AGENDA AND SUPPORTING PAPERS
FOR THE MEETING OF THE
GLOUCESTERSHIRE HOSPITALS
NHS FOUNDATION TRUST
MAIN BOARD
TO BE HELD AT 9.00 a.m.
IN THE LECTURE HALL, SANDFORD
EDUCATION CENTRE, CHELTENHAM
ON THURSDAY 12 JULY 2018

(PLEASE NOTE: Date and venue for this meeting.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 12 July 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

27th June 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 10 May 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 31 May 2018 and 28 June 2018	**PAPER** (Claire Feehily)		
	• Trust Risk Register	**PAPER** (Deborah Lee)		
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 30 May 2018 and 27 June 2018	**PAPER** (Keith Norton/Mike Napier)		
	Break			11:00 - 11:10
10.	Workforce:		For assurance	11:10
	• 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 June 2018	**PAPER** (Tracey Barber)		
11.	Audit and Assurance:		For assurance	11:30
	• Report of the Chair of the Audit and Assurance Committee meeting held on 15 May 2018	**PAPER** (Rob Graves)		

12.	Gloucestershire Managed Services (GMS): • Report of the Chair of the GMS Committee meeting held on 14 June 2018	**PAPER** (Rob Graves)	**For assurance**	11:40
13.	SmartCare Progress Report	**PAPER** (Mark Hutchinson)	For assurance	11:50
14.	NHS Improvement Undertakings - Financial Undertakings	**PAPER** (Deborah Lee)	To note	12:05
15.	Report from the West of England Academic Health Science Network	**PAPER** (Deborah Lee)	To note	12:10
16.	Research Report	**PAPER** (Simon Lanceley)	For Information	12:15
17.	Annual Organ Donation Report	**PAPER** (Sean Elyan)	For Assurance	12:25
18.	Annual Medical Revalidation Report	**PAPER** (Sean Elyan)	To note	12:30
19.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Sean Elyan)	To note	12:40
20.	Minutes of the meeting of the Council of Governors held on 18 April 2018	**PAPER** (Peter Lachecki)	To note	12:50
	Governor Questions			
21.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions		To discuss	12:52
	Staff Questions			
22.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		To discuss	13:02
	Public Questions			
23.	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	13:12
	Any Other Business			
24.	Items for the Next Meeting and Any Other Business		To note	13:22
	Lunch Break			**13:25 – 13.50**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 3rd JULY 2018

Date of the next meeting: The next meeting of the Main Board will take place at on **Tuesday 11th September 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** at **13:00 pm**

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
Rob Graves	Dr Sean Elyan, Medical Director
Mike Napier	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, 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, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 10 MAY AT 9 AM

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

PRESENT	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Lukasz Bohdan	Director of Corporate Governance
	Dr Sean Elyan	Medical Director
	Steve Hams	Director of Quality and Chief Nurse
	Simon Lanceley	Director of Strategy and Transformation
	Caroline Landon	Chief Operating Officer
	Sarah Stansfield	Interim Director of Finance
	Emma Wood	Director of People and Deputy Chief Executive
	Tracey Barber	Non-Executive Director
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Alison Moon	Non-Executive Director
	Mike Napier	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	None	
IN ATTENDANCE	Suzie Cro	Head of Patient Experience Improvement & Deputy Director of Quality
	Steve Tucker	Patient – Patient Story
	Mark Hutchinson	Digital Recovery Consultant
	Natashia Judge	Board Administrator
	Craig Macfarlane	Head of Communications
PUBLIC & PRESS	One governor, six members of the public.	

The Chair welcomed all to the meeting: in particular he welcomed the Interim Director of Finance to her new role and Mike Napier, the Trust's new Non-Executive Director.

076/18 DECLARATIONS OF INTEREST — ACTIONS

There were none.

077/18 PATIENT STORY

The Head of Patient Experience Improvement and Deputy Director of Quality introduced patient Steve Tucker, who shared his experience of being diagnosed and treated for cancer. His story covered:

- His initial review by his GP and subsequent admission to Accident & Emergency (A&E).
- His experiences and treatment in A&E, describing staff as very good and praising them for listening to him, whilst acknowledging that there was little communication around what his suspected diagnosis was.
- His stay at the hospital and urgent endoscopy. He praised the staff for explaining this well and not making the conversation too technical.
- His discharge from the hospital and the phrase "likely malignancy" on his discharge summary. He advised that it was frustrating to be told "you're going home" and then the process being protracted; several

hours later Mr Tucker was still waiting to be discharged.
- A suggestion that patients be contacted by phone the day after discharge.
- His experience of waiting for his biopsy and how difficult this can be.
- Hospital appointments and the lack of clarity around how long these can take: this may make one anxious about the need to extend the parking time and sometimes lead to incurring a parking fine.
- The chemotherapy alert care and how helpful this is.
- Explanation of diagnosis and how helpful a picture illustrating the human body would be.
- His chemotherapy experience and the administrative problems he encountered, in particular noting that a crucial prescription was sent out second class, not first.
- His radiotherapy and the lack of communication around this.
- Reflection on his healthcare journey and initial ultrasound scan.

The Chair thanked Mr Tucker for sharing his story and invited questions from the Board. The following points and queries were raised:

- Tracey Barber reflected on the points made on communication and felt that the initiative Right Message, Right Time, Right Place would have made a real difference. She stressed the importance of getting the process right. She also agreed that patients needed to be aware of how long they should park their car for, and if this was not possible, there should be a member of staff available who can address this for patients.
- The Medical Director pointed out that as an Oncology patient Mr Tucker should not have been paying for parking; he should have had a parking pass. Dr Elyan would investigate how this was being communicated to patients; he would further look into the initial ultrasound scan issues made by Mr Tucker. Dr Elyan noted that Mr Tucker said that it would be helpful to make comments not complaints, and he felt the Friends and Family Test did not give patients the option to do this. Dr Elyan asked Mr Tucker for his thoughts on what “good” would look like and asked that he consider this and come back to him. **SE**
- The Director of Quality and Chief Nurse asked whether Mr Tucker was assigned a specialist nurse. He answered that he was given a name but never formed a relationship with them. On reflection he felt this would have been helpful . The Director of Quality and Chief Nurse felt they could and should have been part of the journey, and would follow this up. **SH**
- The Chief Operating Officer shared that work was being undertaken around teams and patients to ensure strong and robust administrative processes.
- The Chair reflected on discussions at the recent Healthcare Overview and Scrutiny Committee about discharge and some of the inefficiencies. Mr Hams explained that there had been a recent review of discharge practices across the Trust and this was now a focus of dedicated improvement work. He agreed that there were a number of opportunities to improve care further.

078/18 MINUTES OF THE MEETING HELD ON 8 MARCH 2018

RESOLVED: Following minor amendments raised by Rob Graves and the Lead Governor, the minutes of the meeting held on 8 March 2018 were agreed as a correct record and signed by the Chair.

079/18 MATTERS ARISING

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 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.

Completed to Board: Revised objective presented and discussed at Board Strategy and Development session on 18th April. Feedback to be shared with Research Team. Final wording of the objective to be signed off by Executive Team in May under the authority delegated by the Board

MARCH 2018 036/18 PATIENT STORY - 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: Phone chargers issue resolved; the infection control implications of introducing buzzers are being appraised. Director of Quality and Chief Nurse actioning.

MARCH 2018 047/18 GOVERNORS' QUESTIONS - 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.

Ongoing: This will be addressed with the auditors at the next Audit and Assurance Committee.

MARCH 2018 041/18 QUALITY AND PERFORMANCE REPORT - 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 Chief Operating Officer to investigate this and feedback to the next Board

Completed: Work being undertaken by ED team to understand trends regarding patients leaving without being seen. Hilary Lucas leading with teams and analysis will be collated for Quarter 1. This will be reported back to Quality and Performance meeting in August.

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. 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.

Completed: The Director of Quality and Chief Nurse has reviewed the current provision of learning disability training. The Trust has 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"*
- *The HCA apprenticeship programme is being revised; it will include a day on patient-centred care covering 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.*

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.

Completed: This topic is now scheduled to be an agenda item for the June Board Strategy and Development Session. (subsequently deferred to August)

MARCH 2018 036/18 PATIENT STORY - 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.

Completed: The Director of Quality and Chief Nurse has worked with Sister Cairns to identify alternative suppliers for disposable blankets, similar to those used by the South West Ambulance Service. A pilot using new fleece blankets has commenced; formal evaluation will give consideration for future use.

MARCH 2018 036/18 PATIENT STORY - 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.

Ongoing: 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 for embedding.

MARCH 2018 036/18 PATIENT STORY - 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.

MARCH 2018 036/18 PATIENT STORY 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, the Divisional Chief Nurse for Women's and Children's, and Director of Midwifery have reviewed alternative access points for deceased children. Suitable alternatives to the

Emergency Department have not been identified; as such ED will continue to deal with such cases sensitively and ensure that patients who are in the corridor are not exposed to such situations. A solution will be identified as part of the capital scheme.

MARCH 2018 041/18 QUALITY AND PERFORMANCE REPORT 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.

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

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.

MARCH 2018 041/18 LEARNING FROM DEATHS - THE CHIEF EXECUTIVE REQUESTED THE NEXT REPORT INCLUDE BENCHMARKING AGAINST OTHER TRUSTS TO ESTABLISH WHETHER THE NUMBER OF DEATHS WHERE SHORTCOMINGS IN CARE HAD BEEN IDENTIFED IN OUR TRUST, WAS COMPARABLE TO THAT OF OTHERS.

Next report to reflect.

Completed: Benchmarking data will be included in the next report (June)

MARCH 2018 042/18 REPORT OF THE FINANCE DIRECTOR - 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.

MARCH 2018 043/18 GENDER PAY GAP REPORT 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.

MARCH 2018 043/18 GENDER PAY GAP REPORT

Chief Executive requested further assurance that the Clinical Excellence Awards process was not favouring one staff group, including gender, over another.

Completed: 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.

MARCH 2018 043/18 GENDER PAY GAP REPORT - 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.
Completed: Workforce Committee considered the gender pay gap audit report and noted actions proposed.

MARCH 2018 045/18 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING - 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.
Completed: 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.

MARCH 2018 047/18 GOVERNORS' QUESTIONS - 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.
Completed: Re-added to the agenda.

080/18 CHAIR'S UPDATE

The Chair presented the paper detailing his activities since December. This aimed to provide the Board with a snapshot of the wider perspective of Chair activities undertaken.

The Chair highlighted that this was Tony Foster's last Board meeting prior to his retirement at the end of May. The Chair thanked Mr Foster for his significant contribution through a period of challenge and change.

081/18 CHIEF EXECUTIVE'S REPORT

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

- Rt Hon Jeremy Hunt's call for a 10 year funding plan and round table events aimed at influencing the content of any such plan, one of which the Chief Executive would be attending.
- Formal consultation on the pay award had concluded; concerns expressed regarding funding and the effect on staff working within NHS subsidiary companies. The Chief Executive stressed that regardless of the national position on pay awards for subsidiary companies' staff, the Gloucestershire Managed Services (GMS)'s staff who had transferred to the subsidiary from the Trust would be treated the same as the Trust staff. The CEO has written to both NHSI and NHSE expressing concern about the proposed approach.
- NHS England's announcement of a failure which has led to approximately 400,000 women missing their final screening invitation for the National Breast Screening Programme. The Trust is working alongside Public Health England and investigating support services as this is estimated to affect up to 2,500 Gloucestershire patients. Post

meeting note: numbers affected c800.

- The Trust's successful bid for £39.5 capital award. The business case is distinct from the One System Business Case in that the capital business case focuses on aspects of the pathway that are delivered by Gloucestershire Hospitals; the two cases will need to be aligned but are distinct on the basis that the capital case is not reliant upon service changes subject to public consultation. The One System Business Case is hoped to be presented to the Board in September 2018 and the Capital Business Case in December 2018.
- The Trust has been released from regulatory action in relation to Accident and Emergency as a consequence of continued strong operational performance in respect of the 4 hour A&E standard.
- The Trust's new units - the Acute Medical Initial Assessment Unit (AMIA) and Clinical Decision Unit (CDU) - were noted as an exciting development to support patients to receive expert care.
- Gloucestershire Managed Services (GMS) was established on 1st April 2018; interim Chair, Kathy Headdon, is now in post.
- Staff were encouraged to celebrate international midwives and nurses day and the value of visible leadership was reinforced, particularly with the award of the Going the Extra Mile (GEM) quarterly award.
- A patient, Eleanor Fox, turned 100 and had a small party on a hospital ward.

In response to the Chief Executive, the following points and queries were raised:

- Claire Feehily raised concern regarding the patients who require breast screening and whether this would affect the Trust financially. She also asked what was being learnt from the number of patients attending A&E to ensure the organisation is future-proofed against sustained increases in demand. The Chief Executive advised that the Trust had been assured, in writing, that the financial impact of the breast screening issue would be met centrally. The Trust has been advised to mobilise recovery and response without regard to resource constraints. Plans to deal with that group of patients will not impact on routine screening due to additional capacity being mobilised in evenings and weekends. The Chief Executive expressed concern regarding the timeline and identification of staff to undertake the work but was confident that our excellent Breast Screening Service would rise to the challenge.
- The Medical Director responded to the question on A&E and advised that work was underway around growth assumptions. He did acknowledge that the last week had seen levels not previously seen by the Trust. Should this continue, this would need to be built into future plans; he also observed this was a national picture and not just local.
- Ms Moon queried the evaluation timeline for the AMIA and CDU. The Chief Operating Officer answered that evaluation would be at the end of July. If they do not add value then the pilots will be reviewed.
- Mr Graves noted the Integrated Care Systems (ICS) timeline and asked how the Trust was involved in this work. The Chief Executive answered that this was being led by the Sustainability and Transformation Partners (STP) Planning and Delivery Board and that she was a member. A visit to one of the national ICS exemplars is planned for the 9th July to learn more what others are achieving but she also welcomed the freedom to innovate locally within the national frameworks.

082/18 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 4-hour A&E Standard for March was 86.94%. March was noted to have been a challenging month with the highest attendances since October 2017. The Trust was affected by high levels of influenza, norovirus and adverse weather. There had however been a strong recovery with April performance of 92% and for May the Trust was at 90.3%. Overall Quarter 1 performance was 91.6% to date. The week prior to Board was noted to have particularly high attendances and yet the Trust was still performing at 91.9%, a testimony to the staff.
- Referral to Treatment (RTT): teams continue to monitor patient tracking lists (PTLs) and hold weekly check and challenge meetings. The Trust is still not nationally reporting but recovery plans to address the underlying causes of poor data quality are progressing well.
- Cancer performance has improved with the Trust achieving 90.4% against the two week wait cancer standards. The quarter 4 position was 89.1%, improved from the quarter 3 performance of 77.1%. This is again testament to staff and the Trust is on track to deliver the recovery plan from July onwards however it was noted that very significant increases in referrals in three specialties was a risk to this timeline. Lower gastrointestinal surgery and upper gastrointestinal surgery remain challenging areas; work continues with GP colleagues though the 'straight to test' pathway work was progressing well.

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

- The number of breaches around mixed sex accommodation has stabilised. Breaches remain related to discharge of patients from Critical Care.
- The Quality Group has commissioned a review of venous thrombo-embolism (VTE) risk assessments.
- There have been issues with tracking aspects of dementia due to changes in electronic systems. The Quality Delivery Group have commissioned a review into this alongside a 12 month improvement programme.
- Clostridium Difficile outturn for 2017/18 was 56. The Trust target was 37. A 12 month improvement plan is in place however slightly higher rates for the next few months are expected until the plan takes effect. A new Associate Chief Nurse and Director of Infection Control joins the Trust in June and this will be his key focus.
- Pressure ulcers have reduced. The Quality and Performance Committee undertook a deep dive in this area and the Trust was supported by the NHSI Improvement Collaborative.
- Overall safety thermometer. New harm events have dropped to 2.4% in March.

The Medical Director shared that the summary scorecard lagged behind in terms of Quality reporting and that the Hospitalised Summary Mortality Ratio (HSMR) for both weekdays and weekends was now within the expected range which was a huge achievement given where the trust was two years ago.

As discussed at the last Board the executive triumvirate are working with teams to update and ensure the correct indicators and thresholds are used in the quality dashboard. This will be investigated over the next three months and shadow-reported to the July Quality and Performance Committee.

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

- Ms Moon acknowledged the good news around MRSA but she reinforced that in regards to C.Difficile, 37 was a limit not a target. She strongly supported the improvement plan and felt this needed to also support small structural changes. The Director of Quality and Chief Nurse advised that doors for bays were being investigated, having been previously removed.
- Mr Foster reflected on the patient story and the Friends and Family Test (FFT) and how observations could be captured. He also reflected on interactions with administrative staff and how those staff are trained.
- The Chief Operating Officer advised that the Diagnostic and Specialties Director of Operations had been working to improve this. The Director of Quality and Chief Nurse noted that the FFT was only one option of patient experience, and the challenge was aggregating all feedback and presenting. The Board discussed the importance of ascertaining and reviewing patient experience, particularly alongside performance, and the use of data.
- The Chair noted that time to treatment under 60 minutes was increasing. The Medical Director assured the Board this was still a focus of attention and was simply down to recent workload. The planned AMIA should support this.
- Mr Graves noted that performance figures in relation to medically fit patients were 50% higher than the target set. He therefore queried whether the target was correct. The Chief Executive advised that there was system wide work on discharge and the Trust performed well relative to its self, last year and other Trusts. The target would be reviewed as part of the work on quality metrics..

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.

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE MEETINGS HELD ON 29 MARCH 2018 AND 26 APRIL 2018

Claire Feehily presented the assurance reports from March and April noting the following from the Committees:

- Appropriate dialogue and challenge taking place within the Committee.
- Presentations were received on the national *Better Births* initiative and stroke services. The presentation on *Better Births* would also be given at the next Governors' Quality Group.
- There had been a series of Never Events within theatres in the last year and an external review had been undertaken. This is being finalised and will return to the June Committee.
- The winter plan for 2018/19 and learning from winter 2017/18 was discussed.

RESOVED: That the report be noted.

LEARNING FROM PATIENT STORIES

The Director of Quality and Chief Nurse presented the Learning from Patient Stories report, updating the Board on the patient experience improvement work that had been initiated in response to the stories presented to the Board from

October 2017 to February 2018. He highlighted that in response to the March patient story new blankets for the ED had been ordered.

It was also highlighted that the Trust had won an award from the Patient Experience Network National Awards for 'Small Steps – Big Changes' an initiative to engage staff in using patient feedback from a range of sources led by staff on Ward 7a and supported by the Patient Experience Improvement Team.

Ms Barber felt the work could be taken one step further, as the response was very reactive and tactical. She felt it was important to look at all the patient stories and analyse key themes. The Chair also thought about the patient experience work from Quality and Performance Committee and whether a patient story might support that. The Director of Quality and Chief Nurse felt it was crucial to spread outstanding work; the Board agreed.

RESOLVED: That the Board note the contents of the Report.

TRUST RISK REGISTER

The Director of Corporate Governance presented the Trust Risks Register providing oversight of the Trust's major risks. He highlighted that there had been five changes since the Board last reviewed the register in March,.

The Trust Chair referred to risk **C2669N Risk of significant harm to patients as a result of falling** and asked if this reflected greater harm from falls or more patients falling. The Director of Quality and Chief Nurse advised that the Trust had received a number of Regulation 28's concerning patients falling and that this had triggered the risk register escalation. He felt the risk was not fully mitigated but he noted that additional investment had been made to support this in the guise of a Falls Practitioner who would support staff to deliver best practice; recruitment for the role was underway.

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.

083/18 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE DIRECTOR

The Director of Finance presented the Financial Performance Report for the year ended 2017/18 financial year; this was subject to external audit as part of the final year end process. Key points highlighted were:

- In 2017/18 the Trust reported a deficit of £51.6m, which included the impact of a £20m impairment charge as a result of the revaluation of Trust estate and assets and therefore the Operational Deficit was £31.6m
- After making technical and control total adjustments in accordance with NHSI guidance, the position is revised to a £33m deficit.
- 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 partially offset by pay underspends which are non-recurring.
- Cost Improvement Plan delivery to the year end was £28.5m (5.7%) which is a very strong performance, relative to the sector and other Trusts in Financial Special Measures.

- The Board were reminded that the deterioration against plan had been flagged consistently through the Board and its Committees since September 2017 and that regulators were also regularly updated.
- In 2017/18 the Trust borrowed £28.7m (revenue) plus £5m for capital; further borrowing will be required for 2018/19.

In response to the Director of Finance, Dr Feehily queried the gap between the level of detail required to understand the position and how the position existed within the public domain. She wondered what could be done to ensure information was clear and comprehensible to staff as well as the public. The Director of People shared that she was working alongside the Head of Communications to create a week of internal and external communications and detailed the stages of this plan which would include an 'Infographic' setting out the financial position which would be supported by a video from the Director of Finance. The Chief Executive felt any feedback could be used to support ongoing finance communications, but reinforced that there had not been a sudden end of year announcement as unhelpfully portrayed in the media but earlier public communications had not been picked up in the way the year end results had. Ms Barber considered the Trust's commitment to openness and transparency and felt regular communications were key; further thought needed to be given on how to do this regularly. .

RESOLVED: That the Board receive the report for assurance in respect of the Trust's Financial Position and asked the Chief Executive to consider the point re improved communication of financial and other results.

ASSURANCE REPORTS OF THE CHAIR OF THE FINANCE COMMITTEE MEETINGS HELD ON 28 MARCH 2018 AND 25 APRIL 2018

Keith Norton presented the March and April assurance reports highlight three areas of challenge within the Committees:

- Whether the Committee was learning from history; how to treat the financial year end and that other Board members other than the Chief Executive and Finance Director should be able to explain the financial position. Assurance was given from the Committee that this was the case and demonstrated throughout the meeting.
- The challenge as to whether the Trust is set up to succeed for the 2018/19 financial year and the setting and agreement of budgets. While the team is slightly behind this should not be an issue and indeed there is a greater understanding of how budgets work.
- The challenge as to whether CIP is both ambitious and realistic; whether all parts of CIP have the same rigour as the best; and whether challenges and complexities are understood. Assurance was given from the Committee that this was the case; complex areas such as clinical productivity will remain on the agenda.

The Chair concurred with the challenge around good financial governance, and felt confident that the Board were able to understand and articulate the Trust's position. He stressed the importance of Governors having the same understanding of the financial position. The Chief Executive shared that the Interim Director of Finance had presented recently at a 100 leaders session and that the feedback had been enormously positive with many staff able to connect and communicate.

RESOLVED: That the report be noted.

[The Board adjourned for 10 minutes]

084/18 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:

- 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 and are starting to return to post winter levels.
- Appraisal Compliance has decreased from 83% to 82%. However, the Trust will maximise the opportunity to further promote appraisals through the launch of the new talent development process over June and July 2018.
- Work continues to ensure establishment data is correct and to ensure staff records are aligned with finance. This has been trialled on doctors' information and is working well; it will now be extended to the corporate division and subsequently clinical staff.
- Vacancies are being controlled in a robust way with a bank employment offer being finalised which should reduce bank and agency expenditure.
- Conversations are progressing around the sustainable workforce with ideas being pulled together into a formal process. An HR Business Partner has been seconded to operationalise this.
- The agility of policies is being reviewed.
- GMS project closure report was shared with the last Workforce Committee; from now on, GMS performance will be reviewed by the GMS Committee.
- Work on Talent Development is progressing, particularly around a new appraisal tool with many appraisal managers engaged in its development. It will be launched over the next few months.
- Musculoskeletal and psychological issues continue to be the leading cause of staff absences. A business case to develop a service to support staff health and wellbeing has been delayed but remains a focus.
- Staff engagement initiatives will be trialled over the next few months with the GEM awards continuing. A staff Experience and Improvement Group has also been created.

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

- Dr Feehily sought to understand the non-applicability of the national pay award to GMS staff and queried what cost pressure this would present and how it would be handled. The Interim Director of Finance advised that work was underway to understand this cost pressure but at present it was estimated to be c£1.5m. As part of the operating plan submission to NHSI, the Trust has outlined that if this is not funded, the Trust would fund this itself and this would affect the financial plan adversely.
- The Chief Executive was encouraged by the work under way. She acknowledged the difficulties around getting the right rigour and insight from data and wondered if there had been signs of improvement. The Director of People shared the current issues with extracting reports from

ERS, skills within teams and basic cost information which is not yet easily available.

- The Digital Recovery Consultant noted that the target for turnover was between 6-11% and he wondered whether less was better. The Director of People clarified that the Trust's target was 11% and that this was a good rate as it enabled recruitment of new staff bringing in new thinking. The Chief executive said the key appeared to be less the % and more the reasons for staff leaving and asked if this data could be made available to the Workforce Committee in due course. The Director of People advised that this information would begin to be analysed in the Staff Experience and Improvement Group.
- The Director of Quality and Chief Nurse was pleased to hear about the work around establishment realignment. He advised that matching of acuity and dependency to create the right sized workforce had begun within nursing and midwifery and that this had been quite complex. He noted the work the Director of People was leading was very helpful.
- Ms Moon wondered whether a team was in place to respond to staff engagement. The Director of People advised that the team had been reconfigured to support this and that HR business partners would own issues with divisional triumvirates.

RESOLVED: That the Trust Board note the key performance metrics shared within the report and note the progress made against key strategic objectives.

ASSURANCE REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE MEETING HELD ON 1 MAY 2018

Tracey Barber presented the assurance report from May noting the following from the Committee:

- The approach to Workforce assurance now mirrors that of the Quality and Performance Committee, with the nursing, medical and operational representation on the Committee.
- There was an increase in agency spend in March and the reasons were being investigated. The Committee found that there was a peak in the number of staff taking holidays, and while the policies around this were robust the application of them was not.
- A report on the gender pay gap went to the last Board and was reviewed again at the May Workforce Committee. This was reviewed in great detail. The combined medical and non-medical pay gap is 11.52% which is lower than other Trusts but for medical staff is 28%; the evidence confirmed this related to tenure and the number of female staff in receipt of Clinical Excellence Awards (which were also linked to length of service).The proportion of women applying for and receiving additional awards was equitable. As more women achieve service comparable to their male counterparts, the gap will inevitably close. The Chief Executive asked the Medical Director to ensure that the CEA application and award process did not favour any particular staff group and was easily accessible to all, including part time staff (irrespective of their gender).
- The Committee reviewed the staff survey report and action plans; these will continue to be monitored.
- Recruitment targets around nurses and health care assistants (HCA) were discussed and the discussion took place on how the team would deliver these. Additional resource has been made available to the Recruitment Team.
- The Board Assurance Framework, risk, alignment of risk and ownership

was discussed as well as connections between the Workforce Committee and the Quality and Performance Committee.
- A deep dive into HCA retention was reported to the Committee. The action plan will return to the next Committee.
- GMS reporting will no longer come through the Workforce dashboard and will come through GMS reporting.

The Chief Executive praised the team for the work around the gender pay gap. She noted that while CEA awards were easier to achieve the longer an individual has been in post, they are not directly linked to length of service and therefore expressed caution that the team were in danger of conflating tenure and CEA awards. She asked if a group of male and female doctors with the same service were reviewed, whether there was a pay gap. The Director of People and Ms Barber advised that there was not. The Chief executive welcomed this assurance.

RESOLVED: That the report be noted.

085/18 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 20 MARCH 2018

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

- The Committee was attended by both PwC, the outgoing internal auditors, and BDO, the incoming internal auditors. The audit plan for the coming year was discussed.
- The external audit process has begun.
- A timeline for the Annual Report was reviewed.
- In May the Audit & Assurance Committee held a walkthrough of the Trust Accounts. This was useful and excellent opportunity for Non-Executive Directors.
- There has been a degree of delay in responsiveness to internal audit reports and requests to management however the Committee has seen an improved rate of response through the recommendation tracker, with a number of open actions vastly reduced. Momentum and pace needs to be maintained. The Director of Corporate Governance was thanked for his significant effort in this regard.

RESOLVED: That the report be noted.

086/18 GLOUCESTERSHIRE MANAGED SERVICES (GMS)

REPORT OF THE CHAIR OF THE GMS COMMITTEE MEETING HELD ON 24 APRIL 2018

Rob Graves presented the April assurance report noting that the group had undertaken some working meetings prior to the first Committee. He shared that high quality discussions were held. The need for a contract management resource to be in place was discussed and an appointment has since been made.

087/18 SMARTCARE PROGRESS REPORT

The Digital Recovery Consultant presented the SmartCare Progress Report, outlining:

- The overarching goals of TrakCare recovery
- The number of data quality issues which remain outstanding and the analysis, categorisation and progression of these. User guides have been created to address issues which stem from user behaviour and issues which require a system fix are being escalated.
- Work is underway around patient outcomes to align the Trust's codes with national codes, and the training and communications around this are progressing with launch of the new codes planned for mid-June.
- The ongoing issue of the speed of TrakCare at Cheltenham General Hospital has progressed with the network reconfigured. Initial feedback reveals that this is most responsive.
- Work is underway alongside the Performance Team to provide more patient tracking lists (PTLs).

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

- The Chief Executive advised that the Trust had received a congratulatory email from NHS Digital as the Trust is the first to get 10/10 in the maternity data set.
- The Director of People noted there was a point within the finance work stream about undertaking a deep dive to understand further opportunities to improve functionality and improve incomes. In the 2018/19 plan a figure was included around what TrakCare might deliver and wondered where the reporting against this was. The Interim Finance Director advised that a report on this was received by the Finance Committee on a monthly basis.
- Ms Barber reflected on user confusion and wondered if there was enough support to address this. The Digital Recovery Consultant advised that there was and that the Chief Operating Officer was always present at meetings, that the data was not being fixed until staff knew how to use the system and that the extensive training was being streamlined and made easier to digest with quick reference guides to support.
- Dr Feehily asked if further detail on progress could be shared with the Board so that there was further clarity on direction and speed. The Digital Recovery Consultant advised that further slides would be in next month's pack. The Chief Executive felt this would demonstrate the gap of not having a Board subcommittee overseeing TrakCare, and did not endorse that much detail being received by the Board. She encouraged a discussion regarding this rather than bringing inappropriate levels of detail to the Board. **MH/ RG**
- Dr Feehily also asked whether the recovery project was agile enough to process quick changes. The Digital Recovery Consultant highlighted the importance of careful prioritisation and recognising what had the greatest impact on patient care. The Chair queried who determined priorities. Mr Hutchinson confirmed that this was the Operational Recovery Group which the Chief Operating Officer attended.
- Mr Norton praised the definition of recovery goals and wondered if staging of these had been considered. The Digital Recovery Consultant advised that a trajectory behind each could be shared.

RESOLVED: That the Board note the report.

088/18 BOARD ASSURANCE FRAMEWORK

The Director of Corporate Governance presented the Board Assurance Framework (BAF). He reminded the Board that major revisions were

undertaken earlier on in the year and that each Committee now reviewed the BAF every quarter. The Audit and Assurance Committee oversees the entire process. The April reviews identified some gaps in assurances and these have been reviewed by Committees, with appropriate actions identified .

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

- The Director of People referred to the report and queried the RAG rating. The Director of Corporate Governance advised that the strategic objectives are due be delivered by March 2019 and that RAG ratings took this timescale into account.
- Mr Graves felt it would be helpful if the appendix included the Committee to display ownership and oversight. The Director of Corporate Governance would include. **LB**
- The Chief Executive felt 4.5 should be downgraded to amber from green and that 4.1 be changed as agreed in previous discussions as this is in conflict with the Trust's plan and is no longer credible.
- The Director of People questioned what indicator was used to measure 4.2, to which the Chief Executive answered that it was made up of a suite of measures.

RESOLVED: That the Board receive the report as assurance that the risks to the Strategic Objectives are controlled as effectively as they can be.

089/18 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 21 FEBRUARY 2018

RESOLVED: That the minutes be noted.

090/18 GOVERNORS' QUESTIONS

The Lead Governor raised the following points:

- He was pleased to see the TrakCare report in the public domain and the definitions of success included.
- He praised the patient story and felt there was a system wide recognition of the value of patient experience and reinforced the importance of this.
- He expressed disappointment with recent media coverage and advised that conversations would continue between the Trust and Governors as regards proactive and reactive communications , as well as pre-warnings for Governors. Governors recognised that recent inaccurate reporting is being addressed.
- He questioned the objective to reduce complaints and felt that while it was good to have fewer complaints, it was important that patients are not discouraged from complaining. The Director of Quality and Chief Nurse agreed, and advised that the strategic objective was created when there were particular issues in outpatients. The Lead Governor felt simply reviewing a number missed the point. Mr Hams agreed but stressed the reduction in complaints pertained to outpatients only and had been used to demonstrate a reduction in complaints which had risen post TrakCare deployment.

The Lead Governor advised that a former governor, Peter Jackson, had sadly passed away. He shared his condolences, as did the Board, and acknowledged Dr Jackson's competent, challenging and gentle approach and support of the Council.

091/18 STAFF QUESTIONS

There were none.

092/18 PUBLIC QUESTIONS

The following question was noted to have been received:

"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?"

The Chair read the response included in the Board papers.

093/18 ANY OTHER BUSINESS

No other business was noted.

094/18 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9 am** on **Thursday 12 July 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital**

095/18 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 12:52pm.

Chair
12th July 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2018

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
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.	*May update: 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 for embedding.*
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 update: This will be addressed with the auditors at the next Audit and Assurance Committee.*
July 2018	May 2018 087/18 Smartcare Progress Report	**MH/RG**	Dr Feehily asked if further detail on progress could be shared with the Board so that there was further clarity on direction and speed.	The Chief Executive encouraged a discussion regarding this rather than bringing inappropriate levels of detail to the Board.	*Ongoing: Discussion ongoing between Chair and CEO in respect of approach to Board assurance.*
May 2018	March 2018 036/18 Patient Story	**SH**	Call bells and phone chargers for A&E.	The Digital Recovery Consultant advised that he would investigate and resolve this as soon as possible.	*Completed: Buzzers now in place and being trialled by the Emergency Department Team at Gloucestershire Royal Hospital.*

July 2018	May 2018 077/18 Patient Story	**SH**	The Director of Quality and Chief Nurse asked whether Mr Tucker was assigned a specialist nurse. He answered that he was given a name but never formed a relationship with them. On reflection he felt this would have been helpful..	The Director of Quality and Chief Nurse felt they could and should have been part of the journey, and would follow this up.	*<u>Completed:</u> Specialist Nurses are assigned to all cancer patients, Mr Tucker's experience has been shared with the Lead Nurse for Cancer Services who will ensure that specialist nurses provide clear guidance to patients on what they can expect from their specialist nurse.*
July 2018	May 2018 077/18 Patient Story	**SE**	The Medical Director pointed out that as an Oncology patient Mr Tucker should not have been paying for parking; he should have had a parking pass.	The Medical Director would investigate how this was being communicated to patients; he would further look into the initial ultrasound scan issues made by Mr Tucker.	*<u>Completed</u>: Patient was given parking pass but availability of Oncology parking slots is limited.* *Further investigation of initial ultrasound findings is ongoing and direct feedback to Mr Tucker will follow.*
July 2018	May 2018 088/18 Board Assurance Framework	**LB**	Mr Graves felt it would be helpful if the appendix included the Committee to display ownership and oversight.	The Director of Corporate Governance would include.	*<u>Completed:</u> This will be included in all future reporting.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2018

CHAIR'S ACTIVITIES UPDATE

In order to present a snapshot of the wider perspective of Chair activities undertaken, a written summary is 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 April to 3rd July 2018.

Trust Activities

DATE	EVENT
27 04 18	Trust 100 Senior Leaders' Quarterly Meeting
30 04 18	Gloucestershire Safety and Quality Improvement Academy Awards
16 05 18	Governor 1:1
18 05 18	Consultant interviews – Trauma & Orthopaedics Paediatrics
21 05 18	Governor – Non-Executive Director Evening at Uni of Glos
23 05 18	'Model Hospital' digital information benchmarking briefing
23 05 18	Trust Innovation Panel Meeting
11 06 18	Alan Thomas, Lead Governor 1:1
11 06 18	Governor 1:1
11 06 18	Director of Finance recruitment Interviews
21 06 18	Trust Medical Education Board meeting

Gloucestershire Health Economy

DATE	EVENT
01 05 18	Stephen Marston, University of Gloucestershire
04 05 18	Meeting with Mark Hawthorne, Leader Gloucestershire County Council
08 05 18	Health and Care Overview and Scrutiny Committee (HCOSC)
17 05 18	Ingrid Barker, 2gether/Gloucestershire Care Services Chair 1:1 plus Hope House visit
15 06 18	Gloucestershire County Council Corporate Peer Challenge: Formal Feedback Meeting
26 06 18	Gloucestershire Strategic Forum Meeting (Shadow Integrated Care System - ICS)
03 07 18	Meeting re. Research4Gloucestershire

National Stakeholders + others

DATE	EVENT
26 04 18	NHS Improvement Financial Special Measures Meeting
02 05 18	David Owen, Chief Executive, gfirst, LEP
04 05 18	Kings School, Gloucester - with Sarah Brown, Volunteers Manager
11 05 18	Sarah Wilkinson, Chief Executive NHS Digital visit to Trust
22 05 18	Call with Dido Harding, Chair, NHSI
12 06 18	NHS Improvement Financial Special Measures Meeting
19 06 18	NHS Providers Chairs' Network Meeting, London

Peter Lachecki
Trust Chair

3rd July 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JULY 2018

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Summer is upon us and, whilst operationally performance is strong, services remain busy with our highest ever number of Accident & Emergency (A&E) attendances occurring in the last three months. Using A&E performance as a barometer for wider performance and flow, positively the Trust exceeded the 90% national trajectory for the first quarter of the year delivering care within four hours to 92.3% of our population. Whilst a positive picture of performance, quarter two is the period when the Trust should be achieving 95%+ and on days when demand is within the expected range, we are consistently exceeding the standard; however, demand has exceeded the contracted levels on more than 50% of days and at times exceeded it by more than 20%. This growth is biased towards presentations from those patients that walk in to the service and typically presenting with more minor conditions. Work is underway with system partners to better understand the drivers for this increase in demand, with the aim of developing mitigations that restore activity to planned levels, with some urgency. This latter point is crucial if we are to ensure staff are supported to enter next winter with sufficient resilience to ensure a positive experience for them and our patients.

2. National and Regional

2.1 On the 5th July, the nation celebrated the 70th anniversary of the NHS and two front line members of Trust staff (a ward sister and a medical secretary) attended the service in Westminster Abby. Twitter followers may have seen the amazing day they experienced. More to follow on our own Trust's celebrations.

2.2 Following the recent consultation on the proposed pay award for NHS staff, unions nationally have given their support to the proposal. Clarity regarding staff working in NHS subsidiaries such as our own Gloucestershire Managed Services (GMS) remains unclear but the Trust is taking every opportunity to raise its concerns with government and the Department of Health, should the policy exclude funding for awards to this staff group. Agenda for Change pay increases will however, be awarded to GMS staff, irrespective of the national approach to funding. The latest information from the Department of Health suggests that decision makers are listening to concerns.

2.3 Following on from NHS England's announcement regarding a failure in the National Breast Screening Programme which resulted in approximately 400,000 women, aged 67 to 71 years of age at the time, missing their final screening invitation, the Trust is now involved in providing screening for those that wish to take up the offer. For Gloucestershire Hospitals, this was, in reality, just under 800 patients and to the credit of staff working in our service, all have now been screened with a lower than average referral for follow up, reflecting the relatively low risk nature of this population.

3. Our System and Community

3.1 Following an unsuccessful first wave bid, the Sustainability and Transformation Partnership (STP) was invited to resubmit its proposal to becoming an Integrated Care System (ICS) and has just been informed that it has been **successful**. A further four health systems have been invited to join the existing ICS group and it is fantastic news (and recognition) for Gloucestershire STP. A visit on the 9th of July from the national ICS team was very positive, with a recognition that much of what an ICS offers is already being achieved or underway in Gloucestershire. The ICS has been awarded £2.04m to enable integration activities and priorities for deploying this funding is underway. Simon Stephens, Chief Executive of NHS England, has set out the following three priorities for the new wave of ICSs:

- More joined up care between components, institutions and team members.
- More 'anticipatory care' to prevent decline and reduce the use of hospital services
- Sharing control of care and health with the person and patient

3.2 Work continues to develop the *One System Business Case* (OSBC) and pace is now gathering towards Board approvals for the consultation business case in August and September – our Trust Board will review the case at its September meeting (now 11th September to accommodate the system timeline). Options continue to be developed with the aim of consulting on a 'preferred' option and the significant decisions to be worked through remain the nature and location of urgent and emergency care services including the nationally mandated Urgent Treatment Centres and the location of some of our own acute services including both surgical and medical based specialities. The system remains on track to commence public consultation in January and assuming Board approvals are secured in September, then pre-consultation engagement will be able to commence.

Work on the capital case is also gathering momentum, with the imminent appointment of Health Planners to help us ensure that we comprehensively identify our patients' and staff needs and design an environment that optimises care.

3.3 Very disappointingly, the University of the West of England has signalled its intention to consult on the withdrawal of its nursing students from the satellite in Gloucester City. The University has cited dwindling student numbers as the reason for the proposal. Typically the Gloucester based cohort is c50 students, 25-30 of whom secure employment with this Trust. The September 2018 intake will continue to enable consultation throughout September. Discussions are already underway with other Universities to mitigate the risk to GHFT of reduced nursing recruitment in the County.

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, as previously publically presented to the Board. Positively, in response to significant and protracted lobbying, the Trust is one of just three Trusts to have received notification that its previous control total of £8m surplus (issued in July 2016) will be revised by £34.88m to a £26.881m deficit control total. Whilst a c£3m stretch from the current plan, after very careful consideration, the Board has accepted the revised control total given the significant benefits if brings to the Trust and the absence of any apparent significant risks. The benefits are set out below:

- Access to up to £8m (£2m per quarter) for every quarter in which the Trust achieves the required financial and operational performance.
- Protection from commissioner imposed fines and penalties for performance standards of up to £4m per annum.
- For both 2016/17 and 2017/18 an incentive regime has operated through which Trusts that had accepted their control totals have been rewarded with 'bonus' payments.
- There have been a number of allocations, in excess of £2m, made available to Trusts in previous financial years that have required an agreed control total before funds can be accessed. This impacted the Trust in 2017/18 when it was nationally allocated capital as part of the Modernising Radiotherapy programme but did not receive its allocation as it did not have an agreed control total.
- Puts the Trust on a more level playing field, for comparator purposes, with the 91% of Trusts who have agreed their control total.

Having agreed to accept the revised control total, the Board was required to resubmit its Operational Plan for 2018/19 by the 20th June and achieved this.

4.2 Reflecting on the recognition of the significantly improved financial, and wider, governance arrangements throughout the Trust, our regulator NHS Improvement have issued a Compliance Notice formally releasing the Trust from the Enforcement Undertakings, issued in October 2016, following the unexpected decline in the Trust's reported financial position. Alongside the recent lifting of the Enforcement Notice in relation to A&E, this is incredibly positive news and further sign that the Trust is on its way to operational and financial recovery. Thanks go to all those who have contributed so significantly to these achievements.

4.3 Last month, we launched a range of new services aimed at further reducing the number patients who are admitted to hospital including a new Acute Medical Initial Assessment Unit (AMIA). One of the goals of the AMIA initiative was to eliminate the use of the Day Surgery Unit (DSU) as overnight escalation capacity when the hospital becomes full overnight. Since the service was launched there has been just one breach (by one patient) of the revised operational policy and as a result day surgery activity has increased by more than 20% and the number of patients inappropriately cared for in DSU overnight has plummeted. Staff have described this change as 'the most positive thing to happen to them and their service, in many years'. DSU however, remains a poor physical environment for patients and staff experience and this has recently been raised as a priority by Governors. Chief Nurse, Steve Hams is working with DSU staff, colleagues in Gloucestershire Managed Services (GMS) and the team working on the strategic capital case to explore what improvements can be achieved in the immediate and medium term.

4.4 The focus on TrakCare recovery resulted is a significant milestone this month with the launch of the new *Outpatient Outcome* module. This is the single biggest area that drives the data quality issues that the Trust continues to experience and that impacted so significantly last year on Trust income; 50% of the erroneous pathways have emanated from this single element of the system. Face to face and e-learning training has been made available to all staff working in outpatients, who need to use this aspect of the system and 'at elbow' trainers walked the floor during the go-live week to ensure all staff are using the new (much simplified) approach to recording the outcome of an outpatient attendance. Feedback from staff was very positive and immediate improvements in data quality and data completion have been seen. Once we have 'turned off the tap' in respect of these errors we will set about 'emptying the bath' of historic issues in preparation for returning to national reporting of Referral to Treatment (RTT) time and full recovery of income. As well as the above issue, another significant reason for the loss of income last year was the operational impact of TrakCare and the reduction in the number of patients booked and seen in our clinics resulting in extended waiting times and/or overdue follow up care for some patients. As a result of the recovery programme, we are not only back on track but our outpatient clinic utilisation of 92% is now exceeding our pre-TrakCare levels of c85% - positive news for staff and patients. With recovery underway, attention is now turning to mobilising future phases of the Electronic Patient Record (EPR) vision which remains at the heart of the SmartCare Programme and with this context, detailed work is now underway to reach agreement with the system supplier on the approach to future phases of the EPR, alongside discussions with NHS Digital and NHSE in relation to a revised financial framework. Of note, the SmartCare Board has agreed a four month period of work to build and evaluate the pathology module and agreed the priority of nursing documentation as the first major development of the EPR, reflecting the magnitude of benefits that are judged to flow form this element of the programme.

4.5 Our *Journey To Outstanding (#J2O)* continues to gather momentum with more and more examples of staff joining this exciting 'improvement movement'. There are three developing strands to the programme reflecting what *outstanding* means for the Trust, a service and for the individual (staff member or patient). A presentation pack to support staff engagement of #J20 has been developed and Divisions are leading this engagement. The lead executives have been asked to consider how patient and public views will be embedded into the work given they are a crucial to judging the quality of

patient experience. With this context, the Trust has recently received the national inpatient survey results; this is a more mixed set of results than we aspire to but positively the areas where we perform below other Trusts are all areas of current focus. Patients currently in the Trust, and for the whole of July, will be the cohort surveyed this Autumn.

4.6 Later this year, we will have the chance to demonstrate our progress towards *Outstanding; t*he Trust was advised at the end of June that it will be subject to a formal Care Quality Commission (CQC) Inspection this year. The inspection will be executed under the new CQC model and comprise three main components: data collection and analysis, unannounced inspection of core services and a planned Well-Led Review. The latter two are expected to take place during the September to November 2018 period. Preparations are well underway and are being led by Steve Hams, Chief Nurse & Director of Quality and Lukasz Bohdan, Director of Corporate Governance. Regular updates will be provided to the Board.

4.7 In addition to national events, the Trust excelled all expectations when staff came together to celebrate NHS70. Hundreds of staff joined in coffee mornings and tea parties across our three sites, and our *100 Leaders* celebrated the day by being out and about the organisation demonstrating and experiencing the benefits of 'visible leadership' whilst sharing tea and cake with staff, patients and visitors. Feedback from staff has been incredibly positive and our *100 Leaders* have captured the seven things that staff are most proud of and positive about, alongside the seven most important issues that the Trust needs to address – of note, none of these latter seven issues were unknown and all are a current focus however, these insights will bring added pace and urgency to resolving the concerns expressed.

4.8 A month cannot go by without numerous people in the Trust being recognised for the amazing things they do. Dr Pippa Medcalf has been awarded an honour (MBE) for her services to the health needs of homeless people; two of our theatres teams at Cheltenham General (Recovery) and Gloucestershire (Head and Neck Services) have won awards in the Oxford Brookes University Placement of the Year' with the former winning the top award of *Placement of the Year;* our Postgraduate Medical Education team has been awarded the first ever *special commendation* as the Trust which offers the best examination experience nationally for examiners, candidates and patients; two of our Healthcare Assistants made it through to the finals of the *Gloucestershire Apprentice of The year* and Trust Healthcare Assistant (HCA), Chloe Pugh won the award in the Outstanding Apprentice of the Year (Health, Education & Care – Private or Public Sector). Finally, I am delighted to announce that the Trust has appointed Sarah Stansfield as its substantive Director of Finance. Sarah is a great example of 'home grown talent' and succession planning at its best - I am delighted to welcome her to the team. Interviews for the substantive Chief Digital and Information Officer are due to take place on 9th July and the Trust has attracted a very strong field.

Deborah Lee
Chief Executive Officer

July 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

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

Purpose

This report summarises the key highlights and exceptions in Trust performance for the May 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

Quality

Friends and family test throughout the services remains broadly static, additional questions are due to be asked through the text messaging service provider to gain further insight into patient's experience.

Additional infection control indicators have been added (Klebsiella and Pseudomonas) so as to ensure we are fully compliant with the expectations from NHS Improvement in relation to infection control performance. Whilst there are currently no expected targets or limits our overall intention is to reduce the harm to our patients because of infections.

Clostridium Difficile (*C.diff)* is still an area of continued focus, there were nine post 48 hour *C.diff* cases during May, all of the transactional interventions identified in the improvement plan have been implemented, further work is now required to ensure consistent delivery.

The ED Safety Checklist continues to be used within both emergency departments, regular spot checks of compliance are completed by the senior nursing team. Under the leadership of the Divisional Chief Nurse for Medicine the checklist is being reviewed so that its full potential can be realised, specifically in relation to improving the effectiveness and safety of handover.

Performance

During May, the Trust met the Trust and NHS I/E Trajectory for A&E 4 hour standard.

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.

In May 2018, the trust performance against the 4hr A&E standard was 91.6%, with ED attendances in May are up against last year by 3.1%. This performance was above the agreed STF trajectory (90%). GHFT. Month to date performance (20 June) is currently 92.1% which is on track to deliver the STF June trajectory (90%). The performance in May 2018 is 11.7% higher than last year. Where appropriate, patients arriving at the Emergency Department are immediately repatriated to Primary Care, through the streaming programme.

The Trust did not meet the diagnostics target in May at 1.2% (un-validated) this is 0.2% above the target range. The failure in delivery was contained to two diagnostic areas, Echo's and Sleep Studies.

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 a slight decline against the 2 week standard for May with performance at 86.3% (Un-Validated). The main tumour site that was compromised on the 2 week pathway remains Lower GI. The majority of tumour sites were impacted by increased unplanned demand in May (see full Cancer Delivery Plan). A Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed and reviewed on a fortnightly basis.

Cancer 62 day Referral to Treatment (GP referral) performance for April was 80.5%. For May (un-validated) current performance is 78.2% this is compromised of 33.5 breaches from 154 treatments.

As last month, 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 continue to review 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, this is delivered through transformational change to patient pathways now robust operating models are developed.

Quality delivery (with the exception of those areas previously discussed) remain stable, further work is being completed to identify a refreshed quality and performance dashboard to widen our understanding of quality and performance delivery.

Recommendations

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

Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.
Impact Upon Corporate Risks
Continued poor performance in delivery of the 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 May 2018

to be presented at June 2018 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During May, 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 in the Spring.

The Trust has met the 4 hour standard in May, 91.6% against the STP trajectory at 90%.

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 & Trust Cancer Manager.

Cancer performance 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, continued through to May and patient choice (sometimes due to short notice appointments) have impacted delivery.
The May figures as yet un-validated that shows 2ww at 86.3%. Within the May cohort 196 breaches, from 293 breaches related to the colorectal pathway, which is anticipated to reduce in June and July as the full implementation impact is realised.

For 62 day, again monthly improvements in breach numbers can be seen, with stabilisation in the high 70%'s. April confirmed position for 62 day is 80.5%.
May is at 78.2% un-validated (with further treatments anticipated). 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. For our key tumour sites, straight to test is now in place for Lung and Colorectal services which will benefit patient quality.
Quality
The Quality Delivery Group has now been established and is now in a regular cycle. The purpose of the Group is to develop and then deliver our quality improvement strategy which includes our key priorities.

The key areas of focus are to improve and strengthen our:-
• Professional nursing standards by implementing the Nursing and Accreditation Scheme (NAAS)
• Pressure ulcer prevention programme
• Falls prevention programme
• Sepsis care
• Dementia care standards
• Discharge experience
• Infection control and prevention
• Person centredness

In summary, the position for the Trust in a number of key quality metrics are noted in the Quality Delivery exception report.

Key areas where additional reports have been provided for the Quality and Performance Committee are:
• Cancer Services Delivery Group – escalation report (including Cancer Delivery Plan)
• Emergency Care Delivery Group– escalation report (including Emergency Care Dashboard)
• Planned Care Delivery Group – escalation report (including RTT Delivery Plan)
Quality Delivery Group - 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 92% as at the 20th June.

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 not delivered 1%, as a result of non-delivery of echo's and some risks in sleep studies. Both areas have a recovery plan and will be addressed in month.
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 to support the increased demand in these areas within cancer care.
Overall clinic slot utilisation is positive, remaining at 92.34% (for CBO booked clinics)in May this is still an area for further development but good progress is being made.

Weaknesses

• 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 successful day #cancer insight, with positive social media interaction.
• Support from our partner commissioners has been sought in relation to cancer across a number of areas:
    - Referral rate increases (colorectal, urology & dermatology) with no impact in detection rates – CCG to support communication to targeted practices in the CGH area, this work continues.
      Notification and actions associated with National campaigns e.g. blood in pee, anticipating a circa 24% increase

• 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.
Nursing Assessment and Accreditation Scheme
The introduction of NAAS will support the Trust’s aim of creating a culture of continuous improvement supported by robust governance and accountability arrangements from Board to Ward which ensures leaders are focused on the key risks to the delivery of excellent care. NAAS is designed to measure the quality of nursing care delivered by individuals and teams. It supports nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed.
NAAS measures the quality of nursing care delivered by individuals and teams, it incorporates Essence of Care standards, key clinical indicators and each question is linked to Compassionate Care - The 6cs of: care, compassion, competence, communication, courage and commitment, whilst providing evidence for the Care Quality Commission’s Fundamental standards.
The framework is designed around 13 standards with each standard subdivided into Environment, Care and Leadership. The 13 standards are: Organisation and Management of the Clinical Area, Safeguarding Patients, Pain Management, Patient Safety (1), Environmental Safety (2), Nutrition and Hydration, End of Life Care, Medicines Management, Person Centred Care, Pressure Ulcers, Elimination, Communication and Infection Control.

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) with no impact in detection rates – 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.
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Risks & Threats

Cancer performance remains a significant risk for the Trust, of particular the sharp increase in April that has continued into June, (highest increase since 2016). 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. 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											
		Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
ED Total Time in Department - Under 4 Hours	Trajectory	89.20%	88.30%	92.20%	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%	90.00%	90.00%
	Actual	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%	91.98%	91.58%
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	76.10%	77.20%	78.40%	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%	92.00%	92.00%
	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	5.26%	5.30%	4.80%	2.90%	0.46%	0.51%	0.75%	0.64%	0.49%*	0.26%	0.56%	1.26%
Cancer - Urgent Referrals Seen in Under 2 Weeks	Trajectory	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	85.90%	79.60%	70.40%	71.20%	74.60%	75.80%	81.20%	86.40%	90.60%	90.50%	86.60%	86.30%*
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.10%	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%	93.20%	93.30%
	Actual	94.10%	57.30%	89.70%	92.70%	89.00%	94.50%	96.30%	92.40%	97.60%	94.50%	91.30%	91.90%*
Cancer - 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.10%	96.20%	96.20%	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%	96.10%	96.30%
	Actual	95.40%	95.80%	96.20%	98.50%	95.10%	96.70%	97.30%	96.00%	97.60%	97.90%	96.70%	95.40%*
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	Trajectory	98.30%	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%	98.50%	100.00%
	Actual	100.00%	100.00%	100.00%	98.50%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%*
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	Trajectory	96.40%	94.90%	94.50%	94.90%	94.10%	94.60%	94.40%	94.40%	94.10%	94.20%	95.50%	95.80%
	Actual	100.00%	100.00%	98.40%	96.60%	97.10%	98.50%	98.10%	100.00%	100.00%	100.00%	100.00%	97.30%*
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	Trajectory	94.00%	95.80%	94.50%	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%	95.10%	95.00%
	Actual	97.90%	93.60%	91.50%	95.50%	94.60%	98.10%	94.90%	93.00%	95.50%	98.00%	94.90%	97.80%*
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	90.00%	94.70%	91.20%	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%	92.00%	94.70%
	Actual	88.90%	89.10%	88.50%	94.90%	87.10%	93.80%	95.50%	98.00%	95.90%	95.90%	100.00%	100.00%*
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	57.10%	77.80%	85.70%	50.00%	60.00%	100.00%	0.00%	80.00%	94.10%	76.50%	69.20%*
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	80.10%	85.40%	85.20%	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%	85.20%	85.40%
	Actual	71.20%	74.70%	80.10%	69.20%	71.40%	76.70%	73.40%	69.70%	79.10%	78.10%	80.30%	76.00%*

Summary Scorecard

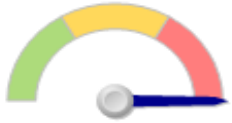
The following table shows the Trust's current performance against the chosen lead indicators within the Trust Summary Scorecard.

QUALITY

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



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	
			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	17/18	18/19
Quality	**Key Indicators - Quality**																			
	Friends and Family Test Score	Friends and Family Test Score - ED % Positive		75.6%	77.5%	84.9%	81.1%	81.0%	87.4%	85.9%	85.6%	82.7%	83.7% *	83.1%	83.2% *	81.7%	81.2%	84.7%	84.0% *	83.0% *	
		Friends and Family Test Score - Inpatients % Positive		91.2%	90.8%	90.9%	90.1%	91.2%	90.6%	91.6%	91.5%	92.0%	89.7% *	90.2%	90.2% *	90.8%	90.6%	91.0%	91.1% *	90.9% *	
		Friends and Family Test Score - Maternity % Positive		97.0%	100.0%	90.0%	94.7%	100.0%	100.0%	90.3%	100.0%	88.9%	93.6% *	97.4%	94.7% *	96.2%	96.3%	97.1%	93.8% *	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%	92.3% *			92.0%	92.9% *		
	Infections	MRSA Bloodstream Cases - Cumulative Totals	0	0 *	1	1 *	1 *	1 *	0	0	0 *	0 *	0 *	1	1					0 *	
	Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	10	16	14	18	19	13	11	5	7	6	8	8	25	48	43	18	134	16 *
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	109.2	105.5	103.9	99.7	97.1	94.8	93.4	93.1	95				109.2	99.7	93.4		95 *	
		Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	115	111.8	110	108.9	103.9	101.5	97.1	95	97.7				115	108.9	97.1		97.7 *	
		Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level	112.3			108.7									112.3	108.7			108.7 *	
	Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	6.8% *	7.0% *	6.9% *	6.5% *	6.5% *	6.7% *	7.6% *	6.3% *	7.9% *	7.2% *	7.4% *		7.1% *	6.8% *	6.9% *	7.1% *	7.0% *	7.4% *
	Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%				91.4% *	90.6% *	86.4% *	86.9% *	78.5% *	76.8% *	79.3% *	80.0% *	79.5% *			88.2% *	78.3% *		79.7% *
	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%	0.7%	1.6%		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%	16.7%		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%		0.0% *			0.0% *	
	ED checklist	ED Safety checklist compliance CGH		81%	74%	72%	79%		78%	92%	86% *	83% *	82% *	82% *	89% *						
		ED Safety checklist compliance GRH	>=80%	56%	57%	53%	79%		68%	67%	72% *	81% *									
	Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		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		98.3% *	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		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	8 *	10	18 *	24 *	29 *	35	41	45 *	49 *	14	5	14					5 *	

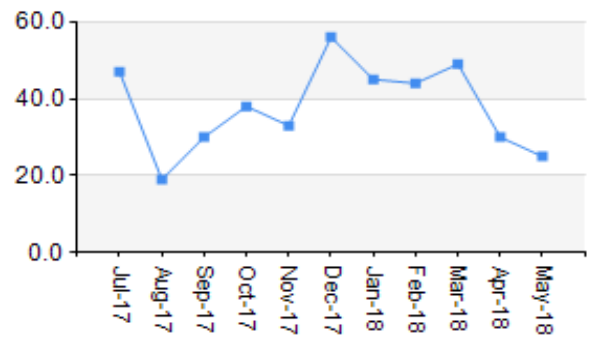
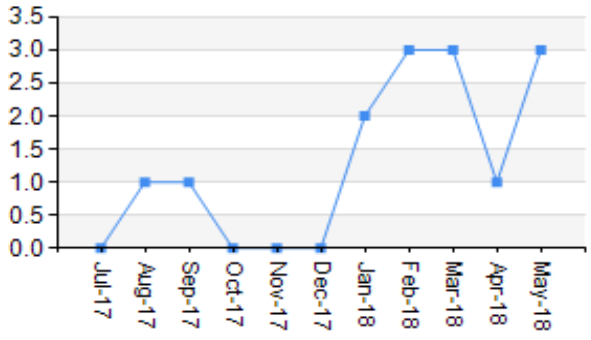
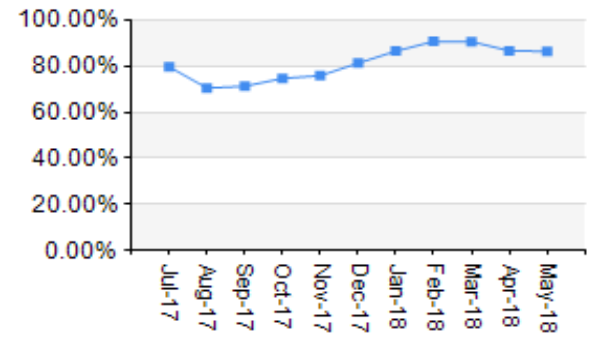
Category	Indicator	Target	Month											Quarter				Annual	
			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	17/18	18/19
Infections	Ecoli - Cumulative Totals		20	37	103 *	119 *	146 *	175	200	222 *	240 *	258 *	17	32						
	Klebsiella - cumulative totals												6	12						
	MSSA Cases - Cumulative Totals	No target	7	15	44 *	54 *	63 *	68	78	89 *	93 *	100 *	9	18					6 *	
	Pseudomonas - cumulative totals												2	3						
Maternity	Percentage of Spontaneous Vaginal Deliveries		65.3% *	62.4% *	63.9% *	64.9% *	60.2% *	57.5% *	60.9% *	57.0% *	63.4% *	61.8% *	57.5% *	61.4% *	63.6% *	64.5% *	59.8% *	60.6% *	62.4% *	61.9% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90	89.2% *	83.2% *	88.1% *	85.9% *	87.8% *	89.5%	86.6% *	88.7% *	89.2% *	89.9% *	92.7% *	90.1% *	85.9% *	88.0% *	90.0% *	90.3% *	89.5% *	91.4% *
Never Events	Total Never Events	0	1 *	0 *	0	1 *	0 *	0 *	1 *	0 *	0 *	1 *	1 *	0 *					2 *	
Patient Falls	Total Number of Patient Falls Resulting in Harm (moderate/severe)		9 *	5 *	8 *	11 *	7 *	4 *	13 *	18 *	10 *	8 *	10 *	8 *	5 *	8 *	8 *	12 *		
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		4 *	2 *	2 *	3 *	1 *	1 *	1 *	3 *	1 *	1 *	2 *	1 *	2 *	2 *	1 *	0 *		
	Number of Patient Safety Incidents Reported		1,148	1,149 *	1,003 *	1,033 *	1,079 *	1,041 *	1,025 *	1,260 *	1,139 *	1,229 *	1,192 *	1,210 *	1,019 *	1,062 *		1,209 *		
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	0.49% *	1.12% *	1.02% *	0.61% *	1.13% *	0.79% *	0.54% *	1.30% *	1.63% *	0.48% *	0.39% *	0.39% *						
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%	0.12% *	0.50% *	0.38% *	0.37% *	0.00% *	0.13% *	0.14% *	0.47% *	0.63% *	0.24% *	0.00% *	0.00% *						
	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%	0.00% *	0.00% *	0.00% *	0.12% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	579 *	162 *	185 *	127 *	60 *	76 *	29 *	80 *	61 *	112 *	42 *	54 *	878 *	474 *	165 *	253 *	1,770 *	19 *
RIDDOR	Number of RIDDOR	Current mean	3 *	2 *	3 *	0 *	3 *	1 *	7 *	1 *	1 *	1 *	4 *	0 *	2 *	2 *	4 *		2	
Safer Staffing	Safer Staffing Care Hours per Patient Day		9	7	7	7	7	7	7	7	7	7	7		8 *	7 *	7		7 *	
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	92.7%	91.3% *	92.6% *	94.2% *	92.9% *	93.0% *	93.1% *	90.1% *	91.8% *	91.5% *	92.8% *	93.8% *	93.0% *	92.7% *	93.0% *	91.1% *		
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	96.6%	95.0% *	96.0% *	97.4% *	97.4% *	97.0% *	96.9% *	96.0% *	96.4% *	97.6% *	98.0% *	97.8% *	96.7% *	96.2% *	97.1% *	96.6% *		
Sepsis Screening	2a Sepsis – Screening	>90%	98.0% *	94.0% *	96.0% *	98.0% *	96.0% *	94.0% *	98.0% *	98.0% *	98.0% *	100.0% *			91.0% *	96.0% *	96.0% *			
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	67.0% *	94.0% *	89.0% *	90.0% *	79.0% *	80.0% *	83.0% *	89.0% *	84.0% *	78.0% *			71.0% *	91.0% *	81.0% *			
	Number of Serious Incidents Reported		1 *	2 *	1	2 *	1 *	1 *	1 *	3 *	10 *	2 *	3 *	10 *						

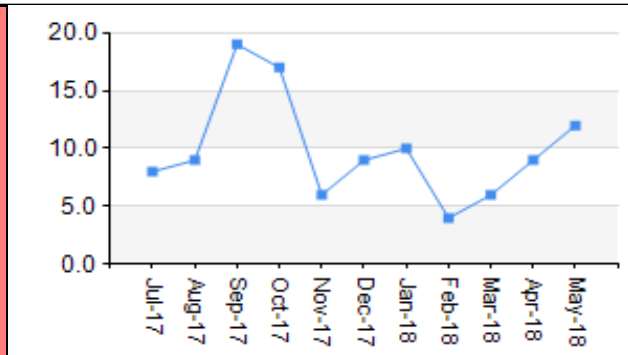
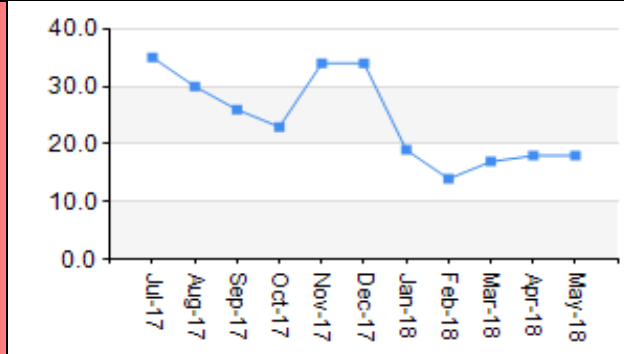
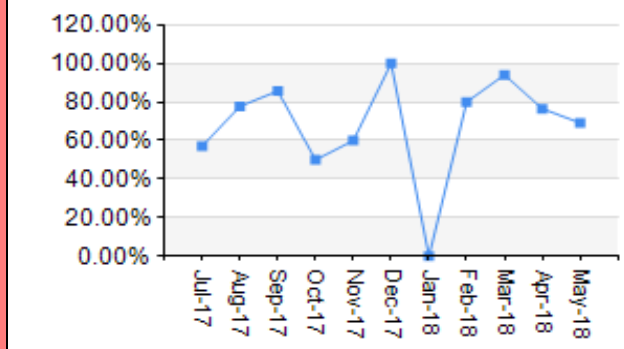
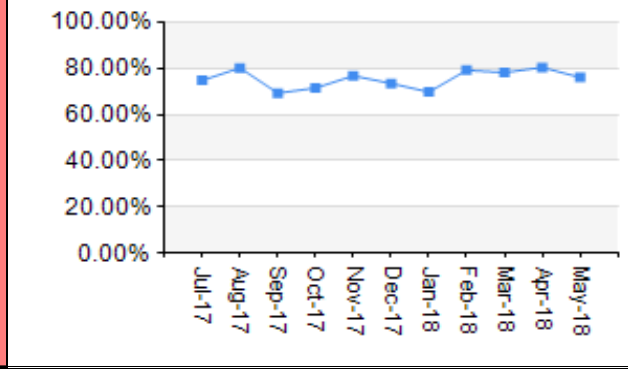
Category	Indicator	Target	Month												Quarter				Annual	
			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	17/18	18/19
	Serious Incidents	Percentage of Serious Incident Investigations Completed Within Contract Timescale	100% *	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% *		100.0% *				
	Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	2.2	2.7 *	1.9 *	.9 *	1.7 *	3.1 *	1.9 *	2.6 *	2.4 *	2.8 *	1.4 *	2.8 *	2 *	1.9 *	2.2 *	2.6 *		
		Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	4.2	2.4 *	3.1 *	2.9 *	2.1 *	2.4 *	1.5 *	1.4 *	2.6 *	2.8 *	4 *	2.8 *	3.3 *	2.8 *	2 *	2.3 *		
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	70.2%	69.1%	66.7%	61.5%	81.0%	78.1%	69.6%	67.7%	60.0%	76.0%	69.4%	73.5%	60.2%	65.2%	76.3%	67.9%	66.9% *	71.4% *
		Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%	26.1%	38.0%	41.8%	45.5%	40.3%	37.1%	33.8%	46.2%	38.2%	41.0%	36.7%	50.0%	30.5%	41.5%	36.8%	41.8%	37.6% *	43.0% *
		Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	92.9%	95.0%	92.3%	98.2%	89.3%	89.4%	74.0%	91.8%	94.4%	73.5%	90.4%		86.4%	95.0%	83.6%	87.9%	88.2% *	90.4% *
	Time to Initial Assessment	ED Time To Initial Assessment - Under 15 Minutes	>=99%	75.9%	87.4%	91.0%	86.2%	86.7%	91.7%	89.9%	91.9%	88.2%	89.5%	90.5%	90.3%	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%	25.7%	32.3%	34.9%	31.2%	37.5%	41.5%	40.7%	43.3%	32.7%	35.2%	36.8%	33.6%	28.0%	32.8%	39.8%	37.1% *	34.5% *	
Operational Performance	**Key Indicators - Operational Performance**																			
		Cancer 62 Day Referral To Treatment (Screenings)	>=90%	88.9%	89.1%	88.5%	94.9%	87.1%	93.8%	95.5%	98.0%	95.9%	95.9%	100.0%	100.0% *	89.3%	90.6%	91.8%	96.6%		
	Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	100.0%	57.1%	77.8%	85.7%	50.0%	60.0%	100.0%	0.0%	80.0%	94.1%	76.5%	69.2% *	100.0%	76.7%	71.4%	80.0%		
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	71.2%	74.7%	80.1%	69.2%	71.4%	76.7%	73.4%	69.7%	79.1%	78.1%	80.3%	76.0% *	75.2%	75.1%	74.4%	75.6%		
	Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	5.26%	5.30%	4.80%	2.90%	0.46%	0.51%	0.75%	0.64%	0.49% *	0.26%	0.56%	1.26%	5.90%				5.54% *	
	ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%	91.98%	91.58%	80.87%	85.87%	91.58%	88.35%	86.70% *	
	Detailed Indicators - Operational Performance																			
	Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	57	47	19	30	38 *	33	56	45	44	49	30	25	145	96	127	138	506	55 *
		Ambulance Handovers - Over 60 Minutes	< previous year	4	0	1	1	0 *	0	0	2	3	3	1	3	5	2	0	8	15	4 *
	Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0							6 *	12 *	25 *	21 *	12 *	23 *					6 *	
	Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	10	8	9	19	17	6	9	10	4	6	9	12						
		Cancer (104 Days) - Without TCI Date	0	32	35	30	26	23	34	34	19	14	17	18	18						
	Cancer (2 Week Wait)	Cancer - Urgent Referrals Seen in Under 2 Weeks	>=93%	85.9%	79.6%	70.4%	71.2%	74.6%	75.8%	81.2%	86.4%	90.6%	90.5%	86.6%	86.3% *	89.1%	73.6%	77.1%	89.2%		
		Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	94.1%	57.3%	89.7%	92.7%	89.0%	94.5%	96.3%	92.4%	97.6%	94.5%	91.3%	91.9% *	92.8%	79.0%	93.4%	94.8%		

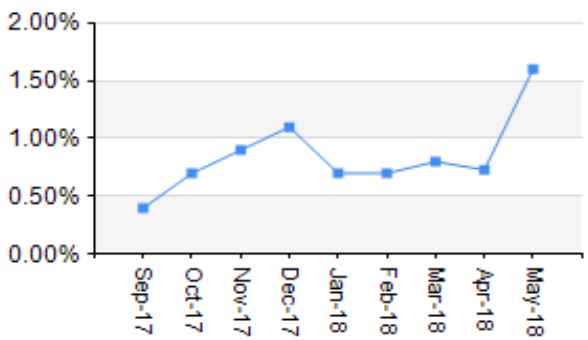
Category	Indicator	Target	Month											Quarter				Annual	
			Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	17/18	18/19
	Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	95.4%	95.8%	96.2%	98.5%	95.1%	96.7%	97.3%	96.0%	97.6%	97.9%	96.7%	95.4% *	95.5%	96.6%	96.2%	97.1%		
		Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0% *	100.0%	99.6%	100.0%	99.6%		
		Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	100.0%	100.0%	98.4%	96.6%	97.1%	98.5%	98.1%	100.0%	100.0%	100.0%	100.0%	97.3% *	99.5%	98.5%	98.5%	100.0%		
		Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	97.9%	93.6%	91.5%	95.5%	94.6%	98.1%	94.9%	93.0%	95.5%	98.0%	94.9%	97.8% *	94.5%	93.3%	96.2%	94.9%		
	Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	32	27	29	32	29	34	41	22	23	34	20 *		32	32			30 *	
	Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End		522		883 *	1,298	1,062	867	733	239 *	106	123	188	223						
	Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	61.5% *	63.7% *	60.9% *	59.8% *	60.0% *	61.1% *	59.9% *	56.9% *	57.7% *	59.4% *	62.2% *		63.1% *	61.5% *	60.3% *	58.0% *	60.7% *	62.2% *
	ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	88.10% *	94.40%	95.00%	93.20%	93.80%	97.10%	96.60%	93.60%	95.10%	96.50%	97.80%	98.10%	90.70%	94.20%		95.10% *	93.90% *	
		GRH ED - Percentage Within 4 Hours	>=95%	75.30%	77.70%	84.60%	82.40%	86.60%	94.40%	88.00%	87.90%	85.30%	82.30%	89.10%	88.10%	75.30%	81.50%	89.60%	85.10% *	83.00% *	
	Inpatients	Stranded Patients		441	451	461	487	479	447	446	472	464	482	384	395 *			457	473	468 *	
		Average Length of Stay (Spell)		4.96 *	4.97 *	4.86 *	4.75 *	5.11 *	5.03 *	4.78 *	5.06 *	5.06 *	4.99 *	5.14 *	4.65 *	4.97 *	4.86 *	4.97 *	5.04 *	4.96 *	4.89 *
	Length of Stay	Length of Stay for General and Acute Elective Spells	<=3.4	2.85 *	2.74 *	2.96 *	2.96 *	3.32 *	2.86 *	2.81 *	2.92 *	3.1 *	3.01 *	2.83 *	2.83 *	2.8 *	2.88 *	3 *	3.01 *	2.92 *	2.83 *
		Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.58 *	5.62 *	5.36 *	5.24 *	5.56 *	5.61 *	5.26 *	5.51 *	5.53 *	5.47 *	5.67 *	5.15 *	5.6 *	5.41 *	5.48 *	5.5 *	5.49 *	5.41 *
	Medically Fit	Number of Medically Fit Patients Per Day	<40	58	63	58	60	62	60	64	55	65	67	67 *	66	56	60	64	62	60 *	
	Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	9 *	13 *	27 *	30 *	30	64 *	74 *	50 *	63	95 *	95	23 *						
	SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *		100.0%	100.0%	100.0%	100.0%	100.0%	
		Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%			99.8%	99.8%	99.8%	99.8%	100.0%	
	Trolley Waits	ED 12 Hour Trolley Waits	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1 *	1 *	
Finance	**Key Indicators - Finance**																				
	Finance	YTD Performance against Financial Recovery Plan		3.36	4.35	4.24	1.87	-.27 *	-2.1 *	-6.4 *	-6.5 *	-10.8 *	-18.4 *	.05	.11						
	Detailed Indicators - Finance																				
		Agency - Performance against NHSI set agency ceiling		3	3	3	4	3	3 *	3 *	3 *	3 *	3 *	2	2						
		Capital Service		4	4	4	4	4	4 *	4 *	4 *	4 *	4 *	4	4						

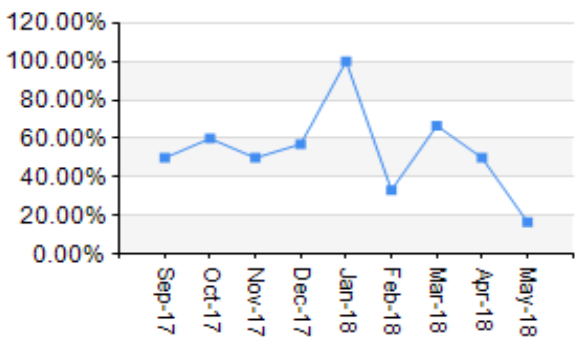
Category		Indicator	Target	Month												Quarter				Annual	
				Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	17/18	18/19
	Finance	Liquidity		4	4	4	4	4	4 *	4 *	4 *	4 *	4 *	4	4						
		NHSI Financial Risk Rating	3	4	4	4	4	4	4 *	4 *	4 *	4 *	4 *	4	4						
		Total PayBill Spend		27.5	27.46	28.25	27.94	27.9	27.9 *	27.7 *	28.1 *	28.5 *	28.5 *	28.4	28.5						
Leadership and Development	Key Indicators - Leadership and Development																				
	Sickness	Sickness Rate	G<3.6% R>4%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	3.9% *	3.9%	3.9%	3.9%	3.9%	3.9%	
	Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71 *	3.67 *			3.71	3.71	3.71		3.67	
	Turnover	Workforce Turnover Rate	7.5% - 11%	12.3%	12.3%	12.4%	12.3%	12.4%	12.1%	11.9%	11.6%	11.4%	12.1%	12.0%	11.7% *	12.3%	12.3%	11.9%	12.1%	12.0%	
	Detailed Indicators - Leadership and Development																				
	Appraisals	Staff having well-structured appraisal Indicator	>3.8	3	3	3	3	3	3	3	3	3 *	2.95 *			3	3	3		2.95	
		Staff who have Annual Appraisal	G>89% R<80%	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%	33.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0% *	30.0% *			34.0%	34.0%	34.0%		30.0% *	
	Training	Statutory/Mandatory Training	>=90%	89%	89%	89%	88%	88%	88%	88% *	73%	79%				89%	89%	88%			

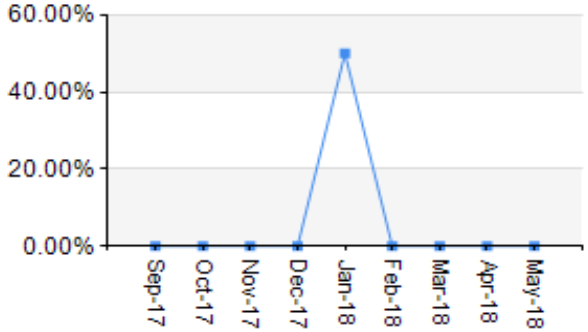
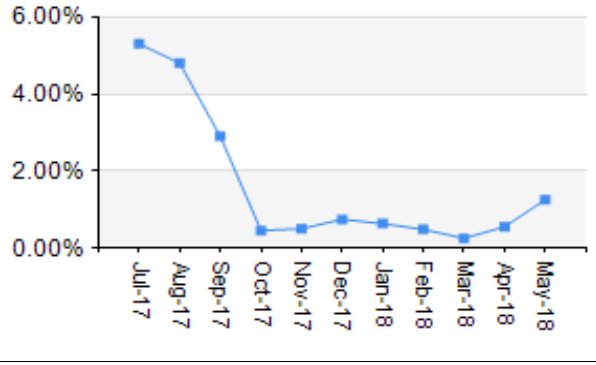
Exception Report

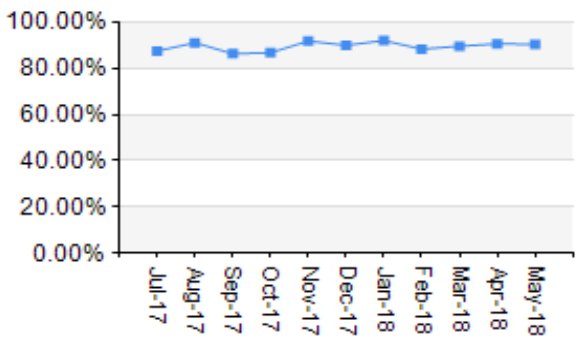
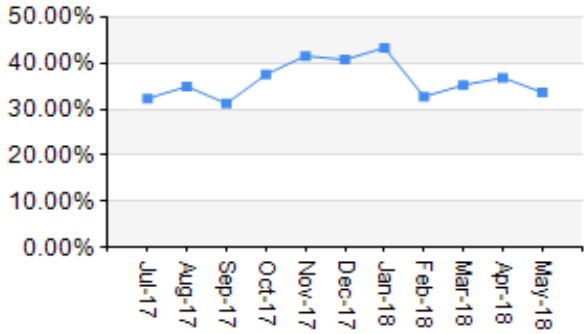
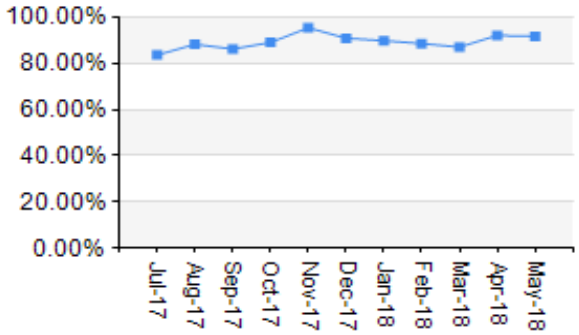
Metric Name & Target	Trend Chart	Exception Notes	Owner
Ambulance Handovers - Over 30 Minutes **Target: < previous year**		Ambulance handover delays remain consistent. Staff have been deployed to minimise the frequency of these occurring and the clinical risk associated. Trend analysis demonstrates the majority of delays occur in the early evening (in line with peak in 999, GP referral and walk in presentations). Work is ongoing with system partners to change the profile of GP attendances in particular – impact anticipated in August/September.	Deputy Chief Operating Officer
Ambulance Handovers - Over 60 Minutes **Target: < previous year**		Small increase in 60 minute handover delays reported however GHT is in the process of querying the numbers of these with SWAST as they are not felt by the department to be an accurate reflection of performance.	Deputy Chief Operating Officer
Cancer - Urgent Referrals Seen in Under 2 Weeks **Target: >=93%**		2ww - May 86.2% in performance. 2130 Date First Seens with 292 breaches. 10 out of 12 specialties met standard (Gynae 91.5% and LGI 50%) 196 of these were LGI. Last three months of referrals seen demand consistently between the 85th percentile (2109) and Upper control limit (2206). May saw the highest number of referrals received in last three years (2208). This equates to 110.4 referrals received per working day (increase of 8.2 referrals per day from April 17 and an 12% increase on demand from May 2017).	Deputy Chief Operating Officer

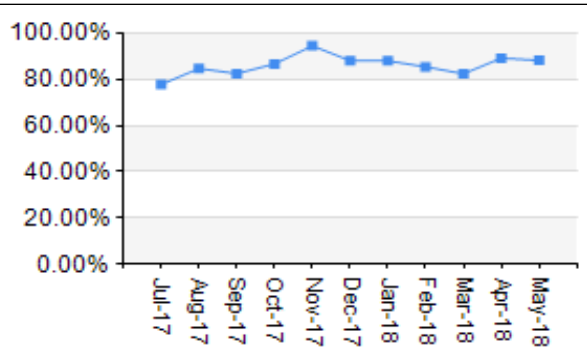
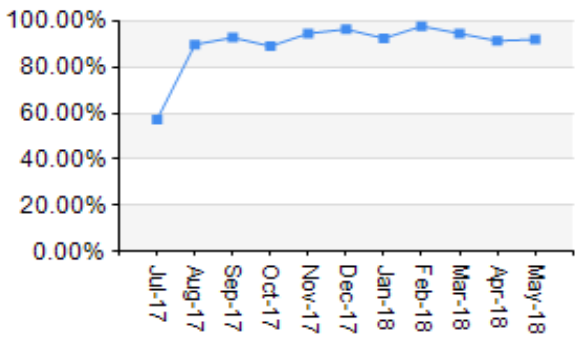
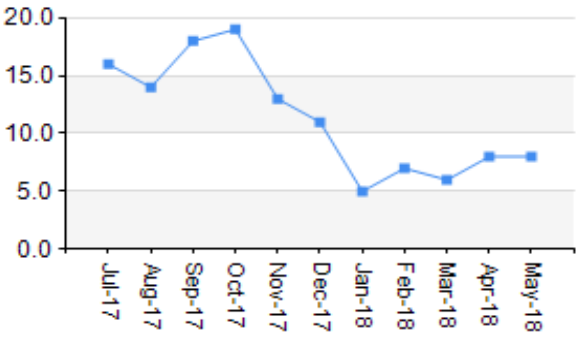
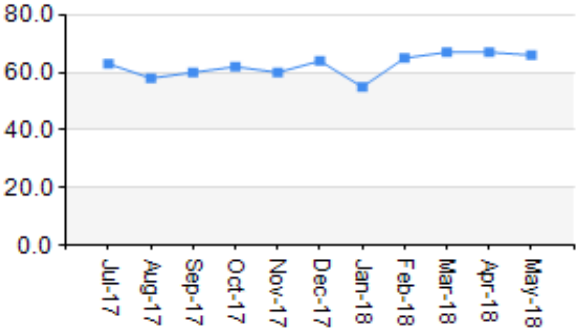
Cancer (104 Days) - With TCI Date **Target: 0**			Deputy Chief Operating Officer
Cancer (104 Days) - Without TCI Date **Target: 0**			Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		Upgrades 69.2% 6.5 treatments with 2 breaches 1 Haem – Complex patient requiring Active Monitoring 0.5 Lower GI- Late tertiary referral from Worcs. Patient had complex diagnostic pathway 0.5 Uro – Late upgrade from Hereford for Surgery	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		62 day 77.2% 134.5 tx 33.5 breaches (un-validated) Other than our main breach sites (Uro 17 and Lower GI 4). Lung had a poor month (72.7% 4.5 breaches along with Haematology 3 breaches (40%)all due to delays associated with internal referrals between specialties (two from H&N and one from Lower GI). Lung Straight to CT project now list as of 14th May. Considerable benefit reported already. Benefit realisation for 62 day projected for end of July. Haem	Deputy Chief Operating Officer

Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		The Dementia section of Nov 2017 in Trakcare is still not as clinician have requested, therefore the section is not being completed and the concerns which were further escalated still remain. Dementia Case Finding and Trakcare (for Medical team) Dementia Case Finding Guidance (for Medical team) It had been requested that the Dementia section be similar to that from the Dementia section of Infoflex and that this be as the AKI section of Trakcare and that this auto populate the discharge page. Feedback by clinicians is – that this is additional work, that it is required to be entered twice, which takes clinicians away from patient care and which has no clinical benefit. It has been stated that the Trakcare section does not follow the clinical pathway in practice. The information is documented in the paper care record and then also has to be free hand entered into the discharge section in addition to recording in the Dementia section. With the support of my line manager Jon Burford, I am restarting the weekly sample audit visits to AMU and to ACUC to give evidence that at a once weekly visit to both locations the clinical assessment is documented for patients who are eligible (75% of patient who are eligible are admitted via the acute care units) From the Dec 2017 sample audit the figures ranged from 50% to 70% completion of the AMT 10 and was less for completion of the 4AT Delirium assessment,(the audit was a sample of 10 patients each visit) this did not assess Trakcare completion by the clinicians. A conference call with the Trust Track clinical leads as below	Deputy Nursing Director & Divisional Nursing Director - Surgery

Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		The Dementia section of Nov 2017 in Trakcare is still not as clinician have requested, therefore the section is not being completed and the concerns which were further escalated still remain. Dementia Case Finding and Trakcare (for Medical team) Dementia Case Finding Guidance (for Medical team) It had been requested that the Dementia section be similar to that from the Dementia section of Infoflex and that this be as the AKI section of Trakcare and that this auto populate the discharge page. Feedback by clinicians is – that this is additional work, that it is required to be entered twice, which takes clinicians away from patient care and which has no clinical benefit. It has been stated that the Trakcare section does not follow the clinical pathway in practice. The information is documented in the paper care record and then also has to be free hand entered into the discharge section in addition to recording in the Dementia section. With the support of my line manager Jon Burford, I am restarting the weekly sample audit visits to AMU and to ACUC to give evidence that at a once weekly visit to both locations the clinical assessment is documented for patients who are eligible (75% of patient who are eligible are admitted via the acute care units) From the Dec 2017 sample audit the figures ranged from 50% to 70% completion of the AMT 10 and was less for completion of the 4AT Delirium assessment,(the audit was a sample of 10 patients each visit) this did not assess Trakcare completion by the clinicians. A conference call with the Trust Track clinical leads as below.	Deputy Nursing Director & Divisional Nursing Director - Surgery

Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		The Dementia section of Nov 2017 in Trakcare is still not as clinician have requested, therefore the section is not being completed and the concerns which were further escalated still remain. Dementia Case Finding and Trakcare (for Medical team) Dementia Case Finding Guidance (for Medical team) It had been requested that the Dementia section be similar to that from the Dementia section of Infoflex and that this be as the AKI section of Trakcare and that this auto populate the discharge page. Feedback by clinicians is – that this is additional work, that it is required to be entered twice, which takes clinicians away from patient care and which has no clinical benefit. It has been stated that the Trakcare section does not follow the clinical pathway in practice. The information is documented in the paper care record and then also has to be free hand entered into the discharge section in addition to recording in the Dementia section. With the support of my line manager Jon Burford, I am restarting the weekly sample audit visits to AMU and to ACUC to give evidence that at a once weekly visit to both locations the clinical assessment is documented for patients who are eligible (75% of patient who are eligible are admitted via the acute care units) From the Dec 2017 sample audit the figures ranged from 50% to 70% completion of the AMT 10 and was less for completion of the 4AT Delirium assessment,(the audit was a sample of 10 patients each visit) this did not assess Trakcare completion by the clinicians. A conference call with the Trust Track clinical leads as below	Deputy Nursing Director & Divisional Nursing Director - Surgery
Diagnostics 6 Week Wait (15 Key Tests) **Target: <1%**			Deputy Chief Operating Officer

ED Time To Initial Assessment - Under 15 Minutes **Target: >=99%**		Performance has remained at approx. 90% for this in May, in spite of an increase in attendances of 11%. Rotas are being reviewed by the Divisional Chief Nurse to see if any staffing modifications can be made to improve this further.	Deputy Chief Operating Officer
ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		Performance continues to be below standard in this field. It is anticipated that performance will improve in Quarter 2 following the introduction of AMIA at GRH and GP streaming for walk-ins.	Deputy Chief Operating Officer
ED Total Time in Department - Under 4 Hours **Target: >=95%**		Whilst performance for May remains below the 95% national standard, it exceeded agreed trajectory with NHSI of 90%. There was a minor deterioration in month but this was against an increase in attendances of approx. 11%. Whilst a number of schemes are responsible for this improved performance, the AMIA had a significant positive impact in May and it is anticipated this will improve further over the next quarter. To note, this level of performance was delivered in conjunction with closing unfunded escalation areas on AMU, ward 9A, dialysis bay and maximising the number of overnight outliers on DSU to 6.	Deputy Chief Operating Officer

GRH ED - Percentage Within 4 Hours **Target: >=95%**		Whilst performance for May remains below the 95% national standard, it exceeded agreed trajectory with NHSI of 90%. There was a minor deterioration in month but this was against an increase in attendances of approx. 11%. Whilst a number of schemes are responsible for this improved performance, the AMIA had a significant positive impact in May and it is anticipated this will improve further over the next quarter. To note, this level of performance was delivered in conjunction with closing unfunded escalation areas on AMU, ward 9A, dialysis bay and maximising the number of overnight outliers on DSU to 6.	Deputy Chief Operating Officer
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms **Target: >=93%**		Breast symptomatic 91.9% 198 Date First Seens 16 breaches All 16 due to patient cancellations	Deputy Chief Operating Officer
Number of Breaches of Mixed Sex Accommodation **Target: 0**			Head of Capacity and Patient Flow
Number of Medically Fit Patients Per Day **Target: <40**			Deputy Chief Operating Officer

REPORT TO MAIN BOARD – JULY 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 31 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
Risk Register	The report identified current strategic risks and areas requiring enhanced surveillance by the Committee. A planned item on an external review of a sequence of surgical-related never events will now be considered at the June Committee. Discussions included risks that might arise should patients go missing in the hospital. Suggestions about the value of closer links to the Emergency Planning team and of simulation exercises were accepted and will be actioned.			Further report June 2018.
Quality and Performance Report	Trust performance to April 2018 was reviewed. Trust met its and NHSI/E's trajectory for A&E 4 hour (92% against 90%).			

	Diagnostic 6 week wait achieved for 7th consecutive month. Trust did not meet national standards or Trust trajectories for for 2 week wait or 62 day cancer standard. Reporting on 18 week referral to treatment (RTT) remains suspended. Discussion about Quality included an update on revised reporting intentions, currently scheduled for the June Committee cycle. Additional work commissioned on dementia case findings, VTE assessments and Safety Thermometer reporting.	Are we learning lessons from neighbouring best practice in Venous Thromboembolism (VTE) performance? What are current themes from Patient Advise and Liaison Service (PALS)?	Yes Difficulties accessing Acute Medical Unit by phone; cancelled appointments; cancelled gynaecology operations, and finding relatives on wards. Cancelled operations to be discussed at next Planned Care Delivery Board. Two wards currently undertaking trial project to extend visiting hours.	Project intentions and timelines for new phone system to be reported to a future Committee.
- **Exception report from**	Demand in April averaged 388 daily attendances (4.9% increase over April 2017). 83%of 996 FFT responses in	Commended sustained performance during a period of exceptional demand levels.		

the Emergency Care Board	April in the Emergency Department were favourable.	Have we any initial conclusions about the impact of the Acute Medical Initial Assessment Unit (AMIA)? How have we satisfied ourselves about the integrity of ED performance data during these periods of high demand? Discussion of an issue raised by staff during an Executive Safety Visit concerning patients being moved to the Emergency General Surgery Unit (EGSU).	Initial data is promising with both a significant reduction in admissions and the effect of enabling patients to be removed from the Day Surgery Unit. Audit assurance received from examination of a random cohort of records. Assurance received about specific circumstances.	
- **Exception report from the Planned Care Board**	- Revision to composition of Planned Care Board - To be chaired by Surgical Chief of Service - Meeting monthly - Upgrade to risk relating to follow-up patient tracking lists - Revised arrangements in place for cancellation of appointments so that senior divisional management sign-off is to be required for specific circumstances.	Discussion of principal reasons for cancelled clinics and how this situation can be improved. Focus on cultural and leadership dimensions and impact for patients. Can Execs consider RAG (Red, Amber, Green) rating this report so that the Committee can gain a clearer sense of levels of confidence about progress? Can future reports include a	Both changes to be adopted for future Exception Reports.	

		commentary from the Chair of the Planned Care Board so that his insights are available to the Committee? Discussion about progress and intentions re clinic typing backlogs and how progress could be more visible in Committee reporting. Discussion about how to increase the Committee's visibility of relevant reporting from the SmartCare Programme Board.		Chair to discuss with Trust Chair.
- **Exception report from the Cancer Delivery Group**	Discussion of impact of lower gastrointestinal (GI) breaches in performance of 2 week standard. Trust is now operating "Straight to Test" and additional clinics to support lower GI performance. Discussions taking place with CCG about significant increase in 2 week referrals.	What are current arrangements for a patient experience group to support and inform cancer services? Is a deep dive into lower GI performance necessary? Can we be assured that the range of additional services e.g. cleaning, are planned and in place for any weekend clinical working?	Meetings are scheduled and engagement is to be re-energised. For now close focus to be maintained by Committee on delivery plan. Specific example of cleaning of clinical environments to be investigated further.	

- **Exception Report from the Quality Delivery Group**	Items discussed included the recent Day Surgery Unit Quality summits. Update provided about predictive analytics (to assist with reporting and using patient experience qualitative data). To be the subject of further reporting.			
Clostridium Difficile Improvement Plan	Update report on Trust's Improvement Plan (2-3 months old). Focus on 3 priority areas: - Cleaning - Buildings and environment - Antimicrobial stewardship Adjustment to reported cases for 2017/18 from 56 to 72 cases (target of 37), including explanation of error. Feedback following input from NHSI after expert visit and review of Improvement Plan Further support commissioned on antimicrobial prescribing from a National NHSI lead, including review of Trust's approach to date.	Is there a benchmark for antimicrobial pharmacists? NB challenge of potential loss of pharmacists to community employment. Can execs give further consideration to the metrics to be reported to provide assurance about Improvement? Is CCG leading on primary care prescribing? How do we ensure that new practices are embedded?	Benchmark material to be identified. To be actioned. Need recognised and work underway re antibiotic prescribing. By seeing infection rates fall Observe a 12-18 month trajectory of improvement.	

CQC Improvement Plan	Latest update on Improvement Plan and its 30 must do actions. 9 have been closed 11 are to be delivered by the next update 7 are rated amber 3 are rated red The Trust's internal auditors have reviewed the plan and provided feedback on levels of evidence of completed actions.	Can any further action be taken to progress the action concerning radiology consultants?	Actions underway to deliver appropriate support, however, further work needed to provide assurance.	Further reporting required in future Improvement Plan updates. Exception reports from Delivery Groups to the Committee will include relevant Improvement Plan updates with Quality Delivery Group having oversight of the entire Plan.
Mortality Report	Report summarising Dr Forster data from May 2018, which includes the period Jan – Dec 2017. Hospital Standardised Mortality Ratio (HSMR) for the Trust is now 96.0. This is within the expected statistical range and is falling. SMR for the Trust has fallen again to 96.8 and now lies within the expected statistical range. Both weekday and weekend emergency admission HSMRs are within the expected statistical range. Update on Trust progress on Learning from Deaths			

	requirements, including work to embed Structured Judgement Review process (planned completion September 2018).			
Safer Staffing	Report to provide assurance about nurse staffing levels for March 2018.	Report included 2% improvement in substantive fill rates; 28 clinical areas not meeting the 75% substantive fill rate. Discussion of those areas with specific concerns about staffing levels. Update about review of Ward-based nursing establishments. Request that findings from staff survey and patient experience survey are brought together so that common themes can be identified. Can we ensure that the Committee is sighted on the strategic intentions with regard to staffing as well as the more operational material that is currently available?	 Report expected in June and possible need for a joint Workforce / Quality and Performance Committee meeting. See above. Strategic workforce intentions will be reported.	

Claire Feehily
Chair of Quality and Performance Committee
3 July 2018

REPORT TO MAIN BOARD – JULY 2018

From Quality and Performance Committee Chair – Alison Moon, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee on 28 June 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	Latest Committee Risk Register (CRR) presented, including the downgrading and closure of some risks.	At the end of the meeting, a review of specific risks and their mitigations was requested to ensure they were accurately reflected. Additional assurance requested re: systems in place re: missing patients.	Evidence of CRR review through operational governance processes and onward to Board. Simulation exercise being planned to test missing person's process.	
Board Assurance Framework (BAF)	Quarter 1 update on BAF and RAG (Red, Amber, Green) rating for each strategic objective Two positive movements in Q1 ratings and one adverse.	Discussion and challenge focused on movements in RAG rating, e.g. green to amber/ amber to green, rationale and evidence, also a focus on any which are giving concern.	Important to understand if any wider learning can be shared from improvements. One area of deterioration re Quality Improvement training, no significant concerns as improvement expected for next reporting period.	Request for brief summary written narrative for future reports if rating changes either positively or negatively.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report	Detailed brief on latest performance, good progress noted in several areas. Additional information now included regarding infection control metrics. Further work noted on a new dashboard/metrics for autumn and presentation received and direction of travel supported.	The value of the current Strengths, Weaknesses, Opportunities, Threats (SWOT) section was discussed and support for review as part of wider reporting changes. Ratings on summary scorecard questioned, two for accuracy (Hospital Standardised Mortality Ratio [HSMR] weekday and weekend) and two requiring further information. (Venous thromboembolism [VTE] and dementia).	More assurance requested in next report on VTE and dementia, some discussion on the data for VTE but triangulation with harm free care in safer staffing report warrants more in depth report.	
Exception Report from the Emergency Care Board	Detailed update on significant work in progress. Performance improvement noted.	Very useful to discuss highlights and plans, specific queries on expected impact of specific actions e.g. Advanced Clinical Practitioner for Stroke services. Good to see patient experience (Friends and Family Test [FFT]) data for the Emergency Department (ED).	Assurance requested to include other patient experience data, correlation with complaints and Patient Advise and Liaison Service (PALS). Also to split out actions which have already been taken and those in planning stage.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Exception Report from the Planned Care Board	Detailed update on wide ranging works streams to improve areas of planned care.	Focus on diagnostics, clinic typing and 52 week waits. Confidence in trajectories discussed.	Assurance received about detail of all individual patients waiting and weekly patient reviews.	
Exception Report from the Cancer Delivery Group	Detailed reports on key areas of cancer performance.	Main area was on the recent increase of 2 week wait referrals, and decline in conversion rates into cancer detection. Internal actions noted in specialties e.g. recruitment. Questions on what part primary care have to play in referral management and any behavioral changes needed.	Assurance given that the Sustainability and Transformation Programme (STP) is sighted on the increase and discussed in the week prior to the Quality and Performance Committee, setting off some system actions on referral patterns.	
Exception Report from the Quality Delivery Group (QDG)	Good to receive the report from QDG, at an early stage and still developing in terms of content and focus on exceptions. Numbers of ESV (Executive Safety Visits) being cancelled mentioned.	Importance of ESVs noted and encouraged to remain a priority.	Key areas noted by Committee being discussed by QDG. Note revised metrics are being developed and will be presented in Autumn. Specific link to VTE reporting needed, triangulating with other reports received by the Committee.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Nursing Assessment and Accreditation Systems	Presentation received on Nursing Assessment and Accreditation System. Fits really well with journey to outstanding and promoting a culture of improvement and CQC domains of ward to board governance.	Systematic approach very much supported, noting the ambition of the plan. Support to prioritise clinical areas linked to risk. Noting that this is a nursing tool but involvement at an early stage with other members of the multi-disciplinary team encouraged.	Involvement of Non-Executive Directors and Governors noted and supported in the Panel to assess areas of outstanding care.	
C. Diff – Improvement Plan	Comprehensive action plan noted. New senior nursing infection prevention and control expert in the Trust welcomed and to attend action plan updates to future meetings	Achievement within set timescales was queried as some actions were rated red and beyond their target date.	Senior internal expertise now in place which will strengthen the implementation of the plan. External Review by Prof Mark Wilcox NHSI) planned for end of July. Focus of the review discussed and noted to be around anti-microbial prescribing. The report of the visit and review will come to the Committee with bi monthly updates on progress of the action plan unless any exceptions. Will be useful for any ESV to include aspects of the action plan e.g. alcohol foam dispensers etc.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Never Events External Review	Chief of Staff and Divisional Chief Nurse presented this paper. The Committee had received the action plan and response to the external review but not the review itself. This was circulated immediately after the meeting.	It was excellent to see senior divisional medical and nursing ownership to the review recommendations. There was extensive discussion on all the recommendations including the cultural changes and improvements needed within the theatre setting. The aim reported was to complete all the elements of the action plan by Dec 2018.	The findings of the review are 'owned' by the senior leaders. They also have confidence in new senior nursing leadership roles with theatre. The Committee wished to keep oversight of progress of the review and provide any additional comments once the report itself had been seen. ESVs in the theatre setting can help to consider the report findings and staffs views.	
CQC Adult Inpatient Survey	Recently published report presented, with comparisons on previous years and with best performing Trusts.		Areas to improve identified from the report fit with the priority areas previously set out internally and actions already progressing. e.g. visiting times, discharge processes, cleaning.	
Mortality Report	Standing item presented to the committee, all HSMR markers now within 'as expected' range including weekends. Update on learning from deaths noted.		Very positive HSMR noted and work in progress to standardise the approach to death reviews.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Safer Staffing	Brief provided on nurse staffing levels, standing item.	Operational processes noted and supported. Questions on the more strategic aspects of recruitment and retention.	Day to day work to ensure safety noted. Request to understand the strategy of/for nurse recruitment and clear links to the Workforce committee. Joint meeting between the two committees explored to receive and discuss. Link to VTE data noted and further work requested.	
Serious Incidents Report	Update received on serious incidents and Parliamentary and Health Service Ombudsman (PHSO) referrals. No new never events noted for this reporting period. Notified that the Trust will be part of the next phase of the national roll out of maternity investigations, starting from July 1st 2018.	How do we focus on the learning aspects not only in the immediate team but wider across the Trust.	All investigative timescales have been met in this reporting period. Link between Safety and Experience Review Group where the learning is discussed and the Committee who receive assurance to continue.	

Board to note

1 Good Governor input to the meeting which should provide useful feedback to CoG and Governors Quality Group
2. Good examples of operational grip in areas of challenged performance.
3. Very full and data / information heavy agenda. Chair of Q and P, second NED and Chief Nurse and Director fo Quality to meet to discuss how this can evolve to ensure we focus on the areas needed for assurance .

Alison Moon
Chair of Quality and Performance Committee
28 June 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

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

Purpose

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

Key issues to note

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

- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register. 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:

June - Nil

July

- **F2724** Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19

Two risks have been **downgraded** in this reporting period.

June

- **C1748COO** The risk of statutory intervention for failing national access standards in relation to cancer – this has been downgraded to 4 x 4 = 16 based on review of recent activity but remains on the Trust Risk Register

July

- **M2473Emer -** The risk of poor quality patient experience during periods of overcrowding in the Emergency Department – downgraded to 3 x3 = 9 based on improved performance against the 4hr wait national standard. Based on this scoring it does not meet the criteria for the Trust Risk Register

Two risks have been **closed**

June

- **D&S2629Path** The risk of not achieving statutory accreditation due to failure of provision of the Haematology, Transfusion and Immunology Laboratory Service
- **S2045T&O** The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal

July – Nil

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)**
					4 July 2018	
Outcome of discussion when presented to previous Committees						

Trust Risk Register - July 2018

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
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)	Likely - weekly (4)	16
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
F2724	4.1, 4.2	Corporate	Finance	Finance Director	Finance Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19	PMO in place to record and Monitor FY19 programme, Weekly TIB	Complete	Catastrophic	Possible	15
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.	PMO in place to record and monitor FY19 programme, Weekly TIB, Monthly monitoring and reporting of perfiormance against Target, Monthly Exective reviews	Partially complete	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
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 reduced safety due to inpatient falls	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		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

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	The risk to patient safety of failure of anaesthetic equipment during an operation	Application to MEF Prioritisation of operations Maintenance by own medical engineering	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Financial Performance Report
Sponsor and Author(s)
Author: Jonathan Shuter, Director of Operational Finance Sponsor: Sarah Stansfield, Director of Finance
Executive Summary
Purpose This report provides an overview of the financial performance of the Trust as at the end of Month 02 of the 2018/19 financial year. Key issues to note - The financial position of the Trust at the end of Month 02 of the 2018/19 financial year is an operational deficit of £8.9m. This is a favourable variance to budget and NHSI Plan of £0.1m. - CIP delivery to Month 02 is £1.95m. This is £0.12m favourable against the plan for the year to date. Conclusions - The financial position for Month 02 shows a favourable variance to budget of £0.1m. Implications and Future Action Required There is a continued need for increased focus on financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trak.
Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.
Impact Upon Strategic Objectives
The financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Impact on deliverability of the financial plan for 2018/19.
Regulatory and/or Legal Implications
The Trust continues to operate in Financial Special Measures which gives 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 May 2018

LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

At Month 2 The Board approved budget for the 2018/19 financial year was a deficit of £29.7m on a control total basis (after removing the impact of donated asset income and depreciation). The Board has since approved a revised control total of £26.9m (excluding PSF) – this will be reflected in the Month 3 reporting. The plan for the first quarter of the year is common to both positions so this has no impact on the position presented in this paper.

The financial position as at May 2018 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and the newly formed Gloucestershire Managed Services Limited , the Trust's wholly-owned subsidiary company.

Group Statement of Comprehensive Income

The table below shows both the in-month position and the cumulative position for the Group.
In May, the Group's consolidated position shows an in month deficit of £3.2m. This reflects a broadly breakeven position against plan.
The year to date deficit of £8.9m is a favourable variance of £0.1m against plan.

Month 02 Financial Position	Annual Budget £000s	M02 Budget £000s	M02 Actuals £000s	M02 Variance £000s	M02 Cumulative Budget £000s	M02 Cumulative Actuals £000s	M02 Cumulative Variance £000s
SLA & Commissioning Income	444,798	37,499	37,446	(53)	71,674	71,872	198
PP, Overseas and RTA Income	6,716	442	589	148	826	885	60
Operating Income	65,441	5,375	4,731	(643)	10,916	10,455	(460)
Total Income	**516,955**	**43,316**	**42,767**	**(549)**	**83,416**	**83,213**	**(203)**
Pay	338,857	29,015	28,535	480	57,681	56,895	786
Non-Pay	180,970	15,317	15,510	(193)	30,747	31,514	(767)
Total Expenditure	**519,828**	**44,332**	**44,045**	**287**	**88,428**	**88,409**	**19**
EBITDA	**(2,873)**	**(1,016)**	**(1,279)**	**(356)**	**(5,012)**	**(5,197)**	**(184)**
EBITDA %age	**(0.6%)**	**(2.3%)**	**(3.0%)**	**(0.6%)**	**(6.0%)**	**(6.2%)**	**(0.2%)**
Non-Operating Costs	25,939	2,270	1,943	326	4,021	3,723	297
Surplus/(Deficit)	**(28,812)**	**(3,285)**	**(3,222)**	**63**	**(9,033)**	**(8,920)**	**113**
Donated Assets Change	(902)	50	12	(38)	100	62	(38)
Surplus/(Deficit)	**(29,714)**	**(3,235)**	**(3,210)**	**25**	**(8,933)**	**(8,858)**	**75**

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 02 Financial Position	M02 Budget £000s	M02 Actuals £000s	M02 Variance £000s	M02 Cumulative Budget £000s	M02 Cumulative Actuals £000s	M02 Cumulative Variance £000s
SLA & Commissioning Income	37,499	37,446	(53)	71,674	71,872	198
PP, Overseas and RTA Income	442	589	148	826	885	60
Operating Income	5,375	4,731	(644)	10,916	10,456	(460)
Total Income	**43,316**	**42,767**	**(549)**	**83,416**	**83,213**	**(203)**
Pay						
Substantive	26,989	26,220	768	53,593	52,179	1,414
Bank	823	864	(41)	1,731	1,900	(169)
Agency	1,204	1,451	(247)	2,358	2,817	(459)
Total Pay	**29,016**	**28,535**	**480**	**57,682**	**56,896**	**786**
Non Pay						
Drugs	5,387	5,305	82	10,519	10,788	(269)
Clinical Supplies	2,515	2,652	(138)	5,730	6,171	(441)
Other Non-Pay	7,415	7,554	(139)	14,498	14,555	(57)
Total Non Pay	**15,317**	**15,511**	**(194)**	**30,747**	**31,514**	**(768)**
Total Expenditure	**44,333**	**44,046**	**286**	**88,429**	**88,410**	**18**
EBITDA	**(1,017)**	**(1,280)**	**(263)**	**(5,013)**	**(5,196)**	**(185)**
EBITDA %age	**(2.3%)**	**(3.0%)**	**(0.6%)**	**(6.0%)**	**(6.2%)**	**(0.2%)**
Non-Operating Costs	2,270	1,943	326	4,021	3,723	297
Surplus/(Deficit)	**(3,286)**	**(3,223)**	**63**	**(9,033)**	**(8,920)**	**113**
Donated Assets Change	50	12	(38)	100	62	(38)
Surplus/(Deficit)	**(3,236)**	**(3,211)**	**25**	**(8,933)**	**(8,858)**	**75**

SLA and Commissioning Income – £0.2m favourable variance. This is driven by an over performance against Gloucestershire CCG but is offset by under performance on the Specialised Services contract.

Private Patient Income – continues to be broadly on plan.

Other Operating Income – The £0.5m adverse variance is partly due to lower than planned donated asset income £0.3m (income is accounted for at the time of purchase).

Pay – expenditure is showing a favourable variance of £0.8m against budgeted levels. This is largely driven by vacancies to substantive posts but is offset by overspends against bank and agency spend.

Non-Pay – £0.8m overspend against budget. Drugs expenditure is showing a £0.3m adverse variance whilst clinical supplies expenditure is £0.4m adverse. Other non-pay is also adverse against plan - £0.1m. The position is offset by over performance on pass-through income of £0.7m.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

1. At Month 2 the trust has delivered £1.95m of CIP YTD against the YTD NHS Improvement target of £1.83m, which is an over performance of £121k. The delivery YTD splits into £1.7m recurrent and £240k of non-recurrent schemes. This translates into a split of 87% of recurrent delivery versus 13% of non-recurrent delivery.

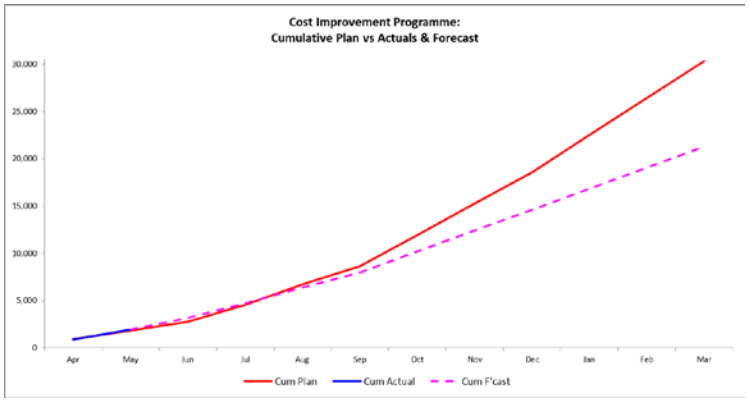
2. The Trust's target for 18/19 has been increased to £30.3m
The target now contains the additional £2.8m additional CIP following formal acceptance of the Control Total, by the Trusts Board. This additional CIP has been phased from Q2.

3. At Month 2, the divisional year end forecast figures indicate delivery of £21.3m against the Trust's target of £30.3m.
The schemes captured in PIDs total £13.1m. Opportunities not yet formalised total £1.6m. The Full Year Effect of schemes from 2017/18 totals £2.35m, the margin on activity total £2.5m, additional income opportunities total £1m. These form part of the delivery plan for 18/19. Therefore the total shortfall to £30.3m is £9m.

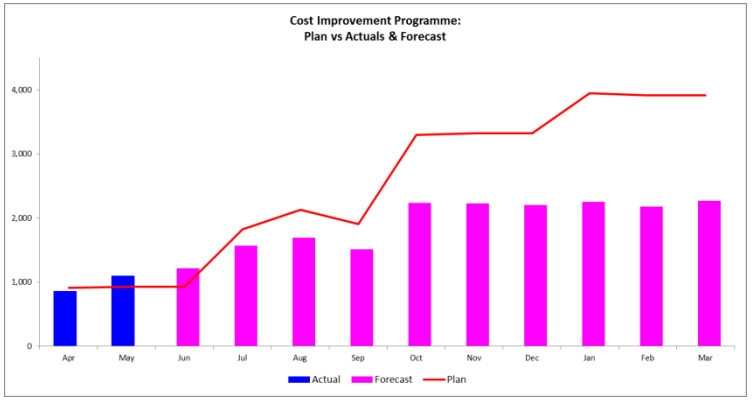
4. The CIP plan reflects £4.1m of Model Hospital opportunities with a further £5m being explored
All Divisions are formally reporting back to the PMO on each opportunity presented.

5. A tender for external support to Surgery and D&S has been posted. Closing on 25/06.
This financial year £30,960k has been spent on interim CIP support whilst substantive recruitment is underway.

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



The graph below highlights the in-month actuals versus the in-month NHSI cost improvement plan



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2018 £000	GROUP Balance as at M2 £000	B/S movements from 31st March 2018 £000
Non-Current Assests			
Intangible Assets	9,130	9,295	165
Property, Plant and Equipment	251,010	250,148	(862)
Trade and Other Receivables	4,463	4,444	(19)
Total Non-Current Assets	**264,603**	**263,887**	**(716)**
Current Assets			
Inventories	7,131	7,202	71
Trade and Other Receivables	19,276	21,822	2,546
Cash and Cash Equivalents	5,447	3,645	(1,802)
Total Current Assets	**31,854**	**32,669**	**815**
Current Liabilities			
Trade and Other Payables	(47,510)	(53,548)	(6,038)
Other Liabilities	(3,284)	(3,115)	169
Borrowings	(4,703)	(4,703)	0
Provisions	(160)	(160)	0
Total Current Liabilities	**(55,657)**	**(61,526)**	**(5,869)**
Net Current Assets	**(23,803)**	**(28,857)**	**(5,054)**
Non-Current Liabilities			
Other Liabilities	(7,235)	(7,174)	61
Borrowings	(111,219)	(114,430)	(3,211)
Provisions	(1,472)	(1,472)	0
Total Non-Current Liabilities	**(119,926)**	**(123,076)**	**(3,150)**
Total Assets Employed	**120,874**	**111,954**	**(8,920)**
Financed by Taxpayers Equity			
Public Dividend Capital	168,768	168,768	0
Equity			
Reserves	43,530	43,530	0
Retained Earnings	(91,424)	(100,344)	(8,920)
Total Taxpayers' Equity	**120,874**	**111,954**	**(8,920)**

The table shows the M02 balance sheet and movements from the 2017/18 closing balance sheet, supporting narrative is on the following page.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 02 balance sheet position against the 2017/18 outturn

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

Current Assets
- Inventories show an increase of £0.07m.
- Trade receivables are £2.5m above the closing March 2018 level.
- Cash has reduced by £1.8m since the year-end, reflecting the deficit position offset by loan finance.

Current Liabilities
- Current liabilities have increased by £5.9m, reflecting an increase in creditors/accruals. This reflects a provision for income risk and a movement on operating expenditure accruals.

Non-Current Liabilities
- Borrowings have increased by £3.2m. This includes £3.5m of distress funding called down and repayments relating to finance leases.

Retained Earnings
- The retained earnings reduction of £8.9m reflects the impact of the in year deficit.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow : May

Cashflow Analysis	Apr-18 £000s	May-18 £000s
Surplus (Deficit) from Operations	**(4,831)**	**(2,512)**
Adjust for non-cash items:		
Depreciation	912	912
Other operating non-cash	0	0
Operating Cash flows before working capital	**(3,919)**	**(1,600)**
Working capital movements:		
(Inc.)/dec. in inventories	0	71
(Inc.)/dec. in trade and other receivables	(4,596)	(2,610)
Inc./(dec.) in current provisions	0	0
Inc./(dec.) in trade and other payables	7,156	1,157
Inc./(dec.) in other financial liabilities	(437)	904
Net cash in/(out) from working capital	**2,123**	**(478)**
Capital investment:		
Capital expenditure	(158)	(207)
Capital receipts	0	0
Net cash in/(out) from investment	**(158)**	**(207)**
Funding and debt:		
PDC Received	0	0
Interest Received	3	13
Interest Paid	(29)	(218)
DH loans - received	3,500	0
DH loans - repaid	0	0
Finance lease capital	(148)	(148)
Interest element of Finance Leases	(12)	(12)
PFI capital element	(95)	(95)
Interest element of PFI	(161)	(161)
PDC Dividend paid	0	0
Net cash in/(out) from financing	**3,058**	**(621)**
Net cash in/(out)	**1,104**	**(2,906)**
Cash at Bank - Opening	**5,447**	**6,551**
Closing	**6,551**	**3,645**

The cashflow for May 2018 is shown in the table :

Cashflow Key movements:

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

Current Assets – Invoiced receivable balances have decreased, whilst accrued receivables have increased. This mainly relates to SLA income.

Trade Payables – Aged payables have reduced whilst accrued payables have increased. The increase in some part relates to the move to quarterly invoicing from some suppliers.

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

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover	(2.55)	(2.59)
Metric		
Rating	4	4
Liquidity	(25.47)	(24.88)
Metric		
Rating	4	4
I&E Margin	(10.79%)	(10.65%)
Metric		
Rating	4	4
I&E Variance from Plan		0.14%
Metric		
Rating		1
Agency	(1.29%)	17.80%
Metric		
Rating	1	2
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.

Performance at month 2 is in line with plan, with a rating of "4".

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The financial position of the Trust at the end of Month 02 of the 2018/19 financial year is an operational deficit of £8.9m. This is a favourable variance to budget and NHSI Plan of £0.1m.

Author: **Jonathan Shuter, Director of Operational Finance**

Presenting Director: **Sarah Stansfield, Director of Finance**

Date: **July 2018**

REPORT TO MAIN BOARD – JULY 2018

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

This report describes the business conducted at the Finance Committee held 30th 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
Financial Performance Report	In Month 01 the Trust reported a deficit of £5.7m. This represents a £50k favourable position against plan. Cash balances for M1 are £6.6m.	Can the full impact of pass-through drugs be shown separately to aid understanding? Can the price/volume split of activity variances be better understood? How is GMS shown within the reporting?	The income is currently included within the commissioning position but will be split out separately in future reports The analysis will be added to future reports GMS is currently aggregated within the Trust position – this will be split under so that the impact for the group is better understood	Drugs and activity variance reporting to be added
Capital Programme Update	£10m loan remains required to fund the entirety of the 2018/19 capital programme – a number of routes through financing the programme were also presented	Have all funding routes been explored?	There remain commercial routes to finance available to the Trust but these are high risk.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Cost Improvement Programme Update	At Month 1 the trust has delivered £860k of CIP against the monthly NHS Improvement target of £910k. A more formal approach to model hospital opportunities is being adopted	Under-performance for M1 continues to show challenges in procurement – how is the committee assured that progress is being made?	New leadership arrangements are now in place with plans to audit the procurement team in Q1	
Clinical Productivity	Significant progress in the approach to agency spend and further focus to be developed around Model Hospital.	Is there was a way the programme plan could include how we are RAG rating and create a savings yield into CIP?	Identification of the financial benefits of the workstream is ongoing	CIP remains to be fully identified in this area
Budgets 2018/19	2018/19 Budget Setting paper to provide the Committee with details of the 2018/19 financial plan and associated Divisional and Directorate budgets.	How are the plan and associated budgets being communicated?	Finance business partners are briefing divisions and there is a central programme of communications around finance planned.	
Risk Register	All risks reviewed and updated to reflect closure of the 2017/18 financial year and updates for 2018/19.	Does a risk need to be added around the central funding of the pay award for all staff groups.	Agenda for change staff awards will be centrally funded – risks will be added for other staff groups.	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – JULY 2018

From Finance Committee Chair – Mike Napier, Non-Executive Director

This report describes the business conducted at the Finance Committee held 27th June 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	At month 2 the Trust has £0.1m favourable variance to plan. Various additions to the Report asked for at the last Committee have been added. Control total agreement yet to be reflected.	How well do we understand income variances in relation to income activity and block contracts? How is the pay award reflected? The Committee requested a greater granularity of information around pay. How do risks manifest themselves on the position for the year?	Developed some additional supporting information in the Report, but work is ongoing to understand the influencable elements and possible impact on contracts. The 1% allowed for in the plan is reflected in the report but we are carrying a risk for Gloucestershire Managed Services and Medical Staff. Report will continue to be updated over the next month. From Q1 a sensitised forecast outturn will be provided as part of the report.	

Capital Programme Update		Ongoing oversight to backlog maintenance to assess whether or not it's growing and its financial and operational impact.		A more detailed paper will be presented to the Committee next month which looks to explain the issues in more detail.
CIP Update	The Trust has delivered £1.95m at M2 against a target of £1.83m and is ahead of plan.	How does quality and/or safety impact upon the programme? How is procurement progressing?	Quality Impact Assessments are done against all schemes and weekly review of all divisional schemes takes into account quality and safety.	Procurement to present to the Committee in August.
Clinical Productivity	Ongoing work documented in the medical productivity Workstream.	Where is the attribution of financial value and delivery to the "bottom-line"?		Financial assessment of the medical productivity programme.
Risk Register	Closure of risk around agreement of control total.	Is the lack of change to the other risks down to lack of review?	All risks have been reviewed and no changes made.	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

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

Purpose
This report provides Trust Board with an overview of current performance, against key performance indicators and outlines progress against the People and OD strategic objectives

Key issues to note
Sickness rates at the end of May 2018 remained static at 3.87%, against a target of 3.50%.

Turnover decreased further in May to 11.77% from 11.98% in the previous month.

The frequency of appraisal and mandatory training reports is currently reduced to quarterly reporting, this is due to a convergence of several national system updates to ESR, data cleansing and the system work associated with two national streamlining projects that we are participating in. In order to ensure that reporting accuracy is not compromised the next available reports will be published by mid July 2018.

Our key focus this quarter has been on reshaping critical recruitment services, balanced with improving development, staff engagement and the overarching staff experience of our workforce. We continue to feel the challenge associated with delivering against these objectives against the backdrop of 'business as usual'.
The Talent Management System will launch week commencing 11th July and will present a new appraisal process and accelerated development pool process to aid talent identification and succession planning.

A recruitment and retention task and finish group has commenced with a nurse and HCA focus.

Temporary staff solutions move ahead and an innovative attraction strategy designed.

The Gender Pay Gap report has been scrutinised by the Workforce Committee and other Trust forums. The emphasis on understanding the key messages and producing a Trust equality of opportunity plan has been agreed and is shared in the WRES report (separate paper).

The Staff Survey results continue to be managed at a local level and considered at the Staff Experience and Improvement Group. A copy of the organisation action plans for staff survey across 3 themes has been provided to capture 'corporate' and cross cutting activity.

Following receipt of a freedom to speak up self-review tool kit from NHSI Executives, the Freedom to Speak Up Guardian, the NED and executive lead are ensuring that the Trusts arrangements are sufficiently embedded. Further work with the Board will be pursued over the coming months.

Key Next Steps identified:

- Uploading the corporate establishment data as part of our establishment alignment project by the end of July 2018, once the process, and data, has been validated we can then establish timescales for the remaining divisions across the Trust.

- Delivery, via the Recruitment Steering Group ,of key immediate recruitment objectives.
- Implementation of revised NHSi agency authorisation levels (1st July 2018).
- Development of the outline business case for the long term workforce plan for Advanced Care Practioners (ACPs) – September 2018
- IT and Comms review of the ArK engagement app
- Continued delivery against the staff survey action plan
- Talent Development system launch 11 July 2018.
- Further engagement, and implementation of, the Equality and Inclusion action plan.
- GMS terms and conditions review & engagement (workforce committee 12 July 2018)

Recommendations
Trust Board are asked to NOTE the performance outlined in our key performance indicators and the progress made against our strategic priorities.
Impact Upon Strategic Objectives
Provides an update on progress against the People and OD strategic priorities and our focus on Journey to Outstanding. Directly impacts on Trust Strategic Objectives, in particular: staff engagement, retention 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)**
Outcome of discussion when presented to previous Committees						
N/A						

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 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 People and OD strategic objectives.

2. Key Performance Metrics

2.1 Sickness Absence

Sickness rates at the end of May 2018 **remained static at 3.87%,** against a target of 3.50%. This compares to an average across acute trusts of 4.51% (Nov 17 national figures). Sickness management continues to form a key part of HR Advisory support to divisions and divisional grip is monitored closely through Divisional Executive Review. A review on the Trusts long term management of sickness absence is underway to ensure appropriate welfare checks are in place.

2.2 Retention

Turnover decreased further in May to 11.77% from 11.98% in the previous month. This takes Trust turnover levels below 2016/17 levels and within 0.77% of our 11% target. Whilst turnover levels decreased across all professional groups, we remain focussed on improving the retention of Healthcare Assistants, with turnover currently at 19.7% within the Medical Division. The July workforce committee spent time discussing the HCA retention action plan and reflecting on the key actions identified in the HCA retention project. These include:

- Formalising career development pathways and developing talent
- Promoting and supporting access to training and development
- Reviewing recruitment and promoting employment benefits
- Reviewing occupational sick pay arrangements

The HR team continue to review roles/ departments with high turnover to investigate reasons and a new review for medical secretaries is underway.

We are now participating in national workshops co-ordinated by NHS England, which focus on identifying innovative recruitment and retention initiatives.

2.3 Appraisal & Mandatory Training

The frequency of appraisal and mandatory training reports is currently reduced to quarterly reporting, this is due to a convergence of several national system updates to ESR, data cleansing and the system work associated with two national streamlining projects that we are participating in. In order to ensure that reporting accuracy is not compromised the next available reports will be published by mid July 2018. For reference, the last report to the Board in May 2018 reported Trust compliance levels of 82% respectively, against a 90% target, for both appraisals and mandatory training.

3.0 Education & Development Update

Our Education and Development teams continue to support the growth and sustainability of our workforce. Key achievements within our Education Services over the past year include:

- Increased number of Nurse Degree Students coming to Gloucestershire (from 95 to 160), and offered placements in GHT
- Increased number of enrolled Apprentices to 100, 26 different qualifications and the potential to increase the levy drawn down by Apprenticeship course providers via the Managed Apprenticeship System
- Completion of the first year of the national two year pilot for 11 Trainee Nursing Associates

and the successful bid and procurement for a second cohort of 18 to commence in September 2018
- Allocated £652,000 to fund education projects across the STP One Gloucestershire to enable transformation and use for Advanced Clinical (nurse) Practitioners
- Reducing duplication of training time via streamlining projects
- Developed a clear career framework for nurses.

Key challenges faced by our services include the impact of national and local upgrades/projects on GHT systems, as reflected in the current reduction in appraisal and mandatory training reports.

4.0 Update on Strategic Priorities

4.1 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 less than accurate establishment reporting, poorer 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 has been slower than anticipated as we focus on determining the 'true' data set to feed into the ESR system. This work begins in the finance department and once fed into ESR, is then validated between HR and Finance teams. We anticipate uploading the corporate establishment data by the end of July 2018, once the process, and data, has been validated we can then establish timescales for the remaining divisions across the Trust.

4.2 Recruitment and Resourcing

Vacancy Control

Vacancies continue to be scrutinised at both 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 quality and service delivery with the Deputy CEO and Director of People and OD approving straightforward replacement posts where criteria agreed has been met.

Recruitment Group

We are working collaboratively to address concerns regarding current vacancy levels across Nurse and HCA groups. A focused task and finish group has been established and reports into the People and OD Delivery Group. Key actions include:

- Review of recruitment materials and marketing strategies
- Vacancy forecasting & trajectory
- Review (and peer review) of processes, reducing 'time to fill'
- Review of initiatives (such as RRP, 'Golden Hello')
- Review of 'how' we recruit, ensuring we prioritise values based recruitment and test situational judgement
- Build on the talent management system visuals and look and feel to create an 'extraordinary talent' recruitment strategy

Temporary Staffing

A creative agency have supported the temporary staffing team to launch and promote new rates of pay for bank work (1st August 2018), alongside a new marketing strategy. The success of this will be reviewed through the recruitment steering group.

Further to a letter received from Ian Dalton, Chief Executive at NHS Improvement, two key changes to agency authorisation have been communicated to our divisions. These changes became effective from 1st July 2018 and include:

- The reduction in sign off limit of high cost agency and bank shifts from £120 per hour to £100 per hour.
- The implementation of Executive Director sign off in advance for all agency shifts that are 50% or more above the price cap but where hourly rate is less than £100.

Internal processes have been amended accordingly, which includes an amendment to the VCP form to capture appropriate authorisation and guidance provided to managers on obtaining authorisation both in and out of hours. In the event that a booking is made without the correct authorisation having been received, this will be discussed and challenged at Divisional Executive Review.

4.3 Sustainable Workforce Agenda

Shirley Daniels, HRBP is working collaboratively with key stakeholders to develop business plans to meet the key drivers in terms of a safe and efficient workforce that meets service needs and supports the delivery of our Journey to Outstanding. The short, medium and long terms plans will form part of a 5 year rolling plan and will include career development pathways and integration with the STP.

The outline business case for the long term workforce plan for Advanced Clinical Practitioners (ACPs) will be presented to the Sustainable Workforce Group in September 2018 and will scope the options available, financial impact and feasibility of this workforce model.

5. Staff Engagement

Freedom to Speak Up

A series of meetings with the Freedom to Speak Up Guardian have been taking place on receipt of the NHSI self-review tool. The tool is for Boards to use to gauge how well embedded the freedom to speak up culture is within their Trust.

The Executive and Non-Executive lead met on 5th July to discuss the tool and agree next steps to ensure continued engagement with the Board and staff on the importance of speaking up to enable continued learning and continuous improvement.

Next steps include refreshing the Board on key themes, finalising the Freedom to Speak Up Strategy with stakeholder engagement and bench marking best practice.

The Freedom to Speak Up annual report was presented at the People and OD Delivery Group on 13th June 2018 and will be followed up and presented to the Workforce Committee on 6th August 2018.

Staff Experience Improvement Group

The group met for the first time in June 2018. The purpose of this group is to 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. The group is keen to ensure that they offer support through solutions and interventions, whilst we work to find resource to support the triangulation of this headline data the group will focus on the information already available to support immediate priorities, such as the HCA retention issues.

Executive Walkabout and Visible Leadership

Exec walkabouts continue and these 'back to the floor' sessions have provided a valuable opportunity to share information about our Journey to Outstanding. At the time of writing this report, we prepare for Board members and our '100 Leaders' network to support a series of celebratory tea parties on the day in our wards, Outpatients areas and departments as part of the 70th birthday celebrations.

A facilitated winter debrief took place in May and June 2018, in order to capture staff views on the winter plan, its execution and Health & Wellbeing issues. A summary of themes and recommendations has been prepared for presentation and further discussion via Trust Leadership Team and other forums.

ArK Engagement App

Proposed use of the 'ArK' engagement app was discussed with IT Leaders and members of the Communications Team in early July 2018. The group agreed to explore the use of the app and potential security concerns in more detail, alongside our new intranet capabilities to ensure that roll out of the system is the best way forward. 'Ark' enables the Trust to share information on mobile and a real time basis.

Staff Survey

In June 2018, The People and OD group received a draft presentation summarising the key themes and focus of the staff survey action plan. As activities develop more actions will be added. The elements of the action plan are broadly grouped into 3 areas: feedback regarding experience in role, health and wellbeing and management. It is in addition to divisional plans and a summary of activity. The summary report is annexed for information.

a. J2O progress

Since engagement with 100 leaders on what outstanding looks like for patients and staff, a slide deck has been produced which has been circulated to divisions to ask them to consider with staff what J2O means for their area or speciality. The purpose is to gather feedback to ensure a bottom up approach is achieved for future strategic plans.

Departments that will enable the journey, such as People and OD, have been asked to start to consider what they may need to achieve (based on early feedback) to help support the delivery of outstanding care. Some of the actions we have commenced as part of this development include:

- The Executive safety visit will be amended to become a 'J2O visit'.
- The new appraisal paperwork includes 'my J2O plan'.
- Team meetings are being encouraged to have J2O as an agenda item.
- Working in partnership with Suzie Cro, Deputy Director of Quality and Freedom to Speak up Guardian, Governors will be engaged with and asked to support engagement of the public to improve our understanding of patient experience and their vision of outstanding.
- The Trust will formally launch 'J2O' to staff in an engagement exercise to improve visibility of the programme, provide J2O with its own identity and on monthly basis link corporate initiatives to J2O.

b. Talent Development

Materials and website content for the Advanced Development Pool and new Talent Management system will be launched 11 July 2018. A series of briefing sessions will take place throughout the summer to show all staff how to use the new appraisal and development paperwork. Staff will also be able to access face to face refresher sessions on how to successfully undertake a 'talent development conversation' along with bitesize training sessions for new managers and appraisers. Tutorials and online guides will also be available to offer ongoing support.

c. Staff Health and Wellbeing

The preparation of the 'One stop shop' business case for health and wellbeing will be a key focus for the People and OD team after the launch of the new talent development process. We have commenced with initial scoping around the costing and potential model for improved MSK support. In addition, we have received feedback to indicate a need for enhanced post-incident support, such as mental health first aid and/or created a peer support network where staff experience traumatic events. These elements will be built into the business case.

Trust Health & Safety objectives were presented to the Workforce Committee on 1st June and represented to the People & OD Delivery Group on 13th June and TLT on 4th July for final ratification.

d. Workforce Equality and Inclusion

The Diversity Network continues to encourage membership and is open to all staff, not just individuals with obvious protected characteristics. The steering group will now be considering the Workforce Race Equality Scheme report and the Gender Pay Gap report in more detail, particularly in regard to the promotion of equality of opportunity. An initial action plan has been developed, focusing on how we can positively promote equality of opportunity. This includes the following key actions and recommendations:

- Mandated delivery of unconscious bias training to Trust Board (both Execs and NEDs) and Divisional Board members
- Mandated delivery of Unconscious Bias training to all lead recruiting Managers
- Executive Board members championing a protected characteristic which is statistically more vulnerable to discrimination – keeping this in mind, championing on behalf of the Trust at Board meetings and other relevant forums
- BAME panellist involvement in senior interview panels
- A clear and supportive review process for reasonable workplace adjustments
- Invite representatives from Trust Diversity Network to participate in HR Policy and Governance group activity.
- Participation in the Stonewall Workplace Equality Index

We are cognisant of the reflections from the CQC during our last inspection, highlighting that the composition of our Trust Board is not reflective of our staff diversity or local community mix, with all voting board members being from a white background. We are seeking external support to consider how to build a pipeline of potential BME NED candidates going forward to ensure that at our next opportunity to recruit Non-Executive Directors includes a planned campaign to attract a more diverse pool of applicants and talent.

The Workforce Committee reviewed the WRES in detail and agreed that an 'equality of opportunity' plan to focus on improvements required, and further comparison on our results with other Trusts would be useful next steps.

e. GMS

Terms and Conditions Development

A proposed terms and conditions framework has been developed for the recruitment of future GMS staff. The key principles are supported by the GMS Board and have been shared with GMS trade union colleagues to ensure we receive staff side feedback. Prior to full GMS board sign off, the Workforce Committee will hold an extraordinary meeting on 12th July 2018 to ensure the Board members are fully engaged with the detail of the proposals and understand the financial modelling associated with these. In accordance with the schedule of reserved matters, this engagement is an important and necessary step in the approval of these proposals.

Colleague to Customer Journey

Our OD team have worked with GMS to design an organisational development plan to support the cultural development of GMS and the transition of both Trust and GMS staff as they transition from a colleague to a customer-supplier relationship. The plan focuses on the development of staff engagement, via a dedicated staff forum, development of the leadership team within GMS and a capacity and skills audit – to begin moving towards a competency model to support the sustainability of the workforce aligned to industry standards and statutory regulations. The plan also focuses on the development of a Corporate Social Responsibility/ Volunteers scheme for GMS staff to participate in.

6. Governance

Proposed amendments have been made to the Terms of Reference for the Workforce Committee (annex 2) inclusive of a change of name to People and OD Committee.

The People and OD Delivery Group met for the first time on 13 June 2018. A number of key issues were discussed and alongside input from operational workstreams, the group reviewed the recruitment and retention action plan, staff survey action plan and health and safety strategic priorities. The next meeting will review a thematic analysis of the freedom to speak up annual report and the work associated with peer mental health support for Junior Doctors.

7. Conclusion

Our key focus this quarter has been on reshaping critical recruitment services, balanced with improving development, staff engagement and the overarching staff experience of our workforce.

We continue to feel the challenge associated with delivering against these objectives against the backdrop of 'business as usual', which in turn means that projects such as the 'one stop shop' and establishment project remain in the early stages of delivery at this stage in the year. As we reach key milestones in the other workstreams outlined in this paper, we will continue to refocus our resource in the most pragmatic way to ensure that progress is achieved across all areas.

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

Author: Alison Koeltgen, Deputy Director of People

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

Annex 1. Staff Survey Action Plan Summary

Annex 2. Terms of Reference – Workforce Committee

Gloucestershire Hospitals
NHS Foundation Trust

Annex 1 , People and OD Report to Main Board, July 2018

NHS Staff Survey 2017
Key Themes and Actions

People & OD Steering Group
June 2018

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STATISTICALLY SIGNIFICANT REDUCTIONS IN SCORES SINCE 2015 AND/OR 2016

Gloucestershire Hospitals NHS Foundation Trust

THEME: JOB	ACTION PLAN
• **KF1** – recommending as a place to work/receive treatment (15/16) • **KF2** – satisfied with quality of work/ level of care delivered (15/16) • **KF8** – satisfied with level of responsibility/involvement (15/16) • **KF9** – effective team working (15) • **KF14** – satisfied with level of resourcing and support (15)	• Launching a Trust-wide staff comms/ engagement app. 'Ark' • Career Pathway development • Trialling 'SPeaC Happy' app in Unscheduled Care • Talent Management System • Journey to Outstanding initiatives for Staff and Patients • Relaunching 'Just Do It' fund • Launched new Staff Experience Improvement Group to undertake thematic analysis of data sources on staff experience • Quality summits following reports on patient care issues ie DSU, Theatres, never events. • Prof Jane Reid report on never events • Engagement events held regularly and planned regarding specific initiatives • New team working designs in place- discharge and transfer team • Rolled out a new e rostering system and launch new bank working options • Improved targeting of recruitment for HCAs and nurses and improved trajectories • Recruitment and retention task and finish groups

STATISTICALLY SIGNIFICANT REDUCTIONS IN SCORES SINCE 2015 AND/OR 2016

Gloucestershire Hospitals NHS Foundation Trust

THEME: HEALTH & WELLBEING	ACTION PLAN
• **KF17** – feeling unwell due to work-related stress (15/16) • **KF18** – attending work in last 3 months despite feeling unwell because of pressure (16) • **KF19** – organisation/management interest/action taken on health and wellbeing (16) • **KF20** – experiencing discrimination in the last 12 months (15)	• Launched Diversity Network December 18 • Junior Doctor mental health programme • Undertaking a review of all staff health and wellbeing services, and creating a 'one-stop-shop' service. Including focused listening events to find out from staff what they would want from this service • Health and Wellbeing Charter • Health and Wellbeing group for staff and patients • Equality of Opportunity Programme • Health campaigns e.g. flu. Dietetics week. Themed menu in restaurants • Unconscious bias training • STP-wide stocktake of HWB activities to identify gaps and share good practice • Flu Vaccine programme • HCA occupational sickness review undertaken and engagement commenced • Improved recruitment team and functions including temporary staffing solutions • Flu Vaccine programme • V&A review and report prepared

STATISTICALLY SIGNIFICANT REDUCTIONS IN SCORES SINCE 2015 AND/OR 2016

Gloucestershire Hospitals NHS Foundation Trust

THEME: MANAGEMENT	ACTION PLAN
• KF5 – recognition and value by my manager/organisation (16) • KF30 – fairness/effectiveness of procedures for reporting errors, near misses, incidents (16)	• Launched Gem Awards January 18 • Local recognition schemes In some areas e.g. the 'O' award (outstanding) • Local promotion of 'see something, say something' • Launched Freedom to Speak Up Guardian • Staff Experience Improvement Group and thematic analysis • Leadership promotion and changes • Foundation of nursing studies assisting matron programme and role • Kitchen table events • Schwartz rounds • Quality summits for raising concerns • Nursing accreditation system • New leadership opportunities: Extended Leaders Network; Apprenticeships; management skills training • Talent management system and new accelerated development pool initiative • Career path development (nursing) • Engagement events :Involve • Social media engagement • Listening events planned – Junior doctor engagement events – New consultant engagement • Quality summits (every 4th Friday)

Annex 2

Workforce Committee
Terms of Reference & Governance Structure

High-Level Priorities Plan	✓
Detailed Action Plans	✓
Operational Issues	✓
Resource Management	✓
Policy	✓

Terms of Reference

The purpose of the People and OD Committee is to assure the Trust Board that the People and OD function is delivering upon the Workforce and associated People Strategies.

The Committee will:

1. Be assured that there are practices in place which ensure the sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention.

2. Be assured that the Trust attracts and retains a high performing workforce capable of delivering the Trust operational clinical strategies.

3. Be assured that the Trust implements effective and equitable reward packages that positively impact on performance and meet national and legislative parameters. .

4. Be assured that strategic education issues and external relationships which impact on supply and engagement are included in Trust planning.

5. Be assured that the Trust delivers services which are fair and equitable promoting diversity and equality of opportunity.

6. Be assured that the Trust is driving improved employee engagement, ensuring appropriate mechanisms for the employee voice to ensure that rapid action is taken to improve staff experience.. Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy.

7. Agree annual objectives for Health and Safety.

8. Agree (where necessary) workforce reports prior to publication and review implications of national reports that have been published.

9. Consider and review Freedom to Speak Up annual reports and matters arising from concerns raised.

10. Identify risks associated with workforce issues ensuring ownership with mitigating actions, escalating to Trust Board as required.

Membership & Responsibilities

Chair:
- Non-Executive Director

Vice Chair:
- Non-Executive Director

Members:
- Non-Executive Director
- Director of People and OD/ Deputy CEO
- Director of Quality and Chief Nurse
- Medical Director
- Deputy Director of People and OD
- Director of Operational Finance
- Head of Leadership and OD
  Associate Director of Education and Development

Governor representative: (1 staff and 1 Patient or Public)

Officer:
- PA to Director of People and OD/Deputy CEO

Quorum:
- Two NED's and at least 3 members, 1 of whom should be an executive

Reporting Line:
Trust Board

Sub-Committees:
- Health & Safety Committee
- Strategic Education and Sustainable Workforce Group
- Equality Steering Group

Frequency of Meetings:

Every two months

Submission / Availability of Minutes:
The Minutes will be presented to the next available Board meeting.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – JULY 2018

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

This report describes the business conducted at the Workforce Committee on 1st June 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 Race Equality Scheme	The committee received the annual WRES report. It was requested that we look at: - Comparable Trusts to better understand the direction of travel and how the Trust compares. - How we can drive momentum behind key initiatives.	An update with context should be brought to the October committee.	The Committee recommended: - the Board undergo unconscious bias training - the report be brought to Board with proposed actions which relate to linking with other equality reports setting an 'equality of opportunity plan' which will be devised by the Equality Steering Group.	None
Revised Terms of Reference	The committee received revised terms of reference in line with the new governance structure. Committee name change proposed to People & Organisational Development Committee to reflect portfolio.	How are we ensuring membership across the Committee structure is equitable and appropriate to Committee needs and quorums - standardised where possible.	It was agreed that the Director of Corporate Governance should look at all Committees and provide recommendations. Paper to be submitted to Board for approval from Director of Corporate Governance.	None

Strategic Risk Assessment	The Committee assessed the risks across the portfolio.	How are we managing risks across Committees and within divisions? Do we understand the process of risk measurement?	It was agreed that the Board should request a session looking at the make-up of risks and how they are scored.	
HCA Action Plan	Following on from the last committee the detailed action plan was received.	How are we ensuring buy in from Health Care Assistants? Are we clear that the actions taken reflect HCA needs? What outcomes do we want?	It was agreed we would: - Set evaluation criteria - Set SMART targets - Review with HCAs - Bring the project plan back to Workforce Committee as for information report.	
H&S Objectives	Initial thoughts were presented.	Are these objectives aligned with the strategic vision? How are they addressing risk? How are they being prioritised?	It was agreed that the objectives should be agreed by the People and OD Delivery Group and reported into the TLT and re-shared with the Committee in August.	
TALENT	The committee received an update on the approach to talent management which shows significant change and was supported by the Committee.	How are we ensuring best practice customer experience? Are we clear that the systems are in place (Intranet) to deliver without falling over? Do we have a Plan B to support in the event of system failure.	Consider staged roll out.	

Annual ELD	The committee received the Annual ELD report which showed significant success across career development pathways.	Given local operational and national initiatives, there are issues tracking statutory and mandatory training monthly (which means reporting has had to move temporarily to quarterly) How are we addressing the complex IT issues to lessen future impact? Are we clear how this is going to affect measurement?		

Key items for the Board to note:

1. WRES paper and equality of opportunity approach
2. Risk alignment process
3. Amendment to Committee name
4. Desire for Board to commit to unconscious bias training as visible leadership and improving recruiting manager's attendance at unconscious bias recruitment training.

REPORT TO MAIN BOARD – JUNE 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 15th 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
Report from the Head of Counter Fraud	Update covering the team's draft annual report, awareness presentations, current pro-active investigation and regional co-operation	Was the recent fraudulent agency invoice activity identified through process or chance? How to obtain an increased understanding of the reduction in referral levels? What is the level of confidence on implementation of the Prescribing and Administering Medicines Policy?	Identified through chance in this instance but processes limit scope of risk. Additional narrative to be provided by case to increase understanding Interim Finance Director to liaise with Medical Director.	Review of processes will be undertaken to provide additional assurance Methodology to be reviewed Furtherer update to be brought to the Committee to ensure adequate steps are being taken.
Internal Audit	Review of Final reports covering, CQC, Core Finance Systems, Manual Expenditure Controls and Final Annual Report and Head of Internal Audit Opinion Indicative Audit Plan for 18/19, Recommendation tracker status	Why does the Quality and Performance Committee's understanding of the CQC report differ? Are there system opportunities that will remove the need for manual intervention to maintain the signatory listings? Is the Executive Team comfortable with the 18/19		Report to be reviewed at Q & P to ensure common understanding Board to be advised of this system shortcoming and the need for it to be addressed in the emerging digital strategy.

		plan? What will be the approach to GMS audit requirements?	Plan to be signed off by Head of Corporate Governance, FD and CEO. Committee to cover Group with appropriate agenda time for Trust and GMS to be allocated	
External Audit	Update on year audit status – no issues identified to undermine the audit opinion. The "Value for Money" conclusion will be qualified.	What are the process and performance factors that influence the value for money conclusion? Are there any material balance mismatches?	Clear explanation offered stressing the need for evidence that new arrangements are fully embedded. Finance Director assured the committee that there are no material mismatches	Opportunity for next year's opinion to be unqualified
Recommendation Tracker	Significant progress made with 128 of 141 actions complete. Ongoing discussion covering outstanding items.	Will Executives attend the committee when critical and high risk recommendations are overdue?	Yes	
Annual Accounts and Governance Letter	Update on status of this workstream. Input from the May 8th detailed accounts review confirmed as incorporated.			
Business Continuity	Update on the approach to Business Continuity following the earlier internal audit review. Highlighted progress but identified current shortcomings in arrangements which are being addressed.	How resilient are the Emergency Planning procedures? How effective are Cyber Security defences		Agreed for this to be reviewed at each future meeting pending achieving comprehensive progress. Special review of Cyber Security scheduled for November meeting

Risk Register	Review of latest Risk Register and changes.	How can the pace between initial identification and mitigation be identified	The timeline (initial identification, current risk, target achievement) is captured in the Datix system	Committee to be shown this data in future
Board Assurance Framework	Latest version shared – opportunity for refinement and summary format identified			
Committee Self-Assessment	Interim assessment reviewed highlighted need for revision to Terms of Reference			

Rob Graves
Chair of Audit and Assurance Committee
May 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – JULY 2018

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

This report describes the business conducted at the GMS Committee held 14th June 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	- Test KPIs under development - New staff Terms & Conditions proposals progressing well - Key position job descriptions - Business planning session scheduled	What is the approach to completion of a transition status report?	A 90 day "wrap-up" will be issued.	

Chief Operating Officer's Report - Contact and Performance Management Arrangements - Performance Measures (GMS Financial Position, Customer Satisfaction etc)	- Client lead contact appointment made and in place - Work commenced on client relationship management system with initial focus on communication	What is the position concerning cleaning standards? How will the "Journey to Outstanding" apply to GMS?	Cleaning standards will be addressed by the Quality and Performance Committee under the leadership of the Director of Quality and Chief Nurse. GMS is being encouraged to participate in the initiative in the same way as other divisions.	
Position on Risk Management and Interim GMS Risk Management Arrangements				Keep under review Position on Risk management
Risk Log	Key transition risks closed/updated.			
Appointment of Auditors and Audit Plan Areas of Focus	Proposal to take a Group Audit approach endorsed GMS Committee.			

GMS Committee Work Plan	Proposed standing items: accepted addition of 90 day wrap up report. Meeting frequency confirmed as monthly in year 1.			

MAIN BOARD – JULY 2018
Lecture Hall, Sandford 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)
- The new, rationalises Outpatient Outcomes went live 20th June with an aim of 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 an expected increase in data quality. So far reporting supports these assumptions.
- Focus has now moved to scoping of the vetting process of referrals as a large proportion of data quality issues are a consequence of this function not working optimally.
- 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)**
					04July18	
Outcome of discussion when presented to previous Committees						

MAIN BOARD – JULY 2018
SMARTCARE PROGRESS REPORT

1. Purpose

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

Following a very positive few weeks the team are pleased to report that the new outcome options have gone live. The next few weeks will see a wrap around approach that should result in decreasing the amount of data quality issues being created as a result of incorrect or suboptimal processes.

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. Data Quality Issues

The current amount of overall data quality issues stands at 205, 677. This has decreased from 300,000 since January, and has decreased by approximately 9000 this month.

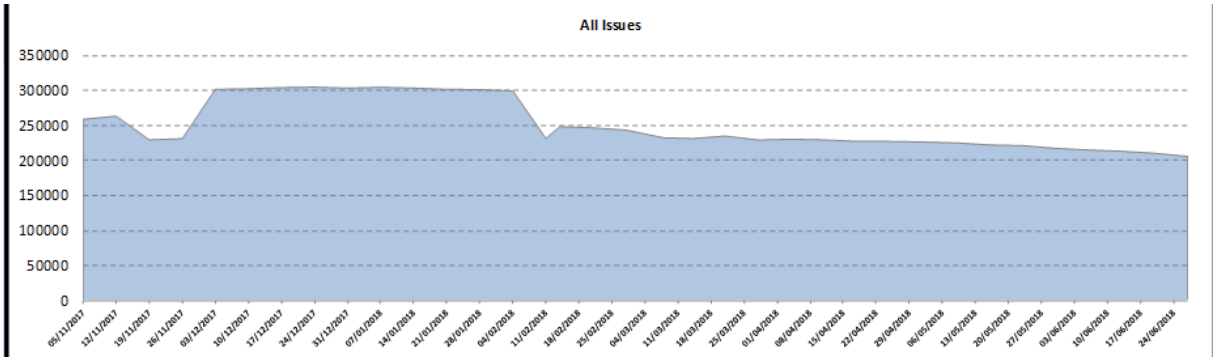

Table to show the change in overall DQ Issues since 23/05/18

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The table below describes how these issues are reflected in the number of records, pathways and patients affected, as one record, pathway or patient could have multiple DQ issues.

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This table shows an overall positive story with a significant downward volume change across most data quality issues. Some of our validation/ correction of data has added to some of the data quality issues however we are comfortable that these issues now sit in more appropriate places and can continue to be further validated.

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DQ Fix/ Validation Guide Progress

- Further Fix Guide completed- plan to begin validating and amending patients being decided.
- 4 in final phase of completion.

- Meaning approximately 80,000 DQ issues will have an accurate process defined that allows the correct and non-consequential fix/ validation to occur.

- Team will then need to identify appropriate skill level required for validation and reach out to appropriate resource.

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The validation team efforts continue to support the delivery of the TrakCare Recovery programme.

Performance % is currently at 69.9% a total increase in 16.8% (this status is however subject to overall reporting and data quality checks). The % is included here to illustrate the impact of validation which is extremely positive. This is not a reflective position of the performance.

The central access team are currently validating back to week 23, which is testament to lots of hard work when you consider our starting position. The PTLs are being refreshed for improved and easier user interface. Validation so far has been focused on ensuring we are cleansing our data from the back end to ensure an accurate picture of performance. What we need to begin exploring is the methods of validation that are being used to ensure they are not creating secondary data quality issues, albeit in less priority areas. Work is underway with the validation team to ensure their process of fixing data is validated by the TrakCare team to ensure that data is validated and fixed in a way that reduces any further data quality issues.

The continued collaborative working between the TrakCare Recovery Team and operational colleagues led by Felicity Taylor-Drewe is essential to ensure joined up working that delivers solutions that are both fit for recovery and will enable a transition to business as usual functionality. It is clear that this engagement and involvement is fundamental to the continued success of the SmartCare programme.

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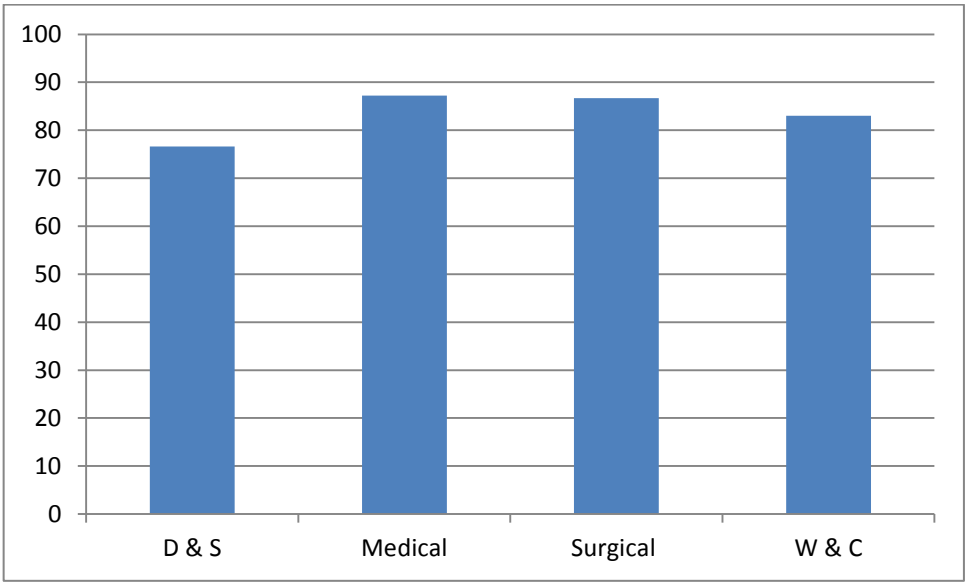
5. Outpatient Outcomes

The 20th June saw the go-live of the new outpatient outcome configuration on TrakCare. The week of go live was very successful with floorwalkers present in all outpatient areas and a control room established to be reactive and responsive to more complex problems. Statistics show that following go-live a higher percentage of clinicians completed outcomes on the day (79.63%) than previously- signposting positive steps and progress. Now that we have a weeks' worth of data this pattern has remained.

On The Day Outcome Completion as of 27/06/18



All in all, over the go-live week, the control room received 104 calls, with the majority of calls being resolved either on the spot or within a short response time. Only 14 calls remain open with the project team liaising with Intersystems as appropriate.

The resounding feedback from clinicians was that the presence of floorwalkers was hugely appreciated with many people seeking reassurance rather than asking complex/ difficult questions. The TrakCare team are planning to maintain this positive feeling and are exploring options of having continued, albeit less intensive floorwalking from across the whole team on a regular basis.

The next few weeks will see the dissemination of reports that allow both operational teams and TrakCare training teams to identify individuals that are not completing

outpatient outcomes in order to maintain the improved daily outcome entry completed by patients. An escalation route will need to be agreed and enforced for those clinicians that continue to not complete outcomes in a timely fashion. The support of the leadership team with this will be essential in improving outcome completion, resulting in improved activity recording and less clinical risk.

Whilst the TrakCare team will continue to support and explore the potential functionality that system can provide this exercise has continued to demonstrate the need for operational teams to define and describe the processes that they choose to use, and for those processes to be validated by both the patient access team from an RTT perspective and the project team to ensure that pathway management continues to be optimised within TrakCare.

6. Plan for the Next Reporting Period:
   a) Disseminaton to operational teams of reporting for clinicians not completing outpatient outcomes. Decision on escalation and approach to moving to 100% completion target.
   b) Quality review of outcome completion to inform further training needs in the following areas: RTT, operational process, TrakCare system
   c) Refresh of next 8 week plan likely to include; DQ6 targeted training to prevent the creation of further DQ6 issues now that data has begun to be validated; scoping of approach to vetting; review of waiting list creation education material and targeted training, Data quality fix guide completion (DQ2, DQ4, DQ7, DQ15 & DQ16), continued validation and data correction
   d) Plan for continued TrakCare floorwalker visibility on a weekly/ monthly basis, likely to include staff from entire project team (TrakSupport, RTT, Training, Config team etc)

7. Risks and Issues

   There is a core group of individuals that are heavily involved in the delivery of TrakCare Recovery. This includes individuals that deliver training, communications, configuration and testing. This is a finite resource and therefore impact on business as usual/ TrakCare developments may not be implemented despite being identified due to the prioritisation of TrakCare recovery. This means that recovery activities need to run sequentially rather than all at once due to limited expertise and resource. This also requires staff engagement to fully understand the reasons why the project team prioritise and carry out the work that is being completed.

8. 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, Trak Recovery/ Transformation Manager**
Presenting: **Mark Hutchinson, Digital Recovery Consultant**

Date: 25th June 2018

MAIN BOARD – JULY 2018
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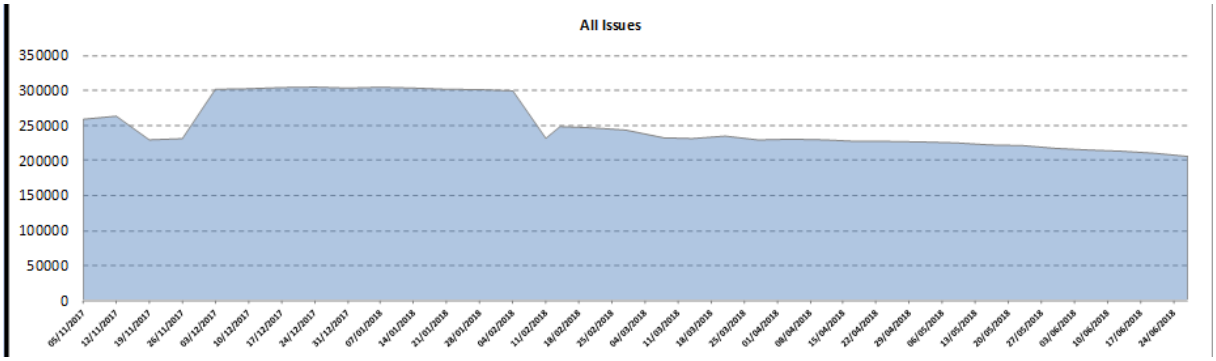

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Performance % is currently at 69.9% a total increase in 16.8% (this status is however subject to overall reporting and data quality checks). The % is included here to illustrate the impact of validation which is extremely positive. This is not a reflective position of the performance.

The central access team are currently validating back to week 23, which is testament to lots of hard work when you consider our starting position. The PTLs are being refreshed for improved and easier user interface. Validation so far has been focused on ensuring we are cleansing our data from the back end to ensure an accurate picture of performance. What we need to begin exploring is the methods of validation that are being used to ensure they are not creating secondary data quality issues, albeit in less priority areas. Work is underway with the validation team to ensure their process of fixing data is validated by the TrakCare team to ensure that data is validated and fixed in a way that reduces any further data quality issues.

The continued collaborative working between the TrakCare Recovery Team and operational colleagues led by Felicity Taylor-Drewe is essential to ensure joined up working that delivers solutions that are both fit for recovery and will enable a transition to business as usual functionality. It is clear that this engagement and involvement is fundamental to the continued success of the SmartCare programme.

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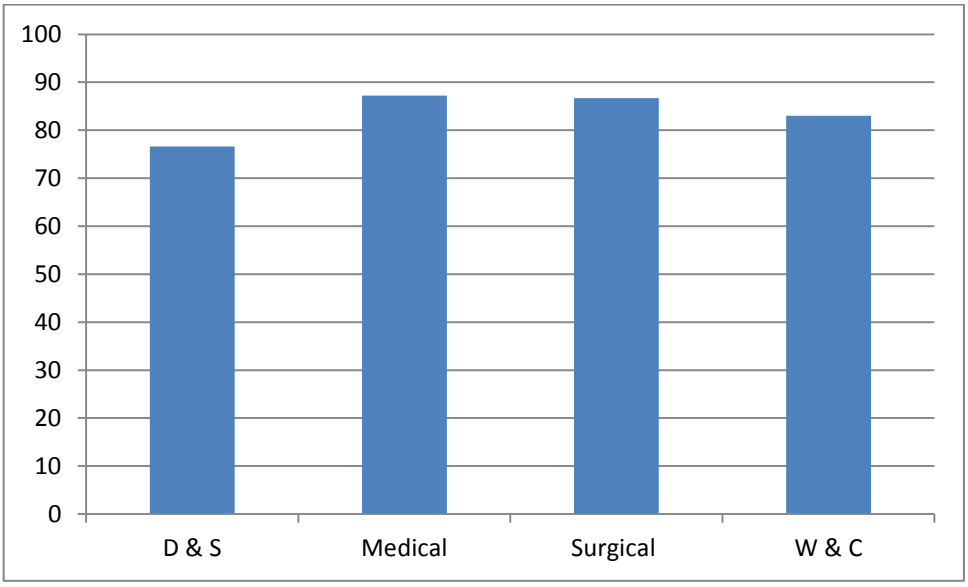
5. Outpatient Outcomes

The 20th June saw the go-live of the new outpatient outcome configuration on TrakCare. The week of go live was very successful with floorwalkers present in all outpatient areas and a control room established to be reactive and responsive to more complex problems. Statistics show that following go-live a higher percentage of clinicians completed outcomes on the day (79.63%) than previously- signposting positive steps and progress. Now that we have a weeks' worth of data this pattern has remained.

On The Day Outcome Completion as of 27/06/18



All in all, over the go-live week, the control room received 104 calls, with the majority of calls being resolved either on the spot or within a short response time. Only 14 calls remain open with the project team liaising with Intersystems as appropriate.

The resounding feedback from clinicians was that the presence of floorwalkers was hugely appreciated with many people seeking reassurance rather than asking complex/ difficult questions. The TrakCare team are planning to maintain this positive feeling and are exploring options of having continued, albeit less intensive floorwalking from across the whole team on a regular basis.

The next few weeks will see the dissemination of reports that allow both operational teams and TrakCare training teams to identify individuals that are not completing

outpatient outcomes in order to maintain the improved daily outcome entry completed by patients. An escalation route will need to be agreed and enforced for those clinicians that continue to not complete outcomes in a timely fashion. The support of the leadership team with this will be essential in improving outcome completion, resulting in improved activity recording and less clinical risk.

Whilst the TrakCare team will continue to support and explore the potential functionality that system can provide this exercise has continued to demonstrate the need for operational teams to define and describe the processes that they choose to use, and for those processes to be validated by both the patient access team from an RTT perspective and the project team to ensure that pathway management continues to be optimised within TrakCare.

6. Plan for the Next Reporting Period:
   a) Disseminaton to operational teams of reporting for clinicians not completing outpatient outcomes. Decision on escalation and approach to moving to 100% completion target.
   b) Quality review of outcome completion to inform further training needs in the following areas: RTT, operational process, TrakCare system
   c) Refresh of next 8 week plan likely to include; DQ6 targeted training to prevent the creation of further DQ6 issues now that data has begun to be validated; scoping of approach to vetting; review of waiting list creation education material and targeted training, Data quality fix guide completion (DQ2, DQ4, DQ7, DQ15 & DQ16), continued validation and data correction
   d) Plan for continued TrakCare floorwalker visibility on a weekly/ monthly basis, likely to include staff from entire project team (TrakSupport, RTT, Training, Config team etc)

7. Risks and Issues

   There is a core group of individuals that are heavily involved in the delivery of TrakCare Recovery. This includes individuals that deliver training, communications, configuration and testing. This is a finite resource and therefore impact on business as usual/ TrakCare developments may not be implemented despite being identified due to the prioritisation of TrakCare recovery. This means that recovery activities need to run sequentially rather than all at once due to limited expertise and resource. This also requires staff engagement to fully understand the reasons why the project team prioritise and carry out the work that is being completed.

8. 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, Trak Recovery/ Transformation Manager**
Presenting: **Mark Hutchinson, Digital Recovery Consultant**

Date: 25th June 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Financial Enforcement Undertakings Compliance Certificate
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance Sponsor: Deborah Lee, Chief Executive
Executive Summary
Purpose The purpose of this paper is to inform the Finance Committee about the outcome of NHS Improvement's Regional Provider Support Group's 22 May 2018 meeting, which concluded that the Trust had complied with the requirements of a number of the financial governance enforcement undertakings and that NHS Improvement should issue the Trust with a compliance certificate in respect of these undertakings. Key issues to note NHS Improvement's Regional Provider Support Group – South (RPSG) met on 22 May 2018 and considered the Trust's progress in addressing the December 2016 enforcement undertakings agreed with NHS Improvement in respect of financial governance, capability and capacity and reporting. RPSG decided that the Trust had complied with the requirements of a number of the financial governance enforcement undertakings and that NHS Improvement should issue the Trust with a compliance certificate in respect of these undertakings. RPSG considers the Trust is yet to fully address the enforcement undertakings relating to financial recovery and recommended that these should remain in place, and the Trust remains in Financial Special Measures (FSM) at this stage. The residual undertakings relating to the external Well Led review will also remain in place until this review has been completed. The NHSI letter and the compliance certificate are enclosed. Conclusions and Implications The decision reflects the progress made in delivering the agreed actions and improvements made to financial governance, as previously reported to the Committee and the Board. Future Action Work will continue on financial recovery with a view of exiting the FSM as soon as possible.
Recommendations
The Committee is asked to note the NHS Improvement decision.
Impact Upon Strategic Objectives
Supports delivery of the objective 'no longer subject to regulatory action'.

Impact Upon Corporate Risks
None.
Regulatory and/or Legal Implications
Reflects regulatory action.
Equality & Patient Impact
N/A

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees
N/A

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

12 June 2018

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

Dear Deborah

NHS Improvement compliance certificate – financial governance enforcement undertakings

Further to our conversation, I am writing to confirm the outcome of NHS Improvement's Regional Provider Support Group – South (RPSG) on 22 May 2018 which considered the Trust's progress in addressing the December 2016 enforcement undertakings agreed with NHS Improvement in respect of financial governance, capability and capacity and reporting.

RPSG decided that the Trust had complied with the requirements of a number of the financial governance enforcement undertakings and that NHS Improvement should issue the Trust with a compliance certificate in respect of these undertakings (paragraphs 2.1 – 2.5, 2.10 – 2.12 and 3.1 – 3.2). RPSG considers the Trust is yet to fully address the enforcement undertakings relating to financial recovery and recommended that these should remain in place, and the Trust remains in Financial Special Measures (FSM) at this stage. The residual undertakings relating to the external Well Led review will also remain in place until this review has been completed.

We would like to commend the Trust on the improvements made to financial governance and in particular action taken to address the recommendations arising from the Deloitte reviews in August 2016 (financial reporting) and June 2017 (financial governance).

The Trust has made good progress with Board appointments. Through our observations of the board we concluded the quality of challenge and scrutiny of the Trust's financial position from NEDs is high and the executive/NED dynamic is appropriate. NHS Improvement will support the Trust in its recruitment process of the new Director of Finance.

The quality of the Board committee finance reports is high and we concluded materially addresses the concerns raised by Deloitte. We note the actions the Trust has taken to strengthen its quality impact assessment (QIA) process, restructure the

PMO and improve overall governance of CIPs since entering FSM. We will continue to monitor CIP delivery through the FSM process.

Undertakings relating to medium-term financial recovery will remain in place given the progress still required to improve the Trust's financial position alongside delivery of its Control Total for 2018/19. Given the imperative to deliver a significant cost improvement programme for 2018/19 and beyond, sustained focus by the Trust on delivery and internal capacity and capability supporting this remains of critical importance. The Trust is currently commissioning a Drivers of the Deficit review and through the FSM process. NHS Improvement will support the Trust to agree a realistic recovery plan that sets out how improvements will be made to deliver the Control Total in 2018/19 and strengthen its financial position beyond this. The Trust will remain in FSM and segment 4 of the Single Oversight Framework at this stage.

Should any significant new governance concerns come to light over this timescale, NHS Improvement will review the need for further action and support.

Next steps

I have enclosed the signed compliance certificate at Annex 1 to this letter. We will also publish the compliance certificate on NHS Improvement's website.

Yours sincerely

Tom Edgell
Interim Delivery & Improvement Director

Cc. Peter Lachecki, Trust Chair
Jennifer Howells, Joint Regional Director (South West)
Mark Shires, Senior Advisor (Restructuring)

COMPLIANCE CERTIFICATE

LICENSEE:

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

In 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 paragraphs 2.1 – 2.5, 2.10 – 2.12 and 3.1 – 3.2 of the Licensee's Enforcement Undertakings accepted by NHS Improvement on 6 December 2016.

Signed: Jennifer Howells

Position: Executive Regional Managing Director – South West

Date: 12 June 2018

Report from West of England AHSN Board

June 2018

1. Purpose

This is the quarterly report for the Boards of the member organisations of the West of England AHSN. Board papers are posted on our website for information.

2. Highlights of our work in Quarter 1 of 2018/19

National Early Warning Scores (NEWS) for early response to deterioration.

Thank you to every West of England organisation who has adopted and used NEWS; we are now the national exemplar in a cross system programme to use NEWS consistently across England. NEWS2 has now been announced and we are working to embed this across the West of England. The AHSN Network published a case study completed by the West of England AHSN on the system approach to NEWS which can be found here.

Emergency Department Safety Checklist

The ED Safety Checklist is now recommended nationally and the AHSN continues to respond to requests for support from other AHSNs supporting this roll out in their areas. West of England AHSN is supporting University Hospitals Bristol NHS Foundation Trust to adapt, implement and evaluate a Paediatric Emergency Department checklist. There is already interest from other Children's EDs across the country, so an evaluation will be important to examine its impact.

Diabetes Digital Coach Testbed

This is an ambitious programme and while we have not yet gone live with the platform we have worked with the funders and sponsors to reset the outputs to demonstrate proof of concept of the DDC platform with as many users as possible. The programme should come to an end in July and we are investigating how we might continue it after this date to maximise opportunities for recruitment.

Wave 2 Testbed programme has been launched; the West of England AHSN supported the four bids from potential testbed sites in our AHSN footprint.

3. Business Plan 2018/19 – National Programmes

The NHS England Board meeting, which was held on 24 May 2018, endorsed the re-licensing of the AHSN Network for the next five years 2018-2023 with the option to extend for a further five years. See here for the Board paper.

The licence includes a shift towards delivering a national innovation agenda including the set-up of an Innovation Exchange. We are linking this to the creation of Innovation Hubs for each STP footprint working with the Innovation Link Directors from each of our member organisations. By doing so we will strengthen opportunities to identify where the real innovations for each STP and member are, for us to work with them to achieve.

The licence also expects that AHSNs will devote a higher proportion of their resources to adoption and spread of seven nationally agreed priorities or "in common" projects across multiple AHSN's. We have already deployed four of the seven national programmes

(Transfers of Care around Medicines, PReCePT, AF and Emergency Laparotomy). See Glossary of terms here for more information.

ESCAPE Pain (New): ESCAPE-pain is a rehabilitation programme for people with chronic joint pain, that integrates educational self-management and coping strategies with an exercise regimen individualised for each participant. It helps people understand their condition, teaches them simple things they can help themselves with, and takes them through a progressive exercise programme so they learn how to cope with pain better.

PINCER (New): PINCER (Pharmacist-led information technology intervention for reducing clinically important errors) is one of the AHSN Network's national programmes of work. It supports GP practices to use software systems alongside root cause analysis to review patient records and identify possible prescribing mistakes.

Serenity Integrated Mentoring (New): This is a programme that links a police officer and a mental health nurse to work with a small number of mental health patients who are high users of services as a result of a mental health crisis. The programme aims to support and change ingrained and repetitive behaviours.

Transfers of Care around Medicine: This programme provides community pharmacist support for patients leaving hospital to help them with their prescription medication.

It is further supported by a secure IT interface called PharmOutcomes to pass patient data quickly and seamlessly between hospital and community pharmacy. West of England AHSN is already engaged with NBT, RUH and UHB in the roll out of this system and will engage with our remaining acute Trusts in 2018/19.

PReCePT: We are the "exporting" AHSN for this programme of work and are supporting the other 14 AHSNs to adopt this treatment for reducing the incidence of cerebral palsy. In doing so we calculate we can collectively save 700 cases of cerebral palsy.

Atrial Fibrillation: We are continuing the roll out of Don't Wait to Anticoagulate (DWAC) and the deployment of the mobile ECG devices.

Emergency Laparotomy Collaborative: West of England were part of the three AHSN pilot for the ELC (along with Wessex and Kent, Surrey and Sussex AHSNs). Our focus will remain on sustainability and sharing of learning.

4. New Local programmes

The West of England Patient Safety Collaborative agreed to adopt the **Recommended Summary plan for Emergency Care and Treatment (ReSPECT)** across all services in the West of England. This was launched on 7 June 2018 with 130 delegates from across all our member organisations: GPs, Out-of-hours services, carers', organisations, hospices and care homes. Follow up work will now take place through STP focussed working groups. Mary Hutton is the SRO for this programme of work.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

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

Purpose

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

Key issues to note

The Medicines and Health Products Regulatory Agency (MHRA) concluded their inspection and accepted the Corrective and Preventative Action plan in March 2018.

Research income remains challenging and the loss of accreditation of the haematology laboratory has created some uncertainties with sponsors and Trials' units. We are working to open studies where this isn't an issue.

There are a number of strategic initiatives underway that will raise the profile of research in the Trust and support the Trust's *journey to outstanding.*

The Research 4 Gloucestershire initiative is developing slowly and has the potential to join up a number of areas of the NHS and Social Care. It covers the STP footprint and once agreed the work plan will provide opportunities for joint working.

Conclusions

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

Implications and Future Action Required

Research activity is reported monthly to the Quality and Performance Committee as part of the Quality and Performance report. Activity and performance is scrutinised at the quarterly Research and innovation Forum.

The Board receives biannual update report to provide assurance of the performance and governance of research within the Trust.

Recommendations
The Board is asked to accept this report as assurance of the performance and governance of research within the Trust.
Impact Upon Strategic Objectives
Impact Upon Corporate Risks
Regulatory and/or Legal Implications
Research activity is covered by specific regulatory framework administered by the Medicines and Health regulatory Authority. The MHRA inspected the Trust in October 2017.
Equality & Patient Impact
Research studies are accessible to all patients who meet the criteria of the studies.

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

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2018

RESEARCH AND DEVELOPMENT REPORT

AIM

To update the board on the Trust's current research portfolio, financial position and other issues of note.

BACKGROUND

Research is an important aspect of the day to day business of the NHS and provides the organisation, its patients and its staff with access to new drugs, devices and developments in the delivery of care that they would otherwise have to wait for. The Trust has a stable portfolio, hosting around 100 which are actively recruiting new participants.

For 2018/19 the Trust has agreed a new research objective: The Trust will have a high quality research portfolio, which is visible to staff and patients, embedded alongside routine care, and achieves the annual High Level Objectives (HLO) defined by the National Institute Health Research (NIHR).

KEY MESSAGES

Research Activity - NIHR Portfolio Studies

We expect to recruit around 800 patients into studies in 2018/19 based on studies that were open to recruitment in March 2018 and new studies in the pipeline and due to open in 2018-19. The loss of Haematology laboratory accreditation (UKAS) has caused some issues with trial sponsors who require certified accreditation to allow us to open the study in our Trust. We have already had one study closed (just after opening) and others will not proceed until this is rectified.

We may need to focus on studies that do not have this requirement or are observational to compensate for this problem to ensure we meet our target. The West of England Clinical Research Network (WE CRN) has imposed a "stretched" target taking us to 1000 participants this year. Our research activity, compared with the other Partner organisations in the WE CRN area is in Table one. These data show recruitment for April 2018 only as there is a delay in data being uploaded to the National portfolio Management System. The recruitment recorded until 31May is 126 and although on track to meet our target of 800 for the year is slightly short of the stretched target set us by the WE CRN.

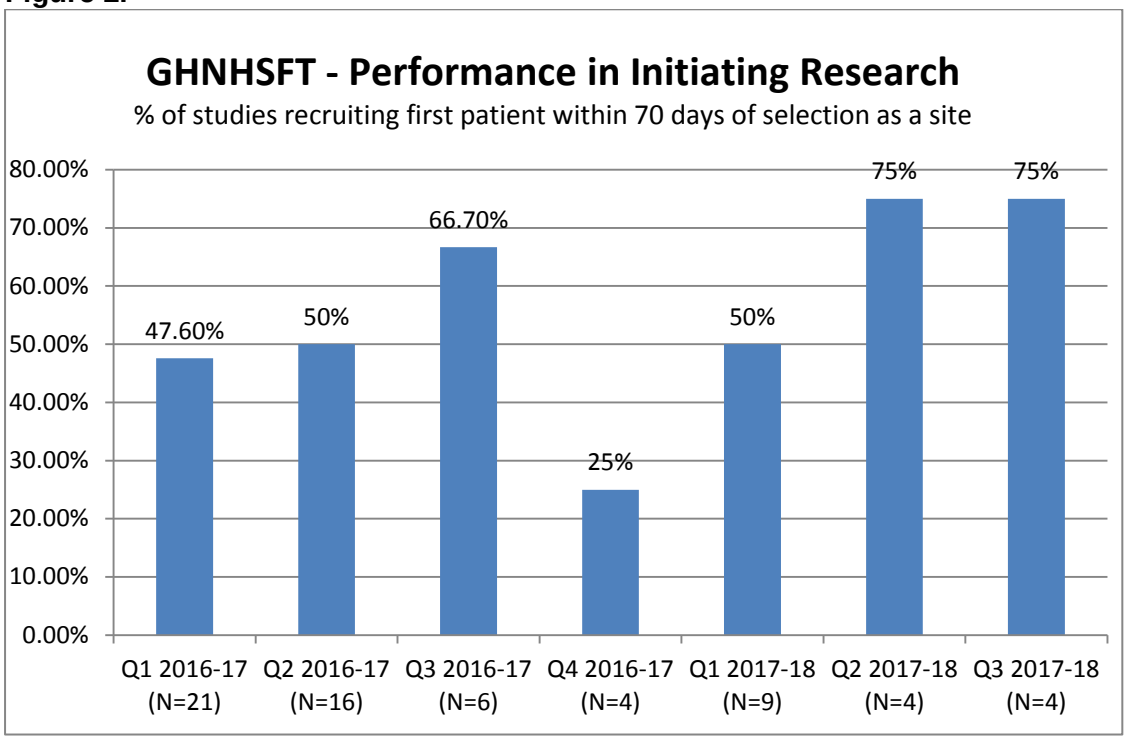
Table one. Research activity in West of England CRN partner organisations (data extracted 30. April)

Trust	Commercial recruitment	Non-commercial recruitment	Total	Weighted recruitment (ABF)	% year-to-date recruitment goal achieved
2Gether NHS Foundation Trust	0	28	28	135.5	122.18%
Avon And Wiltshire Mental Health Partnership NHS Trust	1	70	71	575.0	169.05%
Gloucestershire Care Services NHS Trust	0	9	9	39.0	216.00%
Gloucestershire Hospitals NHS Foundation Trust	1	41	42	356.3	50.40%
Great Western Hospitals NHS Foundation Trust	3	87	90	288.2	126.91%
North Bristol NHS Trust	9	206	215	1063.8	86.00%
Primary Care	21	250	271		58.07%
NHS Bath And North East Somerset CCG	0	6	6	58.5	
NHS Bristol, North Somerset and South Gloucestershire CC	5	77	82	607.0	
NHS Gloucestershire CCG	0	155	155	655.0	
NHS Swindon CCG	0	1	1	3.5	
NHS Wiltshire CCG	16	11	27	113.5	
Royal United Hospitals Bath NHS Foundation Trust	14	114	128	519.1	103.23%
University Hospitals Bristol NHS Foundation Trust	36	777	813	2167.4	143.98%
Weston Area Health NHS Trust	1	17	18	72.6	86.40%

We are performance managed on a number of High Level Objectives (HLO), set by the NIHR. We agreed an annual plan with the WE CRN in March 2018 which details how we propose to contribute to the network's delivery of the NIHR CRN High Level Objectives. Annex A provides the details of this plan, update on the delivery of the plan will be provided in the next report and our performance against HLO 4 and 5 compared with the other partner organisations in the WE CRN is shown in tables two and three in annex B. The NIHR is currently reviewing the HLOs and their definition with an aim to improve the consistency of reporting across different platforms.

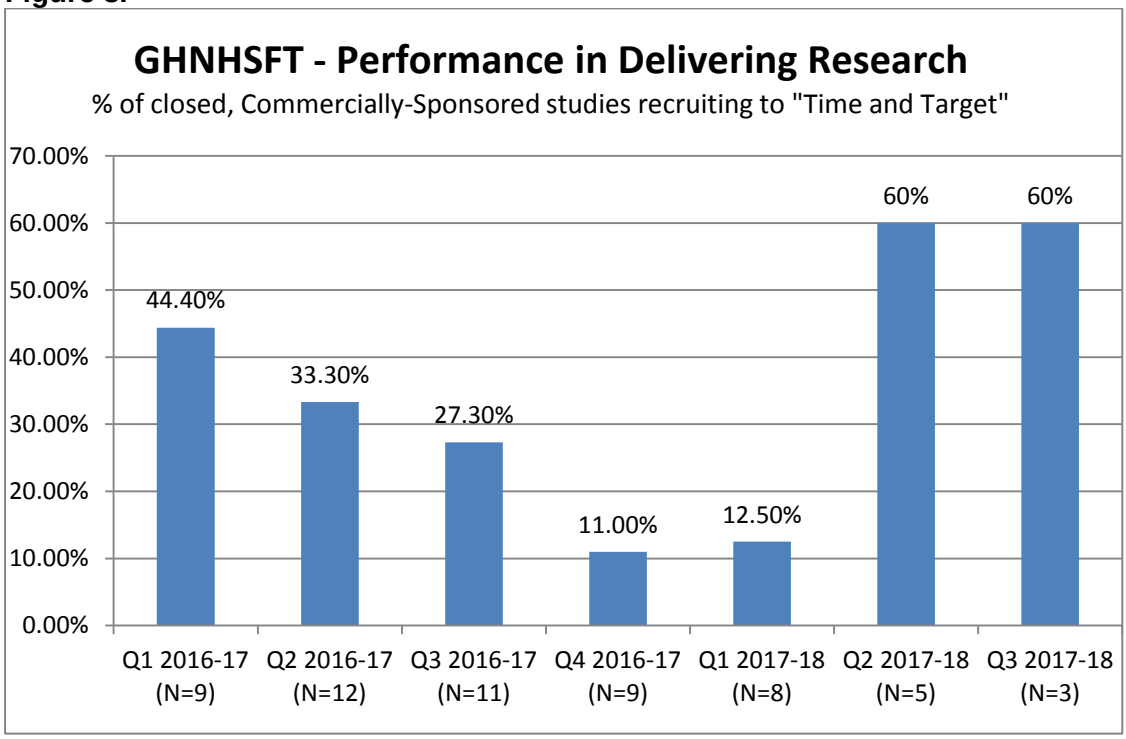
In addition, each quarter we have to report directly to the NIHR on study set up times (Figure two) and recruitment to time and target for commercial trials (Figure three). The calculation of the study set-up/recruitment metric changed in quarter 2 to include all studies reviewed as part of the new Health Research Authority approval process. These data are subject to wide fluctuations due to the small numbers involved and has improved, but we need to maintain our vigilance.

Figure 2.



Our performance in recruiting to Time and Target for commercially-sponsored trials indicates the percentage of closed studies meeting the target, a more difficult measure to achieve because it is not entirely within our control. If a study does not meet its recruitment target, even by one participant, it will be RAG rated red. This includes studies closed early by the company or studies closed by us because they are non-viable. We are trying to improve this performance by more stringent feasibility and by declining studies that we do not feel have realistic targets set by the pharma companies and although this has improved, there is still more to do.

Figure 3.



Research activity - Non- NIHR Portfolio Studies
We have 38 active non-portfolio studies, 36 are sponsored by academic institutions.

Finance
The main source of income is from the WE CRN and the allocation for 2018/19 is £1.1m. This represents a 10% increase in our allocation. We were not anticipating an increase income but changes in the way national allocations were made and our Trust's performance gave us a welcome increase. This may not be sustained into next year if we cannot meet our recruitment targets this year. A summary of R&D income and expenditure is in Annex C.

Additional income is secured through delivery of commercial trials which are reimbursed according to a nationally agreed funding template. At the end of 2017/18 we turned in a small surplus of £26K in spite of a challenging income target to cover the funding gap.

Outcome on the provision of Excess Treatment costs (ETCs)
NHS research can result in excess treatment costs. These are costs that arise as a result of the difference between the cost of standard treatment and the cost of treatment within a research study in non-commercial research projects. The complexity and variation in the process has caused continued frustration for all involved. The outcome of the consultation can be found at https://www.england.nhs.uk/wp-content/uploads/2018/05/supporting-research-in-the-nhs-consultation-response.pdf.

There will a transition phase from October 2018 with full implementation from April 2019. The model using a total (cumulative) ETC threshold per Trust, per financial year, based on Trust income, will be developed. Trust incomes will be banded to offer stability around the threshold year on year. Therefore, for all non-commercial studies that have ETCs, Trusts will be required to absorb them up to their threshold. Once the provider has absorbed their threshold for that year, they will have additional applicable ETCs funded through the new arrangements. Stream-lining of this arrangement will improve the speed that studies can be set up as currently the negotiation of ETCs can be a lengthy process.

Medicines and Health Products Regulatory Agency (MHRA) Inspection
The Corrective and Preventative Action (CaPA) plan was submitted to the MHRA and final closure of the inspection was received on 1. March 2018. Progress against the action plan is reviewed monthly in the R&D management group and by the Research and Innovation Forum quarterly; all of the corrective actions are complete and the preventative actions are on track.

Research Strategy
On 9th July we are running a research strategy development session with a cross-section of staff to define *what an outstanding research and development service looks like*, and the steps we will need to take to get there.

The output from this session will be used to refresh our Trust Research Strategy and provide a shared vision for the Trust ensuring that we can maximise the contribution that research can make to improving care for our patients.

Research culture
There has been a preliminary meeting with lead nurses and AHPs to explore ways in which we can build research capacity in these areas.
The Research 4 Gloucestershire initiative is progressing slowly and members of the steering group recognise the need to embed this initiative in their respective organisations. A role description for the new chair has been agreed and it is hoped that the post will soon be filled.

International Clinical Trials' Day (May 20th) is the annual NIHR I Am Research campaign which encourages patients, carers and the public to get involved in research and for 2018 the campaign also celebrated the NHS' 70th birthday (NHS70). We celebrated in a low key way by a series of tweets about research. We also had the opportunity to give interviews with Radio Gloucestershire on the importance of being able to take part in research; this was given by a patient who had been in a cancer trial and a member of the WE CRN staff. The interview recording has been made available on the NIHR website and can be accessed via https://www.nihr.ac.uk/news/crn-west-of-england-involved-in-lively-radio-debate-about-clinical-research/8776.

An information stand aimed at promoting GHT as a research active organisation gave out leaflets to staff in Foster's restaurant on June 27th. We have hopefully promoted the work of the team and the opportunities that exist for patients to take part in research studies within the Trust.

Patient experience
There is substantial evidence that suggests that patients value the opportunity to take part in trials and this extends beyond those who we treat. The excerpt below was part of a communication received recently from the widow of a patient who was treated as part of a trial.

> "My husband K was diagnosed with oesophageal cancer last August at Worcester Royal Hospital. He received outstanding care and responded well to the treatment. This result made him eligible to join a clinical trial at Cheltenham General Hospital. Our Oncologist at Worcester Dr Cheng Boon liaised with Dr Charles Candish at Cheltenham and very swiftly he began Immunotherapy every fortnight.
>
> We were apprehensive initially as we had an excellent relationship with all staff at WRH but very quickly we were made to feel safe and comfortable in our new surroundings. Sadly my husband died on 7th May in the Rendcomb Ward as the cancer was metastatic. I wish to convey my sincere thanks to all the medical staff we encountered.

> Dr Candish provided wonderful care and very quickly understood my husband. Rehana from the Clinical Trial team gave great reassurances and information, both of which were important to K ".

It was announced this week that a question will be added to the NHS Inpatient survey:

> "During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?

REPORTING

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

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

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

CONCLUSION

Research is an important aspect of the day to day business of the NHS and provides the Trust, its patients and its staff with access to new drugs, devices and developments in the delivery of care that they would otherwise have to wait for. It is part of our Journey to Outstanding.

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

Sponsor: Simon Lanceley, Director Clinical Strategy

3. July 2018

Annex A

Annual plan submitted to WE CRN

HLO	Measure	Performance 2017-18	Goal	Expected performance 2018-19	Three SMART objectives	Timescale	Lead
1	Increase the number of participants recruited to NIHR portfolio studies	We exceeded our target of 1000 this year. This excluded the ophthalmology study that was considered a fortuitous gain when it was adopted late to the portfolio.	Goal for 2018/19 – 800 patients	We expect to recruit 800 patients based on our current open and pipeline studies. We do not know how the loss of accreditation of our haematology lab will affect our ability to recruit to interventional studies so may need to focus on observational studies for the time being.	• To ensure we have a flexible workforce to deliver a range of studies in a potentially shifting portfolio • To open studies where wider clinical support is evident, i.e. cross referrals and clear cooperation across clinical teams • Ensure studies are feasible within the current laboratory constraints	March 2019	Julie Hapeshi

2	Increase the proportion of studies in the NIHR CRN portfolio delivering recruitment to time and to target.	RAG report indicates 50% of closed studies reaching the target	Commercial: 80%	Our target is 80% although our expected performance is 60%	• Ensure accurate initial target setting especially where recruitment windows are short. • Monthly review of studies rated amber to move them back into “green” • To open studies where wider clinical support is evident, i.e. cross referrals and clear cooperation across clinical teams • Monthly review of studies nearing end of recruitment window to ensure they meet their targets	March 2019	JH
		Currently at 50%	Non-commercial: 80%	Our target will be 80% but our expected performance is 60% to improve on last year’s figure	• As above	March 2019	JH

3	Increase the number of commercial studies	At the start of the year we planned to have 20 studies open. We did not meet our target to increase from 20 to 24 open studies by the end of the year. This was affected by 3 studies which were closed early by the sponsor and one study remains suspended.	Maintain level of 20 studies	We will aim to maintain our level at 20 commercial studies. We have 4 studies due to close, 4 in set up and are currently uncertain what the impact of our labs loss of accreditation may have on our ability to open studies.	• Open viable, commercial studies by improving the scrutiny at capacity and capability assessment. • Prompt completion and return of EOIs • Monthly review of EOIs	March 2019	JH
4	Reduce the time taken to start up studies.	We have not achieved our target. 0% commercial (0/1 studies) and 33% non-commercial	80% of all studies achieve ready to start confirmation within 40 calendar days (TBC)	Our target will be 80% but our performance is likely to be 50% for both commercial and non-commercial studies	• Weekly meetings with delivery team and RM&G staff to ensure progress in capacity and capability checks and earlier engagement with delivery teams to clearly identify potential delays in set-up so that they can be dealt with sooner. • Clear communication with wider team around timelines	March 2019	JH

5	Reduce the time taken to recruit the first patient to NIHR portfolio studies	We have not achieved our target. 33% commercial and 50% non-commercial studies	80% of studies recruit first patient within 30 calendar days of NHS permission or site initiation	Our target will be 80% but our performance is 50% of commercial studies and 60% of non-commercial studies meeting the target of first patient recruited within 30 days	• Weekly meetings with Delivery team and RM&G team to ensure they are informed of progress through capacity and capability checks • Preselect patients using registers and by screening clinic attendees where possible • Careful monitoring of communication with trials officers/ sponsors to ensure accurate start and end dates for HLO metrics	March 2019	JH

7	Increase recruitment to DeNDRoN studies	We considered a shared arrangement with 2Gether NHS FT for suitably qualified staff to recruit to dementia studies within the acute setting and a bid for development funding was submitted. This was placed on hold whilst the peripatetic team was established. There were no suitable studies	Goal for 2018/19 Non-dementia neurology study targets are noted in the neurology section	No target	JDR leaflets are circulated within the Trust	N/A	

Annex B

Table 2. NIHR HLO4 – NHS set up at site within 40 calendar days of receiving full HRA pack = site selected by sponsor

Trust	Commercial status	NHS set up at site within 40 calendar days (HLO 4)			
		No. studies	No. achieving HLO 4	%age achieving HLO 4	Median
2gether NHS Foundation Trust	Commercial	2	1	50.00%	-
	Non-commercial	10	8	80.00%	25.5
	Total	**12**	**9**	**75.00%**	**25.5**
Avon and Wiltshire Mental Health Partnership NHS Trust	Commercial	6	5	83.33%	29
	Non-commercial	19	18	94.74%	35
	Total	**25**	**23**	**92.00%**	**35**
Gloucestershire Care Services NHS Trust	Commercial	0	0	-	-
	Non-commercial	1	0	0.00%	64
	Total	**1**	**0**	**0.00%**	**64**
Gloucestershire Hospitals NHS Foundation Trust	Commercial	8	4	50.00%	39.5
	Non-commercial	26	14	53.85%	33
	Total	**34**	**18**	**52.94%**	**36**
Great Western Hospitals NHS Foundation Trust	Commercial	9	4	44.44%	47
	Non-commercial	12	10	83.33%	21
	Total	**21**	**14**	**66.67%**	**22**
North Bristol NHS Trust	Commercial	20	8	40.00%	43
	Non-commercial	53	37	69.81%	24
	Total	**73**	**45**	**61.64%**	**31**
Royal United Hospitals Bath NHS Foundation Trust	Commercial	17	10	58.82%	16
	Non-commercial	28	12	42.86%	58
	Total	**45**	**22**	**48.89%**	**54**
University Hospitals Bristol NHS Foundation Trust	Commercial	49	29	59.18%	32
	Non-commercial	80	61	76.25%	20
	Total	**129**	**90**	**69.77%**	**24**
Weston Area Health NHS Trust	Commercial	1	1	100.00%	29
	Non-commercial	10	9	90.00%	26
	Total	**11**	**10**	**90.91%**	**29**

Table 3 NIHR HLO5 – first participant recruited within 30 calendar days of date Trust confirmed at site

Trust	Commercial status	First participant recruited within 30 days at site (HLO 5)			
		No. studies	No. achieving HLO 5	%age achieving HLO 5	Median
2gether NHS Foundation Trust	Commercial	1	0	0.00%	140
	Non-commercial	9	5	55.56%	29
	Total	**10**	**5**	**50.00%**	**35**
Avon and Wiltshire Mental Health Partnership NHS Trust	Commercial	6	2	33.33%	59.5
	Non-commercial	19	10	52.63%	27
	Total	**25**	**12**	**48.00%**	**32**
Gloucestershire Care Services NHS Trust	Commercial	0	0	-	-
	Non-commercial	0	0	-	-
	Total	**0**	**0**	**-**	**-**
Gloucestershire Hospitals NHS Foundation Trust	Commercial	5	2	40.00%	38
	Non-commercial	22	8	36.36%	45
	Total	**27**	**10**	**37.04%**	**40**
Great Western Hospitals NHS Foundation Trust	Commercial	8	4	50.00%	38
	Non-commercial	12	5	41.67%	40
	Total	**20**	**9**	**45.00%**	**40**
North Bristol NHS Trust	Commercial	18	6	33.33%	40.5
	Non-commercial	45	12	26.67%	44
	Total	**63**	**18**	**28.57%**	**44**
Royal United Hospitals Bath NHS Foundation Trust	Commercial	12	4	33.33%	64
	Non-commercial	22	11	50.00%	28
	Total	**34**	**15**	**44.12%**	**35.5**
University Hospitals Bristol NHS Foundation Trust	Commercial	35	16	45.71%	33
	Non-commercial	64	28	43.75%	41
	Total	**99**	**44**	**44.44%**	**35**
Weston Area Health NHS Trust	Commercial	1	1	100.00%	11
	Non-commercial	9	1	11.11%	42
	Total	**10**	**2**	**20.00%**	**41**

Annex C

Projected Income & Expenditure 2018/19

	£
Projected Expenditure	
Pay	1,870,731
Non Pay	100,684
Overheads to Trust (from CLRN, RCF & RDS Contracts)	89,817
Overheads to Trust (from Commercial studies)	17,443
Total Projected Expenditure 2018/19	**2,078,675**
Projected Income	
WE CLRN Income	1,184,936
Research Capability Allocation (DH)	26,358
Charity Allocation (Linc)	21,995
HTA Grant - BOSS Study	94,003
Biophotonic Grants	125,621
RDS Contract	55,894
GRSS SLA*	48,709
GRSS SLA GHNHSFT Contribution	26,004
Confirmed Income from open studies	115,323
Other (secondment)	3,600
Deferred Income carried forward form from 2017/18	25,926
Total Projected Income	**1,728,369**
Forecasted additional projected related income	327,399
Total Expected Income	**2,055,768**
Income target to balance	**- 22,907**

* under negotiation

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

Report Title
Organ Donation Activities Report
Sponsor and Author(s)
Author: Dr Mark Haslam, Consultant in Anaesthesia and Intensive Care Medicine Sponsor: Dr Sean Elyan, Medical Director
Executive Summary

Purpose

To update the Board on the positive progress in respect of organ donation activities.

Key issues to note

- Management of the Donation after Brain Death (DBD) pathway achieved 100% for all stages to consent for the second consecutive year.
- The pathway involving patients as Donors after Circulatory Death (DCD) continues to show an increased referral rate year. In 2017/2018 our referral rate was 97%, up from 84% last year (national rate 89%).
- 12 patients received life-changing or life-saving transplants as a result of donations from GHNHSFT.

Conclusions

We have achieved a cultural change making organ donation an integral part of End of Life Care in our Trust (referral rates for DBD and DCD were just 50% and 33% in 2010/2011).

Implications and Future Action Required

1. Continue to discuss organ donation openly and honestly with patients and families of those patients who are potential donors.

2. Ensure our staff are adequately trained and supported, working alongside specialist nurses to help families through the donation process.

Recommendations
The Board is asked to receive this report as a source of assurance regarding the quality of organ donation activities in the Trust.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
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)**
Outcome of discussion when presented to previous Committees						
N/A						

Actual and Potential Deceased Organ Donation 1 April 2017 - 31 March 2018

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

Taking Organ Transplantation to 2020

In 2017/18, from 8 consented donors the Trust facilitated 4 actual solid organ donors resulting in 12 patients receiving a life-saving or life-changing transplant.

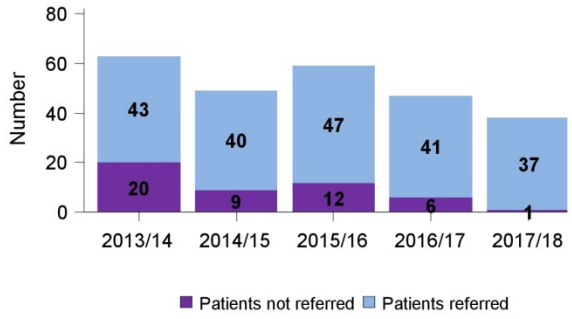
In addition to the 4 proceeding donors there were 4 additional consented donors that did not proceed.

Best quality of care in organ donation

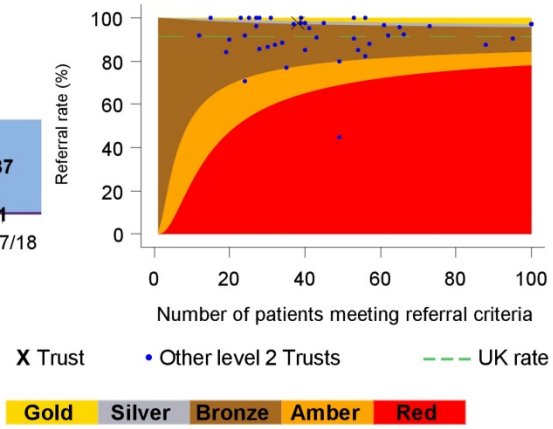
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



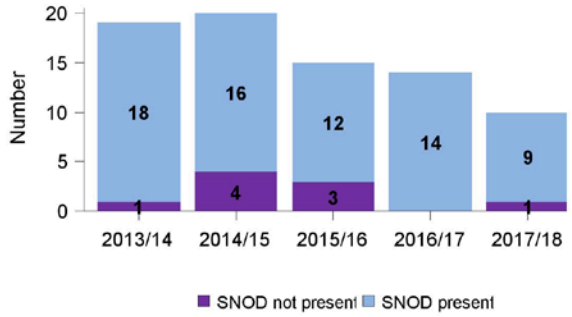
The Trust referred 37 potential organ donors during 2017/18. There was 1 occasion where a potential organ donor was not referred.

When compared with UK performance, the Trust was good (silver) for referral of potential organ donors to NHS Blood and Transplant.

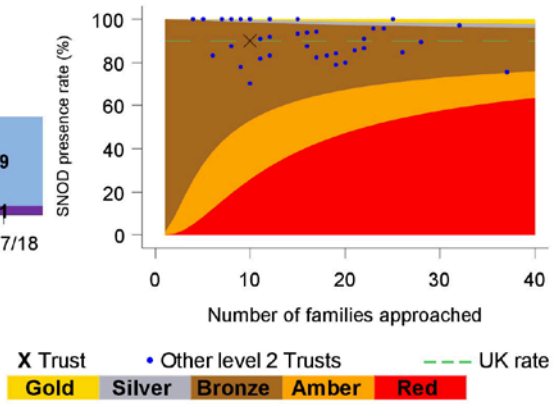
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 9 organ donation discussions with families during 2017/18. There was 1 occasion where a SNOD was not present.

When compared with UK performance, the Trust was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2017 - 31 March 2018		
Deceased donors	118	1,574
Transplants from deceased donors	306	4,012
Deaths on the transplant list	24	426
As at 31 March 2018		
Active transplant list	463	6,045
Number of NHS ODR opt-in registrations (% registered)**	2,543,155 (46%)	24,941,804 (38%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.47 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison.

Key numbers, rates and comparison with UK data, 1 April 2017 - 31 March 2018

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	7	1954	31	6281	38	7978
Referred to Organ Donation Service	7	1929	30	5615	37	7302
Referral rate %	G *100%*	*99%*	S *97%*	*89%*	S *97%*	*92%*
Neurological death tested	7	1676				
Testing rate %	G *100%*	*86%*				
Eligible donors[2]	6	1582	18	4456	24	6038
Family approached	6	1471	4	1858	10	3329
Family approached and SNOD present	6	1394	3	1591	9	2985
% of approaches where SNOD present	G *100%*	*95%*	B *75%*	*86%*	B *90%*	*90%*
Consent ascertained	4	1066	3	1115	7	2181
Consent rate %	B *67%*	*72%*	B *75%*	*60%*	B *70%*	*66%*
Actual donors (PDA data)	2	955	1	613	3	1568
% of consented donors that became actual donors	*50%*	*90%*	*33%*	*55%*	*43%*	*72%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

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

Report Title
Annual Appraisal / Revalidation Board Report – Senior Medical Staff
Sponsor and Author(s)
Author: Dr Elinor Beattie, Associate Medical Director Sponsor: Dr Sean Elyan, Medical Director
Executive Summary
Purpose This is the update on Senior Doctor Appraisal and Revalidation programme which is required to be presented to the Trust Board on an annual basis in line with the national recommendations relating to medical revalidation. Key issues to note • The second cycle of medical revalidation is now in to its second year with processes embedded. • Recruitment of appraisers remains difficult and a number of experienced appraisers have retired in the last 12 months. • Action plan following the Higher Level Responsible Officer quality Review in 2016 has now been completed. Conclusions The Appraisal and Revalidation process within the Trust is now embedded, and the external and internal processes provide assurance that this is being undertaken to the required standard. Implications and Future Action Required Support the alignment of the appraisal resource to the Medical Director budget.
Recommendations
The Board is asked to receive the report as a source of assurance regarding the quality of medical appraisal and revalidation throughout the Trust.
Impact Upon Strategic Objectives
Supporting medical staff to achieve the Trust goals in relation to feeling valued and involved and wanting to improve.
Impact Upon Corporate Risks
None.
Regulatory and/or Legal Implications
Medical Revalidation is a statutory requirement of the General Medical Council.

Equality & Patient Impact							
None.							
Resource Implications							
Finance		**x**	Information Management & Technology				
Human Resources		**x**	Buildings				
Action/Decision Required							
For Decision		For Assurance	√	For Approval		For Information	√

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2018

ANNUAL APPRAISAL / REVALIDATION BOARD REPORT – SENIOR MEDICAL STAFF

1. Purpose of Report

1.1 To provide an up to date review of the Appraisal and Revalidation processes for the Board.

2. Executive Summary

2.1 Revalidation began in December 2012, and the second cycle of revalidation is underway. 515 appraisals were completed last year for a total number of 554 doctors with prescribed connection in this organisation.

2.1 NHS England request quarterly reports and an end of year report. See Appendix 1 which is the end of year return requested by NHS England for the financial year of 2017/18.

3. Background

3.1 The Revalidation Operation Group meets quarterly to ensure that the Revalidation process is working and to discuss any problems. The group is made up of the Responsible Officer, Appraisal Lead, Medical Staffing Manager, Appraisal/Revalidation Officer and Revalidation Administrator.

3.2 The Responsible Officer, along with the Medical Staffing Manager and Appraisal/Revalidation Officer, ensure that all paperwork required for Revalidation is in place. Once a decision has been made by the RO, the GMC are informed of the outcome, along with the doctor.

3.3 Documents relating to the appraisal and revalidation process have been updated to be compliant with the current national guidance and have been added to the appraisal and revalidation site on the intranet.

3.4 The Appraisal Steering Group meets half yearly. Membership consists of:

- The Appraisal Lead (Chair)
- Responsible Officer (Medical Director)
- LNC representative
- Two SAS Doctors, and
- Two Consultants.

3.5 The present members are:

- Dr Sean Elyan, RO
- Dr Steve Cooke, LNC Representative
- Dr Nicol Vaidya, SAS Doctor
- Dr Caroline Harvey, SAS Doctor
- Dr Mark Slade, Consultant
- Dr James de Courcy, Consultant

3.6 The Appraisal Officer services these meetings. The Group reports to the Director of Medical Education, Quality Committee, LNC and Trust Board annually.

3.7 There are forty appraisers. This includes five appraisers who are currently on "zero hours" contracts having retired but who are employed to continue as appraisers.

3.8 A system has been put in place to capture the appraisal of those doctors who have their main employment within Gloucester Care Commission and Care Services along with those on honorary contracts.

4. Quality Assurance

4.1 Appraisees evaluate their appraisals and this feedback is sent to the Appraisers annually.

4.2 Appraisers are required to reflect on their performance. The number of appraisals they carry out, the number signed off within 28 days and the number of Support Groups they attend are recorded. The Appraisers meet with the Appraisal Lead on a yearly basis to discuss their performance.

4.3 Quality Assurance of the appraisal summaries and pdp's using a standard tool is carried out. This has been carried out by the appraisers at the Appraisal Support Groups. We aim to review two summaries form each appraiser. Once marked, the overall score is forwarded to the appraiser for their education. We had an independent verification visit from the team from NHS England in November 2016.

4.4 Report Form A: this form will be completed by the Speciality Director or Chief of Service and will be reviewed at the appraisal by the appraiser. This has been piloted and is being reviewed.

4.5 Four appraiser Support Groups take place each year. Appraisers are expected to attend two. This has ensured that all appraisers are up to date with current legislation and changes to the appraisal revalidation process.

4.6 Two lay representatives have been appointed to support the appraisal process. At present, they are involved in the recruitment of appraisers and attend the appraiser support groups.

5. Clinical Governance

5.1 The appraisal process requires links to strong clinical governance processes. The Audit Department provides details of any audits for which senior medical staff have been nominated as lead. This Risk Department send a report to those who have been involved in a Serious Untoward Incident. A nil return is sent to all other Senior Medical Staff by the Appraisal Administrator.

5.2 New guidance form NHS England requires all appraisals to be carried out within 12 months of the last one. Extensions should be agreed with the RO.

6. Information Systems

6.1 The patient and Colleague feedback process is administered through the appraisal administration team.

6.2 Appraisals themselves are recorded on the MAG (Medical Appraisal Guide) form. Anew MAG form has been produced by NHS England. These should be

completed and returned to the appraisal administration team within 28 days of the date of the appraisal.

7. Financial Implications

7.1 The cost of managing revalidation and appraisal has previously been presented. No new additional costs have been identified. However, as appraisers retire or leave the Trust, retaining the funding for appraisers to maintain an adeuqte4 cohort of appraisers is important.

8. Recommendations – To Note

8.1 The Board is asked to note the current state of progress of medical appraisal and revalidation to national guidelines.

Author: **Dr Elinor Beattie, Associate Medical Director**

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

Date: **July 2018**

APPRAISAL 2018							
1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2018 would be included.		1a	1b	2	3	
	Where the answer is "nil" please enter "0".	Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	TOTAL
	See guidance notes on pages 16-18 for assistance completing this table.						
1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government / other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS Trust where they perform their clinical work).	398	295	76	13	14	398
1.2	**Staff grade, associate specialist, speciality doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government / other public body staff).	76	64	8	3	1	76
1.3	**Doctors on Performers' Lists** (for NHS England and the Armed Forces only, doctors on a medical or ophthalmic performers' list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).						
1.4	**Doctors on practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).						
1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, Trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts etc).	80	68	4	0	8	80
1.6	**Other doctors with a prescribed connection to this designated body** (depending on this type of designated body, this category may include responsible officers, locum doctors, and members of the faculties / professional bodies. It may also include some non-clinical management / leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).						
	TOTAL (this cell sill sum automatically 1.1 - 1.6).	554	427	88	16	23	554

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Guardian for Safe Working – Quarterly Report
Sponsor and Author(s)
Author: Dr Sean Elyan, Medical Director Sponsor: Dr Simon Pirie, Guardian for Safe Working
Executive Summary
Purpose This report covers the period of 1.2.18 – 30.4.18. Key issues to note There were 217 exception reports logged There are a total of 11 fines including those for the last quarter, to the value of £14,869.13. Conclusions The reports identify occasions where doctors in training are working beyond scheduled hours to maintain service delivery. The process continues to identify departments where the workload, staffing numbers and support remain an issue. Meetings have been held with department leads where these high levels of reports occur to further understand the issues and remedy the situation. Implications and Future Action Required Continued support for the Guardian role and for the proposed solutions to issues that arise.
Recommendations
Continue current monitoring and engagement with teams where exception reporting is occurring.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hour's limits.
Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees
N/A

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2018

GUARDIAN REPORT

1. Executive Summary

1.1 This report covers the period of 1.2.18 – 30.4.18. There were 217 exception reports logged; compared to 268 in the last quarter.

1.2 We have seen a number of issues clustering in certain specialties.

1.3 We have needed to levy some fines. These are detailed below, several were carried over from the last quarter, but we are now up to date. There are a total of 11 fines including those for the last quarter, to the value of £14,869.13. Overall, the processing of exception reports has greatly improved as compared to the last quarter; however, there still remain a small number of educational supervisors who have not engaged in the process. The Junior Doctor's forum is fully functioning and meets quarterly.

2. Introduction

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

2.2 Doctors in training may raise an exception report whenever working hours breach those set out in their personalized work schedule. An exception report is initially reviewed and addressed by the educational supervisor or nominated deputy. If appropriate, time off in lieu or payment for extra hours worked is agreed. In certain circumstances, a fine may be levied for exceeding safe working limits (see appendix for links to rota rules and pathways). The aim is to have a system in place where fines are not required.

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

3. High Level Data

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

4. Junior Doctor Vacancies

Junior Doctor Vacancies by department (January 2017)					
Department	***F1***	***F2***	***ST 1-2***	***ST3-8***	***Additional training and trust grade vacancies***
ED	1		2		Core Medical Trainee Y1- Gen Med (Gastro) 1 gap Clinical Fellow- Urology 1 gap Clinical Fellow - ED 2 gaps Chief Registrar- Gen Med 2 gaps Fellow –Ophthalmology – 1 gap
Oncology			2		
T&O			2		
Surgery			1	3	
General Medicine			15	8	
Paeds				4	
Obs & Gynae				2	

5. Locum Bookings

Data from finance team:

The total Junior Medical Locum spend from November 2017 to January 2018 was £639,520.

6. Exception Reports (working hours)

Exception reports by department		
Specialty	***Exceptions carried over from last report***	***Exceptions raised***
General/GI Surgery		38
Urology		
Trauma/ Ortho		16
ENT		
Vascular Surgery		
Ophthalmology		3
Orthogeriatrics		
General/old age Medicine		144
Acute medicine/ ACUA		14
Emergency Department		
Obstetrics and Gynaecology		2
Paediatrics		
Total		217

Exception reports by Division				
Specialty	***Exceptions carried over from last report***	***Exceptions raised***	***Exceptions Closed****	***Exceptions outstanding***
Surgery		57		
Medicine		158		
Women and Children		2		
Diagnostic / specialties		0		
Total		217		

7. Fines this Quarter

Fine by Department				
Rota cycle	***Department***	***Hours***	***Fine***	***When levied***
5.12.17-3.4.18	Neuro	74	2826.39	Mar-18
04.12.17-02.04.18	Renal	20	766.01	May-18
04.12.17-02.04.18	Gastro	92.5	2549.84	May-18
7.8.17-2.4.18	Renal	16.25	622.38	May-18
4.12.17-19.3.18	Colo surg	12.5	478.75	May-18
4.12.17-2.4.18	Neuro	38.25	146**7**.98	May-18
6.11.17-2.4.18	Gastro	39.75	1522.43	May-18
04.12.17-02.04.18	Care of the Elderly	46.75	1790.53	May-18
Total		**340**	**12024.31**	

8. Fines Carried Over from Previous Quarter

Fine by Department				
Rota cycle	**Department**	**Hours**	**Fine**	**When levied**
31.7.17-27.11.17	Neuro	57.25	2203.30	Mar-18
4.12.17-22.1.18	Colo surg	6	229.80	Mar-18
4.12.17-15.1.18	Resp	10.75	411.73	May-18
Total		**68**	**2844.83**	

Fines (cumulative)			
Balance at end of last quarter	***Fines this quarter***	***Disbursements this quarter***	***Balance at end of this quarter***
2844.83	12024.31	14869.14	0

9. Examples of Positive Change

9.1 The new system has helped inform areas of practice where there have been challenges. An example of positive change in the last 6 months has been in neurology, where there were a high number of reports related to workload and finishing late. Working with the departmental leads, DME and TPDs, it was recognised that carrying out a ward round in the afternoon after a morning clinic led to challenges completing tasks from the ward round in time. The department has changed the clinic schedule so that ward rounds occur in the mornings now. This has been accompanied by a good level of Consultant ward support. Exception reports appear to be less in this area for this quarter.

10. Issues Arising

10.1 Four reports were raised as 'immediate safety concerns'. These were related to inadequate staffing and/or inadequate senior cover. Doctors were contacted by the Guardian and meetings arranged with the relevant teams. No patient harm appears to have resulted from these episodes.

11. Actions Taken to Resolve Issues

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

12. Qualitative Information

12.1 The Allocate software for raising exception reports came into use on the 1st October 2017. It remains challenging to retrieve and utilise data. In order to understand whether exceptions have led to fines being indicated, reports need to be reviewed manually which takes a lot of time. Also, medical staffing are working to change the labels for each team on the system, as the current situation is that teams are not logged specifically; ie gen med neurology. Therefore it is hard to look more specifically at each specialty. We have also asked whether it is possible to benchmark our performance with other trusts using Allocate, this is not possible at present.

13. Summary

13.1 A total of 217 working hours exception reports have been made since the beginning of February 2018 – end April 2018. The reports identify occasions where doctors in training are working beyond scheduled hours to maintain service delivery. The process continues to identify departments where the workload, staffing numbers and support remain an issue. Meetings have been held with department leads where these high levels of reports occur to further understand the issues and remedy the situation. I work closely with the Kim Benstead (DME) and training programme directors to continue to focus on safe working and optimal training.

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

Presenting Director: **Dr Sean Elyan**

Date 1/6/2018

Appendices

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 18TH APRIL 2018 AT 5.30PM

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

PRESENT	Sandra Attwood	Staff, Nursing and Midwifery
Governors	Richard Baker	Staff, Other and Non-Clinical
	Geoff Cave	Public, Gloucester
	Anne Davies	Public, Cotswold
	Pat Eagle	Public, Stroud
	Charlotte Glasspool	Staff, Allied Health Professionals
	Andrew Gravells	Appointed, County Council
	Colin Greaves	Appointed, Clinical Commissioning Group
	Marguerite Harris	Public, Out of County
	Alison Jones	Public, Forest of Dean
	Nigel Johnson	Staff, Other and Non-Clinical
	Tom Llewellyn	Staff, Medical and Dental
	Jeremy Marchant	Public, Stroud
	Jacky Martel	Appointed, Carers Gloucestershire
	Sarah Mather	Staff, Nursing and Midwifery
	Maggie Powell	Appointed, Healthwatch
	Alan Thomas	Public, Cheltenham (Lead Governor)
	Valerie Wood	Public, Forest of Dean
Directors	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Tracey Barber	Non-Executive Director
	Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
	Alison Moon	Non-Executive Director
IN ATTENDANCE	Lukasz Bohdan	Director of Corporate Governance
	Sean Elyan	Medical Director
	Simon Lanceley	Director of Strategy and Transformation
	Caroline Landon	Chief Operating Officer
	Sarah Stansfield	Interim Director of Finance
	Natashia Judge	Board Administrator
APOLOGIES	Liz Berragan	Public, Gloucester
	Graham Coughlin	Public, Gloucester
	Jenny Hincks	Public, Cotswold
	Ann Lewis	Public, Tewkesbury
PRESS/PUBLIC	None	

029/18 DECLARATIONS OF INTEREST — ACTION

There were none.

030/18 MINUTES OF THE MEETING HELD ON 21ST FEBRUARY 2018

RESOLVED: The minutes of the meeting held on 21st February 2018 were agreed as an accurate record and signed by the Chair.

031/18 MATTERS ARISING

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. The Lead Governor requested the Director of Corporate Governance review the Constitution and take a view as to what this Trust would do.
Ongoing: This will be addressed as part of the Constitution Review Group

DECEMBER 2017 101/17 ANY OTHER BUSINESS - THE LEAD GOVERNOR NOTED THAT THE PRESENTATION OF BOARD REPORTS AND CHAIR'S REPORTS TO THE COUNCIL MAY NEED TO BE CONSIDERED AS ON SOME OCCASIONS THIS CAN RESULT IN FAIRLY HISTORIC INFORMATION BEING RELAYED
Chair to consider.
Completed: Addressed as part of the agenda

FEBRUARY 2018 005/18 REPORT OF THE CHIEF EXECUTIVE - AMBULANCE HANDOVER IMPROVEMENTS
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.
Completed: By Specialty Director.

FEBRUARY 2018 006/18 REPORTS FROM BOARD COMMITTEES - 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.
Completed: Reports will remain the same however executives will provide a presentation with contemporary updates.

FEBRUARY 2018 006/18 REPORTS FROM BOARD COMMITTEES - COST IMPROVEMENT PLAN (CIP) PRESENTATION
Interim Director of Finance to provide a presentation around CIP.
Completed: Added to work plan.

FEBRUARY 2018 009/18 THE ROLE OF THE AUDIT AND ASSURANCE COMMITTEE
Presentation postponed until the next meeting.
Completed: Added to agenda.

FEBRUARY 2018 011/18 QUALITY ACCOUNT AND GOVERNORS INDICATOR
To be discussed at the next Strategy and Engagement Group.
Completed: Discussed at an extraordinary Council of Governors.

FEBRUARY 2018 011/18 QUALITY ACCOUNT AND GOVERNORS INDICATOR - GOVERNORS ANNUAL WORK PLAN
To be created.
Completed: Created and will be included within the confidential papers moving forward.

032/18 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 advised that following the extraordinary Council of Governors held in March Julius Marstrand was no longer a public governor for Cheltenham. The Chair said that Julius Marstrand had dedicated a considerable amount of time and effort to the Trust and thanked him for his involvement over the years.

The Chair welcomed questions or comments from Governors. The Lead governor asked about the meeting with David Drew, Labour MP for Stroud, and wondered if this was successful. The Chair said that the conversation was broad-ranging and much appreciated. He advised that ongoing dialogue with all MPs was important and felt it had been important to meet with Mr Drew following the concerns he had raised regarding the Estates and Facilities Subsidiary Company, on which he seemed reassured. Regular meetings with all MPs would continue.

033/18 REPORT OF THE CHIEF EXECUTIVE

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

- The recent change in operational performance with the Trust achieving the current national requirement of 90% or above against the four hour Accident and Emergency (A&E) standard.
- The work being undertaken to improve the hospital "back door".
- A recent event EndPJParalysis had been held and the success of the initiative aimed at supporting older patients to be up, dressed and more mobile was described.
- The theme of celebration across the Trust with the Breeze local radio station celebrating local heroes as well as the National Patient Experience Awards.
- The recent proposed changes to the NHS Pay Award and reassurance that this would come from new money in this year's allocation. The Chief Executive felt this would make staff feel more valued and would hopefully increase retention. She reflected on the impact of the award on other sectors such as social care.
- Gloucestershire Managed Services and the new interim Chair, Kathy Headdon, and her passion for innovation and transformation.
- The Trust's successful bid for capital which sees £39.5m allocated. While this does not address all of the Trusts needs, it will enable a great deal of progress. The Chief Executive reinforced that change would not take place overnight and that the timeline would extend to 2021; however as much as possible would be fast tracked.
- The Journey to Outstanding (J2O) event held on 13th April and the success of the movement with staff and clinicians engaged in bringing about outstanding care.

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

- Sandra Attwood queried how the Council would receive updates on Gloucestershire Managed Services (GMS) and performance against KPIs. The Trust Chair advised that the Council would receive the GMS Committee Chair's Report.
- Alison Jones wondered how GMS staff would be affected by the recent changes to staff pay awards and whether this would adversely affect the financial plans. The Chief Executive advised that historically pay awards were funded through the national payment by results tariff for services annual uplift. Colin Greaves expressed concern regarding whether funding would come through tariff as he had heard otherwise, to which

the Chief Executive replied that this had always been the procedure but given the in-year nature of this increase it was possible that the first year may be handled differently but detail wasn't yet available. In response to concerns about GMS staff, she confirmed that whatever the funding source, the Board would honour its commitment to transferring staff Terms & Conditions.

- Nigel Johnson noted the Trust's sickness rates and that work was being undertaken alongside unions to address this. He wondered if this was a national or regional strategy. The Chief Executive advised that this was a national strategy and that as part of the negotiations for the new pay award it was agreed that work would be undertaken to review the high levels of absenteeism. She hoped that the new pay award would support staff in feeling valued, reducing sickness and support recruitment and retention which would put less pressure on staff which we know is a contributor to staff sickness. The Trust is also focusing on managing sickness and absenteeism through a range of local initiatives and programmes and notably by focussing on those areas and staff groups where it is highest. Tracey Barber advised that the Workforce Committee would be looking at different staff groups at its next Committee to investigate specific solutions.
- Geoff Cave reflected on patient experience and wondered what results the project on ward 7a produced. Claire Feehily advised that the project team presented to the Governors Quality Group and that it would be worth the team returning to share how improvements had been embedded and spread. **CF/ SH**
- The Lead Governor advised that governors were keen to focus on patient experience over the next 9-12 months and reinforced the importance of linking patients into the capital work which would be enabled by the recent capital award. The Chief Executive welcomed this, and the Chair advised that he, the Lead Governor and the Chief Executive should meet and discuss how the Governors' Quality Group could be used to enable this. He asked the CEO to arrange. **DL**
- Alison Moon described a recent Journey to Outstanding (J2O) event and how powerful this was. She encouraged governors to attend the next event.

034/18 REPORTS FROM BOARD COMMITTEES

Finance Committee – March Board Report & Chair's Report from 28th February 2018

The Director of Finance presented the March Board report to the Council and provided a contemporary update including the latest forecast position for 2017/18. This would later go to the next Finance Committee and subsequently the Board. Key aspects highlighted included the impact of TrakCare, Cost Improvement Plan (CIP) performance (5.7% for the year), winter pressures funding, commissioner settlements and the projected forecast outturn deficit of £31.8m.

Mr Norton presented the February Finance Committee Chair's Report. He noted the Committee's focus on accurate reporting, budget setting for 2018/19 and the excellent CIP performance. He also highlighted that clinical productivity continued to be a key area and that a presentation was planned for Governors.

In response, the following points were raised by governors:

- The Lead Governor noted the impact of TrakCare and asked the Interim Director of Finance to explain how this affects Trust income. The Interim Director of Finance explained that the two major reasons were the operational impact which has affected the scheduling and filling of

outpatient clinics leading to reduced activity and thus less income; and the Trust's ability to record, count and code activity and thus bill for activity. The Lead Governor queried the communications plan around TrakCare. The Chief Executive advised that the developing 'narrative' was being managed through the SmartCare Programme Board which the Head of Communications now attended. The Chief Executive's Weekly Message would remain a key forum. Geoff Cave wondered how the deficit would impact the Trust moving forward. The Chief Executive advised that the deficit would sit as debt on the Trust's balance sheet but at this stage there was no requirement for repayment. However, the Chief Executive highlighted that borrowing cash to manage the deficit came with significant interest charges which had been higher for Trust's in Financial Special Measures. Andrew Gravells acknowledged the position and queried the affect on next year and percentage of borrowing. The Chief Executive advised that this would be further covered when the Annual Operating Plan was shared with governors.

- Colin Greaves noted an addition error within the figures shared with governors. The Interim Director of Finance would address this. **SS**

Quality & Performance Committee – March Board Report & Chair's Report from 22nd February 2017

The Chief Operating Officer and Medical Director presented the March Board report to the Council and provided a contemporary update. Key aspects highlighted included:

- The challenge of delivering the 4-hour Accident and Emergency Standard and the commitment to deliver 90% going forward.
- Issues around norovirus, the resurgence of flu and the impact of snow.
- Diagnostic performance.
- Improved delivery against cancer standards albeit issues around colorectal two week wait demand. The Trust is working with CCG colleagues and GPs to address this.
- Patient Treatment Lists and the progress made thanks to the Digital Recovery Consultant.
- An increase in Grade 2 and 3 pressure ulcers which are being investigated by the Director of Quality and Chief Nurse and nursing teams to ensure a reduction.
- The significant improvements in the Stroke Service.

Claire Feehily reported the key messages of the February Quality and Performance Committee Chair's Report. She highlighted the discussion around feedback on patients' experience of Emergency Care as well the progress made on improving mortality rates.

In response, the following points were raised by governors:

- Colin Greaves acknowledged the significant performance improvements through February and March. The Chief Operating Officer cited work done to improve the hospital "back door" and praised Sandra Attwood for her involvement in this.
- Andrew Gravells felt it was important to praise the staff involved in the improved areas. The Chief Operating Officer would progress this.

Workforce Committee – March Board Report & Chair's Report from 8th February 2017

The Chief Executive presented the March Board report to the Council and provided a contemporary update. Key messages included:

- Positive news in relation to turnover, in particular in relation to the qualified nursing workforce.
- Future work and plans to reduce turnover and increase retention.
- Improvement in sickness absence rates.
- Appraisal compliance and the continued focus on this.
- Work underway to develop talent and clarity around development pathways. This would be considered as a future agenda item for the Governor Strategy & Engagement Group.
- Mandatory training compliance and what more can be done to make this more accessible and relevant.

Tracey Barber reported the key highlights of the February Workforce Committee Chair's report, and advised that moving forward there would be a focus on staff wellbeing.

In response, the following points were raised by Governors:

- Jeremy Marchant queried the 3.95% sickness absence figure. The Chief Executive explained that this was the percentage of workforce days lost through sickness. Jeremy Marchant wondered if these days had been filled by temporary staff. The Chief Executive explained that this varied depending on the nature of the role and was visible through the fill rate which is in the public Board report. Jeremy Marchant wondered if the Trust tracked the cost of sickness, which the Chief Executive explained that it did but that this was not as accurate as is desirable but this would be improved by a new rostering system.
- Andrew Gravells wondered how the Trust was addressing the areas which were sickness outliers. Tracey Barber answered that deep dives were being undertaken around different areas, and that the results of a deep dive in orthopaedic outpatients would be reviewed at the next Workforce Committee.
- Andrew Gravells expressed disappointment that appraisal compliance was less than 100% and the effect this could have on staff morale. The Chief Executive explained that appraisals were sometimes delayed by operationally challenging periods, and while not ideal, it was of course appropriate as the Trust's priority is always patient care. Jeremy Marchant felt that receiving an appraisal once a year was not essential providing staff were appraised in other ways. The Chair advised that the role of the appraisal within management and development had been discussed at a recent Workforce Committee. Sandra Attwood and Sarah Mather described the pressures that mean sometimes appraisals are delayed though many staff stay late or come in when not rostered to undertake appraisal. The Chief Executive reiterated that performance below 100% did not reflect a lack of value of appraisal itself or our staff.

035/18 THE ROLE OF THE AUDIT AND ASSURANCE COMMITTEE

Rob Graves gave a presentation explaining the role of the Trust's Audit and Assurance Committee. This covered the following points:

- Why the Trust has an Audit Committee.
- Who is involved in the Committee.
- What the Committee does.
- How work is undertaken.
- The Chair's expectations.
- When and where the Committee meet.
- The new external auditors appointed by governors.

In response, the following points were raised by governors:

- Jeremy Marchant queried how much involvement internal audit had in investigating TrakCare. Rob Graves advised that TrakCare had been scrutinised and recommendations made in addition to the thorough review commissioned by the SmartCare Programme Board and undertaken by NHS Digital. Jeremy Marchant queried when the internal auditors became involved with TrakCare, to which Rob Graves explained that there was scrutiny of TrakCare prior to go-live.
- Andrew Gravells praised Rob Graves on the presentation.
- Marguerite Harris raised concerns regarding the TrakCare issues raised and felt this should be top of the key risks. The Chief Executive advised that improvements would be apparent through the annual operating plan and that it was amongst the Trusts top three operational priorities..
- The Lead Governor advised that governors were looking forward to meeting the external auditors. Rob Graves advised that he had discussed a meeting programme with the Chair.

036/18 FINANCIAL GOVERNANCE REVIEW ACTION PLAN

The Chief Executive presented the Financial Governance Review Action Plan progress report to update the Council of Governors on the actions arising from the recommendations of the Deloitte Review into financial governance arrangements at the Trust. The Chief Executive noted that all but one action was completed; the remaining action would be completed by the end of April.

037/18 GOVERNOR' LOG

The Chief Executive presented the Governors' Log and noted that all questions had now been responded to and responses circulated via email.

038/18 ANY OTHER BUSINESS

The Lead Governor noted that it was Tony Foster's last Council meeting and thanked him for all his work as a non-executive director.

039/18 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 20th June 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at **17:30**.

Papers for the next meeting: Papers for the next meeting are to be logged with the Board Administrator no later than **17:00** on **Monday 18th June 2018**

040/18 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
20th June 2018

ITEM 21

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 22

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 23

PUBLIC QUESTIONS

Peter Lachecki
Chair

ITEM 24

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION