Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 13 March 2024 at 09.00 to 12.00

Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1	**Chair's welcome and introduction**	Information		09.00
2	**Apologies for absence**	Information		
3	**Declarations of interest**	Approval		
4	**Minutes of previous meeting**	Approval	Yes	09.05
5	**Matters arising**	Assurance		
6	**Questions from the public**	Information		
7	**Staff story** *James Clifford and Debbie Tunnell, Deputy Director for People and Organisational Development*	Information		09.10
8	**Chair's report** *Deborah Evans, Chair*	Information	Yes	09.25
9	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	Yes	09.35
10	**Board Assurance Framework** *Kerry Rogers, Director of Integrated Governance*	Assurance	Yes	09.45
11	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Yes	09.50
12	**Health and Safety Management Framework Report** *Kerry Rogers, Director of Integrated Governance*	Assurance	Yes	10.00
13	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director*	Assurance	Yes	10.15
14	**Staff Survey 2024/ Results** *Deborah Tunnell, Deputy Director for People & OD*	Information		10.25
BREAK (10 minutes)				
15	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director and Mike Napier, Non-Executive Director*	Assurance	Yes	10.50
16	**Integrated Performance Report** *Al Sheward, Chief Operating Officer and Executive Director colleagues*	Assurance	Yes	11.00
17	**Learning from Deaths** *Mark Pietroni, Medical Director & Director of Safety*	Assurance	Yes	11.20
18	**Maternity Services Regulatory Compliance Report (section 31 Notice Response)** *Matt Holdaway, Chief Nurse & Director of Quality* *Joanne Cowan, Head of Midwifery*	Assurance	Yes	11.35

FINANCE AND RESOURCES				
19	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director*	Assurance	Yes	11.45
STANDING ITEMS				
20	**Any other business**	Information		
21	**Governor observations**	Information		
22	**Date and time of next meeting:** 8 May 2024 at 09.00 Lecture Hall, 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 16th January 2025, 09.00 to 12.00
Room 3, Sandford Education Centre, Cheltenham General Hospital

Present	
Deborah Evans	Chair
John Cappock	Non-Executive Director
Sam Foster	Non-Executive Director
Mike Napier	Non-Executive Director
Kaye Law-Fox	Associate Non-Executive Director and Chair of GMS (Gloucestershire Managed Services)
Sally Moyle	Associate Non-Executive Director
Kevin McNamara	Chief Executive
Karen Johnson	Director of Finance
Professor Mark Pietroni	Medical Director and Director of Safety (Deputy Chief Executive)
Matt Holdaway	Chief Nurse and Director of Quality
Claire Radley	Director for People and Organisational Development
Kerry Rogers	Director of Integrated Governance
Al Sheward	Chief Operating Officer
Will Cleary-Gray	Director of Improvement and Delivery
In attendance	
Sarah Favell	Trust Secretary
Helen Ainsbury	Chief Digital and Information Officer (Interim)
James Brown	Director of Engagement, Involvement and Communications
Lisa Stephens	Director of Midwifery (item 11/25)
Apologies	
Vareta Bryan	Non-Executive Director
Marie-Annick Gournet	Non-Executive Director
Balvinder Heran	Non-Executive Director
Observers	
Governors	Andrea Holder, Mike Ellis, Peter Mitchener, Russell Peek
Lee Pester	Incoming Chief Digital Information Officer
Members of public	Five

Ref.	Item
1/25	**Chair's welcome, apologies for absence and quoracy check**
	The Chair opened the meeting, confirming it was quorate. On behalf of the Board the Chair expressed her thanks to Helen Ainsbury (Chief Digital and Information Officer) who was attending her last Board meeting. Helen's contribution to the digital agenda of the Trust has been significant. Apologies for absence were noted from Balvinder Heran, Marie-Annick Gournet and Vareta Bryan. The Chair confirmed that both she and Vareta Bryan had chosen to prioritise attendance at the Black Maternity Matters Workshop, which was also being attended by Dr Christine Edwards, Consultant Obstetrician and co-author of report for item 11/25. This decision was taken to reflect the Board's commitment to the improvement programme in place within Maternity Services.

2/25	**Declarations of interest**
	There were no declarations of interests.
3/25	**Minutes of previous meeting**
	RESOLVED: The Board **APPROVED** the minutes of the meeting held on 14 November 2024.
4/25	**Matters arising**
	There were no matters arising.
5/25	**Patient Story**
	The Board was joined by Andy, who shared his experience of the impact of urinary incontinence following treatment for bladder cancer. This included an engaging discussion of the challenges he has faced in accessing appropriate emergency support with catheter complications. Both the Medical Director and Chief Nurse were pleased to be able to confirm that the Urology department had recently introduced a direct access service for emergencies which should resolve this issue for patients with long-term catheter use. Andy also described his variable experience as a user of catheter equipment, particularly where supplies are provided by a third-party organisation. He felt many of these issues could be addressed by the training of nursing staff on how to manage and support patients with catheters to ensure issues were resolved during any hospital admission. This would reduce the risk of frequent readmissions. The Board were very appreciative of Andy taking the time to share his experience and also to hear from Kerry Holden, Deputy Director (Infection, Prevention and Control) about the very positive learning from the Urinary Catheter Quality Summit which took place in November 2024.
6/25	**Public Questions**
	The meeting addressed two public questions submitted for discussion. Written responses to be provided to all questions and also shared with all board members. One question, submitted by Bren McInerney, a member of public in attendance, related to the ability of patients, service users and families to raise concerns regarding the care being provided. Both the Chair and Chief Nurse responded to confirm that there is a significant quality improvement project ongoing to ensure the patient voice is heard at point of care. The Chief Nurse outlined the work being undertaken to improve the handling of complaints and communications with patients/families. This work has included the implementation, across both hospitals, of the 'Call for Concern' pilot which provides rapid access to a second clinical opinion. Additionally, the Ward Sister Charter has been introduced, focusing on our promises to patients, what they can expect whilst on the ward including how we will respond to feedback. The Chair also highlighted the Complaints Report for 2023/2024, which has been received by the Council of Governors, and which will be published in the near future. The second question sought reassurance about clinical decision making during any period of critical incident, with a focus on the care of vulnerable patients without capacity. It has been agreed that a full written response will be provide with input from both Chief Nurse and Medical Director

7/25	**Chair's Report** Deborah Evans, Trust Chair
	The Chair confirmed that Non-Executive Directors, Mike Napier and Balvinder Heran will both come to the end of their tenure in May 2025 with the Trust actively progressing recruitment of both Non-Executive and Associate Non-Executive appointments. The Chair was pleased to report that the Trust had received good interest in the roles from a wide range of potential applicants. During the reporting period both Governors and Non-Executive Directors had continued their programme of visits to clinical areas with shared visits to the discharge lounge, integrated flow hub, the Emergency Department and the site management office in December. At a time of increased patient flow it was impressive to witness the expertise of the site management team and senior leaders in responding to the winter pressures, as was the commitment of the wider teams. Sam Foster, Non-Executive Director, and Matt Holdaway, Chief Nurse also spent time visiting the emergency pathway on 23rd December to see the hard work of the teams. A planned visit in January was cancelled due to the critical incident. The Chair recognised that the declaration of a critical incident is not an easy decision and will have been concerning for patients, particularly as the incident was prolonged over several days. The Trust was able to manage this incident well, with visible improvements being made to the patient's journey through both diagnostic and treatment pathways. The Chair repeated her thanks to all teams involved in responding to the Critical Incident across the Trust. Finally, and importantly, the Chair highlighted the honour recently received by Asma Pandor, Admiral Nurse, who has received the British Empire Medal for her service to people with dementia and their families. **RESOLVED:** The Board NOTED the report for information.
8/25	**Chief Executive's Report** Kevin McNamara, Chief Executive
	Kevin McNamara, Chief Executive, echoed the Chair's comments regarding the recent honour received by Asma Pandor who was also awarded the annual Trust Patient's Choice Award in 2023. Another opportunity to celebrate the contribution of the Trust's staff took place in November 2024, with the annual Staff Awards at Cheltenham Racecourse. The Chief Executive also recognised the efforts of the staff during the recent Critical Incident. The Chief Executive spoke about his attendance, alongside executive and non-executive board colleagues, at the Black History Month conference in October, and the constructive positive discussions that took place. The output from the meeting was to be explored by the Trust Leadership Team at its Away Day in January with a further network meeting in February. In the meantime, the momentum will continue with volunteers actioning many of the points raised during the discussions at the October meeting. Discussions continued regarding the national focus on waiting lists with the Elective Reform Plan recently released by the Government. Overall, the Trust's performance in elective care recovery is good with the 65-week Referral to Treatment (RTT) list currently

	reduced to a single patient (defined as outside Trust control). The Chief Executive reinforced that continued focus was needed. The recent delayed publication of the Care Quality Commission Inspection report into Maternity Service has been a source of frustration but has not distracted the Trust from the work necessary to address the concerns identified within the inspection report and the Section 31 Notice issued. Details of this progress was provided within the Board papers and it was anticipated that there would be a re-inspection of the Service in the near future. It was recognised that Members of Parliament, representing all constituencies using Trust maternity services were keen to be kept appraised of the position regarding the provision of maternity services, in particular recruitment and retention and the status of both the Aveta Birth Unit and post-natal beds in Stroud. The Trust has ensured that stakeholders were being kept informed of progress and engaged on issues relevant to the delivery of high-quality services. Discussions took place regarding the need to achieve a balance between engaging with external stakeholders as to future plans regarding service provision and the need to ensure safe and effective core maternity services currently and to fully deliver against the Section 31 Notice. It was noted that the Care Quality Commission has a considerable backlog of inspection reports to be released but it was anticipated the inspection report into Emergency Department services, following an inspection in December 2023, would be released shortly (mid-January). It was recognised that the delay in publication may impact the value of the report as a quality improvement tool but nevertheless it would provide a very useful mirror to the performance of the Trust and it is important that this, together with the concerns raised by mothers using the service, were listened to and responded to. Much has been done to improve services since the Care Quality Commission inspection, based on feedback provided at the time. The Chief Executive also expressed his thanks to the teams involved in providing the Trust's response to the recent critical incident. The Chief Executive led a discussion on the negative impact on clinical and operational performance as a result of the volume of beds currently occupied by patients medically fit for discharge. A significant number of Trust beds (24%) were occupied by patients whose needs would be more appropriately met in a community setting. The work of the Gloucestershire ICS in providing a system wide response was noted. By 10 January it had been possible for the Trust to stand the critical incident down, however the challenge remains regarding inappropriate bed occupancy impacting patient services, with 179 patients (who do not require a hospital bed) remaining in the Trust's wards as at the date of this Board meeting. Whilst it continues to be an issue the Chief Executive was keen that it did not overshadow the efforts of teams across the Trust during this critical period. There will be learning from this critical incident which would support the work on improving patient pathways and operational flow but it was recognised that this would also need a system wide approach and commitment to finding solutions to achieve appropriate and timely discharge of patients **RESOLVED**: The Board NOTED the report for information.
GOVERNANCE AND ASSURANCE	
9/25	**Audit and Assurance Committee Report**

	John Cappock, Non-Executive Director
	John Cappock, Chair of Audit and Assurance Committee, presented the Key Issues and Assurance Report for December 2024. The focus remained on the limited assurance provided in the annual Internal Audit opinion with the Committee being clear it remained a high priority to ensure focus on responsiveness to recommendations made by the audit teams, including the monitoring of the effectiveness of action plans and completion within agreed timescales. The Committee was clear that it will be looking at a return to moderate assurance as a minimum and Internal Audit attendees at the meeting were overall encouraging as to progress to date. Discussions continued regarding the correct forum for oversight and assurance of the Health & Safety function/risks. It remains with the People and Organisational Development Committee but there are ongoing discussions as to the correct forum for Health & Safety as the issues cover a broader spectrum than solely staff. The planned audit of appraisals had moved from the 24/25 audit plan due to an intervening nationally imposed workforce controls audit but the Committee heard from the HR team that it had undertaken an internal review/self-assessment of appraisals. Having had sight of that report, the Committee was moderately assured that there had been some scrutiny, albeit not the fully independent Internal Audit review. The Committee had also scrutinised the updates to the Scheme of Delegations, Standing Financial Instructions and Standing Orders which are before the board at today's meeting. **RESOLVED:** The Board NOTED the report for assurance
10/25	**Scheme of Delegation, Standing Financial Instructions and Standing Orders** Karen Johnson, Director of Finance and Kerry Rogers, Director of Integrated Governance
	Karen Johnson, Director of Finance, and Kerry Rogers, Director of Integrated Governance, presented the report following a regular review of these core governance documents. The report had already been considered at both Finance and Performance Committee (October 2024) and Audit & Assurance Committee (December 2024) and Board approval was sought for the amended documentation, as per the Schedules within the report. It was noted that there were small changes required where there is reference to a legacy title for the Director of Integrated Governance but these are 'de minimis' and will be made administratively. A number of the changes related to the governance and interaction of the Trust and Gloucestershire Managed Services (GMS), a wholly owned subsidiary of the Trust, including changes to the Schedule of Decisions Reserved for the Board. These were discussed for clarity and information. **RESOLVED**: • To APPROVE the Scheme of Delegation • To APPROVE the Standing Financial Instructions • To APPROVE the Standing Orders
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11/25	**Report to the Care Quality Commission (Section 31) Summary Report** Lisa Stephens, Director of Midwifery and Dr Christine Edwards, Consultant, Obstetrics (Apologies received)

	The Chair welcomed Lisa Stephens, Director of Midwifery, to the meeting. The Board received the monthly Section 31 report, which detailed ongoing progress against the improvement programme in place since May 2024, which reports monthly to the Executive Led Maternity Delivery Group. Wider context of the oversight provided internally and by the Integrated Care Board Quality Improvement Group was provided by the Chief Nurse. It was noted that, at the December meeting of the Integrated Care Board Quality Improvement Group, oversight of two workstreams (agency staff and Maternity Obstetric Early Warning Scores audit compliance) were closed recognising the significant progress made, however reporting would continue on these workstreams, for both internal and Care Quality Commission oversight. The Director of Midwifery provided an update on performance indicators for all five workstreams; postpartum haemorrhage, foetal monitoring peer reviews, temporary workforce experience, venous thromboembolism risk assessments and maternal obstetric early warning scores (MOEWS) compliance, with the majority of targets being met. There was discussion regarding the reduction in compliance for foetal monitoring hourly monitoring/assessment in November 2024. This had been recognised promptly and attributed to the recent arrival of a number of new employees who were receiving training. Additional safeguards were put in place including the ability of senior midwifes to remote monitor in real time, an additional support to the midwife in the labour room. Board members commented positively on improvement performance to date and the work done to meet Care Quality Commission requirements over a prolonged period. Additional context was provided by Sam Foster, Non-Executive Director and Chair of Quality and Performance Committee, who was able to confirm the committee did review the data in detail and that, whilst recognising the significant work and improvements made, it was clear there was a need for continued scrutiny, either at Board or Board Committee. It was recognised by the Chief Executive that there was a need to have a conversation surrounding oversight reporting in the long term but the Trust's position remains that it has accepted the findings of the S31 Notice and is keen to continue to hold a mirror to its provision of this service to maternity patients and their families. **RESOLVED**: The Board NOTED the contents of the Section 31 Summary Report and associated metrics for assurance.
11.1/ 25	**Perinatal Quality Dashboard, Quarter 2 (2024)** Lisa Stephens, Director of Midwifery
	Lisa Stephens, Director of Midwifery, presented this report, the first iteration of a report which had been considered by Quality & Performance Committee. In addition to the Quality Dashboard this report provides monthly data alongside emerging themes and trends in addition to a narrative commentary. There was a general discussion regarding the work on health inequalities and particularly enabling access to services for all service users including those from Black and Minority Ethnic communities and those who do not have English as a first language. It was noted that there were disappointing training compliance rates for medical staff but it was also noted that this data would be more useful in understanding the extent of the non-compliance, if it was provided numerically rather than percentage rates. This will be reflected in the next iteration of the report.

	Board members sought assurance as to the management of patient complaints, with 20 complaints being received during the relevant period (Q2). The Director of Midwifery outlined the maternity senior management focus on complaint review and the increased use of offering direct contact/meetings with patients to resolve complaints. This work would be further improved with the arrival of an additional team member whose primary focus will be on patient experience, complaints and feedback management. Finally, it was noted that Quality and Performance Committee will be carrying out a 'deep dive' exercise into maternity service complaints at a future meeting. **RESOLVED**: The Board NOTED the content of the report for assurance
12/25	**Update on development of Trust Strategy** Will Cleary-Gray, Director of Improvement and Delivery
	Will Cleary-Gray, Director of Improvement and Delivery, presented an update on the refreshing of the Trust's strategy. It was acknowledged that since the Trust's last strategy was developed in 2019 there have been significant events, both nationally and internationally, which provide important context for the development of this Trust strategy and the strategic priorities for the period 2025-2030. The current focus of the team was on ensuring high levels of engagement from staff, public and local stakeholders. With the final Strategy due at the end of July this would allow increased time for engagement as well as allowing time to fully consider the expected Government 10-year Health Plan (proposed May release) and a draft Strategy returning to Board during quarter 1, 2025. The Board discussed the impact of the delayed receipt of the NHS 10-year plan on the preparation of the Trust's strategy but with Trust's strategy being focused on the importance of engagement with the local population it was felt the strategy could be easily updated to reflect relevant aspects of the 10-year national Health Plan, if necessary. **RESOLVED**: The Board NOTED the content of the report for assurance
INTEGRATED QUALITY AND PERFORMANCE REPORTING	
13/25	**Quality and Performance Committee, Key Issues and Assurance Report** Sam Foster, Non-Executive Director and John Cappock, Non-Executive Director
	Sam Foster, Non-Executive Director, presented the Key Issues and Assurance Report for the Quality and Performance Committee meeting held on 30 October 2024. The Committee continued its focus on the improvement work within Maternity Services with deep dives planned for future meetings and with the wider Maternity leadership team now attending committee to support wider discussion. At the October meeting the committee focused on stillbirth rates with a noted slight increase in Quarter 3 and 4 (2023/24) noting that the Maternity Improvement Adviser was undertaking a thematic review into stillbirths to ensure adequate improvement plans. The ongoing poor response rates for complaints remains of significant concern and it was noted that this issue was the focus of increased executive oversight, with a further report to be brought to the committee setting out the complaint's handling improvement plan. John Cappock, Non-Executive Director, presented the Report for the Quality and Performance Committee meeting held on 27 November 2024. He highlighted the

	progress made in the completion of outstanding serious incident investigations and significant progress being made on overdue serious incident action plans, with improved management by the introduction of weekly review meetings. There continues to be a significant concern as to the timely delivery of histology reports with 3,000 pending. There were a number of relevant factors, including national workforce issues. An improvement plan will be provided at the next Committee meeting. The Chair, indicated that this should remain a priority focus and that she would be keen to get a comprehensive update at the next Board meeting. **ACTION:** Chief Operating Officer and Medical Director to provide an update report on histology performance to be provided to both Quality and Performance Committee and Board of Directors. **RESOLVED**: The Board NOTED the report for assurance
14/25	**Integrated Performance Report (Operational Performance)** Al Sheward, (Operating officer), Prof Mark Pietroni, (Medical Director & Director for Safety) Matt Holdaway (Director of Quality and Chief Nurse), Karen Johnson, Director of Finance and Claire Radley, Director for People and Organisational Development
	Al Sheward presented the Integrated Performance Report for the period October-November 2024, indicating a focus within the presentation on the areas within the Single Oversight Framework which were demonstrating less progress than target. The Board noted the following key points: **Performance** • 4-hour emergency care standard was not achieved in October with 61% of patients seen, treated and discharged within 4 hours, a 2% decrease against the previous month. Moderate improvement in November (62%). There is a continued focus on the Improvement plan (Emergency Care Improvement Support Team recovery work) with modest improvement in the 12-hour wait but it is recognised this is still not at an acceptable level. • Significant improvement in ambulance handover performance during November with number of hours lost to delays reducing from 120 (October) to 54(November) with the department meeting the average handover target time of 45 minutes. • 52-week wait for elective treatment continue to follow a positive trajectory with current data indicating 1481 patients breaching the target compared to 1615 in October. Focus on reducing these figures in key departments continues with teams committed to achieving target. • 62-day target performance was slightly lower than the Trust's recovery target but there is no complacency with improvement plans in place for urology and a recent focus on reviewing diagnostic and supportive services to minimise patient pathway delays. • Waiting list for angiogram continue to improve. Both Catheter labs are operational with limited (maintenance only) downtime. Indicative that the decision to focus cardiology services on the Gloucester Hospital site was the right service decision, however the Board noted the continued pressures on Echocardiography as a result of workforce challenges at a time of increased patient referrals. There were a number of actions in place designed to address the identified issues with projected trajectory recovery by May 2025.

- Other areas under active monitoring as result of deteriorating performance were Neurophysiology, which will be entering enhanced support focusing on the recruitment of additional resource and improving GP access and training. Also, Histopathology had been a concern for a while in the context of a national shortage of Histopathologists coinciding with a 30% increase in referrals. As a consequence, there was an increased focus on digital pathology with training complete and a period of validation ongoing.
- Increasing bed occupancy linked to demand across both sites. A focus on reducing the number of patients with 'no criteria to reside' whose health needs would be better met in a community or alternative setting would assist with recovery but there has been limited progress and it was recognised by system partners that there needs to be both additional resource (for the most dependent patients) and a focus on system wide delivery.

Quality and Safety metrics

This section of the report was summarised by Prof. Mark Pietroni, Medical Director, and Matt Holdaway, Chief Nurse:

- The Friends and Family response from patients showed an improved score from 91.5% (October) to 92.8% (November), particularly when considering the operational pressures.
- The Patient Advice and Liaison Service (PALS) had seen a deterioration in response time performance, currently at 70% against a target of 75%. This was reflective of a combination of factors, primarily the complexity of cases and staff sickness within the team. The team are taking proactive measures to focus resource on where it would be most beneficial for service users and had taken the decision to suspend face to face meetings with the focus on providing an effective service via email or phone communications whilst there was limited resource within the team.
- Response times for complaints further deteriorated during this period from 18% to 10% being provided within required response times. An improvement project was put in place and improved data has now provided Divisions with increased oversight of complaints.
- November saw an improvement in performance against the mixed sex accommodation target.
- The period saw a close to zero position for Boarded patients and work was continuing to improve digital discharge processes and data accuracy to support patient flow. All recognise the impact of boarding on the experience of the patient and the potential impact on patient dignity, with all reasonable efforts being made to reduce its use.
- Rates of hospital acquired pressure ulcers had continued to reduce with the work of the Tissue Viability Nurses in training ward-based nurses continuing to have a positive impact.
- VTE (Venous Thromboembolism) rates, as per the Dashboard, show high compliance rates where patient's length of stay exceeds 24 and 36 hours. Focus is on improving compliance rates for short stay surgical patients (within 14 hours). Manual audit figures or maternity VTE are at 100% but need assurance via an electronic audit.

- The SHMI (Summary Hospital-Level Mortality Indicator) provides a complex picture and as such is scrutinised by the Integrated Care Board Quality Improvement Group. Relevant factors for Cheltenham General Hospital increased post discharge mortality include the elderly patient population/frailty and the presence of the oncology unit on the site.
- Medical Director is overseeing increased scrutiny of divisional performance with complaint response times with current actions seeing a marginal improvement in response rates but this is expected to show significant improvements once the backlog is cleared and a new operating procedure implemented.

Discussion continued as to the approach being taken to complaints response times and the improved engagement of senior divisional teams. Direct clinician contact by phone or meeting with patients/family is being encouraged but the resource requirement assessment was awaiting the outcome of the quality governance review. These approaches were intended to provide patients and families with more confidence their concerns were being heard (Ref Mr McInerney's question to Board) (Item 6/25) and are part of an approach which would reflect an improved cultural response to complaints, moving away from a traditional legalistic and sometimes defensive approach.

Finance metrics

Karen Johnson, Director of Finance, presented the financial metrics elements of the report for discussion. Overall, the Trust's position was good with a small surplus year to date against a plan of £4.9 deficit. It was noted that the Trust was currently delivering against all 3 national resource matrices; agency spend, year to date delivery of financial sustainability schemes and year to date revenue position. A current slippage in capital spend programmes was highlighted for the Board's attention together with a summary of plans to recover the position through a focus on smaller capital projects as the Trust approaches year end.

People

Claire Radley, Director for People highlighted the content of the workforce slides, particularly the Trust's performance against national targets for the applications to and staff in leadership roles, with a number of actions and recruitment initiatives identified. It was noted that applications received from overseas candidates that would not meet government set visa requirements impacted the data, by reducing the amount of Black and Minority Ethnic applicants which the Trust were able to shortlist. The People and Organisational Development Committee has scheduled a 'deep dive' exercise to provide Non-Executive Directors with an opportunity to comprehensively review recruitment data and the various initiatives in place.

The Director for People focused on Workforce Performance Indicators and in particular performance against target for appraisals and essential training, reminding executive colleagues of the importance of timely completion of both appraisals and training if the Trust is to support the development of its people. Whilst no area was reaching the 90% target for appraisals corporate is significantly below target at 67%. This was a concern and various actions were planned including a deep dive exercise to understand the factors that relate to reporting compliance and the introduction of new appraisal paperwork and the potential to digitalise the process. The variable mandatory training rates were noted with concern, with medical workforce having the lowest compliance levels. The reasons for this were being examined with the support of the Medical

	Director's Service. One issue was the nature of the training grade medical staff's employment. This cohort are with the Trust for relatively short periods as part of the rotational training programme. Work was being done to address this issue with a move to adoption of the NHSE Digital Staff project which enables increased passporting of training across NHS Organisations. The Chair noted the continued commitment to Equality, Diversity and Inclusion work which must remain a central issue for the Trust. **RESOLVED:** The Board NOTED the contents of the Integrated Performance report and associated metrics and remedial actions for assurance.
15/25	**Annual Organ Donation Report** Prof Mark Pietroni, (Medical Director & Director for Safety) and Ian Mean, Chair Gloucestershire Organ Donation Committee and colleagues
	Prof Mark Pietroni presented the report for potential and actual organ donation within the Trust, benchmarked alongside trusts which have a similar donation potential, with the focus being on four main performance indicators: • Referrals – consistently high • Neurological death testing – in line with national trends • Specialist nurse presence – consistently good with support sought if they are able to attend within required timescales • Consent – nationally, consent rates have been a challenge in the last couple of years and this is echoed at the Trust with a downward trend in the last year. During the period (April 2023 to March 2024) from 8 consented donors the Trust facilitated 7 actual solid organ donors resulting in 14 patients receiving a life-saving or life-changing transplant. This was the output from 81(37 meeting national criteria) referrals during the year. The Board were joined by Ian Mean, Chair Gloucestershire Organ Donation Committee and colleagues from the Organ Donor team to hear directly about the work of the team, with a particular focus on tissue donation. The team were also joined by Toni, who was sharing his story as both an employee of NHS Blood & Transplant and a cornea donation recipient and its positive impact on his life and his ability to support the work of NHSBT cornea service. The Chair offered thanks on behalf of the Trust for the dedicated and effective work of the Organ Donation Team. Their work with colleagues across the two hospitals had benefitted many patients, and the increasing corneal donations were a pleasing development. **RESOLVED**: The Board NOTED with thanks the presentation from the Organ Donation Committee and team and NOTED the report for assurance.
PEOPLE AND ORGANISATIONAL DEVELOPMENT	

16/25	**People and Organisational Development Committee Key Issues and Assurance Report (KIAR)** Sally Moyle, Associate Non-Executive Director in the absence of Balvinder Heran, Non-Executive Director provided the report on behalf of the Committee and confirmed that discussions were continuing as to the governance structures in relation to health and safety, with a desire to find a single Committee focus. Kerry Rogers, Director of Integrated Governance commented on the challenges of any single committee given the breadth of matters needing oversight, further advising the Board of the work which was being undertaken on routes of escalation and the introduction of the Health and Safety Committee Key Issues and Assurance report before the operational leadership team, at Trust Leadership Team meetings. Additionally, the governance team are exploring additional Health and Safety assurance reporting to the Audit and Assurance Committee. The Chair requested that a report be prepared for the next Board meeting as to the governance structures for Health and Safety. Kay Law-Fox indicated that Gloucestershire Managed Services would welcome a report that looked to streamline the lower levels assurance meetings with volume of meetings not necessarily equating to assurance. **ACTION:** The Director of Integrated Governance to provide a report to the Board of Directors meeting in March regarding plans for Health & Safety oversight and reporting. **RESOLVED:** The Board NOTED the report for assurance.
FINANCE AND RESOURCES	
17/25	**Finance and Resources Committee Key Issues and Assurance Report (KIAR)** Jaki Meekings-Davis, Non-Executive Director, provided an update on matters discussed at the Finance and Resources Committee meeting in November 2024 and a shorter meeting in December 2024. The Board was updated on the organisation's financial position which was overall positive, subject to the caveat that the long-term position will be challenging with difficult decisions to be made on resourcing with it also being recognised that there would be an impact of capacity constraints as a result of poor estate. Also highlighted for the Board's attention was the potential impact of the new Procurement Act, which will come into force in February 2025, alongside the positive progress made with digital transformation work, including the introduction of the Electronic Patient Record system in Dermatology and a focus on clinical coding. Any impact of the Procurement Act on the Standing Financial Instructions would be considered for inclusion by the Finance Team and would be subsequently reported as necessary. **RESOLVED:** The Board NOTED the report for assurance.
STANDING ITEMS	
18/25	**Any other business**
	There was no additional business.
19/25	**Governor observations**
	Andrea Holder, Lead Governor, extended her congratulations to Asma Pandor on the honour received and commented on the very brave and positive patient story provided by Andy and she noted the very positive news that a Urology assessment service was up and running. She reiterated the Governors keenness to engage with the development of

	the Trust's strategy on behalf of members, an offer that both Chair and Director of Improvement and Strategy acknowledged with a number of engagement opportunities planned.
20/25	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.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
14/25	Report to Board and Quality & Performance Committee providing an update on	Chief Operating Officer and Medical Director	
16/25	Report to Board on Health & Safety assurance routes	Director of Integrated Governance	

Gloucestershire Hospitals
NHS Foundation Trust

Chair's Report to Board of Directors

March 2025

1. Purpose

This report describes some of my activities as Chair of the Trust since the January 2025 Board meeting, 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.

2. Appreciation

This Board meeting is the last one which Balvinder Heran and Mike Napier will attend as Non-Executive Directors of the Trust. They have both fulfilled two terms and served the Trust for over six years. Mike is currently our vice chair and has chaired our Estate and Facilities Committee and our Commercial and Innovation Review Group. Balvinder is currently chair of our People and Organisational Development Committee and has been our Non-Executive Freedom To Speak Up Guardian. Both have made a huge commitment to the Trust in terms of their assurance roles and in a range of other ways such as visiting services, chairing Consultant appointment panels and in Board development settings.

3. New Non-Executive Directors and Associate Non-Executive Directors

Following a huge response to our advertisement for Non-Executive Directors we have concluded the selection process and appointed two new full Non-Executive Directors and two Associate Non-Executive Directors. They will take up their roles in May 2025.

These are Governor led appointments and I was particularly grateful to Peter Mitchener for chairing the stakeholder focus group and to Andrea Holder and Mike Ellis for serving on the interview panel. I am also grateful to Jane Cummings, vice chair of the Integrated Care Board for being our external assessor; its always helpful to have support from our Integrated Care Board or our colleagues from Gloucestershire Health and Care

4. Quality, safety and patient experience

The Chief Executive and I attended the graduation events for the Gloucestershire Quality Improvement Academy on 10th February. This included a dedicated session on Maternity Quality Improvement projects which are one element of the Maternity Incentive Scheme which was approved at a single item Board meeting on 13th February.

Some Non-Executive colleagues were able to join with our Executives to visit Salisbury Hospital to learn about how they have embedded quality improvement in everything they do. This learning is to help us strengthen our approach to Quality

Improvement and to build on the strong record of the Gloucestershire Quality Improvement Academy

5. Governance and Assurance

Over the past few months, the Board has been working with our Governors to review how we work together and specifically how we can review and develop the Council of Governors meetings to focus more fully of patient experience and outcomes and colleague experience. We believe this is a helpful development from our previous practice in which the Council of Governors replicated assurance reports which had been through Committees and Board. We are keen to ensure that all governors feel encouraged to speak at meetings and are on an equal footing with Board members.

I am arranging to spend time with each of our staff governors to shadow them and understand their role more fully. They, in turn are working with Claire Radley our Director for People and James Brown our Director for Communications and Engagement on how we can publicise what they do and seek feedback as well promoting the profile of people issues within the Council of Governors

6. Visits and ambassadorial roles

Since the January Board meeting my visits and ambassadorial commitments have included

- Meeting with Olly Warner, one of our staff governors and attending his team meeting of all the site-specific cancer support workers whom he manages. In this meeting a cancer coordinator and a social prescriber from different GP practices attended to talk about their work and how the cancer support workers can link even better with primary care
- Meeting with Samantha Bostock, one of our staff governors who is a radiographer specialising in holistic care of people who are affected by the late effects of radiotherapy. This is a service which is not fully recognised nationally and in which Sam is coordinating and providing a forum for other colleagues across the South West who are providing a similar service.
- Visiting our Microbiology department and spending time with John Boyes its Specialty Director to learn about his Quality Improvement work
- Visiting Maggie's Centre which supports people with cancer and their families
- Visiting the pharmacy outpatient service in the Oncology Centre and the pharmacy manufacturing unit which makes up our cancer treatments on site
- Opening the Menopause Café meeting

7. Contributing to our One Gloucestershire Integrated Care system

Discussions at the One Gloucestershire Integrated Care System are focussed on how we can deliver the 25/6 Operational Plan which requires that all organisations release at least 1% cash and 4% in productivity. I also attend the Health Overview and Scrutiny Committee which has an interest in the intense Operational pressures we are currently facing and which impact patient outcome and experience.

Chief Executive Report to the Board of Directors – March 2025

1. People and Culture

1.1 Transition CEO of NHS England

Amanda Pritchard has announced her decision to stand down as Chief Executive at the end of this financial year.

Amanda became the first woman to hold the post and has been Chief Executive since August 2021 and Chief Operating Officer since 2019, leading the NHS through the most challenging period in its 76-year history.

Sir James Mackey will be taking over as Transition CEO of NHS England, working closely with Amanda throughout March, before taking up post formally from 1 April 2025. He will step in on a secondment basis, with a remit to radically reshape how NHS England and DHSC work together. To ensure a smooth transition, he will work closely with Amanda until the end of her time in post.

Sir James is currently the Chief Executive of Newcastle Hospitals Foundation Trust and National Director of Elective Recovery, with demonstrable experience of leadership at a local, regional and national level.

1.2 Appointment of new Chief Executive of NHS Gloucestershire ICB

Sarah Truelove has been appointed as the new Chief Executive of NHS Gloucestershire ICB and will take up her post during the summer of 2025.

Sarah was previously Deputy Chief Executive and Director of Finance at Gloucestershire Primary Care Trust for three years and this was followed by four years in the same role at Gloucestershire Hospitals NHS Foundation Trust.

Sarah has built up substantial leadership experience over her 30-year career in the NHS and will be joining the ICB from NHS Bristol, North Somerset, and South Gloucestershire ICB where she has been Deputy Chief Executive and Chief Finance Officer since 2018.

1.3 Appointment of new Chief Executive of Gloucestershire County Council

Jo Walker has been appointed as the new Chief Executive of Gloucestershire County Council. Having served as Chief Executive of North Somerset Council for the past six years, she brings a wealth of experience, including effective leadership during the Covid-19 pandemic.

Her extensive background encompasses regional and national engagement, demonstrated by her success in securing substantial government funding through partnerships like the West of England Combined Authority and the Western Gateway.

Her involvement with the Bristol, North Somerset and South Gloucestershire Integrated Care Board, and her leadership on the Mental Health, Learning Disability and Autism Health System Transformation Board, highlight her commitment to improving health and social care outcomes.

Jo previously held senior positions at Gloucestershire County Council, providing her with a deep understanding of the county where she has also lived for more than 30 years.

1.4 Devolution and ‘strategic authorities’

The government's new devolution white paper (published December 2024) sets out the intended approach to accelerate and standardise the processes by which it passes powers, funding and programmes from Westminster to local areas.

A key element is the creation of "strategic authorities" for areas with over 1.5 million people, with varying power levels based on maturity and mayoral leadership. The aim is universal coverage, ideally with elected mayors, accelerated by a priority programme and elections from May 2026.

The new and statutory devolution framework sets out the areas of competence for strategic authorities. While many of the listed areas are consistent with previous devolution deals, the inclusion of health, wellbeing and public service reform highlights the key role of strategic authorities in addressing the social determinants of health and moving to a more holistic approach, organised around service users.
This will clearly have an impact on our local and regional system and may influence some of the future direction of services.

1.4 Staff Iftars and Fasting Buddy

This year the Trust will again celebrate Ramadan which will start on the sighting of the moon on 28 February or 1 March 2025 and will last for 29 / 30 days. Over the last two years, the Trust has established support for staff and patients, including advice and guidance for colleagues observing fasting during the month of Ramadan. This guidance includes information about how best to plan ahead with a line manager, being considerate of other Muslim colleagues' requirements and requesting leave as appropriate.

We have also held a number of Iftars, the meal served at the end of the day during Ramadan, and again this year we plan to hold two staff events, at Cheltenham General Hospital's Blue Spa, on Thursday 6 March, and Fosters Restaurant, Gloucestershire Royal Hospital, on Thursday 13 March, both at 5pm. The catering team at Gloucestershire Managed Services (GMS) will provide a wide range of food and drink including Halal and vegetarian options.

1.5 National Apprenticeship Week

This year's National Apprenticeship Week (10 to 16 February 2025) was a huge success with many colleagues shining a light on the important contribution and opportunities available through our apprenticeship career pathway.

The Trust and GMS currently has 290 apprentices which includes both existing staff on apprenticeship schemes and those who have been recruited specifically on an apprenticeship. Apprenticeships and T-Levels are just some of the ways we want to create life-changing opportunities and reach out to all parts of our Trust and the wider local community, giving everyone the chance to do something really special.

Throughout the week, the Apprenticeships Team created a range of podcasts providing important information and raising awareness. These can be found on Gloucestershire Hospitals YouTube Channel. They also handed out certificates to apprentices who were nominated for their hard work, covered case studies featuring those studying apprenticeships and T-Levels, and shared infographics showcasing the growth of apprenticeships and T-Levels at Gloucestershire Hospitals.

1.6 Healthcare Science Week

Although Healthcare Scientists make up less than 5% of the NHS workforce, they play a crucial role in over 80% of patient diagnostic tests. These professionals are at the forefront of medical research and innovation, continuously working to enhance patient care.

On Saturday, 8 March, at Cleeve School in Cheltenham, the team showcased their skills and the vital contributions of Healthcare Scientists in delivering patient care. Their aim: to inspire the next generation of healthcare professionals. The event was open to Year 7 students, college students, and parents or carers exploring career opportunities, and offering a valuable insight into this dynamic field.

With more than 20 interactive stands featuring Healthcare Scientists and Allied Health Professionals, attendees will have the opportunity to meet experts who will share their career experiences and passion for their work.

Visitors will also be able to explore the science labs and take part in exciting experiments throughout the day. The 'We Want You' team will be available to provide expert coaching and guidance, along with insightful presentations from healthcare teams to further understanding of the profession.

2 Performance

2.1 Urgent and Emergency Care

Following a challenging start to 2025, January has seen general stabilisation following the intensity of the Critical Incident (8 - 13 January). There has been much learning and reflection internally and across the system and we are already shaping our Policies and Winter 2025/26 plan now. This will allow Divisions the time to prepare rosters and leave in plenty of time to be better placed to respond and ensure the lead up to Christmas and post-holiday response is supplemented.

There were 1400 fewer attendances in January, due mainly to the week of Critical Incident where our local community heard and responded to our pleas for help and not come to the EDs unless it was an emergency. Other indicators also improved including the time to Triage, Time to see a clinician and time spend in ED.

Performance against the 4-hour standard improved slightly with the presence of senior decision makers throughout the period of the Critical Incident from 61% to 63%; Progress against our plans to offload Ambulances more quickly were hit by the very long waits at the beginning of the month, but the ED team, working with SWAST have worked incredibly hard to minimise the impact and recover. Our average handover time increased by 3 minutes from December.

Key challenge for all of the System is the increase in patients waiting to be discharged to another care setting, which is above our target and sits at around 140 currently. We continue to discharge over 100 patient home (P0) and require our colleagues in the ICB to help us discharge a further 20 patients each day. Compared to December when none of the 15 improvement measures showed deterioration against the November position, 11/15 measures showed improvements. Recovery from the challenges presented by the Critical Incident has been sustained.

2.2 Elective (Planned) Care

There is continued positive progress with elective recovery, particularly in relation to the reduction and elimination of 65-week and 52-week breaches for Referral to Treatment (RTT) patients.

At the end of January 2025 GHFT submitted a return detailing 12 patients that had waited more than 65 weeks for treatment. However, all 12 patients are effectively excluded due to the national shortage of material or equipment that prevents these patients from having treatment (namely corneal grafts (9) and patellofemoral joint replacements (3)). Organisationally we are measured against those who are able to be treated in month, meaning that for both December and January a zero-breach position has been achieved.

In conjunction with reducing the risk of 65 week breaches, considerable focus has been placed on reducing those patients waiting 52 weeks or more. At January month-end the validated position was 946 patients breaching this standard, compared to 1,256 in December and 1,479 in November.

The most recent part validated position w/c 23/02/25 demonstrates there are 714 patients currently waiting 52 weeks or more. For context, previous recorded peaks were 3,061 in March 2021 (covid) and 3,022 in August 2023 (industrial action), with current performance demonstrating a notable improvement. Specialties remain committed to reducing this further and continue to work hard in offering additional outpatient clinics and operating lists in order to accelerate treatments, whilst also redesigning referral pathways to avoid unnecessary referrals into the Trust from primary care.

3. Quality & performance

3.1 Carers' Charter Launch

The newly created carers' charter was launched on 19 February in the Atrium at GRH with staff and carers from the community who all helped to shape this charter. The charter summarises what carers can expect from the Trust and how they can support.

In Gloucestershire alone, there are over 52,000 unpaid carers and we are committed to ensuring that carers are identified and supported when they come into our hospitals. They often have crucial insights into a patient’s needs - whether it’s communication preferences, ongoing medical support or medication history.

Carers also play a key role in ensuring a safe and well-planned discharge from hospital and we are very grateful for the partnership we have with them in this process. By working together, we can make sure patients receive the most appropriate care and feel more at ease during their time with us.

This charter runs alongside initiatives like the carers' passports and carer boxes that have been designed to offer support and information to carers.

3.2 Groundbreaking Cancer Surgery

An expert multidisciplinary team at Cheltenham General Hospital has performed the first keyhole total pelvic exenteration in the South West region. This landmark procedure took place on Tuesday 14 January at Cheltenham General Hospital.

A team of highly skilled experts from Gloucestershire Hospitals NHS Foundation Trust were involved in the operation, including the gynaecological oncology team led by Mr Philip Rolland and Miss Kathryn Hillaby and supported by Mr Ed Tudor (urological cancer surgery), Mr Jon Cutting (colorectal cancer surgery), Dr Sheila West (anaesthetics), Miss Alison Montgomery (Subspecialist Trainee), and the Theatre 4 and Surgical Care Practitioner (SCP) team of Ann Stephens, Bilgy Pellisery and Jahra Catungal.

Pelvic exenteration is one of the most complex surgical procedures in the field of surgical oncology, typically reserved for patients with advanced or recurrent cancer in the pelvic region that cannot be managed with other treatments. The surgery involves the removal of multiple organs from the pelvic cavity, such as the bladder, bowel and reproductive organs, depending on the extent of the disease.

Traditionally performed through open surgery involving a large abdominal incision, such major surgery often results in lengthy recovery periods and extended stays in critical care. The operation is designed to cure recurrent gynaecological cancer in the pelvis following radiotherapy.

4. Strategy

4.1 Third IGIS Lab Opens

Following a short delay, Cath Lab 3 in our Imaged Guided Interventional Surgery (IGIS) hub opened at Gloucestershire Royal Hospital on Monday 3 February 2025. This is the final stage of the programme and a major milestone in the delivery of our centres of excellence vision.

Under the IGIS programme the Hospitals Trust has brought together staff and resources to establish a 24/7 hub for IGIS, comprising interventional radiology, vascular surgery and interventional cardiology at GRH.

A satellite IGIS service will operate from CGH, with an interventional surgery suite supporting some elective work alongside urology and cancer image-guided surgery.

4.2 Hyper-Acute Stroke Unit (HASU)

The Hyper-Acute Stroke Unit (HASU) at Cheltenham General Hospital has successfully been re-housed at the newly refurbished Hatherley Ward (5 February 2025).

This significant development brings enhanced facilities and a consolidated specialist team, ensuring first-class care for stroke patients across Gloucestershire and beyond. Alongside IGIS this programme of work is one of the last pieces of jigsaw in enabling our centres of excellence vision.

The new HASU consolidates expertise bringing together specialists and state-of-the-art equipment to provide first-class stroke treatment. Research shows that patients treated in dedicated stroke units experience better outcomes, including reduced mortality rates and fewer long-term disabilities, compared to care provided in general medical wards.

Patients typically remain in the HASU for up to 72 hours before being moved to a specialist ward, such as Woodmancote Ward at Cheltenham General Hospital or the rehabilitation ward at Vale Community Hospital.

Key features of the HASU include:

- Rapid assessment: Patients are quickly assessed upon arrival to determine the most effective treatment pathway.
- Early treatment: Cutting-edge therapies such as clot-busting thrombolysis are administered where necessary and patients who require mechanical thrombectomy are referred rapidly to Southmead Hospital.
- Continuous care: High-dependency beds offer 24/7 monitoring and advanced physiological support.

Stroke care extends beyond the hospital stay. Once stabilised, many patients transition to a specialist rehabilitation ward or receive support in their home or residence from the Stroke Early Supported Discharge Team provided by Gloucestershire Health and Care NHS Foundation Trust. This team helps patients regain independence while transitioning back home, offering tailored therapy and ongoing support.

4.3 New Radiotherapy Truebeam Linear Accelerator Installed

A new Radiotherapy Truebeam Linear Accelerator at Cheltenham General Hospital has been installed by Varian and handed over to our team. Our Medical Physics department is currently undertaking the commissioning process, with the aim of beginning patient treatments in Spring 2025.

As part of our naming tradition, each unit is named after the tree depicted in its sky ceiling and this new unit will be known as "Oak." This addition marks an important milestone for the Radiotherapy department, as it ensures that all our high-energy treatment units are fully aligned, allowing for more streamlined and standardised processes in cancer treatment delivery.

Kevin McNamara
Chief Executive

Report to Board of Directors

Date	13 March 2025
Title	Board Assurance Framework Update
Author	Sarah Favell, Trust Secretary
Sponsoring Director	Kerry Rogers, Director of Integrated Governance

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

The purpose of this report is to:

1. Provide the Board with an update of the position regarding the alignment of the Board Assurance Framework with the Trust's Strategy 2025-2030;
2. Provide a summary update of the Trust's Strategic Risks as at 1 March 2025, since the last update before the Board in November 2024;
3. To seek Board's approval to a new risk for inclusion in the Board Assurance Framework which captures the essence of a strategic risk concerning compliance with Health and Safety (H&S) Regulations. The appendices include a working draft of this risk which is still being contributed to through discussion with the wide array of functional leads across the Trust's H&S environment, and is being influenced by the discovery phase of the H&S Management Framework and the work of the Fire Task and Finish and Rapid Improvement groups.
4. As previously recognised by the Board, the Trust is in a period of transition in terms of the right time to consider holistically that the Trust's strategic risk profile remains relevant. As the new Strategy is finalised it has previously been agreed that the current Board Assurance Framework risks will require alignment to the Strategic Objectives that will be identified through the strategy review process. It is anticipated that a significant number of Strategic Risks will remain unaltered as the focus remains on patient care, staff and culture and financial performance but the detail/description of the risks and supporting controls may be subject to significant review.

Risks or Concerns

1. Following changes of personnel within the Corporate Governance team it is recognised that there is a need to review the current process for the review of Strategic Risks with both Executive Leads and to refresh the Committee process. This will be undertaken on identification of the Strategic Objectives, and consequent risks following the finalisation of the Trust Strategy. This is anticipated for the period April to October 2025.
2. During the transition, the Director of Integrated Governance is keen to ensure the focus of Executives and Board Committees is centred around the reliance placed on the controls to manage risks to the reported residual levels and to achieve target rating. To do that, a greater emphasis needs to be placed on the degree of confidence taken from the evidence presented (3 lines of assurance model) that controls are indeed effective, or plans to address gaps are progressing to target.

Financial Implications

None identified

Equality, Diversity, Inclusion and Workforce Implications

None identified

Sustainability (Environmental) Implications

None identified

Recommendation

The Board is invited to:

1.1. **NOTE** the content of this report and continue to support the plan to align the refresh with the next phase of the strategic direction of the Trust as determined by the impending Strategy approval.

1.2. **APPROVE** adoption on the Framework and the continued development of the new risk concerning Health and Safety regulatory compliance. Broader description of the improvement journey is outlined in the separate Health & Safety Report on the Board agenda.

1.3. **SUPPORT** Board Committee involvement in ongoing developments in scrutiny and oversight of the effectiveness of controls in order to be assured of the management of risk.

Enclosures

Board Assurance Framework Summary : March 2025
Board Assurance Framework New Risk: Health and Safety DRAFT

BOARD ASSURANCE FRAMEWORK
UPDATE REPORT MARCH 2025

1. CONTEXT

1.1. The Board Assurance Framework is an essential strategic tool, designed to identify manage and mitigate strategic risks to ensure the delivery of safe, effective and sustainable healthcare services. It highlights the Trust's major risks as identified by the Board, that could impede the Trust's strategic objectives, offering a structured approach to risk management that aids in decision-making, strategic planning, and resource prioritisation.

1.2. It is important that the Board Assurance Framework is used to enhance accountability, transparency and compliance with regulatory requirements, integrating risk into the overall governance framework and promoting continuous improvement through regular reviews.

2. PURPOSE OF REPORT

2.1. To provide a summary of the current position as regards implementation of a risk management approach for Strategic Risks within the Board Assurance Framework.

2.2. To provide a snapshot picture of the Strategic Risks as at 1 March 2025.

3. CURRENT BOARD ASSURANCE FRAMEWORK PROCESS

3.1. It is acknowledged that there has been a period of significant transition within the Corporate Governance team from 2023 to date with a number of new substantive appointments following a period of interim management. It has been identified that the risk management process in place for the review of Strategic Risks has been adequate during this period but there is now an opportunity to review current process and implement significant changes to improve the mechanisms in place.

3.2. This work will be carried out in parallel with the development and approval of the Trust's next Trust Strategy, and is anticipated to be finalised in Summer 2025.

3.3. This work will be undertaken by the Trust Secretary and involve a series of reviews of each Strategic Risk with the relevant Executive Lead to assess the currency of the risk as drafted, the effectiveness of mitigation and controls and the scoring applied. This work will be done in conjunction with members of the Risk Management team and with appropriate oversight from the Risk Management Group.

3.4. Additionally, the Trust Secretary will meet with each Board Committee Chair to develop guidance as to the scrutiny of Strategic Risks at Committee as, whilst there has continued to be effective review of the risk descriptions and changes month on month, there is potentially a lack of consistency of approach across the Committee structure. The Director of Integrated Governance is keen also that Committee

scrutiny of risks is much more deliberately focused on the confidence held by the executives that the controls as described are effectively mitigating the risks such that members of the Committees can be assured accordingly.

3.5. There will be a review of Trust Risk Management policies, to the extent relevant to the management of Strategic Risks within the Board Assurance Framework, including the process for identifying new risks to be considered as Strategic Risks, formulating those risks, relevant controls and mitigations

3.6. As part of the alignment work with the strategy development process, there will be a review of the Board's risk appetite statement.

4. CURRENT STRATEGIC RISK SUMMARY

4.1. The Board is invited to note the Summary Report annexed to this report.

4.2. The current risk Strategic Risk ratings considered by each of the three Board Committees; Quality & Performance Committee, People & Organisational Development Committee and Finance & Resource Committee remain unaltered (in terms of scoring) since the last report to Board in November 2024

4.3. A number of Strategic Risks have been considered at Committee during January and February with minuted discussions, updates to actions and control logs but no change to their risk scoring.

4.3.1. Finance and Resource Committee have reviewed Strategic Risks 9, 10, 11, 12, 13 and 14 with Strategic Risks relating to digital risks to be subject to detailed future review following the appointment of the Chief Digital Information Officer with no change to scoring or core controls.

4.3.2. People & Organisational Development Committee has reviewed Strategic Risks 16 and 17 with no change to scoring or core controls. Strategic Risk 7 is to be reviewed.

4.3.3. Quality & Performance Committee has reviewed Strategic Risk 2 with updates to actions and controls.

5. NEW BOARD ASSURANCE RISK

5.1. The Board is invited to APPROVE the addition of a new risk in relation to Health and Safety. A draft of the risk is included along with a draft of the control framework, both areas of which are currently being consulted upon with a number of topic experts across the Group.

5.2. It is proposed this risk will be assigned to the Audit and Assurance Committee with additional ownership of the staff wellbeing aspects via the People and Organisational Development Committee.

6. RECOMMENDATIONS:

The Board is invited to:

6.1. **NOTE** the content of this report and continue to support the plan to align the refresh with the next phase of the strategic direction of the Trust as determined by the impending Strategy approval.

6.2. **APPROVE** adoption on the Framework and the continued development of the new risk concerning Health and Safety regulatory compliance. Broader description of the improvement journey is outlined in the separate Health & Safety Report on the Board agenda.

6.3. **SUPPORT** Board Committee involvement in ongoing developments in scrutiny and oversight of the effectiveness of controls in order to be assured of the management of risk.

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
1.	**We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges**								
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	June 2024	June 2024	CNO/MD/COO	QPC	3x3=9	N/A	5x5=25
SR2	Failure to successfully embed the quality governance framework	Dec 2022	October 2024	February 2025	CNO/MD	QPC	3x4=12	4x4=16	5x4=20
2.	**We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people**								
SR16	Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve. (Culture and Retention)	Feb 2024	September 2024	January 2025	DFP	PODC	3x4=12	N/A	5x4=20
SR17	Inability to attract a skilful, compassionate workforce that is representative of the communities we serve (Recruitment and attraction)	May 2024	May 2024	January 2025	DFP	PODC	3x4=12	N/A	5x4=20
3.	**Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other**								
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	October 2024	October 2024	MD/CNO	QPC	2x3=6	N/A	4x4=16
4.	**We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners**								
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	Apr 2024	Apr 2024	COO/DST	QPC	2x3=6	N/A	4x3=12

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**								
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	May 2024	May 2024	DFP	PODC	1x3=3	3x3=9	3x2=6
7.	**We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources**								
SR9	Failure to deliver recurrent financial sustainability	July 2019	October 2024	February 2025	DOF	FRC	2x4 = 8	5x1=5	5x5=25
8.	**We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact**								
SR10	The risk to patient safety, quality of care, reputational damage and contractual penalties as a result of the areas of poor estate and the scale of backlog maintenance.	July 2019	October 2024	February 2025	DST	FRC	4x4=16	N/A	4x4=16
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	October 2024	January 2025	DST	FRC	3x3=9	N/A	3x3=9
9.	**We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care**								
SR12	Failure to detect and control risks to cyber security	Dec 2022	October 2024	October 2024	CDIO	FRC	5x3=15	N/A	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	October 2024	October 2024	CDIO	FRC	2x3=6	N/A	3x4=12
10.	**We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK**								
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	May 2024	January 2025	MD	CIRG	2x3=6	N/A	3x4=12

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY 2025

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
	Failure to take all reasonable steps and exercise all due diligence to prevent the breach of any health and safety regulations	A well-led and established integrated governance framework that meets the needs of the Trust, its wholly owned subsidiaries and other entities and allows for assurance in relation to compliance for health and safety	Failure to implement a robust and integrated health and safety governance framework to support health and safety compliance across the Group (Trust and GMS) and provide robust mechanisms of assurance. A lack of confidence exists in the governance reporting structure between the two organisations. This includes for key areas including, but not limited to: • Water safety • Fire safety • Decontamination • Asbestos management • Ventilation • Waste • Pressure system • Medical gases • Electrical safety • Contracting arrangements	• Unidentified non-compliance leading to harm to staff, patients and visitors • Prosecution by enforcing authorities for systemic or persistent breach of regulations • Fines (into £millions) • Duplication of reporting in some areas and / or inadequate reporting in others within the Group • Personal injury claims and legal fees or complaints • Inquest • Reputational damage / adverse press	Audit & Assurance Committee	LT	#943 (H&S) #368 (asbestos) #355, #377, #765, #810 & #840 (water) #55, #87, #95, #125, #239, #363, #374, #456, #461, #586, #658, #674, #680, #686, #791, #844 and #886 (fire) #55, #399, #344, #352, #452, 842 (ventilation) #655, #422, #268 (access) #364, #375 (electrical) #653 (waste) #869 (decontamination)

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	The Trust has identified gaps in governance which prevents transparency and integrity in relation to safety performance, reporting or assurance within the Group. This places the Group at risk of unchecked poor performance. Examples include: • Lack of robust fire strategy • Lack of robust asbestos management plan • Lack of cohesion of estates strategy to known estates risks	**3x2=8**	There will always be a risk of harm within the healthcare environment. The target score is based on the potential for moderate harm or breach of legislation (3) but with a low likelihood of this occurring. This would be achieved with robust governance that identified gaps at the earliest opportunity, addressed them and provided assurance of a fit for purpose compliance process.	**Risk opened in February 2025**

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

	• Capital planning and funding allocation not aligned to health and safety risks • There is no a full compliment of working groups to support operational management and under pin the strategic committees • Lack of accountability within some operational groups • CQC identified governance weakness increasing likelihood of regulatory intervention			

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Trust H&S Committee • Trust Health & Safety Policy and associated subject-specific policies • GMS Board and health and safety committee • Reporting to Trust leadership team • Appointed exec with accountabilities	• H&S Governance Framework • Fire strategy • Estates strategy • ICS / ICB estate strategy – needs to be aligned to Trust estates strategy • Clear accountability in relation to all executives in the Group • Clear roles and responsibilities for each HTM

ACTIONS PLANNED

Action	Lead	Due date	Update
• Develop and implements a H&S governance framework • Review of relevant operational group TORs • Review of exec level accountabilities for HMTs • Develop and implement a Fire strategy • Develop and implement an Estates Strategy aligned to safety risk and the ICB • Task and finish Group for fire and water – review accountability and responsibilities • QIG Fire to progress immediate fire actions • Water, fire and asbestos actions plans	LT Chairs T&F Group ED W C-G W C-G MP Chairs	April 25025 August 2025 May 2025 May 2025 ? ? ? Ongoing	• Draft H&S framework circulated to key stakeholder for initial comments – going to TLT for approval in February • Review of reporting structure for Trust H&S Committee - proposed Group H&SC to report to TLT and A&AC • Review of H&S governance reporting line completed with Quality lead to align with quality reporting • FSP has developed a draft Retrospective Fire Strategy for the Trust • 98 water actions closed, 8 pending evidence to approve closure, 8 ongoing, 1 re-opened • A draft AMP is in progress and revised Asbestos Management policy – next step is consultation • Task & Finish Group – Governance – overseeing

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

• Completion of 98 actions on the pseudomonas plan • Audit reports from AE to go to TLT • Monitoring of actions at operational groups • KIAR reporting	Rated inadequate in AE audit for asbestos Reporting through PODC workstream is ineffective	Revised reporting structure following the work of the task and finish group. Proposed Group H&SC to report to TLT and A&AC

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – FEBRUARY 2025

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. Explicit follow up actions against the various outstanding items have been assigned and owners of outstanding actions will be invited to the April Audit and Assurance Committee to provide explanations.

The delayed Cancer waits audit was now under way. This should complete within the 2024/25 work plan and will be reported back to the Committee in due course.

Two internal items were not RAG rated as they relate to sector updates. These are the Data Security and Protection Toolkit (DSPT) and compliance with the Mental Health Act. Both reports were helpful. DSPT will be included as part of the Finance and Resources Committee work plan. The Mental Health report was a general NHS wide report, and, given extensive recent scrutiny of Mental Health related matters at the request of management, no new actions had been identified.

Draft Internal Audit Plan 2025/26. The draft plan has been the product of extensive executive engagement and provides broad and effective coverage across the key functional areas of the Trust with good coverage of patient facing and focussed services. The Committee were content to approve subject to the potential inclusion of a review of cleaning standards 2021.

The Committee dealt with a confidential matter. This is covered in the confidential minutes of the meeting and is not further referenced in this KIAR.

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	**Maternity incentive scheme** – The report provided an independent assessment of the sufficiency of the evidence provided by the Maternity Service in support of its submission to NHS Resolution that it has complied with the requirements against each relevant Safety Action	Ensure delivery against agreed outcomes in the management responses.

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.

	within the Maternity Incentive Scheme Guidance provided by NHSR. The Committee were assured as to the Trust's compliance. Rated as amber given the current level of scrutiny of Maternity Services and ongoing CQC monitoring.	
	Key financial systems (Accounts Receivable) – Overall moderate assurance assessment for design and operational effectiveness. The review was very helpful, reflective and well received by both management and the Committee.	Will be followed up according to the agreed schedule and F&R will monitor
	Follow up report – Generally looking 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 and follow up work taking place prior to the next meeting of the Committee to address and ideally close off these items.	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. Corporate governance and Finance will follow up on these matters
Board Assurance Framework (BAF) and Risk Register	**Board Assurance Framework and Risk Register** Currently under review and will report to next meeting. No movement in risks position	Committee will receive an update on proposed revised ways of working at its next meeting.
GMS	The Committee received an audit on recruitment which was moderate by design and limited for effectiveness. This reflected challenges in the SLA between the Trust and GMS for the provision of the service to GMS Positive feedback around joint working 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 – Good progress in year. Focus needed on historic 2023/24 actions		
Good focus on non-traditional audit Committee areas, with focus on patient added value		
Matters arising. No outstanding matters on this occasion		

External Audit Comprehensive planning document received which detailed the approach for the forthcoming external audit and time line to deliver end June approval by Board.
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 several contracts.
Single tender actions report – two waivers, with a total value of £820K, both with accompanying justifications
Losses and compensations – £2.3K of ex – gratia payments made and approved write off of 415 invoices totalling £51K.

Health and Safety Management Framework Report to Board of Directors			
Date		13 March 2025	
Title		Health and Safety Management Framework	
Authors **Sponsoring Director and presenter**		Lee Troake, Head of Risk, Health & Safety 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

Presented to the Board is a DRAFT first version of a proposed Health and Safety Management Framework which reflects the intended structures required to deliver the framework. Despite its comprehensive content, this remains a work in progress while a consultation process remains open and until a sub committee and sub group oversight and reporting structure has been finalised that all parties are confident will be effective.

As part of a phased consultation process, divisional leads, GMS, the unions and subject leaders have been invited to provide feedback as part of the first phase, much of which has been incorporated into version 1.2 of the framework. The Trust Leadership Team has now been invited to provide feedback on this version, with a closing date of 14 March 2025.

The Executive Director lead for Health and Safety (H&S) has transferred to the Director of Integrated Governance who has spent recent months understanding the Trust's systems and processes for the management of health and safety. Amongst areas of good practice there are those parts of the system that would benefit from early improvement activity. These include, but are not limited to the following.

- There is scope to realign accountability and responsibility, across the Group, to ensure any gaps in the oversight of health and safety management are closed and to safeguard the appropriate involvement of the workforce and key contractors (e.g. PFI buildings)
- As individual directors and managers, and collectively across the organisation there is a need to ensure ownership, due diligence and clear responsibilities within health and safety to avoid and to address breaches
- Group safety audits would help describe how well the Trust has embedded the management of health and safety and provide a road map for incremental development of the group safety activities
- A solid and consistent escalation protocol would assist in controlling our high-risk environment by challenging established custom and practice and out of date processes head on
- Improved health and safety training, promotion and communication could better raise health and safety awareness in an environment where it's difficult to get people invested and caring about something they find unchanging.

Within the current governance structure, the Trust Health and Safety Committee (Trust H&SC) reports into the People and OD Committee (PODC) and upwards to Board. Regulatory intervention in 2024 highlighted a lack of escalation of key health and safety matters from the sub-board committee to Board, and ongoing assessment of the H&S architecture recognises the

need to strengthen the remit and import of the Trust H&S Committee.

The proposed framework considers leadership including the visibility of Board members in this area through health and safety site visits, as well as the integration of health and safety within our decision making.

It aims to define group accountabilities and a common suite of standards to ensure consistency in group performance, while maintaining the separate legal responsibility, implementation and day to day management within the Trust and GMS respectively. This includes a more proactive and transparent approach to finding gaps in our controls and seeking to address these as a group.

The proposals include the strategic Trust H&SC being reshaped into a Group H&SC where both the Trust and GMS contribute equally. This is likely to include transferring specific H&S compliance-reporting by GMS from the Contract Management Group to the more visible and centralised space of the new Group H&S Committee. This will allow divisions to escalate estates related health and safety issues at the Group H&SC where sub-chairs and specialist staff from GMS and the Trust can better support a solution.

The Group H&SC would report to the Trust Leadership Team to secure the input of senior leaders into key health and safety matters.

Key matters for escalation will be included in the KIAR from TLT to the Board, an escalation mechanism currently used for high-risk areas of water and fire which has proven successful. The Board will, as a minimum, receive an annual group health and safety report to satisfy is statutory obligations and all Board members will receive training on those obligations.

Assurance reporting from the Group H&SC would move from PODC to Audit & Assurance Committee for an independent overview of compliance matters as part of reviewing the system of internal control. It would retain links to PODC in relation to building a strong health and safety culture, involving employees and with a focus on workforce wellbeing, work-related sickness and the working environment (e.g. welfare facilities, lighting, heating and ventilation). Links to Quality Performance Committee (QPC) will also be strengthened in relation to infection control and water safety.

Further work, following the outcome of consultation, intends to streamline the reporting structures of the numerous operational, working and sub groups with H&S responsibilities. A governance Task and Finish Group is undertaking work to clarify and strengthen governance in two key areas of fire and water safety. The learning from this group will then be implemented in other key health and safety related sub-groups that currently, or should, report to the new Group H&SC and will influence the ongoing development of the proposed Health and Safety Management Framework.

Risks or Concerns

Clarity in relation to accountabilities, duty holders, due diligence and responsibilities across health and safety. Balancing oversight and due diligence with allowing the subsidiary to retain internal control of its own health and safety

Financial Implications

None

Recommendation

The key to the development of our H&S Management Framework is collaboration and the Group organisations' commitment to work together to build on existing foundations to ensure continuous improvement.

On the **recommendation** of the Trust Leadership Committee, Board is invited to:

1. **Approve a recommendation** to the Board to move to a Group Health and Safety Committee from April 2025.
2. **Approve a recommendation** to the Board that the Group H&S Committee report directly to TLT as set out in the Draft Framework and on the system of H&S Management to the Audit & Assurance Committee from April 2025. PODC will continue to receive H&S Reports only with direct relevance to workforce health, safety and wellbeing and against approved performance indicators.
3. **Support the ongoing development** of the H&S Framework and the Board's role in its effective implementation. Members are also invited to contribute to the development of the Framework by providing comments to the Director of Integrated Governance.

Enclosures

Draft Health and Safety Management Framework v1.2

GROUP
HEALTH & SAFETY
MANAGEMENT FRAMEWORK

ROGERS, Kerry (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST)

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

CONTENTS

DN: Finalise following consultation

1. INTRODUCTION

The safety management system is a proactive and integrated approach to managing health and safety. It sets out the structures and accountabilities and it is intended this will continuously be improved. It requires health and safety management to be integrated into the organisation's day to day activities.

An effective safety system and culture requires a shared understanding of safety management principles. There are four recognised areas associated with safety management frameworks, as utilised by such as the Aviation industry, and these will be incorporated accordingly.

- **Health and Safety policy** establishes senior management's commitment to improve safety and outlines responsibilities with consistency, defining the way the Trust needs to be structured to meet safety goals. It outlines the aims and objectives that an organisation will use to achieve its desired safety outcomes.
- **Safety risk management** includes the identification of hazards (things that could cause harm) and risks (the likelihood of a hazard causing harm) and the assessment and mitigation of risks. Once risks are identified and prioritised, appropriate controls can be implemented to reduce the level of risk.
- **Safety assurance** involves the monitoring and measuring of safety performance, evaluating how effectively the Trust is managing risks, the monitoring of risk controls and the continuous improvement of the health and safety management framework.
- **Safety education** includes training, communication and other actions that may help to enable a positive safety culture within all levels of the workforce. It also supports effective two-way communication of safety issues between staff working at an operational level and the organisation's management.
- **Managing change**. Healthcare organisations experience both temporary and permanent change when responding to new demands and when introducing new services. Change may introduce problems that may impact on the effectiveness of care delivery. Process needs to identify unintended consequences that might affect patient safety when new ways of working are introduced.
- **Safety promotion** involves effectively communicating safety risks and how these risks can be managed to both staff and patients.

This health and safety management system is an organised approach to managing safety. It specifies the necessary 'system-wide' processes needed for proactive and reactive safety management. It seeks to proactively mitigate threats to safety before they result in undesirable outcomes. Through the implementation of this safety management system, all those involved in safety can integrate their

activities. This enables a prioritisation of actions to address safety issues and effectively manage resources.

Safety management goes beyond compliance with prescriptive regulations, to a systematic approach where potential safety risks are identified and managed to an acceptable level. This framework intends to enable adoption of a business-like approach to safety, similar to the way that finances are managed, with safety plans, safety performance indicators and targets and continuous monitoring of the safety performance of the organisation. It enables effective risk-based decision-making processes across the business.

[DN: Objectives and KPIs are in the H&S Strategy for 2024-2026- add link]

Risks generated by contracted activities and other third parties should also be considered. Therefore, the Trust's formal agreements with other organisations should include provisions for the management of safety. This should also include reporting procedures for safety related matters. [DN: NEED SECTION ON CONTRACTED ACTIVITIES TO INCLUDE PFI]

2. PURPOSE AND SCOPE

The purpose of a safety management system is to ensure that the Trust achieves its objectives in a safe way and complies with the safety obligations that apply to it. It needs to be a dynamic set of arrangements which grows in maturity and develops as the Trust evolves. This framework is being introduced to improve standardisation in the coordination of health and safety activities within and between the Trust, Gloucester Managed Services and material contractors / stakeholders (e.g. PFI partners), in terms of how risks are escalated and managed.

This document sets out the health and safety management framework applicable to Gloucestershire Hospitals NHS Foundation Trust (parent organisation) and Gloucester Managed Services employees (wholly owned subsidiary); known together as 'the Group'.

It provides information on the system of control within Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and confirms the scope of group health and safety governance arrangements which have been established to ensure proper and effective management of risk, health and safety. It aims to ensure the Group understands the safety of its services and takes an integrated approach to compliance.

This framework document is intended to be a 'living document' which will evolve as the Trust's governance arrangements develop. It will therefore be kept under regular review, with a formal annual review by the Group Health and Safety Committee (Group H&SC) and Board.

The successful implementation of these arrangements requires commitment from all members of staff within the Group. It will give a 'safety voice' to staff, patients and visitors.

3. GUIDING PRINCIPLES

A fundamental set of principles underpin this governance framework. These are:

- **Integrated Board activities, governance and reporting (Trust and GMS) –** silo working within the Group is not only inefficient, but also leaves the Board vulnerable to costly oversights. This health and safety governance structure requires an integrated approach within the Group to serve as a tool for effective Board oversight.

- **Integrated approach to compliance with regulatory and industry standards** – compliance is fundamental to all Board and organisational activities and meeting both regulatory and industry standards will form the foundation of our decision-making. An integrated compliance approach across the Group will uncover insights that might otherwise have remained invisible.

- **Exposure of gaps or weakness** – it is essential a transparent and proactive approach is taken to identifying gaps or weakness in control structures across the Group. The Group should foster a healthy self-assessment culture which optimises opportunities for continual improvement in performance

- **Well-led** – each individual should understand their role and responsibilities in health and safety and demonstrate commitment to achieving a high standard. Accountability is key, as is enabling decision-making at the right level.

- **Strategic audit** – decision makers need data to make effective decisions on health and safety matters. The role of self-assessment, authorised engineer audits, internal auditors, external auditors and independent audits ensure that risks are identified and health and safety management is effective.

Benefits of these guiding principles include:

- **Robust and effective management** identifying, assessing, and managing risks, contributing to better risk management practices
- **Robust compliance mechanisms** and reduced risk of regulatory intervention or civil litigation
- **Clarity of accountabilities and responsibilities** across the group and in relation to the PFI
- **Staff and patient confidence** in our values
- **Transparency** which builds trust, openness and strong relationships
- **Timely** decision-making leading to a better allocation of resources and long-term sustainability
- **Stronger financial performance** as a result of well-informed decision making, and the management of risk before it materialises

The governance structure defined in this framework directs how the Trust and GMS will interact with each other, the regulators and stakeholders on health and safety.

It will centre each organisation's approach around common themes and concerns, will provide a voice to both organisations and confirm authority to make significant health and safety decisions at the appropriate level.

4. COMPLIANCE STANDARDS

Duties relating to health and safety are covered by the Health and Safety at Work etc Act 1974 (HSWA) and associated sets of regulations. Breaches of these duties are a criminal offence and could result in a conviction and large fines for Trust, GMS or both, and in some instances, can result in the criminal conviction, fine, disqualification and even imprisonment of individual directors. Other legislation such as Corporate Manslaughter are also relevant to health and safety.

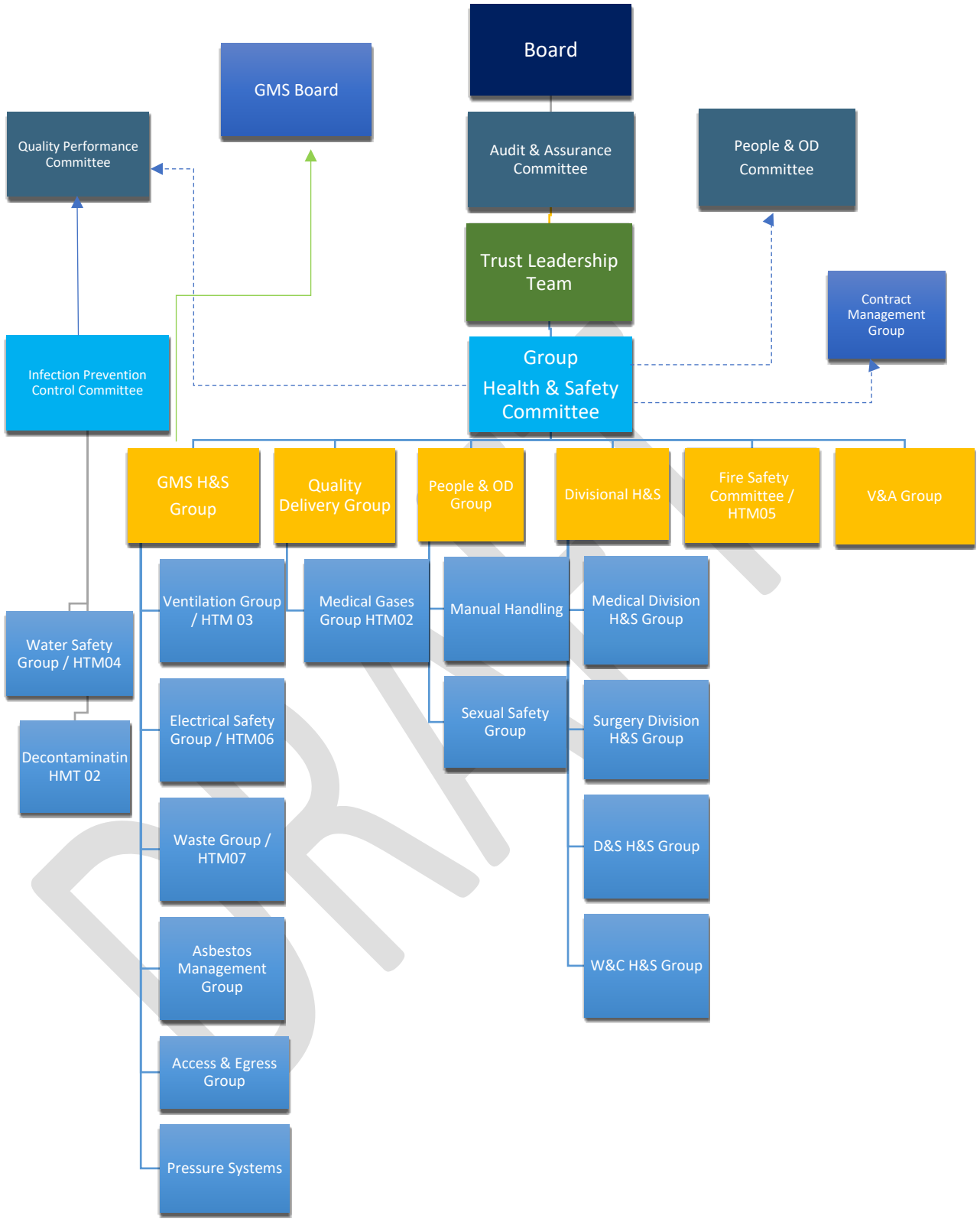
The law protects employees, patients and the public and extends to agency workers and contractors. It is not a defence to any breach that a Board or director has delegated oversight of health and safety, or direct responsibilities, to another. Compliance is not just a legal obligation; it is a conscientious organisational practice.

The Health and Safety Executive and Care Quality Commission enforce health and safety legislation and expect the law, and use associated Healthcare Technical Memorandum's (HTMs) and Approved Codes of Practices (ACOPs) to gauge compliance. An ACOP has a special legal status. If an organisation is prosecuted for breach of health and safety law, and it is proved that it did not follow the relevant provisions of an ACOP, it will need to show that it has complied with the law in some other way or a Court will find it at fault.

A non-exhaustive list of Approved Codes of Practice applicable to health care is provided in Appendix 3.

5. GOVERNANCE STRUCTURE [DN to be finalised following consultation]

Both downstream and upstream health and safety governance flows must be robust and compliance-proof. The Trust has adopted a Group governance operating model to achieve consistency in reporting, minimise duplication and prevent gaps in governance mechanisms. The structure is shown below:



At each level in the structure there are responsibilities and duties expected of members of staff at that level.

Liabilities [place holder]

6. ROLES & RESPONSIBILITIES

The responsibilities of all levels of staff and management are set out clearly in the Trust Health and Safety Policy, along with our Statement of Intent.

The Trust may provide group health and safety standards or expectations which the subsidiary, GMS and PFI contractor is expected to follow. However, each organisation is responsible for ensuring its own legal compliance and for implementing the standards.

A summary of the key responsibilities include: **[DN: include key accountabilities of DH, AE, RP etc. when finalised as part of work on Fire and Water Safety TFG]**

Post	Responsibilities
Chief Executive Officer	Ultimately responsible for compliance of the Health and Safety at Work Act 1974 and other relevant legislation and should ensure, as far as reasonably practical, that there are sufficient resources to discharge its duties
Managing Director GMS	Responsible for compliance of the Health and Safety at Work Act 1974 and other relevant legislation, as well as compliance with the Healthcare Technical Memorandums (HTM) and should ensure, as far as reasonably practical, that there are sufficient resources to discharge these duties
Non-Executive Directors (NEDS) (Trust & GMS)	The role of the NEDs is to scrutinise, constructively challenge and have independent oversight of health and safety at Board level. They will receive assurance from the Chief Executive that health and safety is appropriately managed.
Executive Directors / Directors (Trust & GMS)	Each Executive Director is responsible for promoting a high degree of health and safety awareness, demonstrating good leadership and ensuring a safe environment for colleagues, patients and the public **[DN: reference exec directors' responsibilities in appendix e.g. AS for Fire]**
Executive Director for Integrated Governance (Trust)	Has delegated responsibilities for ensuring a robust strategic approach is adopted, addressing issues of employee's health, safety and wellbeing. This includes fulfilling the role of the Chair of the Group Health and Safety Committee
Divisional Tris/ Senior Managers (Trust & GMS)	Should ensure compliance with CQC and HSE enforced statutory regulations and codes of practice within their areas and adopt an organisational structure that is able to discharge those requirements; resolving issues at their divisional health and safety meetings and escalating to the Group H&SC as appropriate
Managers (Trust & GMS)	Adopt a proactive approach to health and safety, engaging and prioritising activities, as outlined in the Health and Safety Policy, to maintain a healthy and safe environment
Employees (Trust & GMS)	Employees must take reasonable care of their own health and safety and that of others and cooperate with the Trust on health and safety issues
Emergency Planning	**[DN: need section in the body of the report on EPRR]** The ERP should ensure: • An orderly and efficient transition from normal to emergency operations; • Designation of emergency authority and responsibilities; • Authorisation by key personnel for actions contained in the plan; • Coordination with other organisations; • Safe continuation of operations or return to normal operations as soon as practicable

6.1 Sub-groups

A number of relevant sub-groups report to the Group H&SC. These sub-groups relate to functions, legislative requirements and / or relevant Healthcare Technical Memorandums (HTMs). Areas of law that which do not require a subgroup will be encompassed within compliance or health and safety reports from either the Trust or GMS in line with the primary management of the function.

Each sub group is required to oversee and review:

a) Operational effectiveness of the relevant safety risk management processes;
b) Appropriate resolution and mitigation of identified risks;
c) Assessment of the safety impact of operational changes;
d) Implementation of corrective action plans;
e) Corrective action is achieved within agreed timescales;
f) The effectiveness of safety recommendations and safety promoting
g) Results of safety data analysis

Each sub-group must have a Terms of Reference aligned to the Group H&SC programme of work. It must have clear objectives and a defined and planned delivery programme / action plan to which it should hold itself to account. Agendas should include standing items as necessary to ensure continued operational oversight of compliance.

Sub-groups have the authority to work within their budget envelope and to make day to day operational decisions, or take remedial actions, to achieve compliance in their area of expertise and reduce day to day risk.

Each sub-group will present a Key Issues and Assurance Report (KIAR) to the Group Health & Safety Committee in accordance with the agreed rotation of agenda items. Where required, the sub-group will be expected to present full reports, records, presentations and other appropriate supporting documents to evidence compliance.

6.2 Group Health & Safety Committee (Group H&SC)

The Group H&SC is a high-level committee considering strategic safety functions. The lead Executive Director for H&S is required to chair the meeting, and the committee includes the relevant senior management of the organisation. The Group H&SC ensures that appropriate resources are allocated to achieve the established safety performance and gives strategic direction as required to the relevant sub groups where significant risk issues or gaps in control are identified.

The Group H&SC comprises divisional representatives, sub-group chairs, specialist advisors or subject matter experts, Trade Unions and Representatives of Employee Safety. This committee oversees the strategic direction of health and safety with the Group, monitors compliance, and addresses higher level issues escalated by the sub-groups.

The Committee monitors: **[DN: review ToR to align]**

(a) Safety performance against the safety policy and objectives;
(b) Effectiveness of the safety management system;
(c) Effectiveness of the safety oversight of sub-contracted organisations;
(d) Corrective or mitigating actions are being taken in a timely manner;
(e) Effectiveness of the Trust's safety management processes.

The Group H&SC's Terms of Reference outline its purpose and responsibilities. These include, but are not limited to:

- Giving due consideration to laws, regulations and any published guidelines or recommendations
- Checking and challenging compliance
- Reviewing and approving relevant health and safety policies
- Overseeing serious health and safety investigations

The Group H&SC is authorised by the Trust Leadership Team (TLT) to follow up any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees with the Group are directed to cooperate with any request made by the Group H&SC.

The H&SC has unrestricted access to all relevant documents and records within the Trust and GMS to assure compliance, unless access is deemed unlawful.

The Group H&SC is authorised by TLT to obtain external legal or other independent professional advice and to secure the attendance of external parties with relevant experience and expertise if it considers necessary. On occasion, the Trust, GMS, Apleona and interested third parties (e.g. termitary building managers) may find it prudent to seek separate legal or independent advice, but will, where reasonably practicable, predominantly seek to do this jointly. It may challenge the reports and duties of operational sub-groups to ensure due and robust operational processes are in place.

The Group H&SC has delegated authority from TLT to consult on, approve and ratify Trust-owned or Group-owned documents that support health and safety strategies and policies (such as procedures, guidance etc.) including documents relating to its sub-groups. On occasion, the Trust, GMS, Apleona and interested third parties (e.g. termitary building managers) may find it necessary to develop separate documents, but will, where reasonably practicable, predominantly seek too jointly.

The Group H&SC will receive reports and will advise the TLT by exception of issues and concerns. Reports may include:

- Audit reports on health and safety and related matters
- Reports on Radiation Protection and other specialist areas
- Information on changes in legislation and good practice relating to health and safety
- Health & safety risks on the register

- Incident and accident data (to include details of reportable incidents)
- Any enforcement actions
- Key Performance Indicators (KPIs) relating to health and safety
- Sub-group KIARS and reports

Group H&SC will report **quarterly** to the Trust Leadership Team (TLT), a sub-group of the Trust Board and **annually** to the Audit & Assurance Committee (A&AC). This will be via a Key Issues and Assurance Report (KIAR) unless a full report, alongside other appropriate supporting documents, is required.

At least annually, the Group H&SC will review its constitution and terms of reference to ensure it is operating at maximum effectiveness. Where the review has implications for GMS' governance processes, consultation will take place to ensure the governance of all parties are aligned.

[DN: consider PODC role regarding specific staff H&S issues and KPIs]

6.3 Trust Leadership Team (TLT)

The senior leadership team are the principal judges of risk management within the Trust as they have a detailed collective knowledge of the organisation's capabilities. The TLT must hold themselves and others to a good health and safety standard.

All TLT members should understand their individual and collective legal obligations in relation to compliance. The TLT will need to think strategically when considering how to resolve health and safety issues within the Group and have a responsibility to make, and be able to account for, sound risk-based decisions regarding safety. TLT should seek observable outcomes in relation to planned health and safety programmes.

The TLT will be required to submit a report to the Board following receipt of a report from the Group H&SC using the KIAR format on any items that require escalation or oversight.

6.4 Audit and Assurance Committee (A&AC)

A&AC is constituted as a committee of the Board. It is a non-executive committee and has no executive responsibilities nor is it charged with making any decisions unless delegated to it by the Board. It may, however, make recommendations.

A&AC has authority to seek information on health and safety governance and the effectiveness of controls**.** As part of its obligations A&AC will:

- review the comprehensiveness of assurances on health and safety governance, and determine the reliability and integrity of our governance approach;
- Guide the development and direction of assurance activity (including but not limited to internal and external audit) through consideration of the integrated Group assurance plan

- Review and consider the outcomes from any health and safety assurance reviews (including internal audit reports) as reported by the Internal Auditor, assessing the impact on the overall control environment
- Review the adequacy and timeliness of the implementation of management actions to address issues highlighted through health and safety assurance reviews

The A&AC will be required to submit a report to the Board following receipt of an annual report from the Group H&SC using the KIAR format on any items that require escalation or oversight. The A&AC shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

6.5 Trust Board

All Trust Board members should understand their individual and collective legal obligations in relation to compliance. Strong visible leadership is required, working together with GMS. In setting out the rules, procedures and responsibilities within the Group, the Board will ensure accountability, fairness and transparency in the management of health and safety. The Board must ensure it has the ability to exercise proper oversight of the system as a whole.

Safety information requested or received by the Board should be meaningful to ensure that the Board is able to discharge its duties in accordance with health and safety law.

Board members should ensure that staff have the time and resources to explore and address health and safety risks, control measures and concerns.

Board will as a minimum receive an Annual Health and Safety Report that summarises activities that have further developed the H&S Management system as a result of both proactive and reactive responses.

6.5 GMS Board

DN: to be expanded with GMS input

7. CONSULTATION [DN: consider what in section 7 can go in appendices]

There are two sets of regulations requiring an employer to consult with their employees about health and safety. These are:

- The Safety Representatives and Safety Committees Regulations 1977 (as amended); and
- The Health and Safety (Consultation with Employees) Regulations 1996 (as amended).

The first set relates to employees that are represented by a trade union that is recognised by the employer, for example, Royal College of Nursing, Unite or Unison. Anyone elected under these regulations are known as Safety Representatives. The employer is required to consult with Safety Representatives on matters that affect their members.

The second set relates to employees who are not part of a recognised trade union. In this instance an employer can choose to consult either through elected Representatives of Employees Safety, directly with individual employees or a combination of both.

7.1 Elections Safety Representatives/Representatives of Employee Safety

Safety Representatives for a recognised trade union must be appointed by the Trade Union and agreed with the employer. The Regulations require that representatives have either worked for the Trust or GMS for two years or have had at least two years' experience in similar employment. This ensures the person has the necessary experience and knowledge to make an effective contribution to health and safety in our workplace. Representatives of Employee Safety (non-union) are elected by the workforce. Elections will be highlighted at Group H&SC to allow the workforce time to consider and elect candidates.

Those wishing to be considered for either role should approach their union first (Union roles only) and their line manager. Applicants should discuss their application with their line manager as they will need to be able to balance their contractual role with any Union duties. Staff should then complete the form in Appendix 2.

7.2 Approving a Candidate

Unless there are any legitimate submissions from the workforce, trade union members, a senior manager or the candidate's line manager that would prevent their election, then the candidate should be approved and the form should be counter signed as indicated. The original form will then be stored on the individual's Personal Reference File (PRF) and a copy sent to the representative and the Risk, Health and Safety team.

7.3 Number of representatives

The number of safety representatives or representatives of employee safety appointed will depend on the total number of employees, the business structure, the number of workplace locations, the shift system, the work activities and associated inherent risks.

It is for the Trade Unions to ensure that the have enough representatives to provide reasonable cover for the size / demand and complexity of the workforce they

represent. Individual representatives should not be so overwhelmed that they are not reasonably able to meet the demand of their union duties within their allocated hours or where this advisedly impacts on their contractual role or performance.

7.4 Resources for representatives

The Trust is required to provide resources for union-appointed representatives which include:

- reasonable recompense of time to carry out their functions (as agreed with their line manager and staff side)
- access to health and safety information;
- sufficient training to allow them to perform their role (training is often provided by the Union for union safety representatives)

There is no requirement to present health and safety information in a different or separate format for representatives nor to obtain additional information. Safety representatives can find information on the health and safety intranet pages, in our policy library, the Risk Library and on SYPOL. These are all accessible 24/7 by all employees.

Representatives are permitted to use their workplace PC / laptop, printer, telephone (usually their local desk phone), Teams, meeting rooms, a lockable desk drawer for paperwork, our intranet and internet facilities and printers for their Trade Union activities. These facilities are likely to be available locally at the representative's normal place of work and may be shared facilities.

7.5 Role and Functions of Representatives

Although the role of the representatives is similar, there are some slight differences between the legal rights of union and non-union representatives, which are outlined in the figure below:

Safety Representatives and Safety Committees Regulations 1977	Health and Safety (Consultation with Employees) Regulations 1996
Representatives:	
Appointed in writing by a trade union recognised for collective bargaining purposes.	Elected by the workforce, where the employer has decided not to consult directly.
Title/position:	
Safety representatives.	Representatives of employee safety.
Functions:	
Investigate potential hazards and dangerous occurrences at the workplace, complaints by an employee relating to health, safety and welfare at work, and examine causes of workplace accidents.	
Representation to the employer on the above investigations, and on general matters affecting the health and safety of the employees they represent.	Representation to the employer on: ■ potential hazards and dangerous occurrences; ■ general matters affecting the health and safety of the employees they represent; and ■ specific matters on which the employer must consult.
Inspect the workplace.	
Represent employees in dealings with health and safety inspectors.	Represent employees in dealings with health and safety inspectors.
Receive certain information from inspectors.	
Attend health and safety committee meetings.	

Source: Consulting employees on health and safety HSE INDG232

Safety Representatives should be invited to attend their local department health and safety meeting. They may also request an invite to attend a divisional health and safety meeting where the need arises, and this request should be accepted unless there is reasonable justification. Appointed Safety Representatives will be invited to the Group H&SC.

7.6 Consultation Process – staff and representatives

Staff should feel valued and should play an active role in health and safety by talking, listening and co-operating with each other in order to achieve a safer workplace. Whilst we encourage staff to do this every day, consultation with staff can take a number of forms, including:

- informal discussions with individual employees
- formal group meetings e.g., working groups, task and finish groups, workshops, seminars etc.
- health and safety information provided on specialist departmental intranet pages
- emails, global communications, surveys
- any other method relevant to the significant changes being proposed

Formal consultation with Safety Representatives and staff mainly takes place through our Group H&SC and divisional meetings and is in relation to the members they represent.

Broadly we will consult with employees in relation to:

- The introduction of any measure which may substantially affect our employees' health and safety at work (e.g., significant changes not minor amendments)
- The arrangements for securing competent advice on health and safety

- Information on hazards, risk and control measures
- The planning for health and safety training e.g., training needs analysis
- The health and safety consequences of any new technology

7.7 Consultation period

The law requires consultation to be within good time. There is no legal definition for this but in general this requires sufficient time to explain the issue to the employees (or their representatives), for them to consider it and provide an informed response. How long is given, will depend on the complexity of the issue, how many people need to be consulted, the efficiency of the method of consultation and the urgency of the issues at hand. Simple issues are likely to be dealt with via email, with a few days allocated for responses. Urgent issues may equally need to be addressed at speed to ensure safety is preserved. In these instances, co-operation with tight / urgent deadlines is expected.

Feedback is considered and, where appropriate, is incorporated.

8. RAISING HEALTH AND SAFETY ISSUES

All employees, Safety Representatives (Trade Union) and Representatives of Employee Safety are expected to follow the most appropriate route for raising an issue. Whilst it is not possible to prescribe what this might be for every potential issue; the following provides guidance on the starting point for an issue and how to escalate it within the health and safety meeting structure.

8.1 Before raising an issue

It is expected that before raising a concern, employees, Safety Representatives (Trade Union) or Representatives of Employee Safety, will explore the problem as far as is reasonably practicable and gather evidence to help illustrate the issue, the scale or seriousness of it. Generalised statements without exploration, can lead to valuable resources being misdirected rather than focussed on the direct concern.

8.2 Where to raise a concern – line manager

Issues should not be escalated prematurely and must be raised with the local line manager(s) in the first instance. Representatives should encourage staff to take this step themselves to help build a trusting and proactive working relationship between managers and their teams. Where there is a genuine reason that a staff member feels unable to do this, the relevant Representative can refer the issue to the line manager on behalf of any members they represent.

It is every line manager's responsibility to ensure that all staff are included in, or have access to, a local meeting or 1:1 where they can raise health and safety issues. All issues must be raised in a professional and respectful manner. A line manager must be given reasonable opportunity to consider, investigate and respond.

8.3 Next steps – specialist guidance

Where the local line manager advises that they lack the knowledge or experience to support a solution, or where it is prudent to seek support from a specialist, issues should be referred by the employee, their manager or their representative to the most appropriate working group, specialist team or person for guidance.

This is an important step in seeking a solution, and must be taken before escalating the issue to divisional, senior or Group level. The use of specialist groups/ teams or individuals ensures all the right people, with the right knowledge and skills, have had the opportunity to support a solution. Where issues are directed straight to senior managers, directors or executives, this may delay an informed solution and is likely to be de-escalated back to those raising it, to take this step first.

In some instances, the specialist individuals or teams will be based within GMS. In these cases, employees or their representative should refer the matter to the GMS Health and Safety Manager or Compliance Manager, who will be able to direct it to the most appropriate team(s) within GMS for support.

If specialist guidance is not available or the working group / specialist team is unable to support a resolution, the issue should be escalated to the appropriate divisional health and safety meeting(s). For issues affecting corporate staff these can be passed to the Risk, Health and Safety team for support.

8.4 Escalating to the Divisional Health and Safety Meeting

These should be held as a minimum once every quarter and are Chaired by the Divisional leadership. Where it is necessary to raise an issue urgently between meetings the employee or their representative can contact the Chair or the Risk, Health and Safety team to ask that an issue is given due consideration between scheduled meetings.

Every effort should be made to resolve health and safety issues at divisional level. Where the Chair agrees an issue cannot be resolved at divisional level, they may refer it to the Group H&SC, unless there is a more appropriate route. Divisional Chairs should place items on the agenda for the Group H&SC in good time.

GMS as a Ltd company has its own company health and safety meeting which is directly managed and controlled by GMS. GMS employees should follow the governance process related to raising issues at the GMS health and safety meeting.

8.5 Escalating to the Group H&SC

Matters can be raised at this group Committee by the Trust or GMS where one or more of the following apply:

- It has been raised and discussed with the local line managers, specialist groups / teams or individuals and at the divisional meeting but no reasonable solution has been identified and / or implemented within a reasonable time

- It requires discussion at a higher / strategic level due to the potential for serious imminent harm
- A systematic or serious breach has been identified
- A collective decision by senior managers is required which cannot reasonably take place a local or divisional level
- Significant funding is required that is beyond the local or divisional budget
- Significant changes to working practices will impact staff beyond the local departments or a single division and cannot be agreed at a relevant specialist group or via cross divisional working
- It has been referred to a specialist Trust department, GMS or Apleona but no reasonable solution has been identified and / or implemented within a reasonable time
- It is an issue that the Group should be aware or are monitoring

The agenda for the meeting is set approximately 14 days prior to the meeting. Staff and their representatives should contact the Chair and /or the Risk, Health & Safety team for inclusion of a non-standing item.

8.6 Escalating to the Trust Leadership Team

Matters can be raised at TLT where:

- It requires senior leadership input due to the potential for serious imminent harm or a systematic or serious breach has been identified
- A collective decision by senior managers is required which cannot reasonably take place at Group H&SC without recourse to TLT
- Significant funding is required that is beyond the local or divisional budget
- Significant changes to working practices will impact the majority of staff
- It has been referred to a specialist Trust department, GMS or Apleona but no reasonable solution has been identified and / or implemented within a reasonable time
- It relates to subsidiary performance standards
- It relates to likely or imminent statutory intervention in relation to the Trust, GMS or Apleona
- It is an issue that the TLT should be aware or are monitoring

The Group H&SC can raise matters on behalf of the Trust and GMS via the group reporting process to TLT. GMS and Apleona may also raise matters on health and safety or compliance to TLT separately and in their own right.

8.7 Escalating to A&AC or the Trust Board

Matters can be raised by the Trust to the A&AC or the Trust Board respectively where:

- It requires Executive Board level input due to the potential for serious imminent harm or a systematic or serious breach has been identified
- There is a systemic failure in assurance mechanisms or in timely action

- A collective decision by the Trust and /or GMS Board is required
- Significant funding is required that is requires the Trust and /or GMS Board sign-off or input
- It relates to significant performance standards concerns or clarifications within the subsidiary
- It relates to likely or imminent statutory intervention in relation to the Trust, GMS or Apleona
- It is an issue that the Board should be aware or are monitoring

A flowchart for the escalation of issues is provided in Appendix 1.

8.8 GMS Board

GMS as a Ltd company has its own internal escalation process for health and safety matters which are directly managed and controlled by GMS Board.

9. COMPETENT ADVICE

Separately and collectively the Trust and GMS will access to competent advice.

9.1 Competent Person

The law requires that organisations should have access to competent health & safety assistance. Within the Group this is:

- Trust – Risk, Health & Safety Team
- GMS – Compliance Officers and Health & Safety Manager

If the required subject knowledge and/or level of competence does not exist within the organisation, then the duty-holder should employ a specialist adviser (or advisers) to contribute towards overall health & safety management.

9.2 Independent Authorising Engineer

In estates and facilities management, an Authorising Engineer (AE) plays a key role in ensuring safety and compliance and is typically responsible for overseeing, evaluating, and authorising specific processes or systems, such as those related to fire safety, ventilation, confined space, water safety, work at height, or asbestos management. An AE must be independent and is accountable to the Trust as the duty-holder.

Depending on the specialism, an AE will:

- Assess the competency of individuals before their appointment in key roles
- Provide independent advice on the current, relevant legislation, codes of practice, standards and technical guidance
- Carry out assessments to establish the failings in compliance with HTMs or legislation and offer solutions

- Review policies and procedures
- Support the premises assurance model within GMS
- Support action planning
- Provide input into relevant accident investigations
- Undertaking an annual management audit, that is issued to the Responsible Person

The appointment of AE's is managed by GMS and their responsibilities must be made clear with the contractual obligations agreed. GMS must escalate to the Trust as the duty-holder, if there is no available AE for any area of compliance that requires one.

9.3 Responsible Person, Deputy Responsible Person and Appointed Persons

Some HTMs and guidance requires the appointment of a Responsible Person (RP), Deputy Responsible Person (DRP) and Appointed Person(s) (AP). In most cases, the RP will carry specific responsibilities in relation to compliance, supported by the DRP and the APs. GMS are responsible for ensuring suitably competent (trained and experienced) are recruited to fulfil these roles. However, a nominated RP or DRP must be approved by a relevant AE and appointed in writing via a letter of appointment.

GMS must escalate to the Trust as the duty-holder, if there is no available RP, DRP or AP for any area of compliance that requires one or if there is a vacancy in one of these roles. Escalation should be to the chair of the relevant HMT group, and the chair of the Group H&SC.

9.4 External Expertise

There may be occasions where specific expertise is required to support the identification, assessment or control of a risk. The Group H&SC has authority to either instruct such expertise in line with any budget envelope or may request TLT support such an intervention.

10. GROUP H&S POLICIES

All health and safety policies should be group-wide, where reasonably practicable, and must be accessible to all staff. This should include policies associated with health and safety such as whistleblowing procedures and safeguarding. This is to ensure that the Group maintains consistent standards.

However, it is for the subsidiary, GMS, to implement, administer and enforce those policies within GMS.

11. RISK REGISTERS

The subsidiary will use the Trust's risk register process and online platform (DATIX) for reporting, reviewing and managing key Trust risks for which they are the delegated risk lead. Mitigation plans for Trust risks should reflect the Group

response, with both parties contributing to the management of the risk in line with their responsibilities.

As a separate legal entity, GMS will manage its own separate corporate risk register in accordance with its own policy and procedures and report separately reported to the GMS Board.

12. INCIDENT INVESTIGATIONS

The trust has an incident investigation policy which is applicable to health and safety investigations. [add link]

12.1 RIDDOR Reporting Arrangements

As the duty holder in relation to Trust activities, the Trust will report all RIDDORs to the HSE that relate to its staff, patients or visitors. As the duty holder in relation to GMS activities, GMS will report all RIDDORs to the HSE in relation to its' own staff.

Both the Trust and GMS will report any RIDDORs as part of its health and safety reporting obligations to the Group Health and Safety Committee.

13. INTERACTION WITH CQC, HSE & RELEVANT AGENCIES

The Risk, Health and Safety team will liaise with the regulatory bodies on any Trust reported RIDDORs or in relation to any inspections of the Trust. GMS is expected to liaise with the regulatory bodies on any GMS reported RIDDORs or in relation to any inspections of the Trust. However, both parties should work together as far as is reasonably practicable to support any regulatory intervention.

14. MONITORING

14.1 Self-Assessment

The Group should have a programme of self-assessment, which focuses on high-risk or themed areas of health and safety. A minimum of two detailed self-assessments should be carried out within the Group annually. It is likely that this will be carried out in relation to the whole or part of an HTM or piece of legislation. These should be reported to the Group H&SC.

Any significant gaps identified should be escalated appropriately to the TLT, the Audit and Assurance Committee, the Trust Board and GMS Board.

It is expected that each self-assessment will be followed up by an action plan that is monitored via the Group Health and Safety Committee and reported back to the respective Committees and / or Boards.

14.2 Audit

There are three basic types of safety audit:

- **Compliance audit** - checks whether the organisation has complied with all the applicable safety laws, standards, and other requirements.
- **Program audit** - checks the safety program implementations that have been planned have been completed.
- **Safety management system audit** - is an overall audit, where the compliance and program will also be conducted at the same time, besides checking the safety management system itself.

14.2.1 Authorised Engineer Audits

The annual AE audits should be shared with the relevant operational group, as well as the Director of Integrated Governance and the Head of Risk, Health & Safety (as leads for health and safety compliance). All AE audit reports should be presented at the Group H&SC reporting to the Audit and Assurance Committee and the Board.

The Director of Integrated Governance and the Head of Risk, Health & Safety may choose to meet with the AE following an audit. It is expected that each audit will receive a timely management response and will be followed up by an action plan that is monitored via the Group H&SC and Audit and Assurance Committee.

14.2.2 Internal Audit Role

Periodic themed health and safety audits can be carried out by the Internal Auditor. These should be reported to the Group H&SC reporting to the Audit and Assurance Committee and the Board.

It is expected that each audit will receive a timely management response and will be followed up by an action plan that is monitored via the Group H&SC and Audit and Assurance Committee.

14.2.3 Independent audits

From time to time the Group may require additional expertise to audit more complex elements of our health and safety systems, particularly where there is high-risk. This may, for example, include areas like water safety or fire safety.

The Group H&SC can request an independent audit. Where this requires significant funding, the request will need TLT approval/SFI processes.

This does not prevent either the Trust or GMS separately pursuing an independent audit as it sees fit.

15. REVIEW

The Risk, Health and Safety team will prepare an annual report on the Trust's health and safety activities. Where appropriate, GMS may be asked to contribute to

this. This will be submitted to Audit and Assurance Committee and to the Trust Board after the end of the financial year.

The Trust Board will review health and safety performance at least once a year on receipt of the annual report. The review process should:

- Examine whether the health and safety policy reflect the organisation's current priorities, plans and targets
- Examine whether risk management and other health and safety systems have been effectively reporting to the board
- Consider actions to address any weaknesses and a system to monitor their implementation
- Consider immediate reviews in the light of any major shortcomings or events

As a separate legal entity, GMS will manage its own arrangements for annually reporting its health and safety activities to the GMS Board.

16. TRAINING AND EDUCTION

[DN: in main H&S policy – to decide if include or merge documents etc:]

a) Operational staff should have an understanding of the organisation's safety policy and the principles and processes of the Safety Management Framework.
b) In addition to (a) above, managers and supervisors should understand the safety process, hazard identification, risk management and the management of change.
c) In addition to (a) and (b) above, senior managers should understand organisational safety standards, safety assurance and the regulatory requirements for their organisation.
d) The [accountable manager] should have an awareness of safety management roles and responsibilities, safety policy, safety culture, standards and safety assurance.

19. SAFETY COMMUNICATION [DN: in main H&S policy – to decide if include or merge documents etc:]

Safety communication is an essential foundation for the development and maintenance of an adequate safety culture. Types of communication may include:

- Safety policies and procedures;
- Newsletters, safety bulletins and notices;
- Presentations;
- Websites and e-mails;
- Informal workplace meetings between staff and the accountable manager or senior managers.

Safety communication should:

a) Ensure that all staff are fully aware of the safety management framework and the organisation's safety culture;
b) Disseminate safety critical information internally and externally;
c) Explain why certain actions are taken;
d) Explain why safety procedures are introduced or changed;
e) Complement and enhance the organisation's safety culture;
f) Contain a process for assessing the suitability of safety communication and its effect on the organisation.

Add document control table
References

The importance of partnership working on health, safety and wellbeing | NHS Employers

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 11 February 2025

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 including Violence and Aggression	Committee received report from Health and Safety Committee. Currently operational in focus with plans to enhance to a more strategic level. More work to be done in refining how health and safety was reported upwards, particularly in areas related to workforce. Committee noted Chief Executive's report to the board highlighted key issues and agreed the importance of ongoing attention to health and safety at the board level. Legal responsibility of directors for health and safety within the Trust was noted. Governance review had been conducted, leading to the development of a new health and safety framework. This framework included the following key areas of focus: • Leadership visibility regarding health and safety, including the role of board members in site visits and decision-making. • Clarity on accountabilities and consistent definitions in health and safety policies, addressing inconsistencies in legislation. • Oversight of health and safety reporting, including both preventative measures and incident reporting. • Periodic audits of health and safety structures and controls beyond just fire and water safety, to encompass a wider range of health and safety concerns. • Workforce health and safety data, focusing on cultural aspects and worker involvement in assessing their working conditions, such as the quality of breakout areas and sanitation facilities. Importance of developing group-wide health and safety policies and ensuring that the Health and Safety Committee	Committee noted the report

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.

	functioned as a group health and safety committee was key. Annual report on health and safety to be provided to the Board. Planned Board training session in 2025 led by legal experts to include input from wholly owned subsidiaries with overall aim to improve health and safety management and evidence progress since the Pseudomonas incident. Report setting out structure for health and safety moving away from direct reporting to the People and Organisational Development committee and into new arrangements with the Trust Leadership Team and Audit Committee to be confirmed.	
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Recruitment and Attraction	Key activities: - Focus on time-to-hire continues through the ongoing transformation of the end-to-end recruitment journey. A review across medical and consultant recruitment is to commence. Marketing Strategy and work on campaigns making good progress. New recruitment score is currently going through the correct governance route. It will be aligned to the new retention risk (scored 16) and to be confirmed at next PoDC. Feedback from the audit committee in relation to Gloucestershire Managed Services. Some improvements but need for continued focus on background checks and DBS critical. **Workforce Sustainability** Update confirmed that workforce controls were a priority into 25/26. Discussions with Divisions on their role in supporting the need to meet national and system requirements. Senior leadership buy in and commitment to workforce controls is critical. Work underway to ensure this is sponsored from the top.	Review of the risk score and proposals to Board for a review to include the removal of references in the BAF to the pandemic with a focus on current challenges Importance of assessing both qualitative and quantitative impacts, especially considering new workforce targets to understand the impact on both staff and patients.

	Work ongoing to standardise agency and bank staff rates as part of the SW collaboration. The need to continue to reduce temporary staffing and time to hire remained a priority. Planning for the implementation across medical e- rostering underway to maximise use of technology. This is a significant workforce transformation for 25/26. Other areas of work included streamlining processes through greater use of AI and automation. Other impacts such as dealing with estates issues took up valuable clinical time away from patient care and this needed to be addressed as part of the wider strategy.	PoDC to receive update at next meeting.
Culture, experience, and retention	Board Assurance Framework: Current score of 20 to be reviewed with proposal to Board to reduce to 16. Apprenticeship pay review now amber due to a delay in this being taken forward across the System. Discussions however are underway. The need for a review to keep apprenticeship roles attractive acknowledged and clearer links with ICS in relation to future planning and development. Staff Experience Improvement Board meeting held to discuss plans and progress for the upcoming year. Evaluation of current work streams, with change request submitted regarding how teams and services were identified for the well-being collective work, teamwork, and leadership initiatives. Revised risk matrix to allow for better identification of teams requiring intensive support through bespoke interventions and enhanced oversight from the well-being collective for teams requiring additional support. Referral process was rolled out, providing clearer priorities and allowing alignment with the ongoing cultural heat map work, which utilises triangulated data from various sources.	Committee to receive updates and outcomes at future meeting to be confirmed. Committee asked for greater clarity around measuring impact of changes on staff in their day-to-day experiences. Future Committee to receive about representation of all ethnic minorities, and how the Compassionate and Just Culture Programme felt to staff, particularly those who feel undervalued and without

	Anti-Discrimination Report, Support and Learn initiative to be launched in May underpinned by business intelligence and insight to provide better oversight and enabling proactive responses. Anti-racism campaign progressing well. Positive meeting took place with the Black History Month group. People Promise Exemplar Programme continuing – 3 aims - flexibility, valuing each voice, and fostering continuous learning to be embedded as part of the organisation's standard practices. New starter packs, to be implemented with support from the charity. Importance of terminology used in anti-racism efforts was key and an important part of upcoming board development and part of a broader conversation on inclusion and organisational practices. Creation of a language guide in consultation with the Ethnic Minority Network was planned. Workshop taking place on 25 February to review work streams related to staff experience programme to assess whether current work streams were sufficient, whether the pace of progress was fast enough, and determine if any new questions should be included in future surveys.	a clear path to express their concerns. The output from the workshop would be reported at the next People and Organisational Development Committee
People Performance Dashboard	Ongoing work to improve the appraisal process and safeguarding compliance continued with a shift from moving away from a once-a-year conversation to a more continuous dialogue between staff and managers. Aim is to ensure that there were no surprises during annual appraisal, ongoing discussions contributing to the final conversation, ensure appraisals reflected all conversations throughout year and allowed both staff and line manager to track progress and address any issues promptly. This was supported by the Committee.	Report was noted

	Improvements in safeguarding compliance noted.	
Annual Staff Survey Results	Staff experience metrics showed improvements across various areas along with those that required further attention. Significant improvement is evident across the results, and of the 58 Trusts that use Picker as their survey provider, the Trust is the 5th most improved. However, the Trust is still below the national average against almost all metrics (Picker Average). Committee noted results in teamwork and leadership had improved; the gap to the national average had narrowed significantly, however, improvements were slower than anticipated, particularly given the level of investment in the teamwork aspect. National quarterly Pulse survey results showed moderate progress but improvements not as significant as hoped. More focus needed to boost leadership scores within certain divisions of the organisation. Committee noted that while some areas had seen improvements, there was still much work to be done, particularly in reward and recognition.	
Audit Update	Payroll Additions more comprehensive than originally planned and required deeper analysis leading to review of policies that required additional attention. Workforce Controls Audit - currently live as a requirement from NHS England examining the Trust's organisational workforce controls to strengthen financial performance and ensure the effectiveness and robustness of those controls. Vacancy controls is a key focus of the audit, and Committee noted need for more rigorous checks to ensure vacancies were genuinely necessary and alternative methods of filling roles considered.	

	Medical Recruitment Audit - focused on pre-employment checks for new medical staff underway. Organisational Readiness Audit - assessed whether trust was set up for success, ensuring necessary structures, frameworks, governance, and processes were in place to deliver revised strategy. Committee assured trust was on track with the findings from this audit. Freedom to Speak Up Audit - identified areas of improvement. Committee noted progress was on track. Assurance given that live audits, working through recommendations, and regularly reporting to the Audit and Assurance Committee was on track.	

Items not Rated

Risk Register

- One emerging risk going through governance process and to come to next committee – related to recruitment
- No closed risks to report.

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) 27 February 2025		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Maternity Services	The Trust have commissioned 2 reviews for learning which are near completion, it was noted as good practice that we have commissioned these. • Maternal death review • Stillbirth review	Ongoing strengthening of assurance reporting was noted to continue to be required. A deep dive on a maternity related item is tabled for the QPC March meeting Await outcome of any learning from the reviews
Child Protection Medical Assessment-	The CNO presented a briefing to QPC to share several ongoing challenges and mitigation measures in place relating to work to progress consensus as Health partners in relation to our joint working with ICB colleagues in the area of child protection medicals specifically relating to neglect. QPC were assured that there were no risks to children and that executive oversight was progressing with some urgency to align a shared assessment of risk and mitigation to progress.	The CNO and CMO will update QPC with recommendations from an independent expert. The CNO/CMO will work with ICB colleagues to align shared understanding or risk The CNO will work with the Gloucester children's safeguarding partnership board to ensure multi agency working. The CNO and CMO will ensure staff are supported.
Integrated Performance Report	**Urgent Care Update:** Strong performance was noted in P0 patient discharges, but P1–P3 discharges fell short of the target of 20 per day. Ambulance offload delays improved, halving	Eve Olivant was proposed to be invited to QPC to both look back and share lessons from the winter plan and look forward to Easter and system wide planning.

	compared to the previous year, with recognition for January and February achievements. Active escalation plans targeted weekend performance improvements. **Planned Care and Diagnostics Update:** A decline in six-week diagnostic wait performance, with neurophysiology and echocardiography accounting for 70% of breaches was reported RTT waiters reduced from 12,156 in December to 722 by February, with additional activity planned to further decrease waits by March. Clinical harm reviews and revised patient access policies were set for April. Non-RTT services, such as weight management, faced significant delays, with recovery plans expected in March and efforts to identify community alternatives	Address persistent 12-hour wait times through harm reviews and escalation plans. Improve P1–P3 discharge rates, sustain ambulance offload progress, and strengthen staffing and planning for peak periods (e.g., Easter). Reduce RTT waiters further through scheduled activity, resolve six-week diagnostic wait challenges in key modalities, and implement revised patient access and harm policies by April. Address long waits in non-RTT services with recovery plans and community alternatives.
Quality Delivery Group	**Results Acknowledgement**: The ongoing issue of clinicians not consistently acknowledging test results, leading to safety incidents was discussed.	A diagnostic report will be presented at the next QDG meeting, and histology results will be reviewed at the Patient Safety Review Panel
National Patient Safety Alert	One overdue alert, National Patient Safety Agency Alert 2023/010, concerning risks associated with **medical equipment.** The Health and Safety Committee supported reducing the	It was agreed that this item would be followed up as an action in February. NB this has been outstanding for several months mitigations were confirmed to be in place, with updates to be reported at the next meeting.

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	maintenance interval, but funding sources remained undetermined. An update on risk assessments related to **beds and bed rails** was outstanding, delaying closure of the The committee were updated that there is a proposal for a managed bed service in progress	
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Integrated Performance report	**Ambulance Handover Process:** Significant improvements were made in the timely handover process for ambulance offloads, although challenges persisted.	A specific workstream to address the challenges with the ambulance handover process and improve patient flow is under development Improvements to be tracked via IPR
Complaints Management:	The CMO reported a significant reduction in the complaints backlog, with overdue cases down from 65 to 30 and total complaints from 456 to 266. New cases from January onwards were classified as business-as-usual,	further details to be explored in a deep dive review next month.
Regulatory Report	**CQC Engagement and Relationship** There have been no new inspections since the last update. An outstanding report from July 2024 is still awaited. **Compliance with Statutory and Mandatory Training** The CNO highlighted a recurring issue with compliance, particularly	Ongoing engagement with CQC led at Executive Level to provide assurance regarding improvement delivery. Safeguarding training has become a standing agenda item for executive reviews. Each division was now required to provide monthly action plans and updates on their progress, and the organisation continued to

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	around safeguarding training.	actively track and drive performance in these areas. Improvement plans relating To safeguarding training to be shared with QPC
Patient Safety and Risk Assurance Report	**Elective and Contract Improvement Board (ECIB)**: The committee received a presentation that detailed data on cancellations. **Cancer Performance Deep Dive**: The committee reviewed the Quarter 3 performance, with 28-day performance, and the **National Cancer Targets for 2025-2026**	The committee will review cancellation data post-upgrade to assess the impact of these changes. **Cancer Performance Improvement:** Focus on meeting national cancer targets for 28-day and 62-day performance, particularly addressing the 62-day target to avoid 30-40 breaches per month. **Histopathology & Hysteroscopy Pathway:** Address delays in histopathology reporting and the nurse-led hysteroscopy pathway, aiming for timely treatments in line with the 28-day target.
Planning 2025/26	**National Planning Guidance for 2025/26:** The committee were informed that the national planning guidance for the 2025/26 period had been received. Over the past two to three weeks, significant efforts had been made across divisions, corporate services, and external organisations to ensure the first draft could be submitted. The team had ensured compliance at the early stages, but further time would be needed to refine the standards. The next milestone was to submit a fully costed plan in three to four weeks, with the draft evolving as more information became available.	The committee approved the recommendation to approve the draft plan and grant delegated authority for necessary amendments as the plan progressed.
Governance Framework for	Approval was sought to proceed with a proposal to	QPC were supportive of the proposals

Getting It Right First Time (GIRFT)	restructure the GIRFT programme.	
Quarterly IPC Update, including Water Quality	**National cleaning standards** have been implemented, enabling better oversight and improvement. **Surgical Site Infections** It was reported that the trust continued to be an outlier in orthopaedic knee surgeries for surgical site infections. **Water Hygiene Update** The Committee noted that Legionella risk assessments were complete at Cheltenham, with just two remaining at Gloucester. A compliance audit had been presented by GMS against HTM standards, but it was rejected by the Water Safety Group due to insufficient evidence. **Orchard Centre and Water Safety Issues** The DIPC raised a specific issue with the Orchard Centre, where water quality concerns persisted, including frequent Legionella tests returning positive and filtration issues. Engineering solutions were available, but parts of the building remained unfit for use. **Water Safety Reporting** Craig raised concerns about water safety reporting, explaining that IPC nurses were often receiving positive water	Ongoing oversight via Trust governance processes The audit outcome will be reviewed in the next meeting. The Water Safety Group was working on mitigating the risks associated with the Orchard Centre. Regarding D Block (A&E, cardiology, AMU), it was noted that water temperature control had been lost due to the addition of the A&E unit. An engineering solution was in progress, but will not be a short-term solution.

	results before GMs had a chance to review them, leading to delays. However, Craig clarified that this was a timing issue rather than an oversight, and necessary follow-up actions were being taken. He concluded by reassuring the Committee that ongoing monitoring and improvements were being made, with plans to resolve the issues raised and provide further updates in subsequent meetings.	
Item	**Rationale for rating**	**Actions/Outcome**
Maternity	The Trust Chair commended progress in maternity services, particularly the improvement in one-to-one care during labour, which had surpassed 97%. She also praised the patient experience insights provided in the Perinatal Quality and Safety (PQS) report. **Perinatal Quality and Safety Report** The Director of Midwifery reported on the progress of the Perinatal Quality and Safety (PQS) work, highlighting a successful silver Qi award ceremony for teams leading Care Quality Commission (CQC) work streams. She praised the detailed presentations and outcomes, which showcased multidisciplinary team (MDT) efforts. Progress on	Recognition of this achievement to be fed back to the team.

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	the foetal monitoring Qi refresh was noted, particularly regarding concerns raised about "fresh eyes" audits. A refreshed plan and updated priorities had already shown improvements in peer reviews and other areas related to foetal well-being, induction of labour, and feedback from incidents.	
	Martha's Rule Rollout: positive progress was reported with Martha's Rule, allowing patients to alert the Acute Care Response Team about their deterioration. This initiative has received attention from the CQC and NHS England, with 30 calls received so far.	
ACE Accredited Clinical Area Report	**Introduction to the Accreditation Scheme:** The CNO expressed his satisfaction with the revised Trust accreditation scheme's positive transformation. With staff now actively seek accreditation, which demonstrates the success of this change.	• Link accreditation standards to NICE quality statements in the next phase of the accreditation process. • Expand the scope of the accreditation tool to include more clinical areas. • Strengthen multi-professional relationships within the accreditation process. • Consider implementing a platinum standard to encourage cross-ward collaboration and sharing of best practices.
Items not Rated		
SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.		
Governor Observations- Helen Bown appreciated the progress on the bed safety rails issue and emphasised the importance of managing		

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relationships, particularly in winter planning, safeguarding, and the annual report. She praised the cultural shift towards healthy challenge and acknowledged the efforts to manage the CQC relationship. The Chair responded positively, recognising the shift from crisis management to a proactive approach and expressing optimism for continued progress.

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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Integrated Performance Report to Public Board of Directors			
Date		13 March 2025	
Title		Integrated Performance Report (IPR)	
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

URGENT AND EMERGENCY CARE

Previously highlighted to the committee was the impact a challenging Seasonal period presented to performance at the end of December. This also coincided with a very challenging start to 2025 with declaration of a Systemwide Critical Incident on the 8th January; Performance was therefore adversely impacted as a result and has remained in a non-compliant compliant position at the end of January; Recovery has however been strong and sustained;

Of the 15 Urgent and Emergency Care measures which are tracked as part of the improvement journey 11 have shown improvement in January compared to December. For context, the December comparison should a deterioration in all 15 measures;

As Same Day Emergency Care (SDEC) and short stay options continue to positively impact on overall duration and access, the duration and number of patients with an extended stay in the Emergency Department has increased. Focused work for February and March is to continue to reduce offload delays further and improve the flow of access to admitting beds thereby reducing the time spent in the ED following the Decision to Admit (D2A). Generally, flow challenges out of the hospital have remained steady at c100 per day for P0 patients (with the need for care) but remains below the daily target for P1, 2 and P3 patients (20 per day) and we currently are achieving around 10. Generally, flow challenges out of the hospital have remained steady at c100 per day for P0 patients (with the need for care) but remains below the daily target for P1,2 and P3 patients (20 per day) and we currently are achieving around 10. This is reflected in the No Criteria to Reside figure being between 130 and 140, c 40 above target.

PLANNED CARE

Referral to Treatment (RTT)

The Referral to Treatment percentage dipped in month, moving from 67.07% in November to 66.37%, although improvements continued to be made in reducing the number of patients waiting 52 weeks or more. In addition, the total Incompletes improved reducing from 74,112 in November to 72,921 in December.

The Trust's performance against the rest of the South West region still remains favorable, particularly in relation to Referral to Treatment performance and 52 weeks as a percentage of incompletes. Many Trusts have remained relatively static on 52 week waits, where GHT has made reductions.

Diagnostics Waiting Times and Activity (DM01) breach performance for December has deteriorated by approximately 2.5%, with performance moving from 14.05% in November to 16.69% in December.

CANCER

62 Day reportable backlog is 185 as of 03/02/2025

Most of this cohort is held by Urology as demonstrated by the graph however it had decreased significantly over the past few weeks. Other pressure area is Dermatology.

The Trust did not achieve any of the 3 Operational standards for Cancer. This will be covered

off in the Deep Dive Review. Unvalidated figures indicate 2 Week Wait = 89.8%; 28Day = 70.3%; 31Day = 92.9% and 62Day = 66.0%

QUALITY

Patient experience

Friends and Family Test – rate the quality of your care

The overall Friends and Family Test score has increased from 92.2% positive in December to 93.5% in January. Significant improvement has been seen in the Emergency Department (84.0% the most positive score in 3 years) and Inpatient & Day case (94.4%). These increases in positive score are against a backdrop of a critical incident during this month.

Patient Advice and Liaison Service (PALS)

The PALS team have seen a further increase in the number of concerns closed in 5 working days to 80% which is 5% above target. (75%). Despite an increase in concerns received, the new Red-Amber-Green (RAG) rating system piloted to triage and priorities concerns is providing benefit.

Complaints

There has been an increase (12% to 14%) of complaints that have been resolved within our standard response time. This metric remains on enhanced surveillance with focused improvement actions being taken to improve. The Quality Improvement project in Diagnostics & Specialties, Paediatrics and Gynaecology is reporting well and Divisional focus in Medicine, Maternity and Surgery plans to clear the backlog by 31 March 2025. There has been successful recruitment of 2 new band 3 staff. An improvement project has commenced to improve the Standard Operating Procedure (SOP) that was developed.

Safety incident management

Patient Safety Incidents / After Event Review

58 Patient Safety Incidents have required review through Patient Safety Incident Investigation, After Event Review, or Multi Professional Review since the Trust transitioned to Patient Safety Incident Response Plan in March 24; an average of 5.27 per month.

Clinical effectiveness

Integrated Care Board (ICB) Quality Improvement Groups (QIGs) - Post-partum Haemorrhage (PPH) and Summary Hospital-level Mortality Indicator (SHMI)

The ICB has 2 Quality Improvement Groups in place that are supporting our improvement actions.

Post-partum Haemorrhage

Overall Massive Obstetric Haemorrhage (MOH) rates have decreased to below national average for the past 3 months. We have a CQC S31 enforcement notice that requires us to enable improvement for the management of haemorrhage. Key actions have been on the commencement of Carbetocin for all caesarean sections and the implementation of a REDUCE proforma for risk assessment and management plan. Audits of the REDUCE proforma continue to identify areas of focus.

Summary Hospital-level Mortality Indicator (SHMI)

The improvement focus for the SHMI Quality Improvement Group is on the primary diagnosis/ Charlson Scoring work on Acute Medical Unit (AMU), the correction of inaccurate data and clinical audits of Cheltenham data (clinical audits on the frailty, oncology and haematology

clinical coding is in progress to refine the data). 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 10 the Group financial position is a year-to-date deficit of c£2.2m against a planned deficit of c£2.4m - this position includes the consolidation of the Trust's subsidiary, GMS, who are currently reporting in line with plan.

The Trust continues to experience pressures against its planned breakeven financial position. These pressures are primarily linked to the delivery of financial sustainability plans, workforce costs, non-pass-through drug costs and from the costs of clinical supplies and services. All areas are being reviewed to understand the drivers and available mitigations. Despite these pressures there is no reported change in the forecast outturn position of the Trust due to the identification of non-recurrent mitigations.

Against the use of resource metrics, the Trust is currently delivering against 2 of the 3 metrics: agency spend as a % of pay and year to date delivery of financial sustainability schemes. The year-to-date deficit means that the Trust is not achieving the requirement of a breakeven or surplus position on a year-to-date basis.

Capital spend continues to forecast full utilisation by the year end. However, there is an underspend linked to the revision of some schemes and the application of lease costs associated with IFRS16 – plans are in progress to bring forward from the next year to address this slippage.

Risks or Concerns

1. Stubborn recovery for non-criteria to Reside (nCTR) and outward flow for P1,2, and 3.
2. Non-compliant Referral to Treatment (RTT) position and sustained performance going forward
3. Non-compliant position relating to Cancer Standards performance which remain below compliance
4. Impact of loss of Elective Recovery Funding and contribution to waiting times and other access standards considered Very High Risk.

Financial Implications

Recommendation
The Board are asked to receive the Integrated Performance Report.
Enclosures
IPR

Integrated Performance Report (IPR)

January 2025

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

SPC Chart Guidance

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

How to interpret variation results:

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

How to interpret assurance results:

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

- The **red lines** on the charts show the **target** for that performance metric.
- The **black lines** on the charts show the **mean** for that performance metric.

Operational Performance Metrics

Single Oversight Framework

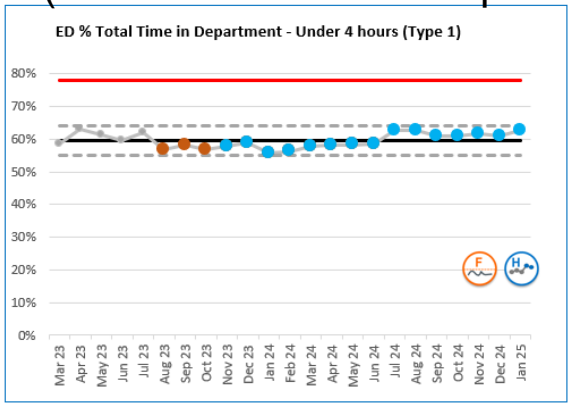
			Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Quality of Care, Access & Outcomes	Elective Care	Total patients waiting more than 52, 65, 78 and 104 weeks to start consultant-led treatment											
		52ww	*0 by Sept 24*	2738	2883	2816	2626	2509	1737	1614	1479	1256	946
		65ww	*0*	379	525	558	512	441	55	8	11	10	12
		78ww	*0*	3	3	0	1	0	0	0	0	0	0
		104ww	*0*	0	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%	109%	108%	105%
		Total diagnostic activity undertaken compared with 2019/20 baseline		145%	135%	150%	135%	147%	136%	133%	138%	128%	
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	*No Target*	159	203	217	201	188	197	191	181	190	185
		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%	8.44%	8.36%
		Proportion of patients meeting the faster cancer diagnosis standard	*75%*	75.3%	78.0%	75.7%	76.2%	72.3%	70.2%	73.9%	72.7%	72.9%	71.8%
		Total patients treated for cancer compared with the same point in 2019/20	*No Target*	339	344	323	364	353	311	326	314	328	305
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		117.2%	111.2%	104.3%	109.1%	110.5%	114.5%	110.8%	109.8%	108.2%	105.0%
	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%	55.3%	54.4%
		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%	11.4%	11.9%
	Primary Care	Proportion of patients discharged from hospital to their usual place of residence	*No Target*	97.47%	97.16%	97.38%	97.22%	97.47%	97.25%	97.25%	97.06%	96.92%	
	Safe Care	Summary Hospital -level Mortality Indicator	*No Target*	1.141	1.146	1.164	1.163	1.158	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	45.5	13.4
		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	40.9	13.4

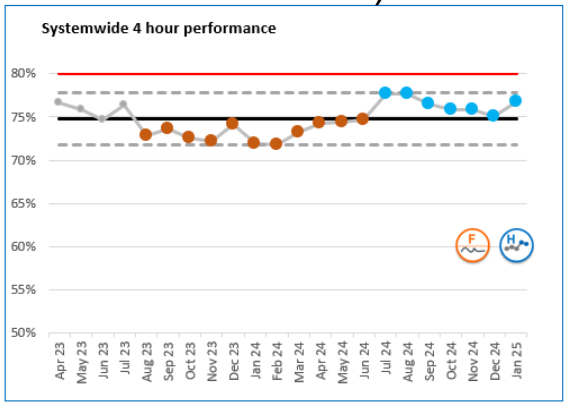
Watch Measures

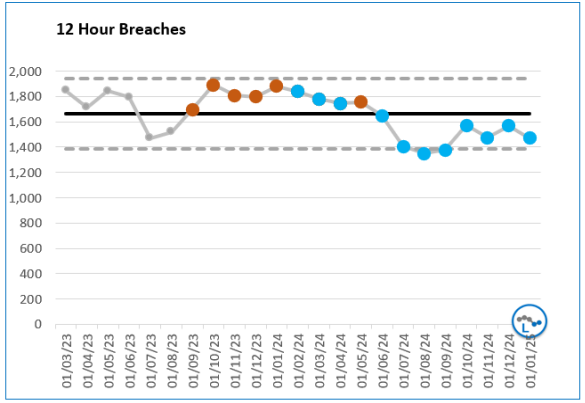
			Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Watch Measures	Diagnostics	**Compliant Diagnostic Modalities**											
		Audiology	*95%*	84%	82%	82%	91%	98%	87%	98%	99%	99%	99%
		Barium Enema Performance	*95%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	73%
		Computed Tomography Performance	*95%*	100%	99%	100%	100%	100%	100%	100%	100%	99%	97%
		DEXA Scan Performance	*95%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Non-obstetric Ultrasound Performance	*95%*	97%	96%	99%	97%	97%	95%	99%	99%	99%	99%
		Severe Harm from Patient Medication Errors	*0*	0	0	0	1	0	0				
	Elective Care	78ww	*0*	3	3	0	1	0	0	0	0	0	0
		65ww	*0*	379	525	558	512	441	55	8	11	10	12

UEC: Seen within 4 hours

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







Commentary:
A particularly challenging December which saw the region declare a Critical Incident during the beginning of January then saw a significant reduction in the number of patients attending the Emergency Department (1,414 fewer patients compared to December 2024).

A result of reduced attendances was an improved 4hr position with 759 fewer breaches in month.

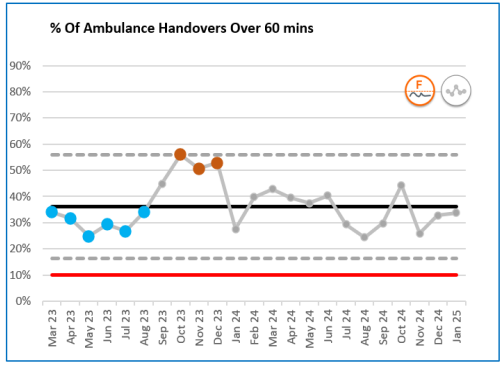
Although flow remained challenged during January due to IP&C (Flu, Norovirus and Covid) there was also a reduction in 12hr breaches, with 97 fewer breaches in month.

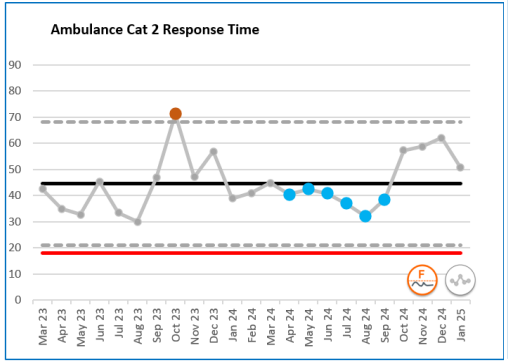
Planned Actions:

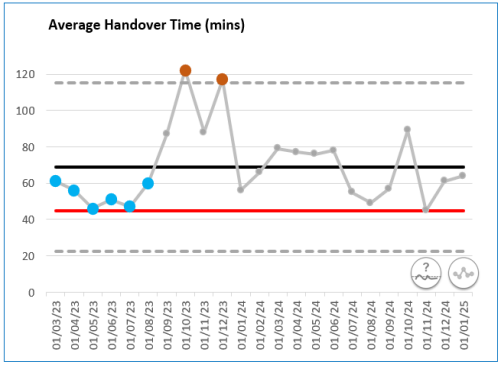
UEC improvement plan ongoing, aimed at targeted improvements with minors, pitstop and streaming.

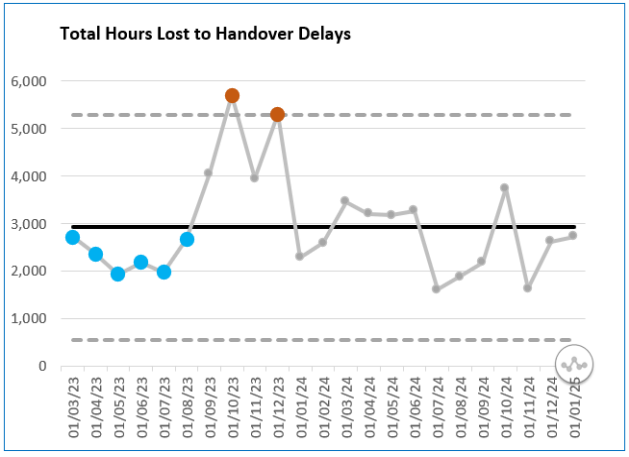
UEC: Average Handover Time

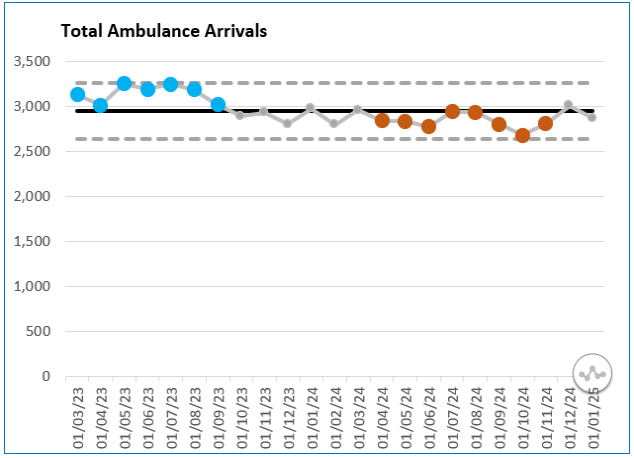
(Standard: Improve Cat 2 ambulance response time to an avg of 30 min across 24/25)











Commentary:
Despite a significant improvement in ambulance handovers during November, there has been a deterioration in the position during December and January, this is despite a reduction in conveyances during January.

The ability to continue to offload ambulances without compromising safety in the Emergency Department caused some extensive delays, particularly at the beginning of January 2025; this resulted in almost 3000 hours of handover delays in month.

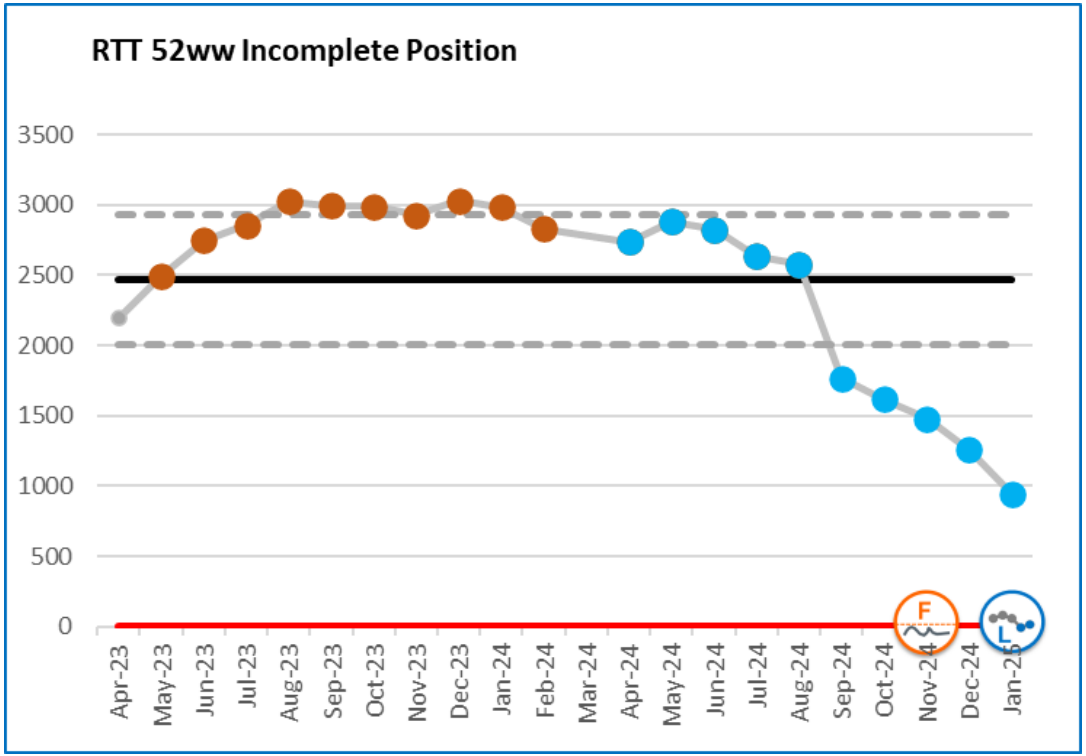
Planned Actions:
Timey Handover Process (THP) remained in place, but the 90minute offload proved extremely challenging requiring a safety-based approach. This resulted in some ED corridor being used to assist with the Critical Incident and REAP4 status declared by SWAST.

The launch of THPV2 is expected to occur in February 2025.

Expected recovery:
UEC improvement plan ongoing, aimed at targeted improvements with minors, pitstop and streaming.
25/26 seeks to reduce THP to 45 minutes by end of April 2025; maximum offload time would therefore by at 30-45 minutes.

Elective: 52 Week Wait

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



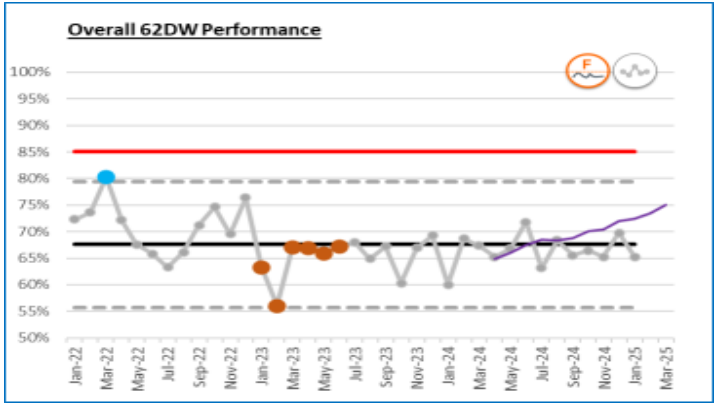
Commentary:
The submitted January month-end position was 946 patients over 52 weeks. This is compared to December's final position of 1,256 so a decrease of 310. Majority of the services made reductions in month, but the most notable decreases being ENT (-188), Oral Surgery (–42), and UGI (–20). 12 patients were reported over 65 weeks (9 Corneal & 3 PFJ)

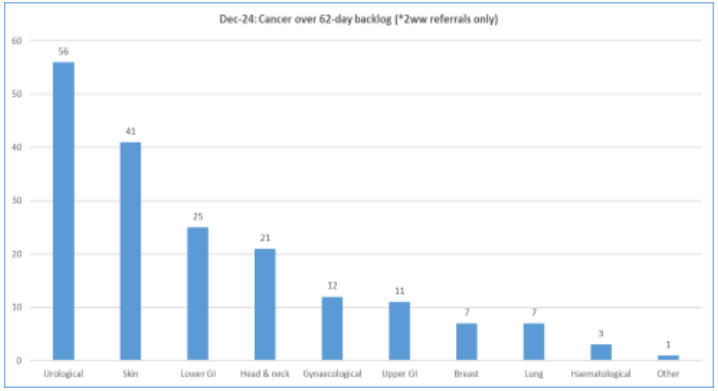
Planned Actions:
Approved ERF schemes are ongoing where applicable. ENT are now in the process of transferring patients to Health Harmonie with a target to transfer 800 patients prior to fiscal year-end (subject to clinical suitability and patient agreement). Scrutiny continues through the various weekly meetings, the PAAF, and support from the validation team/ ECH.

Expected recovery:
Services continue to work to achieving zero 52 weeks by year end, noting several services remain high risk.

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

Standard: 85%



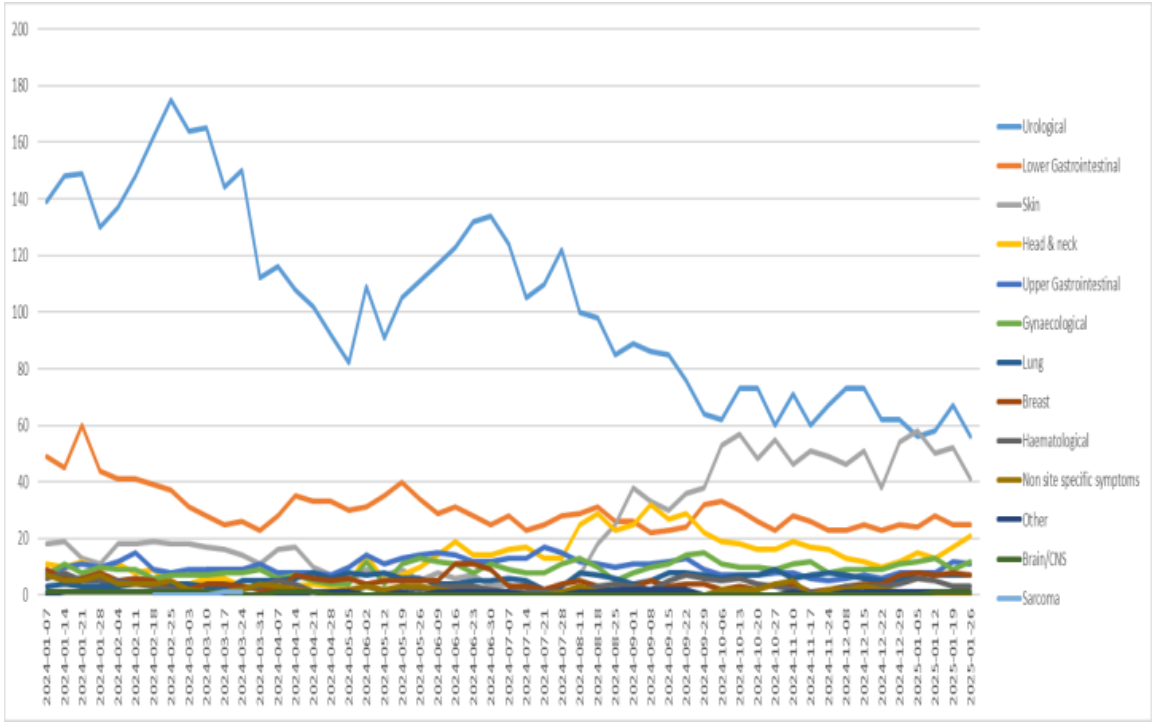


Commentary:
Unvalidated 62 Day standard for January is currently at 66.8% and we will miss this target
This is slightly below our recovery trajectory for 24/25 however we are aware that due to focussing on treating some of our longer patients and significantly reducing our backlog we may see a reduction 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 to support additional LATP and treatment capacity. Local LGI recovery plan being developed with focus on minimising patient delays. Radiology project manager in place to review TATs and improvement plans for diagnostic testing; Review of access policy to support operational decision making and mitigating and performance risk . Review of Cancer Alliance funding for 24/25 with focus on operational delivery against this standard

Expected recovery:
Trajectory has been submitted to ICB for recovery of 62Day at a sustained position of 75% by March-25

Cancer 62 Day Backlog Position



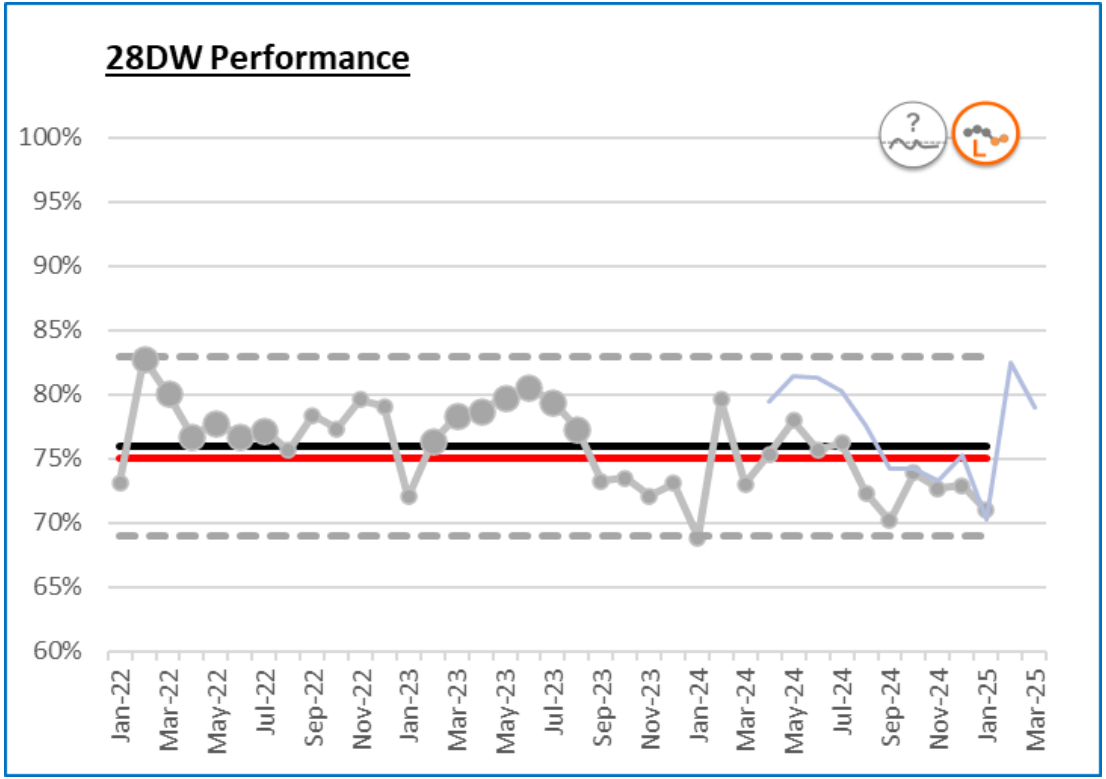
Commentary:
62 Day reportable backlog is 185 as of 03/02/2025
Most of this cohort is held by Urology as demonstrated by the graph however it had decreased significantly over the past few weeks –
The overall delays for Urology are due to the diagnostic phase of this pathway, with many patients waiting after day 62
for diagnostic results or testing, however great improvements have been made to support additional capacity
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 pathways, especially within Urology and Pathology

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 and our aim by (date to be agreed) is to sustain a maximum of 6% backlog moving forward

Cancer: Faster Diagnoses Standard (FDS) % with trajectory

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



Commentary:
Unvalidated 28 Day standard for Nov is currently at 74.1% and we are unlikely to meet this target.
Skin FDS recovery trajectory in progress however is dependent on procurement support, additional capacity

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.

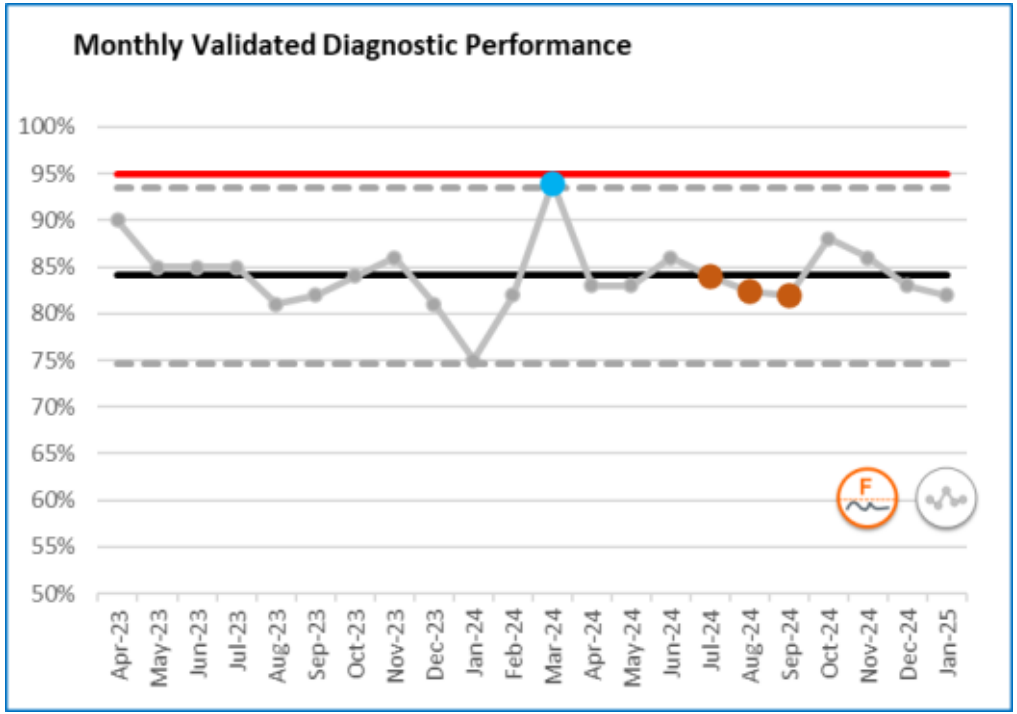
Expected recovery:
Recovery and sustained achievement of the FDS standard is expected by March-25, however, is dependent on all services which support the cancer pathways supporting the actions agreed.

Cancer Waiting Times Performance for the last 3 months

Please Note – January is unvalidated

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Nov-24	Dec-24	Jan-25	Nov-24	Dec-24	Jan-25	Nov-24	Dec-24	Jan-25	Nov-24	Dec-24	Jan-25
Acute leukaemia												100.0%
Brain/CNS	100.0%	100.0%	100.0%	72.7%	83.3%	88.9%	100.0%	100.0%	100.0%			0.0%
Breast	64.4%	87.6%	86.5%	92.2%	90.1%	89.3%	98.1%	99.1%	96.0%	90.3%	93.4%	84.1%
Gynaecological	94.9%	97.9%	95.4%	63.8%	71.7%	61.1%	94.6%	92.2%	86.8%	51.7%	57.9%	57.9%
Haematological	96.0%	90.5%	86.7%	58.8%	45.5%	23.8%	100.0%	100.0%	98.1%	50.0%	56.8%	65.2%
Head & neck	95.0%	96.0%	95.8%	69.5%	69.8%	64.3%	100.0%	91.7%	96.0%	55.0%	55.6%	42.9%
Lower GI	98.8%	99.5%	93.3%	82.7%	78.4%	70.0%	94.7%	95.2%	84.0%	65.9%	66.3%	74.0%
Lung	96.0%	97.6%	100.0%	96.7%	91.7%	85.7%	92.2%	96.3%	100.0%	65.4%	80.6%	52.0%
Other			100.0%			100.0%	100.0%	87.5%	100.0%	66.7%	50.0%	0.0%
Sarcomas							87.5%	100.0%	100.0%	0.0%	50.0%	0.0%
Skin	72.1%	64.7%	75.1%	43.2%	50.8%	53.8%	86.0%	95.2%	87.5%	53.8%	66.7%	75.0%
Non site specific sympto	81.1%	93.1%	72.7%	38.2%	44.1%	29.0%						
Testicular	100.0%	100.0%	100.0%	80.0%	71.4%	88.9%				100.0%	100.0%	
Upper GI	100.0%	98.3%	97.7%	90.4%	91.5%	86.2%	100.0%	100.0%	98.2%	92.0%	97.1%	80.6%
Urological	99.2%	95.1%	94.6%	46.5%	49.2%	53.0%	90.6%	94.9%	85.8%	42.6%	56.1%	41.3%
Trust Total	85.7%	89.2%	89.8%	71.3%	71.9%	70.3%	94.6%	96.4%	92.9%	65.2%	69.7%	66.0%

Diagnostics: Performance Trend



Commentary:
The M10 aggregate diagnostic performance is 18.37% breach performance which is a 1.68% deterioration on the previous month. The total waiting list has decreased in month, from 12,019 in December to 11,957 in January. However, total breaches increased from 2,006 in December to 2,197 in January.

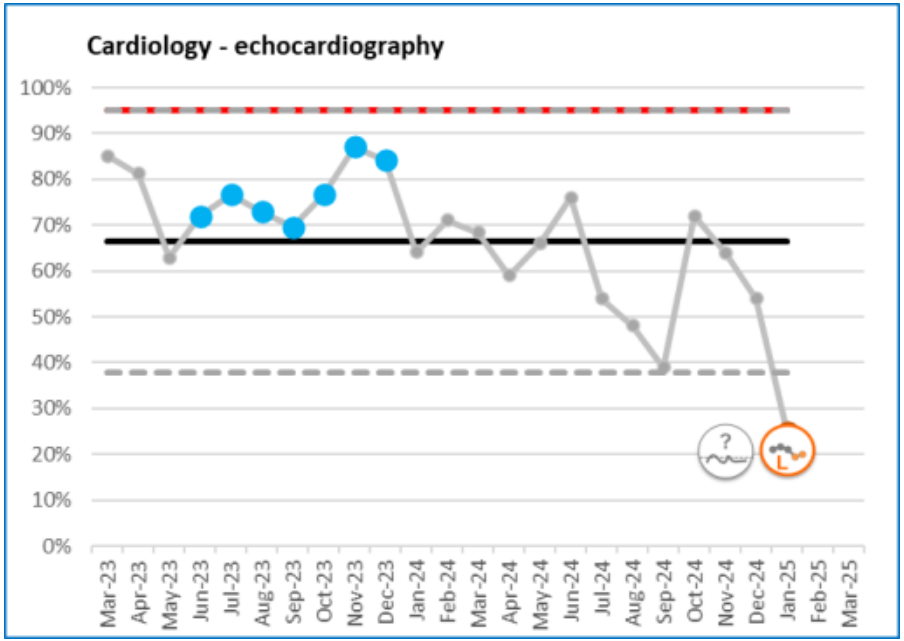
Planned Actions:
The two most challenged specialties remain Neurophysiology and ECHO which account for 69% of all DM01 breaches in month.

Neurophysiology has remained relatively static having dipped 2.23% in month. However Cardiac ECHO has deteriorated by 28.65%, taking the volume of breaches to 1,042 at January month-end.

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. Neurophysiology will continue to deteriorate if additional capacity is not provided within Q4.

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%)

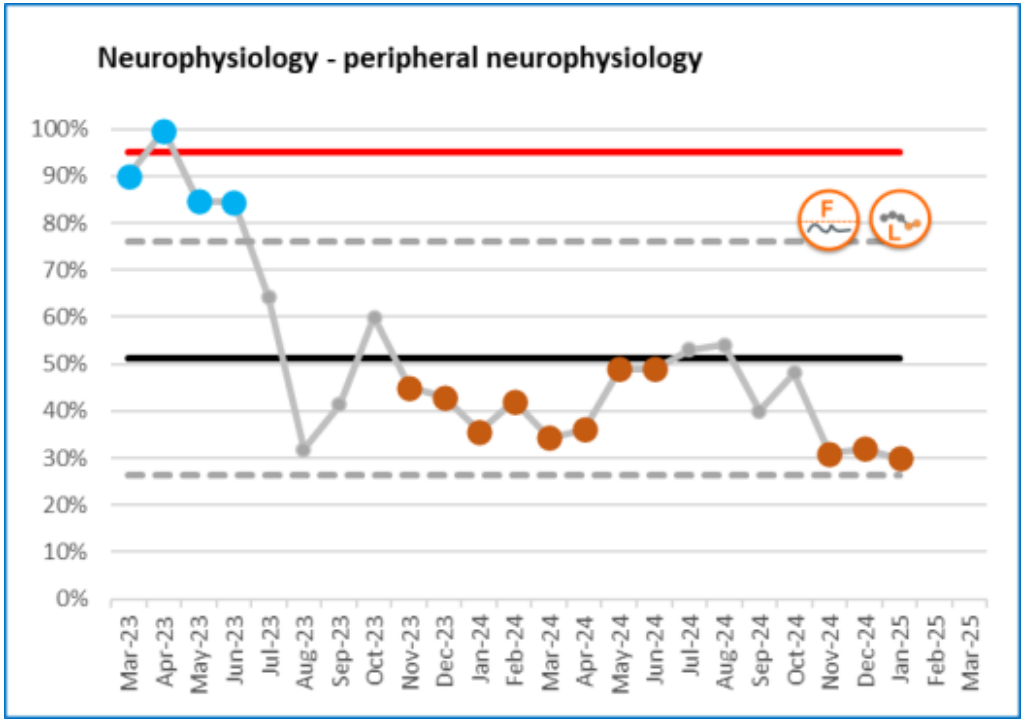


Commentary:
Performance has seen a deteriorate month on month.
Workforce challenges continue and demands for the service is outstripping the capacity available. Demands form from inpatient referrals, the community and other services [POAC, Oncology] have a significant impact. Due to the demands on the service and the removal of the locum Agency, the 2 physiologists rostered to perform inpatient scans on Mondays and Fridays will be reduce to 1 physiologist to support the DMO1 performance. The prioritisation of IP activity has impacted the DMO1 recovery plan. NHSE plan to visit service on 21st February 2025

Planned Actions:
ISCV – dedicated reporting system for the physiology and clinical team. Will support with improving the reporting speed for the physiologists. Launch date of February 2025 has been delayed due to IT issues.
ECHO support worker – Currently being advertised. Benchmarking identifies the success of the role in other Trusts.
Open Access to ECHO by the GP – this option has been put on hold due to staffing issues and lack of information relating to the success and added value of running this service.
Change to staff rotas – BSE MSK guidelines have been incorporated into staff rota's. New templates are on TRAK. MSK guidelines reduce the number of scans physiologists can perform in a session.
DMO1 tracker/validator – dedicated administrator to support with the validating and booking of scans started November 2024. Dedicated RTT & Performance Manager due to start 24th February 2025.
Four Eyes Insight – 3rd party looking at the Capacity vs Demand within the department, final report has been received and will be reviewed as part of NHSE visit on the 21st February 2025.

Diagnostics: Neurophysiology

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)



Commentary:
Drop in performance in January with annual leave and sickness. Large drop following the correction of a data issue where a cohort of patients were not being reported on the DM01 breach report (they were still on the WL).

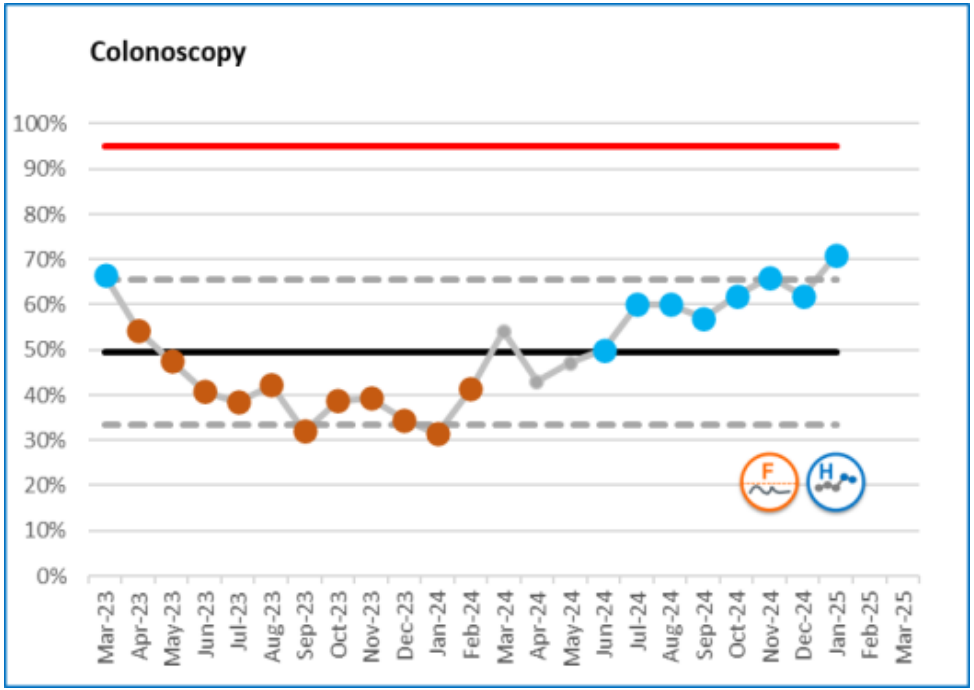
Planned Actions:

- 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 at weekends and evening
- Request to ICB for any other providers under their contract
- Support from IT to enable remote reporting solution that will increase capacity.

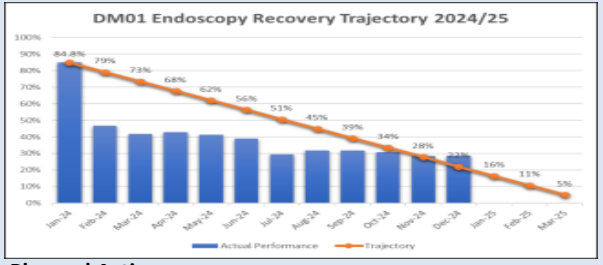
Expected recovery:
Additional 50 tests being provided per month against referrals. Current waitlist 688 (down from 832) with 326 unbooked.

Diagnostics: Colonoscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



Commentary:
Colonoscopy DM01 performance deteriorated slightly in December with 38% against the 34% in November. This was due to the lack of clinical availability over the holiday period.
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 is for DM01 in totality. The service is performing well against the overall DM01 recovery trajectory however it was slightly over in December.

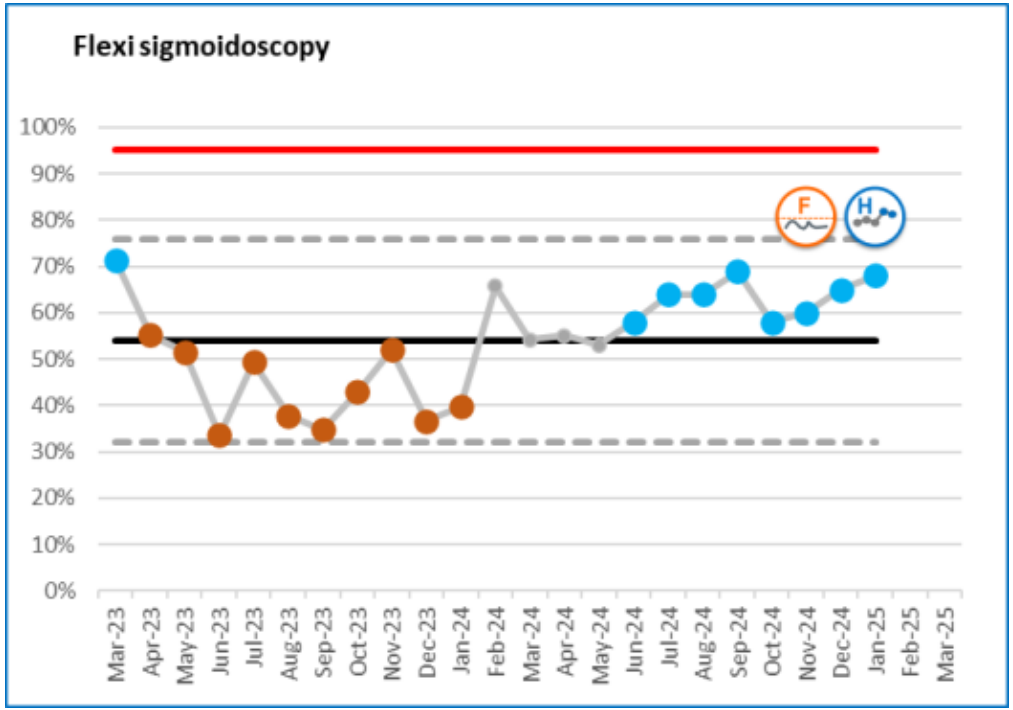


Planned Actions:
-ERF scheme – Consultant in place delivering 5 lists per week – this provision ends March 25
-Provide weekend lists from 14th Dec – 31st March 25
-Investment business case submitted for increasing theatre capacity at GHFT sites including required workforce capacity
-Backfilling of lists by Clinical Endoscopists.
-Deliver on the Endoscopy Recovery and Improvement Programme Plan including development of 3-5-10 year strategy

Expected recovery Risk:
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%)*



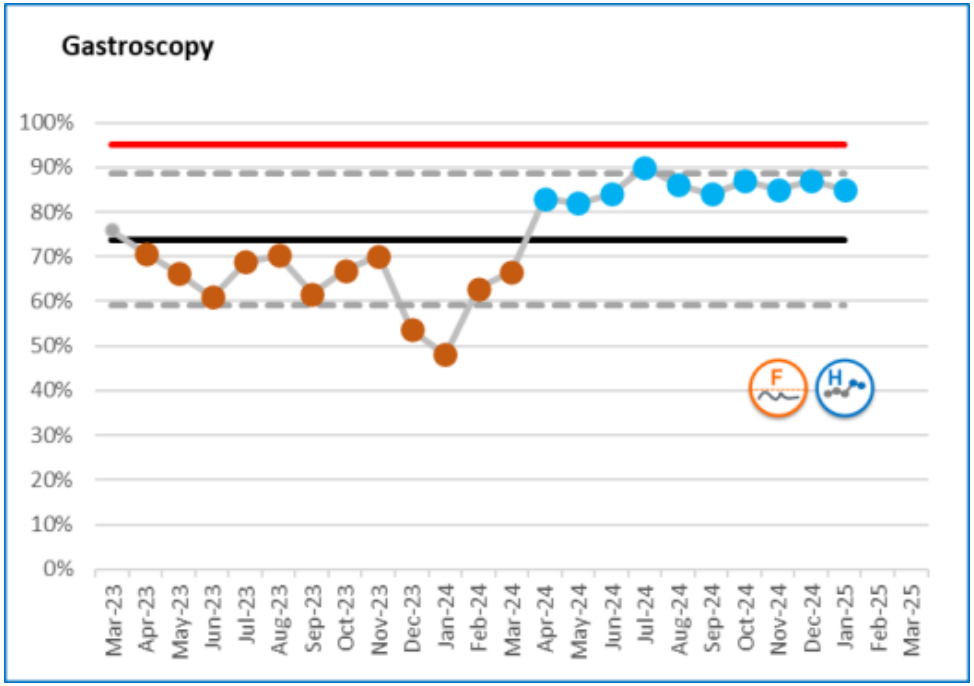
Commentary:
Flexi Sig DM01 performance improved in December with 35% compared to 40% in November.

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 submitted 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 Risk:
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%)*

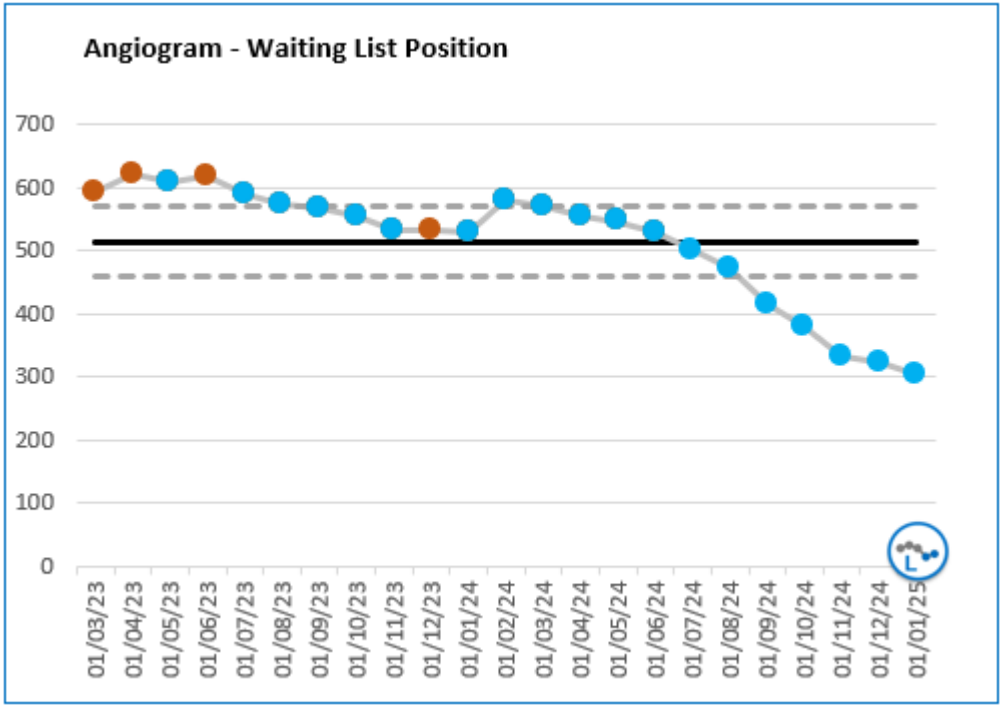


Commentary:
Gastroscopy performance improved in December with 13% against the 15% in November.

Planned Actions:
-ERF scheme – Consultant in place delivering 5 lists per week
-Provide weekend lists from 14th Dec – 31st March 25.
-Investment business case submitted 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 Risk:
Expected DM01 and surveillance recovery by March 2025 is at risk due to lack of theatre and workforce capacity

Angiogram - Waiting List Position



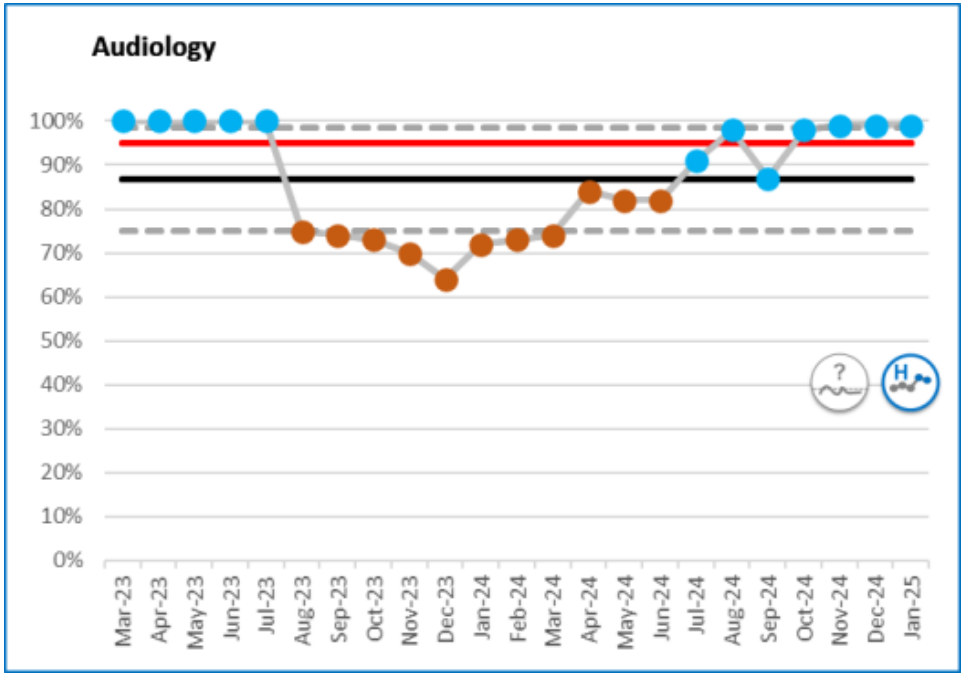
Commentary:
Reduction in waiting list numbers continue, as of January 2025 there were 318 patients on the waiting list. Cath lab 1 & 2 both operational with less downtime unless servicing requirements are needed. Cath lab 3 will be fully operational 17th February 2025. CDCU recovery area in full use [part of IGIS].

Planned Actions:
Additional weekend activity for both angiography and devices 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 Feb 25 to continue with the reduction of the angiogram backlog and reducing LOS for patients waiting for an IP procedure. Average LOS for a patient waiting for angiogram is 48 hours.

Expected recovery:
Waitlist halved by January 2025. Full recovery will be dependent on the 3rd cath lab business case.

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%)



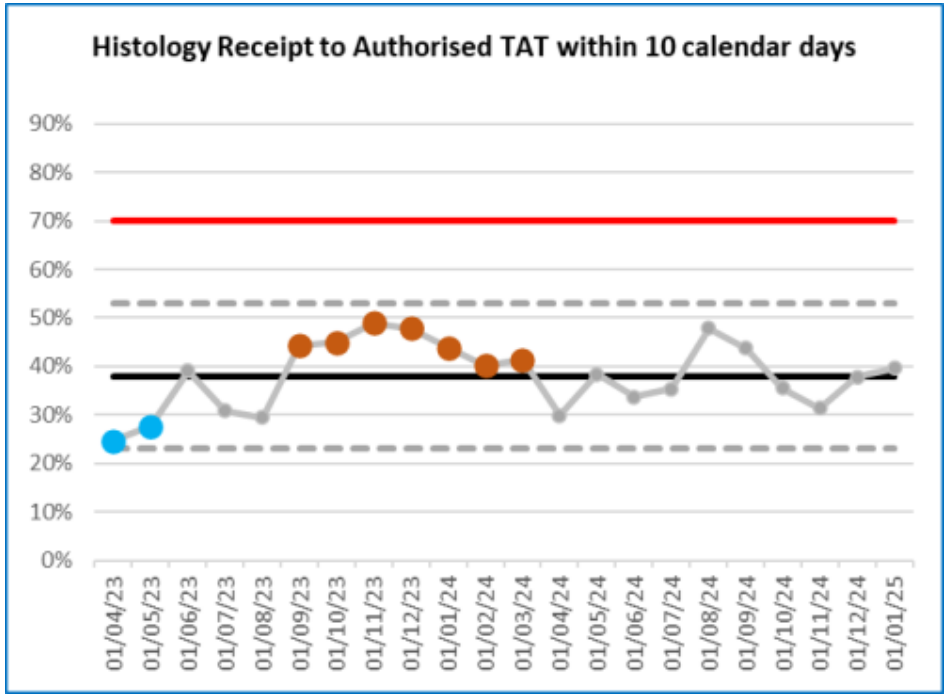
Commentary:
The Change in DM01 Reporting definitions commenced in August 2023 which affected historic 100% performance. DM01 compliant reporting has now been fully applied and reflected.

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 and compliance has been maintained for the last three months.

Planned Actions:
Additional audiology activity continues to support the recovery of DM01 in conjunction with supporting ENT recovery.

Diagnostics: Histopathology 10-day reporting

Standard: Delivering 70% turnaround times

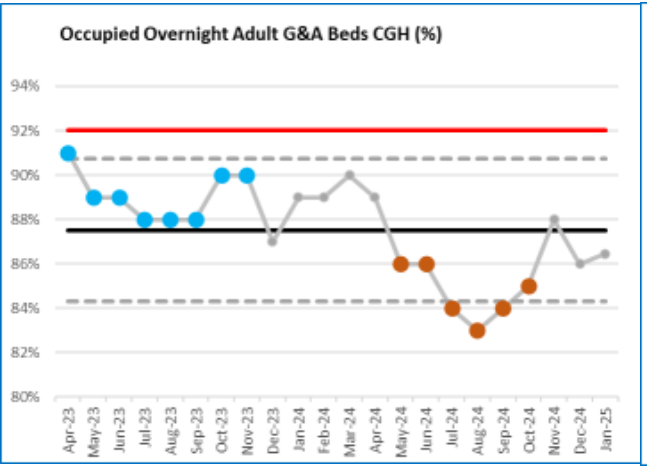


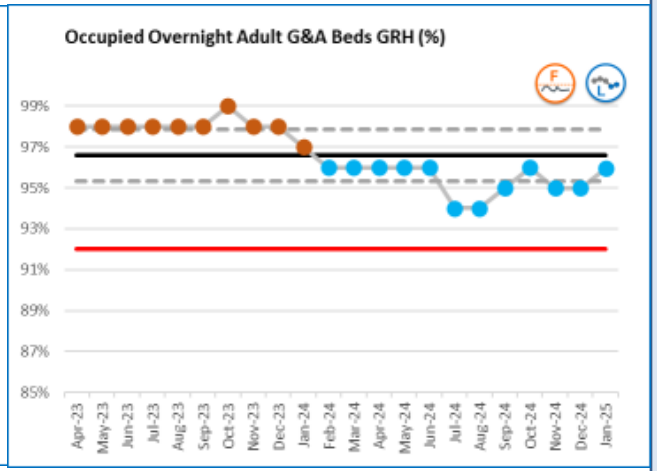
Commentary:
There is a national shortage of Histopathologists and this comes at a time of a 30% increase in Histopathology requests. There are currently three vacancies within the consultant body. The department has old, end of life equipment which is becoming increasingly unreliable causing delays in 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 90% of cases with some cases being reported digitally. Pathologist training is complete and validation is ongoing
Digital outsourcing is being progressed to help with capacity but keep turnaround times down. Efforts to recruit Consultants continue although with limited success

Expected recovery:
There will be an increased reliance on outsourcing to bring reporting times down. A new outsourcing provider is being onboarded.

General & Acute Beds: Occupied



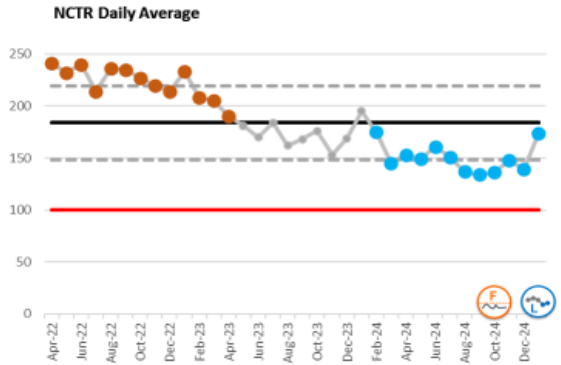


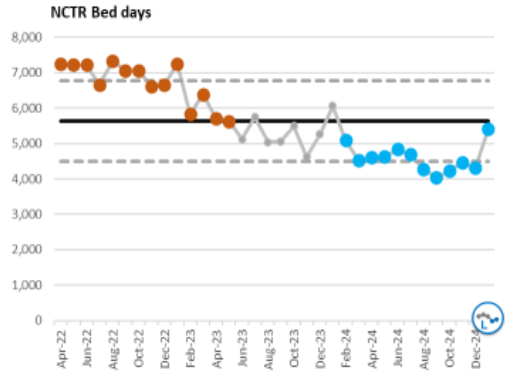
Commentary:
Average bed occupancy went back up in January linked to a period of critical incident at the beginning of the month and then a prolonged recover phase post. Main driver of lower occupancy remains the orthopaedic beds in CGH with changes due towards the end of the financial year which will lesson that impact.
Flu numbers improved, but Noro Virus numbers increased in month leading to a number of beds to be closed and then others to be closed and empty.

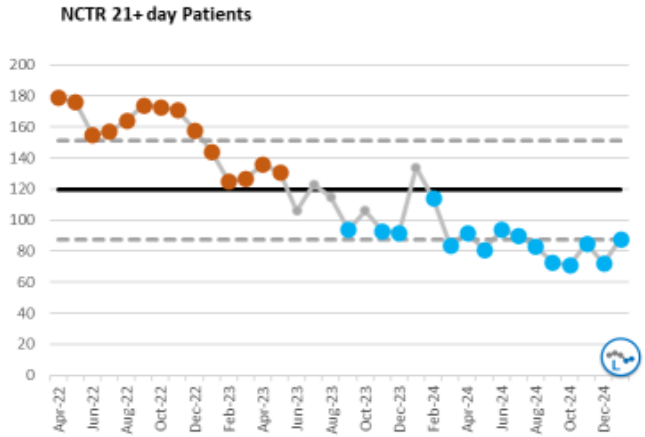
Planned Actions:
Continued pressure to reduce the nCTR numbers will assist in the recovery. Reconfiguration of elective orthopaedic beds will also increase our occupancy as the day case beds are removed from the over bed stock.

Expected recovery:
IPC restrictions likley to improve going into February. Improvements in flow also likely to help reduce outliers, having a knock-on benefit to surgical bed base and lower occupancy levels.

General & Acute Beds Occupied with NCTR







Commentary:
Generally national language now moved to Discharge Ready Date (DRD) for the number of patients affected with nCTR being the reason for not having been discharged.

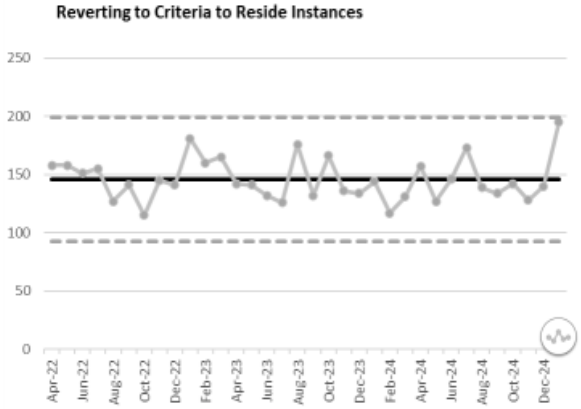
January started with a sharp increase in DRD referrals and then subsequent numbers awaiting discharge with nCTR. This along with delays in discharges across various pathways, meant we had the highest number of bed days lost associated with nCTR since January 2024. DRD for 21+ days saw a slight increase, but the main driver of the overall increase in lost bed days was linked to a significant increase in demand, however this is not unusual for the January month and was acknowledged in this years system plan.

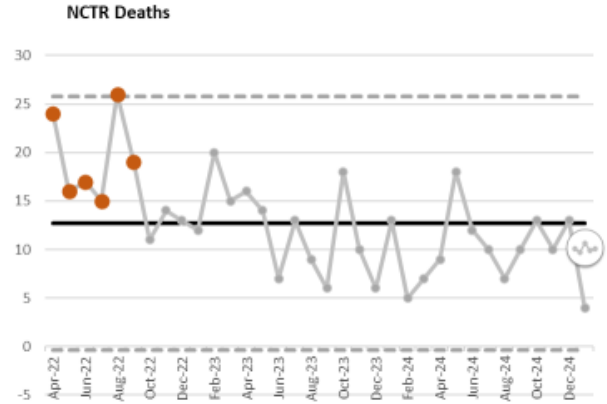
ICS conversations ongoing to rectify and get back towards the 93 DRD patients seen on the 15th December.

Planned Actions:
Additional DCA and P2 beds agreed as part of a system response to the increase in demand seen towards the end of December/beginning of January. Internally, reviews of all long waiters and internal actions to be undertaken as part of OPEL action cards.

Expected recovery:
Expected reduction in nCTR back towards the 93 seen on the 15th December before the end of the financial year.

Delay Related Harm NCTR





Commentary:

Despite the significant increase in bed days lost post Discharge Ready Date (DRD), the number of deaths whilst DRD reduced within January. This likely relates to the volume of referrals being the predominant driver of the increase, rather than an increase in time taken to be discharged post DRD.

1 area of concern was a significant number of patients becoming unwell and subsequently meeting the CTR again. Not unusual for this to spike in the December/January period, but the size of the spike is of concern as much larger than in previous years. This is likely to be related to the significant numbers of patients picking up infections whilst in hospital, but this needs to be considered within the winter debrief.

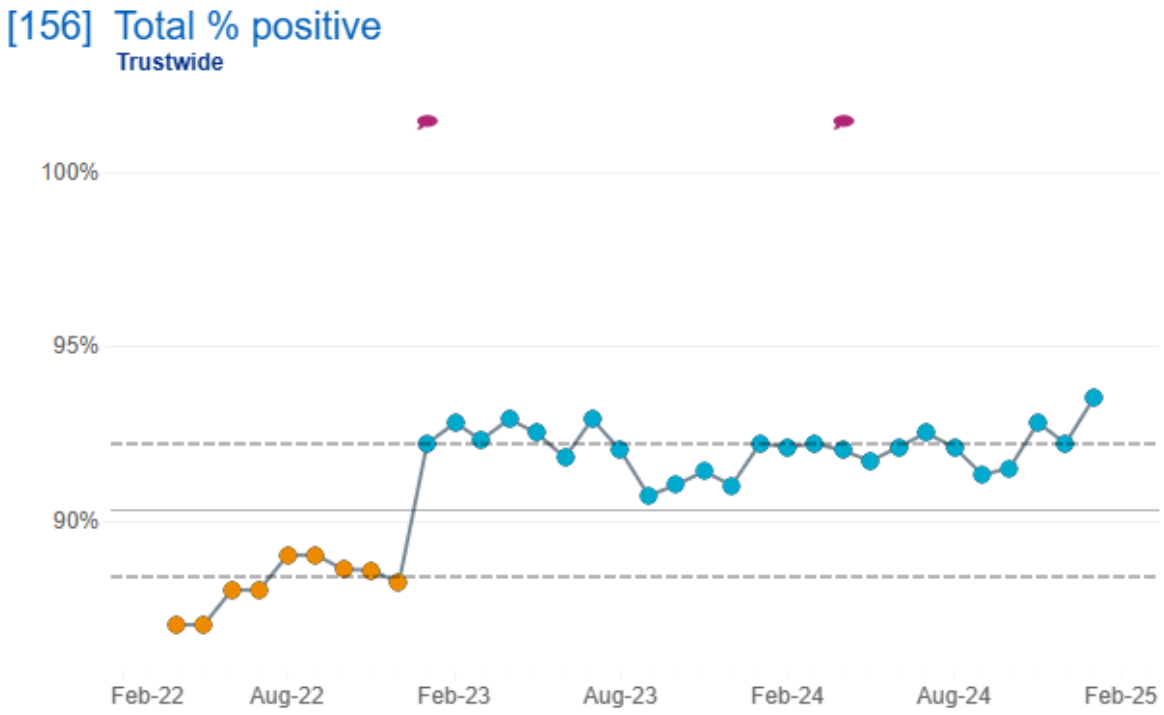
Planned Actions:
Pick up within the winter debrief to consider if any other drivers for such a high spike in patients deteriorating patients. Review through DRH meetings to consider system wide contributions.

Expected recovery:

Hard to predict numbers, but expected reduction in nCTR numbers and median wait likely to see a continued reduction in DRH.

Quality & Safety Metrics

Quality of Care: FFT Positive Response



Commentary:
The overall Friends and Family Test (FFT) score has increased from 92.2% positive in December to 93.5% in January. This is as a result of a increase in score for Emergency Department (84.0%) and Inpatient & Daycase (94.4%). These increases in positive score are against a backdrop of a critical incident during this month. Positively, ED saw its most positive score in over three years with GRH ED moving from 68.5% positive to 79.6%.

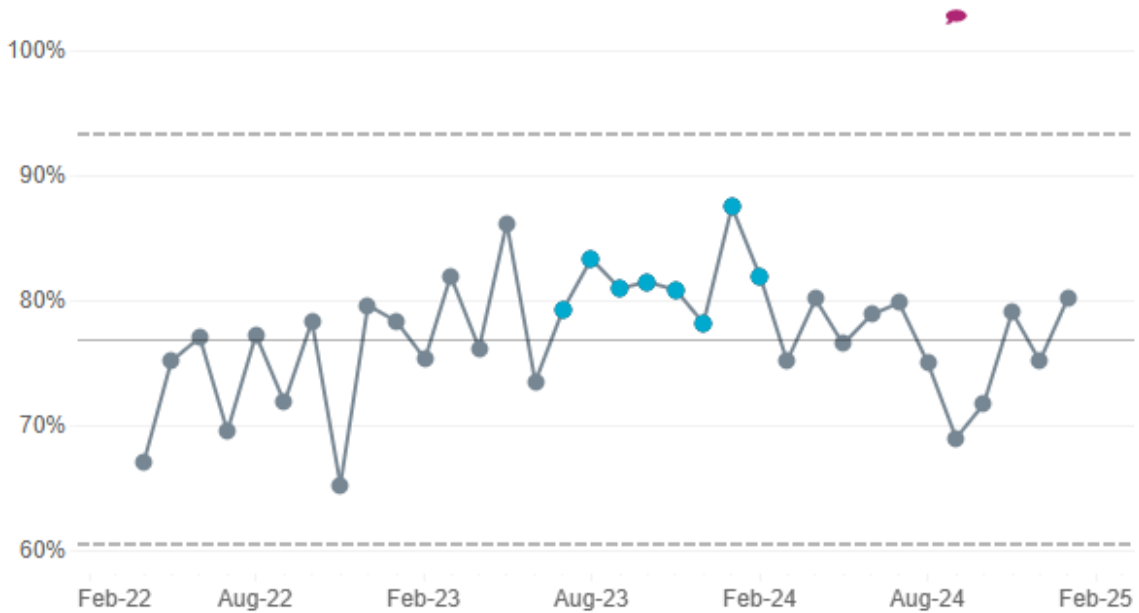
Planned Actions:
To understand how our Trust was working during this month in order for us to look to continue this practice. For divisions to review their data including comments and identify learning and improvement opportunities.

Expected recovery:
We would hope to see our scores hold over the coming month and the positive score in ED to be maintained.

PALS

[569] % of PALS concerns closed in 5 days

Trustwide

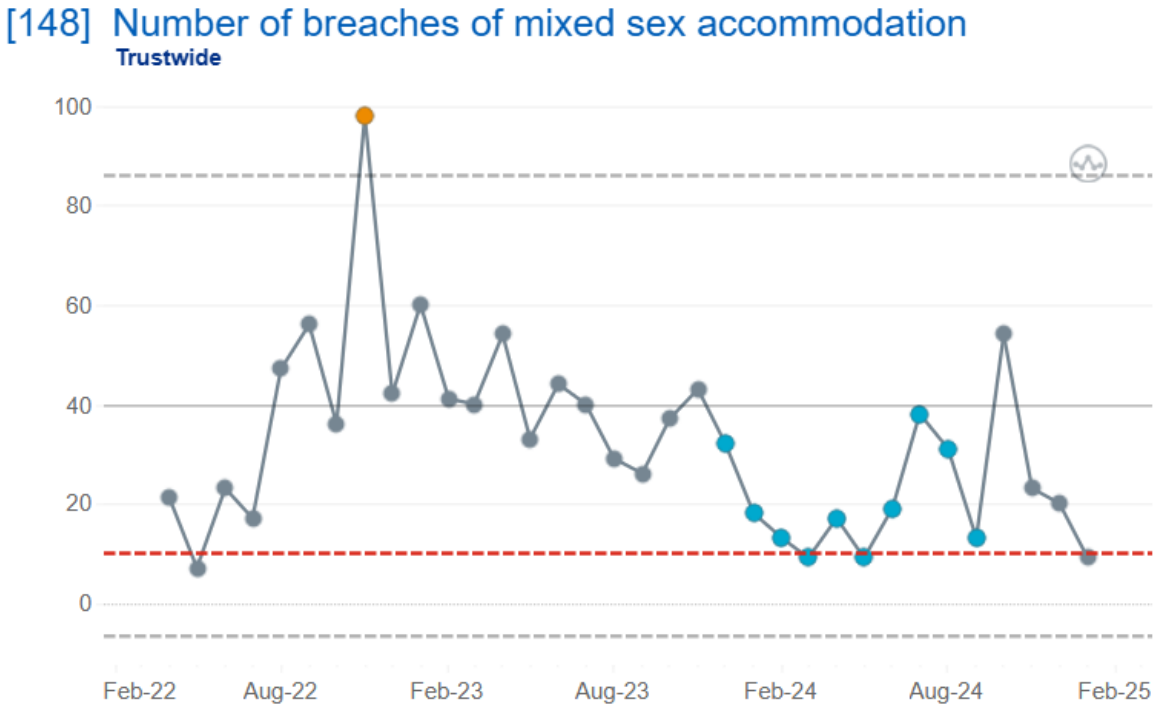


Commentary:
The PALS team have seen a slight increase in concerns closed in 5 working days to 80% which is above target (75%). The team have worked very hard to close cases more quickly and have been working additional hours to support this while there is sickness in the team. There was an increase in the number of concerns but the team are trialling a new RAG approach to the triaging of cases in order to support prioritisation further. Please note that this figure may shift as the team are still updating records on Datix.

Planned Actions:
PALS team continue to provide a responsive service through email and phone but have suspended their drop in offer in order to manage the workload. An additional PALS advisor post has been recruited and is expected to start March 2025. Deep dive into PALS to be taken to Q&P in March 2025.

Expected recovery:
Unlikely to see a significant improvement until at least March. Sickness continues into February. Recruitment of new starter likely to be March 2025.

Patient Care: Mixed Sex Breaches

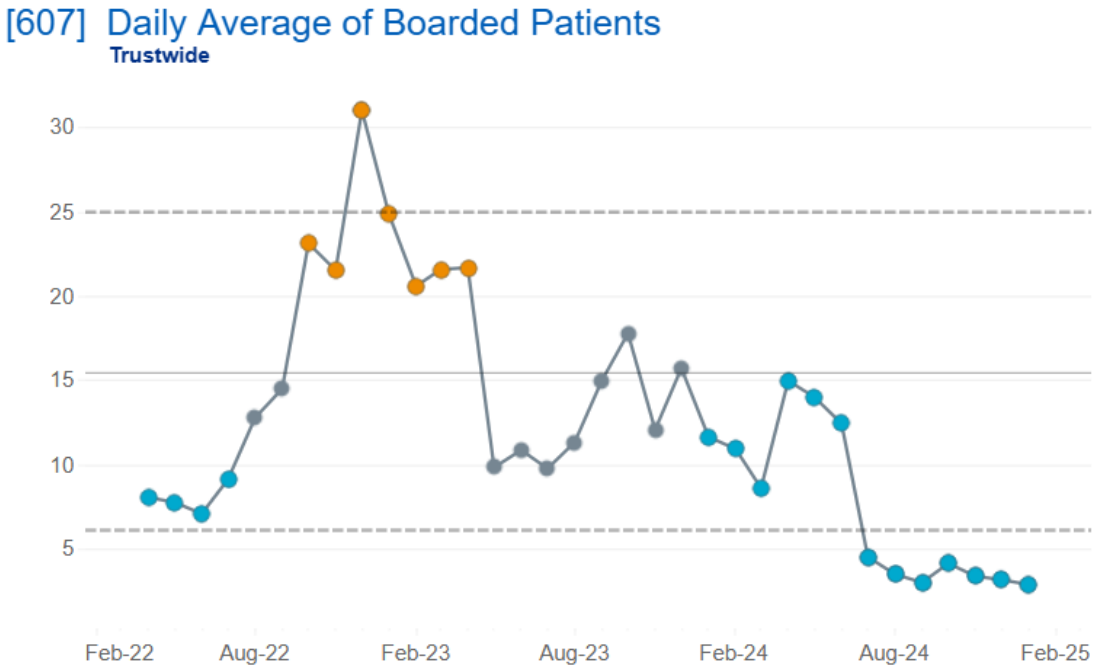


Commentary:
Breaches remain minimal and only when no other option is available. Breaches link directly to challenges in flow towards the end of the month, which saw delays in bed allocations to patients within DCC and the inability to move patients into ward beds within the 4hr timelines.

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



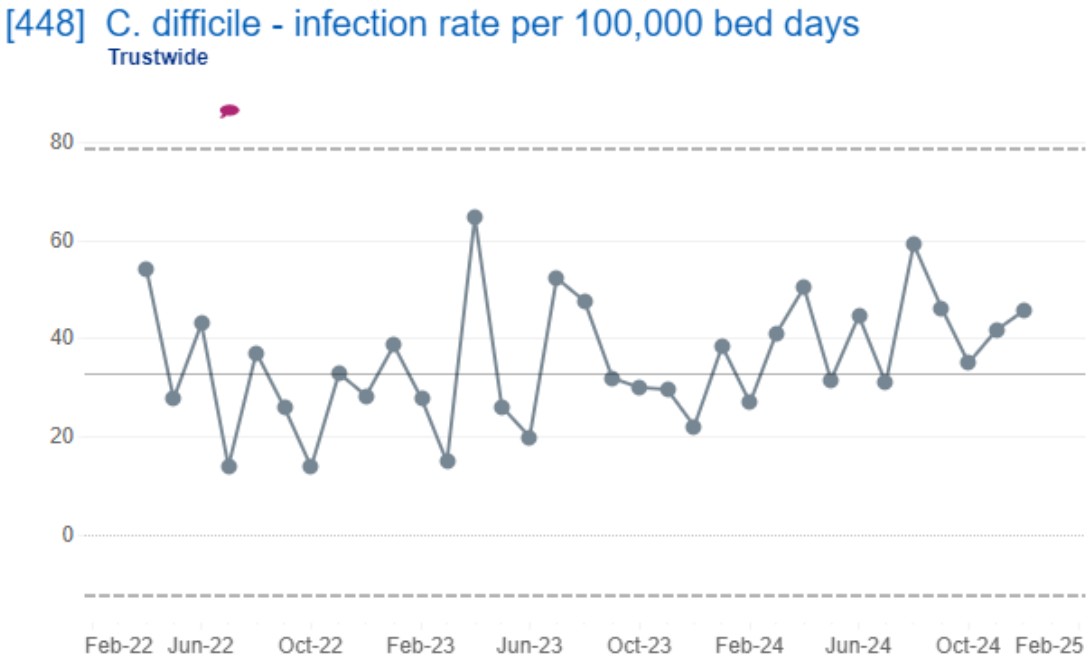
Commentary:
Plus 1 policy has now been agreed through trust governance, however not required during the critical incident process.

Planned Actions:
Clear governance process now in place, only to enacted in Critical Incident and if exec tri agree needed.

Suggest removed from IPR pack

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 87 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.

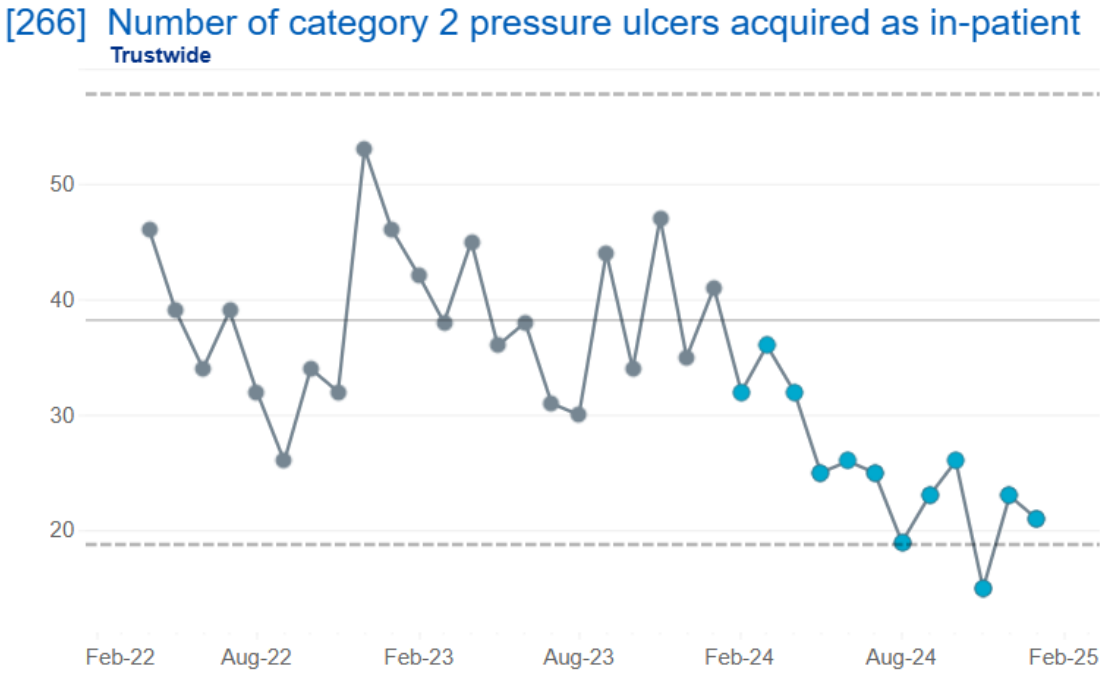
Planned Actions:

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 Feb 2025 we began our deep dive into patients with recurrence of CDI and their care across the system and which will support implementation of focused interventions for this risk group including use of Fidaxomicin.

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). We are currently on trajectory to meet the annual threshold.

Safety Priority: Pressure Ulcers Cat 2

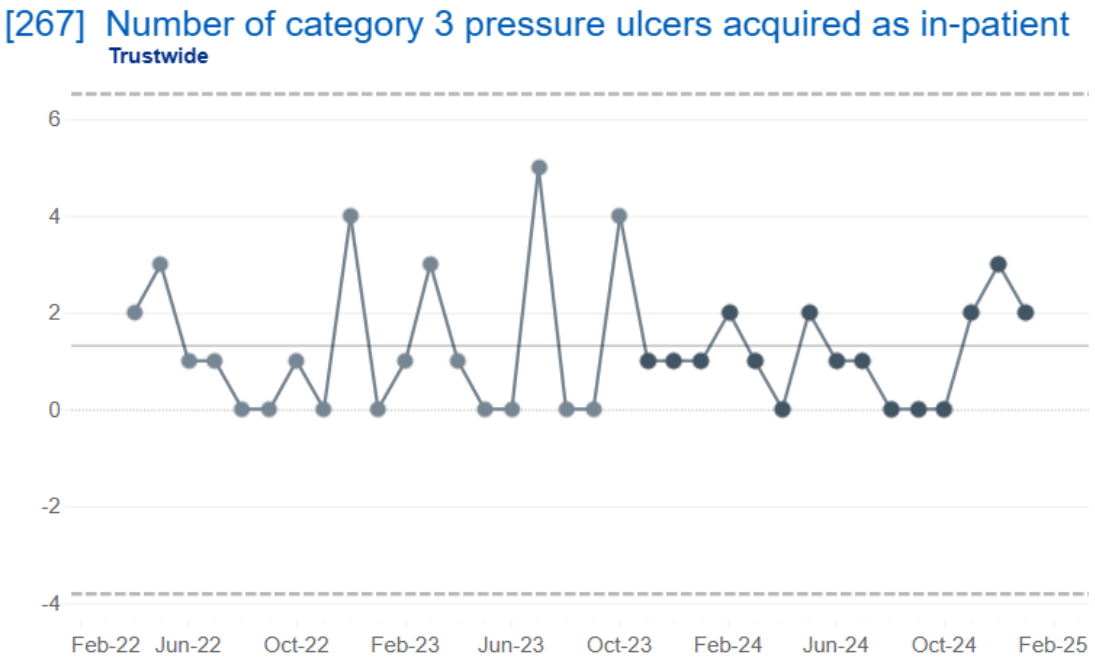


Commentary:
Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of repositioning.
The reduced count over the past 8 reporting periods is possibly a result of reduced corridor usage which was associated with an increase in rates.

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

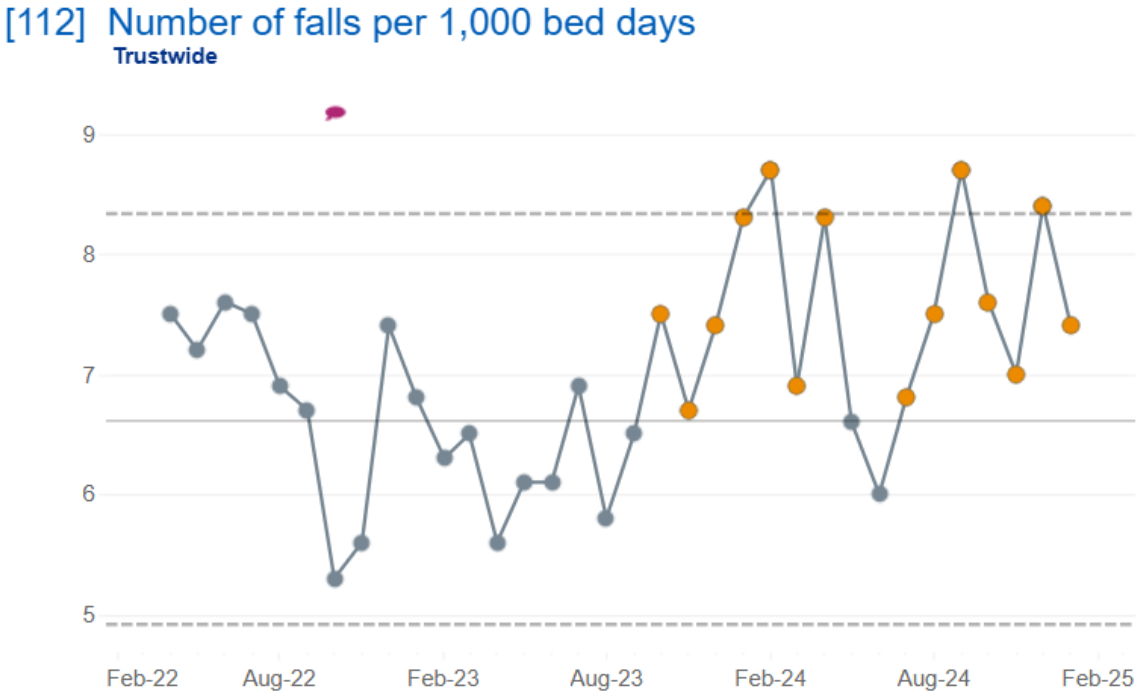


Commentary:
Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated by more patients on a ward than the staffing model accommodates,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

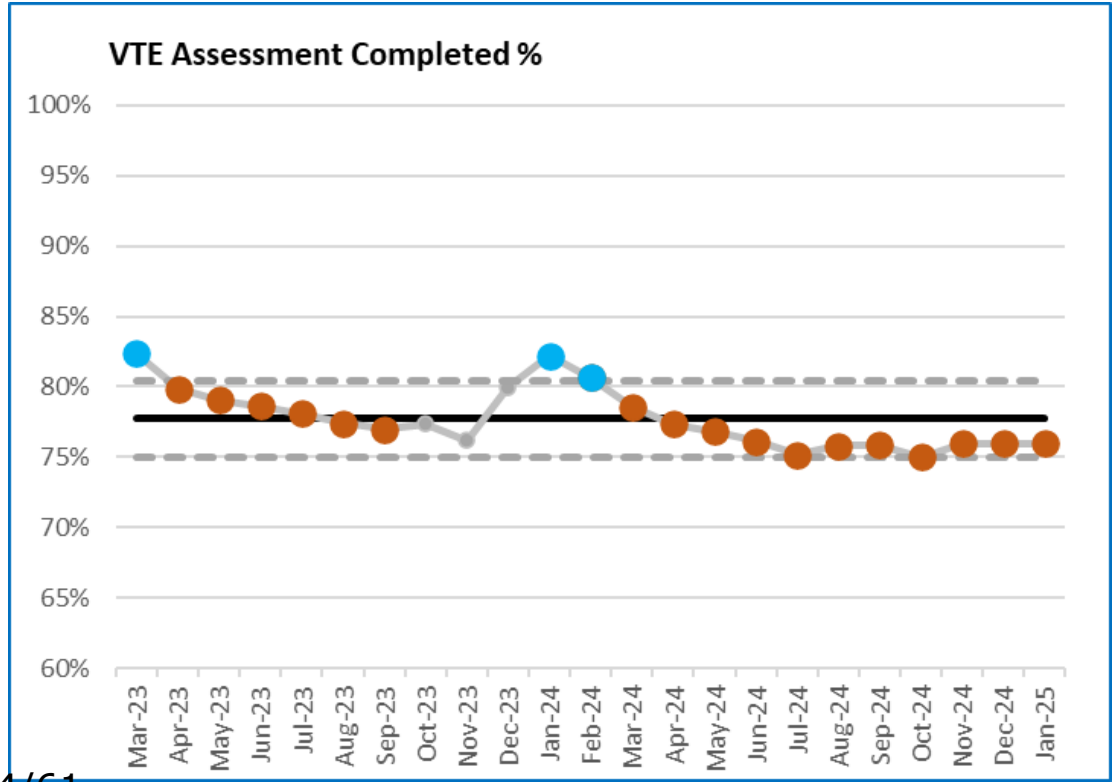


Commentary:
The falls per 1000 bed days continues to fluctuate due to the acuity of the patients , provision of enhanced care. All patients over 65 or at risk of falls have an assessment on admission to guide falls prevention strategies.

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 19/2/25

Data:

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

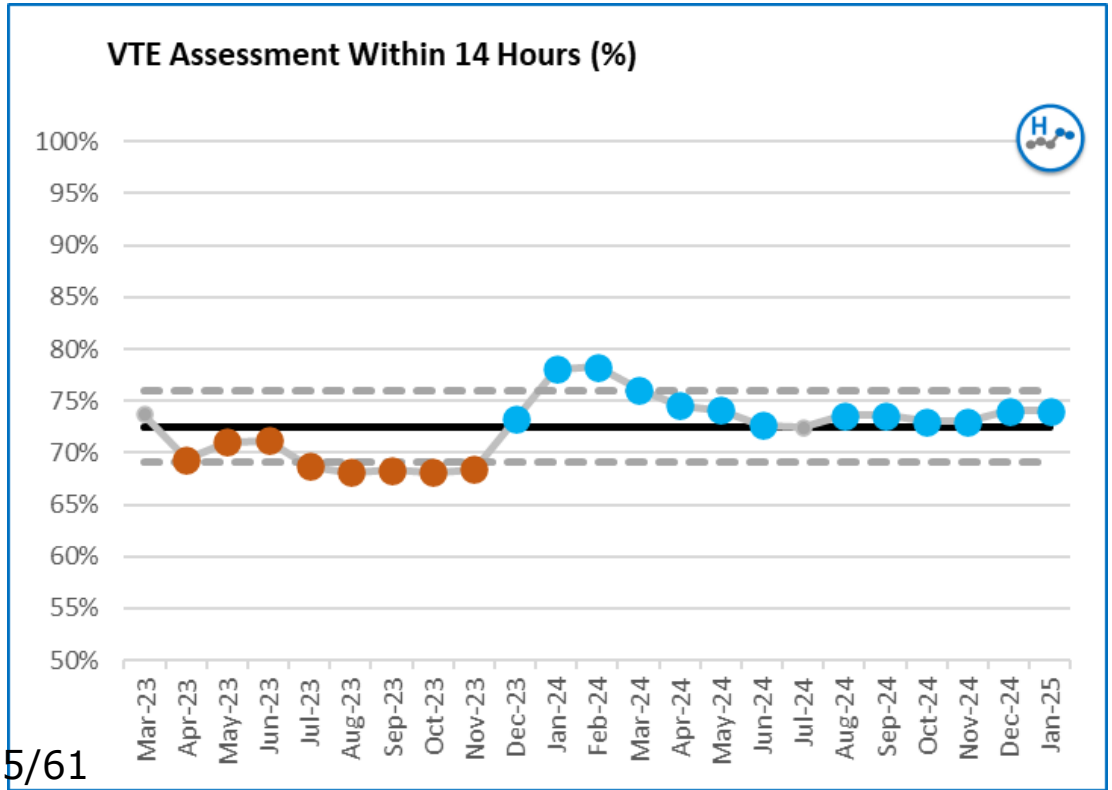
Trust:

- 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 in progress

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
- Formal presentation of manual audit to be presented as a slide at Antenatal Forum, Feb'25

Patient VTE Risk Assessment Within 14 Hours



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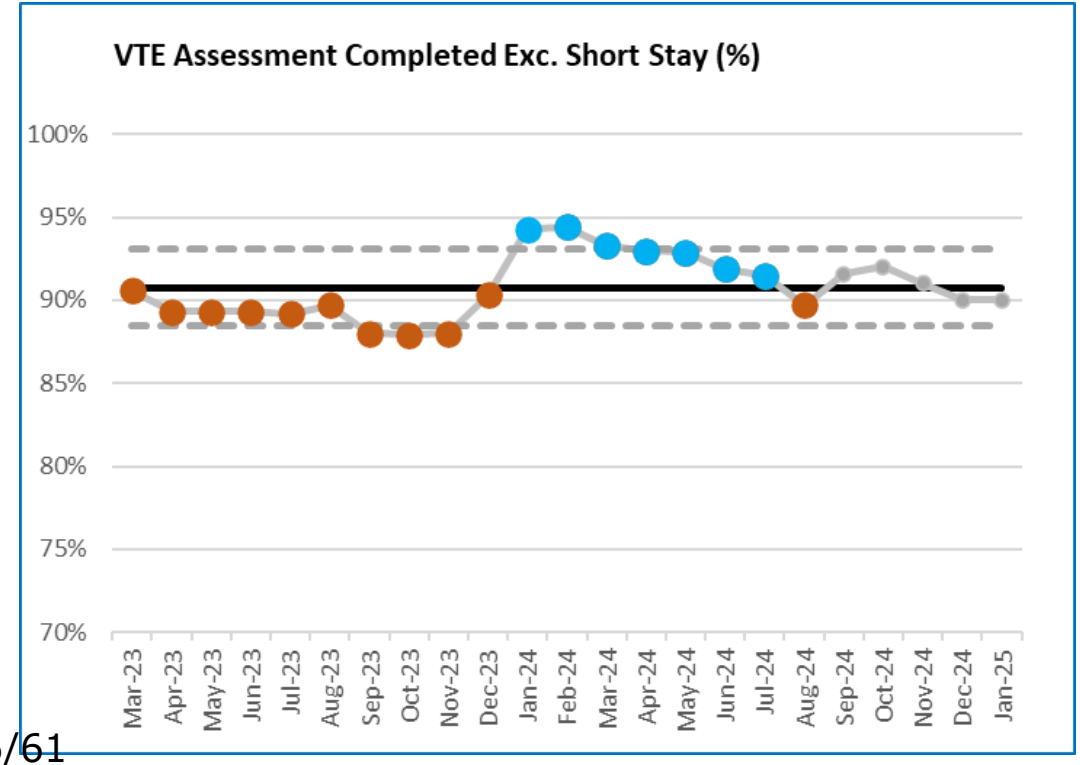
Patient VTE Risk Assessment Excluding Short Stay



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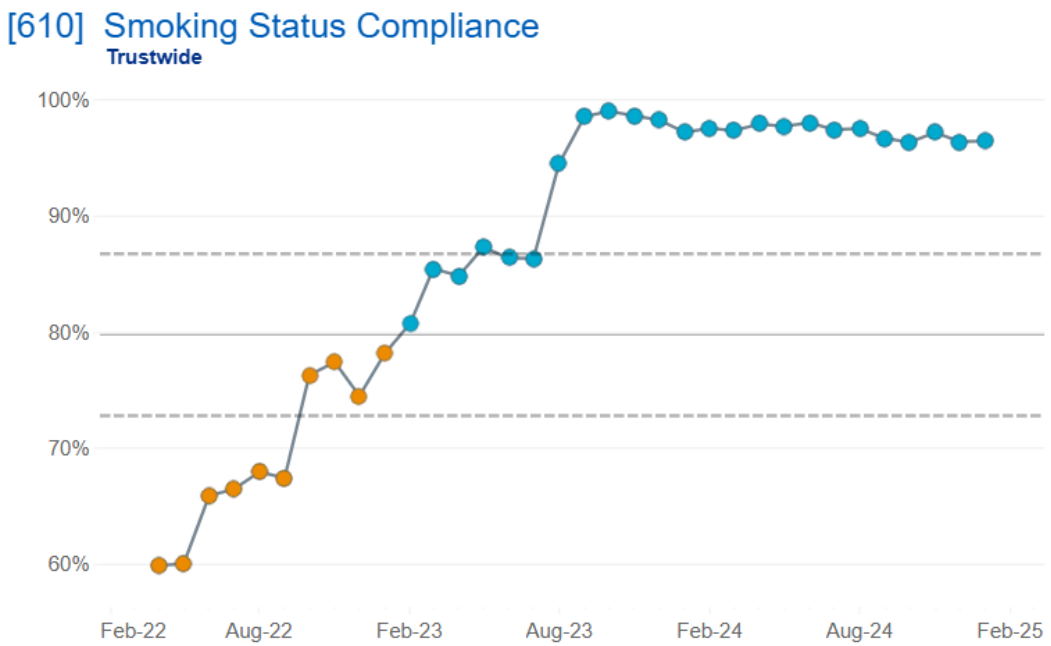
Patient Smoking Cessation

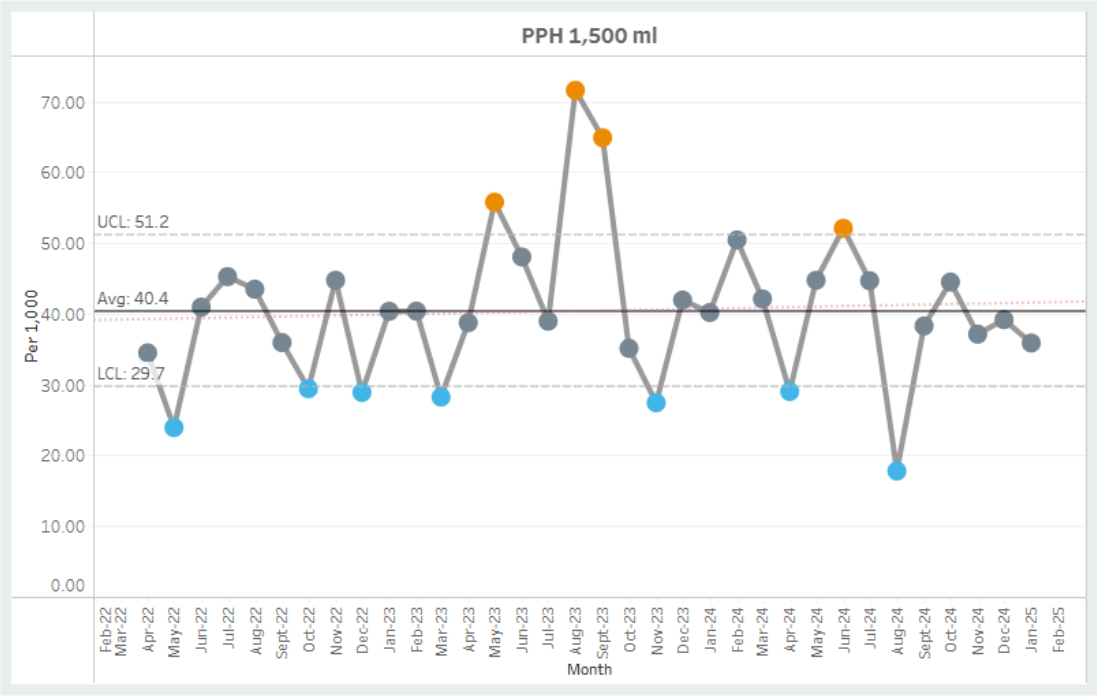


Commentary:
All patients admitted to hospital should be asked about their smoking status by the clinical and admitting teams; this should be recorded on their clinical notes and referred to the Tobacco Free Team.
Smoking should be treated like any other addiction, patients should be offered NRT upon admission.

Planned Actions:
Trust wide communications reminder to record smoking status.
Tobacco Treatment Advisors providing interventions on the ward.
VBA sessions to commence.

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

Maternity Care: Postpartum Hemorrhage >= 1,500 ml



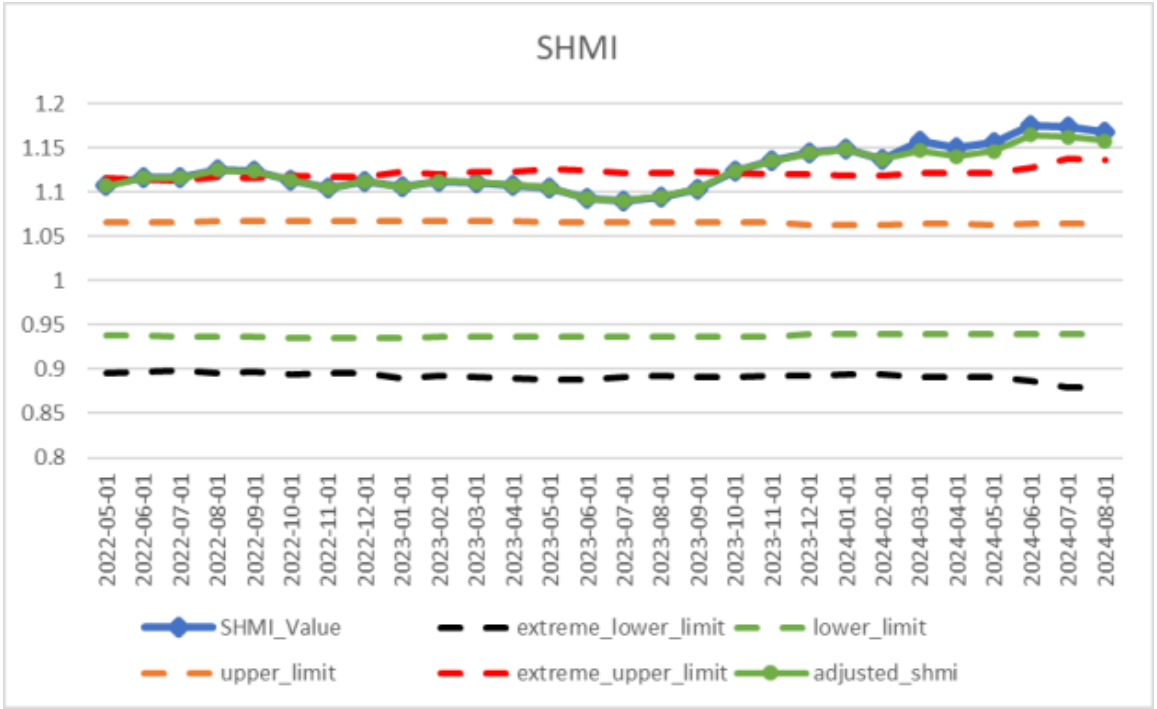
Commentary:
Detection and escalation of maternal and fetal deterioration is one of the areas of improvement for the Trust and this has been identified as one of the Trust Safety **Priorities.** Overall Massive Obstetric Haemorrhage (MOH) rates have decreased. We have a **CQC S31 enforcement notice** that requires us to enable improvement for the management of haemorrhage.

The MOH/PPH improvement team analyse safety incidents on a weekly basis and continue to target their improvement actions using the SEIPS analysis. Key actions have been on the commencement of Carbetocin for all C/S and the implementation of a REDUCE proforma for risk assessment and management plan. Audits of the REDUCE proforma continue to identify areas of focus.

Planned Actions: The next steps are that the QI team are focusing the improvement work in the maternity theatres and also for women who have an instrumental delivery.

Expected recovery: The QI work continues with oversight reported to the **Maternity Delivery Group**.

Mortality – SHMI National Data



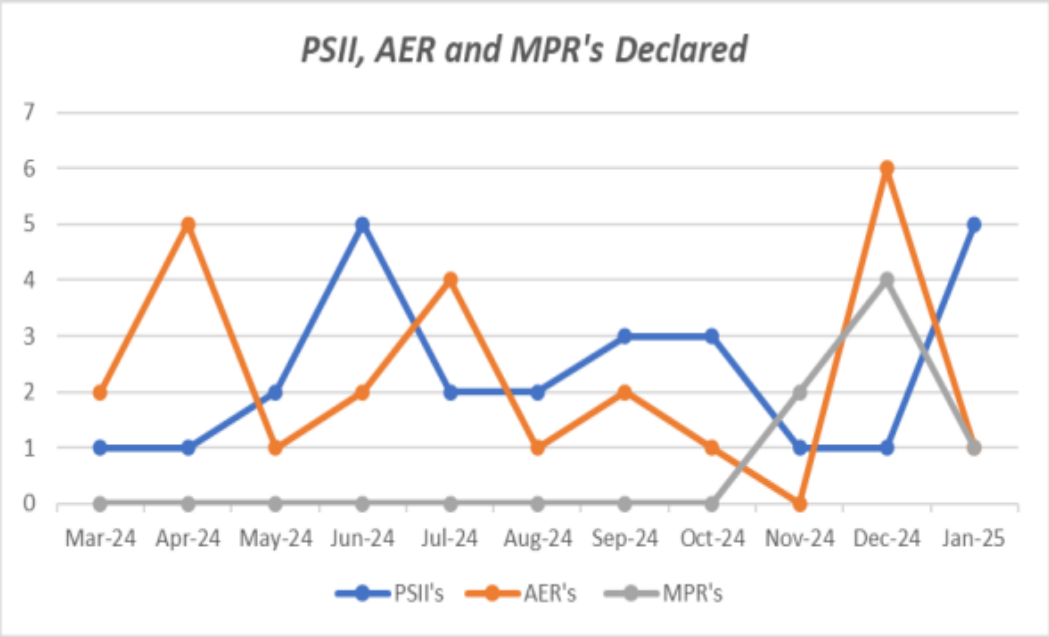
Commentary:
Latest SHMI (NHS Digital) = 1.17

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:

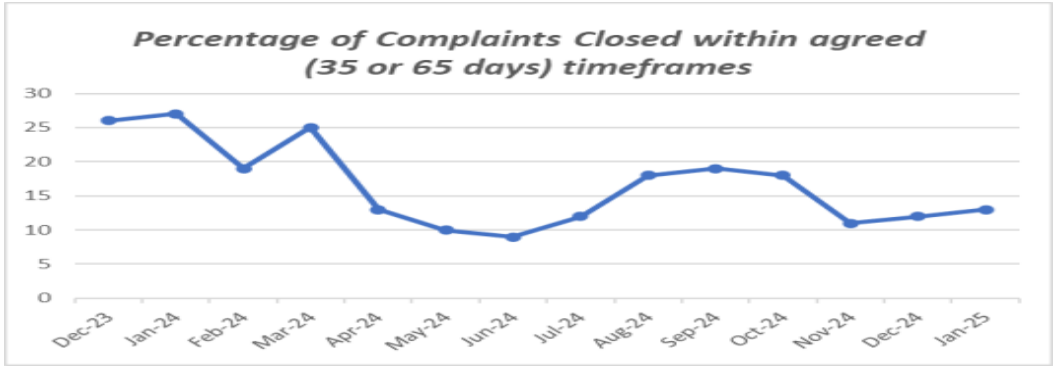
PSII – Patient Safety Incident Investigation. Declared when a problem in care is considered to have contributed to death, or a safety concern is such that a detailed systems approach investigation is indicated

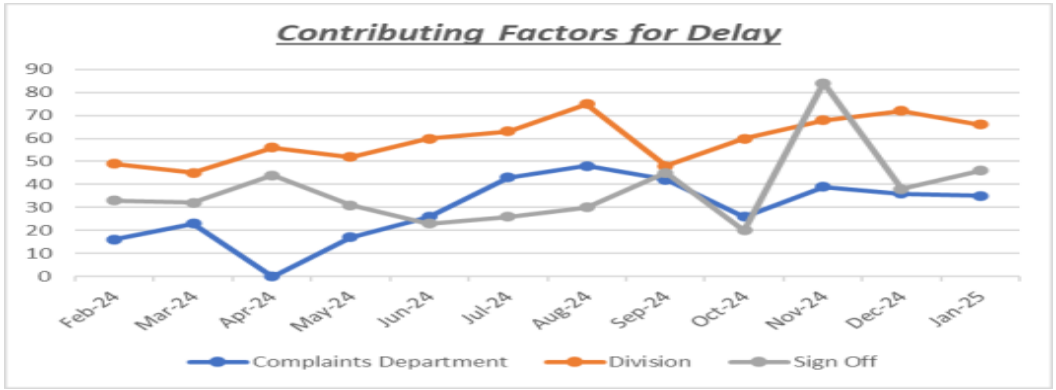
AER – After Event Review. Declared when there is a need for further information to inform action/learning to reduce the risk of recurrence

MPR – Multi Professional Review - Retrospective review of care by relevant specialists; documentation in a summary form

58 Patient Safety Incidents have required review through PSII, AER, or MPR since the Trust transitioned to PSIRF in March 24; an average of 5.27 per month.

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





Commentary:

Ability to meet response times continues to be adversely affected by the number of complaints received, delayed responses from clinical teams, and delays to sign off.

Actions:

- QI project underway; objective to review, implement and embed new Complaint SOP in D&S, Paeds and Gynae, at pace
- Divisional Focus Groups in Medicine, Maternity and Surgery set up to clear backlog (any complaint received prior to 31.12.24) by end of financial year 2024/2025.
- Successful recruitment 2 x B3 Admin posts.
- Divisions assigned individual Complaint Managers
- Weekly meetings with MD and Complaint Dept

Expected recovery:

A significant improvement is expected once the backlog is cleared and new SOP embedded.

Use of Resources Metrics

Financial Metrics

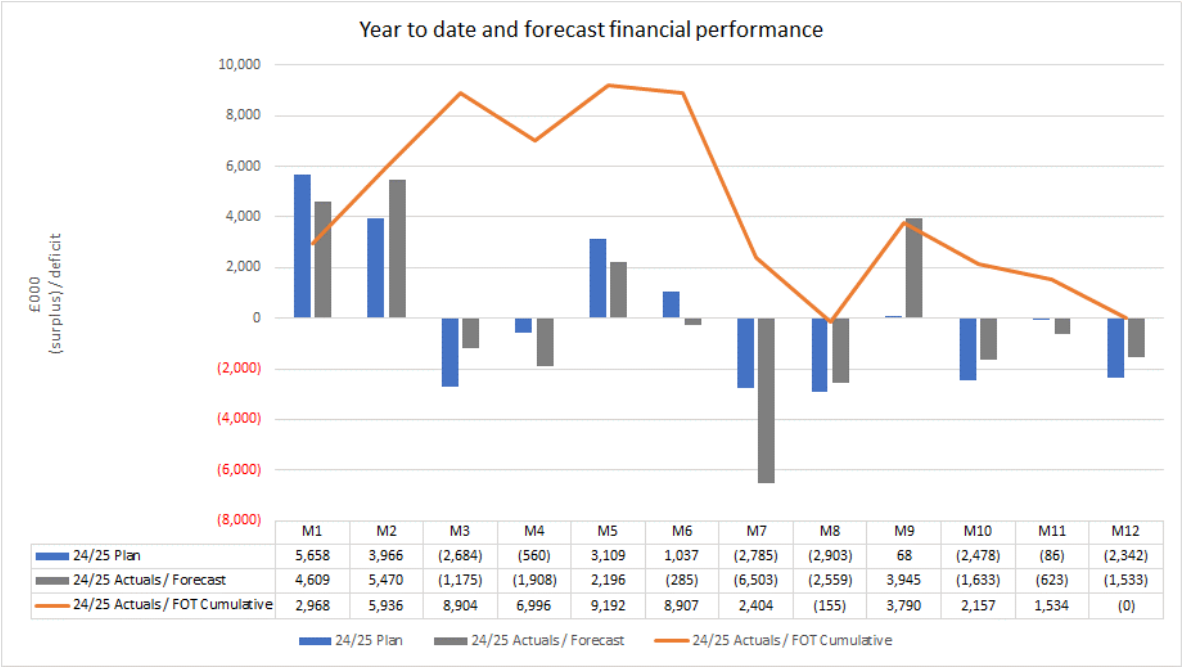
	Metric		Month 7			Month 8			Month 9			Month 10		
			Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
NHS England Oversight Metrics	Revenue (deficit)/surplus	Ytd £'000s	-7,741	-2,404	5,337	-4,838	155	4,993	-4,906	-3,790	1,116	-2,428	-2,157	271
		Forecast £'000s	0	0	0	0	0	0	0	0	0	0	0	0
	Capital vs budget plan	Ytd £'000s	24,585	13,815	-10,770	28,774	16,240	-12,534	32,386	20,382	-12,004	38,033	23,129	-14,904
		Forecast £'000s	45,972	46,358	386	45,972	43,588	-2,384	45,972	43,588	-2,384	45,972	43,588	-2,384
	FSP	Ytd £'000s	15,544	19,490	3,946	19,837	21,318	1,481	24,296	24,848	552	28,358	29,960	1,602
		Forecast £'000s	37,389	37,389	0	37,389	37,389	0	37,389	37,389	0	37,389	37,389	0
	Nos days operating cash		5	31	26	5	24	19	5	19	14	5	14	9
	BPP - nos invoices paid in 30 days		95%	99%	4%	95%	99%	4%	95%	99%	4%	95%	94%	-1%
	Agency spend as % of pay		3.2%	2.7%	-0.5%	3.2%	2.5%	-0.7%	3.2%	2.7%	-0.5%	3.2%	2.6%	-0.6%
	Trust bank spend (incl locum) spend as % of pay		-	9.5%	-	-	9.3%	-	-	9.3%	-	-	8.8%	-

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 £2.157m deficit YTD against a plan of £2.428m deficit. This is £0.27m favourable to plan.
- FSP delivery is £29.96m YTD against a plan of £28.36m. This is £1.6m favourable to plan.
- Agency spend is 2.6% of total pay bill which is 0.6% better than the NHSE target of 3.2%.
- Bank (including locum) spend remains static at 8.8% 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 £23m YTD against a plan of £38m. Spend is behind plan by £14.9m.

M10 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)	3,945	(1,633)	(623)	(1,533)
24/25 Actuals / FOT Cumulative	2,968	5,936	8,904	6,996	9,192	8,907	2,404	(155)	3,790	2,157	1,534	(0)

Commentary

M10 financial position is £2.16m deficit YTD against a plan of £2.43m deficit. This is £0.27m favourable to plan. The Group position includes the GMS position which is in line for delivery of its dividend position.

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 forecast position for the Trust and ICS is unchanged and remains breakeven which is in line with plan. The risks to delivering the plan are being managed across the system and have been discussed with the Board.

M10 Financial Position

Summary I&E Position (Group)	YTD Plan £000	YTD Actual £000	YTD Variance £000
Income	(652,769)	(684,064)	(31,295)
Pay	420,077	425,213	5,136
Non Pay	235,122	261,233	26,111
Total	**2,430**	**2,382**	**(48)**
Donated Assets/Grants/IFRIC 12 Adj	0	(228)	(228)
Adjusted (surplus)/deficit	**2,430**	**2,154**	**(276)**

Summary I&E Position (Trust only)	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(667,344)	(679,364)	(12,021)
Pay	405,442	401,563	(3,878)
Non Pay	264,331	280,186	15,855
Total	**2,430**	**2,382**	**(48)**
Donated Assets/Grants/IFRIC 12 Adj	0	(228)	(228)
Adjusted (surplus)/deficit	**2,430**	**2,154**	**(276)**

Headlines

YTD position is £0.27m 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, updated for the 24/25 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, prior year overperformance 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 £12m. Overperformance includes £3.8m pass through drugs overperformance, prior year income from commissioners and non recurrent income from GICB. There is also £3.1m underperformance on out of area elective activity which are on API contracts. (H&W is c.£1.7m and NHSE Spec Comm is c.£0.7m).

Pay underspend of £3.8m. Underspend includes £3.4m non recurrent benefit of HCSW. Without these non recurrent benefits, pay would be £0.4m underspent.

Non pay overspend of £15.8m. Overspend includes £6m passthrough drugs and £3.3m FSP target that is held in non pay but being delivered against pay (HCSW).

M10 Pay

	YTD Budget	YTD Actual	YTD Variance
Pay M10 YTD	£000	£000	£000
Infrastructure	64,875	63,637	(1,239)
Medical & Dental	124,909	125,132	223
Nursing	155,006	154,897	(109)
Other Clinical Staff	60,112	56,786	(3,327)
Total (excl reserves)	404,903	400,451	(4,452)
Reserves (FSP & other staff)	3,858	852	(3,006)
Divisions (FSP target & vacancy factor)	(3,319)	261	3,580
TOTAL	405,442	401,563	(3,878)

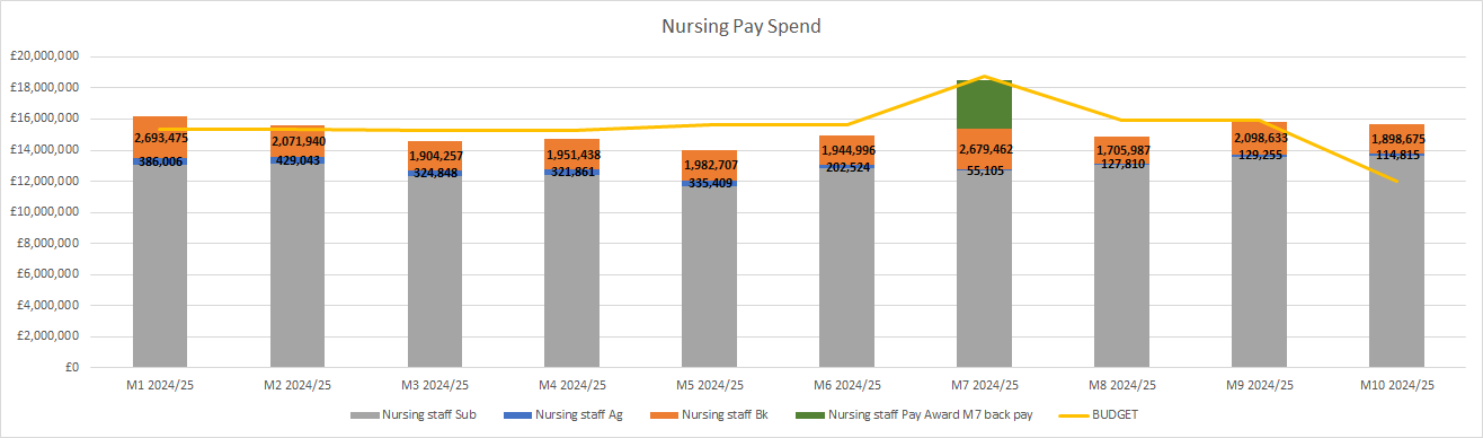
YTD Variance (M10)	Corporate	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Pay YTD Variance including HCSW NR benefit
	£000	£000	£000	£000	£000	£000	£000
Infrastructure	(1,567)	195	137	(159)	(9)	163	(1,239)
Medical	183	42	2,301	(962)	(1,150)	(192)	223
Nursing	238	(206)	4,125	(696)	(2,085)	(1,486)	(109)
Other Clinical Staff	92	(2,868)	(33)	15	(520)	(12)	(3,327)
Other Staff Sub	398	1,382	(6)	(3,006)	1,577	229	573
Pay YTD Variance including HCSW NR benefit	(656)	(1,455)	6,525	(4,808)	(2,186)	(1,298)	(3,878)

Headlines

Pay is £3.9m YTD underspent. This includes the benefit of £1m HCSW rebanding underspend relating to M1 to M5. It also include the release of HCSW accrual of £2.2m. Without these non recurrent benefits, pay would be £0.4m underspent.

- Medical staffing overspend of £0.2m. M10 includes £0.07m costs of the Critical Incident response.
- Nursing underspend of £0.1m. M10 includes £0.157m costs of the Critical Incident response. The HCSW adj has now been aligned with the FSP budget.
- Infrastructure £1.2m underspent, mainly within corporate areas.
- Other clinical staff £3.3m underspent, of which £2.8m is in D&S. £0.5m is in Surgery.
- Other staff £0.6m overspent. This is where FSP negative budget, NR vacancy factor £1.5m and reserves underspends are held.

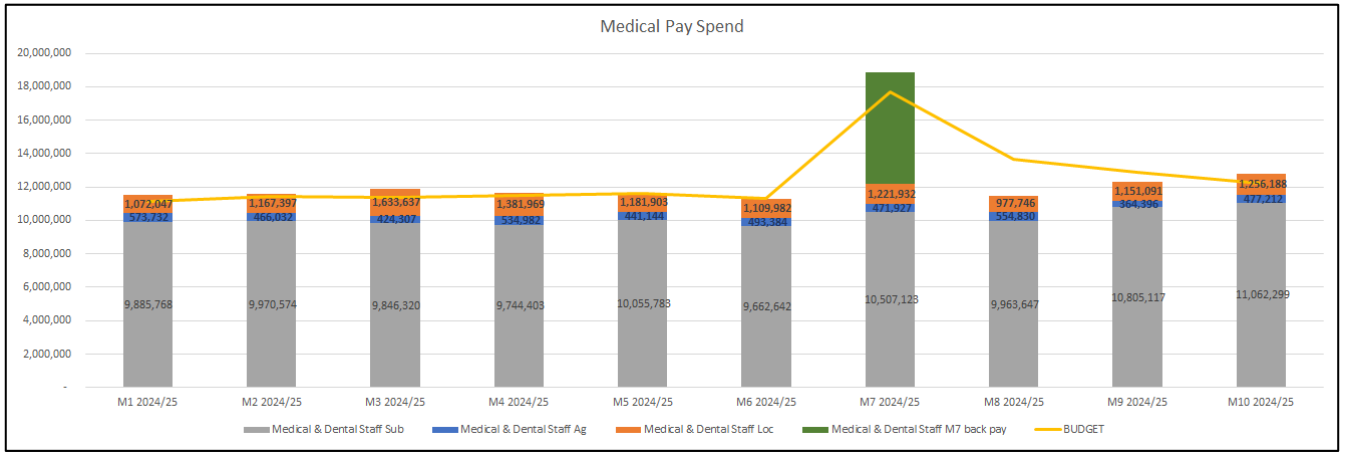
M10 Nursing Pay



Headlines

- Nursing budgets are £0.1m underspent YTD. This includes £0.157m costs of the Critical Incident response.
- In M10, FSP target was allocated to match the NR HCSW FSP. This is illustrated in the budget reduction in the chart above.
- M10 spend is £152k lower than prior month. Of this, £415k is a reduction due to bank holiday enhancements paid in the prior month. There has been an increase of £0.157m due to additional staffing over the Critical Incident period.
- Nursing agency spend has reduced by £14k. Bank spend has reduced by £200k.

M10 Medical Pay



Headlines

Medical staffing budgets are £0.3m overspent YTD. Budget for industrial action costs of £0.6m has been allocated in M9.

Spend has increased by £475k from prior month of which £69k is due to critical incident cover.

- Agency spend has increased by £113k from M9 to M10 (£364k to £477k).
- Locum costs have increased by £105k (£1,151k to £1,256k).

M10 Non Pay

Non Pay	YTD Variance £000 Divisions	Corporate	Reserves/ Central	FSP (pay offsetting non pay)	Total
YTD Variance	22,589	155	-6,884		15,860
Adjusted items and passthrough:					
Pass through drugs and devices	10,417	0	-4,216		6,201
FSP non pay pressure that is covered by HCSW NR benefit (pay)				3,395	3,395
YTD Variance excl adjusted items and pass through	12,172	155	-2,668	-3,395	6,264

Headlines

M10 YTD non pay position is overspent by £15.9m.

This reduces to £6.2m 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 £6.2m is split by:

- Divisional pressures £12m.
  - This is partly offset by the £3.4m NR HCSW FSP delivery held in pay.
  - Divisional FSP pressure of £3.6m
  - This leaves £5m driven by clinical supplies within endoscopy, cardiology, theatres and opcare prior year invoices. Non pass through drugs are also causing pressures due to a combination of price and activity increases.
- Reserves underspend £2.7m. This includes NR benefits e.g pharmacy stock and balance sheet releases.

M10 Income

Income	YTD Budget £000	YTD Actual £000	YTD Variance £000
HEE Income	(15,823)	(18,909)	(3,086)
Other Income from Patient Activities	(8,951)	(19,378)	(10,428)
Other operating income	(26,543)	(23,102)	3,442
PP Overseas and RTA Income	(5,205)	(5,457)	(253)
SLA & Commissioning Income	(610,822)	(612,518)	(1,696)
Total Income	(667,344)	(679,364)	(12,021)

Headlines

M10 YTD income position is £12m favourable to plan. This is driven by:

- HEE income £3m 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 from patient activities:
  - Pass through drugs overperformance £3.8m.
  - Underperformance on out of area elective activity which is an API contract. This is £3.1m of which H&W is c.£1.7m and NHSE Spec Comm is c.£0.7m.
  - Prior year income from commissioners £1.6m
  - CDC, endoscopy and cancer funding £2.3m above budget

M10 Capital Position

in £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	5,953	5,079	874	8,056	8,038	18
MEDICAL EQUIPMENT	6,336	3,450	2,886	11,550	10,367	1,183
ESTATES	17,056	11,441	5,615	18,016	17,818	198
OVERCOMMITTED PROGRAMME - REQUIRES SLIPPAGE	0	0	0	(1,465)	(12)	(1,453)
NBV OF ASSET DISPOSALS	0	(128)	128	(77)	(128)	51
Total Charge against Capital Allocation (excl. IFRS 16)	**29,345**	**19,842**	**9,503**	**36,080**	**36,083**	**(3)**
RIGHT OF USE ASSET	6,644	2,259	4,385	7,412	4,995	2,418
Total Charge against Capital Allocation (incl. IFRS 16)	**35,990**	**22,101**	**13,889**	**43,492**	**41,077**	**2,415**
NAT PROGRAMME, GRANTS, DONATIONS & OTHER	3,635	2,340	1,294	4,344	4,344	0
Gross Capital Spend Total	**39,624**	**24,441**	**15,183**	**47,836**	**45,422**	**2,415**

Gross Capital Spend Total	**39,624**	**24,441**	**15,183**	**47,836**	**45,422**	**2,415**
Less Donations and Grants Received	(1,376)	(1,097)	(279)	(1,575)	(1,575)	(0)
Less PFI Capital (IFRIC12)	(499)	(499)	0	(600)	(600)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	284	284	0	341	341	0
Total Capital Departmental Expenditure Limit (CDEL)	**38,033**	**23,129**	**14,904**	**46,000**	**43,588**	**2,414**

Commentary:
The Trust gross capital expenditure allocation for the 24/25 financial year sits at £47.8m of which £2.4m was reported in Month 8 as a forecast underspend on International Financial Reporting Standard 16 (IFRS16), leaving an remaining allocation of £45.4m.

As of the end of January (M10), the Trust had goods delivered, works done or services received to the value of £24.4m, against a planned spend of £39.6m, equating to a variance of £15.2m behind plan. This leaves £21.0m to spend in the remaining two months of the year.

Other than a small £3k movement due to a lease termination, the forecast has not changed since the approved forecast submitted in Month 8.

As previously reported to achieve a breakeven position a number of high priority equipment schemes were being progressed to offset an potential slippage risk. 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.

Regular liaison with project managers and programme area leads is taking place to identify movements within the forecast to be able to manage the position and report any movements that arise.

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.

The commentary is based on the gross capital spend. The position against CDEL differs as per the table in that adjustments are made for donations, grants and IFRIC 12 spend.

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	Dec 25 £'000	Jan 26 £'000
Opening Balance	**55,176**	**59,364**	**39,309**	**32,237**	**40,838**	**46,441**	**42,939**	**67,710**	**50,590**	**40,710**	**29,392**	**36,273**	**32,016**	**34,893**	**34,478**	**24,950**	**32,725**	**29,106**	**20,402**	**27,492**	**29,438**	**25,798**
Receipts																						
SLA Income	56,603	56,604	53,597	58,941	70,953	62,151	71,929	62,915	60,648	62,805	59,357	61,838	57,088	59,311	57,211	61,107	57,058	58,584	61,890	63,817	63,462	62,805
Other NHS	17,271	2,650	3,025	14,209	4,254	1,963	27,187	5,074	2,197	4,321	10,979	7,779	15,847	2,400	3,125	12,821	2,215	2,015	19,313	2,155	2,371	4,321
Other Non-NHS	2,924	1,941	1,723	1,677	1,487	2,366	2,210	1,819	2,208	2,606	1,855	2,953	2,611	2,039	1,596	2,394	1,934	1,868	2,121	1,645	1,384	2,582
VAT	1,051	3,358	2,455	4,210	2,709	3,080	1,863	2,063	2,634	2,989	2,431	2,214	2,051	2,358	2,444	2,841	3,218	2,166	1,935	2,479	2,095	2,989
Total Receipts	**77,849**	**64,554**	**60,801**	**79,036**	**79,403**	**69,963**	**103,445**	**71,871**	**67,826**	**72,722**	**74,688**	**74,784**	**77,597**	**66,108**	**64,376**	**79,163**	**64,424**	**64,634**	**85,258**	**70,096**	**69,312**	**72,697**
Payments																						
Payroll - Direct payments	(23,625)	(23,934)	(25,273)	(24,715)	(24,750)	(23,999)	(29,887)	(29,591)	(25,053)	(25,442)	(26,124)	(28,950)	(25,944)	(25,879)	(26,521)	(26,054)	(26,015)	(26,064)	(26,061)	(26,016)	(26,049)	(25,442)
Payroll - On costs	(18,111)	(16,960)	(17,234)	(18,108)	(17,474)	(17,195)	(16,990)	(23,610)	(23,341)	(18,415)	(18,096)	(18,065)	(18,091)	(16,946)	(18,069)	(18,549)	(18,045)	(18,045)	(18,085)	(18,065)	(18,064)	(18,415)
Payables	(31,926)	(43,714)	(25,366)	(27,612)	(31,576)	(26,753)	(31,797)	(35,790)	(29,311)	(40,183)	(23,588)	(27,527)	(30,685)	(23,697)	(29,314)	(26,785)	(23,984)	(24,186)	(34,022)	(24,068)	(28,839)	(28,861)
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	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	0	0
Total Payments	**(73,661)**	**(84,609)**	**(67,873)**	**(70,435)**	**(73,801)**	**(73,466)**	**(78,674)**	**(88,991)**	**(77,706)**	**(84,040)**	**(67,807)**	**(79,041)**	**(74,720)**	**(66,523)**	**(73,905)**	**(71,387)**	**(68,044)**	**(73,338)**	**(78,168)**	**(68,150)**	**(72,952)**	**(72,718)**
Net Cashflow	**4,188**	**(20,055)**	**(7,072)**	**8,601**	**5,603**	**(3,502)**	**24,771**	**(17,120)**	**(9,880)**	**(11,318)**	**6,880**	**(4,257)**	**2,876**	**(414)**	**(9,528)**	**7,775**	**(3,619)**	**(8,704)**	**7,090**	**1,946**	**(3,640)**	**(21)**
Closing Balance	**59,364**	**39,309**	**32,237**	**40,838**	**46,441**	**42,939**	**67,710**	**50,590**	**40,710**	**29,392**	**36,273**	**32,016**	**34,893**	**34,478**	**24,950**	**32,725**	**29,106**	**20,402**	**27,492**	**29,438**	**25,798**	**25,777**

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 15 days.
- Note that cash reduces to below £30m in Jan 25 due to an increase in payables.

Workforce

Staff in Senior Leadership Roles watch metric

Proportion of staff in senior leadership roles who are BME	Target (by March 2028 {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%)*

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%)

***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

Gloucestershire female population currently 51% Gloucestershire population data

Commentary: The data highlights incremental progress towards achieving the target of 69 Black Minority & Ethnic (BME) staff in senior leadership roles by March 2028. As of March 2023, the number of BME staff was 35, increasing to 44 by March 2024. However, there has been a slight decline to 41 in August 2024, followed by a marginal increase to 42 in October 2024. While the overall trajectory is positive, the fluctuations indicate challenges in sustaining and accelerating progress.
A closer look at band-specific data reveals key areas of concern. While Band 8a has seen an increase from 24 to 30 BME staff, the percentage remains stagnant at 11%. Band 8b has shown improvement, growing from 3 BME staff (4%) in March 2023 to 6 (7%) in October 2024. However, Bands 8d and above have seen little to no BME representation, indicating a lack of progression pathways into senior leadership for staff at higher bands.

Planned and Current Actions to Meet Model Employer Targets:

- **Targeted Leadership Development Programs:**
  - Such as the aspiring leaders and managers programme for our BME colleagues,
  - Re- establish reciprocal mentoring initiatives pairing BME employees with senior leaders
- **Inclusive Recruitment and Selection Practices:**
  - Strengthen diverse hiring panels and ensure unconscious bias training for all managers within MDP
- **Career Progression Pathways:**
  - Develop clear and transparent career pathways for BME staff at lower bands to progress into leadership roles.
- **Retention and Culture Change Initiatives:**
  - Workplace culture through Trust-wide anti-racism campaign and allyship training.
- **Data Monitoring and Accountability:**
  - Set measurable KPIs for senior leaders linked to the achievement of BME representation goals within Divisional EDI plans

Staff in Leadership roles driver metrics

Ethnicity	Applied	Shortlisted	Interview attended	Appointed	Success at interview
BLACK or BLACK BRITISH - Any other black background	20	2	2	1	50.00%
OTHER ETHNIC GROUP - Chinese	8	4	3	1	33.33%
ASIAN or ASIAN BRITISH - Indian	674	35	26	4	15.38%
WHITE - British	187	75	41	2	4.88%
Not stated	1	1	1	0	0.00%
BLACK or BLACK BRITISH - African	642	47	26	0	0.00%
ASIAN or ASIAN BRITISH - Pakistani	471	7	4	0	0.00%
ASIAN or ASIAN BRITISH - Any other Asian background	277	9	4	0	0.00%
OTHER ETHNIC GROUP - Any other ethnic group	134	11	3	0	0.00%
ASIAN or ASIAN BRITISH - Bangladeshi	109	2	1	0	0.00%
WHITE - Any other white background	92	7	3	0	0.00%
MIXED - White & Black African	52	1	1	0	0.00%
I do not wish to disclose my ethnic origin	40	5	2	0	0.00%
MIXED - any other mixed background	25	1	0	0	0.00%
BLACK or BLACK BRITISH - Caribbean	10	1	1	0	0.00%
MIXED - White & Asian	10	0	0	0	0.00%
MIXED - White & Black Caribbean	4	1	0	0	0.00%
WHITE - Irish	0	0	0	0	0.00%

Commentary:

- This data reflects all applications received from M09 to M10
- Applications from BME staff make up 88% of the 2756 received
- Whilst nearly 88% 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: BLACK or BLACK BRITISH - Any other black background. 2nd is: OTHER ETHNIC GROUP - Chinese. 3rd is: ASIAN or ASIAN BRITISH – Indian

A deep dive of the 12 months of 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 some level of sponsorship to work in the UK.

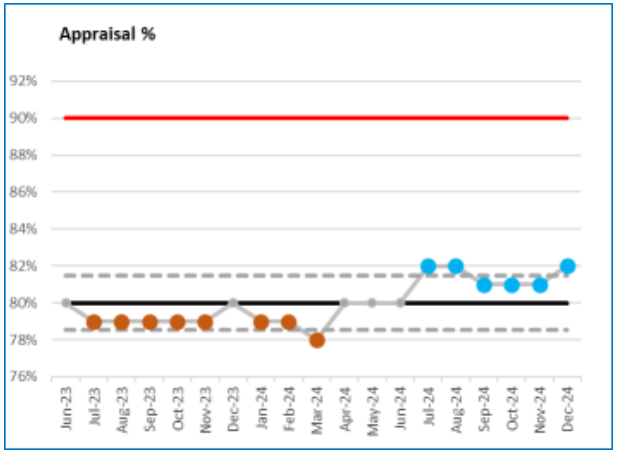
Planned Actions:

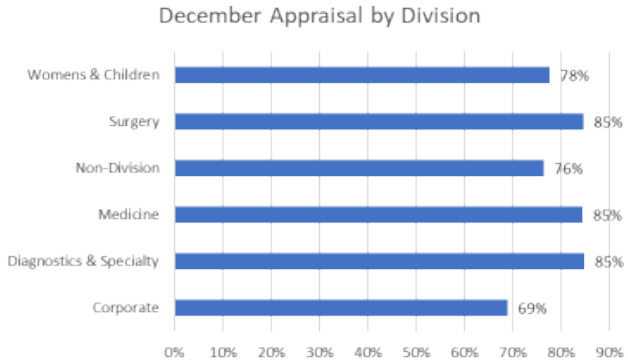
- Comms to encourage disclosure of ethnicity on ESR Jan-March 2025
- Colleagues who join the Inclusion Network will automatically receive notifications and reminders to complete their ESR.
- Encourage attendance at Building Confidence in Interviews Course
- Longitudinal evaluation of the Cohort (18-20 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
- Interviewing with Impact training workshop - April2025
- Development of a Inclusion Champion Training programme for both current and new trainers.

Workforce Performance Indicators

Performance Indicator	Target	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Turnover	13%	11.06%	10.82%	10.93%	10.58%	10.35%	10.55%	9.95%	9.94%	10.03%	9.41%	9.36%	9.30%
Vacancy	8%	6.90%	6.65%	6.59%	6.11%	6%	6.82%	7.24%	7.43%	7.48%	7.51%	7.37%	7.67%
Sickness	5%	4.33%	4.32%	4.29%	4.28%	4.31%	4.32%	4.35%	4.34%	4.34%	4.28%	4.29%	4.57%
Appraisal	90%	79%	79%	78%	80%	80%	80%	82%	82%	81%	81%	81%	82%
Essential Training	90%	85%	86%	85%	86%	86%	87%	87%	88%	88%	88%	89%	89%
Agency (FTE & % of establishment)	2%	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%)	91 (1.1%)	82 (1.0%)	66 (0.9%)
Bank (FTE & % of establishment)	6.5%	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%)	586 (7.2%)	575 (7.1%)	584 (7.8%)

Workforce - Appraisal





December Appraisal by Staff Group	
Add Prof Scientific and Technical	77%
Additional Clinical Services	86%
Administrative and Clerical	73%
Allied Health Professionals	81%
Estates and Ancillary	77%
Healthcare Scientists	79%
Medical Staff - Consultants	90%
Medical Staff - SAS	73%
Nursing and Midwifery Registered	85%

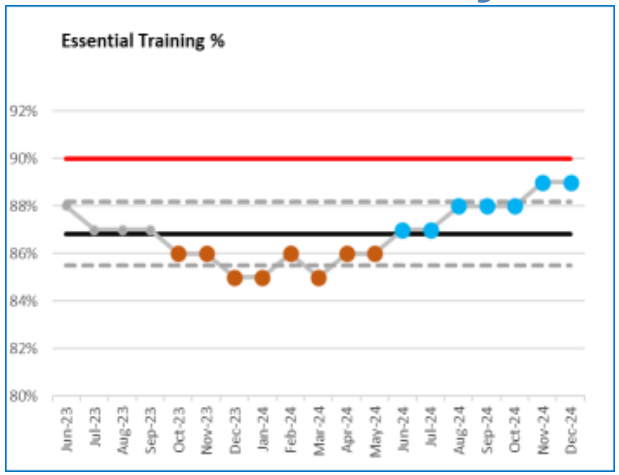
Commentary:
The organisation has set a **90% target** for appraisal compliance. However, compliance has fluctuated between **78% and 82%**, consistently falling short of the target. As of **December**, the organisation achieved **82% compliance**.

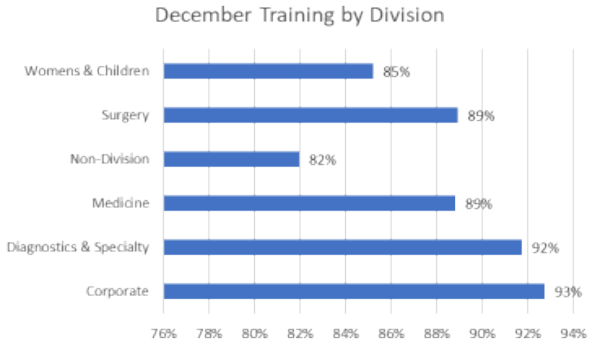
Medical Staff – Consultants continue to lead with **90% compliance**, outperforming the overall organisation.
Corporate Division remains the lowest-performing area at **69%**, despite a **2% increase** in compliance.
Other divisions, including **Surgery, Medicine, and Diagnostics & Specialty**, are performing well, achieving **85% compliance**.
Administrative & Clerical (73%) and **Medical Staff – SAS (73%)** fall below the overall organisation's compliance rate and require further attention.

Planned Actions:
- **New Appraisal Process and paperwork Launch – April 2025:**
  - A refreshed appraisal process will be introduced alongside a new policy currently progressing through governance channels.
  - The impact will be assessed over a 6-month period through a longitudinal evaluation approach
- **In-depth Analysis of Compliance Challenges:**
  - A 'deep dive' will be conducted to investigate barriers to compliance, such as Electronic Staff Record (ESR) issues and non-recording.
  - Ensuring appraisal conversations are accurately recorded and compliance is reported effectively.
- **Digitisation of Appraisal Process:**
  - Exploring digital solutions to enhance compliance recording.
  - A stakeholder task group will be formed to oversee implementation and effectiveness.

Expected Recovery Timeline:
•**April 2025:** Launch of new appraisal paperwork and process
•**October 2025:** Measurable impact of the new paperwork.
•**April 2025 – April 2026:** Digitisation process scoping and plans for rollout (potential for earlier implementation).

Workforce - Statutory and Mandatory Training





December Training by Staff Group	
Add Prof Scientific and Technical	85%
Additional Clinical Services	94%
Administrative and Clerical	94%
Allied Health Professionals	93%
Estates and Ancillary	92%
Healthcare Scientists	92%
Medical Staff - Consultants	82%
Medical Staff - SAS Senior	80%
Medical Staff - Training Grades	62%
Nursing and Midwifery Registered	91%

	Dec
318|LOCAL|Moving and Handling Level 2 (2yr)|	88%
318|LOCAL|Safeguarding Adults Level 2| (new training from 30/10/24)	88%
318|LOCAL|Safeguarding Adults Level 3|	76%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	93%
NHS|CSTF|Fire Safety - 1 Year|	88%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	93%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	94%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	85%
NHS|CSTF|Information Governance and Data Security - 1 Year|	90%
NHS|CSTF|Moving and Handling - Level 1 - 2 Years|	90%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	95%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	86%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	94%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	92%
NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	90%

Commentary:
The target of 90% is not being met, we currently have a 89% compliance rate with Mandatory training.

We continue to see a steady rise in compliance level of Safeguarding Adults L3 training, since the removal of the requirement of virtual bookings and reverting to always accessible content.

A number of divisions are achieving above the 90% target, however other divisions such as Women's & Children and Non-Division are beneath the 90% target.

We have now held our first Local Stat/Man and Essential to Role Training Oversight Group meeting.

Planned Actions:

We have reached out to both the Women's & Children and the Non-Division to identify if there are areas we can support them in achieving increase compliance.

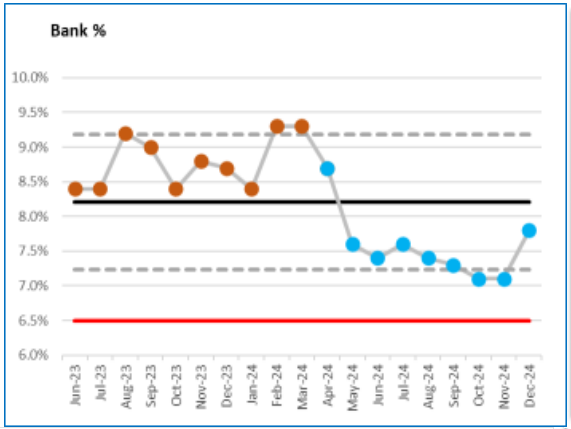
The Local Stat/Man and Essential to Role Training Oversight Group has created a process to review all new requests being made to make training mandatory. The group has also identified the first subjects training needs analysis to be reviewed.

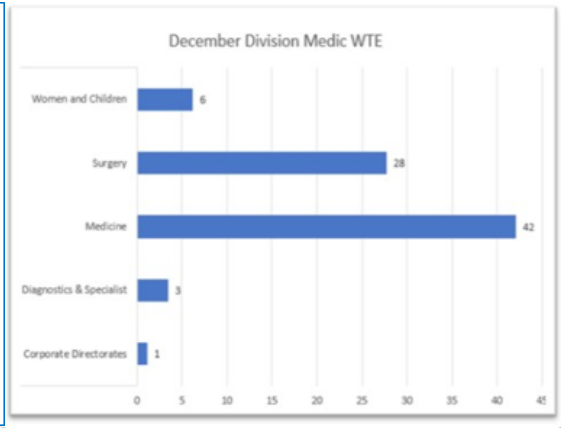
Work with the Resuscitation Education Manager as to how best to support further increases in compliance across the Trust

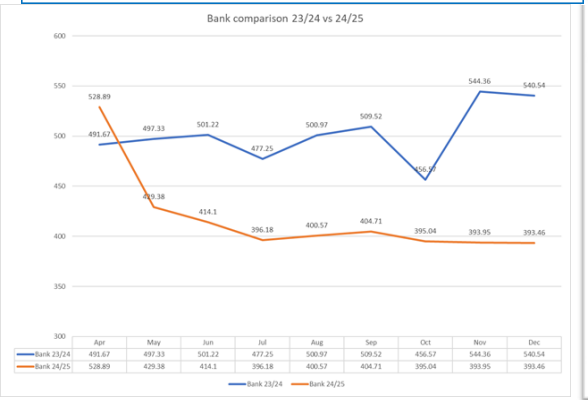
Expected recovery:

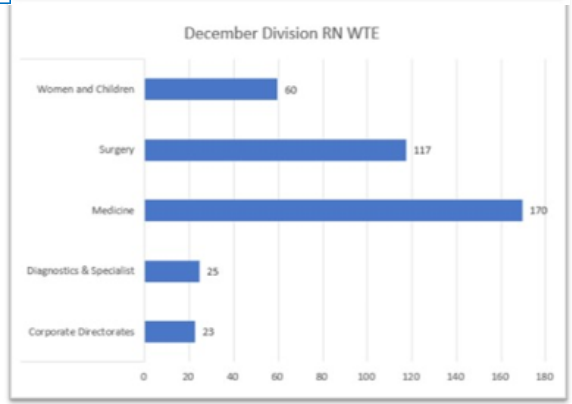
Time frame on national work dictated by NHSE – 24-25 period of work
Work with Divisions over the next 3-6 months

Workforce - Bank









Commentary:

- The Trust target of 6.5% has not been achieved in month 9. The current use is 7.8%.
- This increased 0.7% from the previous month, with an upswing of use for the holiday period.
- Medicine is the highest user of Bank & Locum staff.
- The Emergency Department, COTE and Acute Medicine are the highest users of temporary staffing in Medicine.
- In comparison with the end of the previous financial year there has been a reduction from 602 WTE in March 2024 to 393 WTE in December 2024
- A year-on-year WTE comparison of RN/HCSW temporary staffing use shows the significant improvements achieved

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 M11 returns to the trend shown before the holiday increase, the Trust world expect to be inside the 6.5% target in 6 months time.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Thank you

Learning from Deaths Report to Board of Directors				
Date	13 March 2025			
Title	Learning from Deaths Report (Q1 April – June 24/25)			
Author /Sponsoring Director/Presenter	Sponsor: Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO Authors: Jo Mason-Higgins, Acting Associate Director of Safety (Investigation and Family Support) Charlie Candish, Associate Medical Director (Safety)			
Purpose of Report		Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**		
Regulatory requirement		**To highlight an emerging risk or issue**		
To canvas opinion		**For information**		
To provide advice		**To highlight patient or staff experience**		

Summary of Report

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

Key issues to note

1. All deaths are reviewed within the Trust via the independent Medical Examiner Service.
2. Learning from serious incidents/PSIRF learning response is monitored through SERG, summaries are found in Appendix 1 (for QPC only).
3. There is good local learning from problems in care and ensuring these are being reflected within specialties. The need for the outcome of SJR reviews to be reflected in Trust-wide improvement programmes and (PSIRF safety priorities) is recognised.
4. Timeliness and completion rate of SJR, whilst improving is of concern. A review (utilising a QI approach) of SJR process, compliance and outcomes continue.
5. It is clear that the positive feedback is consistently high regarding the care provided with the care experience being identified as positive as well as our staff being kind and helpful. A review of the Trust's process for feeding back (to families) findings of SJR is being undertaken. It is recognised that proactive feedback may improve experience and reduce concerns and complaints
6. Hospital crude mortality remains low/falling. SHMI remains higher than expected, but has fallen for 3 consecutive months. Coding and care issues influencing the SHMI continue to be investigated including:

    - Coding: Charlson Scores, Primary diagnosis capture and clinician / coding collaboration
    - Variation: Weekend, Site – CGH v GRH, In Hospital / Out of Hospital
    - Specific Diagnostic groups: Fractured Neck of Femur pathway improvement work, COPD coding for patients receiving Non-Invasive Ventilation, Sepsis, Non-specific groups where improved coding is required
    - Delay related harm data review

This SHMI action plan is being monitored by a Quality Improvement Group, chaired by the ICB CMO, with representation from Regional NHSE. Progress will continue to be reported in each Learning from Deaths report.
Recommendation
The report is provided to board for assurance.
Enclosures
Learning from Deaths - Q1 April – June 24/25

TRUST BOARD – 13 March 2025

LEARNING FROM DEATHS REPORT – Q1, April – June 24/25

1. Aim

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

1.2 This report covers the period April to June 2024 and is an update from the previous report.

2. Learning From Deaths

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

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

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

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

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

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

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

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

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

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

2.7 A structured judgment review was undertaken on 66% of death's (requiring review) within this reporting period. Performance and feedback of learning is presented to HMG on a rolling basis from Divisions and examples of this can be seen in Appendix 2 (Q&PC only). Themed issues are being tracked in nine areas over time through datix reporting.

2.8 All Serious Incidents (SIs) and Patient Safety Incident Investigations (PSII's) have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups. Summary reports on closed action plans are included in the report. (Appendix 1).

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

Deaths by Special Type	April-June 2022	Jul-Sept 2022	Oct-Dec 2022	Jan-March 2023	April-June 2023	July -Sept 23	Oct-Dec 23	Jan to March 24	April-June 24
Maternal Deaths (MBBRACE)	0	2	1	0	0	0	0	0	0
Serious Incident Deaths ***Figures represent date investigation complete rather than date SI declared**	7	9	7	6	*1	*9	8*	7*	6*
Learning Difficulties Mortality Review (inpatient deaths)	9	8	7	6	5	5	4	6	11

	Apr-Jun 22	Jul-Sep 22	Oct -Dec 22	Jan -Mar 23	Apr-Jun 23	Jul-Sep 23	Oct-Dec 23	Jan-Mar 24	April – June 24
SB >24 wks	0	4	2	3	6	1	5	5	6
NND >24 wks Born at GRH/Died GRH	2	1	0	0	0	2	1	1	1
NND <24 wks Born at GRH/Died GRH	3*	3*	4*	2*	0	1*	3	0	1*
*NND <24 weeks – Termination of Pregnancy with signs of life at delivery									
NND >24 wks Born & Died Elsewhere	0	1	1	2	0	1	0	0	0
NND <24 wks Born & Died Elsewhere	0	0	0	0	0	1	0	0	0

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

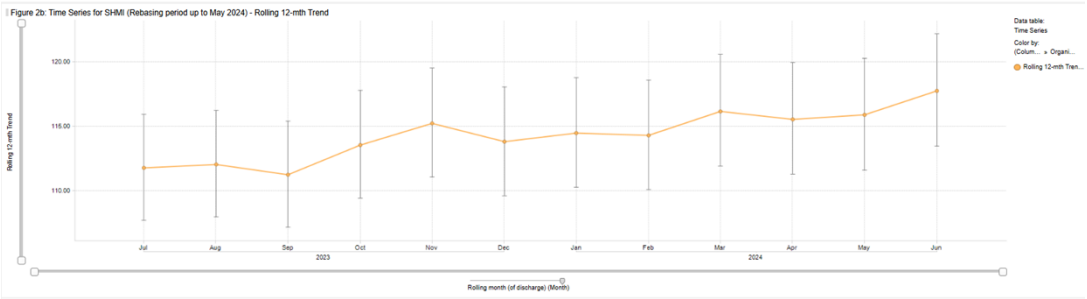
Post Neonatal death							1**	1	0

3. Mortality Data

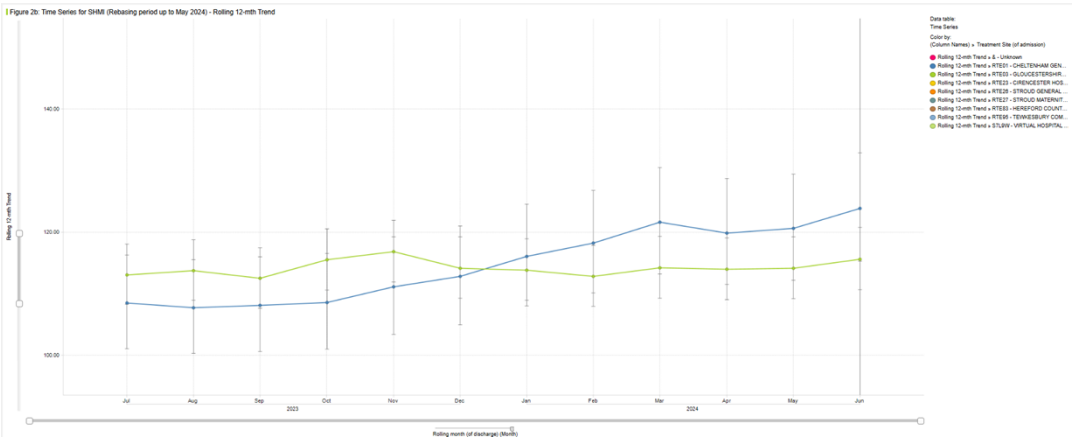
3.1 Summary Hospital Mortality Index (SHMI)

This is the ratio of observed versus expected deaths whilst an in-patient or within 30 days of discharge

At the end of June 2024, SHMI was higher than expected at 1.18 (1.16 at GRH and 1.22 at CGH). Below shows 12 month rolling SHMI.



By Site



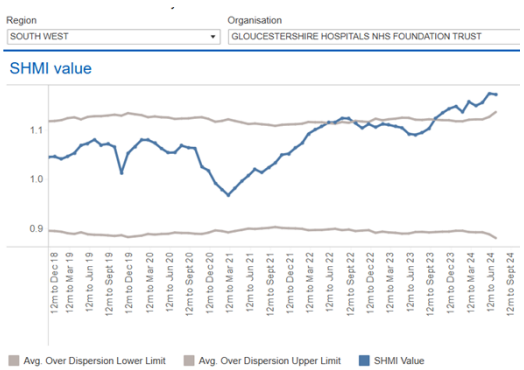
Site	SHMI	Admissions with Pall Care Code	Average co-morbidity per spell	Crude Mortality	Out of Hospital SHMI	Inpatient SHMI	SHMI adjusted for palliative care
CGH	122.28	3,66%	6.18	5.05%	174.44	99.5	114.57
GRH	116.64	1.44%	2.9	2.49%	117.7	116.17	113.42

The increase in CGH SHMI is likely to reflect the patient population with higher co-morbidities (e.g. regional cancer centre, frailty). The high out of hospital SHMI for CGH is likely to reflect the planned discharges for patients towards the end of life. This is currently being audited.

SHMI-National Picture

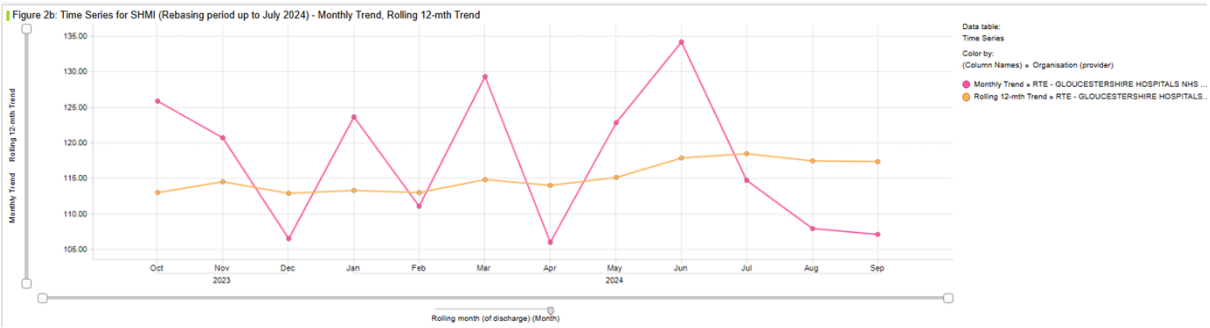
GHT is among 15 trusts in "Higher than Expected" category

SHMI Historic



Current SHMI position – Jan 25:

- The trust is "higher than expected" in overall, 30-day post discharge "out of hospital" and Weekend SHMI indicators, but with signs of improvement due ongoing work by the SHMI Quality Improvement Group. There has been a reduction in SHMI for 3 consecutive months:



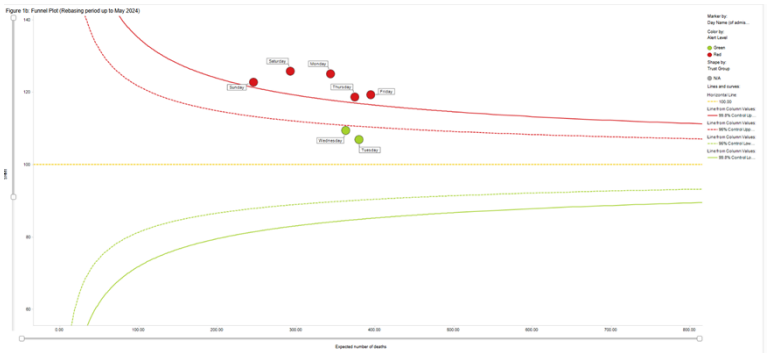
  - The latest published individual month's data (Sept 24) is 107.14, with 12 month rolling average 117.41

SHMI QIG:

- The Hospital Mortality Group in conjunction with system partners/ICB/NHSE meet monthly to monitor actions in relation to:
  - Coding
    - Charlson scores
    - Primary Diagnosis
    - Clinician / Coding Collaboration
  - Variation
    - Weekend
    - Site – CGH v GRH
    - In Hospital / Ou of Hospital
  - Specific Conditions
    - Fractured neck of femur
    - COPD
    - Sepsis
    - Non-specific diagnoses

3.2 Weekend Mortality

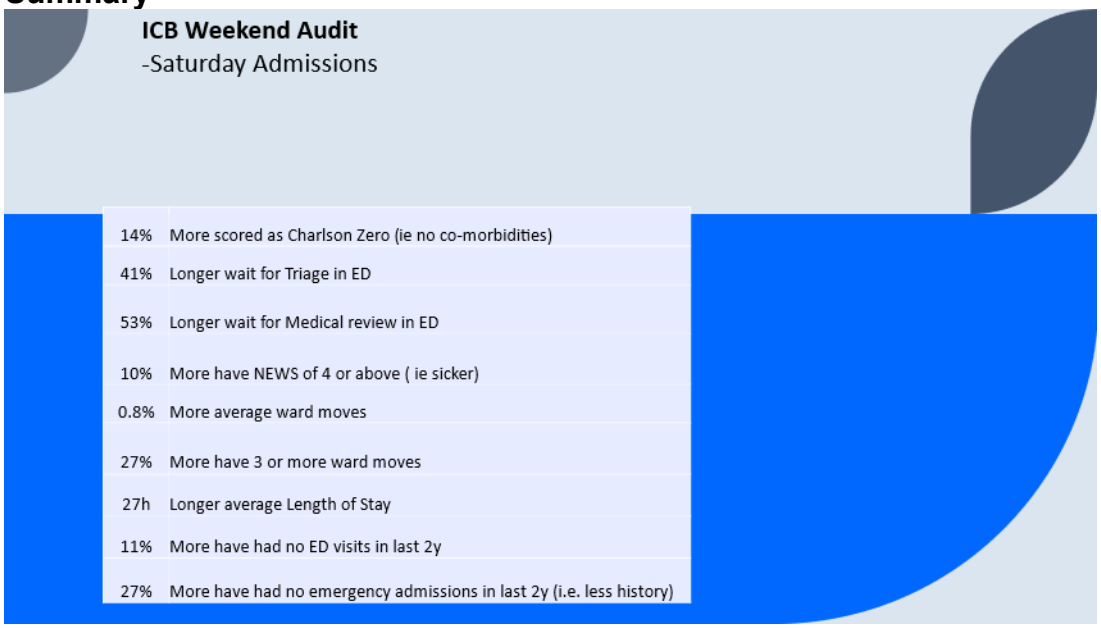
More admission days are now higher than expected so “weekend effect” is less obvious to demonstrate.



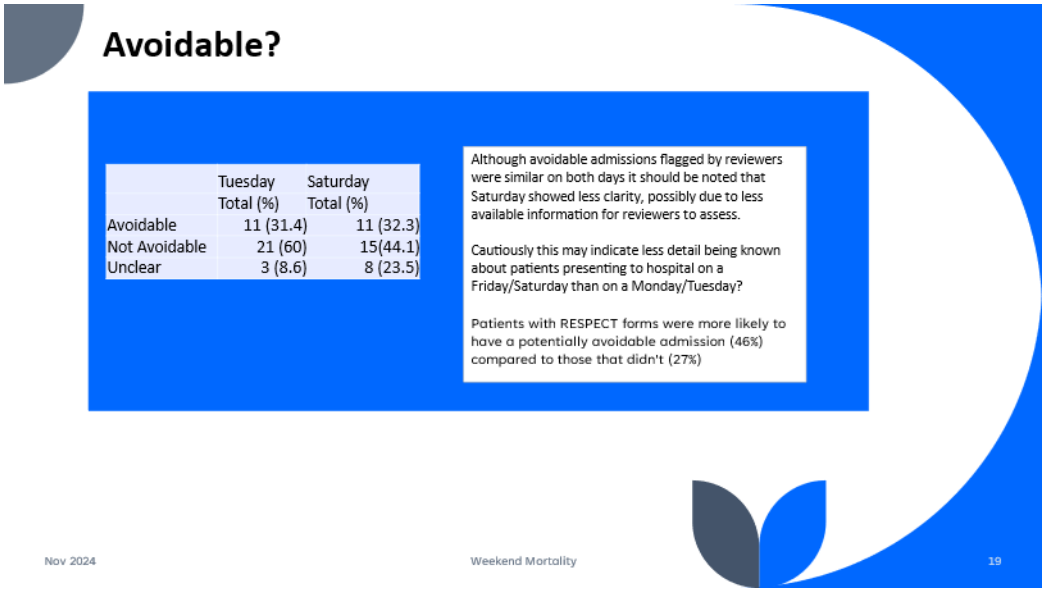
A system-wide project to clinically review a sample of notes from patients aged 85 and
comissioned by the ICB was completed in September 2024. This identified themes in terms of both care and data accuracy across the system.

Audit Results

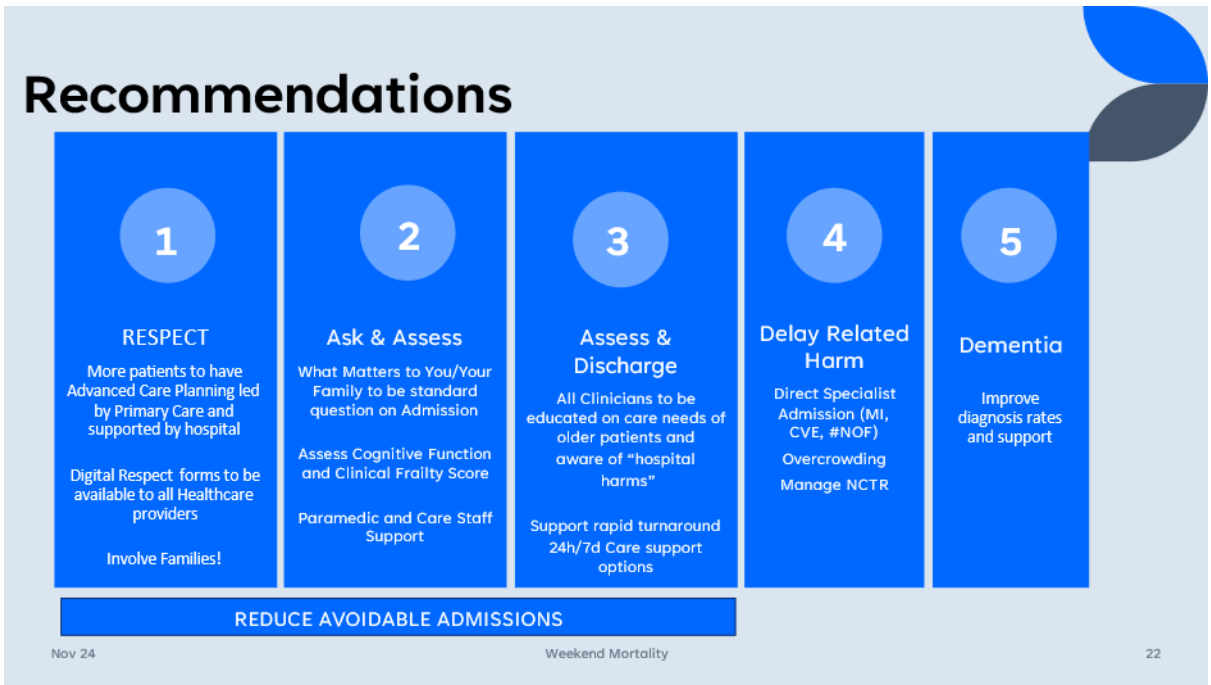
Summary



Reviewers (GP and COTE Consultant) were asked if admissions to an inpatient bed were potentially avoidable and this was similar on both Tuesday and Saturday at 31-33%.

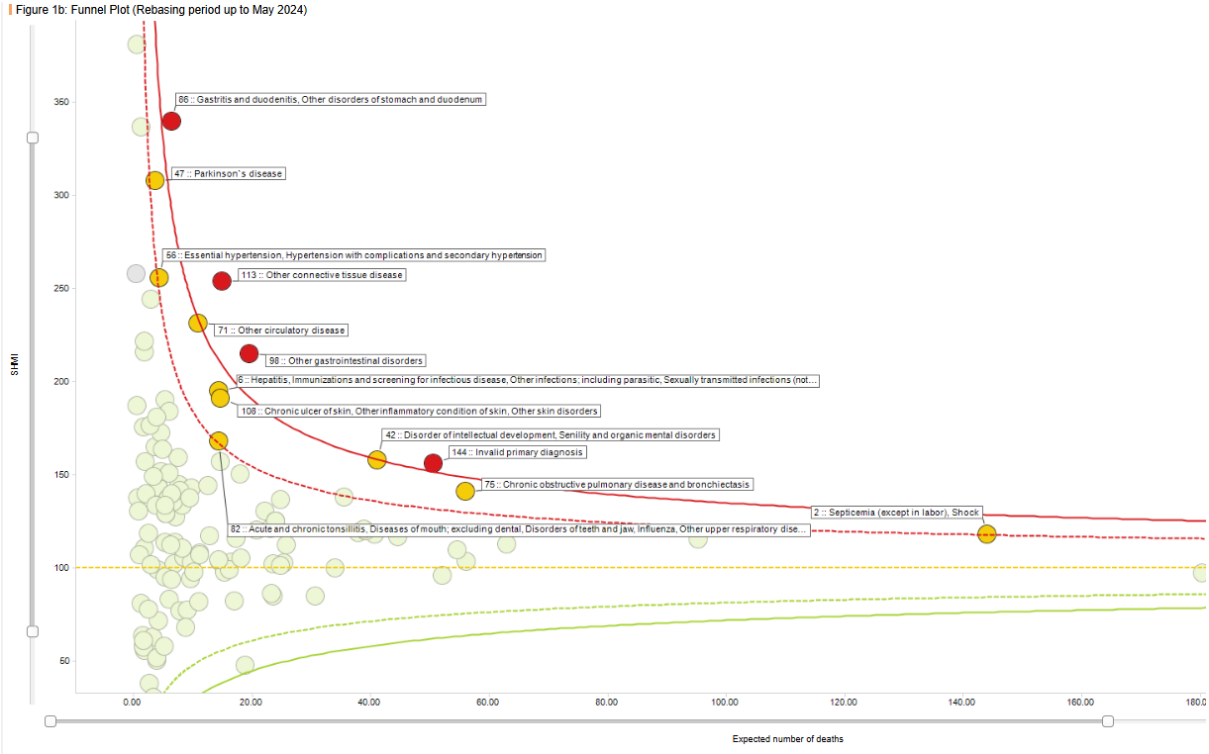


Recommendations were presented at Systemwide Hospital Mortality Group and work is ongoing within current Programs.



3.3 Deaths by SHMI Diagnostic Group

Figure 1b: Funnel Plot (Rebasing period up to May 2024)



- There are 4 red and 9 amber alerts, most of which have occurred before and had a first line review.

A review of clinical records in COPD undertaken by senior clinicians within Respiratory showed that non capture of Respiratory Failure as a diagnostic group (patients requiring NIV or High Flow Nasal Oxygen) would have significantly impacted the “expected deaths”. Clinical care was appropriate.

A local coding agreement now allows coding to better reflect severity of illness.

A review of patients with septicaemia showed most patients were significantly frail or with co-morbidities which may not feature within Charlson score. It did highlight some issues with antibiotic delays and has led to the re-establishment of a Hospital wide Sepsis expert group led by Microbiology to co-ordinate best practice.

One of the red alerts relates to the data submission error for diagnostic code of “invalid primary diagnosis” -this decreases “expected deaths” by approx. 20 so would improve SHMI..

It was noted that several of the alerts occur in diagnostic groups with low expected deaths and small numbers which is statistically more fragile. A coding audit is looking into these vague diagnostic groups-often with the word “other” preceding them. There may be more accurate primary diagnoses which can be assigned which better reflect actual clinical presenting complaints.

Coder – Clinician Collaboration:

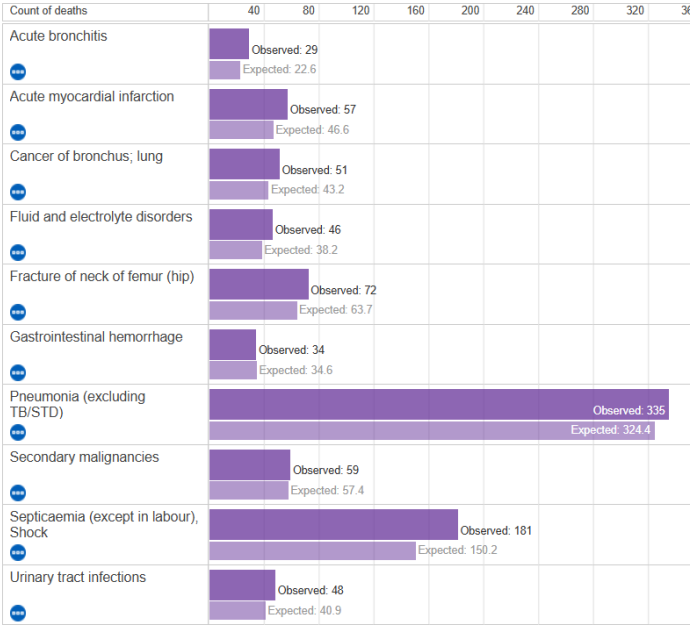
Ongoing work led by a Chief Registrar and the coding team has shown that better understanding of accepted terminology during clerking has the potential to both reduce “vague diagnostic groups” and symptom-based codes and improve capture of co-morbidities at admission. This has already impacted on Acute Medical admissions via AMU and is likely to further improve over next months. Reductions in monthly SHMI have been seen over the summer, and likely reflect this improved coding.

Preview SHMI-NHSE Oct 2024

No diagnostic groups given a SHMI value by NHSE are showing as “Higher than Expected” including those having had previous alerts.

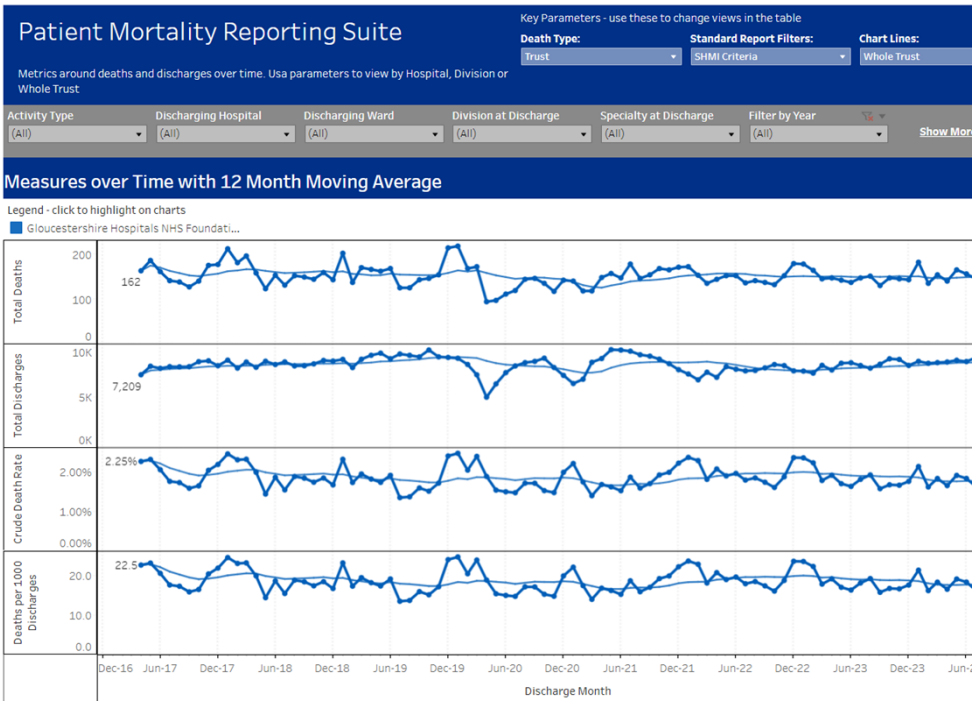
Diagnosis groups • July 2023 – June 2024

With SHMI value:

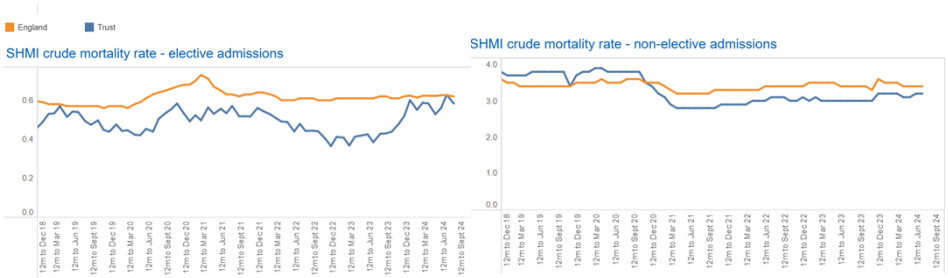


Actual Mortality- see below.

12 month rolling crude mortality still falling over this period



National Crude Mortality



GHT is in middle of the national range for both elective and non-elective admission

4. Structured Judgement Review Process

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

4.2 Deaths identified for review (next page)

Mortality Quarterly Dashboard: Quarter 1 (April- June 24)

Mortality Data

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
537	563	**5**	1	**17**	21	**98**	85	123(22.9%)	121 (21.4%)	**1**	1
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
537	2091	**5**	9	**17**	122	**98**	341	123(22.9%)		**1**	2

***1 Data was originally reported using Datix but all deaths no longer reported on datix therefore the BI Mortality Dashboard now being used for Total Number of Adult. Deaths, excluding all Women's &Children's except for deaths in Gynaecology.**

Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
0	0	**3**	3	**11**	11	**49**	49	**25**	25	**1**	1

***Using data pulled from Datix into BI**

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
1	**1**	**0**	**0**	**2**	**2**	**0**	**0**	**0**	**0**

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

***Data set very sparse in this section.**

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
76(66%)	**50 (67%)**	**1(33%)**	**2 (100%)**	**45(39%)**	**52 (49%)**	**25(21%)**	**54 (50%)**
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
76(66%)		**1(33%)**		**45(39%)**		**25(21%)**	

Please note: Where we have been unable to be assured of the data, cells have been left blank. Data collection is being reviewed in the Quality Improvement review of our SJR process.

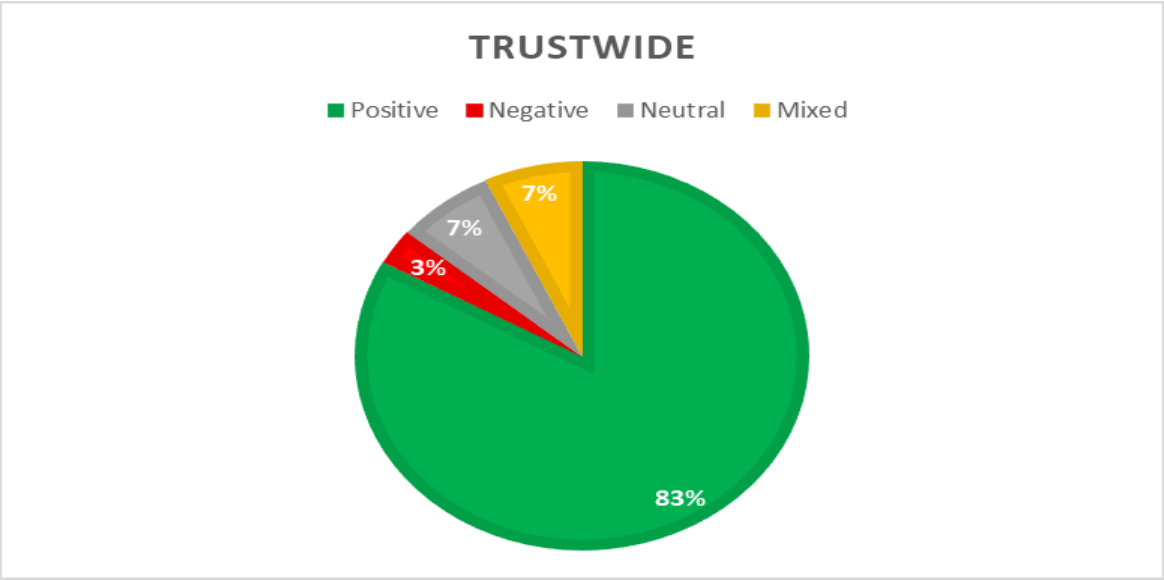
4.3 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach continues to embed within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

4.4 The Performance against standard tables above illustrates that 66% of deaths (requiring review) were reviewed within 3 months in the reporting period, representing a 1% decrease on the previous quarter.

5. Family Feedback from Bereavement team

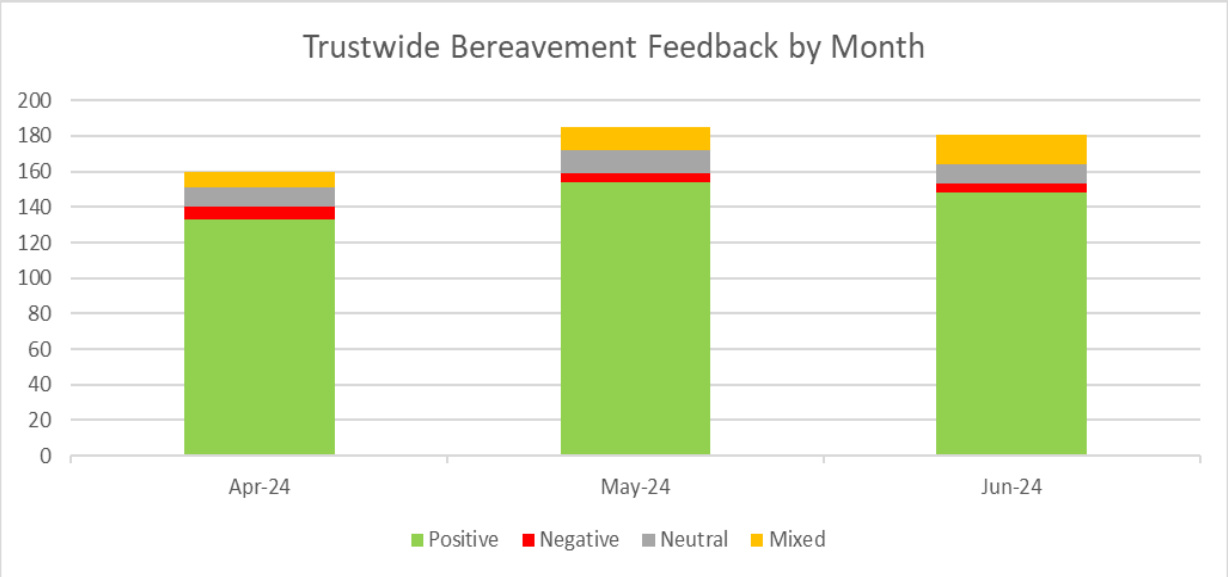
5.1 The following summarises the category of family feedback in the period 1st April 2024 to 30th June 2024 as captured by the bereavement team:

Figure 1



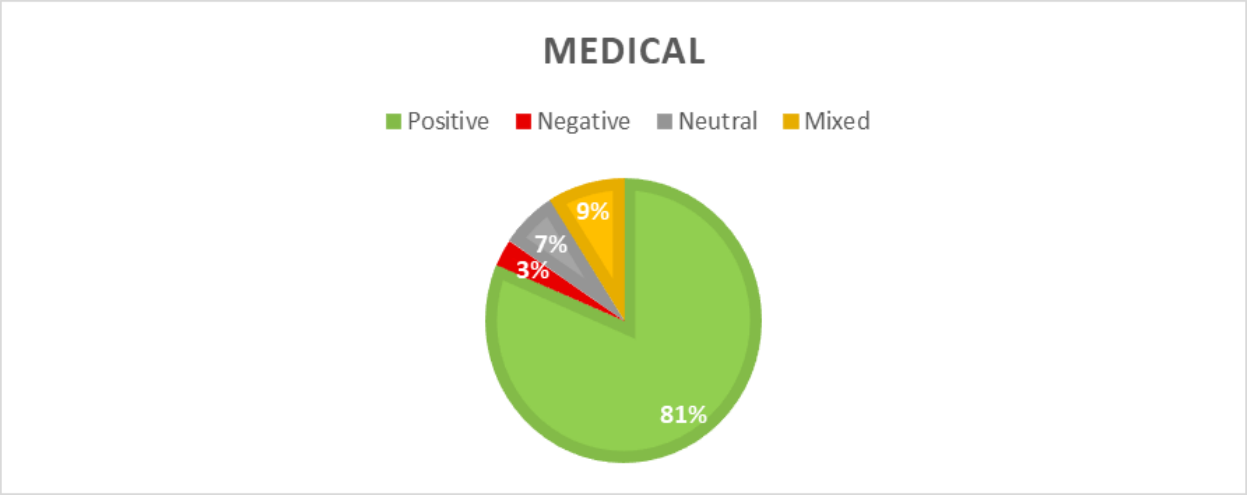
Positive feedback increased from 80% in Q4 of 2023/2024 to – 83 in Q1 of 2024/2025. Negative feedback reduced to 3%.

Figure 2



5.2 Medical Division

Figure 3



Positive feedback in the Medical Division increased from 80% in Q4 of 2023/2024 to 81% in Q1 of 2024/2025. Negative feedback also reduced.

Figure 4

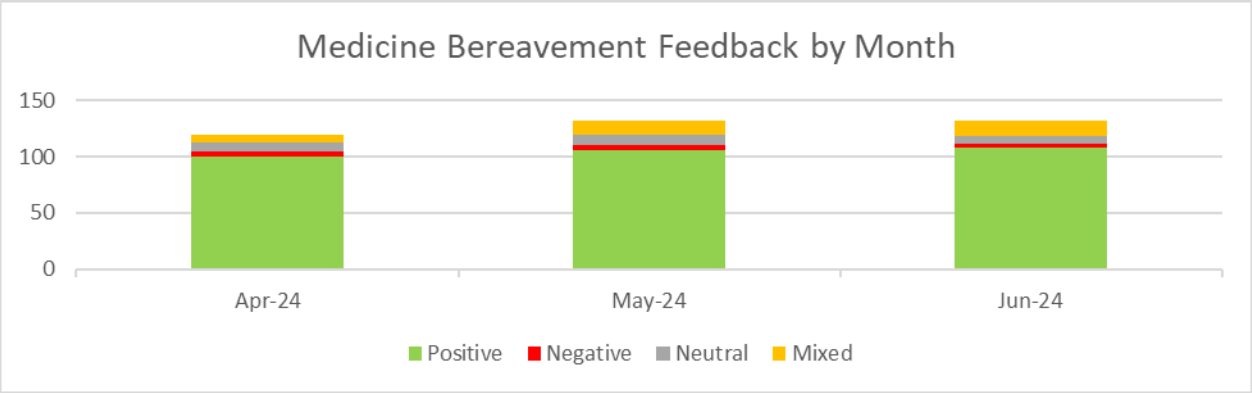
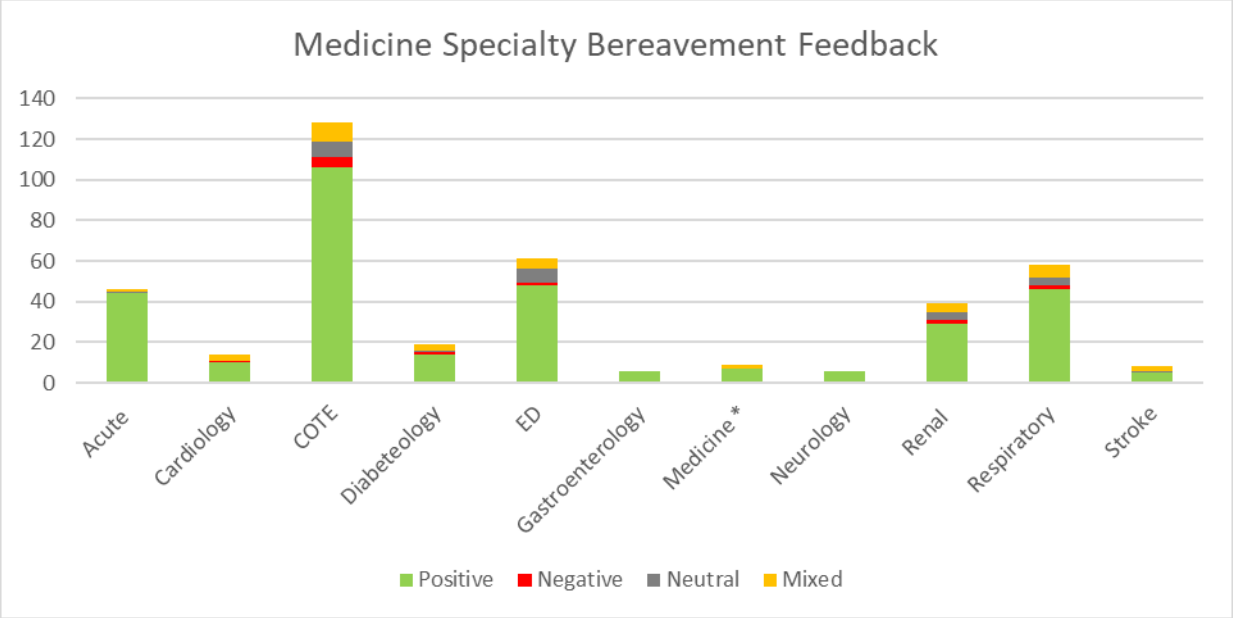


Figure 5



* Contains a mixture of specialties

5.2.1 Medicine Top 5 Specialties Positive and Negative Trends

Acute Medicine

Positive Trends	Negative Trends
Good Care provided	none
Kind and Helpful staff	
Good Communication	
Bereavement office support	
AMU specifically Mentioned	
Clinician mentioned	

Care of the Elderly

Positive Trends	Negative Trends
Good Care provided	Lack of communication
Kind and Helpful staff	4 x PALS Referral
Good Communication	EoL care inadequate
DCC Specifically mentioned	
Pall Care specifically mentioned	

Emergency Department

Positive Trends	Negative Trends
Good Care provided	**None**
Kind and Helpful staff	
Good Communication	
2x Clinician Mentioned	

Respiratory

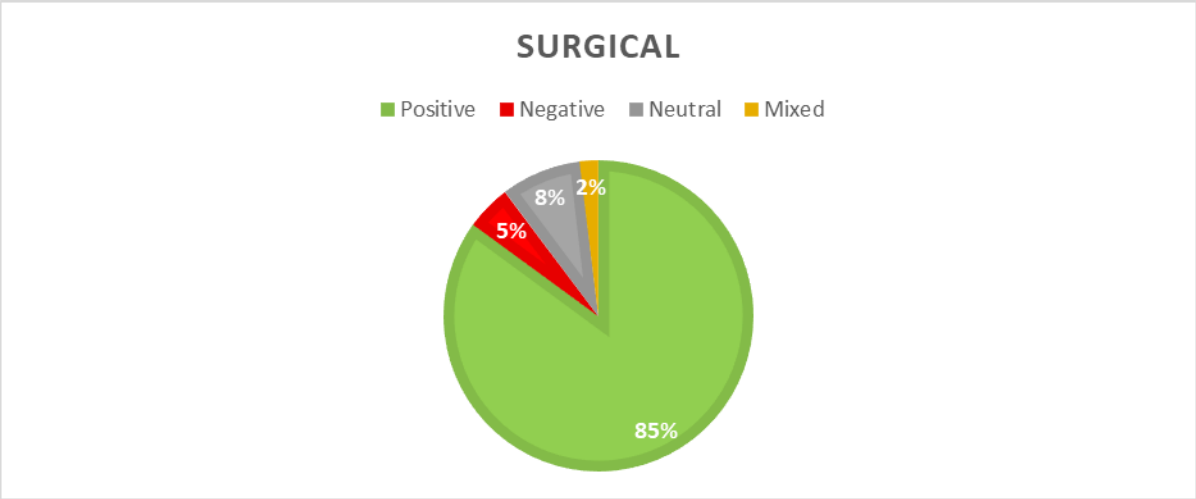
Positive Trends	Negative Trends
Good Communication	2 x PALs Referral
Good Care provided	
Kind and Helpful staff	

Renal

Positive Trends	Negative Trends
Pall care team very informative	Communication
Good Care provided	1 referral to PALS
Kind and Helpful staff	1 referral to complaints
7b Mentioned specifically	
Clinician Mentioned	

5.3 Surgical Division

Figure 6



Positive feedback in the Surgical Division increased from 78% in Q4 of 2023/2024 to 85% in Q4 of 2024/2025. Negative feedback decreased.

Figure 7

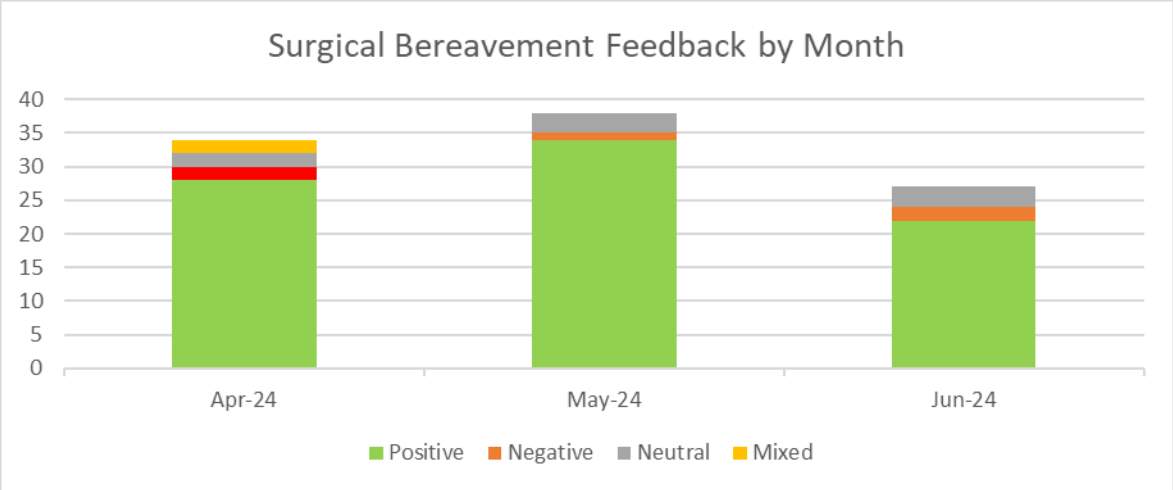
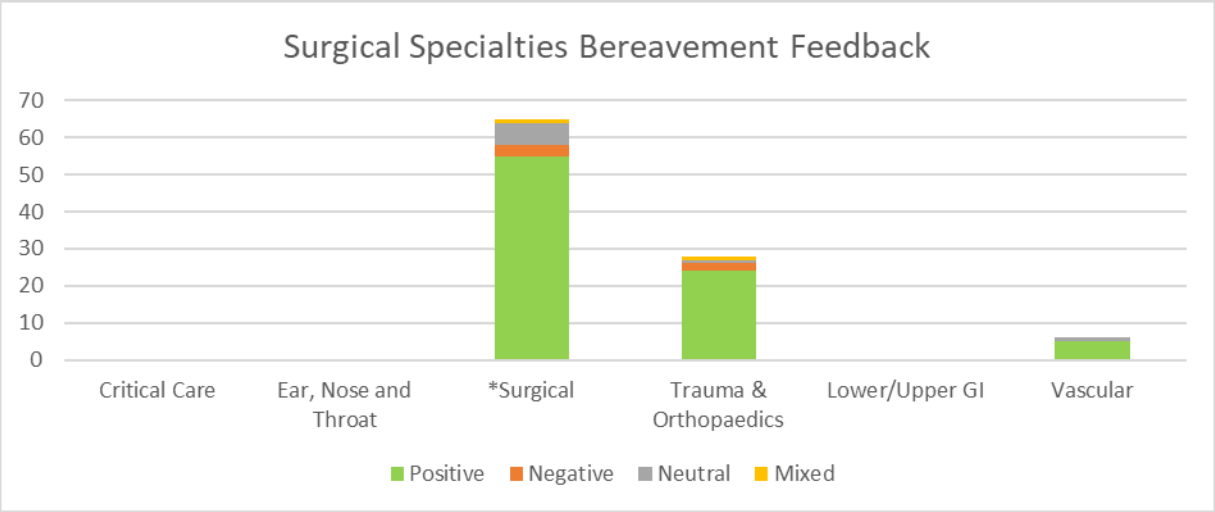


Figure 8



* Contains a mixture of specialties

In Q4 of 2023/2024 there was feedback for Critical Care, ENT and Lower/Upper GI there was no feedback allocated to these specialties in Q1 of 2024/2025.

5.3.1 Surgical Top 5 Specialties Positive and Negative Trends

Surgical

Positive Trends	Negative Trends
Rendcombe and DCC specifically mentioned	1 x PALS Referral
1 clinician specifically mentioned	
Good Care provided	
Kind and Helpful staff	
Good Communication	

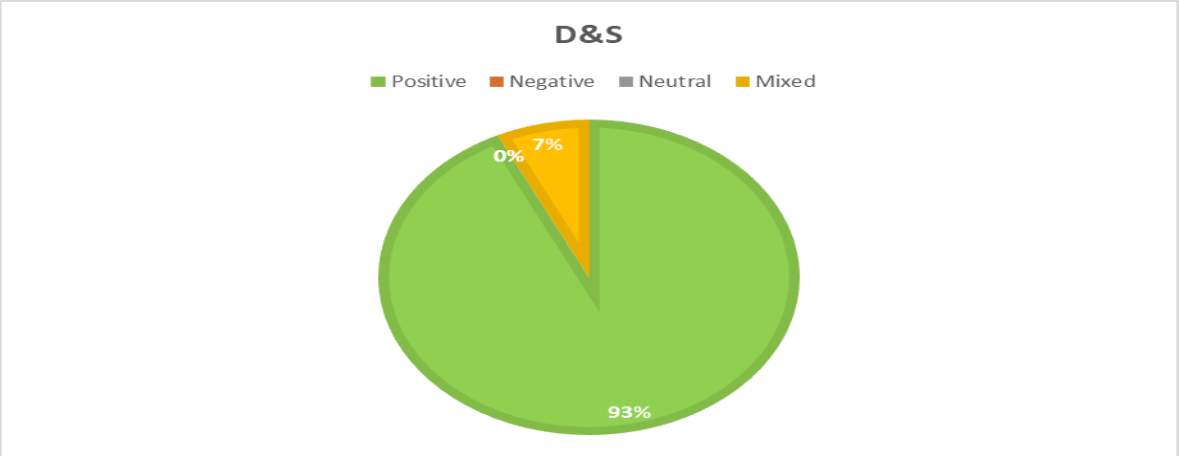
Trauma & Orthopaedics

Positive Trends	Negative Trends
Good Care provided	2x PALS Referral
Kind and Helpful staff	
Clinician specifically mentioned	

Vascular - Number too low to trend.

5.4 Diagnostics and Specialties Division

Figure 9



Positive feedback in Diagnostics and Specialties increased from 86% in Q4 of 2023/2024 to 93% in Q1 of 2024/2025. Negative feedback reduced.

Figure 10

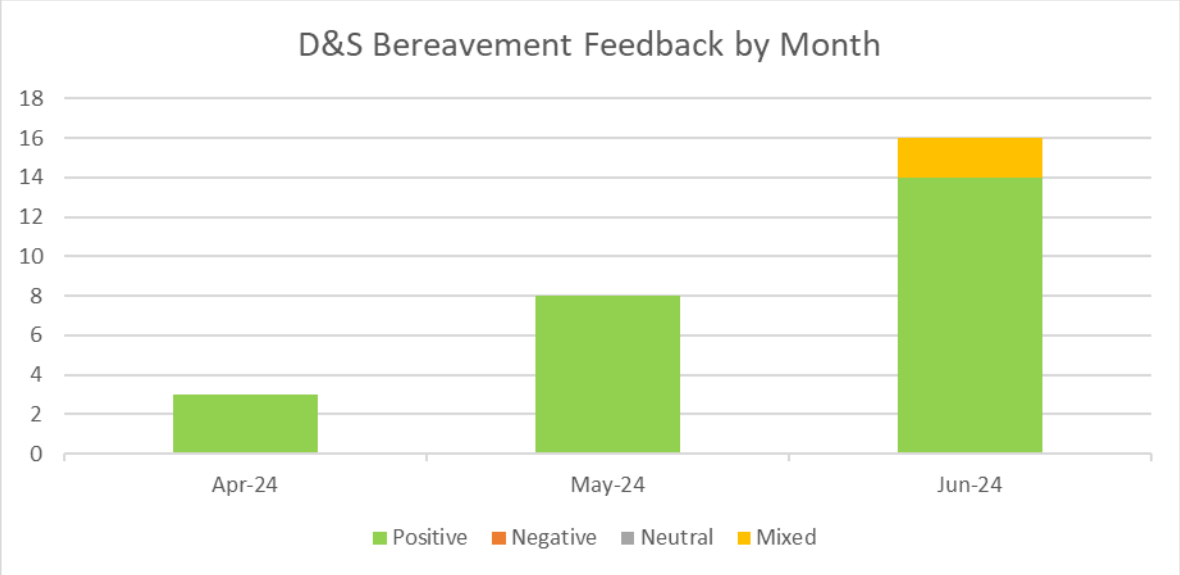
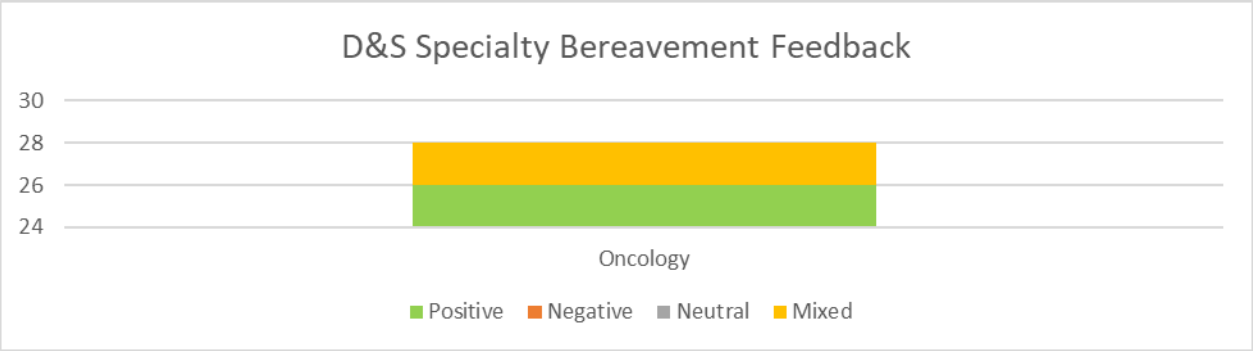


Figure 11



5.4.1 D&S Specialty Positive and Negative Trends

Oncology

Positive Trends	Negative Trends
Pall Care Mentioned	None
Rendcombe and Lillybrook both mentioned	
Good Care provided	
Kind and Helpful staff	
Good communication	

5.5 Women's and Childrens Division. There was no feedback for the reporting period.

5.6 Family Feedback Conclusion

The feedback has been combined for the April to July 2024 period of the Learning from Death's report. It is clear that the positive feedback is consistently high regarding the care provided with the care experience being identified as positive as well as our staff being kind and helpful.

6. LeDeR Report

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

LeDeR reviews usually do not reach the QA panel until at least 6 months after the person has died, as it takes that long for the reviewers to be able to interview family and carers and to review professionals' notes and then write their report. Feedback on deaths of people with LD or autism will therefore not reach staff involved for at least 6 months. Even then, feedback can only be shared if family have given permission for this, and whether they give this consent or not is variable.

There were 11 deaths of patients with either LD or autism during Q1. This is a higher number than average, but was balanced out by a lower than average number in Q2. The majority of these deaths have not yet been through the LeDeR QA panel, but of those reviews which have been completed there are no concerns to report. It was notable during Q1 that most deaths occurred within 24 – 48 hours of arrival at hospital suggesting that the deaths could not be avoided by that stage. It is worth noting that most LD residential accommodation staff are not accustomed to managing death on a regular basis, so no criticism should attach to care staff calling for an ambulance at the point of deterioration. Consideration of how to plan for increasing numbers of LD deaths being at the end of a frailty pathway, rather than other causes, continues.

7. Increased Incidence of Still Birth

Whilst outside the reporting period of this report (Q1 of 2024/2025), an increase in the incidence of still births (September to December 2024) is highlighted. Across this time period 10 still births have been reported. These have undergone a local (Maternity) multi-disciplinary review where immediate learning and themes have been identified. Where problems in care are considered to have caused or contributed to the death, the still birth has been presented to Patient Safety Review Panel and a PSII has been declared. The immediate learning is focussed around midwifery care and has been added to the Maternity team's production boards for weekly monitoring, oversight and escalation.

8. Conclusions

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

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

8.3 Learning from serious incidents and PSII's is monitored through SERG, summaries are found in Appendix 1 (for QPC only).

8.4 Timeliness and completion rate of SJR is of concern. A review (utilising a QI approach) of SJR process, compliance and outcomes is being undertaken.

8.5 It is clear that the positive feedback is consistently high regarding the care provided with the care experience being identified as positive as well as our staff being kind and helpful. A review of the Trust's process for feeding back (to families) findings of SJR is being undertaken. It is recognised that proactive feedback may improve experience and reduce concerns and complaints.

8.6 Hospital crude mortality remains low/falling, whilst SHMI remains higher than expected. The cause of this is multifactorial and both coding and care issues continue to be investigated including:

- Coding
  - Charlson Scores
  - Primary diagnosis capture
  - Clinician / Coding Collaboration
- Variation
  - Weekend
  - Site – CGH v GRH
  - In Hospital / Out of Hospital
- Specific Diagnostic groups
  - Fractured Neck of Femur pathway improvement work
  - COPD coding for patients receiving Non-Invasive Ventilation
  - Sepsis
  - Non-specific groups where improved coding is reuired
- Delay related harm data review

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

9. Recommendations

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

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

Charlie Candish, Associate Medical Director (Safety)

Presenter/s: Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO

Report to the Care Quality Commission - Section 31 Maternity Summary Report to Trust Board of Directors	
Date	13 March 2025
Title	**Report to the Care Quality Commission - Section 31 Maternity Summary Reports**
Authors **Presenter**	Women's and Children's Division Director of Midwifery - Lisa Stephens Women's and Children's Division Speciality Director – Chris Edwards (Supported by Deputy Director of Quality - Suzie Cro) **Director of Quality and Chief Nurse – Matt Holdaway**

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

Summary of Report

The purpose of this coversheet is to summarise the key steps taken to eliminate immediate risk with respect to each point in the CQC Section 31 letter dated 9 May 2024. In summary, the CQC have received monthly reports and all these reports have been provided to Board members in the virtual "Reading Room" (Board access only). A summary of the current progress has been provided at the end of this coversheet (see table at the end).

Quality Improvement Approach

In May 2024, Maternity Clinical Teams were set up to lead the improvement work. The Teams that had not quality improvement (QI) training, completed the 'Silver' course. The last silver QI training session was in October 2024. On 10 February 2025, Teams presented an overview of their QI projects at the Gloucestershire Safety Quality Improvement Academy (GSQIA) graduation ceremony which was attended by Kevin McNamara (CEO) and Deborah Evans (Trust Chair).

Progress

Teams continue to make progress with their improvement projects and report on a monthly basis to the Executive Led Maternity Delivery Group. 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 (February 21 2025) has also been provided to Board members for information. At the December 2024 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 but reporting will continue to CQC.

Reporting

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 by 31 March 2025.

Board members are asked to note that the CQC published their latest inspection report for the GRH site maternity inspection (which was carried out in March 2024) on 7 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
Appendix 1– Table with summary of progress Reading Room (board access only) – January 2025 CQC S31 Report February 2025 CQC S31 Report – 21 February 2025 ICB QIG Presentation (for information) – Coversheet for new Maternity Dashboard highlights (as provided to CQC)

Appendix 1 - CQC S31 enforcement notice

Table: Summary table of actions

<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

– PPH safety incident management using PSIRF principles.

Target

– The target was to have reduced the mean monthly PPH rate >1500ml to 31 per 1000 deliveries by Jan 2025</td>
<td>
Outcome data

CQUIMs – The latest National Data was published on 20 February 2025 (Dec 2024 data) and this demonstrates that our PPH rate for the CQIM metric is just above national average.

NB: The national data and the Trust data are aggregated slightly differently.
<table>
<tr><th>CQIMs 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><th>Dec 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><td>32.0</td><td>32</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><td>29.0</td><td>35</td></tr>
</table>
PPH/MOH Trust data

The Trust data for January 2025 shows a rate that is 35.9 per 1000 deliveries.
<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><th>Dec 2024</th><th>Jan 2025</th></tr>
<tr><td>Trust data</td><td>29.02</td><td>44.64</td><td>52.08</td><td>44.97</td><td>17.78</td><td>38.29</td><td>44.49</td><td>37.1</td><td>39.2</td><td>35.9</td></tr>
</table>
Risk assessments audits (intrapartum)

The audit sample size is 30 patients per month (19% of all women who have PPH/MOH). The
</td>
</tr>
</table>

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

– The Intrapartum Forum have oversight of the PPH improvement work.

Change ideas

Improvement actions are put in place once the data is reviewed and themes/trends are acted upon</td><td>Reduce Checklist tool requires the clinical staff to complete a risk assessment on admission. Compliance for this is reviewed across all intrapartum settings. Current data demonstrates that we have 91.4% compliance of completion of the risk assessment and further work is required to reach the target and to sustain this.

Table: PPH risk assessment on admission (intrapartum)

<table>
<tr><th></th><th colspan="8">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>Dec 2024</th><th>Jan 2025</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>90.4</td><td>91.4%</td><td>95%</td></tr>
</table>

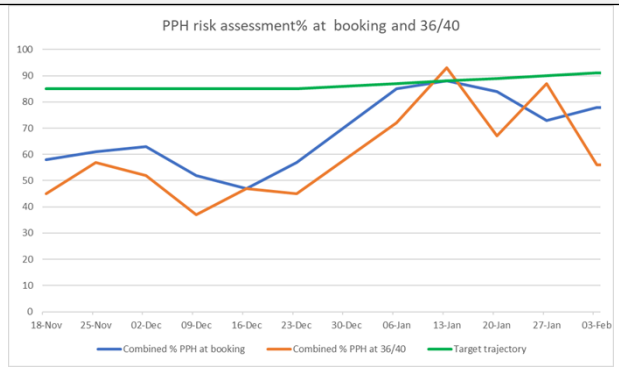
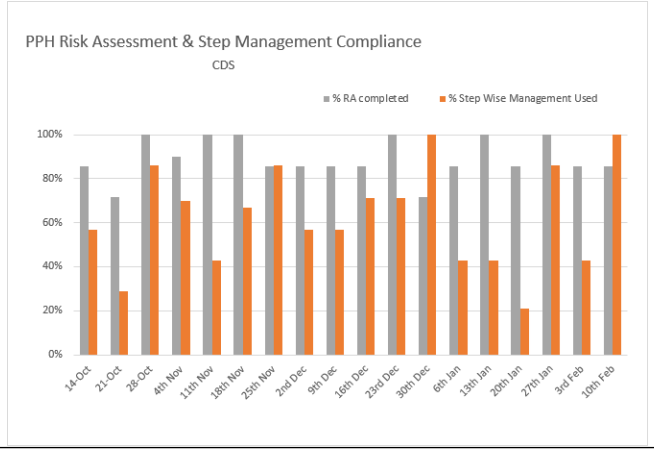
Booking and 36/40 risk assessments

PPH risk assessments at booking and at 36/40 are currently reported within the Production Boards for each community area and improvement is still required. Matrons and Team leaders are working with their teams monitoring the data and taking actions to improve rates. The 36/40 risk assessment metric has decreased by 20%. The team took action and these actions led to an improved rate the following week which will be reported on next month (72%).

<u>Actions</u>

• Data drilled down to identify teams requiring improvement and to work closely with them to look at barriers to completion.
• Reminders sent to all community team leaders.

Chart: risk assessment compliance at booking and 36/40</td></tr>
</table>

Issue	Actions	Data
		 **Reduce Checklist - Stepwise management** Thirty sets of notes are being reviewed on a monthly basis auditing the contemporaneous completion of the Reduce Checklist. This is the “step wise” management. This month the compliance decreased to 45% being completed but increased 100% once immediate actions had been completed to ensure completion of the tool. Table: PPH risk assessment and step wise management compliance 

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

PPH Safety incidents

It was noted that there was a backlog with reviewing MOH/PPH safety incidents and so an immediate improvement plan was put in place.

<u>Governance</u>

- All perinatal safety incidents are managed and reviewed daily by the Perinatal Patient Safety Team.
- There is a daily executive led Incident Review Safety Huddle (IRSH) which reviews all cases that are recorded on Datix as “moderate harm and above” or staff have recorded they are “very concerned”.
- To monitor the timeliness of reviews/scoping the team are doing this via a governance production board at Perinatal Oversight and Assurance Meeting.
- All cases that meet the PSII criteria are being prioritised and are presented to Patient Safety Incident Review Panel (PSRP) and the appropriate learning response is assigned (PSII, AER, multiprofessional review, cluster review).
- In addition, all cases of perinatal mortality regardless of harm level are presented at PSRP.

Expected time scales key performance indicators

- Patient Safety Incident Investigation (PSII) - 6 months
- After Action Review (AAR) - 3 months
- Scoping by perinatal team 3 working days
- The target is to get all of the PPH/MOH cases reviewed by 28 February 2025.

Table: MOH/PPH cases requiring multiprofessional scoping

<table>
<tr><th></th><th>13/12</th><th>20/12</th><th>27/12</th><th>03/01</th><th>10/01</th><th>17/01</th><th>24/01</th><th>30/01</th><th>21/02</th><th>Target 28 Feb</th></tr>
</table>

</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>MOH Overdue</td><td>90</td><td></td><td>35</td><td>35</td><td>25</td><td>24</td><td>18</td><td>19</td><td>3</td><td>0</td></tr>
<tr><td>PPH Overdue</td><td></td><td></td><td>191</td><td>137</td><td>113</td><td>92</td><td>93</td><td>93</td><td>55</td><td>0</td></tr>
</table>
</td></tr>
<tr><td>Work stream 2 – Fetal monitoring peer reviews, accurate assessment and timely escalation of concerns</td><td>Targets

Following the refresh of the QI project the target dates were all extended to 31 May 2025</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>Dec 2024</th><th>Jan 2025</th><th>Target end May 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>100%</td><td>86%</td><td>Target 95%</td></tr>
<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>65%</td><td>67%</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>82%</td><td>71%</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>80%</td><td>86%</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>75%</td><td>93%</td><td>Target 100%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Total mean of hourly intrapartum peer reviews</td><td></td><td></td><td></td><td></td><td></td><td></td><td>77.5%</td><td>82%</td><td>95%</td><td>Target 85%</td></tr>
</table>

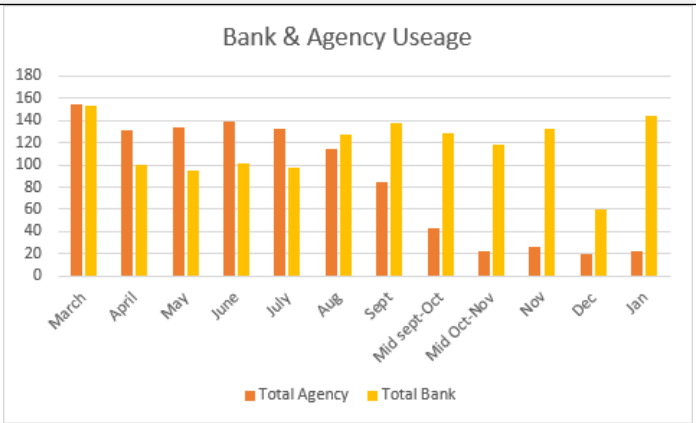
Deep dive at the Quality Improvement Group
- The Fetal Monitoring Team continue auditing 20 sets of notes monthly and there was a QI project refresh in January 2025. Following this there was a decision to host a focus group to talk to staff again about what's going well/not so well. Following that group meeting new change ideas emerged and now will be tested.
- Currently there is no Fetal Monitoring Midwife in post and the QI is being led by the Lead Midwife for Education and Training. The Fetal Monitoring post has been advertised and the practice development team are overseeing aspects of the education and audit part of the role. The plan is for a new Fetal Monitoring Midwife to be in post by June 2023.
- The Training and Education Lead midwife is working with the BI team to create a digital solution for the auditing.
</td></tr>
<tr><td>Work stream 3 – Temporary workforce (agency midwives) experience

CLOSED for reporting at QIG</td><td>Target met as all Agency staff that have worked in the unit have had an induction.

Governance

Temporary workforce usage/issues</td><td>With our vacancies reducing so is our usage of agency. Our January 2025 data informs us we have a 7% vacancy rate for clinical midwives. We have 12 newly qualified midwives starting with the Trust over February and March 2025. The need for agency is escalated through the Trust wide processes and monitored through the Maternity Flow Meeting. Below is the data which demonstrates the continued low level of Agency Midwife usage. All agency midwives will have completed an induction prior to them being accepted for any shifts.

Chart: Maternity Midwifery Bank and Agency Usage</td></tr>
</table>

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr><td></td><td>are reported at the Workforce meeting and through to Perinatal Oversight and Assurance Meeting.</td><td> 
</td></tr>
<tr><td>Work stream 4 – Venous Thromboembolism (VTE) risk assessments</td><td>Target

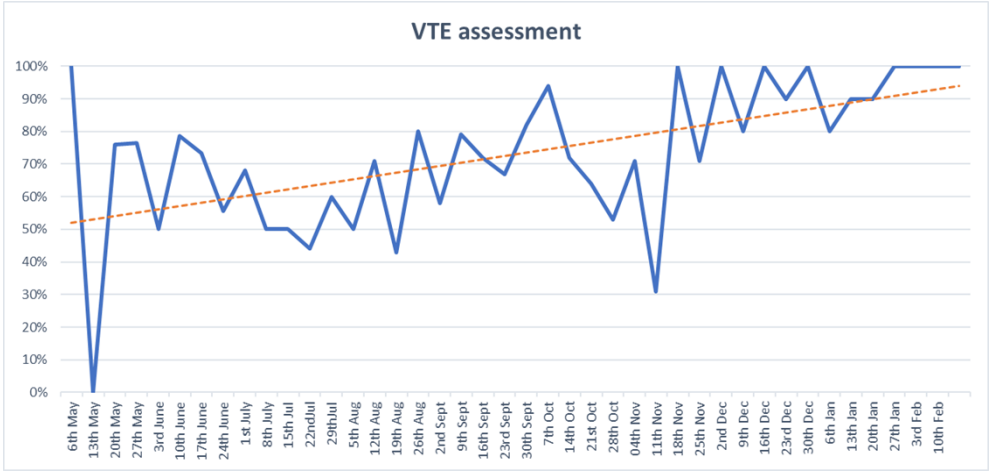
For admission VTE risk assessments to be completed within 14 hours of admission by >95% by end of Feb 2025 (target to be extended).

Improvement actions

– Data</td><td>The focus for this QI work continues to be the “on admission” risk assessments within 14 hours. The service continues to try to be able to pull the data through from the digital systems but until this data is accurate, we will continue to carry out manual audits.

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><th>Dec 2024</th><th>Jan 2025</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><td>*81%</td><td>Data not reliable in electronic systems</td></tr>
<tr><td>Manual audits</td><td></td><td></td><td></td><td></td><td></td><td></td><td>70%</td><td>90%</td><td>100%</td></tr>
</table></td></tr>
</table>

Issue	Actions	Data
	issues are being reviewed.	*Manual audits show 90% compliance and so EPR data being improved as this is the interface between 2 clinical systems (BadgerNet and Sunrise). Chart: Production Board VTE Risk Assessment Compliance  **Thromboprophylaxis audits** The next quarterly audit has been completed which demonstrates: - 100% of women have had their risk assessments. - 100% women were wearing thromboembolic stockings. - However, of the women requiring pharmacological prophylaxis only **2 out of 5 women** had received this (40%) at the time the records were reviewed. The sample size was small and so a larger audit is being now being completed. <u>Immediate safety actions</u> - For the week commencing 24th February, senior team have completed daily checks on the maternity ward.

Issue	Actions	Data
		- In response to this audit the Matron carried out her own review and found much higher compliance rates and so the audit is being repeated. The audit frequency has been increased to weekly (10 sets every week) and medical staff are supporting the data collection. - Once the audit results were shared with the Obstetric Speciality Director, they took immediate safety actions to make sure at the daily ward rounds women's risk assessments were checked and the medication was appropriately prescribed. - There was a request that ward staff improve their documentation if the woman declines medication or if the medication is contraindicated. - Pharmacological prophylaxis was added to Team Talk for Monday (24 February) to increase staff awareness to action. - We will continue to work with Business information to collect data for pulmonary embolus and deep venous thrombosis (incidence very low).

<table>
<tr><th>Issue</th><th>Actions</th><th>Data</th></tr>
<tr>
<td>Work stream 5 - Maternal Obstetric Early Warning Scores (MOEWS) repeating observation when there is a trigger

CLOSED for reporting at QIG</td>
<td>The focus for the improvement work has been the “act on amber” early warning scores with repeat observations happening within 1 hour.

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><th>Dec 2024</th><th>Jan 2025</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><td>71%</td><td>100%</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><td>97%</td><td>100%</td></tr>
<tr><td>Birth Unit GRH</td><td>75%</td><td>80%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>70%</td><td>83%</td><td>83%</td></tr>
<tr><td>Stroud</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>No ambers</td><td>6 monthly audits</td></tr>
</table>
In January compliance with “act on amber” increased on the Maternity Ward and Delivery Suite was at 100%. The data from the Birth Unit required renewed focus. Reminders have been sent to staff as we have had some new starters and the importance of repeating the observations have been reiterated. The new national Maternity Early Warning Scores will be rolled out in the Trust in September 2025 and this rollout being planned for.</td>
</tr>
</table>

DRAFT KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – JANUARY 2025

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 meeting.

Items rated Red

Item	Rationale for rating	Actions/Outcome
SRO9: Failure to deliver recurrent financial sustainability	A three-part agenda item reflecting financial performance in the current year, longer term prospects and a deep dive analysis to identify drivers of the deficit 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 the costs and coverage of back office and operational services, rebasing the block contract, increasing theatre capacity etc.
Performance Report - Month 9	Re 2024/25, at month 9 the Trust is reporting a small a deficit of £4.4m which is £0.5m favourable to plan. The forecast outturn remains at breakeven but this is under increasing pressure as a consequence of the recent critical incident. In addition to measures already agreed including review of the non-pay position and recurrent solutions, attention is turning to the end of year working capital position/management and impact on 2025/26 plans.	
Drivers of the Deficit analysis	The underlying deficit is £62m – of which £21m relates to the pre-Covid period. This independent report reviewed each driver of the deficit and 72% were considered to be "addressable". A large proportion included staffing costs and consequences of capital investments which had not been either properly funded or secured planned income. Estates costs were higher than peers and there is a potential to increase commercial income routes. As a system, Gloucestershire was not underfunded. A further £12m was identified as a consequence of the Trust receiving less contract income when compared to peers.	The Committee received the report as assurance of the depth of analysis and understanding of the longer-term position. A detailed action plan will be presented to a future meeting and discussions held with system partners as to the potential for system wide efficiencies, estate rationalisation, contract rebasing and recurrent funding solutions.
Capital Programme report and Estates Capital Briefing	A two-part agenda item bringing together the 2024/25 financial outturn position and a progress of individual schemes and risks surrounding delivery. Regarding the 2024/25 outturn, the total	The Committee received the report as evidence of assurance of the position. Smoothing the profile of

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

	capital allocation is £47.8m and spend to month 9 is £21.7m against a plan of £34m – a breakeven position is forecast for the year end. As in previous years, this weighting of expenditure towards the financial year end puts inordinate pressure on staff and contractors as well as increasing the risks of non delivery of targets. Regarding the Estates Capital briefing – recent bad weather had added additional essential schemes to the programme at short notice thereby requiring reprofiling of plans. Decisions around Building Control requirements continued to affect progress on Tower block schemes and efforts continued to influence the pace of decision making. Positive progress on delivery of the IGIS scheme was reported as well as the "breakthrough" decision to create a decant ward facility from 2025 onwards.	capital expenditure throughout the year to be considered as a committee objective for 2025/6. The Committee noted the positive assurances given in this report and the delivery of some significant, transformational schemes in what remained a highly challenging situation.
Financial Sustainability Report Month 9 and 2025/26 outlook	The overall target remains at £37.5m including the system stretch targets. At month 9 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. This represented a £15m additional pressure on 2025/26. Significant risks remain around delivery of the "Working as One" programme. The "Drivers of the Deficit" work would be built into 2025/26 plans and inform system wide deliberations. Productivity initiatives continue to deliver improvements but progress overall remains elusive. Plans for 2025/26 would include a number if transformational schemes and be presented to a future meeting.	The Committee noted the achievement of 2024/25 target and 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 an essential requirement of future plans. A report detailing the benefits realisation from capital schemes would be presented to a future meeting. 2025/26 and beyond plans to be presented at next meeting.

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

Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
GMS Key Issues and Assurance Report	A number of red rated items were noted including pseudomonas, IGIS and Theatres 3 and 4. All were being progressed through established channels. Approved engineer roles have now been successfully filled a consequence of a procurement rather than recruitment exercise – a major step forward.	The Committee received the report as assurance that established channels for communication and contract management were working.
Contract Management Group Exception Report	The strengthened contract management arrangements have bedded down and there is improved executive level oversight of the contract. The recent critical incident had demonstrated the effectiveness of new ways of working. A total of 24 surveys relating to fire and estates safety have been or are about to be undertaken – the Committee noted the increased numbers of risks likely to be identified as a consequence of gaining this increased understanding of the estate.	The Committee received the report as assurance of the robust management of the GMS contract and KPIs.
Commercial and Innovations Group KIAR	This group had been established in order to provide Board level oversight around third party contracts. This report was the "handover" document – detailing the risks that remained upon transfer to this committee as the group was to be discontinued and roles dispersed to a number of different directorates. Although some important issues had been taken forward, there remained a lack of clarity around how roles were to be dispersed, financial reporting lines and KPI performance.	The Committee received the report as a statement of work in progress pending consideration by Remuneration Cttee and production of an accountability framework. Updated KIAR to be presented to March meeting.
Research & Innovations Group update	A new Associate Director has been appointed to take forward the Research and Innovation component of the Commercial and Innovations agenda. An external review of operations including protection of the Trust's IPR was to be commissioned and would report back to a later meeting. A comprehensive report of activities was received.	The Committee received the report as assurance that control was evident around the Research and Innovations agenda and looked forward to receiving further updates. The committee supported the permanent addition of 2 PAs to the role of

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		Associate Medical Director.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Costing Five Year Strategy	This was an update on satisfactory progress	Noted excellent work.
GMS Strategic review	An update on progress- all actions were on track.	Similar update re Trust actions to come to a future meeting.
Items not Rated		
Operational Planning 2025/26	This was an update in advance of receipt of Planning guidance due to be published the following day.	
Finance Risk Register	Risk 948 around operating an unsupported legacy system due to delays in implementation of the new finance and procurement system had reduced as a consequence of recent progress	Risk 835 re financial sustainability to be reviewed and uplifted in the light of the non delivery of recurrent schemes.
Contract Management - Group Terms of Reference		To be reviewed before the end of March in the light of recent changes.

Investments		
Case	**Approval**	**Actions**
Medical e-Rostering Implementation Business Case	The Medical e-rostering business case was deferred to the next meeting of this Committee post consideration by TLT.	
Cobalt 3 Month Waiver	The Committee APPROVED the extension of the Cobalt MRI van hire for 3 months beyond the end of the contract via a waiver.	Clarity around the cost of the additional 3 months van hire would be provided.

Impact on Board Assurance Framework (BAF)
SR 9: Failure to deliver recurrent financial sustainability – This remains the biggest concern for the Committee. A full review would be presented to the February meeting.
SR10: Condition of the Estate – A good understanding of the current challenges was shared between ICS partners. Additional sources of funding (e.g. Lottery and Charities) were being explored. To be updated once the 2015/6 allocation was known.
SR11: Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon footprint NHS organisation by 2040 – an ICS wide tender for electric vehicle charging was to be launched by the County Council. The score had been increased following discussion at the last meeting of the Committee.

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