1.33 in 2024.
- Disabled staff are much more likely (3.64) to enter the formal capability process compared to non-disabled staff. This likelihood has increased since 2023.
- Disabled staff are more likely to experience bullying, harassment or abuse from all groups (patients, relatives or the public, managers and colleagues) than non-disabled staff. However, disabled staff reporting experiencing a decrease since the 2022 staff survey (4% decrease from patients, relatives or the public, 3.9% decrease from managers and 1.41% decrease from colleagues).
- Of those that experienced harassment, bullying or abuse, 5.28% less said that they or a colleague reported it in 2023 than in 2022.
- More disabled staff and non-disabled staff believed that the organisation provides equal opportunities for career progression and promotion (4.78% and 1.57% respectively).
- There was a decrease in disabled staff (3.51% decrease) and non-disabled staff (3.76% decrease) reporting feeling pressured to come to work despite not feeling well enough.

There was still considerably more disabled staff than non-disabled staff who felt pressured to come to work.

- 1.64% more disabled staff felt satisfied with the extent to which the organisation values their work.
- Less disabled staff felt that the Trust had made reasonable adjustments to enable them to carry out their work (1.86% decrease).
- The staff engagement score is higher for non-disabled staff compared to disabled staff (6.54 compared to 6.02). The score has increased for both groups since 2022 however.
- There has been no change in disability representation at Board level since 2023, with it still remaining at 0.

2.0 Introduction

Launched in 2019, the Workforce Disability Equality Standard (WDES) requires that all NHS organisations publish data and action plans against ten indicators of workforce disability equality, the aim being to improve the work experience of disabled staff. Each year, comparisons are made to enable the Trust to demonstrate progress against the indicators of disability equality. It also allows the Trust better understand the experiences of its disabled employees and support positive change for all by creating a more inclusive environment.

The data presented in this report will help the Trust create a more inclusive culture, by using a data driven approach to inform organisational change.

Workforce Data	2023/24 Headcount	2024%	2022/23 Headcount	2023%	% Difference
Total Workforce	8686		8095		
Disabled Staff	310	3.57%	238	2.94%	Increase of 0.63% compared to the 2023 data.
Non-Disabled Staff	4758	54.78%	4148	51.24%	Increase of 3.54% compared to the 2023 data.
Disability Unknown	3618	41.65%	3709	45.82%	Decrease of 4.17% compared to the 2023 data.

Aims

- Compare the workplace and career experiences of the Trust's disabled and non-disabled staff, using data drawn from the WDES reporting in 2024.
- Present high-level findings and analysis of the WDES metrics data.
- Highlight trends in the NHS staff survey data published for the year 2024.
- Suggest actions to improve the experiences of disabled staff for each metric.
- Raise awareness of disability equality within the Trusts workforce and outline some of the challenges that disabled staff collectively experience at work.

WDES Metrics

WDES Metric	Disabled, Non-disabled & Disability Unknown or Null
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts
3	Relative likelihood of non-Disabled staff compared to Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure (Metric based on data from a two-year rolling average)
4-9a	NHS Staff Survey data
9b	Has your organisation taken action to facilitate the voices of your Disabled staff to be heard?
10	Percentage difference between the organisations' Board voting membership and its overall workforce

3.0 Data and Summary of Progress

3.1 Workforce Indicators

Percentages presented are rounded to the nearest whole number.
Highlighted in green are where there have been percentage increases in disability representation, and red where there have been percentage decreases.

Indicator	2022/2023				2023/2024			
1. Percentage of staffs in Bands	Non-Clinical							
	Band	**Disabled 2023**	**Non-disabled 2023**	**Unknown/Null 2023**	**Band**	**Disabled 2024**	**Non-disabled 2024**	**Unknown/ Null 2024**
	Under Band 1	0% (0)	7% (1)	93% (13)	Under Band 1	0% (0)	0% (0)	100% (13)
	Band 1	0% (0)	25% (1)	75% (3)	Band 1	50% (1)	0% (0)	50% (1)
	Band 2	6% (5)	38% (84)	56% (123)	Band 2	6% (28)	47% (209)	47% (209)
	Band 3	4% (24)	52% (285)	43% (235)	Band 3	5% (26)	57% (330)	38% (219)
	Band 4	6% (16)	48% (132)	46% (127)	Band 4	8% (24)	54% (159)	38% (114)
	Band 5	7% (6)	53% (88)	44% (73)	Band 5	5% (9)	56% (100)	39% (71)
	Band 6	2% (3)	58% (99)	41% (70)	Band 6	2% (4)	61% (116)	37% (70)
	Band 7	6.3% (5)	49% (39)	44% (35)	Band 7	7% (7)	52% (51)	41% (40)
	Band 8a	4% (2)	44% (24)	53% (29)	Band 8a	6% (4)	48% (33)	46% (32)
	Band 8b	11% (4)	47% (18)	42% (16)	Band 8b	9% (4)	50% (23)	41% (19)
	Band 8c	0% (0)	52% (11)	48% (10)	Band 8c	5% (1)	41% (9)	55% (12)
	Band 8d	0% (0)	50% (6)	50% (6)	Band 8d	0% (0)	50% (6)	50% (6)
	Band 9	0% (0)	50% (1)	50% (1)	Band 9	0% (0)	0% (0)	100% (4)

	VSM	0% (0)	83% (5)	17% (1)	VSM	11% (2)	26% (5)	63% (12)
	Clinical							
	Band	**Disabled 2023**	**Non-disabled 2023**	**Unknown/ Null 2023**	**Band**	**Disabled 2024**	**Non-disabled 2024**	**Unknown/ Null 2024**
	Under Band 1	2% (1)	9% (4)	89% (41)	Under Band 1	0% (0)	29% (4)	71% (10)
	Band 1	0% (0)	0% (0)	0% (0)	Band 1	0% (0)	0% (0)	0% (0)
	Band 2	3% (33)	49% (574)	48% (555)	Band 2	3% (33)	52% (509)	45% (443)
	Band 3	4% (14)	59% (193)	37% (122)	Band 3	3% (11)	55% (179)	41% (133)
	Band 4	4% (14)	39% (147)	57% (216)	Band 4	5% (15)	52% (153)	43% (129)
	Band 5	2% (35)	48% (731)	50% (770)	Band 5	2% (41)	47% (862)	50% (915)
	Band 6	3% (33)	56% (649)	41% (471)	Band 6	4% (51)	59% (716)	37% (442)
	Band 7	2% (13)	50% (301)	48% (287)	Band 7	2% (16)	57% (382)	40% (268)
	Band 8a	4% (7)	44% (72)	52% (84)	Band 8a	2% (5)	54% (116)	44% (95)
	Band 8b	3% (2)	31% (20)	66% (43)	Band 8b	5% (3)	49% (30)	46% (28)
	Band 8c	0% (0)	36% (5)	64% (9)	Band 8c	0% (0)	47% (9)	53% (10)
	Band 8d	0% (0)	83% (5)	17% (1)	Band 8d	0% (0)	57% (4)	43% (1)
	Band 9	0% (0)	40% (2)	60% (3)	Band 9	0% (0)	75% (3)	25% (1)
	VSM	0% (0)	0% (0)	0% (0)	VSM	0% (0)	0% (0)	0% (0)
	Of which Medical and Dental							
	Consultants	2% (9)	55% (244)	43% (190)	Consultants	3% (15)	61% (283)	36% (167)
	Non-consultant Career Grades	1% (2)	61% (112)	38% (70)	Non-consultant Career Grade	4% (5)	58% (65)	38% (43)
	Trainee Grades	1% (3)	70% (294)	29% (122)	Trainee Grades	1% (5)	76% (402)	23% (122)

Non-Clinical

The number of staff declaring a disability has increased from 72 in 2023, to 110 in 2024. This equates to a 1.1% increase.
The number of non-disabled staff has also increased, from 794 to 1041, which is a 3.4% increase.
The number of unknown/null staff has increased from 742 in 2023, to 822 in 2024, however this equates to a 4.4% decrease.

Clinical

The number of staff declaring a disability has increased from 152 in 2023 to 175 in 2024. This equates to a small 0.3% increase.

The number of non-disabled staff has increased from 2703 to 2967, which is a 3.3% increase.
The number of unknown/null staff has decreased from 2602 in 2023, to 2477 in 2024. This equates to a 3.6% decrease.

The representation of staff declaring a disability in senior pay band grouping 8C, 8D, 9 and VSM has increased by 3.4%. The highest representation is in pay band grouping 1, 2, 3 and 4, with 4.7% (138) of staff in these bands declaring a disability.

Band	Total Disability representation in AfC Pay Band Grouping	
AfC Bands 1, 2, 3 and 4	138	Increase of 24 since 2023, which is a 0.9% increase
AfC Bands 5, 6 and 7	128	Increase of 33 since 2023, which is a 0.5% increase
AfC Bands 8A and 8B	16	Increase of 1 since 2023, which equates to a 0.6% decrease
AfC Bands 8C, 8D, 9 and VSM	3	Increase of 3 since 2023, which is a 3.4% increase

3.2 Relative Likelihood Indicators

Indicator	Data Item	Disabled	Non-disabled	Unknown /Null
2. Relative likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants	644	7512	725
	Number appointed from shortlisting	109	1686	307
	Relative likelihood of appointment from shortlisting	0.17	0.22	0.42
	Relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff	1.33		

A figure above 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to non-disabled applicants.

The relative likelihood of non-disabled applicants being appointed from shortlisting compared to non-disabled has decreased slightly by 0.06 from the previous year. Non-disabled applicants are still more likely to be appointed than disabled applicants.

Indicator	Data Item	Disabled	Non-disabled	Unknown/ Null
3. Relative likelihood of staff entering the formal capability process, as measured by entry into the formal capability procedure (two year rolling average)	Number of staff entering the formal capability process	4.5	19	31.5
	Likelihood of staff entering the formal capability process	0	0	0.5
	Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff	3.64		

A figure above 1 indicates that disabled staff are more likely to enter the formal capability process than non-disabled.

Disabled staff are much more likely to enter the formal capability process than non-disabled staff.

3.3 Staff Survey Indicators

Indicator		2022	2023
4a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Disabled	36.24%	32.24%
	Non-disabled	27.05%	24.51%

In 2023, disabled staff reported experiencing 4% less harassment, bullying or abuse from patients, relatives or the public than in 2022. Non-disabled staff experienced 2.54% less harassment, bullying or abuse from this group in 2023 than in 2022.

Indicator		2022	2023
4b. Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	Disabled	20.82%	16.92%
	Non-disabled	11.84%	8.56%

Both disabled and non-disabled staff experienced less harassment, bullying or abuse from managers in 2023 than in 2022 (3.9% and 3.28% respectively).

Indicator		2022	2023
4c. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Disabled	28.31%	26.90%
	Non-disabled	20.27%	17.82%

Disabled staff experienced less harassment, bullying or abuse from other colleagues in 2023 than in 2022 (1.41%). Non-disabled staff also experienced less harassment, bullying or abuse from other colleagues (2.45%).

Disabled staff reported experiencing more harassment, bullying or abuse from all three groups than non-disabled staff.

Indicator		2022	2023
4d. Percentage of staff saying the last time they experienced harassment, bullying or abuse at work they or a colleague reported it	Disabled	49.21%	43.93%
	Non-disabled	44.23%	49.17%

In 2023, 5.28% less disabled staff compared to 2022 said that the last time they experienced harassment, bullying or abuse at work they or a colleague reported in.

Indicator		2022	2023
5. Percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion	Disabled	43.92%	48.70%
	Non-disabled	50.42%	51.99%

For both disabled and non-disabled staff there was an increase in staff believing that the organisation provides equal opportunities for career progression or promotion (4.78% and 1.57% respectively).

Indicator		2022	2023

6. Percentage of staff who have felt pressure to come to work, despite not feeling well enough	Disabled	36.02%	32.51%
	Non-disabled	24.73%	20.97%

Less disabled staff reported feeling pressured to come to work despite not feeling well enough in 2023 than in 2022 (3.51% decrease). Less non-disabled staff also reported feeling pressured (3.76% decrease).

However, there was still considerably more disabled staff that felt pressured to come to work despite not feeling well enough than non-disabled.

Indicator		2022	2023
7. Percentage of staff satisfied with the extent to which the organisation values their work	Disabled	27.11%	28.75%
	Non-disabled	34.76%	38.82%

1.64% more disabled staff felt satisfied with the extent to which the organisation values their work in 2023 than in 2022. 4.06% more non-disabled staff felt the same thing in 2023 than in 2022.

Indicator		2022	2023
8. Percentage of disabled staff saying their employer has made reasonable adjustments to enable them to carry out their work	Disabled	72.39%	70.53%

There has been a decrease of 1.86% since 2022 of staff reporting that their employer has made reasonable adjustments to enable them to carry out their work.

Indicator	Org overall	Disabled	Non-disabled
9a. The staff engagement score of disabled staff, compared to non-disabled staff and the overall engagement score for the organisation (0-10)	6.43	6.02	6.54

The staff engagement score is 0.52 higher for non-disabled staff than disabled. Both disabled and non-disabled staff reported an increased engagement score in 2023 than in 2022 (0.12 and 0.14 respectively).

Indicator	Disabled
9b. Has the organisation taken action to facilitate the voices of the disabled staff to be heard	Yes

The Trust has a number of ways that aim to facilitate the voices of the disabled staff to be heard. These include the staff disability network, the disability peer support group, disability drop-in sessions, focused conferences, awareness events, staff spotlights on staff members with disabilities and disabled staff stories being shared at Board level.

3.4 Board Indicator

Indicator	Data Item	Disabled	Non-disabled	Unknown/Null
10. Percentage difference between the organisations' Board	Total Board Members:	0% (0)	52.6% (10)	47.4% (9)
	Of which: voting Board members	0% (0)	44.4% (4)	55.6% (5)

voting membership and its overall workforce				

There has been no change in representation of disabled total board members from 2023 to 2024.

There has been a decrease in unknown/null disability status in both total board members (12.6%) and voting board members (4.4%).

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WORKFORCE DISABILITY EQUALITY STANDARD – WDES – ACTION PLAN 2024/25

The actions outlined in the Workforce Disability Standard (WDES) are intricately woven into our Equality, Diversity, and Inclusion (EDI) Development Plan, reflecting the Trust's commitment to fostering a diverse and inclusive workplace. The EDI Development Plan integrates the 8 Trust Actions mandated by the WDES, which include improving board representation, supporting career progression, and enhancing equality data reporting. Each action aligns with our EDI Development Plan and, EDI High Impact Actions. These measures seamlessly integrate with our 3 priorities: Recruitment and EDI principles, Anti –Discrimination and Allyship –Leadership Practices. By embedding the WDES actions into our EDI Development Plan, we aim to drive meaningful change, address inequalities, and create an environment where diversity is celebrated and everyone can thrive.

Indicator	**Action taken and planned**
1. Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.	**Delivered 23/24** • As part of the 'Workforce Sustainability Programme', a staff retention group was established. This group focused on three main areas: Exit/Leavers, Retirement Policy, and Transitioning substantive leavers to the bank. The Exit/Leavers Project specifically addressed the Exit Process, Exit Questionnaire/Interview procedures, and the compilation/reporting of exit data. **Planned 24/25** • As part of our ongoing initiatives, we will continuously review, update, and implement the necessary training and support for managers in writing job descriptions and person specifications to ensure they are free from bias. **EDI Trust Action 5 Recruitment Principles** • We will continue to raise staff awareness about the importance of completing their ESR (Electronic Staff Record) review. Additionally, we will review the recommendations from the ESR demographic status report and regularly remind staff of the benefits of updating their disability status in the system. **EDI Trust Action 4 EDI Service** • All members of the Board and Executive team will be required to set SMART objectives related to Equality, Diversity, and Inclusion (EDI), which will be evaluated during their annual performance review. **EDI Trust Action 1 Board Requirements**
2. Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts.	**Delivered 23/24** • For all interviews at Band 8a and above, it is mandatory to include an Inclusion Champion to ensure fairness and transparency. The Inclusion Champion plays a critical role in overseeing the interview process, ensuring that it is conducted impartially and equitably. • In certain areas, candidates are given interview questions in advance to ensure transparency and fairness in the interview process **Planned 24/25**

Indicator	Action taken and planned
	• We will continuously review, update, and implement the necessary training and support for managers in writing job descriptions and person specifications to ensure they are free from bias. **EDI Trust Action 5 Recruitment Principles** • To support staff development opportunities, we will be organising 'Interviewing Impact workshops' aimed at providing support and guidance to our staff. These workshops will focus on refining interview skills and techniques, empowering staff to effectively showcase their capabilities for career progression within the organisation **EDI Trust Action 5 Recruitment Principles and Trust Action 3 EDI Training** • Data from WRES and WDES will be collected by division. Each divisional lead will be required to develop action plans specific to their division based on this data. **EDI Trust Action 8 Divisional Actions**
3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	**Delivered 23/24** • We launched a Trust-wide Staff Experience Improvement Programme led by the Director for People. This will incorporate Just and Restorative culture principles as part of the planned implementation. • We will continue to develop and implement the planned Staff Experience Improvement Programme which includes workstreams focused on the following: o Discrimination o Teamwork and leadership development o Speaking and Raising Concerns • The Trust has recruited a Lead Speak Up Guardian to enhance our commitment to fostering a transparent and supportive workplace. Additionally, we have appointed a part-time Associate Guardian to further support this initiative **Planned 24/25** • We will continue with our Trust-wide Staff Experience Improvement Programme. This ongoing initiative will integrate principles of Just and Restorative culture into its planned implementation. **EDI Trust Action 6 Staff Experience Improvement Programme** • As part of our ongoing initiatives, we plan to update our Inclusion network intranet page. This update will include information on protected characteristics and discrimination, alongside signposts directing staff to available support resources **EDI Trust Action 4 EDI Service**
4a. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers	**Delivered 23/24** • We continued to develop and implement the planned Staff Experience Improvement Programme which includes workstreams focused on the following: o Anti-Discrimination o Teamwork and leadership development o Speaking Up and Raising Concerns • As part of the Teamwork and Leadership Development workstream specific deliverables included:

Indicator	Action taken and planned
iii. Other colleagues 4b. Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	o Workshops for leaders and teams across the Trust which include reflection and skills development on responding to inappropriate behaviours and building psychological safety o Executive and senior leadership workshops o Action Learning Sets for leaders which will have a specific focus on team culture • We launched of a new 'Disability peer support group' within the Trust, ran by the Disability staff network chairs, to give staff the opportunity to access disability specific peer support on issues that may be affecting them within their work life. **Planned 24/25** • We will be launching new groups including the Neurodivergence Peer Support Group with our Disability Network Chairs to give staff more safe spaces to listen and share issues that may be affecting them in the workplace **EDI Trust Action 4 EDI Service** • For 2024/2025, we will commission the delivery of another cohort of the Inclusion Allies training programme in collaboration with One Gloucestershire system partners. This system-wide initiative was not delivered in 2023/2024.**EDI Action 3 EDI Training.** • We plan to streamline the comparison of data sets from sources such as Freedom to Speak Up and the Health and Wellbeing team on harassment, bullying or abuse in order to enable the creation of actions based on this **EDI Trust Action 4 EDI Service** • Continuing work as part of the Teamwork and Leadership Development workstream specific deliverables include: **EDI Trust Action 6 Staff Experience Improvement Programme** o Workshops for leaders and teams across the Trust which include reflection and skills development on responding to inappropriate behaviours and building psychological safety o Executive and senior leadership workshops o Action Learning Sets for leaders which will have a specific focus on team culture • The Staff Experience Improvement Programme's Discrimination Workstream has been actively enhancing discrimination reporting through Datix improvements, promotion, and data analysis. It has engaged divisional leaders, promoted the Mutual Respect Policy, and provided a dedicated landing page for staff engagement. The workstream has also supported colleagues reporting discrimination and leveraged the Inclusion Network. **EDI Trust Action 6 Staff Experience Improvement Programme** • We have EDI Drop-in Clinics for staff, clinics aim to provide a confidential and safe setting for staff to address any EDI-related experiences, offer support and guidance, and exchange positive experiences and ideas. **EDI Trust Action 4 EDI Service**
5. Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides	**Delivered 23/24** • We developed the Reciprocal Mentoring Programme, initially involving Trust Executives paired with colleagues from minority protected characteristics. The second iteration expanded to a system-wide initiative, including

Indicator	Action taken and planned
equal opportunities for career progression or promotion.	colleagues from all protected characteristics. As part of our collaborative efforts within the system, we plan to participate in our third Reciprocal Mentoring Programme. **EDI Trust Action 3 EDI Training** • We launched a new leadership development pathway to make it clearer as to the available routes for development for leaders, managers and supervisors including those who aspire to get into a management role **Planned 24/25** • To support staff development opportunities, we will be organising 'Interviewing Impact workshops' aimed at providing support and guidance to our staff. These workshops will focus on refining interview skills and techniques, empowering staff to effectively showcase their capabilities for career progression within the organisation **EDI Trust Action 5 Recruitment Principles and Trust Action 3 EDI Training** • We will integrate Equality, Diversity, and Inclusion (EDI) principles into the recruitment process as part of the Trust's broader EDI Development Plan. **EDI Trust Action 5 EDI Recruitment Principles** • We will conduct a comprehensive review of current recruitment policies and procedures. **EDI Trust Action 5 EDI Recruitment Principles** • The Staff Experience Improvement Programme's Discrimination Workstream has been actively enhancing discrimination reporting through Datix improvements, promotion, and data analysis. It has engaged divisional leaders, promoted the Mutual Respect Policy, and provided a dedicated landing page for staff engagement. The workstream has also supported colleagues reporting discrimination and leveraged the Inclusion Network. **EDI Trust Action 6 Staff Experience Improvement Principles** • We are reviewing an updated, appraisal document to ensure it promotes inclusivity and encourages colleagues to outline their plans for advancing the inclusion agenda for both patients and staff. **EDI Trust Action 3 EDI Training**
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	**Delivered 23/24** • We reviewed our Reasonable Adjustment processes and guidance and worked to create a new Reasonable Workplace Adjustment policy in collaboration with the Disability Staff Network. This has now been completed in draft ready for launch. **Planned 24/25** • There is a planned launch for the new Reasonable Adjustment policy. Once the documents have gone through the final stage of ratification, there will be a Trust-wide communications plan to launch them and to promote awareness. Promotion of the resources will also be written into a new training session for Managers on 'Supporting wellbeing in teams'. **EDI Trust Action 4 EDI Service**

Indicator	Action taken and planned
	• Launch of a Disability/Workplace adjustments passport, as a resource for staff in reviewing and maintaining their adjustments when moving to different teams **EDI Trust Action 4 EDI Service**
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	**Delivered 23/24** • We developed the Reciprocal mentoring programme involving Executives who will be buddied with colleagues from minority protected characteristics to include all protected characteristics, not just ethnic minorities • We reviewed our Reasonable Adjustment processes and guidance and worked to create a new Reasonable Workplace Adjustment policy in collaboration with the Disability Staff Network. This has now been completed in draft ready for launch. **Planned 24/25** • There is a planned launch for the new Reasonable Adjustment policy. Once the documents have gone through the final stage of ratification, there will be a Trust-wide communications plan to launch them and to promote awareness. Promotion of the resources will also be written into a new training session for Managers on 'Supporting wellbeing in teams'. **EDI Trust Action 4 EDI Service** • Launch of a Disability/Workplace adjustments passport, as a resource for staff in reviewing and maintaining their adjustments when moving to different teams **EDI Trust Action 4 EDI Service** • To support staff development opportunities, we will be organising 'Interviewing with Impact' workshops. These sessions are designed to provide support and guidance, focusing on refining interview skills and techniques. Staff will receive instant feedback during the workshops, empowering them to effectively showcase their capabilities for career progression. Due to lack of funding, we were unable to deliver interview skills training in 2022/2023 **EDI Trust Action 5 EDI Recruitment Principles and Trust Action 3 EDI Training**
8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	**Delivered 23/24** • We reviewed our Reasonable Adjustment processes and guidance and worked to create a new Reasonable Workplace Adjustment policy in collaboration with the Disability Staff Network. This has now been completed in draft ready for launch. • Disability Staff Network chairs are now used to offer colleagues access to peer support. Through this initiative, experienced colleagues can provide guidance and share their experiences of navigating the workplace with reasonable adjustments. This support will continue into 2024/25. **Planned 24/25** • We are planning to launch the new Reasonable Adjustment policy. Once the documents have passed the final stage of ratification, a Trust-wide communications plan will be implemented to promote and raise awareness. Additionally, the promotion of these resources will be incorporated into a new training session for managers on 'Supporting Wellbeing in Teams'.

Indicator	Action taken and planned
	• Launch of a Disability/Workplace adjustments passport, as a resource for staff in reviewing and maintaining their adjustments when moving to different teams
9a. The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	**Delivered 23/24** • We have hosted specific listening events, workshops and focus groups ensuring work is fed into the wider Anti-Discrimination Workstream. **EDI Trust Action 4 EDI Service and Action 6 Staff Experience Improvement Programme** • The launch of a new 'Disability peer support group' within the Trust, ran by the Disability staff network chairs, to give staff the opportunity to access disability specific peer support on issues that may be affecting them within their work life. **EDI Trust Action 4 EDI Service** • Disabled staff stories at Board level – a member of our disability network took her story to Board to share her experiences of working in the Trust with her disability **EDI Trust Action 4 EDI Service** **Planned 24/25** • We will continue to host specific listening events, workshops and focus groups to ensure work is fed into the wider Anti-Discrimination Workstream. • We will be launching new groups including the Neurodivergence Peer Support Group with our Disability Network Chairs to give staff more safe spaces to listen and share issues that may be affecting them in the workplace • We have planned a number of disability specific conferences to engage with our disabled colleagues and give them the opportunity to network with their peers and support ongoing work in the disability space within our Trust • There is a plan in place for disability history month, which includes the promotion of invisible disabilities, using staff that work for our Trust to share their stories and experiences through posters and other promotional work • Deaf awareness week video being created to promote sign language use within the Trust, and share the experiences of those that are deaf or hard of hearing • More staff spotlights being shared in fortnightly inclusion network communications including stories of our disabled colleagues
9b. Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? Yes or No	**Delivered 23/24** • We have hosted specific listening events, workshops and focus groups ensuring work is fed into the wider Anti-Discrimination Workstream. • The launch of a new 'Disability peer support group' within the Trust, ran by the Disability staff network chairs, to give staff the opportunity to access disability specific peer support on issues that may be affecting them within their work life.

Indicator	Action taken and planned
	• Disabled staff stories at Board level – a member of our disability network took her story to Board to share her experiences of working in the Trust with her disability **Planned 24/25** • We will continue to host specific listening events, workshops and focus groups to ensure work is fed into the wider Anti-Discrimination Workstream. **EDI Trust Action 4 EDI Service and Action 6 Staff Experience Improvement Programme** • We will be launching new groups including the Neurodivergence Peer Support Group with our Disability Network Chairs to give staff more safe spaces to listen and share issues that may be affecting them in the workplace **EDI Trust Action 4 EDI Service** • We have planned a number of disability specific conferences to engage with our disabled colleagues and give them the opportunity to network with their peers and support ongoing work in the disability space within our Trust **EDI Trust Action 4 EDI Service** • Deaf awareness week video being created to promote sign language use within the Trust, and share the experiences of those that are deaf or hard of hearing **EDI Trust Action 4 EDI Service** • More staff spotlights being shared in fortnightly inclusion network communications including stories of our disabled colleagues **EDI Trust Action 4 EDI Service**
10. Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated: i. By voting membership of the board ii. By Executive membership of the board	**Delivered 23/24** • We developed the Reciprocal mentoring programme involving Executives who will be buddied with colleagues from minority protected characteristics to include all protected characteristics, not just ethnic minorities **Planned 24/25** • Within our One Gloucestershire Systems framework, we will be initiating another reciprocal Mentoring Programme. We will be expanding the initiative to encompass all staff possessing a protected characteristic. **EDI Trust Action 3 EDI Training**

Report to Board of Directors

Date:	14/11/2024
Title	Guardian of Safe working report 1 January 2024-30 June 2024
Author / Sponsoring Director/ Presenter	Mark Pietroni

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

For the period 01 January 2024 – 30 June 2024,

- A total of 177 exception reports have been raised.
- No fines have been levied during that period.
- The overall number of exceptions reported have decreased compared to a similar reporting period in 2023.
- Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £1288.37 (86 additional hours worked.)
- Total number of hours given as TOIL as result of exception reporting of additional hours worked: 21.5 hours.
- Where necessary, GoSW have liaised with trainees and educational supervisors to ensure that ERs have been reviewed and actions taken appropriately.

Risks or Concerns

- Staff shortages due to acute sickness remain a concern and appears to be a common theme in exception reports.

- There were a disproportionate number of exception reports from ENT during the period, mostly related to insufficient time on the rota for handovers. Their rota has been reviewed and the issue has been resolved.

Financial Implications

- £1288.37 was paid to junior doctors as overtime payment, relating to exception reports; no fines have been levied.
- The trust incurred a total expenditure of £9,757,942 on locum staffing during the period.

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

Recommendation

That the Board accepts the report for assurance and information.

Enclosures

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

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

For Presentation to Public Board Thursday 14 November 2024

1. Executive Summary

1.1 This report covers the period of 1 January 2024 to 30 June 2024 (Quarter 4 and Quarter 1).

1.2 During this period, there were 177 exception reports (ER) logged which is lower compared to a similar reporting period in 2023. There were 203 exception report between January '23 – June '23.

1.3 Between 1 January 2024 - 30 June 2024 no fines were levied.

2. Introduction

2.1 Under the 2016 Terms and Conditions of Service (TCS) for Junior Doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the Board of compliance with safe working hour's limits. The Terms and Conditions have been updated in 2019, with further requirements being monitored.

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

High level data

Number of doctors / dentists in training (total):	496
No. of trust doctors	225
Total Junior doctors	496
Amount of time available in job plan for guardian:	1PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors: (first/additional trainees to maximum 0.5 SPA)	0.25/0.125 PAs

3. Junior Doctor Vacancies - 1 January 2024 – 30 June 2024

Several vacancies remain across the trust with numerous gaps in ED and general medicine. General medicine is also the specialty from which most exception reports are received, while the largest number of datixes relating to staffing comes from ED.

Department	Additional training and trust grade vacancies
ED	4 X Trust St1/2 level
T&O	2x Trust St3+ level
Surgery	Urology F1 level x1 1x Trust ST3 level ENT 1x Trust St1/2 level Vascular 1x Trust St3+ level
General Medicine	2 x Trust St1/2 level Acute 3x Trust ST1/2 level COTE 1x Clinical Fellow St1/2 level COTE/Fraility
Women's & Children's	Obs & Gynae 4x Trust ST3+ level

4. Medical Agency and Bank for Junior Doctors

4.1 This data is supplied by Finance.

4.2 The total expenditure on agency and bank locums, across all divisions and including cover for junior doctors' industrial action, over the reporting period was: £9,757,942.

4.3 The breakdown of medical agency and bank expenditure by month and division can be seen in the table below:

Locum spend - 1 January 2024 – 30 June 2024
(Based on data available at time of writing)

		Jan	Feb	March	April	May	June
Medicine	Agency	356,642	411,033	110,136	401, 745	396,969	318,972
	Bank	563613	768293	1018445	922,678	846,801	514,511
Surgery	Agency	73,014	131,680	136,464	131,680	12,806	66,256
	Bank	360598	268931	244887	450,585	359,180	483,553
Womens & Childrens	Agency	32,792	2,942	-	32,792	2,942	-
	Bank	57887	62822	71283	-	-	-
D&S	Agency	15,040	22,269	9,798	34,783	29,171	47,622
	Bank	57225	51554	44363	93,624	60,388	80,918

Total spend during January 2024 – June 2024

Division	**Type**	**Amount**	
Medicine	Agency	1,593,752	6,228,093
	Bank	4,634,341	
Surgery	Agency	551,900	2,179,634
	Bank	2,167,734	
Women's & Children's	Agency	71,468	263,460
	Bank	191,992	
D&S	Agency	158,683	546,755
	Bank	388,072	
Total Locum Expenditure			9,757,942

5. Additional Costs

5.1 For 1 January 2024 to 30 June 2024 the total expenditure on additional hours paid to junior doctors as a result of their exception reports relating to additional hours was £1288.37, for 86 additional hours**.**

Total number of hours given in TOIL to junior doctors for 1 January 2024 to 30 June 2024 was 21 hours 35 minutes

6. Exception Reports

6.1 For the period, January 2024 to 30 June 2024, the following exception reports were raised across the following specialties:

Speciality	***Working Hours/Pattern***	***Educational Opportunities***	***Service Support Available***	***Of which, no. of ISCs***
A&E	**5**			
Acute Medicine	**1**			
Anaesthetics	**1**			
Cardiology	**2**			
General Medicine	**49**	**2**	**2**	**5**
General Surgery	**25**	**3**	**11**	**2**
Otolaryngology	**65**			
Paediatrics	**5**		**1**	**2**
Medical Oncology	**1**			
General Practice	**1**			
Surgical Specialities	**1**	**1**		
T&O surgery	**1**			
Sub-totals	**157**	**6**	**14**	
Total 177				

7. Fines Levied

7.1 For the period 1 January 2024 to 30 June 2024, no fines have been levied

8. Issues Arising

8.1 There were 9 ERs listed as having an ‘immediate safety concern’. The nature of these concerns related to workload and below adequate staffing levels as a

result of both anticipated staff shortage (i.e., known rota gaps) and unplanned / unexpected staff absence due to sickness.

8.2 Large number of ERs received from ENT – several of these relate to a lack of handover time between shifts, resulting in trainees having to do the handover in 'own time' at variance from their work schedule.

9. Actions Taken to Resolve Issues

9.1 The GoSW and their admin have followed up where necessary on any exception reports which have stalled at local level. This has sometimes involved meeting with the junior doctor who raised the exception report and / or their supervising consultant or more commonly, sending a reminder to the supervising consultant to close the ER.

9.2 Exception reports relating to educational matters have been referred to the Director of Medical Education, Dr Preetham Boddana, for oversight or follow up when necessary.

9.3 Exception reports raising an immediate safety concern were followed up by the Guardian of Safe Working by contacting the reporting doctor and/or their supervisor (if the trainees are not reachable) to ensure that the rotas remained compliant and to remind that vacancies should be put out to locum well in advance. Concerns are escalated to the rota coordinator/clinical/service director as appropriate.

9.4 GoSW also discussed ENT rota with their service director and had a meeting with their rota coordinator. They have assured that their rotas have now changed to take handover times into account. This will be monitored over the coming months.

10. Correlations to Clinical Incident Reporting

9.1 During the reporting period, there have been 66 datix's relating to staffing, though the vast majority of these related to nursing shortages and/or shortage consultants, neither of which have a direct effect on junior doctors' rota, though it may affect the level of service support.

9.2 Among these, 9 datixes from ED and 5 reports from a mixture of other specialties were in relation to junior medical/combined medical and nursing staff shortages. Most of these have been graded as moderate to high risk, though no actual harm to patients have been identified on Datix

9.3 The commonest reported consequence of these staff shortages is a delay in assessing and making appropriate plans for patients presenting to ED followed by a lack of junior doctors for undertaking ward rounds as well as supporting consultants in consultant ward rounds, reviewing patients out of hours, with a consequent delay in undertaking jobs required to progress patient care, including requesting tests, prescribing discharge medications, writing discharge summaries and liaising with other specialties and patients' relatives. This has a detrimental effect on patient flow through the hospital and a significantly negative effect on patient experience.

11. Post Graduate Doctors Forum

11.1 The Post Graduate Doctor's forum (now, Resident Doctors Forum) meets every other month and is a useful forum for juniors to raise any issue of concern and keep informed of current business issues within the Trust.

11.2 Meetings of the forum are attended by the GoSW and DME.

11.3 One of the key functions of the forum is to distribute the monies collected through Guardian fines on suitable projects that will benefit junior doctors. Although, there haven't been any new fines levied in the last year, previously accumulated monies have now been partially allocated for mess refurbishment, an online coaching programme for junior doctors as well as coffee pods for the junior doctors' mess.

12. Summary

12.1 A total of 177 exception reports have been raised between 1 January 2024 to 30 June 2024.

12.2 No fines have been levied during that period.

12.3 The overall number of exceptions reported have decreased compared to a similar reporting period in 2023.

12.4 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £1288.37 (86 additional hours worked.)

12.5 Total number of hours given as TOIL as result of exception reporting of additional hours worked: 21.5 hours.

12.6 Where necessary, GoSW have liaised with trainees and educational supervisors to ensure that ERs have been reviewed and actions taken appropriately.

Author: **Paula Baudry, Governance & Business Lead, Medical Directorate**
Dr Shyam Bhakthavalsala, Guardian of Safe Working Hours for Doctors and Dentists in Training

Presenting Director: **Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO**

Date: **28 October 2024**

Recommendation

X For assurance

□ To approve

Appendices:

Link to rota rules factsheet:
Rota rules at a glance | NHS Employers

Link to exception reporting flow chart (safe working hours):
Safe-working-flow-chart-orange (nhsemployers.org)

KEY ISSUES AND ASSURANCE REPORT
DRAFT FINANCE AND RESOURCES COMMITTEE – OCTOBER 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
SRO9 Failure to deliver Recurrent Financial Sustainability and Performance Report Month 6 AND Medium Term Financial Plan	A two part agenda item reflecting financial performance in the current year and longer term planning/prospects. Re 2024/25, at month 6 the Trust is reporting a deficit of £8.9m which is £1.6m favourable to plan. The forecast outturn remains at breakeven but this remains under significant pressure. Areas requiring further work include income from Out of Area contracts and (as detailed below) the search for recurrent solutions to the Gloucestershire position. Re the longer term, the approach to planning continues to develop and will feed into the Trust's 2025/26 budget setting process. The underlying position of the Trust is now forecast to be £77m (please check) and analysis continues in order to better understand the potential for improvement. Current initiatives include over-performance against the ICB contract, waste reduction and improvements in productivity,	The Committee noted the current and projected position of the Trust and the efforts underway to engage with the wider NHS community in terms of reducing duplication, sharing back office services etc. Outcome of the "Drivers of the Deficit" to be presented to a future meeting.
Financial Sustainability Report Month 6	The overall target remains at £37.5m including the system stretch targets. At month 6 the forecast position is to achieve the required target through Divisions absorbing additional workforce pressures. Delivery of targets through in-year savings rather than by recurrent changes to the baseline (such as reductions in staff numbers, range and nature of services provided and locations) is not a sustainable model. The Trust and wider system need to address the opportunities for transformational change across institutional boundaries. Significant risks remain around delivery of the "Working as One" programme.	The Committee noted the position and received the report as a source of assurance that the financial position was understood. Early sight of plans for 2025/26 to take place including plans to remove excess capacity and waste.
Estates Risk Register	Risks with a score of 12 and actions completed/planned were reviewed. Two risks (both relating to fire safety) have closed recently. A number	The Committee noted the position and received the report as a source of

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.

	of other changes have yet to be considered by the appropriate risk group and will return to a future meeting. Two areas are worthy of note- - Progress in a number of areas is constrained by the lack of decant ward facilities, in particular at the Tower block. - A new security service will commence shortly which is intended to reduce the risks around violence and aggression.	assurance that the risks position was understood. The Committee asked for the issue of decant facilities to be emphasised as a "must do" when prioritising capital funding and in discussion with system partners/
Capital Programme Report Month 6 and Estates Capital Briefing	A two part agenda item bringing the operational and financial aspects of the programme together. At month 6 spend was £8.3m behind plan – expenditure of £12.2m against a plan of £20.5m. Achievement of a break even position is still the aim and the recent deep dive review of schemes has been completed. Mitigating actions – to ensure delivery of a break even position – have been proposed and a full report would be received at the next meeting. A number of IFRS 16 contracts are forecast to underspend due to shorter contract periods than originally assumed – further evidence of the complexities surrounding this new accounting standard. The analysis of progress by larger schemes highlighted a number of risks around delivery to time and costs. Two areas are of particular concern. Firstly, the IGIS programme where a number of building problems have impacted on the build programme and secondly impact of the Building Safety Act 2022 which is delaying a number of schemes (including fire infrastructure) in the Tower block.	Outcome of deep dive review to next meeting. The committee received the report as evidence of assurance of the position. Building Control issues and impact on the programme to be escalated in discussion with Gloucester City Council.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
GMS Key Issues and Assurance report	Continued increase in Violence and Aggression rates – a dedicated security team is to be mobilised in coming weeks.	The Committee received the KIAR as evidence of assurance within GMS.

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

Workforce Sustainability and Oversight update	Whole time equivalent numbers remain above the baseline target despite significant progress in reducing costs across all contract types. New control mechanisms appear to be bedding into routine decision making.	The Committee noted the progress and received the report as evidence of the improved control environment.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
Contract Management Group Exception Report	Continued improvement in reporting and relationships. An Asbestos Group has been established to consider the recommendations of the recent annual audit.	Noted
National Cleaning Standards 2021	Successful implementation of standards.	Noted this significant achievement.
GMS Strategy Planning	Approach to be taken in refreshing current strategy to reflect the outcome of the Strategic Review and align with the upcoming Trust strategy.	Welcomed the approach and linkages with Trust.

Items not Rated

Disposals and Leases Report	A stocktake of current commitments and likely future requirements		
BDO Audit report for GMS	Updated position re implementation of recommendations		
Standing Financial Instructions and Scheme of Delegation	Updated version following review.		Approved

Investments

Case	Comments	Approval	Actions
Medical E-Rostering Procurement Business Case	Please complete	??	?? Full Business Case to a future meeting.

Impact on Board Assurance Framework (BAF)

SR 9 : Failure to deliver recurrent financial sustainability – This remains the biggest concern for the Committee. An independent assessment of the drivers of the deficit has been commissioned and will feed into the preparation of 2025/26 budgets and longer term financial plans.

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

SR 10 – Condition of Estate – Another area of huge concern. Following appointment of a new Director (and 2024 Budget Statement), a review to be undertaken and redraft to next meeting.
SR 11 – Failure to meet statutory and regulatory standards and targets en route to becoming a net zero carbon footprint NHS organisation by 2024 -

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

Report to Confidential Board of Directors

Agenda item:		Enclosure Number:	
Date	**14th November 2024**		
Title	Emergency Preparedness Resilliance and Response (EPRR) assurance report 2024-25		
Author /Sponsoring Director/Presenter	Neil Hardy-Lofaro – Deputy Chief Operating Officer (DCOO) Richard Head – Head of Emergency Preparedness, Resilliance and Response (EPRR) Al Sheward, Chief Operating Officer (COO)		

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

Summary of Report

Purpose

To provide assurance to the Board with regard to the Trust's performance in achieving the set Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

The Deep Dive focusing on Cyber sits separate to the assurance process so does not affect our formal status.

Key issues to note

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

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

3. The Trust self-assesses that it is **Non-Compliant** in **two** Core Standards and self-assesses that it is **Partially Compliant** in **eight** Core Standards. These are laid out in Table 1 below with a brief overview of the corresponding Action Plan for each Core Standard. The Trust assesses all other Core Standards as Fully Compliant. Those that have seen a change from Partially Compliant to Fully Compliant are also listed below. Further detail can be found in the attached Core Standards Toolkit.

4. The Trust therefore has 52 out of 62 Core Standards rated as Fully Compliant and therefore rates itself as **Partially Compliant** overall. The aim is to return to at least Substantially Compliant by Jun 25. This is supported by a review undertaken by the Integrated Care Board (ICB) with a rating of **Partially Assured**.

5. This reporting period continued on from another tough year. Industrial action impacted significantly until Mar 24 on the ability of the Trust to conduct EPRR training and exercises. Despite this it has been encouraging to see how much activity has still been able to take place in certain areas.

6. The quid pro quo to such a responsive year is that the Trust has regularly been solving significant

and new challenges at speed. The frequent activation of the Industrial Action WG in the planning phase, and the subsequent activation of a large Incident Management Team during the execution phase has resulted in an even larger layer of senior and mid-level staff who are experienced planners, able to anticipate and mitigate risk. The early establishment of the Incident Management Team in anticipation of an incident has been a welcome new approach. This has allowed the Trust to prepare itself and often mitigate an emerging issue and prevent it becoming more serious.

7. The Trust continues to remains in a sound position in terms of being able to react to EPRR challenges. The downgrading of Core Standards for Lockdown and Evacuation and Shelter should be viewed in the light of ensuring that we do not settle for a 'sufficient' response when we should demand of ourselves an 'excellent' response.

8. The implementation of an iRESPOND system and the associated improvements across the Business Continuity landscape will see a significant improvement and better assurance in this area. The drive and support from the COO to deliver this is welcomed.

9. **Implications and Future Action Required:** The main focus in the next 6 months will be on Business Continuity and associated processes and structures. While this will require resources to conduct the work the result will be a more robust Business Continuity Management System.

Risks or Concerns

Risks are highlighted in the table showing Core Standards Non-Compliance or Partial Compliance.

Recommendation

The Board accept this report as assurance against the Trusts statutory requirement.

Enclosures

20241105 GHNSFT Board Report
20241105 Appendix 1 GHNHSFT NHS Core Standards Toolkit 2024-25 -TEMPLATE FINAL
2024105 Appendix 2 Action Plan CS 16 Shelter and Evacuation
20241105 Appendix 3 Action Plan CS 17 Lockdown
20241008 Attachment 1 Letter to Neil Hard-Lofaro: Response from ICB following Confirm and Challenge

Please select type of organisation: **Acute Providers**

Click button to format the workbook

Core Standards	Total standards applicable	Fully compliant	Partially compliant
Governance	6	6	0
Duty to risk assess	2	2	0
Duty to maintain plans	11	7	2
Command and control	2	2	0
Training and exercising	4	4	0
Response	7	6	1
Warning and informing	4	4	0
Cooperation	4	4	0
Business Continuity	10	5	5
Hazmat/CBRN	12	12	0
CBRN Support to acute Trusts	0	0	0
Total	62	52	8

Deep Dive	Total standards applicable	Fully compliant	Partially compliant
Cyber Security	11	6	5
Total	11	6	5

Non compliant
0
0
2
0
0
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0
0
0
0
0
2

Non compliant
0
0

Overall assessment:

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Publishing Approval Reference: 000719

Partially compliant

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essment RAG in the 'Deep dive' tab
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click on the 'Format Action Plan' button.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
Domain 1 - Governance				
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans				
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control				
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising				
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response				
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing				
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation				
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
Domain 9 - Business Continuity				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme • process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
Domain 10 - CBRN				
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning

Ref	Domain	Standard
Deep Dive - Cyber Security and IT related incident response (NOT I		
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness
DD2	Deep Dive Cyber Security	Cyber Security & IT related incident response arrangements

DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents
DD4	Deep Dive Cyber Security	Media Strategy
DD5	Deep Dive Cyber Security	Testing and exercising
DD6	Deep Dive Cyber Security	Continuous Improvement
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)
DD8	Deep Dive Cyber Security	EPRR Training

DD9	Deep Dive Cyber Security	Business Impact Assessments
DD10	Deep Dive Cyber Security	Business Continuity Management System
DD11	Deep Dive Cyber Security	Business Continuity Arrangments

Deep Dive question

INCLUDED WITHIN THE ORGANISATION'S OVERALL

Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.

The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.

The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.

The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents

The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.

The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises

Cyber security and IT related incident response roles are included in an organisation's TNA.

The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies

The Cyber Security and IT teams are aware of the organisations's critical functions and the dependencies on IT core systems and infrastrucure for the safe and effective delivery of these services
Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)
IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments

Supporting evidence- including examples of evidence
L EPRR ASSURANCE RATING)
-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy

Arrangements should:
-consider the operational impact of such incidents
-be current and include a routine review schedule
-be tested regularly
-be approved and signed off by the appropriate governance mechanisms
-include clearly identified response roles and responsibilities
-be shared appropriately with those required to use them
-outline any equipment requirements
-outline any staff training needs
-include use of unambiguous language
-demonstrate a common understanding of terminology used during incidents in line with the EPRR framework and cybersecurity requirements.'

Arrangements should consider the generic principles for enhancing communications resilience:
1. look beyond the technical solutions at processes and organisational arrangements
2. identify and review the critical communication activities that underpin your response arrangements
3. ensure diversity of technical solutions
4. adopt layered fall-back arrangements
5. plan for appropriate interoperability

https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf
- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts.
- Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents.
- Documented process for communications to regional and national teams
- Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.

- Evidence of exercises held in last 12 months including post exercise reports
- EPRR exercise and testing programme

- Cyber security and IT colleagues participation in debriefs following live incidents and exercises
- lessons identified and implementation plans to address those lessons
-agreed processes in place to adopt implementation of lessons identified
- Evidence of updated incident plans post-incident/exercise
- TNA includes Cyber security and IT related incident response roles
- Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.

-Cyber security and IT related incidents and emergencies included in EPRR awareness training package

-robust Business Impact Analysis including core systems
-list of the organisations critical services and functions
-list of the organisations core IT/Digital systems and prioritisation of system recovery
-Reflected in the organisation's Business Continuity Policy
-key products and services within the scope of BCMS
-Appropriate risk assessments

- Business Continuity Plans for critical services provided by the organisation include core systems
-Disaster recovery plans for core systems
-Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours

Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in EPRR arrangements. Amber (partially compliant) = Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.
• EPRR policy	Fully compliant
• EPRR TORs (Updated August 2024)	Fully compliant

• EPRR Work Programme	Fully compliant
• MI digital SOP (GHFT - Digital Major Incident Management SOP_v4.4)	Fully compliant
•Risk Assessment (Datix overacrching cyber Risk #122 "The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack" 3x5 15 and specific risk #380 "The risk of prolonged or permanent loss of access to key business and clinical information as a result of insufficient disaster recovery capability and business continuity planning" 2x4 8	Fully compliant
• Incident Management Team practices and procedures ensure there is shared understanding across Trust. Staff training is being expanded to include all DIGITAL GOLDs. Clarification over ambigous language has been paramoint.	Fully compliant
IT DIGITAL GOLD to be part of EPRR training from Sep 24	Partially compliant
• Corporate Comms plan	Partially compliant

• Post Exercise reports	Partially compliant
• Debriefs EPRR (JO)	Partially compliant
• Evidence of changes made (TT)	Partially compliant

Action to be taken	Lead	Timescale
• Review of EPRR policy • Work plan 04/09/24 to follow after leave	**DH / JO**	N/A
	TT/ FF	N/A

TT/FF

N/A

JO

N/A

TT

N/A

JO/TT

N/A

TT

By Oct 24

DH

By Oct 24

TT

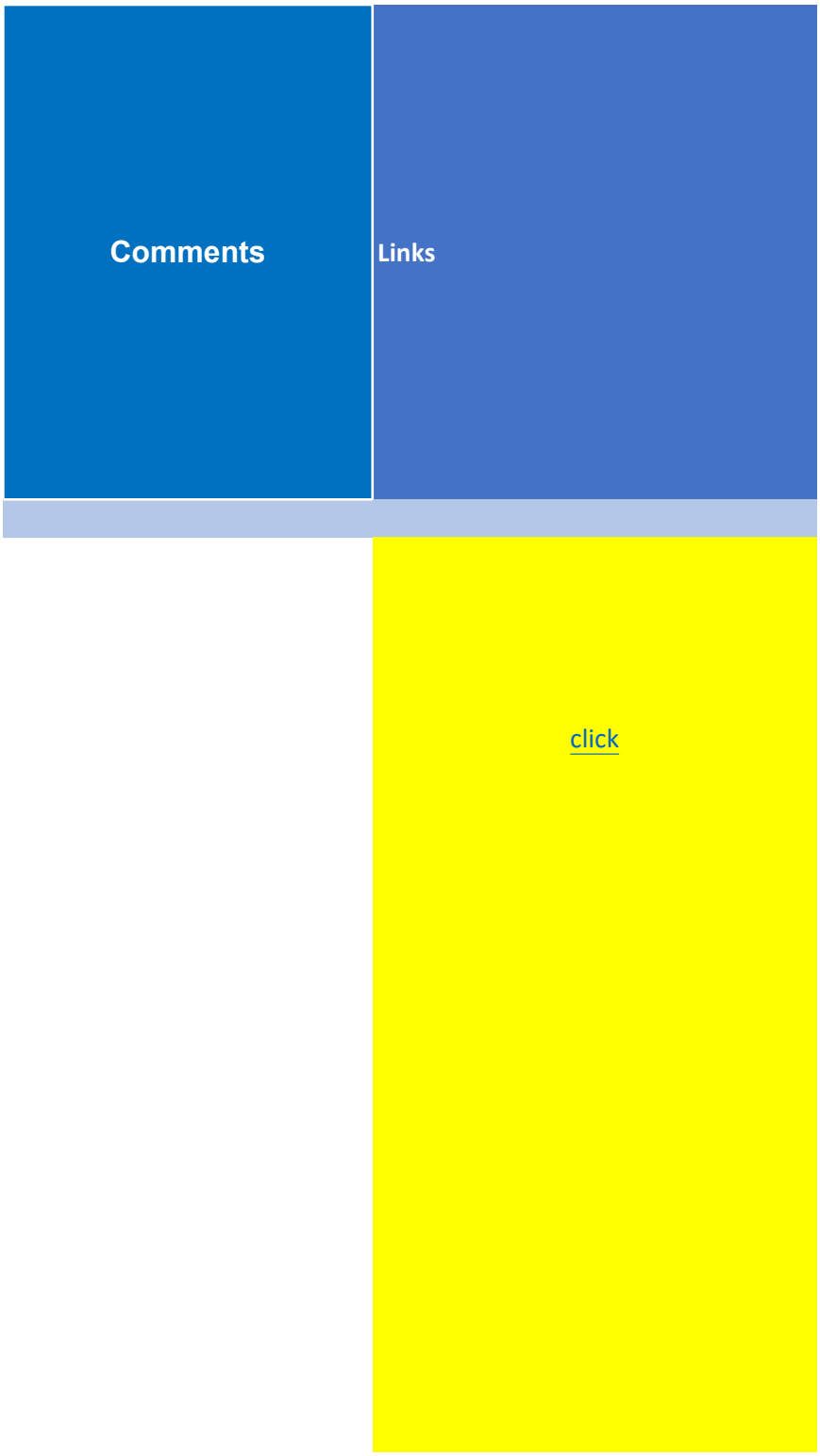
Ongoing. Process now embedded

JO

By end of Jan 25

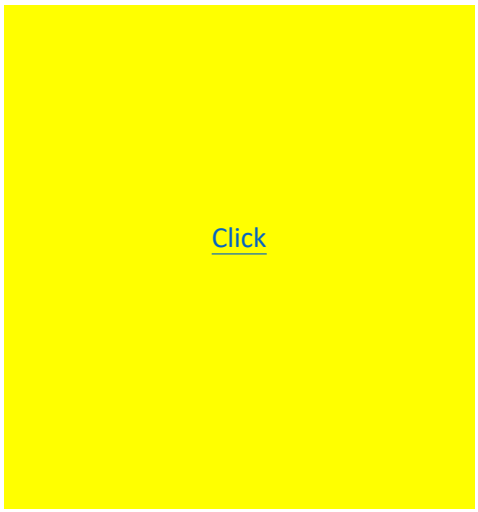
TT

Early 20225


Comments
Links
click

• Evidence of previous incidents ability to reach out to partners	Click
• Digital Gold On Call eastablised • Included in the weekend plan	click
• DH send a line to TT to include in her TNA Current Gold and Silver cohort trained/ briefed n Cyber security outage on a XXXX basis •Gold and Silver traiing not Trust wide •Digital Gold to be included in the training	

- Add CAF requirements



- Link to TORs
- Work programme to follow

Comms strategy

Debrief Master

Copy Purple Folder Index

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence

Core Standards	Total standards applicable	Fully compliant	Partially compliar
Governance	6	6	0
Duty to risk assess	2	2	0
Duty to maintain plans	11	7	4
Command and control	2	2	0
Training and exercising	4	4	0
Response	7	7	0
Warning and informing	4	4	0
Cooperation	4	4	0
Business Continuity	10	6	3
Hazmat/CBRN	12	12	0
CBRN Support to acute Trusts	0	0	0
Total	62	54	7

Deep Dive	Total standards applicable	Fully compliant	Partially compliar
Cyber Security	11	0	0
Total	11	0	0

nt	Non compliant
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0

nt	Non compliant
	0
	0

Evidence
EPRR Policy
Policy Library
On Call Handbook Training SS
Training SS and Trust report

Progress and plan regarding CS16 Evacuation and Shelter

1.0 Introduction

This report details the Fire Safety Work Plan 2024-2025 which is the cornerstone of work that will ensure the transition of the Trust for CS16 Evacuation and Shelter from non-compliant to compliancy.

2.0 Background

The Fire Authorising Engineer provided the annual audit of Fire Safety to the Trust in January 2024. Subsequently, the Fire Safety Committee has approved a Fire Safety Work Plan to improve fire safety compliance across the Trust covering a wide range of topics. Given the requirement to improve at pace, the Fire Safety Work Plan is being provided to Health and Safety Committee and Trust Leadership Team on a regular basis to demonstrate assurance on progress.

3.0 Work Plan Update

The Fire Safety Committee (FSC) continues to manage and monitor the Fire Safety Work Plan. Of the 26 priority one actions, none are red, 5 have amber status, whilst 13 are now at green status and 8 have been completed.

- Whilst the Fire Safety Manager has now completed training, GMS have re-reviewed the original plan given the level of risk and opted to bring in a specialist company to undertake a comprehensive fire door survey to provide a baseline audit. This will be completed in Gloucester and Cheltenham by end of Nov. 24.

- GMS are still awaiting a formal response from Building Control at Gloucestershire County Council regarding the Tower Block footprint. Surveys have started by the contractor installing the new fire alarm system and this can also provide the technical drawings highlighted as a risk on the workplan.

- The Work plan is owned by the Fire Safety Committee. However, to give impetus and senior oversight a short-term Quality Improvement Group headed up by CMO and supported by Hd of EPRR, briefing up to the CEO, has been established, with an estimated life of 4 months. The group are setting short term achievable and measurable goals. The first and primary is the assurance of all locations in the Trust being fully compliant regarding either Fire Evacuation Drills or Fire Drills.

4.0 Evacuation Training

- EPRR undertook an exercise in September to practise vertical evacuation with a ward area. Useful for the staff involved as collectively they realised how long it would take to do an evacuation, but the exercise only emphasised the need for individual wards to practice this themselves.
- The EPRR team also instructed all wards in the Tower Block to carry out drills in September during the night and day – 100% have been completed for day, some still require to be completed by night.
- The Workforce team have agreed to include fire training information on ESR. GMS will provide the information on who has been trained so that Divisions can access reports. This will be delivered in the next month, but data will only go back to June 2024.

5.0 Grenfell Tower Block Fire Report

The report into the Grenfell Tower Inquiry was issued on 4th September 2024: the similarities between the situation regarding the Grenfell Tower, (high number of vulnerable occupants,

tower block, cladding works) and the Tower Block at Gloucestershire Royal have prompted a review of the report by the Associate Director to establish if there are any lessons to be learnt or actions to be taken.

Key learning points: -

- Governance arrangements were not clearly set out between the organisations involved, including accountability for different stages of the building works regarding fire safety.
- There was no fire strategy for the tower block building
- Assurance works across the organisations were started, but not completed
- The client was unaware of their responsibilities under law
- The Emergency Plan was out of date and the TMO (Building Management Team) had not considered evacuation of vulnerable people
- Cost saving was given priority over safety
- Communications were challenging with little co-ordination, high volumes of calls and equipment failures due to construction materials affecting the ability of the Fire Service to co-ordinate their efforts
- Subsequent construction changes post the erection of the building meant that compartmentation was affected: a stay-put strategy into the next compartment only works if the compartmentation is functional
- Ageing pipework, degraded valves and construction over gas pipe outlets created further problems during the fire
- There was no mechanism to accurately record who had been in the building at the time of the fire

The Associate Director is preparing a ‘lessons learnt’ document to share both within the Trust and with GMS with the aim to provide a gap analysis/assurance. The Report also provides recommendations that the Trust will need to enact, so this will also be detailed.

6.0 Next Steps

- Quality Improvement Group – meeting at fortnightly intervals
    - Focus on Fire Drills and Evacuation Drills
- 4 Dec 24: Report to Exec Tri confirming legal status of all locations that require a regular Fire Drill / Fire Evacuation to be conducted. Aim is 100% compliancy.
    - W/C 25 Dec ‘Fire Week’ focus to support above aim.
- Grenfell Lessons Learnt document to TLT by end of Jan 25.
- Fire Safety Committee meeting at monthly intervals
    - Focus on Fire Safety Work Plan

Progress and plan regarding CS17 Lockdown

1.0 Introduction

The focus of long term work will be the reintroduction of a Trust Security Team.

The security provision was originally outsourced, this proved to be unworkable. This is common for NHS trusts and a number of Trusts, such as ESNEFT and Medway have insourced their security teams. The problem has been the security guards failing to turn up with no replacement, or being replaced with unqualified or unsuitable staff. An in-house solution is seen as offering a way of managing this.

The Trust asked for GMS to take on the Security and Portering at GRH and CGH and deliver it through a 'merged team. Porters trained to manage violence and aggression are also called on when there are security incidents. As the team is combined resources are often concentrated in one area at the expense of the other.

The Trust was subject to an inspection by the Health and Safety Executive [HSE] in February 2024. As a result of this inspection a series of material breaches amounting to contraventions of Health and Safety legislation were identified. A formal **Notification of Contravention** was issued by the HSE against the Trust in relation to the material breaches. This HSE investigation is yet to be resolved, they are expecting to see material differences in the way security is undertaken within the Trust, or at least plans to achieve this.

Recently there has been an increase over a number of months with the latest being 146% increase of V&A issues within the Trust. The reports have included incidents where weapons were used / or threatened staff including on broken glass or bladed items. Without appropriate PPE (anti-stab vests), a dedicated security base, adequate numbers of operatives, and associated plans in place there is a serious risk of harm, to staff, patients and visitors and is considered an increased HSE and high-risk issue.

Below is the detail surrounding the reintroduction of a Security Team. In the meantime Hd of EPRR will ensure a number of exercises and training sessions are put in place that bring an element of cohesion to the challenges of Lockdown in the Trust. These will include:

- Baby Abduction Exercise in Jan 25
- Series of local lockdowns – Both GRH and CGH Eds and Paeds in MAr 25
- Perimeter Lockdown of both GRH and CGH in May 25

2.0. Change programme
The following sets out the four phased approach moving from the existing structure to the new structure. It enables financial, HR and system changes to be managed in a co-ordinated approach.

2.1. Phase one – immediate enhancements

- Enhancing the security team
- Providing personal protective equipment, including body worn cameras for security
- Delivering a training programme in the short term to ensure compliance

In order to meet the current requirements of managing V&A behaviour within the emergency department at GRH, during peak periods of V&A incidents it is proposed to use an enhanced GMS service provision

The current contract with the training provider cannot be extended due to procurement regulations, there is a requirement to ensure all relevant staff are trained as part of their mandatory 'MAYBO' training. A new interim contract will be negotiated as soon as possible whilst a more strategic solution to bring the training provision in house is developed Across the Trust there are a number of porters who have dual roles and are fully trained as security officers as well-being porters.

Immediate requirement:

- From the statistical evidence. At GRH there is a requirement for 2 dedicated security staff during the day, and 4 at night. (see appendix D for details)

- Agency staff are to be recruited as porters so that the existing staff will change from being porters/ security to become a dedicated security team.

- At CGH the incidence of V&A is far lower thus existing porter/security team will continue until the proposed demerger of the team in.

- To set-up of a new team and demerger of another will be minimum of 30-day consultation, if there are potential redundancies this will be 45-day consultation. To arrange for HR support and business cases will add another 30 days min, all the relevant business cases and consultations would need to be started February 25, with completion in April 2025.

- The security team at GRH will complete hourly checks within the ED area

- Where there are abnormal incidents of V&A during the day at GRH (for all areas), the existing team of porters/security will be called on to assist the two dedicated security personnel.

- The security team members at GRH will be SIA and V&A trained and will be wearing a high visibility vest, their SIA Licence arm band, body warn cameras and have a pager.

- The body worn cameras which are on loan, will be purchased for this period of transition for all porter/security and dedicated security team at GRH and CGH

- Provision of an interim training arrangement for Violence and Aggression management techniques for porters, security and all relevant hospital staff.

4.2. Phase two – developing the full business case.
It is proposed to appoint a consultant team to assist in the development of the full Business Case, Lexica have been asked for a quote. This will be presented for approval through the Governance process **in November/December 2024**.

The full business case will include the following:

- An options appraisal for demerging the porters and security provision
    - A trust managed service
    - A GMS provided service
    - A subcontracted service (sub-contracted by GMS to a company such as G4S, OCS)

- A specification of new porters and security teams created in liaison with the Trust.

- There will be a review of the existing porters' team to calculate additional requirements.

- A consultation and recruitment process will be necessary as the terms and conditions of employment be changed.

- The required range of specialist ‘standard operating procedures’ [SOP] manuals, guidance, instructions and support documents for those staff performing the security and restraint roles, and changed porter roles, will be developed and approved.

- The Service level agreements and KPI's will be created and presented for approval.

- The implementation of new CCTV and security monitoring equipment and Operational hub.

- A specification for the porter’s team across the Trust.

- A costed plan.

- A programme for delivery

4.3. Phase three- The implementation programme
If approval is given for the business case, from March/April 2025 a programme of change will be implemented to create the new security and porter teams dependent on the approved option.

- There will be a permanent base for the security management team at GRH and a satellite base in CGH.
- GRH provision will include a fully compliant control Room, with remote connection to Access Control, CCTV and Security Alarm Systems across the whole of the Trust estate.
- The provision of an inhouse Training facility for Violence and Aggression management techniques for porters, security and hospital staff,
- GMS directly employed trainers and staff.

4.4. Phase four – cultural and strategic change
Under the former NHS Protect (ceased around 2015) a full survey of the NHS estate was required annually to establish potential security breaches and areas of harm. This ensured a culture of awareness around security management; this culture is no longer evident and so there are common breaches in site security. Key management, lockdown and other areas, as referred to in section 3 above.

Running parallel to the implementation of the new security teams will be the following:

- Security survey of the GRH and CGH estate
- Review and report of the current access control, CCTV and security alarms across Trust
- Capital replacement programme
- Lock down plan
- Culture of security management change programme

Where immediate high-risk issues are found, these will be presented back to TLT with recommendations for resolution.

5.0 Timeline

Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26

Phase 1 – Immediate Change

- Enhancing the security team
- Providing personal protective equipment, including body worn cameras for security
- Revised security provision within ED
- Delivering a training programme in the short term to ensure compliance

Phase 2 – Developing a FBC

Developing a FBC for enhanced physical security provision deployment, inhouse training provision and a security hub. The FBC will include:

- Appoint an exert in security management with project management skills to assist with development of FBC. This FBC will include:
- A new specification for the porters and security team. A consultation process will be undertaken
- Recruitment of additional porters
- Development of specialist SOP's for security team
- Renewed SLA and KPI's for security team
- Renew and implementation of CCTV, security monitoring, equipment and operational hub
- Development of inhouse V&A training, provided by GMS, which is to include conflict resolution training,

Phase 3 – Implementation

If approval is given for the business case, then from March/April 2025 a programme of change will be implemented to create a new security and porter teams managed on behalf of the Trust by GMS.
Included will be the provision of an inhouse Training facility for Violence and Aggression management techniques for porters, security and hospital staff, with GMS directly employed trainers and staff.
As part of their V&A training, most staff in the Trust are required to have a minimum level of V&A management training. This will be provided for by GMS.

Phase 4 - Cultural and Strategic Change

It is recommended that as part of the security plan, a review of the estate is carried out.

- Security survey of the GRH and CGH estate
- Review and report of the current access control, CCTV and security alarms across Trust
- Capital replacement programme
- Lock down plan

7.0. Additional notes

- GMS is compliant with the requirements of the Security Industry Act 2001 and regulation by the Security Industry Authority

- GMS is compliant with the legislation regarding provision of licensable security operatives, providing unlicensed porters do not attend V&A and security incidents.

- There are wider matters that the Trust are responsible for as well as the provision of a dedicated security team, these are not currently contracted for from GMS or funded via the capital programme (CCTV signage, external lighting, environmental, training specification).

- There is a separate requirement for a CCTV licence. I.e., to view or manage through CCTV (e.g., someone could legitimately have a CCTV licence, but not a 'manned guarding' licence). Any GMS staff who view CCTV (to identify where someone has gone real time or not, or to burn a recording for the police etc) is licensable.

- The current CCTV provision is currently compliant with the requirements of the Information Commissioners' Office regulation of surveillance. The signage inside and outside is Trust responsibility and is not compliant with ICO regulation. Secure access-controlled viewing CCTV monitors at GRH is not compliant. It's in an open area with no access control. CGH is in a locked room in Riverside

NHS Gloucestershire
Shire Hall
Westgate Street
Gloucester
GL1 2TG

9th October 2024
Marie.crofts@nhs.net

Via email
Neil Hardy-Lofaro
Interim Accountable Emergency Officer
Gloucestershire Hospitals NHS Foundation Trust

Dear Neil,

EPRR Assurance 2024 – Gloucestershire Hospitals NHS Foundation Trust

We would like to thank you for the submission of your Trust Emergency Preparedness, Resilience and Response (EPRR) core standards annual assurance return this year along with your attendance at a "Confirm and Challenge" meeting on 3rd October 2024 along with Dickie, Jill and Jason. Please accept my apologies I was unable to attend the meeting.

Having spoken with Andy and Rachel following the meeting, I understand that Gloucestershire Hospitals NHS Foundation Trust's self-assessment was identified as "Partially" assured. On review of the evidence submitted, NHS Gloucestershire ICB has also assessed your organisation as:-

Partially Assured.

There were a number of matters that were discussed at the meeting on the 3rd and achieving a more rounded response to these may just move you to a higher assurance rating in years to come. The key points are outlined in this letter.

We have concerns around the long timescale (December 2025) provided for improving compliance against Evacuation and Shelter. Whilst acknowledging that the Trust may never reach a green rating on fire and evacuations, we feel that the urgent actions and work underway should go some way to improving the score and that the aspiration should be well before December 2025.

In some areas, progress has been muted and there are concerns around how the Trust would deliver EPRR statutory duties if the EPRR team has similar IA pressures in the coming year. Neil feels that these will be partially mitigated by the work plan for 24/25 year, which is being developed.

Evacuation and Shelter – As with previous submissions and discussions, with the size of your Trust's estate and the age of the GRH, it was suggested that it is nigh on impossible to achieve compliance with this standard. A summary of the issues discussed is shown below:

- An overlapping set of issues regarding fire alarms and fire doors and then the mapping of those fire doors. In addition, the schedule and tracking of the repairs.
- Reference to a capital programme this financial year that is looking to address but not fix, fire compartmentalization and fire door issues identified and the overall Fire Protection system. This is a priority within the capital plan.
- It was noted that regular training and the fire safety management team's availability has now improved as a result of now being fully resourced.

We have suggested participating in a GHC EMERGO evacuation exercise and supporting GHC who are also participating in this event. This should hopefully provide tips on managing evacuation with a view to improving the arrangements at the Trust.

Lockdowns –

- It is concerning that Lockdown has not been practiced for a consider amount of time. Whilst there are longstanding issues with lockdown - the ability to seal off doors simultaneously and the control being located elsewhere in the building, there should be a more robust exercising regime in place. You have also reference the baby abduction exercise due in the next few weeks which should provide learning for improvements here.
- In addition, you informed us that the site are without a dedicated security team. The function is performed alongside porter's duties (a decision taken some time ago).
- You have informed us that there is a business case in place for re-establishing a security team which should go some way to making lock down significantly easier.

Maintaining Plans – We discussed your Major Incident Plan and the fact that some of the action cards are out of date. Whilst IA planning and other challenges have been referenced as impacting this work, this is concerning to us and it is suggested this is prioritized for action.

EPRR Training – It is impressive to see such a robust training program and schedule of exercises within the Board report and we note this area is rated as "Fully Compliant" for the second year. The senior level endorsement of the training on offer and encouragement of take up across the organization appears to have had an impact here.

Business Continuity –

- This has been rated 'amber' and continues to present a significant challenge for the Trust.
- Business Continuity sits clearly with divisions and departments, with the Head of EPRR and others providing assurance over the top and the low-level work and updating of business continuity plans has not been taking place.
- The Trust will introduce (as directed by the Chief Operating Officer), a system currently named 'Irespond'. It's an effective way of accessing business, continuity plans day and night, and particularly the associated action cards assessable to the responders. This equates to

desktop type direct access to a SharePoint (as they do for polices) for BCM plans and business impact assessments.

- We recognise the positive impact BCM incidents have had recently inc. IA in the last year and establishment of the Incident Coordination Centre and Incident Management Teams have been well rehearsed.
- Consideration is being given to introducing a dedicated BCM lead to monitor and drive BCM across the Trust (GHC use this model) and we would support this approach as a way of improving the scoring in this area.
- Another area identified is communication challenges with the absence of net radios or Tanoy system and no ability for messages to be quickly communicated to wards and departments. This should be addressed.

Data Protection Toolkit – It is noted that last year, this standard was found to be not at an acceptable level and we acknowledge the good work undertaken by the Trust to get this to Fully Compliant level this year. We would hope this work continues to achieve a Fully Compliant score in next year's submission.

Our final thoughts –

As agreed at the Confirm and Challenge meeting and email exchange you have had with the team since, the expected outputs include updating the Board report to include minor amendments that have stemmed from the internal Governance Process by 11 Oct 24.

We have also requested a detailed Action Plan concerning the Reds and Amber rated issues, setting out how the score will be improved along with key dates and milestones **by 31 Oct 24**. This action plan may include a request for support, potentially financial, to assist Fire Team Training support.

Our EPRR manager will meet with you through regular assurance review meetings aligned with your action plan for the next year.

Should you require further information, please contact Andy as below.

Andrew.bruce8@nhs.net

I would like to thank you and your Trust's EPRR team for all the hard work they have done this year and for being open and honest around the challenges impacting the scoring within the submission.

Yours sincerely,

Marie Crofts
Executive Chief Nurse / AEO

Cc Andy Bruce, Senior EPRR Manager, GICB
Dickie Head, EPRR Lead GHFT

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
EPRR REPORT 2024-25 TO BOARD

EPRR/Assurance/2024-25/GHNHSFT Response

As at 6 Nov 2024

References:

A. Emergency Preparedness, Resilience, and Response (EPRR) Annual Assurance Process for 2023/24 - dated 15 Jul 2024
B. NHS core standards for emergency preparedness, resilience, and response guidance dated Jul 24

Introduction

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

2. The process for 2024-25 continues the standard process using the EPRR Toolkit.

3. The number of Core Standards sits at 62 in 2024-25. The Deep Dive for 2024-25, which while part of the assurance process does not count towards the scoring, has focused on Cyber. The response is a Countywide IT Services (CITS) response and is led by the ICB. The detail covering the Core Standards are found in Appendix 1.

4. To comply with NHSE Assurance there is a requirement to submit a report covering EPRR to the Board. This report fulfils that requirement. The report is subject to a Confirm and Challenge by the ICB which took place on 3 Oct 24. The ICB response which acknowledged our report, and supported our plans, can be found at Attachment 1.

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

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

7. The following report has been modified from previous years to more closely follow the structure of the Core Standards Toolkit and hence make cross-reference easier. Compared to previous reports there is a shift to more future activity than past activity.

NHSE Annual Assurance Compliance 2024-25

8. The Trust has strived to continue to update and revise policies, procedures, training, action plans and action cards. However, this has been impacted in the first part of the year by planning and executing plans to mitigate the impact of the extended periods of Industrial Action the NHS has faced. The Trust has focused on key risks in priority areas, while also reacting to challenges and incidents throughout the year. While internal auditing has understandably been challenging, it is assessed that this has been mitigated by the Trust regularly using internal and external EPRR networks on a

weekly, daily and sometimes hourly basis, as well as the frequent implementation of EPRR plans due to incidents throughout the reporting period.

9. The Trust self-assesses that it is **non-Compliant** in **two** Core Standards and self-assesses that it is **Partially Compliant** in **eight** Core Standards. These are laid out in Table 1 below with a brief overview of the corresponding Action Plan for each Core Standard. The Trust assesses all other Core Standards as Fully Compliant. Those that have seen a change from Partially Compliant to Fully Compliant are also listed below. Further detail can be found in the attached Core Standards Toolkit

10. The Deep Dive this year concerns Cyber Security. It has been completed by the Digital Team and can be found in the Core Standards Toolkit. It is not part of the overall assessment of the Trust.

11. The Trust therefore has 52 out of 62 Core Standards rated as Fully Compliant and therefore rates itself as **Partially Compliant** overall. The aim is to return to at least Substantially Compliant by Jun 25.

Non- Compliant and Partially Compliant Core Standards 2024-25

a.	b.	c.	c.	d.
No.	**Core Standard**	**Action Plan**	**Status 23-24**	**Status 24-25**
CS 10	Incident Response	Exercises and Training	FULLY COMPLIANT	PARTIALLY COMPLIANT
CS 15	Mass Casualty	Exercises and Training. System level exercise planned for 19 Nov 24	FULLY COMPLIANT	PARTIALLY COMPLIANT
CS16	Evacuation and Shelter	Policy Review, Resources, Training and Exercises.	PARTIALLY COMPLIANT	NON COMPLIANT
CS 17	Lockdown	Policy Review, Resources, Training and Exercises	PARTIALLY COMPLIANT	NON COMPLIANT
CS 28	Management of Business Continuity Incidents	Improved rigour and inspection regime regarding Operational Business Continuity Planning and checks	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS 45	Business Continuity Management Systems (BCMS) scope and objectives	Policy Library based.	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS 46	Business Impact Analysis/Assessment (BIA)	Policy Library based. Business Impact Assessment by Service Line and Department.	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT

CS50	BCMS monitoring and evaluation	iRESPOND based, data-based reminders for review. EPRR process for Incident Debriefs.	**PARTIALLY COMPLIANT**	**PARTIALLY COMPLIANT**
CS51	BC Audit	External Audit – Recommended Apr 25, following implementation of iRESPOND.	**PARTIALLY COMPLIANT**	**PARTIALLY COMPLIANT**
CS 52	BCMS Continuous Improvement Process	iRESPOND based, EPRR Working Group, EPRR Process for Incident Debriefs.	**PARTIALLY COMPLIANT**	**PARTIALLY COMPLIANT**
Core Standards that have moved from Partially Compliant to Fully Compliant in last 12 months				
CS49	Data Protection and Security Toolkit	Following Digital drive to raise Trust level of compliance above 955	PARTIALLY COMPLIANT	FULLY COMPLIANT
CS59	Chemical Biological Radiological Nuclear	Following an 18 month delivery of training at Level 1, 2, and 3 by Trust Chemical Biological Radiological Nuclear Lead and focus from ED department on this critical area.	**PARTIALLY COMPLIANT**	**FULLY COMPLIANT**

Table 1

Overview

12. **Impact of Industrial Action.** The effect that prolonged Industrial Action since late Nov 22 has had on conducting planning, training and exercising cannot be underestimated and continued in to 2023 and early 2024. The nature of relatively short notice strikes and of planning and mitigating risk continued to be challenging. EPRR has had the central coordinating role throughout the period focusing mainly through the pan-Trust Industrial Action Working Group in the planning phases and then the Incident Management Team during the execution. The main impact has essentially been three-fold. The EPRR team has had reduced ability to revise and review a number of standing plans and SOPs; planned EPRR activity has had to be cancelled on a number of occasions at short notice; and the availability of staff across the Trust to conduct EPRR training has also been severely limited by the frequency of industrial action. It has been noticeable that since the end of industrial action the output and ability to focus on routine EPRR issues has improved.

13. **Incident Response**. The overall awareness, relevance and application of EPRR good practice continues to increase and improve across the Trust. Indeed, the pan-Trust planning processes that have been implemented during this period are now regarded as standard practice and have led to an increasingly efficient and robust approach. The use of an Incident Management Team (IMT) approach early on in reacting to unforeseen challenges is now accepted practice and well-rehearsed.

14. **Statutory Inquiry**. Head of EPRR and the Senior EPRR Manager provided the coordination function for the final response by the CMO to the Statutory Inquiry until May 2024.

Governance and Assurance

15. EPRR governance continues to be delivered by a series of Steering Groups, Committees and Working Groups including:
    a. EPRR Steering Group
    b. EPRR Working Group (formerly the EPRR Compliance Meeting)
    c. Fire Safety Management Committee
    d. Security Management Group
    e. Incident Debriefs – as required

16. The frequency at which these groups meet brings an ability to horizon scan and respond to arising issues often before they become significant challenges. The EPRR Working Group delivers the operational output, while the EPRR Steering Group focuses more on Tactical and Strategic issues, particularly focussing on integrating work-strands across functional areas.

17. The above groups escalate issues and risks in to the rest of the Trust governance framework on a regular basis including:
    a. Exception reports from the Security and Fire groups to the Health and Safety Committee.
    b. Risks reviewed regularly and escalated to Risk Management Group
    c. Regular NHSE EPRR Assurance through quarterly Updates through Divisional Operations Advisory Group and the Trust Leadership Team.
    d. Annual NHSE EPRR Assurance through the Trust Leadership Team, Audit and Assurance Committee, Board and then to ICB for Confirm and Challenge.

18. Some recent incidents, for example concerning Electronic Patient Record Business Continuity Practices, have demonstrated how even a small gap in assurance processes, where it is assumed that a system is in place and has been checked, can present significant issues to the Trust. A review of such low-level assurance will take place in Autumn 2024 to assess how better to close such gaps.

19. Lessons Identified and Lessons Learnt. The Trust has strived to ensure such lessons are embedded through a combination of a set of common processes and procedures a stronger, faster, and more thorough process for debriefing incidents that places the responsibility for resolving issues on those who have the correct expertise and authority. The process seeks to turn Lessons Identified in to Lessons Learned through the Structured Debrief Process. The EPRR team has conducted training in this approach and will ensure it continues as a Trust-wide policy when delivering learning from significant incidents.

Duty to Risk Assess

20. The Trust continues to horizon scan across a wide spectrum for threats or challenges including adverse weather; travel restrictions including strikes. The EPRR team are automatically linked in to UK Health Security Agency Health Alerts and Met Office Weather Alerts. EPRR and a wider network constantly and dynamically risk assess threats and are able to respond either in a planned or short-notice manner. This year significant preparation went in to preparing the Trust for hot weather. While relatively successful at a Tactical level Operational lessons have been learnt that will improve the response in the future. Winter Planning from an EPRR perspective will be woven in to the Trust's overall response for Winter 24-25.

Duty to Maintain Plans

21. The decision to downgrade the two Core Standards for Lockdown and Evacuation and Shelter to Non-Compliant has been a deliberate move to provide focus on these two vital plans and responses. Action Plans are in place as described below and will be coordinated through the EPRR SG and delivered by the EPRR WG.

22. CS 16 Lockdown. A review and rewrite of the Lockdown Policy and the linked Access Control Policy will be conducted. A Key Policy will be put in place delivering Lock and Key Registers. Individual and Collective Training will be delivered by Head of Security, Head of EPRR, the Site Team and Divisional EPRR Leads. A number of exercises will focus on this particular area e.g. Baby Abduction Exercises. Target date to return to at least Partially Compliant – Apr 25.

23. CS 17 Evac and Shelter. The Fire Safety Policy is already under review through the Fire Safety Management Committee. Fire Compartmentalisation will be checked. The approach to Individual and Collective Training has already been changed with the Fire Team having immediate access to senior Trust. The Fire Alarm system is under review. Fire Extinguisher training will be brought in for staff. A risk assessment for High Risk Wards will be conducted to review positioning in the GRH Tower. Planned and no-notice fire evacuation exercise are scheduled to take place at an increasing frequency. Target date to return to at least Substantially Compliant May 25. A more detailed Action Plan is at Appendix 2

24. CS 28, 45, 46, 50, 51 and 52 have been categorised as Partially Compliant. The drive to improve all Core Standards concerning Business Continuity revolves around the implementation of the iRESPOND framework. The challenge of providing a strong Business Continuity framework has been a long-standing issue in the Trust with individual departments having their own approaches, without an overarching Tactical approach being in place that is pan-Trust. A detailed implementation plan has been briefed to the EPRR Steering Group stakeholders that will bring the required level of cohesion as well as addressing the detailed requirements in the associated Core Standards. This will be a considerable piece of work from across the Trust and support services that aims to deliver a more robust and resilient response to business Continuity challenges. Target date to achieve Full Compliancy is Sep 25.

25. CS 10 and 15. The requirements to return these Core Standards to Full Compliance revolve around clear and defined requirements concerning exercises and training – some of which have already taken place. Target date to return to Full Compliance is Apr 25.

Training and Exercising

26. With the requirement to meet Minimum Occupational Standards for On Call Managers now in place the provision of formal training by ICB has been most welcome. This is putting senior staff in a stronger position to react to challenging scenarios. GOLD and SILVER staff continue to receive a formal induction from the EPRR team that covers the key aspects of SILVER and GOLD responsibilities as well as the use of the ICC and the Virtual On-Call Dashboard. GOLD and SILVERs also are given the opportunity to attend regular updates from the EPRR and Site Team to ensure currency in Incident Response and the Escalation Policy.

27. A training programme is now in place for members of BRONZE (Site), SILVER and GOLD that has delivered:
    a. Joint Emergency Services Interoperability Programme training
    b. Principles of Health Command training
    c. MAGIC Lite training (Strategic level training for GOLD)
    d. Structured Debrief training
    e. Strategic Leadership in Crisis and Emergency training
    f. Loggist Training
    g. CBRNe training is a major focus for the Trust with 3 levels delivered:
        i. Awareness Training
        ii. Decontamination Training
        iii. Incident Coordination Training
28. The recent CBRNe Audit conducted by SWAST was successfully passed for the first time in 5 years with extremely positive comments indicating the Trust was at the forefront of best practice in the South West.

29. These courses have been delivered to a spread of senior and junior staff and are recorded by the EPRR Manager with an overview presented below in Table 2.

Key Minimum Operational Standards

Training	Mandated	Group	Total	Trained	Outstanding	Comment
Principles of Health Command (PHC)	**Yes**	GOLD	17	11	6	Brought in mid-23
		SILVER	25	22	3	Essentials covered in PHC
JESIP	No	SILVER	NA	3	NA	
Loggist training	No	NA	10	10	NA	
Trust led On Call Training						
GOLD SILVER On Call Training	No	Gold	17	6	11	ICC familiarisation
				16	1	Virtual Desk
		Silver	21	19	2	Virtual Desk and ICC
CBRNe as at 6 Sep 24						
Level 1: Awareness	No	Staff Area	Total	Trained	Requiring Training	Percentage Trained
		ED Receptionists	33	23	10	70%
		ED Staff (All)	202	188	14	93%
Level 2: Decontamination		Porters	53	28	22	53%
		ED Staff (Band 6 and below)	184	79	105	43%
Level 3: Incident Management		ED Staff (Band 7 and above); Site; SILVERs; GOLDs	101	47	54	47%

Table 2

Planned Exercises

30. An exercise programme has been developed and continues to be refined. The programme is divided in to Routine Exercises that are to take place on a regular basis

and Scheduled Exercises that support the programme or focus on a particular Risk area,

31. Routine Exercises
    a. Annual table-top exercise – Major Incident – ICB / South West Ambulance Service Foundation Trust lead
    b. Mass Cas Distribution Exercise by 1 Jan 24 – planned for 27 Nov 24- System lead
    c. A communications cascade exercise every 3 months – EPRR lead
        i. Either Internal or External
    d. Annual Command Post Exercise – EPRR Lead
    e. Annual (minimum) Trust level Fire Evacuation Exercises in both GRH and CGH – Fire Team lead

32. Scheduled Exercises:
    a. Trust Led Fire Evacuation Training
        i. GRH Tower – 26 Sep 24
        ii. CGH – W/C 2 Dec 24
    b. CBRNe Live Ex
        i. GRH - 20 Nov 24
        ii. CGH – W/C 9 Dec 24
    c. Lockdown
        i. Baby Abduction Exercise: Jan 25
    d. Power Outage – Jan 25
    e. Electronic Patient Record Business Continuity Practice exercises / checks – regular monthly intervals

Response

33. **Incident Control Centre (ICC) & GOLD/SILVER On-Call Training.** The GRH ICC is now well established, subject to routine inspection and, when required, activated. The Trust is assured of a robust capability which is also used for an increasing number of non-EPRR events such as the recent Clinical Vision of Flow focus events. The intent to set up a second ICC on the CGH site remains.

Warning and Informing

34. The EPRR team attend Site Safety Meetings on a daily basis ensuring the Trust is updated on future threats ranging from weather to cyber-attacks on local government and the necessary responses required.

35. Close linkages with the Communications Team ensure that a number of mediums are optimised to inform staff and, if necessary, the wider community of any critical information. These can range from global emails, screensavers, and the use of social media.

Cooperation

36. Strong linkages and collaborative working remain the bedrock for a wider EPRR response in Gloucestershire and the wider Region. The Trust's EPRR team has continued to develop and build networks across Gloucestershire and the South West.

Relationships with the ICB remain strong, open, and transparent. The Trust EPRR team feels well supported by a forward thinking NHSE South West EPRR team.

37. A regular liaison meeting with Police and Fire and Rescue Service has been established. Police have provided a direct liaison to EPRR for non-urgent cooperation.

38. Relationships and responses in the Local Resilience Forum and Local Health Resilience Partnership are well-rehearsed with both formal and less formal meetings at 100% attendance. Internal linkages remain active and continue to develop with a focus on ensuring Gloucestershire Management Services and Apleona are better linked in to Trust operational processes.

39. Internal planning and preparation is greatly aided by the weekly Estates Planned Works Briefing that ensures a coherent approach to all planned works across the Trust.

Next Steps and Summary

40. This reporting period continued on from another tough year. industrial action impacted significantly until Mar 24 on the ability of the Trust to conduct EPRR training and exercises. Despite this it has been encouraging to see how much activity has still been able to take place in certain areas.

41. The quid pro quo to such a responsive year is that the Trust has regularly been solving significant and new challenges at speed. The frequent activation of the Industrial Action Working Group in the planning phase, and the subsequent activation of a large Incident Management Team during the execution phase has resulted in an even larger layer of senior and mid-level staff who are experienced planners, able to anticipate and mitigate risk. The early establishment of the Incident Management Team in anticipation of all forms of incident, potential or actual, has been a welcome new approach. This has allowed the Trust to prepare, mitigate, and respond effectively to emerging issues and prevent them becoming more serious.

42. The Trust continues to remain in a sound position in terms of being able to react to EPRR challenges. The downgrading of Core Standards for Lockdown and Evacuation and Shelter should be viewed in the light of ensuring that we do not settle for a ‘sufficient’ response when we should demand of ourselves an ‘excellent’ response. These two areas will be the priority for EPRR over the short to medium term in to early 2025.

43. The implementation of an iRESPOND system and the associated improvements across the Business Continuity landscape will see a significant improvement and better assurance in this area. The drive and support from the Chief Operating Officer to deliver this is welcomed.

Dickie Head
Head of Emergency Preparedness, Resilience and Response GHNHSFT