GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 8 March 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

22nd February 2018

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 11 January 2018	**PAPER**	**To approve**	09:32
5.	Matters Arising	**PAPER**	**To note**	09:35
6.	Chair's Update	**VERBAL** (Peter Lachecki)	**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 Reports of the Chair of the Quality and Performance Committee meetings held on 25 January 2018 and 22 February 2018	**PAPER** (Claire Feehily)		
	• Learning from Deaths	**PAPER** (Sean Elyan)		
	• Trust Risk Register	**PAPER** (Lukasz Bohdan)		
9.	Financial Performance:		**For assurance**	10:40
	• Report of the Finance Director	**PAPER** (Steve Webster)		
	• Assurance Reports of the Chair of the Finance Committee meetings held on 31 January 2018 and 28 February 2018	**PAPER** (Keith Norton)		
	Break		**11:10 - 11:20**	
10.	Workforce:		**For assurance**	11:20
	• Report of the Director of People and Deputy Chief Executive	**PAPER** (Emma Wood)		
	• Gender Pay Gap Annual Report	**PAPER** (Emma Wood)		
	• Assurance Report of the Chair of the Workforce Committee meeting held on 8 February 2018	**PAPER** (Tracey Barber)		

11.	Audit and Assurance: • Report of the Chair of the Audit and Assurance Committee meeting held on 16 January 2018	**PAPER** (Rob Graves)	**For Assurance**	11:50
12.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Sean Elyan)	For Assurance	12:00
13.	NHS Improvement Undertakings - Financial Undertakings - Accident & Emergency Undertakings	**PAPER** (Deborah Lee)	For Assurance	12:15
14.	Minutes of the meeting of the Council of Governors held on 18 October 2017 & 6 December 2017	**PAPER** (Peter Lachecki)	**To Note**	12:30
	Governor Questions			
15.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To discuss**	12:35
	Staff Questions			
16.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To discuss**	12:45
	Public Questions			
17.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**To discuss**	12:55
	Any Other Business			
18.	Items for the Next Meeting and Any Other Business		**To note**	13:05
	Lunch Break			**13.15 – 13.45**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE BOARD ADMINISTRATOR NO LATER THAN 17:00 ON TUESDAY 27th FEBRUARY 2018

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 10 May 2018** in the **Lecture Hall, Redwood 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	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, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 11 JANUARY 2018 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
	Dr Claire Feehily	Non-Executive Director
	Steve Hams	Director of Quality and Chief Nurse
	Simon Lanceley	Director of Strategy and Transformation
	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
	Rob Graves	Non-Executive Director
	Alison Moon	Non-Executive Director
APOLOGIES	Tony Foster	Non-Executive Director
	Keith Norton	Non-Executive Director
IN ATTENDANCE	Suzie Cro	Deputy Director of Quality
	Natashia Judge	Board Administrator
	Mark Hutchinson	Digital Recovery Consultant
	Bev Farrar	Learning Disability Liaison Nurse
	Carol Forbes	Learning Disability Liaison Nurse
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	Two Governors, five members of the public, one member of staff.	

The Chair welcomed all to the meeting.
Mr Foster's and Mr Norton's apologies were noted.

001/18 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

002/18 PATIENT STORY

Prior to the Patient Story, the Deputy Director of Quality updated the Board that two of the Trust's patient experience projects had been shortlisted for national awards: the Ward 7A Project and the project around Deaf Communication Cards. The patient experience team have also secured the Point of Care Foundation to come and run the Sweeney Programme, an initiative similar to the Trust's Quality Academy but regarding Patient Experience. A celebratory event is planned for April.

The Deputy Director of Quality introduced Ms Farrar and Ms Forbes, the Trust's Learning Disability Liaison Nurses who gave a presentation detailing their roles and work undertaken by their team.

The presentation highlighted:

- National context and the importance of getting learning disability (LD) care right as LD is lifelong condition.
- Admissions and mortality figures for LD patients.
- Systems available for registering LD patients and the improvements needed.
- The butterfly badge used to identify patients with learning and cognitive disabilities, including positive response to the pilot and subsequent widespread implementation.
- Training and workshops previously offered and the positive feedback received in response. This has since been discontinued.
- The Emergency Department and how the lack of continuity of care affects patients. A great deal of work has been done to deliver training to unscheduled care resulting in a substantial improvement with reasonable adjustments now being made. An alert has been implemented to highlight LD patients and their support plans. Work is underway to improve the transition children with learning disabilities moving to adult care.
- The Trust's Health User Group, including its membership, operation, achievements so far and future plans.
- The importance of outstanding care and the work undertaken in Day Surgery Unit. It was acknowledged that at present good practice was very much personality driven.
- LD Champions, their roles and their distribution across the Trust.
- Areas for improvement identified in the presentation included: training; attendance of LD champions at regular meetings; the Mental Capacity Act in practice; what best interest meetings should look like; discharge planning; admin support and office space.

The Chair thanked Ms Farrar and Ms Forbes for their presentation, and invited questions from members of the Board:

- The Deputy Director of Quality committed to investigating improvements to office space. **SC/SH**
- The Medical Director committed to meeting with the team to discuss doctor engagement and F1 training. He would also investigate the possibility of doctors joining the team on the "Find You Way Around The Hospital" sessions run by the LD team, where LD patients attempt to navigate the hospitals using signage and help from staff. **SE**
- The Director of Clinical Strategy and Medical Director praised the team for their transformational approach over the years. The Director of Clinical Strategy highlighted the importance of equality of outcome and introducing this language across the Trust to change the design for patients.
- The Director of Quality and Chief Nurse and Director of People agreed to investigate training (specifically inclusion in staff induction) and e-learning, including the option of "in-situ" training. **SE/EW**
- Ms Moon asked the Director of Quality and Chief Nurse how the Trust could ensure a mainstream approach to LD across its services to support patients without a formal diagnosis that could benefit from additional support. The Director of Quality

and Chief Nurse reinforced the importance of establishing what outstanding looks like and ensuring reasonable adjustments are made for patients. He felt that mapping what this looked like through the Trust's Journey to Outstanding was important so that all staff understood what was needed and would act accordingly.

- Ms Carol McIndoe, Disability Equality Manager, who was in attendance at the Board meeting, advised that there was functionality within the TrakCare system that the team was utilising and the data showed that more patients were being flagged as having a LD since the function was available.
- The Chief Executive requested the Chief Operating Officer investigate why special dental services had moved from the Orchard Centre to Day Surgery Unit and whether this was unavoidable given the less positive environment for patients with a learning disability. **CL**

[The Deputy Director of Quality, Bev and Carol left the meeting]

003/18 MINUTES OF THE MEETING HELD ON 13 DECEMBER 2017

An amendment would be made to page 12 of the minutes. **NJ**

RESOLVED: That the minutes of the meeting held on 13 December 2017 be agreed as a correct record and signed by the Chair.

004/18 MATTERS ARISING

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.

Complete (to Board): Action now picked up in Quality and Performance Committee and discussion is ongoing between the Head of Planned Care and Deputy Director of Quality.

DECEMBER 2017 279/17 QUALITY AND PERFORMANCE REPORT - 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. This will be included within the March Quality and Performance Board report.

DECEMBER 2017 279/17 QUALITY AND PERFORMANCE REPORT - 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.

DECEMBER 2017 279/17 ASSURANCE REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 30 NOVEMBER 2017 - 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.

DECEMBER 2017 279/17 TRUST RISK REGISTER - 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.

Completed.

DECEMBER 2017 279/17 LEARNING FROM PATIENT STORIES - LEARNING FROM PATIENT STORIES PAPER

This would be circulated to Board members.

Completed: Circulated by the Board Administrator.

DECEMBER 2017 279/17 LEARNING FROM PATIENT STORIES - 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.

DECEMBER 2017 279/17 LEARNING FROM DEATHS - 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.

DECEMBER 2017 279/17 LEARNING FROM DEATHS - 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: Report format amended.

DECEMBER 2017 279/17 LEARNING FROM DEATHS - 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.

DECEMBER 2017 283/17 SMARTCARE PROGRESS REPORT - 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 Information Safety Meeting.

DECEMBER 2017 286/17 GOVERNOR QUESTIONS - 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 following the STP Delivery Board.

005/18 CHAIR'S UPDATE

The Chair acknowledged that this would be the Director of Clinical Strategy's last Board meeting and expressed his sincere gratitude for all of her work, noting the respect it received inside and outside of the Trust.

The Chair also advised that Governors would shortly be commencing the recruitment of two new Non-Executive Directors, one to replace Mr Foster whose terms of the office ends in May 2018 and another to fill a longstanding vacancy. Members of the Board will be involved in this Governor-led process.

006/18 CHIEF EXECUTIVE'S REPORT

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

- The Trust has experienced challenging performance following Christmas though there have been 4 to 5 days of improved operational performance with improvement at the "back door" as the system is able to respond more fully. She praised the excellent planning and sheer commitment and dedication of staff.
- Performance prior to Christmas was noted to have been exceptional with the Trust only moving into escalation Level 4 on one occasion. Outpatient clinics were not stopped as it was felt that the staff this would affect could not support the Emergency Department (ED). Out of a target of 94 patients, 80 elective patients were operated on per day.
- Over the previous 12 hours, performance was noted to have become tough once again with occupancy in excess of 100% and flow challenging.
- The Chief Executive praised the executive triumvirate for their time spent in the ED supporting and understanding how patients and staff felt. She shared that she had learnt a lot from her own experiences and a structured debrief would be held to capture and share learning.
- A recent letter from the Secretary of State for Health, Rt Hon Jeremy Hunt, praising the positive work being done by the Trust, was noted.
- The current timeline for commencing consultation on the One System Business Case is July or September 2018.
- Professor Tim Briggs, National Lead for the Getting It Right First Time (GIRFT) Programme visited the Trust to hear of

the progress of the Trauma and Orthopaedic reconfiguration. Prof Briggs is promoting the work as an exemplar approach. On 1st February Professor Briggs will bring representatives from four Trusts from across the country to learn from Gloucestershire's' experience.

- Good progress is being made with preparations for the establishment, subject to Board's approval, of a subsidiary company. While some concerns have been raised regarding staff involvement, it was important to stress that 34 events have been held, attended by 300 staff. Engagement will enable development of a model that staff think will serve their and organisational needs best. She acknowledged that this proposal represented change for the staff potentially affected and she was grateful that the Board was listening and responding to their concerns; going beyond that lawful requirement to ensure staff's terms and conditions could not be eroded in the future.
- *Going the Extra Mile (GEM)* monthly recognition awards scheme have been established. This will be a huge boost for staff morale.
- Following on from the Deputy Director of Quality's announcement regarding nomination for national awards, the Chief Executive has requested the Director of Quality and Chief Nurse begin a catalogue of accolades the Trust has achieved.
- It was noted that the Director of Quality and Chief Nurse had done great work around nursing development and she felt this should be acknowledged.

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

- Mr Graves noted the recent performance challenges and how staff had responded. The Chair agreed to circulate a letter to all staff acknowledging their extraordinary efforts and contributions. **PL**
- Ms Moon and Dr Feehily queried whether there was any more the Board could do to support staff. The Chief Executive agreed to consider this further.
- Dr Feehily wondered what needed to happen across the system to undertake a review of where pinch points are in the discharge process and wondered whether there was a mechanism in place for such a review. The Chief Operating Officer answered that she had been reviewing learning and operations and had instigated changes with results such as reduced breaches and reduced congestion in the ED. She felt it was important to address now the "back door" and has been reviewing the way the Trust use the Onward Care Team. The Chief Operating Officer also acknowledged the Trust's higher rate of admission conversion rates in comparison to others. The Board acknowledged the cultural piece around the ED being seen as a place of safety whereas in reality there are many situations where the hospital is not the optimal place for patients to be. The Medical Director noted that many patients waiting for tests as an inpatient could be seen as outpatients. It was noted that a system wide discharge task force had been established, with conference calls each day. Of note the system was in the top ten for

England in respect of low rates of Delayed Transfers of Care.

007/18 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 November 2017. She provided a contemporary update, noting that:

- The Trust was beginning to look more "green" operationally.
- Performance against the 4hr A&E Standard for December was 90.8%.
- For Q3 the expectation from NHSI was that the Trust would deliver 85.22% against the 4hr A&E Standard however the Trust delivered 91.6%.
- January performance against the 4hr A&E Standard has been difficult, month to date this was noted to be 83.5%. The Trust has its breach tolerance for 90% and has a plan to achieve this.
- The position around cancer has improved from the report following further validation of treatment and the Trust is currently at 75.8% against the two week wait cancer target standard. The Trust achieved 81% unvalidated in December.
- Performance against the 62 day wait cancer standard is at 76.7% and for December this was at 72.2% unvalidated.
- The Trust is on track to deliver the diagnostics standard again this month.

The Director of Quality and Chief Nurse advised that:

- Concerns remained around the number of mixed sex accommodation breaches however progress was being made and a standard operating procedure between site management and the intensive care unit has been approved.
- Compliance against the ED Checklist is 68% at GRH and 78% CGH. The team acknowledged the importance of improving this further and noted that a senior nurse in GRH was undertaking a Silver QI project in this area..
- With regard to infections, there were a further 6 C.Difficile cases in November, 28 cases of E.Coli and 5 cases of MRSA. An outbreak meeting has been held to address increased rates of C.Difficile. A plan is being developed and will be presented at the February Quality and Performance Committee. External support has been secured to provide impetus to this issue.

In response to the Chief Operating Officer's and the Director of Quality and Chief Nurse's comments, the following points were raised by the Board:

- Mr Graves reflected on the summary dashboard and the number of targets that were not being achieved. He queried what sort of quality of care patients received and whether the dashboard was truly reflective of this. The Director of Quality and Chief Nurse answered that currently the dashboard simply detailed the likelihood of experiencing certain issues

and that the metrics would be revised over the next year to include outcomes and experience. The Chief Executive reinforced the importance of standard setting and getting a balanced scorecard which paints an accurate, rounded picture.

- Dr Feehily felt it would be helpful for the Board to build on Quality and Performance Committee discussions on which indicators the Trust would begin reporting on to provide a sense of where pressures are high. The Director of Quality and Chief Nurse noted the balancing measures such as the Friends and Family Test and cancelled operations which will give a general sense of how the organisation is performing and how patients are experiencing care. He also felt it was important the organisation get a real-time sense of patient experience.
- Ms Barber felt it was important to consider what was measured and how performance is translated across the organisation to ensure it is owned in different areas, with clear priorities at all levels in the organisation?
- The Director of Corporate Governance advised of a discussion at the Trust Leadership Team (TLT), and the importance of cascading the Board Assurance Framework (BAF) through the organisation. Divisions had been asked to rate themselves against the BAF as part of their Operational Plan submission.
- The Chair noted that within the report there was a comment around clinics being cancelled due to "normal seasonal patterns of leave" and wondered why this could not be planned for. The Chief Executive advised that she had written to all consultants and reinforced the message that the Trust has a six-week leave notification policy and there should be no unplanned seasonal leave. Within this she shared specific patient complaints related to last minute leave.
- The Chair noted that performance against the two week cancer standard was improving for December. He questioned the Chief Offering Officer as to what was enabling this and what was still causing concern. The Chief Operating Officer responded that the cancer recovery plan which addressed the causes of previous breaches in detail, at pathway level was the reason for the Trust's success and detailed some of the specific initiatives. She noted that she still had concerns about the colorectal service due to high referral growth and ongoing vacancies; however she would be pursuing head hunting alongside the Director of People's team. She summarised that cancer and RTT standards were more complex to deliver than A&E.
- The Chair noted recent national news regarding problems with recruiting staff, and the Medical Director explained this related to Oxford Hospitals' difficulties in attracting chemotherapy nurses. He reflected on the reasons behind this and felt it was important to look at leadership in hard to recruit areas.
- The Chief Executive noted that dementia performance was poor. The Director of Quality and Chief Nurse noted that this was a recording issue as only recently had it been possible to record within TrakCare and staff are still getting used to it. A plan is in place and the Medical Director advised that this was an issue with coding and discharge and that the

Safeguarding Lead was working with consultant teams to address.

- The Chief Executive also wondered whether systematic work had been done to examine the relationship between recruitment, retention, sickness etc. The Director of People noted that this had not been done but was picked up at the last Workforce Committee where the Committee discussed the best way to triangulate data; this would be addressed.
- Ms Moon noted that the Quality and Performance Committee now had a cycle of deep dives investigating areas which required improvement. Emergency readmissions would be discussed at the January Committee meeting, followed by the C.Difficile discussion, prompted by a recent outbreak. Initial learning will be shared in the January meeting followed by a an in-depth discussion the following month.
- The Digital Recovery Consultant noted that the cover sheet of the report expressed the intention to return to RTT reporting from January 2018. He explained that this would take further time to understand and the timescale would be clarified but was likely to be towards the end of the year. The CEO confirmed this had been previously reported to the Board and NHSI were also aware and accepting of the movement.
- The Medical Director acknowledged the improvement in diagnostics. He also felt it was important to note mortality figures, and highlighted that HSMR had dropped below 100 for the first time in a long time. This reflected improvements in both recording and clinical outcomes.

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 21 DECEMBER 2017

De Feehily presented the assurance report noting the following from the Committee:

- A sense of improved performance.
- Deep understanding and a clear grip in the Committee taking responsibility for issues coming through.
- Better understanding of aspects of the patient experience delays and the communication and dialogue around this.
- Detailed investigations into surgical site infection.
- Revised governance arrangements and the presentation the Committee received detailing proposed plans.

The Chair thanked Dr Feehily and felt the report was concise and insightful, reflecting the continuous improvement of the Committee's ways of working.

RESOLVED: That the report be noted.

TRUST RISK REGISTER

The Director of Corporate Governance presented the Trust Risk Register to the Board, noting that the TLT had not met prior to publication of the papers therefore the report matched that seen last month. TLT met the day prior to the Board Meeting, therefore he provided a contemporary verbal update.

It was noted that new risks had been presented to TLT for consideration: one concerning the financial plan, another one around sterile equipment in the Central Sterile Services Department and a third around the timeliness of follow ups.

The Chief Executive added that TLT had reassessed the patient experience risk related to the Emergency Department and agreed it was not the right time to de-escalate and therefore this would remain. 13 risks await review and 30 have been reviewed. She confirmed that the 13 were new risks and not part of the original cohort.

The internal audit have undertaken a review of risk culture where leaders working at Band 7 or above were surveyed. This was a positive audit and noted better understanding and knowledge of risk. It was found that the Trust's arrangements were proper and effective.

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.

008/18 FINANCIAL PERFORMANCE

REPORT OF THE DIRECTOR OF FINANCE:

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

- The Trust's financial position at the end of Month 8 is an operational deficit of £22.6m. This is an adverse variance to budget and NHSI plan of £2.1m. If the position was compared against month 8 forecast it would show the Trust is about 300k ahead of that forecast. This will be addressed moving forward.
- There team have provisional figures for Month 9 and the Trust is £0.3m ahead of plan.
- Pay and non-pay cumulative positions were noted but no comparison of trend. If included this would show that pay spend is falling, following a rise in the summer.
- Drugs overspend was noted to be £3.1m. While some is offset by pass through drugs this still remains at £2.7m. A more detailed piece of work around this will go to Finance Committee in February as the impact of drugs on Trust expenditure is significant. This is thought to be a budget setting error rather than overspend.
- Progress is being made with Cost Improvement Plan (CIP) Delivery. Against the £6m targeted, £3.5m has been delivered to date.

- Another aspect of financial improvement is to reduce cost pressures and there has been less success with this, with the biggest element noted to be non-pay.
- A separate paper regarding the forecast will be received within confidential Board.
- The balance sheet remains in a similar position with borrowing significantly below the deficit with £ 20.6m borrowed to Month 9 against a cumulative I&E deficit of £28.2m. No payments to suppliers are being withheld.
- The theatre managed service contract has been signed and is moving to implementation.

In response to the Director of Finance, the following points were raised by the Board:

- Mr Graves requested further clarification around drugs overspend and whether the budget was incorrect. The Director of Finance advised that it was, and was the symptom of the income budget not being devolved. The Chief Executive reminded the Board that this had been previously raised as difficult to do and would require improvements in future processes.
- Ms Moon queried the progress of CIP and what had been achieved over the past few years. The Finance Director advised that the level of CIP delivered over the last few years had been low. The Trust currently had a high target of 7% compared to the national average of around 3-4%. The Trust was delivering 5.5%; compared to historical performance of 2-3%, the improvement was significant.
- Ms Barber queried the drug discrepancy, income and expenditure and whether a process was in place to ensure this discrepancy would not appear elsewhere outside the drugs process and questioned whether the Finance Director was confident in this. The Director of Finance responded that he was confident this was would be eradicated for drugs and that the next areas to be reviewed would be medical and surgical supplies which was the only other area susceptible to this type of error..

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 20 DECEMBER 2017

Dr Feehily presented the assurance report noting the following from the Committee:

- Historic CIP and the step change, with a significant part of Committee time about being assured that processes are in place.
- The importance of being sighted on how the organisation as a whole had contributed towards CIP.
- Escalation of the capital programme issue for which the Chief Executive was thanked.
- A piece around one CIP scheme, Medical Productivity and the different focus and approach that will be taken..

The Medical Director expanded on the point around Medical Productivity, noting that the previous emphasis had been on understanding each clinician's roles and job planning. However, clinicians have since offered to investigate ways to improve clinical productivity time and will take control of looking at expectations from job plans and identifying and monitoring within each area. This was noted to be an exciting opportunity with clinicians and directors driving ownership in their areas. In summary moving away from an emphasis on timetabled activities to one looking at individual consultant productivity against expected.

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

009/18 WORKFORCE

REPORT OF THE DIRECTOR OF PEOPLE

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

- The Trust has a pay under-spend of £4.7m against budget, with £6.4m against substantive staff, agency at breakeven and an overspend on bank staff of £1.7m.
- There has been slight reduction in turnover; however, areas of concern remain and therefore the Workforce Committee have identified areas for deep dives.
- The Trust's annual sickness absence rate is 3.9%; a peer review has been requested.
- Appraisal compliance rose slightly in November but remains below the target.
- The staff survey has closed and formal publication will take place in February. The response rate was 47% as opposed to 51% in the prior year with 168 fewer staff responding. However, the Trust remains above the national average for acute Trusts.

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

- Ms Barber noted the importance of building upon staff survey results and felt the response rates were heartening, with an increase in non-medical areas such as procurement, engineering and finance; areas which can easily be overlooked.
- Dr Feehily queried Vacancy Control Panel (VCP) arrangements following a recent safety visit and expressed concern that the process was not fast enough for the divisions. Dr Feehily queried whether there was a risk that budgetary controls were getting in the way of urgent staff appointments. The Director of People responded that where urgent appointments arise the divisions contact the Director of Quality and Chief Nurse and the Medical Director to review request outside of the VCP process. The Chief Executive noted that the pre-VCP processes within divisions can cause delay and therefore it was important to be rigorous and to scrutinise. She felt it was important to consider how further agility could be applied to the divisional processes. The

Board discussed the previous review undertaken by the Workforce Committee and its findings. The Director of People clarified the process and explained that divisions often rejected 70% of requests to fill, and that the VCP was driving a cultural change.

- The Chair noted that work was planned to investigate health care assistant (HCA) turnover. The Director of People advised that hotspots would be known by February with work resulting from this. The Board discussed the culture around HCAs, the importance of strong leadership and welcoming HCAs into ward teams, as well as ensuring options for progression.
- The Chair queried long term sickness rates, and the Director of People advised that she was interested in the Trust practice and policy and would be looking at a sample alongside a peer review from another Trust which has significantly reduced long term sickness.
-

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

ASSURANCE REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE MEETING HELD ON 8 DECEMBER 2017

Ms Barber presented the assurance report, noting that the Committee discussed a revised focus on six month priorities, including review of establishment, needs versus budget, continued CIP, reduced bureaucracy, talent and development plans, staff engagement and health and wellbeing.

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

010/18 BOARD ASSURANCE FRAMEWORK

The Director of Corporate Governance presented the report to the Board, noting the evolution of the BAF, including recent revisions led by new executives. He noted that further work needed to be done to improve consistency, but that the format would remain broadly similar for the time being. He reinforced the importance of mapping assurances across the board to ensure coverage, and noted that each Board committee would take ownership for oversight of relevant objectives.

The Board noted the report and raised the following points in response:

- Ms Barber and Mr Graves praised the paper and noted the importance of integrating the BAF across the Committees.
- The Board discussed avoiding duplication whilst acknowledging that sometimes certain objectives may need to be reviewed by more than one Committee.
- The Chief Executive noted that TLT had not reviewed the BAF before, and that it was important that the divisions were delivering its components. The BAF will therefore be reviewed by TLT moving forward and Divisions had been asked to set out their contributions to delivering the corporate

objectives and assess their own progress against them.

- The Director of Corporate Governance also noted he would be taking a paper around governance framework to the next Audit and Assurance Committee.
- The Medical Director shared that he extracted and reworded the Trust's goals and objectives into a performance review that Specialty Directors have with clinicians which has produced interesting feedback and comments. He will be further pursuing this through iLead and will feedback.
- The Medical Director that he had undertaken appraisal reviews and when probing on the Trusts goals and vision responses were enlightening. Mr Barber reinforced that to deliver targets and maintain resilience, understanding what the organisation wanted from the Board was important.
- Mr Graves raised the importance of cross referencing the BAF against divisional levels. The Board discussed this, and agreed that a conversation about the relationship between the Board and divisions be held during a Board Strategy and Development Session. **PL**
- Ms Moon contemplated her involvement in consultant interviews and how the questions provided were very traditional and did not prompt discussions around improvement of services. Board agreed that the questions actually asked should be captured and used instead. The Chief Executive said that she had asked the Medical Director to consider whether our current approach to consultant recruitment reflected best practise. He said that the Deputy Medical Director was reviewing this. **SE**

RESOLVED: That the Board 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.

011/18 SIX-MONTHLY RESEARCH REPORT

[Dr Julie Hapeshi, Associate Director of Research and Development joined the meeting]

The Director of Clinical Strategy presented the six-monthly research report and noted that Annexe A was missing from the report. She would share this with the Board Administrator to update. She noted that performance had improved across all metrics and this is attributed to the research time and engagement of clinical team. **SP**

Following an inspection by the Medicines and Health Products Regulatory Agency (MHRA) in October no critical findings were found but three major quality assurance findings were highlighted alongside four "other" findings. These will all be incorporated and addressed by the Corrective and Prevention Action plan. She reassured the Board that this sort of outcome was not unusual and should not raise alarm.

The Trust has signed a statement of intent alongside University of Gloucestershire on a common approach to research. December saw the first meeting of the Research 4 Gloucestershire Steering group.

The Board noted the report and raised the following points in response:

- Ms Moon shared that she was unable to tease out the research governance aspects and wondered whether they should be reviewed by Quality and Performance Committee. The Director of Clinical Strategy answered that there were very rigorous governance arrangements which had been tested in the context of clinical trials and the MHRA. Research reports to the Research and Innovation Forum which reports to TLT and is part of the broader quality and improvement agenda. The Chief Executive advised that the MHRA inspection thoroughly tested research governance and no further review was warranted.
- The Chief Executive queried what leadership looked like within the team and felt there was an opportunity for growth in non-medical and non-clinical research. The Associate Director of Research and Development agreed to further discuss this with the Director of Quality and Chief Nurse. The Director of Clinical Strategy added that a section around academic activity could be added to the report for clarity. **SH**
- Ms Moon shared that she had implemented the Culyer Report recommendations in a previous role and really valued the contribution that Research and development plays in Trust core business and the Director of Clinical Strategy noted it may be helpful for her to join the Research and Innovation Forum Meeting. **AM**
- Ms Moon also felt it was important to consider how research could link into the organisational objectives. The Board agreed it may be worth adding another strategic objective and asked the Director of Strategy and Transformation to put a proposal to the next Board Seminar. **SL**

RESOLVED: That the Board accept the report as assurance of the performance and governance of research within the Trust.

012/18 GOVERNOR QUESTIONS

The Lead Governor raised the following points:

- He thanked the Director of Clinical Strategy for all of her work over the years.
- He noted that one of the Trust's staff governors was part of the SubCo staff engagement and had given assurances to other governors regarding the extent of this.
- He praised the Trust's approach to winter planning and felt this had helped reduce performance issues.
- He praised the communication regarding trust performance via Twitter and Facebook, noting that even Trust partners engaged with this. The Board concurred, formally thanking the Head of Communications for his work around this.
- He referenced Mr Graves's point regarding the Quality dashboard, and felt it was important the Board consider how it is perceived.
- He praised the BAF and was pleased to see inclusion of governors within it, acknowledging their contributions and assurances.

013/18 STAFF QUESTIONS
There were none.

014/18 PUBLIC QUESTIONS
There were none.

015/18 ANY OTHER BUSINESS:
No other business was noted.

016/18 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9 am** on **Thursday 8 March 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital**

017/18 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 12.20 pm.

Chair
8th March 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
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 11.01.18 - Data quality issues since introduction of TrakCare. Remains priority for resolution by InterSystems and workaround now being reviewed as aggregate reporting is still happening. This will be included within the March Quality and Performance Board report.
May 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 11.01.18 - Format of risk registers/reports will be reviewed as part of work on the Board Assurance Framework in Quarter 4 2017/18.
March 2018	January 2018 002/18 Patient Story	**SE/EW**	Discontinuation of Learning Disability Training.	The Director of Quality and Chief Nurse and Director of People agreed to investigate training (specifically inclusion in staff induction) and e-learning, including the option of “in-situ” training.	Ongoing We are assured there is an e-learning package that is essential for some roles. Awaiting view on HCAs training.

March 2018	January 2018 002/18 Patient Story	**CL**	Relocation of Special Dental Services	Chief Operating Officer investigate why special dental services had moved from the Orchard Centre to Day Surgery Unit and whether this was unavoidable given the less positive environment for patients with a learning disability.	Ongoing Decision historical to current operational teams. The operational team does take steps to identify patients which may require relocation from the current DSU to main theatres. The operational team is reviewing possible alternatives within the current estate provision.
March 2018	January 2018 010/18 Board Assurance Framework	**PL**	Mr Graves raised the importance of cross referencing the BAF against divisional levels	The Board discussed this, and agreed that a conversation about the relationship between the Board and divisions be held during a Board Strategy and Development Session.	Ongoing Discussion held with CEO to progress - date tbc.
March 2018	January 2018 011/18 Six Monthly Research Report	**SP now SL**	Ms Moon felt it was important to consider how research could link into the organisational objectives.	The Board agreed it may be worth adding another strategic objective and asked the Director of Strategy and Transformation to put a proposal to the next Board Seminar.	Ongoing: Draft research Trust objective below for consideration by Board. "The Trust will have a high quality research portfolio embedded alongside routine care which is visible to staff and patients" We can discuss whether to add a metric e.g. xx% of patients will be enrolled in clinical trials.
March 2018	January 2018 002/18 Patient Story	**SH/SC**	Learning Disability Team Office Space	The Deputy Director of Quality committed to investigating improvements to office space.	Completed Hot desk office space has been provided within the patient experience team based at the GRH site.

March 2018	January 2018 002/18 Patient Story	**SE**	Doctor Engagement.	The Medical Director to meet with the Learning Disability Team to discuss doctor engagement and F1 training. He would also investigate the possibility of doctors joining the team on the "Find You Way Around The Hospital" sessions run by the LD team.	Completed Short interactive training programme for foundation doctors being developed. Dr Elyan to join in on "Finding a Way Around the Hospital" event.
March 2018	January 2018 003/18 Minutes of the meeting held on 13 December 2017	**NJ**	Minute Amends	An amendment would be made to page 12 of the minutes.	Completed Amendments made.
March 2018	January 2018 006/18 Chief Executive Report	**PL**	Mr Graves noted the recent performance challenges and how staff had responded.	The Chair agreed to circulate a letter to all staff acknowledging their extraordinary efforts and contributions.	Completed Via Chief Executive weekly blog link.
March 2018	January 2018 010/18 Board Assurance Framework	**SE**	Consultant Interview Questions	The Board agreed that the questions actually asked should be captured and used instead. The Chief Executive said that she had asked the Medical Director to consider whether our current approach to consultant recruitment reflected best practise. He said that the Deputy Medical Director was reviewing this.	Completed The questions the panel used were reviewed and resubmitted for future interviews.
March 2018	January 2018 011/18 Six Monthly Research Report	**SP now SL**	The Director of Clinical Strategy presented the six-monthly research report and noted that Annexe A was missing from the report.	She would share this with the Board Administrator to update.	Completed Uploaded.

March 2018	January 2018 011/18 Six Monthly Research Report	**SH**	The Chief Executive queried what leadership looked like within the team and felt there was an opportunity for growth in non-medical and non-clinical research.	The Associate Director of Research and Development agreed to further discuss this with the Director of Quality and Chief Nurse.	Completed Meeting arranged for 7th March 2018 to discuss.
March 2018	January 2018 011/18 Six Monthly Research Report	**SP now SL**	Research and Innovation Forum Meeting	Ms Moon to join the meeting.	Completed Invited to the next meeting.

ITEM 6

CHAIR'S UPDATE

VERBAL

Peter Lachecki
Trust Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Winter continues as the current cold snap reminds us and despite the number of new cases of influenza finally starting to decline, operational pressures remain significant across the Trust; Gloucestershire Royal Hospital, in particular, is experiencing exceptionally high levels of bed occupancy. However, despite such high bed occupancy the Trust and its staff have much to be proud of with some of the strongest performance in recent years both regionally and nationally. In January the Trust was the 15th best performing Trust (out of 137) for the 4-hour A&E waiting standard and achieved over 99% on the 7th February 2018 – an all-time high and performance recognised by both NHS Improvement and NHS England. Of particular note is the improvement against last year's performance, set out below.

November 2017	December 2017	January 2018
95.3%	90.7%	89.7%
November 2016	**December 2016**	**January 2017**
86.62%	73.86%	74.69%
% Point Improvement		
+ 8.68%	+16.84%	+15.01

Figure 1: Performance against the four-hour standard - *95% of patients attending an A&E department must be seen, treated, and admitted or discharged in under four hours.*

1.2 Another key measure of Winter performance is the number of patients whose handover to hospital, from ambulance conveyance, is delayed and again this year we have seen some of the strongest performance nationally; not only is this good for the patients in transit but it also ensures that ambulance crews are back on the road as soon as possible and ready to respond to the next call for help. Of note, no patient has waited more than hour for handover in to either of our Emergency Departments contrasted to in excess of 35,000 nationally in January and 13 in our own Trust last Winter. In February, NHS providers shone a spotlight on the adverse impact of these delays on response times for patients experiencing potential stroke or heart attack.

October 2017	November 2017	December 2018
38 (1%)	33 (0.9%)	56 (1.3%)
October 2016	**November 2016**	**December 2017**
187 (5.4%)	99 (2.9%)	282 (5.7%)
Reductions in Handover Delays		
-149	-66	- 226

Figure 2: Ambulance Handover Delays greater than 30 minutes

1.3 In June 2017 all Trusts were categorised in respect of their A&E performance from (highest performer) to 4 (those with most challenged performance) in order to target specific support and interventions to improve performance. Given the position at the time GHNHSFT was categorised as the most challenged - Category 4. Following a national review at the end of January 2018, and as a result of the sustained improvement in performance, GHNHSFT is the only Trust to have moved out of Category 4 and has not only been re-categorised but has been placed directly in Category 2. This year's winter plans have been the most comprehensive to date and this achievement could only have been made through the hard work and commitment of our staff and the continued support and contribution of our partners.

1.4 However, volatility in performance remains, as the recent half term week showed us; evidence that all of our changes are not yet fully embedded but we shouldn't be surprised or disappointed by this – embedding change during winter is always a huge challenge and credit to the whole hospital that, whilst driving forward both operational and cultural change, we massively outperformed on last year

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 were lifted at the start of February though the Trust has continued to maintain significant activity throughout the period, whilst maintaining strong A&E performance. As part of the 'support offer' to Category 4 Trusts, the Chief Executives of these Trusts have all been provided with a 'buddy' who is a senior member of NHSI, NHSE or Government. James Kent, Specialist Adviser to the Prime Minister has been twinned with myself and spent a day in the Trust on the 29th January 2018 learning more about our A&E journey and meeting staff in a number of service areas. The visit was positive and the relationship continues to build through regular calls, with a further meeting planned for March 2018.

2.2 In January 2018, the Trust was commended by the Medical Director of NHS England for its improved performance in the area of sepsis care. GHNHSFT has been highlighted by NHS England as one of the most improved Trusts in England for identifying and treating sepsis. Sepsis is a life-threatening condition; however it can be treated successfully if caught early. Sepsis could occur as the result of any infection and is a serious condition that can initially look like flu, gastroenteritis or a chest infection. According to the UK Sepsis Trust, it affects more than 250,000 people every year in the UK. The contribution of this and other work to the Trust's mortality data is now showing in our monthly data as evidenced below.

2.3 Since the NHS England sepsis CQUIN* was launched in 2015, Gloucestershire Hospitals has increased assessment (screening) for sepsis in the Emergency Departments (A&Es) from 52% to 96% and timely treatment from 49% to 91% in the same period through an ongoing improvement programme. The Trust is now not only one of the most improved organisations but is in the top 10% of Trusts nationally. The Trust did this by successfully developing an approach to better identify and treat sepsis. The aim of doing this was to both identify patients presenting with the condition and to treat it promptly.

2.4 The Gloucestershire Safety and Quality Improvement Academy team has worked alongside our clinical staff and our pharmacy team to train staff and develop an ongoing programme of continuous improvement that's embedded in future ways of working. GHNHSFT has been asked to share the approach with NHS England to help other organisations to learn from our experience and has been asked to peer review work being led by the Royal Liverpool and Broadgreen NHS Trust who as part of the Global Digital Exemplar programme are developing an e-Sepsis tool.

2.5 Initiative such as this, alongside other huge improvements in quality of care such as a 37% reduction in deaths from hip fracture have resulted in huge improvements in the Trust's mortality data, having previously being an outlier nationally. The graph below shows another positive improvement.

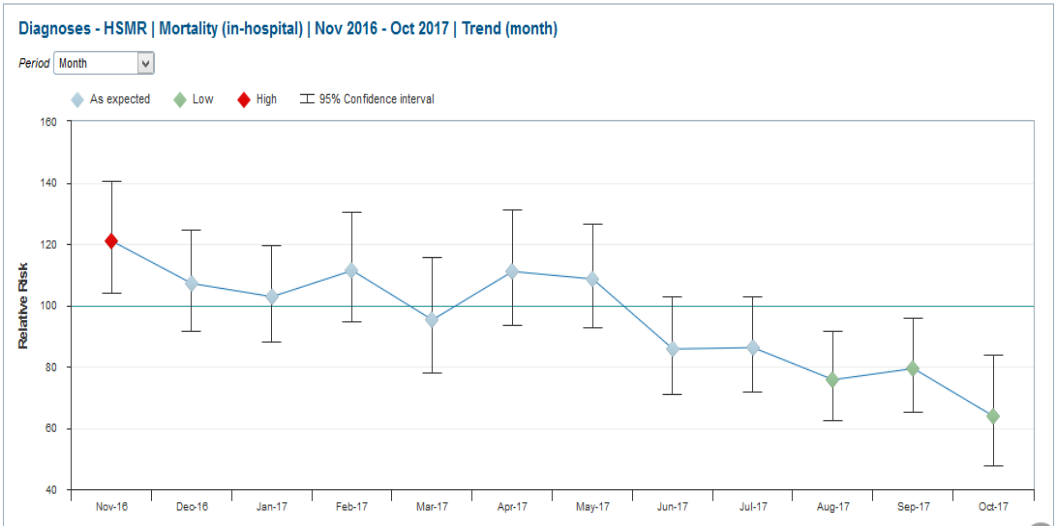


Figure 3: In Hospital Standardised Mortality Ratio (month on month)

3. Our System and Community

3.1 Work continues to develop the One System Business Case though progress is not as had been hoped due to the complexity of the modelling required. There remains the risk that the revised consultation timeline may not be met and therefore internal work has commenced to consider the Trust priorities that need to be addressed in advance of next winter. The Trust is also discussing with The Health and Care Overview and Scrutiny Committee the approach it takes to the continuation of the pilot of trauma and orthopaedic services in light of public consultation not having commenced as originally expected.

3.2 Following an unsuccessful first wave bid, the Sustainability and Transformation Partnership (STP) has been invited to resubmit its proposal to becoming an Integrated Care System (formerly Accountable Care System). If successful the system would join wave two systems (known as fast followers) and in doing so gain access to support, development opportunities and potentially additional resources to expedite our work on developing integrated commissioning and service provision. A local bid has been developed and submitted, pending further work by the STP to understand any risks and the benefits associated with progressing in this direction.

3.3 In January Gloucestershire County Council celebrated its third consecutive month in the top ten performing councils in England (out of 152) for the lowest number of Delayed Transfers of Care (DToC). This is a huge achievement and credit to the way in which partners across the system are working together for the benefit of patients. We know that these benefits extend way beyond the patient who is delayed to those patients who need admission to hospital but whose journey is delayed whilst they await a bed to become free.

4. Our Trust

4.1 The Trust's bid for Sustainability and Transformation (STP) capital (£40m) continues to progress with the Trust submitting the refreshed case to the national timeline of 31st January 2018. We are told that announcements are expected on the 12th March 2018 after which successful Trusts will be invited to develop an Outline Business Case. Of note, the Trust's bid is not contingent upon major service change and as such is not directly linked to the One System Business Case and need for public consultation which will allow progress to be made independent of wider system changes.

4.2 On a smaller scale, the Trust Board approved the investment of £920k of nationally awarded capital to develop our Cheltenham General Estate and specifically the Emergency Department. The scheme however, will also being benefits to a number of

other services affected by the expansion of ED including the provision of much need clinic space for the urology service to enable them to further roll out their 'one stop shop' service model.

4.3 On the 1st February, Professor Tim Briggs CBE and Lord Carter joined staff from the Trust and four visiting Trusts from across England to hear about the recent reconfiguration of trauma and orthopaedic services. Whilst only 10 weeks into the pilot, early signs are very promising with evidence of both patient and staff experience having improved significantly as a result of the changes.

- 20% more elective orthopaedic operations undertaken in January 2018 compared to January 2017.
- A 50% reduction in the number of patients cancelled in the week prior and on the day (90% of cancellations that occurred attributable to unfit patients and only one to lack of beds).
- Trauma cancellations per week down from an average of 8 patients to 3 and (6 of the 9 weeks in the period had ZERO cancellations).
- There has been a 15% reduction in fracture clinic appointments since trauma triage has been introduced.
- The average wait for upper limb trauma surgery (from injury) reduced from an average of 16.2 days to 8.1.
- The number of A&E breaches, attributable to T&O, down from an average of 8 per week to 1 per week.

4.4 The last few months have been characterised by a number of successes and what is most pleasing is the breadth of the improvements. This month we are celebrating two more areas of significant improvement; the first is stroke care where we are making steady progress against the national quality measures for stroke – a few highlights are below (A is good and E is poor) and this week, we were informed that the previously elusive accreditation of our endoscopy services has finally been achieved – the first time in 13 years! Not only is this great for patients and staff but it also brings with it significantly more income for the Trust under the *Best Practice Tariff* regime. Evidence that improving quality, improves finances.

- The '90% stay on the stroke unit' has jumped from 81.8% (C) to 90.7% (A)
- %swallow screen within 4h has gone from 57.9% (E) to 78.8% (B)
- Time to stroke nurse review from 4h 14mins (E) to 2h 45mins (C)
- Time to stroke consultant review from 13hr 46min (D) to 9hr 22min (C)
- Patients with continence plans within 3 weeks from 85% (B) to 97.8% (A)

4.5 Sticking with positive news, the Trust is working with its regulator NHS Improvement to prepare a proposal for consideration by the national panel that would see the trust discharged from the regulatory enforcement action which is currently in place in respect of both A&E performance (since August 2016) and financial governance (October 2016). If successful the Trust would be released from Enforcement Undertakings in both areas at the start of the new financial year in April 2018. To support the case, a number of 'evidence gathering' activities are underway including reviewing Board and committee reports, observing governance meetings and spending time with staff in urgent and emergency care services.

4.6 In addition to the above, the Trust is also working with NHS Improvement on a case to support the Trust to exit the Financial Special Measures (FSM) regime. The FSM team accept that the financial governance failings which contributed to the Trust being placed in FSM have been addressed and whilst the Trust has not delivered the financial recovery plan for 2017/18, the reasons for this (income under performance) are understood and importantly the Trust has delivered its 5.5% Cost Improvement Plan. A credible plan for 2018/19 will be crucial to supporting these efforts. Finally, the Trust continues to present its case for a revised financial control total in order to ensure

that it can access both Sustainability and Transformation Funding (STF) and capital allocated to Gloucestershire. Currently, the Trust has been issued with a Control Total of £24,240m surplus (including £16,121m STF), therefore a net position of £8.119m which given the forecast out turn for 2017/18 is £27.4m deficit, this reflects a further year when the Trust will be unable to access much needed revenue (and cash). The Board will give very careful consideration to the options open to it to ensure that the Trust is not further disadvantaged by the prevailing regime.

4.7 On the 26th February, the University of Bristol visited the Trust to undertake their annual review of the Trust's approach to undergraduate medical student teaching. The University was incredibly positive about the quality of the students experience during their placements with us and in respect of the quality of the teaching itself, the exposure they get to real 'work experience' and also (increasingly so) the quality of the support services we now provide, such as good accommodation. Organisations that embrace teaching and learning are more successful than those that don't and I am especially grateful that our staff continue to embrace their teaching responsibilities with such enthusiasm and passion.

4.8 On the 28th February, after many months of work to establish the feasibility and desirability of establishing a subsidiary company, the Board approved the proposal to proceed. The company (SubCo) will employ approximately 675 support staff from estates and facilities, sterile services and materials management functions. The Board was clear that it could only approve the proposal if the evidence pointed to long term benefits for staff and patients, which it resolved was the case. The Board concluded that the new organisation will deliver a wide range of benefits and will address many of the challenges it is facing, through the focus that will come from establishing a subsidiary company whose primary purpose is to deliver truly excellent support services to NHS patients and staff. The proposal also demonstrated how the model will deliver better value for money to the Trust thereby supporting its aim to deliver higher quality services at lower cost. SubCo will become effective from the 1st April 2018 and heralds the start of an exciting journey for the Trust and its staff towards delivering even better support services for the NHS staff and patients they serve.

4.9 Finally, in this the 70th anniversary year of the NHS, I am delighted that a number of our front line nursing staff have been invited to this year's celebrations at Buckingham Palace. The event takes place annually to recognise the extraordinary efforts of front line staff working in public services. Congratulations this year go to Tiffancy Cairns, Senior Nurse Practitioner in the Emergency Department, Helen Russell, Surgical Ward Sister and Shiranthie Vithanage, Gallery Wing Ward Sister. Invites are still coming so there may be more to celebrate in weeks to come.

Deborah Lee
Chief Executive Officer

March 2018

National Medical Directorate
Skipton House
80 London Road
LONDON
SE1 6LH

15th January 2018

Ms Deborah Lee
Chief Executive
Gloucestershire Hospitals NHS Foundation Trust

Dear Ms Lee,

Reducing the impact of serious infection: Sepsis/AMR CQUIN – great improvements made by your trust

As you are aware the sepsis CQUIN was launched in 2015 in order to incentivise improvements in the timely identification and treatment of sepsis. The CQUIN is already delivering change.

NHS England data shows on average: an increase in Emergency Department assessment for sepsis from 52% to 89% since this part of the CQUIN started in April 2015 and timely treatment increased from 49% to 76% in the same period.
In-patient assessment for sepsis increased from 62% to 70% since this part of the CQUIN started in April 2016 and timely treatment has increased from 58% to 80% for these patients.

I am delighted to inform you that you are one of the trusts which has seen the greatest improvements in indicators 2a) timely identification and 2b) timely treatment of sepsis from the data we have received on the CQUIN.

I would like to congratulate you and your colleagues for all the hard work and dedication you have shown, which has enabled these improvements in sepsis recognition and treatment to take place. Please pass my thanks on to the staff concerned for their achievements in improving the care for patients with sepsis. We would be very interested in hearing more about the improvements you have made and the steps you have taken to make these changes in your sepsis care.

Continue……/…2

If you would like to share your learning with us in order to help other organisations please contact Helen Wilkinson helen.wilkinson22@nhs.net to take this forward.

With best wishes.

Celia Ingham Clark

Medical Director for Clinical Effectiveness
NHS England

Cc: Dr Nigel Acheson – Regional Medical Director
South Region

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period January 2018

to be presented at February 2018 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During December, the Trust did not meet the national standards or Trust trajectories for 2 week wait and 62 day cancer standard and suspended 18 week referral to treatment (RTT) standard continues. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care over 104 days to ensure that patients do not come to harm due to delays in their treatment, these are being reviewed to ensure we have fully reviewed these cases since 01 April 2017.
The Trust has met the 4 hour standard in January with the month to date position at 89.7% and delivered the Diagnostic target in December at 0.64% un-validated.
The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan is reviewed fortnightly 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 February position is too early to report for the time of committee. But the positive signs continue from December. The January figures as yet un-validated that shows 2ww at 87.2%. Importantly the number of breaches have consistently decreased month on month from 451 in October, 436 in November, 309 in December and 227 in January. A significant contribution to this performance improvement is from the skin tumour site which has again delivered across both the 2ww and 62 day pathways.
For 62 day, again monthly improvements in breach numbers can be seen, from 44 in October, 38 in November, 35.5 in December and as at the time of writing 48.5 in January. December performance is currently 74.9% (un-validated) and January is at 68% un-validated. This performance relates to the continued issues in colorectal and issues within the lung pathway. So, we had seen positive developments in this pathway across tumour sites, but have January declined our performance.
The focus continues 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). We have committed to work to a day 8 escalation point for booking of patients and also there is significant development working with primary care on the re-launch of our 2ww electronic referral forms. For elective care, 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 (including Emergency Care Dashboard)
• 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 88.1% as of the 16th February.
Medically fit at 64 remains relatively stable during the winter period, work with system partners continues to progress this area for patient care.
Achievement of the national standard for % of patients seen within 6 weeks for Diagnostic tests, whilst not delivering against target at 0.86% for January (un-validated), is demonstrating a sustained recovery.
The engagement of Glanso has continued to support a number of RTT specialities (>52) and to release capacity in key cancer tumour sites, and diagnostics areas and is being utilised in the right operational "hot-spots". We are reviewing our requirements for 2018/19 in this area.
Overall clinic slot utilisation is positive, remaining at 87% 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
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.

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. We have a number of patients that are awaiting first out patient appointments around 45 weeks. We are mitigating booking out of chronological order, through a review of the clinics post 45 weeks available to book into by specialties; vetting; CBO processes and support. However this will continue as we make progress to validation and implementation of the correct utilisation of the system to prevent future errors.

• 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 >33 weeks for all specialities within the RTT PTL, which is one of 3 PTLs that are combined to support operational management. 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, breach numbers had decreased which was positive, the January position however is disapointing and we are working to tackle our 104 day patients. The risk to delivery is around capacity and any increases in referral numbers.

Opportunities

• Development of Standard Operating Procedure (SOP) for the Central Booking Office. This provides 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 further SOPs in alignment with the Trak Care Deep Dive Recovery Plan. This will be managed through the Planned Care Delivery group. We are also supporting the 2ww booking team to deliver by day 8 of the patient pathway a booked appointment in one pilot speciality in the spring.

• The Trust had a critical friend visit (09/17) that reviewed the current Cancer Recovery Plan, including some observations on the MDT role and the opportunities for patients at Day 49 plus. This remains an area that the Trust continue to explore around the Decision to Treat from initial appointment time period, this is being reviewed in terms of the speciality level plans to deliver.

• 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). Re-launch of the new 2ww forms, supporting us in utilising a cancer service for patients who are aware and ready to be referred on the relevant pathway.

• 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. The issue of patient choice has been raised with the LMC and working in partnership with the CCG new 2 week wait referral forms will be published at the end of February. Referrals that are appropriate for a suspected cancer service where our capacity meets demand is crucial to delivery
Looking forward into 2018, colorectal & urology remains key to delivery of aggregate 62d wait.
Dermatology has delivered performance, at 62 days at 100% for the last 3 months and this continues to be one of the best performing tumour sites in the country.
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.
The validation volumes for the PTL and incorrect processes remain a risk, as does any change to the existing PTLs or change in practice. Operational colleagues are represented at the Governance structure relating to the Trak Deep Dive Recovery programme.

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%	90.76%	89.73%		
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%	0.51%	0.75%	0.64%*		
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%	74.60%	75.80%	81.20%	86.40%*		
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.40%	93.00%	93.10%	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%
	Actual	90.40%	94.00%	94.10%	57.30%	89.70%	92.70%	89.00%	94.50%	96.30%	92.40%*		
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%	95.10%	96.70%	97.30%	97.00%*		
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	Trajectory	98.40%	100.00%	98.30%	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	98.50%	100.00%	100.00%	100.00%	97.10%*		
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%	97.10%	98.50%	98.10%	98.60%*		
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%	94.60%	98.10%	94.90%	97.90%*		
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%	87.10%	93.80%	95.50%	98.00%*		
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	80.00%	100.00%	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	100.00%	100.00%	57.10%	77.80%	85.70%	50.00%	60.00%	100.00%	0.00%*		
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%	71.40%	76.70%	73.40%	67.40%*		

Summary Scorecard

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

RAG Rating : Overall RAG rating for a domain is an average performance of lead indicators, where data is not available the lead indicator is treated as Red

QUALITY

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

OPERATIONAL PERFORMANCE

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

FINANCE

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

LEADERSHIP AND DEVELOPMENT

- Sickness Rate
- Workforce Turnover Rate

Trust Scorecard

* = unvalidated data

Category		Indicator	Target	Month												Quarter				Annual	
				Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	16/17	17/18
Quality	Key Indicators - Quality																				
	Friends and Family Test Score	Friends and Family Test Score - ED % Positive		80.3%	85.5%	86.9%	84.4%	75.6%	77.5%	84.9%	81.1%	81.0%	87.4%	85.9%		83.9%	81.7%	81.2%	84.7%	86.5%	81.3% *
		Friends and Family Test Score - Inpatients % Positive		100.0%	91.6%	89.3%	92.2%	91.2%	90.8%	90.9%	90.1%	91.2%	90.6%	91.6%		93.5%	90.8%	90.6%	91.0%	94.0%	90.8% *
		Friends and Family Test Score - Maternity % Positive		100.0%	98.9%	94.5%	96.8%	97.0%	100.0%	90.0%	94.7%	100.0%	100.0%	90.3%		99.1%	96.2%	96.3%	97.1%	98.6%	96.6% *
		Friends and Family Test Score - Outpatients % Positive								91.2%	91.5%	91.3%	92.2%	92.4%					92.0%		
	Infections	MRSA Bloodstream Cases - Cumulative Totals	0	2	3	0	0	0 *	1	1 *	1 *	1 *	0	0	0 *	3				3	0 *
	Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	0	3	4	11	10	16	14	18	19	13	11	5	6	25	48	43	39	121 *

Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	113.5	110.7	111	109	109.2	105.5	103.9	99.7	97.1				110.7	109.2	99.7		110.7	97.1 *
	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	116.8	115.1	116.5	114.6	115	111.8	110	108.9	103.9				115.1	115	108.9		115.1	103.9 *
	Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level		111.5			112.3								111.5	112.3			111.5	112.3 *
Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	6.1% *	5.1% *	7.2% *	7.1% *	6.7% *	6.9% *	6.8% *	6.5% *	6.4% *	6.7% *	7.4% *		5.8% *	7.0% *	6.7% *	6.8% *	6.4% *	6.8% *
Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%								91.4% *	90.6% *	86.4% *	86.9% *	78.6% *				88.2% *		
Detailed Indicators - Quality																				
Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2>87%Q3>88%Q4>90%								0.4% *	0.7% *	0.9% *	1.1%	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%	100.0% *			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%	50.0% *			0.0% *			0.0% *

ED checklist	ED Safety checklist compliance CGH		82%	77%	72%	68%	81%	74%	72%	79%		78%	92%							
	ED Safety checklist compliance GRH	>=80%	29%	42%	56%	60%	56%	57%	53%			68%	67%							
Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		41.6 *	44.9 *	46.1 *	44.3 *	49 *	50.9 *	56 *	59.7 *	46.9 *	47.6 *	43.1 *		44.9 *	47.2 *	53 *	46.7 *		
	Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		100.0% *	97.1% *	98.0% *	98.4% *	98.3% *	96.8% *	96.9% *	98.5% *	98.2% *		98.4% *		94.7% *	98.3% *	97.4% *	98.9% *		
	Fracture Neck of Femur Patients Treated Within 36 Hours		80.0% *	75.4% *	76.5% *	78.1% *	71.2% *	59.7% *	67.7% *	66.7% *	80.4% *	67.2% *	81.4% *		77.8% *	75.3% *	64.7% *	76.3% *		
Infections	C.Diff Cases - Cumulative Totals	17/18 = 37	34	42	1	5	8 *	10	18 *	24 *	29 *	35	41	45 *	42				42	5 *
	Ecoli - Cumulative Totals						20	37	103 *	119 *	146 *	175	200	222 *						
	MSSA Cases - Cumulative Totals	No target	105	114	6 *		7	15	44 *	54 *	63 *	68	78	89 *	114 *				114	6 *
Maternity	Percentage of Spontaneous Vaginal		61.1%	61.9% *	61.2% *	64.4% *	65.3% *	62.4% *	63.9% *	64.9% *	60.2% *	57.5% *	60.9% *	57.0% *	61.7% *	63.6% *	64.5% *	59.8% *	63.6% *	62.1% *

	Deliveries																		
	Percentage of Women Seen by Midwife by 12 Weeks	>90	86.9% *	88.8% *	89.3% *	84.9% *	89.2% *	83.2% *	88.1% *	85.9% *	87.8% *	89.5%	86.6% *	88.7% *	81.5% *	85.9% *	88.0% *	90.0% *	87.3% *	89.3% *
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean																		
Never Events	Total Never Events	0	0	0	0	2	1 *	0 *	0	1 *	0 *		1 *		0				2	2 *
Patient Falls	Total Number of Patient Falls Resulting in Harm (moderate/severe)		7 *	6 *	3 *	4 *	9 *	5 *	8 *	11 *	7 *	4 *	13 *		8 *	5 *	8 *	8 *		
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		0	3 *	3 *	0 *	4 *	2 *	2 *	3 *	1 *	1 *	1 *		3 *	2 *	2 *	1 *		
	Number of Patient Safety Incidents Reported		1,162	1,144 *	900 *	1,268	1,148	1,149 *	1,003 *	1,033 *	1,079 *	1,041 *	1,025 *		1,197 *	1,019 *	1,062 *			
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	0.97%	0.87%	0.50%	1.23%	0.49% *	1.12% *	1.02% *	0.61% *	1.13% *	0.79% *	0.54% *							
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%		0.37%	0.13%	0.12%	0.12% *	0.50% *	0.38% *	0.37% *	0.00% *	0.13% *	0.14% *							

	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% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	64	78	123	176	307 *	162 *	185 *	127 *	60 *	74 *	29 *	10 *	88				3,045	1,525 *
RIDDOR	Number of RIDDOR	Current mean	5	2	2	2	3 *	2 *	3 *	0 *	3 *	1 *	7 *		3	2 *	2 *	4 *	2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		7	7	7	7	9	7	7	7	7	7			7	8 *	7 *		8	7 *
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	90.6%	91.3%	94.0%	92.4%	92.7%	91.3% *	92.6% *	94.2% *	92.9% *	93.0% *	93.1% *		91.3% *	93.0% *	92.7% *	93.0% *		
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	97.1%	97.0%	97.7%	95.8%	96.6%	95.0% *	96.0% *	97.4% *	97.4% *	97.0% *	96.9% *		97.0% *	96.7% *	96.2% *	97.1% *		
Sepsis Screening	2a Sepsis – Screening	>90%	98.0%	96.0%	88.0% *	88.0% *	98.0% *	94.0% *	96.0% *	98.0% *					96.0%	91.0% *				
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	70.0%	64.0%	78.0% *	69.0% *	67.0% *	94.0% *	89.0% *	90.0% *					0.0% *	71.0% *				

	Number of Serious Incidents Reported		2			5	1 *	2 *	1	2 *	1 *	1 *	1 *							
Serious Incidents	Percentage of Serious Incident Investigations Completed Within Contract Timescale		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% *			
	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	1.4	2.1	1	1.2	2.2	2.7 *	1.9 *	.9 *	1.7 *	3.1 *	1.9 *		1.9	2 *	1.9 *	2.2 *		
Staff Safety Incidents	Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	1.9	2.6	2.3	3.1	4.2	2.4 *	3.1 *	2.9 *	2.1 *	2.4 *	1.5 *		2.4	3.3 *	2.8 *	2 *		
	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	68.2%	68.4%	64.0%	41.9%	70.2%	69.1%	66.7%	61.5%	81.0%	78.1%	69.6%	67.7%		60.2%	65.2%	76.3%		66.7% *
Stroke Care	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%	33.8%	46.2%		30.5%	41.5%	36.8%		37.2% *
	Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	87.3%	66.1%	81.8%	84.6%	92.9%	95.0%	92.3%	98.2%	89.3%	89.4%	74.0%		0.0% *	86.4%	95.0%	83.6%		88.3% *
Time to Initial	ED Time To Initial Assessment - Under	>=99%	68.5%	80.2%	81.9%	80.2%	75.9%	87.4%	91.0%	86.2%	86.7%	91.7%	89.9%	91.9%	69.1%	79.9%	88.2%	89.4%		83.4% *

	Assessment	15 Minutes																		
	Time to Start of Treatment	ED Time to Start of Treatment - Under 60 Minutes	>=90%	34.0%	31.2%	29.5%	28.8%	25.7%	32.3%	34.9%	31.2%	37.5%	41.5%	40.7%	43.3%	33.4%	28.0%	32.8%	39.8%		30.3% *
Operational Performance	**Key Indicators - Operational Performance**																			
	Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	92.3%	95.5%	86.3%	91.8%	88.9%	89.1%	88.5%	94.9%	87.1%	93.8%	95.5%	98.0% *	90.1%	89.3%	90.6%	91.8%		
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%		100.0%	100.0%	100.0%	100.0%	57.1%	77.8%	85.7%	50.0%	60.0%	100.0%	0.0% *	100.0%	100.0%	76.7%	71.4%		
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	70.0%	70.7%	78.3%	75.9%	71.2%	74.7%	80.1%	69.2%	71.4%	76.7%	73.4%	67.4% *	68.5%	75.2%	75.1%	74.4%		
	Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	1.8%	4.6%	7.2%	5.3%	5.3%	5.3%	4.8%	2.9%	0.5%	0.5%	0.8%	0.6% *	2.5% *	5.9%				5.5% *
	ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	76.96%	77.86%	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	76.56%	80.87%	85.87%	91.58%		82.87% *
	Referral to Treatment (RTT) Performance	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%													74.3% *					

Detailed Indicators - Operational Performance

Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	104	47	34	54	57	47	19	30	38 *	33	56		352	145	96	127	1,884	279 *
	Ambulance Handovers - Over 60 Minutes	< previous year	1	0	1	0	4	0	1	1	0 *	0	0		8	5	2	0	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	12	11	10	8	10	8	9	19	17	6	9	10						
	Cancer (104 Days) - Without TCI Date	0	42	42	47	80	32	35	30	26	23	34	34	19						
Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	94.7%	94.6%	91.4%	90.5%	85.9%	79.6%	70.4%	71.2%	74.6%	75.8%	81.2%	86.4% *	91.9%	89.1%	73.6%	77.1%		
	Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	95.0%	97.1%	90.4%	94.0%	94.1%	57.3%	89.7%	92.7%	89.0%	94.5%	96.3%	92.4% *	94.0%	92.8%	79.0%	93.4%		
Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	93.6%	96.8%	94.9%	95.9%	95.4%	95.8%	96.2%	98.5%	95.1%	96.7%	97.3%	97.0% *	93.8%	95.5%	96.6%	96.2%		

	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	97.1% *	100.0%	100.0%	99.6%	100.0%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	100.0%	98.6%	98.5%	100.0%	100.0%	100.0%	98.4%	96.6%	97.1%	98.5%	98.1%	98.6% *	99.1%	99.5%	98.5%	98.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	97.7%	87.8%	90.0%	97.5%	97.9%	93.6%	91.5%	95.5%	94.6%	98.1%	94.9%	97.9% *	89.2%	94.5%	93.3%	96.2%		
Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	44	37	28	30	32	27	29	32					37	32	32		33	30 *
Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End		694 *	681		963 *	522		883 *	1,298	1,062	867	733	239 *	681				7 *	
Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	52.9% *	57.4% *	63.2% *	64.5% *	61.5% *	63.8% *	61.0% *	59.9% *	60.1% *	61.1% *	60.0% *		51.7% *	63.1% *	61.6% *	60.4% *	75.4% *	61.6% *
ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	88.42%	88.50%	91.80%	92.30%	88.10% *	94.40%	95.00%	93.20%	93.80%	97.10%	96.60%	93.60%	88.00% *	90.70%	94.20%		91.60%	92.30% *
	GRH ED - Percentage Within 4 Hours	>=95%	70.56%	71.80%	77.90%	72.90%	75.30%	77.70%	84.60%	82.40%	86.60%	94.40%	88.00%	87.90%	70.00% *	75.30%	81.50%	89.60%	79.20%	77.70% *

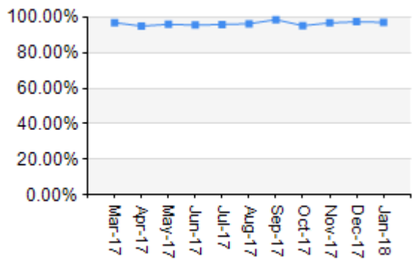
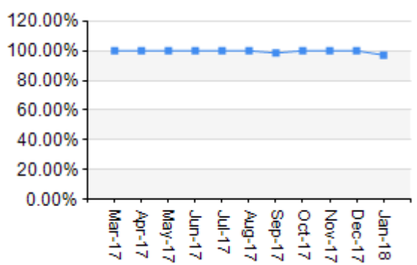
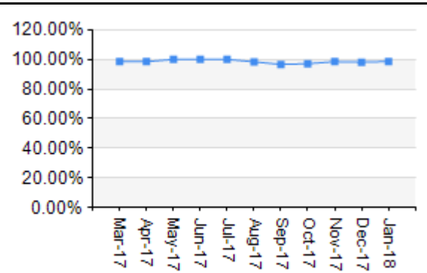
Inpatients	Stranded Patients				397	420	441	451	461	487	479	447	446	472				457		466 *
Length of Stay	Average Length of Stay (Spell)		5.57 *	5.33 *	5.11 *	4.87 *	4.96 *	4.96 *	4.86 *	4.79 *	5.1 *	5.02 *	4.79 *	5.12 *	5.55 *	4.98 *	4.87 *	4.97 *	5.37 *	4.96 *
	Length of Stay for General and Acute Elective Spells	<=3.4	3.03 *	2.8 *	2.83 *	2.66 *	2.84 *	2.73 *	2.98 *	3.15 *	3.29 *	2.86 *	2.82 *	3.07 *	2.87 *	2.78 *	2.95 *	2.99 *	3.08 *	2.92 *
	Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	6.3 *	6.19 *	5.78 *	5.48 *	5.58 *	5.62 *	5.35 *	5.24 *	5.56 *	5.6 *	5.27 *	5.56 *	6.35 *	5.61 *	5.41 *	5.48 *	6.08 *	5.5 *
Medically Fit	Number of Medically Fit Patients Per Day	<40	84	68	59	55	58	63	58	60	62	60	64	55	75	56	60	64		59 *
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 35+ Weeks (Number)																			
	Referral To Treatment Ongoing Pathways 40+ Weeks (Number)																			
	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	7 *	4 *	13 *	9 *	9 *	13 *	27 *	30 *	30	64 *	74 *	50 *						

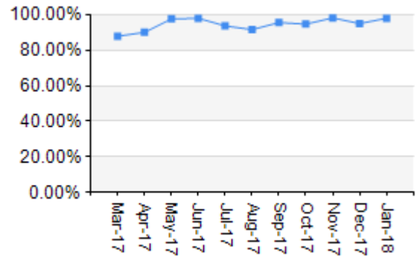
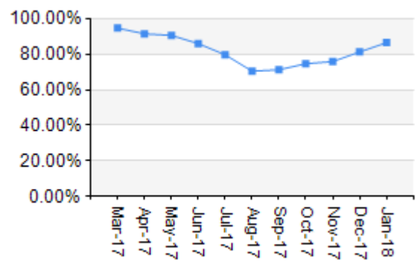
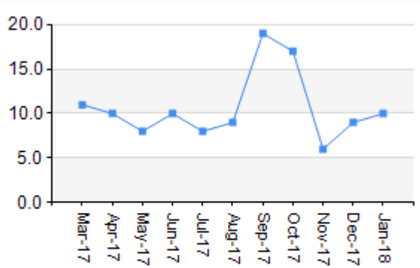
	SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *			100.0%	100.0%	100.0%		100.0%	100.0% *
		Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%				99.8%	99.8%	99.8%		99.8%	99.8% *
	Trolley Waits	ED 12 Hour Trolley Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0 *
Finance																					
	Key Indicators - Finance																				
	Finance	YTD Performance against Financial Recovery Plan		-18 *	.07	-.95	-10.15	3.36	4.35	4.24	1.87	-.27 *	-2.1 *								
	Detailed Indicators - Finance																				
		Agency - Performance against NHSI set agency ceiling				3	3	3	3	3	4	3	3 *								
	Finance	Capital Service				4	4	4	4	4	4	4	4 *								
		Liquidity				4	4	4	4	4	4	4	4 *								

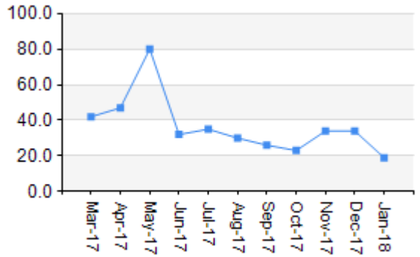
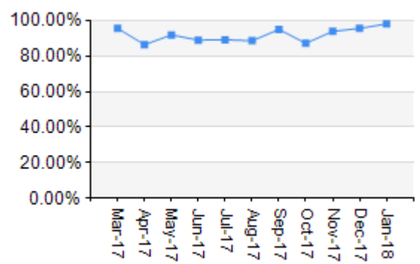
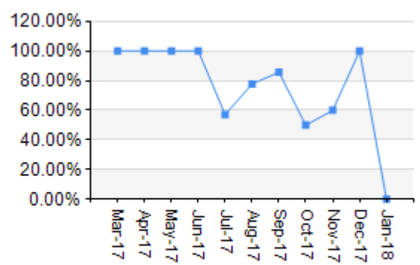
		NHSI Financial Risk Rating	3	1		4	4	4	4	4	4	4	4 *									
		Total PayBill Spend		27240		27.67	27.52	27.5	27.46	28.25	27.94	27.9	27.9 *									
Leadership and Development	**Key Indicators - Leadership and Development**																					
	Sickness	Sickness Rate	G<3.6% R>4%	3.9%	4.0%	4.0%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9% *	3.9%	3.9%	3.9%	3.9%			
	Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	.04	3.71	3.71	3.71			
	Turnover	Workforce Turnover Rate	7.5% - 11%	12.0%	11.5%	12.1%	12.0%	12.3%	12.3%	12.4%	12.3%	12.4%	12.1%	11.9%	11.5% *	11.8%	12.3%	12.3%	11.9%			
	Detailed Indicators - Leadership and Development																					
	Appraisals	Staff having well-structured appraisal Indicator	>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%	82.0%	82.0%	80.0%	79.0%	78.0%	79.0%	79.0%	79.0%	83.0%	84.0%	84.0%	83.0%	81.6%	79.0%	79.0%	82.0%			

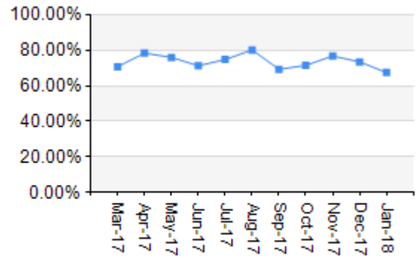
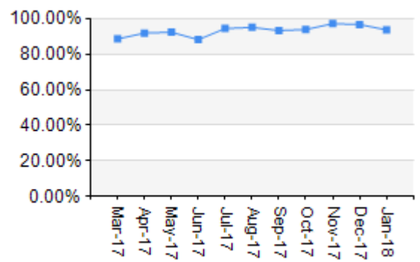
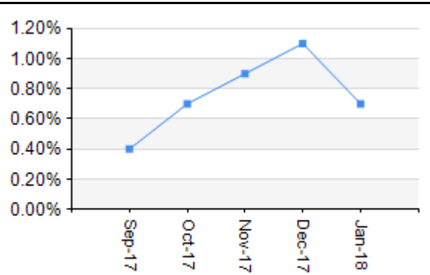
Staff Survey	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	33.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%				
Staffing Numbers	Total Worked FTE		7,239 *																			
Training	Statutory/Mandatory Training	>=90%	89%	90%	89%	89%	89%	89%	89%	88%	88%	88%	88% *	73%	89%	89%	89%	88%				

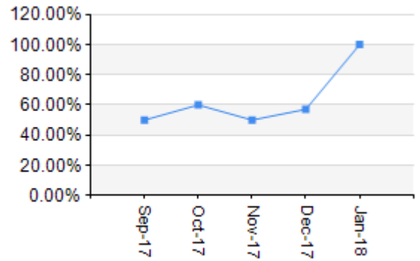
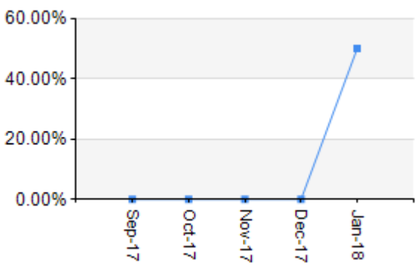
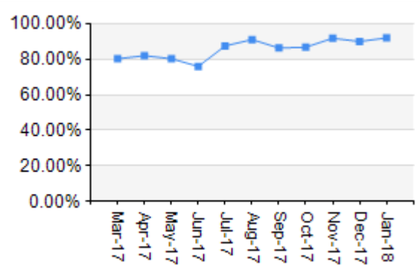
Exception Report

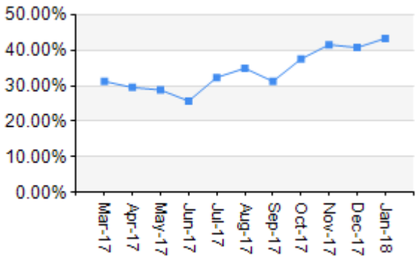
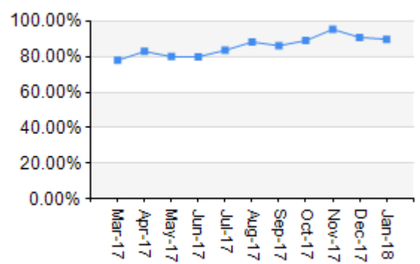
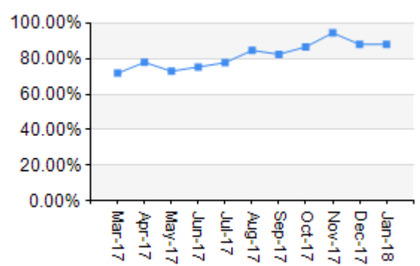
Metric Name & Target	Trend Chart	Exception Notes	Owner
Cancer - 31 Day Diagnosis To Treatment (First Treatments) **Target: >=96%**		Indicator is green no exception report required	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) **Target: >=98%**		Indicator is red at 97.1% un-validated perforamnce	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) **Target: >=94%**		Indicator is green no exception report required.	Deputy Chief Operating Officer

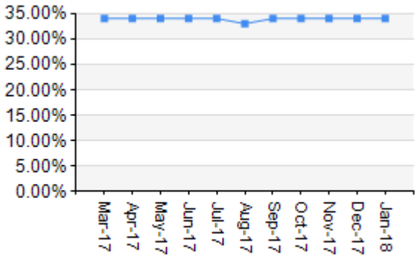
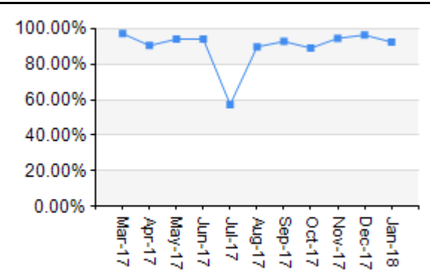
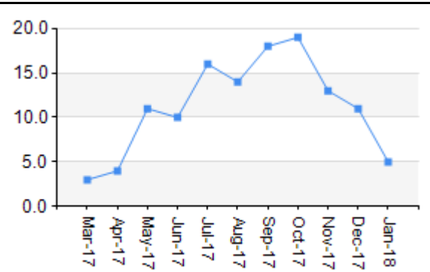
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) **Target: >=94%**		Indicator is 97.9% un-validated	Deputy Chief Operating Officer
Cancer - Urgent referrals Seen in Under 2 Weeks **Target: >=93%**		Jan performance = 87.2% (unvalidated); target = 93% Performance has improved since October(74.6%) and it is anticipated that all tumour sites (except colorectal) will deliver the standard by the end of February. There are recovery plans for colorectal, with delivery anticipated by the end of February 2018 but this will require additional clinics to manage the increased demand. - 2ww PTL developed (go live before end of January)to emailed daily to stakeholders - 2ww Ops meeting every Monday to discuss reconciliation/ DNA/ breach report - 2ww SPC charts developed and disseminated to each specialty See Cancer Delivery Plan & Cancer Escalation report.	Deputy Chief Operating Officer
Cancer (104 Days) - With TCI Date **Target: 0**		Performance - 10 There are currently 10 patients with a TCI date with plans.A number of patients are urological patients and there is a specific urology recovery plan that addresses long waiting performance which has been previously provided. Of those 9, there are a number have already been treated and are awaiting histology results and those are awaiting Robot Assisted Laparoscopic Prostatectomy (RALP). There is a plan to provide more RALP capacity from December onwards. See Cancer Delivery Plan.	Deputy Chief Operating Officer

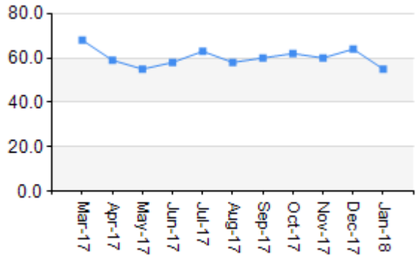
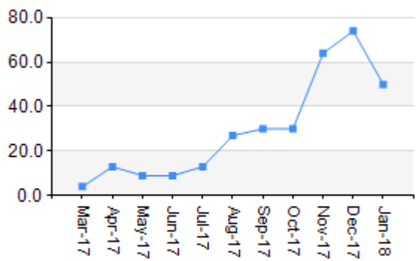
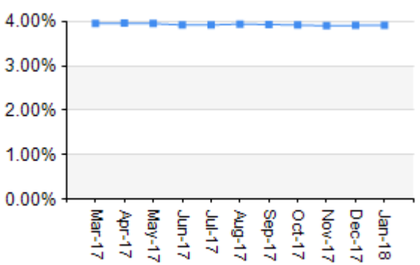
Cancer (104 Days) - Without TCI Date **Target: 0**		Performance 19 patients, without a TCI. 19 patients over 104 days with no TCI. A weekly process to review those patients on the 104 list that is accurate is now in place which relates to the national submission. Alongside this there has been progress to treat the longest waiting patients. A few patients during the month have been late referrals into the Trust and / or waiting specialist care in other Hospitals. The appointment of a locum urology consultant will continue to positively impact the performance in future months. Of the non-urology patients, all of the remainder were waiting due to complex pathways, shared pathways with other Trusts, patient choice for a specific procedure or unfit for treatment. All of these patients are being monitored. The Trust has developed a Clinical Validation Policy which includes a review of all patients waiting 104 days or more on a 62 day pathway, the processes by which this policy is adhered to is being reviewed for April 2018/19. In addition the policy is under review and aligned with the Patient Access Policy.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Screenings) **Target: >=90%**		Indicator is green. No exception report required. See cancer exception report for full cancer delivery plan.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		Relates to 3 patients and all are treated	Deputy Chief Operating Officer

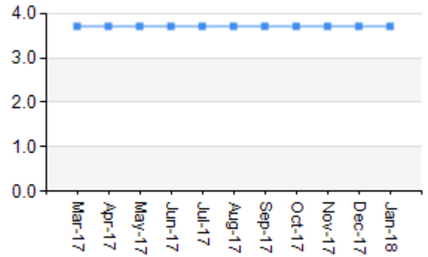
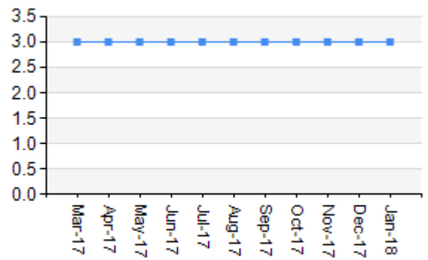
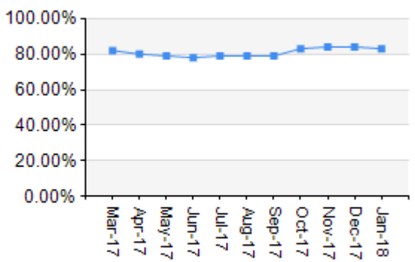
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		Dec breaches 35.5 (Uro 15.5 Gynae 5.5 UGI 3 LGI 3) Jan breaches 48.5 (H&N 5, LGI 9.5, Lung 6, Uro 19)	Deputy Chief Operating Officer
CGH ED - Percentage within 4 Hours **Target: >=95%**		See Emergency Care Delivery Group report	Deputy Chief Operating Officer
Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Trakcare process for recording engaged, but outside of other clinical clerking. Junior Medical staff reminded to access this field in Trak to enter this data.	Deputy Nursing Director & Divisional Nursing Director - Surgery

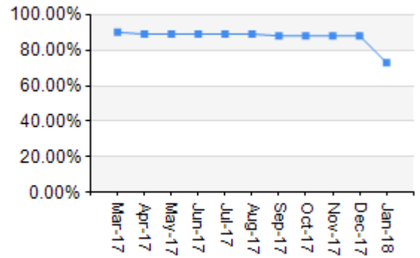
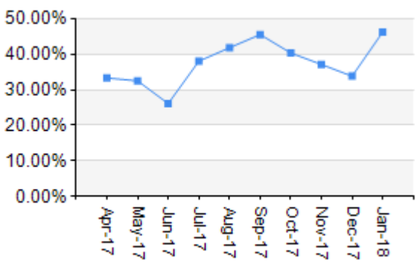
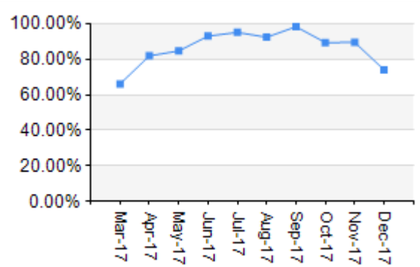
Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Trakcare process for recording engaged, but outside of other clinical clerking. Junior Medical staff reminded to access this field in Trak to enter this data.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Trakcare process for recording engaged, but outside of other clinical clerking. Junior Medical staff reminded to access this field in Trak to enter this data.	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. Performance against the 15 minute standard for initial triage continues to fall below the standard required at both sites, with performance failing following surges in ambulance arrivals.	Deputy Chief Operating Officer

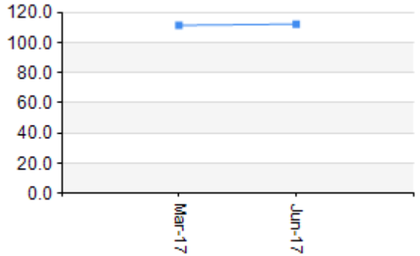
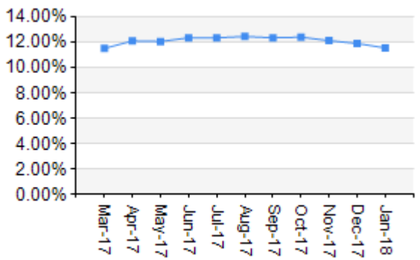
ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		Performance against this standard is still not being met on either side of the county. A detailed review of the data has confirmed that we are underreporting against this key safety metric as we are not coding all of the senior decision makers appropriately. This is in the process of being rectified by the ED team. Time for escalation is now reviewed on the daily escalation reports and conference calls. Performance against this standard is still not being met on either side of the county. Detailed focus is required on this key safety metric to improve time to first assessment. A short term task and finish group has been established.	Deputy Chief Operating Officer
ED Total Time in Department - Under 4 Hours **Target: >=95%**		Please see Emergency Care Delivery Group Exception Paper 4hr performance January 89.7%	Deputy Chief Operating Officer
GRH ED - Percentage Within 4 Hours **Target: >=95%**		GRH failed to achieve the performance standard for ED in December due to operational challenges that are internal to ED and wider GHT areas. A detailed action plan is in place to rapidly improve processes within GHT both within the Emergency Department but also across the key clinical inpatient and support services. Performance for December has delivered the Trust STP trajectories at aggregate level.	Deputy Chief Operating Officer

Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey) **Target: >38%**		This indicator is proposed to be removed as it is annual measure. it will therefore be reported in the month of the survey.	Director of Human Resources and Operational Development
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms **Target: >=93%**		Performance has improved since November (93.9%). Our December position is 183 First seens with 11 breaches. January performance shows a deterioration with 225 First Seens with 17 breaches.	Deputy Chief Operating Officer
Number of Breaches of Mixed Sex Accommodation **Target: 0**		Performance for December has delivered the Trust trajectories at aggregate level. The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. A total of 5 breaches declared by the Trust for the month of January 2018 (a decrease), impacting on 23 occurrences. The analysis shows that all 11 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. The Standard Operating Plan has been 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 medically fit patients has increase over the past month against last month's performance. One of two reasons behind this has been the surges during the week in ED attendances & admissions which leads on to a back log of Social Care Assessments. Mitigations for this have been an increase in the number of social workers working on Saturday and Sundays and OCT working over both Saturday and Sunday each week. The second reason to note is that we appear to have an increase in the number of patients awaiting Community Social Work assessment. We are discussing this with our partners, as this may be an impact of community social work having to focus in late January on community hospital discharges in support of the Trust Flow. A number of work streams continue to support reduced LoS through Stranded patient reviews. January position is 55 medically fit patients.	Deputy Chief Operating Officer
Referral To Treatment Ongoing Pathways Over 52 Weeks (Number) **Target: 0**		See Planned Care Exception Report.	Deputy Chief Operating Officer
Sickness Rate **Target: G<3.6% R>4%**			Director of Human Resources and Operational Development

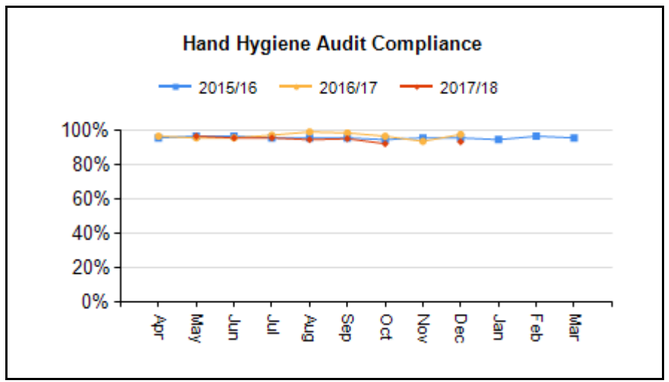
Staff Engagement Indicator (as Measured by the Annual Staff Survey) **Target: >3.8**		Annual Staff Survey	Director of Human Resources and Operational Development
Staff having well-structured appraisal Indicator **Target: >3.8**		Appraisals as at Dec = 84% 2017 staff survey expected Spring 2018. Talent Management project starting in January to include Appraisals.	Director of Human Resources and Operational Development
Staff who have Annual Appraisal **Target: G>89% R<80%**			Director of Human Resources and Operational Development

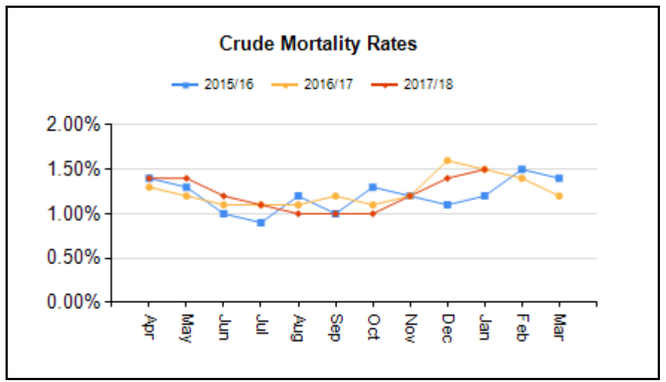
Statutory/Mandatory Training **Target: >=90%**		As predicted, overall compliance is lower (73%) primarily due to the need to refresh Safeguarding Adults Awareness, Safeguarding Children Awareness and Prevent Basic Awareness due to changes in legislation and government guidelines. A global email has been sent to staff and staff will be chased with the aim of compliance being back up by the end of March.	Director of Human Resources and Operational Development
Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour **Target: >=50%**		The organisation is still striving 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. As a result of the performance, the Director for Operations, Medicine is meeting with all parties involved to address the performance position. Update for March 2018 to be provided.	Director of Operations - Medicine
Stroke Care: Percentage Spending 90%+ Time on Stroke Unit **Target: >=80%**		Performance has deteriorated in this field, in January due to increased bed pressures across the organisation, resulting in less patients being admitted directly into the Stroke Ward. The Director of Operations, Medicine, is working closely with the Deputy COO, Unscheduled Care to ensure the policy of having a ring-fenced stroke bed is adhered to and through the ward appropriate step-down patients are identified.	Director of Operations - Medicine

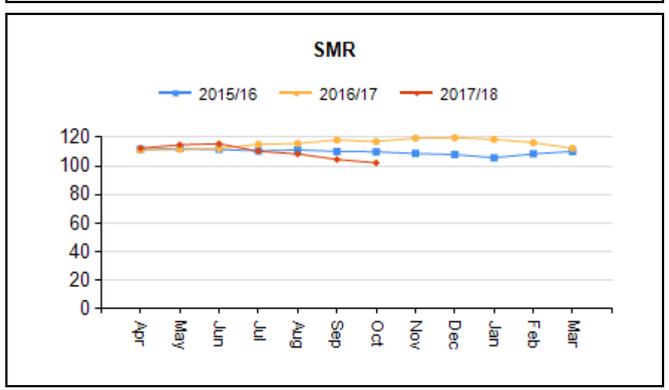
Summary Hospital Mortality Indicator (SHMI) - National Data **Target: Dr Foster confidence level**			Medical Division Audit and M&M Lead
Workforce Turnover Rate **Target: 7.5% - 11%**			Director of Human Resources and Operational Development

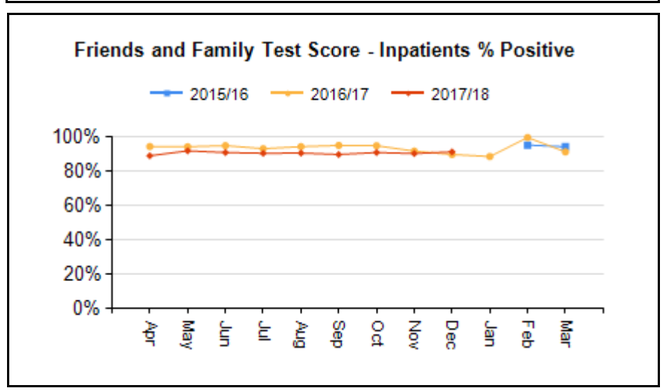
Contextual Indicators

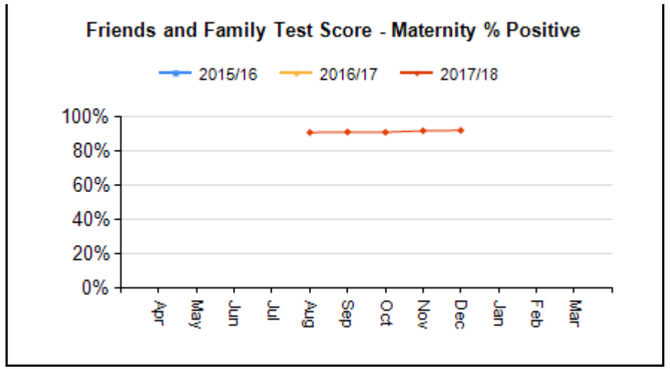
This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

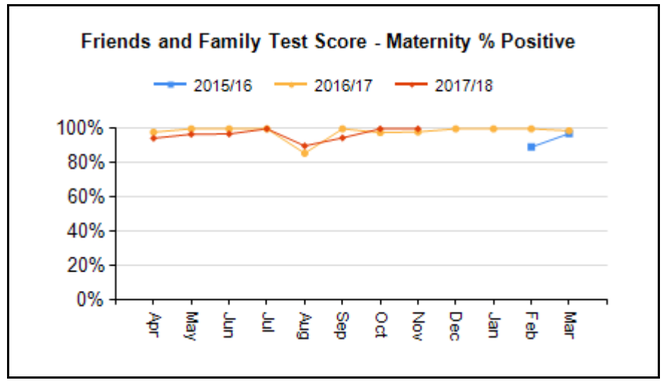


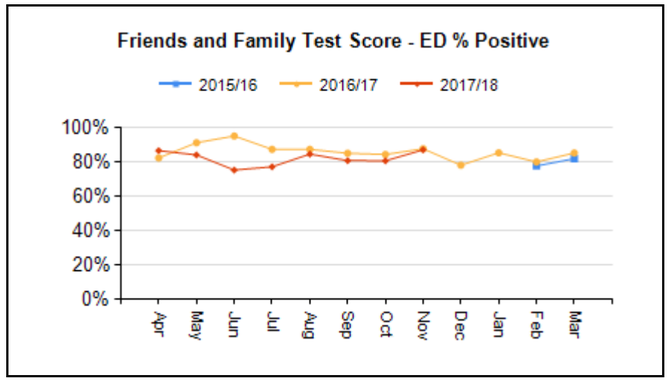


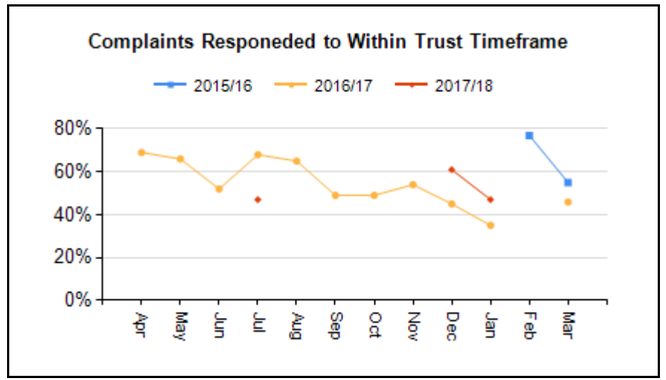


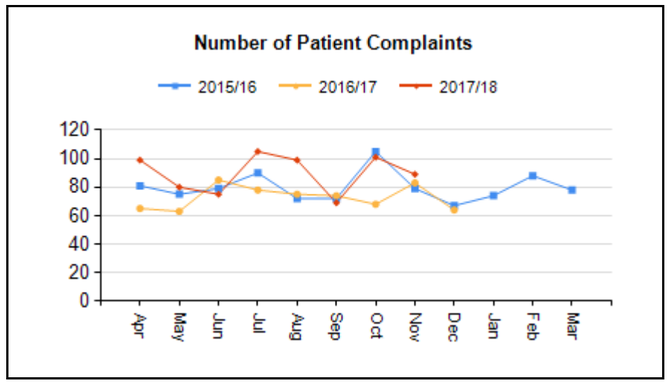


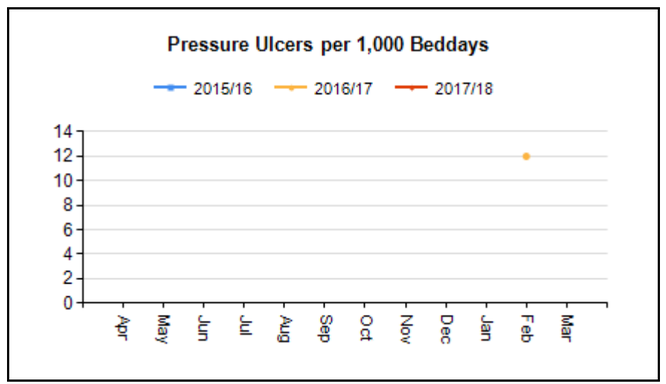

Friends and Family Test Score - Maternity % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

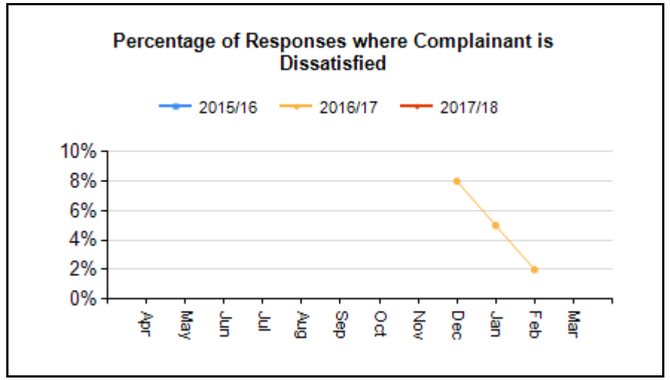

Friends and Family Test Score - Maternity % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

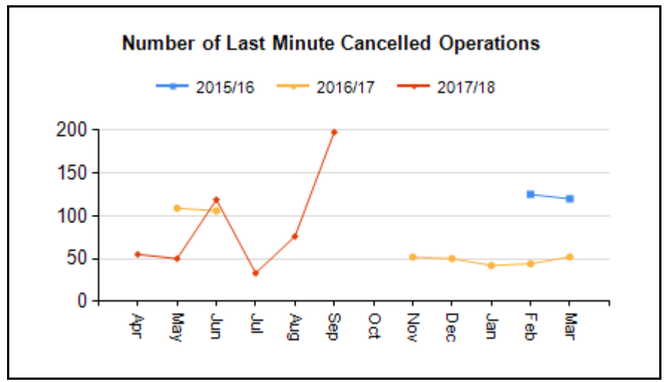

Friends and Family Test Score - ED % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

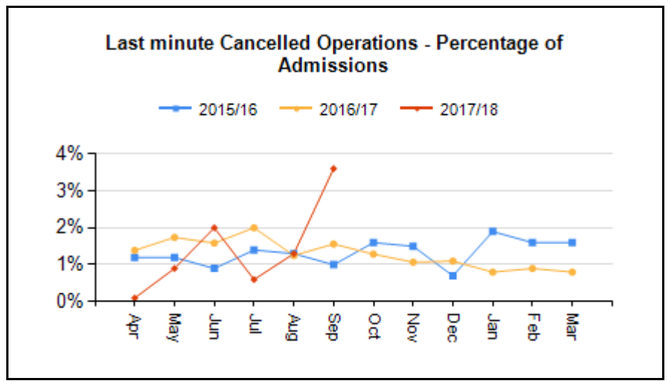

Complaints Responeded to Within Trust Timeframe
2015/16
2016/17
2017/18
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

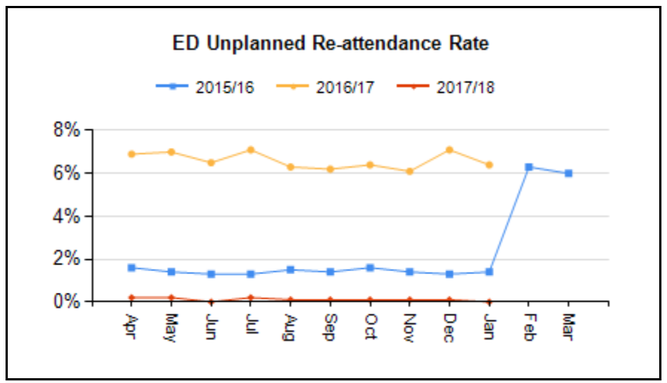

Number of Patient Complaints
2015/16
2016/17
2017/18
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

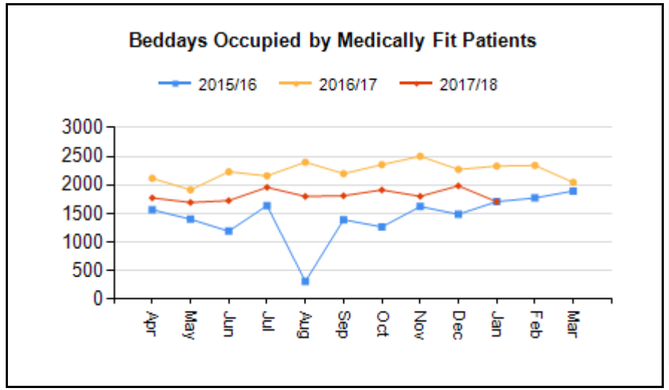

Pressure Ulcers per 1,000 Beddays
2015/16
2016/17
2017/18
14
12
10
8
6
4
2
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

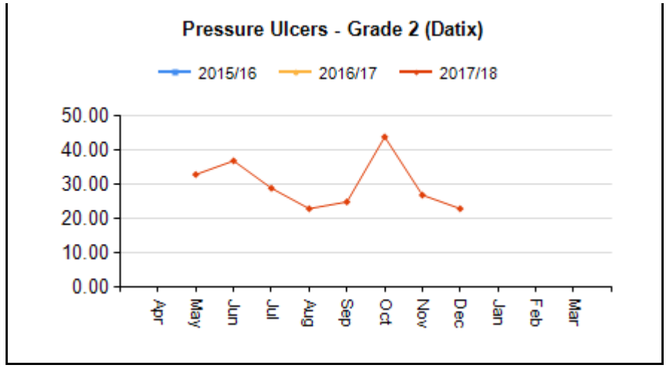

Percentage of Responses where Complainant is Dissatisfied
2015/16
2016/17
2017/18
10%
8%
6%
4%
2%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

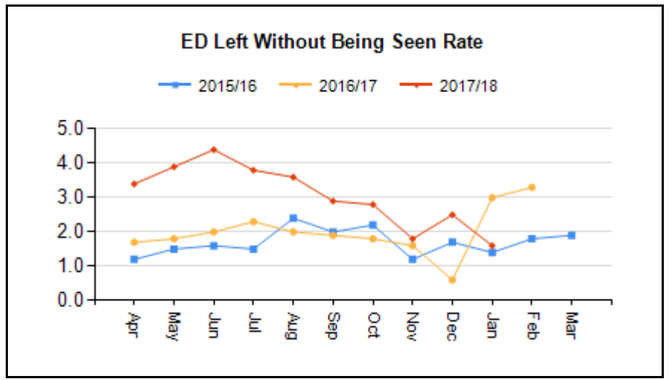

Number of Last Minute Cancelled Operations
2015/16
2016/17
2017/18
200
150
100
50
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Last minute Cancelled Operations - Percentage of Admissions
2015/16
2016/17
2017/18
4%
3%
2%
1%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


ED Unplanned Re-attendance Rate
2015/16
2016/17
2017/18
8%
6%
4%
2%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Beddays Occupied by Medically Fit Patients
2015/16
2016/17
2017/18
3000
2500
2000
1500
1000
500
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Pressure Ulcers - Grade 2 (Datix)
2015/16
2016/17
2017/18
50.00
40.00
30.00
20.00
10.00
0.00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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
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Sep
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Nov
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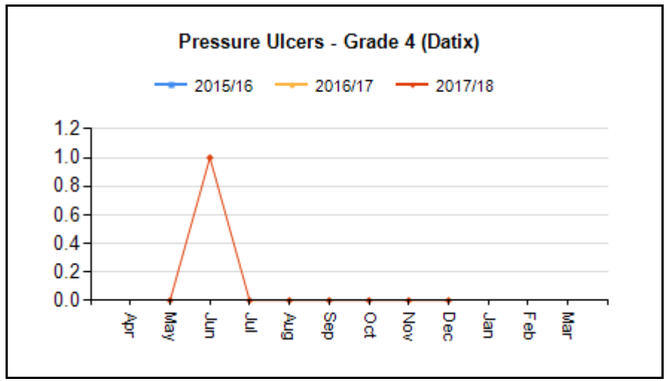
Mar


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
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Sep
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Nov
Dec
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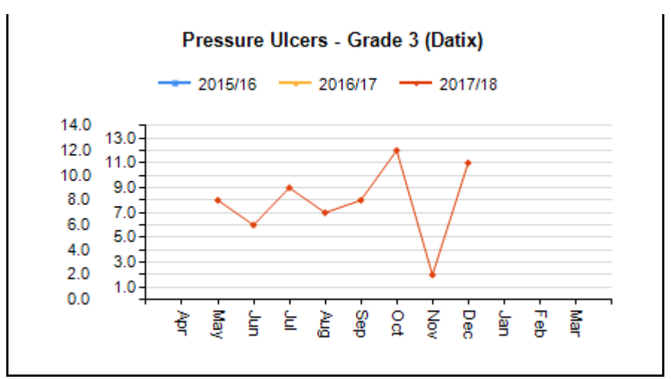
Feb
Mar


Pressure Ulcers - Grade 3 (Datix)
2015/16
2016/17
2017/18
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
13.0
11.0
9.0
7.0
5.0
3.0
1.0
Apr
May
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Jul
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REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Quality and Performance Committee on 25 January 2018, 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	Some changes to format of report on Trust's key risks for this Committee. Aim is to extend commentary and develop reporting of themes and cross-referencing into other assurance reports. Two further risks have been added, relating to harm arising from lack of availability of sterile equipment, and to volume of delayed follow up appointments beyond patients' recall dates within Ear Nose and Throat clinics.	Could we be sighted on mitigations when new risks are escalated to Committee?	Recent positive report to Audit Committee on risk management and culture. New risk reporting format in development will demonstrate controls and actions for new risks, and make the existence of any gaps in controls and assurances more evident.	New report style from March 2018.
Board Assurance Framework (BAF)	Update report on Committee's sections of the BAF that was reviewed at December's Board Meeting.	Authors commended for content and progress in achieving improved staff involvement in production of BAF.		

	Good evidence that the BAF tool was proving to be useful in strengthening assurance of quality of care and helping to identify any assurance gaps.	How will the Committee be involved in he development of the Patient Experience Strategy?	Further opportunities later in Quarter 4 for input.	Next iteration of BAF to Committee in April.
Sepsis Performance Improvement Letter	The Trust has been formally commended by NHSE's National Medical Directorate for its improvements in the identification and treatment of sepsis. The exceptional performance (98% for initial assessment and 90% for the delivery of antibiotics) was discussed and attributed in part to the benefits of a quality improvement approach.	The Committee congratulated executives on such a significant achievement. How might even further improvement be possible?	Continued effort at maintaining embedded best practice.	
Quality and Performance Report	Emergency Care: In December the Trust achieved 90.8%, well in excess of its trajectory (77.4%) for the 4 hour standard.	Committee commended the team for its exceptional performance in month and evidence that this was being broadly maintained in January, albeit with some difficult days at the beginning of the month. Which areas is the team working on to develop the sustainability of improved performance?	Indication that Trust's national classification rating for And E (currently Cat 4) is to be improved. Reconfiguration of site management in hand which will improve deployment of the bed base.	

		Do we have evidence of patients' response to being treated more quickly?	There has been a 10% improvement in patient experience as measured by Friends and Family Test.	
		Is there a connection between increased speed of patient flow through the hospital and the incidence of C.diff?	There are complex explanations that include occupancy and the ability and time to undertake deep cleaning.	Further developments in train for improved and more agile responsiveness from cleaning services to meet needs arising from improved patient flow.
	Planned Care: 18 week RTT standard reporting remains suspended.	How can we explain the delays to patients' first appointment?	Combination of system problems and insufficient capacity.	
	Good performance against diagnostics targets, which has been commended by the Secretary of State. Problem areas include quality of patient waiting lists and number of long waits for treatment. 74 cases of waiting times in excess of 52 weeks were reported in December and these will continue in the short term. Clinic typing highlighted as a concern.	Can we be assured about clinical validation arrangements within future reports?	Available.	For inclusion in future reports.

	Cancer standards: The Trust did not meet the national standards or Trust trajectories for 2 week and 62 day cancer standards. However, there has been a 5.6% improvement over November in the 2 week wait position to 81.2%, which has been sustained in January. Detailed and comprehensive presentation of performance, improvements and challenges across each of the tumour sites. Mixed Sex Accommodation breaches are attributable to Critical Care Department and NHSI discussion to take place about consistent reporting methodology. Variable compliance with ED Safety Checklist reporting across CGH and GRH sites. Improvement work focussing on consistent practice and compliance.	How sustainable are staffing levels for the validation work that is required?	Recruitment has commenced. Reiteration of absolute focus on cancer standards and strengthening of performance management by general as well as senior managers.	
Clostridium Difficile Improvement Plan	Analysis and improvement plan to address recent increase in incidence of C. Difficile.	Are cleaning standards satisfactory in high-risk areas?	Room for further improvement which is reflected in the Action Plan.	Progress to be reported to Committee.

Emergency Readmissions Report	Preliminary report to brief the Committee about the intention to undertake a deeper investigation of avoidable readmissions. Specialties with relatively high numbers were identified. It was recognised that readmissions rates constitute an important balancing measure to provide valuable insights into the quality of care. A sample of current pathways and their rates of readmissions will be examined, together with a detailed consideration of a number of cases in conjunction with CCG.	The intention to examine this area in detail was welcomed.		Further report to Committee in May.
Quarterly Patient Experience Report	Report to summarise Patient Experience to quarter 2. Key points included: - Increased number of complaints - Slight reduction in Friends and Family responses - Trust success in national Maternity Service survey (2nd best performance in UK) - Improvement focus will be on better response rates, and data quality.	How can response rates be improved as there are currently significant numbers of responses that take in excess of 35 days? How can we improve Trust learning from complaints? Are there any further issues of concern to patients	Staff do need to become more engaged in complaints processes and outcomes System improvement underway to improve thematic analysis within complaint data. Deputy Director of Quality regularly meets PALS team.	

		received via PALS that were not captured in this report?	There are increasing numbers of patients who are contacting PALS from wards. Problems with outpatient appointments are another key theme.	
Mortality Report	HSMR and SMR are declining, reflecting, in particular, improved coding of palliative care and improved outcomes in fractured neck of femur treatment. Weekend mortality data is to be considered further with analysts from Dr Foster. Progress report on Learning from Deaths requirements.	What are the new reporting arrangements to be to meet Learning from Deaths requirements? How can attendance at the Mortality Group be improved, as there are a large number of apologies received?	Reporting lines from divisions to the Mortality Group to Committee and Board were explained. It is intended to extend divisional attendance	

Claire Feehily
Chair of Quality and Performance Committee
25 Jan 2018

REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Quality and Performance Committee on 22 February 2018, 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	Further improvements to the reporting format, enabling identification and discussion of emerging themes and lessons being learned and embedded.	Re falls: what is the robustness of arrangements for observation and escalation, especially at night?	Re falls: Deep dive to be undertaken and action plan produced.	Further specific investigations to take place; enhanced surveillance by Committee agreed, and future reporting confirmed for specific risks.
	Specific issues reported related to risks arising from: - Sequence of surgical related never events - Inpatient falls, including discussion of coronial interest - C-diff - Delayed treatment and diagnosis arising from delays to follow-up care	Need to maintain urgent and sustained progress to address and clear backlogs as well as effective oversight of patients whose treatment has been delayed.	Re never events: Trust's report and action plan to include input from an external expert for additional assurance Arrangements for identifying, reviewing and prioritising patients were described. Improvement and recovery trajectories are in place.	Review of cases where follow-up has not taken place or been delayed to be undertaken. CCG to participate. Update reporting through Committee.

		Although numbers of such delayed patients are relatively small, are we clear of sources of ongoing risk from historic cases?	Actions to remedy difficulties with patient lists being addressed within TrakCare project	
Quality and Performance Report	Emergency Care: In January Trust achieved 89.7%, well in excess of its trajectory (80%) for 4 hour standard. Significant growth in demand (10.2% increase on Jan 2017) Strong A&E performance regionally and nationally. Achieved diagnostic 6 week wait target.	Committee commended team for evidence of significant and sustained improvement in A&E and diagnostics. Particular mention was given to improvements in performance of care and treatment for stroke patients. What is our progress in meeting the 60 minute target time for patients seeing a clinical decision-maker? What current feedback do we have from patients about their experience of emergency care and any specific issues?	Further report received on good compliance with NHSI Enforcement Undertakings re A&E performance. Trust rating for A&E moved from Cat 4 (most challenged) direct to Cat2. Trust not yet where it needs to be on this, particularly when the emergency department is crowded. Main theme is from families identifying difficulty in accessing Emergency Dept and AMU by phone, especially locating patients once transferred.	Performance to be the subject of a task and finish group to secure improvements in coordination; embedding of best practice; and consistency of practice within and between teams. New telephony system planned during 2018 that should improve call management.

		What efforts are being made to understand and respond to such a scale increase in demand and what are we learning about planning for the next holiday period?	In part we are seeing what is being experienced nationally. There is more that the Trust can do to anticipate demand and improve the planning of staffing. More system-wide planning coordination needed for staffing availability in non-acute services too.	Opportunities for further coordination and joint planning to be investigated.
	Planned Care: 18 week RTT standard Reporting remains suspended. Improvements to management of patient lists were described, together with a targeted training programme to improve staff confidence and understanding with relevant elements of TrakCare. 50 cases of waiting times in excess of 52 weeks were reported in January and we will continue to see these occurring in near future. Some areas of typing backlog were reported.	Where does the team feel improvement efforts are most challenged?	Notwithstanding efforts and commitment, in high volume areas, especially Trauma and Orthopaedics, where the task of booking clinics correctly is challenging. Good evidence of cooperation with IT colleagues for system enhancements. Urology is also experiencing capacity problems. Evidence of much improved coordination of improvements with divisional clinical leadership.	Revised recovery plan in preparation.

		Are there any specific current themes from patient feedback?	Fewer issues being raised with PALS than previously relating to booking and appointments.	
	Cancer standards: Trust did not achieve 2 week wait and 62 day cancer standard. Particular capacity problems for colorectal treatment on 2 week pathway. Discussion of delays arising from exercise of patient choice and delays in patients' readiness to be booked into 2 week pathway. Valuable recent work with CCG Dep Clinical Chair to strengthen how "we" (Trust and GPs) communicate with patients about the importance of timely actions to optimise use of specialist cancer resources. Specific commendation to Dermatology and Gynaecology Teams for their innovation and level of sustained improvement.	Are we satisfied *that we are* and *with how we are* communicating with people whose cancer treatment has been delayed	New patient letters were described as well as types of conversations that are being had with patients about their delays. It was recognised that such communication is more straightforward for some types of treatment (e.g. Dermatology) than others.	
	Areas of concern include Urology and lower and Upper GI tumour sites.	What is the specific concern about Urology and can it be resolved?	Problem of capacity to maintain current activity while also addressing backlog. Plans for extended and weekend lists are in place.	Revised recovery plan to Committee.

		How can the Straight to Test plans be accelerated?	Process maps are currently being prepared to help determine a proposal	Focused support and advice to specific GP surgeries being planned.
CQC Action Plan Progress Report	Comprehensive quarterly report updating Cttee on progress against Must Do and Should Do actions from last CQC inspections.	Authors were commended for detail and transparency of the report and its evidence of close supervision of progress.		
	RAG rating against current status and description of how Executive have assured themselves re progress, including intention to use Internal Audit and Audit Cttee to test and review aspects of implementation.	Given level of activity, occupancy and pressure, how can we be assured that CQC matters receive priority and attention in the daily work settings?	The sense of priority is understood and there is good team understanding and engagement. However there are difficulties that arise from a transient workforce and from challenge of tackling some estate matters because of "busyness".	Plan to renew flooring in 9th floor in GRH in hand which need a ward to be freed up.
	Some difficulties were described in ensuring implementation,, arising from pressure on some areas of service, mix of permanent and temporary staff and estate and equipment needs.	Be sure to use Charitable Funds options where appropriate additional investment might be mobilised quickly,		
	Progress on two specific recommendations was escalated, relating to cleaning and equipment, and to a backlog of typing.	Are we making sure we make good connections on these staffing challenges to Workforce Committee where they have not yet been flagged?		Consider at Workforce Committee.

Mortality Report	HSMR and SMR are now within the expected range (likely to lead to very early achievement of Trust strategic goal). Evidence was reported of a better understanding of the factors that are driving the improvement in Trust performance. Update on measures to extend family involvement in reviews of deaths, including suggestions for collecting feedback in the most empathetic way that we can. Improvements in database for recording review details, enabling learning.	Update on very valuable NED meeting with Dr Elyan and Dr Foster team to extend our understanding of reporting arrangements and potential for further improvement. What are the arrangements in the event that someone with learning disabilities dies and are we confident that correct triggers to conduct review will be applied? How will themes be reported and extracted?	Yes, the Trust is strong in this area and separate reporting and review arrangements apply. Quarterly reporting format in development.	
Safer Staffing	Briefing provided on overview of staffing position. January had been particularly demanding with relatively high sickness rates. Specific recruitment pressures were described, especially concerning A&E nursing. Specific pressures in AMU re permanent to temporary ratios.	Need for closer cross-reporting into Workforce Committee		Closer examination of this topic at next Q&P.

Claire Feehily
Chair of Quality and Performance Committee
28 Feb 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Learning from Deaths
Sponsor and Author(s)
Author: Dr Sean Elyan, Medical Director Sponsor: Dr Sean Elyan, Medical Director
Executive Summary

Purpose

- To update the Board on the Trust's progress on learning from death reviews and present the data on death reviews.

Key issues to note

- Considerable progress has been made to ensure database recording of all deaths and high-level reviews of all deaths through the bereavement team and the Medical Examiners
- Embedding the recording of the Structured Judgment Review (SJR) in the database will enable thematic learning to be developed
- Family input has been reviewed and progressed with further developments planned
- The use of the SJR is progressing
- Good progress has been made with system partners to standardise our approach between providers including primary care

Conclusions

- Satisfactory progress is being made in the implementation of the National Guidance on Learning From Deaths

Future Action Required

- Further work on bereaved family engagement
- Recording of SJRs in the database
- Develop an approach to extracting and disseminating overarching learning themes

Recommendations
To accept this update as assurance of progress of our death review process and note the data included.
Impact Upon Strategic Objectives
Links to our goal of being safe in our care.
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Important to assure the regulator of progress in this area

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018

LEARNING FROM DEATHS QUARTERLY REPORT

1. Aim

This paper is required to comply with the National Guidance on Learning from deaths. This guidance states that a quarterly update should be presented to the open session of The Board.

2. Executive Summary

2.1 100% of deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.

2.2 We now have an established database contained within the Trust Datix system in which all deaths are recorded.

2.3 Detailed mortality reviews are triggered from the Bereavement Office as a result of the Speciality reviews or as a result of incident reporting.

2.4 Progress has been made with respect to reviewing our current and future approach to family engagement.

2.4 The low level of deaths identified as arising from problems in care is consistent with the levels identified in other Trusts in the South West Academic Health Science Network

3. Mortality Review Process

3.1 All deaths are recorded by our Bereavement Team which also meets every family of deceased patients. This team, in conjunction with the Medical Examiners, register the patient details, the responsible clinical team, the recorded cause of death and any triggers, at a Trust level that require a detailed mortality review by the Specialty.

3.2 Specialities review deaths identified by the Bereavement team and Medical examiner within their normal mortality and morbidity review processes. Specialty reviews are undertaken by clinical staff not responsible for the in-patient care. In addition specialities review deaths with a view to a more detailed assessment using the Structured Judgement Review (SJR) unless alternative requirements are present. This particularly applies to patients where the Learning Disabilities Mortality Review (LeDeR) approach is required and for paediatric or neonatal deaths including Stillbirths. These examples require multi-agency involvement and have a Nationally defined format.

3.3 Excellent progress has been made in adopting the SJR approach in Medicine and in Diagnostics and Specialities Divisions. In Surgery, targeted work is underway to convert the current mortality review process to the SJR methodology.

3.4 The Datix mortality database has also been developed to mirror the SJR documentation and will greatly facilitate reporting as it is adopted.

3.5 Where mortality reviews identify a death that has arisen from problems in care, this will now be logged as a serious incident within the Datix system and reviewed by

our investigation team. Using this approach assumes that all such incidents will trigger a Duty of Candour process and family involvement.

4. Family Involvement

4.1 Our aim is to comply with the letter and spirit of close family involvement in our mortality review process.

4.2 Our Bereavement Office Team have particular training to work with families at this difficult time.

4.3 We have reviewed our process with one family and we are undertaking further reviews with other bereaved families to adopt our current approach to meet the families' needs.

4.4 We have developed an approach of contacting all bereaved families. This was very well received by the family we have already met and we will pilot this in one area before launching generally. We seek to receive feedback on areas of care that could be improved and areas of high quality care.

4.5 National guidance from NSHI on engagement of bereaved families is expected soon and our approach will be tested against this guidance.

5. Learning from Deaths

5.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Learning and actions are developed through this process.

5.2 Dissemination of this learning has been particularly well developed within the Emergency Department where exemplary communication is achieved. We propose to extend this approach to all Specialities after review through the Quality and Performance Committee.

5.3 Embedding the reporting of mortality reviews where there are problems in care contributing to deaths through the serious incident process will also ensure development of consistent action plans.

5.4 It has been agreed through the Hospital Mortality Group to bring the Learning from Death Reviews in each Division through the HMG to develop overarching themes of learning. This work will take some time to develop.

6. Learning with Partners

6.1 We continue to work with colleagues in the South West through the Academic Health Science Network giving us the opportunity to ensure that our approach mirrors that in other Trusts in the South West.

6.2 We have set up a countywide Mortality Review Group to share practice and to undertake joint death reviews where appropriate. The first two cross-sector review cases are being currently undertaken. This work includes primary care, Care Services, and 2Gether Trust.

7. Mortality Dashboard

7.1 The Trust is required to collect data to include:

a) The total number of deaths;

b) The number of deaths having a high level review;

c) The number of deaths where problems in care contribute significantly (a score of < 3 in SJR);

d) The number of deaths investigated under the Serious Incident approach;

e) Themes and issues identified;

f) Any changes that have resulted.

7.2 This data is summarised in Appendix I.

8. Conclusions

8.1 All deaths are now reviewed within the Trust via the bereavement and the Medical Examiner approach.

8.2 Good progress is being made on family engagement and embedding a standard approach to assessment.

8.3 Further work is required to disseminate learning from reviews at a Speciality level and to develop Trust-wide themes and learning.

9. Recommendations

The Board is asked to note the second Learning from Deaths Quarterly Report.

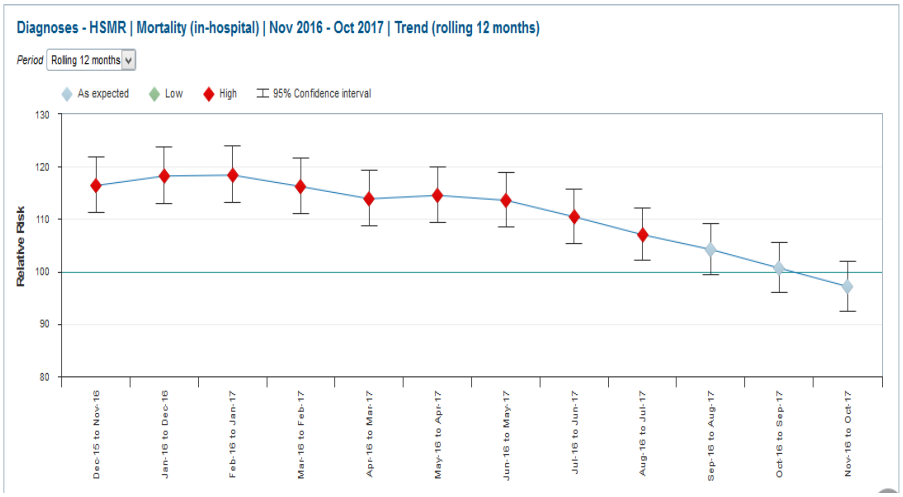
Dr Sean Elyan
Medical Director

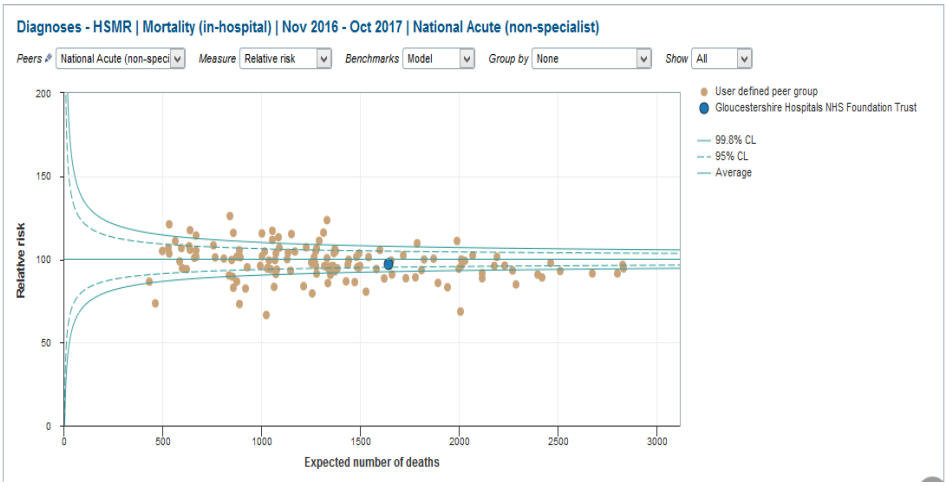
APPENDIX I

HSMR Dashboard			
	Deaths	**Bereavement**	**ME Review**
Q1	547	-	547
Q2	428	-	428
Q3	527	527	527

HSMR Graph

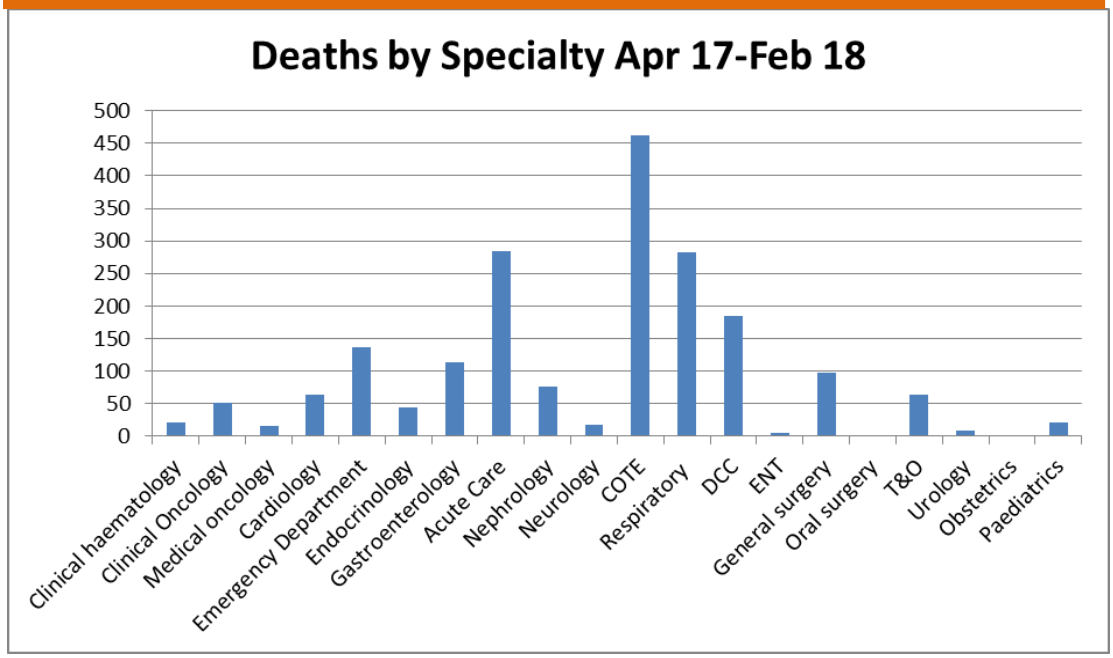
The graph below shows the rolling 3 month average HSMR in hospital indicator showing a downward trend within the expected range on the funnel plot





DEATHS BY SPECIALITY DASHBOARD (April 2017-Dec 2017)			
W+C	**Surgery**	**Medicine**	**D+S**
30 (including stillbirths	290	1126	70

DEATHS BY SPECIALITY GRAPH (note period covered)



Total inpatient deaths to date 1955

DEATH REVIEWS BY SPECILITY April 2017 – Dec 2017					
Division	**Deaths**	**ME +/- bereavement review**	**Speciality Review**	**SJR**	**Deaths where problems in care contribute**
W+C	30 (including stillbirths)	30	30	National process	0
Surgery	290	290	290	54	0
Medicine	1126	1126	627	238	20
D+S	70	70	41	18	2

DEATHS REVIEWS BY SPECIAL TYPE		
Type	**Number**	**Period**
LeDeR	10	Apr2017 - current

Paediatrics	30	2017
Coroner Inquests	10	July 2017 - current
SI	17	July 2017 - current

GENERAL LEARNING THEMES		ACTIONS
1	Prompt treatment of sepsis	Use the ED checklist
2	Checking of patient blood results on discharge from ED or handover to another ward	Pilot of new paperwork in the Emergency Dept
3	Prioritisation of urgent CT head scans across both sites	New policy with X ray
4	Falls in at risk patients	Testing red blankets in ED
5	Recognising deteriorating patient	Deteriorating patient group to review

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Bev Williams, Risk and Assurance Manager 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 12+ for safety and 15+ other domains 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 domains that have not yet been migrated to the Trust Risk Register.

Changes in Period

TLT have agreed the following risks to be **added** to the Trust Risk Register

January 2018
- **F2623** - 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 resulting in extension of Financial Special Measures and increased regulatory action
- **S2595Th** - The risk of harm to patients due to correct and sterile equipment not being available from CSSD
- **C1798COO** - The risk of delayed treatment and diagnosis due to delays in follow up care in a number of specialties including neurology, cardiology, rheumatology, ophthalmology and ENT.

February 2018
- Nil

March 2018
- **D&S2629Path** - The risk of failure to recover and re-accredit following a critical CPA /UKAS report on the provision of the Haematology, Transfusion and Immunology Laboratory Services

- **S2568Anaes** - the risk to patient safety due to failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up (consequence catastrophic (5))

There have been no risks downgraded in this time period

There are currently 10 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)**
					7 March 2018	
Outcome of discussion when presented to previous Committees						

Trust Risk Register

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the above controls?	Consequence	Likelihood	Score	Action / Mitigation	Review date
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	Complete	Catastrophic (5)	Almost certain - Daily (5)	25		30/03/2018
F2335	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance Committee, 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.	Incomplete	Major (4)	Almost certain - Daily (5)	20	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures	02/03/2018
D&S2629Path	Diagnostics and Specialties, GP Services / NHS England, Medical, Surgical, Women's and Children's	Statutory		Divisional Board	The risk of failure to recover and re-accredit following a critical CPA /UKAS report on the provision of the Haematology, Transfusion and Immunology Laboratory Services	VCPs and QIAs completed for all vacancies. Retired staff employed on bank contracts. Trainees employed as MLAs. Bank MLAs employed to ensure all tasks that do not require registered staff are completed. Recruitment and Retention premium paid for unsocial hours. Training payment agreed for staff working hours above contract. Agency staff employed to enable experienced staff to maintain service to critical areas, supervise and train new and inexperienced staff.	Complete	Major (4)	Almost certain - Daily (5)	20		14/03/2018
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	Complete	Catastrophic (5)	Likely - Weekly (4)	20		28/02/2018

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the above controls?	Consequence	Likelihood	Score	Action / Mitigation	Review date
C1748COO	Diagnostics and Specialties, Medical, 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)	Incomplete	Major (4)	Almost Certain (5)	20	Re establish Planned care board Interim action plan to recover position	30/03/2018
C1798COO	Medical, Surgical	Safety	Chief Operating Officer	Quality and Performance Committee	The risk of delayed treatment and diagnosis due to delays in follow up care in a number of specialties including neurology, cardiology, rheumatology,ophthalmology and ENT.	Each is developing a specialty delivery plan PTL for follow up pending is in place - validation by specialities is required to provide a clear list.	Incomplete	Major (4)	Likely - Weekly (4)	16	Revise systems for reviewing patients waiting over time Assurance from specialities to complete f/u plan	30/03/2018
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	Incomplete	Major (4)	Likely - Weekly (4)	16	Escalation	30/03/2018
M2473Emer	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	CQC action plan for ED	30/04/2018

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the above controls?	Consequence	Likelihood	Score	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 11. Implementation of Bank / agency block bookings / long lines of work to locations of high vacancy and or Mat Leave	Complete	Moderate (3)	Almost certain - Daily (5)	15	Monitoring at Workforce Committee Establish Quality Impact Assessment for project Overseas recruitment programme	03/04/2018
F2623	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Director of Financee	Finance Committee	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 resulting in extension of Financial Special Measures and increased regulatory action	Regular NHSI FSM meetings Monthly monitoring, forecasting and reporting of performance against budget by finance business partners PMO in place to record and monitor the FY18 programme (including monitoring and reporting of performance against target) Turnaround Implementation Board scrutiny of delivery 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. Monthly executive reviews Smartcare Programme Board overseeing Trak recovery and regular monitoring and analysis of data completeness (and quality) and income recovery	Complete	Catastrophic (5)	Possible - Monthly (3)	15		30/03/2018

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the above controls?	Consequence	Likelihood	Score	Action / Mitigation	Review date
S2595Th	Estates and Facilities, Surgical	Safety		Divisional Board, Infection Control Committee, Quality and Performance Committee, Trust Decontamination Group	The risk of harm to patients due to correct and sterile equipment not being available from CSSD	Heavy contaminated sets go through pre clean All sets go through washer disinfectors All machines have valid testing certificates Internal non conformist reports Bioburden testing Quarterly testing on clean room (external) Checks in CSSD prior to dispatch Extra integrity check for heavier sets External audit of full process of decontamination Corner protectors and tray liners used on both sites Point protectors used on both sites Transportation trays removal of 3rd wrap on sets Dryness tests of sutoclaves Quality management systems - accredited ISO13485 reusable medical devices	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Commission external company to review operational processes Introduce new method of wrapping sets to prevent holes Review education process in CSSD Estates review of lighting in CSSD both sites provide break down of torn wrap percentages for Trust recruitment to vacancies in CSSD standard operating procedure for checking of sets additional trials of different wraps capital bid for washer disinfectors and autoclaves Review of theatre equipment and standardisation implement the action plan from external audit trial of metal containers to avoid use of tray wrap staff engagement event External company to review production pathway	31/01/2018
C2614NIC	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality & Chief Nurse	Infection Control Committee, 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.	Complete	Moderate (3)	Likely - Weekly (4)	12	Create business case for new IC Net system	22/12/2017
C2628COO	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Operating Officer	Quality and Performance Committee	The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times. The risk on non-reporting of RTT (incomplete) standards.			Moderate (3)	Likely - Weekly (4)	12		30/03/2018

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the above controls?	Consequence	Likelihood	Score	Action / Mitigation	Review date
C1945NTVN	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality/ Chief Nurse	Quality and Performance Committee	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Nursing pathway documentation and training in place Pressure Ulcer expert committee reviewing practice and incidents to identify learning Monitoring through incident investigation\RCA Divisional committees overseeing RCAs Safety Thermometer data review as part of Safer Staffing	Incomplete	Moderate (3)	Likely - Weekly (4)	12	To create a rolling action plan to reduce pressure ulcers	22/12/2017
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	Complete	Major (4)	Possible - Monthly (3)	12	Deliver the agreed action fractured neck of femur action plan	23/05/2018
Consequence catastrophic												
S2568Anaes	Surgical	Safety		Divisional Board	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	Application to MEF Prioritisation of operations Maintenance by own medical engineering service loan request	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5	Request for 5 x Induction machines and 5 x anaesthetic machines Ensure risk raised to all surgical board meetings To request further equipment replacement before end of September 2017 to ensure all oldest machines are replaced. List of machine to be replaced on that action to be drawn up. E-mail to medical engineering to obtain that list.	30/04/2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Financial Performance Report - Period to 31st January 2018
Sponsor and Author(s)
Author: 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 10 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 10 of the 2017/18 financial year is an operational deficit of £29.5m. This is an adverse variance to budget and NHSI Plan of £6.5m.

- 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 10 is £20.4m. This is £5.4m worse than the plan for the year to date.

- The current CIP delivery forecast for the year is £28.2m as compared to a £34.7m plan.

- The forecast outturn is £28.7m which is £14.1m adverse to plan. This is a £0.9m deterioration from the previous forecast outturn, which relates to the crystallisation of an existing income risk relating to specialist commissioning.

Conclusions

- The financial position for Month 10 shows an adverse variance to budget of £6.5m. 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 continued need for increased focus on financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trak.

Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.

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

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 31st January 2018

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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.

Statement of Comprehensive Income

2016/17 Outturn £000s	Month 10 Financial Position	Annual Budget £000s	M10 Cumulative Budget £000s	M10 Cumulative Actuals £000s	M10 Cumulative Variance £000s
433,665	SLA & Commissioning Income	439,649	363,904	356,402	(7,502)
4,604	PP, Overseas and RTA Income	4,734	3,904	3,924	20
66,388	Operating Income	62,270	51,921	52,930	1,009
504,657	**Total Income**	**506,653**	**419,729**	**413,256**	**(6,473)**
329,809	Pay	335,777	282,505	277,864	4,641
174,906	Non-Pay	160,607	139,374	146,457	(7,083)
504,716	**Total Expenditure**	**496,384**	**421,879**	**424,321**	**(2,442)**
(59)	**EBITDA**	**10,269**	**(2,150)**	**(11,064)**	**(8,914)**
(0.0%)	**EBITDA %age**	**2.0%**	**(0.5%)**	**(2.7%)**	**(2.1%)**
21,135	Non-Operating Costs	24,885	20,779	18,386	2,393
(21,193)	**Surplus/(Deficit)**	**(14,616)**	**(22,929)**	**(29,450)**	**(6,521)**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,616)**	**(22,929)**	**(29,450)**	**(6,521)**

In January the Trust has delivered an in-month deficit of £1.3m and a cumulative deficit of £29.5m

This represents a year to date adverse variance to plan of £6.5m as at Month 10.

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 £1.5m. This is addressed in further detail on pages 2 to 4 of this report.

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Detailed Income & Expenditure

Annual Budget £000s	Month 10 Financial Position	M10 Cumulative Budget £000s	M10 Cumulative Actuals £000s	M10 Cumulative Variance £000s
439,649	SLA & Commissioning Income	363,904	356,402	(7,502)
4,734	PP, Overseas and RTA Income	3,904	3,924	20
62,280	Operating Income	51,921	52,930	1,009
506,663	**Total Income**	**419,729**	**413,256**	**(6,473)**
	Pay			
312,180	Substantive	262,127	255,843	6,284
6,551	Bank	5,776	8,063	(2,287)
17,049	Agency	14,602	13,958	644
335,780	**Total Pay**	**282,505**	**277,864**	**4,641**
	Non Pay			
55,539	Drugs	46,808	51,376	(4,568)
40,159	Clinical Supplies	34,016	34,633	(616)
64,916	Other Non-Pay	58,549	60,448	(1,899)
160,614	**Total Non Pay**	**139,374**	**146,457**	**(7,083)**
496,394	**Total Expenditure**	**421,879**	**424,321**	**(2,442)**
10,269	**EBITDA**	**(2,150)**	**(11,064)**	**(8,914)**
2.0%	**EBITDA %age**	**(0.5%)**	**(2.7%)**	**(2.1%)**
24,885	Non-Operating Costs	20,779	18,386	2,393
(14,616)	Surplus/(Deficit)	(22,929)	(29,450)	(6,521)
	STF Funding			
(14,616)	Surplus/(Deficit)	(22,929)	(29,450)	(6,521)

The table opposite shows the detailed income and expenditure position.

SLA and Commissioning Income – a £7.5m 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. Within this there is £1.5m over performance on pass-through income, resulting in an underlying under-performance on non-passthrough income of £6.0m. Pass-through drugs is £2.5m favourable, whereas devices are £1.0m adverse. Most of the underperformance on devices relates to ICDs moving to the zero-cost model.

Private Patient Income – continues to be on track.

Pay – expenditure is showing a favourable variance of £4.6m 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 remains close to the peak level of £4.9m in month 7.

Non-Pay – Drugs expenditure is showing a £4.6m adverse variance (£2.1m excluding passthrough) whilst Clinical Supplies are £0.6m adverse (£1.6m excluding passthrough). Use of Glanso represents £0.7m of this variance. Other non-pay is £1.2m 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.

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Cost Improvement Programme

At Month 10 we have delivered £20.4m* against the NHS Improvement plan target of £22.3m and the Trusts own target of £25.8m which is an under achievement of £5.4m against the trust plan.

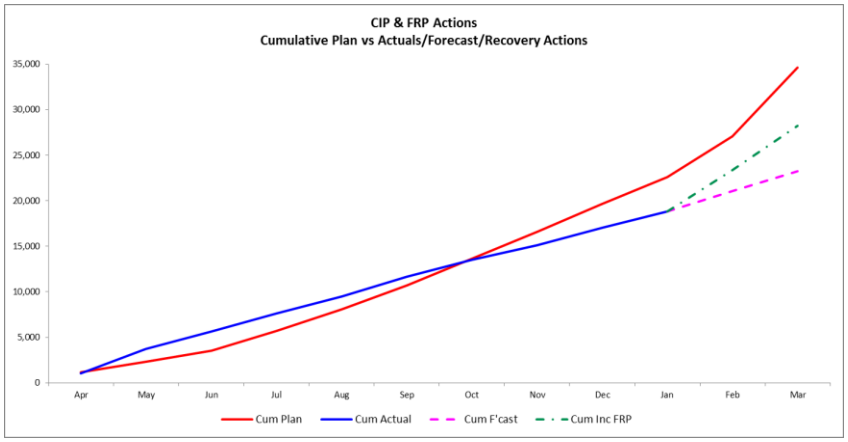
At Month 10, the divisional year end forecast figures indicate confidence in delivering £28.2m* against the Trust's target of £34.7m. The month 9 FOT was £28.1m, reflecting an increase of £0.1m.

Performance on the FRP has deteriorated by £0.1m in month along with other forecast cost pressures, the key areas are:

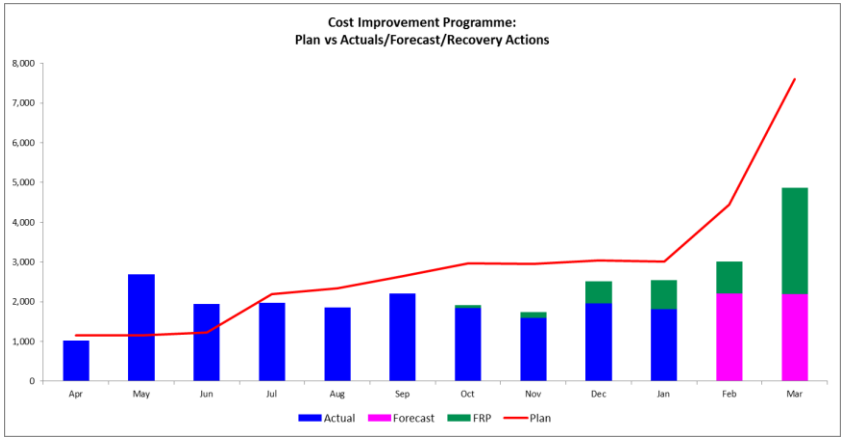
- Drugs expenditure has increased by £0.5m net of pass through income in month.
- MSE cost pressures net of pass through income have fallen by £0.1m in month.
- Glanso costs have increased by £0.1m in month.

The CIP FOT of £28.2m splits into £21.3m of recurrent schemes and £6.9m of non-recurrent schemes. This leaves a shortfall for 18/19 of £13.4m. The non-recurrent schemes include an agency scheme (no non-clinical agency over Christmas), annual leave accrual scheme and some vacancy factor.

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



* This includes £6m recovery actions

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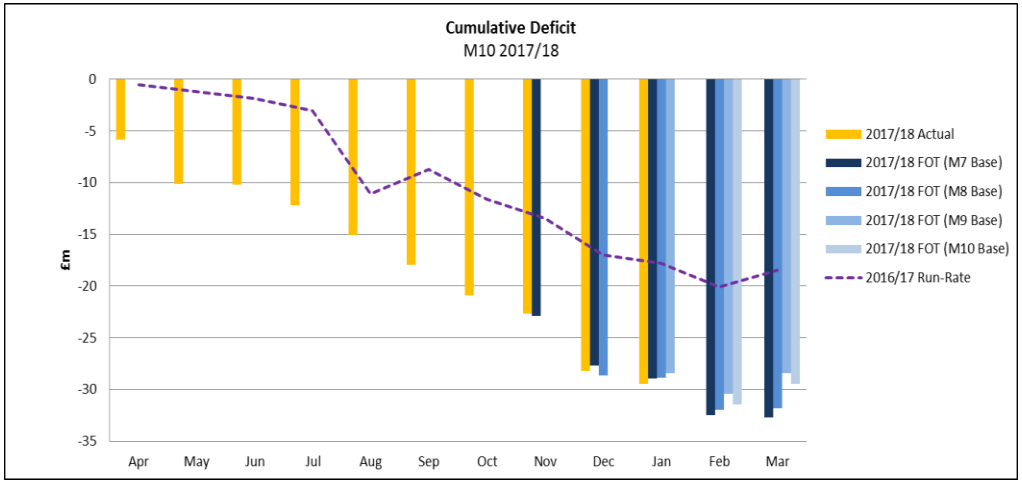
Forecast Position

2017/18 Forecast	2017/18 Budget £000s	2017/18 Forecast £000s	Variance £000s
SLA & Commissioning Income	439,649	433,179	(6,470)
PP, Overseas and RTA Income	4,734	4,762	28
Operating Income	62,306	64,063	1,757
Total Income	**506,689**	**502,004**	**(4,685)**
Pay	335,777	334,227	(1,549)
Non Pay	160,622	176,090	15,467
Total Expenditure	**496,399**	**510,317**	**13,918**
EBITDA	**10,290**	**(8,313)**	**(18,603)**
EBITDA %	**2.0%**	**(1.7%)**	**(3.7%)**
Non Operating Costs	24,921	20,340	4,581
Surplus/(Deficit)	**(14,631)**	**(28,653)**	**(14,022)**



The Trust's forecast outturn for 2017/18 after month 10 is a deficit of £28.7m against the budget of £14.6m. This is £14.0m adverse, and a deterioration of £0.9m on last month.

The main drivers of the deterioration are:

- £0.9m specialist commissioning risk crystallising
- £0.6m pay increase (half relating to AMU/USC)
- £0.5m non-passthrough drugs increase
- £0.3m recognition of internal funds
- £0.1m continued increase in use of Glanso

These are partly offset by:

- £0.2m additional winter pressures funding
- £0.2m underlying income improvement
- £0.2m improvement to RTA bad debt provision
- £0.1m lower MSE costs across the trust
- Further CIPS/cost pressure reductions of £0.8m

The chart shows the cumulative deficit as it builds up each month and compares actuals (amber) and forecast (blue) against prior year actuals (purple dotted line).

Forecasts are updated each month. These show how the forecast profile is refined month on month. The oldest forecast (M7) is shown in dark blue with lighter colours reflecting the more recent forecasts.

The Trust is now forecasting a surplus in M12 of just under £2.5m. This is driven by back-ended CQUIN from GCCG (£1.4m) and a proportion of the anticipated receipt of winter pressures funding (£1.7m) as well as typically being a high activity month.

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Forecast Position – Sensitivity Analysis

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Our current assessment of risks and mitigations indicate our forecast deficit is likely to be between £28.7 and £33.2m. The realistic stretch includes an offer that the Trust has made in respect of Specialist Commissioning which worsens the forecast by £0.9m but if accepted by NSHE will remove £1.1m of further risk from the worst case, bringing it to £32.1m.

	Upside	Realistic Stretch	Downside	Comments
Plan	**(14.6)**	**(14.6)**	**(14.6)**	
Month 6 divisional forecast	**(27.9)**	**(27.9)**	**(27.9)**	
Additional CIP & further measures assumed	6.0	6.0	4.1	
Deployment of CCG NR funding to GHFT	8.0			
Income recovery/blocking lower then forecast	(0.7)	(2.0)	(2.0)	
Winter pressures			0.0	
Month 6 forecast to Board	**(14.6)**	**(23.9)**	**(25.8)**	
Income risk recognised	(2.8)	(2.0)	(2.0)	
CQUIN - system risk reserve			(2.0)	Further NHSI guidance saying system risk reserve CQUINs should NOT be assumed by trusts not achieving their 16/17 control total. Need to consider including this loss in the realistic stretch forecast
Updated Month 6 forecast to NHSI in November meeting	**(17.4)**	**(25.8)**	**(29.7)**	
Movements - as per divisional forecasts for Month 7:				
£1.9m identified against £6m target	(4.1)	(4.1)	(2.2)	Total CIP and other cost reductions identified £1.9m
Cost pressures	(2.9)	(2.9)	(2.9)	
Total movement	**(6.9)**	**(6.9)**	**(5.0)**	
Month 7 divisional forecast	**(24.3)**	**(32.7)**	**(34.7)**	
Further CIP forecast to Month 8 against £6m target	1.6	1.6	1.6	Made up of £1.3m MEA and £0.2m other CIPs
Cost pressure improvement to Month 8	0.4	0.4	0.4	Takes cumulative CIP and other gains against £6m target to £3.9m
Month 8 divisional forecast	**(22.3)**	**(30.7)**	**(32.8)**	
Balance to £5m against £6m target -identified in M9	1.5	1.5	1.5	Takes cumulative CIP and other gains against £6m target to £5.4m.
Further CIPs or reduction of cost pressures	0.6	0.6	0.6	Takes cumulative CIP and other gains against £6m target to £6.0m
Winter pressures funding - tranche 1	1.2	1.2	1.2	Assumed to benefit bottom line but this is a risk given January Winter pressures on staffing costs
SubCo Set Up costs	(0.4)	(0.4)	(0.5)	Increase in net costs of implementing SubCo as company will not now be able to start in 2017/18. Previous matching savings assumed from ppre 1/4/18 start
Remove assumed blocking gain from South Worcs/Wales			(0.4)	South Worcs CCG insisting on full contract mechanisms including flex & freeze etc. £0.4m is impact of no block but flex and freeze set aside.
Failure to agree extension of spec comm block to M7-12			(2.0)	Spec comm block proposal does not recognise Trak issues, would give c£3m downside and is unacceptable to the Trust. £2.0m downside is estimated impact of variable contract M7-12 with no flex and freeze
Month 8 forecast	**(19.4)**	**(27.8)**	**(32.4)**	
Additional CIPS and reduction in cost pressures	0.0	0.0	0.0	£1.5m CIPS forecast but not fully identfied in M8 now firmly forecast at M9. £0.6m remains not fully identfied
MSE, Glanso and other minor cost pressures	(0.8)	(0.8)	(0.8)	These two Month 9 movements to the forecast are neutral taken together
Catch up in passthrough drugs income	0.8	0.8	0.8	
Month 9 forecast	**(19.4)**	**(27.8)**	**(32.4)**	
Cost pressure deterioration in M10	(1.3)	(1.3)	(1.3)	Incl. £0.6m pay, £0.5m drugs, £0.1m Glanso
Partially offest by income improvements in M10	0.5	0.5	0.5	Incl. £0.3m addtl Winter Pressures, £0.2m underlying activity improvement
Month 10 divisional forecast	**(20.2)**	**(28.6)**	**(33.2)**	
Additional CIPS and reduction in cost pressures	0.8	0.8		£0.8m of savings remain unidentified, but action is being agreed by Execs.
Month 10 underlying forecast	**(19.4)**	**(27.8)**	**(33.2)**	
Materialisation of SpecComm risk	(0.9)	(0.9)		Reflecting an offer which the trust has made to NHSE to attempt to reach resolution on the 17/18 income
Month 10 forecast	**(20.3)**	**(28.7)**	**(33.2)**	
Variance to plan	*(5.7)*	*(14.1)*	*(18.6)*	

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Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M10 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	8,643	1,250
Property, Plant and Equipment	296,272	294,747	(1,525)
Trade and Other Receivables	4,668	4,445	(223)
Total Non-Current Assets	**308,333**	**307,835**	**(498)**
Current Assets			
Inventories	7,400	7,545	145
Trade and Other Receivables	17,697	20,421	2,724
Cash and Cash Equivalents	7,974	3,441	(4,533)
Total Current Assets	**33,071**	**31,407**	**(1,664)**
Current Liabilities			
Trade and Other Payables	(44,355)	(47,880)	(3,525)
Other Liabilities	(2,089)	(2,006)	83
Borrowings	(5,356)	(5,355)	1
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(55,423)**	**(3,441)**
Net Current Assets	**(18,911)**	**(24,016)**	**(5,105)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,298)	314
Borrowings	(83,126)	(106,429)	(23,303)
Provisions	(1,524)	(1,462)	62
Total Non-Current Liabilities	**(92,262)**	**(115,189)**	**(22,927)**
Total Assets Employed	**197,160**	**168,630**	**(28,530)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	167,439	920
Reserves	70,501	70,501	0
Retained Earnings	(39,860)	(69,310)	(29,450)
Total Taxpayers' Equity	**197,160**	**168,630**	**(28,530)**

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The table shows the M9 balance sheet and movements from the 2016/17 closing balance sheet, supporting narrative is on the following page

Balance Sheet (2)

Gloucestershire Hospitals NHS
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Commentary below reflects the Month 10 balance sheet position against the 2016/17 outturn

Non-Current Assets

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

Current Assets

- Inventories show a decrease of under £0.2m.
- Trade receivables are £2.7m above their closing March 2017 level.
- Cash has reduced by £4.5m since the year-end, and increased by £1.3m in month.

Current Liabilities

- Trade payables have increased by £3.5m over the closing March level (a £2.3m decrease on the month 9 level).
- Other liabilities have decreased by £0.1m since year end.

Non-Current Liabilities

- Borrowings have increased by £23.3m. A further £4.3m of distress financing to fund deficit support was drawn down in December bringing the total of drawn down distress and capital funding and additional PDC to £27.8m. Total distress funding drawn to date is £25.8m, capital funding is £1m and additional PDC is 0.9m. The balance in the Trust's required funding is being financed by improvement in working capital (combination of working capital available from GP training, income over and above I&E balances and creditor/accruals balances). We are forecasting that our distress financing will need to be at least equal to the I&E deficit before taking account of the capital loan before the end of year.

Reserves

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

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Cashflow : January

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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	Dec-17 £000s	Jan-18 £000s
Surplus (Deficit) from Operations	**(4,958)**	**(3,284)**	**935**	**(1,031)**	**(1,940)**	**(1,953)**	**(1,955)**	**(783)**	**(4,591)**	**(327)**
Adjust for non-cash items:										
Depreciation	946	1,719	975	975	975	975	975	975	975	975
Impairments within operating result	0	0	0	0	0	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0	0	0	0	0	0
Provisions	0	0	0	0	0	0	0	0	0	0
Other operating non-cash	(58)	(59)	(58)	(58)	(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**	**(3,674)**	**590**
Working capital movements:										
(Inc.)/dec. in inventories	(150)	(1,118)	349	192	367	132	68	0	344	(371)
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(157)	633	379	1,940	(1,849)	(508)	877	(1,163)
(Inc.)/dec. in current assets	0	0	0	0	0	0	0	0	0	0
Inc./(dec.) in current provisions	0	0	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)	1,343	(5,806)
Inc./(dec.) in other financial liabilities	(562)	3,448	(58)	(181)	(129)	153	21	0	0	0
Other movements in operating cash flows	835	(995)	32	(31)	32	(79)	206	32	32	32
Net cash in/(out) from working capital	**(13)**	**2,863**	**(1,943)**	**83**	**1,163**	**(986)**	**1,147**	**(2,813)**	**2,596**	**(7,308)**
Capital investment:										
Capital expenditure	(148)	(989)	(348)	(214)	(909)	(608)	(1,636)	(1,365)	(1,759)	(515)
Capital receipts	0	0	0	0	0	0	0	0	0	0
Net cash in/(out) from investment	**(148)**	**(989)**	**(348)**	**(214)**	**(909)**	**(608)**	**(1,636)**	**(1,365)**	**(1,759)**	**(515)**
Funding and debt:										
PDC Received	0	0	0	0	0	0	0	0	0	920
Interest Received	4	3	2	3	3	3	2	3	3	3
Interest Paid	0	(162)	(42)	0	0	(1,329)	(29)	(163)	0	(87)
DH loans - received	0	0	0	2,355	0	8,864	1,664	3,452	4,321	6,233
DH loans - repaid	0	0	0	0	0	(1,318)	0	0	0	0
Other loans	0	0	0	0	0		0	0	0	0
Finance lease capital	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)
PFI/LIFT etc capital	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)
PDC Dividend paid	0	0	0	0	0	(3,091)	0	0	0	0
Other	0	0	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**	**4,123**	**6,868**
Net cash in/(out)	**(4,428)**	**(110)**	**(680)**	**1,912**	**(967)**	**298**	**(91)**	**(953)**	**1,286**	**(365)**
Cash at Bank - Opening	**7,974**	**3,546**	**3,436**	**2,756**	**4,668**	**3,701**	**3,999**	**3,908**	**2,955**	**4,241**
Closing	**3,546**	**3,436**	**2,756**	**4,668**	**3,701**	**3,999**	**3,908**	**2,955**	**4,241**	**3,876**

The cashflow for January 2018 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 timing.

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

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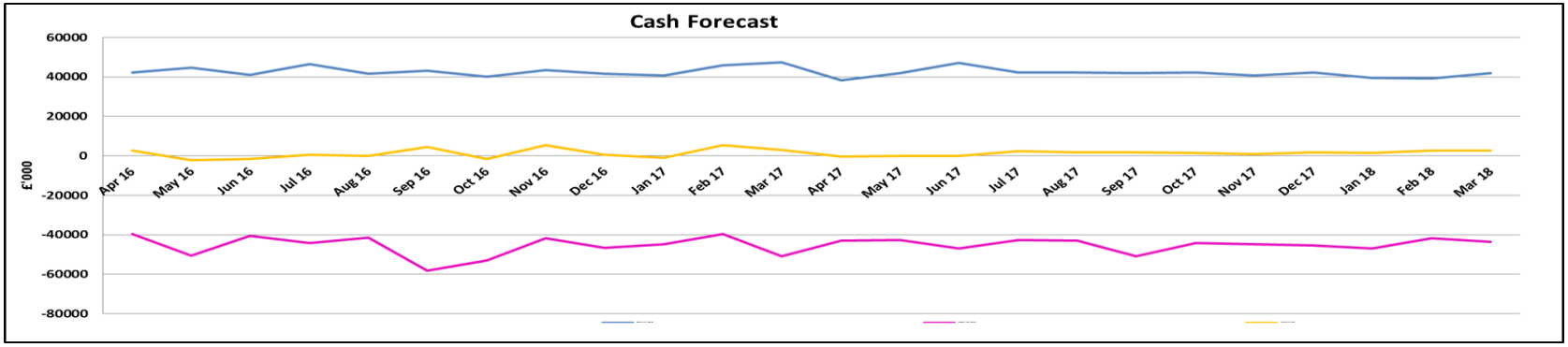
Short Term Cashflow Forecast

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
Opening Balance	**7,979**	**5,340**	**11,637**	**7,974**	**3,423**	**2,565**	**2,614**	**4,494**	**3,773**	**3,702**	**3,473**	**2,790**	**3,806**	**3,441**	**4,490**	**4,635**	**5,003**
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	34,773	34,277	34,097	34,098	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	4,534	4,974	3,499	3,433	3,389	4,780	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	1,073	1,238	1,329	895	3,860	1,200	1,260
VAT	646	408	1,135	0	805	607	618	535	875	378	586	1,242	334	634	500	550	550
Funding	1,506	3	3	4	3	3	2,358	3	8,867	1,667	3,455	4,328	7,159	3,917	2,000	3	3
Total Receipts	**42,112**	**45,834**	**47,448**	**38,226**	**41,786**	**47,138**	**44,627**	**42,318**	**50,765**	**43,927**	**44,134**	**46,555**	**46,598**	**42,975**	**43,847**	**41,713**	**41,823**
Payments																	
Payroll	(25,455)	(25,792)	(26,193)	(25,926)	(27,000)	(26,541)	(26,807)	(26,692)	(27,248)	(27,862)	(27,520)	(26,866)	(27,357)	(29,802)	(29,488)	(25,875)	(25,875)
Payables	(16,159)	(13,226)	(18,447)	(14,699)	(13,374)	(18,020)	(13,304)	(13,812)	(15,404)	(13,207)	(14,619)	(15,833)	(17,213)	(11,605)	(9,836)	(13,230)	(12,032)
Other payables	(1,542)	(520)	(1,133)	(633)	(365)	(784)	(848)	(793)	(858)	(1,344)	(772)	(1,096)	(561)	(520)	(500)	(400)	(500)
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	(1,811)	(1,811)
Loan & Interest	0	0	(5,337)	0	(162)	0	(45)	0	(5,582)	0	(163)	0	(87)	0	(3,877)	(29)	(218)
Funding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**(44,751)**	**(39,537)**	**(51,111)**	**(43,001)**	**(42,645)**	**(47,089)**	**(42,747)**	**(43,040)**	**(50,835)**	**(44,156)**	**(44,817)**	**(45,538)**	**(46,963)**	**(41,926)**	**(43,702)**	**(41,346)**	**(40,436)**
Net Cashflow	**(2,639)**	**6,297**	**(3,663)**	**(4,776)**	**(859)**	**49**	**1,880**	**(722)**	**(70)**	**(229)**	**(683)**	**1,016**	**(365)**	**1,049**	**145**	**368**	**1,388**
Closing Balance	**5,340**	**11,637**	**7,974**	**3,423**	**2,565**	**2,614**	**4,494**	**3,773**	**3,702**	**3,473**	**2,790**	**3,806**	**3,441**	**4,490**	**4,635**	**5,003**	**6,391**
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)
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)
'Available' Balance	**(1,068)**	**5,229**	**2,791**	**(485)**	**(49)**	**(0)**	**2,420**	**1,771**	**1,773**	**1,544**	**861**	**1,877**	**1,512**	**2,561**	**2,706**	**3,074**	**4,461**



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.

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NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover	(0.16)	(0.79)
Metric		
Rating	4	4
Liquidity	(22.28)	(22.76)
Metric		
Rating	4	4
I&E Margin	(5.52%)	(7.03%)
Metric		
Rating	4	4
I&E Variance from Plan		(1.51%)
Metric		
Rating		3
Agency	44.88%	37.65%
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 M10, which is in line with Plan, and continues to show performance at a "4".

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Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The financial position of the Trust at the end of Month 10 of the 2017/18 financial year is an operational deficit of £29.5m. This is a adverse variance to budget and NHSI Plan of £6.5m.
- The variance is reflective of both year to date pay underspends and phasing adjustments within the income position.
- The divisional Month 10 forecast is for a £28.7m deficit outturn assuming delivery of the FRP actions agreed through the weekly deep dives. This is a deterioration £0.9m on last month, relating to crystallisation of income risk relating to specialist commissioners.
- This forecast will be reported to NHSI through the usual monthly FSM meetings.

Author: **Tom Niedrum, Associate Director of Financial Management**

Presenting Director: **Steve Webster, Director of Finance**

Date: **February 2018**

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REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Finance Committee held 31st January 2018, 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	The cumulative deficit to Month 9 is £28.2m. This is £6.4m adverse to plan, but is broadly in line with the profile of the £27.8m year end forecast deficit submitted to NHSI earlier in January.	How confident are we regarding the further £0.6m CIPs required but not yet firmed up?	The Financial Director stated that there a number of opportunities to achieve the further reduction, and there is a reasonable basis for the forecast outturn, but that position remains very tight and there is a degree of risk to the forecast.	Residual risk around achievement of forecast, excluding income downsides declared to NHSI, but considered to be small.
		Is the forecasted improved financial position over Q4 robust?	Other than the residual further CIPs required as noted above, the rest of the improvement in Q4 is based on normal seasonal trends and known factors such as the Winter Pressures funding, as so it is robust.	Downside income risks remain and are likely to crystallise to some extent, but NHSI recognise this is outside the Trust's control.
		Why do the cash balances shown on the short term cash flow forecast and on the balance sheet not match exactly.	The Finance Director agreed to review this. Post meeting note – these small differences should not be there and this will be addressed in future month's reports.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Regulatory Review Update	The recent correspondence indicating that the control totals notified in 2016 would continue to apply in 2018/19. This is extremely disappointing as significant STF funding is linked to this.	What action can the Trust take?	The Chief Executive is continuing to engage with NHSI on this, but it is unlikely to change.	
Capital Programme Update	The balance of the capital plan is now being committed given confirmation of the £5m capital loan.	How can the Committee be assured that risk was being managed correctly?	Urgent requests are considered when necessary, sometimes out of committee when particularly urgent, and £300k contingency remains. But the prioritisation of larger items of expenditure is also important, such as major theatre investment and replacement of aging IT equipment. The capital budget setting process will be reported to the February Finance Committee.	The limited capital funding ability of the Trust will make capital prioritisation decisions and capital budget setting in 2018/19 very challenging.
Agency Update	All contracted nurse agency suppliers have signed up to new charge caps, and the Trust has requested breakdowns of charges between nurse pay and commission elements.			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Cost Improvement Programme Update (CIP)	Core CIPs forecasted remain stable at £23.1m, and further CIPs against the £6m target are now forecast at £5.1m. This is a significant improvement on the previous month, which largely relates to the MEA revaluation.			
Medical Productivity Update	A new approach to medical productivity was agreed, which has sign up from Specialty Directors. This focuses on improving medical productivity from direct clinical sessions (DCCs).	Is medical productivity the correct term for what is proposed? How can we monitor improvement against the broader programme proposed?	The approach is broader than just "medical productivity" but there is a major contribution of medical staff to it. The "term" for it will be given further consideration. The key is additional activity and income for the same cost or reduced cost for the same activity.	
NHS Improvement Financial Special Measures Undertakings - **Financial Governance Review Action Plan**	The Committee agreed that it has sufficient assurance to recommend to NHSI that the Trust believes it has discharged the undertakings in the Enforcement Notice.			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Asset Revaluation	The Committee noted the asset revaluation exercise that the Trust has conducted, with resulting dividend savings of £1.67m per annum.	Does this mean that an aspect of the future dividend payments, reflecting efficiencies in site configuration, is now already committed and fixed as a contribution to CIPs?	Yes, this does fix and important aspect of future dividend payments.	
Recovery - 2018/19 Developing Financial Plan Bridged from the 2016/17 Outturn	The bridges set out • The key impact Trak has had on 17/18 financial performance • A high level top down financial plan for 2018/19 which delivers a deficit of £22.4m before any STF funding	What are the key dependencies in the 2018/19 top down plan? Is the high level plan understood by Executives and the leadership team?	The key dependencies for achievement of the £22.4m deficit in 2018/19 in the bridge analysis are:- • CIPs equivalent to that projected to be delivered in 2017/18(£28.7m) • Trak recovery of counting and coding and of real activity, to the value of £10.6m • Additional funding from commissioners to address Trust proposed tariff changes(£7.8m) Yes, the key elements of the factors driving the Trust financial performance in 2017/18 and the high level developing plan for 2018/19 and the assumptions behind it are understood by the senior leadership team.	A number of aspects of the plan need to be further tested through engagement with commissioners and through internal budget setting and CIP development.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
2018/19 Budget Setting Process	The proposed budget setting process for 2018/19 was noted, with key principles being ownership by divisions and appropriate linkages and consistency between income and expenditure budgets.	What is the level of confidence around successful application of the process.	Time has been lost due to the additional focus on 2017/18 financial improvement (the £6m target), but a real focus will now be given to budget setting.	
Board Assurance Framework	The Finance Committee is the owner of three of the strategic objectives in the Board Assurance Framework. These will be reviewed quarterly.			
Risk Register	No changes since last meeting.	The wording of Fin 7 was challenged – as it doesn't express the risk to delivery.	Fin 7 will be re-worded to reflect delivery risk.	
Any Other Business **- Business Rates Deed** **- Stephen Hay Letters**	A deed confirming that the Trust will participate in the rates relief claim was agreed to be sealed.			

REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Finance Committee held 28th February 2018, 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	Year to date deficit is £29.4m, a deficit against plan of £6.5m. The trend of recent pay expenditure reductions ended, partly due to January activity and partly due to December bank holiday enhancements paid in February. Year end forecast worsened by £0.9m to £28.7m due to crystallisation of existing specialist commissioning income risk outside Trust control. Further income risks may come into the forecast next month The non-income aspects of the forecast remain with a degree of risk.	How will NHSI see the income deterioration? What are the further income risks? What is the quantum of potential risk to the element of the forecast wholly within Trust control?	The risk has been extensively flagged and we do not believe it will be seen as a deterioration in the financial performance of the Trust. The risks around system CQUINS (£2m) and Worcestershire CCG (£0.4m), and the residual further specialist commissioning risk. The value of this risk is considered to be relatively small (the sensitivity analysis in the report indicates £0.8m).	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Regulatory Review Update	NHSI remains positive about the potential for the Trust to exit Financial Special Measures.			
Capital Programme Update	An underspend of £0.9m is projected, reflecting draw down of funding for the GP Streaming scheme at CGH, for which the vast bulk of spending will fall into 2018/19.			
Capital Expenditure Budget Setting 2018/19	The budget setting process was described, together with an outline of the range of scenarios being considered. These range from total expenditure of c £11m to c £18m, with NHS capital loan requirements of between £2m and £9m.	What are the trade-offs that will have to be made? Is £1m enough for enabling key service changes?	Key trade-offs are between the requirement for greater investment in IT than previous years (£6.1m proposed), backlog maintenance schemes(particularly the Apollo theatre scheme - £1.9m), equipment replacement, and enabling service change(£1m). It will not be sufficient to meet all requirements, but it is a manageable sum given the circumstances.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
CGH ED GP Streaming Proposal	Approval was sought to go to tender to seek firm values for the GP streaming scheme at CGH within the available NHSE funding of £920k. This will go to Trust Board for final approval.			
Cost Improvement Programme Update (CIP)	Total forecast CIPs have increased by £0.1m to £28.2m. CIPs provisionally identified for 2018/19 total £15.6m against the £28.6m draft plan expectation. There have been a number of reasons for a slow start to 2018/29 CIP development but this is progressing more strongly now.	What level of risk is there to the achievement of £28.6m CIPs in 2018/19?	The risk is such that the target is likely to have to be reduced, and the planned deficit increased commensurately.	The need to consider an amendment to the CIP target, and to the draft financial plan for 2018/19
Medical Productivity Update	The work being undertaken to develop the approach to medical productivity agreed at the previous Finance Committee was outlined.	The need to ensure the same level of focus on medical productivity as on other productivity improvement in other staff groups was emphasised.	Assurance was given on this point	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Trakcare Counting and Coding and Activity Recovery	The actions being taken to address the various areas of Trak recovery improving activity recording and delivery and income were outlined, which have ab expected impact of £10.6m in the draft financial plan.	Can assurance be given on the delivery of this level of improvement?	Insufficient assurance can be given at present. Detailed action plans are needed for each area, with timescales and responsible managers, and with tracking of the trajectory of improvement put in place.	
Matters to be Escalated to the Board	The proposed GP Streaming Capital Case.			
Governors Comments	The areas previously flagged as being of interest to governors were re-stated - particularly medical productivity and other CIP projects and overview.			

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Workforce Report
Sponsor and Author(s)
Author: Alison Koeltgen, Acting Deputy Director of People & OD 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 key performance indicators and outlines progress against the short term strategic objectives as identified in November 2017.

Key issues to note

Further **reductions in turnover** taken the Trust rolling total to 11.88%. This is **closer to the target of 11%,** this goes against typical trends experienced at this time of year.

The Trust **annual sickness absence rate** of 3.93% remains **significantly lower than the national average for Large Acute Trusts (4.57% to Nov 17).** Despite the usual increase in winter sickness absence, reported levels remain below those experienced in previous years.

Appraisal compliance deteriorated in January, with EFD being the only division to achieve compliance above the 90% Trust target. This is largely expected due to seasonal pressures and will be considered as part of the talent management system development.

Mandatory training figures suffered similar deterioration, however it is noted that this is largely due to a requirement to refresh safeguarding training for all employees, therefore we expect to see this improve again in coming months.

6-12 month priorities: Progress is noted within the report against all of the projects identified in November 2017 to the Main Board and Workforce Committee these include:

- Establishment realignment
- CIP Delivery
- Talent Management System Development
- Staff Health and Wellbeing
- Staff Engagement

The development of the Subco proposals has been excluded from this summary due to the extraordinary Trust Board meeting being held at the time of writing this paper.

Conclusions

Performance against both Sickness Absence and Turnover targets is promising, reflecting a more positive position compared to previous years. Appraisal compliance is of concern and is being considered as we develop a revised talent management process. Whilst mandatory training compliance has declined, we understand this dip in performance to be temporary due to a safeguarding training requirement in month.

Implications and Future Action Required

Full Staff Survey results will be discussed at TLT 7th March 2018.
Update on key projects to next Trust Board and Workforce Committee.

Recommendations

The Trust Board is asked to NOTE performance against our key indicators and the progress made against our 6-12 month priorities.

Impact Upon Strategic Objectives

- Supporting Financial Recovery and Cost improvement activity
- Supporting Increased Staff Engagement, Wellbeing
- Ensuring we attract and retain a sustainable workforce

Impact Upon Corporate Risks

Ensuring staff turnover remains at an acceptable level supports the mitigation of the risk of being unable to match recruitment needs with suitably qualified staff, impacting on the delivery of the Trusts strategic objectives.

Similarly, through reduced sickness absence and turnover we reduce the demand for temporary staff in both clinical and non-clinical professions.

Regulatory and/or Legal Implications

NHSI scrutiny of agency spend and financial recovery.

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

N/A

MAIN BOARD – MARCH 2018

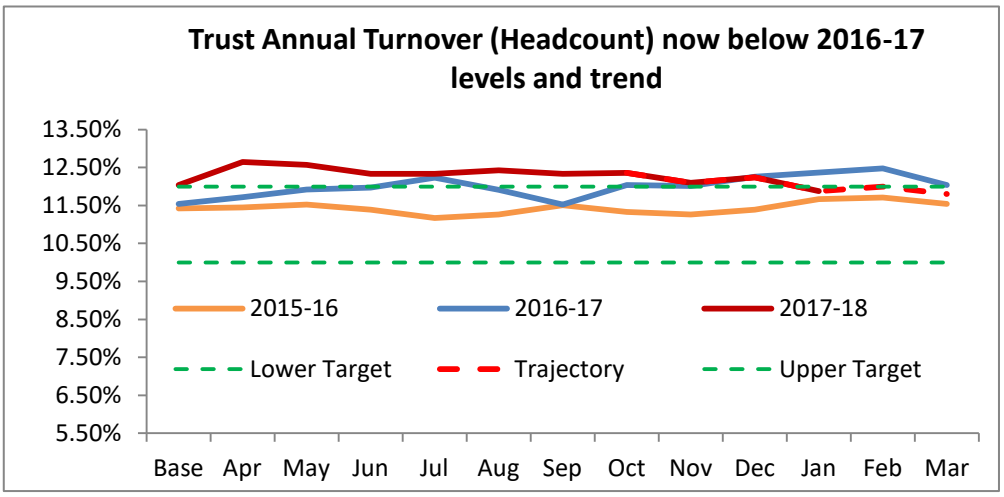
WORKFORCE REPORT

1. Aim

This report provides Trust Board with an overview of current performance, against key performance indicators and outlines progress against the short term strategic objectives as identified in November 2017 to the Workforce Committee.

2. Staff Turnover

Current performance places us at 11.88%, whilst this is above the target of 11% it falls within a range of turnover (10-12%) which we have identified as reasonable, based on benchmarking with other acute trusts. This reduction in turnover goes against previous trends, as we often see a slight increase in turnover at the beginning of the calendar year.

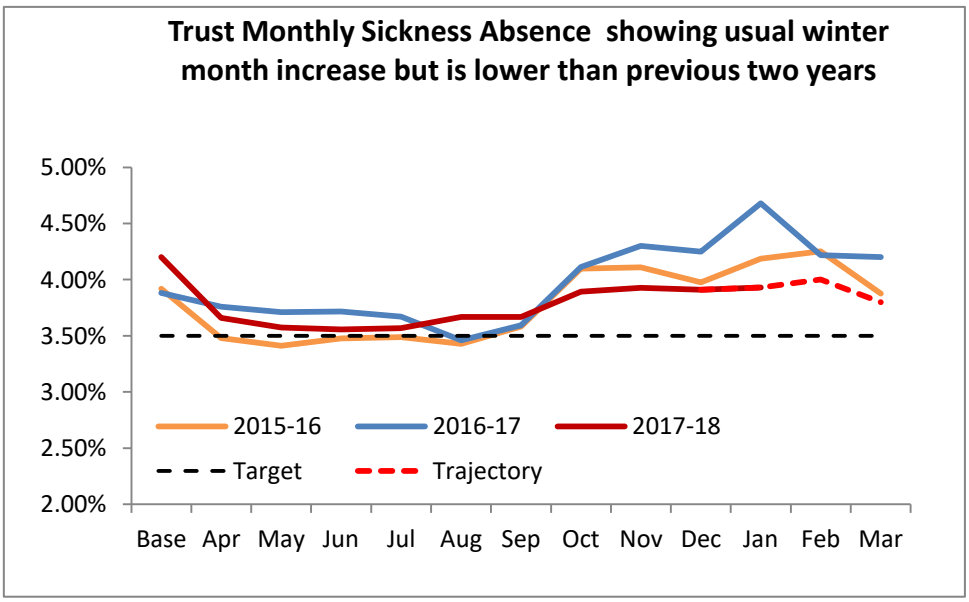


Description	Current Performance		Movement since last Month	
Turnover is measured using the total leavers (heads) as a percentage of the average headcount for the reporting period. The Trust target is 10% - 12% with the red threshold above 15% and below 6%.	12 months to 31 January 2018	**Actual % TO**		
	Trust Total	**11.88%**	↘	Decrease
	Corporate	13.77%	↘	Decrease
	Diagnostics & Specialty	11.38%	↘	Decrease
	Estates & Facilities	7.65%	↘	Decrease
	Medicine	13.25%	↘	Decrease
	Surgery	11.74%	↘	Decrease
	Womens & Children	12.36%	↘	Decrease
	Add Prof Scientific and Technic	8.71%	↗	Increase
	Additional Clinical Services	14.48%	↘	Decrease
	Administrative and Clerical	14.49%	↘	Decrease
	Allied Health Professionals	12.34%	↘	Decrease
	Estates and Ancillary	8.80%	↘	Decrease
	Healthcare Scientists	10.70%	↗	Increase
	Medical and Dental	5.87%	↘	Decrease
	Nursing and Midwifery Registered	10.89%	↘	Decrease
	Staff Nurses	12.13%	↘	Decrease
	Significantly above upper target limit (>15%)			
	Above upper target limit (12%)			
	Between target limits (10-12%)			
	Within target or below (10%)			

3. Sickness Absence Management

The Trust annual sickness absence rate of 3.93% remains significantly lower than the national average for Large Acute Trusts (4.57% to Nov 17). Despite the usual increase in winter sickness absence, reported levels remain below those 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.

With long term absence accounting for approximately 49% of absence it is essential that all Line Managers follow the process outlined in the Trust Sickness Absence policy, to support the reduction in long term absence levels. Further HR support has been made available to a number of managers to facilitate the management of this absence, alongside a peer review of our absence policy to ensure the toolkit available is both appropriate and efficient. The estimated cost of annual sickness absence is circa £7.2m (in lost hours, not including backfill costs).



Description	Current Performance			Sickness Absence by month						Movement Dec to Jan	
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% with the red threshold 0.5% above this figure.	12 months to Jan 18 (Annual)	**Actual**	**KPI**	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18		
		% Abs	**% Abs**								
	Trust Total	3.93%	3.50%	3.67%	3.67%	3.88%	4.05%	4.24%	4.81%	↗	increase
	Corporate	4.10%	3.50%	3.88%	3.90%	4.26%	4.06%	4.61%	5.14%	↗	increase
	Diagnostics & Specialty	3.78%	3.50%	3.66%	3.56%	4.06%	3.90%	4.15%	5.04%	↗	increase
	Estates & Facilities	4.40%	3.50%	3.96%	4.11%	3.87%	4.32%	3.81%	4.60%	↗	increase
	Medicine	3.66%	3.50%	3.08%	3.28%	3.94%	4.01%	4.07%	4.64%	↗	increase
	Surgery	4.13%	3.50%	3.82%	4.05%	3.81%	4.26%	4.61%	4.79%	↗	increase
	Womens & Children	3.72%	3.50%	3.99%	3.17%	3.13%	3.70%	3.70%	4.51%	↗	increase
	Add Prof Scientific and Technic	3.48%	3.50%	4.32%	2.79%	2.47%	2.67%	2.57%	2.89%	↗	increase
	Additional Clinical Services	4.81%	3.50%	4.64%	4.73%	5.25%	5.16%	5.83%	6.38%	↗	increase
	Administrative and Clerical	4.24%	3.50%	3.73%	3.70%	3.97%	4.10%	4.22%	4.96%	↗	increase
	Allied Health Professionals	2.83%	3.50%	3.08%	3.24%	3.01%	2.55%	3.02%	3.34%	↗	increase
	Estates and Ancillary	4.39%	3.50%	4.17%	3.97%	3.93%	4.44%	4.32%	5.02%	↗	increase
	Healthcare Scientists	2.84%	3.50%	2.66%	3.80%	3.42%	2.85%	2.37%	4.18%	↗	increase
	Medical and Dental	1.67%	3.50%	1.28%	1.68%	1.44%	1.65%	1.58%	1.48%	↘	decrease
	Nursing and Midwifery Registered	4.37%	3.50%	4.05%	3.94%	4.39%	4.84%	5.03%	5.70%	↗	increase

4. Appraisals and Mandatory Training

In January we observed a decline in both Appraisal and Mandatory Training Compliance. Whilst the decline in these figures can be largely predicted at this time of year, it remains a concern. EFD remain the only Division to have met the 90% appraisal rate.

The requirement for all staff to renew Safeguarding training impacted on the Mandatory Training rates in January, which are now showing a decline across all divisions.

Appraisals	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Movement since last Month	
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Corporate	82%	86%	82%	82%	75%	76%	77%	77%	80%	82%	83%	82%	↘	decrease
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Medicine	77%	79%	78%	79%	79%	79%	78%	77%	81%	82%	81%	79%	↘	decrease
Surgery	83%	82%	80%	79%	78%	80%	79%	77%	79%	83%	82%	81%	↘	decrease
Women & Children	80%	78%	77%	81%	83%	82%	81%	80%	85%	85%	86%	85%	↘	decrease
Trust	**82%**	**82%**	**80%**	**79%**	**78%**	**79%**	**79%**	**79%**	83%	84%	84%	83%	↘	decrease

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Surgery	90%	90%	90%	91%	91%	90%	90%	90%	89%	90%	77%	↘	decrease
Women & Children	89%	89%	88%	88%	89%	89%	88%	88%	87%	87%	75%	↘	decrease
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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.
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Progress Nov-Jan 18:

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Both HR and Finance Leads have determined the scope of the project and identified resource within existing teams to lead on key aspects of the data cleanse and process mapping work.

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The two greatest causes of staff absence are MSK and psychological issues. The Trust has many channels of support however the accessibility of these and our response to immediate need seems challenging. A review of services will commence to determine if more can be achieved within our financial envelope.

Progress Dec- Jan 18

The Trust Staff Health & Wellbeing Group spent time in December 2017 reassessing priorities and establishing key areas of focus, which link to employee absence. In particular focussing on stress/ mental wellbeing and musculoskeletal issues.

Next Steps (progress expected by April 2018):

- Identification of the current return on investment for employee Health and Wellbeing services. To include: Occupational Health, Staff Support, Physiotherapy services. – Review February 2018, redesign with business case to DOG/TLT in March 2018.
- Begin benchmarking with other organisations 'one stop shop' provisions.

Staff Engagement

The Trust prides itself in open and transparent communication, two way feedback and listening. Staff are actively encouraged to contribute to the Trust decision making and have a voice.
With so much change and information sharing the Trust must be certain that two way feedback is preserved and all opportunities to capture staff opinion noted and exploited. With this in mind a review of staff engagement models will be undertaken to see if we can build upon our current practice.

Progress Dec- Jan 18

- Staff recognition awards (GEM) Awards were 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 and presentation to 100 Leaders presentation took place in January.
- Investigations into a staff engagement app in conjunction with One Gloucestershire STP 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'.
- Trust-wide listening events ran Jan-Feb focusing on Travel to Work

Next Steps

- Continue investigations into engagement App to determine suitability.
- Merging a number of current forums into a new 'staff involvement and engagement forum' to be the central point for capturing inputs from staff engagement and listening events.

7. Conclusion

Performance against both Sickness Absence and Turnover targets is promising, reflecting a more positive position than in previous years. However appraisal compliance is of concern and this is being considered as we develop a revised talent management process. Whilst mandatory training compliance has declined, we understand this dip is associated with a requirement to refresh safeguarding training, therefore we expect this to improve again in future reports.
Progress has been made against all of our key priorities that were identified to the Workforce Committee in November 2017 including the development of proposals to create a Subco, the detail of which has been excluded from this report. The challenge in delivering against these objectives against the backdrop of 'business as usual' is considerable, however it is important to recognise that these priorities are critical to meeting the overarching strategic aims of the Workforce Strategy.

The Trust Board is asked to NOTE performance against our key indicators and the progress made against our 6-12 month priorities.

Author: Alison Koeltgen, Acting Deputy Director of People & OD
Sponsor: Emma Wood, Deputy Chief Executive and Director of People & OD.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Workforce Report
Sponsor and Author(s)
Author: Alison Koeltgen, Acting Deputy Director of People & OD 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 key performance indicators and outlines progress against the short term strategic objectives as identified in November 2017.

Key issues to note

Further **reductions in turnover** taken the Trust rolling total to 11.88%. This is **closer to the target of 11%,** this goes against typical trends experienced at this time of year.

The Trust **annual sickness absence rate** of 3.93% remains **significantly lower than the national average for Large Acute Trusts (4.57% to Nov 17).** Despite the usual increase in winter sickness absence, reported levels remain below those experienced in previous years.

Appraisal compliance deteriorated in January, with EFD being the only division to achieve compliance above the 90% Trust target. This is largely expected due to seasonal pressures and will be considered as part of the talent management system development.

Mandatory training figures suffered similar deterioration, however it is noted that this is largely due to a requirement to refresh safeguarding training for all employees, therefore we expect to see this improve again in coming months.

6-12 month priorities: Progress is noted within the report against all of the projects identified in November 2017 to the Main Board and Workforce Committee these include:

- Establishment realignment
- CIP Delivery
- Talent Management System Development
- Staff Health and Wellbeing
- Staff Engagement

The development of the Subco proposals has been excluded from this summary due to the extraordinary Trust Board meeting being held at the time of writing this paper.

Conclusions

Performance against both Sickness Absence and Turnover targets is promising, reflecting a more positive position compared to previous years. Appraisal compliance is of concern and is being considered as we develop a revised talent management process. Whilst mandatory training compliance has declined, we understand this dip in performance to be temporary due to a safeguarding training requirement in month.

Implications and Future Action Required

Full Staff Survey results will be discussed at TLT 7th March 2018.
Update on key projects to next Trust Board and Workforce Committee.

Recommendations

The Trust Board is asked to NOTE performance against our key indicators and the progress made against our 6-12 month priorities.

Impact Upon Strategic Objectives

- Supporting Financial Recovery and Cost improvement activity
- Supporting Increased Staff Engagement, Wellbeing
- Ensuring we attract and retain a sustainable workforce

Impact Upon Corporate Risks

Ensuring staff turnover remains at an acceptable level supports the mitigation of the risk of being unable to match recruitment needs with suitably qualified staff, impacting on the delivery of the Trusts strategic objectives.

Similarly, through reduced sickness absence and turnover we reduce the demand for temporary staff in both clinical and non-clinical professions.

Regulatory and/or Legal Implications

NHSI scrutiny of agency spend and financial recovery.

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

N/A

MAIN BOARD – MARCH 2018

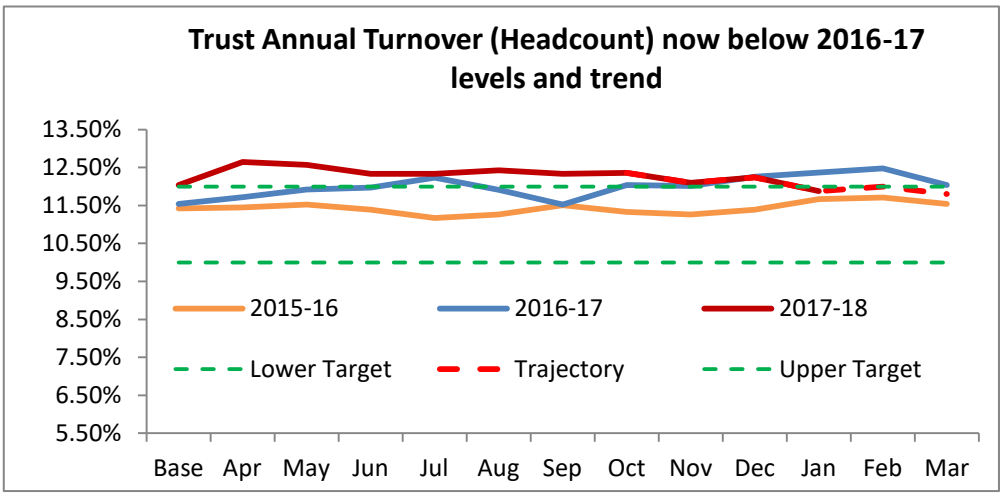
WORKFORCE REPORT

1. Aim

This report provides Trust Board with an overview of current performance, against key performance indicators and outlines progress against the short term strategic objectives as identified in November 2017 to the Workforce Committee.

2. Staff Turnover

Current performance places us at 11.88%, whilst this is above the target of 11% it falls within a range of turnover (10-12%) which we have identified as reasonable, based on benchmarking with other acute trusts. This reduction in turnover goes against previous trends, as we often see a slight increase in turnover at the beginning of the calendar year.

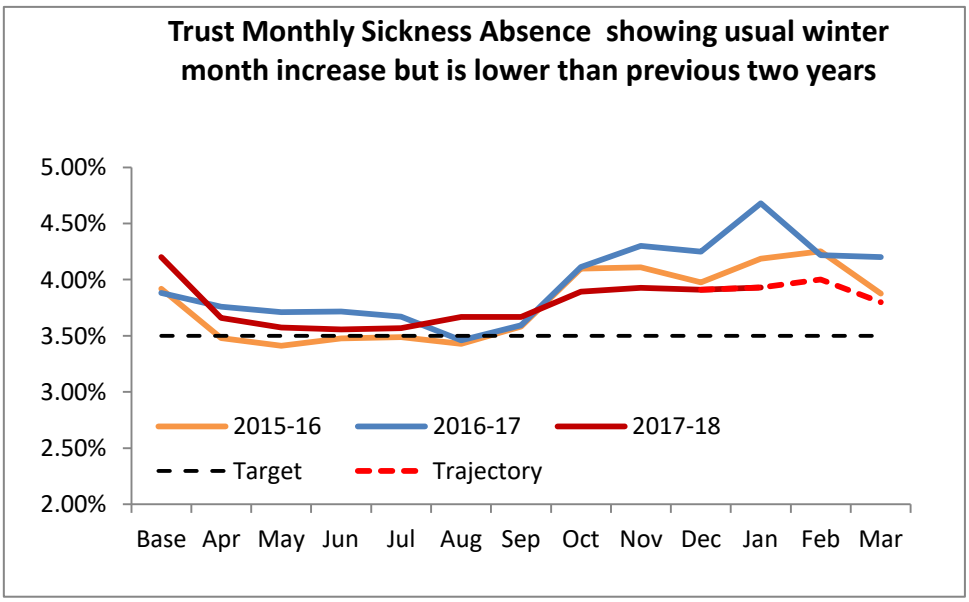


Description	Current Performance		Movement since last Month	
Turnover is measured using the total leavers (heads) as a percentage of the average headcount for the reporting period. The Trust target is 10% - 12% with the red threshold above 15% and below 6%.	12 months to 31 January 2018	**Actual % TO**		
	Trust Total	**11.88%**	↘	Decrease
	Corporate	13.77%	↘	Decrease
	Diagnostics & Specialty	11.38%	↘	Decrease
	Estates & Facilities	7.65%	↘	Decrease
	Medicine	13.25%	↘	Decrease
	Surgery	11.74%	↘	Decrease
	Womens & Children	12.36%	↘	Decrease
	Add Prof Scientific and Technic	8.71%	↗	Increase
	Additional Clinical Services	14.48%	↘	Decrease
	Administrative and Clerical	14.49%	↘	Decrease
	Allied Health Professionals	12.34%	↘	Decrease
	Estates and Ancillary	8.80%	↘	Decrease
	Healthcare Scientists	10.70%	↗	Increase
	Medical and Dental	5.87%	↘	Decrease
	Nursing and Midwifery Registered	10.89%	↘	Decrease
	Staff Nurses	12.13%	↘	Decrease
	Significantly above upper target limit (>15%)			
	Above upper target limit (12%)			
	Between target limits (10-12%)			
	Within target or below (10%)			

3. Sickness Absence Management

The Trust annual sickness absence rate of 3.93% remains significantly lower than the national average for Large Acute Trusts (4.57% to Nov 17). Despite the usual increase in winter sickness absence, reported levels remain below those 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.

With long term absence accounting for approximately 49% of absence it is essential that all Line Managers follow the process outlined in the Trust Sickness Absence policy, to support the reduction in long term absence levels. Further HR support has been made available to a number of managers to facilitate the management of this absence, alongside a peer review of our absence policy to ensure the toolkit available is both appropriate and efficient. The estimated cost of annual sickness absence is circa £7.2m (in lost hours, not including backfill costs).



Description	Current Performance			Sickness Absence by month						Movement Dec to Jan	
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% with the red threshold 0.5% above this figure.	12 months to Jan 18 (Annual)	**Actual**	**KPI**	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18		
		% Abs	**% Abs**								
	Trust Total	3.93%	3.50%	3.67%	3.67%	3.88%	4.05%	4.24%	4.81%	↗	increase
	Corporate	4.10%	3.50%	3.88%	3.90%	4.26%	4.06%	4.61%	5.14%	↗	increase
	Diagnostics & Specialty	3.78%	3.50%	3.66%	3.56%	4.06%	3.90%	4.15%	5.04%	↗	increase
	Estates & Facilities	4.40%	3.50%	3.96%	4.11%	3.87%	4.32%	3.81%	4.60%	↗	increase
	Medicine	3.66%	3.50%	3.08%	3.28%	3.94%	4.01%	4.07%	4.64%	↗	increase
	Surgery	4.13%	3.50%	3.82%	4.05%	3.81%	4.26%	4.61%	4.79%	↗	increase
	Womens & Children	3.72%	3.50%	3.99%	3.17%	3.13%	3.70%	3.70%	4.51%	↗	increase
	Add Prof Scientific and Technic	3.48%	3.50%	4.32%	2.79%	2.47%	2.67%	2.57%	2.89%	↗	increase
	Additional Clinical Services	4.81%	3.50%	4.64%	4.73%	5.25%	5.16%	5.83%	6.38%	↗	increase
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The Trust Staff Health & Wellbeing Group spent time in December 2017 reassessing priorities and establishing key areas of focus, which link to employee absence. In particular focussing on stress/ mental wellbeing and musculoskeletal issues.

Next Steps (progress expected by April 2018):

- Identification of the current return on investment for employee Health and Wellbeing services. To include: Occupational Health, Staff Support, Physiotherapy services. – Review February 2018, redesign with business case to DOG/TLT in March 2018.
- Begin benchmarking with other organisations 'one stop shop' provisions.

Staff Engagement

The Trust prides itself in open and transparent communication, two way feedback and listening. Staff are actively encouraged to contribute to the Trust decision making and have a voice.
With so much change and information sharing the Trust must be certain that two way feedback is preserved and all opportunities to capture staff opinion noted and exploited. With this in mind a review of staff engagement models will be undertaken to see if we can build upon our current practice.

Progress Dec- Jan 18

- Staff recognition awards (GEM) Awards were 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 and presentation to 100 Leaders presentation took place in January.
- Investigations into a staff engagement app in conjunction with One Gloucestershire STP 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'.
- Trust-wide listening events ran Jan-Feb focusing on Travel to Work

Next Steps

- Continue investigations into engagement App to determine suitability.
- Merging a number of current forums into a new 'staff involvement and engagement forum' to be the central point for capturing inputs from staff engagement and listening events.

7. Conclusion

Performance against both Sickness Absence and Turnover targets is promising, reflecting a more positive position than in previous years. However appraisal compliance is of concern and this is being considered as we develop a revised talent management process. Whilst mandatory training compliance has declined, we understand this dip is associated with a requirement to refresh safeguarding training, therefore we expect this to improve again in future reports.
Progress has been made against all of our key priorities that were identified to the Workforce Committee in November 2017 including the development of proposals to create a Subco, the detail of which has been excluded from this report. The challenge in delivering against these objectives against the backdrop of 'business as usual' is considerable, however it is important to recognise that these priorities are critical to meeting the overarching strategic aims of the Workforce Strategy.

The Trust Board is asked to NOTE performance against our key indicators and the progress made against our 6-12 month priorities.

Author: Alison Koeltgen, Acting Deputy Director of People & OD
Sponsor: Emma Wood, Deputy Chief Executive and Director of People & OD.

REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Workforce Committee on 8th February 2018 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
Temporary Staffing	Functional and operational changes recommended as part of a drive to re-launch Bank. Focus on reducing the cost of agency and attracting more people to the bank.	How are we ensuring the new approach is taken and used? How are we attracting and targeting people to join the Bank Have we mapped the end to end recruitment and on boarding process and understood the cultural impact of change?		Current approach to driving staff to register for the bank needs strengthening – with a new Comms strategy. But we need to ensure we have the capacity to deliver as a new brand and look and feel is needed along with a new approach Need to consider target market outside own staff. Progress update requested to ensure assurance that the innovations described have embedded.
Sickness absence	Deep dive into Orthopaedic outpatients' sickness absence at request of committee.	How can we ensure issues are progressed effectively and people supported in the right way.		

Appraisals **PWC Audit Prevention of illegal working**	Discussion around how we are measuring performance effectively. And if appraisals as a single measure really offers assurance on performance management success. Actions all complete bar one. Engaged with Diversity group to ensure lessons learnt regarding handling strategy to audit recommendation.	What is the best way to measure performance and understand what success looks like to drive performance?	6 month governance report to this committee.	We need to consider a new framework for defining success.
Strategic priorities on BAF	Reduced and removed risks into two residual open risks. Divisional risks being reviewed and need to ensure divisional risks are brought to Workforce.	How are divisions grading their risks and how are HRBPs engaged in that process.	Updated risk register to come back to workforce.	
Establishment	1to1 positioning codes being developed and used to enable us to identify establishment.	Aware could be a complex journey but a step forward. How could we use VCP process better with such controls in place?		
Staff health and wellbeing	Update received on plan to create a business case to improve staff wellbeing services.	Are we able to resource and support staff in the right way to deliver against their needs? Where should the focus and energy be in helping staff?		Business case will be available for information at April committee.

Subco	Received an update on Subco. One of the main staff questions is around identity – which is being progressed. The Board will be looking at not just how or when but is this the right thing to do.	Important to engage with Governors. How do we ensure we have the comparative POV from other Trusts? Have we engaged the customer effectively		
Talent Management	Objective to get better at having conversations with staff. Appraisals are only part of our talent management system.	How do we ensure we deliver what the divisions need as well as the organisation needs?	TLT to review and approve the process as it is developed	Committee will be appraised of programme for information.
HCA **Freedom to speak up Guardian** **Equality report**	A clear methodology was presented and endorsed by the committee to understand HCA sickness absence and related turnover The committee received an update which would come again in 6 months. Hugely impressive and reassuring start Received and noted progress		Applying the same approach and deep dive to other professional groups	

Board to note specifically:

Work against the strategic priorities and incorporation into the BAF
Talent Management recommendations and plan to move forward
Work of the Freedom to Speak up Guardian

REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Audit and Assurance Committee held 16th January 2018, 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
Internal Audit - **Progress Report**	Overall progress in line with plan for the majority of reviews.	Clarity sought on the timing of the Business Intelligence review and associated triangulation of data. What is the status of the Mortality Review?	Report will be final in June. The Executive Director of Quality and Chief Nurse will be proactive in establishing ward dashboards. Documents are outstanding from the Trust but the review has commenced.	
Internal Audit - **Risk Management**	The audit focussed on next steps and the approach to the risk management group. Identified only low risk recommendations and overall of positive progress.			
Internal Audit - **Business Continuity**	Following the completion of this report in the summer of 2017 resulting on 2 high risk recommendations follow up work is still outstanding.	What is the status of this work and action on recommendation?	The Chief Operating Officer described a situation in which more basic work is required to embed the process. A revised list of actions is in preparation supported by appropriate and realistic deadlines.	This is incomplete and must be reviewed at the next and subsequent A & A Committees until satisfactorily addressed.

Internal Audit - **Information Governance**	GDPR Readiness Assessment Report – identified best practice and required work needed to achieve compliance.	Are there insurmountable barriers preventing acceptable progress?	While time and resources are a constraint a plan is in place to progress to full compliance and the Information Commissioner's Office acknowledges that no acute hospital will be 100% compliant from day 1.	Detailed monitoring at the Information Governance Committee with relevant updates to Audit and Assurance.
Internal Audit - **Latest Recommendations Tracker**	The Director of Corporate Governance has worked with Executives to review reasonability and achievability of deadlines.	What should the committee's approach be to missed high priority deadlines?	Agreed the relevant Executive director will attend Committee if high priority deadline(s) missed.	Terms of reference to be modified to include this requirement.
External Audit - **Progress Report**	Briefing provided on the transition process that is under way by our new external Auditors.	Will the in depth review of year end accounts undertaken for 16/17 be repeated for 17/18.	A review meeting will be scheduled and conduced along the same lines for this year end.	Set meeting date to in year accounting timetable.
Cyber Security Update	A follow up review of current initiatives provided by the Trust's' IT security officer.	What action is being taken following the PWC phishing exercise and will further tests be carried out?	A focus area for the team which will include a centrally hosted tool deploying regular tests.	This topic to remain a regular item on the agenda.
Trust Risk Register	Update provided on the increased focus on risk management and the Risk Register.	As the data shown is at high level what analysis is available to show relative activity by division?	Analysis by division is routinely available and will be incorporated in future reports.	

Clinical Audit	The Director of Safety outlined the work that was underway to create a new quality framework model that supersedes more traditional clinical audit approaches.	How are quality projects reviewed and assessed for success? How are recommendations captured and monitored?		Work in progress – detailed findings to be reviewed in Quality and Performance committee. Audit and Assurance Committee to be briefed on process progress in 6 months' time.
Reports from the Finance Director - **Losses and Compensation** - **Single Tender Actions**	Detailed analysis provided of losses and compensations and Single Tender actions	Can more detailed analysis of the reason for waivers be provided? Can cumulative analysis be included in the reporting?		Reports to be amended to address both questions
Proposed change in outturn forecast	Preparation process and proposed submission reviewed in accordance with NHSI guidance		A new process that is being followed and complies with mandated procedure	

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Quarterly Report on Safe Working Hours for Doctors and Dentists in Training
Sponsor and Author(s)
Author: Dr Simon Pirie, Guardian of Safe Working Hours **Sponsor**: Dr Sean Elyan, Medical Director
Executive Summary
Purpose: To outline the number of exception reports and immediate safety concerns reported in the period Nov 17 – Jan 18. Key issues to note: New process in place since December 17 which has improved response rates for reports. There have been some clusters of reports which have correlated with staffing gaps and work scheduling. We are working closely with training programme directors, director of medical education and clinical leads to address these issues. Conclusions: All trainees are now on the new contract and are using the reporting system. Areas with higher numbers of reports tend to be those with staffing gaps. Implications and Future Action Required: Continued monitoring and collection of data.
Recommendations
The Board accept this report as assurance.
Impact Upon Strategic Objectives
Our Patients: Ensure appropriate staffing levels to allow for safe care for our patients. Our Staff: Oversee appropriate work schedules for staff to allow them to work contracted hours and take rest breaks in a timely manner. Our Services: By making sure work schedules are correct, staffing levels are adequate and training opportunities are accessed; staff will be able to provide the best possible care for our patients. Our organisation: These measures will optimise efficiency and performance levels.
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
As per 2016 Junior Doctor terms and conditions.

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 - MARCH 2018

Quarterly Report on Safe Working Hours for Doctors and Dentists in Training

1. Executive summary

1.1 This report covers the period of 1st November 2017 – 31st January 2018. This is my first report as Guardian for Safe working at Gloucestershire Hospitals NHS Foundation Trust. I have been working closely with training programme directors and the Director of Medical Education to fully understand the challenges faced by teams and to find solutions where Doctors are reporting frequently.

1.2 Positives: I and the medical staffing department have worked hard to improve the exception reporting process. Previously, a significant number of reports were not being processed by supervisors and ended up just being paid and closed. However, we now have an agreed template to identify which supervisor will process reports, we have a weekly reminder system in place and a deadline after which the trainee will be paid and a notification sent to the supervisor and the head of department. This has helped to give the trainees confidence that the system is actually functioning. We have already seen a definite improvement in response rates.

1.3 Challenges: there have been a large number of reports in a couple of specialties and these have correlated with real staffing issues in those areas. We now need to work with these areas to improve conditions; and will continue to monitor this with our reporting system.

2. Introduction

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

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

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

3. High level data

Number of doctors / dentists in training (total):	459
Number of doctors / dentists in training on 2016 TCS:	459
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors: (first/additional trainees to maximum 0.5 SPA)	0.25/0.125 PAs

4. Junior Doctor Vacancies

Junior Doctor Vacancies by department (January 2017)					
Department	F1	F2	ST 1-2	ST3-8	Additional training and trust grade vacancies
Emergency Dept			1	0.2	2 trust doctors at ST1/2 level
Anaesthetics					
ENT					
General Medicine			5	5	13 tier 1 trust doctors, 5 tier 2 trust doctors
General Surgery				1	1 tier 1 trust doctor, 4 tier 2 clinical fellow/trust doctors
Histopathology					
Obs & Gynae				1	
Ophthalmology					1 trust doctor
Oral & Max Fax			1		
Trauma & Ortho			1		2 tier 1 trust doctors
Paediatrics				3	1 trust doctor
Urology					
Vascular surgery					
Total			8	10.2	18 tier 1, 11 tier 2 trust doctors

5. Locum bookings

Data from finance team:
Total spend November 2017 – January 2018 on Junior Medical Locum £544,933.

6. Exception reports (working hours)

Exception reports by department		
Specialty	Exceptions carried over from last report	Exceptions raised
General/GI Surgery		21
Urology		4
Trauma/ Ortho	2	10
ENT		
Vascular Surgery		
Ophthalmology		
Orthogeriatrics		
General/old age Medicine	38	203
Acute medicine/ ACUA		3
Stroke		
Neurology		
Cardiology		
Respiratory		4
Endocrinology		3
Oncology		2
Haematology		
Gastroenterology		2
Renal medicine		

Exception reports by department		
Emergency Department		
Obstetrics and Gynaecology		1
Paediatrics		15
Total	40	268

Exception reports by division				
Specialty	Exceptions carried over from last report	Exceptions raised	Exceptions Closed*	Exceptions outstanding
Surgery	2	35	32	3
Medicine	38	215	188	27
Women and Children	0	16	16	0
Diagnostic / specialties	0	2	2	0
Total	40	268	238	30

Exception by month (Allocate from October 2017)			
August – Oct 2017	November 2017	December 2017	January 2018
520	68	87	113

7. Fines

Fines by department		
Department	Number of fines levied	Value of fines levied
Nil	Nil	Nil
Total	0	0

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

8. Issues arising

8.1 Five doctors raised a total of 10 possible safety concerns. These were related to inadequate staffing and/or inadequate senior cover; several episodes occurred when sickness caused further gaps in an already understaffed rota. Doctors were contacted by the Guardian and meetings arranged with the relevant teams.

9. Actions taken to resolve issues

9.1 Immediate potential safety concerns were escalated to the senior medical staff and agreements made to address the issues.

10. Qualitative information

10.1 The new Allocate software for raising exception reports came into use on the 1st October 2017. This seems to allow easy reporting of exceptions, but it is hard to retrieve data. In order to understand whether exceptions have led to fines being indicated, reports need to be reviewed manually which takes a lot of time.

10.2 The area which has improved in the last three months is the response rate and times. Since producing a reporting pathway and implementing a reminder system, the majority of reports are being reviewed and dealt with in a timelier manner.

11. Summary

11.1 A total of 268 working hours exception reports have been made since the beginning of November 2017 – end January 2018. The reports identify occasions where doctors in training are working beyond scheduled hours to maintain service delivery. The process has identified departments where the workload, team expectation or available support for junior doctors results in a high level of exception reporting. Meetings are being held with department leads where these high levels of reports occur to further understand the issues and remedy the situation.

Author: **Dr Simon Pirie, Guardian of Safe Working Hours**

Presenting Director: **Dr Sean Elyan, Medical Director**

Date 28/2/2018

Recommendation.

- To endorse
- To approve

Appendices

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

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

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

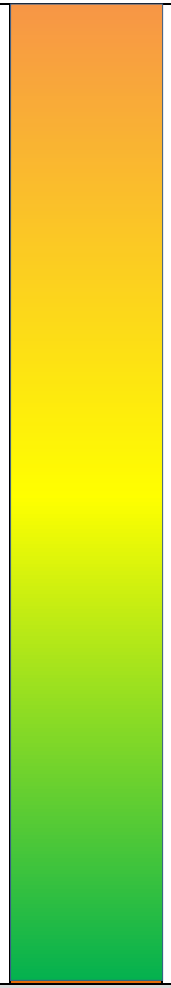
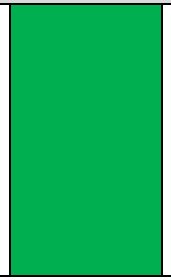
Report Title
Financial Enforcement Undertakings Review
Sponsor and Author(s)
Author & Sponsor: Deborah Lee, Chief Executive
Executive Summary
Purpose The purpose of this paper is to provide the Board with the quarterly update on progress to comply with the Enforcement Undertakings put in place by its Regulator, NHS Improvement. This paper has been reviewed and endorsed by the Board's Finance Committee. Key issues to note The Trust is fully compliant with all Undertakings. However, the one entitled '*The Licensee will take all reasonable steps to secure that it is able to deliver the FSMRP once it has been agreed by NHS Improvement'* is rated amber to reflect that the Trust, supported by the FSM team, believes it has taken all reasonable steps to secure the plan but, due to a number of unforeseen changes to the original planning assumptions, the recovery plan has not been delivered. Conclusions and Implications The Trust has discharged all the Undertakings set out in the Enforcement Notice issued by its regulator, NHSI but recognises that despite this the plan has not been delivered. However, it believes this position is supportive of the regulator's intention to consider the readiness of the Trust to be discharged from these undertakings Future Action This update will be included as a source of evidence to the regulator for the review of the Enforcement Undertakings, when that takes place later this month or early April.
Recommendations
The Board is asked to note the progress against the actions described and confirm that this is sufficient assurance to recommend to NHS Improvement that the Trust believes it has discharged the Undertakings set out in the 2016 Enforcement Notice.
Impact Upon Strategic Objectives
Supports delivery of the objective 'no longer subject to regulatory action'.
Impact Upon Corporate Risks
None.
Regulatory and/or Legal Implications
Reflects regulatory action.

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)**
	31st January 2018					
Outcome of discussion when presented to previous Committees						
Recommendation endorsed by Finance Committee						

NHS IMPROVEMENT ENFORCEMENT UNDERTAKINGS – January 2018			
	CURRENT POSITION	**RATING**	**KEY RISKS TO DELIVERY BOF ACTIONS**
Governance			
1.1 Within the timescales specified by NHS Improvement, the Licensee will: 1.1.1Publish a statement on its website homepage explaining that the Licensee has been placed in Financial Special Measures and the reasons for this (taking into account the explanation provided by NHS Improvement). The statement will include a link to the Financial Improvement Notice issued to the Licensee by NHS Improvement. 1.1.2.Notify its council of governors that the Licensee has been placed in Financial Special Measures, the reasons for it and the planned response.	<u>Action Completed</u> Statement published on 31st October 2016 with a link from the Home Page. <u>Action Completed</u> Governors updated at the Council of Governors meeting on the 2nd November 2016.		
Financial Recovery Plan			
1.2 As soon as reasonably practicable after receiving the Financial Improvement Notice, the Licensee will identify and set out in writing the key financial issues, including an analysis of the underlying causes of the Licensee's financial position, that need to be addressed to ensure the Licensee's financial recovery ('Diagnostic').	<u>Action Completed</u> Diagnostic presented to NHS Improvement/ NHS England "kick off" meeting and subsequently in detail to NHSI improvement Director (ID). 21st October 2016.		
1.3 Taking into the account the findings of the Diagnostic, the Licensee will develop a Financial Special Measures Recovery Plan ('FSMRP'). The scope and detailed content of the FSMRP will be as agreed with NHS Improvement.	<u>Action Completed</u> FSMRP presented to Finance Committee, Board and agreed with NHSI 1st December 2016.		

1.4 When developing the FSMRP, the Licensee will engage effectively with key stakeholders, including commissioners, and will reflect their views appropriately.	Action Completed The FSMRP was developed in conjunction with key stakeholders including CCG and NHS England commissioners to ensure underpinning planning assumptions, notably income and activity assumptions, were aligned to their plans.		
1.5 The Diagnostic and the FSMRP will be delivered to NHS Improvement at least 2 working days in advance of the Progress Review Check (defined at 3.2 below). The Diagnostic and FSMRP are subject to review and approval by NHS Improvement.	Completed FSMRP and diagnostic reviewed and agreed by NHSI 22nd February 2017. Monthly Progress Review Checks have been undertaken and supporting paperwork submitted.		

1.6 The Licensee will take all reasonable steps to secure that it is able to deliver the FSMRP once it has been agreed by NHS Improvement.	<u>Ongoing With Risks</u> The Board, through Finance Committee, and NHSI have been regularly appraised of the reasons for the variance and the mitigating actions taken. Of note, the Trust has delivered the (non-income related) cost improvements and maintained a pay underspend. In respect of action, the Finance Committee and FSM team have confirmed that there is significant evidence that Trust has taken 'all reasonable steps' to deliver the plan including use of external support, securing block agreements with commissioners to mitigate income risk; implementation of a range of 'unpalatable' measures - such as staff car parking charge increases, staff vacancy freeze, strategic change projects such as considering setting up a subsidiary company and service configuration (including implementation of the GIRFT T&O project).		The Trust is forecasting a £12.8m variance to the 2017/18 FSM plan. The key drivers for this are income under performance relating to the impact of TrakCare deployment on recording and reporting of activity and delivery of activity.
Financial Control			
1.7 The Licensee will comply with any arrangements specified by NHS Improvement for the approval of the Licensee's decisions on expenditure.	<u>Complete</u> Vacancy Control Panel established and changes to delegated limits of expenditure have been made as required and remain in place.		

Further Requirements			
2.1 The Licensee will take all practical steps to implement and maintain robust financial governance arrangements: including but not limited to those set out in paragraphs 2.2 to 2.5 below.	Complete Requirements 2.2 to 2.5 implemented alongside the recommendations set out in the Deloitte Financial Governance Review, aimed at strengthening financial governance.		
2.2 The Licensee will take all practical steps to facilitate and support completion of the Financial Governance Review (FGR)	Complete Review completed and published July 2017.		
2.3 The Licensee will develop a detailed action plan to address the recommendations of the review. The Licensee will agree the action plan with NHS I, to a timescale agreed with NHSI.	Complete Action plan developed and agreed with NHSI		
2.4 The Licensee will deliver the FGR action plan	Complete Regular updates provided to the Board and implementation complete. For review at January Finance Committee and subsequent Board with recommendation to close out FGR Action Plan.		
2.5 The Licensee will embed improved financial control and forecasting processes to support effective scrutiny and oversight of the financial position by the Board and its sub-committees.	Complete Revised reporting suite to Board and committees to include full year I&E and cash forecasts, risks to delivery and mitigations, working capital movements and debtor / creditor performance, and distressed finance utilisation.		
2.6 The Licensee will take all reasonable steps to return to financial sustainability including but not limited to those in 2.7 to 2.9 below			

2.7 The Licensee will submit to NHSI its two year operational plan in line with national planning timetable for 2017/18 and 2018/19. The Plan must demonstrate planned recovery of the financial position through quarter on quarter improvements in I&E and cash run rates.	Complete Two year plan, meeting NHSI requirements submitted in line with national guidance and timelines.		
2.8 The Licensee will take all practical steps to facilitate and support completion of the Cost Improvement Programme and financial baselining external reviews and develop plans to respond to their findings.	Complete CIP delivery plan developed and integrated into FSMRP. External baselining review undertaken by KPMG and findings acted upon and incorporated into underlying position upon which FSMRP based. This resulted in Prior Year Adjustment of £7m.		
2.9 The Licensee should keep the two year plan under review and provide appropriate assurance to its Board that the plan is sufficient to recovery the Licensee's financial position.	Partially Complete Monthly updates provided to the Board and Finance Committee. Remedial actions taken to support recovery of the plan as the forecast deteriorated, including identification of a further £6m of CIP and negotiation of a block contract with commissioners to mitigate £9m of income risks.		Due to the unforeseen impact of TrakCare the Trust will not deliver its original Recovery Plan of £14.6m deficit and a revised FOT of £27.4m has been submitted to NHSI in January 2018.
2.10 The Licensee will implement sufficient programme management and governance arrangements to enable delivery of its plans.	Complete Director of Programme Management appointed and in post and full PMO established during 2017. PMO reporting suite, including dashboards developed and accessed by all staff who require access. Accountability meetings established including CEO-chaired Turnaround Improvement Board, with Divisional		

	accountability reviews as part of agenda. Executive Review Meetings established monthly, chaired by Chief Operating Officer.		
2.11 The licensee will conduct a capacity and capability review of its finance team, scope to be agreed with NHSI. Review should include assessing and strengthening financial planning processes, guidance and training for staff to support delivery of two year plan.	<u>Complete (and ongoing)</u> Revised team structure agreed and new appointments made to key roles. Training rolled out for finance staff and general managers on CIP delivery and budget management. Controls and delegated authorities revised. Support and approach to Divisional forecasting strengthened.		
2.12 The Licensee will conduct a skills assessment of its Board and provide a summary of key issues and actions it will take to NHSI.	<u>Complete (and ongoing)</u> Agreed with NHSI and Governors to appoint two additional NEDs with financial and governance experience – both appointed in early 2017. Subsequent agreement that residual gap was for a clinical NED and appointment made in September 2017. Recent skills assessment undertaken to inform recruitment to upcoming vacancy and new NED. Executive Director skills assessment resulted in revised executive portfolios including establishment of a Director of Quality (and Chief Nurse), Director of Transformation and Strategy, Chief Information Officer and Director of Corporate Governance.		

2.13 The Licensee will commission an agreed external governance review in line with NHSI's Well-Led Framework, taking into account Board capacity and capability	Ongoing Agreed with NHSI that in light of recent CQC inspection and Deloitte external review that this would be deferred and an assessment of the future timing be informed by a Trust self-assessment against the Well-Led framework due to commence in February 2018.		
2.14 The Licensee will implement the actions and recommendations identified in the Board governance review	N/A in light of 2.13		
2.15 The Licensee will co-operate and work with the Financial Improvement Director (FID) to oversee and provide independent assurance to NHSI on the Licensees actions to deliver its FSMRP.	Complete Constructive and regular contact between Trust and FID.		
Reporting			
3.1 The Licensee will develop and agree with NHSI a set of KPIs which allow the licensee to track progress against delivery of the actions.	Complete Board reporting format developed and agreed. Quarterly reports to the Board and/or Finance Committee documenting progress.		
3.2 The Licensee will meet with NHS, including the FID, within one month of receiving the Financial Improvement Notice.	Complete Initial Progress Review Meeting 21st October 2016; FID present.		
3.3 The Licensee will attend any other meetings, conference calls as required.	Complete (and ongoing)		
3.4 The Licensee will comply with any additional meeting, reporting or information requests made by NHSI	Complete (and ongoing)		

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Enforcement Undertakings A&E Standard
Sponsor and Author(s)
Author: Sue Milloy, Director of Unscheduled Care, Felicity Taylor-Drewe, Director of Planned Care Sponsor: Caroline Landon, Chief Operating Officer
Executive Summary

Purpose

The purpose of this paper is to provide the Board with the quarterly update on progress to comply with the Enforcement Undertakings put in place by its Regulator, NHS Improvement in relation to the A&E standard.

This report has been received and endorsed by the Board's Quality & Performance Committee

Key issues to note

- The Trust is fully compliant with all Undertakings.
- The residual Amber rating, at last update has now been Green rated (surge plan).
- Performance of the A&E Standard at GHFNHST has significantly improved since the last update.
- Sustainability remains the greatest challenge. The Operational team has taken all reasonable steps to secure the plan and the associated delivery against set trajectories. Additionally the service is reviewing its 'balancing metrics' to ensure that patient safety and patient experience are optimised (and reviewed) alongside waiting time performance improvement.

Conclusions and Implications

The Trust has discharged all the Undertakings set out in the Enforcement Notice issued by its regulator and the Trust is currently exceeding its NHSI performance trajectory.

Future Action

This update will be included as a source of evidence to the regulator for the review of the A&E Enforcement Undertakings, set to take place later this month or early April 2018.

Recommendations
The Board is asked to note the progress against the actions described and confirm that this is sufficient assurance to recommend to NHS Improvement that the Trust believes it has discharged the Undertakings set out in the 2016 A&E Enforcement Notice.
Impact Upon Strategic Objectives
Supports delivery of the objective 'no longer subject to regulatory action'.
Impact Upon Corporate Risks
None.

Regulatory and/or Legal Implications
Reflects regulatory action.
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

NHS IMPROVEMENT ENFORCEMENT UNDERTAKINGS – January 2018			
	CURRENT POSITION	**RATING**	**KEY RISKS**
A&E RECOVERY PLAN			
• Develop a comprehensive A&E Recovery Plan to include a comprehensive diagnostic of the factors under the control of the licensee. • Develop a prioritised plan of actions to address these factors. • Deliver performance improvement commensurate with the recovery trajectory.	• In January 2017, the trust performance against the 4hr A&E standard was 89.7% with an average of 400 attendances per day. This performance was above the agreed STF trajectory (80%). GHFT. Month to date performance (16 February) is currently 88.1% which is 8.1% above the agreed STF February trajectory (80%). Note, January attendances were 10.2% above last year's levels. • System partners A&E Delivery Board have supported the Trust with delivery and a recovery plan inclusive of Trust partners response.		Workforce sustainability across the Trust and system partners. System partners approach to management of system demand across health and social care.
WORKFORCE AND CAPACITY PLAN			
• Develop a workforce demand and capacity plan. • Develop demand and workforce capacity plan that aligns workforce with daily demand including known peaks in activity. • Establish recruitment plan to address key gaps in workforce including emergency department staff, operational improvement staff and 'silver command' rota. • Financial investment plan to strengthen capacity and capability.	• Work to progress 'heat map' completed for medicine • Proposal to develop revised silver command arrangements for April • Internal mock event for silver and gold on-call planned for April • Revised training to support roll out of revised arrangements, planned for Summer 2018. • Work to commence winter plan brief from April 2018, first meeting in place • Revised oversight arrangements 'task and finish group' in place which include bi-weekly operational review of all work streams (core and enabling) and monthly Emergency Care Delivery Group being developed.		Identifying and recruiting appropriately skilled staff to support ED activity and the on-going programme i.e. the recruitment to agreed clinical service roles, notably ENPS and junior / middle grade medical staff in ED & ACU, project management and programme clinical and operational leads. Exploring models to overcome issues of middle grade skill availability as implemented at other Trusts (notably Derby)

• Establish effective performance management arrangements for executive and Divisional management teams. • Plans for sufficient project management and operational support to deliver recovery plan.			UPDATE: Consultant recruitment now complete but middle grade recruitment continues with significant gaps still in rota – remains one of the issues with workforce sustainability
GOVERNANCE PLAN			
• Clear lines of accountability from ward to Board for the delivery of the Emergency Care Plan.	• Emergency Care Programme Diagnostic and Brief sets out lines of accountability and reporting arrangements for each element of the programme Submitted to and approved by Trust Board August 2016.		COMPLETED 2016/17
• Clarity regarding the distinct roles and responsibilities of key governance meetings, including the assurance each provides to the Board.	• Terms of reference agreed for Emergency Care Programme. Trust Board and sub-committee assurance report have been developed for discussion/approval at September Trust Board.		COMPLETED 2016/7
• Appropriate escalation methods for the reporting of underperformance, including lead and lag indicators.	• Metrics suite to support Board and sub-committee reporting in development. Revised draft with work streams. Targeted date for completion September 30, 2016		COMPLETED UPDATE: New management arrangements in place.
• Succession plan for the Improvement Director.	• Discussions ongoing in respect of succession plan and linked to wider discussions regarding Executive Team portfolios. Recruitment of two Associate Director roles is commencing. The Associate Director, Performance Assurance has now closed to applicants (18 September, 2016), applications are being assessed and candidates will be invited for interview 27		Senior Medical Lead in place April 2017 COO commenced October 2017 Director of Unscheduled Care / Deputy COO commenced November 2017

• Establish an escalation policy and procedure to respond to surges in demand, including actions to be taken in different circumstances. • Take reasonable steps to ensure senior clinical oversight within ED, assessment and ward areas to ensure patients remain safe.	September, 2016. Associate Director, Service Delivery recruitment planned w/c 3rd October 2016. Escalation Plan developed and submitted to regulator – feedback received and plan formally signed off at September ECPB to be ratified at Trust Policy Group (October 2016). Implementation and communication plan under development • Established, further work required to embed "surge response" – see below.		
• Ensure an effective "surge plan" is in place to respond to acute peaks in demand so that patients remain safe during such times. This plan should be regularly tested for effectiveness.	• System wide plan in place and monitored through A&E Delivery Board. • New escalation framework in development. • Plan in development (as at Feb 2018) for winter 2018 to develop an Emergency Zone in GRH to better support medical and surgical admissions. • Surge response plan in place which includes: - Hourly review of attendance pattern - Additional clinical staff mobilised to department - ED corridor staffed and prioritised for triage and medical assessment - Additional porters diverted to transfer - Silver mobilised to department Gold to ops centre		Training and embedding policy and process across the Trust and wider system to ensure consistent application of plan, irrespective of personnel.

• Agree the Board oversight arrangements for ensuring delivery of the undertakings to include clear line of sight of delivery progress, risks to delivery and ability to hold individuals to account.	• Executive Oversight Group (EOG) established, first meeting took place w/c 05.09.16, chaired by CEO • EOG to report to Board and develop assurance for monthly Performance Review meetings with NHS Improvement. • In August, the Board considered change to Board sub-committee structure to strengthen reporting and scrutiny arrangements. It was agreed that, to ensure appropriate reporting, the Quality Committee would become the Quality and Performance Committee to capture all issues relating to Patient experience, safety and service quality under one umbrella.		Accessing the required skills and capacity to develop comprehensive reporting information to enable revised governance arrangements to operate effectively Clarity of decision making across the system in respect of changes within Emergency Care for any partner. Embedding new ways of working within Quality & Performance Group. UPDATE: Governance arrangements refreshed. Biweekly Task and Finish Group, monthly ECDG, chaired by COO and Board oversight through monthly Quality & Performance Committee.
• Establish sufficient programme management and governance arrangements to ensure delivery of the undertakings.	• As outlined in the Workforce & Capacity plan section.		As outlined in the Workforce & Capacity plan section UPDATE: CCG support for Winter 2017/18 by appointment of System Flow Director, and Winter programmes. System wide workforce constraints well documented at A&E Delivery Board.

• Provide NHSI with regular reports in a format to be agreed including evidence of the assurance the Board has relied upon in relation to its monitoring and scrutiny function.	• First review with NHSI took place 13 September and progress to date was positively received. Focus on the next review (proposed date: 14 October 2016) will shift towards length of stay, management of medically fit for discharge patient groups and delays to transfers of care.		UPDATE: Regular meetings in place between Trust and NHSI. A&E Delivery Board membership contains all parties.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTER ROYAL HOSPITAL ON TUESDAY 18TH OCTOBER 2017 AT 5.15PM

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

PRESENT

Governors	Ms S Attwood	Staff, Nursing and Midwifery
	Mr R Baker	Staff, Other and Non-Clinical
	Dr L Berragan	Public, Gloucester
	Mr G Coughlin	Public, Gloucester
	Mrs A Davies	Public, Cotswold
	Mrs P Eagle	Public, Stroud
	Mr C Greaves	Appointed, Clinical Commissioning Group
	Ms M Harris	Public, Out of County
	Mr N Johnson	Staff, Other and Non-Clinical
	Mrs A Jones	Public, Forest of Dean
	Dr T Llewellyn	Staff, Medical and Dental
	Mr J Marchant	Public, Stroud
	Mr J Marstrand	Public, Cheltenham
	Ms S Mather	Staff, Nursing and Midwifery
	Mrs A Lewis	Public, Tewkesbury
	Mr A Thomas	Public, Cheltenham (Lead Governor)
	Mrs V Wood	Public, Forest of Dean
Directors	Mr R Graves	Chair / Non-Executive Director
	Ms D Lee	Chief Executive
	Mr T Foster	Non-Executive Director
	Mr K Norton	Non-Executive Director
IN ATTENDANCE	Dr S Elyan	Medical Director
	Ms L Courtier	Corporate Governance Administrator
	Mr N Jackson	Director of Estates and Facilities
	Ms C Landon	Chief Operating Officer
	Mr D Smith	Director of Human Resources and Organisation Development
APOLOGIES	Mr P Lachecki	Chair of the Trust
	Ms T Barber	Non-Executive Director
	Mr G Cave	Public, Tewkesbury
	Dr C Feehily	Non-Executive Director
	Ms C Glasspool	Allied Healthcare Professionals
	Cllr A Gravells	Appointed, Gloucestershire County Council
	Mrs J Hincks	Public, Cotswold
	Ms A Moon	Non-Executive Director
PRESS/PUBLIC	None	

The Chair welcomed members of the Council, in particular the newly appointed and thanked Governors for attending.

069/17 DECLARATIONS OF INTEREST

There were none.

070/17 MINUTES OF THE MEETING HELD ON 5TH SEPTEMBER 2017

Minor amendments to be made to attendees section. Subject to these changes the minutes have been agreed as an accurate record. **NJ**

071/17 MATTERS ARISING

SEPTEMBER 2017 058/17 CHAIR'S UPDATE

Mr Greaves felt it would be useful and interesting to receive a list of all the meetings the Chair attends. Chair will share updates with the Council.

ACTION: This will be discussed at the next meeting. **PL**

SEPTEMBER 2017 058/17 CHAIR'S UPDATE

Mr Gravells queried whether Governors were ever invited to join the Chair on visits around the hospitals. The Lead Governor asked for the dates of the visits to be reissued.

The Board Administrator will contact the Director of Quality and Chief Nurse for the remaining dates for 2017 and circulate and develop proposals for next year. **SH/NJ**

RESOLVED: That a schedule of future dates be developed by the new Chief Nurse and Board Administrator for circulation to Governors.

072/17 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented the report to provide an update to the Council. The following points were raised:

- Mr Marstrand shared that he felt the communication of the Trauma & Orthopaedic (T&O) reconfiguration could have been managed better, particularly in respect to ambulance crews. He also expressed concerns over rumours of Cheltenham A&E closing. The Chief Executive confirmed there were no plans to change the hours or nature of operations at Cheltenham currently beyond those relating to T&O though she recognised that the closure of the Cheltenham site had been confused with the T&O changes; this was a miscommunication by the media and others which the Trust had sought to correct, She confirmed that the future model for urgent and emergency care was under review across the County and any changes would be subject to full public consultation.
- Mr Marstrand raised concerns over the public consultation with Sustainability and Transformation Partnerships (STP) that was scheduled to go ahead in May 2017 but due to purdah was postponed. He went on to say that Governors were then advised of a series of dates which had also not progressed. He also highlighted a motion that had been passed by Cheltenham Borough Council calling for the full restoration of the Cheltenham A&E. Mr Marstrand expressed concern that the Trust was not managing information leading to the communications team having to respond to rumours.

- The Chief Executive acknowledged Mr Marstrand comments and said the Trust was continually reviewing its approach to communication and working increasingly closely with other STP partners in pursuit of joined up communication. She agreed that the delays to consultation were unfortunate but had happened for a variety of reasons including a desire to ensure the final proposals were as robust as possible. She confirmed that the STP Delivery Board had been tasked with proposing a revised timescale for consultation to the Gloucestershire Strategic Forum as soon as practical. She confirmed this timeline would be influenced by the national gateway requirements which were increasingly onerous and the planned local elections in May 2018.
- Mrs Lewis asked if there had been any further development on the inpatient stroke unit in the community hospitals. The Chief Executive advised this had been through the clinical senate for a second time and gained support. The Chief Executive reported that the Trust stroke team were positive about the proposals. Discussions are ongoing around the nature of public engagement and whether public consultation will be required. Stroke rehabilitation care is already delivered within the Trust and providing this within community hospitals would likely be considered a relocation of a service and thus warrant consultation but this would be a decision for the local Health & Care Overview and Scrutiny Committee (HCOSC). She advised that the decision would be known within a few weeks.
- Mrs Lewis asked if the Trust currently had enough therapists. The Chief Executive advised the Trust did not have exceptionally high vacancy rates however maternity leave was impacting significantly on temporary vacancy levels. It was acknowledged however, that therapy support to stroke patients was below the national standard in respect of hours of therapy per patient and this would be addressed through the business case by retaining the current level of hospital based therapy but distributed over fewer beds and patient days.

073/18 REPORTS FROM BOARD COMMITTEES

Finance Committee – October Board Report & Chair's Report from 27th September 2017

The Chief Executive reported the key highlights to the Council and the following points were raised:

- Mr Thomas queried at what point in the planning process the Trust decides if it is going to achieve the predicted forecast. The Chief Executive explained that the forecast is reviewed every month and amended in line with current and predicted performance. Recently, this forecast was presented as a range reflecting best, likely and worse case scenarios. The current "likely" scenario reflected an adverse variance of £9m to the plan.
- Mr Greaves expressed that the variance and income was disappointing and he felt that TrakCare had played a large part. He queried if the Trust put in enough assets in the short term whether it would see any benefit in income within the financial year. The Chief Executive advised a large part of the Trust's income was now within block contracts and the scope for improving income recovery was thus limited. The focus and priority was to ensure that the issues affecting recording and

reporting of activity and thus income, are addressed before the start of the next financial year and this will be a focus of the recovery work, alongside issues affecting patient safety.

Quality & Performance Committee – October Board Report & Chair's Report from 22nd September 2017

The Chief Executive and the Chief Operating Officer reported the key highlights to the Council and the following points were raised by Governors:

- Mr Thomas welcomed the new Chief Operating Officer Caroline Landon and thanked her for her optimistic update.

Workforce Committee – October Board Report

The Director of Human Resources and Organisational Development (DHR&OD)reported the key highlights to the Council and the following points were raised:

- The Chair of the Council commented a Chairs report was not included as the Workforce Committee did not meet this month.
- Ms Attwood raised there had been real success with the overseas nurses within her department. Despite concern early on in the recruitment process the nurses have completed their training and intend to continue with the Trust. The DHR&OD advised that a further visit to the Philippines was planned to recruit more nurses. A trip to Ireland took place over the weekend as part of the STP and was reported to be very successful
- In response to a question, the DHR&OD described our approach to staff health and wellbeing and in particular how the Trust kept staff well. The Trust has recently received accreditation in the wellbeing charter by Public Health England. Positively, the Trust was rated excellent against 8 points. The Chief Executive highlighted a positive trend regarding sickness and staff moral detailed in the graph provided within the report.
- The DHR&OD advised there were still challenges around appraisals and each Division had an action plan.
- The DHR&OD advised that the staff survey was up and running and that the response rate was currently above the national average. The Chief Executive raised concerns that despite being above the national average, still only half of staff were completing the survey. The Trust's top three priorities were set by the survey and if only half the voices of the Trust were captured then priorities may not be accurately reflected. She intended to promote completion of the survey through her weekly message.
- Mr Thomas queried the language tests taken by nurses joining the Trust from abroad. The DHR&OD advised these have now been changed and the tests will be linked to the profession the nurses will be working in making it much more relevant and hopefully result in more nurses passing the test. It was acknowledged that the current IELTS test set a very high bar.
- Mr Marstrand commented there were communication issues both ways for staff and patients in particular those with hearing impairments. He felt this had not been addressed sufficiently previously. The DHR&OD agreed this was an issue and that the tests did not take into account factors such as accents but

regrettably this was not something we could influence. If communication proved to be a problem for any staff member, irrespective of their assessed competency, this would be managed through the usual capability framework.

The Chair acknowledged this was the last Council of Governors meeting the Director of Human Resources and Organisational Development would attend. The Council thanked him for all his contributions to the Trust and wished him all the best for future.

Audit & Assurance Committee – Chair's Report from 7th September 2017

The Chair of the Council, Mr Graves reported the key highlights to the Council. No further comments were made.

074/17 CODE OF CONDUCT

The revised Code of Conduct was presented to the Council for approval. The Code of Conduct was previously seen and agreed at the Governance & Nominations Committee subject to a few alterations which have now been made.

Mr Thomas advised the reason for the alterations was to establish a disciplinary process within the Code which had previously not been outlined. Mr Marstrand confirmed the document was discussed at the Governance & Nominations Committee and that the document presented is as was agreed.

The Council agreed to adopt this Code of Conduct subject to a minor alteration agreed by the Council. **NJ**

075/17 GOVERNANCE & NOMINATIONS COMMITTEE APPOINTMENT

The Chair of the Council presented the report to the Council and the following points were raised:

- An annual review of the Committee must take place at membership and function and this was now in hand.
- It is an individual's decision should they wish to put their names forward to be included within the new Governance & Nominations Committee. If more than three Governors put their names forward a ballot will be held. The meetings will be held 4-5 times per year taking place in the early evening. In the interim the membership will remain as it is and will be replaced at the next Council of Governors meeting. The process will be managed by the Board Administrator with oversight by the Chair.

076/17 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The following points were raised:

- It was highlighted that the implementation of 'Contact your Governor' was still awaited. The Chief Executive advised this would be live once the website rebuild was complete which would be early next year.
- Mr Marstrand commented that he liaises with members of the public and reports back to the Council. The comments and concerns raised were as a result of feedback received from

various groups of people outside of the Trust. The Chief Executive reflected that a conversation would be useful around some of the discussion raised by Mr Marstrand as although born from good intentions, topics raised were somewhat operational. **DL / JMs**

- Mr Marchant raised that in other organisations there are targets for Member numbers. He asked whether this was the case with this Trust and if so how they were managed. The Chief Executive advised it has been agreed the membership strategy will be re-reviewed. This will fall under the remit of the Strategy & Engagement Group. She advised further that rather than supporting targets a set of aims and objectives with the focus on engagement would be emphasised.
- Mr Thomas acknowledged more needed to be done to engage young members. Mrs Davies proposed that the Strategy & Engagement working group aim to work alongside younger members.

077/17 ANY OTHER BUSINESS

- **Strategy & Engagement Group Terms of Reference –** The Council agreed to adopt these Terms of Reference and these have now been ratified.
- **Governors Governance & Nominations Committee Terms of Reference –** The Council agreed to adopt these Terms of Reference and have now been ratified
- **Hospital Sign at Gloucestershire Royal Hospital –** It was raised that the main entrance sign at Gloucestershire Royal Hospital was unclean and did not provide a good first impression. The Director of Estates & Facilities agreed to take this forward. **NJa**

078/17 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 6th December 2017** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at **17:30pm**. **PLEASE NOTE DATE & TIME OF MEETING**

Papers for the next meeting: Papers for the next meeting are to be logged with the Board Administrator no later than **17:00pm** on **Monday 27th November 2017**

079/17 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960

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

The meeting ended at 19.00 pm.

Chair
6th December 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 6TH DECEMBER 2017 AT 5.30PM

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

PRESENT

Governors	Mrs S Attwood	Staff, Nursing and Midwifery
	Mr R Baker	Staff, Other and Non-Clinical
	Dr L Berragan	Public, Gloucester
	Mr G Cave	Public, Gloucester
	Mrs A Davies	Public, Cotswold
	Ms C Glasspool	Staff, Allied Health Professionals
	Cllr A Gravells	Appointed, County Council
	Mr C Greaves	Appointed, Clinical Commissioning Group
	Ms M Harris	Public, Out of County
	Mrs J Hincks	Public, Cotswold
	Mr N Johnson	Staff, Other and Non-Clinical
	Mrs A Lewis	Public, Tewkesbury
	Dr T Llewellyn	Staff, Medical and Dental
	Mr J Marstrand	Public, Cheltenham
	Mrs M Powell	Appointed, Healthwatch
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Mr P Lachecki	Chair of the Trust/ Chair
	Ms D Lee	Chief Executive
	Ms T Barber	Non-Executive Director
	Mr T Foster	Non-Executive Director
	Mr R Graves	Non-Executive Director
	Mr K Norton	Non-Executive Director
	Ms A Moon	Non-Executive Director
IN ATTENDANCE	Mr L Bohdan	Director of Corporate Governance
	Dr S Elyan	Medical Director
	Mr S Hams	Director of Quality and Chief Nurse
	Ms N Judge	Board Administrator
	Ms C Landon	Chief Operating Officer
	Mr S Webster	Director of Finance
	Ms E Wood	Director of People and Organisational Development and Deputy Chief Executive
APOLOGIES	Mr G Coughlin	Public, Gloucester
	Mrs P Eagle	Public, Stroud
	Dr C Feehily	Non-Executive Director
	Mrs A Jones	Public, Forest of Dean
	Mr J Marchant	Public, Stroud
	Ms S Mather	Staff, Nursing and Midwifery
	Mrs V Wood	Public, Forest of Dean
PRESS/PUBLIC	None	

The Chair welcomed members of the Council, in particular

091/17 DECLARATIONS OF INTEREST

There were none.

092/17 MINUTES OF THE MEETING HELD ON 18TH OCTOBER 2017

The minutes were presented for information and would be signed by the Chair at the next Council meeting. **NJ**

The Lead Governor expressed concern at the late circulation of papers. It was agreed that should any governors have any suggested amendments to the minutes that they should contact the Board Administrator. **ALL**

093/17 MATTERS ARISING

OCTOBER 2017 070/17 MINUTES OF THE MEETING HELD ON 5TH SEPTEMBER 2017 - MINOR AMENDMENTS TO BE MADE TO ATTENDEES SECTION

The Board Administrator would update the minutes.
Completed.

OCTOBER 2017 071/17 MATTERS ARISING - LIST OF ALL MEETINGS THE CHAIR ATTENDS

This will be discussed at the next meeting.
Completed: Included within the December papers.

OCTOBER 2017 071/17 MATTERS ARISING - GOVERNOR HOSPITAL VISITS

The Board Administrator will contact the Director of Quality and Chief Nurse for the remaining dates for 2017 and circulate and develop proposals for next year.
Completed: Dates arranged by the Director of Quality and Chief Nurse and included within the December papers.

OCTOBER 2017 074/17 GOVERNANCE & NOMINATIONS COMMITTEE APPOINTMENTS - CODE OF CONDUCT

The Council agreed to adopt this Code of Conduct subject to a minor alteration agreed by the Council.
Completed: Code of Conduct adopted and circulated for completion by all governors.

OCTOBER 2017 076/17 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT - MEMBER ENGAGEMENT AND GOVERNOR APPROACH

The Chief Executive reflected that a conversation would be useful around some of the discussion raised by Mr Marstrand as although born from good intentions, topics raised were somewhat operational.
Completed: The Chief Executive and Mr Marstrand agreed that this matter was now closed.

OCTOBER 2017 077/17 ANY OTHER BUSINESS - HOSPITAL SIGN AT GLOUCESTERSHIRE ROYAL HOSPITAL

It was raised that the main entrance sign at Gloucestershire Royal Hospital was unclean and did not provide a good first impression. The Director of Estates & Facilities agreed to take this forward.
Completed: This has been cleaned.

094/17 CHAIR'S UPDATE

The Chair presented the paper detailing his activities since the Council of Governors meeting in September. This aimed to provide governors with a snapshot of the wider perspective of Chair activities undertaken. It was agreed that should any governor wish to know further details of any of the listed activities then they could contact the Chair directly.

Mrs Lewis queried the visit to Worcestershire Health and Care Trust NED Panel and the Chair explained that he attended as an invited external assessor on the panel due to his relationship with that Trust.

095/17 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented the report providing an update to the Council regarding the significant improvements in Accident and Emergency (A&E) four hour standard, the 10% improvement in A&E patient experience, the success of the Trauma and Orthopaedic (T&O) reconfiguration, the progress of the establishment of a subsidiary company and TrakCare. She also advised that the Director of Clinical Strategy would be leaving the Trust at the end of January 2018 and she wished to formally thank her for her contribution to the Trust and wider County.

In response, the following points were raised:

- The Lead Governor thanked the Director of Clinical Strategy for her work, particularly her involvement with Governors and praised her communication.
- Cllr Gravells congratulated staff on the recent successes in A&E. He then advised that in the past the Health Care Overview and Scrutiny Committee (HCOSC) had found that most patients waited until the end of the four hour period to be seen. The Chief Executive stressed that the Trust's focus was on patients leaving once they had received the care they needed and not before though it was inevitable, given the standard and the model of escalation that patients would be expedited in their last hour of care. She stressed that the Trust has a robust approach to validate all breaches and the four hour standard. The Chief Operating Officer concurred with the Chief Executive and advised that assurance work was underway where patient notes would be reviewed on a quarterly basis to ensure the correct process was taking place and this would include looking at patients in the window immediately before and after the four hours. She also shared that both sites aimed to identify a plan for each patient within two hours.
- Mr Baker queried whether the changes in the Emergency Department (ED) were linked to the winter plan and if so would the Trust revert to previous arrangements once winter was over. The Chief Executive advised that the changes were a combination, and while some services would not be required during the summer other services would hopefully continue. The T&O reconfiguration was noted to be a pilot and would be reviewed for extension and taken through HCOSC, if successful.
- Mr Greaves praised the Trust, and felt the last six weeks demonstrated that the Trust and the system was capable of

delivering targets and this boded well for the future.

- Dr Llewellyn raised a query regarding doctor training and disparity between the Trust's trainees and that of Bristol, and wondered if a strategy or plan was in place to address this. The Chief Executive shared that she and the Medical Director had met with the deanery. Information shared with them demonstrated a significant skew to allocation of trainees to the London Deaneries and until this was addressed, it will be difficult to increase numbers to Trusts such as GHFT which had fewer trainees than a 'fair shares' approach would indicate they were entitled to. On a positive note, the Severn Deanery accepted that GHFT had fewer than comparable Trusts in the region and had recently offered new / additional trainees to the Trust.

096/17 REPORTS FROM BOARD COMMITTEES

Finance Committee – November Board Report & Chair's Report from 25th October 2017

The Director of Finance reported the key highlights of the November Board report to the Council, in particular that the Trust's end of year forecast was a deficit of £23.9m against a challenging plan of £14.6m. In response, the following points were raised by Governors:

- The Lead Governor highlighted that he attended the Finance Committee as governor observer and queried whether a further update to the report could be shared. The Chair noted that this would be included in December's Board meeting however, the Director of Finance provided a verbal update and advised that the forecast has deteriorated since the November Board report and was now a forecast of £28.6m deficit. He explained the key reasons for the movement; the majority of which were outside the Trust's control.
- Mr Marstrand queried what proportion of the shortfall of income related to Trakcare and how much was due to other factors. The Director of Finance answered that the estimated impact was £7.6m which included mitigation through block contracts with Gloucestershire Clinical Commissioning Group (CCG) and specialist commissioners. A further impact of c£4m was being felt due to the impact of the block contracts on income related Cost Improvement Plans, which were an indirect consequence of TrakCare.
- Mr Johnson queried whether, given changes at the executive level, there was any opportunity of exiting special measures. The Chief Executive shared that criteria regarding this were clearly set out and related to the Trust's reasons for entering special measures, which were linked to financial governance as much as the financial position. Confidence in the Trust is growing however the forecast for 2017/18 put this at risk. Mr Johnson went on to query whether finance could be made available via the CCG, to which the Chief Executive explained the CCGs proposal of additional funding, and noted that conversations were underway between NHSE and NHSI but she was not hopeful this would come to fruition. Mr Greaves shared that the Chief Finance Officer at the CCG was aware of the request.
- Mrs Lewis noted that the Trust was under budget for pay, largely driven by the vacancy factor, and wondered if when the Trust did recruit to certain posts how this would affect the

finances. The Director of Finance answered that while there were vacancies earlier in the year, these had now been filled and therefore the under-spend would not increase. The Trust has since been spending the budget month on month and in future underlying efficiencies and productivities would need to be identified to reduce the pay spend.

Mr Norton reported the key highlights of the October Finance Committee Chair's Report to the Council and noted in particular noted the importance of Cost Improvement Plans (CIP) and scrutinising the initiatives put forward as well as the work underway around Medical Productivity. In response, the Lead Governor felt the Council would welcome a presentation regarding Medical Productivity. The Board Administrator would note this for June 2018.

Quality & Performance Committee – November Board Report & Chair's Report from 26th October 2017 **NJ**

The Director of Quality presented the highlights of the November Board Report noting that the paper was jointly authored by himself, the Medical Director, the Director of People and Chief Operating Officer. The following points were raised by governors:

- Mrs Davies noted that she was approached by a patient on the two week wait pathway who was cancelled twice via impersonal letters. She thanked the Chief Executive for responding to this concern in the manner she had and said she was reassured that future communications would be tailored and more sensitive. The CEO confirmed that the Quality Committee had oversight of this issue.
- Mrs Lewis shared that she felt cancer issues were down to lack of staff and queried how the Trust was approaching this. The Chief Operating Officer noted that the reasons for not achieving the target were multi-factorial and staffing was one issue but not the most significant. A programme is underway entitled the Sustainable Workforce to ensure the Trust is looking outside of the usual approach when addressing long standing vacancies. The Director of Quality and Chief Nurse updated the Council regarding the University of Gloucestershire student nurses keen to join the Trust at the. Mr Johnson queried how the Trust would retain these nurses, to which the Director of Quality and Chief Nurse replied it was important to ensure that we create exciting career development pathways for nurses such as the Level 7 Masters programmes that he is working on currently.
- Cllr Gravells asked about the Trust's Oncology Services. The Medical Director responded that these covered Gloucestershire, Herefordshire, parts of Powys and South Worcestershire and offered a range of cancer management to a very high quality, as evidenced by Peer Review. Cllr Gravells enquired whether the Trust received financial resources for this. The Chief Executive confirmed that we did.
- Cllr Gravells expressed disappointment that the Trust was failing to meet the cancer standards and queried the target and timeframe to achieve these. The Chief Operating Officer advised that a Cancer Recovery Plan had been created and that the Chief Executive had challenged the team to deliver by April 2018. She said that the team was committed to this bit also explained some of the risks within the plan.
- Finally, Cllr Gravells queried the level of radiology the Trust

currently had which impacted target times. The Chief Executive shared that there were 2.4 whole time vacancies against 24 roles, and the Trust was close to being fully established in Radiology. The Chief Executive stressed it was important to not overplay the impact of staffing on cancer waiting times and stressed the importance of focussing upon process and pathway design alongside adequate capacity in outpatients and theatres.

- The Lead Governor queried the rise in mixed sex breaches and what was being done to address this. The Director of Quality and Chief Nurse explained that this was down to a change in reporting and that these were localised to the Intensive Care Unit. A standard operating procedure was being developed to help ensure patients are moved as soon as possible from ICU when they are ready to go. He also noted that he believed very few Trusts were reporting correctly, as GHFT is, and he had raised this with NHS Improvement.

The Chair's report from the October Quality and Performance Committee was taken as read.

Workforce Committee – November Board Report & Chair's Report from 10th November 2017

The Director of People presented the Workforce November Board Report to the Council. No further comments were made.

Mr Norton reported the key highlights of the November Workforce Committee Chair's Report and noted in particular that temporary staffing office was now available 7 days a week and that moving forward year end projections would be included within Workforce reporting.

Cllr Gravells raised concerns regarding the Trust's appraisal rates. The Director of People shared that the data included was historic and that the Trust was now achieving 88% compliance.

Audit & Assurance Committee – Chair's Report from 7th November 2017

Mr Graves reported the key highlights to the Council, noting in particular that the Committee was making good process. Medical productivity was discussed and the Trust's new auditors attended for the first time. The Director of Corporate Governance has now joined the Committee and will be working alongside Mr Graves and the Director of Finance. **RG/NJ**

The Lead Governor acknowledged the work underway and felt a presentation detailing this to the Council would be well received. Mr Graves shared that he was happy to do this alongside the external auditors if possible.

(The Director of Quality and Chief Nurse left the meeting)

097/17 GOVERNANCE AND NOMINATIONS COMMITTEE APPOINTMENT

The Board Administrator shared the results of the election held to appoint three governors to the Governance and Nominations Committee. The following governors were appointed to serve on the Committee alongside the Chair, , Mr Graves and the Lead Governor:

- Mr Marstrand
- Dr Llewellyn
- Mr Johnson

The Council congratulated the three new members on their success in the election.

098/17 NEW CONFLICTS OF INTEREST POLICY

The Director of Corporate Governance gave a presentation summarising the Trust's new Conflict of Interest Policy. He gave examples of potential conflicts of interests that can arise as well as the different categories of conflicts. Governors will need to complete the Conflict of Interest declarations annually and have a duty to update the Trust as and when circumstances change. Governors are also required to declare any gifts or hospitality. At the beginning of each meeting, all members are asked to declare any conflicts that may arise due to the agenda. Under some circumstances, members may be excluded from discussions and decision-making.

- Mr Greaves noted that NHS England were in the process of issuing a training package around Conflicts of Interest which would be available on 1st April 2018.
- The Lead Governor queried whether being a governor at two foundations Trusts would constitute a conflict of interest. The Director of Corporate Governance would investigate and advise outside of the meeting. **LB**
- Mr Marstrand expressed concerns regarding the policy, stating that most governors could be classified as having an interest. The Director of Corporate Governance and Chair reinforced that the policy was not about restriction but about raising awareness and increasing transparency. An interest was not always a conflict.
- Mr Marstrand also expressed concern regarding governors declaring whether they were service users of the Trust and this could be considered an intrusion their entitled privacy. The Director of Corporate Governance reinforced that each individual could be a customer of the Trust, and that it was only important to consider if you are involved with a decision that is significant and benefits your own care.

099/17 GOVERNORS LOG

The Chief Executive presented the Governors Log and noted that three new questions had been received since publication.

In future only entries received since the last Council would be included as opposed to the entire record. **NJ**

100/17 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The Council agreed that this agenda item would be best served under the Governors Strategy and Engagement Group.

The Board Administrator would therefore remove this from future

agendas and include within the agenda for the Strategy and Engagement Group. **NJ**

101/17 ANY OTHER BUSINESS

- The Lead Governor noted that the presentation of Board reports and Chair's reports to the Council may need to be considered as on some occasions this can result in fairly historic information being relayed. **PL**
- Mr Johnson shared that he had recently attended the Diversity Network launch and felt this was a positive start for the Trust. The Chair shared that he had also attended and felt the event was excellent and informative. Mr Foster concurred, sharing that the event was deeply moving. The Chief Executive reflected on the launch and reinforced the importance of diversity within the workforce and shared that she would be happy to further discuss the initiative via the Governors Quality Group as this affects patients also.

102/17 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 21st February 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** commencing at **17:15pm**.

Papers for the next meeting: Papers for the next meeting are to be logged with the Board Administrator no later than **17:00pm** on **Monday 19th February 2018**

103/17 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960

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

The meeting ended at 18.50 pm.

Chair
21st February 2018

ITEM 15

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 16

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 17

PUBLIC QUESTIONS

Peter Lachecki
Chair

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

The Trust welcomes feedback from members of the public. We are committed to delivering the best care and constantly looking at ways to improve the services we provide at out hospitals. There are a variety of ways in which you can give your feedback. These are:-

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail ghn-tr.pals@gloshospitals@nhs.net or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail ghn.tr.complaints.team@nhs.net or by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the last Friday of the month and alternate between the Sandford Education Centre in Cheltenham and the Redwood Education Centre at Gloucestershire Royal Hospital. Meetings normally start at 9.00am

All feedback is taken seriously and is used to either praise staff for the excellent care or service they have provided or used to make improvements where needed.

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust (including members of the Trust who live outside of the County) may ask the Chair of the Trust Board a question on any matter which is within the powers and duties of the Trust.

Ten minutes will be allocated at the end of the public section of each Board meeting for written questions from the public to be answered. Where it is not possible for all written questions to be dealt with within this timeframe a written response will be provided to the questioner and copied to all Board members within 7 working days of the meeting. In exceptional circumstances, the Chair may extend the time period for public questions.

Notice of questions

A question may only be asked if it has been submitted in writing to the Board Administrator by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Board Administrator, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN or by e-mail to natashia.judge@nhs.net.
No more than 3 written questions may be submitted by each questioner.

Procedure

At the Board meeting the questioner, if present, will be invited to read out the question. If absent, the Chair may read out the question. A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chair. Copies of the questions and

the responses will be recorded in the minutes.

Additional Questions

A questioner who has submitted a written question may, with the consent of the Chair, ask an additional oral question arising directly out of the original question or the reply.

An answer to an oral question will take the form of either:

- A direct oral answer; or
- If the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board

Unless the Chair decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chair considers that they:

- are not on any matter that is within the powers and duties of the Trust
- are defamatory, frivolous or offensive
- are substantially the same as a question that has been put to a meeting of the Trust Board and been answered in the past six months; or
- would require the disclosure of confidential or exempt information

For further information, please contact Natashia Judge, Board Administrator on 0300 422 2932 by e-mail natashia.judge@nhs.net

ITEM 18

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION