GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 16 January 2025 at 09:00 to 12:00

Room 3, Sandford Education Centre, Cheltenham General Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1	**Welcome, apologies for absence and quoracy check**[1]	Information		
2	**Declarations of interest**	Approval		
3	**Minutes of previous meeting**	Approval	ENC 1	09:05
4	**Matters arising**	Assurance	ENC 2	
5	**Patient Story**	Information	ENC 3	09:10
6	**Public questions**	Information		09:30
7	**Chair's Report** *Deborah Evans, Trust Chair*	Information	ENC 4	09:45
8	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	ENC 5	09:55
GOVERNANCE AND ASSURANCE				
9	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	ENC 6	10:05
10	**Scheme of Delegation, Standing Financial Instructions and Standing Orders** *Karen Johnson, Director of Finance, Kerry Rogers, Director of Integrated Governance*	Approval	ENC 7	10:10
MATERNITY SERVICES TRANSFORMATION				
11	**Report to the Care Quality Commission - Section 31 Summary Report** *Lisa Stephens, Director of Midwifery and Dr Christine Edwards, Consultant, Obstetrics*	Assurance	ENC 8	10:15
11.1	**Perinatal Quality Dashboard, Quarter 2, 2024** *Lisa Stephens, Director of Midwifery*	Assurance	ENC 9	10.25

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

REF	ITEM	PURPOSE	REPORT	TIME
STRATEGY				
12	**Update on development of our Trust Strategy** *Will Cleary-Gray, Director of Improvement and Delivery*	Information	ENC 10	10:35
INTEGRATED QUALITY AND PERFORMANCE REPORTING				
13	**Quality and Performance Committee Key Issues and Assurance Report** *Sam Foster, Non-Executive Director and Mike Napier, Non-Executive Director*	Assurance	ENC 11	10:45
14	**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 12	10.55
15	**Annual Organ Donation Report** *Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO, Ian Mean, Chair Gloucestershire Organ Donation Committee and colleagues*	Approval	ENC 13	11:15
PEOPLE AND ORGANISATIONAL DEVELOPMENT				
16	**People and Organisational Development Committee Key Issues and Assurance Report** *Balvinder Heran, Non-Executive Director*	Approval	ENC 14	11:35
FINANCE AND RESOURCES				
17	**Finance and Resources Committee Key Issues and Assurance Report** *Jaki Meekings-Davis, Non-Executive Director*	Approval	ENC 15	11:45
STANDING ITEMS				
18	**Any other business**	Information		11:55
19	**Governor observations**	Information		
20	*Resolution by the Board to exclude the public and conduct its business in private for confidential matters which may be prejudicial to the public interest if conducted in public or for other reasons.*	Approval		
21	**Date and time of next meeting** *Thursday 13 March 2025, 09.00 to 12.00 Room 3, Sandford Education Centre, Cheltenham General Hospital*	Information		
Close by 12:00				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Draft Minutes of the Board of Directors' meeting held in Public.
Thursday 14 November 2024, 13.00
Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

Present		
Deborah Evans	DE	Chair
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
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
Will Cleary-Gray	WCG	Executive Director of Improvement and Delivery
Attending		
James Brown	JB	Director of Engagement, Involvement and Communications
Lisa Stephens	LS	Director of Midwifery (item 77/24)
Helen Ainsbury	HA	Chief Digital and Information Officer (Interim)
Michael Weaver	MW	Deputy Trust Secretary (minutes)
Dr. S Bhakthavalsala	SB	Guardian for Safe Working (item 82/24)
Apologies		
Jaki Meekings-Davis	JMD	Non-Executive Director
Vareta Bryan	VB	Non-Executive Director

Observers
Four members of the public and seven governors observed the meeting

Ref.	Item
64/24	**Chair's welcome and introduction**
	The Chair opened the meeting, confirming it was quorate, and shared the sad news of the death of Alan Thomas, the Trust's former lead governor. The Chair acknowledged his substantial contributions to the Trust and health and care services in Gloucestershire, describing him as a dedicated public servant whose loss was deeply felt by all. Funeral details for Wednesday, 27 November, would be shared, with anyone upon request.

Ref.	Item
65/24	**Apologies for absence**
	Apologies for absence were noted as above.
66/24	**Declarations of interest**
	There were no declarations of interests.
67/24	**Minutes of previous meeting**
	RESOLVED: The Board **APPROVED** the minutes of the meeting held on 12 September 2024.
68/24	**Matters arising**
	RESOLVED: The Board **NOTED** there were no reported matters arising.
69/24	**Patient Story**
	Members of the Board were informed that due to unforeseen circumstances it would be necessary to postpone the Patient Story until the Trust Board meeting in Public in January 2025.
70/24	**Public questions**
	The meeting addressed four public questions submitted for discussion. Written responses would be provided to all questions, per standard procedure, and shared with all board members. Questions included the implementation of Martha's Rule, safeguarding practices concerning gender and biological sex in care, and single sex changing facilities for staff. A detailed discussion centred on a question raised by a healthcare support worker about pay discrepancies and union recognition for bank staff. The board acknowledged the concerns, confirmed a meeting between the Chief Executive Officer and staff to discuss the issue, and assured all present that their concerns were noted.
71/24	**Chair's Report**
	The Chair presented a written report to the board for the first time. The report highlighted the Trust governors' valuable contributions, particularly when leading inpatient assessments of clinical environments supported by volunteers and other members of the community and using feedback to enhance service improvements. The Chair stressed the importance of visiting areas under pressure, with structured programmes involving board members and governors. Recent visits included Cheltenham General and Gloucestershire Royal Emergency Department. Non-executive directors attended the Gloucestershire Safety and Quality Improvement Academy graduation ceremonies, which showcased staff projects aimed at improving services. The Chair discussed ambassadorial duties, such as supporting the fundraising appeal for the cancer centre extension and outlined significant involvement in the Gloucestershire Integrated Care System, where non-executive directors participate actively in various system-wide groups. The report concluded without further questions from the Board. **RESOLVED:** The Board **NOTED** the report for information

Ref.	Item
72/24	**Chief Executive's Report**
	Kevin McNamara, Chief Executive Officer, announced the appointment of Lee Pester as the new Chief Digital Officer, set to join the Trust in February 2025, succeeding Helen Ainsbury, who was commended for her contribution as Interim Chief Digital and Information Officer. Kevin McNamara reported significant progress in fundraising for the cancer centre, nearing the halfway mark, highlighting its value to the community. During the meeting, Kevin McNamara addressed ongoing staffing challenges in maternity services, stressing the need for clear and transparent communication with the public. Reflecting on insights from the NHS Providers Conference, he highlighted national efforts to strengthen leadership, improve capabilities, and advance digital innovations, such as the NHS app. The Chief Executive Officer encouraged the Trust to explore opportunities for collaboration, including network partnerships and the federated data platform, to enhance patient outcomes. Discussions also focused on financial pressures, compliance with safety standards, and the importance of strategic partnerships, particularly in out-of-hospital care and primary care integration, to support the Trust's objectives. These insights would inform development of the Trust's strategy in the coming months. **RESOLVED:** The Board **NOTED** the report for information.
73/24	**Audit and Assurance Committee Report**
	Minutes from the previous Trust Board meeting in Public held on 12 September 2024 recorded that John Cappock, the chair of the Audit and Assurance Committee, provided a detailed oral update on the committee's discussions of its meeting held on 10 September 2024. Given the time constraints on the agenda the Board noted the written report for assurance. **RESOLVED:** The Board **NOTED** the report for assurance.
74/24	**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 discussed the evolving framework for managing strategic and operational risks, focusing on improving reporting mechanisms to enhance oversight and ensure alignment with strategic objectives. Trust Board Committee oversight played a critical role, offering board members insights into key risks addressed since the previous meeting. Future reports to the Board would concentrate on the quality of controls and the effectiveness of assurances. Mike Napier, Non-Executive Director questioned the tone of the report, which was at risk of potentially underplaying some significant challenges, particularly in finance and estate sustainability. The board acknowledged the need to balance transparency and accountability, aiming for reports that reflect the true complexity of the risks being managed. Health and safety governance emerged as a significant concern, with members highlighting the need for a more centralised and strengthened approach. The discussion emphasised the complex nature of health and safety risks, which encompassed multiple areas, posing challenges to effective governance.

Ref.	Item
74/24	**Strategic and Operational Risk**
	The board acknowledged the progress achieved, particularly in integrating health and safety into the trust's wider risk management structures. However, they emphasised the need for further improvements to ensure robust oversight. Members agreed that ongoing refinement of these processes was essential for strengthening risk management and aligning it with the organisation's strategic objectives. **RESOLVED:** The Board **NOTED** the report for assurance.
75/24	**National Health Service Provider Licence**
	Kerry Rogers introduced the updated NHS provider licence, effective from April 2023, which required healthcare providers to meet rigorous conditions to enhance patient care and address challenges such as climate change and system integration. The board confirmed that the trust complied with these requirements through annual self-certification, ensuring board members meet the Fit and Proper Person Test and adhered to governance standards. The trust's governance framework, supported by dedicated committees, effectively managed risks while maintaining high standards of quality and safety. Environmental sustainability was prioritised, with the Green Plan targeting net-zero emissions by 2040 through initiatives such as energy-efficient infrastructure and sustainable waste management. Financial oversight was also highlighted, focusing on resource management and operational cost control. The board approved the report, confirming compliance with all licence conditions and alignment with national legislative and regulatory requirements. The board reviewed the updated licensing requirements and acknowledged the delayed submission of the self-certification, recognising the need to address this in future governance cycles. Members noted the removal of certain self-certification obligations, such as corporate governance statements and registration with the Care Quality Commission, to reduce duplication with annual reporting. Discussions highlighted compliance in areas such as digital transformation, collaboration, and risk management, with an emphasis on improving evidence of board and committee effectiveness and enhancing scrutiny of organisational risks. The board stressed the importance of maintaining clarity on asset registers, particularly concerning services requested by commissioners, and aligning with the Trust's accountability framework. The board agreed that the trust met the requirements of general conditions on governance, compliance, and risk management, as well as commitments to providing data and achieving net-zero targets. These compliance statements were approved, with a commitment to integrate these activities into future governance processes. **RESOLVED:** The Board **NOTED** and **AGREED** the Trust met the requirements of General Conditions G3 and G5 of the NHS Provider Licence and requirements detailed in conditions NHS1 and NHS2. **RESOLVED:** The Board **NOTED** and **AGREED** the Chief Executive Officer would complete and sign the Declarations required by Continuity of Service condition 7 of the NHS provider licence.

Ref.	Item
76/24	**Integrated Performance Report**

Members of the Executive Director team presented the Integrated Performance Report for September 2024. The Board noted the following key points:

Performance

- The 4-hour emergency care standard was not achieved in September, with 62.9% of patients seen, treated, and discharged within 4 hours, marking a slight decline from August; however, performance improvements were noted in October.
- Ambulance handover times had worsened in September, with 30% of patients waiting over 60 minutes to be offloaded, but more recent data (mid-November) showed an average handover time of 23 minutes over the last 10 days.
- Referral to Treatment times had improved, reducing the number of patients waiting over 52 weeks from 1,700 in September to 1,600 in October. The Trust planned to eliminate 65-week waits by November.
- The Trust achieved three months with no 78-week breaches, reduced 65-week breaches from 1,448 in September to eight in October, and planned to declare zero in November. Despite ongoing challenges, progress continued on reducing the 62-day cancer backlog and integrating lessons into future planning.
- Diagnostic performance (DM01) fell short of the 15% target in September, with a validated position of 18.01%, alongside slight improvements in Virtual Ward utilisation.
- A new clinical vision of flow had been launched to replace previous initiatives, supported by external partners and workshops, resulting in improvements aimed at decongesting the emergency department and enhancing patient care.

Quality and Safety metrics

- The resolution of concerns within five days showed some improvement.
- Mixed-sex accommodation breaches had reduced due to better management practices.
- Flow out of critical care improved, supporting patient movement and reducing delays.
- Patient falls increased, prompting the rollout of new training programmes to address the issue.
- Pressure ulcer rates remained consistently low, reflecting sustained preventative efforts.
- Challenges with maternity satisfaction scores were identified and were under close monitoring.
- A recent issue with incorrect data uploads would artificially inflate Summary Hospital-Level Mortality Indicator (SHMI) for the next 12 months due to the use of a 12-month rolling calculation. The Integrated Care Board had established a Quality Improvement Group to provide support and oversight of actions aimed at improving the Trust's Summary Hospital-Level Mortality Indicator (SHMI) data.

Ref.	Item
76/24	**Integrated Performance Report**
	Finance • As of Month 6, the Trust reported a favourable position to plan by £1.6 million, though a deficit of £8.9 million remained, posing a significant challenge to achieving a break-even position by year-end. • Financial sustainability remained a concern, with a high level of non-recurrent savings identified and a gap in recurrent savings expected to impact the financial position later in the year. • Agency spend was below the national ceiling at 2.9% (against a 3.2% ceiling), marking the lowest level in recent years, though further reductions remained a priority. • Workforce controls reduced nursing expenditure while medical staff showed a year-to-date overspend of £600,000 (excluding costs related to industrial action), reflecting the need for continued monitoring. • The Trust remained above funded establishment by 60 whole-time equivalents, largely in nursing, with contributing factors including maternity leave and increased care for complex patients. Further data analysis was underway to identify genuine and allowable over-establishment. • Non-pay costs, particularly in drugs and supplies, continued to pressure financial sustainability targets, despite being partially offset by income. A new non-pay oversight group was established to address overspending. • Capital expenditure was underspent year-to-date, though significant progress was made on key schemes to ensure spending was optimised within the financial year, avoiding cost risks in the next financial year. • The cash position remained healthy. The Director of Finance advised the Board the Trust would continue to monitor potential challenges in the next year, particularly if the cash balance neared critically low levels, such as five days of operating cash flow. **Workforce** • The Trust continues to underperform with regards to some of the key EDI targets. The initial March 2025 target has been extended to March 2028, with plans under review to address this and EDI will be the focus of significant development work in 2025 to strengthen the Trust approach. • Staff engagement metrics showed improvement but remained below the benchmark for acute hospitals. Positive developments were noted in bullying, harassment, and leadership perception scores. • Efforts to improve appraisal compliance in challenging areas, such as medicine and women and children, resulted in progress, with compliance increasing in some divisions. A six-month pilot of a revised appraisal processes had been launched. • Training compliance improved slightly, with safeguarding training up 6%, fire safety at 92%, and information governance just below the 95% target. A training oversight group had been established to strengthen governance. • Bank staff usage exceeded targets but showed reductions, with over 140 fewer full-time equivalents used, sustained over four months through stricter monitoring and roster reviews.

Ref.	Item
76/24	**Integrated Performance Report**
	Sally Moyle, Associate Non-Executive Director, raised concerns about the reported increase in patient falls, which had led to the introduction of a new training programme. She observed that the underlying trend suggested a rise in falls and expressed interest in understanding the programme's effectiveness. Matt Holdaway, Chief Nurse and Director of Quality, agreed that the Trust should evaluate the programme's impact and proposed that the Board review the detailed patient falls report previously presented to the Trust's Quality and Performance Committee. Kevin McNamara sought assurance regarding the reported data upload error affecting the Summary Hospital-Level Mortality Indicator and asked how the Trust could ensure the accuracy of its mortality data. Professor Mark Pietroni, Medical Director, Director of Safety, and Deputy Chief Executive, explained that the indicator measured the ratio of observed to expected deaths, accounting for all-cause mortality within 30 days of hospital care. Expected deaths are calculated based on diagnoses and co-morbidities, reflecting patient risk factors. The error occurred when numerous uncoded deaths were submitted to NHS England, reducing the expected deaths figure and artificially worsening the mortality ratio. Although NHS England acknowledged the error, they declined to amend the national figures. The Trust planned to calculate the error's impact locally to provide accurate data for internal reporting to the Quality and Performance Committee and Trust Board, while accepting that national figures will remain unchanged. It was also noted that, in five days, the Integrated Care System would introduce a new integrated Urgent Care Coordination Hub to address systemic challenges, such as ambulance delays and emergency department congestion, with updated escalation protocols aimed at enhancing accountability and fostering collaborative solutions among system partners. Marie-Annick Gournet, Non-Executive Director, requested clarification on the target for increased minority ethnic representation in senior staff leadership roles in the Trust, noting that the original goal of 2025 appeared to have shifted to 2028. She observed that the Trust had previously performed better in higher pay bands, particularly in leadership representation, and questioned whether this adjustment reflected stalled progress. She also asked about steps being taken to address these challenges and advance leadership progression and promotion. Claire Radley, Director for People and Organisational Development, acknowledged that while the Trust previously lacked a clear plan to meet its target, a more detailed strategy was now under review by the People and Organisational Development Committee, aligned with the race equality agenda. She explained that 2028 was a more realistic timeline for improvement and noted that small data sets could lead to significant apparent variations over time. Kevin McNamara reported that during the Black History Month event, it became clear that staff felt frustrated and angry about perceived commitments the Trust had failed to deliver. He shared that he and Claire were working with an external facilitator, who had helped other organisations shift similar conversations, to develop a scope for Board and wider senior leadership development for 2025, together with helping support the development of the staff networks Kevin highlighted 2025 as a target year for making meaningful progress on inclusion and acknowledged that external support would likely be essential in achieving this goal.

Ref.	Item
76/24	**Integrated Performance Report**
	Balvinder Heran, Non-Executive Director, commended the progress and effort behind the Integrated Performance Report, praising its clarity, accessibility, and reader-friendly format. A query was raised about the use of grey icons on page four of the single oversight framework, which indicated targets were sometimes achieved and sometimes missed, suggesting that areas without defined targets could be misleading and should be excluded until targets were established. In response, it was clarified that most areas have defined targets outlined in the framework's rule book. The Trust committed to reviewing and confirming these targets, particularly the ambulance offload metric within 30 minutes, to ensure greater clarity and consistency in future reports. **RESOLVED:** The Board **NOTED** the contents of the Integrated Performance Report and associated metrics for assurance.
77/24	**Report to the Care Quality Commission - Section 31 Summary Report**
	The Chair welcomed Lisa Stephens, Director of Midwifery, to the meeting. The Board received the monthly Section 31 report, which detailed ongoing quality improvement initiatives in maternity services, including recent quality review training sessions held in October and improvement project graduations planned for February 2025. Monthly progress reports were submitted to the Chief Nurse for escalation of concerns or additional support. The first phase of the new governance structure had been implemented, with maternity service forums reporting to the Maternity Delivery Group; one meeting had taken place, with another scheduled the following week. Updated reports and dashboards were being shared regularly as required by the Care Quality Commission, with external assurance provided fortnightly to the ICB Quality Improvement Group and updates shared with NHS regional and national teams. The Board reviewed actions addressing postpartum haemorrhage rates, noting pre-delivery assessments and compliance with the reduced pro forma, alongside close monitoring of a slight increase in cases involving 1500ml blood loss. Significant improvements in scanning services were reported, reducing delays, particularly for cases involving reduced foetal movements, from 7-10 days to 2-3 days. Workforce initiatives and cross-divisional collaboration were addressing capacity challenges, including exploring senior scanning roles and reducing midwife reliance for third-trimester scans. Governance enhancements were discussed, with new forums structured around maternity pathways providing monthly updates and escalating risks to the Oversight and Assurance Committee. The revised Perinatal Quality Statement report was recognised as a key improvement in governance clarity. Board members stressed the importance of achieving meaningful outcomes for the community and prioritising integrated reporting to reduce manual effort. The Board noted the report, commended the extensive work, and expressed confidence in the robust improvement programme in place. **RESOLVED:** The Board **NOTED** the contents of the Section 31 Summary Report and associated metrics for assurance

Ref.	Item
78/24	**Quality and Performance Committee Key Issues and Assurance Report**
	Sam Foster, Non-Executive Director, presented the Key Issues and Assurance Report for the Quality and Performance Committee meeting held on 25 September 2024. The committee maintained oversight of Maternity services, with an in-depth review of stillbirth rates in progress. Complaints management showed some improvement in response rates but required further enhancement. Cancer performance indicators, particularly in urology and skin services, fell short of targets, though recovery plans were in place. Ambulance handover times have improved significantly, but system flow and discharge processes continue to present challenges. Endoscopy services demonstrated notable recovery, while diagnostic areas, including echocardiography and cystoscopy, remained non-compliant. Efforts to address delay-related harm in emergency care were discussed focusing on reducing waiting times and enhancing mortality metrics. Updates on winter planning, falls management, and the Board Assurance Framework underscored both progress and the need for continued attention. Governance and system-wide collaboration were emphasised as essential for addressing persistent issues. **RESOLVED:** The Board **NOTED** the report for assurance.
79/24	**Winter Plan**
	Al Sheward introduced the 2024/2025 Winter Plan, outlining a comprehensive strategy aimed at improving existing processes and addressing the challenges of the upcoming winter season through targeted and sustainable approaches. The plan focused on workforce planning, with an emphasis on pastoral care to support staff wellbeing, enhanced portering services, and extended medical team coverage into later hours to meet peak demand periods. Key initiatives included specialty in-reach services designed to expedite patient discharges, the increased uptake of virtual wards to reduce pressure on escalation wards, and improved integration with community health plans. The plan highlighted a strategic approach to ensuring patients could be referred to virtual wards earlier in their care journey, helping to optimise resource use and improve outcomes. Additionally, flu and COVID vaccination campaigns were prioritised to mitigate the risks of seasonal illnesses. The plan emphasised sustainable improvements rather than relying on traditional temporary measures, such as increasing staff or adding beds, which were noted to have limited long-term impact. Significant focus was placed on enhancing acute care areas, refining priority pathways, and improving discharge processes to address systemic pressures more effectively. Improvements to electronic systems were also identified as a critical component for streamlining operations and enabling more efficient care delivery. Throughout the discussion, leadership and collaboration with system partners were stressed as essential elements of success, particularly in managing patients without Criteria to Reside and ensuring the delivery of Integrated Urgent Care by November 2024. At the conclusion, Balvinder Heran, Non-Executive Director, enquired about the Integrated Care Board's winter plan. It was confirmed that the Integrated Care Board would produce a system-wide plan informed by contributions from all system partners. The plan remains dependent on additional funding, with specific outcomes and measures to be included in subsequent updates as they are developed. **RESOLVED:** The Board **NOTED** the contents and narrative of the 2024/2025 Winter Plan.

Ref.	Item
80/24	**Learning from Deaths Report**
	The report, introduced by Professor Mark Pietroni, Director for Safety, Medical Director, and Deputy Chief Executive, highlighted that all deaths within the organisation are reviewed by the independent Medical Examiner Service. Learning from serious incidents was monitored through the Serious Event Review Group (SERG), with summaries provided in relevant appendices. Positive local learning from care issues was acknowledged, though there was a recognised need to incorporate Structured Judgment Review outcomes into wider improvement programmes. Concerns about the timeliness and completion rate of Structured Judgment Reviews persisted despite improvements in the last quarter, prompting consideration of a process review using a quality improvement approach. Feedback regarding care experience was predominantly positive, highlighting staff kindness, though communication about next steps required improvement. Proactive family feedback processes were under review to enhance experiences and reduce complaints. Hospital crude mortality rates remained low, but the Summary Hospital-level Mortality Indicator had risen, driven by multifactorial causes under investigation, including coding, comorbidity scoring, and pathway and audit improvements. An action plan addressing these issues was being monitored by a Quality Improvement Group, with regular progress updates in Learning from Deaths reports. **RESOLVED:** The Board **NOTED** the report for assurance.
81/24	**Workplace Race Equality Standard / Workforce Disability Equality Standard (WRES/WDES) Submission**
	Claire Radley, Director for People and Organisational Development presented the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2022/2023 report and action plans. The Board was informed that this was the first time the report included an accompanying action plan. The latest data on race equality within the organisation highlighted both progress and areas of concern. Positive developments included a reduction in reported experiences of discrimination and negative behaviours among staff, as well as increased perceptions of equal opportunities among ethnic minority colleagues. Furthermore, the proportion of ethnic minority staff across the organisation had grown, reflecting efforts to improve diversity. However, the data also revealed significant challenges. The likelihood of ethnic minority staff being appointed from shortlisting had declined, raising concerns about recruitment practices. Additionally, disparities in disciplinary processes persist, with ethnic minority staff remaining more likely to face disciplinary action, although the disparity was narrowing. These issues underlined the need for continued monitoring and the implementation of targeted interventions to ensure sustained progress in achieving race equality within the organisation. There had been an improvement in the number of staff declaring a disability, attributed to enhanced data collection on the electronic staff record. The board noted a decrease in reports of bullying, but these incidents remained disproportionately high among disabled colleagues. Additionally, there was an improvement in the satisfaction levels of disabled staff regarding how their work was valued. However, disabled staff continued to face challenges, including significantly lower appointment rates compared to non-disabled staff and a higher likelihood of entering capability processes. Concerns were also raised regarding the adequacy of reasonable adjustments, despite the introduction of a new policy and resources to guide managers.

Ref.	Item
81/24	**Workplace Race Equality Standard / Workforce Disability Equality Standard (WRES/WDES) Submission**
	The data highlighted the need for a cultural shift to address persistent inequities. While many initiatives were evidence-based and well-intentioned, their impact had historically been limited. Members of the Board emphasised the importance of embedding these efforts within divisional ownership, requiring divisions to take accountability for their local data, setting clear targets, and driving progress. To support this, the Associate Director of Culture had initiated divisional engagements to provide access to relevant data and establish clear expectations for monitoring and reporting. Board members stressed the importance of creating an environment where staff felt empowered to engage in difficult but constructive conversations and contribute to the co-creation of solutions. Members of the Board acknowledged the discomfort such discussions could provoke but emphasised the need to balance challenging dialogue with an inclusive approach to encourage broad participation. The board discussed the need to adopt a stronger zero-tolerance stance on unacceptable behaviours, drawing comparisons to practices in other organisations, and emphasised the urgency of addressing systemic challenges in tackling bullying, harassment, and discrimination embedded in the organisation's culture. Members highlighted the importance of combining senior leadership visibility with local ownership to build trust and drive sustainable change. The board committed to embedding accountability at all levels and fostering a culture where equality and inclusion were realised as tangible outcomes. Members expressed cautious optimism, recognising the introduction of actionable plans, divisional accountability, and leadership engagement as significant progress, with the impact of these initiatives to be evaluated through future equality data, including the next assessment in 2025. **RESOLVED:** The Board **NOTED** the Workplace Race Equality Standard / Workforce Disability Equality Standard (WRES/WDES) data and action plans.
82/24	**Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training, 1 January to 30 June 2024**
	The Chair welcomed, Dr. S Bhakthavalsala, Guardian for Safe Working to the meeting. The Board received the Guardian of Safe Working Hours report, presented by Professor Mark Pietroni. The report focused on exception reports submitted by Doctors in Training through an online mechanism reviewed by educational supervisors. It was noted that the number of exception reports had slightly decreased compared to previous years, although this reduction did not necessarily indicate improved conditions and might reflect changes in reporting behaviour. Specific issues included problems in ear, nose, and throat services due to contract time calculations, which had been resolved, and occasional reports of immediate safety concerns related to staffing shortages affecting clinical care, though no significant adverse outcomes had been identified. The report also highlighted an expenditure of £9.8 million on temporary staffing, which was noted as high but in line with industrial action and efforts to reduce agency costs. **RESOLVED:** The Board **NOTED** and **APPROVED** the Guardian of Safe Working Hours for Doctors and Dentists in Training, 1 January to 30 June 2024.

Ref.	Item
83/24	**Finance and Resources Committee Key Issues and Assurance Report**
	In the absence of Jaki Meekings Davis, Non-Executive Director and Chair of the Finance and Resources Committee, Karen Johnson, Director of Finance, provided an update on matters discussed the Trust Board Finance and Resources Committee meeting in October 2024. The Board was updated on the organisation's financial position, noting the ongoing reliance on non-recurrent savings to address the recurrent structural deficit. This remains an area requiring strategic focus and careful management to ensure long-term sustainability. An overview of fire safety concerns within the estate was provided, highlighting issues such as fire alarms, compartmentalisation, fire doors, and horizontal evacuation. While these were identified as areas requiring improvement, they were not deemed immediate critical risks. These matters have been escalated to the Trust Leadership Team, where fire safety has been prioritised as a key focus for targeted action. The update also addressed emergency planning, referencing broader safety considerations and comparisons to high-profile incidents. Assurance was provided that robust planning processes are in place, with ongoing efforts to strengthen preparedness and mitigate risks effectively. **RESOLVED:** The Board **NOTED** the report for assurance.
84/24	**Emergency Planning Response and Resilience (EPRR)**
	Al Sheward, Chief Operating Officer, presented the Emergency Preparedness, Resilience, and Response assurance report for 2024-25. The Board reviewed the report, noting the Trust's statutory responsibilities as a category one responder and its performance against 62 core standards across 11 domains. The Trust participated in the annual assurance process with the Integrated Care Board on 3 October, which resulted in a letter highlighting limited assurance, particularly concerning evacuation, shelter, and lockdown procedures. Two core standards were downgraded following a review by the Emergency Preparedness, Resilience, and Response Steering Group due to insufficient assurance in these areas. Specific concerns included the adequacy of evacuation plans for patients and the limitations of achieving a full lockdown capability due to the estate's age and complexity. Progress was acknowledged in fire safety training, with a significant increase in staff participation, and in the development of evacuation plans overseen by the Fire Safety Committee. The Board identified the need to establish clear ownership and timelines for addressing the gaps, including a review of fire safety technical standards and the introduction of additional training initiatives. A key action agreed upon was to finalise and implement a comprehensive roadmap addressing non-compliant areas, particularly evacuation and lockdown capabilities, by the end of the second quarter of 2024. The Board accepted the report as evidence of progress against statutory requirements, recognising areas of non-compliance and the need for continued monitoring and action. Discussions with the Integrated Care Board will continue to ensure these gaps are addressed effectively and in a timely manner. **RESOLVED:** The Board **NOTED** and **APPROVED** the Emergency Preparedness, Resilience, and Response assurance report for 2024-25, noting the Trust's statutory responsibilities as a category one responder.

Ref.	Item
85/24	**Any other business**
	The Chair extended thanks to Mike Weaver for his service as interim Board secretary during his final board meeting and welcomed his successor, Sarah Favell, who will formally take on the role of Board Secretary on 7 January 2025.
86/24	**Governor observations**
	Andrea Holder, Lead Governor, expressed gratitude for the privileged role of governors within the Trust, emphasising the enhanced level of involvement compared to other Foundation Trusts. She commended the quality and clarity of presentations, recognising the effort invested in making complex information accessible. Andrea acknowledged the constructive collaboration and expressed her optimism for continuing this positive approach.
87/24	**Date and time of next meeting**
	Thursday 16 January 2025, 09.00 to 12.00 Venue to be confirmed.

Report to Board of Directors meeting held in Public	
Date	16 January 2025
Title	Patient Story - Life with a Urinary Catheter
Author /Sponsoring Director/Presenter	**Authors and Presenters –** Andy, Patient Kerry Holden, Deputy Director – Infection, Prevention and Control Katherine Holland, Head of Patient Experience **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.

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

Gloucestershire Hospitals
NHS Foundation Trust

Chairs Report to Trust Board - January 2025

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. Appointment of Non-Executive Directors and Associate Non-Executive Directors

Our longest serving Non-Executive Directors, Mike Napier and Balvinder Heran both come to their end of their tenure in May 2025. They have given unstinting service to the Trust both having served as committee chairs, as well as taking on other roles such as Freedom to Speak Up and Vice Chair of the Trust. Their independence of thought and constructive input have been greatly appreciated.

We are in the process of recruiting non-executive directors to replace them and are also seeking to attract one or more associate non-executive directors In Foundation Trusts, this process is one which is led by our Governors, who have so far debated and approved the person specifications and refreshed the role descriptions. Governors will serve on the focus group for the selection day and on the appointment panel. In all appointment processes we have a keen eye on how to ensure a good mix of backgrounds and perspectives on the Board both in terms of people with protected characteristics and diversity of thought. In this particular appointment round we will be seeking to attract some applicants who live in Gloucestershire or who use Gloucestershire's health services and also those whose professional backgrounds lie outside the NHS.

Applications close on 26 January 2025 and the selection day is scheduled for 20th February.

3. Quality, safety and patient experience

The cycle of governor and non-executive director visits to our services continues. On 11th December I joined some of our Governors in a visit at Gloucestershire Royal Hospital which spanned the discharge lounge, the integrated flow hub, the Emergency department and the site management office. We were very impressed at the use of data in real time to help support flow through the hospitals and pinpoint where action was needed. The expertise of our site management team members and senior leaders was very evident.

Sam Foster, Non-Executive Director spent Monday 23rd December spent time visiting the emergency pathway with our Director of Nursing, Matt Holdaway. She

and I are due to spend the morning in Same Day Emergency care on 9th January and the afternoon visiting the Central Booking office. This visit will be with Graham Russell the chair of Gloucestershire Health and Care.

4. An anchor institution

As we review and refresh the Trust's strategy, we are reflecting on what it means to be an anchor institution. One angle on this came my way on 18th December when I was invited to host a choir from Widden School in Gloucester. The children sang a selection of Christmas songs and were rewarded by our catering team at GMS with a festive spread of snacks. I was able to chat to the children on each table and talk with them about what jobs they would like to do if they came to work in our hospitals– we had brain surgeons, heart surgeons, blood takers, cooks, porters, radiographers and physicians.

Many thanks to the colleagues who organised the visit and to Gloucestershire Managed Services for their thoughtful and genuine support.

5. British Empire Medal

It was a pleasure to learn that Asma Pandor, who is our Admiral Nurse has received the British Empire Medal for her service to people with dementia a d their families. Apart from her professional role, Asma is one of our staff governors and very much valued in this role too.

6. Appreciation

Our hospitals have been incredibly busy over the holiday period with large numbers of people with influenza. We never have a quiet period of the year, but so many colleagues will have worked harder than ever to provide treatment and care in very challenging circumstances. This is greatly appreciated.

Chief Executive Report to the Board of Directors – January 2025

1. People and Culture

1.1 Trust Nurse recognised in New Years Honours

Asma Pandor, an Admiral Nurse at Gloucestershire Hospitals NHS Foundation Trust, was awarded the British Empire Medal in the New Year's Honours for her outstanding services to nursing.

Admiral Nurses are dementia care specialists and in this vital role, Asma has made a profound and lasting impact on the lives of patients with dementia and their families. This led Asma to win the annual Trust Patient's Choice Award in 2023.

Born and raised in Gloucester, Asma trained at the University of the West of England (UWE) and returned to the county after moving to London as a newly qualified nurse. She held several key nursing positions before being appointed to the Admiral Nurse role, a joint position between Gloucestershire Hospitals NHS Foundation Trust and Dementia UK. Her extensive experience and unwavering commitment have been instrumental in enhancing dementia care within the county.

Asma's achievement stands as a testament to the transformative impact that healthcare professionals can have on their communities. It also serves as an inspiration for others in nursing to pursue excellence and compassion in their practice.

1.2 Staff Awards 2024

We came together for our annual Staff Awards at Cheltenham Racecourse at the end of November 2024, which was our biggest-ever event with more than 800 nominations for staff and services. It was a privilege to celebrate the many extraordinary people who make Gloucestershire Hospitals such a special place. The room was filled with inspiring stories of compassion, innovation and dedication.

From those on the frontline delivering outstanding care to teams working tirelessly behind the scenes, each story highlighted the impact we have on the lives of our patients and the wider community here in Gloucestershire.

It was humbling to see so many of our staff recognised for going above and beyond. There was a clear sense of energy and positivity at the event, and indeed since, and I know many people felt as I did, that it was an opportunity to reflect on the work we all do to care for others and to be part of such a talented and committed people that makes us all proud to work here.

You can find out more about the awards and see some of the winners here: https://www.gloshospitals.nhs.uk/about-us/news-media/press-releases-statements/celebrating-our-staff-awards-2024/

1.3 Staff Survey Update

The NHS Staff Survey concluded on 29th November 2024 and the Trust managed to record a completion rate of 60.74%. It is worth noting that this figure may increase slightly after NHS England verifies the responses, as they typically exclude the 'non-division' category in their calculations. While that is slightly down on last year's 68% response rate, nonetheless it does represent a good uptake.

Initial high-level results from Picker, our survey provider, were shared with the Trust in late December and are currently under analysis. These are under strict embargo to be released in March 2025.

1.4 Racism

In early December 2024 I had the opportunity to build on a conversation that I had with colleagues that was part of the Black History Month conference in October. At that conference colleagues shared deeply personal stories about equality, inclusion, and the profound impact of racism on their lives – both in work and outside of it.

These stories were eye-opening and put into sharp focus the need for greater attention on what we are doing to support all colleagues to feel welcome and supported in our Trust.

We used the time together to help turn the conversation into a focus for action. A chance for us all to share ideas for how we address these issues and break down the barriers that are getting in the way. Issues discussed included our key HR policies (which are currently being re-written), recruitment practices, what visible leadership looks like, training and development for staff and what accountability looks and feels like when it comes to equality, diversity and inclusion (EDI).

It was an incredibly important session and I am grateful for colleagues who gave up their time to share their views and for those who have stepped forward to help us take forward those ideas to help shape a clear plan.

I made a promise to follow up on these conversations, so we will be taking the work we do to our Trust Leadership Team (Executive Directors, Deputies and Divisional Leadership Teams) at the end of January for input before bringing colleagues I met with recently back together in early February to develop our plan.

The meeting also follows my attendance in November of the Disability Awareness Month launch and heard stories about how our systems and processes are getting in the way of colleagues with a disability being able to access the right support. Again, something I have committed us to sorting swiftly.

Developing a culture where every individual feels valued and heard, where everyone has the opportunity to reach their full potential is a very personal goal not only for me but also the wider Board and work is under way to outline a programme of Board

development work on EDI for 2025-2026.

1.5 Pride in Place

Pride in Place is an initiative that the Trust piloted in the autumn with the aim of restoring pride in the workplace as well as making positive changes to create an improved, more attractive and more organised environment for our staff and patients. We want our working environment to reflect the care we provide and to help create this we are providing support to make positive changes with the following aims:

- Clearing clutter: We have been removing items from clinical / non-clinical areas that are overstocked, damaged, not fit-for-purpose, not in the correct location, not needed and / or surplus to requirements.
- Reporting of maintenance tasks: Having a clear and responsive reporting line for repairs such as damage on walls, doors, skirting, frames, windows, etc.
- Removal of old Signage – removal of any old, damaged, unwarranted signage/posters.

The pilot focused on Alexander House, Cheltenham General Hospital, Beacon House and Gallery Ward 1, Gloucestershire Royal Hospital. Successes included:

- 522 items registered to be removed, re-used or recycled. That's 2.5 shipping containers of items that would otherwise be cluttering up areas of the hospitals.
- In Gloucester we re-used 157 items, 139 recycled/disposed items and stored 5 items.
- In Cheltenham we re-used 114 items, 105 recycled/disposed items and stored 2 items.

While the pilot has had a positive impact it also highlighted areas of work for further development as the Trust now looks to roll-out and embed these ways of working more broadly as part of business as normal.

Key areas to develop include better staff engagement as well as further strengthening of processes and systems for raising and following through on 'small jobs' e.g. minor repairs. The programme team is exploring how to conduct regular audits (Patient-Led Assessment of the Care Environment), build in best practice as part of business as usual and how to take this initiative to the next level.

2 Performance

2.1 Urgent and Emergency Care

Like many hospitals across the country, we experienced significant additional pressures due to flu and norovirus over the festive period and in the new year. At the time of writing this report these pressures continued. The media has described this as part of the "quad-demic of winter viruses" alongside Flu, COVID-19 and RSV.

These viruses are particularly challenging for our most vulnerable patients, including the very old and very young and of course contribute to staff sickness at the same

time. Compared to the last winter season, we have a seen a much sharper and earlier spike in flu cases in December and into early January which has contributed significantly to the pressures we have been dealing with.

In November and into early/mid-December, the Trust had been making strong progress in reducing ambulance handover delays. Comparing performance for November this year to 2023, we saw a reduction in ambulance handover time by c40minutes which is a material different compared to last year where we were a significant outlier and a significant reduction in the number of delays over four hours.

However, pressures continued to build on the lead up to Christmas and over that period we saw an increase in ambulances arriving by an average of 5 a day with more patients coming to hospital for respiratory issues. This was in addition to an extra 46 patients (average) arriving by their own accord each day during December this year compared to last year.

These issues were also compounded by the growth in the number of patients who remain in hospital but who should be cared for either at home or in other settings. As at 7th January, 24% of Trust beds were occupied by Non-Criteria to Reside (NCTR) patients and the issue of low discharges has been subject to significant system-wide discussion to seek alternatives to reduce the risk in terms of demand at the front door.

As ever, resolving these issues requires a whole team effort not just within the Trust but with partners to and so the focus remains on resetting back to where we had seen positive progress through November and into early December. A more contemporaneous update will be provided verbally at the meeting.

2.2 Elective (Planned) Care

Within elective care GHFT continues to make strong progress in the elimination of 65-week breaches for Referral to Treatment (RTT) patients. Performance is split into two groups; patients who are able to receive treatment and those who cannot due to national shortages of equipment or materials that are essential to treatment.

In November the month ended with 12 breaches (11 Corneal graft patients unable to receive treatment due to a national shortage and 1 ENT patients who was unwell on the day of planned surgery). In December performance improved further, with GHFT finishing the month with 10 breaches (9 corneal graft patients and 1 orthopaedic patient who were all unable to be treated due to national material and equipment shortages). Organisationally we are measured against those who are able to be treated in month, meaning December has achieved a 0-breach performance.

The next improvement focus will be on eliminating patients waiting over 52 weeks for treatment by March 2024. Progress continues to deliver a reduction in month end patients waiting; reducing from 1,615 in October to 1,481 in November. Specialties continue to work hard in offering additional outpatient clinics and operating lists throughout January to March in order to accelerate treatments, whilst also redesigning referral pathways to avoid unnecessary referrals into the trust from primary care.

Many Board members will have seen in the press at the beginning of January a clear steer from the Government on its priorities for the NHS during the course of the next year and beyond – particularly with regards to reducing waiting lists and getting back to the 18 week wait standard by the end of this parliament (March 2029) and for every Trust to deliver a minimum 5% improvement in referral to treatment performance by March 2026 to contribute to achieving the 65% goal nationally. Assurance on how this will be achieved will come through the Annual Plan submission which this Board will be required to assure itself against.

To achieve these aims more generally, the government will be focussing on patient choice including the use of alternative providers, expanding the use of Patient Initiated Follow Ups (PIFU), increased access to diagnostic tests seven days a week, and greater use of the NHS App to help patients manage appointments and access themselves.

3. Quality & Performance

3.1 Care Quality Commission (CQC): Maternity report

At the time of writing this report the CQC was planning to publish its latest maternity report on Friday 10 January 2025. The delayed publication of the report, which followed an unannounced inspection in March 2024, has resulted in the service retaining an 'inadequate' rating and a Section 31 notice – the later having been issued to the Trust at that time. The full report will be available on the CQC's website.

Since the inspection 9 months ago the team has been meeting fortnightly with regulators as part of a system Quality Improvement Group, which oversees progress against the Section 31 improvement notice, and significant progress has already been made in addressing many of the issues.

Examples of good progress, which the Board will be aware of through the regular reporting process directly and through the Quality and Performance Committee include:

- Clinical practice: The formation of clinically-led quality improvement teams who are driving up standards of care in their areas of work, for example, clinical observations of mums and improvements across postpartum haemorrhage. The rates of postpartum haemorrhage have now dropped to below national average.
- Material reduction in delays to screening.
- Governance: Strengthening of management systems and processes across maternity so that teams consistently deliver best practice care and maximise learning from clinical learning
- Staff training: A 100% compliance record of induction training among agency staff meaning all agency midwives have working knowledge and access to systems meaning safer care for mums and their babies.
- Staff recruitment: Staffing numbers have improved despite a national shortage of key skills and good recruitment is strong. We have developed additional

'pipelines' of students including working with new University partners such as Oxford Brooks
- There are regular safety walkabouts led by the Chief Nurse and Director of Midwifery across the maternity service in their roles as safety champions.

Across maternity the following practice at GRH was identified for praise in the report:

- A public survey, CQC's National Maternity Survey based on women's views in Feb 2024, showed that over 85% of people who used the service had a positive experience.
- Staffing numbers had improved and newly recruited staff were positive about the support they received.
- Staff know how to report incidents and felt confident to raise concerns with their line manager or freedom to speak up manager.
- Staff were positive about the support provided by the Practice Development Midwives particularly for internationally recruited and newly qualified midwives.
- Staff were also positive about the newly introduced role of 'Flow Midwife' who reviewed staffing and activity levels across the unit.
- Staff were provided opportunities to develop their roles and advance their skills.

Inspectors identified the following practice for improvement:

- The CQC remained concerned about how the trust managed systems to identify risks to mothers, babies and people using the service.
- Some people told inspectors that they didn't always feel safe in the department.
- Learning from previous incidents didn't result in changes that would improve care.
- Staff felt there wasn't a proactive safety culture. While some felt they hadn't been supported after raising concerns and were reluctant to do so again as a result.

The Trust expects the CQC to re-inspect the service in the near future and will be working with colleagues and partners to obtain an improved overall rating.

Like other Trusts, we continue to experience significant delays in terms of receiving reports following inspections from the CQC. The last unannounced inspection took place on 16-18 July 2024 at Cheltenham General Hospital for Medical Services including Oncology. The Trust awaits the inspection report.

The Trust has recently received the draft CQC reports for factual accuracy checking for the unannounced inspection of the Emergency Department at GRH (December 2023). In due course they will confirm a timeline for publication.

3.2 Maternity update

The seven Gloucestershire Members of Parliament wrote a joint letter to Gloucestershire Hospitals NHS Foundation Trust and NHS Gloucestershire. The letter reinforced their support for local maternity services; which was highlighted in the parliamentary debate held on 9 October 2024. The MPs have also asked for an update on progress for recruitment and retention, and on the Aveta Birth Unit in Cheltenham and post-natal beds in Stroud.

The Trust remains committed to providing safe and high-quality maternity care across all services in Gloucestershire and is actively working with key partners, including the Stroud League of Friends, Stroud Motherhood Collective, and other community groups, to explore solutions for promoting maternity services and support groups within the community.

A collaborative meeting was held in Stroud in late November to explore ideas, and this included a focus on promoting the hospital's existing maternity support services, available daily from 8:00 AM to 8:00 PM, which provide general one-on-one support, including feeding and bathing assistance, which is used by around 50 people each month.

There was also agreement on strengthening and widening the existing diverse range of community support groups, including: Pregnancy Yoga; Mum and Baby Yoga; MamaSings; New Mothers Wellbeing Circle; Infant Sleep Support Group; Mothers Sharing Circle and Baby Massage Group. There is also work underway to explore the potential to introduce more groups, including peer support for Dads; support around baby loss and support for birth trauma.

A community survey will be shared in January 2025 to capture the views and help ensure the work reflects what matters most to local families and professionals.

4. Strategy

4.1 Medical Day Unit (MDU)

Christmas Eve marked a fresh chapter for Cheltenham General Hospital’s Medical Day Unit (MDU) after it opened in its new home on Oakley Ward, Centre Block, and I had the privilege of cutting the ceremonial ribbon declaring the unit open. It has relocated from its previous site near A&E.

The MDU provides vital intravenous (IV) therapies for conditions such as multiple sclerosis, rheumatoid arthritis, inflammatory bowel disease, osteoporosis, iron deficiency anaemia, asthma and renal issues. Many patients attend regularly for IV infusions while others complete their course of treatment after being discharged from hospital.

The new MDU not only provides a modern, welcoming environment but also enhances patient safety. The bright, open space allows us to accommodate 14 recliner chairs - two more than before - while ensuring staff can observe all patients easily. This greater capacity helps us treat more people and reduce costly hospital admissions, freeing up acute care beds.

The new location has been completely refurbished to meet modern healthcare standards. While it is housed in one of the hospital’s oldest areas, the wide, traditional Nightingale-style layout offers advantages over the previous cramped unit. Patients had raised concerns about privacy and dignity in the former location and these have been addressed in the design of the new space.

The move marks another milestone in Cheltenham General Hospital's ongoing work to improve care quality and patient experience, offering an environment where individuals can feel supported and respected as they undergo treatment.

4.2 Gastrointestinal (GI) reconfiguration

The Gloucestershire health system undertook extensive public consultation in 2020 and again between 2022 and 2023 on shaping the future of local hospital services.

This programme of work, called Fit for the Future (FFTF), focused on strengthening 11 specialist services across our two main hospital sites: Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). In doing so this would ensure that highly specialist care would be provided to more patients, waiting times would be lower, patient experience would be improved and patient outcomes would be better.

To date nine of these 11 service improvements have been completed and we are well on track to complete the remaining two in the early part of this year (2025). Work currently underway to complete this programme are the reconfiguration of Gastrointestinal (GI) Services at CGH and GRH, due to take place in March, and the final stages of establishing an Image Guided Interventional Surgery (IGIS) hub at GRH and satellite at CGH.

Under the reconfiguration of GI Surgery, which was part of the FFTF public consultation in 2020, the following work will be undertaken:

- The transfer of c1500 short stay and day case general surgery patients to Cheltenham General Hospital (CGH) from Gloucestershire Royal Hospital (GRH).
- The creation of specialised centres at CGH for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer.
- *Co-location of all resectional Upper Gastrointestinal Surgery at GRH.
- Co-location of all resectional Colorectal resectional surgery at GRH.

*The co-location of all resectional Upper Gastrointestinal Surgery to GRH has already been completed.

The benefits of developing services in this way means:

- Patients are more likely to see the right specialist, first time, 24/7 and have the best possible outcome and experience of care.
- There is more robust staff cover (and rotas) for the service (consultants and junior doctors) and better supervision of junior doctors 24/7.
- There are fewer cancelled or delayed operations.

In developing services in this way Cheltenham General Hospital will benefit from:

- The establishment of four specialised centres for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer and the transfer of approximately 1500 short stay

and day case GI patients from GRH means Cheltenham General will treat more patients.
- Many of these patients being transferred from Gloucester to Cheltenham will be cared for in Chedworth Surgical Unit, a modern, purpose-built facility costing £7.9m and dedicated to the needs of patients which opened in 2023.

In developing services in this way Gloucestershire Royal Hospital will continue to benefit from:

- The co-location of resectional Upper Gastrointestinal Surgery will continue at GRH where it is aligned with Emergency GI and forms a longstanding Three Counties Oesophagogastric surgery centre.

4.3 Trust Strategy

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

Work is now well underway to involve staff, partners and communities in shaping a new Trust Strategy that will guide us and unite us in the work we do together every day. To date we have held over 40 staff sessions, listening to more than 550 people and we have also begun work with Inclusion Gloucestershire and Healthwatch to start our public and community engagement. We would also like Governors to support us, and an engagement programme has been shared.

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

We want all staff, patients and communities to help shape our strategy and we want to capture ideas and understand what matters most about our hospitals and acute services.

5 National issues

5.1 Physician Associates (PAs) and Anaesthesia Associates (AAs)

The Secretary of State for Health and Social Care, Wes Streeting, announced an independent review of Physician Associates (PAs) and Anaesthesia Associates (AAs) and alongside General Medical Council (GMC) regulation of these roles from 13 December 2024.

The review, to be chaired by Professor Gillian Leng, will report by the spring and will explore how to continue to provide patient safety, better care, and improved access and, provide clarity to the roles of PAs and AAs.

Our hospitals employ a number of PAs who come to work every day wanting to do their best for patients, just like any other staff member and are valued members of the NHS team who deserve support, care and respect.

It is important to acknowledge that many colleagues carrying out these roles are facing a difficult time, and in particular have been distressed at some of the commentary on social media.

From 13 December 2024 the General Medical Council (GMC) began to regulate AA and PA roles which will strengthen patient safety, professional standards and accountability.

Although PAs and AAs are not legally required to register until December 2026, they are being encouraged to apply as soon as they are invited to by the GMC. The 2-year transition period, specified in legislation, is designed to allow PAs and AAs to complete the necessary steps for registration while continuing to work.

Kevin McNamara
Chief Executive

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – DECEMBER 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 was reminded of the limited assurance in the annual head of internal audit opinion. The reasons for these have been well rehearsed and it remains a high priority for the work of the Committee for the remainder of this year 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 we remain consistent in our delivery against management actions and show similar vigilance against follow up actions.

The Chair updated the Committee on the H&S discussion at the recent PODC meeting and the Committee reflected on oversight of this. It is currently a work in progress with PODC maintaining responsibility at present. It is likely to be the subject of a future NED conversation to ensure that there is clarity around where responsibility lies and is ultimately discharged. It was agreed that this would be beneficial given some changes in NED and Exec membership since this was last considered.

The planned appraisal audit has had to be slipped to 25/26 audit plan. Whilst this is disappointing it was necessary to accommodate a nationally imposed workforce controls audit. The HR team have undertaken a self-assessment around appraisals which was helpful and reflective and the Committee welcomed having sight of this and to see that there has been some scrutiny albeit not the fully independent assurance that will be obtained from BDO in due course.

The Committee also approved updates to the Scheme of Delegations, Standing Financial Instructions and Standing Orders

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	Procurement and contract management – Design moderate, effectiveness limited. Some disappointing findings to this but overall, a very helpful review with effective management responses. Rated as amber given the rating of effectiveness as limited.	Ensure delivery against agreed outcomes in the management responses.
	Mental capacity Act audit – Overall limited assurance assessment for design and operational effectiveness. This review was requested by management into an area that was causing them some concern. The review was very helpful, reflective and well received by both management and the Committee. The Trust holds significant deprivation of liberty powers and it is very important to ensure that these are being used proportionately. Follow up work will ultimately come back to Audit and Assurance.	Will be followed up according to the agreed schedule and Vulnerable People Group and Q&P will monitor regularly

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.

	However, the Vulnerable People Group and Q&P will receive more regular updates on the implementation of the findings and lessons learned.	
	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	**Board Assurance Framework** Very helpful cover paper with this report. Committee commented on the very useful summary. Recognition that the report is a work in progress but very much moving in the right direction. The report is a fair reflection of the current ongoing issues and the work ongoing through the various Committees to address.	Continued sustained scrutiny and focus through the various Committees of the Board on the items highlighted.
	Risk register position noted. H&S has been highlighted elsewhere in this report and is likely to feature as part of the work ongoing around sponsorship of risk. New risks around reduced foetal movement and anaesthetic practitioners were agreed as appropriate for escalation	Committee will receive an update on proposed revised ways of working at its next meeting.
GMS	The Committee received an audit on portering which was moderate by design and effectiveness. Positive feedback around progress, recommendations and learning. The GMS management confirmed the value of the report	Deliver against the agreed management actions

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.		
External Audit brief verbal report which confirmed that Charity A/Cs have been signed off, GMS to be completed shortly and the year-end plan will be received at the February meeting.		
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.		
Trust seal – Committee noted the use of the seal in respect of the novation of the Aviva Contract previously approved by the Board at its meeting in September		
Single tender actions report – two waivers, one with a total value of £35K, the second with a value of £9.8M (Trust to Trust, Wye Valley), both with accompanying justifications		
Losses and compensations – £5.3K of ex – gratia payments made and approved write off of invoice totalling £11K.		

Report to Board of Directors meeting held in Public	
Date	Thursday 16 January 2025
Title	Scheme of Delegation, Standing Financial Instructions, Standing Orders review 2024
Author	Michael Weaver, Interim Trust Secretary Steve Perkins, Director of Operational Finance Edward Taylor, Head of Procurement
Sponsoring Director/Presenter	Karen Johnson, Director of Finance and Kerry Rogers, Director of Integrated Governance.

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

Summary of Report

Regularly reviewing the Trust's Scheme of Delegation, Standing Financial Instructions, and Standing Orders is essential to ensure governance frameworks remain effective and aligned with current legislation, regulatory requirements, and organisational objectives. These documents define the delegation of authority, financial control, and operational procedures, ensuring transparency, accountability, and compliance with NHS guidelines. Regular updates allow the Trust to adapt to changes in healthcare policies, financial management standards, and procurement regulations, reducing risks of mismanagement, non-compliance, or inefficiency. Such reviews also ensure that decision-making structures are fit for purpose, promoting effective resource allocation and safeguarding public funds Key changes in each document are highlighted in blue text and summarised in the following tables.

Schedule of decisions reserved for the Board and the Scheme of Delegation

Page	Section / Ref.	Summary of changes
4	1.4	Clarified arrangements for the delegation of powers in the absence of an officer, director of Chief Executive as per Model Standing Orders.
7	3.2	Updated to reference NHS England or the Secretary of State.
9	7.2	Updated to reference NHS England
10	8.14	Updated to reference to Trust Finance and Resources Committee
14	Gloucester Managed Services	Removed text highlighted in blue, there are no Trust Directors that are also directors of Gloucester Managed Services.
19	8.7.2	Updated to reference NHS England
24	3.1.1 and 3.1.2	Section re-numbered
25	4.2.1 and 4.3.2	Added additional text regarding budget holder responsibilities
28	9.2.2	Updated to reference Workforce Impact Group
28	9.3.1	Updated to reference Workforce Impact Group

Schedule of decisions reserved for the Board and the Scheme of Delegation

Page	Section / Ref.	Summary of changes
30	11	Treasury Management Section renumbered.
30	11	Added reference to Investments and Cash Flow Monitoring
30	11.3.1	Updated to reference to Trust Finance and Resources Committee
32	14.1.2	Updated to reference responsibilities of Director of Finance
33	16.3	Updated to reference Chief Nurse
33	18	Updated section on acceptance of gifts and other benefits in kind by staff
33	20.1	Updated to reference Risk Management Strategy
33	20.4	Updated to reference NHS Resolution.
35	1.4	Financial Delegation Limits. addition of text references Provider Selection Regime and IFRS16.
35	a.	Delegated authority limits associated with tendering (SFI 8.5) reference to Trust Expenditure Controls and approval by NHS England for requests exceeding £50k.
20	9.22	Updated to reference Workforce Impact Group.
21	9.23	Added, Budget Holders are responsible for operating within their funded establishments.
22	9.5.1	Updated to reference Director for People and Organisational Development.
25	10.2.6 a.	Additional text, All contracts should be assessed for the impact of IFRS16 before agreement, and where contracts are for the provision of services, they should be consistent with the provider selection regime.

Schedule of decisions reserved for the Board and the Scheme of Delegation

Gloucestershire Managed Services Schedule of Matters Reserved and Delegated[1]

Page	Ref.	RM.	Summary of changes
10	8.15	23	Additional text from GMS 'for fees and costs exceeding £50,000)
10	8.16	28	Additional text from GMS 'which substantially differs from the purpose of the OHFA.
10	8.17	32	Approval to acquire or to dispose of assets with a value exceeding £1,000,000.
10	8.21	43	Original text in Trust SoRD - '*Enter into or to renew a contract or series of connected revenue or capital contracts within their financial allocation for any material for consideration payable being in excess of £5,0000,000; or consideration receivable represents on average in excess of £5,0000,000; per annum'.* GMS Text - *GMS to enter into or to renew a contract or series of connected revenue or capital contracts, through a compliant route to market, for any material for consideration payable being in excess of £5,000,000)*

[1] Vn.5 of the Gloucestershire Managed Services Schedule of Matters Reserved and Delegated relating to GMS following GMS Board, Finance and Resources Committee and Trust Board respective approvals in July and September 2023

Schedule of decisions reserved for the Board and the Scheme of Delegation

Gloucestershire Managed Services Schedule of Matters Reserved and Delegated

Page	Ref.	RM.	Summary of changes
11	8.24	49	Original text in Trust SoRD, Reserved to the Board – '*Approval of staffing establishment and structure that could adversely affect services provided to a client or have significant impact on the staffing structure (e.g. redundancies)'.* GMS Text, Reserved to Trust Finance and Resources Committee - *Approval of staffing establishment and structure that could adversely affect services provided to the Trust or have significant impact on the staffing structure not within the approved plan for the year (e.g., redundancies) **
11	8.25	51	Original text in Trust SoRD – '*Approval of frameworks to terms and conditions, excluding non-contractual policies, for employees who transfer from the Trust to GMS'* GMS Text, '*Approval of changes to terms and conditions, (excluding non-contractual policies), for employees who transfer from the Trust to GM'.*

Standing Financial Instructions

Page	Section / Ref.	Summary of changes
39	5.6	Additional text, Prior to entering into a contract for the provision of services budget holders must ensure that any process has been reviewed in line with the "Provider Selection Regime" and that it has been considered for the impacts of IFRS16.
39	16, 16.1	Additional text, Prior to entering into a contract for the provision of services budget holders must ensure that any process has been reviewed in line with the "Provider Selection Regime" and that it has been considered for the impacts of IFRS16.
39	Appendix 1, 18, 18.1 and 18.2	Additional text, Research and Innovation Applications.
39	Appendix 1, 19, 19.1	Additional text, Intellectual Property.
40	Appendix 1, 20, 20.1, 20.2 and 20.3	Additional text, On-Call and Out-of-Hours Decision Making.

Standing Orders

Page	Section / Ref.	Summary of changes
6	3.36	Updated to reference NHS England.
8	5.1 and 5.2	Updated to reference NHS England.
8	5.8	Updated to reference Trust Board Committees
9	6.4	Updated to reference NHS England.
10	6.9	Updated to reference Director of Integrated Governance.
11	8. 8.2 to 8.6	Tendering and Contract Procedure, summary of additional text: • UK procurement legislation applies to all contracts, including advertising and award requirements, as if part of the Standing Orders. • The Trust must comply, where practicable, with the NHS Executive "Capital Investment Manual" and Cabinet Office/NHS England spend controls. • Competitive tenders or quotations are required for goods, services, and works, except for spending under £10,000, with safeguards against disaggregating spending to avoid competition. • The Director of Finance maintains a list of applicable exemptions for waiving competition. • Procurement legislation dictates how total contract value is calculated, requiring review for continuous spending or disaggregation to ensure compliance. • Modifications to contracts below the threshold must be reported to Procurement, and additional governance rules apply if the value exceeds the threshold.
13	8, 8.12 to 8.14	Tendering and Contract Procedure, summary of additional text: • Tendering procedures are outlined in Annex A. • Pre-Market Engagement with suppliers must be conducted fairly, without giving any supplier an advantage, and an audit record must be maintained. • Procurement objectives, non-discrimination requirements, and conflict of interest rules apply to pre-market engagement. • Examples of pre-market engagement include detailed conversations, event attendance, and seeking proposals. • Staff engaging in Pre-Market Engagement should consult Procurement for advice. • Quotations are required for expenditure expected to exceed £10,000 but less than £50,000 (excluding VAT).
14	8, 8.23 to 8.26	Tendering and Contract Procedure, summary of additional text: • The Trust aims to achieve best value for money in all contracts. • A contract manager must be named at the point of contract award to ensure performance levels are met and value for money is maintained. • Planned contract amendments or changes to the contract manager must be reviewed by Procurement for compliance with legislation and updates to the contract register. • The Chief Executive will delegate officers with authority to enter contracts for staff employment, regrading, and the hiring of agency or temporary staff, following NHS Agency Rules.

Standing Orders

Page	Section / Ref.	Summary of changes
15	8.30.3.1 and 8.30.3.2	Additional text relating to the Bribery Act.
17	13.1	Updated to reference NHS England.
18	2, 2.3 and 3, 3.1 to 3.4 and 4, 4.1 to 4.9.	Receipt, Safe Custody and Record of Formal Tenders, summary of additional text: • For tenders received outside the E-Tendering system, the Chief Executive designates non-originating department officers to handle tenders and ensure their security until opening. • Tenders not submitted through the E-Tendering system must be opened by two senior officers, designated by the Chief Executive, not from the originating department. • A permanent record must be maintained for each set of tenders, detailing invited firms, received tenders, prices, and key dates/times, with records signed or electronically stored. • Electronic tendering packages automatically log all procurement actions and clarify tender alterations in writing to maintain an audit trail. • When considering tenders, designated officers assess value for money and competition; in case of doubt, they consult the Chief Executive. • Late tenders may only be considered under exceptional circumstances, as determined by the Chief Executive or nominated officer, and must be reported to the Board if accepted. • When only one tender is received, the Trust must ensure the price is fair and reasonable. • For contracts with a fluctuation clause, price variation requests must be submitted in writing and approved by the Chief Executive or nominated officer.
27	5, 5.1 TO 5.2	Additional text relating to approved firms for building and engineering works.
27	6, 6.1	Additional text relating to Conflicts of interest.

Report previously considered

- Trust Board Finance and Resources Committee meeting Thursday 31 October 2024.
- Trust Board Audit and Assurance Committee meeting Tuesday 3 December 2024.

Recommendation

The Board is asked to:

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

Enclosures

Scheme of Delegation, Standing Financial Instructions, Standing Orders

Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS

NHS FOUNDATION TRUST

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

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following January 2019 Audit and Assurance Committee feedback
1.0	Lukasz Bohdan	14-02-2019	Version approved by the Trust Board at its 14 February 2019 meeting with the exception of Section 3.2 'Estates Committee'
1.1	Cecilia Price & Lukasz Bohdan	31-05-2019	Amendments made following February 2019 Board feedback and changes to Committee ToRs
1.2	Lukasz Bohdan	Aug 2019	Version approved by the Trust Board at its June 2019 meeting
1.3	Lukasz Bohdan	Aug 2019	Amendments made to Director of Corporate Governance - August
1.4	Sim Forman	April 2020	Review
1.5	Karen Johnson, Steve Perkins, Kat Cleverley, Alex Gent	November 2022	Review
1.6	Steve Perkins Edward Taylor Michael Weaver	October 2024	

Contents

1 Introduction

1.1 Reservation of powers

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

1.2 Role of the Chief Executive

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

1.3 Caution of the use of delegated powers

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

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

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

1.5 Review and awareness of delegated powers

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

2 Schedule of Decisions Reserved to the Board

No	Decision	Reserved to the Board	Or authority delegated to:	Ref.[1]
General Enabling Provision				
1.	The Board of Directors may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.	√		
4.	**Regulation and Control**			
1.1	Approve Standing Orders (SOs) and Reservation of Powers to the Board.	√		
1.2	Suspend SOs, subject to SOs 3.30-3.34.	√		SOs 3.30-3.34
1.3	Amend SOs, subject to SO 3.3.5.	√		SO 3.3.5.
1.4	Approve Standing Financial Instructions (SFIs), including Financial Delegation Limits.	√		
1.5	Ratify the exercise of powers, which the Board has retained to itself, by the Chief Executive and the Chair in emergency, subject to SO 4.2.	√		SO 4.2.
1.6	Approve a scheme of delegation of executive powers from the Board of Directors to committees or sub-committees, which it has formally constituted, and authorise the delegation of a committee's executive powers to a sub-committee.	√		SO 4.4 SO 5.5
1.7	Require and receive the declaration of Directors' interests that may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration in accordance paragraph 11 of the Constitution.	√		
1.8	Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on such reports.	√		

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

No	Decision	Reserved to the Board	Or authority delegated to:	Ref.
1.	**Regulation and Control**			
1.9	Confirm or otherwise the recommendations of the Trust's committees where the committees do not have executive powers	√		
1.10	Establish terms of reference and reporting arrangements of all committees that are established by the Board of Directors.	√		
1.11	Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.	√		
1.12	Authorise the use of the seal and agree a policy to define those documents that must be sealed.	√		SFI 17.1 SO 2.2 C 19.1 SO 11.2
1.13	Ensure the quality and safety of healthcare services, education, training and research delivered by the NHS Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, the CQC, and other relevant NHS bodies.	√		
2.	**Appointments/ Dismissal**			
2.1	Appoint one of the independent Non-Executive Directors to be the Senior Independent Director in consultation with the Council of Governors.	√		C 9.7
2.2	Approve the appointments to each of the committees, which it has formally constituted, and approve the terms of such appointments.	√		SO 5.6
2.3	Confirm appointment of members of any committee of the Trust as representatives on outside bodies.	√		SO 5.6
2.4	Approve proposals of the Remuneration Committee regarding the remuneration and terms of service of Directors.	√		SFIs 9.1.3 & 9.1.4

No	Decision	Reserved to the Board	Or authority delegated to:	Ref.
3.	**Strategy, Plans and Budgets**			
3.1	Define the strategic aims and objectives of the Trust each year.	√		SFI 1.3.1
3.2	Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by NHS England or the Secretary of State.	√		
3.3	Approve and monitor the Trust's risk management strategy.	√		SFI 20.1
3.4	Approve the Trust's financial plan and annual budget.	√		
3.5	Approve the Trust's capital programme.	√		SFI 4.1.5
3.6	Approve annually the Trust's Operational Plan.	√		
3.7	Approve Private Finance Initiative proposals (subject to any guidance issued by the Regulator).	√		
3.8	Approve the opening of bank or investment accounts.	√		
3.9	Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, over £5,000,000.	√		SFI A1.5.2
3.10	Approve capital expenditure, business cases and PFI schemes, including approval of variations, amounting to over £1,000,000.	√		
3.11	Approve of increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves where the increase is >10% of the value in the agreed financial plan.	√		SFI A1.1.3
3.12	Approve purchase orders amounting to over £500,000.	√		SFI A1.3

No	Decision	Reserved to the Board	Or authority delegated to:	Ref.
3.	**Strategy, Plans and Budgets**			
3.13	Approve participation in a tendering exercise where retaining a service provided by the Trust amounts to over £50,000,000 and where acquiring a new service amounts to over £25,000,000.	√		SFI 8.5
3.14	Approve individual compensation payments.	√		SFI 2.1.1
3.15	Approve the level of non-pay expenditure on an annual basis.	√		SFI 10.1.1
3.16	Approve long term and short-term borrowing facilities.	√		SFI 11.1
4.	**Policy Determination**			
4.1	Determine insurance policy.	√		
5.	**Audit**			
5.1	To provide feedback to Governors to inform the appointment (and, where necessary, dismissal) of the External Auditor.	√		
5.2	Approve the appointment (and where necessary, dismissal) of the Internal Auditors.	√		
5.3	Receive reports of the Audit and Assurance Committee meetings, highlighting significant internal and external audit issues, and take appropriate action.	√		
5.4	Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice of the Audit and Assurance Committee where appropriate	√		
6.	**Annual Reports and Accounts**			
6.1	Approve the Trust's Annual Report, the Quality Account and Annual Accounts.	√		
7.	**Monitoring**			
7.1	Receive Board Assurance Framework reports and reports from committees in respect of their exercise of powers delegated such as the Board of Directors sees fit.	√		

No	Decision	Reserved to the Board	Or authority delegated to:	Ref.
7.	**Monitoring**			
7.2	Continuous appraisal of the affairs of the Trust by means of the provision of information to the Board as the Board may require from Directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS England shall be reported, at least in summary, to the Board of Directors.	√		
7.3	Receive reports on all aspects of the Trust's performance, and particularly those covering performance against budget, financial plans, performance improvement plans, internal or national targets, and measures of activity and quality.	√		
8.	**Matters concerning Gloucestershire Managed Services**			
8.1	Responsibilities of the Trust as shareholder of GMS as defined in company law.	√		
8.2	Admission of additional shareholders for Gloucestershire Managed Services (GMS)	√		
8.3	Approval to issue any shares in GMS or grant any options or other right to subscribe for shares in GMS.	√		
8.4	Approval to consolidate, sub-divide, convert, cancel, reduce, redesignate, purchase or redeem any share capital of GMS.	√		
8.5	Approval of any change to the registered or trading name(s) of GMS, or to its brand.	√		
8.6	Approval to change the location of GMS' registered office or its principal place of business.	√		
8.7	Engage, carry on or establish any business outside of the United Kingdom or provide for the payment of any monies other than in good faith for the purposes of or in connection with the carrying on of such business outside of England and Wales.	√		
8.8	Dissolution of GMS	√		

No	Decision	Reserved to the Board	Or authority delegated to:	Ref.
8.	**Matters concerning Gloucestershire Managed Services**			
8.9	Approval and amendment of GMS' articles of association.	√		
8.10	Appointment and removal of directors and the company secretary for GMS.	√		
8.11	Appointment of a director to act as Chair of the GMS Board of Directors.	√		
8.12	Approval of the terms and conditions of appointment for directors and the company secretary of GMS.	√		
8.13	Approval of the GMS' schedule of matters reserved and delegated.	√		
8.14	Approval of the membership and responsibilities of the Trust Finance and Resources Committee.	√		
8.15	Oversight and approval to issue, defend or settle any litigation, claim or other legal proceedings (other than actions to recover debts in the ordinary course of business) for fees	√ (for fees and costs exceeding £50,000)		
8.16	Change the nature of GMS' business or commence any new business which is not ancillary or incidental to the business (otherwise than in accordance with approved business plan) which substantially differs from the purpose of the OHFA.	√		
8.17	Approval to acquire or to dispose of assets with a value exceeding £1,000,000,	√		
	Enter into a loan agreement with GMS on behalf of the Trust, including any mortgage or other charge		√ FRC	
8.18	Enter into a loan agreement with another lender, on behalf of GMS, including any mortgage or other charge with a value exceeding £1,000,000.	√		
8.19	Approval to create issue or allow to come into being any encumbrance over the whole or any part of the undertaking or assets of GMS (save for charges arising by operation of law in the ordinary course of business or under retention of title covenants with suppliers to GMS).	√		
8.20	Approval to make any capital distributions or dividend distributions.	√		

8.21	GMS to enter into or to renew a contract or series of connected revenue or capital contracts, through a compliant route to market, for any material for consideration payable	√ (being in excess of £5,000,000)		

No	Decision	Reserved to the Board	Or authority delegated to:	Ref.
8.	**Matters concerning Gloucestershire Managed Services**			
8.22	Approval of capital transactions or contracts not within the approved Trust capital plan for the year.	√		
8.23	Providing parent company guarantees for new GMS contracts.	√		
8.24	Approval of staffing establishment and structure that could adversely affect services provided to the Trust or have significant impact on the staffing structure not within the approved plan for the year (e.g., redundancies		√ Trust Finance and Resources Committee	
8.25	Approval of changes to terms and conditions, (excluding non-contractual policies), for employees who transfer from the Trust to GMS.	√		
8.26	Approval of pension scheme arrangements for employees who transfer from the Trust to GMS.	√		

3 Decisions/Duties delegated by the Board to Committees

3.1 Audit and Assurance Committee

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

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

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

Oversight of the Trust's subsidiaries' audit arrangements

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

GMS Schedule of Matters Reserved and Delegated:

- Appointment or removal of the external auditor for GMS
- Appointment or removal of any internal auditor for GMS
- Approval of any change to GMS' accounting reference date
- Obtain assurance that the findings and recommendations of GMS-related internal audit reports have been addressed by the GMS.

3.2 Finance and Resources Committee

The Finance and Resources Committee will:

To seek assurance on and be responsible for:

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

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

GMS Schedule of Matters Reserved and Delegated

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

- Approval of the responsibilities of the GMS Board of Directors. As expressed in the GMS Board Terms of Reference
- Approval of arrangements to ensure compliance with regulatory requirements.
- Ensure GMS compliance with the health and safety legal and regulatory requirements.
- Approval of GMS' corporate strategy/strategic direction.
- Approval of the annual business plan and annual budget for GMS (including objectives and any other strategic measures of performance), and any amendments to them as well as any subsequent business cases for new or changed services where the proposal's impact is deemed 'significant'
- Approval for any of GMS' services to be sub-contracted to another provider.
- Change the nature of GMS' business or commence any new business which is not ancillary or incidental to the business (otherwise than in accordance with approved business plan) which substantially differs from the purpose of the OHFA.
- Approval to acquire or to dispose of assets with a value exceeding £500,000 and up to £1,000,000.
- Enter into a loan agreement with GMS on behalf of the Trust, including any mortgage or other charge
- Enter into a loan agreement on behalf of GMS with another lender, including any mortgage or other charge with a value exceeding £20,000 and up to £1,000,000.
- Acquisition of any interest or share capital in another body corporate.
- GMS to enter into or to renew a contract or series of connected revenue or capital contracts, through a compliant route to market, for any material for consideration payable being in excess of £1,000,000 and up to £5,0000,000;.
- Approval of capital transactions or contracts not within the approved Trust capital plan for the year.
- Approval of revenue transaction over £250,000 and not within the approved business plan for the year.
- Approval of staffing establishment and structure that could adversely affect services provided to the Trust or have significant impact on the staffing structure not within the approved plan for the year (e.g., redundancies)

3.3 People and Organisational Development Committee

The People and Organisational Development Committee will:

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

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

3.4 Quality and Performance Committee

The Quality and Performance Committee will:

- Monitor the Trust's arrangements to ensure its services are safe, effective, caring, responsive and well-led.
- Scrutinise the assessment of quality and performance risks identified in the Board Assurance Framework, ensuring there is sufficient assurance that these risks are adequately managed, including actions to eliminate gaps in controls.
- Review the arrangements in place to monitor compliance with key statutory requirements and guidance including, in particular, the Health and Social Care Act 2008 and associated regulations.
- Oversee the process by which quality and performance measures are developed and maintained and recommend to the Board the range of indicators that should be monitored.

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

3.5 Remuneration Committee

The Remuneration Committee will:

A. Appointments Role

- Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes.
- Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.
- Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

B. Remuneration Role

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

4. Scheme of Delegation of Powers from the Constitution

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

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

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

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

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

SFI Ref	Delegated to	Authorities/Duties Delegated
1. Introduction		
1.3.6 & 1.3.9	Chief Executive	Ensuring that all members of the Board, employees of the Trust and contractor are notified of and understand their responsibilities within SFIs.
1.3.7	Finance Director	1 Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies; 2 Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; 3 Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; 4 Ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors; 5 Providing of financial advice to the Trust and its Directors and employees; 6 Designing, implementing and supervising of systems of internal financial control; and 7 Preparing and maintaining of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
1.3.8 & 1.3.9	All directors, staff and contractors	Security of Trust property; avoiding loss; exercising economy and efficiency in the use of resources; conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation; and reporting suspected theft or fraud to the Director of Finance.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
2. Audit		
2.1.1	Audit and Assurance Committee	1 Overseeing Internal and External Audit services; 2 Reviewing systems of internal control and ensuring they are fit for purpose; 3 Monitoring compliance with Standing Orders and Standing Financial Instructions; and 4 Reviewing schedules of losses and compensations and making recommendations to the Board.
2.1.3	Director of Finance	Ensuring adequate internal audit service is provided
2.1.4	Audit and Assurance Committee	Making a recommendation to the Council of Governors to the appointment of external auditors; assessing the external (financial) auditors on an annual basis in terms of the quality of their work

SFI Ref	Delegated to	Authorities/Duties Delegated
2 Audit		
2.2.1	Chief Executive / Director of Finance	Monitoring and ensuring compliance with the directions issued by the Secretary of State for Health and/or NHS Counter Fraud Authority on fraud, bribery and corruption.
2.2.4	Local Counter Fraud Specialist	Providing a written report at least annually on counter fraud work within the Trust.
2.2.5	All staff	Informing the Finance Director or Local Counter Fraud Specialist if they discover or suspect a loss of any kind
2.3.1	Director of Finance	1 Ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function; 2 Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards; 3 In conjunction with the Counter Fraud and Security Management Service, deciding at what stage to involve the police in cases of misappropriation, and other irregularities; 4 Ensuring that an annual Internal Audit Report is prepared for the consideration of the Audit and Assurance Committee and the Board; 5 Ensuring that a three year strategic Internal Audit Plan is prepared for the consideration of the Audit and Assurance Committee and the Board; and 6 Ensuring that an annual Internal Audit Plan is produced for consideration by the Audit and Assurance Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year.
2.3.3	All staff	Notifying the Director of Finance or Local Counter Fraud Service whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature.
2.4.1	Director of Finance	Ensuring an Internal Audit function is in place and operates efficiently and effectively.
2.4.2	Internal Auditor	1 Providing assurances about the effectiveness of controls in place across all of the Trust's activities; 2 Reviewing the overall arrangements the Board itself has in place for securing adequate assurances and providing an opinion on those arrangements to support the Statement on Internal Control; and 3 Reviewing the way in which the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.
2.5.2	Council of Governors	Appointing (or removing) the external (financial) auditor on behalf of the Trust in accordance with the selection criteria in the Audit Code for NHS Foundation Trusts.
2.6.1	Chief Executive	Ensuring compliance with the Audit Code for NHS Foundation Trusts.

SFI Ref	Delegated to	Authorities/Duties Delegated
3 Financial Targets		
3..1.1	Chief Executive	Ensuring the Trust aims to maintain its financial viability and meets any specific financial targets set by the regulator; setting appropriate internal targets in order to ensure financial viability; signalling to the Finance and Digital Committee and the Board where the Trust's financial viability or key targets are at risk.
3.1.2	Director of Finance	1 Advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate; 2 Ensuring that adequate systems exist internally to monitor financial performance; 3 Managing the cash flow and external borrowings of the Trust; and 4 Providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
4 Business Planning, Budgets and Budgetary Control		
4.1.1	Council of Governors	Providing the Board with its views on the Trust's forward plans for each financial year.
4.1.1	The Board	Consulting the Council of Governors on the Trust's forward plans for each financial year.
4.1.2	Chief Executive	Compiling and submitting to the Board and the Council of Governors an annual business plan which takes into account financial targets and forecast limits of available resources.
4.1.3	Chief Executive	Submitting the approved Business Plan to the Regulator as required.
4.1.4	Chief Executive	Ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.
4.1.5	Director of Finance	Preparing and submitting revenue and capital budgets for approval by the Board.
4.1.6	Director of Finance	Monitoring financial performance against budget and the Business Plan and report to the Board.
4.1.7	Budget holders	Providing information as required by the Director of Finance to enable budgets to be compiled and to explain variances.
4.1.8	Director of Finance	Ensuring adequate, on-going training is delivered to budget holders to help them manage their budgets successfully.
4.2.1	Director of Finance	Delegate the management of a budget to permit the performance of a defined range of activities.

SFI Ref	Delegated to	Authorities/Duties Delegated
4 Business Planning, Budgets and Budgetary Control		
4.2.1 & 4.3.2	Budget holders	The management of a budget to permit the performance of a defined range of activities. Budget holders are responsible for operating within agreed staffing establishments and ensuring non-pay expenditure contracts within their assigned portfolio are performance managed to ensure value for money is being received and any replacement plans are in place with Procurement.
4.3.1	Director of Finance	Devise and maintain systems of budgetary control including monthly financial reports to the Board containing sufficient information to ascertain financial performance.
4.3.3	Chief Executive	Ensuring the identification and implementation of cost improvements and income generation initiatives in accordance with the requirements of the annual Business Plan and agreed Control Total.
4.3.4	Director of Finance	Advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and also on the financial implications of future plans and developments proposed by the Trust.
4.5.1	Chief Executive	Providing the Regulator with the appropriate monitoring information.
4.5.2	Chief Executive	Ensuring the Trust contributes to standard national NHS data flows required for NHS policy development/ funding decisions as well as performance assessment by the Healthcare Commission.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
5 Annual Accounts and Reports		
5.1	Director of Finance	1 Preparing annual accounts in accordance with the Regulator's Manual of Accounts and any other guidance from the same, the Trust's accounting policies and generally accepted accounting practice; 2 Preparing and submitting annual accounts to the Board and an audited summary of the Main Financial Statements to an Annual Members' Meeting convened by the Council of Governors, certified in accordance with current guidelines; and 3 Laying a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.
5.4.1	Trust Secretary	Preparing and submitting annual reports to the Board and an audited summary to an Annual Members' Meeting convened by the Council of Governors.

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

SFI Ref	Delegated to	Authorities/Duties Delegated
8 NHS Contracts for the Provision of Services		
8.2	Chief Executive	Ensuring the Trust works will all partner agencies involved in both the delivery and the commissioning of the service required.
8.3	Director of Finance	Ensuring regular reports are provided to the Finance and Digital Committee and the Board detailing forecast/ budgeted and actual income from contracts with NHS commissioners, particularly highlighting the impact of differences between planned and actual numbers of patients treated and outline any action required to address such variances and periodically providing information on the impact of differences between the actual cost to the Trust of treating patients in individual service lines and the relevant national tariff.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
9 Terms of Service and Payment of Directors and Employees		
9.1.2	Remuneration Committee	1 Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes; 2 Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future; 3 Appoint candidates to fill all the executive director positions on the Board; 4 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract; 5 Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process; 6 Determine the remuneration and terms of service of Executive Directors; 7 Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors; 8 Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole); and 9 Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.
9.1.3	Remuneration Committee	Send recommendations in report to the Board.

SFI Ref	Delegated to	Authorities/Duties Delegated
9 Terms of Service and Payment of Directors and Employees		
9.2.2	Workforce Impact Group	Authorise changes to the funded establishment.
9.3.1	Workforce Impact Group	Authorise changes in any aspect of remuneration, unless the changes are within the limit of the employee's approved budget and funded establishment.
9.3.1	Budget holders	Recruit to vacancies provided that this is within their approved budget and funded establishment.
9.4.1	Director of Finance	1 Specifying timetables for submission of properly authorised time records and other notifications; 2 Authorising the final determination of pay; 3 Making payment on agreed dates; and 4 Agreeing method of payment.
9.4.2	Director of Finance	Issuing instructions regarding processing of payroll.
9.4.3	Nominated managers	1 Submitting time records, and other notifications in accordance with agreed timetables; 2 Completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and 3 Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.
9.4.4	Director of Finance	Ensuring the chosen method for providing the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.5.1	Director of People and OD	1 Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and 2 Dealing with variations to, or termination of, contracts of employment.

SFI Ref	Delegated to	Authorities/Duties Delegated
10 Non-pay Expenditure		
10.1.1	Chief Executive	Determine level of delegation to budget managers.
10.1.2	Director of Finance	Set out the list of managers who are authorised to place requisitions for the supply of goods and services; and the maximum level of each requisition and the system for authorisation above that level.
10.1.3	Director of Finance	Ensuring the Trust has clearly established arrangements for the purchase of goods and services.
10.1.4	Director of Finance	Ensuring the Trust makes optimum use of corporate, national or regional contracts for the acquisition of goods and services, in order to ensure best value for money.
10.2.1	Requisitioners	Obtain the best value of money for the Trust when choosing an item to be supplied, seeking the advice of the Procurement Shared Service.
10.2.2	Director of Finance	Paying accounts and claims promptly and paying contract invoices in accordance with contract terms or otherwise national guidance.
10.2.3	Director of Finance	1 Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; 2 Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; 3 Be responsible for the prompt payment of all properly authorised accounts and claims and for advising the Board on a monthly basis of performance against targets set under the Government's Better Payments Practice Code; 4 Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. 5 Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, except in exceptional circumstances where prepayments are permitted. 6 Be responsible for ensuring due diligence checks are carried out on new or any changes made to existing supplier details before updating the finance system.
10.2.4	Budget holders	Ensuring all items due under a prepayment contract are received and informing the appropriate manager if problems are encountered.
10.2.4	Director of Finance	Be satisfied with the proposed arrangements for prepayments before contractual arrangements proceed.
10.2.6	Managers	Ensure full compliance with the guidance and limits specified by the Director of Finance concerning contracts and other commitments which may result in a liability.
10.2.7	Director of Finance	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the appropriate guidance.

SFI Ref	Delegated to	Authorities/Duties Delegated
11 Treasury Management		
11.1.2	Director of Finance	Advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health and report periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts,
11.1.4	Director of Finance	Make, or delegate an employee to make, any application for a loan, financing facility or overdraft.
11.1.3	Director of Finance	Prepare detailed procedural instructions concerning applications for loans, financing facilities and overdrafts.
11.1.6	Director of Finance	Authorise short term borrowing requirements.
11 Investments		
11.2.2	Director of Finance	Advise the Board on investments and report periodically to the Board concerning the performance of investments held, other than short term temporary cash surpluses.
11.2.3	Director of Finance	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
11 Cash Flow Monitoring		
11.3.1	Director of Finance	Manage and monitor the overall cash flow of the Trust and provide reports thereon to the Finance and Resources Committee and the Board.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
12 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets		
12.1.1	Chief Executive	Ensure adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and ensure that the capital investment is not undertaken without consideration of the availability of resources to finance all revenue consequences, including capital charges.
12.1.2	Chief Executive	Ensure that for every capital expenditure proposal a business case is produced, and the Director of Finance has certified to the costs and revenue consequences detailed in the business case which is approved by the Board subject to agreed delegated limits.
12.1.3	Director of Finance	Issue procedures for the management of capital schemes where the contracts stipulate stage payments; and issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

SFI Ref	Delegated to	Authorities/Duties Delegated
12 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets		
12.1.4	Chief Executive	Issue necessary authority to the manager responsible for any capital programme and a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.
12.1.5	Director of Finance	Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
12.2.1	Director of Finance	Demonstrate the use of private finance represents value for money and appropriately transfers significant risk to the private sector.
12.3.1	Responsible Officer	Maintain registers of assets and arrange a physical check of assets against the asset register to be conducted once every two years.
12.3.5	Director of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
12.4.1	Chief Executive	Control of fixed assets.
12.4.2	Director of Finance	Approve asset control procedures.
12.4.4	Directors and senior employees	Apply appropriate routine security practices in relation to NHS property.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
13 Stores and Receipt of Goods		
13.2	Chief Executive	Delegate day-to-day responsibility for the control of stores of goods, subject to the responsibility of the Director of Finance for the systems of control.
13.3 & 13.7	Designated Manager / Pharmaceutical Officer	Define in writing the responsibility for security arrangements and the custody of keys for all stores and locations; be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles; and report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice.
13.4	Director of Finance	Set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
13.5	Director of Finance	Agree stocktaking arrangements.
13.8	Director of Finance	Identify those authorised to requisition and accept goods supplied via the NHS Supply Chain central warehouses.

SFI Ref	Delegated to	Authorities/Duties Delegated
14 Disposals and Condemnations, Losses and Special Payments		
14.1.2	Director of Finance	Prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers. The Director of Finance is responsible for reviewing and signing any losses and special payments for lost or damaged property.
14.1.4 & 14.1.5	Director of Finance	Authorise employees to condemn or otherwise all unserviceable articles; approve the form in which this is recorded; and take appropriate action if there is evidence of negligence.
14.1.4 & 14.1.5	All staff	If authorised by the Director of Finance, condemn or otherwise all unserviceable articles; record in a form approved by the Director of Finance; and report any evidence of negligence in use to the Director of Finance.
14.2.1	Director of Finance	Prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
14.2.2	All staff	Inform their head of department if they discover or suspect a loss of any kind, who must immediately inform the appropriate officer.
14.2.3	Director of Finance	Report losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, to the Audit and Assurance Committee.
14.2.4	Director of Finance	Take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
14.2.5	Director of Finance	Consider whether any insurance claim can be made for any loss.
14.2.6	Director of Finance	Maintain a Losses and Special payments Register.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
15 Information Technology		
15.2	Director of Finance	Ensuring the accuracy and security of the computerised financial detail.
15.3	Director of Finance	Ensuring an appropriate Business Case is prepared and approved for a new financial system or significant amendment to a current financial system.
15.5	Director of Finance	Ensuring contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage.
SFI Ref	**Delegated to**	**Authorities/Duties Delegated**
16 Patients' Property		
16.2	Chief Executive	Ensuring patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

SFI Ref	Delegated to	Authorities/Duties Delegated
16 Patients' Property		
16.3	Chief Nurse	Provide arrangements for the administration of patient property.
18 Acceptance of Gifts and other benefits in kind by Staff		
18.1	Director of Finance	Ensure staff are aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.
19 Retention of Documents		
19.1 & 19.3	Chief Executive	Maintaining archives for all documents required to be retained in accordance with Department of Health guidelines; instigating the destruction of these documents and maintaining a record of destroyed documents.
20 Risk Management & Insurance		
20.1	Chief Executive	The Chief Executive shall ensure that the Trust has a risk management strategy, in accordance with current controls assurance guidance, which must be approved and monitored by the Board.
20.4	Director of Finance	Ensure that insurance arrangements exist where appropriate. In this context, insurance will include any scheme administered by NHS Resolution (such as the risk pooling schemes) in addition to policies operated by commercial organisations.

Appendix 1: Financial Delegation Limits

1.1 Revenue and Capital Expenditure (SFI Appendix 1.1.3)

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

1.1.1 Authorisation of Virement (SFI Appendix 1.1.4-1.1.5)

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

1.2 Purchase Orders (SFI Appendix 1.3)

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

1.3 Tendering Limits (SFI Appendix 1.4)

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

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

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

Prior to entering into a contract for the provision of services budget holders must ensure that any process has been reviewed in line with the "Provider Selection Regime" and that it has been considered for the impacts of IFRS16.

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

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

a. Consultancy Services (SFI 10.2.6)

Any plans to incur spend on consultancy projects, including the extension or variation of existing projects, should comply with the Trust expenditure controls. Where a request is above £50k it will also require approval by the regional NHS England office.

b. Charitable Funds (SFI Appendix 1.6)

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

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following January 2019 Audit and Assurance Committee feedback
1.0	Lukasz Bohdan	14-02-2019	Version approved by the Trust Board at its 14 February 2019 meeting with the exception of Section 3.2 'Estates Committee'
1.1	Cecilia Price & Lukasz Bohdan	31-05-2019	Amendments made following February 2019 Board feedback and changes to Committee ToRs
1.2	Lukasz Bohdan	Aug 2019	Version approved by the Trust Board at its June 2019 meeting
1.3	Lukasz Bohdan	Aug 2019	Amendments made to Director of Corporate Governance - August
1.4	Sim Forman	April 2020	
1.5	Kat Cleverley	January 2023	Approved by Finance and Resources Committee
		March 2023	Ratified by Board of Directors
1.6	Steve Perkins Edward Taylor Michael Weaver	October 2024	Finance and Resources Committee Board of Directors

GLOUCESTERSHIRE HOSPITALS

NHS FOUNDATION TRUST

Standing Financial Instructions (SFIs)

Version	Author(s)	Date	Comment
V1.0	Alex Gent, Karen Johnson, Steve Perkins, Kat Cleverley	November 2022	Review and update to increase threshold from £5000 to £10,000 Change of terms of reference following absorption of Estates and Facilities Committee into Finance and Resources Committee
V2.0	Kat Cleverley	January 2023	Approved at Finance and Resources Committee
		March 2023	Ratified at Board of Directors

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Foreword

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

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

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

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

1. Introduction

1.1 General

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

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

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

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

1.2 Terminology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

r. "SFIs" means Standing Financial Instructions;

s. “SOs” means Standing Orders; and

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

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

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

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a. formulating the financial strategy;

b. requiring the submission and approval of budgets;

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

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

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

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

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

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

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

1.3.7 The Director of Finance is responsible for:

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

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

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

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

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

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

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

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

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

a. the security of the property of the Trust;

b. avoiding loss;

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

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

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

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

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

2. Audit

2.1 Audit and Assurance Committee

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

a. overseeing Internal and External Audit services;

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

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

d. reviewing schedules of losses and compensations

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

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

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

2.2 Fraud and Corruption

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

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

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

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

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

2.3 Director of Finance

2.3.1 The Director of Finance is responsible for:

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

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

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

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

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

   ii. major internal control weaknesses discovered,

   iii. progress on the implementation of internal audit recommendations,

   iv. progress against plan over the previous year;

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

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

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

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

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

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

d. explanations concerning any matter under investigation.

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

2.4 Role of Internal Audit

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

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

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

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

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

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

2.5 External Audit

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

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

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

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

2.6 Audit Code

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

3. Financial Targets

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

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

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

3.4 The Director of Finance is responsible for:

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

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

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

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

4. Business Planning, Budgets and Budgetary Control

4.1 Preparation and Approval of Business Plans and Budgets

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

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

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

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

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

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

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

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

b. accord with workload and manpower plans;

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

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

e. identify all sources of those funds; and

f. identify potential risks.

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

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

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

4.2 Budgetary Delegation

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

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

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

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

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

4.3 Budgetary Control and Reporting

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

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

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

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

d. monitoring of management action to correct variances; and

e. arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

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

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

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

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

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

4.4 Capital Expenditure

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

4.5 Performance Information and Monitoring Returns

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

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

5. Annual Accounts and Reports

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

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

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

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

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

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

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

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

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

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

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

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

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

g. any other information required by the Regulator.

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

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

6. Bank Accounts

6.1 General

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

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6.2 Bank Accounts

6.2.1 The Director of Finance is responsible for:

a. bank accounts

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

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

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

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

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

6.3 Banking Procedures

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

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

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

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

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

6.4 Tendering and Review

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

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

7.1 Income Systems

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

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

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

7.2 Fees and Charges

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

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

7.3 Debt Recovery

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

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

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

7.4 Security of Cash, Cheques and Other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

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

b. ordering and securely controlling any such stationery;

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

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

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

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

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

8. NHS Contracts for the Provision of Services

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

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

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

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

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

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

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

g. previously agreed developments or investment plans.

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

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

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

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

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

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

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

9. Terms of Service and Payment of Directors and Employees

9.1 Remuneration Committee

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

9.1.2 The Committee will:

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

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

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

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

9.2 Funded Establishment

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

9.2.2 The funded establishment of any department may not be varied without the approval of the Workforce Impact Group.

9.2.3 Budget holders are responsible for operating within their funded establishments

9.3 Staff Appointments

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

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

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

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

9.4 Processing of Payroll

9.4.1 The Director of Finance is responsible for:

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

b. the final determination of pay;

c. making payment on agreed dates; and

d. agreeing method of payment.

9.4.2 The Director of Finance will issue instructions regarding:

a. verification and documentation of data;

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

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

d. security and confidentiality of payroll information;

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

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

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

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

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

j. pay advances and their recovery;

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

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

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

9.4.3 Appropriately nominated managers have delegated responsibility for:

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

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

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

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

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

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

10. Non-pay Expenditure

10.1 Delegation of Authority

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

10.1.2 The Director of Finance will set out:

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

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

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

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

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

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

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

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

10.2.3 The Director of Finance will:

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

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

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

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

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

ii. Certification that:

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

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

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

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

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

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

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

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

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

10.2.5 Official Orders must:

a. be consecutively numbered;

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

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

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

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

a. all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Shared Service and the Director of Finance in advance of any commitment being made. All contracts should be assessed for the impact of IFRS16 before agreement, and where contracts are for the provision of services they should be consistent with the provider selection regime.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.3 Grants to Local Authorities and Voluntary Bodies

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

11. Treasury Management

11.1 External Borrowing

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

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

b. any additional degree of scrutiny required by financial institutions

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

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

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

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

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

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

11.2 Investments

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

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

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

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

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

11.3 Cash Flow Monitoring

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

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

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

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

12.1 Capital Investment

12.1.1 The Chief Executive:

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

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

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

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

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

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

ii. appropriate project management and control arrangements.

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

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

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

a. specific authority to commit expenditure;

b. authority to proceed to tender; and

c. approval to accept a successful tender.

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

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

12.2 Private Finance

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

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

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

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

12.3 Asset Registers

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

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

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

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

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

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

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

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

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

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

12.4 Security of Assets

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

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

a. recording managerial responsibility for each asset;

b. identification of additions and disposals;

c. identification of all repairs and maintenance expenses;

d. physical security of assets;

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

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

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

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

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

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

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

13. Stores and Receipt of Goods

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

a. kept to a minimum;

b. subjected to annual stocktake; and

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

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

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

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

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

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

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

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

14. Disposals and Condemnations, Losses and Special Payments

14.1 Disposals and Condemnations

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

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

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

14.1.4 All unserviceable articles shall be:

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

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

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

14.2 Losses and Special Payments

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

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

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

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

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

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

15. Information Technology

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

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

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

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

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

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

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

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

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

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

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

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

16. Patients' Property

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

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

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

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

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

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

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

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

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

17. Funds Held on Trust (Charitable Funds)

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

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

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

18. Acceptance of Gifts by Staff

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

19. Retention of Documents

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

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

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

20. Risk Management & Insurance

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

20.2 The programme of risk management shall include:

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

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

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

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

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

f. decision on which risks shall be insured; and

g. arrangements to review the risk management programme.

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

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

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

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

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

Appendix 1: Financial Delegation Limits

11. Revenue and Capital Expenditure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. Revenue and Capital Income

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

2.2 The Chief Executive will

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

2.3 The Director of Finance will

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

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

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

13. Purchase Orders

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

Upto £1,000	Budget Holder

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

Additional governance and approvals for spends over 10k may be required. A PO will not be created without all related governance being completed first.
Purchase order limits and authorisation apply to agreed goods and services that are exempt from P2P.

14. Tendering Limits

4.1 The following limits will apply

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

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

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

5.2 The delegated authority limits for contract approval are:

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

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

5.4 All relevant external Spend Control's must also be secured prior to the final approval group.

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

5.6 Prior to entering into a contract for the provision of services budget holders must ensure that any process has been reviewed in line with the "Provider Selection Regime" and that it has been considered for the impacts of IFRS16

16. Consultancy Services

6.1 Any plans to incur spend on consultancy projects, including the extension or variation of existing projects, should comply with the Trust expenditure controls. Where a request is above £50k it will also require approval by the regional NHS England office.

17. Charitable Funds

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

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

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

18. Research and Innovation Applications

18.1 All applications for research and innovation funding require approval from the Director of Finance or a designated deputy. This applies to applications to both NHS funders, such the National Institute for Health Research, and to non-NHS organisations, such as charitable bodies and research councils.

18.2. All other documents* relating to Research and Innovation will require approval from the Director of Research & Innovation or a designated deputy, once all the necessary checks have been carried out, including finance checks where applicable. *other documents include research contracts with funding bodies, collaboration agreements, commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.

19. Intellectual Property

19.1. The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project

20. On-Call and Out-of-Hours Decision Making

20.1. Staff designated as on-call are authorised to make urgent decisions during out-of-hours periods in line with their role and responsibilities, ensuring that patient care and safety are not compromised.

20.2 Decisions made during on-call and out-of-hours periods must comply with delegated financial authority levels as outlined in the Trust's delegated limits. Staff should refer to the relevant financial limits in their respective roles, ensuring that any expenditure or commitments made do not exceed these limits.

20.3 Where financial or operational decisions exceed the authority of the on-call staff member, the decision must be escalated to the relevant senior manager or executive director as per the agreed escalation protocol.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

STANDING ORDERS

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Contents

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

1. Interpretation

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

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

2. The Trust

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

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

3. Meeting of the Board of Directors

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

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

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

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

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

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

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

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

3.7 Meetings of the Board may only be called in accordance with this paragraph. The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that

purpose, signed by at least one-third of the whole number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

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

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

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

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

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

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

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

3.15 Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

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

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

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

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

Chair.

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

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

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

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

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

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

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

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

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

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

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

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

3.31 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without

formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

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

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

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

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

3.35.1 either or both of those persons may attend or take part in meetings of the Board:
3.35.2 if both are present at a meeting, they should cast one vote if they agree:
3.35.3 in the case of disagreements no vote should be cast.
3.35.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.43 (Quorum).

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

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

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

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

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

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

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

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

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

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

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

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

4. Arrangements for the exercise of functions by delegation

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

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

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

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

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

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

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

5. Committees

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

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

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

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

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

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

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

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

- Audit and Assurance Committee
- Appointments and Remuneration Committee
- Quality and Performance Committee
- Finance and Resources Committee

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

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

6. Declarations of Interests and Register of Interests

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

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

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

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

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

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

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

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

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

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

6.3 When contracting for non-pay expenditure, all the induvial(s) involved in the process, must complete a project specific declaration of interest. These declarations will need to be re-submitted at the different stages of the procurement process, as advised by Procurement.

Nature of interests

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

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

6.5.1 Directorships, including non-executive Directorships held in any other organisation which is doing or is likely to be doing business with an organisation in receipt of NHS funding.
6.5.2 employment in an organisation which is doing or is likely to do business with an organisation in receipt of NHS funding; or
6.5.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing or is likely to do business with an organisation in receipt of NHS funding.

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

6.6.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body.
6.6.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts.
6.6.3 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or
6.6.4 of any remuneration or allowances payable to a Director in accordance with the Constitution.

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

6.7.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or
6.7.2 a member of a lobbying or pressure group with an interest in health and/or social care.

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

6.7.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of the Director.
6.7.2 close friends and associates; and
6.7.3 business partners.

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

Register of interests

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

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

6.11 The register will be available to the public.

7. Standards of Business Conduct

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

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

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

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

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

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

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

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

8. Tendering and Contract Procedure

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

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

8.3 The Trust shall comply as far as is practicable with the requirements of the NHS Executive "Capital Investment Manual". In the case of Cabinet Office and NHS England spend controls the Trust shall comply as far as is practicable with current guidance.

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

procurement process. The Director of Finance or nominated officer shall maintain a list of applicable exemptions from waivering competition.

8.5 The Procurement legislation sets out rules on how to calculate the total contract value, and this value is to used to confirm the total spend value. Continuous spend with a supplier, and/or disaggregation across orders/waivers will require review with Procurement to ensure compliance.

8.6 Contract modifications of below threshold contracts, must be captured and reported to procurement. Once the value exceeds the relevant threshold it will trigger additional governance and transparency requirements to be followed, as advised by Procurement.

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

8.6.1 the estimated expenditure or income is above or is reasonably expected to be above £10,000 excluding VAT and does not, or is not reasonably expected to, exceed £50,000 excluding VAT and.
8.6.2 there is an urgent requirement and/or.
8.6.3 the goods, services or works are of a special characteristic that, in the opinion of the Chief Executive or the nominated officer, it is not possible or desirable to undertake a competitive process and/or.
8.6.4 Where the supply is proposed under special a rrangements negotiated by the Department of Health in which event the said special arrangements must be complied with.

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

8.7.1 the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
8.7.2 specialist expertise is required and is available from only one source: or
8.7.3 the task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
8.7.4 there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or
8.7.5 Where provided for in the Capital Investment Manual.

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

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

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

8.11 The Board shall ensure that the organisations invited to tender / quote for building and engineering works shall be those on an approved list in accordance with Annex A section

5. Where, in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

8.12 Tendering procedures are set out in Annex A.

8.13 **Pre-Market Engagement** – Any staff involved in Pre-Market Engagement discussions with suppliers in order to support their design/tailor their requirements for a business case and/or a competitive procurement procedure must be conducted in a way that does not give a supplier an unfair advantage or distort competition and maintain an audit record. The procurement objectives, non-discrimination requirements and conflicts of interest obligations also apply to preliminary market engagement.

8.13.1 Activities with suppliers such as; detailed telephone conversations, attendance at events and asking for proposals are some examples of pre-market engagement. Any staff planning to undertake Pre-Market Engagement to seek advice form Procurement.

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

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

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

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

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

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

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

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

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

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

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

with:

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

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

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

8.24 **Contract Management** – At point of contract award, a contract manager shall be named to manage the contract. This induvial shall be responsible for ensuring the performance levels of the contract are met and value for money is achieved by the Trust over its term.

8.25 Any planed contract amendments or changes to the contract manager must be provided to Procurement for formal review against the Procurement Legislation, and any and updates required to the Trust contract register.

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

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

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

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

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

8.31 **Determination of Contracts for Failure to Deliver Goods or Material** - There shall be inserted in every applicable written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

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

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

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

8.30.1 doing, or refraining from doing anything in their official capacity; or
8.30.2 owing favour or disfavour to any person in their official capacity.
8.30.3 The Bribery Act 2010 replaces the fragmented and complex offences at common law and in the Prevention of Corruption Acts 1889-1916. This broadly defines the two sections below

8.30.3.1 two general offences of bribery:

I. offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly.

II. requesting or accepting a bribe either in exchange for acting improperly or
where the request or acceptance is itself improper.

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

9. Disposals

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

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

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

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

d) items arising from works of construction, demolition or site clearance, which should be dealt

with in accordance with the relevant contract.

10. In-House Services

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

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

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

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

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

10.3 The evaluation group shall make recommendations to the Board.

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

11. Custody of Seal and Sealing of Documents

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

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

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

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

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

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

11.6.1 All contracts for the purchase/lease of land and/or building.

11.6.2 All contracts for capital works exceeding £1,000,000.

11.6.3 Any contract or agreement with organisations other than NHS or other government

bodies including local authorities where the whole-life value exceeds or is expected to exceed £10,000,000, except for contracts within the Group; and

11.6.4 Any contract where the other party requests a seal.

12. Signature of Documents

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

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

13. Miscellaneous

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

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

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

13.4 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Trust.
The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

Annex A: Tendering Procedure

1 Invitation to Tender

1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted electronically, via the Trust E-Tendering system. Approval from the Head of Procurement must be obtained for exceptional circumstances where the E-Tendering system cannot be used. Where tenders are not submitted through the E-Tendering system, they must be submitted in a plain, sealed package bearing the word 'Tender' followed by the Tender Reference Number and the latest date and time for the receipt of such tender. A minimum of two people must open tenders. At least one person must not be involved in the tender process. Neither must be from the originating department.

1.2 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 1.3 and 1.4 below.

1.3 Every tender for building and engineering works, except for maintenance work only where Health Technical Memoranda (HTMs) guidance should be followed, shall use the appropriate Joint Contracts Tribunal (JCT) or NEC terms amended via Z clauses to comply with the Construction Act (as amended). JCT and NEC contracts to encompass, where relevant, Design Warranties, Collateral Warranties and third-party rights to mitigate project risk and protect the Trust. Tendering based on other forms of contract may be used only after prior consultation with the Shared Services Procurement Department.

1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Conditions of Contract, or other appropriate public sector Conditions that may apply. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

2. Receipt, Safe Custody and Record of Formal Tenders

2.1 Formal competitive tenders shall be submitted on the Trust's E-Tendering system or addressed to the Head of Procurement, Victoria Warehouse where approved in accordance with 1.1 above.

2.2 The date and time of receipt of each tender together with the details of the date, time and persons opening the documents will be recorded in the E-Tendering system.

2.3 Where tenders are received outside the E-Tendering system in accordance with 1.1, the Chief Executive shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.

3 Opening Formal Tenders

3.1 Where tenders are not submitted through the E-Tendering system, as soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened in the presence of two senior officers designated by the Chief Executive and not from the originating department.

3.2 A permanent record shall be maintained to show for each set of competitive tender invitations despatched:

a) the names of firms/individuals invited.
b) the names of and the number of firms/individuals from which tenders have been received.
c) the total price(s) tendered.

d) closing date and time.
e) date and time of opening.
f) and the record shall be signed by the persons present at the opening or recorded electronically in an E-Tendering system.

3.3 Where an electronic tendering package is used all actions by both procurement staff and suppliers are recorded within the system audit reports

3.4 All tender clarifications shall be captured in writing via the E-Tendering system. Maintaining a clear audit trial record of all alterations.

4 Admissibility and Acceptance of Formal Tenders

4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

4.2 Tenders received after the due date and time (whether hard copy or via electronic means) may be considered only if the Chief Executive or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re- tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

4.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

4.4 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.

4.5 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his/her offer.

4.6 Necessary discussions with a tenderer of the contents of his/her tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

4.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under

consideration and while the tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

4.8 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

4.9 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

4.11 All Tenders should be treated as confidential and should be retained for inspection for the period of the contract awarded. Successful tenders should be retained for six years after the expiry of the contract awarded.

5 Approved Firms for Building and Engineering Works

5.1 The Trust shall use suppliers on appropriate national frameworks for the provision of design, construction, and engineering works, from whom in the first instance proposals, quotations and tenders may be invited. For other services where tenders or quotations are required the Trust will use the processes established by the Procurement Shared Service.

5.2 Any Director may request a report on the financial standing of the favoured tenderer which will be carried out by an independent firm of financial advisers.

6 Conflicts of Interest

6.1 All Trust staff that are involved in a formal tender process shall sign a declaration of Conflict of Interest. These declarations must be revisited at stages throughout the procurement process, and updated / confirmed as no change, as advised by Procurement. Declarations must be retained with Tender records

Report to Trust Board of Directors	
Date	16 January 2025
Title	**Report to the Care Quality Commission - Section 31 Summary Reports**
Authors	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)
Presenter	**Director of Quality and Chief Nurse – Matt Holdaway**

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

Summary of Report

The purpose of 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 completed quality improvement (QI) training. The last QI training session was in October and the Teams are preparing their projects for the GSQIA graduation ceremony in February 2025. The teams are all making progress with their improvement projects and will continue to report on a monthly basis to the Executive Led Maternity Delivery Group. There is an improvement programme for Maternity Governance and new structures have been implemented (there are 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 31 January 2025. 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 (13 December 2024) has also been provided to Board members for information. At the last QIG 2 work streams were closed (Agency staff induction and Maternity Obstetric Early Warning Scores (MOEWS) audit compliance) as significant progress had been made. Reporting on all metrics will continue to CQC.

Board members are asked to note that the CQC are due to publish their latest inspection report for the GRH site maternity inspection (which was carried out in March 2024 - expected week

commencing 13 January 2025). Significant progress has been made with improving maternity governance systems since this inspection and will continue with the Maternity Senior Leadership Team preparing for the next CQC inspection.
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) – November 2024 CQC S31 Report – December 2024 CQC S31 Report – 13 December 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 data

<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 an audit demonstrated 93% women have had checklist completed.
– PPH Guideline has been updated (M1042).
– PPH safety incident management is in line with PSIRF.

Target

- This month the Trust rate is below the national rate.
- The target was to have reduced the mean monthly PPH rate >1500ml to 31 per 1000 deliveries by Jan</td><td>CQUIMs – National Data published 20 December 2024

The latest data has shown we are below the national average. 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><th>Sept 2024</th><th>Oct 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><td>32.0</td><td>32.0</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><td>32.0</td><td>28.0</td></tr>
</table>

PPH/MOH Trust data

The Trust data for November 2024 shows a rate that is within standard deviation and not flagging on the SPC charts.

<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><th>Oct 2024</th><th>Nov 2024</th></tr>
<tr><td>Trust</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><td>44.49</td><td>37.1</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr>
<td></td>
<td>2025 (in line with national average). When using the national data our rolling 6-month average is 37.6 per 1000 deliveries.
-
Governance

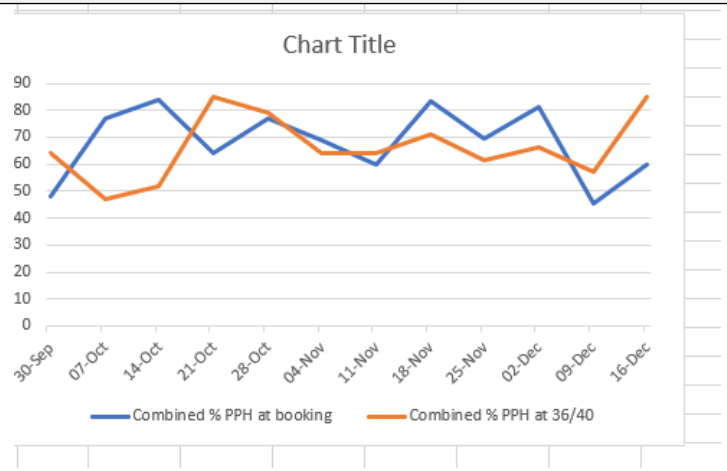
– The Intrapartum Forum have oversight of this improvement work and PPH outcome data. Escalation of issues is to the Maternity Oversight and Assurance Committee.
– Due to sickness within the maternity governance team a backlog of safety incidents (mainly PPH/MOH) requiring review has built up. The number of safety incidents has increased due to all cases being recorded as a safety incident rather than only those with care or service delivery problems. This issue has now been managed and the numbers have significantly reduced due to a new post being recruited to. Figures will</td>
<td>Risk assessments

The Reduce Checklist continues to be consistently used in practice.

<table>
<tr><th colspan="7">PPH risk assessment completed on admission - all areas</th></tr>
<tr><th>Month</th><th>July 2024</th><th>Aug 2024</th><th>Sept 2024</th><th>Oct 2024</th><th>Nov 2024</th><th>Target</th></tr>
<tr><td>Trust data</td><td>72.1</td><td>82.9</td><td>91.2</td><td>95</td><td>95</td><td>95%</td></tr>
</table>

Now intrapartum risk assessment compliance is being maintained the focus for the next period will be risk assessments at booking and 36/40. This is currently reported within the Production Boards for each community area and improvement is still required.

Chart: risk assessment compliance at booking and 36/40</td>
</tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>be presented next month.</td><td> 

Clinical safety incident review and closure

A production board with associated with key patient safety metrics has just been developed for the maternity governance team and this will be reported on next month.</td></tr>
<tr><td>Work stream 2 – Fetal monitoring peer reviews, accurate assessment and timely escalation of concerns</td><td>Targets

– To increase initial intrapartum risk assessment to 95% by end of Feb 2025 (updated).
– To increase hourly risk assessment to 85% by end of Feb 2025 (updated).
– To increase our hourly peer review rate to 85% during intrapartum care by end of</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>Oct 2024</th><th>Nov 2024</th><th>Target Feb 2025</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>90%</td><td>100%</td><td>Target 95%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>Feb 2025 (updated).
– To increase the accurate interpretation of CTGs to 85% (escalated appropriately for their interpretation) by end of Feb 2025 (updated).

Improvement actions

– Project reset with new lead.</td><td>
<table>
<tr><td>Hourly risk assessment</td><td>80%</td><td>75%</td><td>42%</td><td>65%</td><td>85%</td><td>70%</td><td>50%</td><td>Target 85%</td></tr>
<tr><td>Hourly peer review</td><td>85%</td><td>75%</td><td>70%</td><td>65%</td><td>85%</td><td>70%</td><td>50%</td><td>Target 85%</td></tr>
<tr><td>Accurate assessment</td><td>67%</td><td>78%</td><td>92%</td><td>85%</td><td>90%</td><td>95%</td><td>60%</td><td>Target 85%</td></tr>
<tr><td>Escalation</td><td>89%</td><td>84%</td><td>80%</td><td>92%</td><td>85%</td><td>100%</td><td>100%</td><td>Target 100%</td></tr>
</table>

A new metric was introduced in November to assess overall compliance with the total number of intrapartum risk assessments as a percentage for each case. This will be reported monthly:
<table>
<tr><th colspan="3">New Metric: total number of hourly intrapartum risk assessment</th><th>Target: Feb 25</th></tr>
<tr><th>Trust data</th><th>Oct 2024</th><th>Nov 2024</th><th></th></tr>
<tr><td>Trust data</td><td>78%</td><td>83%</td><td>Target: 85%</td></tr>
</table>
</td></tr>
<tr><td>Work stream 3 – Temporary workforce (agency</td><td>Target met as all Agency staff that have worked in the unit have had an induction. Agency usage</td><td>This target has been met and so no new data provided. Temporary work force data will be included in the Perinatal Workforce Report which comes to the Quality and Performance Committee (sub board) every 6 months.</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td>midwives) experience</td><td>is now minimal and all staff must sign that they have read the induction book before being able to work a shift. Induction book checked and updated if required quarterly.

Governance

Temporary workforce reported at the Workforce meeting and within the Perinatal Workforce Report received by Board 6 monthly as required by the Maternity Incentive Scheme.</td><td>Table: Induction completion rates August 2024

<table><tr><th>Action</th><th>Number</th><th>%</th></tr><tr><td>Induction and checklist complete</td><td>16/16</td><td>100%</td></tr></table></td></tr>
<tr><td>Work stream 4 – Venous Thromboembolism risk assessments</td><td>– The focus continues to be the “on admission” risk assessments within 14 hours.
– The next VTE prophylaxis audit has been completed
○ 85% compliance with risk assessment
○ 88% completed within 14 hours
○ 94% appropriate treatment in place

Target – updated</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 2024</th><th>Oct 2024</th><th>Nov 2024</th></tr><tr><td>On admission (14hrs)</td><td>67%</td><td>76%</td><td>80%</td><td>82.5%</td><td>75%</td><td>77%</td><td>*76%</td></tr></table>* Manual audits show 100% completed. The data is being interrogated as the admission assessment is being completed in Triage and this is before the time of admission is recorded on Trac and so this data needs to be included (currently excluded as before admission time).</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>– For admission VTE risk assessments to be completed within 14 hours of admission by >95% by end of Feb 2025.

Data

– Data issues are being reviewed.</td><td></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 Birth Unit compliance decreased to 70% this month (1 case) and so this will continue to be audited until sustained improvement.

Target

To increase compliance with acting on amber observations to 80% within 3 months (July), and 95% within 6 months target February 2025.</td><td>Table: “Act on Amber” compliance

<table>
<tr><th>Area</th><th>May 2024 (Target 80%)</th><th>June 2024 (Target 80%)</th><th>July 2024 (Target 80%)</th><th>Aug 2024</th><th>Sept 2024</th><th>Oct 2024 (By Oct 95%)</th><th>Nov 2024</th></tr>
<tr><td>Maternity Ward</td><td>63%</td><td>83%</td><td>86%</td><td>94%</td><td>89%</td><td>*80%</td><td>95%</td></tr>
<tr><td>Delivery Suite</td><td>87%</td><td>90%</td><td>83%</td><td>100%</td><td>100%</td><td>*60%</td><td>85%</td></tr>
<tr><td>Birth Unit GRH</td><td>75%</td><td>80%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>70%</td></tr>
<tr><td>Stroud</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td></tr>
</table></td></tr>
</table>

Issue	Actions	Data							
			ambers	ambers	ambers	ambers	ambers	ambers	ambers

Gloucestershire Hospitals
NHS Foundation Trust

Perinatal Quality Dashboard

Quarter 2, 2024

the Best Care for Everyone
care / listen / excel

Contents

Making data count

This report contains data from the Perinatal Quality dashboard. The report uses SPC charts to identify variation based on NHSE making data count guidance:

SPC Chart Guide

- The reference lines in the charts indicate the normal level of variation in the dataset – the upper and lower 'control limits' are calculated from the total average, + or – this standard amount of variation.
- Data points are highlighted in orange or blue if they fall above or below this 'normal' range. They are grey if they plot within the upper and lower control limits. (See key)
- This is not a RAG-rating or an indication of whether a data point is 'good' or 'bad', just highlights points of interest that fall outside expected variation

Variation		
		
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

Quality Dashboard

Quality measure	Regional benchmark if applicable	National Benchmark if applicable	Apr	May	Jun	Jul	Aug	Sept
After event Review (AER)	N/A	N/A	3	6	3	0	1	1
Patient Safety Incident Investigation (PSII)	N/A	N/A	0	4	0	0	0	0
Quality Summit (QS)	N/A	N/A	0	0	1	1	0	0
NEW MNSI referrals	N/A	N/A	0	4	0	0	0	0
Direct maternal death	0 per 100,000	13 per 100,000	0	0	0	0	0	0
Stillbirths (24 weeks gestation and above)	2.8 per 1000	3.4 per 1000 births	3 (6.8 per 1000)	0	3 (7.69 per 1000)	1 (2.11 per 1000)	0	1 (2.2 per 1000)
Neonatal Deaths (> 24 weeks gestation)		1.6 per 1000 births	0	0	1 (2.6 per 1000)	0	1 (2.24 per 1000)	0
Babies born at < 27 weeks gestation at GHNHSFT	3.6 per 1000	4.1 per 1000	0	0	0	0	0	0
Term admissions into the neonatal unit (ATAIN)	/	5% (50 per 1000 births)	2.9 (29 per 1000)	2.1 (21 per 1000)	4.9 (49 per 1000)	3.4 (34 per 1000)	2.7 (27 per 1000)	4.3 (43.3 per 1000)
Coroner Regulation 28 made directly to the Trust	/	/	0	0	0	0	0	0

Operational Activity – July, Aug, Sept 2024

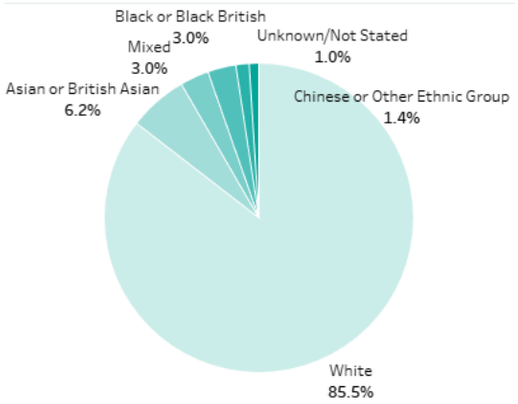
Births

Total Births (Registerable)

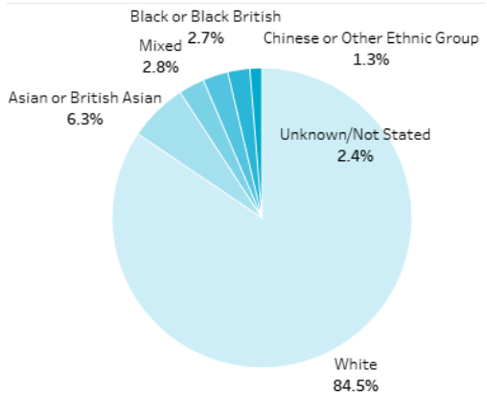
Location

Delivery Suite Gloucester	Birth Unit Gloucester	Planned home birth	Birth Centre Stroud	BBA	Maternity Ward Glouces..	Triage Gloucester	Other
1,132	190	20	26	12	4	2	1

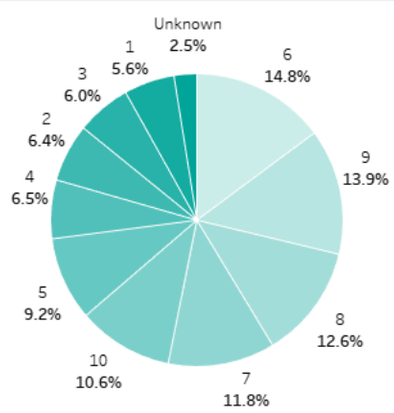
Bookings by Ethnicity



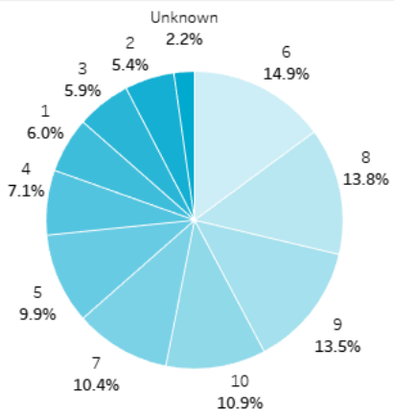
Births by Ethnicity



Bookings by Deprivation



Births by Deprivation



Births

Ethnicity

Deprivation

Operational Activity

Above Standard Deviation | Within Standard Deviation | Below Standard Deviation

C-sections

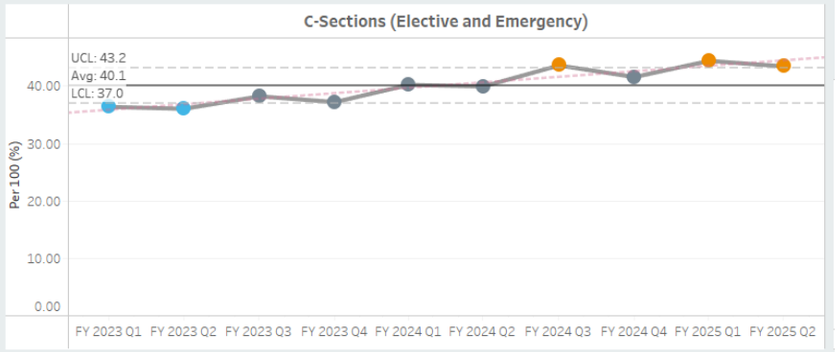
Latest Month

Metric ⓘ

Metric:	C-Sections (Elective and Emergency)
Rate of:	C-Section Births (Registerable)
Per 100 (%):	Registerable Births

43.5

Trend



Notes

We have noted a gradual increase in our caesarean section rate over the past 12 months in line with the national picture. Whilst we are not monitored on our overall caesarean section rate, an increase has an impact on staffing, patient and staff experience. Our elective caesarean section list is now running with 6 regular slots instead of 4. Maternity and obstetric staffing is being reviewed to improve the support to this service.

Induction of Labour

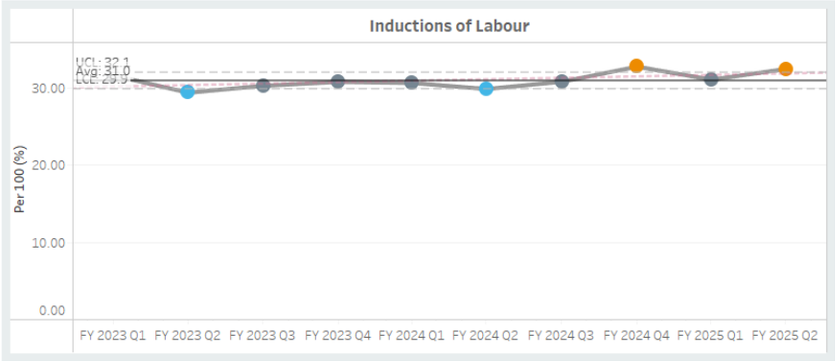
Latest Month

Metric ⓘ

Metric:	Inductions of Labour
Rate of:	Induced Deliveries (Registerable)
Per 100 (%):	Registerable Deliveries

32.5

Trend



Notes

The induction of labour QI is in progress. All preterm inductions of labour are now carried out on the delivery suite to ensure increased surveillance. Our induction of labour rate has remained stable since March 2024.

Instrumental Births

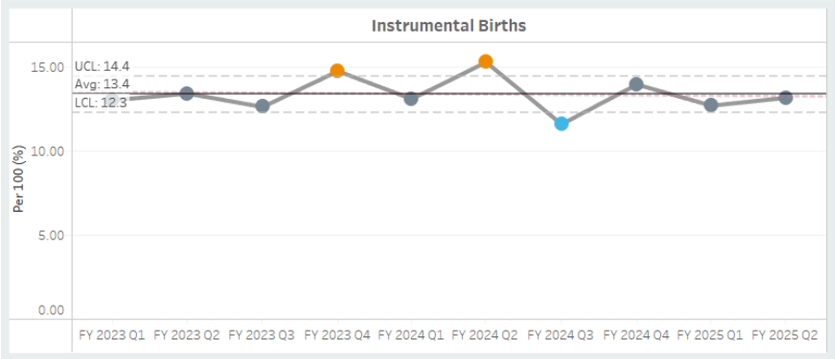
Latest Month

Metric ⓘ

Metric:	Instrumental Births
Rate of:	Ventouse and Forceps Births (Registerable)
Per 100 (%):	Registerable Births

13.2

Trend



Notes

.To continue to monitor.

SVB

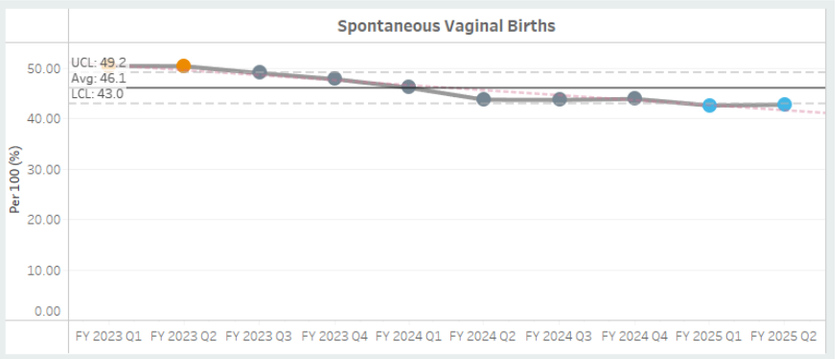
Latest Month

Metric ⓘ

Metric:	Spontaneous Vaginal Births
Rate of:	Spontaneous Vaginal Births (Registerable)
Per 100 (%):	Registerable Births

42.8

Trend



Notes

September saw a reduction in the number of spontaneous vaginal births and this is in line with the current National picture

Emerging issues

Stillbirths – updated position as of the end of quarter 3

As of November 2024 we have seen a further 4 stillbirths above 24 weeks. This takes the total number of stillbirths across September, October and November to 9.

All cases have undergone a multi-disciplinary review where immediate learning and initial themes have been identified. These themes include care issues involving midwifery fundamentals, such as urinalysis, blood pressure monitoring and escalation, fetal heart auscultation, and the management of reduced fetal movements.

Out of the 6 cases across September and October, 3 have been reported as patient safety incident investigations (PSII). An additional case from November has been reported as a PSII and fits criteria to be reviewed by MNSI. Immediate learning has already been identified and actioned. Learning has been shared with the wider teams and leads. The midwifery fundamentals have now been added to the production boards for weekly monitoring, oversight and escalation. Our mandatory midwifery fundamentals training has now commenced with positive feedback.

PPH/MOH

Our PPH and MOH rates remain high, however we have seen a slow downward trend over the past few months. As an updated position (October 2024 data), our Clinical Quality Improvement Metrics (CQIMS) data shows us that we are currently sitting below the national average for PPH at 28.0 per 1000 births, compared to 32.0 per 1000 births (October data).

Triage

It has been highlighted following incident reviews that there are some potential problems with processes within maternity triage. Examples include the pathway for spontaneous rupture of membranes, and advice given over the telephone for both antenatal, postnatal and neonatal concerns. Individual incidents have been reviewed and managed, with learning shared as required. A quality improvement workstream is to be launched within maternity triage with a focus on processes, guidelines and the maternity advice line. This will commence in January 2025.

VTE

The booking and postnatal compliance is for VTE risk assessment is achieving over 95% consistently.

The antenatal admission VTE risk assessment has been processed mapped as there are queries regarding data collection between Badgernet and manual data with a 25% discrepancy. The Badgernet data shows 74% compliance, however this data is reliant on Trakcare being completed in a timely manner. BI are currently working on this. A manual audit of 10 sets of notes was undertaken for the weekly production boards and this showed 100% compliance. Teaching is in progress which includes micro teaching sessions at the safety huddle and throughout the clinical area.

Fetal Monitoring

The ongoing audits for the fetal monitoring CQC workstream have shown that compliance with hourly peer review is not yet reaching the locally agreed figure of 85%. AS an updated position as of November 2024, we are 50% compliant across delivery suite for hourly peer review. On further review our low compliance is more prevalent across the newly qualified midwifery staff group. Following consultation with this staff group, we have found that process knowledge and availability of peer reviewers are a barrier to completion. We have placed step by step process instructions in each delivery room, discussion and oversight by the delivery suite coordinator on the confidence levels of the midwives completing peer review on each shift, inclusion of face to face peer review training on staff induction, to scope for escalation to flow when there are difficulties finding available staff for peer review.

Hourly intrapartum risk assessment in labour is also 50% and will be included in the work detailed above.

Obstetric Anal Sphincter Injury (OASI)

The perinatal dashboard has highlighted that the third and fourth degree tear rates have steadily increased following spontaneous vaginal births. The OASI bundle is being launched at the end of January to educate staff using local data as examples for learning. The mandatory PROMPT training 2025 will include a station on OASI, and the theme of the month for February will be dedicated to OASI, with daily teaching and communication to staff. We will continue to monitor datix incident reports related to OASI, and outcomes shared by BI.

Outcomes

Metric ⓘ

Metric:	Stillbirths => 24 Wks
Rate of:	Stillbirths => 24 Wks
Per 1,000:	Births => 24 Wks

1.4

Metric ⓘ

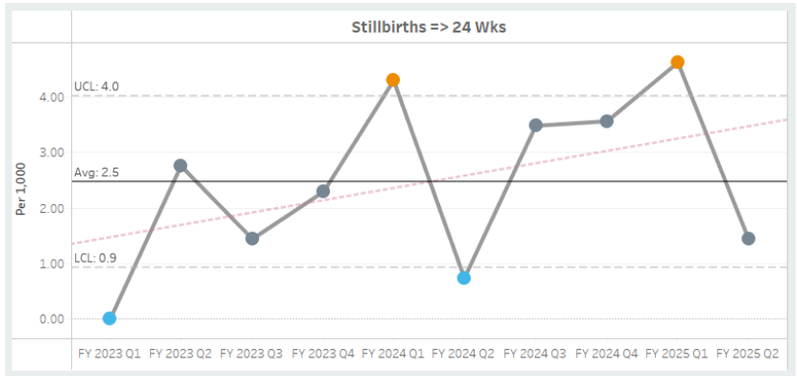
Metric:	Neonatal Deaths =>22 Wks
Rate of:	Neonatal Deaths =>22 Wks
Per 1,000:	Live Births

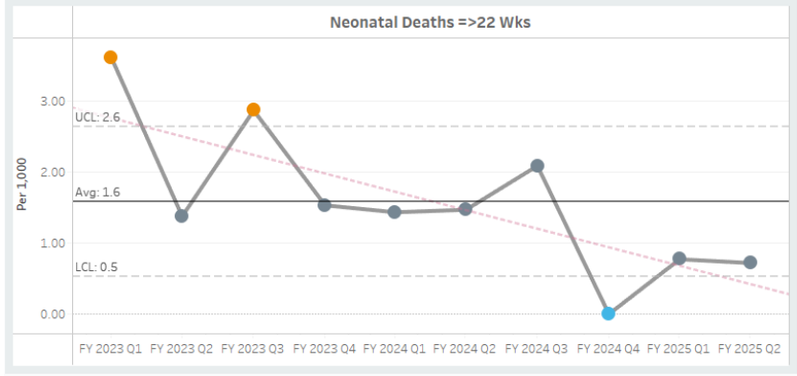
0.7

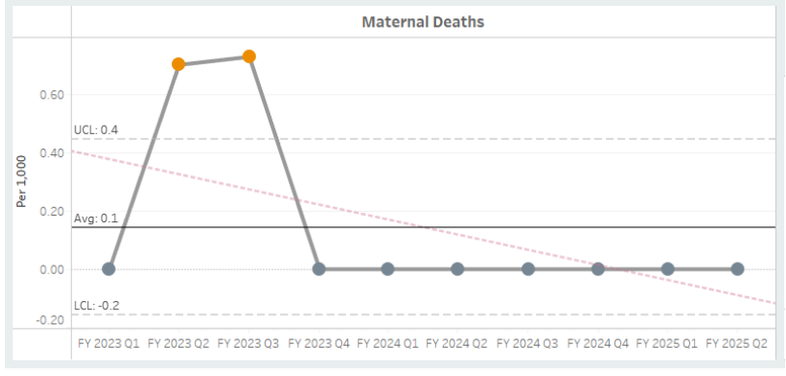
Metric ⓘ

Metric:	Maternal Deaths
Rate of:	Maternal Deaths
Per 1,000:	Maternities (Deliveries over 24 Weeks/Maternal Deaths)

0.0







Quarter 2		
Type of loss	**Monthly figure**	**Rate per 1000 births across the quarter**
Stillbirth > 24 weeks	July 1 Aug 0 Sept 1	1.4 per 1000
Neonatal death	July 0 Aug 1 Sept 0	0.7 per 1000
Maternal Death	July 0 Aug 0 Sept 0	0 per 1000

What is the intelligence telling us?

During Q2 there were 2 stillbirths reported above 24 weeks gestation. Both cases have received multi-professional review (MPR) and have been presented at patient safety review panel. The case reported in July had no immediate care issues identified, however the case from September has been reported as a patient safety incident investigation (PSII) based on the learning identified.

It has been agreed that all stillbirths, and neonatal deaths will be presented at patient safety review panel for oversight, regardless of outcome at multi-professional review.

As an updated position, there have been 9 stillbirths across the months of September, October, November and December. This has taken us above both the regional and national benchmarking figure for stillbirth. All cases have been through a robust multi-professional governance process, with 6 being reported as PSII's and 1 case fitting the criteria to be investigated by the Maternity and Neonatal Safety Investigations (MNSI) team.

Of the 9 stillbirth cases, 4 were mothers of non-white ethnicity with the other 5 cases being mothers of white ethnicity. 2 of the mothers required the use of interpreting services, with challenges to the current service being identified through the review processes. We now have access to a Wordski on Wheels for use in the clinical areas, and learning has been shared regarding our interpreting services. We are awaiting the publication of a local EDI report to help support our next steps to improve access to translation services for our women and families.

Immediate learning has been identified following the review of each of the stillbirth cases and has been focused on midwifery fundamentals, urinalysis, blood pressure monitoring, fetal movements.

What is going well?

- Robust governance processes to support the timely review of perinatal outcomes from a multi-disciplinary perspective
- Proactive support from community leads to audit and identify areas for improvement within midwifery fundamentals, providing 1:1 feedback where required
- Midwifery fundamentals represented on the production boards. Monitored weekly and presented monthly at Production board meeting led by the Head of Midwifery
- Midwifery fundamentals training launched with positive engagement and feedback from staff
- Changes to the PMRT process have been implemented to ensure it is more robust, increase parent engagement and the monitoring and completion of actions and learning

Outcomes continued

Focus for the next period

The external stillbirth review continues supported by the midwifery MIA. The table below identifies some emerging themes and the actions taken to address these so far

Emerging Theme	High level summary of actions in place
Scanning capacity	Ongoing issue. Seeking Exec sponsorship to escalate Risk Register scoring from 16 to 20. Escalation via MDG to Trust Board. Paper included within this pack
Information relating to reduced fetal movement's, a persistent theme	Trust has requested LMNS to lead on Community communication on acting on reduced fetal monitoring Trust has also led on posters/digital communication
Parental engagement in the PMRT process Delay in PMRT taking place	PMRT Action plan in progress and meeting timescales
Absent documentation of routine maternal observations including FH in community appointments	Included within Fundamentals of midwifery study day running Oct-Dec 2024 Audit plan in place
Poor quality reviews with no MDT initial review No assurance that any of the were actions were monitored or completed and therefore no evidence of learning	MDT reviews now 3 times per week Review of all action plan quality via SERG
Lack of information and triangulation with the datix system	Being reviewed by Patient Safety Team

Risks and resources required

Continued multi-professional support for incident reviews

To continue to utilise BI intelligence to monitor and recognise any deviations in data, and to escalate via the new governance structure

Patient and staff experience

To continue to inform and support parents to access the Maternity and Neonatal Independent Senior Advocacy service (MNISA)

Continued focus on improving parental engagement as per the Perinatal Mortality Review Tool (PMRT) process, under the leadership of the perinatal Quality and Governance Lead

Bereaved parents feedback to be shared, actioned and monitored at the patient experience monthly meeting as part of the new governance structure

Staff are supported to attend AER's, including stillbirths and neonatal deaths to support psychological safety, and to provide valuable insight and feedback

Where do we want to be?

To continue to implement and embed robust governance processes

Aim to meet or improve our local perinatal outcome rates against both regional and national benchmarking over the next 12 months

Robust intelligence regarding ethnicity and deprivation data in relation to outcomes

Outcomes – Perinatal Mortality Review Tool Q2

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

Notify all deaths: *all eligible perinatal deaths (22 weeks gestation and above for stillbirths, 22 weeks gestation and up to 28 days for neonatal deaths) should be notified to MBRACE-UK within 7 working days .* We are currently 100% compliant at GHNHSFT for the notification of deaths to MBRRACE-UK.

Seek parents' views of care: *For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.*
100% of parents are notified that a review of their care is taking place, and an opportunity is provided to feedback their perspectives to support the review of care. This process has been strengthened as part of the PMRT action plan, including face to face information provided by the maternity patient safety team and bereavement midwives, a named point of contact, refreshed PMRT letter using the updated MBRRACE-UK template, follow up by the named point of contact midwife and/or the bereavement midwives.

Review the death and complete the review: *For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.*
The review of cases where babies were born and died at GHNHSFT, that have been started within 2 month is currently at 100%. We have met the 6 month target for completion of reports within 6 months, currently compliant at 75%. There are a number of factors that impact the closure of reports within 6 months, including awaiting postmortem results and external investigations such as MNSI.

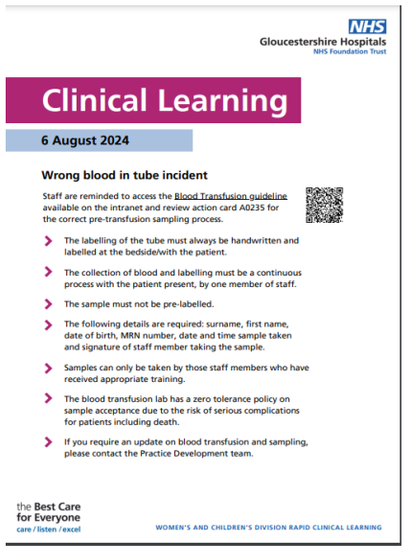
Report to the Trust Executive: *Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.*
This is in place and will continue to be reported at Trust Board on a quarterly basis.

Month	Brief summary	Review process completed/agreed learning outcome	Learning identified	Actions taken
July	Term stillbirth	A multi-professional review (MPR) Perinatal Mortality Review Tool (PMRT) – review complete and report published Included in the external stillbirth review supported by the MIA	No immediate safety concerns were identified at the MPR No care issues were identified during the PMRT review	No actions required
September	28/40 stillbirth	A multi-professional review (MPR) Presented at Patient Safety Review Panel – decision for Patient Safety Incident Investigation (PSII) with primary care Perinatal Mortality Review Tool (PMRT) - review completed with support from tertiary Trust – care graded as a D leading up to the death of the baby. This indicates that there were care issues identified that were likely to have impacted on the outcome for the baby Ongoing PSII	Need to improve staff adherence to local guideline Need to improve communication between primary care and the maternity service	Learning and comms have been shared with the maternity teams Learning and communication has been shared with primary care through the LMNS Public health awareness through the LMNS Communication between microbiology and maternity processes strengthened

PSIRF

PERINATAL QUALITY AND SAFETY REPORT

Quarter 2 2024	
Met MNSI criteria	0
PSIIs	1
AERs	1
Quality Summits	1
Coroner Reg 28	0


NHS Gloucestershire Hospitals NHS Foundation Trust

Clinical Learning

6 August 2024

Wrong blood in tube incident

Staff are reminded to access the Blood Transfusion guideline available on the intranet and review action card A0235 for the correct pre-transfusion sampling process.

- The labelling of the tube must always be handwritten and labelled at the bedside/with the patient.
- The collection of blood and labelling must be a continuous process with the patient present, by one member of staff.
- The sample must not be pre-labelled.
- The following details are required: surname, first name, date of birth, MRN number, date and time sample taken and signature of staff member taking the sample.
- Samples can only be taken by those staff members who have received appropriate training.
- The blood transfusion lab has a zero tolerance policy on sample acceptance due to the risk of serious complications for patients including death.
- If you require an update on blood transfusion and sampling, please contact the Practice Development team.

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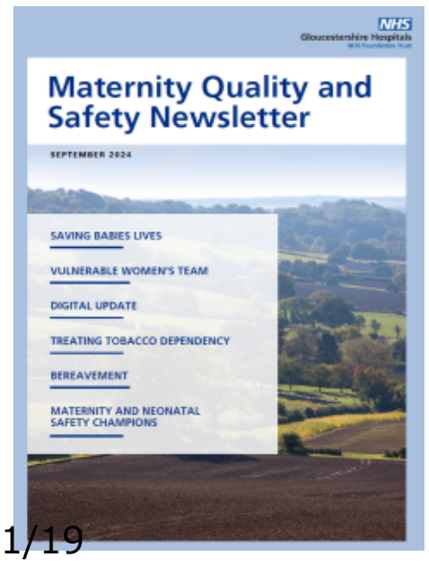
WOMEN'S AND CHILDREN'S DIVISION RAPID CLINICAL LEARNING


NHS Gloucestershire Hospitals NHS Foundation Trust

Maternity Quality and Safety Newsletter

SEPTEMBER 2024

SAVING BABIES LIVES

VULNERABLE WOMEN'S TEAM

DIGITAL UPDATE

TREATING TOBACCO DEPENDENCY

BEREAVEMENT

MATERNITY AND NEONATAL SAFETY CHAMPIONS

Key Performance Indicator	2021-22	2022-23	2023-24	2024-25 YTD
Eligible for MNSI referral	12	8	12	4
Accepted MNSI referrals	11	6	12	3
MNSI referrals declined by HSIB	0	0	0	1
MNSI referrals declined by family	1	2	0	0

Risk ID	Risk	Risk owner	Current rating
409	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.	TJ	20
499	Midwifery staffing	LS	20
861	Massive obstetric haemorrhage	RH/VC	20
751	The risk of failure to provide a safe and high quality ultrasound service	AH	16

What is the intelligence telling us?

During quarter 2 there was 1 patient safety incident investigation reported. This case has been detailed in slide 10 and was a stillbirth at 28 weeks gestation. The learning identified was agreed to have likely impacted on the outcome for the baby.

A Quality Summit (QS) was held during July supported by the regional maternal medicine network to review the 3 cardiac arrest cases that had occurred over the past 12 months. The review highlighted good practice and a high standard of care, with praise for the multi-disciplinary teams involved.

All stillbirth cases, MNSI cases and cases reported as PSII's/requiring duty of candour have been provided with information both verbally and written, signposting them to the Maternity and Neonatal Independent Senior Advocacy Service (MN ISA)

What is going well?

We continue to embed PSIRF processes within maternity

We continue to share learning via a variety of channels, including a theme of the month, quality and safety newsletter, rapid clinical learning and Fetal Wellbeing Wednesday

No MNSI reportable cases during Q2

The clinical matrons have robust oversight of their clinical outcome and audit measures through the weekly production boards. A monthly production board oversight meeting is led by the Head of Midwifery.

Focus for the next period

- Increased frequency of MDT reviews
- Trigger list for MDT reviews
- Appropriate updating of risks on the risk register (dependent on rating) by risk owners
- Risk register training to be booked by any staff member who requires
- Align Trust and LMNS risk registers, bi-monthly meetings to be scheduled

Risks & Resources required

- Obstetric time allocated for regular MDT reviews of patient safety incidents
- Clear process for MDT reviews including those cases that meet criteria, possibly terms of reference required
- Maternity specific PSIRF guidance required with clear priorities
- Increased focus and resource required on local datix incident reviews

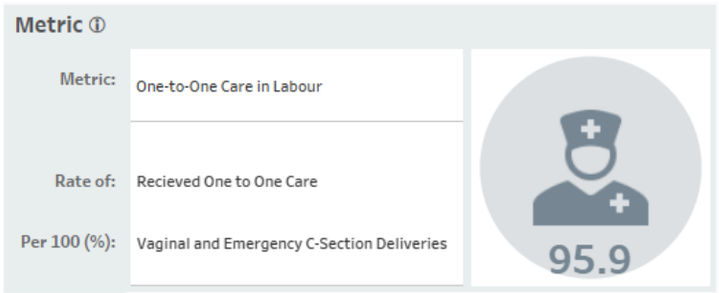
Patient and Staff Experience

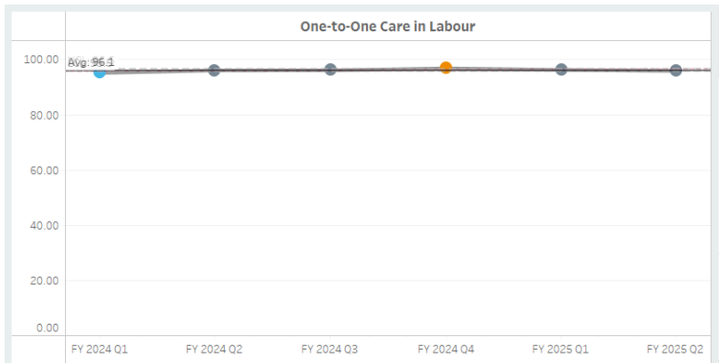
- PSIRF and wider governance training to be included within the PROMPT mandatory update day from January 2025
- To increase and improve patient engagement with incident reviews
- Education and training on duty of candour to be provided during the PROMPT training day for all staff

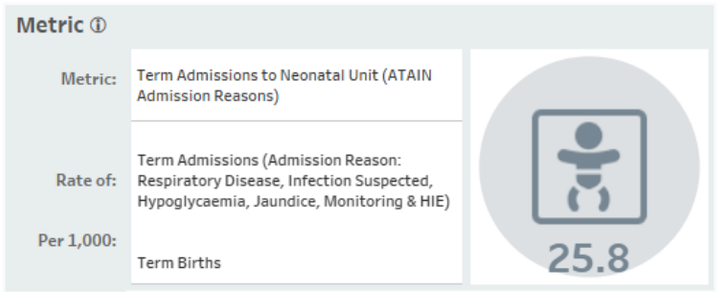
Where do we want to be?

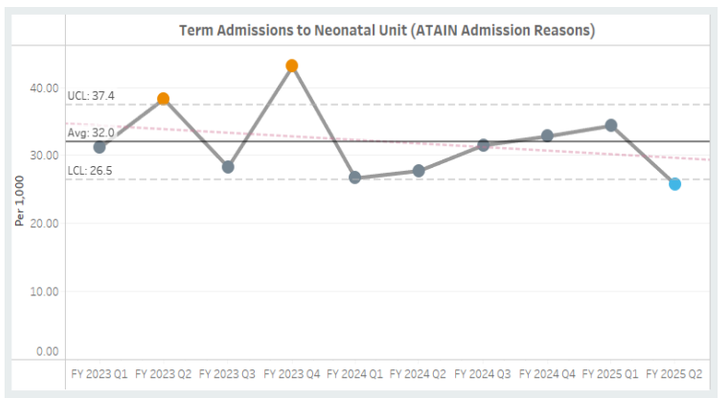
- Streamline MDT process with trigger list
- Continue to implement and embed robust governance processes and structure
- Wider maternity understanding of governance processes

Quality – Quarter 2









What is the intelligence telling us?

1:1 care in labour is defined as care provided to women throughout labour by a midwife solely dedicated to her care. This does not have to be the same midwife (NICE, 2015). 1:1 care in labour has remained reasonable consistent, but is however falling slightly below the required 100% figure. An action plan is now in place and will be monitored through perinatal oversight and assurance and action plan oversight. Staff will be asked to complete a datix when 1:1 care in labour is not achieved to understand why this has not occurred.

Our current ATAIN figures sit below the national benchmarking figure of 5%, however we currently have a backlog of ATAIN reviews requiring an MDT approach. As an updated position, we have now 50 open ATAIN cases with 31 overdue. Regular ATAIN meetings have been scheduled with a focus on reviewing cases involving low cord gases, low APGARS, and/or resuscitation required at birth

What is going well?

We continue to achieve 100% for our supernumerary delivery suite coordinator

ATAIN cases are now monitored on the governance production board weekly, and presented monthly to the Head of Midwifery at the Production Board meeting

Focus for the next period

1:1 care in labour – to update the current escalation policy in line with MIS requirements and continue to monitor

Datix review cases where 1:1 care has not been achieved who have not received 1:1 care in labour

Risks & Resources required

Obstetric resource is required for a full MDT review for ATAIN cases

Patient and Staff experience

There have been no themes reported through patient experience regarding lack of 1:1 care in labour, however we will continue to monitor

Where do we want to be?

To have a robust review process embedded for the review of all ATAIN cases, in a timely manner (the following month)

Completion of the 1:1 care in labour action plan

Achieving 100% 1:1 care in labour for all women

Quality – Training Compliance

Staff group	Benchmark	Jul	Aug	Sept
Maternity Mandatory Midwives	90%	92	88%	89%
Maternity Mandatory MCA/MSW	90%	91	91%	84%
PROMPT Part 1 Midwives	90%	94	93%	95%
PROMPT Part 1 MCA/MSW	90%	87%	88%	92%
PROMPT Part 1 Obstetric Consultants	90%		85%	92%
PROMPT Part 1 Obstetric Registrars	90%		77%	86%
PROMPT Part 1 Obstetric ST1/ST2	90%		100%	100%
PROMPT Part 1 GP Trainee/FY	90%			
PROMPT Part 1 Anaesthetic Trainees	90%		87.5%	87.5%
PROMPT Part 1 Anaesthetic SAS/Consultants	90%		64%	64%
PROMPT Part 2 Midwives	90%		92%	94%
PROMPT Part 2 MCA/MSW	90%		88%	88%
PROMPT Part 2 Obstetric Consultants	90%		85%	92%
PROMPT Part 2 Obstetric Registrars	90%		72%	86%
PROMPT Part 2 Obstetric ST1/ST2	90%		100%	100%
PROMPT Part 2 GP Trainee/FY	90%			
PROMPT Part 2 Anaesthetic trainees	90%		87.5%	87.5%
PROMPT Part 2 Anaesthetic SAS/Consultants	90%		64%	64%
Fetal Monitoring Day Midwives	90%		96%	93%
Fetal Monitoring Day Obstetric Consultants	90%		85%	85%
Fetal Monitoring Day Obstetric Registrars	90%		82%	82%
Fetal Monitoring Day Obstetric ST1/ST2	90%		100%	100%
Neonatal Life Support Midwives	90%		88%	89%
Neonatal Life Support NICU Nurses	90%		74%	88%
Neonatal Life support NICU ANNP	90%			100%
Neonatal Life Support NICU Consultants				

What is the intelligence telling us?

- Training compliance is monitored monthly through our Training and Education meeting, through to Oversight and Assurance for any escalation
- Figures are now broken down by staff group for increased oversight, which allows for targeted action
- The July figures were not broken down by staff group, but an overall figure for obstetrics, anaesthetics etc
- The Maternity Incentive Scheme (MIS) year 6 (safety action 8) requires us to be 90% compliant with mandatory training across specified staff groups
- An updated position for the end of Quarter 3 shows that we have achieved the 90% standard set by MIS year 6, across all staff groups

What is going well?

- Surveillance of mandatory training now by staff group
- Successful commencement of Badgernet Digital CTG training roll out, go live 26/11 (staggered)
- Practice development & patient safety theme of the month implemented
- Midwifery Fundamentals launched 25/10.
- Band 7 practice development role recruited to
- We continue to report on training broken down by specific staffing groups as per MIS reporting requirements
- The GP trainee staff group are 100% compliance with PROMPT training as of November 2024 data
- All staff groups
- The midwifery fundamentals training has now been implemented and has received positive feedback from staff who have attended

Focus for the next period?

- Completion of Midwifery Fundamentals
- 2025 training in line with MIS & Core Competency Framework
- Launch of new Perinatal Update day in 2025 (with NICU colleagues)
- Recruitment – two posts, Student Practice Facilitator & Fetal Wellbeing

Risks & Resources

- Safeguarding compliance – focus for December theme of the month & inclusion in Perinatal Day 2025
- Monthly skills drills – no longer running community PROMPT, need to implement monthly community skills drills and mandate once yearly attendance & support via backfill

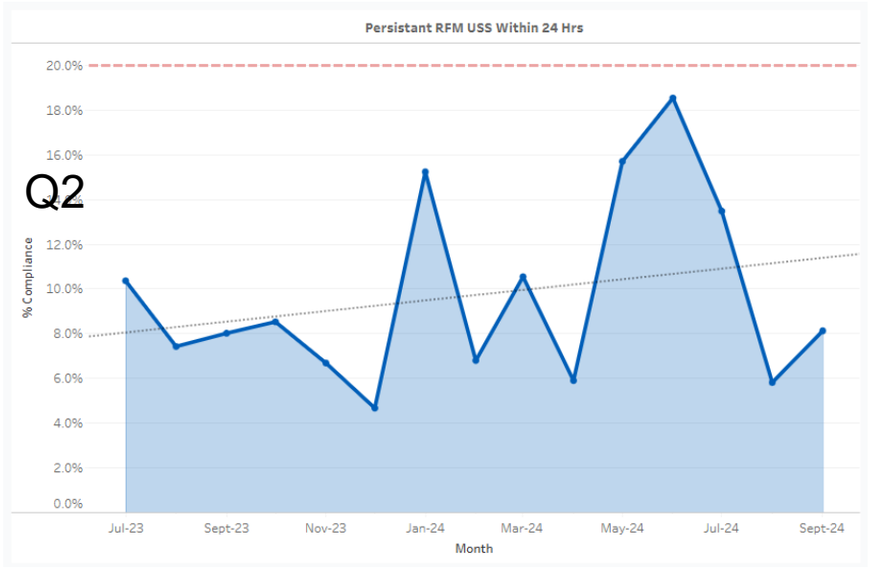
Patient and Staff experience

- Staff feedback is collated post study day, assisting with the planning and implementation of training for 2025
- Midwifery Fundamentals has a 4.4/5 feedback score
- Patient experience themes to be monitored through the Training & Education meeting

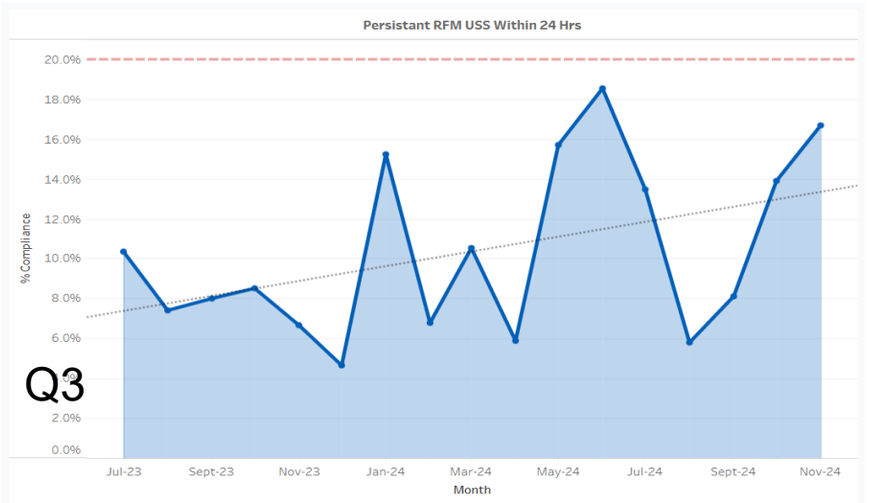
Where do we want to be?

- Clearer oversight of compliance with use of a more dynamic tool
- An accountable team that are aligned with our strategic goals to support a culture of continuous improvement through education and training
- Monthly skills drills that have a dynamic evaluation and learning focus

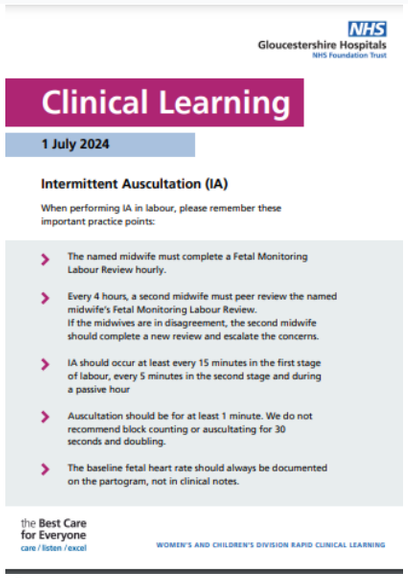
Priorities – Fetal Wellbeing



Q2



Q3



NHS
Gloucestershire Hospitals
NHS Foundation Trust

Clinical Learning

1 July 2024

Intermittent Auscultation (IA)

When performing IA in labour, please remember these important practice points:

- The named midwife must complete a Fetal Monitoring Labour Review hourly.
- Every 4 hours, a second midwife must peer review the named midwife's Fetal Monitoring Labour Review. If the midwives are in disagreement, the second midwife should complete a new review and escalate the concerns.
- IA should occur at least every 15 minutes in the first stage of labour, every 5 minutes in the second stage and during a passive hour
- Auscultation should be for at least 1 minute. We do not recommend block counting or auscultating for 30 seconds and doubling.
- The baseline fetal heart rate should always be documented on the partogram, not in clinical notes.

the Best Care for Everyone
care / listen / excel

WOMEN'S AND CHILDREN'S DIVISION RAPID CLINICAL LEARNING

What is the intelligence telling us?

Improvement required with compliance with ultrasound scanning for persistent fetal movements within 24 hours in line with Saving Babies Lives Care Bundle version 2

Mitigation required for mothers with persistent reduced fetal movements who are awaiting ultrasound scan

Support for triage required for both midwives and obstetricians, on the recognition and management of women with risk factors for stillbirth who attend with fetal movements concerns

What is going well?

Updated position as of Q3

There have been further improvements to the ultrasound scanning compliance within 24 hours as per the slide below. Work will continue in this area with further improvement work expected month on month

The daily CTG's for women who experience recurrent fetal movements is now in place and women are invited to attend the day assessment unit (DAU) daily for fetal wellbeing reassurance until they have received an ultrasound scan to assess fetal growth and liquor volume

Focus for the next period

Recruitment to fetal wellbeing midwife post

Launch of CTG's on Badgernet

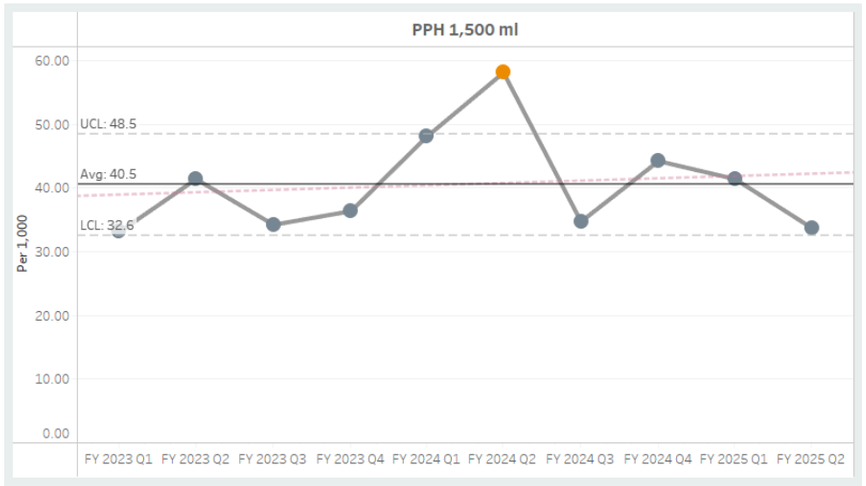
Risks & Resources required/ Where do we want to be?

Continued improvements in USS wait times for recurrent reduced fetal movements within 24 hours

Launch of triage QI

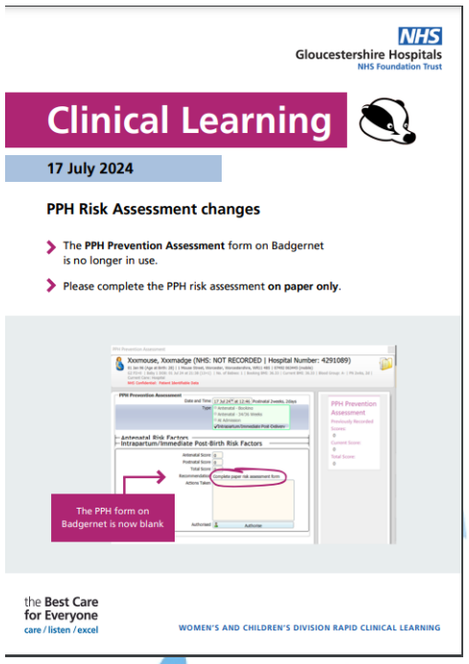
The flowchart for the management of reduced fetal movements is being finalised

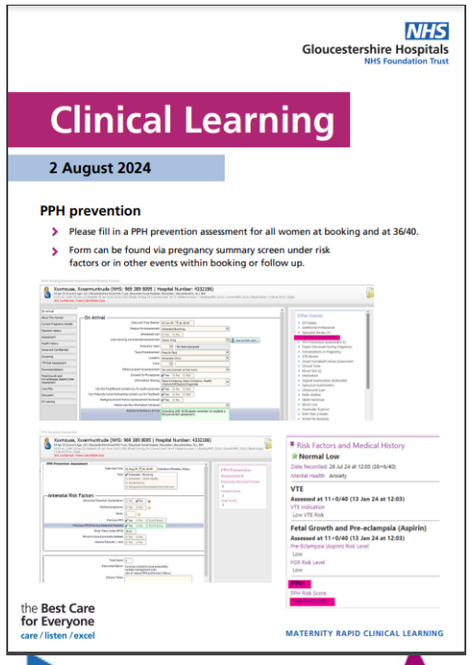
Priorities - MOH

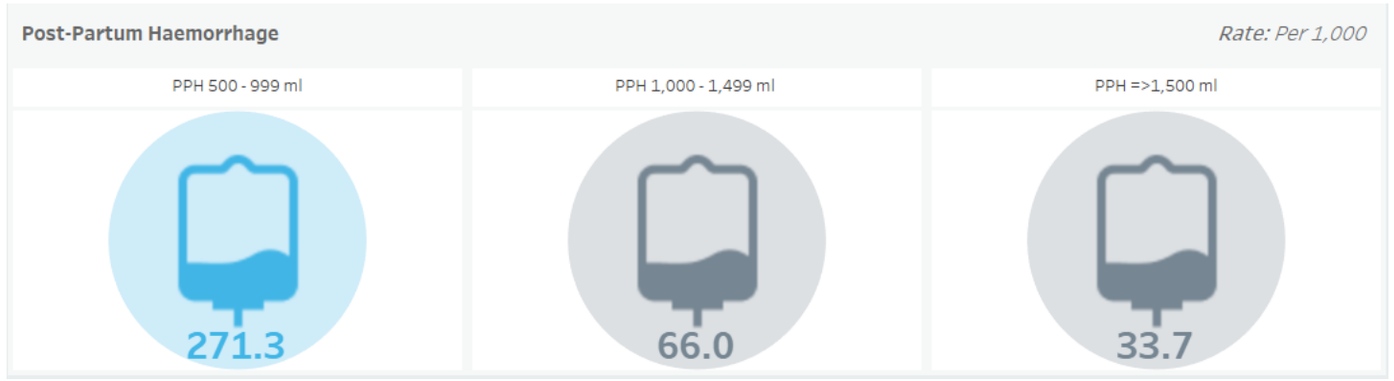


CQUIMs Data	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024
National average	30.0	30.0	30.0	31.0	31.0	32.0	32.0
Trust data	42.0	38.0	36.0	37.0	41.0	32.0	28.0

An updated position as above shows that our Clinical Quality Improvement Metrics (CQIMS) data shows that we are currently sitting below the national average for PPH at 28.0 per 1000 births, compared to the national average of 32.0 per 1000 births (October data)







What is the intelligence telling us?

- The REDUCE project continues to work well and show consistent improvements in our MOH rate.
- Massive obstetric haemorrhage rate sitting slightly above the national average for November. All MOH cases continue to have an MDT review for identification of learning themes and trends, with work ongoing via REDUCE.
- PPH risk assessment completed - audit shows 95% compliance.

What is going well?

Continued improvements via REDUCE project

Carbetocin audit achieved 100% (100% of CS received Carbetocin)

PPH/MOH data presented at tertiary unit's PPH forum, excellent feedback received

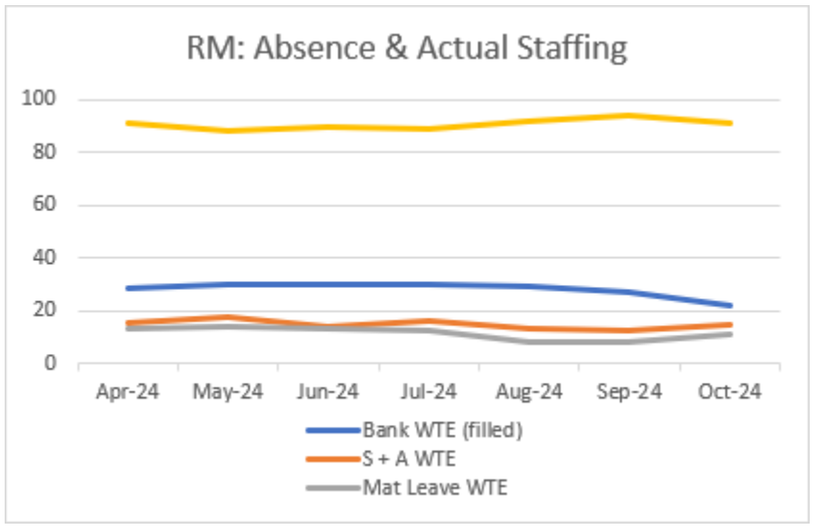
Focus for the next period

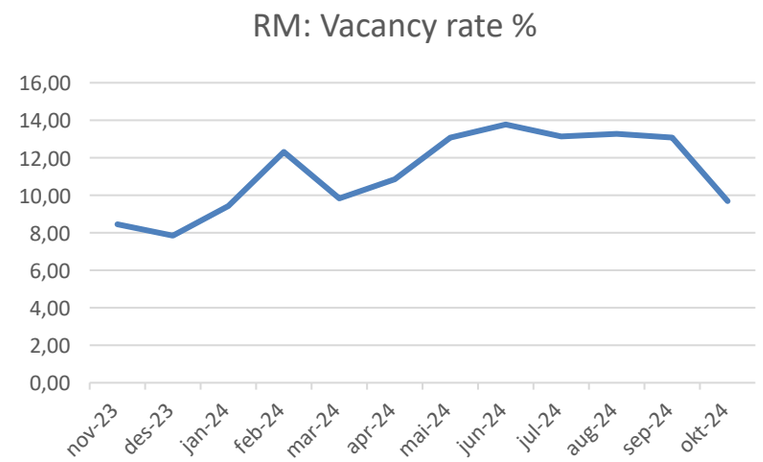
- Deep dive into themes around PPH and MOH
- Literature review on patient experience of PPH
- Meeting with Head of Patient Experience to be arranged
- The REDUCE team are meeting to plan next steps
- Update REDUCE proforma following staff feedback
- Robust datix incident reviews of PPH cases between 500-1499mls

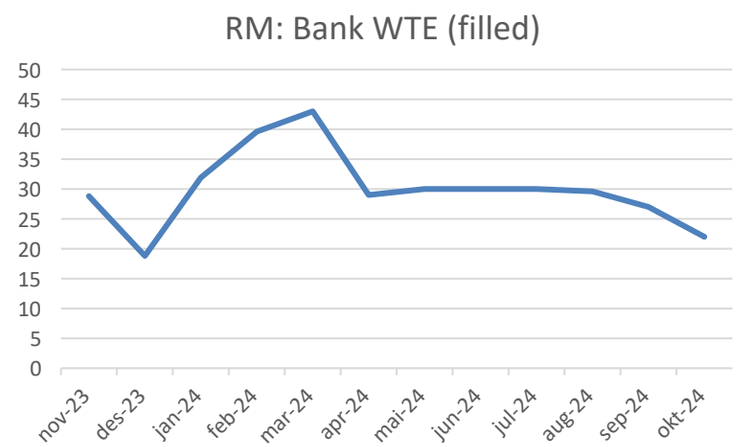
Risks & Resources required/ Where do we want to be?

- Rotem – increased use – cross-divisional discussion underway. Procurement of additional Rotem to be progressed via 2024/25 business planning process.
- Risks: manual audit = time intensive
- Risk identified through MDT review of escalation when cell selvage in use with measurement of ongoing blood loss

Maternity Workforce







What is the intelligence telling us?

- Steady progress evident on the current midwifery vacancy rate over Q2 see chart- remains on the risk register at 20
- Key metrics relating to safety still being meet despite shortfall in midwifery staff
- Reliance on bank and agency slowly reducing across Q2

Updated position as per the end of Q3

- Reduced the vacancy rate by 10 WTE (13 headcount) – vacancies now at 9%
- To review risk on register and downgrade
- As the substantive vacancy rate has reduced as has the bank use.
- Obstetric consultant gaps are due to short and long term absence, 1x fixed term locum consultant roles are currently being advertised, 1x fixed term locum commenced post, 1 x substantive obstetric consultant post recruited to, 1 x substantive post out to advert, interviews planned for January 2025

What is going well?

- 100% supernumerary status of labour ward coordinator
- Midwife to birth ratio 1:26
- Recruitment to Consultant vacancy

Focus for the next period

- To launch the community transformation QI project to address key issues in community services- October 24
- Campaign to attract midwives into working in the community teams
- Request to recruit additional substantive Consultant is being progress via MIS Year 5 funding request.

Risks & Resources required/ Where do we want to be?

- Birthrate plus assessment planed for spring 25
- Recruitment plan to continue
- Plans to review Cons workforce with MIA
- Benchmarking exercise for medical workforce required to ensure that sufficient capacity is available.

Neonatal Workforce

What is the intelligence telling us?

- The Neonatal Unit are budget compliant with meeting the Local Neonatal Units Standards of Tier 1 and Tier 2 separate rotas for the junior medical workforce to meet BAPM requirements.
- There are gaps within the rotas due to sickness absence and maternity leave, however these gaps are filled largely by internal locums. The LMNS have been informed of these standards being met through the SW NICU/LNU Medical Workforce Stocktake.
- The Unit remains challenged in relation to nurse staffing. September 24 nurse staffing figures demonstrate a gap of 14 WTE, comprised largely of maternity leave (6.7 WTE), one long term sickness absence, a small number of vacancies (5 WTE) and two members of staff appointed but not yet in post. Maternity leave is only predicted to slightly decrease from its current level.

What is going well?

- There continues to be no vacancies in band 2/3 or 4 roles. The vacancies are only in band 6/7 neonatal nursing roles that require QIS qualification.
- BAPM compliant in neonatal medical staffing.

Focus for the next period

- Succession planning for ANNPs.
- Continue with the neonatal retention and recruitment action plan with no overdue actions, 6 in progress

Neonatal Nursing Workforce Action plan	Sept 24 (Updated and Revised for 24/25 not including previously closed actions)
Overdue	0
In Progress	6
Complete	14
Total number of elements	20

Risks & Resources required

- Escalation plans have been instigated when activity increases/staffing is impaired to support nursing, which has included utilising all nursing time into clinical shifts (cancelling/postponing study leave/admin time/teaching days), flexing staff on and off shifts to match demand and booking of bank/agency nurses. However, this then impacts on the available time for admin, training and other management requirements such as conducting appraisals.
- Bank are utilised if required however there is a very limited pool of bank staff with neonatal skills, especially so if QIS cover is needed.

Staff Experience

Culture Survey (SCORE)

Themes identified as part of action plan:

What is the intelligence telling us?

Safety Champions

The safety champions walkabout for July took place on the delivery suite, and the safety champions meeting took place following this in the clinical area. The safety champions walkabout was attended by the executive and no-executive safety champions, director of midwifery, perinatal quality and governance lead, freedom to speak up guardian and the women and children's communications lead. A safety concern was raised around the obstetric registrar's current workload and on call responsibilities. This is a current area of focus and obstetric staffing is on the risk register. The most recent insight visit advised a benchmarking exercise of similar sized units to look at consultant numbers and on call structure. The current risk and its associated actions will be monitored through the new governance process, and feedback will be provided to staff following the walkabout.

During September the Safety Champions walkabout took place on Gloucester Birth Unit (GBU). This was followed by the Safety Champions meeting, providing the opportunity for staff to attend. No safety concerns were raised by staff.

Where do we want to be?

- To further increase staff engagement via our safety champions walkabouts and meetings
- To increase clinical safety champions presence
- Increase comms and awareness around FTSU
- Completion of the outstanding actions within the SCORE survey action plan

What is going well?

- Staff engagement has increased over the past 2 safety champions walkabouts, and increased attendance is now noted at the safety champions meetings since being held in the clinical areas
- Staff feedback and ideas have been put into practice
- Challenges with community staffing and escalations have been listened to and discussed by the senior teams, and a community QI will commence at the end of December, beginning of January.
- The culture plan continues with support from our People and OD link and the work with Korn Ferry has advanced with all consultant obstetricians and Band 8 Midwives had met with them on a 1:1 /group basis.
- The board safety champions are continuing to meet with the Quad bi-monthly to offer support to the division including any issues raised through safety champions and the culture programme.

Focus for the next period

- Schedule Patient Safety Champions walkabouts and meetings for 2025
- The culture plan continues with support from our People and OD link.
- There is some focused work with matrons planned for 2025, including: a session using Insights Discovery to begin to think about different leadership styles and different ways of working and communicating particularly difficult conversations around giving and receiving feedback and managing conflict.
- A follow on session regarding how we might turn towards difficulties and distress in the team/workplace and how we respond from a place of threat, in order to develop some skills and practices which would help team members move into different systems to enable them to manage more challenging situations.
- The culture plan will be updated post review of the recent pulse survey.
- To improve feedback channels for staff to raise safety concerns outside of the safety champions process.
- Continued awareness of the FTSU champions and process

Risks & Resources required

Comms support with updating of safety champions material and feedback

Patient Experience

Number of complaints received	Number of concerns received	Number of claims/ disclosures
20	6	5

CQC Maternity Survey Action Plan Update

- Infant Feeding- regular communication by the team to staff including newsletters and comms regarding training and patients through Facebook Live.
- IOL workshops on MS teams for patients with positive feedback and 22 women attending in 2 weeks.
- Recent Doula and Midwife engagement activity at Cheltenham.
- To improve call bell response times; noise has changed to be louder and has night mode. More MSWs recruited to support staff to answer call bells.

What is the intelligence telling us?

During Q2 we reviewed the maternity claims scorecard for the year 6 MIS reporting period. The main themes of alleged areas of negligence within the scorecard are the mismanagement of care, both antenatally and intrapartum leading to poor outcomes for babies, both stillbirth and hypoxic ischaemic encephalopathy (HIE). The majority of the cases within the claim's scorecard are historic, with a small proportion of incident dates from 2022 and 2023. There are only 2 claims without an incident investigation. All other claims had incident reports that were reviewed at the time of the incident and learning taken forward. The 2 cases without a review included 1 case where a mother's care was transferred antenatally, and we were therefore unaware of the baby's outcome. The second case involved a mother who had a delay in treating chorioamnionitis leading to exposure to sepsis and subsequent brain damage. We have shared our claims scorecard with our maternity MIA to seek advice on a further approach to thematic analysis of cases.

We received 20 complaints across Q2. Themes included communication, concerns with clinical care and staff attitude. Feedback is provided to individuals as required and Learning has been shared via the theme of the month and quality and safety newsletter

What is going well?

Improved process within maternity to address complaints in a more timely manner, with oversight from the Head of Midwifery and Divisional Quad

FFT responses remain positive on the whole with good engagement from service users

Focus for the next period

Continued triangulation of complaints, claims and incidents

The teams to address complaints in a timely manner and the offer of a debrief/face to face meeting with all complainants

To ensure more robust oversight and action following complaints from patients through the new governance structure

Risks & Resources required

To scope for complaints training for the team

Patient and Staff experience

To improve communication regarding escalating concerns whilst patients are admitted/within the hospital, to resolve concerns timely.

Consider:

- Social media posts
- Internal comms and posters
- Information available on the internet

Where do we want to be?

To see a reduction in the number of complaints received due to improved experiences for our families

A more proactive approach to patient concerns at the time of admission

Raised awareness to patients regarding the PALS compliments process

Proactive 'Conversation with the community' following improvement in response to the CQC S31 to build confidence and knowledge

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Trust Board (Public)				
Date	16 January 2025			
Title	Trust Strategy refresh – update			
Author /Sponsoring Director/Presenter	Will Cleary-Gray - Executive Director of Improvement and Delivery			
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 paper is to provide a brief update to board on progress made refreshing the Trusts strategy including:

- the approach to developing our refreshed strategy and agreed timeline
- engagement with staff, patients, the public and wider stakeholders to inform and shape the strategy
- early feedback on vision, values and behaviours and emerging key themes to inform strategic priorities
- next steps

Since, our last strategy was developed in 2019 there have been some significant events and changes internationally, nationally and locally which are important strategic context within which the NHS operates and care is delivered locally. These require careful consideration to inform and shape our strategy and strategic priorities for the years ahead to ensure we continue to be ambitious for our patients and communities.

Our ambition is to build on our 2019-24 strategy to co-produce with our staff and partners a new strategy for 2025 and beyond. It will be strategically focused on purpose, vision values and behaviors and what we are trying to achieve for the people we serve with a small number of strategic objectives which will secure delivery. The aim is a strategy that is succinct and accessible and able to be refreshed as needed, aligned to our system plans and clearly reflects what we, as a Trust, should uniquely deliver and where we need to get alongside others to deliver for our patients and communities maximising the opportunity of our role as an important anchor organisation and partner in our region.

Work began refreshing our strategy at the end of the summer 2024 with a clear focus and commitment to engagement and co-design. Following agreement with Board in November 2024 the timeline for finalising our new strategy is the end of July 2025. This supports increased time for engagement given likely service pressure over winter as well as time to fully consider the expected 10-Year Health plan

Recommendation
The board is asked to: • Note and consider the approach to developing our refreshed strategy and agreed timeline including the Darzi report and what we know of the anticipated 10 Year Plan • Consider the progress made on engagement with staff, patients, the public and wider stakeholders to inform and shape the strategy • Note and consider the early feedback of vision, values and behaviours and emerging key themes to inform strategic priorities • Note and consider next steps as set out • Receive a further update in March
Enclosures
Enc 1 - Trust Strategy refresh – update

Gloucestershire Hospitals NHS Foundation Trust Strategy refresh – update

Trust Board – in public

16 January 2025

Purpose

1. The purpose of this paper is to provide a brief update to board on progress made refreshing the Trusts strategy including:

   - the approach to developing our refreshed strategy and agreed timeline
   - engagement with staff, patients, the public and wider stakeholders to inform and shape the strategy
   - early feedback on vision, values and behaviours and emerging key themes to inform strategic priorities
   - next steps

Background

2. In 2024 the board supported a refresh of our Trust strategy. The Strategy had been co-produced with staff, patients, communities and key stakeholders and ran from 2019 – 2024.

3. It set out a clear **purpose** to improve the health, wellbeing and experience of the people and communities we serve by delivering outstanding care every day, a simple **vision** to provide the best care for everyone and core **values** and **behaviours** of caring, listening and excelling to develop and embed a culture of continuous improvement of quality and standards.

4. The strategy began with 10 strategic priorities identified to achieve the Trusts vision and were the result of analysing and synthesising national, regional and local context including Gloucestershire's Joint Strategic Needs Assessment (JSNA) and population health analysis, key challenges facing the trusts delivery of high-quality services and support and feedback from engagement with our staff and key stakeholders. These objectives were:

   1. Outstanding care
   2. Companionate workforce
   3. Quality improvement
   4. Care without boundaries
   5. Involved people
   6. Centres of Excellence
   7. Financial balance
   8. Effective estate
   9. Digital future

10. Driving research

5. A significant feature of the strategy was that it was underpinned by an ambitious programme to transform hospital services for the future across the Trust including clinical services at Cheltenham General Hospital, Gloucester Royal Hospital and Stroud Maternity Unit. The COVID-19 pandemic happened early on in the lifetime of the strategy and both its immediate and longer-lasting effects impacted on the course of the strategy.

6. The strategic objectives were revised for 2023-2024 to focus on 3 new strategic objectives which remain current, these are:

    1. Flourishing workforce
    2. Care delivery
    3. Productivity and sustainability

    A summary of the key elements of our current strategy can be found at **Appendix, A**

Strategic context

5. Since our last strategy was developed in 2019 there have been some significant events and changes internationally, nationally and locally which are important strategic context within which the NHS operates and care is delivered locally. These require careful consideration to inform and shape our strategy and strategic priorities for the years ahead to ensure we continue to be ambitious for our patients and communities.

6. These include the withdrawal of the UK from the European Union, the impact and learning from Covid-19, the cost-of-living crisis, implementation of the Health and Care *Act* 2022, bringing online statutory Integrated Care Boards as the new commissioner of healthcare, Integrated Care Partnerships, with responsibility for setting local care system strategy, a new duty to collaborate and focus on partnerships placed on all statutory health and care organisations and a revised procurement regime reflecting this duty to collaborate, a new government, a published Independent Review of the State of the NHS, a 10 Year Health Plan expected later in 2025 and renewed focus on devolution from central government with the 2024 Devolution Bill.

Lord Darzi Report and the National 10 Year Health Plan

7. Many of the above events and changes feature in the Independent Investigation of the National Health Service in England which was led by Lord Ara Darzi and published in September 2024. It focuses on both the performance of the NHS and the key drivers of performance. It explores four interrelated drivers including, funding, investment and technology, the impact of the pandemic, patient voice

and staff engagement and NHS structures and systems together with a number of critical themes including the declining nations health, increasing access challenges and waiting lists, spend and financial flows misaligned with a policy for left shift, lower levels of productivity, NHS economic contribution still to be maximised.

8. It positions NHS performance challenges within the changing and challenging external environment the NHS is operating in. It reflects that many of the factors that are contributing to the NHS's challenges are outside of its direct control, including wider determinants of health and a decline in the nation's health.

   A summary of key elements of the report can be found at **Appendix, B**

9. The challenges identified in the Darzi Report continue to impact across the NHS and are applicable to Gloucestershire and GHFT. Many are already reflected in our Board Assurance Framework (BAF) and priorities reviewed with work already to address these.

10. The National 10 Year Health Plan is expected to be published in summer 2025. The Plan is anticipated to reflect on the issues raised in the Darzi Report and underpinned by a health mission including areas that sit within local health and care systems and those that require significant input from cross government and wider society to address the wider determinants of health. The goals/vision of the 10 Year Health Plan is:

    - An NHS and social care that is there when people need it including access to high quality health and care.
    - Fewer lives lost to the big killers including early deaths from major conditions including cancer, diabetes and heart disease.
    - A fairer Britain where everyone lives well for longer including reducing the number of years spent in ill health.

    Delivery will be through the following three shifts:

    1. **Hospital to home** - Change so that more people get care in the community or closer to home
    2. **Analogue to digital -** Change so that we have the workforce we need with the technology and innovation to deliver the best care
    3. **Treatment to prevention -** Change so that we focus on prevention

11. The NHS Change Conversation to inform the development of the National Plan opened on 21st October. GHFT has contributed through a number of forums and events to the development of the 10 Year Plan including a South West region engagement session in November. GHFT is also working with ICS partners on further local engagement which is being aligned were possible with our engagement work on our Trust strategy.

12. Our population and the health of our population continues to change as does their health and care needs. The latest Joint Strategic Needs Assessment (JSNA) tells us that by 2043 the population of Gloucestershire will grow to 683,849 by 2028 and to 738,482 by 2043, approximately 8% growth. The notable feature of the projections is the sharp increase in the 65 or over age group, which is projected to increase from 134,973 in 2018 to 205,865 in 2043, a 52.5% increase over this period which is higher than the national trend for England (at 44.7%). This indicates potential increase in demand for care and support with increasing prevalence of major conditions and people living with multiple long-term conditions.

Summary of approach, timeline, progress and early insights

13. Our ambition is to build on our 2019-24 strategy to co-produce with our staff and partners a new strategy for 2025 and beyond. It will be strategically focused on purpose, vision values and behaviors and what we are trying to achieve for the people we serve with a small number of strategic objectives which will secure delivery. The aim is a strategy that is succinct and accessible and able to be refreshed as needed, aligned to our system plans and clearly reflects what we as a Trust should uniquely delivery and where we need to get alongside others to deliver for our patients and communities maximizing the opportunity of our role as an important anchor organisation and partner in our region.

Approach and timeline

14. Work began refreshing our strategy in summer 2024 with a clear focus and commitment to engagement and co-production. Key elements of the framework are summarised below:

    a) An engagement plan with associated materials and toolkit to gain insights and feedback from our staff, patients, communities and key stakeholders
    b) Reviewing what we set out to achieve in our 2019-24 strategy including realisation the benefits of key enabling strategies including, workforce, quality, clinical, digital, estates research and innovation
    c) A baseline assessment of quality and outcomes, our work on health inequalities, performance delivery and finance and work and insights from our medium-term planning (MTP)
    d) An assessment of changing demographics across Gloucestershire and consideration of our JSNA and how these impact on future services development and delivery
    e) Horizon scanning key developments and advancements
    f) PESTEL analysis, considering local and national context and alignment with other plans for example Integrated Care Strategy and Joint Forward Plan and the anticipated 10 Year Health Plan expected in 2025

15. Following agreement with board in November 2024 the timeline for finalising our new strategy is the end of July 2025. This supports increased time for

engagement given likely service pressure over winter as well as time to fully consider the expected 10-Year Health plan.

A strategy development timeline set against other key development timelines can be found at **Appendix, C**

Our engagement so far

16. A main focus of the strategy development to date has been focussed on engagement with our staff, patients, communities and key stakeholders which has been ongoing since the summer and continues. A strategy development engagement tool kit was developed to support engagement and provide a framework and approach to support feedback and developing insights. This toolkit is underpinned by a series of open-ended questions intended to gain as much feedback and insights as possible about the kind of organisation our staff and stakeholders want us to be, what matters to them and what we need to focus on.

17. More than 1000 individual staff members have contributed so far with the support of more than 20 internal trained facilitators supporting over 55 facilitated sessions with individual teams, services, divisions, including corporate and groups. Further sessions are planned and will continue to engage our staff including clinical team, Gloucestershire Managed Services (GMS), Trust Charity and Governors over the coming months. There will also be a focus on community engagements with key dates and collaboration with the Integrated Commissioning Board (ICB) and Gloucestershire Cancer Institute (GCI) with the NHS Information Bus visiting Tewksbury, Forest of Dean, Gloucester, Stroud, Cheltenham and Cotswolds across January and February. The Trust has also been supported by Inclusion Gloucestershire and held a workshop with Healthwatch Gloucestershire's Board in December 2024. In addition, there is a mapping exercise underway to identify any gaps in reaching and engaging with groups with protected characteristics.

    A summary of our engagement approach and toolkit and groups providing feedback so far can be found in **Appendix, D**

Early feedback and insights

18. Whist our engagement work still continues early analysis of the feedback received so far from more than 1000 of our staff indicate that the purpose, vision, values and behaviours in our current strategy which were co-produced with our staff remain relevant to delivering our ambition. A headline summary of key themes from feedback so far includes the following which are important to our staff:

- Being Patient and people focussed
- Delivering high quality safe and effective care
- Supporting and developing our workforce and staff wellbeing
- A greater focus on prevention and improvement
- Being inclusive, empowered, empowering, valued and valuing, recognised and giving recognition
- Sense of pride and getting the basics right
- Being psychologically safe
- A sense of team, collaborative and partnership working
- Advancing treatment and innovation for the future
- Maximising on the opportunity of being an anchor organisation
- A clear connection and balance between vision and ambition in our strategy and the day-to-day reality
- Doing things sustainably and making best use of resources

Next steps

- Continuing with our engagement and involvement.
- Continue to work through our development framework a-f including taking into account the anticipated updated JSNA along with the key challenges facing the trust and delivery of high-quality care.
- Undertake a full assessment of feedback so far and what is emerging from our work to refresh, purpose, vision, values and behaviours and strategic objectives.
- Provide an update to Trust Leadership Team (TLT) at the end of January and to system partners in February
- Produce a first draft of the strategy for consideration and feedback at Board in March.

Recommendations

The board is asked to:

- Note and consider the approach to developing our refreshed strategy and agreed timeline including the Darzi report and what we know of the anticipated 10 Year Plan
- Consider the progress made on engagement with staff, patients, the public and wider stakeholders to inform and shape the strategy
- Note and consider the early feedback of vision, values and behaviours and emerging key themes to inform strategic priorities
- Note and consider next steps as set out
- Receive a further update in March

Appendix, A

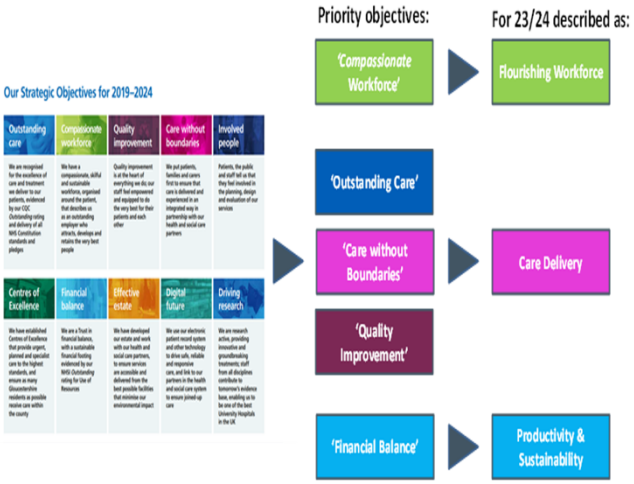
Where are we coming from - Our 2019-24 strategy

Purpose: To improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day

Vision: Best Care for Everyone

Values:

- **Caring:** we care for our patients and colleagues by showing respect and compassion;
- **Listening:** we actively listen to better meet the needs of our patients and colleagues;
- **Excelling:** we strive to excel through learning, and we expect our colleagues to do and be the best they can.



Appendix, B

Key points from Darzi Report, published on 12 September 2024.

The report explores four interrelated drivers of NHS performance, funding, investment and technology, the impact of COVID-19, patient voice and staff engagement and NHS Structure and systems and a number of critical themes including the declining nations health, increasing access challenges and waiting lists, spend and financial flows misaligned with a policy for left shift, lower levels of productivity, NHS Economic contribution still to be maximised.

i. **Funding, investment and technology** – The report outlines that 2010s were the most austere decade since the inception of the NHS with funding growth of 1% between 2010-2018 (compared with the long-term average of 3.4%). It also identifies an underinvestment in capital and technology, and a significant reduction in the public health grant resulting in a failure to divert resources into prevention.

ii. **The impact of COVID 19** – The report suggests that the UK entered the pandemic with lower levels of resilience than other health care systems due to underinvestment, which contributed to higher bed occupancy and workforce challenges. Consequently, it identifies that the NHS cancelled more routine care during the pandemic than other counterparts. It acknowledges the lasting impact of the pandemic.

iii. **Patient voice and staff engagement** – The report outlines that patient satisfaction with the NHS has declined and the number of complaints has increased. It highlights that patients indicate they feel less empowered to make choices about their care and notes a reduction in discretionary effort by staff.

iv. **NHS structures and systems** – The report supports the implementation of Health and Care Act 2022, which placed integrated care systems on a statutory basis, and its focus on collaboration. It highlights the growth in NHS England and the Department of Health and Social Care (DHSC) and reaffirms the change needed with the Clinical Quality Commission and it acknowledges variation in how ICBs' are dispatching their role and suggests that this would benefit from greater clarity and consistency. It also notes the need to refresh the effectiveness of the framework of national standards, financial incentives and earned autonomy.

In addition to the interrelated drivers of performance there is considerable detail across a range of themes in the report which can be summarised as follows:

- **Declining nation's health** – The report identifies several indicators of a deterioration in the nation's health, most starkly captured by the national decrease in healthy life expectancy. The report indicates that where we have previously seen improvements such as reductions in premature mortality for cardiovascular disease progress has now stalled, and we are seeing increases in inequalities between our most and least deprived communities in these indicators. Thus, demonstrating an increase in health inequalities. The report focuses more specifically on a range of health needs, including long term conditions, mental health and cancer. It notes that nationally we have seen a significant increase in long term conditions, partly driven by an ageing population, but evident across all age cohorts. The prevalence of diabetes, respiratory conditions, and cardiovascular diseases are highlighted as particular challenges.

- **Increasing access challenges / waiting lists** - The focus on the performance of the NHS recognises the increasing access challenges, with growing waiting lists for hospital, community, and mental health provision, for adults, and children and young people. It notes that key access targets have mostly not been met since 2015 due to increasing demand, greater complexity, and lower levels of productivity. It identifies the unprecedented pressure faced by urgent and emergency care and our A&E departments. Despite the challenges it outlines that in most cases people are in receipt of high-quality care, although it does identify several areas of concern including maternity care. It also flags that we are falling behind international comparators in areas such as cancer care, noting that we have not consistently met cancer standards since 2015.

- **Spend and financial flows misaligned with left shift policy direction** - The report is clear that although the policy direction has been to move care into the community and closer to home for several years, this has not been realised. It sets out that nationally we have less GPs and lower levels of spend outside of hospital, whilst spend in hospital has increased. Suggesting that current financial flows and underinvestment in capital have inhibited delivery of care in the community.

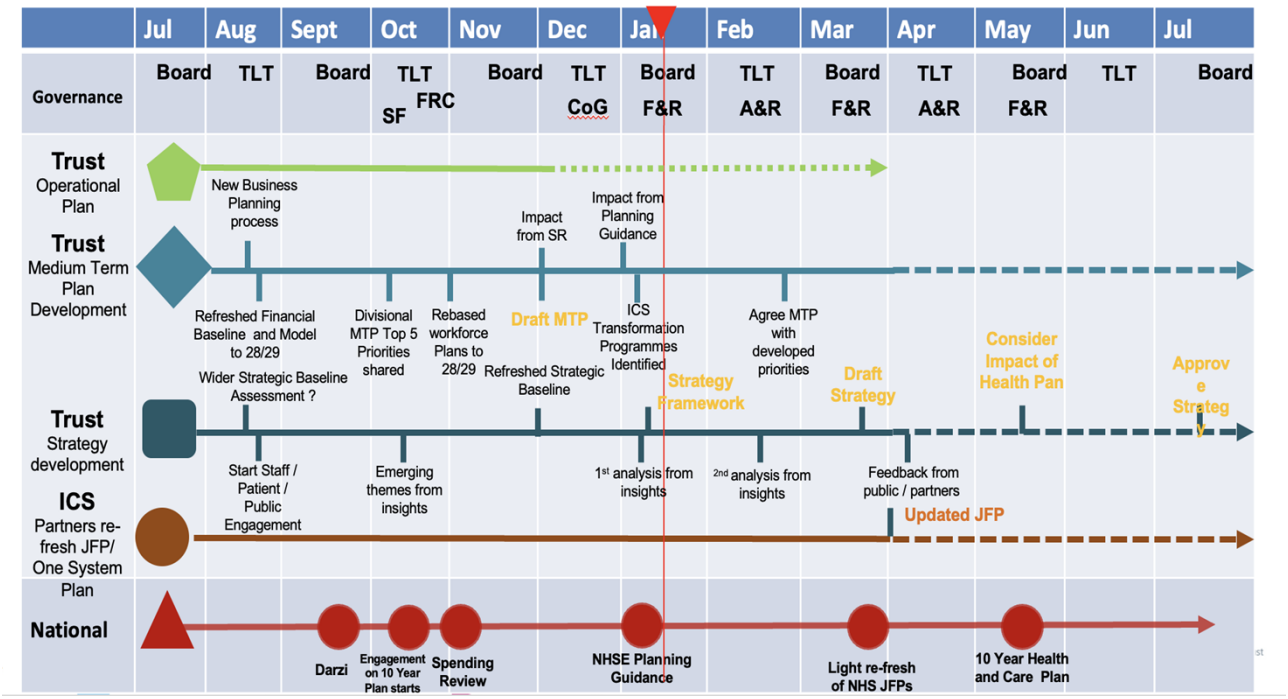
- **Lower levels of productivity** – Despite increased spend in hospitals the report indicates that we have not seen the equivalent increase in productivity. It connects this to the challenging context within which services are operating, with limited availability of capital and under investment in social care hindering patient flow.

- **NHS contribution to economic development still to be maximised** – The NHS and economic growth is a recurring theme in the report. This aligns well to the fourth core purpose of an Integrated Care System to maximise the contribution the NHS can make to social and economic development. The report reiterates the importance of the interrelated relationship between the NHS, health, and the economy. It emphasises the impact of ill health on ability

to work, and the symbiotic relationship between work and health, noting that healthier workers are more productive. It also outlines that the UK has a strong life sciences industry and that this is a driver of innovation.

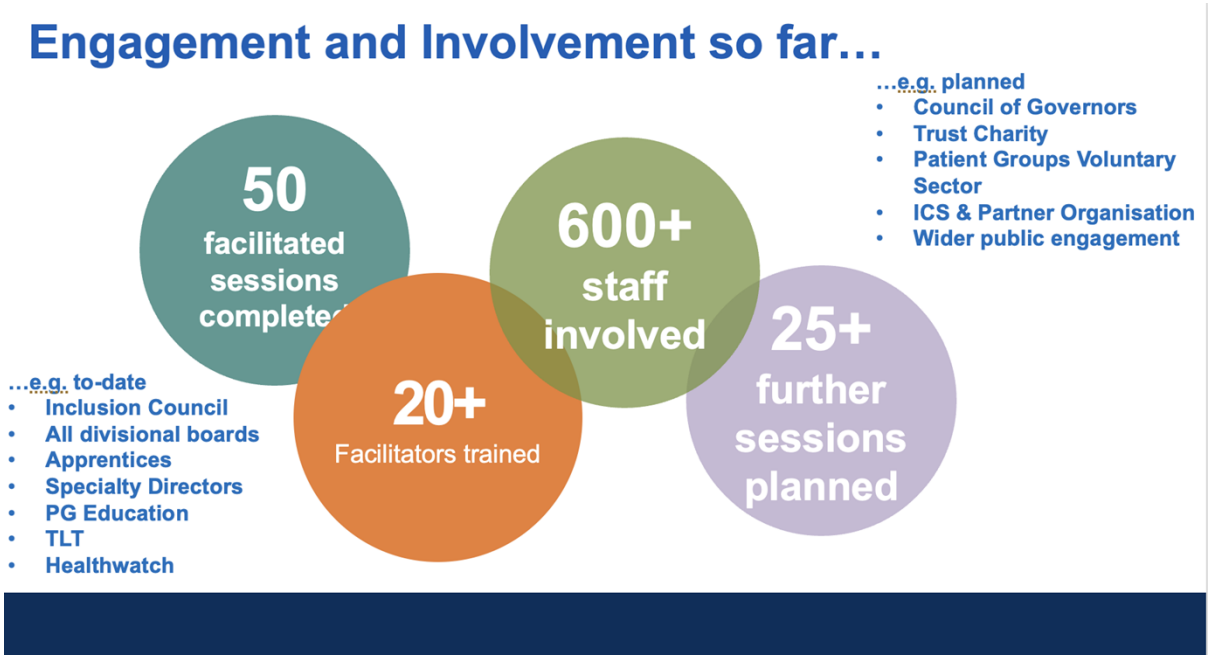
Appendix, C

Timeline and approach to strategic and operational planning



Appendix, D

Summary of engagement approach and toolkit and groups providing feedback so far



Planned NHS Information bus visits across the county:

Date	Time	Location
Wednesday 22nd January	10-3 pm	High Street, Cheltenham
Thursday 23rd January	10-3 pm	Livestock Farming, Cirencester
Thursday 24th January	10-3 pm	Forest of Dean - Travellers Site
Wednesday 29th January	10-3 pm	Stroud, High Street or Stratford Park
Thursday 30th January	10-3 pm	St Paul's Medical Centre
Friday 31st January	10-3 pm	Gloucester, The Cross
Monday 3rd February	10-3 pm	Dursley, Town centre
Wednesday 5th February	10-3 pm	Forest of Dean, Cinderford at Tesco car park
Thursday 6th Feb	10-3 pm	Cirencester, Marketplace
Friday 7th Feb	10-3 pm	Lydney, Tesco car park

Wednesday 19th Feb	10-3 pm	Gloucester, Asda at Kingsway
Friday 21st February	10-3 pm	Forest of Dean Coleford, Roundabout
Wednesday 26th February	10-3 pm	Burton-on-the-Water, Co-op
Thursday 27th February	10-3 pm	Friendship Café, Barton and Tredworth

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) 30th October		
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 requiring continued **oversight.** The committee will be receiving deep dives into maternity care areas to ensure thorough review and oversight of planned improvements – the wider maternity leadership team will now also be attending QPC to support wider discussion and assurance. One of the current areas of focus is **still birth rates** The committee received the statistical review, comparison and analysis of the Trust's current stillbirth rate. This metric has a national focus for improvement. It was reported that local data demonstrated a slight increase in stillbirth rates in Q3 and Q4 2023/24. The CNO shared that the NHSE Trust Maternity Improvement Advisor was undertaking a thematic review into **still birth rates to** ensure that our improvement plans captured all learning opportunities. It was reported previously to QPC that improvements were required to increasing the availability of maternity sonography capacity to reduce scan waiting times – the committee were updated that additional resource had been approved and recruitment was in progress The Perinatal Mortality Review Tool (PMRT) Improvement plan was noted at the Maternity Delivery Group. Members were not assured (as dates were missing from the plan) and a	Ongoing strengthening of assurance reporting was noted to be in progress. An updated position and actions will come back to QPC

	more developed plan would be provided next month.	
Patient Safety investigation and complaint report	The committee continues to seek assurance regarding timeliness and **handling of complaints.** Response rates do not currently meet the required standards. Assurance that actions are in place with executive oversight was given.	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 were provided with an update on key metrics within the Integrated Performance Report, highlighting current performance levels and actions taken to address non-compliance. progressing undertaking work to rag rate all areas of the Single Oversight Framework. The CMO updated the committee regarding progress of performance regarding monthly monitoring of **Venous Thromboembolism assessments.** An update on local safety priorities was noted, this included updates on **pressure**	Planned deep dives would be presented to QPC as per forward plan. IPR to be presented at Trust Board. ICB Urgent Care Director to be invited to future QPC to enable ongoing collaborative discussions and to enable the committee to seek assurance from system plans and monitoring Continued delivery of actions overseen by CMO on QPC action log for ongoing oversight

Glossary:
H1/H2= first/second half of the financial year
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	ulcers and **maternity.** The Committee noted that updates would be provided in each report going forward. An update on the quality summit was also noted.	
DM01 Diagnostics	The committee received an assurance report that the Trust was now meeting the **14-day cancer target** and actions related to the endoscopy programme were being worked through. The Committee noted that workforce numbers were now sufficient but physical space remained an issue, with approaching NHS England may for funding for recovery to stabilise the service being a possibility. The committee noted that **cystoscopy** had sustained a non-compliant position for three rolling months. Compliance in **echocardiography** was linked to the sonographer shortage. The position in **neurophysiology** had deteriorated and the plans to address this were noted. It was added that the service was focussing on patients waiting over 30 weeks to drive waits down to six weeks.	Ongoing monitoring and Quarterly reports would update QPC as per forward plan.
Regulatory Report	The Committee noted the report which outlined any breaches to those obligations and provided assurance that improvement action plans were put in place to enable the Trust to meet requirements. It was reported that **no new inspections** had taken place since the last report to this Committee. The Committee noted that the Trust continued to meet with the Care Quality Commission on a fortnightly basis, with the CQC Inspectors requesting further information about various issues regularly. At the last meeting colleagues were informed that the Trust would be a pilot site for new style engagement meetings going forward.	Monthly reporting to QPC to continue Ongoing engagement with CQC led at Executive Level

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	It was reported that colleagues were currently unable to access the Care Quality Commission portal and there are **3 outstanding inspection reports** (Emergency Department (Gloucester) December 2023, Maternity (Gloucester) March 2024 and Medicine and Oncology (Cheltenham) awaited. It was reported that the Emergency Department report had now been outstanding for ten months. The Committee noted that the Care Quality Commission had published it before the Trust had looked at a draft and it was taken down from the site after colleagues challenged its publication. It was reported the Care Quality Commission were now unable to resend it through their portal.	
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
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
2023/2024 Quarter Learning from Deaths Report	The lead Doctor provided the Committee with assurance of the governance systems in place for reviewing deaths and in addition demonstrated compliance with the National Guidance on Learning from Deaths. The report covered the period January to March 2024. The commitee discussed deaths occurring outside of hospital, considerations for our patients who occupy a no criteria to reside definition, and weekend mortality. All areas were currently under review as part of our	There are several actions being progressed outlined in the report – progress will be reported in the next quarterly report.

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	routine analysis, and this included system discussions It was noted as positive assurance to see family experience of the medical examiner service positively reported.	
Clinical Effectiveness and Gloucestershire Safety and Quality Improvement Academy Report	Alexandra Purcell provided the committee with assurance on the oversight of the **Clinical Effectiveness Improvement and Quality Improvement function**, and information on the Gloucestershire Safety and Quality Improvement Academy future plans and training. The Committee noted that the Clinical Effectiveness and Improvement team had oversight responsibility for several regulatory areas. They produced valuable key performance indicators and reported to the Quality Delivery Group on a quarterly basis. It was reported that the team endeavoured to review and evaluate support to clinical colleagues. In the last year the assurance, audit and QI prioritisation matrix, to support PSIRF requirements were updated. A visual representation of the audit cycle linked with Gloucestershire Safety and Quality Improvement Academy structure had been developed to embed the idea that poor audit compliance required improvement before further reaudit. 'Audit on a Page' templates, had been introduced both for general audit and maternity specific audit. The training was regularly reviewed and updated. The Committee noted the list of projects undertaken and the Committee. Quality Improvement drop-in sessions would be taking place in the coming months.	
Items not Rated		
SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.		

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Governor Observations

Andrea Holder noted the amount of work that had gone into producing the reports for the meeting. She highlighted the Annual Equality report and reported that Governors would welcome being involved in that work. She referred to the Care Quality Commission regime and highlighted that the Care Quality Commission did not currently seek the views of Governors.

Helen Bown welcomed the progress outlined in the reports and the helpful debate that took place throughout the meeting. She noted the National Patient Safety Alert related to medical beds, trolleys, bed rails and welcomed the inclusion of the risk on the Committee action log. She was pleased to note the progress on complaints.

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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KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) 30th October		
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 requiring continued **oversight.** The committee will be receiving deep dives into maternity care areas to ensure thorough review and oversight of planned improvements – the wider maternity leadership team will now also be attending QPC to support wider discussion and assurance. The Committee noted that Compliance with Safeguarding Children Level 3 training in maternity stood at 54%, which was well below the 80% target, marking it as a high-risk area. Revised governance processes and monthly updates via the Maternity Delivery Group aimed to improve this. Concerns about delayed ultrasound scans for reduced fetal movements were mitigated with cardiotocography as a temporary measure, though scans remained the priority. The Committee particularly commented on fragmented data, particularly the drop in appraisal compliance to 54%, and suggested a consolidated reporting schedule for better oversight. Lisa Stephens raised concerns about rising caesarean section rates and midwifery documentation inconsistencies in community settings. To address these, targeted audits and learning initiatives on maternal and fetal monitoring were launched.	Ongoing strengthening of assurance reporting was noted to be in progress. An updated position and actions in respect of governance will come back to QPC
Patient Safety investigation and complaint report	The committee continues to seek assurance regarding timeliness and handling of complaints. Jo Mason-Higgins reported that all outstanding serious incident investigations were completed, including a delayed case that had been awaiting external input; the final report was now under review. Significant progress was being made on overdue	QPC will receive an update following TLT agreed complaints handling improvement plan

	serious incident action plans, with the number of overdue plans significantly reduced due to the introduction of weekly Surge meetings. Progress on red-flagged actions was steady, though many were tied to ongoing improvement projects.	
atient Safety Reports	Victoria Wills reported positive progress in patient safety training, with Level 1 completion rates improving and Level 2 training now aligned and mandatory. Communication campaigns and integration with other programmes were underway to promote uptake and monitor progress. No new patient safety or quality risks were reported.	
Quality Delivery Group	Safeguarding training was under enhanced surveillance with efforts to improve compliance, particularly in the corporate division. Actions were being taken to address concerns raised in Care Quality Commission reports for children's and maternity services at Stroud and Gloucestershire Royal Hospital. Histology reports had 3,000 pending, and Suzie Cro confirmed this was a high concern, with an improvement plan expected at the next meeting. The Quality Delivery Group would continue supporting governance processes. An improvement in complaint resolution rates to 18% was noted,	Improvement plan to come to Q&P
Planned Care and Improvement Board	Performance reviews highlighted ongoing challenges. The Committee noted that by the end of October, eight patients had waited over 85 weeks for treatment, with delays linked to national shortages of materials and isotopes. Efforts to manage the 65-week waiting list continued, with 11 corneal graft patients excluded due to shortages. Diagnostic improvements were noted, with October's breach rate dropping to 11%, led by a 33% reduction in cardiology echocardiogram backlogs. Urodynamics and cystoscopy also improved, while endoscopy services faced ongoing challenges meeting colorectal straight-to-test pathway demands. However, the Lower Gastrointestinal pathway saw improvements, achieving the	

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	28-day faster diagnostic standard for cancer care.	
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Integrated Performance report	The Committee were provided with an update on key metrics within the Integrated Performance Report, highlighting current performance levels and actions taken to address non-compliance. progressing undertaking work to rag rate all areas of the Single Oversight Framework. Al Sheward updated that the **DM01** Diagnostics position for September had improved to 11.75%, exceeding the 15% target. This was driven by better Echocardiogram recovery, however, delays in histopathology and endoscopy pathways, particularly colorectal colonoscopies, still required additional intervention.	Planned deep dives would be presented to QPC as per forward plan. IPR to be presented at Trust Board.
Guardian of Safe Working Hours	Shyam Bhakthavalsala reported that for the period 1 July to 30 September 2024, a total of 110 exception reports were raised, reflecting a decrease when compared to the same period in 2023. No fines were levied during this time.	
Infection Control and Water Safety	Craig Bradley reported that Clostridium Difficile infection rates remained high despite efforts to reduce them. The Trust established an improvement group with strong support, but national rates had increased, with the Southwest region particularly affected. Last year, the Trust slightly exceeded its target and was on track to breach it again this year. A trial with a new cleaning product yielded excellent results, with no C. Difficile cases in areas where it was used, though cases returned after the product was withdrawn, indicating its effectiveness. The Trust planned to implement this product across the organisation. Craig Bradley raised concerns about water safety in D Block, the Cardiology ward, and the Acute Medical Unit due to temperature control issues. Retrofits had enabled	

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	filtering, but long-term solutions, including shutting off D Block's water supply, posed risks. Further actions were planned to address water safety in D Block and the Orchard Centre, improve infection control measures, and review antibiotic therapy for Clostridium Difficile	
Regulatory Report	The Committee noted the report which outlined any breaches to those obligations and provided assurance that improvement action plans were put in place to enable the Trust to meet requirements. It was reported that **no new inspections** had taken place since the last report to this Committee. The Committee noted that the Trust continued to meet with the Care Quality Commission on a fortnightly basis, with the CQC Inspectors requesting further information about various issues regularly. At the last meeting colleagues were informed that the Trust would be a pilot site for new style engagement meetings going forward. The committee was reminded of the enforcement notices issued for maternity services, particularly the Section 31 notice. Documents related to these notices had been included in the appendices for assurance regarding ongoing work and responses to the Care Quality Commission. A recurring theme across all inspections had been safeguarding and training compliance. This issue was being addressed through the Quality Delivery Group	Monthly reporting to QPC to continue Ongoing engagement with CQC led at Executive Level
Maternity Health Inequalities	Deborah Evans praised the work on maternity health inequalities but raised concern about alcohol use during pregnancy, noting that 360 to 600 babies in Gloucestershire were born with foetal alcohol spectrum disorder annually. She questioned whether alcohol use was adequately prioritised in maternity services and suggested a report to assess responses,	

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	adherence to NICE guidelines, and midwives' confidence in addressing the issue	
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Items not Rated		
SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.		
Governor Observations Susan Mountcastle acknowledged the ongoing challenges common across trusts nationwide. She noted the proactive steps being taken to address these issues, supported by collaborative efforts. The commitment and teamwork demonstrated by all involved were recognised, offering a positive outlook for progress.		
Impact on Board Assurance Framework (BAF)		
All strategic risks discussed. Challenge given on current and target risk scores		

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Report to Board of Directors meeting held in Public			
Date		16 January 2025	
Title		Integrated Performance Report (IPR) for November 2024	
Author / Sponsoring Director/ Presenter		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

Operational Performance

The 4-hour emergency care standard was not achieved in October. 61% of patients were seen, treated and discharged within 4 hours, a 2% decrease in performance compared to September 2024. However, an additional 800 attendances in October greatly contributed to this position. The system performance was also not achieved.

Ambulance Handover Times – October saw a worsening position for Ambulance Handover Times, increasing from 57 to 89 minutes average. This corresponds to the system Cat 2 response time. November has seen some improvement with the number of Ambulance delays >30 mins reducing from 60.3% in October to 47.1% in November.

No Criteria to Reside (NCRT) - Limited progression with reducing nCTR numbers, although bed days occupied has improved with overall the median wait showing an improved downward trend.

Referral to Treatment – Current data suggests approx. 1500 patients breaching 52 weeks in November. This is compared to 1,615 in the month of October. This is linked to the work undertaken to address patients waiting >65 weeks. The number of patients waiting >65 weeks at the end of November was 11 (excluding patients that are unable to be treated due to a national shortage of essential material such as cornea graft, specific knee joints and radioactive isotopes required for certain diagnostic testing). The trust is focusing on 52-week compliance over quarter 4.

Cancer - Unvalidated 62 Day standard for Nov is currently at 65% and we will miss this target. This is slightly below our recovery trajectory for 24/25 however we are aware that due to focusing on treating some of our longer patients and significantly reducing our backlog we may see a reduction over the next few months

The Faster Diagnostic Standard (FDS) improved with a performance in November of 74.1% against the target of 75%. The 31-day standard was also not achieved with a November performance of 93% against a target of 96%. Dermatology “Mandated support” has been launched in December 2024 and a thorough recovery plan has been generated.

DM01 – The final validated position for November was 14.07 against a target of 15% which is a 2.37% deterioration on the previous month. A significant pressure continues in Histopathology report turnaround times and additional intervention is required to mitigate the negative impact this is having on cancer pathway improvements. here has been a large drop in performance this month due to the identification of a reporting error. This is a historic data issue where patients who had an RTT end date on their pathway were being excluded, resulting in identification of a cohort of patients that we should have been reporting. These patients have been being seen and booked in order along with all patients, however have not been reported against the

diagnostic standard.

Quality

Patient experience

Friends and Family Test – rate the quality of your care

The overall FFT score has increased from 91.5% positive in October to 92.8% in November. This is because of increased or static scores for all four care types, namely Outpatient, Maternity and Emergency Department. This is a positive picture for this time of year, particularly against a backdrop of operational pressures.

Patient Advice and Liaison Service (PALS)

The PALS team have seen a further decrease in the number of concerns closed in 5 working days to 70% which is below target (75%). This is reflective of the complexity of cases, particularly relating to bereavement. Staff sickness is contributing to an increase in workload for the remaining team. This is a metric that is now on "enhanced surveillance" so that we are taking actions now to prevent a further decrease to scores. An improvement plan will be discussed at the executive-led Quality Delivery Group (10 Dec).

Complaints

There has been a decrease (to 10% from 18%) in the number of complaints that have been sent within our standard response time. This metric remains on enhanced surveillance with focused improvement actions being taken to improve. Data is improving so that the Divisional Leadership Teams have oversight of their complaints and any delays. There has been successful recruitment of 2 new band 3 staff. An improvement project has commenced to improve the SOP that was developed.

Safety incident management

PSII/AERs

37 Patient Safety Incidents have required review through PSII or AER, since the Trust transitioned to PSIRF in March 24; an average of 5.2 per month.

Clinical effectiveness

ICB Quality Improvement Groups (QIGs) (PPH and SHMI)

The ICB has 2 QIGs in place that are supporting our improvement actions.

PPH

The first is the Maternity QIG which has oversight of the improvement work for the CQC S31 enforcement notice for which management of postpartum hemorrhage is an issue. The service has key clinicians monitoring safety incidents and using QI methodology to make improvements to the safety system. Last month our Trust and the national rates were the same, meaning that the QI actions had improved rates so that we are at national average. The focus of the improvement actions is in theatres and in leadership of the PPH cases on the delivery suite.

SHMI

The improvement focus for the SHMI QIG is on the primary diagnosis/ Charlson Scoring work on AMU, the correction of inaccurate data and clinical audits of CGH data (focused on the frailty, oncology and haematology services). SHMI is a 12 month rolling data metric and these actions will take 3-6 months before improvement is seen.

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 month 8 the Group financial position is £155k surplus YTD against a plan of £4.9m deficit. This is £4.9m favourable to plan and £1.4m better than the internal forecast. The Group position includes the GMS position which is in line for delivery of its dividend position at £0.12 below plan (FYE).

The Trust is currently experiencing pressure against its planned breakeven financial position primarily linked to the delivery of financial sustainability plans, workforce costs, non-pass-through drug costs and from clinical supplies and services. These areas are all under review to seek to address the causes of the pressures where possible.

Against the national use of resource metrics, the Trust is currently delivering against all 3 metrics: agency spend as a % of pay target, ytd delivery of financial sustainability schemes being ahead of plan and the ytd revenue position being breakeven or better.

Capital spends continued to forecast full year utilisation of available resources – there is an in-year underspend linked to the revision of some schemes and the application of lease costs associated with IFRS16. Plans to address slippage in schemes and bring forward spend from the next year continue.

Risks or Concerns	
Financial Implications	
Recommendation	
The Board are asked to receive the Integrated Performance Report.	
Enclosures	
IPR	

Integrated Performance Report (IPR)

November 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

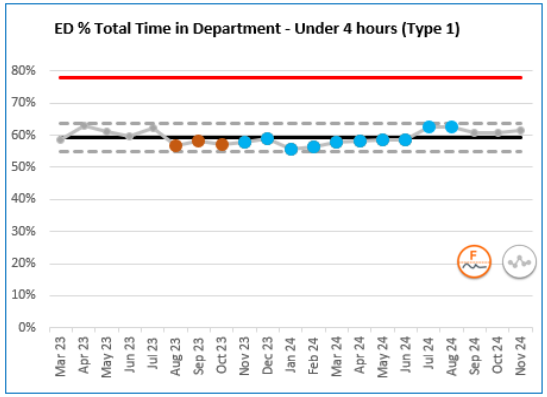
			Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Quality of Care, Access & Outcomes	Elective Care	Total patients waiting more than 52, 65, 78 and 104 weeks to start consultant-led treatment									
		52ww	*0 by Sept 24*	2738	2883	2816	2626	2509	1737	1614	1502
		65ww	*0*	379	525	558	512	441	55	8	11
		78ww	*0*	3	3	0	1	0	0	0	0
		104ww	*0*	0	0	0	0	0	0	0	0
		Total elective activity undertaken compared with 2019/20 baseline		115%	110%	105%	108%	110%	112%	108%	
		Total diagnostic activity undertaken compared with 2019/20 baseline		145%	135%	150%	135%	147%	136%	133%	
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	*No Target*	159	203	217	201	188	197	191	181
		Total patients waiting over 62 days to begin cancer treatment compared with baseline	*<=6%*	6.93%	8.21%	8.73%	7.64%	7.34%	7.47%	7.69%	7.55%
		Proportion of patients meeting the faster cancer diagnosis standard	*75%*	75.3%	77.9%	75.8%	76.3%	72.4%	70.3%	74.0%	74.1%
		Total patients treated for cancer compared with the same point in 2019/20	*No Target*	339	344	323	362	352	307	322	240
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		117.3%	111.3%	104.4%	109.0%	110.1%	113.8%	110.5%	109.5%
	Urgent Care	Proportion of ambulance arrivals delayed over 30 minutes	*0%*	59.7%	57.6%	60.2%	50.9%	47.0%	52.8%	60.3%	47.1%
		Proportion of patients spending more than 12 hours in an emergency department	*0%*	13.9%	13.0%	12.8%	11.0%	10.7%	11.0%	11.8%	11.1%
	Primary Care	Proportion of patients discharged from hospital to their usual place of residence	*No Target*	97.46%	97.16%	97.38%	97.22%	97.47%	97.25%	97.26%	97.08%
	Safe Care	Summary Hospital -level Mortality Indicator	*No Target*	1.141	1.146	1.164	No Data	No Data	No Data	No Data	No Data
		Clostridium difficile infection rate per 100,000 bed days	*104*	50.3	31.4	44.5	30.8	59.1	46.1	34.9	41.6
		E. coli bloodstream infection rate per 100,000 bed days	*71*	36.6	31.4	22.3	26.4	27.3	27.7	26.2	4.6

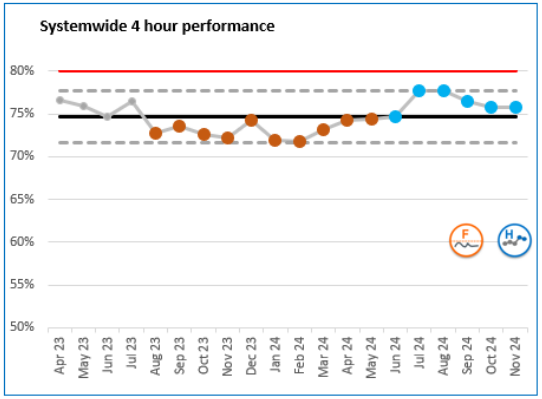
Watch Measures

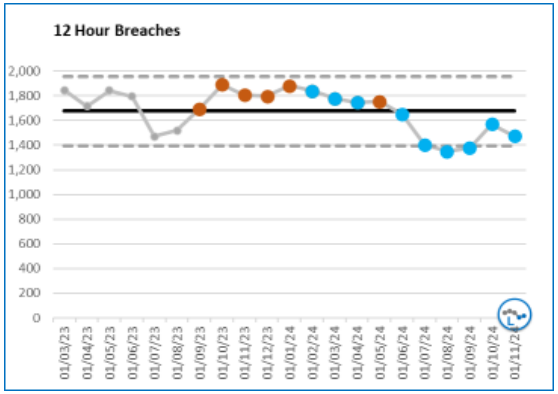
			Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Watch Measures	Diagnostics	**Compliant Diagnostic Modalities**									
		Audiology	*95%*	84%	82%	82%	91%	98%	87%	98%	99%
		Barium Enema Performance	*95%*	100%	100%	100%	100%	100%	100%	100%	100%
		Computed Tomography Performance	*95%*	100%	99%	100%	100%	100%	100%	100%	100%
		DEXA Scan Performance	*95%*	100%	100%	100%	100%	100%	100%	100%	100%
		Non-obstetric Ultrasound Performance	*95%*	97%	96%	99%	97%	97%	95%	99%	99%
	Elective Care	Severe Harm from Patient Medication Errors	*0*	0	0	0	1	0	0		
		78ww	*0*	3	3	0	1	0	0	0	0
		65ww	*0*	379	525	558	512	441	55	8	11

UEC: Seen within 4 hours

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







Commentary:

We've seen an improvement in the four-hour performance from 60.9% in October to 62% in November. Contributing to a system wide performance of 75.8% in month. Notable areas of improvement in the month were a reduction in the time to triage and the average time taken from DTA to departure which overall led to the reduction in number of 4-hour breaches in month.

Planned Actions:

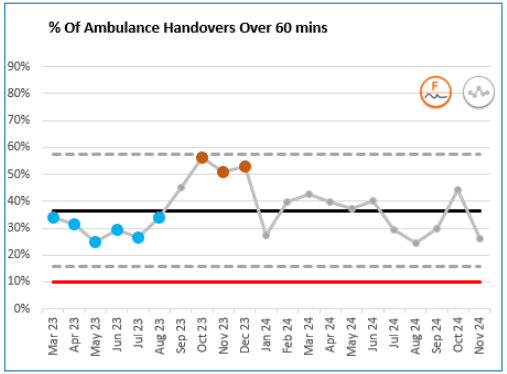
We continue to follow the PIP and actions included from the ECIST recovery work, specialty engagement and CVOF. From November to December there is additional focus on clear escalations to be made within department, working in line with an internal escalation process.

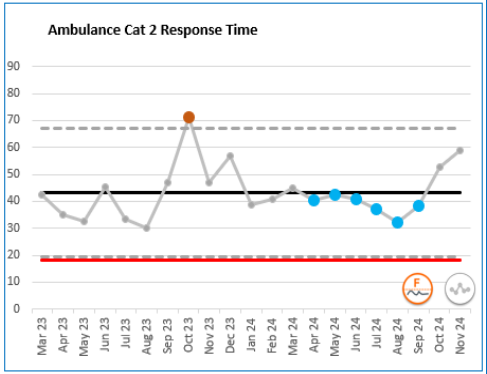
Expected recovery:

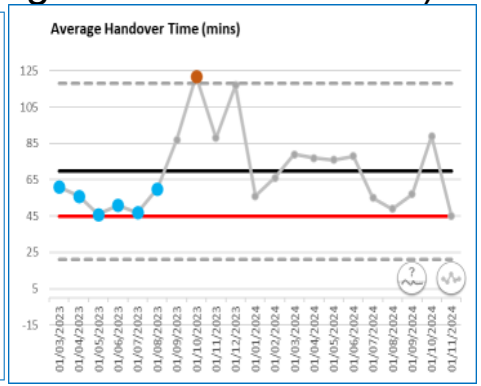
To continue in line with the agreed trajectory and in anticipation of the ICUS and CAS Service which was launching in November 2024.

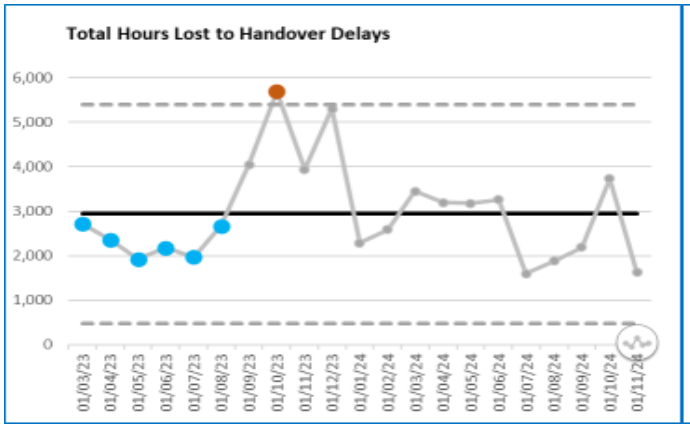
UEC: Average Handover Time

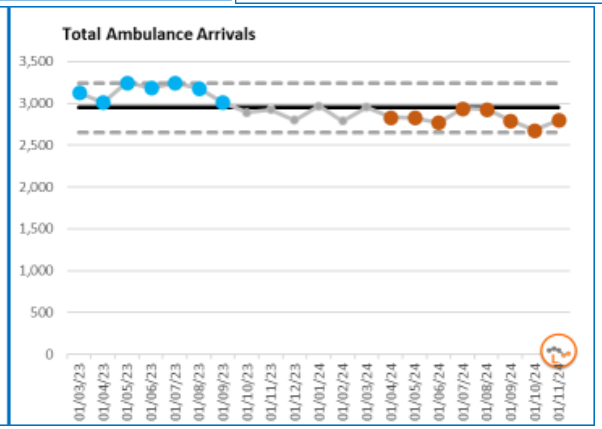
(Standard: Improve Cat 2 ambulance response time to an avg of 30 min across 24/25)











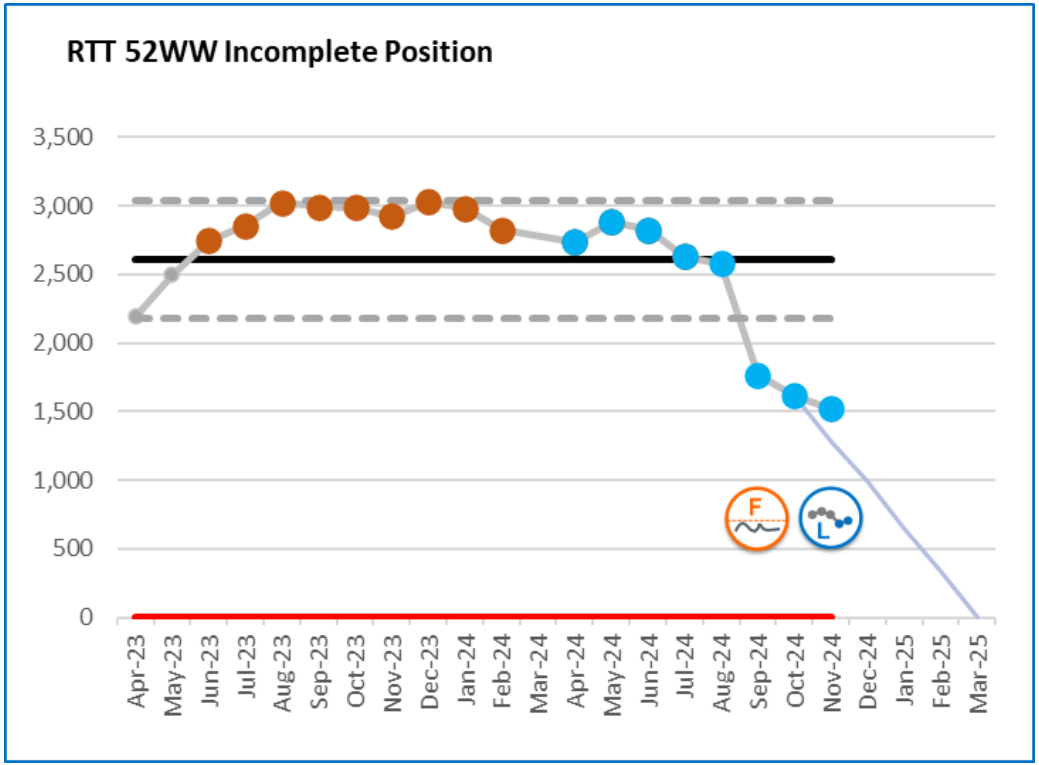
Commentary:
There was a significant improvement in the ambulance handover performance during November with the number of hours lost to handover delays reducing from 120 in October to 54 in November. The average handover time reduced from 89 mins in October and met the average handover target time of 45 minutes in November. Total ambulance arrivals were 2,801 in November, an increase of 123 arrivals compared to October.

Planned Actions:
Ongoing work with SWAST is taking place including a review of data. In addition there will be ongoing work in relation to the new CAS service and the 90 minutes Timely Handover Policy (THP) which went live on the 25th November. Clear escalations in place for ambulances at an >45 minutes

Expected recovery:
In line with agreed trajectories but with consideration of the CAS and THP impact.

Elective: 52 Week Wait

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



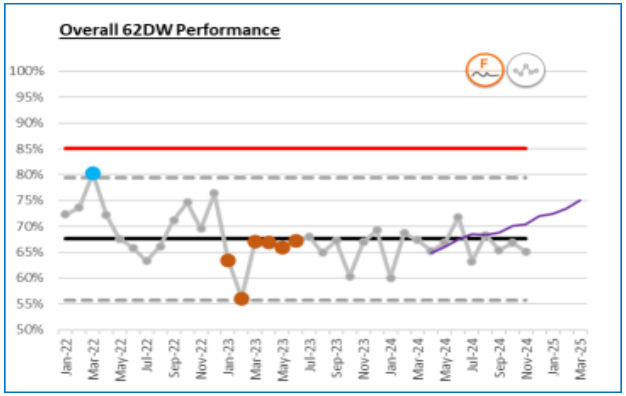
Commentary:
The November month-end position is currently unsubmitted and may reduce slightly. Current data suggests 1,481 patients breaching 52 weeks. This is compared to 1,615 last month. Greatest movement has been observed in Oral Surgery (-97) and ENT (-101), however T&O / Spines have increase by +42. Most other specs remain similar to last month.
Four specialties have >100 breaches, namely Urology (126); Oral Surgery (128); T&O (192) and ENT (628)

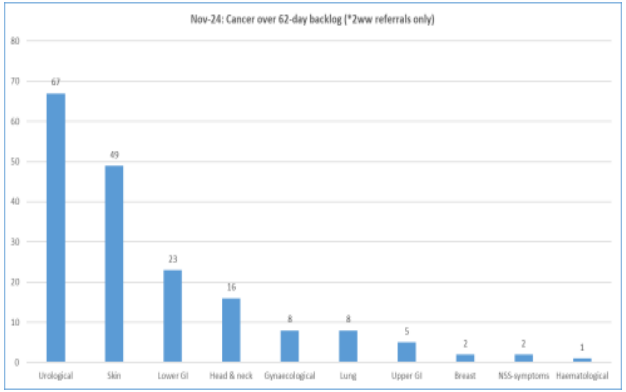
Planned Actions:
ERF schemes are continuing, with additional capacity allowing a reduction in treatment times. The use of independent providers is to continue, with further options being explored with Optimised Care and Heath Harmonie. Scrutiny continues through the various weekly meetings, the PAAF, and support from the validation team/ ECH.

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

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

Standard: 85%



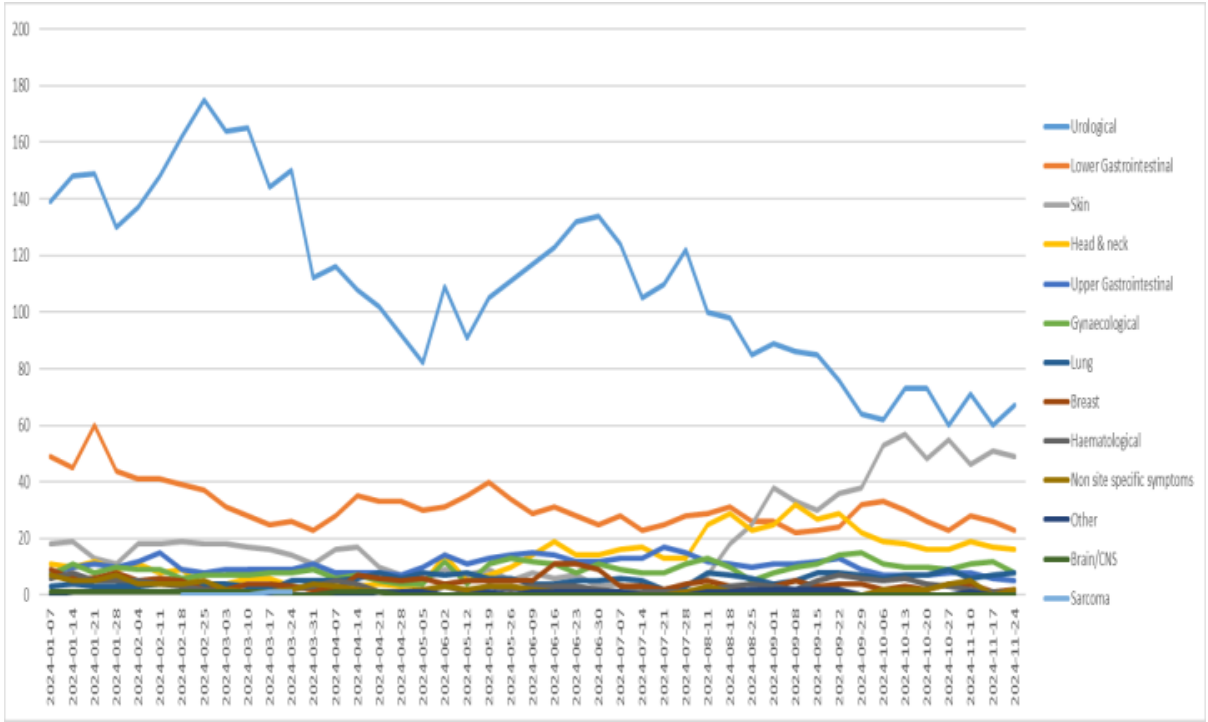


Commentary:
Unvalidated 62 Day standard for Nov is currently at 65% and we will miss this target
This is slightly below our recovery trajectory for 24/25 however we are aware that due to focussing on treating some of our longer patients and significantly reducing our backlog we may see a reduction over the next few months
Reviewing the diagnostic element of the cancer pathway and focusing on improvements within this will support overall improvement of our 62 day as demonstrated in our 31-Day Performance

Planned Actions:
Focus on specialty level recovery and diagnostic pathways :Urology improvement plan agreed by Trust and in November we completed a timed pathway challenge, Local LGI recovery plan being developed with focus on minimising patient delays.
Review of diagnostic and supportive services and use of AI to support turnaround times which are in line with best practice for cancer pathways
Review of access policy to support operational decision making and mitigating and performance risk
Recommendations from Cancer Delivery Group for mandated support within Dermatology to focus on the increasing backlog, and action plan being reviewed
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
However, due to delays in our diagnostic pathway and delays with surgical capacity for robotic and minor ops, we have struggled to achieve this position thus far

Cancer 62 Day Backlog Position



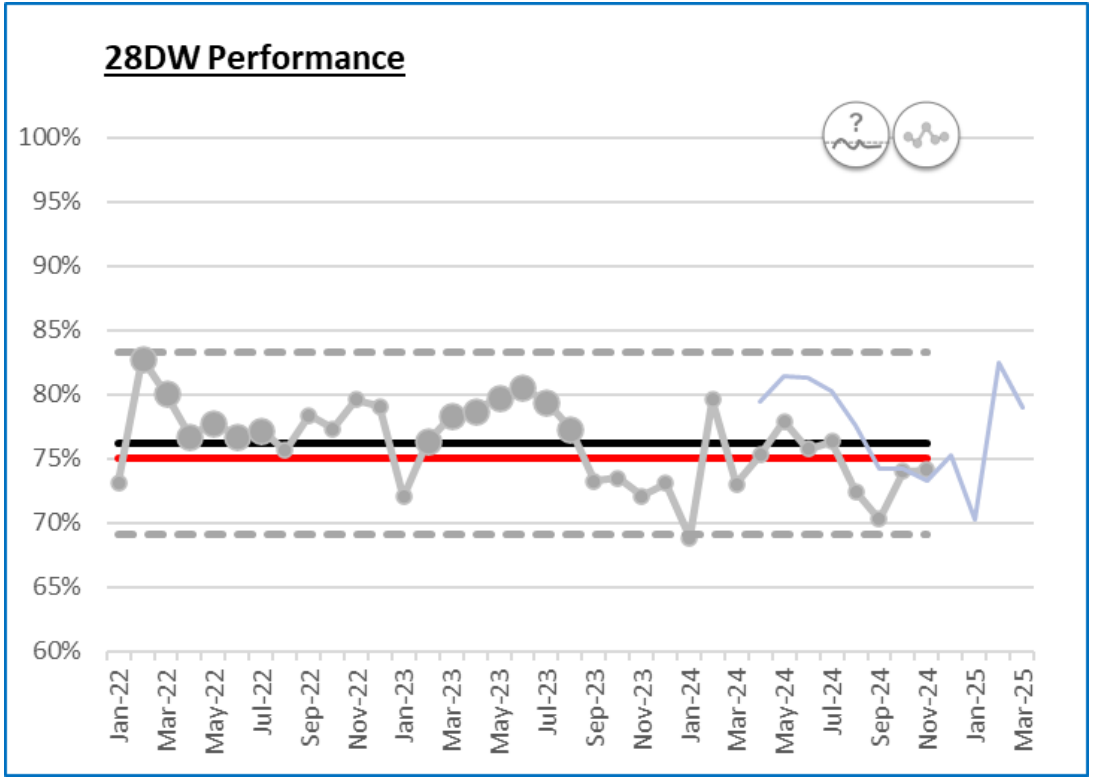
Commentary:
62 Day reportable backlog is 181 as of 24/11.
Most of this cohort is held by Urology as demonstrated by the graph however it had decreased significantly over the past few weeks –
The overall delays for Urology are due to the diagnostic phase of this pathway, with many patients waiting after day 62
for diagnostic results or testing, however great improvements have been made to support additional capacity and decrease the waiting time to treatment
Due to the delays and constraints within Skin and their Minor Ops Capacity, we have seen a dramatic increase in their backlog and is now the second largest specialty

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 services, with planned deep dives for Gynaecology and Haematology
Recommendations from Cancer Delivery Group for mandated support within Dermatology to focus on the increasing backlog, and action plan being reviewed

Expected recovery:
Sustained backlog recovery of no more than 6% of our PTL expected August-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

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 Nov is currently at 74.1% and with validation, we are potentially able to regain this position
Skin FDS recovery trajectory in progress however is dependent on procurement support, additional capacity
Urology has seen a marked improvement within FDS and achieved 59.5% FDS, which is over 20% more than their previous average

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
Pathology focus on 10- and 7-day turnaround; Pathology escalation process in place

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.

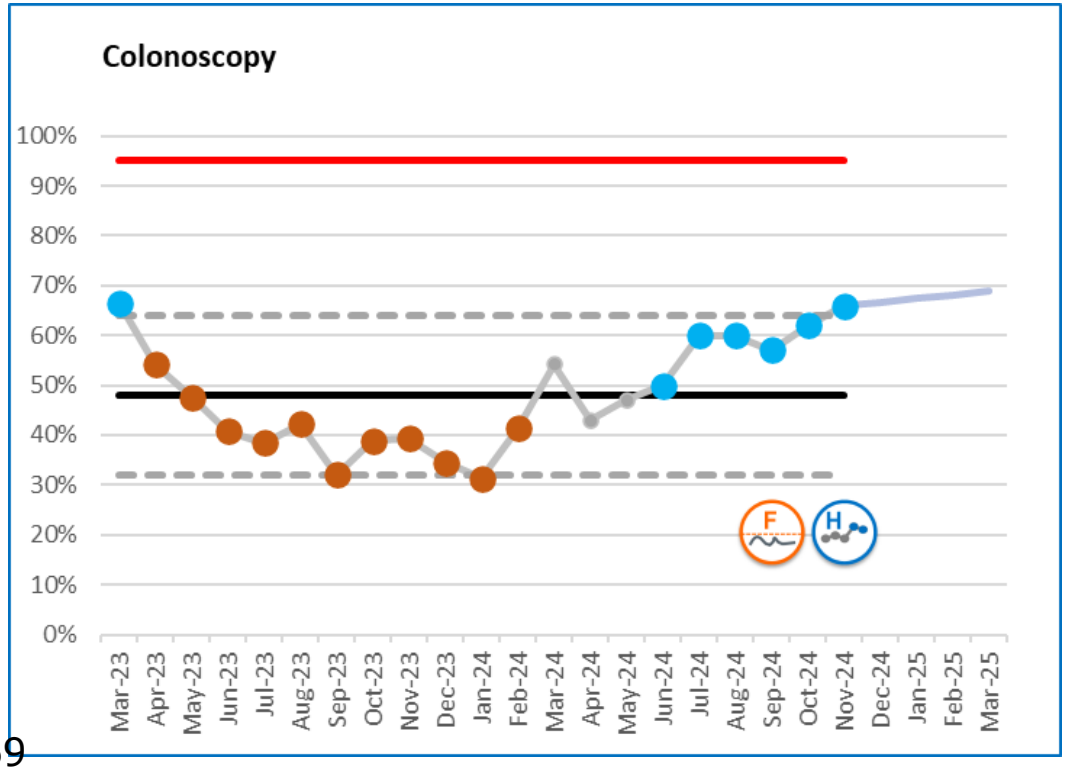
Cancer Waiting Times Performance for the last 3 months

Please Note – November is unvalidated

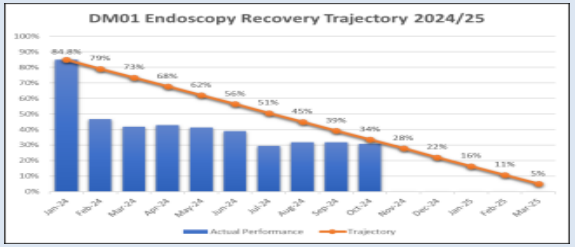
CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Sep-24	Oct-24	Nov-24	Sep-24	Oct-24	Nov-24	Sep-24	Oct-24	Nov-24	Sep-24	Oct-24	Nov-24
Acute leukaemia											100.0%	
Brain/CNS	100.0%	100.0%	100.0%	100.0%	81.8%	72.7%	100.0%	100.0%	100.0%			
Breast	15.1%	17.1%	64.5%	85.4%	89.7%	92.0%	98.2%	97.7%	96.5%	95.6%	92.1%	90.3%
Gynaecological	94.4%	96.0%	94.9%	70.4%	65.6%	66.9%	81.7%	91.5%	89.2%	63.9%	55.9%	45.5%
Haematological	100.0%	100.0%	96.0%	23.1%	42.9%	58.8%	98.2%	100.0%	100.0%	52.9%	70.0%	50.0%
Head & neck	87.1%	87.8%	95.0%	62.6%	69.2%	70.0%	94.9%	90.9%	96.4%	53.3%	60.0%	47.1%
Lower GI	79.4%	92.7%	98.8%	79.0%	76.5%	82.4%	90.8%	88.2%	91.1%	69.4%	61.3%	62.3%
Lung	100.0%	97.3%	95.8%	100.0%	95.5%	93.3%	86.0%	95.1%	92.1%	42.0%	52.6%	60.9%
Other							92.9%	100.0%	85.7%	78.6%	33.3%	50.0%
Sarcomas							100.0%	100.0%	75.0%	0.0%	0.0%	
Skin	69.6%	61.3%	72.2%	47.2%	48.6%	45.4%	89.3%	86.3%	93.9%	79.5%	64.8%	63.2%
Non site specific symptoms	89.7%	85.7%	81.1%	42.1%	57.6%	34.4%						
Testicular	100.0%	100.0%	100.0%	80.0%	85.7%	66.7%					100.0%	
Upper GI	99.6%	97.7%	100.0%	91.2%	90.8%	92.7%	98.1%	100.0%	100.0%	81.3%	90.0%	91.1%
Urological	94.5%	96.9%	99.2%	42.9%	59.5%	46.6%	86.9%	86.9%	81.0%	40.0%	43.6%	29.3%
Trust Total	70.5%	72.0%	85.8%	68.9%	72.9%	72.8%	92.4%	92.9%	92.5%	65.4%	66.8%	65.1%

Diagnostics: Colonoscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



Commentary:
Colonoscopy DM01 performance improved in October with 38% compared to 43% in September.
Endoscopy sustainably manage lists by booking to clinical need and date and as such do not dedicate specific lists to individual modalities, Therefore the recovery trajectory the service is working to is for DM01 in totality. The service is performing well against the overall DM01 recovery trajectory with 30.9% against the 34% trajectory for October.

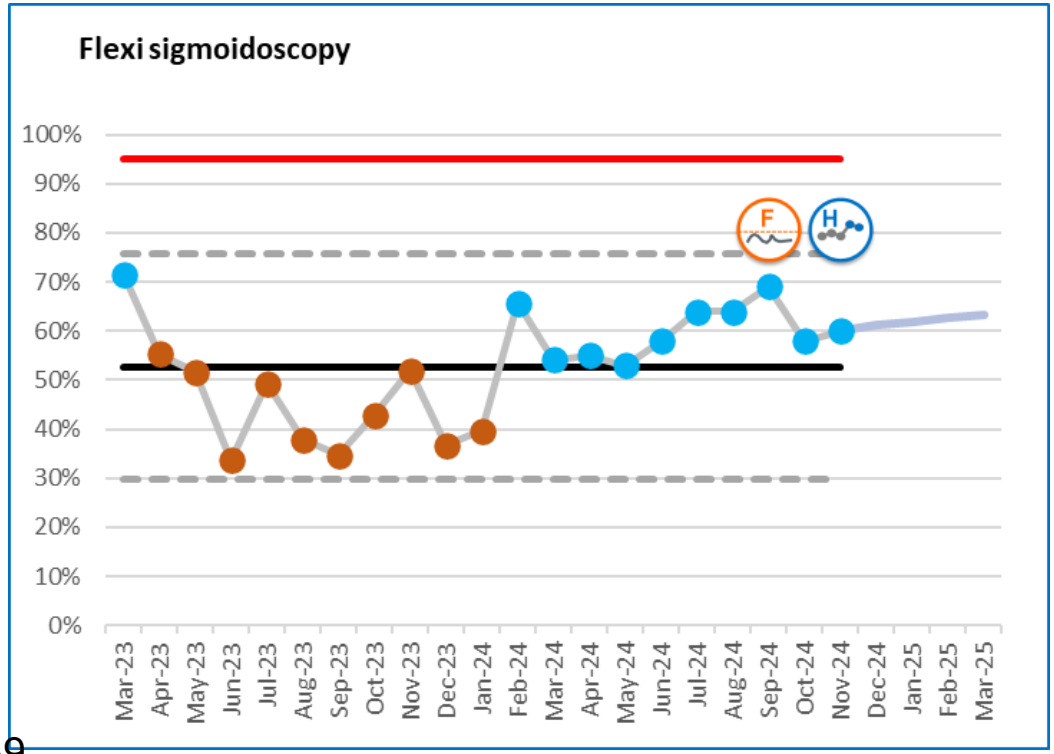


Planned Actions:
-ERF scheme – Consultant in place delivering 5 lists per week
-Provide weekend lists from 14th Dec – 31st March 25
-Investment business case prepared for increasing theatre capacity at GHFT sites including required workforce capacity
-Backfilling of lists by Clinical Endoscopists.
-Deliver 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 is at risk due to lack of theatre and workforce capacity

Diagnostics: Flexi Sigmoidoscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



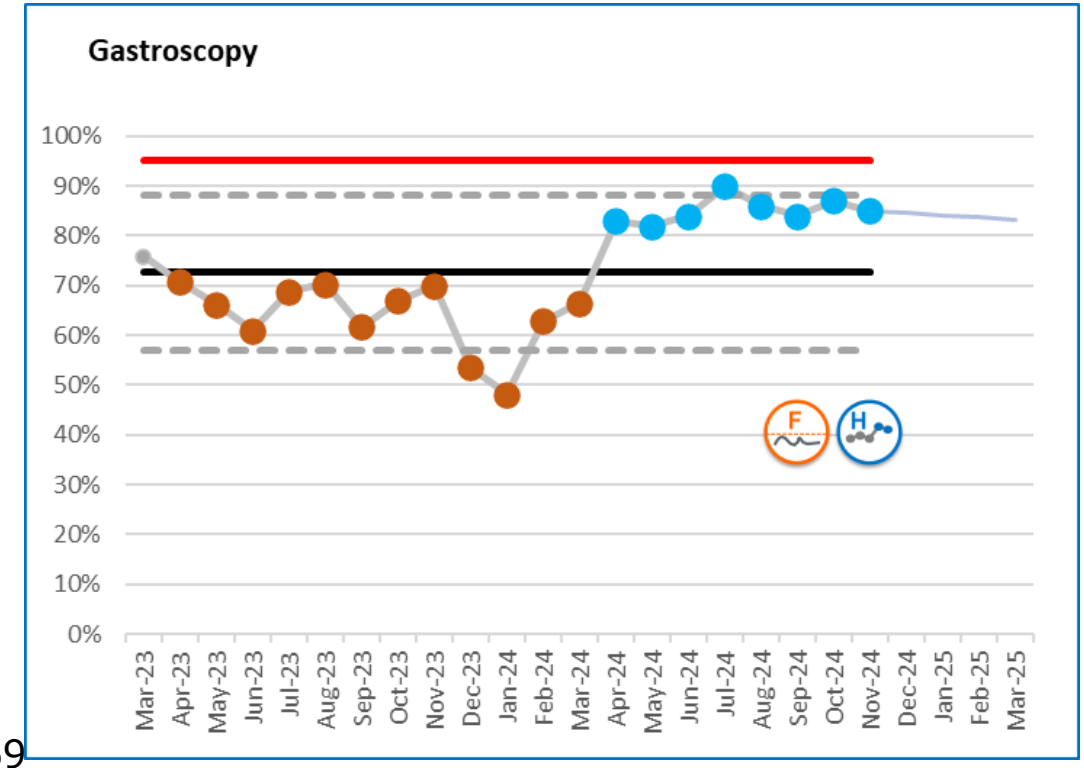
Commentary:
Flexi Sig DM01 performance deteriorated in October with 42% compared to 31% in September. This was in part due to the lack of clinical theatre availability. Endoscopy sustainably manage lists by booking to clinical need and date and as such do not dedicate specific lists to individual modalities. Therefore, the recovery trajectory the service is working to is for DM01 in totality. The service is performing well against the overall DM01 recovery trajectory with 30.9% against the 34% trajectory for October.

Planned Actions:
-ERF scheme – Consultant in place delivering 5 lists per week
-Provide weekend lists from 14th Dec – 31st March 25. Dedicated Flexi Sig lists have been offered to CE's which will enable the modality to recover
-Investment business case prepared for increasing theatre capacity at GHFT sites including required workforce capacity
-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 is at risk due to lack of theatre and workforce capacity

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 improved in October with 13% compared to the 16% in September.

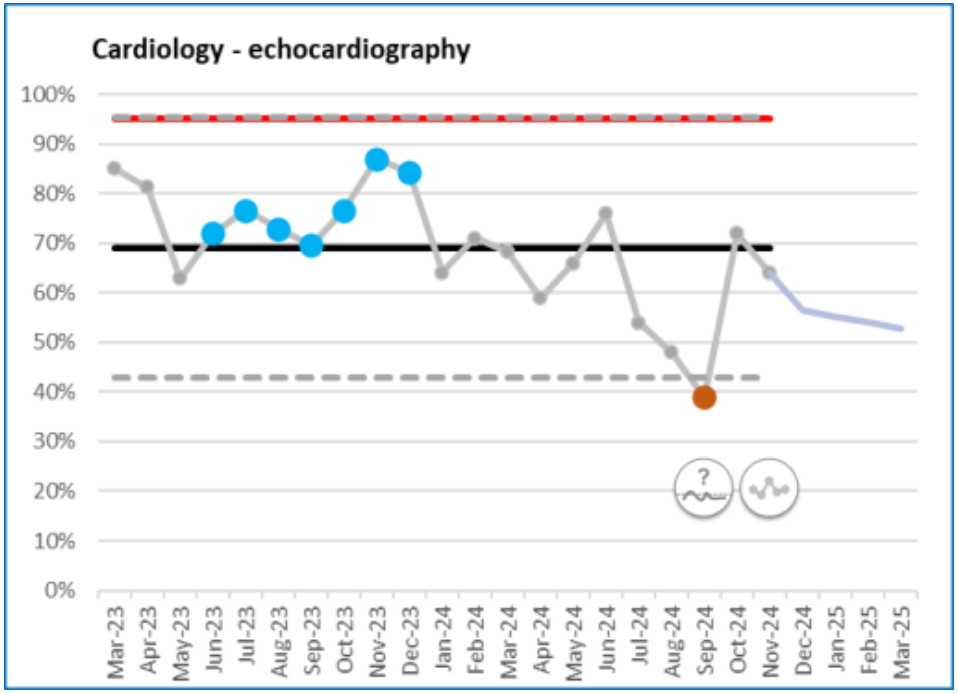
Endoscopy sustainably manage lists by booking to clinical need and date and as such do not dedicate specific lists to individual modalities. Therefore, the recovery trajectory the service is working to is for DM01 in totality. The service is performing well against the overall DM01 recovery trajectory with 30.9% against the 34% trajectory for October.

Planned Actions:
-ERF scheme – Consultant in place delivering 5 lists per week
-Provide weekend lists from 14th Dec – 31st March 25.
-Investment business case prepared for increasing theatre capacity at GHFT sites including required workforce capacity
-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 is at risk due to lack of theatre and workforce capacity

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%)

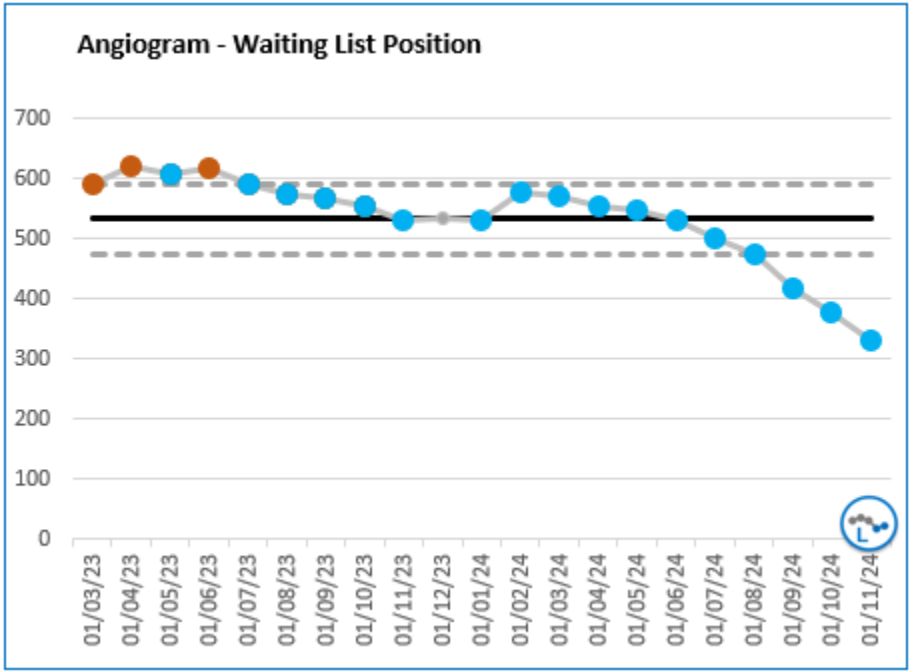


Commentary:
Performance improved in October to 73% from under 40% in September due to improved capacity and reduction in absences.
Workforce challenges continue and referrals are above expected levels specifically from inpatient settings, the community and other services [POAC, Oncology]. 2 physiologists perform inpatient scans on Mondays and Fridays to support with Trust flow. The prioritisation of IP activity has impacted the DMO1 recovery plan

Planned Actions:
ISCV – dedicated reporting system for the physiology and clinical team. Will support with improving the reporting speed for the physiologists. Launch date Feb 2025.
ECHO support worker – Currently being advertised. Benchmarking identifies the success of the role in other Trusts.
Open Access to ECHO by the GP – discussions with the ICB have commenced.
Change to staff rotas – delay in implementation due to TRAK care. New templates active from 25th November. Additional slots have reduced to mitigate the MSK requirements from BSE guidelines. Limits the number of scan performed per day due to MSK injuries.
DMO1 tracker/validator – dedicated administrator to support with the validating and booking of scans [starting 19/11/2024]. Benchmarking with other Trusts for shared learning on the delivery of DMO1 [Oxford, Swindon and Bristol]

Expected recovery:
Trajectory to recover DM01 by May 25

Angiogram - Waiting List Position



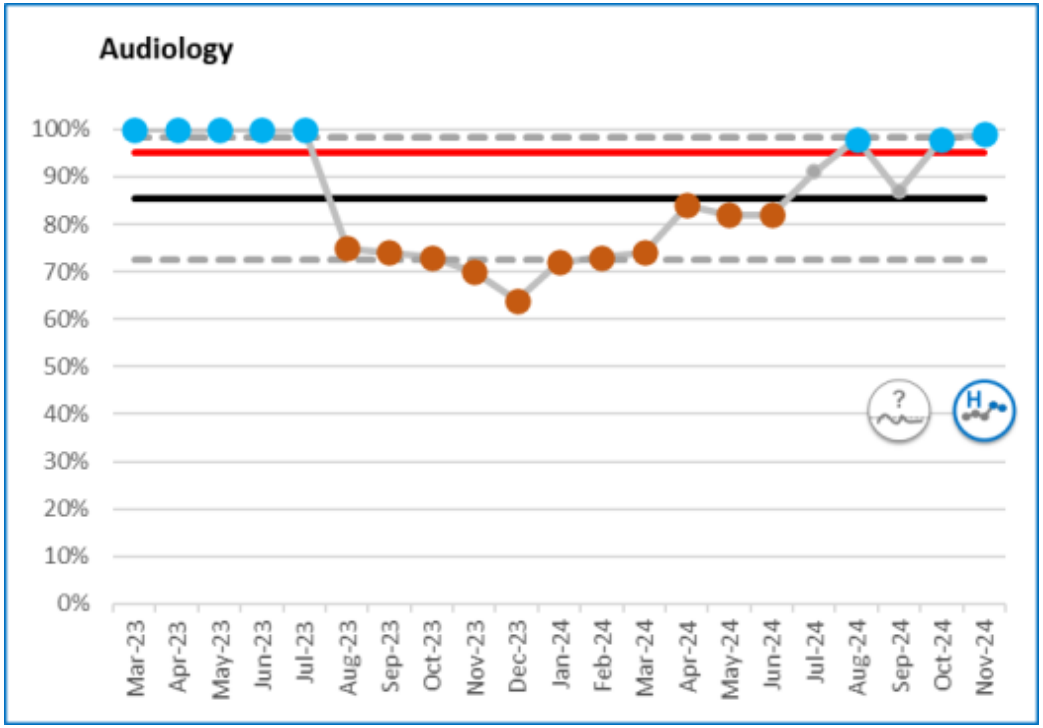
Commentary:
Reduction in waiting list numbers continue. Cath lab 1 & 2 both operational with no downtime unless servicing requirements are needed. CDCU recovery area in full use [part of IGIS]

Planned Actions:
Additional weekend activity using our own staff and estate. This is funded via ERF and weekend activity started October 2024 and plan to run through to Feb 25.
Utilisation of 3rd cath lab from Jan 25 to continue with the reduction of the angiogram backlog.
7th Interventional Consultant recruited to [started October 2024]

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%)



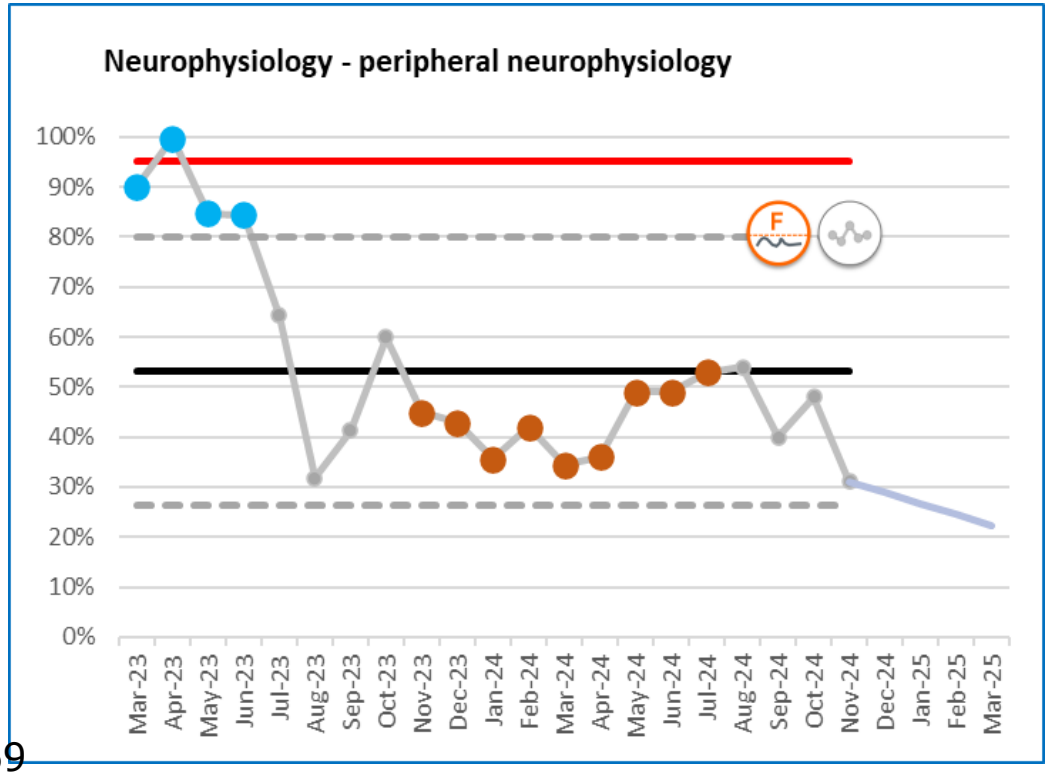
Commentary:
The Change in DM01 Reporting definitions commenced in August 2023 which affected historic 100% performance. DM01 compliant reporting has now been fully applied and reflected.

The service is now demonstrating DM01 compliance since August 2024. The position deteriorated slightly in September due to Audiology delivering an additional 1,000 appointments from Aug-Sept 24 to support ENT 65-week recovery. This has now improved since October.

Planned Actions:
Additional audiology activity continues to support the recovery of DM01 in conjunction with supporting ENT recovery.

Diagnostics: Neurophysiology

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)



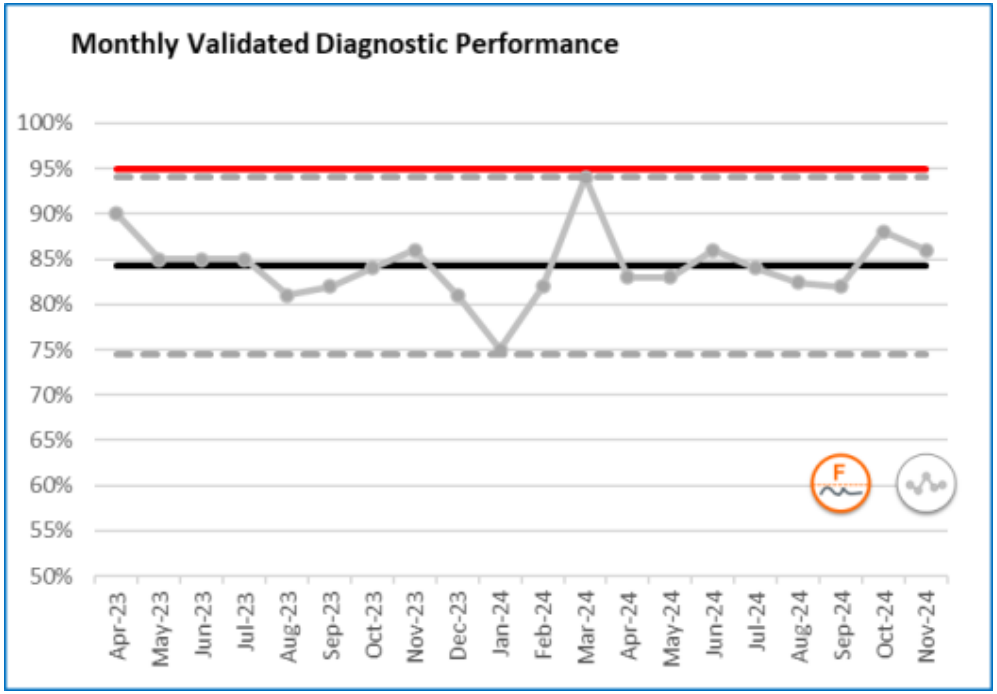
Commentary:
There has been a large drop in performance this month due to the identification of a reporting error. This is a historic data issue where patients who had an RTT end date on their pathway were being excluded, resulting in identification of a cohort of patients that we should have been reporting. These patients have been being seen and booked in order along with all patients, however have not been reported against the diagnostic standard.

Planned Actions:

- 2 x B7 Neurophysiologists are now recruited and started in September 2024. They both require some training in NCS procedures which is limiting immediate impact on DM01.
- Increase in hours of one B7
- New GP referral form live and embedded
- Aim to develop education programme for GP's and trainees
- Full validation of list now taking place.
- Additional capacity being provided.

Expected recovery:
Additional clinics taking place on evenings and weekends to create additional capacity and aid recovery, with upward trajectory forecasted. Additional 50 tests being provided per month against referrals.

Diagnostics: Performance Trend



Commentary:
The M8 aggregate diagnostic performance is 14.05% breach performance which is a 2.37% deterioration on the previous month.

Planned Actions:
Recovery in the three most challenged modalities (Cystoscopy, Echo and Urodynamics) has been delivering in line with recovery plans but has now started to deteriorate in two modalities (Echo and Urodynamics, noting that the overall PTL has reduced since the previous month in both specialties).

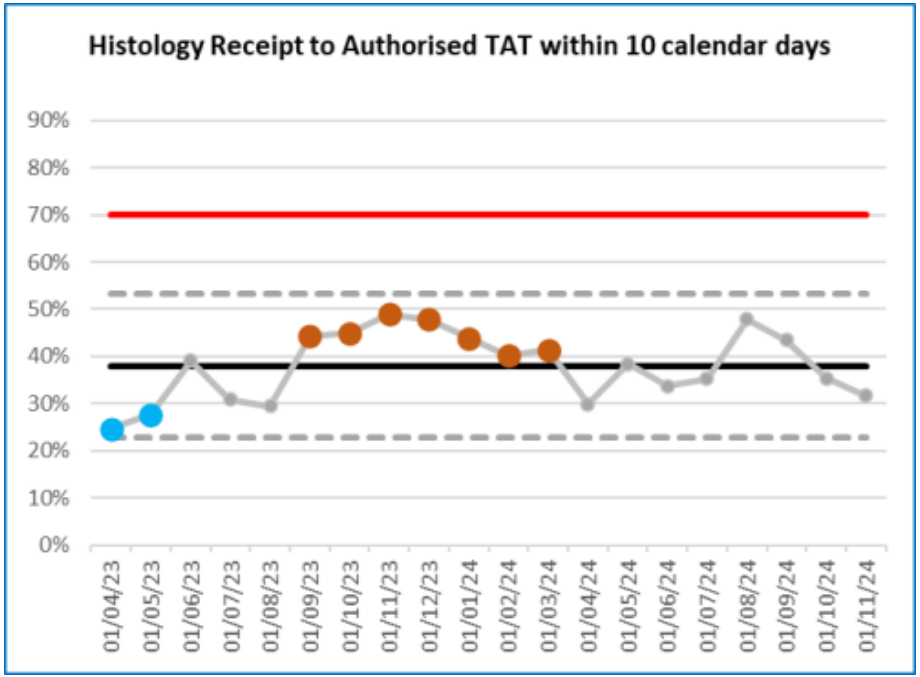
Cardiac ECHO has deteriorated by 8.99% in a single month. Urodynamics has deteriorated by 26.65% since last month. Cystoscopy is the most improved modality in November, having improved by 9.11% associated with the additional cancer sustainability capacity investment 2024.

Additional capacity for Obstetric Ultrasound is being explored to reduce waiting times for pregnant women (risk raised October 2024)

Expected recovery:
ECHO performance continues to fluctuate in delivery and current recovery actions are difficult to definitively align with either reductions or improvements in performance. The overall waiting list for DM01 has increased by circa 200 patients (Neurophysiology associated).

Diagnostics: Histopathology 10-day reporting

Standard: Delivering 70% turnaround times

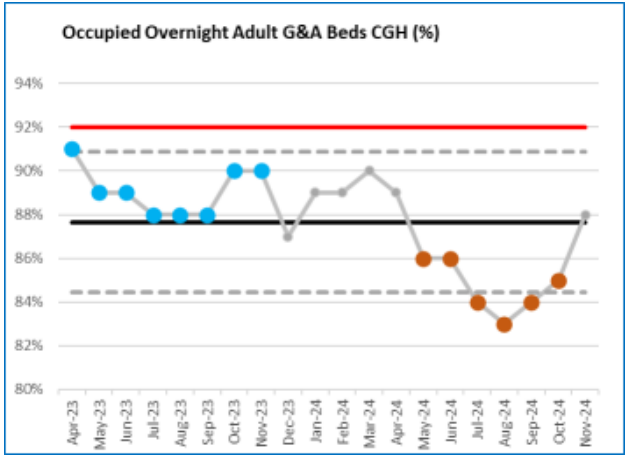


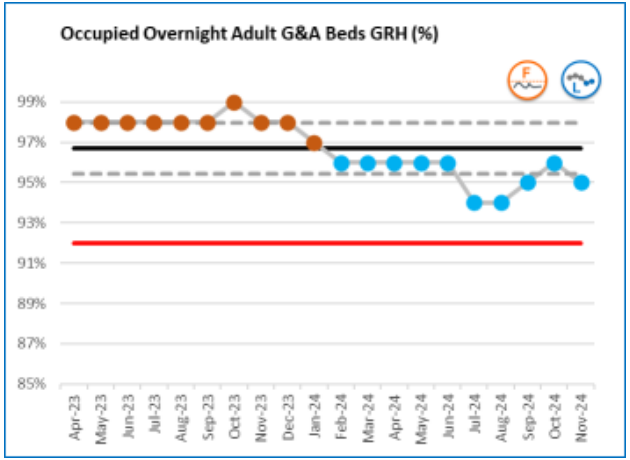
Commentary:
There is a national shortage of Histopathologists and this comes at a time of a 30% increase in Histopathology requests. There are currently three vacancies within the consultant body. The department has old, end of life equipment which is becoming increasingly unreliable causing delays in 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:
The department has gone live with Digital Pathology and are already scanning up to 80% of cases with some cases being reported digitally. Pathologist training is complete and validation is ongoing
Digital outsourcing is being explored to help with capacity but keep turnaround times down. Efforts to recruit Consultants continue although with limited success

Expected recovery:
Next quarter actions to be focussed on recovery with a plan being formulated on how to achieve a 10-day turnaround time across all specialties in the department. There will be an increased reliance on outsourcing to bring reporting times down

General & Acute Beds: Occupied



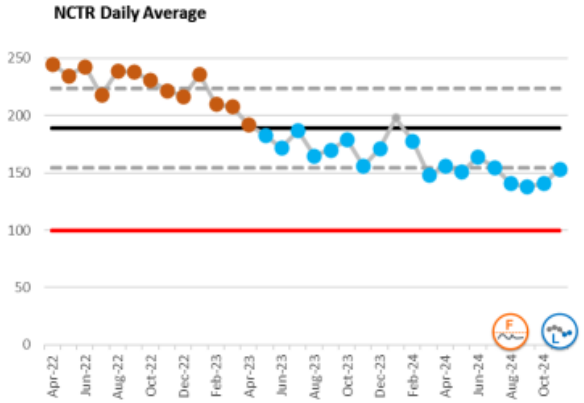


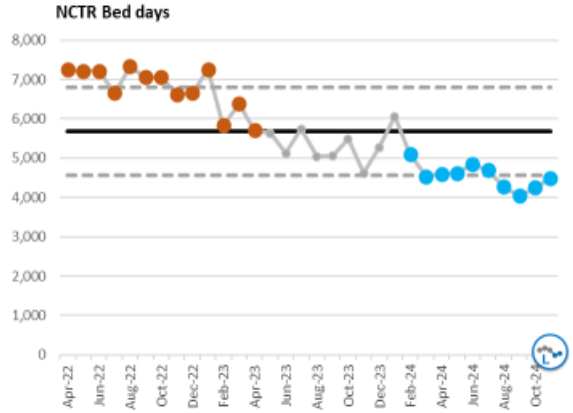
Commentary:
Increasing bed occupancy links directly to the increased demand in terms of attendances and conversion to admissions, along with changes to the bed base made in line with the FTFF programme.

Planned Actions:
Continued pressure to reduce the nCTR numbers will assist in the recovery. This remains above the planned target of 87. With consistently sub-optimal P1,2,3 discharges not reaching the daily target of 20 it will be difficult to see significant improvement in the next period.
Alongside this, further improvements in P0 discharges and reduction in DRH/deconditioning will reduce the high level of onward care demand.

Expected recovery:
Occupancy likely to deteriorate initially as the bed base is adjusted to better represent the inpatient UEC pathways. Next period is predicting another deterioration as available beds have been reduced due to ongoing IPC challenges; There has been a reliance on escalation capacity consistently in the first third of December.

General & Acute Beds Occupied with NCTR





Commentary:
Limited progression with reducing nCTR numbers, although bed days occupied has improved with overall the median wait showing an improved downward trend. IPC restrictions both internally and across external partners have played a part in reducing the flow across pathway 2 within the last months data. This corresponds with an increase in nCTR during that period.

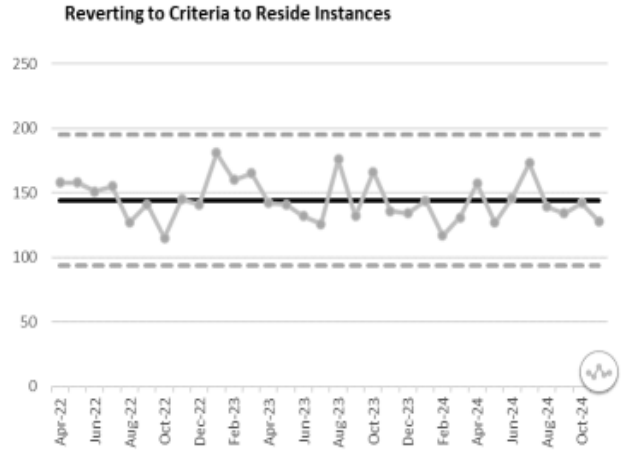
Planned Actions:
NCTR improvement plan part of UECFIB and UEC CPG. Going live with enabling the SRF to be completed 48hrs prior to nCTR across all ward areas, after a successful pilot period. This will be in place before Christmas, just confirming exact date once digital enablers completed.

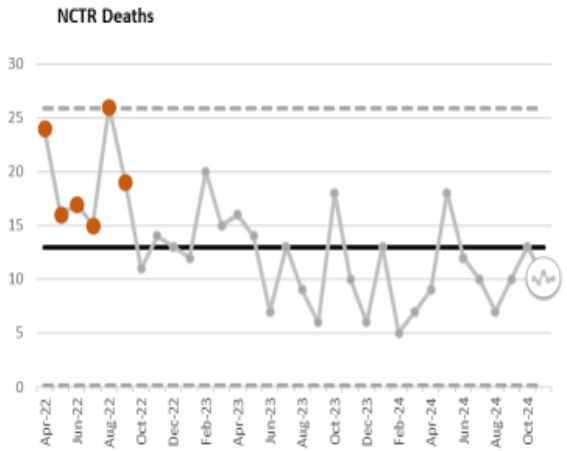
P2 LOS programme currently being undertaken with ICS CEO involvement, with agreement regarding additional resource for the most dependent of our patients, often those waiting the longest has hard to place.

New ICS patient flow delivery board started with UCF being a key agenda item to agree acceptable timelines and subsequent escalations. New DRH meetings happening twice weekly to target the longest and most challenging nCTR patients.

Expected recovery:
Still aiming to reach as close to 100 pre Christmas as possible, whilst working to the pre set 87 by the end of the financial year.

Delay Related Harm NCTR





Commentary:

Reduction in median wait for P1-3 has seen a corresponding reduction in the number of patients becoming unwell and meeting the CTR once having a period of nCTR. There has been a sustained reduction in deaths during a period of nCTR, although there are ongoing pieces of work around CHC and palliation process to reduce this further.

Planned Actions:
New twice weekly DRH meetings stood up to focus on the most complex patients, along with anyone with clear signs of DRH. Individual patient actions plans agreed, alongside themes around challenges needing targeted work to resolve. These are being captured and played into the new system Pathway Flow improvement board.

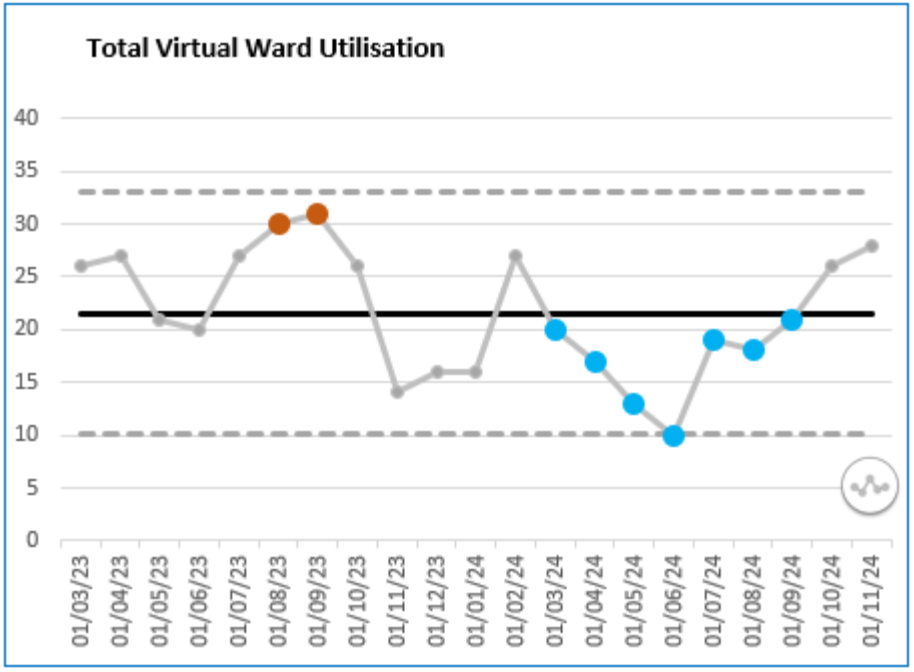
Targeted work on the palliative group of patients as often the patients who pass away whilst waiting for onward care, as the follow the same normal pathways as others.

Expected recovery:

Hard to predict numbers, but expected deduction in nCTR numbers and median wait likely to see a continued reduction in DRH. Targeted work also expected to reduce the occurrence of similar situations, further improving the outcomes for patients.

Virtual Wards: Utilisation

Standard: 80% occupancy of available capacity



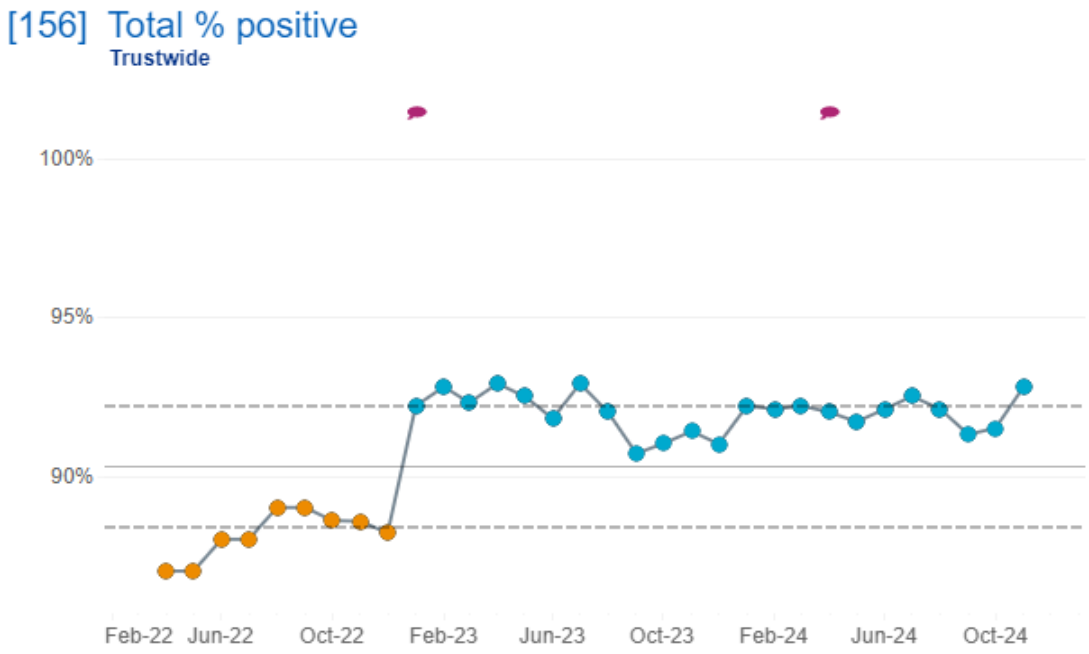
Commentary:
Gloucestershire systemwide occupancy remains above 80% since Jan 24. Continuing work around respiratory, frailty and surgical virtual wards with a focus on step up into VW as well as the more established step down pathways.

Planned Actions:
The Virtual Ward teams are working with the acute medical and frailty teams to consider a CGH space and presence to drive VW practices across both sites. The Launch of the new CAS (19/11/24) should more readily funnel appropriate activity to the VW environment.

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

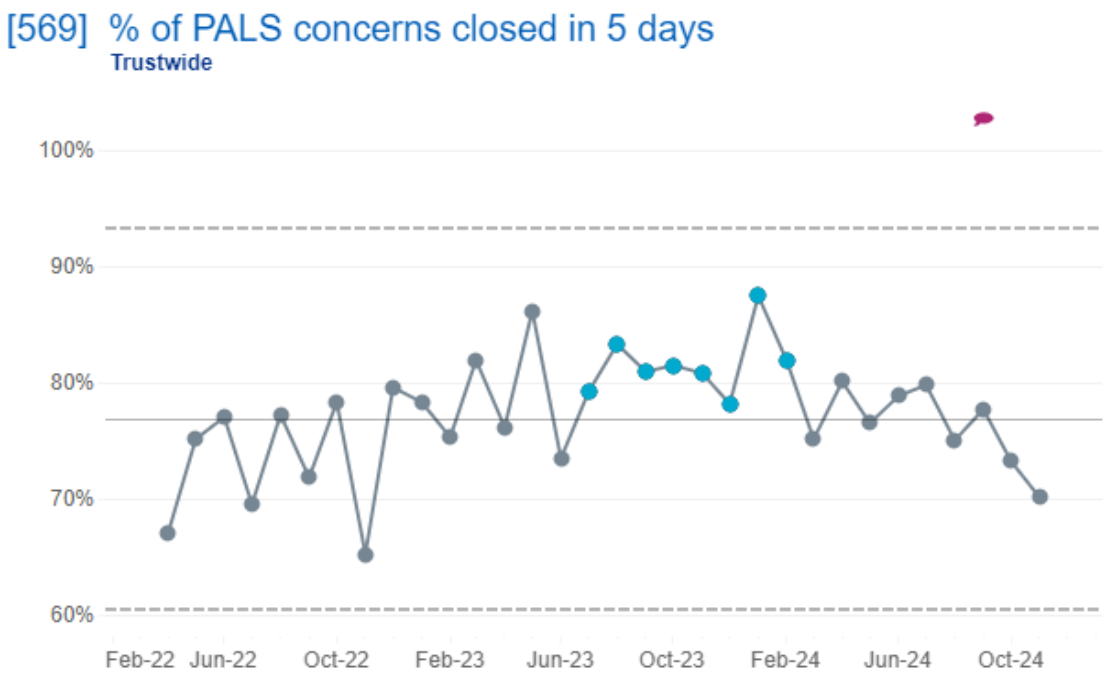


Commentary:
The overall FFT score has increased from 91.5% positive in October to 92.8% in November. This is as a result of increased or fairly static scores for all four care types, namely Outpatient, Maternity and Emergency Department. This is a positive picture for this time of year, particularly against a backdrop of operational pressures.

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 with an increase in December.

PALS

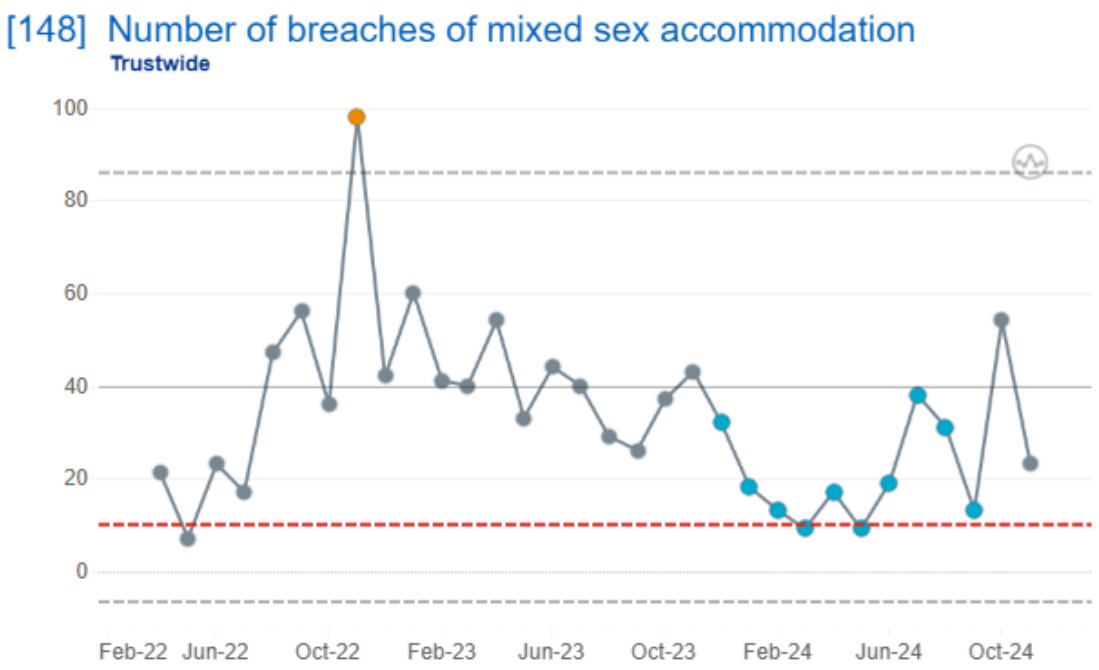


Commentary:
PALS team have seen a further decrease in the number of concerns closed in 5 working days to 70% which is below target (75%). This is reflective of the complexity of cases, particularly relating to bereavement. Staff sickness is contributing to an increase in workload for the remaining team.

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. A decision has been taken to close the service to face to face visits to help reduce delays. Review of whether additional resource can be provided to support the team

Expected recovery:
Unlikely to see a significant improvement until at least January. Sickness continues into December and we usually see an increase in concerns over the winter months, with a slight reduction over the Christmas period.

Patient Care: Mixed Sex Breaches

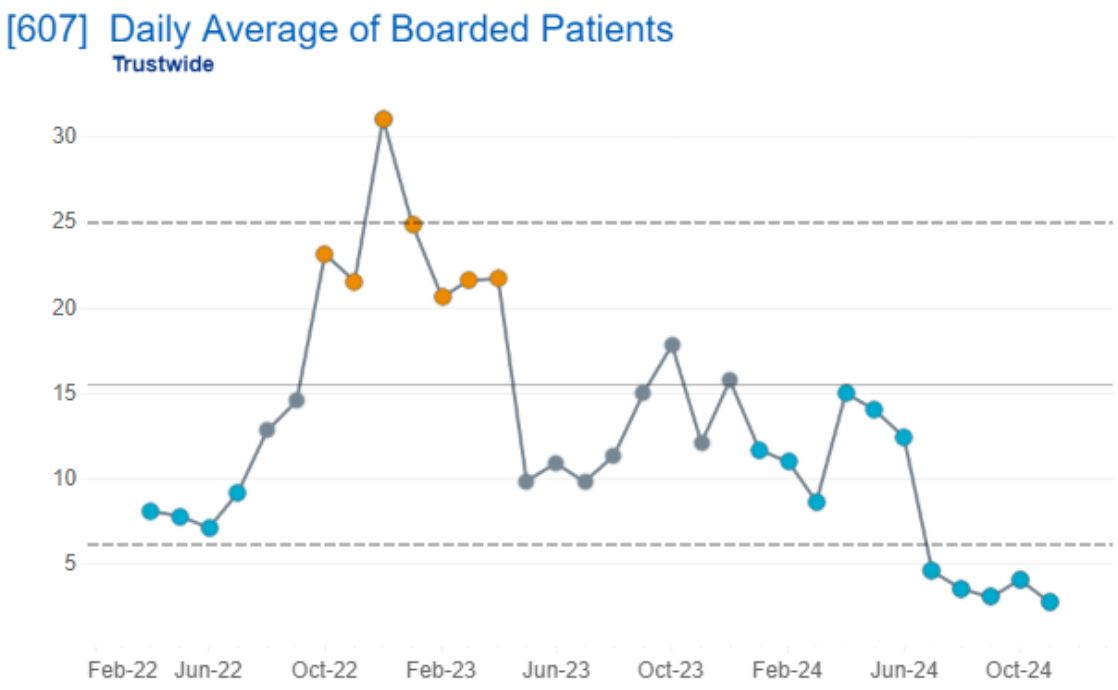


Commentary:
November saw an improvement in performance, but still slightly higher than previous months. This links directly to challenges in flow towards the end of the month, which saw delays in bed allocations to patients within DCC and the inability to move patients into ward beds within the 4hr timelines.

Planned Actions:
Continued implementation and optimisation of the DCC processes, as the main area whereby mix sex breaches are occur.

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

Patient Care: Boarded Patients

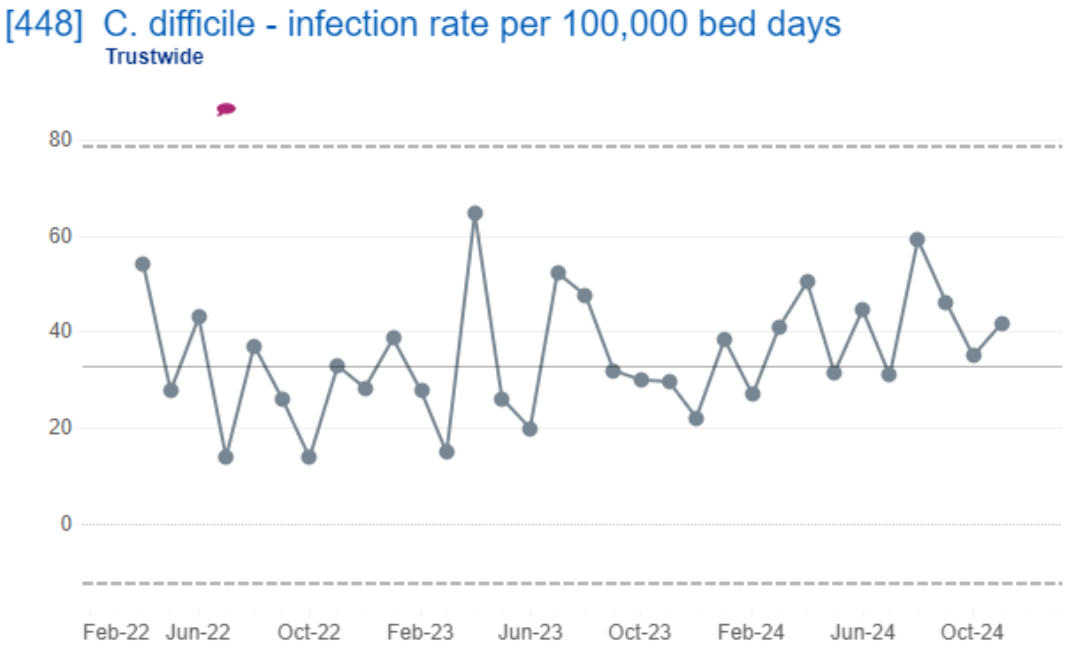


Commentary:
Numbers remain extremely low with issues ongoing around the odd use of pre empt spaces digitally. Operationally there has been no decision to board as part of the escalation policy.

Planned Actions:
Ongoing work needed around digital discharge processes within an agreed timeline. This is as much to ensure GPs receive discharge documentations, as to improve the accuracy of the utilisation of boarding.

Expected recovery:
Sustained non use of corridors to provide care, outside of critical incidents, inline with the revised escalation policy and OPEL framework.

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 74 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 in the community.

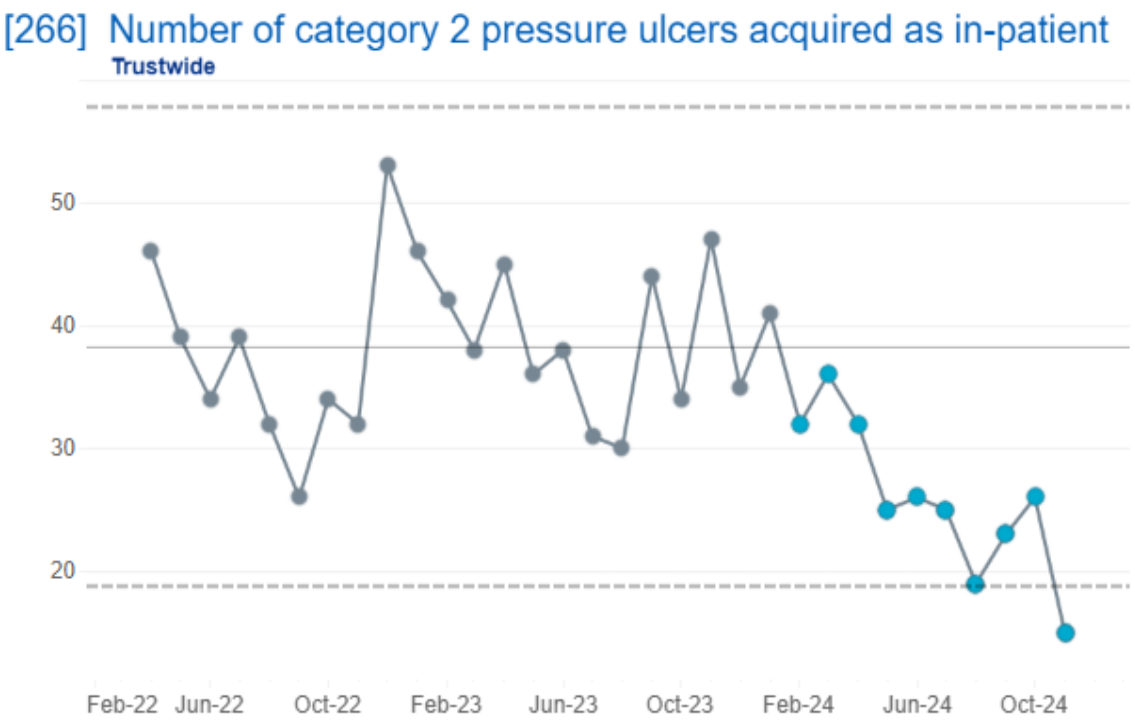
Planned Actions:

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.* There is a particular focus on delivering the national cleaning standards and move towards Peracetic acid cleaning 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. 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 led by NHSE. During December it was agreed we would undertake a deep dive into patients with recurrence of CDI and their care across the system and explore focused interventions for this risk 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

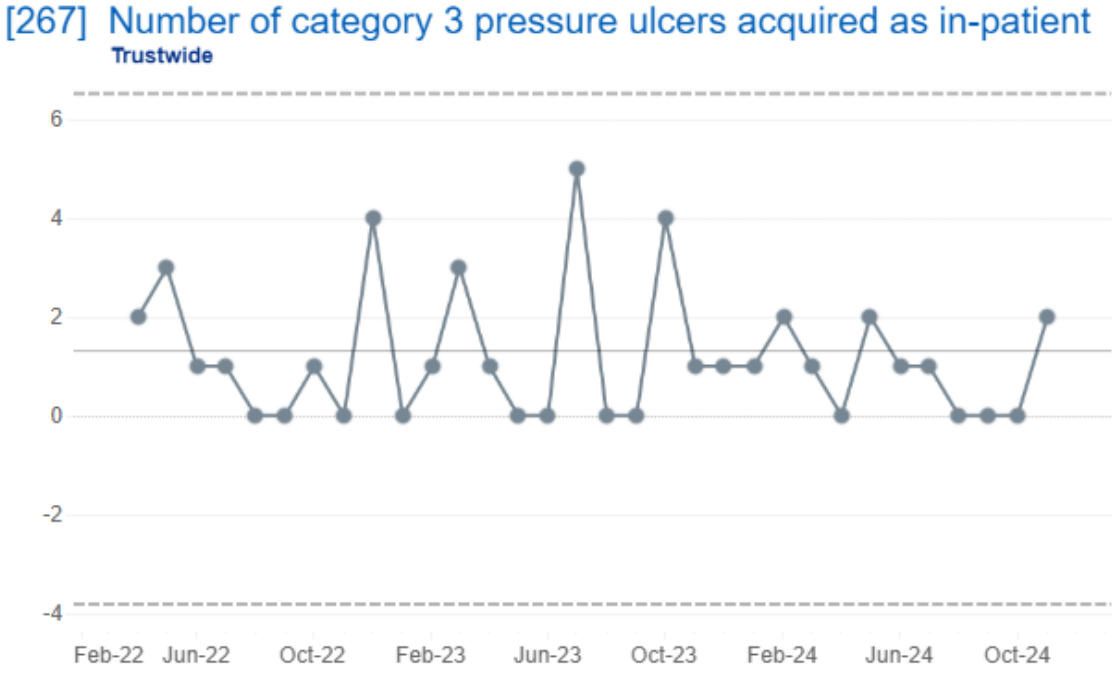


Commentary:
Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated by more patients on a ward than the staffing model accommodates,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

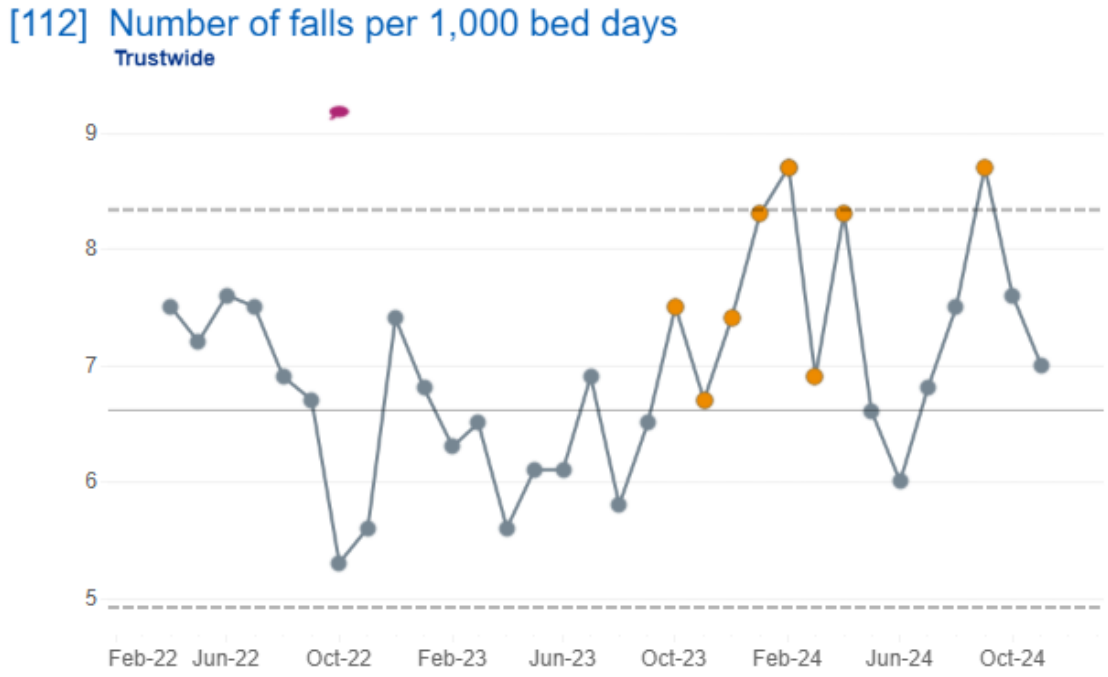


Commentary:
Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated by more patients on a ward than the staffing model accommodates,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

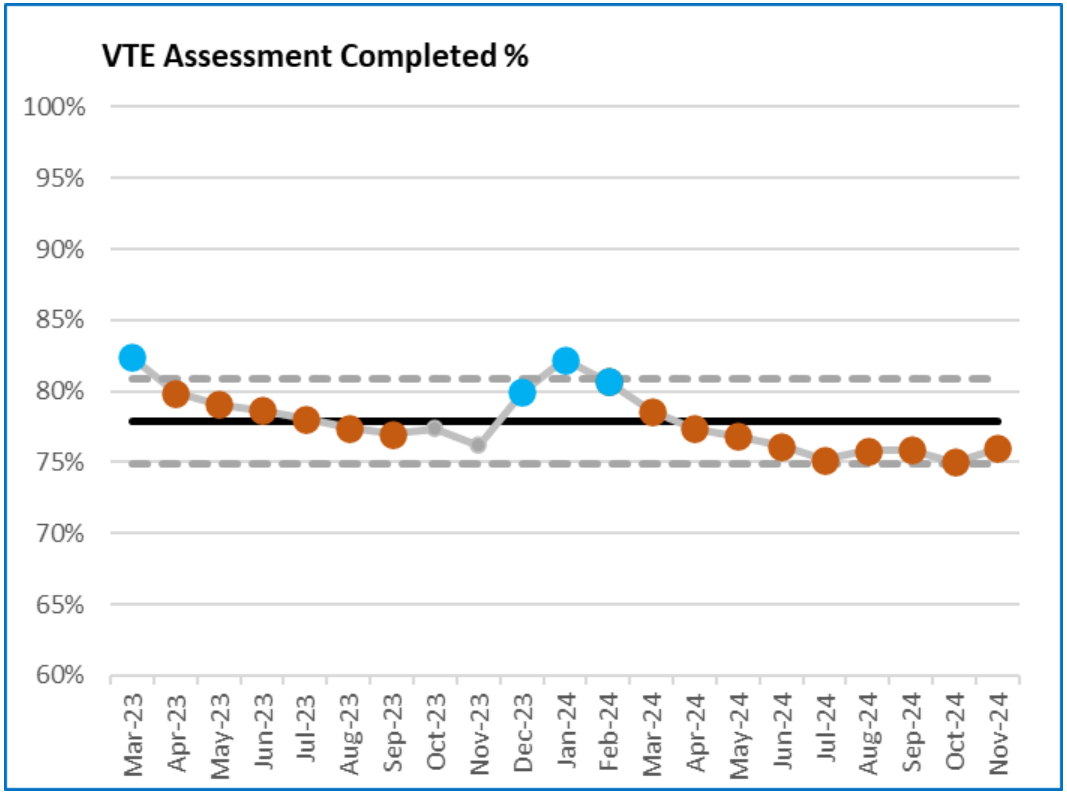


Commentary:
There was a steady rise in the number of Falls per 1000 days between June 24 to September 24, this correlates with a focus on enhanced care usage and a reduction of that provision. The rate of falls is linked closely to acuity of patients and availability of nursing staff. All patients over 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.
Falls Quality Summit held 26 November 24.
Quality Improvement programmes launched in Datix development, Hot Debriefs post falls and Electronic Patient Record Development.

Expected recovery:
The rate of falls will continue to fluctuate with us aiming for a rate 10% lower.

Patient VTE Risk Assessment



Next Review at VTE Committee on 18/12/24

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

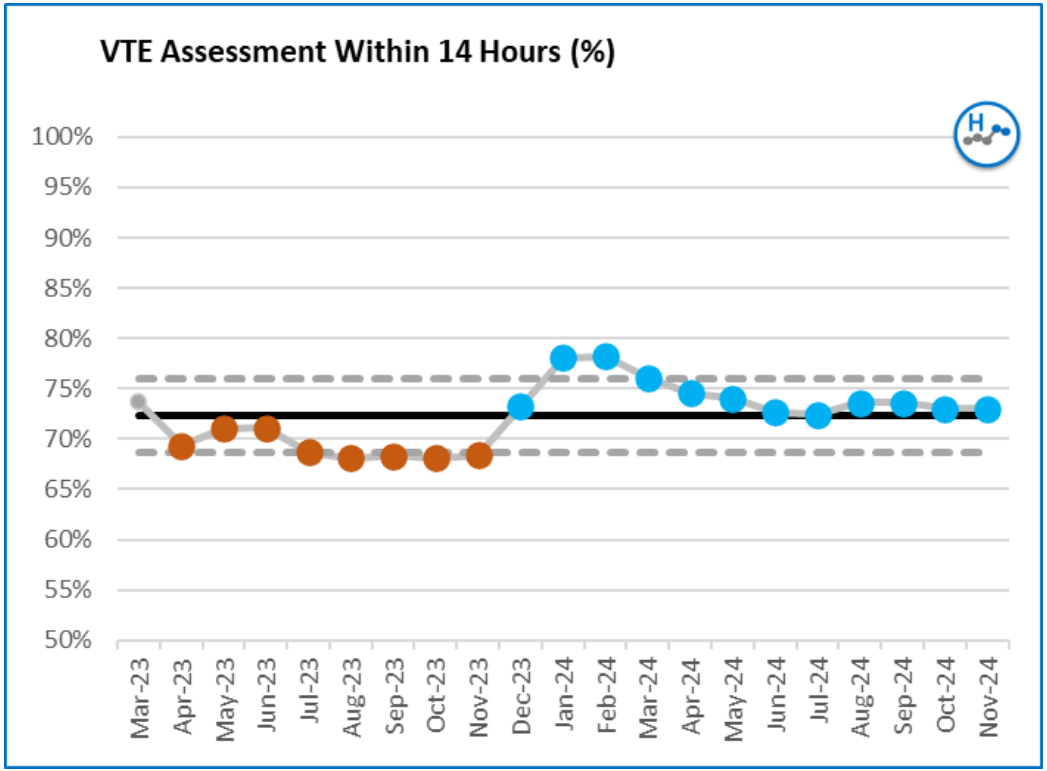
Trust:

- 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

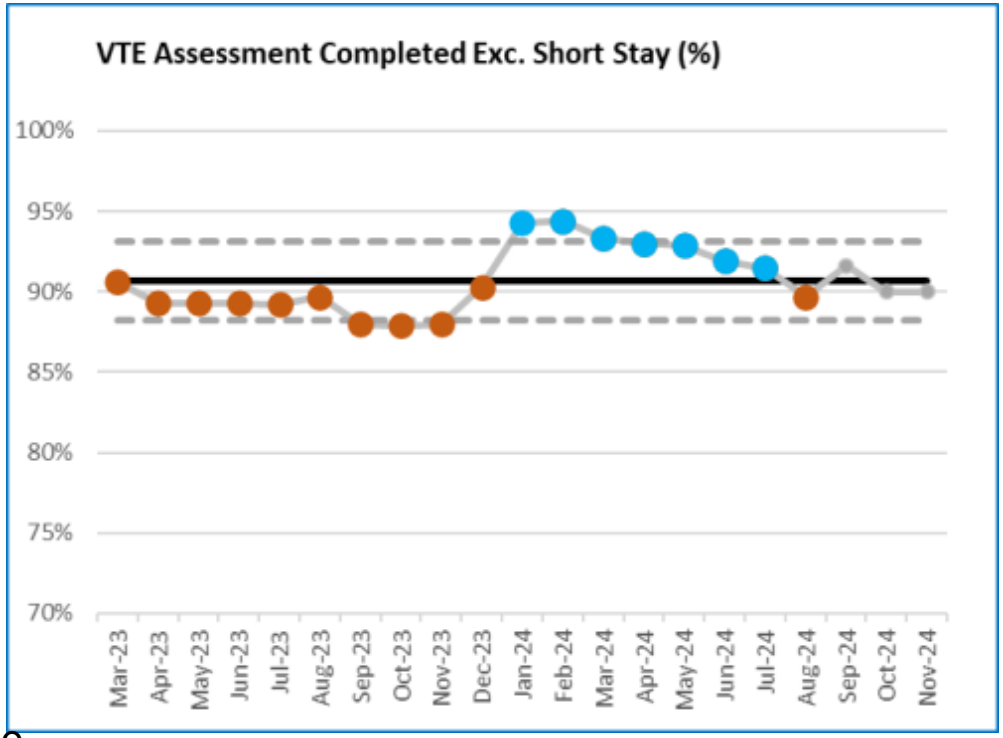


Commentary: As above

Planned Actions:

Expected recovery:

Patient VTE Risk Assessment Excluding Short Stay

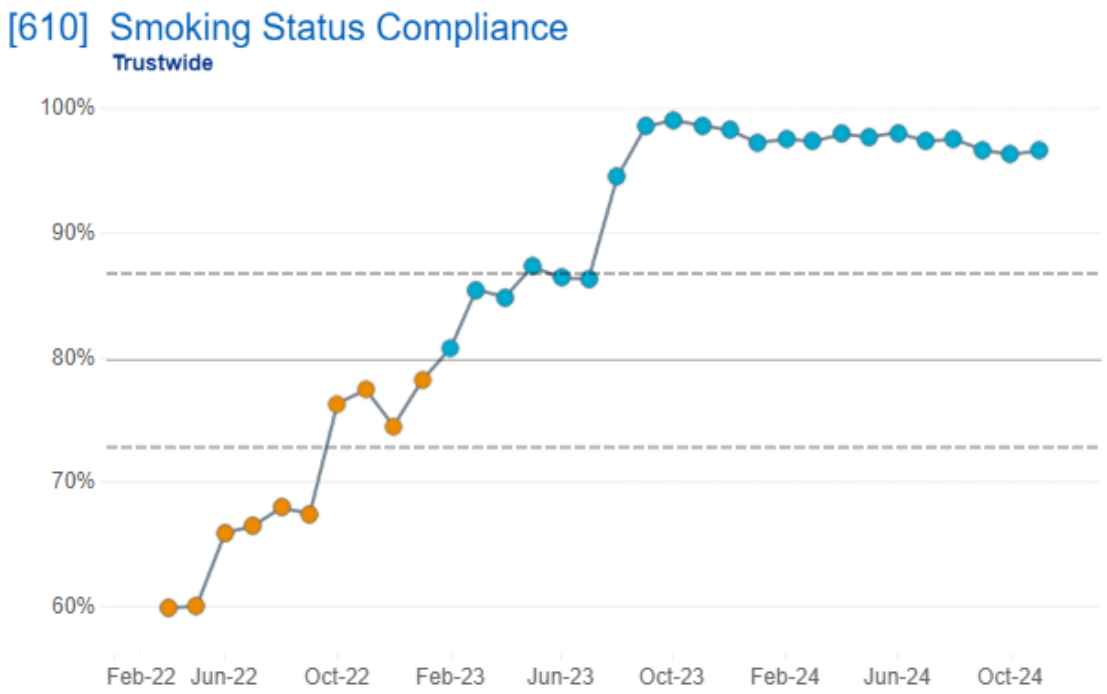


Commentary: As above

Planned Actions:

Expected recovery:

Patient Smoking Cessation

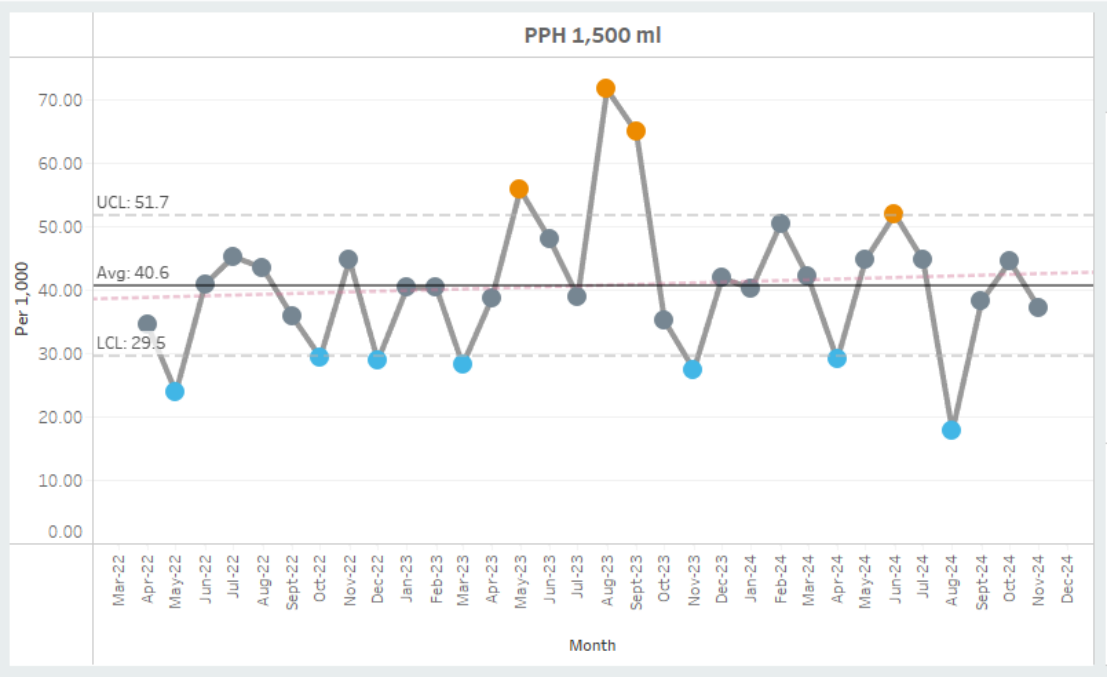


Commentary:
All patients admitted to hospital should be asked about their smoking status by the clinical and admitting teams; this should be recorded on their clinical notes and referred to the Tobacco Free Team.
Smoking should be treated like any other addiction, patients should be offered NRT upon 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 of advisors in place- starting in Dec/Jan

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 fetal deterioration is one of the areas of improvement for the Trust's **Safety Priorities.**

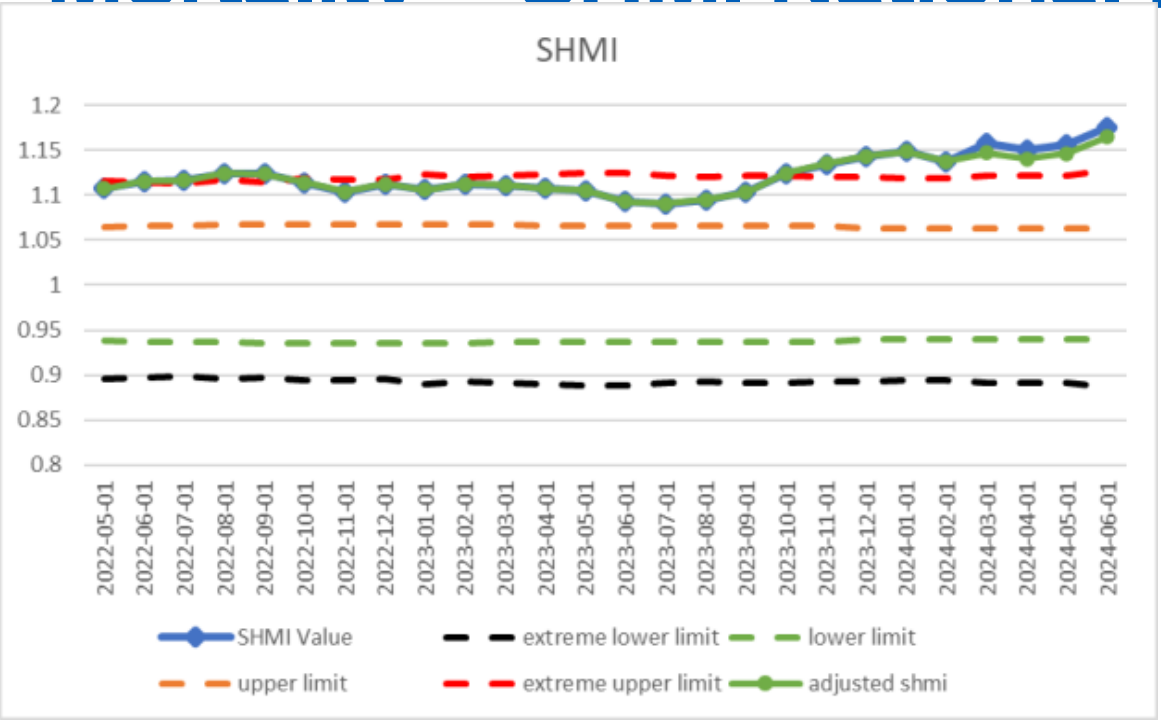
The PPH rate has decreased this month to 38 per 1000 deliveries (national average 31) The PPH improvement team continue to analyse safety incidents on a weekly basis to target their improvement actions as the focus is to learn when cases happen to see how we can improve the management of incidences.

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



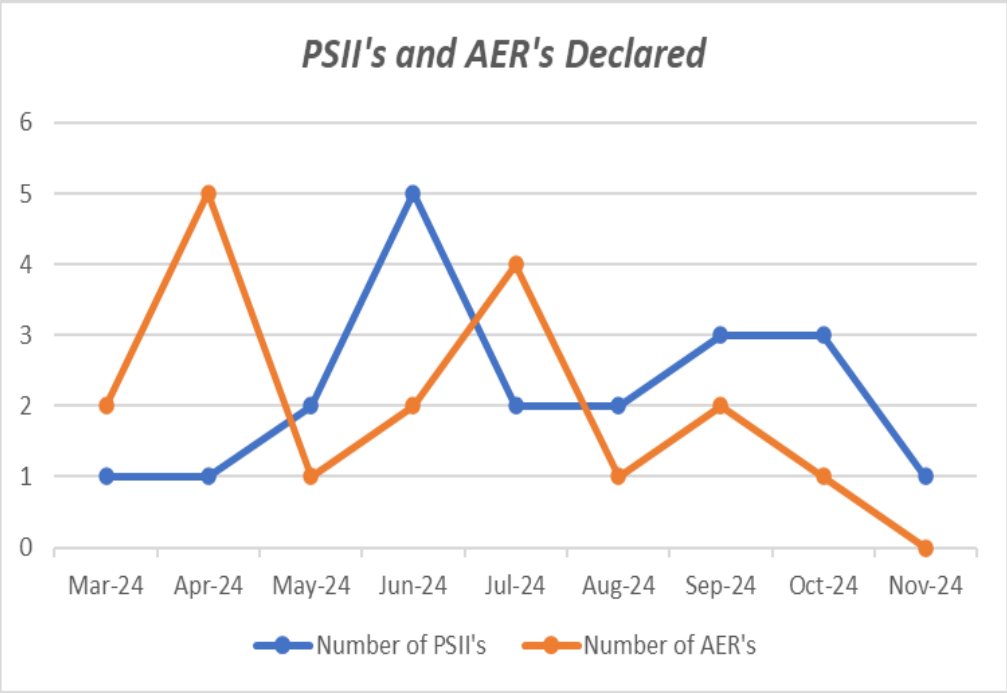
Commentary:
Latest SHMI (NHS Digital) = 1.17

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

- Primary Diagnosis/Charlson scoring coding work focussed on Acute Medical Unit.
- Correction of incorrect data upload (leading to fewer expected deaths for GHT, therefore increasing SHMI due to additional "R" codes)
- CGH increased SHMI relates to post discharge mortality from Oncology/Haematology/Frailty. Clinical audits of coding of these patients underway.
- Weekend/weekday ICB Clinical Audit complete

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



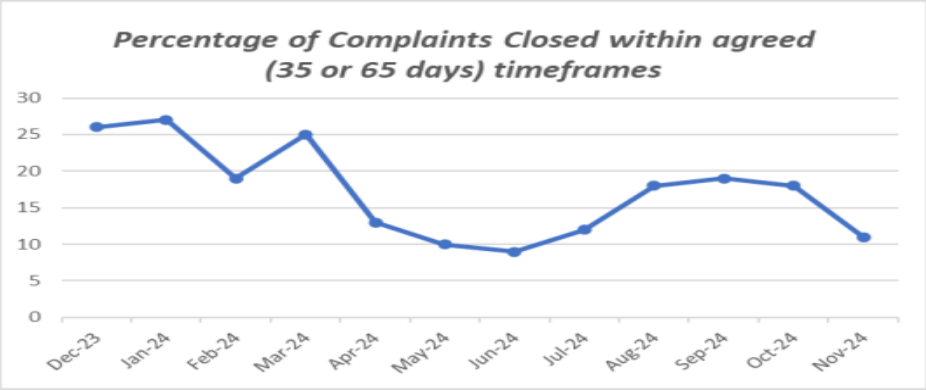
Commentary:

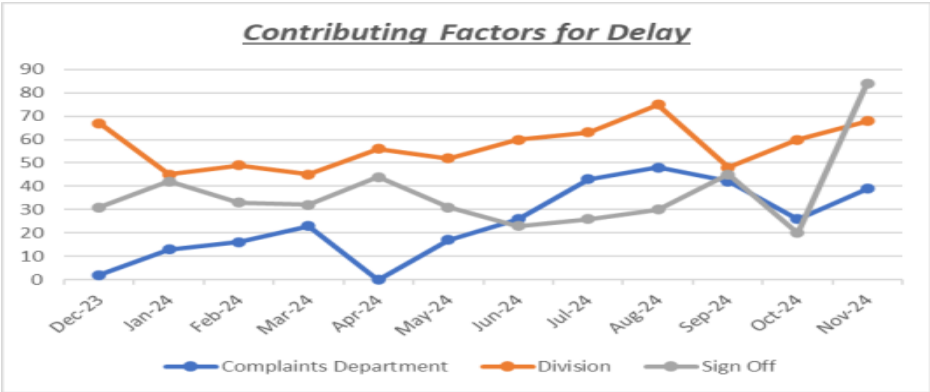
PSII – Patient Safety Incident Investigation. Declared when a problem in care is considered to have contributed to death, or a safety concern is such that a detailed systems approach investigation is indicated

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

37 Patient Safety Incidents have required review through PSII or AER, since the Trust transitioned to PSIRF in March 24; an average of 5.2 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
- Design of new Standard Operating Procedure (SOP) and improvement initiatives across all Divisions has commenced
- Proposals for focussed project group to clear backlog
- Successful recruitment 2 x B3 Admin posts.
- Complaint Response Huddle 3 x weekly

Expected recovery:
Current actions in place are providing a marginal improvement in response rates. A significant improvement is expected once the backlog is cleared and new SOP embedded.

Use of Resources Metrics

Financial Metrics

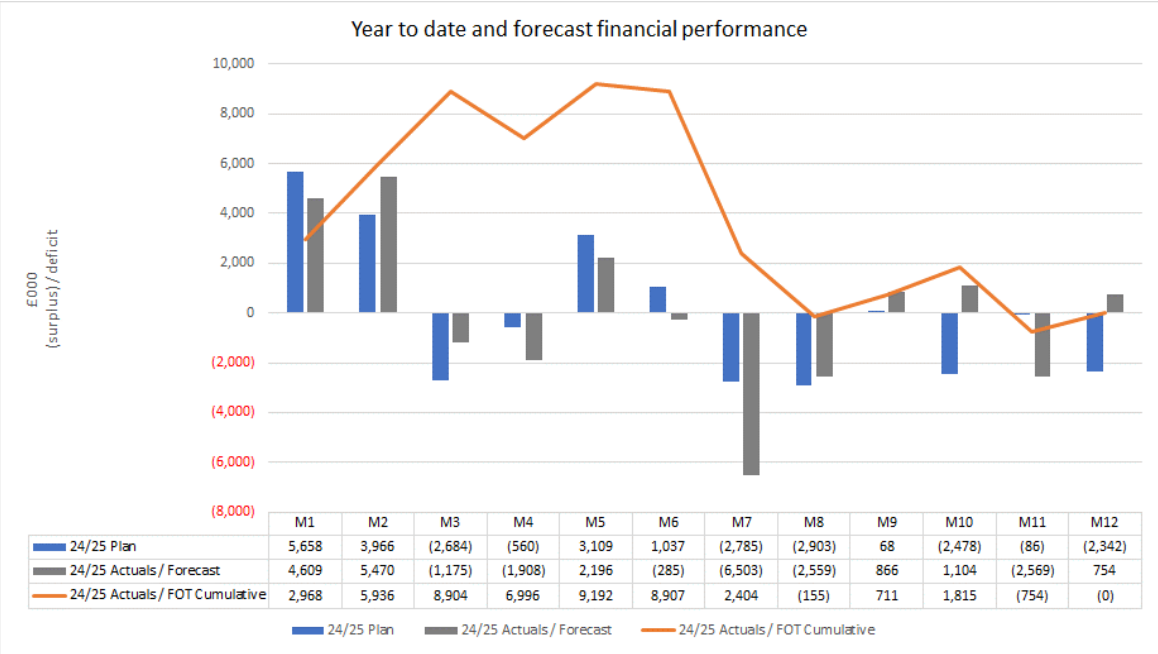
	Metric		Month 6 Plan	Month 6 Actual	Month 6 Var	Month 7 Plan	Month 7 Actual	Month 7 Var	Month 8 Plan	Month 8 Actual	Month 8 Var
NHS England Oversight Metrics	Revenue (deficit)/surplus	Ytd £'000s	-10,526	-8,907	1,619	-7,741	-2,404	5,337	-4,838	155	4,993
		Forecast £'000s	0	0	0	0	0	0	0	0	0
	Capital vs budget plan	Ytd £'000s	19,153	11,023	-8,130	24,585	13,815	-10,770	28,774	16,240	-12,534
		Forecast £'000s	45,972	45,972	0	45,972	46,358	386	45,972	43,588	-2,384
	FSP	Ytd £'000s	11,476	14,332	2,856	15,544	19,490	3,946	19,837	21,318	1,481
		Forecast £'000s	37,389	37,389	0	37,389	37,389	0	37,389	37,389	0
	Nos days operating cash		5	25	20	5	31	26	5	24	19
	BPP - nos invoices paid in 30 days		95%	99%	4%	95%	99%	4%	95%	99%	4%
	Agency spend as % of pay		3.2%	2.9%	-0.3%	3.2%	2.7%	-0.5%	3.2%	2.7%	-0.5%
	Trust bank spend (incl locum) spend as % of pay		-	9.7%	-	-	9.5%	-	-	9.3%	-

Key Messages

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

- Revenue I&E position is £0.155m surplus YTD against a plan of £4.8m deficit. This is £4.99m favourable to plan & £1.4m better than the internal forecast.
- FSP delivery is £21.3m YTD against a plan of £19.8m. This is £1.5m favourable to plan.
- Agency spend is 2.7% of total pay bill which is 0.5% better than the NHSE target of 3.2%.
- Bank (including locum) spend is 9.3% of total pay bill. This is a new internal metric created to compare the change in agency % against change in bank %. Bank spend as a % of total pay bill has reduced each month for the past three months.
- Capital spend is £16m YTD against a plan of £29m. Spend is behind plan by £12.5m.

M08 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)	(6,503)	(2,559)	866	1,104	(2,569)	754
24/25 Actuals / FOT Cumulative	2,968	5,936	8,904	6,996	9,192	8,907	2,404	(155)	711	1,815	(754)	(0)

Commentary

M08 financial position is £155k surplus YTD against a plan of £4.9m deficit. This is £4.9m favourable to plan and £1.4m better than the internal forecast. The Group position includes the GMS position which is in line for delivery of its dividend position at £0.12 below plan (FYE).

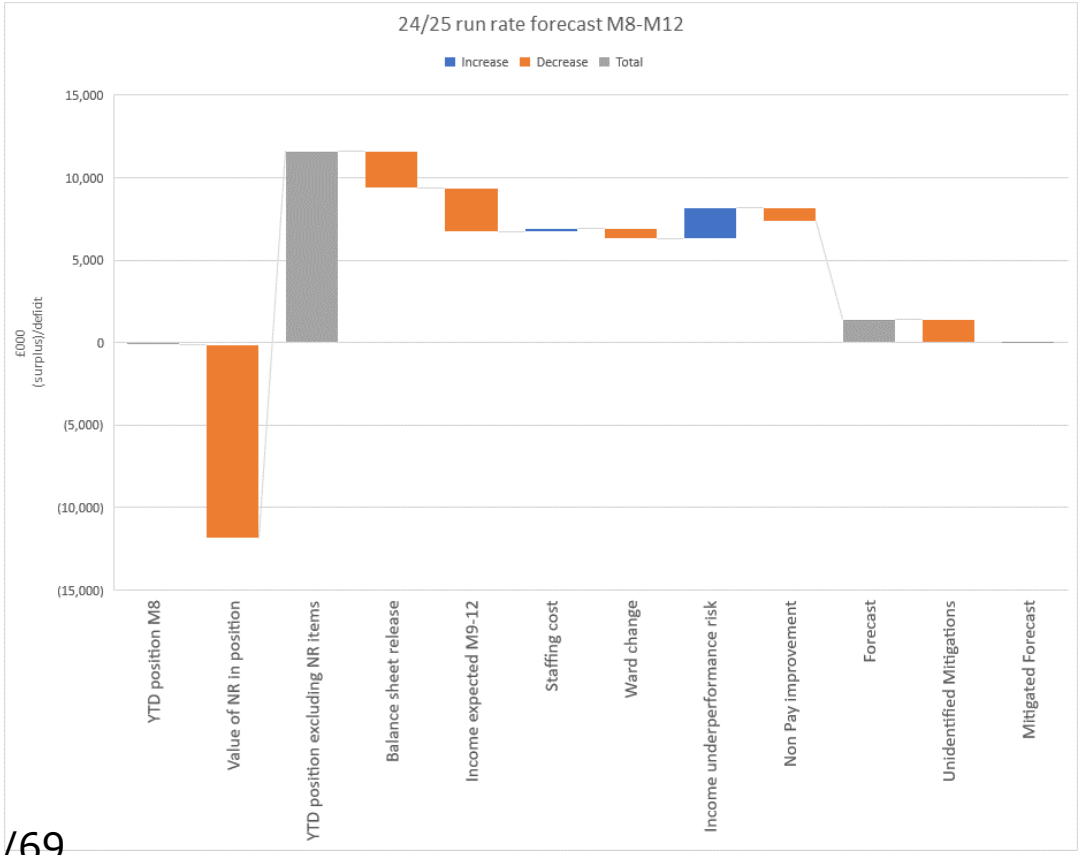
Planned Actions:

- Recurrent financial sustainability opportunities continue to be explored.
- Non Pay Oversight Group is meeting monthly.
- 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 and have been discussed with the Board.

M08 to M12 Run Rate



Commentary

The YTD position is a surplus of £155k which is £4.9m favourable to plan. This favourable position has been achieved through having £11.7m non recurrent benefits in the position. These will not continue in the latter part of the year which means the favourable position against plan will reduce and internally we are currently forecasting a £1.37m deficit against plan. Further mitigations of £1.37m will need to be found to deliver the breakeven plan reported to NHSE.

Planned Actions for M9-M12

- £2.2m balance sheet items will be released in M9-M12 to support the position
- £2.6m additional income is expected
- Dixton ward closure will mean costs reduce
- Improvement in divisional non pay positions is expected
- We are forecasting to continue to have underperformance on elective out of county activity.
- Divisional forecasts are being reviewed to understand the recurrent impact of the M8 position being ahead of forecast.

M08 Financial Position

Summary I&E Position (Group)	YTD Plan £000	YTD Actual £000	YTD Variance £000
Income	(522,165)	(546,417)	(24,252)
Pay	337,160	339,587	2,427
Non Pay	189,843	206,530	16,687
Total	4,838	(300)	(5,138)
Donated Assets/Grants/IFRIC 12 Adj	0	145	145
Adjusted (surplus)/deficit	**4,838**	**(155)**	**(4,993)**

Summary I&E Position (Trust only)	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(533,510)	(542,708)	(9,199)
Pay	324,145	320,628	(3,517)
Non Pay	214,201	221,783	7,582
Total	**4,838**	**(300)**	**(5,138)**
Donated Assets/Grants/IFRIC 12 Adj	0	145	145
Adjusted (surplus)/deficit	**4,838**	**(155)**	**(4,993)**

Headlines

YTD position is £4.9m favourable to plan. This is driven by one-off benefits and FSP schemes delivering ahead of plan.

The Group position includes GMS and is compared to the original plan submitted in June 24, update for the recent pay awards. 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 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 £9m. Overperformance includes £2.9m pass through drugs overperformance, prior year income from commissioners and non recurrent income from GICB. There is also £2.6m underperformance on out of area elective activity which are on API contracts. (H&W is c.£1.2m and NHSE Spec Comm is c.£1m).

Pay underspend of £3.5m. Underspend includes £2.8m non recurrent benefit of HCSW. Without these non recurrent benefits, pay would be £0.7m underspent.

Non pay overspend of £7.5m. Overspend includes £2.9m passthrough drugs and £2.8m FSP target that is held in non pay but being delivered against pay (HCSW).

M08 Pay

	YTD Budget	YTD Actual	YTD Variance		YTD Variance excl NR benefits
Pay M8 YTD	£000	£000	£000		£000
Infrastructure	51,675	50,914	(761)		(761)
Medical & Dental	99,772	100,016	244		244
Nursing	127,090	123,409	(3,682)		(855)
Other Clinical Staff	48,012	45,303	(2,709)		(2,709)
Total (excl reserves)	326,548	319,641	(6,907)		(4,080)
Reserves (FSP & other staff)	794	783	(11)		(11)
Divisions (FSP target & vacancy factor)	(3,197)	205	3,401		3,401
TOTAL	324,145	320,628	(3,517)		(690)

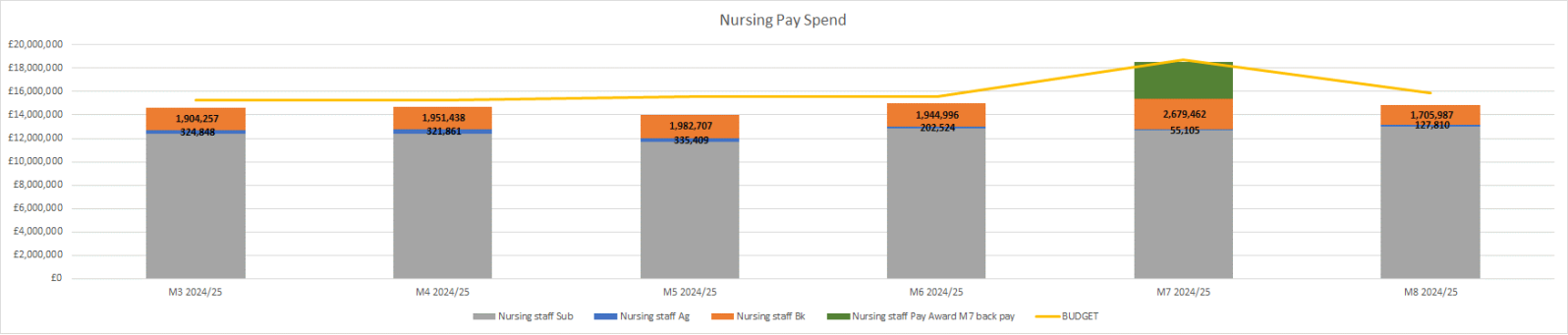
YTD Variance (M8)	Corporate	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Pay YTD Variance including HCSW NR benefit	Less HCSW NR benefit	Pay YTD Variance excluding HCSW NR benefit
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Infrastructure	(1,017)	155	130	(129)	(16)	117	(761)		(761)
Medical	159	(52)	2,718	(1,566)	(884)	(131)	244		244
Nursing	129	(70)	3,364	(4,052)	(1,832)	(1,221)	(3,682)	(2,827)	(855)
Other Clinical Staff	77	(2,263)	(68)	7	(451)	(11)	(2,709)		(2,709)
Other Staff Sub	309	1,240	479	(11)	1,220	153	3,390		3,390
Pay YTD Variance including HCSW NR benefit	(342)	(990)	6,624	(5,751)	(1,964)	(1,094)	(3,517)	(2,827)	(690)
Less HCSW NR benefit				(2,827)			(2,827)		
Pay YTD Variance excluding HCSW NR benefit	(342)	(990)	6,624	(2,924)	(1,964)	(1,094)	(690)		

Headlines

Pay is £3.5m YTD underspent. This includes the benefit of £1m HCSW rebranding 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 £0.7m underspent.

- Medical staffing overspend of £0.2m including industrial action costs of £0.6m (matched by income).
- Nursing underspend of £3.7m which includes HCSW adj. Without this, nursing is £0.8m underspent YTD.
- Infrastructure £0.8m underspent, mainly within corporate areas.
- Other clinical staff £2.7m underspent, of which £2.1m is in D&S. £0.6m is in Surgery.
- Other staff £3.4m overspent. This is where FSP negative budget £3m and NR vacancy factor £1.4m is held. This also includes £1.2m underspend due to slippage in reserves and HRI.

M08 Nursing Pay

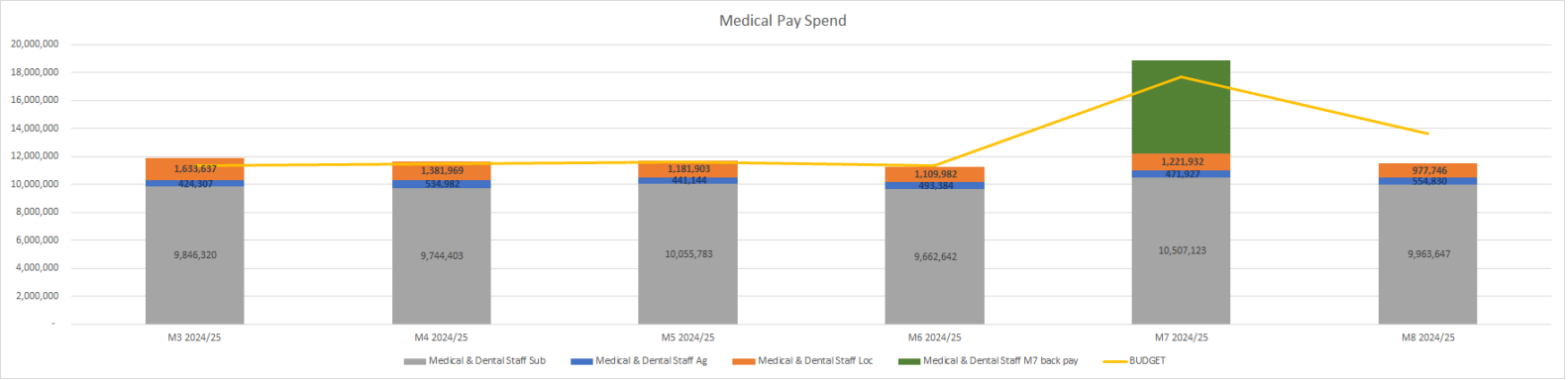


Headlines

Nursing budgets are £3.7m underspent YTD. This includes the benefit of £1.8m from releasing HCSW recognition payment accrual which is not needed and slippage in rebranding of £1.03m. Without these benefits, **pay is £0.8m underspent YTD.**

- M8 spend is £246k lower than prior month (excluding pay award). Agency has increased by £73k, bank and substantive has increased by £319k.
- Nursing agency spend has increased by £73k from M7 to M8 (£55k to £128k) but this is because last month saw a £73k pay award accrual that had been incorrectly applied to agency dropping out.

M08 Medical Pay



Headlines

Medical staffing budgets are £0.2m overspent YTD. This includes industrial action costs of £616k which has now been funded centrally.
The position looks favourable in month because HEE funding for the resident doctor pay award for M1-8 has been included in the M8 position.

- Agency spend has increased by £83k from M7 to M8 (£472k to £555k). The main increase is within D&S.
- Locum spend has reduced in month by £244k (£1,222k to £978k). There has been a £126k reduction in Medicine and a £170k reduction in Surgery.

M08 Non Pay

Non Pay	YTD Variance £000				
	Divisions	Corporate	Reserves/ Central	FSP (pay offsetting non pay)	Total
YTD Variance	15,583	-593	-7,407		7,582
Adjusted items and passthrough:					
Pass through drugs and devices	6,669	0	-3,795		2,874
FSP non pay pressure that is covered by HCSW NR benefit (pay)				2,827	2,827
YTD Variance excl adjusted items and pass through	8,914	-593	-3,612	-2,827	1,881

Headlines

M8 YTD non pay position is overspent by £7.5m.

This reduces to £1.8m after removing:

- 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 £1.8m is split by:

- Divisional pressures £9m.
  - This is partly offset by the £2.8m NR HCSW FSP delivery held in pay.
- Corporate underspend £0.6m
- Reserves underspend £3.6m. This includes NR benefits e.g. pharmacy stock and balance sheet releases.

M08 Income

Income	YTD Budget £000	YTD Actual £000	YTD Variance £000
HEE Income	(12,667)	(15,075)	(2,408)
Other Income from Patient Activities	(8,918)	(15,408)	(6,490)
Other operating income	(19,138)	(18,182)	956
PP Overseas and RTA Income	(4,188)	(4,435)	(247)
SLA & Commissioning Income	(488,598)	(489,608)	(1,009)
Total Income	(533,510)	(542,708)	(9,199)

Headlines

M8 YTD income position is £9m favourable to plan. This is driven by:

- HEE income £2.4m which offsets costs within divisions

- Non Recurrent income & balance sheet releases including:
  - Funding repayment £0.8m
  - Depreciation funding £2.4m
  - Spec comm bowel scope £0.5m

These NR items offset £2.5m FSP target

- SLA, Commissioning and other income form patient activities:
  - IA funding £0.6m
  - Pass through drugs overperformance £2.9m.
  - Underperformance on out of area elective activity which is an API contract. This is £2.6m of which H&W is c.£1.2m and NHSE Spec Comm is c.£1m.
  - Prior year income from commissioners £1.6m
  - System risk share income £1.25m
  - CDC, endoscopy and cancer funding £2.1m above budget

M08 Capital Position

in £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	4,413	3,648	764	7,020	8,056	(1,036)
MEDICAL EQUIPMENT	4,094	1,075	3,019	9,516	11,550	(2,034)
ESTATES	12,902	8,939	3,963	19,544	18,016	1,528
OVERCOMMITTED PROGRAMME - REQUIRES SLIPPAGE	0	0	0	0	(1,465)	1,465
NBV OF ASSET DISPOSALS	0	(77)	77	0	(77)	77
Total Charge against Capital Allocation (excl. IFRS 16)*	**21,409**	**13,586**	**7,823**	**36,080**	**36,080**	**0**
RIGHT OF USE ASSET	5,785	1,816	3,969	7,412	4,997	2,415
Total Charge against Capital Allocation (incl. IFRS 16)	**27,193**	**15,401**	**11,792**	**43,492**	**41,077**	**2,415**
NAT PROGRAMME, GRANTS, DONATIONS & OTHER	3,005	2,085	920	4,699	4,344	355
Gross Capital Spend Total	**30,198**	**17,486**	**12,712**	**48,192**	**45,421**	**2,770**

Gross Capital Spend Total	**30,198**	**17,486**	**12,712**	**48,192**	**45,421**	**2,770**
Less Donations and Grants Received	(1,252)	(1,073)	(179)	(1,575)	(1,575)	(0)
Less PFI Capital (IFRIC12)	(399)	(399)	0	(600)	(600)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	227	228	(0)	341	341	0
Total Capital Departmental Expenditure Limit (CDEL)	**28,774**	**16,241**	**12,533**	**46,358**	**43,588**	**2,770**

Note:

*The actual forecast system capital allocation is £36,052k but is showing in the table as £36,080k as £28k of the allocation is sitting with the ICB.

It is expected that the allocations for the Right of Use assets and the National Programme will be reduced in line with the current forecast outturn in the future but have not been reflected in the above for illustrative purposes.

Commentary:

The Trust submitted a gross capital expenditure plan for the 24/25 financial year of £47.7m. A further £0.5m of National Programme and Grant funding has been approved bringing the allocation to £48.2m.

As of the end of November (M8), the Trust had goods delivered, works done or services received to the value of £17.5m, against a planned spend of £30.2m, equating to a variance of £12.7m behind plan. In month, gross capital expenditure totalled £2.5m.

On 21st November National Health Service England (NHSE) sent a letter to all NHS organisations asking Boards to formally sign off the capital forecast position based on month 8. This declaration could be provided by the Chief Finance Office or Chief Executive Officer on behalf of the board and needed to be reflected in the month 8 Provider Financial Return forms.

Following a detailed forecast assessment, which included several discussions between interested parties across numerous departments within the Trust, Gloucestershire Managed Service (GMS) and contractors/suppliers, it was recommended that the Trust submit the following position:

For Operational System Capital (excluding IFRS16) submit a breakeven capital forecast.
For International Financial Reporting Standard 16 (IFRS16) submit an underspend of £2.4m.
For National Programme return funds of £355k.

To achieve a breakeven position on the Operational System Capital programme, £3.8m of high priority equipment scheme mitigations are being progressed to offset an assessed forecast underspend position of £2.3m with a further £1.5m of known risks included within the forecast. The delivery of these schemes will be carefully managed as we go through the remaining months of the financial year and deliveries pushed back to April should they be required.

On Monday 9th December, the board agreed to the capital forecast position.

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	Nov 25 £'000
Opening Balance	**55,176**	**59,364**	**39,309**	**32,237**	**40,838**	**46,441**	**42,939**	**67,710**	**50,590**	**36,001**	**27,005**	**36,267**	**26,380**	**29,257**	**28,842**	**16,545**	**24,320**	**20,701**	**11,997**	**19,087**
Receipts																				
SLA Income	56,603	56,604	53,597	58,941	70,953	62,151	71,929	62,915	59,691	62,448	59,865	61,527	57,088	59,311	57,211	61,107	57,058	58,584	61,890	63,817
Other NHS	17,271	2,650	3,025	14,209	4,254	1,963	27,187	5,074	2,625	3,069	10,514	2,460	15,847	2,400	3,125	12,821	2,215	2,015	19,313	2,155
Other Non-NHS	2,924	1,941	1,723	1,677	1,487	2,366	2,210	1,819	1,474	1,827	2,012	2,953	2,611	2,039	1,596	2,394	1,934	1,868	2,121	1,645
VAT	1,051	3,358	2,455	4,210	2,709	3,080	1,863	2,063	2,634	3,019	2,431	2,214	2,051	2,358	2,444	2,841	3,218	2,166	1,935	2,479
Total Receipts	**77,849**	**64,554**	**60,801**	**79,036**	**79,403**	**69,963**	**103,445**	**71,871**	**66,564**	**70,363**	**74,822**	**69,154**	**77,597**	**66,108**	**64,376**	**79,163**	**64,424**	**64,634**	**85,258**	**70,096**
Payments																				
Payroll - Direct payments	(23,625)	(23,934)	(25,273)	(24,715)	(24,750)	(23,999)	(29,887)	(29,591)	(26,346)	(26,205)	(26,281)	(28,950)	(25,944)	(25,879)	(26,521)	(26,054)	(26,015)	(26,064)	(26,061)	(26,016)
Payroll - On costs	(18,111)	(16,960)	(17,234)	(18,108)	(17,474)	(17,195)	(16,990)	(23,610)	(18,067)	(18,050)	(18,111)	(18,065)	(18,091)	(16,946)	(18,069)	(18,549)	(18,045)	(18,045)	(18,085)	(18,065)
Payables	(31,926)	(43,714)	(25,366)	(27,612)	(31,576)	(26,753)	(31,797)	(35,790)	(36,738)	(35,105)	(21,168)	(27,527)	(30,685)	(23,697)	(32,083)	(26,785)	(23,984)	(24,186)	(34,022)	(24,068)
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	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	0
Total Payments	**(73,661)**	**(84,609)**	**(67,873)**	**(70,435)**	**(73,801)**	**(73,466)**	**(78,674)**	**(88,991)**	**(81,152)**	**(79,360)**	**(65,560)**	**(79,041)**	**(74,720)**	**(66,523)**	**(76,674)**	**(71,387)**	**(68,044)**	**(73,338)**	**(78,168)**	**(68,150)**
Net Cashflow	**4,188**	**(20,055)**	**(7,072)**	**8,601**	**5,603**	**(3,502)**	**24,771**	**(17,120)**	**(14,589)**	**(8,997)**	**9,262**	**(9,886)**	**2,876**	**(414)**	**(12,297)**	**7,775**	**(3,619)**	**(8,704)**	**7,090**	**1,946**
Closing Balance	**59,364**	**39,309**	**32,237**	**40,838**	**46,441**	**42,939**	**67,710**	**50,590**	**36,001**	**27,005**	**36,267**	**26,380**	**29,257**	**28,842**	**16,545**	**24,320**	**20,701**	**11,997**	**19,087**	**21,033**

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 10 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	No. BME Staff Oct 2024
Trust Wide Total (B8a - VSM)	69	35	44	41	42
Band Specific					
B8a	41	24 (11%)	32 (12%)	30 (11%)*	30 (11%)*
B8b	17	3 (4%)	7 (7%)	5 (5%)*	6 (7%)*
B8c	7	5 (14%)	4 (11%)	6 (14%)*	6 (14%)*
B8d	4	2 (11%)	1 (5%)	0 (0%)*	0 (0%)*
B9	2	0 (0%)	0 (0%)	0 (0%)*	0 (0%)*
VSM	2	1	0 (0%)	0 (0%)*	0 (0%)*

***66 staff between bands 8a to VSM have no ethnicity data in ESR**

Model employer WRES

Gloucestershire BME population currently 6.9% Gloucestershire population data

Proportion of staff in senior leadership roles who are female	Mar-21	Mar-22	Mar-23	Mar-24	Oct - 24
Trust Wide Total (B8a - VSM)	233	248	273	327	331
Band Specific					
B8a	143 (78%)	156 (77%)	168 (77%)	209 (77%)	215(77%)
B8b	47 (64%)	49 (64%)	56 (67%)	68 (69%)	64(69%)
B8c	16 (46%)	21 (58%)	22 (61%)	20 (53%)	24(56%)
B8d	12 (67%)	12 (71%)	11 (61%)	13 (68%)	12(67%)
B9	5 (71%)	2 (40%)	4 (57%)	7 (78%)	8(73%)
VSM	10 (43%)	8 (32%)	12 (48%)	10 (45%)	8 (40%)

Gloucestershire female population currently 51% Gloucestershire population data

Commentary:

The overall picture suggests steady but slow progress with regards to the model employer aspiration target.
The Model Employer target was set by NHSE in 2018. We have until 2028 to achieve the target, however a decision was made in 2022 that we bring that target forward to the next year (2025 for example) to ensure that we have that target to work towards. Each year we use the 2028 target as that years target.

We are currently not meeting the target.

Planned Actions:

- A meeting with NHSE is scheduled within the next couple of weeks to review the targets set and any changes made since 2018
- There are action plans being worked through with divisions for the WRES data during Q3 and Q4 of 24/25 which supports the formal risk raised with specific divisional actions.
- A trajectory is being developed for the remaining years of the original target to identify areas of priority.
- Inclusive recruitment and development talent planning is being undertaken during Q3 and Q4 of 24/25
- An Interviewing with Impact workshop was piloted in Aug 24. Plans are in place to hold 3 further workshops in 2025.
- The EDI Lead offers individual interview preparation for staff who have been invited to an interview

Staff in Leadership roles driver metrics

Ethnicity declared in TRAC	Applied	Shortlisted	Interview attended	Appointed	Success at interview
MIXED - any other mixed background	21	3	2	1	50.00%
I do not wish to disclose my ethnic origin	37	6	5	1	20.00%
WHITE - Any other white background	89	16	11	2	18.18%
WHITE - British	377	139	64	9	14.06%
ASIAN or ASIAN BRITISH - Any other Asian background	415	12	8	1	12.50%
ASIAN or ASIAN BRITISH - Indian	539	54	21	1	4.76%
BLACK or BLACK BRITISH - African	614	56	26	1	3.85%
MIXED - White & Black African	38	0			0.00%
ASIAN or ASIAN BRITISH - Pakistani	321	11	5	0	0.00%
OTHER ETHNIC GROUP - Any other ethnic group	99	9	4	0	0.00%
ASIAN or ASIAN BRITISH - Bangladeshi	54	4	2	0	0.00%
BLACK or BLACK BRITISH - Any other black background	28	3	1	0	0.00%
BLACK or BLACK BRITISH - Caribbean	16	5	2	0	0.00%
OTHER ETHNIC GROUP - Chinese	13	3	3	0	0.00%
MIXED - White & Black Caribbean	9	4	1	0	0.00%
MIXED - White & Asian	9	1	1	0	0.00%
WHITE - Irish	4	2	1	0	0.00%

Commentary:

- This data reflects all applications received from M05 to M07
- Applications from BME staff make up 81% of the 2683 received
- Whilst nearly 81% of applications are BME, our local population is much smaller at 6.9% BME.
- Overseas applicants - there is a large reduction between applicant numbers and those that are shortlisted due to applicants not meeting essential criteria; if they are from a Red List country, sponsorship is not available.
- The recruitment system TRAC used in the Trust does not disclose the ethnicity to managers during the shortlisting process.
- The highest success rate at interview is seen by: MIXED - any other mixed background. 2nd is: I do not wish to disclose my ethnic origin. 3rd is: WHITE - Any other white background
- Candidates of Asian/Asian British, Bangladeshi, Pakistani, and other ethnic groups, along with those of Mixed White and Black African backgrounds, tend to have lower success rates in interviews.

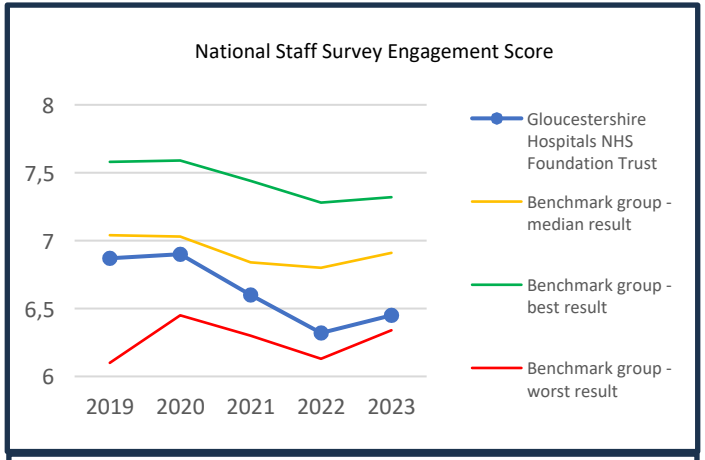
A deep dive of the data was completed & shows:

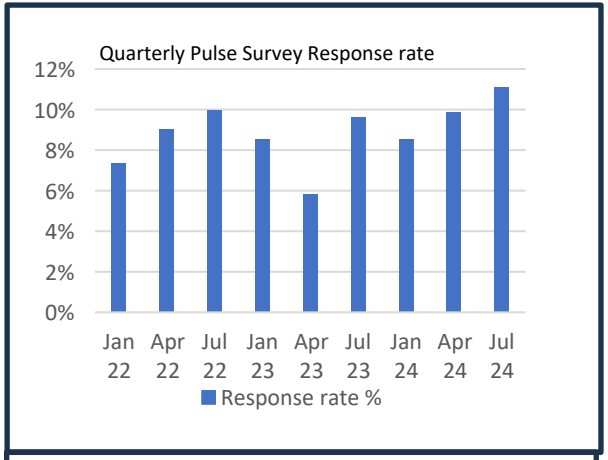
- UK based BME applicants are more successful than overseas BME applicants through the recruitment process.
- BME applicants attended less interviews than WHITE applicants for a number of self selected reasons; primarily citing being offered an alternative role and problems with travel arrangements.
- Over 10% of applicants are from red list countries, which skews the data in reducing the amount of BME staff being shortlisted.
- Nearly 75% of applicants require sponsorship to work in the UK.

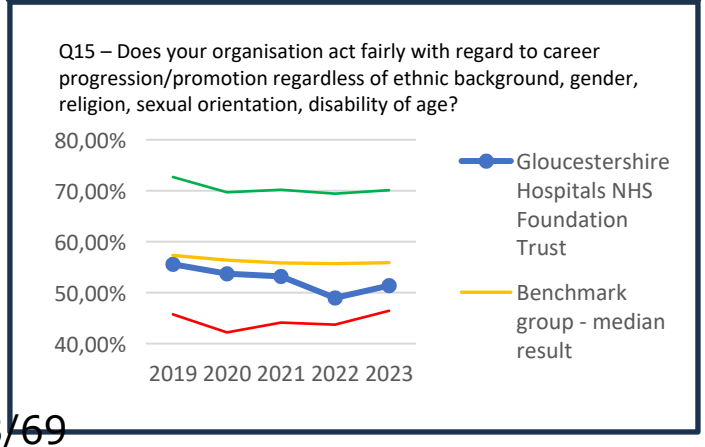
Planned Actions:

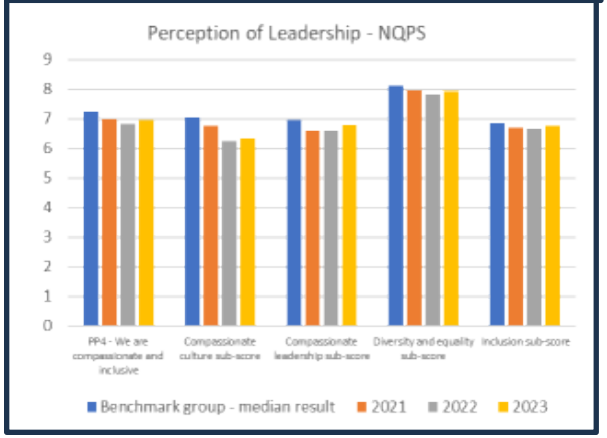
- Comms to encourage disclosure of ethnicity on ESR Jan-March 2025
- Colleagues who join the Inclusion Network will automatically receive notifications and reminders to complete their ESR.
- Encourage attendance at Building Confidence in Interviews Course
- Longitudinal evaluation of the Cohort (18-20 funded) Florence Nightingale Foundation for the IENM Online Leadership Programme
- Creation of an EDI Talent Management Plan to work in conjunction with Inclusive recruitment
- Training events for positive action, writing inclusive job descriptions and person specifications

Staff Engagement - National Staff Survey watch metric









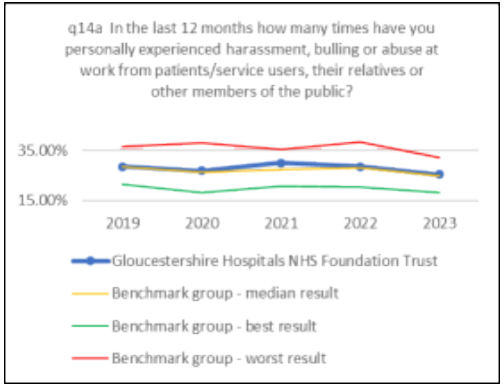
Commentary:
The 2024 Staff Survey has now closed, and while we await the initial results, early indications suggest a slightly lower response rate compared to 2023.

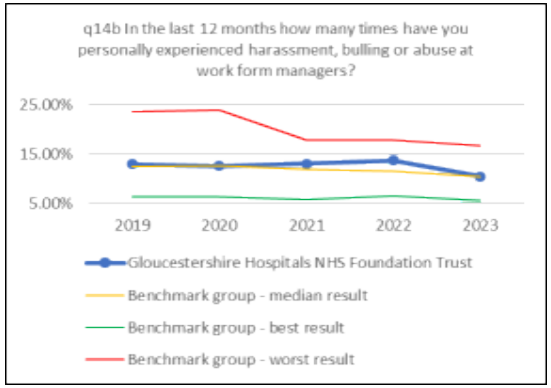
The final response rate for the Trust will be confirmed following the national publication.

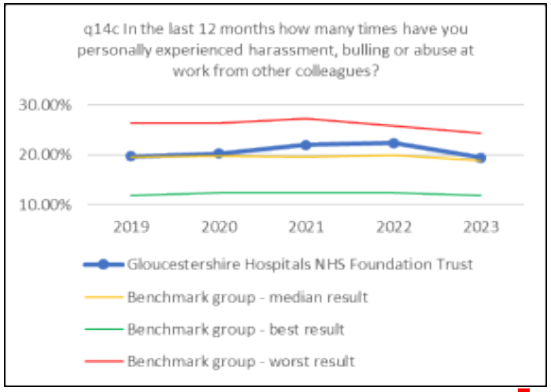
Updated data, including the 2024 NSS Engagement score, NSS Q15 results, and the January 2025 Quarterly Pulse Survey (NQPS), will be available in January/February. This will provide a clearer picture of the Trust's current position.

Planned Actions:
Planning is in progress for the analysis, distribution and presentations of the 2024 results ahead of the embargo being lifted in March 2025.

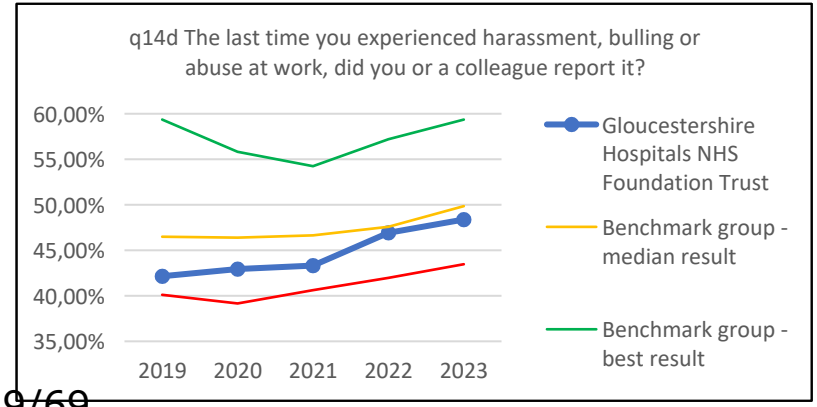
Staff Engagement - National Staff Survey watch metric







% of staff saying they experienced at least one incident of harassment, bullying or abuse



% 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"

Commentary:
Scores and results remain the same from last month until the NSS24 results are released.

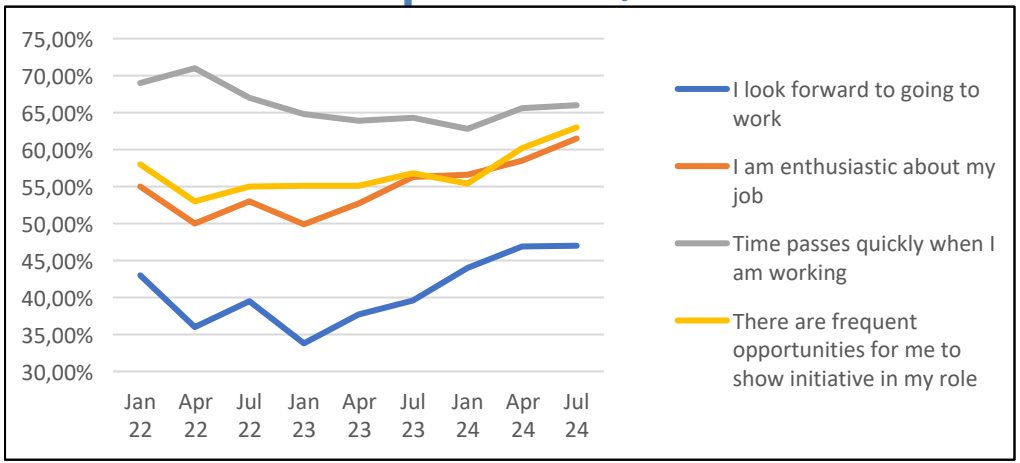
The staff survey shows slight improvements in leadership culture, engagement, and reductions in bullying and harassment.

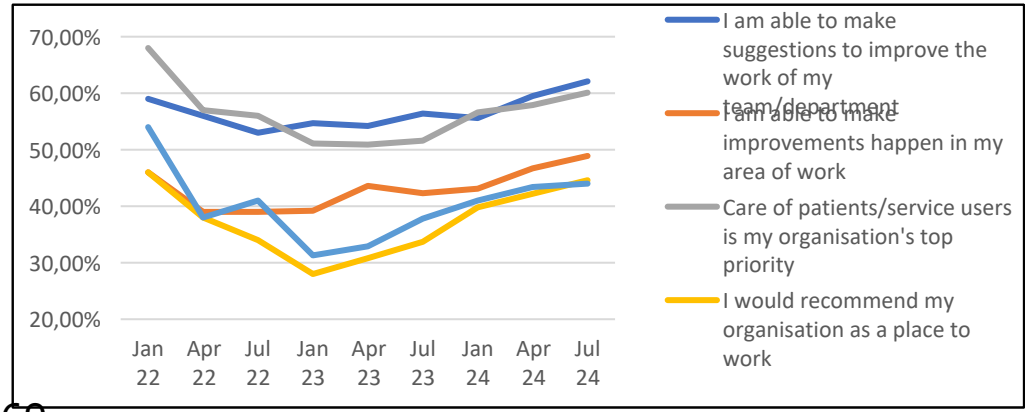
While encouraging, these gains highlight the need for ongoing efforts to drive sustainable change and strengthen the workplace culture.

Planned Actions:
The anti-discrimination workstreams plans to procure a 'Report and Support' platform allowing for more detailed metrics on the reporting of harassment, bulling or abuse. This workstream continues to progress with this initiative.

NQPS Job Perception

3 monthly watch metrics





Commentary:

Scores and results remain the same from last month until the Jan 25 NQPS is completed and results published.

There are improvements across all measured aspects of job perception since January 2023.

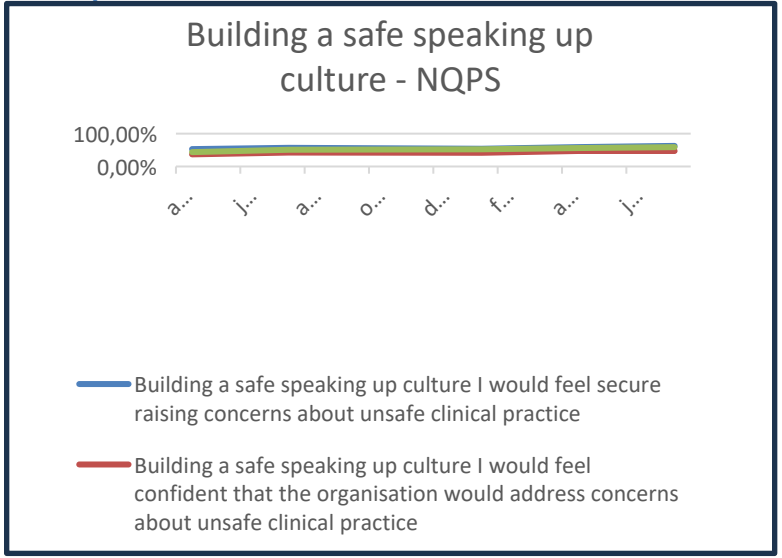
Planned Actions:

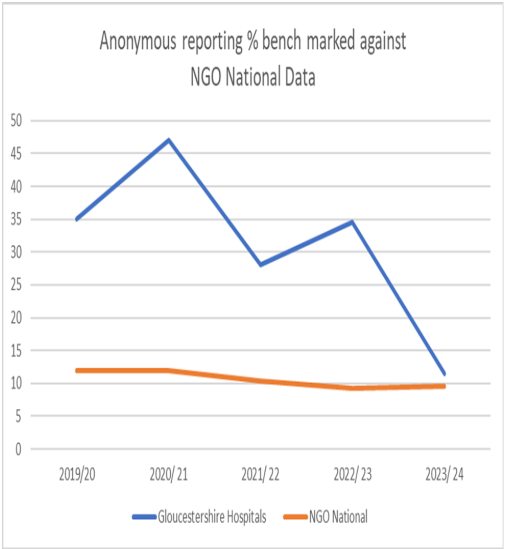
The Staff Experience Improvement Programme (SEIP) utilise these metrics as proxy measures of improvement for 'culture'.

Future work on establishing an embedded Trust-wide approach will support further improvement.

NQPS Building a safe speaking up culture Workstream Metrics

3 monthly watch metrics





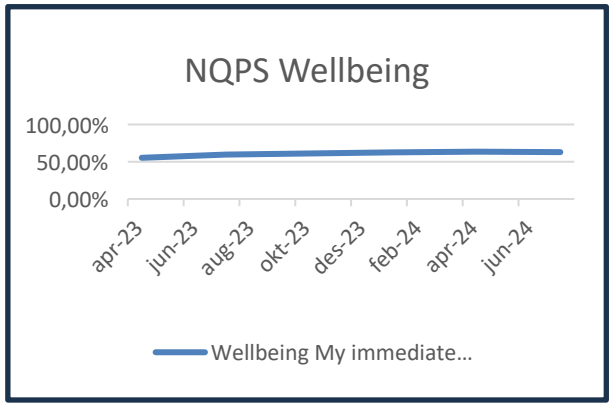
Workstream	NQPS SEIP	Apr-23	Jul-23	Jan-24	Apr-24	Jul-24
Building a safe speaking up culture	I would feel secure raising concerns about unsafe clinical practice	52.90%	56.80%	54.00%	59.00%	62.70%
	I would feel confident that the organisation would address concerns about unsafe clinical practice	36.90%	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%

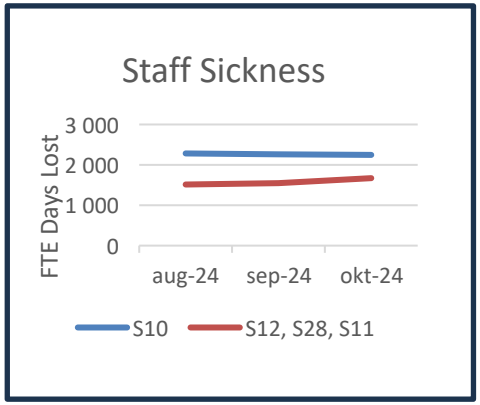
Commentary:
FTSU continues to be an active service with 165 cases raised to date compared with 152 raised at this point in 2023.
A champion network is evolving with 20 champions trained throughout October, FTSU month was marked with a visibility campaign, visiting all areas of the organisation out of hours to meet and raise awareness of the service to staff.

Planned Actions:
Developing manager support point of contact and enabling weekly training available to support managers receiving FTSU concerns. Q3
Review of staff survey results and meaning for the FTSU service as this becomes available
Progress with Board Review Tool Q4
Continued work to identify barriers to speaking up and methods of breaking down these barriers Q4

Expected recovery:
See above

NQPS Wellbeing Workstream Metrics 3 monthly watch metrics





Workstream	NQPS SEIP	Apr-23	Jul-23	Jan-24	Apr-24	Jul-24
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 wellbeing	-	-	-	-	47.90 %

Sickness code	Aug-24	Sep-24	Oct-24
S10: Anxiety/stress/ depression/other psychiatric illnesses.	2,283	2261	2247
S12, S28, S11: MSK related illnesses.	1,513	1547	1671

Commentary:
As presented in the last IPR report, there was a consistent positive response to *my immediate line manager takes a positive interest in my health and wellbeing* with a slight drop in July 24 by 0.6%.

NB: A new watch metric has been added to this report: sickness data linked to wellbeing.
'Stress, anxiety, depression, other psychiatric illness' remains the highest sickness reason, accounting for 23% of all sickness absence.

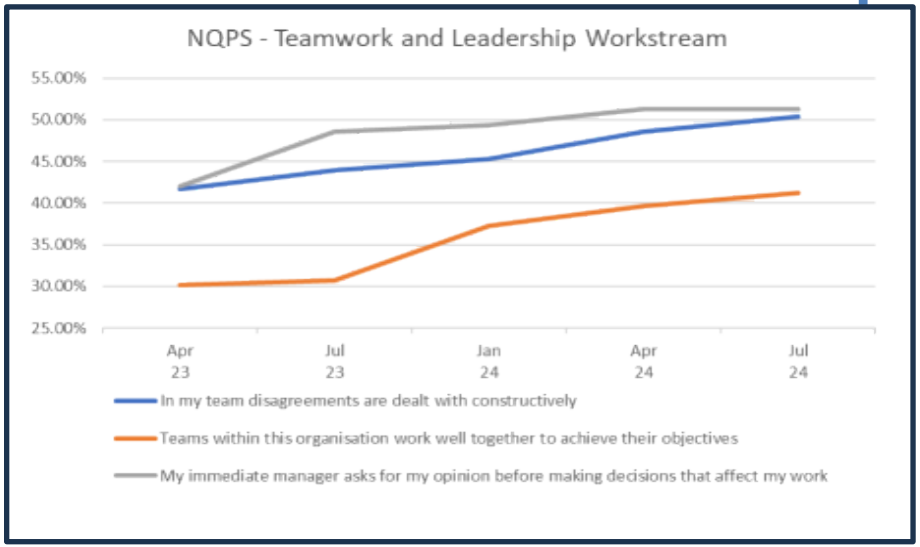
Planned Actions:
A new Wellbeing Strategic Action Plan has been signed off by the Wellbeing Steering Group; to drive all wellbeing work in 2025 to mitigate staff sickness and enhance workplace wellbeing.
Key actions include:

- Launch new 'Wellbeing Nurse' service for provision of in-work health checks to all staff (February 2025).
- Review of Employee Assistance Programme provision.
- Identify a Wellbeing Guardian at Board level.
- Identify Divisional Wellbeing Leads, and work in collaboration to support divisional wellbeing needs.
- Design and launch of new 'Taking Breaks campaign'.
- Work with Comms to build trust in confidentiality of the offer.
- Embed the new tools for managers; including Menopause Guide, Wellbeing conversations guidance, and tools to navigate the offer for varying levels of need.

Expected recovery:
n/a

NQPS Teamwork and Leadership Workstream Metrics

3 monthly watch metrics



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%

Commentary:
To adapt to the evolving needs of the organisation and foster a culture of continuous improvement, the programme has been redesigned to take on a flexible structure and a "needs-led" approach. This allows us to effectively shape and develop team culture and drive positive change across the Trust.

The proposal is to commence delivery via triage by referral process.

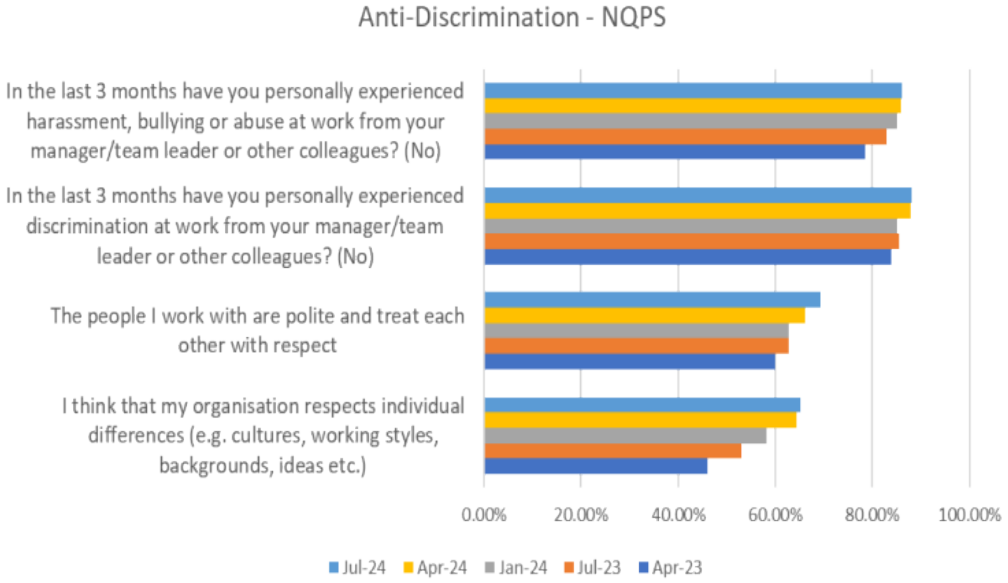
Divisions have been met with and priority areas have been agreed and will be approached throughout December.

Planned Actions:
Longitudinal evaluations planned with cohorts to assess longer-term quality and impact.

Review of team selection process to enable the most meaningful impact by using a refined risk-based selection process.

Expected recovery:
To be enabled by additional internal delivery via OD team.

NQPS Anti-Discrimination Workstream Metrics 3 monthly watch metrics



Commentary:

- Works continue to progress the onboarding of a reporting software ('Report and Support'), to streamline reporting of staff to staff discrimination, bullying, harassment, sexual misconduct and incivility.
- A process mapping session has taken place to understand the process that will follow once a report has been submitted. This involved colleagues from HR and the Wellbeing hub.
- Running in parallel is the an anti-racism campaign. An initial T&F group set up enabling a collaborative design process.

Planned Actions:

- Stakeholder events held post the BHM on Oct and work with the inclusion network to ensure views are heard about key decisions and policies. Dec 24- March 25
- Map out timeline for reporting platform (including process) and anti-racism campaign and ensure alignment
- Continue to map the reporting process and once a draft has been completed, engage with clinical and operational colleagues to obtain feedback. This will also be shared via the inclusion council.
- Embark on the procurement process for the reporting software
- Continue to develop an anti-racism campaign agreeing milestones. The campaign will encompass how to support colleagues who experience or witness this behaviour can appropriately challenge this within the workplace

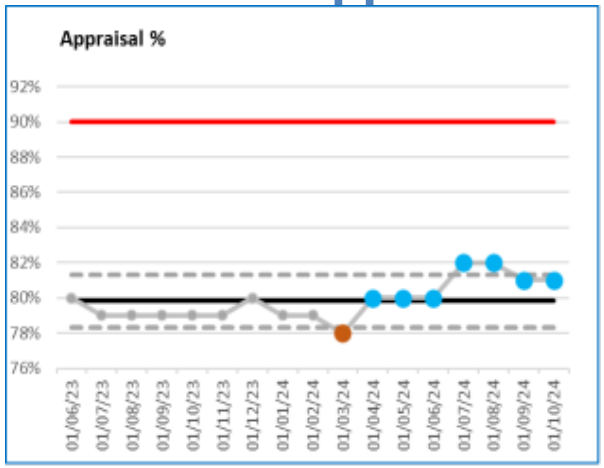
Expected recovery:

January 25 is the next NQPS for this data.
Once the reporting platform is available, further data will be produced to identify key actions.

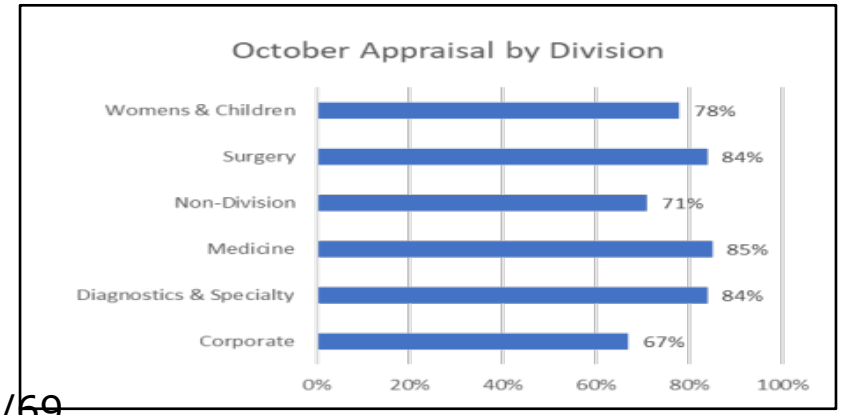
Workforce Performance Indicators

Performance Indicator	Target	Nov-23	Dec-23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24	Oct 24
Turnover	**13%**	11.37%	11.27%	11.06%	10.82%	10.93%	10.58%	10.35%	10.55%	9.95%	9.94%	9.93%	8.95%
Vacancy	**8%**	5.86%	6.54%	6.90%	6.65%	6.59%	6.11%	6%	6.82%	7.24%	7.43%	7.48%	7.51%
Sickness	**5%**	4.36%	4.34%	4.33%	4.32%	4.29%	4.28%	4.31%	4.32%	4.35%	4.34%	4.34%	4.31%
Appraisal	**90%**	79%	80%	79%	79%	78%	80%	80%	80%	82%	82%	81%	81%
Essential Training	**90%**	86%	85%	85%	86%	85%	86%	86%	87%	87%	88%	88%	88%
Agency (FTE & % of establishment)	**2%**	111 (1.4%)	104 (1.3%)	119 (1.5%)	132 (1.7%)	132 (1.7%)	98 (1.2%)	94 (1.2%)	97 (1.2%)	84 (1.1%)	93 (1.12%)	72 (0.9%)	67.78 (0.84%)
Bank (FTE & % of establishment)	**6.5%**	689 (8.8%)	679 (8.7%)	667 (8.4%)	742 (9.3%)	736 (9.3%)	686 (8.7%)	599 (7.6%)	592 (7.4%)	604 (7.6%)	597 (7.4%)	587 (7.3%)	575.14 (7.1%)

Workforce - Appraisal



October Appraisal by Staff Group	
Add Prof Scientific and Technical	72%
Additional Clinical Services	83%
Administrative and Clerical	71%
Allied Health Professionals	82%
Estates and Ancillary	80%
Healthcare Scientists	80%
Medical Staff - Consultants	90%
Medical Staff - SAS	74%
Nursing and Midwifery Registered	85%



Commentary:

There is a target of 90% and despite fluctuations of overall compliance between 78% - 82% we remain consistently below the target

Since March 24 there has been a 14% increase for the Add Prof Scientific & Technical staff, which mainly sits with Pharmacy, though not exclusively. Conversations with pharmacy have seen the increase in compliance for Add Prof Scientific & Tech group

There are no divisions who met the target of 90%, with the lowest at 67%. – Corporate.

Planned Actions:

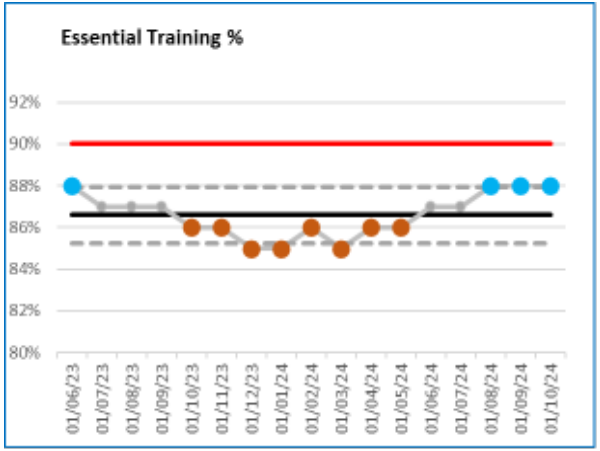
There will be a 'deep dive' into understanding the factors that relate to reporting compliance (ESR and non recording) and therefore 'compliance' of appraisal conversation with a solution focus.

New iteration of the appraisal paperwork will be trialled with stakeholder groups and evaluated during and after a 6 month period - a longitudinal evaluation process to understand impact.

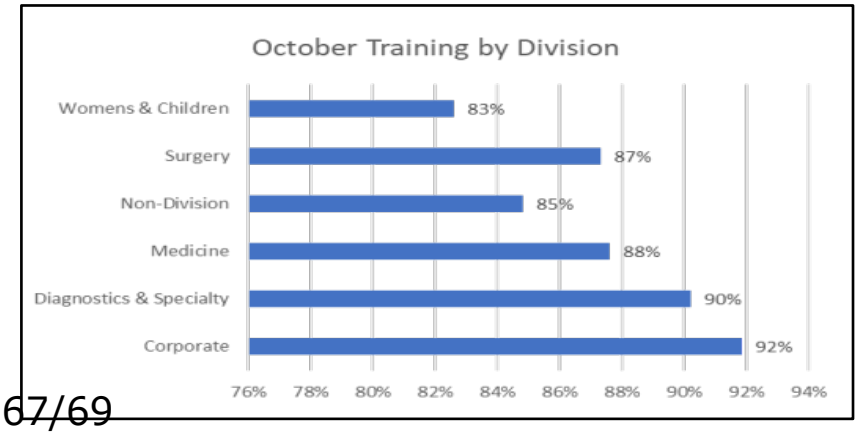
Exploration of the digitisation of appraisal paperwork to address issues of recording compliance

Expected recovery:
Launch of new paperwork February 2025
The impact of the new paperwork – Sept 2025
Digitisation – Commencing April 2025 through to Dec 2025, (though this could be sooner)

Workforce - Statutory and Mandatory Training



October Training by Staff Group	
Add Prof Scientific and Technical	84%
Additional Clinical Services	93%
Administrative and Clerical	93%
Allied Health Professionals	90%
Estates and Ancillary	92%
Healthcare Scientists	91%
Medical Staff - Consultants	79%
Medical Staff - SAS Senior	76%
Medical Staff - Training Grades	59%
Nursing and Midwifery Registered	89%



Commentary:
The target of 90% is not being met, we currently have a 88% compliance rate with Mandatory training.

Some Divisions are achieving above the 90% compliance target (e.g. Corporate), however other divisions such as Women's & Children are at 83%, common reasons identified for low compliance are lack of time, competing priorities and complex requirements, especially regarding safeguarding training. The data above also highlights the low completion rates within Training Grades (Medical Staff).

Planned Actions:
Establishment of a Local Stat/Man and Essential to Role Training Oversight Group, to review all mandatory/Statutory training requirements.

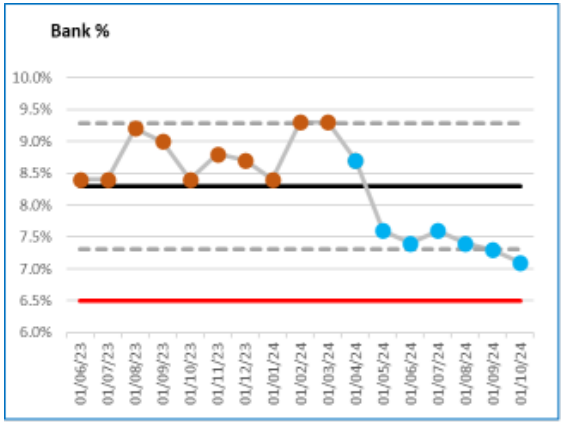
As part of NHS England's national review of Statutory and Mandatory Training Programme, which in turn feeds into the NHS Digital Staff Passport project, the Trust has moved the 11 core mandatory subjects across to the national content offering, thus enabling increased passporting of training between all NHS organisations. This is nationally aimed at increasing compliance of Training Grades Medical Staff whilst moving around placements.

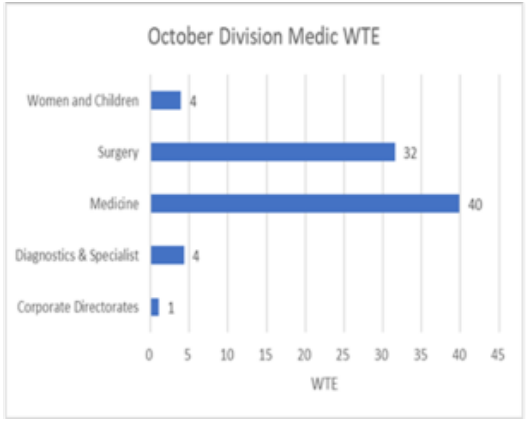
Remove requirement of virtual bookings for Safeguarding training and revert to always accessible content.

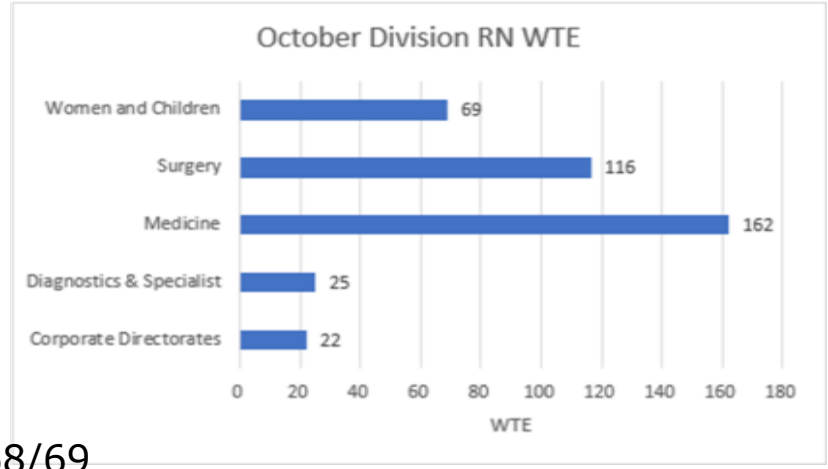
Expected recovery:

Time frame on national work dictated by NHSE – 24-25 period of work
End of Dec 24 safeguarding work
Local Group established – plans for continuation of group indefinitely

Workforce - Bank







Commentary:

- The Trust target of 6.5% has not been achieved in month 7. The current use is 7.1%, which notably is the lowest number achieved in the last 12 months.
- Medicine is the highest user of Bank & Locum staff, accounting for 42.5% of the overall use.
- The Emergency Department, COTE and Acute Medicine are the highest users of temporary staffing in Medicine, accounting for 61% of the divisions use.
- In comparison with the end of the previous financial year there has been a reduction from 602 WTE in March 2024 to 476 in October 2024

Planned Actions:

- Continued scrutiny and redesign of Nurse & HCSW rosters, reducing agency & bank use through tightened authorisation procedures and accurate reflections of WTE funded position.
- Effective recruitment to key vacancies inside the trust that are resulting in high use or spend in clinical roles.
- Continued scrutiny of bank and agency use through Grip & Control meetings.
- Implementation of e-Rostering solution for Medical Workforce, to deliver reductions in temporary staffing use.

Expected recovery:

- If the current trend continues, the Trust world expect to be inside the 6.5% target in 6 months time.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Thank you

Report to Board of Directors			
Date:		16 January 2025	
Title		Actual and Potential Organ Donation 01/04/2023-31/03/2024 Gloucestershire Hospitals	
Author / Sponsoring Director/ Presenter		Mark Pietroni, Deputy Chief Executive and Medical Director	
Purpose of Report (Tick all that apply ✓)			
To provide assurance		To obtain approval	✓
Regulatory requirement		To highlight an emerging risk or issue	
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

Annual report for Potential and actual Organ Donation within Gloucestershire Hospitals. Data is collected by Specialist Nurses Organ Donation within the trust and the report is produced by NHSBT.

We will be joined by Ian Mean, Chair Gloucestershire Organ Donation Committee and colleagues who will give a presentation on organ donation.

The data is benchmarked alongside national and trusts who have a similar donation potential. The focus is on four main performance indicators: referral, neurological death testing, Specialist Nurse presence and consent.

There were 7 proceeding donors in the 12 months with 14 patients receiving a solid organ transplant as a result.

Referral rates remain consistently high, Specialist Nurse presence is consistently good with support sought if they are not able to attend in the timeframe required, neurological testing rates are in line with national trends, our main area of concern is consent. Consent rates have nationally been a challenge in the last couple of years and we have seen this in the trust last year. We hope to explain some of this and the theories behind the change.

Risks or Concerns

Consent is nationally a major challenge and we have seen a downward trend in the last year in Gloucestershire, numbers are small, but we hope to explain some of the theories and the ongoing work we are doing both within the hospital and community to help support higher consent rates.

NHSBT are aware of the difficulties with supporting Organ retrievals in theatres due to capacity and pressure post the pandemic. SCORE is an ongoing initiative to ensure sustainability and certainty within the organ donation process to ensure we are utilising all possible resources in the most efficient way with the least impact on our donating and transplanting hospitals.

Financial Implications

None

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

Recommendation

Continued support of the organ and tissue donation initiatives within the trust. Continued work with theatres to develop an action card for organ retrievals in Cheltenham Continued close working relationships between the Trust and NHSBT
Enclosures
Attached is the Summary report, detailed report and letter from NHSBT

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2023 - 31 March 2024

Gloucestershire Hospitals NHS Foundation Trust

Table of Contents

Further Information

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

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2024 based on data meeting PDA criteria reported at 8 May 2024.

1. Donor Outcomes

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

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2023 and 31 March 2024, Gloucestershire Hospitals NHS Foundation Trust had 7 deceased solid organ donors, resulting in 14 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2022/23. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

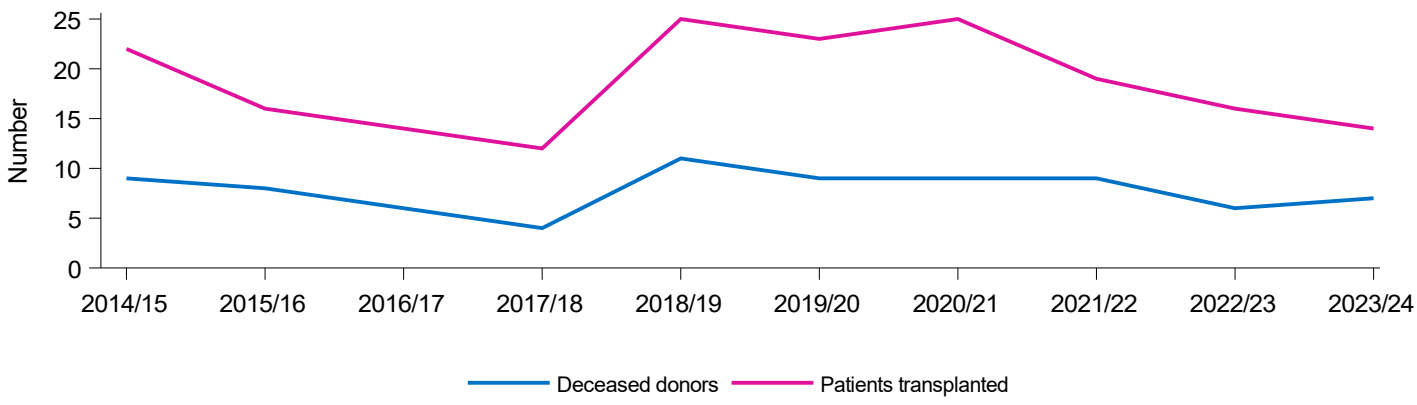
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		Average number of organs donated per donor UK	
DBD	4	(3)	9	(7)	3.0	(3.0)	3.6	(3.4)
DCD	3	(3)	5	(9)	2.0	(3.3)	2.9	(2.8)
DBD and DCD	7	(6)	14	(16)	2.6	(3.2)	3.2	(3.2)

In addition to the 7 proceeding donors there was one additional consented donor that did not proceed, where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	6	(4)	0	(0)	2	(3)	1	(0)	0	(0)	0	(0)
DCD	4	(6)	0	(0)	1	(2)	0	(0)	0	(2)	0	(0)
DBD and DCD	10	(10)	0	(0)	3	(5)	1	(0)	0	(2)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2014 - 31 March 2024



2. Key Rates in Potential for Organ Donation

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

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

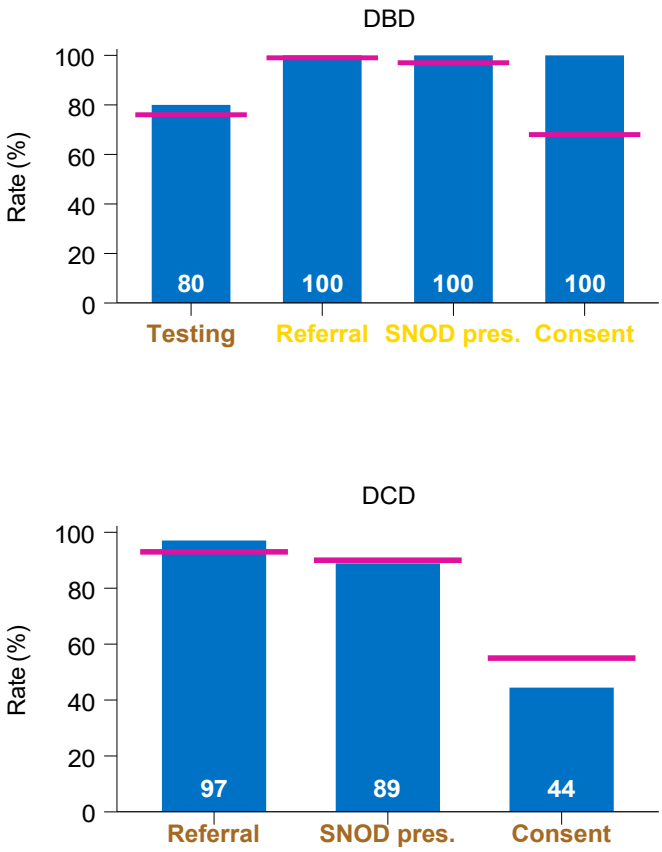
This section presents specific percentage measures of potential donation activity for Gloucestershire Hospitals NHS Foundation Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2023/24 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2023 - 31 March 2024



Trust — UK

Gold | Silver | Bronze | Amber | Red

Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2019 - 31 March 2024

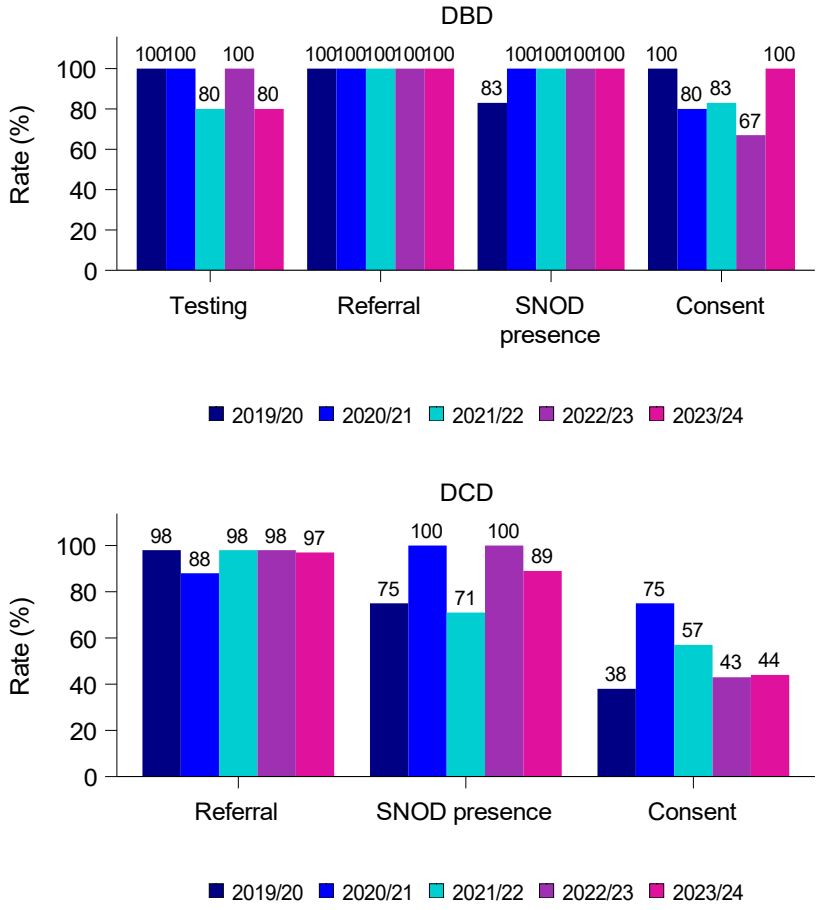


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	5	2029	34	5331	38	6911
Referred to Organ Donation Service	5	2017	33	4949	37	6522
Referral rate %	G *100%*	*99%*	B *97%*	*93%*	B *97%*	*94%*
Neurological death tested	4	1534				
Testing rate %	B *80%*	*76%*				
Eligible donors[2]	4	1426	26	3635	30	5061
Family approached	4	1259	9	1849	13	3108
Family approached and SNOD present	4	1215	8	1672	12	2887
% of approaches where SNOD present	G *100%*	*97%*	B *89%*	*90%*	B *92%*	*93%*
Consent ascertained	4	858	4	1023	8	1881
Consent rate %	G *100%*	*68%*	B *44%*	*55%*	B *62%*	*61%*
- Expressed opt in	3	533	1	637	4	1170
- Expressed opt in %	*100%*	*95%*	*100%*	*85%*	*100%*	*89%*
- Deemed Consent	1	246	3	323	4	569
- Deemed Consent %	*100%*	*58%*	*50%*	*47%*	*57%*	*51%*
- Other*	0	78	0	63	0	141
- Other %*	*N/A*	*52%*	*0%*	*34%*	*0%*	*42%*
Actual donors (PDA data)	4	788	3	710	7	1499
% of consented donors that became actual donors	*100%*	*92%*	*75%*	*69%*	*88%*	*80%*

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

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

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

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

Gold Silver Bronze Amber Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

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

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

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2019 - 31 March 2024

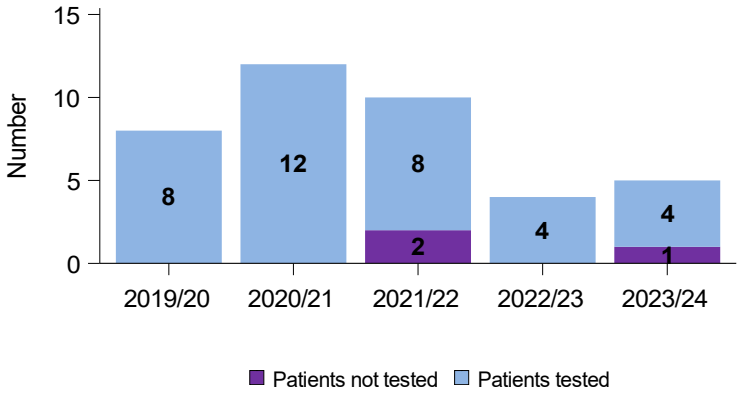


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2023 - 31 March 2024

	Trust	UK
Biochemical/endocrine abnormality	-	32
Clinical reason/Clinician's decision	-	72
Continuing effects of sedatives	-	15
Family declined donation	-	40
Family pressure not to test	-	55
Hypothermia	-	1
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	58
Patient had previously expressed a wish not to donate	-	4
Patient haemodynamically unstable	1	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	13
Treatment withdrawn	-	20
Unknown	-	8
Total	**1**	**495**

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

3.2 Referral to Organ Donation Service

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

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

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

Figure 3.2 Number of patients meeting referral criteria, 1 April 2019 - 31 March 2024

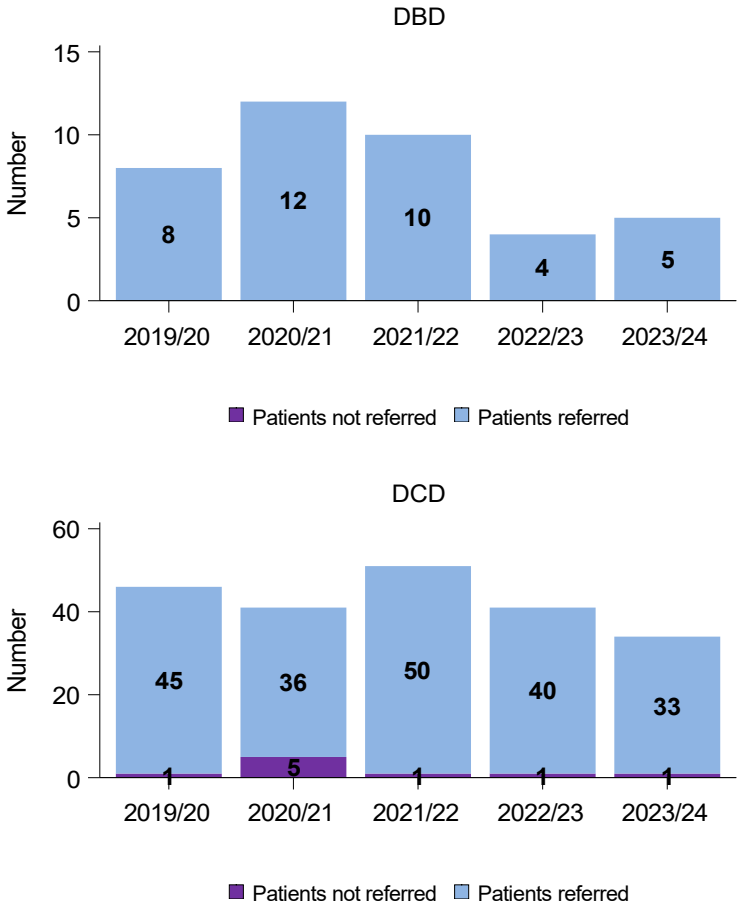


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner / Procurator Fiscal reason	-	1	-	-
Family declined donation following decision to remove treatment	-	-	-	9
Family declined donation prior to neurological testing	-	-	-	1
Medical contraindications	-	-	-	42
Not identified as potential donor/organ donation not considered	-	8	1	260
Other	-	1	-	9
Patient had previously expressed a wish not to donate	-	-	-	2
Pressure on ICU beds	-	-	-	5

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

Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	-	-	42
Uncontrolled death pre referral trigger	-	2	-	6
Total	**-**	**12**	**1**	**382**

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

3.3 Contraindications

In 2023/24 there were 11 potential donors in your Trust with an ACI reported, 11 DBD and 11 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

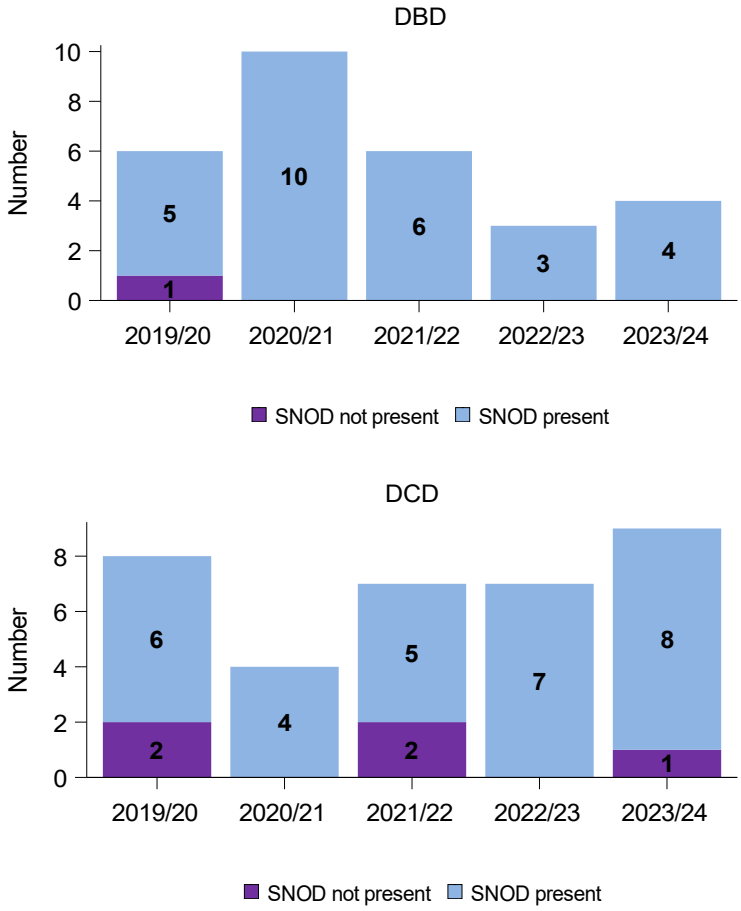
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

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

In the UK, in 2023/24, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 23% and 14%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 60%, respectively, when a SNOD was present.

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

Figure 3.3 Number of families approached by SNOD presence, 1 April 2019 - 31 March 2024



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 8 May 2024]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 8 May 2024]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 8 May 2024]

3.5 Consent

In 2023/24 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2019 - 31 March 2024

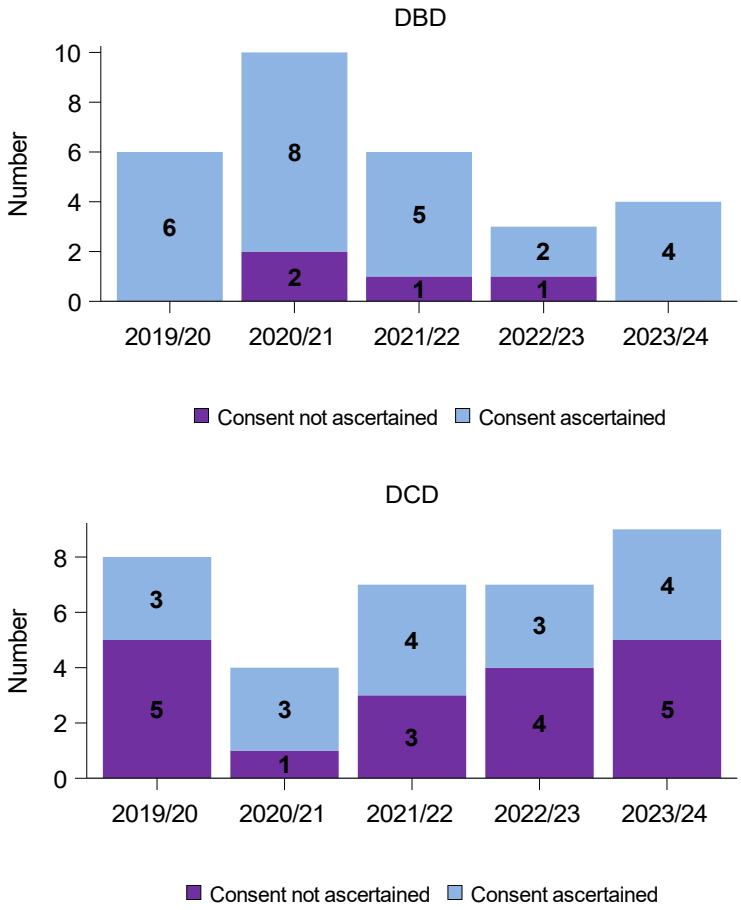


Table 3.3 Reasons given why consent was not ascertained, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	UK	Trust	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	-	-	1
Family concerned other people may disapprove/be offended	-	3	-	4
Family concerned that organs may not be transplantable	-	2	-	8
Family did not believe in donation	-	5	-	9
Family did not want surgery to the body	-	42	-	57
Family divided over the decision	-	12	-	20
Family felt it was against their religious/cultural beliefs	-	49	1	28
Family felt patient had suffered enough	-	24	1	78
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	13	1	17
Family felt the length of time for the donation process was too long	-	30	-	167
Family had difficulty understanding/accepting neurological testing	-	3	-	-

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

Table 3.3 Reasons given why consent was not ascertained, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family wanted to stay with the patient after death	-	5	-	17
Family were not sure whether the patient would have agreed to donation	-	49	1	113
Other	-	24	-	57
Patient had previously expressed a wish not to donate	-	94	1	167
Patient had registered a decision to Opt Out	-	21	-	43
Strong refusal - probing not appropriate	-	25	-	39
Total	**-**	**401**	**5**	**825**

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

3.6 Solid organ donation

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

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	3	-	5
Clinical - Considered high risk donor	-	4	-	8
Clinical - DCD clinical exclusion	-	-	-	2
Clinical - No transplantable organ	-	7	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	17	-	58
Clinical - Organs deemed medically unsuitable on surgical inspection	-	9	-	6
Clinical - Other	-	3	-	7
Clinical - PTA post WLST	-	-	1	164
Clinical - Patient actively dying	-	4	-	7
Clinical - Patient asystolic	-	3	-	1
Clinical - Patient's general medical condition	-	1	-	6
Clinical - Positive virology	-	2	-	-
Clinical - Predicted PTA therefore not attended	-	-	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	-	10	-	8
Consent / Auth - Family placed conditions on donation	-	-	-	1
Consent / Auth - NOK declined organ donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	6	-	22
Consent / Auth - Other	-	-	-	1
Logistical - Other	-	-	-	1
Logistical - Retrieval team not available	-	-	-	1
Logistical - Unit unable to maintain patient	-	-	-	1
Total	**-**	**70**	**1**	**312**

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

4. Comparative Data

A comparison of performance in your Trust/Board with national data

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

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

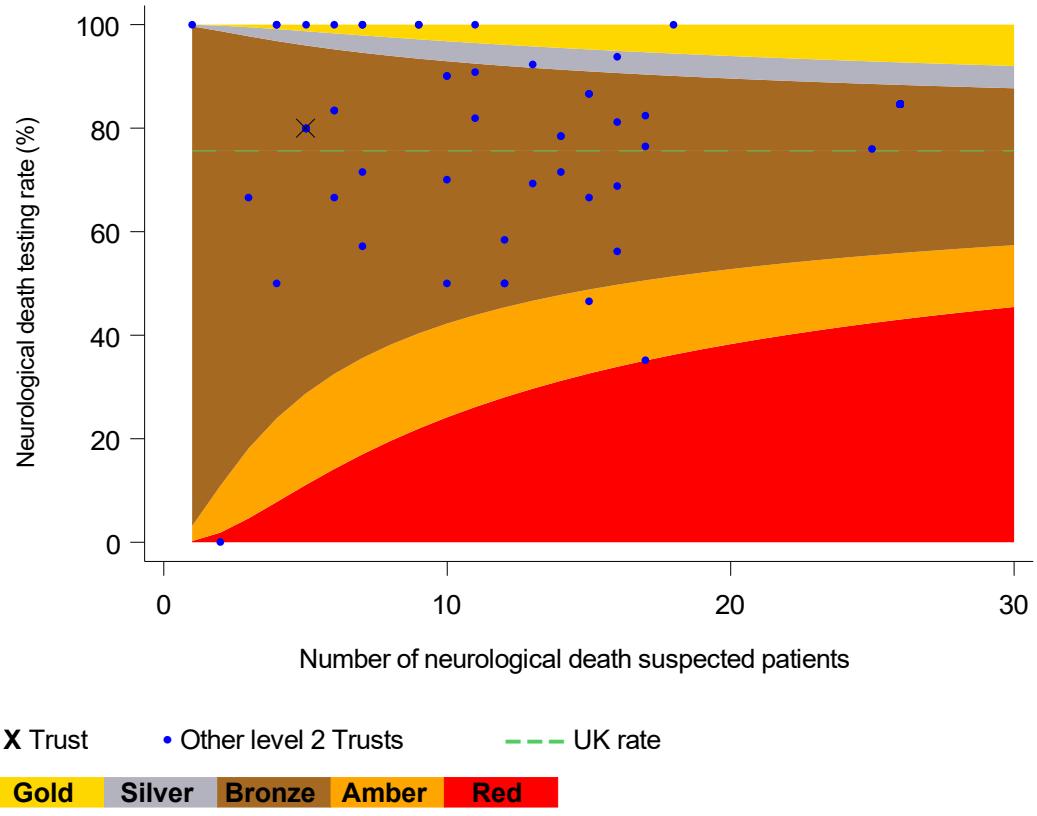
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2023 - 31 March 2024

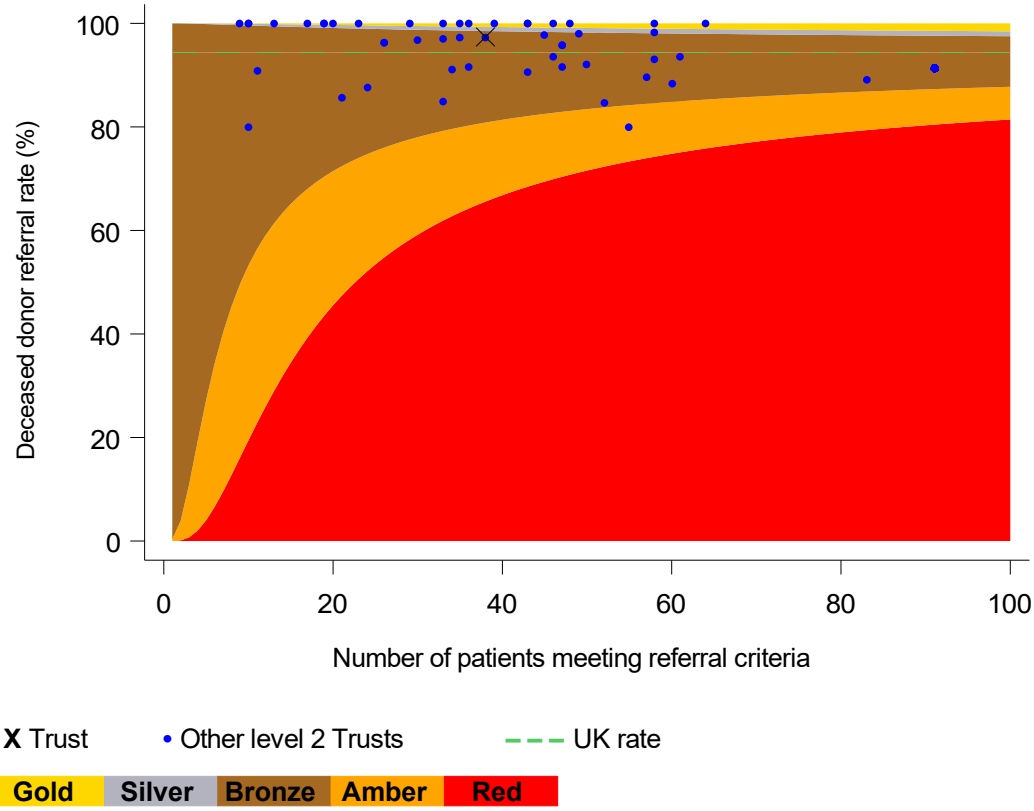


When compared with UK performance the neurological death testing rate in Gloucestershire Hospitals NHS Foundation Trust was average (bronze).

4.2 Referral to Organ Donation Service

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

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2023 - 31 March 2024

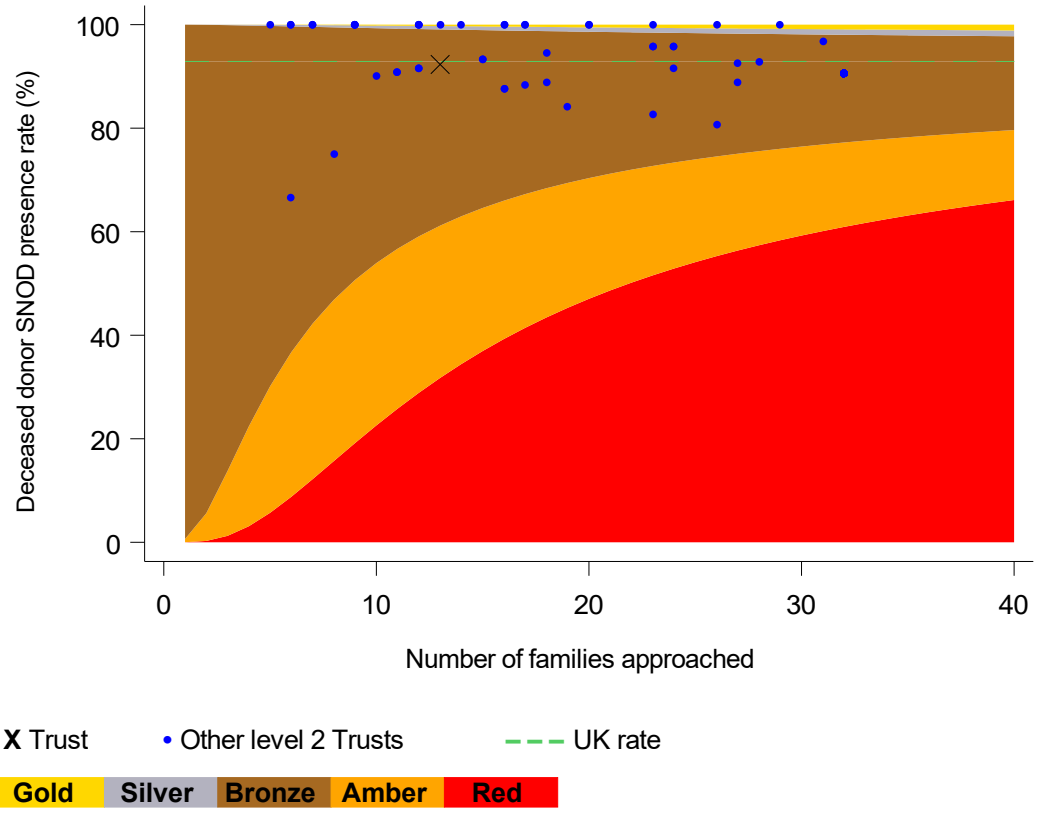


When compared with UK performance Gloucestershire Hospitals NHS Foundation Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

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

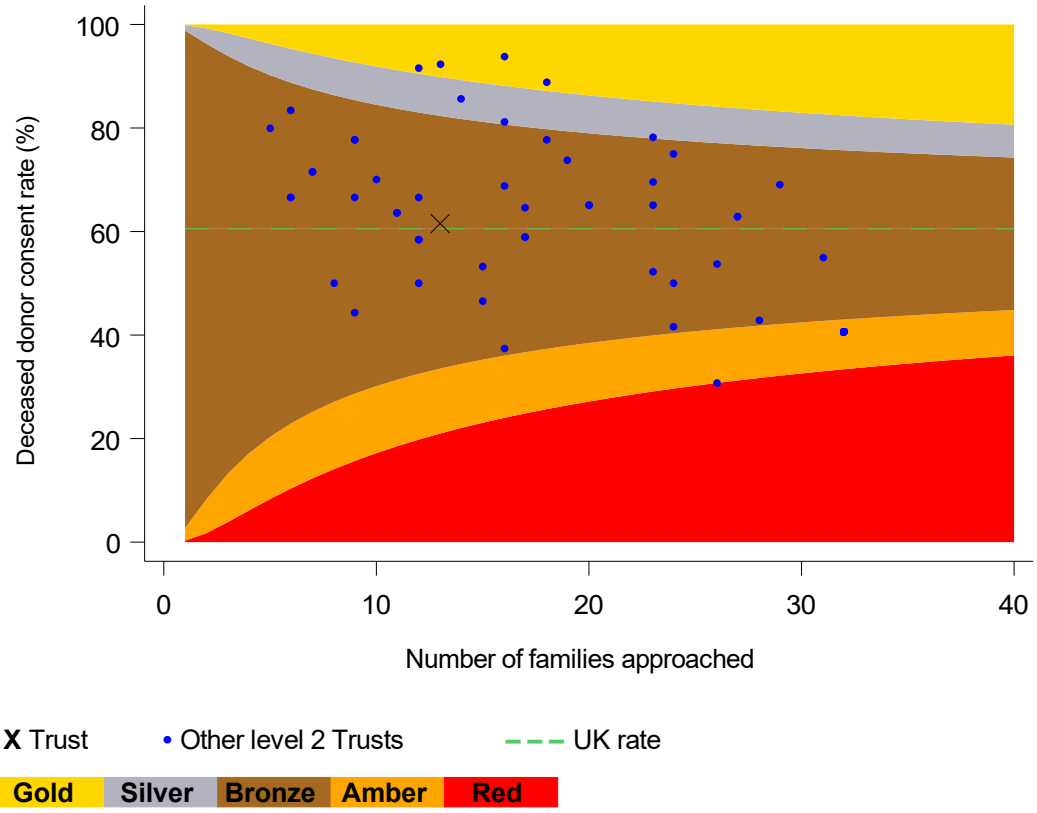
Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2023 - 31 March 2024



When compared with UK performance Gloucestershire Hospitals NHS Foundation Trust was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2023 - 31 March 2024



When compared with UK performance the consent rate in Gloucestershire Hospitals NHS Foundation Trust was average (bronze).

5. PDA data by hospital and unit

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

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

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Cheltenham, Cheltenham General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	1	1	-	1	-	1	1	1	1	-	1	-	1
Gloucester, Gloucestershire Royal Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	4	3	-	4	-	3	3	3	3	-	3	-	3

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Cheltenham, Cheltenham General Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	8	8	-	8	6	2	2	-	2	-	2
Gloucester, Gloucestershire Royal Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	26	25	96	26	20	7	6	-	2	-	1

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Gloucestershire Hospitals NHS Foundation Trust in 2023/24 there were 0 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

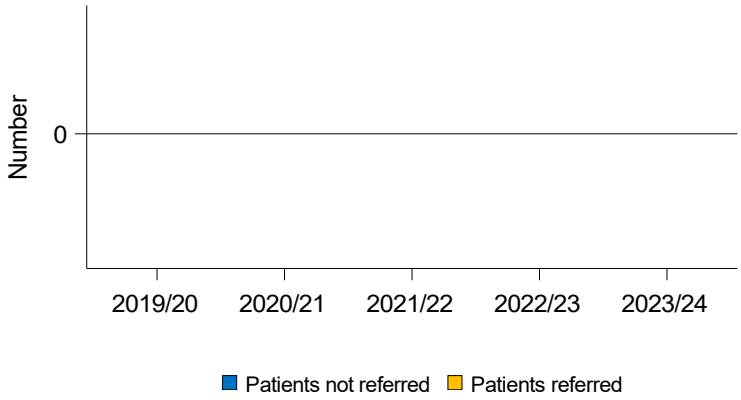
Data in this section is obtained from the National Potential Donor Audit (PDA)

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

6.1 Referral to Organ Donation Service

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

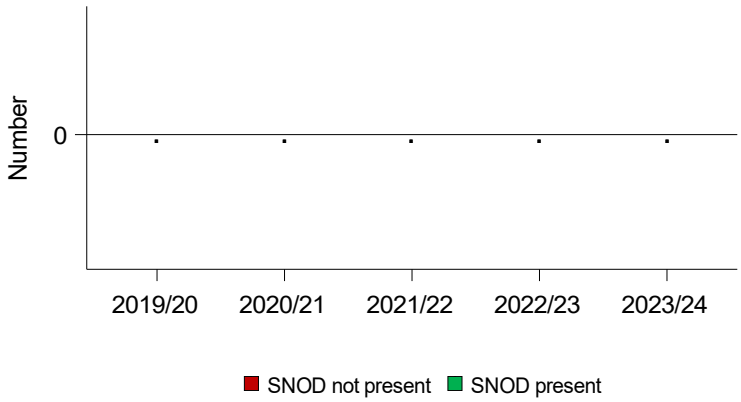
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2019 - 31 March 2024



6.2 Organ donation discussions

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

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2019 - 31 March 2024



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 8 May 2024]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2023 - 31 March 2024		
Deceased donors	157	1,510
Transplants from deceased donors	261	3,723
Deaths on the transplant list	28	418
As at 31 March 2024		
Active transplant list	551	7,484
Number of NHS ODR opt-in registrations (% registered)**	2,872,363 (50%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	118,055 (2%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
** % registered based on population of 5.71 million, based on ONS 2021 census data

Key numbers and rates on the potential for organ donation

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

7.2 Trust/Board Level Benchmarking

Gloucestershire Hospitals NHS Foundation Trust has been categorised as a level 2 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	36
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	51
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	31
Level 4	3 or less (≤ 3) proceeding donors per year	39

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	5	4	-	5	-	4	4	4	4	-	4	-	4
Level 1	1183	881	74	1174	99	858	814	715	682	95	483	68	451
Level 2	539	414	77	538	100	402	388	344	339	99	242	70	220
Level 3	169	138	82	167	99	138	130	119	116	97	81	68	72
Level 4	138	101	73	138	100	98	94	81	78	96	52	64	45

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

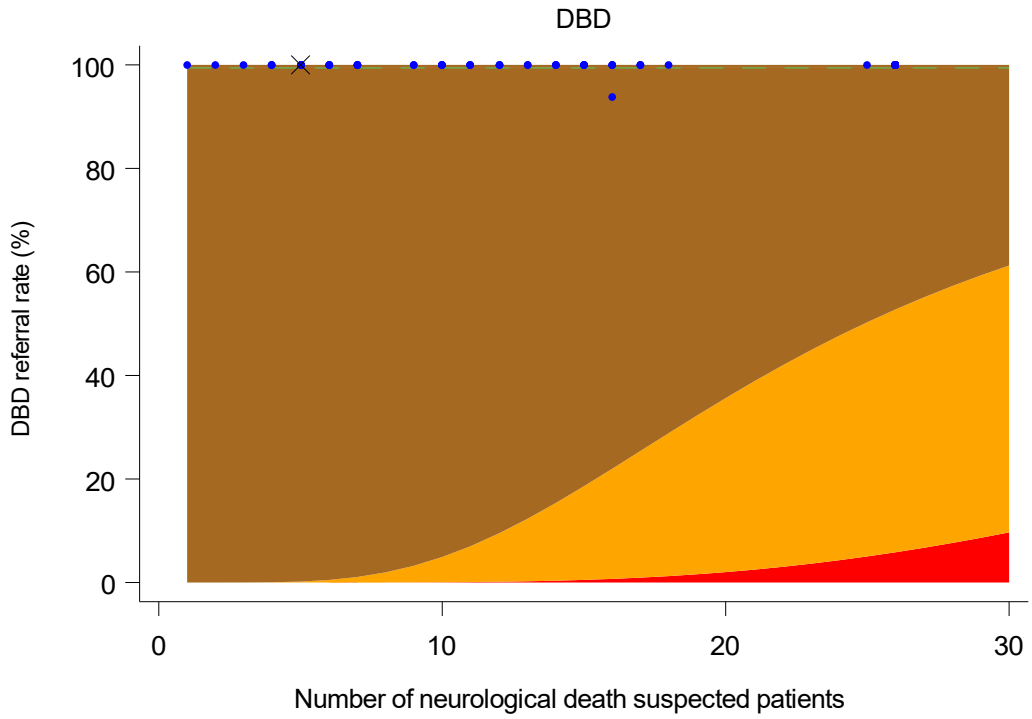
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	34	33	97	34	26	9	8	-	4	-	3
Level 1	2735	2533	93	2669	1932	1066	965	91	590	55	430
Level 2	1532	1426	93	1494	1039	499	454	91	285	57	187
Level 3	583	547	94	559	353	167	154	92	93	56	54
Level 4	481	443	92	464	311	117	99	85	55	47	39

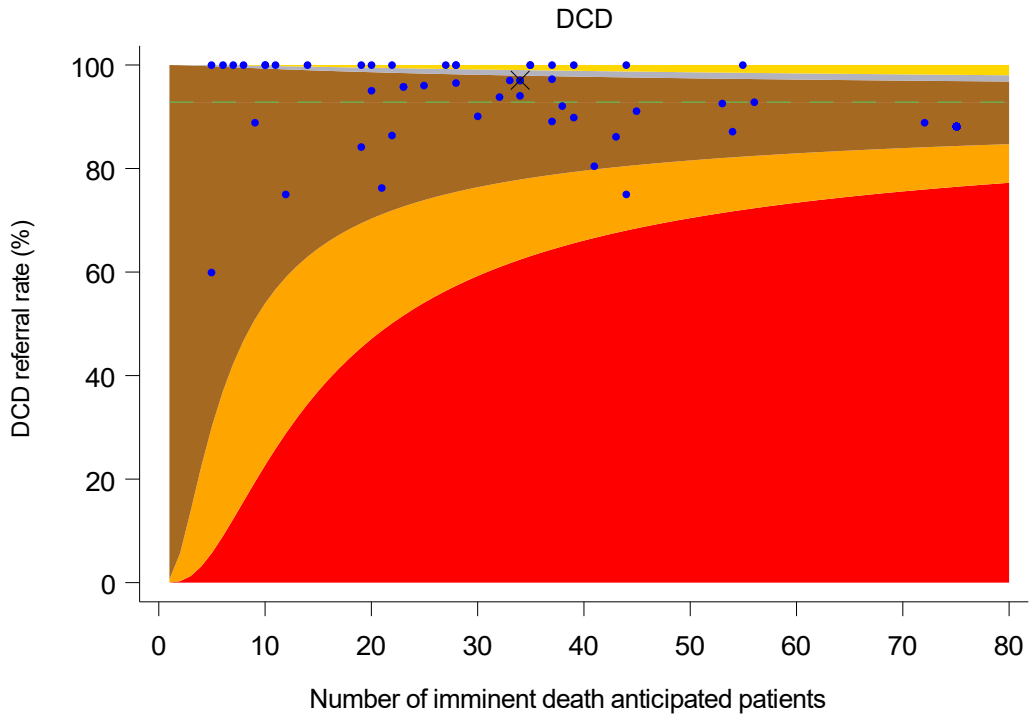
7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2023 - 31 March 2024



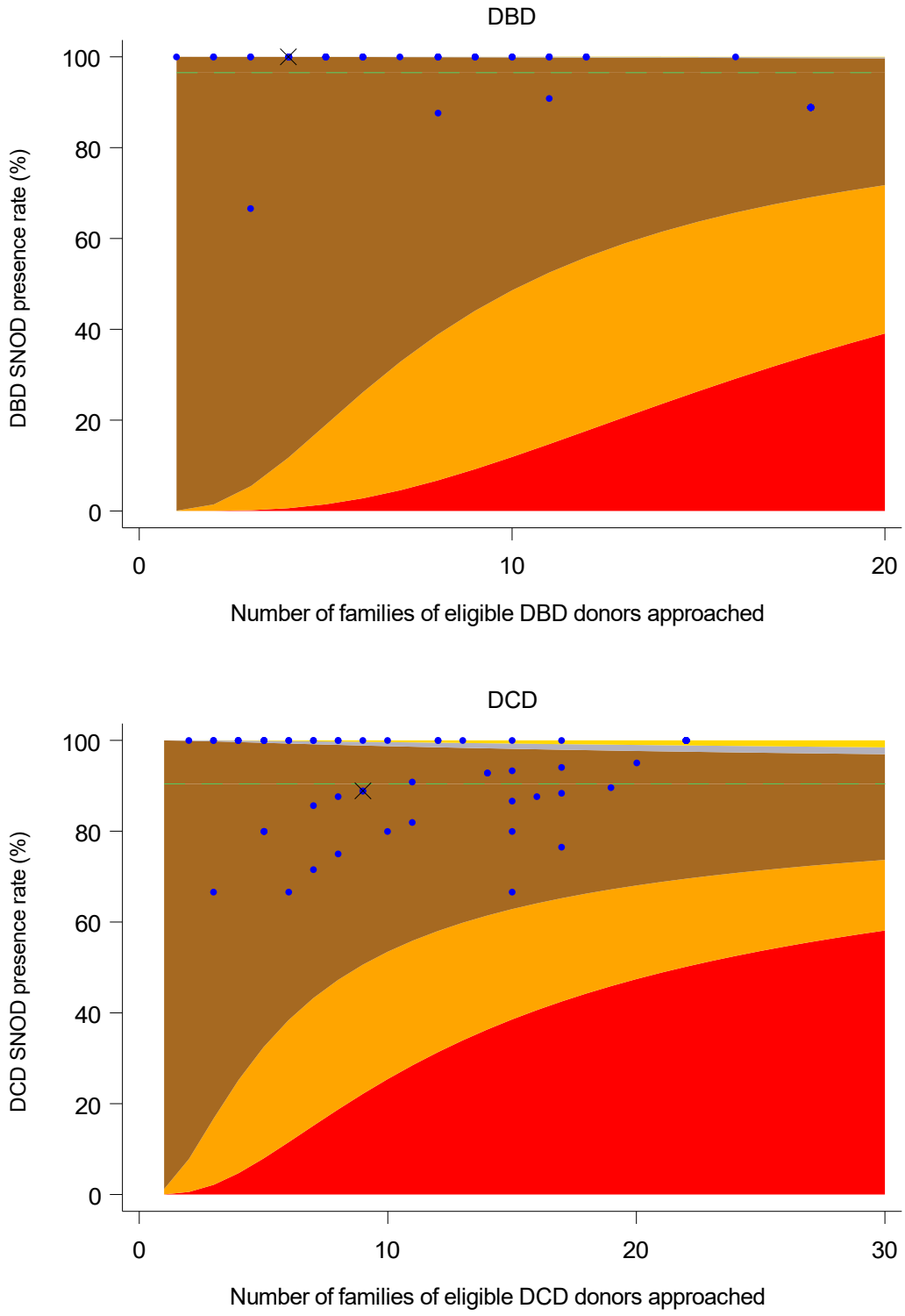


X Trust • Other level 2 Trusts – – – UK rate

Gold | Silver | Bronze | Amber | Red

When compared with UK performance Gloucestershire Hospitals NHS Foundation Trust was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2023 - 31 March 2024

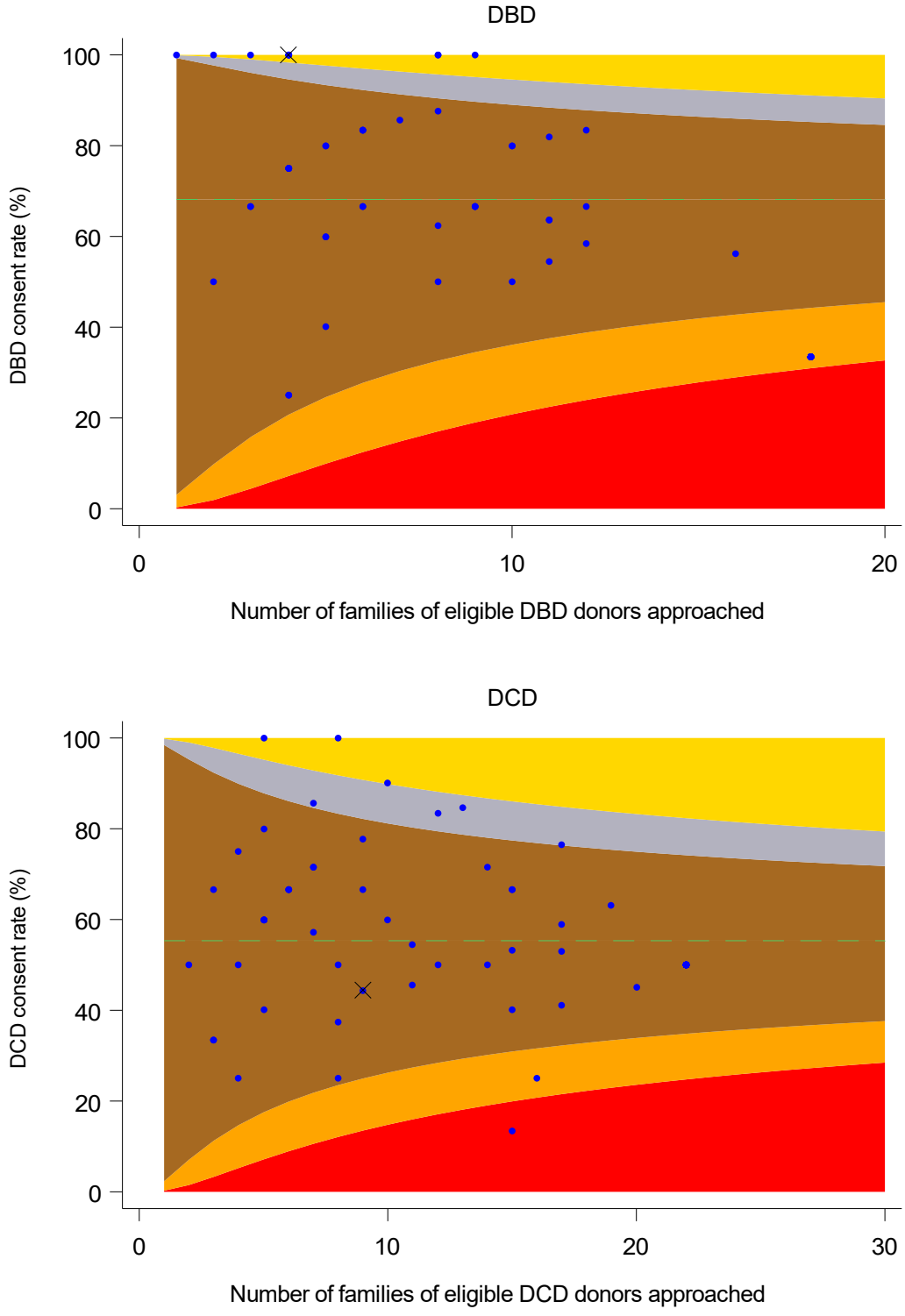


X Trust • Other level 2 Trusts – – – UK rate

Gold | Silver | Bronze | Amber | Red

When compared with UK performance Gloucestershire Hospitals NHS Foundation Trust was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2023 - 31 March 2024



When compared with UK performance the consent rate in Gloucestershire Hospitals NHS Foundation Trust was exceptional (gold) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

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

Donors after brain death (DBD) definitions

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

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

Donors after circulatory death (DCD) definitions

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

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

Deemed Consent/Authorisation

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

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

Consent/Authorisation groups

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

UK Transplant Registry (UKTR) definitions

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

Appendix A.2 Data Description

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

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

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

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

Appendix A.3 Table and Figure Description

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

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

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

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data	
Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit	
Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data	
Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

Actual and Potential Deceased Organ Donation 1 April 2023 - 31 March 2024

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2023/24, from 8 consented donors the Trust facilitated 7 actual solid organ donors resulting in 14 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

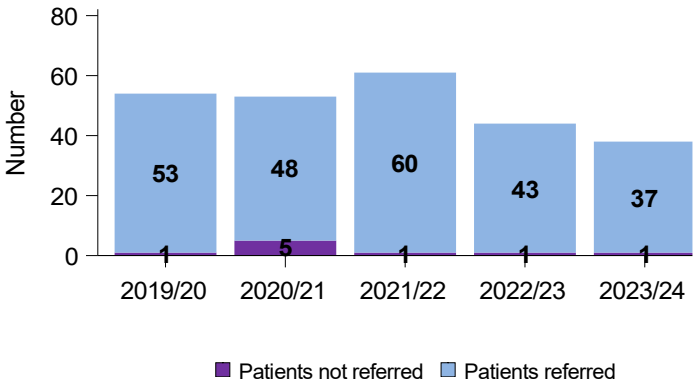
In addition to the 7 proceeding donors there was one consented donor that did not proceed.

Best quality of care in organ donation

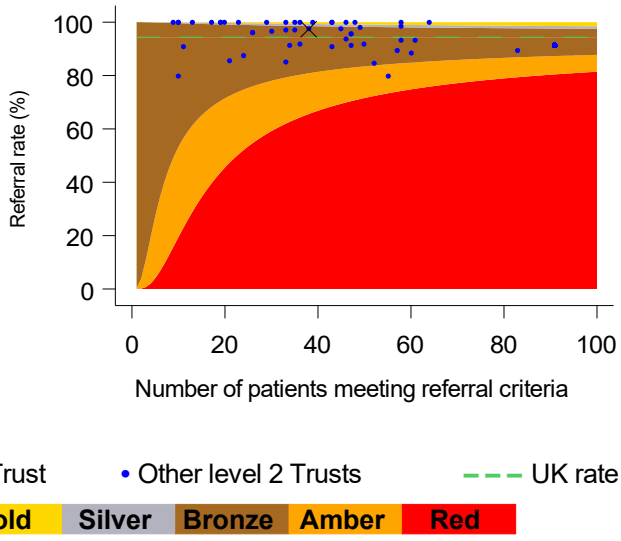
Referral of potential deceased organ donors

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

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



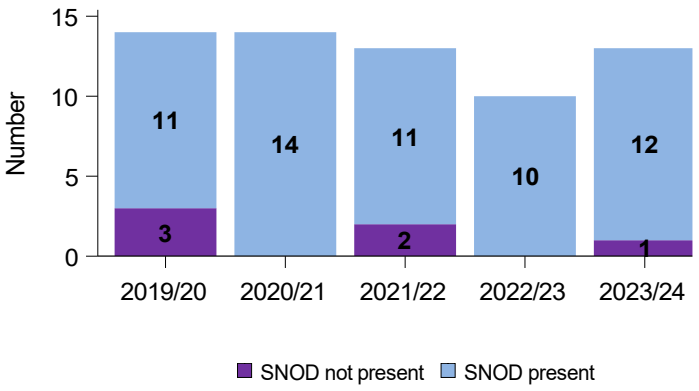
The Trust referred 37 potential organ donors during 2023/24. There was 1 occasion where a potential organ donor was not referred.

When compared with UK performance, the Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant.

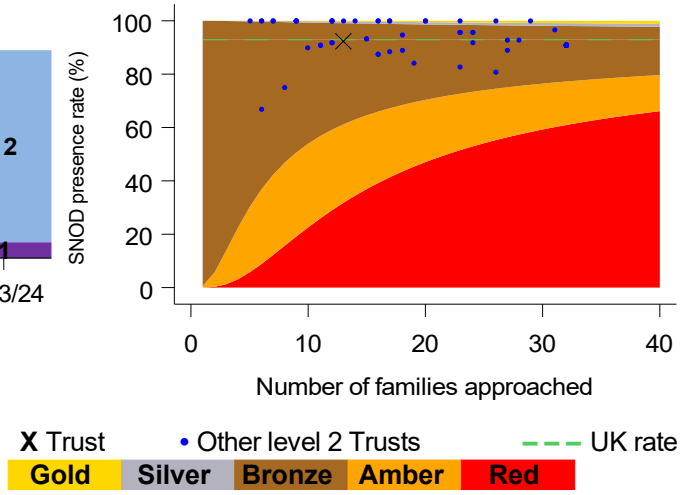
Presence of Specialist Nurse for Organ Donation

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

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 12 organ donation discussions with families during 2023/24. There was 1 occasion where a SNOD was not present.

When compared with UK performance, the Trust was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Why it matters

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

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

	South West*	UK
1 April 2023 - 31 March 2024		
Deceased donors	157	1,510
Transplants from deceased donors	261	3,723
Deaths on the transplant list	28	418
As at 31 March 2024		
Active transplant list	551	7,484
Number of NHS ODR opt-in registrations (% registered)**	2,872,363 (50%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	118,055 (2%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
* % registered based on population of 5.71 million, based on ONS 2021 census data

Further information

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

Key numbers, rates and comparison with UK data, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	5	2029	34	5331	38	6911
Referred to Organ Donation Service	5	2017	33	4949	37	6522
Referral rate %	G *100%*	*99%*	B *97%*	*93%*	B *97%*	*94%*
Neurological death tested	4	1534				
Testing rate %	B *80%*	*76%*				
Eligible donors[2]	4	1426	26	3635	30	5061
Family approached	4	1259	9	1849	13	3108
Family approached and SNOD present	4	1215	8	1672	12	2887
% of approaches where SNOD present	G *100%*	*97%*	B *89%*	*90%*	B *92%*	*93%*
Consent ascertained	4	858	4	1023	8	1881
Consent rate %	G *100%*	*68%*	B *44%*	*55%*	B *62%*	*61%*
- Expressed opt in	3	533	1	637	4	1170
- Expressed opt in %	*100%*	*95%*	*100%*	*85%*	*100%*	*89%*
- Deemed Consent	1	246	3	323	4	569
- Deemed Consent %	*100%*	*58%*	*50%*	*47%*	*57%*	*51%*
- Other*	0	78	0	63	0	141
- Other %*	*N/A*	*52%*	*0%*	*34%*	*0%*	*42%*
Actual donors (PDA data)	4	788	3	710	7	1499
% of consented donors that became actual donors	*100%*	*92%*	*75%*	*69%*	*88%*	*80%*

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

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

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

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

Gold | Silver | Bronze | Amber | Red

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

NHS
Blood and Transplant
www.nhsbt.nhs.uk

May 2024

Dear Mr McNamara and Dr Pietroni,

The number of donors and transplants in the UK have continued to improve and we are returning to pre-pandemic levels. Please accept our recognition and thanks for the effort of your staff.

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

Organ and tissue donation and transplantation activity - 2023/24

From 8 consented donors, Gloucestershire Hospitals NHS Foundation Trust facilitated 7 actual solid organ donors resulting in 14 patients receiving a transplant during the time period. Additionally, 123 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - 2023/24

When compared with national data, during the time period your Trust was:

- In line with the national average for the referral of potential organ donors
- In line with the national average for Specialist Nurse presence when approaching families to discuss organ donation

- Your Trust referred 81 patients to NHSBT's Organ Donation Services Team; 37 met the referral criteria and were included in the UK Potential Donor Audit. There was a further 1 audited patient that was not referred.
- A Specialist Nurse was present for 12 organ donation discussions with families of eligible donors. There was 1 occasion when a Specialist Nurse was absent for the donation discussion.
- In South West, 50% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

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

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Deemed Consent Legislation - England

England introduced deemed consent (Max and Keira's Law) in May 2020. In England between 20 May 2020 – 31 March 2024 there were 1812 occasions when consent was deemed from 3215 occasions where deemed consent applied.

Why it matters

In 2023/24, 261 people benefited from a solid organ transplant in the South West. However sadly, 28 people died on the transplant waiting list during this time.

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

Yours sincerely,

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

Gloucestershire Hospitals NHSFT

Organ and Tissue Donation Committee Presentation

Trust Board Meeting 16th January 2025

Ian Mean, Marcin Pachucki, Kate Hurley, Trudie Neveu, Leanne Fare

April 2023-March 2024 7 Donors	Retrieved	Transplanted	Recipients	Offered for Research
Lungs Liver Heart Pancreas	0 3 1 0	0 3 1 0	0 3 1 0	0 0 0 0
Kidneys	11	11	11	0
Total	15	15	15	0

April 2024-December 2024 8 Donors	Retrieved	Transplanted	Recipients	Not transplanted/Offered for Research
Lungs Liver Heart Pancreas	2 6 1 1	2 6 1 0	1 6 1 0	0 1 segment 0 1
Kidneys	16	14	13	2 kidneys
Total	26	23	21 (lungs & dual kidneys)	4

Headline activity

- April 2023-March 2024
- 100% referral rate for DBD (5/5)
- 97.1 referral rate for DCD (33/34)
- 92% SNOD/SR involvement when family asked for final decision on donation (1 coached approach) (12/13)
- 62% combined DBD & DCD consent rate for reporting criteria
- 100% DBD/44.4% DCD consent rate
- 1 Cardiothoracic donor

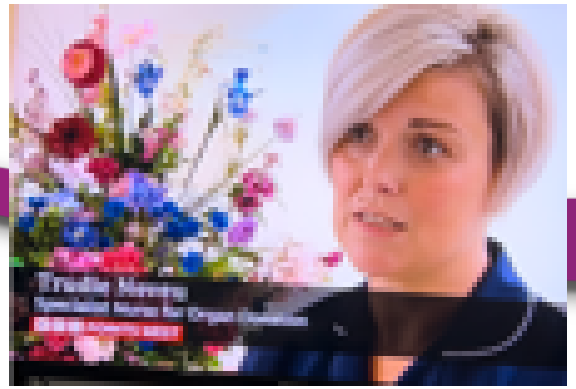
April 2024-December 2024

- 100% referral rate for DBD (7/7)
- 100% referral rate for DCD (31/31)
- 85.7% SNOD/SR involvement when family asked for final decision on donation (12/14)
- 64.2% combined DBD & DCD consent rate
- 60% DBD/66.7%DCD Consent rate
- 2 Cardiothoracic donors
- **3 donors in 3 days June and then a week with 3 donors in November**

[Organ Donation Week: Donor gave veteran a 'reason to live' - BBC News]

Organ donor gave veteran a 'reason to live'

Adrienne Fry's husband and daughter said an anonymous veteran reached out to them after she died and donated her organs



Race for Recipients
Organ Donation

Gloucestershire Hospitals NHS Foundation Trust

Thank you for participating in the Race for Recipients challenge 2024.

Your team of **39 racers** collectively travelled **1,398.1 km** in honour of our organ donors, transplant recipients and everybody waiting for a life-saving transplant

Together, we can make a difference

Yes I donate ORGAN DONATION

NHS Blood and Transplant

NHS Gloucestershire Hospitals NHS Foundation Trust

Home / About us / News and media / Press releases and statements

First Gloucestershire team to compete in the British Transplant Games

25 JUL 2024, 5 P.M.

We are incredibly proud of all our competitors and their supporters attending our first entry to the British Transplant Games. Some of the team share their stories below.

- About us
- News and media
- Press releases and statements
  - Public car park disruptions
  - Quality Summit: Patient Falls (26 November 2024)
  - Shaping Our New Strategy

Yes I donate ORGAN DONATION

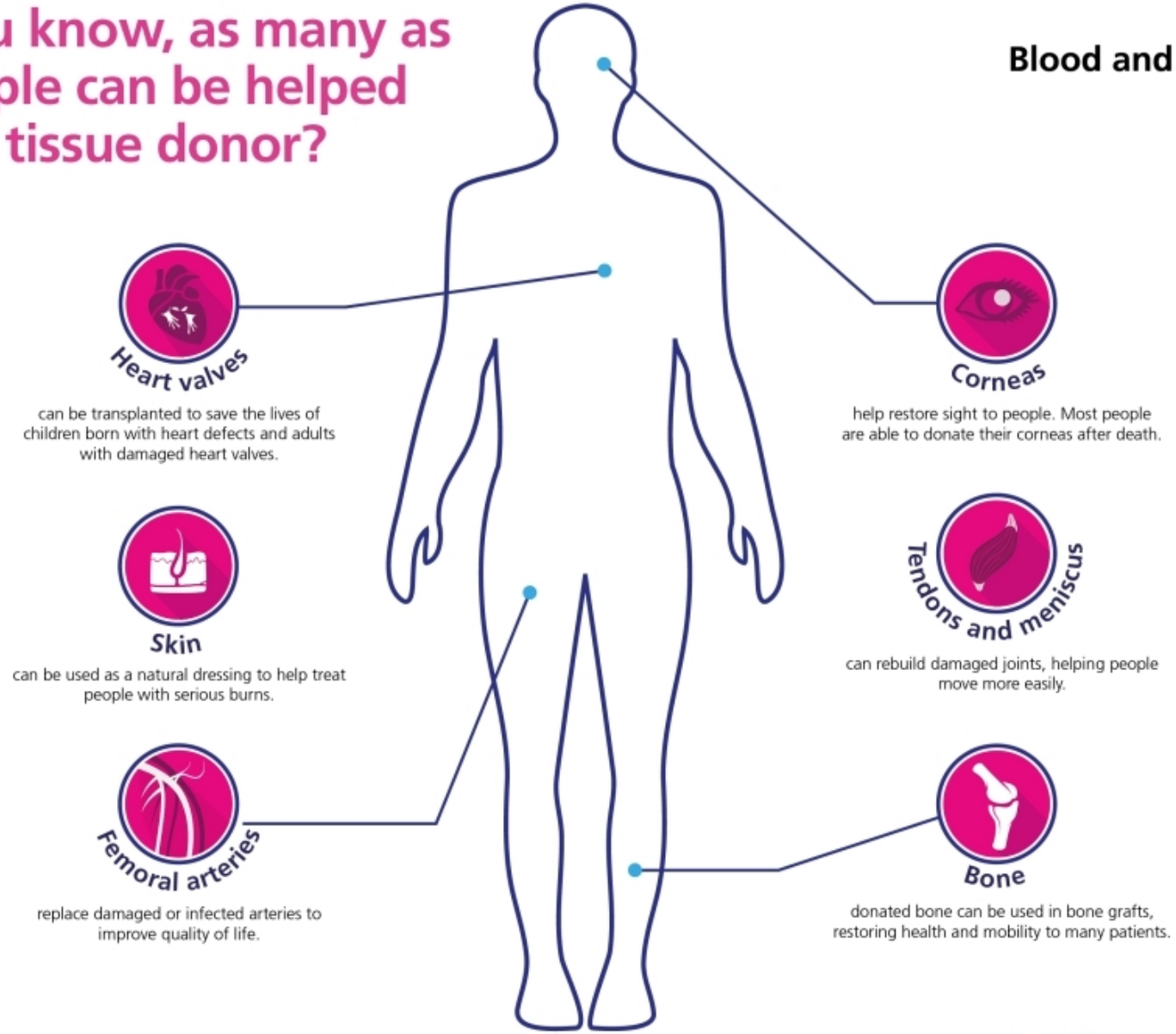
Tissue Donation

Leanne Fare

Specialist Nurse in Tissue Donation

Did you know, as many as 50 people can be helped by one tissue donor?

NHS
Blood and Transplant



Heart valves

can be transplanted to save the lives of children born with heart defects and adults with damaged heart valves.

Skin

can be used as a natural dressing to help treat people with serious burns.

Femoral arteries

replace damaged or infected arteries to improve quality of life.

Corneas

help restore sight to people. Most people are able to donate their corneas after death.

Tendons and meniscus

can rebuild damaged joints, helping people move more easily.

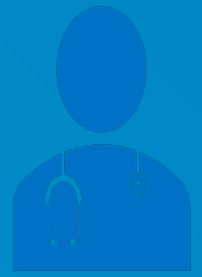
Bone

donated bone can be used in bone grafts, restoring health and mobility to many patients.

Donated tissues can dramatically improve the quality of life for others and even save lives.
See the difference you could make at www.organdonation.nhs.uk

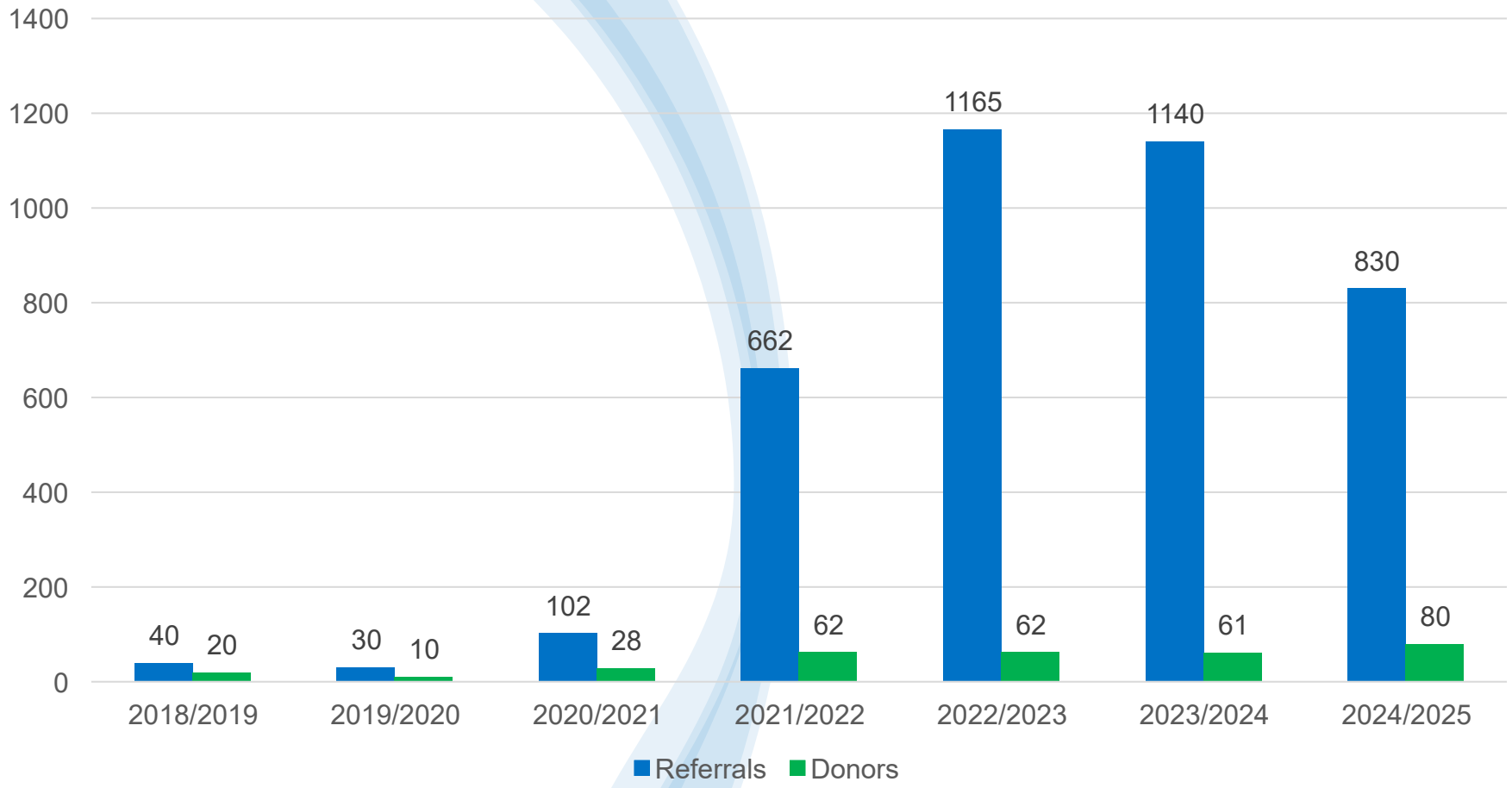
Yes I donate
ORGAN DONATION

Normalizing Tissue Donation within Gloucester & Cheltenham Hospitals



- Tissue Donation is being embraced as **normal practice** and a **routine part** of EOL care.
- Currently offering eye & heart for valves donation only.
- A family may become more distressed if an opportunity to donate or carry out the decision of the deceased to donate is missed
- All the major religions in the UK support the principal of donation and transplantation and accept that donation is an individual's decision

Referrals & Donors for GHNHSFT



Recipients

- ‘I feel forever grateful to my donor and their family. Words are not enough to express my gratitude’
- Laura.

be/7JQXYBJVl2ohttps://youtu.

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 26 November 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
Health and Safety	Committee remains concerned about fragmented governance structures in relation to health and safety, with no single committee overseeing this area, leading to gaps in oversight. This overall area is RED. Committee re-confirmed the need for clear accountability and Governance reviewing reporting arrangements as part of a revised committee structure including the need for statutory requirements around comprehensive health and safety reporting. Other updates beginning with asbestos management recent audit revealed minimal improvement, raising compliance concerns. Other key points highlighted: Fire Safety - fire alarm system at Gloucester Royal Hospital was obsolete, issues with fire compartmentalisation and fire doors posed a major risk, potentially undermining entire fire protection system. Security - nearly £500,000 of changes approved including addition of new security guards to support the violence and aggression programme in the ED. Sexual safety policy - collaborative work with HR to refine and align policies on discipline and mutual respect. Training through NHS England would be made available and action plan was in progress. Management and procurement of medical devices - medical gas audit revealed outstanding actions from previous audits that were now being addressed as a matter of urgency. Nitrous oxide (Entonox) exposure in maternity and endoscopy departments, flagged by NHS England and the CQC as area of concern. Lack of funding to improve ventilation to required standards exacerbated the problem. Other areas for improvement included water and electrical safety audits being addressed.	Detailed overview of fire safety compliance and the current action plan to be available in January for review. Committee confirmed that ownership of this needed to be resolved urgently to meet legislative requirements and ensure appropriate oversight. Update in January. The committee noted the report.
EDI Update	**Annual Equality Report** –update on staff engagement and training attendance including recent session by the Equality, Diversity & Inclusion team had been well-received but with low attendance. A key area for action if we are truly demonstrating importance of valuing staff contributions and prioritising their professional development evidenced.	Update at next meeting on how staff could be given time to attend from member of TLT.

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.

	Update given on progress with recruitment and EDI - inclusion champion role, unconscious bias in interviews, and accessible job descriptions. Concerns about ownership and coordination following cancellation of the inclusion champions' workgroup meeting. Committee members were appraised of changes to consultant interviews in relation to EDI. However, members who had chaired the panels did not recall that change being implemented. Staff feedback still highlighting discrimination and unequal opportunities, but progress remains slow. Highlighted many inclusion champions did not fully understand the concept of positive action and further work needed. Proposed that inclusion champions be involved in consultant interview panels, as it would signal the organisation's commitment to diversity. Agreed and work to be undertaken to see how an inclusion champion could be on every interview panel for roles at pay band 8A and above. Claire Radley provided an update on a follow-up session to the October Black History Month event, which was scheduled for 9 December 2024. The session aimed to explore barriers, refine strategies, and develop an action plan on representation, bias in recruitment, and diversity commitments. **EDI Recruitment Plan** Organisation still not reaching all staff and communities, highlighted during Black History Month in October. Many staff unaware of ongoing initiatives and sought tangible change. Recruitment a key priority and task and finish group been formed to review the recruitment policy, with a focus on inclusion champions. Survey findings revealed many inclusion champions lacked confidence, particularly for lower-band roles and concerns around fairness still an issue. Face-to-face training for current and new inclusion scheduled for rollout in 2025.	Committee to receive clarification around absence of inclusion champions on consultant interview panels and report back to next Committee. Committee to receive update at next meeting on progress with actions (recruiting managers allocate time for training and development, progress with the inclusion champions' programme, job descriptions) Committee to receive update at next meeting Contents noted by Committee with further updates and performance data to be bought to future committee
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Recruitment and Attraction	Key activities: - Work to improve time-to-hire showing - slight decrease - delays mainly due to hiring managers', impacted by operational pressures. Monitoring of KPIs with divisions to focus on reducing time to hire underway.	This item is AMBER and Committee to receive update at next PODC.

	Integration of a new OH system and identification verification technology expected to enhance efficiency and experience for new starters. Ongoing work to reduce nurse agency spend includes a production of a standardised rate card with Southwest partners. Off-framework usage increased due to operational pressures and acuity but under ongoing monitoring. Progress on medical staffing controls, includes removal of locally agreed locum bank enhancements and addressing inconsistency around paid breaks underway. There is a continued focus on agency reduction across all other staff groups, supported by ongoing recruitment campaigns to fill substantive posts, particularly hard to fill specialties Workforce plan, aligned with NHS reforms, now focused on 2025-2026. This will align with the ICS System Plan, the Trust's own operational and business plans. The workstream is overseen by the Workforce Sustainability Programme. The raising of a new recruitment risk is underway, following the review of the legacy risk and the new retention risk. This will be presented at the next PODC. Other issues to be reviewed - dropout rates and shortlisting-to-appointment ratios. **Workforce Sustainability – Proposed new Trust JD template** Presentation received and welcomed on the new templates for job descriptions, recruitment microsite and key information to show full range of benefits to prospective candidates. Project aims to ensure job descriptions are clear, consistent, inclusive, and reflective of cultural values to attract top talent. Tailored to specific staff groups while aligning with the trust's "nurturing ambition" recruitment brand. Review of existing templates revealed significant variation in format and detail. Concerns about outdated job descriptions for existing staff and how these will be updated. Suggested staff who felt their current job descriptions no longer reflected their roles should discuss updates with their line managers, with Human Resources Business Partners offering support on a case-by-case basis to ensure a review is undertaken at a local level. Challenges of updating current job descriptions - agreed a prompt for job description reviews to be added to the appraisal process, ensuring line managers regularly evaluated these documents.	

	Trust Attraction Brochure being developed to provide an overview of the Trust's culture, values, and benefits including details on staff networks, flexible working, and health and wellbeing initiatives and intended to be available digitally for job postings and in print for recruitment fairs. Query about timing of Trust Attraction Brochure and alignment with upcoming Trust Strategy. Clarified brochure could be amended and aligned to the Trust's values and strategic direction. Agreed a wider update was required to confirm progress to date, outstanding issues and impact. Review of BAF is underway with Corporate Governance to ensure committee received focussed information. Progress welcomed - trend tracking, strategic alignment of the risks but acknowledged that more focussed work was needed to ensure committee could receive assurance on the impact of the area of focus.	
Culture, experience, and retention	Risk Management Group reviewed risk and proposed score of 16, pending final confirmation through governance processes. The committee agreed that a revised approach to Board Assurance Framework reporting was needed to better represent priorities, actions, and measurable impacts. The committee noted the contents of the report. Concerns in relation to addressing staff morale and trust, particularly unrepresented voices and systems like Freedom to Speak Up. Further demonstration of impact and cultural change needed to be presented. Further work on developing effective measurement of impact/outcomes along with evaluation needed.	Revised approach to Board Assurance Framework reporting needed to better represent priorities, actions, and measurable impacts
People Performance Dashboard	Dashboard including new metrics from the Communications team included for first time. Areas of focus/exceptions: Increased bank staff usage noted. *This realises positive benefits if there is a direct correlation with a reduction in agency use. Understanding reasons behind the rise in bank usage is therefore important, monitoring fill rate against demand, targeting areas with high usage, and maintaining cost control.* Remains RED. Vendor performance marked as AMBER and concerns about mandatory training, particularly safeguarding training and information governance, a persistent issue, with safeguarding adults Level 3 training significantly behind target. Previous questions about whether training complexity was the barrier still outstanding.	Report was noted

	Confirmed work underway with subject matter experts to make training less complex, along with changes at national level should help improve.	
Audit Update	**NHSE Workforce Controls Audit** NHS England requested an internal audit of workforce controls as part of its concern with workforce growth; Full-time equivalent workforce exceeded funded establishment. Significant work undertaken since January 2024, to strengthen workforce controls but further work required to fully embed these processes and ensure effectiveness and impact Terms of reference for the audit are been developed, with a start date planned for January 2025 Audit was an ad-hoc audit requested by NHS England and prioritised accordingly, resulting in rescheduling of other audits, including appraisal audit. **Appraisal Audit Update** Audit postponed to Quarter 1/2 of 2025. Progress to date included incorporation of risk management into development conversations. New appraisal form trialled, with feedback incorporated. NHS People Promises integrated to ensure alignment throughout employees' journeys. Focus shifted towards supporting new line managers in conducting appraisals, with an emphasis on understanding staff needs rather than completing forms. Working ongoing on digitalising appraisal process to enable better data extraction. Six-month and twelve-month evaluations would be conducted to assess the impact of the new process on a selected cohort. **Payroll Additions Audit** Conducted in May 2024 identifying several gaps in Trust's payroll processes. Additional Payments Working Group formed in August 2024 to address findings. The audit focused on policies related to flexible working, overtime, enhanced payments, waiting list initiatives, bank rates, and on-call working. Working group reviewing policies to improve authorisation and processing of additional payments to embed rigour and controls. Some progress made; further improvements still required.	Audit plan would be bought to next committee, along with updates on live and upcoming audits, including status, assurance ratings, and action plans, to ensure clear tracking of audit progress. Committee requested this audit try to be undertaken in Q1 given delays to date and impact on enhancing employee culture, well-being, and performance. Committee asked for progress update on appraisals and their importance. The committee noted the report. The committee noted the report.

	Updated policies for Recruitment and Retention Premia, Overtime, Waiting List Initiatives, On-Call Working, and Temporary Staffing expected to be finalised by the end of the financial year, improving oversight and authorisation processes	

Items not Rated

Risk Register

- Two emerging risks going through governance process and to come to next committee – related to recruitment and increased sickness levels.
- No closed risks to report.

KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – NOVEMBER AND DECEMBER 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 meetings are available. This report is a summary of discussions held at the full meeting held in November and the shorter meeting held in December which was focussed on a restricted agenda.

Items rated Red

Item	Rationale for rating	Actions/Outcome
SRO9 Failure to deliver Recurrent Financial Sustainability and Performance Report, Months 7&8	A two-part agenda item reflecting financial performance in the current year and longer-term planning/prospects. Re 2024/25, at month 8 the Trust is reporting a small surplus of £0.2m which is £4.99m favourable to plan. The forecast outturn remains at breakeven but this remains under significant pressure. Areas requiring further work include the non-pay position which is £6m overspent to date, better understanding the impact of reduced theatre capacity on income from Out of Area contracts and (as detailed below) the search for recurrent solutions to the Gloucestershire position.	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, rebasing the block contract, increasing theatre capacity etc.
Operational Planning 2025/26	Re 2025/26, plans continue to develop and are awaiting national guidance. This will feed into the Trust's 2025/26 budget setting process. The underlying position of the Trust is now forecast to be a deficit of c£67m and analysis continues in order to better understand the potential for improvement. Headlines include- - Sustainability target will need to be a 3% minimum - Financially there is a challenge of between £27- 60m - The operational, workforce and quality implications of these parameters are being modelled	Outcome of the "Drivers of the Deficit" to be presented to January meeting.
Financial Sustainability Report Month 8 and 2025/26 outlook	The overall target remains at £37.5m including the system stretch targets. At month 8 the forecast position is to deliver 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	The Committee noted this positive position and congratulated the team on the outcome. It received the report as a source of assurance that the financial position was understood. However, efforts to shift from non-recurrent fixes to recurrent changes in capacity and practice was

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.

	institutional boundaries. Significant risks remain around delivery of the "Working as One" programme.	an essential requirement of future plans.
Capital Programme Report Month 8 and update re 2025/26 Plan	At month 8 spend was £12.7m behind plan – expenditure of £17.5m against a plan of £30.2m. The recent deep dive review of schemes resulted in the following forecast outturn positions which have been reported to NHSE following Board approval - - Operational Capital (excluding IFRS) – breakeven - IFRS 16 – underspend of £2.4m - National Programme – return funds of £355k In order to achieve the breakeven position on Operational Capital, £3.8m of high priority equipment schemes have been brought forward. Re 2025/26 plans, discussions were taking place with a view to a discussion at the Board Development session in January. This would include a review of learning opportunities from recent performance and impact on operational performance.	The Committee received the report as evidence of assurance of the position.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Procurement Bi-Annual Performance and Assurance report	A largely positive picture was received, drawing upon national benchmarked indicators and local CIP savings/procurement targets. The new Procurement Act will now come into force in February 2025 (previously October 2024). Approval had been secured for additional staffing costs within the team in order to reflect the twin pressures of recruitment/retention difficulties and increasing workload as a consequence of legislative changes.	The Committee were assured by the report which confirmed achievement of targets, benchmarked performance and no legal proceedings/procurement challenges during the reporting period.
Digital Transformation Report	Some very positive developments including Electronic Patient Record (EPR) System going live in Dermatology and a successful Clinical Coding initiative.	The Committee noted the progress to date and took assurance from the report.

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

	The national HIMMS standards, relating to digital maturity, would be the subject of discussion at a future meeting. The Committee noted that in terms of EPR, clinician experience was poor with information held in a number of places. This issue to be a priority for the incoming Director.	A review of EPR and action plan to return to a future meeting.
Financial System implementation	The Programme Board had approved a revised target delivery date following a review of the current delivery status and confidence in achieving a revised Go Live date of November 2025. Financial impact of the changes was not material although it would now be treated as revenue rather than capital expenditure. The impact of a mid-year implementation would be discussed with external auditors.	The Committee noted the progress and revised timetable and received the report as evidence of the improved control environment.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
CITS Performance	This is a shared service within the ICS with a responsiveness rate in the high 90's.	To be highlighted at a forthcoming meeting of ICS NEDs.
Capital Post Year End Review	This review had focussed on the potential to improve the system rather than individual schemes and recommended earlier prioritisation of schemes, improved scrutiny of business cases including a "deliverability" test and a clear process map. Communications around approvals and decisions could be improved. The Committee welcomed the report and its recommendations.	Post project evaluations are underway for four capital projects and would be presented to Committee at a later stage.
Items not Rated		
2025/26 Budget setting methodology	Produced in advance of the national planning guidance in order that the Trust could prepare for 2025/26 as early as possible.	
Finance Risk Register	An updated assessment had been prepared. The Committee requested that the risk around recruitment in the Procurement team be added	
Consultant Job Planning	as a consequence of a recent audit, a response plan had been prepared and a substantive job planning coordinator post established. A new compliance report had been introduced and there was oversight through the Medical Job Planning Consistency Panel. A review of policy and stocktake of compliance was underway.	
Chief Digital and Info Officer Risk Report	The report highlighted a number of estate issues which posed a risk to delivery of IT services, these were to be progressed through the capital planning route. Positive evidence of increased involvement of IM&T in programme delivery.	
Investments		
Case	**Approval**	

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Genmed Contract Extension	The Committee APPROVED the extension of the existing contract for a maximum of 4 years, valued at £104.5M excluding VAT (£125.4M including VAT).
Procurement of Turnkey Modular MRI	The Committee SUPPORTED the placement of an order with Siemens Healthineers up to the sum of £2,641,510.
Procurement of Temporary Pharmacy Manufacturing Unit	The Committee SUPPORTED the placement of an order with Guardtech via the Constellia procurement framework for the sum of £1,434,203.32
Patient Bed Maintenance	
Portable Appliance Testing (PAT) contract	
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. This will be presented to the Committee in January and feed into the preparation of 2025/26 budgets and longer term financial plans.	
SR 12: Cyber Security – this risk remains at 15 and is likely to remain so. A system wide Cyber Security strategy is under development and would be presented to a future meeting before finalisation in May.	
SR 13: Digital Systems Functionality – this risk remains at 12. Staff retention remains a pressure on services. ?? do we need to update re PACs here?	

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