GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 10 May 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

24th April 2018

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
3.	Patient Story			09:02
4.	Minutes of the meeting held on 8 March 2018	**PAPER**	**To approve**	09:32
5.	Matters Arising	**PAPER**	**To note**	09:35
6.	Chair's Update	**PAPER** (Peter Lachecki)	**To note**	09:40
7.	Chief Executive's Report	**PAPER** (Deborah Lee)	**To note**	09:45
8.	Quality and Performance:		**For assurance**	10:00
	• Quality and Performance Report	**PAPER** (Caroline Landon, Sean Elyan, Steve Hams & Emma Wood)		
	• Assurance Reports of the Chair of the Quality and Performance Committee meetings held on 29 March 2018 and 26 April 2018	**PAPER** (Claire Feehily)		
	• Learning from Patient Stories	**PAPER** (Suzie Cro)		
	• Trust Risk Register	**PAPER** (Lukasz Bohdan)		
9.	Financial Performance:		**For assurance**	10:40
	• Report of the Finance Director	**PAPER** (Sarah Stansfield)		
	• Assurance Reports of the Chair of the Finance Committee meetings held on 28 March 2018 and 25 April 2018	**PAPER** (Keith Norton)		
	Break			**11:10 - 11:20**
10.	Workforce:		**For assurance**	11:20
	• Report of the Director of People and Organisational Development	**PAPER** (Emma Wood)		
	• Assurance Report of the Chair of the Workforce Committee meeting held on 1 May 2018	**PAPER** (Tracey Barber)		

11.	Audit and Assurance: • Report of the Chair of the Audit and Assurance Committee meeting held on 20 March 2018	**PAPER** (Rob Graves)	**For Assurance**	11:40
12.	Gloucestershire Managed Services (GMS): • Report of the Chair of the GMS Committee meeting held on 24 April 2018	**PAPER** (Rob Graves)	**For Assurance**	11:50
13.	SmartCare Progress Report	**PAPER** (Mark Hutchinson)	For Assurance	12:00
14.	Board Assurance Framework	**PAPER** (Lukasz Bohdan)	For Assurance	12:15
15.	Minutes of the meeting of the Council of Governors held on 21 February 2018	**PAPER** (Peter Lachecki)	**To Note**	12:25
	Governor Questions			
16.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To discuss**	12:35
	Staff Questions			
17.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To discuss**	12:45
	Public Questions			
18.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**To discuss**	12:55
	Any Other Business			
19.	Items for the Next Meeting and Any Other Business		**To note**	13:05
	Lunch Break			**13:15 – 13.45**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE BOARD ADMINISTRATOR NO LATER THAN 17:00 ON TUESDAY 1st MAY 2018

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 12 July 2018** in the **Lecture Hall, Sandford Education Centre, Gloucestershire Royal Hospital** at **9.00 am.**

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Tracey Barber	Deborah Lee, Chief Executive
Dr Claire Feehily	Lukasz Bohdan, Director of Corporate Governance
Tony Foster	Dr Sean Elyan, Medical Director
Rob Graves	Steve Hams, Director of Quality and Chief Nurse
Keith Norton	Caroline Landon, Chief Operating Officer
Alison Moon	Simon Lanceley, Director of Strategy and Transformation

Sarah Stansfield, Interim Director of Finance
Emma Wood, Director of People and Deputy Chief Executive

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 8 MARCH AT 9 AM

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

PRESENT	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Lukasz Bohdan	Director of Corporate Governance
	Dr Sean Elyan	Medical Director
	Dr Ms Feehily	Non-Executive Director
	Steve Hams	Director of Quality and Chief Nurse
	Simon Lanceley	Director of Strategy and Transformation
	Caroline Landon	Chief Operating Officer
	Steve Webster	Director of Finance
	Emma Wood	Director of People and Deputy Chief Executive
	Tracey Barber	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Alison Moon	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	None	
IN ATTENDANCE	Suzie Cro	Head of Patient Experience Improvement & Deputy Director of Quality
	Sue Fleet	Patient – Patient Story
	Katherine Holland	Patient Experience Manager
	Mark Hutchinson	Digital Recovery Consultant
	Natashia Judge	Board Administrator
	Sarah Stansfield	Director of Operational Finance
	Tiffany Cairns	Senior Nurse Practitioner (Emergency Department)
	Craig Macfarlane	Head of Communications
PUBLIC & PRESS	Two governors, four members of the public.	

The Chair welcomed all to the meeting.

035/18 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

036/18 PATIENT STORY

The Deputy Director of Quality introduced patient Sue Fleet, Tiff Cairns, the Emergency Department (ED) Senior Nurse Practitioner (SNP) and Katherine Holland, Patient Experience Manager who gave a presentation on patients treated in the corridor in the ED. The Patient Experience Manager advised that she had spent time within the ED liaising with patients and carers and observing the care provided. She amalgamated these experiences and the views of patients into a story and fictitious patient named "Beryl". Beryl's experience in ED pointed to numerous positive observations but also a significant number of concerns regarding queues, drinking facilities, being cold, being unable to locate personal belongings, lack of pillows and blankets, lack of privacy, busy staff, and poor communication.

The ED SNP acknowledged the concerns raised in the patient story, and advised that she was personally undertaking her Silver Quality Improvement (QI) project looking at improving patient experience within the corridor. She explained the layout of the ED and stressed that while all steps were taken to avoid treating patients in the corridor, at times of pressure this unfortunately occurred. She also pointed out that when activity peaks occur, if patients were not cared for in corridors they would be left to queue in an ambulance which the service considered less safe so whilst far from ideal it was considered the right approach but the experience of those queuing could be improved which was where the focus was.

The ED SNP advised that a number of steps were being taken to address these issues. These included:

- A newly established ED Patient Experience Group.
- Soup and drinks now available to patients with a tea trolley where patients and relatives can help themselves.
- More blankets have been ordered.
- A noisy door disturbing patients has been fixed.
- A change in the focus of the volunteer force with more volunteers available in the afternoon for feeding.
- Information sheets for patients.
- Increased ED Checklist compliance.

A number of issues remain however, including: safe storage of notes, phone chargers for patients, the need for warmer blankets, the need for a handheld call bell system, lack of portering support and the management of out of hospital paediatric deaths.

The Chair thanked Sue Fleet, the ED SNP and the Patient Experience Manager, for their presentations and invited questions from members of the Board:

- The Director of Quality and Chief Nurse advised that he would investigate the need for warmer blankets and pillows and resolve this as soon as possible. **SH**
- The Digital Recovery Consultant advised that he would investigate the need for calls bells and phone chargers and resolve this as soon as possible. **MH**
- Considering the request for further portering staff: The Director of Quality and Chief Nurse noted the transfer team in the ED and Acute Medical Unit (AMU) but recognised that there had been issues with attracting dedicated porters. The Chief Operating Officer concurred, noting that this needed to be improved for next winter and a pilot was shortly due to commence. **CL**
- The Director of Corporate Governance acknowledged the fantastic work undertaken by staff in the ED and the support of volunteers, and wondered if there was anything further the Board could do to help attract volunteers. The ED SNP responded that there were historical problems with attracting volunteers due to the high pressure environment but that this was being investigated by the patient experience project manager. The Director of People offered the support of her team to think creatively about recruitment. The CEO asked whether we were working closely with our local universities and colleges given the age profile of these potential volunteers, many of whom are study health or social care related subjects and maybe well suited to ED volunteering.
- Ms Moon reflected on how Room 24 was a central theme in many

issues and therefore structure and flow needed to be addressed. The Director of Strategy & Transformation answered that a recent bid for capital would address the physical constraints of the department and explained that at present the Trust was sized for activity levels lower than needed. The Chief Executive asked the Executive Tri to look into what interim changes could be effected to address this issue in the interim. **CL/SE/SH**

- The Director of Quality and Chief Nurse advised that he was delighted to see the inclusion of the tea trolley and the increased compliance with the ED Checklist. He stressed that treating patients in the corridor was not accepted as best and optimal care and that ultimately the aim was to care for no patients in our corridors. The Medical Director highlighted that care in corridors was down to determination to not have patients waiting in ambulances.
- Mr Norton asked the ED SNP what the response was to items needed by the department. She answered that she was listened to much more so now than in the past, and that the patient experience team were very engaged, alongside the Director of Quality and Chief Nurse. The Chief Executive expressed concern that the need for warmer blankets had had to make it as far as the Board before being addressed, and wondered why such a simple problem had not been addressed by the leadership team. Ms Barber concurred and felt assurance was needed around the operational processes.
- Ms Barber wondered if there was anything the Board could do to support recruitment of volunteers, perhaps through the communications team. The Deputy Director of Quality advised that the team were further investigating evening volunteers. Ms Barber suggested a specific message be put out sharing the Trust was seeking volunteers within the ED. The Chief Executive also suggested targeting Gloucestershire University Students in Health and Social Care. The Chair advised that he would shortly be meeting with a local school and would raise volunteering opportunities.
- Ms Feehily reflected on how important such accounts were when considering the Trust Estates. She reflected on the Care Quality Commission (CQC) action plan and the evidence within used to assure the Board on these issues.
- The Chief Executive reflected on the management of out of hospital paediatric deaths, which required the deceased child to be brought to the hospital, and how this could be sensitively managed. The Director of Quality and Chief Nurse would further investigate. **SH**
- The Chair reflected on the comments regarding lack of information. The Deputy Director of Quality advised that cards reminding patients what tests they are waiting for were being progressed.

The Chief Executive praised the ED SNP and her team for the great care delivered, and stressed that the Board would do all that they could to address the issues raised. She advised that complaints regarding the ED were now rare in contrast to a year ago and that she received a great deal of praise.

[The Deputy Director of Quality, Patient Experience Manager, ED SNP and Sue Fleet left the meeting]

037/18 MINUTES OF THE MEETING HELD ON 11 JANUARY 2018

RESOLVED: That the minutes of the meeting held on 11 January 2018 be agreed as a correct record and signed by the Chair.

038/18 MATTERS ARISING

DECEMBER 2017 279/17 QUALITY AND PERFORMANCE REPORT - CANCELLED CANCER OPERATIONS

The Chief Operating Officer would ensure cancellations are reported monthly as art of the regular performance report, as they had been previously.

Completed: Data quality issues since introduction of TrakCare. Remains priority for resolution by InterSystems and workaround now being reviewed as aggregate reporting is still happening. This will be included within the March Quality and Performance Board report.

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

The option of individual reports is being reviewed and this will be explored with the Director of Corporate Governance.

Completed: Changes are underway and this will be reviewed by the Audit and Assurance Committee.

JANUARY 2018 002/18 PATIENT STORY - DISCONTINUATION OF LEARNING DISABILITY TRAINING

The Director of Quality and Chief Nurse and Director of People agreed to investigate training (specifically inclusion in staff induction) and e-learning, including the option of "in-situ" training.

Ongoing: The Chief Executive reminded the Board that the Learning Disability Training had fallen out of induction and the team were calling for re-instatement of face to face training. Director of People to investigate alongside Director of Quality and Chief Nurse. **SH/EW**

JANUARY 2018 002/18 PATIENT STORY - RELOCATION OF SPECIAL DENTAL SERVICES

Chief Operating Officer investigate why special dental services had moved from the Orchard Centre to Day Surgery Unit and whether this was unavoidable given the less positive environment for patients with a learning disability.

Completed: Decision historical to current operational teams. The operational team does take steps to identify patients which may require relocation from the current DSU to main theatres. The operational team is reviewing possible alternatives within the current estate provision. This will be further addressed within Quality and Performance Committee.

JANUARY 2018 010/18 BOARD ASSURANCE FRAMEWORK- MR GRAVES RAISED THE IMPORTANCE OF CROSS REFERENCING THE BAF AGAINST DIVISIONAL LEVELS

The Board discussed this, and agreed that a conversation about the relationship between the Board and divisions be held during a Board Strategy and Development Session.

Ongoing: Discussion held with Chief Executive to progress – date for seminar to be confirmed.

JANUARY 2018 011/18 SIX MONTHLY RESEARCH REPORT - MS MOON FELT IT WAS IMPORTANT TO CONSIDER HOW RESEARCH COULD LINK INTO THE ORGANISATIONAL OBJECTIVES

The Board agreed we should add another strategic objective and asked the Director of Strategy and Transformation to put a proposal to the next Board Seminar.

Completed: Research objective agreed for final approval as part of Board Review of Board Assurance Framework.

JANUARY 2018 002/18 PATIENT STORY - LEARNING DISABILITY TEAM OFFICE SPACE

The Deputy Director of Quality committed to investigating improvements to office space.

Completed: Hot desk office space has been provided within the patient experience team based at the GRH site.

JANUARY 2018 002/18 PATIENT STORY - DOCTOR ENGAGEMENT

The Medical Director to meet with the Learning Disability Team to discuss doctor engagement and F1 training. He would also investigate the possibility of doctors joining the team on the "Find You Way Around The Hospital" sessions run by the LD team.

Completed: Short interactive training programme for foundation doctors being developed. Dr Elyan to join in on "Finding a Way Around the Hospital" event.

JANUARY 2018 003/18 MINUTES OF THE MEETING HELD ON 13 DECEMBER 2017 - MINUTE AMENDS

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

Completed: Amendments made.

JANUARY 2018 006/18 CHIEF EXECUTIVE REPORT - MR GRAVES NOTED THE RECENT PERFORMANCE CHALLENGES AND HOW STAFF HAD RESPONDED

The Chair agreed to circulate a letter to all staff acknowledging their extraordinary efforts and contributions.

Completed: Via Chief Executive weekly blog link.

JANUARY 2018 010/18 BOARD ASSURANCE FRAMEWORK - CONSULTANT INTERVIEW QUESTIONS

The Board agreed that the questions actually asked should be captured and used instead. The Chief Executive said that she had asked the Medical Director to consider whether our current approach to consultant recruitment reflected best practice. He said that the Deputy Medical Director was reviewing this.

Completed: The questions the panel used were reviewed and resubmitted for future interviews.

JANUARY 2018 011/18 SIX MONTHLY RESEARCH REPORT - THE DIRECTOR OF CLINICAL STRATEGY PRESENTED THE SIX-MONTHLY RESEARCH REPORT AND NOTED THAT ANNEXE A WAS MISSING FROM THE REPORT.

She would share this with the Board Administrator to update.

Completed: Uploaded.

JANUARY 2018 011/18 SIX MONTHLY RESEARCH REPORT - THE CHIEF EXECUTIVE QUERIED WHAT LEADERSHIP LOOKED LIKE WITHIN THE TEAM AND FELT THERE WAS AN OPPORTUNITY FOR GROWTH IN NON-MEDICAL AND NON-CLINICAL RESEARCH

The Associate Director of Research and Development agreed to further discuss this with the Director of Quality and Chief Nurse.

Completed: Meeting arranged for 7th March 2018 to discuss.

JANUARY 2018 011/18 SIX MONTHLY RESEARCH REPORT - RESEARCH AND INNOVATION FORUM MEETING

Ms Moon to join the meeting.

Completed: Invited to the next meeting.

039/18 CHAIR'S UPDATE

The Chair reflected on the number of people who give up their time volunteering and raising funds for the Trust and the wider NHS, including the Trust's 500 Volunteers, the Free Wheelers Charity, the new Trust Muslim Chaplain, the Muslim community who have raised a great deal of money for the Trust, the Friends of the Hospitals and the Governors. He expressed thanks to all.

He also noted the work being undertaken around red blankets for patients susceptible to falls by Dr Tanya De Weymarn (Consultant in Emergency Medicine) and felt such a creative scheme brought light to the issue in a simple way.

040/18 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented her report to the Board and advised that the performance headlines contained within it had been presented to the Health Care Overview and Scrutiny Committee (HCOSC) earlier in the week who had commended the Trust and wider system's performance over winter.

Key points within the Chief Executive's report were as follows:

- The improvements in performance against a wide range of 'winter' metrics; all of which reflected improvement on the prior year's performance.
- Quality progress and the improvement journeys which have led to improved sepsis performance and month by month improvements in the Hospital Standardised Mortality Ratio (HSMR). The improvements in HSMR are supported by improvement work focused on fractured neck of femur and the Medical Director's work with teams to change practice.
- The performance of the system in relation to delayed transfers of care and the improvements worth celebrating, with Gloucestershire County Council one of the highest performing councils in England. The Chief Executive acknowledged however that there are still delays in other aspects of care.
- News regarding the Trust's bid for Sustainability and Transformation (STP) capital of £40m was still awaited. The Finance Committee and Trust Board had recently approved the investment of £920k of nationally awarded capital to develop the CGH Emergency Department; significant enabling moves were also required and every effort was being made to ensure that services which needed to move would also benefit.
- Information on the Trauma & Orthopaedic reconfiguration was presented to HCOSC and met with positive feedback.
- The Trust is delivering dramatic improvements in terms of stroke care. Further progress is needed, but this largely relates to system wide plans for a specialist community stroke rehab team. It is hoped that this will be established prior to next winter.
- The Trust is being visited by John Lester from NHS Improvement as part of the regulator's due diligence on the Financial Governance Review recommendations and resulting action plan with a view to lifting the current Enforcement Notice.
- The Trust Board has made a decision to establish an Estates and Facilities subsidiary company (SubCo). This decision was deliberated in great detail and, while not an easy decision, the Board believes this model gives the Trust the best chance of addressing the challenges facing these services, without recourse to an outsourced model. The Chief Executive stressed the importance of the Trust remaining connected to its subsidiary and noted that while at day 1 it would be business as usual, an improvement journey would be progressed over

the next 12 months.

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

- Ms Feehily requested information on the work around the TrakCare recovery work and specifically how this was affecting the Trust financially. The Chief Executive advised the Board that good progress was now being made under Mark Hutchinson's leadership though the project was not moving at the pace that patients require; this was due to its complexity but she was confident the approach was the right approach and would result in embedded and therefore sustained improvement. Governance is much improved and metrics are being scrutinised, with graphics and user reference guides now created. Data is beginning to be cleansed and a project has been broadly scoped in three phases, with phase 2 most visible to staff and expected to commence in June with the launch of a new approach to outpatient 'out-coming'. A considerable amount of validation work is still required and external support for this is being procured. A trajectory is expected to be seen at the next SmartCare Programme Board. Positively, the number of complaints and calls to the Patient Advice and Liaison Team (PALS) related to TrakCare has reduced significantly. The Digital Recovery Consultant updated the Board further, pointing out that data quality issues and reporting functionality were being worked through and problems pinpointed. The team are working to address the background technical issues.
- Alison Moon noted the recent visit from the University of Bristol around medical training. She advised that a well understood rule of thumb was that if staff are offered a good experience this reflects well on patient experience. In pressurised times student training can suffer. Ms Moon praised the Medical Director for his work in this area. She queried how the Trust faired in comparison to others. The Director of Quality and Chief Nurse advised that in regards to the University of Gloucestershire the early feedback was positive. Ms Moon felt it would be helpful if going forward the areas with variable student experience were investigated to see if there was any correlation with patient experience and retention of substantive staff. The Director of Quality and Chief Nurse answered that this was part of the triangulation process and the importance of bringing individuals together in order to get a rounded view of care delivered to patients.
- Mr Graves queried how the Trust was engaged with the timetable for the proposal to become an Integrated Care System. The Chief Executive noted that the System had submitted the proposal before the deadline however there is currently no timetable with milestones beyond the submission date. The Chief Executive reflected on the bigger issues around control totals and partners' concerns in this regard and agreed to keep the Board briefed as the bid progressed.

041/18 QUALITY AND PERFORMANCE:

QUALITY AND PERFORMANCE REPORT

The Chief Operating Officer presented the Quality and Performance Report and provided a contemporary update, noting:

- Performance against the 4hr A&E Standard for January 89.7% with a 10% increase in attendances on last year which contrasted to the national picture still placed the Trust in the upper quartile.

- No significant ambulance delays and the Trust continues to work well with the ambulance teams.
- The Trust is currently at 86.3% against the two week wait cancer standard and remains on track to achieve the national standard in June 2018..
- There has been deterioration against the 62 day Referral to Treatment (RTT) performance standard and this is in relation to tumour sites in Lower GI, Lung and complex Head and Neck however this links to a loss of capacity associated with unexpected weather and CL said that she remained confident that the standard would be delivered from June 2018.
- The Trust continues to meet the diagnostic standard.
- The Trust continues to not report on RTT but the team are working on the recovery of TrakCare as this is integral for delivery. Work is also underway around clinic templates and understanding of capacity and demand. There is currently a six week delay in the programme and any impact of this on the return to reporting is being reviewed.

The Director of Quality and Chief Nurse further advised the Board that:

- There has been a slight decline in the Friends and Family Test (FFT) results with regards to inpatients; however, there has been an increase in outpatients and maternity.
- Compliance against the ED Checklist was 72% for January and 81% for February against the 90% standard.
- With regards to infection control there have been 45 Clostridium Difficile cases, i.e. 5 above the target. The Quality and Performance Committee have undertaken a number of deep dives around Clostridium Difficile and an improvement programme is in place, to deliver improvements over the next year.
- The Safety Thermometer harm-free care rate was 90.1% for January which represents a slight reduction. This is being reviewed with teams.
- Complaints answered within the Trust timescale have reduced over the past few months from 60+ to 20. While further progress is still needed the improvement was recognised.
- There has been a significant increase in the number of patients leaving the ED without being seen which was surprising given the improvements in waiting time. The Chief Executive asked the COO to investigate this and feedback to the next Board **CL**

In response, the following points were raised by the Board:

- The Medical Director added that he had recently attended the Cancer Clinical Programmes Group where cancer waiting times were discussed with the Clinical Commissioning Group and primary care colleagues. There was acknowledgement of the tremendous progress around two week wait patients and the effort around redesigning pathways. The Chief Executive acknowledged that this was a crucial part of sustainable care and whilst the design has taken longer than anticipated it has moved the Trust forward.
- Keith Norton noted the final sentence of the executive summary which summarised that “the position for the Trust in a number of key performance metrics is significant” He felt this could be a stronger statement and explained further given such good progress.
- Rob Graves acknowledged the progress the Trust was making but stressed his point made at a previous Board that the summary scorecard was not necessarily reflective of this. The Director of Quality and Chief Nurse advised that this was being reviewed and will be

addressed in the new financial year. The Board discussed this and agreed that metrics needed reviewing and improvements conveyed, even when the Trust was not achieving the constitutional standards. Mr Graves queried the Hospital Mortality Indicator and felt this was unclear. The Chief Executive requested all graphs have clear labels and axis and that this be addressed for Quality and Performance Committee. **CL/SH**

- Ms Moon noted that the Quality and Performance Committee were investigating Clostridium Difficile and felt it was important that for the next year the Trust must have fewer cases than the limit. She wondered whether the Associate Director of Infection Control role had been filled. The Director of Quality and Chief Nurse answered that interviews had taken place and the role had been offered to an exceptional individual and further news would follow. Post meeting note – Mr Craig Bradley has been appointed into post from University Hospitals Birmingham where he holds a similar role.
- Mr Foster felt the Quality Indicators could be split further. The Director of Quality and Chief Nurse advised that Quality had three bundles: patient experience, outcome and safety therefore the team will aim to work across these going forward as well as using the NHS Improvement (NHS) outcome framework and five domains of the CQC. The Chief Executive felt this was a considerable piece of work and the team would need to spend time getting this right but the Executive Operational Triumvirate had the work in hand.

RESOLVED: That the Trust Board receive the report as assurance that the Executive Team and Divisions fully understand the current levels of performance and have actions plans to improve the position where it is required. The Board noted the very positive trends.

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE MEETINGS HELD ON 25 JANUARY 2018 AND 22 FEBRUARY 2018

Dr Feehily presented the assurance reports from January and February noting the following from the Committees:

- The comprehensive CQC action plan had been reviewed at February Committee. The Committee reviewed actions to ensure they were being progressed. Highlights would be included in future Chair Assurance Reports. **CF**
- The review of Serious Incidents and Never Events and their relationship with the Risk Register. The Director of Safety is supporting the Committee well and there is progress with learning and tracking of this.
- Time has been spent on core standards, understanding the cancer pathway and how the Committee can get to the heart of communicating with long wait patients.
- Safer Staffing and work underway to draw out a more holistic understanding of the position on the wards with proportions of permanent staff against temporary staff and what enables executives to understand if the wards are as safe as can be.

The Director of Quality and Chief Nurse advised that the team were clear in terms of the red rating items on the CQC Improvement Plan; conversations are being had within the Trust Leadership Team also. The internal auditors are also auditing the Must Do Action Plan; this will go to the next Audit and Assurance Committee. Importantly, the residual 2 RED rated must do actions were now due to be closed out.

RESOVED: That the report be noted.

LEARNING FROM DEATHS

The Medical Director presented the report to update the Board on the Trust's progress on learning from death reviews:

- The Medical Director praised the Bereavement Team and the considerable work done to improve the recording of deaths within the Trust. A consistent, reliable approach is now in place, which is supported by each death being reviewed by the Medical Examiner.
- High-level notes reviews are supporting learning as well as process improvement.
- Progress is also being made with regards to family engagement.
- The Trust Hospital Mortality Group has seen a change amongst Divisions with commitment to drive improvement projects.

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

- The Chair recognised that the learning from divisional death reviews to develop overarching themes of learning would take some time and wondered what the barriers to this were. The Medical Director answered that a barrier was consistent system recording of death and embedding this within the specialities.
- Mr Foster questioned how the HSMR graph should be interpreted: whether performance was reducing or plateauing and if so why. The Medical Director answered that there were two main drivers to the improvements: reductions in mortality around sepsis and pneumonia and the concept of expectation of death and recording of this.
- Mr Graves questioned how the Medical Director ascertained that he should be satisfied with progress at this point. The Medical Director answered that he sat with the Academic Health Science Network on this subject and that there were only one or two Trust's ahead, with most Trust's in a similar position, as many Trusts were struggling with family involvement. He advised that he felt the Trust was leading the way in respect of involvement across the community. Mr Graves wondered whether there was national written guidance to measure achievement, and the Medical Director answered that with regard to some aspects there was, but good family engagement was not defined.
- The Chief Executive asked about the weekend mortality issue, which came up through the Quality Dashboard. The Medical Director explained that aside from one Trust, all hospitals in the country had a higher mortality rate for patients admitted on Saturdays and Sundays. The explanation for this was complicated, and that while it had been suggested that care felt short on weekends, patients are much more likely to receive senior medical review. A recent paper published by the Lancet found that patients admitted at the weekend were sicker than those admitted during the week. Figures are falling within the expected range. The Chief Executive requested the next report include benchmarking against other Trusts to establish whether the difference in our Trust was comparable to that of others. **SE**

RESOLVED: That the Board accept the update as assurance of progress of the Trust's death review process but requested further relative data to be included in future reports.

TRUST RISK REGISTER

The Director of Corporate Governance presented the Trust Risks Register to Board, noting that this was received as a late paper so that the Board was able to review the most up to date picture following the Trust Leadership Team's meeting held on the previous day. The Director of Corporate Governance noted the five new entries and advised that while the Board normally sees risks rated 15 and above (and 12 and above in the safety domain), this one a risk with a rating of 5 was included. This is because while the likelihood of this risk is rare (i.e.1), should it occur the consequences would be catastrophic (5).

The Chair queried why risk *C1798COO – The risk of delayed treatment and diagnosis due to delays in follow up in care in a number of specialities including neurology, cardiology, rheumatology, ophthalmology and ENT* had been added. This Chief Executive advised this was a composite risk created because a number of specialities were recording this, and therefore it was added to provide Board oversight.

RESOLVED: That the Board 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.

042/18 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE DIRECTOR

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

- The financial position of the Trust at the end of Month 10 is an operational deficit of £29.5m. This is an adverse variance to budget and NHSI plan of £6.5m.
- No Sustainability and Transformation funding (STF) has been assumed in the actual position, given that the Trust has not agreed a control total for the 2018/19 financial year.
- Cost Improvement Plan (CIP) delivery to month 10 is £20.4m. This is £5.4m adverse variance to the plan.
- The current CIP delivery forecast for the year is £28.2m as compared to a £34.7m plan.
- The forecast outturn is £28.7m which is £14.1m adverse to plan. This is a £0.9m deterioration from the previous forecast outturn, which relates to the crystallisation of an existing income risk relating to specialist commissioning. The risk around specialist commissioning has been consistently flagged to NHSI throughout the year.
- While pay expenditure decreased through the autumn, January saw the pay bill increase. The team had been investigating the factors behind this and it is attributed to emergency pressures and additional medical nursing and December bank holiday premiums.
- Areas of anticipated pressure include pay expenditure, which could continue to increase, and pass-through drug income. The understanding of fluctuations in the pass through drugs income has been debated within Finance Committee.
- In order to get back to the forecast position, setting aside the specialist commission, further CIP is needed. A number of opportunities have been identified. The Trust is forecasting that it will achieve the core forecast plus the deterioration in specialist commissioning; however there is a risk around this.

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

- The Chief Executive noted that a risk had emerged in the last week that a sum allocated to the Trust from NHSI/ NHSE may not materialise. This is not included within the position presented. Dialogue is underway with NHSE and NHSI as £250k was confirmed as funding which has been committed, however the Trust was advised this week that only £50k would be made available to the Trust. Post meeting noted; the full 250k was provided following escalation by the CEO.
- Mr Graves felt the report highlighted the odd phasing in the original budget for the year with the variance changes in the last two months, in particular the underspend on non-pay. He stressed that the team needed to be alert when looking at phasing for future years. He also noted that the detailed cash flow did not reconcile with the balance sheet with differences in the closing balance. The Finance Director would investigate. **SW (now SS)**
- The Chief Executive reminded the Board that the phasing was examined in great detail by the Board and there were several material issues. This year's plan may have similar phasing.
- Dr Feehily reflected that the Board were seeing a consistent level of financial reporting, particularly around CIP, with nothing introduced that was not flagged at an earlier point, suggesting good comprehensive levels of variables and relationships. She wondered whether anything had arisen which was not anticipated to which the Finance Director answered that there were no major new factors but a number of positive and negative variables.
- The Director of Quality and Chief Nurse noted the month 10 pay position but highlighted that although bank spend had increased, agency spend had decreased which is therefore a positive movement despite being focused on temporary staff.

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

ASSURANCE REPORTS OF THE CHAIR OF THE FINANCE COMMITTEE MEETINGS HELD ON 31 JANUARY 2018 AND 28 FEBRUARY 2018

Mr Norton presented the January and February assurance reports:

- The level of scrutiny around the forecast ensuring that all elements are included.
- Budget setting for 2018/19, the delegation of budgets and assurance that budget holders are involved and understand what they can spend. These were acknowledged to be a little later than last year.
- The fantastic CIP performance despite the challenges and the extraordinary work undertaken by staff.
- Medical Productivity and how this will be split into three projects in order to gain grip alongside further resources as the view of the Committee is that there are still benefits to be gained.
- Finance Committee approval for the application of the Trust Seal to the Mandatory Rate Relief Claim which was being pursued by a collection of NHS Trusts, at its January meeting.

RESOLVED: That the report be noted and that the Board supports the decision to progress with the legal proceedings related to the business rates challenge.

[The Board adjourned for 10 minutes]

043/18 WORKFORCE

REPORT OF THE DIRECTOR OF PEOPLE AND ORGANISATIONAL DEVELOPMENT

The Director of People and Organisational Development presented the Workforce report and emphasised the key points noted within:

- There have been further reductions in turnover which now stands at 11.8%. This is close to the target of 11%. Nursing turnover is the lowest in the South West.
- The Trust's annual sickness absence rate of 3.93% is significantly lower than the national average for Large Acute Trusts.
- Appraisal compliance deteriorated in January however this is largely related to new mandated safeguarding training and is expected to improve in the coming months.
- There are concerns regarding long term sickness which accounts for 49% of all sickness. Peer review of the policy around sickness management is underway but there is no evidence that the Trust's approach is not robust.
- A project is currently underway with Health Case Assistants investigating absence and turnover.
- The response rate to the staff survey was 47%; while this is down 3% from last year is still 3% over the national average for acute Trusts. The Trust Leadership Team are reviewing the results and feedback from staff to address the issues and triangulating with other sources of staff feedback. The Director of People confirmed that a Staff Experience Group was being set up to oversee the collation and analysis of staff experience insights.
- The Sustainable Workforce Group now has a much more focused agenda looking at future roles developed to different profiles, which would result in longer term CIP savings while maintaining the same level of patient care and standards. An HR Business Partner has been seconded into the corporate team to lead on this.
- A new system is in place for talent management and succession planning and this will likely be launched in May subject to adequate progress with the Trust's new intranet.
- Health and Safety and Health and Wellbeing agenda now fall within the Director of People's portfolio and she will be investigating how to meet corporate objectives. There are ongoing concerns around musculoskeletal and psychological issues related to staff absence and wellbeing. A new service offer is being scoped and the business case is expected towards the end of March / early April.

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

- The Director of Quality and Chief Nurse was pleased to see a reduction in turnover for nurses and health care assistants. He was however struck by the overall sickness absence rate during December and January. While this has increased, it is lower than previous years; The Director of Quality and Chief Nurse wondered if this was related to increased flu vaccination rates and advised that he was committed to further improving the flue vaccination take up for next winter. He expressed concern regarding the establishment and registered nurse vacancies and confirmed that addressing nursing and HCA vacancies was one of his highest priorities. The Director of People advised that

she was seeking to unpick reporting and look at trajectories for bulk roles and investigate supply and demand. The Trust can then tweak its approach. Collecting data and business information was noted to be difficult. SH noted the risk to nurse recruitment arising from vacancies in the recruitment team and confirmed that he and EW were discussing how to address this.

- Ms Moon wondered if there had been any further thoughts about a more systematic approach to real staff feedback. The Director of People advised that this had been discussed at Trust Leadership Team (TLT), which acknowledged that the Staff Survey results were six months out of date on publication. She felt pulse surveys in areas where problems are suspected would be sensible. Ms Moon stressed that the priorities in response to the staff survey should be more intuitive. Progressing this sat in the soon to be established Staff Experience Group.
- The Chair acknowledged the concern regarding staff engagement with staff feeling is it the Board talking to them rather than engagement taking place with supervisors and managers. 100 Leaders have previously considered how they can be move visible and the Chair queried whether staff engagement models would be reviewed. The Director of People advised this was also being investigated and the ability to manage teams would fall within the talent management piece.

RESOLVED: That the Board note performance against key indicators and the progress made against our 6-12 month priorities.

GENDER PAY GAP ANNUAL REPORT

The Director of People noted that the report contained the information published as part of the legal requirement to participate in national Gender Pay Gap reporting, whilst making sense of the data within the context of Gloucestershire Hospitals Trust. She explained that any gap over 5% needed to be examined and the factors at play investigated. The report stated that:

- There was no gender pay gap in the non-medical workforce
- There is a gender pay gap wider than 5% (c25%) within the medical workforce. However the analysis concluded this is attributable to two factors:
    - Pay systems are based on length of service and there are a greater number of men with longer service.
    - Clinical Excellence Awards are a key part of consultant remuneration and also impacted by length of service.

- The Director of People therefore explained that this was an objectively justified gap and not a concern for the Trust. She anticipated that as the Trust continues to recruit more women to consultant posts, this gap will reduce.
- The report also contains analysis undertaken around recruitment trends. The report demonstrates a small bias to the appointment of men in the Agenda for Change bands 1-4 and a bias to women in bands 5-8. The Director of People drew the Board's attention to the absence of bias at shortlisting (where applications were anonymised for gender and name). She stressed that she was assured that all interviews included a trained interviewer to ensure no inappropriate bias was being introduced at interview. Moving forward the team will run campaigns to insure panels are fair as well as providing unconscious bias training.

The Board highlighted that the full report was not included within the pack. The Board Administrator would circulate this and upload to the website. In response **NJ**

to the Director of People, the following points were raised:

- Ms Barber felt that although the gender pay gap was important, a crucial factor was equality of opportunity, irrespective of where staff sat within the organisation. She felt the Board needed to ensure that we are enabling people, irrespective of gender, to achieve what they wished to achieve. She summarised that while the Trust was better than most organisations, they could be better still. The Chief Operating Officer concurred, and felt the historical patriarchy in medicine was visible in the figures: highlighting the inequality of access 40 years ago. She was heartened to see the Trust recruiting more women and the improved quality of access.
- The Chief Executive asked whether the analysis had adjusted for the impact of length of service and, if so, did it demonstrate that the medical pay gap could be wholly attributed to this factor. The Director of People answered that if length of service was 'normalised' then no gap was present.
- The Chief Executive stated that she was not convinced that the Clinical Excellence Awards were directly linked to length of service but were in fact linked to many other factors that made them more accessible to some groups above others, for example full time workers. She requested further assurance that the Clinical Excellence Awards process was not favouring one staff group, including gender, over another and evidence that the gap evident between the pay of male and female medical staff could be objectively justified, be presented to the Workforce Committee. **EW/ SE** **EW/ TB**

The Chair queried where attention to equal opportunities was addressed within the Workforce Strategy. The Director of People answered that this was within the Diversity Strategy. The Chair felt this could be further emphasised and discussed at the next Workforce Committee.

RESOLVED: That the Board note that there is no Gender Pay Gap across our Non- medical workforce, which accounts for 82% of the total workforce.

That the Board be advised that collectively, the gender pay gap report shows a pay gap of 11.52% (median hourly rate) when both medical and non-medical staff groups are combined driven by a gap of 25% in medical workforce.

The Workforce Committee was asked to further investigate the evidence associated with the medical pay gap and present back to the May Board.

ASSURANCE REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE MEETING HELD ON 8 FEBRUARY 2018

Ms Barber presented the assurance report from February noting the following from the Committee:

- Work was underway to ensure the right people are recruiting into the Bank to support temporary staffing.
- There was a focus on talent management and how the Trust approaches appraisals and talent.
- A deep dive was underway into sickness absence, recruitment and retention within HCAs
- The importance of nursing and medical representation within the Committee was stressed to ensure fusion between the Workforce and Quality and Performance Committees.

RESOLVED: That the report be noted.

044/18 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 16 JANUARY 2018

Rob Graves presented the January assurance report noting the following from the Committee:

- Work had been undertaken to improve the process around recommendations and how these are progressed. This has highlighted past inadequacies and is being firmed up moving forward.
- New internal auditors will be beginning in the new financial year – a detailed meeting is planned in the next week.
- There will be a detailed financial review of the year end before the accounts are finalised, similar to last year.

The Chair queried whether there were any key items he wished to progress with the internal auditors, to which he answered there were many, including internal control framework and review of clinical audit.

RESOLVED: That the report be noted.

045/18 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

The Medical Director presented the report which outlined a number of exception reports in the period from November 2017 to January 2018. He congratulated the new Guardian of Safe Working Hours, Dr Simon Pirie, on his recent appointment and praised the positive impact Dr Pirie has had, noting that Dr Pirie would attempt to attend and present the report personally as often as possible.

There has been a rise in the number of exception reports for November, December and January. The Medical Director advised caution with regards interpretation of this, as the new reporting system, Allocate, came into place in October and therefore some of the rise can be attributable to this. The Medical Director reflected on the importance of overlaying the data alongside the information from the Deanery and Staff Survey to identify areas under particular pressure such as Urology, Gastroenterology and General Surgery. He reminded the Board that the layout of the report was dictated nationally.

In response to the Medical Director, Ms Barber wondered where the Trust sat in comparison to others. The Medical Director advised that this can be difficult to ascertain as there is no database published nationally but the guardians do meet. Ms Barber felt this made benchmarking difficult and therefore the Chief Executive requested that the Medical Director further investigate. **SE**

RESOLVED: That the Board accept the report as assurance.

046/18 NHS IMPROVEMENT UNDERTAKINGS

- **FINANCIAL UNDERTAKINGS**
- **ACCIDENT & EMERGENCY UNDERTAKINGS**

The Chief Executive presented an update on the Trust's NHSI undertakings in relation to Financial Governance and A&E as part of the quarterly progress review.

The Chief Executive noted that the Financial Undertakings had been to the Finance Committee and drew the Boards attention to the two actions that, while not green, were on their way to being so. This is because while the actions themselves have been completed, unfortunately they did not deliver the expected results.

The Chief Executive noted that the A&E undertakings had been to the Quality and Performance Committee and highlighted that since that review the final action, relating to the Safety and Experience Review Group, has changed from amber to green. The plans are further set out within the report.

Feedback is expected from the NHSI regional panel in early April.

RESOLVED: That the Board note the progress against the actions described and confirm that this is sufficient assurance to recommend to NHS Improvement that the Trust believes it has discharged the Undertakings set out in the 2016 Enforcement Notice.

047/18 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 18 OCTOBER 2017 AND 6 DECEMBER 2017

RESOLVED: That the minutes be noted.

048/18 GOVERNORS' QUESTIONS

Anne Davies, Public Governor for the Cotswold Constituency raised two questions:

- The first regarding the patient experience report and the emergency department. She queried how patients were prioritised as they come in and noted there was no mention of mental health patients. She wondered if there was a designated room for mental health patients and whether they were classified as urgent. The Director of Quality and Chief Nurse answered that there was a designated room at Gloucestershire Royal Hospital with one being created in Cheltenham General Hospital. He also advised that mental health patients were classified according to their severity and that all patients were expected to be triaged within 15 minutes of arrival and more than 90% now were.
- The second question regarding the high rate of sickness amongst Health Care Assistants (HCAs). On a recent nurse induction day a HCA mentioned that they felt unable to advance, and Anne Davies reflected that a feeling of being stuck may increase the amount of sickness days taken. She wondered if this had been examined. The Director of People answered that there were numerous career paths to develop from HCA to nurse and develop the role of those that remained HCAs but agreed that further attention to this was crucial if turnover rates were to be reduced and also reflected that we should be clear with HCA applicants about what they could expect in respect of progression.

The Lead Governor raised the following points:

- He found it discouraging that the issues raised within the patient story were not addressed by management.
- Concern was expressed regarding consistency of colour usage, with

yellow and purple used in some reports. The Chief Executive agreed that the Red, Amber, Green (RAG)-rating against milestones, as used in the Board Assurance Framework, was to be used moving forward.

- TrakCare was noted to have been a public agenda item which is now discussed in private. The Chief Executive noted this was simply due to a change in personnel and noted that this would be moved back to the public session starting at the next Board. **NJ**
- He felt the Learning from Deaths report was more informative and advised that he was a patient representative on the National Committee working on this issue. He also advised that he had asked for definitions regarding mental illness consistently, but no answer had been received as yet.
- New external auditors were noted and the Lead Governor wondered who would hold them responsible for actioning what was promised on recruitment. Rob Graves advised that he would raise this with them when they next met. **RG**
- He praised a recent Governors' Quality Group and the representation from 2gether Trust and hoped that this was the beginning of many meetings involving partners. The Director of Quality and Chief Nurse felt a similar focus on Child Safeguarding would be good.

049/18 STAFF QUESTIONS

There were none.

050/18 PUBLIC QUESTIONS

There were none.

051/18 ANY OTHER BUSINESS

The Chair highlighted that this would be the Director of Finance's last Board meeting and thanked him for all of his work.

Mr Graves reflected on the patient story and its operational nature. He requested a list of what is and isn't addressed, which the Chief Executive reminded him would be covered as part of the quarterly patient story actions' report which now came from the Director of Quarterly..

052/18 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9 am** on **Thursday 10 May 2018** in the **Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital**

053/18 EXCLUSION OF THE PUBLIC

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

The meeting ended at 12:30pm.

Chair
10th May 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MAY 2018

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
March 2018	January 2018 011/18 Six Monthly Research Report	**SL**	Ms Moon felt it was important to consider how research could link into the organisational objectives.	The Board agreed it may be worth adding another strategic objective and asked the Director of Strategy and Transformation to put a proposal to the next Board Seminar.	*Ongoing:* *Revised objective discussed at Board Strategy & Development session on 18th April. Feedback to be shared with Research team and refined objective to be agreed by Executive Team in May.*
May 2018	March 2018 036/18 Patient Story	**MH**	Call bells and phone chargers for A&E.	The Digital Recovery Consultant advised that he would investigate and resolve this as soon as possible.	*Ongoing - The infection control implications of introducing buzzers are being appraised. The issue around phone chargers is however completed.*
May 2018	March 2018 047/18 Governors' Questions	**RG**	New external auditors were noted and the Lead Governor wondered who would hold them responsible for actioning what was promised on recruitment.	Rob Graves advised that he would raise this with them when they next met.	
May 2018	March 2018 041/18 Quality and Performance Report	**CL**	There has been a significant increase in the number of patients leaving the ED without being seen which was surprising given the improvements in waiting time.	The Chief Executive asked the COO to investigate this and feedback to the next Board	*Ongoing: Work being undertaken by ED team to understand trends re:patients leaving without being seen. Hilary Lucas leading with teams and analysis will be collated for qtd 1.*

March 2018	January 2018 002/18 Patient Story	**SH/EW**	Discontinuation of Learning Disability Training.	The Director of Quality and Chief Nurse and Director of People agreed to investigate training (specifically inclusion in staff induction) and e-learning, including the option of "in-situ" training. <u>March update:</u> The Chief Executive reminded the Board that the Learning Disability Training had fallen out of induction and the team were calling for re-instatement of face to face training. Director of People to investigate alongside Director of Quality and Chief Nurse.	<u>*Completed:*</u> *The Director of Quality and Chief Nurse has reviewed the current provision of learning disability training.* *We currently have a number of opportunities to support staff in better understanding the needs of patients with learning disabilities.* - *-eLearning package is available for all staff and will be made "essential to role"* - *-We are revising the HCA apprenticeship programme which will include a day on Patient-centred care and this will include learning disability.* - *-A café slot – will be available at corporate induction as part of the wider response to improving understanding of 'adults at risk' (safeguarding)* - *-There are learning disability champions throughout the Trust and they have a remit for promoting best practice locally* - *Preceptorship for newly qualified nurses has a session on equality and diversity, which includes*

					learning disability. - *- A designated section on the Trust intranet site which provides useful information and signposting for staff.* -
March 2018	January 2018 010/18 Board Assurance Framework	**PL**	Mr Graves raised the importance of cross referencing the BAF against divisional levels	The Board discussed this, and agreed that a conversation about the relationship between the Board and divisions be held during a Board Strategy and Development Session.	*<u>Completed</u>* *This topic is now scheduled to be an agenda item for the June Board Strategy and Development Session.*
May 2018	March 2018 036/18 Patient Story	**SH**	Warmer Blankets and pillows for A&E.	The Director of Quality and Chief Nurse advised that he would investigate and resolve this as soon as possible.	*<u>Completed.</u>* *The Director of Quality and Chief Nurse has worked with Tiff Cairns to identify alternative suppliers for disposable blankets, similar to those used by the South West Ambulance Service NHSFT. A pilot has commenced with using new fleece type blankets, formal evaluation will give consideration for future use.*
May 2018	March 2018 036/18 Patient Story	**CL**	Considering the request for further portering staff: The Director of Quality and Chief Nurse noted the transfer team in the ED and Acute Medical Unit (AMU) but recognised that there had been issues with attracting dedicated porters.	The Chief Operating Officer concurred, noting that this needed to be improved for next winter and a pilot was shortly due to commence.	*<u>Completed</u>* *Trial of dedicated porter transfer team commenced in April, proved successful and more robust than rostering HCAs. Trial extended into May, Hilary Lucas linking in with portering team to understand cost and potential.*

May 2018	March 2018 036/18 Patient Story	**CL/ SE / SH**	Ms Moon reflected on how Room 24 was a central theme in many issues and therefore structure and flow needed to be addressed. The Director of Strategy & Transformation answered that a recent bid for capital would address the physical constraints of the department and explained that at present the Trust was sized for activity levels lower than needed.	The Chief Executive asked the Executive Tri to look into what interim changes could be effected to address this issue in the interim.	*Completed:* *The Chief Operating Officer, Medical Director and Director of Quality and Chief Nurse have reviewed the issues relating to room 24. The recent capital bid will alleviate the physical constraints of the emergency department, in the meantime there is continued focus on operational flow and use of appropriate side rooms and space (within the emergency department and out with)should the need arise.*
May 2018	March 2018 036/18 Patient Story	**SH**	The Chief Executive reflected on the management of out of hospital paediatric deaths and how this could be sensitively managed.	The Director of Quality and Chief Nurse would further investigate.	*Completed* *The Director of Quality and Chief Nurse has reviewed with the Divisional Chief Nurse for Women's and Children's and Director of Midwifery alternative access points for deceased children. Suitable alternatives to the emergency department have not been identified, as such will continue to deal with such cases sensitively and ensure that patients who are in the corridor are not exposed to such situations.*
May 2018	March 2018 041/18 Quality and Performance Report	**CL/SH**	Mr Graves queried the Hospital Mortality Indicator and felt this was unclear.	The Chief Executive requested all graphs have clear labels and axis and that this be addressed for Quality and Performance Committee.	*Completed* *Item noted and updated for the Quality and Performance Committee.*

May 2018	March 2018 041/18 Assurance Report Of The Chair Of The Quality And Performance Committee Meetings Held On 25 January 2018 And 22 February 2018	**CF**	The comprehensive CQC action plan reviewed at February Committee. The Committee reviewed actions to ensure they were being progressed.	Highlights would be included in future Chair Assurance Reports.	*Completed* *Future reports will reflect updates received.*
May 2018	March 2018 041/18 Learning from Deaths	**SE**	The Chief Executive requested the next report include benchmarking against other Trusts to establish whether the difference in our Trust was comparable to that of others.	Next report to reflect.	*Completed* *Benchmarking data will be included in the next report (June)*
May 2018	March 2018 042/18 Report of the Finance Director	**SS**	Rob Graves noted that the detailed cash flow did not reconcile with the balance sheet with differences in the closing balance.	The Finance Director would investigate.	*Completed.* *This was an error that has been addressed in ongoing reporting*
May 2018	March 2018 043/18 Gender Pay Gap Report	**NJ**	The Board highlighted that the full report was not included within the pack.	The Board Administrator would circulate this and upload to the website.	*Completed* *Circulated.*

May 2018	March 2018 043/18 Gender Pay Gap Report	**EW/SE**	She requested further assurance that the Clinical Excellence Awards process was not favouring one staff group, including gender, over another.		*<u>Completed</u>* *The gender pay gap report was discussed at Workforce Committee and the Committee were assured that there is no disproportionate award of CEA's by gender. The percentage of women applying for a CEA is proportionate to the number of female clinicians who are eligible to apply and the percentage of women achieving success in the award process is proportionate to applications if not slightly above male counterparts. The panels who review applications and make decisions on awards include members of both genders. Workshops to encourage more women to apply will be held to encourage those younger in service to have confidence to apply.*
May 2018	March 2018 043/18 Gender Pay Gap Report	**EW/TB**	The Chair queried where attention to equal opportunities was addressed within the Workforce Strategy. The Director of People answered that this was within the Diversity Strategy.	The Chair felt this could be further emphasised and discussed at the next Workforce Committee.	*<u>Completed</u>* *Workforce Committee considered the gender pay gap audit report and noted actions proposed.*

May 2018	March 2018 045/18 Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**SE**	In response to the Medical Director, Ms Barber wondered where the Trust sat in comparison to others. The Medical Director advised that this can be difficult to ascertain as there is no database published nationally but the guardians do meet. Ms Barber felt this made benchmarking difficult.	The Chief Executive requested that the Medical Director further investigate.	*<u>Completed</u>* *Review with Guardian of safe working indicates that we appear to be a relatively low reporter overall and he is exploring with Allocate the possibility of obtaining national data from the reporting system. As much data as possible will be included in the next Guardian report.*
May 2018	March 2018 047/18 Governors' Questions	**NJ**	TrakCare was noted to have been a public agenda item which is now discussed in private. The Chief Executive noted this was simply due to a change in personnel.	This would be moved back to the public session starting at the next Board.	*<u>Completed</u>* *Re-added to the agenda.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MAY 2018

CHAIR'S ACTIVITIES UPDATE

In order to present a snapshot of the wider perspective of Chair activities undertaken, a written summary will be prepared and presented for comment at every Public Trust Board meeting. This excludes regular meeting attendances at Board, Council of Governors, Board Committees and 1:1s with Directors.

The latest of these appears below and covers the period of 26th February to 27th April 2018.

Trust Activities

DATE	EVENT
1st March	SubCo Staff Briefing * 2. Gloucestershire Royal Hospital (GRH)
7th March	Governor 1-1
9th March	Meeting with Gloucestershire Managed Services Chair
13th March	Meeting re. school pupils' hospital volunteering
14th March	Serving teas on Ward 6A (part of National Hydration week)
26th March	Communications Meeting – Ian Mean (Media Expert)
29th March	Rob Graves (Non-Executive Director) annual appraisal meeting
4th April	Visit to Gloucestershire Royal Hospital with Mark Pietroni (Speciality Director – Unscheduled Care)
5th April	Chairing Urology Consultant recruitment panel
6th April	Mini-military leadership challenge – Colerne Barracks
9th April	Chair's visit to Materials Management - Cheltenham General Hospital
12th April	Cheltenham General Hospital League of Friends AGM
12th April	Claire Feehily (Non-Executive Director) annual appraisal meeting
13th April	'Journey to Outstanding ' Quality Improvement Celebratory Event
17th April	Gloucestershire Royal Hospital Friends' AGM
19th April	Non-Executive Director recruitment interview panel
24th April	Chair's visit to Mortuary, Gloucestershire Royal Hospital
25th April	Governor 1:1

Gloucestershire Health Economy

DATE	EVENT
26th February	Meeting with Chris Creswick – (Sustainability and Transformation Partnership Chair)
27th February	Gloucestershire Strategic Forum (Sustainability and Transformation Partnership)
27th February	Sustainability and Transformation Partnership Advisory Group
1st March	Gloucestershire Care Services Chair appraisal feedback call
6th March	Health and Care Overview and Scrutiny Committee (HCOSC)
20th March	Gloucestershire Health and Well Being Board
3rd April	Meeting with David Drew MP
24th April	Gloucestershire Strategic Forum (Sustainability and Transformation Partnership)

National Stakeholders + others

DATE	EVENT
26th February	NHS Improvement (NHSI) Oversight call
8th March	NHS Improvement Financial Governance Interview
16th March	Worcestershire Health and Care Trust r Non-Executive Director ecruitment panel - external assessor
22nd March	NHS Providers Chairs' and Chief Execs' Network meeting - London
27th March	NHS Improvement Oversight call
16th April	Informal visit by Peter Wyman – Chair of Care Quality Commission
25th April	Meeting with Rachel Pearce - NHS England, South West Regional Director of Commissioning
26th April	Financial Special Measures Meeting with NHS Improvement
27th April	Hosting meeting with Chris Hopson - CEO NHS Providers

Peter Lachecki
Trust Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MAY 2018

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Thankfully, there are finally signs that winter is over with negligible new cases of influenza this month; it has been both an unusually protracted flu season as well as there being high volumes at its peak. Operational performance has strengthened significantly with strong A&E performance of 92% in April in and May continues in a similarly strong vein. Progress towards delivering cancer targets from June 2018 continues to be made.

2. National and Regional

2.1 In recognition of the increasingly strong and sustained performance across a number of the urgent and emergency care metrics, the Trust's regulator has recently reviewed the Enforcement Undertakings placed upon the Trust in August 2016 and very positively has now released the Trust from this regulatory action. This is a huge credit to the staff across the Trust, under the leadership of the Executive Triumvirate, who have turned performance around. Not only will this action reduce the regulatory burden on senior managers it is another signal to staff and prospective staff that the Trust is improving.

2.2 Discussions continue in respect of the approach to funding the recently announced pay award for NHS staff and early indications are that the funding for 2018/19 will flow directly to providers as an allocation but will be allocated through the national tariff in future years. Concerns regarding the approach to staff working in Gloucestershire Managed Services (GMS) have been raised and the Trust has been quick to confirm to all staff in GMS that the national Agenda for Change pay increases will apply to them, irrespective of the national approach to funding.

2.3 Regrettably, NHS England announced this week a failure in the national breast screening programme which has resulted in approximately 400,000 women, aged 67 to 71 years of age at the time, missing their final screening invitation. The Secretary of State for Health has confirmed that all these women will be invited for screening with the intention of completing this programme by Autumn 2018. For Gloucestershire Hospitals, this is estimated to be in the region of 2,500 additional patients though work is now underway to clarify the precise number of women affected. The Trust is currently mobilising an operational plan to address this backlog of screening which will require significant additional working at weekends and evenings. The key constraint will be the availability of staff and notably screening radiographers, who are typically hard to recruit.

3. Our System and Community

3.1 Work continues to develop the *One System Business Case* (OSBC) and pace is now gathering. The system now has the (nice) problem of developing this case alongside the business case for the recently announced £39.5m capital award. The key challenge will be ensuring that planning assumptions within the two cases are aligned and importantly that financial benefits are not attributed to both cases i.e. double counted not least as the assurance and oversight process will be one and the same. The timelines for the two business cases are compatible and the OSBC phasing now indicates the commencement of public consultation in January 2019, assuming all prior approvals are successful (which is not a given). The first significant milestone for the Trust Board is approval of the Business Case, at its September Board.

3.2 Following an unsuccessful first wave bid, the Sustainability and Transformation Partnership (STP) has been invited to resubmit its proposal to becoming an Integrated Care System (formerly Accountable Care System). If successful the system would join wave two systems (known as fast followers) and in doing so gain access to support, development opportunities and potentially additional resources to expedite our work on developing integrated commissioning and service provision. Feedback and outcomes from the Gloucestershire bid are still awaited but an outline of the key milestones and associated timelines is set out in Appendix 1.

4. Our Trust

4.1 At the end of April, the Trust submitted its proposed Operational Plan for 2018/19 to the Board and its regulator NHS Improvement. The former approved the Plan which reflects an ambitious year ahead with significant anticipated improvements in operational performance and quality. The financial aspects of the plan set out a proposed £29.714m deficit which reflects a c£3m improvement on the prior year's outturn. Whilst this scale of improvement is limited, relative to the sector it is reflective of the majority of Trusts. Correspondence from NHSI following the meeting describe the regulator as 'content' with the plan though formal sign off is awaited. Of note, the Trust continues to lobby NHSI for a review of the Trust's Control Total with the hope of reaching agreement on a revised Total for the year 2018/19 which would hopefully then enable the Trust to access much needed Sustainability and Transformation Funding.

4.2 As part of the Trust's preparations for winter 2018, we will be commencing two new services w/c 8th May as part of our 'test and learn' approach to finalising the model of care for our proposed Acute-care Centre of Excellence. The Acute Initial Medical Assessment Unit (AMIA) will provide rapid assessment by a Consultant or Senior Decision Maker who will see, treat and discharge directly from the AMIA, or alternatively, stream the patient to the most appropriate pathway. It is anticipated that the above will enable the Trust to reduce potentially avoidable admissions and facilitate the *right patient, right place, first time* approach. If successful this will not only improve care for the patients seen within the AMIA but it is anticipated that its impact on admission rates, length of stay and bed occupancy will mean that services such as Day Surgery Unit, which are regularly impacted by the operational pressures arising from urgent and emergency care, will also benefit. The AMIA will operate from 08.00 to 22.00 hours but when not in service, a second new model of care will also commence during May; the Clinical Decision Unit (CDU) will be established starting initially with three pathways (head injury, renal colic and chest pain). The purpose of the CDU is to provide an area for patients to be observed before making a decision as to the next step in their care. For example: a patient with a head injury who may be experiencing mild concussion would be observed before a decision is made as to whether to admit them or send them home; evidence from elsewhere indicates that, again, fewer patients are likely to be admitted as a result of a period of observation.

