GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Wednesday 11 October 2017** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

20 September 2017

AGENDA

				Approximate Timings
	Patient Story			09:00
1.	Welcome and Apologies			09:30
2.	Declarations of Interest			
3.	Minutes of the meeting held on 13 September 2017	**PAPER**	**To approve**	09:32
4.	Matters Arising	**PAPER**	**To note**	09:35
5.	Chief Executive's Report October 2017	**PAPER** (Deborah Lee)	**To note**	09:40
6.	Quality and Performance:		**For Assurance**	09:50
	• Quality and Performance Report - Update of the Chief Operating Officer	**PAPER** (Caroline Landon)		
	• Assurance Report of the Chair of Quality and Performance Committee meeting held on 28 September 2017	**PAPER** (Claire Feehily)		
	• Trust Risk Register	**PAPER** (Deborah Lee)		
7.	Financial Performance:		**For Assurance**	10:20
	• Report of the Finance Director	**PAPER** (Steve Webster)		
	• Assurance Report of the Chair of the Finance Committee meeting held on 27 September 2017	**PAPER** (Claire Feehily)		
8.	Workforce:		**For Assurance**	10:50
	• Report of the Director of Human Resources and Organisational Development	**PAPER** (Dave Smith)		
9.	Audit and Assurance:		**For Assurance**	11:10
	• Report of the Chair of the Audit and Assurance Committee meeting held on 7 September 2017	**PAPER** (Rob Graves)		
	Break *(& Flu Inoculations)*			**11:20 - 11:40**
10.	Smartcare Progress Report	**PAPER** (Sally Pearson)	To Note	11:40
11.	Board Assurance Framework	**PAPER** (Deborah Lee)	**For Approval**	11:50

12.	Winter Plan	**PAPER** (Caroline Landon)	**For Assurance**	12:05
13.	Items for the Next Meeting and Any Other Business	**DISCUSSION** (All)	**To Note**	12:15
	Governor Questions			
14.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To Discuss**	12:20
	Staff Questions			
15.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	12:30
	Public Questions			
16.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**Close**	12:40
	Lunch			**12.50 – 13.10**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE BOARD ADMINISTRATOR NO LATER THAN 17:00PM ON MONDAY 2ND OCTOBER

Date of the next meeting: The next meeting of the Main Board will take place at on **Wednesday 8 November 2017** in the **Lecture Hall, Redwood Education Centre, Gloucester Royal** 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

Tracey Barber
Dr Claire Feehily
Tony Foster
Rob Graves
Keith Norton
Alison Moon

Executive Directors

Deborah Lee, Chief Executive
Steve Hams, Director of Quality and Chief Nurse
Steve Webster, Finance Director
Dr Sean Elyan, Medical Director
Dr Sally Pearson, Director of Clinical Strategy
Dave Smith, Director of Human Resources and Organisational Development
Caroline Landon, Chief Operating Officer

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 WEDNESDAY 13 SEPTEMBER 2017 AT 9AM

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

PRESENT	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Maggie Arnold	Director of Nursing
	Tracey Barber	Non-Executive Director
	Dr Sean Elyan	Medical Director
	Arshiya Khan	Interim Chief Operating Officer
	Dr Sally Pearson	Director of Clinical Strategy
	Dave Smith	Director of Human Resources and Organisational Development
	Steve Webster	Director of Finance
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
	Alison Moon	Non-Executive Director
APOLOGIES	None	
IN ATTENDANCE	Natashia Judge	Board Administrator
	Suzie Cro	Head of Patient Experience
	Sheila Bowes	Patient
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	Two Governors, seven members of the public, one member of the press and no members of staff.	

The Chair welcomed all to the meeting and welcomed Ms Moon to the team who began on 4th September. The Chair requested all Board members introduce themselves. No apologies were noted.

174/17 PATIENT STORY

The Head of Patient Experience introduced Sheila Bowes who shared her experience of being a patient. Sheila informed the Board that she has also been a volunteer with the Trust for ten years.

In 2016, Sheila fell and broke the neck of her femur and was admitted to the Emergency Department. She summarised the experience, stating that:

- She felt the paramedics were brilliant and settled her nerves.
- She was able to attend Cheltenham General Hospital at her request. She found the staff calming and noted that they asked all appropriate background questions.
- Sheila underwent an x-ray and was transferred to Dixton Ward (Trauma and Orthopaedics) where she was looked after by Mr Clint. She describes the team positively stating that they were very honest in their communication with her

which she appreciated and felt the ward staff helped her maintain her dignity as a patient.

- Sheila underwent 6 hours of surgery however she explained that her husband was informed that this would be 1-2 hours, causing undue worry.
- Issues arose around food as Sheila suffers from Irritable Bowel Syndrome and though this was explained hospital food was not served as per Sheila's needs. Sheila's husband therefore bought food on to the ward however they were met with some resistance to this from administrative staff and Sheila queried whether there was a clear protocol regarding this for staff to refer to. She also noted that the blood clotting injections she was given disrupted her stomach. This was discussed with her consultant and a joint decision made regarding her progress and Sheila appreciated this shared discourse. She did however note that Trauma & Orthopaedics did not communicate with Gastroenterology regarding her care.
- It was reinforced to Sheila that she must remain hydrated however at one point she requested water from a member of staff who responded that it was not within her contract to distribute water at this time. This caused Sheila discomfort and upset as she did not wish to disrupt the nurses.
- Sheila remarked that the ward buzzer was disruptive at night however she acknowledged that this could not be helped.

Sheila also shared her post-operative experience with the Board, in particular expressing disappointment with her follow up plan and physiotherapy support. Fortunately, Sheila has a friend who is a physiotherapist. However, she acknowledged that others may not be as fortunate. She explained that the lack of information regarding her expected progress left her feeling low and depressed. Thankfully, her friend was able to explain this to her. After six months Sheila was able to return to her position as a volunteer within the hospital. Sheila suggested that access to a website such a YouTube with videos detailing exercises would be helpful to patients.

The Head of Patient Experience shared with the Board that she had reviewed Sheila's medical notes and established that the physiotherapist had discharged Sheila from therapy care but Sheila felt she still had considerable needs in this regard.

The Chair thanked Sheila for sharing her story and the Board members went on to discuss her experience and ask questions:

- The Director of Nursing shared that the wards do have an open policy for patients bringing food from home and she vowed to ensure that clerical staff understood this and would raise this at the next Senior Nursing and Midwifery Council. **MA**
  While patients can bring their own food to the ward storage is not encouraged due to infection control and the contamination of other foods. She also expressed concern that Sheila was not assessed for a raised toilet seat and would investigate to ensure patients are being discharged correctly. **MA**

- The Medical Director queried whether there was anything that could be learned from Sheila's positive experience with Mr Clint that could be shared with other medical practitioners. Sheila answered that his and the team's openness was the aspect she appreciated the most as this meant she could set realistic expectations for herself.
- The Director of Finance queried why Sheila was discharged from physiotherapy and the Director of Nursing vowed to investigate this as Sheila should have been referred to a physiotherapist in the Community. . **MA/SC**
- Dr Feehily felt that the ward should be able to handle exceptional food cases such as these. Sheila explained that the ward did send a dietician but problems still arose.
- The Chief Executive sought to establish who was responsible for informing families of progress whilst in theatre. The Nursing Director explained that ward staff should contact theatre and up-date relatives. She noted that Sheila should never have been given an estimate of 1-2 hours for surgery and for this she apologised. MA to reinforce the importance of ward staff liaising with theatres and families.
- The Chief Executive also enquired whether we offered ear plugs to patients given the recurrent theme of noise at night which affects patients sleep. The Director of Nursing explained that they can be offered but are not given out routinely and she would raise this with her ward sisters.
- Finally, the Chief Executive informed Sheila that the Trust had had a 29% improvement in mortality outcomes for fractured neck of femurs through dietary changes (by increasing calories by 500) and noted that this must have been a challenge for her reinforcing the importance of her earlier comments about her special diet..

The Chair thanked Sheila for her story and noted that he was heartened to hear that she had positive comments in addition to the areas for improvement noted.

[09:30]

175/17 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

176/17 MINUTES OF THE MEETING HELD ON 12 JULY 2017

RESOLVED: Amends suggested by Dr Feehily were acknowledged to have been received prior to the Board and these changes would be made. It was agreed that following these amends the minutes of the meeting held on 12 July 2017 would be agreed as a correct record and signed by the Chair.

177/17 MATTERS ARISING

All Matters Arising were noted to have been updated and completed prior to the meeting and the Chair thanked all Board members for

their input.

JUNE 2017 146/17 GOVERNOR QUESTIONS - CAPACITY ISSUES AND EXTENDED WAITING TIMES

The Interim Chief Operating Officer to review the content of letters, and share information more widely with staff about extended waiting times. To also explore the possibility of providing generic information in out-patient areas. The Chief Executive suggested that receptionists and volunteers might also be well placed to advise patients about likely waiting times.

Completed: Nursing staff and receptionists communicate to the patients when a clinic is running more than 30 minutes late. The same information is displayed on the white boards and electronic boards. As a result of the query we have asked for a quick audit to see compliance in all areas. We have also asked for facility for this information on self-check in desks when these are released.

JULY 2017 158/17 CHIEF EXECUTIVE'S REPORT - WHETHER RISE IN DEMAND WAS RELATED TO THE WARM WEATHER AND IF A SIMILAR TREND HAD BEEN IDENTIFIED ELSEWHERE

The Associate Director of Planning and Performance resolved to investigate this as reviewing the data for June demand has increased by 3.6% with an increase in minor injuries after 8-10pm.

Completed: June was a high demand month across the NHS which in our local health economy was related to the staffing shortages in MIUs and out of hours GP cover.

JULY 2017 159/17 QUALITY AND PERFORMANCE REPORT – REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 28 JUNE 2017 - THE IMPORTANCE OF LEARNING FROM TRAKCARE AND THAT THIS WAS A PROJECT ABOUT BEHAVIOURAL CHANGE WITH AN INFORMATION TECHNOLOGY (IT) COMPONENT RATHER THAN AN IT PROJECT WITH A BEHAVIOUR CHANGE COMPONENT. IMPORTANT THAT THE IT DID NOT COMPLETELY TAKE OVER.

The Director of Human Resources and Organisational Development shared that he would align with the Head of Leadership and Organisational Development and the project team.

Completed: The Head of Leadership and Organisational Development has joined the SmartCare Programme Board with a view to assisting with 'lessons learned' and considering OD support for future phases.

JULY 2017 160/17 FINANCIAL PERFORMANCE REPORT – REPORT OF THE CHAIR OF THE FINANCE COMMITTEE MEETING HELD ON 29 JUNE 2017 - AT A RECENT LOCAL NEGOTIATING COMMITTEE (LNC) DOCTORS CONFESSED TO A LACK OF UNDERSTANDING OF CIP

The Director of Human Resources and Organisational Development suggested the Director of Finance attend this committee in order to explain and engage staff further.

Completed: The Director of Finance and Director of Programme Management will attend the October Committee.

JULY 2017 161/17 WORKFORCE REPORT – REPORT OF THE DIRECTOR OF HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT – LESS NURSE RECRUITS FOR SEPTEMBER WERE NOTED AND FURTHER INVESTIGATION IS NEEDED AROUND WHAT COULD BE DONE TO RECRUIT MORE THROUGH CLEARING.

Chief Executive to discuss further with the Director of Nursing and Director of Human Resources.

Completed: Incentives agreed for students applying to UWE and Gloucestershire University resulting in target recruitment numbers being achieved by both institutions

JULY 2017 162/17 BOARD ASSURANCE FRAMEWORK- QUARTERLY PROGRESSING OF THE REPORT, PINPOINTING KEY ACTIVITIES WITHIN A PERIOD THAT HAVE BEEN COMPLETED WHICH CONTRIBUTE TO DELIVERY WHILST ALSO CONSIDERING KEY ACTIVITIES IN THE FUTURE PERIOD TO ESTABLISH WHAT SHOULD BE DONE

BAF template to be developed to include.

Completed: Added to Work Plan for October 2017.

JULY 2017 163/17 SMARTCARE PROGRAMME BOARD - BENEFITS TRACKING

Director of Clinical Strategy responded that she would further investigate this as a specific portion of the funding had been allocated to this and explained that she was currently investigating working alongside the Department of Health to develop benefits tracking. Further information would be provided in the next report.

Completed: Central funding for Benefit Realisation support agreed to enable the creation of benefit dashboards, benefit realisation consultancy support and a longer term clinical impact analysis on a set of defined areas to be agreed across the three Trusts in the SmartCare collaborative group. This equates to a total of £199,625 over the contracted period.

Future report will include a section on progress with benefits realisation.

JULY 2017 164/17 RESEARCH UPDATE

The Director of Finance requested to meet with the Director of Clinical Strategy outside the meeting to further discuss the topic.

Completed: Finance support for research activity clarified.

JULY 2017 166/17 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 19 JUNE 2017 - MINUTE AMENDMENTS

Dr Feehily noted that within page 7, bullet point 2 the minutes referred to morality as opposed to mortality. The Board Administrator would correct this.

Completed: Minutes amended.

JULY 2017 167/17 GOVERNOR QUESTIONS - BENEFITS REALISATION: THE BENEFITS OF TRAKCARE TO BE SHARED WITH GOVERNORS

To be progressed by the Director of Clinical Strategy.

Completed: Linked to 163/17.

Presentation to a future CoG when first benefits dashboards are available.
[09:37]

178/17 CHIEF EXECUTIVE'S REPORT

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

- A heightened focus on Accident and Emergency (A&E) services was noted across the NHS and as a result the Chief Executive had spoken with Pauline Philip (National Director of Urgent and Emergency Care) and would be attending a further national meeting the following Monday. She went on to note that this year's Winter Plan, developed by the Chief Operating Officer, was the most robust the Trust had ever developed.
- A&E performance at Gloucester Royal Hospital was noted to have peaked at 99.1% last week though the Chief Executive reflected that there were issues with volatility with a recent poor performance over the last week. These are suspected to be in relation to changes in activity with a real impact being felt when other services are not working to normal volumes. The Chief Executive did however explain that performance was 5% better than the previous quarter which was an encouraging position, going into the winter months
- The Board was updated regarding progress within the Sustainability and Transformation Plan (STP) with proposals having been recently presented to the Health and Care Overview and Scrutiny Committee from Gloucestershire Care Services (GCS) for a single Community Hospital in the Forest of Dean. The Chief Executive noted that this had been a long running aspiration and would address the current two hospitals which were not well placed to deliver modern healthcare and were outdated. The plan was noted to have strong support from the Health and Care Overview and Scrutiny Committee (HCOSC) and public consultation would begin on 13th September.
- Further progress was noted to have been made with regards to the STP Capital Bid with this having been submitted on 1st September. Though the bid was green rated the value of bids have exceeded the resources available.
- The paper celebrated success within the Trust and the Chief Executive went on to encourage the Board to think about how they are recognising success in their teams. Further work around celebrating success would be taken forward by the Director of Human Resources and Organisational Development. She also highlighted the Staff Awards which would take place on 21st September and thanked the community for its support and sponsorship which had resulted in the Trust being able to really invest in the awards.
- The Financial Governance Review action plan was presented at HCOSC with positive feedback received in response to progress against recommendations.

- The Chief Executive briefed that she and the Chair had met with the Deputy CEO/Executive Director of Regulation at NHSI to discuss the Trust's financial forecast. The Trust is currently forecasting an adverse position and the meeting had focused on actions to get plans and results back on track. She confirmed that in her opinion, the team and staff in Divisions were very focussed on this

In response to the Chief Executive a number of points were highlighted:

- Ms Barber noted the impact external trends can have on performance and shared that a session would be had with Governors regarding this. She felt interrogation and being aware of vulnerabilities was key.
- Reflecting on a point the Chief Executive made about the focus on flu, the Chair expressed how difficult freeing beds for flu would be. The Chief Executive recognised that the Trust has a significant flu vaccination campaign and reinforced that every opportunity would be taken to remind patients to get the flu jab and the Director of Nursing and Medical Director were investigating how to increase the number of staff who take up the jab. The Chief Executive felt it was important they link with the Communications team and 2gether Trust who had over 90% of staff receiving the jab last year. The Director of Human Resources and Organisational Development requested all executives reinforce the need for flu jabs whilst on their executive walkabouts. The Board agreed to lead the way by undertaking their vaccination at the October Board. **MA/SE** **ALL**

RESOLVED: That the report be noted.

[09:54]

179/17 QUALITY AND PERFORMANCE:

QUALITY AND PERFORMANCE REPORT – UPDATE OF THE CHIEF OPERATING OFFICER

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

Key points highlighted within the report were:

- 4.1% improvement in Trust performance against the 4-hour A&E standard in comparison to June.
- A&E attendances in July increased with 700 more patients seen than this time last year. In one day A&E was noted to have received 490 attendances against an average of 370, with 32-33 more patients being admitted than normal.
- Some partners such as Minor Injury Units (MUI) were noted

to be struggling with staffing resulting in reduced opening hours on occasions. GP out of hours coverage in July was also highlighted to have been challenging.

- Referral to Treatment (RTT) was reinforced to only be reporting in shadow form. 11 patients were noted to have had a 52 week breach in July and as a result all patients over 45 weeks will be reviewed and harm reviews undertaken.
- Cancer performance remains challenging with deterioration in comparison to June as a result of poor performance in colorectal, breast and dermatology services. The issues within Colorectal were noted to be primarily around excess demand and the Trust is working with its primary care partners to manage the increase in demand over the last few years as although referrals have increased, cancer rates have not.
- 62 Days cancer performance was noted to be 74% which is below trajectory though the most challenged service, urology, was now ahead of plan..
- July saw an increase in patients declining cancer 2 week wait appointments. Work has begun around this throughout August and this will be compared against 2016 and bought to the next Board Committee. **AK**
- Diagnostic performance continues to be challenging. This continues from February 2017 and is related to demand, mainly within colorectal with endoscopy services under pressure and also audiology. The team are attempting to combat this through Waiting List Initiatives (WLI's) and incentivisation. For the Trust to achieve the standards for endoscopy and audiology it needs to improve significantly as they are two very high volume specialities.

Overall the Interim Chief Operating Officer noted that the Trust was making progress against reporting national standards however Length of Stay (LoS) and admissions within 28 days were still challenging due to data quality issues and required a fix from InterSystems and this has been raised as a priority.

The Board further discussed the point around patient choice and the Chief Executive requested exploration of alerting GPs to a first refusal so they can contact patients to stress the importance of attending. The Medical Director would address these issues within iLead. **SE**

Mr Graves observed the summary scorecard and raised the possibility of deep dives in appropriate areas however the Chief Executive suggested that we use the Board Committees and Board Strategy & Development sessions to execute deep dives..

The Nursing Director sought to clarify a point within the paper which noted the cumulative number of patients with Clostridium Difficile (C-Diff) to be 42 – some of these were unavoidable. Overall there were 35 cases at the end of the year with an increased incidence on Ryeworth ward being investigated by infection control.

[10:11]

RESOLVED: That the 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 this position.

ASSURANCE REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 22 AUGUST 2017

Ms Barber presented the assurance report (having chaired the Committee on behalf of Claire Feehily) noting in particular the Winter Plan, Getting It Right First Time (GIRFT), TrakCare and Urology performance:

- She acknowledged that the Winter Plan had been developed early and was robust and thorough, though it needed a detailed supporting action plan. A review of this would be undertaken in the Governors' Strategy and Engagement Group.
- The GIRFT work was noted to be a positive governance framework that understood and celebrated best practice and ensured it was utilised elsewhere (with a particular focus on cost improvement). The Chief Executive concurred that the GIRFT plan was making good pace. The Medical Director highlighted that the work focused on the positives and opportunities of having a two-sited hospital.
- A deep dive into Trakcare would be discussed in the upcoming Board Strategy and Development Session.
- A deep dive into the Urology Department has been undertaken and a detailed action plan has now been created looking at performance. The Interim Chief Operating Officer noted this was having a positive effect with the team delivery over trajectory and the recovery plan would be presented to this month's Quality & .Performance Committee.

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

[10:19]

TRUST RISK REGISTER

The Chief Executive presented the Risk Register and noted that the register was unchanged from the July Board Meeting. She went on to explain that there were currently 30 risks that met the criteria for the register. This had been heavily debated at Trust Leadership Team (TLT) and the three relevant Divisions all had reviews of these risks in hand for presentation at October's TLT. It was expected that very few would be escalated to the Board once Divisional Board review was completed. .

Dr Feehily raised the risk around clinic builds and errors in templates and wondered how the Board was ensuring they received sufficient assurance regarding the issue. The Chief Executive reassured that this risk would be reviewed at the October Quality and Performance

Committee and the Interim Chief Operating Officer confirmed this was being reviewed by the Outpatient Steering Group and that the risk had been de-escalated as a result of the majority of the clinic templates now having been rebuilt and clinic utilisation having improved.

It was confirmed that the relevant risks and registers are reviewed at all Board Committees.

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.

[10:25]

PATIENT EXPERIENCE IMPROVEMENT IN RESPONSE TO BOARD STORIES

The Director of Nursing presented the report summarising the results and actions taken following previous patient stories and reminded the Board that this would continue as an ongoing quarterly report. All patients would receive feedback regarding the progress made.

Dr Feehily queried the process of accessing records and wondered whether the cost was a prohibitive barrier and felt it was worth discussing. The Chief Executive noted that a change to national guidance has been signalled which will remove the charge however, this will import a significant cost pressure if implemented as the Trust employs two WTE to service these requests which are funded from income.

RESOLVED: That the report be noted.

[10:29]

MORTALITY REVIEW

The Medical Director presented the report providing a summary against national guidance. He explained that the work was being overseen by the Hospital. The Medical Director emphasised that mortality reviews focus on improving care through identifying what can be learnt. Further work is being done to ensure investigations yield learning and that there is local ownership as currently this is only embedded within certain areas.. He noted that families are engaged via the Bereavement Team and that the medical examiner is undertaking investigations independent from the Trust and liaises with the family to identify whether there are any concerns, within 24 hours.

Mr Graves noted the included table of actions and queried whether the target dates would be achieved. It was agreed this would be further discussed at Quality and Performance Committee. **SE**

The Chief Executive asked whether the notion of avoidable death

was being explored through the approach to mortality reviews. The Medical Director responded that once structured reviews are done it is possible to assign avoidability however these reviews were not being done universally yet. He emphasised that learning was the crucial aspect of the review approach and training..

RESOLVED: That the Board accept the update as assurance of progress in line with the national guidance on mortality reviews.

[10:41]

180/17 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE DIRECTOR:

The Director of Finance presented the Financial Performance Report to the Board and gave a summary of the key points covered within. While the year to date position for the Trust is better than projection at £4.3m ahead of plan with the deficit at the end of month 4 at £12.2m the Director of Finance focused on the forecast which is significantly adverse:

- The annual plan for the Trust is £14.6m deficit. The current forecast, prior to mitigating actions, shows a deficit of £23.3m, an adverse variance of £8.7m.
- Work is under way to address the forecast with planned actions detailed within the report.
- It was noted that the Trust had agreed block contacts with commissioners to help mitigate the income risk however where this has not been possible there is a £8.9m shortfall - a £3.8m shortfall on variable income and a further £5.1m shortfall is a consequence of blocking and loss of the upside of over-performance against the contract.
- Two other factors were noted to offset one another. Cost Improvement Programmes (CIPs) have a total shortfall of £9.4m. The income element of this equates to £5.1m leaving an expenditure of £4.3m. This is offset by a pay underspend of £4.8m.
- Further plans for cost reduction are being developed and discussed with Divisions and NHSI.

The Board noted the Director of Finance's updates and raised questions in response:

- Ms Moon queried whether the new CIPs had been risk assessed. The Director of Finance responded that they had been through high level assessments but had not yet been risk assessed though work is ongoing around this. Ms Moon also queried the process around clinical sign off of CIPs and the Medical Director confirmed that Project Initiation Documents (PIDs) go through himself, the Director of Nursing and the Director of Safety and undergo specialty based impact assessment. Projects cannot progress until they undergo Quality Impact Assessment (QIA).
- Mr Foster noted the downside of block contracts in that

though they protected income they reduced the benefit of innovative ideas that improve income. The Director of Finance reinforced that even so schemes still needed to be developed given we will likely return to variable contracts next year.
- Mr Graves noted the importance of cost reduction and queried the Trust's resources around this. The Director of Finance explained that the Project Management Office (PMO) was currently suffering from staffing issues and were seeking to recruit further but he confirmed that the staff in post are focussed on the greatest opportunities.
- The Chief Executive noted the potential conflict between quality within the Emergency Department, addressing RTT and cancer against the financial situation.

RESOLVED: That the Board receive the report for assurance in respect of the actions being taken to improve the Trust's Financial Position.

[10:57]

ASSURANCE REPORT OF THE CHAIR OF THE FINANCE COMMITTEE MEETING HELD ON 30 AUGUST 2017

Mr Norton presented the report from the Finance Committee on 30 August which focuses particularly on the Capital Programme, the telephony project, income, CIP and medical productivity.

- It was confirmed that currently there is no available contingency within the Capital Programme position and that the contingency is instead built into the existing spend and relies on savings being made on planned projects. Whether an extra contingency should be created will be reviewed.
- Leasing may not be an option for the telephony project which will have significant implications on funding. This will be discussed further at the next Finance Committee.
- The Finance Committee debated whether CIP had lost momentum. The Chief Executive didn't believe this to be the case but the scale of the challenge has increased significantly and therefore even greater focus is now required.
- Medical productivity would continue to be a standing item at Finance Committee due to concerns regarding delivery of savings.
- The Finance Risk register will be further reviewed in light of escalating risks in respect of the Financial Recovery Plan.

In response to the report, Ms Barber felt that a focus on embedding CIP within the organisation was key, with ownership amongst areas. The Chief Executive noted that she felt there was evidence of embedded awareness – the recent listening events with administrative and clerical staff revealed that they were very aware of CIP but in large part this was because of the impact of CIP controls in respect of discretionary spend.. She also anticipated that new executives set to join the Board would aid CIP with new perspectives and experience from within their current organisations..

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

(The Board adjourned from 11:10 to 11:25)

181/17 WORKFORCE

REPORT OF THE DIRECTOR OF HUMAN RESOURCES AND ORGANISATIONS DEVELOPMENT

The Director of Human Resources and Organisational Development presented the Workforce Report and emphasised the key points noted within:

- Sustained nursing reduction work continues alongside the Director of Nursing and Divisional Nursing Directors to avoid spikes associated with holiday periods.
- The pay bill for July was £300k less than July 2016. Figures for August are not yet confirmed however a similar level of reduction is anticipated arising from greater agency controls; similar traction needs to be extended to medical expenditure. The primary strategic aim is to fill positions substantively however, a medical bank is being developed to limit spend on locums in the interim. It was noted that the bulk of pay reduction would be achieved in February and March. Supply and retention was also emphasised as a key element to keeping costs down.
- There has been a positive recruitment campaign over summer with the newly qualified nurses and as a result 70 out of the 90 nurses who expressed an interest in joining the Trust will be starting with the Trust.
- Retention figures are improving and this is attributed to continued efforts around staff engagement, incentivisation and review and response to issues coming out of exit interviews.
- Annual sickness rates remain below average. The Chair challenged within Workforce Committee whether these figures were accurate and this is being investigated.
- Appraisals are down at 79%. Reasons for this vary however The Director of Human Resources and Organisational Development reiterated that these must be done and this message is being reinforced through the divisions.
- Mandatory training is at 90% (against the 95% standard) and this will therefore be a focus for the executive divisional reviews.
- PWC have been asked to audit practice around visa and immigrations requirements in order to obtain a robust view on compliance with policy in light of recent issues.

Following the presentation a few points were noted and raised by the Board:

- Mr Norton highlighted the review of Vacancy Control Panel

(VCP).

- The Chief Executive wondered how the newly qualified nurses would be deployed to support wards with many vacancies and the Nursing Director explained that this is being investigated but would focus on a rotation system in order for nurses to gain a breadth of experience. There would however be incentivisation for nurses to work on more challenged wards. The Chief Executive said that despite previous assurances, she had visited a ward where 75% of qualified staff on shift were temporary staff and asked that the Director of Nursing investigate this again. **MA**

The Director of Nursing stated she would investigate this but noted that the Trust cannot compel nurses to work on certain wards.

- The Chair felt a strong focus was needed on investigating why staff who manage others, may not be acknowledging appraisals as key priorities.

RESOLVED: That the Board note the positive trends illustrated in the report.
[11:42]

ASSURANCE REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE ON THE MEETING HELD ON 24 AUGUST 2017

Ms Barber presented the report from Workforce Committee on 24 August 2017 and noted in particular the VCP review, the Workforce Race Equality Standard and the Leadership Strategy. The Leadership strategy was noted to be in its first draft and touches on appraisals and how talent is identified. The Chief Executive noted that the Leadership Strategy had gone straight to Committee without going via the Education, Leadership and Development (ELD) Strategy Group. The Director of HR & OD said he was aware of this and it would be shared with members of ELD, and the incoming Director of People, for comment prior to final Board approval.

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

[11:44]

WORKFORCE RACE EQUALITY STANDARD

The Director of Human Resources and Organisational Development presented the Workforce Race Equality Standard (WRES) and explained that the report was in its third year and would be followed by further investigations into disability and sexual orientation. Key points highlighted from the report were:

- Progress has been made in regards to five indicators, three indicators have deteriorated and one has remained static.
- There will now be a focus on re-energising the Equality Steering Group with the new chair and vice chair.
- The report details the summary of the Trust's performance

and reflects that the workforce population is changing with an increased percentage of Black, Asian & Minority Ethnic (BAME) staff than that of the Gloucestershire population in general. This is not reflected within senior roles however it is within the medical workforce.

- The likelihood of BAME staff being appointed has increased and BAME staff believe the gap for opportunities is narrowing however there is still a 7% gap which the Director of Human Resources and Organisation Development noted was important to focus on. He also challenged the Board that it should aspire to be representative of the people of Gloucestershire in its demographic make-up..

The Chair thanked the Director of Human Resources and Organisational Development and acknowledged that the report was important and felt the team were focusing importantly on unconscious bias.

RESOLVED: That the Board

- Accept the findings in the WRES report
- Accept the action plan 2017-2018 for the Equality Steering Group

  Provide visible leadership and support, as required, to ensure successful delivery of the action plan and consider the diversity of Board members when making future appointments to the Board.

[11:49]

182/17 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 11 JULY 2017

Mr Graves presented the report from Audit and Assurance Committee on 11 July 2017 and noted in particular the internal audit report, cybersecurity presentation and recommendations tracker.

The cybersecurity presentation detailed a phishing exercise by PWC where staff were asked questions for identification. The response to this was relatively high prompting a number of actions. It was however noted that in order to conduct the exercise the information technology department did have to lower a security wall.

Many actions were noted to be outstanding within the recommendations tracker however executives have been processing this and the number has decreased significantly since the last committee..

Dr Feehily queried the internal controls over agency and where the sharing of information is noted. The Medical Director explained that the Director of Operations for Women's and Children's has transferred to Medicine, thereby transferring skills. The Director of Human Resources and Organisational Development also noted this is discussed within Agency Programme Board.

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

[11:55]

183/17 SMARTCARE PROGRESS REPORT

The Director of Clinical Strategy presented the SmartCare progress report to the Board to provide assurance from the Trust Leadership Team and the Smartcare Programme Board, on progress towards the stable operation of TrakCare post Phase 1 go-live and planned implementation of Phase 1.5. Key points highlighted within this were:

- A significant update has been received which has had little impact on service at the point of update. This update has fixed a number of issues.
- There is an improving relationship between Intersystems and the Trust regarding how we raise requests for change. Work is also being done on improving understanding of issues with the first link team and correct articulation of issues.
- Further roll out of TrakCare is being discussed at the Smartcare Board with the addition of the ability for clinicians to order and view imaging through the system. Provisional date for deployment of this is 18th October in the A&E Department. The Interim Chief Operating Officer is leading work around operational readiness. It was also noted that the system is working with a test environment so staff can practice utilising this..
- Understanding needs to be clarified around where the Trust stands regarding contractual obligations to deliver functionality within certain time periods. A meeting will take place with Intersystems which the Chair will join.
- Benefits realisation has been of interest to Governors and this is being reviewed. This will potentially be brought to November Board but will be reviewed at Smartcare Programme Board initially. **SP**
- Increasing reliance on TrakCare as roll out proceeds presents issues for staff who require access to support as the help desk is only accessible between 9-5 and she reinforced the importance of taking this into account and investigating extended levels of cover. Funding for an extended help desk had been agreed as part of budget setting and the Chief Information Officer had been tasked with understanding why this hadn't progressed and taking remedial action.

The Chief Executive noted that further deployment of future system functionality had been discussed at some length at TLT and agreed that despite challenges this should be progressed and further thought given to how staff are re-engaged on the back of what should be additional clinical value. TLT had concluded that there was significant evidence of lessons learnt from the initial deployment of the system had been built into the approach to further roll out.

Dr Feehily queried whether Phase 1.5 would have any effect on patients and the Director of Clinical Strategy explained that it should not however patients should experience quicker flow of their care.

RESOLVED: That the Board note the report as a source of assurance that the programme to identify issues within the respective operational and support areas to achieve a satisfactory recovery for Phase 1 and planning for subsequent phases is developing..

[12:16]

184/17 RISK MANAGEMENT STRATEGY

The Chief Executive presented the Risk Management Strategy to the Board which brings together key learning points and system improvement to the Strategy. She drew particular attention to the section regarding Risk Appetite. The incoming Director of Quality and Chief Nurse has reviewed the document and provided further comments and therefore the Chief Executive asked for delegated authority to make what were further minor changes to the strategy document in respect of the role of the Director of Quality.

The Chair wondered whether risk appetite should be discussed at a Board Strategy and Development Session and the Chief Executive felt this could be a useful debate provided it was debated in the context of its practical application. The Board Administrator would note this for an upcoming Strategy & Development session. **NJ**

RESOLVED: That the Board approve the Risk Management Strategy and delegated responsibility to the Chief Executive to make minor changes as described above.

[12:22]

185/17 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

The Medical Director presented the quarterly report on Safe Working Hours for Doctors and Dentists in Training and thanked the author Russell Peak, the Trust Guardian of Safe Working Hours. He explained that there is a requirement for organisations to have a Guardian independent of the general structure of the Trust. Key points highlighted from the report were:

- A higher number of exception reports than previously. This is reflective of an increase in the number of doctors moving to new contacts. and challenges in the
- The highest number of exceptions remains in the neurology department. Work is ongoing to investigate solutions but there is currently no evidence that doctors are routinely working unsafe hours.
- The Medical Director explained that where an issue is raised the resolution is down to the education supervisor. Further work needs to be done around the prompt and effective

resolution of these issues as opposed to simply exception reporting them.
- Some time frames and targets have been missed in particular one around the introduction of the system Allocate however this is now within the organisation and training is ongoing with implementation scheduled from 1st October.
- There are currently 42 gaps in the training cohort of doctors and though this is worrying it is in line with other Trusts.
- It was noted that Mr Peek has stood down from his role as Guardian due to another role and the Trust has advertised for expressions of interest with interviews scheduled for mid-October. The Board asked for their thanks to be passed across the Dr Peek for his work to establish the new system.

Dr Feehily wondered whether staff were encouraged to use Freedom To Speak Up services and the Director of Human Resources and Organisational Development explained that this was available to everyone but that he was not aware of any issues coming via this medium. The Chief Executive noted that because of the relationship between doctors and supervisors issues are normally raised directly between the two. It was also noted that junior doctors could go to Local Negotiating Committee (LNC), Junior Doctors' Forums and the Deanery as well as complete GMC surveys.

The Chief Executive asked the Medical Director to work with the Director of Safety to investigate the incident profile and outcomes in relation to what junior doctors are reporting so this could be included in future reports as a further source of evidence in respect of safe working practices . **SE**

RESOLVED: That the Board accept the report as assurance that the Trust is meeting the national requirements in respect of the Guardian role and that matters of concern raised in the paper are being addressed by the Executive leads

186/17 GOVERNOR QUESTIONS

The Lead Governor thanked the Board for their reports and noted the following points:
- He was pleased to read the reports updating on the actions taken in response to patient stories, TrakCare, risk strategy and mortality.
- With regards to mortality, he queried whether external medical examiners were a national initiative and the Medical Director confirmed they were but that our Trust was a pilot and therefore ahead of the curve.
- He noted the first matter arising and felt though the update was informative this item was not yet closed. It was agreed this would instead go through the Governors Log.
- Support for the STP changes was noted however the Lead Governor wondered how the patients of the Forest of Dean felt and noted the media perspective towards the topic.

Mr Marstrand queried whether the Trust was aware of the proposed reduction in community beds in the Forest of Dean and what risk

assessments were being done in regards to the reduction in beds across the community. The Chief Executive explained that she was aware of this and the STP was the vehicle through which these impacts and interdependencies were worked on. Of note she added that, the reduction in beds reflected those beds which accommodated patients from outside the Forest. Gloucestershire Care Services (GCS) are to develop virtual wards which will care for with patients in their homes with extra support who would otherwise have been admitted to a community hospital. £2.5m of funding had been granted to GCS, from the Better Care Fund, to develop this.. The Chief Executive also reinforced that any changes in the Forest of Dean were subject to consultation. The Director of Clinical Strategy noted that there are many more services offered in the community than ever before and that *One System Business Case* being developed by STP partners would need to demonstrate how such risks were to be mitigated.

187/17 STAFF QUESTIONS

There were none.

188/17 PUBLIC QUESTIONS

There were none.

189/17 ANY OTHER BUSINESS:

It was explained that this would be the Nursing Director's last Board meeting before her retirement. The Chair thanked the Nursing Director on behalf of the Board and Governors for her work and emphasised that she would be missed across the Trust.

ITEMS FOR THE NEXT MEETING:

None were noted.

190/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Wednesday 11 October 2017** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital**

191/17 EXCLUSION OF THE PUBLIC

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

The meeting ended at 12.53 pm.

Chair
11 October 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
October 2017	September 2017 174/17 Patient Story	**MA/SH**	Policy around patients bringing food from home.	The Director of Nursing vowed to ensure that clerical staff understood this and would raise this at the next Senior Nursing and Midwifery Council (SNMC)	*Completed: Discussed at September SNMC.*
October 2017	September 2017 174/17 Patient Story	**MA/SH**	Trauma Discharge Process	The Director of Nursing expressed concern that Sheila was not assessed for a raised toilet seat and would investigate to ensure patients are being discharged correctly.	*Completed: The Head of Patient Experience has meet with the therapy team to seek assurances that patients are appropriately assessed as part of a comprehensive discharge process. Further improvement work is planned with the therapy and nursing team.*
October 2017	September 2017 174/17 Patient Story	**MA/SH**	Discharge from physiotherapy services	The Director of Nursing vowed to investigate this as Sheila should have been referred to a physiotherapist in the Community.	*Completed: The senior physiotherapy team have reviewed their referral process and have strengthened links with community services.*
October 2017	September 2017 178/17 Chief Executive's Report	**MA/SH/ SE**	Flu vaccination	The Director of Nursing and Medical Director were investigating how to increase the number of staff who take up the jab.	*Completed: Communication to medical staff undertaken as part of Flu communications campaign.*
October 2017	September 2017 179/17 Quality And Performance Report – Update Of The Chief	**AK / CL**	Patients declining 2 week wait appointments.	Work has begun around this throughout August and this will be compared against 2016 and bought to the next Board Committee.	*Completed: We have not been able to compare fully with the 2016 data due to lack of information available. However, for June, July and August 2017 patient choice is*

	Operating Officer				*noted as the reason for decline in appointment 49, 40, 64, 44 times respectively for each month for 2ww appointments with 8,6 and 4, 4 patients declining a treatment dates on the 62 day pathway for June, July and August, September respectively. These are the highest recorded numbers since December 2016. In respect of cancer patients, the Central Booking Office looks to verbally agree two week wait appointments where possible.*
October 2017	September 2017 179/17 Quality And Performance Report – Update Of The Chief Operating Officer	**SE**	Alerting GPs to first refusal of appointments so they can contact patients to stress the importance of attending	The Medical Director would address these issues within iLead.	*Completed: Discussed at joint GP meeting and a number of joint training initiatives in place to ensure patients aware of importance of attending appointments.*
October 2017	September 2017 179/17 Mortality Review	**SE**	Mr Graves noted the included table of actions and queried whether the target dates would be achieved.	It was agreed this would be further discussed at Quality and Performance Committee.	*Completed: Target dates will be achieved and monitored through the Q+P committee.*
October 2017	September 2017 181/17 Report Of The Director Of Human Resources And Organisations Development	**MA**	Distribution of newly qualified nurses	The Chief Executive said that despite previous assurances, she had visited a ward where 75% of qualified staff on shift were temporary staff and asked that the Director of Nursing investigate this again.	*Action will be progressed by the Director of Quality and Chief Nurse as part of the due diligence relating to nursing workforce and safe staffing, this will be completed by the end of October 2017.*
October 2017	September 2017 184/17 Risk Management Strategy	**NJ**	The Chair wondered whether risk appetite should be discussed at a Board Strategy and Development Session and the Chief Executive felt this could be a useful debate	The Board Administrator would note this for an upcoming Strategy & Development session.	*Completed: noted.*

			provided it was debated in the context of its practical application.		
October 2017	September 2017 185/17 Guardian Report On Safe Working Hours For Doctors And Dentists In Training	**SE**	To investigate the incident profile and outcomes in relation to what junior doctors are reporting so this could be included in future reports as a further source of evidence in respect of safe working practices.	The Chief Executive asked the Medical Director to work with the Director of Safety.	*Completed: This will be developed with the new junior doctors' guardian and included in the quarterly report.*

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
November 2017	September 2017 183/17 Smartcare Progress Report	**SP**	Benefits realisation has been of interest to Governors	This is being reviewed. This will potentially be brought to November Board but will be reviewed at Smartcare Programme Board initially.	*Commitment from Smartcare Team to provide a refresh of the history of decision making around Smartcare for the Board and for Governors. Awaiting for date to be identified*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2017

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Operational pressures remain volatile with September unexpectedly seeing one of our busiest days of the year resulting in 470 people attending our Accident and Emergency (A&E) departments in contrast to the usual average of 370. Detailed analysis of the picture on this particular Sunday revealed nothing extraordinary within the system. Demand for services was up across the County with minor injury units and our ambulance partners reporting record level of attendances; similarly significantly more people were admitted to our hospitals as a result of their attendance. This is a reflection of the acuity of some of this excess demand but equally demand for minor injury and minor ailment care was also up. Days like this one, reinforce the importance of the work we are doing as part of our *Sustainability and Transformation Programme (STP)* to support people to keep themselves well and to consider alternatives to hospital before they present to services like A&E. In respect of A&E performance against the 4 hour waiting time standard, we ended September slightly below August's levels of performance though we continue to achieve the national standard (and our recovery trajectory) on more days than we did in the previous quarter which tells me that when demand is on line with our plan, performance is significantly improved but when demand is higher than expected we fail to hold performance. Whilst this is not where we want to be, this of itself is a valuable insight into where our next focussed effort needs be. Work to review our current 'surge' plan is underway and is a priority for Winter.

2. National and Regional

2.1 On the 4th September I attended a national event addressed by Rt Hon Jeremy Hunt, (Secretary of State for Health) Simon Stevens (Chief Executive NHS England) and Jim Mackey (Chief Executive NHS Improvement). The event was targeted at the Trust's most at risk of not achieving the A&E improvement trajectory over the winter period and who therefore fall into category 3 or 4 of the national risk profile. Ministerial expectations for the coming winter are high, as one would expect given the importance of this agenda however, there was clear recognition that the threat of a flu pandemic increased the risk profile in respect of performance against the 4 hour standard. The meeting was also addressed by David Beehan (Chief Executive of the Care Quality Commission - CQC) who focussed positively on the importance of keeping patients safe whilst in our urgent and emergency care services and particularly at times of peak activity – he reiterated the growing mantra that an empty A&E is a safe A&E. He confirmed that a number of Trusts would receive unannounced inspections of their services over the winter months and given that our most recent CQC rating for urgent care was *Requires Improvement*, the Trust is likely to be inspected. External eyes on our services are always welcome and we shall embrace this for the opportunity. It affords us to receive external assurance of our services and provide insights into areas where we have further scope for improvement.

2.2 Nationally, NHS Providers (NHSP) continues to raise many valuable issues on behalf of provider organisations. Chris Hopson (Chief Executive of NHSP) has taken the time to understand our own Trust's position and is a positive advocate for the organisation in many settings. Currently NHSP is raising concerns about the national approach to control totals, and the absence of a system view of finances, which is particularly germane given our own context; they are also shining a welcome light on the impact of patients whose discharge from hospital is delayed. Positively, last month our own Delayed Transfers of Care were better than the national target for the first time in more

than a year – our focus remains however as every patient who experiences a delay, is a delay too many.

2.3 NHS Improvement has approached a small number of Trusts to contribute to a piece of national work to develop the next phase of the national Financial Improvement Programme (FIP3). The Trust was invited to join four other organisations following a recommendation from Professor Tim Briggs (National Lead for the Getting It Right First Time Programme) as a result of what was described as our 'impressive commitment to performance improvement'. Huge credit to Dr Sean Elyan (Medical Director) Mr Vinay Takwale (Chief of Service – Surgery) Dr Daniel Engelke (Speciality Director for Trauma and Orthopaedics, Debbie DeWitt (Project Lead) and a host of others (too many to mention) that have led the Trauma and Orthopaedic reconfiguration work that Professor Briggs has been so impressed by.

2.4 Last week, following a shadow period, the Boards of NHS England and NHS Improvement approved revised arrangements for regional oversight of providers and commissioners, resulting in the alignment of responsibility for the accountabilities of both organisations being vested in single individual, on a geographical foot print. In practice, this means that we will move from being part of the South Sector to being part of the smaller South West sector and have a single accountable officer (AO) for both NHSE and NHSI, as opposed to two. The AO for the South West is Jennifer Howells; Jennifer was previously AO for NHSE South. These new arrangements were launched with a meeting of all Chief Executive Officers (CEO) on the 4th October at which Jennifer described the regional priorities which she set out as Urgent & Emergency Care, Cancer, Mental Health and Primary Care. Further detail can be found at Appendix 1. There are potentially significant benefits to be realised from this approach, particularly if this alignment is mirrored beneath the AO role.

3. Our System and Community

3.1 The One Gloucestershire Sustainability and Transformation Partnership (STP) has had its first meeting under the leadership of its new independent chair, Mr Chris Creswick. Chris has much history with the County from previous roles and is bringing a welcome fresh perspective and healthy challenge to the Partnership. Of particular note is Chris' aim to ensure that the different pieces of "architecture" in the STP arrangements are value adding and complimentary in their approach. The Gloucestershire Strategic Forum (GSF) remains the key oversight forum for the STP and this is where Chris is targeting his considerable expertise and knowledge. Chris is passionate about demonstrating improvement and impact and is rightly pressing us all to consider how we will better define, measure and demonstrate the STP's impact.

3.2 There have been a number of significant strategic milestones within the STP since my last report which are worthy of note. Firstly, commencement of public consultation on the reprovision of community hospital facilities in the Forest of Dean which positions a 'strongly preferred' option of a single, new hospital for the Forest, replacing the two existing facilities. Its first public airing at the Health & Care Overview and Scrutiny Committee (HCOSC) was well received. In addition, the STP re-presented its vision for the development of stroke services to the South West Clinical Senate, following on from the initial review earlier this year, which raised some concerns about the proposals. The team were commended for the work that has been completed in the intervening period and the Senate positively endorsed the proposal. In summary, the proposal, when implemented, will provide an additional community based specialist stroke rehabilitation unit (within one of the existing community hospital facilities) and also result in the further development of acute inpatient stroke care through the enhancement of therapy input including physiotherapy, occupational therapy and speech & language therapy. One of the most impressive aspects of the presentation to the Senate was the scale of improvement that has been achieved against the national stroke quality measures since the last presentation. The team were also able to show how those measures that still fall short of the required standards will be met through the community rehabilitation proposal.

3.3 Looking forward, the focus of the next month will be the finalisation of the *One System Business Case* which will set out the vision for the development and reconfiguration of urgent, emergency and some elective care services across the County, with a particular focus on aligning the model for urgent and emergency care with the new national expectations for care and services. As part of this wider case, the Trust is developing its own component case for those changes which affect our own services and this will be presented to the Board in November. The thrust of the case is to ensure that wherever patients reside in the County, they get access to the very best specialist care, in a timely way and with outcomes that match the best – to achieve this we will be continuing the journey started many years ago to consolidate some of our specialist services on one or the other of our sites as we have done for children and oncology services.

4. Our Trust

4.1 There are numerous exciting service developments in the final stages of implementation as we head towards winter. The most significant of these is the reconfiguration of Trauma and Orthopaedic services, with the aim of ensuring that patients awaiting routine orthopaedic care, do not experience the effects of winter pressures as they did last year which resulted in large numbers of operations being cancelled and/or deferred until the spring. The proposals, which are to be implemented from the 23rd October, will result in the majority of planned, inpatient orthopaedic surgery (for adults) being undertaken on the Cheltenham site. The only exception to this is spinal surgery, which will continue to be delivered on our Gloucester site alongside inpatient trauma care which will be concentrated on the Gloucester site. The expected benefits to this approach are multiple but the key benefits are the 'ring fencing' of elective care in the winter months to ensure operations are not cancelled as they have been previously (as a result of pressures elsewhere in our hospitals) and, based on experience elsewhere, the model is expected to result in significant productivity improvements which will allow more elective patients to be treated than is currently possible in the model we have, thus expediting care and reducing waiting times. Finally, if we realise our vision it is hoped that much of the elective work being undertaken in local independent sector hospitals can be repatriated to our Trust with the associated income benefits.

4.2 Other developments including the expansion of frailty services, particular at the front door of our hospitals to reduce the number of older patients who are admitted to hospital and as a consequence experience a loss of independence with the resulting consequences, the establishment of a Surgical Emergency Assessment Unit which will enable patients with suspected surgical problems to be assessed more promptly and on occasions without recourse to A&E en route – again evidence from elsewhere shows not only a more positive and timely patient experience but fewer admissions following assessment by surgical specialists. Both of these developments have been funded through the additional resources allocated to local authorities following the last budget which were aimed at improving A&E performance.

4.3 On the 21st September more than 300 staff and guests came to together for the Trust's Annual Staff Awards. Although in its seventh year, it is clear from the feedback that this year's awards reached new heights in respect of the evening itself and impacted on both those who attended and staff morale. The evening was generously supported by a number of sponsors including Interserve, Alpha Colour, Colour Connection, Vital Energi and donors Gatenby Sanderson and the West of England. Such was the success of the evening, one of our major sponsors has doubled their pledge for next year! Details of award winners can be found of the Trust website.

4.4 On the 3rd October the Trust welcomed more than 70 foundation Trust members to its Annual Members Meeting (AMM). The event was a chance to look back on both the challenges and successes of 2016, as well as sneak look at the year ahead. Without doubt, the highlight of the event was the presentation from Dr Peter Kempshall which showcased the fabulous work he and a dedicated team of staff have done in the last year to improve care and, most importantly, improve outcomes for the hundreds of patients who are unfortunate enough to suffer a fractured neck of femur following a fall. A year into the project, the team have delivered a 36% reduction in deaths following a fractured neck of femur as a result of the improvement project – equivalent to saving 20 lives. The meeting also announced the appointment of a number of new Governors and Alan Thomas, Lead Governor, took the opportunity to thank those Governors who have retired or resigned from their role this year.

4.5 Recruitment to the executive team is almost complete following the recent appointment of Lukasz Bohden to the post of Director of Corporate Governance. Lukasz joins us from the Oxfordshire health system and brings a wealth of experience and notably an exciting vision for the role, alongside an obvious passion for the Trust and county. Interviews for the Director of Strategy and Transformation take place on the 3rd November and again, I am heartened by the strength of the field.

4.6 Finally, since my last report, the findings and recommendations arising from the Financial Governance Review have been presented to the September meeting of the Health and Care Overview & Scrutiny Committee (HCOSC). The report was well received and Trust members present were thanked for their openness and transparency in respect of the review and commended on the progress towards implementation of the arising recommendations.

Deborah Lee

Chief Executive Officer

October 2017

APPENDIX 1

NHS Improvement NHS England

Top priorities – progress and next steps

Cancer

- 7000+ more people surviving cancer
- Fast track cancer drug fund
- 1.7 million urgent referrals from GPs

Mental health

- 2/3 country covered by criminal justice liaison
- 3x fall in use of police cells as places of safety
- 2/3 increase in Dementia diagnosis rate

UEC

- 23 million patient visits to A&E in 16/17
- NHS 111 takes 15 million calls each year
- Expanded ‘head and treat’ & see and treat ambulance service

Primary Care

- Service for GPs suffering mental ill health
- Modernising GP buildings and IT
- Funding up by 8% over the past 3 years

Cancer

- Speed up & improve diagnosis
- 5,000 more people to survive cancer over the next two years
- Largest radiotherapy equipment update in 15 years

Mental health

- 60,000 more people with access to therapies
- 280,000 extra health checks
- 24 hour MH liaison teams availablele in more A&Es

UEC

- Free up 2-3,000 hospital beds
- Roll out standardised UTC
- Increase number of clinically assessed 111 calls

Primary Care

- Access to evening & weekend appoints by Q4 18/19
- By 2020/21 5,000 more doctors
- Six million patients to benefit from locating pharmacies with GPs

MAIN BOARD – OCTOBER 2017

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

Report Title
Quality and Performance Report
Sponsor and Author(s)
Authors: Felicity Taylor Drewe, Associate Director Planning & Performance and Arshiya Khan, Interim Chief Operating Officer Sponsor: Caroline Landon, Chief Operating Officer
Executive Summary

Purpose

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

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

Key Issues to note

During August, the Trust did not meet the national standards or Trust trajectories for A&E 4 hour wait; 2 week wait and 62 day cancer standard; 18 week referral to treatment (RTT) standard (shadow reporting); and 6 week diagnostic wait. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care to ensure that patients do not come to harm due to delays in their treatment.

However, in August 2017, the trust performance against the 4hr A&E standard showed an improvement of 4.63% compared to July 2017. Whist, this represents the best performance against the 4-hour standard since November 2016 and continued improvement, the year to date performance and Q2 performance remains under the national standard and the NHSI trajectory. During August performance of 90% or over was seen on 15 days which was a significant improvement from previous months. Month to date performance for September is 86.3%

A&E attendances followed a similar pattern to June, with ED attendances in August compared to last year increased by 3.9%. Overall year to date activity is 2.8% higher. The Minor Injuries & Illness Units continued to face staffing challenges which coupled with out of hour staffing gaps which has impacted on our A&Es attendances.

Within the trust the various work streams under the Emergency Care Programme have gained moment and good progress was noted for the numbers seen by GPs at the front end in Gloucester A&E, overall numbers going through our ambulatory care services, continued downward trend in the medically fit for discharge patient numbers, early Comprehensive Geriatric Assessment and discharge from A&E by our geriatricians were extended service is provided during the weekdays. These initiatives have improved the flow of patients on the emergency care pathways with fewer bed related breaches.

The main focus for the next quarter is improvement in the number of breaches due to late assessments in A&E through efficiencies within the A&E, the implementation of a Surgical Assessment Unit, extended opening hours for ambulatory care at Gloucester and establishment of medical HOT clinics.

In respect of RTT, we continue to monitor and address the data quality issues following the migration to TrakCare. We have started reporting the RTT position in shadow form and will return to full reporting for December 2017. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways; however, as reported previously to the Board we will continue to see 52 week breaches until full data cleansing exercise is completed. In August we are reporting 19 breaches. All patients have a TCI date. No clinical harm has been reported, from the reviews undertaken to date. A new protocol to review all patients waiting >45 weeks will be implemented from September.

Our performance against the cancer standard saw deterioration against the 2 week standard with performance at 70.3% (Un-Validated). The main tumour sites that were compromised on the 2 week pathway were colorectal which continues to see a very high demand resulting in capacity issues, dermatology due to a combination of increased demand and capacity issues. With breast operating with some residual capacity issues. This shows the relatively low capacity resilience due to national staff shortages in some of our highly subscribed services. Waiting list initiatives are in place and performance for breast and dermatology is expected to deliver against the standard from September in respect of 2 week wait whilst work continues with our primary care colleagues for managing demand on our colorectal services. In, addition, to these three areas a higher than average of patient choices contributed to the breaches. The impact of the un-delivery in the 2 week wait pathway will impact on the 62 day pathway performance in the coming months.

62 days Referral to Treatment performance was 79.8% (Un-validated) which represents an improvement in performance compared to July, however, as noted above the pressures on the 2 week pathway will impact on this in later months. The Cancer trajectory for this metric is under review and will be presented to October Cancer Services Management Board for evaluation and agreement.

The Trust did not meet the diagnostics target in August at 4.8%, mainly driven by underperformance in two areas; colonoscopy with 240 breaches (190 in July); audiology with 57 breaches. Recovery plans are in place for these diagnostic areas, an assessment of performance of all the diagnostic areas, capacity and individual recovery plans is being undertaken for delivery against the standard by December 2017.

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

<u>Conclusions</u>

Cancer under-performance is significant this month and relates to the 2 week wand 62 day pathway. For the former, issues with capacity, some issues of referral increase (Dermatology and Colorectal) and patient choice (sometimes due to short notice appointments) have impacted delivery. Diagnostic recovery and underlying issues with Endoscopy remains an area of focus as it impacts other pathway's delivery. Additional waiting lists undertaken by the Trust and through external parties will support recovery. Alongside this the Board level support for the Central Booking Office and RTT validation will significantly positively impact team's ability to manage breaches and forward plan the required capacity ahead of time.

Significant focus from operational teams continues in order to improve performance against the national standards. Clinical oversight of patients awaiting care continues to ensure that no patients come to harm due to delays in their treatment.

Recommendations

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

Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients
Impact Upon Corporate Risks
Continued poor performance in delivery of the four national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators
Regulatory and/or Legal Implications
The Trust remains under regulatory intervention for the A&E 4-hour standard.
Equality & Patient Impact
Failure to meet national access standards impacts on the quality of care experienced by patients. There is no evidence this impacts differentially on particular groups of patients.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period August 2017

to be presented at September 2017 Quality and Performance Committee

Executive Summary

The following summarises the key successes in August 2017, along with the weaknesses, opportunities, risks and concerns for the Trust into September 2017.
Executive Summary:
Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During August, the Trust did not meet the national standards or Trust trajectories for A&E 4 hour wait; 2 week wait and 62 day cancer standard; 18 week referral to treatment (RTT) standard; and 6 week diagnostic wait. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients awaiting care to ensure that patients do not come to harm due to delays in their treatment. The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The trajectory for delivery of cancer performance of the 62 day pathway was set to deliver from July 2017, which has not been achieved. The trajectory for 62 days will be reviewed and submitted to the Cancer Services Management Board for approval. Alongside this there has been a failure to deliver in the 2 week wait pathway.

Cancer underperformance is significant this month and relates to both the 2 week wait and 62 day pathway. For the former, issues with capacity, some areas of referral increase and patient choice (sometimes due to short notice appointments) have impacted delivery. Diagnostic recovery and underlying issues with Endoscopy remains an area of focus as it impacts on other pathway's delivery. Additional waiting lists undertaken by the Trust and through external parties will continue to support the Trust's recovery. Alongside this the Board level support for Central Booking Office and RTT validation will significantly positively impact teams to manage breaches and forward plan the required capacity ahead of breaches.
Key areas where additional reports have been provided for the Quality and Performance Committee are:
• Trakcare Operational Recovery (including Reporting Re-commencement template & summary)

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

Strengths

• A&E 4 hour performance has continued to deliver improved performance and is encouraging, however performance is below the trajectory set and agreed with NHS I.
• 104 days performance has stabilised and is a significant improvement in the catergory of patients who do not have a TCI (21 June to 8 in July), which is positive, this combined with our analsysis of 62 day pathway 'long wait category' indicates we are making progress for our longest waiting patient cohort,though conversely this impacts on our overall performance. Since December 2016, when we reported 62 patients over >104 days, to 46 in September 2017.• Medically fit at 58 remains relatively stable during this period as would be anticipated for the summer period.
• Stabilisation of non-elective length of stay at(5.36%), is a positive position and to be anticipated during the summer months.
• The engagement of Glanso will continue to support a number of RTT specialities and diagnostics areas and is being utilised in the right operational "hot-spots".
• Overall clinic slot utilisation is positive, this is still an area for further development but good progress is being made.
• Performance in the majority of the additional quality measures has been good; the three exceptions remain the same this month as last.

Weaknesses

• Due to the implementation of the new EPR system we are shadow reporting the number of patients waiting 18 weeks from referral to treatment.
• Patient Treatment Lists (PTLs) have residual data quality issues which continues to impact management of patient journeys. This will be addressed through the deployment of additional clerical staff as approved at May Board. Despite this, teams are focused on reviewing patients >35 weeks and predicting potential breaches on a more routine basis.
• Achievement of the national standard for % of patients seen within 6 weeks for Diagnostic tests is not delivering against target at 4.8% for August (un-validated). Performance issues in colposcopy remain a significant concern and breach numbers have increased during August.
• Achievement of the Cancer standards is a significant concern, whilst the 62 day performance was not expected to deliver in the earlier part of the year, performance will not meet the required recovery trajectory. 2 week wait cancer standard has been impacted by issues of demand in colorectal but other specialities have also not delivered which has impacted on the overall performance. 2 week wait performance was not anticipated to fail in 2017/18.
A number of statutory returns and reporting requirements are not able to be reported due to issues with TrakCare. Separate assurance through the Appendix detailing the reporting areas and the return to reporting due date will be provided on a monthly basis as part of the TrakCare recovery report, for Quality and Performance committee, September 2017.

Opportunities

• Development of Standard Operating Procedures (SOP) for key areas being developed across teams. This will provide action cards supporting staff to enter it right first time and to provide corporate guidance on operating procedures e.g. DNA's. There is some evidence that we are not operating our Access Policy in full and this has led to some breaches e.g. >52 week waits, which will be addressed through the development of SOPs. This will be managed through the Planned Care Programme Board.
The development of the Cymbio work to support the diagnostic and identification of the remaining issues to support operational recovery and the data quality issues raised through input of data into trak. These can then be addressed with targeted training support to prevent the issues re-occurring.
• The South West Cancer Alliance has provided additional funding, £60k to support the delivery of the colorectal pathway, which has been deployed to support the MRI capacity for the prostate pathway.

The Trust had a critical friend visit that reviewed the current Cancer Recovery Plan, including some observations on the MDT role and the opportunities for patients at Day 49 plus.
• Support from commissioners has been sought in relation to cancer across a number of areas:
- Referral rate increases (colorectal & dermatology) – CCG to support communication to targeted practices in the CGH area.
- Clinical support for triage of 2ww pathway patients in Lower GI supporting communication with Primary Care on appropriate pathway utilisation.
• 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.
• The September Q&P committee are receiving a review of the Urology recovery plan. Early indications are that the speciality is making improvement in the 'long-waiting' patients and that the MAD clinic configuration is having an impact to stabilise performance. A recent locum urologist appointment commencing in September represents a significant opportunity for this speciality to deliver the routine long waiting performance in Cancer and RTT pathways.

Risks & Threats

• Cancer performance remains a significant risk for the Trust. 2 week wait analysis shows a combination of factors have led to a decline namely: capacity; clinic cancellations and patient choice. Patient choice levels are being benchmarked as the Trust needs to ensure we are offering reasonable notice of appointments. In relation to clinic cancellations the process is smoother, there have been some cancellations due to the normal seasonal pattern of leave and some that have been related to the operational practice to support trak. This combined with an increase in specific specialities has impacted the overall delivery of 2 week wait and is forecasted to continue to impact delivery to target for August & September. Key tumour sites are Breast; Lower GI and Skin which are impacted by Capacity related issues. 2 week wait for September currently shows a slightly worse position than August, which would representing a significant decline since April 2017. This represents a significant Trust risk.
• For 62 day cancer, since last year there has been an increase in the number of breaches per month but a number of patients on the 62 day pathway has decreased. Capacity and backlog are the main reasons for breaches. Performance excluding Urology impacts of a range between 5 % to 9%. Performance of long-waiting patients overall is improving.
• The Diagnostic target, is under-delivering at 4.8% (where we failed to deliver against the 1% of patients to wait over 6 weeks). This was mainly attributable to Colonoscopy (240 breaches; Audiology (57 breaches).Recovery plans for these areas are in place, delivery remains a risk across the summer period. Outsourcing and waiting list initiatives remain a component part of the recovery plan for Gastroscopy and Colonoscopy modalities.

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%							
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%*							
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%	70.30%*							
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%*							
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%	96.30%*							
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%*							
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%*							
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%*							
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%							
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%	80.00%*							
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%	80.00%							

Summary Scorecard

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

QUALITY

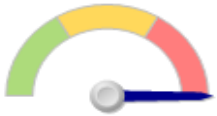
Adult Inpatients who received a VTE Risk Assessment	Emergency Readmissions Percentage
Friends and Family Test Score - ED % Positive	Friends and Family Test Score - Inpatients % Positive
Friends and Family Test Score - Maternity % Positive	Hospital Standardised Mortality Ratio (HSMR)
Hospital Standardised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

OPERATIONAL PERFORMANCE

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

FINANCE

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



LEADERSHIP AND DEVELOPMENT

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

STRATEGIC CHANGE

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Key Indicators - Quality																				
Friends and Family Test Score	Friends and Family Test Score - ED % Positive		85.4%	84.7%	88.0%	78.4%	85.7%	80.3%	85.5%	86.9%	84.4%	75.6%	77.5%	84.9%	87.0%	84.8%	83.9%	81.7%	86.5%	81.4% *
	Friends and Family Test Score - Inpatients % Positive		95.3%	95.2%	92.0%	90.1%	88.9%	100.0%	91.6%	89.3%	92.2%	91.2%	90.8%	90.9%	94.4%	93.0%	93.5%	90.8%	94.0%	90.8% *
	Friends and Family Test Score - Maternity % Positive		100.0%	97.8%	98.2%	100.0%	100.0%	100.0%	98.9%	94.5%	96.8%	97.0%	100.0%	90.0%	92.3%	98.2%	99.1%	96.2%	98.6%	96.4% *
Infections	MRSA Bloodstream Cases - Cumulative Totals	0	1	1	1	1	2	2	3	0	0	0 *	1	1 *	1	1	3		3	0 *
Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	0	0	5	0	3	0	3	4	11	10	16	14	9	5	6	25	39	55 *
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	111.8	113	112.9	115.2	115.5	113.5	110.7	111	109				111.8	115.2	110.7		110.7	109 *
	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	119.5	119.9	117.4	119.3	118.7	116.8	115.1	116.5	114.6				119.5	119.3	115.1		115.1	114.6 *
	Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level	115.6			114									115.6	114				
Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	6.2%	6.4%	5.8% *	7.0% *	6.4% *	6.1% *	5.1% *	6.9% *	7.1% *	6.5% *	6.5% *		6.5%	6.4% *	5.8% *	6.8% *	6.4% *	6.7% *
Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%	93.9%	93.1%	92.2%										93.7%					
Key Indicators - Operational Performance																				
Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	100.0%	85.7%	97.0%	100.0%	82.8%	92.3%	95.5%	86.3%	91.8%	88.9%	89.1%	87.5% *	96.0%	96.0%	85.7% *	89.3%		
	Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	100.0%	50.0%			100.0%		100.0%	100.0%	100.0%	100.0%	57.1%	80.0% *	71.4%	71.4%	100.0% *	100.0%		
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	76.8%	72.9%	79.2%	72.0%	62.7%	70.0%	70.7%	78.3%	75.9%	71.2%	74.7%	80.00%	76.9%	76.9%	66.3% *	75.2%		
Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	1.5%	1.8%	0.9%	1.5%	1.2%	1.8%	4.6%	7.2%	5.3%	5.3%	5.3%	4.8% *	0.8%	1.4% *	2.5% *	5.9%		5.5% *
ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	88.97%	86.05%	86.67%	74.12%	74.75%	76.96%	77.86%	82.85%	79.96%	79.90%	83.50%	88.13%	88.48%	82.40%	76.56%	80.87%		82.87% *
Referral to Treatment (RTT) Performance	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%	90.2%	89.9%	87.0%	75.2% *									90.7%	84.4% *	74.3% *			
Key Indicators - Finance																				
Finance	YTD Performance against Financial Recovery Plan		-23.8	-23.9	-18.7	-18	-18	-18 *	.07	-.95	-10.15	3.36	4.35	4.24	-23.8	-18				

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Key Indicators - Leadership and Development																				
Sickness	Sickness Rate	G<3.6% R>4%	3.8%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	4.0%	3.9% *			3.8%	3.9%	3.9%	4.0% *		
Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	.04	.04	.04	.04	.04	3.71	3.71	3.71	3.71	3.71			.04	.04	.04	3.71		
Turnover	Workforce Turnover Rate	7.5% - 11%	11.1%	12.0%	11.5%	11.7%	11.8%	12.0%	11.5%	12.1%	12.0%	11.8% *			11.5%	11.7%	11.8%	12.0% *		
Detailed Indicators - Quality																				
Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2 >87%Q3>8 8%Q4>90%	86.3%	88.6%	90.4%										88.3%					
	Dementia - Fair question 2 - Appropriately Assessed	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%	100.0%	100.0%										100.0%					
	Dementia - Fair question 3 - Referred for Follow Up	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%	100.0%	100.0%										100.0%					
Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		68	49.2	40.5	49.1	47 *	41.6 *	44.9 *	46.1 *	44.3 *	49 *			63.7	46.9	44.9 *	47.2 *		
	Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		96.2%	100.0%	95.8%	100.0%	89.7% *	100.0% *	97.1% *	98.0% *	98.4% *	98.3% *			96.6%	98.0%	94.7% *	98.3% *		
	Fracture Neck of Femur Patients Treated Within 36 Hours		67.3%	68.3%	81.7%	63.5%	79.2% *	80.0% *	75.4% *	76.5% *	78.1% *	71.2% *			67.2%	71.6%	77.8% *	75.3% *		
Infections	C.Diff Cases - Cumulative Totals	17/18 = 37	20	21	25	27	34	34	42	1	5	8 *	10	18 *	20	27	42		42	5 *
	Ecoli - Cumulative Totals											20	37	103 *						
	MSSA Cases - Cumulative Totals	No target	59	71	79	90	95	105	114	6 *		7	15	44 *	59	90 *	114 *		114	6 *
Maternity	Percentage of Spontaneous Vaginal Deliveries		63.3%	63.1%	61.1%	61.3%	60.0%	61.1%	61.9% *	61.2% *	64.4% *	65.3% *	62.4% *	63.9% *	63.5%	61.8%	61.7% *	63.6% *	63.6% *	64.3% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90	91.5%	91.6%	90.6%	86.2% *	93.4% *	86.9% *	88.8% *	89.3% *	84.9% *	89.2% *	83.2% *	88.1% *	92.3%	89.9% *	81.5% *	85.9% *	87.3% *	89.1% *
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.6	3.6	2.9										3.6					
Never Events	Total Never Events	0	0	1	0	0	0	0	0	0	2	1 *	0 *	0	1	1	0		2	2 *
Patient Falls	Falls per 1,000 Beddays	Current mean	6.7	5.6	6.2										6					
	Total Number of Patient Falls Resulting in Harm (moderate/severe)		11 *	6 *	4 *	17 *	12 *	7 *	6 *	3 *	4 *	9 *	5 *	8 *						

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		3	3	8	1	4	0	3 *	3 *	0 *	4 *	2 *	2 *	2	4				
	Number of Patient Safety Incidents Reported		962	909	986	1,064	1,285	1,162	1,144 *	900 *	1,268	1,148	1,149 *	1,003 *	998	986				
	Patient Safety Incidents per 1,000 Beddays		33.7	31.1	34.5										34.7					
Performance Initiation & Delivery	Performance in Delivery: Recruiting to Time for Commercially Sponsored Studies														33.3%	27.3%				
	Performance in Initiation: Percentage of Studies that are Eligible to Meet 70 Day Target														50.0%	66.7%	25.0%			
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	0.71%	0.61%	1.14%	1.62%	0.57%	0.97%	0.87%	0.50%	1.23%	0.49% *	1.12% *	1.02% *						
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%	0.12%	0.12%	0.11%	0.12%	0.23%		0.37%	0.13%	0.12%	0.12% *	0.50% *	0.38% *						
	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%								0.13%	0.12%	0.00% *	0.00% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	126	104	144	66	90	64	78	123	176	292 *	149 *	115 *	135	104	88	717 *	3,045	1,115 *
RIDDOR	Number of RIDDOR	Current mean	1	0	0	4	1	5	2	2	2	3 *	2 *	3 *	1	1	3		2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		7	7	7	11	7	7	7	7	7	9	7	7 *	7	8	7	8 *	8	8 *
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	92.9%	92.9%	92.8%	91.4%	91.4%	90.6%	91.3%	94.0%	92.4%	92.7%	91.3% *	92.6% *	93.1%	92.4%	0.0% *			
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	97.8%	97.8%	97.7%	95.4%	96.7%	97.1%	97.0%	97.7%	95.8%	96.6%	95.0% *	96.0% *	98.0%	97.0%	0.0% *			
Sepsis Screening	2a Sepsis – Screening	>90%	98.0%	98.0%	98.0%	96.0%	100.0%	98.0%	96.0%	88.0% *	88.0% *	98.0% *			97.0%	97.0%	96.0%			
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	41.0%	60.0%	65.0%	69.0%	44.0%	70.0%	64.0%	78.0% *	69.0% *	67.0% *			45.0%	64.0%	0.0% *	71.0% *		
Serious Incidents	Number of Serious Incidents Reported		3	4	4	2	1	2			5	1 *	2 *	1	2	3				
	Percentage of Serious Incident Investigations Completed Within Contract Timescale		100%	100%	100%	100%	100%	100%			100%	100% *	100% *	100%	100%	100%				
	Serious Incidents - 72 Hour Report Completed Within Contract Timescale		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0% *	100.0% *	100.0%	100.0%	100.0%				
Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	1.2	2.2	1.8	2.4	2.2	1.4	2.1	1	1.2	2.2	2.7 *	1.9 *	1.7	2.1	1.9			

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Staff Safety Incidents	Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	3	2.7	1.8	1.9	2.7	1.9	2.6	2.3	3.1	4.2	2.4 *	3.1 *	3.3	2.1	2.4			
Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	63.9%	65.4%	70.4%	85.2%	75.9%	68.2%	68.4%	64.0%	41.9%	70.2%	69.1%	66.7%	69.8%	73.8%		60.2%		62.2% *
	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%								33.3% *	32.5% *	26.1%	38.0%	41.8%				30.5%		34.6% *
	Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	88.9%	88.8%	93.3%	84.3%	83.6%	87.3%	66.1%	81.8%	84.6%	92.9%	95.0%		90.0%	88.6%	0.0% *	86.4%		89.3% *
Time to Initial Assessment	ED Time To Initial Assessment - Under 15 Minutes	>=99%	78.2%	77.7%	79.8%	48.8%	57.9%	68.5%	80.2%	81.9%	80.2%	75.9%	87.4%	91.0%	78.6%	69.0%	69.1%	79.9%		83.4% *
Time to Start of Treatment	ED Time to Start of Treatment - Under 60 Minutes	>=90%	44.9%	46.8%	49.1%	27.6%	35.4%	34.0%	31.2%	29.5%	28.8%	25.7%	32.3%	34.9%	46.0%	41.3%	33.4%	28.0%		30.3% *
Detailed Indicators - Operational Performance																				
Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	187	186	99	189	201	104	47	34	54	57	47	19	541	474	352	145	1,884	211 *
	Ambulance Handovers - Over 60 Minutes	< previous year	0	1	0	13	7	1	0	1	0	4	0	1	1	14	8	5	26	6 *
Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0	2	3	0										10					6 *
Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	9	9	10	11	11	12	11	10	8	10	8	9						
	Cancer (104 Days) - Without TCI Date	0	65	49	45	49	56	42	42	47	80	32	35	30						
Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	88.6%	89.0%	93.5%	92.6%	85.1%	94.7%	94.6%	91.4%	90.5%	85.9%	79.6%	70.3% *	88.2%	91.7%	90.1% *	89.1%		
	Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	96.4%	95.7%	92.5%	88.3%	89.4%	95.0%	97.1%	90.4%	94.0%	94.1%	57.3%	89.7% *	93.7%	92.0%	92.2% *	92.8%		
Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	98.8%	96.7%	93.8%	94.1%	90.1%	93.6%	96.8%	94.9%	95.9%	95.4%	95.8%	96.3% *	99.2%	94.9%	91.9% *	95.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *	100.0%	100.0%	100.0% *	100.0%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	98.3%	100.0%	100.0%	95.0%	98.4%	100.0%	98.6%	98.5%	100.0%	100.0%	100.0%	98.4% *	99.5%	98.6%	99.2% *	99.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	100.0%	100.0%	89.4%	83.7%	84.2%	97.7%	87.8%	90.0%	97.5%	97.9%	93.6%	91.5% *	99.4%	90.7%	90.0% *	94.5%		
Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	36	45	47	36	31	44	37	28	30	32			36	36	37	30 *	33	30 *

Trust Scorecard

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Category	Indicator	Target	Month											Quarter				Annual	
			Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End		405	350	375	465 *	268 *	694 *	681		963 *	522		883 *	405	465 *	681		7 *	
Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	87.6%	88.9%	86.6%	31.2% *	44.2% *	52.9% *	57.4% *	63.2% *	64.7% *	61.7% *	64.0% *		88.3%	71.3% *	51.7% *	63.2% *	75.4% *	63.4% *
ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	96.09%	91.32%	94.36%	84.33%	87.47%	88.42%	88.50%	91.80%	92.30%	88.10% *	94.40%	95.00%	95.46%	92.79%	88.00% *	90.70%	91.60%	92.30% *
	GRH ED - Percentage Within 4 Hours	>=95%	84.81%	83.08%	82.38%	68.47%	67.83%	70.56%	71.80%	77.90%	72.90%	75.30%	77.70%	84.60%	84.49%	82.64%	70.00% *	75.30%	79.20%	77.70% *
Inpatients	Stranded Patients									397	420	441	451	461						
Length of Stay	Average Length of Stay (Spell)		5.55	5.39	5.67	5.84 *	5.76 *	5.57 *	5.34 *	5.11 *	4.87 *	4.99 *	4.96 *	4.87 *	5.38	5.54 *	5.55 *	4.99 *	5.38 *	4.96 *
	Length of Stay for General and Acute Elective Spells	<=3.4	3.65	3.52	3.5	3.58 *	2.8 *	3.03 *	2.8 *	2.86 *	2.66 *	2.99 *	2.75 *	3.02 *	3.69	3.32 *	2.87 *	2.84 *	3.08 *	2.85 *
	Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	6.03	5.87	6.32	6.53 *	6.58 *	6.3 *	6.19 *	5.78 *	5.48 *	5.58 *	5.62 *	5.36 *	5.79	6.24 *	6.35 *	5.61 *	6.08 *	5.56 *
Medically Fit	Number of Medically Fit Patients Per Day	<40	73	76	83	73	75	84	68	59	55	58	63	58	73	73	75	56		59 *
Referral to Treatment (RTT) Performance	Referral to Treatment Number of Ongoing Pathways Over 18 Weeks		4,850	4,978	6,574										13,887					
Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways 35+ Weeks (Number)		476	536	579										1,367					
	Referral To Treatment Ongoing Pathways 40+ Weeks (Number)		250	215	250										643					
	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	3	4	3										7					
SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *
	Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%			99.8%	99.8%	99.8%	99.8%	99.8%	99.8% *
Trolley Waits	ED 12 Hour Trolley Waits	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1	0	0	2	0 *
Detailed Indicators - Finance																				
	Agency - Performance against NHSI set agency ceiling									3	3	3	3	3						
	Capital Service									4	4	4	4	4						

Trust Scorecard

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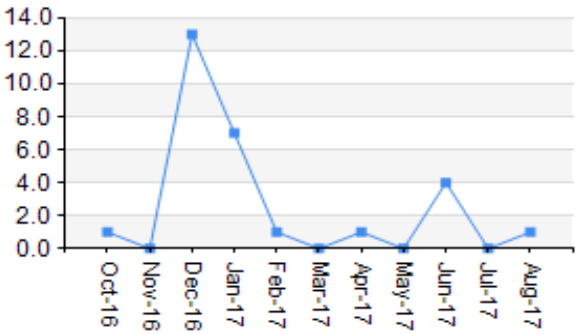
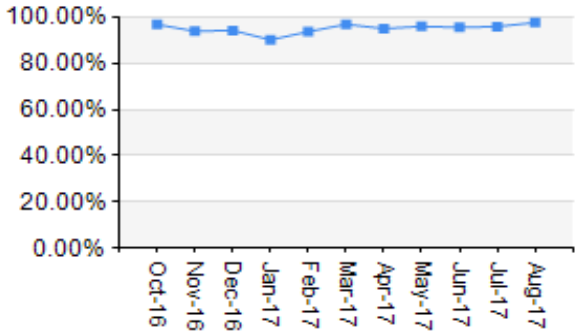
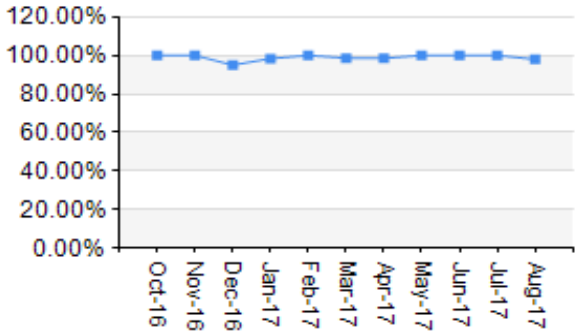
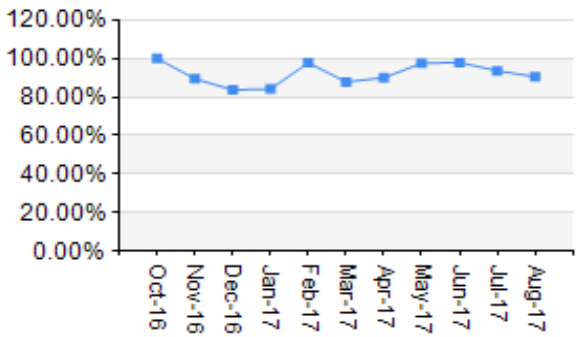
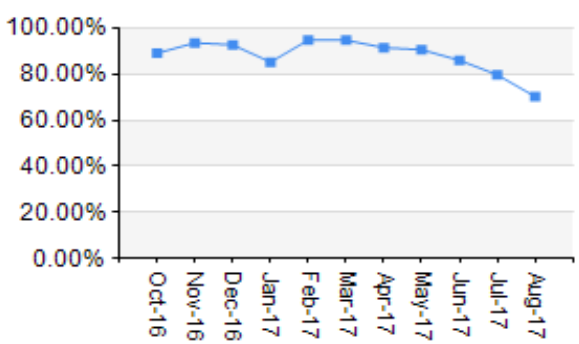
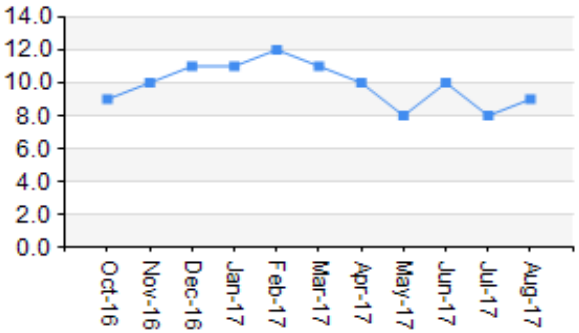
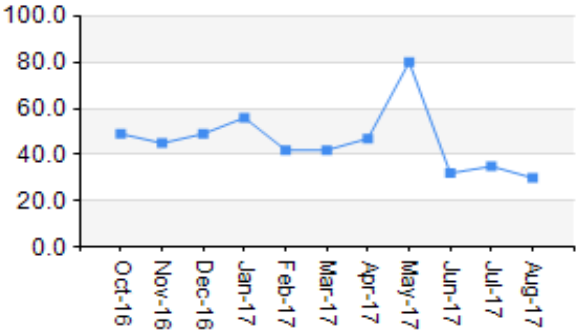
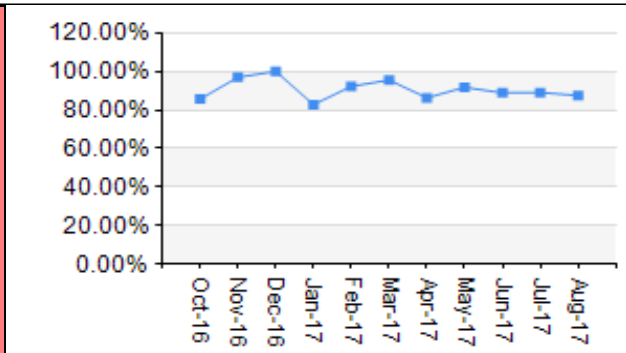
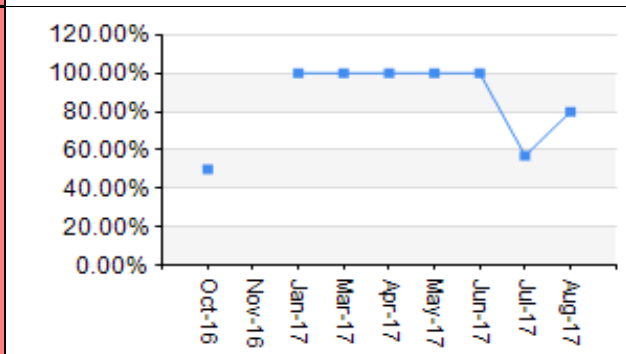
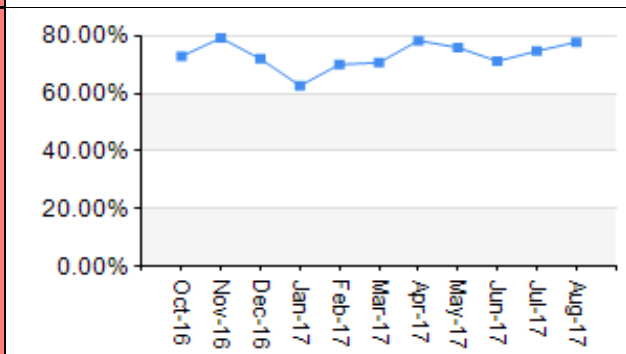
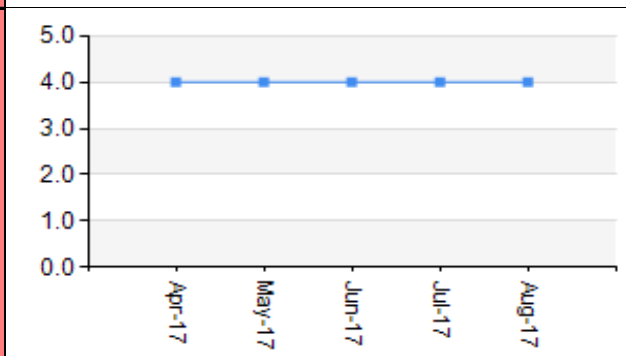
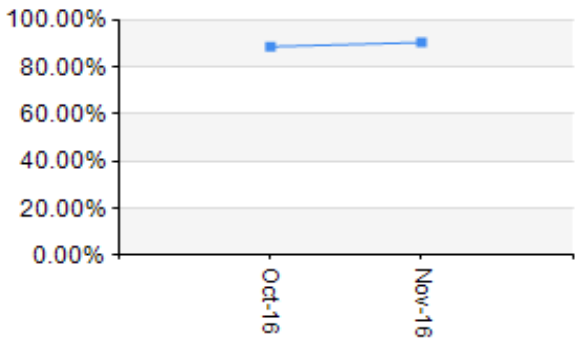
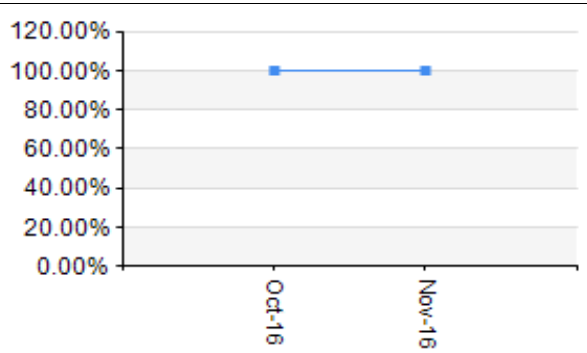
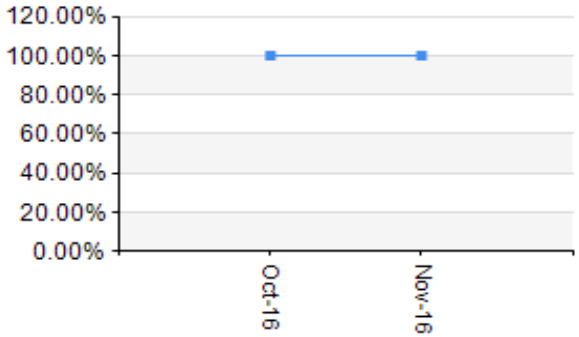
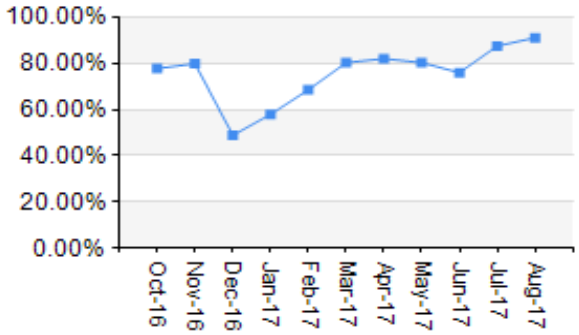
Category	Indicator	Target	Month											Quarter				Annual	
			Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Finance	Liquidity									4	4	4	4	4						
	NHSI Financial Risk Rating	3	1	1	1	1	1	1		4	4	4	4	4	1	1				
	Total PayBill Spend		27400	28000	27900	27466	26998	27240		27.67	27.52	27.5	27.46	28.25	83100	83346				
Detailed Indicators - Leadership and Development																				
Appraisals	Percentage of Staff Having Well Structured Appraisals in Last 12 Months	>3.8	3	3	3	3	3	3	3	3	3	3			3	3	3	3		
	Staff who have Annual Appraisal	G>89% R<80%	80.0%	80.0%	80.0%	80.0%	80.0%	82.0%	82.0%	80.0%	79.0%	78.0%			80.3%	80.0%	81.6%	79.0%		
Staff Survey	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%			34.0%	34.0%	34.0%	34.0%		
Staffing Numbers	Total Worked FTE		7,299	7,290	7,226	7,200	7,238	7,239 *							7,299	7,200				
Training	Essential Training Compliance	>=90%	91%	91%	89%	89%	89%	89%	90%	89%	89%	89%			91%	90%	89%	89%		

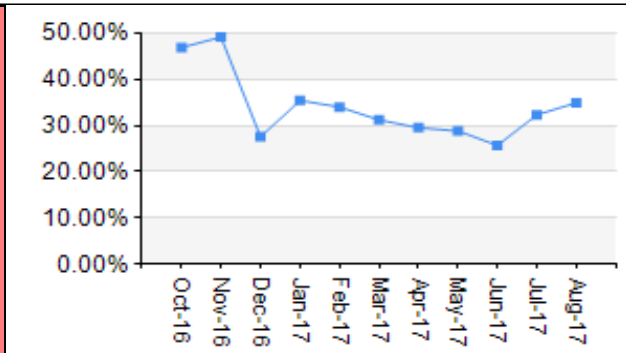
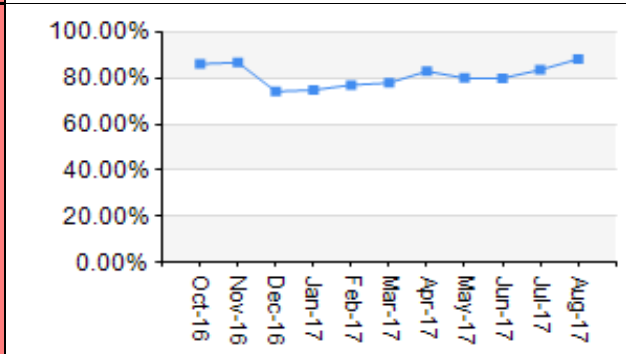
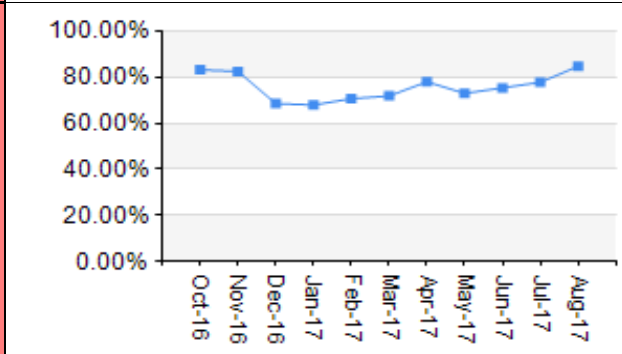
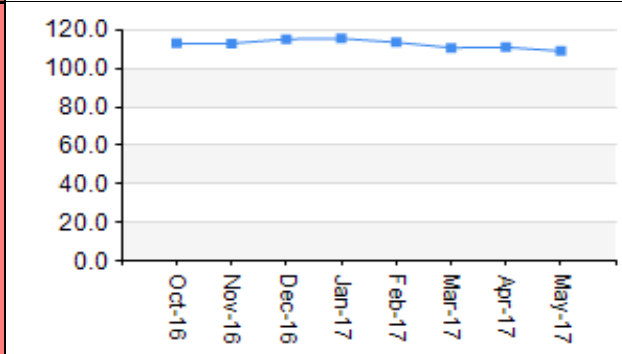
Exception Report

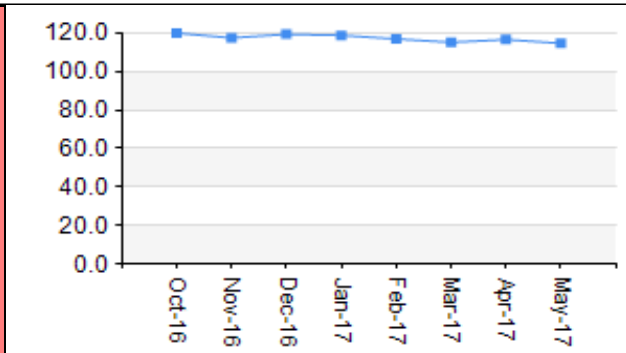
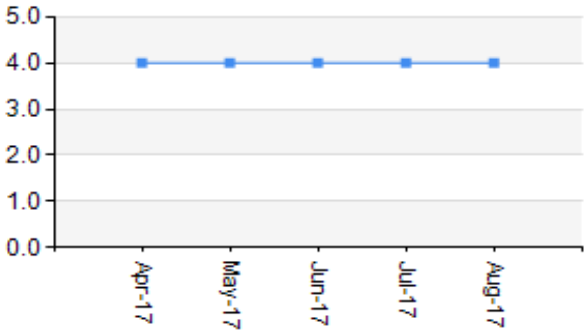
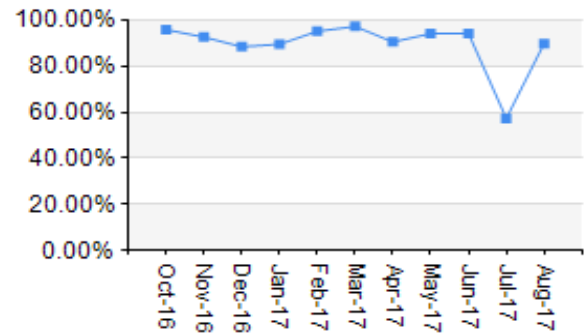
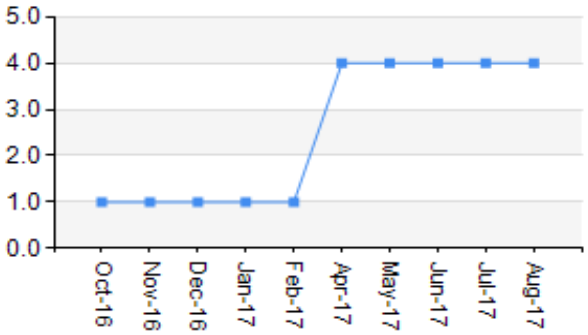
Metric Name & Target	Trend Chart	Exception Notes	Owner
Ambulance Handovers - Over 60 Minutes **Target: < previous year**		Ambulance handover there was one delay for August, this will be subject to validation and a full RCA review as appropriate.	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (First Treatments) **Target: >=96%**		Narrowly missed this target of >96% achieving 95.8% for July. this was due to surgical capacity. mitigations to continue at pace with plan.	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) **Target: >=94%**		Diagnosis to subsequent radiotherapy is down by 2% in August at 98% compared to July 2017 position	Deputy Chief Operating Officer

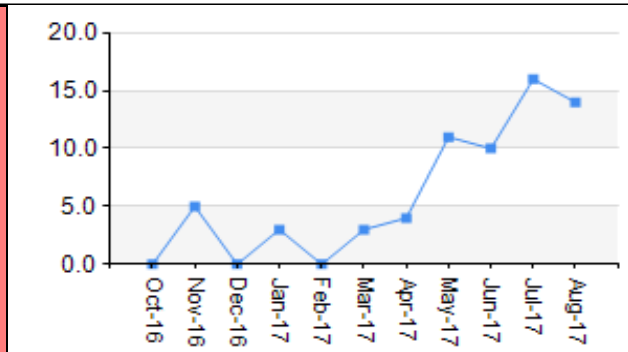
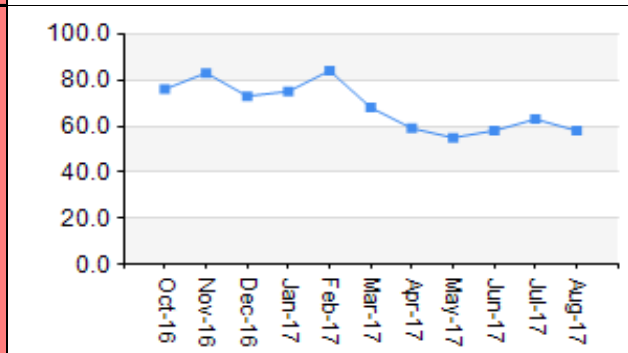
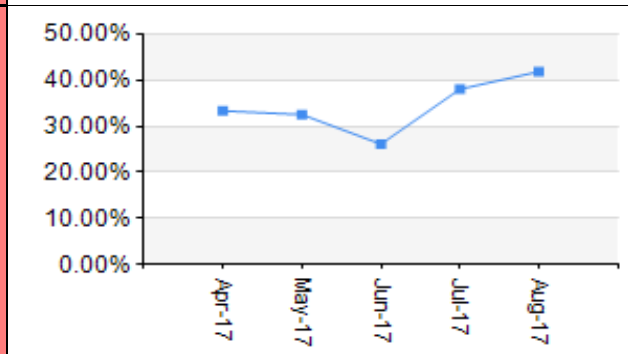
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) **Target: >=94%**		93.6% against a target of >94% again an increased focus through the cancer services delivery board which will now be chaired by Deborah Lee.	Deputy Chief Operating Officer
Cancer - Urgent referrals Seen in Under 2 Weeks **Target: >=93%**		79.6% July Performance >93% Target The root cause relates to Colorectal and Dermatology increased demand. 1. Colorectal are working with the CCG on plans that include vetting referrals form GP's & exploring advice and guidance options. the Trust is also working to provide additional routine capacity through Glanso, this impacts positively to provide capacity in the 2 week wait slots for the increased demand the Trust is experiencing. For Dermatology, additional capacity will be delivered through super-clinics in November.	Deputy Chief Operating Officer
Cancer (104 Days) - With TCI Date **Target: 0**		There are currently 9 patients with a TCI date for August all with plans. 1 more than last month and no improvement on the same time last year. This on the whole is complex patients pathways or patient choice is urology and lower GI.	Deputy Chief Operating Officer
Cancer (104 Days) - Without TCI Date **Target: 0**		Performance 28 (as at 18.09.17) Target 0 There are currently 28 patients waiting over 104 days without a TCI, 15 of whom are urology patients. The trajectory for Urology was recovery in July for this cohort of patients. Progress has been made in this speciality to address the long-waiting patients but the trajectory has not been met. Of the non-urology patients, all of the remainder were waiting due to complex pathways, patient choice or because they were not fit for treatment. All of these patients have plans. 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. These patients will have a clinical harm review at the point at which they reach 104 days and	Deputy Chief Operating Officer

Cancer 62 Day Referral To Treatment (Screenings) **Target: >=90%**		Performance: 87.5% Target: >=90% The issues are similar as for the overall 62 day performance. Diagnostic capacity and surgical capacity are the root cause of under-performance. The Cancer Recovery Plan is included in the Q&P papers for ease of reference.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		A significant deterioration in performance at 57% against the month of July, however; we are dealing with very small numbers and 1 patient could make this difference.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		performance for July 2017 74.7% against the target of 85%REcovery plan is still on-going, however; this now has a renewed focus with Deborah Lee chairing the Cancer Services Management Group	Deputy Chief Operating Officer
Capital Service **Target:**		The Trust currently scores 4 on the NHSI Capital Services Rating. Whilst this is rated red, given it is the indicator of highest financial risk, it does not reflect a variance from plan. The Trust's planned I&E deficit is the main driver of the rating.	Director of Finance

Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		A questionnaire has been developed to capture this information. A training programme has been undertaken with the August cohort of Junior Doctors and a training programme to continue this is being developed. We are recommencing reporting of this indicator. As described in July, an internal audit was completed of those patients sampled there was a 37% compliance (40 records at each site).	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		We are recommencing reporting this indicator.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		We are recommencing reporting this indicator.	Deputy Nursing Director & Divisional Nursing Director - Surgery
ED Time To Initial Assessment - Under 15 Minutes **Target: >=99%**		Performance - 91% Performance continues to improve in August within this metric.	Deputy Chief Operating Officer

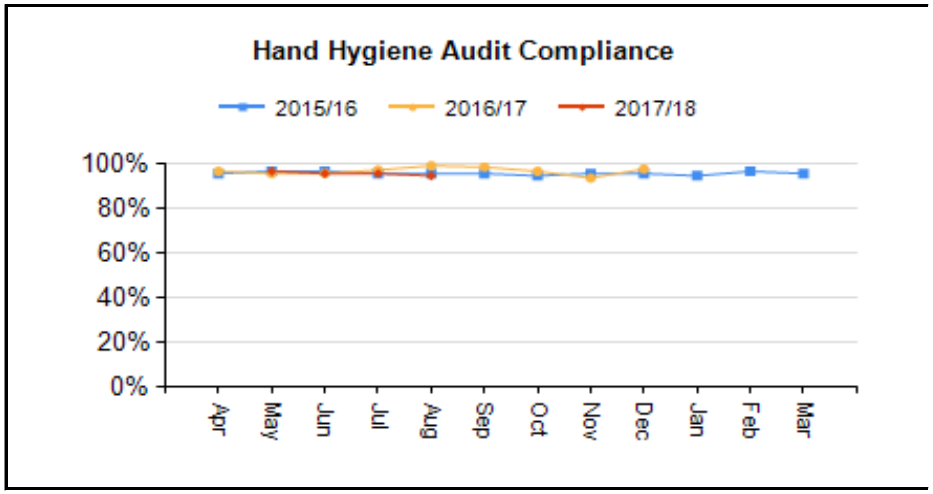
ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		The operational team are undertaking an audit of start of treatment time under 60 mins due to be completed at the end of September. Early indications in the audit indicate performance comparable pre-trak, e.g. >40%. At present, trak is adding a larger cohort of patients within the denominator. For example, patients referred directly to specialities and patients seen by GPs and EMPs.	Deputy Chief Operating Officer
ED Total Time in Department - Under 4 Hours **Target: >=95%**		Performance: August Target > The overall Trust Performance against the 4 hour national standard of 95% for August was 88.13% A significant programme of improvement is in place across the Trust to maintain an upward trajectory. Surges in activity remain an issue later in the day. A workforce review to meet surges in demand is underway in both ED and operations management (site). Whilst performance has improved, we are still failing to achieve the key metric. Steps taken to improve performance going forwards:	Deputy Chief Operating Officer
GRH ED - Percentage Within 4 Hours **Target: >=95%**		GRH 84.6% August Performance Trajectory 90.4% Performance against previous month is up by 5.9%. Whilst performance improved in August we are still not delivering this key metric. ED action plan with regards work force has identified 2 options 2 enable 24/7 senior cover. GP streaming continues and numbers are increasing. The confidence of the coordinators in ED is growing daily.	Deputy Chief Operating Officer
Hospital Standardised Mortality Ratio (HSMR) **Target: Dr Foster confidence level**		The HSMR has fallen over the last 5 measurements although it still remains above the expected level. This is monitored through the Hospital Mortality Group and actions are in place to bring this in line with the expected level (100) by 2019 (Trust Strategic objective). The indicator is driven by the number of deaths, the coding accuracy any outlier diagnostic codes which drive specific areas of work with clinical pathways	Medical Division Audit and M&M Lead

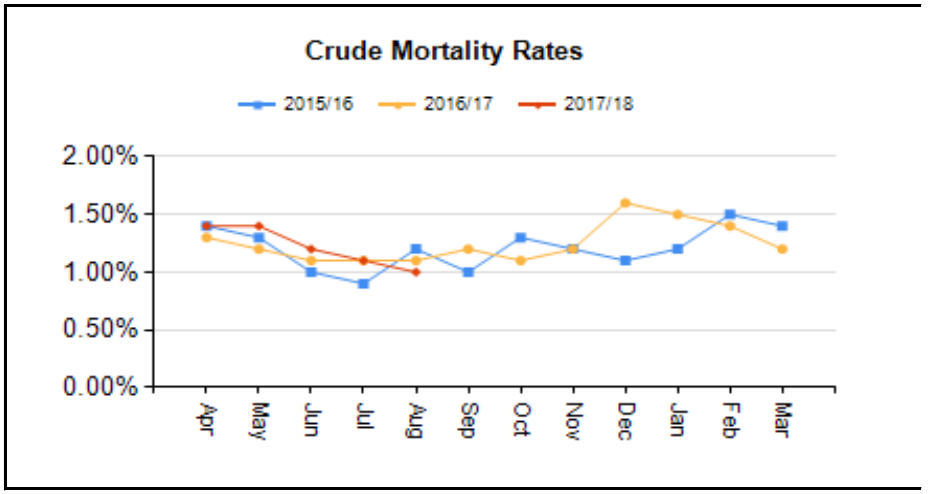
Hospital Standardised Mortality Ratio (HSMR) - Weekend **Target: Dr Foster confidence level**		The Observed weekday and weekend mortality are both above the expected range. Weekend mortality varies on a monthly basis but there is speciality input across all areas and no evidence that clinical pathways vary from weekday care.	Medical Director
Liquidity **Target:**		The Trust currently scores 4 on the NHSI Liquidity Rating. Whilst this is rated red, given it is the indicator of highest financial risk, it does not reflect a variance from plan. The Trust's planned I&E deficit is the main driver of the rating.	Director of Finance
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms **Target: >=93%**		57.3% July Performance 93% Target This is due to capacity issues with Radiologists support. This is now mostly resolved and as from September radiologists will be available.	Deputy Chief Operating Officer
NHSI Financial Risk Rating **Target: 3**		The Trust currently scores 4 on the NHSI Financial Risk Rating. Whilst this is rated red, given it is the indicator of highest financial risk, it does not reflect a variance from plan. The Trust's planned I&E deficit is the main driver of the rating.	Director of Finance

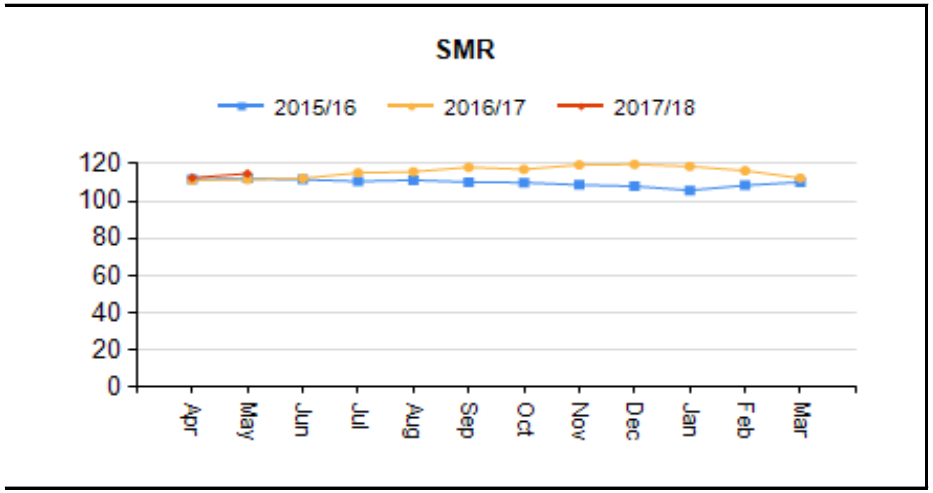
Number of Breaches of Mixed Sex Accommodation **Target: 0**		The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. Performance has declined in August. A total of 23 breaches affecting 77 patients was declared by the Trust for the month of August 2017. The analysis shows that all 23 breaches were within the Critical Care departments with the split being 11 at GRH and 12 at CGH. All breaches were due to the inability to move patients out of Critical Care areas once they had been made wardable. This is particularly prevalent at the GRH site where the operational OPEL status is often at level 3 (red) or 4 (black) and bed availability poor.	Head of Capacity and Patient Flow
Number of Medically Fit Patients Per Day **Target: <40**		The number of patients medically fit per day has reduced by 5 patients against performance in July and significantly improved against the same time last year. However; we have not met the target of <40 patients per day. Mitigating actions to continue the downward trend are Daily Navigation meetings weekly partnership review meetings for blocked or stranded patients development of a performance framework of 10 core standards across organisations to measure and unblock delays. Internal professional standards for Therapy, Pharmacy, Imaging and Pathology are now signed off and will be reported for October 2017	Deputy Chief Operating Officer
Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour **Target: >=50%**		A significant amount of work is being undertaken between the Stroke/ED/Imaging teams to improvce performance for this key quality standard. Thorough weekly breach meetings have been established to review each breach - these are then being taken forward in the main Trust ED breach meetings. Common themes/actions have been pulled together for the last month and these have been cascaded to all departments. A wider communications drive is planned for the Organisation at the end of September.	Director of Operations - Medicine

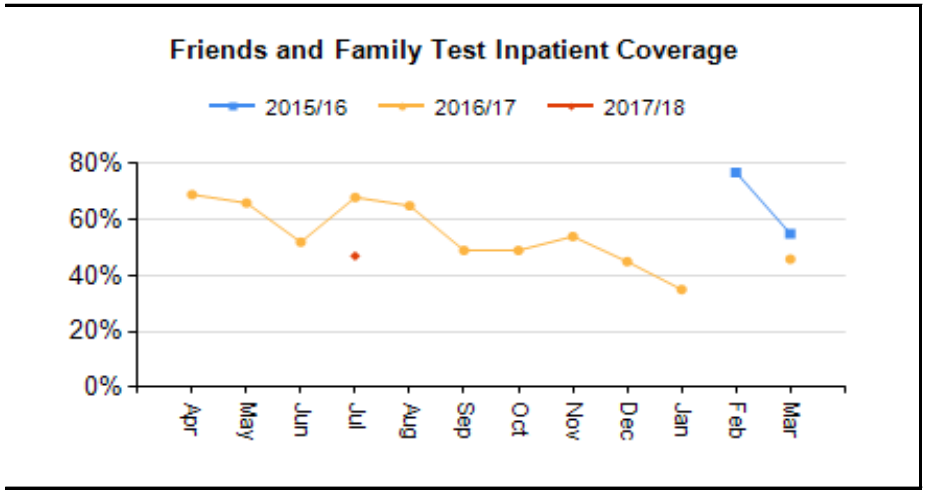
Contextual Indicators

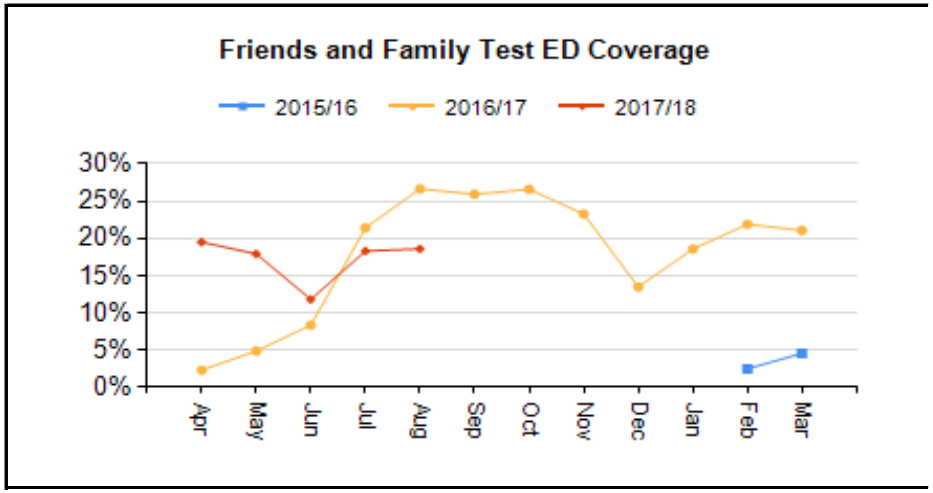
This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

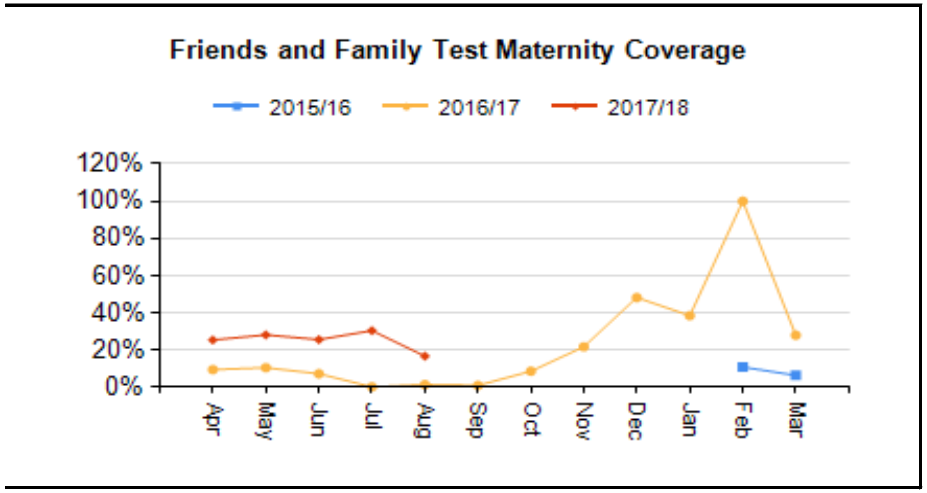


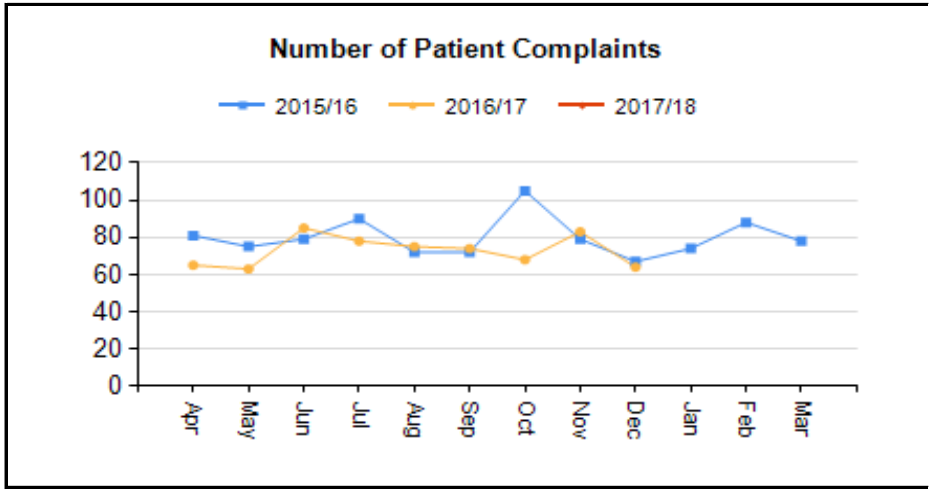


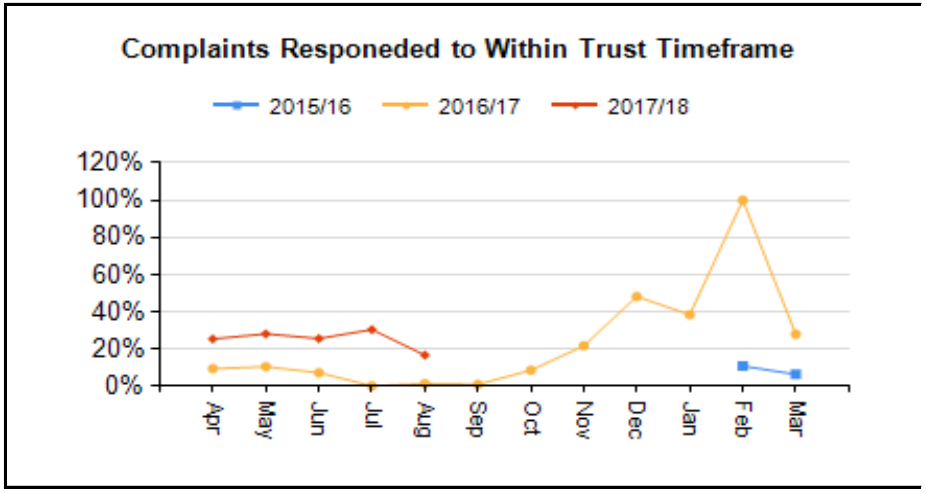


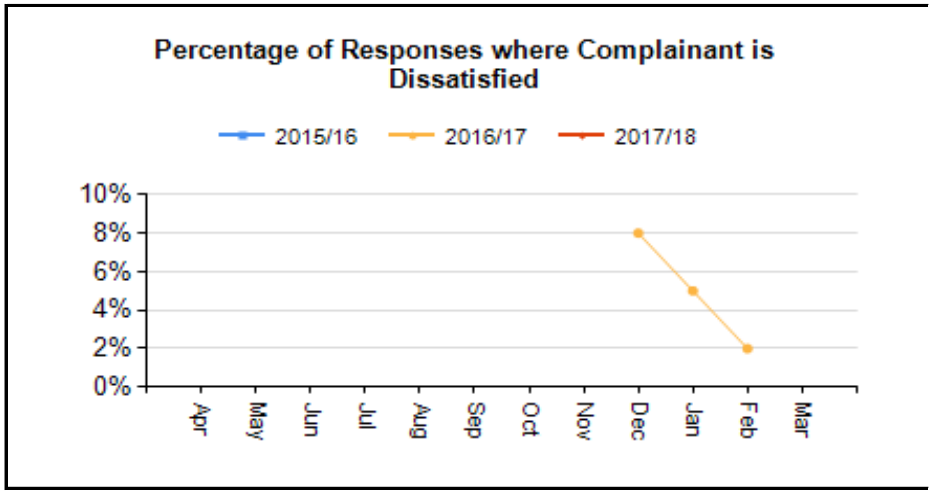


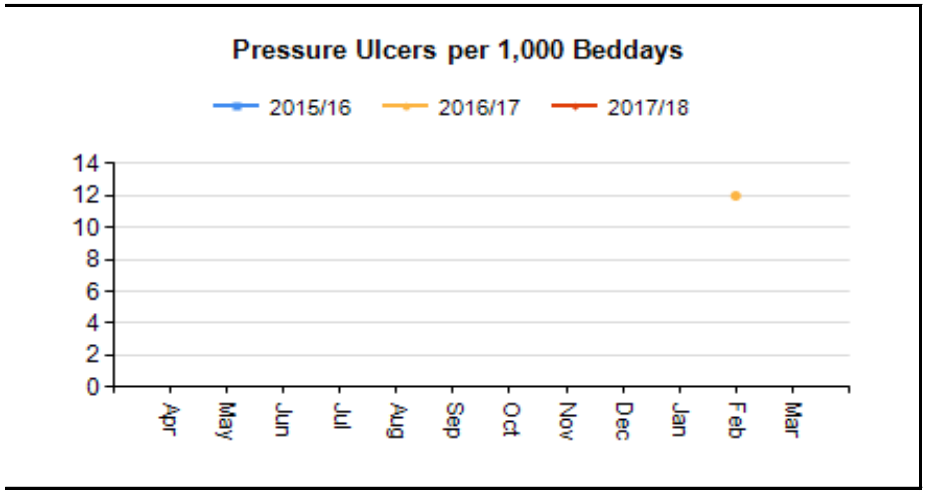

Friends and Family Test ED Coverage
2015/16
2016/17
2017/18
30%
25%
20%
15%
10%
5%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Friends and Family Test Maternity Coverage
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

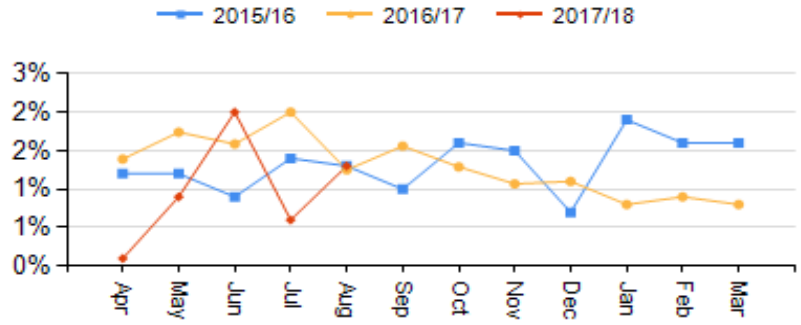

Number of Patient Complaints
2015/16
2016/17
2017/18
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Complaints Responeded to Within Trust Timeframe
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

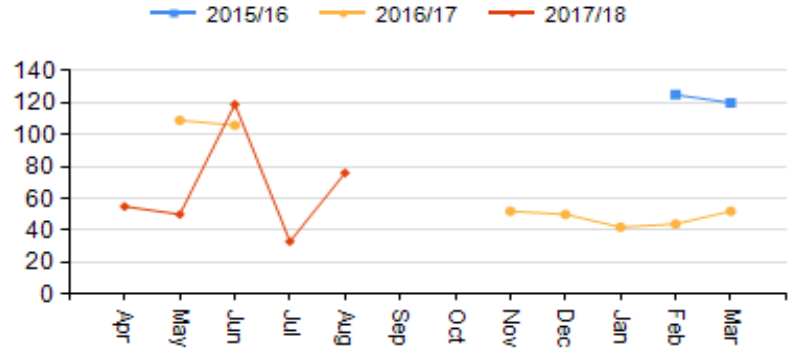

Percentage of Responses where Complainant is Dissatisfied
2015/16
2016/17
2017/18
10%
8%
6%
4%
2%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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

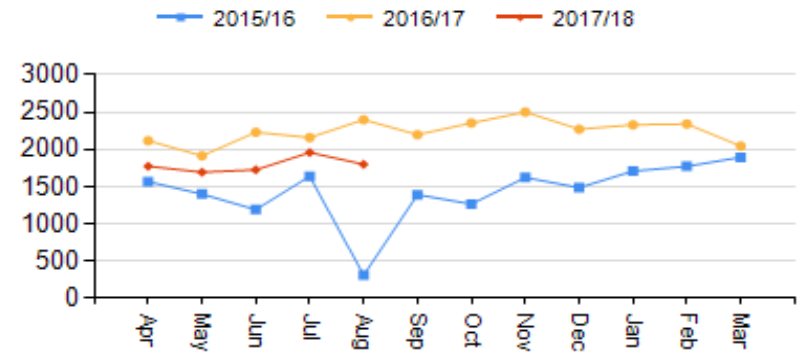
Last minute Cancelled Operations - Percentage of Admissions



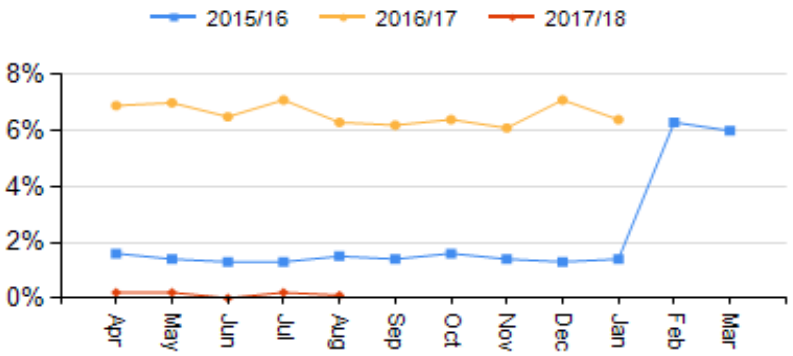
Number of Last Minute Cancelled Operations



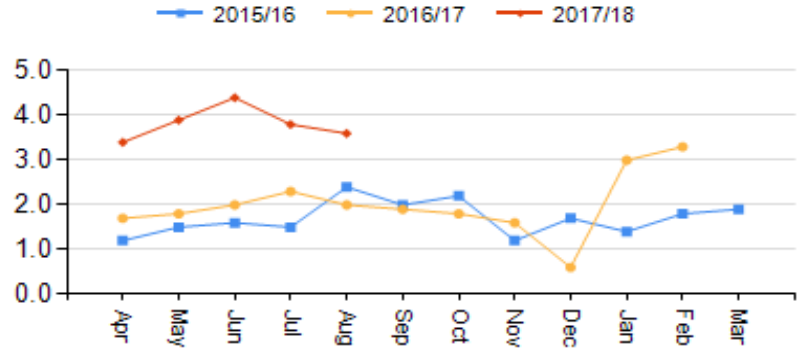
Beddays Occupied by Medically Fit Patients



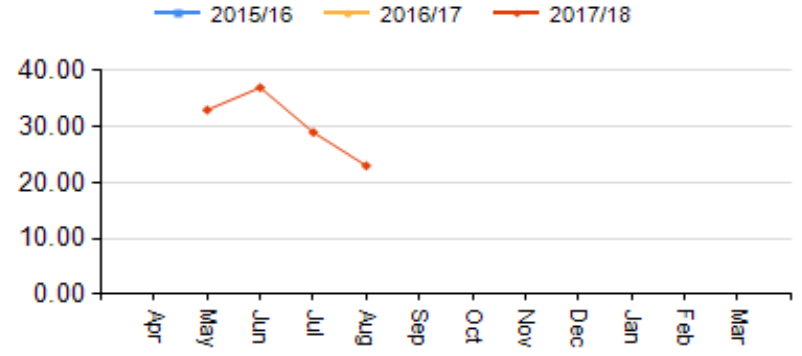
ED Unplanned Re-attendance Rate

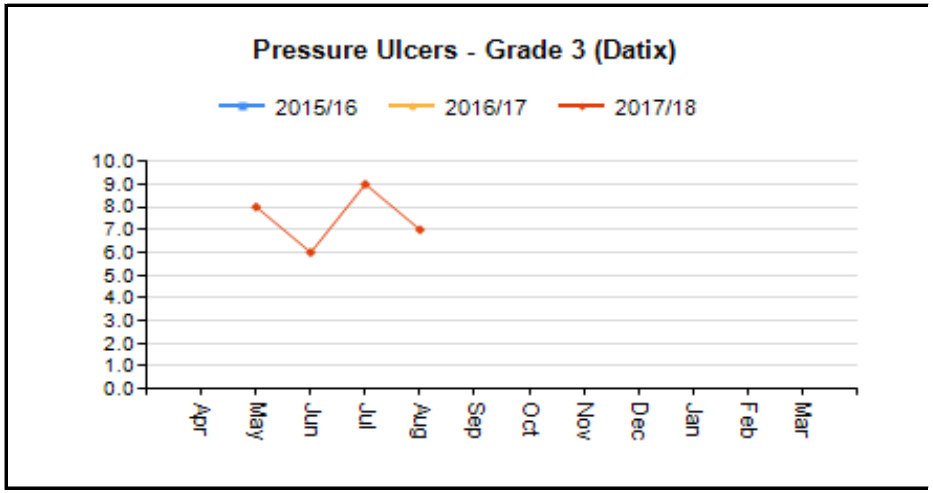


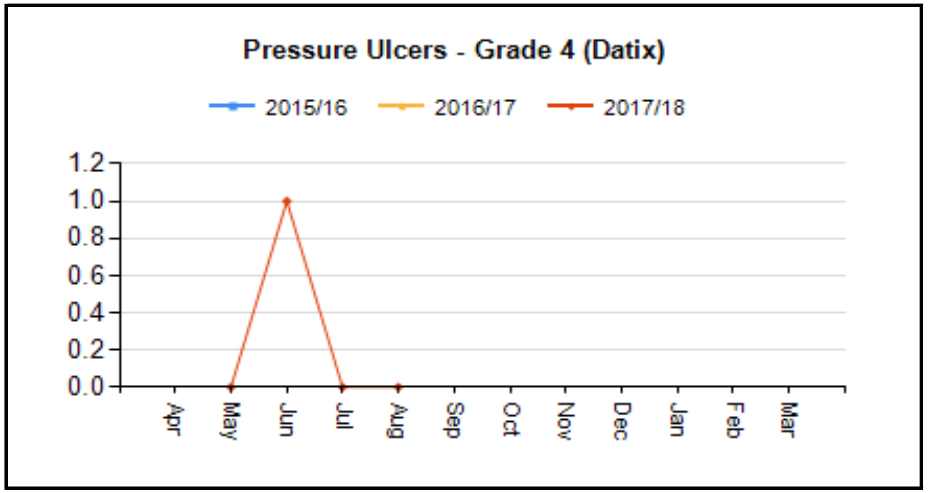
ED Left Without Being Seen Rate



Pressure Ulcers - Grade 2 (Datix)




Pressure Ulcers - Grade 3 (Datix)
2015/16
2016/17
2017/18
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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

REPORT TO MAIN BOARD – OCTOBER 2017

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

This report describes the business conducted at the Quality and Performance Committee on 28th September 2017 indicating the NED challenges made, the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Winter Plan	Update to the plan with further detail of Trust's initiatives that contribute to the system-wide plan. Preliminary identification of potential risks, notably delay to plans, staffing, and progress with system-wide plans	How will we monitor adherence to the plan? What is the learning from previous years' plans and experience?	Escalation from Emergency Care Board (ECB) to Quality and Performance (Q&P) of departure from plan by exception. Greater robustness in this plan; much earlier detailed planning; external confirmation of maturity of plan and evidence; improved bed supply as we approach winter compared to 2016-17 Positive external feedback from NHSE/I re relatively advanced level of completeness compared to previous years	Future assurance on risks and mitigation (appendix 1) to be reported to next Committee.

Risk Register	Report that focused on those risks for which Q&P Committee has oversight. Report content had not yet been considered by Trust Leadership Team (TLT) after which further significant revision was expected	How do we gain assurance on completion of action plans when some of the presentation is at a summary level?	Managed through Risk Management Group. Important to avoid duplication between that Group and the assurance Committee.	Clarify timing of reports from Risk Management Group to Q&P Committee. Consider common reporting format e.g. standardise to style of Finance Committee so that shifts in risk scoring over time, together with reasons, are clearly evident
Quality & Performance Report	During August, the Trust performance across the operational standards remained challenging. There was failure to meet the national standards or Trust trajectories for Accident & Emergency(A&E) 4 hour wait; 2 week wait and 62 day cancer standard; 18 week referral to treatment (RTT) standard; and 6 week diagnostic wait. A&E performance has improved on previous month attributable in part to improved flow and discharge, and improved 15 minute triage performance. However, overall performance remains below NHSI trajectory. Attendances are 3.9% higher than in August 2016.	How can we improve compliance with Emergency Department Checklist and speciality response within 30 minutes? (Where performance has been externally confirmed as poor) What are compliance levels within relevant processes?	Compliance improving particularly at Cheltenham General Hospital. Chief Nurse is reviewing approach which the aim of improving compliance further.	Escalation Report from ECB to be strengthened including revised dashboard (to be revised by Sean Elyan & Steve Hams). Audit of speciality response and Emergency Department Safety Checklist to be undertaken and reported.

	Deterioration of cancer performance against 2-week standard. Main tumour sites affected were identified with reasons given. Increased level of 2 week wait referrals from GPs. Revised cancer services trajectory for 62 days RTT performance to be adopted during October, Arrangements for monitoring and improving data quality issues within RTT position were described. Arrangements for identifying and then managing patients with long waits were discussed. 19 52 week breaches were reported.	How proactive are commissioners in terms of demand management? Discussion around location of breaches by service.	Proactive but always more to be done. • Joint initiatives • Advice and guidance • Referral protocols • Further work required There is a cancer recovery plan but this was not available to the Committee and will need to be considered at a future meeting No Urology breaches which is evidence of improvement. Tracking of individual breaches taking place.	Work continuing with Primary Care to differentiate between genuine urgent two week wait patients versus “soon”. Cancer trajectory to be reset during October and reported to next Q&P Committee In depth analysis of breaches to take place through the Planned Care Board.
CQC Insight for Acute NHS Trusts	New style CQC report will be used to inform CQC inspections. Refreshed quarterly.	How to ensure that we use the information within the report.	The report is for insight rather than assurance as a “work in progress”.	Consider whether 12 Trust Composite Score indicators can form part of Performance Management Framework.

		Are we convinced as to data accuracy?	May provide valuable benchmarking data that the Trust cannot easily maintain e.g. Comparators of Clinical Audits.	Assessment of whether Trust is collecting data for its current indicators in a consistent way.
Complaints and Concerns Q1	Overview of reported position to end of Q1. Increases of 0.24% in complaints (same period 2016) and 20% in Concerns to PALS. Top 3 complaints themes: Communication, Clinical Treatment, Nursing Care Top 3 PALS concerns: Communication, Appointments, Clinical Treatment Trust overall Friends and Family Test score of 91.5% (response rate of 17%) against Trust target of 93. Multiple reasons and focus of the Patient Experience Improvements. Response rate to complaints within standard of 35 days has declined to 59%	How is learning embedded and spread across the organisation? Is there clarity of ownership of who is responsible for resolving concerns before they become complaints?	Responsibility for ownership of processes and embedding of lessons learned is at divisional level. Further development work is taking place to strengthen these dimensions and to address inconsistent practice between divisions.	

	Summary results of four national surveys discussed	What was the response of Emergency Dept leadership to survey findings	Not currently known	Quality and improvement projects being devised by department in conjunction with Head of Patient Experience which will involve interrogation of survey results and other data.
Operational Recovery Report •TrakCare Recovery	Summary of progress in August, including: Rebuild and roll out of clinics close to completion with evidence of improvement in completeness of clinics and in associated income. Continuing focus on Theatre-related items Focused work commenced on process-mapping in Opthalmology with other specialties planned for Sept and Oct. Inability to report still a key issue. Specific immediate focus to be on three reports: Venous thromboembolism (VTE), Cancelled Operations and recording of Dementia. Progress by Cymbio continuing in line with project plan.	Is the situation around duplicate letters and other appointment problems for patients improving?	This is being monitored through the content of complaint letters with evidence of slow improvement. GPs have also raised concerns about appointment booking and impacts for patients which are being investigated. A dedicated email and phone line has been established for GPs' use to enable them to escalate concerns.	Continuing difficulties with quality of waiting list data. Non-delivery against recovery trajectory attributable in part to user errors. To continue to be reported to Q&P. Preliminary report on impact of recovery approach has been considered by board members. Analysis of comments and complaints relating to Outpatients ongoing.

Urology	Update on current performance, actions that have been taken to achieve improvements and further planned actions Continued service redesign and investment needed for delivery of national access targets New clinical lead has been appointed.	What is current status of Multi-assessment and Diagnostic Service (MAD) model and its place in achieving access standards?	New clinical lead to assess appropriateness of MAD model for referrals once in post.	Given change in leadership, improvement trajectory to be revised and reported to next Q&P Committee. Demand and capacity plans (excluding GP care work) to be revised.
Mortality Report	Update on current key mortality indicators and on Trust progress against National Guidance on Learning from Deaths. Mortality indicators are above the expected range although falls in Hospital Standardised Mortality Ratio (HSMR) were noted. Improvement in Fracture Neck of Femur and Trauma positions. Trust policy on Learning from Deaths was published within required timescale.	What are the reporting intentions in terms of terminology and use of terms such as “avoidable” and “unavoidable” deaths. NB risk that such terms are misunderstood. What is latest position on concerns around Pneumonia and mortality as discussed at previous Committee?	Group involving patients and governors has been set up to enable lay involvement in the review process and testing of use of language This is no longer showing as being statistically significant and there are no concerns to report in respect of care following review by former Chief Registrar.	Report in shadow form to Quality & Performance Committee in October. Report to next Committee to include a closing of this issue.

	Good progress with establishment of a recording database that will enable Trust-wide and detailed reporting of Structured Judgement Review (SJR) findings. Possible progress reported to unlock the issue of recording data in respect of those patients who have been discharged from the Trust.			Further developments of mortality dashboard to be included in future reports
Patient Safety and TrakCare	Summary of governance arrangements was reported to provide assurance that effective risk management arrangements are in place for those risks that will arise, some unexpected, from the introduction of new systems	How confident are we that staff will be on board with changing processes and system requirements, and proactive in improving practices, given levels of inconsistency that have been seen?	There are areas where compliance levels are high and engagement very positive. As processes are defined, training will be a key to success and enthusiasts can be encouraged to support others. Intention to ensure new systems are mapped and tested before release where possible and embedded effectively after release. Approaches to be scrutinised by the Trakcare Operational Group.	

	Reporting of a related serious incident in respect of Trust process for initiating an appointment to see a new patient. Possible patient harm is being assessed.	Incident highlights the importance of rigorous application of process. Are there any other processes that ought to be reviewed in the light of what has been learned so far in this incident?	Other potential pathways impacted have been checked.	Case-by-case review underway Final report findings to be reported to Q&P Committee.
Serious Untoward Incidents Report	Report to provide assurance that contractual standards for investigation and learning have been met One never event had taken place (a no harm event) Investigation timescales had been met in most cases	When will a thematic analysis of leaning and assurance about embedding of learning be reported?	To be reported in December for the prior 6-month period. A root cause analysis of reasons for delays in notes being made available to be undertaken. Processes to be reviewed as such delays are not acceptable in these circumstances.	Future monthly reports to include greater detail as to explanations for delays
Infection Control Annual Report	Overview of achievements to year and challenges for next year.	Do we need to change antibiotic policy for Sepsis? Differences in cleanliness scores will influence re-procurement of cleaning services.	The antibiotic policy is clear and encourages clinicians to select antibiotics based on the likely source of Sepsis.	

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

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

Purpose

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

Key issues to note

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

Changes in Period

New risks agreed by TLT

- N1945 - The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls.
- S2275 - The risk to workforce of an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers.

Upgrading

- F1339 - Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18.
- F2518 - Risk that FY18 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation.

Downgrading

- DSP2462OPD - Risk of compromised quality and patient experience due patients being unable to be offered an appointment within expected waiting time.
- DSP 2460OPD - Risk of reduced quality and patient experience as a result of errors in clinic templates.
- F2515 - Risk that the Trust does not agree a FY18 Control Total with NHS Improvement resulting in no access to the Sustainability & Transformation Fund and is also subject to contractual fines and penalties.
- F2511 - Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the FY18 Financial Recovery plan.

There are currently 23 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 15 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)**
					4th October	
Outcome of discussion when presented to previous Committees						

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
M2488 Card	Medical	Safety	Medical Director	Divisional Board, Specialty Meeting, Trust Leadership Team	Risk of Harm to patients as a result of delay in receiving essential, required cardiac interventions.	Efficiency review of cath lab provision suggesting means of increasing throughput which has been actioned. Glanso implemented and ongoing reviewed regularly to ensure within financial allowance for Cardiology Active recruitment strategy to fill consultant posts. Progression of design for nursing/ physiology led roles to support the inability to recruit to consultant posts. Experienced Head of cardiac investigations recruited substantially commencing Nov 2017 previous experience includes advanced practice role development.	Inadequate	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Business case	23/10/2017
M1746 Diab	Diagnostics and Specialties, Medical, Surgical	Safety	Medical Director	Divisional Board, Specialty Meeting, Quality and Performance Committee	Risk of patients having potentially avoidable procedures (minor or major) due to the lack of a designated Multidisciplinary Footcare Team.	Clinical assessment as required through clinical assessment Referral to specialty in hospital teams on assessment Follow up by surgical specialty team	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	NHSE bid	03/10/2017

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
WF1609	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Workforce	Director of Nursing	Quality and Performance Committee	Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.	1. Pilot of extended Bank office hours 2. Agency Taskforce 3. Bank incentive payments and weekly pay for bank staff 4. General and Old Age Medicine Recruitment and Retention Premium 5. Master vendor for medical locums 6. Temporary staffing tool self assessment 7. Daily conference calls to review staffing levels and skill mix. 8. Ongoing Trust wide recruitment drive 9. Divisions supporting associate nurse and CLIP programme. 10. Initiatives to review workforce model, CPN's, administrative posts to release nursing time	Adequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Monitoring at Workforce Committee Establish Quality Impact Assessment for project Overseas recruitment programme	28/09/2017
DSP2404haem	Diagnostics and Specialties	Safety	Medical Director	Divisional Board	Risk of reduced quality care as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of clinical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients.	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Develop Business case to meet capacity demand	20/09/2017

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	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	Adequate	Catastrophic (5)	Almost certain - Daily (5)	25	15 - 25 Extreme risk		30/09/2017
F1339	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18	PMO in place to record and monitor the FY18 programme Weekly Turnaround Implementation Board Monthly monitoring and reporting of performance against target Monthly executive reviews	Adequate	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk		31/10/2017
DSP2513path	Diagnostics and Specialties, GP Services / NHS England, Medical, Surgical, Women's and Children's	Safety	Trust Medical Director	Divisional Board	Risk to patient safety due to delayed diagnosis because of shortage of Histopathology Staff	Locum laboratory staff in place Permanent staff recruitment in progress Locum consultant approved Outsourcing of reporting organised	Inadequate	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	fill vacant histopathologist post complete business case for Histopathology including workforce plan	09/08/2017

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S2275	Surgical	Workforce	Medical Director		The risk to workforce of an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers.	Attempts to recruit Agency/locum cover for on-call rota Nursing staff clerking patients Prioritisation of workload Existing junior drs covering gaps where possible Consultants acting down	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Escalation	18/09/2017
WF2335	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Director of HR & OD	Workforce Committee	The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2.Increase challenge to agency requests via VCP 3. Convert locum\agency posts to substantive 4. Promote higher utilisation of internal nurse and medical bank.	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures	10/10/2017
S1748	Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee	The risk of failing national access standards including RTT and Cancer	1. Weekly meetings between AGM and MDT Coordinators to discuss pathway management and expedite patients as appropriate. 3. Performance Management at Cancer Management Board 4. Escalation procedure in place to avoid breaches 5. Performance trajectory report for each pathway	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Re establish Planned care board Interim action plan to recover position	22/09/2017

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
M2473 Emer	Medical	Quality	Director of Nursing	Quality and Performance Committee	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	CQC action plan for ED	08/11/2017
S2045	Surgical	Safety	Medical Director	Quality and Performance Committee	The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Ward move to improve patient environment and aid therapy Supplemental Patient nutrition with employment of nutrition assistant Increased medical cover at weekends OG consultant review at weekends Increased therapy services at weekends Senior DCC nurses on secondment to hip fracture ward for education and skill mix improvement Review of all deaths	Adequate	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Deliver the agreed action fractured neck of femur action plan	17/10/2017

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
N1945 TVN	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Nursing	Quality and Performance Committee	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Nursing pathway documentation and training in place Pressure Ulcer expert committee reviewing practice and incidents to identify learning Monitoring through incident investigation\RCA Divisional committees overseeing RCAs Safety Thermometer data review as part of Safer Staffing	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	To create a rolling action plan to reduce pressure ulcers	13/07/2017

MAIN BOARD – OCTOBER 2017

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

Report Title
Financial Performance Report - Period to 31st August 2017
Sponsor and Author(s)
Author: Sarah Stansfield, Director of Operational Finance Jo Burrows, Director of Programme Management Sponsoring Director: 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 05 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 05 of the 2017/18 financial year is an operational deficit of £15.1m. This is a favourable variance to the budgeted position of £4.2m.
- 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 05 is £9.4m. This is £1.4m better than the plan for the year to date.
- The current CIP delivery forecast for the year is £25m as compared to a £34.7m plan.
- The annual plan for the Trust is a **£14.6m** deficit. The current forecast, prior to mitigating actions, shows a deficit of **£23.3m**, an adverse variance of **£8.7m**.

Conclusions

- The financial position for M05 shows a favourable variance to budget of £4.2m. The favourable variance is reflective of both pay underspends and phasing adjustments within the income position, both of which are non-recurring.
- The underlying financial position is adverse to plan
- **Without further action**, the Trust is currently projecting a £23.3m deficit and the focus therefore is identification of further opportunities to reduce costs and improve income.

Implications and Future Action Required

There is a need for increased focus on financial improvement, in the form of both cost improvement programmes, 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)**
Outcome of discussion when presented to previous Committees						

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 31st August 2017

LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

Gloucestershire Hospitals NHS
NHS Foundation Trust

Introduction and Overview

The Board approved budget for the 2017/18 financial year is for a deficit of £14.631m.

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 £14.631m 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 now reflects performance against the aligned budget and plan.

Statement of Comprehensive Income

2016/17 Outturn £000s	Month 05 Financial Position	Annual Budget £000s	M05 Cumulative Budget £000s	M05 Cumulative Actual £000s	M05 Cumulative Variance £000s
433,665	SLA & Commissioning Income	439,649	176,947	176,779	(168)
4,604	PP, Overseas and RTA Income	4,759	1,878	1,775	(103)
66,388	Operating Income	61,760	25,855	25,914	59
504,657	**Total Income**	**506,169**	**204,680**	**204,469**	**(212)**
329,809	Pay	335,424	142,906	138,404	4,502
174,906	Non-Pay	160,491	70,691	71,932	(1,241)
504,716	**Total Expenditure**	**495,915**	**213,597**	**210,336**	**3,261**
(59)	**EBITDA**	**10,254**	**(8,916)**	**(5,867)**	**3,049**
(0.0%)	**EBITDA %age**	**2.0%**	**(4.4%)**	**(2.9%)**	**1.5%**
21,135	Non-Operating Costs	24,885	10,390	9,196	1,194
(21,193)	**Surplus/(Deficit)**	**(14,631)**	**(19,306)**	**(15,063)**	**4,243**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,631)**	**(19,306)**	**(15,063)**	**4,243**

In August the Trust has delivered a deficit of £2.89m and a cumulative deficit of £15.06m

This represents a favourable variance to budget and plan of £4.24m as at Month 5.

The Trust has now reached agreement with both major commissioners for a block contract arrangement. This means that income for the five months outstrips budget for those commissioners and gives a favourable variance. Income is further flattered by a favourable variance on pass-through drugs.

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Annual Budget £000s	Month 05 Financial Position	M05 Cumulative Budget £000s	M05 Cumulative Actual £000s	M05 Cumulative Variance £000s
439,649	SLA & Commissioning Income	176,947	176,779	(168)
4,759	PP, Overseas and RTA Income	1,878	1,775	(103)
61,760	Operating Income	25,855	25,914	59
506,169	**Total Income**	**204,680**	**204,469**	**(212)**
	Pay			
310,453	Substantive	131,842	127,348	4,494
7,613	Bank	3,585	4,013	(427)
17,358	Agency	7,478	7,043	435
335,424	**Total Pay**	**142,906**	**138,404**	**4,502**
	Non Pay			
55,539	Drugs	23,537	25,068	(1,530)
40,143	Clinical Supplies	17,327	16,833	494
64,809	Other Non-Pay	29,826	30,031	(205)
160,491	**Total Pay**	**70,691**	**71,932**	**(1,241)**
495,915	**Total Expenditure**	**213,597**	**210,336**	**3,261**
10,254	**EBITDA**	**(8,916)**	**(5,867)**	**3,049**
2.0%	**EBITDA %age**	**(4.4%)**	**(2.9%)**	**1.5%**
24,885	Non-Operating Costs	10,390	9,196	1,194
(14,631)	**Surplus/(Deficit)**	**(19,306)**	**(15,063)**	**4,243**
	STF Funding			
(14,631)	**Surplus/(Deficit)**	**(19,306)**	**(15,063)**	**4,243**

The table opposite shows the detailed income and expenditure position.

SLA and Commissioning Income – a £0.2m adverse position. This adverse variance is driven by a combination of budget phasing, the impact of block agreements, under-performance with commissioners other than GCCG and Specialised Commissioners and risk assessment.

Private Patient Income – below budget levels.

Pay – expenditure is showing a favourable variance of £4.5m against budgeted levels. This is largely driven by vacancy factor, combined with under-spends in divisions against budget profile.

Non-Pay – Drugs expenditure is showing a £1.5m adverse variance whilst Clinical Supplies are £0.49m below budget levels. Other sub-categories of non-pay show small adverse variances.

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

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

At Month 5 we have delivered £9.4m against the NHS Improvement plan target of £8.0m which is an overachievement of £1.4m against plan. The over performance this month is largely due to the vacancy factor as well as the operational growth margin.

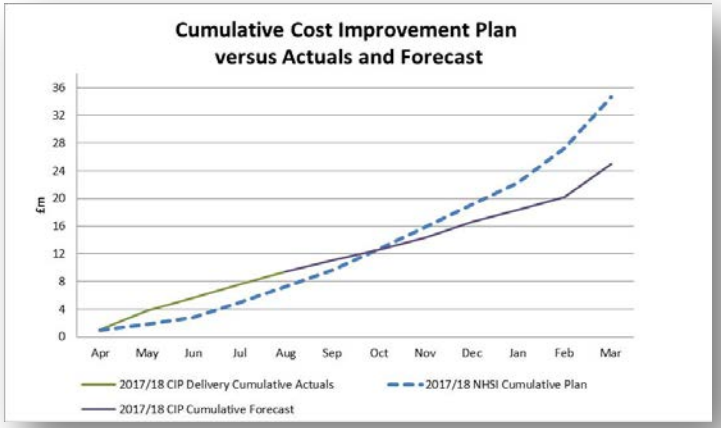
At Month 5, the divisional year end forecast figures, indicate confidence in delivering £25m against the Trust's target of £34.7m. The forecast includes £2.5m for the rates rebate scheme which remains high risk.

The forecast outturn is indicating a negative variance to planned delivery from October.

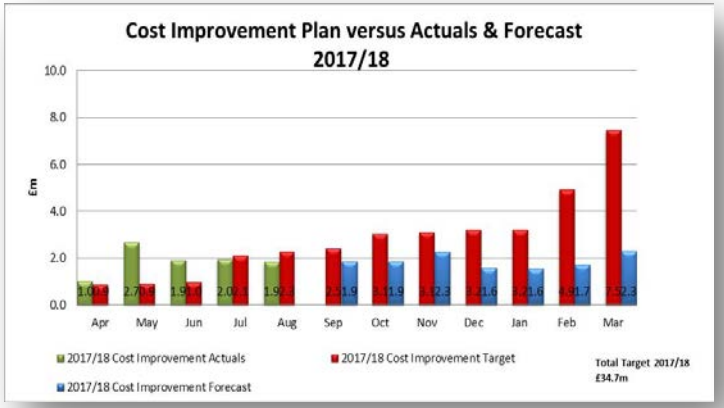
Key Actions

- Reviewing the divisional recovery plans to ensure they provide robust actions to mitigate the gap
- Further developing the Financial Recovery Plan (to include the divisional recovery actions) and ensuring engagement and ownership from across the organisations

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



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



Forecast Outturn

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust is forecasting a CIP shortfall of £9.4m and an overall Income and Expenditure deficit £8.7m adverse to plan (ie £23.3m vs planned £14.6m).

Trust Forecast Outturn					
Based on first draft forecast	**CIP**	**Pay Underspend**	**Activity**	**Other**	**FOT - Variance to Plan**
FOT - Income CIPs not identified seperately	(9.4)	4.8	(3.8)	(0.3)	(8.7)
Shortfall in income CIPs	5.1		(5.1)		0.0
Restated Forecast Outturn	**(4.3)**	**4.8**	**(8.9)**	**(0.3)**	**(8.7)**
Underlying assessment					
FOT - Income CIPs not identified seperately	(11.4)				(11.4)
Shortfall in income CIPs	5.1		(5.1)		0.0
Restated Forecast Outturn	**(6.3)**	**0.0**	**(5.1)**	**0.0**	**(11.4)**

The table above shows the main drivers for the current forecast movement away from plan. The position is then shown on an underlying basis:

- CIP deficit increases due to non-recurrent delivery on the current outturn
- Pay underspend is assumed to be non-recurrent (pending ongoing 1:1's and strategic VCP) so is removed
- Activity variances assumed to be non-recurrent (pending further analysis of income variances)

Forecast Key Messages and Actions

Gloucestershire Hospitals NHS
NHS Foundation Trust

Key messages

- We are forecasting a CIPS shortfall of £9.4m, and an overall deficit £8.7m higher than plan (ie £23.3m vs planned £14.6m)
- The in year expenditure CIPS shortfall is broadly balanced by projected pay underspends, but the non-recurring CIPS and pay underspends are not projected to continue at the current level
- The income shortfall (even after blocking) plus the income element of the CIPS shortfall total £8.9m. This relates to a combination of Trak issues and broader capacity issues
- The FYE of recurrent CIPS is £23.3m, £11.4m short of plan. The overall normalised deficit is therefore £11.4m short of plan

Key focus of action required – with pace - to address the in year and normalised shortfalls

- Maximise in year expenditure CIPs in 17/18 and maintain the pay underspend
- Maximise impact of all current CIP schemes – Cross Cutting and Divisional
- Generate material new recurrent CIPS – particularly from service improvement/re-design and informed by benchmarking refresh
- Further develop other potential actions identified to improve the financial position

Balance Sheet(1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M5 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	7,713	320
Property, Plant and Equipment	296,272	294,693	(1,579)
Trade and Other Receivables	4,668	4,557	(111)
Total Non-Current Assets	**308,333**	**306,963**	**(1,370)**
Current Assets			
Inventories	7,400	7,460	60
Trade and Other Receivables	17,697	18,496	799
Cash and Cash Equivalents	7,974	3,308	(4,666)
Total Current Assets	**33,071**	**29,264**	**(3,807)**
Current Liabilities			
Trade and Other Payables	(44,355)	(50,620)	(6,265)
Other Liabilities	(2,089)	(4,649)	(2,560)
Borrowings	(5,356)	(5,355)	1
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(60,806)**	**(8,824)**
Net Current Assets	**(18,911)**	**(31,542)**	**(12,631)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,455)	157
Borrowings	(83,126)	(84,346)	(1,220)
Provisions	(1,524)	(1,524)	0
Total Non-Current Liabilities	**(92,262)**	**(93,325)**	**(1,063)**
Total Assets Employed	**197,160**	**182,096**	**(15,064)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	166,519	0
Reserves	70,501	70,501	0
Retained Earnings	(39,860)	(54,924)	(15,064)
Total Taxpayers' Equity	**197,160**	**182,096**	**(15,064)**

The table shows the M5 balance sheet and movements from the 2016/17 closing balance sheet, supporting narrative is on the following page.

Balance Sheet(2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 5 balance sheet position against the 2016/17 outturn

Non-Current Assets

- There is a reduction in non-current assets which reflects depreciation charges in excess of capital additions for the year-to-date.

Current Assets

- Inventories show a marginal increase of £0.06m. A reduction of £0.4m in August. The movement reflects changes in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors.
- Trade receivables are £0.8m above their closing March 17 level. Invoiced debt balances have dropped by £0.4m in month. This has been offset by accrued income of a similar value to reflect the agreement on block contracts.
- Cash has reduced since the year-end.

Current Liabilities

- Trade payables have increased by £6.3m above their closing March level (a £1.2m increase on the prior month).

	Financial Year 2016/17		Current Month August	
	Number	£'000	Number	£'000
Total Bills Paid Within period	51,762	98,509	12,308	21,649
Total Bill paid within Target	45,837	80,158	10,243	17,785
Percentage of Bills paid within target	89%	81%	83%	82%

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

Non-Current Liabilities

- Borrowings have increased as £2.4m of distress financing to fund deficit support was drawn down in July.

Reserves

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

Cashflow : August

Cashflow Analysis	Apr-17 £000s	May-17 £000s	Jun-17 £000s	Jul-17 £000s	Aug-17 £000s
Surplus (Deficit) from Operations	**(4,958)**	**(3,284)**	**935**	**(1,031)**	**(1,940)**
Adjust for non-cash items:					
Depreciation	946	1,719	975	975	975
Impairments within operating result	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0
Provisions	0	0	0	0	0
Other operating non-cash	(58)	(59)	(58)	(58)	(58)
Operating Cash flows before working capital	**(4,070)**	**(1,624)**	**1,852**	**(114)**	**(1,023)**
Working capital movements:					
(Inc.)/dec. in inventories	(150)	(1,118)	349	192	367
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(157)	633	379
(Inc.)/dec. in current assets	0	0	0	0	0
Inc./(dec.) in current provisions	0	0	0	0	0
Inc./(dec.) in trade and other payables	4,930	328	(2,109)	(530)	514
Inc./(dec.) in other financial liabilities	(520)	3,448	(58)	(181)	(129)
Other movements in operating cash flows	835	(995)	32	(31)	32
Net cash in/(out) from wokring capital	**29**	**2,863**	**(1,943)**	**83**	**1,163**
Capital investment:					
Capital expenditure	(148)	(989)	(348)	(214)	(909)
Capital receipts	0	0	0	0	0
Net cash in/(out) from investment	**(148)**	**(989)**	**(348)**	**(214)**	**(909)**
Funding and debt:					
PDC Received	0	0	0	0	0
Interest Received	4	3	2	3	3
Interest Paid	0	(162)	(42)	0	0
DH loans - received	0	0	0	2,355	0
DH loans - repaid	0	0	0	0	0
Other loans	0	0	0	0	0
Finance lease capital	(20)	(20)	(20)	(20)	(20)
PFI/LIFT etc capital	(181)	(181)	(181)	(181)	(181)
PDC Dividend paid	0	0	0	0	0
Other	0	0	0	0	0
Net cash in/(out) from financing	**(197)**	**(360)**	**(241)**	**2,157**	**(198)**
Net cash in/(out)	**(4,386)**	**(110)**	**(680)**	**1,912**	**(967)**

Cash at Bank - Opening	**7,539**	**3,153**	**3,043**	**2,363**	**4,275**
Closing	**3,153**	**3,043**	**2,363**	**4,275**	**3,308**

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

Key movements:

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

Current Assets – Invoiced debtor balances have decreased in month due to timely settlement of in-month SLA invoices. This has been offset by accrued income to reflect the block agreements.

Trade Payables – reduced in August. Aged creditors shows reduction in creditors below and above30 days, thus reducing overdue debt.

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover	(1.46)	(1.03)
Metric		
Rating	4	4
Liquidity	(23.94)	(28.37)
Metric		
Rating	4	4
I&E Margin	(9.50%)	(7.40%)
Metric		
Rating	4	4
I&E Variance from Plan	0.00%	2.17%
Metric		
Rating		1
Agency	49.40%	38.70%
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 M05.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee is asked to note:

- The financial position of the Trust at the end of Month 5 of the 2017/18 financial year is an operational deficit of £15.1m. This is a favourable variance to budget and NHSI Plan of £4.2m.

- The current forecast before any mitigating actions is for a £23.3m deficit, this is £8.7m adverse to plan. Key areas for focus and action to improve the position have been identified for implementation

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

REPORT TO MAIN BOARD – OCTOBER 2017

From Finance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Finance Committee held 27th September 2017, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Capital Programme & Capital Control Group Update Subco	Received re-worked capital programme updated for latest scheme forecasts and programme information. Current commitments have been reviewed together with possible deferrals into 2018/2019. Risks associated with delays and re-profiling have been identified. Update on sources of NHSI loan finance.	What is the outlook for 2018/2019 re proposed programme including 2017/2018 deferrals? Clarity sought re-timing of loan availability.	2018 / 19 business planning process was described, incorporating capital planning. Need for loan and other financing dimensions still to be identified. Briefing provided regarding how 2017/2018 programme is being re-profiled with the involvement of appropriate clinical and operational oversight. Estimated to be one week.	2017/18 financing sources may require further re-profiling of programme.
Subsidiary company briefing re business case	Briefing received on financial dimensions to business case.	What are the underlying assumptions and the sensitivities to movement in key variables?	KPMG available to present and discuss modelling and underpinning assumptions.	Further modelling required. 'Real life' business experience from other Trusts to be sought.

	Opportunity to understand and test assumptions built into financial model.	Clarity sought around further aspects of tax dimensions.		
Financial Performance Report	Year to date deficit is £15m which is favourable to planned position by £4.2m. Forecast deficit is £22.9m - £8.28m short of plan.	What can we learn from agency cost benchmarking data? What is not yet identified in the forecast? Probing of CIP assumptions on forecast (see below)	Benchmarking to form part of wider agency control and divisional workforce profiling. Some emerging items still to be reflected in greater detail e.g. in paybill, drugs costs.	
Income Variance Analysis Report	First report to brief the Committee on examination of income position. Enables much clearer understanding of any underreporting and any under-activity with explanations	What is the organisational readiness for re-setting of income assumptions and devolution of responsibility/ accountability?	Intention to further refine the analysis Intention to move to a more devolved income position to optimise operational accountabilities around income.	More granular analysis and forecasts to future Committees

	Good first consideration of this item. Work in progress. Will help with future prioritisation of actions to address income shortfalls.		Executive confirmation of divisional appetite for much greater involvement in income	
Cost Improvement Programme Update (CIP)	Very comprehensive report showing schemes' progress and levels of confidence in extent of timing of CIP release. Some progression in achieving greater accountability for Corporate schemes. Detail still to be refined. Identification of need for divisions to confirm resource needs to support CIP efforts. Month 5 delivery exceeds target but forecast delivery for full year currently £9.5m below target of £34.7m plan.	Recognition given to the significant efforts that are evident in terms of CIP identification and progress. What is organisational grasp of the need for involvement in CIP? What variation is there between divisions?	Range of further actions described to improve forecast. Currently recruiting to Project Management Office (PMO) interim posts to support delivery. PWC to complete audit assessment of CIP activity to provide appropriate assurance and identify any opportunities	Additional schemes to be generated / finalised under oversight of Turnaround Implementation Board (TIB) More sophisticated RAG rating to be introduced to provide assurance of scheme elements and scheme progress rather than to mark them as absolute red / green
Medical Productivity Update	Opportunities for a deep dive into 2 major CIP schemes with significant impact: update on move to a more strategic	What is the best measure of progress from which the Committee could draw assurance as to	Further reports to include plan to progress on Job Plan reviews at a divisional level so that we can see release of Programmes Activities (PA's) and evidence of contribution to CIP target.	Lack of visibility and progress against plan and CIP achievement.

	approach at Vacancy Control Panel. Progress on Job Plan reviews.	progress on Job Plan reviews related to CIP?		
Development Of Plan To Recover Current Year Finances	Report on methodology for identifying and evaluating further options to improve current forecast position.			
Financial Risk Register	Three risks have been escalated: ▪ Risk of not achieving CIP ▪ Income recovery due to data inaccuracies ▪ Capital loan funding risks	What consideration is required of risks associated with capacity constraints in driving CIP in divisions / finance and PMO teams?	Verbal supplementary to a very clear report with mitigations evident. Intention that additional resource needs will be identified.	

MAIN BOARD – OCTOBER 2017

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

Report Title
Workforce Report
Sponsor and Author(s)
Author and Sponsoring Director: David Smith, Director of Human Resources and Organisational Development
Executive Summary

Purpose

This report presents progress against the Workforce Strategy

Key issues to note

- The development of a detailed KPI Matrix and reporting cycle has provided a framework for the Workforce Committee to measure progress against the Workforce Strategy.
- Agency expenditure reversed the trend of previous 'month 5's' by reducing (£35k). It was particularly pleasing to witness nursing agency reduce by £350k on the prior year. Agency expenditure overall is now 26% lower than the comparative figure for last year and is a consequence of a number of issues regarding increased control, improved roster management, reduced vacancies and the tactical use of incentives. .
- The pay bill generally continues its improved trajectory of savings over the comparative period last year. Spend did increase in the month, largely driven by divisions filling previously approved posts.
- There was an impact on overall medical expenditure driven by the transition of junior doctors from the old to new contracts and bringing with it an element of pay protection. The impact of this and in particular, the recurrent element, is still being determined.
- To ensure the recent improvements in staff turnover we are assessing the impact of a number of key actions as well as determining future direction and this strategic consideration will be brought to Workforce Committee in December.
- Appraisal compliance, at 79%, remains unacceptable and divisions have been asked to submit their trajectories to compliance as these are also part of our consolidated action plan in response to the last CQC visit. Mandatory Training compliance remains stable at 89%, close to the Trust target of 90%.
- The NHS 2017 Staff Survey has launched with certain divisions being selected to complete 'on-line'

Conclusions

Reductions in Agency expenditure are encouraging and continue to demonstrate a more favourable position than last year. However, given the profiling of workforce savings, both the benefits in pay and reduced agency costs are expected to dissipate over the last 7 months unless additional impetus is brought to tackling some of those high costs areas. Key to this is engaging staff at all levels in

determining the solutions.

Implications and Future Action Required

- Work has already begun at Divisional level and the implementation of Strategic VCP's is ensuring that focus is being placed not just on short term but long term solutions.
- Engagement has commenced with staff representatives, with follow up actions determined, to ensure that we begin to capture and develop staff input.
- The Reward Strategy Group will review the developing Reward Strategy following feedback from the Workforce Committee as well as evaluating the impact of incentivised shift payments on bank and agency usage over the summer period and their applicability/extension at other times, to other parts of the workforce.
- Implementation of The Medical Bank (TEMPRE) and embedding of the Allocate exception reporting system for junior doctors.

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

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

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

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

MAIN BOARD – OCTOBER 2017

WORKFORCE REPORT

1. Aim

This report provides Trust Board with an overview of performance, against the Trust Workforce Strategy.

2. Background – Development of a Reporting Matrix and Annual Plan

The Workforce Committee has spent time scrutinising a matrix of proposed indicators against each element of the Workforce Strategy. Some elements remain under development; however a standard suite of information is presented at each Committee Meeting to indicate overall performance.

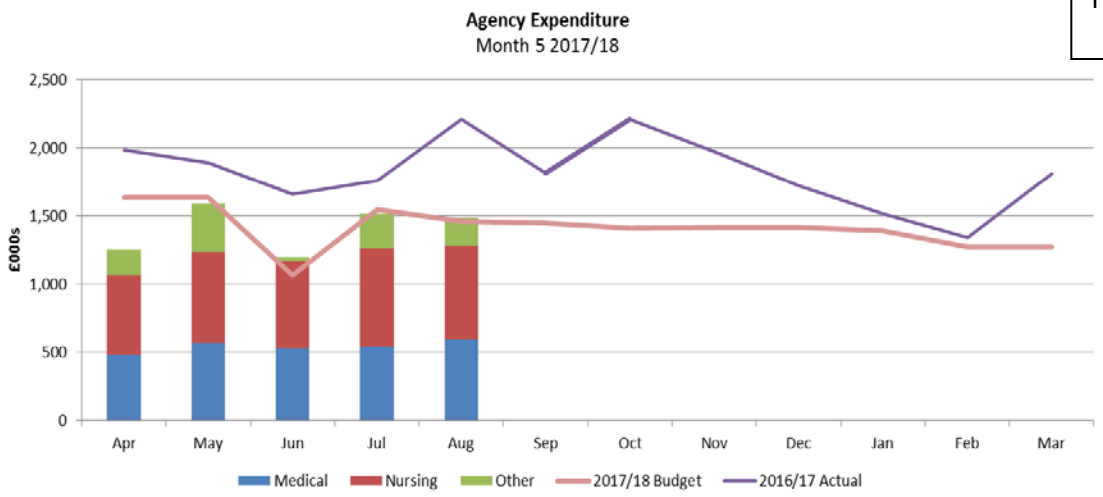
In addition to this and in order to measure success against overarching strategic aims and ongoing development work within the Workforce function, the Committee are working to an agreed reporting cycle for in depth progress reports.

3. Workforce

We continue to focus on the reduction of expenditure on agency staff and compliance with NHSI regulations.

3.1 Reducing Agency Expenditure

Figure 1



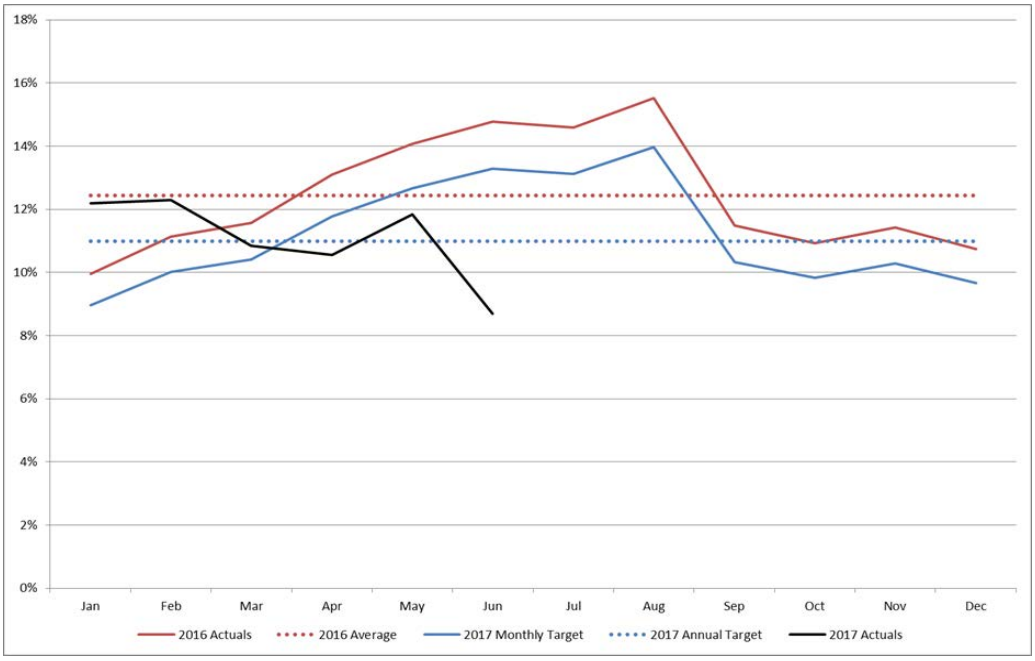
It was pleasing to see a £35k reduction in overall agency spend between month 4 and month 5 but even more so to witness the reduction in Nursing agency expenditure against the prior period last year. It is clear that the planning for the anticipated shortage of supply in this period, which involved the establishment of an appropriate incentive and increased scrutiny of the rotas, was instrumental in reducing the expenditure. Whilst this has contributed to an overall year on year reduction in agency expenditure of £2.5m (circa 26%), it is likely that this rate of improvement will slow done considerably, in line with the increased grip that was applied from month 7 last year. Whilst significant improvements have been made we are still dependent (albeit it to a lesser degree) at critical times on nursing agencies such as Thornbury as well as the employment of numerous long term expensive medical locums.

The overall reduction in agency was also reflected with an increase in the year to date underspend against the pay budget. The Month 5 paybill did rise however by £780k (of which £150k was fully funded as it related to 'hosted services). Within this £630k rise, £230k was accounted for by the increase in bank hours following the launch of the Summer incentive programme. The rise was not unexpected as it also related primarily to the divisions successfully recruiting posts previously approved and as a consequence, drawing down the budget to match the recruitment. It is also noted that the rise in medical expenditure is partly explained by the transition to the new junior doctor contract of the 'new house' of juniors in August and the impact of pay protection as they transition from one contract to another. We are currently assessing the impact of this and determining the extent of the recurrent cost pressure.

3.2 Recruiting to Nurse Vacancies

In order to reduce demand on temporary staffing services, it is critical to maximise recruitment to our Nursing establishment.

Figure 2



Band 5 Registered Nurse Leavers (WTE)

*Total Leavers data for 2017 is the forecasted end of year position based on current trends.

Figure 3

	2016	2017	Target
Last Month (May)	10.01	10.00	10.00
This Month (June)	11.29	5.54	10.00
Year to Date	72.74	58.44	60.00
Total Leavers	142.43	114.43 *	120.00

The vacancy forecast has improved considerably, both as a result of improved recruitment and a reduction in establishment of 23.16. It is expected that the vacancies will reduce to circa 80, once our Newly Qualified Nurses have gained registration

The current vacancy rate for Band 5 Nursing & Midwifery staff is 8.88% (April 2017: 9.04%), and is forecasted to remain around this level until November 2017, when it is expected to reduce further to the lowest level recorded in recent times: 5.71%.

To ensure recruitment pipelines continue to deliver through 2018/19 the Recruitment Strategy Group investigated the feasibility of further Philippines and Non EU Nurse recruitment and this has now been agreed by the Chief Nurse. What is critical is that our conversion rates improve (ie the numbers who successfully pass their OSCE test) and we are in discussions with other trusts who have adopted a 'boot camp' approach to this to see if we can adapt for our own use.

3.3 Turnover

Last month, commentary focused on the reduction in staff turnover and some of the steps taken to assist this, including 'new starter questionnaires' and improved management of exit interviews. We are working to a historic benchmark of 9.50% which is currently under review by the Workforce Committee, particularly as comparative figures from other Trusts suggest turnover ranges between 10-13.5%. The Workforce Committee will receive an in-depth analysis of current trends for December, mirroring some of the national work and reporting on progress in the following areas;

- looking at our data in depth
- asking our people what is important to them
- how do we follow a more systematic improvement methodology
- the role of developing organisational values and culture
- how we are supporting new starters
- how we are supporting flexible working
- the role of development and career planning
- how we can improve flexible retirement options
- building line manager capability

A summary of this will be provided in the December Board report. Pending this, in November, we will return to highlighting the current trends in divisions.

4. HR Operations & Staff Health and Wellbeing

The Trust annual sickness absence rate of 3.92% remains **lower than the national average** for Large Acute Trusts (4.39% to Jan 17). Long term absence accounts for approximately half of the absence recorded. The estimated cost of sickness absence, excluding backfill is approximately £7.1m.

Figure 4

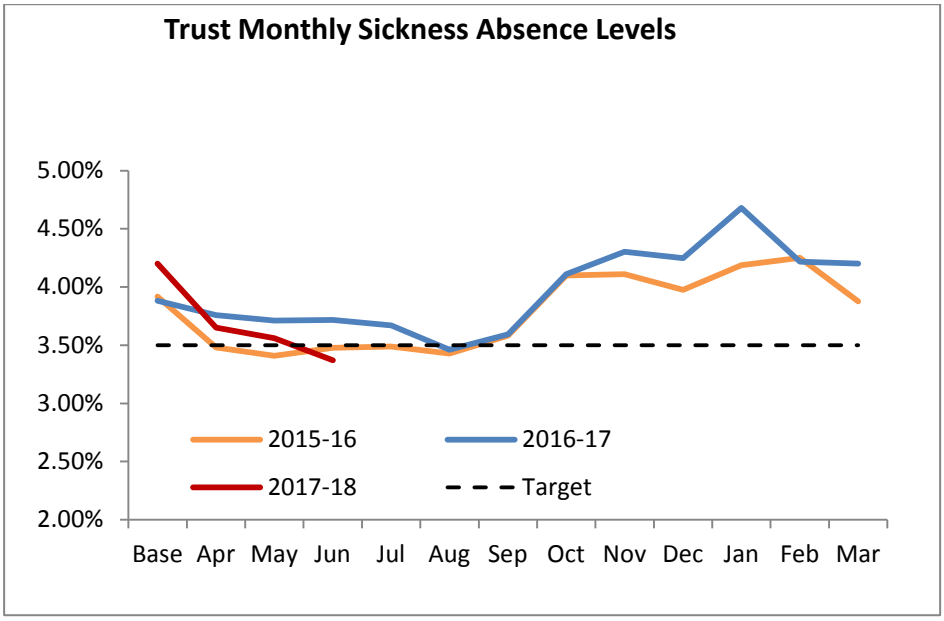


Figure 5

Current Performance (measured as % of available fte)			Sickness Absence by month							Movement Jun to Jul	
12 months to June 17 (Annual)	Actual	KPI	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17		
	% Abs	% Abs									
Trust Total	3.92%	3.83%	4.67%	4.21%	4.19%	3.65%	3.56%	3.37%	3.50%	↗	increase
Corporate	3.90%	3.50%	4.20%	4.39%	4.51%	3.48%	3.65%	3.20%	3.73%	↗	increase
Diagnostics & Specialty	3.59%	3.50%	4.51%	3.51%	3.55%	3.29%	3.31%	3.48%	3.27%	↘	decrease
Estates & Facilities	4.58%	3.50%	5.21%	5.41%	5.78%	5.21%	4.15%	3.81%	3.81%	→	stable
Medicine	3.66%	3.50%	4.67%	3.85%	4.20%	3.66%	3.24%	2.96%	2.76%	↘	decrease
Surgery	4.06%	3.50%	4.70%	4.53%	4.11%	3.72%	3.87%	3.71%	4.00%	↗	increase
Womens & Children	4.28%	3.50%	4.92%	4.56%	4.47%	3.34%	3.39%	2.84%	3.66%	↗	increase

Whilst the overall picture is comparatively positive, it remains important that we do further work to understand those areas where they appear to be outliers. As a consequence, particular emphasis is currently being placed on areas such as Haematology and Estates and Facilities.

5. Education, Learning and Development - Appraisals

Appraisal compliance (fig 7) has seen a moderate increase of 1% albeit this remains significantly below the 90% target both internally set, but also a key element of our CQC action plan. All divisions have been asked to produce their action plans by the 15th October and they continue to be challenged on this performance through the Divisional Executive Review process. All cost centre managers receive granular reports regarding which departments and individuals within their areas are compliant.

In similar vein, continued focus on Mandatory Training (fig 8) means compliance remains stable and close to the Trust target of 90% and there is no reason why every division should not be above the expected reporting threshold.

Figure 6 & 7

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

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

6. Key Progress against the Workforce Strategy

The following additional progress has been made against the workforce strategy during September 2017.

- Submission and consideration of the annual report on Education to the Workforce Committee.

- An assessment of progress of the workforce work streams within the STP.

- The Strategic VCP process has been launched, helping to focus the divisions on a more holistic view of their workforce and the development of 'heat maps' which correlate spend with workforce supply challenges.

- Presentation of the developing Reward Strategy has been made to the Workforce Committee

7. Short Term Priorities

Workforce Planning
This year's Business planning round will feature a requirement to consider workforce planning and all Divisions will be expected to engage with HR Business Partners through October 2017 to ensure that Workforce Plans align to operational demands. This will also align with the fortnightly (for each division) Strategic VCP reviews.

Winter Planning
The alignment of rosters and incentives with known workforce supply challenge times is equally relevant beyond the Summer as we approach 'half-term', Christmas and Easter. Divisions will be tasked with providing similar assurance for these periods as for the Summer. Integral to this will also be ensuring that as many staff as possible are vaccinated for influenza.

Recruitment Audit (Immigration)
Price Waterhouse Coopers (PWC) were invited to carry out a sample audit of our recruitment practice around immigration and visa requirements. Based on the initial findings we will be carrying out further work with PWC to ensure that our data and governance structures in these areas are of the highest standards

Incentive / Reward Analysis
The Reward Strategy Group will fully evaluate the impact of incentivised shift payments on bank and agency usage over the summer period (early indications are that bank utilisation increased as agency useage decreased), but also the potential for incentivising pure 'bank' work and the extension of Recruitment and Retention premia into selected high cost areas of nursing and medical expenditure.

Implementation of a Medical Bank (TEMPRE) and launch of Allocate 'exception reporting'
We continue to work on the Launch of a Web based internal medical bank model, planned for late October 2017 – to ensure that we maximise opportunities for NHS Locum work as an alternative to employing high cost Medical Agency workers. We are also embedding the Allocate software to improve the robustness of exception reporting by junior doctors as highlighted in the September Board report of the Guardian of Safe Working

Engagement
We will continue with the successful model of 'listening events' implemented across the Summer for staff, led by the CEO and various executive colleagues. We have also launched the 2017 NHS Staff Survey and this year have taken the opportunity to place the survey 'on-line' for a number of selected staff groups. To engage staff further in solutions to our financial challenges, the Director of Finance has presented to both staff side representatives and to medical workforce representatives and these dialogues will continue.

Medical Staffing
We will assess the cost and recurrent impact of the transitioning between the old and new contracts of the junior doctors.

8. Conclusion

Reductions in Agency expenditure are encouraging and continue to demonstrate a more favourable position than last year however it is clear that on both agency and pay costs generally, the excellent start may not be retained without some very challenging discussions about our continued use of certain high cost agency staff, in addition to accelerating the development of alternative roles and it is clear that staff at all levels need to be involved in those discussions. The engagement agenda remains of the highest importance, particularly in terms of openness and transparency and remains the key to unlocking so many of our financial and operational improvements.

The Board are asked to note the progress against key elements of the Workforce Strategy

David Smith
Executive Director of HR and OD
October 2017

REPORT TO MAIN BOARD – OCTOBER 2017

From Quality and Performance Committee Chair – Rob Graves, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee on 7th September indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Head of Counter Fraud Report	Updated the committee on - Current awareness activity - Current cases under investigation	What is the quality of the record keeping for cases progressed? What is the process to support individuals who are the subject of allegations? What opportunities are there for greater use of the intranet to support awareness communication?	Comprehensive records are maintained. While processes are in place via HR and external agencies to support individuals this will be reviewed with HR for adequacy	
Cyber Security Update	Follow up briefing from the Chief Information Officer on actions arising from the Internal Audit Phishing report			Agreed 6 monthly updates unless events trigger a special review – next scheduled session January 2018
Internal Audit - Medical Productivity Report	Finance Director shared the report presented at the Finance Committee which has highlighted the need for integrated review of expenditure to seek greater understanding of the drivers of Medical Agency Spend	When will the broader review be completed? How best to co-ordinate the review between committees?	Incomplete	Requires agreement on cross – committee review approach

Losses and Compensations	Report from the Finance Director on year to date expenditure.	Additional supporting analysis required at Committee level	Lessons have been learnt from the detailed analysis conducted. Supplementary analysis will be incorporated in future Committee papers	
Single Tender Actions	Report from the Finance Director on actions taken	Is the number of actions a potential source of concern?	Detailed discussion in Committee of the individual cased provided assurance	Supplementary analysis should accompany the report to provide documentary assurance and obviate discussion
Work plan 2017 & Future Focus	Workplan updated to incorporate latest inputs for balance of 17/18. Committee chair proposed items for future consideration	Prioritisation? Integration with other Committees and the Internal Audit Programme? Clinical audit & Whistleblowing?		Work required to develop the programme with close liaison with the Director of Corporate Governance and Committee chairs

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

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

Purpose

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

Key issues to note

- The programme is set at amber status based upon achieving acceptable level of resolution of issues identified that are impacting on operational activity.
- Performance against contracted services is being monitored and reported in line with SLA based reporting and delivery of contracted functionality.
- Key high priority system related issues (TRC) are identified and reported with current status.
- Executive level review with InterSystems held.
- Service Reviews continuing within Programme Team until such time that BAU consultation process has completed. Next meeting scheduled for 11th October.
- Full Phase 1.5, 2 & 3 deployment plan with corresponding CCN to be presented to the October Programme Board.
- 2017.2 MR3.3 upgrade scheduled for January 2018 will include the ECDS requirement. Earlier deployment of 2017.2 MR3.1 planned for end November 17.
- Risk to Phase 2 proposed go-live for Oncology including Chemotherapy prescribing is the timeline for proposed planned go-live of Pharmacy in February 2018.
- Phase 2 Operational Assessments to commence in November 2017.
- Oncology progressing well with PID issued for approval.
- Training progressing with priority based upon preparation for Phase 1.5 Radiology Order Comms
- Programme Team attendance at Operational Impact Group maintained and resources assigned as available.

Conclusions

TrakCare is in full Phase 1 operation across the Trust but with operational issues as identified. Recovery action plans are in place or being progressed to achieve resolution with Cymbio involvement having commenced. The project team are supporting the BI related activity in this respect.

Implications and Future Action Required

The programme will continue to provide assurance to the Smartcare Programme Board
A further update for the Board will be provided in November.

Recommendations
Implementation of phase 2 of Smartcare will reduce the risk on the corporate risk register associated with the instability of the Oncology Prescribing system. Additionally, the Clinical Risk Review process will identify any additional corporate risks and their mitigation.
Impact Upon Strategic Objectives
Prerequisite for the achievement of the strategic objective.
Impact Upon Corporate Risks
Implementation of phase 2 of Smartcare will reduce the risk on the corporate risk register associated with the instability of the Oncology Prescribing system. Additionally, the Clinical Risk Review process will identify any additional corporate risks and their mitigation.
Regulatory and/or Legal Implications
None at present.
Equality & Patient Impact
The patient benefits from the implementation of Smartcare will be realised across all patient groups.

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

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						Smart -care Program-me Board 2/10/17
Outcome of discussion when presented to previous Committees						
Endorsed.						

PROGRESS REPORT SmartCare			
Date completed:	29/09/17	**Version**	1.0
Project Sponsor:	**Dr Sally Pearson**	**TRUST RAG Status**	**AMBER**
Project Manager:	Gareth Evans		

SmartCare Progress Report – October 2017

Executive Summary & Programme Status

An overall Trust RAG status of **AMBER** until such time that phased deployment timescales for all deliverables are agreed.

Phase 1

Contract performance

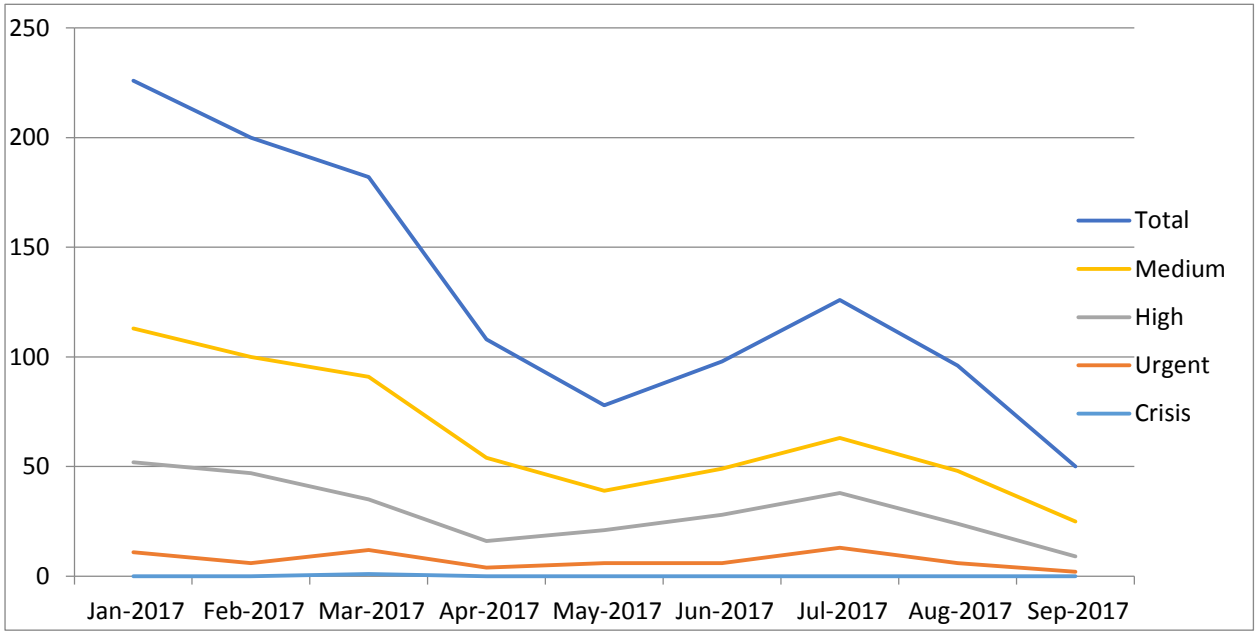
Contract Performance is measured against Incident call statistics against the InterSystems Call Centre (TRC) and availability of TrakCare to end users. Current trends and ongoing totals provided below.

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

TRC Incident reporting Summary: Jan – Sept 2017

Incidents Opened YTD:	585
Incidents Closed YTD:	538
Incident Closure (%):	92
Open Incidents:	155

Trend for Open Incidents



A report on Open URGENT and HIGH Priority TRC issues is provided to the SmartCare Programme Board. A revised copy of the report is to be provided to subsequent Board meetings with corresponding Trust priority and impact identified so as to enable closer monitoring of high priority issues for resolution.

- The highest priority issue raised recently was in respect to the correct offering of appointments against clinic schedules. This has been implemented as an ad-hoc patch from InterSystems and is now in operation.
- The current high priority issue is in respect of incorrect assignment of Finished Consultant Episodes (FCE's) which has impact on accurate reporting of utilisation and subsequent billing. This has been escalated to ISC senior management and a meeting is scheduled for Wednesday 4th October to review the issue with a corresponding action plan to be developed. The issue is complex and has corresponding user-actions coupled with a potential system related issue. The issue will be reported through to the Programme Board membership and Operational Impact Board in terms of progress and anticipated resolution.

Overall TRC logging trend has continued to decrease in the last month.

A Service Review with InterSystems has been scheduled for 11th October. The review will cover standard SLA and TRC reporting/progress but will also be followed with a contractual review of service activity.

Status reporting of all identified 'system' issues relating to Operational Impact is provided in the Operational Impact Log. In addition, a weekly review of TRC status is being undertaken for reporting back to the Operational Impact Group. The Group has raised its concern on the length of time to resolve identified issues.

Senior Executive Meeting with InterSystems

A meeting was held between the Trust and InterSystems with senior executive attendance. Attendees included Trust Chair, SmartCare SRO, Programme Manager and Clinical Lead; InterSystems UK Country Manager and ISC Clinical Engagement Director (Europe) to review Trust concerns within the overall delivery of the Programme.

Open discussion was held in respect of the following:

- Availability of a fully defined Programme Delivery plan within the funded timescales – ISC commitment made to provide the current plan with any necessary revision for the October Programme Board. It was noted that the Operational workshops in November would enable detailed finalisation. Peter commented specifically that the plan needs to include key deliverables, risks and resources required to be successful and what could be done differently this time to ensure a more robust plan?

- Request for a revised CCN in line with the overall programme plan once agreed.

- Support. Trust yet to identify a dedicated service management team to enable transfer of knowledge and capability from InterSystems to Trust.

- Issues around the use of analytics indicated a need to review local use and methodology to enable production of a report with recommendations by ISC.

- Review of current planned deliverables for Radiology Order Comms, Pharmacy and Labs with concern regarding project delays. Assurance of go-live dates for Radiology and Pharmacy.

- Oncology – Requires detailed project initiation document detailing scope, timeline and responsibilities..

- Clinical Risk – Patient slot anomalies in respect of 52 week waits identified as an area of concern. The main clinical risk is a consequence of operational impact of system leading to long waits, rather than safety arising from the system itself. All issues and incidents continue to be reviewed.

Overall, the meeting provided a level of reassurance from InterSystems and a commitment was made for the SRO and InterSystems' UK Country Manager to follow up regularly and to attend future Programme Board meetings from November onward.

System Deliverables

System related progress during this period has been in respect of the preparatory work required to complete the work required for preparing all technical environments as a pre-requisite for the Radiology Order Comms go-live and Pathology build continuation.

Progress included the application of the ad-hoc patch update to resolve the priority TRC related to the correct offering of appointment slots

The technical re-baseline work required a significant effort from JW and the Pathology Team in progressing CCR updates to enable the re-baseline activity to commence on schedule. This was duly noted by InterSystems with recognition of this successful completion. The re-baseline activity is now in progress. The original completion was set for 29/09/17 but an issue with a code table has caused this to move to Tuesday 3rd October. This is currently on schedule. There is a 'freeze' on all system changes prior to completion.

The project team has been working with InterSystems to provide an all-encompassing Programme Delivery plan for all component deliverables within Phases 1.5, 2 and 3. The plan and associated CCN are due to be presented to the October Programme Board.

Phase 2 Operational Assessments for the Advanced Clinical components are due to commence in November. A matrix of required clinical and business based attendees is being prepared for issue with relevant clinical notice periods.

InterSystems has confirmed that in reference to the previously reported restriction – **Customer developed and built questionnaires** and use of **Layout Editor** is to be provided as originally requested.

Contract Payment schedule and any variance from plan

A revised milestone payment schedule is required urgently to be incorporated into the Contract Change Note (CCN) to be raised by InterSystems in respect to planned implementation schedule for Phases 1.5 and 2. This is to be produced in line with the revised Programme Plan for all phases and is to be presented in draft form to the October Programme Board.

Angela Cox and GE have reviewed existing contract and CCN. Angela will attend Programme Board.

Central Funding

The submission to SLCS for the next six-month funding period has been submitted. It has identified those elements within the phased deployment that have defined payment milestones associated to enable release of funding. The Phase 1.5 elements of Radiology Order Comms and Pharmacy will effectively release a total of 40% of the Phase 1.5 funding with the remainder released against the delivery of Pathology. Subsequent matching payment milestones for InterSystems will be incorporated into the pending CCN.

Service Review and Phase 1 Recovery

The Programme Team is continuing to engage with ISC Support in terms of Service Management until such time that the BI consultation process has completed and this element can be moved into BAU activity.

The next Service Review is scheduled for 11th October.

The recent Maintenance Release (MR7), which included fixes to a significant number of reported issues. Details of the operationally affected items resolved was distributed via the TrakCare Operational Lead communication and is included below.

Function	Issue	Change/fix
Admissions	When an Inpatient Preadmission (TCI) was created for a patient it was possible to select a Care Provider that did not have inpatient rights.	Now, only Care Providers with inpatient rights should be displayed in the Care Provider lookup field.
	The user was able to record a TCI as 'declined' but then proceed to book a TCI date against the declined offer.	Users will not be able to re-select a declined TCI and book a TCI date against it.
Bed Management	Previously if a bed manager updated a bed from the "Request" link they could not flag the bed as ready.	Able to flag the bed as ready when accessed from the "Request" link from the Bed request Summary menu.
	When sorting the Booked bed list summary the information was not being displayed correctly.	Can now sort the Booked bed list summary – by start date and start time.
Booking	OP Worklist screen when overbooking into a Not available period, user not receiving a warning prompt.	Users will now receive a warning prompt.
	Appointments slots with "0" availability are allowed to be picked and used	System will no longer allow this.
	Slots incorrectly polling to eRS	Now fixed
	Number of clinic slots displayed incorrectly, did not correlate to the numbers under the columns for appointments Booked, vacant etc.	Fixed, number will display correctly
	Cancelled slots allowing overbooking	Fixed
Discharge summary	GP address not full address making it difficult to post summary	GP address now display in full, also on printed version
	Customers want the GP to continue field to say Yes or No	On the printed discharge summary the GP to continue field is now populated with No or Yes and never blank
Maternity	Pre-discharge assessment – Error message: Questionnaire selected has not been generated	Fixed
Operating Theatre	Only allow authorised staff to create ad-hocs and delete sessions	New security group – ENNX Theatre Super
	Laterality details are not retained on Update	Primary and secondary procedure laterality is saved and displayed correctly
Reception	If patient is ticked as arrived and seen in error, if undone the seen box remains ticked.	Within the OP Worklist there is the ability to check patients as arrived. If this needs to be reversed the check box now becomes unticked.
Vetting		Vetting list can now be sorted by Referral Priority and Days on List.

The effect of the update has resulted in some operational areas having to review their process to remove 'work-rounds' that are no longer necessary. The change has brought about a number of new issues being identified and these are being progressed through support and with InterSystems.

The booking related high priority issue that was logged and escalated with InterSystems has been resolved with the application of an ad-hoc patch fix. The issue was that TrakCare was not offering all appropriate and available appointment slots against clinic schedules leading to a combination of under-utilisation of clinics and inappropriate

appointments.

The current High Priority issue for resolution is in respect to the incorrect creation of Finished Consultant Episodes (FCE's). This is a set of associated individual issues that have been reported that collectively create a significant operational and billing related problem for the Trust. The collated problem has been escalated with InterSystems and was specifically included in the recent Executive meeting.

A meeting between ISC and the respective TRC issue owners is to be arranged for week commencing 2nd October to determine an accurate assessment of the overall FCE problem. An action plan with agreed activity will be produced and timeline for addressing specific issues determined as appropriate.

The Trust Programme / Project Team and ISC implementation resources continue to support Operational Services in resolving issues associated with the use of TrakCare. To support this process and to supplement the pending BAU activity, a weekly review of TRC issues is being undertaken to ensure that appropriate escalation is maintained as well as improving local call logging quality.

A review of booking processes and the associated action plan related to the re-training and improvement in the Central Booking Office and associated devolved areas is in progress. The enabling of the revised training was subject to
the provision of an ad-hoc patch to fix the issue where appointment slots are not being offered as per the TRC identified above.

Phase 1 Deployment Lessons Learned

The Action Plan against the lessons learned report is in preparation.

Phase 1.5

Preparation and planning

A full programme plan to incorporate all of the deliverable clinical functionality within the centrally funded timescale is in final stages of completion and will be presented to the Programme Board on 2nd October.

The plan will include confirmation of delivery for the Phase 1.5 components - Radiology Order Comms, Pharmacy Stock Control and Pathology (including pathology order Comms). The plan will identify key software upgrade stages and the provision of a schedule for all Phase 2 deliverables.

Phase 2 - Component delivery.

Phase 2 detailed planning is subject to the outcome from Operational Assessments. The assessment required to establish both deliverable scope and resource alignment from a both operational and clinical perspectives are being scheduled to commence from mid-November but with Oncology assessment taking place in October.

Operational Assessments will be based upon:

- Electronic Prescribing & Medicines Administration (ePMA)
- Advanced Clinicals
- Oncology
- Theatres Clinicals

The operational Assessment requires specific InterSystems resource allocation and demonstration capability for all clinical functionality.

InterSystems have proposed to use similar structural processes in the Operational Assessment as recently successfully used at Liverpool.

Risks to Planned Phase 1.5 & 2 Timelines

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

Key Trust engagement across divisional areas impacted is essential, not only in respect of further training but in terms of setting operational requirements against as-is and to-be processes. Training attendance or completion of e-Learning is a major requirement to enable access to a new 'sandpit' environment and the clarification of operational use prior to go-live.

As previously reported. Specific groups of staff required to engage with functional testing of new or upgraded deployments will be requested via the Operational Impact Board.

A specific risk to Oncology as an early Phase 2 implementation is the timely go-live of Pharmacy Stock Control in Phase 1.5 (early March). Any delay will impact the provision of ePMA as a pre-requisite to Chemotherapy prescribing.

Radiology Order Communications

Order Communications maintains positive progress within Radiology and the initial deployment within ED is scheduled for 1st November. The requirement to extend into the In-patient areas is recognised as needing to progress as quickly as possible but this is restricted by the implementation of the 2017.2 MR3.4 release into the live environment as this contains fixes to specifically identified Level 1 JIRAs (faults) logged.

The combined Radiology and ED team members will be undertaking final User Acceptance Testing as part of the planned deployment. Overall acceptance of the solution prior to go live will be via the ATP process. The ATP itself is being maintained against the project deliverables and includes operational review and agreement.

Summary position of outstanding ATP items is included below. The information provided identifies the items requiring additional action to complete either with existing resources (13) or the application of additional resource (3) to meet the requirement prior to a go-live decision. There are a total of 34 ATP items within the process, 19 of which are either complete or on schedule for completion as planned.

The status indicates those items that require additional work in terms of mitigation. The majority are able to be met with additional effort from within the project team and associated departments of ED & Radiology.

ATP Progress

The next full ATP review will include SRO and Operational attendance to ensure that appropriate levels of assurance are provided. ATP reviews are carried out in the weekly project workstream meetings. A formal full ATP review prior to go-live authorisation is to be scheduled for week commencing 16th October. This will ensure that any outstanding items have time for essential completion prior to final go-live permission being provided.

ID	Area/ Workstream	Item Description	Project Dependency	Status for Stage Authorisation	Mitigating/management actions to complete items, including additional resources
RADOC-01	Business Change	Radiology As-Is Processes - completed and signed off.	3.Operational	Recoverable: existing resource	Assurance = documentary evidence Confirmation of out of hours 'as-is' process for inclusion in To-Be processes.
RADOC-02	Business Change	Radiology To-Be Processes - completed and signed off.	3.Operational	Recoverable: existing resource	Assurance = documentary evidence Completion of process in accordance with revised urgency notification. Decisions to be taken w/c 2/10 and documented.
RADOC-03	Business Change	ED AS-Is Processes - completed and signed off.	3.Operational	Recoverable: existing resource	Identify PACS review processes format to be updated

RADOC-04	Business Change	ED To-Be Processes - completed and signed off.	3.Operational	Recoverable: existing resource	include non sign off of reports where appropriate. Test CRIS configuraton – P.Dunmall
RADOC-06	Build	Core Radiology Build complete for ED use. P1 JIRA's - 5 P2 JIRA's - 0	2. Business Critical	Recoverable: existing resource	Pending JIRA resolution with ISC. Testing of fixes to commence after completion of re-baseline actvity from 4/10/17.
RADOC-08	User Configuration	Care Providers all required care providers are setup to sign off Orders	2. Business Critical	Recoverable: existing resource	Confirm that ALL non-clinical care providers configured. – Clinical Systems.
RADOC-19	Business Change	Sandpit environment configured and available for use by users to confirm end-to-end processes.	3.Operational	Recoverable: existing resource	ISC provision of Sandpit environment including Test SPINE access for full end-to-end use. Build and config to be confirmed.
RADOC-21	Interfaces - ISC	Interfaces under ISC responsibility in here. Steve to advise	2. Business Critical	Recoverable: existing resource	Pending SP return from leave w/c 2/10/17
RADOC-22	Interfaces - Trust	Interfaces under HSS responsibility in here. Steve to advise	2. Business Critical	Recoverable: existing resource	Pending SP return from leave w/c 2/10/17
RADOC-23	Interfaces - Trust	Interfaces under Trust responsibility in here. Steve to advise	2. Business Critical	Recoverable: existing resource	Pending SP return from leave w/c 2/10/17
RADOC-24	Operational Support	Support structure defined for Radiology Order Comms Support owner confirmed Hours of support provision agreed Support Transition plan agreed	1. Clinical Safety	Recoverable: extra resource	Support to be defined within BAU subject to clarification following current consultation process. (ZP) No current support transition in place. Should this be BI or Radiology? Radiology currently support ICE requesting.
RADOC-26	Clinical Safety	Based on all relevant ATP items in the round. Open P1 JIRA - open P2 JIRA - Safety Case issued	1. Clinical Safety	Recoverable: existing resource	Safety Case process of CDA/Programme Board/Trust Quality or Board. Incorporation of modified to-be process and safety impact analysis. (PD)

		and approved			
RADOC-27	Cutover	Cutover Plan completed Communicated to Operational Leads Communicated to Trust Emergency Planning Manager	2. Business Critical	Recoverable: existing resource	Review with Spi & ISC w/c 2/10/17. Cut-over detail to be confirmed from Programme Plan as endorsed 2/10/17.
RADOC-28	Cutover	Confirmation of Trust go-live support Number/type of staff Duration	1. Clinical Safety	Recoverable: extra resource	Confirmation from ED in respect of floor-walking support and ED mgmt availability for revised go-live timetable of 1st November.
RADOC-30	Business Readiness	Based on all relevant ATP items in the round. Confirmation from Operational Leads Group that business state is ready for ED Go-Live Sign-off from Radiology Chief of Service Sign off from ED Chief of Service Sign off from COO	3.Operational	Recoverable: extra resource	Request for staff involvement in User Acceptance Testing – responded verbally as OK but requiring written confirmation of named users. Issue of ED statement to include Operational Leads/CoS/COO
RADOC-32	Business Continuity	Revised ED BC processes confirmed and signed off Revised Radiology BC processes confirmed and signed off Revised BC processes distributed via Trust Emergency Planning Officer	1. Clinical Safety	Recoverable: existing resource	EPO contacted. EPO updating available documentation followed by JB/ED/Rad review. To be completed by 6/10/17. ED & Radiology to provide confirmation that BC in place.

Pharmacy Update

Pharmacy Stock Control is subject to confirmation within the revised Programme Plan but is currently in for live deployment early March 2018.

Build and process work is continuing to progress within Pharmacy. The 2017.2 upgrade is a specific pre-requisite for the continued build and go-live of Pharmacy Stock Control.

Oncology

The Oncology project is progressing well with a well engaged and established core team that meets fortnightly. The PID for the Oncology project has been distributed for approval and has been approved by Chemo Sub Group and CDA. Programme Board approval is sought at the October Board.

Within Process Analysis, process mapping is well underway across all areas and ISC are producing the proposed To-Be processes.

Specific Operational Assessment Workshops are being arranged for Oncology. Preparatory material production is complete including requirements capture templates.

Access management – definition of user types and required activities is in progress and will inform development of security groups and access profiles.

Identification of Top10 Oncology and Top10 Haem protocols – complete

Order Set data capture from OPMAS – in progress – will help to inform the build strategy.

Data migration strategy – in progress – collaboration with Infoflex project required.

Pathology Update

Pathology build continues to be subject to a ‘freeze’ due to the continuing ongoing issue with the complete resolution of the issue where 17 specific system components were identified as not being progressed in line with the MR5.1 update.

The revised timescale for 2017.2 MR3.4 delivery has moved the Pathology build activity to recommence from 31st October. The time during this non-build period will be used to review functional improvements prior to availability of the 2017 BASE environment.

The detailed planning of Pathology is undergoing a significant review in terms of being able to deliver specific disciplines rather than a single ‘big bang’ approach to the whole of Pathology. This is subject to operational review of working practices for ordering of tests as well as a review of Pathology internal practices to enable the phased delivery to be appropriate. Planning for this phased approach will be finalised after provision of the outline plan for all other aspects. Currently planned Pathology delivery is on a ‘worst-case’ basis but is still achievable within the overall timeframe.

Training

The Training team is actively working on preparation for Radiology Order Comms as well as maintaining existing training requirements. Reviews of training material have been undertaken with ED and was deemed appropriate. Revision of training material may be required in respect of identified process changes and will be incorporated.

The second part of the overall Training/Learning & Development review has yet to be completed.

InterSystems are currently delivering a further Analytics training session to nominated BI staff, operational staff and a group of clinicians.

Programme Resourcing

Resource requirements will be reviewed against the revised forecast and structural definition.

The previously advised 4x contract based test analysts are in post.

The role of Interface Developer is still to be determined in terms of Trust engagement but is an increasingly urgent and necessary requirement for progressing both the project in a timely manner and general interface support due to the workload application on SPi who is acting as this role in addition to technical Architect.

Finance

Trust Budgeted Expenditure

The table below details the M5 position for the project, the forecast spend for 2017/18 and the overall project:

The 2017/18 year to date capital spend for the project is £0.662m and the forecast for the remaining months of the year is £0.6m giving a total spend for the year of £1.3m.

SmartCare Financial Position & Forecast - M5

	Actual £k			Actual/Forecast £k		Forecast
	2014/15	*2015/16*	2016/17	*2017/18*	*2017/18*	Spend
Capital	***Full Year***	***Full Year***	***Full Year***	***YTD***	***Full Year***	**£000**
Internal Recharges	*266.4*	*1,329.7*	1,256.9	218.4	*429.0*	3,282.0
External suppliers	*318.6*	*1,063.0*	2,255.6	391.9	*769.9*	4,407.1
Un-reclaimed VAT	*9.0*	*192.3*	296.2	51.5	*101.1*	598.6
	594.0	***2,585.0***	**3,808.7**	**661.7**	***1,300.0***	**8,287.7**
Business Case Capital Allocation (incl contingency)						7,693.0
Variance from BC allocation						**594.7**
Training Costs (Revenue)			548.4	47.0	*125.0*	673.4

It was envisaged when the business case was written that the TrakCare system would be fully operational with 24 months of the start of the project however current indications are that the project will run beyond March 2018 which will put the duration of the project in excess of 36 months. The forecast for 2018/19 is being constructed and is dependent on the successful implementation of phase 1.5, scheduled to start in November 2017.

Programme Risks

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

Operational Activity

The team is supporting the activity undertaken and managed through the Operational Leads Group. Attendance is maintained at the weekly Operational Impact Board meeting and any relevant escalations managed. In addition, the project team is supporting the initial BI related work that Cymbio are undertaking in terms of reporting and production of their Dashboard. Initial meetings have been held and actions agreed for taking forward the data collection activity.

The involvement of Programme Team members within the recovery aspect continues but it should be noted that a significant oversubscription on the time required from individual contract based staff is being made and further operational support activity is required.

Next Planned activities

Phase 2 planning definition in line with requested Operational Assessment.

Definition of internal referral functionality requirement within TrakCare for deployment.

Completion of Radiology Order Comms ATP requirements.

Confirmation of Business based support management.

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

Continuation of Phase 1 recovery action plan activity via the Operational Impact Board incorporating Cymbio activity supported by Project team as appropriate.

Status against communications plan

Communication via Emergency Planning process of planned downtime.

TrakCare comms via Operational Lead.

Progress
(against project plan / project brief)

Tasks/Milestones completed

Task	Start	Finish/ % comp.	Comments
Detailed implementation Plan		31/03/15	Version 1.0 Completed for payment milestone confirmation.
Project Initiation Document		29/04/15	Version 1.0 Completed for payment milestone confirmation.
Phase 1 Operational Assessment Stage Complete		31/05/15	Milestone Achievement Certificate Issued.
Phase 1.5 Operational Assessment Complete		30/09/15	Milestone Achievement Certificate Issued.
Phase 1 Build Milestone		17/07/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16.
Phase 1 ATP Complete (Technical Live)		25/10/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16 on basis of Technically LIVE system being available and supported.
Revised Milestone Plan pending InterSystems CCN		Dec 16	CCN has been completed and signed off.
Phase 1 ATP Complete (Operationally Live)		5 Dec 16	System Live
Phase 1 Deployment Verification Complete		6 Mar 17	Completed

Milestones approaching

Milestone	Due	Activity to progress
Phase 1.5 Radiology Order Comms ATP Complete (Live Deployment)	Nov 17	Completion of configuration and ATP approval for System and Operational go-live.
Phase 1.5 Radiology Order Comms Deployment Verification Complete	Jan 18	Post go-live verification (45-days)

Risks (where score on risk log requires escalation to Programme Board) **NOTE: All risks under review in line with Issue Management**		
Title & Description	**Impact**	**Resolution**
Level of clinical engagement is key to the successful implementation of agreed strategy and solution.	10	Monitored and actioned by clear prioritization by collaborative and Trust Boards. Datix Risk 2006
Scale of operational change may require additional and possible external resource to be identified to progress in parallel with implementation.	8	To be revised in line with identified Issues and remedial action plans. Datix Risk 2069
Lack of power/network in areas not covered by generators leading to lack of access to TrakCare.	12	Risk to be assessed with input from Estates. Datix Risk 2320
Lack of Trust resource assigned to project configuration/validation for Pathology. Original level of resource agreed is not being provided.	12	In progress with Phase 1.5 planning in Pathology. Datix Risk 2362

PUBLIC BOARD MAIN BOARD – OCTOBER 2017

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

Report Title
BOARD ASSURANCE FRAMEWORK
Sponsor and Author(s)
Author(s) – Executive Directors Sponsor - Deborah Lee, Chief Executive
Executive Summary

Purpose

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

The BAF also provides a narrative on the progress towards achievement of the objective and this is presented as both a narrative and RAG rating. The key for rating is

RED – not on track to be achieved
AMBER – not on track at this stage but still expected to be achieved
GREEN – achieved or on track to achieve.

Key issues to note

- The Board has recently reviewed and refreshed its strategic objectives (SO) for the period 2017-2019 and these are now reflected in the Board Assurance Framework.
- The Framework documentation has been revised to include information on supporting strategies and enablers, oversight responsibility and progress against delivery of the objective.
- The work to complete this new style BAF has been significant and further work is still required to maximise the value that the BAF can afford the Board. Review of the BAF and our approach will be an early priority for the incoming Director of Corporate Governance.
- Delivery of objective 20 requires achievement of objectives 1, 3 and 16 and as such a separate proforma has not been produced.
- Updates will be provided to the Board quarterly with monthly reporting by exception from sub-committees should the risk profile of any objective change materially.
- Further attention, from 'owners' needs to be given to the actions which will drive delivery of the objectives and mitigate any inherent risks to their achievement. Similarly, the progress update needs to be more explicit regarding measurable progress to date and actions in hand.

Conclusions

This revised BAF is a significant step in developing a more robust approach to oversight of progress and risks in respect of the Trust's Strategic Objectives. The picture at quarter two reflects a number of risks to these objectives, with few currently assessed as GREEN and on target. The executive team will be undertaking a 6 monthly review of the strategic objectives at their October management team meeting on the 10th October.

Implications and Future Action Required

Further refinement and completion of the BAF and iteration of the approach as requested by the Board, led by the incoming Director of Corporate Governance.

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources	x	Buildings	

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

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

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework

Q2 Update

11th October 2017

Gloucestershire Hospitals
NHS Foundation Trust

Our vision: Best care for everyone

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

Our goals

Our patients will

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

Our staff will

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

Our services will

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

Our organisation will

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

Our Strategic Objectives

Our patients

By April 2019 we will...

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

Our staff

By April 2019 we will...

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

Our services

By April 2019 we will...

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

Our organisation

By April 2019 we will...

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

(1.1) Strategic Objective - To Be Rated Good Overall in Our CQC Rating

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that our Trust will not be rated Good overall post CQC inspection.	Director of Nursing Quality & Performance Committee	1. Divisional /Executive Monthly monitoring. 2. Divisional reviews / presentations to Quality and Performance Committee 3. SNMC 4. CCG Quality and contracting reviews 5. Regular monitoring and analysis of data of key themes at Patient Experience Committee 6. Quarterly meetings with Governors with specific focus on quality topics.	1. Divisional Quality Report 2. Matron Audit reports to their divisional quality committees	1. Quarterly in real time audits/ reviews	3 x 4 = 12
				Gaps in Assurance	Direction of Travel
				1. Reliable data for actual performance surveys not reported in real time	↔

Potential Risk Exposure	Related risks on Trust Risk Register		
• Improvement in ED reliant on improved capacity and flow throughout our trust and wider county providers • Staffing and vacancies may impact on abilities to maintain consistency and release of staff to undertake quality improvement reviews.			3x4 =12

Actions Agreed for any gaps	By Whom	By When	Update
Meetings scheduled throughout year to undertake quality improvement reviews	MDT	4 per year	One undertaken; using mainly matrons and band 7 ward managers using NHSE checklists
Action plan for improvement within in ED in place and implementation being overseen by ECB	Medical Division Nursing Director	June 2017	Monthly reports to main ECB

Patient Experience improvement plans in clinical areas working with Oxford university and our trust academy	Divisional Nursing Directors & Patient experience improvement team.	March 2018	Ward 7a process now completed reported to Q&P and SNMC ready for roll out to other wards.
Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience Strategy	Patient Experience Committee	Quality & Performance Committee	
Quarterly Progress Report Against Delivery			RAG Rating

- One quality /review undertaken, with staff trained in process supported by NHSI/ NHSE. Action formed and shared at SNMC
- Awaiting final published CQC report from their inspection in January 2017 , expected first week in July
- Care and compassion noted to be good overall and significant improvement in care of the dying.
- Experience of patient in ED still of concern as capacity and high attendances impacting on flow throughout our organisation

<u>Update for October 2017</u>

- Quality /review rescheduled due to unavailability of staff. New dates to be set.
- CQC report published and we were rated as good in the Caring domain in all the services they inspected across both services.
- The Gloucestershire Elderly Emergency Care project (GEEC) was recognised as an outstanding project by CQC. The Patient Experience Improvement Team is supporting the collation of data for more improvement work to be done within this project.
- The experience of patients waiting in ED remains an area of operational and executive focus.
- There is an action plan for improvement from the latest CQC inspection report and there is Divisional attendance at the monthly monitoring meeting.
- Patient Experience Strategy to be approved within the next two months.
- Self-assessment against the five CQC domains to be completed by January 2018.

(1.2) Strategic Objective - To be Rated Outstanding in our CQC Rating For Caring

<table>
<tr><th>Principle Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director & Committee)</th><th>Key Controls</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Risk Rating (Likelihood x Impact)</th></tr>
<tr><td rowspan="4">Risk that our Trust will not be rated Outstanding in our CQC rating for Caring</td><td rowspan="4">Director of Nursing

Quality & Performance Committee</td><td rowspan="4">1. Divisional /Executive Monthly monitoring.
2. Divisional reviews / presentations to Quality and Performance Committee
3. SNMC
4. CCG Quality rand contracting reviews
5. Regular monitoring and analysis of data of key themes at Patient Experience Committee
6. Quarterly meetings with Governors with specific focus on quality topics.
7. Reports to Q&P on complaints and concerns.</td><td>1. Divisional Quality Report

2. Matron Audit reports to their divisional quality committees</td><td>1. Quarterly in real time audits/ reviews</td><td>3 x 4 = 12</td></tr>
<tr><td></td><td>Gaps in Assurance</td><td>Direction of Travel</td></tr>
<tr><td></td><td>1. Reliable data for actual performance surveys not reported in real time</td><td>↔</td></tr>
<tr><td></td></tr>
<tr><td>Potential Risk Exposure</td><td colspan="2">Related risks on Trust Risk Register</td><td></td><td></td></tr>
<tr><td colspan="5">• Improvement in ED reliant on improved capacity and flow throughout our trust and wider county providers
• Staffing and vacancies may impact on abilities to maintain consistency and release of staff to undertake quality improvement reviews.</td><td>3x4 =12</td></tr>
</table>

Actions Agreed for any gaps	By Whom	By When	Update
Meetings scheduled throughout year to undertake quality improvement reviews. Contact trust that are already rated outstanding to under peer review	MDT DoN	4 per year July 2017	One undertaken; using mainly matrons and band 7 ward managers using NHSE checklists CNO in Bristol contacted and ideas gathered likewise great Western Hospital has given information regarding their improved plan for their ED department which are deemed excellent by NHSI
Action plan for improvement within in ED in place and implementation being overseen by ECB	Medical Division Nursing Director	June 2017	Monthly reports to main ECB
Patient Experience improvement plans in clinical areas working with Oxford university and our trust academy	Divisional Nursing Directors & Patient experience improvement team.	March 2018	Ward 7a process/ plan now completed reported to Q&P and SNMC; ready for roll out programme to other wards.
Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience Strategy	Patient Experience Committee	Quality & Performance Committee	Draft strategy agenda item for patient experience committee 3/7/17
Quarterly Progress Report Against Delivery			RAG Rating
• One quality /review undertaken, with staff trained in process supported by NHSI/ NHSE. Action formed and shared at SNMC • Awaiting final published CQC report from their inspection in January 2017 , expected first week in July • Care and compassion noted to be good overall and significant improvement in care of the dying. • Experience of patient in ED still of concern as capacity and high attendances impacting on flow throughout our organisation.			

October update 2017 • The upscale of the 7A project to other areas has begun and the project is now called “Small Steps – Big Changes”. Alstone ward started in August and there is a plan for 3B, Dixton, Avening and Hazelton to start in the next two months. • Silver quality improvement projects relating to improving patient experience have started on 4A, Day Surgery/Snowshill, Maternity Triage and 2A. These projects are being supported by the GQSIA and also the Patient Experience Improvement Team. • Contact has been made with the Director of Patient Experience at Northumbria NHS Trust which was rated as Outstanding by CQC and a planned visit will take place before December 2017. Their real time surveys “2 minutes of your time” were commended as good practice and also their spiritual needs assessment work as this was being championed by their executive team.	

Strategic Objective(s) – Meet all national access standards and no longer subject to regulatory action for the four hour A&E standard

Principal Risks to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Failure to recover A&E performance sufficiently to enable current Enforcement Undertakings to be removed	Chief Operating Officer Trust Board	Monthly MDT Emergency Care Operational Group chaired by the Specialty Director for Emergency Medicine Emergency Care Operational Group provides assurance to the trust board via the Emergency Care Programme Board chaired by the CEO. A weekly 14+ LoS meeting with system partners is in place. System wide A&E Delivery Board.	An integrated Emergency Care Improvement Plan and an integrated KPIs dashboard is in place and actions are reviewed at the weekly multi-disciplinary seniors meeting with monthly updates to the Operational Group and the Emergency Care Programme Board. Emergency Care report to the Quality and Performance Committee. System wide A&E Delivery action plan	Monthly reporting to the trust Q&P And the system Delivery Board	4x4=16
				Gaps in Assurance	**Direction of Travel**
			System wide control mechanisms are reactive rather than proactive to the emerging issues. Slow progress against key actions due to staffing, activity flow	None	↓

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Failure to deliver the national access standards for RTT and Cancer	Chief Operating Officer Trust Board	Weekly PTL meetings Monthly Planned Care Board Monthly Cancer Services Board	RTT waiting list validation recovery plan in place Cancer and capacity and recovery plans in place	Performance reports to the Q&P	4x3=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Demand out strips capacity plans Lack of clean PTLs Lack of demand and capacity plans for RTT delivery (post track) Divisional oversight and drive	RTT reporting	↓

Potential Risk Exposure	Related risks on Trust Risk Register				
Demand continues to outstrip capacity STP does not deliver the expected benefits	Risk Ref no and detail	Risk Ref no and detail			

Actions Agreed for any gaps	By Whom	By When	Update
Review of the A&E system action plan	COO	October 2017	
Support from ECIP	COO	July 2017	
Validation of all PTLs, establish RTT reporting , complete demand and capacity modelling and recovery plans for delivering 18 w RTT	COO	Dec 2017	
Enabling Strategy	Oversight Committee	Executive Group	
Clinical strategy , STP	Q&P	Emergency Care Programme Board, Planned Care Board	
Quarterly Progress Report Against Delivery			RAG Rating
To the Trust Board via the Quality and Performance Committee.			

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that changes to process and clinical pathways do not achieve an HSMR below 100	Medical Director Hospital Mortality Group	1. Regular monitoring of mortality indicators though Hospital Mortality Group 2. Close working with Dr Fosters to report on HSMR, identify factors driving high rates and investigate the drivers behind these 3. Agreed areas of clinical pathway work to identify improvements in care, coding and pathways 4. Regular reporting by division to the HMG 5. Mortality dashboard reporting to divisional and speciality level 6. Monitoring through Q+P and with partners through CCG quality monitoring group and through the joint NHSI and NHSE Quality Improvement Group 7. # Neck of femur group monitoring action plan for improved care. Similar model to be applied for other care pathways as appropriate. 8. Trauma mortality review through trauma lead. 9. Mortality database and initiation of mortality reviews though bereavement office	Mortality Report to Q+P committee monthly	Reporting to the Q+P committee	2X4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			Data capture in Trak of number of episodes of inpatient care results in risk of	Reporting and detail of oversight at Q+P and Trust Board to be finalised Inability to model the impact of changes on HSMR	Dr Foster shows improvement in HSMR NHS digital SHMI not within expected range

Potential Risk Exposure	Related risks on Trust Risk Register				
Reliability of admission diagnosis and clinical linkage to coding	S2045 The risk of poorer than average outcomes for patients presenting with fractured neck of femur at Gloucestershire Royal Hospital				

Actions Agreed for any gaps	By Whom	By When	Update
Approach to reporting for Q+P in development in conjunction with Dr Foster and Trust Information team	Medical Director	September 2017	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Mortality Strategy	Quality and Performance Committee	Hospital Mortality Group	
Quarterly Progress Report Against Delivery			**RAG Rating**
Reporting schedule to be established			

(1.5) Strategic Objective – To Have More Than 35% of Our Patients Responding to our Family Friendly Tests and of Those at Least 93% Would Recommend Us

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that our trust will not meet our stretch target of more than 35% of patients responding to the FFT and of those responding at least 93 % would recommend us to their friends and family	Director of Nursing Quality & Performance Committee	1. Divisional /Executive Monthly monitoring. 2. Divisional reviews / presentations to Quality and Performance Committee 3. SNMC 4. CCG Quality and Contracting reviews 5. Regular monitoring and analysis of data of key themes at Patient Experience Strategic Group 6. Quarterly meetings with Governors with specific focus on quality topics. 7. Reports to Q&P on complaints and concerns.	1. Divisional Quality Report 2. Matron Audit reports to their divisional quality committees	1. Quarterly in real time audits/ reviews	Under review
				Gaps in Assurance	Direction of Travel
				1. Reliable data for actual performance surveys not reported in real time	↔
Potential Risk Exposure	Related risks on Trust Risk Register				
• Patients have previously been able to respond using methods such a 'token as used in supermarkets' which appeared to improve Responses especially in ED. This method has now been stopped by NHSE. • Our trust data had previously already indicated we were ahead of national benchmark • Texting methodology recently implemented had compensated for loss of Token system; however implementation of track care has restricted the texting methodology. A solution is being sought.					4x3=12

Actions Agreed for any gaps	By Whom	By When	Update
Reports are sent regularly to clinical areas to ensure continual focus is given.	Head of Patient Experience improvement	Monthly	

Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience Strategy	Patient Experience Strategic Group	Quality & Performance Committee	Draft strategy agenda item for patient experience Strategic Group November 2017
Quarterly Progress Report Against Delivery			RAG Rating
FFT numbers awaited for first quarter <u>October 2017</u> • The response rate is no longer a recognised measure of FFT by NHS England as now the emphasis is on the positive scores. The Trust overall positive score was 91.5% for quarter 1 and a report shared with September Q&P committee. • The Patient Experience Improvement team alert ward managers, matrons and Divisional Nurse Director when the scores give cause for concern and they also use the data with the team undertaking the "Small Steps- Big Changes" projects. • The Divisional Score are posted on the intranet for all staff to see. All wards can access their own data now and populate "You said – we did" posters. A presentation on FFT and the data is booked at Senior Nursing and Midwifery Committee in November.			

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that our trust will not have reduced the complaints received regarding the care in our outpatient departments by 25% by 2019	Director of Nursing Quality & Performance Committee	1. Divisional /Executive Monthly monitoring. 2. Divisional reviews / presentations to Quality and Performance Committee 3. SNMC 4. Outpatient department forum 5. Regular monitoring and analysis of data of key themes at Patient Experience Strategic Group 6. Quarterly meetings with Governors with specific focus on quality topics. 7. Reports to Q&P on complaints and concerns.	1. Quality & Performance committee	1. Complaints review	3 x 3 = 9
				Gaps in Assurance	Direction of Travel
					↔
Potential Risk Exposure	Related risks on Trust Risk Register				
• None					4x3=12

Actions Agreed for any gaps	By Whom	By When	Update
Reports are sent regularly to clinical areas to ensure continual focus is given.	Head of Patient Experience Improvement	Monthly	
Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience Strategy	Patient Experience Strategic Group	Quality & Performance Committee	Draft strategy agenda item for patient experience Strategic Group November 2017

Quarterly Progress Report Against Delivery	RAG Rating
October 2017 update • A quarterly Patient Experience Feedback Report is now being produced which include data on complaints. This report was received by the Quality and Performance Committee in September 2017. • A paper is tabled for the next PESG in October on outpatient complaints with all the PALs and FFT data included. • A meeting is planned between the patient experience team and the communications team to ensure alignment of issues and communications.	

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of static or reduced engagement with staff which negatively impacts on our vision and movement towards Best Care for Everyone	Director of HR & OD Workforce Committee	1. Trust wide survey action plans 2. Divisional action plans 3. Staff Listening Events 4. Involve sessions 5. Executive Walkabouts 6. Trust Leadership Team	1. Quarterly review of trust wide survey plans at Workforce Committee 2. Scrutiny of divisional plans at executive reviews	1. Plans have been developed	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
				1. Plans not implemented to gain sufficient traction. 2. Need to develop/ procure real time feedback tool.	↔
Potential Risk Exposure	Related risks on Trust Risk Register				
1. Inability to attract/ retain key staff, leading to an over-reliance on agency staff at premium cost.	WF2335 The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.				

Actions Agreed for any gaps		By Whom	By When		Update
1. Plans to be presented at TLT 2. Identify an on-line tool (using STP funding) to ensure more frequent opportunities to test engagement.		Abby Hopewell/Dave Smith	Wednesday 5th July		Plans presented and divisions have submitted their own plans
Enabling Strategy		Oversight Committee	Executive Group		
Workforce Strategy		Workforce Committee			
Quarterly Progress Report Against Delivery					RAG Rating
Plans presented and adopted at TLT. Divisional Engagement plans are also showing strong traction, particularly in W+C and D+S where engaging on staff on the key issues which matter to them have really been adopted. In particular, D+S are focusing heavily on local reward mechanisms (Diamond Awards). Listening events have continued and been extended to managers and further events are scheduled for October. The 110 Leaders event in September included a session on improving senior manager visibility and there will be further sessions scheduled for staff representatives to ensure that they are fully engaged with the solutions/ideas required to improve our financial position. The staff survey for 2017 has now launched and selected groups will complete on-line.					

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Reduced workforce supply, high vacancy rates, and turnover across the NHS make further reductions challenging	Director of HR&OD Workforce Committee	1. Workforce plans being produced for each division/specialty in alignment with operational plans 2. Countywide Workforce Planning Group overseeing combined Workforce Plan 3. Exit interviews 4. New Starter Questionnaires 5. Staff focus groups	1. Recruitment strategy group analysing data and trends 2. Divisional Boards reviewing localised data 3. Reward Strategy Group reviewing effective recruitment and retention strategies 4. Divisional Executive Reviews 5. Reward Strategy Group reviewing Recruitment and Retention premium (RRP)	1. Data on turnover by staff group and division readily available	3x3=9
			Gaps in Controls	Gaps in Assurance	Direction of Travel
			1. Limited compliance with exit interviews	1. Limited evidence of local plans/solutions to address	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
Shortages develop in specific occupations impacting on our ability to deliver services	DSP2513pa Risk to patient safety due to delayed diagnosis because of shortage of Histopathology Staff				

Actions Agreed for any gaps	By Whom	By When	Update
1. Implement default that exit interviews are mandatory 2. Production of divisional' heat maps' to help focus on key areas.	DS/MA/AK	Immediate	On-line facility now created to increase numbers

Enabling Strategy	Oversight Committee	Executive Group	
Workforce	Workforce Committee	Recruitment Strategy Group	

Quarterly Progress Report Against Delivery	RAG Rating
Reward Strategy Group reviewed RRP's from Pharmacy and Pathology, agreeing to a re-banding exercise for certain Pharmacy positions and whilst agreeing continuation of Pathology RRP's, requested division work with HRBP to develop longer term plans. New Starter questionnaires implemented in Nursing from August. Assistant Director of Workforce has produced draft Reward Strategy for consideration at Workforce Committee. Divisions have been asked to produce 'heat maps' which align their key shortage areas with high cost and demand. Turnover has slowed down in Medicine Division, particularly amongst Band 5 Nursing due to lead work on collating best practice Reward strategies.	

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director& Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Staff feeling that they are not being heard/listened to Staff feeling that patients are not being heard/listened to Potential for miscommunication of key strategic decisions	Director of HR&OD Workforce Committee	1. Staff Survey Action Plans (local and trust wide) 2. Staff Listening events 3. Involve 4. Divisional Engagement groups 5. Quality Improvement Groups 6. Patient Experience Group 7. 100 Leaders 8. This Week messages	1. Staff feedback on variety of issues	1. Engagement on parking/travel options 2. Engagement on models of care 3. Feedback on staff listening events	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
				1. Lack of real time engagement tool. 2. Rumour mill working as fast as official channels	↔
Potential Risk Exposure	Related risks on Trust Risk Register				
Staff not willing to act as positive advocates could impact attraction and retention of key staff going forward					

Actions Agreed for any gaps	By Whom	By When	Update
1. Increase visibility of line managers	1. Leadership Team (key action in this year's staff survey response)	1. Immediately (some actions in train already)	1.100 Leaders session held in September and inclusion in Divisional Engagement plans
2. Provide opportunities for staff voice to be heard at Board	2. Chair/CEO/Dir HR&OD	2. September 2017	2.Not designed yet – will reschedule meeting to agree format
3. Develop opportunities with Staff Governors to hear the views of broader groups of staff.	3. Dir HR &OD, Lead Governor, Head of Leadership & OD	3. November 2017	3. Scoping meeting held and direct engagement session being planned with Staff Governors
Enabling Strategy	Oversight Committee	Executive Group	
Workforce	Workforce Committee	Trust Leadership Team	
Quarterly Progress Report Against Delivery			RAG Rating
Challenging but hugely informative listening events held with A+C staff with full report and actions/responses. Ownership of A+C group and sponsor at Board identified as COO. Exercise repeated with other staff groups, including managers who are so pivotal to the engagement of their teams. CQC report and FGR reports fully shared with staff and engagement has continued on travel and parking options. Further opportunities to hear the employee voice in October listening events as well as greater engagement/ideas generation on the financial outturn.			

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that target numbers will not be achieved as staff will not be able to access training due to operational pressure preventing release to attend	Medical Director Gloucestershire Quality Improvement Academy	1. Monitoring of numbers trained through the GSQIA 2. Identification of those for higher training through projects in line with strategic objectives 3. Training programme agreed 4. Performance against programme monitored	Monitoring of training numbers	Report of progress to Trust Board	2x2=4
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	Regular reports on progress to the Q+P and TMT	

Potential Risk Exposure	Related risks on Trust Risk Register				
Operational pressures prevent training	none				

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to GQIA	Medical Director	September 2019	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Quality Improvement Strategy	Q+P	GSQIA	
Quarterly Progress Report Against Delivery			**RAG Rating**

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
1. Failure to engage staff sufficiently in activities to help them improve and maintain their wellbeing 2. Increase in stress/mental health issues linked to high demand and workforce shortages	Director of HR & OD Workforce Committee	1. Quarterly sickness data by reason, staff group and division 2. Both long and short term sickness managed locally by divisions supported by HR Advisors 3. Key programmes of work promoting health linked to CQINS 4. Flu vaccination campaign launched early to drive up numbers 5. Collaboration and promotion across county on specific programmes such as 'One You' 6. Collaboration with Catering Department on 'healthy eating' 7. Development of Health and Wellbeing web pages with signposting to resources	1. Staff Health and Wellbeing Group 2. Trust Health and Wellbeing Group 3. Establishment of STP Health and Wellbeing Group 4. Positively received sessions on 'resilience' and 'identifying mental health' 5. Current sickness levels (including stress/mental health) below national levels 6. Awaiting assessment under the Workplace Wellbeing Charter	1. Work programmes and data frequently reviewed	2x3=6
			Gaps in Control	Gaps in Assurance	Direction of Travel
				1. An understanding from staff as to what would truly engage them 2. Limited current availability of healthy options out of hours	↔

				3. Improvements in flu vaccination numbers encouraging but insufficient to hit targets.	
Potential Risk Exposure	Related risks on Trust Risk Register				
Increased staff sickness could reduce key workforce supply at critical times					
Actions Agreed for any gaps		By Whom	By When		Update
1. Nursing Director chairing Flu Action Plan Group		Maggie Arnold	6th July		1. In train
2. Relaunch of timetable for 'resilience' and 'identifying/managing mental health sessions		Dave Smith/Leslie Morrison	July 31st		2. Funding obtained from ELD 3. Sub-Group designing
3. Launch survey to staff ascertaining views on those programmes that would engage them to improve their health		Dave Smith/Staff Health and Wellbeing Group	September 30th		questions but will follow on from 2017 staff survey once key results analysed 4. Plans received at September Staff Health and Wellbeing Group
4. Confirmation of plans for out of hours vending to be received and publicised		Neil Jackson	July 31st		
Enabling Strategy		Oversight Committee	Executive Group		
Staff Health and Wellbeing Strategy/Workforce Strategy		Workforce Committee			
Quarterly Progress Report Against Delivery					RAG Rating
Positive progress on redesign of web pages to create links to health and wellbeing activities and signposting to support services. Positive support for the 'Gloucestershire One You' campaign with participation and pledges from senior leaders. An STP group has also been recently established					

to focus on Health and Wellbeing with a particular focus on stress/mental health (ensuring current resources are shared). Engaging staff with what matters to them and in particular, those programmes that they would be interested in is key activity for the next quarter as will be shifting the perception that this is a management agenda rather than a shared focus	

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
The risk that the proposals will not secure the support of key stakeholders preventing implementation	Director of Clinical Strategy Main Board	1. Development of proposals through clinical leadership model 2. Staff engagement plan 3. Alignment of proposals within STP Case for Change plans 4. Creation of high quality consultation material 5. Clinical leadership of engagement activities 6. Outline Business Case October Board 7. Full Business case July Board	NHSE Assurance Process SW Clinical Senate Assurance process	Strategic Outline Case June 2017 Output from NHSE stage 1 assurance	2X4-8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	↔
Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
The risk that the proposals cannot be implemented without impacting on operational performance or quality of care	Director of Clinical Strategy Main Board	Detailed implementation plan with modelling of impact of service change Impact Assessment and Quality Impact Assessment of all proposals Risk assessments for operational processes Outline Business Case October Board Full Business case July Board	Full Business Case including impact assessments	Strategic Outline Case June 2017 Output from NHSE stage 1 assurance	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
National political processes Unexpected increase in demand for services	S1748. The risk of failing national access standards	S1851. The risk that patients receive poor quality care as a consequence of the demand for beds exceeding the beds available	S2045. The risk of poorer than average outcomes for patients presenting with fractured neck of femur	M2473. The risk of poor quality patient experience during periods of overcrowding in the ED	
Enabling Strategy		Oversight Committee	Executive Group		
New Clinical Model Strategic Outline Case		Main Board	New Clinical Model Programme Board		
Quarterly Progress Report Against Delivery					RAG Rating
Programme reports monthly to the Trust Leadership Team. Regular updates to Board Seminars and to Governors' Strategy and Engagement Sessions No slippage against programme plan to date					

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

Principle Risks to Achievement of The Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that the functionality of the software is not sufficiently well developed leading to delays in deployment and continuing dependency on old platform	Director of Clinical Strategy Main Board	1. Implementation plan with critical plan for software releases 2. Rigorous testing of applications prior to deployment 3. Collaboration with other live sites	Authority to Proceed gateways	Monthly reports to Main Board on contract performance	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	↔
Principle Risks to Achievement of The Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Service is not operationally prepared for go live, delaying deployment	Director of Clinical Strategy Main Board	1 Rigorous process to identify "as is" and "to be" processes 2 Engagement of TrakCare Operational Group 2.Comprehensive role based training programme 3.Sign off by Trakcare Operational Group of operational readiness	Authority to Proceed gateways	Monthly reports to Main Board on contract performance	3x4=12
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	
Potential Risk Exposure	Related risks on Trust Risk Register				
Delays beyond February 2019 impacting on central funding	F1339. Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the financial recovery plan				

Enabling Strategy	Oversight Committee	Executive Group	
Smartcare Business Case. Will be covered by emerging Digital Strategy	Main Board	Smartcare Programme Board	
Quarterly Progress Report Against Delivery			RAG Rating
Monthly reports to Main Board from Programme Board Project set to amber as deployment dates for subsequent phases not yet agreed			

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that resources are not available to achieve compliance	Director of Clinical Strategy Quality and Performance Committee	1. Programme of target specialities identified 2. Priority services for full compliance identified 3. Action plans in place to achieve compliance developed in each service 4. Business cases	GIRFT Governance Framework action plans in each specialty	Governance Framework endorsed at August Q&P Committee GIRFT standing agenda item on Executive Divisional Reviews	2x3=6
			Gaps in Control	Gaps in Assurance	Direction of Travel
			Gap analysis for compliance across all specialities	Gap analyses	↔
Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that actions to secure compliance will constitute significant service change delaying implementation	Director of Clinical Strategy Quality and Performance Committee	1. Development of proposals through clinical leadership model 2. Staff engagement plan 3. Early discussions with commissioners 4. Creation of high quality consultation material 5. Clinical leadership of engagement activities	NHSE Assurance Process SW Clinical Senate Assurance process	Strategic Outline Case June 2017 Output from NHSE stage 1 assurance	3x3=9
			Gaps in Control	Gaps in Assurance	Direction of Travel

Potential Risk Exposure	Related risks on Trust Risk Register				
none	S2045. The risk of poorer than average outcomes for patients presenting with fractured neck of femur	F1339. Risk that the Trust does not achieve the required cost improvement .resulting in failure to deliver the financial recovery plan			

Actions Agreed for any gaps	By Whom	By When	Update
GIRFT action plans to be item on agenda for Surgical Division Executive Review	COO	July 2017 meeting cycle	COMPLETE
GIRFT to be regular reporting item on Q&P committee	Director of Clinical Strategy	July 2017 meeting cycle	COMPLETE
Gap analysis of actions plans to determine priority services to secure compliance	Associate Director of Planning and Performance	November 2017	
Enabling Strategy	Oversight Committee	Executive Group	
New Clinical Model Strategic Outline Case	Quality and Performance committee	New Clinical Model Programme Board (transformational) Trust Leadership Team (operational)	
Quarterly Progress Report Against Delivery	RAG Rating		
Action plans following each review now being developed within specialties and progress reviewed in Executive Divisional Reviews			RAG Rating
Reconfiguration of T&O service to support compliance agreed from October to March to support the Winter Plan			

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that staff will not be able to access training due to lack of availability or difficulty being released from roles	Director of Clinical Strategy Health and Wellbeing Group	1. Identification of target staff in all clinical areas 2. Training offer clarified with ICE Creates 3. Training programme agreed 4. Performance against programme monitored		High level reports to Health and Wellbeing Group	2x2=4
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	Regular reports on progress to the Health and Wellbeing Group	
Potential Risk Exposure	Related risks on Trust Risk Register				
none	none				

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to Health and Wellbeing Group	Director of Clinical Strategy	September 2017	COMPLETE
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Health and Wellbeing Strategy	Trust Leadership Team	Health and Wellbeing Group	
Quarterly Progress Report Against Delivery			RAG Rating
Reporting schedule established			

(4.1) Strategic Objective – Be in Financial Balance by April 2019

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that the Trust does not deliver the required savings and budgetary efficiencies resulting in failure to deliver the Financial Recovery Plan	Director of Finance Finance Committee	1. Regular NHSI FSM meetings 2. Monthly monitoring, forecasting and reporting of performance against budget by finance business partners 3. PMO in place to record and monitor the FY18 programme (including monitoring and reporting of performance against target) 4. Turnaround Implementation Board scrutiny of delivery 5. Monthly 1:1 meetings with Divisions and workstreams on CIP 6. Monthly executive reviews 7. Regular monitoring and analysis of data completeness (and quality) and income recovery	1. Finance Report 2. Audit reports 3. CIP Report 4. Performance reporting	1. NHSI agreement to Financial Recovery Plan 2. Initial Deloitte review and implemented actions	4 x 5 = 20
				Gaps in Assurance	Direction of Travel
				1. Reliable data for activity impacting billing and income recovery	↔

Potential Risk Exposure	Related risks on Trust Risk Register		
• Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18			4 x 5 = 20
• Risk that the Trust does not exit Financial Special Measures in a timely way and as a result is subject to interest charge "penalties"			4 x 2 = 8
• Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the FY18 Financial Recovery plan			4 x 3 = 12
• 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			5 x 5 = 25

Actions Agreed for any gaps	By Whom	By When	Update
PMO supports in-year delivery alongside any in-year recovery. The PMO works with divisions to understand and recover slippage and identify new schemes. TIB used as escalation forum for issues that cannot be resolved at divisional level.	Director of CIP PMO	Ongoing	CIP programme showing favourable variance to plan for period to end May
Progress/slippage is tracked and reported weekly to Execs (through the dashboard) and monthly via other forums including to the finance committee.	Director of CIP PMO	Ongoing	Dashboard format will be updated to better KPIs
TIB to be chaired by the CEO to reiterate the importance of CIP delivery and to support the resolution of any escalated issues.	Director of CIP PMO	Ongoing	Commencing from September 17
Finance business partners work with divisions to recover slippage and identify mitigating actions Escalation to DoF where Executive intervention required (part of Executive reviews)	Director of Operational Finance	Ongoing	Expenditure budgets showing favourable variance to plan overall for period to end May
Enabling Strategy	Oversight Committee	Executive Group	
	Finance Committee	Turnaround Improvement Board and Trust Leadership Team	
Quarterly Progress Report Against Delivery			RAG Rating
The overall I&E position to end August is showing a £4.2m favourable variance against budget. The budget position for income includes an allowance for depressed activity in Q1 to reflect risk around TrakCare. The Trust has now reached agreement with both major commissioners for a block contract arrangement. This means that income for the five months outstrips budget for those commissioners and gives a favourable variance. The detailed forecast outturn for 2017/18 currently shows a projected position of £X.Xm deficit if not further action is taken, largely driven by variances on income as a result of TrakCare deployment issues. The Trust is currently working up a detailed recovery plan to mitigate this forecast deficit with a view to delivering the original plan of £14.6m.			

(4.2) Strategic Objective – Be among the top 25% of trusts for efficiency.

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Failure to deliver full efficiencies for Length of Stay, theatres, outpatients and back office functions.	COO	1. Weekly operational meetings in place. 2. Monitoring at the CIP/Transformation board. 3. Monitoring at the Emergency Care Programme Board and the Planned Care Board.	1. All programmes have been fully developed and are being monitored at various levels. 2. Progress reports to the trust board and the finance committee.	Transformation Board in place.	4x4
				Gaps in Assurance	Direction of Travel
			Progress is slow due to key transformation/programme support staff vacancies.	1.	↔

Potential Risk Exposure	Related risks on Trust Risk Register		
	• Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18		4 x 5 = 20
	• 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		5 x 5 = 25

Actions Agreed for any gaps	By Whom	By When	Update
Recruit to the project support positions at speed.	Director of Transformation	November 2017	

PMO supports in-year CIP delivery alongside any in-year recovery. The PMO works with divisions to understand and recover slippage and identify new schemes. TIB used as escalation forum for issues that cannot be resolved at divisional level.	Director of CIP PMO	Ongoing	CIP programme showing favourable variance to plan for period to end May
Continue to identify actions/schemes to mitigate non delivery	DOPs, DoT	November 2017	
Enabling Strategy	Oversight Committee	Executive Group	
Clinical strategy, theatre strategy, STP	Finance Committee	Transformation Board and the Trust Leadership Team.	
Quarterly Progress Report Against Delivery			RAG Rating

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that new models of integration reduce income to the trust without reducing costs	Director of Clinical Strategy Trust Leadership Team	Oversight from Clinical Programme Board of STP Adherence to "design" and "design for delivery"stages of programme change Open book costing of model Endorsement by Resources Steering Group of STP prior to implementation Systemwide approach to risk sharing	Business case endorsed through Resources Steering Group	STP Memorandum of Understanding Risk sharing agreement as part of MOU	2X3=6
			Gaps in Control	Gaps in Assurance	Direction of Travel

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of failure to recruit to staffing model for integrated service	Director of Clinical Strategy Trust Leadership Team	Oversight from Clinical Programme Board of STP Adherence to "design" and "design for delivery "stages of programme change Oversight from STP workforce group	STP workforce strategy	Principles of integrated working endorsed by Clinical Programmes Board	2X3=6
			Gaps in Control	Gaps in Assurance	Direction of Travel

Potential Risk Exposure	Related risks on Trust Risk Register				
	F2511 Risk that the Trust expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY18	WF 2335 Riisk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy level			

Enabling Strategy	Oversight Committee	Executive Group	
One Gloucestershire , Transforming Care, Transforming Communities	Main Board	Trust Leadership Team	
Quarterly Progress Report Against Delivery			RAG Rating
Lead for Integrated Respiratory Team agreed and selection process in place Model for integrated leg ulcer service agreed. Awaiting funding for implementation of community clinics from CCG			

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

Report Title
Winter Plan 2017/2018
Sponsor and Author
Sponsor: Caroline Landon – Chief Operating Officer Author: Sharon Nicholson – DCOO

Executive Summary

Purpose

Winter is the busiest time of the year for the NHS and for Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT). This paper presents the Gloucester Hospitals NHS Foundation Trust winter plan for 2017-18.

The plan with the exception of additional external ward capacity does not create additional beds in GHFT other than the existing escalation capacity beds. It does provide a plan for identifying safe appropriate additional capacity from elective areas for Medicine the biggest user of acute capacity over the winter months. It does identify clear actions for changes to clinical pathways that will support the flow of the right patient to the right bed. The plan takes into account:

- The safety and quality of care of our patients
- Achieve National 4 hour Standard for ED
- Identification of escalation capacity for medicine
- Maintenance elective & Non-Elective flow
- Implementation of strategic objectives

Key issues to note

The time line for implementation - most changes will need to be in place between mid-October and November
Recruitment to medical staffing and hard to fill posts needs to take a priority with delays minimised in process and HR function.
Robust planning and capture of progress against each part of the plan is required
Community partner involvement in the Trust is a must in particular LoS, DToC, community escalation and capacity.
The external community sub-acute ward will require significant drive and clinical decision making

Overarching Plan

GHNHSFT will work collaboratively with partners to implement an integrated approach to communications to help ease seasonal pressure on NHS urgent care and emergency services.

- Seasonal flu vaccination
- Norovirus
- Keeping people well
- Encouraging best use of health services across the county

There are ten core work streams to ensure winter resilience, these are:

1. Surgical assessment unit at GRH with funding from the system partners – Oct 17
2. Integrated frailty model with enhanced OPAL 0800- 2000 GRH with funding from the system partners – Oct 17
3. Additional bed capacity in Chapel Lane for MFFD with funding from the system partners – Oct 17
4. Additional acute bed capacity at GRH provided by the swap of wards at GRH – complete
5. GP admissions direct to the assessment unit (AEC) at GRH – Oct 17
6. Extension of the AEC at GRH opening hours – end Oct
7. GP streaming at the front of ED - enhanced cover from Oct 17
8. Ring fence 1x bed vascular and 1 x urology for direct admissions from ED at GRH
9. T&0 trauma to GRH and electives at CGH
10. Convert a CGH day units to 23 hour unit and 1 unit single sex medical ward medial beds(10) beds

Conclusions

The winter plan and the safe running of the emergency departments are the responsibility of every divisional senior clinical and managerial leader. It is therefore essential we have timely clinical engagement and ownership to ensure all mitigations for winter are in place and that obstacles to implementation are resolved with speed or alternative provision made. This will be the key success factor to the timeline of this ambitious plan.
The winter plan involves a number of pathway changes across the Trust, effective communication and implementation plans are central to the success. Corporate support will be required to ensure drive and high level executive support will be key.

Implications and Future Action Required

Senior clinical engagement, leadership, drive alongside robust standard operating procedures and mechanisms for holding to account for ensuring clinical pathways are adhered too through winter are essential. Therefore the winter plan will be monitored via the emergency and planned care boards.

Recommendations

To agree the proposed Winter plan so that implementation can continue at pace
To agree PMO & corporate support

Impact Upon Strategic Objectives

Meeting all strategic and National requirements

Impact Upon Corporate Risks

Minimal Risk with full implementation

Regulatory and/or Legal Implications

The Trust remains under regulatory intervention for performance against the national A&E 4-hour. Standard. This plan is in support of achieving 4 hour integrated Action plan. Meet the National Standards.

Equality & Patient Impact

No specific patient groups are known to have been affected or harmed by the issues raised in this report.

Resource Implications

Finance	**x**	Information Management & Technology	x
Human Resources (PMO)	x	Buildings	**x**

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval	X	For Information	X

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

WINTER PLAN 2017 - 2018

1. AIM

1.1 To present the Board the winter plan which has been developed to ensure operational resilience for the winter period 2017/18. This plan has been produced based on learning from 2016/17, the refreshed winter bed modelling, strategic requirements for divisional transformation & sustainability and the NHS Improvement guide (*Focus on Improving Patient Flow 2017)*
The plan also takes account of NHS England Winter priorities and requirements letter July 2017 and the Gloucester CCG priorities. The plan will be subject to further refinement throughout the winter period reflecting Trust developments and wider community actions over the coming months.

System wide winter plans are being finalised which will complement the trust plans.

1.2.1 Principles

The safety of our patients
Improving patient flow into and out of the acute trust
Achieving our 4 hour emergency department target
Reducing our delayed transfers of care (DToC)
Reducing delays for our medically fit for discharge patients (MFFD)
Ensuring elective activity
Resilience over the BH periods
Achieving T&O GIRFT
Elective bed utilisation 90% & non elective 95%

2. INTRODUCTION

2.1 The NHS England letter actions refer directly to Acute Trusts:

Front door:

Focus on processes in A&E departments to prevent avoidable breaches, particularly amongst ‘minors’ and non-admitted patients referred for specialist assessment. Effective and adequately resourced command and control is essential.

Implement the SAFER Patient Flow Bundle on every ward. Implementing SAFER reduces stranded patient numbers and reduces deconditioning that results from prolonged hospital stays

Monitor and manage ‘stranded patients’. Use ‘mini-MADE’ (Multi-agency discharge events) events early when stranded patient numbers rise

Monitor and manage occupancy levels, with regular reporting to boards

Discharge:

Implement the Eight High Impact Changes for Managing Transfers of Care

Implement a 'placement without prejudice' process. When a patient has been identified as potentially requiring CHC, he/she is discharged to an appropriate environment out of hospital while the assessment and decision is made.

Use the trusted assessor guide, (NHS Improvement will publish imminently)

Better planning for peaks in demand over weekends and bank holidays

Demand and capacity planning needs to have been conducted and tested before the end of October.

Community Partner Assumptions:

The Government has published indicative expectation for Local Authorities to reduce social care-attributable DTOCs this has been mapped to individual CCGs:

i. The Government's published indicative expectation for jointly attributable DTOCs to be maintained at baseline levels have also been mapped to individual CCGs;

ii. The CCG will not be allowed to have a target for NHS-attributable delays which assumes any deterioration from the baseline position in Q4, 2016/17.

2.2 The period of winter for planning purposes is considered to be from 1 November 2017 to 31 March 2018. To ensure elective resilience we propose 14 December 2017 to 31 March 2018. Christmas and New Year's Day both fall on Mondays so the will be on the 4 day weekends during this period.

The overall Time line for the winter planning and preparation:

Timetable for 2017/18 system wide Winter Resilience Plan and Escalation Plan & Framework + Internal organisational escalation plans, winter plans and demand & capacity modelling

Date	Action
1st August 2017	Winter and Escalation workshop – review of last winter and discussion around escalation and system support for this winter
25th August 2017	Submissions to be received from providers and CCG: • provider internal escalation plans, winter plans and demand & capacity modelling. • contributions to system wide Winter Resilience Plan 2017/18 and whole system Escalation Plan & Framework 2017/18
21-29th August 2017	CCG to review and translate all returns including detail contained within organisational demand & capacity modelling (including bed modelling) to inform the wider system wide Winter Resilience Plan 2017/18.
29th August 2017	Submission to NHS England of initial draft of system wide Winter Resilience Plan 2017/18 and the new NHSE Winter Plan assurance Framework. (Note: this deadline was initially 8th September)
29th August 2017	System wide Winter Resilience Plan 2017/18 to be circulated to A&E Delivery Board members for review and comment prior to submission to NHS England on 8th September.
6th September 2017	A&E Delivery Board member feedback to be received into the CCG in order that further NHSE submission can take place.
15th September 2017	Winter and escalation workshop for whole system – Review of a high escalation day and a low escalation day.
18th September 2017	A&E Delivery Board to receive overview of Winter Resilience Plan.
September & October 2017	Providers and CCG to submit draft Winter Resilience Plan 2017/18 to relevant organisational Boards for sign off.
16th October 2017	Final documents to be presented to A&E Delivery Board with plans published on necessary websites post meeting.
Early November 2017	Implementation workshop – all organisations represented.
Mid November 2017	Commence planning for Christmas & New Year 2017/18

2.3 The Trust winter plan **(Appendix 1)** has a three phased approach:

i. Review of the expected demand profile
ii. Delivery of operational and discharge schemes to improve flow through the hospitals
iii. A review of the workforce availability

The Trust has taken a systems approach to ensure that issues affecting one part of the organisation are considered by all Divisions monitored through the unscheduled care senior leaders meeting and the Emergency Care Board (ECB).

2.4 This plan sets out the actions the Trust is taking to ensure it is resilient to the pressures placed on the whole healthcare system during the winter period. The plan sets out to maintain safe, high quality services for patients, including effective management of infection, ensuring patients are seen in the right place, at the right time, first time, whilst maintaining privacy and dignity. It takes account of:

- Key pressures that arise from winter
- Detailed demand and capacity modelling
- Areas of learning from last year's winter experience
- Healthcare System planning process for 2017/8
- Implementation of Strategic plans (T&O, MAU/AEC)
- Early identification of risks and mitigations to capacity constraints
- Operational response and monitoring

This plan should be read in conjunction with the following Trust plans:

- Escalation Policy
- Pandemic Flu plan
- Major Incident Plan
- Business Continuity Plan

2.5 This Trust winter plan has been developed with the involvement of representatives from all Divisions, through engagement at the Emergency Care Board and with partner organisations. The plan will be exercised and refined as necessary in the run up to the winter period.

2.6 Planning events and workshops have been held with partners from across the NHS and social care in Gloucestershire to develop the NHS Gloucestershire Operational Resilience and Capacity Plan.

2.7 The Executive Lead for the Winter Plan is Caroline Landon, Chief Operating Officer.

3. KEY PRESSURES

3.1 The key pressures posed by winter include:

- A tendency for a more complex/dependant case mix leading to an increase in length of stay (LOS) and a subsequent reduction in capacity.
- Reductions in timely discharge of patients due to increased demand from the hospital and primary care for capacity in community/social care.
- Increased demand for acute services due to higher levels of infection within the community.
- Significant peaks of bed closures due to sustained infection (e.g. Norovirus) outbreaks.

- Increase in medical outliers, cancelled operations and ambulance handover delays.
- Pressure on adult critical care and paediatric high dependency capacity across the network.
- Unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus).
- Adverse weather resulting in difficulty in discharging patients and affecting staff getting to and from work.

3.2 In managing these pressures this winter, the overriding objectives are to:

- Sustain safe, high quality services for patients including effective management of infection, ensuring patients are seen in the right place and right time, whilst maintaining privacy and dignity.
- Achieve the key areas of service performance; including 4 hour performance, reduction of ambulance turnaround times and waiting time's standards for patients with suspected cancer and 18 week referral to treatment.
- Implement the Trust strategy for the optimised model of service for T&O by aligning trauma on one site and elective surgery on the other in the long term. (The GIRFT T&O Project Brief was approved at Trust Leadership Team in April, 2017)

4. LEARNING FROM 2016/17

4.1 Whilst many of the pressures posed by winter are predictable, the learning from previous years is valuable. As an example there were approximately 261 elective operations cancelled over the period of October to March in 2016/17 at GRH due to the closure of the elective inpatient arthroplasty ward. In addition there were further cancellation of elective surgery 'on the day' due to Trauma pressures. A review of the effectiveness of last years' plan identified a number of areas that required additional consideration for 2017/18:

- Better profile capacity and demand to enable the planned opening of additional capacity as required.

- The plan has been supported by modelling and information analyst support with real time analysis of bed requirements given changes in demand and success of admission avoidance initiatives over the winter period.

- The plan will be monitored by the Emergency Care and Planned Care Boards and its performance reflected in the Performance Management Framework.

- Given the impact on surgical activity over the winter consideration has been given to the management of current elective pathways to maintain resilience. It is expected that a further 45 such cancellations will be prevented by implementing the new clinical model in alignment with Trust Winter Plans for 17/18. This will also improve the quality of care on GRH ED by expediting via trauma pathways to the dedicated ward base and onwards to theatre.

- Trust Escalation Policy will be reviewed to:

    - Include the changes to the Operational Pressures Escalation framework (OPEL)
    - Include risk assessments for all additional capacity areas to be considered at each escalation stage.

- Give clear criteria for escalation and links to the major incident plan.
- Once escalation has occurred, actions to return to a lower state of escalation should be identified.

The values and assumptions GHFT has adopted for the 2017/18 plan are:

- Engagement of senior nurses in supporting flow through the hospital on a routine basis rather than just when in escalation.(daily SAFER &MFFD reviews)
- Setting Estimated Date of Discharge (EDD) within 48 hours for all patients
- Clinical leaders making timely decisions (including when colleagues are absent on leave)
- Medical Staff taking timely actions and ensuring juniors undertake the same
- Proactively managing patients discharge with a zero tolerance on delays 'Home is Best' philosophy.
- Actively promoting Discharge Waiting Area, discharges before 12, Transport and TTO's day before ensuring a culture of 'No Delays' (Red to Green)
- Planning early and involving staff in making decisions about how additional escalation capacity will be used.
- Publication of an updated Trust Escalation Policy in accordance with the recommendations in the winter plan review including:
  - Cross Site transfer policy GHT AMU to CGH wards and vice versa
  - Bed escalation order of priority.
  - Pre-emptive Transfer Policy (PET) for the movement of patients from the Emergency Department and MAU
  - Updated outlier protocol.
  - Revision of TTO policy, particularly for the use of the Discharge Waiting Area (DWA).
- Ensuring effective board rounds and subsequent activities in support of the discharge of patients (the SAFER Bundle).
- Asking staff to make their own contingency plans in the event of adverse weather.
- Promoting the flu vaccination programme with targeted vaccinations in clinical areas
- Proactively working with our partners across health and social care in Gloucestershire to ensure services are aligned and or integrated.
- Working jointly with our partners on a communication strategy and joint action plan.
- Review of elective activity to maximise day case and 23 hour capacity
- Implementation of HOT clinic and ESAU for admission prevention
- Reduction of activity levels on the days after the key Bank Holidays.
- Consider cancelling outpatient attendance on the afternoons of 24 and 31 December, re-investing consultant time in supporting flow and patient discharges.

5. DEMAND PROFILE

5.1 Demand is expected to be similar to last winter, where from mid-October through to the 8 March the 4 hour target was missed nationally every week.

5.2 A detailed bed profile has been conducted by the Trust Information Team and reviewed by Divisions

Bed Modelling Assumptions

5.3 Assumptions used for the bed modelling exercise are as follows:

- The two hospitals have been combined in the model but capacity levels adjusted to take account of their separate operating conditions.
- The scenarios available to use in the model are:
    - Better care better values benchmarks
    - Overall growth rate of 2.5%
    - 90 elective & 95% non-elective bed occupancy levels

5.4 Length of Stay (LOS)

- LOS based on midnight occupancy
- Average LOS calculated as monthly bed days per specialty divided by monthly admissions per specialty
- Zero LOS patients and day cases are presented as separate categories
- Benchmarked against national and peer group LOS by specialty published by NHS Better Care, Better Value Indicators - no split by elective/non-elective
- Day case rate calculated as the number of day cases divided by the number of beds

5.5 Bed Base

All physical adult non critical care beds/chairs available across the Trust by site and specialty.
Split by: site; division; specialty; funded beds; escalation beds; ring-fenced beds; maternity; paediatrics; trolleys; assessment areas

5.6 Activity

- Monthly activity based on admission month (hospital provider spell)
  Split by:
    - elective inpatients; elective inpatients with zero LOS; elective day cases; non-elective; specialty; gender; private patients
- Elective activity is as per the HSCIC Data Dictionary and includes:
    - Waiting list admissions; booked admissions; planned admissions
    - Elective inpatients are all elective admissions classified as 'Ordinary admission.' or 'Mother and baby using delivery facilities only' in DW
- Elective day cases are all elective admissions classified as 'Day case admission.' in DW
- Non-elective activity will be broken down in to the following sections:
    - emergency admission; maternity admission; paediatric admission; other admission
- Specialty is based on the treatment function code at admission and excludes:
    - well babies rate calculated as the number of day cases divided by the number of beds

Actions from Bed Modelling Exercise

5.7 A summary of the actions to be taken following the bed modelling exercise is below:

- Length of Stay resilience schemes are to be assessed for their likelihood to deliver under winter capacity conditions (operational standards & external winter ward).
- Additional System Improvement Schemes being developed should be reviewed with regard to delivery before winter (virtual ward & trusted Assessor).
- **Potential for** additional nursing home beds to be reviewed with the CCG.
- Efficiency of elective work will be improved by consolidation of the majority of orthopaedic elective activity on one site, reducing variation and protecting capacity. In addition profiling of surgical activities across the winter period to avoid adverse impact of potential surge in non-elective activity.(review Monday elective activity & conversion to 23 hour)
- Day Surgery to be ring fenced.
- The risk of resilience schemes delivering to the best case is high and therefore other methods of mitigating the predicted bed shortage need to be identified. (Possible mitigation required short term planned reduction in elective activity February)

Demand Summary

5.6 Based on the current bed model and assumptions the Trust expects to face a bed shortage of 46 beds (based on refreshed bed modelling) with the potential to have shortages peaking to 80 in extreme escalation. The Trust will manage this bed gap by the following initiatives/plans:

Initiative	Bed Benefit	RAG rating
Chapel lane winter beds	20	
SAU	4	
Frailty	4	
CGH DSU	10	
SAS side rooms	4	
Additional reablement and D2A (CCG)	30	
Total	**72**	
Additional capacity in Internal major incident		
AEC	6	
DSU	16	
Total	**22**	

Details of the bed benefits:

- Bed 16-20 beds from the external ward scheme at Chapel Lane
- Bed 10 beds from CGH day case to 23 hour unit and release day case for 10 bedded single sex ward

To address the remaining gap the trust has invested in a number of nationally proven

initiatives to provide additional capacity by a reduction in LoS, and admissions

- The establishment of a 12 trollies SAU in October will reduce surgical admissions and further reduce LoS for general surgery patients creating flow. Based on the current LoS and taking into account last year's activity the SAU will reduce the zero day LoS admissions by circa 45%. Full implementation of the model without blocking the trolleys for medical intake will give an additional flow on 4 beds.

- Extended AEC opening hours during weekdays at GRH from October 2017 and additional 4 side rooms on the current SAS with HOT clinics.

- Extended OPAL at GRH. As described in section 6.10 will release six beds

- SAFER and Breaking the Cycle initiatives

- Reducing medical outliers by cohorting on 9A(6 beds) and 12 beds from surgery to medicine

6. INTERNAL IMPROVEMENT SCHEMES AND ACTIVITIES

6.1 There is no capacity to open internal winter wards' and it is therefore necessary to deliver capacity through effective and efficient flow through the hospitals. A number of internal system-wide improvement schemes are being developed and agreed these will be driven through the planned and emergency care boards in order to co-ordinate and drive progress. Some of these schemes will deliver bed capacity and others improve efficiency and effectiveness and will therefore drive down Length of Stay.

6.2 A total number of flow Improvement schemes are currently being worked though:

- GRH
  - ESAU 12 beds – direct GP take
  - T&O – 12 beds +/- to Med
  - Surgery level 5 - 6 beds +/- to Med
  - Gynae SAU 6 beds – direct triage from ED
  - Additional AMU capacity
  - 4a Frailty model/ 4AMUa pathway ring-fenced
  - AEC - Direct Admission GP
  - Urology – 1 hot Bed for ED assessment
  - Vascular – 1 Hot Bed for ED assessment
  - Conversion gen elective cases to DSU 23 hour (Gynae & Gen surg)
  - Conversion of Monday GRH list to Monday CGH (Gynae)
  - Additional 4 trollies for recovery GRH
  - Criteria led Discharge
  - Transfer team review to cover peak hours of demand

- CGH
  - Convert day case ward to 23 hour recovery (reduce LoS surgery) release beds med e.g. urology)
  - Release 1 ward (above) 10 beds – Med (permanently staffed or Sunday to Thursday)
  - Twilight Transfer Team
  - Criteria Led Discharge

- Support Services
  - Increased pharmacy dispensary hours
  - OOH pharmacist on call remains on site until 16:00

- Daily navigation meetings MDT & SC
- Weekly multi agency face to face escalation meeting blocked/ stranded patients
- Partnership weekly coding meeting CCG/ SC GHT & GCT to identify whole system delays
- Therapies 7/7 or 6/7
- Cross site transport arrangements
- Professional Standards diagnostics 1 hour turn around emergency zone (ED, AMU, AEC)
- Specialist referral to ED 30 minutes (must do)

For the full list of schemes for the winter plan 2017/18 see Appendix 1

Escalation

6.5 The Trust Escalation policy is again being revised to take account of the OPAL changes, recommendations from the ECIP review and to reflect the need to address flow through the hospital earlier in the process. Key changes are:

- Pre-emptive Transfer Policy (PET). The PET policy now incorporates MAU to wards, has been moved to Amber in the escalation policy and allows for the movement of patients from an overflowing ED to other wards in the Trust. The Trust uses the concept of the Full Capacity Protocol which is well known in healthcare and ensures the whole system is engaged when the hospital reaches a high escalation level. It is important to take a system view of the solution and there is therefore a requirement to move patients from the ED/ACU to the wards in order to keep the flow moving. The concept in GHFT is described in the Pre-emptive Transfer (PET) protocol. When considering boarding, patients should be assessed as stable, orientated and should not be receiving active treatment or require intensive monitoring. The maximum boarding in each ward will be determined and multiple moves minimised.

- This process is an Assessment and Treatment process. These patients will have a rapid senior assessment to determine acuity, immediate tests and treatment initiated and the patient is then moved out of the Emergency Department and admission details completed by the inpatient teams.

- Internal professional standards **(Appendix 3)** for our DSS support services (pharmacy, imaging, therapy and pathology have been agreed with core metrics for monitoring purposes.

- The delay in writing up TTO is evidenced as one of the greatest causes for delayed discharges and senior medical support is required. In addition all Junior Drs have through induction been given core priorities for discharge planning and screen savers are already in place.

- Discussions have also been held with commissioners and ARRIVA Transport Solutions to ensure the protocol shares a common understanding, that capacity is maximised at peak demand and that aborts are minimised.

- A revised outlier's protocol to provide clear guidance on the selection criteria for patients to be placed in the formalised outlier wards will be agreed.

- A revised bed meeting escalation approach with the Executive On-call leading the weekend and BH meetings so that full engagement in decision making to the

highest level supports early and proactive action in the management of demand.

- A clear linkage to the Major Incident and Business Continuity Plans.
- A clear drive to take measures to reduce escalation once it has been raised.

Senior Nursing Leadership and General Manager Engagement

6.3 The existing Escalation Plan provides guidance for General Manager Engagement as the Trust status escalates. It has been assessed that senior nursing and general management engagement early in the process is essential and the roles, escalation process and cover arrangements by Divisions must be formalised and adhered to.

Specialist and enhanced nurses need to support an overall focus on discharge planning and discharges over the weekend. The robustness of criteria led discharge cannot be assumed in 17/18 and so the specialist workforce can provide confidence in discharge decision making

SAFER Bundle

6.8 The SAFER – red to green work stream continues with full role out to all divisions by November. The work stream now also included the joint agreement of 10 operational standards to monitor internal and external delays to discharge. All partner organisation have been asked to take part and a daily navigation meeting, weekly coding and partnership review meeting (One Gloucestershire meeting) has been put in place by the Trust to support the identification, ownership and proactive management of delays

6.9 Board Rounds in the core wards will consider outlier patients rather than them being considered in separate rounds later in the day. Early discharge is a feature of the project with the aim of achieving a higher proportion of discharges before 1200hrs (currently an average of 18% in the Trust). Another element of the SAFER education process is an effort to improve the recording and accuracy of EDDs Confidence in the accuracy is particularly low and there is a lack of common understanding of the processes across staff in the Trust. The Trust will conduct focused SAFER Trolley dashes to the wards each month throughout the winter period.

Frailty Pathways

6.10 There is an urgent need for additional consultant geriatrician support at the front door in ED and on the medical assessment unit (MAU) at GRH to provide (CGA) comprehensive geriatric assessment.

- The redesign of the bed base at GRH has facilitated a larger facility to manage the medical take and within that foot print it is proposed within (F) Bay (Frailty) to have OPALS beds for patients that require a short stay and who can be managed with geriatrician input and with the expertise of the acute medicine team where needed.
- The resource is proposed to be available between 08:00 to 20:00 over 7/7 days. The additional posts would contribute to the OPAL service rota and provide clinical support to community MDT's, virtual ward and provide a resource to other community based teams.

  Based on the pilot in July and August there was circa 60% turnaround i.e. admission avoidance by the CoE Consultants on the shifts they covered out of hours in ED. This equates to 2 less admission per day for the frail elderly.

  On the current LoS for this cohort, increase in demand for >75 frail elderly and

increase in acuity in the winter the bed efficiency released through the extended Frailty model equates to **four less beds** in the winter.

However, this is the highest risk scheme due to lateness in implementation and difficulties in engaging good CoE consultants.

Ambulatory Emergency Care (AEC)

6.11 A review of the AEC service provision has been undertaken at GRH and is now adjacent to the MAU above the Emergency Department this aligns well to the pull model in place with ED and the developing model for ward 4a as a short stay frailty unit.

Linked to the T&O Winter plan is the potential for additional capacity for AEC in the current SAS space that will be vacated following relocation of spinal surgery to 2A in January providing a bigger space for AEC, HOT Clinics and additional 4 side rooms.

6.12 Trauma and Orthopaedic Strategy

The Trust has developed detailed plans for T&O alignment which would see trauma at one site and elective surgery at the other. The expected benefits to be accrued as a consequence of migrating to a split site model include progress towards delivery of 7 day Trauma and Orthopaedic services; an optimised annual service delivery plan for Elective and Non-elective activity with improved alignment of capacity and improved patient experience.

For winter 17/18 we will move all trauma to Gloucester Royal Hospital and as much elective work as possible to Cheltenham General Hospital.

GRH Phase 1:

- All Clinical Pathways for Trauma.
- All Spinal Surgery Pathways in ultraclean ward.
- Selected Day Surgery Clinical Pathways.

GRH Phase 2:

- Move elective spinal surgery to 2A.
- Vacated SAS to be used for additional AEC, HOT clinics and 4 additional side rooms for medicine.

CGH Phase 1:

- Selected Elective Clinical Pathways in ultraclean wards.
- Selected Day Surgery Clinical Pathways.

CGH Phase 2: CGH

- All Elective Clinical pathways to CGH in alignment with other Surgical/Trust service reconfiguration plans and implementation of EGSU/SAS

The benefits associated with GIRFT Programme delivery are as follows:

- Improved patient experience
- Empowered and enabled surgeons

- Improved patient safety
- Improved clinical outcomes (joint longevity, infection/SSI/ complications, and mortality
- Improved cost effectiveness of the service: increased income reduced LOS, reduced litigation, consumables and loan kit costs

Primary Care Streaming in ED

6.13 The Primary Care (in-hours) streaming model of ANP and GP is in place with full funding agreed. The full benefit of the model is starting to be realised as gaps in the rota reduce. Plans are in place to continue to mitigate this and recruitment initiatives continue.

To assist in the streaming of patients to the most appropriate care setting, the main reception desk is manned by both Acute Trust and at time of peak demand an ED ANP is able to support streaming Work is ongoing to improve the effectiveness of the streaming process to avoid unnecessary 'triangulation' of patient pathways.

Dedicated Discharge Vehicle

6.15 A Dedicated Discharge Vehicle is aligned to the discharge waiting areas delivered through a contract with Arriva Transport Solutions Limited. The Statement of Requirement is being reviewed in order to ensure a responsive service is provided.

Elective Activity

6.16 Divisions are exploring the pathway opportunity for elective activity converting in patient stays to 23 hour units. The Trust is examining benchmarking data in relation to BAD's to ensure every opportunity is taken to reduce Length of stay in preparation for the anticipated increased demand in order to improve the balance of elective and unplanned patients and the patient experience.

Clinical Pathway

6.18 The clinical pathways for urology and vascular have been reinforced with the SPCA to ensure GPs are confident to refer directly to CGH, particularly when out of hours. In addition to this the Trust proposes a HOT bed model for immediate referral to specialty by ED in support of the 30 minute to assessment and 4 hour target.

7. Gloucestershire Health & Care Plans – Primary Care, community, social acre

7.1 The Gloucestershire wide health and social care Operational Resilience and Capacity Plans are defined. Representatives from the Trust have been involved in helping shape these plans. These plans were submitted to NHS England in September 2017. Partnership plans across the system led by the Trust are included in the overarching winter plan **(Appendix 1)**

- Funding for 16 beds a 'therapy led' facility near GRH (reablement & POC MFFD)
- Funding 4 beds Dementia (Reablement & POC MFFD)
- 1 additional Allocated Transport Vehicles to GRH to support the external ward
- Uplift front door re-ablement to AEC & AMU
- Week end admission to residential care homes
- Trusted assessor or 6/7 day assessment from care homes

- Additional support from social care in the form of increased wte Social workers both in acute and community care
- 30 additionally funded discharge to assess (D2A) beds

8. STAFFING

Annual Leave

8.1 There is a requirement to consider leave of senior posts across the Trust. Whilst each specialist area considers a 'vertical' approach to leave[1], there needs to be a horizontal view taken of the number of senior posts on leave at the same time. A minimum number of General Managers, Associate General Managers, Modern Matron and other senior staff will be identified. Divisions will ensure that the minimum numbers of senior permanent staff are available throughout the winter period with particular consideration for the Bank Holiday periods.

8.2 **Sickness and Absence**

Sickness and absence management will require robust monitoring and all divisions will be expected to garner assurance that policies are adhered to.

8.3 **Weekend Ward Clerks**

Weekend ward clerk cover arrangements need to be strengthened to cover all ward areas.

8.4 **Trust Portering Services**

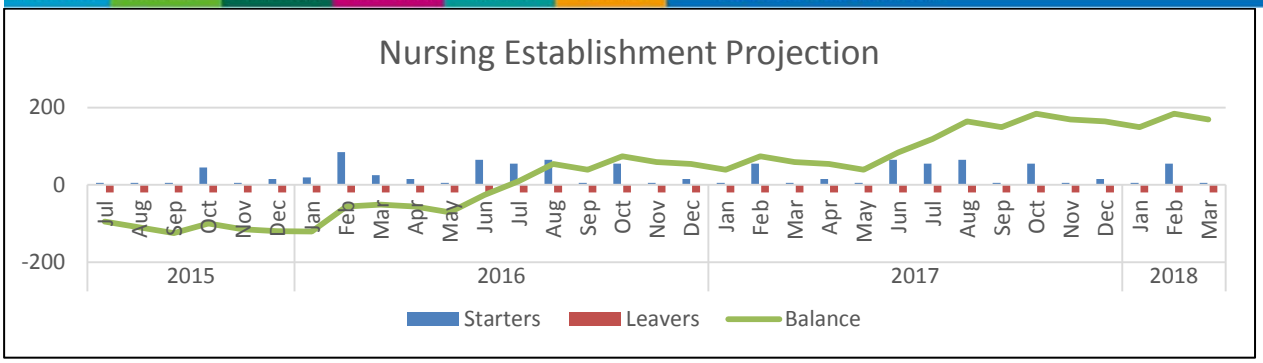
Portering services have a departmental standard of commencement of the patient move within 15 minutes of the request. A PDSA model of change is proposed from November to maximise portering capacity in particular at core time of demand and weekends.

8.5 **Nursing**

There are approximately 120 vacancies (mainly in the medicine disciplines) at any given time with particular shortages in GOAM. Surgery is less of a concern with successful recent targeted work to support Theatres. Within Women and Children's, sufficient neo-natal nursing care is a challenge. The Minimum Manning Leave policy will ensure that core staff over the Bank Holiday periods are available, supplemented by Bank or Agency staff as necessary. It is anticipated the vacancies will reduce to 70 by December 2017

8.6 The Trust consistently exploring new and innovative solutions to these workforce problems with a comprehensive recruitment plan which encompasses EU, non-EU and UK based recruitment as well as our newly-qualified intakes. Other schemes include Refer a Friend and Return to Acute Practice. Demand is currently outstripping supply as shown in the figure below:

[1] There is an annual leave tolerance of 14% built in to the budget (22% built into Nursing/Midwifery budgets 14% A/L, 6% Sickness, and 2% training). Some wards operate at 18% (between 14% to 17% is considered manageable, the further from 14% the greater impact on shift cover). Any annual leave set at 18% and above will start to impact on shift cover numbers.



Medical Staffing

8.3 There are a number of vacancies, primarily in Medicine and ED. These are being proactively managed by the Medical Division and Staffing recruitment team with a view to securing substantive appointments in advance of the winter period the biggest risk area being the Emergency Department and the ability to cover the rota. A review of demand is now being aligned to job planning.

Temporary Staff

8.4 The Divisions are working on placing pre-planned requirements for temporary staff (Bank, agency and Locum) once detailed rota reviews have been conducted and other avenues explored; Trust HR is currently exploring the overtime policy for staff to ensure existing staff are employed to meet gaps ahead of resorting to agency staffing.

9. INFECTION PREVENTION AND CONTROL

9.1 There is an increased risk of infection transmission during periods of escalation. During winter the levels of community acquired infections (including Norovirus) are higher. Every winter there is an influenza season and these impacts significantly on the Trust. Seasonal flu results in additional admissions from the community either directly due to influenza infection or indirectly due to flu-related admissions caused by secondary bacterial pneumonia, and infective exacerbations of COPD and asthma. Many of these patients have active infectious influenza infection at the time of their hospitalisation. High levels of influenza in the community can be associated with localised outbreaks of influenza in hospital wards and other institutional settings. The risk of influenza outbreaks can be minimised by a range of measures including comprehensive and consistent application of the Flu Bundle, achieving high levels of staff influenza vaccination, and prompt exclusion from work of clinical healthcare workers if they develop symptoms of influenza or other viral respiratory tract infections.

Robust and consistent application of the Flu Bundle applied to patients as soon as they are suspected to have symptoms of influenza will reduce hospital transmission to HCWs and other patients. This will in turn minimise the risk of localised ward outbreaks of influenza.

An Influenza Outbreak Policy is being developed. The Seasonal Flu meetings will also consider measures that the Trust can take that will minimise influenza transmission whilst maximising the available open bed complement. Incorrect placement of patients with influenza during 2016-17 contributed to hospital influenza transmissions, ward outbreaks and the need to close some communal clinical areas as influenza patients had been admitted into bays inappropriately. Lessons need to be learnt from our experience dealing with influenza last year and decision-making around appropriate placement of infectious patients who are being admitted will need to be improved to

minimise hospital spread and resultant loss of hospital activity. Admission pathways for patients with suspected influenza need to be developed as part of the Influenza Outbreak Policy. A key principle will be that patients are isolated immediately on clinical suspicion and only moved to communal areas when influenza (and other respiratory viral infections) has been excluded by laboratory investigations.

All wards will have new posters placed at their entrances that have been developed by Comms and the ICT to remind visitors of their responsibilities not to visit the wards when they have symptoms of common infections (flu-like symptoms or features of gastroenteritis). These posters will remain in place year round and it is hoped that these will reduce the number of infections introduced onto the wards and contribute to minimising the risk of ward outbreaks occurring.

9.2 Infection Control measures need to be reinforced following trust policy. Early identification and isolation of patients symptomatic with diarrhoea and/ or vomiting or respiratory symptoms on admission must be enforced. This should include obtaining travel history to identify patients who might have more crucial infections that have an absolute requirement for strict isolation. Actively enquiring is a patient has flu-like and/or respiratory symptoms will help identify priority patients to isolate and in whom to apply the Flu Bundle. This helps minimise in-hospital infection transmission and prevent outbreaks of infection. Priority for isolation will follow trust policy using the priority for isolation matrix and the inability to isolate patients will be escalated.

9.3 Outbreaks of suspected and confirmed viral gastroenteritis will be managed using a locally adapted version of the South West Norovirus Toolkit, detailing the escalation procedure for the management and communication of norovirus outbreaks within the Trust. There has been a programme of deep cleaning instigated over the summer in preparation for the winter. An enhanced programme of cleaning will be implemented as required. It is normal practice to introduce enhanced cleaning in hospital public toilets throughout the winter period.

The *Combat Norovirus* campaign will be refreshed and continued highlighting the with key messages aimed at visitors, patients and staff detailing symptoms, promoting hand washing and restricted visiting and restrictions for returning to work.

9.4 From October 2017 to May 2018 the Infection Control Nurses will provide an additional service to review known outbreaks of suspected and confirmed viral gastroenteritis and ward influenza outbreaks at weekends and bank holidays from 0830-1215 hours by telephone from home. Advice will be available for affected areas where the outbreak is known to the ICT by the preceding Friday afternoon. This is a limited and unfunded service so the infection control nurses work flexibly over the winter to cover. If there are no known outbreaks on the Friday afternoon, the additional service will not be activated for the weekend. It is recognised that the availability of an Infection Control Nurse at these times has been beneficial and has contributed to managing the outbreaks and the operational pressures that occur as a result of ward closures. To provide this service there will be a reduction in Infection Control Nurses availability for some meetings and normal working hours' activity.

The graph below illustrates the number of beds closed due to suspected and confirmed outbreaks of viral gastroenteritis during winter 2014-15.

Prompt identification of suspected outbreaks and early interventions can minimise the size and duration of an outbreak and associated lost bed days.

10. SEASONAL FLU – STAFF VACCINATION

10.1 The Trust has a comprehensive seasonal Flu plan. A key part of this is staff vaccination and an internal communications strategy will be launched ahead of vaccination roll-out. A proactive roll-out of the Trust vaccination programme commences in October 2017, with Occupational Health (*Working Well*) targeting and

Vaccinating front-line staff in high risk areas locally, including providing evening sessions for maximum uptake and the use of local Flu Champions giving vaccines in the high risk areas. A Flu Communications Campaign will be developed to engage staff.

10.2 The aim is to vaccinate more staff than were vaccinated in 2016/17 with a target of 4000 staff. A proactive campaign will be launched and staff will be strongly encouraged to take up the vaccine. Uptake of the flu vaccination will be regularly reviewed and monitored by staff group and clinical areas. Staff should take up the free flu vaccination and we hope they will believe the messages (and underpinning evidence) about the benefits of vaccination to themselves, their loved ones and their patients.

11. COMMUNICATIONS AND MARKETING CAMPAIGN

11.1 For 2017/18, it is assumed that NHS England, Public Health England (PHE), and the Department of Health will join up the winter campaigns.

11.2 A focused behaviour change programme will be developed through a single campaign approach, covering a variety of media including television, radio, outdoor and social media. To ensure that this campaign is as effective as possible, commissioners and providers including the Trust will use nationally consistent messaging to guide patients and the public. The Trust will align its local activity with Gloucestershire CCG and the national approach.

11.3 The campaign will be designed to encourage appropriate use of services in Gloucestershire and provides care advice by condition. The campaign will be rolled out from October onwards including a leaflet drop in every household in Gloucestershire.

12. ADVERSE WEATHER

12.1 The Trust receives severe weather warnings as well as weather alerts and forecasts from the Local Resilience Forum and the Meteorological Office. This allows the Trust to put into operation the appropriate plans in a timely fashion. In the event of adverse weather such as snow, ice and flooding, a control room will be activated so there is a single point of focus. In addition this year we are encouraging staff to plan ahead and develop their own personal contingency plans.

13. FINANCE

13.1 Funding form social care has been allocated to the Trust through the CCG in support of the Emergency surgical assessment unit, External winter pressures Ward and Frailty pathway to the sum of approximately £550k

13.2 There has been no allocation to the Divisions this year for winter 2017/18. Discussions will need to take place with regards the funding to support the Escalation Beds and outlying medical cover.

14. MORTUARY SERVICES

14.1 The Trust will assure temporary capacity to ensure Mortuary Services are maintained throughout the winter period and escalation plans are in place to meet increased demand over the Bank Holiday periods.

15. RISK AND MITIGATION

15.1 The risks have been identified with mitigating actions described **(Appendix 2).** These risks and mitigations will be reviewed constantly throughout winter period via the emergency Care Board and Trust Leadership Team. The top 6 risks are:

	Risk	Mitigating Actions	Risk Score
1	Recruitment to key posts unsuccessful (ED, Site team, senior management, Nursing)	Utilisation of all professional skill sets and professions to include pharmacy, phlebotomy, ENP's ANP's and therapies & acting down. Release of corporate clinical posts to support clinical services (Where skills & competencies allow)	16
2	Community Capacity – reablement & packages of care	Immediate escalation to CCG and pathway review for all patients. Top Ten Operational standards implementation to proactively identify changes in demand and capacity	16
3	Estates works for pathway reconfiguration	Estates works for the reconfiguration of services, GSAU, SAU, MAU & T&O if delayed into winter will impact on the reopening of beds	16
4	System-wide improvement schemes do not deliver to plan	Reviewed by ECB and seek assurance from partners that alternative plans are available and put in place	15
5	Insufficient capacity to cope with demand	Early decision on bed-base. Proactive management of LOS through SAFER and LoS improvement schemes.	15
6	Number of admissions exceeds capacity plan	Implement internal escalation measures Implement Pre-emptive Transfer Policy. Request additional medical board rounds Focus on DWA & TTO Ensure all community capacity utilised Engage with CCG call to gain system-wide support and reinforce alternatives to admission Deliver CIP LoS schemes. Improve discharges; engage with ARRIVA Transport Solutions for additional support.	15

16. MONITORING AND ESCALATION

16.1 Daily operational situation reports of bed capacity, ED attendances, daily admission and discharge predictors, infection outbreaks, patient safety, staffing issues, violence & aggression, deprivation of liberties (DOLS) are communicated to the site team and Director of operations, in accordance with the Escalation Plan.

16.2 Admissions v Predictors, Emergency admissions, average length of stay and DToC to be monitored weekly against the agreed operational standards by the Deputy Chief Operating Officer

16.3 Whole system performance is reviewed at the weekly meeting of executives from Acute, Ambulance, Community, Social Care and CCG Commissioner (the system-wide ALAMAC call).

16.4 The winter plan will be reviewed monthly by Trust Leadership Team.

17. RECOMMENDATION

17.1 The Trust Board is asked to:

- Approve the winter Plan (Appendix 1)
- Support and engage in the internal approach to improving flow through the hospital.
- Note that there is ongoing work with our partners across the health and social care services in Gloucestershire to assure system wide solutions to the pressures likely to be faced.

Author: **Sharon Nicholson Deputy Chief Operating Officer**

Presenting Director: **Caroline Landon Chief Operating Office**

October 2017

BEST CARE FOR EVERYONE

Gloucestershire Hospitals NHS
NHS Foundation Trust

WINTER PLAN 2017/18

This is a high level Winter Plan for the Gloucestershire Hospitals NHS Foundation Trust in preparing for the winter 2017/18. The implementation of the Winter plan will be put in place between 1st October and November 2017. We have taken into account the recommendations of the NHSI and our plan reflects how we aim to manage capacity by Reducing occupancy through admission avoidance, managing surge in activity,> 7 LoS daily reviews, pre-planned cohorting medical patients a winter allocation of beds from Surgery, senior medical cover over weekends, enhanced support from Onward Care team, MADE (Breaking the Cycle events) and reducing Length of Stay through initiatives within Divisions and Support of the elective inpatient activity post Xmas period by undertaking breaking the Cycle 2-Gether 2nd week in February

There are twelve core work streams to ensure winter resilience, these are:

1. Surgical assessment unit at GRH with funding from the system partners – Oct 17
2. Integrated frailty model with enhanced OPAL 0800- 2000 GRH with funding from the system partners H – Oct 17
3. Additional therapy supported bed capacity (x16) in the community for MFFD with funding from the system partners – Oct 17
4. GP SPA referrals for admission avoidance
5. GP (SPA) admissions direct to the assessment unit at GRH – Oct 17
6. Extension of the AEC at GRH opening hours – end Oct
7. GP streaming at the front of ED - enhanced cover from Oct 17
8. Ring fence 1x bed vascular and 1 x urology for direct admissions from ED at GRH
9. T&0 trauma to GRH and electives at CGH
10. Convert CGH day unit to overnight medical beds (further planning)
11. Review escalation protocols and actions with partners & report to NHSI and NHS England using the new reporting tools and escalation protocols.

Actions are only rated green where complete and monitoring taking place

	Organisation/ Division	Plan	Actions	Progress	Next Steps	Due Date	Accountable officer	RAG
Beds & Capacity								
	Operations	MADE Events	Two Trust wide clinically led multi-stakeholder Breaking the Cycle together (MADE) events are planned for w/c 30 October and w/c 8th February 2017. The events will build on the SAFER initiative and Red/Green days that have already been rolled out across the Trust and aim to improve patient flows and release capacity during the period of increased pressure on services during winter.	Allocated Lead. Emailed all senior leaders, exec team and partner organisations dates and request for participation.	Develop Daily board round SAFER tool kit for peer review by senior clinicians and partners on board rounds. Develop Rota of cover for all wards to have peer review of board rounds at least twice in week.	Oct-17	S Nicholson	Amber
	Partnership	Additional Capacity	Work with partners in the development of a model for Chapel House, an external ward to the acute Trust to ensure reduced LoS and flow GRH. 16 Beds	Patient co -hort identified and agreed by D'Nursing, Therapy leads and DCOO, paper written for agreement of funding. Funding agreed.	Clear Governance framework for monitoring and documentation of care post discharge.	Sep-17	S Nicholson A Hosking	Green
	Trust Wide	Whole staff Engagement	From 2nd January to 12th January All Divisional senior leadership teams will ensure a clear presence on Wards and at bed meetings. All other meetings must be kept to emergency pressures only.	Support of Trust Executive Team.	Sign off required by CEO.	Jan-18	COO	Red
	Operations	Reducing Delays - SAFER	Develop Support Service Metrics for turn around time of Pharmacy Pathology Imaging and therapy assessment.	Internal Professional Standards agreed and signed off by divisions for pharmacy, pathology, diagnostics & Therapies split into 1 hour turnaround around time for ED, AEC EDSAU.	Agree baseline to set targets. Launch across the Trust during MADE Event 2017.	Sept 2017 October 2017	S Nicholson & PMO	Green

	All Divisions	Discharge Planning (SAFER & SORT)	Wards will book transport the day before (or sooner if planned) for next day discharges. Board rounds will take place daily with a senior decision maker. Ward Huddles will take place at 14:00 hours to account for any am actions.	Performance metrics in place . Ward SAFER toolkit under development to share data ward by ward. SAFER focus on the Breaking the Cycle events. TTO guidance provided on induction to all new junior Dr's.	Better Board Round Guidance and SORT.	Oct-17	PMO, S Nicholson & Directors Nursing	Amber
	All Divisions	Discharge Planning (SAFER & SORT)	Junior Dr's will transcribe TTO's day before discharge or on the morning if agreed discharge form Board round.	TTO guidance provided on induction to all new junior Dr's. Performance metrics in place. Screen Savers developed and live.	PDSA cycles of change to demonstrate TTO day before impact on discharges before 12. Chiefs of Service to ensure permission to leave board rounds for TTO's identified on the day.	Sept 2017 Aug 2017	S Nicholson Chiefs of Service	Red
	Site	DCC Capacity	Maximise capacity of DCC whilst minimising mixed sex breaches.	Revisit the SOP for DCC ensure 1 bed empty at all times. Review Step down to HDU and develop core clinical criteria.	Review data and process for mixed sex breaches. Indentified lead from site for DCC. Allow for flexing of staff within the unit to maximise 24/7 highly skilled delivery and bed optimisation	Sep-17	Director Nursing & S Bonser, S Nicholson	Amber
	DSS	Capacity GRH	To facilitate the increased demand for inpatient activity on the GRH site, the Radiology department will divert as much OP activity to CGH as possible. This will facilitate additional IP slots at GRH. During periods of prolonged divert the balance of OP/ IP across sites will be reviewed.	In discussion.	Agree baseline to set targets. Launch across the Trust during MADE Event 2017.	Nov-17	T Iles	Amber
	Surgery & Medicine	Electives & unplanne	Convert CGH day unit to overnight medical beds or in EXTREME escalation Convert 1 ward from surgical day unit (M/F) to medicine by allocating male or female elective cases to 1 ward and converting to 23 hour unit	Plan in early stages of development.	Plan being considered and discussions to take place with Urology and other specialties.	Nov-17	H Lucas & B Woodall	Amber
	Surgery	Trauma & Orthopaedic reconfiguration across sites	GRH will become the Hot site. Trauma bed base (3A, 3B, 2A) = 85 beds. Spinal Surgery bed base (SAS) = 9 beds. Ultra clean facility. Recovery step down = 4 trollies. Day Surgery Unit: 21 Trollies and 6 beds to support all surgical and trauma take +/- W&C. * 9A (release of Vascular Lab to ground floor gallery) = assessment/DSU/capacity = 6* CGH will become the elective site. Elective bed base (Half of Ryeworth, Alstone, Dixton) = 56 beds. Day Surgery Unit: Kemerton & Chedworth (utilisation under review within all day list reconfiguration for rest of surgery).	Estates & Divisional planning taking place with timeline agreed.	Works on 9A on hold until April to minimise bed closure. Vascular lab will move and enable Gynae ward Trolley assessment area.	Oct-17	Beryl Woodall J Hernandez	Amber
	All Divisions & Infection control	Cohorting Medical outliers	T&O – 12 beds +/- to Med Surgery level 5 - 6 beds +/- to Med Gynae SAU 6 beds – direct triage from ED	Identification of co--hort beds across division using Bed model v1 2017.	Review of bed model to incorporate T&O strategic plan (staffing) model for covering cohort patients to ensure daily board round and senior nurse review.	Oct-17	S Nicholson Divisional Tri	Amber
	Operations	Reduced Length of S	Identification and implementation of Ten core Standards to jointly monitor internal and external delays to discharges.	Governance Framework in place, standards identified that are the greatest delays to discharge.	Sign off with partners to agree standards. This will take place via the Admissions Avoidance Group. Identify the number of beds possible to save. Set trajectory for achievement cross system. Weekly Coding meeting supporting the top ten operational standards and identifying core themes to delays.	Oct 107	S Nicholson S Bonser	Green

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11. Review escalation protocols and actions with partners & report to NHSI and NHS England using the new reporting tools and escalation protocols.

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	Organisation/ Division	Plan	Actions	Progress	Next Steps	Due Date	Accountable officer	RAG
FLOW - DTOC & Medically fit								
	All Divisions SAFER	<3 & <=7 simple discharge planning	Matrons will review patients with ward managers tipping to >7 day and identify actions to mitigate delays with the ward.	Audit Tool to be developed to undertake a 1 week review of all patients tipping over >6 days		Oct-17	Divisional Matrons	Amber
	Medicine	AMU capacity	Continuance of pathway development for increased flow though AMU , AEC & Frailty Additional AMU capacity.	4a/AMUa Frailty model Staffing agreed and proposal to ring fence 4/6 beds for frailty short stay.		Oct-17	Mark Pietroni Hilary Lucas	Amber
	All Divisions SAFER	Reduced Length of Stay	All Wards will implement the SAFER Red to Green process.	first 6 wards in place Medicine.	Role out to all of Medicine Role out to all other Divisions.	Oct 2017 Nov 2017	Dr K Hellier, Matrons & D' nursing	Amber
	Operations	14+ Day Length of Stay (LoS) Discharge Facilitation	Improve outcome for patients with > 14 days LoS: Setting up governance framework and metrics for management. Daily navigation meetings MDT & SC. Weekly multi agency face to face escalation meeting blocked/stranded patients with attendance by clinical lead nurse for each division with delay patients they wish to escalate. Partnership weekly coding meeting CCG/ SC GHT & GCT to identify whole system delays and address bottle necks.	Pilot phase with 6 wards, daily navigation meetings identifying and unblocking delays. Weekly Partnership stranded patients review MDT and representatives from all providers.	Rolling out to all of Medicine. Rolling out to Surgery. Member ship agreed, model shared with partners, operation standards to be agreed. First meeting for weekly partnership stranded patient review booked for October.	Sept 2017 Oct 2017 Sept 2017	S Nicholson S Bonser, A Hosking	Amber
	Partnership - CCG & Operations	Escalation process	Review Acute & System Opal Escalation Actions and ensure robust communications and actions across System.	Acute Escalation Actions Reviewed	Awaiting sign off and production by CCG.	Aug 2017 Sept 2017		Green
	Partnership	CCGGCH LA & GHNHST	Implementation of 90 + National Standards for identifying and reducing internal and external delays to discharge.	System wide governance framework for supporting flow and identifying delays.	Meeting with CCG has taken p[lace to discuss. National standards shared with CCG.		S Nicholson S Parker	Amber
	Partnership	CCG & GHNHST	Identification of Trusted Assessor for Acute Trust Assessment of Residential and Care Home placements.	Partial cover for Care home in place.	Further meeting agreed to discuss full cover.	Nov-17	S Scott A Hosking	Amber

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	Organisation/ Division	Plan	Actions	Progress	Next Steps	Due Date	Accountable officer	RAG
Emergency Department Pressures - 4 hour Target								
	All Divisions	4 hour Target	Ensure attendance within 30 minutes for specialist referral to ED	Specialties to ensure attendance at ED when a referral is received within 30 minutes.	Agreeing mitigating actions when this is not adhered too. This could be direct transfer of the patient to the speciality ward.	Sep-17	Chiefs of Service	Red
	Medicine	Admission avoidance	GP streaming at the front of ED - Development of pull model or clear pathway development for Frail and AEC patients e.g. all GP patients go to AEC Ward 4A to be frailty Short stay. Integrated frailty model with enhanced OPAL 0800- 2000 GRH with funding from the system partners H – Oct 17.	Pathway and medical cover agreed.	Enhanced cover from Oct 17 SOP for the site management of flow to 4A to be agreed with senior clinicians.	Oct-17	H Lucas, Ian Donald, S Bonser	Green
	Partnership CCG,GHNHSFT, GCS	Admission Avoidance	GP to stream GP referrals through SPA for admission avoidance to ED.	Proposal to trial GP referrals to ED AMU through SPA for GP triage.			M Pietroni, H Goody, SN, K Norton	Red

	Partnership	GP Streaming	GP streaming at the from door	GP streaming model in place through CCG and funded.	Identification of GP's to fully commit to the rota, recruitment to ENP for streaming. Funding transfer to GHNHSFT for the full streaming service 1x ENP, 1x band 3 & GP cover 7/7	Sep-17	S Cheal	Green
	Medicine	Access	Access to AEC extended	AEC will provide a service from 08:00 - 20:00 hours		Sep-17		Green
	Partnership CCG & GHNHST	Right bed first time	GP (SPA) admissions direct to the assessment unit at GRH – Oct 17	planning - in discussion		Nov-17	M Pietroni, H Goody, SN,	Red
	Partnership & ECIP	Admission Avoidance	Multi provider (clinical and operational) review of patients arriving by ambulance at the acute site. The review team will consist of a small group of clinical staff, including some of the following: GP, Ambulance clinician, Acute clinician, DOS or CCG lead, and therapist. Together they will review conveyed patients to capture the details of the arrivals to consider learning and options for improvement	Provide the teams with a detailed review of ambulance arrivals identifying priority issues through comparators and driver diagrams.	Presentation by the providers to the A&E DB to include the below. 3. Hold a workshop for partner providers to identify improvement cycle priority.	Sep-17	ECIP, S Nicholson, S Cheal	Amber
	DSS	Attendance avoidance	Review of hours of Radiographer hours provided to core Treatment Centres to meet GRHNHSFT peaks in demand.	consideration of DSS ability to re-provide hours lost to Stroud urgent treatment centre to avoid surge in paediatric activity in ED early evening.		Oct-17	T Iles	Red
	Surgery	Right Bed first Time	ESAU 12 beds – direct GP take. Development of an Emergency Surgical Assessment Unit (SAU) with HOT clinic to 5th Floor	Funding agreed with CCG. Estates Modelling and time line in draft form.	Engagement with clinical staff in the development of pathways.	Oct-17	B Woodall	Amber
	Surgery	Activity	Vascular & Urology services plan to continue to deliver against commissioned activity for both emergency and electives as county wide provision for which access needs to be maintained.	Identifying that BADs is adhered to. Conversion of inpatient to day case/23 hour unit.	Planning in progress	Oct-17	B Woodall	Amber
	W&C	Capacity GRH	Day case to CGH Monday list Gynae.	Proposal being developed to move a Monday day case list to CGH as a mitigation against cancellation and increasing capacity at GRH.	Discussions only	Nov-17	J Hernandez	Red
	Surgery & Medicine	Admission avoidance	Ring fence 1x bed vascular and 1 x urology for direct admissions from ED at GRH SOP for use overnight from 22:00 & recovery of bed by 8am.	Discussions under way with Specialities.	Pathways and Standard operating procedure required.	Nov-17	B Woodall S Bonser	Red
	DSS	Diagnostics	Additional fracture clinic sessions to be commissioned to cover off anticipated post trauma take.				T Iles	Red
	DSS	Therapies	Therapies will move MSK outpatient staff to ACUs and 9A over Christmas and New Year.	Discussion stages only			T Iles	Amber

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7. GP streaming at the front of ED - enhanced cover from Oct 17
8. Ring fence 1x bed vascular and 1 x urology for direct admissions from ED at GRH
9. T&0 GIRFT strategy (trauma to GRH and electives at CGH)
10. Convert CGH day unit to overnight medical beds
11. Review escalation protocols and actions with partners & report to NHSI and NHS England using the new reporting tools and escalation protocols.

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Organisation/Division	Plan	Actions	Progress	Next Steps	Due Date	Accountable officer	RAG
Staffing							
Partnership	Additional Capacity	Work with partners in the development of a workforce model for the implementation and management of Chappell House and ensure Therapy cover (GRH) Social Care (CCG) and Nursing (Chapel house).	Paper written for agreement of funding. Funding agreed Work force Model agreed	Recruitment to take place for: 10 Patients Oct & further 6 patients November.	01/09/2017 Oct 2017 Nov 2017	S Nicholson	Green
Medicine	Cohort patient Medical Cover	Identify medical cover and senior nursing cover for daily review and management of Outlying patients.	TBC	TBC	Oct-17	H Lucas, M Silva	Amber
Medicine	ED medical cover	Ensure a resilient rota that meets the peaks in demand of the service.	Workforce reviewed against peaks in demand.	Model Job plans against flows of the department and identify possible solution to meeting demand at peak times.	Oct-17	H Lucas	Amber
Corporate	Co-ordinated and consistent communications	All rosters are completed 6 weeks in advance. Staffing levels across both hospitals are reviewed at the daily meetings so that any expected gaps can be covered with minimal impact on service.	TBC	TBC	Oct-17	Chiefs of Service Directors of Nursing	Red
All Divisions	7 Day services	7 day therapy cover. Extended pharmacy opening hours. Bioquel hour to be extended 6/7. Portering services OOH to be reviewed. In medicine, all relevant accredited Consultants will contribute, an occasional additional evening weekday session.	Reviewing therapy cover for weekend to identify options for 6/7 cover. Meeting with DS Divisional Director to agree cover arrangement for additional hours for pharmacy & Path specimen reception.	Meet with Bioquel to develop winter cover and weekend arrangement.	Sep-17	T Isles, S Bonser	Amber
Operations	Site Management	Elective work will be reviewed daily in line with the trust escalation protocols at times of increased emergency activity leading to pressures on inpatient beds. Surgical specialities will maximise the use of the Day Surgical Unit. At times of prolonged Black Escalation COO or Gold authorisation will be requested for cancellation of any electives other than: cancers, over 52 week waits, patients that have been cancelled twice before, other urgent clinical need for surgery.	Opel Escalation cards updated	winter on call manager training to be delivered for sharing reviewed policies and roles and expectations	Dec 2017	S Bonser B Woodall	Amber

Operations	Site Team & Silver Rota	Meet the needs of the Trust during escalation and OOH: Review silver rota to maximise capacity OOH and minimise disruption to service delivery in hours. Review funding and structure of site team and recruit to all vacancies. Review Bed meetings and align to Daily Navigation meeting at 11am. Review senior site cover at CGH OOH. Elective work will be reviewed daily in line with the trust escalation protocols at times of increased emergency activity leading to pressures on inpatient beds. Surgical specialities will maximise the use of the Day Surgical Unit. At times of prolonged Black Escalation COO or Gold authorisation will be requested for cancellation of any electives other than: cancers, over 52 week waits, patients that have been cancelled twice before, other urgent clinical need for surgery.	Silver rota Reviewed and proposed model identified.	This can not be put in place until the Site team structure, recruitment and leadership model has been put in place.	Dec 2017	S Bonser S Nicholson Coo	Red
Operations	Transfer team	Structure and align Transfer teams to AMU /ACUC . Investigate possibility of Transfer team twilight shift for CGH.	Fully recruit to transfer team GRH. Consider funding to Develop a Transfer team for CGH 16:00 - 22:00	Funding Identified recruitment to band 1 porters to support existing HCA band 2 Hours of cover being reviewed to align to peaks in demand.	Oct-17	S Bonser	Amber
Operations	Structure & Alignment OCT to Wards	Review Structure of OCT to maximise input to wards fully recruit to the model. Set Daily discharge target for OCT and all wards. The team will spend 90% of their working day directly on the wards completing SPCA forms, accessing Community Hospitals, Discharge to Assess, Community Reablement beds and ensuring good social work support. OCT will have in place a resilience plan to ensure cover to all medical wards in times of escalation. OCT will lead and participate in the daily navigation meetings and week key coding meetings.	Res structure being drafted, funding identified within budget. Full recruitment campaign underway for replacing vacant and long term sickness hours. Resilience plan and allocations plan for wards in escalation complete. OCT leading daily navigation meetings	Discharge target for wards and OCT. Reduce steps needed to get a referral to a community hospital accepted	Oct-17	S Bonser	Amber
Partnership Arriva, GHNHSFT & CCG	Transport Response Times	Review of Transport arrangements and delivery of contract to GHNHS Trust.	Meeting to discuss how we can improve on response times for inpatient transport and identify the reasons for the Aborted Pickups has taken place	Meeting with CCG to identify areas for improvement and improved reporting. Work with wards on ensuring booking where possible day before	Sep-17	G Bridgland, S Bonser, S Nicholson & S Parker	Amber

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Corporate Governance								

	Partnership	Communications	As well as ensuring local winter messages are consistent and co-ordinated, GHNHSFT will work closely with its partners including GCCG to take account of national messaging and timings, make the most of the campaign resources available and use local partner networks and communication channels to maximise impact. This plan also recognises the move towards supporting greater resilience across the whole healthcare system, regardless of the time of year. As part of this process, communications leads have been identified to attend each of the local System Resilience Groups in order to: 1. Understand the local position and outlook 2. Provide Advice 3. Share intelligence and facilitate communications planning across organisations. The aim will be to secure economies of scale by using common materials and maximising partner organisation communication channels, routes and audiences.	The plan relies on the use of national promotional materials e.g. 'Stay Well This Winter,' existing local campaign materials e.g. 'ASAP' and 'Combat Norovirus,' local Web and App tools already in place, direct marketing, targeted social media advertising and local PR and public information broadcasting opportunities.	Assurance plans for the Holiday season are required. The key components of the plan must be : Communication campaign regarding use of alternative services Us of GPs at the front door. Flu campaign. Rapid Response service. Reduction in LoS in community hospitals. Improved response time by transport providers. Improved information sharing by SWAST i.e. alerting to high demand.	Nov-17	C MacFarlane	Amber
	Corporate HR & Divisions	Sickness & Absence	A Robust assurance Framework for the monitoring and proactive management of sickness and absence	Ensure appropriate systems are in place across Divisions and monitor compliance with targets		Oct-17	D Smith	
	Staffing	Infection control	Flu Vaccination Programme to ensure all front line staff and patients are protected	Meeting with Occupational Health to ensure a robust programme and capacity of Staff to meet need		Sep-17	R Minnett	Red

Corporate	Infection control	The Infection Control Team and Communication Team will re enforced the Combat Norovirus campaign. Wards have a copy of the Norovirus toolkit and access to the Trust management of viral gastro enteritis policy. Outbreaks of diarrhoea and vomiting will be managed using the Southwest Norovirus toolkit detailing the escalation procedure for the management and communication of norovirus outbreaks within the Trust. The Infection Prevention and control Team offered extra Norovirus information sessions to the site management teams. Infection Control Nurses will provide an additional service to review outbreaks of diarrhoea and vomiting at weekends and bank holidays from 0830-1215 hours by telephone from home. The DIPC is working closely with our local Public Health team to provide extra information Influenza, RSV and patients with flu like illness also require immediate isolation, priority for isolation must follow trust policy using the priority for isolation policy and the inability to isolate patients must be escalated. The infection prevention and control nurses with help from Comms team launched a flu campaign to increase the numbers of vaccination uptake.	A winter planning meeting with infection control and pathology has taken place with the proposal for a cohort ward for influenza patients should there be another outbreak such as 16/17.	A trigger tool is being developed and will be based upon numbers of positive tests through pathology. The co--hort ward best suited to this would be 9A. Mitigations for service provision for W&C should 9A be required as an isolation suite. Spot check & Hand washing audits to be undertaken in the lead up to Winter.		J Hernandez Sue Clague, S Bonser	Amber
All Divisions	Emergency Planning	The Emergency Planning Officer & Site Team will monitor the issuing of Cold Weather Alerts, and other severe weather warnings as they are issued to the hospital. These will be cascaded to senior managers for awareness and action as required. Further messages will also be issued to staff where necessary to ensure that they are informed of the likely impacts and local actions that they can take to protect themselves and services in the event of cold or severe weather during the winter period. Refer to the Adverse Weather Plan.				R Minnet S Bonser	Red

Appendix 2 – WINTER Plan Risks & Mitigations

Risk	Mitigating Actions	Risk Score
Internal system improvement schemes do not deliver to plan	Operational Capacity Meeting to monitor progress and report confidence levels to ECB on a weekly basis. Review of communications and staff engagement. Senior leadership presence driving delivery	12
Recruitment to key posts unsuccessful (ED, Site team, senior management, Nursing)	Utilisation of all professional skill sets and professions to include pharmacy, phlebotomy, ENP's ANP's and therapies & acting down (Where skills & competencies allow). Release of corporate clinical posts to support clinical services	16
Community Capacity – reablement & packages of care	Immediate escalation to CCG and pathway review for all patients. Top Ten Operational standards implementation to proactively identify changes in demand and capacity	16
System-wide improvement schemes do not deliver to plan	Reviewed by ECB and seek assurance from partners that alternative plans are available and put in place	15
Insufficient capacity to cope with demand	Early decision on bed-base. Proactive management of LOS through SAFER and LoS improvement schemes.	15
Patients remaining in hospital who no longer require acute care	Proactive management of patients on the Medically Stable List through engagement with the OCT, social care and partners ensure system-wide engagement. Clear information for patients on discharge planning and adherence to discharge process by Ward staff	12
Emergency Department attendances increase above plan	Ensure all escalation action taken Allocate additional transfer teams Allocate Senior Site team member to MAU for Flow All senior nursing staff released form meetings to support wards Engagement with CCG system-wide providers. Communications plan.	12
Number of admissions exceeds capacity plan	Implement internal escalation measures Implement Pre-emptive Transfer Policy. Request additional medical board rounds Focus on DWA & TTO Ensure all community capacity utilised Engage with CCG call to gain system-wide support and reinforce alternatives to admission Deliver CIP LoS schemes. Improve discharges; engage with ARRIVA Transport Solutions for additional support.	15
Lack of uptake for seasonal flu vaccination	Early communications campaign Regular data on vaccination rates by clinical area. Example shown by clinical leaders.	12
Loss of capacity for prolonged periods of time due to adverse weather, staff absence, norovirus	Trust escalation plan Trust adverse weather policy Trust Business Continuity Plan.	9
Loss of elective capacity	Explore potential for capacity in private hospitals. Additional day case capacity and as an interim re allocate medical staff to ward and board rounds cross sites to release beds.	12
OOH GP not available	Review staffing rotas, request ENP cover. Engage with CCG and system-wide escalation.	12
Estates works for pathway reconfiguration	Estates works for the reconfiguration of services, GSAU, SAU, MAU & T&O if delayed into winter will impact on the reopening of beds	16

Appendix 3

Internal Professional Standards for a SAFER length of Stay 2017/18

Area	Sub Category	Professional Standard	Target (to be amended based on current performance)
Therapies	All ward patients	All patients referred at board rounds, to be seen within 24 hours of referral	Conservative 85% Stretch 90%
Radiology	ED CT/X-Ray/Ultrasound	Referrals will be scanned within 1 hour of referral received	Conservative 85% Stretch 90%
	ACU CT/X-Ray	Referrals will be scanned within 1 hour of referral received*	Conservative 85% Stretch 90%
	Ward CT/X-Ray	Referrals will be scanned within 24 hours of referral received	Conservative 85% Stretch 90%
	MRI	Referrals will be scanned within 24 hours of referral received**	Conservative 85% Stretch 90%
	Ultrasound	Referrals will be scanned within 24 hours	Conservative 85% Stretch 90%
Pathology	ED Haem ED Biochem	On sample receipt* referrals will be reported within 30 mins for critical, 1 hour urgent, 2 hour routine	Conservative 85% Stretch 90%
	AMU Haem AMU Biochem	On sample receipt referrals will be reported within 30 mins for critical, 1 hour urgent, 2 hour routine	Conservative 85% Stretch 90%
	AEC Haem AEC Biochem	On sample receipt referrals will be reported within 30 mins for critical, 1 hour urgent, 2 hour routine	Conservative 85% Stretch 90%
	Ward Haem Ward Biochem	On sample receipt referrals will be reported within 2 hours On sample receipt referrals will be reported within 2 hours	Conservative 85% Stretch 90%
Pharmacy	TTOs	All discharge medication will be dispensed within 4 hours (excluding compliance aids) provided TTO received in the dispensary by 2pm weekdays. For EASU, AMU and ACUC discharge medication will be dispensed within 90 minutes of receiving the TTO in pharmacy.	Conservative 85% Stretch 90%

*(Currently performing to 4 hour target)

** (Currently performing to 72 hour target)

ITEM 13

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 14

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 15

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 16

PUBLIC QUESTIONS

(Procedure attached)

Peter Lachecki
Chair

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

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

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

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

Written questions for the Board Meeting

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

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

Notice of questions

A question may only be asked if it has been submitted in writing to the 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@glos.nhs.uk No more than 3 written questions may be submitted by each questioner.

Procedure

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

the responses will be recorded in the minutes.

Additional Questions

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

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

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

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

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

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

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