GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Tuesday 31st January 2017 in the **Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham** commencing at 9.00 a.m. with tea and coffee. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

24th January 2017

AGENDA

				Approximate Timings
	Patient Story			09:00
1.	Welcome and Apologies			09:30
2.	Declarations of Interest			
	WELL LED			
	Minutes of the Board	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 25th November 2016	**PAPER**	**To approve**	09:32
4.	Matters Arising	**PAPER**	**To note**	09:35
	Chief Executive's Report and Environmental Scan			
5.	January 2017	**PAPER** (Deborah Lee)	**To note**	09:40
	EFFECTIVE			
6.	Quality and Performance Report:			
	• Report of the Chair of the Quality and Performance Committee on the meetings held on 21st December 2016 and 27th of January 2017	**PAPER** (Keith Norton)	**For Assurance**	09:50
	• Report of the Interim Chief Operating Officer	**PAPER** (Natasha Swinscoe)		
	• Minutes of the meeting of the Quality and Performance Committee meetings held on 23rd November 2016 and 21st of December 2016	**PAPER** (Keith Norton)		
7.	Financial Performance Report:			
	• Report of the Chair of the Finance Committee on the meetings held on 21st December 2016 and 25th January 2017	**PAPER** (Tony Foster)	**For Assurance**	10:15
	• Report of the Interim Finance Director	**PAPER** (Stuart Diggles)		
	• Minutes of the meetings of the Finance Committee held on 23re November 2016 and 21st December 2016	**PAPER** (Tony Foster)		
8.	Audit & Assurance Committee – 18th January 2017			
	• Report to Chair of the Audit and Assurance Committee	**PAPER** (Rhona McDonald)	**For Assurance**	10:35
	Break			**10.35 - 10.45**

9.	Workforce Report • Report of the Chair of the Workforce Committee on the meetings held on 2nd December 2016 and 6th January 2017 • Report of the Director of Human Resources and Organisations Development • Minutes of the meetings of the Workforce Committee held on 2nd December 2016	**PAPER** (Tracey Barber) **PAPER** (Dave Smith) **PAPER** (Tracey Barber)	**For Assurance**	10:45
10.	Nurse and Midwifery Staffing Report	**PAPER** (Maggie Arnold)	**For Assurance**	11:05
11.	Board Assurance Framework and Trust Risk Register	**PAPER** (Deborah Lee)	**For Assurance**	11:15
12.	Staff Survey Action Plans - Update	**PAPER** (Dave Smith)	**For Assurance**	11:25
13.	SmartCare Progress Report	**PAPER** (Sally Pearson)	**For Assurance**	11:35
	FOR INFORMATION			
14.	Minutes of the meeting of the Council of Governors held on 7th December 2016	**PAPER** (Peter Lachecki)	**To note**	11:50
	Next Meeting			
15.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To note**	11:55
	Governor Questions			
16.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To Discuss**	12:00
	Staff Questions			
17.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	12:10
	Public Questions			
18.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**Close**	12:20 12:30
	Luncheon		**12.30 – 13.00**	

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 24th February 2017** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** at **9.00 am. (PLEASE NOTE VENUE FOR THIS MEETING)**

Public Bodies (Admissions to Meetings) Act 1960
"That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted."

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON FRIDAY 25 NOVEMBER 2016 AT 9AM

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT	Peter Lacheki	Chair
	Deborah Lee	Chief Executive
	Dr Sean Elyan	Medical Director
	Dr Sally Pearson	Director of Clinical Strategy
	Maggie Arnold	Director of Nursing
	Eric Gatling	Director of Service Delivery - Observer
	Natasha Swinscoe	Interim Chief Operating Officer
	Dave Smith	Director of Human Resources and Organisational Development
	Stewart Diggles	Interim Director of Finance
	Tracey Barber	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rhona Macdonald	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	Helen Munro	Non-Executive Director
IN ATTENDANCE	Martin Wood	Trust Secretary
	Dr Mark Silva	Chief of Service – Medicine
PUBLIC/PRESS	Anne Davies	Governor – Cotswold Constituency
	Bren McInerney	Public
	Peter Collins	Clinical Chair University Hospital Bristol
	Dr Claire Feehily	Chair Health Watch
	Alan Thomas	Lead Governor
	Eleanor Massey	Breast Surgeon
	Martina Morris	NHSI
	Craig MacFarlane	Head of Communications

The Chair welcomed the public, Governors and observers to the meeting. This was the first meeting which he was attending as Chair of the Trust and he said that he was proud and privileged to be appointed to that position. He looked forward to working with colleagues and the Governors to cement working relationships and with stakeholders and the public. He was pleased with the Trust policy of Best Care For Everyone and future meetings will contain a patient story.

355/16 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

356/16 MINUTES OF THE MEETING HELD ON 28 OCTOBER 2016

RESOLVED: That the minutes of the meeting held on 28 October 2016 were agreed as a correct record and signed by the Chair subject to the figure of £37M in the second bullet point on page nine

relating to minute 328/16 Financial Performance Report being deleted.

357/16 MATTERS ARISING

285/16 MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 6 SEPTEMBER 2016:

The Director of Clinical Strategy asked if the Board could be supplied with the Internal Audit Work Plan which the Chair of the Committee was happy to arrange. *The Interim Finance Director undertook to provide this to the Board. Ongoing.* **SD**

323/16 SUMMARY OF THE QUALITY AND PERFORMANCE COMMITTEE HELD ON 26 OCTOBER 2016:

The Chair invited the Board to consider whether verbal reports from the Finance Committee and Quality and Performance Committee which met two days before the Board meeting, provided sufficient assurance. The Chairs of the respective Committees were content to provide verbal reports but there were concerns that a written report should be provided. This was an area which would be considered further. *The Chair said that this was an issue larger than verbal or written reports. It was a timing issue between meetings of the Committees and the Board so that a full assurance report could be provided. On this basis the Board meeting schedule is to be re-arranged to allow a greater timeframe between Board Committee meetings and the Board to also give Executives an opportunity to follow up matters arising from the Committee meetings. Completed.*

324/16 MINUTES OF THE MEETING OF THE WORKFORCE COMMITTEE HELD ON 14 OCTOBER 2016:

The Committee agreed that the Workforce Strategy will be presented to the Board in November 2016. This item appeared later in the agenda. *Completed.*

326/16 BOARD COMMITTEE STRUCTURE:

The Chief Executive said that the Terms of Reference of the Finance Committee need to be amended by the addition of point 11 regarding the approval of business cases above £500k. *This has been included in the Committee's Terms of Reference. Completed.*

The Board considered the Non-Executive Director linkages between Finance, Quality and Performance and Audit and Assurance Committees in terms of clarity of purpose for the meetings. It was suggested that the Committee Chairs should meet regularly and Ms Barber undertook to provide a process for providing clarity. *The Chair said that the first meeting of the Non-Executive Directors will take place after the Board meeting. Completed.*

The Chair invited members to provide any textual amendments to the Terms of Reference to the Trust Secretary. *No amendments were made. Completed.*

331/16 BOARD ASSURANCE FRAMEWORK:

The Chief Executive said that the Board at the Seminar should consider how the risks in the Board Assurance Framework are to be effected. *This has been included in the Work Plan. Completed as a matter arising.*

333/16 PREPARATIONS FOR WINTER 2016/17:

The plan will be presented to the Quality and Performance Committee and the Board in November 2016. *This item appeared later in the agenda. Completed.* [09:10]

358/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONEMTAL SCAN

The Chief Executive presented her report and highlighted the very significant focus on developing our Trust's Financial Recovery Plan which has to be presented to our Regulator on 29 November 2016 in line with the requirements of Financial Special Measures. The Plan requires our Trust to identify cost reductions of approximately 5-6%. The message remains clearly focussed on reducing waste and promoting efficiency in the context that high quality care and good financial management go hand in hand. Ideas are being sought from staff to support this. Gloucestershire published its Sustainability and Transformation Plan earlier in the month. The key messages in the plan from our Trust are a commitment to deliver services from both sites; a recognition that the growing demands on Acute Health Services means that more specialist services will be reserved for those that cannot be delivered at home or in the community meaning that services will need to adapt and develop. If Gloucestershire residents are to receive the very best care, with outcomes comparable to the best in the Country, then we will need to bring some of our services together into Centres of Excellence where we can concentrate often scarce expertise. Without such an approach, patients may be required to travel further afield for their care. Our End of Life Service needs to be designed for all and it was pleasing that Sue Higgings, Epilepsy Nurse Specialist and a Doctor Emma Husbands, Consultant in Palliative Care, were part of the Team who won this year's Linda McEnhill Award.

During the course of the discussion, the following were the points raised:-

- Ms Barber enquired how learning is captured for our Trust and not just for the forthcoming CQC inspection. In response, the Chief Executive said that our Trust had created PRIDE to support Better Care for Everyone.
- In response to a question from the Chair about End of Life Care, the Chief Executive explained that this is also an issue for the community as well as our Trust. Suitable staff are required to perform this role. The Medical Director added that End of Life Care is complex and not just about the last few days but more about the last year and the challenge is to train staff to recognise this. The Director of Clinical Strategy echoed the Medical Director's comments.

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted. [09:30]

359/16 QUALITY AND PERFORMANCE REPORT

Report of the Chair of the Quality and Performance Committee on the meeting held on 23 November 2016:
The Chair of the Committee, Mr Keith Norton, presented the report describing the business conducted at the meeting of the Quality and Performance Committee held on 23 November 2016. The Committee had received the Emergency Care Programme Final Report on the work to date of the Emergency Care Programme. Three issues had been identified for our Trust; namely, Senior Leadership and Ownership, the Health System to fulfil its part and focus on the Emergency Department should not be lost whilst our Trust is experiencing financial pressures. The Performance Management Framework Report has shown that our Trust continues to fail to meet national standards for A&E 4 hour standard, two cancer standards and the Referral To Treatment standard. Demand continues to increase and assurance was provided that 18 Weeks will achieve 92% standard in March 2017, the Cancer 62 Day to achieve 85% in January 2017 and the 2 Week Wait to achieve 93% standard in December 2016. The challenges set out in the Emergency Pathway Monthly Report were system working. The Winter Plan was still in development and not as robust as it could be. The update report on safeguarding demonstrated the colossal scale of the work done and the increase in the number of cases.

Report of the Director of Service Delivery:
The Director of Service Delivery presented the report providing assurance to the Board in respect of our Trust's actions to deliver care in line with the mandated national standards. It summarised the key highlights and exceptions in Trust performance up until the end of October 2016 for the financial year 2016/17. The key issues to note were that our Trust continues to fail to meet the national access standards including the A&E 4 hour standard, two Cancer standards and the Referral To Treatment (RTT) standard. Our Trust has achieved the internal recovery trajectory for Cancer 62 Day GP Referral To Treatment Standard. Additional Divisional oversight arrangements have now been established to ensure more robust development and delivery plans in the area of 6 Weeks Diagnostics, Cancer and RTT standards under the leadership of the Director of Service Delivery. Our Trust continues to work closely with Commissioners and NHS Improvement to maintain confidence in our Trust's ability to recover current poor performance. The Executive Team and the Chair of the Committee are currently developing a revised Performance Assurance Framework. Performance against the national standards remains unacceptable and as such is a key area of focus for our Trust. Emergency Department attendances have increased by approximately 20 since the last month and admissions have increased by 2 patients per day. Whilst attendances have increased more patients have been seen within 4 hours. The increase in the Delay Transfer of Care is beyond our control and is being discussed with the Clinical Commissioning Group and the Local Authority. One never event occurred in Surgery which is being investigated with the outcome being reported to the Quality and Performance Committee.

During the course of the discussion, the following were the points raised:-

- In response to a question from Ms Barber about the dependencies on improving performance, the Director of Service Delivery said that there is a recovery trajectory to improve A&E performance. The Referral To Treatment Performance will be referred to the Quality and Performance Committee to consider further. There are issues in Oral Surgery and one additional Consultant has been appointed. The Cancer 2 Week Wait standard should be achieved in November 2016. The main challenge for our Trust is the Cancer 62 Day performance which requires elective surgery.
- In considering all performance issues the Quality and performance Committee should focus on risk. There is a move for Emergency Department performance to be considered business as usual when the Improvement Director leaves although this is a risk. Performance is in line with the trajectory. This is a Trust issue and all Divisions should be engaged. There are risks associated with the Medical Workforce in Urology.

The Chair thanked the Director of Service Delivery for the report.

RESOLVED: That the Integrated Performance Framework report be received as a source of assurance that the Executive Team and Divisional Leaders are addressing the performance deficit highlighted in the report.

Minutes of the Meeting of the Quality and Performance Committee Meeting held on 26 October 2016:

RESOLVED: That the minutes of the meeting of the Quality and Performance Committee held on 26 October 2016 be noted. [09:54]

360/16 FINANCIAL PERFORMANCE REPORT

Report of the Chair of the Finance Committee on the meeting held on 23 November 2016:
The Chair of the Committee, Mr Tony Foster, apologised for the absence of a written report. He said that the Committee had considered in detail and sought assurances on the position with Gloucestershire Care Services, Trade Payables, the discussions with the Clinical Commissioning Group, the update on the recommendations in the Deloitte Report, workforce issues including agency spend and a revised work plan for the Committee in 2017.

Report of the Finance Director:
The Finance Director presented the report providing an overview of the financial performance of our Trust as at the end of month seven of the 2016/17 financial year. It provided the three primary financial statements and a high level analysis of variances and movements against a planned position to NHS Improvement. It also provided an overview of a revised "best endeavours" financial forecast associated with the month seven financial position. The key issues to note were that the financial position of our Trust at the end of month seven of the 2016/17 financial year is an operational deficit of £11.6M which is an adverse variance to plan of £18.9M. There is a

prior period adjustment reversed out of the current year to date cumulative position of £6.0M. The NHS Improvement Plan and the planning process that created it is not as robust as would be expected. The plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes. Our Trust's internal budget does not reconcile, either by cost category or phasing, to the NHS Improvement Plan. The figures presented in the report as "plan" reflect the figures as submitted to NHS Improvement unless explicitly stated otherwise. Our Trust is forecasting an income and expenditure deficit of £23.9M against a planned surplus of £18.2M, representing a £42.1M adverse variance to the NHS Improvement Plan. A further £5.3M of borrowed funds has been received from the Department of Health and there will be further borrowing requirements above this amount.

As at month seven our Trust has delivered £3.6M of the Cost Improvement Programme against the NHS Improvement Plan of £10.6M which is an adverse variance of £7.0M. The Plan was not robust. The cash position is being well managed and there is not requirement to borrow in December 2016.

During the course of the discussion, the following were the points raised:-

- Mr Norton referred to agency spend which following an improvement had now deteriorated and he sought an explanation. In response, the Director of Human Resources and Organisational Development said that there is now a greater grip on agency spend with approximately 3,500 less shifts. The position had deteriorated due to unpaid invoices and the process has been addressed and should not be repeated. The Chief Executive sought assurance that with the reduction in agency shifts there has been no impact on quality of care. The Nursing Director said in response, that the safer staffing details provide that level of assurance with greater visibility of the staffing levels. The work undertaken in Medicine Division on Nursing spend needs to be replicated throughout our Trust.
- The Chair asked about the plans in place to improve the Cost Improvement Programme performance. In response, the Interim Finance Director said that this is a particular area of focus with support being provided to bring forward Cost Improvement Programme Schemes. The Director of Service Delivery added that there are individual Divisional Schemes and Trust-Wide Cost Cutting Schemes, for example length of staff.
- The Chief Executive said that Gloucestershire Care Services are supporting our Trust in Outpatient Services. The Internal Audit are looking at the booking function.

The Chair thanked the Interim Finance Director for the report.

RESOLVED: That:-

1) The financial position of our Trust at the end of month seven of the 2016/17 financial year is an operational deficit of £11.6M which is an adverse variance to plan of £18.9M be noted.

2) There is a total prior period adjustment reversed from the current year to date accumulative position of £6.0M.
3) The NHS Improvement Plan and the planning process that created it is not as robust as would be expected. The plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes. Our Trust's internal budget does not reconcile, either by cost category or phasing, to the NHS Improvement Plan. The figures presented in the report as "plan" reflect the figures as submitted to NHS Improvement unless explicitly stated otherwise.
4) Our Trust is forecasting an income and expenditure deficit of £23.9M against a planned surplus £18.2M, representing a £42.1M adverse variance to the NHS Improvement Plan. This forecast has moved by £0.1M since the prior month. Our Trust has received a further £5.3M of borrowed funds from the Department of Health. There will be further borrowing requirements above this amount.

Minutes Of The Finance Committee held on 26 October 2016:

RESOLVED: That the minutes of the meeting of the Finance Committee held on 26 October 2016 be noted. [10:15]

361/16 AUDIT AND ASSURANCE COMMITTEE – 8 NOVEMER 2016

Report of the Chair of the Audit and Assurance Committee: Ms MacDonald, as Chair of the Audit and Assurance Committee, presented the report of the meeting of the Committee held on 8 November 2016. She highlighted the reports from both the internal and external Auditors providing levels of assurance.

During the course of the discussion, Mr Norton asked if the Committee is planning to expand its work on risk management. In response, the Chief Executive explained that following an Internal Audit Report on risks, further work is required in this area. Firstly, a new Risk Management Group comprising Executive Directors has been established to provide oversight to risks. Secondly, staff are being trained in reporting risks on Datix and thirdly the Board will receive assurance from the Committee on risks. However, she explained that this will take a little time to resolve.

The Chair thanked Ms MacDonald for the report.

RESOLVED: That the report indicating the Non-Executive Director challenges made and the assurance received for residential concerns and/or gaps in assurance be noted.

Minutes of the meeting of the Audit Committee held on 8 November 2016

RESOLVED: That the minutes of the meeting of the Audit Committee held on 8 November 2016 be noted. [10:20]

362/16 NURSE AND MIDWIFERY STAFFING REPORT

The Nursing Director presented the report providing assurance to the Board in respect of Nurse staffing levels for October 2016 against the Compliance Framework "Hard Truths" – Safer Staffing Commitments. The key issues to note that whilst there were no major safety concerns arising from the staffing levels, the individual Divisional reports commented in detail where staffing hours were either lower than the centile set by NHS England, or over, and the rationale behind those findings. There continues to be close scrutiny of agency spend and recruitment. Weekly meetings commenced in October 2016 to review agency spend and actions and included support from KPMG. Recruitment of staff continues including European and international Nurses. The International English Language Test System (IELTS) continues to be challenging to our overseas Nurses in passing this high level test. The over recruitment of HCAs has been examined and the increase is due to long term sickness, maternity leave with over-establishment in some areas. Our Trust is supporting staff through the IELTS but there are issues in how many times the Trust can support Nurses in undertaking this test. There are some Wards where extra Nurses have been provided due to the high risk and the requirement for one to one Nursing. Our Trust is learning from other Trust's to ensure that Best Practice is in place.

During the course of the discussion, the following were the points raised:-

- The Nursing Director said that a risk assessment on whether the number of Nurses is at the right level will be included in the next report.
- The Chief Executive said that she had concerns for Day Surgery patients who were in hospital overnight in areas not designed for that. She said that assurance is as good as it could be that there is no patient safety issues and the plan is not to put patients in those facilities on a regular basis.
- The Nursing Director explained that arrangements are in place for patient notes to be annotated with a stamp for those patients spending a long time in the Emergency Department to be provided with a softer mattress to reduce pressure ulcers. The Nursing Director said that Ward 7A had triggered red in seven areas which is now being reviewed by the Matron and Divisional Nursing Director and the outcome will be known during the following week. The Board invited the Quality and Performance Committee to consider this in detail and to provide assurance regarding the staffing levels on this ward. **MA (MW to note for agenda)**
- In response to a question from Ms MacDonald, the Nursing Director said that there is a link with pressure ulcer information in the Performance Management Framework Report which is included in Divisional Reports to the Quality and Performance Committee.
- The Chair sought assurance that a more holistic view of falls is undertaken. In response, the Nursing Director said that the Trust-Wide Falls Group looks at all factors.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report as a source of assurance that staffing levels across our Trust are delivering safe care be noted. [10:39]

363/16 BOARD ASSURANCE FRAMEWORK AND TRUST RISK REGISTER

The Chief Executive presented the Board Assurance Framework setting out the controls to mitigate the potential risks and to provide assurance that the controls are effective or describes further actions to strengthen the controls and mitigate the risk. Since the last report, Trust Operational Risks have been added and aligned with the risk to the Strategy Objectives. Changes to the risk scores have been effected following the Board Review in October 2016. Our Trust's new External Auditors (KPMG) have recently undertaken a review of Board Assurance Frameworks across Foundation Trusts in the South and our Trust will undertake a review of our own approach against the KPMH Model of Best Practice. The Board Assurance Framework continues to develop and improve although it has yet to achieve its full potential to support the Board in understanding the risks to delivery of the Annual Objectives.

During the course of the discussion, the following were the points raised:-

- In response to a question from the Chair about risks, the Chief Executive explained that risks with a score of 15 and above will be included on the Trust Risk Register and presented to the Board. Work is in progress to ensure that all risks with a score of 15 are fully explained.
- The Chief Executive said that the Trust Risk Register should be reported to the Board monthly and the Board Assurance Framework reported quarterly. **AS/MW (MW to note for agenda)**
- The Chief Executive explained that the Board Assurance Framework should flow from clearly identified strategy objectives and the Director of Clinical Strategy confirmed that the refresh is being undertaken.

RESOLVED: That the report be received as evidence that the Executive Team is tracking the principle risks to delivery of the Strategic Objectives and that assurance in respect of mitigating actions and controls are in place with Board Committee oversight. [10:46]

(The Board Adjourned from 10:46 to 10:55am. The PRIDE information was displayed during the break).

364/16 WORKFORCE STRATEGY

The Director of Human Resources and Organisational Development presented our Trust's Workforce Strategy for approval prior to the planned launch in December 2016. The strategy was shared with stakeholders and following feedback is now recommended for approval by the Workforce Committee. The plan has been developed to ensure that our Trust has a Workforce that is able to deliver Best Care For Everyone whilst delivering a positive employee experience. Oversight of strategy implementation will be undertaken by the Workforce Committee and the strategy will be reviewed in March 2017.

During the course of the discussion, the following were the points raised:-

- Mr Norton said that our Trust must have a Workforce Strategy and the strategy presented is fit for purpose. He asked whether there is sufficient support to the Director of Human Resources and Organisational Development to deliver the strategy. In response, the Director of Human Resources and Organisational Development said that the support now provided by the Programme Management Office is sufficient. He is a member of the Work Groups to ensure delivery of the strategy.
- The Chair suggested that the Workforce Committee as part of the review of the Strategy should consider whether to Workforce priority should be updated.
- The Director of Human Resources and Organisational Development said that the strategy will be launched at the Involve session in December 2016 and then taken to each Division.

The Chair thanked the Director of Human Resources and Organisational Development for the report.

RESOLVED: That the Workforce Strategy be approved for planned launch in December 2016.[11:15]

365/16 SMARTCARE PROGRESS REPORT

The Director of Clinical Strategy presented the report providing assurance from the SmartCare Programme Board on progress towards the implementation of TrakCare, phase 1 and 1.5. The key issues to note were that the programme had progressed to an "amber" status in accordance with the decision from within the Programme and Operational Teams to support the Go-Live date of 5 December 2016 based upon the evidence of satisfactory progress within the reporting and clinical build and validation work streams. The training offered has been re-designed and approximately 6,500 staff have been trained. Approximately 200 staff have been trained using the e-learning modules. The Authority to Proceed Checklist will be considered further after the Board meeting.

During the course of the discussion, the following were the points raised:-

- The Chair invited the Director of Clinical Strategy to consider how the Board could have sight of the operation of TrakCare. **SP**
- Ms MacDonald asked for feedback on the quality of training provided. In response, the Director of Clinical Strategy said that the feedback on face to face training had been positive. The availability of the e-learning training has been welcomed. There will be training support after the Go-Live date. There will be approximately 200 Super Users to assist on Go-Live. The Director of Service Delivery added that a help line operating 24 hours a day will be available and the rota will ensure that staff have been trained.
- In response to a question from Ms MacDonald about the benefits of TrakCare, the Director of Clinical Strategy said that they are both in the form of cash and non-cash benefits and arrangements are in place to ensure that there is no

double counting.

The Chair thanked the Director of Clinical Strategy for the report.

RESOLVED: That the report be noted as a source of assurance that the programme to mobilise Go-Live on the 2-5 December 2016 is robust. [11:35]

366/16 NHS IMPROVEMENT ASSURANCE TEMPLATE ON TEMPORARY STAFFING

The Director of Human Resources and Organisational Development presented the report seeking approval of a self-certification checklist against a set of key actions as being instrumental in reducing agency expenditure. As a consequence of the high levels nationally of agency spend, NHS Improvement has written to Trust's seeking assurance that Board members are sighted on this crucial issue and have the tools to hold Executive Directors to account. One of the assurance tools is the self-certification checklist required to be returned to NHS Improvement by 30 November 2016. Assurance was provided across a range of areas and where this was limited, action plans were reference to address. Whilst the checklist is a strong aid, it is the development of detailed action plans within each work stream in addition to the focus and ownership provided by the Executives Team which will develop the traction required.

The Chair thanked the Director of Human Resources and Organisational Development for the report.

RESOLVED: That the assurance template for submission to NHS Improvement be approved. [11:34]

367/16 PREPARATIONS FOR WINTER 2016/17

The Chair said that the Quality and Performance Committee had raised concerns on the preparations for winter 2016/17 and the report will be considered at the next meeting of that Committee in December 2016. [11:35]

368/16 EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

The Director of Clinical Strategy presented the report providing assurance on our Trust's level of compliance with the national core standards for Emergency Preparedness Resilience and Response (EPRR). The key issues to note were that our Trust has demonstrated a substantial level of compliance against the national EPRR standards. This has been externally validated by Gloucestershire Clinical Commissioning Group and NHS England which represents and improvement on the position last year. Work in year has provided a more robust framework for the management and oversight of our response, including training and learning from incidents and exercises. Development of our Lockdown Plans have been commended. Our Trust is substantially compliant with the national core standards for EPRR, and arrangements are being formalised. A small non-recurring investment is required to maintain the status. The action plan will be monitored through the Emergency Planning, Resilience and Responsiveness Group. With the change

in Executive portfolios, responsibility for Emergency Planning will transfer to the Chief Operating Officer.

During the course of the discussion, the following were the points raised:-

- The Chair expressed his appreciation to the staff for their work in improving on the position from the previous year.
- The Director of Clinical Strategy said that in future the Audit and Assurance Committee will receive appropriate reports.

The Chair thanked the Director of Clinical Strategy for the report.

RESOLVED: That the report be accepted as assurance of our Trust's compliance with Emergency Preparedness Resilience and Response standards. [11:40]

369/16 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 2 NOVEMBER 2016

RESOLVED: That the minutes of the meeting of the Council of Governors held on 2 November 2016 be noted. [11:40]

370/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Any Other Business: No further items of business were identified.

Items For The Next Meeting: No further items were identified for the next meeting. [11:40]

371/16 STAFF QUESTIONS

There were none. [11:40]

372/16 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9AM** on **Tuesday 31 January 2017** in the **Sandford Education Centre.**

373/16 EXCLUSION OF THE PUBLIC

RESOLVED: That in accordance with the provisions Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960 the public be excluded from the remainder of the meeting of the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

The meeting ended at 11:40am.

Chair
31 January 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
November 2016	September 2016 Minute 285/16 Minutes of the meeting of the Audit Committee held on 6 September 2016	**SD**	The Director of Clinical Strategy asked if the Board could be supplied with the Internal Audit Work Plan which the Chair of the Committee was happy to arrange. *The Interim Finance Director undertook to provide this to the Board. Ongoing*
January 2017	Smartcare Progress Report	**SP**	The Chair invited the Director of Clinical Strategy to consider how the Board could have sight of the operation of TrakCare. *Ongoing.*

FUTURE TARGETS

December 2016	September 2016 Minute 293/16 Staff Survey Action Plans - Update	**DS**	The Chair invited the Director of Human Resources and Organisational Development to provide a further update in December 2016. *Ongoing.*

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
November 2016	October 2016 Minute 323/16 Summary of the meeting of the Quality and Performance Committee held on 26 October 29016	**DL**	The Chair invited the Board to consider whether verbal reports from the Finance Committee and Quality and Performance Committee which met two days before the Board meeting, provided sufficient assurance. The Chairs of the respective Committees were content to provide verbal reports but there were concerns that a written report should be provided. This was an area which would be considered further. *The Chair said that this was an issue larger than verbal or written reports. It was a timing issue between meetings of the Committees and the Board so that a full assurance report could be provided. On this basis the Board meeting schedule is to be re-arranged to allow a greater timeframe between Board Committee meetings and the Board to also give Executives an opportunity to follow up matters arising from the Committee meetings. Completed*

November 2016	October 2016 Minute 324/16 Minutes of the meeting of the Workforce Committee held on 14 October 2016	**DS**	The Committee agreed that the Workforce Strategy will be presented to the Board in November 2016. This item appeared later in the agenda. Completed.
November 2016	October 2016 Minute 326/16 Board Committee Structure	**MW**	The Chief Executive said that the Terms of Reference of the Finance Committee need to be amended by the addition of point 11 regarding the approval of business cases above £500k. *This has been included in the Committee's Terms of Reference. Completed.* The Board considered the Non-Executive Director linkages between Finance, Quality and Performance and Audit and Assurance Committees in terms of clarity of purpose for the meetings. It was suggested that the Committee Chairs should meet regularly and Ms Barber undertook to provide a process for providing clarity. *The Chair said that the first meeting of the Non-Executive Directors will take place after the Board meeting. Completed.* The Chair invited members to provide any textual amendments to the Terms of Reference to the Trust Secretary. *No amendments were made. Completed.*
November 2016	October 2016 Minute 333/16 Preparations for Winter 2016/17	**EG**	The plan will be presented to the Quality and Performance Committee and the Board in November 2016. *This item appears later in the Agenda. Completed.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2017

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Since my last report in November much has happened in the Trust. Not unexpectedly, it has been a very challenging time operationally due to the seasonal pressures that have affected the NHS across England but we have also been impacted by the operational issues arising from the go-live of TrakCare, our new electronic patient information system.

1.2 Whilst it has undoubtedly been a very challenging Winter, and continues to be so, there are signs that the Trust has coped better this year than in previous Winters. Unlike the prior two years, the Trust has not had to instigate its internal major incident plan as a response to pressures and again, positively, we have experienced only one breach of the 12 hour trolley wait standard compared to 4 last year. The decision to "swing" two surgical wards to medicine for the crucial first few weeks of January helped considerably with managing urgent care. Regrettably, this has resulted in a reduction in the number of planned surgical operations in late December and January but in contrast to previous approaches, patients were not booked and subsequently cancelled at very short notice. This approach, subsequent to our decision, became a nationally mandated approach for all Trusts not achieving in excess of 80% against the 4 hour A & E waiting time standard. A debrief on the effectiveness of our Winter plans and the lessons learnt for the future will be undertaken by the A & E Delivery Board.

1.3 Despite extensive planning in preparation for implementation of our new health record system, the operational impacts of TrakCare have been considerable. The current focus is on how we address the issues that remain and I am grateful to Nicola Turner, one of our very experienced senior operational managers, for agreeing to accept a secondment into the full time role of TrakCare Operational Lead, to bring much needed capacity and focus to resolve the outstanding issues.

1.4 Alongside these significant challenges, staff have been preparing for the CQC inspection which took place between the 24th and 27th January 2017. I am very proud of how staff have responded to the rally cry to show the CQC the very best of what we do, whilst being open and honest about the challenges that we still face. High level verbal feedback from the Lead Inspectors is expected on the afternoon of the 27th January but it will be approximately 8 weeks before the Trust receives the draft report, and publication of the final report and rating is not expected until late May or early June 2017.

2. Our System

2.1 Partners have continued to work together on the Gloucestershire STP - *One Gloucestershire – Transforming Care, Transforming Communities* with the focus now moving to implementation and delivery. A key component of the plan is how we deliver urgent and emergency care in the future, through a model much less reliant on acute and hospital based care.

2.2 The vision and emerging models of care for the future have been presented to a number of forums as part of the pre-consultation engagement work and this included a presentation to a meeting of our own Governors, the Health and Care Overview and Scrutiny Committee (HCOSC) and a number of other community groups.

2.3 These proposals have been positively received and endorsed by the HCOSC as reflecting the right "direction of travel". Not surprisingly, stakeholders are most interested in what this means for their local area and each of our hospitals. This detail is still the subject of significant work but in February 2017 our Clinical Senate (group where senior clinicians from all disciplines across the Trust, come together to plan) will be finalising their work to identify a number of possible options for the configuration of our services in the future, which in turn will be developed and a business case, setting out the options, put before the Board and Council of Governors in April or early May 2017.

2.4 Key messages from the Trust remain as previously expressed and include a commitment to deliver services from both of our acute hospital sites; a recognition that the growing demands on acute health services mean that our specialist services will be reserved for those that cannot be cared for at home or in the community – this requires the services around us to adapt and develop, most notably in primary and community care. Equally important, if Gloucestershire people are to access care delivering outcomes comparable to the best in the country, then we will need to bring some of our services together into centres of excellence where we can concentrate often scare expertise; without such an approach, patients run the risk of being required to travel further afield for their care.

2.5 The current engagement phase is ongoing, with the intention to commence public consultation in June 2017, if any of the options under consideration trigger this requirement.

3. Our Trust

3.1 The past month has seen the continuation of a very significant focus on developing the Trust's financial recovery plan and importantly moving from identification of savings opportunities to developing and implementing plans. The support from KPMG has reduced and is tapering away as we develop our own in house expertise and Programme Management Office (PMO). An important aspect of our approach to financial recovery is ensuing that any impact on the quality of our services is robustly scoped and understood; the means by which we do this is through a Quality Impact Assessment (QIA) for every proposal, which is reviewed and "signed off" by the Chief Nurse and Medical Director.

3.2 A crucial component of finalising the Financial Recovery Plan for 2017/18 is agreeing the contractual agreements with our main commissioners Gloucestershire CCG and NHS England so we are clear on our expected income for the year ahead. Both of these contracts were agreed in December 2016, in line with national requirements, and as such this clarity regarding income comes some 3-4 months ahead of the timeline achieved in previous years which is very helpful. Huge credit is due to the senior finance team in the Trust who worked tirelessly to achieve this challenging timeline.

3.3 Whilst work is on-going to finalise the plan for 2017/18, the current position is a forecast deficit of £14.6m for the year ahead. There are risks inherent within this plan, not least the scale of cost improvements we need to deliver; this figure also assumes that loan interest rates do not change materially.

3.4 At month 9 this year, the Trust remains on track to deliver this year's revised control total of £18m deficit however the most challenging period of this year's recovery plan is Quarter 4 and operational challenges this month are expected to impact on delivery; offsets to this impact are being pursued.

3.5 I previously updated the Board on the Trust's bid for £69m of STP capital, to support the development of our estate and in so doing, enable the transformation of services as described in our STP. I am very pleased to advise that we have progressed another step and are now one of just three schemes being put forward from NHS England South to the national team. We hope to hear more by the end of February.

3.6 The Trust continues to experience significant challenges in meeting national waiting standards and in Q3 failed to achieve any of the national access standards. Positively, progress continues to be made towards recovery of the cancer standards with achievement of the 2 week wait standard in the month of December, the first time in a year and we remain on track to achieve the 62 day cancer standard in March 2017.

3.7 Of particular concern, however, is the declining performance in respect of Referral To Treatment Times (RTT) and the Trust is currently seeking to source support from the national Intensive Support Team (IST) or similar to support development of a robust recovery plan.

3.8 Away from operational matters, work has continued with our Governors to review the way in which we work together including their role on Board Committees and work to establish two new engagement groups to enable them to become more involved in the issues affecting the Trust and specifically the quality and strategy agendas.

3.9 Finally, we are in the final stages of the independent Financial Governance Review. The final report is expected before the end of February and the current timeline is aiming to achieve publication in early to mid-March. This timeline is, however, subject to all necessary steps being concluded in the timeframes set out.

Deborah Lee
Chief Executive Officer

January 2016

PUBLIC BOARD MEETING – JANUARY 2017

Lecture Hall, Sandford Education Centre, Cheltenham

Report Title
Performance Management Framework
Sponsor and Author(s)
Natasha Swinscoe, Chief Operating Officer

Audience(s)									
Board members	✓	Regulators	✓	Governors	✓	Staff	✓	Public	✓

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance up until the end of December 2016 for the financial year 2016/17.

Key issues to note

- There are a number of areas where data quality is of concern as a result of impacts from TrakCare migration; consequently there are a number of indicators in the report where performance for December is not reported. Oversight and resolution of this reporting issue is sitting with the SmartCare Programme Board. NHSI and commissioners are aware of the position and receiving regular updates. Operational oversight of patients however, is not a risk with key operational reports such as Patient targeted Lists (PTLs) still being available.
- Performance against a number of measures of quality and notably waiting times continues to be very concerning. Unsurprisingly, this is giving the regulator considerable cause for concern.
- This month the Trust has not met any of the four national waiting trajectories for A&E 4 hour wait, 62 day cancer standard, 18 week referral to treatment (RTT) standard or 6 week diagnostic wait.
- Clinical oversight of patients awaiting care has been strengthened to ensure that no patients comes to harm due to delays in their treatment.
- A&E performance has been of particular concern and prompted a review of current actions and recovery plans. This has resulted in the development of a 16 point rapid recovery plan and very recent signs are that this is beginning to impact with the Trust returning to achieving the trajectory in the last week. The Trust has also welcomed the offer of support from the national Emergency Care Intensive Support Team with a focus on support to the Emergency Department and acute care areas.
- The Trust is expected to return to achieving both the 2 week wait for cancer referrals and the 62 day cancer standard this quarter.
- In respect of RTT, concerns regarding data quality, following the migration to TrakCare, has resulted in a decision to cease RTT reporting until the quality of data can be assured. Work to resolve this issue is underway.
- Developing speciality level RTT recovery plans is now underway, though additional support is likely to be required to support speciality managers to complete this work. The focus of this approach is to build plans for sustained delivery of standards and as such a significant piece of work is required to undertake demand and capacity assessments at specialty level.

Conclusions

Performance against the national standards is unacceptably poor and significant focus continues in order to improve this position. Clinical oversight of patients awaiting care has been strengthened to ensure that no patients come to harm due to delays in their treatment.

Implications and Future Action Required

Delivery of agreed action plans is critical to restore performance back to the minimum expected standards and the Chief Operating Officer is leading the work to address this and notably to ensure performance is addressed sustainably.

Recommendations

The Trust Board is requested to receive the Integrated Performance Framework Report as assurance that the executive team and Divisions and appropriately focussed on improving current poor levels of performance.

Impact Upon Strategic Objectives

Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients

Impact Upon Corporate Risks

Delivery of the 18 week referral to treatment target is an issue with Divisions reporting challenges to meet the March RTT trajectory. This also affects the cancer performance and is the subject of another paper to the Q&P committee in January 2017.

Regulatory and/or Legal Implications

The Trust remains under regulatory intervention for the A&E 4-hour standard.

Equality & Patient Impact

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Trust Leadership Team	Other (specify)

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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ASSESSMENT AGAINST THE NHS IMPROVEMENT RISK ASSESSMENT FRAMEWORK

	Target	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	NHSI Weighting
18 WEEKS																						
Incomplete pathways - % waited under 18 weeks	92%	92.2%	92.0%	92.3%	92.1%	92.3%	92.1%	92.2%	92.0%	92.0%	90.7%	*	92.1%	92.0%	92.0%	90.9%	90.9%	90.2%	89.9%	87.0%	*	1.0
ED																						
% patients spending 4 hours or less in ED	95%	93.3%	94.3%	89.5%	82.7%	93.4%	89.7%	85.6%	78.5%	86.7%	88.5%	82.3%	85.4%	87.4%	87.1%	86.3%	90.9%	88.9%	86.38%	86.62%	73.86%	1.0
CANCER																						
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %	85%	88.1%	86.1%	78.4%	77.1%	73.9%	75.6%	79.5%	76.7%	79.0%	76.9%	71.6%	78.2%	77.4%	81.2%	73.6%	79.0%	76.8%	72.9%	72.9%	74.4%	1.0
Max wait 62 days from national screening programme to 1st treatment %	90%	91.4%	97.1%	92.4%	91.3%	97.3%	94.0%	95.6%	94.9%	90.6%	96.0%	92.0%	91.7%	84.6%	95.0%	100%	89.9%	100%	86%	97.0%	100%	
Max wait 31 days decision to treat to subsequent treatment : surgery %	94%	99.0%	100%	100%	98.8%	100%	100%	99.5%	99.5%	99.1%	100.0%	90.3%	98.1%	100%	100%	98.1%	100%	100%	100%	89.4%	80.6%	1.0
Max wait 31 days decision to treat to subsequent treatment : drugs %	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %	94%	100%	98.6%	99.8%	100%	100%	100%	100%	100%	100%	98%	98.4%	100%	100%	100%	100%	100%	98.3%	100%	100%	91.4%	
Max wait 31 days decision to treat to treatment %	96%	99.6%	99.8%	99.5%	100%	99.5%	99.7%	100%	99.8%	99.1%	99.2%	95.2%	98.6%	99.6%	99.0%	99.2%	99.7%	98.8%	98.8%	93.8%	94.8%	1.0
Max 2 week wait for patients urgently referred by GP %	93%	90.5%	94.1%	94.3%	93.0%	91.5%	90.3%	92.4%	88.7%	84.9%	88.2%	91.7%	77.7%	86.5%	90.3%	89.9%	86.2%	88.6%	89.0%	93.5%	92.5%	1.0
Max 2 week wait for patients referred with non cancer breast symptoms %	93%	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%	93.4%	95.3%	93.1%	93.7%	92.0%	94.6%	94.3%	90.5%	91.2%	93.4%	96.4%	95.7%	92.5%	88.3%	
INFECTION CONTROL																						
Number of Clostridium Difficile (C-Diff) infections - post 48 hours	37/yr	9	6	8	13	8	10	10	13	10	10	7	5	3	2	5	1	4	1	4	2	

In month position, therefore figure not validated

* Due to the implementation of a new EPR system we are currently unable to report on this data

PERFORMANCE MONITORING AGAINST THE SUSTAINABILITY AND TRANSFORMATION PLAN

2016/17

		Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
ED																	
% patients spending 4 hours or less in ED	Trajectory	80.00%	85.00%	85.00%	83.50%	87.00%	87.00%	91.90%	88.50%	89.10%	91.20%	85.70%	88.70%	85.10%	80.10%	89.60%	85.19%
	Actual	85.38%	87.41%	87.06%	86.90%	86.00%	90.66%	88.94%	88.48%	86.04%	86.62%	73.86%	82.30%				
% patients spending 4 hours or less in ED (incl. Primary Care ED cases)	Trajectory	80.00%	85.00%	85.00%	83.50%	87.00%	87.00%	91.90%	88.50%	89.10%	91.20%	85.70%	88.70%	85.10%	80.10%	89.60%	85.19%
	Actual	85.70%	87.73%	87.36%	86.96%	86.34%	90.85%	89.28%	88.78%	86.38%	87.07%	74.57%	82.81%				
18 WEEKS																	
Incomplete pathways - % waited under 18 weeks	Trajectory	92.02%	92.00%	92.01%		92.04%	92.04%	92.00%		92.00%	92.04%	92.01%		92.00%	92.00%	92.00%	
	Actual	92.10%	92.01%	92.00%	92.04%	90.90%	90.90%	90.20%	90.60%	89.90%	86.96%	*	*				
DIAGNOSTICS																	
15 key Diagnostic tests : % waiting over 6 weeks at month end	Trajectory	2.71%	2.16%	1.46%		0.99%	0.99%	0.99%		0.99%	0.94%	0.99%		0.98%	0.99%	0.99%	
	Actual	5.06%	1.34%	1.40%	1.40%	0.49%	0.49%	1.40%	1.14%	1.85%	0.90%	*	*				
CANCER																	
Cancer: Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) % *RAG rated against the STP Trajectory*	Trajectory	77.17%	80.37%	82.64%		82.91%	93.70%	85.31%		85.03%	85.19%	85.03%		85.00%	85.07%	85.62%	
	Actual	78.2%	77.4%	81.1%	79.0%	73.1%	79.0%	76.8%	76.9%	72.9%	79.2%	74.4%	76.1%				
Cancer: Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) % *RAG rated against the internal recovery trajectory*	Trajectory					78.26%	73.46%	80.92%		72.21%	74.77%	76.77%		84.98%	85.30%	85.76%	
	Actual	78.2%	77.4%	81.1%	79.0%	73.1%	79.0%	76.8%	71.3%	72.9%	79.2%	74.4%	76.1%				

In month position, therefore figure not validated.

* Due to the implementation of a new EPR system we are currently unable to report on this data

TRUST PERFORMANCE & EXCEPTIONS (as at end December 2016)

SAFETY

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	Q4	2016/17 Q1	Q2	Q3	Oct	Nov	Dec	FORECAST Jan	Feb	Mar	Apr	May	Jun	FoT	Standard	Target Set By	How often	Data Month
INFECTION																				
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		10	13	10	10	7	1	4	2	4	3	3	TBC	TBC	TBC		37 cases/year	NHSI	M	Dec
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		2	1	1	0	0	0	0	0	0	0	0	TBC	TBC	TBC		0	GCCG	M	Dec
MORTALITY																				
Crude Mortality rates %		1.2%	1.4%	1.2%	1.1%	*	1.1%	1.2%	*	1.2%	1.2%	1.2%	TBC	TBC	TBC		<2%	Trust	M	Nov
Summary Hospital-Level Mortality Indicator		110.7															≤1.1%	Trust	Q	Dec-15
HSMR (Analysis-relative risk-basket HSMR basket of 56-mortality in hospital) (rolling 12 months)		107.5	106.8	108.0	111.8												Confidence interval	Dr Foster	M	Sep
SMR (rolling 12 months)		108.0	110.2	112.3	118.2												Confidence interval	Dr Foster	M	Sep
SAFETY																				
Number of Never Events		1	0	0	1	1	1	0	0	0	0	0	TBC	TBC	TBC		0	GCCG	M	Dec
% women seen by midwife by 12 weeks		90.0%	89.6%	87.2%	92.3%	*	91.6%	90.6%	*	90.0%	90.0%	90.0%	TBC	TBC	TBC		>90%	GCCG	M	Nov
CQUINS																				
Acute Kidney Infection (AKI)		29%	50%	42%	60%	64%	47%	77%	69%	55.0%	55.0%	55.0%	TBC	TBC	TBC		>90% by Q4	National	M	Dec
Sepsis Screening 2a		96%	92%	96%	97%	arrears	98%	arrears	arrears	90%	90%	90%	TBC	TBC	TBC		>90% of eligibles	National	M	Oct
Sepsis Antibiotic Administration 2b		43%	49%	55%	45%	arrears	arrears	arrears	arrears	90%	90%	90%	TBC	TBC	TBC		>90% of eligibles	National	M	Sep
Dementia - Seek/Assess		88.8%	86.3%	88.1%	88.3%	*	88.6%	90.4%	*	90%	90%	90%	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
Dementia - Investigate		100%	100%	100%	100%	*	100%	100%	*	100%	100%	100%	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
Dementia - Refer		100%	100%	100%	100%	*	100%	100%	*	100%	100%	100%	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
ED																				
% patients triaged in ED in 15 minutes		57.9%	53.7%	75.3%	78.6%	*	77.7%	79.8%	*								≥ 99%	Trust	M	Nov
% patients assessed by doctor in ED in 60 minutes		44.7%	43.3%	47.1%	46.0%	*	46.8%	49.1%	*								≥ 90%	Trust	M	Nov

* Due to the implementation of a new EPR system we are currently unable to report on this data

In month position, therefore figure not validated.

TRUST PERFORMANCE & EXCEPTIONS (as at end December 2016)

RESPONSIVE

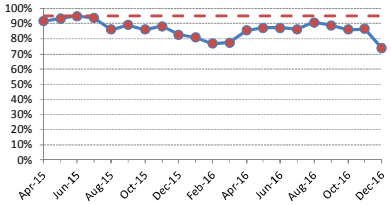
MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	Q4	2016/17 Q1	Q2	Q3	Oct	Nov	Dec	FORECAST Jan	Feb	Mar	Apr	May	Jun	FoT	Standard	Target Set By	How often	Data Month
ED																				
% patients spending 4 hours or less in ED		85.6%	78.5%	86.9%	88.5%	82.3%	86.0%	86.6%	73.9%	85.1%	80.1%	89.6%	TBC	TBC	TBC		≥ 95%	NHSI	M	Dec
Number of ambulance handovers delayed over 30 minutes		241	428	517	541	*	186	99	*	100	100	90	TBC	TBC	TBC		< previous year	GCCG	M	Nov
Number of ambulance handovers delayed over 60 minutes		28	33	3 **	1	*	1	0	*	11	11	9	TBC	TBC	TBC		< previous year	GCCG	M	Nov
18 WEEKS																				
Incomplete pathways - % waited under 18 weeks		92.2%	92.0%	92.0%	90.7%	*	89.9%	87.0%	*	92.0%	92.0%	92.0%	TBC	TBC	TBC		≥ 92%	NHSI	M	Nov
15 key Diagnostic tests : % waiting over 6 weeks at month end		1.5%	4.0%	2.6%	0.8%	*	1.82%	0.90%	*	1.0%	1.0%	1.0%	TBC	TBC	TBC		<1% waiting at month end	GCCG	M	Nov
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates		142	225	441	405	*	350	375	*	100	100	100	TBC	TBC	TBC		< 1% waiting at month end	GCCG	M	Nov
CANCER																				
Max 2 week wait for patients urgently referred by GP %		92.4%	88.7%	84.9%	88.2%	91.7%	89.0%	93.5%	92.5%	92.0%	92.0%	92.0%	TBC	TBC	TBC		≥ 93%	NHSI	M	Nov
Max 2 week wait for patients referred with non cancer breast symptoms %		93.4%	95.3%	93.1%	93.7%	92.0%	95.7%	92.5%	88.3%	94.0%	94.0%	94.0%	TBC	TBC	TBC		≥ 93%	NHSI	M	Nov
Max wait 31 days decision to treat to treatment %		100%	99.8%	99.1%	99.2%	95.2%	96.7%	93.8%	94.8%	100%	100%	100%	TBC	TBC	TBC		≥ 96%	NHSI	M	Nov
Max wait 31 days decision to treat to subsequent treatment : surgery %		99.5%	99.5%	99.4%	99.4%	90.3%	100.0%	89.4%	80.6%	100%	100%	100%	TBC	TBC	TBC		≥ 94%	NHSI	M	Nov
Max wait 31 days decision to treat to subsequent treatment : drugs %		100%	100%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	100%	TBC	TBC	TBC		≥ 98%	NHSI	M	Nov
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %		100%	100%	100%	99.5%	98.4%	100.0%	100.0%	91.4%	100%	100%	100%	TBC	TBC	TBC		≥ 94%	NHSI	M	Nov
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		79.5%	76.7%	79.0%	76.9%	76.1%	72.9%	79.2%	74.4%	85.0%	85.0%	85.0%	TBC	TBC	TBC		≥ 85%	NHSI	M	Nov
Max wait 62 days from national screening programme to 1st treatment %		95.6%	94.9%	90.6%	96.0%	92.0%	85.7%	97.0%	100%	92.0%	92.0%	92.0%	TBC	TBC	TBC		≥ 90%	NHSI	M	Nov
Max wait 62 days from consultant upgrade to 1st treatment %		100%	100%	100%	71.4%	50.0%	50.0%	-	-	100%	100%	100%	TBC	TBC	TBC		≥ 90%	NHSI	M	Nov

* Due to the implementation of a new EPR system we are currently unable to report on this data

In month position, therefore figure not validated.

RESPONSIVE

MEASURE	QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
% patients spending 4 hours or less in ED Standard is ≥95%							Chief Operating Officer

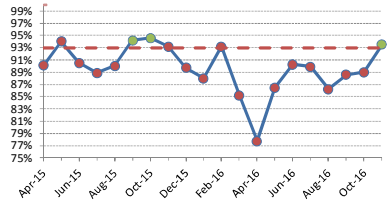


Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Pathway Report. Recovery plan in place to improve performance in line with the agreed trajectory.

Max 2 week wait for patients urgently referred by GP
Standard is ≥93%

Chief Operating Officer



Commentary on what is driving the performance & what actions are being taken

November's final uploaded position was 93.5%. There are no breaches due to capacity – all breaches are patient initiated (patient choice, patient unavailable or DNA).

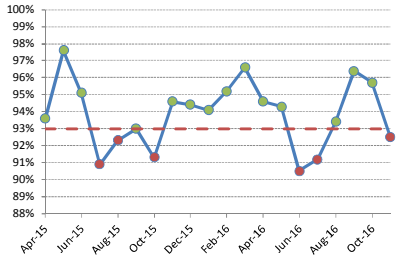
December 2016's performance has improved slightly from the PMF reported position of 92.5% to 92.6% following validation which is still ongoing. The under-performance against this standard and the trajectory of 93% is primarily due to Trakcare operational issues following implementation on the 3rd December 2016, which led to 28 of the 114 breaches being due to capacity issues. The operational issues have been addressed during January and all patients are being offered an appointment within 2 weeks and delivery of the standard is expected to be met from February 2017. The remaining breaches were patient initiated (patient choice, patient unavailable or DNA).

The Trust has developed an action plan and a trajectory to recover the 2WW performance by 31st October 2016, which has been shared with Gloucestershire CCG, NHS England and NHS Improvement and it has been approved. Delivery of the 2WW slipped by a month due to urology capacity and was met in November 2016 and has slipped again due Trakcare operation issues. All Trakcare operational issues are being addressed.

	September 16			Q2 16/17	October 16			November 16			December 16			Q3 to date	Average treatments / month (rolling 12 months)
Target	Latest Position	Breaches	Treatments		Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments		
93%	88.6%	192	1680	88.6%	89.0%	188	1711	93.5%	119	1835	92.6%	114	1531	91.7%	1676
Brain / CNS	73.1%	7	26	73.1%	95.8%	1	24	90.0%	3	30	95.8%	1	24	93.6%	23
Breast	97.4%	6	232	97.4%	96.7%	8	245	96.7%	8	246	92.7%	19	259	95.3%	260
Gynaecological	96.2%	4	106	96.2%	98.4%	2	122	97.5%	4	159	100.0%	0	95	98.4%	118
Haematological*	90.9%	1	11	90.9%	75.0%	4	16	100.0%	0	16	100.0%	0	16	91.7%	11
Head & Neck	94.9%	10	195	94.9%	90.9%	16	175	94.7%	10	188	95.2%	8	168	93.6%	171
Lower GI	92.1%	26	331	92.1%	93.1%	22	317	96.5%	11	315	94.8%	14	267	94.8%	322
Lung	95.6%	2	45	95.6%	100.0%	0	34	98.0%	1	51	95.8%	2	48	97.7%	47
Skin	93.9%	22	363	93.9%	90.1%	31	313	93.9%	24	391	96.3%	9	246	93.3%	319
Testicular	77.3%	5	22	77.3%	66.7%	7	21	88.2%	2	17	92.3%	1	13	80.4%	18
Upper GI	87.7%	20	163	87.7%	81.3%	39	209	86.2%	30	218	84.8%	32	211	84.2%	188
Urological	51.1%	89	182	51.1%	74.7%	57	225	87.2%	26	203	84.8%	28	184	81.9%	200

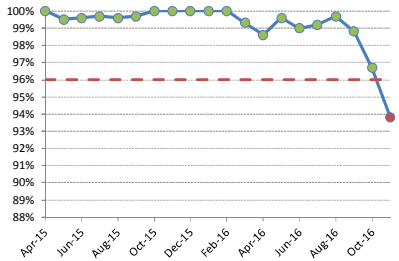
* Excludes acute leukaemia

RESPONSIVE

MEASURE		QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
Max 2 week wait for patients referred with non cancer breast symptoms Standard is ≥93%		●	●	●		●	●	Chief Operating Officer

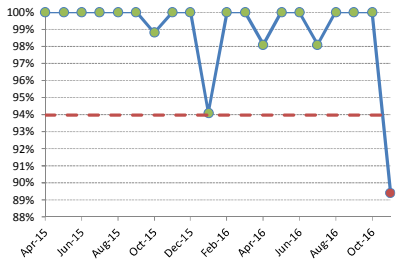
Commentary on what is driving the performance & what actions are being taken

November's final position was 92.5% against a target of 93%. There were 14 breaches, all due to patient choice.

Max 31 days decision to treat to treatment Standard is ≥96%		●	●	●		●	●	Chief Operating Officer

Commentary on what is driving the performance & what actions are being taken

There were 22 breaches in November, giving a performance of 93.8% (against a target of 96%). 19 of these breaches were due to elective capacity, mainly in urology. There were 11 breaches in December, giving a performance of 95%. 7 of these breaches were due to elective capacity, 2 of the others were due to patient choice and patient fitness. The remaining 2, the reason is unknown until the information is complete.

Max wait 31 days decision to treat to subsequent treatment : surgery % Standard is ≥94%		●	●	●		●	●	Chief Operating Officer

Commentary on what is driving the performance & what actions are being taken

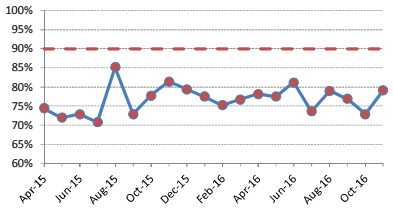
The performance for November was 89.4% and for December was 80.6% against a target of 94%, however it is not possible to find more detail without access to Infoflex.

RESPONSIVE

MEASURE	QUARTERLY PROGRESS						OWNER
	Q4	Q1	Q2	Q3	NOW	FOT	
							Chief Operating Officer

Max wait 62 days from national screening programme to 1st treatment

Standard is ≥90%



Commentary on what is driving the performance & what actions are being taken

November's final uploaded position was 79.2% against a projected 74.8%; with 5 fewer breaches and 25 more treatments than projected.

December's current partially validated postion is 73.6%, which shows a slight deterioration of the PMF reported position of 74.4%, which is a fully unvalidated postion. Current data shows that the Trust had 34 fewer treatments and 4 fewer breaches than projected in December (121 treatments and 32 breaches).

The Trust has developed an action plan and a trajectory to recover the 62 day performance by 31st January 2017, which has been shared with Gloucestershire CCG, NHS England and NHS Improvement and it has been approved. 62-day performance has been on trajectory but there is a high risk that the trajectory of delivery of the standard in Janaury 2017 will not be met due to slippage in the urology recovery plan and Trakcare operational issues. The cancer recovery plan is being updated to reflect this. All Trakcare operational issues are being addressed.

	42614			Q2 16/17	October 16			November 16			December 16			Q3 to date	Average treatments / month
Target	Latest Position	Breaches	Treatments		Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments		
85%	77.3%	37.0	163.0	77.3%	72.9%	39.5	146.0	80.2%	35.0	176.5	73.5%	31.0	117.0	76.0%	152
Breast	91.7%	2.0	24.0	91.7%	100.0%	0.0	17.0	100.0%	0.0	23.5	94.7%	1.0	19.0	98.3%	24
Gynaecological	80.6%	3.0	15.5	80.6%	66.7%	5.0	15.0	87.5%	1.0	8.0	66.7%	4.0	12.0	71.4%	11
Haematological*	59.1%	4.5	11.0	59.1%	50.0%	4.0	8.0	42.9%	8.0	14.0	100.0%	0.0	7.0	58.6%	8
Head & Neck	85.7%	0.5	3.5	85.7%	58.3%	2.5	6.0	88.9%	1.0	9.0	66.7%	1.0	3.0	75.0%	7
Lower GI	68.4%	6.0	19.0	68.4%	90.3%	1.5	15.5	89.4%	2.5	23.5	76.2%	5.0	21.0	85.0%	16
Lung	84.0%	2.0	12.5	84.0%	69.4%	5.5	18.0	84.8%	2.5	16.5	88.5%	1.5	13.0	80.0%	12
Other	66.7%	1.0	3.0	66.7%	100.0%	0.0	2.0	25.0%	1.5	2.0	0.0	1.0	1.0	50.0%	2
Sarcomas									0.0	0.0		0.0	0.0		1
Skin	95.8%	1.5	35.5	95.8%	100.0%	0.0	22.0	100.0%	0.0	31.0	100.0%	0.0	12.0	100.0%	31
Upper GI	95.5%	0.5	11.0	95.5%	89.5%	1.0	9.5	100.0%	0.0	13.0	70.8%	3.5	12.0	87.0%	12
Urological	42.9%	16.0	28.0	42.9%	39.4%	20.0	33.0	47.9%	18.5	35.5	17.6%	14.0	17.0	38.6%	28

* Excludes acute leukaemia

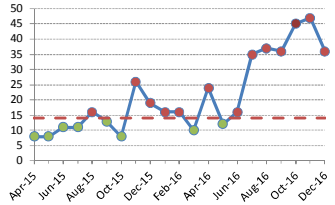
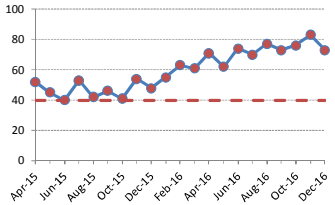
EFFECTIVE

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	Oct	Nov	Dec	FORECAST Jan	Feb	Mar	Apr	May	Jun	FoT	Standard	Target Set By	How often	Data Month
CLINICAL OPERATION																				
% stroke patients spending 90% of time on stroke ward		91.4%	86.0%	85.1%	81.0%	arrears	88.8%	*	arrears	82.0%	82.0%	82.0%	TBC	TBC	TBC		> 80%	GCCG	M	Oct
% of eligible patients with VTE risk assessment		94.2%	93.7%	93.6%	93.7%	*	93.1%	92.2%	*	93.0%	93.0%	93.0%	TBC	TBC	TBC		> 95%	GCCG	M	Nov
Emergency re-admissions within 30 days - following an elective or emergency spell		6.1%	6.4%	6.7%	6.5%	arrears	6.4%	*	arrears	6.4%	6.4%	6.4%	TBC	TBC	TBC		Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%	Trust	M	Oct
Number of Breaches of Mixed sex accommodation		17	30	19	9	5	0	5	0	10	0	0	TBC	TBC	TBC		0	GCCG	M	Dec
Number of delayed discharges at month end (DTOCs)		19	10	16	36	36	45	47	36	16	16	16	TBC	TBC	TBC		<14	Trust	M	Dec
No. of medically fit patients - over/day		48	60	69	73	73	76	83	73	40	40	40	TBC	TBC	TBC		≤ 40	Trust	M	Dec
Bed days occupied by medically fit patients		1,457	1,791	2,086	2,252	2,376	2,355	2,502	2,271	1,450	1,450	1,450	TBC	TBC	TBC		None	Trust	M	Dec
Patient Discharge Summaries sent to GP within 24 hours		88.6%	85.6%	85.7%	88.3%	arrears	88.9%	86.6%	arrears	88.5%	88.5%	88.5%	TBC	TBC	TBC		≥85%	GCCG	M	Nov
BUSINESS OPERATION																				
Elective Patients cancelled on day of surgery for a non medical reason		1.3%	2.0%	1.6%	1.6%	*	1.3%	1.1%	*								≤ 0.8%	Trust	M	Nov
Patients cancelled and not rebooked in 28 days		15	27	35	10	*	3	0	*								0	GCCG	M	Nov
GP referrals year to date - within 2.5% of previous year		2.9%	3.7%	7.9%	5.1%	*	4.4%	3.8%	*								range +2.5% to -2.5%	Trust	M	Nov
Elective spells year to date - within 2.5% of plan		5.0%	7.3%	4.9%	1.6%	*	16.1%	-2.7%	*	1.0%	1.0%	1.0%	TBC	TBC	TBC		range ≥-1% to plan	Trust	M	Nov
Emergency Spells year to date - within 2.5% of plan		6.9%	7.1%	7.7%	3.8%	*	1.7%	9.2%	*	1.0%	1.0%	1.0%	TBC	TBC	TBC		range ≤2.5% over plan	Trust	M	Nov
LOS for general and acute non elective spells		5.7	6.0	5.9	5.8	*	5.9	6.3	*	5.4	5.4	5.4	TBC	TBC	TBC		Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Nov
LOS for general and acute elective IP spells		3.6	3.6	3.3	3.7	*	3.5	3.5	*	3.5	3.6	3.6	TBC	TBC	TBC		≤ 3.4 days	Trust	M	Nov
OP attendance & procedures year to date - within 2.5% of plan		0.6%		0.5%	-1.5%	*	0.4%	2.6%	*	0.2%	0.2%	0.2%	TBC	TBC	TBC		range +2.5% to -2.5%	Trust	M	Nov
Records submitted nationally with valid GP code (%)		100%	99.9%	99.9%	100%	arrears	100%	100%	arrears	100%	100%	100%	TBC	TBC	TBC		≥ 99%	Trust	M	Nov
Records submitted nationally with valid NHS number (%)		99.7%	99.8%	99.8%	99.8%	arrears	99.8%	99.8%	arrears	99.6%	99.6%	99.6%	TBC	TBC	TBC		≥ 99%	Trust	M	Nov

* **Due to the implementation of a new EPR system we are currently unable to report on this data**

In month position, therefore figure not validated.

EFFECTIVE

MEASURE		QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
Number of delayed discharges at month end (DTOCs) Standard is <14								Chief Operating Officer
No. of medically fit patients - over/day Standard is <40								Chief Operating Officer

Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Care Report.

Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Care Report.

The main issue driving the medically fit is access to domicillary care and community hospital beds. Alternative options are being explored and developed as part of the Emergency Care Pathyway Plan. Working with our systems partners.

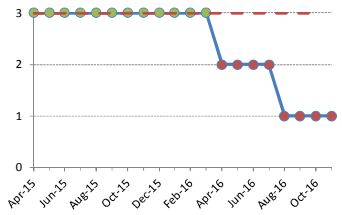
TRUST PERFORMANCE & EXCEPTIONS (as at end December 2016)

WELL LED

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	Q4	2016/17 Q1	Q2	Q3	Oct	Nov	Dec	FORECAST Jan	Feb	Mar	Apr	May	Jun	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																				
NHSI Financial Risk Rating (YTD)		3	3	2	1	arrears	1	1	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Level 3	NHSI	M	Nov
Achieve planned Income & Expenditure position at year end		-£1.6m	-£1.6m	£18.2m	-£23.8	arrears	-£23.9	-£18.7	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Achieved or better at year end	NHSI	M	Nov
Total PayBill Spend (£K)		£78.0m	£78.7m	£82.1m	£83.1m	arrears	£28.0m	£27.90m	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Nov
Total worked WTE		7,098	7,153	7,121	7,299	arrears	7,290	7,226	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Nov
WORKFORCE HEALTH																				
Annual sickness absence rate (%)		3.8%	3.8%	3.8%	3.8%	3.9%	3.9%	3.9%	3.8%	3.8	3.8	3.8	TBC	TBC	TBC		green < 3.6% red >4%	Trust	M	Nov
Turnover rate (FTE)		11.1%	11.7%	11.6%	11.5%	11.5%	12.0%	11.5%	11.6%	11.7	11.7	11.7	TBC	TBC	TBC		7.5-9.5%	Trust	M	Nov
Staff who have annual appraisal (%)		83%	83%	83%	80%	80%	80%	80%	80%	85.0	85.0	85.0	TBC	TBC	TBC		green >89% red < 80%	Trust	M	Dec
Staff having well structured appraisals in last 12 months (staff survey, on a 5 point scale)		38%	38%	3.0	3.0	3.0	3.0	3.0	3.0	3.1	3.1	3.1	TBC	TBC	TBC		> 3.8	Trust	A	Dec
Staff who completed mandatory training (%)		91%	91%	92%	92%	90%	91%	89%	89%	91.0	91.0	91.0	TBC	TBC	TBC		> 90%	Trust	M	Dec
Staff Engagement indicator (measured by the annual staff survey on a 5 point scale)		3.66	3.69	3.71	3.71	3.71	3.71	3.71	3.71	3.8	3.8	3.8	TBC	TBC	TBC		> 3.8	Trust	A	Dec
Improve communication between senior managers & staff (staff survey) (%)		35%	34%	34%	34%	34%	34%	34%	34%	34.0	34.0	34.0	TBC	TBC	TBC		> 38%	Trust	A	Dec

In month position, therefore figure not validated.

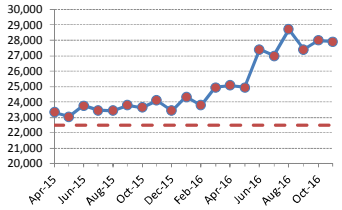
WELL LED

MEASURE		QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
NHSI Financial Risk Rating Standard is Level 3								Director of Finance

Commentary on what is driving the performance & what actions are being taken

Please refer to the Trust Finance report for a full explanation of the drivers of the Trust financial performance.

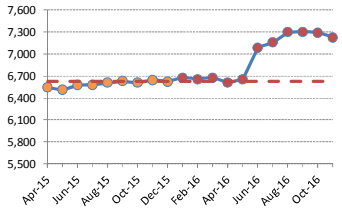
December Finance data not yet available.

Total PayBill spend £M Standard is Target + 0.5%								Director of Finance

Commentary on what is driving the performance & what actions are being taken

The Trust total PayBill for November is £27.9m. This is broadly in line with previous month, but £300k higher than the YTD average.

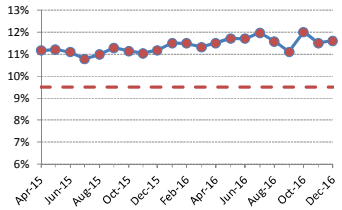
December data not yet available.

Total worked WTE Standard is Target + 0.5%								Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

The Worked WTEs reflects the Trust Total which includes Hosted GP Services and Shared Services. This is consistent with reporting within the NHS Improvement plan and total reported pay bill in table above.

December data not yet available.

Turnover rate (FTE) Standard is Target 7.5% - 9.5%								Director of Human Resources

Commentary on what is driving the performance & what actions are being taken

Turnover continues to run at high levels and a mix of corporate and local solutions (where appropriate) are being applied. Corporate solutions include focus groups for nursing staff led by Leadership and OD to capture experience across the years. Particular focus is also being paid to other areas such as haematology and cardiac physiology.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST QUALITY AND PERFORMANCE COMMITTEE HELD IN THE BOARDROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 23 NOVEMBER 2016 2:23PM

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT	Keith Norton	Non-Executive Director (Chair)
	Peter Lachecki	Chair of the Trust
	Dr Sean Elyan	Medical Director
	Maggie Arnold	Nursing Director
	Eric Gatling	Director of Service Delivery
	Natasha Swinscoe	Interim Chief Operating Officer
	Andrew Seaton	Director of Safety
	Dr Peter Jackson	Governor – Forest of Dean Constituency
	Becky Parish	Gloucestershire Clinical Commissioning Group
IN ATTENDANCE	Martin Wood	Trust Secretary
APOLOGIES	Helen Munro	Non-Executive Director
	Debra Clark	Acting Head of Patient Experience

145/16 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

146/16 MINUTES OF THE QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 26 OCTOBER 2016

RESOLVED: That the minutes of the meeting of the Quality and Performance Committee held on 26 October 2016 were agreed as a correct record and signed by the Chair.

147/16 MATTERS ARISING

074/16 QUALITY RISKS AND PRIORITIES PROGRAMME:

The Committee invited the Director of Safety to present a 6 monthly review in October 2016 to align the priorities in the quality risks programme to Board priorities. The areas for deep dives to be determined at that meeting. *The Director of Safety reported that this will be built in to quality risks which are reported to the Committee. Completed as a Matter Arising.*

114/16 COMPLAINTS AND CONCERNS Q1:

The Senior Patient Experience Manager said that the role of lead

investigator is being advocated; although it is acknowledged that this is a time consuming role the quality outcome is improved. The Chair asked how this will be taken forward and the Director of Clinical Strategy undertook to arrange for this to be considered by the Trust Leadership Team. *The Trust Secretary undertook to pursue this with the Acting Head of Patient Experience. Ongoing.* **MW**

125/16 TERMS OF REFERENCE:

The Nursing Director said that infection control issues should be included in the Committee's work plan. *This will be included in the work plan for 2017. Completed as a Matter Arising.*

148/16 EMERGENCY CARE PROGRAMME FINAL REPORT

(Sue Barnett, Improvement Director, attended the meeting for the presentation of this item).

The Improvement Director presented the report describing the diagnostic of Emergency Care in our Trust, the root causes and underlying corporate issues that may impinge on other areas of the organisation. It described the work done to identify the priorities, the structure devised to bring these to life, progress and achievements to date and matters still to be embedded or addressed. She apologised for the minor grammatical errors in the documentation.

Progress has been made in improving the performance of the A&E standard but with risk most notably in the delays both internal and external which result in high occupancy. The context within which our Trust is now working, the staff changes and increasing financial focus will also require a level of balance to the requirements that the Board will need to have assurance is appropriate. Relative performance and delivery of the trajectory will be a requirement to providing better care and ensuring our Trust is addressing root causes. This will also impact on our Trust's ability to revoke the breach of its license.

The Improvement Director said that our Trust has a level of good quality staff and there is a need to engage them. This has led to improvements in other organisations where she has worked but it does not occur in our Trust. Our Trust has acknowledged that there is an issue with the Utopia Model with its delivery and outcomes not working. This model only operates in approximately 5% of Trusts. Staff need to accept that it is a challenge and not necessarily a fair. The coterminosity of boundaries of our Trust, the County Council and the Clinical Commissioning Group is seen as poor and unhelpful rather than a benefit compared to other areas. There needs to be greater staff engagement and our Trust rarely goes out to see what is happening on the front line. This happens with Clinical Teams but rarely with Operational Teams. With the onset of winter and the other issues facing our Trust, the practices previously seen by the Improvement Director when she arrived are beginning to creep back. Staff are working in silos. Previously there have been too many layers of plans leading to confusion. Our Trust needs to be working in a different way.

During the course of the discussion, the following were the points raised:-

- The Chair of the Trust asked the Improvement Director what she considered would be the best ways to improve performance. In response, she said that real ownership collectively amongst the Executive Team is required to enable our Trust to get through winter and the position with our partners is fragile and needs senior leadership over the whole winter period. The local health system needs to take the opportunity to address the Medically Fit for Discharge list which she described as a wicked issue. The staff recruitment need to be addressed. Our Trust must not lose focus of the Emergency Care Programme whilst addressing the financial pressures.
- The Medical Director said that our Trust should focus on a smaller number of the issues to make progress and should not make improvements in isolation from partner organisations. The message for our Trust is not right in that Emergency Department performance is not just a matter for the Emergency Department but for the whole Trust. Service reconfiguration is pivotal to sustainability during the winter of 2017/18. Our Trust has an opportunity to get through the forthcoming winter if some of the actions fall into place.
- The Director of Service Delivery said that the Improvement Director's challenges particularly to the local health system had been helpful but there is a risk that our Trust will slip back upon her departure. Our Trust is reliant on a small core of people to drive forward improvements. The Improvement Director said that our Trust is showing signs of "green shoots" to improve and sustain performance.
- The Interim Chief Operating Officer sought assurance on the structure to improve performance. In response, the Improvement Director said that the structure exists with the single programme management office approach which needs greater rigour in its operation.

The Chair thanked the Improvement Director for an informative report.

RESOLVED: That the report be noted providing assurance on the diagnostic of Emergency Care in our Trust.

149/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK REPORT

The Director of Service Delivery presented the report providing assurance to the Committee in respect of our Trust's actions to deliver care in line with the mandated national standards. Of the key issues to note were that our Trust continues to fail to meet the national access standards including the A&E 4 hour standard, two cancer standards and the Referral To Treatment (RTT) standard. The Trust has achieved the internal recovery trajectory for Cancer 62 Day GP Referral to Treatment standard. Additional Divisional oversight arrangements are now established to ensure more robust development and delivery plans in the area of six week diagnostics, cancer and RTT standards, under the leadership of the Director of

Service Delivery. Our Trust continues to work closely with its commissioners and NHS Improvement to maintain confidence in our Trust's ability to recover current poor performance. Demand is rising in all key performance areas and this has been escalated to the Clinical Commissioning Group and NHS England to help us manage. The Executive Team and Quality and Performance Chair are currently developing a revised Performance Assurance Report. Performance against the national standards remains unacceptable and as such is a key area of focus for our Trust. However, there is evidence that current oversight arrangements are not sufficiently robust and this has been addressed. Delivery of agreed action plans are critical to return back to the minimum expected standards however, there is evidence that current oversight arrangements are not sufficiently robust to ensure timely delivery and this is being addressed by the Director of Service Delivery.

Referral To Treatment (RTT) performance is just below the standard at 89.9%. The key issue is in Oral Surgery which is now at 75% with approximately 1,000 patients waiting in excess of 18 weeks. This has been logged with NHS England and a Recovery Plan is in place with additional capacity being provided at weekends with the aim to clear the backlog in March 2017. A new Oral Surgeon has been appointed and efforts are in place to create a second Surgeon but this is a national issue. The non-admitted outpatient activity is being increased as there will be a reduction in elective activity during the winter. 108 Audiology assessments are impacting on the 15 diagnostic tests. This has arisen due to a change in leadership and coding issues. The cancer two week wait standard is planned to be achieved in November 2016. There are issues with patient choice and our Trust is offering appointments beyond the two weeks. Currently our Trust offers a choice of location between Cheltenham, Gloucester or Community Hospitals and we have agreed with the Clinical Commissioning Group to reduce the offer of locations to improve performance. The Chair of the Trust suggested that the offer of location within two weeks should be made to provide patient choice. A relatively small number of patients are meeting the maximum two week wait for patients urgently referred by GP. Urology is the area containing the largest number of breaches. The one stop clinics have been well received by patients. With regard to cancer 62 day performance the backlog is being cleared where approximately 50% of the breeches occur in Urology. Clearing the Urology backlog with get performance to where it should be.

During the course of the discussion, the following were the points raised:-

- The Chair of the Trust asked what is being done to improve cancer performance. In response, the Director of Service Delivery said that the Cancer Manager is focusing to resolve basic practical issues. The 104 day long waiters has now reduced to approximately 50 patients from 100. The majority are in Urology and a small number in other specialities. A Clinical Review process is in place.

- The Medical Director referred to the increase in the number of delayed discharges at month end and the number of medically

fit patients over the standard of 40 and sought an explanation for the increase. In response, the Director of Service Delivery said that this is largely due to delays within the Local Authority in gaining packages of care. A new supplier has been appointed with the quality of care improving. There have been staffing issues and increased demand. This has resulted in some patients remaining in hospital for an extra five days.

- The Director of Safety questioned whether the MAD Clinics are delivering quality of care and whether the focus is on achieving targets or actual quality of care. The Director of Service Delivery said in response that the outcome will be presented in Divisional Reports as part of the Quality Impact Assessments. The Medical Director added that the aim is to improve which will in turn improve performance. The Chair suggested that this issue should be considered at the Committee in December 2016, if not possible, in January 2017. **SE (MW to note for Agenda)**
- The Chair asked for the level of assurance to be reported to the Board regarding meeting performance targets. In response, the Director of Service Delivery said that the 18 week standard of 92% will be met in March 2017; the Cancer 62 day target of 85% in January 2017, the Cancer 2 week wait target in December 2016 and the Emergency Department trajectory for the remainder of the year.
- The Clinical Commissioning Group representative referred to patient choice and the availability of clinics from attendance at a patient group early in the week of the meeting. The Medical Director said in response that the views of service users help to get the balance right between availability and time of appointment.

The Chair thanked the Director of Service Delivery for the report.

RESOLVED: That the Integrated Performance Framework Report be noted as a source of assurance that the Executive Team and Divisional Leaders are addressing the performance deficits highlighted in the report.

150/16 EMERGENCY PATHWAY REPORT

(The Chair of the Trust left the meeting meaning that there was no quorum. Given that the remaining items were for discussion and no decision required the meeting continued).

The Director of Service Delivery presented the report providing the Committee with assurance that our Trust continues to address the previously identified concerns relating to delivery of Emergency Care within our Trust. The report provided evidence of progress against key quality, safety and performance indicators, described key risks and provided a progress update against the Emergency Care Programme Board Milestone Plan. The key issues to note that whilst the NHS Improvement Recovery trajectory was met for quarter two, there is a risk for quarter three with the performance in October 2016 below trajectory.

Continued excess demand and high levels of patient delay both impact on the ability to deliver and maintain the Emergency Department performance. However, the number of patients seen, treated and admitted or discharged within 4 hours in October 2016 was higher than in the same period last year, despite total attendances increasing by 5.6%. Recruitment within the Emergency Department continues to be a risk, with significant gaps in Junior and Middle Grade Posts. Alternative solutions are being progressed, including the development of Physician Assistant posts. These are not immediate solutions and agency interims continue to be used to maintain the rota. Good progress is being made across all work streams with the exception of work stream 6 whereby the outcome of discussions with partners to resolve the direction of travel have resulted in a change of scope for the work stream. This has caused significant delays, but a new plan is now being progressed. Impact of high occupancy levels, average length of stay, medically fit for discharge patients and delayed transfers of care continue to be felt. A system-wide *Discharge Summit* (convened by the Trust Chief Executive) was held in October 2016, as a means of bringing partners back together to address this issue collectively. A new nationally endorsed initiative *Red & Green Days* has been launched in period and roll out is now underway. The initiative has been launched on 15 wards across the Trust and train-the-trainer sessions have been held for senior staff. Good progress is being made against the milestones set out in the Emergency Care Programme, with the exception of the issues set out above. Governance arrangements are considered robust and effective and continue to benefit from good engagement. The key risk to performance delivery remains high occupancy and actions to address this remain the key focus of all work streams.

There is increased focus and engagement on external factors affecting discharges ahead of winter, full implementation of red/green days and increasing direct referrals into Ambulatory Emergency Care.

During the course of the discussion, the following were the points raised:-

- The Director of Safety said that our Trust should celebrate the number of patients seen within the time to initial assessment of 15 minutes. In October 2015 the figure was 6,406 and in October 2016 was 9,089. This was despite an increase in attendances.
- The CCG representative commented on the big increase in the response rate for the Friends and Family Test following the introduction of new digital methodology being launched in July 2016 negating the need for Emergency Department staff to hand patients a card to complete on discharge.
- The Chair asked where the work undertaken by the GP in the Emergency Department was recorded. In response, the Director of Service Delivery said that it is included within the "majors" figures. It is provided by Primary Care and it is too early to gauge its effectiveness. The position will be reviewed in conjunction with the Clinical Commissioning Group. The Interim Chief Operating Officer asked how the impact of the GP was assessed in terms of quality, quantity and embedding

into the systems. In response, the Director of Service Delivery said that a member of Trust staff has undertaken work looking at the broader system benefits.

- The Chair asked for the extent of the introduction of Red and Green Days. The Director of Service Delivery said in response that approximately 66% of wards are covered by the scheme and full coverage is anticipated in December 2016. Its introduction is to be tested in December 2016 to assess its operation. The test will also focus on Red Days where there are external delays.
- The Chair asked for information on the outlook for recruiting staff. In response, the Director of Service Delivery said that the position is likely to deteriorate further before it improves. Two locum Doctors have been appointed to substantive posts and there is funding for 20 Emergency Department Doctors. There are issues with middle grade and Junior Doctors and agency staff are being used to fill the gaps. Creative ways are being considered to improve the position where at weekends a Trauma and Orthopaedic Consultant works in lieu of an Emergency Department Doctor. There are now ten Emergency Nurse Practitioner vacancies with approximately six staff starting in the next few weeks. Three staff have left within the past week citing winter pressures as a reason for leaving. It will not be possible to replace those staff before Christmas. A Medical Doctor is working every shift which can only be sustained in the short term.

The Chair thanked the Director of Service Delivery for the report.

RESOLVED: That the report be noted as a source of assurance that good progress continues to be made in the Emergency Care Programme and that all major risks to meeting the Performance Recovery trajectory are being actively managed.

151/16 PREPARATIONS FOR WINTER 2016/17

(Dr Elyan left the meeting)

The Director of Service Delivery presented the report providing the details of how our Trust is preparing for winter 2016/17. This updated the Committee following the report on the actions presented in October 2016 that are being taken to ensure that services will be safe and operationally resilient to the anticipated pressures placed on health services during the winter period. He apologised for the late submission on the paper which was due to meetings with external partners.

Bed capacity and staffing levels are the biggest risks to the delivery of the plan and therefore the report focused mainly on the actions to address these issues. Our Trust bed modelling work indicates that at an ideal occupancy of 85% for elective cases and 90% for emergency, our Trust will have, before any mitigating actions, a peak bed deficit of 91 cases at Gloucestershire Royal Hospital in February 2017 and a peak bed deficit of 26 beds at Cheltenham General Hospital in March 2017. A range of action plans to mitigate this risk

with bed capacity include implementation of Red and Green days to identify and take action to address any non-value adding waits in the inpatient pathway. Rapid access to senior decision makers via a hot-phone for General Practitioners and Emergency Department Doctors to offer a clinical opinion and provide, if possible, an alternative to an admission is being introduced. The Ambulatory Care Unit will be opened at weekends at Gloucestershire Royal Hospital. Changes to the Integrated Discharge Team are being introduced by separating into two teams, one team focusing on front door admission avoidance and being run by Gloucestershire Care Services working alongside Rapid Response and Community Teams. The second team will be focused on ward discharges and will be run by our Trust. From December 2016 Ward Discharge Teams will provide "wrap around" support for all wards across our Trust. Three multi-agency discharge events are planned building on the SAFER Initiative and the Red and Green days. There will an extension to pharmacy services provided over the weekend. Ward moves are planned to take place at Gloucestershire Royal Hospital to improve the location for patients in Gynaecology, Fracture Neck of Femur, Care of the Elderly and Acute Medicine. Each Division and Corporate Services are finalising a directory of services for the holiday season that will form part of the local and Gloucestershire plans for Christmas and New Year. As at 14 November 2016 the number of staff vaccinated with the Flu Vaccination was 2,948 against an aim at least 4,000 staff. The issue is that our Trust is not in a position to know whether staff have received the vaccination elsewhere.

During the course of the discussion, the following were the points raised:-

- In response to a question from the Chair about our Trust staff involvement in the preparation of the plan, the Director of Service Delivery said that Divisions, Specialty Directors, the A&E Delivery Board with the Leads from other organisations and the Deputy Chief Operating Officer have been involved.
- The Chair asked for the level of confidence to achieve the plan. In response, the Director of Service Delivery said that our Trust has good and bad performance days. There needs to be a focus on the actions to get into a position where our Trust needs to be. An escalation policy is in place to ensure patient safety. The physical capacity of the Emergency Department is not being expanded. Additional equipment is being sourced to provide high dependency cubicles. There will be a reduction in elective activity with more outpatient and day cases being undertaken as they are not bed dependent.
- The Interim Chief Operating Officer said that assurance in the plan was difficult at the current time as it was yet to be finalised. The Nursing Director added the an action plan had been developed from the recent County Summit.

The Chair thanked the Director of Service Delivery for the report.

RESOLVED: That the Winter Plan be not approved but the actions being taken be endorsed and that there is ongoing work with our partners to assure system-wide solutions to the pressures likely to be faced.

152/16 SURGICAL SERVICES INCIDENT

The Medical Director informed the Committee of the background surrounding a Surgical Services incident. He assured the Committee that the correct procedures had been followed and that there were no flaws in the procedure and no learning for our Trust.

The Chair thanked the Medical Director for the report.

RESOLVED: That the level of assurance provided regarding the Surgical Services incident be noted.

153/16 SERIOUS UNTOWARD INCIDENTS

The Director of Safety presented the report briefing the Committee on current Serious Untoward Incidents (SUIs), never events, high level reviews and RIDDOR reportable incidents. The purpose of the report was to provide assurance that SUI investigations are carried out in a timely way and investigations and their action plans are closed. The Duty of Candour Team will be at full staffing compliment from the end of November 2016 leading to improved investigations. The Duty of Candour is a CQC requirement and with a full staffing compliment will lead to improved reporting by the end of the current financial year. Our Trust is within the national average for reporting SUI incidents.

The Chair thanked the Director of Safety for the report.

RESOLVED: That the report be noted providing assurance that SUI investigations are carried out in a timely way and investigations and their action plans are closed.

154/16 SAFEGUARDING UPDATE

The Chair, as Non-Executive Director lead for safeguarding, introduced the report stating that he had been struck by the staff professionalism in dealing with safeguarding issues. This was particularly evident from the Committees which he had attended.

The Nursing Director presented the report providing an update to the Committee on activity and progress made by our Trust Safeguarding Adults and Safeguarding Children Boards against key defined priorities and actions at November 2016. There are three distinctive, yet overlapping areas in safeguarding namely, safeguarding adults at risk, domestic abuse and safeguarding children and young adults. Each is underpinned by legislation; each involves a multiple agency approach, supported by multi-agency policies and procedures. Our Trust plays a major role in Gloucestershire's Safeguarding Adults and Children's Boards. All Trust staff and volunteers are defined as being in a "Position of Trust" which places a legal duty upon everyone to be aware of individual and collective safeguarding responsibilities. At the end of October 2016, 90% of staff have completed the appropriate training courses at level one and level two. In accordance with national guidance, multi-agency safeguarding children level three training has been implemented with multi-agency safeguarding adult at risk level three training planning in development. The e-learning for

phase two becomes operational from 29 November 2016. The Nursing Director was proud of the Safeguarding Team and the phenomenal engagement in safeguarding from consultants. She drew attention to the 496 "cause for concern" cases recorded in Maternity from April 2016, whilst a high number demonstrated the improved alert systems.

During the course of the discussion, the following were the points raised:-

- The Chair stressed that the multi-agency work is of a high standard to which our Trust should be proud.
- The Director of Service Delivery asked how our Trust ensures that staff do not become drained due to the type of work. In response, the Nursing Director said that there is a supervisor for staff dealing with cases and an escalation policy to support staff.

The Chair thanked the Nursing Director for the report.

RESOLVED: The update on activity and key priority actions at November 2016 be noted.

155/16 MINUTES OF THE PATIENT SAFETY FORUM MEETING HELD ON 9 NOVEMBER 2016

The Director of Safety presented the minutes of the meeting of the Patient Safety Forum held on 9 November 2016. He highlighted the missed fractures newsletter which regularly included updates on key safety issues as well as progress of the Missed Fractures Quality Improvement Project. The discussion on the Medicine Safety Thermometer focused on the omission of critical medicines where it was confirmed that our Trust was close to the National mean (6.1%). However, on review of specific patients, the reasons for omission were appropriate and hence an approved clinical exception, so the data was misleading. The next focus will be to reduce omissions on all medicines.

Ms Parish sought information on the backlog of radiology x-rays. In response, the Director of Safety said that progress is being made and the number of outstanding x-rays is approximately 30,000 (and not 100,000 as reported earlier in the day). Plans are in place to reduce this backlog.

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

156/16 MINUTES OF THE HEALTH AND SAFETY COMMITTEE MEETING HELD ON 24 OCTOBER 2016

The Director of Safety presented the minutes of the meeting of the Health and Safety Committee held on 24 October 2016. He highlighted the sentencing guidelines changes issued by the Ministry of Justice implying a significant potential impact on our Trust for all health and safety offences, corporate manslaughter and food safety

and hygiene. The guidelines were not based on harm but culpability. The Director of Safety undertook to circulate the safety briefing to the Committee. **AS**

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

157/16 ANY OTHER BUSINESS

Physical Estate: The Nursing Director reported that the Director of Safety and the former Head of Patient Experience are collecting the necessary data for the CQC inspection in January 2017. Whilst there will be a perception that certain works have been undertaken in advance of the inspection, the Nursing Director said that due to timings improvement works had been undertaken to the flooring in SSD, redecoration of Prescott Ward, side rooms in Rendcomb Ward, new storage facilities for cleaning materials in Gloucestershire Royal Hospital, new flooring in Ward 9A and works in DSU.

Gloucestershire Safety and Quality Improvement Academy awards: The Director of Safety informed the Committee that the Gloucestershire Safety and Quality Improvement Academy Awards and Graduation will take place on 8 December 2016 between 2 and 5pm in the Lecture Hall at Redwood Education Centre.

158/16 QUALITY AND PERFORMANCE COMMITTEE WORK PLAN

The Trust Secretary was invited to update the work plan as follows:- **MW**

- December 2016 – Add End of Life Care Report and mortality.

The Chair said that he would be meeting the Nursing Director, Director of Safety and the Trust Secretary shortly to determine the work plan for 2017.

159/16 COMMITTEE REFLECTION

(Dr Elyan re-joined the meeting)

The Committee reflected on the meeting observing that assurance can be provided to the Board on certain areas but not all areas such as the preparations for winter. Discussions on the quality side would be helpful for the Clinical Commissioning Group. It was appropriate that the Emergency Care Programme final report was presented to the Committee.

160/16 DATE OF NEXT MEETING

The next meeting of the **Quality and Performance Committee** will be held on **Wednesday 21 December 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital** commencing at **2pm.**

Papers for the next meeting: Papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Monday 12**

December 2016.

The meeting ended at 4:25pm.

Chair
21 December 2016

GLOUCESTERSHIRE NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST QUALITY AND PERFORMANCE COMMITTEE HELD IN THE BOARDROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 21 DECEMBER 2016 AT 2PM

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT	Keith Norton	Non-Executive Director (Chair)
	Peter Lachecki	Chair of the Trust
	Helen Munro	Non-Executive Director
	Dr Sean Elyan	Medical Director
	Maggie Arnold	Nursing Director
	Natasha Swinscoe	Interim Chief Operating Officer
	Andrew Seaton	Director of Safety
	Debra Clark	Acting Head of Patient Experience
	Kay Haughton	CCG Quality Lead
GOVERNOR REPRESETNATIVE	None	
IN ATTENDANCE	Martin Wood	Trust Secretary
APOLOGIES	Eric Gatling	Director of Service Delivery

161/16 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

162/16 MINUTES OF THE QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 23 NOVEMBER 2016

RESOLVED: That the minutes of the meeting of the Quality and Performance Committee held on 23 November 2016 were agreed as a correct record and signed by the Chair subject to the sentence in the seventh line of the third paragraph of minute 148/16 (Emergency Care Programme Final Report) reading "Staff need to accept that it is a challenge and not necessarily regarded as fair from their perspective."

163/16 MATTERS ARISING

114/16 COMPLAINTS AND CONCERNS Q1:

The Senior Patient Experience Manager said that the role of lead investigator is being advocated; although it is acknowledged that this is a time consuming role the quality outcome is improved. The Chair asked how this will be taken forward and the Director of Clinical Strategy undertook to arrange for this to be considered by the Trust

Leadership Team. *The Trust Secretary reported that this will be discussed at the January 2017 meeting of the Trust Leadership Team. Completed as a Matter Arising.*

149/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK REPORT:

The Director of Safety questioned whether the MAD Clinics are delivering quality of care and whether the focus is on achieving targets or actual quality of care. The Director of Service Delivery said in response that the outcome will be presented in Divisional Reports as part of the Quality Impact Assessments. The Medical Director added that the aim is to improve which will in turn improve performance. The Chair suggested that this issue should be considered at the Committee in December 2016, if not possible, in January 2017. *It has agreed that this issue will be included in the next Surgery Division report to the Committee. Completed as a Matter Arising.*

156/16 MINUTES OF THE HEALTH AND SAFETY COMMITTEE MEETING HELD ON 21 OCTOBER 2016:

The Director of Safety highlighted the sentencing guidelines changes issued by the Ministry of Justice implying a significant potential impact on our Trust for all health and safety offences, corporate manslaughter and food safety and hygiene. The guidelines were not based on harm but culpability. *Ongoing. The Director of Safety undertook to provide the briefing to the Trust Secretary for circulation to the Committee. Completed.*

Prior to the consideration of the reports, the Chair stressed that given the workload of the Committee reports need to be concise with a conclusion presented. He drew attention to the Complaints and Concerns report which he suggested was a model for other authors.

164/16 DIRECTORS' STATEMENT TO THE QUALITY AND PERFORMANCE COMMITTEE

The Medical Director presented the Directors' Statement setting out the key issues relating to the Quality of Care delivered in our Trust from the perspective of the Nursing and Medical Directors. He explained that there will be better alignment with the quarters and the data and that a report will be presented in April 2017 and quarterly thereafter. The key issues to note were that the Emergency Department Indicators of fifteen minutes triage and one hour to senior assessment remain under the standard. This is being addressed through the Emergency Department Improvement Plan. Issues with variable demand and fluctuating high levels of ambulance attendance still directly affect these Indicators, and it was suggested that a deep dive review of this performance be undertaken at the Committee's meeting in January 2017. Our Trust recognises that a number of Key Mortality Indicators currently fall above the expected ranges. A forward looking strategy including the impact of these actions is being prepared. Meeting national waiting time targets for Cancer and for Diagnostic Tests remain a challenge. The Recovery Action Plans for

SE/MA
(MW to note for work plan)

MA
(MW to note for agenda)

these areas have been established. Operational pressures are creating huge challenges to the delivery of safe, effective and compassionate care and the Nursing and Medical Directors believe that our Trust has systems that identify and take actions on key concerns that will help our Trust to improve. Through our Improving Governance Systems our Trust can gain appropriate assurances that systems are in place to monitor quality care.

During the course of the discussion, the following were the main points raised:-

- Both the Nursing and Medical Directors stressed that operational pressures are a challenge to safety. They expressed confidence that safety is being maintained but operating in those pressures is not sustainable.
- The Interim Chief Operating Officer explained that further work is being undertaken on the data in the Integrated Performance Report so that the same information is presented to relevant Committees and the Board. It is likely to be February 2017 before such a comprehensive report is available.
- The Medical Director said that the CQC pre-assessments undertaken by clinical staff have provided a fresh approach and should be more widely used.
- The Chair said that further work is required on the Quality Map and he invited the Director of Safety to present the details to the Committee in January 2017. **AS (MW to note for agenda)**
- The Chair commented that from previous reports to the Committee it was understood that despite operational pressures all Performance Indicators would improve in quarter four which is now clearly not the case. In response, the Medical Director said that there are now particular issues with meeting the Referral To Treatment target.
- The Chair commented on the better presentation of the dashboard but from the narrative could not be assured that our Trust is meeting the respective domains. In response, the Medical Director said that this is a point well-made and the narrative currently did not provide a sense of Trust performance. Further work is required in this area on both the data and the resultant narrative.

The Chair thanked the Medical Director for the report.

RESOLVED: That the report be noted as a source of assurance relating to the Quality of Care delivered in our Trust.

165/16 FEEDBACK FROM STAKEHOLDERS ON QUALITY PRIORITIES

The Medical Director said that feedback is currently being sought from Stakeholders on the Quality Priorities and the closing date for such feedback is later in the month.

166/16 END OF LIFE QUALITY GROUP

(Dr Emma Husbands, Consultant in Palliative Medicine and Jon Burford, Divisional Nursing Director, Diagnostics and Specialties Division, attended the meeting for the presentation of this item).

The Consultant in Palliative Medicine gave a presentation on the End of Life Quality Group at our Trust and the 2017/2020 vision for End of Life Care. The vision is to embed pride in End of Life Care delivery across our organisation to ensure that we can make End of Life Care as good as it can be for every individual and those important to them every time. The CQC inspection in March 2015 for End of Life Care resulted in

- Safe – Requires improvement
- Effective – Requires improvement
- Caring – Good
- Responsive – Good
- Well Lead – Requires improvement
- Overall – Requires improvement

The presentation covered patient experience, clinical effectiveness including the establishment of the End of Life Care Group and patient safety.

During the course of the discussion, the following were the points raised:-

- The Medical Director commented that End of Life Care should form part of the mandatory training for our Trust but was unsure of the format it should take. Following discussion, it was concluded that mandatory training should be included in the learning tree for all staff at a basic level and that this recommendation should be referred to the Education and Learning Development unit. **SE**
- The Consultant in Palliative Medicine referred to the Trust Charter (tabled) and before launch work is to take place to ensure that all areas understand the Charter. The Charter, once finalised, will be presented to the Board.

The Chair thanked the Consultant in Palliative Medicine and the Divisional Nursing Director, Diagnostics and Specialities Division, for an informative presentation.

RESOLVED: That the presentation be noted.

167/16 DIVISIONAL ATTENDANCE – WOMEN AND CHILDREN'S

(Mrs Vivien Mortimore, Divisional Nursing Director and Edwoud Vorstman, attended the meeting for the presentation of this item)

The Divisional Nursing Director presented the Division's Quarter 2 Quality Report. She referred to the following:-

- Quality Assurance – Developments
- Well Lead – Our patients, performance issues
- Well Lead – Our services
- Safe – Staffing within paediatrics
- Safe – Staffing within Obstetrics and Gynaecology
- Safe – Learning
- Effective
- Caring – Patient and staff experience
- Caring
- Responsive

During the course of the discussion, the following were the points raised:-

- Mrs Munro referred to the low level of Midwifery Supervisors and asked how assurance was gained that the service is operating safely. In response, the Divisional Nursing Director said that our Trust follows a Policy Model for Supervision and a further paper is to be presented in February 2017.
- Mrs Munro referred to the six unfunded beds on Ward 2A which have resulted in ongoing cancellation of surgery due to the lack of bed capacity for Gynaecological patients failure to receive referral to treatment, poor performance experience and staff experience. In response, the Divisional Nursing Director said that funding for beds on smaller wards has now been provided.
- The Medical Director said that it was a credit to the Division for the honesty in their Duty of Candour rates.
- The Medical Director said that our Trust should celebrate the maternal death which was a traumatic experience for staff and the rallying the Team provided extraordinary care to the mother and family.
- The Chair of the Trust enquired about staffing levels. In response, Edwoud Vorstman said that incentive schemes are being introduced to limit agency staff. In Gynaecology, Consultants are working at Registrar level. Consultant hours have been extended to 10pm at night and during weekends. The appointment of Assistant Physicians and Advanced Nurse Practitioners particularly in Neo-natal services have been successful.
- The Chair of the Trust referred to the serious incident performance observing that under 70% are completed within 3 months. In response, the Divisional Nursing Director said that often serious incidents are challenging and take time to work through there were four such incidents between July and October 2016.

The Chair thanked the Divisional Nursing Director and (Edward Vorstman for the report and presentation.

RESOLVED: That the report be noted in order to recognise areas of good practice and assurance that the Divisional Team is addressing in areas of concern.

168/16 REVIEW OF TERMS OF REFERENCE

The Trust Secretary presented the Terms of Reference and invited the Committee to ensure that they reflected the new operating arrangements.

During the course of the discussion, the following were the points raised:-

- It was agreed that performance be included in purpose number four relating to ensuring our Trust delivers services which consistently meet nationally defined minimum standards and performance.
- The Trust Secretary was invited to determine whether the **MW**

Committee is responsible for the Quality Group.

The Chair thanked the Trust Secretary for the report.

RESOLVED: That the Committee's Terms of Reference be approved with the above amendments.

169/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Interim Chief Operating Officer presented the report summarising the key highlights and exceptions in Trust performance up until the end of November 2016 for the financial year 2016/17. She updated the Committee on the validated November performance position of the following:-

- 18 Week Referral To Treatment – 86.94%
- Emergency Department Performance – 86.62%
- Cancer – 2 Week wait – 93.5%
- - 62 Days – 79.9%
- - 6 Week Diagnostics – 0.98%

The Interim Chief Operating Officer said that the RTT trajectory is to reach 92% by March 2017. However, this is now unlikely in that the Demand and Capacity Model did not fully take into account winter pressures and the impact on elective work. There are capacity issues in Urology and the expectation was that Trauma and Orthopaedics would also not deliver the trajectory. The Demand and Capacity Model was prepared in November 2016 without the full involvement of managers. The introduction of TrakCare also had an impact. The RTT trajectory was established but there was not the confidence in Divisional ability to deliver. The Interim Chief Operating Officer had paused the inputting of PTL on TrakCare as there was not sufficient confidence that all data had been input. This together with the poor Demand and Capacity Model had led to the deterioration in performance. Work is underway with Divisions to improve performance. A revised Demand and Capacity Model for Surgery Division will be available in early January 2017 taking into account the availability of beds, Ward 9A, the Cirencester Hospital and outsourcing. It is hoped that by the end of January 2017 all modelling will be completed and performance back on track by the end of March 2017.

During the course of the discussion, the following were the points raised:-

- The Chair enquired as to the level of competence to get back on track. In response, the Interim Chief Operating Officer said that there is confidence from what we know. The Nursing Director expressed concern that it was not clear that Divisions are managing their caseloads following a review of the target. To enable the Committee to provide escalation to the Board, the Chair invited the Interim Chief Operating Officer to present to the January meeting of the Committee the Demand and Capacity Model and trajectory to return to performance. **NS (MW to note for Agenda)**
- In response to a question from Mrs Munro, the Interim Chief

Operating Officer undertook to provide her with the background to the red risk areas of the RTT 18 week reporting for November 2016. **NS**

- The Chair said that assurance on the 18 week RTT performance could not be provided to the Board and that information on improving performance should be presented to the Committee in January 2017.

The Chair thanked the Interim Chief Operating Officer for the report.

RESOLVED: That the Integrated Performance Framework Report be noted as a source of limited assurance that the Executive Team and Divisional Leaders are addressing the performance deficits highlighted in the report.

170/16 EMERGENCY PATHWAY REPORT

The Interim Chief Operating Officer presented the report providing assurance that our Trust continues to address the concerns identified which relate to the delivery of Emergency Care within our Trust. The report provided evidence of progress against key quality, safety and performance indicators, described key risks and provided a progress update against the Emergency Care Programme Board Milestone Plan. She said that the trajectory of 91.2% was not met with performance being 87.07%. In December 2016 ED reporting was suspended due to issues with TrakCare with issues around the stop and starting of the clock. During the week of the meeting, performance was 80%. The introduction of Red and Green Days had reduced the number of medically fit patients awaiting discharge and it is about embedding the process on a daily basis.

On 14 December 2016 a 12 hour breach occurred directly related to TrakCare and a root cause analysis is being undertaken which will be presented to the Committee.

The Operational Plan to be submitted by 23 December 2016 will indicate that Emergency Care Performance will meet the 95% target during 2017/18.

During the course of the discussion, the following were the points raised:-

- The Chair of the Trust asked whether any assistance was needed to improve performance. In response, the Interim Chief Operating Office said that with the introduction of TrakCare and winter pressures lead to a difficult time.
- The Chair of the Trust indicated that meeting the 95% performance target in 2017/18 was achievable.
- The Interim Chief Operating Officer said that there were no concerns regarding patient safety but there were issues with the introduction of TrakCare.
- The Director of Safety said that there were two serious incidents in the Emergency Department prior to the introduction of TrakCare.

The Chair thanked the Interim Chief Operating Officer for the report.

RESOLVED: That the report be noted as a source of assurance that progress continues to be made in the Emergency Care Programme and that all major risks to meeting the Performance Recovery Trajectory are being actively managed.

171/16 MORTALITY STRATEGY

The Medical Director presented the Strategy to inform the Committee that appropriate actions are in place to understand mortality rates in our Trust, undertake and learn from mortality reviews and reduce rates to levels below the expected range over time. He apologised for the late distribution of this report. The key issues to note were that measures of mortality (Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Index (SHMI)) are above the expected range. A strategy to reduce these rates and ensure appropriate reviews of the care of patients who die has been developed which includes a series of initiatives and will be supported by an action plan which will be monitored through the Hospital Mortality Indicators Group. The mortality rates are high and programmes of work are in place to ensure these rates are reduced. The reviews undertaken give assurance that apart from #Neck of Femur these indicators are not reflecting poor care. The service improvements for #Neck of Femur are showing reductions include mortality rates.

During the course of the discussion, the following were the points raised:-

- The Director of Safety said that coding is a concern as the Medical Director indicated that 5 patients died after discharge. However, there is now better reporting of data.
- The Chair expressed concern over Fractured Neck of Femur and suggested that the trajectory to improve performance be presented to the Committee once determined.
- The Committee noted the additional item relating to the report prepared by the CQC on learning, candour and accountability – a review of the way NHS Trusts review and investigate deaths of patients in England.
- The Medical Director explained that our Trust is part of a group sharing learning and standards of reviews and training which allows a process of comparable data.

The Chair thanked the Medical Director for the report.

RESOLVED: That the report be noted providing assurance on the actions being undertaken to reduce mortality rates to levels below the expected range over time.

172/16 DUTY OF CANDOUR UPDATE REPORT

The Director of Safety presented the report providing an update on progress on the delivery of Duty of Candour. The report provided a summary of activity in respect of notifiable safety incidents which have triggered the Duty of Candour. The report highlighted activity measured from 1 October to 30 November 2016 following the recruitment of a new Duty of Candour Team. Data prior to that period

would not be a true and accurate reflection of incidents managed under the Duty of Candour process. The report discussed the significant and multifactorial difficulties faced by our Trust in adhering to our statutory duty and the steps which have now been put in place to support these difficulties. Focus was on the positive and significant changes that have been made in 2016, namely with the recruitment of the Duty of Candour Co-ordinator role and two new Duty of Candour case managers to support the Safety Department. This Team will allow a high quality patient focussed system. The Safety Team will continue to monitor and improve the process and outcomes for Duty of Candour incidents and report these through the current serious incident report process. A 90% compliance rate is anticipated for the first letter response and internal standard for final response by 1 April 2017. It is expected that there will be an increase in reported incidents as the revised Duty of Candour training and education package is rolled out in early 2017; this might have effect on performance depending on volume.

During the course of the discussion, the Acting Head of Patient Experience said that there is a link with complaints and it is necessary to prevent duplication of investigation.

The Chair thanked the Director of Safety for the report.

RESOLVED: That the report be noted as a level of assurance on progress in delivery of the Duty of Candour.

173/16 STAFFING AND ASSOCIATED QUALITY ISSUES ON T7A (GASTROENTEROLOGY)

(Mrs Susan Milloy, Divisional Nursing Director, Medicine Division, attended the meeting for the presentation of this item)

The Divisional Nursing Director presented the report on the current staffing situation on Ward 7A and to detail some of the associated risks and controls which have been put in place to mitigate them. Ward 7A has been open to 30 beds for 24 months, two of which are unfunded and due to operational pressures remain open. The cohort of patients includes those being supported with alcohol and substance abuse who often also have challenging behaviour, and patients with acute bleeds who are admitted directly from the Emergency Department to 7A for urgent management. Recruitment and retention of staff has been challenging and the ward currently has 7.8 full time equivalent staff nurse vacancies from a total of 18.13 funded staff. Staff cite the pressure and intensity of caring for disruptive and often violent and aggressive patients and their families as one of the reasons for leaving. The most recent staff stress survey highlighted this as a concern. Despite actions in place to support the Team, skill mix is poor and the ward is relying on temporary staff to support the substantive staff rota. Some issues regarding nursing care are being monitored including falls, medication errors and pressure ulcers. However, despite concerns, the rates are not any higher than expected. The Specialty and Division recognise the strength of clinical leadership in the band 7 Sister in maintaining standards of care in a difficult situation, but also acknowledge that the situation is not sustainable in the long term.

During the course of the discussion, the following were the points raised:-

- The Divisional Nursing Director explained that the additional Nurse co-ordinator helps but does not absorb the pressures. The Nursing Director added that the Keith Hurst benchmarking data indicates that the ward has the required staffing level; however, the Divisional Nursing Director is providing support.
- Due to the disruptive and often violent and aggressive patients and their families, all staff on the ward and the equivalent ward at Cheltenham General Hospital, Hazelton, are to receive violence and aggression training.
- The Nursing Director said that a proposal to reinforce and support staff is being presented to the Trust Leadership Team in January 2017.
- The Director of Safety explained that service changes in the Community lead to more patients being admitted to Ward 7A. The Nursing Director added that there are no beds within the County for the type of patient. She added that Nurses trained in alcohol related issues are working in the Emergency Department.
- The Chair invited the Medical Director and the Nursing Director to prepare for his signature a letter to staff on the Ward thanking them for their work. **SE/MA**
- The Interim Chief Operating Officer said that alcohol abuse is the one of the priorities in the Sustainability and Transformation Plan and our Trust can learn from the work being undertaken in University Hospital Bristol.

The Chair thanked the Divisional Nursing Director for the report.

RESOLVED: That the report be noted as a source of assurance of the controls which have been put in place to mitigate the risks on Ward 7A.

173/16 QUALITY MANAGEMENT PROGRAMME

The Director of Safety presented the report introducing a revised local quality structure to support continuous improvement. The introduction of the Quality and Safety Improvement Academy (GCQIA) has been developing a continuous improvement culture. The Academy and improvement need to be matched to a revised quality structure. Trust's with successful Quality Management Systems combine clinical engagement with front line responsibility to create continuous quality improvement cultures. Introducing a new Quality Programme will require testing, collaboration and engagement through a structured programme to ensure robust reliable systems can be developed. Transformational change in quality management will involve large scale change affecting behaviours and more fundamentally the culture of our organisation. The end point will be that each Department through distributed quality leadership and management will have the ability and responsibility for quality. A pilot is to be undertaken over the next year to see what works well and the evaluation will be presented to the Committee before being rolled out across our Trust.

During the course of the discussion, the Medical Director said that the challenge is for teams to take ownership and is important for engagement. The Chair emphasised that this is essential for our Trust to deliver.

The Chair thanked the Director of Safety for the report.

RESOLVED: That the project to transform quality management arrangements be endorsed.

174/16 COMPLAINTS AND CONCERNS QUARTER 2

The Acting Head of Patient Experience presented the report providing information on the complaints and concerns reported to our Trust during quarter 2 of 2016. She explained that our Trust response rate of 35 days is never met due to complex medical records which are not readily available. It will be some time before the introduction of TrakCare improves the position. The Medical Director added that it is the process which drives the delay. He suggested that this target be reduced for simpler complaints and extended for those which are more complex. It was acknowledged that there is scope to improve the process and the Acting Head of Patient Experience was to consider this further and report back to the Committee.

The Chair thanked the Acting Head of Patient Experience for the report.

RESOLVED: That the report be noted.

175/16 USER ENGAGEMENT IN OUR TRUST

The Acting Head of Patient Experience presented the report providing an update on user engagement activity. Our Trust's current model engagement with our service users is set out in two key strategies; "Improving Patient and Carer Experience Strategy 2015-17" and "Membership Engagement Strategy 2014-16". Both were designed using feedback from a wide range of patients and stakeholders. The approach has been to implement a model of engagement and wherever possible and appropriate our Trust work directly with patients and their family/carers to capture their experience and to learn from them what works and where we can improve further in the design and delivery of our services. Engagement with our members remains very active with over 13,000 public members of whom over 2,600 have chosen to more actively involved with our work. The report demonstrated an effective and integrated approach to seek out the views of patients, carers and members of our Trust using a wide range of user engagement and involvement approaches.

During the course of the discussion, the following were the points raise:-

- In response to a question from the Chair of the Trust about Member Events, the Acting Head of Patient Experience explained that our Trust endeavours to provide these on a monthly basis at both sites during the early evening. Attendance varies depending on the topic. She acknowledged

that our Trust needs to engage with our younger members.

- The Medical Director said that Member Events would provide a good opportunity to inform the public and Governors of the reconfiguration of services and the Chair suggested that this should be fed back to the Sustainability and Transformation Plan representative. **SE**
- The Nursing Director expressed her appreciation to the Acting Head of Patient Experience for stepping up into the role and for quality of the report which should be a model for other report authors.

The Chair thanked the Acting Head of Patient Experience for the report.

RESOLVED: That the information contained within the report and it's use to inform future strategic development be noted.

176/16 CARE QUALITY COMMISSION – LEARNING, CANDOUR AND ACCOUNTABILITY

This was referred to in minute 171/16 above relating to the Mortality Strategy.

177/16 MINUTES OF THE PATIENT EXPERIENCE STRATEGIC GROUP MEETING HELD ON 22 NOVEMBER 2016

The Acting Head of Patient Experience presented the minutes of the meeting of the Patient Experience Strategic Group held on 22 November 2016. She explained that the Terms of Reference and Membership are being revised to provide a more operational focus with the Nursing Director being Chair.

The Chair thanked the Acting Head of Patient Experience for the minutes.

RESOLVED: That the minutes be noted.

178/16 ADDITIONAL ITEM – NURSE AND MIDWIFERY STAFFING

The Nursing Director presented the report providing assurance in respect of Nurse staffing levels for November 2016 against the Compliance Framework "Hard Truths" – Safer Staffing Commitments. Whilst there were no major safety concerns arising from the staffing levels, the individual Divisional reports commented in detail where staffing hours are either lower than the centile set by NHS England, or over, and the rationale behind those findings. She explained the outcome of the further investigations undertaken by Divisional Nursing Directors into the over establishment of HCAs. Investigation concluded that it is reasonable to assume that having substantive NHS employed staff gives better value for money offering better patient safety and experience. The target for Nurse vacancy reduction was set at 13% to be reached by 31 March 2017. It was pleasing to note that on 2 December 2016 our Trust Nursing vacancies had reduced to 10.93%. Likewise, the target for 2016/17 was to reduce the Nursing agency spend by £369k, of which £561k

has already been recorded. The Nursing Director had met representatives from NHS Improvement on 19 December 2016 and had submitted the Model Hospital Tool for benchmarking purposes.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report be noted as a source of assurance that staffing levels across our Trust are delivering safe care.

179/16 ANY OTHER BUSINESS

Mrs Helen Munro: The Chair said that this would be the last meeting which Helen Munro would be attending. He thanked her for her service to the Committee particularly during her time as Chair.

Matters To Escalate: The Chair said that the 18 Week to Treatment performance should be escalated to the Board. The Medical Director added that he would consider whether mortality should be included on the Trust Risk Register.

Quality Impact Assessments: The Medical Director explained the process whereby he and the Nursing Director sign off all Quality Impact Assessments before the request is submitted for funding. This is a separate process to the Divisional Executive Reviews. It was agreed that the process be presented to the Committee in February 2017. **SE (MW to note for agenda)**

180/16 QUALITY AND PERFORMANCE COMMITTEE WORK PLAN

The Trust Secretary and the Director of Safety were invited to update the Work plan to map CQC requirements. **MW/AS**

In response to a question from Mrs Munro about research undertaken by Michael West relating to patient safety, the Director of Safety undertook to pick this up as a possible matter for the Workforce Committee. **AS**

181/16 COMMITTEE REFLECTION

The Committee reflected on the meeting with the main observation being that it is still too long a meeting.

182/16 DATE OF NEXT MEETING

The next meeting of the **Quality and Performance Committee** will be held on **Thursday 26 January 2017** in the **Board Room, Alexandra House, Cheltenham General Hospital** commencing at 9:30am.

Papers for the next meeting:
Papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Tuesday 17 January 2017.**

The meeting ended at 4:55pm.

Chair
26 January 2017

REPORT TO MAIN BOARD - JANUARY 2017

From Finance Committee Chair – Tony Foster, Non-Executive Director

This report describes the business conducted at the Finance Committee held on 25 January 2017, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Financial Performance Report	Month 9 deficit in line with forecast – the third in a row. Now reporting primarily against revised plan – not original.	Deficit now £17.0m but FRP Commitment for full year is £18.0m	CIP delivery to date is £1.3m greater than recorded. Plans in place to deliver further £7m CIP in last quarter. March is a long month with above average operational activity. March contains £1m profit on College Lawn sale.	Big challenge still to deliver last quarter plans
	Encouraging trend down in pay, clinical supplies and other non-pay in last 4 months			Can this trend continue through challenging winter
	Drugs income/expenditure variances	Need in future to separate pass through drugs where no risk to Trust from others where there is		
	Debtors increased by £1.2m		Still large amounts with Specialist Commissioners and GCS but hopeful negotiations with these and others will conclude before	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
			year end. Audit Committee have now agreed criteria for provisions and write-offs of aged debtors. There will be a further amount in PPA by year end.	
	Creditors up £1.4 m	Is this a set back?	Assured not – normal variation because of Christmas period	
	Better payment practice code	It has been discovered that payments of tax, NIC and pensions have wrongly been included in the past – now corrected		
Deloitte Financial Reporting Review Recommendations	Remain on track to complete all 34 recommendations by 31 March 2016 with the exception of the Hereford Radiotherapy Unit	Overall contractual position is unclear on Hereford.		Further work to ascertain precise requirements of the agreements and options available
Workforce Report	Further reduction in overall paybill between months 8 and 9.	Need to better track movement in numbers employed, substantive paybill and agency spend		Task passed to Workforce Committee
	Agency spend lowest for 5 months	While evidence of grip and reduction in nursing spend, no such evidence in medical	There was a once off increase in medical agency in M5 as result of conscious decision to increase emergency locums	Workforce Committee to work on medical plans

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Financial Recovery Plan	We have committed to deficit of £18.0m for this year. Still in discussions with NHSI for next two years figures. Next review meting 7 Feb.			
Cost Improvement Programme Update	CIP target for 2017/18 is £31.7m of which £18.3m is so far developed.	Discussion of opportunities for securing balance of £13m. Committee asked for breakdown of recurrent and non-recurrent savings in future.	Ideas for £7.3m outlined but still have stretch of £6m to identify	
Capital Programme Update	Prioritisation has reduced original budget down from £18.5m to £12.7m.	How to assess risk to interruption and safety from schemes not in programme	There is a risk framework in place	This needs to be assessed by Quality and Performance Committee
Contracting update	Main contract for Gloucestershire CCG for 2017/18 has been signed at £307m. Specialised Commissioning contract signed for £82m.	Some details of these discussed and impact on 2017/18 out turn		
	Other Commissioners	Another £45m of income is at various stages of agreement	Expect all agreements to be finalised by year end. This is a major improvement on previous years.	

REPORT TO THE BOARD OF DIRECTORS MEETING - TUESDAY 31 JANUARY 2017

FROM AUDIT & ASSURANCE CHAIR – RHONA MACDONALD, NON-EXECUTIVE DIRECTOR

This report describes the business conducted at the Audit and Assurance Committee held Wednesday 18 January 2017, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Future Approach to Audit and Assurance	The perspective Chair of the committee attended to discuss how the committee will develop. Reference was made to training needs and the use of risk based assessments to develop future audit programmes.		The discussion was part of an overall programme to improve assurance arrangements.	
Draft External Audit Plan	The plan was discussed and clarification sought around key risks and materiality			
Internal Audit report	The committee received four reports. - Internal Audit Progress Report - Consultant Job Planning - Temporary Staffing Financial Controls (Nursing) - Clinical Coding The committee discussed the	The committee requested a fuller management response should be included in future reports. There was a need to clarify how actions would be delivered as well as timescales. The committee sought to understand the extent to which culture and behaviour	The CEO reported that the Nursing Director could provide evidence of a number of good practices for managing the spend on temporary staffing. The updated Tracker is to be provided for the next committee.	The Medical Director provide greater context to the consultant job planning audit and explained that lack of appropriate systems and information data had inhibited the adoption of best practice

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	need for other committees to have sight of internal audit reports and it was agreed that a mechanism to do that would be introduced	impacted and where changes were required to address some of the issues raised in the report on consultant job planning and temporary staffing.		
Tracker Recommendations	The CEO reported that further work and been competed since the last committee this had identified a further numbers of actions and further completed actions	The committee asked for an update on the four uncompleted high risk outstanding recommendations. This resulted in one being reclassified and further information clarifying that the others had been completed.		
Bad Debt Provision and write offs	Methodology for determining bad debt provision was agreed and the resulting implications for write offs as part of the prior year adjustments was noted.	The committee sought clarity about the extent to which external auditors were engaged in the process of agreeing these policies, clarification of the impact on the current report of deficit.	The external auditors confirmed discussions were ongoing and the prior year adjustments had been identified as raiding the level of risk from an audit perspective.	
Counter Fraud Report	The report covered time spent on governance, involvement and prevention work.	The committee noted the absence of any record of fraud under investigation or closed and requested that this should form an annex to the regular report.		

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD - JANUARY 2017

From Workforce Committee Chair – Tracey Barber, Non-Executive Director

This report describes the business conducted at the Workforce Committee on 3 December, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Terms of Reference	- Approved with the addition of Risk and - Clarification on Quorate Membership Additional Governor representation required	Are we ensuring that we have the right Committee capabilities and input ?	To be quorate we will have NED, HR, Clinical and Finance in attendance Governor member to be confirmed prior to next meeting	The impact of STP needs to be included moving forward . Meeting frequency to remain at monthly until reviewed in March 2017
Review of Annual Workplan	- Agreed and to be used as the template moving forward . The annual agenda reflects the Board priorities - Risk to be added as a standing item .	Are we able to manage capacity and ensure the right focus on the right things?	The Annual agenda plan would be reviewed as part of the Committee audit of performance and effectiveness in March 2017 ELD be added into Annual Agenda plan to reflect the focus on broader education	
Assurance Workforce Report	The ongoing analysis of Pay expenditure was discussed at length	At what point was analysis complete and the focus turning into action and impact? Why were there questions around insights drawn in the Workforce report ?	The Workforce report would not be shared at any committee without sign off from HR Director , An executive summary with conclusions would be included from now on	Triangulation between committee Chairs on shared issues and impact
	Approach to HCAs in terms of test and learn for coaching through IELTS was recognised as a sound initiative	How are we ensuring patient care and quality of provision remains paramount ?	Quality and performance reporting and triangulation across Committees	

Financial Rigour Agency/Temporary Staffing	Governance structure and terms of reference presented. The committee noted the report for assurance	Is it realistic to use Southern region agency performance report as a comparative? Are we comparing like with like? Are the deadlines realistic and are they been met? Have we the assurance in place with meetings happening as outlined. Weekly meetings in place but Recovery Board yet to meet	Agreed need to understand the right comparatives Some deadlines missed . Need to ensure appropriate tracking to map progress Confirmation of meeting schedules for Recovery Board and appropriate tracking of assurance process to be confirmed back to Committee
Resources Review Workforce Strategy Communications Plan	The committee received the outline strategy for Workforce engagement which was agreed but with a number of queries	Is there the capacity in the business to deliver the plan? How do we ensure that we create Comms champions ? How do we ensure that the workload is equitable and appropriate – particularly within the HR leads? Engagement is clearly key but with recognised constraints	Response back to the Committee on who is doing what, by when and what is doable against the broader business needs
Reports from Sub-Committees			
Agency	Individual budget holders and individual leaders are taking responsibility for measurement and control to ensure Agency reduction with the high level plan being translated into work stream plans supported by Project Initiation Documents (PID's). The challenge of attributing actions to achievements in a linear fashioned was outlined by the	Is there a possibility of double counting savings as so many of the actions impact within and across work streams?	The Committee will receive at the next meeting the same report as received by the Turnaround Implementation Board

	Medical Director			
Recruitment Strategy	Recruitment Strategy Group continues to work towards its 2 key objectives: 1. Reduce Band 5 vacancies from 15.5% to 13% by 31 March 2017. 2. Reduce turnover of Band 5 nurses from 16.2% to 15% (run rate) by 31 March 2017. Progress is positive to date: 1. Band 5 Nurse vacancies are at 10.93% as of Month 7. 2. As at Month 6 turnover was 15.03%. Having increased steadily since 2013, Band 5 nursing turnover has started to reduce from month 4 and is now at its lowest point since August 2015.	The lack of dedicated procurement support presents a risk in terms of our ability to consider with our overseas recruitment plans. How are we sharing success and delivering the good news story ?	Recruitment Strategy Group meets on a monthly basis to review progress against the targets.	
Employee Engagement	The steering group have been revisiting their terms of reference with a focus on being enablers to engagement within and across divisions. There was a strong focus on promoting the staff survey and rates are holding up compared to last year. The group also considered how the potential changes to travel should be presented for broad engagement with a paper for TLT being presented this week.	A challenge was made to anecdotal feedback that the staff survey results were likely to be disappointing as there is no firm evidence of this.	Initial 'raw data' results (not for publication) could be considered at the next committee meeting.	Clarity in the report on what the steering group have done and what activitites are scheduled next (including who by and when

JSCC	The last JSCC meeting was attended by the CEO, Interim Finance Director, Director of Estates and Facilities and the Improvement Director. Much of the business as usual format was turned over to presentations about PRIDE, the Financial Recovery Plan, Improving Flow and Travel options.	Will the planned session with staff side chairs to discuss agency/pay group issues, include LNC?	Update on progress of discussions to come to next Workforce Committee	
Reward	Group considered requests for WLI payments for Echocardiographers, retention proposals for clinical coders (both needed further development), the final draft of the WLI policy and a range of pay grip initiatives discussed with KPMG. Set out programme for reviewing current RRP arrangements.	Can we develop traction on issues beyond those proposed by KPMG?	Status of pay grip initiatives to come to next Workforce Committee	
Items from the Board or other Committees	The KPIs for Workforce strategy were agreed for the next 6 months only. These would be reviewed in March 2017 and reassessed	Have we smart objectives set and bought in to? How are we measuring success?	Reporting structure through sub committees track performance against Workforce strategy KPIs	The Committee requested detail of by who and by when to be include in all sub-committee reports to ensure performance is assessed appropriately

Items for Board to note specifically :

1. **Agency/temporary staffing – not all deadlines for deliverables are being met. How i sthe Recovery Board managing oversight?**
2. **Workforce strategy requires Comms support to manage the launch appropriately – this needs to be deliverable and proportionate to other Comms demands**
3. **KPIs have been set for Sub committees and within Workforce strategy. Reporting from Sub Committees has been made consistent.**
4. **Band 5 Nurse vacancies are at 10.93% as of Month 7 (delivering against target)**

REPORT TO MAIN BOARD - JANUARY 2017

From Workforce Committee Chair – Tracey Barber, Non-Executive Director

This report describes the business conducted at the Workforce Committee on 6th January 2017 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Workforce Tracker including FTE and Agency Programme Board Update	Pay expenditure is down in November with the reclassification of Smartcare Gap between those employed and those funded stands at 192, with pay costs at a premium against demand	Can we compare our approach for premium pay management against other SW Trusts and access learnings where relevant?	Report and recommendations back to the Committee in February	
	Management of costs across disciplines showed exploration needed on allocation of costs for pregnancy	How can we incorporate an allowance for pregnancy costs in our Outturn budget setting?	Follow up with Finance team as part of Outturn budget setting	
	Sickness and absence levels saw a peak over the Christmas period	Are we able to better monitor sickness absence to reduce impact on Agency?	Nursing policy to be reviewed by Maggie Arnold and broader Medical Policy checked with staffside.	Policy to be reviewed and process for correct implementation to be put in place by Feb meet
Annual agenda Plan	The Annual Agenda plan was reviewed as part of the overall assessment of Committee performance and deliverables	Whilst the committee focus needs to remain on key areas of cost and quality , how do we maintain a focus on the	A report from the Workforce strategy and organisational development Group Chaired by the CEO would be	

		long term strategic issues of reducing ongoing Agency usage ?	brought to the Committee in February	
Equality and Diversity Report	Whilst we are not a significant outlier in terms of Workforce Race Equality , there remains a lot to do to address diversity issues	What are we doing to access learning from beyond the NHS and utilise best practice engagement strategies from industry?	Meetings to be co ordinated with external Partners to draw on additional learning opportunities which we can apply	Presentation back to the Committee in April to assess progress made
Education and Medical Focus	The committee received a comprehensive report on Education and Medical focus which highlighted a number of successes = specifically we are recognised as providing an environment of positive learning . However, there was discussion around a number of areas: How do we recruit PAs and utilise them more effectively? The level of consent taken by Foundation Doctors The handover between emergency dept and the rest of the hospital The workload levels of both	How are we addressing the concerns raised in the report and where is the corresponding action plan ? How specifically are we addressing the handover between emergency and the rest of the hospital ?	Agreed need to consolidate actions and prioritise , with a paper back to the committee end of 2017 Issue of handover raised to the Risk Register as an ongoing concern to be addressed	 To be reported through the Risk Register and Board

	trainers and trainers The Deanery level 3 visit and preparation happening Rota management and the number of trainees		
Reward strategy Group	The committee received the update on Rewards and specifically looked at Recruitment and retention premia	Are we on track to achieve a pay offering which increases bank shift take up by 10% ?	Response back to the Committee by end March on progress made
Items from the Board or other Committees	Inclusion of End of Life training as part of stat and mandatory training moving firward	How can we ensure End of Life care capability is embedded across the organisation ?	

Items for Board to note specifically :

1. **Pay expenditure is down in November with the reclassification of Smartcare**
2. **Sickness and absence levels saw a peak over the Christmas period, so the committee has requested a deep dive for February**
3. **Equality and Diversity approach is being re invigorated to look at how we can access learning from external parties**
4. **We are looking through the Reward Strategy group at how our pay offering could increase bank shift take up by 10%**
5. **Issue of handover from Emergency to rest of hospital raised to the Risk Register as an ongoing concern to be addressed**

Report Title
Workforce Report - Period to 31st December 2016

Sponsor and Author(s)

Authors: Dave Smith, Director of Human Resources and Organisational Development
Eve Russell, Associate Director Workforce
Sarah Stansfield, Director of Operational Finance

Sponsoring Director: David Smith, Director of Human Resources and Organisational Development.

Audience(s)

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

This report provides an overview of the workforce performance of the Trust as at the end of Month 9 of the 2016/17 financial year. It provides information on the continuing overspend on pay (including agency) costs, movements in headcount as well as further information on two of the key drivers of spend, turnover and sickness.

Key issues to note

- It is pleasing to see a reduction in the overall paybill between M8 and M9 of £0.43m, building on the previous month's reduction of £0.13m. The paybill is at its lowest level since July.
- Whilst there was a reduction in 'worked' employees of 26 wte on the prior month, the number of 'paid' employees reduced by 137 reflecting a reduction in premium time payments.
- Agency expenditure reduced to £1.7m, a £250k reduction on the prior month, adding to a £230k reduction between months 7 and 8 and it is very pleasing to see some of the perceived 'grip' arising from the work streams reporting into the Agency Programme Board coming to fruition. Agency spend overall is at its lowest level since June.
- Whilst pleasing, January is typically challenging operationally and continued focus and grip needs to be applied to agency expenditure.
- Equal focus is being applied between agency expenditure and pay expenditure generally and engagement with staff representatives on key initiatives continues with the support of the CEO.
- We continue to make inroads into qualified nursing vacancies albeit there has been an increase in vacancies within Medicine Division (14.62) during the month. The overall growth in fte numbers witnessed between months 4 and 6 as we focused on filling our critical workforce gaps has now stabilised and has also been balanced by the reported reduction in pay and agency spend.
- The Committee is provided with 2 appendices which reflect reporting into the Turnaround Implementation Board and which set out in greater detail the work being undertaken to reduce overall pay expenditure and reduce agency spend.

Conclusions

The increased scrutiny of agency use and spend appears to be having an impact with a reduction in the overall spend in this area. This has been largely attributable to the increase in substantive nursing numbers, and we need to ensure that similar traction is developed within the medical and corporate areas in reducing spend.

Implications and Future Action Required

The focus on reducing agency use and reducing vacancy levels appears to be having a positive impact and must be maintained and increased. Work to leverage off the experience of other organisations in controlling both agency and general pay expenditure is ongoing.

Recommendations
The Committee is asked to note the report.
Impact Upon Strategic Objectives
A failure to improve the financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Significant impact on deliverability of the financial plan for 2016/17.
Regulatory and/or Legal Implications
A failure to control all elements of the paybill will impact the Financial Recovery Plan and may lead to increased regulatory activity by NHS Improvement around the financial position of the Trust
Equality & Patient Impact
It is essential that any steps taken to curb pay expenditure are impact assessed to ensure that quality and safety of patient services are assured

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources	✓	Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Gloucestershire Hospitals NHS
NHS Foundation Trust

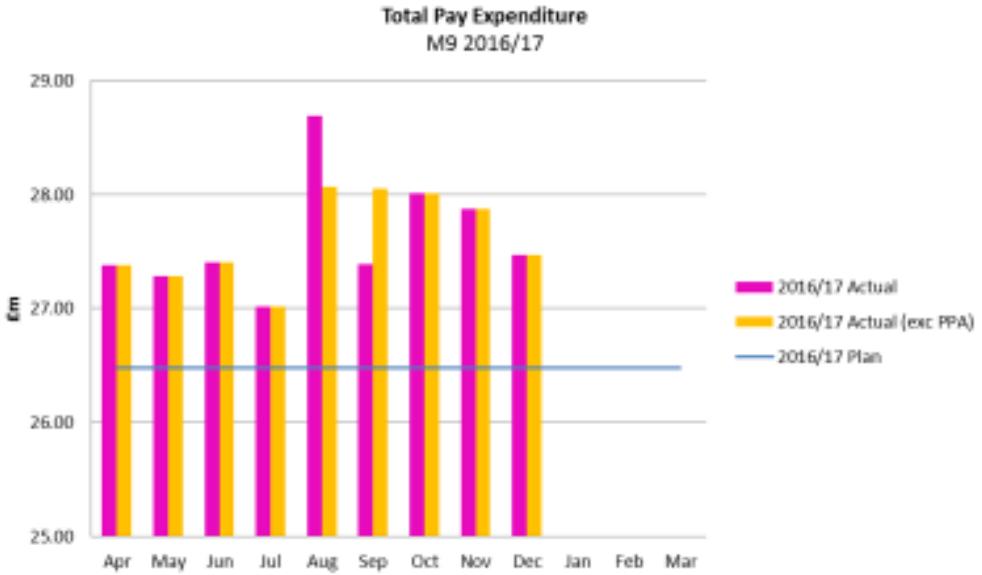
Report to the Main Board

Workforce Report
Period to 31st December 2016

Introduction and Overview

The purpose of this presentation is to provide an overview for the Finance Committee of our current position in terms of Workforce expenditure and other relevant Performance Indicators. It will include a breakdown of current pay, sickness absence and turnover, along with a description of actions being taken to address any concerns.

Pay Expenditure



NB: The NHSI Plan and the planning process that created it is not as robust as would be expected. The Plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes. The Trusts internal budget does not reconcile, either by cost category or phasing, to the NHSI plan. The figures presented in this report as 'plan' reflect the figures as submitted to NHSI unless explicitly stated otherwise.

Pay expenditure reflects the total expenditure across the Trust, including bank and agency. It includes all hosted and shared services. The chart shows the position inclusive and exclusive of financial adjustments for the prior period so the run-rate is comparable for trend analysis.

Total pay expenditure reduced in December 2016, which is a positive reflection of the significant measures being taken to deliver Workforce CIP and efficiencies. The challenge now will be to ensure that this reduction is sustained and improved upon.

Pay Expenditure

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Movement M6-M7	Movement M7-M8	Movement M8-M9
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
2016/17 Actual	**27.38**	**27.28**	**27.41**	**27.02**	**28.69**	**27.39**	**28.01**	**27.87**	**27.47**			
2016/17 Actual (exc PPA)	**27.38**	**27.28**	**27.41**	**27.02**	**28.07**	**28.05**	**28.01**	**27.87**	**27.47**	**(0.05)**	**(0.13)**	**(0.41)**
Medicine	6.44	6.25	6.31	6.35	6.87	6.56	6.58	6.35	6.40	0.03	(0.23)	0.05
Surgery	7.36	7.10	7.21	7.16	7.29	7.29	7.54	7.35	7.16	0.25	(0.19)	(0.18)
Women and Children	2.94	2.89	2.90	2.82	2.89	2.98	2.96	2.94	2.89	(0.02)	(0.02)	(0.05)
Corporate Services	1.65	1.81	1.71	1.81	1.68	1.78	1.83	2.14	1.85	0.05	0.31	(0.29)
Diagnostics & Specialist	5.10	5.04	5.20	5.06	5.15	5.17	5.12	5.04	5.09	(0.05)	(0.08)	0.05
Estates and Facilities Division (EFD)	1.17	1.18	1.18	1.15	1.18	1.18	1.15	1.15	1.19	(0.03)	0.00	0.04
Hosted Services - GP	2.27	2.30	2.22	2.21	2.51	2.37	2.30	2.26	2.30	(0.08)	(0.04)	0.04
Other (inc. Trustwide & Shared Services)	0.46	0.69	0.68	0.45	0.49	0.72	0.52	0.64	0.57	(0.20)	0.12	(0.07)
Trust*	**24.62**	**24.43**	**24.72**	**24.42**	**25.00**	**25.17**	**25.24**	**25.11**	**24.68**	**0.07**	**(0.13)**	**(0.44)**
Hosted*	**2.77**	**2.85**	**2.69**	**2.60**	**3.07**	**2.88**	**2.76**	**2.76**	**2.79**	**(0.12)**	**(0.00)**	**0.03**
Total	27.38	27.28	27.41	27.02	28.07	28.05	28.01	27.87	27.47	(0.04)	(0.13)	(0.41)

It is pleasing to note that the month-on-month reduction in total pay expenditure has now been sustained for a 2nd consecutive month with the Trust paybill reducing to its lowest level since July 2016. This would suggest that the spike occasioned in September and October and reflecting increased recruitment activity in this period is now tapering off with the enhanced controls and greater scrutiny being applied to all areas of pay expenditure beginning to deliver positive results.

The biggest decrease in month 9 has been in Corporate Services. This in part reflects the reduction in costs incurred in Month 8 as a consequence of capitalising the training costs within SmartCare.

Pay expenditure by division

Pay Analysis Divisional	Budget £000's	Substantive £000's	Bank £000's	Agency £000's	Total £000's	Variance £000's
Surgery	62,052	59,682	1,857	2,912	64,451	(2,400)
Medicine	48,349	43,883	2,942	10,605	57,429	(9,080)
D&S	46,606	44,779	534	590	45,904	703
W&C	24,580	24,000	827	1,206	26,033	(1,452)
EFD	9,938	9,829	646	63	10,539	(600)
Corporate*	39,612	39,318	899	1,855	42,072	(2,459)
Total Pay	**231,138**	**221,491**	**7,705**	**17,231**	**246,427**	**(15,289)**

* Includes Trustwide and hosted services

NB: The budget figures reflect those on the financial ledger and do not reconcile, either by cost category or phasing, to the NHSI plan.

Pay expenditure reflects the total expenditure across the Trust. It includes all hosted and shared services. In addition to the efforts being made to reduce Agency expenditure, work continues in relation to control and reduction of non-agency pay costs. This project now includes a number of work streams, all of which are overseen by the Executive Director of HR and OD and current progress is reported below:

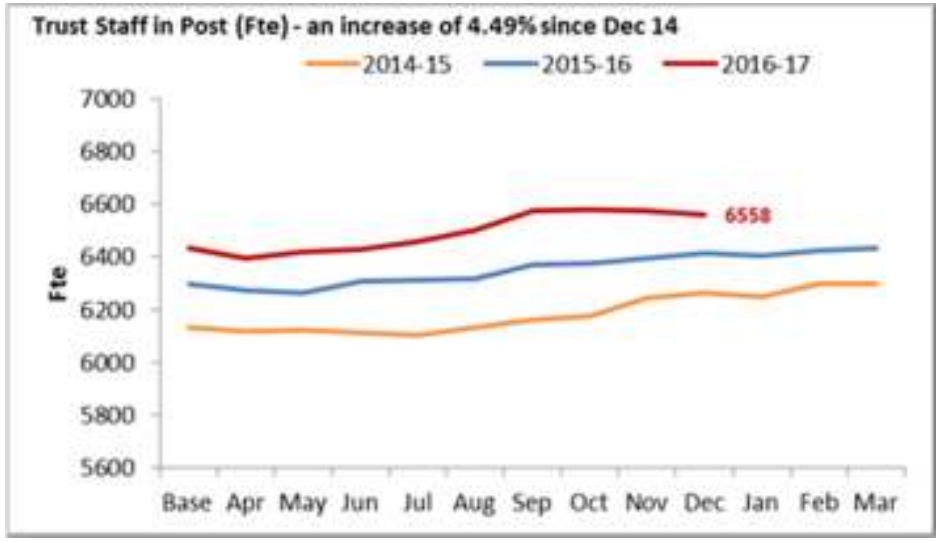
1. Executive Authorisation of non-clinical overtime has now been fully implemented
2. The Vacancy Control Panel (VCP) meets weekly for 2-3 hours. Whilst there is a high approval rate (currently 90%), data is being collated on the divisional approval rates.
3. Review of HR Policies (selling annual leave, mileage rates, organisational change)
4. Promotion of Salary Sacrifice opportunities in final quarter in light of changing regulations
5. Review of annual leave accrual and future reduction in annual leave policy of 'carry forward' amounts
6. Nursery income generation – suggested increase in charges
7. Change of notice periods for Band 5 staff (increase to 8 weeks) implemented for new starters and undergoing consultation for existing staff
8. Increase in number of apprenticeships both to offset the expected Apprenticeship Levy and build a steady pipeline for our future workforce
9. Recruitment income generation, including charging for DBS Checks

Agency Spend

The focus on reducing Agency Spend continues through the Agency Programme Board (chaired by the Executive Director of HR and OD), through which a comprehensive programme of actions designed to reduce agency spend is being tracked and managed. It is extremely pleasing to see that progress is being made; agency spend in Month 9 reduced to its lowest level since Month 3. This may be in part due to differing operational arrangements over the Christmas period, but it is hoped that the significant efforts being expended through the Agency Programme Board are also beginning to deliver results., particularly in Nursing. Similar traction now needs to develop In Medical Agency reductions.

Agency Category	M1 £000s	M2 £000s	M3 £000s	M4 £000s	M5 £000s	M6 £000s	M7 £000s	M8 £000s	M9 £000s
Nursing	1,294	959	755	1,012	1,052	650	968	628	616
Medical	420	552	509	487	873	835	937	704	803
Scientific, Professional & Technical (inlcuding AHPs)	117	144	241	135	111	137	118	103	86
Ancillary	5	11	15	2	10	5	6	0	10
Admin, Clerical & Management	152	225	143	128	165	188	178	536	208
Total Expenditure	1,988	1,891	1,663	1,764	2,211	1,816	2,209	1,971	1,721

Staff in Post



Division - Establishment - Month 9	Funded WTEs	Contracted WTEs	Worked WTEs	Paid WTEs	Funded less contracted WTEs
Surgery	1,815	1,746	1,771	1,856	70
Medicine	1,508	1,377	1,504	1,554	131
D&S	1,641	1,571	1,558	1,575	70
W&C	707	713	713	764	(6)
EFD	497	480	509	553	16
Corporate*	1,112	1,191	1,144	1,148	(79)
Total WTEs	**7,281**	**7,078**	**7,200**	**7,450**	**202**

* Includes Trustwide and hosted services

Gloucestershire Hospitals NHS
NHS Foundation Trust

Detailed analysis of the substantive staffing levels reveal that since 31 March 2016 there has been growth in the number of substantive Nurses, HCAs and Doctors, accompanied by a decline in the number of substantive administrative and clerical staff (reduction of 18 WTE since March 2016). This is really positive in that it demonstrates that the reduced spend is being delivered not by a reduction in clinical staff numbers, but by a reduction in non-clinical staff numbers and a reduced reliance on high-cost temporary clinical staff (on the basis that substantive staffing numbers have increased).

We are pleased to report continued positive progress with Nurse recruitment; vacancies for Registered Nurses at Band 6 have reduced in all Divisions, and have reduced or remained static for Registered Nurses at Band 5 in D&S, Surgery, and W&C. However, vacancies at Band 5 have increased in Medicine by 14.62 WTE and as a consequence this will be an area of particular focus for the coming months. We have also worked to re-balance HCA staffing levels following a deliberate over-establishment at this grade earlier in the year.
The table shows the current M9 FTE data against the establishment. **Definitions:**

- **Establishment** – the FTE value held within the financial ledger to reflect budget
- **Contracted WTE** – reflects contracted substantive WTE
- **Worked WTE** – reflects WTE's worked within the month, includes bank and agency
- **Paid WTE** – reflects WTE's paid in the month (includes premiums, unsocial hours etc. – converted to WTE)

It is pleasing to see in this context that whilst the 'worked' number of WTE'S reduced in the month by 26, the 'paid' number reduced by 137.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee are asked to :

- NOTE the contents of this paper and APPROVE the actions being taken

Author: **Sarah Stansfield, Director of Operational Finance; Eve Russell, Associate Director of HR**

Presenting Director: **David Smith , Director of Human Resources and Organisational Development**

Date: **January 2017**

Appendices

- Agency Programme TIB update (17.01.2017)
- Pay Grip TIB update (17.01.2017)

Agency

Accountable Officer: Dave Smith, Director of HR/OD
Date Completed: 13.01.2017
For TIB on: 17.01.2017

2016/17 Summary						2017/18 Summary			
Pre-FRP Target (£k)	Actual (£k)	FRP Target (£k)	Actual (£k)	No. of Level 5 Schemes	No. of Pipeline Schemes	FRP Target (£k)	Actual (£k)	No. of Level 5 Schemes	No. of Pipeline Schemes
3,000	560	565	565 (forecast per PID)	0	2	2,584	2,584 (forecast per PID)	0	2

2016/17 – Scheme Detail:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes				2		2
Value (£k)				565		565

- There are 4 PIDs dealing with Agency, being the 4 workstreams ie Nursing, Medical, Workforce, and Operations. These have been aggregated into 1 scheme for TIB reporting purposes

2017/18 Scheme Detail:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes				2		2
Value (£k)				2,584		2,584

- Figures shown above are cumulative savings (whilst FRP reports non-cumulative savings)

Delivered since previous TIB:

- Progression of PID documents to level 4, with QIA pending completion. FY1718 PIDs drafted and progressed to level 4

Plan for next period:

- Confirmation of completion of discussions with medical locums around conversion to substantive
- Nursing – Incentivisation proposal to be finalised
- Side by side review of Great Western/Swindon plans
- Medical - Master Vendor financial assessment and review

Key Risks to Delivery:

Risk:	Mitigation	Owner
Operational pressures necessitating need for temp staff	Strong authorisation process	Execs
Continued use of unfunded/escalation areas	Concerted action on reviewing bed base	NS
Limited resource in Finance to support the Agency programme workstreams	CIP office support now in place	DS

Pay Grip

Accountable Officer: Dave Smith, Director of HR/OD
Date Completed: 13.01.2017
For TIB on: 17.01.2017

Gloucestershire Hospitals NHS
NHS Foundation Trust

2016/17 Summary						2017/18 Summary			
Pre-FRP Target (£k)	Actual (£k)	FRP Target (£k)	Actual (£k)	No. of Level 5 Schemes	No. of Pipeline Schemes	FRP Target (£k)	Actual (£k)	No. of Level 5 Schemes	No. of Pipeline Schemes
0	0	614	584 (forecast per PID)	0	8	1,780	1,730 (forecast per PID)	0	8

2016/17 – Scheme Detail:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes	1	1		6		8
Value (£k)	0	0		584		584

- Increase revenue from nursery scheme (at level 1) has moved across from Corporate PID to Pay Grip.
- New recruitment income generation pipeline scheme has been worked up, and is at level 2, delivering in FY1718

2017/18 Scheme Detail:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes	1	1		6		8
Value (£k)	30	60		1,640		1,730

- Retention Payments challenge has decreased from £120k to £10k, owing to lack of success in removing historic RRPs at Reward Strategy Group meeting in December.
- (Note that figures above are cumulative, whilst FRP shows non-cum)

Delivered since previous TIB:

- Progression of PID documents to level 4, with QIA pending completion. FY1718 PIDs drafted and progressed to level 4

Plan for next period:

- Annual leave accrual basis of calculation to be finalised
- Promotion of salary sacrifice schemes – communication to be issued to all staff
- Side by side review of Pay grip initiatives completed at Great Western
- Implement changes to mileage and business travel policies

Key Risks to Delivery:

Risk:	Mitigation	Owner
Retention issues	Offer non-cash incentives	DS
Compliance with notice period policy	Establish controls to ensure compliance	DS

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST WORKFORCE COMMITTEE HELD IN THE BOARD ROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON FRIDAY 2 DECEMBER 2016 AT 3PM

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT	Tracey Barber	Non-Executive Director (Chair)
	Keith Norton	Non-Executive Director
	Dave Smith	Director of Human Resources and Organisation Development
	Maggie Arnold	Nursing Director
	Dr Sean Elyan	Medical Director
	Eve Russell	Associate Director of HR
	Sean Ceres	Finance Department for Sarah Stansfield, Director of Operational Finance
GOVERNOR	Carol McIndoe	Staff Governor
APOLOGIES	Sarah Stansfield	Director of Operational Finance
IN ATTENDANCE	Martin Wood	Trust Secretary
	Craig Mcfarlane	Head of Communications

The Chair welcomed the members of the Committee to the meeting. She thanked Keith Norton for his work as Chair of the Committee.

019/16 DECLARATIONS OF INTEREST **ACTION**

There were none.

020/16 MINUTES OF THE ADJOURNED MEETING HELD ON 16 SEPTEMBER AND THE RE-CONVENED MEETING HELD ON 14 OCTOBER 2016

RESOLVED: That the minutes of the adjourned meeting held on 16 September and the re-convened meeting held on 14 October 2016 were agreed as a correct record and signed by the Chair subject to the addition of Carol McIndoe and Rob Randles to the list of Governors present for both meetings.

021/16 MATTERS ARISING

013/16 WORKFORCE STRATEGY:

The Associate Director of Human Resources asked Mr Randles to share with her examples of where there were issues regarding generic recruitment. The Associate Director of Human Resources reported that

there was no HCA agency used in the last two weeks. The Chair said that these circumstances should be considered further at the next meeting of the Committee.

The Director of Human Resources and Organisational Development undertook to develop the tracker and circulate it to the Committee for comment during the forthcoming week so that it could be completed by the end of October 2016.

The Chair said that both of these matters will be developed as part of the Workforce Strategy. Completed.

016/16 ANY OTHER BUSINESS – RISK MANAGEMENT GROUP:
The Director of Human Resources and Organisational Development reported that a new Risk Management Group has been established reporting to the Trust Leadership Team. The Committee at their next meeting should consider workforce risk. *The Chair said that risks relating to workforce should be reported to the Committee and that this should form a standing agenda item. Completed.*

ER
(MW to note for agenda)

022/16 REVIEW OF TERMS OF REFERENCE

The Chair presented the Terms of Reference and Governance Structure for the Committee which had been approved by the Board in October 2016. She invited the Committee to consider whether any further adjustments were necessary in the light of the Committee's working arrangements.

During the course of the discussions, the following adjustments were made:-

Frequency of Meetings:
Monthly to the end of the 2016/17 financial year and bi-monthly thereafter.

Governor Representative:
One staff Governor (currently Carol McIndoe) and one public or patient Governor (to be determined).

Quorum:
One NED and one clinical, financial and human resources representative.

6. Identify risks associated with workforce issues ensuring ownership with mitigating actions, escalating **risk registers** to Trust Board as required.

Sub-Committees:
Add staff side County groups. Additionally, the notes of County Sustainability and Transformation Plan notes relating to workforce issues will be presented to the Committee.

RESOLVED: That the Committee's Terms of Reference be approved subject to the above amendments.

023/16 REVIEW OF ANNUAL WORKPLAN

The Associate Director of Human Resources presented the Workforce Annual Agenda.

During the course of the discussion, the following were the points raised:-

- The Chair said that the Sustainability and Transformation Plan regarding workforce issues should be included at appropriate intervals with risks being highlighted under the Risk Register Review.
- Mr Norton said that Committee meetings should provide sufficient time to discuss real issues rather than being presented with too many items for discussions.
- The Medical Director said that to ensure oversight on medical education, Dr Kim Benstead is to attend the meeting in January 2017. He also enquired whether the Committee wished to receive reports from other staff groups such as Nurses and AHPs to ensure that their voice is being heard. In response, the Director of Human Resources and Organisational Development said that the Education and Learning Development Committee is to report to the Committee and presentations from other staff groups can be scheduled to the Committee's Workforce Annual Agenda to ensure transparency. **DS (MW to note for agenda)**
- In response to a question from the Finance Department Representative, the Director of Human Resources and Organisational Development said that Staff Survey issues would be captured as part of staff engagement.
- The Associate Director of Human Resources said that there are a number of inter-relationships with the reports from the Committee and it may be that these can be consolidated for the meeting in January 2017. **ER**
- The Chair said that for the first three months of 2017 the Committee should receive reports on all areas and that a review of reporting be undertaken at the meeting in March 2017. **DS (MW to note for agenda)**

The Chair thanked the Associate Director of Human Resources for the report.

RESOLVED: That the Workforce Annual Agenda be approved subject to the above amendments.

024/16 WORKFORCE REPORT

The Director of Human Resources and Organisational Development presented the report providing an overview of the workforce performance of our Trust at the end of month 7 of the 2016/17 financial year. It provided information on the continuing overspend on pay (including agency) costs, movements in headcount as well as further information on two of the key drivers of spend, turnover and sickness. The key issues to note were the continuing overspend on pay which represented one of the largest threats to the financial position of our Trust at the end of month 7 with a reported variance of £13.3M of which more than 50% is made up of overspend in Medicine Division. Within this overspend, agency expenditure of £13.5M reflects the largest

concern. There are signs of increased grip, particularly within nurses and this traction needs to be maintained and extended to the other workstreams managed by the Agency Programme Board. A significant increase in pay expenditure was noted between months 5 and 6. Whilst some of this was a timing issue, including the new intake of junior doctors and a cohort of newly qualified nurses, the overall increases in headcount from the beginning of the financial year have not yielded reductions in temporary staffing costs. Significantly greater control to all elements of the pay bill needs to be exerted at both corporate and divisional level. A Vacancy Control Panel process has been introduced which scrutinises every request for a new hire and also encapsulates any request where an increase in pay would be the outcome. A detailed review of the workforce spend is being undertaken with the Finance Team.

(The Head of Communications joined the meeting)

During the course of the discussion, the following were the points raised:-

- The Trust Secretary was invited to arrange a meeting with the Chair of the Committee, the Chair of the Quality and Performance and Finance Committees, and the Chair of the Trust to determine which aspects of the workforce agenda were presented to which committee. **MW**
- Mr Norton enquired to the extent to which budget holders know their responsibilities to deliver workforce savings. In response, the Director of Human Resources and Organisational Development said that he is not the custodian of the individual budgets which is a matter for individual budget holders to manage. He referred to the work undertaken by KPMG on the workforce analysis. There is a planned reduction of £610k before year end in workforce costs. Our Trust is undertaking discussions with the Trade Unions to extend the notice period for Band 5 staff which will impact on the 2017/18 run rate.
- The Chair observed that if deadlines for completion of the actions slipped, this will adversely affect the savings programme.
- The Chair acknowledged the considerable task and asked what assistance was required to deliver. In response, the Director of Human Resources and Organisational Development said that staff resources to deliver the task is the issue and resources have now been provided for two days per week to assist the agency workstream. He acknowledged the comprehensive assistance provided by KPMG and the Cost Improvement Programme office. This was reinforced by the Committee.
- The Chair referred to sickness absence and staff turnover and asked what assurance could be provided to the Committee that these areas of activity are being actively managed. The Director of Human Resources and Organisational Development said in response that we compare well with other large acute Trusts and the information will be presented to the Committee in January 2017. **DS**
- With regard to staff turnover, the Director of Human Resources and Organisational Development referred to the headcount

tracker which demonstrated that the headcount was down but there was no corresponding decrease in agency spend. This will be addressed by the Vacancy Control Panel and the challenge to Divisions is to ensure that our Trust has the right level of staff which may necessitate re-configuring roles.
- Mr Norton stressed that for future reports there should be conclusion on the data.

The Chair thanked the Director of Human Resources and Organisational Development for the report.

RESOLVED: That the Committee:-

1) Note the contents of the paper;
2) Approve the actions listed in relation to the delivery of the Cost Improvement Programme and the support to the Financial Recovery Plan through workforce savings and efficiencies.

025/16 AGENCY/TEMPORARY STAFFING

The Director of Human Resources and Organisational Development presented the report setting out the Governance arrangements for the Agency Programme. He said that he chairs the Agency Programme Board and other members are the Nursing Director, the Medical Director, the Director of Operational Finance, the Associate Director of Human Resources and Paula Perks. The Board meets on a weekly basis. The Recovery Board has yet to meet and will be chaired by the Chief Executive.

During the course of the discussion, the Chair said that the Committee will need to seek assurance that the meetings in the structure are taking place and that the processes are being followed.

The Chaired thanked the Director of Human Resources and Organisational Development for the report.

RESOLVED: That the governance arrangements for the Agency Programme be noted.

The Director of Human Resources and Organisational Development then presented the NHS Improvement South monthly Regional Agency Performance Report for September 2016. This was the such Performance Report providing a monthly update to Trusts with further information in the region on combined efforts to reduce spend on agency staff. The document will allow our Trust to see how it and its peers are performing on key agency metrics and provides updates on support available and steps to take to maintain the momentum.

During the course of the discussion, the following were the points raised:-

- The Nursing Director stressed that there are different operating models in each Trust and therefore it is difficult to compare the data to obtain a reasonable comparison. Information on the

percentage of Nurses to beds was not available.

- The Medical Director emphasised that Junior Doctors are allocated by the Deanery which traditionally disadvantaged non-teaching hospitals who are required to use a greater number of agency staff to maintain safe services.
- The Director of Human Resources and Organisational Development drew a comparison with Gloucestershire Care Services where beds are not being opened as escalation beds and thereby leading to difficulties in data comparison.

The Chair thanked the Director of Human Resources and Organisational Development for the report.

RESOLVED: That the report be noted.

026/16 WORKFORCE STRATEGY COMMUNICATIONS PLAN

The Head of Communications circulated the Communications and Engagement Activity Map for 2016/17 as part of the Workforce Strategy. He explained the Communications and Engagement Activity was from November 2016 to March 2017 building on existing work, for example our Trust as an Employer of Choice and the professional edge to communications work. There are nine sub-groups to the Work Programme.

During the course of the discussion, the following were the points raised:-

- Mr Norton questioned whether the resource investment in branding the Communication Strategy could be better used. In response, the Director of Human Resources and Organisational Development said that it was right to inform staff of the Workforce Strategy and the monthly discussions on certain issues. The Strategy should be a live document although he acknowledged the balance between branding and use of resources.
- The Chair referred to the nine key messages in the sub-groups and the description of the work required to cascade those messages enquiring about the capacity to deliver. In response, the Head of Communications said that as far as possible the Strategy is being regarded as business as usual but the resource constraints will be reflected in what can be undertaken. The Director of Human Resources and Organisational Development added that it is the responsibility of the identified leaders to deliver the Strategy with implementation reports being presented to the Committee. Discussions will take place to ensure that the Communications and Engagement message is cascaded. The Chair suggested that internal Communications Champions could be identified to cascade the Strategy.
- The Chair said the Strategy should be reviewed in March 2017. **CM (MW to note for agenda)**

The Chair thanked the Head of Communications for the report.

RESOLVED: That the report be noted.

027/16 REPORTS FROM SUB-COMMITTEES

The Committee received the reports from the following sub-committees:-

AGENCY

The Director of Human Resources and Organisational Development circulated the Agency Reduction Report. In Quarter 2 the substantive full time equivalent (FTE) increased by 158 whilst temporary spend (bank and agency) increased by 1% from Quarter 1 to Quarter 2. The gap between actual FTE and establishment has closed significantly, being 265 FTE in March 2016 and recognising that there is an over-establishment of HCAs which our Trust needs to reverse, the vacancy position has closed to approximately 150.

During the course of the discussion, the following were the points raised:-

- The Nursing Director referred to the over-establishment of HCAs stating that some will be taken out from the workforce figures to undertake intensive training to obtain their examination in accordance with the English Language Education Test System (IELTS) and then to be appointed to fill Band 5 vacancies. There is a risk to this process due to the difficulty in being successful in the examination.
- The Medical Director said that medical agency spend is being scrutinised before recruitment takes place. There have been reductions in medical agency spend which has then increased. The workforce is being re-designed and there is a risk of double counting. He stressed the strong focus to reduce medical agency spend. The Director of Human Resources and Organisational Development stressed that our Trust must not let the quality of care suffer due to our financial position and this message needs to be reinforced with staff.
- The Associate Director of Human Resources referred to incentives for staff to become bank staff by more frequent payments for undertaking that work.
- The Nursing Director and the Director of Human Resources and Organisational Development expressed greater confidence in reducing agency expenditure with the transfer of more staff to Trust employees and tighter controls around the procurement of locums..

RECRUITMENT

The Associate Director of Human Resources circulated the priority tracker for the Recruitment Strategy Group. The two clear objectives for the group are to reduce Band 5 vacancies from 15.5% to 13% by 31 March 2017 and to reduce turnover of Band 5 nurses from 16.2% to 15% (run rate) by 31 March 2017. The offers of appointment to candidates recruited in the Philippines are conditional upon them obtaining the ILETS which is a slow process. The Band 5 nurses' turnover rate has reduced to 9.9% which, if confirmed, will be promoted as a good news story.

The Medical Director said that entry criteria for both consultants and nurses should be undertaken along the lines of why they applied for positions in our Trust and what should our Trust do to keep them here. He added that social media is a good avenue for appointment to Clinical Fellow positions.

The Chair suggested that the tracker should contain details of target dates for the actions and leads.

EMPLOYEE ENGAGEMENT

The Director of Human Resources and Organisational Development reported on employee engagement, commenting that over 50% of staff have so far completed the Staff Survey. The focus is on developing travel plans which is a form of engagement but may delay the identification of solutions.

In response to a question from Mr Norton, the Director of Human Resources and Organisational Development said that employee engagement has improved tear on year but due to the timing of Staff Surveys, the results are a reflection of a moment in time and given how swiftly events happen, may be out of date by the time they are published.

JOINT STAFF CONSULTATIVE COMMITTEE

The Director of Human Resources and Organisational Development reported on a constructive meeting on the Joint Staff Consultative Committee where PRIDE, finance, patient flow and travel had been discussed. The outcome was generally positive. There was a further agreement to meet to discuss some of the challenging decisions which may have workforce implications going forward.

REWARD

The Director of Human Resources and Organisational Development said that a meeting is to be held later in December 2016 to review recruitment and retention premia.

The Chair thanked the Director of Human Resources and Organisational Development and the Associate Director of Human Resources for the reports.

RESOLVED: That the reports be noted.

028/16 ITEMS FROM THE BOARD OR OTHER COMMITTEES

WORKFORCE STRATEGY PRIORITIES

The Chair commented that Key Performance Indicators are included in the Workforce Strategy which will be developed within existing resources and reviewed in March 2017. **DS (MW to note for agenda)**

ITEMS FROM THE BOARD OR OTHER COMMITTEES

The Committee noted that there was a Non-Executive Director

membership overlap between the Committee and the Quality and Performance and Finance Committee. The Nursing Director commented that staffing issues on Ward 7A are to be presented to the Quality and Performance Committee in December 2016 as requested by the Board.

029/16 QUESTIONS FOR OURSELVES

The Chair said that as part of the Committee's Annual Work Plan it is important that assurance is provided to the Committee at each meeting by asking the following three questions:-

1) Are we clear this month where we should be focussing on as a business?
2) Are we clear what our successes are?
3) Impact of discussions on Recovery Plan?

In asking those questions the Committee concluded the following in response to each questions:-

1) Yes
2) It is importance to focus on successes especially the reduction in Nursing vacancies to 9.9%, if confirmed, which is above the trajectory.
3) Noted that there are issues around capacity to deliver the Communications and Engagement Activity Map. The Nursing Director added that there are capacity issues in the whole local health system particularly staffing issues for patients to be transferred to Community Hospitals. Mr Norton stressed that the impact on the staffing numbers should not be double counted.

030/16 COMMITTEE REFLECTION

This was dealt with in minute 029/16 above.

031/16 ANY OTHER BUSINESS

SCHEDULED MEETING DATES FOR 2017
The Trust Secretary circulated details of scheduled meeting dates for 2017.

RESOLVED: That meetings of the Committee on 2017 should take place as follows:-

Friday 6 January 2017 – 2pm – Board Room – Alexandra House
Friday 3 February 2017 – 2pm – Board Room – Alexandra House (From Thursday 2 February 2017)
Friday 3 March 2017 – 2pm – Board Room – Alexandra House
Thursday 6 April 2017 – 2pm – Board Room – Alexandra House
Friday 9 June 2017 – 2pm – Board Room – Alexandra House
Thursday 3 August 2017 – 2pm – Board Room – Alexandra House
Thursday 5 October 2017 – 2pm – Board Room – Alexandra House
Thursday 7 December 2017 – 2pm – Board Room – Alexandra House

032/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospital's Foundation Trust's Workforce Committee will be held on **Friday 6 January 2017** at **2pm** in the Board Room, Alexandra House.

Papers for the next meeting: Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Tuesday 3 January 2017.**

The meeting ended at 5:13pm.

Chair
6 January 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING TUESDAY 31ST JANUARY 2017
Sandford Education Centre, Cheltenham General Hospital commencing at 9.00 a.m

Report Title									
NURSE AND MIDWIFERY STAFFING **January 2017**									
Sponsor and Author(s)									
Maggie Arnold – Executive Director of Nursing and Midwifery									
Audience(s)									
Board members	**x**	Regulators	**x**	Governors	**x**	Staff	**x**	Public	**x**

Executive Summary

Purpose

The purpose of this report is to provide assurance to the Trust Board in respect of nurse staffing levels for December 2016, against the compliance framework *'Hard Truths' – Safer Staffing Commitments*.

Key issues to note

- All Divisions are reporting a deterioration in their Harm Free Care ratings compared to the prior month and further work is required to understand the correlation between this picture and staffing levels.
- The individual divisional report comment in detail where staffing hours are either lower than the centile set by NHS England, *or over, alongside the rationale behind these findings and any associated impact on care quality.*
- A second nurse staffing benchmark exercise against the Hurst Staffing Database has been undertaken.
- A reduction for month 8 in Nursing and Midwifery Agency spend and downward trend in year.
- A revised 'stretch target' RAG report for Harm Free care has been developed
- The NHS Improvement 'Model Hospital' database has been accessed, and high level comparators are within this report, but a more detailed report will form part of the February 2017, Safer Staffing report.
- That a meeting has been held with Professor Mark Radford, Director of Nursing, NHS Improvement, to discuss nursing developments. That a letter following that meeting has recently been received and will form the basis of an action plan for the February 2017 report
- There continues to be close scrutiny of agency spend and recruitment and an update on progress is demonstrated. Weekly meeting are now scheduled for the Executive Nursing Director and Divisional Nursing Directors to oversee the agency reduction action plan
- That an attempt at correlation of the Safer Staffing report and Harm Free care data has been made.
- As stated, the divisional nursing directors have analysed their department's data and have individually responded for the purpose of this report.
- The deep dive into ward 7a has now been reported to Quality and performance committee and the conclusion was that it should be submitted to trust Leadership team in February to ascertain next step refunding requirements.

Conclusions, implications and Next Steps

In summary, the use of agency staff continues to reduce and whilst there is no evidence that this has directly resulted in a reduction in the safety or quality of nursing care there are some concerning features of performance in December with all four Divisions showing a deterioration in the measures of Harm Free Care. Further work has been instigated to look at the drivers for this deterioration and to

develop further assurance for the Board that this is not linked to staffing levels. Of note, further work is now being undertaken to review the methodology underpinning the judgements regarding correlation between harm and staffing levels.

Recommendations

The Board is asked to receive this report as a source of assurance that staffing levels across the Trust are not impacting adversely on safe care. In light of the harm free care indicators, it is recognised that for this month only "limited assurance" can be provided pending further work.

Impact Upon Strategic Objectives

Patient numbers and the required increase staffing to care for them impacts both on patient experience and on finance.

Impact Upon Corporate Risks

Delivery of safe, substantive staffing impacts of a number of identified risks including quality of care and financial risks.

Regulatory and/or Legal Implications

The Trust's regulator, NHSI have set a cap for Trust spending on agency staffing, which the Trust is currently breaching.

Equality & Patient Impact

No specific patient group is impacted by this report.

Resource Implications

Finance	X	Information Management & Technology	
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

NURSE AND MIDWIFERY STAFFING
JANUARY 2017

1 Purpose

The aim of this paper is to update our Trust Board on the exception reports made regarding compliance with the 'Hard Truths' – Safer Staffing Commitments for December 2016.

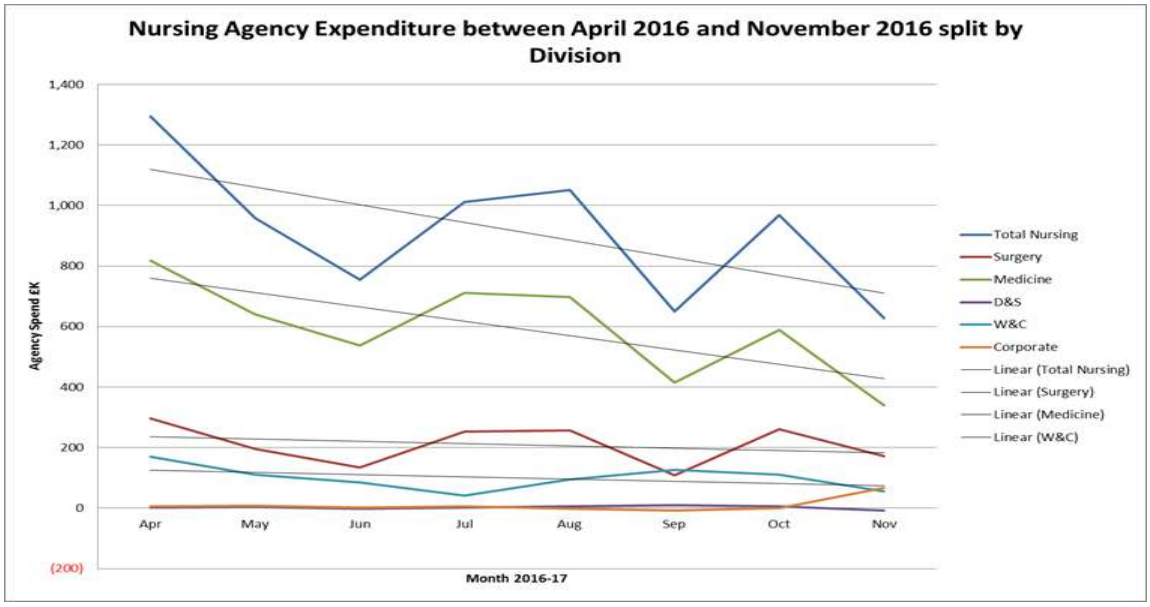
2 Background

Monthly reports have been submitted to our Board on our nursing and midwifery staffing numbers. Information has been uploaded onto the UNIFY system as required as have links to NHS Choices. Information is also available on our own Trust website and now includes data regarding care hours per patient day as per as explained in last month's Board paper.

3 Findings

3.1 With regard to the over establishment of band 2 and 3 budget lines (and the reasons for this) the divisions are now looking to move, particularly overseas nurses awaiting Nursing and Midwifery Council registrations into upcoming band 2 and 3 vacancies. There has been some reduction therefore in the budget report, for month 8, in the level of over-establishment of these banded staff. The situation will continue to be reviewed and worked upon

3.2 Nursing Agency has again reduced in the Month 8 period, and continues to be monitored at Divisional level, through initiatives such as daily conference calls around staffing shortfalls (and redeployments) and requests for framework agency through Divisional Nursing Directors, and, escalation to non-framework agencies via executive agreement.



3.3 As requested from the Francis Review, and mandated by NHS Improvement, as part of the bi-annual benchmark of nursing staffing, in December 2016, a further review was undertaken (appendix 1). There is usually little change expected, given funded establishments are set by this time, and the benchmark methodology used (Hurst) is not refreshed mid-year. Nevertheless, the report highlights the changes with wards 2a, 4a and 9a at Gloucestershire Royal Hospital, with the change to specialities within the wards. Of special note, these wards will also undertake a paper based patient acuity exercise during January, 2017, to ensure benchmarked averages for staffing, meet the actual patient acuity within these areas. In essence the majority of ward establishment match the suggested averages of the Hurst methodology. There are a few wards that, from the benchmark, require review and possibly further investment. Of note are the Acute Care Units, Ward 8a (Neurology), and ward 3b (trauma and orthopaedic). There is an allocation of resource, and both the Medical and Surgical Division can access these monies once staff are recruited into the establishment. The benchmarking exercise will again be repeated in June 2017, with a following Board Report.

3.4 Following a meeting with Professor Mark Radford, Director of Nursing, NHS Improvement, the Trust has now access to the 'Model Hospitals' database. This is a national comparator database. In addition to comparisons with 'Clinical Service Lines', such as Orthopaedic Surgery, and 'Operational', such as Pharmacy and Medicines, and Estates and Facilities, the database has a 'People' element which includes Nursing and Midwifery. Whilst this indicator is still in development, the Trust is able to compare fairly high level data (so at Trust level, rather than ward level). A full report on the comparisons will form part of the February 2017 report to Board, but in summary, the Trust compares favourably against a number of subject areas, but needs ongoing work on others. For example:-

- Cost per Weighted Acuity Unit – Cost of total registered nursing and midwifery is £625, with a National median of £710.
- Cost per Weighted Acuity Unit - HCA is £144 compared to £151 nationally.
- Care hours per patient day - Total nursing and midwifery low 6.91 compared to 7.76 nationally (which fits in with the finance above)
- Sickness absence is above the national (4.13%) compared to 4.21%
- Staff retention for HCA is low at 82.6% compared to 84.6% nationally
- Harm free care is below the national at 93.2% (94% nationally – higher better)
- Falls is higher 2.5% (1.6% nationally)
- Pressure ulcers (new) is at the national, both 0.8%
- New UTI is above at 1.8% (nationally 1%)
- Delayed transfers of care is higher at 2,233, compared to 925 nationally.

Additionally, following the meeting with Professor Radford, an action plan of other initiatives the Trust may wish to pursue has been received. Once considered, how the Trust plans to take these ideas forward will form part of the February 2017 report.

4 Divisional Safer Staffing Reports

4.1 Surgical Division

Nursing Metrics Focus
From a nursing metrics performance, all areas were GREEN, except ward 5b who submitted a partial report with some data missing. The Modern Matron for the ward has discussed this with the ward sister, and, a retrospective review has been completed showing no triggering around these elements of the metrics.

Safer Staffing Focus
The following wards are reported due to being exceptional from either an under or over provision.

Alstone	HCA 157.5%	This is a combination of covering RGN vacancies, and over-establishment of Band 2 and 3 overseas nurses.
2b	HCA 161%	Medical outliers of higher dependency requiring higher level of supervision (funded for 1 HCA at night)
DCC (both)	variable	Reflect staff internally flexing off at quieter times to cover periods of increased activity to avoid agency

Care Hours per Nursed Day Focus
We have now been provided access to the 'Model Hospital' database, as a comparison tool, as supplied by NHS Improvement. Data is not aggregated at ward level yet as this is "under development". It is anticipated that future development will allow speciality ward comparisons.

Harm free Care Focus
We have continued to develop an understanding of where we feature in comparison to other organisations. It should be noted there is no overarching 'national' RAG rating for HARM FREE and NEW HARMS therefore our Clinical Audit department have attempted to look at the national mean and develop a RAG scoring suggestion against that.

	Nat. Median			
Harm free	93.75%	92%+	91% - 89%	<88%
New harm free	97.62%	96%+	95%-94%	<93%
	Nat. Median			
Pressure ulcers (new)	0.99%	≤1.1%	1.2%-1.4%	>1.41%
Falls with harm	0.69%	≤1.09%	1.10%-1.59%	>1.6%
Catheter and UTI	0.80%	≤0.90%	0.91-1.30%	>1.31%
New VTEs	0.40%	≤0.50%	0.51-0.80%	>0.81%

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Harm free	94.4%	96.0%	95.6%	91.8%	89.6%	91.5%	92.6%	93.4%	92.3%	93.6%	94.2%	91.7%	90.9%	94.9%	91.0%
New harm free	97.6%	98.9%	98.4%	95.3%	96.5%	96.1%	98.5%	98.2%	97.4%	98.5%	98.2%	95.5%	95.1%	97.5%	95.3%
Pressure ulcers - new	1.59%	0.74%	0.40%	1.95%	1.54%	1.55%	0.37%	1.10%	1.48%	0.75%	1.08%	1.52%	0.75%	0.73%	0.39%
Falls with harm	0.00%	0.00%	0.00%	1.56%	0.39%	0.78%	1.11%	0.37%	0.74%	0.00%	0.36%	1.89%	1.51%	0.36%	1.96%
Catheter and UTI	2.78%	1.47%	1.59%	2.73%	1.93%	1.55%	1.48%	3.66%	1.11%	1.87%	1.81%	2.27%	3.02%	1.46%	1.96%
New VTEs	0.40%	0.37%	0.40%	0.39%	0.39%	0.39%	0.00%	0.37%	0.74%	0.37%	0.36%	0.38%	0.75%	0.00%	1.18%

There are three areas which 'trigger' for December, these being falls with harm, catheter and UTI, and new VTE. For falls the Division has used, and continues to use the 'Falls Swarm' methodology, to help identify key reasons for patient falls. There is ongoing work to look at peri-operative and post-operative use of catheters, and this work also supports the use of the Catheter Passport to ensure good clinical care of catheters.

The following wards are reported as to new harm triggers. Again, the percentage harm is against the patients within the ward at the time of the audit (2nd Wednesday of the Month). Therefore often there is one patient harm within the total audit, which caused an adverse score.

Ward	Harm free care	Reason for Trigger	Correlation with safer staffing concerns
Bibury (urology)	90%	2 patients with new UTI following catheterisation	No
DCC (CGH)	89%	1 patient fall with low harm (audit population 9 patients)	No
Guiting	89%	2 patient falls with low harm and 1 DVT (new VTE)	No
DCC (GRH)	90%	1 Pressure ulcer	No
3a	94%	1 patient fall low harm	No
3b	94%	1 patient fall low harm. 1 UTI following catheterisation	No
5a	95%	1 DVT (new VTE)	No

Finance and Vacancy Focus
The Agency spend fell in month, to £170.96k (£1.676m to date), and is below the trajectory set but both the Trust and NHS I. The main cause of Agency spending, as before, was the ongoing staffing for the use of unfunded areas, such as Day Surgery units, due to Black escalation. Bank spend is at £163.65k, which is a fall over last month, and again is used mostly to support vacancies within the RGN line.

Sickness levels, whilst above the Trust set average has risen this month and will continue to be worked upon. Turnover for RGN is within the national average. HCA turnover reflects a number of staff entering nurse training during the year.

The bottom line nursing staffing funded vacancy position within the division remains similar to last month at 12.65fte 'pure' bottom line vacancies. However, it must be remembered that the band 2/3 lines are over established with mainly overseas nurses (26.13 fte over) awaiting NMC registration. However, there has been a large reduction in this total since last reported, through moving these staff to cover Band 2 vacancies in other areas, and a number being successful in NMC registration which has correspondingly contribute to a fall in our Band 5 vacancies to 41.93 fte (52.59fte last month). Ongoing recruitment exercise are in place.

4.2 Medical Division

Nursing Metrics Focus
ED CGH did not submit data for this month – this will be addressed with the UC matron for CGH. Cleanliness remains a big challenge with activity on medical wards; the overall score has decreased from 35 in November to 33 in December so constant significant improvement is required. Hand hygiene also stands out in December as a challenging metric, 6 wards are RAG rated as red, with 13 wards RAG rated as green. This is concerning and is being picked up by the matrons for immediate action.

Targeted work to improve this position is planned to commence in February 2017. EWS Score and Action has improved with 18 wards RAG rated as green. Medication Errors have stayed the same with 8 in December, maintaining the RAG rating to red. Further work is required to understand the best methodology to adopt to improve. The overall pressure ulcer score stayed the same at 28 with 6 wards red in December 2016. This remains the same 6 wards – being Avening and Ryeworth at CGH and Cardiac, 7A, 8B and 9B at GRH. Pressure Ulcer stamps have now been introduced in all areas of the medical division throughout November/ December to identify patient problems during care rounding. Early feedback is positive, this will be audited alongside the metric data within medicine and reported back within the quality and performance report. Falls have increased from 39 in November to 42 in December across the division. However, this includes data from GWW1 which was not submitted in November.

Safer Staffing Focus

The following wards are reported due to being exceptional from either an under or over provision.

Woodmancote	Night 127.96% RGN's	Permission to increase establishment above funded position to maintain patient safety and experience particularly at night where there has been an increase in significant harm due to falls.
8A	Day 164.06% Care staff Night 203.23% Care staff	Specialling of patients who are risk assessed as requiring enhanced observation to prevent harm to self or others
9B	Day 132.47% Care staff Night 129.03% Care staff	Specialling of patients who are risk assessed as requiring enhanced observation to prevent harm to self or others
GW1	Day 135.48% Care staff Night 66.67% Care staff	Specialling of patients who are risk assessed as requiring enhanced observation to prevent harm to self or others

Care Hours per Nursed Day Focus

We have now been provided access to the 'Model Hospital' database, as a comparison tool, as supplied by NHS Improvement. Data is not aggregated at ward level yet as this is "under development". It is anticipated that future development will allow speciality ward comparisons.

Harm free Care Focus

We have continued to develop an understanding of where we feature in comparison to other organisations. It should be noted there is no overarching 'national' RAG rating for HARM FREE and NEW HARMS therefore our Clinical Audit department have attempted to look at the national mean and develop a RAG scoring suggestion against that.

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Catheter and UTI	0.80%	≤0.90%	0.91-1.30%	>1.31%
New VTEs	0.40%	≤0.50%	0.51-0.80%	>0.81%

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Harm free	92.6%	91.2%	89.2%	88.9%	89.6%	92.5%	93.6%	92.6%	92.1%	91.1%	92.2%	92.8%	91.5%	90.7%	91.6%
New harm free	97.9%	96.2%	96.8%	96.3%	95.8%	98.3%	98.6%	97.7%	97.5%	98.5%	97.3%	98.9%	97.3%	97.5%	95.7%
Pressure ulcers - new	0.24%	2.95%	1.51%	1.23%	1.04%	0.43%	0.80%	0.84%	1.04%	0.87%	1.83%	0.22%	1.54%	1.74%	2.37%
Falls with harm	1.44%	0.42%	0.86%	2.05%	0.84%	0.43%	0.00%	0.21%	0.83%	0.22%	0.00%	0.22%	0.58%	0.39%	1.29%
Catheter and UTI	0.72%	1.26%	1.08%	1.43%	2.09%	1.50%	1.00%	1.48%	2.28%	2.39%	0.69%	1.96%	1.93%	0.77%	0.65%
New VTEs	0.24%	0.00%	0.22%	0.00%	1.67%	0.21%	0.00%	0.21%	0.21%	0.22%	0.69%	0.22%	0.19%	0.19%	0.65%

There are three themes which 'trigger' for December; these being falls with harm, pressure ulcers and new VTE. For falls, the Division continues to monitor the number of falls by ward and time of day to identify trends and adjust staffing levels and skill mix to mitigate risk. This remains challenging with the level of vacancies the division is currently carrying. Several GOAM wards have had bespoke training with the physiotherapists to improve knowledge and skills to prevent falls. The division continues to hold monthly pressure ulcer meetings to review the root cause analysis of pressure ulcers. This supports shared learning and development and provides an opportunity for seeking assurance that continued work is ongoing to reduce pressure ulcer development and trust policy is followed and staff are compliant.

The following wards are reported as to new harm triggers. Again, the percentage harm is against the patients within the ward at the time of the audit (2nd Wednesday of the Month). Therefore often there is one patient harm within the total audit, which caused an adverse score.

Ward	Harm free care	Reason for Trigger	Correlation with safer staffing concerns
ACUA	95.83%	1 Low harm fall (24 Patients)	No
4B	96.00%	New PE (25 Patients)	No
6B	94.12%	1 Low harm fall (17 Patients)	No
7B	95.83%	1 Low harm fall (24 Patients)	No
8A	93.33%	2 New Cat 2 PU (30 Patients)	No
8B	96.55%	1 New Cat 2 PU (29 Patients)	No
GW1	92.31%	2 Low harm falls (26 Patients)	No

Of the 24 Medical wards 17 scored 100% and 7 scored below 100% for Harm Free Care.

Ward 7a Deep Dive.

In November Our Trust Board requested that a 'deep dive into ' ward 7a this was undertaken as this had triggered some concerns. The Quality and performance committee received the report in December and concluded that further consideration to increasing the staffing should be submitted to trust leadership team. Therefore the report will be tabled at that meeting for consideration in February; however it should be noted that data in December noted that ward 7a was not triggering any further concerns. Therefore the divisional team will continue to analyse data over a longer period of time to ascertain if this could be normal variation or real change in quality of care levels

Finance and Vacancy Focus

The spend on Qualified & Unqualified Agency is overall reducing, in Month 1 the spend in the month was £818k, in M8 in the month it is £340k. The actual agency hours worked in Month 1 were 11,406 hrs and in Month 8 there were 8,599 qualified hours worked and 441 hours unqualified worked. There are significant RGN vacancies across the Medical division with particular emphasis showing in unscheduled care, stroke and neurology, GOAM and gastroenterology.

The bottom line nursing staffing funded vacancy position, when comparing substantive funding against contracted, has risen to 44.37 FTE. However, it should be noted the band 2/3 lines are over established with mainly overseas nurses awaiting IELTS/ CBT/OSCE's to achieve their NMC registration (total unqualified over-established is 41.61 FTE over). The division continues to be actively involved in staff recruitment.

4.3 Diagnostics and Specialties Division

Nursing Metrics Focus
From a nursing metrics performance, Lilleybrook Ward is GREEN, Rendcomb Ward has only submitted a partial report with some data missing. The Modern Matron for the ward is discussing this with the ward sister and a retrospective review will be completed.

Safer Staffing Focus
The following wards are;

Lilleybrook	RGN 102% HCA 97%	GREEN
Rendcomb	RGN 102% HCA 98%	GREEN

Care Hours per Nursed Day Focus
We have now been provided access to the 'Model Hospital' database, as a comparison tool, as supplied by NHS Improvement. Data is not aggregated at ward level yet as this is "under development". It is anticipated that future development will allow speciality ward comparisons.

Harm free Care Focus
We have continued to develop an understanding of where we feature in comparison to other organisations. It should be noted there is no overarching 'national' RAG

rating for HARM FREE and NEW HARMS therefore our Clinical Audit department have attempted to look at the national mean and develop a RAG scoring suggestion against that.

	Nat. Median			
Harm free	93.75%	92%+	91% - 89%	<88%
New harm free	97.62%	96%+	95%-94%	<93%
	Nat. Median			
Pressure ulcers (new)	0.99%	≤1.1%	1.2%-1.4%	>1.41%
Falls with harm	0.69%	≤1.09%	1.10%-1.59%	>1.6%
Catheter and UTI	0.80%	≤0.90%	0.91-1.30%	>1.31%
New VTEs	0.40%	≤0.50%	0.51-0.80%	>0.81%

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Harm free	97.4%	89.7%	97.5%	97.3%	100.0%	97.5%	95.1%	91.1%	90.0%	91.4%	92.5%	97.4%	89.7%	100.0%	90.9%
New harm free	97.4%	92.3%	97.5%	100.0%	100.0%	100.0%	97.6%	100.0%	95.0%	100.0%	97.5%	97.4%	92.3%	100.0%	93.2%
Pressure ulcers - new	0.00%	7.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	0.00%	2.50%	2.63%	5.13%	0.00%	2.27%
Falls with harm	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	2.27%
Catheter and UTI	2.63%	2.56%	0.00%	2.70%	0.00%	0.00%	2.44%	6.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
New VTEs	0.00%	0.00%	2.50%	0.00%	0.00%	0.00%	2.44%	0.00%	0.00%	0.00%	0.00%	0.00%	2.56%	0.00%	2.27%

There are three areas which 'trigger' for December, these being falls with harm, new pressure ulcers, and new VTE. For falls with harm both wards undertake a route cause analysis to identify contributory factors, learning and an action plan is agreed.

The following wards are reporting new harm triggers. Again, the percentage harm is against the patients within the ward at the time of the audit (2nd Wednesday of the Month). Therefore often there is one patient harm within the total audit, which caused an adverse score.

Ward	Harm free care	Reason for Trigger	Correlation with safer staffing concerns
Lilleybrook	87.5%	1 patient with new pressure ulcer/fall	No
Rendcomb	95.0%	1 patient with new VTE	No

Finance and Vacancy Focus

The Agency spend fell and is currently year to date £21.8k. The use of Agency in D&S is minimal as both Oncology Wards have a high retention level and nursing vacancies are low. Bank spend is £14.8k which is a fall from the previous month and year to date is £153.6k, bank is mostly used to cover over running clinics and day case activity which has overrun due to the Trust being in black escalation and non-inpatient areas being opened. Agency is mostly used due to last minute sickness.

Sickness levels for RGN are below the Trust target at 2.03% and above the Trust target for HCA's at 3.81%. Turnover for RGN and HCA is below national average for this month.

The bottom line nursing staffing funded vacancy position within the division is 1.4fte 'pure' bottom line vacancies.

4.4 Women and Children's Division

Nursing Metrics Focus

The Division have recently started to collect a Paediatric and Maternity specific set of Safety Thermometer. These will be reported in the February 2017 paper.

Safer Staffing Focus

No areas within the Division 'triggered' red on the Safer Staffing return.

Care Hours per Nursed Day Focus

Intrapartum Maternity Care
In line with the recommendations with in Care HPPD in Maternity consideration has been given to how we monitor the collection of staffing data in areas providing intrapartum care namely the Delivery Suite and the Birth units at Gloucester and Cheltenham. However, the complexities have made it difficult to provide meaningful data in this same format as for other ward areas, as staffing levels in intrapartum areas need to fluctuate frequently according to activity. As a result it has been decided to present 1:1 care data for intrapartum care areas as this is collected on all women in all intrapartum care settings and provides a more accurate evaluation of staffing in these areas as it describes the number of women who have 1:1 care in labour. In November, overall 1:1 care in labour was 97.5%

Harm free Care Focus

Except for ward 2a (Gynaecology) all other areas are awaiting the Paediatric and Maternity specific Safety Thermometer data breakdown, where reporting will be in the February 2017 report.

Maternity and Children's in Patient Services
Maternity inpatients areas have moved to Maternity Specific safety thermometer and paediatrics moved to the paediatric thermometer, but no meaningful data is available at present.

To support this staffing data a midwifery led care dashboard is being developed in conjunction with a set of "Red Flag events" as described NICE NG 4 Safe midwifery staffing for maternity settings, that capture patient experience and outcomes and it is intended that this will be presented alongside the staffing ratios. This dashboard is under development. In addition, the birth rate plus acuity tool is currently used to monitor staffing on the high risk Delivery suite and alongside birth unit at Gloucester royal. The tool in its current format is not intended for use in other free standing birth units .The tool records staffing versus activity every 4 hours during the day and every two hours at night .

The Midwife to birth ratio is currently 1:29.6 across the Trusts acute and community based service, which is green on the obstetric Dashboard. The Dashboard is monitored monthly by the division alongside the aggregated outcomes from across the service, and outcome measures are bench marked with the South West Maternity dash board .The data is reviewed by the maternity clinical governance group and exceptions are escalated

	Nat. Median			
Harm free	93.75%	92%+	91% - 89%	<88%
New harm free	97.62%	96%+	95%-94%	<93%

	Nat. Median			
Pressure ulcers (new)	0.99%	≤1.1%	1.2%-1.4%	>1.41%
Falls with harm	0.69%	≤1.09%	1.10%-1.59%	>1.6%
Catheter and UTI	0.80%	≤0.90%	0.91-1.30%	>1.31%
New VTEs	0.40%	≤0.50%	0.51-0.80%	>0.81%

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Harm free	98.0%	100.0%	100.0%	100.0%	97.8%	95.1%	100.0%	97.9%	97.4%	100.0%	93.3%	95.5%	100.0%	98.0%	92.7%
New harm free	99.0%	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	97.9%	97.4%	100.0%	93.3%	100.0%	100.0%	100.0%	95.1%
Pressure ulcers - new	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.44%
Falls with harm	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.44%	0.00%	0.00%	0.00%	2.44%
Catheter and UTI	1.02%	1.06%	0.00%	0.00%	0.00%	0.00%	0.00%	1.00%	1.11%	0.00%	0.95%	1.20%	0.00%	0.00%	0.00%
New VTEs	0.00%	0.00%	0.00%	0.00%	0.00%	2.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Trigger reasons for ward 2a.

Ward	Harm free care	Reason for Trigger	Correlation with safer staffing concerns
2a	90%	1 patient with new pressure ulcer, 1 Fall with Moderate harm	No

Finance and Vacancy Focus

Agency spend for month 8 was £56.4k (£795.7k YTD). Bank spend was £78.0K (£684K YTD), both a reduction on month 7. Bank and agency spends were in the main to support the staffing issues around 2a (now resolved with the move to 9a), to cover midwifery vacancies, and the winter acuity within the Children's Centre. From a recruitment perspective, band 2 lines are 5.56 fte over, band 5 lines in balance, and band 6 lines (predominantly midwives) 10.8 fte under. Recruitment events are ongoing.

5 Nursing Workforce Metrics - Recruitment Update

5.1 UK / EU Recruitment

- There are currently 29.28 WTE experienced UK-based Band 5 nurses in the recruitment pipeline, with start dates up to 27 March 2017.
- There are currently 23.69 WTE Newly Qualified Nurses expecting to start between 30 January 2017 and 03 April 2017.
- Preparations are currently underway for the Summer 2017 recruitment campaign for Newly Qualified Nurses, with an interview date confirmed for Saturday 25 March 2017.
- Recruitment to the new Nursing Associate positions (15 WTE) is expected to commence next month, with an anticipated start date in March/April 2017.

- There are currently 16 advertisements live for substantive Band 5 Registered Nurses, plus adverts for Bank RGNs, a Specialist Nurse in Urology (Band 6), and for the Senior Sister in Endoscopy (Band 7).

5.2 Non-EU Recruitment

- The next group of nurses to sit the OSCE examination are scheduled for 17, 19 and 25 January 2017. We also have a group of 10 nurses due to join the Trust imminently.
- Additional charges will be payable by the Trust from 01 April 2017 to obtain a visa.

Status		Nov 15	May 16	Sep 16
Commenced employment	Passed the OSCE – Working as Band 5 Staff Nurse	5	0	0
	Failed the OSCE twice – Returning to the Philippines	1	0	0
	Not yet taken the OSCE – Working as Band 3	7	1	0
Subtotal (commenced employment)		**13**	**1**	**0**
Passed IELTS examination	CBT passed – Visa issued – Awaiting deployment	0	0	0
	CBT passed – Awaiting visa application	9	0	1
	CBT passed – Awaiting NMC Decision Letter	7	8	7
	Awaiting CBT examination	2	4	4
Subtotal (passed IELTS examination)		**18**	**12**	**12**
Not passed IELTS examination	Awaiting examination	52	66	148
	Application currently on hold	11	1	2
Subtotal (not passed IELTS examination)		**63**	**67**	**150**

5.3 Nursing Workforce Metrics

5.3.1 Vacancy Metrics

The number of unregistered nursing vacancies has significantly reduced during the last month, with a considerable reduction of Healthcare Assistants at Band 2 (from 66.13 WTE to 38.88 WTE) due to a recruitment freeze as part of the Vacancy Control Panel work. Recruitment will commence in early 2017 for more Healthcare Assistants to ensure that once the overestablishment has been managed, recruitment continues in line with turnover. Vacancies for Registered Nurses at Band 6 have reduced in all divisions, and have reduced or remained static for Registered Nurses at Band 5 in Diagnostics & Specialties, Surgery, and Women & Children. However, vacancies at Band 5 have increased in Medicine by 14.62 WTE. As the data is from 30 November 2016, all figures are before the planned ward changes affecting Wards 2a, 4a and 9a.

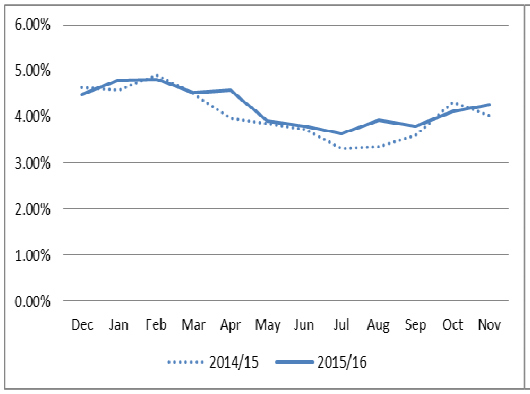
	Diagnostics & Specialties		Medicine		Surgery		Women & Children	
	WTE	%	WTE	%	WTE	%	WTE	%
Apprentice HCA	4.00	40.00%	7.00	38.89%	10.20	42.5%	2.00	40%
Band 2	3.45	6.74%	-18.83	over	-17.67	over	-5.83	over
Band 3	-1.00	over	-33.84	over	-8.46	over	-7.26	over
Band 4	1.03	21.64%	4.06	23.33%	-0.91	over	0.70	7.30%
Band 5	-5.05	over	90.20	19.34%	41.43	7.63%	-12.68	over
Band 6	2.71	6.50%	-5.82	over	-9.11	over	10.94	4.65%
Bands 7+	-3.74	over	1.60	2.40%	-2.86	over	3.86	5.20%

Data Note: Data for this table is from 30 Nov 2016. Women & Children data include Midwives. over = over-established

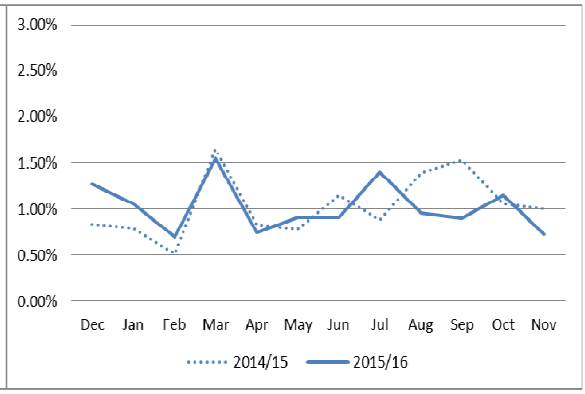
5.3.2 Staffing Metrics

Division	Sickness		Turnover		Parental Leave	
	RGNs	HCAs	RGNs	HCAs	RGNs	HCAs
Diagnostic & Specialties	4.45%	4.53%	8.51%	13.70%	4.17%	2.19%
Medicine	3.44%	5.00%	14.46%	21.18%	3.99%	3.28%
Surgery	4.42%	4.20%	10.94%	17.70%	3.99%	2.55%
Women & Children	4.63%	3.99%	14.00%	13.04%	4.02%	2.24%
Trustwide	**4.22%**	**4.59%**	**12.39%**	**18.14%**	**3.96%**	**3.14%**

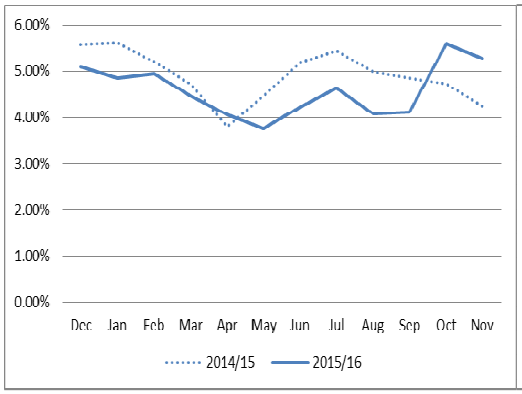
Data Note: 12 month rolling data. Trustwide data includes Corporate Services.



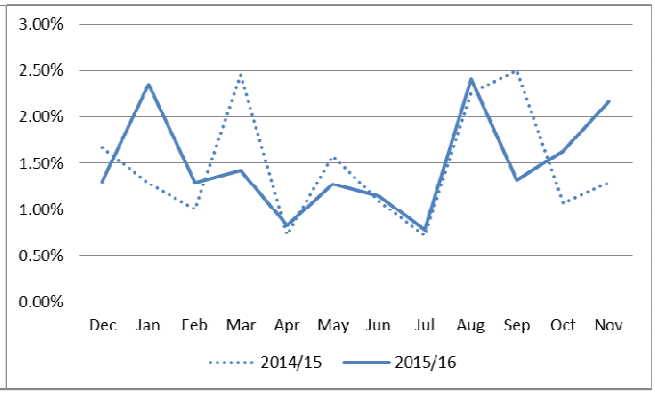
RGN: Sickness Absence by Month (Dec 14 – Nov 16)



RGN: Turnover by Month (Dec 14 – Nov 16)



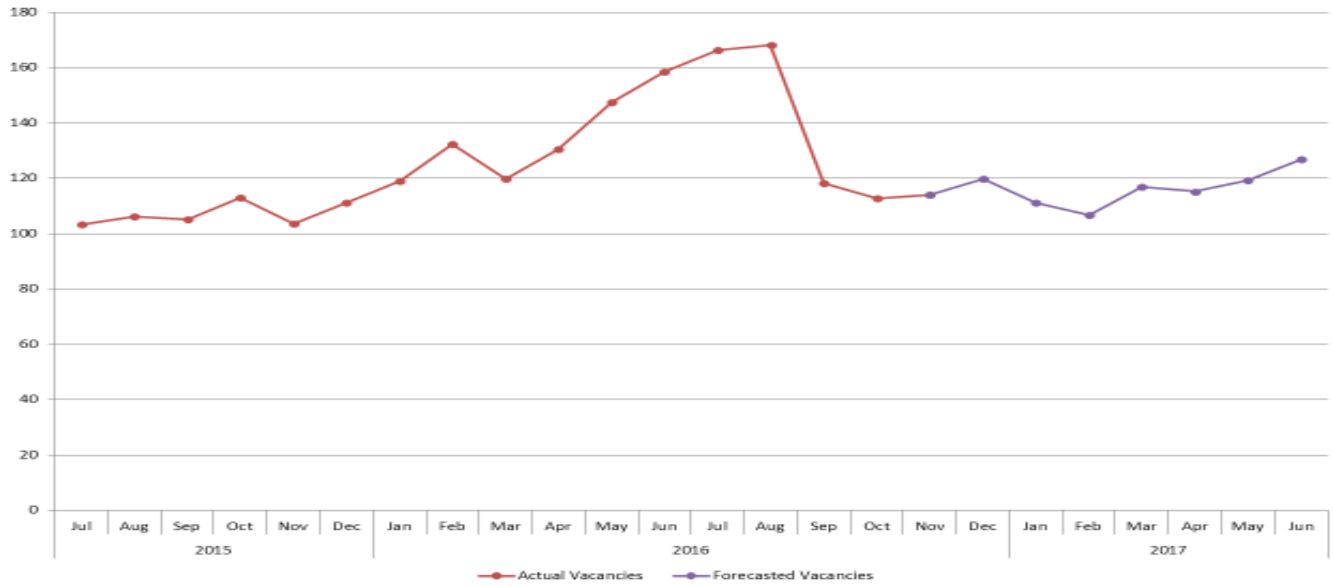
HCA: Sickness Absence by Month (Dec 14 – Nov 16)



HCA: Turnover by Month (Dec 14 – Nov 16)

5.4 Vacancy Forecast

- The establishment for Band 5 Registered Nurses has decresed for a third consecutive month, and is now 11.43 WTE less than August 2016.
- It was forecasted that the number of vacancies would decrease further during November 2016, but the vacancy level has risen by 1.25 WTE to 113.90 WTE.
- It is expected that the number of vacancies will increase in December, before reducing in January and February 2017 due to the new intake of Student Nurses.



6 Revalidation

Revalidation in our Trust is still doing well with 66 staff members Revalidating in November and 49 due in December.48 Revalidated in December as one member of staff chose to retire as she has been on long term sick since March. Nobody as yet to date has been requested to be verified by the NMC in our trust. Workshops are still very well attended and bookings continue through next year. Below is a table of to date figures.

MONTH	DUE FOR REVALIDATION	REVALIDATED	NOT REVALIDATED (SEE CODE BELOW)	VERIFIED by NMC
APRIL 2016	40	39	1	0
MAY 2016	26	26		0
JUNE 2016	21	19	1 & 5	0
JULY 2016	114	111	1 & 1 & 6	0
AUGUST 2016	46	44	6 & 4	0
SEPTEMBER 2016	171	171		0
OCTOBER 2016	45	45		0
NOVEMBER 2016	66	66		0
DECEMBER 2016	49	48	2	0
JANUARY 2017	35		1	
FEBRUARY 2017	112			
MARCH 2017	68			

CODE-
1-Retired
2-long term sick
3-Pregnancy related
4-Non compliant
5-Left Trust

7 Next Steps and Communication

- Note the Hurst benchmarking comparisons (which will be repeated in June 2017)
- Continue with comparison analysis using the 'Model Hospitals' database
- Continue to develop the RAG ration around Harm Free care, and explore correlations to harm and Safer Staffing outcomes.
- Continue with proactive recruitment.
- Continue to manage Agency spend

8 Recommendations

The Board is asked to receive this report as a source of assurance that staffing levels across the Trust are delivering safe care.

Authors: **Divisional Nursing Directors:**

Presenting Director: **Maggie Arnold Director of Nursing & Midwifery**

January 2017

Hurst Nursing Staffing Benchmarking Exercise - December 2016

MEDICINE (Speciality)

Ward	Hurst RGN	Hurst HCA	Total Est.	Funded RGN	Funded HCA	Total Est.	Diff. RGN	Diff.HCA	Recommendation
6a	21.3	15.9	37.2	21.41	16.4	37.81	0.11	0.5	Maintain
6b	18.6	13.9	32.5	17.97	12.43	30.4	-0.63	-1.47	Business case
7a	26	12.3	38.3	21.96	15.39	37.35	-4.04	3.09	Skill mix review
7b	18.9	11.8	30.7	16.31	14.44	30.75	-2.59	2.64	Skill mix review
8a	23.35	16.45	39.8	21.36	16.37	37.73	-1.99	-0.08	Business case
8b	22.5	10.8	33.3	20.91	14.83	35.74	-1.59	4.03	Skill mix review
Cardio GRH	35	17.5	52.5	39.34	11.8	51.14	4.34	-5.7	Skill mix review
Cardio CGH	19.2	9.6	28.8	25.58	2.87	28.45	6.38	-6.73	Maintain (covers CCU)
Avening	20.3	10.5	30.8	19.67	16.37	36.04	-0.63	5.87	Skill mix review
Hazelton	18.9	9.2	28.1	15.55	14.54	30.09	-3.35	5.34	Skill mix review
Knightsb'ge	13.5	9.1	22.6	12.14	9.06	21.2	-1.36	-0.04	Business case
Totals	**237.55**	**137.05**	**374.6**	**232.2**	**144.5**	**376.7**	**-5.35**	**7.45**	

MEDICINE (GOAM)

Ward	Hurst RGN	Hurst HCA	Total Est.	Funded RGN	Funded HCA	Total Est.	Diff. RGN	Diff.HCA	Recommendation
4b	17.9	17	34.9	20.1	17.97	38.07	2.2	0.97	Rebalance within Service
9b	18.51	17.7	36.21	21.23	19.17	40.4	2.72	1.47	Rebalance within Service
GW1	18.5	17.7	36.2	21.36	17.73	39.09	2.86	0.03	Rebalance within Service
Woodman'e	20.9	19.9	40.8	22.23	19.3	41.53	1.33	-0.6	Rebalance within Service
Ryeworth	23.85	17.35	41.2	21.81	20.52	42.33	-2.04	3.17	Rebalance within Service
Totals	**99.66**	**89.65**	**189.31**	**106.73**	**94.69**	**201.42**	**7.07**	**5.04**	

MEDICINE (UNSCHEDULED CARE)

Ward	Hurst RGN	Hurst HCA	Total Est.	Funded RGN	Funded HCA	Total Est.	Diff. RGN	Diff.HCA	Recommendation
ACUA	32.8	13.4	46.2	28.67	11.88	40.55	-4.13	-1.52	Business case
4a	21.5	15.3	36.8	21.5	15.3	36.8	0	0	**New Ward**
ACUC	31.5	14.2	45.7	26.42	12.34	38.76	-5.08	-1.86	Business case
Totals	**85.8**	**42.9**	**128.7**	**76.59**	**39.52**	**116.11**	**-9.21**	**-3.38**	

SURGERY (GENERAL)

Ward	Hurst RGN	Hurst HCA	Total Est.	Funded RGN	Funded HCA	Total Est.	Diff. RGN	Diff.HCA	Recommendation
5a	19.3	10	29.3	18.33	11.65	29.98	-0.97	1.65	Rebalance within Service
5b	29.1	15.1	44.2	28.66	13.73	42.39	-0.44	-1.37	Rebalance within Service
Bibury	17.6	10.1	27.7	15.55	9.18	24.73	-2.05	-0.92	Rebalance within Service
Snowshill	17.9	7.2	25.1	18.44	6.3	24.74	0.54	-0.9	Maintain
Guiting	30.5	11.1	41.6	32.44	12.91	45.35	1.94	1.81	Rebalance within Service
Prescott	28.4	15.8	44.2	30.45	13.86	44.31	2.05	-1.94	Rebalance within Service
Totals	**142.8**	**69.3**	**212.1**	**143.87**	**67.63**	**211.5**	**1.07**	**-1.67**	

SURGERY (T&O)									
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**
2a	19.5	12	31.5	19.5	12	31.5	0	0	**New ward**
3a	17.5	12.7	30.2	18.22	13.29	31.51	0.72	0.59	Rebalance within Service
3b (35 beds)	26.5	16.7	43.2	22.41	19.24	41.65	-4.09	2.54	Business case
Alstone	19.3	12	31.3	19.58	9.59	29.17	0.28	-2.41	Rebalance within Service
Dixton	13.1	8.2	21.3	11.43	9.37	20.8	-1.67	1.17	Rebalance within Service
Totals	**76.4**	**49.6**	**126**	**71.64**	**51.49**	**123.13**	**-4.76**	**1.89**	

SURGERY (H&N)									
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**
2b (all beds)	21.9	5.9	27.8	21.5	7.44	28.94	-0.4	1.54	Skill mix review
Totals	**21.9**	**5.9**	**27.8**	**21.5**	**7.44**	**28.94**	**-0.4**	**1.54**	

D&S									
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**
Lillybrook	25.5	6.2	31.7	18.87	9.16	28.03	-6.63	2.96	Business case
Rencombe	20.1	10.1	30.2	22.96	9.34	23.07	2.86	-0.76	Rebalance within Service
Totals	**45.6**	**16.3**	**61.9**	**41.83**	**18.5**	**51.1**	**-3.77**	**2.2**	

W&C (GYNAE)									
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**
9a	15.46	6	21.46	15.46	6	21.46	0	0	**New Ward**
Totals	**15.46**	**6**	**21.46**	**15.46**	**6**	**21.46**	**0**	**0**	

PUBLIC BOARD MEETING TUESDAY 31st JANUARY 2017

Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham General Hospital
commencing at 9.00

Report Title
COMBINED BOARD ASSURANCE FRAMEWORK
Sponsor and Author(s)
Deborah Lee – Chief Executive Andrew Seaton – Director of Safety

Audience(s)									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The Board Assurance Framework is the means through which the Board receives assurance in respect of the delivery of its stated annual objectives through the oversight of risks which have the potential to undermine delivery of the objectives. The BAF sets out the controls to mitigate the potential risks and provides assurance that the controls are effective or describes further actions to strengthen the controls and mitigate the risk.

Key issues to note

- Work is now in hand to review and refresh the strategic objectives and annual milestones for the coming year 2017/18
- In respect of this year's objectives, a number are at risk on not being met and these include those relating to financial plan delivery, achievement of national waiting time standards, workforce and timely discharge of patients awaiting discharge.
- Plans to mitigate the risks described above are in place but achievement of these objectives will not be met this year.
- Additional resources have been mobilised to mitigate the risks arising from the launch of TrakCare and a "lessons learnt review" will be undertaken before the next phase is implemented.
- The Sustainable Workforce Group, identifying key areas of difficulty, establishing role definitions, recruitment paths and educational support has been established.
- To support the monitoring and performance of planned care the Planned Care Board group has been re-established.
- The new executive group to oversee the BAF and Trust risk register met for the first time in December but their review (and revision) of risks has not yet migrated to this update due to the requirement for them to be signed off by the Trust Leadership Team (TLT) first.

Conclusions

The Board Assurance Framework continues to develop and improve though it has yet to achieve its full potential to support the Board in understanding the risks to delivery of the annual objectives. There remain four principals risks rated 15 or higher, which therefore have the potential to undermine delivery of key strategic objectives. These are:

- Risk of not being able to recruit and retain a workforce with the right profile to deliver the

clinical services (4*5 = 20) – this risk is being actively managed in the Workforce Committee
- Risk of not meeting financial targets (5*5=25) – this risk is being actively managed by the Finance Committee
- Risk of delays to patient discharge impacting on patient experience and the timely delivery of care closer to home (4*4) – this risk is being actively managed through the Emergency Care Programme Board and A&E (system) Delivery Board
- Risk of the failure of the local health and social care system to manage demand with agreed levels (5*4) this risk is being actively managed through the Emergency Care Programme Board and A&E (system) Delivery Board.

Implications and Future Action Required

Review the BAF against the KPMG best practice review and notably, review the appropriateness of the strategic objectives as part of the annual planning process.

Recommendations
To note the report
Impact Upon Strategic Objectives
The report identifies the risk and mitigation to the Strategic objectives
Impact Upon Corporate Risks
None
Regulatory and/or Legal Implications
None
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	√	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
		18th January 2017			

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD / JANUARY 2017

COMBINED BOARD ASSURANCE FRAMEWORK

1 Purpose of Report

1.1 To receive the update on the 2016/17 Board Assurance Framework (BAF).

2 Background

2.1 The Board Assurance Framework (Appendix 1) is the means through which the Board tracks delivery of its stated annual objectives through the tracking of risks which have the potential to undermine delivery of the objectives.

2.2 The BAF sets out the controls to mitigate the potential risks and provides assurance that the controls are effective or describes further actions to strengthen the controls.

2.3 Where the risk exposure becomes significant through failure of the controls or unexpected events in the year, these risks will appear on the Trust Risk Register to ensure there is clear visibility and oversight of the risk and the controls and actions to mitigate or eliminate the risk.

2.4 So that the Board can understand the level of assurance carried by the evidence a simple rating scheme has been included as follows:

Level 1	Internal Management reviewed assurance
Level 2	Board reviewed assurance (Usually Board reports e.g. PSF)
Level 3	External provided assurance (e.g. External assessments\sign off)

3 Key Changes

To support the monitoring and performance of planned care the Planned Care Board group has been re-established.

There has been a short term post established to support private patient activity.

Extra key controls were established for the TrakCare programme launch with support from Internal Audit to inform the next stage implementation.

The Sustainable Workforce Group, identifying key areas of difficulty, establishing role definitions, recruitment paths and educational support has been established

4 Recommendation

To receive the updated Assurance Framework and note the potential risks to the 2016/17 objectives and the controls in place to mitigate these risks.

Author: **Andrew Seaton, Director of Safety**
Presenting Director: **Deborah Lee, Chief Executive Officer**

Date: **January 2017**

February 2016 - Full Assurance Framework - Key - for reference
Strategic Objective……

Principal Risks to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
What could prevent the above principal objective being achieved? You may have more than 1 risk Start with Risk of…….	Which Director is responsible and which assurance committee is responsible for monitoring?	What management controls/systems we have in place to assist in securing delivery of our objective The controls and assurance are rated by level of assurance **Management Reviewed Assurance = 1** **Board Reviewed Assurance = 2** **External Reviewed Assurance = 3**	Where we can gain independent evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks, and objectives are being delivered	Assessment of the quality of the controls to manage the risk (not assessment of the risk itself)
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Where do we still need to put controls/ systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/ systems, on which we place reliance, are effective	Are the controls and assurances improving? ↑ ↓ ↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
Key potential risks that may occur during the year and have a significant effect on achieving the annual plan.	Current risks that are related to the Principle risk and\or potential risks that have occurred.				

Actions Agreed for any gaps in controls or assurance		**By Whom**	**By When**	**Update**
1				
2				

Strategic Objective - To continue to improve the quality of care we deliver to our patients and reduce variation

Principal Risks to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of safe standard approaches to patient care not being applied consistently.	**Medical Director** **Quality and Performance Committee**	1. Development of internal professional standards for clinicians. (1) 2. Clinical leadership in the SAFER ward based project (1) 3. Maintaining involvement through the Clinical design authority who are responsible for the clinical design of Trakcare (1)	1. Emergency pathway report (Stream 11) 2. Emergency pathway report (Stream 3) 3. Progress monitored in the Smartcare Board(2)	1. Emergency pathway report to Board (2) 2. Smartcare Board report (2) 3. Quality & Performance report (1)	2x4=8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Required funding to support clinical back fill to facilitate time to engage 2. Insufficient real time data	1. Available real time data.	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating (Likelihood x Impact)**
Risk to safety due to delay to the development and implementation of standardised pathways to reduce variation in practice as a consequence of the delay of implementing Trakcare	**Medical Director** **Quality and Performance Committee**	1. Maintaining involvement in the Reducing Clinical Variation workstream of the Gloucestershire STP 2.Maintaining involvement through the Clinical design authority who are responsible for the clinical design of Trakcare (1) 3. Reducing Clinical variation Board as part of STP	1. Monitored STP governance arrangements 2.Progress with clinical design of phase 2 Trakcare monitored in the Smartcare Board	1.Monthly reports to board on progress	2x4=8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Unexpected high mortality data linked to variation in practice. 2. Delay in delivery of clinical benefits to reduce variation from Trakcare	M1 Risk to patient safety in the Emergency department at times of peak activity	S118 A risk that patients receive poor quality care as a consequence of demand for beds exceeding the beds available which could include cancelled operations, being cared for on a non-specialty ward or being cared for in an escalation area	F7 The risk of delayed treatment and diagnosis due to delays in follow up care in a number of specialties including neurology, cardiology, rheumatology and ophthalmology	DSP2288 The risk of failure to deliver required standards for End of Life care due to Inadequate staffing capacity to cover workload growth Blank	S127 The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal

	Actions Agreed for any gaps	By Whom	By When	Update
	Extra investment to be agreed to provide backfill to support Emergency Pathway	Medical Director	October 2016	Agreed at Board Seminar
	Discuss real time data capture methods from current sources	Medical Director	December 2016	Ongoing

Strategic Objective - To continue to align our services between our sites

Principal Risks to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of being unable to implement the Trust's clinical strategy and preferred model of care.	**Director of Clinical Strategy** **Trust Board**	1. Outline Site Development plans agreed by Board (2) 2. Site Development plans reflected in the emerging Sustainability and Transformation Plan the STP submission (2) 3. Bid to NHSE for capital allocation 4. Stakeholder engagement plan	1. Progress reports on site development plans (2) 2. Sustainability and Transformation Plan programme reports	Board endorsement of outline business cases.	3X3=9
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Availability of capital		↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. An unexpected political process leading to purdah. 2. Unexpected significant deterioration in clinical services requiring urgent service change	S100 The risk of failing national access standards including RTT and Cancer	F7 The risk of delayed treatment and diagnosis due to delays in follow up care in a number of specialties including neurology, cardiology, rheumatology and ophthalmology	Blank	Blank	Blank

Actions Agreed for any gaps		By Whom	By When	Update
1	To scope the Modernising Our Hospitals Workstream of the Transformation Programme	Director of Clinical Strategy	December 2016	Ongoing
2	Maintain "no surprises" commitment to key stakeholders, through regular engagement	Director of Clinical Strategy	On going	Ongoing

Strategic Objective To future proof our services through clinical collaboration

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of organisations serving neighbouring populations seeking clinical collaborations with other providers	**Director of Clinical Strategy** **Trust Leadership Team**	1. Regular executive level meetings with neighbouring trusts (2)	1.Review of clinical services by clinical senates and Strategic Clinical Networks (1)	None	2X4=8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1.Links with neighbouring STPs	None	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of key stakeholders not supporting any significant service changes required	**Director of Clinical Strategy** **Trust Leadership Team**	1. Participation in system wide engagement activities (1) 2. Stakeholder engagement plan (2)	1. Board report on progress of changes.(2) 2. Transformation programme reports (2)	None	2X4=8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1.Revised STP footprint that would challenge existing clinical networks	S100 The risk of failing national access standards including RTT and Cancer	F7 The risk of delayed treatment and diagnosis due to delays in follow up care in a number of specialties including neurology, cardiology, rheumatology and ophthalmology	Blank	Blank	Blank

Actions Agreed for any gaps	By Whom	By When	Update
Maintain “no surprises” commitment to key stakeholders, through regular engagement	Director of Clinical Strategy	On going	None

Strategic Objective To improve the health and wellbeing of our staff, patients and the wider community

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of inability to demonstrate the impact of health & wellbeing initiatives to support continued allocation of resources.	**Director of Clinical Strategy** **Health & Wellbeing Committee**	1. Staff survey (3) 2. Monitoring of impact of healthy living services (1) 3. Participation in Healthiest Workplace Initiative (2) 4. Representation on Gloucestershire Health and Wellbeing Board (2)	1. Staff survey results (3) 2. Health & Well Being Committee (2)	None	2X3=6
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Baseline information on Health and lifestyle status of staff	None	↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
None	HR2b The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	F2 Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.	Blank	Blank	Blank

	Actions Agreed for any gaps	By Whom	By When	Update
1	To review specification and outcome of tender for healthy living services	Director of Clinical Strategy	February 2017	None

Strategic Objective To continue to treat our patients with care and compassion

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of providing a poor patient experience as a consequence of pressures on the emergency pathway creating temporary beds and extra use of temporary staffing solutions with patients being placed in outlying beds different to their required specialty to manage flow and bed pressures	**Director of Nursing** **Quality and Performance Committee**	1. Recruitment Standards(1) 2. Trust Education programmes (1) 3. Nursing & Midwifery Strategy (2) 4. Patient Experience Strategy (2) 5. Management of the 4Cs (1) 6. Senior Nurse and Midwifery Committee (1) 7. Safer Staffing Report including recruitment & Retention(2) 8. ECB workstream action plans particularly 3&6 (2) 9. Countywide system call 10. Infection control\Flu plan	1. Directors statement (2) 2. Divisional Quality Report (1) 3. Family & Friends Test (3) 4. Patient Surveys (3) 5. Formal comments – Health watch, Governors (3) 6. Local Supervisors of Practice Annual report(3) 7. ECB report (2)	None	3x4=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of a poor patient experience arising from staff who fail to demonstrate the appropriate skills in respect of care, compassion and communication	**Director of Nursing** **Quality and Performance Committee**	1. Recruitment Standards(1) 2. Trust Education programmes (1) 3. Nursing & Midwifery Strategy (2) 4. Patient Experience Strategy (2)	1. Directors statement (2) 2. Divisional Quality Report (1) 3. Family & Friends Test (3) 4. Patient Surveys (3) 5. Formal comments – Health watch,	None	3x4=12

		5. Management of the 4Cs (1) 6. Senior Nurse and Midwifery Committee 7. Safer Staffing Report including recruitment & Retention(2) 8. ECB workstream action plans particularly 3&6 (2)	Governors (3) 6. Local Supervisors of Practice Annual report(3) 7. ECB report (2)		
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. Prolonged outbreak of Infection. 2. Industrial action	S118 A risk that patients receive poor quality care as a consequence of demand for beds exceeding the beds available which could include cancelled operations, being cared for on a non-specialty ward or being cared for in an escalation area	M1 Risk to patient safety in the Emergency department at times of peak activity	F7 The risk of delayed treatment and diagnosis causing harm because of a backlog of follow-up appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	C11 The risk of poor patient experience due to the failure of timely patient transport	
Actions Agreed for any gaps			**By Whom**	**By When**	**Update**
1 None					

Strategic Objective To provide care closer to home where safe and appropriate

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of delays to discharging patients in a timely manner causing an increase above agreed system wide targets for medically fit patients, high occupancy, delays in patient flow and poor patient experience.	**Director of Service Delivery** **Quality & Performance Committee** **Emergency Care Board**	1. System Resilience Group (3) 2. Emergency Care Board (1) 3. Emergency Care plan(2) 4. Integrated Discharge Team Implementation Plan & Steering Board(1)	1. PMF (2) 2. Emergency Care Report (2) 3. Weekly system wide call of all Nursing Directors to review medically fit list	Blank	4x4=16
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	Blank	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of the failure of local health & social care system to manage demand within the current agreed contracted capacity leading to insufficient internal capacity, displacement of elective activity, loss of income and potential compromised care.	**Director of Service Delivery** **Quality & Performance Committee**	1. Emergency Care Plan(2) 2. RTT plan (2) 3. Cancer Plan (2) 4. Winter plan (2) 5. CCG Contract(3) 6. CCG Contract Review Board(3) 7. Financial & Performance Committee(2) 8. Gloucestershire A&E Delivery Board (3) 9. Sustainability & Transformation Plan 10. 2016-17 QIPP plans	1. Emergency care Board & Report (2) 2. Planned Care Board (1) 3. Finance & Performance Committee 4. Quality Committee	Blank	5x4=20
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Insufficient plan to manage the difference between contracted post QIPP activity and actual activity.	None	↔

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurance	Risk Rating (Likelihood x Impact)
Risk of inability to reduce demand for outpatients follow up activity in line with commissioner plan	**Director of Service Delivery & Medical Director** **Quality & Performance committee**	1. Outpatient CIP Board (1) 2. Individual specialty recovery plans (1) 3. CCG contract (3) 4. CCG performance review (3)	1. Performance Management Report (2)	None	4x3=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Planned Care Board	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register			
1. Prolonged outbreak of Infection. 2. Industrial action 3. Adverse weather	M1 Risk to patient safety in the Emergency department at times of peak activity	S118 A risk that patients receive poor quality care as a consequence of demand for beds exceeding the beds available which could include cancelled operations, being cared for on a non-specialty ward or being cared for in an escalation area	F7 The risk of delayed treatment and diagnosis causing harm because of a backlog of follow-up appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	Blank

	Actions Agreed for any gaps	By Whom	By When	Update
1	Revised Emergency Pathway Report	Director of Service Delivery	June 2016	Completed
2	Plan to address difference between contracted gap and actual expected activity	Director of Service Delivery	August 2016	Now part of the Emergency Care Plan
3	Response to NHSI investigation	Director of Service Delivery	End of July 2016	Completed
4	Revise reporting arrangements to F&P	Director of Service Delivery	August 2016	Completed
5	Re-established Planned Care Board	Chief Operating Officer	February 2018	

Strategic Objective - To improve our internal efficiency

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of Inability to deliver financial targets caused by a failure to reduce expenditure as per plan particular agency costs, reducing the ability to invest in our estate, affecting our Monitor Risk Rating and STP.	**Director of Finance** **Finance Committee**	1. Operational Plan (3) 2. Divisional & Corporate Budgets (1) 3. Periodic review by NHSI (3) 4. Executive Divisional Reviews (1) 5. Turnaround Implementation Board 6. Vacancy Control Panel 7. Agency Programme Board	1. PMF 2. Finance Report(2) 3. Audit reports (3) 4. Carter Review outputs (1) 5. CIP Report (1) 6. Approved recruitment report	Deloitte Financial Review and delivering agreed recommendations	**5x5=25 (5x4=20)**
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Blank	Blank	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Changes to national financial assumption	HR2b The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels..	F2 Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas	. Blank	Blank	Blank

	Actions Agreed for any gaps	By Whom	By When	Update
1	Appoint Lead Director to revise and monitor CIP plans & Agency costs	DoF	April 2016	Completed
2	Appoint Operation Finance Director to provide operations oversite	DoF team	May 2016	Completed

Strategic Objective - Exploiting the opportunities for new markets

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of competition in the private patient marketplace slowing development – Other than for paediatrics all private services the Trust is delivering or expanding are already delivered by other providers locally	**Director of Finance** **Private Patient Committee**	1. Short-term: Differentiation of GH NHS FT private patient offer on price point (1) 2. Medium term: Differentiation of GH NHS FT on environment and service provision (1)	1. Regulator Reports from PP (1) 2. Periodic reports to Board (2)	None	3x3=9
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. None	1. No regular formal reporting to a Board level	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of delivery of an expanded private patient unit – The management and commercial infrastructure is currently under-developed	**Director of Finance** **Private Patient Committee**	1. Recruitment to key posts as expansion progresses (1)	1. Regulator Reports from PP (1) 2. Periodic reports to Board (2)	None	2x3=6
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
				1. No regular formal reporting to a Board level	↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
To be revised	F2 Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas	Blank	Blank	Blank	Blank

	Actions Agreed for any gaps	By Whom	By When	Update
1	Review the reporting arrangements to ensure sub Board \Board level monitoring	Director of Finance	August 2014	None
2	Short term resource required to support development of PP actvity	Head Of Operational Finance	October 2016	Complete – in post January 2017

Strategic Objective To improve our clinical estate

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of the condition and responsiveness of the estate affecting and limiting the planning and development of the site and the ability to improve overall patient experience.	**Director of Finance** **Capital Control Group**	1. Backlog maintenance programme (1) 2. Estates strategy (2) 3. Management of Space process (1) 4. Oversite of the service reconfiguration programme (Infrastructure workstream) (2)	1.Risk identification from programmes. (1) 2. Annual update on estates strategy (2) 3, E&F Risk Register (1)	1.Quality of space management information 2.Back log maintenance programme	**3x4=12**
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Blank	Blank	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Unexpected decline or finding of unfit for purpose inspection of the estate. 2. Sudden damage to estate.	Blank	Blank	Blank	Blank	Blank

	Actions Agreed for any gaps	By Whom	By When	Update
1	Commission further six facet survey of site	Director of E&F	March 2017	Blank
2	Prioritise key back log maintenance and address in capital programme	Director of E&F	April 2016	Completed

Strategic Objective - Harnessing the benefits of information technology

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of unsuccessful implementation of Trakcare	**Director Of Clinical Strategy** **Smartcare Programme Board**	1. Implementation Plan reviewed by HSCIC and Internal Audit (3) 2. Authority to Proceed processes reviewed by Internal Audit (3) 3. Learning from successful implementations in other Trusts (1) 4. Phase 1 go live proceeded 5 December 2016 . Process for identifying and mitigating risks to operational delivery in place 5. Formal Go Live review supported by internal audit to inform subsequent phases	1. HSCIC/DH Gateway Review (3) 2. Internal Audit (3) 3. Programme report to Board (2) 4. Non executive lead	Monthly Programme Board Reports to Board	2x5=10
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of technical infrastructure not being able to support developing technology	**Director of Clinical Strategy** **Trust IM&T Board**	1. IT Blueprint strategy (1) 2. Network Business Case (1) 3. Local Digital Roadmap submission to NHSE (3)	1. NHSE assessment of LDR	None	2x5=10
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Loss of business critical systems 2. Loss of business critical systems to other providers due to shared nature of the infrastructure	Blank	Blank	Blank	Blank	Blank

Actions Agreed for any gaps	By Whom	By When	Update
Formal Go Live review supported by internal audit to inform subsequent phases	SP	1/03/2017	In planning

Strategic Objective - To develop leadership both within our organisation and across the health and social care system

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that current Leadership Development Programme does not deliver the internal leadership capability required.	**Director of HR and OD** **Workforce Committee** **Education, Learning and Development Committee**	1. Objectives and workplan for Leadership reviewed by Workforce Committee (1) 2. Coaching Faculty established internally (1) 3. Access to national programmes via Leadership Academy(2) 4. Periodic reviews of talent/succession by senior team (1) 5. Leadership capabilities scored on annual appraisals (1) 6. Leadership development needs analysis	Programmes (accredited and non-accredited) established for entry level managers upwards and including clinical staff (3)	Workplan established and coaching faculty fully operational.	2x4 = 8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Succession planning and talent management insufficiently linked to access to national courses and/or allocation of investment	Partial compliance with leadership behaviour scores on appraisal. No real assessment of health of current trust leadership.	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk that partners do not engage with senior leadership of the Trust, for the benefit of the system	**Chief Executive** **Trust Board**	1. CEO and leadership team actively engage in partnership working and notably STP work programme (1)	1.External assurance on progress of STP (3) 2. Internal Audit review(s) of partnership working and other third party feedback (3)	NHS E and NHS I review of STP plan and progress. (3)	2 x 4 = 8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Capacity of L&OD to deliver plan	HR2b The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels..	F2 Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas			

	Actions Agreed for any gaps	By Whom	By When	Update
1	Complete succession planning exercise for all key posts and assess gaps/actions to follow	DS	Feb 17	Scheduling next review of submissions at end of February
2	Collate results of Trust leadership development needs analysis	AH	March 17	Report to Workforce Committee

Strategic Objective - To redesign our workforce

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of not being able to recruit and retain a workforce with the right profile to deliver the changing clinical/service needs of the organisation, resulting in shortages in specific occupations.	**Director of HR & OD** **Workforce Committee Fed by;** **Sustainable Workforce Group** **Education, Learning and Development Committee** **Recruitment Strategy Group**	1. Workforce plans produced by each division/specialty in alignment with operational plans. (1) 2. Individuals (and HRBP's) trained within divisions on workforce planning(1) 3. 6 monthly review of safer staffing metrics (2) 4. Annual job planning process in place (1) 5. Workforce Strategy (2) 6. Annual programme of work for sub-groups of Workforce Committee (1) 7. Countywide workforce planning group and development of consistent workforce planning tools (3)	1. Workforce Committee establishing and reviewing programme of work for each sub-group (1)	1. Nurse Recruitment strategy in place and active local, national and international recruitment (2)	4x5=20
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Sustainable Workforce Group has not developed traction and has not set/agreed programmes of work for sub-groups.	1. Limited plans beyond Nursing (specifically for Junior Doctors/Middle Grades) 2. Impact of removal of Nursing Bursaries not clear.	. ↔

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of poor engagement with staff which negatively impacts on our vision and movement towards Best Care for Everyone	**Director of HR & OD** Workforce Committee Divisional Engagement Group	1. Staff Survey Action Plan (2) 2. Divisional/Department Action Plans (1) 3. Joint working programme with Staff Side/LNC (1) 4. Executive Walkabouts (1) 5. Involve (1)	1. Staff Survey results (3) 2. Divisional Engagement Group feedback (2)	1. Current Staff survey results showing moderate improvement	**3x4=12**
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Survey does not capture sufficient 'real time' feedback 2. Plans too 'corporate' in nature.	1. Further work required with specific staff groups (eg Medics and EFD)	↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. Inability to recruit sufficient nurses to plan 2. Failure of overseas staff to satisfy UK registration requirements. 3. Sudden or unplanned loss of specialist staffing that affects the delivery of a service 4. Industrial action	HR2b The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels..	F2 Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas	Blank	Blank	Blank

Actions Agreed for any gaps		By Whom	By When	Update
1	Establish Workforce Committee with clear programme of work for sub-groups below.	Dir HR&OD Dir HR&OD	September 16 August 16	Completed - Priorities agreed by Workforce Committee at October meeting (adjourned from September)

2	Establish focused strategy for reduction of agency costs focusing on Controls, Alternative Roles and Plan to close Escalation Areas	Dir HR&OD	October 16	Plan agreed and being managed through Agency Programme Board reporting to Turnaround Implementation Board
3	Share plans with NHSI for assessment/additions	Dir HR&OD	October 16	Shared with Mark Hackett and Tom Edgell
4	Establish campaign headed up by CEO to resolve 'top 3' issues relating to staff engagement (Parking/Repairs/Bureaucracy)	Dir HR&OD	July 16	Launched and Board updated in September and January 2017
5	Establish Sustainable Workforce Group, identifying key areas of difficulty, establishing role definitions, recruitment paths and educational support	Dir HR&OD (with CEO)	February 17	First meeting held and TOR agreed. Baseline analysis and detailed programme of work to be agreed at next meeting in February

January Trust Risk Register

Ref	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Commitee	Inherent Risk	Consequence	Likelihood	Score	Current
S118	Quality	Chief Operating Officer	Quality & Performance Committee	A risk that patients receive poor quality care as a consequence of demand for beds exceeding the beds available which could include cancelled operations, being cared for on a non-specialty ward or being cared for in an escalation area	Major (4)	Will undoubtedly recur, possibly frequently (5)	20	15 - 25 Extreme risk
DSp2288PALL	Quality	Medical Director	Quality & Performance Committee	Risk of failure to deliver national standards for End of Life Care due to inadequate staffing capacity to cover workload growth.	Moderate (3)	May recur occasionally (3)	9	8 -12 High risk
F2	Quality	Director of Nursing	Quality & Performance Committee	Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.	Moderate (3)	Will undoubtedly recur, possibly frequently (5)	15	15 - 25 Extreme risk
M1	Safety	Medcial Director	Quality & Performance Committee	Risk to patient safety in the Emergency department at times of peak activity	Major (4)	Do not expect it to happen again but it is possible (2)	8	8 -12 High risk
N17	Statutory	Director of Nursing	Safeguarding Committee	The risk of being considered non-compliant with the Trust CQC registration due to providing care to an increasing number of adolescents 12-18 year presenting with self harming behaviour who require a place of safety but do not require medical care	Moderate (3)	May recur occasionally (3)	9	8 -12 High risk
F7	Safety	Chief Operating Officer	Quality & Performance Committee	The risk of delayed treatment and diagnosis due to delays in follow up care in a number of specialties including neurology, cardiology, rheumatology and ophthalmology	Major (4)	May recur occasionally (3)	12	8 -12 High risk
HR2b	Finance	Director of HR&OD	Workforce Committee	The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	Major (4)	Will undoubtedly recur, possibly frequently (5)	20	15 - 25 Extreme risk
S100	Statutory	Chief Operating Officer	Quality & Performance Committee	The risk of failing national access standards including RTT and Cancer	Major (4)	Will undoubtedly recur, possibly frequently (5)	20	15 - 25 Extreme risk
M1b	Quality	Director of Nursing	Quality & Performance Committee	The risk of poor quality care arising from a deficit of appropriate skill mix to deliver safe and effective care, as a consequence of the lack of availability of key groups of staff	Minor (2)	Will undoubtedly recur, possibly frequently (5)	10	8 -12 High risk
S127	Safety	Medical Director	Quality & Performance Committee	The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Major (4)	Will probably recur, but is not a persistent issue (4)	16	15 - 25 Extreme risk
IT2246	Business	Director of Clinical Strategy	Trust Leadership Team	The risk to delivery of trust business due to Operational disruption caused by loss of critical business systems.	Major (4)	Do not expect it to happen again but it is possible (2)	8	8 -12 High risk

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD MEETING - TUESDAY 31st JANUARY 2017
Sandford Education Centre, Cheltenham General Hospital commencing at 9.00 a.m

Report Title									
Staff Survey Update on Action Plans									
Sponsor and Author(s)									
Dave Smith and Abby Hopewell									
Audience(s)									
Board members	**x**	Regulators		Governors	**x**	Staff	**x**	Public	

Executive Summary

Purpose
To update the Board on actions taken by the Trust against the 'top 3' priorities identified by staff within the 2015 annual staff survey as well as the key local actions carried out by divisions.

Key issues to note
Staff identified 3 main issues and these were agreed by the Trust Board;
Travel (parking) – Significant engagement has/is taking place on this subject, as the emphasis has moved from the simple acquisition of more parking spaces to a radical rethink on travel to work options.
Routine (local) maintenance – Whilst the initial plan of recruiting additional handymen has not been realised, a significant focus has been placed on prioritising local maintenance and repairs.
Need to reduce bureaucracy – Staff have been significantly engaged with the 'Ideas' programme. The 'meetings mania' challenge has also been well received. Whilst the previous 'Permission to Fill' (PTF) process was the driver behind a number of complaints about bureaucracy, its replacement, the Vacancy Control Panel is now accepted as a more efficient vehicle whilst allowing for an increase in controls.

Conclusions
Progress has been made, however it is set against a context of significant change within the Trust and a reset of our financial performance. In this context, whilst engagement activity will have increased and improved, this may not lead to a direct increase in engagement scores when the 2016 results are published.

Implications and Future Action Required
The engagement of staff is crucial to delivering 'Best Care for Everyone' and we will need to ensure we assess progress against the soon to be published 2016 results and update the action plans in line with latest feedback.

Recommendations

The Board is asked to note progress against the priorities

Impact Upon Strategic Objectives

Reduced employee engagement would impact upon all aspects of our strategic objectives

Impact Upon Corporate Risks

Reduced engagement may impact upon employee retention and key workforce shortages

Regulatory and/or Legal Implications

N/A

Equality & Patient Impact

It is recognised that optimum care is provided by a consistent, engaged workforce and in determining priorities and solutions it is important to ensure that engagement on these issues is across the totality of our workforce.

Resource Implications

Finance	**x**	Information Management & Technology	
Human Resources	x	Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	x

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Workforce Committee

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2017

STAFF SURVEY ACTION PLANS -UPDATE

1. Aim

To update the Trust Board on progress regarding the key action plans at Trust and Divisional level arising from the NHS 2015 staff survey findings. Whilst we are expecting to receive the results of the 2016 survey imminently, it is important that we demonstrate that the work to address the issues raised in 2015 has not stopped as a consequence of a new survey being issued.

2. 2015 Staff Survey – Trust Action Plan Update

In the spring of 2016 the Trust made a decision to focus efforts on three key priorities which emerged out of the Staff Survey results. These were: Improving travel to work arrangements (parking), increasing routine maintenance, and reducing bureaucracy. Underpinning each of these was the desire of the Trust Board to communicate open and transparent decision making. Progress on the main themes is described below;

2.1 Travel to Work

The Trust began a conversation with staff at a cross-divisional engagement event in October 2016 to discuss the challenges around Travel to Work and associated parking issues. The initial feedback we received from delegates informed our plans for engaging with the wider workforce.

Since the beginning of January 2017 we have been engaging proactively with staff on three main topics related to travelling to work:

1. Options and opportunities around the 99 bus service as the contract is up for renewal
2. Seeking opinions on new criteria for allocating a parking permit
3. Understanding what would incentivise staff to use alternative modes of transport to get to work

We have been engaging with staff in the following ways:

1. Created a **webpage** on the Intranet to explain the challenges and ask for feedback
2. Arranged regular, weekly **drop-in stands** in Fosters restaurant, Blue Spa restaurant and the Atrium at GRH. Staff can talk to members of the Leadership & OD and Estates & Facilities teams to learn more and complete a **paper survey** to give their views
3. Scheduled two **listening events** to take place in February
4. Created an **online survey** for staff to submit their views and feedback

As of Friday 20th January 2017 we have held three drop-in stands and received a combined total of 250 completed paper and online surveys. The formal engagement process will close on Tuesday 28th February 2017.

Following this we will update the Trust on the Travel Plan in the springtime about the next steps, including:

- proposals for the 99 bus service contract
- plans to address the parking issues
- options of alternative means of travelling to work and how they will be encouraged and supported.

2.2 Maintenance

The Trust has been doing a lot of work to improve the environment and get better and quicker at fixing things, including very simple issues such as handles and shelves. The Trust did advertise for two 'handymen' (painter/decorator and carpenter) however because these were short fixed-term posts we unfortunately did not attract any applicants.

In its place, therefore, a Trust-wide Environment Improvement Programme has been established. This has allocated funds to a number of improvements on both sites including:

- on-going programme of painting public spaces
- new floor layering e.g. theatres; main corridor outside Alex House; ward 9a
- a team of groundsmen to fix potholes on and around the site
- bathroom and shower refurbishment on various wards
- refurbishment of lung function, GRH
- new window film on various wards

This programme of work is overseen and led by Maggie Arnold, Director of Nursing.

We propose to explore ways to publicise and celebrate these environmental improvements, and seek feedback from staff on other ways we can improve the environment and our response time to niggling issues in the future.

2.3 Bureaucracy

In an effort to reduce some of the bureaucracy which surrounds our work activities, the following initiatives have been established:

- **Meeting Mania Challenge** – a challenge from the Chief Executive for everyone to review all meetings they hold or attend, to ascertain whether they are necessary or can be shortened. A guide/list of questions for meetings to ask of its members about the structure, purpose and length of future meetings has been published on the Intranet.
- **1000-1 Ideas –** a 'doing things better, doing better things' campaign has been launched which encourages staff to suggest ideas for how we can reduce bureaucracy, support our financial recovery and support quality and safety. Over 220 ideas have been submitted to our email ideas@glos.nhs.uk and some of these will have real potential to improve how we do things but clearly demonstrate a willingness for staff to engage, particularly where the feedback loop is clear and consistent.
- **Vacancy panel** – whilst the Trust did remove the previous rule which required new posts and vacancies at a certain level to be considered at the weekly 'Directors Group' meeting, it has been replaced by a new Vacancy Control Panel in response to the financial controls and challenges we are facing. Despite the introduction of what could have been considered as new 'bureaucracy' this new approach is considerably more efficient than our old one as decisions are made quickly and once vacancies are approved by the panel they are added to the recruitment system immediately. This means that posts are advertised promptly reducing the need for agency or long gaps with no one in post.

2.4 Openness and Transparency

This finds expression in a number of ways;

- The Trust financial position. There has been open communication to staff on issues surrounding both the declaration of the Trust financial position and the

steps needed to get to full recovery. This will be further supplemented by the publication of the results of the Governance Review conducted by Deloittes.

- The filming of the Involve sessions which has enabled individuals to hear from the CEO directly on issues and for managers to use within team meetings. Within this setting, the launch of 'PRIDE' has been particularly well received.
- The engagement on travel options referred to previously is a departure from how changes would have been introduced. Resolving the issues surrounding travel are far from simple and will result in a radically different approach which will be better informed by staff engagement.
- Engagement regarding the 'administrative hub' proposed for Beacon House has commenced with a number of open sessions and again provides the opportunity for staff involved to input to the solutions rather than be on the end of formal consultation about solutions that have already been determined.
- Preparation for the CQC visit has included the CEO sharing slides of her 'day zero' presentation with staff and in responding to concerns from staff as to how they or their service may be viewed by the CQC, has encouraged them to '*be open, be honest and be proud of what you do'*

3. 2015 Staff Survey Action Plans - Divisions

The clinical divisional engagement plans are attached (Appendix 1). Key highlights include;

3.1 Surgery

- Better Tri level visibility by committing to ' walkabouts', newsletters and Divisional 'Questions and Answer' email address
- Better information sharing / feedback on issues raised including patient/service user feedback
- Better Speciality level engagement , each speciality to own their own engagement agenda and agree their own action plan (now incorporated into the overall engagement plan for the Division).

3.2 Diagnostics and Specialties

- Staff Engagement - D&S Quartet (plus HRBP) – now have a rolling programme to attend Department team meetings for an open Q&A session – ensuring feedback for any actions that are taken away from the meeting.
- Staff Motivation - Focus groups have been established to understand what motivates/demotivates staff in the workplace and to look at how quality of work and patient care can be improved.

3.3 Medicine

- Continued emphasis on improving communication/better information sharing
- Improve feedback at both Corporate and Divisional level, including patient/service user feedback and learning lessons for datix reporting
- Improve Work/life balance. Division recognise that staff are working under continuing operational pressures, particularly in acute area's such as ED, working lots of additional hours. Tri working with teams to improve this wherever possible

3.4 Women's and Children

- To undertake an internal survey to better understand internal culture and identify the issues that contribute to the bullying, harassment and behavioural concerns that staff have raised
- Reduce the concerns regarding harassment and bullying from patients , friends and relatives – a contract of behavioural standards has been drafted and is being progressed

4. Conclusions

We are making progress in a number of areas however we recognise that there is much more to be done and that the context for the Trust, certainly financially, has radically changed. The results from the 2016 survey will give us the opportunity to determine if the priorities identified for staff have changed and as usual, we will test these with staff.

To support our on-going work with these priorities, and to support a 'you said….we did' approach to developing and improving staff engagement at GHFT, our plans for 2017 include:

- **Monthly listening events** (rotating between each site) – these will be topical and include an Executive present at each meeting.
- **A 'listening'/staff engagement webpage** – a "one-stop shop" on anything to do with staff engagement, giving feedback, raising concerns, updates regarding the staff survey and specific staff engagement/listening campaigns.
- **Regular updates to staff about staff survey actions** – a year-long communications plan to keep staff informed about progress we are making with our Trust and divisional priorities, including a monthly column in 'Outline'.
- **We will be implementing an engagement tool to provide real-time feedback** - joining up with our colleagues across the STP to procure an appropriate solution.

The Board is asked to**:**

- **Note** the progress made with the 'top 3 priorities' and the individual divisional engagement plans
- **Agree** to receive a report on the 2016 staff survey in February 2017 and a revised priority list and action plan in May 2017

Author: **Abby Hopewell, Head of Leadership and OD**

Presenting Director: **David Smith, HR & OD Director,**

January 2017

MEDICAL DIVISION 2015 STAFF SURVEY ACTION PLAN LINKED WITH DIVISIONAL STAFF ENGAGEMENT AGENDA

July 2016

Priority Area	Actions Identified	Owners	Timescales	Update information As At 1 Dec 2016	RAG Rating As At 1 Dec 2016
Re-branding and re-launch of the staff engagement Strategy within medicine. Actions to address Key Findings: KF7: Staff contribution at work. KF8: Satisfaction with responsibility and involvement. KF9: Effective team working. KF14: Satisfaction with resourcing and support. KF17: Stress in the workplace. KF19: Organisation interest in health and wellbeing.	• Bi-monthly rebranded '*staff involvement forum'* with a 'bottom up approach' focusing on actions/solutions and staff involvement in problem solving and decision making. • Immediate 'Quick Wins' for the division to be identified to improve staff and patient experience and optimise best use of resources. • Opportunity to debrief and share confidentially at the close of Staff Involvement Forum gaining advice and support from a multi-professional perspective.	Eve Olivant (EO)/Sara Lees (SL). Div Tri/ Speciality Tri's/ Matrons/Dept leads EO/SL, Matrons/dept leads	Dates to be arranged from Sept 2016 End of August 2016 Dates to be arranged from Sept 2016	Bi-monthly forum dates schedules although poor attendance so far. Quick wins identified some actions still outstanding. Confidential session at the end of forums that is not minuted	Orange Orange. Green
Communication Strategy Actions to address Key findings: KF5: Recognition and value of staff by managers and organisation. KF6: Reporting good	• Feedback from Speciality Tri at 'Staff Involvement Forums' incorporating dissemination of key information and priorities from Trust/divisional meetings. • Re-Launch of 'Walkabouts' at speciality and divisional Tri level-feedback and monitoring	Div Tri Div Tri's/Speciality Tri's	Dates to be arranged from Sept 2016 Dates to be arranged from Sept 2016	Speciality Tri have been unable to attend a forum yet however the last date had to be cancelled. A number of walkabouts have taken place	Orange Green

communication between senior management and staff. KF10: Support from immediate mangers.	through Divisional Board H&S etc. • Increased networking; exploring uses of blogs apps/social media to gain feedback from staff and extend the 'reach' from bottom up to top down. • Dynamic multi- faceted approach to comms throughout the division to ensure all staff groups are captured. ➢ Face to Face. ➢ Multi-media ➢ 'Quick Wins Posters-*'You said We did'* ➢ Forums ➢ Social engagements	EO/SL/Communications Team, All staff Division, Matrons Ward/Dept managers all staff.	Ongoing Ongoing.	particularly by the DND Ongoing work with the comms team to update our intranet pages and develop posters following outcome of our quick wins	Orange
Quality of Staff Recognition and Feedback. Actions to address Key Findings: KF2: Staff satisfaction with the quality of work and patient care they are able to deliver. KF3 Agreeing role makes a difference to service users. KF4: Staff motivation at work. KF5: Recognition and Value of staff by managers and the organisation.	• Medical Division Strategy Day to be held yearly to include a range of speakers/activities and sharing of success and best practice. • Medical Division Awards ceremony to recognise outstanding staff contribution in all staff groups. • Proud to care awards for nomination of staff by patients for excellence in care delivery.	Div Tri, Matrons/Dept leads. EO/SL to lead Div Tri, Matrons/Dept Leads. EO/SL to lead. Div Tri, Matrons, Dept Leads	March 2017 April 2017. Monthly from Sept 2017.	Provisional dates booked scope of content and programme agreed with Carol Hewitt. Development of the strategy day/awards ceremony concept has resulted in the idea for 1 event which involves development of divisional strategy and celebration of success. A proud to care element will be incorporated.	Orange Orange

SURGICAL DIVISION
STAFF SATISFACTION AND SPECIALITY LEVEL ENGAGEMENT
POSITION – January 2017

SPECIALITY	TOP THREE	LEAD	UPDATE – January 2017
Division wide	1) Commitment to 'walkabouts' to all areas within the Division at least twice a year.	Divisional Tri	Implemented - ongoing
	2) Quarterly Divisional Newsletter		Implemented - ongoing
	3) Set up Divisional 'Question and Answer' email address	Divisional Tri	Implemented – ongoing
	4) Speciality Tri's to develop local engagement plans, based on the breakdown of 2015 Staff Survey results, applicable to their areas.	Divisional Tri Divisional Tri	Implemented – Speciality plans now incorporated into Divisional Action plan and reviewed with Divisional Nurse Director and HRBP/Divisional Board quarterly.
Head and Neck/Ophth	1) Introduced H&N Departmental Bulletin – to be circulated monthly	SLTri	1st August 2016 launched – ongoing. Frequency has been revised to quarterly rather than monthly to avoid overlap with Divisional bulletin.
	2) Review appraisal reports and target underperforming areas to ensure all up to date.	SLTri/Managers	Ongoing – reminders sent to all Heads of Departments to complete timely appraisals. Progress monitored.
	3) Use of Patient/service user feedback. Review feedback at Tri meetings and identify areas for improvement.	SLTri	Ongoing - Service improvement plans to be agreed at January Tri meeting. Additional clinics/theatres already taking place to help reduce overall wait times. East Block waiting area congestion improved following the opening of Fairview Ophthalmology clinics.
Theatres	1) Rapid development of the recently introduced Theatres Bulletin – 'The Hive', to ensure key messages are cascaded throughout the department.	SLTri	Newsletter issued in December 2016. Future editions to be reviewed to accommodate some formatting changes. Next issue due February 2017.
	2) General Manager's office to be relocated to within the Theatre Department to ensure better visibility and communication and engagement with all staff.	SLTri	Substantive GM to commence in post within new office within Theatres from Day 1. GM moved into Theatre office in December 2016.
	3) Promote Kindness and Respect – Our Standards of Behaviour' Guidelines/Policy. Ensure this is discussed at	SLTri	To be progressed – GM to take this item forward through February Tri meeting.

	Appraisals and PDPs		
T&O	1) To run a topic of the week for promoting dignity and respect and equality within all areas to gain an understanding of what it means for the staff working in each area.	SLTri	Implemented in Ward and OPDE areas – ongoing. Report completed November 2016. Review in February to agree any further actions.
	2) Team meetings to commence to discuss shared Objectives and handover topic each day "What does this team need to achieve today?"	Matrons	Implemented – ongoing.
	3) Matrons attend ward staff meeting to give opportunity to staff to discuss concerns and to discuss new initiatives for divisional engagement questions and answers.	Matrons	Implemented –ongoing. .
Anaes/DCC	1) Departmental 360°. We are going to ask other departments what they think we do well and what could be improved.	SLTri	To be progressed. Plan to do this in February/March.
	2) Management team Myers-Briggs to establish how we will work together to aid communication	SLTri	To be progressed. Plan to do this in February/March 17.
Gen Surgery	1)Trainees. As a transient group, we do not find out their views, so we are planning two social events (covering both sides of the county) with Simon and I taking the juniors out for a meal. This will be to share with them and learn from them.	SLTri	Two events set up in October 2016. Limited take up so further events planned - ongoing.
	2) Management team asked to improve communication so will be discussing in our Tri meetings how to do this. The 'good, bad, better' approach seems useful so will probably try that.	SLTri	Discussed at Service Line Tri decided against 'good, bad, better approach', for now. Tri are working on suggestions that come through the 'Ideas' email address and ensuring that staff suggestions are explored or have feedback. First meeting with member of staff held in January.
	3) GM would also like to look at having some informal meetings with groups of staff to ascertain their employee value proposition	SLTri	Small focus group to be arranged in March to review progress and agree further actions necessary.
	4) Niggle' line (phone ext with message service) to be established. mid – February will be advertised in Ward area's	GM	In progress for implementation mid-February, will be advertised in Wards.

Division of Diagnostics and Specialties 2016 Staff Survey Action Plan

Priority Area	Actions Identified	Owners	Timescales	Outcomes / Progress
Staff Engagement Key Findings: Engagement Score 3.66 KF6: Reporting good communication between senior management and staff. KF7: Staff contribution towards improvement at work. KF8: Satisfaction with levels of responsibility and involvement.	• Relaunch a quarterly Divisional Staff Engagement Forum with involvement from all departments in the Division • Divisional Quartet to attend Department meetings for an open Q&A forum – ensuring there is a process put in place to feedback on any actions that are taken from the meeting. For depts. where attendance at a team meeting is impractical, a walkabout might work better • Ensure key messages are cascaded top-down, i.e. from 100 leaders, via Divisional Newsletter and management meetings in the Division • Managers to create opportunities for staff to be more involved in decision making at local level • Implement a 'spotlight on' interview with a staff member for the staff magazine.	AW/JB Quartet Quartet/Senior Department Leads Department Leads Quartet	Dates to be arranged from August 2016 Dates already in Department up until December 2016 Ongoing Ongoing Ongoing	Arranged – next meeting 6th Feb Ongoing – timetable of visits and "walkabouts" Not yet implemented
Staff Motivation (reward and recognition) Key findings: KF4 – Staff Motivation at Work KF5: Recognition and value of staff by managers and organisation. KF10: Support from immediate managers.	• Division to set up mechanism for recognising good work within the Division on a monthly basis (possibly some sort of 'Employee/Team of the month), which could then feed into nominations for the annual staff survey. Could be divisive and demotivating – better to organise focus groups with staff (to include local manager(s) and Divisional rep) to ask what is motivating and demotivating – and ask "What does good management look like?" Also – make use of information from exit interviews/questionnaires and improved quality of information gained from F and FT	Quartet	To be up and running by October 2016	Forums being arranged with a couple of larger departments to explore motivation

KF2: Staff satisfaction with quality of work and patient care	• Use focus groups to ask how quality of work and patient care could be improved • Division to develop a reward strategy to look at non-financial ways of incentivising staff, i.e. different job titles within bands, recognising experience and capability • Develop a programme of 'shadow buddy 'visits where staff can get to understand other departments job roles.	Quartet Quartets/HR Quartet	 September 2016 Ongoing	
Staff Health and Well-Being Key Findings: KF14: Staff satisfaction with resourcing and support. KF18 Feeling pressure in the last 3 months to attend work when feeling unwell	• Departments to undertake the stress risk assessment, and develop a local action plan, and feedback to the quartet. • Ensure effective management of absence is maintained, and that staff are supported and have access to staff support services	Department leads. Department Leads/HR	All assessments to be completed by Nov 2016. Ongoing	Need to check completion

MAIN BOARD – Friday 27th January 2017

Report Title
SMARTCARE PROGRESS REPORT
Sponsor and Author(s)
Sponsor: Dr Sally Pearson Author: Gareth Evans: Smartcare Programme Manager
Audience(s)

Board members	X	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To provide assurance to the Board, from the Smartcare Programme Board, on progress towards the stable operation of TrakCare post Phase 1 go-live and planned implementation of Phase 1.5

Key issues to note

- The programme is set at amber status after Phase 1 go-live was achieved over the period 2nd – 5th December 2016 and based upon achieving acceptable level of resolution of issues identified that are impacting on operational activity.
- Issues identified generally fall into the following identified areas:
  - Access and Role Profiles
  - Operational Readiness
  - Inpatient processes
  - Outpatient Clinic Booking
  - Reporting (Statutory & Business)
  - Help Desk Support
- An Operational Delivery structure to support the recovery plans has been put in place with active involvement on a divisional basis.
- An established method of identifying issues on a divisional basis together with Core identification with prioritisation has been established and is being used to produce and manage issue-specific recovery action plans.
- Backlogs of data entry have been identified and plans to progress in specific areas are being put in place with the Operational and Divisional leads.
- A weekly operational risk review meeting has been established with operational and programme representation (including the medical director) to review all incidents or risks where there may be a link to the use of the system and to ensure adequate mitigations are in place. To date there is no evidence of harm as a consequence of any of these risk or issues.
- Training has been re-established with face-to-face sessions and eLearning development plus additional Q&A forum for staff groups to attend,
- The establishment of TrakCare 'Champions' from within the business areas is in progress.
- Phase 1.5 planning is being undertaken to include lessons learned from the Phase 1 go-live.

Conclusions

Phase 1 Go-Live has been achieved and TrakCare is in full Phase 1 operation across the Trust but with operational issues as identified. Recovery action plans are in place or being progressed to achieve resolution.

Implications and Future Action Required

The programme will continue to provide assurance to the Smartcare Programme Board
A further update for the Board will be provided in February.
A formal review of the go live period is planned for February, supported by PWC as our internal auditors. The lessons learned from this process will be applied to the planning for subsequent phases of the programme

Recommendations

The Board is asked to note this report as a source of assurance that the programme to identify issues within the respective operational and support areas to achieve a satisfactory recovery for Phase 1 and planning for subsequent phases is robust.

Impact Upon Strategic Objectives

Contributing to ensuring our organisation is stable and viable with the resources to deliver its vision, through harnessing the benefits of information technology

Impact Upon Corporate Risks

Implementation of phase 2 of Smartcare will reduce the risk on the corporate risk register associated with the instability of the Oncology Prescribing system

Regulatory and/or Legal Implications

The implementation is covered by a contractual agreement with InterSystems. At present the delays to implementation are not impacting on the contract

Equality & Patient Impact

The patient benefits from the implementation of Smartcare will be realised across all patient groups

Resource Implications

Finance	**X**	Information Management & Technology	X
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
					SmartCare Programme Board

Outcome of discussion when presented to previous Committees

PROGRESS REPORT SmartCare			
Date completed:	20/01/17	**Version**	1.0
Project Sponsor:	**Dr Sally Pearson**	**TRUST RAG Status**	**AMBER**
Project Manager:	Gareth Evans		

Joint Trust & InterSystems SmartCare Progress Report– January 2017

Executive Summary & Programme Status

Phase 1 went live over the weekend 3-4 December as planned with the first department ED coming on-line at around 17:00 on Saturday 3rd December.

The go-live process was followed according to plan without any major technical problems resulting in all planned functional areas live between Saturday and Monday. The InterSystems Support Team has now assumed full responsibility for new incidents and continues to work with the Trust in support of the Controlled Change processes.

An overall RAG status of **AMBER** is assigned pending acceptable levels of resolution of issues identified.

Extensive use of floor-walking support was required in each of the functional areas – ED, Theatres, Maternity as well as generic support for Wards and administrative functions – particularly those associated with outpatients and Clinic management.

Monday saw the main operational activity commencing with Outpatients. Floor walking support was overwhelmed with the requirements for assistance across all operational areas and this activity continued to be provided with up to 24-hour support availability throughout the week and at extended times thereafter.

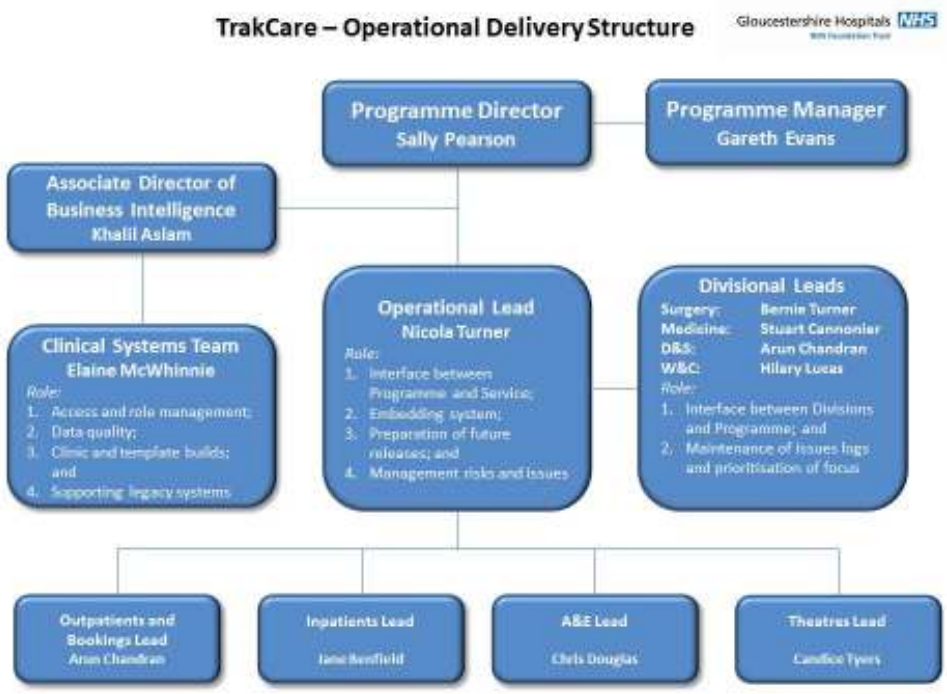
The predominant issues encountered during the go-live were either access related (TrakCare or Smartcards) or lack of knowledge (Training/familiarisation).

Operational issues were also encountered within the Central Booking Office (CBO) functions in addition to those devolved clinic-booking areas. InterSystems provided additional resources in the CBO to support the operational staff for a number of days, which did have a positive effect albeit this remains problematic.

The Programme recognises the level of service interruption and change that is prevalent across the organisation and that this has caused a significant level of disruption and stress. There is a process in place for the reporting of individual issues via the Service Desk and operational governance arrangements (see below) have been put in place to escalate, investigate, resolve and respond to service issues..

Operational leadership and Governance

With the implementation of Phase 1 of the programme, the emphasis has moved to obtaining full functionality of the system. To achieve this, an operational delivery structure has been put in place to support recovery plans for identified issues. This is shown diagrammatically:



Leading this part of the programme from an Organisation perspective is the Operational Lead (Nicola Turner) who is an experienced senior operational manager and who is the main interface between the programme and service delivery across the Trust. The role will be to ensure that the system is embedded into normal business; risks and issues are identified and managed in a timely manner; as well as preparing the services and advising the programme on future updates and phases to the programme.

Each Division has identified a Divisional Lead and their role is to act as an interface between the Divisions and their service lines with the Operational Lead and the programme. They are responsible for managing local Divisional issues logs, managing risks and prioritising areas for attention.

As well as the Divisional, four 'themes' leads have been identified to pick up the cross-cutting programmes of work of Outpatients and Booking, Inpatients, A&E and Theatres.

Responsibility for back-office support for TrakCare has been allocated to the Trust Clinical Systems & PAS Team which is part of the Information Unit. This team is managing role and access issues; undertaking new clinic builds on the system; maintaining data quality; as well as systems management support for the other legacy systems still in use across the Trust.

Issue and Risk Process:

The programme continues to maintain its issues and risks log as prior to Go live, utilising the JIRA application

Operational issues consequent on the deployment of Trakcare are being captured in Divisional Issues logs (which are maintained by the divisional leads). Key issues for the programme are then identified through regular review of these logs by the Programme Team and operational leads and captured in a Core Issues log. Regular meetings involving the Operational Leads allow the continual review of these issues and their priority, and the associated risk assessments. Any issues identified that are creating risks to operational delivery are then captured in the relevant section of trust's risk register on Datix.

The Core Issues log is maintained by the Programme to ensure all issues have a clear owner and action plan. Changes to the issues log are reported to the Programme SRO on a daily basis and regularly to the relevant Boards.

Any incidents where Trakcare may have contributed, are reported using the existing Datix system, and the potential link to TRakcare identified. Incidents are investigated in the usual way and anywhere Trakcare has been shown to have contributed are referred to the Clinical System Safety Group (which reports to the Patient Safety Group) to determine the action required to prevent further incidents. A weekly operational risk review meeting has been established with operational and programme representation (including the medical director) to review all incidents or risks where there may be a link to the use of the system and to ensure adequate mitigations are in place. To date there is no evidence of harm as a consequence of any of these risk or issues

Implementation issues

The identified areas of concern in the Core Issues Log can be categorised as follows:

- Access and Role Profiles
- Operational Readiness
- Inpatient
- Outpatient Clinic Booking
- Reporting (Statutory & Business)
- Help Desk Support

Helpdesk support - Priority 1

As part of the Go Live arrangements, a helpdesk was established, initially managed by the TrakCare programme team. This took over 2000 calls over the first 2 weeks. From mid December 2016 the helpdesk migrated to a business as usual function with the Service Desk managed by Countywide IT services. All calls are logged and assigned to the relevant support team to resolve – the top three call volumes are related to system issues which are dealt with by the Trust Clinical Systems team, IT and hardware issues which are dealt with by Countywide IT services and NHS Smartcard issues which are dealt with by the HR systems team.

The TrakCare call backlog within the Clinical Systems Team is also being reviewed under the issue Management process whereby the divisional leads are reviewing and prioritising calls for resolution. This will identify issues that are no longer relevant or are duplicates as well as those that have been resolved by activity undertaken by the respective project team members as part of ongoing training and local assistance.

The InterSystems Support Team have now assumed full responsibility for new incidents.

Discussion has been held with InterSystems in respect of Service Review Reporting. The initial post go-live report is due to be supplied and will be reviewed with the respective support areas. A defined Trust Support Structure for managing ongoing service reporting will be identified as an update to the Contract Management Manual created during the procurement process to ensure appropriate representation and correct service reporting.

Access and role profile issues – Priority 1

Operational use of the system revealed a number of areas where Security Groups / User Profiles do not meet the operational need. This remains the most common reason for calls to the Clinical Systems team. In most instances this can be resolved when the extent of the role is better understood, but for some roles, temporary work around s have been put in place.

This backlog of calls and the knowledge within the Clinical Systems team to quickly resolve these queries is the biggest risk to returning back to business as usual for the service. To address this additional staff from the programme team have been added to the team and further additional staff have been requested along with a clearer triage and prioritisation process with the Divisional leads. Call volumes and clearance rates are being reviewed daily. The Associate Director of Business Intelligence is currently finalising the plan and timeline to clear the backlog of calls. The team are now able to manage the new calls and are working with the Operational Lead to address the backlog. We are undertaking a full review of role requirements with InterSystems which has commenced with a workshop process on Friday 20th January.

Operational readiness – Priority 1

Despite preparation and training, many staff were not sufficiently familiar with the system at the point of go live, with many of the calls to the helpdesk post go live related to logging on issues and simple queries which were part of the training or within the user guides. In addition to helpdesk support, floor walkers and trainers were allocated to priority areas but the resources available were not able to meet the demand, so a number of clinical areas experienced significant waits to receive support. Going forward a training action plan is to be produced to maximise efficient use of superusers and those staff that have emerged as proficient users so that initial queries can be resolved locally without the need to escalate to the helpdesk. These staff will then be expected to undertake cascade training in their areas. Additional training and support is also being provided to the Clinical Systems Team.

Outpatient clinic booking - Priority 1

The outpatient booking office covers about 70% of the outpatient bookings with the remaining 30% being managed in a few large departments. The new processes involved with booking on TrakCare combined with operational issues with scanning/upload of vetting referral letters have put considerable strain on the booking teams as each booking transaction is mow taking longer. Staff have been moved from medical records to the booking teams to make sure that all referrals are recorded in a timely way so that patients are booked into the correct clinic and that clinic utilisation is maximised. This will remain under review.

A review of Schedule configuration is being undertaken involving the individual specialties. This will be planned and actioned in conjunction with the Operational and Divisional Leads.

Theatre scheduling – Priority 1

The theatre module was a late release just before go live leaving limited time for training. All the theatre lists and schedules for both December and January have been built manually which is a very timely task with risk of transcription errors. A fix has been requested from InterSystems to automate this process with effect from February onwards. An on-site InterSystems presence was requested to assist in this process but the investigation into the issue has proven to require development work at InterSystems. This issue continues to be monitored with appropriate escalation to ensure timely resolution.

The directory of procedures available is not comprehensive. A series of mitigating actions have been put in place to manage the risk of the theatre lists being incomplete.

There was an instance where two patient's details were confused on the Spine and this was traced to a particular Theatres related workflow. Full investigation revealed that the root cause was a cache that was not being cleared and this had the possibility to impact over 90 workflows. An Edition resolution has been developed and tested for inclusion in MR5 (currently in its initial local test phase), but in the meantime, two local level changes have been implemented in Gloucestershire for the workflows that are known to be used and causing problems.

Emergency Department

The two ED departments initially had issues in accessing and using elements of the system to support their operational processes. This has improved and a number of modifications have been requested to improve visibility of patients between departments. Audits have been undertaken to confirm that all patients are on the system. Similar to the booking office the departments are also experiencing issues scanning patient records on paper into the system. The scanning issue is under review with the programme team to find an alternative work flow that is compatible between our hardware and the system.

Inpatients – Priority 1 (Discharge Summaries)

The most significant issue experienced by the inpatient wards is the workflow associated with Inpatient Discharge Summaries. Soon after go live there was a technical problem with generating and sending discharge summaries. This was resolved by InterSystems but discharge summaries continue to be issued at significantly lower rates than normal. A specific recovery plan is being developed to enable additional support to be provided targeted where the completion of discharge summaries is lowest.

The handover sheet, generated by the system does not have all the fields that that the clinical teams require. The required changes will need to be requested from InterSystems.

Reporting – Priority 1

We are technically able to report all Statutory Reports and Key Business Reports. Due to a backlog of activity that was recorded on paper records over the go live period and beyond, the completeness of the data is compromising our ability to report in some areas. There are a limited number of reports where changes will need to be made to the system to collect the correct data.

Backlogs

Detail identification relating to backlogged work in ED, Central Booking Office and other Operational areas is being carried out by the Operational team via the Divisional Leads. Approximately 25 areas of backlog work have been identified and action plans for resolution are being developed.

Training

The Training team have been supporting the operational areas as well as providing additional support resource to the Clinical Systems team since go-live. Emphasis is now on maintaining a BAU training process with the addition of additional training related activities to aid staff.

Face-to-face training has restarted in both Redwood and Sandford Education Centres. The course structure is more granular that pre go-live and has taken into account many of the lessons learned for the experience of go-live and operational use thereafter.

The training team have also set-up regular Q&A sessions for staff groups to attend and will review overall training requirements as part of the operational issues. Initial interest in the sessions planned is encouraging and will help to engender more effective and knowledgeable working within operational areas.

The process of identifying operationally based Champions is being carried out with the cooperation of the divisional leads. Appropriate training will support those identified.

The Clinical For a have also been reinstated based on two sessions per week.

The eLearning facility continues to grow in terms of content and practical progress is being made to move this to the Trust Education and Learning environment. This will not only place a greater emphasis on the governance of training in conjunction with other eLearning initiatives but will make access available to staff from outside of the Trust.

Programme Forward Planning

Formal Review of Phase 1

A formal review of the go live period is planned for February, supported by PWC as our internal auditors. The lessons learned from this process will be applied to the planning for subsequent phases of the programme

Phase 1.5 & Phase 2

There is no Trust section for Phase 1.5 in this month's report as output from the Programme Board review of Phase 1 together with the output from the Joint Trust/InterSystems meeting to review Post Phase 1 activity will provide overall direction for onward planning.

Initial planning sessions have been held with InterSystems and plans for the respective Phase 1.5 components are being produced together with an overall Programme Level plan for Phase 1.5.

Plans are to be developed for:

- Radiology OrderComms
- Pharmacy Stock Control and Dispensing
- Pathology (incl Pathology OrderComms)
- Overall Phase 1.5 plan

Phase 1.5 Progress Updates:

InterSystems are working on required updates to the FDB drug load to provide additional items (Type 1 and 2) required for dispensing. Progress has been made and only a small number of Type 2 items remain and this load is being progressed with urgency.

Pathology Workflow Progress – 117 key workflows have been identified and documented across pathology to ensure alignment in understanding of how key business processes will be implemented within TrakCare Lab Enterprise.

SNOMED CT – dataset loaded into the LAB PRE-RELEASE environment to support testing.

System Interfaces – OPMAS, VitalPulse and SGSS testing in progress.

Data Migration – Good progress is being made with Chemistry (1 year creatinine data to support AKI). Some issues to resolve with Cytology (10yr Gynaecology) dataset and Transfusion Medicine (Blood Groups, Antibodies, SICN, EDD, 3 Month Transfusion).

A full Phase 1.5 update will be provided for the February Programme Board and associated reporting areas.

The process used for Change Management in the Programme and in relation to the Live system is under review to incorporate requirements specifically for Phase 1.5/2 change management.

A review of resource assignment will be included in the respective plans for the identified component areas within Phase 1.5.

Initial review of Phase 2 requirements with respective proposed planning including resource allocation has been initiated with functionally focussed sessions to follow.

Contract Change Note (InterSystems)

The Contract Change Note (CCN) was approved and signed together with Milestone Achievement Certificates for Build Complete and Operational milestones thereby enabling invoice for payment.

Corresponding changes to Purchase orders have been made in line with the CCN for Phases 1 and 1.5.

A PO is in progress of being set-up for the invoicing of monthly Support and Technical Assistance (SUTA) charges in Phase 1. This is due to be completed by 13/01/17.

Finance

SmartCare Financial Position & Forecast (Capital) M8

	Actual £k			Forecast £k			Forecast Project Spend
	2014/15 Full Year	*2015/16 Full Year*	2016/17 YTD M8	2016/17 M9-M12	*2016/17 Full Year*	*2017/18 Full Year*	£000
Internal Recharges	*266.4*	*1,329.7*	793.4	495.9	***1,289.3***	*611.3*	3,496.7
External suppliers	*318.6*	*1,063.0*	1,104.0	428.8	***1,532.8***	*850.7*	3,765.1
Un-reclaimed VAT	*9.0*	*192.3*	213.8	85.8	***299.6***	*170.1*	671.0
	594.0	***2,585.0***	**2,111.2**	**1,010.5**	***3,121.7***	***1,632.1***	**7,932.8**
Business Case Capital Allocation (incl contingency)							7,693.0
Variance from BC allocation							**239.8**
Training Costs (Revenue)			357.5	184	541.5	310.8	852.3

Next Planned activities

Review of Post Go-Live issues and production/management of respective Action Plans

Formal review of Go Live, to produce lessons for future deployments

Review of Post Phase 1 activities including planning exercise for Phase 1.5 and Phase 2 components.

Programme Team activities to be identified in line with agreed planning of post Phase 1 actions and future phase development.

Status against communications plan

Continuation of communications with all stakeholders regarding TrakCare.

Modification to be made to distribution of TrakCare notices to include all Community based sites and external stakeholders.

Progress
(against project plan / project brief)

Tasks/Milestones completed

Task	Start	Finish/ % comp.	Comments
Detailed implementation Plan		31/03/15	Version 1.0 Completed for payment milestone confirmation.
Project Initiation Document		29/04/15	Version 1.0 Completed for payment milestone confirmation.
Phase 1 Operational Assessment Stage Complete		31/05/15	Milestone Achievement Certificate Issued.
Phase 1.5 Operational Assessment Complete		30/09/15	Milestone Achievement Certificate Issued.
Phase 1 Build Milestone		17/07/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16.

Phase 1 ATP Complete (Technical Live)		25/10/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16 on basis of Technically LIVE system being available and supported.
Revised Milestone Plan pending InterSystems CCN		Dec 16	CCN has been completed and signed off.
Phase 1 ATP Complete (Operationally Live)		5 Dec 16	System Live

Milestones approaching

Milestone	Due	Activity to progress
Phase 1 Deployment Verification Complete	2 Feb 17	Pending P1 & P2 issues being raised.

Risks

(where score on risk log requires escalation to Programme Board)

NOTE: All risks under review in line with Issue Management (Jan 17)

Title & Description	Impact	Resolution
Lack of NHS SmartCard provision will cause delay to SPINE compliance and will produce a mixed economy in terms of TrakCare access with work-around requiring to be implemented for retrospective entering of SPINE data. Risk under review and added to Datix prior to logging with Trust Risk Register. SmartCare Project impact assigned at 8 pending review.	8	Risk now associated with setting of correct role assignments following go-live commencement. Datix Risk 2007
Level of clinical engagement is key to the successful implementation of agreed strategy and solution.	10	Monitored and actioned by clear prioritization by collaborative and Trust Boards. Datix Risk 2006
Scale of operational change may require additional and possible external resource to be identified to progress in parallel with implementation.	8	To be revised in line with identified Issues and remedial action plans. Datix Risk 2069
Lack of power/network in areas not covered by generators leading to lack of access to TrakCare.	12	Risk to be assessed with input from Estates. Datix Risk 2320
Lack of Trust resource assigned to project configuration/validation for Pathology. Original level of resource agreed is not being provided.	12	In progress with Phase 1.5 planning in Pathology. Datix Risk 2362
Data Migration and Associated Outpatient Clinic set-up across the Divisions may not be sufficient to ensure a safe and operationally effective go-live.	0	Closed. Remove from next report. Datix Risk 2386
Lack of available Statutory Report output and Key Operational Reports from day 1 of go-live.	12	Monitored in line with actual reporting capability since go-live. Ref Appendix 1. Datix Risk 2387

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE GLOUCESTERSHIRE ROYAL HOSPITAL, ON WEDNESDAY 7 DECEMBER 2016 AT 5.30PM

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT

Governors/ Constituency	Mrs S Attwood	Staff, Nursing and Midwifery
	Mr G Cave	Public, Tewkesbury
	Mr G Coughlin	Public, Gloucester City
	Mrs A Davies	Public, Cotswold
	Prof Chris Dunn	Public, Stroud
	Mrs P Eagle	Public, Stroud
	Dr C Feehily	Appointed, Health Watch
	Mr Colin Greaves	Appointed, Clinical Commissioning Group
	Mrs J Hincks	Public, Cotswold
	Dr P Jackson	Public, Forest of Dean
	Dr T Llewellyn	Staff, Medical and Dental
	Mr J Marstrand	Public, Cheltenham
	Mrs J Harley	Patients Governor
	Mrs A Lewis	Public, Tewkesbury
	Mrs D Powell	Public, Gloucester City
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Mr Peter Lachecki	Chair
	Ms D Lee	Chief Executive
	Mr T Foster	Non-Executive Director
	Ms R Macdonald	Non-Executive Director
	Mr Keith Norton	Non-Executive Director
IN ATTENDANCE	Mrs K Green	Minute taker
APOLOGIES	Ms T Barber	Non-Executive Director
	Mrs J Harley	Patient Governor
	Cllr B Oosthuysen	Appointed, Gloucestershire County Council
	Mr R Randles	Staff, Nursing and Midwifery
PRESS/PUBLIC	None	

The Chair welcomed members of the Council and thanked Governors for attending.

145/16 DECLARATIONS OF INTEREST

There were none.

146/16 MINUTES OF THE MEETING HELD ON 2 NOVEMBER 2016

RESOLVED:- That the minutes of the meeting held on 2 November 2016 were agreed as a correct record and signed by the Chair, subject to the addition of Mrs A Lewis and Mrs D Powell being added to the list of those present.

147/16 MATTERS ARISING

081/16 Q1 PERFORMANCE: **TB**

TB - Chair advised he will ensure mandatory training goes to the Workforce Committee

085/16 UPDATE FROM GOVERORS ON MEMBER ENGAGEMENT:
JM reported been in touch with the complainant. He will contact MW. **CLOSED**

104/16 ANNUAL OPERATIONAL AND FINANCIAL RECOVERY PLAN 2017 - 19 - AT asked for presentation to be circulated as it had not been seen yet. MW action please to circulate. **CLOSED** **MW**

Governors requested, where possible, to have presentations in advance of meetings.

106/16 NOVEMBER 2016 GOVERNOR REPRESENTATION ON BOARD COMMITTEES:
PL advised that this was on agenda

108/16 SUB COMMITTEE REPORTS – HEALTH AND WELL BEING COMMITTEE:
JM advised Stop Smoking responsibility taken from Glos Care and now contracted to Oxford based company. CD advised there is still a service funded through local pharmacies. **CLOSED**

148/16 CHAIRS UPDATE

The Chair presented what he said would be a short update. Having met with the Lead Governor, the intention was to have a much better relationship between the Governors and the Board.

(Deborah Lee, Chief Executive, arrived)

JM asked that the public are encouraged to use Governors as communication channel AT reported that main Board meetings to be held alternatively at Sandford Education Centre, Cheltenham General Hospital and Redwood Education Centre Gloucestershire Royal Hospital and to be made more accessible to members of the public

Recruitment of the Non-Executive Directors – a shortlist had been produced to fill 2 x NED roles. A panel interview was to take place on Monday 12th December 2016. JM said that the Council of Governors had, in past, seen the applications in advance of interviews and asked if that this would be possible in future. DL reported this was unusual because the applications are confidential. AT said that Council of Governors were usually happy as PL and AT were on the interview panel.

The Chair reported back on the work he had undertaken in his first month in the post, which had had an external focus on meetings. He had also attended 2 x Staff Involve sessions alongside the CEO.

149/16 THE REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented her report. She focussed initially on the Progress Review Meeting (PRM) as part of the accountability arrangements for Trusts in Financial Special Measures. The Trust was represented by the Chair, Chief Executive and Interim Director of Finance, Stuart Diggles. Feedback from Stephen Hay, Head of Regulation at NHSI, had been positive in respect of the progress made to date. DL noted that good engagement had been achieved, in a short period of time but the key challenge ahead was one of delivery.

DL advised that the 2016/17 plan was now a £18m deficit plan however, this would be achieved through significant non recurrent measures (ie the sale of College Lawn, which cannot be repeated). We will therefore open 2017/18 financial year with a deficit of £33.7 million when non recurrent measures have been reversed and new cost pressures included.

There are new pressures on the plan, such as the National Pay Awards and changes to National Tariff (the Trust will potentially lose £4-5mill in income because of the tariff change).

The current plan achieved a £16.7m deficit by the end of 2017/18 but work was underway to try and better this position given the NHSI expectation of a planned deficit closer to £10m. The most significant opportunity for improvement rested with an improved income position as the cost reductions were already very significant at c7%.

The Chief Executive also highlighted the launch of TrakCare which had gone live at the weekend. She reported that technically it went well, although there was a slight delay in data migration. However she said that operationally there were very significant challenges and staff were feeling under significant pressure as a result of the new system. Additional staff were being deployed to support the go-live.

The following points were raised:

SA: Very proud of how ward staff, secretaries etc. have coped with the move to Trackcare. There has been a lot of frustration, and worries about day to day issues that aren't resolved quickly enough, although people have been finding their own solutions.

TL: The challenges of implementing Trackcare are slowing staff down and impacting upon operational practice; this situation has been compounded by significant operational pressures and as a result ED staff have been working long hours. DP advised that she was in ED yesterday and how the staff there had been amazing, considering how busy it was.

AT: Commended the Trust for going live and questioned what Phase 1 includes. He asked if the Governors could have an updated summary of what is covered in this phase. It was also reported that Junior Doctors said if the start date had been a week earlier it would not have doubled up on training. DL replied that interserve only offered two go-live slots; one in December 2016 and one in March 2017 and as such the Junior doctor impact was unavoidable, regrettably.

(Dr C Feehily joined the meeting)

Can others feedback on Trackcare issues for example staff at Tewkesbury Hospital? DL responded that she was only aware the feedback mechanisms are available to Trust staff but if Governors wished to flag issues then they could email Sally Pearson, Director of Clinical Strategy and executive lead for TrakCare.

JM: Asked if the Governors' Log could be used as a feedback communication tool. DL suggested not, as for example there might be multiple issues that need responding to and the Governors' Log is set up for a different use.

CF: Asked about the home care position. DL: Discussions have been underway all week that included social care. Discussions with Gloucestershire County Council yesterday resulted in domestic care hours being diverted to support getting patients out of hospital. This was a good tactical response, and it had started a strategic debate about whether there was sufficient capacity in the homecare market, in Gloucestershire. PL commented that all parties need to work together in a different way and the STP provided a good opportunity to take this forward.

PJ: A question on finances – What work has the Trust been doing with patients that we have not been paid for? How much and what for? DL: There has been c£1 million of work undertaken that we haven't been paid for. For example, the Commissioners are looking at procedures that shouldn't be undertaken on the NHS unless it is causing a significant problem, e.g. varicose veins. We are not applying these criteria robustly and hence not being paid for work undertaken. Natasha Swinscoe is looking at our systems and what safety nets we can put in place. Everyone from consultants to booking clerks need to know what the criteria are. DL reported that she was confident we can make inroads into this agenda.

CD: Reported on pharmacist outcomes – and that hospital and community pharmacists working together with patients results in reduction in admissions.

AT: Are we confident College Lawn will sell? DL: yes, we are confident

DL: We should do more to celebrate and recognise success, having been delighted to be at the inaugural Gloucestershire Health and Social Care Awards.

127/16 ELECTION OF LEAD GOVERNOR

It was proposed by Mrs A Lewis, seconded by Mrs J Hincks and **RESOLVED** that Mr Alan Thomas be elected Lead Governor.

There were 16 votes in favour, none against and no abstentions.

128/16 ELECTION OF GOVERNORS TO SERVE ON THE GOVERNANCE AND NOMINATIONS COMMITTEE

Governance and Nomination Committee : 3 vacancies with 3 nominations. All were elected. These are Mr J Marstrand, Dr P Jackson and Mrs J Hincks.

AT: resignation of 2 Governors. MW asked to proceed with recruitment to fill Governor and Staff Governor vacancies ACTION MW **MW**

129/16 BOARD COMMITTEE STRUCTURE

The Chief Executive had discussed with the new Chair and Lead governor a Board Committee structure that would enable Governors to fulfil their statutory role of holding Non-Executive Directors to account. Each Committee would have a named Governor representative and a named Deputy Governor representative who would attend if the Governor representative was not available. The exception would be Workforce Committee which would have two Governors – one Public and one Workforce as representataive, each with a deputy. Training would be available to both representatives.

DECISION: The Council approved the proposal.

During the course of the discussion the following points were raised:

It was requested that the Staff Governor representative on the Workforce Committee should reflect Staff Governor interest.

It was asked if this left the Governors without a forum to engage with the Quality Agenda? DL: Alongside the Governance & Nominations Committee there are two new groups being proposed, Quality & Performance Group and the Strategy & Engagement Group that will report to the Council of Governors on a bi-monthly basis. The Strategy & Engagement Group will cover the Annual Operational Plan development. Work on the Membership Strategy also reports through Strategy & Engagement Group.

AT: On the Working Groups 1 & 2, we had a discussion in our pre meeting as the Working Groups haven't actually happened ie met yet. He acknowledged that Governors have had some issues with the Committees, and he would encourage colleagues to think of this as a package of ways for the Board and C of G to work together, including Governors now being invited to ask questions at Board meetings. The Governors Questions log is a different means and way for Governors to pose questions and receive a timely response from a named executive director. AT said he was convinced by it 'in the round'

PL responded that he thought this allows deeper and better interaction through council/board/ execs and Non-executive Directors. It enables Governors to bring questions through the Log. He emphasised how NEDs are held to account is a very specific objective for Governors, to ensure NEDs are fulfilling their role.

AT: Governors found it difficult sitting at meetings 3 hrs or more, effectively sitting on their hands. Should Governors be allowed a slot at end of Committee Meetings to raise specific issues? They have found not being able to engage in meetings and ask specific questions difficult, and some Governors don't therefore want to attend the meetings.

AD: Asked if there could there be an agenda item at end of each committee meeting for Governors to raise any questions or concerns? Can we help prevent more meetings by allowing this at the end of each agenda? PL commented that there was an agenda item at the end of

each Committee meeting to review it, and this could be used by Governors to comment on the proceedings.

JM: Principle he would like to see continued would be no committee meetings, as Governors are volunteers. If, say, during the day some Governors are at work and therefore can't attend the meetings, the committee representation becomes exclusive. Over time it is difficult for Governors to attend committee meetings every month, particularly when Governors are not able to make contributions to those meetings, therefore they don't want to attend. It also creates an issue of time commitment on the part of volunteers.

Confusing to have two bodies named similar things - the Q&P Group and Q&P Committee is confusing. AT to liaise with Q&P chairs and agree name for governor quality group.

Do the Membership Strategy and the Trust Strategy both fit in the same Strategy & Engagement Group, as both are very different? DL: Dr Sally Pearson leads on both, so we didn't want to create another group. Therefore this could be a meeting of two halves but she also saw alignment and overlap between the two agendas.

PL made an observation that this journey started as Governors wanted to be more involved. This approach is considered to be progressive. If there are better ways to oversee NEDs performance, then we can explore them. This is something that was asked for by Governors and we can review it if it is as unattractive as it sounds. In any case NEDs will attend CoG meetings as part of this process,but also so that NEDs can understand the broader workings and concern of the council. It is not expected that Exec Directors would routinely attend CoG.

CD: I think it is a useful package. Will Governors be Full Members of committees? DL No, they will be in attendance, primarily as observers.

AD: as a new Governor arriving to find a difficult financial situation, complete transparency is very welcome, as is sitting on committees. Governors sitting, observing Non Executive's but not allowed to say anything at the time, it could be another month before a particular issue could be addressed.

PL: Watching NEDs in action is good way of observation. We can think about how committee functions could allow for Governor contribution and feedback. Questions for clarification or understanding of any point can be asked at meetings, where it is about items being transacted.

AT: Propose we accept the assurances of DL & PL going forwards, with a review in six months.

SA: It is a good way to be able to feedback on NEDs performance, otherwise you never see them. Being in meeting means you can give feedback.

JM: This Trust is seen as beacon for other NHS Trusts. At a Governors conference I attended recently, participation by Governors on Board Committees was received very positively at the Conference.

CF: Remember the context in which the idea was first formulated, as Governors wanted a way in to find out what was going on. First we

should see how it works and then review if necessary.

PL: We will press ahead with proposal. Review in six months. Happy to implement changes if not working. I will look into the naming of the committees.

AD: Thank you for listening to Governors and increasing the representation on Committees to include nominated deputies

130/16 GOVERNORS' LOG

DL talked through the Governors log process, administered by MW. A question is raised, and an answer will be received from the CEO or the Executive Team within 10 days.

PJ: How will you police 10 day response? DL: MW will monitor the system, carrying out a day 7 chase and a day 9 follow up to the CEO if a response has not been received.

GC: I understand the difficulty of giving Governors access to nhs.net. How will confidential answers be recorded? DL: the system is secure for Governors only. The site will be updated on a monthly basis by MW and the Governors informed by MW when that update has taken place, rather than there being multiple updates and multiple emails.

JM: A question on Contact a Governor. Some questions are taken through PALS, and the Governors never find out if they have had a satisfactory answer. DL: Once case referred to PALS we wouldn't expect the Governor to hear back. The Governors have to trust organisation to do its job, otherwise it will introduce another layer and the tasks will become too onerous. DL said she would reflect on it further, but that is her immediate response.

PL: Taking it as a positive step forwards. DL: Launch will be at end of January 2017.

MW

131/16 PREPARATION FOR THE CQC INSPECTION

DL gave overview of preparations for the CQC inspection. We are working with staff and others to put their 'inspection eye's on – to see everything in a new light, and therefore what needs sorting. There will be a Governor preparation event in the New Year – date will be confirmed this week.

AT: There was one focus group for Governors before the last inspection. DL confirmed that Governors should expect to hear quickly what the CQC inspectors are requesting. There will be a public meeting event day before the inspection commences. .

JM: There is a perception amongst staff that a huge resource is going into preparations for the CQC inspection. We must ensure that any changes must be sustainable. DL: Confirmed that we haven't put great resourcing in so she would welcome more information from JM on this. Heather Beer is back part time to do the preparation for the visit and Andrew Seaton is providing significant support, from within his existing role.

SA: Staff are doing the work in addition to their day job. There is no

extra resource going in. We are able to make small changes through the 'Just Do It' fund. We want to be goo and ideally outstanding in due course.

132/16 DATES OF MEETINGS FOR 2017

PL: We are allowing time between committee meetings and Board to enablepreparation of written reports for Board and for Execs to follow up on key topics in order to give the Board assurance and enable escalation of risks.DL confirmed SEC stands for Sandford Education Centre, Cheltenham General Hospital and REC is Redwood Education Centre, Gloucestershire Royal Hospital.

133/16 FEEDBACK FROM NEDS ON COMMITTEE

Audit and Assurance Committee – 8 November 2016:
RM reported on the Audit and Assurances Committee, its first meeting with its wider remit of Audit and Assurance. She highlighted the particular need for the remit of the committee to be better articulated across organisation. The question was asked how do we know the assurances work? DL: Through practice and culture. The tracking of actions not happening quickly enough for example. DL said that she was 'on case' and that Internal Audit were doing more work on risk management and process, and particularly the weaknesses identified in their report.
AT: reported that he was on the Committee. He had observed a different approach and was pleased to see it.

Finance Committee – 23November 2016:
TF: Finances – as report

CF: Asked about the Capital Programme Report and how are NEDs assured of the clinical risk associated with the delayed implementation and that there aren't further risks incurred? DL: where not able to process projects with tolerable risk the risk will be entered on the appropriate risk register to ensure ongoing oversight. She had recently asked for a more formalised approach to this, to be put in place.

JM: Asked a question about agency staffing: ownership of NHS Professionals changing. Is there a risk associated with staffing from there with associated costs? DL: we run own internal staff bank, we don't use NHS Professionals.

AT: The initial Deloitte FinancialReporting Report - colleagues have not seen it. Is it available to them? DL: It is not in the public domain, and a Freedom of Information request made was exempted. DL: The Deloitte Financial Reporting report and recommendations have been tracked through the Finance Committee. AT: Governors will need to differentiate what is public and what private when attending Board Sub-committees. PL acknowledged the importance of this point.

TF: Governors can see the 34 recommendations. DL: Agreed. Action MW to circulate Finance Committee report.

Quality and Performance Committee – 23 November 2016:

KN: Quality & Performance Committee – as report

PJ: I was the Governor representative on the committee. KN is to be commended on what has been achieved.

TL: How can we be reassured that the Improvement Director, Sue Barnett, will be replaced by the Senior Leadership Team and that they don't become dependent on the Improvement Director? DL: SB's focus has been to embed her work in 'business as usual'. To establish different divisional leadership approaches and ensure ownership of the A&E target across the whole organisation not just the A&E department.. The new Director of Operations will take the 'helicopter view' and take up link with other areas following SB's departure. .

JM: The ED Emergency Pathway Report was excellent. Has it disappeared?

DL: Apologies for the missing paper.

JM: The 'Assurances' column has a lack of evidence to support the assurances.

CF: The biggest challenge faced is 'what is evidence of performance'. This and what are the systems and how do we challenge them? KN: These questions are being asked at Committee – there is more work to be done.

Workforce Committee – 2 December 2016:

PL: will have paper at next meeting

134/16 GOVERNOR QUESTIONS

AT: Thanks to DL for the intervention on induction training and Governors are now attending staff induction

AT: Governor visits - we were able to see aspects of Trusts work before, which is really useful if done occasionally. Can they be re-introduced? PJ: can the Governors go with the Exec walk about, for example? DL: Exec walk about is not the right forum. PL: NED walk about would be better and he will investigate.

135/16 ANY OTHER BUSINESS

There were no further items of business.

136/16 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held in the Lecture Hall, Sandford Education Centre on 22nd February 2017 commencing at 5.30pm.

137/16 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960

RESOLVED:- That under the provisions of Section 1(2) of the Public Bodes (Admission to Meetings Act) 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of

the business to be transacted.

The meeting ended at 7.40pm.

Chair
22 February 2017

ITEM 15

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 16

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 17

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 18

PUBLIC QUESTIONS

(Procedure attached)

Peter Lachecki
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

The Trust welcomes feedback from members of the public. We are committed to delivering the best care and constantly looking at ways to improve the services we provide at out hospitals. There are a variety of ways in which you can give your feedback. These are:-

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments.
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail pals@gloucestershirehospitals@glos.nhs.uk or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail complaints.team@glos.nhs.uk of by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address.
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the last Friday of the month and alternate between the Sandford Education Centre in Cheltenham and the Redwood Education Centre at Gloucestershire Royal Hospital. Meetings normally start at 9.00am

All feedback is taken seriously and is used to either praise staff for the excellent care or service they have provided or used to make improvements where needed.

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust (including members of the Trust who live outside of the County) may ask the Chair of the Trust Board a question on any matter which is within the powers and duties of the Trust.

Ten minutes will be allocated at the end of the public section of each Board meeting for written questions from the public to be answered. Where it is not possible for all written questions to be dealt with within this timeframe a written response will be provided to the questioner and copied to all Board members within 7 working days of the meeting. In exceptional circumstances, the Chair may extend the time period for public questions.

Notice of questions

A question may only be asked if it has been submitted in writing to the Trust Secretary by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Trust Secretary, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN or by e-mail to martin.wood@glos.nhs.uk No more than 3 written questions may be submitted by each questioner.

Procedure

At the Board meeting the questioner, if present, will be invited to read out the question. If absent, the Chair may read out the question. A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chair. Copies of the questions and the responses will be recorded in the minutes.

Additional Questions

A questioner who has submitted a written question may, with the consent of the Chair, ask an additional oral question arising directly out of the original question or the reply.

An answer to an oral question will take the form of either:

- a direct oral answer; or
- if the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board.

Unless the Chair decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chair considers that they:

- are not on any matter that is within the powers and duties of the Trust;
- are defamatory, frivolous or offensive;
- are substantially the same as a question that has been put to a meeting of the Trust Board and been answered in the past six months; or
- would require the disclosure of confidential or exempt information.

For further information, please contact Martin Wood, Trust Secretary on 0300 422 2932 by e-mail martin.wood@glos.nhs.uk