4.3 On Wednesday 3rd May 2018, the Trust's Leadership Team received a presentation from Ellen Rule, STP Director of Transformation and Service Redesign which was very positively received. It is now intended to deliver the presentation to the next public Board meeting and Governors' Strategy Group. The presentation set out the very positive progress achieved to date and the priorities for 2018/19.

4.4 On the 1st April 2018, the Trust established its subsidiary company (SubCo), Gloucestershire Managed Services (GMS) under the leadership of its new Chair, Kathy Headdon. Kathy is currently acting in an interim capacity to support GMS in its first six months, during which a substantive Chair will be recruited. Kathy brings a wealth of highly relevant experience having worked as a non-executive director and chair in the

NHS, as well as professional experience and expertise in estates and facilities – both public sector (including NHS) and commercial. As expected, the first month of GMS has reflected the 'business as usual' approach heralded by the team in the preparation phase. The new GMS Board has now met and is scoping its initial priorities and focus for the coming year. Communication and support for those that have transferred and those embarking upon the *colleague to customer* journey, is in hand.

4.5 After a protracted process, it has been confirmed that the Trust's bid for Sustainability and Transformation (STP) capital funding of £39.5m was successful. This is a huge achievement by the Trust, not least given the number of bids and limited funds available – the Trust secured the fourth highest award of all those who were allocated funds. Huge credit goes to the Trust team who have worked on this proposal and its numerous iterations. Next steps are to develop the Outline Business Case (OBC), followed by the Full Business Case (FBC), both of which will require Board and external approval by NHS England and others. The timeline for completion of these next stages is not yet finalised but we are aiming to complete both steps by the end of this calendar year with works commencing in Spring 2019; not unusually this requires some parallel work to develop the business cases whilst procuring a construction partner. The proposal will be the first major 'test' of the Trust and its subsidiary company, Gloucestershire Managed Services (GMS), working together on a project of this scale and represents an exciting opportunity for both.

4.6 Whilst the benefits of the capital case and the return on capital invested are not negotiable, the OBC provides an opportunity for the Trust to revisit the scheme and ensure the current design meets our developing vision for services across the county. Once complete, the scheme will provide improved facilities and optimise models of care, in line with our vision for Centres of Excellence, at both our Cheltenham General and Gloucestershire Royal hospitals.

4.7 The Trust's recently launched approach to more regular staff recognition has just announced the second round of GEM (Going the extra Mile) award winners. Next month will see the awards for the team category being announced, reinforcing the importance of team work in our *Journey To Outstanding (J2O)*. On the 13th April the Trust, under the leadership of Steve Hams, Director of Quality & Chief Nurse, ran its first formal J2O event PechaKucha style – twenty services delivered the requisite 6 minute, 20 slide presentation describing their own services *Journey To Outstanding.* The event was very well received and will be the first of many such initiatives going forward. The reach and impact of J2O has taken many, including myself by (very pleasant) surprise though feedback continues to be received and the messages continue to become nuanced for the many different audiences.

4.8 Preparation for our annual Staff Awards ceremony is also underway with nominations opening soon and judging taking place in September, culminating in the grand event on the 29th November; as last year governor representatives will be invited to join the evening. On a more informal basis, the Trust repeated last year's **Big Staff Thank You** event at Over Barn and more than 150 staff joined the leadership team to for something that felt like a celebration of the end of winter, not least as the weather was particularly kind to us.

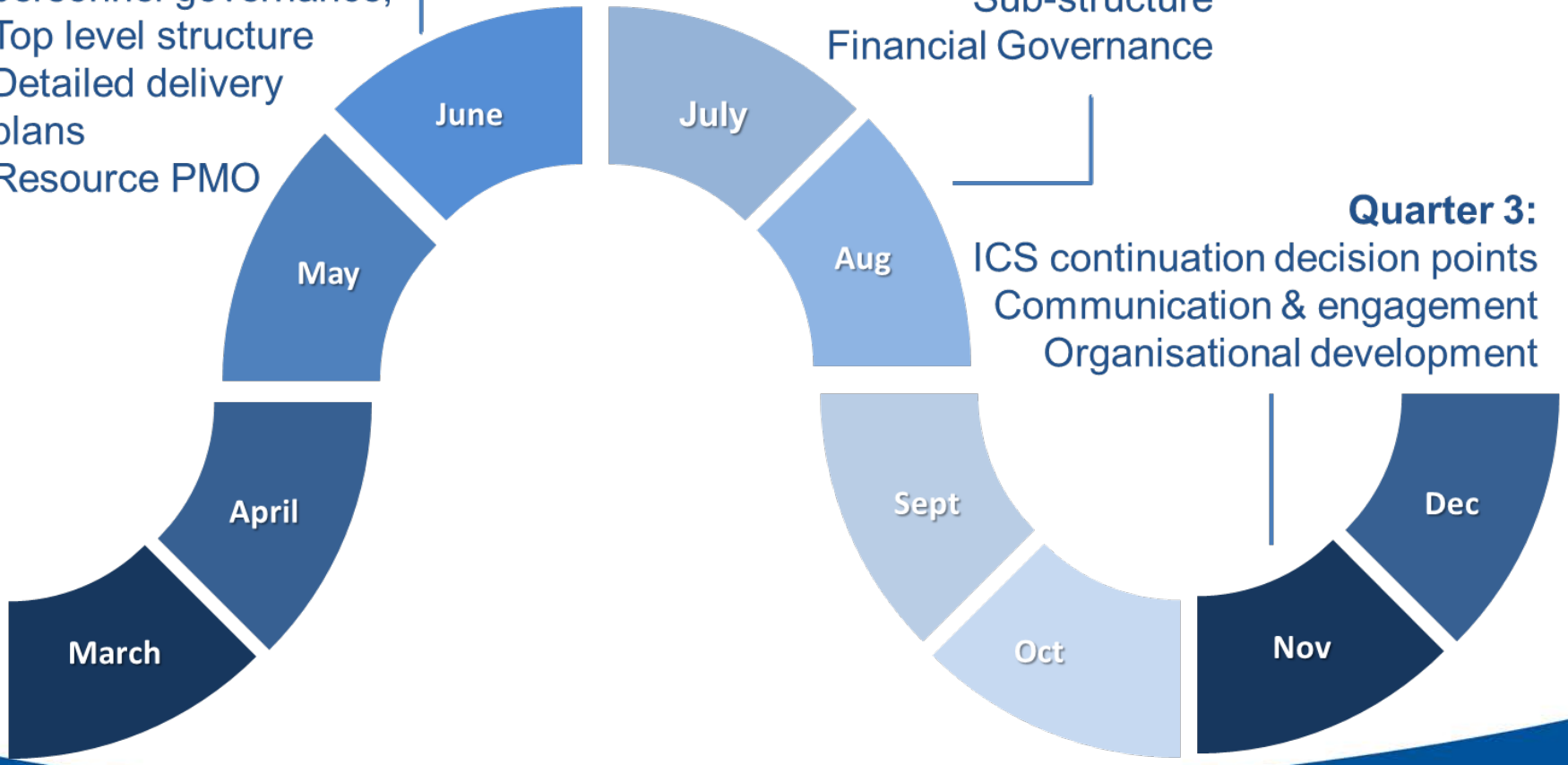
Deborah Lee
Chief Executive Officer
May 2018

ICS Governance Plan

Quarter 1:
personnel governance,
Top level structure
Detailed delivery plans
Resource PMO

Quarter 2:
Workshops ICS governance
Sub-structure
Financial Governance

Quarter 3:
ICS continuation decision points
Communication & engagement
Organisational development



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

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

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the March 2018 reporting period.

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 across Quality and Performance.

Key Issues to note

During March, the Trust met the Trust and NHS I/E Trajectory for A&E 4 hour standard and Diagnostic 6 week wait. The Trust did not meet the national standards or Trust trajectories for; 2 week wait and 62 day cancer standard and the Trust has suspended reporting on the 18 week referral to treatment (RTT) standard. There remains significant focus and effort from operational teams to support performance recovery and sustained delivery. There remains the clinical review and oversight of patients waiting care to ensure that patients do not come to harm due to delays in their treatment in accordance with the Trusts Clinical Policy, which is under review, simultaneously with the Trusts Access Policy for final publication in Spring.

In March 2018, the trust performance against the 4hr A&E standard was 86.94% with an average of 392 attendances per day. This performance was above the agreed STF trajectory (83.5%). The Quarter 4 performance was also above the Trust agreed trajectory at 88.35% (81.25%). GHFT. Month to date performance (30 April) is currently 92% which is on track to deliver the STF April trajectory (90%).
March attendances were 5.6% above last year's levels, an increase of 646 attendances with an average increase of 21 attendances per day. Fridays are the only day to have shown a decrease against last year; the highest increasing day was Tuesday with an additional 47 attendances per day.
The Trust met the diagnostics target in March at 0.26% (un-validated), for the 6th consecutive month the focus is on sustainability across the range of diagnostic tests we provide and the key risk to sustainability remains our workforce.

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 internally and will continue to suspend national reporting of this target. 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 and our patient tracking list is accurate. Alignment with the Trak Recovery Programme in relation to RTT

operational management remains vital.

Our performance against the cancer standard saw continued improvement against the 2 week standard for March with performance at 90.4% (Un-Validated). The main tumour site that was compromised on the 2 week pathway remains Upper and Lower GI which continues to see a very high demand resulting in capacity issues (see full Cancer Delivery Plan). In respect of 2 week wait whilst work continues with our primary care colleagues for managing demand on our colorectal & dermatology services and the implementation of new referral forms and guidance for primary care. The final submitted position for February 2 week wait is 90.6% and the Quarter 4 position is 89.1% compared to Quarter 3 was 77.1%. The impact of the delivery in the 2 week wait pathway will impact positively on the 62 day pathway performance in the coming months. A revised Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed and reviewed on a fortnightly basis. Performance for April has been impacted by the snow Gloucestershire experienced in late March and patient cancellations.

Cancer 62 day Referral to Treatment (GP referral) performance for February was 79.1%, this compromised of 31.5 breaches from 151 treatments. The key specialities that breach this performance standard are 15 Urological; 5 Upper GI; 2 Lung; 4.5 Lower GI; 1 H and Neck; Haematological 3 and 1 Breast.

We are addressing our longest waiting patients and reviewing the opportunities for how we can support a reduction in the 104 patient cohort. Significant progress has been made with our longest waiting patients as we are reporting the lowest number in this category for over a year. This position has stabilised and now we are working to reduce our long waiters with our tertiary centres.

The Cancer trajectory and delivery plan has set out the delivery of this national standard across each tumour site this is monitored fortnightly alongside a weekly patient level challenge meeting to support the management of every patient over 40 days. We are reviewing our timescales for both initial booking at 7 days, on a 2 week wait pathway and also the opportunity to bring forward the decision to treat period from 'first seen' to improve patient care and experience.

<u>Conclusions</u>

Cancer delivery and sustaining A&E performance is the priority for the operational teams to continue the positive performance improvement. A process of review for every patient over 40 weeks in their referral to treatment pathway and every patient over 40 days in their Cancer pathway (including non-cancer patients) in order to improve performance against the national standards at a weekly check and challenge meeting, remains in place. Clinical oversight of patients awaiting care continues to ensure that no patients come to harm due to delays in their treatment.

Recommendations

The 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 two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.

Regulatory and/or Legal Implications
The Trust has been removed from 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 March 2018

to be presented at April 2018 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During March, the Trust did not meet the national standards or Trust trajectories for 2 week wait and 62 day cancer standard and suspended reporting of the 18 week referral to treatment (RTT) standard continues. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care over 104 days to ensure that patients do not come to harm due to delays in their treatment, these are being reviewed to ensure we have fully reviewed these cases since 01 April 2017. The policies that support these are under review with stakeholders and anticipate final approval at Planned Care Delivery Group on the 11 May.

The Trust has met the 4 hour standard in March against the STP trajectory at 86.94% (81.25%)and delivered the Diagnostic target in March at 0.26% un-validated.
The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan is reviewed fortnightly and each tumour site has specific identified actions with an associated allocation in breach improvement numbers. The Cancer Patient List for every patient over day 28 is reviewed weekly by the Director of Planned Care.

Cancer underperformance remains a significant concern relating to the 2 week wait and 62 day pathway. For the former, issues with capacity, a significant and unexpected referral increase in March and patient choice (sometimes due to short notice appointments) have impacted delivery.
The March figures as yet un-validated that shows 2ww at 90.4% (2.6% below target). Importantly the number of breaches have consistently decreased month on month from 451 in October, 436 in November, 309 in December, 225 in January and 159 in February and 178 in March, this illustrates the progress in the 2ww pathway that has been made since November. The April position at the time of writing is 86.1% , which is a decrease but definitive impact from patient cancellations during the periods of snow. A significant contribution to this performance improvement continues to be from the skin tumour site which has again delivered across both the 2ww and 62 day pathways. For 62 day, again monthly improvements in breach numbers can be seen, from 44 in October and as at the time of writing 32 breaches in March. February performance is currently 79.1% and March is at 77.5% un-validated (and some treatments to add). This performance relates to the continued issues in colorectal and issues within the lung pathway. So, we had seen positive developments in this pathway across tumour sites, but whilst February performance has recovered to trajectory for June recovery, the referrals to the GI service remain a risk. A key strength has been the reduction of our 104 patients which has been significant and is positive for this patient group.
The focus has continued on developing the joint work between the Central Booking Office and specialities to support appropriate booking for patients (now all clinics are available for booking for next year). We have committed to work to a day 8 escalation point for booking of patients and also there is significant development working with primary care on the re-launch of our 2ww electronic referral forms. For elective care, the levels of validation across the RTT incompletes, Inpatient and Outpatient Patient Tracking List (PTL) is significant.
Key areas where additional reports have been provided for the Quality and Performance Committee are:

- Cancer Services Management Group – escalation report (including Cancer Delivery Plan)
- Emergency Care Board – escalation report (including Emergency Care Dashboard)
- Planned Care Board – escalation report

In summary, the position for the Trust in a number of key performance metrics are noted in the respective exception reports.

Strengths

4 hour performance continues to perform well, delivering month to date 90.1% as of the 19th April.
Medically fit at remains relatively stable during the winter period, work with system partners continues to progress this area for patient care.
The ED Safety Checklist continues to embedded within both emergency departments, additional support and adhoc assurance checks being delivered by the shift leaders.
The national standard for % of patients seen within 6 weeks for Diagnostic tests, has delivered for the 6th month in a row at 0.26% (un-validated).
The engagement of Glanso has continued to support a number of RTT specialities (>52) and to release capacity in key cancer tumour sites, and diagnostics areas and is being utilised in the right operational "hot-spots". We have reviewed our requirements for 2018/19 in this area, and they match our key performance areas e.g.colorectal and endoscopy only to support the increased demand in these areas within cancer care.
Overall clinic slot utilisation is positive, remaining at 88.91% (for CBO booked clinics) (& 91.77% for April to date) this is still an area for further development but good progress is being made.

The FFT was initially intended to provide comparable information, and is published on NHS Choices as a performance measure. However, NHS England now acknowledge that the FFT cannot be used to benchmark or compare between organisations; massive invitation and response biases render such an activity meaningless (and the national patient survey programme already fulfils this accountability and performance management function anyway). From working with the data for a year now FFT doesn't really help us to identify where to focus the patient experience improvement effort. The cost of our current system far outweighs the benefits of the data that it produces. What is needed is a real time survey programme which can be adjusted to the needs of the organisation which is properly resourced. Then we will be able to do focused improvement work and achieve the Outstanding CQC rating that other Trusts using this programme have achieved.

Weaknesses

• Due to the implementation of the new EPR system we continue to shadow reporting the number of patients waiting 18 weeks from referral to treatment. We have a number of patients that are awaiting first out patient appointments around 45 weeks. We are mitigating booking out of chronological order, through a review of the clinics post 45 weeks available to book into by specialties; vetting; CBO processes and support. However this will continue as we make progress to validation and implementation of the correct utilisation of the system to prevent future errors.

• Patient Treatment Lists (PTLs) have residual data quality issues which continues to impact management of patient journeys. This is being addressed through the deployment of additional clerical staff as approved at May Board. Despite this, teams are focused on reviewing patients >45 weeks, across most specialities and predicting potential breaches on a more routine basis. The validation team are now operating at >29 weeks for all specialities within the RTT PTL, which is one of 2 PTLs, (new PTL revised w/c 12/03) that are combined to support operational management. Work to support the Outpatient PTL validation team is being put in place to support the validation of this list which will support forward capacity planning.
• Achievement of the Cancer standards remains a risk as we plan to deliver the 62 day pathway from April 2018, breach numbers had decreased which is positive for February but some issues due to patient cancellations as a result of snow days will impact some patient journeys. The risk to delivery is around capacity and any increases in referral numbers.

Opportunities

• A review of the Patient Access Policy simultaneously with the Clinical Risk Policy will provide an opportunity to strengthen both the policy and its deployment across the organisation, this is on track for approval in the spring 2018, with an implementation period for action cards post its agreement.
• Raising the profile of the Trusts Cancer services - a day has been planned with a communication day at the end of May 2018.
• Support from our partner commissioners has been sought in relation to cancer across a number of areas:
- Referral rate increases (colorectal, urology & dermatology) – CCG to support communication to targeted practices in the CGH area, this work continues.
-Re-launch of the new 2ww forms, supporting us in utilising a cancer service for patients who are aware and ready to be referred on the relevant pathway. Whilst this has unfortunately it was delayed but launched at the end of March.

• 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. Noting that the request for information in relation to Tertiary Centre referrals from us, also provides the opportunity to ensure we are correctly managing these patients journeys and improving patient care.

Risks & Threats

Cancer performance remains a significant risk for the Trust, of particular the sharp increase in March and early April. Patient choice levels are being benchmarked (and case stories provided) as the Trust needs to ensure we are offering reasonable notice of appointments. The issue of patient choice has been raised with the LMC and working in partnership with the CCG new 2 week wait referral forms will be published in April, later than anticipated. Referrals that are appropriate for a suspected cancer service where our capacity meets demand is crucial to delivery. For cancer services delivery for colorectal & urology remains key to delivery of aggregate 62d wait.

As ever in unscheduled and elective care, unplanned increases in activity remain a risk either daily or weekly.

The validation volumes for the PTL (new and follow up patients) and incorrect processes remain a risk, as does any change to the existing PTLs or change in practice, aligned with the recovery pace for Trak Recovery. Operational colleagues are represented at the Governance structure relating to the Trak Deep Dive Recovery programme.

Performance Against STP Trajectories

* = unvalidated data

Indicator		Month											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
ED Total Time in Department - Under 4 Hours	Trajectory	87.70%	89.50%	89.20%	88.30%	92.20%	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%
	Actual	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	73.80%	75.00%	76.10%	77.20%	78.40%	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%
	Actual												
Diagnostics 6 Week Wait (15 Key Tests)	Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Actual	7.22%	5.30%	5.26%	5.30%	4.80%	2.90%	0.46%	0.51%	0.75%	0.64%	0.49%*	0.26%
Cancer - Urgent referrals Seen in Under 2 Weeks	Trajectory	93.00%	93.00%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	91.40%	90.50%	85.90%	79.60%	70.40%	71.20%	74.60%	75.80%	81.20%	86.40%	90.60%	90.50%*
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.40%	93.00%	93.10%	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%
	Actual	90.40%	94.00%	94.10%	57.30%	89.70%	92.70%	89.00%	94.50%	96.30%	92.40%	97.60%	94.50%*
Cancer - 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.40%	96.20%	96.10%	96.20%	96.20%	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%
	Actual	94.90%	95.90%	95.40%	95.80%	96.20%	98.50%	95.10%	96.70%	97.30%	96.00%	97.60%	97.80%*
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	Trajectory	98.40%	100.00%	98.30%	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	98.50%	100.00%	100.00%	100.00%	98.90%	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%	96.60%	97.10%	98.50%	98.10%	100.00%	100.00%	100.00%*
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	Trajectory	94.90%	94.80%	94.00%	95.80%	94.50%	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%
	Actual	90.00%	97.50%	97.90%	93.60%	91.50%	95.50%	94.60%	98.10%	94.90%	93.00%	95.50%	97.30%*
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	92.00%	94.40%	90.00%	94.70%	91.20%	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%
	Actual	86.30%	91.80%	88.90%	89.10%	88.50%	94.90%	87.10%	93.80%	95.50%	98.00%	95.90%	95.60%*
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	80.00%	100.00%	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	100.00%	100.00%	57.10%	77.80%	85.70%	50.00%	60.00%	100.00%	0.00%	80.00%	100.00%*
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	77.70%	79.40%	80.10%	85.40%	85.20%	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%
	Actual	78.30%	75.90%	71.20%	74.70%	80.10%	69.20%	71.40%	76.70%	73.40%	69.70%	79.10%	75.60%*

Summary Scorecard

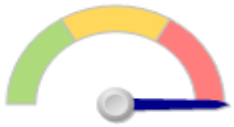
The following table shows the Trust's current performance against the chosen lead indicators within the Trust Summary Scorecard.

QUALITY

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

OPERATIONAL PERFORMANCE

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



FINANCE

- YTD Performance against Financial Recovery Plan

LEADERSHIP AND DEVELOPMENT

- Sickness Rate
- Workforce Turnover Rate

Trust Scorecard

* = unvalidated data

Category		Indicator	Target	Month												Quarter				Annual	
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	16/17	17/18
Quality	**Key Indicators - Quality**																				
	Friends and Family Test Score	Friends and Family Test Score - ED % Positive		86.9%	84.4%	75.6%	77.5%	84.9%	81.1%	81.0%	87.4%	85.9%	85.6%	82.7%	83.7% *	81.7%	81.2%	84.7%	84.0% *	86.5%	83.0% *
		Friends and Family Test Score - Inpatients % Positive		89.3%	92.2%	91.2%	90.8%	90.9%	90.1%	91.2%	90.6%	91.6%	91.5%	92.0%	89.7% *	90.8%	90.6%	91.0%	91.1% *	94.0%	90.9% *
		Friends and Family Test Score - Maternity % Positive		94.5%	96.8%	97.0%	100.0%	90.0%	94.7%	100.0%	100.0%	90.3%	100.0%	88.9%	93.6% *	96.2%	96.3%	97.1%	93.8% *	98.6%	95.6% *
		Friends and Family Test Score - Outpatients % Positive						91.2%	91.5%	91.3%	92.2%	92.4%	93.3%	93.1%	92.3% *			92.0%	92.9% *		
	Infections	MRSA Bloodstream Cases - Cumulative Totals	0	0	0	0 *	1	1 *	1 *	1 *	0	0	0 *	0 *	0 *					3	0 *
	Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	4	11	10	16	14	18	19	13	11	5	7	6	25	48	43	18	39	134
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	111	109	109.2	105.5	103.9	99.7	97.1	94.8	93.4				109.2	99.7	93.4		110.7	93.4 *
		Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	116.5	114.6	115	111.8	110	108.9	103.9	101.5	97.1				115	108.9	97.1		115.1	97.1 *
		Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level			112.3										112.3				111.5	112.3 *
	Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	7.2% *	7.2% *	6.7% *	7.0% *	6.9% *	6.5% *	6.5% *	6.7% *	7.6% *	6.3% *	7.7% *		7.0% *	6.8% *	6.9% *		6.4% *	6.9% *
	Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%						91.4% *	90.6% *	86.4% *	86.9% *	78.5% *	76.8% *	79.5% *			88.2% *	78.4% *		
	Detailed Indicators - Quality																				
	Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2>87%Q3>88%Q4>90%						0.4% *	0.7% *	0.9% *	1.1%	0.7% *	0.7%	0.8%		0.4% *				0.6% *
		Dementia - Fair question 2 - Appropriately Assessed	Q1>86%Q2>87%Q3>88%Q4>90%						50.0% *	60.0% *	50.0% *	57.1%	100.0% *	33.3%	66.7%		50.0% *				57.1% *
		Dementia - Fair question 3 - Referred for Follow Up	Q1>86%Q2>87%Q3>88%Q4>90%						0.0% *	0.0% *	0.0% *	0.0%	50.0% *	0.0%	0.0%		0.0% *				0.0% *
	ED checklist	ED Safety checklist compliance CGH		72%	68%	81%	74%	72%	79%		78%	92%	86% *	83% *							
		ED Safety checklist compliance GRH	>=80%	56%	60%	56%	57%	53%			68%	67%	72% *	81% *							
	Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		46.1 *	44.3 *	49 *	50.9 *	56 *	59.7 *	46.9 *	47.6 *	43.1 *	45.7 *	42.3 *	64.4 *	47.2 *	53 *	46.7 *				
		Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		98.0% *	98.4% *	98.3% *	96.8% *	96.9% *	98.5% *	98.2% *	98.4% *	100.0% *	98.5% *	100.0% *	98.4% *	98.3% *	97.4% *	98.9% *			
		Fracture Neck of Femur Patients Treated Within 36 Hours		76.5% *	78.1% *	71.2% *	59.7% *	67.7% *	66.7% *	80.4% *	67.2% *	81.4% *	73.9% *	83.8% *	64.4% *	75.3% *	64.7% *	76.3% *			
		C.Diff Cases - Cumulative Totals	17/18 = 37	1	5	8 *	10	18 * 7	24 *	29 *	35	41	45 *	49 *	56 *					42	5 *

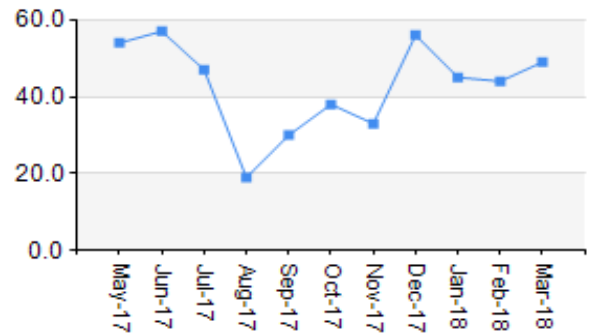
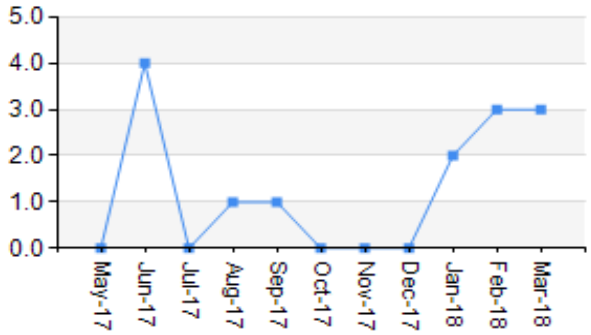
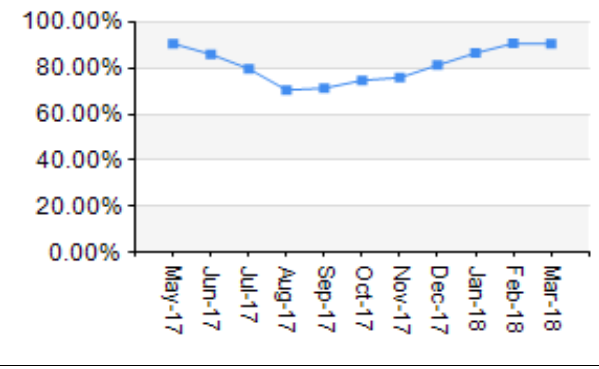
Category	Indicator	Target	Month												Quarter				Annual	
			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	16/17	17/18
Infections	Ecoli - Cumulative Totals				20	37	103 *	119 *	146 *	175	200	222 *	240 *	258 *						
	MSSA Cases - Cumulative Totals	No target	6 *		7	15	44 *	54 *	63 *	68	78	89 *	93 *	100 *					114	6 *
Maternity	Percentage of Spontaneous Vaginal Deliveries		61.2% *	64.4% *	65.3% *	62.4% *	63.9% *	64.9% *	60.2% *	57.5% *	60.9% *	57.0% *	63.4% *	61.8% *	63.6% *	64.5% *	59.8% *	60.6% *	63.6% *	62.4% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90	89.3% *	84.9% *	89.2% *	83.2% *	88.1% *	85.9% *	87.8% *	89.5%	86.6% *	88.7% *	89.2% *	89.9% *	85.9% *	88.0% *	90.0% *	90.3% *	87.3% *	89.5% *
Never Events	Total Never Events	0	0	2	1 *	0 *	0	1 *	0 *		1 *	0 *	0 *	1 *					2	2 *
Patient Falls	Total Number of Patient Falls Resulting in Harm (moderate/severe)		3 *	4 *	9 *	5 *	8 *	11 *	7 *	4 *	13 *	18 *	10 *	8 *	5 *	8 *	8 *	12 *		
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		3 *	0 *	4 *	2 *	2 *	3 *	1 *	1 *	1 *	3 *	1 *	1 *	2 *	2 *	1 *	0 *		
	Number of Patient Safety Incidents Reported		900 *	1,268	1,148	1,149 *	1,003 *	1,033 *	1,079 *	1,041 *	1,025 *	1,260 *	1,139 *	1,229 *	1,019 *	1,062 *		1,209 *		
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	0.50%	1.23%	0.49% *	1.12% *	1.02% *	0.61% *	1.13% *	0.79% *	0.54% *	1.30% *	1.63% *	0.48% *						
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%	0.13%	0.12%	0.12% *	0.50% *	0.38% *	0.37% *	0.00% *	0.13% *	0.14% *	0.47% *	0.63% *	0.24% *						
	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%	0.13%	0.12%	0.00% *	0.00% *	0.00% *	0.12% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	123	176	579 *	162 *	185 *	127 *	60 *	76 *	29 *	51 *	33 *	13 *	878 *	474 *	165 *		3,045	1,614 *
RIDDOR	Number of RIDDOR	Current mean	2	2	3 *	2 *	3 *	0 *	3 *	1 *	7 *	1 *	1 *	1 *	2 *	2 *	4 *		2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		7	7	9	7	7	7	7	7	7	7	7	7	8 *	7 *	7	7	8	7.2
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	94.0%	92.4%	92.7%	91.3% *	92.6% *	94.2% *	92.9% *	93.0% *	93.1% *	90.1% *	91.8% *	91.5% *	93.0% *	92.7% *	93.0% *	91.1% *		
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	97.7%	95.8%	96.6%	95.0% *	96.0% *	97.4% *	97.4% *	97.0% *	96.9% *	96.0% *	96.4% *	97.6% *	96.7% *	96.2% *	97.1% *	96.6% *		
Sepsis Screening	2a Sepsis – Screening	>90%	88.0% *	88.0% *	98.0% *	94.0% *	96.0% *	98.0% *	96.0% *	94.0% *	98.0% *				91.0% *	96.0% *	96.0% *			
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	78.0% *	69.0% *	67.0% *	94.0% *	89.0% *	90.0% *	79.0% *	80.0% *	83.0% *				71.0% *	91.0% *	81.0% *			
Serious Incidents	Number of Serious Incidents Reported			5	1 *	2 *	1	2 *	1 *	1 *	1 *	3 *	10 *	2 *						
	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% *				

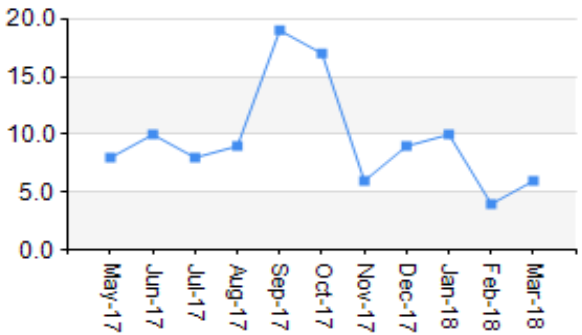
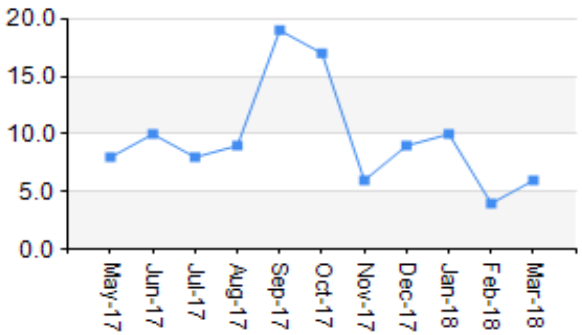
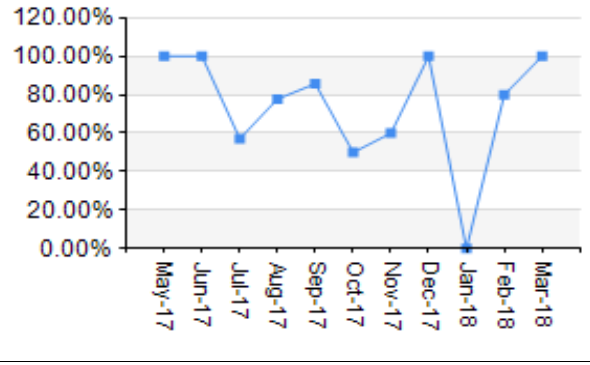
Category		Indicator	Target	Month												Quarter				Annual	
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	16/17	17/18
	Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	1	1.2	2.2	2.7 *	1.9 *	.9 *	1.7 *	3.1 *	1.9 *	2.6 *	2.4 *	2.8 *	2 *	1.9 *	2.2 *	2.6 *		
		Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	2.3	3.1	4.2	2.4 *	3.1 *	2.9 *	2.1 *	2.4 *	1.5 *	1.4 *	2.6 *	2.8 *	3.3 *	2.8 *	2 *	2.3 *		
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	64.0%	41.9%	70.2%	69.1%	66.7%	61.5%	81.0%	78.1%	69.6%	67.7%	60.0%	76.0%	60.2%	65.2%	76.3%	67.9%		66.9% *
		Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%	33.3% *	32.5% *	26.1%	38.0%	41.8%	45.5%	40.3%	37.1%	33.8%	46.2%	38.2%	41.0%	30.5%	41.5%	36.8%	41.8%		37.6% *
		Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	81.8%	84.6%	92.9%	95.0%	92.3%	98.2%	89.3%	89.4%	74.0%	91.8%	94.4%		86.4%	95.0%	83.6%			89.3% *
	Time to Initial Assessment	ED Time To Initial Assessment - Under 15 Minutes	>=99%	81.9%	80.2%	75.9%	87.4%	91.0%	86.2%	86.7%	91.7%	89.9%	91.9%	88.2%	89.5%	79.9%	88.2%	89.4%	89.9% *		86.7% *
	Time to Start of Treatment	ED Time to Start of Treatment - Under 60 Minutes	>=90%	29.5%	28.8%	25.7%	32.3%	34.9%	31.2%	37.5%	41.5%	40.7%	43.3%	32.7%	35.2%	28.0%	32.8%	39.8%	37.1% *		34.5% *
Operational Performance	Key Indicators - Operational Performance																				
	Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	86.3%	91.8%	88.9%	89.1%	88.5%	94.9%	87.1%	93.8%	95.5%	98.0%	95.9%	95.6% *	89.3%	90.6%	91.8%			
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	100.0%	100.0%	100.0%	57.1%	77.8%	85.7%	50.0%	60.0%	100.0%	0.0%	80.0%	100.0% *	100.0%	76.7%	71.4%			
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	78.3%	75.9%	71.2%	74.7%	80.1%	69.2%	71.4%	76.7%	73.4%	69.7%	79.1%	75.6% *	75.2%	75.1%	74.4%			
	Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	7.22%	5.30%	5.26%	5.30%	4.80%	2.90%	0.46%	0.51%	0.75%	0.64%	0.49% *	0.26%	5.90%					5.54% *
	ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%	80.87%	85.87%	91.58%	88.35%		86.70% *
	Detailed Indicators - Operational Performance																				
	Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	34	54	57	47	19	30	38 *	33	56	45	44	49	145	96	127	138	1,884	506
		Ambulance Handovers - Over 60 Minutes	< previous year	1	0	4	0	1	1	0 *	0	0	2	3	3	5	2	0	8	26	15
	Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0									6 *	12 *	25 *	21 *						6 *
	Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	10	8	10	8	9	19	17	6	9	10	4	6						
		Cancer (104 Days) - Without TCI Date	0	47	80	32	35	30	26	23	34	34	19	14	17						
	Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	91.4%	90.5%	85.9%	79.6%	70.4%	71.2%	74.6%	75.8%	81.2%	86.4%	90.6%	90.5% *	89.1%	73.6%	77.1%			
		Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	90.4%	94.0%	94.1%	57.3%	89.7%	92.7%	89.0%	94.5%	96.3%	92.4%	97.6%	94.5% *	92.8%	79.0%	93.4%			
		Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	94.9%	95.9%	95.4%	95.8%	96.2%	98.5%	95.1%	96.7%	97.3%	96.0%	97.6%	97.8% *	95.5%	96.6%	96.2%			

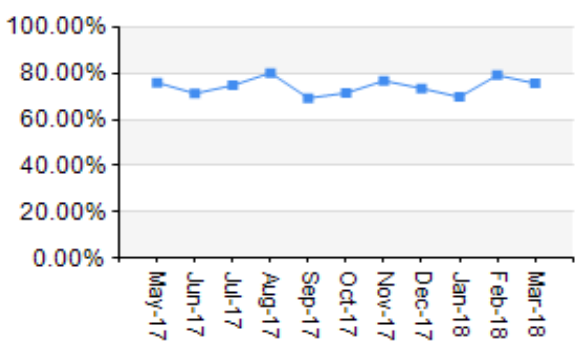
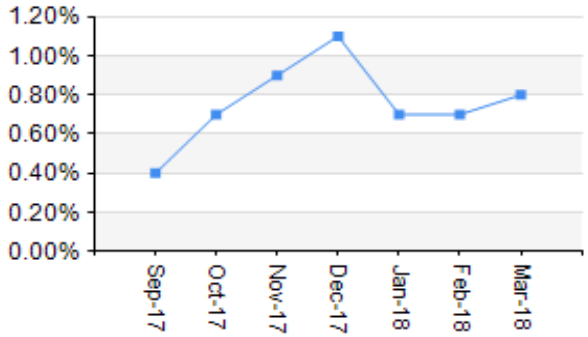
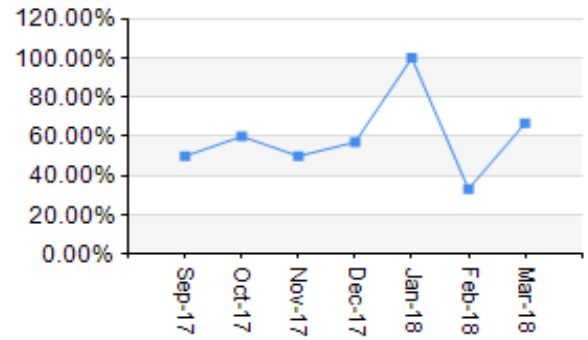
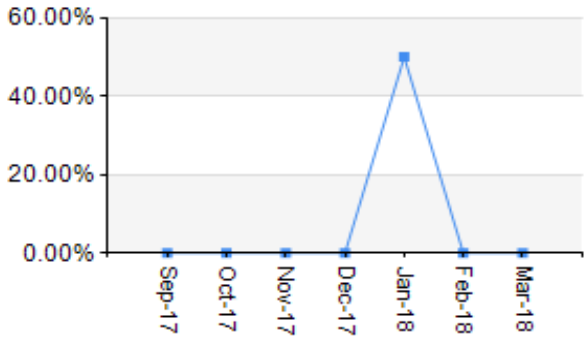
Category		Indicator	Target	Month												Quarter				Annual	
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	16/17	17/18
	Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0% *	100.0%	99.6%	100.0%			
		Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	98.5%	100.0%	100.0%	100.0%	98.4%	96.6%	97.1%	98.5%	98.1%	100.0%	100.0%	100.0% *	99.5%	98.5%	98.5%			
		Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	90.0%	97.5%	97.9%	93.6%	91.5%	95.5%	94.6%	98.1%	94.9%	93.0%	95.5%	97.3% *	94.5%	93.3%	96.2%			
	Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	28	30	32	27	29	32	29	34	41	22	23	34	32	32			33	30 *
	Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End			963 *	522		883 *	1,298	1,062	867	733	239 *	106						7 *	
	Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	63.2% *	64.5% *	61.5% *	63.8% *	60.9% *	59.8% *	60.0% *	61.1% *	59.9% *	57.0% *	57.8% *		63.1% *	61.5% *	60.4% *		75.4% *	60.8% *
	ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	91.80%	92.30%	88.10% *	94.40%	95.00%	93.20%	93.80%	97.10%	96.60%	93.60%	95.10%	96.50%	90.70%	94.20%		95.10% *	91.60%	93.90% *
		GRH ED - Percentage Within 4 Hours	>=95%	77.90%	72.90%	75.30%	77.70%	84.60%	82.40%	86.60%	94.40%	88.00%	87.90%	85.30%	82.30%	75.30%	81.50%	89.60%	85.10% *	79.20%	83.00% *
	Inpatients	Stranded Patients		397	420	441	451	461	487	479	447	446	472	464	482			457	473		468 *
	Length of Stay	Average Length of Stay (Spell)		5.07 *	4.87 *	4.96 *	4.97 *	4.86 *	4.75 *	5.11 *	5.03 *	4.79 *	5.1 *	5.06 *	5 *	4.97 *	4.86 *	4.98 *	5.05 *	5.37 *	4.96 *
		Length of Stay for General and Acute Elective Spells	<=3.4	2.83 *	2.68 *	2.85 *	2.74 *	2.96 *	2.96 *	3.32 *	2.86 *	2.81 *	2.92 *	3.11 *	3.05 *	2.79 *	2.88 *	3 *	3.03 *	3.08 *	2.92 *
		Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.74 *	5.48 *	5.58 *	5.62 *	5.36 *	5.24 *	5.56 *	5.61 *	5.28 *	5.56 *	5.53 *	5.46 *	5.6 *	5.41 *	5.48 *	5.52 *	6.08 *	5.5 *
	Medically Fit	Number of Medically Fit Patients Per Day	<40	59	55	58	63	58	60	62	60	64	55	65	67	56	60	64	62		60 *
	Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	13 *	9 *	9 *	13 *	27 *	30 *	30	64 *	74 *	50 *	63	95 *						
	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% *
		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% *
	Trolley Waits	ED 12 Hour Trolley Waits	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1 *	2	1 *
Finance	Key Indicators - Finance																				
	Finance	YTD Performance against Financial Recovery Plan		-.95	-10.15	3.36	4.35	4.24	1.87	-0.27	-2.1	-6.4	-6.5	-10.8	-18.4						
	Detailed Indicators - Finance																				
		Agency - Performance against NHSI set agency ceiling		3	3	3	3	3	4	3	3	3	3	3	3						
		Capital Service		4	4	4	4	4	4	4	4	4	4	4	4						

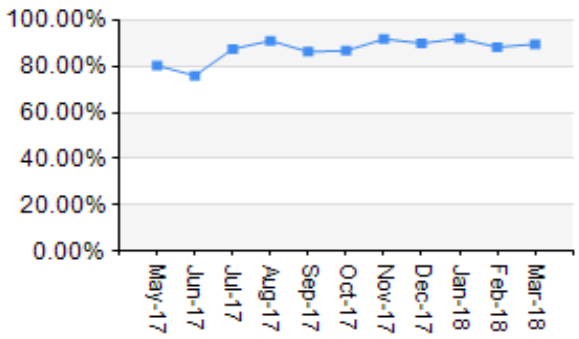
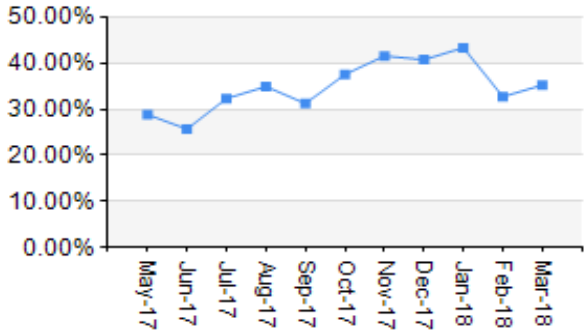
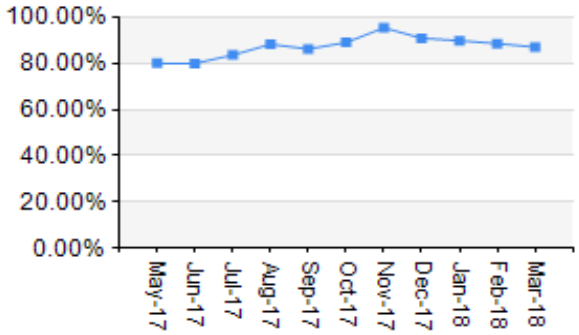
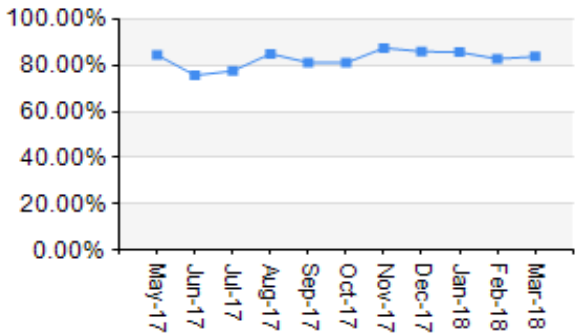
Category		Indicator	Target	Month												Quarter				Annual	
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	16/17	17/18
	Finance	Liquidity		4	4	4	4	4	4	4	4	4	4	4	4						
		NHSI Financial Risk Rating	3	4	4	4	4	4	4	4	4	4	4	4	4						
		Total PayBill Spend		27.67	27.52	27.5	27.46	28.25	27.94	27.9	27.9	27.7	28.1	28.5	28.5						
Leadership and Development	Key Indicators - Leadership and Development																				
	Sickness	Sickness Rate	G<3.6% R>4%	4.0%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0% *	3.9%	3.9%	3.9%	3.9% *		
	Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71 *	3.67 *	3.71	3.71	3.71			
	Turnover	Workforce Turnover Rate	7.5% - 11%	12.1%	12.0%	12.3%	12.3%	12.4%	12.3%	12.4%	12.1%	11.9%	11.6%	11.4%	11.6% *	12.3%	12.3%	11.9%	11.7% *		
	Detailed Indicators - Leadership and Development																				
	Appraisals	Staff having well-structured appraisal Indicator	>3.8	3	3	3	3	3	3	3	3	3	3	3 *	2.95 *	3	3	3			
		Staff who have Annual Appraisal	G>89% R<80%	80.0%	79.0%	78.0%	79.0%	79.0%	79.0%	83.0%	84.0%	84.0%	83.0%	83.0%	82.0%	79.0%	79.0%	82.0%	83.0%		
	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%	33.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0% *	30.0% *	34.0%	34.0%	34.0%			
	Training	Statutory/Mandatory Training	>=90%	89%	89%	89%	89%	89%	88%	88%	88%	88% *	73%	79%		89%	89%	88%			

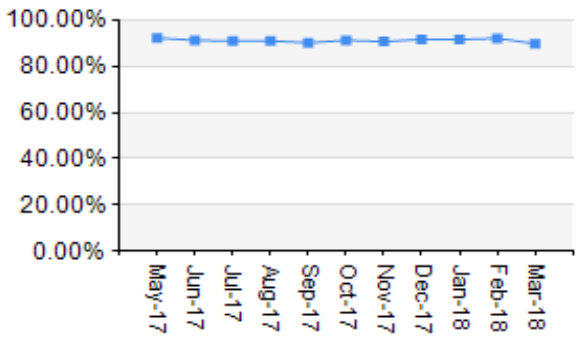
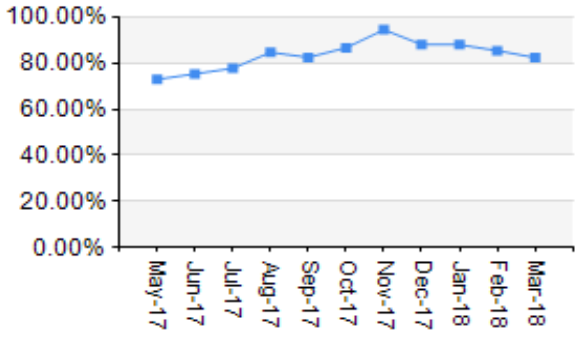
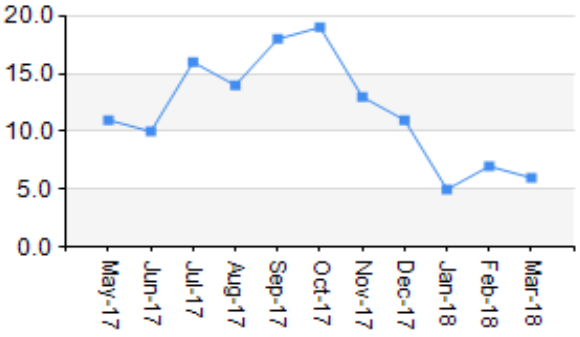
Exception Report

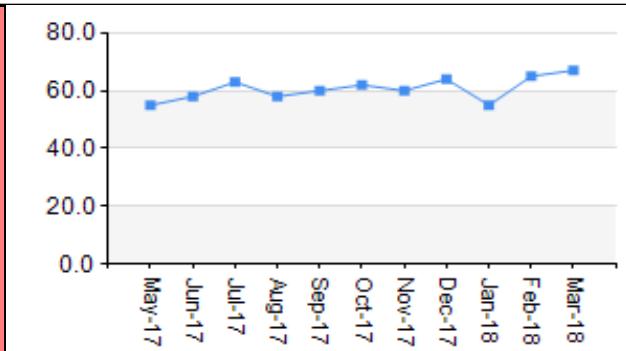
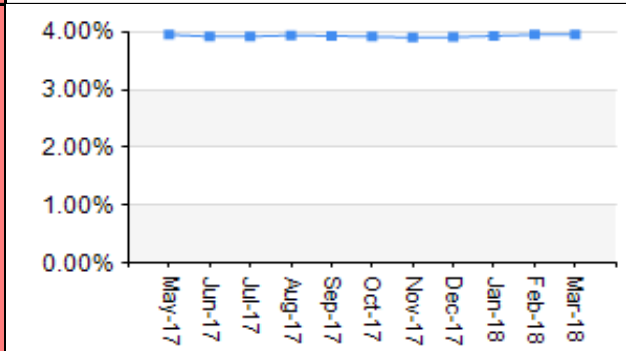
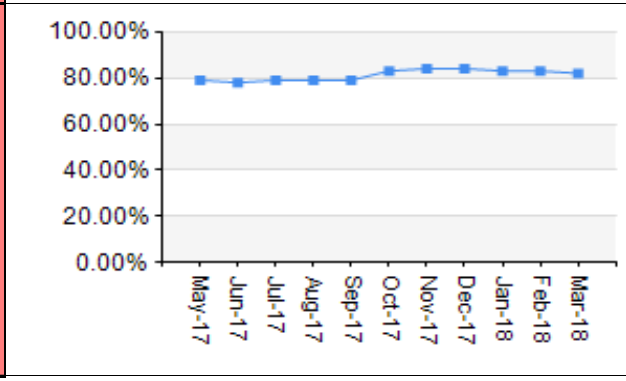
Metric Name & Target	Trend Chart	Exception Notes	Owner
Ambulance Handovers - Over 30 Minutes **Target: < previous year**		Ambulance handover delays now minimised with new majors receptionist and ED triage nurse with Patient handover at point of entry to ED. Work is taking place with system partners to reduce evening ambulance surges, by managing the GP referrals through a bookable AEC. Improved flow out of the Emergency Department is assisting with this standard.	Deputy Chief Operating Officer
Ambulance Handovers - Over 60 Minutes **Target: < previous year**		Ambulance handover delays now minimised with new majors receptionist and ED triage nurse with Patient handover at point of entry to ED. Work is taking place with system partners to reduce evening ambulance surges, by managing the GP referrals through a bookable AEC. Improved flow out of the Emergency Department is assisting with this standard.	Deputy Chief Operating Officer
Cancer - Urgent referrals Seen in Under 2 Weeks **Target: >=93%**		March performance - 90.4% (unvalidated) Target 93% All specialties bar two met the standard. Lower GI 73.2% (269 - 72 breaches) and UGI 78.7% (245 - 52 breaches). LGI Glanso clinics booked for 14th April (80+ clinic) with two more in May to reduce backlog UGI - Streamlined process so that Endo referrals go straight to Endoscopy. April performance shows improvement but endo capacity still impacting performance with demand at present.	Deputy Chief Operating Officer

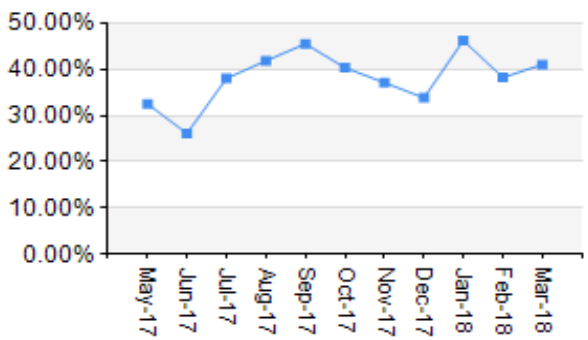
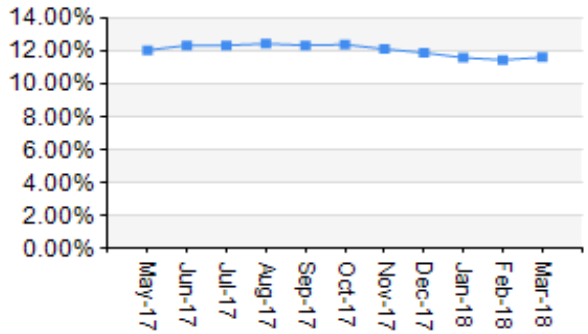
Cancer (104 Days) - With TCI Date **Target: 0**		104 day patients = 28 With TCI = 10 Without TCI = 18 LGI = 10 Uro = 13 UGI = 3 H&N = 1 Haem = 1 104 day number has been dropping over last 3 months. However numbers seem to be stagnant at an average 21 patient over last 6 weeks.	Deputy Chief Operating Officer
Cancer (104 Days) - Without TCI Date **Target: 0**		104 day patients = 28 With TCI = 10 Without TCI = 18 LGI = 10 Uro = 13 UGI = 3 H&N = 1 Haem = 1 104 day number has been dropping over last 3 months. However numbers seem to be stagnant at an average 21 patient over last 6 weeks.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		March performance 93.7% improvement on 80% for February (target 90%)	Deputy Chief Operating Officer

Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		March performance = 76.7% unvalidated Uro - 15.5 LGI - 6 Lung 2.5 13 breaches due to complex pathway 12 breaches due to elective care capacity 5 breaches due to pathology/radiology 3 patient choice breaches	Deputy Chief Operating Officer
Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Continued struggle to encage Junior Doctors to complete the clinical information assessment 'page' in Trakcare. Monthly alerts to juniors, also being led by Dr Alexander, and the Dementia team	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Continued struggle to encage Junior Doctors to complete the clinical information assessment 'page' in Trakcare. Monthly alerts to juniors, also being led by Dr Alexander, and the Dementia team	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Continued struggle to encage Junior Doctors to complete the clinical information assessment 'page' in Trakcare. Monthly alerts to juniors, also being led by Dr Alexander, and the Dementia team	Deputy Nursing Director & Divisional Nursing Director - Surgery

ED Time To Initial Assessment - Under 15 Minutes **Target: >=99%**		Physical environment for nurse led triage in ED GRH has been altered and IT systems updated to facilitate improved performance against quality standard (NHSI 90% Feb 18)(National 95%). Staffing challenges have prevented this from operating fully to date, but it is anticipated we will be able to operate this model 24/7 from late April 2018.	Deputy Chief Operating Officer
ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		60 minute medical assessment standard is improving but considerable work still to be achieved. Less congestion and flow with a better fill rate on the rota has made a slow, gradual improvement. Focus is being placed on this standard within the Emergency Department to understand how we can improve against this quality metric.	Deputy Chief Operating Officer
ED Total Time in Department - Under 4 Hours **Target: >=95%**		Performance was above the STF trajectory for March at 86.4%. Separate Emergency Care exception report is provided.	Deputy Chief Operating Officer
Friends and Family Test Score - ED % Positive **Target:**		The general increase in the positive score reflects the work being undertaken in ED to move the patients through within the 4 hours target. Despite another challenging month within the system, staff have worked hard to deliver a positive patient experience. Staff have also embraced quality improvement with the introduction of several initiatives including improving the experience of our older patients and those who are at risk of falling. Following the presentation of a patient story to Trust Board about the experience of having to wait in one of our corridors have further improvements have been made including investigating availability of warmer blankets and call bells.	Head of Patient Experience Improvement

Friends and Family Test Score - Inpatients % Positive **Target:**		Developing divisional and speciality dashboards for scores; supporting ward teams to introduce Patient Experience Quality Improvements: supporting staff to understand their data. Specific work in Paediatrics to improve accessibility to the FFT to help provide further insight data by using the 'Wise Owl' approach has now commenced. Looking at other methods in areas with low uptake of the test.	Head of Patient Experience Improvement
GRH ED - Percentage Within 4 Hours **Target: >=95%**		Please see Emergency Care Delivery Group Exception Paper Whilst the Trust did not deliver the National 4hr performance standard in February it did deliver against the STP trajectory. March performance was 86.94% against a target of 83.5%.	Deputy Chief Operating Officer
Number of Breaches of Mixed Sex Accommodation **Target: 0**		Performance for December has delivered the Trust trajectories at aggregate level. The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. A total of 6 breaches declared by the Trust for the month of March 2018, impacting on 20 patients. The analysis shows that all 6 breaches were within the Critical Care departments. All breaches were due to the inability to move patients out of Critical Care areas once they had been made wardable. This is particularly prevalent at the GRH site where the operational OPEL status is often at level 3 (red) or 4 (black) and bed availability poor. The Standard Operating Plan has been developed and this issue has been escalated to the Chief Nurse.	Head of Capacity and Patient Flow

Number of Medically Fit Patients Per Day **Target: <40**		The number of medically fit patients per day has risen again in March, by 2 due to increased ED admissions and the demand placed upon adult Social care for patients waiting for or in assessment. Actions taken by the Flow Taskforce to rectify this include the development of a discharge task force including a Junior Doctor, a senior nurse manager and a senior therapist they undertake Monday, Wednesday and Friday deep dives to include chasing diagnostics, reviewing result's bring forward therapy reviews and writing TTO and discharge summaries. Daily reviews of all medical outliers take place through the MDT navigation meetings and in support of this is the weekly system partnership meeting to discuss complex cases and resolve issues. The top 12 Delayed Transfer of Care standards now in place report monthly on longest delays, trends and themes to guide work streams for the Taskforce. For March the NHSI have now released a Delayed Transfer of Care toolkit to further inform work streams. A number of work streams continue to support reduced LoS through Stranded patient reviews. LOS remains in the green range.	Deputy Chief Operating Officer
Sickness Rate **Target: G<3.6% R>4%**		Sickness Absence peaked during winter months, however has begun to reduce to normal levels again (rolling 12 month figure is 3.95% against a target of 3.50%)	Director of Human Resources and Operational Development
Staff who have Annual Appraisal **Target: G>89% R<80%**		Appraisal Compliance has decreased from 83% to 82%. However, we will maximise the opportunity to further promote appraisals as we launch our new talent development process over May-June 2018.	Director of Human Resources and Operational Development

Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour **Target: >=50%**		The organisation is still striving to achieve the target of scan within 1 hour of arrival. This is primarily due to insufficient awareness of the standards and also linked to time to assessment within ED. Stroke champions have been created within the ED nursing and medical teams to ensure all staff are aware of the quality standards for this service and improved communication, escalation and response times for patients awaiting diagnostic tests features on the ED task and finish action plan. Following review between Medical Divisional Team, an education and communication programme will be launched to increase awareness of this key quality standard within ED and with our partners in SWAST. Tara Wilson to present roll out plan to Medical Division in May 2018.	Director of Operations - Medicine
Workforce Turnover Rate **Target: 7.5% - 11%**		Turnover continues to decrease, at 11.44% this now sits below 2016-17 levels and closer to our target of 11%. RGN turnover in particular has reduced to 10.49%	Director of Human Resources and Operational Development

REPORT TO MAIN BOARD – MAY 2018

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

This report describes the business conducted at the Quality and Performance Committee on 29th March 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	The report identified current strategic risks and areas requiring enhanced surveillance by the Committee. It also provided further detail of new risks and the opportunity for assurance-based discussion. Never events: update received concerning review of surgical-related never events by specialist investigator Prof Jane Reid. Risk of reduced safety due to patient falls. Day surgery unit safety concerns have arisen as a consequence of how the area has been used during the winter period and its impact on staff and patients.	Are we satisfied that we have taken sufficient short term action in respect of the surgical never events in advance of Prof Jane Reid's report.	Report and action plan expected May 2018. Full compliance with serious incident report arrangements Report expected May 2018	Will this be presented by the surgical division? Outcome of a quality summit on this issue to be reported in April. The issue will also form part of the wider review of the Winter Plan.

		Progress against patient story issues raised in Board about corridor waits.	Director of Quality and Chief Nurse confirmed immediate steps re blankets, charges and call bells.	
Quality and Performance Report	Trust performance to Feb 2018 reviewed. Trust met Trust and NHSI/E trajectory for A&E 4 hour (88.5% against 80%) and Diagnostic 6 week wait for 5th consecutive month. Trust did not meet standards for for 2 week wait or 62 day cancer standard. Resting on 18 week referral to treatment (RTT) remains suspended. Verbal update on progress with Clostridium Difficile. NHSI regional lead for infection control has reviewed Trust oversight and assurance arrangements.	Positive news re outpatients Friends and Family results. Areas for further development include grade II pressure ulcers. Re Performance, discussion focused on need to further improve patient treatment lists (PTLs). Generally positive response to formats and content of Emergency Care and Cancer exception reports. However, RTT reporting still shows areas of imprecision.	Further improvements to RTT reporting to take place as Trakcare recovery project progresses.	Future reports to QandP to include trajectory of delivery on plans to accurately record RTT pathways. Further information requested on 4 hour trolley waits to understand outliers.
Exception report from the Emergency Care Board	Emergency Care: Briefing received re staffing changes to locate discharge responsibility with wards.	What are the concerns arising from rotas within ED?	ED rotas being reviewed.	Leadership dimensions to be considered within Workforce Cttee.

	CQC letter received re winter pressures. Particular discussion on requirements for staffing to be responsive to changing levels of patient activity and dependency.		Current means of providing data were described. E-rostering implementation from April 2018 will assist further.	
Exception report from the Planned Care Board	Planned Care: Particular discussion of: - Follow-up appointments; - - Clinic typing; - Work with GCCG to address levels of Did-Not Attends and cancellations.	How will work to address cancellation of clinics be led? What can be learned from RCA of breaches?	Secondment to post has been confirmed Review process described but still a lack of review capacity. Arrangements for strengthening clinic typing were described.	
Exception report from the Cancer Delivery Group	- 2 week wait position holding at 90.6% - New 2 week wait forms likely to reduce inappropriate referrals - Confirmed sustained reduction in patients waiting 104 days - Concerns at levels of upgrade from routine to urgent and resource implications.	How do improvements in 62 day performance compare to the same period in 2017? What issues have been identified recently on this and other areas of service from patient feedback?	They compare favourably. Concerns raised re inability to get through on telephones. 9 of 15 vacancies in booking office have been recruited to. New telephone system implementation being planned.	
Feedback from CQRG (full title)	CCG representative identified principal issues discussed at last meeting being ED checklist, CQC action plan, Staff Survey, and the deteriorating patient.			

Feedback from Audit and Assurance	Relevant issues for Q&P included the Trust's Risk Register and consideration of how assurance committees are considering their individual risks. There was also a report from internal audit concerning mortality which received a medium risk rating.			
Stroke Action Plan	Presentation received from the Clinical Lead for the Stroke Service. The presentation explained the Trust's history within the Sentinel Stroke National Audit Programme and the associated improvement initiatives. Plans to improve the stroke pathway were identified and the ambition to move from a current SSNAP score of a high D to C within the near future. Current challenges include stroke consultant and specialist nurse staffing; levels of therapy provision, weekend coverage and an outcome re: community stroke rehabilitation unit. A case study demonstrated excellent working with specialist provision at Southmead and the outcome for the patient.	The report was commended for its clarity, evident passion for improvement and for how it integrated a wide range of datasets in a compelling way. What action is needed to address nursing levels and ratios?	Director of Nursing currently reviewing nursing skills mixes and deployment for 2018/19 planning purposes.	

Mortality Report	HSMR and SMR continue to be within the expected range and confirm achievement of Trust's strategic goals for HSMR. Evidence of innovative approach to Learning from Deaths in the form of a staff newsletter in the Emergency department which briefs staff on the outcomes of structured judgement reviews and relevant learning.			
Safer Staffing	Briefing provided of overview of staffing position as at the end of February 2018. For the second month a very demanding situation was reported attributable particularly to flu and patient demand. Specific pressures were identified at GRH on ward 9A, day surgery unit, emergency department and AMU and at CGH in the emergency department. The regional context was reported as demonstrating a very difficult position across other Trusts. Percentage of new harms has reduced to 3.6% from 4.1%. The report identified current activity to determine optimum staffing levels and skill mixes.	There seems to be evidence of a correlation between harm and staffing levels. While short term actions appear to be in place what are the strategic intentions for addressing nursing levels?	The current baseline assessment will inform strategic recruitment intentions.	Quality and Performance and Workforce Committees to maintain a joint approach to oversight of progress.

Serious Untoward Incidents Report	Report provided assurance that the Trust had met contractual standards for investigation and learning in Serious Incidents. There has been one further Never Event since the last report which is a wrong site pain block. The new healthcare safety investigation branch are to investigate certain categories of maternity incidents during 2018/19. Exact arrangements as to how this will work and how HSIB will interface with the Trust still to be determined.	Positive feedback about the value of 72hr reports being available for the Committee to consider. How are our learnings from serious incidents for patients with a learning disability identified? The importance of investigations facilitating swift learning and improvement activity was stressed.	Director of Quality and Chief Nurse confirmed intention to report fully with annual safeguarding item.	Further work to align safeguarding reporting with revised Q&P arrangements.

Claire Feehily
Chair of Quality and Performance Committee
29th March 2018

REPORT TO MAIN BOARD – MAY 2018

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

This report describes the business conducted at the Quality and Performance Committee on 26 April 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	The report identified current strategic risks and areas requiring enhanced surveillance by the Committee. Discussion focused on an update re external review of sequence of surgical-related never events. Report will be considered at the Committee in May. Cultural dimensions, particularly quality of communication will feature.			Further report May 2018
Quality and Performance Report	Trust performance to March 2018 reviewed. Trust met Trust and NHSI/E trajectory for A&E 4 hour (86.94 % against 83.5%). Qtr 4 performance was also above agreed trajectory. Diagnostic 6 week wait achieved for 6th consecutive month.	The Committee commended the team on clear evidence of progress across a range of standards and indicators, and for achieving such an improved year-end dashboard.		Greater focus on data about quality required in future reporting. Greater analysis of qualitative patient experience material required eg on experience of ED waits.

	Trust did not meet standards for for 2 week wait or 62 day cancer standard. Resting on 18 week referral to treatment (RTT) remains suspended. Discussion about the balance of the current performance report, particularly the need to integrate more qualitative information from patient sources for regular consideration alongside performance metrics.			
Exception report from the Emergency Care Board	Emergency Care: Particular highlights: - A&E trajectory achieved - Excellent performance re ambulance handovers - Comprehensive improvement for stroke patients across a range of indicators Areas for further focus and improvement: - Acute floor changes at GRH - Staffing changes to improve nurse triaging - 60 minute medical assessment standard - Capturing and understanding patient experience to drive quality improvements	When will we be able to identify lessons from review of winter plan?	Review process is continuous however formal review about to be undertaken and will be brought to Cttee in June.	

Exception report from the Planned Care Board	Planned Care: Particular discussion of: - Improvements to RTT lists and quality of patient data - Delivery plan for RTT now segmented by specialty - 52 week breaches and fact that Trakcare improvements mean more of these cases are now known about - Clinic typing update, including how to ensure GPs receive most appropriate and urgent information.		Discussion of processes in place to support such long-waiting patients.	This analysis to be included in future reports.
Exception report from the Cancer Delivery Group	Cancer Care: - Discussion of performance at specialty level. Skin and Gynaecology performance especially strong - Challenges in Urology and Lower GI - Implications of patient choice where urgent appointments are not being taken up - Challenge of managing escalating volume of referrals and discussion of work with GCCG to address with GPs.	Generally positive feedback re high quality of exception reporting on cancer and planned care which enables good discussion and challenge. See earlier point the need to integrate qualitative information.		

- **Exception Report from the Quality Delivery Group**	First of the new-style exception reports from this new group was received - Review of quality dashboard taking place; - Development work on quality strategy; - Focus on CQC action plan: - Discussion of very successful Pecha Kucha event; celebrating our improvement culture; - Increase in number of issues raised in quarter with Freedom to Speak Up Guardian (23).	When will we begin to receive routine updates on Safeguarding matters?	Format and frequency of Cttee's oversight to be determined.	Circulate three most recent sets of minutes to Q&P members. Cttee NEDs to meet lead Exec to see revised reporting intentions.
Patient Experience Improvement Report	Overview of Quarter 3 reported experience. -Key issues included complaints: 254 received (7% decrease on previous quarter) with 97% acknowledgment within 3 days but 67% response rate within local standard of 35 days, which is a 13% improvement from last quarter - 91% FFT recommendation. Wider discussion across several. Items about the need to bring a patient experience strategic discussion and focus to QandP, which will have implications for how we report performance as	Can we have more benchmarking data in future reports to understand our comparative position with similar Trusts? Can we have divisional data for our complaints response performance in future? Could we orientate future reporting more towards outcomes of our patient experience activity? Currently the report's focus is upon processes.	Feedback noted for future reporting.	

	well as patient feedback.			
Better Births Plan	Divisional attendance to present Gloucestershire's Plan, updating on progress in Plan's first 8 months and identifying comprehensive and wide-ranging set of work streams. Good ownership of the Plan was reported to support a significant engagement and quality improvement effort.	What are the specific peri-natal mental health dimensions? What are the governance arrangements around these major transformation projects? How does the project tackle the complex and challenging diversity issues that need to be addressed?	These were summarised and the importance of achieving a correct internal as well as external focus was identified. The Trust has a peri-natal mental health nurse in post. Governance structure was visible but work to do to assess what of this to report into Cttee and when / how. The engagement process and progress was described. Specific support from Healthwatch was acknowledged, supporting specific communities to highlight their views and experiences. Some difficulty in finding appropriate venues for engagement were flagged.	Some residual concerns re whether diversity dimension is entirely addressed. Team to receive any ideas from a Cttee members and to work with patient experience team.

Claire Feehily
Chair of Quality and Performance Committee
3 May 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

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

Purpose

To provide an update on the patient experience improvement work that has been initiated in response to the stories presented to Board from October to February 2018.

Key issues to note

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

Conclusions

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

Implications and Future Action Required

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

Recommendations
The Board are asked to note the contents of this report.
Impact Upon Strategic Objectives
Outstanding rating by CQC in the domain of caring Friends and Family Test positive score of 93% Improving the outpatient experience (complaints to less than 30 per month)

Impact Upon Corporate Risks
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
Improvement work being carried out in response to stories.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

MAIN BOARD - MAY 2018

PATIENT EXPERIENCE IMPROVEMENT IN RESPONSE TO BOARD STORIES

1 Patient Experience Improvement Work

The aim of this paper is to give the Board an update on the patient experience improvement work that has been initiated in response to the stories that have been presented to Board October – February 2017/18.

2 Patient Experience Stories

2.1 Collaborative working with the voluntary sector Carers Gloucestershire - Carers experience story October 2017

Carers Gloucestershire was founded over 20 years ago. Today, they continue to provide vital services, support and advice for carers when they need it most. Established in 1992, they are one of the Carers Trust's 'Centres of Excellence'. Their mission is to empower carers in Gloucestershire, promote carers rights and enable carers to make positive choices to improve the quality of carers' lives. A carer is anyone who gives unpaid support to someone who can't look after themselves. Being a carer can be isolating and exhausting. Carers Gloucestershire offer support for carers to help, not only their physical and emotional well-being, but to help carers to make informed decisions so that have a positive, lasting influence on their lives. Most importantly they offer services to carers which are free of charge.

In October Louise De Lloyd came and spoke about her experience working as our Carers Gloucestershire Hospital Liaison Officer.

Quality Improvements

Louise works closely with the Patient Experience Improvement Team and so since her presentation to Board we have supported Louise by:-

- Making her role more visible in the Trust by introducing her role on the **Trust Induction Training.**
- Involving Carers in our **discharge quality improvement work streams**. A focus group is being held on 3rd May 2018 with our Members many of whom are attending as they are Carers.
- Assisting Louise to attend the **GSQIA quality improvement training** and now after her bronze training she is working towards gaining her silver award. Louise's project aims to recruit and train volunteers who will in turn identify carers and give them information packs or refer to her as the Hospital Liaison Officer. So far we have recruited and trained 4 volunteers to support Louise. As a Gold Coach in training the Deputy Director of Quality is acting as Louise's support.
- Once she has finished her Silver award the Patient Experience Improvement team will work with her to develop a **quality improvement strategy for Carers.**

2.2 Paediatric Oncology Experience

Sarah Sadler shared her family's experience whilst her son was under the care of the paediatric oncology team. When Sarah told Michael and her family's story she drew out some key points:

- The creative activities available on the paediatric ward and the availability of play specialists who helped Michael with his anxiety were fabulous. In particular, they made Michael's Hickman line less traumatic and covering the blood machine in balloons made the treatment less intimidating. Michael made twenty trips to theatre

and initially this filled him with anxiety: he was restrained on the first 5 or 6 occasions. The paediatric team set up a treasure hunt and a scooter to get him to theatre and the entire experience reformed.

- Sarah praised their paediatric consultant and his clear and to-the-point approach.
- Sarah had not appreciated what the practice of ringing the bell at the end of treatment and the closure this brings would bring to her.

Quality Improvements in Paediatrics

Paediatrics have a suite of quality improvement work; currently one project is a co-design project where the play specialists have sought views from patients aged 8-15 and their pathway through Paediatric Assessment Unit has been process mapped. Observations of care took place the week commencing 8th January 2018. Staff interviews also took place on 8th January 2018. Many of the things that Sarah had said were important have also been raised. Children like to have continuity of care as this is really important to them. They dislike repeating their histories each time they meet a new clinician. This important work is ongoing and will be reported to Board in the future.

2.3 December 2017 GEEC! Gloucestershire Elderly Emergency Care

Dr de Weymarn came and talked about Gloucestershire Elderly Emergency Care (GEEC). The programme's aim was to ensure that best practice was adopted throughout the Emergency Department in the care of the older person. Dr de Weymarn then shared a video in which a local actor played the part of an elderly patient challenging the onlooker to see a person in front of them, not just a patient or the diagnosis. Dr de Weymarn described that patients who were confused found hospitals terrifying.

Quality improvements

- Twiddlemitts have been provided to the South West Ambulance Trust to help confused patients whilst they are being transferred to hospital.
- "Tanya's Telly"; is proving to be a success (this is a television with a DVD player, so that patients could watch films in a home-like environment, taking their mind away from a busy hospital environment, etc.). Staff are complimentary about the television and its calming effect (it was noted the television worked equally well with children).
- On Valentine's Day Tanya had a whole day devoted to falls prevention and implemented red blankets for those patients who were at risk of falls. There were also education elements for staff but also it was a fun day. Dr De Weymarn filled the Emergency Department with lots of falls information, balloons, there were quizzes for staff (with prizes), cakes to have on their coffee break, there were posters on the wall with information tips for staff (heart shaped of course) and she was there to answer their questions. In the fracture clinic were cards advising patients and staff that if someone sustains a fracture after a fall from standing height or less then a bone health assessment should be offered.
- Dr De Weymarn recently won the 999 Breeze award in recognition of her work that she does in the Emergency Department.
- Focus groups are planned for the Summer to find out from users of the services what improvements they would like to see (co-design).

2.4 January 2018 The Learning Disability Nurses

The Trust's Learning Disability Liaison Nurses gave a presentation detailing their roles and work undertaken. The presentation highlighted:

- The butterfly badge used to identify patients with learning and cognitive disabilities, including positive response to the pilot and subsequent widespread implementation.
- The Emergency Department and how the **lack of continuity of care** affects patients. A great deal of work has been done to deliver training to unscheduled care resulting in a substantial improvement with reasonable adjustments now being made.
- An alert has been implemented to highlight LD patients and their support plans. Work is underway to improve the transition children with learning disabilities moving to adult care.
- The Trust's Health User Group, including its membership, operation, achievements so far and future plans.

<u>Quality Improvements</u>

- The LD team are working with matrons and ward managers to get attendance of LD champions at regular meetings.
- Work continues with supporting staff to understand the Mental Capacity Act in practice.
- A work stream is proposed to improve discharge and discharge planning within the larger QI programme of work.
- The LD nurses team are now based with the Patient Experience Improvement Team.
- There should be **equality of outcome** and this should be introduced as part of the QI strategy and the Journey to Outstanding. Mapping LD care through the Trust's Journey to Outstanding.
- Work is underway to improve the transition children with learning disabilities moving to adult care.
- TrakCare system that the team was utilising and the data showed that more patients were being flagged as having a LD since the function was available.

Patient Experience Network National Awards (PENNA)

The non-profit Patient Experience Network (PEN) announced winners for its national healthcare awards to recognise outstanding initiatives and national good practice across the NHS. From these, an overall category winner was chosen by the judges. This year, the winning project was from our Trust for 'Small Steps – big Changes', an initiative to engage their staff more in using patient feedback data from a range of sources – such as surveys, the Friends and Family Test and routine comments to staff – to turn into action to improve patient experience. The project began on one ward and is currently being rolled out across more areas. Judges felt it was innovative in the way it empowered staff to take ownership of issues identified by patients and to drive changes that could make a difference – even if only to a few people at a time. The Trust was also runner up in the category Communicating Effectively with Patients and their families for the Deaf Communication cards.

3 Recommendation

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

Author: Suzie Cro, Deputy Director of Quality & Freedom to Speak Up Guardian
Presenting Director: Steve Hams Director of Quality and Chief Nurse
Date: 2nd May 2018

MAIN BOARD – MAY 2018
Redwood Education Centre commencing at 09:00

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Bev Williams, Risk and Assurance Manager Sponsor: Lukasz Bohdan, Director of Corporate Governance

Executive Summary

Purpose

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

Key issues to note

- The Trust Risk Register enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.

- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register. Risk assessed as having an impact of catastrophic (5) need to be considered for inclusion in this process as per Risk Register Procedure.

- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context.

- Work continues to review those Divisional risks at 12+ for safety and 15+ for other risk domains that have not yet been migrated to the Trust Risk Register. This number currently stands at 8, which continues to demonstrate an improvement in process over previous months.

- The Trust Risk Register has been adapted to include reference to Board Assurance Framework (BAF) elements providing further basis of issues associated with the achievement of the Strategic Objectives.

Changes in Period

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

April
- Nil

May 2018
- **C2669N** - Risk of significant harm to patient as a result of falling (Safety 12).
- **C2667NIC** - The risk of regulatory intervention as a result of exceeding the avoidable annual *C. diff* target (Statutory 16). Upgraded following an NHS Improvement visit in March 2018.

Three risks have been downgraded in this reporting period.

April

- **C2614NIC** – The safety risk of delayed tracking and treating on infections as a consequence of relying on a manual system – confirmation was received that an upgrade of the current electronic tracking system had been purchased and that the existing system remains functional until it is installed later this year. **Risk closed**

May

- **F2518** - Risk that Financial Year (FY) 2017/18 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation.
- **F1339** - Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for Financial Year 2017/18.

TLT agreed that the financial risks should be closed as referring to financial year 2017/18; while recognising that there would be 2018/19 iterations. At this stage though they do not trigger the criteria for inclusion on the Trust Risk Register

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

Conclusions

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

Implications and Future Action Required

To ensure that the work to migrate or de-escalate all Divisional risks 15+ is concluded and to progress the review of all safety risks of 12 or over for future incorporation on to the Trust Risk Register.

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					2 May 2018	
Outcome of discussion when presented to previous Committees						

Trust Risk Register

May-18

Ref	BAF ref	Division	Highest Scoring Domain	Executive Lead	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
F2335	4.3	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance Committee, Workforce Committee	The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2.Increase challenge to agency requests via VCP 3. Convert locum\agency posts to substantive 4. Promote higher utilisation of internal nurse and medical bank.	Incomplete	Major (4)	Almost certain - Daily (5)	20
C1748COO	1.3, 3.1	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee	The risk of statutory intervention for failing national access standards in relation to cancer.	1. Weekly meetings check and challenge with all specialties, patient by patient level review 2. Dir-Ops weekly challenge with COO and Director of Planned Care 3. Validation of Patient tracking list daily by GMs 4. Performance trajectory in place for cancer pathways 5. Action plan in place for Delivery of Cancer Trajectory (30 April 18)	Incomplete	Major (4)	Almost certain - Daily (5)	20
D&S2629Path		Diagnostics and Specialties, GP Services / NHS England, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Divisional Board	The risk of failure to recover and re-accredit following a critical CPA /UKAS report on the provision of the Haematology, Transfusion and Immunology Laboratory Services	VCPs and QIAs completed for all vacancies. Retired staff employed on bank contracts. Trainees employed as MLAs. Bank MLAs employed to ensure all tasks that do not require registered staff are completed. Recruitment and Retention premium paid for unsocial hours. Training payment agreed for staff working hours above contract. Agency staff employed to enable experienced staff to maintain service to critical areas, supervise and train new and inexperienced staff.	Complete	Major (4)	Almost certain - Daily (5)	20
S2275	2.2	Surgical	Workforce	Medical Director	Workforce Committee	The risk to workforce of an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers.	Attempts to recruit Agency/locum cover for on-call rota Nursing staff clerking patients Prioritisation of workload Existing junior drs covering gaps where possible Consultants acting down	Incomplete	Major (4)	Likely - Weekly (4)	16

Ref	BAF ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
C2667NIC		Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee	The risk of regulatory intervention as a result of exceeding the avoidable annual C.Diff target.	Detailed action plan has been developed and reviewed by the Infection Control Committee, focusing on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the environment and antimicrobial stewardship.	Partially complete	Major (4)	Likely - Weekly (4)	16
F2623	4.1	Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Finance	Interim Director of Finance	Finance Committee	The risk that the Trust is unable develop a financial plan that is acceptable to the Board and/or to agree the proposed Control Total for 2018/19 with NHSI resulting in extension of Financial Special Measures and increased regulatory action	Regular NHSI FSM meetings Monthly monitoring, forecasting and reporting of performance against budget by finance business partners PMO in place to record and monitor the FY18 programme (including monitoring and reporting of performance against target) Turnaround Implementation Board scrutiny of delivery Weekly 1:1 meetings with Divisions on financial recovery with strengthened Executive membership and chaired by the Head of Operational Finance and Recovery. Bi-weekly meetings with cross cutting themes. Monthly executive reviews Smartcare Programme Board overseeing Trak recovery and regular monitoring and analysis of data completeness (and quality) and income recovery	Complete	Catastrophic (5)	Possible - Monthly (3)	15
M2473Emer	1.2, 1.5, 3.1	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	Incomplete	Moderate (3)	Almost certain - Daily (5)	15

Ref	BAF ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
C1609N		Corporate, Diagnostics and Specialties, Estates and Facilities, Medical, Surgical, Women's and Children's	Safety	Director of Quality/ Chief Nurse	Quality and Performance Committee, Workforce Committee	Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.	1. Pilot of extended Bank office hours 2. Agency Taskforce 3. Bank incentive payments and weekly pay for bank staff 4. General and Old Age Medicine Recruitment and Retention Premium 5. Master vendor for medical locums 6. Temporary staffing tool self assessment 7. Daily conference calls to review staffing levels and skill mix. 8. Ongoing Trust wide recruitment drive 9. Divisions supporting associate nurse and CLIP programme. 10. Initiatives to review workforce model, CPN's, administrative posts to release nursing time 11. Implementation of Bank / agency block bookings / long lines of work to locations of high vacancy and or Mat Leave	Partially complete	Moderate (3)	Likely - Weekly (4)	12
C1798COO	1.3	Medical, Surgical	Safety	Chief Operating Officer	Quality and Performance Committee	The risk of delayed treatment and diagnosis due to delays in follow up care in a number of specialties including neurology, cardiology, rheumatology,ophthalmology, general surgery, urology, vascular, T&O and ENT.	Each is developing a specialty delivery plan PTL for follow up pending is in place - validation by specialities is required to provide a clear list.	Incomplete	Moderate (3)	Likely - Weekly (4)	12
C2669N		Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Quality and Performance Committee	Risk of significant harm to patients as a result of falling	Patient Falls Policy Falls Care Plan post falls protocol Falls Training Trust Falls Steering Group Trust Falls Action Plan Group NICE Falls Clinical Guidance Harm Review Group HCA specialing Training #Little Things Matter Campaign Equipment to support falls prevention and post falls management	Complete	Major (4)	Possible - Monthly (3)	12

Ref	BAF ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
S2595Th		Estates and Facilities, Surgical	Safety	Chief Nurse, Director of Quality	Divisional Board, Infection Control Committee, Quality and Performance Committee, Trust Decontamination Group	The risk of harm to patients due to correct and sterile equipment not being available from CSSD	Heavy contaminated sets go through pre clean All sets go through washer disinfectors All machines have valid testing certificates Internal non conformist reports Bioburden testing Quarterly testing on clean room (external) Checks in CSSD prior to dispatch Extra integrity check for heavier sets External audit of full process of decontamination Corner protectors and tray liners used on both sites Point protectors used on both sites Transportation trays removal of 3rd wrap on sets Dryness tests of sutoclaves Quality management systems - accredited ISO13485 reusable medical devices	Incomplete	Moderate (3)	Likely - Weekly (4)	12
C2628COO	1.4, 3.1, 3.3	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Operating Officer	Quality and Performance Committee	The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times. The risk on non-reporting of RTT (incomplete) standards.	The standard is not being met and reporting has been suspended. This risk is aligned with the recovery of Trak. Controls in place from an operational perspective are the design and implementation of a patient tracking list, resource to support central and divisional validation of the patient tracking list. Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. A delivery plan for the delivery to standard across specialities is under development but this will need to align with the timeline for trak recovery.	Partially complete	Moderate (3)	Likely - Weekly (4)	12

S2045T&O		Surgical	Safety	Medical Director	Quality and Performance Committee	The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Ward move to improve patient environment and aid therapy Supplemental Patient nutrition with employment of nutrition assistant Increased medical cover at weekends OG consultant review at weekends Increased therapy services at weekends Senior DCC nurses on secondment to hip fracture ward for education and skill mix improvement Review of all deaths	Complete	Major (4)	Possible - Monthly (3)	12
Ref	BAF ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
C1945NTVN		Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality/ Chief Nurse	Quality and Performance Committee	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Nursing pathway documentation and training in place Pressure Ulcer expert committee reviewing practice and incidents to identify learning Monitoring through incident investigation\RCA Divisional committees overseeing RCAs Safety Thermometer data review as part of Safer Staffing	Incomplete	Moderate (3)	Likely - Weekly (4)	12
Risks assessed with an impact of catastrophic (5)											
Ref	BAF ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
S2568Anaes		Surgical	Safety	Medical Director	Divisional Board, Quality and Performance Committee	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	Application to MEF Prioritisation of operations Maintenance by own medical engineering service loan request	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Financial Performance Report - Period to 31st March 2018
Sponsor and Author(s)
Author: Tom Niedrum, Associate Director of Financial Management Sponsor: Sarah Stansfield, Director of Finance
Executive Summary

Purpose

This report provides an overview of the financial performance of the Trust for the year ended 2017/18 financial year. The performance reported here remains subject to external audit as part of the final year-end process. It provides the three primary financial statements along with analysis of the variances and movements against the planned position.

Key issues to note

- In 2017/18 the Trust reported a deficit of £51.6m, which included the impact of a £20m impairment charge.
- After making technical and control total adjustments in accordance with NHSI guidance, the position is revised to a £33m deficit.
- No STF funding has been assumed in the actual position given that the Trust did not agree a control total for the 2017/18 financial year.
- CIP delivery to the year end was £28.5m (5.7%).

Conclusions

- The financial position for 2017/18 showed an adverse variance to plan of £18.4m. The adverse variance is reflective of material income under-performance with commissioners partially offset by pay underspends which are non-recurring.

Implications and Future Action Required

Going into 2018/19, there is a continued need for increased focus on financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trak.

Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.
Impact Upon Strategic Objectives
The financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks

Regulatory and/or Legal Implications							
The variance to plan of the financial position presented in this paper will continue to give rise to increased regulatory activity by NHS Improvement around the financial position of the Trust							
Equality & Patient Impact							
None							
Resource Implications							
Finance	✓	Information Management & Technology					
Human Resources		Buildings					
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 31st March 2018

Introduction and Overview

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

Subject to external audit, the Trust is reporting an actual income and expenditure deficit of £51.6m for the 2017/18 financial year. After making technical adjustments for impairments in accordance with NHSI guidance, this position is revised to a £31.6m operational deficit against a planned deficit of £14.6m. Control total measurement requires further adjustment on capital donations and CQUIN which are shown in the table below. This position was reported to NHSI on 17th April via the Trust's Key Data submission.

The Key Data submission reflects a technical adjustment of £1.5m for the CQUIN risk reserve that commissioners were originally advised to withhold from the Trust in 2017/18, and adjustments for the impact of impairment and donated assets, resulting in a revised deficit of £33m.

Statement of Comprehensive Income

Month 12 Financial Position	M12 Cumulative Budget £000s	M12 Cumulative Actuals £000s	M12 Cumulative Variance £000s
SLA & Commissioning Income	439,649	429,305	(10,344)
PP, Overseas and RTA Income	4,734	4,653	(81)
Operating Income	62,659	64,927	2,268
Total Income	**507,042**	**498,884**	**(8,158)**
Pay	335,864	334,822	1,041
Non-Pay	160,924	176,524	(15,600)
Total Expenditure	**496,788**	**511,347**	**(14,559)**
EBITDA	**10,254**	**(12,463)**	**(22,717)**
EBITDA %age	**2.0%**	**(2.5%)**	**(4.5%)**
Non-Operating Costs	24,885	39,100	(14,215)
Surplus/(Deficit)	**(14,631)**	**(51,563)**	**(36,932)**
Fixed Asset Impairments	0	(19,971)	19,971
Surplus/(Deficit) after Impairments	**(14,631)**	**(31,592)**	**(16,961)**
Capital Donations I&E Impact	0	(90)	90
CQUIN Risk Reserve	0	1,536	(1,536)
Surplus/(Deficit) After Tech Adjustments	**(14,631)**	**(33,038)**	**(18,407)**

Note: The actual deficit reported in the Trust's annual accounts will be £51.6m including the impact of impairment on the Trust's assets, and donated asset income and expenditure. These are excluded when measuring the Trust's performance.

After adjusting for technical items this represents a full year adverse variance to plan of £18.4m.

During the year, the Trust reached agreement with both major commissioners for a block contract arrangement. This meant that income for the six months outstripped budget for those commissioners and gave a favourable variance for that period. Within income there is a favourable variance on pass through drugs and devices of £1.8m.

Detailed Income & Expenditure

Month 12 Financial Position	M12 Cumulative Budget £000s	M12 Cumulative Actuals £000s	M12 Cumulative Variance £000s
SLA & Commissioning Income	439,649	429,305	(10,344)
PP, Overseas and RTA Income	4,734	4,653	(81)
Operating Income	62,659	64,927	2,268
Total Income	**507,042**	**498,884**	**(8,158)**
Pay			
Substantive	312,351	307,850	4,501
Bank	6,561	10,276	(3,716)
Agency	16,951	16,696	255
Total Pay	**335,864**	**334,822**	**1,041**
Non Pay			
Drugs	55,508	61,318	(5,810)
Clinical Supplies	40,178	42,183	(2,004)
Other Non-Pay	65,238	73,024	(7,786)
Total Non Pay	**160,924**	**176,524**	**(15,600)**
Total Expenditure	**496,788**	**511,347**	**(14,559)**
EBITDA	**10,254**	**(12,463)**	**(22,717)**
EBITDA %age	**2.0%**	**(2.5%)**	**(4.5%)**
Non-Operating Costs	24,885	39,100	(14,215)
Surplus/(Deficit)	**(14,631)**	**(51,563)**	**(36,932)**
Fixed Asset Impairments	0	(19,971)	19,971
Surplus/(Deficit) after impairments	**(14,631)**	**(31,592)**	**(16,961)**
Capital Donations I&E Impact	0	(90)	90
CQUIN Risk Reserve	0	1,536	(1,536)
Surplus/(Deficit) After Tech Adjustments	**(14,631)**	**(33,038)**	**(18,407)**

Gloucestershire Hospitals NHS
NHS Foundation Trust

SLA and Commissioning Income – £10.3m adverse position. This is driven by a combination of the impact of block agreements, under performance with commissioners other than GCCG and risk assessment. Within this there is £1.8m over performance on pass through income, resulting in an underlying under performance on non pass through income of £12.1m. Pass through drugs are £3m favourable, whereas devices are £1.2m adverse. Most of the underperformance on devices relates to ICDs moving to the zero-cost model.

Private Patient Income – continues to be broadly on track.

Pay – expenditure is showing a favourable variance of £1m against budgeted levels. This is largely driven by vacancies, combined with under spends in Divisions against budget profile and is further analysed in the pay section of this report. The underspend has reduced from a peak level of £4.9m in month 7 which largely reflects Pay CIPs being profiled towards the end of the financial year.

Non-Pay – Drugs expenditure is showing a £5.8m adverse variance (£2.8m excluding pass through) whilst Clinical Supplies are £2m adverse (£3.2m excluding pass through). Other non-pay is £7.8m adverse including use of Glanso (£1m), external consultancy (£1.2m), an increase in bad debt provision (£0.4m), an unmet rates CIP target (£2.5m) and other unmet CIP targets (£3.8m).

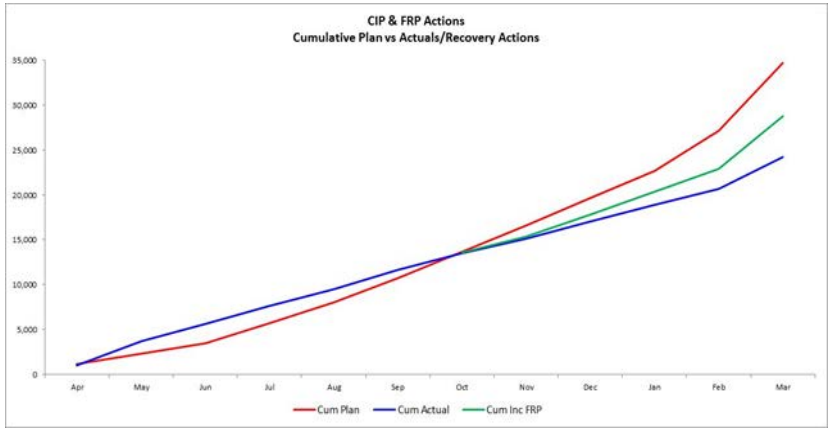
Non Operating Costs – overspend is due to the impact of impairment.

Cost Improvement Programme

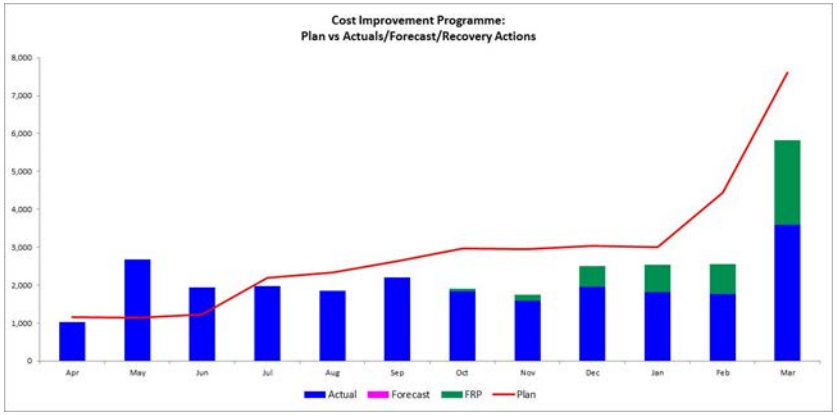
1. At Month 12 we have delivered £24.2m of CIP and £4.5m of Financial Recovery Actions which total £28.7m against the NHS Improvement target of £34.7m
This is an improvement on the Month 11 FOT which was £28.2m.

2. The delivery of £24.2m CIP splits into £17.3m of recurrent and £6.8m of non-recurrent schemes
The non-recurrent schemes include an agency scheme, annual leave accrual scheme and some vacancy factor.

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



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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M12 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	9,131	1,738
Property, Plant and Equipment	296,272	251,010	(45,262)
Trade and Other Receivables	4,668	4,465	(203)
Total Non-Current Assets	**308,333**	**264,606**	**(43,727)**
Current Assets			
Inventories	7,400	7,131	(269)
Trade and Other Receivables	17,697	14,964	(2,733)
Cash and Cash Equivalents	7,974	5,497	(2,477)
Total Current Assets	**33,071**	**27,592**	**(5,479)**
Current Liabilities			
Trade and Other Payables	(44,355)	(43,247)	1,108
Other Liabilities	(2,089)	(3,284)	(1,195)
Borrowings	(5,356)	(5,689)	(333)
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(52,402)**	**(420)**
Net Current Assets	**(18,911)**	**(24,810)**	**(5,899)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,236)	376
Borrowings	(83,126)	(110,234)	(27,108)
Provisions	(1,524)	(1,450)	74
Total Non-Current Liabilities	**(92,262)**	**(118,920)**	**(26,658)**
Total Assets Employed	**197,160**	**120,876**	**(76,284)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	168,767	2,248
Reserves	70,501	43,533	(26,968)
Retained Earnings	(39,860)	(91,424)	(51,564)
Total Taxpayers' Equity	**197,160**	**120,876**	**(76,284)**

The table shows the M12 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 12 balance sheet position against the 2016/17 outturn

Non-Current Assets
- The reduction in non-current assets reflects depreciation charges in excess of capital additions for the year-to-date, and revaluation of assets.

Current Assets
- Inventories show a decrease of £0.3m.
- Trade receivables are £2.7m below their closing March 2017 level.
- Cash has reduced by £2.5m since the year-end, and increased by £1.8m in month.

Current Liabilities
- Trade payables have decreased by £1.1m over the closing March level (a £1.9m increase on the month 11 level).
- Other liabilities have increased by £1.2m since year end.

Non-Current Liabilities
- Borrowings have increased by £32.7m. In the year the Trust received total distress funding of £27.8m and capital funding of £5m. The balance in the Trust's required funding is being financed by improvement in working capital (combination of working capital available from GP training.

Reserves
- The Reserve movement reflects the impact of revaluation.

Retained Earnings
- The retained earnings movement reflects the impact of the in year deficit.

Cashflow : March

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-17 £000s	May-17 £000s	Jun-17 £000s	Jul-17 £000s	Aug-17 £000s	Sep-17 £000s	Oct-17 £000s	Nov-17 £000s	Dec-17 £000s	Jan-18 £000s	Feb-18 £000s	Mar-18 £000s	Year ending 31.3.18 £000s
Surplus (Deficit) from Operations	(4,958)	(3,284)	935	(1,031)	(1,940)	(1,953)	(1,955)	(783)	(4,591)	(327)	1,450	(4,070)	(22,507)
Adjust for non-cash items:													
Depreciation	946	1,719	975	975	975	975	975	975	975	975	975	(1,470)	9,970
Other operating non-cash	(58)	(59)	(58)	(58)	(58)	(58)	(58)	(58)	(58)	(58)	(58)	287	(352)
Operating Cash flows before working capital	(4,070)	(1,624)	1,852	(114)	(1,023)	(1,036)	(1,038)	134	(3,674)	590	2,367	(5,253)	(12,889)
Working capital movements:													
(Inc.)/dec. in inventories	(150)	(1,118)	349	192	367	132	68	0	344	(371)	0	(82)	(269)
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(157)	633	379	1,940	(1,849)	(508)	877	(1,163)	(1,851)	914	(4,651)
Inc./(dec.) in trade and other payables	4,495	328	(2,109)	(530)	514	(3,132)	2,701	(2,337)	1,343	(5,806)	(1,087)	6,450	830
Inc./(dec.) in other financial liabilities	(562)	3,448	(58)	(181)	(129)	153	21	0	0	0	0	0	2,692
Other movements in operating cash flows	835	(995)	32	(31)	32	(79)	206	32	32	32	32	(57)	71
Net cash in/(out) from working capital	(448)	2,863	(1,943)	83	1,163	(986)	1,147	(2,813)	2,596	(7,308)	(2,906)	7,225	(1,327)
Capital investment:													
Capital expenditure	(148)	(989)	(348)	(214)	(909)	(608)	(1,636)	(1,365)	(1,759)	(515)	(1,691)	(3,811)	(13,993)
Net cash in/(out) from investment	(148)	(989)	(348)	(214)	(909)	(608)	(1,636)	(1,365)	(1,759)	(515)	(1,691)	(3,811)	(13,993)
Funding and debt:													
PDC Received	0	0	0	0	0	0	0	0	0	920	0	1,329	2,249
Interest Received	4	3	2	3	3	3	2	3	3	3	3	3	35
Interest Paid	0	(162)	(42)	0	0	(1,329)	(29)	(163)	0	(87)	0	(1,115)	(2,927)
DH loans - received	0	0	0	2,355	0	8,864	1,664	3,452	4,321	6,233	3,909	2,000	32,798
DH loans - repaid	0	0	0	0	0	(1,318)	0	0	0	0	0	(1,318)	(2,636)
Finance lease capital	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(240)
PFI/LIFT etc capital	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(2,172)
PDC Dividend paid	0	0	0	0	0	(3,091)	0	0	0	0	0	(1,284)	(4,375)
Other	0	0	0	0	0	0	0	0	0	0	0	3,000	3,000
Net cash in/(out) from financing	(197)	(360)	(241)	2,157	(198)	2,928	1,436	3,091	4,123	6,868	3,711	2,414	25,732
Net cash in/(out)	(4,863)	(110)	(680)	1,912	(967)	298	(91)	(953)	1,286	(365)	1,481	575	(2,477)
Cash at Bank - Opening	7,974	3,111	3,001	2,321	4,233	3,266	3,564	3,473	2,520	3,806	3,441	4,922	7,974
Closing	3,111	3,001	2,321	4,233	3,266	3,564	3,473	2,520	3,806	3,441	4,922	5,497	5,497

The cashflow for March 2018 is shown in the table opposite. The major movements are consistent with those already identified within income and expenditure and the balance sheet.

Key movements:

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

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

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

Cash Flow Forecast – The Trust continues to forecast a short term positive cash balance.

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Full Year Plan	Full Year Actual
Capital Service Cover Metric	0.60	(0.93)
Rating	4	4
Liquidity Metric	(16.27)	(21.95)
Rating	4	4
I&E Margin Metric	(2.92%)	(6.63%)
Rating	4	4
I&E Variance from Plan Metric		(3.72%)
Rating		4
Agency Metric	38.80%	37.21%
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 M12, which is in line with Plan, and continues to show performance at a "4".

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The financial position of the Trust at the end of the 2017/18 financial year is an operational deficit of £51.6m, which included the impact of a £20m impairment charge. Excluding fixed asset impairments, the deficit is an adverse variance to budget and NHSI Plan of £18.4m.
- The variance is reflective of both year to date pay underspends and phasing adjustments within the income position.

Author:	**Tom Niedrum, Associate Director of Financial Management**
Presenting Director:	**Sarah Stansfield, Director of Finance**
Date:	**May 2018**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – MAY 2018

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

This report describes the business conducted at the Finance Committee held 28th March 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	The Trust is still forecasting £28.7m deficit before income downsides outside Trust control. The income downsides due to potential loss of system CQUINs and in relation to specialist income are likely to crystallise in month 12.	What are the reasons for increases in longer debts and creditors? What is being done to understand the medical and surgical supplies spending?	This largely relates to Gloucestershire Care Services (GCS) and the settlement has been agreed which will enable GCS debts and creditors to be cleared. It was clarified that the variances are not due to budget setting errors in the way that occurs with drugs and the expenditure variances have been investigated as part of the 2018/19 budget setting process.	
Capital Programme Update	The forecast spend remains as previously with planned slippage due to the Cheltenham General Hospital GP streaming project.	How does Subco and GenMed contract change the options for funding capital expenditure in the future?	The Trust has got these new options for funding capital expenditure in the future and work is being done to define a process between Subco and the trust on capital spending.	How soon can the process be in place and working?

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Update on Contracting Round and 2018/19 Financial Plan	The potential for improvement to the 2018/19 plan was noted, however, this is subject to the outcome of commissioner negotiations and further internal work on planning assumptions.	What are the risks to commissioner negotiations?	There is a substantial difference between the Trust and commissioner positions that needs to be resolved during April.	
Cost Improvement Programme (CIP) Update	Forecast 2017/18 CIP is £28.3m in line with previous forecasts. This represents around 5.5% of total expenditure. Work continues to develop 2018/19 CIPs.	What impact is there on culture and do people feel unduly pressurised by their CIP obligations?	A number of safeguards are in place such as Freedom to Speak Up and the QIA process. Leadership by example and visibility play a crucial role.	
Medical Productivity Update	The new approach previously discussed to Clinical Productivity was fleshed out further and now has the same rigour as the rest of CIP.	Do we have the same grip on medical productivity as CIP reporting?	We have and demonstrate through reporting.	Will remain on committee agenda.

REPORT TO MAIN BOARD – MAY 2018

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

This report describes the business conducted at the Finance Committee held 25th April 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Clinical Productivity	Extended analysis with the speciality directors showed variances against benchmark expectations. Close involvement from head of CIP and recognition that there are further opportunities to be realised.	Benchmarking supports the indicative opportunity but implementation and delivery remain a challenge.	CIP disciplines are being followed and resource to support is now better defined.	
Financial Performance Report	Operational deficit for 2017/18 of £31.6m against a plan for £14.6m (downside performance on income due to TrakCare) NHSI technical control total measurement £33m deficit.		Due to management of expectations with NHSI the Trust has delivered the elements of the financial position within its control and NHSI have been well briefed on the final outturn.	The position remains subject to external audit and any change of perspective from NHSI.

Capital Programme Update	Final capital outturn for 2017/18 is £14m against a £15.4m plan. Underspend reflects GP streaming capital and retention of an element of the contingency.	Funding for the 2018/19 capital programme is yet to be formally secured.	The Trust is following the NHSI process for this funding.	Dependent on loan approval capital cash flow may be significantly impacted.
Cost Improvement Programme Update	2-17/18 outturn is £28.5 which represented approx. 6% which is a very strong performance compared to other trusts. Planning for 2018/19 has identified £15.4m against the indicative requirement. The Trust had developed an action plan as a result of a light touch review by PWC. Further rigour being applied in approach and reporting of CIP. The Trust has now demonstrated two years of significantly above average delivery.	Remains a gap.		

Budget Setting	Finance budgets will be released to the organisation in may			
BAF	Already agreed to have Trakcare reported at the next Finance meeting.			
Matters to be Escalated to the Board	- Annual Operating Plan including CIP for 2018/19 - Financial Performance Report for Month 12 including the Capital Programme and CIP			

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

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

Purpose

This report provides Trust Board with an overview of current performance, against key performance indicators and outlines progress against the 6-12m People and OD objectives which link to the Board Assurance Framework.

Key issues to note

- **Turnover** continues to decrease, at 11.44% this now sits below 2016-17 levels and closer to our target of 11%. RGN turnover in particular has reduced to 10.49%

- The Trust **sickness absence** level sits at 3.95%. Despite the usual increase in winter sickness absence, reported levels remain below those experienced in previous years

- **Appraisal** Compliance has decreased from 83% to 82%. However, we will maximise the opportunity to further promote appraisals as we launch our new talent development process over May-June 2018.

- **Mandatory Training** increased from 79% to 82%, compliance appears reduced following a recent change to mandatory requirements – we expect this to continue to improve as staff update their e-learning profiles. We also expect mandatory training to continue to rise following the recent fall in reported compliance associated with the requirement to re-complete safeguarding training.

Progress has been made, and is noted within the report, against all of the key 6-12 month People and OD priorities. The challenge in delivering against these objectives against the backdrop of 'business as usual' is considerable, however we recognise that these priorities are critical to meeting the overarching strategic aims of the Workforce Strategy. **Next Steps** are identified as follows:

Establishment Project

- Align the establishment for the entire Corporate Division (May 2018)
- Use the corporate Division to test and, if necessary, modify the processes supporting the flow of information between support services to ensure establishment alignment can be accurately maintained.
- Confirm the timescales, and commence the alignment of the clinical divisions establishment data (based on the Corporate Division test)

CIP Delivery

- Finalise and promote the revised employment offer to Temporary Staff (new joiners)
- Agree our revised approach to Medical Study Leave payments, in line with benchmarking results and in collaboration with our Local Negotiating Committee.
- Agree amendments to the Trust Organisational Change Policy
- Shirley Daniels to commence the more detailed work behind the Sustainable Workforce project; linking Advanced Clinical Practitioner and alternative role development to business and workforce development plans.

Staff Health and Wellbeing

- Negotiate an extension to the current Occupational Health contract, without increased costs.
- Identify a resource to support the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.

Talent Management

- Launch the new talent management system; supporting staff with tutorials, web based materials and briefing sessions.

Creating Efficiencies and Reducing Bureaucracy (NHSGMS)

- Develop new terms and conditions package (for new employees)
- Embed new Trade Union recognition arrangements
- Commence workforce policy review
- Supporting the cultural change required in the 'colleague to customer journey' through Leadership and Organisational Development intervention and a bespoke package of support.

Staff Engagement

- Trial the use of 'SpeaC Happy App' communications tool with a nominated group of staff, to assess the effectiveness of this tool in providing feedback and improving two way communications.
- Launch the Staff Experience and Improvement Group and associated work to triangulate staff experience data.

Recommendations

Trust Board are asked to NOTE the key performance metrics shared within the report and NOTE the progress made against the key strategic priorities.

Impact Upon Strategic Objectives

Provides an update on progress against the 6-12m Strategic priorities (as endorsed by the Workforce Committee in November 2017). Directly impacts on Trust Strategic Objectives, in particular: staff engagement, turnover and health and wellbeing.

Impact Upon Corporate Risks

The report outlines progress to support the mitigation of the risk of being unable to match recruitment needs with suitably qualified staff, impacting on the delivery of the Trusts strategic objectives.

Regulatory and/or Legal Implications

n/a

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)**
			1.5.18			
Outcome of discussion when presented to previous Committees						
n/a						

MAIN BOARD – MAY 2018

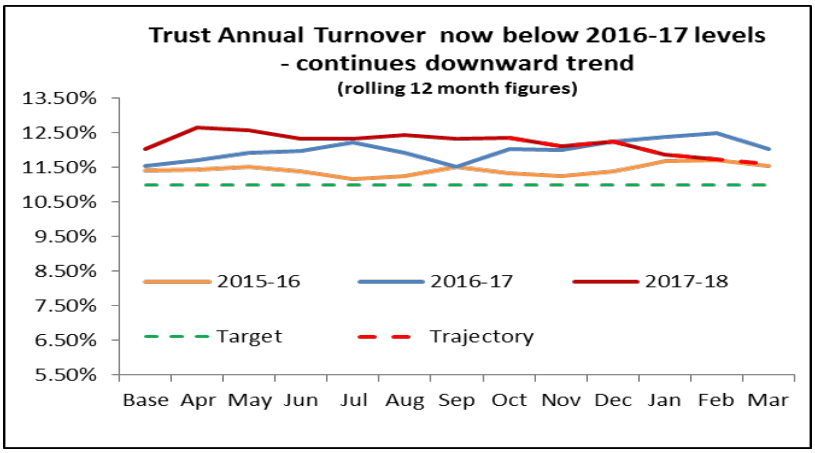
WORKFORCE REPORT

1. Aim

This report provides Trust Board with an overview of current performance, against key performance indicators and outlines progress against the 6-12m People and OD objectives which link to the Board Assurance Framework.

2. Staff Turnover

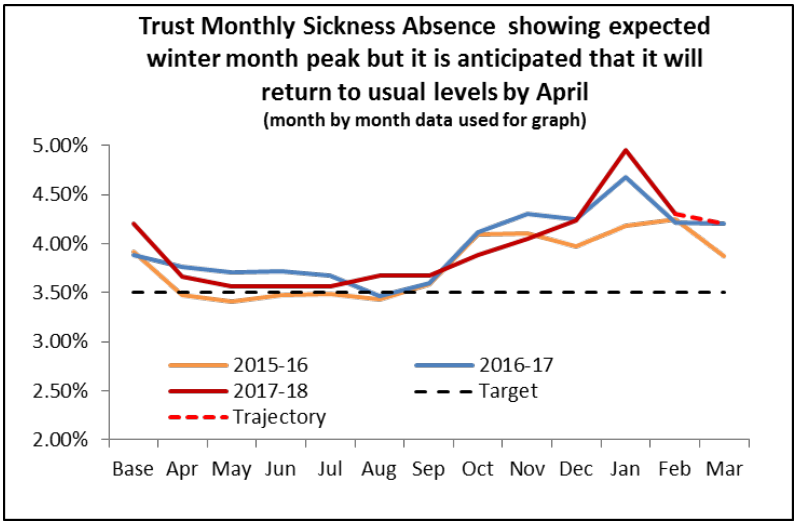
Turnover continues to decrease, at 11.44% this now sits below 2016-17 levels and closer to our target of 11%. RGN turnover in particular has reduced to 10.49%. Divisional and Professional Group analysis indicates current areas of exception, with higher turnover experienced within groups such as: Allied Health Professionals, Additional Clinical Services staff (HCA's) and Admin and Clerical groups.



Description	Current Performance			Movement since last Month	
Turnover is measured using the total leavers(fte) as a percentage of the average fte for the reporting period. The Trust target is 11% with the red threshold above 15% and below 6%. NB Turnover now reported as fte based in line with QPR reporting	12 months to 28th February 2018	**Actual**	**KPI**		
		%TO	**%TO**		
	Trust Total	11.44%	11.00%	↘	decrease
	Corporate	13.47%	11.00%	↘	decrease
	Diagnostics & Specialty	11.39%	11.00%	→	stable
	Estates & Facilities	7.54%	11.00%	↘	decrease
	Medicine	12.65%	11.00%	↘	decrease
	Surgery	11.07%	11.00%	↘	decrease
	Womens & Children	11.13%	11.00%	↘	decrease
	Add Prof Scientific and Technic	9.20%	11.00%	↗	increase
	Additional Clinical Services	13.09%	11.00%	↘	decrease
	Administrative and Clerical	13.78%	11.00%	↘	decrease
	Allied Health Professionals	14.19%	11.00%	↗	increase
	Estates and Ancillary	8.85%	11.00%	→	stable
	Healthcare Scientists	11.07%	11.00%	↗	increase
	Medical and Dental	5.94%	11.00%	↗	increase
	Nursing and Midwifery Registered	10.49%	11.00%	↘	decrease
	Staff Nurses	11.81%	11.00%	↘	decrease
	Significantly above upper target limit (>15%)				
	Betw een 11.01 & 14.99%				
	Within target or below (11%)				

3. Sickness Absence Management

The Trust sickness absence level sits at 3.95%. Despite the usual increase in winter sickness absence, reported levels remain below those experienced in previous years.



A peer review of our Attendance Management Policy took place in February 2018. This further confirmed that our policy is robust and easy to follow. We considered the suggestion that we could remove a stage of formal management and have ensured that it is made clear within the policy that the initial sickness management process (via the Line Manager) constitutes the first formal stage of our process.

4. Appraisals and Mandatory Training

Appraisal Compliance has decreased from 83% to 82%. However, we intend to maximise the opportunity to further promote appraisals as we launch our new talent development process over May-June 2018.

Mandatory Training increased from 79% to 82%, compliance appears reduced following a recent change to mandatory requirements – we expect this to continue to improve as staff update their e-learning profiles. We also expect mandatory training to continue to rise following the recent fall in reported compliance associated with the requirement to re-complete safeguarding training.

Month by month data													Movement since last Month	
Appraisals	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18		
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate	82%	82%	75%	76%	77%	77%	80%	82%	83%	82%	83%	80%	↘	decrease
Diagnostics	86%	84%	84%	83%	83%	83%	85%	85%	84%	84%	85%	83%	↘	decrease
Estates & Facilities	63%	60%	59%	60%	68%	72%	94%	95%	93%	92%	90%	90%	→	stable
Medicine	78%	79%	79%	79%	78%	77%	81%	82%	81%	79%	78%	76%	↘	decrease
Surgery	80%	79%	78%	80%	79%	77%	79%	83%	82%	81%	82%	82%	→	stable
Women & Children	77%	81%	83%	82%	81%	80%	85%	85%	86%	85%	84%	84%	→	stable
Trust	**80%**	**79%**	**78%**	**79%**	**79%**	**79%**	83%	84%	84%	83%	83%	82%	↘	decrease

Month by month data													Movement since last Month	
Mandatory Training	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18		
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate excl Bank	92%	92%	92%	92%	91%	91%	90%	90%		76%	81%	85%	↗	increase
Diagnostics	94%	94%	94%	93%	93%	93%	92%	92%		74%	83%	88%	↗	increase
Estates & Facilities	87%	83%	80%	85%	88%	86%	86%	89%		65%	75%	77%	↗	increase
Medicine	89%	89%	89%	88%	88%	87%	86%	86%		73%	78%	81%	↗	increase
Surgery	90%	91%	91%	90%	90%	90%	89%	90%		77%	82%	85%	↗	increase
Women & Children	88%	88%	89%	89%	88%	88%	87%	87%		75%	80%	83%	↗	increase
Trust	**89%**	**89%**	**89%**	**89%**	**89%**	**88%**	**88%**	**88%**		73%	79%	82%	↗	increase

5. Update on 6-12 m Strategic Priorities

5.1 Establishment Realignment

Our current establishment data is held in both the Electronic Staff Record system (ESR) and on the purchase ledger. These data sets vary, which results in inaccurate establishment reporting, poor quality workforce information and restricted vacancy profile reporting. Through a review of establishment need versus budget and the agreement of a baseline funded position financial control would be improved as would workforce planning and design. Services, such as recruitment, education, learning and development could be proactive (and longer term orientated) rather than reactive.

Progress Jan-Apr 18:

- **Right-sizing the Establishment**

Finance Business Partners have focused on ensuring that they work with Divisions, as part of the 18/19 Budget setting process to validate Establishment figures and determine the 'true data' set to feed into the ESR system. This process is complex, as it identifies housekeeping issues with cost centres and reporting lines which require further maintenance.

- **Stakeholder engagement**

An exercise was conducted to fully scope the potential impact of changes within ESR on other system users such as training systems. This exercise, combined with advice from ESR (IBM) has helped to determine the structure we will need the data to sit within and the approach to take going forward. With the exception of Doctors in training, we determined the need to merge the data per division, rather than across professional groups, to enable clearer cost centre management.

- **Doctors in Training**

The trust is participating in a national pilot to streamline the recruitment process for Doctors in Training. As part of the preparation for the recruitment of these Doctors, we have successfully set up 800+ individual Doctor positions within ESR, aligned to the finance establishment. This provides us with an opportunity to test the reporting mechanisms and processes between HR, Training, Finance and Payroll.

Next Steps (Progress expected by June 2018)

- Align the establishment for the entire Corporate Division (May 2018)
- Use the Corporate Division to test and, if necessary, modify the processes supporting the flow of information between support services to ensure establishment alignment can be accurately maintained.
- Confirm the timescales, and commence the alignment of the clinical divisions establishment data (based on the Corporate Division test)

5.2 CIP Delivery

There are a number of ways in which we contribute to the delivery of CIP and the Trusts financial recovery programme.

Progress Jan - Apr 18:

- Departmental CIP plan for 18/19 Identified

- **Continued Vacancy Control**

  Vacancies continue to be scrutinised at departmental and divisional level. With vacancies presented to the Executive Vacancy Control Panel for debate where appropriate. Pragmatic measures have been put in place to expedite vacancies which are clearly within budget , associated with approved business case funding or funded by external monies, to minimise any impact on service delivery with the Deputy CEO and Director of People and OD approving straightforward replacement posts.

- **Reducing Bank and Agency Expenditure**

  Joint working with the Head of Temporary Staffing has identified a number of opportunities within the scope of the bank employment offer, to reduce bank expenditure whilst remaining an attractive employment option. A revised terms and conditions package is currently being worked up with initial suggestions discussed with Trade Union colleagues in March 2018.

- **Sustainable Workforce and ELD priorities**

  We confirmed the organisations 'heat map', in terms of identifying the opportunities across the organisation to increase the number of ACP posts. A significant piece of work still exists in order to establish how this work links to strategic business plans across the trust and STP, linking to the 'one place' initiative, long term workforce planning and the impact on CIP delivery. Shirley Daniels will lead on this work during 2018/19.

  Our current cohort of Trainee Nursing Associates (11 x TNAs) are now starting their second year of training. Going forward, work is now starting with clinical staff to plan what this newly qualified Band 4 Nursing Associate role will be, what the future staff model will look like and how the role complements the Band 5 Nurse role. The county has applied to offer a further 41 TNAs (18 in GHFT) for a second cohort to start in the summer of 2018, this time through the apprenticeship route.

  As a way to attract a talent pool of newly qualified AHPs and Nurses who have successfully achieved a high grade degree and completed the first preceptorship year post graduation, GHT is introducing a new and innovative development opportunity – for a combination of both in-house staff and as an attraction to recruit new. The Chief Nurse Junior Fellow programme, for between 12 - 15 people, will involve a role in one of the work areas where it is currently hard to recruit to, but accompanied by a dedicated day per week of targeted personal development, mentored by a Nursing Director and supported in a service improvement project (trained to Silver academy level). This will start in June 2018 (September 2018 for external candidates) and allow the Chief Nurse Junior Fellows the chance to be added to the Talent Pool at the end of the year for a fast-tacked career in GHT.

- **Benchmarking and Revision of Study Leave Payments**

  At the medical Local Negotiating Committee (LNC) in April 2018, we shared benchmarking data which illustrates Our Trust as a significant outlier in the payment of expenses for study leave, highlighting potential savings. The exercise prompted us to consider easier ways that the medical community can claim study leave expenses via the e-expense system. Feedback from medical colleagues is currently being sought via the LNC, before we implement a change to the study leave expenses threshold.

- **Policy Development**

  As part of our ongoing commitment to CIP we regularly review our workforce policies to identify where we might be an outlier in comparison to other organisations. This

benchmarking activity has highlighted our organisational change policy as having significantly more favourable pay protection arrangements in place, which are not compatible with the scale and pace of change faced by our Trust. We are currently developing a revised policy and will be taking this to our HR Policy group to discuss with Trade Union colleagues in May 2018.

Next Steps (progress expected by June 2018):

- Finalise and promote the revised employment offer to Temporary Staff (new joiners)
- Agree our revised approach to Medical Study Leave payments, in line with benchmarking results and in collaboration with our Local Negotiating Committee.
- Negotiate changes to the Trust Organisational Change Policy
- Shirley Daniels (HRBP) to commence the more detailed work behind the Sustainable Workforce project; linking ACP and alternative role development to business and workforce development plans.

5.3 Reducing bureaucracy and creating efficiencies – Subco Development

In creating efficiencies and adding value; a key programme of work has been the design and delivery of the Subco, NHSGMS. Despite national trade union pressure against the development of these proposals, our collaborative working relationship with local trade union colleagues resulted in a meaningful and engaging consultation process with our workforce and the development of proposals which were strongly influenced by the voice of our workforce; such as lifetime protection of Agenda for Change terms and conditions for transferring staff. Following the launch of NHS GMS, Trade Unions asked members to consider whether they wished to ballot on potential industrial action over the creation of NHSGMS. The Trust has since received confirmation that this ballot was not supported by staff.

We have now embarked on the 'post go-live' priorities associated with the launch of a subsidiary company which includes a number of key workforce initiatives which contribute towards an agenda of improved efficiency:

- The development of a new terms and conditions package **(by June 2018)**
- Embedding new Trade Union recognition arrangements (**by May 2018)**
- Workforce policy review
- Supporting the cultural change required in the 'colleague to customer journey' through Leadership and Organisational Development intervention and a bespoke package of support.

5.4 Talent Development

A new system of talent management and succession planning is currently being refined. Initial proposals were first shared with the Trust '100 Leaders' forum in January 2018 and a series of workshops engaging with a variety of staff have followed on from this during March and April 2018.

Next Steps (progress expected by June 2018)

- Materials and website content to be developed to coincide with new intranet launch during May 2018.
- Briefing sessions will take place throughout spring and summer to show all staff how to use the talent development paperwork
- Face to face refresher sessions will be offered on an ongoing basis to train managers on how to successfully host a 'talent development conversation'.
- Bitesize training sessions will be available for new managers and appraisers
- Video tutorials and online guides will be launched to offer ongoing support.

5.5 Staff Health & Wellbeing

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

Progress Jan – April

The former Staff Health & Wellbeing Group has been dismantled. The priorities from the group have now been added to the overarching Health and Wellbeing Group which will oversee key work programmes associated with the Health and Wellbeing of Staff, patients and the wider community.

Whilst we had originally aimed to design a business case on the feasibility of a 'one stop' health and wellbeing service to take to DOG/TLT in March 2018, progress has been slower than anticipated against this strategic priority, with resource constraints and lack of transparency around the cost and return of investment associated with the current MSK provision. This has impacted on the speed in which this project has developed.

Next Steps (progress expected by June 2018)

- Negotiate an extension to the current Occupational Health contract, without increased costs.

- Build outline business case for a 'one stop' staff health and wellbeing service.

5.6 Staff Engagement

In order to fully capture feedback and improve engagement with our staff we are reviewing our current staff engagement mode. There are a number of developments in this area:

Progress Jan – Apr 2018

- Staff recognition awards (GEM) Awards were launched divisionally in January 2018.
- Investigations into a staff engagement app in conjunction with One Gloucestershire STP partners. STP funding is available to support this. A free app is also being explored which is currently used with some success in a number of Trusts around the country including St George's and Guy's & St Thomas'.
- Monthly Trust-wide listening events have continued with a particular focus on Travel to Work.
- The review of governance and subsequent launch of a new **Staff Experience Improvement group** will support the delivery of a number of priorities associated with staff engagement staff health and wellbeing. In particular the group will seek to triangulate data from a range of sources including: annual NHS Staff Survey; turnover and sickness absence; feedback from listening events and campaigns; Staff Friends and Family Test; Diversity Network; Staff Health and Wellbeing/Stress surveys; bespoke/adhoc surveys to determine the best ways to improve staff experiences.

Next Steps (progress expected by June 2018)

- Identify a resource to support the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.
- Trial the use of 'SpeaC Happy App' communications tool with a nominated group of staff, to assess the effectiveness of this tool in providing feedback and improving two way communications.

- We will have agreed the launch of the aforementioned free staff engagement app, in collaboration with our STP colleagues.

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6. Conclusion

Progress has been made against all of the key priorities identified to the Workforce Committee in November 2017. The challenge in delivering against these objectives against the backdrop of 'business as usual' is considerable, however we recognise that these priorities are critical to meeting the overarching strategic aims of the Workforce Strategy.

7. Recommendations

Trust Board are asked to **NOTE** the performance outlined in our key performance indicators and the progress made against the renewed strategic priorities.

Author: Alison Koeltgen, Acting Deputy Director of People

Sponsor: Emma Wood, Deputy Chief Executive and Director of People.

May 2018

REPORT TO MAIN BOARD – MAY 2018

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

This report describes the business conducted at the Workforce Committee on 1st May 2018 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Workforce Dashboard	Agency spend increased In March above February spend.	Why was there an increase, was this an annual occurrence and if so how can we guard against it next year?	Assurance given on the multiple factors behind increase. Compliance with annual leave policies and particular impact of taking leave and managing the roster around key holidays and end of holiday year is an issue being addressed. Policies are robust but adherence and implementation by managers needs improvement.	Annual leave policy to be adhered to. Leadership to own and drive compliance within Divisions.
	Turnover continues to decrease.	How are we addressing outliers?	Deep dives take place where outliers are evident.	
	Mandatory training has increased to 82%.			
	Sickness absence sits at 3.95% with local plans in place and showing results		Local plans in place and working in CSSD admin and Orthopaedic OPD.	
		Where is the future forum for monitoring GMS figures?	Highlight to Board that GMS people oversight should sit within GMS but key data fed to the Sub-Committee.	

Gender Pay Gap	The purpose of our interrogation into the gender pay gap is to ensure equality of opportunity. What we see is that there is no gender pay gap across our non-medical workforce. There is gender pay gap of 11.52% when medical and non-medical staff are combined.	How do we review and promote the CEA awards and ensure women are supported through the process? How are we ensuring that we are providing the right circumstances for men and women to achieve the career paths they want?	Data indicates that the proportion of women applying and achieving awards is equitable. Additional support is being provided to female medics. Talent processes should enable clarity on career paths.	
Staff Survey	Details presented alongside action plan. What was clear was that we needed to triangulate against broader information – ESVs, Real time feedback.	How do we ensure triangulation of information with and to other data sources?	Action plans being disseminated at a divisional level and reported back in August The staff experience and improvement group will triangulate data from multiple sources.	
Reporting structure and Governance	The Committee received comprehensive recommendations to revisit reporting and to put in place establish a new governance structure per Q and P. This was approved by the committee	How are we amending our Terms of Reference (ToR) and membership to reflect the new proposals? How does that feed in to our Work Plan?	Revised ToR and membership to come to the next Committee.	

Recruitment	The Committee received a paper reviewing the recruitment team function. It noted recommendations that the team needed to be increased and refocused to meet demands on the service for staff, particularly nurses and HCAs	Are we on track to achieving recruitment targets for bulk roles such as nurses and HCAs and can we achieve supply for winter?	Without expanding the team and skill sets there is a lack of capacity to meet demand for services.	Additional funding will be sought to ensure the Trust can meet its workforce needs.
BAF	The committee received the key risks and performance against the 6 strategic priorities. Whilst on track, progress was slower than expected against time frames set.	To deliver we need to ensure we have the right information available and the quality of business analytics to inform decision making. Is there an overlap in risks around ID 1437 across workforce and quality and performance? Should we be aligning these and reviewing?	There is a clear and ongoing gap in business intelligence and infrastructure which slows progress. This has to be addressed. The executive leads would review risks across Committees and be clear where assurance and oversight rests and align risks where appropriate.	
SubCO Closure report	Received by the Committee and approved.			

PWC Audit action plan	Received by the Committee following oversight at Audit and Assurance committee. Actions were agreed			
HCA Retention project action plan	The Committee received a very comprehensive report on HCA retention – reasons for leaving, issues and where to address.	Strategically what is the importance of HCA retention and how are we prioritising alongside broader retention issues?	The Committee will receive a revised action plan in June and a strategic review of the approach we will take to attraction across nursing in August.	

Issues to escalate to Board:

1. Where is GMS reporting and should it be part of the Workforce Operational Dashboard.

2. We need to align the level of risk across similar and dependent risk profiles.

3. Business intelligence infrastructure

REPORT TO MAIN BOARD – MAY 2018

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

This report describes the business conducted at the Audit and Assurance Committee on 20th March 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters arising from prior meetings	Understanding reduction in number of referrals.	What national benchmarking information is available?		Counter fraud looking at enhancement of tracking referral levels and trends.
Counter Fraud Report	Update on all activities notably Counter Fraud Survey and detailed case updates.	How can "unaware" staff be best reached?	"e-learning tool" being explored for longer service employees.	
Internal Audit	Draft plan for 2018/19 – served as a basis for discussing priorities. 17/18 programme progress report highlighted that 3 reports will be delayed until the May meeting	What is the approach to finalise quarter 1 priorities and overall year plan? Why the delay?	BDO to meet with Executives and propose refined plan at May meeting.	Management responsiveness is the cause of the delay – increased traction from recommendation tracker process not yet fully embedded

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Clinical audit – Mortality report highlighted areas of good practice with medium level recommendations focussing on information flows. Latest Recommendations Tracker - considerable progress made	What is the process to embed the new policy operationally? What is the process to progress remaining overdue items?	Site visits by area planned organisation-wide following pilot in Surgical Division. Director of Corporate Governance to follow up as required	
External Audit	Update on 17/18 audit strategy.	Is the programme on track at this stage? What is the status of the land and buildings valuation review?	While some delays in responsiveness have occurred at this stage the Finance team has a full list of outstanding issues.	Potential impact on fee level Review by E & Y not yet finalised
Board Assurance Framework	New format representing a significant improvement in layout, content and impact which is considered helpful in focussing the committee's attention and directing auditors' efforts.			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Annual Report Project Plan	A detailed timeline of tasks and responsibilities to meet the statutory reporting deadlines.	Is the detailed accounts review date of May 8th appropriate?	The date does allow for corrections to be processed in the event of a major issue being identified.	Earlier timing should be considered in future years.

REPORT TO MAIN BOARD – MAY 2018

From GMS Committee Chair – Rob Graves, Non-Executive Director

This report describes the business conducted at the GMS Committee held 24th April 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
GMS Chair's Report	First formal report to the Committee from the GMS Chair: - Progress - Issues and Risks - Next Steps Special acknowledgement of the Shared Service Centre's efforts and commitments in meeting the first payroll obligations.	What are the plans to incorporate role specific objectives in the generic director's job description?	Specific responsibilities by role will be incorporated via links from the generic job description. These are in development and will be shared at the next GMS Committee meeting.	
Chief Operating Officer's Report	Reviewed status of: - Contract and Performance Management Arrangements - Draft Performance Measures including GMS financial position and client satisfaction	What is the status of the recruitment of contract management resource?	Recruitment interviews scheduled week commencing April 30th.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	- Reinforced the importance of dedicated contract management resource.			
GMS Standing Financial Instructions and Standing Orders	Documents adopted following submission by professional advisers and internal scrutiny. Further review in 6 months to address any practical issues arising from operational reality.			
Proposed changes to GMS Articles of Association and Board Terms of Reference	Technical adjustments to formal documents to align operational mode to Trust Board's plans.			
Risk Log	First draft of log after "go live".			
GMS Committee Work Plan and future ways of working	Timing of and participation in GMS Committee meetings considered.	Is the proposed meeting timetable appropriate and doable? What should the approach be to GMS Director participation in the Committee?	Timetable accepted - GMS and Trust administrators to liaise to agree and schedule specific meeting dates Participation form all parties to be the norm, limited participation (Trust only) by exception.	

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

Report Title
SmartCare Progress Report
Sponsor and Author(s)
Author: Leah Carey, Project Manager, Trakcare Recovery Sponsor: Mark Hutchinson, Digital Recovery Consultant
Executive Summary

Purpose

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

Key issues to note

- Expected Progress is being made on understanding the data quality issues, fixing the historic data and developing user guides and SOPs to improve the future position.
- Progress is being made on capturing and submitting Maternity minimum data set, NHS Digital have recognised this as we exceeded our submission requirements for February 2018 for the first time since Dec 2016 (i.e. since Trak go-live)
- There is significant focus activity on rationalising Outpatient Outcomes, and ensuring real-time data completion in clinics. This will affect all clinical staff involved in OP activity and will address a significant cause of variability in use with the an expected increase in data quality.
- Implementation of new functionality, (originally planned as phase 1.5/phase 2) (within or outside of Trakcare) is the subject of wider consultation and a plan will be developed on the back of this.
- Whilst we have a core team of staff who are working on recovery activities, we need to enhance the capacity and capability of the team to ensure BAU support, recovery support and future development work is adequately resourced to ensure delivery risks are minimised and benefits are realised from digital initiatives.

Conclusions and Implications

- Whilst the focus of the effort is Trak Recovery activities, the Smartcare Board have recognised the need for planning the post-recovery (Optimisation) phases to take advantage of digital solutions.

Future Action

- The Smartcare programme board continues to provide oversight and governance of the programme and will provide further regular updates to the Board.

Recommendations
The Board is asked to note this report.
Impact Upon Strategic Objectives
Contributing to ensuring our organisation is stable and viable with the resources to deliver its vision, through harnessing the benefits of information technology.

Impact Upon Corporate Risks
A number of clinical safety, operational and financial risks have been highlighted which the recovery programme is designed to mitigate.

Regulatory and/or Legal Implications
The Trust has been informed by NHSI that It was satisfied formal regulatory action in respect of TrakCare recovery is not appropriate at this time. We have a contractual agreement with the supplier of TrakCare (Intersystems) which we are reviewing with external advice and in conjunction with other TrakCare Trusts.

Equality & Patient Impact
Patient Safety is a key workstream of the recovery programme.

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)**
					02 May2018	

Outcome of discussion when presented to previous Committees

MAIN BOARD – MAY 2018

TRAKCARE RECOVERY PROGRESS REPORT

1. Purpose

This report provides an update on the progress of the recovery programme following the implementation of Trak in December 2016.

It is recognised that there is significant work required before stability and the return to business as usual- the impact of implementing Trak Care has had repercussions wider than the failed implementation of a PAS.

2. Defining the goal of recovery

The Trust will consider that recovery has been completed when the following have been achieved:

a) User understanding and use of the system is consistent with clearly communicated quick reference guides and SOPs

b) We have a clean and validated set of Waiting Lists/ PTL's for In Patients and Out Patients

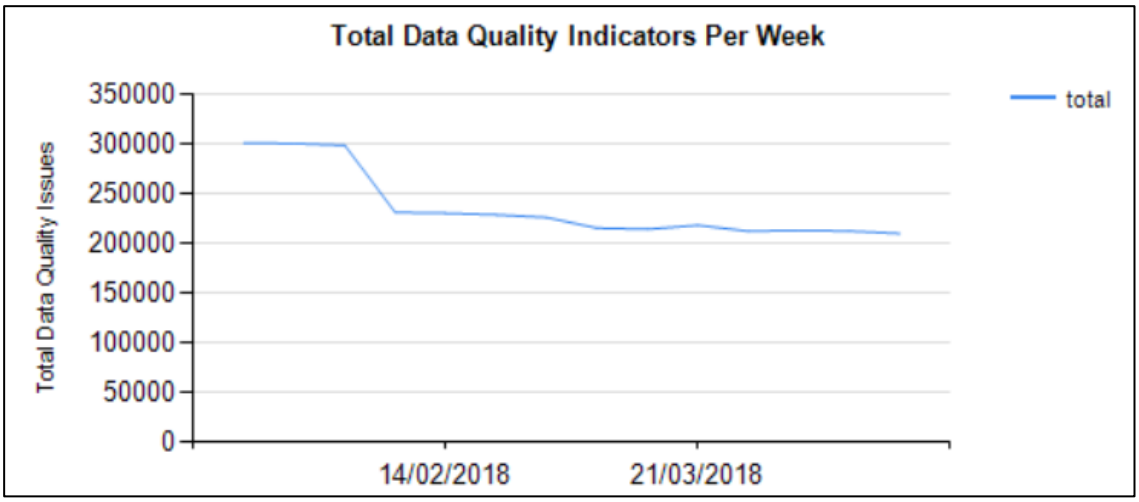
c) The Trust has returned to national RTT reporting

d) Activity Recording is consistent and reliable such that all activity is able to be accurately billed for

e) Use of the system is sufficiently reliable and understood such that minimum levels of data quality issues are occurring each week

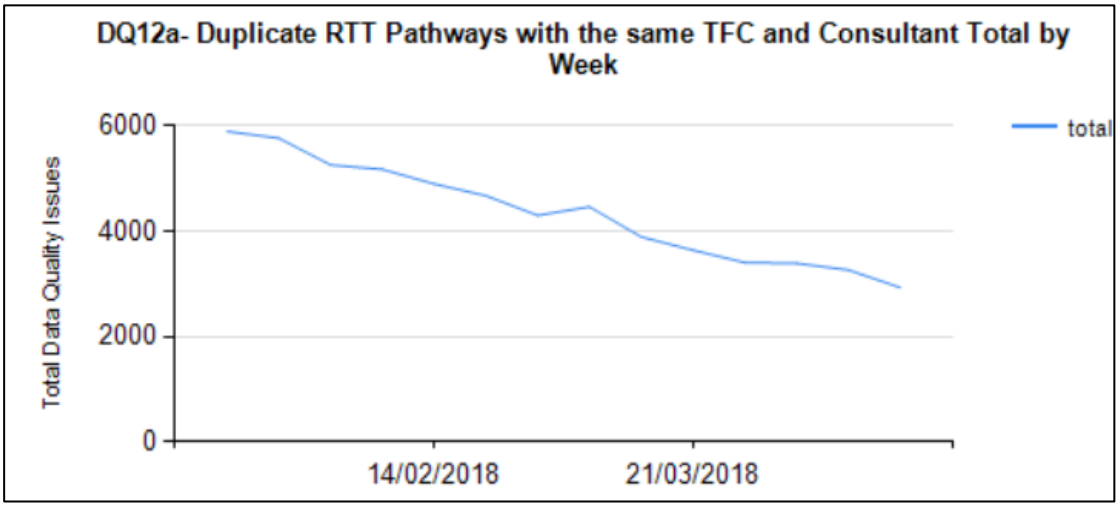
3. Main areas of progress since the last report

Overall



The total number of issues has been slow to decrease throughout March and April at no more than 100/200 per week decreasing. This has been predominantly due to reduced staffing throughout the bank holiday periods and staff using leave prior to the end of the Annual leave year. This in the last week has now begun got decrease at a greater rate of 1k.

Data Validation



The decrease in duplicate pathways has occurred due to 2 main reasons:

1. The internal RTT validation team has been closing down incorrect pathways
2. The number of new duplicates being created has declined steadily

- Validation Team efforts continue to make extremely positive strides to assuring our position. Total incomplete pathways now stand at 90753. This has seen a total reduction since the start of the plan of 41007 which is a commendable effort. Over 18 week incompletes have reduced by 15009 and over 35 week incompletes have reduced by 10728

- The validation team are currently validating back to week 27. Performance is currently at 60.6% which shows an improvement of 7.5% since the start of the plan, this data is still being further refined and developed for accuracy.

- Maternity

    - Data catch up is ongoing – 1,390 sets of notes in total to date. This is 25% of the total notes required to be completed with expected completion planned for the end of May.
    - From maternity review we have assessed the local changes that can be done and prioritised them, in order of preference or priority vs how easy they are to do. These will then be prioritised alongside other trak recovery activities as will pull on the same core group of individuals to delivery configuration, testing and implementation.
    - Hardware is improving with 5 widescreens delivered Friday but more widescreen pc's are needed to enable real time data inputting

- Theatres

    - Work currently being undertaken to review missing procedure codes and progress local configuration on reasons for cancellations. A key part of this work will be planning the transition to Trak 2017 as this will allow multiple local codes to be applied to a single national code.
    - Large training exercise undertaken to review processes. Received very well by staff who are now more confident and able to use Trak in the correct work flow.

- IT Infrastructure

    - The new Internet site is now live and there has been significant senior leadership involvement around the migration and move towards a new site.
    - Work has begun to rationalise our aging IT server estate and old unsupported servers by migrating to newer servers. This is expected to take about 6 months, so complete October 2018
    - Ophthalmology services have been migrated to a faster network link to speed up images transfer from server at GRH to clients at CGH

- Outpatient Outcomes

    - Work began in March to rationalise outpatient outcomes. This is a key first step in ensuring a level playing field across all outpatient scenarios as initial approaches to building and configuration has created lots of variation with lots of potential for human error and incorrect data inputting.
    - Rebuild sees a left hand RTT column and a right hand onward action column being reconfigured.
    - The completion of outpatient outcomes must be done real time in clinics by the individual that has seen the patient- it is not an administrative function.
    - This piece of work is now at the testing phase which is taking longer than anticipated so whilst initially we hoped to launch the new outcomes mid-May but this may now push back to June. Testing complications have been exacerbated by staffing issues including sickness. It is important that we can assure all of our users that the system is working exactly as we anticipate it should prior to going live.
    - The communication and education approach to tell all users about this change has been planned with a new and updated e-learning package designed that not only details the process that needs to be followed but also explains what different outcomes mean and reinforce the importance of following the correct process. This e-learning will replace the old outcome module on the LMS so will be easily accessible and it is anticipated that it will take no longer than 20 minutes to complete. There will be face to face drop in sessions available for those that would rather this option than e-learning. It is imperative that all individuals that see patients in an outpatient setting complete this training prior to go-live so communications will be issued in a timely fashion.
    - It is worth noting that this is the first phase of outcome development and the team will then be working with specialities to evolve and develop Trak to work as effectively and efficiently as possible for each area.

4. Trak Recovery Plan

4.1.1 Data Quality Work stream

Key Achievements this period

- Analysis of multiple Data Quality Indicators from cycle 2 have now been completed ahead of schedule and are now in the process of being mapped for resolution guide creation.

- Internal GHFT Validation staff having continued positive impact on our performance status. Weekly validation activities have been providing us with confident and assured positions, increasing visibility of accurate patient pathways.

- Work stream for Resolution Guides for fixing of historic data has been slow to progress and this has had an impact on the ability to continue analytics and subcategorization at pace initially described in plan. A new process for the creation of resolution guides has been devised and is now underway allowing for the majority of resolutions to be mapped and the guides to commence being created at pace.

- Resolution of some specific issues is under testing to be corrected by an automated solution to reduce the amount of resource required. A large amount of testing will be required prior to relying on this methodology however if successful this could for the initial cohort reduce the days required from 250 to 5 (based on 1 WTE). The output of this investigation is expected by the end of May.

4.2 People & Process Work Stream

Key Achievements:

- Efforts have largely been focused with supporting the outcomes workstream to ensure training, education and communication approaches are aligned and ready for the new outcomes.

- The Trak team have made contact with all areas to identify and refresh the champions network. It is the vision that the organisation has a good spread of individuals across all roles and areas who have more knowledge than those that have just completed e-learning. Over the next month champions will be contacted to identify how they use trak and to review their knowledge and abilities. A train the trainer model is being designed to upskill champions with trainer level knowledge. These individuals will not be expected to deliver training formally but they will be expected to assist colleagues and be a local source of knowledge as need arises.

- Operational leads have supported that all GMS and AGMs will have champion level knowledge to support their staff

- Consultant champions have also been sought. We require engagement across all areas so that we can consult and sense check any problems people are experiencing but also any developments we are making with trak to ensure that they will work within all areas. The time commitment for this is still being reviewed but should be no more than 45 minutes bi-monthly. Consultants will be contacted and a time arranged at a convenient time for them in recognition that diaries can be difficult to flex.

- Business as Usual Training for Trak currently being reviewed. E-learning is in the process of being reviewed to ensure modules and options are specific to the user. The training team are happy to design and deliver bespoke training if there is a need for this. They can be contacted on ghn-tr.smartcaretraining@nhs.net

4.3 Clinical Safety Work Stream

Key Achievements:

- Red Risk Patient Groups that have been identified and need progressing to configuration change status based on the feedback to be received from specialities. SUIs are being reviewed to ensure that the revised approach to configuration / categorisation addresses root cause issues and allows these patients to be tracked, found and identified easily.

4.4 Finance Work stream

Key Achievements:

- Finance work stream now fully stood up. Key areas that are currently being explored are sharing and understanding the modelling that suggests that £10millon pounds have been lost due to the implementation of Trak Recovery.

- This month Finance leads are producing and reviewing month 12 numbers to complete a full analysis to identify areas that have demonstrated a loss of income for targeted deep dive to identify opportunities to improve Trak functionality to improve income.

5. Focus for the next month

- Continued work on Outcomes
- Corporate communication strategy to evolve
- Accurate current financial opportunity based on Month 12

6. Risks and Issues

There is a core group of individuals that are heavily involved in the delivery of Trak Recovery. This includes individuals that deliver training, communications, configuration and testing. This is a finite resource and therefore impact on business as usual/ Trak developments may not be implemented despite being identified due to the prioritisation of Trak recovery. This means that recovery activities may need to run sequentially rather than all at once due to limited expertise and resource.

7. Recommendations

To note the progress within made in the past month, the plan for future work and the likely timescales for recovery.

Author: **Leah Carey, Project Management, Trak Recovery**
Presenting: **Mark Hutchinson, Digital Recovery Consultant**

Date: 25th April 2018

Sent via email to:
Deborah Lee, Chief Executive
Gloucestershire Hospitals NHS Foundation Trust

27 April 2018

Dear Deborah,

NHS Improvement compliance certificate – 4 hour performance; and TrakCare recovery

I am writing to confirm the outcome of NHS Improvement's Regional Provider Support Group – South (RPSG) which considered the Trust's progress in addressing the August 2016 enforcement undertakings agreed with NHS Improvement in respect of 4-hour performance, and the Trust's progress in developing and delivering a recovery programme for its TrakCare patient record system.

4-hour performance

RPSG agreed the Trust had complied with the requirements of the 4-hour enforcement undertakings and NHS Improvement should issue the Trust with a compliance certificate in respect of these undertakings. In doing so we are closing the formal regulatory action in respect of the Trust's 4-hour performance agreed with the Trust in August 2016.

We would like to commend the Trust on the significant progress it has made to improve emergency flow to achieve this. There is now a clear, compelling vision for flow improvement focused on the Trust's patients and quality of care which is widely understood by staff across the hospitals. This is underpinned by strengthened executive and clinical leadership, autonomy and support to teams who are taking responsibility for designing and delivering improvements to flow in their services, and a clinically-led improvement plan that significantly improves hospital flow and right-sizes critical services in Medicine and Surgery.

We also recognise the significant work undertaken by Gloucestershire NHS and social care partners to improve the responsiveness of services across the whole emergency pathway, including rapid response for both physical and mental health patients to avoid unnecessary hospital admission; effective partnership working and reduction of back door delays; and strengthened whole system escalation

arrangements to manage during periods of unprecedented demand for emergency services over winter.

This has supported a step-change in 4-hour performance delivered over winter that the Trust and local partners can be proud of. We welcome the system's ambition to continue to deliver monthly performance of at least 90% across 2018/19 and encourage further work and ambition to improve beyond this as new initiatives embed. With NHS England colleagues we will continue to work with the system through the A&E Delivery Board and Sustainability & Transformation Partnership to support further improvement work.

We have summarised in the annex to this letter the areas for further improvement identified by the Trust and our team in the course of understanding the actions taken by the Trust to date. We hope these provide a useful focus in supporting improvement work for the year ahead, recognising the steps you are already taking in these areas. We will review progress against these areas with the Trust informally over the year ahead.

TrakCare recovery

RPSG considered the action the Trust has taken to develop and deliver a recovery plan for its TrakCare electronic patient record system, with support from NHS Digital and North Tees & Hartlepool as 'buddy' trust since November 2017. While recognising the considerable clinical, operational and financial risks and recovery timescales related to TrakCare, RPSG was satisfied with the progress the Trust had made in addressing the governance concerns highlighted in Amanda Lyons' letter to you of 12 October 2017. It was satisfied formal regulatory action in respect of TrakCare recovery is not appropriate at this time.

Our informal oversight of recovery progress will continue through the Trust's monthly SmartCare Programme Board and monthly oversight calls with you, NHS Digital and NHS England while the Trust remains in recovery. Oversight of clinical risks including the outcome of clinical harm reviews will be through NHS Improvement's Regional Medical Director (South) in liaison with the Trust's Medical Director. Progress on addressing the financial concerns linked to TrakCare will be reviewed through ongoing Financial Special Measures meetings. Should any significant new governance concerns come to light over this timescale, NHS Improvement will review the need for further action and support.

As the recovery timelines means the Trust will remain off national RTT reporting until November 2018, oversight of incomplete, planned and any other significant waiting lists on TrakCare remains crucial .The Trust must ensure it is taking sufficient action to validate and resolve data quality issues to support a return to national RTT reporting and effective waiting list management within this time horizon.

Next steps

I have enclosed the signed compliance certificate at Annex 1 to this letter and the informal actions for further flow improvement at Annex 2. We will also publish the compliance certificate on NHS Improvement's website. I would be grateful if you could review the actions at Annex 2 and confirm in writing if these are agreed and reflected in the Trust's improvement plans for the year ahead. We would like to congratulate the Trust on the significant improvement it has already made.

Yours sincerely

Tom Edgell
Interim Delivery & Improvement Director, South-West (North)

Cc. Peter Lachecki, Trust Chair
Jennifer Howells, Joint Regional Director, South-West

COMPLIANCE CERTIFICATE

LICENSEE:

Gloucestershire Hospitals NHS Foundation Trust ('the Licensee')
Great Western Road
Gloucester
Gloucestershire
GL1 3NN

For the purposes of this certificate, "NHS Improvement" means Monitor.

In accordance with paragraph 12(1) of Schedule 11 to the Health and Social Care Act 2012 , NHS Improvement hereby certifies that it is satisfied that the Licensee has complied with all of the Licensee's Enforcement Undertakings in relation to A&E accepted by NHS Improvement on 17 August 2016.

Signed:

Tom Edgell

Position: Interim Delivery & Improvement Director, South West (North) and member of the Regional Provider Support Group (South)

Date: 27 April 2018

Annex 2 – areas for further improvement

The table below includes areas for further improvement identified in the course of our work with the Trust to understand the progress and improvement it had made to date. We ask that the Trust considers these areas and build them into forward plans as appropriate.

Area	Context	Action already being taken
Evaluation of 2017/18 key flow improvement schemes to inform 2018/19 winter planning and recurrent investment.	The Trust commenced a number of changes to processes and the emergency pathway during 2017/18. The Gloucestershire system received £1.2m national winter monies in December 2017, of which c. £0.7m went towards in-hospital schemes. Robust evaluation of schemes is important to assess impact and recurrent financial investment needed.	Trust evaluation commenced April 2018.
Further work in ED and wider emergency zone to respond to surges in demand with particular focus on improving the 60 min time to treatment metric, especially out of hours.	Development of the Emergency Zone has allowed the Trust to expand its medical assessment, short-stay and frailty offerings with streaming of GP expected patients direct to MAU, avoiding waits in ED. This has supported improvement in the 15 min time to triage metric to over 80%, but 60 min time to treatment remains a challenge at below 40% of patients. Increased use of ambulatory care with a focus on achieving or bettering the target recommended by ECIP of 30% of the medical take (Trust currently at c.25%), development of the in-hospital frailty pathway and extended use of hot clinics are areas for further improvement.	Trust exploring options to achieve this with teams as part of 2018/19 planning.
Further strengthen and embed consistent use of SAFER across all specialty teams.	The Trust has strengthened back door flow working with partners through the Partnership meeting, through a new weekend discharge team and increased leadership of the back door. There is senior clinical leadership for SAFER on the wards but further work is	Re-launch of SAFER through 'Leading Length of Stay' work, and re-launch of internal professional

Area	Context	Action already being taken
	important to ensure this is embedded and owned consistently by all specialty teams and is not seen as the responsibility of supporting back door teams.	standards is commencing with triumvirate leadership.
Continue to explore new workforce opportunities linked to quality and flow improvement work, for example a 7-day emergency matron role and non-clinical navigators.	The Trust is looking at a range of potential workforce options and making progress on nursing recruitment albeit overall vacancy levels remain challenging. We recommended the Trust also consider: - Extension of the new emergency matron role to 7 day, and how this could support flow improvement. The role so far has demonstrated an improved focus on ensuring moving of patients to the right area. Extending this should provide greater continuity of leadership in this area. - The use of non-clinical navigators to support front door streaming, including registration of patients with a community GP where appropriate. The model developed at the Homerton may be useful.	New workforce approaches to support improvement work are being considered.
Focus on staff engagement and continued empowerment to take ownership for local improvement work, including through use of 'Medical Engagement Scale' tool.	The 2017 Staff Survey continued to identify staff engagement as an important area for improvement needing focus and energy from Trust senior leaders. NHS Improvement has proposed the Medical Engagement Scale tool to support engagement work with the Trust's clinical leaders.	Trust work programme to understand staff concerns and respond being developed. Medical Engagement Scale tool will be used led by Trust Medical Director.
Implementation of electronic bed management system to support whole hospital flow and decision making.	The Trust has operated with a manual system throughout winter 2017/18, reducing visibility of available bed capacity to decision makers in the Trust's control room.	Bed management system implementation planned from April 2018.

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

Report Title
Board Assurance Framework
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance and Executive Directors Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary

Purpose

- To receive the report for assurance that the risks to the Strategic Objectives controlled effectively.

Key issues to note

Assurance

The Board Assurance Framework (BAF) report is the means through which the Board receives assurance in respect of the delivery of its stated Strategic Objectives by April 2019, through the oversight of principal risks which have the potential to undermine delivery of the objectives.

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

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

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

- Since the BAF report was last presented to the Board in January 2018, work has been undertaken to further develop the framework and include information on supporting strategies and enablers and address cross-cutting issues (e.g. gaps or overlaps in assurances). The Director of Corporate Governance and the Risk and Assurance Manager met with BDO, the new internal auditors, and reviewed examples of good practice, which will be applied to future iterations of the framework
- Further, the Board Committees have now undertaken a detailed scrutiny of components parts of the BAF assigned to each committee and received positive assurances that the risks to the Strategic Objectives are controlled as effectively as they can be. Where the BAF analysis identified gaps in assurance the Trust has taken steps to close them i.e. development of the Quality Governance architecture and the Overall Quality Improvement Strategy. This process also identified further areas of focus and scrutiny for the Committees, with relevant items now built into the work plans.
- An update of progress in the achievement of the strategic objectives is included in Appendix 1 demonstrating that an additional three elements demonstrate that the target will be met. At the same time, delivery four new objectives (2.1, 2.2, 2.3 and 2.5) is rated Amber.

Conclusions

In summary, the Board can take assurance from this paper, the other papers on the agenda, and the detailed scrutiny and challenge undertaken in the Board Committees, that the risks to the Strategic Objectives are controlled as effectively as they can be.

Implications and Future Action Required

Further refinement and ongoing development of the BAF led by the Director of Corporate Governance.

Recommendations
To receive the report for assurance that the risks to the Strategic Objectives are controlled as effectively as they can be.
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)**
25th April	25th April	20th March	1st May	N/A		Board Strategy & Development Session
Outcome of discussion when presented to previous Committees						
The Committees received positive assurances that the risks to the strategic objectives were controlled as effectively as they can be.						

Appendix 1

Board Assurance Framework Overview and Progress with Achievement of Strategic Objectives

BAF code	RAG rating		Executive Lead	Objective to be achieved by 31 March 2019
	Qtr 3	Qtr 4		
1.1			Director of Quality & Chief Nurse	Be rated good overall by the CQC
1.2			Director of Quality & Chief Nurse	Be rated outstanding in the domain of 'Caring' by the CQC
1.3			Chief Operating Officer	Meet all national access standards
1.4			Medical Director	Have a hospital standardised mortality ratio of below 100
1.5			Director of Quality & Chief Nurse	Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends
1.6			Director of Quality & Chief Nurse	Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month
2.1			Director of People	Have an Engagement Score in the Staff Survey of at least 3.9
2.2			Director of People	Have a 'Staff Turnover Rate' of Less Than 11%
2.3			Director of People	Have a Minimum of 65% of 'Our Staff Recommending Us as a Place to Work' through the Staff Survey
2.4			Medical Director	Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches
2.5			Director of People	Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)
3.1			Director of Strategy and Transformation	Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery
3.2			Chief Executive	Have systems in place to allow clinicians to request and review tests and prescribe electronically
3.3			Director of Strategy and Transformation	Rolled out Getting it Right First Time Standards across the target specialities and be fully compliant in at least two clinical services
3.4			Director of Strategy and Transformation	Have staff in all clinical areas trained to support patients to make healthy choices
4.1			Director of Finance	Be in financial balance
4.2			Chief Operating Officer	Be among the top 25% of trusts for efficiency
4.3			Director of Strategy and Transformation	Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers.
4.4			Chief Executive	Be no longer subject to regulatory action
4.5			Chief Executive	Be in segment 2 (targeted support) of the NHSI Single Oversight Framework

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 21st FEBRUARY 2018 AT 5.15PM

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

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

001/18 DECLARATIONS OF INTEREST

There were none.

002/18 MINUTES OF THE MEETING HELD ON 18TH OCTOBER 2017 AND 6TH DECEMBER 2017

RESOLVED: The minutes of the meeting held on 18th October 2017 were agreed as an accurate record subject to an amendment to the attendance list.

RESOLVED: The minutes of the meeting held on 6th December 2017 were agreed as an accurate record.

003/18 MATTERS ARISING

DECEMBER 2017 092/17 MINUTES OF THE MEETING HELD ON 18TH OCTOBER 2017 - THE MINUTES WERE PRESENTED FOR INFORMATION AND WOULD BE SIGNED BY THE CHAIR AT THE NEXT COUNCIL MEETING
Board Administrator to include within the papers.
Completed

DECEMBER 2017 096/17 REPORTS FROM BOARD COMMITTEES - THE LEAD GOVERNOR FELT THE COUNCIL WOULD WELCOME A PRESENTATION REGARDING MEDICAL PRODUCTIVITY
The Board Administrator would note for June 2018.
Completed: This has been noted for the June Meeting.

DECEMBER 2017 096/17 REPORTS FROM BOARD COMMITTEES - AUDIT AND ASSURANCE COMMITTEE - THE LEAD GOVERNOR ACKNOWLEDGED THE WORK UNDERWAY AND FELT A PRESENTATION DETAILING THIS TO THE COUNCIL WOULD BE WELL RECEIVED.
Mr Graves said that he would be happy to do this alongside the external auditors if possible.
Completed: Included as part of the February Agenda.

DECEMBER 2017 098/17 NEW CONFLICTS OF INTEREST POLICY - THE LEAD GOVERNOR QUERIED WHETHER BEING A GOVERNOR AT TWO FOUNDATIONS TRUSTS WOULD CONSTITUTE A CONFLICT OF INTEREST.
The Director of Corporate Governance would investigate and advise outside of the meeting.
Ongoing: NHS England guidelines do not cover this explicitly but it is acknowledged that different Trusts have interpreted the guidance in slightly different ways. Further guidance from NHS England is expected in late spring to further guide Trust's in managing Conflicts of Interest. Similarly, this is not mentioned within Monitor's Foundation Trust Code of Governance nor the Monitor Statutory Duties Reference Guide for Governors. The Lead Governor requested the Director of Corporate Governance review the Constitution and take a view as to what this Trust would do.

DECEMBER 2017 099/17 GOVERNOR'S LOG - IN FUTURE ONLY ENTRIES RECEIVED SINCE THE LAST COUNCIL WOULD BE INCLUDED AS OPPOSED TO THE ENTIRE RECORD.
Board Administrator to note.
Completed: This will be actioned moving forward and has been adopted for the February Meeting.

DECEMBER 2017 100/17 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT - THE COUNCIL AGREED THAT THIS AGENDA ITEM WOULD BE BEST SERVED UNDER THE GOVERNORS' STRATEGY AND ENGAGEMENT GROUP.
The Board Administrator would therefore remove this from future agendas and include within the agenda for the Strategy and Engagement Group.
Completed: This has been added to the Strategy and Engagement Group moving forward.

DECEMBER 2017 101/17 ANY OTHER BUSINESS - THE LEAD GOVERNOR NOTED THAT THE PRESENTATION OF BOARD REPORTS AND CHAIRS' REPORTS TO THE COUNCIL MAY NEED TO BE CONSIDERED AS ON SOME OCCASIONS THIS CAN RESULT IN FAIRLY HISTORIC INFORMATION BEING RELAYED.
Chair to consider.
Ongoing: Advance development of CoG agenda will enable identification of papers which could be deemed to be dated and seek to provide additional later versions where possible. This will be addressed from April CoG.

004/18 CHAIR'S UPDATE

The Chair presented the paper detailing his activities since the last Council of Governors meeting in December. This aimed to provide governors with a snapshot of the wider perspective of Chair activities undertaken. He commented on the balance between Trust activities and Gloucestershire Health Economy activities and shared that he was trying to increasingly look across the health economy.

The Chair welcomed any questions or comments from governors. In response:

- The Lead Governor requested the Chair brief the Council on his recent meeting with Tim Poole from Gloucestershire Carers. The Chair advised that he had met with Tim Poole to discuss the option of a member of Gloucestershire Carers becoming the Trust's fourth appointed governor. The Chair confirmed that Tim Poole had nominated a member of the team and further information would be disseminated shortly. The Chair thanked Mrs Hincks for her input in involving Gloucestershire Carers.
- Mr Greaves queried whether the Chair's meeting with Alex Chalk, MP for Cheltenham, was productive. The Chair answered that this had been very productive and helpful and that he and the Chief Executive had updated the MP on the Trust's successes including the recent Trauma and Orthopaedic reconfiguration. The Chair informed the Council that he and the Chief Executive met with Local MPs on a regular basis as key stakeholders.
- Mrs Lewis queried what the Gloucestershire 2050 Launch Event involved. The Chair shared that this was a big initiative by the Council and University. He noted that this was a well-attended event though he acknowledged that it was just the start and that he felt there would need to be wider input as the strategy develops. Conversations are ongoing with Cllr Mark Hawthorne regarding how the Trust could be further involved.

The Chair reminded the Council that should any governor wish to know further details of any of the listed activities then they were welcome to contact him directly.

005/18 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented the report providing an update to the Council regarding:

- The challenging operational week of half term (where ultimately, performance suffered, however quality did not).
- A&E performance measures compared to this time last year, with note to the improvements in ambulance conveyance.
- The Trust's re-categorisation from Category 4 to Category 2 in relation to A&E performance.
- Positive perception of Gloucestershire Hospitals following conversations with James Kent, Specialist Advisor to the Prime Minister, who advised that Gloucestershire was being increasingly described as an "up and coming" health system.
- Improvements in relation to mortality thanks to the improvement journey for fractured neck of femur.
- Sepsis improvements.
- A recent Trust visit from Lord Carter to review the success of the Trauma and Orthopaedic reconfiguration.
- Success and improvements in Stroke Care.

In response to the Chief Executive, the following points were raised by governors:

- Cllr Gravells was pleased to hear about the ambulance handover improvements and reflected on the benefits this had for patients and ambulance targets. The Chief Executive requested Dr Llewellyn share the praise with the Team. The Chair would also seek to praise and recognise the team's efforts. **TL/PL**
- The Lead Governor noted the proposal put forward by the Sustainability and Transformation Partnership (STP) to become an Integrated Care System. He noted the rebranding of the Accountable Care System and reflected on how confusing this must be for the general public. He also noted the lack of timescale and wondered if the Chief Executive knew any further details regarding this. The Chief Executive answered that she did not, and the only timeline published was that around the submission of expression of interest; she further reflected that there was also an absence of detail around what resources, opportunities and bureaucracies that it may bring. She noted that one aspect of single Accountable Care Systems was a single Financial Control Total. The Chief Executive noted the risk this imported for Trust partners.

006/18 REPORTS FROM BOARD COMMITTEES

Finance Committee – January Board Report & Chair's Report from 20th December 2017

The Director of Finance reported the key highlights of the January Board report to the Council, in particular that the Trust had identified £5.1m of the additional £6m Cost Improvement Plans (CIPs) required, the revision to the Trust's 2017/2018 forecast and the £5m Capital Loan the Trust had been awarded.

Mr Norton reported the key highlights of the December Finance Committee Chair's Report and noted in particular the changes to the year end forecast. He advised that one of the challenges of the

Committee was whether the financial position could be explained by Executive Directors other than the Director of Finance. Mr Norton further advised that the Committee received positive assurances in this respect. He also reflected on the conversations about CIP, the rigour around this and what could be learnt from the best CIP projects.

In response, the following points were raised by governors:

- Cllr Gravells shared that he found the verbal update provided difficult to follow and wondered if this could be made more straight forward. The Lead Governor echoed this, and reflected on the timing of reports and verbal contemporary updates. The Chair would further consider this. **PL**
- The Lead Governor reminded the Council that he attended the Trust Finance Committee as an observer and noted the portion of the Trust's deficit attributable to Trakcare. He assured the Council of the good debate amongst NEDs within the Committee and noted the excellent CIP report received by the Committee. The Lead Governor felt the progress made should be applauded. He felt a presentation around CIP would be of benefit to governors. **SS**
- Mr Greaves noted the point around income from specialist commissioners and wondered whether this was significant sum of money which changed the Trust's situation and wondered how the next financial year was looking. The Finance Director shared that the income from specialist commissioners was a multimillion figure known between the Trust and NHS Improvement (NHSI) and would be resolved. He shared that discussions were underway with the commissioners for 2018/19.

Quality & Performance Committee – January Board Report & Chair's Report from 8th December 2017

The Chief Operating Officer presented the highlights of the January Board Report noting that the paper was jointly authored by herself, the Medical Director, the Director of People and the Director of Quality and Chief Nurse. She updated the Council on recent performance figures noting increases in attendances, data quality issues around RTT, improvements against the two week wait standard, the blip in 62 day performance and the achievement of the diagnostic standard for January. The Deputy Director of Quality advised that NHS England would be visiting the Trust the week beginning the 26th February as the Trust had received £50k to improve the Friends and Family Test in Maternity.

Dr Feehily reported the key highlights of the December Quality and Performance Committee Chair's Report and commended the executives on the improvements in performance. She also reflected on the conversations around how patients experience delays and how the Trust communicated with them.

In response, Mrs Lewis observed the engagement of GLANSO and wondered how they were contributing to supporting cancer recovery. The Medical Director advised that GLANSO treated patients who had been waiting the longest; this supports delivery of quicker and more responsive care. The Chief Executive reflected on the different model of working imported by GLANSO and the difficulties of applying this to Trust staff but she felt there were opportunities yet to be captured.

The Medical Director acknowledged the rise in Emergency Department attendances and recognised the astonishing effort of staff.

Workforce Committee – January Board Report & Chair's Report from 8th December 2017

The Director of People presented the Workforce January Board Report to the Council, noting the improvements in appraisal rates, increases in turnover and deep dives into areas of concern and the resetting of Committee priorities. Six areas were discussed and debated as part of this and the recommendations made were accepted and therefore action plans will be implemented moving forward.

Mr Norton reported the key highlights of the December Workforce Committee Chair's Report and also reflected on the conversation around priorities, with a future focus on reviewing establishment need vs budget and improving recruitment and retention.

Mr Coughlin shared that he had seen an article recently around how appraisals were an outdated approach and that a focus on quality throughout the year was a better approach. The Director of People shared that appraisals were a mandatory requirement but reinforced the importance of quality conversations and shared that she would be focusing on redeveloping appraisals in with the talent management system.

Mrs Lewis noted the high turnover amongst health care assistants (HCAs) and felt encouraging the nurse care assistant role would help improve this. She wondered whether this was being implemented. The Director of People confirmed that itwas and added that the Trust had many HCA apprentices but that she would like to introduce nurse degree apprentices, which at the moment was not possible due to NMC require the route to be supernumerary (meaning the HCA is not allowed to work throughout the three years and would have to be a student).

007/18 NON-EXECUTIVE DIRECTORS' RECRUITMENT

The Director of Corporate Governance presented the paper on non-executive director recruitment, noting this had been received at the Governance and Nominations Committee.

He requested the Council approve the approach and the job description/person specification. He advised the Council that the Board undertook a stock take of skills and felt two particular skills sets were needed: digital skills and skills in estates and physical asset management and development. That view was shared by the Governance and Nominations Committee.

RESOLVED: That the Council agree the proposed approach.

008/18 FREEDOM TO SPEAK UP

The Deputy Director of Quality gave a presentation on the Freedom to Speak Up agenda and her work as a Freedom to Speak Up Guardian to support the paper received by the Council. She explained the background of the scheme, how this was being communicated to staff and what her role involves.

The following points were raised by governors:

- Mr Greaves felt there was a natural tension between the Deputy Director of Quality being employed by the Trust and this independent role, however acknowledged that as this is nationally mandated it must be recognised. He wondered whether any thought had been given to utilising an independent source. Dr Feehily advised that she was the nominated NED with responsibility for Freedom to Speak Up, and advised that a group met periodically to discuss the issues being identified.
- Mr Marchant queried how much resource was available to delve down into issues. The Deputy Director of Quality advised that her role was to support and advise, not to investigate, and she ensures that the appropriate individual takes investigation forward.
- Cllr Gravells wondered how the existence of the service could be amplified and the message communicated to staff. He shared that governors would be happy to help with this.

RESOLVED: That the Council endorse the approach being taken to improve the Speaking Up Culture being developed with the Trust.

009/18 THE ROLE OF THE AUDIT AND ASSURANCE COMMITTEE

The Council agreed this item would be postponed and presented at the April meeting. **NJ/ RG**

010/18 GOVERNORS LOG

The Chief Executive presented the Governors Log and noted that no new questions had been received since publication. The Council noted the log.

011/18 QUALITY ACCOUNT AND GOVERNORS' INDICATOR

The Deputy Director of Quality presented a paper to the Council regarding the Quality Account and the indicators to be chosen by governors as part of this. The Lead Governor shared that this had previously been discussed within the Governors' Quality Group and following this governors had reviewed the information and further discussed this with their pre-meeting. He shared the two indicators chose within the pre-meeting:

1. Responsiveness to inpatients personal needs
2. Patient discharge summaries sent to GP within 24 hours

Thoughts were welcomed from those who were unable to attend the Governors' Quality Group. The Chief Executive reflected that the second indicator should not be difficult to measure but wondered if this would be value adding. She cautioned that she was unsure whether any metrics existed around the first measure. She recommended the team investigate how this measure is nationally defined and aim to understand this more fully. The Council debated which indicators would be the most helpful; the Chief Executive noted that perhaps an indicator which highlights where the local approach does not follow the national approach might be helpful.

The Council agreed that this would be further discussed at the next Governors' Strategy and Engagement Group. Mr Graves raised concerns that the process had been somewhat untidy and needed to **SC/ NJ**

be clearer. The Chair shared that an annual work plan would be created for governors moving forward. **LB/ NJ**

012/18 ANY OTHER BUSINESS

No other business was noted.

013/18 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 18th April 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at **17:30pm**.

Papers for the next meeting: Papers for the next meeting are to be logged with the Board Administrator no later than **17:00pm** on **Monday 9th April 2018**

014/18 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960

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

The meeting ended at 18.50 pm.

Chair
18th April 2018

ITEM 16

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 17

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 18

PUBLIC QUESTIONS

Peter Lachecki
Chair

"How many times has Gloucestershire Hospitals NHS Foundation Trust cited the NHS Constitution in its strategic work over the last 12 months? If so, in what context has this been cited?"

As a fundamental document, which establishes the principles and values of the NHS in England, the NHS Constitution is part of the strategic context within which the Gloucestershire Hospitals NHS Foundation Trust operates. As such, the Constitution, and constitutional targets supporting it, are reflected in the work of the Trust on a daily basis. Specific examples include:

- Explicit references to the NHS Constitution in the Operational Plan 2018/19 and supporting presentations delivered to stakeholders, including the Council of Governors
- Regular references to constitutional standards in the public Board (6 meetings a year) and Committee (up to 12 meetings times a year) papers
- Regular references to constitutional standards in Trust papers, for example the Quality and Performance report
- Where appropriate, references to (risks to delivery of) constitutional standards on the Trust Risk Register (e.g. Risk C1748COO The risk of statutory intervention for failing the national access standards in relation to cancer)
- Regular references to performance against the constitutional standards in Trust's internal strategic meetings, including the Trust Leadership Team (monthly) and Executive Divisional Reviews (quarterly)
- References to NHS Constitution on the Trust webs site https://www.gloshospitals.nhs.uk/about-us/our-trust/our-values/
- References to NHS Constitution in staff induction (delivered fortnightly) and induction materials
- Inclusion of the NHS Constitution in Governors' Handbook and Non-Executive Directors' Handbook
- Chief Executive explaining the Trust's performance against the constitutional standards Annual Members Meeting -2017
- Current performance against constitutional standards displayed on screens on hospitals sites (24/7, updated in real time)
- Explicit references to the NHS Constitution in training and development aimed at the Board and aspiring directors, for example *The Healthy NHS Board* report used as a reference by the Board members; Board members and the next tier down graduating from the NHS Leadership Academy's Nye Bevan Programme, with its strong focus on the NHS Constitution

Finally, the (implicit) reference to NHS Constitution forms part of the Non-Executive Directors challenge in the Board and Committee discussions and of 'giving account' through the Council of Governors, Annual Report and Annual Members meeting. In summary, the NHS Constitution permeates through the work of trust: at the strategic level; operationally; and in day-to-day conversation amongst staff and between staff and patients, their families and carers.

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

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

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

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

Written questions for the Board Meeting

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

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

Notice of questions

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

Procedure

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

the responses will be recorded in the minutes.

Additional Questions

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

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

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

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

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

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

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

ITEM 19

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION