GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Wednesday 7 June 2017** in the **Subscription Rooms, George Street, Stroud** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

2nd June 2017

AGENDA

				Approximate Timings
	Patient Story			09:00
1.	Welcome and Apologies			09:30
2.	Declarations of Interest			
	Minutes of the Board	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 26th May 2017	**PAPER**	**To approve**	09:32
4.	Matters Arising	**PAPER**	**To note**	09:35
5.	Chief Executive's Report June 2017	**PAPER** (Deborah Lee)	**To note**	09:40
6.	Quality and Performance		**For Assurance**	09:55
	• Update Report of the Interim Chief Operating Officer	**PAPER** (Arshiya Khan)		
	• Trust Risk Register	**PAPER** (Deborah Lee)		
	• Report of the Chair of the Quality and Performance Committee meeting held on 25 May 2017	**PAPER** (Clair Feehily)		
7.	Financial Performance:		**For Assurance**	10:35
	• Report of the Chair of the Finance Committee meeting held on 24 May 2017	**PAPER** (Keith Norton)		
	Break	**10:45 – 10:55**		
8.	Audit and Assurance: • Report of the Chair of the Audit and Assurance Committee meeting held on 23 May 2017	**PAPER** (Rob Graves)	**For Assurance**	10:55
9.	SmartCare Programme Board Report	**PAPER** (Sally Pearson)	**For Assurance**	11:05
10.	Medical Revalidation Report	**PAPER** (Sean Elyan)	**For Assurance**	11:20
11.	Appointment of Senior Independent Director	**PAPER** (Peter Lachecki)	**For Approval**	11:35
12.	Minutes of the meeting of the Council of Governors held on 5 April 2017	**PAPER** (Peter Lachecki)	**To Note**	11:40
13.	Items for the Next Meeting and Any Other Business	**DISCUSSION** (All)	**To Note**	11:50

Governor Questions

14.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions	**To Discuss**	12:00

Staff Questions

15.	A period of 10 minutes will be provided to respond to questions submitted by members of staff	**To Discuss**	12:10

Public Questions

16.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.	**To Discuss**	12:20

Luncheon **12.30 – 13.10**

Date of the next meeting: The next meeting of the Main Board will take place at on **Wednesday 12 July 2017** in the **Lecture Hall, Redwood Education Centre, Gloucester** at **9.00 am.**

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."

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Tracey Barber	Deborah Lee, Chief Executive
Dr Claire Feehily	Maggie Arnold, Nursing Director
Tony Foster	Sarah Stansfield, Acting Finance Director
Rob Graves	Dr Sean Elyan, Medical Director
Keith Norton	Dr Sally Pearson, Director of Clinical Strategy
Vacancy	Dave Smith, Director of Human Resources and Organisational Development
	Arshiya Khan, Interim Chief Operating Officer

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 26 MAY 2017 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 Lachecki	Chair
	Deborah Lee	Chief Executive
	Dr Sean Elyan	Medical Director
	Maggie Arnold	Director of Nursing
	Arshiya Khan	Interim Chief Operating Officer
	Dave Smith	Director of Human Resources and Organisational Development
	Sarah Stansfield	Acting Director of Finance
	Dr Sally Pearson	Director of Clinical Strategy
	Tracey Barber	Non-Executive Director
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	None	
IN ATTENDANCE	Martin Wood	Trust Secretary
	Natashia Judge	Board Administrator
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	No Governors, no members of the public and no members of staff.	

The Chair welcomed all to the meeting.

120/17 PATIENT STORY **ACTIONS**

(Kim Fletcher, Victoria Banks (British Sign Language Interpreter) Carol McIndoe (Disability Equality Manager) and Suzie Cro (Head of Patient Experience) attended the meeting for the presentation of this item)

Kim Fletcher presented her patient story (alongside her interpreter Victoria) of her experience of attending the Emergency Department as well as her experience at two separate outpatient clinics. Her story, written in her own words, had been previously shared with the Board electronically accompanied by an explanation as to why communicating through writing is not a good option for deaf people. Kim began by stating that she would share her negative experience first followed by her positive experience.

In January, 2013, Kim was out walking her dogs in icy weather and suffered a fall where she slipped and fell backwards. She continued on with her walk as normal but as the day progressed she found that her neck became worse. She was unsure how to proceed as her local GP was closed and she was unable to utilise

the 111 Service (as this is telephone based and there is no alternative for the deaf). Therefore, Kim attended the Emergency Department.

Kim described her care in the Emergency Department noting several issues from her arrival. She noted the department desk is quite tall and difficult to look over: making lip reading challenging. Kim explained that she had to lip-read each time a person was called in for their initial assessment and that this was very tiring. Once called through for assessment: she found it difficult to explain her condition to the Doctor through gesture. Whilst waiting for her second assessment she was unable to identify her name being called as the doctor had a large beard – her only indication was that nobody else in the waiting room had stood up. Kim explained to the Board that she would have preferred a doctor without a beard to aid lip reading but did not want to ask to see anyone else.

Difficulties continued during Kim's examination: she struggled to understand the doctor and felt the consultation was unnerving and little was explained to her. Kim then became panicked and the situation escalated to her being sedated and held down for several hours. Eventually, at around 5:30am, Kim decided to text a contact from Gloucestershire Deaf Association and explain the situation. Unfortunately she did not get a response and therefore texted a British Sign Language. Kim was then seen by a female doctor where she managed to communicate. Once the interpreter arrived Kim immediately felt relieved and with their help the doctor explained that Kim had a deformation in her spine and needed an MRI but for now she could go home.

Kim also shared a positive experience of attending an outpatient clinic alongside an interpreter and the Disability Equality Manager who joined her to observe. This experience began with the interpreter taking a step back so that the Disability Equality Manager could see how a deaf person approaches the situation by themselves. Kim noted that again the reception desk was too tall affecting her ability to lip read. Whilst waiting to be called for her appointment a nurse instead came up to Kim and shared a piece of paper with her showing an ear illustrating the sympathetic hearing scheme accompanied by her name. Kim expressed that she felt this was fantastic. She followed the nurse to the doctor's room though she noted this room was too bright and she could not see well. At this point they brought in the interpreter and Kim explained to the doctor that good lighting is needed in order for her to see. Kim discussed the problem she was having and the doctor explained the issue and detailed her options to address these. Kim remarked that she left the consultation comfortable in the knowledge that she understood the issue and potential treatments.

Kim also shared her concerns regarding Audiology Clinic with the Board. Kim explained that she has been attending audiology appointments for a long time and therefore feels confident in attending without an interpreter however the practice in Audiology Clinic is to call patient's names aloud which she feels is very inappropriate. She reminisced that this had been the same for 40

years and that Gloucestershire deaf Association repeatedly asked for this process to be changed but it had never progressed. Kim also wondered whether it was feasible to separate the audiology clinic from the other clinics, meaning that deaf patients would not have to queue alongside patients from other departments at only one desk.

Following Kim's story the Chair thanked her and expressed that he wanted to convey how very sorry he was to hear of her negative experiences and that deaf patients go through such stressful situations in the Trust, especially given there appear to be some simply steps that could be taken to improve things. The Chair queried whether Kim would accept questions from the Board and Kim agreed.

- The Chair could not understand why the practice of calling names in audiology outpatients had not been resolved. The Chief Executive raised this question with the Disability Equality Manager and expressed her surprise that the audiology service was so poorly equipped in this regard given the nature of their patients. She asked that she clarify her role in moving these issues forward and wondered how this had been approached in the past. The Disability Equality Manager shared that a hearing audit had been undertaken last in 2009 looking at the risks deaf patients encounter. She noted that hearing induction loops were available in some areas but Kim explained these were not suitable for someone who is profoundly deaf, only users of hearing aids. The Disability Equality Manager also shared that there was previously an Outpatient Experience Working Group who investigated the possibility of a virtual display which could be used to display patient's names however this idea did not progress. This group previously noted problems with hearing services across the departments as contact is always by phone and this excludes the deaf. They to discussed ways that patients could identify they have a hearing loss but there were concerns regarding the ethics of this and the idea never progressed. The Disability Equality Manager noted that one solution to the issue in audiology would be to place a whiteboard within the department so that staff could note down patients names. The Chief executive noted that basic but valuable adjustments could be made with staff trained with the most appropriate way to call a patient and was disappointed that something so fundamental had not been addressed. The Chief Executive also remarked that she was used to clinical information systems recording patient information such as hearing impairment.
- The Medical Director thanked Kim for her compelling story and echoed the Chief Executive's concerns regarding the audiology department and suggested The Disability Equality Manager contact the Charitable Funds Committee regarding resources to improve the experience for deaf patients in the hospital. Mr Foster introduced himself as head of the Charitable Funds Committee and explained that he would **TF** **SE**

raise this with the charity team. The Medical director also asked that Kim think about what three key signing messages should be taught to all doctors so that these could be introduced.

- Ms Barber thanked Kim for highlighting issues such as light level and beards and felt that these could be reflected in statutory and mandatory training. The Disability Equality Manager explained that sensory training for communication with hearing and visually impaired patients had been undertaken in the past and pictograms were available on the wards as well as information sheets. The Director of Human Resources and Organisational Development requested the Disability Equality Manager liaise with Jo Dutton (Advanced Hearing Therapist) to arrange to attend the Education and Early Development sub group to investigate how training could be developed. **SC**
- The Head of Patient Experience noted that the Disability Equality Manager was undertaking Silver Quality Improvement Training and that learning would be progressed and put into actions. Patient journeys have been mapped and issues with Trakcare noted. Issues have arisen with changes in appointments, lack of text service and lack of alerts regarding British Sign Language users. The Chair queried the timeframe of this and the Head of Patient Experience explained that there were quick wins which could be put into place immediately.
- The Director of Nursing thanked Kim for her story and shared her apologies regarding Kim's experience in the Emergency Department. She explained that she felt nurses learnt better from conversation and asked that Kim and Victoria attend an upcoming strategy day. The Head of Patient experience will link in with Fran Wilson (Matron for Outpatients) to discuss the outpatient forum. Mr Graves also queried whether Kim would be comfortable with recording a session so that this can be shared with multiple nurses and the Head of Patient Experience confirmed that this was in process. [09:30] **SC/MA**
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The Chair thanked Kim, Victoria, Carol and Suzie for their openness and constructive feedback on observations where the Trust can make improvements.

121/17 DECLARATIONS OF INTEREST

There were none.

122/17 MINUTES OF THE MEETING HELD ON 10 MAY 2017

RESOLVED: That the minutes of the meeting held on 10 May 2017 were agreed as a correct record and signed by the Chair.

123/17 MATTERS ARISING

101/17 PATIENT STORY

Dr Feehily asked for a sense of how many other patients had not received discharge summaries and whether this raised safety issues. In response the Chief Executive said that there are TrakCare challenges to electronic summary production and currently around 70% of summaries are sent electronically but all patients should leave with a printed summary to give to their GP. She asked the Medical Director to investigate Lucy's experience. *Completed as a Matter Arising.*

103/17 MINUTES OF THE MEETING OF THE TRUST LEADERSHIP TEAM HELD ON 12 APRIL 2017

The Chief Executive said that the Quality and Performance Committee should be informed of the evidence for supporting the decision to close the TrakCare tracker. *This has been included in the Committee's work plan. Completed.*

106/17 QUALITY AND PERFORMANCE REPORT - REPORT OF THE INTERIM CHIEF OPERATING OFFICER

The Trust reported four 52 week breaches in March 2017 with 11 in April and a similar number expected in May 2017 when the expectation was nil in May 2017. The Chief Executive said that the Quality and Performance Committee should understand the reasons for the poor performance and poor forecasting. *This appeared later as an agenda item. Completed.*

106/17 QUALITY AND PERFORMANCE REPORT - REPORT OF THE INTERIM CHIEF OPERATING OFFICER

The Chief Executive said that the 15 minutes to triage and the Patient Safety Checklist be added to the Performance Framework Dashboard. This has been included in the report. *Completed.*

106/17 QUALITY AND PERFORMANCE REPORT - REPORT OF THE INTERIM CHIEF OPERATING OFFICER

In response to a question from Mr Foster about the term "arrears" in the report, the Chief Executive said that this pertained to data that, due to the validation process, did not appear in the reporting period but in arrears and was not related to issues with TrakCare though there were still gaps in reporting which were. The Chair said that it will be useful for the Quality and Performance Committee to be sighted on the programme to recommence reporting with an understanding of the enablers to hit the required performance standards. *Completed.*

106/17 QUALITY AND PERFORMANCE REPORT - TRUST RISK REGISTER (TRR)

The Trust Leadership Team is to review the TRR in June 2017 and a greater time period for discussion at the June Board meeting will be required as it is expected a number of risks will be added in period for the request to review all safety risks rated 12+. *This will*

be incorporated in Agenda planning. Completed as a Matter Arising.

109/17 WORKFORCE REPORT

The Chief Executive Officer enquired why there was a cost pressure relating to the Tower Block ward moves given the significant work done to re-pattern nursing staff to ensure no cost pressure materialised. Nursing Director explained the background to the moves in wards 2A, 4A and 9A which provided a better patient experience and did not result in an increase in nursing spend. The Chief Executive Officer thanked the Nursing Director but sought future further explanation on the origins of the very significant cost pressure set out in the paper in light of her comments. *Completed.*

109/17 REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE ON THE MEETING HELD ON 6 APRIL 2017

Ms Barber invited the Trust Secretary to list the acronyms in future reports. This will be undertaken for future reports. *Completed as a Matter Arising.*

112/17 OUR GOALS AND OBJECTIVES FOR 2017 -19

The objective supporting health promotion alongside treatment referred to staff not patients and the CEO said this would be amended and the staff objective would remain but be aligned to the workforce goal. *Completed.*

112/17 OUR GOALS AND OBJECTIVES FOR 2017 -19

The CEO said that as a reflection of the “top down” development of the goals, we should consider a brief period of staff engagement to ensure staff were supportive of the direction and priorities proposed. The Chief Executive said that she would include the goals and objectives in her blog and invited the Medical and Nursing Directors to present them to the Local Medical Committee and Senior Nursing Committee respectively. *Completed.*

113/17 END OF LIFE CARE STRATEGY AND CHARTER

Mr Graves referred to the introduction of the Charter and the references to patients and staff which he thought could be expressed differently, He would meet the Consultant in Palliative Medicine to discuss. *Completed.*

113/17 END OF LIFE CARE STRATEGY AND CHARTER

The Chair invited the Consultant in Palliative Medicine to liaise with the Head of Communications to communicate the launch of the Charter. *Completed.*

114/17 GOVERNOR QUESTIONS

The list of acronyms had been made available to Governors but had

yet to appear on the website. This would be addressed by the Trust Secretary and Head of Communications. This has been included on the Trust website. *Completed.*

[09:35]

124/17 ANNUAL ACCOUNTS 2016/2017

The Acting Finance Director presented the Annual Accounts and noted that they include both the Trust and Group positions – the latter including the Trust's charitable funds. The Group position shows the consolidated position and therefore she focused on the Trust Position only.

Key figures noted:

- £32.3m deficit including impairment
- £14m Impairment impact from revaluation of fixed assets due to new guidance
- £18m Operating deficit position for 2016/2017
- £32k positive variance to recovery target agreed with NHS Improvement

The Acting Finance Director shared that the audit was completed by KPMG who have issued a 'clean' opinion. Since finalisation at the end of April 2017 no changes have been advised that impact on the overall results presented. She drew the Board's attention to the prior period adjustments agreed with the auditor relating to factors that should have been included in the 2015/16 accounts which were not.

Key highlights noted by the Acting Finance Director:

- Reduction in non-current assets.
- Significant reduction in Trade Receivables due to collection of outstanding amounts
- Trade payables reduction due to increased payments to suppliers. This manifests as an increase to long term borrowing
- Cash flow statement
- Movements to work capital
- Capital expenditure
- Receipts and a range of financial transactions.
- Overall net cash position has increased by £4m compared to the prior year.

The Acting Finance Director informed the Board that the Audit and Assurance Committee have reviewed the Annual Accounts with input from KPMG and were assured as to the process used to prepare the accounts. Detailed notes that support the accounts are included in the papers and add detail. The Chair of Audit confirmed the rigour associated with this approach.

At the end of the discussion, the Acting Finance Director welcomed questions from the Board.

- The Chair queried whether there was any risk in relation to terms of availability of cash to borrow and relayed that the Department of Health had previously said there would be limits on lending to Trusts that didn't have enough cash. The Acting Finance Director noted that this was highlighted in the concerns and that NHSI and Department of Health would need greater assurance as to why it is required. She noted no material risk. The Chief Executive noted that the predicted deficit for the NHS as a whole was significantly less than in prior years and thus the draw upon cash nationally, would be less than it had been. **CM**
- The Chief Executive asked that the Head of Communications develop clear and understandable communications regarding the deficit focusing on the £18m operational figure given the complexity of the consolidated position and impairment impact.
- The Director of Human Resources and Organisational Development queried whether there had been any difference in the methodology of the auditors that the Board could take comfort in. The Acting Finance Director explained that there was a lower level of materiality and that with a lower level of materiality and difference in focus of audit there is increased rigour. The auditors were given a more in depth look at the Trust's processes to reassure themselves. They were asked to give a view as to whether the accounting judgements were cautious, balanced or optimistic and the accounts have been judged to be balanced. Mr Graves reinforced the Acting Director of Finance's point and explained that the Audit and Assurance Committee had reviewed the accounts at length and that the accounts are now very clean and easy to map out financial recovery. Mr Graves thanked the Acting Director of Finance and Stuart Diggles (Interim Finance Turnaround Advisor) for their leadership in solving issues and has authorised a letter thanking them for their significant efforts.
- The Acting Director of Finance noted that any recommendations bought forward from 2015/2016 have been closed or superseded and that KPMG have not raised any additional recommendations.
- The Medical Director queried the length of the Audit Contract and the Acting Director of Finance explained that Good Practice Guidance suggests that the contracted can be awarded for a number of years. Given the new Audit Independence Rules which came into place on 1st April the Trust cannot have an audit firm provide advice in the same period. She noted that previously Audit and Tax advice had come from KPMG. The audit contract will be re-procured.
- The Chief Executive noted that there would be a Governor Session regarding the accounts on 1st June.
- The Medical Director queried whether there would be a conflict of interest between the accounts with KPMG and not CIP. The Acting Finance Director explained that Independence Rules do not apply until April 1st and this is detailed in note 5.2 of the report.

RESOLVED: That the accounts be approved. [10:00]

125/17 QUALITY REPORT

The Director of Clinical Strategy presented the Quality Report and thanked the Board for taking this out of the Assurance Cycle to meet the deadline of submission on 31 May.

Key points noted:

- The covering paper sets out the significant elements of the report
- The format is nationally prescribed and all organisations submit to the same structure
- The report includes a requirement to include statements from stakeholders. The Board may be interested in observations those bodies have made as perspective of assurance
- Another aspect of assurance comes from a requirement for the account to be externally audited and this is set out in the draft Auditors Statement.

The Director of Clinical Strategy explained that the report is here for the Board to endorse before submission to NHSI and NHS Choices Website and welcomed any questions.

- Dr Feehilly shared that she was familiar with reading accounts and that often stakeholder feedback takes a particular form. She noted that the CCG had been very supportive of improvements made and difficulties faced however the Trust had not quite met expectations on reporting patient experience and data regarding type of engagement and therefore asked that this is addressed. The Director of Clinical Strategy noted that she would work with the Head of Patient Experience to strengthen the information taken and had discussed in Quality and Performance Committee looking at a more robust set of indices to give assurance on safety in the Emergency Department. **SP/SC**
- The Medical Director felt that an illustration was needed on page 12 of the report regarding QI and a graph of missed fractures.
- Mr Foster raised an issue on page 17 of the report regarding application of funding in March 2017. The Director of Clinical Strategy will investigate.
- Mr Graves noted that the font of the account was small and difficult to read. The Director of Clinical Strategy noted that a web version is relied upon which has been designed to be read on a website with changeable font sizes. She also noted that a Brail option could be produced.

The Chair thanked the Director of Clinical Strategy for a well-produced and visual report.

RESOLVED: That the Board approve the Quality Account.
[10:12]

126/17 GOVERNOR QUESTIONS

There were none. [10:12]

127/17 STAFF QUESTIONS

There were none. [10:13]

128/17 PUBLIC QUESTIONS

There were none. [10:14]

129/17 ANY OTHER BUSINESS:

Safety Walkabouts: The Chair asked that the Head of Patient Experience liaise with the Director of Safety and look at collating information regarding trends and issues raised during Safety Walkabouts. The Chair also requested the Director of Safety bring issues regarding safety to the Quality and Performance Committee **SC/AS** **AS**

ITEMS FOR THE NEXT MEETING:

Staff Stories: The board discussed the option of hearing staff stories as well as patient stories. The Chair agreed this was a good suggestion and would investigate having one staff story a year. The Medical Director noted that stories of staff experiences whilst patients themselves were also very helpful. **PL**

Board Work plan: Mr Graves noted that work plans were available at Board Committees and asked that the Main Board work plan be displayed within the papers. **NJ**

Patient Story: The Chair reinforced that a follow up action plan should be shared with the Board three months after each patient story.

[10:26]

(The Board adjourned from 10:26am to 10:45am)

130/17 ANNUAL ACCOUNTS LETTER AND QUALITY REPORT LETTER

The Board re-opened to note and approve the supporting letters of the Annual Accounts and Quality Report.

RESOLVED: That the Annual Accounts supporting letter be approved with the addition of the word relevant. The Acting Finance Director to sign and submit.

RESOLVED: That the Quality Report supporting letter be approved by the Board.

[10:54]

131/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Wednesday 7 June 2017** in the **Subscription Rooms, George Street, Stroud.**

132/17 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 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 10.54 am

Chair
7 June 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 7 JUNE 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
June 2017	May 2017 120/17 Patient Story	**TF**	The Medical Director thanked Kim for her compelling story and echoed the Chief Executive's concerns regarding the audiology department and suggested The Disability Equality Manager contact the Charitable Funds Committee regarding resources. Mr Foster introduced himself as head of the Charitable Funds Committee and explained that he would raise this with the charity team.
June 2017	May 2017 120/17 Patient Story	**SE**	The Medical director also asked that Kim think about what three key signing messages should be taught to all doctors so that these could be introduced.
June 2017	May 2017 120/17 Patient Story	**SC/ CM**	The Director of Human Resources and Organisational Development requested the Disability Equality Manager liaise with Jo Dutton (Advanced Hearing Therapist) to arrange to attend the Education and Early Development sub group to investigate how training could be developed.
June 2017	May 2017 120/17 Patient Story	**SC**	The Director of Nursing thanked Kim for her story and shared her apologies regarding Kim's experience in the Emergency Department. She explained that she felt nurses learnt better from conversation and asked that Kim and Victoria attend an upcoming strategy day. The Head of Patient experience will link in with Fran Wilson (Matron for Outpatients) to discuss the outpatient forum.
June 2017	May 2017 124/17 Annual Accounts	**CM**	The Chief Executive asked that the Head of Communications strategise clear and understandable communications regarding the deficit focusing on the £18m operational figure.
June 2017	May 2017 125/17 Quality Report	**SP/SC**	Dr Feehilly shared that she was familiar with reading accounts and that often stakeholder feedback takes a particular form. She noted that the CCG had been very supportive of

			improvements made and difficulties faced however the Trust had not quite met expectations on reporting patient experience and data regarding type of engagement and therefore asked that this is addressed. The Director of Clinical Strategy noted that she would work with the Head of Patient Experience to strengthen the information taken and had discussed in Quality and Performance Committee looking at a more robust set of indices to give assurance on safety in the Emergency Department.
June 2017	May 2017 125/17 Quality Report	**DL**	The Chief Executive raised concerns with information cascade in the CCG and will investigate this.
June 2017	May 2017 129/17 Any Other Business – Safety Walkabouts	**SC/AS**	The Chair asked that the Head of Patient Experience liaise with the Director of Safety and look at collating information regarding trends and issues raised during Safety Walkabouts. The Chair also requested the Director of Safety bring issues regarding safety to the Quality and Performance Committee.
June 2017	May 2017 129/17 Items for the next meeting – Staff Stories	**PL**	The board discussed the option of hearing staff stories as well as patient stories. The Chair agreed this was a good suggestion and would investigate having one staff story a year. The Medical Director noted that stories of staff experiences whilst patients themselves were also very helpful.
June 2017	May 2017 129/17 Items for the next meeting – Workplan	**NJ**	Mr Graves noted that work plans were available at Board Committees and asked that the Main Board work plan be displayed within the papers.

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
August 2017	May 2017 101/17 Patient Story	**SC**	In response to questions from Ms Barber and Mr Foster about learning for the Board, the Chief Executive said that a quarterly review after the patient story will be presented to the Board. *Ongoing.*

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
June 2017	May 2017 101/17 Patient Story	**SE**	Dr Feehily asked for a sense of how many other patients had not received discharge summaries and whether this raised safety issues. In response the Chief Executive said that there are TrakCare challenges to electronic summary production and currently around 70% of summaries are sent electronically but all patients should leave with a printed summary to give to their GP. She asked the Medical Director to investigate Lucy's experience. *Completed as a Matter Arising.*
May 2017	May 2017 103/17 Minutes of the Meeting of the Trust Leadership Team held on 12 April 2017	**NS/AK**	The Chief Executive said that the Quality and Performance Committee should be informed of the evidence for supporting the decision to close the TrakCare tracker. *This has been included in the Committee's workplan. Completed.*
May 2017	May 2017 106/17 Quality and performance report - Report of the interim chief operating officer:	**NS/AK**	The Trust reported four 52 week breaches in March 2017 with 11 in April and a similar number expected in May 2017 when the expectation was nil in May 2017. The Chief Executive said that the Quality and Performance Committee should understand the reasons for the poor performance and poor forecasting. *This appeared later as an agenda item. Completed.*
June 2017	May 2017 106/17 Quality and performance report - Report of the Interim Chief Operating Officer	**NS/AK**	The Chief Executive said that 15 minutes to triage and the Patient Safety Checklist be added to the Performance Framework Dashboard. *This has been included in the report. Completed.*
June 2017	May 2017 106/17 Quality and performance report - Report of the interim chief operating officer	**NS/AK**	In response to a question from Mr Foster about the term "arrears" in the report, the Chief Executive said that this pertained to data that, due to the validation process, did not appear in the reporting period but in arrears and was not related to issues with Trakcare though there were still gaps in reporting which were. The Chair said that it will be useful for the Quality and Performance Committee to be sighted on the programme to recommence reporting with an understanding of the enablers to hit the required performance standards. *Completed.*

June 2017	May 2017 106/17 Quality and performance report - Trust Risk Register	**MW**	The Trust Leadership Team is to review the TRR in June 2017 and a greater time period for discussion at the June Board meeting will be required as it is expected a number of risks will be added in period for the request to review all safety risks rated 12+. *This will be incorporated in Agenda planning. Completed as a Matter Arising.*
June 2017	May 2017 109/17 Workforce Report	**MA**	The Chief Executive Officer enquired why there was a cost pressure relating to the Tower Block ward moves given the significant work done to re-pattern nursing staff to ensure no cost pressure materialised. Nursing Director explained the background to the moves in wards 2A, 4A and 9A which provided a better patient experience and did not result in an increase in nursing spend. The Chief Executive Officer thanked the Nursing Director but sought future further explanation on the origins of the very significant cost pressure set out in the paper in light of her comments. *Completed.*
June 2017	May 2017 109/17 Report of the Chair of the Workforce Committee on the Meeting Held On 6 April 2017	**MW**	Ms Barber invited the Trust Secretary to list the acronyms in future reports. *This will be undertaken for future reports. Completed as a Matter Arising.*
June 2017	May 2017 112/17 Our Goals And Objectives For 2017 -19	**SP**	The objective supporting health promotion alongside treatment referred to staff not patients and the CEO said this would be amended and the staff objective would remain but be aligned to the workforce goal. *Completed.*
June 2017	May 2017 112/17 Our Goals And Objectives For 2017 -19	**DL/SE/MA**	The CEO said that as a reflection of the "top down" development of the goals, we should consider a brief period of staff engagement to ensure staff were supportive of the direction and priorities proposed. The Chief Executive said that she would include the goals and objectives in her blog and invited the Medical and Nursing Directors to present them to the Local Medical Committee and Senior Nursing Committee respectively. *Completed.*

June 2017	May 2017 113/17 End Of Life Care Strategy And Charter	**RG/EH**	Mr Graves referred to the introduction of the Charter and the references to patients and staff which he thought could be expressed differently, He would meet the Consultant in Palliative Medicine to discuss. *Completed.*
June 2017	May 2017 113/17 End Of Life Care Strategy And Charter	**EH/CM**	The Chair invited the Consultant in Palliative Medicine to liaise with the Head of Communications to communicate the launch of the Charter. *Completed.*
June 2017	114/17 Governor Questions	**MW/CM**	The list of acronyms had been made available to Governors but had yet to appear on the website. This would be addressed by the Trust Secretary and Head of Communications. *This has been included on the Trust website. Completed.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JUNE 2017

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 The operational context reflects more typical seasonal patterns which has been a welcome progression however, periods of peak activity continue to be experienced – particularly in the early part of each week and during these times patient experience is adversely impacted with A&E waits and cancelled operations still being a feature of some patients care. The Executive team and staff across the Trust remain very focussed on this priority both in respect of immediate steps and the more strategic solutions to the issues that create these conditions. Since the last report, there have been signs of improvement, notably in the days following the May Bank Holiday period – a typically challenging period – the Trust achieved in excess of 90% performance against the 4 hour A&E standard at both sites.

2. National

2.1 NHSI have announced an intention to review the arrangements pertaining to Private Finance Initiatives (PFI) many of which are considered to represent poor value for the NHS. It is not yet know what form the review will take but the Trust will be watching developments closely to understand what, if any, opportunities this might afford for our own scheme.

2.2 Following a recent Board discussion on smoking on NHS sites, the Director of Clinical Strategy was asked to write to Duncan Selby, the Chief executive of Public Health England. The Trust has received a positive response to this letter, commending the Trust for the work it has done, and continues to do, in this area. The letter is attached at Appendix 1.

3. Our System

3.1 The Gloucestershire system partners recently met with Matt Swindells, National Director for Commissioning Operations for NHS England who visited the patch at the request of the Sustainability and Transformation Partnership (STP). It was clear from the visit that the national view of our system is currently mixed and that our ongoing performance in respect of A&E and other national standards is a considerable concern to NHSE. However, the day was broadly positive with the Trust and partners taking the opportunity to showcase many of the positive initiatives underway in Gloucestershire. STP Chairs and Chief Executives took the opportunity to explore our vision for developing an Accountable Care System model for Gloucestershire, though at this time we were encouraged to focus on addressing our performance challenges before submitting a proposal to develop an ACS. Work is now underway to explore further how a 'shadow ACS' might develop as a means to addressing the shortcomings in performance through even closer integration between the STP organisations.

3.2 County Council has launched the One You Pledge campaign with many Trust Board members submitting a personal pledge. The Trust has agreed to become a partner within the "healthy workplace" element of this important initiative reflecting the growing importance being placed on staff health and wellbeing.

3.3 System partners recently received an interesting presentation from the Countywide Information Management and Technology Lead setting out the Digital Strategy for the County. This was an incredibly information session, with the strategy providing a helpful framework within which the Trust can develop its own strategic response. Zack Pandor has very recently joined the Trust on secondment from the County-wide IT

Service (CITS) as Chief Information Officer and one of his early priorities will be the development of the Trust's Digital Strategy.

4. Our Trust

4.1 The past month has seen significant focus on developing our proposal for our site redevelopment plans. The strategic planning, finance and estates team have been working together with colleagues in NHS England to refine our bid. Initial feedback remains very positive though national bids significantly exceed sums available.

4.2 This month the Trust has published its two year strategic objectives and staff are being encouraged to provide feedback on them as part of our engagement activities. Our aim is to ensure that, through good line management and appraisal, every member of staff understands their personal contribution to these goals.

4.3 Since my last report, the Trust has experienced the global cyber-attack. Our own Trust and indeed the wider health system faired very well. Thanks to the proactive and professional approach of our County-wide IT services, who had proactively ensured that we were benefiting from the most up to date anti-virus software, none of the Trust's systems were affected. Huge thanks go to Zack Pandor and his team. Further measures to protect us against subsequent attacks are being put in place.

4.4 Activities to secure substantive directors to the Board continue and following the successful appointment of a Finance Director, who will commence on the 19th June, we are now advancing plans for the appointment of a substantive Chief Operating Officer and Deputy Chief Executive with interviews scheduled for the 5th June 2017 and Chief Nurse interviews scheduled for 20th June. Following a successful eight years in the Trust, Dave Smith, Director of Workforce and Organisational Development will be leaving the Trust in the autumn. Dave has led a very successful and progressive function in the Trust and is renowned not only for his professional skills but his contribution to Trust life more generally – his place as compere of our staff awards will be difficult to fill! Recruitment for his successor has commenced and interviews are scheduled for the 6th July 2017.

4.5 Whilst awaiting the final Care Quality Commission report, the Trust continues to advance its actions to address the issues highlighted through the Commission's initial feedback. Publication has been delayed to allow the CQC more time to consider the factual accuracy submission from the Trust and is now likely to be later in June or early July.

4.6 The Trust continues to take every opportunity to recognise and celebrate success. This month the Trust was recognised nationally for the work it has done with STP partners in relation to musculoskeletal services and was awarded a 'highly commended' status in the acclaimed Health Service Journal Awards. On this theme, the Trust was also re-inspected and maintained its UNICEF baby friendly status; this 'kite mark' assures that babies in Gloucestershire get the very best start in life and thanks go to Sue Maxwell, Infant Feeding Lead, Sophie Ferguson and Emma Taylor, Infant Feeding Support Midwives alongside the whole maternity and neonatal team who have embraced this global initiative. Away from the "front line" staff in our procurement team were also recognised for being in the top 10% of Trusts nationally against a range of metrics which set out "what good looks like" in the procurement world – this feedback is highly valued by staff working in our support services and back office in particular. Finally, the Trust Leadership Team hosted our Big Staff THANK YOU in May in the form of a barn dance and hog roast. Around 200 staff from throughout the organisation – clinical, non-clinical, front line, back office joined in what was a terrifically successful evening; thanks to the hospitals' charity that provided funding for the event.

4.7 Finally, as reported last month we are in the final stages of the independent Financial Governance Review. The draft report was received by the Board at its May meeting and members broadly accepted the findings and recommendations. The Board welcomed the extent to which the majority of recommendations have already progressed, reflecting significant strengthening of Board governance.

Deborah Lee

Chief Executive Officer

June 2017

Public Health England

Protecting and improving the nation's health

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17 May 2017

Sent by post and email: sally.pearson@glos.nhs.uk

Dear Sally

Thank you for your letter of 2 May and I warmly welcome your support for a tobacco-free NHS across England.

First, I congratulate Gloucestershire Hospitals NHS FT on its achievements on tobacco control as part of your Health and Wellbeing Strategy. The range of initiatives in place to support patients, staff and people in the wider community who smoke to quit is very good indeed. It would be hard to find a Trust which has done more to implement the evidence-based recommendations set out in NICE public health guidance on smoking cessation in secondary care settings.

PHE recognises the implementation challenges of introducing smokefree hospital grounds. You may have seen my recent Public Health Matters blogpost on this.

Our advice is to focus on making compliance with your smokefree policy as easy as possible. This can include communicating with patients and their families to ensure no-smoking expectations are set in advance of visiting the Trust (for instance including warnings in appointment letters), good signage throughout the trust estate and creating a sustainable culture amongst all staff that supports the smokefree policy. PHE will be liaising with training providers to encourage the development of a training package for staff, to give them the knowledge and skills needed to act as effective "smokefree ambassadors".

I would also encourage you to consider the role of e-cigarettes. Last year PHE published advice for organisations on developing a vaping policy that supports smokers to quit and stay smoke free. A number of Trusts have taken this on board, for instance by replacing previous smoking shelters with clearly signposted vaping zones.

Public Health England

Gloucestershire is a great example of what it means to be a tobacco-free NHS, working with partners across the healthcare and public health system to help reduce smoking in your local community. Eliminating all smoking from your hospital grounds is the last hurdle to clear and I wish you the very best in gradually educating your community to adhere to your smokefree policy.

Finally, you set out a clear argument for the role of further legal sanctions and this is being considered with Department of Health colleagues as part of our ongoing work on tobacco control.

Thank you again for writing to me and for everything you are doing to tackle what remains the biggest avoidable killer in the UK.

With best wishes

Yours sincerely

Duncan Selbie
Chief Executive

cc. Professor John Newton, Director of Health Improvement, PHE
Lee Bailey, Director of Communications, PHE
Dr Jenny Harries, Regional Director South of England, PHE
Professor Debra Lapthorne, Centre Director South West, PHE

MAIN BOARD MEETING – 7th JUNE 2017
STROUD SUBSCRIPTION ROMMS

Report Title
Performance Management Framework
Sponsor and Author(s)
Arshiya Khan, Interim Chief Operating Officer

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

Executive Summary

- The Trust performance in April was a mixed picture. Whilst the performances against the 4-hour A&E and 62 day cancer standards improved, we saw a deteriorating picture for two week waits, 31 days cancer pathways and diagnostics.

- The performance against the 4-hour A&E waiting time standard improved by almost 5% relative to March with fewer ambulance handover delays and with pressures easing on the emergency care pathway following the winter months. The number of medically stable for discharge patients continued to see the seasonal downward trend with a similar trend for delayed transfers of care patients that were at 28 compared to 37 in March. However, we continued to struggle to deliver the 60 minute time to see a doctor in A&E which was a combination of process issues and staffing gaps in the medical workforce in A&E. The latter continues to be challenging especially with the new rules governing the booking of locum doctors.

- There were a higher than average numbers of two week waits for colorectal referrals causing capacity issues both in the outpatient clinics and for endoscopies. This increase in demand together with the reported incident of missing clinic letters and patients turning down appointments within the two weeks due to the Easter holidays resulted in the Trust missing the target by 3%. These same issues contributed to a deteriorating performance against the 31 days cancer pathway performance and will affect the 62 day cancer performance for May and June; although in April the performance was 78% which was almost 7% higher than the performance in March and almost 3% over the plan agreed with NHSI. The better than planned performance was due to extra capacity put on by specialities and an operational drive to deliver the performance against the revised plan.

- Whilst we continued to address the backlogs in echocardiograms there was an increase in the number of patients awaiting a diagnostic test after 6 weeks. This was a combination of delays in echocardiograms and endoscopies that were under pressure due to the high number of 2 week wait referrals, a deteriorating picture in angiograms due to capacity constraints and the impact of the missing clinic letters incident in audiology. In April we delivered a performance of 7.2% awaiting a diagnostic test after 6 weeks with increasing pressures in May and June.

- Performance against the well led domain was the same as in previous months.

- We continue to face issues regarding data for the safety and effective domains which are not being reported at present. The issues are being investigated with the aim to re-establish reporting against some within the next month albeit with data quality caveats against these. An update is attached as Appendix 1.

- Although we are at present not reporting against the 18 week referral to treatment standard we are very closely monitoring and managing patients that have been waiting longer than 52 weeks. In April we reported eleven patients that waited 52 weeks and over for treatment to start. All but one patient was treated in May. We are forecasting that we will continue to see 52 week breaches for the next few months whilst the post TrakCare validation exercise is carried out and the data quality issues in the different waiting lists are addressed along with the issues facing the outpatient bookings.

- The following metrics have been removed from the PMF from April 2017 onwards as their methodologies have changed in 2017/18 and they are no longer relevant:
  - GP referrals YTD – within 2.5% of previous year
  - Elective spells YTD – within 2.5% of plan
  - Emergency spells YTD – within 2.5% of plan
  - OP attendance and procedures YTD – within 2.5% of plan

- In June the Q&P will receive the first full draft version of the new Quality and Performance Report.

- The attached analysis on our strengths, priorities, opportunities and threats summarises our performance.

Recommendations

The Trust Board is requested to receive the Integrated Performance Framework Report as assurance that the executive team and Divisions fully understand the current levels of poor performance and have action plans to improve this position.

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

Continued poor performance in delivery of the four national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.

Regulatory and/or Legal Implications

The Trust remains under regulatory intervention for the A&E 4-hour standard and heightened monitoring in respect of other performance concerns, including those associated with TrakCare implementation.

Equality & Patient Impact

Failure to meet national access standards impacts on the quality of care experienced by patients. There is no evidence this impacts differentially on particular groups of patients.

Resource Implications

Finance		Information Management & Technology	
Human Resources	X	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	Trust Leadership Team	Other (specify)
✓				✓	

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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Performance Overview

The following summarises the key strengths in May 2017, along with the weaknesses, opportunities, risks and threats for the Trust.

Strengths	Priorities
• The 15 minute triage quality standard continues to show improvement with 81.9% in April • The Trust continues to manage 104 days cancer pathway patients with the lowest ever numbers for urology in the last 18 months. Whilst urology long waiters are attribute to capacity the reaming are either late referrals from other hospitals or patient choice. • DTOC in April reduced by 821 bed days as compared to March and number of discharges form the MSFD ward continue to be high • The number of discharge summaries sent to GPs within 24 hours has improved to 65% the highest ever since January 17 • The downturn in registered nursing turn over has continued and is now at its lowest since February 2015 • Continued focus on the reduction of agency usage and sickness absence • Performance against most of the additional quality measures has been good	• Establish reporting on all performance indicators • Management of data quality issues within the waiting lists remains a priority • Continued focus on validation of the incomplete 18 week referral to treatment so that we establish national reporting • Prioritise the rebuild of the high risk outpatient clinics to ensure outpatient efficiencies to help improve RTT and cancer performance • Continued improvement in the 15 minute time to triage, 60 mins time to be seen by a decision maker in ED, early identification and management of long waiters i.e. patients on cancer and RTT pathways • Achievement of the recovery target of 87.7% (agreed trajectory with NHSE)for patients spending 4 hours or less in ED • Continue to reduce patients that are DTOCs and establish LoS reporting and data • Deliver the echo recovery plan so that the performance on the diagnostics target improves whilst also agree a recovery plan for endoscopy and angiograms
Opportunities	**Risks and Threats**
• The trust has engaged in a novel way of delivering extra work through insourcing. 6 endoscopy lists will be delivered in May as a precursor to a significant programme of work to deliver our cancer recovery plan and manage a number of long waiters on the RTT pathway • The trust has engaged with an IT company to provide expertise and resources for addressing Trak related issues • The MSFD ward has had a positive impact on discharge of medically fit patients. Consideration to be given to a similar ward or space at CGH • With the CCG support continue to outsource • Research accruals have increased which will help to maintain our research infrastructure through the activity based funding model • Vacant slot report now available which should improve clinic utilisation	• JAG accreditation will be affected by the backlog surveillance endoscopy waiting list • Capacity in endoscopy and urology remain a concern for delivery of the cancer target in July • Continued underperformance of the 4 hour ED target with a number of non-admitted breaches in the late evenings due to some badging of ambulance conveyances and gaps in ED medical staffing as the main contributory factors • Waiting lists data quality issues continue to pose significant operational challenges • Clinic re-builds for all OP clinics remains a risk due to the resource implications • We are not meeting the target for the time to initiate and recruit to commercial research trials. This potentially could make us less attractive for a site for commercial research.

ASSESSMENT AGAINST THE NHS IMPROVEMENT RISK ASSESSMENT FRAMEWORK

		2014/15				2015/16				2016/17															NHSI
	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	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%	74.69%	77.00%	77.86%	82.85%	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%	76.9%	78.2%	77.4%	81.2%	73.6%	79.0%	76.8%	72.9%	72.9%	72.0%	62.7%	70.0%	70.7%	78.0%	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%	96.0%	91.7%	84.6%	95.0%	100%	89.9%	100%	86%	97.0%	100.0%	82.8%	92.3%	95.5%	86.3%	
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%	90.7%	98.1%	100%	100%	98.1%	100%	100%	100%	89.4%	83.7%	84.2%	97.7%	87.8%	89.4%	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%	100%	100%	100%	96.0%	
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %	94%	100%	98.6%	99.8%	100%	100%	100%	100%	100%	100%	98%	99.5%	100%	100%	100%	100%	100%	98.3%	100%	100%	95.0%	98.4%	100%	98.6%	96.1%	
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%	94.9%	98.6%	99.6%	99.0%	99.2%	99.7%	98.8%	98.8%	93.8%	94.1%	90.1%	93.6%	96.8%	94.4%	0.0
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%	92.6%	85.1%	94.7%	94.6%	91.4%	0.0
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%	89.4%	95.0%	97.1%	90.3%	
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	7	0	8	1	0.0

In month position, therefore figure not validated

PERFORMANCE MONITORING AGAINST THE SUSTAINABILITY AND TRANSFORMATION PLAN

		2016/17												2017/18				
ED		Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Apr
% 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%	87.75%
	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%	74.69%	77.00%	77.86%	76.56%	82.85%
% 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%	87.75%
	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%	75.40%	77.60%	78.35%	77.13%	83.16%
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%	*	*	1.18%	1.79%	4.59%	2.54%	7.22%
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%	72.0%	76.9%	62.7%	70.0%	70.7%	66.3%	78.0%
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%	72.0%	76.9%	62.7%	70.0%	70.7%	66.3%	78.0%

In month position, therefore figure not validated.

TRUST PERFORMANCE & EXCEPTIONS (as at end April 2017)

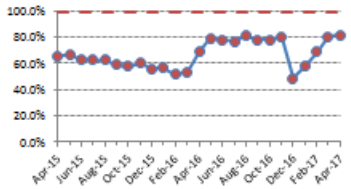
SAFETY

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q4	2016/17 Q1	Q2	Q3	Q4	Feb	Mar	Apr	FORECAST May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
INFECTION																				
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		13	10	10	7	15	0	8	1	TBC	TBC	TBC	TBC	TBC	TBC		37 cases/year	NHSI	M	Apr
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		1	1	0	0	2	0	1	0	TBC	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Apr
MORTALITY																				
Crude Mortality rates %		1.4%	1.2%	1.1%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		<2%	Trust	M	Nov
Summary Hospital-Level Mortality Indicator		113.2	112.4	115.6	arrears	arrears	arrears	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		≤1.1%	Trust	Q	Sep
HSMR (Analysis-relative risk-basket HSMR basket of 56-mortality in hospital) (rolling 12 months)		106.8	108.0	111.8	115.2	arrears	arrears	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Confidence interval	Dr Foster	M	Jan
SMR (rolling 12 months)		110.2	112.3	118.2	119.8	arrears	arrears	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Confidence interval	Dr Foster	M	Jan
SAFETY																				
Number of Never Events		0	0	1	1	0	0	0	0	TBC	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Apr
% women seen by midwife by 12 weeks		89.6%	87.2%	92.3%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		>90%	GCCG	M	Nov
CQUINS																				
Acute Kidney Infection (AKI)		50%	42%	60%	64%	65%	59%	58%	arrears	TBC	TBC	TBC	TBC	TBC	TBC		>70% by Q4	National	M	Mar
Sepsis Screening 2a		92%	96%	97%	97%	96%	98%	96%	arrears	TBC	TBC	TBC	TBC	TBC	TBC		>90% of eligibles	National	M	Mar
Sepsis Antibiotic Administration 2b		49%	55%	45%	64%	64%	70%	64%	arrears	TBC	TBC	TBC	TBC	TBC	TBC		>50% of eligibles	National	M	Mar
Dementia - Seek/Assess		86.3%	88.1%	88.3%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
Dementia - Investigate		100%	100%	100%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
Dementia - Refer		100%	100%	100%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
ED																				
% patients triaged in ED in 15 minutes		53.7%	75.3%	78.6%	69.0%	69.1%	68.5%	80.2%	81.9%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 99%	Trust	M	Apr
% patients assessed by doctor in ED in 60 minutes		43.3%	47.1%	46.0%	41.3%	33.4%	34.0%	31.2%	29.5%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 90%	Trust	M	Apr

* 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.

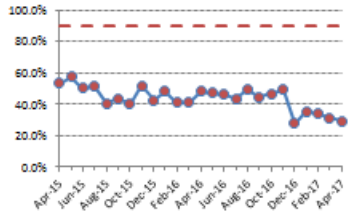
SAFETY

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
% patients triaged in ED in 15 minutes Standard is ≥ 99%								Director of Nursing and Midwifery

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

The actions implemented so far are:
Immediate triage at point of arrival by triage trained nurse rather than co-ordinator. A triage nurse is placed in the main corridor where the ambulances arrive to initiate point of contact and visibility of the patient. A receptionist is identified daily to work with the triage nurse booking the patient in on Trak care. A Senior Nurse has been identified for minor's triage and a second triage nurse will continue to work alongside.

Performance in March increased to 83.1% at GRH and 79.8% at CGH.

% patients assessed by doctor in ED in 60 minutes Standard is ≥ 90%								Director of Safety

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

Time to see a doctor remains a challenge. Demand capacity analysis has identified risk times for breaches. From April the ED has changed its rotas to optimise scheduling. The department has benchmarked productivity of doctors of different grades against clinicians working in other departments and has demonstrated a comparable work rate. The CQC interim report and a recent ECIP visit has highlighted the high work rate of medical staff and questioned sustainability. ECIP has offered support from the Regional Clinical Director, and meetings are underway. The department continues to have vacancies at all levels. It is hoped that some junior posts will be filled in the near future by developing a new post of physicians assistant, recent interviews recruited 1 PA who will start in August. Junior doctor interviews held in April recruited 2 Fellows to start in August. We have been informed of 3 vacancies in the GP training posts from August and 2 current Clinical Fellows finish in August. These vacancies have been advertised and shortlisting is in progress. Recruitment of middle grades is a persistent problem with consultants acting down regularly at night. A 20th consultant has been appointed with a start date of 21st August.

TRUST PERFORMANCE & EXCEPTIONS (as at end April 2017)

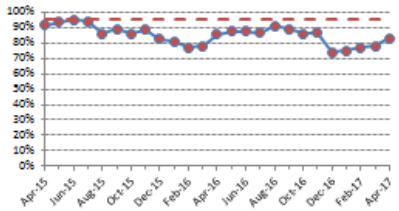
RESPONSIVE

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q4	2016/17 Q1	Q2	Q3	Q4	Feb	Mar	Apr	FORECAST May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
ED																				
% patients spending 4 hours or less in ED		78.5%	86.9%	88.5%	82.4%	76.6%	77.0%	77.9%	82.9%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 95%	NHSI	M	Apr
Number of ambulance handovers delayed over 30 minutes		428	517	541	474	352	104	47	34	TBC	TBC	TBC	TBC	TBC	TBC		< previous year	GCCG	M	Apr
Number of ambulance handovers delayed over 60 minutes		33	3 **	1	14	8	1	0	1	TBC	TBC	TBC	TBC	TBC	TBC		< previous year	GCCG	M	Apr
18 WEEKS																				
Incomplete pathways - % waited under 18 weeks		92.0%	92.0%	90.7%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		≥ 92%	NHSI	M	Nov
15 key Diagnostic tests : % waiting over 6 weeks at month end		4.0%	2.6%	0.8%	1.4%	2.5%	1.79%	4.59%	7.22%	TBC	TBC	TBC	TBC	TBC	TBC		<1% waiting at month end	GCCG	M	Mar
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates		225	441	405	*	681	*	681	*	TBC	TBC	TBC	TBC	TBC	TBC		< 1% waiting at month end	GCCG	M	Mar
CANCER																				
Max 2 week wait for patients urgently referred by GP %		88.7%	84.9%	88.2%	91.7%	91.9%	94.7%	94.6%	91.4%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 93%	NHSI	M	Mar
Max 2 week wait for patients referred with non cancer breast symptoms %		95.3%	93.1%	93.7%	92.0%	94.0%	95.0%	97.1%	90.3%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 93%	NHSI	M	Mar
Max wait 31 days decision to treat to treatment %		99.8%	99.1%	99.2%	94.9%	93.8%	93.6%	96.8%	94.4%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 96%	NHSI	M	Mar
Max wait 31 days decision to treat to subsequent treatment : surgery %		99.5%	99.4%	99.4%	90.7%	89.2%	97.7%	87.8%	89.4%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 94%	NHSI	M	Mar
Max wait 31 days decision to treat to subsequent treatment : drugs %		100%	100%	100%	100%	100%	100%	100%	96.0%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 98%	NHSI	M	Mar
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %		100%	100%	99.5%	98.6%	99.1%	100%	98.6%	96.1%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 94%	NHSI	M	Mar
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		76.7%	79.0%	76.9%	75.4%	68.5%	70.0%	70.7%	78.0%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 85%	NHSI	M	Mar
Max wait 62 days from national screening programme to 1st treatment %		94.9%	90.6%	96.0%	92.2%	90.1%	92.3%	95.5%	86.3%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 90%	NHSI	M	Mar
Max wait 62 days from consultant upgrade to 1st treatment %		100%	100%	71.4%	50.0%	100%	-	100%	100%	TBC	TBC	TBC	TBC	TBC	TBC		≥ 90%	NHSI	M	Mar
Number of patients who have breached beyond 104 days - without a decision to treat date			80	65	49	42	42	42	47	TBC	TBC	TBC	TBC	TBC	TBC		0	Trust	M	Apr
Number of patients who have breached beyond 104 days - with a decision to treat date			9	9	11	11	12	11	10	TBC	TBC	TBC	TBC	TBC	TBC		0	Trust	M	Apr

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

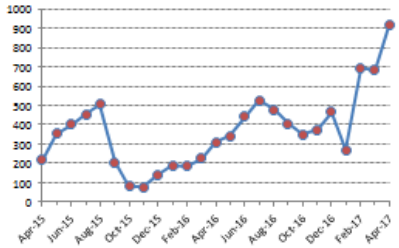
In month position, therefore figure not validated.

RESPONSIVE

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	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.

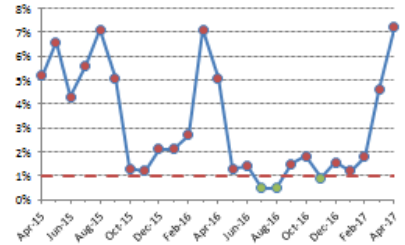
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates Standard is < 1% waiting at month end								Chief Operating Officer

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

The speciality is working closely with Informatics to refine the PTL data. Patients that were wrongly on other PTLs following the new IT system implementation have now been placed on the planned list.

- The speciality is carrying out generating 50 procedures over two weekends in May - a mix of Diagnostic 2ww and Planned Surveillance slots to start to recover in both areas
- 30 per week to be outsourced to Emerson Greens

RESPONSIVE

MEASURE		QUARTERLY PROGRESS						OWNER
		Q1	Q2	Q3	Q4	NOW	FOT	
15 key Diagnostic tests : % waiting over 6 weeks at month end Standard is < 1%		●	●			●	●	Chief Operating Officer

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

There were 459 patients waiting 6+ weeks at the end of April 2017, of which:

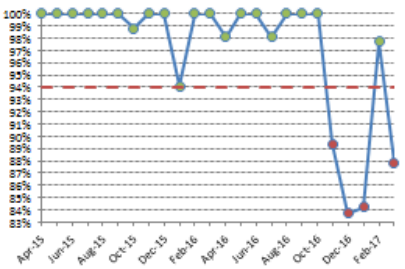
106 cardiology breaches

92 audiology breaches

116 gastroscopy, 107 colonoscopy, 17 flexi sigmoidoscopy breaches:
Demand for Colorectal 2ww diagnostic procedures continues to rise in line with the increase in 2ww new referrals into the Colorectal outpatient service. Demand and capacity work is ongoing in order to try and make slot availability to the new peak demand for 2ww slots and additional capacity is being organised in order to try and manage regular 6ww diagnostic monthly demand.

10 urodynamics (unvalidated)

8 cystoscopy

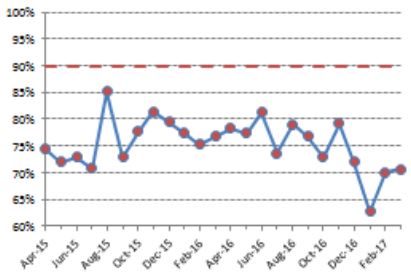
Max wait 31 days decision to treat to subsequent treatment : surgery % Standard is ≥94%		●	●	●	●	●	●	Chief Operating Officer

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

The performance for March 17 was 87.8% against a target of 94% (49 treatments and 8 breaches). All 8 breaches were due to capacity. 5 of these cases were in Urology. Actions to improve the position are included in the wider Cancer Waiting Times recovery plan, but specifically in Urology:

- Additional consultant capacity is now in place and will start to have an impact
- The service is moving to generic pre-assessment – implementation began in April
- The Urology admissions team is now in post and having a positive impact
- The pooling of theatre lists has begun and is ongoing

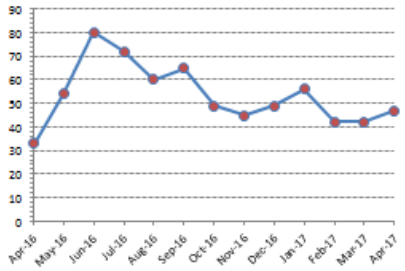
RESPONSIVE

MEASURE		QUARTERLY PROGRESS						OWNER
		Q1	Q2	Q3	Q4	NOW	FOT	
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) % Standard is ≥90%		●	●	●	●	●	●	Chief Operating Officer

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

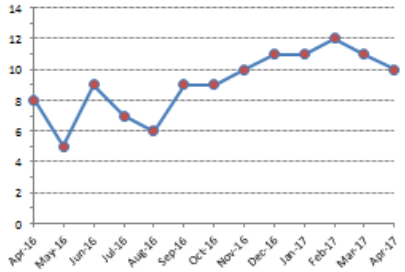
March's validated position is 71.6%, against a standard of 85% and against a trajectory of 78.4%. There were 20.5 more treatments than projected (178.5 as opposed to 158) and 16 more breaches than projected (50 as opposed to 34). 13 of these breaches were the result of backlog clearance in Urology and there were a few breaches where the implementation of TRAK caused difficulties with tracking these cases as 2ww referrals.

The Trust has an agreed revised trajectory to recover the 62 day performance by July 2017 following Trakcare operational issues and delays in implementing multi-assessment and diagnostic clinics in Urology. This plan has been shared with Gloucestershire CCG, NHS England and NHS Improvement and it has been approved. All Trakcare operational issues are being addressed, but remain a risk to recovery as well as the delivery of the full urology recovery to plan to timescale. 2ww capacity, particularly in Endoscopy, is also a risk to recovery as demand exceeds capacity. There are further risks due to consultant vacancies in Head and Neck and Haematology.

Number of patients who have breached beyond 104 days - without a decision to treat date Standard is 0		●	●	●	●	●	●	Chief Operating Officer

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

The trajectory for March shows 48 patients waiting over 104 days (45 in Urology and 3 in other tumour sites) and the target is 0 patients. The trajectory for Urology shows recovery by July 2017 as the backlog is cleared. Of the non-urology patients, all were waiting due to complex pathways, or patient choice or because they were not fit for treatment.

Number of patients who have breached beyond 104 days - with a decision to treat date Standard is 0		●	●	●	●	●	●	Chief Operating Officer

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

The target is 0 patients waiting beyond 104 days. There were no patients waiting due to capacity issues - all were waiting due to complex pathways, patient choice or because they were not fit for treatment.

TRUST PERFORMANCE & EXCEPTIONS (as at end April 2017)

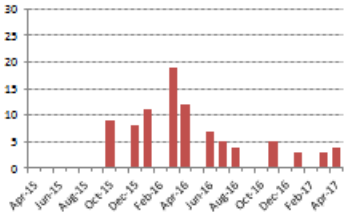
EFFECTIVE

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q4	2016/17 Q1	Q2	Q3	Q4	Feb	Mar	Apr	FORECAST May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
CLINICAL OPERATION																				
% stroke patients spending 90% of time on stroke ward		86.0%	85.1%	90.0%	88.6%	arrears	87.3%	66.1%	arrears	TBC	TBC	TBC	TBC	TBC	TBC		> 80%	GCCG	M	Mar
% of eligible patients with VTE risk assessment		93.7%	93.6%	93.7%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		> 95%	GCCG	M	Nov
Emergency re-admissions within 30 days - following an elective or emergency spell		6.4%	6.7%	6.5%	*	*	*	*	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%	Trust	M	Oct
Number of Breaches of Mixed sex accommodation		30	19	9	5	6	0	3	4	TBC	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Apr
Number of delayed discharges at month end (DTOCs)		10	16	36	36	37	44	37	28	TBC	TBC	TBC	TBC	TBC	TBC		<14	Trust	M	Apr
No. of medically fit patients - over/day		60	69	73	73	75	84	68	59	TBC	TBC	TBC	TBC	TBC	TBC		≤ 40	Trust	M	Apr
Bed days occupied by medically fit patients		1,791	2,086	2,252	2,376	2,239	2,342	2,044	1,770	TBC	TBC	TBC	TBC	TBC	TBC		None	Trust	M	Apr
Patient Discharge Summaries sent to GP within 24 hours		85.6%	85.7%	88.3%	*	*	*	*	arrears	TBC	TBC	TBC	TBC	TBC	TBC		≥85%	GCCG	M	Nov
BUSINESS OPERATION																				
Elective Patients cancelled on day of surgery for a non medical reason		2.0%	1.6%	1.6%	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		≤ 0.8%	Trust	M	Nov
Patients cancelled and not rebooked in 28 days		27	35	10	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Nov
LOS for general and acute non elective spells		6.0	5.9	5.8	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		Q1/Q2 <5.4days, Q3/Q4 <5.8days	Trust	M	Nov
LOS for general and acute elective IP spells		3.6	3.3	3.7	*	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		≤ 3.4 days	Trust	M	Nov
Records submitted nationally with valid GP code (%)		99.9%	99.9%	100%	100%	arrears	100%	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		≥ 99%	Trust	M	Feb
Records submitted nationally with valid NHS number (%)		99.8%	99.8%	99.8%	99.8%	arrears	99.8%	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		≥ 99%	Trust	M	Feb

* 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.

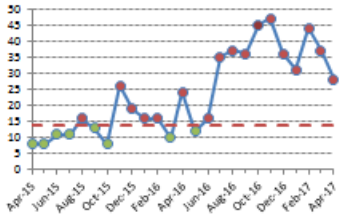
EFFECTIVE

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Number of breaches of mixed sex accommodation Standard is 0								Director of Nursing and Midwifery

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

The majority of breaches are within the DCC and mainly within DCC at GRH. This is simply due to wardable patients (i.e. those that have been deemed as fit to transfer out of DCC to wards) not being moved within a 4 hour window. DCC staff send Site Teams at both sites an email daily identifying patients which can be transferred out; this is subsequently discussed at each and every site meeting with ED flow and capacity also considered when this occurs. It is often the case that patient flow and physical bed capacity on wards proves to be the main factor when we are unable to move patients out of DCC.

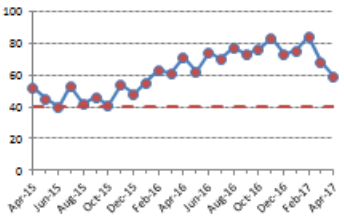
Every effort is made on a daily basis to prevent the breaches with close monitoring applied throughout each 24 hr period.

Number of delayed discharges at month end (DTOCs) Standard is <14								Chief Operating Officer

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

Please refer to Emergency Care Report.

There were 1,481 beddays lost due to Delayed Transfers of Care in April 2017.

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.

The main issue driving the medically fit is access to domiciliary care. Alternative options are being explored with the CCG primarily around pathway 1 for Discharge to Assess. In addition the new medically fit ward is operational now which will be a pull model for the community services.

There were 1,770 beddays lost due to medically fit patients in April 2017, showing improvement from March 2017.

TRUST PERFORMANCE & EXCEPTIONS (as at end April 2017)

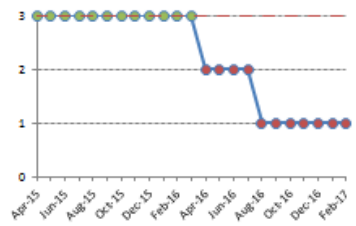
WELL LED

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q4	2016/17 Q1	Q2	Q3	Q4	Feb	Mar	Apr	FORECAST May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																				
NHSI Financial Risk Rating (YTD)		3	2	1	1	arrears	1		arrears	TBC	TBC	TBC	TBC	TBC	TBC		Level 3	NHSI	M	Feb
Achieve planned Income & Expenditure position at year end		-£1.6m	£18.2m	-£23.8	-£18.0	arrears	-£18.0		arrears	TBC	TBC	TBC	TBC	TBC	TBC		Achieved or better at year end	NHSI	M	Feb
Total PayBill Spend (£K)		£78.7m	£82.1m	£83.1m	£83.3m	arrears	£27.24m		arrears	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Feb
Total worked WTE		7,153	7,121	7,299	7,200	arrears	7,239		arrears	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Feb
WORKFORCE HEALTH																				
Annual sickness absence rate (%)		3.8%	3.8%	3.8%	3.9%	3.9%	3.9%	4.0%	3.9%	TBC	TBC	TBC	TBC	TBC	TBC		green < 3.6% red > 4%	Trust	M	Mar
Turnover rate (FTE)		11.7%	11.6%	11.5%	11.7%	11.7%	12.0%	11.5%	12.1%	TBC	TBC	TBC	TBC	TBC	TBC		7.5-9.5%	Trust	M	Mar
Staff who have annual appraisal (%)		83%	83%	80%	80%	82%	82%	82%	80%	TBC	TBC	TBC	TBC	TBC	TBC		green > 89% red < 80%	Trust	M	Apr
Staff having well structured appraisals in last 12 months (staff survey, on a 5 point scale)		38%	3.0	3.0	3.0	3.0	3.0	3.0	3.0	TBC	TBC	TBC	TBC	TBC	TBC		> 3.8	Trust	A	Apr
Staff who completed mandatory training (%)		91%	92%	92%	90%	89%	89%	90%	89%	TBC	TBC	TBC	TBC	TBC	TBC		> 90%	Trust	M	Apr
Staff Engagement indicator (measured by the annual staff survey on a 5 point scale)		3.69	3.71	3.71	3.71	3.71	3.71	3.71	3.71	TBC	TBC	TBC	TBC	TBC	TBC		> 3.8	Trust	A	Apr
Improve communication between senior managers & staff (staff survey) (%)		34%	34%	34%	34%	34%	34%	34%	34%	TBC	TBC	TBC	TBC	TBC	TBC		> 38%	Trust	A	Apr

* 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.

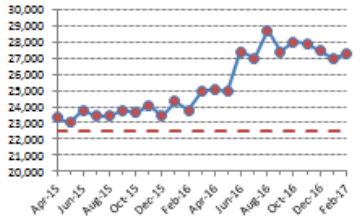
WELL LED

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	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.

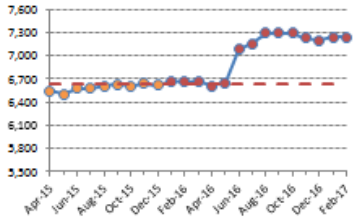
March data not yet available.

Total PayBill spend £K 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 February is £27.24m. This is in line with average.

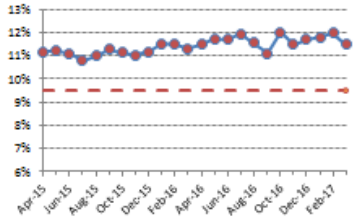
March data not yet available.

Total worked WTE Standard is Target + 0.5%								Chief Operating Officer

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.

March 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

The downturn in Registered Nursing turnover has continued and it is now at its lowest level since February 15. With the exception of Corporate Division & the Admin & Clerical staff group, other rates have also decreased or at least remained steady. However Corporate's has continued to climb. Although 20% of its turnover is attributable to retirement, analysis has indicated that there are some individual areas of concern which will continue to be monitored. Current leaver numbers indicate that the turnover rate will reduce from June 17.

Overview

The following summarises the key strengths in May 2017, along with the weaknesses, opportunities, risks and concerns for the Trust.

Strengths	Priorities
• The 15 minute triage quality standard continues to show improvement with 81.9% in April • The Trust continues to manage 104 days cancer pathway patients with the lowest ever numbers for urology in the last 18 months. Whilst urology long waiters are attribute to capacity the reaming are either late referrals from other hospitals or patient choice. • DTOC in April reduced by 821 bed days as compared to March and number of discharges form the MSFD ward continue to be high • The number of discharge summaries sent to GPs within 24 hours has improved to 65% the highest ever since January 17 • The downturn in registered nursing turn over has continued and is now at its lowest since February 2015 • Continued focus on the reduction of agency usage and sickness absence • Performance against most of the additional quality measures has been good	• Establish reporting on all performance indicators • Management of data quality issues within the waiting lists remains a priority • Continued focus on validation of the incomplete 18 week referral to treatment so that we establish national reporting • Prioritise the rebuild of the high risk outpatient clinics to ensure outpatient efficiencies to help improve RTT and cancer performance • Continued improvement in the 15 minute time to triage, 60 mins time to be seen by a decision maker in ED, early identification and management of long waiters i.e. patients on cancer and RTT pathways • Achievement of the recovery target of 87.7% (agreed trajectory with NHSE)for patients spending 4 hours or less in ED • Continue to reduce patients that are DTOCs and establish LoS reporting and data • Deliver the echo recovery plan so that the performance on the diagnostics target improves whilst also agree a recovery plan for endoscopy and angiograms
Opportunities	**Risks and Concerns**
• The trust has engaged in a novel way of delivering extra work through insourcing. 6 endoscopy lists will be delivered in May as a precursor to a significant programme of work to deliver our cancer recovery plan and manage a number of long waiters on the RTT pathway • The trust has engaged with an IT company to provide expertise and resources for addressing Trak related issues • The MSFD ward has had a positive impact on discharge of medically fit patients. Consideration to be given to a similar ward or space at CGH • With the CCG support continue to outsource • Research accruals have increased which will help to maintain our research infrastructure through the activity based funding model • Vacant slot report now available which should improve clinic utilisation	• JAG accreditation will be affected by the backlog surveillance endoscopy waiting list • Capacity in endoscopy and urology remain a concern for delivery of the cancer target in July • Continued underperformance of the 4 hour ED target with a number of non-admitted breaches in the late evenings due to some badging of ambulance conveyances and gaps in ED medical staffing as the main contributory factors • Waiting lists data quality issues continue to pose significant operational challenges • Clinic re-builds for all OP clinics remains a risk due to the resource implications • We are not meeting the target for the time to initiate and recruit to commercial research trials. This potentially could make us less attractive for a site for commercial research.

APPENDIX 1

PMF - Reporting Frequency of Metrics

Business Intelligence Unit
15/05/2017

Metric	Standard Reporting Frequency	Issues Currently Affecting Reporting Frequency	Update
SAFETY			
INFECTION			
Number of Clostridium Difficile (C-Diff) infections - p	Previous month	None	N/A
Number of Methicillin-Resistant Staphylococcus Au	Previous month	None	N/A
MORTALITY			
Crude Mortality rates %	Previous month	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to issues with the denominator (number of discharges). Discharges are lower than expected due: to 1,500+ inpatient records not being extracted into the data warehouse from Trak, these records are therefore not available for the coders to code; theatre patients have not always had their theatre episode correctly finalised and then these patients cannot be discharged.	Agreed to extract 17/18 data thereby addressing the issue of the backlogs.Report from May. However, going forward a work around is being investiated
Summary Hospital-Level Mortality Indicator	Approx. 8 months arrears (published by Dr Foster)	None	N/A
HSMR (Analysis-relative risk-basket HSMR basket	3 months arrears	None	N/A
SMR (rolling 12 months)	3 months arrears	None	N/A
SAFETY			
Number of Never Events	Previous month	None	N/A
% women seen by midwife by 12 weeks	Previous month	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to a large backlog of maternity data to be entered onto Trak operationally.	Perform an end to end process mapping to identify the issue. Update by end of June
CQUINS			
Acute Kidney Infection (AKI)	1–2 months arrears	None	N/A
Sepsis Screening 2a	1–2 months arrears	None	N/A
Sepsis Antibiotic Administration 2b	1–2 months arrears	None	N/A
Dementia - Seek/Assess	Previous month	Data has not been reported since Trak implementation in December 2016. Training required for ED to complete dementia data on Trak.	Investigated by DON and Track clinical lead. Agreed to start assessments in ACUA/C with new doctor intake in August.
Dementia - Investigate	Previous month	Data has not been reported since Trak implementation in December 2016. Training required for ED to complete dementia data on Trak.	Same as above
Dementia - Refer	Previous month	Data has not been reported since Trak implementation in December 2016. Training required for ED to complete dementia data on Trak. Discussions are taking place in May to establish how the IP referral dementia data will be collected on Trak.	Same as above.
ED			
% patients triaged in ED in 15 minutes	Previous month	None	N/A
% patients assessed by doctor in ED in 60 minutes	Previous month	None	N/A
RESPONSIVE			
ED			
% patients spending 4 hours or less in ED	Previous month	None	N/A
Number of ambulance handovers delayed over 30 r	Previous month	None	N/A
Number of ambulance handovers delayed over 60 r	Previous month	None	N/A
18 WEEKS			
Incomplete pathways - % waited under 18 weeks	Previous month	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to large quantities of poor RTT data being created and retained operationally. Current estimates suggest that 40-50% of pathways are affected by data quality issues.	Expected September following validation exercise
15 key Diagnostic tests : % waiting over 6 weeks at	Previous month	None	N/A
Planned/surveillance endoscopy patients - nos. wai	Previous month	None	N/A
CANCER			
Max 2 week wait for patients urgently referred by G	1 month arrears	None	N/A
Max 2 week wait for patients referred with non canc	1 month arrears	None	N/A
Max wait 31 days decision to treat to treatment %	1 month arrears	None	N/A
Max wait 31 days decision to treat to subsequent tr	1 month arrears	None	N/A
Max wait 31 days decision to treat to subsequent tr	1 month arrears	None	N/A
Max wait 31 days decision to treat to subsequent tr	1 month arrears	None	N/A
Max wait 62 days from urgent GP referral to 1st trea	1 month arrears	None	N/A
Max wait 62 days from national screening programr	1 month arrears	None	N/A
Max wait 62 days from consultant upgrade to 1st tre	1 month arrears	None	N/A
Number of patients who have breached beyond 10	Previous month	None	N/A
Number of patients who have breached beyond 10	Previous month	None	N/A
EFFECTIVE			
CLINICAL OPERATION			
% stroke patients spending 90% of time on stroke v	1 month arrears	None	N/A
% of eligible patients with VTE risk assessment	Previous month	VTE data has not been reported since Trak implementation in December 2016 as this was not raised as a requirement with the project team prior to go-live. VTE assessment tool does exist in the system, requires to be switched on and staff trained to complete the data.	Removed from tracker now
Emergency re-admissions within 30 days - following	1 month arrears	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to a variety of operational issues with Trak data entry, e.g. patients have been incorrectly categorised as elective, day case or non-elective admissions on Trak; 1,000+ inpatient records have not being extracted into the data warehouse from Trak, these records are therefore not available for the coders to code; theatre patients have not always had their theatre episode correctly finalised and then these patients cannot be discharged.	Intersystems / operational issue, TRC logged. No date confirmed as yet
Number of Breaches of Mixed sex accommodation	Previous month	None	N/A
Number of delayed discharges at month end (DTO(	Previous month	None	N/A
No. of medically fit patients - over/day	Previous month	None	N/A
Bed days occupied by medically fit patients	Previous month	None	N/A
Patient Discharge Summaries sent to GP within 24	1 month arrears	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to the large backlog in discharge summaries not entered onto Trak operationally and training required to understand the new process for completing discharge summaries.	Start reporting from May
BUSINESS OPERATION			

Metric	Standard Reporting Frequency	Issues Currently Affecting Reporting Frequency	Update
Elective Patients cancelled on day of surgery for a r	Previous month	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to issues with the denominator (number of admissions). Issues include: patients being incorrectly categorised as elective, day case or non-elective admissions on Trak; 1,000+ inpatient records have not being extracted into the data warehouse from Trak, these records are therefore not available for the coders to code; theatre patients have not always had their theatre episode correctly finalised and then these patients cannot be discharged.	Intersystems / operational issue, TRC logged. Reporting date tbc in June
Patients cancelled and not rebooked in 28 days	Previous month	Data has not been reported since Trak implementation in December 2016 due to appropriate cancellation reasons not being available on Trak and cancellations not being entered onto Trak operationally. Cancellation reasons have been added into the test but not live version of Trak.	Intersystems issue, TRC logged.Reporting date tbc in June
LOS for general and acute non elective spells	Previous month	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to the following issues: patients being incorrectly categorised as elective, day case or non-elective admissions on Trak; 1,000+ inpatient records have not being extracted into the data warehouse from Trak, these records are therefore not available for the coders to code; theatre patients have not always had their theatre episode correctly finalised and then these patients cannot be discharged.	Intersystems / operational issue, TRC logged.Reporting date tbc in June
LOS for general and acute elective IP spells	Previous month	Data has been reported as 'unvalidated' since Trak implementation in December 2016 due to the following issues: patients being incorrectly categorised as elective, day case or non-elective admissions on Trak; 1,000+ inpatient records have not being extracted into the data warehouse from Trak, these records are therefore not available for the coders to code; theatre patients have not always had their theatre episode correctly finalised and then these patients cannot be discharged.	Intersystems / operational issue, TRC logged.Reporting date tbc in June
Records submitted nationally with valid GP code (%	1–2 months arrears	None	N/A
Records submitted nationally with valid NHS numbe	1–2 months arrears	None	N/A
WELL LED			
FINANCIAL HEALTH			
NHSI Financial Risk Rating (YTD)	1 month arrears	None	N/A
Achieve planned Income & Expenditure position at	1 month arrears	None	N/A
Total PayBill Spend (£K)	1 month arrears	None	N/A
Total worked WTE	1 month arrears	None	N/A
WORKFORCE HEALTH			
Annual sickness absence rate (%)	1 month arrears	None	N/A
Turnover rate (FTE)	1 month arrears	None	N/A
Staff who have annual appraisal (%)	Previous month	None	N/A
Staff having well structured appraisals in last 12 mc	Previous month	None	N/A
Staff who completed mandatory training (%)	Previous month	None	N/A
Staff Engagement indicator (measured by the annu	Previous month	None	N/A
Improve communication between senior managers	Previous month	None	N/A

Report Title
TRUST RISK REGISTER
Sponsor and Author(s)
Author - Andrew Seaton, Director of Safety Sponsor – Deborah Lee, Chief Executive
Executive Summary

Purpose

The purpose of this report is to provide the Board with oversight of the key risks within the organisation and to provide the Board with assurance that the Executive is actively controlling and pro-actively mitigating risks so far as is possible.

Key issues to note

- The Trust Risk Register enables the Board to have oversight, and be assured of the active management of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters
- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 15+ risks and safety risks 12+ to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register
- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context
- Work has been completed to review and escalate those Divisional risks at 15+ that had not previously been migrated to the Trust Risk Register
- Work has now been completed to review all Divisional SAFETY risks 12 or more for consideration of inclusion on the Trust Risk Register

Changes in Period

The following safety risks have been accepted onto the risk register (12 and above)

DSP2513PATH Risk to patient safety due to delayed diagnosis because of shortage of histopathology staff

M2488Card Risk of harm to patients as a result of delay in receiving essential cardiac interventions.

M1746Diab Risk of patients having potentially avoidable procedures

The following Quality risks have been accepted onto the risk register (15 and above)

DSP2462OPD & DSP2460OPD are quality risks around the clinic operational management that impacts on the patient experience.

Two other risks were considered linked to clinic operational management

TC2501Paed/Gyn & S2455ALL involving clinic management and income were scored as red financial

risk in the relevant specialties for loss of at least 1% of expected income. The Trust level impact assessment doesn't meet the 1% level for the overall Trust budget so doesn't meet the level to enter the TRR. This means that they will stay as red risk at Divisional level and the Finance committee will consider the overall impact and review the finance income risk.

The following finance risk has been accepted onto the risk registers (15 and above)

F2515 Risk that the Trust does not agree a FY18 Control Total has been accepted on to the register

The full Trust Risk Register with current risks is attached (appendix 1)

Conclusions

The 15 risks on the Trust Risk Register have active controls to mitigate the impact or likelihood of occurrence, alongside actions aimed at significantly reducing or ideally, eliminating the risk.

Implications and Future Action Required

To ensure that the work to migrate or de-escalate all Divisional risks 15+ and Safety risks 12+ continues on a continuous basis.

Recommendations
To receive the report as assurance that the Executive is actively controlling and pro-actively mitigating risks so far as is possible and approve the changes to the Trust Risk Register as set out.
Impact Upon Strategic Objectives
Supports delivery of a wide range of objectives relating to safe, high quality care and good governance.
Impact Upon Corporate Risks
The Trust risk register is included in the report.
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
None.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	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)**
				31st May 2017	

Trust Risk Register Report June 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
F1339	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Acting Director of Finance	Finance Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18	PMO in place to record and monitor the FY18 programme Monthly monitoring and reporting of performance against target Monthly executive reviews	Adequate	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Major		30/06/2017
F1609	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	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.	1. Pilot of extended Bank office hours 2. Agency Taskforce 3. Bank incentive payments and weekly pay for bank staff 4. General and Old Age Medicine Recruitment and Retention Premium 5. Master vendor for medical locums 6. Temporary staffing tool self assessment 7. Daily conference calls to review staffing levels and skill mix. 8. Ongoing Trust wide recruitment drive 9. Divisions supporting associate nurse and CLIP programme. 10. Initiatives to review workforce model, CPN's, administrative posts to release nursing time	Adequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	Monitoring at Workforce Committee Establish Quality Impact Assessment for project Overseas recruitment programme	28/07/2017

Trust Risk Register Report June 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
M1746Diab	Diagnostics and Specialties Division, Medical Division, Surgical Services Division	Safety		Divisional Board, Quality Committee, Specialty Meeting	Risk of patients having potentially avoidable procedures (minor or major) due to the lack of a designated Multidisciplinary Footcare Team.	Clinical assessment as required through clinical assessment Referral to specialty in hospital teams on assessment Follow up by surgical specialty team	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	NHSE bid	04/07/2017
S1748	Surgical Services Division, Women's and Children's	Statutory	Chief Operating Officer	Quality & Performance Committee	The risk of failing national access standards including RTT and Cancer	1. Weekly meetings between AGM and MDT Coordinators to discuss pathway management and expedite patients as appropriate. 3. Performance Management at Cancer Management Board 4. Escalation procedure in place to avoid breaches 5. Performance trajectory report for each pathway	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Catastrophic	Re establish Planned care board Interim action plan to recover position	06/06/2017
S1851	Surgical Services Division	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	1. Extended site management - Silver rota 2. Escalation policy and procedures for use of extra beds 3. Risk assessments evaluating the change in function of the areas.	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	Delivery of Winter plan Easter Bank Holiday Plan	15/06/2017

Trust Risk Register Report June 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S2045	Surgical Services Division	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	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Ward move to improve patient environment and aid therapy Supplemental Patient nutrition with employment of nutrition assistant Increased medical cover at weekends OG consultant review at weekends Increased therapy services at weekends Senior DCC nurses on secondment to hip fracture ward for education and skill mix improvement Review of all deaths	Adequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	Deliver the agreed action fractured neck of femur action plan	30/06/2017

Trust Risk Register Report June 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
WF2335	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	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.	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2.Increase challenge to agency requests via VCP 3. Convert locum\agency posts to substantive 4. Promote higher utilisation of internal nurse and medical bank.	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Catastrophic	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures	02/06/2017
DSP2404haem	Diagnostics and Specialties Division	Safety	Medical Director	Divisional Board	Risk of reduced quality care as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of clinical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients.	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	Develop Business case to meet capacity demand	30/06/2017
DSP2460OPD	Diagnostics and Specialties Division, Medical Division, Surgical Services Division, Women's and Children's	Quality	Director of Strategy	Divisional Board	Risk of reduced quality and patient experience as a result of errors in clinic templates leading patient attending the wrong clinic.	Central Booking Office staff, identify and fix any errors identified To restart the clinic validation exercise by working with the specialities, Central Booking Office, Trakcare clinic build team and the Trakcare team. This is led by the Trakcare operational lead	Adequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	To rebuild clinic templetes for all specialities Escalation to the Trust Risk register through executive director for Trakcare	28/06/2017

Trust Risk Register Report June 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
DSP2462OPD	Diagnostics and Specialties Division, Medical Division, Surgical Services Division, Women's and Children's	Quality	COO	Divisional Board	Risk of compromised quality and patient experience due patients being unable to be offered an appointment within expected waiting times because of increased workload growth in CBO following introduction of Trakcare.	Recruited additional bank and agency staff to help with the workload Additional staff training Identify issues that causes additional workload and report to the Trakcare team to identify a permanent solution by releasing the booking service manager from her current role to work with the Trakcare team. Work with the learning and development team to improve staff morale	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	To complete a Business Case - Recommending additional work force Learning & Development Escalate to executive director to agree further escalation	28/06/2017
M2473	Medical Division	Quality	Director of Nursing	Quality & Performance Committee	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	CQC action plan for ED	08/06/2017

Trust Risk Register Report June 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
M2488Card	Medical Division			Divisional Board, Specialty Meeting	Risk of Harm to patients as a result of delay in receiving essential, required cardiac interventions.	Efficiency review of cath lab provision suggesting means of increasing throughput which has been actioned. Plan to progress to using GLANSO. Active recruitment strategy to fill consultant posts.	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Business case	28/07/2017
F2511	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's		Acting Director of Finance	Finance Committee	Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY18	Monthly monitoring, forecasting and reporting of performance against budget by finance business partners Monthly executive reviews Performance management framework		Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Major		30/06/2017
DSP2513path	Diagnostics and Specialties Division, GP Services / NHS England, Medical Division, Surgical Services Division, Women's and Children's	Safety	Trust Medical Director	Divisional Board	Risk to patient safety due to delayed diagnosis because of shortage of Histopathology Staff	Locum laboratory staff in place Permanent staff recruitment in progress Locum consultant approved Outsourcing of reporting organised	Inadequate	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	fill vacant histopathologist post complete business case for Histopathology including workforce plan	09/08/2017

Trust Risk Register Report June 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
F2515	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's		Acting Director of Finance	Finance Committee	Risk that the Trust does not agree a FY18 Control Total with NHS Improvement resulting in no access to the Sustainability & Transformation Fund and is also subject to contractual fines and penalties	Regular NHSI FSM meetings	Adequate	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Major		30/06/2017

REPORT TO MAIN BOARD – MAY 2017

From Quality and Performance Committee Chair – Claire Feehily, Non-Executive Director – Chair for the meeting

This report describes the business conducted at the Quality and Performance Committee held 25 May 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
Divisional Attendance – Women & Children	Well-structured report. Trakcare impacting on a number of aspects of delivery	How are we communicating with patients relating to the impact of Trakcare?	Additional standard operating procedures in place for administrative staff to mitigate the risk. Commitment to look at additional resources but need to agree the most appropriate model	Cancellation rate and RTT performance improvement
	Commended for use of cultural survey to help understand staff turnover rate	Does this provide opportunities for generalised learning?	Learning predominantly in the area of the team's context, but methodology would be transferable	
	Deterioration in appraisal performance noted	What has contributed to this and what actions are in place to restore performance?	Trakcare was a distraction which would have impacted on performance. Improved team structure and line management following change in ward environment. Recruitment improving through building relationships with Worcester University.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	No site level information included in report	What processes are in place to ensure consistency between sites?	Development of a maternity dashboard which will give division visibility of site performance. Rotation of staff between sites. Core staff required to attend update days.	
	Challenging CIP target	What is the level of staff involvement in the financial challenge and ownership/ understanding of budgets for 17/18.?	Division engaged in more transparent budget setting process. Clinicians engaged in the identification of CIP. .	Majority of schemes relate to income generation
	Safeguarding	What are the arrangements for providing a “place of safety” for young people?	Specialist facility in 2Gether Proposal from commissioners that an inpatient ward could also be a place of safety for young people	To be discussed with commisioner
	Improvement in agency spend	How was this achieved?	Improved recruitment to substantive posts and incentives for own staff to cover gaps	Transferable learning being picked up through Agency Productivity Group
Integrated Performance Management Framework	Only partial assurance possible due to incomplete papers. Performance against all wait	What are the arrangements for reporting on performance in future ?	Revised report consistent with NHSI Single Oversight Framework will be presented to June Committee, as part	From June 2017 revised reporting framework will be introduced.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	times targets still challenging.		of the overarching Performance Reporting Framework	
		What is the assurance that the underlying performance on cancer and RTT waits will be improved when the backlog issues are addressed?	More detailed report giving assurance we are on track to remedy the performance by July and greater visibility of underlying performance for new referrals	Report to June Committee
		What is the trajectory for clearing all 52 week breaches?	There will be 5 reported in May, only 3 of which will be cleared, due to patient choice	Revised trajectory of 52 week performance
		What would be the implications of failure to achieve JAG accreditation?	Inability to deliver bowel screening programme and loss of income	
Emergency Care	4 hour performance remains below improvement trajectory.	To what extent is there a culture of a combined team across the two sites?	Staff rotate between sites. Bed base in Acute Assessment Units and ED assets being managed as a single entity	
	Improved performance in 15 minute triage but 60 minute to assessment performance has	Is this simply formalising a process that has already been described as practice?	The formalisation and monitoring will provide more visibility at a greater degree	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	fallen. Procedures in place to ensure patients at greatest risk are triaged within the standard	What is being done to address the deterioration in quality measures for patients with stroke, sepsis and for Fractured Neck of Femur.	of granularity. Clinical leadership has been assigned to this area Relaunch of internal Professional Standards and reporting of performance	Stroke performance to be a specific item for further scrutiny on future agenda
	ED Survey shows an improved position. Currently ranked 24 out of 75 Trusts. Lead clinician progressing action plan as a silver project in the Quality Academy	When the survey was conducted survey?	November 2016	
TrakCare Operational Progress Report	Only partial assurance possible due to incomplete papers. Performance of Trakcare still impacting on operational performance	Is there a resource plan to support recovery?	Trust Leadership Team to considering resource plan in June.	Proposal to Board
NHSI Returns	Reporting schedule: Dementia, VTE and discharge summaries have not been reporting nationally but are to to recommence from June 2017. Date to be confirmed. RTT will be suspended until validation complete	What is the control mechanism to suspend/reinstigate reporting? What is the timeline for reinstating reporting	NHSI advice to continue to suspend reporting until more work done to address data quality	Control mechanism for reporting changes to be clarified. Where reporting not re-established in next month will require detailed recovery plan for next meeting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
CQC	Progress with action plan initiated after initial feedback following CQC visit	Delays in recruiting coordinator posts?	Specification of the post changed but interim roles in place ahead of substantive appointment, impacting on 15 minute triage	Action plan needs to be expanded to include actions from subsequent letter from CQC. RAG rating of the actions to be added
Mortality	Verbal report from Medical Director Mortality Group considered an initial mortality report, which covers the areas required but presentation is not yet sufficiently accessible	Need a clear timeline for establishing reporting to committee and board on trends in mortality and progress on Learning from Deaths programme.	Report being developed consistent with guidance received from the West of England AHSN and will take into account NHSE guidance when it is published	Dashboard to be presented to next committee, with advice from this committee prior to presentation to the board. Proposed report to be shared with chair before next committee. Updates to be included in report to next committee.
Serious Untoward Incidents	2 never events since the last meeting. High level review and detailed review of each incident instigated	What actions have been taken to mitigate harm from the incidents?	Review of all cases to determine any significant delays Contact with all GPs Cohort of all patients affected identified and any harm reassessed at next appointment No harm identified to date.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Safer Staffing	Format of report to change in July No correlation between staffing and harm	What are the key issues from model hospital comparison?	Comparison with the model hospital has commenced but needs more work, in particular around appropriate comparator sites Will be used alongside the next iteration of the Keith Hurst model	
Theatres Management Equipment Service	Proposal for a managed equipment service for theatres developed through stakeholder engagement with support of all relevant specialty directors	How have frontline staff, including consultants been involved?	Discussed and developed through Theatre Management Group. Briefings provided to all staff. Impact on staff will be limited due to model of contract. Further engagement will follow decision by Board.	Open forums to discuss the plan in accessible locations and times, utilising the consultants aligned to the T&O reconfiguration project
		What plans are in place to ensure continuity of governance processes?	Team to review existing SOPs for governance in similar arrangements	Future Reports to Planned Care Board
Notes of the meeting of the Patient Experience Strategic Group (PESG) held on 4th May 2017		Timetable for publication of Patient and Carer Experience Strategy	Currently in consultation. September	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Matters to be Escalated to the Board	Managed Service Proposal			
Comments From Governors	Evidence of improvement although pace could be quicker Transparency improved			
Papers for Circulate to Governors	None			

REPORT TO MAIN BOARD - JUNE 2017

From Finance Committee Chair – Keith Norton, Non-Executive Director

This report describes the business conducted at the Finance Committee held 24th May 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	This is a month one report with a significant variance from plan mainly as a result of the adverse income position.	Will this adverse performance continue through the year?	We are still in line with forecast year end and month one has shown a number of positive and negative variances. Contractual income arrangements are being reviewed.	Scale of continued adverse impact of Trakcare.
Deloitte Financial Reporting Review Recommendations	With two items going in to quarterly review by Finance Committee, all items have now been completed.	How will this committee review those two items?	Put into Finance Committee work plan.	None.
Regulatory Review Update	Update received from Chief Executive.			
Cost Improvement Programme Update	CIP Total is £34.7m • All items have now been allocated a RAG status • 53% are rated red.	• Is this achievable in total? • With more than half rated red is there an implication for achievability? • Is responsibility for achievement now properly	• This is only month one. • Every CIP item has been RAG rated and the process this year is far more thorough than anything previously. • The Chief Executive reassured the committee that responsibility for CIP delivery is at divisional level. • Further CIP to be documented	One residual issue is CIP phased achievement over the year. This will be presented at the next meeting.

		allocated?	which will reduce percentage shown as red.	
Risk Register	• Updated Risk Register presented. • Discussion about where risks are held, for example: agency costs and whether this should be Workforce Committee or Finance Committee.	All the risks need to be in the right place so that there is ownership and no duplication.	Acting Director of Finance will review all risks to check they are in the correct place.	Cross checking that risks have been properly allocated.
Infoflex Contract Renewal	The paper has been approved by the Board. This was for information.			
Theatres – Managed Equipment Service	• The business case is strong even if there has been a slight delay. • There needs to be the commitment of the clinical leaders which has been referred to Quality & Performance. It is still to be	• Ensuring proper consultation including with Governors. • Confirmation that financial benefits will be realised.	KPMG who advise on indirect taxes have reassured us that the financial structure will be allowable but of course this is not definitive.	• Degree of consultation • KPMG advice.

	confirmed whether this is a "Significant Transaction" or not.			
Notes of the Capital Control Group	Minutes were noted.			
Matters to be escalated to Board	Acting Director of Finance and Committee Chair to discuss if anything needs to be escalated.			
Governors Comments	Lead Governor queried whether the Trust had financially compensated any patients for travel due to Trakcare issues.		Acting Director of Finance confirmed that she was not aware of any compensation having been authorised.	
Papers for Circulation to Governors	Lead Governor to receive a copy of the Workforce Report once done.			

Report to the Board of Directors meeting – June 7th 2017

From Audit & Assurance Chair – Robert Graves, Non-Executive Director

This report describesthe business conducted at the Audit and Assurance Committee held Tuesday 23 May 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
Counter Fraud Report	A thorough report on recent and planned activity including the welcome addition of an anonymised case summary. A detailed review of the self assessment review tool.	1. What is the status of the initiative to ensure long service employees have access to fraud awareness training the training? 2. What is the plan to move amber assessed items to green in the coming year?	Ongoing contact with the Training team on how best to accomplish this Action plan to be developed with a mid-year update to Committee	
External Audit	All aspects of the formal year end reporting cycle reviewed and discussed.	1. Is everything going to plan in terms of time and deliverables? 2. Key judgement assessment questioned for debtors provision	Overall yes but finalisation of the annual report text should have been achieved sooner Methodology described satisfactorily.	Drafting timetable and process needs to be reviewed and refined ahead of 17/18 yearend

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Internal Audit	Smartcare lessons report Agency doctor usage report List initiatives review Cirencester benefits realisation Core financial systems report 17/18 Plan Draft 16/17 annual report and Head of Internal Audit Opinion reviewed and accepted Recommendations Tracker	Numerous detailed questions. Key challenges: 1. Why is there not full visibility of management responses in reports? 2. There needs to be a further review of the agency doctor usage report 3. Why has the number of outstanding recommendations increased very significantly?	Future report content will be modified to make management response timing and content clear Further review of agency report scheduled for July with Executive review in the interim Chief Executive committed to oversee action on the outstanding recommendations	Effectiveness of sustained follow-up needs to be kept under review
Annual Accounts for year ended 31 March 2017 and Analytical Review	Final accounts reviewed and consistent with previous in depth working session Draft Annual governance statement reviewed together with formal supporting documentation	Detail of year on year change in accrued debt questioned	Acting Finance Director to provide supporting detail	
Risk And Policy Assurance Report	Update provided on risk management process and policy review approach		Acknowledged to be work in progress with ongoing regular reviews as the approach is refined	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Acting Finance Director Report	Received and reviewed - Losses and Compensations - Single Tender Actions - Capital Programme post implementation review proposal		Major project review to be introduced following the pending appointment of the new capital manager	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – Wednesday 7th JUNE 2017
Subscription Rooms, Stroud

Report Title
SmartCare Progress Report
Sponsor and Author(s)
Sponsor: Dr Sally Pearson Author: Gareth Evans: Smartcare Programme Manager
Executive Summary

Purpose

To provide assurance to the Board, from the Smartcare Programme Board, on progress within the continued operation of TrakCare and planned implementation of Phases 1.5 and 2.

Key issues to note

- The programme is set at amber status due to the persistence of some system issues impacting on operational performance and delayed implementation of phase 1.5
- Performance against contracted services is being monitored and reported in line with SLA based reporting and delivery of contracted functionality
- Key high priority system related issues are identified and reported with current status
- Contractual and functional review of the system meeting OBS requirements under way
- Regular Service Reviews implemented with contractual support from Procurement
- Training extended to provide 'Champion' sessions and targeted additional training e.g. Discharge Summary process for Nursing Staff
- Phase 1.5 Planning in progress to provide confirmed proposal for implementation of Radiology Order Comms, Pharmacy, Labs and Labs Order Comms taking into account lessons learned from Phase 1 (user acceptance testing) and external factors relating to other SmartCare trusts. Planning will take into account technical issues encountered with Pathology build
- Any movement in the implementation plans from those previously proposed will require a financial forecast review
- Granular approach to go-live for Phase 1.5 components to be incorporated into the plans rather than 'big-bang' approach for Radiology Order Comms
- Phase 2 progress with Oncology continuing in the planning stages. Overall Phase 2 scope and operational assessment to commence

Conclusions

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.

Phase 1.5 plans are pending ISC determination for resolution of Pathology issue identified and subsequent software dependent provision.

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 June.

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 but a full review will be undertaken in respect of the revised timescales from the re-planning exercise.
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:	26/05/17	**Version**	1.0
Project Sponsor:	**Dr Sally Pearson**	**TRUST RAG Status**	**AMBER**
Project Manager:	Gareth Evans		

SmartCare Progress Report – Main Board – June 2017

Executive Summary & Programme Status

An overall Trust RAG status of **AMBER** as deployment dates for subsequent phases are still to be confirmed.

This report identifies performanceand progress in the following Phases:

- Phase 1
- Phase 1.5
- Phase 2

Phase 1

Contract performance

Contract Performance is measured against Incident call statistics against the InterSystems Call Centre (TRC) and availability of TrakCare to end users. Current trends and ongoing totals provided below.

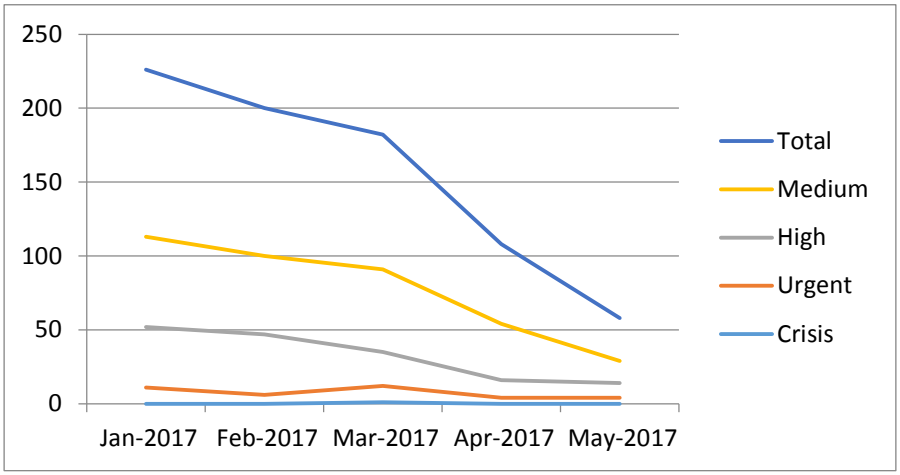
In reference to the previous report that highlighted the downtime experienced in March, the Service Review has concluded that a total of £14,524 is to be incorporated as Service Credits against scheduled service charges.

A review of the SmartCare contract is to take place with Angela Cox as the Procurement owner.

TRC Incident reporting Summary: Jan – May 2017

Incidents Opened YTD:	387
Incidents Closed YTD:	336
Incident Closure (%):	87
Open Incidents:	132

Trend for Open Incidents



There are number of TrackCare Service Requests (TRCs) that the Trust and ISC have deemed as high priority, which needed to be addressed as matter of urgency.

- Patients being placed 'On Hold' following clinic roll-over extension. – Resolved
- Trust Vacant Slot Report – Review of clinic rebuild is a dependency for the correct use of this report. ISC on-site review held and report due to be submitted prior to Programme Board. Locally produced Vacant Slot report in use across divisions
- Implementation of the OPCS 4.8 code tables - Resolved
- Resolution of postcode issues QAS TRUD files. – In progress with missing postcode work round awaited
- Provision of the Analytics "mirror" server. – Completed

Status reporting of all identified 'system' issues relating to Operational Impact is provided in the Operational Impact Log.

Crisis Incident

An issue that had previously been reported was escalated to Crisis level on 11th May. The issue was with appointments being placed on hold when a clinic was 'rolled over' for extended schedules to be available. The impact was significant with potential for major impact on the operational service. The issue was resolved on 13th May with a revised process. The process is to be updated in InterSystems documentation and distributed to all English Edition customer sites. It was not a system malfunction.

Clinics 'roll-over' for July/August completed as originally planned.

System Deliverables

A review of the Output Based Specification (OBS) provided in the SmartCare procurement is to be performed to identify any omissions from the delivered Phase 1 implementation. This will take place over May. Review session set for Wednesday 24/5/17. Results of the review will feed into the contract review with Procurement.

Contract Payment schedule and any variance from plan

There are no reported variances to the contracted milestone payments.

A revised milestone payment schedule will be incorporated into the Contract Change note (CCN) to be raised by InterSystems in respect to planned implementation schedule for Phases 1.5 and 2.

Service Review

A quarterly Service Review meeting was held with InterSystems on Tuesday 2nd May.

The purpose of the meeting is to review the service performance as per the reports generated on a monthly basis by InterSystems with the aim of identifying methods of service improvement to end users.

The meeting reviewed incident performance to date against reported statistics. The downtime experienced in March was significant and a resultant summary of service credits has been prepared and issued to InterSystems for formal agreement.

Whilst there is an improvement in overall levels of incident reporting and management, there is a requirement for the Trust to improve the level of support provided to end users within the Trust. The current level of support leads to a larger than expected number of calls being raised inappropriately or without initial investigations than expected. This causes a greater support load and does lead to incidents taking longer to resolve.

At this time, the Trust does not have an identified support owner. Discussion has taken place with the Associate Director of Business Intelligence to identify this role in the proposed changes to the BI structure. From that discussion, it has been stated that the new deputy to the Associate Director of BI, Lei Lei Zhu will take the role of support ownership from a Trust perspective. Lei Lei is due to start with the Trust at the beginning of June 2017 and arrangements will be made for an initial meeting and familiarisation with project and ISC staff.

Update releases

The provision of Maintenance Releases to TrakCare will continue throughout the lifetime of the solution.

MR6.3 has been loaded into the initial 'scratch' environment for non-live testing of functionality. This will progress through the testing process into the BASE and TEST environments where testing of actual data will be undertaken prior to any planned update to LIVE. The MR6.3 update is required to meet the requirements for progressing the move from Infoflex and to implement required functionality for the Pathology build continuation.

2017.2 is a major release update that is under current planning by the Trust and InterSystems to determine an appropriate process but will be constrained to meet the needs of the Pathology deployment with functionality maintained on an as-is basis rather than deployment of new functions or major changes.

Any potential downtime associated with the implementation of the releases will be established and notified. Changes in process identified since the previous MR5.1 update have been implemented to reduce risk of unplanned or excessive downtime.

Phase 1.5

Preparation and planning

A post MR5.1 deployment issue with the Pathology implementation revealed that a set of key deliverable system components were not included that prevented continuation with the technical build. A plan was put in place to complete this exercise by 18th April but technical difficulties have resulted in an extended period of completion. The impact of this issue has affected the build progress with Pathology.

Progress has continued within the planning and implementation of Order Communications

(Radiology & Pathology), Pharmacy and Pathology as preparation for Phase 1.5 with the knowledge obtained from the above issue and planned software deliverables.

Impact of Phase 1 ongoing Operational issues

Incidents impacting the live service are contributing to a reduction in confidence of the Trust team in the release management processes.

A formal plan is to be assessed by the project team and InterSystems technical management team prior to submission to the Programme Board and operational Impact Board.

InterSystems are holding an internal review of planned implementation milestones for the Trust in conjunction with activities associated with Northern Devon and Yeovil that are required to be met within the same contracted period. The meeting to review these at a senior and technical level is planned for 23/5/17 from which a proposed implementation timescale for Phases 1.5 and 2 will be provided.

Overall Phase 1.5 Planning

Phase 1.5 consists of four distinct components in respect of go-live planning:

- Radiology Order Comms
- Pharmacy Stock Control and Dispensing
- Pathology Order Comms
- Pathology (TrakCare Lab Enterprise)

The previous plan had a proposed go-live for Radiology Order Comms at the end of July 2017. Whilst progress continues with the preparation and build configuration with Radiology, the requirement for system software in MR6.3 has impacted the planned schedule.

Radiology Order Comms high-level outline plan (pending ISC review):

- SOP construction / Training prep – Ongoing with project team and Radiology staff including trainers from both PACS and project
- Build/Config into Technically Live system for user access – End July
- User Acceptance testing in Technically Live system – August
- End user training – August/September (to include new intake of Junior Doctors)
- Initial go-live (ED proposed to reduce current clinical risks as per Datix reporting) – Mid September

It is proposed to progress with a rolling and evolutionary go-live across operational areas with completion by end of FY17/18 rather than attempt a ‘big-bang’ approach. This will enable a more gradual training process and continued use of the technically live system for familiarisation and testing of revised SOP’s.

The proposal to start rollout with ED is a clinical proposal based upon issues raised with their current use of paper-based order Comms.

The continuation of Phase 1.5 implementation with Pharmacy and Pathology, including Pathology Order Comms, is dependent upon the implementation of the 2017.2 upgrade. This is a complex process and is currently being planned in detail to reduce risk to the operation and minimise downtime. The specific pre-requisite software environment for Pathology is 2017.2 with MR3 and this is planned for implementation in Live in mid-October.

A revised timescale for Pharmacy and Pathology build completion and subsequent validation moving to go-live is to be prepared for the June Programme Board for consideration. Any delay to the provision of this plan will also need to be communicated to the Programme

Board on 5th June and any alternative planning schedule confirmed.

Risks to Planned Phase 1.5 Timeline

The planned timeline will be dependent upon resource availability and software deliverables in order to meet the requirements for each stage.

The requirement for the delivery of Phase 1.5 and 2 are currently under review internally by interSystems to maximise the opportunities for delivery across the whole of the SmartCare Programme. The Trust Programme Management Team have contributed to the identification of the of the "windows of opportunity" where the programmes deliverables may go live taking into account known dependencies and aversion to risk.

InterSystems Plans that will been submitted to their Head of Projects **are NOT** ratified by the Trust Programme Board and further detailed planning will be required to provide the assurances that all parties can deliver against the proposed schedule.

Current estimation of required resources within each of the Phase 1.5 elements is appropriate for completing the activities defined and based upon the build capability currently established.

Pharmacy has had reduced levels of InterSystems support since Phase 1 go-live. This has predominantly been due to concentration on Northern Devon proposed go-live in April but we are expecting a greater emphasis from InterSystems now that Northern Devon have successfully completed their go-live of Phase 1.

The implementation of Pharmacy go-live is also dependent upon the successful deployment to both Yeovil and Northern Devon in order to mitigate risk. The implementation review within InterSystems will take the proposed go-live dates at both sites into account before proposing the planned go-live for GHT.

Phase 1 Deployment Lessons Learned

The lessons learned report from PWC has been submitted to the Trust and will be reviewed at the June SmartCare Programme Board.

Order Communications Update

Order Communications is progressing significantly within Radiology as there are fewer software dependencies other than MR6.3. The proposal for go-live with Radiology Order Comms is to commence with ED as there are existing clinical risks identified with current ordering processes. This will allow a more granular training activity and ensure that a controlled commencement of roll-out within a closed area is enabled.

The process of rolling out to operational areas within the remainder of the Trust will be a clinically led exercise and planned to complete by 31/03/2018. Detailed planning taking into account respective ‘to be’ process review for each area is to be established in June.

Pharmacy Update

Confirmation of software pre-requisite deployment is pending together with the overall trust plan to establish a re-planned go-live for Pharmacy.

A request for additional ISC Pharmacy resource to be available has been raised now that the go-live of Northern Devon Phase 1 implementation has completed.

Pathology Update

Pathology build has been subject to a 'freeze' due to an issue where 17 specific system components were identified as not being progressed in line with the MR5.1 update.

A complex technical process to implement the 17 components has ensued which was due for completion by 18th April. 16 of the 17 components have installed correctly but the final item has proven to have technical complications that have prevented full completion. The process has been and build can only recommence for all areas upon completion. This has impacted the previously issued delivery plan for November go-live for Pathology. A full status update is to be presented to the Programme Board on 5th June. Any movement to currently forecast implementation plans will require a financial forecast review.

The resultant go-live plan for Pathology is dependent upon the result of the ISC planning exercise being undertaken.

Whilst progress on the build is pending, Pathology has continued to develop test scripts prepare for initial testing of interfaces between analysers and TrakCare.

Data migration activity is continuing with Transfusion Medicine and data quality checks in progress for Chemistry and Cytology.

Pathology validation planning is continuing. Validation scripts for General Pathology, Specimen Reception, Microbiology, Chemistry, Haematology, Immunology and Cytology are complete with Histology, Phlebotomy and Transfusion Medicine in progress. Validation plans are to be completed as part of this process.

Phase 2

The current outline planned timeline for Phase 2 is scheduled to complete initial deployment by March 2018 although this is subject to the implementation planning review by InterSystems.

Detailed planning with the Trust for Phase 2 has yet to commence but is required to do so in order that defined deliverables are able to be determined for the component parts of Phase 2 and within the timescales planned.

Discussion of Phase 2 content with other Trusts using or embarking on use of TrakCare has commenced with Trust membership of the 'English Edition TrakCare User Group'. This group enables the exchange of information and ideas as well as shared discussion of any issues of proposed changes to the system that would affect multiple customers.

Detailed delivery planning of Oncology is progressing.

The review for Medical Device implementation with ISC partner Qualcomm has commenced with site surveys completed at Gloucester and Cheltenham.

Training

Training is continuing to provide face-to-face and Champion sessions with good engagement from the Trust.

Additional sessions have been held for reinforcing Discharge Summary processes with nursing staff. Despite an initial low turnout, later sessions have seen extended attendance.

The Training team within PAS has completed a recruitment exercise for three additional trainers – all from existing roles within the Trust. The team will embark upon a train the

trainer process form commencement of engagement and this will be based upon core TrakCare requirements together with the inclusion of Phase 1.5 functionality.

The extension of training with additional operational staff is to be delayed until the PAS training team is up to operational strength. This will help to maintain total resources within the operational areas in terms of remedial operational activity rather than reduce them at this time.

A revision of training provision as a whole for TrakCare both in its current form and for future clinical enhanced functionality is to take place.

Programme Resourcing

The Programme resource structure continues to be reviewed to better embed ownership of the programme across the organisation

The use of contract resources will be limited to those necessary to complete the implementation tasks or to enable sufficient knowledge transfer to Trust resources over the Phase 1.5 implementation.

The move of functional support to substantive resources is likely to expose gaps within the current workforce in terms of availability and capability. The programme will identify those gaps and report through the Programme Board including development of mitigation for the roles.

At the Service Review undertaken with InterSystems, the establishment of a formal support structure with adequate resourcing within the Trust was raised. Current support capabilities of the PAS and Clinical Systems team are stretched and lack a suitable level of TrakCare knowledge. The extension of these resources is key to establishing a responsive and capable support function that does not rely unnecessarily on external support.

The provision of TrakCare support for out-of-hours is also a key area of concern. Currently there is no application support available to users outside of normal business hours. A review of support requirements is required to be reconsidered with the progress toward a more clinically focussed use of TrakCare in Phases 1.5 and 2.

In discussion, it has been recognised that the Clinical Safety Case – ISB0160 needs to include an assessment of acceptable support capability prior to any go-live of additional clinical functionality.

Programme Risks

The Programme continues to monitor Issues and Risks through the reporting structure used by the Support Team as well as the Operational Impact Board. Any Clinical Risks are monitored by the Clinical Risk Review Group.

Next Planned activities

Re Baselined Plan for Phase 1.5 to be agreed and signed off by all parties

Ongoing development of the Phase 2 Scope and associated delivery plan

Statement of Work to be completed for Medical device Integration. Phase 2 delivery

Review of OBS for delivered components

Continuation of Phase 1 recovery action plan activity with Operational Leads and Operational

Impact Board

Phase 1.5 preparations and development in line with identified software release dependencies and joint Trust go-live requirements.

Status against communications plan

Continuation of communications with all stakeholders regarding TrakCare – both from Programme and Operational perspectives via regular global updates.

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
Phase 1 Deployment Verification Complete		6 Mar 17	Completed

Milestones approaching

Milestone	Due	Activity to progress

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

NOTE: All risks under review in line with Issue Management

Title & Description	Impact	Resolution
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	8	To be revised in line with identified Issues and remedial action plans. Datix Risk 2069

implementation.		
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

MAIN BOARD – JUNE 2017
BOARDROOM, SUBSCRIPTION ROOMS, STROUD

Report Title
ANNUAL APPRAISAL/ REVALIDATION BOARD REPORT SENIOR MEDICAL STAFF
Sponsor and Author(s)
Author: Janet Ropner Presenting Director: Dr Sean Elyan, Medical Director
Executive Summary
Purpose This is the update on Senior Doctor Appraisal and Revalidation programme which is required to be presented to the Trust Board on an annual basis in line with the national recommendations relating to medical revalidation. Key issues to note ▪ The first round of medical revalidation has been completed since the last Board report ▪ The Higher level Responsible Officer Quality Review took place in November 2016 (Appendix 2) and gives assurance of the revalidation process within the Trust ▪ There is increasing pressure on recruiting appraisers although alignment of the appraisal budget to the Medial Director Budget will ensure protection of this resource ▪ An annual performance review aligned to the Trust's Strategic objectives, feeding into the appraisal process has been developed with the Speciality Directors Conclusions The appraisal and revalidation process within the Trust is now embedded, and the external and internal processes provide assurance that this is being undertaken to the required standard. Implications and Future Action Required Support the alignment of the appraisal resource to the Medical Director budget.
Recommendations
The Board is asked to receive the report as a source of assurance regarding the quality of medical appraisal and revalidation throughout the Trust.
Impact Upon Strategic Objectives
Supporting medical staff to achieve the Trust goals in relation to feeling valued and involved and wanting to improve.
Impact Upon Corporate Risks
None.
Regulatory and/or Legal Implications
Medical Revalidation is a statutory requirement of the General Medical Council.

Equality & Patient Impact							
None.							
Resource Implications							
Finance		**X**	Information Management & Technology				
Human Resources		X	Buildings				
None							
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)**

MAIN BOARD June 2017

ANNUAL APPRAISAL/ REVALIDATION BOARD REPORT SENIOR MEDICAL STAFF

1 Purpose of Report

To provide an up to date review of the Appraisal and Revalidation processes for the Board

2 Executive Summary

Revalidation began in December 2012, and the three year cycle has been completed with 428 doctors having been revalidated by the end of March 2017.

NHS England request quarterly reports and an end of year report. See **Appendix 1** which is the end of year return requested by NHS England for the financial year of 2016-17.

3 Background

3.1.1 The Revalidation Operation Group meets quarterly to ensure that the Revalidation process is working and to discuss any problems. This group is made up of the Responsible Officer, Appraisal Lead, Medical Staffing Manager, Appraisal/Revalidation Officer and Revalidation Administrator.

3.1.2 The Responsible Officer along with the Medical Staffing Manager and Appraisal/Revalidation Officer, ensure that all paperwork required for Revalidation is in place. Once a decision has been made by the RO, the GMC are informed of the outcome, along with the doctor.

3.1.3 Documents relating to the appraisal and revalidation process have been updated to be compliant with current national guidance and have been added to the appraisal and revalidation site on the intranet.

3.1.4 The Appraisal Steering Group meet half yearly. Membership consists of the Appraisal Lead (Chair), Responsible Officer (Medical Director), LNC representative, 2 SAS Doctors and 2 Consultants. The present members are:- Dr Sean Elyan, RO, Dr Janet Ropner, Chair, Dr Steve Cooke LNC representative, Dr Nicol Vaidya, and Dr Caroline Harvey representing the SAS Doctors and Dr Michelle Hamilton-Ayres, and Dr James DeCourcy representing the Consultants. The appraisal officer services these meetings. The Group reports to the Director of Medical Education, Quality Committee, LNC and Trust Board annually.

3.1.5 There are 38 appraisers, One appraiser has resigned and one is appraising reduced numbers. This gives an overall number of 37 appraisers doing the requisite number of appraisals.

3.1.6 A system has been put in place to capture the appraisals of those doctors who have their main employment within Gloucester Care Commissioning and Care Services along with those on honorary contracts.

3.2 Quality Assurance

3.2.1 Appraisees evaluate their appraisals and this feedback is sent to the Appraisers annually.

3.2.3 Appraisers are required to reflect on their performance. The number of appraisals they carry out, the number signed off within 28 days and the number of Support Groups they attend are recorded. The Appraisers meet with the Appraisal Lead on a yearly basis to discuss their performance.

3.2.4 Quality Assurance of the appraisal summaries and pdp's using a standard tool is carried out. This has been carried out by the appraisers at the Appraisal Support Groups. We aim to review 2 summaries from each appraiser. Once marked the overall score is forwarded to the appraiser for their education. We had an independent verification visit from the team from NHS England in November 2016. See **Appendix 2** for report and **Appendix 3** for the action plan.

3.2.5 Reporting Form A: A new Form A has been developed which will replace the old Form A. This form will be completed by the Specialty Director or Chief of Service and will be reviewed at the appraisal by the appraiser. This has been piloted and is being reviewed.

3.2.7 Four Appraiser Support Groups take place each year. Appraisers are expected to attend two. This has ensured that all appraisers are up to date with current legislation and changes to the appraisal and revalidation process.

3.3 Clinical Governance

3.3.1 The appraisal process requires links to strong clinical governance processes. The Audit Department provide details of any audits for which senior medical staff have been nominated as lead. The Risk Department send a report to those who have been involved in a Serious Untoward Incident. A nil return is sent to all other Senior Medical Staff by the Appraisal Administrator. The Complaints Department continue to send reports to those involved in complaints.

New guidance from NHS England requires all appraisals to be carried out within 12 months of the last one. Extensions should be agreed with the RO

3.4 Information Systems

3.4.1 The Patient and Colleague feedback process is administered through the appraisal administration team.

Appraisals themselves are recorded on the MAG (Medical Appraisal Guide) form. A new MAG form has been produced by NHS England. These should be completed and returned to the appraisal administration team within 28 days of the date of the appraisal.

4 Financial Implications

The cost of managing revalidation and appraisal has previously been presented. No new additional costs have been identified. However as appraisers retire or leave the Trust, retaining the funding for appraisers to maintain an adequate cohort of appraisers is important.

5 Recommendation – To Note

The Board is asked to note the current state and progress of medical appraisal and revalidation to national guidelines.

Author: **Janet Ropner Associate Medical Director**

Presenting Director: **Sean Elyan Medical Director**

Date **May 2017**

Appendix 1

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	335	235	84	5	11	335
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	64	40	15	3	6	64
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	13	3	3	0	7	13
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	412	278	102	8	24	412

Appendix 2

Higher Level Responsible Officer Quality Review Summary

Date of Review: 23 November 2016 **Designated Body: Gloucestershire Hospitals NHS FT**

Designated Body:	**Gloucestershire Hospitals NHS FT**	**Review Team involved:**
Type/sector of Designated Body	Acute Care/Secondary Care	Ros Crowder, Deputy Director Revalidation, NHS England (South), Regional Representative Claire Brown, Revalidation Manager, NHS England (South), Regional Representative Tony Berendt, Medical Director, Oxford University Hospitals NHS Foundation Trust, Oxford, RO Representative Iona Neeve, Head of Professional Performance, NHS England South (South Central), Local Office Representative Stephen Barasi, Lay Representative Elizabeth Abbott, Lay Representative (Observer)
Responsible Officer	Sean Elyan	
Appraisal Lead	Janet Ropner	
Revalidation Manager	Sarah Antrobus Holder	
HR Lead	Richard Giles	
Clinical Governance Lead	Andrew Seaton	
Patient Safety Lead	Andrew Seaton	
Patient Experience Lead	Debra Clark	

-

Summary:

The Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist care for a population of more than 612,000 people. The Trust was formed in 2002 with the merger of Gloucestershire Royal and East Gloucestershire NHS Trusts and runs both Cheltenham General and Gloucestershire Royal Hospitals. Our doctors and nurses also see patients at clinics in all of the smaller hospitals across the county.

In July 2004 we became one of the UK's first NHS Foundation Trusts.

The Trust was inspected by the CQC in 2015 and on 19/6/15 was rated as “Requires Improvement”. Of the 5 elements of the report we were rated “Good” for

Caring and Well Led and “Requires Improvement” for “Safe”, “Effective” and “Responsive”. The CQC will return in January 2017.

Current performance on 4 hour waits and cancer are subject to improvement plans. Recent investigations into Trust finances have identified financial issues placing the Trust in Financial Special Measures with NHS I.

There are 494 doctors who undergo senior medical appraisal and revalidation. Revalidation: from the beginning of this cycle of revalidation 400 doctors have been revalidated and 44 doctors have been deferred, no doctors have been noted as “non-engaged. Appraisal of the 494 doctors from the consultants and NCCG doctors 24 are out of date for their appraisal, 21 either have a date set or have had appraisal and paperwork awaited. 25 are new starters in correspondence with appraisal team regarding their appraisal and revalidation.

On the day of the review, meetings were held with:
Responsible Officer
Appraisal Lead
Revalidation Manager
HR Lead
Clinical Governance and Patient Safety Lead
Patient and Public Involvement Lead
X 2 Appraisees
X 8 Appraisers

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
The Designated Body and Responsible Officer		
The RO reports a good level of interest in the annual report on revalidation, including a summary of 360 feedback, from the Trust's Board. An event to celebrate the completion of the first round of revalidation has been organised in the Trust, with input from the GMC and consideration of the next stage. The RO carries out a check of doctors' whole scope of practice to be assured that private practice has been included. The Trust has introduced an Improvement Academy and has trained staff in improvement methodology, including all consultants to bronze level. There is potential for alignment with the appraisal requirements for inclusion of a quality improvement activity and the Trust's priorities. A peer review exercise has been carried out with another Trust to share and compare processes.	In addition to the Operational Group which meets quarterly to review revalidation and appraisal processes, consider using an advisory group to support the RO's decisions about recommendations for individual doctors. Encourage others supporting the RO function to attend the Responsible Officer training. Consider giving the Revalidation Manager access to the Electronic Staff Record (ESR), to make sure an accurate list of connected doctors is maintained and cross referenced with the GMC Connect list. Once the planned staffing changes supporting the RO function have been implemented, keep under review to make sure appropriate levels of help and assistance are maintained. Consider reviewing processes to make	Suggested challenging questions for the Board:  Challenging Questions for Boards. If responses to requests for information are not forthcoming from other ROs the regional team are available to help. The GMC publishes Revalidation Operational Data reports about the revalidation decisions it makes for each designated body. The reports included data for the late recommendations made by each designated body.

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
	sure the Revalidation Manager and RO have appropriate oversight of up and coming recommendations to make sure no recommendations are submitted late. (GMC data confirms a total of 5 late recommendations submitted during 2016.)	
Appraisal		
Appraisers have a good level of peer support and the Appraisal lead meets with each appraiser annual to discuss scores from benchmarking against EXCELLENCE tool and output of feedback questionnaires. Each appraiser does around 10 appraisals per year which makes sure their skill levels are maintained. A process is in place for doctors to have a performance review prior to their appraisal and to include the completed Form A in their appraisal portfolio. Although the requirement is for the summary only to be included the majority of doctors include the whole of their performance review paperwork in their medical appraisal.	Review the process for obtaining feedback from doctors on their appraisals, to look at ways to try to increase the return rate of the questionnaire. Consider exempting appraisers from the usual restrictions on email inbox size to enable them to more easily receive doctors' appraisal paperwork which can be extensive. Continue reinforcing the need for doctors to take individual responsibility for gathering and submitting all the necessary information for their appraisal and, where appropriate, consider making	Appraisal Logistics Handbook – link to website: https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2015/11/med-apprs-logstc-hndbk.pdf Quality Assurance of medical appraisal: guidance notes: https://www.england.nhs.uk/revalidation/appraisers/qa-guidance-notes/. Appraisal QA Tools - ASPAT, Progress & Excellence: 150217_MAPS A1 App1_ASPAT form dr; PROGRESS QA template Sept 2012.d; Excellence QA tool Oct 2013 v2.doc

The Review Team's Summary:

- **Examples of good practice identified during discussions on the day**
- **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**

Examples of good practice	Areas for development	Resources that may be helpful
The Trust administers its patient feedback in-house using the Bristol University Online System (BOS) which gives an analysis of the results. Each doctor invites 45 patients to complete the questionnaire - handed out consecutively. A review of the questionnaire has identified additional questions on teamwork and communication for inclusion. Doctors are required to write a reflection on their 360 feedback and meet separately with their appraiser to discuss, usually just prior to their next appraisal. Quality assurance of appraisals is undertaken by a group of volunteer appraisers who review anonymised summaries and score them using the EXCELLENCE tool. A number of senior appraisers in the Trust provide training for appraisers externally, enabling sharing of good practice more widely.	a request for the GMC to send a non-engagement concern letter (REV6). Options for sharing appraisers are being explored with neighbouring Trusts gaining assured that the quality of their appraisals meets the requisite standard. Continue to explore options for case studies to help inform/remind doctors about the importance of making sure the entirety of their medical practice is covered in the description of their scope of practice. Continue to explore ways to help doctors to undertake structured reflection on their 360 feedback. Consider options for external benchmarking of appraisals. Perhaps exploring sharing training with neighbouring Trusts where appraisers could learn from others experiences.	Appraisal summary and PDP audit tool (ASPAT) – explanatory notes October 2016: 20160628 Draft NHS England ASPAT guida Link to Appraiser Training and Support: https://www.england.nhs.uk/revalidation/appraisers/app-train-sup/ Examples of good appraisal – Primary care: Summary of appraisal discussion - 3. Summary of the appraisal discussion - Examples of good appraisal – Secondary care & leadership roles: Summary of appraisal discussion - RO appraisal summary example (gc Useful appraisal summary stems:

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
		 Appraisal summary stems.pptx Link to appraiser skills videos https://www.fmlm.ac.uk/resources/medical-appraisal-scenarios http://www.england.nhs.uk/revalidation/Clinical appraisal skills video workshops https://www.youtube.com/playlist?list=PL6IQwMACXkj1zbMA27JZs9SgPXOuwgPWm A guidance document on inputs to appraisal: https://www.england.nhs.uk/revalidation/appraisers/improving-the-inputs-to-medical-appraisal/ GMC Case Studies on collecting patient feedback: http://www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp GMC REV6 – request to send a non-engagement concern letter: http://www.gmc-uk.org/Template_Form_REV6_RDT_Request_for_GMC_to_send_a_non_engagement_concern_to_doctor__DC3165.pdf_50534040.pdf Where local processes are ongoing to secure a doctor's

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
		engagement, an RO can use the REV6 form where a doctor (whether under notice or not) is not engaging in appraisal or other activities or the level of their engagement is not sufficient, to support a recommendation.
Monitoring Performance and Responding to Concerns		
The RO meets individually with doctors when information in their 360 feedback gives rise to concerns and will use a performance process where appropriate. Where a doctor's feedback gives a low score for honesty, the RO will write separately to everyone invited to complete a questionnaire to ask if they'd be prepared to give more information. The Trust has a culture of supporting doctors through extensive use of coaching.		Risk assessment for establishing levels of concerns: Establishing Levels of concerns.pdf Link to NHS England information flows guidance to support medical governance and responsible officer statutory function. It sets out the common legitimate channels and arrangements for the flow of information flows and gives toolkits and good practice examples. The guidance is relevant to ROs, appraisal leads, HR and clinical governance colleagues. https://www.england.nhs.uk/revalidation/ro/info-flows/

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
Recruitment and Engagement		
	Consider asking doctors at the time they apply, to confirm the date of their next appraisal and any other relevant information relating to their revalidation and appraisal. Review recruitment processes for checking that doctors have the necessary knowledge of English to make sure these are robust and applied systematically to all groups of doctors including short and longer term locum appointments. Consider learning from Trusts that have introduced values based recruitment processes and the involvement of patients/public in the selection process. Consider the need for tightening up the use of exit reports on locums for locum agencies.	Link to NHS Employment Check Standards: http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards Link to GMC guidance on employing a doctor http://www.gmc-uk.org/doctors/register/employing_a_doctor.asp Letter from Nigel Acheson to Responsible Officers, Medical Directors and Directors of HR (South region) about employing doctors  160106 To ROs,MDs & HRDs re Employmer Information about HPANs: http://www.ncas.nhs.uk/about-ncas/alert-notices/ NHS Employers information and toolkits for helping the NHS recruit staff with values that fit with their organisation: http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/values-based-

The Review Team's Summary: • **Examples of good practice identified during discussions on the day** • **Suggested areas for development and resources, some discussed on the day and others identified subsequently by the review team. Both are intended to help with the development of an action plan**		
Examples of good practice	**Areas for development**	**Resources that may be helpful**
		recruitment
Other - Public and Patient Involvement etc		
Surveying Trust members for their thoughts about public, patient and lay involvement in the appraisal and revalidation process and running a focus group to explore the suggestions made.	Reviewing the use of data made available to wards and departments from the Friends and Family test to see if doctors have accessed the information and whether it's a source of data which they could reflect upon and bring to their appraisal.	Suggested opportunities for involving patients & public:  Opportunities for Patient and Public Enc Leaflets - information for patients – Hapia & GMC:  Revalidation_Leaflet-AUGUST19-2013-2-M  GMC Patient feedback.pdf

Appendix 3

NHS England

ACTION PLAN TEMPLATE

Higher Level Responsible Officer Quality Review (HLROQR)

This template is provided for documenting actions if desired.

Designated Body:	GLOUCESTERSHIRE HOSPITAL NHS FT	**Date of HLROQR:**	23/11/16
Responsible Officer:	SEAN ELYAN		
Area for development identified at HLROQR	**Action**	**Responsibility**	**Timescale**
Develop advisory group to support RO's decisions for doctors	To be discussed at Steering Group	S Elyan RO	February 2017
Encourage others supporting RO function to attend RO training	Decision to be taken when new team in place	S Elyan RO	01/04/17
Revalidation Manager should have access to ESR	Complete		
When staffing changes to support RO function are complete keep under review to ensure appropriate levels of assistance	15 hours of band 4 time still to be advertised. Band 3 job share in post but requires time and space for handover	R Giles HR	By end of January 2017

HLROQR Action Plan Template v1.0
GHNHSFTJR/SE

Page **1** of **2**

Area for development identified at HLROQR	Action	Responsibility	Timescale
Review processes to ensure that Revalidation Manager and RO have oversight of recommendations so none are late.	It has not been possible to corroborate these findings	RO	
Review the process for obtaining appraisee feedback to improve the return rate	Appraisee feedback will be required before the appraisal is signed off as complete. Senior Medical Staff informed.	J Ropner Appraisal Lead	01/04/17
Increase size of e-mail in boxes of appraisers	Via IT department	S Elyan RO	01/04/17
Consider sharing appraisers with neighbouring Trust	Meeting planned with Appraisal Lead of 2gether Trust	J Ropner Appraisal Lead	20/01/17
Educate doctors in use of structured reflection on 360 feedback	Via appraisers at Support Groups	J Ropner Appraisal Lead	April/May 2017
Consider external benchmarking of appraisals	Discuss at Steering Group	S Elyan RO / J Ropner Appraisal Lead	February 2017
I confirm that the action plan above has been discussed and agreed with my Board or equivalent		*Responsible officer - Signature & Date*  *09/01/17*	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 7th JUNE
STROUD SUBSCRIPTIONS ROOMS

Report Title
APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR (SID)
Sponsor and Author(s)
Peter Lachecki - Chair. Sponsor and Author
Executive Summary

Purpose

To approve the appointment of a Senior Independent Director.

Key issues to note

1. The Board is required, in consultation with the Council of Governors, to appoint one of the Non-executive Directors to be the Senior Independent Director to provide a sounding board to the Chair and to serve as an intermediary for the other Directors when or if necessary. The SID should be available to Governors if they have concerns that contact through the normal channels of Chair, Chief Executive or Trust Secretary has failed to resolve, or for which such contact is inappropriate. The SID also plays a key role in the appraisal of the Chair's performance and supports the Governance and Nominations Committee to carry out its functions in this regard.

2. Following changes to the Non-executive team in recent months there is currently no Non-executive performing the SID role, and after considering the particular requirements of the role, the Chair consulted with Governors through the Lead Governor, on the appointment of Rob Graves with effect from the 7th June 2017.

3. Following this consultation which resulted in general consent, the Board is asked to approve the appointment of Rob Graves as Senior Independent Director.

Recommendations
The Board is asked to approve the appointment of Rob Graves as Senior Independent Director.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
None
Regulatory and/or Legal Implications
N/A
Equality & Patient Impact
None
Resource Implications

Finance		Information Management & Technology	

Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval	X	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)**
Outcome of discussion when presented to previous Committees					

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 5 APRIL 2017 AT 5.00PM

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	Mr G Cave	Public, Tewkesbury
Governors/	Mr G Coughlin	Public, Gloucester City
Constituency	Mrs A Davies	Public, Cotswold
	Prof Chris Dunn	Public, Stroud
	Mrs P Eagle	Public, Stroud
	Mr C 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 A Lewis	Public, Tewkesbury
	Mrs D Powell	Public, Gloucester City
	Mr R Randles	Staff, Nursing and Midwifery
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Mr P Lachecki	Chair
	Ms D Lee	Chief Executive
	Mr T Foster	Non-Executive Director
	Mr R Graves	Non-Executive Director
	Mr K Norton	Non-Executive Director
IN ATTENDANCE	Mr M Wood	Trust Secretary
APOLOGIES	Mrs S Attwood	Staff, Nursing and Midwifery
	Mrs J Harley	Patient Governor
	Cllr B Oosthuysen	Appointed, Gloucestershire County Council
	Ms T Barber	Non-Executive Director
	Dr C Feehily	Non-Executive Director
PRESS/PUBLIC	None	

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

024/17 DECLARATIONS OF INTEREST

There were none.

025/17 MINUTES OF THE MEETING HELD ON 22 FEBRUARY 2017

The Lead Governor said that given the late circulation of the papers with Governors only having one day to read and digest the content it was not satisfactory for Governors to be asked to confirm the minutes as a correct record. Mr Foster supported the Lead Governor's comments. The Chair said that it was unacceptable for papers to be circulated so late and this would not be repeated with a hard copy being made available to Governors at least five working days before the meeting. He invited comments on the accuracy of the minutes within the next few days observing that minute 010/17 regarding the appointment of an additional Non-Executive Director should be clarified regarding the appointing organisation. The minutes would be presented to the next Council of Governors meeting for confirmation.

RESOLVED:- That the minutes of the meeting held on 22 February 2017 be deferred to the next meeting.

026/17 MATTERS ARISING

005/17 VACANCIES ON THE COUNCIL OF GOVERNORS: The Chief Executive reported that arrangements had been made with the 2gether Trust for their Trust Secretary to act as Returning Officer for the staff elections with the administration being undertaken within our Trust. Details of the vacancies were published on 2 April 2017 with the closing date for nominations on 24 April 2017. If there were more nominations than vacancies then an election will be held.

The Lead Governor referred to the Healthwatch vacancy on the Council of Governors. He said that it was important for the appointed Governor to be representative of patients and Healthwatch fulfilled this requirement. There was a consensus that the Wiltshire Healthwatch (the successor body covering Gloucestershire) should be invited to appoint a Governor when the new structure for Gloucestershire became clearer. The Chair said that he would purse this with Healthwatch. Mr Marstrand questioned whether the new Healthwatch was a membership body. In response the Lead Governor said that the existing Healthwatch membership would transfer to the new organisation. **PL**

007/17 THE QUALITY REPORT 2016/17:– The Lead Governor said that falls per 1,000 patients had been selected as the local indicator for review in the Quality Report. The Chair thanked Governors for their contributions for the selection process.

012/17 GOVERNORS' LOG:– This item appeared later in the Agenda.

RHONA MACDONALD, NON-EXECUTIVE DIRECTOR:– The Chair said that Rhona Macdonald had stepped in at the last minute to help our Trust as an Interim Non-Executive Director. Her appointment had been extended for three months from February 2017. Rhona has enquired whether her appointment was required for the third and final month. The Chair had discussed this with Rhona and given the Non-Executive Director requirements in that month, her existing commitments and following that discussion Rhona has resigned as an Interim Non-Executive Director from 31 March 2017. He placed on record her valuable contribution to our Trust which he would convey to her. **PL**

NED "6" RECRUITMENT:– The Chair updated the Council of Governors on the recruitment process for the appointment of NED "6" with a clinical background. The position has been advertised but there were no suitable candidates. The recruitment agency had been rebriefed with a wider geographical are to include Bristol. There was a consensus that the preference should be for a candidate who would be available and have flexibility to meet our Trust's needs even if they had a reasonable distance to travel. It was acknowledged that the requirement to be available for three days a month was incorrect and this would be addressed as part of the recruitment process.

The view was that the geographical area for the Public Constituency be extended to include the local authority areas of Bristol City, South Gloucestershire and North Somerset. The Trust Secretary was invited to prepare a report for the Governance and Nominations Committee for **MW**

formal recommendation to the Council of Governors.

027/17 THE REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented her report as printed and invited questions from Governors and the following were the points raised:-

- Prof Dunn referred from personal experience and intervention to the delay of three months in receiving an appointment letter to attend Tetbury Hospital citing issues with TrackCare for the delay. Mrs Powell added that there are similar issues in Gloucester. In response, the Chief Executive explained that this was as a result of the impact of the new Patient Administration System (PAS) in TrackCare. Performance is currently sub optimal. Workarounds are being developed. The oversight and governance arrangements for TrackCare have been revised with the aim of expediting recovery and providing greater assurance to the Board.

- The Lead Governor sought further information on the bid for University Technical Colleges (UTC). In response, the Chief Executive said that partners have agreed to bid for the new national model to establish a UTC for 14 to 24 year olds with a health bias.

- The Lead Governor asked for an update on the Financial Recovery Plan. The Chief Executive said in response that she, the Chair and Interim Finance Director had recently attended NHS Improvement in London for a planned review meeting, but Stephen Hay was not able to attend the meeting so there was little discussion on our Financial Recovery Plan.

- The Lead Governor commended our Trust on the transitioning of Gallery Wing Ward at Gloucestershire Royal Hospital into a reablement ward targeted at those patients who are medically stable for discharge but whose discharge is delayed. The Chief Executive added that many patients return home and not to community places.

- The Lead Governor referred to the “Centres of Excellence” for those patients requiring planned or more specialist care. The Chief Executive stressed that there are a number of options emerging in the Clinical Senate that will improve the quality of care offered to patients requiring urgent care whilst supporting the development of such centres. Governors input to the options will be through the Strategy and Engagement Group at which the Director of Clinical Strategy would attend.

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted.

028/18 REPORTS FROM BOARD COMMITTEES

The Chair expressed his appreciation to the Non-Executive Directors for their work in chairing Board Committees. In particular, Keith Norton for chairing the Workforce and Quality and Performance Committees, Tony Foster for chairing the Governors Quality and Performance Group

and Rob Graves for chairing the Quality and Performance Committee. The respective Non-Executive Directors present at the meeting reported on the following Board Committee meetings.

Finance Committee – Mr Norton reported on meetings of the Committee held on 23 February and 29 March 2017. He focused on the later meeting saying that the month 11 forecast was not met with a negative variance of £700k with the view that this will be addressed in month 12. The challenge is that all income due is received in month. He had sought and received as far as is known an assurance that there are no outstanding invoices within the Trust requiring payment of which the Finance Team is not aware. The budget for 2017/18 is being prepared with the involvement of budget holders to ensure that they understand how the budget has been constructed and how it is to be achieved.

The Lead Governor said that from his observation at the Committee there was probing and satisfactory challenge from Non-Executive Directors and the Chief Executive with more rigour of the issues. The Financial Risk Register had yet to be presented to the Committee and so no assurance on financial risks could be provided.

Mr Marstrand referred to the £14.7m financial deficit in 2017/18 which the Chief executive said was included in the Financial Recovery Plan when submitted. Additional financial pressures have been identified which may mean than the Plan is adjusted or a variance of between £2 and £3m is absorbed. The Board will be invited to take a decision.

(Mr Graves joins the meeting)

Quality and Performance Committee 22 February and 30 March 2017. Mr Graves reported on the meeting of the Committee held on 30 March 2017 which he had chaired. The Committee had received assurance form the Medicine Division presentation. There was considerable learning and greater time should be allocated for Divisional presentations to ensure that the time is used effectively.

Workforce Committee – Mr Norton reported on the meetings of the Committee held on 3 March and 6 April 2017. He focused on the later meeting saying that controls on agency expenditure are working well. The Vacancy Control Panel (VCP) is performing its role and there are no adverse impact of decisions on quality and patient experience. The Committee is looking at staff retention to understand that this is a great place in which to work.

Mr Randles asked how the Committee receives assurance that decisions of the VCP are not having a detrimental clinical impact. He also said that last week there were 107 Band 2 vacancies unfilled on Rosterpro which were not permitted to be filled by agency staff. Band 3 nurses are in a Band 2 line and undertaking Band 5 work with the exception of drugs. In response, the Chief Executive said that Quality Impact Assessments are undertaken for each application and is addressed through attendance by the Nursing and Medical Directors. The Nursing Director presents the monthly Safer Staffing Report to the Quality and Performance Committee and to the Board providing assurance on staffing levels based on the Keith Hurst model. This is triangulated against the quality report. Staffing levels are not influenced by vacancies.

Mr Cave said that the changes are not seen against the backdrop of what the Trust is trying to achieve in terms of a reduction in turnover against plan.

Mr Norton said that he would raise these issues at the Workforce Committee meeting on 6 April 2017.

Dr Llewellyn said that there is no safer staffing levels for doctors. The Chief Executive said that there is no national database, but the Royal College assesses our Trust.

Audit and Assurance Committee – Mr Graves presented the report of the Committee held on 10 March 2018 which was noted.

The Chair thanked the Non-Executive Directors for their respective reports.

RESOLVED: That the reports be noted.

(Mr Norton left the meeting)

029/17 GOVERNOR VISITS AND TRAINING UPDATE

The Trust Secretary presented the report setting out the arrangements for Governor Training and Trust visits. Arrangements are being made for two half day sessions for Governors – one delivered by an in house team and the second externally by Charlie Helps. Dates are being canvassed for the training to take place before the end of the first half of the year and would be circulated to Governors as soon as they were determined.

Dates were set out for Governors to visit both Cheltenham and Gloucestershire Royal Hospital on two occasions during the year. The visits had been arranged by the Nursing Director and Governors were invited to contact her with areas which they would like to see. Each visit would accommodate a maximum of four Governors. The Lead Governor said that priority would be given to the newer Governors. The Lead Governor was invited to liaise with the Nursing Director before the visits took place to determine their purpose. **AT/MA**

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

- Mr Marstrand asked that the similar training be planned for the new Governors following the elections later in the year. In response, the Chief Executive said that this training was intended for existing Governors and training for Governors after the elections would be considered at that time.

- The Trust Secretary was invited to ensure that all Governors had access to the e-learning modules by mid April 2017. **MW**

The Chair thanked the Trust Secretary for the report.

RESOLVED: That the arrangements for Governor training and visits be noted.

030/17 GOVERNORS' LOG /CONTACT YOUR GOVERNOR

The Trust Secretary presented the Governors' Log providing Governors with an opportunity to consider those items included.

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

- Mrs Davies said that the meeting referred to in her question on trolley waits had been cancelled three times. The Chief Executive undertook to ascertain the reasons for the cancellation. **DL**
- Mr Marstrand asked that the second "Governor" column be deleted as it was superfluous. This was agreed. **MW**
- The Lead Governor said that he had made some suggested changes to the Standard Operating procedure and the Trust Secretary was invited to update and circulate by mid April 2017. **MW**

RESOLVED: That the Governors' Log be noted.

031/17 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The Chair invited Governors to report on any member engagement activity which they had undertaken and the following were reported:-

Prof Chris Dunn – Said that he had attended two seminars.

Dr Peter Jackson – said that he continues to attend meeting of the Forest of Dean Health Forum.

Mr Randles reported on a meeting he had held with staff constituents.

Mrs Davies reported that she continues to contribute to a local parish magazine. She is receiving feedback on organ donation and is able to explain issues such as improved patient flow in Oncology.

The Chair thanked Governors for their updates.

032/16 GOVERNOR QUESTIONS

None submitted. It was agreed that this item be deleted from future Agendas given the opportunities now available to Governors to ask questions through the Governors' Log.

033/16 ANY OTHER BUSINESS

There were no further items of business.

034/16 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be now held in the Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham **on Monday 19 June 2017** commencing at 5.30pm. (from 14 June 2017).

035/16 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 6.50 pm.

Chair
19 June 2017

ITEM 13

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 14

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 15

STAFF QUESTIONS

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

ITEM 16

PUBLIC QUESTIONS

(Procedure attached)

Peter Lachecki
Chair