GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 11 January 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal 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

21 December 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 13 December 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	**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 21 December 2017	**PAPER** (Tracey Barber)		
	• Trust Risk Register	**PAPER** (Lukasz Bohdan)		
9.	Financial Performance:		**For assurance**	10:40
	• Report of the Finance Director	**PAPER** (Steve Webster)		
	• Assurance Report of the Chair of the Finance Committee meeting held on 20 December 2017	**PAPER** (Claire Feehily)		
	Break		**11:10 - 11:20**	
10.	Workforce:		**For assurance**	11:20
	• Report of the Director of People and Deputy Chief Executive	**PAPER** (Emma Wood)		
	• Assurance Report of the Chair of the Workforce Committee meeting held on 8th December 2017	**PAPER** (Tracey Barber)		
11.	Board Assurance Framework	**PAPER** (Lukasz Bohdan)	**For assurance**	11:40

12.	Six-Monthly Research Report	**PAPER** (Sally Pearson)	**For Information**	11.55
	Governor Questions			
13.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To discuss**	12:10
	Staff Questions			
14.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To discuss**	12:20
	Public Questions			
15.	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**	12:30
	Any Other Business			
16.	Items for the Next Meeting and Any Other Business		**To note**	12:40
	Lunch Break			**12.45 – 13.15**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE BOARD ADMINISTRATOR NO LATER THAN 17:00 ON TUESDAY 2nd JANUARY

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 8 March 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General 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
	Simon Lanceley, Director of Strategy and Transformation
	Steve Webster, Finance Director
	Emma Wood, Director of People and Deputy Chief Executive

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM ON WEDNESDAY 13 DECEMBER 2017 AT 9 AM

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
	Lukasz Bohdan	Director of Corporate Governance
	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	Director of People and Deputy Chief Executive
	Tracey Barber	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
	Alison Moon	Non-Executive Director
APOLOGIES	Dr Claire Feehily	Non-Executive Director
IN ATTENDANCE	Jill Wood	PA to the Chair and Chief Executive
	Suzie Cro	Head of Patient Experience
	Tanya de Weymarn	Consultant in Emergency Medicine
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	One Governor, three members of the public, three members of staff.	

The Chair welcomed all to the meeting and apologised for the late publication of the Board papers this month. Dr Claire Feehily's apologies were noted.

273/17 PATIENT STORY

The Head of Patient Experience introduced Dr Tanya de Weymarn, Consultant in Emergency Medicine.

Dr de Weymarn said that the Emergency Department (ED) is a pivotal service area as it sets the course for what will subsequently happen to patients. Tanya advised that 30% of our patients are over 65 years old and their needs are often complex, however, despite this challenge; Tanya felt that they were given individual and excellent care in a pragmatic way. She acknowledged, however, for many older people, hospital is far from ideal as they can quickly deteriorate and lose their independence and therefore her goal was always to support older people to return home wherever safe to do so.

Tanya explained that she had developed a focus on care for the elderly in ED which was known as GEEC – or Gloucestershire Elderly Emergency Care and the programme's aim was to ensure that best practice was adopted throughout the ED in the care of the older person.

Dr de Weymarn then shared a video in which a local actor played the part of an elderly patient challenging the onlooker to see a person in front of them, not just a patient or a medical case. The Board found the clip very moving.

Tanya described that patients who were confused found hospitals terrifying. She advised that twiddle mittens (a knitted sensory aid) had been a massive success with patients who sit and play with them, which in turn calms them down.

Dr de Weymarn had been working with Charitable Funds to introduce "Tanya's Telly"; a television with a DVD player, so that patients could watch films in a home-like environment, taking their mind away from a busy hospital environment etc. Staff had been complimentary about the television and its calming effect. It was noted the television worked equally well with children.

Tanya further explained that GEEC were working with other groups and South West Ambulance Service (SWAST) to offer integrated care and shorten patient stay.

The Chair thanked Dr de Weymarn for her presentation and invited questions from members of the Board.

Mr Norton thanked Dr de Weymarn for her excellent presentation and asked her how the team broke down barriers to deliver person-centred care. Dr de Weymarn described some of the approaches taken by staff.

Mr Graves recalled his recent personal experience of ED and noted that it was thanks to Tanya and her colleagues that his relative was well looked after. Mr Graves asked what specific support Tanya and her team would like from the Board. Dr de Weymarn identified the following priorities:

- a number of initiatives which required minor funding.
- Messaging about impact of other functions on care provided in ED – for example, radiology scans done promptly.
- a clear corridor;
- links with the CCG; and
- administrative support.

It was noted that the CQC were sighted on the work of Tanya and her team and recognised it as best practice.

The Director of Quality and Chief Nurse thanked Tanya for her work and suggested that this could be shared across other areas. Dr de Weymarn advised that she currently worked with the Older Persons Assessment and Liaison Team (OPAL) and General and Old Age Medicine (GOAM) team and was looking to engage other services.

Mr Foster (Chair of Charitable Funds Committee) encouraged Dr de Weymarn to get in touch with the Head of Fundraising as the Committee was currently considering "matched funding bids"; if Dr de Weymarn and her team raised 50% of the required funds Charitable Funds could match these. The Charity could also look at

getting sponsorship from the community. Dr de Weymarn advised the Board that she would be trialling "red blankets" (for those patients who have a risk of falls) and requested "match funding in kind". Mr Foster suggested that the Committee might be able to double the red blankets through match funding.

Dr de Weymarn further described her vision for a Frailty Unit and advised that if it was at the front door it would allow the coming together of ED with OPAL and other specialities. This, in turn, would ensure that those patients return home quicker as the expertise is co-located and patients receive specialist care they require.

The Medical Director felt the power of the video was compelling and suggested that a 2 minute video might also benefit other teams. Dr de Weymarn advised that she was working with Patient Experience to produce one for staff. It had been suggested that patients are part of the focus groups to help promote this initiative; this would be trialled with SWAST at the end of March.

The Chair advised members that he had visited the stroke ward this week and there too he witnessed passion for patient care, the Chair noted there were many areas around the Trust caring for the elderly and asked what we could do with this specific group of people to make this person-centred behaviour more embedded. The Director of Quality and Chief Nurse advised that we would try and find a way of sharing such examples of living the Trust's values.

The Chief Executive felt that there was a need to reflect in the near future, when considering our strategy, whether going forward we would aspire to be renowned for elderly care. The Chair noted that the University of Worcester had strategically focussed on one group of students and that there may be parallels to learn from.

The Chair thanked Dr de Weymarn and Head of Patient Experience for this fascinating presentation.

274/17 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

275/17 MINUTES OF THE MEETING HELD ON 9 NOVEMBER 2017

RESOLVED: That the minutes of the meeting held on 9 November 2017 be agreed as a correct record and signed by the Chair.

276/17 MATTERS ARISING

Updated matters arising had been circulated to members prior to the meeting.

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.

NOVEMBER 2017 243/17 PATIENT STORY - BEADS OF COURAGE

Mr Foster agreed to pursue these via the Charitable Funds Committee.

Completed: Charitable Funds Committee has approved funds for licence and beads for premature babies unit.

NOVEMBER 2017 247/17 CHIEF EXECUTIVE'S REPORT – FINANCE COULD BE AVAILABLE TO ACQUIRE A REAL TIME BED STATUS SYSTEM

The Chief Executive advised that following Pauline Philips' visit to the Trust, during which having a real time bed state was discussed, deploying a real time bed system had been expedited with InterSystems.

Completed.

NOVEMBER 2017 247/17 CHIEF EXECUTIVE'S REPORT - 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.

Completed: 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.

NOVEMBER 2017 249/17 REPORT OF THE FINANCE DIRECTOR - CASH FLOW FORECAST

It was agreed the cash flow for the full year would be included in future reports.

Completed and included.

NOVEMBER 2017 250/17 REPORT OF THE DIRECTOR OF PEOPLE - 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.

Completed: The 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 Nursing and Midwifery Council 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.

NOVEMBER 2017 251/17 SMARTCARE PROGRESS REPORT - ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST REPRESENTATIVE TO ATTEND A

BOARD STRATEGY AND DEVELOPMENT SESSION OR SIMILAR
Chief Executive would investigate.
Completed: 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.

277/17 CHAIR'S UPDATE

The Chair advised that conversations had taken place in respect of a Vice Chair role. Mr Rob Graves is currently the Senior Independent Director (SID) and does deputise for the Chair, whilst the latter is on annual leave or absent for another reason. The Chair proposed Mr Rob Graves is formally elected Vice-Chair of the Board. Members agreed to this proposal.

RESOLVED: That Mr Rob Graves be elected Vice-Chair of the Board.

278/17 CHIEF EXECUTIVE'S REPORT

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

- During November the Trust achieved the 4 hour A&E standard. It was noted that it had been several years since this was last achieved and that the whole hospital was supporting delivery of the standard. Staff are to be congratulated on this achievement. The Chief Executive was, however, mindful that we were not 'pushing on a single front' and that we needed to recognise achievements in other areas too. The previous week had been very challenging for the Trust as it was for other Trusts nationally which was evidence that the recent success was not fully embedded and performance remain fragile until the planned changes were fully embedded.

- At the end of November the Influenza Vaccination Target of 70% had been achieved. The Chief Executive praised the Director of Quality and Chief Nurse for his focus and leadership which she said had been pivotal to the success. A recent Lancet publication had been proven that a 10% increase in flu vaccinations resulted in a 10% improvement in sickness absence and therefore we should push on towards 80%.

- Regionally and nationally there had been a lot of discussion following the Chancellor's announcement in the Autumn Budget of extra £337m funding for the NHS and £137m had been made available for Winter pressures initiatives funding. The Trust and system partners had bid for this and had submitted a robust proposal for £2m of winter funding. It was noted that the £200m balance would be allocated to Trust's on a formula basis. From the national conference calls, DL said that our Trust was being viewed very positively by the national team, who recognised our efforts in dealing with winter pressures and a large deficit.

- Finance – this subject would be covered more fully later on in the meeting. The Chief Executive advised that she, along with

the Chair and the Director of Finance, would be attending the NHS Improvement oversight meeting the following day and would be reporting that while steady progress was being made, the Trust was not on track to deliver against the £14.7m financial plan.

- Frustrations are being expressed in respect of the limited progress perceived in respect of the *One Place Business Case*, which is causing concerns for our staff - especially those based at Cheltenham, who are unclear of their future and who are feeling vulnerable. The Chief Executive advised that she had spent time on Monday with senior nurses describing the vision for Cheltenham which has a vibrant and important future within the Trust and she foresaw no scenario where there would not be a 24/7 urgent care offer at Cheltenham General Hospital. A personal letter to staff working in those areas would be sent shortly aiming to reassure them about their future.

- In respect of our bid for £40m capital funding we had received some clarity on the next steps though further work was now required with a refreshed submission by end of January 2018. Only 5% of bidding Trusts had received a letter like ours, requesting further work to be done on their Business Case, so it was considered positive news. This would be discussed with NHSI further tomorrow.

- The CEO gave an update of the progress being made in respect of SubCo establishment and said she was particularly grateful to the Director of People and Deputy CEO for establishing sound programme arrangements. The feedback received from staff is that they are feeling more assured. Staff consultation is underway and going well and union liaison continues.

- The CEO advised that the recent TrakCare Deep Dive report had been received and endorsed, with some caveats, by the SmartCare Programme Board; all recommendations were accepted either in full or in part. The Council of Governors had received the report positively and the summary report would be published internally within the Trust the following week.

- Finally the Chief Executive praised the Library Service under the leadership of Lisa Riddington; in particular recognising how good the service was and how proactive the team were. The Library Service provide a world class library function to staff in the Trust. The work of Lisa and her team had been recognised through a recent Peer Review, which resulted in a rating of 100% compliance with defined quality standards. The Chair also praised the service and invited his Non-Executive Director colleagues to drop into the Libraries.

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

- Ms Moon commented that the A&E performance was fantastic and an amazing achievement. Ms Moon asked how the Trust communicated with staff to minimise rumours regarding changes and also how we let staff know that we were proud of

what they were doing. Ms Moon also asked whether winter funding money was put into the balance sheet or elsewhere. The CEO explained how the winter pressures funding would support both the existing schemes started in Q3 into Q4 and described some new initiatives that the funding would support. She also explained the targeted correspondence which would be sent to staff working in urgent and emergency care services.

- The Chair was aware that A&E was high on the staff agenda but asked for thoughts on how to improve the importance and focus on cancer performance. The Chief Executive felt that we could do more in terms of communication including face to face when walking around the hospital. We should also communicate how much we have achieved in cancer care, and not just highlight our achievements within A&E.

279/17 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 October 2017. This report had previously been to the Quality and Performance Committee for assurance.

Key points highlighted from the report were:

- Performance against the 62 day target was 73% in October
- Performance against the 2 week cancer target standard for October was 74.5% and improved slightly in November at 75.6%
- Diagnostics – standard delivered in October but it was felt that it would be a challenge to achieve this for November; plans are in place to assist with this delivery target.
- Performance within the emergency department for October was 88.93% and November 95.2%; Quarter 3 is 91.5% to date with an NHSI trajectory of 85.2%. Plans are in place due to the challenges this week (internal and external) but the team are working on delivering the 90%.

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

- Mr Graves queried the difference between sustainability and achievement and whether the team reviewed plans to identify triggers. The Chief Operating Officer answered that it was important to work well with teams, get the processes right (resulting in empty beds), have an adequately staffed ED and establish a change in culture, i.e. one with ward environments where we do not have to look for beds. She said that recent changes were not yet embedded and some volatility in performance was to be expected therefore, in the months ahead.

  The Chief Executive gave some examples of how the executive team spent time reviewing the impact and possible unintended consequences of the recent changes. She advised that the *Escalation pre-emptive transfer* policy had been reviewed

recently following concerns expressed by nursing staff; the Executive team concluded that the policy was the right one but there was evidence that staff were not complying with it all the time and steps to address this had been taken.

A positive correlation had been noted between patient experience and our performance. The Chief Executive stressed that the Trust would do the right thing for patients and would listen and re-set the policy, if it had unintended consequences.

The Medical Director felt that a lot could be learnt from the Getting It Right First Time (GIRFT) Trauma and Orthopaedics (T&O) restructure, as the impact of improvements became apparent. He felt that more work needed to be done to further align services.

The Chair queried when the Board would know that the outcomes had been embedded. The Chief Operating Officer advised this would be:

- when we have empty beds;
- when Gallery Ward 1 is empty at the weekend;
- the wards come to the bed management team regarding beds rather than the bed management team chasing the wards.

The Chief Operating Officer felt that this was a cultural change for the organisation, not just for the ED department, with everyone involved from the front door onwards.

- Ms Moon asked about the focus on cancer. The Chief Operating Officer explained the new arrangements that were in place; a consolidated team had seen a significant improvement in Colorectal and Neurology although a lot of work is still to be done. Ms Moon also asked about cancelled operations. The Chief Operating Officer advised that she approved all cancelled cancer operations and that cancer procedures had not been cancelled over the past 4 weeks and that these procedures would only be cancelled in extreme circumstances. The Chief Executive re-confirmed the intolerance of cancelling cancer operations. The Chief Operating Officer would ensure cancellations are reported monthly as part of the regular performance report, as they had been previously. **CL**

The Director of Quality and Chief Nurse advised that in respect of:

- Mixed Sex breaches – these had increased slightly and the team were currently going through the Standard Operating Procedure. It was noted that the Trust had been flagged as an outlier nationally. The Director of Quality and Chief Nurse further advised that all these breaches were in critical care and related to delayed transfers out to ward beds. The outlier position reflected the inconsistent approach to capturing performance in this area which had been flagged to NHSI.
- ED Checklist – this is being completed but not consistently and

remained a focus for improvement.

- The Clostridium Difficile (C-Diff) rate is concerning. A summit is taking place on 15th December and Sue Roberts, an Infection Control Specialist, is working with us for the next few months. We would be asking NHSI for additional support next year.
- Pressure Ulcers - the recent Quality and Performance Committee had received details of a recent deep dive in this area - Grade 3 ulcers had dropped but there were still concerns in respect of Grade 2. The team will now be brought together in one location.

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

- Mr Foster noted that the complaints responded to were down 50% and asked if we were accurately reporting. It was confirmed that we were reporting correctly; the Head of Patient Experience gives weekly updates, revises the escalation process and is constantly driving for improvement but the Director of Quality and Chief Nurse recognised that more work needed to be done. The Chief Executive further advised that she signed all complaint letters and if she was not happy with the response then they were returned to clinicians etc. which in turn may delay the process.
- Ms Moon welcomed the openness around pressure ulcers and agreed that this was not where we wanted to be but applauded the processes and work in this area. She also felt that the resources coming from Infection Control were excellent especially the focus on C-Diff. The Director of Quality and Chief Nurse had looked at historical data trends in respect of ulcers etc. and had noted that some data was missing; he would review this. **SH**
- The Chief Executive advised that NHSI were interested in our e-coli rates as they are relatively low. The Director of Quality and Chief Nurse advised that the team were doing good work and ensured that reporting was done correctly. The Medical Director advised that the microbiologists paid a lot of attention to this.

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 action plans to improve the position.

ASSURANCE REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 30 NOVEMBER 2017

Ms Barber presented the assurance report noting in particular:

- Risk Report Consideration; the option of individual reports are being reviewed and this will be explored with the Director of **LB**

Corporate Governance.

- Patient Experience and Friends and Family reports; there is a need to look at how to triangulate these and focus on the patient.
- Mortality and Learning from Deaths; it was agreed the process around these would be investigated.
- Pressure Ulcers; how we have sight of this.

Ms Moon advised that at the January meeting with Dr Foster we would be looking at learning from deaths in more detail and that we would see more benchmarking with other organisations. The Medical Director advised that in respect of mortality there were two separate issues – investigation of death and indicators which are moving in the right direction.

RESOLVED: That the report be noted.

TRUST RISK REGISTER

The Chief Executive presented the Risk Register noting that progress continued to be made with just 9 outstanding risks being reviewed by Divisions which she hoped would be closed by the January Board.

The Risk of Harm to patients as a result of delay in receiving essential, required cardiac interventions has been downgraded to 3 x 3 = 9 following the appointment of staff to increase capacity.

A new risk (N2614) is to be added, which is being assessed by the Infection Control team and is in respect of the ability to electronically track infections when the ICNet is phased out by the supplier next year. We are looking to build this functionality into TrakCare and considering when this can be delivered. In parallel, the Trust is looking at alternative arrangements which may result in the need to procure a different system in the interim period.

The Chief Executive noted that the amber-rated risk did not need to appear on the Register and that the risk regarding poor quality patient experience within ED, rated 5 for likelihood, was being reviewed by the Director of Quality and Chief Nurse as it was felt that this risk had been significantly reduced and could be downgraded. **SH**

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.

LEARNING FROM PATIENT STORIES

The Chair apologised that this paper had not been circulated with the papers and would therefore be added to the January Board Agenda. **NJ**

However, the Head of Patient Experience was in attendance to update members. She advised that the paper gave the Board an update on the patient experience improvement work that had been initiated in response to the stories presented to Board. The Head of Patient Experience noted that each story was taken back to the relevant clinical areas so that those areas could take ownership of

the improvements.

As a result of Kim's story, deaf communication cards had been created. Following the introduction of these cards there has been a decrease in the number of occasions when the Gloucestershire Deaf Association (GDA) had learnt of the appointment from the Deaf British Sign language (BSL) user rather than the hospital.

There had also been 10,000 responses on Facebook and an increasing number of people wanting these cards. The communication cards have also generated significant media attention and a joint story ran on BBC Points West. Easy read letters have been approved and rolled out Trust wide. 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.

In response to the Head of Patient Experience paper the following points were raised by the Board:

- Ms Barber was keen to see that the Trust took the identified themes and trends, triangulated them with evidence from other areas, and developed a strategic response going forward. The Chief Executive felt that this was being addressed.

- Mr Norton was concerned that names were still being called within Audiology. It was noted that some patients could hear their names and that an audit was being done to ensure that the boards were also being used. The Chief Executive enquired why we were not developing an electronic / LED solution as most hospitals and suggested funds could be sought through the Charitable Funds Committee if this was the block. The Chief Nurse was asked to look into this. **SH**

LEARNING FROM DEATHS

The Medical Director presented the Learning from Deaths Report advising the Board that there was a typographical error on the cover sheet which should read 48% in Quarter 2 reporting. There were also some additional deaths not included in the total.

The Medical Director summarised the key points:

- All deaths are reviewed and we are well ahead of the national programme and the Medical Examiner reviews them at high level.
- Each death is summarised by Division with high level learning and good practice documented.
- It is Trust policy that if anything is identified as a shortfall in care it is referred to the Duty of Candour process; this is consistent within the South West and there are a small number of cases which fall in to this category.
- Within Surgery there are 2 pilot areas taking forward the next stage of the key components of the Guidance.

Mr Foster felt that there was a lot of learning within each column with five deaths arising from problems with care, but that it was not easy to follow. It was noted that some problems with care did not

contribute to death and that improvement in care would not have prevented death. Still, it was important to capture learning from such deaths and identify areas for improvement. It was stressed that the Duty of Candour process was a robust process.

The Chief Executive noted that in respect of Duty of Candour, in a number of cases there is the potential that problems with care could have contributed to deaths, but as no incidents were associated with them so they were not reported accordingly. There was a need to ask the question as to what triggered Duty of Candour process. The Medical Director explained the process and confirmed that the report would be amended to reflect this. **SE**

The Director of Quality and Chief Nurse said that most of the data in the table is effectively a breakdown of the total number of hospitals deaths. The Medical Director advised that he would ensure that presentation is clearer in future reports. **SE**

Ms Moon asked how we capture the data in respect of near-misses and how we learn from these; the Medical Director confirmed that incident reporting of near misses is actively encouraged and the analysis of incidents and learning themes included near misses.

The Chair thanked the Medical Director for his report.

EMERGENCY PLANNING RESILIENCE AND RESPONSE

The Chief Operating Officer presented the Emergency Planning Resilience and Response report advising that plans were in place to address the few areas which were not Green rated.

The Trust has demonstrated a substantial level of compliance against the national EPRR standards and this has been externally validated by Gloucestershire CCG and NHS England. 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. There had been some challenges in our Business Continuity Planning management but Rachel Minett, Emergency Planning Manager has focussed on Intensive Therapy Unit (ITU), Emergency Department (ED) and Theatres to ensure all planning was up to date.

The Board noted the Chief Operating Officer's report and raised the following points in response:

- Ms Moon advised that she had taken part in a good meeting with the Emergency Planning Manager and felt that the Trust had substantial assurances and performed well when compared to other local systems.

  The Auditors had drawn up the business continuity plans which the Audit and Assurance Committee were happy with. The Chief Operating Officer felt that some of the recommendations were aspirational but what we had was "fit for purpose". PriceWaterhouseCoopers have completed a review.

RESOLVED: That the Board receive the report as assurance of the Trust's compliance with EPRR standards.

(The Board adjourned from 11:00 am to 11:10 am)

280/17 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE DIRECTOR:

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

- 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 an adverse variance to budget and NHSI Plan of £0.3m.
- Income is behind plan and there is an adverse variance on the CIP month deficit.
- The Trust is forecasting an adverse variance to plan by the year end.

The Director of Finance focussed on the forecast position

- Month 6 base forecast is £27.8m; work is ongoing as part of the CIP deep dives to increase delivery of the £6m. However there is a high level of uncertainty in respect of income.
- Following the last NHSI meeting further work has been done in respect of coding issues.
- Prior to the November NHSI meeting amendments were made to the Month 6 position; £2m additional income risk was recognised and reported to NHSI.
- During Month 7 Divisions were asked to report back on what they have delivered against the £6m target. The Divisional forecasts have currently only identified £1.9m of the £6m and a further £2.9m additional cost pressures have emerged which are detailed on page 4 of the performance report.

The Director of Finance advised that the position was very concerning and the £4.1m shortfall was disappointing and required improvement. He confirmed that weekly deep dives, with the Executives present, were taking place. Divisions were challenged about their cost pressures, the forecast savings and the targets that had been set. The feedback was that we were slightly ahead but these meetings would continue through to the end of the year. The forecast is for a further improvement of £3m but this remains a risk. With targeted improvements the forecast for year end is estimated to be £28.6m deficit.

Discussions had previously taken place around securing £8m of additional funding from the Clinical Commissioning Group but this was now looking less likely. There were 2 or 3 key areas within the CIP causing a concern plus risks around our CQUIN.

The outturn deficit of £14.6m can only be changed at the end of the Quarter after a due diligence exercise takes place so we can only do this after Quarter 3. NHSI are aware of our position but it had not been formally reported but would be done so through the January returns.

In respect of the Balance Sheet and Cash there is a £20.9m deficit to date with cash flow movements in our favour; consequently, the

distress funding drawn to date is £12.9m, but we will need to borrow more in the coming months.

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

- Mr Graves thanked the Director of Finance for his explanation acknowledging that there was still a lot of work to be done within the Divisions. Mr Graves was concerned that meeting weekly may be inefficient. The Chief Executive felt that it was necessary that these continue at the present time to maintain focus and traction.
- The Chief Executive advised that there had been a delay in approving the capital; she had escalated this as there were concerns that we might not be able to proceed on some IM&T. If clarity is not received at the NHSI meeting tomorrow the Board may be required to approve some priority capital investment. Post meeting note, capital now approved.
- The Director of Quality and Chief Nurse advised that in respect of the CIP process he felt that the Executives found the process helpful and that the weekly meetings helped drive the programme and kept the commitment. He also felt there was a strong clinical component, which, from a nursing perspective, was hugely valuable.
- The Chair queried the amount of distress funding available to us; the Director of Finance advised that there was no limit on the day to day borrowing as the system is not constrained in the same way as the capital loan.
- The Chair further queried the extent of NHSI awareness; the Director of Finance confirmed that the financial special measures team and the regional team have been made aware of the issues and of the potential of further deterioration this month.
- Mr Graves asked if we had savings numbers in mind for each Division; the Director of Finance advised that we did but that some elements are cross cutting and not allocated to Divisions.

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 29 NOVEMBER 2017

Mr Norton presented the assurance report highlighting in particular:

- That there was appropriate financial control.
- There was a CIP deep dive in respect of medical productivity.
- E-rostering business case had been discussed in detail.

RESOLVED: That the report indicating the Non-Executive Director challenges made and the assurance received be noted.

281/17 WORKFORCE

REPORT OF THE DIRECTOR OF PEOPLE

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

- Month 7 saw an increase in agency expenditure however there continues to be a downward trend year on year.
- Temporary staffing – the team have moved under the portfolio of the Director of Quality and Chief Nurse to assist with the CIP delivery. Work continues in respect of the agency bank ratio.
- Pay expenditure – a positive downward trend stabilised in month 7. With effect from November a recruitment freeze had been applied to recruitment activity until April; it is anticipated that this will release a further £1m in CIP.
- Turnover – currently stable at 12.36%.
- Sickness – lower than the national average but long term sickness accounts for approximately half of the absence recorded.
- Mandatory Training and Appraisals – static.
- Staff Survey – this has now closed with a response rate of 47% which is down on last year. However, the national picture is 45% so the Trust is above this.
- Workforce Strategy – work has been done to identify priority areas. It was noted that the data held by Finance and Human Resources did not match therefore a review will need to be done so a baseline can be agreed. Work will continue on this over the next six months.
- CIP – new models of workforce are to be considered but more work needs to be done here.
- Efficiencies – a key programme of work is the design and delivery of SubCo. A Programme Board has been established to oversee the delivery of key items.
- Talent Development - a talent management and succession planning system is to be developed over the next six months. This will 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.
- Staff Health and Wellbeing – a review of what we are doing has commenced.
- Staff Engagement – there is a need to ensure that information received is captured and noted so a review of staff engagement models will be undertaken so that current practice can be built upon.

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

- Ms Barber felt that with the new priorities we needed to be clear what success would look like. She also felt that the Staff Survey response rate was disappointing as ideally we wanted to exceed the national average. The CEO advised that we had exceeded the average for acute Trusts nationally but agreed with the principle of striving for a higher response rate.
- Mr Graves asked about the status of the 'Speak up Initiative'. It was confirmed that this was on the agenda for the next Workforce Committee.
- Following a request from the Chief Executive the Director of People discussed her experience in respect of 'talent management'. She advised she had introduced this at the South West Ambulance Service (SWAST). She felt that there were different ways to identify talent and have meaningful

conversations with staff, regardless of whether they wanted to progress their careers or were happy to stay in their current roles. Staff should have an opportunity to advise what attributes they have and how to embed talent management into the business. Individuals would go in to a Talent Pool where their development would be supported. They would sit in the pool for a year but would have the opportunity to re-apply. When these individuals had been identified an 'Aspiring Leadership' peer review would be completed; the Executive team would oversee. This would be linked in with mentoring and coaching. It was noted that this would take time to embed and we would need to map the journey and build up excellence within a role.

- Ms Moon asked how we support our staff in developing desired culture. The Director of People advised that she would be leading a piece of work around behaviours i.e. what is expected of you and your peers etc. and that this would be completed in the next six months and become integral to the developing appraisal approach.
- The Medical Director felt that we needed to feed this in to the Medical Appraisal process and that we need to include trainees within this process.

RESOLVED: That the Board note the report.

ASSURANCE REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE MEETING HELD ON 10 NOVEMBER 2017

Mr Norton presented the assurance report highlighting in particular:

- Year-end forecast was not included within this month's report but it would be reported in future.
- Reward strategy – this would need approval as part of a suite of HR strategies.

RESOLVED: That the report indicating the Non-Executive Director challenges made and the assurance received be noted.

282/17 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 7 NOVEMBER 2017

Mr Graves updated members on the issues discussed at the November meeting:

- Counter Fraud report – noted that the counter fraud team were professional and effective. The Head of Counter Fraud updated members on national initiatives including unidentified fraud and anti-bribery act compliance. The Head of Counter Fraud was investigating evidence of missed instance of fraud.
- Internal Audit – identified historical batch of recommendations. Agreed that this was an opportunity to make some improvements. Executive Directors were addressing this.
- New External Auditors – the Committee were very impressed with their style and the fact that the team who would be working for the Trust were the same as team met at the bidders' presentations.

- Risk Management and Clinical Audit – this was work in progress. Members would look at the processes in the organisation and ensure issues are discussed further within relevant Committees.

RESOLVED: That the Board note the report.

BOARD STATEMENT ON BRIBERY

The Director of Corporate Governance presented the report to the Board and highlighted the key points within the paper:

- In accordance with the Bribery Act 2010 the Trust is liable if a senior person within the Trust commits an offence and it is proven that adequate procedures were not in place. It was noted that counter fraud is covered in policies and staff were made aware of their obligations through the staff induction programme, other training and briefings.
- This statement had been agreed by the Trust's Audit and Assurance Committee.
- It was now presented to Board for approval to demonstrate our commitment to good governance practices. Once approved, it would be published on the Trust's internet and intranet pages and cross-references in policies and procedures.

RESOLVED: That the Board approve the statement.

283/17 SMARTCARE PROGRESS REPORT

The Chief Executive presented the SmartCare Progress Report to provide assurance to the Board on the current position of the SmartCare Programme. The key points highlighted from the report were:

- The programme is set at 'red' status which reflects the scale of recovery still required and delays to the forward programme.
- In response to this a Deep Dive, led by NHS Digital, had been undertaken and the Deep Dive report had been received and discussed in detail at the SmartCare Programme Board.
- In order to deliver the recommendations within the report the Trust has engaged Mark Hutchinson – Digital Recovery Consultant who would work directly to the Chief Executive as Senior Responsible Officer for the programme.
- Following a look at the resources this week it had been established that an enhanced infrastructure is required as well as non-recurrent resources to support recovery if the Trust were to address some basic shortcomings as well as achieve its vision for digital healthcare.
- There were some funding sources available through the Gloucestershire Clinical Commissioning Group to support recovery in 2017/18.
- In respect of clinical risk – oversight arrangements had been strengthened and a Clinical Systems Safety Group established Chaired by the Medical Director reporting in to the Quality and Performance Committee.
- Deployment of future phases had been paused in particular the roll out of Radiology; Oncology; Order Comms and Pathology although the Chief Executive felt that some areas may proceed

sooner with the exception of Oncology which required greater recovery within outpatients more generally before proceeding.
- The Chief Executive felt that this was a positive way forward and that while there were significant issues in some areas - e.g. outpatients – she recognised that some areas are working better than others and that the Trust is currently utilising just a proportion of the system's capabilities.
- Recovery work is focussed on outpatients and theatres.

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

- Mr Norton welcomed the report and noted additional benefits that had not been previously appreciated.
- It was noted that this was the first time that the project had been rated 'red'. However, as a positive we are about to enter the recovery stage and there are significant benefits still to come.
- The Chair asked whether the 'red' open incidents have TrakCare dimensions. The Medial Director would look into this.
- The Chair felt that the team were getting to grips with the recovery process, noting that it would not be a quick process. The Chair believed the Board should have confidence with the recovery process. **SE**

RESOLVED: That the report be noted.

284/17 QUARTERLY REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

The Medical Director advised the Board that this was not his report but wished to relay his personal thanks to Dr Russell Peek who had written the report. Dr Peek started off in the role of Guardian of Safe Working Hours, but was now moving on to a more senior post within the Deanery.

The Medical Director presented the report highlighting the key points:

- The Allocate report system is in place and is operational.
- Administration support and a new Guardian of Safe Working are now in place.
- There are a number of exception reports, but it is felt that this is in line with other Trusts and there were no areas for major concern.
- There is operational pressure on the junior doctors in training and we have high work intensity compared to some Trusts but incident reporting did not reveal any specific issues relating to junior doctors that were attributable to excessive working.
- The CEO advised that the Medical Education Board were very focussed and pro-active in respect of junior doctor health and wellbeing and the impact of work intensity.
- Progress has been made within Neurology and there has been a change in working patterns.
- Simon Pirie, Paediatric Consultant, is the new Guardian of Safe Working Hours.

The Board noted the Medical Director's report and raised the

following points in response:

- The Director of Finance asked what were the fundamental concerns identified in the exception reports. The Medical Director advised that the main concerns were junior doctors staying over their contracted hours and noted that there was a limit of 30 minutes. The exception was closed if educational support is provided which addressing the issue.
- The Medical Director advised that since the introduction of the new Junior Doctor contract only one fine had been levied.
- Mr Graves felt the observations and numbers were good but queried what they actually told the Board. The Medical Director advised that he had looked at how other Trusts report the data and this is a standard format showing where we are but accepted it had limitations but was a national format and requirement.
- The Chief Executive took assurance from the statements detailed in section 7 of the report in respect of incidents and suggested developing this section to add more value.
- Ms Moon welcomed a quarterly report as it was good to see trends and identifying near misses. The Medical Director advised that none of the near misses had led to any harm and confirmed that there was a safety trigger in the wording of the report which is reviewed by the Educational Supervisor.
- The Medical Director advised that there was a Junior Doctor Forum, Deanery Visits and a GMC Survey. He noted that how we took this information back to the junior doctors was important. Work was ongoing and the Medical Education Board was focussing on how we used this information. The Medical Director would reflect on this linking with the Medical Education Board to ensure this information is captured and reported at future Board meetings.

RESOLVED: That the report be noted.

285/17 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNROS 5 SEPTEMBER 2017

RESOLVED: That the Trust Board receive the minutes of the meeting.

286/17 GOVERNOR QUESTIONS

The Lead Governor thanked the Board for their reports noting that there had been a range of very interesting topics covered and he felt that Finance, TrakCare and SubCo had all been well covered at various other meetings attended by Governors.

The Lead Governor commented about the accuracy of the minutes as some of the comments last month were incorrect. The Chair advised the Lead Governor he was welcome to comment on the accuracy of the minutes as they were reviewed at the beginning of each meeting and did not need to wait until his allocated time under the Governor Questions item.

In respect of the items discussed the Lead Governor commented:

- Mortality – although this was still work in progress, the Lead

Governor was encouraged by the report. In respect of the patient lead it would be good to have an overview of the effects bereavement has on the family and learn from these experiences.

- Pro-active communications – the Lead Governor asked whether the Trust should consider more communication in respect of A&E as governors talk to the public and the response is still one of confusion. The Lead Governor also queried how the Trust could more proactively engage with the Clinical Commissioning Group as there was a lot of change in the community externally and internally and not everyone was aware of this. The Chief Executive agreed that this was frustrating but that the Trust was constrained in terms of what it could communicate due to factors such as STP-level responsibility for communications and local elections' purdah period. The Chief Executive would ask the system communications group to consider producing a "System on a Page" document to enable a dynamic picture of services to be maintained at all times so that changes such as the recent T&O one were captured and readily available The Chief Executive would ask the system communications group to consider producing a "System on a Page" document to enable a dynamic picture of services to be maintained at all times so that changes such as the recent T&O one were captured and readily available. **DL**

287/17 STAFF QUESTIONS

The Chair read out the reply to the staff question regarding the increase in price of staff parking. The reply noted that the Board had carefully considered this decision and that it was made in in line with the agreed principles, including limiting the impact on lowest earning staff and therefore considered its decision to have been ethical.

288/17 PUBLIC QUESTIONS

There were none.

289/17 ANY OTHER BUSINESS:

No other business was noted.

290/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9 am** on **Thursday 11 January 2018** in the **Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital.**

291/17 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 12.35 pm.

Chair
11 January 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANAURY 2018

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.	Complete (to Board) Action now picked up in Q&P Committee and discussion ongoing between Head of Planned Care and Head of Patient Experience.
January 2018	December 2017 279/17 Quality and Performance Report	**CL**	Cancelled Cancer Operations	The Chief Operating Officer would ensure cancellations are reported monthly as art of the regular performance report, as they had been previously.	Ongoing Data quality issues since introduction of TrakCare. Remains priority for resolution by InterSystems and workaround now being reviewed as aggregate reporting is still happening.
January 2018	December 2017 279/17 Quality and Performance Report	**SH**	Pressure Ulcer Data	The Director of Quality and Chief Nurse had looked at historical data trends in respect of ulcers etc. and noted that some data was missing; he would review this.	Completed This has been included within the Quality and Performance Report.

March 2018	December 2017 279/17 Assurance Report of the Chair of Quality and Performance Committee meeting held on 30 November 2017	**LB**	Risk Report Consideration	The option of individual reports are being reviewed and this will be explored with the Director of Corporate Governance.	Ongoing Format of risk registers/reports will be reviewed as part of work on the Board Assurance Framework in Quarter 4 2017/18.
January 2018	December 2017 279/17 Trust Risk Register	**SH**	Risk related to poor quality patient experience within ED.	Being reviewed by the Director of Quality and Chief Nurse as it was felt that this risk had been significantly reduced and could be downgraded.	Ongoing The current winter pressures have impacted on the experience of our patients in ED and so this risk has been reviewed and currently has not reduced.
January 2018	December 2017 279/17 Learning from Patient Stories	**NJ**	Learning from Patient Stories paper.	This would be circulated to Board members.	Completed Circulated by the Board Administrator.
January 2018	December 2017 279/17 Learning from Patient Stories	**SH**	Audiology Outpatients - The Chief Executive enquired why we were not developing an electronic / LED solution as most hospitals and suggested funds could be sought through the Charitable Funds Committee if this was the block.	The Chief Nurse was asked to look into this.	Completed A handheld buzzer system is being currently being reviewed, tested and costed.
January 2018	December 2017 279/17 Learning from Deaths	**SE**	Triggering of the Duty of Candour process.	The Medical Director explained the process and confirmed that the report would be amended to reflect this.	Completed Future report format amended.

January 2018	December 2017 279/17 Learning from Deaths	**SE**	Data within the report.	The Director of Quality and Chief Nurse said that most of the data in the table is effectively a breakdown of the total number of hospitals deaths. The Medical Director advised that he would ensure that presentation is clearer in future reports.	Completed Future report format amended.
January 2018	December 2017 279/17 Learning from Deaths	**SE**	Family engagement and learning from experiences.	The Medical Director confirmed that a timeline for actions was in hand which he would detail for the next Quality and Performance Committee.	Complete (to Board) Added to Quality and Performance Work Plan.
January 2018	December 2017 283/17 Smartcare Progress Report	**SE**	Open incidents	The Chair asked whether the 'red' open incidents had TrakCare dimensions. The Medial Director would look into this.	Completed. All Trakcare incidents are reviewed at the monthly Clinical Unformation Safety Meeting.
January 2018	December 2017 286/17 Governor Questions	**DL**	Communications around Accident & Emergency.	The Chief Executive would ask the system communications group to consider producing a "System on a Page" document to enable a dynamic picture of services to be maintained at all times so that changes such as the recent T&O one were captured and readily available.	Completed Action accepted by STP Communications Group, format and timeline for production to be confirmed subsequently to STP Delivery Board.

ITEM 6

CHAIR'S UPDATE

VERBAL

Peter Lachecki
Trust Chair

MAIN BOARD – JANUARY 2018

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 The Trust is currently in the grip of winter pressures although in the period leading up to Christmas the Trust continued to perform well compared to other Trusts nationally. However, like the majority of Trusts in England, the period following Christmas has been very challenging and performance has deteriorated to pre-improvement levels. The reasons for this are multi-factorial and again mirror the national picture with increases in the numbers of patients presenting with respiratory conditions including influenza, an increase in the number of patients and staff with norovirus. Of particular note has been a significant reduction in the rate of discharge over the festive period and a review of the reasons for this will be crucial to informing the coming weeks and plans for future bank holiday periods.

1.2 As ever, our amazing staff have risen to the challenge and patients have received safe care, albeit with some extended waits. To date the Trust has avoided any 12 hour breaches, in contrast to many Trusts nationally and reported fewer ambulance handover delays than other Trusts in our region – both markers of good care. I have spent time, with other executive colleagues, in emergency and urgent care services and have seen for myself the efforts of staff and the quality of care delivered, despite the operational challenges.

1.3 As a result of the robust approach to winter planning, the Trust has preserved much outpatient and elective activity though it is anticipated that some routine work will be cancelled due to the excessive pressure on beds but every effort to avoid this is being made. At the time of writing the Trust has not escalated to Opel Level 4, the only Trust in the local region not to have done so at this stage.

2. National and Regional

2.1 Nationally, the focus has been almost exclusively on winter with significant national oversight and direction of the urgent and emergency care system. Directions to recommend Trusts significantly limit elective and outpatient care has attracted media attention and in doing so fuelled some local media interest. Of note, the Trust's own social media has been characterised by patients describing their positive experiences of local care and their admiration for hardworking NHS staff.

2.2 On the 16th December 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 still being considered by NHSI and NHS England. Stephen Hay, Head of Regulation also indicated that a review of the Trust's Special Measures status warranted review and he was actively considering the timing for putting a proposal to the national panel for consideration, not least as one of the key drivers for the review was the previous governance failings which all accepted were now remedied.

2.3 NHS Improvement has recently announced its new Chief Executive, Ian Dalton, CBE. Ian will be visiting the South west Chief Executive's meeting on the 24th January and I have been asked to describe our A&E improvement journey, which is a fantastic opportunity for the Trust to showcase the work it has been doing. In a similar vein, I was also delighted to receive a letter from Rt Hon Secretary of State Jeremy Hunt, celebrating the recent achievements of the Trust which included moving A&E performance from 83.8% to 90% and diagnostic performance from 97.1% to 99.5% against the 99% standard; the letter is included at Appendix 1.

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 the final business case is still underway though on track to be presented to the Board at the end of February. Once approved the case will then need to flow through the various regional and national approval and assurance mechanisms. The current timeline for commencing consultation is now proposed to be in the period July 2018 to September 2018 and discussions to finalise this are yet to be concluded. If the Trust were to exit Financial Special Measures in Q4 this timetable may be expedited to late May / early June as the national assurance gateway would no longer be required.

3.2 On the 2nd January Professor Tim Briggs visited the Trust and met with CCG colleagues to hear more about the progress of the changes to trauma and orthopaedic services outside of the hospital and again he was impressed with the work being led through the STP clinical programmes work stream to redesign the musculoskeletal pathway from end to end. Professor Briggs is promoting the work done in Gloucestershire Hospitals as an exemplar approach to service reconfiguration and on the 1st February will be bringing four Trusts from across the country to hear about the work done in Gloucestershire.

4. Our Trust

4.1 The Trust has now received confirmation that it has progressed to the next stage in the bidding process for the national STP capital funding and has been asked to submit a further refresh by the 31st January 2018. Whilst this protracted process is frustrating, it remains positive that our scheme continues to progress. Timelines for final decisions remain unstated.

4.2 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. To date 34 meetings involving 360 staff have taken place as part of the consultation activities with more to follow in the remaining weeks. Feedback from staff remains broadly supportive as more and more of their questions and concerns are addressed though the scale of the potential change is not under estimated by any of the team.

4.3 We recognise that the success of our hospitals is built on the dedication and hard work of our staff and we know that we could not have achieved all we have over the last year without their continued commitment, professionalism and dedication. In support of celebrating staff's achievements, we have now established monthly recognition awards and following a staff competition have chosen the winning name 'GEM Awards' – Going

the Extra Mile Awards. As well as the annual awards, there will now be monthly occasions for us to celebrate the achievements of staff in each of our six divisions. The awards have been sponsored by the Trust's charity and each month six staff will be recognised and awarded a certificate and gift voucher.

4.4 Sticking with the theme of recognising success, I was delighted to hear just before Christmas that we have been shortlisted for the Patient Experience Network National Awards in two categories. Firstly, for the Small Changes, Big Steps project and also for the Deaf Communication Cards project which was recently described to the Board through a patient story - congratulations to all those involved, it's great to be recognised for all the hard work involved. I was also pleased to end last year with two positive stories which really help to contribute to our strive for excellence. One of the things that has struck me since day one, is the willingness and ability of our staff and teams to innovate. However busy staff are, time and time again, there is evidence of how staff have given thought to developing their service for the future as well as responding to the needs of patients and colleagues in the here and now. Firstly, local boy Thomas was the first patient at our hospital to join *Harvey's Gang* - a national scheme where seriously ill children come to visit the pathology labs to see what happens to their blood when it is taken. Every year, approximately 1 million blood samples are collected from children for testing in the UK, in what can sometimes be a traumatic experience for those involved. As well as the visit being a positive experience for Thomas and his family, it was great to see staff from our children's team working with the scientists in pathology to make this a very special day for Thomas and his brother. The second example which caught my attention is a development in our women's service. Women suffering from Hyperemesis Gravidarum (excessive nausea and vomiting in pregnancy) can now be looked after as day cases following the development of an innovative care model designed to improve patient experience. Women with the condition can become quickly dehydrated and frequently need hospital admission, but the new service will now enable most of these women being treated as day cases on Ward 9A of the tower block at GRH.

4.5 One of the things our Trust has led the way on is supporting developing nurses and, more recently, other allied health professionals (AHP), to undertake roles often done by medical staff however our approach has been somewhat 'organic' but this is set to change. Where these developments have happened, we have some phenomenal models of care and practice and given the opportunities it affords for professional development, and the problems it can potentially solve in medical recruitment hot spots, we need to do more of it but in a planned and strategic manner. As services change and develop, we envision that there will be opportunities for those interested to develop their skills further and therefore we plan to expand the number of enhanced roles. To this end, Chief Nurse and Director of Quality Steve Hams (working with colleagues in Education, Learning & Development) has started a piece of work to undertake a stock take of all advanced practitioners in the Trust with a view to creating a strategy for where we will focus the development of these roles and, alongside this, Steve is now working with the University of Gloucestershire to develop a level 7 advanced practice master's degree programme to support staff in the Trust who might otherwise be moving on to neighbouring Trusts, to access these opportunities. Steve has also recognised that talent needs to be nurtured from the outset, and he and his team are also developing a Nursing Fellows programme which will enable band 5 nurses (and subsequently AHPs) to spend 20% of their time on research, innovation and/or service improvement; it is hoped this kind of offer will attract progressive nurses into the Trust and not only bring added value but fill vacancies in crucial areas.

4.6 Finally, one of the things you will hear a great deal about throughout the year is that 2018 marks the 70th anniversary of the founding of the NHS. NHS England describes it as 'the perfect opportunity to celebrate the achievements of one of the nation's most loved institutions, to appreciate the vital role the service plays in our lives, and to recognise and thank the extraordinary NHS staff – the everyday heroes – who are there to guide, support and care for us, day in, day out'. As a Trust, we will be linking many of our news stories throughout the year to this celebration. I would like to think

that the occasion will give cause for the media to be celebrating, rather than 'critiquing' the NHS and we will be making every effort to ensure our local media partners have lots of rich material to tell a positive story for the NHS in Gloucestershire.

Deborah Lee
Chief Executive Officer

January 2018

MAIN BOARD – JANUARY 2018
Lecture Hall, Redwood 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, Director of Quality and Chief Nurse Sean Elyan, Medical Director

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for November 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 November, the Trust did not meet the national standards or Trust trajectories for; 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 for those patients waiting over 104 days in a cancer pathway or 52 weeks in a referral to treatment pathway.

In November 2017, the Trust performance against the 4hr A&E standard was 95.3% with an average of 400 attendances per day. This performance exceeded 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%). 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, in January 2018. 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 November we are reporting 64 breaches. The majority of patients have a TCI date. No clinical harm has been reported, from the reviews undertaken to date, full Root Cause Analyses (RCA) have been requested. A subsequent report on the November long-waiters will be provided to committee following the submission of the RCA's on the 20th December.

Our performance against the cancer standard saw an improvement against the 2 week standard with performance at 75.6% (Un-Validated) for November. 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. 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 continues to impact on the 62 day pathway performance in the coming months.

Cancer 62 day Referral to Treatment (GP referral) performance for November is 74.4% (un-validated), which represents an improvement in performance compared to October (66.7%). 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 33 breaches to date (11/12), given the early reporting, 13.5 urological, 3 Head and Neck, 2.5 Haematology. The Cancer trajectory and delivery plan has set out the delivery of this national standard across each tumour site later in 2018, after we meet it at aggregate level in April 2018.

The Trust met the diagnostics target in November at 0.37% (un-validated), mainly driven by planned recovery. The key risk to both diagnostic areas, as identified last month, is workforce related in the former capacity and workforce across the diagnostic specialities. The focus has moved to sustaining the delivery and this applies across all the diagnostic areas to ensure sustained delivery of this target. The diagnostics position is monitored on a weekly basis.

Conclusions

Cancer delivery is the priority for the operational teams. A process of review for every patient over 40 weeks in their referral to treatment pathway and every patient over 40 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. We are reviewing our processes for reporting 104 day patients and for notification of where we are dependent on other Trusts. We will be reviewing our trajectory for recovery for 104 day patients.

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**

Outcome of discussion when presented to previous Committees

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period November 2017

to be presented at December 2017 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During November, 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 95.3% and delivered the Diagnostic target in November at 0.37% un-validated.

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.

The focus is on developing the joint work between the Central Booking Office and specialities to support appropriate booking for patients (now all clinics are available for booking for next year). The levels of validation across the RTT incompletes, Inpatient and Outpatient Patient Tracking List (PTL) is significant.

Key areas where additional reports have been provided for the Quality and Performance Committee are:
- 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

4 hour performance continues to perform well, delivering month to date 89.3% as of the 13th December.

• 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 5.6%, 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. FFT scores are available to staff on the wards and they need to log onto the FFT system to see the results for their local areas as this indicates why people are reporting in the way that they have (positive of negative feedback) Divisions/ Specialities/Wards or clinical areas will do improvement work in response to the feedback. Currently there are a number (approximately 20) of ad hoc projects across the Trust that have been commenced to improve patient’s experience at a ward or clinical area level. FFT is one of the patient experience indicators.

Maternity were awarded £50k by NHS England to make improvements to the FFT reporting and we have commence a project which asks women to record which staff had “gone the extra mile” for them. The staff that are mentioned are provided with certificates of recognition. The staff in the areas really appreciate the positive feedback that has been provided. The final report for the project evaluation is due at the end of January.

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. The validation team are now operating at >35 weeks for all specialities within the RTT PTL. Work to support the Outpatient PTL validation team is being put in place to support the validation of this list which will support forward capacity planning.

• Achievement of the Cancer standards remains a risk as we plan to deliver the 62 day pathway from April 2018. 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 plans to deliver from February 2018.

Opportunities

• Development of Standard Operating Procedures (SOP) for key areas being developed across teams, particularly for the Central Booking Office. 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 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 Delivery group.

• 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 December, colorectal remains key to delivery of aggregate 2 week wait performance, Urology capacity will impact on delivery for both the 62 day pathway and long waiters during December through to mid February. Dermatology has delivered performance, all breaches are as a result of patient choice. Fortnightly meetings are in place where delivery against plan is monitored. Joint work with the CCG is in place regarding the re-development of the 2 ww referral forms which support referral when cancer is suspected. Unplanned increases in activity remain a 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%	95.25%				
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%	0.36%*				
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%*	75.60%*				
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%*	94.50%*				
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%*	96.80%*				
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%*	98.60%*				
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%*	98.50%*				
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%*	100.00%*				
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%*	93.40%*				
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%*	60.00%*				
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%	73.20%*	74.40%*				

Summary Scorecard

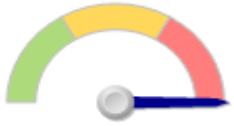
The following table shows the Trust's current performance against the chosen lead indicators within the Trust Summary Scorecard.

QUALITY

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

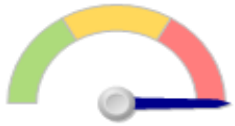
OPERATIONAL PERFORMANCE

- 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	
			Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Quality	**Key Indicators - Quality**																			
	Friends and Family Test Score - ED % Positive		78.4%	85.7%	80.3%	85.5%	86.9%	84.4%	75.6%	77.5%	84.9%	81.1%	81.0%	87.5%	84.8%	83.9%	81.7%	81.2%	86.5%	81.3% *
Friends and Family Test Score	Friends and Family Test Score - Inpatients % Positive		90.1%	88.9%	100.0%	91.6%	89.3%	92.2%	91.2%	90.8%	90.9%	90.1%	91.2%	91.7%	93.0%	93.5%	90.8%	90.6%	94.0%	90.8% *
	Friends and Family Test Score - Maternity % Positive		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%	92.20%						
Infections	MRSA Bloodstream Cases - Cumulative Totals	0	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	0	3	0	3	4	11	10	16	14	18	19	13	5	6	25	48	39	105 *
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	115.2	115.5	113.5	110.7	111	109	109.2	105.5	103.9				115.2	110.7	109.2		110.7	103.9 *
	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	119.3	118.7	116.8	115.1	116.5	114.6	115	111.8	110				119.3	115.1	115		115.1	110 *
	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	7.0% *	6.4% *	6.1% *	5.1% *	7.2% *	7.2% *	6.6% *	6.9% *	6.7% *	6.4% *	6.2% *		6.4% *	5.8% *	7.0% *	6.6% *	6.4% *	6.7% *
Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%										91.4% *	90.6% *	86.4% *						
	Detailed Indicators - Quality																			
Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2>87%Q3>88%Q4>90%										0.4% *	0.7% *					0.4% *		0.6% *
	Dementia - Fair question 2 - Appropriately Assessed	Q1>86%Q2>87%Q3>88%Q4>90%										50.0% *	60.0% *					50.0% *		57.1% *
	Dementia - Fair question 3 - Referred for Follow Up	Q1>86%Q2>87%Q3>88%Q4>90%										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)		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		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		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	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	90	95	105	114	6 *		7	15	44 *	54 *	63 *		90 *	114 *			114	6 *

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Maternity	Percentage of Spontaneous Vaginal Deliveries		61.3%	60.0%	61.1%	61.9% *	61.2% *	64.4% *	65.3% *	62.4% *	63.9% *	64.9% *	60.2% *	57.5% *	61.8%	61.7% *	63.6% *	64.5% *	63.6% *	63.0% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90	86.2% *	93.4% *	86.9% *	88.8% *	89.3% *	84.9% *	89.2% *	83.2% *	88.1% *	85.9% *	87.8% *	89.5%	89.9% *	81.5% *	85.9% *	88.0% *	87.3% *	89.0% *
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean																		
Never Events	Total Never Events	0	0	0	0	0	0	2	1 *	0 *	0	1 *	0 *		1	0			2	2 *
Patient Falls	Falls per 1,000 Beddays	Current mean																		
	Total Number of Patient Falls Resulting in Harm (moderate/severe)		17 *	12 *	7 *	6 *	3 *	4 *	9 *	5 *	8 *	11 *	7 *	4 *	9 *	8 *	5 *	8 *		
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		1	4	0	3 *	3 *	0 *	4 *	2 *	2 *	3 *	1 *	1 *	4	3 *	2 *	2 *		
	Number of Patient Safety Incidents Reported		1,064	1,285	1,162	1,144 *	900 *	1,268	1,148	1,149 *	1,003 *	1,033 *	1,079 *	1,041 *	986	1,197 *	1,019 *	1,062 *		
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	1.62%	0.57%	0.97%	0.87%	0.50%	1.23%	0.49% *	1.12% *	1.02% *	0.61% *	1.13% *	0.79% *						
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%	0.12%	0.23%		0.37%	0.13%	0.12%	0.12% *	0.50% *	0.38% *	0.37% *	0.00% *	0.13% *						
	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%					0.13%	0.12%	0.00% *	0.00% *	0.00% *	0.12% *	0.00% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	66	90	64	78	123	176	293 *	155 *	114 *	98 *	53 *	44 *	104	88	860 *	469 *	3,045	1,407 *
RIDDOR	Number of RIDDOR	Current mean	4	1	5	2	2	2	3 *	2 *	3 *	0 *	3 *	1 *	1	3	2 *	2 *	2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		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%	91.4%	91.4%	90.6%	91.3%	94.0%	92.4%	92.7%	91.3% *	92.6% *	94.2% *	92.9% *	93.0% *	92.4%	91.3% *	93.0% *	92.7% *		
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	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%	97.0% *	96.7% *	96.2% *		
Sepsis Screening	2a Sepsis – Screening	>90%	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%	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		2	1	2			5	1 *	2 *	1	2 *	1 *	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% *		
Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	2.4	2.2	1.4	2.1	1	1.2	2.2	2.7 *	1.9 *	.9 *	1.7 *	3.1 *	2.1	1.9	2 *	1.9 *		
	Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	1.9	2.7	1.9	2.6	2.3	3.1	4.2	2.4 *	3.1 *	2.9 *	2.1 *	2.4 *	2.1	2.4	3.3 *	2.8 *		

Trust Scorecard

* = unvalidated data

Category		Indicator	Target	Month												Quarter				Annual	
				Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	85.2%	75.9%	68.2%	68.4%	64.0%	41.9%	70.2%	69.1%	66.7%	61.5%	81.0%	78.1%	73.8%		60.2%	65.2%		66.2% *
		Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%					33.3% *	32.5% *	26.1%	38.0%	41.8%	45.5%	40.3%	37.1%			30.5%	41.5%		36.6% *
		Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	84.3%	83.6%	87.3%	66.1%	81.8%	84.6%	92.9%	95.0%	92.3%	98.2%	89.3%		88.6%	0.0% *	86.4%			90.9% *
	Time to Initial Assessment	ED Time To Initial Assessment - Under 15 Minutes	>=99%	48.8%	57.9%	68.5%	80.2%	81.9%	80.2%	75.9%	87.4%	91.0%	86.2%	86.7%	91.7%	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%	27.6%	35.4%	34.0%	31.2%	29.5%	28.8%	25.7%	32.3%	34.9%	31.2%	37.5%	41.5%	41.3%	33.4%	28.0%	32.8%		30.3% *
Operational Performance	Key Indicators - Operational Performance																				
	Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	100.0%	82.8%	92.3%	95.5%	86.3%	91.8%	88.9%	89.1%	88.5%	94.9%	80.0% *	93.4% *	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% *	60.0% *	71.4%	100.0% *	100.0%	76.7%		
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	72.0%	62.7%	70.0%	70.7%	78.3%	75.9%	71.2%	74.7%	80.1%	69.2%	73.2% *	74.4% *	76.9%	66.3% *	75.2%	75.1%		
	Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	1.5%	1.2%	1.8%	4.6%	7.2%	5.3%	5.3%	5.3%	4.8%	2.9%	0.5%	0.4% *	1.4% *	2.5% *	5.9%			5.5% *
	ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	74.12%	74.75%	76.96%	77.86%	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	82.40%	76.56%	80.87%	85.87%		82.87% *
	Referral to Treatment (RTT) Performance	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%	75.2% *												84.4% *	74.3% *				
	Detailed Indicators - Operational Performance																				
	Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	189	201	104	47	34	54	57	47	19	30	38 *	33	474	352	145	96	1,884	279 *
		Ambulance Handovers - Over 60 Minutes	< previous year	13	7	1	0	1	0	4	0	1	1	0 *	0	14	8	5	2	26	7 *
	Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0																		6 *
	Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	11	11	12	11	10	8	10	8	9	19	17							
		Cancer (104 Days) - Without TCI Date	0	49	56	42	42	47	80	32	35	30	26	23							
	Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	92.6%	85.1%	94.7%	94.6%	91.4%	90.5%	85.9%	79.6%	70.4%	71.2%	74.4% *	75.6% *	91.7%	90.1% *	89.1%	73.6%		
		Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	88.3%	89.4%	95.0%	97.1%	90.4%	94.0%	94.1%	57.3%	89.7%	92.7%	89.1% *	94.5% *	92.0%	92.2% *	92.8%	79.0%		
	Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	94.1%	90.1%	93.6%	96.8%	94.9%	95.9%	95.4%	95.8%	96.2%	98.5%	95.0% *	96.8% *	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%	98.5%	100.0% *	98.6% *	100.0%	100.0% *	100.0%	99.6%		
		Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	95.0%	98.4%	100.0%	98.6%	98.5%	100.0%	100.0%	100.0%	98.4%	96.6%	95.7% *	98.5% *	98.6%	99.2% *	99.5%	98.5%		
		Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	83.7%	84.2%	97.7%	87.8%	90.0%	97.5%	97.9%	93.6%	91.5%	95.5%	95.3% *	100.0% *	90.7%	90.0% *	94.5%	93.3%		
	Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	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		465 *	268 *	694 *	681		963 *	522		883 *	1,298	1,062	867	465 *	681			7 *	

Trust Scorecard

* = unvalidated data

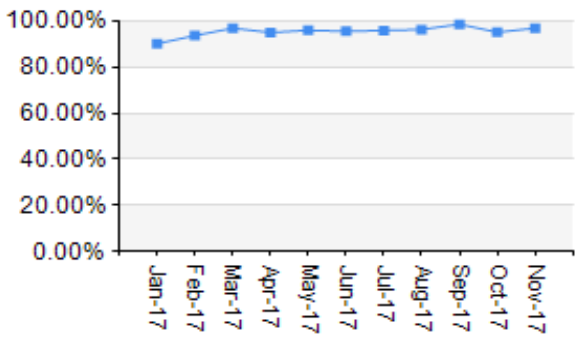
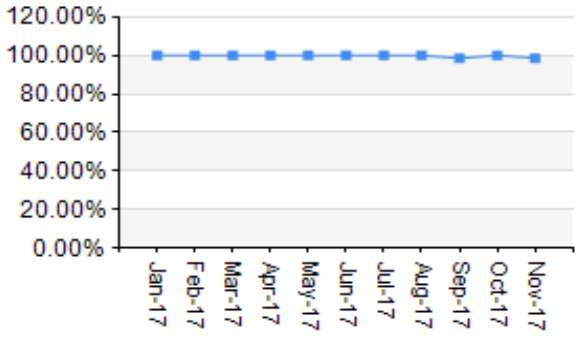
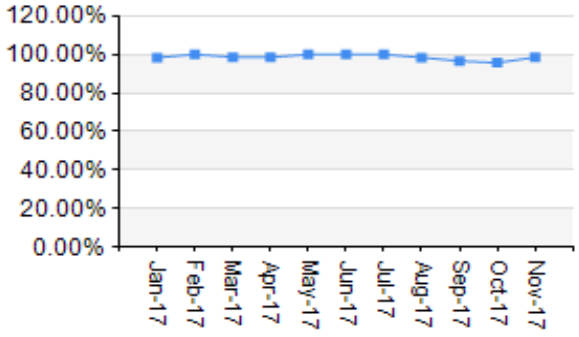
Category		Indicator	Target	Month												Quarter				Annual	
				Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
	Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	31.2% *	44.2% *	52.9% *	57.4% *	63.2% *	64.5% *	61.6% *	63.9% *	61.0% *	59.9% *	60.1% *		71.3% *	51.7% *	63.1% *	61.7% *	75.4% *	62.0% *
	ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	84.33%	87.47%	88.42%	88.50%	91.80%	92.30%	88.10% *	94.40%	95.00%	93.20%	93.80%	97.10%	92.79%	88.00% *	90.70%	94.20%	91.60%	92.30% *
		GRH ED - Percentage Within 4 Hours	>=95%	68.47%	67.83%	70.56%	71.80%	77.90%	72.90%	75.30%	77.70%	84.60%	82.40%	86.60%	94.40%	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)		5.84 *	5.76 *	5.57 *	5.33 *	5.11 *	4.87 *	4.96 *	4.97 *	4.87 *	4.79 *	5.12 *	5.01 *	5.54 *	5.55 *	4.98 *	4.87 *	5.37 *	4.96 *
		Length of Stay for General and Acute Elective Spells	<=3.4	3.58 *	2.8 *	3.03 *	2.8 *	2.83 *	2.66 *	2.86 *	2.73 *	2.99 *	3.15 *	3.39 *	2.81 *	3.32 *	2.87 *	2.78 *	2.95 *	3.08 *	2.92 *
		Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	6.53 *	6.58 *	6.3 *	6.19 *	5.78 *	5.48 *	5.58 *	5.62 *	5.36 *	5.24 *	5.56 *	5.6 *	6.24 *	6.35 *	5.61 *	5.41 *	6.08 *	5.53 *
	Medically Fit	Number of Medically Fit Patients Per Day	<40	73	75	84	68	59	55	58	63	58	60	62	60	73	75	56	60		63 *
	Referral to Treatment (RTT) Performance	Referral to Treatment Number of Ongoing Pathways Over 18 Weeks																			
	Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0																		
	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% *
	Trolley Waits	ED 12 Hour Trolley Waits	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0 *
Finance	Key Indicators - Finance																				
	Finance	YTD Performance against Financial Recovery Plan		-18	-18	-18 *	.07	-.95	-10.15	3.36	4.35	4.24	1.87	-.27 *		-18					
	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		83346					

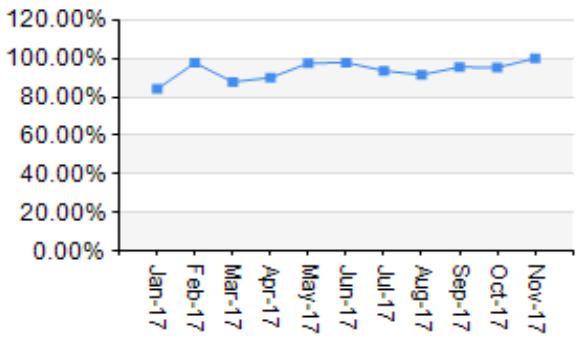
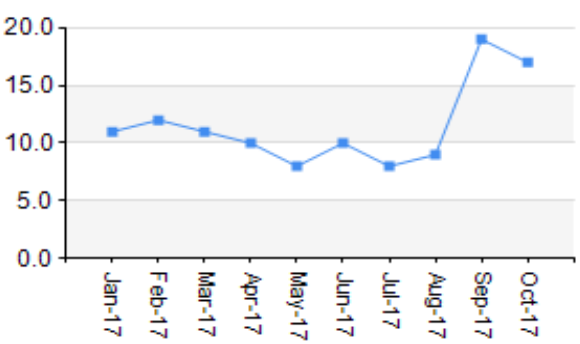
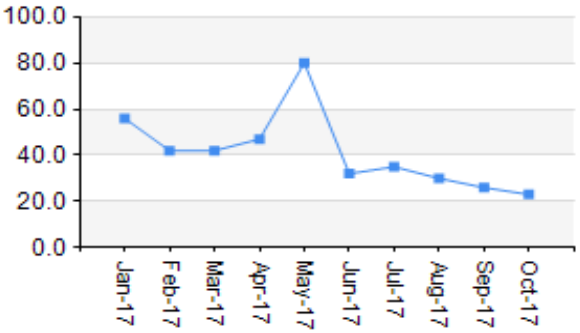
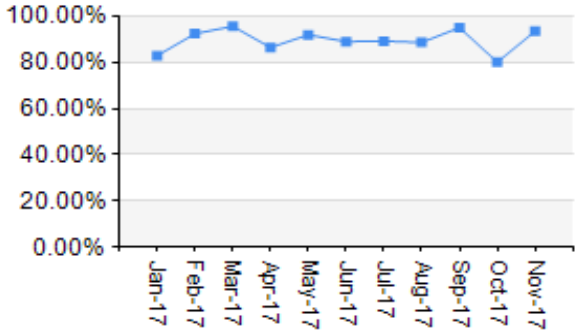
Trust Scorecard

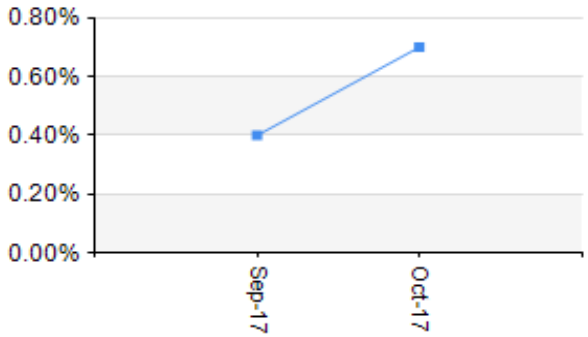
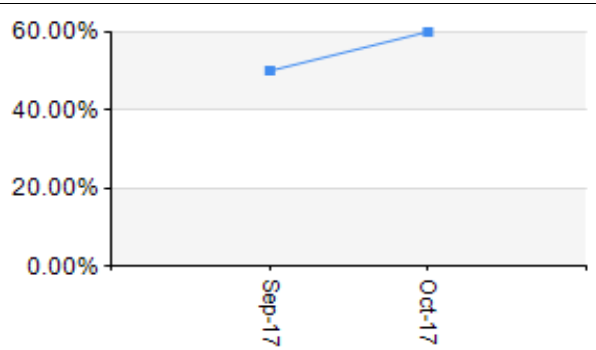
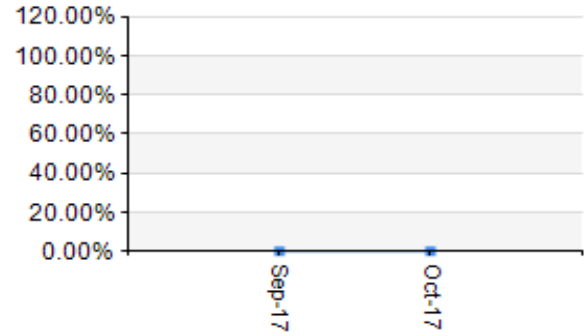
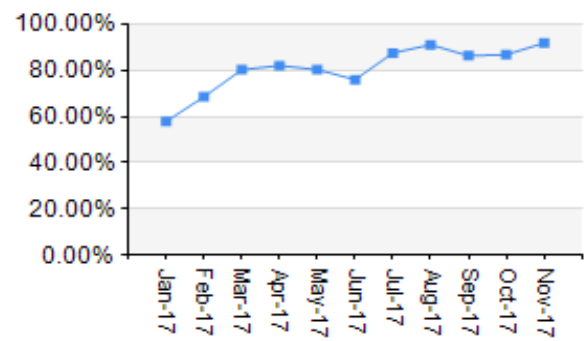
* = unvalidated data

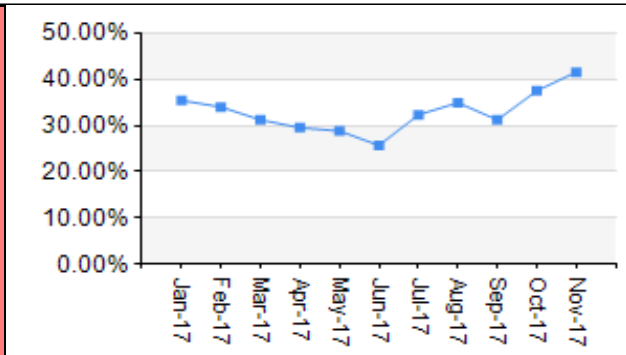
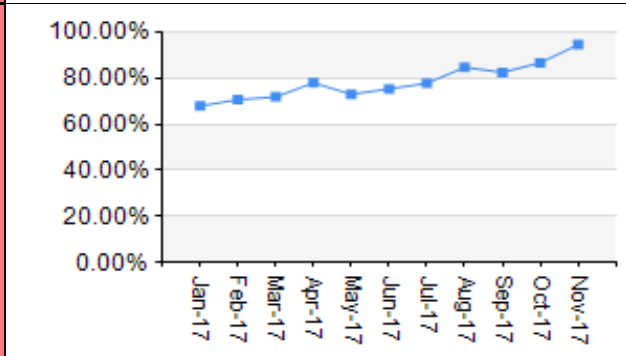
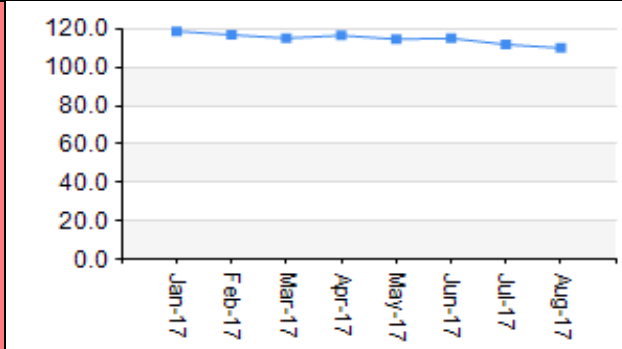
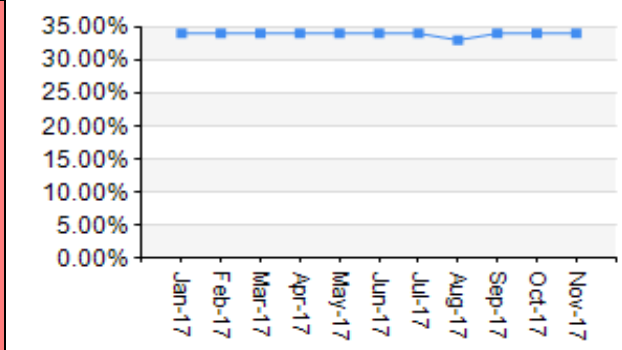
Category		Indicator	Target	Month												Quarter				Annual	
				Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	16/17	17/18
Leadership and Development	Key Indicators - Leadership and Development																				
	Sickness	Sickness Rate	G<3.6% R>4%	3.9%	3.9%	3.9%	4.0%	4.0%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9% *	3.9%	3.9%	3.9%	3.9%		
	Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	.04	.04	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	.04	.04	3.71	3.71		
	Turnover	Workforce Turnover Rate	7.5% - 11%	11.7%	11.8%	12.0%	11.5%	12.1%	12.0%	12.3%	12.3%	12.4%	12.3%	12.4%	12.4% *	11.7%	11.8%	12.3%	12.3%		
	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	3	3	3	3	3		
		Staff who have Annual Appraisal	G>89% R<80%	80.0%	80.0%	82.0%	82.0%	80.0%	79.0%	78.0%	79.0%	79.0%	79.0%	83.0%	83.0% *	80.0%	81.6%	79.0%	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%	33.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%		
	Staffing Numbers	Total Worked FTE		7,200	7,238	7,239 *										7,200					
	Training	Statutory/Mandatory Training	>=90%	89%	89%	89%	90%	89%	89%	89%	89%	89%	88%	88%	88% *	90%	89%	89%	89%		

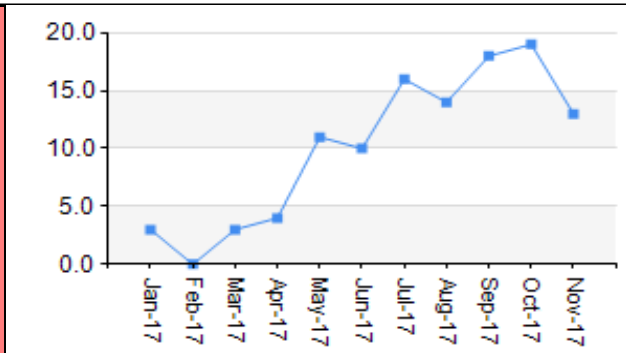
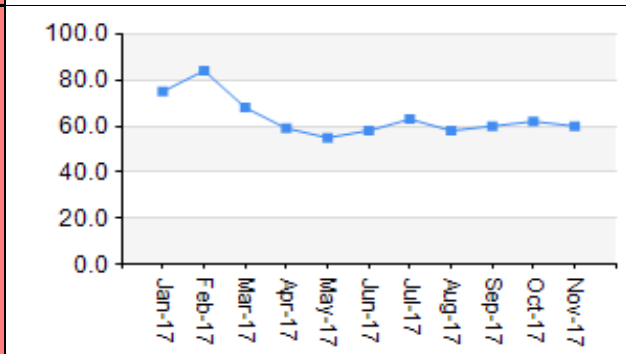
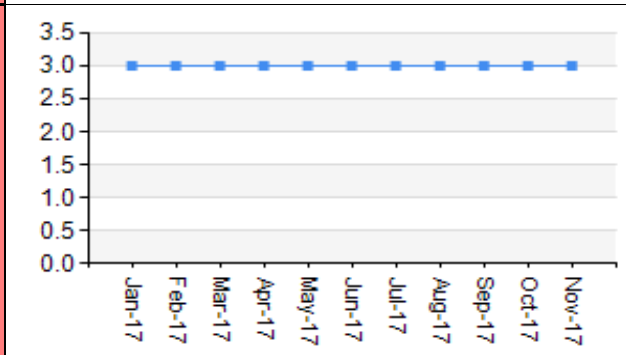
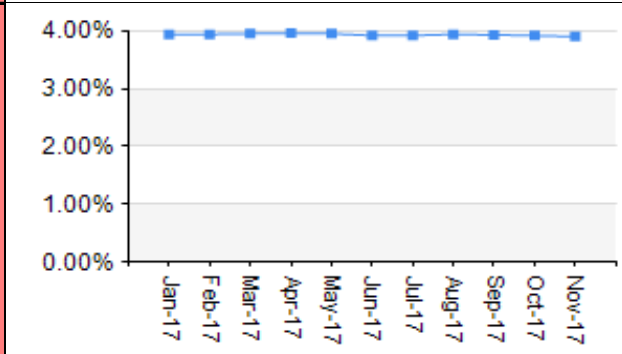
Exception Report

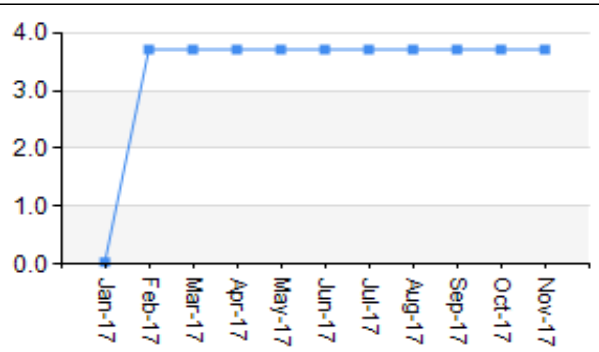
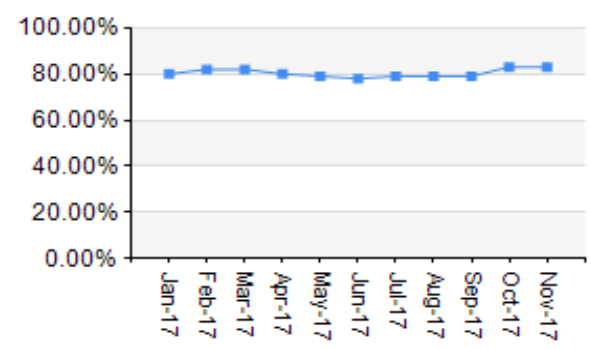
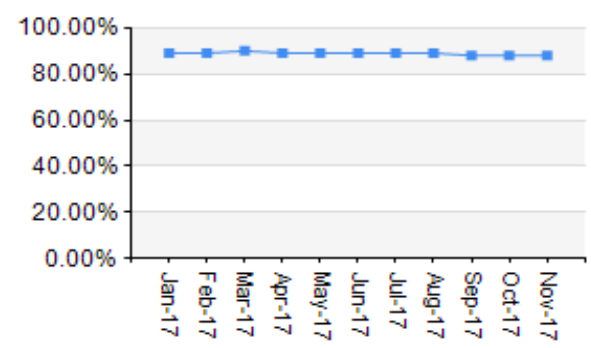
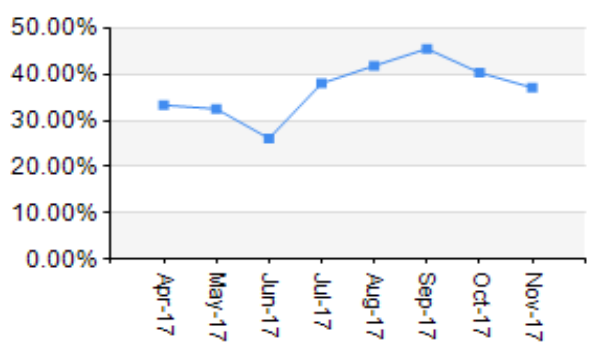
Metric Name & Target	Trend Chart	Exception Notes	Owner
Cancer - 31 Day Diagnosis To Treatment (First Treatments) **Target: >=96%**		November performance green - 96.8%	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) **Target: >=98%**		Performance is green 98.6% Green	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) **Target: >=94%**		November performance green - 98.5%	Deputy Chief Operating Officer

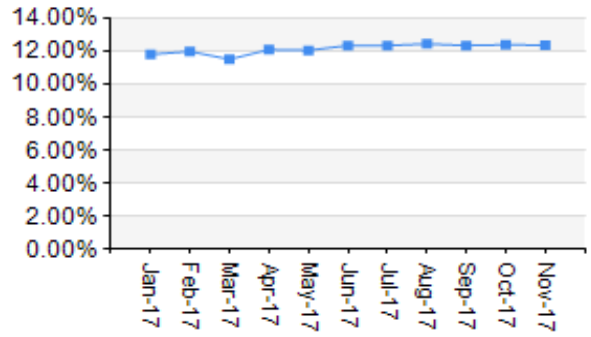
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) **Target: >=94%**		November performance 100% Green	Deputy Chief Operating Officer
Cancer (104 Days) - With TCI Date **Target: 0**		Not available at time of report.	Deputy Chief Operating Officer
Cancer (104 Days) - Without TCI Date **Target: 0**		Not available at time of report	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Screenings) **Target: >=90%**		November performance 93.4% Green	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.	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.	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.	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 was 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 has been planned for 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
GRH ED - Percentage Within 4 Hours **Target: >=95%**		GRH failed to achieve the performance standard for ED in November due to operational challenges that are internal to ED and wider GHT areas. 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) - Weekend **Target: Dr Foster confidence level**		Weekend mortality is the subject of considerable discussion nationally. Recent peer reviewed published data confirm the excess of patients with a higher acuity at weekends. Our own case review of specific diagnostic codes do not identify variation in care at weekends compared to weekdays. We will continue to monitor this measure to ensure consistent care throughout the week.	Medical Director
Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey) **Target: >38%**			Director of Human Resources and Operational Development

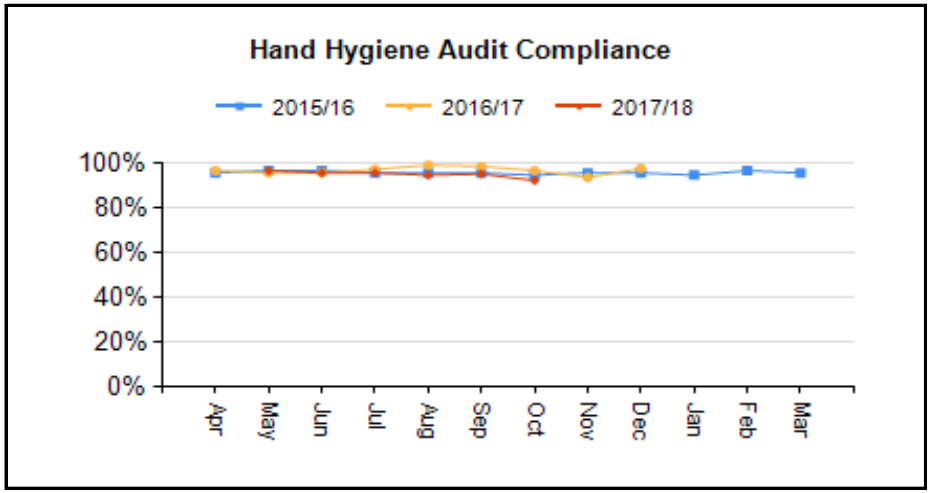
Number of Breaches of Mixed Sex Accommodation **Target: 0**		The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. A total of 13 breaches declared by the Trust for the month of November 2017. The analysis shows that all 19 breaches were within the Critical Care departments. 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
Number of Medically Fit Patients Per Day **Target: <40**		The number of patients medically fit per day has stabilised at 60 patients in November. We have not met the system wide target of <40 patients per day. Mitigating actions to continue the downward trend in place, as last month: Daily Navigation meetings. Weekly partnership review meetings for blocked or stranded patients. Development of a performance framework of 10 core standards across organisations to measure and unblock delays - in progress. Internal professional standards for Therapy, Pharmacy, Imaging and Pathology are being reported on a monthly basis at Emergency Care Board.	Deputy Chief Operating Officer
Percentage of Staff Having Well Structured Appraisals in Last 12 Months **Target: >3.8**		The 2017 survey for appraisals has just closed, no results currently available. The action plan remains in place from the March results and we continue to monitor appraisal rates through the Divisional reporting structures. Appraisal performance increased significantly within EFD who are the only Division to exceed the 90% target. All other Divisions are working to local improvement action plans and performance increased across all areas in month.	Director of Human Resources and Operational Development
Sickness Rate **Target: G<3.6% R>4%**		The overview of sickness management performance highlights outliers within CSSD and Orthopaedic Outpatients, both departments experiencing significant long-term sickness pressure. Remedial action plans are in place within both levels and further challenge is provide through the Executive Divisional review process. Aim is to reduce sickness to under 5% in key areas of concern	Director of Human Resources and Operational Development

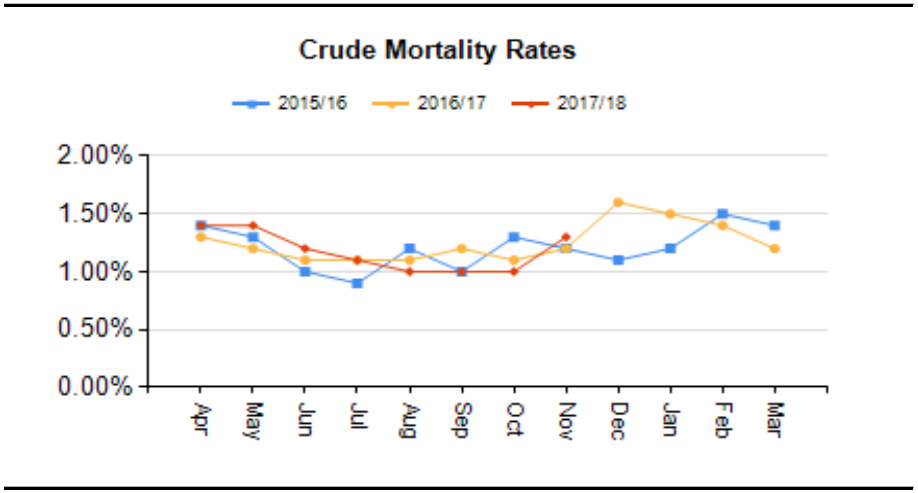
Staff Engagement Indicator (as Measured by the Annual Staff Survey) **Target: >3.8**			Director of Human Resources and Operational Development
Staff who have Annual Appraisal **Target: G>89% R<80%**		This benchmarks well with local Acute Trusts (average 84%) but remains below our target of 90%. Appraisal training is currently targeted in low-compliance areas/managers and more support from HRBPs and divisional leads to raise the compliance levels in their areas. This has worked well in Estates and Facilities recently where 94% was reached in October. A review of the appraisal process will be part of the Talent Management workstream in 2018.	Director of Human Resources and Operational Development
Statutory/Mandatory Training **Target: >=90%**		Mandatory training figures are less positive and whilst close to the 90% target we remain un a stable position at 88%	Director of Human Resources and Operational Development
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

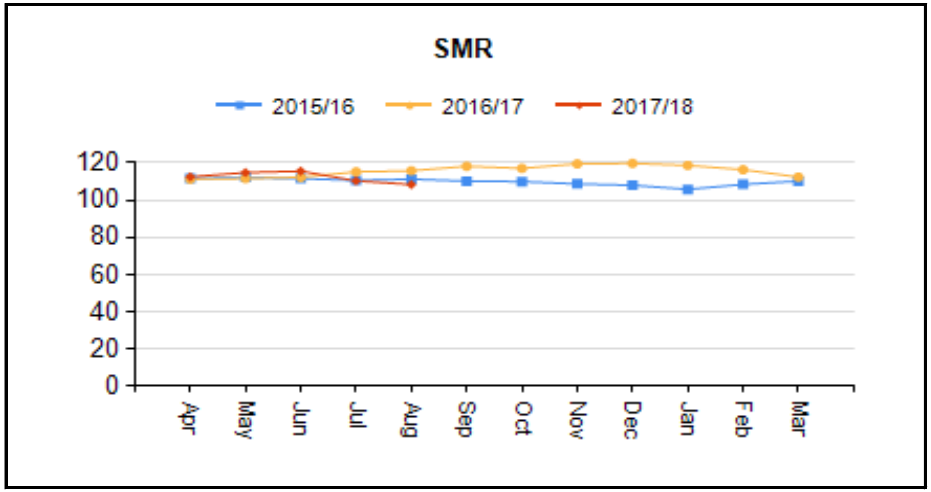
Workforce Turnover Rate **Target: 7.5% - 11%**		• The trust turnover target was previously set at 9.50%. This target is significantly below Turnover experienced. UK average labour market turnover sits at 15% (across all sectors) , however this reduces significantly in the public sector. Our local benchmarking 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. • 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). Recommendations are made to progress work in this area through a collaborative CQIA project involving	Director of Human Resources and Operational Development

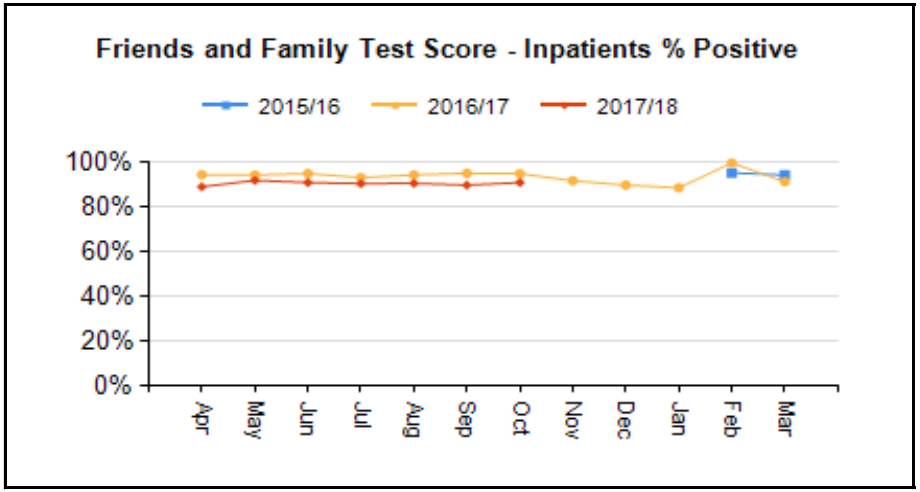
Contextual Indicators

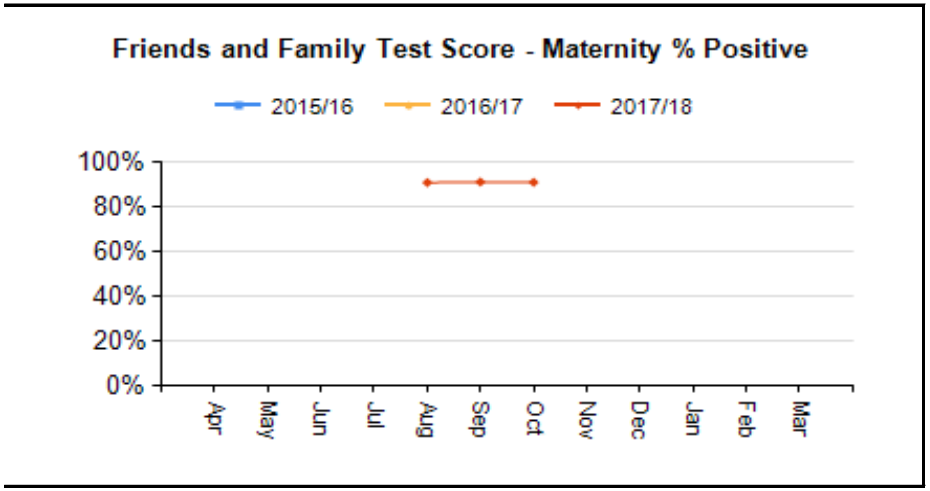
This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

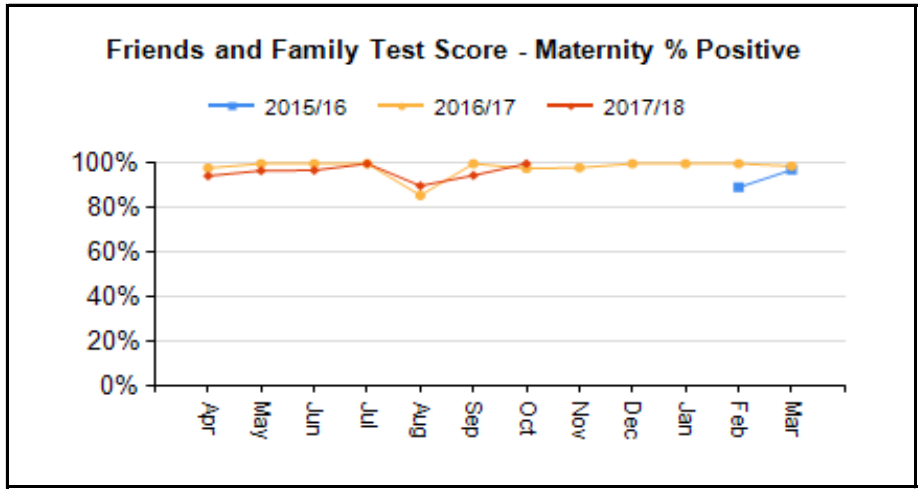


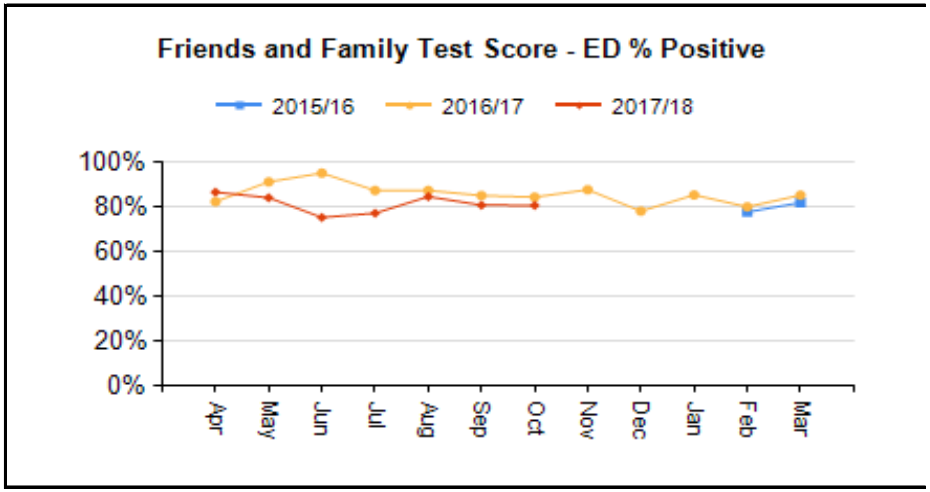


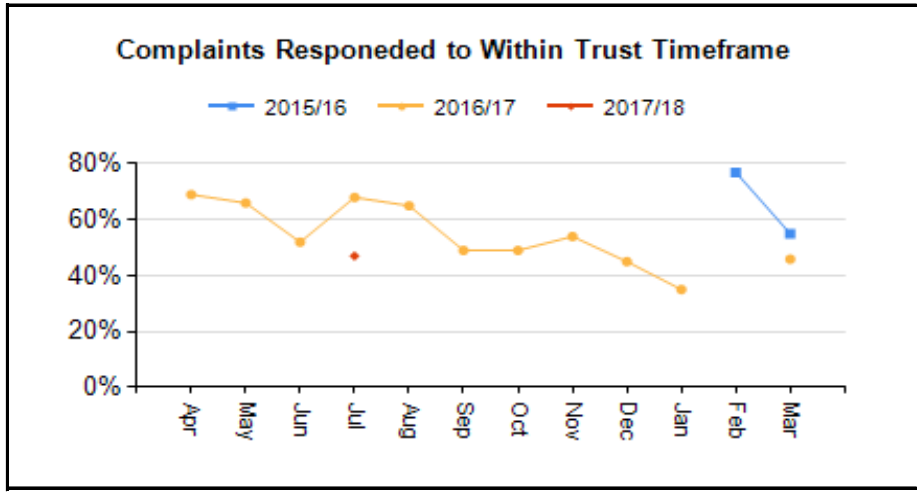


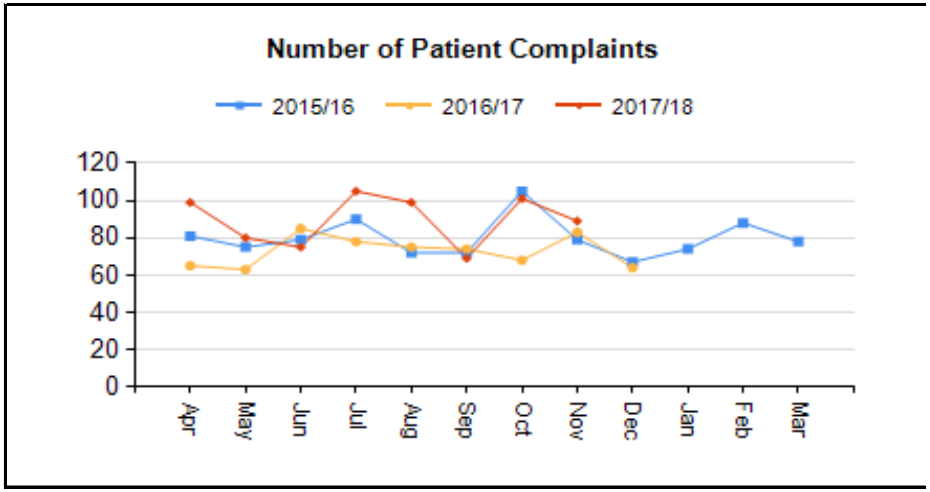


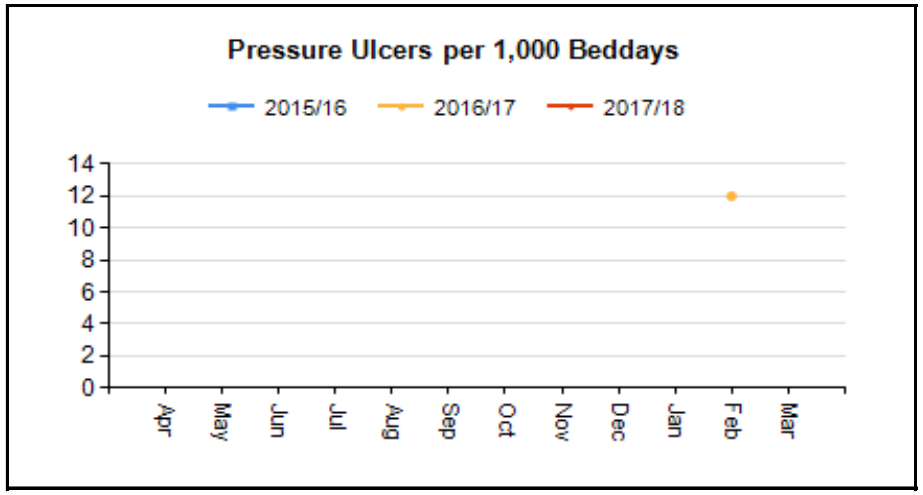

Friends and Family Test Score - Maternity % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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

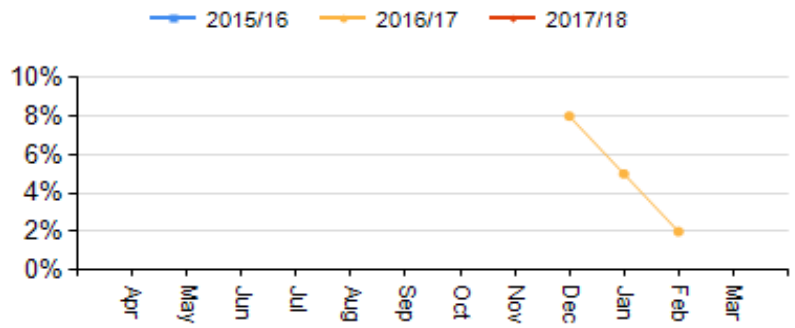

Friends and Family Test Score - ED % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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

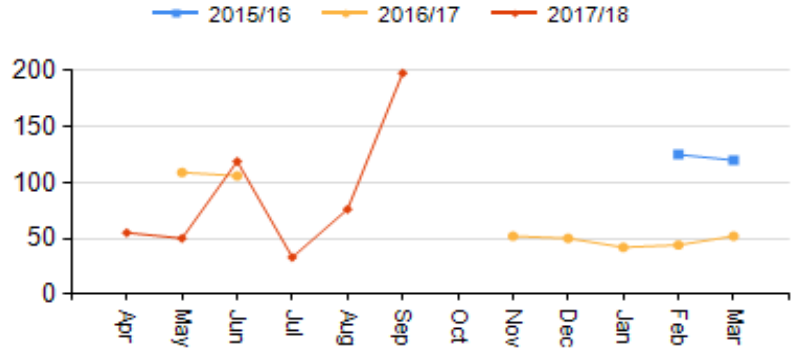

Number of Patient Complaints
2015/16
2016/17
2017/18
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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

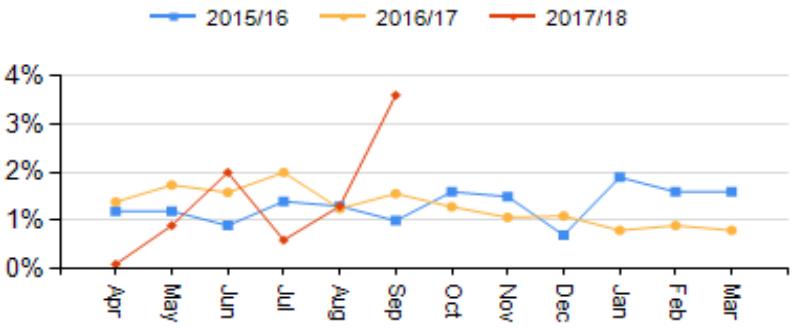
Percentage of Responses where Complainant is Dissatisfied



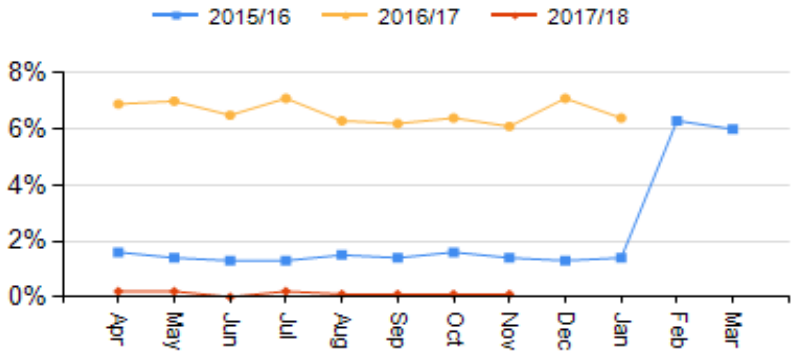
Number of Last Minute Cancelled Operations



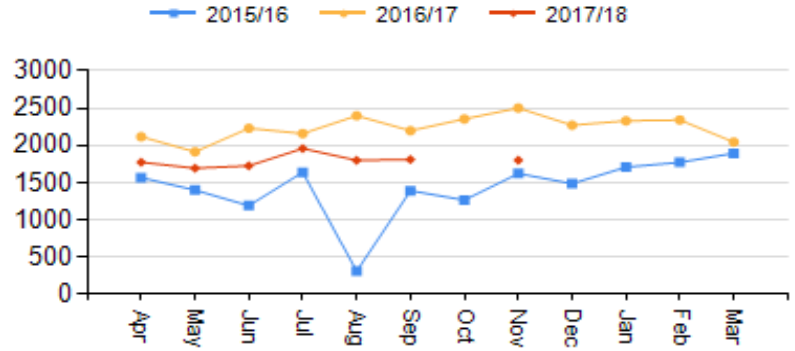
Last minute Cancelled Operations - Percentage of Admissions



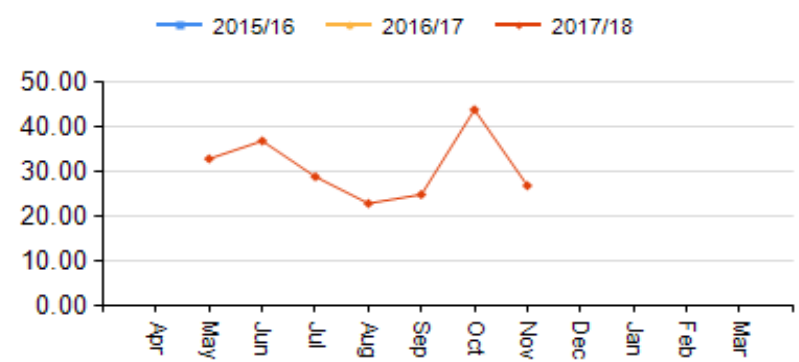
ED Unplanned Re-attendance Rate

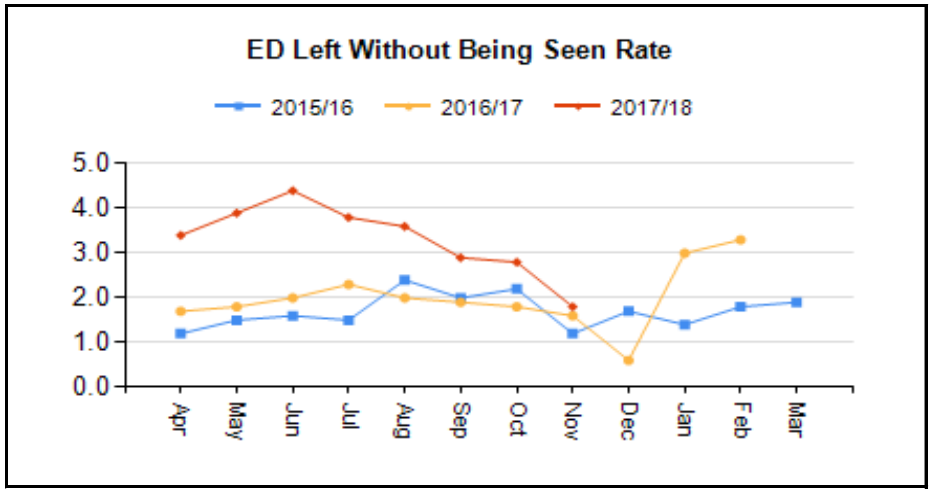


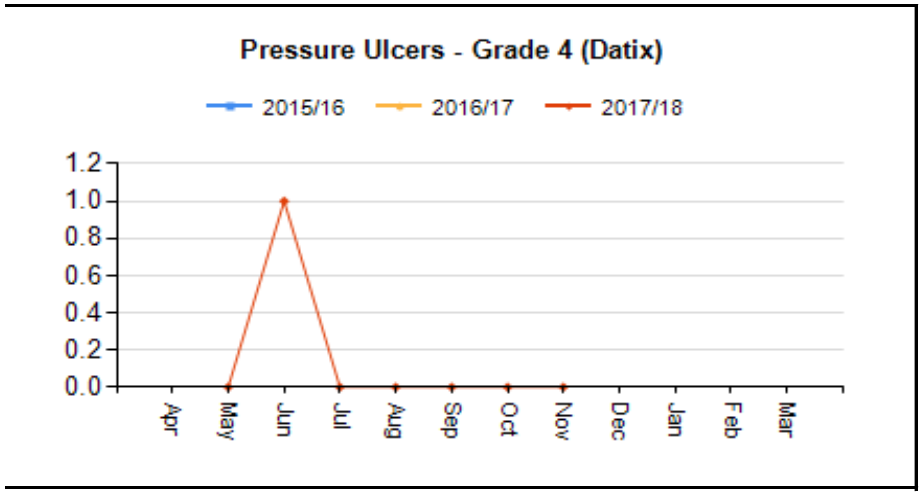
Beddays Occupied by Medically Fit Patients

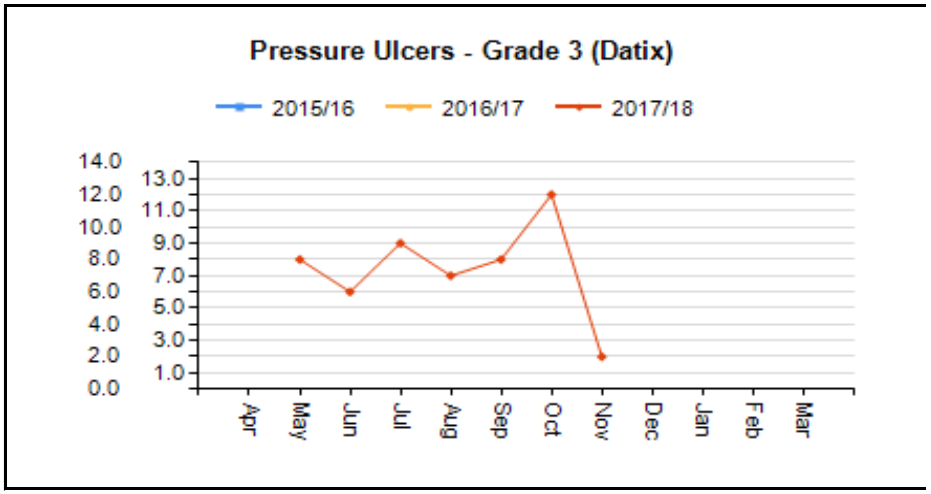


Pressure Ulcers - Grade 2 (Datix)




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
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – JANUARY 2017

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

This report describes the business conducted at the Workforce Committee on 21st December 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		How are we mitigating the risk of not being able to track areas of infectious disease with unsupported system loss.	- Explain functionality in TrakCare - Backup manual systems - Possible business case for replacement system	
Draft Quality Governance Structure	Discussion of early proposals for revisions to Quality Governance reporting and oversight arrangements.	How does the Quality and Performance Committee gain assurance concerning divisional activity. What will the relationship be between oversight by Trust Leadership Team and assurance role of Quality and Performance Committee?	- Through divisional governance which will be templated to align with the 5 domains of CQC - Through Executive Divisional Reviews - Through Exception Reports from Executive Divisional Reviews quarterly	- Once draft structure is finalised, it will need endorsement by the Board for introduction from 1 April 2018. - Once established there will be an internal audit to test the robustness of the framework.
NHSE Quality Improvement Group	Of the 3 areas of concern, 2 (Mortality and CQC action plan) have been referred to business as usual. Future meeting to focus on TrakCare.	How is the Quality and Performance Committee sighted on risks from TrakCare during this period prior to revised governance arrangements being in place?	- Risk Register - Reports in future from the Clinical Systems Safety Group	

Surgical Site Infections	Report presenting current Trust performance in each of mandatory reporting sites; areas of outlier status and action plan to deliver improvement.	Report shows significant room for improvement. What is different about the plan for the next 18 months?	- Additional senior support - Improved clinical engagement - Learning from other organisations	Revised plan to be presented to the Infection Control Committee and Quality and Performance Committee in February.
Feedback from CQRG	NHS England (NHSE) concerns re performance on mixed sex accommodation.		All clustered in one area (DCC).	Require NHSE to confirm the standard.
Quality and Performance Report	Summary of key highlights and exceptions in Trust performance for November 2017. Improved performance in 4 hour wait (95.3%) Improved visibility of patients on waiting lists. However, in November the Trust did not meet national standards or Trust trajectories for 2 week wait and 62 day cancer standard and 18 week referral to treatment (RTT) standard (shadow reporting).	Accident and Emergency Care performance acknowledged. What has delivered the improvement?	- Consistent clarity of expectations from the Operational Directors - Holding to account across all the pathways - Changes to surgical and trauma pathway - Alignment of space for emergency care - Relocation of the site team - Initiatives in the community	Need to ensure we are sighted on the impact of staff as route to sustainability. Considering options to create additional availability on the GRH site to prevent the use of the Day Surgery Unit. Quality and Performance committee to see cancelled operations reporting. More generally, need to ensure that data we have about patient experience is more effectively integrated into performance and exception reports.

Quality and Performance Report		How are we monitoring the experience for patients waiting for cancer treatment and ensuring that they are communicated with effectively?	- All patients post 62 days are reviewed by the Clinical Lead - All patients post 104 days are reviewed by the Medical Director - Deployment of Cancer trackers in contact with patient post first appointment	Creation of information for the patient at the time of booking to be prioritised.
Mortality Report		At what point will we have comprehensive use of Structured Judgement Reviews across all divisions? How do we respond to Dr Foster/CQC outlier alerts?	May 2018 There is an agreed protocol which will be shared with the Non-Executives in the Committee.	
Radiology Backlog Reporting	Response to CQC.	Improved performance over the past 18 months. How will this be sustained?	Specialty Director has proposals for realizing capacity to respond to increasing demand.	
Safer Staffing		How are you responding to the metrics from wards on level 8?	Level 8 is a respiratory area with vacancies due to difficulty in recruitment. Working with the ward team to review staffing skill mix model including the role of volunteers and families.	
Serious incidents		How do we ensure the dissemination of early learning ahead of a full investigation?	All cases are initially reviewed in 72 hours and wider learning disseminated.	Learning from the 72 hour review to be included in assurance reports.

MAIN BOARD – JANUARY 2018
Lecture Hall, Redwood 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 at the December Board meeting, the following risk was removed from the Trust Risk Register as it did not meet the criteria for inclusion (i.e. quality risk with a score of 12):

D&S2404CHaem - 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.

At the time of drafting the report, the TLT have not made any further changes to the Trust Risk register. However, the TLT was due to consider new risks submitted for its consideration at its meeting on 10th January 2018. Updated Trust Risk Register will be presented to the Board at its March meeting.

There are currently 13 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)**
					10th January 2018	
Outcome of discussion when presented to previous Committees						

Trust Risk Register - January 2018

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
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
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

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
C2335HR &OD	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Director of People and Organisational Development	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 in relation to cancer.	1. Weekly meetings check and challenge with all specialties, patient by patient level review 2. Dir-Ops weekly challenge with COO and Director of Planned Care 3. Validation of Patient tracking list daily by GMs 4. Performance trajectory in place for cancer pathways 5. Action plan in place for Delivery of Cancer Trajectory (30 April 18)	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Re-establish Planned care board Interim action plan to recover position	31/01/2018
M2473Em er	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 (ED)	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
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	17/01/2018

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
C2614NIC	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.	Adequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Create business case for new IC Net system	22/12/2017
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

PUBLIC BOARD MAIN BOARD – JANUARY 2018
Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
Financial Performance Report - Period to 30th November 2017
Sponsor and Author(s)
Author: Sarah Stansfield, Director of Operational Finance Tom Niedrum, Associate Director of Financial 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 8 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 8 of the 2017/18 financial year is an operational deficit of £22.6m. This is an adverse variance to budget and NHSI Plan of £2.1m.
- 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 8 is £15.1m. This is £1.5m worse than the plan for the year to date.
- The current CIP delivery forecast for the year is £22.9m as compared to a £34.7m plan.
- There is a separate report setting out the forecast position.

Conclusions

- The financial position for Month 8 shows an adverse variance to budget of £2.1m. 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.

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 30th November 2017

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 and this report reflects performance against the aligned budget and plan.

There will be a separate report on the Board agenda regarding a formal re-forecast of the outturn, and therefore the forecast section is omitted from this report. The outcome of this will be reported in the open section of the Board at the next meeting.

Statement of Comprehensive Income

2016/17 Outturn £000s	Month 8 Financial Position	Annual Budget £000s	M8 Cumulative Budget £000s	M8 Cumulative Actuals £000s	M8 Cumulative Variance £000s
433,665	SLA & Commissioning Income	439,649	290,114	285,383	(4,731)
4,604	PP, Overseas and RTA Income	4,734	3,088	3,156	69
66,388	Operating Income	62,001	41,481	41,995	514
504,657	**Total Income**	**506,384**	**334,683**	**330,534**	**(4,149)**
329,809	Pay	335,372	226,835	222,103	4,732
174,906	Non-Pay	160,740	111,718	116,342	(4,623)
504,716	**Total Expenditure**	**496,113**	**338,553**	**338,445**	**108**
(59)	**EBITDA**	**10,271**	**(3,870)**	**(7,911)**	**(4,041)**
(0.0%)	**EBITDA %age**	**2.0%**	**(1.2%)**	**(2.4%)**	**(1.2%)**
21,135	Non-Operating Costs	24,885	16,623	14,714	1,909
(21,193)	**Surplus/(Deficit)**	**(14,614)**	**(20,493)**	**(22,625)**	**(2,131)**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,614)**	**(20,493)**	**(22,625)**	**(2,131)**

In November the Trust has delivered an in-month deficit of £1.7m and a cumulative deficit of £22.6m

This represents a year to date adverse variance to plan of £2.1m as at Month 8.

The Trust has now reached agreement with both major commissioners for a block contract arrangement. This means that income for the six months outstrips budget for those commissioners and gives a favourable variance. Within income there is a year to date favourable variance on pass-through drugs and devices of £0.4m.

The cumulative actual is £0.3m favourable to the "realistic stretch" forecast for month 8.

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Annual Budget £000s	Month 8 Financial Position	M8 Cumulative Budget £000s	M8 Cumulative Actuals £000s	M8 Cumulative Variance £000s
439,649	SLA & Commissioning Income	290,114	285,383	(4,731)
4,734	PP, Overseas and RTA Income	3,088	3,156	69
62,001	Operating Income	41,481	41,995	514
506,384	**Total Income**	**334,683**	**330,534**	**(4,149)**
	Pay			
312,355	Substantive	210,603	204,201	6,402
6,473	Bank	4,861	6,529	(1,668)
16,544	Agency	11,370	11,373	(3)
335,372	**Total Pay**	**226,835**	**222,103**	**4,732**
	Non Pay			
55,539	Drugs	37,382	40,532	(3,150)
40,134	Clinical Supplies	27,207	27,540	(333)
65,067	Other Non-Pay	47,129	48,269	(1,140)
160,740	**Total Pay**	**111,718**	**116,342**	**(4,623)**
496,113	**Total Expenditure**	**338,553**	**338,445**	**108**
10,271	**EBITDA**	**(3,870)**	**(7,911)**	**(4,041)**
2.0%	**EBITDA %age**	**(1.2%)**	**(2.4%)**	**(1.2%)**
24,885	Non-Operating Costs	16,623	14,714	1,909
(14,614)	**Surplus/(Deficit)**	**(20,493)**	**(22,625)**	**(2,131)**
	STF Funding			

The table opposite shows the detailed income and expenditure position.

SLA and Commissioning Income – a £4.7m 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 and is addressed in detail on the preceding pages.

Private Patient Income – beginning to improve.

Pay – expenditure is showing a favourable variance of £4.7m 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 now peaked falling from a high of £4.9m in month 7.

Non-Pay – Drugs expenditure is showing a £3.2m adverse variance whilst Clinical Supplies are £0.3m adverse. Other non-pay is £1.1m 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

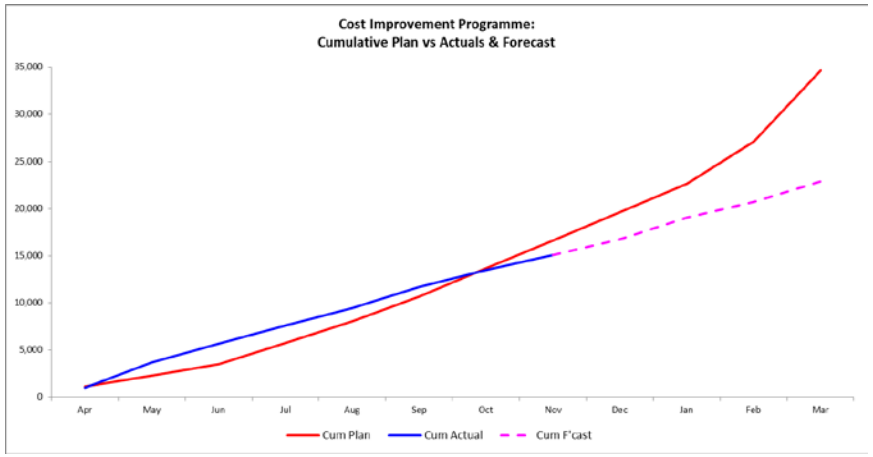
At Month 8 we have delivered £15.1m against the NHS Improvement plan target of £16.6m which is an under-achievement of £1.5m against plan. The over performance this month is largely due to the level of unidentified CIPs.

At Month 8, the divisional year end forecast figures, indicate confidence in delivering £22.9m* against the Trust's target of £34.7m. The month 7 forecast was £23.4m, which shows a deterioration of £0.5m. The deterioration is mostly attributable to reduced pay grip including agency and vacancies. (*This does not include the additional CIPs and further measures).

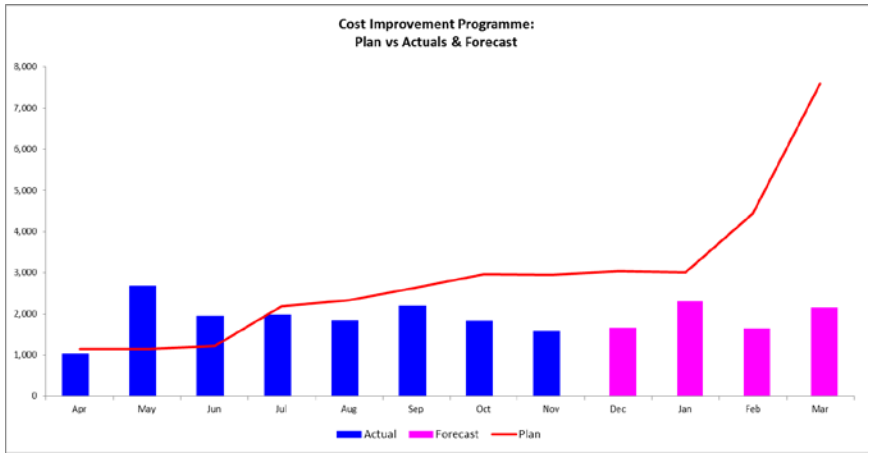
The FOT of £22.9m splits into £17.0m of recurrent schemes and £5.9 of non-recurrent schemes. This leaves a shortfall for 18/19 of £17.7m. The non-recurrent schemes include vacancy factors, an agency scheme (no non-clinical agency over Christmas), and an annual leave accrual scheme.

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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M8 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	8,506	1,113
Property, Plant and Equipment	296,272	294,605	(1,667)
Trade and Other Receivables	4,668	4,490	(178)
Total Non-Current Assets	**308,333**	**307,601**	**(732)**
Current Assets			
Inventories	7,400	7,518	118
Trade and Other Receivables	17,697	20,135	2,438
Cash and Cash Equivalents	7,974	2,520	(5,454)
Total Current Assets	**33,071**	**30,173**	**(2,898)**
Current Liabilities			
Trade and Other Payables	(44,355)	(48,077)	(3,722)
Other Liabilities	(2,089)	(4,457)	(2,368)
Borrowings	(5,356)	(5,355)	1
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(58,071)**	**(6,089)**
Net Current Assets	**(18,911)**	**(27,898)**	**(8,987)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,361)	251
Borrowings	(83,126)	(96,328)	(13,202)
Provisions	(1,524)	(1,480)	44
Total Non-Current Liabilities	**(92,262)**	**(105,169)**	**(12,907)**
Total Assets Employed	**197,160**	**174,534**	**(22,626)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	166,519	0
Reserves	70,501	70,501	0
Retained Earnings	(39,860)	(62,486)	(22,626)
Total Taxpayers' Equity	**197,160**	**174,534**	**(22,626)**

The table shows the M8 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.
- New capital commitments have been limited in recent months due to uncertainty regarding approval of the Trust's capital loan request. This loan has now been approved and will be drawn down later in the month, and planned capital commitments can now be released.

Current Assets

- Inventories show a slight decrease of under £0.1m.
- Trade receivables are £2.4m above their closing March 2017 level.
- Cash has reduced by £5.5m since the year-end, and £1m in month.

Current Liabilities

- Trade payables have increased by £3.7m over the closing March level (a £2.6m reduction on the month 7 level).
- Other liabilities have increased by £2.4m since year end.

Non-Current Liabilities

- Borrowings have increased by £13.2m. A further £3.5m of distress financing to fund deficit support was drawn down in November. Total distress funding drawn to date is £16.3m against a deficit of £22.6m – 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.
- As noted above, the requested £5m capital loan will be drawn down later in the month.

Reserves

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

Cashflow : November

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	Nov-17 £000s
Surplus (Deficit) from Operations	**(4,958)**	**(3,284)**	**935**	**(1,031)**	**(1,940)**	**(1,953)**	**(1,955)**	**(783)**
Adjust for non-cash items:								
Depreciation	946	1,719	975	975	975	975	975	975
Impairments within operating result	0	0	0	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0	0	0	0
Provisions	0	0	0	0	0	0	0	0
Other operating non-cash	(58)	(59)	(58)	(58)	(58)	(58)	(58)	(58)
Operating Cash flows before working capital	**(4,070)**	**(1,624)**	**1,852**	**(114)**	**(1,023)**	**(1,036)**	**(1,038)**	**134**
Working capital movements:								
(Inc.)/dec. in inventories	(150)	(1,118)	349	192	367	132	68	0
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(157)	633	379	1,940	(1,849)	(508)
(Inc.)/dec. in current assets	0	0	0	0	0	0	0	0
Inc./(dec.) in current provisions	0	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	(2,337)
Inc./(dec.) in other financial liabilities	(562)	3,448	(58)	(181)	(129)	153	21	0
Other movements in operating cash flows	835	(995)	32	(31)	32	(79)	206	32
Net cash in/(out) from working capital	**(13)**	**2,863**	**(1,943)**	**83**	**1,163**	**(986)**	**1,147**	**(2,813)**
Capital investment:								
Capital expenditure	(148)	(989)	(348)	(214)	(909)	(608)	(1,636)	(1,365)
Capital receipts	0	0	0	0	0	0	0	0
Net cash in/(out) from investment	**(148)**	**(989)**	**(348)**	**(214)**	**(909)**	**(608)**	**(1,636)**	**(1,365)**
Funding and debt:								
PDC Received	0	0	0	0	0	0	0	0
Interest Received	4	3	2	3	3	3	2	3
Interest Paid	0	(162)	(42)	0	0	(1,329)	(29)	(163)
DH loans - received	0	0	0	2,355	0	8,864	1,664	3,452
DH loans - repaid	0	0	0	0	0	(1,318)	0	0
Other loans	0	0	0	0	0		0	0
Finance lease capital	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)
PFI/LIFT etc capital	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)
PDC Dividend paid	0	0	0	0	0	(3,091)	0	0
Other	0	0	0	0	0	0	0	0
Net cash in/(out) from financing	**(197)**	**(360)**	**(241)**	**2,157**	**(198)**	**2,928**	**1,436**	**3,091**
Net cash in/(out)	**(4,428)**	**(110)**	**(680)**	**1,912**	**(967)**	**298**	**(91)**	**(953)**
Cash at Bank - Opening	**7,539**	**3,111**	**3,001**	**2,321**	**4,233**	**3,266**	**3,564**	**3,473**
Closing	**3,111**	**3,001**	**2,321**	**4,233**	**3,266**	**3,564**	**3,473**	**2,520**

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

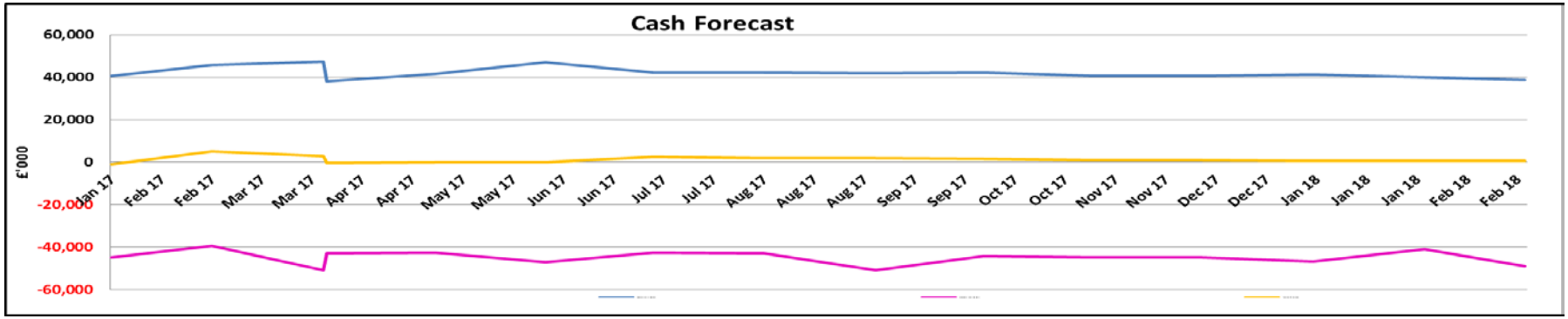
Current Assets – Invoiced debtor balances have increased in month, timely settlement of in-month SLA invoices offset by increase in Hosted Services income as a result of GP Payroll reporting issues.

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**	**2,789**	**2,803**	**2,654**	**2,654**	**2,654**	**2,654**	**4,034**
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	35,154	35,163	35,163	35,163	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	4,527	3,959	4,389	3,289	1,889	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	1,071	959	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	500	550	550
Funding	1,506	3	3	4	3	3	2,358	3	8,867	1,667	3,455	4,321	5,233	830	10,100	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**	**44,124**	**44,893**	**46,606**	**40,982**	**48,912**	**41,663**	**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)	(26,319)	(26,320)	(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)	(15,819)	(15,859)	(18,355)	(14,362)	(16,723)	(13,541)	(12,032)	(15,032)
Other payables	(1,542)	(520)	(1,133)	(633)	(365)	(784)	(848)	(793)	(858)	(1,344)	(764)	(956)	(550)	(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)	(218)	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)**	**(44,809)**	**(44,879)**	**(46,755)**	**(40,982)**	**(48,912)**	**(41,664)**	**(40,443)**	**(43,325)**
Net Cashflow	**(2,639)**	**6,297**	**(3,438)**	**(4,776)**	**(859)**	**49**	**1,880**	**(722)**	**(70)**	**(229)**	**(684)**	**15**	**(149)**	**0**	**0**	**(1)**	**1,380**	**(1,502)**
Closing Balance	**5,340**	**11,637**	**8,199**	**3,423**	**2,565**	**2,614**	**4,494**	**3,773**	**3,702**	**3,473**	**2,789**	**2,803**	**2,654**	**2,654**	**2,654**	**2,654**	**4,034**	**2,532**
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**	**860**	**874**	**725**	**725**	**725**	**724**	**2,105**	**603**



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	(0.35)	(0.76)
Metric		
Rating	4	4
Liquidity	(20.50)	(25.50)
Metric		
Rating	4	4
I&E Margin	(6.19%)	(6.85%)
Metric		
Rating	4	4
I&E Variance from Plan	0.00%	(0.66%)
Metric		
Rating		2
Agency	47.29%	39.84%
Metric		
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 M8, which is in line with Plan, and continues to show performance at a "4".

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee is asked to note:

- The financial position of the Trust at the end of Month 8 of the 2017/18 financial year is an operational deficit of £20.9m. This is a adverse variance to budget and NHSI Plan of £2.1m.
- The variance is reflective of both year to date pay underspends and phasing adjustments within the income position.
- There will be a separate paper on forecast.

Author:	**Sarah Stansfield, Director of Operational Finance** **Tom Niedrum, Associate Director of Financial Management**
Presenting Director:	**Steve Webster, Director of Finance**
Date:	**January 2017**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – JANUARY 2018

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

This report describes the business conducted at the Finance Committee held 20th December 2017, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Month 8 performance is slightly better than expected. A range of forecasts were discussed which indicated that it is feasible, but extremely challenging, to deliver £27.4m deficit that we believe is the minimum expectation of NHS Improvement.	Why has the forecast fluctuated since Month 7? What additional changes to the forecast will need to be anticipated in the remainder of the year? Drivers for drugs overspend need to need to be understood more urgently?	Forecast is understood by the Executives and the key members of the management team and is actively worked on.	Further work required ahead of February.
Cost Improvement Programme Update	Positive progress against £6m. The Cost Improvement Programme (CIP) pipeline is being developed but much more work is required.	How does our level of CIP compare with other trusts? Procurement CIPs are underperforming. More pace and impact need to be demonstrated.	GHFT CIPs are in line with others in the South West group. We are also looking at the national picture for further opportunities. Approach to supplier meetings is being sharpened and external NHS Improvement support is being sought.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Capital Programme Update	No NHS Improvement (NHSI) response to our £5m capital local application is a major concern.	Should this be escalated?	Chief Executive to escalate to Department of Health.	
Medical Productivity Update	A refinement of the current approach was agreed, which involves completing accurate job plans within the current financial year and driving productivity from direct clinical care from next financial year.	Given the scale of benefit is this work proceeding fast enough? Are medical staff engaged?	The work is driven by Medical Director at pace. Both the medical Director and Chief Executive have engaged with medical staff and in addition to leadership from the top this work is now owned by Specialty Directors and others in positions of authority.	
Risk Register	Since the register was presented to the Committee in November an additional risk has been added and is rated 15 (5 x 3) – this will go to the next Trust Leadership Team for escalation to the Trust Risk Register: The risk that the Trust is unable develop a financial plan that is acceptable to the Board and/or to agree the proposed Control Total for 2018/19 with NHSI.			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Primary Percutaneous Coronary Intervention (PPCI) service Business Case	Business case proposing expansion of Primary Percutaneous Coronary Intervention service to 24/7 was approved by the Committee.			
Any Other Business: Theatres Managed Service Contract – Approval for the Application of Trust Seal	The Committee confirmed it has agreed that the Theatres Managed Service Contract be signed and sealed. This will be reported to the Board.			

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2018
Lecture Hall, Redwood Education Centre commencing at 09:00

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

Purpose

This report provides Trust Board with an overview of current performance, against the existing key performance indicators and outlines progress against key objectives.

Key issues to note

- At Month 8 a **pay** underspend of £4.7m against budget is reported. Underspends are noted against substantive (£6.4m), whilst agency is breakeven, offset by an overspend on bank staffing (£1.7m).
- Continued **vacancy control** aims to release a further £1m in CIP, with posts only being authorised for recruitment where there are significant or intolerable risks to safety or reputation.
- A slight reduction in **turnover** is shown however previous trends lead us to believe this will increase again slightly (as is common in the New Year) and forecasts a stable position for the remainder of the financial year.
- High turnover within Additional Clinical Services (HCA's) is noted and plans for further intervention are being developed.
- The Trust annual **sickness absence rate** of 3.90% remains significantly 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.
- This improvement in overall sickness absence performance is influenced by a number of factors including: the introduction of a revised sickness absence management process in February 2017, additional scrutiny of sickness patterns at Divisional Executive Review and targeted interventions, in areas with higher than average sickness.
- **Appraisal compliance** rose slightly in November, however remains well below the Trust target of 90%. EFD compliance is the most improved and sits above target.
- **Mandatory training** figures remain static and continue to fall just below the target of 90%.
- Quality Health have confirmed the Trust overall response rate to the **Staff Survey** as 47%, sitting above the National Average response rate of 44% for Acute Trust.

Conclusions

Overall progress in Sickness Absence management is encouraging. Turnover, Appraisal and Mandatory Training require further focus and improvement.

Implications and Future Action Required

- HCA Turnover is of concern. Further work is now being commissioned in collaboration with Nursing, HR and the Trust Improvement Academy to investigate the root causes of high turnover within this staff group and produce recommendations for improvement.

- Continued further scrutiny of Long Term Sickness absence is required. The HR Team are currently scrutinising a number of cases of long term sickness to ensure Managers have the support in place to manage these cases in accordance with Trust policy and best practise.

Recommendations

The Board is asked to note the 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

Regulatory and/or Legal Implications

NHS Improvement 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

MAIN BOARD – JANUARY 2018

WORKFORCE REPORT

1. Aim

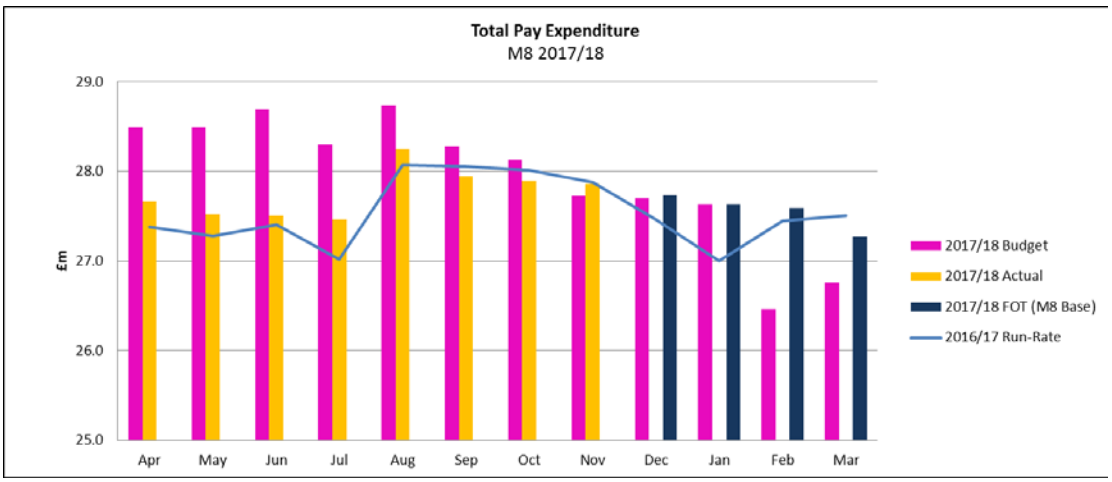
This report provides Trust Board with an overview of current performance, against the existing key performance indicators and outlines progress against key objectives.

3. Pay Expenditure

At Month 8 a pay underspend of £4.7m against budget is reported. Underspends are noted against substantive (£6.4m), whilst agency is breakeven, offset by an overspend on bank staffing (£1.7m).

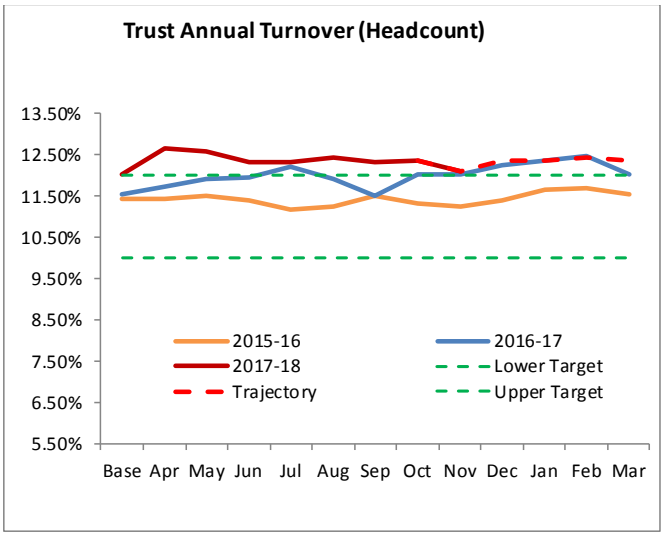
The budget profile included assumptions on the time taken to fill vacant posts and new posts that had not been backfilled, many of these posts have been in process of recruitment and are now beginning to be filled meaning that the level of vacancy savings has reduced. Pay spend in Month 8 at £27.9m was in line with Month 6 and 7.

Continued vacancy control aims to release a further £1m in CIP, with posts only being authorised for recruitment where there are significant or intolerable risks to safety or reputation.



4. Turnover

The turnover target indicates a range between 10-12% as an acceptable yet aspirational turnover level (compared to an average of 11-13% across other Acute Trusts). Current performance is higlighted below. This shows a slight reduction in overall turnover in month. Previous trends lead us to believe this will increase again slightly (as is common in the New Year) and forecasts a stable position for the remainder of the financial year.



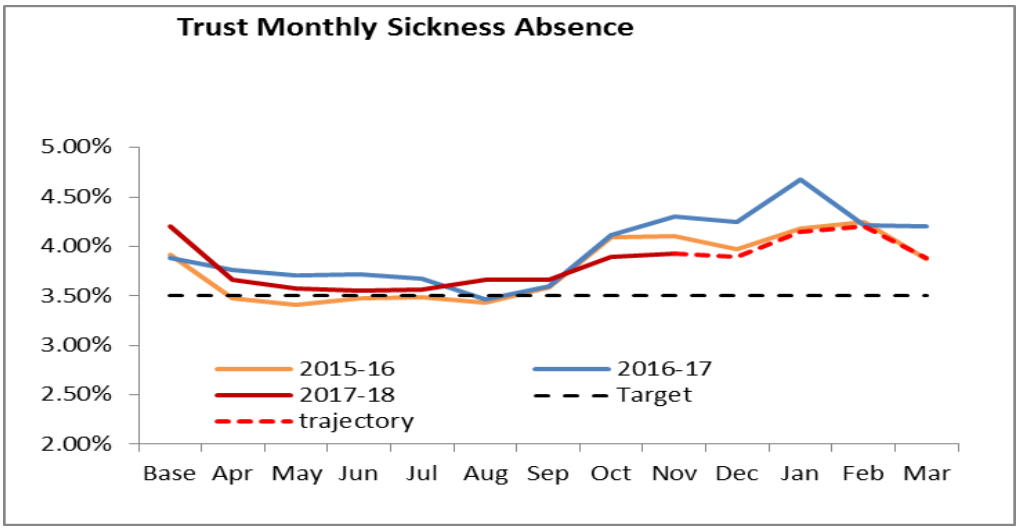
Current Performance		Movement since last Month	
12 months to November 17	Actual % TO		
Trust Total	**12.10%**	↘	decrease
Corporate	13.20%	↘	decrease
Diagnostics & Specialty	11.34%	↗	increase
Estates & Facilities	7.84%	↗	increase
Medicine	13.47%	↘	decrease
Surgery	12.36%	↘	decrease
Womens & Children	12.86%	↘	decrease
Add Prof Scientific and Technic	8.02%	↗	increase
Additional Clinical Services	14.84%	↘	decrease
Administrative and Clerical	14.29%	↘	decrease
Allied Health Professionals	13.25%	↗	increase
Estates and Ancillary	8.81%	↗	increase
Healthcare Scientists	10.70%	↘	decrease
Medical and Dental	7.00%	↘	decrease
Nursing and Midwifery Registered	11.17%	↘	decrease
Staff Nurses	12.14%	↘	decrease
Significantly above upper target limit (>15%)			
Above upper target limit (12%)			
Between target limits (10-12%)			
Within target or below (10%)			

As mentioned in the last report to Board, 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 is now being commissioned and, in collaboration with Nursing, HR and the Trust Improvement Academy 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 3.90% remains significantly 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.

Despite the usual increase in early winter sickness absence, levels remain below sickness absence experienced in previous years. This improvement in overall performance is influenced by a number of factors including the introduction of a revised sickness absence management process in February 2017. This has had a notable impact on manager's ability to swiftly and proactively support and manage absent staff. Scrutiny of sickness patterns at Divisional Executive Review and targeted interventions, in areas with higher than average sickness, has contributed to our current position. Further work is now planned (at a local level) to continue to support the reduction of long term absence.



Current Performance			Sickness Absence by month							
12 months to Nov 17 (Annual)	Actual	KPI	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Movement Sep to Oct	
	% Abs	% Abs								
Trust Total	3.90%	3.50%	3.56%	3.57%	3.67%	3.67%	3.89%	3.93%	↗	increase
Corporate	3.92%	3.50%	3.41%	3.74%	3.88%	3.88%	4.40%	4.00%	↘	decrease
Diagnostics & Specialty	3.68%	3.50%	3.85%	3.42%	3.66%	3.56%	4.04%	3.58%	↘	decrease
Estates & Facilities	4.53%	3.50%	3.91%	3.82%	3.96%	4.11%	3.87%	4.28%	↗	increase
Medicine	3.70%	3.50%	3.08%	2.79%	3.08%	3.27%	3.94%	3.97%	↗	increase
Surgery	4.08%	3.50%	3.82%	4.05%	3.82%	4.05%	3.81%	4.18%	↗	increase
Womens & Children	3.85%	3.50%	2.97%	3.78%	3.99%	3.17%	3.15%	3.60%	↗	increase
Add Prof Scientific and Technic	3.75%	3.50%	3.56%	4.79%	4.31%	2.78%	2.46%	2.74%	↗	increase
Additional Clinical Services	4.71%	3.50%	4.56%	4.36%	4.64%	4.72%	5.21%	4.84%	↘	decrease
Administrative and Clerical	4.21%	3.50%	4.02%	4.21%	3.74%	3.69%	4.04%	3.79%	↘	decrease
Allied Health Professionals	2.88%	3.50%	3.08%	3.26%	3.08%	3.24%	3.01%	2.26%	↘	decrease
Estates and Ancillary	4.43%	3.50%	4.09%	4.13%	4.17%	3.97%	3.93%	4.39%	↗	increase
Healthcare Scientists	2.78%	3.50%	2.43%	1.50%	2.66%	3.80%	3.42%	2.68%	↘	decrease
Medical and Dental	1.75%	3.50%	1.79%	1.40%	1.28%	1.68%	1.44%	1.57%	↗	increase
Nursing and Midwifery Registered	4.29%	3.50%	3.42%	3.56%	4.05%	3.94%	4.39%	4.94%	↗	increase

6. Appraisals and Mandatory Training

Appraisal compliance rose slightly in November, however remains well below the Trust target of 90%. EFD compliance remains the most improved and is testament to a significant 'push' from senior managers within the Division to prioritise appraisals.

Mandatory training figures remain static and continue to fall just below the target of 90%.

Appraisals	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Movement since last Month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate	83%	80%	82%	86%	82%	82%	75%	76%	77%	77%	80%	82%	↗	increase
Diagnostics	86%	87%	88%	88%	86%	84%	84%	83%	83%	83%	85%	85%	→	stable
Estates & Facilities	76%	77%	77%	74%	63%	60%	59%	60%	68%	72%	94%	95%	↗	increase
Medicine	74%	74%	77%	79%	78%	79%	79%	79%	78%	77%	81%	82%	↗	increase
Surgery	80%	81%	83%	82%	80%	79%	78%	80%	79%	77%	79%	83%	↗	increase
Women & Children	77%	78%	80%	78%	77%	81%	83%	82%	81%	80%	85%	85%	→	stable
Trust	**80%**	**80%**	**82%**	**82%**	**80%**	**79%**	**78%**	**79%**	**79%**	**79%**	83%	84%	↗	increase

Mandatory Training	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-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%	91%	91%	90%	90%	→	stable
Diagnostics	94%	94%	94%	94%	94%	94%	94%	93%	93%	93%	92%	92%	→	stable
Estates & Facilities	90%	89%	88%	89%	87%	83%	80%	85%	88%	86%	86%	89%	→	stable
Medicine	88%	88%	88%	89%	89%	89%	89%	88%	88%	87%	86%	86%	→	stable
Surgery	89%	90%	90%	90%	90%	91%	91%	90%	90%	90%	89%	90%	↗	increase
Women & Children	88%	88%	89%	89%	88%	88%	89%	89%	88%	88%	87%	87%	→	stable
Trust	**89%**	**89%**	**89%**	**90%**	**89%**	**89%**	**89%**	**89%**	**89%**	**88%**	**88%**	**88%**	→	stable

7. Staff Survey

Quality Health confirmed the Trust overall response rate as 47%, sitting above the National Average response rate of 44% for Acute Trust. This fell just below the response rate for last year (50%) with 168 *fewer* staff completing the survey overall. The response rate can be further broken down as follows:

Divisional Picture

- Highest response rate in numbers: Diagnostics & Speciality [1056]
- Highest response rate in % terms: Corporate [67%]
- Most improved to date: Women and Children's [48% vs 42% 2016]

Team Picture

- Best performing teams in % terms to date: **Patient Experience [100%],** Finance Shared Services [94%], Training [93%] Medical Engineering [89%]
- Most improved teams in % terms: Procurement 71% up from 37% 2016, Engineering & Building Services 68% up from 44%, Information 86% up from 65%, Finance Shared Services 94% up from 73%.

Staff Group picture

- Highest response rate in number: Nursing and Midwifery [1006]
- Highest response rate in % terms: Allied Health Professionals (69%)
- Most improved to date: Healthcare Scientists (67% vs 63% 2016)

7. Conclusions

The Board are asked to NOTE the information enclosed in this report and progress made to date.

Author: Alison Koeltgen, Acting Deputy Director of People
January 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – JANUARY 2017

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

This report describes the business conducted at the Workforce Committee on 8th December 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
Operational Dashboard	Focus should be on - Where we are getting better - How we are versus others - Can we understand what is driving performance			
	It was agreed that we needed to look at maintaining freeze on recruitment.	How are we ensuring recruitment freeze was not impacting on quality and safety?	Vacancy Control Panel (VCP) and Executive quality oversight.	
	The Trust turnover target was agreed at 11% in line with strategic objectives.	A deep dive analysis was required into retention (Nursing and Health Care Assistants) to better understand impact of General and Old Age Medicine (GOAM) . It was also agreed that we needed to triangulate the key themes across Retention, Appraisals and Sickness/Absence to identify themes and any areas of concern.	Deep dive to February committee	

	Reduce sickness absence to under 5%. Appraisal and Mandatory training rates were close to 90%.	 Was it realistic to see the Estates figure increase from 72% to 94%?	 Verified as completed and to a quality we wanted.	
Our Six Month Priorities	The Committee reviewed progress against the Workforce strategy and agreed a 6 month set of priorities to come to Board for ratification. These were : 1. Workforce – a review of establishment need versus budget and reaching a baseline funded position to enable financial control and future planning 2. Continued cost improvement management 3. Reduced bureaucracy through the Subsidiary Company (SubCo) and Internal People and organisational development streaming 4. Talent and development (system approach to be introduced) 5. Staff engagement (beyond survey) 6. Staff health and Wellbeing	Are we clear what success looks like across each of the priorities and that we are clear on risk? Have we the right assurance measures in place. How are we ensuring that the fuller engagement picture is being captured? E.g. the executive staff visits and learnings and the staff commentary via the patient stories. Multiple layers and feedback loops need to have the appropriate evidence and governance.	The action plans from the priorities would be brought to the Committee in February and measurement would form part of the Board Assurance Framework review.	

Risk Register	It was agreed that a revised approach to the Risk Register was needed.	Where are the risks that we are seeing within the operational dashboard? Should these not be captured in a risk report and the major risks included in the Risk Register?		
Revised Workforce Committee Work Plan	The revised plan was presented to the Committee and it was agreed that the Committee would move to bi-monthly meetings.			

Key points for Board to focus on:

1. Revised 6 month priorities
2. Strength of analysis and workforce focus n Operational Dashboard noting the revised Turnover Target of 11%

PUBLIC BOARD MAIN BOARD – JANUARY 2018

Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
Board Assurance Framework

Sponsor and Author(s)	
Author:	Lukasz Bohdan, Director of Corporate Governance and Executive Directors
Sponsor:	Deborah Lee, Chief Executive

Executive Summary

Purpose

The Board Assurance Framework (BAF) report is the means through which the Board receives assurance in respect of the delivery of its stated strategic objectives, through the oversight of principal risks which have the potential to undermine delivery of the objectives.

In a broader sense, the Board Assurance Framework is the *system* the Trust puts in place to ensure delivery of its strategic objectives and to receive assurance in respect of their delivery. As such, the BAF sets out the controls to mitigate the potential risks and provides assurance on whether the controls are effective, identifying further actions to strengthen the controls, mitigate the risks and close assurance gaps, if necessary.

The BAF report describes the above elements and also provides a narrative on the progress towards achievement of the objectives. This is presented as both a narrative and RAG rating. The key for rating is:

RED – not on track to be achieved
AMBER – not on track at this stage; delivery at risk
GREEN – achieved or on track to achieve.

Key issues to note

- The Board reviewed and refreshed its strategic objectives (SO) for the period 2017-2019 and these are reflected in the Board Assurance Framework.
- Delivery of objective 20 (*Be in segment 2 (targeted support) of the NHSI Single Oversight Framework*) requires achievement of objectives 1, 3 and 16 and as such a separate BAF report proforma has not been produced.
- Since the BAF report was last presented to the Board in October 2017, the newly appointed Executive Directors have reviewed and revised principal risks to objectives, controls and assurances for their respective objectives.
- The format of the attached BAF report has remained largely unchanged, with some improvements made to the presentation (e.g. adding an overview page and 'direction of travel' indicators).
- The Director of Corporate Governance and Executive Directors will be further reviewing the framework documentation to include information on supporting strategies and enablers and address cross-cutting issues (e.g. gaps or overlaps in assurances).
- Board Committees will review elements of BAF related to the strategic objectives they own and use the reviews to structure their work programmes. Updates will be provided to the Board every quarter, with reporting by exception should the risk profile of any objective change materially. A review schedule is set out in Appendix 1.

Conclusions

This revised BAF is a significant step in developing a more robust approach to oversight of progress and risks in respect of the Trust's Strategic Objectives. The picture at quarter three reflects a number of risks to these objectives, with 9 out of the 18 currently assessed as 'Green' (achieved or on track to achieve).

Implications and Future Action Required

Further refinement and completion of the BAF and iteration of the approach as requested by the Board, co-ordinated Director of Corporate Governance.

Recommendations
To receive the report for assurance that the Executive is sighted on and actively controlling the potential risks to achievement of the Trust's objectives whilst noting that in parts this assurance is only partial and further work and subsequent assurance is now required.
Impact Upon Strategic Objectives
The report identifies the risk and mitigation to the Strategic objectives
Impact Upon Corporate Risks
Links between risk to delivery of strategic objectives aligned to known corporate risks
Regulatory and/or Legal Implications
There are no specific regulatory or legal implications arising from this report.

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						
N/A						

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework

Q3 Update

11th January 2018

Board Assurance Framework Overview and Confirmation of Designated Executive Lead

BAF code/ RAG rating	Direction of Travel	Lead Executive	Objective
1.1	↔	Director of Quality & Chief Nurse	Be rated good overall by the CQC
1.2	↔	Director of Quality & Chief Nurse	Be rated outstanding in the domain of Caring by the CQC
1.3	↑	Chief Operating Officer	Meet all national access standards
1.4	↓	Medical Director	Have a hospital standardised mortality ratio of below 100
1.5	↔	Director of Quality & Chief Nurse	Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends
1.6	↔	Director of Quality & Chief Nurse	Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month
2.1	↔	Director of People	Have an Engagement Score in the Staff Survey of at least 3.9
2.2	↔	Director of People	Have a 'Staff Turnover Rate' of Less Than 11%
2.3	↔	Director of People	Have a Minimum of 65% of 'Our Staff Recommending Us as a Place to Work' through the Staff Survey
2.4	↔	Medical Director	Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches
2.5	↔	Director of People	Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)
3.1	↔	Director of Clinical Strategy	Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery
3.2	↔	Chief Executive	Have systems in place to allow clinicians to request and review tests and prescribe electronically
3.3	↔	Director of Clinical Strategy	Rolled out Getting it Right First Time Standards across the target specialities and be fully compliant in at least two clinical services
3.4	↔	Director of Clinical Strategy	Have staff in all clinical areas trained to support patients to make healthy choices
4.1	↓	Director of Finance	Be in financial balance
4.2	↔	Chief Operating Officer	Be among the top 25% of trusts for efficiency
4.3	↔	Director of Clinical Strategy	Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers.

Key: **RED** – not on track to be achieved **AMBER** – not on track at this stage; delivery at risk **GREEN** – achieved or on track to achieve

Gloucestershire Hospitals
NHS Foundation Trust

Our vision: Best care for everyone

Our mission: Improving health by putting patients at the centre of excellent specialist health care

Our goals

Our patients will

- Be safe in our care
- Be treated with care and compassion
- Be treated promptly with no delays
- Want to recommend us to others

Our staff will

- Put patients first
- Feel valued and involved
- Want to improve
- Recommend us as a place to work
- Feel confident and secure in raising concerns

Our services will

- Make best use of our two sites
- Be organised to deliver centres of excellence for our population
- Promote health alongside treating illness
- Use technology to improve

Our organisation will

- Use our resources efficiently
- Use our resources effectively
- Be one of the best performing trusts
- Be considered to be a good partner in the health and wider community

Our Strategic Objectives

Our patients

By April 2019 we will...

- Be rated good overall by the CQC
- Be rated outstanding in the domain of Caring by the CQC
- Meet all national access standards
- Have a hospital standardised mortality ratio of below 100
- Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends
- Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month

Our staff

By April 2019 we will...

- Have an Engagement Score in the Staff Survey of at least 3.9
- Have a staff turnover rate of less than 11%
- Have a minimum of 65% of our staff recommending us as a place to work through the staff survey
- Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches
- Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)

Our services

By April 2019 we will...

- Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery
- Have systems in place to allow clinicians to request and review tests and prescribe electronically
- Rolled out Getting it Right First Time Standards across the target specialities and be fully compliant in at least two clinical services
- Have staff in all clinical areas trained to support patients to make healthy choices

Our organisation

By April 2019 we will...

- Be in financial balance
- Be among the top 25% of trusts for efficiency
- Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers
- No longer subject to regulatory action
- Be in segment 2 (targeted support) of the NHSI Single Oversight Framework

(1.1) Strategic Objective - Be Rated Good Overall by the CQC

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.1.1 Risk that our Trust will not be rated Good overall at our next CQC (Care Quality Commission) inspection because of new style of inspections 1.1.2 Risk that all the CQC Domains that were rated as Requires Improvement will not have improved 1.1.3 Risk that the CQC Domains that were rated as Good will decline 1.1.4 Risk that Divisions do not identify their risks to delivery of the CQC registration standards and do not have action plans in place for improvements that are required	**Director of Quality & Chief Nurse** **Quality & Performance Committee** (Responsive/ Effective/ Safe/ Caring) **In addition** **<u>Well-led</u>** **Director of People and Organisational Development** **Workforce Committee** **<u>Sustainable use of resources</u>** **Director of Finance** **Finance Committee**	**External** 1. Gloucestershire CCG (Clinical Commissioning Group) Clinical Quality Review Group (CGRG) 2. Quality Improvement Group (QIG) (NHS England/Improvement oversight) 3. Health Overview and Scrutiny Committee (HOSC) 4. CQC provider meeting. **Internal** 5. CEO (Chief Executive Officer) quarterly Executive Review meetings and monthly Executive Review meetings with Divisions	**External** 1. Report and meeting with GCCG quality team 2. Attendance and papers to QIG 3. HOSC attendance 4. Action plan in response to last CQC inspection. **Internal** 5. Divisional attendance and reports at Executive Review meeting 6. Divisional Annual operating plans 7. Quality Account 8. Quality and Performance Committee Report 9. Exception Reports (Cancer Services Task Group, Planned Care Board, Emergency Care Board)	1. November GCCG CQRG meeting report to Q&P 2. Letter from QIG Q&P 3. HOSC attendance November 2017 4. CQC Provider meeting 5. December review meetings 6. Quality account report and preparations 2016/17 and 2017/18 December Q&P meeting 7. Governor meetings 8. TLT December 2017 meeting 9. Risk Management Group report to September Board 2017	↔

1.1.5 Risk that Divisions have not included this objective in their annual operational plans 1.1.6 Risk that Medical Division will not be able to sustain improvements because of operational capacity demands over the winter.		6. Quality and Performance Committee (Sub-Committees of Q&P (Infection Control Committee, Hospital Mortality Indicator Group, Safeguarding Adults and Children Committee, Clinical Systems Safety Group)) 7. Council of Governors meeting and Governors' Quality and Performance meeting 8. Trust Leadership Team (TLT) 9. Risk Management Group 10. Audit Committee 11. CQC review Group 12. Divisional Board Meetings (Quality Boards/ Speciality Governance meetings).	10. Minutes from key meetings (SERG (Safety And Experience Review Group), PESG (Patient Experience Strategic Group), Hospital Transfusion Committee, Resuscitation and Deteriorating Patient Group, Medicines Optimisation Committee) 11. Annual Reports from key Committees 12. Quality and Performance Committee reports and presentations to Governors 13. Risk Registers 14. CQC Responsive Improvement Plan 15. Risk Registers 16. Safety Reports 17. External Auditors reports and action plans 18. Internal audits and action plans 19. National audit reports and action plans 20. CQC Responsive Improvement Plan	10. Audit and Assurance Committee meeting November 2017 11. CQC improvement Meeting December 2017 12. TLT meeting December 2017.	

			21. Divisional Reports and minutes to TLT.		
				Gaps in Assurance	**Direction of Travel**
				1. Possible gaps within Divisions in meeting every CQC registration standard as part of their business as usual plan at all times 2. Slow progress on the completion of all the “must do” and “should do” actions within the responsive quality improvement plan because of operational pressures 3. No overall proactive Quality Improvement Strategy (Good > Outstanding)	↔

				4. New CQC methodology for inspections which includes sustainable use of resources and well-led Domains 5. Limited regular benchmarking and gap analysis within Divisions against CQC KLOEs (Key Lines of Enquiry) and Domain characteristics to ensure improvement or maintenance of standards.	

Potential Risk Exposure	Related risks on Trust Risk Register		Score
• All current risks on Trust Risk Register • All current risks on Divisional Risk Registers • All current risks on Speciality Risk Registers • Sub-Board Committees Risk Registers • **C1850NSafe** - The risk of being considered non-compliant with the Trust CQC registration due to providing care to an increasing number of adolescents (12-18 years) presenting with self-harming behaviour who require a place of safety but do not require medical care. • **C2619MDEOL** - Risk of inadequate improvement for next CQC End of Life (EOL) assessment.			3 x 3 = 9 (Statutory)

Actions Agreed for any gaps	By Whom	By When	Update
1. Overall assurance mapping of all registration standards from Ward to Board and vice versa.	DoQ & CN, Medical Director, Director for Safety	March 2018	Gap analysis and assurance mapping underway.
2. Development of "must do" action plan with the "should do" actions to have a responsive plan.	DoQ & CN, Medical Director, Director for Safety	December 2017	Complete.
3. Development of an overall proactive quality improvement strategy (#J2O – Journey to Outstanding).	DoQ & CN, Medical Director, Director for Safety	March 2018	Strategy in development.
4. Strengthening and development of quality governance structures/architecture and reporting arrangements.	DoQ & CN, Medical Director, Director for Safety	March 2018	Structures under review proposed new structures to Q&P December 2017.
5. Review of our quality measures (Ward to Board systems).	DoQ & CN, Medical Director, Director for Safety	March 2018	Quality system measurements being reviewed and agreed.

Enabling Strategies	Oversight Committee	Executive Group	
Risk Management Strategy	Risk Management Group	Trust Leadership Team	
Dementia Strategy	Patient Safety Forum	Quality & Performance Committee	
Staff Health and Wellbeing Strategy	H&W Committee	Quality & Performance Committee	
Improving Patient and Carer Strategy	PESG (Patient Safety and Experience Strategic Group)	Quality & Performance Committee	
Food and Drink Strategy	Patient Safety Forum	Quality & Performance Committee	
Workforce Strategy	Workforce Committee	Workforce Committee	

Quarterly Progress Report Against Delivery	RAG Rating

Baseline assessment July 2017

- The Trust remains at Requires Improvement overall and for both sites after the latest CQC report for the announced inspection visit on 24-27 January 2017 and unannounced February 2017 (published July 2017).
- There were 11 Domains across the Divisions that were rated as Requires Improvement (Maternity 1, Medical 4, Urgent and Emergency Care 2, Surgery 2 and OPA 2).
- Overall 73% of ratings were Good or Outstanding (an improvement from 68% in 2015).

Where are we now (see table below)

A “must do” action plan was developed to respond to the areas of concern that needed addressing immediately and this has now been refined into a more responsive quality improvement plan addressing all the “should do” actions as well.

Update for this quarter December 2017

1. With the appointment of a new Director for Quality & Chief Nurse in October 2017 an opportunity has been taken to review the current quality governance arrangements at Corporate and Divisional levels (strategies, structures and systems) for Ward to Board delivery of all our regulated activity and our quality standards.
2. A new driver diagram and project plan has been developed for this key strategic quality objective and these now form part of the overall quality delivery plan.
3. The Head of Patient Experience Improvement has now been appointed as the Deputy Director of Quality to assist the Director of Quality & Chief Nurse with the delivery of the quality agenda.

4. Meeting CQC registration standards should be our “business as usual” with us being “CQC-ready” everyday with the certainty of being rated as Good if not Outstanding if CQC were to visit unannounced. The CQC plan we have in place now is a responsive plan as it responds to all the concerns that were raised by CQC at the last inspection, and so a more proactive plan is being developed to assure that we are maintaining current Domains rated Good, with a further plan to raise the standards to meet the Outstanding characteristics for all the KLOEs for all the Domains within the key specialities.
5. The new quality governance arrangements are going through consultation processes, and if agreed, should then be operational by April 2018. The proposed structures were presented to the Quality and Performance Committee 22nd December 2017 and the Committee approved their continued development.
6. An assurance mapping process has begun with the Director of Safety and Deputy Director of Quality reviewing terms of reference, dashboard reporting and minutes for all key quality meetings at corporate, divisional and speciality levels. CQC has published an update on how they monitor, inspect and regulate NHS Trusts and this new guidance will be used as a key document within our assurance mapping exercises.
7. A review of the Corporate Quality and Performance dashboard has also begun to make sure that we have oversight of all the key indicators monitored with CQC and by NHS Improvement (the NHSI Oversight Framework was also updated in November 2017).
8. The development of our quality priorities for 2017/18 within our Quality Account has begun and a review of our progress against our 2016/17 priorities is being prepared for publication in May 2018.
9. As part of the “Gold” level training the Gloucestershire Safety and Quality Improvement Academy (GSQIA) is working with nominated Speciality Directors to review how the Quality Model can be delivered within the Divisions.
10. The Divisions are currently preparing their annual operating plans and the plans will include how they will deliver all the strategic objectives. The draft plans are currently being reviewed before final approval.

Domain	Rating GRH 2017	Rating CGH 2017	Overall Rating 2015
Maternity overall			Good
Maternity Safe	Requires improvement	Not rated	Requires improvement
Medical care including elderly care overall	Requires improvement	Requires improvement	Requires improvement
Medical Safe	Requires improvement	Requires improvement	Requires improvement
Medical Responsive	Requires improvement	Requires improvement	
Medical Effective	Requires improvement	Requires improvement	Requires improvement
Medical Well-led	Requires improvement	Requires improvement	Requires improvement
Urgent and Emergency care overall	Requires improvement	Requires improvement	Requires improvement
U&EC Safe	Requires improvement	Requires improvement	Requires improvement
U&EC Responsive	Requires improvement	Requires improvement	Requires improvement
Surgery overall			Good
Surgery Safe	Requires improvement	Requires improvement	Good
Surgery Responsive	Requires improvement	Requires improvement	Requires improvement
OPA and Diagnostics			Requires improvement
OPA and Diagnostics Safe	Requires improvement	Good	Requires improvement
OPA and Diagnostics Responsive	Requires improvement	Requires improvement	Requires improvement

(1.2) Strategic Objective - Be Rated Outstanding in the Domain of Caring by the CQC

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that our Trust will not be rated Outstanding in our CQC (Care Quality Commission) rating for Caring because the CQC have changed their inspection methodology.	**Director of Quality & Chief Nurse** **Quality & Performance Committee (Q&P)**	**External** 1. Gloucestershire CCG (Clinical Commisioning Group) Care and Quality Review Group and CCG attendance at Q&P, PESG (Patient Experience Strategic Group) & SERG (Safety and Experience Review Group) 2. NHS England review and validation of FFT (Friends and Family Test) data 3. Healthwatch reporting of concerns and deep dive reviews 4. DoH (Department of Health) complaints data validation and reporting 5. The Parliamentary and Health Service Ombudsman (PHSO) cases and complaint monitoring 6. National Survey Programme by CQC 7. CQC regulation, monitoring and inspections	1. Reports to Q&P, Governors, SERG and PESG on patient experience indicators (which includes PHSO, FFT, Survey data, compliments, complaints, concerns and PLACE data) 2. Divisional presentations and reports to Executive monthly monitoring 3. Matron audit reports to their Divisional Boards and quality Committees (safe, clean and personal care) 4. Regular monitoring and analysis of key patient experience data.	1. Patient experience indicators reported to Q&P quarterly last report July 2017 2. Patient experience stories taken to every Board meeting (last story December 2017) 3. Attendance and presentations by Divisions at PESG in November 2017 4. Patient experience indicators monitored and PESG 5. Serious complaints and PHSO action plans reviewed December 2017 SERG.	↔

		8. PLACE (Patient-led Assessments of the Care Environment) inspections with patient representatives 9. Voluntary sector attendance at Patient Experience Strategic Group (Carer's UK, & Carer's Alliance). **Internal** 10. Board patient experience stories 11. Executive Monthly Divisional monitoring 12. Quality and Performance Committee 13. Senior Nursing and Midwifery Committee meeting (SNMC) 14. Patient Experience Strategic Group (PESG) 15. Safety and Experience Review Group (SERG) 16. Governor Q&P meetings.		**Gaps in Assurance**	**Direction of Travel**
				1. Patient experience strategy requires updating 2. Benchmarking, gap analysis between Good and Outstanding characteristics for Caring Domain by all Divisions with the development of Divisional Patient Experience Quality Improvement plans 3. Continuous compliance monitoring by regular Division checks and reviews.	↔

Potential Risk Exposure	Related risks on Trust Risk Register		Score
• **M2473Emer** - The risk of poor quality patient experience during periods of overcrowding in the Emergency Department. • **M727Emer -** The risk to patient safety of delay to diagnosis and treatment reducing quality of care to patients and decrease in staff morale due to diverts. • **M2434Emer -** The risk of reduced safety, patient experience and quality of care due to inability to recruit and retain qualified nursing staff across Unscheduled Care. • **M2484Emer** - The risk of poor patient quality due to lack of visibility of Decision to Admit times on TrakCare • **C2619MDEOL** - Risk of inadequate improvement for next CQC End of Life (EOL) assessment.			3 x 5 = 15 (Quality) 2 x 4 = 8 (Safety) 3 x 3 = 9 (Safety) 3 x 3 = 9 (Quality)

Actions Agreed for any gaps	By Whom	By When	Update
Quality improvement strategy to be developed with section on Patient experience improvement.	Director of Quality & Chief Nurse	End of March 2018	Strategy in development.
Gap analysis to be undertaken for the difference between the CQC Good and the Outstanding characteristics by all Divisions and to have plans in place to make improvements.	Divisional Nursing Directors	End of March 2018	Workshop held in SNMC in December 2017 looking at the Key Lines of Enquiry and Outstanding characteristics and change ideas generated.
PLACE inspection report action plan to PESG in January 2018.	Deputy Director Estates	January 2018	Action plan in development for the latest inspection.
Contemporaneous assessment of current position using consistent Quality Model across all divisions.	Divisional Nursing Directors	March 2018	Divisional reports to come to PESG in January 2018.

Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience and Carer Strategy 2015-2017.	Patient Experience Strategic Group	Quality & Performance Committee	Strategy being updated.

Quarterly Progress Report Against Delivery | **RAG Rating**

Position April 2017

Maternity, children & young people, end of life, surgery, medical care, urgent and emergency care and outpatients and diagnostics all rated by CQC as Good at CQC inspections.
Critical care rated as outstanding.

Position July 2017 after last CQC report published

CQC Caring Domain	CQC Rating
Maternity	Good
Children and Young People	Good
End of Life	Good
Critical Care	Outstanding
Medical care including elderly care	Good
Urgent and Emergency care	Good
Surgery	Good
OPA and Diagnostics	Good

Progress report December 2017

1. Quality improvement driver diagram and delivery plan developed for this objective.
2. Within the SNMC we have established a Trust-wide improvement collaborative focused on CQC Caring Domain. The first event focused on what change ideas staff would like to implement (suggestions were an Always events programme, Nursing Assessment and Accreditation Scheme at ward level, 15 step challenge programme, Person Centre Care programme, Going the Extra Mile dialogue).
3. Engagement events with women booked for January in Maternity and for our patients and carers an event will be held in March 2018.

4. The Journey to Outstanding (#J20) communication plan and branding are being developed. 5. An "Outstanding Celebratory Conference" has been organised for the 13th April 2018 Pecha Kucha style and will be supported by Members of the Board. 6. Patient Experience Stories have taken to Board by the Head of Patient Experience Improvement in October, November and December 2017 with a focus on this Domain. 7. The latest inpatient national survey data has been collated and the report to be published for internal use in January 2018. 8. Progress on the CQC "must do's" and "should dos" that relate to privacy and dignity, personalised care and kindness and respect in the responsive plan have been reported quarterly to the Q&P committee. 9. Divisional reviews are being carried out of their patient experience indicators with patient experience quality improvement programmes being developed. This work has been supported by the Patient Experience Improvement Team and there are currently 20 Silver QI projects. 10. The Head of Patient Experience Improvement was notified that 2 projects have been shortlisted as potential finalists by the Patient Experience Network National Awards (PENNA) in December 2017 (Finalists will be announced in March 2018 at National Awards Ceremony supported by NHS England). 11. The Patient Experience Improvement Team have continued to roll out the 7A project which is now called the Small Steps- Big Changes project and are now working on 4 wards. 12. The Quality Improvement Manager (Disability Equality) has completed her Silver QI project which she co-designed with the Gloucestershire Deaf Association and it is this project that has been nominated for a PENNA Award.	

(1.3) Strategic Objective(s) – Meet all national access standards

Principal Risks to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.3.1 Failure to recover A&E (Accident and Emergency) performance sufficiently to enable current Enforcement Undertakings to be removed.	**Chief Operating Officer (COO)** **Quality and Performance Committee (Q&P)**	Bi-weekly hospital-wide Task and Finish Group chaired by Medicine COS (Chief of Service) Bi-weekly Unscheduled Care operational meeting chaired by Unscheduled Care Specialty Director Weekly Unscheduled Care senior team meeting chaired by Director of Unscheduled Care Monthly Unscheduled Care Delivery group chaired by COO Creation of Director of Unscheduled Care/Deputy COO role to provide focus and direction across Unscheduled Care agenda	A hospital-wide Unscheduled care delivery plan involving all internal stakeholders to review process and patient pathways through Unscheduled Care hospital-wide Unscheduled Care report to the Quality and Performance Committee System-wide discharge plan signed up to by all providers across health economy System-wide A&E Delivery action plan.	Monthly reporting to the Trust Q&P Monthly reporting to system wide A&E Delivery Board.	↑
			Gaps in Controls	**Gaps in Assurance**	
			Demand management at front door Right sized capacity allocation cross site	None	

		Creation of system-wide discharge team staffed by senior managers from all providers across health economy System-wide A&E Delivery Board.	Nurse staffing gaps across ED (Emergency Department)/AMU (Acute Medical Unit).		
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
1.3.2 Failure to deliver the national access standards for RTT (Referral to Treatment) and Cancer.	**Chief Operating Officer (COO)** **Quality and Performance Committee (Q&P)**	Weekly PTL (Patient Tracking List) meetings Monthly Planned Care Board Monthly Cancer Services Board Creation of Director of Scheduled Care/Deputy COO role to provide focus and direction across the Scheduled Care agenda.	• Referral to Treatment waiting list validation recovery plan in place • Cancer capacity and recovery plans in place.	Performance reports to the Q&P Committee.	
			Gaps in Control	**Gaps in Assurance**	
			• Demand outstrips capacity plans • Lack of clean patient tracking lists • Lack of demand and capacity plans for RTT.	RTT reporting.	

Potential Risk Exposure – Confirmed Risks on Trust / Divisional Risk Registers		Mitigation
• **S1748** - The risk of statutory intervention for failing national access standards in relation to cancer. • **S2628** - The risk of failure to deliver RTT impact. • **C2402SC** - The risk of potentially increased RTT times and delays to diagnosis & treatment as a result of requirement to vet referrals on TrakCare. • **S2046Uro, S2472UGI, S618ENT & S2470CR** - The risk to patient safety as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) and within Cancer waiting times (Cancer) due to a lack of capacity across the following elements of the pathway; outpatients, diagnostics and theatres (linked to S1748/ S2628). • **D&S2398Canc** - Risk of reduced quality service as patients not treated on time; nationally published Cancer data is inaccurate/ incomplete.	5 x 4 = 20 (Statutory) 3 x 4 = 12 (Safety) 3 x 4 = 12 (Safety) 3 x 4 = 12 (Quality) 3 x 4 = 12 (Quality)	

Actions Agreed for any gaps	By Whom	By When	Update
Review of system-wide demand management.	COO	April 2018	
Review of capacity allocation cross site.	COO	Links in to one place business case	
Validation of all PTLs, establish RTT reporting, complete demand and capacity modelling and recovery plans for delivering 18w RTT.	COO	Links in to Trak recovery plan	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Clinical strategy, STP (Sustainability and Transformation Plan)	Q&P Committee	Unscheduled Care Programme Board, Planned Care Board	

Quarterly Progress Report Against Delivery	RAG Rating
See the Trust Board Quality and Performance report for comprehensive up[date on performance but in summary A&E performance for Q1 was 91.6% for Quarter 3 – strongest performance in many years and ahead of NHSE (NHS England) trajectory. Commitment from NHSE to review segment classification from S4 to better. NHSI (NHS Improvement) commitment to review Enforcement Undertakings in Q4. Diagnostic 6 week standard met for last two months. Cancer recovery plan presented and endorsed by Q&P committee with planned recovery from Q1 2018/19. RTT recovery plan yet to be delivered and timeline for development linked to Trakcare recovery plan but unlikely to be achieved in 2018/19.	

(1.4) Strategic Objective: Have a Hospital Standardised Mortality Ratio Below 100

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that changes to process and clinical pathways do not achieve a Hospital Standardised Mortality Ratio (HSMR) below 100.	**Medical Director** **Quality and Performance Committee (Q&P)** **Hospital Mortality Group**	1. Regular monitoring of mortality indicators though Hospital Mortality Group (HMG) 2. Close working with Dr Foster to report on HSMR, identify factors driving high rates and investigate the drivers behind these 3. Agreed areas of clinical pathway work to identify improvements in care, coding and pathways 4. Regular reporting by division to the HMG Mortality dashboard reporting to divisional and speciality level 5. Monitoring through Q&P and with partners through CCG (Clinical Commisioning Group) quality monitoring group and through the joint NHSI (NHS Improvement) and NHSE (NHS England) Quality Improvement Group	Monthly Mortality Report to Q&P Committee.	Reporting to the Q&P Committee.	

		6. Neck of femur group monitoring action plan for improved care. Similar model to be applied for other care pathways as appropriate 7. Trauma mortality review through trauma lead 8. Mortality database and initiation of mortality reviews though bereavement office.	**Gaps in Control** Data capture in TrakCare of number of episodes of inpatient care results in risk of underscoring of episodes of care and therefore miscalculation of crude mortality.	**Gaps in Assurance** Reporting and detail of oversight at Q&P and Trust Board - to be finalised Inability to model the impact of changes on HSMR.	
Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers				**Score (CxL)**	
• Reliability of admission diagnosis and clinical linkage to coding • **S2045** -The risk of poorer than average outcomes for patients presenting with fractured neck of femur at Gloucestershire Royal Hospital.				4 x 3 = 12 (Safety)	
Actions Agreed for any gaps		**By Whom**	**By When**		**Update**
Approach to reporting for Q&P in development in conjunction with Dr Foster and Trust Information team.		Medical Director	February 2018		Underway

Enabling Strategy	Oversight Committee	Executive Group	
Mortality Strategy	Quality and Performance Committee	Hospital Mortality Group	
Quarterly Progress Report Against Delivery			**RAG Rating**
• Current trends indicate that mortality rates are falling • Mortality dashboard now ready to use • The continued fall suggests the correct actions are in place to achieve our aim of HSMR of 100 by 2019 • Satisfactory progress is being made on learning from deaths.			

(1.5) Strategic Objective – To have our patients responding to our Family Friendly Tests and 93% providing a positive score

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.5.1 Risk that our trust will not meet target of more 93% FFT (Friends and Family Test) positive score 1.5.2 Risk that staff will not be able to carry out reviews of their data and quality improvement work because of operational pressures.	**Director of Quality and Chief Nurse** **Quality & Performance Committee**	**External** 1. CCG (Care Quality Commission) CQRG (Clinical Quality Review Group) 2. NHS England reporting 3. CQC insight. **Internal** 4. Divisional /Executive Monthly monitoring 5. SNMC (Senior Nursing and Midwifery Committee) 6. Patient Experience Strategic Group 7. Quarterly meetings with Governors with specific focus on quality topics 8. Reports to Q&P on patient experience indicators which includes complaints and concerns.	1. External reporting of data to NHSE and CQC 2. Divisional Quality Presentations 3. Matron Audit reports to their divisional quality committees 4. Reports to PESG and Q&P (Quality and Performance) 5. External publication of data on Trust website.	1. Patient Experience Indicators reported to Q&P in September 17 2. FFT national data published on NHS England website 3. FFT data published on Trust website.	↔
				Gaps in Assurance	
				1. Reliable data for actual performance surveys not reported in real time.	

Potential Risk Exposure	Related risks on Trust Risk Register		Score
• **M2473Emer** - The risk of poor quality patient experience during periods of overcrowding in the Emergency Department. • **M727Emer -** The risk to patient safety of delay to diagnosis and treatment reducing quality of care to patients and decrease in staff morale due to diverts. • **M2434Emer -** The risk of reduced safety, patient experience and quality of care due to inability to recruit and retain qualified nursing staff across Unscheduled Care. • **M2484Emer** - The risk of poor patient quality due to lack of visibility of Decision to Admit times on TrakCare • **C2619MDEOL** - Risk of inadequate improvement for next CQC End of Life (EOL) assessment.			3 x 5 = 15 (Quality) 2 x 4 = 8 (Safety) 3 x 3 = 9 (Safety) 3 x 3 = 9 (Quality)

Actions Agreed for any gaps	By Whom	By When	Update
Reports are sent regularly to clinical areas to ensure continual focus is given.	Head of Patient Experience Improvement	Monthly	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience and Carer Strategy 2015-2017	Patient Experience Strategic Group	Quality & Performance Committee	New draft quality improvement strategy being developed.

Quarterly Progress Report Against Delivery

RAG Rating

Current position

Current combined (maternity, ED, inpatient and OPA) FFT score is 90.2% for Quarter 2 which is a slight decline from Quarter 1 (91.5%). The ED score in November rose by 10% when the organisation was able to meet the 4 hour ED wait target.

The response rate is no longer a recognised measure of FFT by NHS England as now the emphasis is on the positive scores.

<u>December 2017</u>

- Driver diagram and improvement plan developed for this objective.
- Patient Experience Indicator report presented to Q&P in September 2017 and next report due in January 2018.
- The Patient Experience Improvement team alert ward managers, matrons and Divisional Nurse Directors when the scores give cause for concern and automatic reports have been set up.

• There are at least 20 Patient Experience Improvement projects in progress within the clinical areas and many have used the FFT score data to design their projects. • The NHS England funded (£50k) Maternity Insight FFT project continues to be a success with staff. This project asks women, after the FFT mandatory question, additional questions - one of which being "Which member of staff went the extra mile for you?" The staff receive certificates of recognition with the woman's comment on. The team have received many emails from staff saying that receiving these certificates had made their day, as they felt valued.	

(1.6) Strategic Objective – To Have Reduced the Number of Complaints Received Regarding Care and Experience in our Outpatients Departments by 25% By 2019

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.6.1 Risk that our trust will not have reduced the complaints received regarding the care in our outpatient departments by 25% by 2019 1.6.2 Risk that the operational IT system that manages appointments continues to impact on our ability to deliver an efficient service to our patients.	**Director of Quality & Chief Nurse** **Quality & Performance Committee**	**External** 1. Complaint reports to DoH (Department of Health) 2. CCG CQRG (Clinical Commissioning Group Clinical Quality Review Group). **Internal** 3. Divisional /Executive Monthly monitoring 4. Outpatient department forum 5. Outpatient Improvement Group 6. Outpatient Senior Nurse Forum 7. Patient Experience Strategic Group (PESG) 8. SERG (Safety and Experience Review Group) 9. Quarterly meetings with Governors with specific focus on quality topics.	1. Reports to Quality & Performance Committee 2. Reports to PESG and SERG 3. CBO (Central Booking Office) operational report 4. Trakcare operational impact report 5. SI (Serious Incident) report.	1. OPA (Outpatient appointments) complaints review and Outpatient Improvement Group meeting December 2017. **Gaps in Assurance** 1. Detailed diagnosis of issues within the OPA complaints.	↔

Potential Risk Exposure	Related risks on Trust Risk Register		Score
• **D&S2556OPD** - Risk of poor patient experience and outcomes due to patient unknowingly being transferred to 'hold' file and not being actioned.			3 x 4 = 12 (Quality)

Actions Agreed for any gaps	By Whom	By When	Update
Data is sent to operational delivery Committees so that reports are produced.	Head of Patient Experience Improvement	Monthly	Data being sent to groups working on improvements.
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience Strategy 2015-2017	Patient Experience Strategic Group	Quality & Performance Committee	New draft quality improvement strategy being developed with a patient experience chapter.

Quarterly Progress Report Against Delivery

RAG Rating

April 2017

- Across the organisation, we provide approximately 200,000 outpatient episodes every quarter.
- Prior to the implementation of the IT system Trakcare the number of complaints for outpatients' episodes of care was approximately 30 per month (as reported to PESG in November 2016).
- In April 2017, our outpatient complaints rose to 96 for that month and they then peaked at 120 in July 2017.

Current position

Our latest figures are that in September 2017 we received 96 outpatient complaints (we have 35 working days to respond so that is our last completed month).

December 2017 update

- A small task and finish group has been set up to look at all the experience and care elements of the outpatient complaints. This task and finish group will report into the Outpatient Experience Improvement Group. The first meeting of this group was held in early December 2017. The Outpatients Matrons will be key in leading this work.
- A review meeting with the Matrons has been set up for early January 2018 to review all the outpatient complaints in one month (July peak month) to look at the themes and trends.

• A draft driver diagram has been prepared and the plan is to implement improvements once the diagnosis phase has been completed. • The Head of Patient Experience Improvement has completed an audit of outpatient care using the new NHS England Outpatient 15-step challenge toolkit and there will be a plan to carry out these observational visits to all outpatient areas with the aim of auditing and then improving the experience for our patients. • The PALs (Patient Advice and Liaison Service) team are supporting this project and are collating weekly thematic data that relates to why our patients are calling them with OPA concerns.	

(2.1) Strategic Objective – Have an Engagement Score in the Staff Survey of at Least 3.9

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
Risk of static or reduced engagement negatively impacts staff morale and retention & places a risk on our vision of Best Care for Everyone.	**Director of People and Organisational Development** **Workforce Committee**	1. Workforce strategy 2. Policies which encourage engagement & feedback 3. Freedom to Speak Up Guardian 4. Grievance Policy 5. Datix 6. Communications strategy.	1. Reprioritised work programme for 2017-18 to ensure a staff engagement model and programme captures 2 way feedback 2. Board agreement on reprioritisation November & December 2017 3. Engagement Steering Group 4. Staff Health and Wellbeing Steering Group 5. 100 Leaders 6. Diversity Network 7. Staff survey process & action planning; corporate & local 8. Lessons learnt processes	1. Annual staff survey report to Workforce Committee 2. Revision of engagement model & progress bi-monthly to Workforce Committee 3. Scrutiny of employee issues at Directors Operational Group, Trust Leadership Team & Executive Team meetings 4. Equality and Diversity report to Workforce Committee 5. Freedom to Speak Up annual report to Workforce Committee	↔

			9. LNC (Local Negotiating Committee) & JSCC (Joint Staff Consultative Committee) processes 10. Family & friends test (FFT) results 11. Executive Reviews and walkabouts 12. Trust Leadership Team (TLT) and Directors Operational Group (DoG) process 13. Back to floor days 14. Datix review and feedback 15. Internal Comms agenda and intranet use for key messages & blogs 16. Listening events 17. Involve 18. I Lead 19. CQC (Care Quality Commission) and J2O (Journey to Outstanding) agenda.	6. Monitoring of engagement plans at Divisional Boards and Executive Divisional Review.	

			Gaps in Control	**Gaps in Assurance**	
				Plan to define and deliver 2-way feedback to capture all learning (by Q4 2017/18).	
Potential Risk Exposure – Confirmed risks on Trust / Divisional Risk Registers				**Score**	
None identified					
Actions Agreed for any gaps	**By Whom**	**By When**			**Update**
Enabling Strategy	**Oversight Committee**	**Executive Group**			
Workforce Strategy	Workforce Committee				
Quarterly Progress Report Against Delivery					**RAG Rating**

- Staff recognition awards (GEM Awards) have been launched divisionally in January 2018.
- Junior doctor engagement/ listening events launched within acute medical areas from December 2017.
- Diversity Network launched in November 2017. Over 45 members joined so far. First network meeting scheduled 17th January 2018.
- Investigations into a staff engagement app in conjunction with One Gloucestershire STP (Sustainability and Transformation Plan) partners. STP funding is available to support this. A free app is also being explored which is currently used with some success in a number of Trusts around the country including St George's and Guy's & St Thomas'. A meeting has been requested with the provider to learn more about its potential.
- Monthly Trust-wide listening events ongoing. January-February events focusing on Travel to Work which was one of the priorities identified following 2016 staff survey.

(2.2) Strategic Objective - Have a Staff Turnover Rate of Less Than 11%

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
High turnover results in a gap in care, potential increased cost to fill temporarily and a delay in attraction – resulting in potential service delivery delay.	Director of People and Organisational Development **Workforce Committee**	1. Vacancy Control Panel (VCP) process enabling speedier fill to post process 2. VCP cost control, agency & bank 3. Recruitment & Selection Policy 4. Exit Interviews 5. Education programme's linked to improving supply e.g.: apprentices and nurse associates.	1. Reprioritised work programme for 17/18 to ensure a basic funded establishment is produced with supply & demand for key roles established – Board agreed prioritisation in November/ December 2017 2. Workforce Sustainability & Education Learning and Development (ELD) group 3. Divisional plans for hard to fill roles & forward planning 4. Human Resources Business Partner and Finance Business Partners involvement in vacancy projection	1. Operational dashboard published with trends and future projection at Workforce Committee 2. Annual Education, learning and development report to Workforce Committee 3. Sustainable workforce report to Workforce Committee 4. STP (Sustainability and Transformation Plan) update & impact to workforce to Board.	↔

			5. Workforce plans aligned to operational capacity and demand work within divisions 6. Education work strands to improve career planning & career routes/pathways 7. Bespoke retention projects and listening events (i.e. Band 5 nurses) 8. STP work to reduce competitive recruitment between STP partners 9. Robust training plans for all staff grades and provision for staff to develop themselves 6. Coaching offer STP leadership behaviour definition.		

			Gaps in Controls	**Gaps in Assurance**	
			1. Limited compliance with exit interviews	1. Robust talent management system to link development opportunities with succession planning and career management (now reprioritised objective for 17/18 as approved by Workforce Committee in November/ December) 2. One version of data – Finance and HR records on establishment do not match (to be achieved 17/18) 3. Demand and supply routes to be developed (17/18) 4. Increased engagement on career pathways and targeting workforce supply	

				5. To continue to develop Nurse Associate roles, Nurse apprenticeships and advanced clinical practice 6. Reducing HR bureaucracy & streamlining to ensure new starters & potential joiners have the best experience within the Trust 7. Mentorship programme to be offered to staff (by April 2019) 8. Positioning of Gloucester as employer of choice 9. Highlighting talent early on in careers with Gloucester – on Training rotation on placement pre course graduation.	
Potential Risk Exposure – confirmed risk entries on Trust Divisional Risk Registers				**Score**	
Shortages develop in specific occupations impacting on our ability to deliver services examples to include: • **D&S2513Path** - Risk to patient safety due to delayed diagnosis because of shortage of Histopathology Staff.				3 x 4 = 12 (Quality)	

• **D&S2564Path** - Risk to patient safety due to insufficient Consultant Medical Microbiologist resource. • **D&S2540Path** - Risk of reduced workforce due to inability to recruit and retain cervical screening staff. • **S2775** - The risk to workforce of an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers. • **S2390Anaes** - The risk of reliance on voluntary additional paid sessions, (that enable the anaesthetic department to function), which could be withdrawn, impacting on the workforce and affecting our ability to deliver waiting time targets in line with our statutory obligations and affecting our financial state. • **S2393Anaes -** The risk of reduced numbers of pre-assessment staff affecting the delivery of service and putting undue pressure on the workforce, as well as the risk of inadequate preparation for theatre affecting patient safety.	3 x 4 = 12 (Workforce) 3 x 4 = 12 (Workforce) 4 x 4 = 16 (Workforce) 4 x 2 = 10 (Statutory) 3 x 4 = 12 (Workforce)	

Actions Agreed for any gaps	By Whom	By When	Update
1. Robust talent management system to link development opportunities with succession planning and career management	Alison Koeltgen	Now reprioritised objective for 17/18 as approved by Workforce Committee in Nov/Dec)	
2. One version of data – Finance and HR records on establishment do not match	Alison Koeltgen	Work to have commenced January 2018	
3. To continue to develop Nurse Associate roles, Nurse apprenticeships and advanced clinical practice	Steve Hams/ Dee Gibson-Wain		
4. Doctors in Training Streamlining Programme, to ensure new starters & potential joiners have the best experience within the Trust	Richard Giles	August 2018	
5. Mentorship programme to be offered to staff.	Dee Gibson-Wain	April 2019	

Enabling Strategy	Oversight Committee	Executive Group	
Workforce Strategy	Workforce Committee		
Quarterly Progress Report Against Delivery			**RAG Rating**
Workforce Committee has endorsed 6-monthly strategic priorities in this area. Plans are underway to deliver the priorities.			

(2.3) Strategic Objective - Have a Minimum Of 65% of Our Staff Recommending Us as a Place to Work through the Staff Survey

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director& Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
Staff do not recognise us as an employer of choice or recommend us to others, as such increasing retention and reducing attraction. Retention and attraction issues may result in poor service delivery and an inability to deliver upon Best Care for Everyone.	**Director of People and Organisational Development** **Workforce Committee**	1. Workforce Strategy 2. Health & Wellbeing strategy 3. Education, learning and development resources on line and policies for CPD (Continuing Professional Development) 4. Policies which encourage engagement & feedback • Freedom to Speak Up Guardian • Grievance • Datix 5. Communications strategy 6. Reward Strategies i.e. Nurse incentive payments.	1. Workforce Sustainability & ELD (Education Learning and Development) group 2. Divisional plans for hard to fill roles & forward planning 3. HRBP (Human Resources Business Partners) & FBP (Finance Business Partners) involvement in vacancy projection 4. Education work strands to improve career planning & career routes/pathways 5. Robust training plans for all staff grades and provision for staff to develop themselves 6. Coaching offer	1. Annual staff survey report to workforce Committee 2. Scrutiny of employee issues at DOG (Directors Operational Group), TLT (Trust Leadership Team) & Executive Team meetings 3. Equality and Diversity report to Workforce Committee 4. Freedom to Speak Up annual report to Workforce Committee 5. Staff Friends & Family quarterly survey results	↔

			7. STP (Sustainability and Transformation Plans) leadership behaviour definition 8. Leadership development programmes to improve management skills and approach 9. Diversity network 10. Reprioritised work programme for 17-18 to ensure a staff engagement model & programme captures 2-way feedback 11. Board agreement on reprioritisation November & December 2017 12. 100 Leaders 13. Diversity Network 14. Staff survey process & action planning; corporate & local 15. Lessons learnt processes 16. LNC (Local Negotiating Committee) & JSCC (Joint Staff Consultative Committee) processes	6. Monitored through Executive Divisional Reviews/Divisional Board structure.	

			17. Family & friends results 18. Exec Reviews and walkabouts 19. TLT (Trust Leadership Team) and DOG (Directors Operational Group) process 20. Back to floor days 21. Datix review & feedback 22. Internal Comms agenda and intranet use for key messages & blogs. 23. Listening events 24. Involve 25. I Lead 26. CQC (Care Quality Commission) and J2O (Journey to Outstanding) agenda 27. Reward Strategy Group.		
			Gaps in Control	**Gaps in Assurance**	
				1. Lack of real time engagement tool 2. Rumour mill working as fast as official channels.	

Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Register			
Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Workforce	Workforce Committee	Trust Leadership Team	
Quarterly Progress Report Against Delivery			**RAG Rating**
Recruitment and Retention Premium review (General and Old Age Medicine), scheduled February 2018.			

(2.4) Strategic Objective: Have Trained a Further 900 Bronze, 70 Silver and 45 Gold Quality Improvement Coaches

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that target numbers will not be achieved as staff will not be able to access training due to operational pressure preventing release to attend.	**Medical Director** **Quality and Performance Committee** **Gloucestershire Quality Improvement Academy**	1. Monitoring of numbers trained through the GSQIA (Gloucestershire Safety and Quality Improvement Academy) 2. Identification of those for higher training through projects in line with strategic objectives 3. Training programme agreed 4. Performance against programme monitored.	Monitoring of training numbers **Gaps in Control** None	Report of progress to Trust Board **Gaps in Assurance**	↔
Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers					
Operational pressures prevent training.					

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to GQIA	Medical Director	September 2019	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Quality Improvement Strategy	Quality and Performance	GSQIA	
Quarterly Progress Report Against Delivery			**RAG Rating**
The Academy continues to deliver Bronze, Silver and Gold training as planned. A recent GSQIA graduation and awards event recognised quality improvement work delivered by the Trust staff.			

(2.5) Strategic Objective - To Be Recognised as Taking Positive Action on Health and Wellbeing by 95% Of Our Staff (Responding 'Definitely' Or 'To Some Extent' in the Staff Survey)

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
Failure to engage staff in activities to improve their physical and emotional wellbeing can give rise to additional stress and sickness which impacts upon patients & service delivery.	**Director of People and Organisational Development** **Workforce Committee**	1. Workforce Strategy 2. Health & Wellbeing strategy 3. Health promotion programmes 4. Provision of staff support programmes 5. Catering 'healthy options' on site 6. Health and Wellbeing web resource.	1. Sickness management policies 2. Reprioritised work programme for 17-18 to simplify employee Support Services 3. Diversity network 4. Staff Health and Wellbeing Steering Group.	1. Annual staff survey report to Workforce Committee 2. Monthly data on absence to Workforce Committee 3. Annual Health & Wellbeing report to Workforce Committee 4. Sickness absence levels/ reasons for absence monitored through Executive Divisional Reviews/Divisional Board structure.	↔
			Gaps in Control	**Gaps in Assurance**	
				Simplified "one stop shop" for employee health and wellbeing initiatives.	
Potential Risk Exposure – confirmed risk entries on Trust / Divisional Risk Registers					

Actions Agreed for any gaps	By Whom	By When	Update
Identification of potential solution to “one stop shop” for employee health and wellbeing initiatives.	Alison Koeltgen	October 18	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Staff Health and Wellbeing Strategy/Workforce Strategy	Workforce Committee		
Quarterly Progress Report Against Delivery			**RAG Rating**
To be updated by the Health & Wellbeing report.			

(3.1) Strategic Objective: Have a Model For Urgent Care That Ensures People Are Treated In Centres with the Very Best Expertise and Facilities to Maximise Their Chances of Survival And Recovery

<table>
<tr><th>Principal Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director& Committee)</th><th>Key Controls and Mitigation</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Direction of Travel</th></tr>
<tr><td rowspan="3">The risk that the proposals cannot be implemented without impacting on operational performance or quality of care.</td><td rowspan="3">Director of Clinical Strategy

Main Board</td><td rowspan="3">1. Detailed implementation plan with modelling of impact of service change
2. Impact Assessment and Quality Impact Assessment of all proposals
3. Risk assessments for operational processes
4. Outline Business Case March 2018
5. NHSE (NHS England) stage 2 Assurance Process
6. Full Business case July 2018 Board.</td><td>Full Business Case including impact assessments.</td><td>Strategic Outline Case June 2017 Output from NHSE (NHS England) stage 1 assurance.</td><td rowspan="3">↔</td></tr>
<tr><td>Gaps in Control</td><td>Gaps in Assurance</td></tr>
<tr><td>None</td><td>None</td></tr>
<tr><td colspan="4">Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers</td><td></td><td></td></tr>
<tr><td colspan="6">National political processes could introduce delays into the proposed timetable.
Unexpected increase in demand for services.</td></tr>
<tr><td colspan="4">• S1748 - The risk of failing national access standards.

• M2473 - The risk of poor quality patient experience during periods of overcrowding in the ED (Emergency Department).

• S2045 - The risk of poorer than average outcomes for patients presenting with fractured neck of femur.</td><td>5 x 4 = 20 (Statutory)

3 x 5 = 15 (Quality)

3 x 4 = 12 (Safety)</td><td></td></tr>
</table>

Enabling Strategy	Oversight Committee	Executive Group	
New Clinical Model Strategic Outline Case One Gloucestershire STP (Sustainability and Transformation Plan)	Main Board	New Clinical Model Programme Board Now reporting to One Place Programme Board	
Quarterly Progress Report Against Delivery			**RAG Rating**
In the last quarter significant work has been undertaken within the Trust and with system partners to work through the emerging new clinical model, its assumptions and the impact that wider STP initiatives around the urgent and emergency pathways would have upon the Trust. The work has now been scoped into the "One Place Programme". The aim of the programme is: • To deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for urgent care set out in "One Gloucestershire" STP. • New Clinical Model Programme Board (meeting fortnightly) has been restructured to include all Executive Directors and Chiefs of Service.			

(3.2) Strategic Objective: Have Systems in Place to Enable Clinicians to Request and Review Tests & Prescribe Electronically

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
3.2.1 Risk that the functionality of the software is not sufficiently well developed by InterSystems leading to delays in deployment and continuing dependency on old platform.	**CEO (Chief Executive Officer) as SRO (Senior Responsible Owner) of SmartCare Programme** **SmartCare Programme Board reporting to Main Board**	1. Implementation plan with critical plan for software releases 2. Rigorous testing of applications prior to deployment 3. Collaboration with other live sites 4. Strengthened assurance gateways.	Authority to Proceed gateways.	Monthly reports to Main Board on programme performance.	↔
			Gaps in Control	**Gaps in Assurance**	
			Ability to control supplier factors remains a gap in controls that cannot be addressed further.	None	
Principle Risks to Achievement of The Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls and Mitigations**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
3.2.2 Service is not operationally prepared for go live, delaying deployment.	**CEO as SRO of SmartCare Programme** **SmartCare Programme Board reporting to Main Board**	1. Rigorous process to identify “as is” and “to be” processes 2. Engagement of TrakCare Operational Group 3. Comprehensive role based training programme, including competency assessment 4. Sign off by TrakCare Operational Group of operational readiness.	Authority to Proceed gateways.	Monthly reports to Main Board on programme performance.	↔
			Gaps in Control	**Gaps in Assurance**	
			None	None	

Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers		Mitigation
• **C2624SC** - Risk of regulatory action being taken by NHS Improvement as a result of failure to adequately remedy the impacts arising from the recent deployment of a new Electronic Patient Record (EPR).	4 x 3 =12 (Business)	• Deep Dive Findings and Recommendations being developed into comprehensive recovery plan • Monthly regulator oversight call to ensure regulator confidence in actions being taken.
• **C2621SC** - Risk that EPR deployment is delayed resulting in roll out extending beyond funded timeline and potential loss of national funding.	4 x 3 = 12 (Statutory)	• Forward programme being re-cast in light of Recovery Plan impact on future phases • Dialogue with SLCS (system funding body) to explore potential for revised funding structure.

Enabling Strategy	Oversight Committee	Executive Group	
Digital Strategy SmartCare Benefits Realisation	SmartCare Programme Board to Trust Board	SmartCare Programme Board	

Quarterly Progress Report Against Delivery	RAG Rating
• Project set to amber as deployment dates for subsequent phases not yet agreed. • Governance arrangements for TrakCare revised and strengthened and plan to re-profile programme and future phases deployment timeline in hand. • Digital Recovery Director appointed and commenced; resource plan agreed.	

(3.3) Strategic Objective: Rolled Out Getting it Right First Time Standards in all Target Specialties and be Fully Compliant in at Least 2 Clinical Services

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
3.3.1 Risk that resources are not available to achieve compliance.	**Director of Clinical Strategy** **Quality and Performance Committee**	1. Programme of target specialities identified 2. Priority services for full compliance identified 3. Action plans in place to achieve compliance developed in each service 4. Business cases to deliver compliance to be considered through 2018/19 Planning Cycle.	GIRFT (Getting It Right First Time) Governance Framework action plans in each specialty.	Governance Framework endorsed at August Q&P (Quality & Performance) Committee GIRFT standing agenda item on Executive Divisional Reviews.	↔
			Gaps in Control	**Gaps in Assurance**	
				Escalation from EDRs (Executive Divisional Reviews) to Board Sub-Committees not yet established.	

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
3.3.2 Risk that actions to secure compliance will constitute significant service change delaying implementation.	**Director of Clinical Strategy** **Quality and Performance Committee**	1. Development of proposals through clinical leadership model 2. Staff engagement plan 3. Early discussions with commissioners 4. Creation of high quality consultation material 5. Clinical leadership of engagement activities.	NHSE (NHS England) Assurance Process SW Clinical Senate Assurance process. **Gaps in Control**	Strategic Outline Case June 2017 Output from NHSE stage 1 assurance. **Gaps in Assurance**	↔
Potential Risk Exposure – confirmed risks on the Trust/ divisional Risk Registers				**Score**	
• **S2045.** The risk of poorer than average outcomes for patients presenting with fractured neck of femur. • **F1339.** Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the financial recovery plan for FY18.				4 x 3 = 12 (Safety) 5 x 4 = 20 (Finance)	

Actions Agreed for any gaps	By Whom	By When	Update
GIRFT action plans to be item on agenda for Surgical Division Executive Review	COO	July 2017 meeting cycle	COMPLETED
GIRFT to be regular reporting item on Q&P committee	Director of Clinical Strategy	July 2017 meeting cycle	COMPLETED
Gap analysis of actions plans to determine priority services to secure compliance	Associate Director of Planning and Performance	November 2017	Being progressed through Executive Divisional Reviews
Escalation Reports from EDR to Board Subcommittees to be agreed.	Director of Corporate Governance	April 2018	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
New Clinical Model Strategic Outline Case Divisional Business Plans 2018/19.	Quality and Performance Committee	New Clinical Model Programme Board (transformational) Trust Leadership Team (operational)	

Quarterly Progress Report Against Delivery	RAG Rating
Action plans following each review now being developed within specialties and progress reviewed in Executive Divisional Reviews. Template for reporting issues from EDRs to Board Sub-Committees in development.	
Reconfiguration of T&O (Trauma & Orthopaedics) service to support compliance implemented from October 17 to March 18 to support the Winter Plan. Benefits tracking in place.	

(3.4) Strategic Objective: Have Staff in all Clinical Areas Trained to Support Patients to Make Healthy Choices

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
Risk that staff will not be able to access training due to lack of availability or difficulty being released from roles.	**Director of Clinical Strategy** **Health and Wellbeing Group**	1. Identification of target staff in all clinical areas 2. Training offer clarified with ICE Creates 3. Training programme agreed 4. Performance against programme monitored.		High-level reports to Health and Wellbeing Group.	↔
			Gaps in Control	**Gaps in Assurance**	
			None	Regular reports on progress to the Health and Wellbeing Group.	
Potential Risk Exposure	**Related risks on Trust Risk Register**				
none	none				

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to Health and Wellbeing Group.	Director of Clinical Strategy	September 2017	COMPLETED
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Health and Wellbeing Strategy.	Trust Leadership Team	Health and Wellbeing Group	

Quarterly Progress Report Against Delivery	RAG Rating
Reporting schedule to Health and Wellbeing Board established Linkages with wider system initiatives and opportunities for training being explored Given additional impetus through publication of the National Tobacco control Plan and recommendations for a Smoke Free NHS Board and Governors supportive of trialling London Clinical Senate approach On line training being explored Number of staff trained: 128.	

(4.1) Strategic Objective – Be in Financial Balance

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that the Trust does not deliver the required savings and budgeted levels of income and/or efficiencies resulting in failure to deliver the Financial Recovery Plan.	**Director of Finance** **Finance Committee**	1. Regular NHSI (NHS Improvement) FSM (Financial Special Measures) meetings 2. Monthly monitoring, forecasting and reporting of performance against budget by finance business partners 3. PMO (Programme Management Office) in place to record and monitor the FY18 programme (including monitoring and reporting of performance against target) 4. Turnaround Implementation Board scrutiny of delivery 5. Weekly 1:1 meetings with Divisions on financial recovery with strengthened Executive membership and chaired by the Head of Operational Finance and Recovery. Bi-weekly meetings with cross cutting themes. 6. Monthly Executive reviews	1. Finance Report 2. Audit reports 3. CIP (Cost Improvement Plan) Report 4. Performance reporting.	1. NHSI agreement to Financial Recovery Plan 2. Initial Deloitte review and implemented actions.	↓
				Gaps in Assurance	
				Reliable data for activity impacting billing and income recovery.	

		7. SmartCare Programme Board overseeing Trak recovery and regular monitoring and analysis of data completeness (and quality) and income recovery.			
Potential Risk Exposure	**Related risks on Trust Risk Register**				
• Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for Financial Year (FY) 18. • Risk that the Trust does not exit Financial Special Measures in a timely way and as a result is subject to interest charge "penalties". • Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the FY18 Financial Recovery plan. • 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. • Risk that the Trust is unable to develop a financial plan that is acceptable to the Board and/or to agree the proposed Control Total for 2018/19 with NHSI (NHS Improvement).					4 x 5 = 20 2 x 4 = 8 4 x 3 = 12 5 x 5 = 25 5 x 3 = 15
Actions Agreed for any gaps	**By Whom**	**By When**	**Update**		
PMO supports in-year delivery alongside any in-year recovery. The PMO works with divisions to understand and recover slippage and identify new schemes. TIB (Turnaround Implementation Board) used as escalation forum for issues that cannot be resolved at divisional level.	Director of CIP PMO	Ongoing	CIP programme showing £0.9m favourable variance to plan for period to end October.		
Progress/slippage is tracked and reported weekly to Executives (through the dashboard) and monthly via other forums including to the Finance Committee.	Director of CIP PMO	Ongoing	Dashboard format will be updated to better KPIs		

TIB chaired by the CEO (Chief Executive Officer) to reiterate the importance of CIP delivery and to support the resolution of any escalated issues.	Director of CIP PMO	Ongoing	In place from September 17
Finance business partners work with divisions to recover slippage and identify mitigating actions Escalation to Director of Finance where Executive intervention required (part of Executive reviews).	Director of Operational Finance	Ongoing	Overall I&E (Income & Expenditure) performance has moved into a cumulative unfavourable variance against plan of £2.1m.
Development of 2018/19 Financial Plan & Budget.	Director of Finance	31/3/18	High level plan developed. Detailed budget setting timetable in place and being worked through over January to March.
Development of 2018/19 CIP plans.	Director of CIP (Cost Improvement Plan) PMO (Programme Management Office)	31/3/18	Each Division has identified its top 3 transformational schemes. Divisions are valuing these schemes by 8/1/18 and producing their first cut overall CIP plans by 31/1/18. Further development of CIP plans to achieve required targets by 31/3/18.

Enabling Strategy	Oversight Committee	Executive Group	
	Finance Committee	Turnaround Improvement Board and Trust Leadership Team	
Quarterly Progress Report Against Delivery			**RAG Rating**
The overall Income and Expenditure position to end November 2017 is showing a £2.1m unfavourable variance against budget. The detailed forecast outturn for 2017/18 currently shows a projected "realistic stretch" position of a £28.6m deficit. This is an increase of £2.9m over the £25.8m deficit forecast to NHS Improvement. The £2.9m increase to the forecast is due to unplanned cost pressures which are being challenged by the Executive. £1m of these are assumed to be removed from the forecast. It assumes that the £5m of the planned £6m additional CIP will be delivered, of which £3.0m has now been forecast by divisions and £2m remains to be identified. An initial high level 2018/19 financial plan has been developed supported by a high level CIP plan. This has been shared with NHSI. Development of 2018/19 CIP plans and pipeline is underway.			

(4.2) Strategic Objective – Be among the top 25% of Trusts for Efficiency.

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel)
Failure to deliver full efficiencies for Length of Stay, Theatres, Outpatients.	**COO (Chief Operating Officer)** **Finance Committee**	1. Weekly operational meetings in place 2. Monitoring at the CIP (Cost Improvement Plan)/Transformation Board 3. Monitoring at the Emergency Care Programme Board and the Planned Care Board.	1. Opportunities for improvement have been evaluated 2. Progress reports to the Finance Committee.	Transformation Board in place.	↔
			Gaps in Controls	**Gaps in Assurance**	
			TrakCare has impacted progression of these projects. Detailed project plans and associated resourcing is required.		
Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers					
• **F2518** - 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. • **F1339** - Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18.				4 x 5 = 20 (Finance) 5 x 5 = 25 (Finance)	

Actions Agreed for any gaps	By Whom	By When	Update
Develop detailed project plans and associated quantified benefits for implementation in 2018/19, and identify resourcing requirements to deliver the project.	COO (Chief Operating Officer)	February 2018	
PMO (Programme Management Office) supports in-year CIP delivery alongside any in-year recovery. The PMO works with divisions to understand and recover slippage and identify new schemes. TIB (Turnaround Implementation Board) used as escalation forum for issues that cannot be resolved at divisional level.	Director of CIP PMO	Ongoing	

Continue to identify actions/schemes to mitigate non delivery	DOPs (Directors of Operation), DoT (Director of Transformation)	March 2018	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Clinical Strategy, Theatre Strategy, STP (Sustainability and Transformation Plans)	Finance Committee	Transformation Board and the Trust Leadership Team.	
Quarterly Progress Report Against Delivery			**RAG Rating**
The identified additional CIPs and further measures have begun to be delivered. Weekly deep dives with divisions, COO (Chief Operating Officer), Chief Nurse, Medical Director and Director of Programme Management have been established to increase pace to year end. Detailed project plans and associated quantified benefits for implementation in 2018/19 are in development. Resourcing requirements to deliver the project are being identified.			

4.3 Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
4.3.1 Risk that new models of integration reduce income to the Trust without reducing costs.	**Director of Clinical Strategy** **Trust Leadership Team**	1. Oversight from Clinical Programme Board of STP (Sustainability and Transformation Programme) 2. Adherence to "design" and "design for delivery" stages of programme change 3. Open book costing of model 4. Endorsement by Resources Steering Group of STP prior to implementation 5. System-wide approach to risk sharing.	Business case endorsed through Resources Steering Group. **Gaps in Control** none	STP Memorandum of Understanding (MOU) Risk sharing agreement as part of MOU. **Gaps in Assurance** none	↔
Principle Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**)
4.3.2 Risk of failure to recruit to staffing model for integrated service.	Director of Clinical Strategy Trust Leadership Team	Oversight from Clinical Programme Board of STP Adherence to "design" and "design for delivery "stages of programme change Oversight from STP workforce group.	STP workforce strategy. **Gaps in Control** none	Principles of integrated working endorsed by Clinical Programmes Board. **Gaps in Assurance** none	↔
Potential Risk Exposure – confirmed risks on Trust and Divisional Risk Register				**Score (CxL)**	
C2335HR&OD - Risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy level.				4 x 5 = 20 (Finance)	

Enabling Strategy	Oversight Committee	Executive Group	
One Gloucestershire, Transforming Care, Transforming Communities	Main Board	Trust Leadership Team	
Quarterly Progress Report Against Delivery			**RAG Rating**
Lead for Integrated Respiratory Team appointed. Slippage to the HR legal framework, financial model and the smaller delay in developing the clinical model has meant that the timescale to integrate the teams by April 2018 is no longer realistic and has been delayed to October 2018 in time for next winter. Model for integrated leg ulcer service agreed. Awaiting funding for implementation of community clinics from CCG. Roll out of new MSK model progressing.			

APPENDIX 1 - BOARD ASSURANCE FRAMEWORK (BAF) 2017/18 AND 2018/19 REVIEW DATES

Board/Committee ***Ownership/focus*** **Review date**	**Main Board** ***Whole BAF***	**Audit and Assurance Committee** ***Whole BAF***	**Finance Committee** ***Strategic Objectives 1.1, 4.1 and 4.2***	**Quality and Performance Committee** ***Strategic Objectives 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.4, 3.3***	**Workforce Committee** ***Strategic Objectives 1.1, 2.1, 2.2, 2.3 and 2.5***
Quarter 4 2017/18	January 2018	March 2018	January 2018	January 2018	February 2018
Quarter 1 2018/19	May 2018	May 2018	April 2018	April 2018	April 2018
Quarter 2 2018/19	July 2018	July 2018	June 2018	June 2018	June 2018
Quarter 3 2018/19	November 2018	November 2018	October 2018	October 2018	October 2018
Quarter 4 2018/19	March 2019	January 2019	February 2019	February 2019	February 2019

Please note:

- Principal risks to Strategic Objective 3.1 *Have a Model For Urgent Care That Ensures People Are Treated In Centres with the Very Best Expertise and Facilities to Maximise Their Chances of Survival And Recovery* are owned by the Trust Board
- Principal risks to Strategic Objective 3.2 *Have Systems in Place to Enable Clinicians to Request and Review Tests & Prescribe Electronically* are owned by the SmartCare Programme Board reporting to Main Board
- Principal risks to Strategic Objective 3.4 *Have Staff in all Clinical Areas Trained to Support Patients to Make Healthy Choices* are owned by the Health and Wellbeing Group
- Principal risks to Strategic Objective 4.3 *Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers* are owned by are owned by Trust Leadership Team

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2018

UP-DATE ON RESEARCH IN GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

1. Aim

To provide the Board with an up-date on the current research activity and finance relating to the delivery of research studies.

2. Background

Under the NHS Constitution (2009) it is expected that research is a core part of the business of the NHS which enables the NHS to improve the current and future health of the people it serves. NHS organisations must do all they can to ensure that patients are made aware of research that is of particular relevance to them. To enable studies to recruit, conclude and report in a timely way we need to promote research to staff and patients. The Government intends us to give patients more information on research studies that are relevant to them, and more scope to join in if they wish. Patients should be encouraged to enroll into research studies on the basis that it is the best way of improving treatment options.

Research activity in the NHS is managed through the National Institute for Health Research (NIHR), which was established in April 2006. It provides the framework by which the Department of Health fund the research, research staff and research infrastructure of the NHS in England as a national research facility. The NIHR also actively encourages partnerships with the commercial sector and this is a key area of income generation for the Trust.

3. The Local Context

The Trust is currently hosting over 300 studies, over 100 of which are actively recruiting new participants with the rest closed to recruitment but still in the follow-up phase. These studies form part of the NIHR portfolio of adopted studies and a list of studies that are currently recruiting new participants can be found in annex A to this paper. Many of these are multi-centre studies that originate from outside the organisation for which we are a centre for recruitment, treatment and follow-up. We have a much smaller portfolio of locally generated studies, some funded by NIHR and other funders but also student projects undertaken by members of our staff. We also have around 15-20 commercial studies open at any one time.

Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in Gloucestershire County Council. Funding described in the SLA supports the Research Management and Governance, design and delivery of non-NIHR portfolio studies including local service evaluation projects and student projects. The GRSS hosts the Gloucester office of the NIHR Research Design Service South West (NIHR RDS SW) which provides a free support service for study design and applications for funding to approved NIHR funders.

4. Key Messages

Research Activity

The Trust receives funding from the NIHR via the West of England Clinical Research Network (WE CRN) which supports the infrastructure to deliver hosted studies that are adopted by the NIHR. Research activity fluctuates depending on the studies we have available to us to recruit to and the number of participants can be heavily distorted by one or two high recruiting studies. The Trust's recruitment target for 2017/18 is 1100 participants. This target was based on studies that were open to recruitment in March 2017 and new studies in the pipeline and due to open in 2017-18. This was a stretched target which we have already exceeded. Our research activity compared with the other Partner organisations in the WE CRN area is in Table 1.

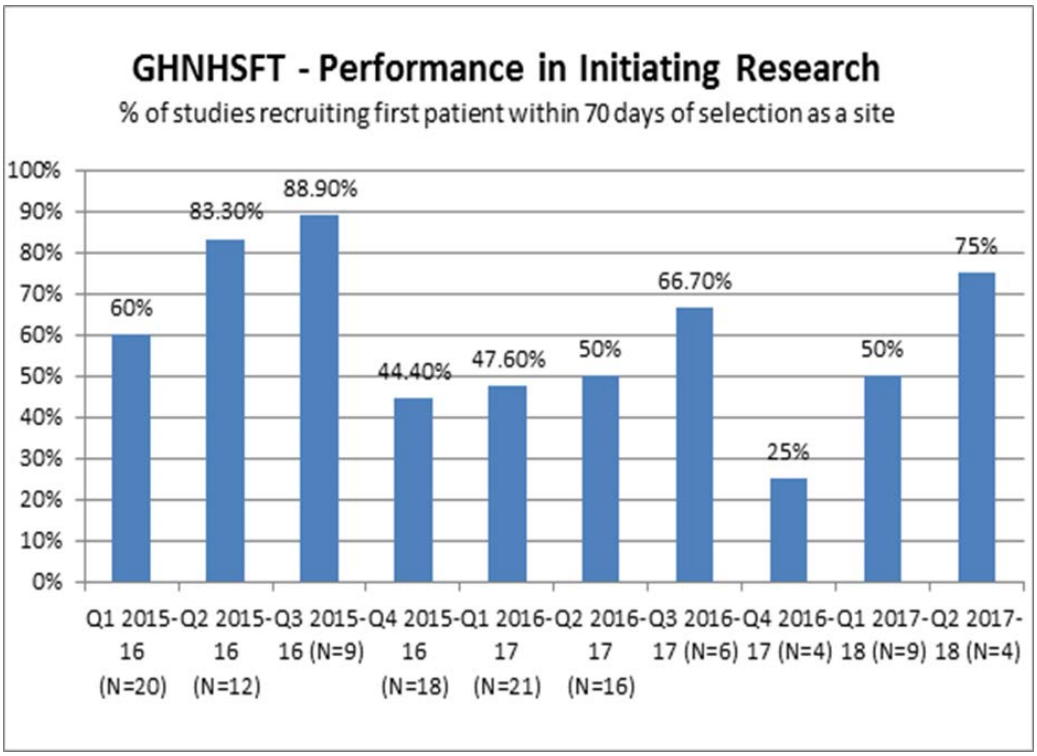
Table 1. Research activity in West of England CRN partner organisations (data extracted 4.12.17)

Trust	Commercial recruitment	Non-commercial recruitment	Total	Weighted recruitment (ABF)	% year-to-date recruitment goal achieved
2Gether NHS Foundation Trust	0	216	216	1273.5	185.14%
Avon And Wiltshire Mental Health Partnership NHS Trust	10	398	408	1385.5	106.95%
Gloucestershire Care Services NHS Trust	0	46	46	348.5	525.71%
Gloucestershire Hospitals NHS Foundation Trust	64	1348	1412	6588.8	130.42%
Great Western Hospitals NHS Foundation Trust	36	737	773	1932.4	147.24%
North Bristol NHS Trust	197	2163	2360	9469.3	112.44%
Primary Care	433	1197	1630		39.92%
NHS Bath And North East Somerset CCG	93	120	213	715.0	
NHS Bristol CCG	0	440	440	3589.2	
NHS Gloucestershire CCG	0	184	184	1524.0	
NHS North Somerset CCG	79	168	247	818.0	
NHS South Gloucestershire CCG	81	162	243	1129.5	
NHS Swindon CCG	0	22	22	149.5	
NHS Wiltshire CCG	180	101	281	583.5	
Royal United Hospitals Bath NHS Foundation Trust	120	1296	1416	7332.4	118.70%
University Hospitals Bristol NHS Foundation Trust	157	3726	3883	17180.5	133.13%
Weston Area Health NHS Trust	4	129	133	315.1	65.14%

We agreed an annual plan with the WE CRN in March 2017 which details how we propose to contribute to the network's delivery of the NIHR CRN High Level Objectives. Annex B provides the details of this plan with up-dates on progress towards these goals.

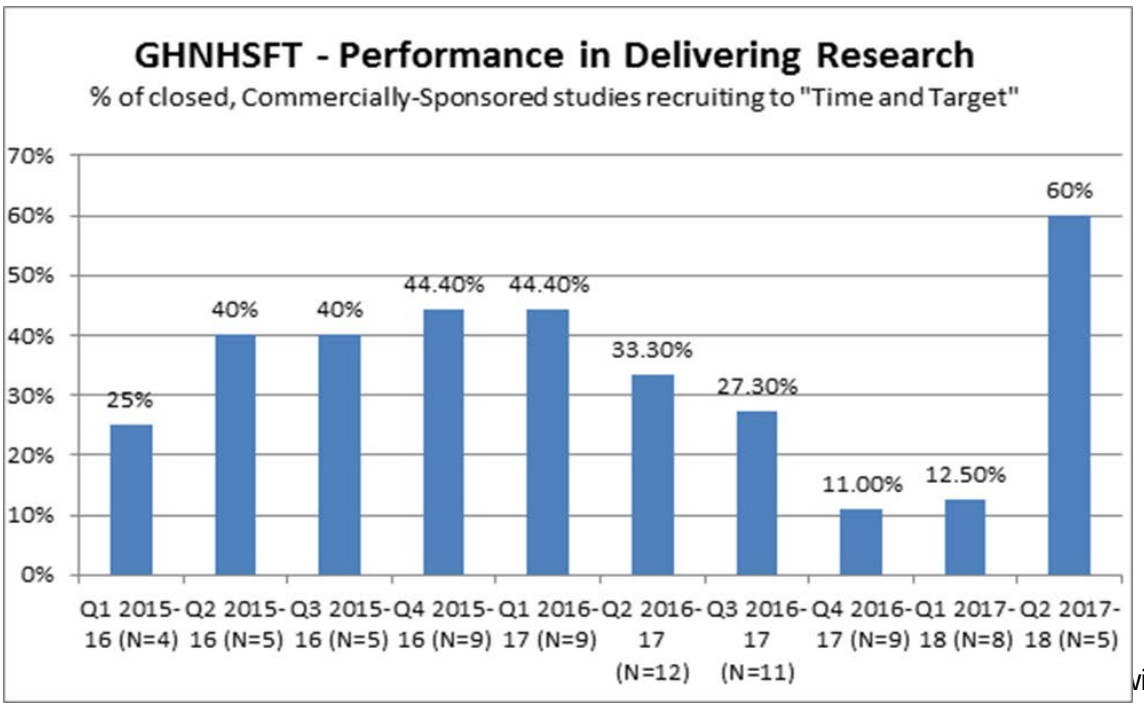
We are performance managed on a number of high level objective set by the NIHR, including study set up times (figure 2) and recruiting to time and target (figure 3). The calculation of the study set-up/recruitment metric changed in quarter 2 to include all studies reviewed as part of the new Health Research Authority approval process. These data are subject to wide fluctuations due to the small numbers involved and although showing an improving picture, there is more to do.

Figure 2. The percentage of studies recruiting the first patient within 70 days of site selection (Target 80%)



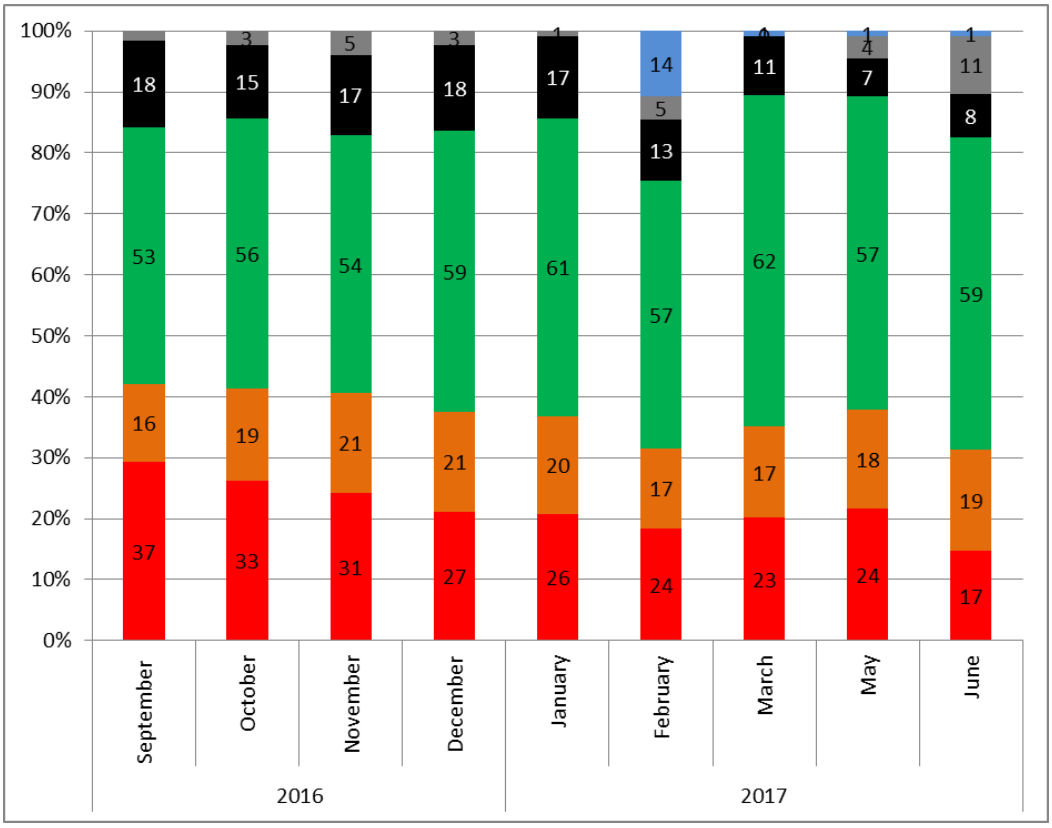
The measure of how commercial studies that have closed recruited participants on time and to target (figure 3) is more difficult to achieve because if a study does not meet its recruitment target, even by one participant, it will be RAG rated red. This includes studies closed early by the company which we have no control over, or studies closed by us because they are non-viable. We are trying to improve this performance by more stringent feasibility and by declining studies that we do not feel have realistic targets set by the pharma companies

Figure 3. The percentage of closed, Commercially-Sponsored studies recruiting to "Time and Target" (Target 80%)



within GHNHSF

Figure 4. The "RAG" rating for recruitment into all trials.



RAG Definitions		
BRAG	Open studies	Closed studies
Black	Study not reported recruitment or study has not recruited	Study not reported recruitment or study has not recruited
Red	% Recruitment is more than 30 behind % time elapsed, i.e. Difference < -30	Site recruitment is less than Project Site Target
Amber	% Recruitment is less than 30 behind % elapsed time but more than 0 behind % elapsed time, i.e. -30 < Difference < 0	
Green	% Recruitment is equal to or greater than % elapsed time, i.e. Difference >= 0	Site recruitment is equal to or greater than Project Site Target
Grey	Unable to calculate RAG due to record missing at least one data point	Unable to calculate RAG due to record missing at least one data point
Blue	Recruitment target of zero with no recruitment	Recruitment target of zero with no recruitment

Funding

Research is funded from income streams that are independent of the other NHS budgets. The main source of income is from the WE CRN allocation of just over £1m in 2017/18. The NIHR utilises an activity based funding (ABF) model, based on the number of recruited subjects and weighted depending on the complexity of the study. However, this is not a direct "pass through" model where we receive a fixed amount per participant recruited. Up until now there has been a protective "cap and collar" of 5% in the WE CRN allocations but this is currently under review and is likely to change. We are anticipating a reduction in funding in 2018/19 in spite of exceeding our recruitment target due to the overall performance of the WE CRN relative to the other networks in England. A summary of R&D income and expenditure is in Annex B.

Additional income is secured through delivery of commercial trials which are reimbursed according to a nationally agreed funding template. At the start of 2017/18 our predicted income target was £263K to enable the Research budget to break even. At the end of quarter 3, we have a deficit of £49k. The current suspension of two studies by the commercial sponsors has resulted in a loss of projected income estimated to be in the region of £25K. This gap will be challenging to close especially if further studies are closed early. However, we do have two studies in the pipeline which may open early in the New Year.

Consultation on the provision of Excess Treatment costs (ETCs)

There is a national consultation on the provision of ETCs open until 1. February 2018. There is a proposal that ETCs should be managed by the CRNs and there would be some implications for NHS Trusts to absorb ETCs below £5k per project. Changes will be made to the standard NHS contract to enforce this.The details of this can be found at: https://www.engage.england.nhs.uk/consultation/simplifying-research-arrangements/

Medicines and Health Products Regulatory Agency (MHRA) Inspection

The Trust was subject to a planned inspection by the MHRA from 16-19 October 2017. The MHRA inspection aims to contribute to quality improvement as well as compliance with the Clinical Trials' Regulations and this was the first inspection since 2011. As anticipated the process identified a number of areas of good practice and others requiring improvement. The Trust's role as research sponsor was reviewed. This is a relative area of weakness as it is very small area of our work, and we currently only sponsor one study involving medicines (CTiMP study).

The result of the inspection are as follows: there were no critical findings, three major; quality assurance relating to the implementation of the action plan from the last inspection, oversight of CTiMP studies and our Quality Systems relating to standard operating procedures. There were four "other" findings relating to monitoring, pharmacovigilance, record keeping, contracts and agreements. The definitions of the categories for these findings are;

- Critical – safety has been (potentially) compromised or data are (potentially) unreliable. A deficient TMF can be deemed critical
- Major – significant departure from the legal requirements but falls short of critical
- Other – not critical or major

We have to submit a Corrective and Preventative Action (CaPA) plan to the MHRA by January 22nd. The CAPA plan needs to consider how these findings may impact on all open trials, not just those reviewed by the inspector or the ones we sponsor. We have been advised not to embark on the sponsorship of any new CTiMP studies until we are satisfied that we can meet the standards required.

Research culture

The first meeting of the Research 4 Gloucestershire steering group took place in December and an agreed work plan is being developed to deliver the objectives of the Statement of Intent. It is hoped that this partnership across the NHS, Social Care and Public Health provider organisations, Gloucestershire CCG and the University of Gloucestershire will provide a new, reinvigorated focus for research across the county.

5. Reporting

This report is submitted to the board biannually providing a summary of trial activity, finance and any additional noteworthy items.

The recruitment of patients to trials (activity) and the performance in initiating and delivering research against the NIHR targets is reported directly, every quarter, to the Trust Chief Executive by the NIHR Coordinating centre. In addition, the activity is reported to the Trust's Quality and Performance Committee and the Research and Innovation (R&I) Forum along with other clinical research meetings.

Finance reports are provided each quarter to the West of England network

.

Author: **Dr Julie Hapeshi, Associate Director of R&D**

Sponsor: **Dr Sally Pearson, Director Clinical Strategy**

January 2018

Annex A.

NIHR Portfolio Studies currently open and recruiting

Project Short title	Title	Principal Investigator	Project type	Total Recruited
Medical				
PANTS-E	Investigation of the clinical, serological and genetic factors that determine primary non-response, loss of response and adverse drug reactions to Anti-TNF drugs in patients with active luminal Crohn's Disease - EXTENSION	Dunckley, Dr Paul	Non-commercial portfolio	3
Airway Management in cardiac arrest patients (AIRWAYS-2)	Cluster randomised trial of the clinical and cost effectiveness of the i-gel supraglottic airway device versus tracheal intubation in the initial airway management of out of hospital cardiac arrest	Benger, Prof Jonathan R	Non-commercial portfolio	11
I--CARE - IBD Cancer and Serious Infections in Europe	I--CARE - IBD Cancer and Serious Infections in Europe	Shaw, Dr Ian	Non-commercial portfolio	1
PBC Genetics Study	Investigation of the Genetic and Molecular Pathogenesis of Primary Biliary Cirrhosis	Hollywood, Dr Coral	Non-commercial portfolio	1
TARGET trial	Randomised controlled trial to compare the diagnostic yield of Positron Emission Tomography Computerised Tomography (PET-CT) guided pleural biopsy versus CT-guided pleural biopsy in suspected pleural malignancy.	Steer, Dr Henry	Non-commercial portfolio	1
RESTART study	REstart or STop Antithrombotics Randomised Trial	Dutta, Dr Dipankar	Non-commercial portfolio	1
Cholecalciferol in Patients on Dialysis - SIMPLIFIED	Survival Improvement with Cholecalciferol in Patients on Dialysis – The SIMPLIFIED Registry Trial	Pickett, Mr Thomas	Non-commercial portfolio	1
PD COMM - Lee Silverman Voice Treatment	A multi-centre randomised controlled trial to compare the clinical and cost effectiveness of Lee Silverman Voice Treatment versus standard NHS speech and language therapy versus control in Parkinson's disease (PD COMM)	Kulkarni, Dr Sangeeta	Non-commercial portfolio	2
STOP-ACEi	Multi-centre Randomised Controlled Trial of Angiotensin Converting Enzyme inhibitor (ACEi) / Angiotensin Receptor Blocker (ARB) withdrawal in advanced renal disease; The STOP-ACEi Trial	Moriarty, Dr Jim	Non-commercial portfolio	2
CRASH-3	Tranexamic Acid for the Treatment of Significant Traumatic Brain Injury: An International, Randomised, Double Blind, Placebo Controlled Trial.	De Weymarn, Dr Tanya	Non-commercial portfolio	2
TICH2	Tranexamic acid for hyperacute primary IntraCerebral Haemorrhage TICH2	Dutta, Dr Dipankar	Non-commercial portfolio	3
STRO 3595 NAVIGATE ESUS	Multicenter, randomized, double-blind, double-dummy, active-comparator, event-driven, superiority phase III study of secondary prevention of stroke and prevention of systemic embolism in patients with a recent Embolic Stroke of Undetermined Source (ESUS), comparing rivaroxaban 15 mg once daily with aspirin 100 mg (NAVIGATE ESUS)	Dutta, Dr Dipankar	Commercial portfolio	4
RIGHT-2	Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial-2 (RIGHT2): Assessment of safety and efficacy of transdermal glyceryl trinitrate, a nitric oxide donor, and of the feasibility of a multicentre ambulance-based stroke trial	Dutta, Dr Dipankar	Non-commercial portfolio	7
Novel use of TXA to reduce the need for nasal packing in epistaxis	A randomised controlled trial of topical intranasal tranexamic acid versus placebo to reduce the need for nasal packing in patients presenting to the Emergency Department with spontaneous epistaxis.	De Weymarn, Dr Tanya	Non-commercial portfolio	9
StartRight (Main Study)	StartRight: Getting the right classification and treatment from diagnosis in young adults with diabetes	Beames, Miss Sue	Non-commercial portfolio	9
HALT-IT	Haemorrhage alleviation with tranexamic acid - Intestinal System	De Weymarn, Dr Tanya	Non-commercial portfolio	13
DRN 552 (Incident and high risk type 1 diabetes cohort – ADDRESS-2)	An incident and high risk type 1 diabetes research cohort - After Diagnosis Diabetes REsearch Support System-2 (ADDRESS-2)	Abitha Kujambal, Dr VC	Non-commercial portfolio	14
LoTS2Care Feasibility Study	A longer-term care strategy for stroke – a feasibility study	Ward, Mrs Deborah	Non-commercial portfolio	25
Surgical				
CARD 3867 VOYAGER	A Multicenter, Randomized, Double-blind, Placebo-Controlled Study Comparing the Efficacy and Safety of Oral Rivaroxaban Xarelto® with Placebo for the Reduction of Thrombotic Vascular Events in Subjects with Peripheral Artery Disease Undergoing Infrainguinal Revascularization Procedures	Bulbulia, Mr Richard	Commercial portfolio	1
ACST-2	Asymptomatic Carotid Surgery Trial-2 surgery versus stenting	Bulbulia, Mr Richard	Non-commercial portfolio	1
Developing an activity pacing framework for chronic pain/fatigue	Developing an activity pacing framework for the management of chronic pain/fatigue	Ashworth, Polly	Non-commercial portfolio	1
CALIBER	CALIBER – A phase II randomised feasibility study of Chemoresection and surgicAl management in Low rIsk non muscle invasive Bladder cancER	Davenport, Miss Kim	Non-commercial portfolio	3
OMASPECT	A multicener, Open-Label, Extension Study To Evaluate The Long-Term Safety And Tolerability Of Lampalizumab In Patients With Geographic Atrophy Secondary To Age-Related Macular Degeneration Who Have Completed A Roche-Sponsored Study.	Mohamed, Mr Quresh	Commercial portfolio	5
FASBAT	FASBAT	Fletcher, Dr Emily	Non-commercial portfolio	10
Care.Know.Do Pilot: Version 1	Pilot evaluation of Care.Know.Do: a selfmanagement intervention to support patients with chronic kidney disease	Boddana, Dr Preetham	Commercial portfolio	11
Chart review of patients with geographic atrophy (GA)	Chart review of patients with confirmed geographic atrophy (GA) diagnosis secondary to age-related macular degeneration and non- GA controls	Mohamed, Mr Quresh	Commercial portfolio	12
Satisfaction and Wellbeing in Anaesthetic Training (SWeAT) V1.1	Professional satisfaction and wellbeing among specialty trainees in Anaesthesia within the Southwest of England and Wales; a mixed-methods collaborative study	Looseley, Dr Alex	Non-commercial portfolio	22
OPHT 4824	DRAKO-A non-interventional study to assess the effectiveness of aflibercept in routine clinical practice in patients with visual impairment due to diabetic macular oedema (DMO)	Scanlon, Prof Peter	Commercial portfolio	30
The GRASP Trial	GRASP: Getting it Right: Addressing Shoulder Pain. Clinical and cost effectiveness of progressive exercise compared to best practice advice, with or without corticosteroid injection, for the treatment of rotator cuff disorders: a 2x2 factorial randomised controlled trial	Willmore, Ms Elaine	Non-commercial portfolio	45
Epidemiology of Critical Care provision after Surgery (EpiCCS)	The Second UK Sprint National Anaesthesia Project: Epidemiology of Critical Care provision after Surgery	,	Non-commercial portfolio	94
Predict-CAT	Predicting Self-Reported Benefit, Supporting Decision Making and Calibrating Health Utilities for Cataract Surgery	Scanlon, Prof Peter	Non-commercial portfolio	105
The B-ADENOMA Study	The B-ADENOMA Study: Bowel Scope - Accuracy of Detection using ENdocuff Optimisation of Mucosal Abnormalities	Hellier, Dr Simon	Non-commercial portfolio	132
High-Intensity Specialist-Led Acute Care (HiSLAC)project	Evaluation of the Impact of High-Intensity Specialist-Led Acute Care (HiSLAC) on Emergency Medical Admissions to NHS Hospitals at Weekends	,	Non-commercial portfolio	156
The CVI Project: Prevalence Study	The CVI Project: Prevalence of Cerebral Visual Impairment (CVI) in primary school children	Bishop, Miss Estelle	Non-commercial portfolio	1,072
Corporate				
US-PEx: Understanding how frontline staff use patient experience data	Understanding how frontline staff use patient experience data for service improvement - an exploratory case study evaluation	Beer, Heather	Non-commercial portfolio	239

Project Short title	Title	Principal Investigator	Project type	Total Recruited
Medical				
PANTS-E	Investigation of the clinical, serological and genetic factors that determine primary non-response, loss of response and adverse drug reactions to Anti-TNF drugs in patients with active luminal Crohn's Disease - EXTENSION	Dunckley, Dr Paul	Non-commercial portfolio	3
Airway Management in cardiac arrest patients (AIRWAYS-2)	Cluster randomised trial of the clinical and cost effectiveness of the i-gel supraglottic airway device versus tracheal intubation in the initial airway management of out of hospital cardiac arrest	Benger, Prof Jonathan R	Non-commercial portfolio	11
I--CARE - IBD Cancer and Serious Infections in Europe	I--CARE - IBD Cancer and Serious Infections in Europe	Shaw, Dr Ian	Non-commercial portfolio	1
PBC Genetics Study	Investigation of the Genetic and Molecular Pathogenesis of Primary Biliary Cirrhosis	Hollywood, Dr Coral	Non-commercial portfolio	1
TARGET trial	Randomised controlled trial to compare the diagnostic yield of Positron Emission Tomography Computerised Tomography (PET-CT) guided pleural biopsy versus CT-guided pleural biopsy in suspected pleural malignancy.	Steer, Dr Henry	Non-commercial portfolio	1
RESTART study	REstart or STop Antithrombotics Randomised Trial	Dutta, Dr Dipankar	Non-commercial portfolio	1
Cholecalciferol in Patients on Dialysis - SIMPLIFIED	Survival Improvement with Cholecalciferol in Patients on Dialysis – The SIMPLIFIED Registry Trial	Pickett, Mr Thomas	Non-commercial portfolio	1
PD COMM - Lee Silverman Voice Treatment	A multi-centre randomised controlled trial to compare the clinical and cost effectiveness of Lee Silverman Voice Treatment versus standard NHS speech and language therapy versus control in Parkinson's disease (PD COMM)	Kulkarni, Dr Sangeeta	Non-commercial portfolio	2
STOP-ACEi	Multi-centre Randomised Controlled Trial of Angiotensin Converting Enzyme inhibitor (ACEi) / Angiotensin Receptor Blocker (ARB) withdrawal in advanced renal disease; The STOP-ACEi Trial	Moriarty, Dr Jim	Non-commercial portfolio	2
CRASH-3	Tranexamic Acid for the Treatment of Significant Traumatic Brain Injury: An International, Randomised, Double Blind, Placebo Controlled Trial.	De Weymarn, Dr Tanya	Non-commercial portfolio	2
TICH2	Tranexamic acid for hyperacute primary IntraCerebral Haemorrhage TICH2	Dutta, Dr Dipankar	Non-commercial portfolio	3
STRO 3595 NAVIGATE ESUS	Multicenter, randomized, double-blind, double-dummy, active-comparator, event-driven, superiority phase III study of secondary prevention of stroke and prevention of systemic embolism in patients with a recent Embolic Stroke of Undetermined Source (ESUS), comparing rivaroxaban 15 mg once daily with aspirin 100 mg (NAVIGATE ESUS)	Dutta, Dr Dipankar	Commercial portfolio	4
RIGHT-2	Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial-2 (RIGHT2): Assessment of safety and efficacy of transdermal glyceryl trinitrate, a nitric oxide donor, and of the feasibility of a multicentre ambulance-based stroke trial	Dutta, Dr Dipankar	Non-commercial portfolio	7
Novel use of TXA to reduce the need for nasal packing in epistaxis	A randomised controlled trial of topical intranasal tranexamic acid versus placebo to reduce the need for nasal packing in patients presenting to the Emergency Department with spontaneous epistaxis.	De Weymarn, Dr Tanya	Non-commercial portfolio	9
StartRight (Main Study)	StartRight: Getting the right classification and treatment from diagnosis in young adults with diabetes	Beames, Miss Sue	Non-commercial portfolio	9
HALT-IT	Haemorrhage alleviation with tranexamic acid - Intestinal System	De Weymarn, Dr Tanya	Non-commercial portfolio	13
DRN 552 (Incident and high risk type 1 diabetes cohort – ADDRESS-2)	An incident and high risk type 1 diabetes research cohort - After Diagnosis Diabetes REsearch Support System-2 (ADDRESS-2)	Abitha Kujambal, Dr VC	Non-commercial portfolio	14
LoTS2Care Feasibility Study	A longer-term care strategy for stroke – a feasibility study	Ward, Mrs Deborah	Non-commercial portfolio	25
Surgical				
CARD 3867 VOYAGER	A Multicenter, Randomized, Double-blind, Placebo-Controlled Study Comparing the Efficacy and Safety of Oral Rivaroxaban Xarelto® with Placebo for the Reduction of Thrombotic Vascular Events in Subjects with Peripheral Artery Disease Undergoing Infrainguinal Revascularization Procedures	Bulbulia, Mr Richard	Commercial portfolio	1
ACST-2	Asymptomatic Carotid Surgery Trial-2 surgery versus stenting	Bulbulia, Mr Richard	Non-commercial portfolio	1
Developing an activity pacing framework for chronic pain/fatigue	Developing an activity pacing framework for the management of chronic pain/fatigue	Ashworth, Polly	Non-commercial portfolio	1
CALIBER	CALIBER – A phase II randomised feasibility study of Chemoresection and surgicAl management in Low rIsk non muscle invasive Bladder cancER	Davenport, Miss Kim	Non-commercial portfolio	3
OMASPECT	A multicener, Open-Label, Extension Study To Evaluate The Long-Term Safety And Tolerability Of Lampalizumab In Patients With Geographic Atrophy Secondary To Age-Related Macular Degeneration Who Have Completed A Roche-Sponsored Study.	Mohamed, Mr Quresh	Commercial portfolio	5
FASBAT	FASBAT	Fletcher, Dr Emily	Non-commercial portfolio	10
Care.Know.Do Pilot: Version 1	Pilot evaluation of Care.Know.Do: a selfmanagement intervention to support patients with chronic kidney disease	Boddana, Dr Preetham	Commercial portfolio	11
Chart review of patients with geographic atrophy (GA)	Chart review of patients with confirmed geographic atrophy (GA) diagnosis secondary to age-related macular degeneration and non- GA controls	Mohamed, Mr Quresh	Commercial portfolio	12
Satisfaction and Wellbeing in Anaesthetic Training (SWeAT) V1.1	Professional satisfaction and wellbeing among specialty trainees in Anaesthesia within the Southwest of England and Wales; a mixed-methods collaborative study	Looseley, Dr Alex	Non-commercial portfolio	22
OPHT 4824	DRAKO-A non-interventional study to assess the effectiveness of aflibercept in routine clinical practice in patients with visual impairment due to diabetic macular oedema (DMO)	Scanlon, Prof Peter	Commercial portfolio	30
The GRASP Trial	GRASP: Getting it Right: Addressing Shoulder Pain. Clinical and cost effectiveness of progressive exercise compared to best practice advice, with or without corticosteroid injection, for the treatment of rotator cuff disorders: a 2x2 factorial randomised controlled trial	Willmore, Ms Elaine	Non-commercial portfolio	45
Epidemiology of Critical Care provision after Surgery (EpiCCS)	The Second UK Sprint National Anaesthesia Project: Epidemiology of Critical Care provision after Surgery	,	Non-commercial portfolio	94
Predict-CAT	Predicting Self-Reported Benefit, Supporting Decision Making and Calibrating Health Utilities for Cataract Surgery	Scanlon, Prof Peter	Non-commercial portfolio	105
The B-ADENOMA Study	The B-ADENOMA Study: Bowel Scope - Accuracy of Detection using ENdocuff Optimisation of Mucosal Abnormalities	Hellier, Dr Simon	Non-commercial portfolio	132
High-Intensity Specialist-Led Acute Care (HiSLAC)project	Evaluation of the Impact of High-Intensity Specialist-Led Acute Care (HiSLAC) on Emergency Medical Admissions to NHS Hospitals at Weekends	,	Non-commercial portfolio	156
The CVI Project: Prevalence Study	The CVI Project: Prevalence of Cerebral Visual Impairment (CVI) in primary school children	Bishop, Miss Estelle	Non-commercial portfolio	1,072
Corporate				
US-PEx: Understanding how frontline staff use patient experience data	Understanding how frontline staff use patient experience data for service improvement - an exploratory case study evaluation	Beer, Heather	Non-commercial portfolio	239

Annex B Progress Against Annual Plan agreed with the WE CRN in March 2017

HLO	Measure	Objective / Goal	Three Key Actions / Initiatives	Timescale	Lead	Progress
1	Increase the number of participants recruited to NIHR portfolio studies	Our projected stretched target is 1000 participants. This is below our achievement for last year due to the closure of several large recruiting studies which have not been replaced on our portfolio.	• We will not open any new studies until we have completed the local workforce review due to complete at the end of April 2017 and the teams have had chance to settle • The only exception will be commercial trials or simple, large recruiting studies with limited follow-up, this includes an MSK study in set-up. • The current recruitment projection is 846 based on open studies and the recruitment anticipated from studies in set-up. This is a cautious target as some of the studies in set up have no agreed recruitment targets as yet with think that we can stretch this to 1000	June 2017 March 2018	Julie Hapeshi	**We opened more studies than planned in quarter one than at any other time this year.** We were encouraged to increase our recruitment target to exclude the unexpected gains from a high recruiting ophthalmology study, which we have agreed to. **We have achieved our recruitment target with 3 months to spare.**
2	Increase the proportion of studies in the NIHR CRN portfolio delivering recruitment to time and to target.	2a. Our average RTT over last year was 36%. This was adversely influenced by a stringent portfolio review, closing poorly performing studies. We aim to increase our RTT to 50% this year.	Systems in place to ensure: • Accurate initial target setting • Improve the scrutiny at feasibility stage to minimise opening studies that will close early • To not open studies where wider clinical support is not evident, i.e. no cross referrals, or clear clinical team "buy-in" • Focus on studies rated amber to move them back into "green" • Focus on studies nearing end of recruitment window to ensure they meet their targets	March 2018	Julie Hapeshi	We have regular meetings to review the RTT reports and especially consider "red-rated" studies to decide if they are still viable and what remedial action needs to be taken to deliver to time and target. The "amber" rated studies are reviewed to decide what action needs to be taken to move them into "green". **HLO 2a: currently at 80%**
		2b. Our average RTT over last year was 36%. This was adversely influenced by a stringent portfolio review, closing poorly	Systems in place to ensure: • Accurate initial target setting • Improve the scrutiny at feasibility stage to minimise opening studies that will close early • Not open studies where wider clinical support is not evident, i.e. no cross	March 2018	Julie Hapeshi	Actions as above **HLO 2b: currently at 50%**

HLO	Measure	Objective / Goal	Three Key Actions / Initiatives	Timescale	Lead	Progress
		performing studies. We aim to increase our RTT to 50% this year	referrals, or clear clinical team "buy-in" • Focus on studies rated amber to move them back into "green" • Focus on studies nearing end of recruitment window to ensure they meet their targets			
3	Increase the number of commercial studies	We currently have 20 studies on our portfolio with 6 due to complete in the next few months. We have 5 in set-up which will replace those closing and we hope to further increase our commercial portfolio by another 4 studies, 24 open studies in total	• We will open viable commercial studies but need to improve the scrutiny at feasibility stage to minimise opening studies that will close early	March 2018	Julie Hapeshi	**The number of commercial studies available to us to open has not met projections. We have only opened 2 new commercial studies since April, leaving 10 active and 3 other open studies suspended. We are unlikely to meet the target of 24 open studies by the end of March.**
4	Reduce the time taken to start up studies.	80% of all studies achieve ready to start confirmation within 40 calendar days. We averaged 63% through 2016/17 and aim to improve this to 70% this year	• Review RM&G office processes to ensure clear procedures in place for communication with the wider team when the minimum data set received to reduce early delays. • Careful monitoring of communication with trials officers/ sponsors to ensure accurate start and end dates for HLO metrics	June 2017	Mark Walker	We have put in place a number of initiatives to improve the communication between the governance and delivery teams to enable this target to be met. **We are still struggling to meet this metric: 0/1 for commercial trials and 3/9 for non-commercial. National performance 60%.** **We are continually trying to identify the key issues that delay study set up. This is likely to become a formal Quality Improvement project in 2018.**[1]
5	Reduce the time taken	We will not attain the	• Review RM&G office processes to	June 2017	Janet	See above

[1] The data reported via the CRN are from a different time period and do not consider instances where delays are outside our control. The data reported directly to NIHR provide a more optimistic view of our performance which is reported in figures 2 and 3

HLO	Measure	Objective / Goal	Three Key Actions / Initiatives	Timescale	Lead	Progress
	to recruit the first patient to NIHR portfolio studies	80% target of studies recruiting first patient within 30 calendar days of NHS permission or site initiation as so many studies on our portfolio have low target recruitment. We will aim to recruit the first patient within 30 calendar days in 80% of studies where recruitment is estimated to be greater than one per month.	ensure clear procedure in place to achieve prompt SIV dates • Preselect patients using registers and by screening clinic attendees where possible • Careful monitoring of communication with trials officers/ sponsors to ensure accurate start and end dates for HLO metrics		Forkes	**For commercial studies 1/3 and non-commercial 3/6. National performance 22% and 50% respectively.**
7	Increase recruitment to DeNDRoN studies – GHT has never set a target for Dementia studies as we do not have them on our portfolio or staff with the appropriate skills to deliver these studies.	We will set targets for Dementia studies will be set when bid outcome is known.	We are proposing a shared arrangement with 2Gether NHS FT to employ a suitably qualified member of staff to recruit to dementia studies – a bid for development funding has been submitted. Non-dementia neurology study targets are noted in the neurology section.	March 2018	Julie Hapeshi	**The bid for funding was put on hold by the WE CRN pending the review of the team based in AWP. There are currently no suitable studies for this patient group. The network portfolio facilitators are looking out for suitable studies that could be run by the new peripatetic team.**

Annex C

Research & Development Projected Income & Expenditure 2017/18

	£
Projected Expenditure	
Pay	1,827,133
Non Pay	65,412
Overheads to Trust (CLRN, RCF & RDS Contracts)	79,278
Overheads to Trust (Commercial studies)	13,614
Total Projected Expenditure 2017/18	**1,985,437**
Confirmed Income	
WoE CLRN Income	1,077,424
Research Capability Allocation	31,912
Charity Allocation (Link)	15,000
HTA Grant - BOSS Study	93,486
Biophotonic Grants	87,548
RDS Contract	64,793
GRSS SLA	49,547
GRSS SLA GHNHSFT Contribution	25,999
Confirmed Income from open studies	344,543
Deferred Income carried forward form from 2016/17	70,229
Total Confirmed Income	**1,860,482**
Forecasted additional project related income	**76,513**
Total expected Income	**1,936,995**
Remaining Income target	**-48,442**

MAIN BOARD – JANUARY 2018
Lecture Hall, Redwood Education Centre commencing at 09:00

Report Title
Up-date on Research in Gloucestershire Hospitals NHS Foundation Trust
Sponsor and Author(s)
Author: Julie Hapeshi, Associate Director of Research and Development Sponsor: Sally Pearson, Director of Clinical Strategy
Executive Summary

Purpose

To provide an up-date for the Board on the current status of research activity within the Trust

Key issues to note

Research activity within the trust is significant and compares favourably to other Trusts in the West of England Clinical Research Network.

Our performance against the national metrics is variable (largely due to small numbers of trials included in the measures) but improving.

The income for research comes from streams that are independent of the main health care budgets. The value of research activity in the trust approaches £2m but the non-recurring nature of the funding streams makes management of this budget challenging. Income to date is in line with the planned trajectory.

There is a strong history of joint working to support research across the health and social care organisations in Gloucestershire. This will be further strengthened by the recent Memorandum of Understanding between these organisations and the University of Gloucestershire.

Conclusions

Research is an important aspect of the day to day business of the NHS and provides the organisation, it patients and its staff with access to new drugs, devices and developments in the delivery of care that it would otherwise have to wait for. Reporting to the board provides an opportunity to improve the visibility of this important area of the Trust's work.

Implications and Future Action Required

Research activity is reported monthly to the Quality and Performance Committee as part of the Quality and Performance report. Activity and performance is scrutinised at the quarterly Research and innovation Forum.
The Board receives biannual update reports to provide assurance of the performance and governance of research within the Trust

Recommendations
The Board is asked to accept this report as assurance of the performance and governance of research within the Trust.

Impact Upon Strategic Objectives
Impact Upon Corporate Risks
None
Regulatory and/or Legal Implications
Research activity is covered by specific regulatory framework administered by the Medicines and Health regulatory Authority. The MHRA are due to visit the Trust in September.
Equality & Patient Impact
Research studies are accessible to all patients who meet the criteria of the studies.

Resource Implications			
Finance	**X**	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

ITEM 13

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 14

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 15

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 16

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION