GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Wednesday 13 December 2017** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** 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

22 November 2017

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
3.	Patient Story			09:02
4.	Minutes of the meeting held on 8 November 2017	**PAPER**	**To approve**	09:32
5.	Matters Arising	**PAPER**	**To note**	09:35
6.	Chair's Update	**VERBAL**	**To note**	09:40
7.	Chief Executive's Report December 2017	**PAPER** (Deborah Lee)	**To note**	09:45
8.	Quality and Performance:		**For Assurance**	10:00
	• Quality and Performance Report	**PAPER** (Caroline Landon, Sean Elyan, Steve Hams & Emma Wood)		
	• Assurance Report of the Chair of Quality and Performance Committee meeting held on 30 November 2017	**PAPER** (Tracey Barber)		
	• Trust Risk Register	**PAPER** (Lukasz Bohdan)		
	• Learning from Patient Stories	**PAPER** (Steve Hams)		
	• Learning from Deaths	**PAPER** (Sean Elyan)		
	• Emergency Planning Resilience and Response	**PAPER** (Caroline Landon)		
9.	Financial Performance:		**For Assurance**	10:50
	• Report of the Finance Director	**PAPER** (Steve Webster)		
	• Assurance Report of the Chair of the Finance Committee meeting held on 29 November 2017	**PAPER** (Keith Norton)		
	Break		**11:20 - 11:30**	
10.	Workforce:		**For Assurance**	11:30
	• Report of the Deputy Chief Executive and Director of People	**PAPER** (Emma Wood)		

	• Assurance Report of the Chair of the Workforce Committee meeting held on 10th November 2017	**PAPER** (Keith Norton)		
11.	Audit and Assurance:		**For Assurance**	11:50
	• Report of the Chair of the Audit and Assurance Committee meeting held on 7 November 2017	**PAPER** (Rob Graves)		
	• Board Statement of Bribery	**PAPER** (Deborah Lee)	**To Approve**	
12.	SmartCare Progress Report	**PAPER** (Deborah Lee)	To Note	12:00
13.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Sean Elyan)	For Assurance	12:15
14.	Minutes of the meeting of the Council of Governors held on 5 September 2017	**PAPER** (Peter Lachecki)	To Note	12:30
	Governor Questions			
15.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To Discuss**	12:35
	Staff Questions			
16.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	12:45
	Public Questions			
17.	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**	12:50
	Any Other Business			
18.	Items for the Next Meeting and Any Other Business		**To Note**	12:55
	Lunch		**13.00 – 13.30**	

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE BOARD ADMINISTRATOR NO LATER THAN 17:00PM ON MONDAY 4th DECEMBER

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 11 January 2017** in the **Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital** 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	Lukasz Bohdan, Director of Corporate Governance
Tony Foster	Dr Sean Elyan, Medical Director

Rob Graves	Steve Hams, Director of Quality and Chief Nurse
Keith Norton	Caroline Landon, Chief Operating Officer
Alison Moon	Dr Sally Pearson, Director of Clinical Strategy
	Steve Webster, Finance Director
	Emma Wood, Deputy Chief Executive and Director of People

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTER ROYAL HOSPITAL ON WEDNESDAY 8 NOVEMBER 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
	Steve Hams	Director of Quality and Chief Nurse
	Caroline Landon	Chief Operating Officer
	Dr Sally Pearson	Director of Clinical Strategy
	Steve Webster	Director of Finance
	Emma Wood	Deputy Chief Executive and Director of People
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
	Alison Moon	Non-Executive Director
APOLOGIES	Tracey Barber	Non-Executive Director
IN ATTENDANCE	Natashia Judge	Board Administrator
	Suzie Cro	Head of Patient Experience
	Sarah Sadler	Patient's parent
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	Three Governors, three members of the public, one member of the press and five members of the paediatric team.	

The Chair welcomed all to the meeting and in particular welcomed Ms Wood to the team.
Ms Barber's apologies were noted.

243/17 PATIENT STORY

The Head of Patient Experience introduced Sarah Sadler who shared her son Michael's background and her family's experience whilst he was under paediatric care. Michael was admitted one afternoon with pain in his leg and was diagnosed with leukaemia the same evening. He went on to spend over three years undergoing treatment. Recounting Michael's story, Sarah noted:

- The speed of diagnosis – Michael was diagnosed with leukaemia within six hours.
- The creative activities available on the paediatric ward and the availability of play specialists who helped Michael with his anxiety. In particular, they made Michael's Hickman line less traumatic and covering the blood machine in balloons to make this less intimidating.
- Michael made twenty trips to theatre and initially this filled him with anxiety: he was restrained on the first 5 or 6 occasions. The paediatric team set up a treasure hunt and a scooter to get him to theatre and the entire experience

reformed.
- Sarah praised the paediatric consultant, Dr Thomas Kus, on his clear and to-the-point approach.
- Michael's beads of courage were shared with the Board and Sarah explained that each bead represented a different treatment, such as an occasion where Michael had bloods taken, stayed the night or had a procedure. She explained the comfort and order the beads brought to their family, helping her feel in control and aiding Michael in communicating about his treatment.
- The practice of ringing the bell at the end of treatment and the closure this brings to patients.
- The support offered post-treatment by social workers and how invaluable this was.

Overall Sarah had high praise for the ward, however she noted the difficulty of reliving Michael's story when the consultant who knew Michael well, was not around and encouraged the Board to think about how better continuity of care could be maintained. The Chair thanked Sarah for sharing Michael's story. Following Sarah's permission, the Board went on to ask her and the paediatric team the following questions:

- The Director of Quality and Chief Nurse was struck by the personalisation the team brought to Michael's care and wondered how this could be applied to other patients. The paediatric team agreed the key was consciously identifying each patient's individual needs.
- Mr Norton queried what support Sarah and her husband received to help cope with Michael's diagnosis and treatment. Sarah responded that while she felt in control, her husband needed counselling and guidance, which they received through the social workers and consultants.
- The Medical Director noted his role as a Consultant Adult Oncologist and highlighted the difficulty many adults had with achieving closure. He felt Michael's story was unique and needed to be shared. Sarah praised the nursing staff, noting their excellent record keeping led to consistent care. The paediatric team agreed that much of the personal information is generated from the play specialists and the inclusion of a chronology in the front of patients notes, created from combined nursing and doctor notes.
- The Chief Executive shared that she was conscious of the fear of not being able to access a known consultant, and felt simple practices such as using key phrases that patients recognised could alleviate this. She questioned whether we could use technology to perhaps provide a video summary of a child's care and needs to avoid repetition by the parents and bring the child's story to life.
- The Director of Clinical Strategy acknowledged the differences in approach between doctors and nurses and the centrality of *what matters to you* in nursing engagement.

The Head of Patient Experience and the Paediatric Team noted the difficulty around the cost implications of the Beads of Courage,

highlighting they were currently supplied by a charity. Mr Foster introduced himself as the Chair of Charitable Funds and agreed to pursue this via the Committee. **TF**

244/17 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

245/17 MINUTES OF THE MEETING HELD ON 11 OCTOBER 2017

RESOLVED: That the minutes of the meeting held on 11 October 2017 be agreed as a correct record and signed by the Chair.

246/17 MATTERS ARISING

The Chief Executive reinforced the importance of providing updates for the Matters Arising before the Board meeting. **Executive Team**

SEPTEMBER 2017 183/17 SMARTCARE PROGRESS REPORT - BENEFITS REALISATION HAS BEEN OF INTEREST TO GOVERNORS
This is being reviewed. This will potentially be brought to November Board but will be reviewed at SmartCare Programme Board initially.
Completed: Benefits realisation approach is being reviewed as part of the deep dive recommendations. This will be discussed at the Board Strategy and Development session in February 2018 and the Governor Strategy and Engagement Group in March.

OCTOBER 2017 208/17 PATIENT STORY - HOSPITAL LIAISON OFFICER AND INDUCTION TRAINING
Reintroduce Louise De Lloyd's involvement in the induction training. Ms Moon felt this should also be available for all staff, not just clinical staff.
Completed: The Head of Patient Experience is working with Carers Gloucestershire to:

- *Develop overview presentation for induction.*
- *Recruit 4 – 6 ward based volunteers who will be 'carers advocates' and to raise the profile of Carers Gloucestershire*
- *Develop a Carers Strategy for publication in Spring 2018*

OCTOBER 2017 208/17 PATIENT STORY - DISCHARGE LIST PROMPTING THE INVOLVEMENT OF CARERS TO BE INVESTIGATED (SIMILAR TO THAT USED WITHIN END OF LIFE CARE)
Director of Quality and Chief Nurse to investigate this alongside the Head of Patient Experience.
Completed: A trigger will be included as part of the patient profile to help identify patients who are or could be carers.

OCTOBER 2017 208/17 PATIENT STORY - FURTHER RESOURCES FOR HOSPITAL LIAISON OFFICER
Chief Executive shared that she would soon be involved with the planning cycle for Sustainability and Transformation Partnership

(STP) priorities and therefore she would take the discussion forward into the STP Delivery Board.
Completed: Chief Executive has written to the GCCG asking them to consider this in the forthcoming planning round.

OCTOBER 2017 210/17 MINUTES OF THE MEETING HELD ON 13 SEPTEMBER 2017 - MINUTE AMENDS
These would be taken forward by the Board Administrator.
Completed: Amendments made.

OCTOBER 2017 210/17 MINUTES OF THE MEETING HELD ON 13 SEPTEMBER 2017 - FURTHER INVESTIGATION NEEDED REGARDING HOW PATIENTS ARE PRIORITISED AT THE WEEKENDS GIVEN REDUCED STAFF
The Director of Quality and Chief Nurse would investigate this as well as the patient story from September 2017 to identify what went wrong.
Completed: This has been investigated and the patient's care went wrong due to a variety of different reasons The patient's notes have been reviewed and learning identified.

OCTOBER 2017 212/17 CHIEF EXECUTIVE'S REPORT - CHRIS HOPSON TO BE INVITED TO A FUTURE 100 LEADERS.
Chief Executive to invite at next meeting.
Completed.

OCTOBER 2017 213/17 QUALITY AND PERFORMANCE REPORT - CANCER PERFORMANCE AND HOW THE TRUST MIGHT COMMUNICATE AND REASSURE LONG WAIT CANCER PATIENTS
The Interim Chief Operating Officer would investigate this acknowledging the importance of ensuring patients understood the reason and duration of likely delays and most importantly, that it was safe for patients to wait where this occurred.
Ongoing: The Cancer Services Board has been refreshed to focus on recovery and the Associate Director of Planning and Performance is working with services to identify individual communications to send to patients which are approved by clinicians. High level conversations are ongoing with the Communications Team and a further update will be brought to December Board.

OCTOBER 2017 213/17 ASSURANCE REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE - INCLUSION OF THE PATIENT SAFETY CHECKLIST IN THE EMERGENCY DEPARTMENT TO BE INCLUDED WITHIN THE QUALITY DASHBOARD.
The Director of Quality and Chief Nurse would ensure this happened.
Completed for Gloucestershire Royal Hospital data, Cheltenham General Hospital data to be included from December 2017.

OCTOBER 2017 214/17 REPORT OF THE FINANCE DIRECTOR - TRADE PAYABLES
The Chair expressed concern over trade payables and shared that he has asked the Finance team to review this and for this to be

discussed further at Finance Committee.
Completed: Discussed at Finance Committee and included within the Finance report.

OCTOBER 2017 215/17 REPORT OF THE DIRECTOR OF HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT - STAFF ACCESS TO MONTHLY ONE-TO-ONES AND TEAM MEETINGS
It was agreed this would be raised at the next 100 leaders.
Completed: A seminar session is being organised for January 2018.

OCTOBER 2017 215/17 REPORT OF THE DIRECTOR OF HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT - THE DIRECTOR OF FINANCE FELT THE REPORT HIGHLIGHTED THE ALIGNMENT BETWEEN WORKFORCE REPORTING AND FINANCE PROJECTIONS AND THE FORECAST OF A REDUCED VACANCY RATE FOR BAND 5 NURSES
The Finance Director highlighted that this should be reducing the agency forecast and that he would investigate.
Completed: Discussed. The former Director of Human Resources and Organisational Development believed the reduced vacancy rate was due to a methodological change and not due to more nurses.

OCTOBER 2017 217/17 SMARTCARE PROGRESS REPORT - NOT ENOUGH STAFF READING THE REGULAR TRAKCARE UPDATES
Head of Communications to think about how this could be done differently.
Completed: Action new approach to TrakCare communications and engagement under consideration and will be agreed at NHS Digital Deep Dive.

OCTOBER 2017 220/17 GOVERNOR QUESTIONS - DESPITE COMMUNICATION ON THE CHANGES TO ORTHOPAEDIC SERVICES, MISINFORMATION WAS CIRCULATING WHICH THE COMMUNICATIONS TEAM WERE SEEKING TO CORRECT
Director of Clinical Strategy and Head of Communications to progress this further and provide clarity.
Completed: Comprehensive communication including Frequently Asked Questions, shared with the media and posted on website in week commencing 23 October.

[09:42]

247/17 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented her report to the Board and highlighted the key points within the paper:

- The Trust is currently experiencing improvements in flow and improved operational performance, particularly with regards to the Accident & Emergency (A&E) 4 hour standard thanks to reconfiguration of the Trust's Trauma and Orthopaedic (T&O) services and implementation of the Winter Plan. The Trust is currently 13th in the national league tables. The Chief Executive thanked the Chief Operating Officer, Medical

Director and Director of Quality and Chief Nurse for their support with this. She also thanked Andrea Clarke from the Health and Care Overview and Scrutiny Committee (HCOSC), who was present at the meeting, for enabling the Trust to bring in changes quickly. Several clinical staff have praised the T&O reconfiguration noting the improvements in care this has enabled.

- On 1st November Pauline Phillips (National Director for Urgent and Emergency Care) visited the Trust. As well as discussing the urgent care pathway with staff, the transport service offered by Arriva was discussed, with the team highlighting the fact that that contractual standards were not being delivered. Discussions suggested that finance could be available to acquire a real time bed status system; the Chief Operating Officer would investigate this. **CL**
- On 2nd November, the Sustainability and Transformation Partnership (STP) had an away day to discuss proposals for the One System Business Case. Some frustration was noted amongst the public and partners with speculation that plans were being withheld from them. The Chief Executive confirmed that there were no firm plans that had not been shared and that the Trust continued to work together with the STP to ensure clarity on urgent and emergency care over the next few months. She stressed that despite speculation, the only changes to Cheltenham A&E related to the T&O reconfiguration, with staffing models and hours of operation the same. Any future changes would be subject to public consultation.
- Establishment of a Subsidiary Company (SubCo) has progressed with engagement of staff and research into other Trusts, which operate the same model. In particular, the Queen Elizabeth Facilities SubCo, in Gateshead had shared the benefits to patients and clinical services including improved levels of staff satisfaction. The case will be further considered in the Confidential Board session and, if approved, the next steps would involve further staff engagement alongside conversations with unions.
- A new approach to TrakCare recovery is underway alongside NHS Digital with a Deep Dive planned for 14t - 17 November. This will enable a recovery programme to be developed, which expedites recovery. The Chief Executive has taken over as Senior Responsible Owner (SRO) for the programme and has begun as chair of the SmartCare Programme Board.

The Chair thanked the Chief Executive for her report and invited questions from other members of the Board:

- Mr Norton commended the team on the performance improvements in A&E and attributed these to teamwork, leadership, determination and confidence. He reflected that often lessons are learnt when plans go awry, but wondered in contrast if lessons would be learnt from this success? The Chief Executive noted that the improvements in performance were attributable to good design which would enable long term success. She noted the Trust was improving against the

national trend but cautioned that recent improvements are not yet embedded and we should therefore expect some volatility in performance.

- Dr Feehily noted Pauline Phillips comment on the Trust's classification as a category four Trust in respect of A&E performance, and the possibility of this improving and queried the implications of this. The Chief Executive answered that in the classification of the Trust, including the status of the enforcement undertakings would be reviewed by NHSI in January 2018. She reflected that improvements in this regard this would be a positive message to staff and patients displaying that services are improving.
- Mr Graves noted the opportunities for technology and the Chief Executive reflected on her discussions with David Walliker, Chief Information Officer at the Royal Liverpool and Broadgreen University Hospitals who were the Global Digital Exemplar Trust. She would be liaising with the Head of Communications to further discuss how the Trust could develop our own vision and articulate this to staff. **DL/CM**

248/17 QUALITY AND PERFORMANCE:

QUALITY AND PERFORMANCE REPORT

The Chief Operating Officer presented the Quality and Performance Report which summarised the key highlights and exceptions in the Trust's performance for September 2017. This report had previously been to the Quality and Performance Committee for assurance.

Key points highlighted from the report were:

- Performance against the 4 hour A&E standard was 86.1% for September, which was 4.8 percentage points below the agreed STF trajectory. This improved however to 89.1% for October and stood at 95% for November.
- Diagnostics for September showed improvement with the Trust on track for full recovery by the 30th December 2017.
- Performance against the 2 week cancer standard improved slightly in October and stood at 74.2% (unvalidated)
- While the Trust is achieving the 31 day cancer target it continued to struggle in achieving the 62 day target with 66.5% achieved in September and 72.3% in October.
- Operational plans are in place to recover the position with cancer patients and improve the emergency department (ED), supported by changes in the performance team. The structure will now include a Director of Planned Care and a Director of Unscheduled Care as opposed to one deputy to ensure focus on the planned and unscheduled care pathways. The two week wait bureau will be moved out of the booking office and placed under the cancer services team, with oversight by the Director of Planned Care as opposed to diagnostics.
- The Chief Executive has challenged the Chief Operating Officer to deliver the 62 day target by April 2018 and this

challenge has been relayed to divisions. The Chief Operating Officer acknowledged that this has not been delivered for 4 years and that it was imperative to improve the breach position and that challenging work needed to be undertaken.
- Chief Operating Officer stressed that she was committed to ensuring that the Trust would not return to delivering below 90% in performance against the A&E 4 hour standard.

In response to the Chief Operating Officer's report the following points were raised by the Board:

- Ms Moon shared that she was pleased to hear about the structural changes and noted their importance in improving performance. She queried what support was required from commissioners. The Chief Operating Officer outlined that she would focus on addressing what was "within her grasp" whilst having conversations with commissioners around challenging tumour sites. Ms Moon further queried whether the plan was an incremental one or one of step change and wondered whether initiatives around 62 days needed to settle in first. The Chief Operating Officer responded that she had challenged the divisions with creating appropriate trajectories in order to tackle big issues whilst identifying process change. She noted she was confident the Director of Planned Care would focus on this.
- Mr Foster acknowledged the additional leadership, energy and ambition amongst new executives but noted that without good design personal characteristics can fade and therefore wondered what design changes had been made? The Chief Operating Officer shared that for A&E there were task and finish plans and milestones for delivery every two weeks with clinical involvement and plans for cancer were being built which were all about systems and processes and not people. She reinforced that success was about process and should not be person-dependant but did not foresee a scenario where her own energy and focus would fade.
- Mr Graves felt that a recurrent issue had always been identifying the enablers of improvements and wondered if specific enablers could be described. The Director of Quality and Chief Nurse and the Medical Director detailed a number of transformational items which would improve processes.
- The Chair queried when a clear trajectory for cancer would be available and the Chief Operating Officer explained this would be visible at the next Quality and Performance Committee. The Chair also queried what future challenges had been identified and the Chief Operating Officer pointed out 'Straight to Test' and job plans.
- The Chief Executive noted the increase in referrals to the gastrointestinal pathway and changes to the guidelines in relation to dermatology, acknowledging that these factors were outside of the Trust's control and therefore addressing these issues with partners was also important.

The Director of Quality and Chief Nurse presented an update on quality:

- Dementia indicators were included within the report for the first time. He acknowledged that although performance had yet to improve it was important to acknowledge that the reporting mechanism was still being developed.
- Mixed sex accommodation figures had increased due to a change in reporting. Previously the Trust was reporting patients after 24 hours whereas this now takes place after 4 hours. The Director of Quality and Chief Nurse said he was working with the site team in order to develop a standard operating procedure to address the issue but confirmed all of the breaches reported had occurred in one area (critical care) where delays to the ward were the reason.
- Performance against the ED safety checklist continues to improve but compliance is not yet what it needs to be. Thanks to the work undertaken to embed the document over the last year and the emphasis given to this area, the Director of Quality and Chief Nurse advised the Board he was confident further progress could and would be made.
- Infection Control rates are deteriorating with an increase of clostridium difficile. NHS Improvement (NHSI) has offered support via the National Lead for Infection Control and this has been accepted. There would be a vacancy in the leadership role shortly and he was carefully considering the approach to filling this gap in light of the challenges.
- Pressure ulcer rates were discussed at the Quality and Performance Committee with a Deep Dive planned for the next meeting as part of the NHSI collaborative.
- The Complaints Team now hold a weekly briefing to discuss complaints over 35 days which had not been addressed. The Director of Quality and Chief Nurse highlighted that there were some complaints beyond 65 days therefore he was working with the divisions to resolve, offering support and challenge.

In response to the Director of Quality and Chief Nurse's report the following points were raised by the Board:

- Ms Moon shared that she was heartened to hear of the importance placed on the fundamentals of care with the ED safety checklist providing a framework for staff. The Chief Executive queried whether the checklist could be amended to a 3 hour checklist and the Director of Quality and Chief Nurse and Chief Operating Officer agreed to consider this.
- Mr Graves queried how the situation around complaints had arisen and the Director of Quality and Chief Nurse explained this was due to the system process and anxiety around escalation. The team would now systemise executive intervention. The Chief Executive reinforced that the Complaints Team were available to support the investigation of complaints, not to conduct this on behalf of clinicians and that it was important staff involved in poor care took ownership of each complaint.
- The Chief Executive reflected that for every 1,000 contacts the Trust received 1.19 complaints and also received many

more compliments than complaints and therefore it was equally important to learn from praise. The Director of Quality and Chief Nurse advised that an improvement project was underway to create antithesis to Datix: *Greatix*, in order to recognise success.
- Mr Norton raised that he felt safeguarding should be reviewed by the Board on a much more regular basis. It was agreed this would be addressed by the Quality and Performance Committee.

The Medical Director presented an update to the Board, noting:

- The stranded patient metric and the difficult and emotive language around this. He explained the metric to the Board noting that this was being reviewed nationally and that the new Chief of Service for Diagnostics and Specialties, Kate Hellier, who previously worked on the SAFER project, would focus on improving this.
- Mortality indicators and the ongoing work to reduce mortality. The Hospital Standardised Mortality Ratio (HSMR) has dropped. The Medical Director shared that while complex, no difference was noted between the care of patients seen on weekdays versus weekends but the belief was that the severity of illnesses on weekends are higher. He stressed the importance of consistent care seven days a week.

The Chair thanked the Chief Operating Officer, the Director of Quality and Chief Nurse, and the Medical Director for their reports.

RESOLVED: That the Trust Board receive the report as assurance that the Executive Team and Divisions fully understand the current levels of poor performance and have actions plans to improve the position.

ASSURANCE REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 26 OCTOBER 2017

Dr Feehily presented the assurance report noting in particular:

- Performance figures, which at the time of the Committee meeting, had not yet been affected by the T&O reconfiguration and the Winter Plan.
- Cancer performance and how the Trust was supporting patients who have exceeded target timeframes.
- The progression of the agenda influenced by the Trust Risk Register with exception reporting and less operational discussion.
- A new risk around pressure ulcers and the further examination of this at the next Committee.
- Additional items discussed by the Committee including the Medicines Optimisation Report and the Annual Report of the

Screening Programmes.

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

TRUST RISK REGISTER

The Chief Executive presented the Risk Register noting that the process of reviewing risks within the Trust Leadership Team was working well with 4 risks debated at length which will be reassessed, reviewed and likely de-escalated. She shared that progress was being made with divisional level reviews. 18 risks were not yet included within the Trust Risk register, however these would proceed through the process, with the Chief Executive confident that the vast majority would be de-escalated once reassessed.

RESOLVED: That the Board receive the report as assurance that the systems of internal control are actively controlling and pro-actively mitigating risks so far as possible and approve the changes to the Trust Risk Register as set out.

249/17 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE DIRECTOR:

The Director of Finance presented the Financial Performance Report to the Board summarised the key points.

In September the Trust has delivered a deficit of £2.91m and a cumulative deficit of £17.97m This represents a favourable variance to budget and plan of £1.87m

While the year to date position for the Trust is better than planned, the Director of Finance focused on the forecast, which is significantly adverse. Key issues to note were:

- The Trust is forecast to move to an unfavourable variance next month.
- No Sustainability and Transformation Funding (STF) has been assumed in the actual position given that the Trust has not agreed a control total for the 2017/18 financial year.
- Cost Improvement Programme (CIP) delivery to Month 06 is £11.7m. This is £1.4m better than the plan for the year to date. However, the current CIP delivery forecast for the year is £23.3m - as compared to £34.7m in the plan.
- The annual plan for the Trust is a £14.6m deficit. The current forecast, prior to mitigating actions, shows a deficit of £27.9m - an adverse variance of £13.3m.
- Once further financial recovery actions and risk is accounted for the Trust is projecting an outturn of between £14.6m and £27.8m deficit, with a realistic stretch scenario of £23.9m

deficit.

- Additional CIPs and other measures have been identified in order to enable £6m of savings. Plans to deliver these are being embedded. The Director of Finance noted that the key scheme around rates was high risk and therefore has been withdrawn, reducing the amount of savings by £2.5m.
- The Trust has been forecasting an improvement in income from TrakCare related to counting and coding however this has reduced by £3m due to a variety of factors. Discussions are ongoing with commissioners.
- There is potential that GCCG could offer additional resources of £8m, however this is dependent NHS England and NHS Improvement agreeing to the funds being transferred to the Trust by the GCCG without adverse impact on GCCG control total.
- Uncertainty remains around income and winter pressures.

The Board noted the Director of Finance's report and raised the following points in response:

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- Mr Graves thanked the Director of Finance for his explanation and reflected that the risk could be measurably worse than the plan and queried whether there was a risk of negative fallout from missing a target? The Director of Finance felt this was a risk however the Trust is taking steps ensure the risk is mitigated. He distinguished that the £6m of additional CIP was the key deliverable within the Trust's control.
- The Chair and Chief Executive recognised that new ideas for CIP were coming from the clinical teams and encouraged staff not to wait for the end of the financial year before sharing and implementing these.
- Dr Feehily queried how confident the Board were that they had the balance right between controlling spend and avoiding unintended consequences on quality. The Chief Executive shared that the team were listening and engaging with staff, releasing controls at lower levels and agreeing parameters. There were clear messages to staff that patient safety must always come first and she was not aware of any incident that had arisen from a financial control.
- The Chair queried whether the Board should be concerned regarding the £0.9m drug negative variance. The Director of Finance responded that they were right to express concern and that this issue was being examined within the Finance Committee and that the finance team were working with the pharmacy team to gain clarity over the situation.
- The Chair also queried the cash flow forecast and the inclusion of September only. It was agreed the cash flow for the full year would be included in future reports. **SW**

RESOLVED: That the Board receive the report for assurance in respect of the Trust's Financial Position.

ASSURANCE REPORT OF THE CHAIR OF THE FINANCE COMMITTEE MEETING HELD ON 25 OCTOBER 2017

Mr Norton presented the assurance report highlighting in particular:

- The excellent quality of reporting from the finance team
- The challenges around the current plan for cost reduction and savings
- The tactical and strategic changes being progressed

The Committee Chair (?) commended the finance team on the £6m CIP plans, acknowledging that aside from the Trust's position this was an achievement.

The Director of Finance highlighted that confirmation of the loan had still not been received and this was captured on the Trust Risk Register.

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

(The Board adjourned from 11:05am to 11:25am)

250/17 WORKFORCE

REPORT OF THE DIRECTOR OF PEOPLE

The Deputy Chief Executive and Director of People presented the Workforce Report and emphasised the key points noted within:

- A reduction in agency expenditure continued in Month 5 and 6 alongside a reduction in the pay bill. The team are investigating how the vacancy position can be better managed to enable to pay bill reduction to continue for the next 5-6 months.
- Recruitment to nursing vacancies is outlined within the paper with future international trips planned.
- Retention figures remain stable with no points of concern highlighted
- Further focus needs to be given to how the Trust is managing long term sickness.
- Appraisal rates continue to give cause for concern at 79%. The internal target is 90%. This is being addressed via divisional reviews with a focus on simplifying paperwork and improving quality. The Deputy Chief Executive and Director of People would be focusing on this moving forward.
- Workforce strategy is the focus of many conversations within the Sustainability and Transformation Partnership (STP). The Trust's reward strategy would be received at the next Workforce Committee and the Deputy Chief Executive and Director of People acknowledged that work around SubCo would consume a considerable amount of HR resources. The team are beginning to investigate how the strategy can be managed effectively.
- A new diversity network will be launched on 10 November reinvigorating the case for diversity.
- Listening events continue to be held.

- Staff survey response rates are encouraging at 38% and need to be built upon.

The Board noted the Deputy Chief Executive and Director of People's report and raised the following points in response:

- Mr Norton advised that he would be chairing the next Workforce Committee and that he was pleased see a strategic approach going forward.
- The Chair shared that a recent national report on nurse recruitment displayed the change from non-European union recruitment to European recruitment in 2012-2013. This is now reversing and he wondered whether the team fully understood the situation at that time, the context behind it and therefore the current relevance The Deputy Chief Executive and Director of People would take this back to the team. **EW**
- The Director of Quality and Chief Nurse felt the Chair's point related to the supply chain for nursing. He said that 60 students from the University of Gloucestershire had joined the Trust alongside 40 from the University of West England and 20 from the University of Worcester. He queried how the Trust could ensure it was providing an opportunity for existing staff? The Deputy Chief Executive and Director of People responded that opportunities were available and that work she was doing on a Talent Management System would support this aim.
- The Chair noted that the Secretary of State for Health, Rt Hon Jeremy Hunt, would be outlining the new workforce strategy and how this might be funded and looked forward to seeing how this would be progressed by the Deputy Chief Executive and Director of People.

RESOLVED: That the Board note the positive trends illustrated in the report.

251/17 SMARTCARE PROGRESS REPORT

The Director of Clinical Strategy presented the SmartCare Progress Report to provide assurance to the Board, from the SmartCare Programme Board, on the current position of the SmartCare Programme. The key points highlighted from the report:

- Plans to deploy TrakCare Radiology Order Comms in A&E have been halted so that focus and resources can be targeted at recovery. This will also enable the team to address the internal support for users of the system, which is required to support the role out of further clinical functionality.
- At October Board the Director of Clinical Strategy highlighted a recent data issue involving TrakCare. This has been investigated and sufficient assurance received that data has been secured and was not available to the public. This has been reported to the Information Commissioner who is reviewing the actions undertaken. Intersystems have also

provided assurance that the error that enabled the breach could not occur again.
- As mentioned by the Chief Executive, a Deep Dive is scheduled for the week commencing 13th November.
- Further updates to the system will progress, however the data element will be delayed until February 2018. Updates will address a number of issues causing operational difficulties as well as addressing the outstanding issues inhibiting role of order communications in Radiology.

The Board noted the Director of Clinical Strategy's report and raised the following points in response:

- Dr Feehily queried whether patients had received communication as part of addressing the data breach. The Director of Clinical Strategy advised this was part of the process but pending a response from the Information Commissioner, patient communications had not yet taken place..
- The Chair queried how the Deep Dive would differ from previous internal work. The Chief Executive responded that this work was commissioned by her and would report directly to her. The amount of time and resources devoted to this was considerable and the review would be underpinned by a robust methodology. The Chief Executive explained that this would be very distinct from the work undertaken by Cymbio which was different in scope and focus:.the investigation by Cymbio provided the Trust with lines of insight and enquiry that a Deep Dive could further pursue. She shared that new governance arrangements were in place around SmartCare and that she was the new Senior Responsible Owner (SRO). She reflected that it was important to engage staff and offer resources to support the system whilst identifying champions.
- Mr Graves queried the ongoing process for keeping the Board involved and the Chief Executive responded this would continue on a monthly basis.

RESOLVED: That the report be noted.

252/17 GOVERNOR QUESTIONS

The Lead Governor thanked the Board for their reports and raised the following points:

- Governor concern regarding portering was noted within the Quality and Performance Chair's report. The Lead Governor expanded that this was raised following a governor visit to radiology where concerns with portering staff levels, low morale, effect on services and the loss of private patients were noted. The Chief Executive acknowledged there were issues in the way staff interfaced with porters. The Chief Executive advised that the Chief Operating Officer would be working alongside the Head of Estates and Facilities to build relationships and ensure the Trust had the correct portering resources, while investigating the options around

departmental portering and zoning. (The Chief Operating Officer said that she had also met with the Chiefs of Service to identify and discuss with consultants how the Trust could repatriate some of the private activity back to the Hospital. The Medical Director would be involved within this also).(?)

- The Lead Governor thanked the Board for the updates around performance improvement.
- Whilst attending a consultation session in the Forest of Dean the Lead Governor noted that while the Trust was mentioned frequently there was no Trust representative in attendance. He raised concern regarding this. The Chief Executive responded that this was a valuable insight and shared that there had been much debate within the STP regarding the best approach to public consultation. She advised that she had been unaware of the meeting.
- Reflecting on the Matters Arising, the Lead Governor expanded on the matter related to TrakCare benefits realisation. He requested that the initial benefits of TrakCare, established before implementation, be shared with governors. The Director of Clinical Strategy said she would ensure the governors see the original presentation explaining the benefits. The Chief Executive said she felt reassured that the Royal Liverpool and Broadgreen University Hospitals NHS Trust, an acute Global Digital Exemplar, had chosen to use TrakCare. She would consider asking the Trust whether a representative could attend a Board Strategy and Development session or similar. **DL**
- With regards to the TrakCare Deep Dive, the Lead Governor reinforced the importance of addressing the aspects which had gone wrong for patients. The Chief Executive reassured that the Deep Dive would focus on patient safety and experience.

253/17 STAFF QUESTIONS

There were none.

254/17 PUBLIC QUESTIONS

There were none.

255/17 ANY OTHER BUSINESS:

No other business was noted.

ITEMS FOR THE NEXT MEETING:

None were noted.

256/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Wednesday 13 December 2017** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital.**

257/17 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 12.08 pm.

Chair
13 December 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – DECEMBER 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
November 2017	October 2017 213/17 Quality and Performance Report	**CL**	Cancer performance and how the Trust might communicate and reassure long wait cancer patients.	The Interim Chief Operating Officer would investigate this acknowledging the importance of ensuring patients understood the reason and duration of likely delays and most importantly, that it was safe for patients to wait where this occurred.	*Ongoing: The Cancer Services Board has been refreshed to focus on recovery and the Associate Director of Planning and Performance is working with services to identify individual communications to send to patients which are approved by clinicians. High level conversations are ongoing with the Communications Team and a further update will be brought to December Board.*
December 2017	November 2017 243/17 Patient Story	**TF**	Beads of Courage	Mr Foster agreed to pursue these via the Charitable Funds Committee.	*Charitable Funds Committee has approved funds for licence and beads for premature babies unit*
December 2017	November 2017 247/17 Chief Executive's Report	**CL**	Finance could be available to acquire a real time bed status system	The Chief Operating Officer would investigate this.	
December 2017	November 2017 247/17 Chief Executive's Report	**DL/CM**	Opportunities for technology	The Chief Executive would discuss with the Head of Communications how the Trust could develop its own vision and articulate this to staff.	*The 100 Leaders event in January will involve the Trust's new digital partners from Liverpool and North Tees as part of developing the Trust's digital vision and associated communication*

December 2017	November 2017 249/17 Report of the Finance Director	**SW**	Cash Flow Forecast	It was agreed the cash flow for the full year would be included in future reports.	*Completed.*
December 2017	November 2017 250/17 Report of the Director of People	**EW**	Context and relevance behind changes in non-European union and European nurse recruitment	The Deputy Chief Executive and Director of People would take this back to the team.	*Director of People and OD confirmed that fewer EU staff were coming to the UK as they were once exempt from a difficult language test. Since 18 January 2016 the NMC required nurses registering from the European Union to have the same English examination results as non-EU nurses. Therefore, there was a sharp decline in registrants. While the media have linked the decrease in EU nurse registrants to the Brexit vote, in practice the trend was already starting six months prior to the Brexit referendum. We have anticipated that and consequently international recruitment continues.*
December 2017	November 2017 251/17 Smartcare Progress Report	**DL**	Royal Liverpool and Broadgreen University Hospitals NHS Trust representative to attend a Board Strategy and Development session or similar	Chief Executive would investigate.	*The 100 Leaders event in January will involve the Trust's new digital partners from Liverpool and North Tees as part of developing the Trust's digital vision and associated communication*

ITEM 6

CHAIR'S UPDATE

VERBAL

Peter Lachecki
Trust Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – DECEMBER 2017

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 The Trust is currently enjoying one of the most positive periods of operational performance in recent times. Changes to models of care in orthopaedics, surgery and medicine, alongside revisions to the Trust's daily operational rhythm have resulted in significant improvements in Accident and Emergency (A&E) performance against the four hour standard and other important metrics including a 10% improvement in reported patient experience in A&E. The Trust position in respect of national A&E performance has peaked at 4th nationally out of 136 Trusts, with performance consistently above the England average in the most recent weeks. The Trust is ahead of the recovery trajectory it has agreed with its regulator, NHS Improvement and delivered the 95% 4 hour A&E standard for the month of November, the first time in a number of years the standard has been met for the month. Activity has risen in early December but again positively, strong operational performance has been maintained. Also of note, is predicted delivery of the 6 week diagnostic target – early results for November suggest this elusive target has also been met; this is great for diagnostics generally but is also a vital part of the cancer pathway improvement work.

1.2 The Trust also achieved the national 70% standard for staff flu vaccination thanks to the amazing efforts of our Peer Vaccinators and others. Myself and Steve Hams will be taking staff to afternoon tea, in January, as a thank you for the work they have done which really has reflected them going above and beyond the expected to help us achieve this very challenging target – the Trust's best prior performance was 58%, achieved last year. There are still two months of vaccination season left and I hope that unvaccinated staff will be spurred on by a recent publication in the Lancet Medical Journal which reports a study confirming the relationship between a vaccinated work force and reduced sickness absence.

2. National and Regional

2.1 Nationally, there remains a huge focus on preparations for winter, in particular protecting patients and NHS staff against the threat of flu. Resources to support Winter were announced in the Chancellor's recent budget, to the tune of £337m and I am keen that our health system gets a good proportion of this. To this end, a team from across the Sustainability and Transformation Partnerships (STP) in Gloucestershire have developed and submitted what I believe represents a very strong bid – we still await the outcome of the prioritisation process but it is clear from the tone and nature of the national calls that we have had, that we are being viewed VERY positively by the national team for our efforts and progress in respect of Winter planning and performance improvement. I'm hopeful that this will result in a generous allocation for Gloucestershire!

2.2 On the 16th November myself, the Chair and members of the executive team took part in the monthly regulatory Financial Special Measures oversight meeting with colleagues from NHS Improvement (NHSI). The meeting was broadly positive, with NHSI recognising the reason for the Trust's variance from its current plan and commending the Trust for the progress it has made on delivering its Cost Improvement Plan and identifying the additional savings now required to offset reductions in income. The Trust submitted a proposal, previously agreed with its commissioners, for the Clinical Commissioning Group (CCG) to provide the Trust with non-recurrent financial support in 2017/18 to support achievement of the Trust's plan. This proposal is now being considered by NHSI and NHS England. The Trust is extremely grateful for the support it continues to receive from Gloucestershire CCG and other Sustainability and Transformation partners (STP).

2.3 NHS Improvement has recently announced its new Chief Executive. Ian Dalton, CBE will take over the baton from the outgoing CEO, Jim Mackey who will be returning to run health services in the North East.

2.4 Ian has much experience in healthcare delivery, joining NHSI from Imperial Healthcare NHS Trust, where he was CEO. Ian describes himself as passionate about the NHS and has already pledged his support to ensure he follows the work started by Jim Mackey to; he is committed to spending time with the provider sector as part of ensuring he remains in touch with the challenges we face once embedded in regulation. Ian took up post on the 4th December 2017 and an invitation to join us in Gloucestershire has already been extended.

3. Our System and Community

3.1 Following on from the workshop on the 2nd November, STP partners continue to work together to develop the approach to delivering the *One System Business Case.* Whilst some progress is being made, changes to the national policy landscape alongside changes to local aspirations means that we are some months off a final business case. Once completed this will then need to flow through the various approval and assurance mechanisms. The Gloucestershire Strategic Forum has requested a firm timeline for public consultation be developed and put to them at their next meeting.

3.2 Following on from the recent endorsement by the South West Clinical Senate, the STP Delivery Board has agreed in principle the proposal to develop a specialist rehabilitation service, distinct from the acute stroke pathway. Next steps are for the Trust and Gloucestershire Care Services to develop and evaluate a range of options for this service followed by the likely scenario of public consultation on the location of the service, though this last point has yet to be confirmed by the NHS Reference Group and Health & Care Overview and Scrutiny Committee.

4. Our Trust

4.1 As mentioned in my introduction, there remains much to be recognised and celebrated within the Trust. The recent changes to surgical and trauma services continue to bed in and deliver fruit and more plans are afoot to further strengthen our approach. Whilst performance is outstanding, it is fragile and is consuming more operational focus and grip than ideal and so our aim is to build a truly sustainable model. Next steps are about building a sustainable platform from which delivery flows, by design rather than through the unrelenting efforts of lots and lots of people. Embedding delivery of the urgent and emergency care pathway is crucial not least as we now need to turn our sights further to cancer standards delivery and Referral To Treatment Time (RTT) recovery.

4.2 The Trust still awaits news on our bid for £40m capital funding though promisingly, the capital allocation to the NHS in last month's budget was a positive settlement. I am hopeful that by the time we meet this month, we may have had positive news about our bid. However, one piece of good news we have received is that the 920k allocated to the Trust some months ago, to develop our A&E streaming model, can now be drawn down for investment in an expanded A&E environment at Cheltenham General Hospital; this development will also enable other accommodation shortcomings to be addressed including an expanded fracture clinic environment.

4.3 Work continues on development of the SubCo model and I am especially grateful to the energy and focus that Emma Wood, Director of People & Deputy CEO has brought to the project. Emma has already established strong programme arrangements and, following November's Board decision to proceed to the next steps, initiated formal staff and union consultation. Feedback from staff and local staff-side feels more positive as more information has become available about the benefits, particularly the non-

financial benefits, associated with the proposal. Feedback from staff and staff-side through the formal consultation will be crucial information for the Board to consider when it makes the final decision in late February.

4.4 Considerable work continues to develop the next steps in respect of TrakCare recovery and development. The Trust is now working closely with NHS Digital to access expertise to expedite the pace and scale of recovery. To this end, a "deep dive" exercise, resulting in the development of a comprehensive recovery and development programme, took place over the 14th to 17th November. The exercise was be led by a team of specialists including members of NHS Digital, staff from North Tees NHS Trust (who deployed TrakCare two years ago) and other experts in the field from around the country working closely with Trust staff; terms of reference for the review are being finalised. One exciting opportunity which this approach affords the Trust is the chance not only to expedite recovery but to develop further than might have been the case through the alliances built with NHS Digital and exemplar Trusts across the country. The final report was received by the Trust on the 25th November and was endorsed by the SmartCare Programme Board at its meeting on the 4th December and all recommendations were accepted in full or in part. Next steps are to assign the 65 recommendations to an owner and develop the required actions to respond to the individual findings and recommendations. It is clear that significant additional resources will be required to implement the recommendations and an experienced Recovery Director has been recruited to support myself as SRO to take this forward and Mark Hutchinson joins the Trust this month, in this role. Mark is a very experienced and successful Chief Information Officer, who led the first electronic patient record deployment in Salford some 7 years ago and was also the co-lead of the ground breaking work on telehealth and telemedicine that Airedale NHS Trust led a decade ago; Mark joins us from University Hospitals South Manchester.

4.5 Finally, an often unsung service in the Trust is our Library Service which under the leadership of Lisa Riddington provides a world class library function to staff in the organisation. However, I am delighted that the work of Lisa and her team has been formally recognised through a recent Peer Review (known as the NHS Library Quality Assurance Framework) which resulted in a rating of 100% compliance with the defined standards – we are one of only two Trusts to achieve this accolade.

Deborah Lee
Chief Executive Officer

December 2017

MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title
Quality and Performance Report
Sponsor and Author(s)
Authors: Felicity Taylor Drewe, Director of Planned Care, Deputy Chief Operating Officer Sponsor: Caroline Landon, Chief Operating Officer Steve Hams, Executive Director of Quality and Chief Nurse
Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for October 2017.

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The QPR includes the SWOT analysis that details the Strengths, Weaknesses, Opportunities and Threats facing the organisation in the Quality and Performance context.

Key Issues to note

During September, the Trust did not meet the national standards or Trust trajectories for A&E 4 hour wait; 2 week wait and 62 day cancer standard and 18 week referral to treatment (RTT) standard (shadow reporting). There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care to ensure that patients do not come to harm due to delays in their treatment.

In October 2017, the trust performance against the 4hr A&E standard was 88.93% with an average of 400 attendances per day. This performance was 1% below the agreed STF trajectory (90%). Year to Date performance (October) is currently 84.3% which is 5.4% below the agreed STF YTD trajectory (89.7%).
October attendances were 6% above last year's levels, an increase of 705 attendances with an average increase of 23 attendances per day (377 to 400). Month to date performance for November, as at 21st, is 95.2%. There were three periods during the first half of the month where activity was significantly higher than last year. On average, this year saw 23 additional attendances per day with those patients being admitted accounting for almost all of this. Sundays and Tuesdays have seen the biggest increase per day at 38 and 42 additional attendances respectively. Mondays and Sundays continue to be the busiest days by average volume levels.
October admitted proportion (35%) continues to be slightly higher than normal ED percentages (32-33%); peak in this month was during the 26th which had an admitted proportion of 43%.
The main focus for the next quarter remains sustainable delivery as has been demonstrated in November.

In respect of RTT, we continue to monitor and address the data quality issues following the migration to TrakCare. We have started reporting the RTT position in shadow form and will return to full reporting for December 2017. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways; however, as reported previously to the Board we will continue to see 52 week breaches until full data cleansing exercise is completed. In October we are reporting 32 breaches, 2 greater than in September, this comprised 1 from August and 4 from September. All patients have a TCI date. No clinical harm has been reported, from the

reviews undertaken to date.

Our performance against the cancer standard saw an improvement against the 2 week standard with performance at 74.5% (Un-Validated). The main tumour sites that were compromised on the 2 week pathway were colorectal which continues to see a very high demand resulting in capacity issues, dermatology due to a combination of increased demand and capacity issues. With breast operating with some residual capacity issues. This shows the relatively low capacity resilience due to national staff shortages in some of our highly subscribed services. A revised Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed. In respect of 2 week wait whilst work continues with our primary care colleagues for managing demand on our colorectal services and the development of the straight to test pathway. The impact of the non-delivery in the 2 week wait pathway will impact on the 62 day pathway performance in the coming months.

Cancer 62 day Referral to Treatment (GP referral) performance for October was 73% (un-validated), which represents a slight improvement in performance compared to September (69.2%). A number of specialities continue to be impacted by demand on key specialities with significant breach numbers impacting the aggregate position. A number of tumour sites did not deliver the required standard, of the 43 breaches, 20 urological, 1 Upper GI, 8.5 Lower GI, 4 Haematology, 2 Lung and 4 breaches in Gynaecology. The Cancer trajectory and delivery plan has set out the delivery of this national standard across each tumour site.

The Trust met the diagnostics target in October at 0.46% (un-validated), mainly driven by planned recovery in two areas; colonoscopy and audiology. The key risk to both diagnostic areas, as identified last month, is workforce related in the former capacity and the latter recruitment of a key staff group. Recovery plans are in place for these diagnostic areas, to ensure that continued focus remains across all the diagnostic areas to ensure sustained delivery of this target.

As requested during the May Trust Board members received in June the breakdown of the reporting regime against each of the targets, in particular those that are reported quarterly or in arrears and those that we cannot at present report because of data quality issues. A summary of the indicators and their reporting status is provided within the Trak Care report to the Quality and Performance committee.

<u>Conclusions</u>

Cancer delivery is the priority for the operational teams. A process of review for every patient over 45 weeks in their referral to treatment pathway and every patient over 45 days in their Cancer pathway (including non-cancer patients) in order to improve performance against the national standards at a weekly check and challenge meeting. Clinical oversight of patients awaiting care continues to ensure that no patients come to harm due to delays in their treatment.

Recommendations

The Trust Board is requested to receive the 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.
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		Buildings	
No change.			

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓					✓	
Outcome of discussion when presented to previous Committees						

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period October 2017

to be presented at November 2017 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During October, the Trust did not meet the national standards or Trust trajectories for A&E 4 hour wait; 2 week wait and 62 day cancer standard and 18 week referral to treatment (RTT) standard. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care to ensure that patients do not come to harm due to delays in their treatment.

The Trust has met the 4 hour standard in November with the month to date position at 95.2% and delivered the Diagnostic target in October at 0.46%.

The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan has been reviewed and each tumour site has specific identified actions with an associated allocation in breach improvement numbers. Cancer underperformance remains a significant concern relating to the 2 week wait and 62 day pathway. For the former, issues with capacity, some areas of referral increase and patient choice (sometimes due to short notice appointments) have impacted delivery. Diagnostic recovery has been positive this month, with a step change in delivery that has resulted in delivery for October. Alongside this the Board level support for Central Booking Office and RTT validation will significantly positively impact teams to manage breaches and forward plan the required capacity ahead of breaches.

Key areas where additional reports have been provided for the Quality and Performance Committee are:
- Trakcare Operational Recovery (including Reporting Re-commencement template & summary)
- Cancer Services Management Group – escalation report (including Cancer Delivery Plan)
- Emergency Care Board – escalation report
- Planned Care Board – escalation report

In summary, the position for the Trust in a number of key performance metrics is significant.

Strengths

• A&E 4 hour performance has significantly improved in November, delivering month to date 95.2%.

104 days performance has stabilised and is a significant improvement in the category of patients who do not have a TCI (28 September, 12 Urological), which is positive, this combined with our analysis of 62 day pathway 'long wait category' indicates we are making progress for our longest waiting patient cohort.

• Medically fit at 60 remains relatively stable during this period as would be anticipated for the September period.

• Stabilisation of non-elective length of stay at 5.23%, is a positive position and to be anticipated during the end of the summer months.

Achievement of the national standard for % of patients seen within 6 weeks for Diagnostic tests, whilst not delivering against target at 2.97% for September (un-validated), is demonstrating recovery in line with plan.

• The engagement of Glanso will continue to support a number of RTT specialities and diagnostics areas and is being utilised in the right operational "hot-spots".

• Overall clinic slot utilisation is positive, this is still an area for further development but good progress is being made.

• Performance in the majority of the additional quality measures has been good; the three exceptions remain the same this month as last.

• A number of statutory returns and reporting requirements have been developed this month to enable us to report and are presented within the report for the first time. We do have residual issues with some reports in terms of User entry and data quality but this is positive progress. Separate assurance through the Appendix detailing the reporting areas and the return to reporting due date will be provided on a monthly basis as part of the TrakCare recovery report, for Quality and Performance committee, October 2017. We have made a number of notable inclusions (Cancelled Operations; Dementia Indicators; VTE; Ed Safety Checklist (GRH site).

Weaknesses

• Due to the implementation of the new EPR system we continue to shadow reporting the number of patients waiting 18 weeks from referral to treatment.

• Patient Treatment Lists (PTLs) have residual data quality issues which continues to impact management of patient journeys. This is being addressed through the deployment of additional clerical staff as approved at May Board. Despite this, teams are focused on reviewing patients >45 weeks, across most specialities and predicting potential breaches on a more routine basis.

• Achievement of the Cancer standards is a significant concern, whilst the 62 day performance was not expected to deliver in the earlier part of the year, performance did not meet the planned recovery trajectory. 2 week wait cancer standard has been impacted by issues of demand in colorectal but other specialities have also not delivered which has impacted on the overall performance. 2 week wait performance was not anticipated to fail in 2017/18 but continues below standard.

Opportunities

• Development of Standard Operating Procedures (SOP) for key areas being developed across teams. This will provide action cards supporting staff to enter it right first time and to provide corporate guidance on operating procedures e.g. DNA's. There is some evidence that we are not operating our Access Policy in full and this has led to some breaches e.g. >52 week waits, which will be addressed through the development of SOPs. This will be managed through the Planned Care Programme Board.

• The South West Cancer Alliance has provided additional funding, £243k (total) to support the delivery of the colorectal pathway, and £178k in September, which has been deployed to support the MRI capacity for the prostate pathway. Funding arrangements for 18/19 are also positive of additional funding sources.

•

The Trust had a critical friend visit that reviewed the current Cancer Recovery Plan, including some observations on the MDT role and the opportunities for patients at Day 49 plus.

• Support from commissioners has been sought in relation to cancer across a number of areas:

- Referral rate increases (colorectal & dermatology) – CCG to support communication to targeted practices in the CGH area, this work continues.
- Clinical support for triage of 2ww pathway patients in Lower GI supporting communication with Primary Care on appropriate pathway utilisation, including a new 2 week wait referral form for primary care, supported by clinical information on G-Care (the CCG system for supporting primary care).

• Confirmation from local Commissioners that they will support escalation of late cancer referrals to neighbouring Trusts. It is recognised that these are small in number but have caused breaches in the 62 day pathway for patients.

Risks & Threats

• Cancer performance remains a significant risk for the Trust. 2 week wait analysis shows a combination of factors have led to a decline namely: capacity; clinic cancellations and patient choice. Patient choice levels are being benchmarked as the Trust needs to ensure we are offering reasonable notice of appointments. In relation to clinic cancellations the process is smoother, there have been some cancellations due to the normal seasonal pattern of leave and some that have been related to the operational practice to support Trak. This combined with an increase in specific specialities has impacted the overall delivery of 2 week wait and has impacted as forecasted to impact delivery to target in September. Key tumour sites are Breast; Lower GI and Skin which are impacted by Capacity related issues. Looking forward into November, the tumour sites of colorectal and Dermatology are key to delivery of aggregate 2 week wait performance, these sites have plans that will enable delivery in January 2018. The Cancer Delivery Plan has been significantly reviewed alongside the Governance structure. Fortnightly meetings are in place where delivery against plan is monitored. This represents a significant Trust risk.

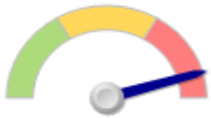
Performance Against STP Trajectories

* = unvalidated data

Indicator		Month											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
ED Total Time in Department - Under 4 Hours	Trajectory	87.70%	89.50%	89.20%	88.30%	92.20%	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%
	Actual	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%					
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	73.80%	75.00%	76.10%	77.20%	78.40%	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%
	Actual												
Diagnostics 6 Week Wait (15 Key Tests)	Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Actual	7.22%	5.30%	5.26%	5.30%	4.80%	2.90%	0.46%					
Cancer - Urgent referrals Seen in Under 2 Weeks	Trajectory	93.00%	93.00%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	91.40%	90.50%	85.90%	79.60%	70.40%	71.20%	74.40%*					
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.40%	93.00%	93.10%	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%
	Actual	90.40%	94.00%	94.10%	57.30%	89.70%	92.70%	89.10%*					
Cancer - 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.40%	96.20%	96.10%	96.20%	96.20%	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%
	Actual	94.90%	95.90%	95.40%	95.80%	96.20%	98.50%	95.00%*					
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	Trajectory	98.40%	100.00%	98.30%	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	98.50%	100.00%*					
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	Trajectory	95.30%	95.70%	96.40%	94.90%	94.50%	94.90%	94.10%	94.60%	94.40%	94.40%	94.10%	94.20%
	Actual	98.50%	100.00%	100.00%	100.00%	98.40%	96.60%	95.70%*					
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	Trajectory	94.90%	94.80%	94.00%	95.80%	94.50%	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%
	Actual	90.00%	97.50%	97.90%	93.60%	91.50%	95.50%	95.30%*					
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	92.00%	94.40%	90.00%	94.70%	91.20%	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%
	Actual	86.30%	91.80%	88.90%	89.10%	88.50%	94.90%	80.00%*					
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	80.00%	100.00%	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	100.00%	100.00%	57.10%	77.80%	85.70%	66.70%*					
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	77.70%	79.40%	80.10%	85.40%	85.20%	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%
	Actual	78.30%	75.90%	71.20%	74.70%	80.10%	69.20%	71.70%*					

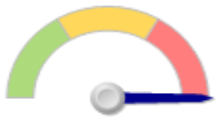
Summary Scorecard

The following table shows the Trust's current performance against the chosen lead indicators within the Trust Summary Scorecard.



QUALITY

Adult Inpatients who received a VTE Risk Assessment	Emergency Readmissions Percentage
Friends and Family Test Score - ED % Positive	Friends and Family Test Score - Inpatients % Positive
Friends and Family Test Score - Maternity % Positive	Friends and Family Test Score - Outpatients % Positive
Hospital Standardised Mortality Ratio (HSMR)	Hospital Standardised Mortality Ratio (HSMR) - Weekend
MRSA Bloodstream Cases - Cumulative Totals	Number of Breaches of Mixed Sex Accommodation
Summary Hospital Mortality Indicator (SHMI) - National Data	

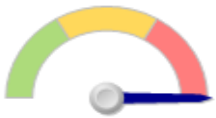


OPERATIONAL PERFORMANCE

- Cancer 62 Day Referral To Treatment (Screenings)
- Cancer 62 Day Referral To Treatment (Upgrades)
- Cancer 62 Day Referral To Treatment (Urgent GP Referral)
- Diagnostics 6 Week Wait (15 Key Tests)
- ED Total Time in Department - Under 4 Hours
- Referral To Treatment Ongoing Pathways Under 18 Weeks (%)

FINANCE

- Performance against CIP - % QIA's from PMO completed
- YTD Performance against Financial Recovery Plan



LEADERSHIP AND DEVELOPMENT

- Sickness Rate
- Staff Engagement Indicator (as Measured by the Annual Staff Survey)
- Workforce Turnover Rate

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Key Indicators - Quality																				
Friends and Family Test Score	Friends and Family Test Score - ED % Positive		88.0%	78.4%	85.7%	80.3%	85.5%	86.9%	84.4%	75.6%	77.5%	84.9%	81.1%	81.0%	84.8%	83.9%	81.7%	81.2%	86.5%	81.3% *
	Friends and Family Test Score - Inpatients % Positive		92.0%	90.1%	88.9%	100.0%	91.6%	89.3%	92.2%	91.2%	90.8%	90.9%	90.1%	91.2%	93.0%	93.5%	90.8%	90.6%	94.0%	90.8% *
	Friends and Family Test Score - Maternity % Positive		98.2%	100.0%	100.0%	100.0%	98.9%	94.5%	96.8%	97.0%	100.0%	90.0%	94.7%	100.0%	98.2%	99.1%	96.2%	96.3%	98.6%	96.6% *
	Friends and Family Test Score - Outpatients % Positive											91.2%	91.5%	91.3%						
Infections	MRSA Bloodstream Cases - Cumulative Totals	0	1	1	2	2	3	0	0	0 *	1	1 *	1 *	1 *	1	3			3	0 *
Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	5	0	3	0	3	4	11	10	16	14	18	19	5	6	25	48	39	92 *
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	112.9	115.2	115.5	113.5	110.7	111	109	109.2	105.5				115.2	110.7	109.2		110.7	105.5 *
	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	117.4	119.3	118.7	116.8	115.1	116.5	114.6	115	111.8				119.3	115.1	115		115.1	111.8 *
	Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level		114			111.5								114	111.5			111.5	
Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	5.8% *	7.0% *	6.4% *	6.1% *	5.1% *	7.2% *	6.8% *	6.3% *	6.8% *	6.6% *	6.3% *		6.4% *	5.8% *	6.8% *	6.5% *	6.4% *	6.7% *
Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%	92.2%										91.4% *	90.6% *						
Key Indicators - Operational Performance																				
Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	97.0%	100.0%	82.8%	92.3%	95.5%	86.3%	91.8%	88.9%	89.1%	88.5%	94.9%	80.0% *	96.0%	85.7% *	89.3%	90.6%		
	Cancer 62 Day Referral To Treatment (Upgrades)	>=90%			100.0%		100.0%	100.0%	100.0%	100.0%	57.1%	77.8%	85.7%	66.7% *	71.4%	100.0% *	100.0%	76.7%		
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	79.2%	72.0%	62.7%	70.0%	70.7%	78.3%	75.9%	71.2%	74.7%	80.1%	69.2%	71.7% *	76.9%	66.3% *	75.2%	75.1%		
Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	0.9%	1.5%	1.2%	1.8%	4.6%	7.2%	5.3%	5.3%	5.3%	4.8%	2.9%	0.5%	1.4% *	2.5% *	5.9%			5.5% *
ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	86.67%	74.12%	74.75%	76.96%	77.86%	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%	82.40%	76.56%	80.87%	85.87%		82.87% *
Referral to Treatment (RTT) Performance	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%	87.0%	75.2% *											84.4% *	74.3% *				

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Key Indicators - Finance																				
Finance	YTD Performance against Financial Recovery Plan								-10.15	3.36	4.35	4.24	1.87	-.27 *	-18					
Key Indicators - Leadership and Development																				
Sickness	Sickness Rate	G<3.6% R>4%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	4.0%	3.9% *					3.9%	3.9%	4.0% *			
Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	.04	.04	.04	3.71	3.71	3.71	3.71	3.71					.04	.04	3.71			
Turnover	Workforce Turnover Rate	7.5% - 11%	11.5%	11.7%	11.8%	12.0%	11.5%	12.1%	12.0%	11.8% *					11.7%	11.8%	12.0% *			
Detailed Indicators - Quality																				
Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2 >87%Q3>8 8%Q4>90%	90.4%										0.4% *	0.7% *				0.4% *		0.6% *
	Dementia - Fair question 2 - Appropriately Assessed	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%										50.0% *	60.0% *				50.0% *		57.1% *
	Dementia - Fair question 3 - Referred for Follow Up	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%										0.0% *	0.0% *				0.0% *		0.0% *
ED checklist	ED Safety Checklist	>=80%				29%	42%	56%	60%	56%	57%	53%								
Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		40.5	49.1	47 *	41.6 *	44.9 *	46.1 *	44.3 *	49 *					46.9	44.9 *	47.2 *			
	Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		95.8%	100.0%	89.7% *	100.0% *	97.1% *	98.0% *	98.4% *	98.3% *					98.0%	94.7% *	98.3% *			
	Fracture Neck of Femur Patients Treated Within 36 Hours		81.7%	63.5%	79.2% *	80.0% *	75.4% *	76.5% *	78.1% *	71.2% *					71.6%	77.8% *	75.3% *			
Infections	C.Diff Cases - Cumulative Totals	17/18 = 37	25	27	34	34	42	1	5	8 *	10	18 *	24 *	29 *	27	42			42	5 *
	Ecoli - Cumulative Totals									20	37	103 *	119 *	146 *						
	MSSA Cases - Cumulative Totals	No target	79	90	95	105	114	6 *		7	15	44 *	54 *	63 *	90 *	114 *			114	6 *
Maternity	Percentage of Spontaneous Vaginal Deliveries		61.1%	61.3%	60.0%	61.1%	61.9% *	61.2% *	64.4% *	65.3% *	62.4% *	63.9% *	64.9% *	60.2% *	61.8%	61.7% *	63.6% *	64.5% *	63.6% *	63.8% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90	90.6%	86.2% *	93.4% *	86.9% *	88.8% *	89.3% *	84.9% *	89.2% *	83.2% *	88.1% *	85.9% *	87.8% *	89.9% *	81.5% *	85.9% *	88.0% *	87.3% *	88.9% *
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	2.9																	
Never Events	Total Never Events	0	0	0	0	0	0	0	2	1 *	0 *	0	1 *	0 *	1	0			2	2 *

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Patient Falls	Falls per 1,000 Beddays	Current mean	6.2																	
	Total Number of Patient Falls Resulting in Harm (moderate/severe)		4 *	17 *	12 *	7 *	6 *	3 *	4 *	9 *	5 *	8 *	11 *	7 *	9 *	8 *	5 *	8 *		
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		8	1	4	0	3 *	3 *	0 *	4 *	2 *	2 *	3 *	1 *	4	3 *	2 *	2 *		
	Number of Patient Safety Incidents Reported		986	1,064	1,285	1,162	1,144 *	900 *	1,268	1,148	1,149 *	1,003 *	1,033 *	1,079 *	986	1,197 *	1,019 *	1,062 *		
	Patient Safety Incidents per 1,000 Beddays		34.5																	
Performance Initiation & Delivery	Performance in Delivery: Recruiting to Time for Commercially Sponsored Studies														27.3%		12.5% *			
	Performance in Initiation: Percentage of Studies that are Eligible to Meet 70 Day Target														66.7%	25.0%	50.0% *			
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	1.14%	1.62%	0.57%	0.97%	0.87%	0.50%	1.23%	0.49% *	1.12% *	1.02% *	0.61% *	1.13% *						
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%	0.11%	0.12%	0.23%		0.37%	0.13%	0.12%	0.12% *	0.50% *	0.38% *	0.37% *	0.00% *						
	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%						0.13%	0.12%	0.00% *	0.00% *	0.00% *	0.12% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	144	66	90	64	78	123	176	307 *	162 *	183 *	124 *	31 *	104	88	860 *	469 *	3,045	1,360 *
RIDDOR	Number of RIDDOR	Current mean	0	4	1	5	2	2	2	3 *	2 *	3 *	0 *	3 *	1	3	2 *	2 *	2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		7	11	7	7	7	7	7	9	7	7	7	7	8	7	8 *	7 *	8	7 *
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	92.8%	91.4%	91.4%	90.6%	91.3%	94.0%	92.4%	92.7%	91.3% *	92.6% *	94.2% *	92.9% *	92.4%	91.3% *	93.0% *	92.7% *		
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	97.7%	95.4%	96.7%	97.1%	97.0%	97.7%	95.8%	96.6%	95.0% *	96.0% *	97.4% *	97.4% *	97.0%	97.0% *	96.7% *	96.2% *		
Sepsis Screening	2a Sepsis – Screening	>90%	98.0%	96.0%	100.0%	98.0%	96.0%	88.0% *	88.0% *	98.0% *	94.0% *	96.0% *	98.0% *		97.0%	96.0%	91.0% *			
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	65.0%	69.0%	44.0%	70.0%	64.0%	78.0% *	69.0% *	67.0% *	94.0% *	89.0% *	90.0% *		64.0%	0.0% *	71.0% *			
Serious Incidents	Number of Serious Incidents Reported		4	2	1	2			5	1 *	2 *	1	2 *	1 *	3					
	Percentage of Serious Incident Investigations Completed Within Contract Timescale		100%	100%	100%	100%			100%	100% *	100% *	100%	100% *	100% *	100%			100% *		
	Serious Incidents - 72 Hour Report Completed Within Contract Timescale		100.0%	100.0%	100.0%	100.0%			100.0%	100.0% *	100.0% *	100.0%	100.0% *	100.0% *	100.0%			100.0% *		

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	1.8	2.4	2.2	1.4	2.1	1	1.2	2.2	2.7 *	1.9 *	.9 *	1.7 *	2.1	1.9	2 *	1.9 *		
	Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	1.8	1.9	2.7	1.9	2.6	2.3	3.1	4.2	2.4 *	3.1 *	2.9 *	2.1 *	2.1	2.4	3.3 *	2.8 *		
Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	70.4%	85.2%	75.9%	68.2%	68.4%	64.0%	41.9%	70.2%	69.1%	66.7%	61.5%	81.0%	73.8%		60.2%	65.2%		64.2% *
	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%						33.3% *	32.5% *	26.1%	38.0%	41.8%	45.5%	40.3%			30.5%	41.5%		36.6% *
	Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	93.3%	84.3%	83.6%	87.3%	66.1%	81.8%	84.6%	92.9%	95.0%	92.3%	98.2%		88.6%	0.0% *	86.4%			91.1% *
Time to Initial Assessment	ED Time To Initial Assessment - Under 15 Minutes	>=99%	79.8%	48.8%	57.9%	68.5%	80.2%	81.9%	80.2%	75.9%	87.4%	91.0%	86.2%	86.7%	69.0%	69.1%	79.9%	88.2%		83.4% *
Time to Start of Treatment	ED Time to Start of Treatment - Under 60 Minutes	>=90%	49.1%	27.6%	35.4%	34.0%	31.2%	29.5%	28.8%	25.7%	32.3%	34.9%	31.2%	37.5%	41.3%	33.4%	28.0%	32.8%		30.3% *
Detailed Indicators - Operational Performance																				
Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	99	189	201	104	47	34	54	57	47	19	30	38 *	474	352	145	96	1,884	279 *
	Ambulance Handovers - Over 60 Minutes	< previous year	0	13	7	1	0	1	0	4	0	1	1	0 *	14	8	5	2	26	7 *
Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0	0																	6 *
Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	10	11	11	12	11	10	8	10	8	9	19	17						
	Cancer (104 Days) - Without TCI Date	0	45	49	56	42	42	47	80	32	35	30	26	23						
Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	93.5%	92.6%	85.1%	94.7%	94.6%	91.4%	90.5%	85.9%	79.6%	70.4%	71.2%	74.4% *	91.7%	90.1% *	89.1%	73.6%		
	Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	92.5%	88.3%	89.4%	95.0%	97.1%	90.4%	94.0%	94.1%	57.3%	89.7%	92.7%	89.1% *	92.0%	92.2% *	92.8%	79.0%		
Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	93.8%	94.1%	90.1%	93.6%	96.8%	94.9%	95.9%	95.4%	95.8%	96.2%	98.5%	95.0% *	94.9%	91.9% *	95.5%	96.6%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	100.0% *	100.0%	100.0% *	100.0%	99.6%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	100.0%	95.0%	98.4%	100.0%	98.6%	98.5%	100.0%	100.0%	100.0%	98.4%	96.6%	95.7% *	98.6%	99.2% *	99.5%	98.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	89.4%	83.7%	84.2%	97.7%	87.8%	90.0%	97.5%	97.9%	93.6%	91.5%	95.5%	95.3% *	90.7%	90.0% *	94.5%	93.3%		
Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	47	36	31	44	37	28	30	32	27	29	32		36	37	32	32	33	30 *
Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End		375	465 *	268 *	694 *	681		963 *	522		883 *	1,298	1,062	465 *	681			7 *	

Trust Scorecard

* = unvalidated data

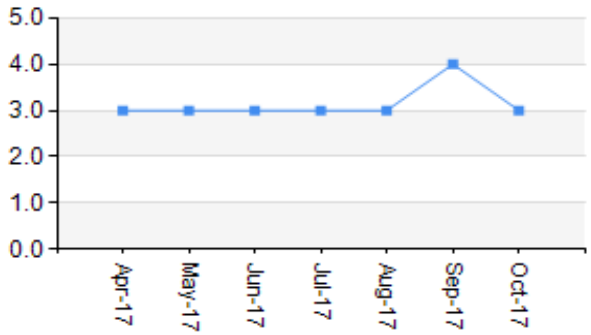
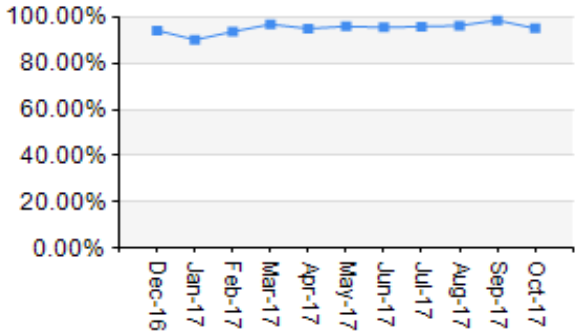
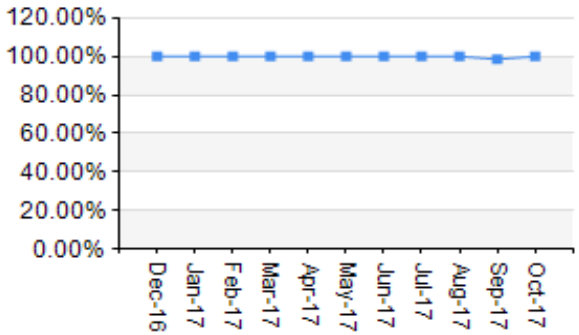
Category	Indicator	Target	Month											Quarter				Annual	
			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	86.6%	31.2% *	44.2% *	52.9% *	57.4% *	63.2% *	64.5% *	61.7% *	63.9% *	61.0% *	60.0% *		71.3% *	51.7% *	63.1% *	61.7% *	75.4% *	62.4% *
ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	94.36%	84.33%	87.47%	88.42%	88.50%	91.80%	92.30%	88.10% *	94.40%	95.00%	93.20%	93.80%	92.79%	88.00% *	90.70%	94.20%	91.60%	92.30% *
	GRH ED - Percentage Within 4 Hours	>=95%	82.38%	68.47%	67.83%	70.56%	71.80%	77.90%	72.90%	75.30%	77.70%	84.60%	82.40%	86.60%	82.64%	70.00% *	75.30%	81.50%	79.20%	77.70% *
Inpatients	Stranded Patients							397	420	441	451	461								
Length of Stay	Average Length of Stay (Spell)		5.67	5.84 *	5.76 *	5.57 *	5.33 *	5.1 *	4.87 *	4.96 *	4.96 *	4.86 *	4.77 *	5.1 *	5.54 *	5.55 *	4.98 *	4.86 *	5.37 *	4.95 *
	Length of Stay for General and Acute Elective Spells	<=3.4	3.5	3.58 *	2.8 *	3.03 *	2.8 *	2.82 *	2.66 *	2.86 *	2.73 *	2.99 *	3.09 *	3.42 *	3.32 *	2.87 *	2.78 *	2.93 *	3.08 *	2.93 *
	Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	6.32	6.53 *	6.58 *	6.3 *	6.19 *	5.78 *	5.48 *	5.58 *	5.61 *	5.35 *	5.23 *	5.53 *	6.24 *	6.35 *	5.61 *	5.4 *	6.08 *	5.51 *
Medically Fit	Number of Medically Fit Patients Per Day	<40	83	73	75	84	68	59	55	58	63	58	60	62	73	75	56	60		59 *
Referral to Treatment (RTT) Performance	Referral to Treatment Number of Ongoing Pathways Over 18 Weeks		6,574																	
Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways 35+ Weeks (Number)		579																	
	Referral To Treatment Ongoing Pathways 40+ Weeks (Number)		250																	
	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	3	1 *	7 *	7 *	4 *	13 *	9 *	9 *	13 *	27 *	30 *	30						
SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *		100.0%	100.0%	100.0%		100.0%	100.0% *
	Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8% *	99.8% *	99.8%	99.8%	99.8%	99.8%		99.8%	99.8% *
Trolley Waits	ED 12 Hour Trolley Waits	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0 *
Detailed Indicators - Finance																				
Finance	Agency - Performance against NHSI set agency ceiling							3	3	3	3	3	4	3						
	Capital Service							4	4	4	4	4	4	4						
	Liquidity							4	4	4	4	4	4	4						
	NHSI Financial Risk Rating	3						4	4	4	4	4	4	4	1					
	Total PayBill Spend							27.67	27.52	27.5	27.46	28.25	27.94	27.9						

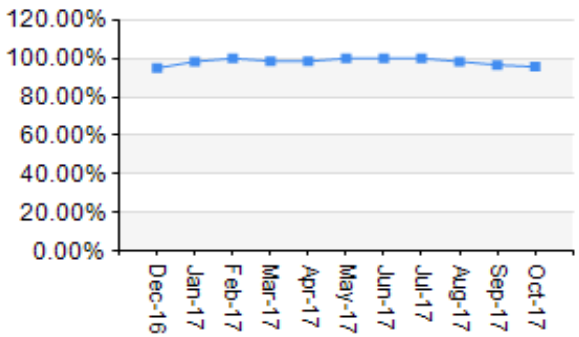
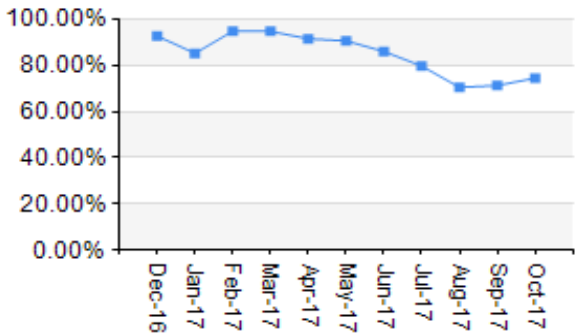
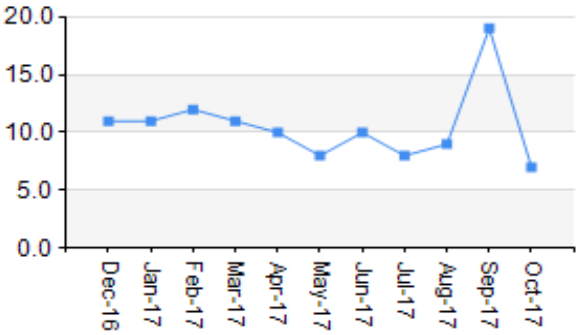
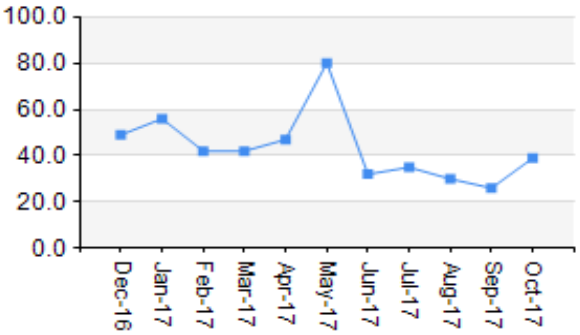
Trust Scorecard

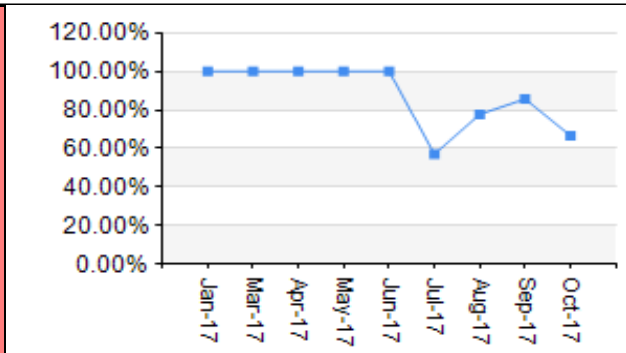
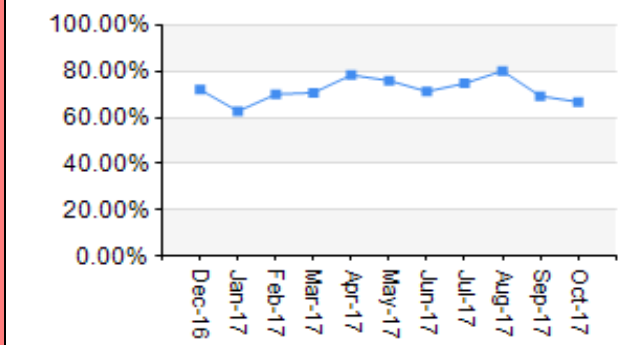
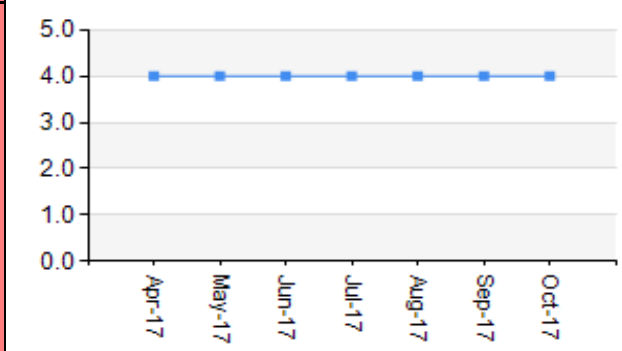
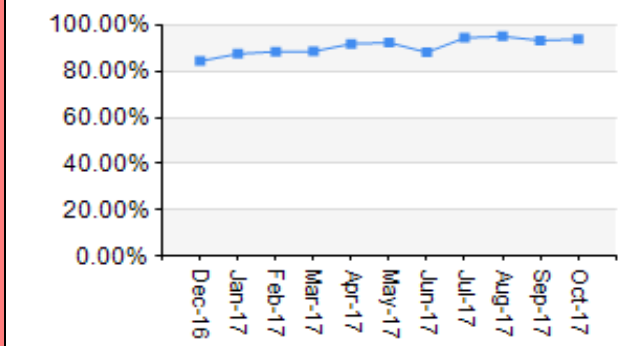
* = unvalidated data

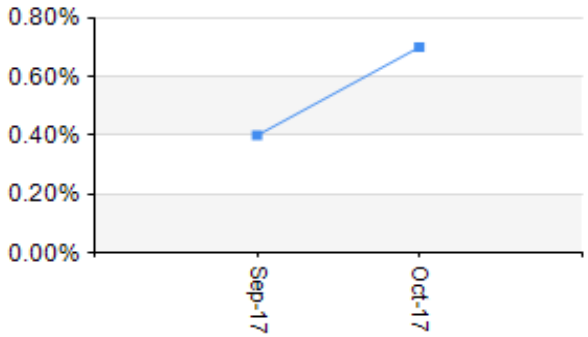
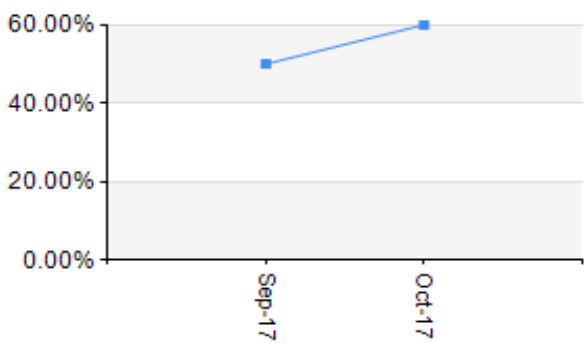
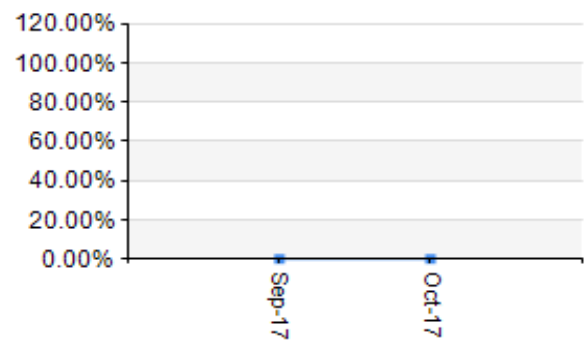
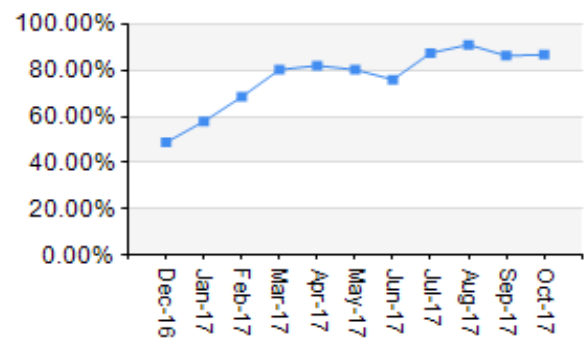
Category	Indicator	Target	Month											Quarter				Annual	
			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Detailed Indicators - Leadership and Development																				
Appraisals	Percentage of Staff Having Well Structured Appraisals in Last 12 Months	>3.8	3	3	3	3	3	3	3	3					3	3	3			
	Staff who have Annual Appraisal	G>89% R<80%	80.0%	80.0%	80.0%	82.0%	82.0%	80.0%	79.0%	78.0%					80.0%	81.6%	79.0%			
Staff Survey	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%					34.0%	34.0%	34.0%			
Staffing Numbers	Total Worked FTE		7,226	7,200	7,238	7,239 *									7,200					
Training	Essential Training Compliance	>=90%	89%	89%	89%	89%	90%	89%	89%	89%					90%	89%	89%			

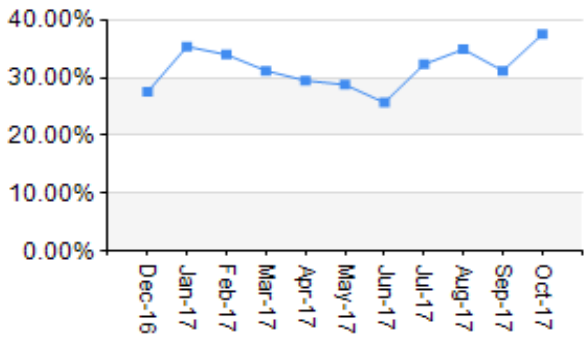
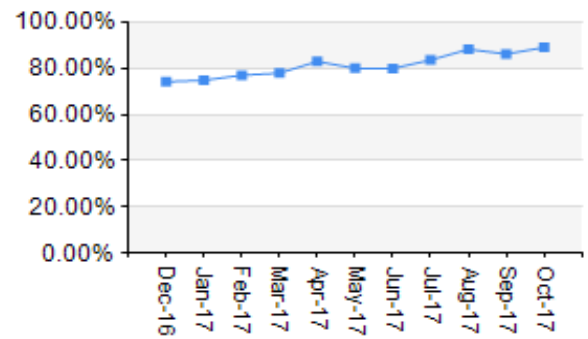
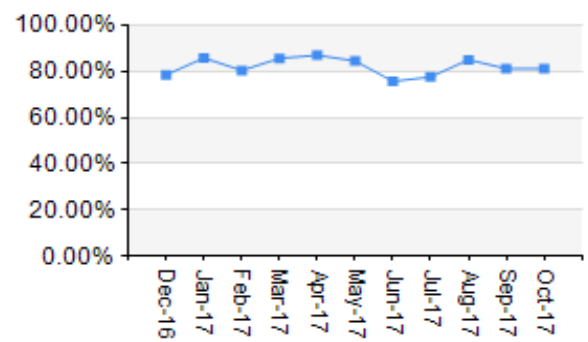
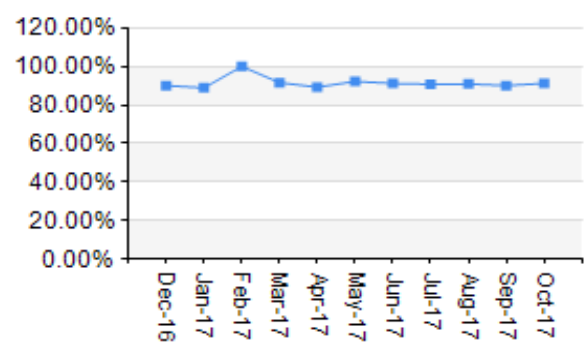
Exception Report

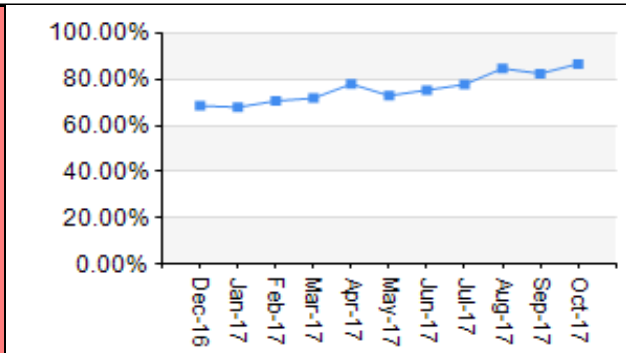
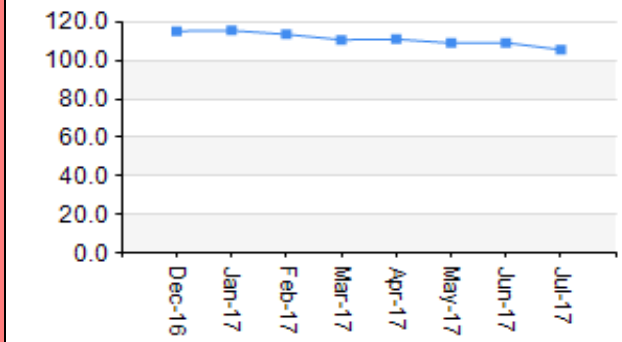
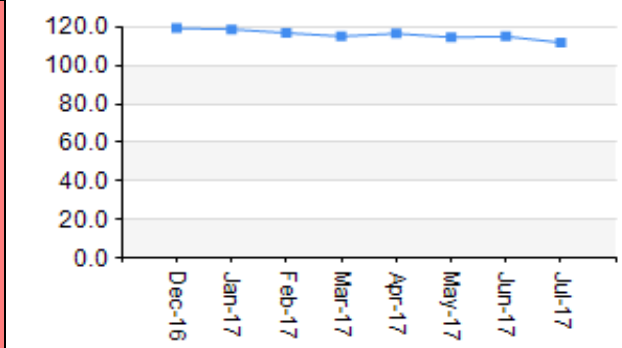
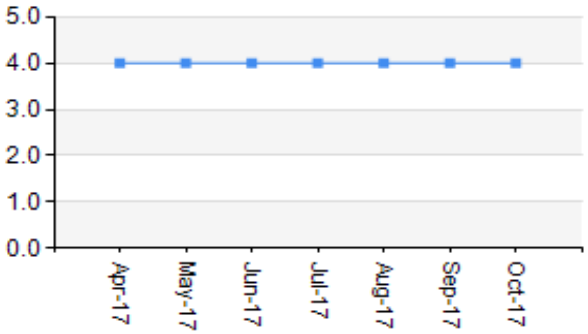
Metric Name & Target	Trend Chart	Exception Notes	Owner
Agency - Performance against NHSI set agency ceiling **Target:**		The Trust currently scores 3 on the NHSI Agency Rating. Whilst the Trust has delivered a significant reduction in agency run-rate over the same period last year it still remains baove the NHSI mandated cap. Additional CIP focus in this area is ongoing.	Director of Finance
Cancer - 31 Day Diagnosis To Treatment (First Treatments) **Target: >=96%**		October performance is currently 95% (unvalidated) against a target of 96%. There have been 13 breaches of this target to date in October, 11 in Urology - mostly due to a lack of surgical capacity, including waiting for Robot-Assisted Laparoscopic Prostatectomy (RALP) and increased activity by the newly appointed locum Urology consultant. The recovery plan for Urology cancer has been shared previously, but is currently being updated and includes additional RALP capacity from Dec 2017.	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) **Target: >=98%**		Oct performance: 100% (unvalidated) This standard is currently being met.	Deputy Chief Operating Officer

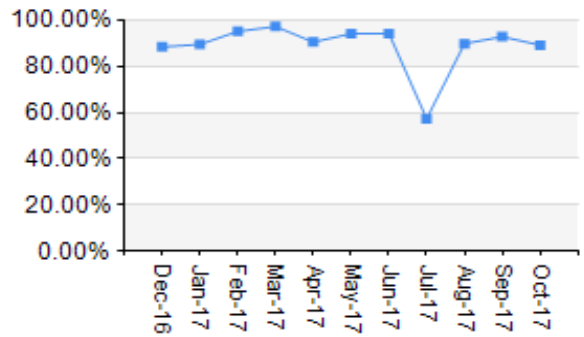
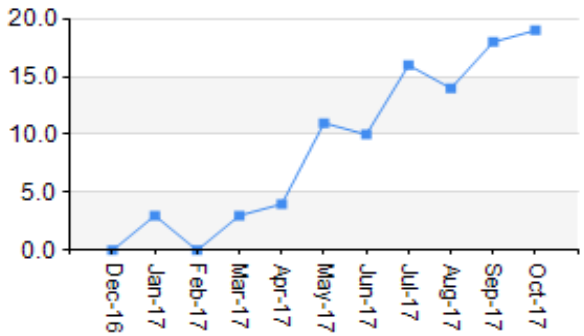
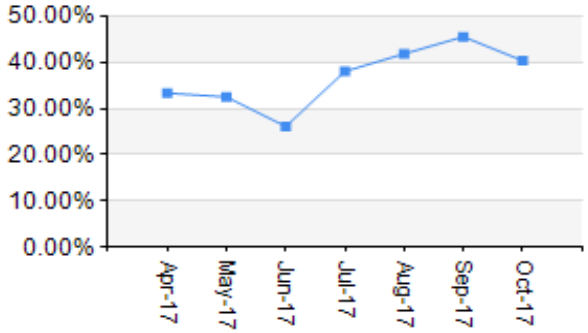
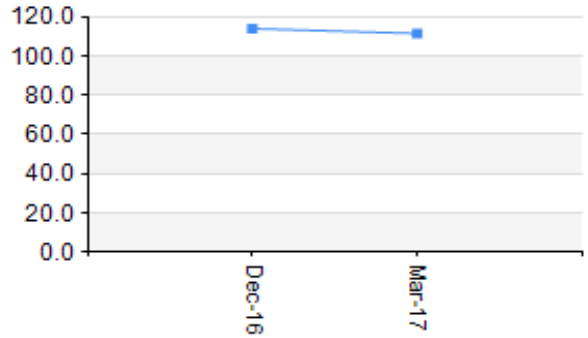
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) **Target: >=94%**		Oct performance 95.7% (unvalidated). Target is 94%. This target is currently being met.	Deputy Chief Operating Officer
Cancer - Urgent referrals Seen in Under 2 Weeks **Target: >=93%**		Oct performance = 74.4% (unvalidated); target = 93% Performance has improved since September (71.2%) and it is anticipated that all tumour sites (except colorectal and skin) will deliver the standard by the end of February. There are recovery plans for colorectal skin, with delivery anticipated by the end of January 2018. See Cancer Delivery Plan & Cancer Escalation report.	Deputy Chief Operating Officer
Cancer (104 Days) - With TCI Date **Target: 0**		Performance - 17 There are currently 17 patients with a TCI date with plans. This number has decreased since last month. 10 of the 17 patients are urological patients and there is a specific urology recovery plan that addresses long waiting performance which has been previously provided. Of those 10, 3 have already been treated and are awaiting histology results and 4 are awaiting Robot Assisted Laparoscopic Prostatectomy (RALP). There is a plan to provide more RALP capacity from December onwards. See Cancer Delivery Plan.	Deputy Chief Operating Officer
Cancer (104 Days) - Without TCI Date **Target: 0**		Performance 23 patients, without a TCI. 23 patients over 104 days with no TCI. The number has decreased since last month - but there are still patients who are on the list as a result of the 2ww upgrade reconciliation undertaken in September. Of the 28 patients, 8 relate to the Urology speciality. The appointment of a locum urology consultant will continue to positively impact the performance in future months. Of the non-urology patients, all of the remainder were waiting due to complex pathways, shared pathways with other Trusts, patient choice or unfit for treatment. All of these patients are being monitored. The Trust has developed a Clinical Validation Policy which includes a review of all patients waiting 104 days or more on a 62 day pathway	Deputy Chief Operating Officer

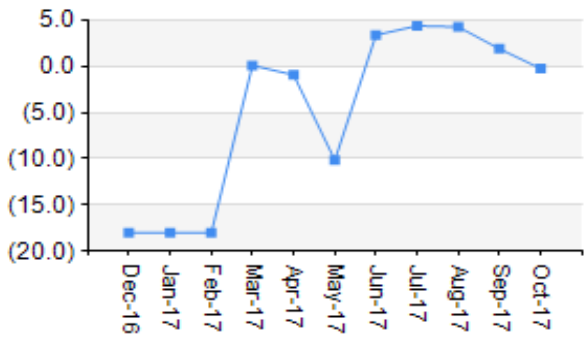
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		Oct performance = 66.7% (unvalidated); target = 90% 1.5 breaches (2 patients – one breached due to a late letter informing that the treatment intention was “active monitoring”; one breached due to a late decision to change treatment modality from chemo to radiotherapy).	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		Oct performance = 75.8% (unvalidated); target = 85% Performance has improved since September (68.3%) and a revised recovery plan and trajectory is being developed to deliver the standard by September 2018. Full escalation report provided in QPR papers and Cancer Delivery Plan for speciality by speciality actions for recovery.	Deputy Chief Operating Officer
Capital Service **Target:**		The Trust currently scores 4 on the NHSI Capital Services Rating. Whilst this is rated red, given it is the indicator of highest financial risk, it does not reflect a variance from plan. The Trust's planned I&E deficit is the main driver of the rating.	Director of Finance
CGH ED - Percentage within 4 Hours **Target: >=95%**		Metric: CGH ED - Percentage within 4 Hours Performance: 93.8% Target: >=95% CGH performance remained static in October. Flow continued to be challenged through diverts (ambulance/GP/Surgical takes) from the GRH site, Cath Lab downtime and periods of reduced medical staffing cover. Amendments within corporate site management processes will enable improved visibility in future to facilitate better planning of estate works going forward. The trauma and orthopaedic bed base was realigned mid-month in line with the CIRET agenda – the impact of this needs to be closely monitored to	Deputy Chief Operating Officer

Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		The revised process for data entry and collection was launched in late September, therefore, we are continuing to roll out the education process to junior doctors who need to assess the patient and enter the data. Compliance figures are fed back to the juniors. Further amendments to the Trakcare process to collect this data is also on-going with a further request made to streamline data submission on the 15/11/17.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		The revised process for data entry and collection was launched in late September, therefore, we are continuing to roll out the education process to junior doctors who need to assess the patient and enter the data. Compliance figures are fed back to the juniors. Further amendments to the Trakcare process to collect this data is also on-going with a further request made to streamline data submission on the 15/11/17.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		The revised process for data entry and collection was launched in late September, therefore, we are continuing to roll out the education process to junior doctors who need to assess the patient and enter the data. Compliance figures are fed back to the juniors. Further amendments to the Trakcare process to collect this data is also on-going with a further request made to streamline data submission on the 15/11/17.	Deputy Nursing Director & Divisional Nursing Director - Surgery
ED Time To Initial Assessment - Under 15 Minutes **Target: >=99%**		Performance against the 15 minute standard for initial triage has slightly decreased but continues to fall below the standard required at both sites, with performance failing following surges in ambulance arrivals. The physical space at GRH is being altered along with the staffing support to enable this key safety metric to be achieved. Alterations to the physical space were completed in early November, staffing model due to be implemented during December.	Deputy Chief Operating Officer

ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		Performance against this standard is still not being met on either side of the county. A detailed review of the data has confirmed that we are underreporting against this key safety metric as we are not coding all of the senior decision makers appropriately. This is in the process of being rectified by the ED team. Following the opening of a larger area for triage of ambulance arrivals in GRH. A PDSA cycle was scheduled during October, this was cancelled due to staff sickness and has been planned for early December. The outcome of this will be reported on in January If this model is effective we will look to roll out on both sides of the county. Time for escalation is now reviewed on the daily escalation reports and conference calls.	Deputy Chief Operating Officer
ED Total Time in Department - Under 4 Hours **Target: >=95%**		Performance: 88.93% Target: >=95% The ED standard was not achieved on either side of the county in September, a full action plan is in place. An escalation report is provided to complement the Quality and Performance Report. Performance in November, month to date is 95.2%.	Deputy Chief Operating Officer
Friends and Family Test Score - ED % Positive **Target:**		The overall ED positive score has risen by 10% since June. The ED team are working on quality improvement patient experience programmes of work with the intention of their projects improving this score.	Head of Patient Experience Improvement
Friends and Family Test Score - Inpatients % Positive **Target:**		The FFT positive score shows the number of patients who are "likely" or "extremely likely" to recommend us. The scores are available externally on the NHS England website and they are also available to our patients and to all our staff. The trend data are currently reviewed by the PESG and are sent to the Divisions within their quarterly patient experience reports. The mandatory FFT question is followed up by just one question which is - "Please explain why you have answered the way you have?". This feedback is currently being used to drive quality improvements projects and must be used if we want to improve our positive score. The data can be viewed at ward/department, speciality and divisional levels.	Head of Patient Experience Improvement

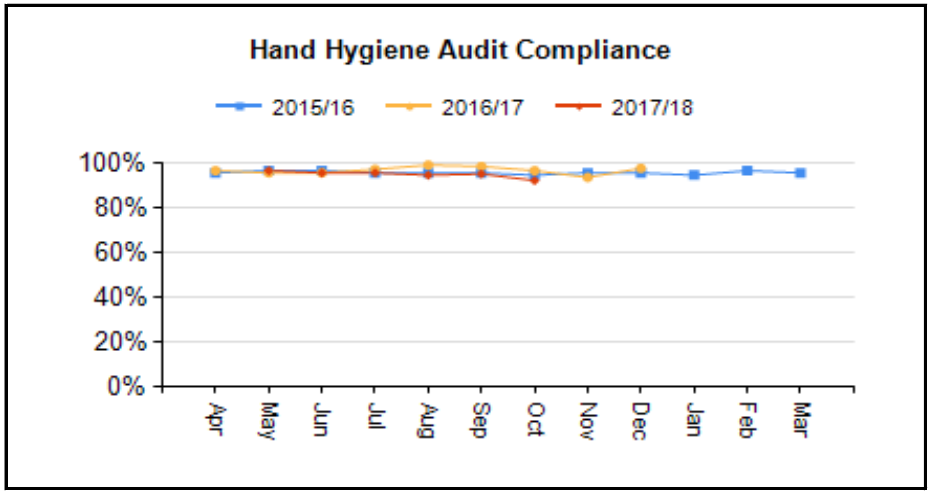
GRH ED - Percentage Within 4 Hours **Target: >=95%**		GRH failed to achieve the performance standard for ED in September due to significant operational challenges that are internal to ED and wider GHT areas, coupled with pressures with CCG/2Gether services. A detailed action plan is being developed to rapidly improve processes within GHT both within the Emergency Department but also across the key clinical inpatient and support services. Performance for November has delivered at aggregate level.	Deputy Chief Operating Officer
Hospital Standardised Mortality Ratio (HSMR) **Target: Dr Foster confidence level**		The most recent HSMR is the fourth in the series to indicate a drop in mortality ratios. Though the Trust remains higher than expected, the trend is positive. To date, outlier status has resulted in reviews of all diagnostic groups where CUSUM alerts have been received and a very small number of cases have been referred for SUI review. Palliative care coding has increased to above the national average. Cheltenham General is within the expected range and Gloucestershire Royal has a stastically significant higher than expected relative risk. When analysed by day of admission, Sunday has a stastically significant higher than expected relative risk.	Medical Division Audit and M&M Lead
Hospital Standardised Mortality Ratio (HSMR) - Weekend **Target: Dr Foster confidence level**		The most recent HSMR is the fourth in the series to indicate a drop in mortality ratios. Though the Trust remains higher than expected, the trend is positive. To date, outlier status has resulted in reviews of all diagnostic groups where CUSUM alerts have been received and a very small number of cases have been referred for SUI review. Palliative care coding has increased to above the national average. Cheltenham General is within the expected range and Gloucestershire Royal has a stastically significant higher than expected relative risk. When analysed by day of admission, Sunday has a stastically significant higher than expected relative risk.	Medical Director
Liquidity **Target:**		The Trust currently scores 4 on the NHSI Liquidity Rating. Whilst this is rated red, given it is the indicator of highest financial risk, it does not reflect a variance from plan. The Trust's planned I&E deficit is the main driver of the rating.	Director of Finance

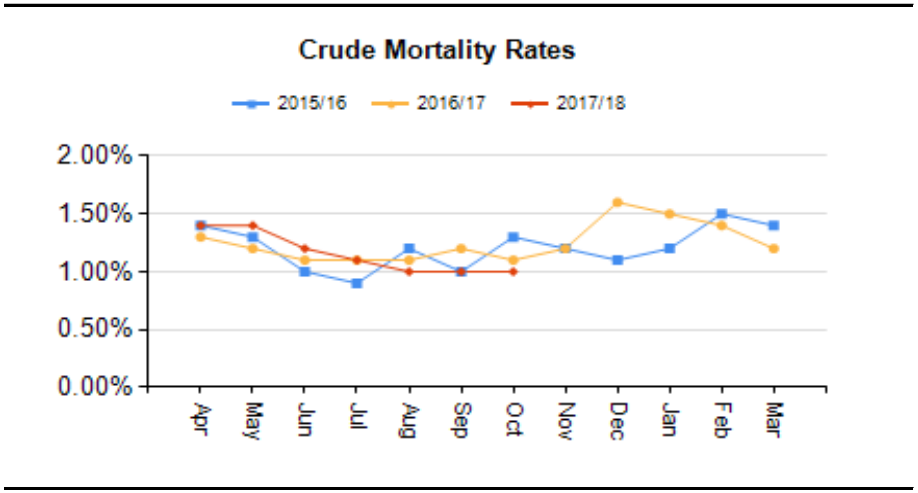
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms **Target: >=93%**		Oct performance = 89.1% (unvalidated); target = 93% Performance has deteriorated since September (92.7%) due to a high number of patient choice breaches (17 breaches – all patient choice). See Cancer Delivery Plan.	Deputy Chief Operating Officer
Number of Breaches of Mixed Sex Accommodation **Target: 0**		The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. A total of 32 breaches affecting 153 patients was declared by the Trust for the month of September 2017. The analysis shows that all 19 breaches were within the Critical Care departments with the split being 18 at GRH and 14 at CGH. All breaches were due to the inability to move patients out of Critical Care areas once they had been made wardable. This is particularly prevalent at the GRH site where the operational OPEL status is often at level 3 (red) or 4 (black) and bed availability poor. One breach could be excluded due to Opel 4 level escalation. The Standard Operating Plan is being developed and this issue has been escalated to the Chief Nurse.	Head of Capacity and Patient Flow
Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour **Target: >=50%**		There has been a significant improvement within the stroke pathway since the development of a detailed recovery plan in July 2017. However, the organisation is still struggling to achieve the target of scan within 1 hour of arrival. Stroke champions have been created within the ED nursing and medical teams to ensure all staff are aware of the quality standards for this service and improved communication, escalation and response times for patients awaiting diagnostic tests features on the ED task and finish action plan.	Director of Operations - Medicine
Summary Hospital Mortality Indicator (SHMI) - National Data **Target: Dr Foster confidence level**			Medical Division Audit and M&M Lead

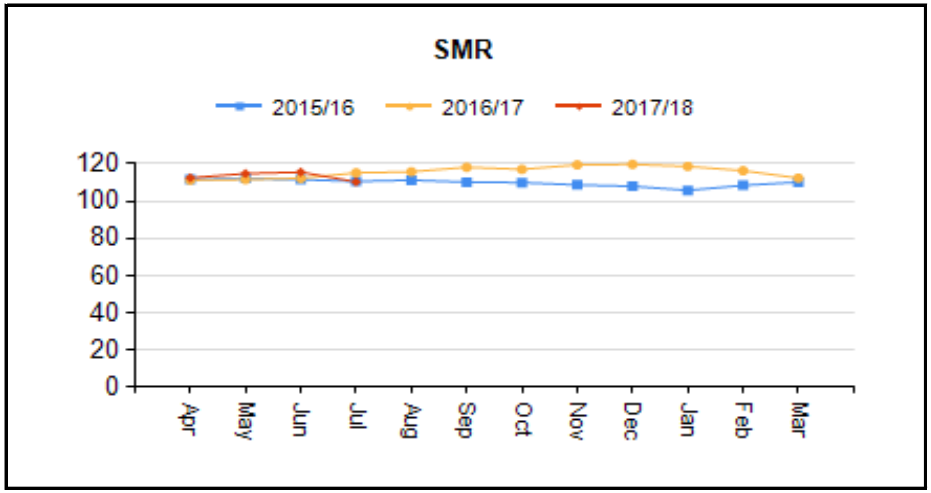
YTD Performance against Financial Recovery Plan **Target:**		The Trust has recorded an adverse variance to plan in M7 of the financial year. Recovery actions have been agreed and are ongoing.	Director of Finance

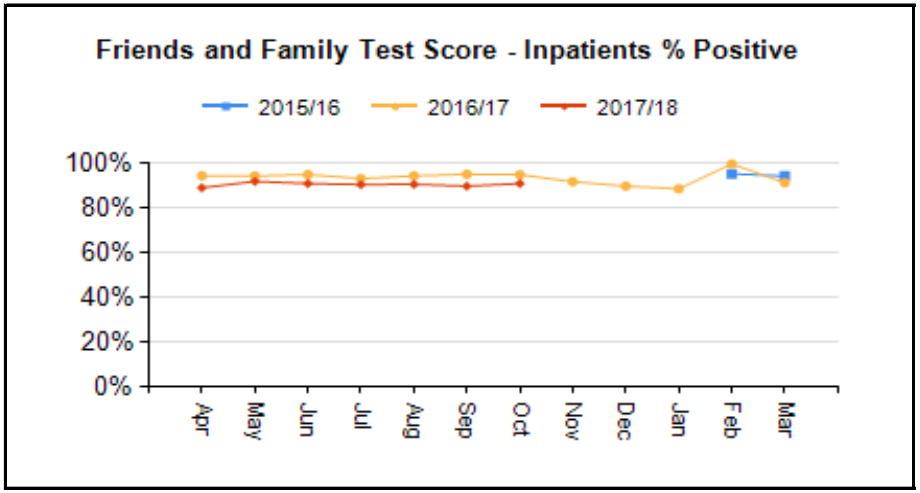
Contextual Indicators

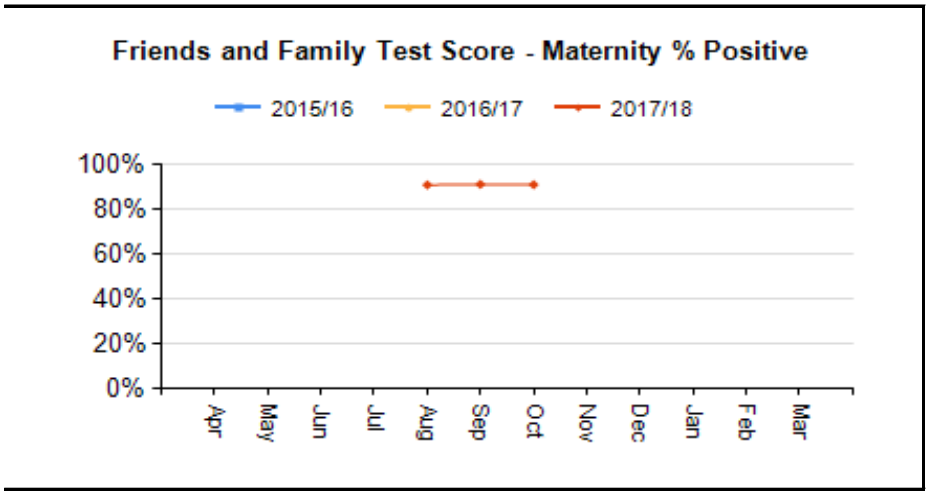
This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

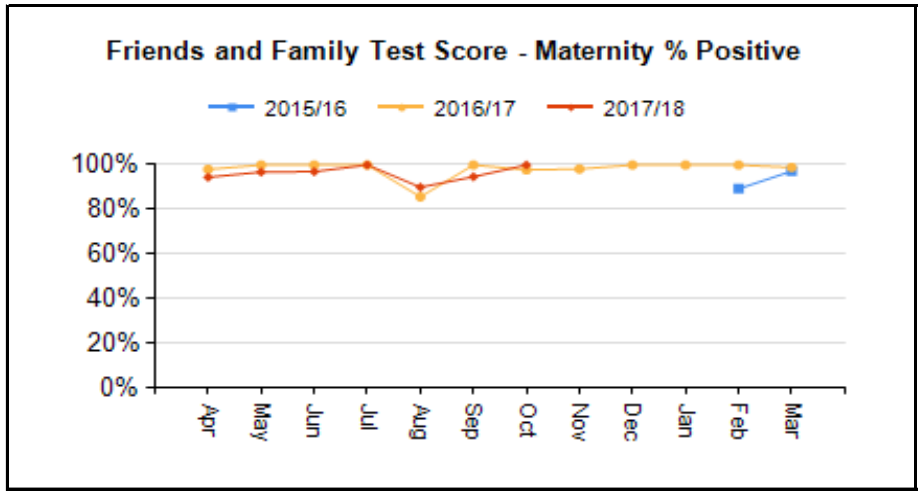


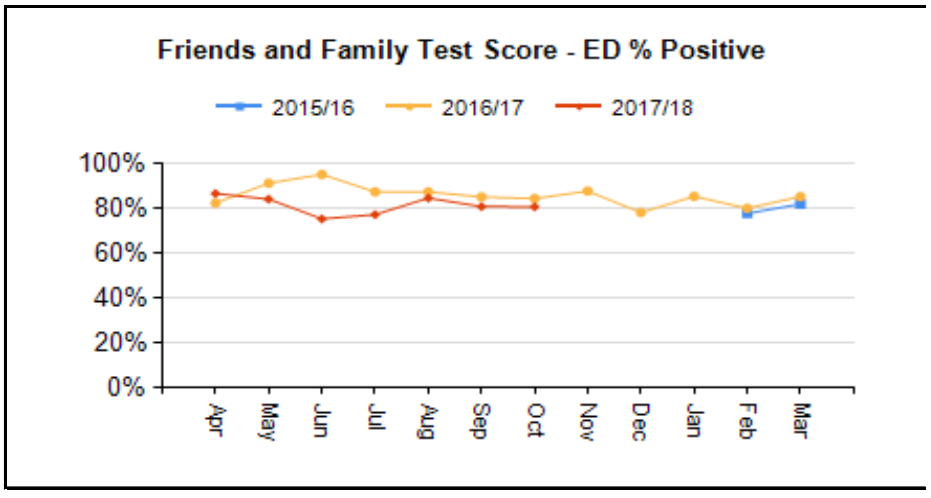


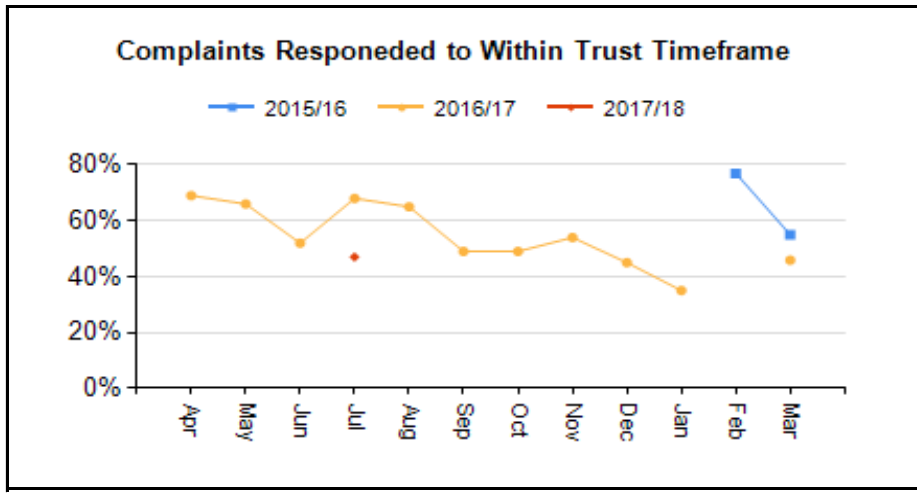


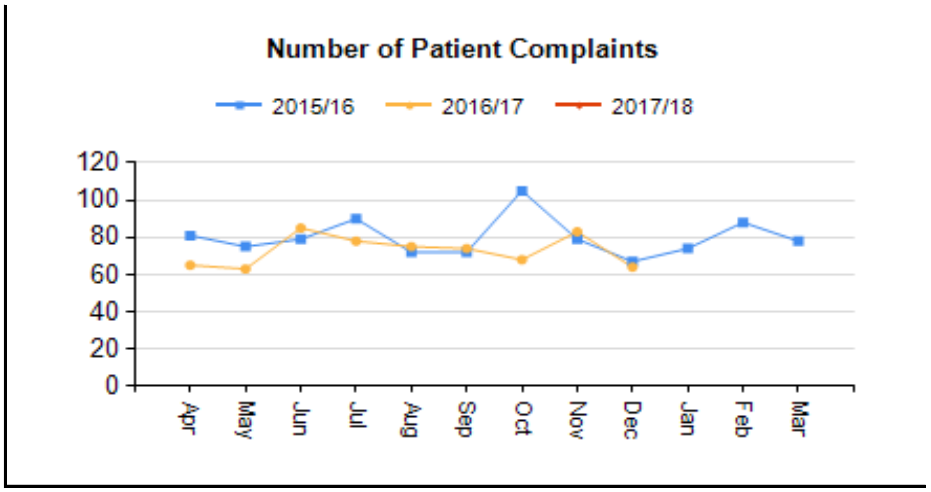


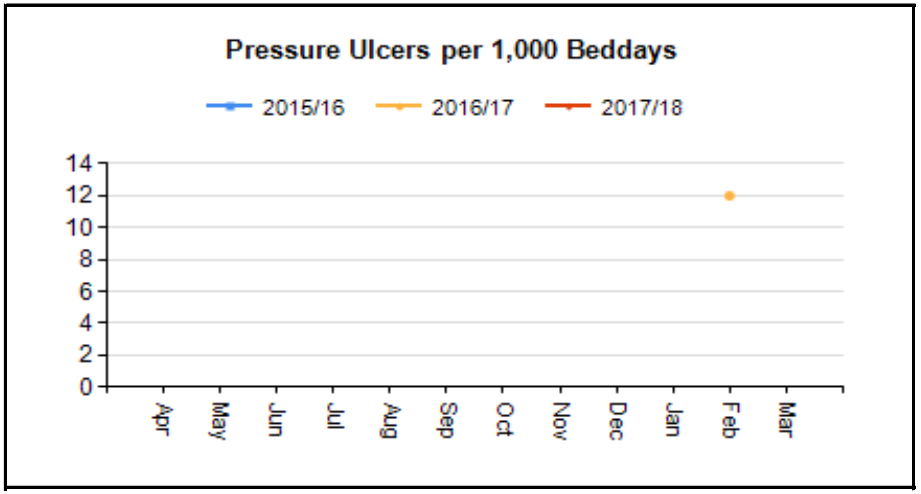

Friends and Family Test Score - Maternity % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

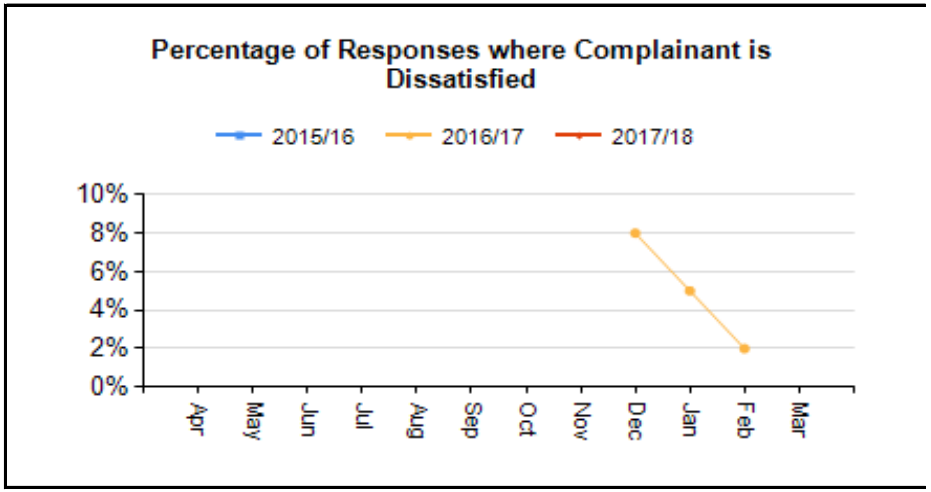

Friends and Family Test Score - Maternity % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

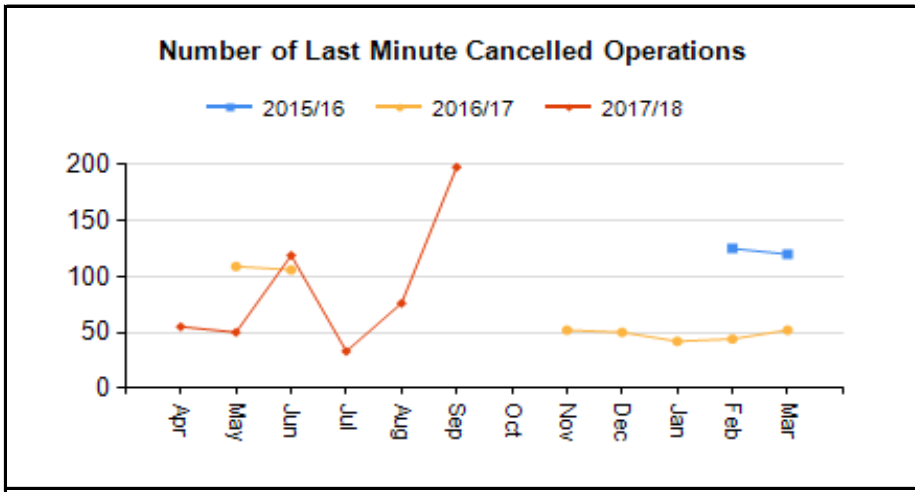

Friends and Family Test Score - ED % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Complaints Responeded to Within Trust Timeframe
2015/16
2016/17
2017/18
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

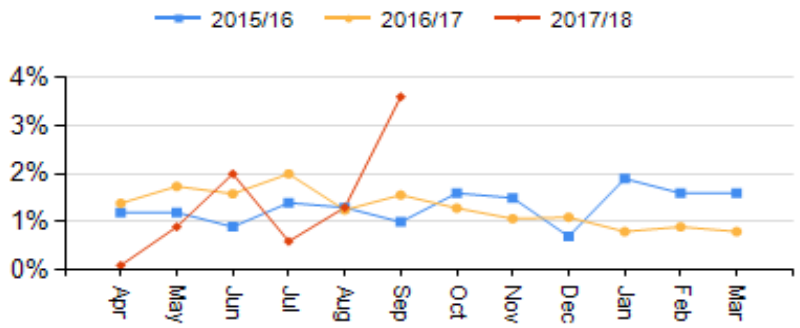

Number of Patient Complaints
2015/16
2016/17
2017/18
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Pressure Ulcers per 1,000 Beddays
2015/16
2016/17
2017/18
14
12
10
8
6
4
2
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

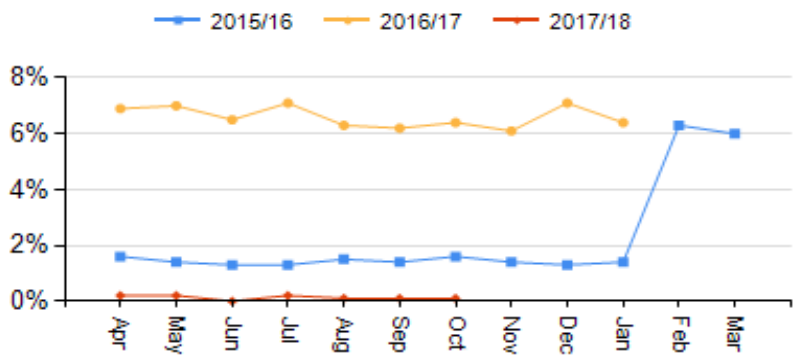

Percentage of Responses where Complainant is Dissatisfied
2015/16
2016/17
2017/18
10%
8%
6%
4%
2%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Number of Last Minute Cancelled Operations
2015/16
2016/17
2017/18
200
150
100
50
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

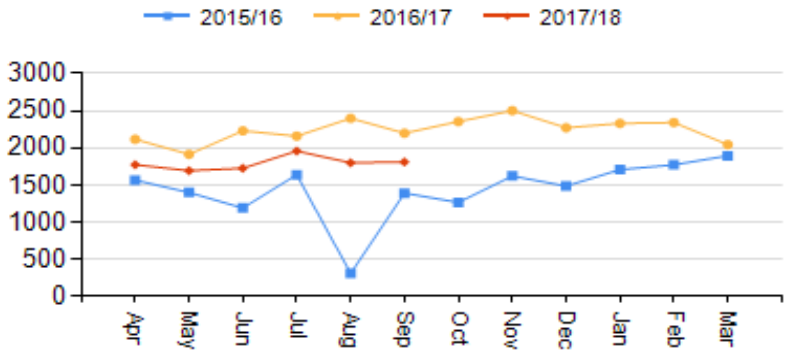
Last minute Cancelled Operations - Percentage of Admissions



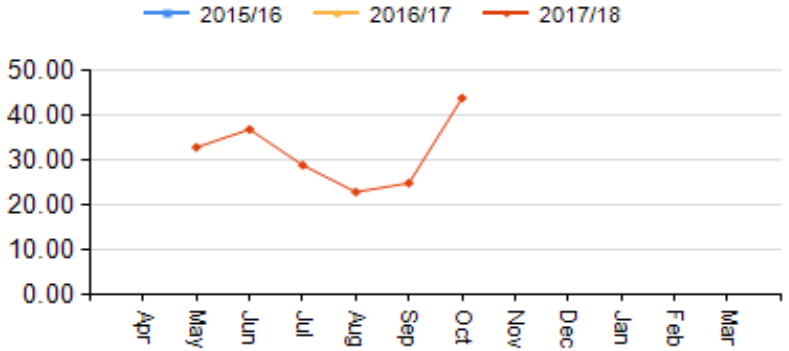
ED Unplanned Re-attendance Rate

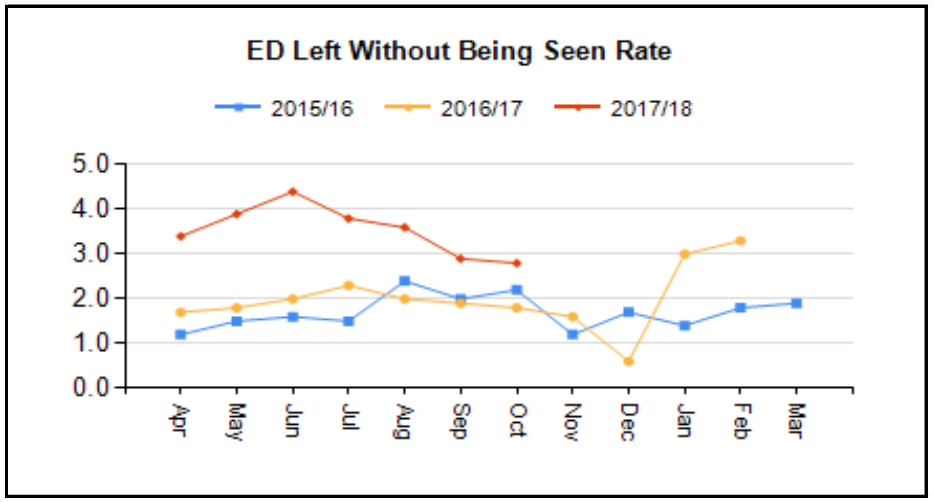


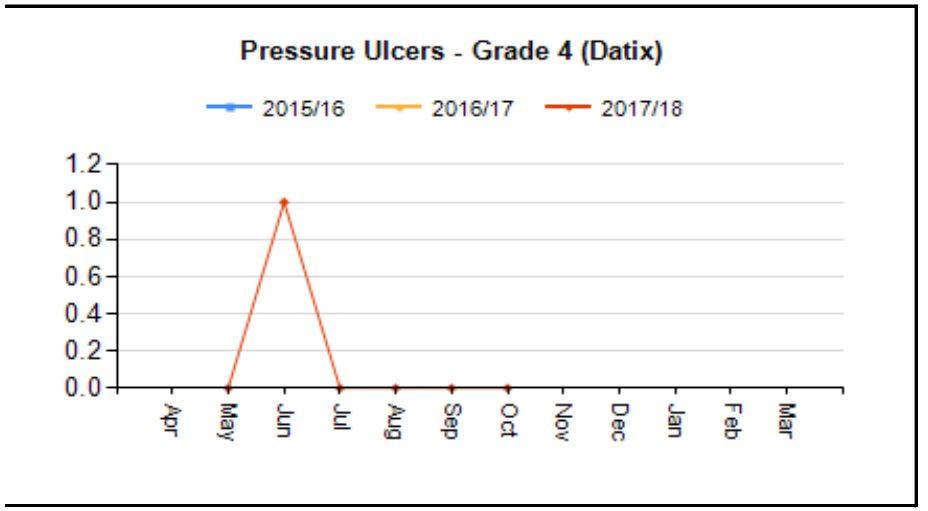
Beddays Occupied by Medically Fit Patients

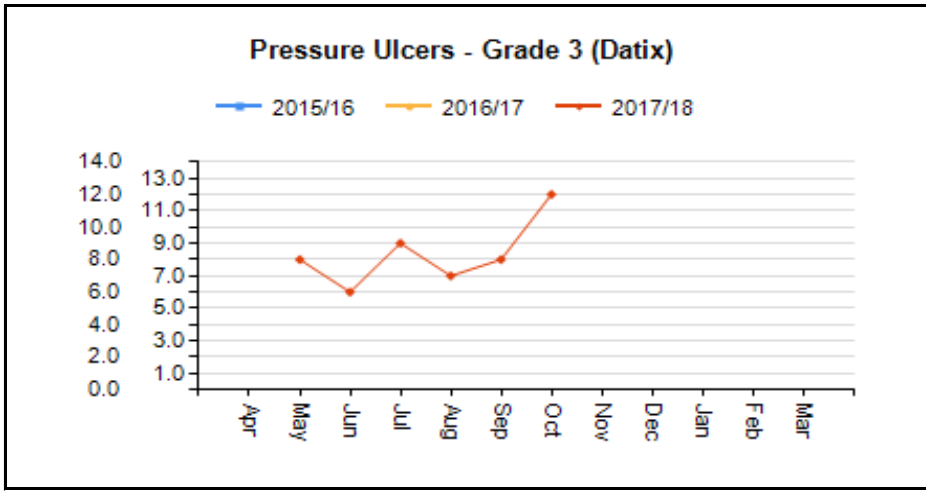


Pressure Ulcers - Grade 2 (Datix)




ED Left Without Being Seen Rate
2015/16
2016/17
2017/18
5.0
4.0
3.0
2.0
1.0
0.0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Pressure Ulcers - Grade 4 (Datix)
2015/16
2016/17
2017/18
1.2
1.0
0.8
0.6
0.4
0.2
0.0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Pressure Ulcers - Grade 3 (Datix)
2015/16
2016/17
2017/18
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
13.0
11.0
9.0
7.0
5.0
3.0
1.0
Apr
May
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Jul
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REPORT TO MAIN BOARD – DECEMBER 2017

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

This report describes the business conducted at the Quality and Performance Committee on 30th November 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
Risk Register	More robust approach welcomed but need additional detail on timescales and adequacy of controls.	Where is the evidence of controls?	Evidence held in web based Datix system of which only elements are presented in this report.	Standardisation of approach across all Board subcommittees. Consideration of a risk report as opposed to a register.
CQC Action Plan Progress Report	Systematic approach to monitoring progress welcomed. Will develop into the Quality Improvement Plan and our Journey To Outstanding (J2O)	What is the evidence for the "green" rating for every speciality having visibility of their waiting times? How are consistent levels of embeddedness being tested?	One single PTL being monitored weekly through a check and challenge meeting with the divisions.	Future reporting will be determined by emerging governance structure for quality with exception report in 3 months.
Feedback from CQRG	No issues formally escalated from the group to this Committee. Gloucestershire Clinical Commissioning Group (GCCG) have noted improved sense of transparency, but TrakCare recovery remains area of highest concern.	What is the Trust's approach to developing the response for deteriorating patient?	Resuscitation leads, both Medical and Nursing, had engaged with Academic Health Science Networks (AHSN) work in this area. Track and trigger thresholds are being reviewed.	Minutes of CQRG to be reviewed by Director of Quality and Chief Nurse and Director of Safety when available.

GHFT Quality Improvement Group (QIG)	2 key issues: CQC actions plan - NHS England/ Improvement content with approach and discharge back to CCG - TrakCare and 52 week wait - QIG process to continue awaiting recovery report but will downgrade to a quarterly assurance meeting			
Quality and Performance Report	Improved reporting implemented to give early visibility of patients ready to move from critical care.	Noted that no consistent guidance nationally on mixed sex and breaching from critical care. What impact has the improved Emergency Department (ED) performance had on patient experience elsewhere in the hospital?	Currently reporting greater than 4 hour delays. Will not move reporting threshold with further discussion. Family Friend Test (FFT) in ED has improved. Too early to see impact on wards.	Algorithm for summary scorecard to be made explicit. Patient experience dimensions to range of performance and exception reports to be further developed
Four Hour Performance Report **-Issues Escalated from Emergency Care Board**	Improved performance in October. November figures have significantly improved, despite a rise in attendances by 6%.	Formally recording appreciation to leadership team for improvement with ED performance. What assurance do we have that patients who do need to be in the department over four hours are not rushed.	Reporting system is comprehensive with checks and validations at a number of pathways. Random pull of patients waiting 3-4 hours quarterly to validate patients.	

			95% target reflects a tolerance for clinical breaches and that clinical decisions are not compromised.	
RTT Performance	Review of Referral to Treatment (RTT) escalation policy. Implementation and revised procedures with booking processes.			Recovery plan for elective performance being developed.
Cancer Performance	Revised governance structure through 2 weekly cancer delivery group. Trajectories have been put in place for 2 weekly and 2 day performance.	What are the key challenges? What progress are we making with adopting pathways proven to be effective elsewhere?	Dermatology, Urology and Colorectal Pathways are most challenging. Significant risk to urology plan due to workforce constraints. Straight to test pathway agreed in colorectal.	
TrakCare Operational Recovery Report	Operational Recovery Group will be refocused to align with the recommendations of the TrakCare Deep Dive.	Is it possible that colleagues are tolerating rather than reporting difficulties?	Risks and issues log for TrakCare is extensive. Some issues are still talking longer to resolve than desirable.	Last report of this format. Q&P will receive report from clinical system review group.
Mortality Report	Though Mortality Indicators remain high, it is an improving position. No consistent pattern of weekend versus weekday mortality.	What could be driving a differential in mortality based on day of admission?	Case reviews and audits of deaths with pneumonia and fractured neck of femur show no difference in care provided based on day of admission.	Learning from Deaths Report will be presented to December Board. Future QandP report to include RAG rated progress against action plan.

Pressure Ulcer Prevention	Current position is double the national average and is not acceptable. Pressure ulcer prevention is a window on care in general. Chief Nurse to chair a system wide Pressure Ulcer Group to including Nursing and Residential home providers.	Is the action plan adequate?	Root cause analysis will inform a review of the existing action plan into a pressure ulcer prevention strategy.	Issue to be progressed through Quality Delivery Group with further oversight by QandP Further analysis of Falls and Surgical Site Infection to be brought to future QandP
Safer Staffing – Approach & Report	Presentation on the issues impacting on safer staffing, including planned initiatives to improve care and motivation. Issues of staffing on Ward 4a now resolved. Substantive fill concerns relating to Gloucester Royal Hospital Emergency Department and 8A.	How do you triangulate staffing and harm? Do the average fill rates mask significant vacancies?	Chief Nurse has visibility of all harm events through Datix system. Currently unable to review consistently on a shift by shift basis but this will be resolved by new system.	Further reports will include monthly Rosterpro KPI report. Update on initiatives to a further Board Development Session.
Serious Untoward Incidents Report & Action Plan for Review of Never Events in Trauma and Orthopaedics	Further Never Event (wrong site surgery) since the report. 5 Never Events so far this year. Review of Never Events in theatres being progressed as an improvement project.	Is this likely to trigger a review by the Care Quality Commission (CQC)?	Nationally, Never Event levels are increasing. Possibly need to understand why this was not picked up through divisional reporting.	Need to ensure data incident is reported as a Serious Untoward Incident. Consider a review of all Never Events to determine a proactive approach.
Committee Reflection	Better prioritised in depth discussions related to the risk register.			

Claire Feehily
Chair of Quality and Performance Committee
30th November 2017

MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Andrew Seaton, Director of Safety Sponsor: Lukasz Bohdan, Director of Corporate Governance
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 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 continues to review those Divisional risks at 12+ for safety and 15+ for other risk that have not yet been migrated to the Trust Risk Register.

Changes in Period

Following review by TLT, the following actions were agreed:

M2488Card - Risk of Harm to patients as a result of delay in receiving essential, required cardiac interventions has been downgraded to 3x3=9 following appointment of staff to increase capacity and returned to the Medicine Divisional Risk Register

N2614 - A new risk was added involving the ability to electronically track infections with the imminent closure of IC Net, requiring manual systems to be established. Action is underway to remedy this situation and a further assessment of the risk score is to be undertaken.

There are currently now only 9 risks being reviewed by Divisions for escalation to TLT, these will be further reviewed by the Division and Executive following the normal process to ensure the appropriate significant risks are escalated onto the Trust risk register.

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

Conclusions

The remaining 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+ is concluded and to progress the review of all safety risks of 12 or over for future incorporation on to the Trust Risk Register.

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 & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					✓	
Outcome of discussion when presented to previous Committees						

Trust Risk Register - December

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
C1609N	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Workforce	Director of Quality/ Chief Nurse	Quality and Performance Committee, Workforce 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 Extreme risk	Monitoring at Workforce Committee Establish Quality Impact Assessment for project Overseas recruitment programme	02/01/2018

Trust Risk Register - December

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
D&S2404C Haem	Diagnostics and Specialties	Quality	Medical Director	Divisional Board, Quality and Performance Committee	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. Business case to address workload growth with permanent staffing agreed Agreement to fund locum - suitable replacement obtained and is in place.	Inadequate	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Develop Business case to meet capacity demand	07/03/2018
F2518	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that FY18 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation	TrakCare Recovery Oversight Meeting Regular monitoring and analysis of data completeness (and quality) and income recovery	Adequate	Catastrophic (5)	Almost certain - Daily (5)	25	15 - 25 Extreme risk		21/12/2017
F1339	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	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 Weekly Turnaround Implementation Board Monthly monitoring and reporting of performance against target Monthly executive reviews	Adequate	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk		22/12/2017

Trust Risk Register - December

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
S2275	Surgical	Workforce	Medical Director	Workforce Committee	The risk to workforce of an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers.	Attempts to recruit Agency/locum cover for on-call rota Nursing staff clerking patients Prioritisation of workload Existing junior drs covering gaps where possible Consultants acting down	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Escalation	02/01/2018
C2335HR&OD	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Director of People	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 Extreme risk	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures	02/01/2018
S1748	Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee	The risk of statutory intervention for failing national access standards including RTT and Cancer	1. Weekly meetings check and challenge with all specialties 2. Dir-Ops weekly challenge with DMs 3. Validation of Patient tracking list daily by GMs 4. Performance trajectory in place for cancer pathways 5.	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Re establish Planned care board Interim action plan to recover position	20/12/2017

Trust Risk Register - December

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
M2473Emer	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and 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 Extreme risk	CQC action plan for ED	29/01/2018

Trust Risk Register - December

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
S2045T&O	Surgical	Safety	Medical Director	Quality and 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)	Possible - Monthly (3)	12	8 -12 High risk	Deliver the agreed action fractured neck of femur action plan	22/12/2017
C2614NICC	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality & Chief Nurse	Quality and Performance Committee	The safety risk of delayed tracking and treating of infections as a consequence of relying on a manual system	Short term contingency plan based around manual systems to track patients with infections.		Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Create business case for new IC Net system	22/12/2017

Trust Risk Register - December

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
C1945NTVN	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality/ Chief Nurse	Quality and Performance Committee	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Nursing pathway documentation and training in place Pressure Ulcer expert committee reviewing practice and incidents to identify learning Monitoring through incident investigation\RCA Divisional committees overseeing RCAs Safety Thermometer data review as part of Safer Staffing	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	To create a rolling action plan to reduce pressure ulcers	22/12/2017

MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title
Patient Experience Improvement in Response to Board Stories
Sponsor and Author(s)
Author: Suzie Cro, Head of Patient Experience Improvement and Freedom to Speak Up Guardian Sponsor: Steve Hams, Director of Quality and Chief Nurse

Executive Summary

Purpose

To provide an update on the patient experience improvement work that has been initiated in response to the stories presented to Board since April 2017.

Key issues to note

Fundamental to the principle of quality improvement is an understanding that those closest to the patients are often best placed to find the solutions for improvement (King's Fund 2017). The Patient Experience Improvement Team are embedding a culture of quality improvement for patient experience by working with Matrons, Ward Managers and clinical teams directly. We have moved away from the imposition of our solutions to recognising that our frontline teams, service users and their carers are often better placed to develop their own solutions through a process of discovery. We assist with providing toolkits so that they try different approaches. However, quality improvement is not a simple fix, nor just something to add on to existing management practices as it involves a cultural shift in which leaders model the values of quality improvement, demonstrate constancy of purpose and influence the spread across the organisation. A patient experience story is data as it is a narrative of their care and staff need to understand their patient experience "data" to then develop effective solutions. Patient stories are an important component in understanding what has happened to a patient, in conjunction with their perceptions of the health care they have received.

Conclusions

To give assurance that there has been both listening, learning and improvement action in response to each story.

Implications and Future Action Required

The Head of Patient Experience will continue to provide the Board with stories and will include all the improvement work that has happened at a ward level as result.

Recommendations

The Board are asked to note the contents of this report.

Impact Upon Strategic Objectives

- Outstanding rating by CQC in the domain of caring
- Friends and Family Test positive score of 93%
- Improving the outpatient experience (complaints to less than 30 per month)

Impact Upon Corporate Risks

Regulatory and/or Legal Implications
None.

Equality & Patient Impact
Improvement work being carried out in response to stories.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					✓	

Outcome of discussion when presented to previous Committees

MAIN BOARD - DECEMBER 2017

PATIENT EXPERIENCE IMPROVEMENT IN RESPONSE TO BOARD STORIES

1 Patient Experience Improvement Work

The aim of this paper is to give the Board an update on the patient experience improvement work that has been initiated in response to the stories that have been presented to Board.

2 Patient Experience Stories

2.1 April 2017 Karen's Story

Karen Bradshaw presented her patient story on what she described as the "*good, the bad and the ugly*" side of a NICU journey. She described the journey of the birth and care of her two premature babies including the stays in both Bristol and Gloucestershire Royal Hospital. She expressed admiration for all the dedicated staff working in the NHS. From her excellent personal experiences, she offered some suggestions for improvement.

Issue	Explanation	Improvement actions taken
Free parking	There were parking costs at Gloucestershire Royal Hospital which were free at Bristol and could consideration be given to this.	Neonatal staff cannot issue a Carer's Passport to families as being a parent does not make them a carer and so they don't meet the current criteria. Parents can get a pass which means that they get a weekly reduction and this pass costs £14.
Hydration and nutrition for families	Meals were available in Foster's Restaurant but it would be such an improvement if meals could be provided to parents on the ward to avoid them leaving the unit. A drinking water supply just outside of the unit would ensure hydration which is critical when mothers are breastfeeding.	The neonatal Matron has been looking at having more volunteers within the unit and this could be a role that they could help with. They have also asked for the trolley to visit so that parents can buy food and snacks without leaving the nursery. Water is readily available within the family room and a quote has just been received to put a new hydration station nearer the nurseries.
Nutrition for baby	Can the sterile bags be changed to those used in Maternity Wards? Could more up-to-date breast pumps be available to parents?	The bags have been changed and are now the same as maternity. A quote has been obtained and the staff are going to charitable funds so that they can purchase four units at £1500 each.
Accommodation	Accommodation for parents was available in Bristol on the unit but no such facility is available at Gloucestershire Royal Hospital. There are two	There is accommodation on the unit as there are two bedrooms but there is not enough room for every parent to stay over and so priority is given the families who are taking their babies home or to the parents of the sickest child.

Issue	Explanation	Improvement actions taken
	rooms for staff accommodation adjacent to the unit which she suggested could be made available to parents.	
Communication	Bristol provided a password system to assist with telephoning the hospital which helped with accessing information when off site and could a similar facility be provided? Staff behaviours helped but a reduction and explanation of medical terminology would be helpful.	Work in still in progress. The staff have listened to this feedback and so are trying to explain things to families in less medical language.
Transport	It was difficult to drive to Bristol with reliance on family and friends. In Bristol there was a local charity operating a service to pick up parents for visiting. It was difficult for one parent to visit in Bristol and one to remain looking after the second child. Again, could a similar facility be provided?	Discussions are still ongoing with the Voluntary services manager to see if volunteers could be recruited to this role.

2.2 10th May 2017 Lucy's Story

Lucy Mathieson came to the Board and told her personal story about two ward experiences. She experienced exceptional care on one ward and then she experienced aspects of care that could have been improved on another.

After the story the Head of Patient Experience Improvement went and visited the ward with the Infection Control team and reviewed the whole ward. They made sure that hand gels were available at the bottom of every bed. They checked the toilets and saw that they were clean but the toilet bowls were very stained. The staining was due to necessary chemicals being put in the water. The chemicals had an unfortunate side effect of staining the lime scale brown. The toilets had been reported to Estates and were due to be replaced as they were very old. The ward area on that day was very clean and there was no clinical waste on the floor. The Infection Control team continue to work with the ward by carrying out regular audits.

In response to this story the Ward Manager wanted to make improvements to patient experience and so joined a cohort of ward staff who were all undertaking a bespoke Silver quality improvement programme with the Patient Experience Improvement Team and the Academy. The project he chose to do was that he wanted to improve the welcome that patients received on arrival and their care in the first few hours on the ward. The ward have been testing a few change ideas and the Manager is due to graduate from the Academy in mid-December. They have also recruited 4 volunteers to work on the ward to provide

additional caring support to the patients (such as making drinks, fetching newspapers and offering befriending services).

2.3 26th May 2017 Kim's Story

There is clear evidence which shows that deaf patients are often unable to access clinical services and take part in health consultations in a way hearing people often take for granted. Studies have shown this 'inadvertent negligence' leads to poorer health outcomes (*source: SignHealth 'Sick of It' 2014 report*).

In 2015 Gloucestershire Hospitals NHS Foundation Trust awarded Gloucestershire Deaf Association (GDA) the contract for British Sign Language interpretation services. In order to meet the specific aim set out above, GHNHSFT identified the following objectives it expected GDA to meet:

- GDA to operate a 24hour, 7 day a week BSL interpreting service, with 'standard hours' meaning Monday to Friday 8am to 8pm.

- GDA to allow for both planned and unplanned appointments and undertake a fulfilment rate of 100% for planned appointments with two or more days' notice; and more than 90% for appointments with 24 hours or less notice.

- GDA to provide a BSL interpreting service at all times that is Effective, Efficient and proves Satisfactory for all involved.

The GDA contract monitoring and evaluation report for one six-month period during 2016, showed that out of 192 BSL interpreter assignments, GDA only learnt of the hospital appointments because the Deaf person notified them, rather than the hospital, on 58 occasions (30%).

The Head of Patient Experience Improvement and the Patient Experience Improvement Manager (Disability Equality) went to the GDA and asked how we could improve and this led to a focus group being held in April 2017. The contract review meeting and the listening event triggered a programme of quality improvement work with the Deaf community, led by the Patient Experience Improvement Manager (Disability Equality).

After the focus group, to understand the importance of the BSL Interpreter, Kim Fletcher, who is a Deaf BSL user, agreed to be shadowed to an outpatient appointment. After this appointment we heard in more detail about Kim's experiences, some of which were very good and some experiences that definitely required improvement. We asked her to share her patient experience story to the Board facilitated by BSL Interpreter Victoria Bond.

Kim told her compelling story to the Board in May and we are now able to report back on the many improvements that we have made since that story was heard. The Patient Experience Improvement Manager has been doing her Silver GSQIA award and is due to graduate in December. Listed below are some of the change ideas that were put in place as part of that project.

1. We have created **Deaf Communication Cards** in partnership with the GDA and corresponding reception counter-top notices for deaf patients. The counter-top notice prompts Deaf BSL users to present their card to the receptionist and also provides contact details for GDA on the reverse for staff.

   The purpose of the wallet-sized plastic cards is to help identify patients immediately as Deaf BSL users and that there is a need for communications support. It also includes the 24-hour-a-day contact details for GDA, so that clinical staff also have the information to hand to book a BSL interpreter, particularly for unscheduled care. Although initially introduced for acute hospital appointments only, the cards are making such an impact that Gloucestershire Care Services

and 2Gether have also adopted the cards, adapting them for their own organisations.

GDA's Chief Executive said "*We are enormously grateful to Gloucestershire Hospitals NHS Foundation Trust for putting their trust in deaf patients to know what works for them. Initial objections to the cards centred around the idea that an ID card somehow stigmatises the deaf patient, but this is a hearing person's false perception. Deaf people feel no stigma about being deaf. However, because it is so easy mistake deafness for other conditions, including dementia or learning difficulties, it is critical that in a medical situation particularly, it is recognised immediately and communication support is put in place promptly.*"

GDA promoted the deaf communication cards on their social media pages and attracted more than 10,000 responses in the first 24 hours. This is a good example of an extraordinarily simple and cost effective solution being used to improve the experience of disadvantaged patients when attending hospital.

Picture: The Deaf Communication Card

In the first three months since the change ideas have been implemented (Aug-Oct 2017), out of 109 BSL interpreter assignments, there have been just 9 (8%) occasions when GDA has learnt of the appointment from the Deaf BSL user rather than the hospital, which shows an immediate and significant **22%** improvement compared to the preceding months. In September, GDA received 100% of the 19 BSL interpreter bookings from the hospital.

The Deaf Communication Cards have generated a significant media attention and a joint story ran on BBC Points West which was filmed with Kim in our Emergency Department.

Picture: BBC Points West 231117 - Deaf Communication Cards

The success of this story and quality improvement project has shown us that Deaf BSL users are happy to disclose their communication needs, but our systems and processes have been barriers to making use of that information to enhance the experiences of patients and staff. This was important learning for us.

2. In liaison with GDA, we now have clearly identified all our patients who are Deaf BSL users with the use of **electronic alerts** being added onto the patient's notes on Trakcare. The alert indicates that an individual has a communication need, prompting staff to take appropriate action and triggering auto-generation of information in an accessible format. The aim of the alert is to flag and share a patient's communication need so that these needs are anticipated and are met at all stages of the patient's journey, in accordance with the Accessible Information Standard.

3. **Patients' appointment letters** have been created in a more accessible format, by reworking them to incorporate Plain English and ensure that the most important information on the letter is concise and easy to understand. This letter has been so well received by senior staff in the Trust, that in addition to being used for Deaf BSL users, it is due to replace the standard patients' letter for use Trustwide.

4. **Hard of hearing communication cards** are being developed in collaboration with GDA.

5. **Wipe boards** were purchased for use in Audiology so that staff could call out someone's name and also show the patients name written on the board at the same time. There was a decision made by the leadership team that they would only use them for patients who have a greater hearing loss of 40 decibels. The use of the boards have been audited and they are being used 50% of the time with an improvement required to make sure that they are being used for the right patients all of the time. We have asked the GDA Deaf community to report back their experiences.

Key learning points from this improvement journey have been that we must:

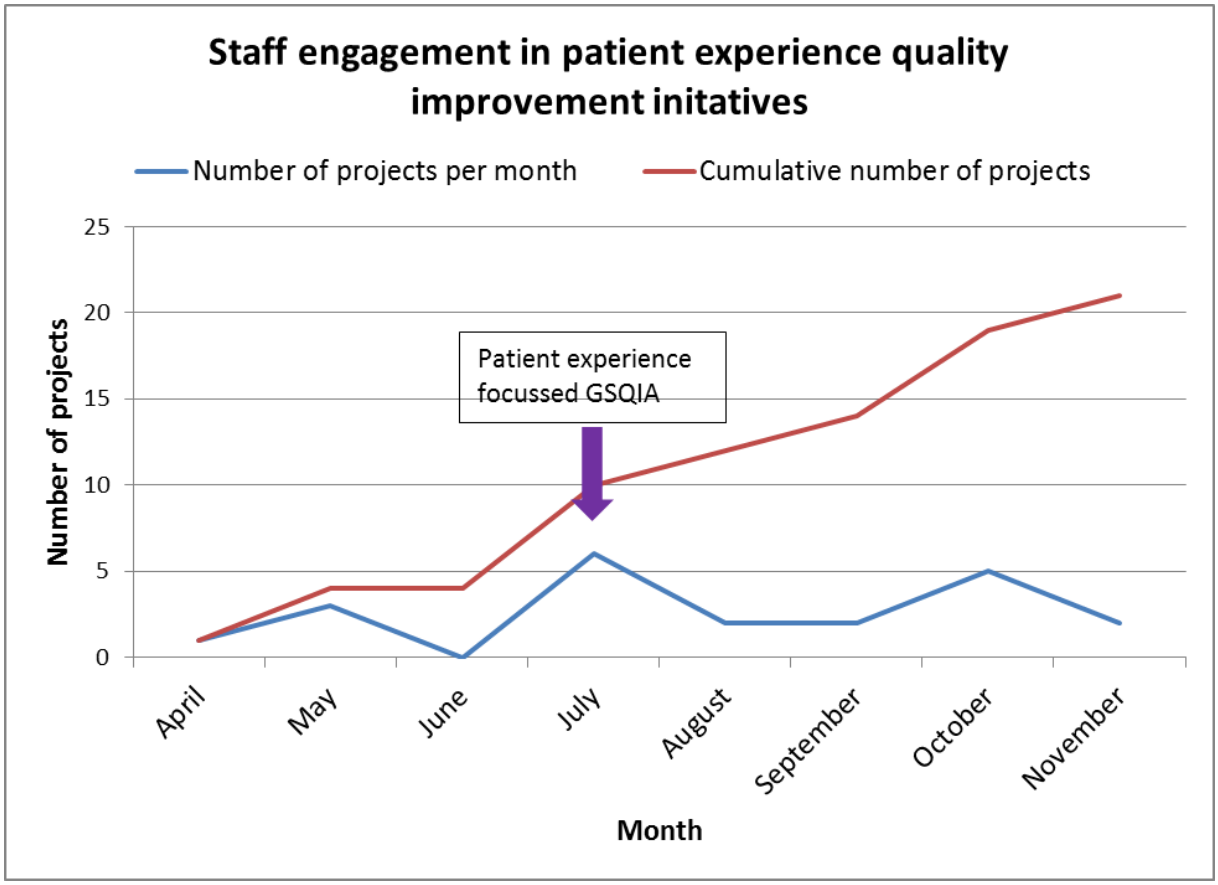
- Have a genuine desire to listen and learn
- Not dismiss any ideas without carrying out a proper investigation
- Enlist the right people onto our team who can unblock impasses in our project
- Communicate regularly with our team members and key people
- Be prepared to make adjustments to our project work in response to comments from people with lived experience

- Not assume - have a conversation with a person with lived experience and believe what they are saying.

2.4 June Story "530 patient voices"

The story in June was the results of the National In-patient Survey which had just been published that week by CQC. Receiving the inpatient survey has led to a change in working practice for the Patient Experience Improvement Team which led to the Head of Patient Experience Improvement and one of her team engaging in a whole programme of work and a Silver GSQIA project. Our project is entitled "Engaging frontline staff in quality improvement science improves patient experience" and we will graduate in December 2017. The problem with experience/insight feedback data is staff taking ownership, as they often say "*that's not my data and so this is not my problem*". Our project was innovative as we took selected ward staff through a bespoke Silver award through the Academy. The Patient Experience Improvement Team demonstrated to staff the patient experience toolkit that they could use on their wards. Also part of the approach was that we ensured each area got to see the ward's own personalised patient experience data.

The success of this project can be measured by how many staff have become involved in patient experience improvement projects through learning the QI techniques and their involvement in the Academy. The Patient Experience Improvement Team have added their patient experience toolkits to the Academy and take a lead role in coaching staff who have a patient experience project. Other wards have heard of our approach and more wards are keen to be involved.



Quality Improvement Title	**A journey to outstanding for patient experience (twitter #J20) Engaging frontline staff in quality improvement science improves patient experience**
Quality Improvement Presenter(s)	Katherine Holland – Patient Experience Improvement Manager Suzie Cro – Head of Patient Experience Improvement and Freedom to Speak Up Guardian
Quality Improvement Team	**Patient Experience Improvement Team** **Gloucestershire Safety and Quality Improvement Academy (GSQIA)** **Ward and department managers and staff**
Quality Improvement Description	It is recognised that staff engagement directly affects patient outcomes and experience. By empowering staff to engage with patient experience data and make change happen can help staff to reconnect with their fundamental values (US-PEx: 2016). The Trust National Inpatient Survey results were not improving and the Staff Survey tells us that we do not use patient feedback effectively and that they are not satisfied with the quality of work and care they are able to deliver. We learned that the traditional approach of a Trustwide action plan going from the top down is not yielding the improvements needed as reported by patients. The focus of this work was in adult inpatient areas. *Aim:* To improve staff engagement in patient experience quality improvement initiatives by 50% by 30th November 2017. *Method:* To encourage a range of patient experience focussed quality improvement initiatives based on feedback from patients and other metrics within individual areas. A patient experience focussed Silver programme with the GSQIA enabled frontline staff to develop an increase in knowledge around quality improvement methodology. *Results:* The expectation was for frontline staff to embark on a quality improvement project utilising the US-PEx resource book. It became clear that in order to truly empower staff they needed to be able to choose their improvement project based on their knowledge of their area. The number of projects with a focus on patient experience has more than doubled since the initial drive for engagement. *Implications:* The concept of engaged and empowered staff having a positive impact on patient outcomes and experience has a clear evidence base. The next stages will be to continue to coach and support staff to engage with quality improvement science to enable our Trust to achieve its strategic objectives and an improvement in the national inpatient survey results. Individual quality improvement initiatives often take considerable time to demonstrate impact, and even the most successful efforts will face obstacles and setbacks along the way.

Our conclusion has been that ownership of feedback data has to be closest to the patient to make the biggest difference to staff wanting to make improvements. We have rolled out this approach with the other National Surveys.

- The Children and Young People Survey showed that children were not as involved in decision making as they wished and so the GSQIA silver project in response to this result is a co-design project with children aged 8-13 and looking at ways to improve their involvement.

- The Cancer Survey results showed that there was inconsistency with communication and so this will be their improvement project.

- The Maternity Survey results will be linked to the *Better Births* programme of work and this will be led by the team working on personalisation and choice.

- The Outpatient Survey results are linked with improvement projects being initiated in Endoscopy, Colposcopy and Breast Care.

- The Emergency Department Survey has 2 nurses currently reviewing their data and deciding which areas they would like to improve that will have the biggest impact to patient experience.

2.5 September Sheila's Story

In 2016, Sheila fell and broke her leg and was admitted to the Emergency Department and then went to Dixton ward. Actions have already been taken to improve patient experience in response to Sheila's story and in addition to this the ward is now part of the "**Small Steps-Big Changes**" project which is the roll out of the award winning project that was completed on 7A.

Improving patient experience is the whole focus of this work but the introduction of improvements are done in a stepped way (small steps) and the project starts with staff experience as we want to show staff that we are listening to their improvement suggestions so we ask them first, via a flip chart and post it note system, to suggest improvements to make their experience of working on the ward better. These suggestions are anonymous but we need enough detail to be able to act on the suggestions so for example 'Need more support' must be expanded with examples before we can take action. Every idea will be implemented immediately by the Ward Manager or passed to the relevant person who can deal with it. The consultants on the ward can also make requests and suggestions. As staff realise that we are serious about making things better, they will come up with more suggestions. We will spend a month concentrating purely on staff improvements. The staff need to be realistic and not ask for things that we were obviously unable to change i.e. salaries or structural environmental changes.

Following this, we will then ask the staff for suggestions on how we could improve the experience of the patients based on what they had observed on the ward or from suggestions made by patients during conversations. Again, this will be via a post it note but not necessarily anonymously. Suggestions will be considered by the team with a view to supporting the staff to implement as many as possible unless there was good reason why not – even if the initiative only improved the experience of a couple of patients.

The next step will be for the entire ward to hear Sheila's story (either in person or video) and then they will need to respond and make improvements rather than an action plan arriving in an inbox. There has been a slight delay to this happening because of the service re-design work.

3 Recommendation

The Board are asked to note the contents of this report.

Author:	**Suzie Cro, Head of Patient Experience Improvement**
Presenting Director:	**Steve Hams Director of Quality and Chief Nurse**
Date	**4th December 2017**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – DECEMBER 2017

LEARNING FROM DEATHS

1 Aim

1.1 This paper demonstrates the Trust's progress to compliance with the National Guidance on Learning from Deaths.
1.2 Included is the first of the Quarterly reports to the open section of the Trust Main Board on the deaths reviewed at the Trust and learning from these.

2 Executive Summary

2.1 The National Guidance on Learning from Deaths and progress towards compliance was reviewed at the Trust Main Board in September 2017.
2.2 Monthly reports on progress against the National Guidance are taken to the Trust Quality and Performance Committee.
2.3 This paper includes an update on further progress towards compliance and the first report with respect to the data on the number of deaths reviewed and learning from these reviews.

3 Background

3.1 The National Guidance on Learning from Deaths (https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf) was published in March 2017. It stemmed from two key publications. The Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and by the findings of the CQC Report Learning, Candour and Accountability (December 2016 http://www.cqc.org.uk/content/learning-candour-and-accountability). They emphasised the need to develop a policy on learning from deaths, standardising the approach to these investigations and the importance of family engagement in the process.
3.2 Further guidance has been published by NHS improvement 'Implementing the Learning from Deaths framework: key requirements for Trust Boards'.
3.3 As a Trust we have had in place a key component of the Guidance (the Medical Examiner) for a number of years having been one of two national pilots for this work. This recommendation is due for full national implementation by April 2019. The development of the Bereavement office as the central point of death certificate issue and family contact remains a key component of our policy.
3.4 The most current national recommendation is to include deaths that arise from problems in care as part of this report.
3.5 Comprehensive progress against the Guidance is summarised in the action plan (Appendix 1).

4 Progress

4.1 We published our local policy with respect to learning from deaths as required on the Trust public access web site in September 2017 (http://glnt313/sites/ghnhsft_policy_library/WPP/A2217.aspx). Although we have not yet had any feedback on this policy, simultaneous to its publication national guidance has been produced. In the spring of 2018 we will review our guidance in line with this document, any other feedback and advice we have received.
4.2 Our policy includes a number of triggers to be used at a Trust level for initiation of a mortality review.
4.3 In the absence of a national database we have adapted our DATIX (incident reporting system) to log all deaths through the bereavement office. This team are also identifying deaths that trigger a review based on the trigger list. Mortality

reviews will be logged through this system which is structured in line with the Structured Judgement Review (SJR) process.

4.4 The Mortality Dashboard has been developed and is now being tested allowing specialities to identify deaths by speciality and individual Consultant.

4.5 All deaths of those with learning disabilities are reviewed as part of a multidisciplinary process using the LeDeR methodology.

4.6 All deaths of infants or children under 18 are reviewed on a countywide basis by a multidisciplinary team and published as part of the Annual Report for Child Death Reviews Gloucestershire Safeguarding Children Board

4.7 All perinatal deaths and maternal deaths are reviewed through our serious incident review process.

4.8 We are working to ensure our family involvement fulfils the letter and spirit of the Guidance. Families have the opportunity to raise concerns with the bereavement team when they visit to collect the death certificate. Our Duty of Candour team have a well-developed approach to family engagement including sharing the full findings of the investigation with the family. However we believe there are further opportunities for developing this aspect of our approach. In association with the patient experience team we are meeting with the Lead Governor and some families in the New Year to review our current approach and refine this. Changes will be incorporated within the new policy. In addition we are using our links with the Academic Health Science Network and other Trusts to learn for others.

4.9 We are broadening our Medical Examiner team to include front line clinical staff (currently exclusively undertaken by the pathologists).

5 Mortality Data

Period covered: Q2 2017/18 (July – Sept)

	Number	Learning	Good practice	Deaths that arise from problems in care
Total in hospital deaths	406			
Deaths reviewed Medicine	132 (71 by SJR)	Symptom observation charts should be utilised in palliative patients. Reminder that Parkinson's meds should be given on time. Reminder of recognition of sepsis NIV prescription chart important. COPD care includes repeat ABG at 1 hr. Consultant review of high risk patients – over 70 yrs with abdo pain. Careful handover to specialties.	Feedback to team in ED through newsletter	

		Patients in resus at the end of the night shift should be reviewed by ED senior after handover ABG when unable to obtain sats in critically ill patients Consider starting end of life care in ED for patients with terminal diseases		
Deaths reviewed Surgery	45 (0 SJR)	Palliative patients - clear plan required with regards appropriate opn. Better clarity re fitness for surgery	Palliative input All #NOF patients reviewed	
Deaths reviewed D+S	18 (6 SJR)	UP status revision - use new form. Readmission in 3 days of discharge monitor bloods before discharge Fluid balance for pt admitted with GI bleed and sepsis.	Timely antibiotic administration	
Total deaths reviewed (%)	195 (48% total 19% by SJR)			
Deaths reviewed by LeDeR*	11**	Lack of senior review (1 case) Missed fracture Planning of UP pre-hospital and in hospital for 2 Swallowing and weight loss	LD is team involved L Dis care plans in all patients Good palliative care (last 24h) for all 1 hour target met for IV antibiotics on admission	
Child deaths reviewed ***	38*		Multiagency review of all cases	
Perinatal and stillbirths	10			
Duty of Candour**	28	The themes arising from these reviews into patient deaths can be summarised as inpatient falls, premature discharge, delay to diagnosis and treatment.	Areas of good practice have also been identified including a dedicated and centralised	5 (+ 2 inconcl)

			investigation team for SI and moderate harm investigations. In addition all family members affected by these incidents are offered a meeting to discuss the investigation prior to completion of the report and after the findings have been shared.	

*LeDeR covers period Jan 2017 –Sept 2017
**Note data for Child deaths covers all deaths in health community in one year period. Learning complex and contained within full report
*** DoC covers whole year

6 Remaining Issues

6.1 We need to train more clinical staff to undertake SJR assessments. This is particularly true in the surgical division. A number of reviews are currently not carried out using this process. As the use of SJR becomes consistent across the Trust the identification of shortcomings in care that will be fed through the DoC process may identify more deaths that arise from problems in care.

6.2 Our database and mortality dashboard are new and needs close monitoring over coming months.

6.3 We need to develop our approach to family engagement.

7 Recommendation

To note the further development of our death review processes and the early accumulated data.

Author: Dr Sean Elyan

Presenting Director: Dr Sean Elyan

Date: December 2017

National Guidance on Learning from Deaths-National Quality Board
Executive Sponsor: Dr Sean Elyan, Medical Director
A Framework for NHS Trusts and Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

Recommendation	Trust Position	Development Required	Lead	Completion Date	RAG Rating
Board Leadership Mortality Governance should be a key priority for Trust Boards. Executives and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge. A lead Executive Director and Non-Executive Director should be identified to lead and provide scrutiny and oversight.	1. Lead Director - Medical Director. 2. Lead Non-Executive Director Chair of the Clinical Governance Committee. 3. Hospital Mortality Group (HMG) chaired by the Medical Director with multidisciplinary and Gloucestershire Clinical Commissioning Group representation. Reporting monthly to the Trust Quality and Performance Committee and to the Board via the NED chair of this group.	1. Briefing paper to the Board outlining the Trust's position and the new recommendation to include on a quarterly basis a paper and supporting data to the public Board meeting.	Dr Sean Elyan	April 2017	G
		2. Trusts should publish by September 2017 on the Trust public website, an updated policy on how it responds to and learns from, deaths of patients who die under its management and care.	Dr Sean Elyan	Sept 2017	G
		3. Changes to Quality Accounts regulations will require that the data providers publish will be summarised in the Quality Accounts from June 2018.	Dr Sally Pearson	June 2018	G
<u>Data Collection and Reporting</u> From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on	1. Head of Business Intelligence to provide deaths on a monthly basis to Chiefs of Service for distribution to specialities via Speciality Directors. 2. Mortality reviews completed by adult specialties using standardised	1. Reporting system now finalised to report deaths to clinical teams allowing easy identification of deaths under a particular Consultant or team.	Leilei Zhu Business intelligence	Nov 2017	G

deaths (Policy and approach by end of Q2 and publication of the data and learning points from Q3 onwards. The data should include the total number of the Trusts inpatients deaths (including emergency department deaths) and those deaths that the Trust has subjected to a case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged to have been due to problems in care	mortality proforma (structured judgement review) and reported through divisional governance process. 3. Data and learning to be reported to and reviewed at the Hospital Mortality Group. 4. The Board receives Integrated Performance Dashboard monthly including mortality indicators including Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR) and Standardised Mortality Ratio (SMR). Clinical Indicators requiring close scrutiny are reviewed at the HMG. 5. The Trust responds to and reviews any alerts raised by Dr Foster. 6. Initial investigations of unexpected deaths are reviewed by the Speciality Director and reported through the Divisional Governance process. 7. The Trust has in place an established Medical Examiner process through which all deaths have a high level review.	2. Database to collect and report outcomes of investigations has been developed in DATIX. This is now being used by the Bereavement team and will go into use by specialties for recording their outcomes from SJRs once the bereavement team are fully trained.	Andrew Seaton	October 2017	G

Responding to Deaths Incident Reporting and Investigation National Guidance on Learning from Deaths should be aligned to existing Serious Incident frameworks.	The Trust has in place a Risk Management Incident Reporting System (DATIX). The Director of Safety and wider Divisional teams reviews incidents daily. Staff report unexpected deaths via DATIX and are investigated using Root Cause Analysis methodology. 2. The Trust has in place a Serious Incident Policy. 3. All incidents clinical related incidents are uploaded to the National Reporting Learning Service on a weekly basis. 4. The Trust has in place a Duty of Candour and Being Open Policy. 5. The Trust has in place a Duty of Candour investigation and family liaison team.		Andrew Seaton	Completed	G
Skills and Training Providers should review skills and training to support the National Guidance with specialist training and protected time under their contract hours to review and investigate deaths to a high standard	1. The Trust has undertaken training in the use of the Structured Judgement Review (SJR) process with clinical teams. 2. The Trust is participating in a national research programme to investigate the comparative value of the Medical Examiner and SJR process. This will include training of a group of clinical staff in the use of the SJR.	A wider group of clinical staff require training in the use of the SJR	Pam Adams Trust Clinical Mortality Lead Co-ordinator Professor Neil Shepherd Lead Medical Examiner.	May 2018	A

Engagement with Bereaved Families and Carers Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.	1. The Trust has a centralised bereavement office through which all families obtain their death certificates and are offered support 2. The Trust has a bereavement service, specialist bereavement Midwife, Learning disability Nurses, Safeguarding Childrens lead, Adult Safeguarding lead, Heads of Nursing and Matrons. 3. The Trust has in place a Duty of Candour and Being Open Policy. 4. The Trust has in place a Bereavement Policy. 5. The Q+P committee has reviewed the current approach to family engagement and in conjunction with the Head of Experience and lay representatives will be undertaking a review of current provision and appropriate changes to the provision.	More work need to be done through the Patient and Family experience team including an engagement session with families and the Lead Governor.	Dr Sean Elyan	May 2018	A
Children and Young People NHS England is currently undertaking a review of child mortality review process both in hospital and Community. A National Mortality Database is	1. The Trust has Executive representation at Safeguarding Childrens' Board. 2. Statutory Policies and Procedures are in place. 3. Lead Paediatricians in place. 4. Multi-Agency Safeguarding Hub (MASH) arrangements in place. 5. Office for Standards in Education		Chief of Service Women's and Children's Division	Completed	G

currently being commissioned. Further guidance is expected in late 2017.	(Ofsted) and CQC reviews completed. 6. All child deaths in hospital are reviewed on monthly basis and reported as per guidance.				
Maternity Services Maternal deaths and stillbirths occurring in acute and community Trusts should be included by Trusts in quarterly reporting from April 2017. This will also include deaths that occur in local midwifery units, or during home births. The definition also covers up to 42 days after the end of pregnancy.	1. Women and Children's Division have in place a process for review of all maternal deaths. 2. Governance leads Policies and Procedures relating to neonatal and maternal deaths are in place. 3. Any unexpected death is investigated using Root Cause Analysis methodology. 4. These deaths are reported through the Divisional Governance process.		Chief of Service Women's and Children's Division	Completed	G
Mental Health Regulations require registered providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay.	1. The Trust is registered with the CQC to provide care to patients detained under the Mental Health Act and is fully compliant with notification and investigation requirements. 2. The Trust has in place a Mental Health Partnership arrangement with the local Mental Health provider. 3. Any unexpected death will be subject to Root Cause Analysis Investigation and reported to the CCG.		Steve Hams	Completed	G

Learning Disabilities There is unequivocal evidence that demands additional scrutiny be placed on deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review Programme. Once fully rolled out by NHS England, the programme will receive notification of all deaths of people with Learning Disabilities. This will support a standardised approach and trained staff will conduct the reviews.	1. The Director of Nursing sits on both Safeguarding Adult Board and Safeguarding Children's Board. 2. Learning Disabilities Nurses are in place. 3. Safeguarding Children's teams in place. 4. Safeguarding Adult lead in place. 5. All unexpected deaths are subject to a Root Cause Analysis Investigation and reported to the CCG. All deaths of patients on the Learning Disability Register are reported to the Gloucestershire LeDeR panel for external review.		Steve Hams	Completed	G
Cross System Reviews and Investigations	1. The Trust has agreed to with the STP clinical forum to undertake cross-service mortality reviews through this group under the Chairmanship of the STP clinical Lead 2. Mortality indicators and investigations are reviewed with commissioners through the Clinical Quality Review Group.	1. Methodology to identify patients dying after discharge from hospital not yet confirmed.	Dr Sean Elyan	March 2018	G

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title

ANNUAL REPORT ON THE TRUST'S EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ARRANGEMENTS

Sponsor and Author(s)

Author: Rachel Minett; Emergency Planning and Resilience Manager.
Sponsor: Caroline Landon; Chief Operating Officer

Executive Summary

Purpose

To provide assurance to the Board on the Trust's level of compliance with the national core standards for Emergency Preparedness Resilience and Response (EPRR).

Key issues to note

The Trust has demonstrated a substantial level of compliance against the national EPRR standards. This has been externally validated by Gloucestershire CCG and NHSE. This represents an improvement on the position last year.
Work in year has provided a more robust framework for the management and oversight of our response, including training and learning from incidents and exercises.

Conclusions

The Trust is substantially complaint with national core standards for EPRR, and arrangements are being formalised. A small non-recurring investment is required to maintain this status.

Implications and Future Action Required

The action plan will be monitored through the Emergency Planning, Resilience and Preparedness Group, to ensure that we continue to be compliant with the standards throughout the year.
A further report for assurance will be provided to the Board in November 2018.

Recommendations

The Board is asked to:

- Accept this report as assurance of the Trust's compliance with EPRR standards
- Agree the carry forward of £5k from 2016/18 to 2017/18 to maintain decontamination and emergency response kit.

Impact Upon Strategic Objectives

No specific impact although failure to meet the national EPRR standards would impact on the operational resilience of the trust during an emergency

Impact Upon Corporate Risks
No specific risk identified.
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
No specific patient group is affected by the issues addressed in this report.

Resource Implications			
Finance	x	Information Management & Technology	
Human Resources	x	Buildings	
Allocation of £5k non recurrently from an existing allocation requested			

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 & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					✓	Emergency Planning and Resilience Group (EPRG)
Outcome of discussion when presented to previous Committees						

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – DECEMBER 2017

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE 2017

1 Aim

To provide the Board with an update on the emergency preparedness activity since the last report (November 2016) and the position against the NHS Emergency Preparedness Resilience and Response (EPRR) core standards.

2 Background

Each year the Trust Emergency Preparedness Resilience and Response (EPRR) is reviewed through the NHS England assurance process. http://www.england.nhs.uk/ourwork/eprr/. The process is an evidence based internal self-assessment against nationally defined standards. This assessment is then reviewed by the relevant Clinical Commissioning Group (in our case Gloucestershire) and the local area team of NHS England.

The structure of this report follows the main headings of the National Standards.

3 Governance

3.1 Appendix 1 sets out our self-assessment against the national EPRR Standards. It is based on the position in August 2017. The national standards are detailed in the left hand column, followed by our assessment of the level of the evidence we have in place to demonstrate compliance. Green indicates evidence in place, amber, partial evidence and red, no evidence. The right hand column details the actions in place to improve compliance where required. At present NHSE have given a rating of substantial compliance for the standards overall, this is an improvement from last year. We are likely to remain amber for: fuel shortage plans and training due to staff turnover, however we have a rolling training program in place. Appendix 2 sets out our improvement plan.

3.2 Of note, PWC undertook a BCM audit in August with highlighted the gaps in our Business Continuity Management that we were already seeking to address, the audit process was a good opportunity to stand back and review and the report gives us good direction and action plan on which to focus. However the action plan dates were too aspirational and have been readjusted to make them more achievable.

3.3 This year's annual Chemical, Biological, Radiological, Nuclear (CBRN)audit gave us a red risk for low numbers trained able to respond, this has now been addressed and I am anticipating us to be compliant for the February 2018 audit. The dynamics for maintaining CBRN preparedness for the GHT and for Gloucestershire has changed with the reduction in the number of fire service Mass Decontamination units, putting a higher emphasis on local CBRN preparedness.

3.4 The Emergency Planning and Resilience Group (EPRG) meetings have structured agendas to address the main headings of the national standards. The governance for action cards and plans has been reviewed to give clarity to the process and the responsibilities of departments and divisions.

4 Maintenance of plans

4.1 A rolling timetable for reviewing plans is now in place, plans are reviewed annually unless otherwise stated or in line with incorporating lessons learned from exercises and incidents or changes in national guidance. This year we have:

4.2

- BCM plan will be reviewed to reflect recommendations from BCM audit.
- Major Incident plan reviewed, no significant changes.
- County wide Health IT resilience and incident response review.
- Reviewed The Pandemic Flu plan. This dovetails with our Infection Control plans and the Local Resilience Forum (LRF) plans.
- Updated the Adverse Weather Plan
- Updated the CBRN (Chemical Biological Radiation Nuclear) decontamination plan.
- Human Resources Business Continuity policy has been reviewed in line with and dove tails into the Local Health Resilience Partnership (LHRP) Mutual Aid Plan.
- Reviewed and combined Mass casualties P3 (walking wounded) with Mass Prophylaxis plan using the same pathway.
- Updated the Heatwave plan.

5 Command Control and Communication

5.1 The Local Health Resilience Partnership tests the incident notification cascade, through Exercise Bugle. This has now reduced to six monthly from monthly. This was tested with the Cyber-attack early in the year and through the recent Cheltenham area water outage.

5.2 With the review for the operational Silver and Gold training/workshops, on call operational guidance has been written and dove tails into the rolling Incident training.

5.3 The Next Generation Telecommunications project is now underway and it has been requested that an automated switch board alerting system be added as soon as possible.

6 Training, Exercising and Incident Reviews

6.1 An EPRR training matrix has been further reviewed in line with LHRP training matrix and reflecting training needs identified in the assurance process and health community. The majority of training is in house with multiagency training arranged locally for our LHRP and Local Resilience Forum (LRF).

6.2 This year the Emergency Planning Manager successfully completed BTEC level 3 Award in Education and Training and EMERGO Senior Trainer.

6.3 Exercises this year have included:

- Lockdown exercises for: baby abduction, moving a patient with suspected highly infectious condition and security risk scenario.
- Exercise Bugle - health community incident cascade test
- Chemical Biological Radiation and Nuclear (CBRN) and Hazardous Materials (Hazmat) team training 6 monthly internal. External Multiagency seminar and exercise.
- SWAST Ambulance emergency department major incident notification, exercise Connecting

- Exercise Prestbury Park. GHT Major Incident desk top exercise based on an incident at Cheltenham races.
- Internal command post exercise for a cyber-attack.
- Exercise Brimstone multiagency communicable disease exercise.
- Exercise Laithwaite multiagency Cyber exercise.
- Exercise Ashanti south west trauma network exercise.
- Internal Major Incident cascade exercise.
- Introduction Into Integrated Major Incident Management (IIEM) multiagency command and control for Silver and Gold.

This excludes individual departmental discussion/desk top exercises.

The learning from all exercises is reported to the EPRG using a standard template report. Learning points are reflected in the regular reviews of our plans or added to the action plan for the EPRG.

Appropriate staff now targeted for selection and training to support incidents. Requests for these staff will be made up as far as possible and appropriate proportionality from across divisions.

6.4 There are debriefs following all declared incidents. The findings are reported to the EPRG using a standard debriefing and report template that meets national guidance. Key themes, need for ongoing training, need for local ownership to local plans and action cards.

7 Resources

Last year the Board agreed to a non-recurring allocation of £25k to replace the CBRN specialist suits. Subsequent to this the Government agreed nationally to replace these suits. The Trust still needs to maintain all other decontamination and emergency response kit. The requirements will be driven by the recommendations of the audit of CBRN kit performed by SWAST. Some of the CBRN Kit is old and is likely to need replacing in 2018, this will be reviewed at the next CBRN kit check in February. It is recommended that £5k of the £25k identified for 2016/17 is carried forward to 2017/18 to meet these requirements.
Review of resources needed to support the Trusts EPRR requirements in relation to training, exercising and admin is to be undertaken in line with the recent service changes.

8 Recommendation

The Board is asked to:

- Accept this report as assurance of the Trust's compliance with EPRR standards
- Agree the carry forward of £5k from 2016/17 to 2017/18 to maintain decontamination and emergency response kit.

Author: **Rachel Minett Emergency Planning Manager**
Presenting Director: **Caroline Landon**

PUBLIC BOARD MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Financial Performance Report - Period to 31st October 2017
Sponsor and Author(s)
Author: Sarah Stansfield, Director of Operational Finance Jo Burrows, Director of Programme Management Sponsor: Steve Webster, Director of Finance
Executive Summary

Purpose

This report provides an overview of the financial performance of the Trust as at the end of Month 07 of the 2017/18 financial year. It provides the three primary financial statements along with analysis of the variances and movements against the planned position.

Key issues to note

- The financial position of the Trust at the end of Month 7 of the 2017/18 financial year is an operational deficit of £20.9m. This is a adverse variance to budget and NHSI Plan of £0.3m.
- No STF funding has been assumed in the actual position given that the Trust has not agreed a control total for the 2017/18 financial year.
- CIP delivery to Month 07 is £13.6m. This is £0.9m better than the plan for the year to date.
- The current CIP delivery forecast for the year is £23.4m as compared to a £34.7m plan.
- The divisional Month 7 forecast is for a £32.7m deficit outturn assuming no further action. This has not been accepted by the Executive and urgent action is being taken to mitigate this. With targeted improvements this would decrease to £28.6m.

Conclusions

- The financial position for M07 shows an adverse variance to budget of £0.3m. The adverse variance is reflective of material income under-performance with commissioners partially offset by pay underspends which are non-recurring.
- The underlying financial position remains adverse to plan.
- The Divisional Month 7 forecast is for a £32.7m deficit outturn assuming no further action. This has not been accepted by the Executive and urgent action is being taken to mitigate this. With targeted improvements this would decrease to £28.6m.

Implications and Future Action Required

There is a need for increased focus on financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trak.

Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.
Impact Upon Strategic Objectives
The financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Impact on deliverability of the financial plan for 2017/18.
Regulatory and/or Legal Implications
The variance to plan year-to-date of the financial position presented in this paper will continue to give rise to increased regulatory activity by NHS Improvement around the financial position of the Trust
Equality & Patient Impact
None

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 31st October 2017

LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

Gloucestershire Hospitals NHS
NHS Foundation Trust

Introduction and Overview

The Board approved budget for the 2017/18 financial year is for a deficit of £14.6m.

During April, as part of the detailed budget reconciliation and review process and in support of agreeing a reflective control total the profiling of Income, Expenditure and CIP was considered and it was concluded that the monthly outturn profiles should be changed, the outturn deficit of £14.6m was not changed. NHSI have allowed a resubmission of the plan to reflect this change but would not allow change to Q1. As such the plan and budget are consistent in profile from Month 4 onwards and this report reflects performance against the aligned budget and plan.

Statement of Comprehensive Income

2016/17 Outturn £000s	Month 7 Financial Position	Annual Budget £000s	M7 Cumulative Budget £000s	M7 Cumulative Actuals £000s	M7 Cumulative Variance £000s
433,665	SLA & Commissioning Income	439,649	252,182	248,387	(3,795)
4,604	PP, Overseas and RTA Income	4,734	2,677	2,601	(75)
66,388	Operating Income	61,984	36,320	36,342	21
504,657	**Total Income**	**506,367**	**291,179**	**287,330**	**(3,849)**
329,809	Pay	335,405	199,129	194,241	4,888
174,906	Non-Pay	160,696	98,127	101,101	(2,974)
504,716	**Total Expenditure**	**496,101**	**297,256**	**295,342**	**1,913**
(59)	**EBITDA**	**10,267**	**(6,077)**	**(8,012)**	**(1,935)**
(0.0%)	**EBITDA %age**	**2.0%**	**(2.1%)**	**(2.8%)**	**(0.7%)**
21,135	Non-Operating Costs	24,885	14,545	12,875	1,671
(21,193)	**Surplus/(Deficit)**	**(14,619)**	**(20,622)**	**(20,887)**	**(265)**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,619)**	**(20,622)**	**(20,887)**	**(265)**

In October the Trust has delivered an in-month deficit of £2.9m and a cumulative deficit of £20.9m

This represents a cumulative adverse variance to budget and plan of £0.3m as at Month 7.

The adverse variance is reflective of material income under-performance with commissioners partially offset by pay underspends which are non-recurring.

Within income there is a year to date favourable variance on pass-through drugs and devices of £0.4m.

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Annual Budget £000s	Month 7 Financial Position	M7 Cumulative Budget £000s	M7 Cumulative Actuals £000s	M7 Cumulative Variance £000s
439,649	SLA & Commissioning Income	252,182	248,387	(3,795)
4,734	PP, Overseas and RTA Income	2,677	2,601	(75)
61,984	Operating Income	36,320	36,342	21
506,367	**Total Income**	**291,179**	**287,330**	**(3,849)**
	Pay			
312,195	Substantive	184,597	178,690	5,906
6,516	Bank	4,427	5,744	(1,317)
16,694	Agency	10,105	9,807	298
335,405	**Total Pay**	**199,129**	**194,241**	**4,888**
	Non Pay			
55,539	Drugs	32,802	35,209	(2,406)
40,113	Clinical Supplies	23,912	23,908	4
65,043	Other Non-Pay	41,413	41,985	(572)
160,696	**Total Pay**	**98,127**	**101,101**	**(2,974)**
496,101	**Total Expenditure**	**297,256**	**295,342**	**1,913**
10,267	**EBITDA**	**(6,077)**	**(8,012)**	**(1,935)**
2.0%	**EBITDA %age**	**(2.1%)**	**(2.8%)**	**(0.7%)**
24,885	Non-Operating Costs	14,545	12,875	1,671
(14,619)	**Surplus/(Deficit)**	**(20,622)**	**(20,887)**	**(265)**
	STF Funding			
(14,619)	**Surplus/(Deficit)**	**(20,622)**	**(20,887)**	**(265)**

The table opposite shows the detailed income and expenditure position.

SLA and Commissioning Income – a £3.8m adverse position. This adverse variance is driven by a combination of budget phasing, the impact of block agreements, material under-performance with commissioners other than GCCG and Specialised Commissioners and risk assessment.

Private Patient Income – is broadly on track.

Pay – expenditure is showing a favourable variance of £4.9m against budgeted levels. This is largely driven by vacancy factor, combined with under-spends in divisions against budget profile and is further analysed in the pay section of this report. The under-spend has stabilised and is now static in the region of £4.9m.

Non-Pay – Drugs expenditure is showing a £2.4m adverse variance whilst Clinical Supplies are in line with budget. Other non-pay is £0.6m adverse of which £0.4m is a prior month increase to the bad debt provision.

Non Operating Costs – underspend is due to delivery of CIPs on depreciation, Interest Payable and PDC Dividend. This is reflected as part of CIP although is a non-cash saving for depreciation.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

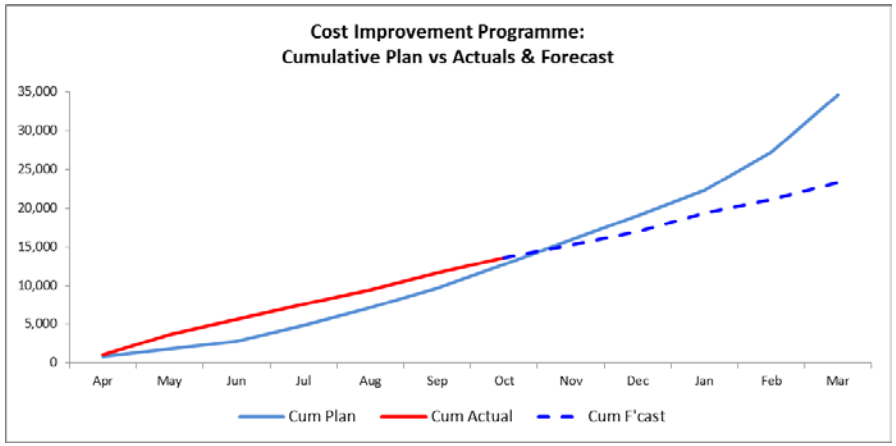
At Month 7 we have delivered £13.6m against the NHS Improvement plan target of £12.7m which is an overachievement of £0.9m against plan. The over performance this month is largely due to the vacancy factor as well as Agency Reduction.

At Month 7, the divisional year end forecast figures, indicate confidence in delivering £23.4m* against the Trust's target of £34.7m. The month 6 FYE was £23.3m, which shows an improvement of £100k. The improvement is mostly attributed to additional vacancy factor. *This does not include the additional CIPs and further measures.

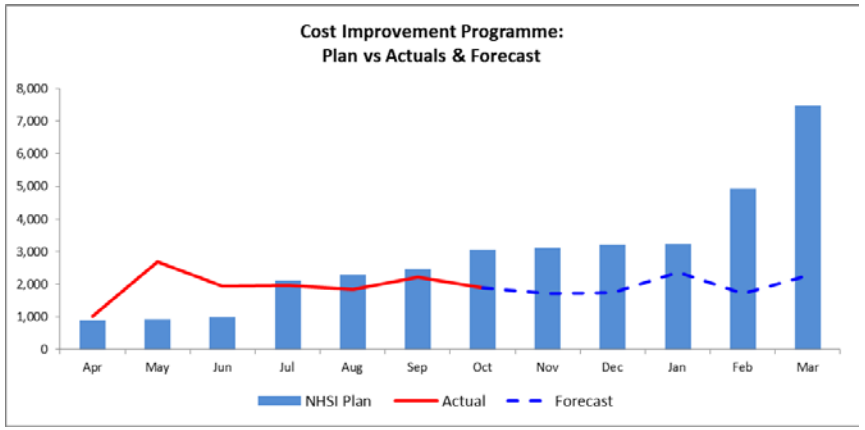
The FOT of £23.4m splits into £17,213 of recurrent schemes and £6,146 of non-recurrent schemes. This leaves a shortfall for 18/19 of £17.5m. The non-recurrent schemes include an agency scheme (no non-clinical agency over Christmas), annual leave accrual scheme and some vacancy factor.

The identified additional CIPs and further measures have begun to be delivered. A number of schemes are not in the FOT at month 7 as either further detailed planning is underway or mitigating schemes are being developed. Weekly deep dives with divisions, COO, Chief Nurse, Medical Director and Director of PM have been established to increase pace to year end.

The graph below highlights the cumulative actuals and forecast versus the cumulative NHSI cost improvement plan



The graph below highlight the in-month actuals and forecast versus the in-month NHSI cost improvement plan



Forecast Position

Gloucestershire Hospitals NHS
NHS Foundation Trust

£m	Continue M1-7 trend	Best Case	Realistic stretch	Downside
Plan	**(14.6)**	**(14.6)**	**(14.6)**	**(14.6)**
Month 6 base forecast		**(27.9)**	**(27.9)**	**(27.9)**
Additional CIP & further measures		**6.0**	**6.0**	**4.1**
Deployment of CCG NR funding to GHFT		**8.0**		
Income recovery/blocking lower then forecast		**(0.7)**	**(2.0)**	**(3.0)**
Winter pressures				**(1.0)**
Total M6 forecast	**(35.8)**	**(14.6)**	**(23.9)**	**(27.8)**
Income risk recognised		(2.8)	(2.0)	(2.0)
CQUIN - system risk reserve				(2.0)
Forecast (as to NHSI in November)		**(17.4)**	**(25.8)**	**(31.8)**
Movements - as per divisional forecasts				
£1.9m identified against £6m target		(4.1)	(4.1)	(2.2)
Cost pressures (as per P.10)		(2.9)	(2.9)	(2.9)
Total movement	**-**	**(6.9)**	**(6.9)**	**(5.1)**
Month 7 divisional forecast	**(35.8)**	**(24.3)**	**(32.7)**	**(36.8)**
CIP weekly deep dives - Week 1 anticipated improvement		1.1	1.1	1.1
Balance to £6m - not yet identified		3.0	3.0	1.1
	-	**(20.2)**	**(28.6)**	**(34.6)**
Variance to plan	*(21.2)*	*(9.7)*	*(18.1)*	*(22.2)*

The table shows the movements between the Month 6 and Month 7 forecasts in all three of the scenarios presented to NHS improvement as part of the ongoing FSM process. The Month 6 position showed a deficit range of between £14.6m and £27.8m.

Prior to meeting with NHSI in November 2 amendments were made to the M6 position:

- £2.0m of additional income risk recognised (higher in the upside scenario)
- £2.0m of CQUIN system risk reserve – discussions remain ongoing with CCGs around securing this income

The basis of the baseline income has been discussed at Finance Committee.

The divisional forecasts have currently only identified £1.9m of the £6m savings target and have recognised a further £2.9m of additional cost pressures over the prior month:

- Non-pass-through drugs and clinical supplies: £1m
- Increased medical staffing, particularly Medicine: £0.5m
- Increased use of premium work in Ophthalmology: £0.3m
- Increase nursing costs for higher acuity in Medicine: £0.3m
- Other non-pay pressures, including BI team and coders, VAT over-recovery, overseas recruitment: £0.8m

The restated deficit range, based on the amendments and the divisional positions, is £24.3m to £36.8m. Work remains ongoing as part of CIP deep dives to both increase delivery against the £6m and minimise the additional cost pressures. The table reflects the anticipated position after the first of the new deep dive sessions and presents the position, assuming that the gap to £6m is also bridged by the year-end (currently unidentified). This gives a final deficit range of £20.2m to £34.6m.

Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M7 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	8,425	1,032
Property, Plant and Equipment	296,272	294,674	(1,598)
Trade and Other Receivables	4,668	4,512	(156)
Total Non-Current Assets	**308,333**	**307,611**	**(722)**
Current Assets			
Inventories	7,400	7,560	160
Trade and Other Receivables	17,697	20,617	2,920
Cash and Cash Equivalents	7,974	3,473	(4,501)
Total Current Assets	**33,071**	**31,650**	**(1,421)**
Current Liabilities			
Trade and Other Payables	(44,355)	(50,652)	(6,297)
Other Liabilities	(2,089)	(4,781)	(2,692)
Borrowings	(5,356)	(5,355)	1
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(60,970)**	**(8,988)**
Net Current Assets	**(18,911)**	**(29,320)**	**(10,409)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,392)	220
Borrowings	(83,126)	(93,104)	(9,978)
Provisions	(1,524)	(1,524)	0
Total Non-Current Liabilities	**(92,262)**	**(102,020)**	**(9,758)**
Total Assets Employed	**197,160**	**176,271**	**(20,889)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	166,519	0
Reserves	70,501	70,501	0
Retained Earnings	(39,860)	(60,749)	(20,889)
Total Taxpayers' Equity	**197,160**	**176,271**	**(20,889)**

The table shows the M7 balance sheet and movements from the 2016/17 closing balance sheet, supporting narrative is on the following page.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 7 balance sheet position against the 2016/17 outturn

Non-Current Assets

- The reduction in non-current assets reflects depreciation charges in excess of capital additions for the year-to-date.

Current Assets

- Inventories show an increase of £0.2m. The movement reflects changes in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors.
- Trade receivables are £2.9m above their closing March 2017 level. Invoiced debt balances have decreased by £0.3m in month.
- Cash has reduced by £4.5m since the year-end.

Current Liabilities

- Trade payables have increased by £6.3m over the closing March level (a £4.0m increase on the month 6 level, but a return to month 5 levels).

	Cumulative for Financial Year		Current Month October	
	Number	£'000	Number	£'000
Total Bills Paid Within period	72,709	144,784	12,301	22,323
Total Bill paid within Target	62,725	119,433	10,630	18,808
Percentage of Bills paid within target	86%	82%	86%	84%

- BPPC performance is shown opposite and currently only includes those invoices that are part of the creditors ledger balance. Performance reflects invoices processed in the period (both cumulative and in-month) rather than the invoices relating to that period. It should be noted that whilst driving down creditor days as far as possible we are not compliant with 30 day terms across all suppliers.

Current Liabilities

- BPPC performance shows that in October the volume of invoices paid within the 30 day target has increased by 14%, in value terms there has been a minor decrease of 1%. Invoices are processed as they become due for payment – as such movements in BPPC are due to monthly fluctuations rather than active cash management.

- Other liabilities have fallen by £2.7m since year end. In October prepayments increased by £1.3m which relates to better information and analysis as this was previously reported as a reduction in creditors.

Non-Current Liabilities

- Borrowings have increased by £10m. A further £1.7m of distress financing to fund deficit support was drawn down in October. Total distress funding drawn to date is £12.9m against a deficit of £20.9m – the balance is being financed by improvement in working capital (combination of working capital available from GP training, income over and above I&E balances and creditor/accruals balances). We are forecasting that our distress financing will need to be at least equal to the I&E deficit before taking account of the capital loan before the end of year.

Reserves

- The I&E reserve movement reflects the year to date deficit.

Cashflow : October

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-17 £000s	May-17 £000s	Jun-17 £000s	Jul-17 £000s	Aug-17 £000s	Sep-17 £000s	Oct-17 £000s
Surplus (Deficit) from Operations	**(4,958)**	**(3,284)**	**935**	**(1,031)**	**(1,940)**	**(1,953)**	**(1,955)**
Adjust for non-cash items:							
Depreciation	946	1,719	975	975	975	975	975
Impairments within operating result	0	0	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0	0	0
Provisions	0	0	0	0	0	0	0
Other operating non-cash	(58)	(59)	(58)	(58)	(58)	(58)	(58)
Operating Cash flows before working capital	**(4,070)**	**(1,624)**	**1,852**	**(114)**	**(1,023)**	**(1,036)**	**(1,038)**
Working capital movements:							
(Inc.)/dec. in inventories	(150)	(1,118)	349	192	367	132	68
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(157)	633	379	1,940	(1,849)
(Inc.)/dec. in current assets	0	0	0	0	0	0	0
Inc./(dec.) in current provisions	0	0	0	0	0	0	0
Inc./(dec.) in trade and other payables	4,930	328	(2,109)	(530)	514	(3,132)	2,701
Inc./(dec.) in other financial liabilities	(562)	3,448	(58)	(181)	(129)	153	21
Other movements in operating cash flows	835	(995)	32	(31)	32	(79)	206
Net cash in/(out) from working capital	**(13)**	**2,863**	**(1,943)**	**83**	**1,163**	**(986)**	**1,147**
Capital investment:							
Capital expenditure	(148)	(989)	(348)	(214)	(909)	(608)	(1,636)
Capital receipts	0	0	0	0	0	0	0
Net cash in/(out) from investment	**(148)**	**(989)**	**(348)**	**(214)**	**(909)**	**(608)**	**(1,636)**
Funding and debt:							
PDC Received	0	0	0	0	0	0	0
Interest Received	4	3	2	3	3	3	2
Interest Paid	0	(162)	(42)	0	0	(1,329)	(29)
DH loans - received	0	0	0	2,355	0	8,864	1,664
DH loans - repaid	0	0	0	0	0	(1,318)	0
Other loans	0	0	0	0	0		0
Finance lease capital	(20)	(20)	(20)	(20)	(20)	(20)	(20)
PFI/LIFT etc capital	(181)	(181)	(181)	(181)	(181)	(181)	(181)
PDC Dividend paid	0	0	0	0	0	(3,091)	0
Other	0	0	0	0	0	0	0
Net cash in/(out) from financing	**(197)**	**(360)**	**(241)**	**2,157**	**(198)**	**2,928**	**1,436**
Net cash in/(out)	**(4,428)**	**(110)**	**(680)**	**1,912**	**(967)**	**298**	**(91)**

Cash at Bank - Opening	**7,539**	**3,111**	**3,001**	**2,321**	**4,233**	**3,266**	**3,564**
Closing	**3,111**	**3,001**	**2,321**	**4,233**	**3,266**	**3,564**	**3,473**

The cashflow for October 2017 is shown in the table opposite. The major movements are consistent with those already identified within income and expenditure and the balance sheet.

Key movements:

Inventories – Stock movements, other than at year-end, reflect movements in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors

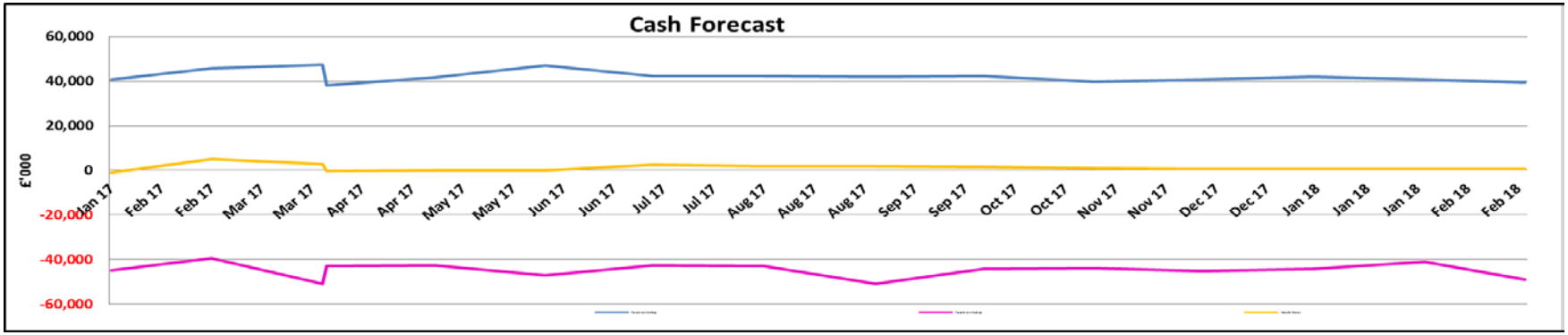
Current Assets – Invoiced debtor balances have increased in month, timely settlement of in-month SLA invoices offset by increase in Hosted Services income as a result of GP Payroll reporting issues.

Trade Payables – increased in month. Aged creditors shows increase in creditors below 30 days and a decrease above.

Short Term Cashflow Forecast

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Jan 17 £'000	Feb 17 £'000	Mar 17 £'000	Apr 17 £'000	May 17 £'000	Jun 17 £'000	Jul 17 £'000	Aug 17 £'000	Sep 17 £'000	Oct 17 £'000	Nov 17 £'000	Dec 17 £'000	Jan 18 £'000	Feb 18 £'000	Mar 18 £'000	Apr 18 £'000	May 18 £'000	Jun 18 £'000
Opening Balance	**7,979**	**5,340**	**11,637**	**8,199**	**3,423**	**2,565**	**2,614**	**4,494**	**3,773**	**3,702**	**3,473**	**2,715**	**2,654**	**2,654**	**2,654**	**2,654**	**3,014**	**4,456**
Receipts																		
SLA Income	34,026	39,046	35,382	34,272	35,547	35,363	35,140	36,121	35,184	35,303	34,486	35,235	35,374	35,235	35,235	35,180	35,180	35,180
Other NHS	4,607	5,117	6,675	2,545	4,176	9,305	5,294	4,318	4,641	5,482	3,289	3,959	4,889	3,789	2,389	4,780	4,830	4,830
STF Funding																		
Other Non-NHS	1,327	1,260	4,252	1,406	1,255	1,861	1,217	1,342	1,198	1,098	1,437	1,140	1,321	1,200	1,260	1,200	1,260	1,260
VAT	646	408	1,135	0	805	607	618	535	875	378	586	500	500	500	500	550	550	550
Funding	1,506	3	3	4	3	3	2,358	3	8,867	1,667	3,452	4,321	2,222	258	9,528	3	3	3
Total Receipts	**42,112**	**45,834**	**47,448**	**38,226**	**41,786**	**47,138**	**44,627**	**42,318**	**50,765**	**43,927**	**43,250**	**45,155**	**44,306**	**40,982**	**48,912**	**41,713**	**41,823**	**41,823**
Payments																		
Payroll	(25,455)	(25,792)	(25,968)	(25,509)	(26,052)	(26,263)	(25,793)	(26,302)	(26,603)	(26,198)	(26,052)	(26,225)	(26,020)	(26,020)	(26,225)	(25,950)	(25,950)	(26,150)
Payables	(16,159)	(13,226)	(18,447)	(15,116)	(14,322)	(18,298)	(14,317)	(14,202)	(16,049)	(14,871)	(15,408)	(16,648)	(15,855)	(14,362)	(16,723)	(13,230)	(12,032)	(15,032)
Other payables	(1,542)	(520)	(1,133)	(633)	(365)	(784)	(848)	(793)	(858)	(1,344)	(643)	(600)	(600)	(600)	(500)	(400)	(500)	(400)
NHSLA	(1,595)	0	0	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	0	0	(1,743)	(1,743)	(1,743)
Loan & Interest	0	0	(5,337)	0	(162)	0	(45)	0	(5,582)	0	(163)	0	(87)	0	(5,464)	(29)	(156)	0
Funding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**(44,751)**	**(39,537)**	**(50,886)**	**(43,001)**	**(42,645)**	**(47,089)**	**(42,747)**	**(43,040)**	**(50,835)**	**(44,156)**	**(44,009)**	**(45,216)**	**(44,306)**	**(40,982)**	**(48,912)**	**(41,353)**	**(40,381)**	**(43,325)**
Net Cashflow	**(2,639)**	**6,297**	**(3,438)**	**(4,776)**	**(859)**	**49**	**1,880**	**(722)**	**(70)**	**(229)**	**(758)**	**(61)**	**0**	**0**	**0**	**360**	**1,442**	**(1,502)**
Closing Balance	**5,340**	**11,637**	**8,199**	**3,423**	**2,565**	**2,614**	**4,494**	**3,773**	**3,702**	**3,473**	**2,715**	**2,654**	**2,654**	**2,654**	**2,654**	**3,014**	**4,456**	**2,954**
Reserved Funds																		
TrakCare	(2,808)	(2,808)	(2,808)	(2,808)	(1,514)	(1,514)	(974)	(902)	(829)	(829)	(829)	(829)	(829)	(829)	(829)	(829)	(829)	(829)
Other	(3,600)	(3,600)	(2,600)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)
'Available' Balance	**(1,068)**	**5,229**	**2,791**	**(485)**	**(49)**	**(0)**	**2,420**	**1,771**	**1,773**	**1,544**	**786**	**725**	**725**	**725**	**725**	**1,085**	**2,527**	**1,025**



Receipts; SLA income has been forecast based on recent trend and with a view of monthly contract values

Payments; Payables are built from recent trends and accounts for significant movements such as capital and project spend.

The table highlights future forecast funding requirements based on latest forecast.

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover Metric	(0.61)	(0.87)
Rating	4	4
Liquidity Metric	(20.64)	(26.72)
Rating	4	4
I&E Margin Metric	(7.16%)	(7.27%)
Rating	4	4
I&E Variance from Plan Metric	0.00%	(0.11%)
Rating		2
Agency Metric	48.63%	37.80%
Rating	3	3
Use of Resources rating	4	4

The Single Oversight Framework (SOF) has been developed by NHSI and replaces Monitor's Risk Assessment Framework and TDA's Accountability Framework. It applies to both NHS trusts and NHS foundation trusts. The SOF works within the continuing statutory duties and powers of Monitor with respect to NHS foundation trusts and of TDA with respect to NHS trusts. The framework came into force on 1st October 2016.

The performance reported here reflects that for M07.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee is asked to note:

- The financial position of the Trust at the end of Month 7 of the 2017/18 financial year is an operational deficit of £20.9m. This is a adverse variance to budget and NHSI Plan of £0.3m.
- The variance is reflective of both year to date pay underspends and phasing adjustments within the income position.
- The divisional Month 7 forecast is for a £32.7m deficit outturn assuming no further action. This has not been accepted by the Executive and urgent action is being taken to mitigate this. With targeted improvements this would decrease to £28.6m.

Author:	**Sarah Stansfield, Director of Operational Finance** **Jo Burrows, Director of Programme Management**
Presenting Director:	**Steve Webster, Director of Finance**
Date:	**November 2017**

REPORT TO MAIN BOARD – DECEMBER 2017

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

This report describes the business conducted at the Finance Committee held 29th November 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 and Cost Improvement Programme Update	Forecast range was shown: the stretch forecast has deteriorated because of £2.6m cost pressures, and a £4.1m shortfall against the £6m extra CIPs within divisional forecasts. This has not been accepted by the Executive, and corrective actions are underway.	Were there governance issues around the increased cost pressures? Can we be assured about the impact of additional action being taken?	The gap is largely around forecasting changes that have not yet taken place and some elements of the additional cost pressures forecast are capable of correction. The new approach to performance management of CIPs and financial management is already showing benefits and the Committee were assured that the executives are focused on it.	Forecast variability Executive focus.
Capital Programme Update	The additional loan requested from NHSI has not yet been confirmed. This has been escalated and a decision is expected shortly.			Unless rapid confirmation is received, mitigation planning will have to begin.
Workforce Update and E-rostering Business Case	The importance of improved rostering and improving internal bank arrangements to reduce agency was stressed.		The E-Rostering Business Case was approved and the Trust will move to Health Roster provided by Allocate. Reporting of actual benefits against expected benefits will be undertaken	

			routinely once the system is in place.	
Medical Productivity Update	The deep dive had revealed many challenges – a good quality report. The report showed a high proportion of job plans were out of date or not signed up, or at least not recorded as such.	Are we confident that the job plan reviews will take place in a robust way by the agreed date?	The existing governance approach around the delivery of this project has been changed to incorporate it within the weekly CIP deep dives with the input of the Medical Director.	The full benefit has not been quantified and won't be until job planning is complete.
Progress Update on Contracting	A briefing on the activity and income versus plan and how this is being affected by TrakCare and other factors was given alongside the approach to contracting for 2018/2019.		The TrakCare related improvements to income will be managed through the SmartCare Programme Board.	
Theatre Managed Equipment Service	The Committee noted the actions taken to reduce the risks around the theatres managed service and the contract improvement. The Committee remain content to proceed.			
Finance Committee Work Plan	An update on cash forecasts was added to the work plan for December, potentially to			

	be included as an addition to the Month 8 Finance Report.			
Matters to be Escalated to the Board	None were noted.			
Governors Comments	Interest in the discussion around Safe Staffing and the vacancy freeze: this was highlighted as a topic of interest to governors. Positive to see the granularity of detail in the medical productivity report.			
Papers for Circulation to Governors	None were noted.			
Committee Reflection	Executive level meeting but not unusually so with good questions and lines of enquiry. High performing with good challenge and attendance.			
Any Other Business	An update on the TrakCare deep dive was provided.			

PUBLIC BOARD MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Workforce Report
Sponsor and Author(s)
Author: Emma Wood, Deputy Chief Executive and Director of People Sponsor: Emma Wood, Deputy Chief Executive and Director of People
Executive Summary

Purpose

This report presents progress against the Workforce Strategy

Key issues to note

- The development of a detailed KPI Matrix and reporting cycle has provided a framework for the Workforce Committee to measure progress against the Workforce Strategy.
- Agency expenditure continued its downward trend reducing by £150k in month 6, including a £110k reduction in Medical Agency costs and a further reduction in Nursing of £54k, offset by a small increase in 'Corporate'. This maintains the year on year reduction of 26% in agency costs. The governance structure for agency control is being revised to see closer alignment of the key medical and nursing workforce work streams.
- The pay bill also witnessed a £310k reduction of which £100k was on substantive staff costs, reversing the trend of the prior month. Whilst significantly within the original pay budget, the current spend levels are significantly over the planned for run-rate at the end of the year and thereby requiring swift action. The VCP is being refreshed to recognise the challenge of reducing recruitment in the last third of the year, supported by a full Quality Impact Assessment process.
- Staff engagement sessions continue with a particular current emphasis on SubCo and ensuring that staff have the opportunity to find out first-hand about proposals and to receive consistent and accurate answers to their questions.
- A session on improving Medical Staff engagement is planned for December with LNC members.
- Appraisal rates continue to give cause for concern. November's figures (not yet received) are expected to improve however not to the mandated standard.
- Staff survey response rates are encouraging and now need to be built upon.

Conclusions

Reductions in Agency expenditure and control of pay remain encouraging however require further traction if the benefits are not to dissipate. Key to this is the collaborative working between the Director of Quality and Chief Nurse and the Medical Director.

Implications and Future Action Required

- Publishing but more importantly, delivering the new governance structure for agency oversight, which combines the two key clinical work streams.
- Publishing and implementing the revised VCP process to support the challenge on appropriate recruitment levels between now and year end.
- Providing maximum opportunities for Estates and Facilities staff to hear about proposals for the establishment of a SubCo and to maintain the integrity of the published Q+A.
- Plan the desired outcomes and terms of reference for the key medical engagement event in December
- Continue to positively promote participation in the annual staff survey.
-

Recommendations
The Board. is asked to note the positive trends illustrated in the enclosed report
Impact Upon Strategic Objectives
It remains of critical importance that we continue to operate within our financial envelope, reducing agency expenditure and recruiting to establishment as appropriate. Improving engagement is a key strategic objective and underpins all aspects of performance
Impact Upon Corporate Risks
Agency expenditure is currently rated as one of the Trusts highest risks to achieving financial balance.
Regulatory and/or Legal Implications
NHSi will continue to scrutinise our performance, particularly in relation to medical agency spend
Equality & Patient Impact
n/a

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			✓			
Outcome of discussion when presented to previous Committees						

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – DECEMBER 2017

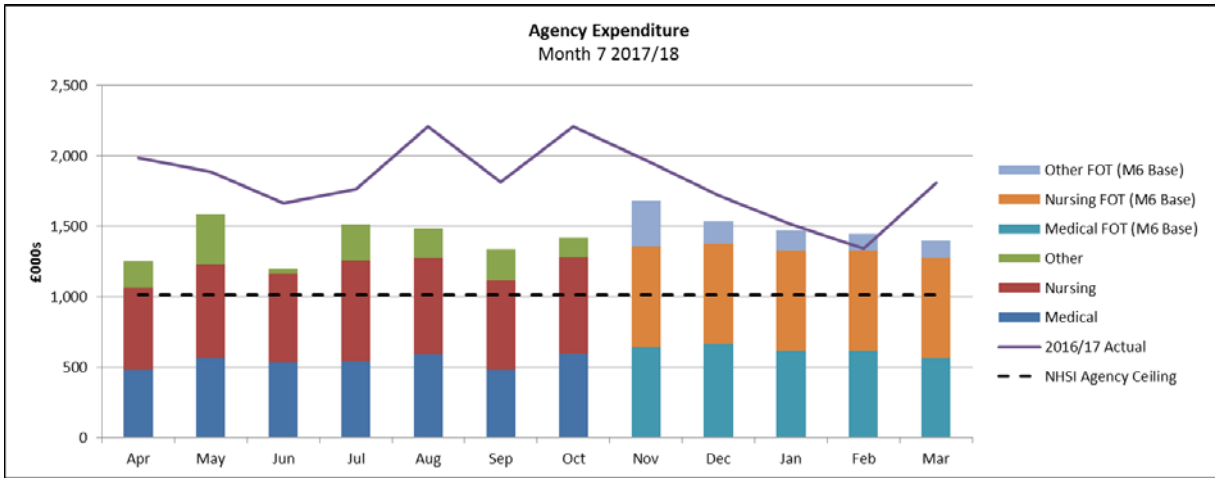
WORKFORCE REPORT

1. Aim

This report provides Trust Board with an overview of current performance, against the existing key performance indicators and outlines the renewed priorities for delivery over the next 6-12 months.

2. Agency Expenditure

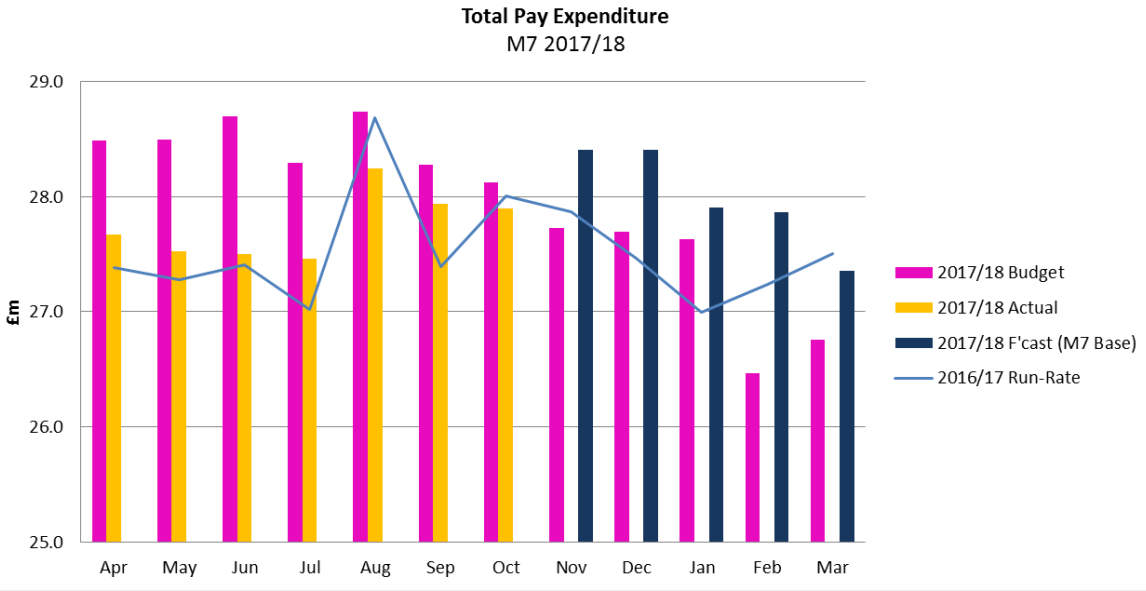
Month 7 saw an increase in agency expenditure by £80K however we continue to spend significantly less than in the 2016-17 financial year; reflecting a reduction of circa £3.7m in comparison to the 2016/17 run rate. With effect from 20th November, The Temporary Staffing team moved under the portfolio of Stave Hams, Executive Director of Quality and Chief Nurse. This move will help to facilitate greater alignment between Temporary Staffing and Rota Management going forward.



3. Pay Expenditure

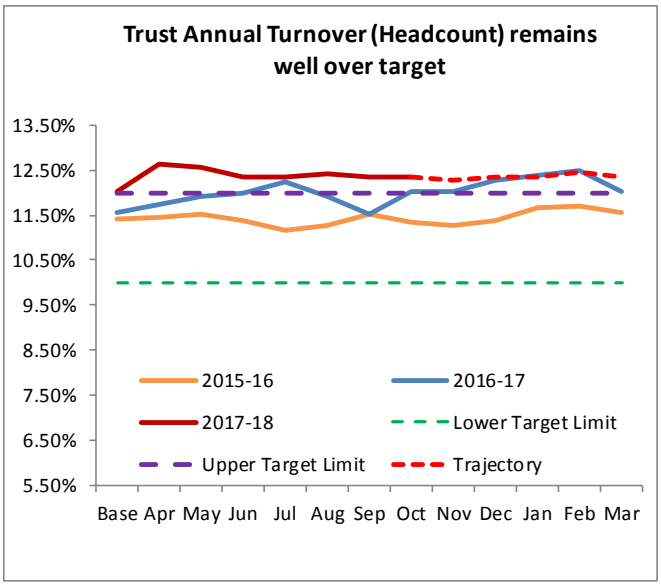
The positive, downward trend we observed this financial year stabilised in M7, with a total reduction of £50K, with Hosted Services observing a £40k reduction. The the variation between Actual and Budget positions has now reduced significantly; we expect to see this position deteriorate over the remainder of the financial year.

With effect from 15th November a recruitment freeze has been applied to recruitment activity until 31 March 2018. Vacant posts will be frozen; unless there are significant intolerable risks to either safety or reputation which suggest the decision needs to be otherwise. We anticipate this will realise a further £1m in CIP.



4. Turnover

The Trust turnover target was previously set at 9.50%. This target is significantly below turnover our Trust has experienced in recent years. The UK average labour market turnover sits at 15% (across all sectors). Our local benchmarking with other Acute Trusts suggests that average turnover sits between 11-13%; however these figures must be interpreted with caution due the variation in method when calculating turnover and inclusion/ exclusion of different staff groups. It is proposed that we set a revised target band, between 10-12% which whilst remaining aspirational provides a more flexible and pragmatic approach to measuring performance. Current performance is higlighted below:

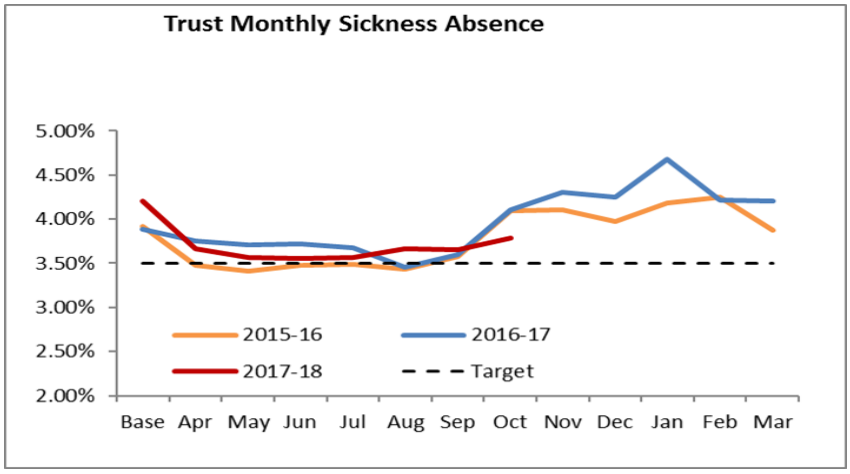


Current Performance		Movement since last Month	
12 months to October 17	Actual % TO		
Trust Total	**12.36%**	↗	increase
Corporate	14.38%	↘	decrease
Diagnostics & Specialty	11.09%	↘	decrease
Estates & Facilities	7.63%	↗	increase
Medicine	13.90%	↘	decrease
Surgery	12.60%	↗	increase
Womens & Children	13.63%	↗	increase
Add Prof Scientific and Technic	7.72%	↗	increase
Additional Clinical Services	15.61%	↘	decrease
Administrative and Clerical	14.55%	↘	decrease
Allied Health Professionals	12.56%	↘	decrease
Estates and Ancillary	8.57%	↗	increase
Healthcare Scientists	11.98%	↘	decrease
Medical and Dental	7.48%	↘	decrease
Nursing and Midwifery Registered	11.31%	↗	increase
Staff Nurses	12.34%	↗	increase
Significantly above upper target limit (>15%)			
Above upper target limit (12%)			
Within target or below (10%)			

The Divisional and Professional Group analysis indicates areas of exception. In particular we observe high levels of turnover in 'Additional Clinical Services' staff (predominantly HCA's). Further work will be commissioned in collaboration with Nursing, HR and the Trust Improvement Academy in the New Year to investigate the root causes of high turnover within this staff group and finalise recommendations for improvement.

5. Sickness Absence Management

The Trust annual sickness absence rate of 3.92% remains **lower than the national average** for Large Acute Trusts (4.39% to Jan 17). Long term absence accounts for approximately half of the absence recorded.



Description	Current Performance			Sickness Absence by month							
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% w ith the red threshold 0.5% above this figure. Target is set annually by HR Director	12 months to Oct 17 (Annual)	**Actual**	**KPI**	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Movement Sep to Oct	
		% Abs	**% Abs**								
	Trust Total	3.92%	3.50%	3.57%	3.56%	3.57%	3.67%	3.65%	3.79%	↗	increase
	Corporate	3.92%	3.50%	3.65%	3.41%	3.74%	3.88%	3.88%	4.33%	↗	increase
	Diagnostics & Specialty	3.69%	3.50%	3.32%	3.85%	3.42%	3.67%	3.53%	3.83%	↗	increase
	Estates & Facilities	4.54%	3.50%	4.09%	3.91%	3.82%	3.96%	4.11%	3.71%	↘	decrease
	Medicine	3.68%	3.50%	3.26%	3.08%	2.79%	3.05%	3.22%	3.85%	↗	increase
	Surgery	4.09%	3.50%	3.93%	3.82%	4.05%	3.81%	4.04%	3.76%	↘	decrease
	Womens & Children	4.01%	3.50%	3.40%	2.97%	3.78%	3.99%	3.17%	3.15%	↘	decrease
	Add Prof Scientific and Technic	3.87%	3.50%	4.70%	3.56%	4.79%	4.31%	2.78%	2.31%	↘	decrease
	Additional Clinical Services	4.78%	3.50%	3.81%	4.56%	4.36%	4.64%	4.72%	4.98%	↗	increase
	Administrative and Clerical	4.29%	3.50%	4.12%	4.02%	4.21%	3.73%	3.68%	3.86%	↗	increase
	Allied Health Professionals	2.93%	3.50%	2.02%	3.08%	3.26%	3.14%	3.25%	3.03%	↘	decrease
	Estates and Ancillary	4.46%	3.50%	3.97%	4.09%	4.13%	4.17%	3.97%	3.91%	↘	decrease
	Healthcare Scientists	2.86%	3.50%	2.30%	2.43%	1.50%	2.66%	3.80%	3.34%	↘	decrease
	Medical and Dental	1.75%	3.50%	1.93%	1.79%	1.40%	1.28%	1.68%	1.51%	↘	decrease
	Nursing and Midw ifery Registered	4.22%	3.50%	3.93%	3.42%	3.56%	4.03%	3.88%	4.31%	↗	increase

6. Appraisals and Mandatory Training

We observed a positive upward trend in appraisal compliance in month, with exceptional results in EFD

Mandatory training figures are less positive and whilst close to the 90% target we remain in a stable position at 88%

Appraisals	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Movement since last Month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate	82%	83%	80%	82%	86%	82%	82%	75%	76%	77%	77%	80%	↗	increase
Diagnostics	86%	86%	87%	88%	88%	86%	84%	84%	83%	83%	83%	85%	↗	increase
Estates & Facilities	76%	76%	77%	77%	74%	63%	60%	59%	60%	68%	72%	94%	↗	increase
Medicine	75%	74%	74%	77%	79%	78%	79%	79%	79%	78%	77%	81%	↗	increase
Surgery	79%	80%	81%	83%	82%	80%	79%	78%	80%	79%	77%	79%	↗	increase
Women & Children	78%	77%	78%	80%	78%	77%	81%	83%	82%	81%	80%	85%	↗	increase
Trust	**80%**	**80%**	**80%**	**82%**	**82%**	**80%**	**79%**	**78%**	**79%**	**79%**	**79%**	83%	↗	increase

Mandatory Training	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Movement since last Month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate excl Bank	92%	92%	92%	92%	92%	92%	92%	92%	92%	91%	91%	90%	↘	decrease
Diagnostics	95%	94%	94%	94%	94%	94%	94%	94%	93%	93%	93%	92%	↘	decrease
Estates & Facilities	88%	90%	89%	88%	89%	87%	83%	80%	85%	88%	86%	86%	→	stable
Medicine	87%	88%	88%	88%	89%	89%	89%	89%	88%	88%	87%	86%	↘	decrease
Surgery	89%	89%	90%	90%	90%	90%	91%	91%	90%	90%	90%	89%	↘	decrease
Women & Children	88%	88%	88%	89%	89%	88%	88%	89%	89%	88%	88%	87%	↘	decrease
Trust	**89%**	**89%**	**89%**	**89%**	**90%**	**89%**	**89%**	**89%**	**89%**	**89%**	**88%**	**88%**	→	stable

7. Staff Survey

The staff survey launched at the beginning of October and at the time of writing (end of week 4) the headlines are as follows;

National Picture

- ✓ As at 27th October, the national mean response rate for all Trusts using Quality Health was 28%. Acute Trust average was 27%. **Gloucestershire Hospitals NHS Foundation Trust** was **32%**. [Source: Quality Health]

Divisional Picture

- ✓ Highest response rate in numbers: **Diagnostics & Speciality [737]**
- ✓ Highest response rate in % terms: **Corporate [53%]**

Team Picture

- ✓ Best performing teams in % terms to date: **Patient Experience [94%], Finance Shared Services [91%]**

Staff Group picture

- ✓ Highest response rate in number: **A&C [729]**

  Highest response rate in % terms: **Healthcare Scientists**

8. Readjusting Priorities

The current Workforce Strategy describes 9 areas under which activity is being managed and led to deliver noted outcomes.

This suggested plan of activity supports the Workforce Strategy but focusses on the areas the newly appointed Deputy Chief Executive and Director of People and OD believes will add most value to performance recovery.

Commitments made in the Workforce strategy will continue and a twice yearly report will provide assurance of this, however short term focus (6-12 months) is suggested on the following:

9. Workforce

The Trust holds data regarding establishment in ESR and on the purchase ledger. This data does not match and an agreed funded establishment remains unclear. By driving a review of establishment need versus budget and agreeing a baseline funded position financial control would be improved as would workforce planning and design. Services, such as recruitment,

education, learning and development could be proactive (and longer term orientated) rather than reactive.

This programme of work will entail a review of data held by HR, finance departments and engagement with service lines on models of staffing, patient safety requirements and need. It is accepted that the Trust is in perpetual change with local changes and system changes, however, establishing a baseline for a moment in time which could be adapted accordingly would be useful.

A fixed term programme lead will be appointed by January 2018 and will work with finance, HRBP's and their service leads to commence the review for a number of months initially.

Alongside this data cleanse and base line reconfiguration a long term modelling exercise for key roles establishing supply routes and demand has commenced to assess what further activity may be required to deliver on our workforce needs.

Further it is imperative that the Trust considers alternative workforce pathways which support our services. Funding for career pathways have been negatively impacted over the years however there are opportunities in advanced clinical practice and apprenticeships, both of which could positively support our delivery of services and create alternative roles to meet workforce supply issues.

The Workforce Committee would be able to take assurance that our data will be accurate and will inform future planning.

10. CIP Delivery

It is incumbent on the People and OD function to consider future CIP's via departmental efficiencies and organisational change.

New models of workforce could offer CIP if alternative roles to traditional posts can be developed, such as Advanced Clinical Practitioners or further use of AHP's. Whilst long term in nature creating a sustainable workforce and improved planning could deliver CIP and new career pathways.

Improved supply and targeting of key staff groups would also add financial gains where staff are identified earlier thereby reducing agency and bank spend.

Control of agency, temporary staffing and bank will continue and the People function will assist in the drive to re balance agency use to internal banks.

The Workforce Committee would be able to take assurance that CIP is a core part of any decision making for any new and existing roles and temporary cover.

11. Reducing bureaucracy and creating efficiencies

In creating efficiencies and adding value a key programme of work is the design and delivery of SubCo which is under the Executive leadership of the Deputy Chief Executive and Director of People and OD. A Programme Board has been established to oversee the delivery of key items divided amongst 5 sub-groups shown in **Appendix 1**.

Given the enormity of the staff change it would seem prudent that the Workforce Committee is kept abreast of activity to provide assurance to the Board that matters relating to consultation and specifically TUPE has been adequately provided.

On a more departmental level the People and OD function must look to streamline process, refine policy to declutter and reduce bureaucracy. It must be a service fit for purpose without duplication. A review on opportunities to improve service provisions delivery will be a priority within the next 6 months.

The Workforce Committee would be able to take assurance that the People and OD function is providing the best and most efficient service to the organisation.

12. Talent Development

A system of talent management and succession planning should be designed within 6 months. Any design should enable the creation of talent pools and an easy means to fill vacancies, succession plan, address secondment opportunities and focus initiatives such as learning and development opportunities effectively.

The principle of meritocracy will pervade, as will the ability for staff to be both recommended as 'talent' and also 'staff identity.'

An improved link to appraisal and a shift from appraisals being a means to performance management alone to being one where it is also about a career conversation will need to be considered.

The Workforce Committee would be able to take assurance that initiatives deliver the leadership and reward and retention strategic ambitions.

13. Staff Health & Wellbeing

A new emphasis on diversity has commenced and this should remain a key focus to ensure all our staff are embraced and reflect the patients we serve.

Our operational dashboard provides us with data on why staff are not at work. The two greatest causes are MSK and psychological issues. The Trust has many channels of support however the accessibility of these and our response to immediate need seems challenging. A review of services will commence to determine if more can be achieved within our financial envelope.

The Workforce Committee would be able to take assurance that our Support Services for staff health and wellbeing are sufficient in terms of breadth and demand.

14. Staff Engagement

The Trust prides itself in open and transparent communication, two way feedback and listening. Staff are actively encouraged to contribute to the Trust decision making and have a voice.

With so much change and information sharing the Trust must be certain that two way feedback is preserved and all opportunities to capture staff opinion noted and exploited. With this in mind a review of staff engagement models will be undertaken to see if we can build upon our current practice.

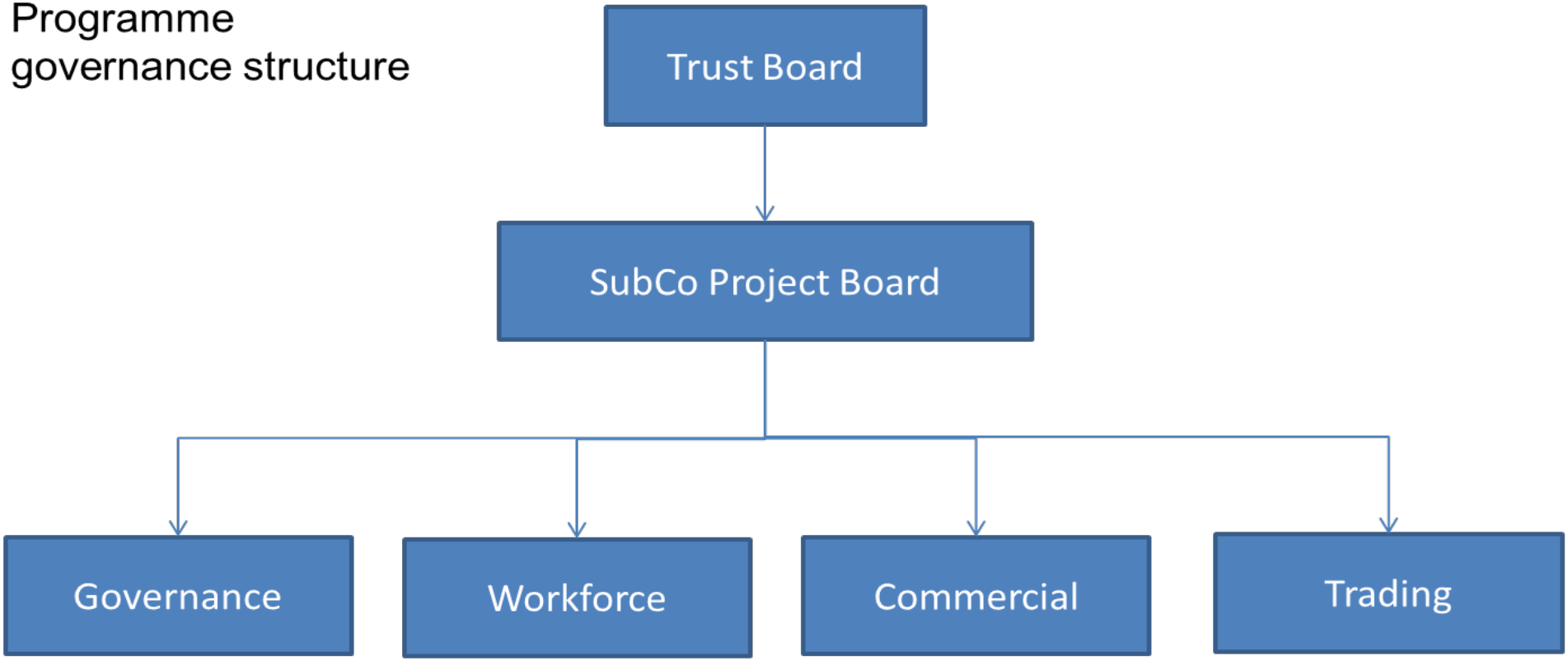
The Workforce Committee would be able to take assurance that staff have the opportunity to be involved and that their voice is heard throughout the organisation.

Conclusion

The Board are asked to **NOTE** this refocus and **ENDORSE** the priorities going forward.

Author: Emma Wood, Deputy Chief Executive and Director of People
December 2017

Programme governance structure



Chair: Lukasz Bohdan, Director of Corporate Governance

Key tasks:

- Establishing company and structures
- SubCo Board governance structure
- Due diligence

Chair: Alison Koeltgen Acting Deputy Director of People

Key tasks:

- Policies
- Consultation
- Comms and Engagement

Chair: Steve Webster, Director of Finance

Key tasks:

- Service Level agreements and KPIs
- Managed Healthcare Facilities agreement
- Corporate support agreement

Chair: Neil Jackson, Director of Estates and Facilities

Key tasks:

- Supply chain transfer
- SubCo internal arrangements

REPORT TO MAIN BOARD – NOVEMBER 2017

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

This report describes the business conducted at the Workforce Committee on 10th November 2017 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Workforce Dashboard	The Committee took assurance that appraisals were improving and that turnover and sickness are stable. Agency spend is decreasing, as is pay.	No current reporting on future trajectories.		Future trajectories and how these will be actioned by the department will be presented going forward, specifically year end forecast.
Temporary staffing Report	A 7 day a week office is now open and is having traction within the organisation.	No current reporting on future trajectories.		Quality of reporting and specifically year end forecast.
Education Report	Education pathways and apprenticeship advanced clinical progress were noted.	Educational pathways are not linked to a workforce plan because there isn't one.	There is a great deal of activity but no real link to achievement of a strategy.	
Reward Strategy	The Committee decided not to progress the reward strategy and include reward in attraction and retention strategies and programmes of work.			

Medical Productivity	Commitment to break down the silos between nursing and medical and combine to discuss clinical matters.	Much further scope for savings but only if the basis is changed to a clinical productivity.	Progress is underway around Multi-disciplinary team meetings.	
Work plan	The Committee acknowledged that a number of new strategies were required including Health and Wellbeing, a workforce plan, and a talent strategy which should be presented in Jan/ Feb 2018.		The Committee endorsed the revision of the workforce strategy.	A revised work plan will be received at the next Committee.
Questions to Ourselves		Are we clear how we are supporting the Workforce strategy and meeting KPI's? How are we delivering against short term financial rigours and quality initiatives? Have we clearly identified risk?	As they currently stand but this will be amended moving forward. The group were unsure whether this was an appropriate question for the Committee. Yes.	

REPORT TO MAIN BOARD – DECEMBER 2017

From the Audit and Assurance Committee Chair – Robert Graves, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee held 7th November 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
Head of Counter Fraud Report	Updated the committee on - National initiatives including unidentified fraud and Anti Bribery Act compliance - Current awareness activity - Current cases under investigation	What is the process to identify the extent to which our Trust experiences unidentified fraud in the light of the latest national announcement? Are appropriate links made between the Anti-Bribery Act requirements and our Gift and Hospitality Policy? How will the 3 amber rated assessments on the Self Review be improved to green?	The Head of Counter Fraud will investigate this further considering evidence of missed fraud instances and the cost effectiveness of further measures Procedures are in place in procurement to ensure compliance The Head of Counter Fraud described the steps being taken to achieve a 100% green assessment	

Internal Audit	The Internal Audit team reviewed - Overall progress - Business continuity management report - HR Visas and immigration report - Core financial systems report - CIP report - Shared Services Contract management report - Non-Medical Prescribing report	Why is there inconsistency in the approach to incorporating management responses?		Opportunity identified to achieve consistency of approach and clarity between recommendations and agreed actions
Recommendation Tracker	Reviewed the absolute numbers of outstanding items	Why has the number increased?	Now under regular review – actions in hand to address	
Reports from the Finance Director	Received reports covering Losses & Compensations, Debtors and associated write-offs, Single tender actions			
Job Planning and Medical Productivity Update	The Medical Director reported on the deployment of the job planning process which is achieving positive results where applied	How will this be deployed more widely?	This is work in progress	To be kept under review

External Audit	The new External Audit team described their approach and process			
Trust Risk Register	Overview of the evolving risk identification and management process	How should the committee be kept informed of progress and the current situation? How is the cyber security risk captured (it does not appear on the Trust Risk Register)?	Formal report to the committee twice a year Risk held at IM & T level Main Board seminar to receive wide ranging IM & T update	
Clinical Audit Report	Overview of Clinical audit reporting	What is our specific process to receive assurance?	Formal report to be prepared twice a year	Content to be agreed with Director of Safety

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title
Chief Executive's Statement on Anti-Bribery
Sponsor and Author(s)
Authors: Lee Sheridan, Head of Counter Fraud Sponsor: Deborah Lee, Chief Executive Officer and Lukasz Bohdan, Director of Corporate Governance
Executive Summary
Purpose There is no mandatory requirement for the Trust to have a statement by the Board on anti-bribery. However, in accordance with the Bribery Act 2010, the organisation could be liable if a senior person within the Trust commits an offence under the Bribery Act as this person's activities would then be attributed to the organisation. Further offences could be committed if an employee/agent/contractor pays a bribe specifically to get business or gain a business advantage on behalf of the Trust. However, the organisation would have a full defence and avoid criminal action if it could show they had adequate procedures in places to prevent bribery. In order to rely on a defence, the Trust would need to demonstrate that they had fully communicated and reinforced the message to staff/contractors that bribery is not tolerated. Bribery is currently covered by the Trust through the induction programme and other ad-hoc fraud awareness presentations. The organisation also has a Counter Fraud policy which is cross referenced in the Trust's SFI's. NHS Counter Fraud Authority guidance on the Bribery Act now also recommends that the Trust's Chief Executive should make a statement in support of anti-bribery. It is common practice for NHS organisations to publish anti-briber statements via their websites.
Recommendations
It recommended that this statement is now adopted by the Trust and published on the Trust's intranet and public facing internet sites. The Trust should consider cascading this statement via This Week and Outline. The anti-bribery statement will also be included within every tender exercise through Procurement or other departments and in the contractors' annual induction programme (a requirement for every external contractor undertaking activity on Trust premises). The Trust's Purchase Order template will be revised referencing the Bribery statement.
Impact Upon Strategic Objectives
Anti-bribery statement supports good governance and, in turn, delivery of the Trust's Strategic Objective.
Impact Upon Corporate Risks
Not applicable.

Regulatory and/or Legal Implications							
Not applicable.							
Equality & Patient Impact							
Not applicable.							
Resource Implications							
Finance				Information Management & Technology			
Human Resources		x		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 & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
		November 2017				
Outcome of discussion when presented to previous Committees						
The Audit and Assurance Committee endorsed the Statement and recommended the Statement be approved by the Board.						

ANTI-BRIBERY AND CORRUPTION STATEMENT: OUR COMMITMENT

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) is committed to applying the highest standards of ethical conduct and integrity in its business activities. Every employee and individual acting on behalf of GHNHSFT is responsible for maintaining the organisation's reputation and for conducting GHNHSFT's business lawfully and professionally.

The Trust defines bribery as a financial advantage or other reward that is offered to, given to, or received by an individual or company (whether directly or indirectly) to induce or influence that individual or company to perform public or corporate functions or duties improperly. Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event. Employees and others acting for or on behalf of the organisation are strictly prohibited from making, soliciting or receiving any bribes or unauthorised payments. Employees and other individuals acting for the organisation should note that bribery is a criminal offence that may result in up to 10 years' imprisonment and/or an unlimited fine for the individual and an unlimited fine for the organisation.

Bribery and corruption has a detrimental impact on the GHNHSFT business by undermining good governance and organisational integrity. We benefit from carrying out our functions in a transparent and ethical way and thereby helping to ensure that there is honest, open and fair competition in the NHS. Where there is a level playing field, GHNHSFT can lead by example and deliver excellent services to our patients.

The Board and senior management team are committed to implementing and enforcing effective systems throughout GHNHSFT to prevent, monitor and eliminate bribery, in accordance with the Bribery Act 2010.

The GHNHSFT has developed, and regularly reviews, key policies outlining our position on preventing and prohibiting fraud and bribery, promoting the highest standards of business conduct and managing conflicts of interest. These policies include the Counter Fraud Policy, Bribery and Corruption policy, Standards of Business Conduct and the Speaking Out Policy. These policies, which are available on the GHNHSFT intranet, apply to all employees as well as temporary and agency workers, management consultants and contractors acting for or on behalf of the GHNHSFT. All employees and other individuals acting for the GHNHSFT are required to familiarise themselves with the GHNHSFT policies and comply with any amendments with immediate effect.

As part of its anti-bribery measures, the organisation is committed to transparent, proportionate, reasonable and bona fide hospitality and promotional expenditure. Such expenditure must only be offered or accepted in accordance with the procedures set out in the organisation's policies. A breach of the organisation's Standards of Business Conduct policy by an employee will be treated as grounds for disciplinary action, which may result in a finding of gross misconduct, and immediate dismissal.

GHNHSFT will not conduct business with service providers, agents or representatives that do not support the organisation's anti-bribery objectives. We reserve the right to terminate its contractual arrangements with any third parties acting for, or on behalf of, the organisation with immediate effect where there is evidence that they have committed acts of bribery.
The success of the organisation's anti-bribery measures depends on all employees, and those acting for the organisation, playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for, or on behalf of, the organisation are encouraged to report any suspected bribery. Employees are encouraged to use internal reporting procedures as set out in the Speaking Out Policy and the Counter Fraud, Bribery and Corruption policy. GHNHSFT will support any individuals who make such a report, provided that it is made in good faith.

However, employees can also report their concerns externally as an alternative to internal reporting procedures if they wish to remain anonymous to the Local Counter Fraud Service on ghn-tr.fraudaccountmailbox@nhs.net or call 01452 318 842/826; http://www.gloshospitals.nhs.uk/en/Wards-and-Departments/Other-Departments/Counter-Fraud-Service/Contact-Us/ or via

The NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or by filling in an online form at www.reportnhsfraud.nhs.uk This provides an easily accessible route for the reporting of genuine suspicions of fraud / bribery within or affecting the NHS. All calls are dealt with by experienced caller handlers.

Deborah Lee
Chief Executive Officer
On behalf of the Gloucestershire Hospitals Foundation Trust Board of Directors

MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title
SmartCare Progress Report
Sponsor and Author(s)
Author: Gareth Evans, SmartCare Programme Manager Sponsor: Deborah Lee, Chief Executive
Executive Summary

Purpose

To provide assurance to the Board, from the Smartcare Programme Board, on the current position of the Smartcare Programme.

Key issues to note

- The programme is set at red status as the deployment of further functionality has been paused pending development of a revised forward programme.
- The Programme Team continues to provide maintenance and preparatory development of the current TrakCare implementation.
- Planning for the implementation of the next TrakCare release, T2017.2 is in progress but is pending agreed build recommendations from the Deep Dive report.
- The deployment of T2017.2 will incorporate changes to the ED environment in respect of streaming services and the provision of Emergency Care Data Set reporting capability. A joint clinical, operational and project based workstream has been defined to undertake the planning and deployment.
- System comparison in terms of build and configuration with a view of operational use is being undertaken with colleagues in North Tees. Differences will be identified and rationale investigated prior to any consideration for change in the GHT environment.
- The SmartCare Programme will be aligned with the overall Recovery Programme.
- Clinical Operational Assessment workshop for ePMA is planned for 12th/13th December.

Conclusions

Planning for the delivery of all phases subsequent to Phase 1 will be undertaken in conjunction with approved recovery programme objectives and recommendations.

System development in terms of essential planned system upgrade (2017.2) will continue and be planned appropriately taking into account the ‘clean data’ objectives from the recovery programme.

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 January.

Recommendations
The Board is asked to note this report.

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. In respect of the delayed implementation, a full review will be undertaken in respect of the revised timescales from the subsequent 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 & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						Smart Care Program-me Board
Outcome of discussion when presented to previous Committees						

PROGRESS REPORT SmartCare			
Date completed:	30/11/17	**Version**	1.0
Project Sponsor:	**Dr Sally Pearson**	**TRUST RAG Status**	**RED**
Project Manager:	Gareth Evans		

SmartCare Progress Report – November 2017

Executive Summary & Programme Status

The programme is set at **RED** status pending the review of the programme as a whole combined with the Recovery Programme has been finalised.

Activity within the Programme has centred on engagement within the 'Deep Dive' process around TrakCare Recovery with NHS Digital and our partners at North Tees & Liverpool.

The Programme Team continue to provide maintenance and development in preparation for the next major process of upgrade to T2017.2 release of TrakCare. This included the completion of currently outstanding Radiology Order Comms preparation work in readiness for a resumption of activity post-upgrade in line with the recovery principles.

Planning for the implementation of TrakCare T2017.2 is in full progress. The planning to date has centred on the technical implementation based upon known constraints but will need to assess any recommendations emanating from the Deep Dive report.

A significant element of the T2017 upgrade is the provision of ECDS and related ED operational changes. A separate project workstream has been identified and a workstream initiation meeting proposed with the identified ED staff. The initiation meeting has dependencies on the provision for the parallel T2017 environments that InterSystems are in the process of testing. Dr Tom Mitchell has been proposed to take the clinical lead role within ED, supported by Admin Lead (Andy Carter proposed) and a Lead Nurse (TBA). The remainder of the workstream will be supported from within the project, BI and Clinical Systems.

The planning to date has included provisional resourcing and has a resultant proposed T2017 'live' date of 26th March 2018. This is however, dependent upon the recommendations from the Deep dive exercise which will see the go-live being referred to as a 'Relaunch of TrakCare' with respective training and competency based access. The impact of the revised training and competency testing is to be identified.

Phase 1

Contract performance

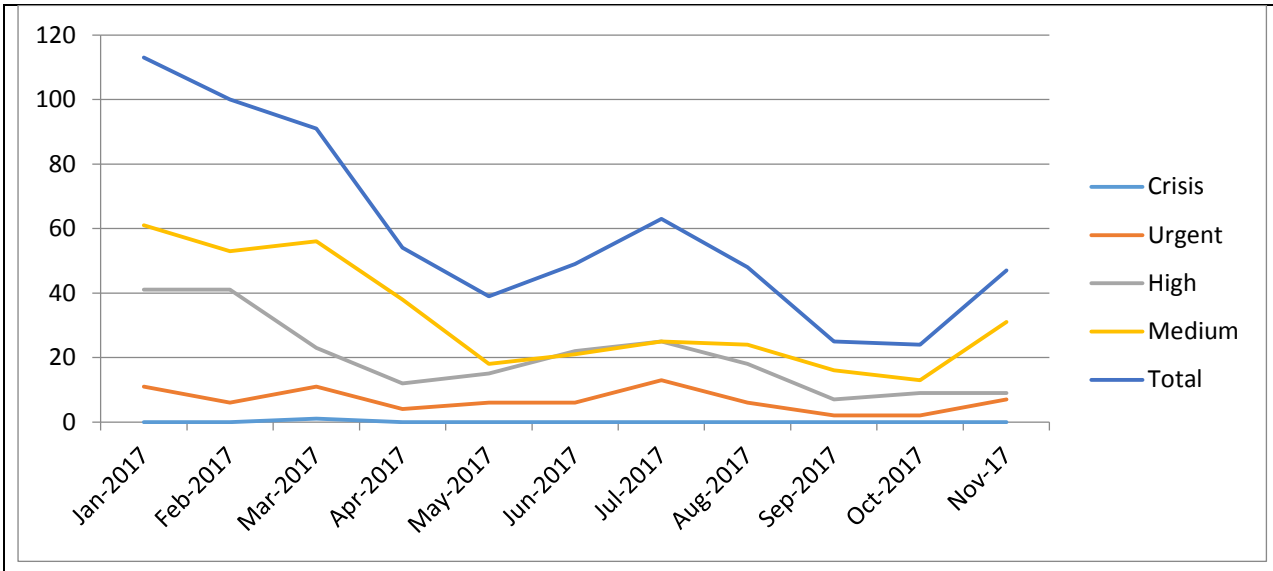
Contract Performance is measured against Incident call statistics against the InterSystems Call Centre (TRC) and availability of TrakCare to end users. Current trends and ongoing totals provided below.

Contract review still requires the revised CCN to be presented and any revised financial milestones reconciled.

TRC Incident reporting Summary: Jan – Nov 2017

Incidents Opened YTD:	669
Incidents Closed YTD:	604
Incident Closure (%):	90
Open Incidents:	152

Trend for Open Incidents



Trust management of TRC reporting has been highlighted in previous meetings and as part of the Depp Dive recommendations. As an initial move to dedicated support of TRC management, Elaine McWhinnie from Clinical Systems is to assume this role from 1st December until such time that a defined support and service management stream is confirmed.

Primary TRC Issue – FCE's

As reported in November, investigation both within the Trust and with InterSystems identified areas for more concentrated test and review. The test exercises have been completed and three potential causes identified. These were reviewed with Luke Ridding at ISC. All identified 'causal' issues have been raised as TRC's in order to track progress to fix. Fixes to the three causal TRC's are pending ISC confirmation although Trust requirement is at least for this to be provided within T2017.2 at go-live.

The FCE issue impacting most records is TC-108197 "Patients can be 'arrived' in Theatre before being admitted via IP Registration" A request has been raised for a potential ad-hoc fix in our current environment (T2016) together with any additional available fixes. At the time of writing this report we are waiting on confirmation.

It is recognised that the use of 'real-time' data entry within the Trust would significantly reduce the number of FCE related issues but there is still a genuine requirement for post real-time data change that is impacted by the reported issues. Complete testing of FCE related issue will not be possible until implementation of fixes to all of the currently identified causal TRC's.

Overall TRC logging trend has seen a slight increase in the last month.

Implementation Review and Phase 1 Recovery – 'Deep Dive'

As indicated above, the Programme Team have engaged and supported the activity within the deep dive process that took place over the 13th – 16th November, taking part in individual interviews and workshops. This support has included colleagues from InterSystems who have maintained a full and detailed involvement.

The resultant report from the deep dive process has been received and is subject to review before wider distribution. It is understood that a number of recommendations within the report will impact the current planning and ongoing development for the TrakCare T2017 solution.

The Programme Team is engaging with North Tees in respect of system configuration comparison and subsequent build recommendations for T2017 taking into account the recommendations of the Deep dive report.

Phases 1.5, 2 & 3 Preparation and planning

Progress with the preparation for Pharmacy Stock Control, Oncology and planning for the delivery of all phases subsequent to Phase 1 will be undertaken at the appropriate time following the activity determined by the Phase 1 recovery activity and the associated 'deep dive' outcome.

System development is progressing in terms of T2017 requirements. The deep dive report has a number of technical considerations that will be taken into account once a finalised format for upgrade/re-launch is confirmed.

The operational Assessment workshop for the ePMA phase of Phase 2 is to be undertaken on 12th/13th December as originally planned as this includes a number of clinicians who have made specific arrangements to attend. The outcome of the workshop will provide significant knowledge of future capabilities of TrakCare and will aid regeneration of clinical engagement.

Training

The Training team will actively take part in the recovery programme with the refinement of training material and provision of additional TrakCare training as required to support the re-launch of TrakCare. This is in addition to maintaining current training provision.

The training session for development of TrakCare Questionnaires has been completed.

Programme Resourcing

Programme resourcing will be reviewed in line with the resultant system maintenance, development and recovery requirements.

Finance

A continued review of the potential impact of the delayed Phase 1.5/2 implementation and the recovery programme will be undertaken. Meeting with SC on 1/12/17.

Programme Risks

A review of risks associated with SmartCare/TrakCare has been undertaken and operationally focussed risks have been updated and reassigned to the respective specialties to manage. The current operational system risks have been reassessed as part of this exercise.

Operational Activity

The Programme team actively support the Operational Recovery Board and will continue to do in line with the recommendations from the deep dive report and subsequent Programme Board direction.

Next Planned activities

Revised planning of restructured Programme incorporating System Development and Stabilisation activity.
T2017.2 upgrade planning, including:

- Confirmation of technical solution methodology for 'clean data' utilisation
- Proposed technical process
- The agreement of Standard Operating Procedures (SOPs) – essential to ensure the Trust regression test against actual workflows.
- The creation of updated test scripts – adhering to the SOPs.

Continuation of Phase 1 recovery with Programme resources against revised planned activity.

Progress build in T2016.2 for pathology and pharmacy stock that does not impact recovery in terms of operational use or resource allocation.

Status against communications plan

To be incorporated into revised Operational Recovery planning activity.

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
Milestones to be reviewed following the outcome of the “deep dive”		

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

Risk review to be distributed to Programme Board for November meeting by 3rd November 2017

MAIN BOARD – DECEMBER 2017
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title
Quarterly Report on Safe Working Hours for Doctors and Dentists in Training
Sponsor and Author(s)
Author: Dr Russell Peek, Guardian of Safe Working Hours Sponsor: Dr Sean Elyan, Medical Director
Executive Summary
Purpose The required quarterly update Report on Safe Working Hours for Doctors and Dentists in Training from the guardian of safe working. Key issues to note - The Allocate reporting system has been introduced which has enabled and enhanced the ease of reporting for junior doctors. - The reporting identifies areas where work with the clinical teams can address changes to working patterns to reduce the exception rate. - Administrative support and the appointment of a new Guardian of safe working are now complete. Conclusions Significant progress in the support for the GSW has now enabled a more efficient process and will allow better data capture Future Action Required The development with the Educational Supervisors and the divisional teams the appropriate actions and to respond to and resolve the exception reports
Recommendations
To accept this update as appropriate progress.
Impact Upon Strategic Objectives
Links to our goal of our staff feeling valued and involved, recommending us as a place to work and feeling confident and secure in raising concern.
Impact Upon Corporate Risks
NA.
Regulatory and/or Legal Implications
National requirement to receive this report at Board level.

Equality & Patient Impact							
NA.							
Resource Implications							
Finance			Information Management & Technology				
Human Resources	✓		Buildings				
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	✓

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees						

MAIN BOARD – DECEMBER 2017

QUARTERLY REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

1. EXECUTIVE SUMMARY

The majority of junior doctors working in the Trust are now on 2016 terms and conditions of service (TCS) and are able to exception report. This paper summarises 520 new exception reports made between 1st August and 31st October 2017.

Most exceptions highlight occasions where doctors have worked beyond scheduled hours to manage a large clinical workload. Patterns of repeated exceptions occur where regular working hours do not match those set out in the doctor's work schedule.

On the 1st October 2017, the trust introduced the Allocate Software system for exception reporting. This has improved the quality of data from exception reporting and the timeliness of response to immediate safety concerns.

2. INTRODUCTION

Under the 2016 terms and conditions of service (TCS) for junior doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hours limits.

Doctors in training may raise an exception report whenever working hours breach those set out in their personalised work schedule. An exception report is initially reviewed and addressed by the educational supervisor or nominated deputy. If appropriate, time off in lieu or payment for extra hours worked is agreed. In certain circumstances, a fine may be levied for exceeding safe working limits (see appendix for links to rota rules and pathways).

The structure of this report follows guidance provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	390
Number of doctors / dentists in training on 2016 TCS:	370
Amount of time available in job plan for guardian: member of staff appointed	2PA
Amount of job-planned time for educational supervisors:	0.25/0.125 PAs. (first/additional trainees to maximum 0.5 SPA)

3. JUNIOR DOCTOR VACANCIES

Junior Doctor Vacancies by department (January 2017)					
Department	F1	F2	ST 1-2	ST 3-8	Additional training and trust grade vacancies
Emergency Dept			3	0.2	
Anaesthetics					
ENT					1 trust doctor vacancy
General Medicine			3	2	13 trust doctor vacancies
General Surgery				1	Trust doctor vacancy
Histopathology					
Obs & Gynae			1	1	
Ophthalmology					3 trust post vacancies
Oral & Max Fax			1		
Trauma & Ortho			1		4 trust doctor vacancies
Paediatrics				2	1 specialty post vacancy
Urology					Registrar fellow vacancy
Vascular surgery				2	Trust doctor and registrar posts vacant
Total			9	8.2	

4. LOCUM BOOKINGS

Data from finance team:

Total spend August - October 2017 on Junior Medical locum cover was £979,453

5. EXCEPTION REPORTS (working hours)

Exception reports by department		
Specialty	Exceptions carried over from last report	Exceptions raised
General/GI Surgery	25	62
Urology	1	9
Trauma/ Ortho	5	7
ENT	0	2
Vascular Surgery	0	8
Ophthalmology	0	2
Orthogeriatrics	4	0
General/old age Medicine	5	170
Acute medicine/ ACUA	21	11
Stroke	1	11
Neurology	55	33
Cardiology	0	41
Respiratory	17	16
Endocrinology	0	7
Oncology	4	8
Haematology	2	6
Gastroenterology	28	63
Renal medicine	3	53
Emergency Department	0	0

Sexual Health	0	0
Obstetrics and Gynaecology	0	5
Paediatrics	24	6
Total	195	520

Exception reports by division				
Specialty	Exceptions carried over from last report	Exceptions raised	Exceptions Closed*	Exceptions outstanding
Surgery	31	90	120	1
Medicine	140	419	523	36
Women and Children	24	11	35	0
Diagnostic / specialties	0	0	0	0
Total	195	520	678	37

*Assurance received that all exceptions on the old system will be resolved by December 2017

6. FINES

Fines by department		
Department	Number of fines levied	Value of fines levied
Neurology	1	
Total		

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter

7. ISSUES ARISING

Nine doctors raised a total of 28 safety concerns through exception reporting. No episodes of patient harm were reported. Concerns related to

1. the number of medical staff on duty for the number of patients or ward areas covered. This was generally due to staff vacancy or acute sickness, when the junior doctor was asked to cover a larger patient population than usual, or
2. the availability of senior support at night (clinical supervision out of hours). In one specialty out of hours, the foundation year 1 doctor felt unsupported by the middle grade trainee. This concern was escalated to the consultant, chief of service and director of medical education

Junior doctors raising concerns were contacted by the guardian to confirm that they had raised them with the consultant on duty at the time and that their concerns had been addressed.

8. ACTIONS TAKEN TO RESOLVE ISSUES

Immediate safety concerns were clarified and escalated to senior medical staff. No trainee safety concerns related to unsafe working hours.

9. QUALITATIVE INFORMATION

The new Allocate software for raising exception reports came into use on the 1st October 2017. Initial experience is that this makes it easier to review patterns of exception reporting and resolution of reports by the educational supervisor. It automates the process of flagging an immediate safety concern to the guardian of safe working (via email). The way the system is currently set up makes it more difficult to identify which department trainees are working in when they report. This could be remedied by re-classifying rotas in the database.

Many doctors are new to exception reporting and are finding out how best to use the system effectively. This is a consistent finding from guardian experiences across the country. National guidance on when to exception report from the BMA, NHS employers and the TCS is not entirely clear. Rather than setting up a 'clocking in and clocking out' culture, the aim is said to be to highlight systemic and repeated problems so that trusts can focus on addressing problem areas.

10. SUMMARY

A total of 823 working hours exception reports have been made since trainees started to move onto the new TCS in December 2016. The reports identify occasions where doctors in training are working beyond scheduled hours to maintain service delivery. The process has identified departments where the workload, team expectation or available support for junior doctors results in a high level of exception reporting.

Author: **Dr Russell Peek, Guardian of Safe Working Hours**

Presenting Director: **Dr Sean Elyan**

Date 30/11/2017

Recommendation.

- To endorse
- To approve

Appendices

Link to rota rules factsheet:
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20August%202016%20v2.pdf

Link to exception reporting flow chart (safe working hours):
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Safe%20working%20flow%20chart.pdf

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTER ROYAL HOSPITAL ON TUESDAY 5TH SEPTEMBER 2017 AT 5.15PM

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 R Baker	Staff, Oncology
Governors/	Mr G Cave	Public, Tewkesbury
Constituency	Mr G Coughlin	Public, Gloucester City
	Mrs A Davies	Public, Cotswold
	Mrs P Eagle	Public, Stroud
	Cllr A Gravells	Appointed, Gloucestershire County Council
	Ms C Graves	Healthwatch
	Mr R Graves	Non-Executive Director
	Mr C Greaves	Appointed, Clinical Commissioning Group
	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)
	Ms S Attwood	Staff, Nursing and Midwifery
Directors	Mr P Lachecki	Chair
	Dr C Feehily	Non-Executive Director
	Ms D Lee	Chief Executive
	Mr R Graves	Non-Executive Director
	Ms T Barber	Non-Executive Director
IN ATTENDANCE	Michele Pashley	PA to the Director of Human Resources and Organisational Development
	Mr D Smith	Director of Human Resources and Organisation Development
	Ms S Pearson	Director Clinical Strategy
	Mr N Jackson	Director of Estates and Facilities
APOLOGIES	Mrs J Hincks	Public, Cotswold
	Prof Chris Dunn	Public, Stroud
	Mr N Johnson	Staff, Research
	Mr T Foster	Non-Executive Director
	Mr K Norton	Non-Executive Director
	Ms A Moon	Non-Executive Director
PRESS/PUBLIC	None	

The Chair welcomed members of the Council and thanked Governors for attending. He introduced Cllr Andrew Gravells as this was his first meeting.

054/17 DECLARATIONS OF INTEREST

There were none.

055/17 MINUTES OF THE MEETING HELD ON 19TH JUNE 2017

The Lead Governor felt that there had been an omission in the minutes and asked that the following is inserted "The Lead Governor asked that

the Council receive a summary on TrakCare to enable the Governors to understand the benefits of Trak and why it was introduced in the first place." **NJ**

Otherwise the minutes were agreed as a correct and accurate reflection of the meeting.

056/17 ACTION TRACKER

All items on the tracker are complete.

057/17 MATTERS ARISING

Update on Governor Vacancies & Elections

The Chief Executive reported that nominations had been received for every constituency where elections were required:

- Three were contested, with a ballot to be held for Cheltenham District Council Area, Gloucester City Council Area and Cotswold District Council Area.
- One nomination was received for Out of County.
- Dr Llewellyn would continue as Medical and Dental Staff Governor.
- Mr Randles is standing down and 1 nomination had been received for Nursing Staff Governor.
- A ballot would be held for Allied Healthcare Professionals with 2 nominations have been received for AHPs.

Update on Review of Constitution

The Chief Executive noted that the Constitution would benefit from review and modernisation. This will be completed once the new Director of Corporate Governance is in post.

Update of Executive Team Appointments

The Chief Executive reported the following:

- Mr Steve Hams (Chief Nurse & Director of Quality) starts on 25th September.
- Ms Caroline Landon (Chief Operating Officer) will start on 9th October.
- Ms Emma Wood (Director of People and Organisational Development) will start on 1st November.
- Maggie Arnold (Director of Nursing) leaves in September, and the Governors will be receiving an invite to leaving party.
- Sally Pearson (Director of Clinical Strategy) has announced her intention to retire in January 2018.

058/17 CHAIRS UPDATE

The Chair updated that since the last Committee:

- He had been recently heavily involved in communications around the Financial Governance Review (FGR) including meeting stakeholders, interviews and staff briefings.
- Had spent considerable time in areas such as Catering, Estates and Portering and found this time invaluable.
- Attended the Volunteers Award Ceremony on 14th July.
- Joined Mark Pietroni for a Saturday morning ward round in the

Acute Medical ward and spent time observing and meeting teams in the operating theatres.

In response a few points were raised:

- Mr Greaves felt it would be useful and interesting to receive a list of all the meetings the Chair attends. This could be used as mechanism to show exactly what the Chair does. **PL**
- The Lead Governor requested that the dates for the governor's visits are reissued.
- Mr Gravells queried whether Governors were ever invited to join the Chair on visits around the hospitals. The Lead Governor asked for the dates of the visits to be reissued. **NJ**

059/18 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive highlighted some of the issues in her report:

- Accident & Emergency performance is showing a sustained level of improvement to the previous quarter but remains volatile with significant daily performance fluctuations.
- The Sustainability and Transformation Plan (STP) has submitted a bid in the region of £35m. The Chief Executive is very thankful to the team who have all worked incredibly hard to develop the bid against challenging timelines.
- Operational issues arising from TrakCare are causing increasing concern. The impact is felt mostly in outpatient services. The Trust will be embarking on a 'deep dive' into 4 outpatient specialties with the aim of getting them 'TrakFit', and the Board will be devoting time at the next Board Seminar to take stock of where the Trust is with TrakCare and what steps are required in light of the ongoing issues.
- The Chief Executive felt it also important to remind ourselves what we do well and highlighted the Trust's excellence in teaching which has been recognised by our junior doctors. The Trusts Cardiology service was rated the best in the country, by trainees working in the service for overall satisfaction.

In response a few points were noted:

- Dr Llewellyn asked if there would be a different approach to winter planning this year. The Chief Executive responded that a draft plan has been created, noting that this had been done more so in advance than ever before. She went on to explain that the plan was very tangible, the key constraints being bed capacity and that unlike last year, there are a number of initiatives that have been resourced by the system which will bring extra beds into play over winter. She also observed that there had been better and earlier engagement with clinical staff.
- Ms Barber shared that the plan had been aired at the Quality and Performance Committee and from a governance perspective there had been a level of scrutiny that hadn't been possible before due to the late development of the plan.
- The Lead Governor enquired regarding the CQC Action Plan and how Governors would be able to access it. The Chief Executive responded advising that this could be brought through the Governors Quality Group, where every Governor could request sight of the report.

RESOLVED: That the report be noted and the CQC action plan be taken to the next Governors' Quality Group.

060/17 REPORTS FROM BOARD COMMITTEES

The Chair asked that the main points be highlighted to allow time for questions and to enable assurance from the Board.

Finance Committee – 31st May 2017 – the Chair recognised this report was out of date however it was the last financial report taken to Open Board in July. In future reports would be current.

The Lead Governor mentioned there was an increasing concentration on trends and challenging questions of the finance team. There appeared to be a lot of gaps and the 'assurance' columns are empty. The Chair assured the Governors that in future four or five big topics would be looked at and the columns would be completed as opposed to every agenda item being listed.

The Chief Executive gave a verbal update on finances to ensure Governors had the most up to date information:-

- The Trust was noted to be ahead of its plan at Month 5 but the forecast for the year end is now adverse to the tune of £8m
- Income is significantly below plan, arising in large part from the impacts of TrakCare though this is after considerable mitigation having been secured through block contract arrangements.
- Spend on pay is less than plan and whilst this supporting the position, the reasons for this are being investigated not least in case there is opportunity to review future pay budgets in support of the underlying financial position.

Quality and Performance Committee – July 2017 - The key points noted were as follows:

- The winter plan was presented and assurance on preparedness sought.
- Significant debate on cancer targets and plans to increase the rate of recovery
- The role of Quality & Performance Committee which is to receive assurance from committees and groups beneath it and this could work better in the future
- Considered the CQC action plan, and understood who is taking responsibility for each element. Further work requested on mapping progress and evidence to support assurance.
- Lengthy debates about TrakCare, a number of suggestions were put to the Committee and a request for an action plan to ensure PALS receive less TrakCare complaints was requested.

Workforce Committee – 30th April 2017 – The key points noted by Ms Barber of the August Committee were:

- 1st draft of the Leadership Strategy has been developed; additional input has been requested from Ms E Wood and the Education, Learning and Development Group. (ELD).

- Workforce Race Equality Standard (WRES) to go to the Board to ensure appropriate level of Non-Executive awareness public and scrutiny.
- Vacancy Control Panel, changes to make the process more streamlined and give it a greater strategic focus; will be reviewed again at the end of 2017.
- Ms Attwood raised a point that Band 5 nurses are showing as 0.5 adrift. The Chief Executive assured that this should show as 'against plan'; the report will be changed to reflect this.

Audit and Assurance Committee – 11th July 2017

Mr Graves shared the key topics which were discussed. He noted the Director of Organisation Development and Human Resources and the Medical Director were present to discuss agency spend in the medical area and the Committee will continue to review this.

The Lead Governor queried the use of auditors as the Trust can no longer use KPMG and highlighted the new appointment process in keeping with Council of Governors responsibility. Mr Graves responded that the Committee are reviewing who will take over from KPMG at the end of the week following a competitive tendering exercise.

061/17 APPOINTED GOVERNOR VACANCY

The Council agreed it would be beneficial that the 4th Governor should be a Carer Representative. The Chair and Lead Governor will now take forward discussions with the Chair of Carers Gloucestershire. **PL/AT**

062/17 USE OF GOVERNORS LOG & GUIDANCE NOTE

The Chief Executive shared the Governors' Log alongside an accompanying guidance note, created to help the Governors best utilise this. It also sets out other vehicles which governors can utilise to engage in dialogue with the Trust. Cllr Gravells expressed concern that perhaps the tone could be considered discouraging however the Chief Executive reinforced that the log could only play a small part in dialogue between executives and governors and therefore the guidance should further inform on the best ways to address concerns. She apologised if the note conveyed the wrong impression not least as its intention was to encourage, not discourage, Governor engagement.

063/16 CONTACT YOUR GOVERNOR UPDATE AND PROPOSAL

The Chief Executive shared that due to the diligence of the new Board Administrator, 137 emailed unanswered enquiries have been uncovered which had come into the trust via the Contact Your Governor Portal.. These will be dealt with in due course.

The Lead Governor thanked the Board Administrator for her diligence. He felt the portal was an important two way process which gave Governors the ability to contact members which improves engagement and therefore thanked the Chief Executive for agreeing to get this back on track in due course. Governors supported the decision to "suspend" the portal until the issues causing the original problem were resolved.

064/17 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

Mr Marstrand shared that he had spoken with a few members who had raised concerns regarding the procedure around appointment letters in Orthopaedics. The Chief Executive acknowledged that there had been many developments around clinic processes and encouraged Mr Marstrand to contact her outside the meeting so that she could contact the Interim Chief Operating Officer regarding any specific issues.

065/17 UPDATED GOVERNORS' CODE OF CONDUCT FOR APPROVAL

The Chair asked Council to read, sign and return to the Board Administrator. **ALL**

066/17 ANY OTHER BUSINESS

Mrs Powell said as it was her last official meeting she would like to thank the Committee. The Chair thanked Mrs Powell and also Mr Randles for all their helpful contributions and service to the Council of Governors.

067/17 DATE OF NEXT MEETING

18th October 2017

068/17 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
18th October 2017

ITEM 15

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 16

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 17

PUBLIC QUESTIONS

(Procedure attached)

Peter Lachecki
Chair

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 ghn-tr.pals@gloshospitals@nhs.net 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 ghn.tr.complaints.team@nhs.net or 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 Board Administrator 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 Board Administrator, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN or by e-mail to natashia.judge@nhs.net.
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 Natashia Judge, Board Administrator on 0300 422 2932 by e-mail natashia.judge@nhs.net

ITEM 18

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION