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, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 8 NOVEMBER 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 8 November 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

24th October 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 13 September 2018	**PAPER**	**For approval**	09:32
5.	Matters Arising	**PAPER**	**For assurance**	09:35
6.	Chair's Update	**PAPER** (Peter Lachecki)	**For information**	09:40
7.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For information**	09:45
8.	Quality and Performance:			10:00
	• Quality and Performance Report	**PAPER** (Steve Hams, Sean Elyan, Caroline Landon)	**For assurance**	
	• Assurance Reports of the Chair of the Quality and Performance Committee meetings held on 27 September 2018 and 25 October 2018	**PAPER** (Claire Feehily)	**For assurance**	
	• Trust Risk Register	**PAPER** (Lukasz Bohdan)	**For assurance**	
	• Board Assurance Framework	**PAPER** (Lukasz Bohdan)	**For assurance**	
	• Learning from Patient Stories	**PAPER** (Steve Hams/ Suzie Cro)	**For assurance**	
	• Emergency Planning Resilience and Response Annual Report	**PAPER** (Caroline Landon)	**For assurance**	
	• 'Winter Readiness in the NHS-Next Steps' Joint NHE Improvement and NHS England letter	**PAPER** (Caroline Landon)	**For information**	
9.	Financial Performance:		**For assurance**	11:00
	• Report of the Finance Director	**PAPER** (Sarah Stansfield)		
	• Assurance Reports of the Chair of the Finance Committee meetings held on 26 September 2018 and 31 October 2018	**PAPER** (Keith Norton)		
	Break			11:20 – 11:30
10.	People and Organisational Development:		**For assurance**	11:30
	• Report of the Director of People and Organisational Development	**PAPER** (Emma Wood)		

	• Assurance Report of the Chair of the People and Organisational Development Committee meeting held on 11 October 2018	**PAPER** (Alison Moon)		
	• Assurance Report of the Chair of the joint Quality and Performance and People and Organisational Development Committee held on 25 October 2018	**PAPER** (Alison Moon)		
	• Freedom to Speak up Report	**PAPER** (Emma Wood/ Suzie Cro)		
11.	Audit and Assurance:		**For assurance**	12:05
	• Report of the Chair of the Audit and Assurance Committee meeting held on 18 September 2018	**PAPER** (Rob Graves)		
12.	Gloucestershire Managed Services (GMS):		**For assurance**	12:15
	• Report of the Chair of the GMS Committee meeting held on 10 September 2018 and 9 October 2018	**PAPER** (Mike Napier)		
13.	Governance Documents:	**PAPER** (Lukasz Bohdan)		12:25
	- Modern Slavery Act Statement		**For approval**	
	- Respective Roles of the Chair and Chief Executive		**For approval**	
	- Terms of Reference review update		**For information**	
14.	One Place Business Case Update	**PAPER** (Simon Lanceley)	**For assurance**	12:35
15.	SmartCare Progress Report	**PAPER** (Mark Hutchinson)	**For assurance**	12:45
16.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Sean Elyan)	**For assurance**	12:55
17.	Minutes of the meeting of the Council of Governors held on 15 August 2018	**PAPER** (Peter Lachecki)	**For information**	13:05
	Governor Questions			
18.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions			13:10
	Staff Questions			
19.	A period of 10 minutes will be provided to respond to questions submitted by members of staff			13:20
	Public Questions			
20.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.			13:30
	Any Other Business			
21.	Items for the Next Meeting and Any Other Business		**For information**	13:40
	Lunch Break		**13:45 – 14:15**	

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 30th OCTOBER 2018

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 10th January 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** at **09:00 am**

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Dr Claire Feehily	Deborah Lee, Chief Executive
Rob Graves	Lukasz Bohdan, Director of Corporate Governance
Mike Napier	Dr Sean Elyan, Medical Director
Keith Norton	Steve Hams, Director of Quality and Chief Nurse
Alison Moon	Mark Hutchinson, Chief Digital and Information Officer
	Caroline Landon, Chief Operating Officer
	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, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 13 SEPTEMBER 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
	Mark Hutchinson	Chief Digital & Information Officer
	Simon Lanceley	Director of Strategy and Transformation
	Sarah Stansfield	Director of Finance
	Emma Wood	Director of People and Organisational Development and Deputy Chief Executive
	Dr Claire Feehily	Non-Executive Director
	Rob Graves	Non-Executive Director
	Alison Moon	Non-Executive Director
	Mike Napier	Non-Executive Director
APOLOGIES	Caroline Landon	Chief Operating Officer
	Keith Norton	Non-Executive Director
IN ATTENDANCE	Suzie Cro	Deputy Director of Quality
	Caroline Martin	Patient – Patient's Daughter (for the *Patient Story* item)
	Emma Husbands	Consultant in Palliative Care Medicine (for the *Patient Story* item)
	Natashia Judge	Corporate Governance Manager
	Craig Macfarlane	Head of Communications
	Sam White	Lead Nurse for Specialist Palliative and End of Life Care (for the *Patient Story* item)

PUBLIC & PRESS Three governors, no members of the public.

The Chair welcomed all to the meeting.

172/18 DECLARATIONS OF INTEREST **ACTIONS**

The Director of Corporate Governance and Director of Finance declared interests, noting that they were both GMS Directors.

173/18 PATIENT STORY

The Deputy Director of Quality introduced Dr Husbands, Consultant in Palliative Care Medicine, Sam White, Lead Nurse for Specialist Palliative and End of Life Care and former carer Caroline Martin. Caroline described her experience of losing her father, and Dr Husbands and Ms White provided further insight into end of life care and the changes and improvements being made.

The presentation covered Caroline's father's background and chronic health condition, Chronic Obstructive Pulmonary Disease (COPD) and the missed opportunities to make the management of this as smooth as possible. While the medical care and attention her father received on each of his admissions was fantastic, they were described as isolated episodes, with no correlation drawn between them. After Caroline's father's final admission, attempts were made to

deliver care at home. The story highlighted issues with joined up care, conversations around end of life care, uncertainty around eligibility for palliative care team support, misleading language such as the phrase “Medically Fit For Discharge” and inaccurate discharge summaries. Caroline advised that during her father’s last week of life they did not receive help at home and felt let down. She also had to chase when promises were not kept, which proved difficult and time consuming and diverted her from spending time with her dad in final days of his life.

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

- The Director of Corporate Governance noted that Caroline’s father received a survey regarding his care but found it difficult to complete it. Had it not been for Caroline’s help in completing the survey, the Board might have not heard today’s story. The Director of Corporate Governance asked whether, in Caroline’s view, the Trust could have done anything to help her dad complete the survey. Caroline felt that support from a nurse would have helped.
- The Medical Director asked Ms White whether, after reviewing Caroline’s father’s notes, she had a sense of whether clinicians were too fearful to discuss palliative care or did not have the right knowledge to communicate the message. She responded that she felt it was a combination of both, as there were clear references in in the notes as to his frailty. She felt that respiratory physicians grappled with COPD and the uncertainty around this. She stressed that acknowledging the dying process was not a self-fulfilling prophecy and it was important it was discussed with the patients and their carers. Dr Husbands reflected that often hospital care can be very much focused on the situation occurring in the moment, rather than planning and discussing the bigger picture. Ms White said that there was a Parallel Plan project, involving the respiratory wards, under way; it aimed to encourage conversations about end of life outside of the acute context.
- Ms Moon queried what could be learnt from Caroline’s father’s story and reflected on the importance of what she described as a “helicopter view”. She questioned how clinicians could be encouraged to take a step back and consider a patient’s entire care plan. Dr Husbands responded that role modelling around end of life care, and the last year of life was needed, to encourage acute physicians to think about the next steps after discharge. She felt an IT system which highlighted previous admissions would facilitate this.
- The Chief Executive acknowledged how important it was that the Trust was considering End of Life Care for patients other than cancer patients and how crucial it was to look at getting this right. She reflected on how end of life care had developed.
- The Digital Recovery Consultant acknowledged the issues around joined up care and how important it was that care is joined up electronically.
- Dr Feehily felt that Caroline’s father’s story raised an ethical debate to the extent in which palliative patients should be discharged, whether the choice was appropriate and how questions should be asked. Dr Husbands answered that end of life care was often difficult with situations changing rapidly and that teams needed to rely on one another and have honest conversations. Dr Husbands advised that the national thinking was that the preferred choice of patients was to die at home, but that often what felt an acceptable situation in the afternoon did not feel the same at night with a lack of services in the community and services needed to be more responsive to changing situations. The Chief Executive reflected that the Trust received a huge amount of

compliments regarding End of Life Care and that many patients in Gloucestershire experienced a 'good death' but stressed it was still important to learn from the family's experience to further improve care.

- The Director of Strategy and Transformation questioned whether there was a better term than 'Medically Fit for Discharge'. The Chief Executive advised that the language had since changed to 'Medically Stable For Discharge' but was not being adopted by everyone. Chief Operating Officer to ensure correct language was used in all written communication to reinforce the change of language. **CL**

The Chair thanked Caroline for sharing her father's story and encouraged her to reflect on whether there was anything further the Trust could do to support her mother.

174/18 MINUTES OF THE MEETING HELD ON 12 JULY 2018

RESOLVED: The minutes of the meeting held on 12 July 2018 were agreed as a correct record and signed by the Chair.

175/18 MATTERS ARISING

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.

Completed: Trial of dedicated porter transfer team commenced in April, proved successful and more robust than rostering HCAs. Trial extended into May. The impact of the trial has now been assessed and it has been agreed to move to a dedicated Porter/HCA model. The approach and finances have been agreed and GHT/GMS are aiming to have the service operationalised by November 2018.

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.

Completed: Discussions with external auditors held and expectations set. The Audit and Assurance Committee, without the external auditors present, will monitor and assess the delivery of what was promised during the recruitment process.

JULY 2018 133/18 FINANCIAL PERFORMANCE – REPORT OF THE FINANCE DIRECTOR - THE CHIEF EXECUTIVE SAID IT WAS NOT CLEAR, GIVEN THE IMPROVED UTILISATION WHETHER THE UNDER PERFORMANCE REFLECTED REDUCED ACTIVITY OR FAILURE TO CAPTURE AND RECORD ACTIVITY APPROPRIATELY

She asked the Director of Finance and Chief Operating Officer to investigate this.

Completed: Associate Director of Planned Care and Director of Operational Finance conducting an audit in outpatients for one week during the month of September and will report back to SmartCare Programme Board or Planned Care Programme Board.

MAY 2018 087/18 SMARTCARE PROGRESS REPORT - DR FEEHILY ASKED IF FURTHER DETAIL ON PROGRESS COULD BE ADVISED 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.

Completed: Agreement reached to establish 'Digital' Committee, with effect from October.

JULY 2018 127/187 PATIENT STORY - MR GRAVES SUGGESTED BECKY SHARE HER EXPERIENCE WITH GLOUCESTERSHIRE CARE SERVICES (GCS) BOARD WHO DIRECTLY MANAGE THE COMMUNITY SERVICES

The Trust Chair would discuss this further with the Chair of GCS.

Completed: Discussion with GCS chair has taken place.

JULY 2018 127/187 PATIENT STORY - THE CHIEF EXECUTIVE FELT THAT THE FAMILY SHOULDN'T HAVE TO PAY PRIVATELY FOR THE PHYSIOTHERAPY SERVICES THAT MAGGIE WAS RECEIVING AS THEY SEEMED TO BE CORE TO HER REHABILITATION

Chief Nurse to follow this up.

Completed: The Chief Nurse has reviewed the case with the patient experience team and the stroke team. Early Supported Discharge was established following discharge, included physiotherapy and support from the Community Stroke Co-ordinator. The Chief Nurse has recently spoken to Maggie's family and she is progressing well with her rehabilitation.

JULY 2018 132/18 QUALITY AND PERFORMANCE – TRUST RISK REGISTER - DEMAND AND PRESSURE THROUGHOUT THE SUMMER MONTHS

The Chief Executive asked the Chief Operating Officer to review the risk register and consider whether this risk was adequately captured and if not ensure it was added.

Completed: Chief Operating Officer reviewed the register. The risk is captured on the Medicine Division's risk register under (ref 2772).

JULY 2018 134/18 WORKFORCE – REPORT OF THE DIRECTOR OF PEOPLE AND ORGANISATIONAL DEVELOPMENT - APPRENTICESHIP LEVY AND TARGET

This is being investigated and a report on the Apprenticeship Strategy will come to a future People and Organisational Development Committee. Date to be confirmed to the Corporate Governance Manager for Committee Work Plan.

Completed: Added to work plan as part of the sustainable workforce agenda item.

JULY 2018 136/18 GLOUCESTERSHIRE MANAGED SERVICES – REPORT OF THE CHAIR OF THE GMS COMMITTEE MEETING HELD ON 14 JUNE 2018 - THE TRUST CHAIR ASKED ABOUT THE GMS WORKFORCE. THE DIRECTOR OF PEOPLE RESPONDED SAYING THERE HAD BEEN A LOT OF WORK ON ENGAGEMENT BY THE MANAGEMENT TEAM, THERE HAD BEEN NO INCREASE IN TURNOVER OR GRIEVANCES: AN INDICATOR THAT STAFF ARE SATISFIED.

The Chief Executive asked that the question is posed to the committee and formal measures of staff satisfaction are established.

Completed: GMS will be conducting its own staff survey to measure engagement and staff satisfaction by the end of the calendar year.

JULY 2018 141/18 ANNUAL ORGAN DONATION REPORT - ANNUAL ORGAN DONATION REPORT RECEIVED, DEMONSTRATING PROGRESS
The Chief Executive asked the Medical Director to draft a letter to Ian Mean, Director of Business West in Gloucestershire thanking him and his team for their leadership and action.
Completed: Letter drafted and sent.

JULY 2018 143/18 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING - ALLOCATE REPORTING SYSTEM IS NOW BEING USED, ALTHOUGH IT IS NOT USER FRIENDLY
The Medical Director agreed to take forward with supplier and national team.
Completed: It is a supplier issue and the national team are working with the supplier to address it.

JULY 2018 143/18 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING - THE CHIEF EXECUTIVE HAD PREVIOUSLY ASKED THE DIRECTOR OF SAFETY FOR TRIANGULATION OF DATA WITH THE DATIX REPORTING SYSTEM
This information is not included in this quarter's report and asked for this to be reinstated.
Completed: It will be included within the next report.

176/18 CHAIR'S UPDATE

The Chair presented the report detailing his activities since July. This aimed to provide the Board with a snapshot of the wider perspective of Chair activities undertaken. He highlighted that on 12th September staff from the local Fire Service concluded a sponsored 160 mile bed push around Gloucestershire to raise funds for the Trust's oncology service. The Chair advised that he had met with the team to discuss future plans and relationships.

177/18 CHIEF EXECUTIVE'S REPORT

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

- Operational context remains unchanged from previous discussions. The Trust is experiencing high demand, a reflection of the national picture. The Trust is currently reporting 90.4% against the 4hr Accident and Emergency (A&E) Standard quarter to date and 88.1% month to date. The Trust's trajectory is 90%. There are issues around flow and difficulty accessing community services at the 'back door' of hospital. This means that patients who are Medically Stable for Discharge cannot be discharged in a timely way. The system partners continue to focus on this.
- Positively, despite increases in urgent care activity, the Trust is still delivering good levels of elective activity. The Trust is slightly behind plan by about 3% but this is reflective of a small number of cases; the focus had been on addressing complex cases and cancer backlogs. The Chief Executive stressed that this was the right thing to do and was confident the Trust would deliver the activity plan for the year.
- Cheltenham MP, Alex Chalk, had been appointed Parliamentary Private Secretary (PPS) to the Secretary of State for Health and Social Care, the Rt Hon Matt Hancock MP.
- The One System Business Case has been delayed as leaders have reviewed the final draft of the business case and concluded that the proposed clinical model of care could not be implemented as planned.

This would be discussed further at a future Board Strategy and Development Session and a timeline brought to a future Board. The One System Business Case will now move forward in three phases, addressing issues such as Out of Hospital Care Services, Urgent Treatment Centres (both rural and urban), Trauma and Orthopaedics formal consultation and winter planning changes around Gastrointestinal Surgery and General Surgery. **NJ** (for work plan)

- The Capital Business case is progressing to timeline and a construction partner has been identified through the procurement process. Innovative ideas were identified in the process.
- The Trust has secured £1.3m of national capital funding which will be used to enable capital works to the acute floor model at Gloucestershire Royal Hospital, following the work undertaken at Cheltenham General Hospital last year. It will also support information management system development in theatres and bed management.
- The Trust and three partner initiatives have been shortlisted for Health Service Journal awards – finalists will be announced in November.

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

- Ms Moon said she felt the Trust's performance in light of demand had been commendable. She noted that the Chief Executive often mentioned that system partners were investigating solutions, and wondered whether this was yielding any change or results? The Chief Executive answered that when the Trust was experiencing pressure it now received a more robust operational response from system partners than ever before. While this was much appreciated, the discussion now needs to focus on why such pressures arise in the first place, so that the system can be more proactive. The Chief Executive summarised that the greatest issue at present was the divide between primary care access being described as improved but patients still reporting that they are unable to get an appointment in a timely way and/or not even trying to get one She noted that a survey done with A&E patients had drawn out this feedback repeatedly.
- Ms Moon also highlighted that the Quality and Performance Committee had recently received an excellent presentation on Stroke Services and observed the recent visit by the National Stroke Team and the improvements to be made in response. The Chief Executive advised that the areas where the Trust was making the least progress were in relation to therapy hours provided to patients in the acute aspects of the pathway as there are inadequate levels of speech and language therapists, dietetics, OT and physio in the stroke pathway. These issues were now on their way to resolution as funding had been secured and the posts are now out to advert. Once these individuals are in post, the Trust would meet the national standard. The other significant issue, which was the Trust's responsibility to address, is the early identification of stroke patients in A&E and work was in hand to improve performance in this area.
- Dr Feehily reflected on local authority commissioning and the budgetary profile around delayed transfers - she queried the level of confidence in their resilience and ability to rescale as winter approaches. The Chief Executive highlighted that the local Council continues to be an upper decile performer for patients whose discharge was delayed due to social care requirements and she reinforced that the increase in the number of medically stable patients who remain in Trust beds is not exclusively a reflection of social care constraints. She advised that the Director of Social Care was actively engaged in winter planning and while there

have been two care home closures in the last two weeks, social care have been very responsive. There are challenges in the CCG-commissioned discharge to assess pathway and some apparent delays in the Brokerage Service.

- Dr Feehily also queried whether there were any internal constraints with the Trust's ability to deploy staff to support the information management system changes in the Emergency Departments. The Digital Recovery Consultant advised that the Trust was recruiting to the Electronic Patient Record Team to support the work.
- Mr Graves thanked all involved in securing the winter pressure money – the Chief Executive answered that this was down to the Chief Operating Officer and Director of Unscheduled Care. He reflected on the high demand over summer and to what extent this was being reflected in modelling for this winter. The Chief Executive answered that plans acknowledged that there were seasonal changes and allowed for the usual variance between the summer and winter season. The reconfiguration of the acute floor will build capacity into the system and the timeline for the completion of work is 24th December, which would support the Trust in quarter 4, the most difficult quarter of the year.
- The Trust Chair queried how the Trust would support staff moving from a difficult summer into winter. The Director of People answered that work in this areas was under way; she described the Health and Wellbeing Hub and how staff are being supported - particularly ensuring that line managers are checking in with staff and aware of those who may be more vulnerable. The Director of Quality and Chief Nurse added that relationships with nursing and midwifery leaders had been key and reinforced the importance of listening to challenges and rewarding great performance. The Medical Director advised that staff were reporting feelings of improvements in the Emergency Department (ED) but he expressed concern regarding the Acute Medical Unit and the difficulty of the environment due to through put and staffing challenges. The Chief Executive reflected on the importance of recognition, reward and fixing the small problems which frustrate staff but can positively contribute to staff resilience when done well.

RESOLVED: That the report of the Chief Executive be noted.

178/18 QUALITY AND PERFORMANCE:

The Director of Quality and Chief Nurse presented the Quality and Performance Report and highlighted that:

- There were 7 cases of C.Diff for the month of July. The Trust has a clear improvement plan which has been tested and assured through the Quality and Performance Committee.
- There was one MRSA Bacteraemia in July and moving forward this will be a focus of attention.
- Dementia has been highlighted as an area of concern by the Quality and Performance Committee. An audit will be undertaken to ensure that there is not a mismatch between what is being recorded and what is happening in practice – an issue that arose around venous thrombo-embolism (VTE). The Chief Executive highlighted that data which demonstrated no increase in the incidence of VTE would assure the Board and requested that the data be reviewed at the next Quality and Performance Committee. **SE**

In response:

- Mr Graves advised that the Quality and Performance Committee recently received a presentation on the Nursing Assessment and Accreditation System (NAAS) and noted from the report that this had since started. He queried what the response from teams rated red was. The Director of Quality and Chief Nurse answered that the response had been variable and that around 15 NAAS audits had been undertaken with 40% red, 40% green and 20% rated amber. Red-rated areas, in which the leaders recognise and understand the rating, have taken the opportunity for improvement. However, there are a couple of wards where this has not been the case - potentially reflective of leadership capacity and capability. All red areas will be supported by Divisional Chief Nurses and Matrons; improvement plans will be in place within 2 months and re-inspections will follow. Mr Graves further queried whether there was any triangulation between the areas performing less well and performance appraisals of the team. The Director of Quality and Chief Nurse answered that there was; NAAS had shown that this did not correlate with staffing levels but rather good leadership.
- Mr Graves highlighted that the report used the phrase Medically Fit for Discharge and not Medically Stable for Discharge and wondered whether there was a difference in assessment. The Chief Executive answered that there was not, it was simply a change of language as reflected in the earlier discussion.

RESOLVED: That the Board receive the Report as assurance that the executive team and Divisions fully understand the current levels of poor performance and have action plans to improve this position.

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE MEETINGS HELD ON 26 JULY 2018 AND 30 AUGUST 2018

Dr Feehily presented the assurance reports from the July and August Quality and Performance Committees, highlight that:

- The Committee is moving to a new reporting suite, however it is still using the current dashboard and there are a few examples where incorrect data entries have been found; this will be corrected for the next iteration.
- The Committee is looking to see where the impact of demand is being felt and triangulating this with data received.
- The Committee is beginning to partner with GMS Committee in order to scrutinise infection control and cleanliness. There has been close scrutiny of the Infection Control Report and related action plan.
- Recent governor input within the Committee was commended for its content and quality with a particular focus on patients who need mental health support and how they constitute a significant population of the 12 hour wait patients due to delays in receiving specialist mental assessments.
- The August Committee received progress updates against CQC “Should Dos” and while broadly good progress had been achieved, there were 2 or 3 areas with intractable concerns about how the Committee could assure itself that the change has ‘stuck’ reliably.
- The Committee is also seeking to exercise its oversight on the safety risks around TrakCare which sit within Quality and Performance with output from the Clinical Systems Safety Group.

The Trust Chair said that he had recently spent some time with the Infection Control Team as well as the Consultant Microbiologists. He noted that they were working incredibly hard but realised how much more was still to be done. The team also recognise that they now have the leadership in place to champion their cause and were very focused on action plans.

RESOLVED: That the reports be noted.

TRUST RISK REGISTER

The Director of Corporate Governance presented the Trust Risk Register noting that there have been two changes since July,

- *C2768IC – There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards in some areas* – Added to the Register following consideration at Infection Control Committee and review at Trust Leadership Team (TLT)

- *C2667NIC – The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection* – Downgraded to 4x3 following the removal of the threat of regulatory action.

Dr Feehily noted that C2768IC had not been through the Quality and Performance Committee. The Chief Executive reminded the Board that it was the Trust Leadership Team's (TLT) responsibility to assess and set scoring which were then reported to Q&P. The Director of Quality and Chief Nurse advised that a report had been received from Professor Mark Wilcox, the national lead for C.Diff, following his review of the Trust, and this contained a number of recommendations though significant good practice was also noted. This would be received at the next Quality and Performance Committee.

The Trust Chair queried C2667NIC and that this was downgraded following the removal of the threat of regulatory action. The Chair thought the wording did not capture the full risk. The Director of Quality and Chief Nurse answered that the reduction in score was more to do with the frequency of which harm may occur. The Chief Executive expanded that there were a number of factors driving the score, and that the driver for the score and experience were unchanged but the regulatory threat had reduced but agreed the wording should be reviewed.

RESOLVED: That the Board receive the report as assurance that the Executive Directors are actively controlling and pro-actively mitigating risks so far as is possible and approve the changes to the Trust Risk Register as set out.

179/18 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE DIRECTOR

The Director of Finance presented the Financial Performance Report to provide an overview of the financial performance of the Trust as at the end of Month 4 of the 2018/19 financial year. Key points highlighted included:

- The financial position of the Trust at the end of Month 4 is an operational deficit of £12.9m. This is a favourable variance to budget and NHS Improvement plan of £0.1m.
- There is a pay underspend across all pay-groups which is offsetting some of the income under recovery and non-pay issues.
- With regards the drugs overspend of just under £0.6m, £0.565m is high cost drugs which have been recovered largely through the income

baseline.

- Cost Improvement Programme (CIP) delivery to Month 4 is £6.9m. This is £2.4m favourable against the plan for the year to date, due to several schemes delivering earlier than initially phased.
- The Trust is currently still forecasting £18.8m deficit i.e. delivery of the control total but there are downside risks in relation to under delivery of the CIP programme, emerging costs pressures due to national funding rules and income risks in relation to commissioner income under delivery. If these materialised they would present a risk to the Provider Sustainability Funding (PSF) in quarter 4.
- The Trust is working alongside colleagues from PWC to bridge gaps within the Trust's CIP.
- The Trust will now be producing quarterly finance information to share with the Board, internal and external stakeholders. A podcast also accompanies that.

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

- Ms Moon queried the detail and focus of the work being undertaken by PWC and whether there would be any in-year benefits. The Director of Finance answered that PWC were working with the Surgery and Diagnostics and Specialties Divisions using a methodology called Priority Based Budgeting. This involves assessment of each service line and challenge as to whether all resources committed are appropriate and necessary – similar to zero based budgeting. All executives have been involved. There has been variability across service lines, with some divisions coming across with in-year opportunities (mainly income) and others not likely to proceed to the next stage due to no opportunities being identified. She concluded that the process had been valuable, would contribute to the 2019/20 pipeline but was unlikely to deliver the £7m being pursued. The Chief Executive observed that the work is however providing assurance on how efficient many services are and should demonstrate that there is less to come out of the organisation in terms of organisational efficiency. She said she awaited the *Drivers of Deficit* report to see if this finding was triangulated by that work.
- Mr Graves noted the comment regarding the offset of drugs overspend appearing as a high level of income. He thought that if removed then the overall income shortfall was much greater and noted this was not captured in the notes. The Director of Finance answered that there was an underlying underperformance across the variable income contracts – underperformance across all points with specialised commissioners and under delivery across Worcester and Hereford commissioners. Work is in progress to understand this. The Trust has also since entered into a block contract with Worcester and Hereford commissioners which guards against the underperformance deteriorating further. The CEO said she has asked for reports to be presented to the Finance Committee which showed 'underlying' performance where blocks were in place.
- Mr Graves observed that the payment practice statistics were under the 80% but didn't understand the comment about the percentages and wondered whether the numbers were being suppressed. The Director of Finance answered that the numbers presented are the actual performance. Mr Graves further queried what was limiting this being better, to which the Director of Finance answered that there had been some issues with processing but also reflective of the Trust carefully managing its cash position. Further information would be bought to the next Finance Committee, alongside benchmarking. The Director of

Finance stressed that invoices were not being held and anything on the payment run was being paid.

- Mr Napier noted the forecast position and income risk of £1.5m; he highlighted that the shortfall for this month and month 4 was greater than this. The Director of Finance answered that profiling of income was currently based on year to date and was based on seasonality: some of the underperformance would significantly recoup itself as it is a seasonal trend to resolve the issue towards the end of the year.
- Mr Napier also referred to the note regarding the full impact of the pay award being funded; he noted the movement by the Department of Health regarding this and whether this should be noted. The Chief Executive advised that this would be included in the future forecast, but further clarity on how the risk will be mitigated was being sought.
- The Trust Chair queried the date for formal reforecast. Director of Finance answered that any reforecast would need to be done by the quarter end and would require prior Board briefing. She outlined that the Trust was still forecasting delivery of its financial plan. The Chief Executive said that she would welcome a review of the strategy for the rest of the year at the Finance Committee. **SS**
- With regard to the podcast and infographic, Dr Feehily felt there had been a shift in messaging away from just the CIP but that the scale of the challenge was not quite clear. The Director of Finance felt this came through the narrative of the podcast but would give further thought for development of the next report. Mr Napier also queried whether a written narrative should accompany the podcast. The Chief Executive asked the Head of Communication to consider this. **CM**

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

ASSURANCE REPORTS OF THE CHAIR OF THE FINANCE COMMITTEE MEETINGS HELD ON 29 JULY 2018 AND 30 AUGUST 2018

RESOLVED: That the reports be noted.

[The Board adjourned for 10 minutes]

180/18 PEOPLE AND ORGANISATIONAL DEVELOPMENT

REPORT OF THE DIRECTOR OF PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD)

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

- Sickness absence remains static with 3.86% at the end of June and 3.87% at the end of July (against a target of 3.50%).
- Turnover has increased by 0.5% over the summer, which follows a 3-year trend. This is expected to return to lower levels in the autumn.
- Nursing and Midwifery turnover is approximately 8% lower than other large Trusts.
- The People and OD Committee recently received a presentation on the new recruitment and retention plans for nursing and midwifery staff (health care assistants specifically). The general recruitment team has increased activity by over 100% each month since July. We are expecting about 198 staff to be recruited by September, including circa 65 nurses.
- Appraisal compliance is at 74% as compared to a target of 85% and

mandatory training is at 87% compared to a target of 90%. The Trust has a specific working group investigating appraisal compliance.
- Temporary staffing has been identified as a strategic priority and a great deal of work has been undertaken i.e. relaunch of the temporary service, and implementing new pay rates. Reviewing medical and dental rates for both locums and agency will be the next steps.
- There has been a 34% increase in bank shifts which is a step towards the Trust achieving its goal to swap the agency and bank usage rates.
- A Freedom to Speak Up Survey (FTSU) has taken place; information gathered will inform the development of the FTSU strategy.
- The business case for the One Stop Shop is at an advanced stage.
- The Trust has recently participated in the Stonewall Equality Index Survey.

Mr Napier queried whether the Trust should have a key performance metric around number of vacancies. The Director of People answered that a recent People and OD Committee had agreed that headcount as well as percentage would be included in the Board report from November onwards.

The Trust Chair queried whether alternative approaches to improving appraisal compliance rates were being considered, for example additional appraisers. The Director of People answered that traditionally appraisals are done by line managers; the Director of Quality and Chief Nurse was liaising with teams to ensure time was being scheduled to conduct appraisals and encouraging staff to come in slightly before shifts to undertake appraisals. The working group for appraisals is also investigating recording of appraisal compliance and ensuring data is correct; anticipated that this may result in small improvements. The topic will also be raised at Executive Divisional Reviews.

RESOLVED: That the Board note the performance against the key workforce performance indicators and the progress made against the workforce strategic priorities.

ASSURANCE REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE MEETING HELD ON 6 AUGUST 2018

Ms Moon presented the assurance report from the August Committee, highlighting the following points:

- The workforce dashboard was being refined.
- The Committee's focus has been on staff retention and in particular understanding why staff leave the organisation. At present the Trust is obtaining exit interviews in 30-35% of cases and has been challenged to improve on this.
- Areas of concern regarding the statutory and mandatory training compliance have been identified and will be discussed by the Committee.
- The Committee received a high level update on the Staff Survey and requested more information around priorities and how staff and managers are engaged in developing action plans.
- The Committee reviewed Health and Safety and how this applies to Gloucestershire Managed Services.
- The Committee is aiming to understand the workforce aspects of the Integrated Care System.
- Work is underway on the Committee agenda to ensure enough time is spent on strategy.
- A joint Workforce and Quality and Performance Committee will take place at the end of October.

The Director of People reflected on the low number of exit interviews and advised that the culture around exit interviews and retention plans was being challenged.

RESOLVED: That the Board receive the report for assurance in respect of the Trust's people and organisational development performance.

181/18 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 17 JULY 2018

Mr Graves presented the assurance report from the July Committee, highlighting that:

- The Committee received an internal audit report on serious incidents; this was the first report by the new internal auditors, BDO. BDO have a slightly different approach for scoring reports – their audits looks at systems and process as well as the effectiveness of their application. The report found that the documented policy and procedures for Serious Incidents was lacking behind the practice in place, which was better. The Committee are also seeking additional intelligence on how effectively learning is shared within the organisation.
- External audit reviewed the post year end situation and overall the Trust is satisfied with the service and outcome.
- The Committee will continue to focus on emergency planning; while excellent work has been done, further work and review is needed. The Committee felt the potential risks of this area were not captured on the Trust Risk Register which it has asked the COO to address.

RESOLVED: That the report be noted.

ANNUAL AUDIT LETTER

The Director of Corporate Governance presented the Annual Audit Letter for information, noting that this was received by the Council of Governors on 15th August.

RESOLVED: That the Board note the contents of the Annual Audit Letter.

BOARD ASSURANCE FRAMEWORK

The Director of Corporate Governance presented the Board Assurance Framework (BAF), highlighting that this had completed the Committee/Board assurance cycle. The amendments requested by the Board and the Committees have now been reflected within the report. The BAF is now also used to set the agenda for Committees.

The Director of Corporate Governance added that further changes were being considered to improve presentation of information. The Chief Executive advised that an external consultant had reviewed the BAF against other organisations and found that it was one of the best reports, therefore it was worth considering whether content should be traded for complexity. The Director of Corporate Governance added that the report was sizeable due to the number of the Trust Strategic Objectives and at the next review of the strategy there will be a natural opportunity to revise and further develop the BAF.

Dr Feehily felt that further commentary could be added to *4.2 Be Among the top 25% of Trusts for efficiency* and wondered how the Finance Committee was structuring the work on this objective. The Chief Executive answered that this was much broader than the Finance Committee and should include measures such as length of stay, use of medicines, theatre and outpatient productivity.. The Chief Executive said that the data being used for the Use of resources Review from Model Hospital would be a better measure and this would be considered when setting the 2019-20 objectives.

RESOLVED: That the Board receive the report for assurance that the risks to the Strategic Objectives are controlled effectively.

ANNUAL TRUST SEAL REPORT

The Director of Corporate Governance presented the Annual Trust Seal Report, highlighting that there have been four applications of the Trust Seal since September 2017.

RESOLVED: That the above be noted.

182/18 GLOUCESTERSHIRE MANAGED SERVICES (GMS)

REPORT OF THE CHAIR OF THE GMS COMMITTEE MEETING HELD ON 13 AUGUST 2018

Mr Napier presented the assurance report from the August Committee, highlighting that:

- The Committee received a wrap-up report in which outstanding actions were handed over to the Chief Operating Officer.
- There is some tension between the Trust and GMS in terms of establishing relationships and how the dynamic works.
- Three areas of focus are cleaning, CSSD and Trust wide catering. Plans are being drawn up by GMS which will be reviewed by the Chief Operating Officer and subsequently the next GMS Committee.
- The GMS Business Plan has been reviewed by Trust Leadership Team and discussed by the Committee.
- Risk management remains an open issue with overlap between the Committee and the Quality and Performance Committee. The Director of Corporate Governance is investigating the governance around this.
- Gaps and inconsistencies were identified within the Key Performance Indicators Report and therefore the report requires further work.

The Chief Executive felt it would be helpful to discuss overlapping agendas at Board Strategy and Development Sessions rather than through joint Committees. Dr Feehily queried whether the Board was conscious of any gaps not being picked up by the current Committee structure, particularly around estates and Health and Safety. Mr Napier responded that this was discussed at the August Committee and a need to bring GMS Health and Safety responsibilities into the Committee were identified. At present there has been little discussion around hard services and the capital programme. The Chief Executive said that at the time of setting up GMS the lack of strategic estates advice within the Trust was identified as a risk; this is being explored by the Chief Executive.

The Director of Strategy and Transformation highlighted that the first page of the report noted that GMS had produced a Regional Estates Strategy; he clarified that this should read “presented”, not “produced”.

RESOLVED: That the report be noted.

183/18 AMENDMENTS TO THE TRUST CONSTITUTION

The Director of Corporate Governance presented a paper detailing the proposed amendments to the Trust Constitution, highlighting that this work was led by the Constitution Review Group. Proposed changes had been supported by the Governors' Governance and Nominations Committee and approved by the Council of Governors at its August meeting..

In response:

- The Trust Chair thanked governors, in particular the Lead Governor, for their involvement in the process.
- Dr Feehily noted that Audit Committee Chairs across the ICS were coming together to consider the organisational impacts of greater collaboration and queried how the constitution fit into this and whether a process needed to be created to ensure it kept pace with any ICS changes. The Chief Executive advised that there was a Workstream within the ICS regarding integrated governance. The Director of Corporate Governance added that the Constitution reflected the policy and legal framework that still applied to the Trust.
- The Lead Governor pointed out a typographical error in Annex 1 and asked for the amendments to be made so that the text therein aligned with the provisions in the body if the Constitution. **NJ**

RESOLVED: That the Board approve the amendments to the Trust Constitution.

184/18 ANNUAL SAFEGUARDING REPORTS
- **SAFEGUARDING ADULTS**
- **SAFEGUARDING CHILDREN**

The Director of Quality and Chief Nurse presented the Safeguarding Adults Annual Report and Safeguarding Children Annual Report, advising that these reports had previously been received by the Quality and Performance Committee.

With regards to the Safeguarding Adults report, the Director of Quality and Chief Nurse highlighted the increasing complexity in safeguarding and the increased capacity in the adult safeguarding team and domestic violence team. He noted that the Mental Capacity Acts and Deprivation of Liberty Safeguards would likely be a focus in the upcoming CQC inspection.

With regards to the Safeguarding Children report, the Director of Quality and Chief Nurse highlighted the increase in the number of children subject to a child protection plan and the increase in the number of children and young people self-harming. The report also described problem areas, including system issues and the use of the recently deployed Child Protection and Information system.

In response:

- Ms Moon praised the report and the changes made since the Quality and Performance Committee and welcomed the increase in capacity in adult safeguarding and the new governance structure. Ms Moon would discuss with the Director of Quality and Chief Nurse how often the Quality and Performance Committee should receive safeguarding **AM/SH**

updates. She noted the reference to the addition of a safeguarding outcome within the TrakCare report and questioned whether it should be included and what the governance around the decision should be. The Chief Executive highlighted that TrakCare has the ability to include a safeguarding concern flag; however this was not universally used and attention was being given to this.

- The Trust Chair reminded the Board that Ms Moon was the Non-Executive Director Lead for Safeguarding.
- Mr Graves queried the statutory requirements of the reports, to which the Director of Quality and Chief Nurse answered that the requirement was to publish the reports and that the Gloucestershire Safeguarding groups and commissioners would be interested in both.
- The Chief Executive referred to a significant increase in the Maternity Safeguarding Concerns and queried whether this was in relation to a change in the maternity case mix, a change in the threshold to which individuals are referred, or better recording. The Director of Quality and Chief Nurse answered that this was a result of all three factors. The Chief Executive requested the Safeguarding Board review benchmarking for referrals to understand whether this trend mirrored elsewhere and warranted action. **SH**
-

RESOLVED: That the Board note both reports, including activity, risks and issues.

185/18 INFECTION CONTROL ANNUAL REPORT

The Director of Quality and Chief Nurse presented the Infection Control Annual Report, highlighting that this had previously been received by the Quality and Performance Committee. Over the last year work has focused on C.Diff and building capacity and capability within the team. He praised the work of the team whilst acknowledging that there was much more work to be done and that the improvement programme over the next year would be driven by NAAS.

The Trust Chair congratulated executives on being open and proactively inviting outside experts in to the Trust, as in this case, in order to enhance learning and improvement.

RESOLVED: That the Board note the report and receive assurance that the review of the 2017/18 year provides evidence of the Trust's obligations according the Health and Social Care Act Code of Practice.

186/18 GHNHSFT ANNUAL REPORT AND ACCOUNTS

The Director of Corporate Governance presented the Annual Report, advising the Board that the Trust has met its statutory responsibility of submitting the Annual Report and Accounts to the Parliament. The Report and Accounts are available on the Trust website and will be presented at the Annual Members Meeting on 20th September alongside a summary version.

RESOLVED: That the Board note the report.

187/18 SMARTCARE PROGRESS REPORT

The Digital Recovery Consultant presented the Smartcare Progress Report to provide assurance to the Board on the current position of the Smartcare Programme. He highlighted:

- Significant progress has been made with resolving data quality issues, which have more than halved.
- An external company is on site validating records.
- Vetting of referrals is being piloted beginning with Paediatrics and Orthopaedics.
- The focus over the next period will be to ensure that the plan for returning to Referral to Treatment (RTT) reporting is reviewed at the October SmartCare Programme Board.

In response:

- The Director of Quality and Chief Nurse advised that the team had undertaken great exploratory work around nursing documentation. The Digital Recovery Consultant said that while addressing Trakcare Recovery was a priority, the team were also taking steps to develop a longer-term plan supporting the Trust's digital ambition. The Board reflected on the potential of the patient record to change patient care.
- Dr Feehily expressed concern that the full risk picture related to the data quality concerns was not visible in the relevant places. The Chief Executive responded that she struggled to recognise this. She added that risks, which had been caused through the poor deployment of TrakCare were on the risk register and a considerable focus of the Q&P Committee in her view. In relation to delays to care she cited over 52 week patients, 104 day cancer patients and overdue follow up care – all of which were receiving significant attention and Committee scrutiny. Risks to the EPR programme itself were monitored in the SmartCare Programme Board. The Chair invited Dr Feehily to reflect further and advise him if any further assurance was sought. Dr Feehily also asked about the level of confidence management had that data quality issues were not continuing. The Digital Recovery Consultant answered that this was explained on page 2 and that the issue had reduced substantially.
- Mr Graves pointed out that a note page 10 referred to a high level plan, but it was not included in the report. The Digital Recovery Consultant apologised and explained that since writing the report a decision had been made not to include this but the reference was not removed. The high level plan will first be reviewed by TrakCare Group and then the SmartCare Programme Board in October. He would discuss with the Chief Executive whether this should be brought to the Board or taken to Quality and Performance as assurance.

RESOLVED: That the Board note the report.

188/18 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 20 JUNE 2018

RESOLVED: That the minutes be noted.

189/18 GOVERNORS' QUESTIONS

The following points were raised by governors:

- Mrs Harris described her recent visits to Accident and Emergency and Cardiology and how impressed she was with the positivity of staff.
- Mrs Davies said that she was disappointed to see the latest C.Diff figures. The Director of Quality and Chief Nurse responded that the improvement plan would take 12-18 months before tangible results were visible, and noted that antimicrobial prescribing was also an issue to be addressed within the community. The Medical Director also added that

there was a regular audit of compliance with anti-microbial guidelines. Mrs Davies said that the Equality and Diversity Steering Group has discussed swing door maintenance across the site. The Chief Operating Officer would resolve this. **CL**

- The Lead Governor:
    - Praised the recent finance podcasts and infographics and encouraged further use of these.
    - Felt encouraged by the safeguarding reports
    - Expressed his concern regarding transition of patients from children to adults when they reach adulthood and encouraged the system to collectively address the issues. The Director of Quality and Chief Nurse noted the Ready, Steady Go programme but agreed that further work needed to be undertaken with partners.
    - Noted how powerful the patient story was and stressed the importance of the Chief Executive's point around improving end of life care for non-cancer patients.
    - Advised of his recent attendance at a conference on informed consent and expressed interest in this topic. The Medical Director agreed to update the Lead Governor on the Trust's work in this area. **SE**

190/18 STAFF QUESTIONS

There were none.

191/18 PUBLIC QUESTIONS

There were none.

192/18 ANY OTHER BUSINESS

There was none.

193/18 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at 09:00hrs **Thursday 8 November 2018** in **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital**

194/18 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 12:45pm.

Chair
8th November 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – NOVEMBER 2018

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
November 2018	September 2018 189/18 Governors Questions	**CL**	Mrs Davies said that the Equality and Diversity Steering Group has discussed swing door maintenance across the site.	The Chief Operating Officer would resolve this.	*Ongoing* *Added to GMS Work plan for discussion at November Committee.*
November 2018	September 2018 173/18 Patient Story	**CL**	'Medically Stable For Discharge' language not being adopted by everyone.	Chief Operating Officer to ensure correct language was used in all written communication to reinforce the change of language.	*Completed: (to Board)* *Ongoing education with divisions, Onward Care Team and site.*
November 2018	September 2018 178/18 Quality and Performance	**SE**	The Chief Executive highlighted that data which demonstrated no increase in the incidence of VTE would assure the Board.	She requested that the data be reviewed at the next Quality and Performance Committee.	*Completed:* *The longitudinal data over the last two years for admissions with diagnosis of deep vein thrombosis and pulmonary embolus have been reviewed. This includes admissions and readmissions. There has been no rise in this diagnosis but we will do further work through audit to investigate further.*
November 2018	September 2018 179/18 Report of the Finance Director	**SS**	Delivery of the Trust Financial Plan.	Review of the strategy for the rest of the year at the Finance Committee.	*Completed:* *The Finance Committee has reviewed the FOT and capital positions for the year to go as required.*

November 2018	September 2018 179/18 Report of the Finance Director	**CM**	Written narrative to support the Finance podcast.	Head of Communication to consider this.	*Completed:* *Podcast audio successfully received. Will continue to monitor and evaluate for effectiveness.*
November 2018	September 2018 183/18 Amendments to the Trust Constitution	**NJ**	The Lead Governor pointed out a typographical error in Annex 1 and asked for the amendments to be made so that the text therein aligned with the provisions in the body if the Constitution.	Corporate Governance Manager to amend.	*Completed:* *Error addressed.*
November 2018	September 2018 184/18 Annual Safeguarding Reports	**AM/SH**	Safeguarding reports to Quality and Performance Committee.	Ms Moon would discuss with the Director of Quality and Chief Nurse how often the Committee should receive safeguarding updates.	*Completed:* *Revised work plan has been agreed by the Quality and Performance Committee and the frequency of safeguarding updates to quarterly has been set.*
November 2018	September 2018 184/18 Annual Safeguarding Reports	**SH**	Increase in Maternity Safeguarding Concerns.	Safeguarding Board to review benchmarking for referrals to understand whether this trend mirrored elsewhere and warranted action.	*Completed:* *Benchmark data developed as part of the child safeguarding dashboard development and as part of wider system working across the South West.*
November 2018	September 2018 189/18 Governors Questions	**SE**	Lead Governor advised of his recent attendance at a conference on informed consent and expressed interest in this topic.	The Medical Director agreed to update the Lead Governor on the Trust's work in this area.	*Completed* *Communication with Lead Governor undertaken with a view to further discussions with the Head of Legal Services to ensure current approach covers any new insights.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – NOVEMBER 2018

CHAIR'S ACTIVITIES UPDATE

In order to present a snapshot of the wider perspective of Chair activities undertaken, a written summary is presented at every Public Trust Board meeting. This excludes regular meeting attendances at Board, Council of Governors, Board Committees and 1:1s with Directors. This report covers the period from 4th September to 1st November 2018.

Trust Activities

DATE	EVENT
10 09 18	Non-executive appraisal
12 09 18	Freedom to Speak Up meeting
12 09 18	Meet Fireservice Charity bed push - CGH
18 09 18	Non-executive appraisal
24 09 18	Governor 1:1
02 10 18	Visit to Children's inpatient and Neonatal Intensive Care Unit
07 10 18	Trust Charity 'Walk for Wards' start
15 10 18	Personal Appraisal
15 10 18	National Allied Health Professional Day - visit to Woodmancote Ward CGH
15 10 18	Governor 1:1
18 10 18	NHS Imporvement Use of Resources briefing
19 10 18	100 Leaders meeting - hosting Duncan Selbie (CEO Public Health England) guest speaker
24 10 18	Governor 1:1
30 10 18	Presentation of certificates at iAspire training programme

Gloucestershire Health Economy

DATE	EVENT
11 09 18	Health and Care Overview and Scrutiny Committee meeting
12 09 18	Meeting with Sarah Scott (Gloucestershire Care Services) re. Research4Gloucestershire
12 09 18	Meeting with Rob Walker (2gether Trust) re. Research4Gloucestershire
18 09 18	Gloucestershire Health and Wellbeing Board meeting
19 09 18	King's Fund Integrated Care System diagnostics meeting
19 09 18	Michael Richardson (Gloucestershire Care Services) re. Research4Gloucestershire
19 09 18	Diane Crone (University of Gloucestershire) Research4Gloucestershire meeting
25 09 18	Gloucestershire Strategic Forum meeting with King's Fund
27 09 18	Presenting at Gloucestershire NHS70 awards
01 10 18	Marion Andrews-Evans (Clinical Commissioning Group) Research4Gloucestershire meeting
03 10 18	Ingrid Barker (Gloucestershire Care Services + 2gether Trust) 1:1 plus visit to Rapid Response team
17 1018	Research4Gloucestershire meeting
29 10 18	Hosting Countywide Continuous Improvement Conference with Prof. Don Berwick and Prof. Chris Ham (King's Fund)

National Stakeholders + others

DATE	EVENT
07 10 18	Attendance at Lord Lieutenant's Cadet Awards
09 10 18	NHS Providers National Conference
25 10 18	NHS Improvement Financial Special Measures meeting
01 11 18	Attendance at South West Regional Chairs' meeting

Peter Lachecki
Trust Chair
1st November 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – NOVEMBER 2018

REPORT OF THE CHIEF EXECUTIVE

1. Current Operational Context

1.1 The last two months have continued in a similar vein to previously with unusually high attendances and referral levels in a number of specialities and challenging performance in both cancer care and Accident & Emergency (A&E) services. However, despite this, the Trust continues to make progress and achieved the Accident & Emergency (A&E) performance trajectory for Quarter 2 enabling the Trust not only to continue to deliver for our patients but to secure the Provider Sustainability Funding (PSF) which is awarded to those Trusts achieving the A&E trajectory of 90% or more.

1.2 Achievement of cancer standards and reducing waiting times for routine care continues at pace, with considerable evidence demonstrating the success of the initiatives in place. Of note, the number of patients overdue follow up care and without scheduled appointment, has reduced dramatically and a range of transformation initiatives along the outpatient pathway are starting to bear fruit. There remains considerable progress to be made but progress to date is encouraging. Teams are currently finalising plans to ensure we achieve the national standard of a 50% reduction in the number of routine patients waiting more than 52 weeks for an outpatient appointment or elective procedure.

2. National and Regional

2.1 Matt Hancock, the new Secretary of State (SoS) for Health affirmed his priorities for health and social care In his address to NHS leaders at the NHS Providers Conference in early October. Mr Hancock reiterated the role he believes technology can play in reforming the NHS and his determination to be the SoS that addresses the workforce challenges that continue to undermine the success of the NHS. Equally, he affirmed his commitment to ensuring the wise use of recent funding and the emphasis he will ensure the Long Term NHS Plan places on prevention, early intervention and mental health in particular; the announcement of a *Minster for Suicide Prevention* is especially welcome.

2.2 Nationally and regionally, there is much focus on the reorganisation of roles within NHS England and NHS Improvement. As well as aligning the functions more closely and reducing duplication, the reorganisation is required to reduce the management cost of these two bodies by 20%. The reorganisation is likely to take in excess of 12 months and all parties are working to ensure these changes do not impact on 'business as usual'.

2.3 The 15th October was national Allied Health Professionals (AHP) Day; an event targeted at promoting the phenomenal contribution of AHPs to the NHS. Our Trust celebrated the event in a number of ways including individual Board members shadowing AHPs for the day. I spent the day with two super-passionate dieticians working on the 5th and 7th floors of GRH and learned more about their role and contribution to gastrointestinal and renal than I could have learnt from a month with my nose in a book. The Trust is incredibly fortunate in the calibre of AHP staff it attracts and retains.

2.4 Whilst the national Operational Planning Guidance for NHS Trusts is still awaited, proposals for funding acute NHS Trusts in 2019/20, through revisions to the national *Payment by Results* tariff, have recently been published for consultation. An impact assessment of the proposals on Gloucestershire Hospitals' Trust is underway. Ian Dalton, Chief Executive of NHSI has described 2019/20 as a year of 'transition' and

has indicated that control totals will remain for one further year although the value of the Provider Sustainability Funding (currently £8m for GHFT) will be reduced and the funding transferred directly to providers through emergency care tariffs. Key milestones for the planning round were set out in recent correspondence and are summarised below:

- Publication of National Planning Guidance (Including Revised Financial Framework) — 10th December 2018
- Draft Operating Plan Submission — 12th February 2019
- 2019/20 Contract Signature — 21st March 2019
- Final Operating Plan Submission — 4th April 2019

3. Our System and Community

3.1 Following a year of extensive work on the One System Business Case, leaders have now reviewed the final draft business case and concluded that the proposed clinical model of care cannot be implemented as planned. Whilst disappointing, it is imperative that any future service plans are both clinically and operationally viable, as well as affordable and the work done to date demonstrates that the proposed model for acute care cannot be implemented without further change to the overall model for hospital services.

However, the STP Delivery Board believes there remains a compelling case for change in relation to significant aspects of the original model and that the overall vision for *Centres of Excellence* for urgent and planned care remains strategically coherent and worth pursuing. Following the proposal to develop a 'reduced scope' business case, concerns have been expressed by a number of stakeholders, including politicians, about the 'piecemeal' nature of the changes and associated consultation. As a result, the Delivery Board has decided to defer consultation until later next year when it is anticipated that all the proposed service changes, within and outside the hospital, and including both urgent and planned care can be consulted upon in a single engagement exercise. This will require the extension of existing pilots in Trauma & Orthopaedics and Gastroenterology as well as agreement on a pilot for the proposed changes to General Surgery; these permissions will be sought at the November 13th meeting of. Stakeholder communication is included at Appendix 1.

3.2 Work to refine and describe our vision for the Gloucestershire Integrated Care System (ICS) is beginning to pick up momentum with a focus on securing support from those who are more advanced in the planning and/or delivery of integrated care. A number of workshops and development sessions have taken place with the aim of being able not only to articulate the Gloucestershire vision for an ICS but being in a position to set out a (high level) road map which will ensure delivery of that vision.

A Memorandum of Understanding between the participant organisations has now been agreed.

3.3 On the 10th October, around 70 leaders from across Gloucestershire came together with local charity Caring for Communities and People to raise awareness of the growing problem of homelessness in the county and to raise funds to enable shelters to be opened for 90 consecutive nights this winter, in both Cheltenham and Gloucester. Both Peter Lachecki, Trust Chair and myself joined others from around the county, on an unusually balmy October night, to sleep under the stars at Kingsholm rugby ground with nothing more than cardboard and a sleeping bag to see us through the night. We were fortunate to be joined by beneficiaries of CCP who told their stories and the difference support from the charity has made to their lives, many of whom are off the street and in employment. At the time of going to print participants had raised £49, 462.

4. Our Trust

4.1 October has been an incredibly busy month in the Trust with us being examined from multiple angles!

4.2 Week commencing the 8th October saw the Care Quality Commission undertake their unannounced Core Services Inspection of four service domains in the Trust - surgical care, medical care, emergency care and outpatients. Positive verbal feedback was received with inspectors describing staff as engaged, caring and proud; they talked about leaders at every level being visible and empowering and, best of all, they described our approach to quality improvement as 'as good as they had ever seen' with staff, wherever they went, recounting the projects they had done, or were doing, with the support of the Quality Academy. As pleasing, was their observation that, aside from the formal GSQIA work, staff were 'improvement-focussed' and almost all able to describe their services, or their own, *journey to outstanding*. Inevitably, there was lots of feedback where practice wasn't as it should be and some of this was frustratingly in the own-goal territory (fridge temperatures, hand hygiene and troublesome doors to name just a few) but, on the balance of things, positive feedback.

4.3 In keeping with previous inspections, it's not over yet as the inspectors will be back in the next fortnight or so to undertake an out-of-hours visit either on a mid-week evening or at a weekend. When returning, they almost always take the chance to check up on how organisations have responded to their informal feedback and Steve Hams, Chief Nurse and lead for the Core Services Inspection captured 22 elements of feedback, all of which have timed and owned actions against them, with the aim of addressing them all by the time of the Well Led Review.

4.4 On the 17th October, Health Education England visited the Trust for their annual review of our teaching activities, both medical and non-medical. It was a very positive meeting with feedback from learners improving across many areas; of note was the huge improvement in feedback from Trauma & Orthopaedic trainees about the improvements in their teaching and learning experience since the reconfiguration of services last year. The Trust was also commended on its approach to developing alternative roles to address the challenges in medical recruitment.

4.5 On the 18th October 2018, NHS Improvement spent the day with the Trust undertaking element two of the CQC Inspection in the guise of the Use of Resources (UoR) visit. Sarah Stansfield, Director of Finance led preparations for the UoR visit and is to be commended for the work. Feedback was very limited at the end of play but the general sense from those involved was that it too had gone well.

4.6 On the 19th October, our *100 Leaders* were privileged to host a visit from Duncan Selbie, Chief executive of Public Health England. Duncan spoke passionately (and humorously) about the challenges facing the nation and its health. Despite a huge focus on addressing the determinants of ill-health there remains a 19 year gap in life expectancy between the best and worse off places in England. He talked about his belief that public health resources – people and money – are best placed in local authorities and reminded us that the biggest determinants of health and ill-health are wealth and poverty, respectively. Many of us came away from the session with a determination to revisit the work of a decade or so, developed by the World Health Organisation (WHO) regarding the creation of *health promoting hospitals.* Watch this space.

4.7 Work is progressing well with the development of the business case for the major capital schemes (£39.5m) at GRH and CGH. Milestones since the last Board include the appointment of our construction partner, Kier and presentation of the Strategic Outline Case (SOC) to the November Trust Board en route to final sign off at the April 2019 Board. Importantly, the Trust will be using the business case process to continually test that the iterations of the case address the evolving understanding of our future needs and clinical models, as service reconfiguration work progresses.

4.8 With only hours to develop and submit a bid against a notification of national capital to support winter pressures, the Trust has been advised that its FULL bid was successful. As a result the Trust has secured £1.3m of capital funding to enable capital works at GRH in support of the acute floor model and to enable enhanced development of information management systems to support patient flow and theatre productivity.

4.9 In a similarly positive vein we were advised this week, by NHS England, that we have been successful in our bid to the National Modernising Radiotherapy Fund and will receive £1.7m of capital for a new Linear Accelerator (Linac), a state of the art radiotherapy machine. We had been awarded capital last year but were unable to draw down the funding in the end due to the vagaries of Financial Special Measures and control totals.

4.10 Finally, on the technology theme, this week our hospitals' charity launched a major appeal to raise £1.2m of funding to match the generosity of a local anonymous donor, which will enable the Trust to purchase three new CT scanners and two digital mobile x-ray machines. Such funding is crucial to the continued development of the Trust given our challenged capital position. The loan application to the Department of Health, for £10m to enable the delivery of this year's full capital programme remains outstanding.

4.11 The Trust continues with its regular engagement activities with NHSI and the Financial Special Measures (FSM) team. On the 25th October, Chair, Director of Finance and myself met with the NHSI team to formally review the Trust's preparedness for exiting FSM. I am delighted that the team believe that the Trust's financial position and its governance arrangements are such that 'we no longer fit in special measures' and as such our NHSI Improvement Director, Mark Shires will be presenting our case to the national panel with a strong recommendation for our discharge from the regime. A great start to the Well Led Review and a fitting end to the year.

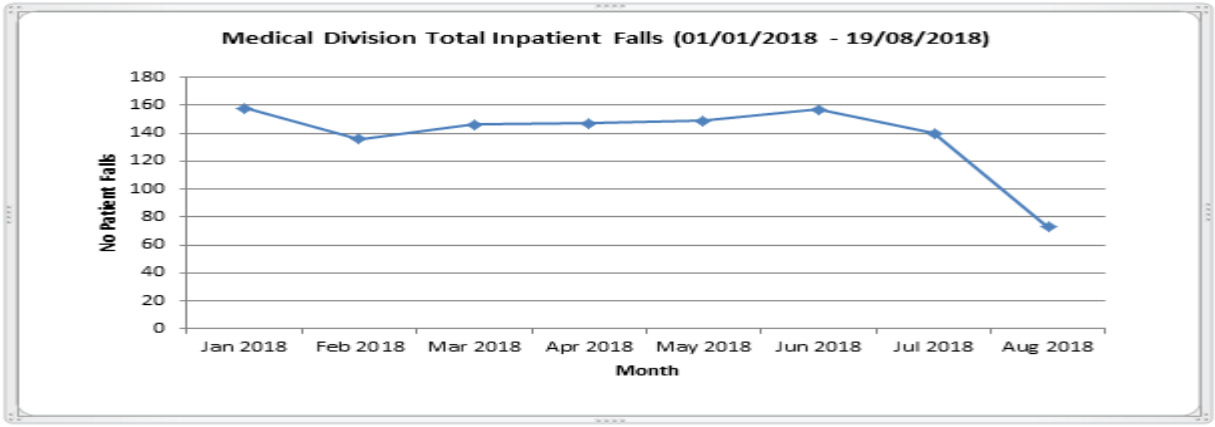
4.12 The continued focus on TrakCare recovery continues with significant improvements in data quality now being demonstrated, including a 50%+ reduction in the number of data quality issues and a very significant reduction in new errors following the development of Standard Operating Procedures and training of staff. NHS Digital completed their review visit following the initial Deep Dive in November 2017 and their final report has now been received and is progressing through several governance points culminating in presentation to the Trust Board in November. The report is very positive and confirms that recovery is firmly underway and close to completion in most areas and will be an important source of assurance for commissioners and regulators.

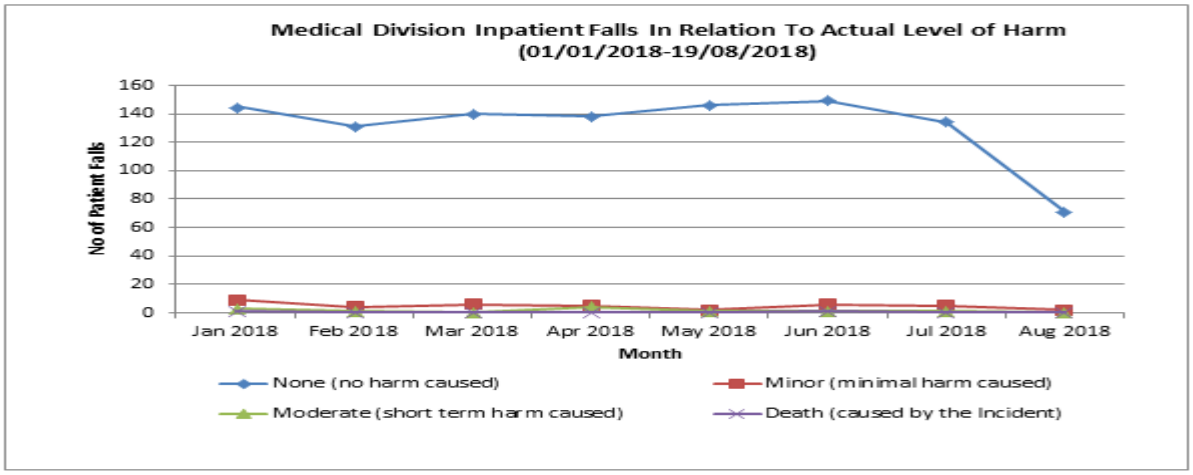
4.13 October was national #SpeakUpToMe month and was embraced by the Trust with much credit to Suzie Cro, Freedom To Speak Up Guardian who arranged multiple activities throughout the Trust and maintained a positive profile on social media throughout the month. As well as focussing attention on this important issue, Suzie also set out to find out more about what needs to change for *speaking up* to be something staff find easy to do and which is welcomed when it happens. There have been lots of activities going on in the Trust from Kitchen Table Events talking about how to create 'safe spaces' that encourage people to feel able to speak up about concerns to an unprecedented number of staff seeking out Suzie to air personal concerns. Access to Suzie has been rising since her role was established over a year ago from an initial five contacts a quarter to more typically five a month, to an all-time high of five on one day during the campaign period. Analysis of the month and the learning from feedback will be evaluated and inform the forward plans for ensuring the Trust continues to develop a positive culture where staff feel able to speak up about things that concern them.

4.14 On Wednesday the 9th October the Trust celebrated World Mental Health (WMH) Day to raise awareness of the importance of supporting staff and patients who suffer from mental health problems and ensuring the Trust is doing all it can to promote the psychological well-being of our staff. My own weekly message on this topic generated an unprecedented level of feedback confirming the importance of this topic through the Trust. Following this the Diversity Network hosted Paul Deemer, NHS Providers

Diversity Lead to explore what more the Trust can do to promote psychological well-being and make the Trust a supportive and inclusive place to work for those that experience mental health problems. One key initiative that I hope will contribute to staff well-being, which was very well received when presented to the Diversity Network is a new *Health and Well-being Hub*. The Hub, which is hoped will go live in April 2019, will provide on-line support, sign-posting and access to a range of information, tools and services to ensure staff have the best chance of being physically and psychologically well. Of note, the aim is to improve access to services such as occupational health and counsellors where currently staff can be exposed to significant waits at a time when they need it most. Finally, many staff responding to the WMH Day messages spoke of the value in having trained 'mental health first-aiders' in each work area in the way we have such volunteers to respond to a cut finger and this is something that the *Health and Well-being Hub* will include.

4.15 Finally, the Board particularly welcomed the changes and extension to visiting hours and a formal evaluation of the changes is now underway and expected to be concluded by the end of November. The impact at ward level has been variable but on the whole the changes are being increasingly well received. Early indications are that some of the benefits seen on the pilot wards are being widely experienced such as a reduction in the number of falls, demonstrated below. Attribution of the reduction directly to a change in visiting hours is not straight forward given the general focus on falls prevention but the timing is interesting!





4.16 A good month by anyone's standard!

Deborah Lee
Chief Executive Officer
November 2018

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

Report Title
Quality and Performance Report
Sponsor and Author(s)
Authors: Felicity Taylor Drewe, Director of Planned Care, Deputy Chief Operating Officer Suzi Cro, Deputy Director of Quality 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 September 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

Caring – patient experience
The FFT SMS system was accidentally switched for a period during September by our supplier. This has been investigated and was a human error after we requested for the additional maternity portal to be switched off and they switched the whole SMS system off for all the areas. We have continued to get voice message scores for ED, Inpatient and OPA and these scores have been submitted to NHS England. As there were no maternity voice messages we could not submit any data and we have had to put in a NIL return for maternity with an explanation. Our supplier has apologised for their error and has transcribed all the voice messages so that we do have experience data for our wards/areas to review.

Performance

During September, the Trust met the Trust and NHS I/E Trajectory for A&E 4 hour standard and diagnostics. 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 September 2018, the trust performance against the 4hr A&E standard was 89% with an average of 416 attendances per day. Month to date performance (18 September) is currently 89.9% which is on track to deliver the STF June trajectory (90%). The quarter 2 performance was 90.2%.

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 have planned to re-report in March 2018. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways; however, as reported previously to the Board we will continue to see 52 week breaches until full data cleansing exercise is completed and our patient

tracking list is accurate. Alignment with the Trak Recovery Programme in relation to RTT operational management remains vital. The Trust continues a review panel with CCG membership for the longest waiting patients now until full recovery of zero long waiting patients.

Our performance against the cancer standard saw a decrease against the 2 week standard for which continued into September, as a result of addressing the Lower GI backlog and impact of the skin increase in referrals with performance at 82.6% (Un-Validated). The main tumour site that was compromised on the 2 week pathway remains Lower GI (180 breaches), and skin (106 breaches), and the current Patient Tracking list illustrates a clear reduction in the backlog for October, for which performance is significantly increased.

The existing Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed and reviewed on a fortnightly basis. One tumour site (urology) continues to demonstrably impacts the aggregate position with significant number of 62day breaches and this has continued into the September position.

Cancer 62 day Referral to Treatment (GP referral) performance for August was 76.4%%, this was an increase in performance, and it was predicted and planned for across the pathways.

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. 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.

Conclusions

Cancer delivery, with a particular focus on Urology recovery, 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 & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓					✓	
Outcome of discussion when presented to previous Committees						

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period September 2018

to be presented at October 2018 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During September 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.

The Trust has met the 4 hour standard in Quarter Two, 90.2% against the STP trajectory at 90% against a backdrop of significant attendances.

The Trust has met the diagnostics standard for September at 0.63%, this is as yet un-validated performance at the time of the report.

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 significant increase in referral rates and the adoption of the new straight to test colorectal pathway whilst successful has meant that we are continuing to treat the backlog.

For elective care, the levels of validation across the RTT incompletes, Inpatient and Outpatient Patient Tracking List (PTL) is significant.

The QPR quality metrics are now reviewed at every Quality Delivery Group (QDG) meeting. Improvement work is ongoing with the QPR system.

Patient experience

The inpatient FFT score remains static and below the target set by the Trust and below the national average. In order to give staff more availability of contemporaneous feedback data a new system (MES) has been purchased for real time surveys and the volunteers have been recruited to start the programme. Testing of the system has started before roll out across the ward and department areas. An implementation plan has been created and an update will be given within each Patient Experience Insight and Improvement Quarterly report.

Metrics

There are improvement work streams for indicators that are being monitored and reported through the QDG. The VTE assessment work stream is being led by the Director of Safety and the Dementia assessment is being led by Divisional Chief Nurse John Buford. Within the QDG exception report there is an update from the improvement groups.

Safety
The Theatre (Never Events) improvement plan is presented at each QDG meeting by the Surgical Division and clear progress is being made on the actions.

In summary, the position for the Trust in a number of key quality metrics are noted in the exception reports:

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

Strengths

4 hour performance continues to perform well, delivering the Q2 position despite average attendances of 416 per day.

The national standard for % of patients seen within 6 weeks for Diagnostic tests, has delivered.

Operational oversight of cancellations, which is now back to pre-trak cancellation levels. Outcome recording and clinic typing through the development of a suite of Business Intelligence reports has been helpful to support operational colleagues. The next stage is to take this through to weekly email issuing. There are still data quality errors with reports across operational areas, resulting in a large degree of validation and / or manual counting in the case of theatre cancellations.

QPR being reviewed at the QDG meeting with Divisional representation present.

A collaborative event in relation to Cancer performance, was initiated by the Trust with CCG colleagues, NHS E and NHS I colleagues to support future plans.

Weaknesses

Referral rates within Unscheduled and Scheduled Care that are significantly above contractual levels and continue to impact into our key metrics.

The Trust has made progress for recovery in a number of key performance areas, however key weakness are around the number of patients waiting past 52 weeks for their treatment and the numbers of patients to be reviewed both administratively and clinically in the follow up group of patients.

Our indicators for Dementia remain a concern and diagnostic work continues to review how we can improve the recoding of this data in Trakcare. An audit has been commissioned to look at the clinical records to compare with the data that is recorded within Trak.

Inpatient FFT score.

For VTE we are submitting clinical audit data instead of TRAK data whilst we improve the recording process.

Opportunities

Nursing Accreditation and Assessment Audits have commenced on the wards with 10 audits completed and the results are that we have 4 red wards, 2 amber and 4 green ward areas. Each of the red wards will be revisited to look for improvements.

Risks & Threats

The risks and threats for remain as last month and whilst there are mitigations in place they are detailed as follows:

Cancer performance remains a significant risk for the Trust, of particular the sharp increase in referrals above any planned increases or seasonal levels, this has continued into August, (e.g. 49% in Dermatology). The Trust is working with the Clinical Commissioning Group on a joint project that is working with Primary Care to address the quality of referrals received into the two week wait team and to audit the patient information leaflets. 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, alongside our sustainable workforce.

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. During September and August, significant validation has been undertaken on the Outpatient Waiting List and a draft Inpatient Waiting List from both the central and speciality teams. Operational colleagues are represented at the Governance structure relating to the Trak Deep Dive Recovery programme. This will remain a risk for 2018, with the appropriate mitigations in place to support operational delivery.

Performance Against STP Trajectories

* = unvalidated data

The following table shows the monthly performance of the Trust's STP indicators.

RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.

Indicator		Month												
		Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
ED Total Time in Department – Under 4 Hours	Trajectory	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%						
	Actual													
% waiting for Diagnostics 6 Week Wait and over (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%	1.00%
	Actual	2.90%	0.46%	0.51%	0.75%	0.64%	0.49%*	0.26%	0.56%	1.26%	0.52%	0.55%	1.27%*	0.63%
Cancer - Urgent Referrals Seen in Under 2 Weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.10%	93.00%
	Actual	71.20%	74.60%	75.80%	81.20%	86.40%	90.60%	90.50%	86.60%	86.30%	88.60%	90.40%	88.90%	82.50%*
2 week wait Breast Symptomatic referrals	Trajectory	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%	93.20%	93.30%	93.40%	93.40%	93.30%	93.20%
	Actual	92.70%	89.00%	94.50%	96.30%	92.40%	97.60%	94.50%	91.30%	91.90%	95.10%	96.00%	97.80%	98.90%*
Cancer – 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%	96.10%	96.30%	96.10%	96.20%	96.30%	96.20%
	Actual	98.50%	95.10%	96.70%	97.30%	96.00%	97.60%	97.90%	96.70%	96.90%	97.10%	96.80%	96.90%	93.90%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	Trajectory	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%	98.50%	100.00%	98.80%	98.10%	100.00%	98.40%
	Actual	98.50%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.70%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	Trajectory	94.90%	94.10%	94.60%	94.40%	94.40%	94.10%	94.20%	95.50%	95.80%	94.60%	95.10%	94.60%	95.00%
	Actual	96.60%	97.10%	98.50%	98.10%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.70%	100.00%	100.00%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	Trajectory	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%	95.10%	95.00%	94.20%	95.90%	94.60%	95.30%
	Actual	95.50%	94.60%	98.10%	94.90%	93.00%	95.50%	98.00%	94.90%	96.60%	94.50%	96.00%	95.70%	90.60%*
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%	92.00%	94.70%	90.50%	90.00%	91.20%	92.10%
	Actual	94.90%	87.10%	93.80%	95.50%	98.00%	95.90%	95.90%	100.00%	94.10%	100.00%	100.00%	100.00%	85.90%*
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	85.70%	50.00%	60.00%	100.00%	0.00%	80.00%	94.10%	76.50%	100.00%	84.60%	53.30%	100.00%	75.00%*
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%	82.80%	84.40%	85.30%	79.70%	77.10%	81.70%
	Actual	69.20%	71.40%	76.70%	73.40%	69.70%	79.10%	78.10%	80.30%	79.90%	66.90%	74.70%	76.30%	61.30%*

Summary Scorecard

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

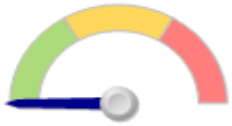
RAG Rating : Overall RAG rating for a domain is an average performance of lead indicators, where data is not available the lead indicator is treated as Red

QUALITY

% of Adult Inpatients who have Received a VTE Risk Assessment	C.Diff Cases – Cumulative Totals
Emergency re-admissions within 30 days following an elective or emergency spell	Hospital Standardised Mortality Ratio (HSMR)
Hospital Standardised Mortality Ratio (HSMR) – Weekend	MRSA Bloodstream Cases – Cumulative Totals
Number of Breaches of Mixed Sex Accommodation	Safety Thermometer – New Harm Free
Total % Positive	

OPERATIONAL PERFORMANCE

% waiting for Diagnostics 6 Week Wait and over (15 Key Tests)
Cancer 62 Day Referral To Treatment (Screenings)
Cancer 62 Day Referral To Treatment (Upgrades)
Cancer 62 Day Referral To Treatment (Urgent GP Referral)
ED Total Time in Department – Under 4 Hours



FINANCE

YTD Performance against Financial Recovery Plan

LEADERSHIP AND DEVELOPMENT

% Sickness Rate
% Turnover

Trust Scorecard

* = unvalidated data

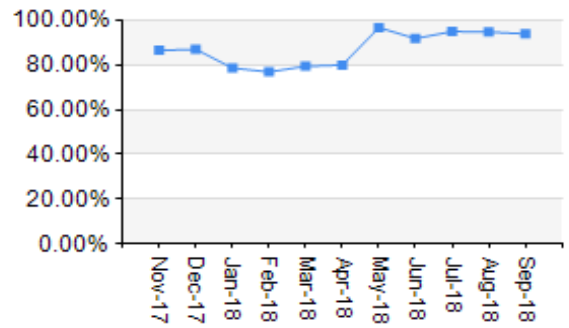
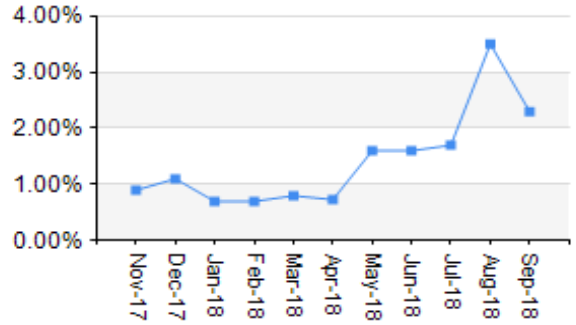
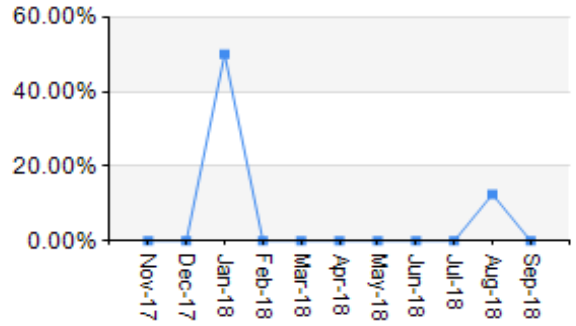
Category	Indicator	Standard 2017/18	Month							Annual	Standard 2018/19	Month						Quarter	Annual
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 Q2	18/19
Quality	**Key Indicators - Quality**																		
	ED % Positive	>=86%	81.1%	81.0%	87.4%	85.9%	85.6%	82.7%	83.7% *	83.0% *	R<81% A81-83% G>=84%	83.1%	83.2%	84.6%	83.6%	82.0%	85.9%	83.5%	83.6% *
	Inpatients % Positive	>=95%	90.1%	91.2%	90.6%	91.6%	91.5%	92.0%	89.7% *	90.9% *	R<93% A93-95% G>=96%	90.2%	91.4%	91.7%	91.7%	90.7%	91.9%	91.4%	91.2% *
Friends & Family Test	Maternity % Positive	>=97%	94.7%	100.0%	100.0%	90.3%	100.0%	88.9%	93.6% *	95.6% *	R<94% A94-96% G>=97%	97.4%	94.0%	95.6%	93.3%	94.7%	0.0%	93.3%	94.8% *
	Outpatients % Positive	>=93%	91.5%	91.3%	92.2%	92.4%	93.3%	93.1%	92.3% *	92.1%	R<91% A91-93% G>=94%	92.0%	92.3%	92.3%	93.3%	91.9%	92.3%	93.3%	92.4% *
	Total % Positive		90.1%	90.8%	91.5%	91.0%	92.2%	91.9%	90.9%	91.1%	R<90% A90-92% G>=93%	90.6%	91.2%	91.3%	91.6%	90.3%	91.6%	91.1%	91.1% *
Infection Control	MRSA Bloodstream Cases – Cumulative Totals	0	1 *	1 *	0	0	0 *	0 *	0 *	1 *	0	1	1	1	2 *	3	5	5	5 *
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	99.7	97.1	94.8	93.4	93.1	95	96	96	Dr Foster confidence level	98.3	95.2	96					96 *
	Hospital Standardised Mortality Ratio (HSMR) – Weekend	Dr Foster confidence level	108.9	103.9	101.5	97.1	95	97.7	98.4	98.4	Dr Foster confidence level	101.1	97.3	97.1					97.1 *
	Summary Hospital Mortality Indicator (SHMI) – National Data	Dr Foster confidence level	108.7			107			107.2	107.2	Dr Foster confidence level								
MSA	Number of Breaches of Mixed Sex Accommodation	0	18	19	13	11	5	7	6	134	R>=20 A11-19 G<=10	8	8	20	5	6	0	11	47 *
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	Q1<6% Q2<5.8% Q3<5.6% Q4<5.4%	6.5% *	6.5% *	6.7% *	7.6% *	6.3% *	7.9% *	7.2% *	7.0% *	R>6.8% G<6.8%	7.4% *	7.1% *	7.5% *	7.5% *	7.9% *			7.5% *
VTE Prevention	% of Adult Inpatients who have Received a VTE Risk Assessment	>95%									R<=95% A96% G>97%	79.9% *	96.6% *	91.7% *	94.8% *	94.6% *	93.8% *	94.4% *	94.0% *
	Detailed Indicators - Quality																		
Dementia Screening	% of patients who have been screened for Dementia (within 72 hours)	>=90%	0.4% *	0.7% *	0.9% *	1.1%	0.7% *	0.7%	0.8%		R<70% A70-89% G>=90%	0.7%	1.6%	1.6%	1.7%	3.5% *	2.3% *	2.9% *	1.4% *
	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	>=90%	0.0% *	0.0% *	0.0% *	0.0%	50.0% *	0.0%	0.0%		R<70% A70-89% G>=90%	0.0%	0.0%	0.0%	0.0%	12.5% *	0.0% *	11.8% *	0.0% *
	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	>=90%	50.0% *	60.0% *	50.0% *	57.1%	100.0% *	33.3%	66.7%		R<70% A70-89% G>=90%	50.0%	16.7%	33.3%	11.1%	41.2% *	18.2% *	37.2% *	24.0% *
ED Checklist	ED Safety checklist compliance CGH	R<50% A50-79% G>=80%	79%		78%	92%	86% *	83% *	82% *		R<50% A50-79% G>=80%	82% *	89% *	84% *	88% *	90% *			
	ED Safety checklist compliance GRH	R<50% A50-79% G>=80%	79%		68%	67%	72% *	81% *	81% *		R<50% A50-79% G>=80%	85% *	73% *	73% *	75% *				
Emergency Department	ED: % of time to initial assessment – Under 15 minutes	>=99%	86.2%	86.7%	91.7%	89.9%	91.9%	88.2%	89.5%	86.7% *	R<92% A92-94% G>=95%	90.5%	90.3%	90.8%	88.6%	90.7%	87.3%	88.6%	90.1% *
	ED: % of time to start of treatment – Under 60 minutes	>=90%	31.2%	37.5%	41.5%	40.7%	43.3%	32.7%	35.2%	34.5% *	R<87% A87-89% G>=90%	36.8%	33.6%	34.1%	31.4%	34.3%	29.0%	31.4%	34.0% *
Infection Control	C.Diff Cases – Cumulative Totals	18/19 = 36	24	29	35	41	45	49	56	56	R>3 G<=3	5	14	16	23 *	29	32	32	32 *
	Ecoli – Cumulative Totals		119 *	146 *	175	200	222 *	240 *	258 *	258 *	TBC	17	32	56	79 *	107	139	139	139 *
	Klebsiella – Cumulative Totals										TBC	6	12	13	22 *	29	39	39	39 *
	MSSA Cases – Cumulative Totals	No target	54 *	63 *	68	78	89 *	93 *	100 *	100 *	TBC	9	18	28	41	49	63	63	63 *
	Pseudomonas – Cumulative Totals										TBC	2	3	6	14 *	17	20	20	20 *
Maternity	Percentage of Spontaneous Vaginal Deliveries		64.9% *	60.2% *	57.5% *	60.9% *	57.0% *	63.4% *	61.8% *	62.4% *	0	57.5% *	61.4% *	60.0% *	64.3% *		63.1% *	62.6% *	61.9% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90%	85.9% *	87.8% *	89.5%	86.6% *	88.7% *	89.2% *	89.9% *	89.5% *	>90%	92.7% *	90.1% *	90.5% *	89.8% *	87.4% *	89.6% *	88.8% *	89.2% *
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.3 *	3.3 *	3.6 *	3.4 *	4.1 *	3.5 *	3.6 *		Current mean	3.6 *	4.6 *	4.4 *	4.3 *	4 *	3.8 *		

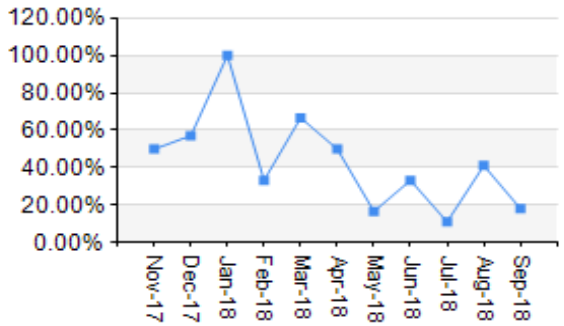
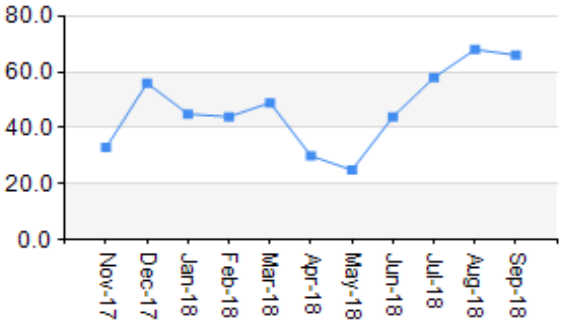
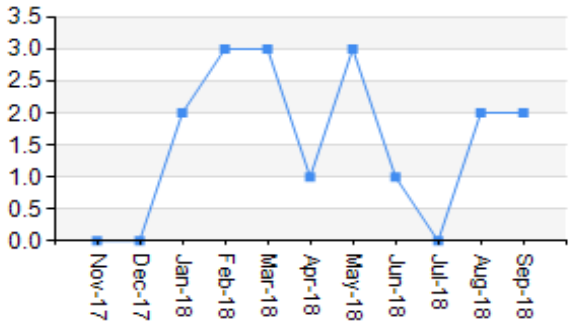
Category	Indicator	Standard 2017/18	Month							Annual	Standard 2018/19	Month						Quarter	Annual
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 Q2	18/19
	Patient Safety Incidents	Number of falls per 1,000 bed days	Current mean	7 *	7.3 *	7 *	8.2 *	7.8 *	7.3 *	7.7 *		TBC	8.3 *	7.6 *	8.3 *	6.9 *	6.3 *	7.5 *		
		Number of falls resulting in harm (moderate/severe)		11 *	7 *	4 *	13 *	18 *	10 *	8 *		TBC	10 *	8 *	7 *	11 *	6 *	9 *	9 *	8 *
		Number of Patient Safety Incidents - severe harm (major/death)		3 *	1 *	1 *	1 *	3 *	1 *	1 *		TBC	2 *	1 *	1 *	1 *	1 *	2 *	1 *	1 *
		Number of Patient Safety Incidents Reported		1,033 *	1,079 *	1,041 *	1,025 *	1,260 *	1,139 *	1,229 *		0	1,192 *	1,210 *	1,199 *	1,206 *	1,142 *	1,202 *	1,183 *	
		Pressure Ulcers – Category 2	R=1% G<1%	0.61% *	1.13% *	0.79% *	0.54% *	1.30% *	1.63% *	0.48% *		R=1% G<1%	0.39% *	0.39% *	0.90% *	0.25% *	0.57% *	0.68% *		
		Pressure Ulcers – Category 3	R=0.3 G<0.3%	0.37% *	0.00% *	0.13% *	0.14% *	0.47% *	0.63% *	0.24% *		R=0.3 G<0.3%	0.00% *	0.00% *	0.00% *	0.13% *	0.14% *	0.00% *		
		Pressure Ulcers – Category 4	R=0.2% G<0.2%	0.12% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *		R=0.2% G<0.2%	0.00% *	0.00% *	0.00% *	0.00% *	0.14% *	0.00% *		
	Research	Research Accruals	17/18 = >1100	127 *	60 *	76 *	29 *	80 *	61 *	112 *	1,770 *	TBC	42 *	54 *	16 *					19 *
	RIDDOR	Number of RIDDOR	Current mean	0 *	3 *	1 *	7 *	1 *	1 *	1 *	2	Current mean	4 *	0 *	1 *	2 *	2 *	5 *	3 *	
	Safe nurse staffing	Care Hours per Patient Day total		7	7	7	7	7	7	7	7		7	7	8	7	7	7	7	7 *
	Safety Thermometer	Safety Thermometer – Harm Free	R<88% A89%-91% G>92%	94.2% *	92.9% *	93.0% *	93.1% *	90.1% *	91.8% *	91.5% *		R<88% A89-91% G>92%	92.8% *	93.8% *		92.2% *	94.2% *	93.4% *	93.2% *	
		Safety Thermometer – New Harm Free	R<93% A94%-95% G>96%	97.4% *	97.4% *	97.0% *	96.9% *	96.0% *	96.4% *	97.6% *		R<93% A94-95% G>96%	98.0% *	97.8% *		98.4% *	97.7% *	98.6% *	98.3% *	
	Sepsis Identification and Treatment	% of patients screened in ED for Sepsis	>90%	98.0% *	96.0% *	94.0% *	98.0% *	98.0% *	98.0% *	100.0% *		R<50% A50-89% G>=90%	98.0% *	98.0% *	100.0% *					
		% of patients who were administered IVABs with 1 hour of arriving to ED	>50%	90.0% *	79.0% *	80.0% *	83.0% *	89.0% *	84.0% *	78.0% *		R<50% A50-89% G>=90%	82.0% *	88.0% *	88.0% *					
	Serious Incidents	Number of Never Events reported	0	1 *	0 *	0 *	1 *	0 *	0 *	1 *	3 *	0	1 *	0 *	0 *	0 *	0 *	0 *	0 *	1 *
		Number of Serious Incidents Reported		2 *	1 *	1 *	1 *	3 *	10 *	2 *		0	3 *	10 *	5 *	0 *	4 *	4 *		
		Percentage of Serious Incident Investigations Completed Within Contract Timescale		100% *	100% *	100% *	100% *	100% *	100% *	100% *		>80%	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% *		G>90%	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	.9 *	1.7 *	3.1 *	1.9 *	2.6 *	2.4 *	2.8 *		Current mean	1.4 *	2.8 *	1.7 *	2.5 *	2.3 *	2.2 *	2.3 *	
		Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	2.9 *	2.1 *	2.4 *	1.5 *	1.4 *	2.6 *	2.8 *		Current mean	4 *	2.8 *	2.5 *	3.3 *	2.1 *	2.9 *	2.8 *	
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	61.5%	81.0%	78.1%	69.6%	67.7%	60.0%	76.0%	66.9% *	>=60%	69.4%	73.5%	69.6%	58.6%	70.8%	51.5% *	59.3%	65.4% *
		Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour	>=50%	45.5%	40.3%	37.1%	33.8%	46.2%	38.2%	41.0%	37.6% *	R<45% A45-49% G>=50%	36.7%	50.0%	40.6%	37.8%	47.0%	41.5%	42.0%	42.1% *
		Stroke Care: Percentage of patients Spending 90%+ Time on Stroke Unit	>=80%	98.2%	89.3%	89.4%	74.0%	91.8%	94.4%	73.5%	88.2% *	R<70% A70-79% G>=80%	90.4%	95.1%	95.6%	94.1%	97.2%			94.2% *
	Trauma & Orthopaedics	% of fracture neck of Femur patients treated within 36 Hours		66.7% *	80.4% *	67.2% *	81.4% *	73.9% *	83.8% *	64.4% *	72.7%	R<80% A80-89% G>=90%	72.2% *	79.4% *	68.3% *	74.2% *	88.7% *	85.5% *	82.7% *	76.0% *
		Fracture Neck of Femur – Time To Treatment 90th Percentile (Hours)		59.7 *	46.9 *	47.6 *	43.1 *	45.7 *	42.3 *	64.4 *	48.5		48.1 *	42.3 *	49.8 *	51.8 *	38.4 *	38.6 *	42.3 *	31 *
		Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		98.5% *	98.2% *	98.4% *	100.0% *	98.5% *	100.0% *	98.4% *	98.4%		94.4% *	91.2% *	93.7% *	100.0% *	98.4% *	98.2% *	90.9% *	99.0% *
Operational Performance	**Key Indicators - Operational Performance**																			
	Cancer	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	94.9%	87.1%	93.8%	95.5%	98.0%	95.9%	95.9%	92.2%	R<85% A85-89% G>=90%	100.0%	94.1%	100.0%	100.0%	100.0%	85.9% *	93.9% *	95.5% *
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	85.7%	50.0%	60.0%	100.0%	0.0%	80.0%	94.1%	79.8%	>=90%	76.5%	100.0%	84.6%	53.3%	100.0%	75.0% *	80.7% *	80.0% *
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	69.2%	71.4%	76.7%	73.4%	69.7%	79.1%	78.1%	75.0%	R<80% A80-84% G>=85%	80.3%	79.9%	66.9%	74.7%	76.3%	61.3% *	77.5% *	76.3% *
	Diagnostics	% waiting for Diagnostics 6 Week Wait and over (15 Key Tests)	<1%	2.90%	0.46%	0.51%	0.75%	0.64%	0.49% *	0.26%	0.26%	R>2% A1.01-2% G<=1%	0.56%	1.26%	0.52%	0.55%	1.27% *	0.63%	0.63%	0.63% *
	ED – Time in Department	ED Total Time in Department – Under 4 Hours	>=95%	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%	86.70% *	R<90% A90-94% G>=95%	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%	91.34%	91.70% *

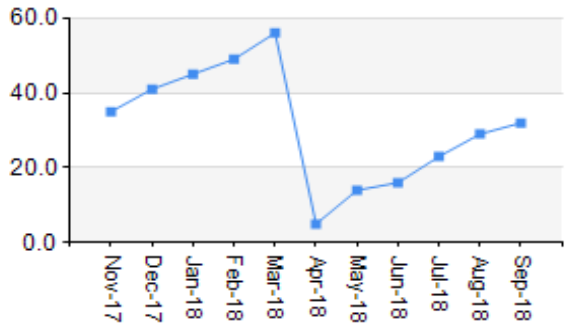
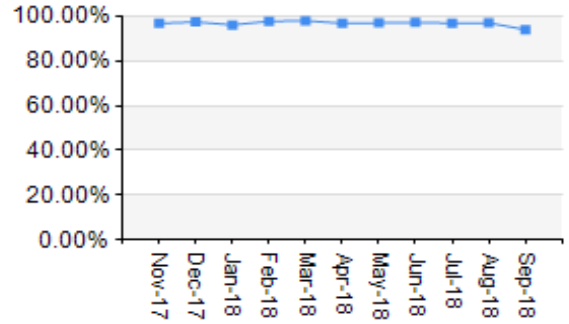
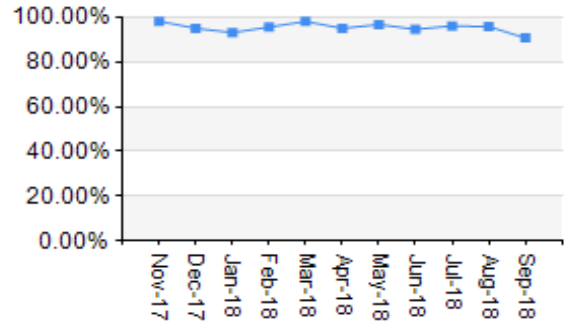
Category	Indicator	Standard 2017/18	Month							Annual	Standard 2018/19	Month						Quarter	Annual
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 Q2	18/19
	Detailed Indicators - Operational Performance																		
	Cancer	2 week wait Breast Symptomatic referrals	>=93%	92.7%	89.0%	94.5%	96.3%	92.4%	97.6%	94.5%	90.4%	R<90% A90-92% G>=93%	91.3%	91.9%	95.1%	96.0%	97.8%	98.9% *	97.4% *	95.6% *
		Cancer – 31 Day Diagnosis To Treatment (First Treatments)	>=96%	98.5%	95.1%	96.7%	97.3%	96.0%	97.6%	97.9%	96.3%	R<94% A94-95% G>=96%	96.7%	96.9%	97.1%	96.8%	96.9%	93.9% *	96.1% *	96.4% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	>=98%	98.5%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.8%	R<96% A96-97% G>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7% *	99.6% *	99.8% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	>=94%	96.6%	97.1%	98.5%	98.1%	100.0%	100.0%	100.0%	99.1%	R<92% A92-93% G>=94%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0% *	99.5% *	99.5% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	>=94%	95.5%	94.6%	98.1%	94.9%	93.0%	95.5%	98.0%	94.8%	R<92% A92-93% G>=94%	94.9%	96.6%	94.5%	96.0%	95.7%	90.6% *	94.6% *	95.3% *
		Cancer - Urgent Referrals Seen in Under 2 Weeks from GP	>=93%	71.2%	74.6%	75.8%	81.2%	86.4%	90.6%	90.5%	82.3%	R<90% A90-92% G>=93%	86.6%	86.3%	88.6%	90.4%	88.9%	82.5% *	87.4% *	87.6% *
		Number of patients waiting over 104 days with a TCI date	0	19	17	6	9	10	4	6	6	0	9	12	6	8	22	26	26	26 *
		Number of Patients waiting over 104 days without a TCI date	0	26	23	34	34	19	14	17	17	TBC	18	18	22	28	24	30	30	30 *
	Diagnostics	The number of planned / Surveillance Endoscopy Patients Waiting at Month End		1,298	1,062	867	733	239 *	106	123	123	TBC	188	223	260	311	407	576	576	576 *
	Discharge	Number of patients delayed at the end of each month	<14	32	29	34	41	22	23	34	34	TBC	37	27	36	47	44	41	41	41 *
		Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	59.8% *	60.0% *	61.1% *	59.9% *	56.9% *	57.7% *	59.4% *	60.7% *	>=85%	62.0% *	60.3% *	64.7% *	62.0% *	62.3% *			62.2% *
	Emergency Department	Ambulance Handovers – Over 30 Minutes	< previous year	30	38 *	33	56	45	44	49	506	< previous year	30	25	44	58	68	66	192	291 *
		Ambulance Handovers – Over 60 Minutes	< previous year	1	0 *	0	0	2	3	3	15	< previous year	1	3	1	0	2	2	4	9 *
		ED: % total time in department - Under 4 Hours CGH	>=95%	93.20%	93.80%	97.10%	96.60%	93.60%	95.10%	96.50%	93.90% *	R<90% A90-94% G>=95%	97.80%	98.10%	96.30%	96.90%	96.00%	96.40%	96.93%	97.00% *
		ED: % total Time in Department – Under 4 Hours GRH	>=95%	82.40%	86.60%	94.40%	88.00%	87.90%	85.30%	82.30%	83.00% *	R<90% A90-94% G>=95%	89.10%	88.10%	91.80%	88.40%	87.40%	85.20%	88.36%	88.90% *
		ED: Number of patients experiencing a 12 Hour Trolley wait (>12hours from decision to admit to admission)	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0 *
	Length of Stay	Average Length of Stay (Spell)		4.75 *	5.11 *	5 *	4.79 *	5.1 *	5.04 *	4.99 *	4.96 *	0	5.14 *	4.65 *	4.57 *	4.52 *	4.61 *	4.48 *	4.54 *	4.66 *
	Operational Efficiency	Length of Stay for General and Acute Elective Spells (Occupied Bed Days)	<=3.4	2.96 *	3.32 *	2.75 *	2.84 *	2.91 *	2.99 *	3.01 *	2.9 *	R>4.5 A3.5-4.5 G<=3.4	2.82 *	2.78 *	2.52 *	2.72 *	3 *	2.88 *	2.86 *	2.78 *
		Length of Stay for General and Acute Non-Elective (Occupied Bed Days) Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.24 *	5.56 *	5.61 *	5.28 *	5.56 *	5.53 *	5.46 *	5.5 *	TBC	5.68 *	5.16 *	5.15 *	4.97 *	4.96 *	4.84 *	4.92 *	5.12 *
		Number of LMCs Not Re–admitted Within 28 Days	0				6 *	12 *	25 *	21 *	6 *	0	12 *	23 *						
		Number of Patients Stable for Discharge	<40	60	62	60	64	55	65	67	60 *	TBC	67	66	71	71	75	80	75	70 *
		Number of stranded patients with a length of stay of greater than 7 days		487	479	447	446	472	464	482	468 *	TBC	384	395	369	373	382	376 *	377 *	381 *
	RTT	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	30 *	30	64 *	74 *	50 *	63	95 *	95 *	0	95	92	98	113	125	105	105	105 *
	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%	>=99%	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%	99.8%	99.8%	99.8%	99.8%				99.8% *
Finance	**Key Indicators - Finance**																			
	Finance	YTD Performance against Financial Recovery Plan		1.87	-.27 *	-2.1 *	-6.4 *	-6.5 *	-10.8 *	-18.4 *		TBC	.05	.07	.09	.18 *	.2	.2		
	Detailed Indicators - Finance																			
	Finance	Agency – Performance Against NHSI Set Agency Ceiling		4	3	3 *	3 *	3 *	3 *	3 *		TBC	2	2	2	2	2	3		
		Capital Service		4	4	4 *	4 *	4 *	4 *	4 *		TBC	4	4	4	4	4	4		
		Liquidity		4	4	4 *	4 *	4 *	4 *	4 *		TBC	4	4	4	4	4	4		
		NHSI Financial Risk Rating	3	4	4	4 *	4 *	4 *	4 *	4 *		3	4	4	4	4	4	4		
		Total PayBill Spend		27.94	27.9	27.9 *	27.7 *	28.1 *	28.5 *	28.5 *		TBC	28.4	28.5	28.05	28.5	30.5	27.5		
Leadership and Development	**Key Indicators - Leadership and Development**																			
	Staff Engagement	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	3.71	3.71	3.71	3.71	3.71	3.67	3.67	3.67	R<3.7% A3.7-3.8% G>3.8%	3.67	3.67	3.67	3.67	3.67	3.67	3.67	3.67 *
	Workforce Expenditure and Efficiency	% Sickness Rate	G<3.6% R>4%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	R>4% A3.6-4% G<=3.5%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9% *	3.9% *	3.9% *
		% Turnover	G<11% R>15%	12.3%	12.4%	12.1%	11.9%	11.6%	11.4%	12.1%	12.0%	TBC	12.0%	11.8%	12.3%	12.3%	12.0%	12.0% *	12.1% *	12.3% *

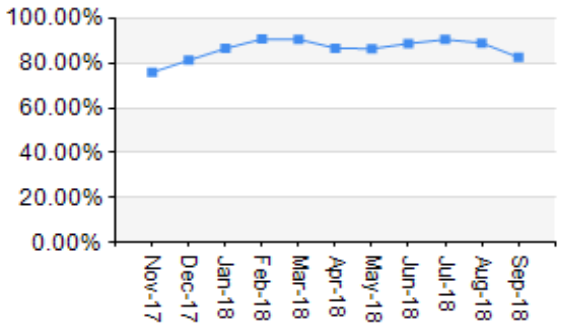
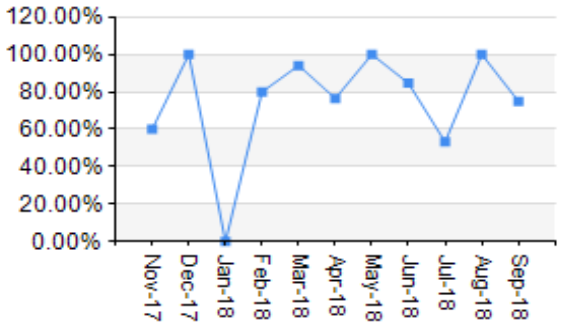
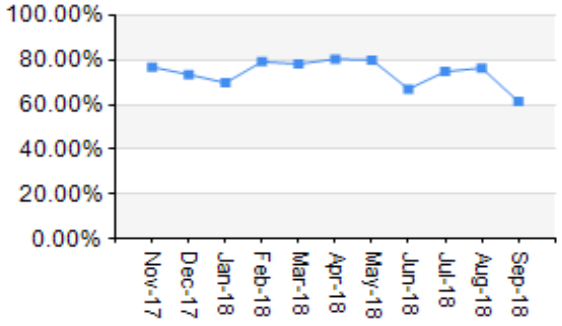
Category	Indicator	Standard 2017/18	Month							Annual	Standard 2018/19	Month							Quarter	Annual
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 Q2	18/19
	Detailed Indicators - Leadership and Development																			
	Staff Having Well-Structured Appraisal Indicator	>=3.1	3	3	3	3	3	3 *	2.95 *	2.95	>=3.1	2.95	2.95	2.95	2.95	2.95	2.95	2.95	2.95 *
	Appraisal and Mandatory Training	Trust total % mandatory training compliance	>=90%	88%	88%	88%	88% *	73%	79%			R<75% A75-89% G>=90%			87%	87%	88%	90% *	90%	90% *
		Trust total % overall appraisal completion	G>=90% R<70%	79.0%	83.0%	84.0%	84.0%	83.0%	83.0%	82.0%	82.0%	R<85% A85-89% G>=90%			74.0%	74.0%	75.0% *	79.0% *	79.0%	79.0% *
	Staff Engagement	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0% *	30.0% *	34.0% *	R<30% A30-34.9% G>=35%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0% *

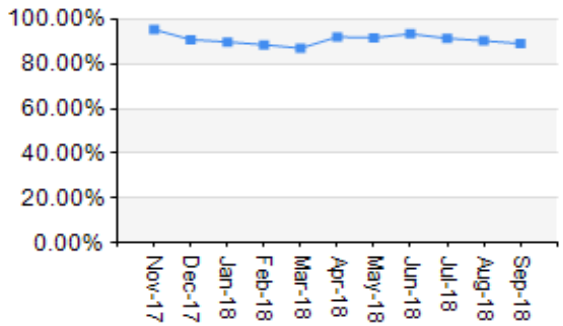
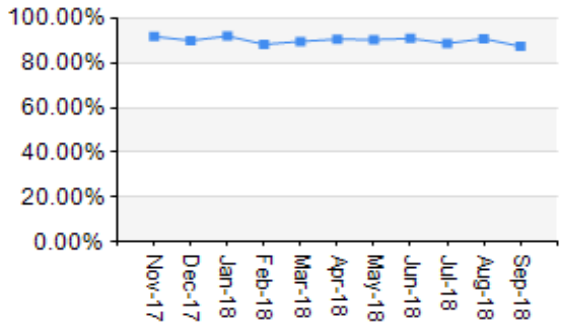
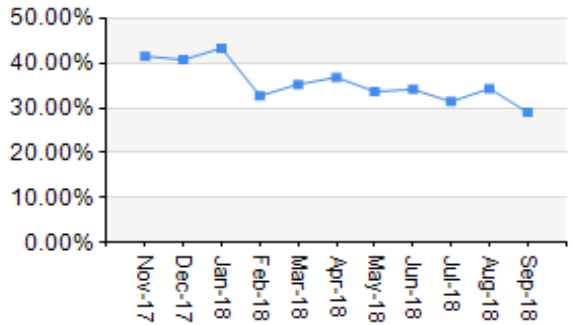
Exception Report

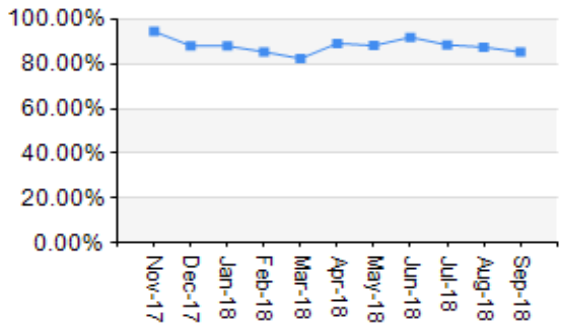
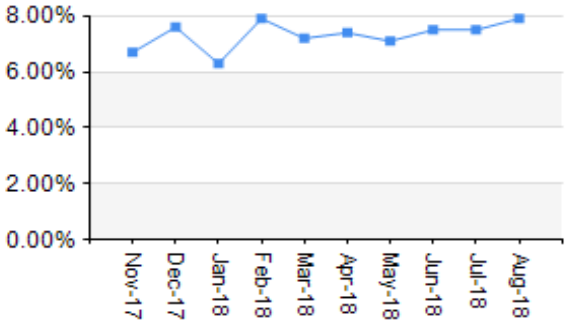
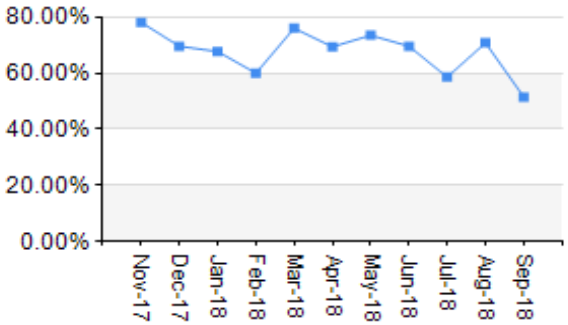
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of Adult Inpatients who have Received a VTE Risk Assessment **Standard: R<=95% A96% G>97%**		VTE reporting from TRAK has been shown to be inaccurate. From May-July clinical audit data of approx 300 patients per month was analysed showing a performance circ 93% for risk assessment. This data will be used for national reporting until data capture on TRAK can be improved. A short term improvement group has been formed to take this issue forward.	Director of Safety
% of patients who have been screened for Dementia (within 72 hours) **Standard: R<70% A70-89% G>=90%**		follow on from last months narrative. A short life working group is being established with TRAC to explore the use of coders to input into TRAC the case finding question, this update has been shared with the CCG. Weekly audits to acute care wards continue and actions as per previous months exception report. We have been informed that the discharge information will automatically populate the discharge letter instead of being inputted separately. This should occur by the end of this year.	Deputy Nursing Director & Divisional Nursing Director - Surgery
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours) **Standard: R<70% A70-89% G>=90%**		please see narrative for casefinding question	Deputy Nursing Director & Divisional Nursing Director - Surgery

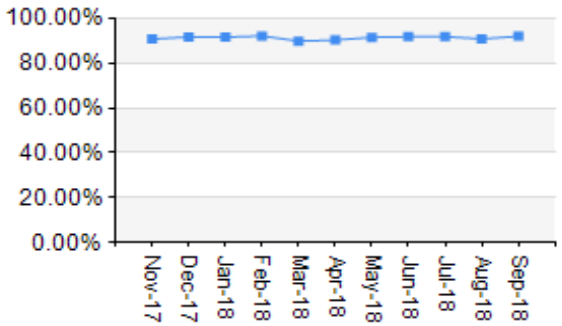
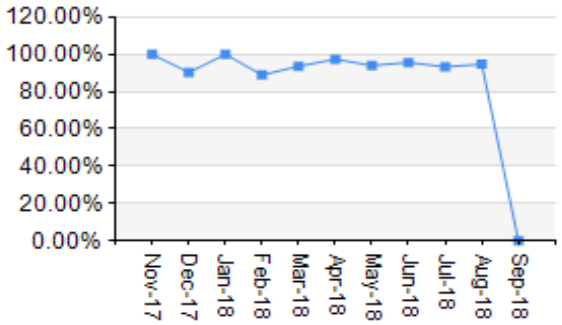
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) **Standard: R<70% A70-89% G>=90%**		please see case finding section.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Ambulance Handovers – Over 30 Minutes **Standard: < previous year**		As triage performance, time to treatment and 4 hour performance decreased in September, ambulance handover delays have increased. This is indicative of a congested emergency department causing delays in handover. Re-launching a nurse and receptionist deployed to the hole in the wall in GRH is being investigated to reduce the number of handover delays.	Deputy Chief Operating Officer
Ambulance Handovers – Over 60 Minutes **Standard: < previous year**		As triage performance, time to treatment and 4 hour performance decreased in September, ambulance handover delays have increased. This is indicative of a congested emergency department causing delays in handover. Re-launching a nurse and receptionist deployed to the hole in the wall in GRH is being investigated to reduce the number of handover delays.	Deputy Chief Operating Officer

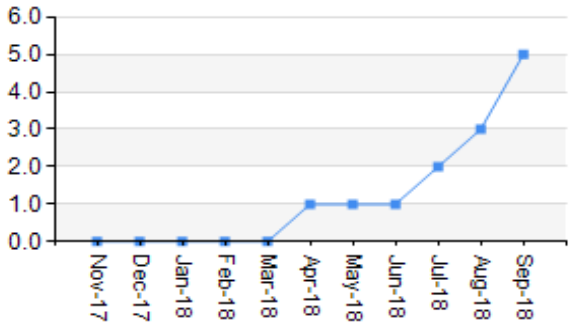
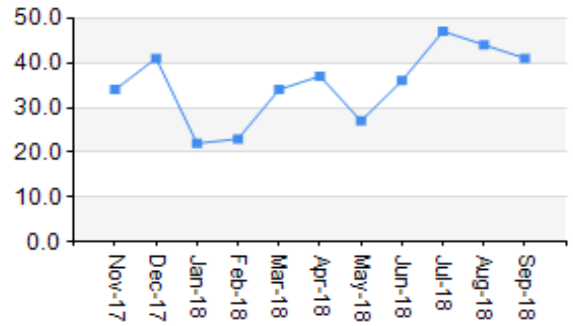
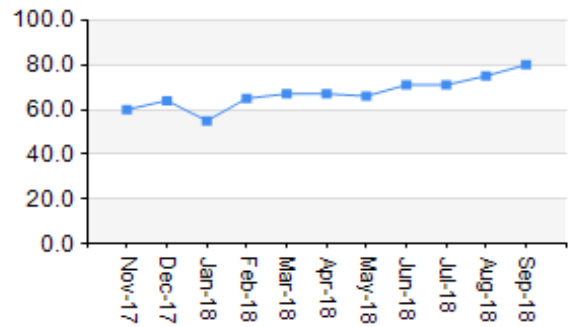
Metric Name & Standard	Trend Chart	Exception Notes	Owner
C.Diff Cases – Cumulative Totals **Standard: R>3 G<=3**		There were 3 cases of trust-apportioned C. difficile during September 2018. Investigations of individual cases have focussed on antimicrobials as a leading risk factor, this case rate is within the expected limits for the month. The trust have a comprehensive action plan to bring about improvements. All cases are reviewed internally and presented to the CCG	Director of Nursing and Midwifery
Cancer – 31 Day Diagnosis To Treatment (First Treatments) **Standard: R<94% A94-95% G>=96%**		94.1% - 96% target All specialties met the standard besides urology. Usually Urology performance is between 85-90% however this slipped in September to 74% due to re booking RALP procedures due to shortage of ANP staff (this is a short team issue, mitigating actions in place for future)	Deputy Chief Operating Officer
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery) **Standard: R<92% A92-93% G>=94%**		September performance 91.2% target 94% Lower GI 0% Upper GI 50% Uro 66.7%	Deputy Chief Operating Officer

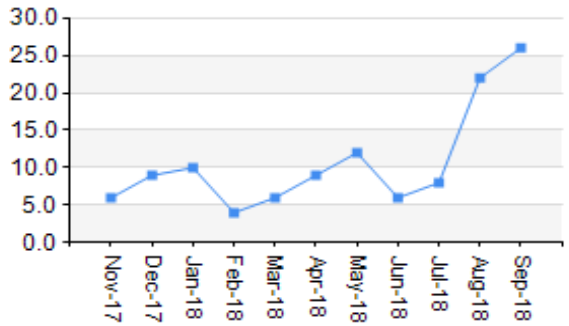
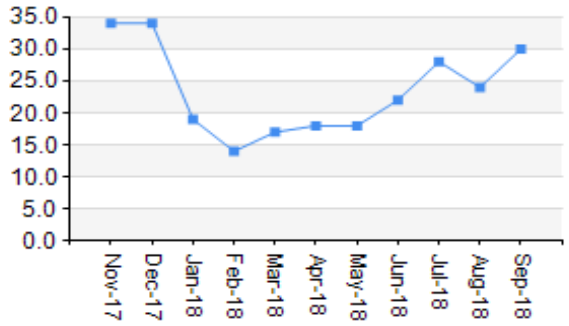
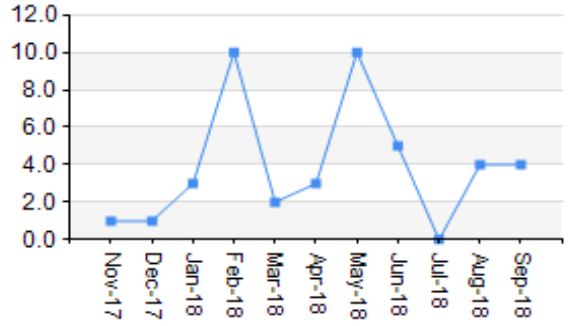
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - Urgent Referrals Seen in Under 2 Weeks from GP **Standard: R<90% A90-92% G>=93%**		September performance 82.6% LGI (52.9%) – 180 breaches Offload of August patients booked into Sept for Colonoscopy Skin (76.5%) – 107 breaches Offload of August patients booked into Sept due to spike in referrals in August (49% increase compared to August 17) Haem (90%) – 1 breach UGI (91.7%) – 78.6% of those breaches were patient choice breach 92 patient choices out of 332 LGI performance has improved in October (unvalidated) Skin performance has improved in October Project initiated for next year for Skin to develop systems to protect Dermatology from high demand surges. Skin performance has improved	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Standard: >=90%**		September performance - 75% 6 treatments 1.5 breaches Lung - 1 breach - Patient holiday Uro - 0.5 breach - Late upgrade (day 69)	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Standard: R<80% A80-84% G>=85%**		September 62 day performance 67.2% Uro - 25 breaches - 30.6% Lung 3 68.4% Lower GI - 4.5 breaches 67.9% Head and Neck 3 breaches 25% Significant issues with pathology reporting and imaging capacity and reporting time. This has elongated the diagnostics pathway for many patients 2ww backlog for colonoscopy in Lower GI has caused breaches in LGI and rarer specialties i.e. Sarcoma and Other.	Deputy Chief Operating Officer

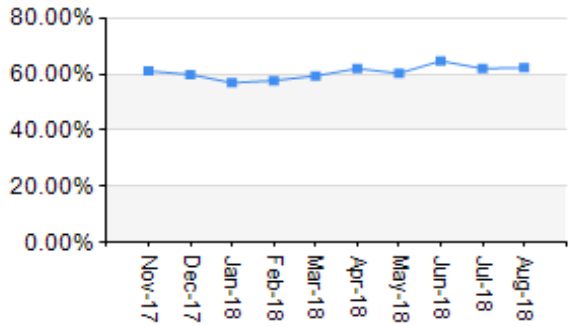
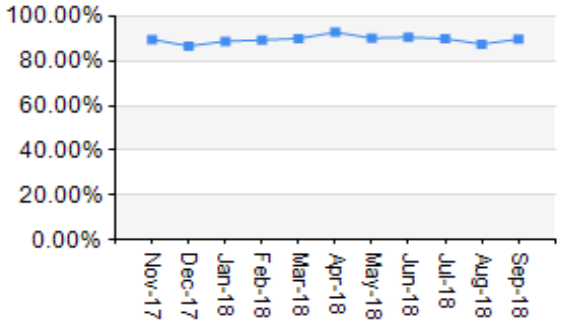
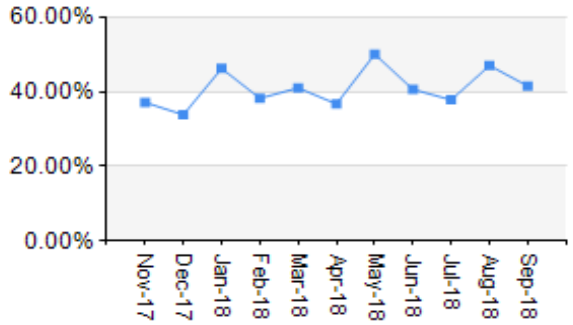
Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED Total Time in Department – Under 4 Hours		Trustwide the emergency department achieved 89.0% in September 2018. Despite falling below 90% in month; Quarter 2 was >90% and therefore above NHSI trajectory. Admitted performance fell to 80% compared to 85% in July whilst non-admitted performance remains consistent. Admitted and in particularly out of hours performance remains the biggest challenge to improving 4 hour performance. Re-launching the importance of and improving upon 2 hour performance/2 hour plans is being addressed to improve performance.	Deputy Chief Operating Officer
ED: % of time to initial assessment – Under 15 minutes		E.D time to initial assessment decreased by 2.1% to 90.7% in September (Compared to August). Both sites experiences the decrease in performance but this is the lowest GRH performance since June 2017. Projects are taking place to improve the safety/quality of triage which are likely to impact upon performance against this metric in the coming months.	Deputy Chief Operating Officer
ED: % of time to start of treatment – Under 60 minutes		E.D time to treatment decreased to 29% in September with both sites experiencing a decrease against this metric. Analysis has highlighted out of hours as a particular concern against this metric where the wait to be seen is often at its greatest. The new house has also been identified as a concern which is evidenced in performance against this metric.	Deputy Chief Operating Officer

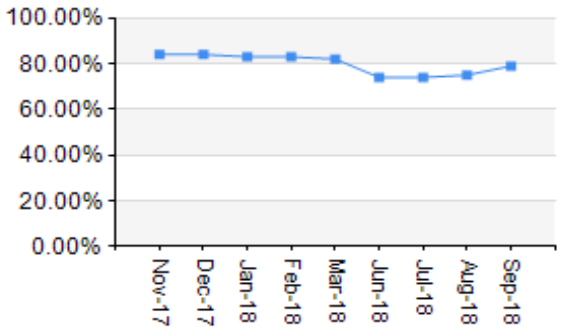
Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total Time in Department – Under 4 Hours GRH		The emergency department at GRH achieved 85.2% in September. Despite this the trust achieved >90% for quarter 2 (above NHSI trajectory). The importance of 2 hour performance and 2 hour plans is being re-launched to improve emergency department performance in addition to continued improvements in the number of patients attending (and being turned around in) assessment units (AMIA/SAU). Admitted performance was 74% in September and needs to be at least 80% to achieve trajectory in the coming months.	Deputy Chief Operating Officer
Emergency re-admissions within 30 days following an elective or emergency spell **Standard: R>6.8% G<6.8%**		Re-admissions increased in September by 0.4% from 7.5% in July to 7.9% in August. Care of the Elderly and General Medicine remain as the 2 specialties with the highest re-admission rates. The frailty service launched in September 2018 and is expected to reduce and the re-admission rate in both of these specialities.	Deputy Chief Operating Officer
High Risk TIA Patients Starting Treatment Within 24 Hours **Standard: >=60%**		During September there was a problem with capacity. Three of the patients presented at the weekend, therefore as no clinic available they were unable to be booked appropriately. General capacity issues existed as clinics were being booked up quickly due to the numbers of patients coming through. There were also problems in respect of patient choice and the inability to contact the patients despite every effort.	Director of Operations - Medicine

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % Positive **Standard: R<93% A93-95% G>=96%**		Patient Experience The FFT SMS system was accidentally switched for a period during September by our supplier. This has been investigated and was a human error after we requested for the additional maternity portal to be switched off and they switched the whole SMS system off for all the areas. We have continued to get voice message scores for ED, Inpatient and OPA and these scores have been submitted to NHS England. As there were no maternity voice messages we could not submit any data and we have had to put in a NIL return for maternity with an explanation. Our supplier has apologised for their error and has transcribed all the voice messages so that we do have experience data for our wards/areas to review. Weakness FFT inpatient - scores only by voice message as a supplier error switched off the SMS system.	Head of Patient Experience Improvement
Maternity % Positive **Standard: R<94% A94-96% G>=97%**		Patient Experience The FFT SMS system was accidentally switched for a period during September by our supplier. This has been investigated and was a human error after we requested for the additional maternity portal to be switched off and they switched the whole SMS system off for all the areas. We have continued to get voice message scores for ED, Inpatient and OPA and these scores have been submitted to NHS England. As there were no maternity voice messages we could not submit any data and we have had to put in a NIL return for maternity with an explanation. Our supplier has apologised for their error and has transcribed all the voice messages so that we do have experience data for our wards/areas to review. Weakness FFT inpatient - scores only by voice message as a supplier error switched off the SMS system.	Head of Patient Experience Improvement

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MRSA Bloodstream Cases – Cumulative Totals **Standard: 0**		During September 2018 the trust had two cases of trust-apportioned MRSA bacteraemia in a patient with a known history of MRSA, thought to be a possible blood culture contaminant and another in a patient with a surgical site infection (associated with another trust). These cases were reviewed by the IPC team and the clinical team.	Director of Nursing and Midwifery
Number of patients delayed at the end of each month **Standard: TBC**		Our Delayed Transfers of Care (DTOC) totalled 41 for September, 14 patients at CGH and 27 patients for GRH. There has been considerable work in month with our ward teams, system partners in Brokerage and Adult Social Care to reduce delays to access care home placements and packages of care.	Deputy Chief Operating Officer
Number of Patients Stable for Discharge **Standard: TBC**		At end of month there were 80 patients on the medically fit list, this number fluctuates daily. There are daily reviews of all patients at the Navigation Meeting on the medically fit list and actions are documented and escalated as needed to ward teams, Adult Social Care and Brokerage. All patients with increased lengths of stay are discussed and actions identified at the weekly partnership meeting.	Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: 0**		Cancer Category Total Haematological 1 Other 1 Skin 1 Upper GI 1 Urological 14 Grand Total 18 Three late referrals (Uro all 90+ days) Majority on prostate pathway for RALPs Other specialties comprise of complex patients with elongated diagnostic pathways	Deputy Chief Operating Officer
Number of Patients waiting over 104 days without a TCI date **Standard: TBC**		Cancer Category Total Haematological 1 Lower GI 15 Lung 1 Other 2 Upper GI 1 Urological 21 Grand Total 41 Lower GI - 4 x Patient initiated delay 5 x Complex patient - failed colonoscopy requiring further diagnostics e.g. CTC 2 x Delay at tertiarycentre//late referral received Uro - RALPs (2 late referrals in). 10 awaiting diagnosis	Deputy Chief Operating Officer
Number of Serious Incidents Reported **Standard: 0**		All serious incidents are investigated along the contractual time lines and patients or NoK are informed following Duty of Candour legislation. Looking at longitudinal data the Trust remains within normal variation parameters for levels of reporting.	Director of Safety

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient Discharge Summaries Sent to GP Within 1 Working Day **Standard: >=85%**		This is under the supervision of the Clinical Systems Safety Group DS performance is reviewed. Targeted work has been done in acute medicine, day surgery and maternity leading to an improvement in the 1 day performance to 70%. Further work is underway to deliver 1 day performance above 85% including ensuring that we remove those discharge summaries that relate to patient episodes that don't need a summary and historically never had one.	Medical Director
Percentage of Women Seen by Midwife by 12 Weeks **Standard: >90%**			Divisional Nursing and Midwifery Director
Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour **Standard: R<45% A45-49% G>=50%**		The recent results for this element are as follows: June 2018 40.6% July 2018 37.8% August 2018 47.0% September 2018 41.5% Actions underway to decrease the time taken to imaging: a) Increase pre-alerts via SWAST to ED b) Increase all pre-alerts of all Strokes from ED to Stroke Nurse c) Educate staff about importance and criteria for urgent scans d) Streamline process to request CT scan e) Stroke nurse training in Radiology requesting	Director of Operations - Medicine

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Trust total % overall appraisal completion **Standard: R<85% A85-89% G>=90%**		Compliance increased significantly in September with 719 appraisals recorded. All divisions increased compliance. Within the last month we have: • Returned to monthly reporting and email reminders • Designed a new part pre-populated reporting form that works on the intranet and moved the appraisal reporting click higher on the webpage. • Targeted the previous known appraiser for staff out of date and sent email requesting their attention/action. • Held T&F group with Divisional Leads to enlist help and ideas: Designed a FAQ sheet to send with reports and add to budget holder reports, email reminders and the webpage. Divisions committed to chasing. • Investigated report s of “queries and inaccuracies” re ESR data – and cleansed data where possible. (Specif. Locum Medical staff or Trainee Grades who rotate).	Director of Human Resources and Operational Development

REPORT TO MAIN BOARD – NOVEMBER 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 27 September 2018, indicating the NED challenges, 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	Monthly update on Committee's key risks, enabling oversight and scrutiny of controls. New risk of avoidable infections arising from failure to meet cleaning standards. Downgrading of C.Diff risk.	Discussion re respective roles of Quality and Performance and GMS Committees in oversight of cleaning performance. Progress on risk assessment of impacts for patients of delays in follow up care.	Verbal update re Clostridium Difficile (C.Diff) action plan as well as views of external expert. Both to be reported to next Committee. Further NED development session being organized.	Further work on disaggregation and categorizing of risks arising from delays in treatment and diagnosis in specific specialties'. Update next Committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report and Exception Reports from Delivery Groups	Committee welcomed first structural changes to the regular performance report. Exception reports from each of the four delivery groups continue to improve.			
Quality Delivery Group	Continuing greater visibility to divisional activity.	- Arrangements for transfer to and from Orchard Centre - Progress with revision to out-of-date policies - Concerns flagging within diabetes management.	Resolved Risk stratification of backlog National Diabetes Audit to come to next Quality and Performance Committee	
Cancer Delivery Group	Clear reporting of performance with good evidence of active management of pathways and focus on reducing backlogs.	- Impacts of staff shortages and sickness - More detail as to time delays for those breaching 62/104 day targets. By how much do people breach these times? And why? - How does patients' feedback inform	Some evidence but more plans in train for Group to use	Revised analysis for Oct Committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		Delivery Group's work?	data from feedback, complaints / compliments and Patient Experience Group.	
Planned Care Delivery Group	Clear and detailed evidence of progress in accuracy and completeness of patient lists.	Discussed: - Need for even closer focus on 52 week breaches and new level of national interest expected. - Progress on clinic typing recovery plan - How far are appointment recall dates being exceeded - Can we support patients whose appointment dates are later than expected / suggested by clinicians.		Further analysis in future reporting. Clinicians need to be clearer re describing range of probable future appointment dates.
Emergency Care Delivery Group	Very clear reporting of August's performance (90.3%) against 4 hour target	- More information re those who exceed the 4 hour wait. How many, by how long and reasons why. - Concerns re continued missing of 60 minute		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		standard for medical assessment - Delays in time to CT for stroke patients - Understanding of stress related staff sickness and how staff are engaged in questions of resilience	Current range of interventions and oversight described. Further consideration planned at a joint meeting of Quality and Performance and Workforce Committees. Further initiatives are being developed and trialed to allow capture of real-time staff feedback. Importance of visible leadership emphasized.	
CQC	Regular update received on progress of Trust's 30 Must Do actions from CQC report. 15 actions are closed, 11 are on track to close. There are 2 amber actions with delivery at risk: • ED staffing, • recording of specific information on patient records	Specific discussions about securing consistency in achieving improvements. What are the structures for continuing oversight of progress outside the Committee?	Delivery Groups to have oversight and report to Committee on exception basis.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	There are 2 red actions that remain risks: • ensuring that all staff are up to date with mandatory training and receiving yearly appraisals • devising a rota for out of hours interventional radiology consultants. Update received on 64 Should Do actions. 22 actions are completed and closed, 15 are on track to close. There are 21 amber rated actions with delivery at risk and 6 red rated actions.	Full discussion of progress with Should Dos and of barriers preventing completion of outstanding requirements.		

Claire Feehily
Chair of Quality and Performance Committee
30 September 2018

REPORT TO MAIN BOARD – NOVEMBER 2018

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

This report describes the business conducted at the Quality and Performance Committee on 25 October 2018, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report and Exception Reports from Delivery Groups	Committee welcomed suite of high quality reports and value of exception reports becoming more familiar, enabling clearer focus on exceptions.			
Quality Delivery Group	Continuing greater visibility to divisional activity. Evidence that CQC Action Plan is being scrutinised in Quality Delivery Group (QDG).	Are themes emerging from incident analysis being grouped where necessary / appropriate so that we avoid considering single incidents in isolation? Are divisions deriving value from seeing other divisions' experience in QDG and is Quality and Performance feedback returning to divisions?	Yes, and themes and trends identified where appropriate. Yes, and good divisional leadership attendance at QDG is strengthening how results / feedback are shared etc.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Cancer Delivery Group	Continued excellent reporting, including improved analysis on breaching patients in terms of their time delays. Specific concerns in period concerning Skin and Lower GI within 2 week wait performance. 62 and 104 day wait times discussed and briefing provided re development of recovery plan and specific intentions re urology.	Discussion re plans for improving delays in histology. How is the Trust performing compared to regional peers?	For 75% of pathways, Trust exceeding average regional performance. Most improvement area: lung. Trust remains an outlier re urology.	Further analysis of reasons for breaches in next reporting cycle.
Planned Care Delivery Group	Clear and detailed evidence of progress in accuracy and completeness of patient lists. 129 breaches of 52 week pathway.	What is our understanding of the breakdown of those breaching 52 weeks? Reasons? Amount of actual delay in excess of 52 weeks?		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Good visibility on analysis of clinic typing performance.	What is the process of review of cases and are patients involved. Discussion re clinic typing backlog. Do we have a profile of backlog that enables an understanding of the risk to patients of they or their GPs not receiving letters within due time? What is the typical content of such letters?	Process described whereby lists are scrutinised, reviewed, and appointments prioritized where necessary. The review process does not involve patients. Process whereby clinicians exercise oversight of letters and urgent content was described. Agreed that a sample audit would be a valuable source of additional assurance. Focus will be on cardiology and diabetic medicine. Results to Dec Committee.	Further analysis to Nov Committee.
Emergency Care Delivery Group	Very clear reporting of September's performance (89.0%) against 4 hour target. 90.02% achieved for Qtr 2. Concerns re 15 minute triage, 60 minute medical assessment standard, and delays in time to CT for stroke patients. Regional context, however, is of continued strong performance compared to peer trusts.	What options are possible re 60 minute standard as performance is largely unchanged for some time. Continued low performance on time to imaging within one hour for stroke patients. What can be done here?	Further focus to look at scope for improvement. Identify and consider options from other trusts. Staffing change and reviewed focus on this problem was described. Deep dive to be undertaken and further report to Quality and Performance Committee in November.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quarter 1 Patient Experience Report	Highlights of report included update that 13 QI projects are in train following patient feedback; progress on the Sweeney programme improvement projects in each division; increased volunteer support to wards. Committee welcomed Trust piloting and reporting using new Patient Voice Tracking System, which will allow more real-time data. Trust not meeting its target Friends and Family Test (FFT) response or response rates. Pressures within Patient Advice and Liaison Service (PALS). Some closure of offices in favour of telephone / email service to cope with demand.	In next report can we have greater assurance as to how patient experience data is integrated into performance reporting? More coverage next time on Trust performance on Cancer Survey. What is impact of walk-in PALS not being available; are ward-staff aware that offices might be closed when advising patients; how are we evaluating required levels of PALS resourcing for demands?	New team is in place and revised service models being developed.	Closer look at complaints performance for Qtrs 1 and 2 at November Committee. PALS offer to patients to be monitored in future Committees.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
CQC Must Dos and Should Dos and Update from Unannounced Inspection	Regular update received on progress of Trust's 30 Must Do actions from CQC report. 16 actions are closed, 13 are on track to close. There is 1 amber action with delivery at risk: • ED staffing Update received on 64 Should Do actions. 21 actions are completed and closed, 17 are on track to close. There are 24 amber rated actions with delivery at risk and 2 red rated actions. The CQC's unannounced inspection of 9-12 October identified problems with 8 of the 30 must do actions from their previous inspection.	Challenge remains to ensure consistent compliance. Discussion about plans in hand to address the 8 areas of concern prior to Well-Led inspection in November.		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Enhanced Care and Mental Health	Presentation to give first look at plans for strategic framework for enhanced care and mental health services, likely to be adopted by Trust in early 2019/20. Learning from Enhanced Care Collaborative confirms value of extending scope of enhanced care to a wider range of people. Clear need to develop and innovate in services for complex care needs.	Progress with resource bid to CCG re Mental Health and Liaison Team. Suggestions for peer learning from Bristol system. And for broadening scope to include substance abuse. Can we ensure the work is well connected to Better Births strategy? Can the early thinking be presented to Council of Governors as part of development of effective lay and expert patient engagement?	Under consideration by CCG. To be presented to Quality Sub-Group in November.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Never Events Improvement Plan Update	Committee welcomed Surgical Division's update on Never Event Improvement Plan. Specific actions to improve communication and safety culture within theatres and to extend knowledge of incidents and never events were discussed. Closer attention to non-compliance and enforcement (e.g. of Bare Below the Elbows) was encouraged.	How do we plan to measure improvement in safety culture? Can we receive further assurance as to how the longer term cultural issues are to be tackled in theatres? How can Committee be assured of progress against the plan especially those actions with deadlines within 2018.	Visits to peer trust has taken place. Potential tools currently being evaluated.	Action Plan to be monitored through Quality Delivery Group and exceptions to return to Quality and Performance Committtee. Cultural dimensions to be further tested within QDG.
Governor's Questions / Feedback	Support for intentions for mental health services; suggestions for possible estate improvements in toilets; support for progress with infection control initiatives but concern about levels of attendance at Infection Control Committee.			

Claire Feehily
Chair of Quality and Performance Committee
5 November 2018

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

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Mary Barnes – Risk Co-ordinator 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. Risks 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.

- A review of Divisional risks scored at 12+ for safety and 15+ for other risk domains have concluded. There are now no risks with those scores which have not yet been escalated to the Trust Leadership Team for potential inclusion onto the Trust Risk Register.

- 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

No risks have been approved by TLT for addition to the Trust Risk Register:

October- Nil
November - Nil

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

October
C1748COO 'The risk of statutory intervention for failing national access standards in relation to cancer'.

Downgraded from a 12 for safety to a 9 for statutory so downgraded to a divisional risk and removed from the Trust Risk Register

C2768NIC 'There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards and effectively manage anti-microbial prescribing in some areas. 'Downgraded from 16 to 12 for Quality but still on Trust risk register as still a 12 for Safety.

November

- C1609N 'Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.' Downgrade. Safety to 3x3=9. And upgrade Quality to 3x 4=12. Quality now highest scoring domain therefore no longer meets criteria for TRR. Executive lead Steve Hams - Operational lead – Steve Hams. Removed from the Trust Risk Register as per recommendation to November TLT**.**

- S2595Th The risk of delay to patients care due to correct and sterile equipment not being available from CSSD ' -'Downgrade Quality to 2x4 =8. No safety element to risk due to effective controls. Highest domain now Business 3x4 =12. Does not now meet criteria for TRR. Executive lead Steve Hams - Operational lead – Candice Tyers. Removed from the Trust Risk Register as per recommendation to November TLT**.**

1 risk has been **upgraded** in this period.

October – Nil

November

C1798COO 'The risk of delayed follow up care due to outpatient capacity constraints in a number of specialties including neurology, cardiology, rheumatology, ophthalmology, general surgery, urology, vascular, T&O and ENT. Risk to both quality of care through patient experience impact (15) and safety risk associated with delays to treatment (4).' Downgrade. Upgrade Quality to 3x 5=15. Downgrade Safety 4x1=4. Quality now highest scoring domain score 15 so still meets criteria for TRR. Executive lead Caroline Landon - Operational lead – Felicity Taylor-Drew. As per recommendation to November TLT**.**

No risks have been **closed**

October – Nil

November - 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)**
					7th November 2018	

Outcome of discussion when presented to previous Committees

Trust Risk Register **November 2018 Board** **Appendix 1**

Ref	BAF Objectives	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
C2628COO	1.3 - Meet all national access standards & no longer subject to regulatory action for the A&E standard	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 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	Major (4)	Likely - Weekly (4)	16
C2667NIC		Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Quality	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee	The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.	Detailed action plan has been developed and reviewed by the Infection Control Committee, focusing on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the environment and antimicrobial stewardship.	Partially complete	Major (4)	Likely - Weekly (4)	16
S2275	2.2 - Staff Turnover Rate of less than 11%	Surgical	Workforce	Medical Director	Trust Leadership Team, Workforce Committee	A risk to staff well-being arising from an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers and vacancies.	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	Partially complete	Major (4)	Likely - Weekly (4)	16
F2335	4.3 - Have worked with partners in the Sustainability & Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions & leg ulcers	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance Committee, Workforce Committee	The risk of agency spend in clinical and non-clinical areas exceeding planned levelsdue to ongoing high vacancy levels, with resulting impact of delviery of FY19 CIP programme	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.	Partially complete	Major (4)	Likely - Weekly (4)	16
F2724	4.1 - Be in financial balance by April 2019, 4.2 - Be amongst the top 25% of trusts for efficiency	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19	PMO in place to record and monitor the FY18 programme Weekly Turnaround Implementation Board Monthly monitoring and reporting of performance against target Monthly executive reviews	Complete	Catastrophic (5)	Possible - Monthly (3)	15
C1798COO	1.3 - Meet all national access standards & no longer subject to regulatory action for the A&E standard	Medical, Surgical	Quality	Chief Operating Officer	Quality and Performance Committee	The risk of delayed follow up care due outpatient capacity constraints in a number of specialties including neurology, cardiology, rheumatology,ophthalmology, general surgery, urology, vascular, T&O and ENT. Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	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.	Partially complete	Moderate (3)	Almost certain - Daily (5)	15
C2768NIC		Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Chief Operating Officer	Quality and Performance Committee	There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards and effectively manage anti-microbial prescribing in some areas.	1, improvement plan developed. 2, review meetings through the GMS contractual mechanisms. 3, matron's undertaking individual audits in preparation for CQC. 4, auditing now completed by designated auditing team. 5, corporate visibility through infection control committee and trust leadership team.	Partially complete	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, Trust Leadership Team	Risk of harm to patients as a results of 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 Acute Specialist Falls Nurse in post HEE Funding for 1 year to continue staff education in falls Improved engagement trustwide at local falls meetings	Partially complete	Major (4)	Possible - Monthly (3)	12
C1945NTVN	1.1 - Rated 'Good' overall in CQC rating, 1.5 - 35% or more of patients responding to 'Family, Friendly tests' with at least 93% recommending us	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 Monitoring through incident investigation\RCA Divisional committees overseeing RCAs Safety Thermometer data review as part of Safer Staffing NHSi collaborative work in 2018 to support evidence based care provision and idea sharing. Pressure relieving equipment in place Trust wide to reduce risk.	Partially complete	Moderate (3)	Likely - Weekly (4)	12
S2568Anaes		Surgical	Safety	Medical Director	Divisional Board, Medical Devices Committee, Quality and Performance Committee	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	Application to MEF Prioritisation of operations Maintenance by own medical engineering service loan request	Partially complete	Catastrophic (5)	Rare - Less than annually (1)	5

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

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

Executive Summary

Purpose

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

Key issues to note

Assurance

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

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

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

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

- Since the BAF report was last presented to the Board in September, the lead Executive Directors have reviewed, and, where appropriate, revised the principal risks to objectives, controls and assurances for their respective objectives
- The Board should note that the oversight of the (amended) Strategic Objective 3.2 *To complete Trakcare recovery work to enable the Trust to resume national RTT reporting by February 2019* has now been assigned to the Finance and Digital Committee.
- The format of the BAF reports presented to the Committees have been developed further to better highlight the progress and key issues requiring the Committee's focus (e.g. gaps in controls and assurances).
- Board Committees continue to undertake a detailed, quarterly scrutiny of components parts of the BAF assigned to them and receive positive assurances that the risks to the achievement of the Strategic Objectives are controlled as effectively as they can be.
- An update of progress in the achievement of the strategic objectives is included in Appendix 1 demonstrating that nine elements expect that the target will be met. At the same time, delivery of ten objectives are rated Amber with achievement identified as at risk; and one is rated Red.

It is noted that many of the strategic objectives (SO) have corresponding risks present on Trust and or Divisional Risk registers i.e. scoring ≥ 8 as illustrated below with RAG rating for the BAF criterion added.

BAF crit/ RAG	1.1	1.2	1.3	1.4	1.5	1.6	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	4.1	4.2	4.3
RR entries	2	6	2	1	6	1	1	1	0	0	0	2	2	1	0	4	4	1

Conclusion

In summary, the Board can take assurance from this paper and the detailed scrutiny and challenge undertaken in the Board Committees, that the risks to the Strategic Objectives are controlled effectively.

The Board is invited to consider further risks to the achievement of Strategic Objectives, if any.

Implications and Future Action Required

Further refinement and ongoing development of the BAF led by the Director of Corporate Governance, as described above.

Recommendations
To receive the report for assurance that the risks to the Strategic Objectives are controlled effectively.
Impact Upon Strategic Objectives
The report identifies the risk and mitigation to the Strategic objectives
Impact Upon Corporate Risks
Links between risk to delivery of strategic objectives aligned to known corporate risks
Regulatory and/or Legal Implications
There are no specific regulatory or legal implications arising from this report.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	x	Buildings	

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

Date the paper was presented to previous Committees						
Quality and Performance Committee	**Finance and Digital Committee**	**Audit and Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
	October 2018		September 2018	N/A		
Outcome of discussion when presented to previous Committees						
The Committees received assurances that the risks to the strategic objectives were controlled effectively. The Committees reviewed gaps and requested management action to address. The Committees used the BAF to inform agenda/workplan setting.						

Appendix 1

Board Assurance Framework Overview and Progress with Achievement of Strategic Objectives

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 1	Qtr 2				
1.1			Director of Quality & Chief Nurse	Quality and Performance *and*: People and OD *(Well-led component)* Finance and Digital *(Sustainable use of resources component)*	Be rated good overall by the CQC	
1.2			Director of Quality & Chief Nurse	Quality and Performance	Be rated outstanding in the domain of 'Caring' by the CQC	
1.3			Chief Operating Officer	Quality and Performance	Meet all national access standards	
1.4			Medical Director	Quality and Performance	Have a hospital standardised mortality ratio of below 100	
1.5			Director of Quality & Chief Nurse	Quality and Performance	Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends	
1.6			Director of Quality & Chief Nurse	Quality and Performance	Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month	
2.1			Director of People	People and OD	Have an Engagement Score in the Staff Survey of at least 3.9	
2.2			Director of People	People and OD	Have a 'Staff Turnover Rate' of Less Than 11%	
2.3			Director of People	People and OD	Have a Minimum of 65% of 'Our Staff Recommending Us as a Place to Work' through the Staff Survey	
2.4			Medical Director	Quality and Performance People and OD	Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches	

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 1	Qtr 2				
2.5			Director of People	People and OD	Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)	
3.1			Director of Strategy and Transformation	Board	Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery	Outline Business Case for new system wide clinical model for urgent care completed in draft form in August. The ICS Programme Board agreed to pause the timeline to allow for further development of the model, and additional public engagement on the care in hospital components. Update on Trust Board agenda.
3.2			Chief Executive	SmartCare Programme Board reporting to Board	To complete Trakcare recovery work to enable the Trust to resume national RTT reporting by February 2019 (amended)	Project plans and testing support change in rating.
3.3			Director of Strategy and Transformation	Quality and Performance	Rolled out Getting it Right First Time Standards across the target specialities and be fully compliant in at least two clinical services	
3.4			Director of Strategy and Transformation	Health and Wellbeing Group	Have staff in all clinical areas trained to support patients to make healthy choices	

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 1	Qtr 2				
4.1			Director of Finance	Finance and Digital	Show an improved financial position	The overall Income and Expenditure position to end September is showing a £0.2m favourable variance to plan. The forecast outturn is currently £3.8m adverse to planned control total, driven by loss of agenda for change funding within GMS and the associated loss of PSF (£2.8m).
4.2			Chief Operating Officer	Finance and Digital	Be among the top 25% of trusts for efficiency	
4.3			Director of Strategy and Transformation	Trust Leadership Team	Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers.	
4.4			Chief Executive	Board	Be no longer subject to regulatory action	
4.5			Chief Executive	Board	Be in segment 2 (targeted support) of the NHSI Single Oversight Framework	
4.6		N/A	Director of Strategy and Transformation	TBC	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: **RED** – not on track to be achieved **AMBER** – not on track at this stage; delivery at risk
GREEN – achieved or on track to achieve

APPENDIX 2 - BOARD ASSURANCE FRAMEWORK (BAF) 2017/18 AND 2018/19 REVIEW DATES

Board/Committee ***Ownership/focus*** **Review date**	**Finance and Digital Committee** ***Strategic Objectives 1.1, 3.2, 4.1 and 4.2***	**Quality and Performance Committee** ***Strategic Objectives 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.4, 3.3***	**People and OD Committee** ***Strategic Objectives 1.1, 2.1, 2.2, 2.3 and 2.5***	**Audit and Assurance Committee** ***Whole BAF***	**Main Board** ***Whole BAF***
Quarter 3 2017/18	January 2018	January 2018	February 2018	March 2018	January 2018
Quarter 4 2017/18	April 2018	April 2018	April 2018	May 2018	May 2018
Quarter 1 2018/19	June 2018	June 2018	June 2018	July 2018	September 2018
Quarter 2 2018/19	October 2018	October 2018	October 2018	November 2018	November 2018
Quarter 3 2018/19	February 2019	February 2019	February 2019	January 2019	March 2019
Quarter 4 2018/19	April 2018	April 2018	April 2018	May 2018	May/June 2018

Please note:

- Principal risks to Strategic Objective 3.1 *Have a Model For Urgent Care That Ensures People Are Treated In Centres with the Very Best Expertise and Facilities to Maximise Their Chances of Survival And Recovery* are owned by the Trust Board
- Principal risks to Strategic Objective 3.4 *Have Staff in all Clinical Areas Trained to Support Patients to Make Healthy Choices* are owned by the Health and Wellbeing Group
- Principal risks to Strategic Objective 4.3 *Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers* are owned by are owned by Trust Leadership Team
- Principal risks to Strategic Objective 4.4 *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)* are owned by are owned Innovation (R&I) Forum, reporting to Trust Leadership Team

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that our Trust will not meet regulatory requirements to the level of "good" at the next planned and unplanned CQC inspections. .	**<u>Unannounced core services Inspection</u>** **Director of Quality & Chief Nurse** **Quality and Performance Committee** (Responsive/ Effective/ Safe/ Caring) **In addition** **<u>Well-led</u>** **Director of Governance and Director of People and Organisational Development Workforce Committee** **<u>Sustainable use of resources</u>** **Director of Finance** **Finance and Digital Committee**	**External** 1. Report and meeting with GCCG quality team 2. Action plan in response to last CQC inspection. **Internal** 3. Divisional attendance and reports at Executive Review meeting 4. Divisional Annual operating plans and Divisional Boards. 5. Quality Account 6. Quality and Performance Committee Report 7. Exception Reports (Cancer Services Delivery Group, Planned Care Delivery Group, Emergency Care Delivery Group, Quality Care Delivery Group). 8. Minutes from key meetings Safety and Experience Review Group), Hospital Transfusion Committee,	**External** 1. Gloucestershire CCG (Clinical Commissioning Group) Clinical Quality Review Group (CGRG) 2. Health Overview and Scrutiny Committee (HOSC) 3. CQC provider engagement meeting. **Internal** 4. Chief Executive Officer led quarterly Executive Review meetings and monthly Executive Review meetings with Divisions. 5. Quality and Performance Committee (Sub-Board Committees of (Key Committees - Infection Control Committee, Hospital Mortality Indicator Group,	1. GCCG CQRG meeting. 2. Quality reports to Q&P. 3. HOSC attendance. 4. CQC Provider meeting 5. Executive review meetings 6. Quality Account 7. Q&P Committee meeting 8. Governor meetings 9. TLT meeting 10. Audit and Assurance Committee meeting. 11. QDG (CQC improvement) Meeting 12. Internal Audit reports	↔

		Resuscitation and Deteriorating Patient Group, Medicines Optimisation Committee) 9. Annual Reports from key Committees 10. Quality and Performance Committee and reports and presentations to Governors 11. CQC Responsive Improvement Plan 12. Risk Registers 13. Safety Reports 14. External Auditors reports and action plans 15. Internal audits and action plans 16. National audit reports and action plans 17. CQC Responsive Improvement Plan. 18. Divisional Reports and minutes to TLT. 19. Freedom to Speak Up Reports and returns.	Safeguarding Adults and Children Committee, Clinical Systems Safety Group). 6. Council of Governors meeting and Governors' Quality and Performance meeting 7. Trust Leadership Team (TLT) 8. Risk Management Group 9. Audit Committee 10. Quality and Delivery Group (CQC review Group) 11. Divisional Board Meetings (Quality Boards/ Speciality Governance meetings).		
			Gaps in Controls	**Gaps in Assurance**	
				1. Possible gaps within Divisions in meeting every CQC registration standard as part of their business as	

				usual plan at all times 2. Slow progress on the completion of all the “must do” and “should do” actions within the responsive quality improvement plan because of operational pressures 3. No overall proactive Quality Improvement Strategy (Good > Outstanding) 4. New CQC methodology for inspections which includes sustainable use of resources and well-led Domains 5. Limited regular benchmarking and gap analysis within Divisions against CQC KLOEs (Key Lines of Enquiry) and Domain characteristics	

				to ensure improvement or maintenance of standards.	
Potential Risk Exposure	**Related risks on Trust Risk Register**				**Score**
• **C1850NSafe** - The risk of being considered non-compliant with the Trust CQC registration due to providing care to an increasing number of adolescents (12-18 years) presenting with self-harming behaviour who require a place of safety but do not require medical care. • **C2619MDEOL** - Risk of inadequate improvement for next CQC End of Life (EOL) assessment.					3 x 3 = 9 (Statutory) 2 x 5 = 10 (Statutory)

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
1. Overall assurance assessment of CQC standards on wards using NAAS	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	March 2019	NAAS to be implemented in July with ward to Board reporting.
2. Development of an overall proactive quality improvement strategy (#J2O – Journey to Outstanding).	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	Nov 2018	Strategy in development.
3. Review of our quality measures (Ward to Board systems).	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	Nov 2018	Quality system measurements being reviewed and agreed.
Enabling Strategies	**Oversight Group**	**Executive Committee**	
Risk Management Strategy/ risk register procedure	Risk Management Group	Trust Leadership Team	
Dementia Improvement Strategy	Quality Delivery Group	Quality & Performance Committee	
Staff Health and Wellbeing Strategy	H&W Committee	Quality & Performance Committee	
Improving Patient and Carer Strategy	Quality Delivery Group	Quality & Performance Committee	

Quarterly Progress Report Against Delivery	RAG Rating
Baseline assessment July 2017 - The Trust remains at Requires Improvement overall and for both sites after the latest CQC report for the announced inspection visit on 24-27 January 2017 and unannounced February 2017 (published July 2017). - There were 11 Domains across the Divisions that were rated as Requires Improvement (Maternity 1, Medical 4, Urgent and Emergency Care 2, Surgery 2 and OPA 2). - Overall 73% of ratings were Good or Outstanding (an improvement from 68% in 2015). **Update on the delivery plan for this quarter October 2018** 1. CQC are currently inspecting 4 core services with a night inspection still to happen (Medical, Urgent and Emergency Care, Surgery and OPA). 2. The Responsive Plan responding to our last inspection has no "red" outstanding actions and all the actions that are outstanding are moving to key committees to monitor their improvement as part of their business as usual. 3. The Quality Improvement Strategy is being tested with key staff groups. 4. The Quality Delivery Group has now had 6 meetings and this group is key to improving the delivery of our regulatory standards. 5. The Quality and Performance Report (QPR) has been reviewed and we have improvement programmes for any indicators that are not to local benchmarks or national standards. 6. The CQC Provider Information Return enabled us to carry out a self-assessment and we rated ourselves as Good overall after reviewing all key current data and information. 7. The use of resources inspection was the 18th October 2018. 8. The "well led" inspection is the 13-15 November 2018. 9. CQC will finalise their inspection findings and a report will be due in early 2019.	

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

(Caring domain = maintaining privacy and dignity, person centred care and being treated with kindness and respect)

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.2.1 Risk that our Trust will not be rated Outstanding in our CQC (Care Quality Commission) rating for Caring because the CQC have changed their inspection methodology. 1.2.2 Risk that the behaviours of our staff towards our patients will not be at the level that meets the outstanding characteristics at the inspection visit (kindness and respect, person-centred care & maintaining dignity and privacy). 1.2.3 Risk that when CQC review patient experience indicators and data that it will not meet the characteristics of the	**Director of Quality & Chief Nurse** **Quality and Performance Committee (Q&P)**	Improve and sustain staff behaviours so that they meet outstanding characteristics by peer observation, role modelling, feedback and staff reward/recognition schemes which reward staff who are "going the extra mile". Implementation of Nursing Accreditation and Assessment Scheme (NAAS) for wards Improve staff engagement with patient experience data and QI work. Liaison with CQC and other trusts rated as outstanding to learn of improvement work undertaken and methodologies adopted and then implement. Implementation of GSQIA work to providing training to staff and mentoring/ coaching of projects to improve patient experience	1. Monitoring of responsive action plan by CQC/QDG group. 2. Improvement projects supported by Patient Experience Improvement Team and GSQIA. 3. Receipt of reports and presentations by Q&P, Governors and Divisional Boards, Divisional Quality Groups on patient experience indicators. 4. Divisional presentations and reports to Executive Reviews (monthly). 5. Matron audit reports to their Divisional Boards and quality Committees 6. Regular monitoring and analysis of key patient experience data (surveys, complaints etc).	**External** – feedback on services/patient experience provided by • National Survey Programme by CQC Patient-led Assessments of the Care Environment inspections with patient representatives **Internal** – feedback obtained from patients/ carers to 1. Board - patient experience stories 2. Quality Delivery Group 3. Governor Q&P meetings. 4. Internal Audit report on	↔

outstanding domain. 1.2.4 Risk that environment and use of corridors in situations of overcrowding does not support staff to maintain privacy and dignity.		of care (see BAF 2.4). Continued close monitoring of patient experience indicator data and working with staff to take improvement action when positive experiences are identified to make sure that they are replicated everyday so this reduces negative experiences. Quality improvement project in ED looking at patient experience in the corridor.	**Gaps in Control**	**Gaps in Assurance** 1. QI strategy requires development. 2. Benchmarking, gap analysis between Good and Outstanding characteristics for Caring Domain by all Divisions with the development of Divisional Patient Experience Quality Improvement plans. 3. Continuous compliance monitoring by regular Division checks and reviews.	
Potential Risk Exposure	**Related risks on Trust Risk Register**				**Score**
• **M2473Emer** - The risk of poor quality patient experience during periods of overcrowding in the Emergency Department. • **M727Emer -** The risk to patient safety of delay to diagnosis and treatment reducing quality of care to patients and decrease in staff morale due to diverts. • **M2434Emer -** The risk of reduced safety, patient experience and quality of care due to inability to recruit and retain qualified nursing staff across Unscheduled Care. • **M2484Emer** - The risk of poor patient quality due to lack of visibility of Decision to Admit times on TrakCare • **C2619MDEOL** - Risk of inadequate improvement for next CQC End of Life (EOL) assessment. • **C2734NPatExp** - The risk of reduced quality for patients approaching PALs with issues/concerns about provision hospital services.					3 x 3 = 9 (Quality) 2 x 4 = 8 (Safety) 3 x 4 = 12 (Workforce) 3 x 9 = 9 (Quality) 2 x 5 = 10 (Statutory) 3 x 4 = 12 (Quality)

Actions Agreed for any gaps	By Whom	By When	Update
Quality improvement strategy to be developed with section on Patient Experience improvement.	Director of Quality & Chief Nurse	End of July 2018	Strategy in development.
Gap analysis to be undertaken for the difference between the CQC Good and the Outstanding characteristics by all Divisions and to have plans in place to make improvements.	Divisional Nursing Directors	End of July 2018 Work in progress	Workshop held in SNMC in December 2017 looking at the Key Lines of Enquiry and Outstanding characteristics and change ideas generated.
PLACE inspection report action plan to PESG in May 2018.	Deputy Director Estates/ PESG	May 2018	Complete as action plan for the areas related to the Caring Domain developed and will be monitored by PESG.
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience and Carer Strategy 2015-2017.	Patient Experience Strategic Group	Quality & Performance Committee	Patient Experience Strategy updated

Position July 2017
Maternity, children & young people, end of life, surgery, medical care, urgent and emergency care and outpatients and diagnostics all rated by CQC as Good at the last CQC inspection in July 2017. With Critical Care being rated as outstanding.

Current position October 2018

1. The Divisions completed a self-assessment rating exercise within the Provider Information Request (PIR) and this was sent to the CQC in July.
2. The CQC have carried out an unannounced inspection into 4 core services. Surgery, OPA, Medicine, Urgent and Emergency Care and OPA have now been inspected. This means that this will be highly unlikely to be rated as outstanding in the Caring Domain as not all the core services have been inspected.

Self assessment rating

CARING	Outstanding	Good	Requires Improvement	Inadequate
Maternity	x			
Children and Young People	x			
End of Life	x			
Critical Care	x			
Surgery		x		
Medical		x		
Urgent and Emergency Care		x		
OPA and diagnostics		x		

(1.3) Strategic Objective(s) – Meet all National Access Standards

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

		providers across health economy System-wide A&E Delivery Board.	Nurse and Medical staffing gaps across ED (Emergency Department)/AMU (Acute Medical Unit).		
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
1.3.2 Failure to deliver the national access standards for RTT (Referral to Treatment) and Cancer.	**Chief Operating Officer (COO)** **Quality and Performance Committee (Q&P)**	PTL (Patient Tracking List) (accuracy related to Trak Recovery Programme) PTL (Patient Tracking List) Cancer 2ww PTL daily in place; 62 d PTL in development Monthly Planned Care Delivery Group Monthly Cancer Delivery Group Fortnightly Cancer 'deep dive' meetings for specialities requiring additional support Creation of Director of Scheduled Care/Deputy COO role to provide focus and direction across the Scheduled Care agenda.	• Referral to Treatment waiting list validation recovery plan in development (aligned to Trak Recovery) • Cancer capacity and recovery plans in place	Performance reports to the Q&P Committee.	↔
			Gaps in Control	**Gaps in Assurance**	
			• Demand outstrips capacity plans • Lack of accurate patient tracking lists • Lack of demand and capacity plans for RTT (that includes the historical position) • Capacity to prevent long waiting patients, post validation	RTT reporting.	

Potential Risk Exposure – Confirmed Risks on Trust / Divisional Risk Registers		Mitigation
• **S1748** - The risk of statutory intervention for failing national access standards in relation to cancer. • **S2628** - The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times. The risk on non-reporting of RTT (incomplete) standards.	3 x 4 = 12 (Statutory) 4 x 4 = 16 (Safety)	

Actions Agreed for any gaps	By Whom	By When	Update
Review of system-wide demand management including review of 2ww referrals received in to the organisation. All referrals received by electronic means 4th June.	COO	April 2018	In collaboration with CCG
Review of capacity allocation cross site.	COO	Links in to One Place business case as part of Capital programme during 2018/19	Outpatient Programme Board STP
Validation of all PTLs, establish RTT reporting, complete demand and capacity modelling and recovery plans for delivering 18w RTT.	COO	Links in to Trak recovery plan – cross reference with other BAF criteria/ SmartCare Commencing May 2018	On-going validation of PTLs continues
Enabling Strategy	**Oversight Group**	**Executive Committee**	
STP (Sustainability and Transformation Plan) Cancer Strategy (in development)	Unscheduled Care Programme Board, Planned Care Board	Q&P Committee	

Quarterly Progress Report Against Delivery	RAG Rating
See the Trust Board Quality and Performance report for comprehensive update on performance but in summary Emergency Department performance for Q2 FY18/19 was 90% – strongest performance in many years and ahead of NHSE (NHS England) trajectory. Trajectory has been set for the year at 90% for the 4 hour standard. Commitment from NHSE to review segment classification from S4 to S2. Referral to Treatment (RTT) reporting has been suspended – see Trak Recovery Plan. Cancer recovery plan presented and endorsed by Q&P committee with planned recovery from Q1 2018/19. Significant progress to date is noted in the Q&P exception report for May which continues to be monitored closely for delivery in summer aligned with trajectory.	

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that changes to process and clinical pathways do not achieve a Hospital Standardised Mortality Ratio (HSMR) below 100.	**Medical Director** **Quality and Performance Committee (Q&P)** **Hospital Mortality Group**	1. Regular monitoring of mortality indicators though Hospital Mortality Group (HMG) 2. Close working with Dr Foster to report on HSMR, identify factors driving high rates and investigate the drivers behind these 3. Agreed areas of clinical pathway work to identify improvements in care, coding and pathways 4. Regular reporting by division to the HMG Mortality dashboard reporting to divisional and speciality level 5. Monitoring through Q&P and with partners through CCG (Clinical Commisioning Group) quality monitoring group and through the joint NHSI (NHS Improvement) and NHSE (NHS England) Quality Improvement Group 6. Neck of femur group monitoring action plan for improved care. Similar model to be applied for other care pathways as appropriate	Divisional reporting to hospital Mortality summarising outcomes of Mortality/ morbidity reviews Medical Examiner (Histo-pathologist) review of all deaths reported via Bereavement Mortality Report to Q&P Committee. Internal Audit review of PwC of mortality Review process authorised via Audit and assurance committee Meeting of all families by the bereavement team and recording of their comments Medical Examiner cohort now extended to range of specialties following interviews. Published policy on learning from deaths	Monthly reporting to the Q&P Committee. Annual internal audit report presented to Audit and Assurance Committee March 2018 Dr Foster data now show HSMR within expected range and below 100 Continued reporting shows HSMR now 95.5 in the latest report and both weekend and weekday mortality are below 100.	↔

		7. Trauma mortality review through trauma lead 8. Mortality database and initiation of mortality reviews though Bereavement Office. 9. Mortality/ Morbidity reviews held in all clinical specialties contributing to Hospital Mortality Group 10. Collective analysis of mortality reviews reported now performed 11. Revised learning from deaths policy published in line with national guidance.	**Gaps in Control** Data capture in TrakCare of number of episodes of inpatient care results in risk of underscoring of episodes of care and therefore miscalculation of crude mortality.	**Gaps in Assurance** Reporting and detail of oversight at Q&P and Trust Board - to be finalised Inability to model the impact of changes on HSMR.	

Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers	**Score (CxL)**
• Reliability of admission diagnosis and clinical linkage to coding • **C2333MD** – The risk of failure to learn from deaths as a result of a lack of standardised process	2 x 2 = 4 (Safety)

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
Reporting into Q+P now established and in use	Medical Director		Completed
Enabling Strategy	**Oversight Group**	**Executive Committee**	
Death Reviews Policy (A2217)	Hospital Mortality Group	Quality and Performance Committee	

Quarterly Progress Report Against Delivery	**RAG Rating**
• Current Dr Foster data shows a HSMR of 95.5 (Oct 2018) • Mortality dashboard now in use for learning from deaths report to the Board • The 2019 objective has been achieved • Enhanced input of Bereavement Team into death review process and recognition of Medical Examiner in national guidance	

(1.5) Strategic Objective – To have more than 35% of patients responding to our Family Friendly Tests and of those 93% recommending us to Family and Friends by April 2019

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.5.1 Risk that the trust does not achieve a 35% feedback response to the Friend and Family test in following depts. • Emergency Dept. • Maternity • Inpatients (inc Day Surgery)	**Director of Quality and Chief Nurse** **Quality and Performance Committee**	1. Automation of requests to patients to participate • Text (SMS) • Phone call • On line 2. Adoption and publicising national initiatives to promote patient engagement e.g. maternity 3. Responses collated by external company prior to internal review and uploading to NHSE. 4. Local review of response rate and variations noted/ acted upon	• Feedback uploaded to national website and results published monthly • Response rate calculated locally **Gaps in controls** • Lack of control over response rate	• Benchmarking with other trusts available on NHSI website of response rates **Gaps in Assurances** • Response rate no longer monitored by NHSE	↔

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.5.2 The risk that 93% of responses do not recommended the Trust to family and friends	**Director of Quality and Chief Nurse** **Quality & Performance Committee**	• Patient Experience team alert matron of results causing concern or on downward trend • Patient Experience Improvement Team work with Matrons / team to identify changes to improve • Adoption of GSQIA methodologies for FFT based improvement projects to demonstrate measured improvement	**Externally published results available to** • CCG (Clinical Commissioning Group) CQRG (Clinical Quality Review Group) • NHS England • Referred to in CQC insight report • Feedback uploaded to national website and results published monthly • Quarterly reports to Patient Experience Steering Group (PESG) and Quality and Performance (Q&P) • Divisional Patient Experience/ Quality reports to PESG • Reports to Q&P on patient experience indicators and insight		↔
			Gaps in controls	**Gaps in Assurances**	
			• Small sample size in response rates may lead to skewing of results • Ability of GSQIA to support number of projects arising from silver courses / gold	• Sentiment analysis produces unreliable data source for improvement	

			coaching projects training (capacity)		
Principle Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
1.5.3 Risk that staff will not be able to carry out reviews of their data and quality improvement work because of operational pressures.	**Director of Quality and Chief Nurse** **Quality & Performance Committee**	1. Divisional matrons notified of availability of results on monthly basis 2. Quarterly meetings with Governors with specific focus on quality topics 3. Quality academy structured approach to improvement work by specialties supported by division/ academy facilitators	1. Matron audit reporting to Divisional Quality Committees 2. Quarterly reports to QDG and Q&P (Quality and Performance) 3. Divisional exception quality reports to QDG 4. Reports to Q&P on patient experience indicators 5. GSQIA reporting to QPC on progress with projects (see BAF 2.4)		↔
			Gaps in Control	**Gaps in Assurance**	
			• Ability of GSQIA to support number of projects arising from silver courses / gold coaching projects training (capacity)	1. Reliable data source for actual performance e.g. surveys not reported in real time. 2. Sentiment analysis produces unreliable data source for improvement	

Potential Risk Exposure	Related Risks on Trust Risk Register	Score
• **M2473Emer** - The risk of poor quality patient experience during periods of overcrowding in the Emergency Department.		3 x 3 = 9 (Quality)
• **M727Emer -** The risk to patient safety of delay to diagnosis and treatment reducing quality of care to patients and decrease in staff morale due to diverts.		2 x 4 = 8 (Safety/Quality)
• **M2434Emer -** The risk of reduced safety, patient experience and quality of care due to inability to recruit and retain qualified nursing staff across Unscheduled Care.		3 x 4 = 12 (Workforce)
• **M2484Emer** - The risk of poor patient quality due to lack of visibility of Decision to Admit times on TrakCare		3 x 3 = 9 (Quality)
• **C2619MDEOL** - Risk of inadequate improvement for next CQC End of Life (EOL) assessment.		2 x 5 = 10 (Statutory)
• **C2734NPatExp** - The risk of reduced quality for patients approaching PALs with issues/concerns about provision hospital services.		3 x 4 = 12 (Quality)

Actions Agreed for any gaps	By Whom	By When	Update
Reports are sent regularly to clinical areas to ensure continual focus is given.	Patient Experience Improvement Manager	Provided monthly	Divisions to act on findings

Enabling Strategy	Oversight Committee	Executive Group
Patient Experience and Carer Strategy 2015-2017. Patient Experience quality improvement strategy draft being reviewed.	Quality Delivery Group	Quality & Performance Committee

Quarterly Progress Report Against Delivery	RAG Rating
Current position The current, April 2018, combined (maternity, ED, inpatient and OPA) FFT score is **91%.** <u>October 2018</u> 1. In quarter 1 we met our strategic objective for FFT of 93% positive score in 1 out of 4 areas, this increased to 2 out of 4 areas in quarter 2 but the Trust overall did not meet this objective. 2. Our strategic objective of 35% of patients responding to the FFT was not met in any area. However, we do perform	

positively against the national average for response rate in all three domains.

3. Table 1 shows the breakdown, by quarter, of each area against the Trust targets and the national averages for quarter 1 and 2 2018/19. Please note response rates are not reported for outpatients.
4. Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement. The FFT question alone is not sensitive enough to assist staff with knowing where to improve services as they need to read all the comments and use the sentiment analysis tools.
5. The FFT score has been a balancing measure for some of our patient experience improvement projects across the services.
6. To improve the position real time surveys are being piloted and will give staff more contemporaneous insight data about what it is like to experience care in that area.

Strategic Objective: Have more than 35% of our patients sending us a friends and family test response, and of those, 93% would recommend us to their family and friends

	Target 2018/19	Quarter 1 2018/19	Quarter 2 2018/19	National Average (quarter 1 2018/19 available only)
Trust positive score	93%	91%	91%	N/A
Inpatient FFT positive score *(includes day case)*	93%	91%	87%	96%
Emergency Department FFT positive score	93%	84%	84%	87%
Outpatient FFT positive score	93%	92%	93%	94%
Maternity (Birth) FFT positive score	93%	96%	94%	97%
Trust response rate	35%	24%	14%	N/A
Inpatient FFT response rate *(includes day case)*	35%	27%	25%	25%
Emergency Department FFT response rate	35%	20%	17%	13%
Maternity (Birth) FFT response rate	35%	25%	21%	22%

(1.6) Strategic Objective – To Reduce the Number of Complaints Received Regarding Care and Experience in Outpatients Departments to less than 30 per month by April 2019

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.6.1 Risk that causes of complaints relating to patients Outpatient experience are not fully understood or acted upon	**Director of Quality & Chief Nurse** **Quality and Performance Committee**	**External –** **1.** Data - we are using nationally agreed codes submitted to Department of Health **Internal -** 1. Analysis of themes from complaints by Patient Experience sent to Division/Executive 2. Outpatient Department Forum 3. Outpatient Improvement Group 4. Outpatient Senior Nurse Forum 5. Escalation of themes / serious complaints through Q&P	1. Reports to Quality & Performance Committee every quarter 2. Quality Delivery Group and Safety & Experience Review Group bi monthly. 3. CBO (Central Booking Office) operational report monthly 4. Outpatient appointments complaints review and Outpatient Improvement Group.	1. Reports show that number of complaints that have an outpatient experience element to them have declined.	↔
			Gaps in Controls	**Gaps in Assurance**	
			Challenges by external stakeholders about actions implemented as a result of complaints or Trust volunteering information	Detailed diagnosis of issues within the OPA complaints from Datix as each complaint letter needs to be read.	

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.6.2 Impact of changes implemented in out-patients not reflected by reduction in complaints as 200,000 outpatient appointments every quarter	**Director of Quality & Chief Nurse** **Quality & Performance Committee**	Quality Improvement project being led by the Outpatient Matrons and Deputy Head of Patient Experience	Every outpatient complaint for 1 month reviewed to see themes and trends. **Gaps in Controls** Each complaint has to be reviewed to see if it has an outpatient element to it and then marked for review.	Report demonstrates number of complaints has declined. **Gaps in Assurance**	↑
Principal Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
1.6.3 Impact of issues relating to introduction of clinical information system and the booking of patient appointments	**Director of Quality & Chief Nurse** **Quality & Performance Committee**	• Appointment of Operational Consultant for Trakcare to troubleshoot arising issues • Training and Standard Operating Procedure for staff on clinical system and booking office.	• Monthly review of issues at Clinical Systems Review Group and Planned Care Board • CBO (Central Booking Office) operational report **Gaps in Controls**	1. Review of complaints data on a regular basis. 2. Task and finish group working on QI project. **Gaps in Assurance**	↑

Potential Risk Exposure	Related risks on Trust Risk Register	Score
• **D&S2556OPD** - Risk of poor patient experience and outcomes due to patient unknowingly being transferred to 'hold' file and not being actioned.		2 x 3 = 6 (Quality)

Actions Agreed for any gaps	By Whom	By When	Update
Data presented to Operational Delivery Committees so that reports can be produced.	Deputy Head of Patient Experience Improvement	Monthly	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Outpatient Transformation Strategy	Planned Care Board / D&S Board	Quality & Performance Committee	

Quarterly Progress Report Against Delivery	RAG Rating
Baseline information • Across the organisation, approximately 200,000 outpatient episodes provided every quarter. • Prior to the implementation of the IT system Trakcare the number of complaints for outpatients' episodes of care was approximately 30 per month (as reported to PESG in November 2016). • In April 2017, Outpatient complaints rose to 96 for that month and peaked at 120 in July 2017. **<u>Current position</u>** The Trust received **91** outpatient related complaints in April, May June 2018 Q1 data. We have now achieved the objective which is an average of 30 complaints per month (these are complaints that have an issue assigned as Service Area – Outpatients). **October 2018 Update** • The Outpatient Transformation Strategy has been developed and this includes a roadmap for outstanding/centres of excellence - ***'Journey to Outstanding - Right Patient, Right Appointment, Right Place, First Time'*** • The Matron for Outpatient Services has been working on Outpatient Department metrics and generic competencies for outpatients. • The Nursing Assessment and Accreditation Assessment system will be rolled into Outpatients in December 2018. • The Central Booking Office have moved into the Corporate Division and their improvement work is being monitored through specific key performance indicators (KPIs). • The Central Booking Office (CBO) has seen significant improvement its KPIs. The new telephone system has now embedded and there has now been a reduction in the complaints received to 30/ month.	

Table 1 below shows the theme, issue and number of times it was raised within the analysed complaints. Some complaints had more than one issue identified in them;

Environment	**Appointments**	**Clinical Treatment**	**Communication**	**Values and Behaviours**
Access **1**	Time waiting for apt date **15**	Failure to diagnose **2**	Breaking bad news **2**	Attitude of nursing staff/ midwife **2**
Signage **1**	Time waiting to be seen in clinic **3**	Dispute over diagnosis **5**	Communication with patient **12**	Attitude of medical staff **2**
Car parking including cost **4**	Appt cancelled and not informed **16**	Incorrect procedure/ treatment **3**	Communication with relatives/carers **1**	Attitude of admin and clerical staff **3**
	Appt letter not clear **3**	Delay or failure in ordering/ acting on test results **4**	Communication with GP **1**	Attitude of other staff (Radiographer) **1**
	Appt letter not received **4**		Inadequate record keeping **1**	Breach of confidentiality by staff **4**
	Unable to contact CBO **3**			
	Appt cancelled several times **4**			

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
Risk of static or reduced engagement.	**Deputy Chief Executive and Director of People** **People and OD Committee**	• Engagement events such as: – 100 Leaders – Medical Education Board – Diversity Network – Executive walkabouts – 'Back to the floor' – Involve – Weekly CEO Blog – Freedom to Speak Up promotion. • Staff survey action plan process informing action planning at a Divisional level and trustwide priorities. • Staff engagement and formal consultation and working groups such as: – Local Negotiating Committee (medical staff) – JSCNC (TU) – Divisional and Trust Health and Safety Forums.	1. People and OD Committee 2. Escalation of issue through Health and Safety Committee to Executive Colleagues. 3. Escalation of issues to Executive Colleagues via a range of communication methods (i.e. open door policy)	1. Regular report to People and OD committee via. Update on priorities and staff survey reports. 2. Annual Staff Survey Report cascaded at all levels across the organisation. 3. Freedom to Speak up annual report to People and OD Committee.	↔
			Gaps in Control	**Gaps in Assurance**	
			Lack of triangulation of staff data relevant to engagement.	Reporting triangulated staff experience data.	

Potential Risk Exposure – Confirmed risks on Trust / Divisional Risk Registers	Score	
C2803P&OD: The risk of continued poor levels of staff engagement is that our staff experience will impact negatively on retention, recruitment and patient experience.	9	

Actions Agreed for any gaps	By Whom	By When	Update
Development of 'Staff Experience Improvement Group' to implement a range of staff engagement, health and wellbeing actions and begin triangulation of data relating to staff experience. The group replaces the former Staff Health and Wellbeing Group and Staff Engagement Steering Group.	Head of Leadership and OD	September 2018 (met May 2018)	Complete
Enabling Strategy	**Oversight Group**	**Executive Committee**	
Workforce Strategy	People and OD Group	People and OD Committee	

Quarterly Progress Report Against Delivery	RAG Rating
• We reduced delivery progress to 'amber' in July 2018 as the Staff Engagement score for 2017 reduced from 3.71 to 3.67. (Nationally the average engagement score for acute trusts also dropped from 3.81 in 2016 to **3.79** in 2017) • Key Staff Survey themes and actions reported to the People and OD Committee, Oct 2018. • Risk updated and added to Datix, Oct 2018. • The 'Staff Experience Improvement Group' are overseeing key work such as: HCA retention plan, whilst developing capability to triangulate data. HCA Turnover project which convened focus groups to seek feedback, which in turn has made recommendations. Feedback to HCA groups planned for 25/10/18. • Staff Survey launched with additional questions relating to Health and Wellbeing Oct 2018. • Established new Extended Leadership Network aimed at mid-level managers, August 2018 • Established GM/AGM Forum and Operational Matrons Group • Monthly Diversity Network coffee socials and bimonthly meetings • Launched new Staff Experience Improvement Group to undertake triangulation of staff experience data and identify priority areas/actions to implement • Promotion of Freedom to Speak Up Friday and FTSU week. • Relaunch of Schwartz rounds • Launch of Nurse Accreditation and Assessment Scheme (NAAS) • Engagement at all levels of Trust to seek feedback on Journey to Outstanding #J2O and ideas for new trust strategic objectives • Increased usage of social media to promote and celebrate great work in Trust using #J20	

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
High turnover results in a gap in care, potential increased cost to fill temporarily and a delay in attraction – resulting in potential service delivery delay.	Deputy Chief Executive & Director of People and OD **People and OD Committee**	1. Vacancy Control Panel (VCP) process enabling speedier fill to post process 2. VCP cost control, agency & bank 3. Recruitment & Selection Policy 4. Exit Interviews 5. Sustainable Workforce and ELD Priorities 6. Recruitment Strategy Group - **linked** to demand and supply routes, student attraction n and increased HE engagement. 7. Dedicated HRBP resource leading on strategic development of sustainable workforce (ACPs, TNAs, Apprentices) 8. New Talent Development System	1. Reprioritised work programme for 17/18 to ensure a basic funded establishment is produced with supply & demand for key roles established. 2. Workforce Sustainability & ELD group priorities 3. Divisional plans for hard to fill roles & forward planning 4. Human Resources Business Partner and Finance Business Partners involvement in vacancy projection 5. Workforce plans to be aligned to operational capacity and demand work within divisions 6. Education work strands to improve career planning & career routes/pathways	1. Operational dashboard published with trends and future projection at People and OD committee 2. Bi-annual Education, learning and development report to People and OD Committee 3. Sustainable workforce report to People and OD Committee 4. STP update & impact included in People and OD report to Board	↔

			7. Bespoke retention projects and listening events (i.e. band 5 nurses) 8. STP work to reduce competitive recruitment between STP partners 9. Robust Training plans for all staff grades and provision for staff to develop themselves 9. Coaching offer STP leadership behaviour definition		
			Gaps in Controls	**Gaps in Assurance**	
			1. Limited compliance with exit interviews	1. **One version of data** – Finance and HR records on establishment do not accurately match impacting on vacancy data transparency. 2. **Mentorship** programme to be offered to staff (by April 2019) 3. Review of HCA terms and conditions	

Potential Risk Exposure – confirmed risk entries on Trust Divisional Risk Registers			**Score**
C1437P&OD The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHP's, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives.			2x4=8 Workforce
Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
1. Robust talent management system to link development opportunities with succession planning and career management	Head of Organisational Development	July 2018	Complete.
2. One version of data – Finance and HR records on establishment do not match	Deputy Director of People and OD	September 2018	Organising data via professional group. Delayed launch to April 2019.
3. To continue to develop Nurse Associate roles, Nurse apprenticeships and advanced clinical practice	Chief Nurse /Director of Quality	August 2018	First cohort due to complete April 2019.
4. Doctors in Training Streamlining Programme, to ensure new starters & potential joiners have the best experience within the Trust	Medical Staffing Manager	August 2018	National pilot postponed, however key principles adopted by GHT. Awaiting national system update, expected Jan 2019.
5. Review of HCA terms and conditions	Deputy Director of People and OD	August 2018	Presented to TLT, agreed to steer through Service Development Process Oct 2018.
6. Review of Exit Interview Process	HR Advisory Team	December 2018	
7. Mentorship Programme Launch	Head of Organisational Development	April 2019	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Workforce Strategy	People and OD Committee		

Quarterly Progress Report Against Delivery	RAG Rating
Recruitment Improvements • The recruitment steering group is now well established. • Recruitment activity has increased phenomenally - previously we averaged 50 – 60 new starts per month, September 2018 we will hit an all time record of 208 new starters across professional groups. • Marketing campaigns are being finalised, with improvements now made to JD's and adverts • Exploring cross STP DBS portability and pre-hire IAT with 2G and GCS • Re-write of DBS policy and guidance (first draft under review) • New team are establishing, new Recruitment office manager appointed , start date TBC • NQN Open Day (End of Sept) , offers made to 38 NQNs to start Spring 2019. • HCA assessment day review – changed assessment process to make more efficient, further days scheduled to support the increase volumes • Career Fair plans are in progress – the Trust visited Dublin in October 2018 • Recruitment Newsletter produced and launched Oct 2018 • We are participating in national workshops via NHSi sharing best practice on recruitment and retention **ACP** • A number of pockets of work around the development of ACPs have already taken place, this project has focused on pulling this work together into a strategy for the development of ACPs which helps to mitigate the risk articulated above. • The ACP role has now been defined with an emergent 'advanced practice' map, which clarifies the characteristics belonging to the different roles falling under the umbrella of advanced practice, such as: ACP, Nurse Practitioner, Clinical Nurse Specialist, Consultant Nurse. • The organisational 'heat map' has been outlined , indicating where we need ACP roles and which areas take priority for the development of ACPs. • We have engaged with a number of other acute Trusts and Gloucestershire ICS. Specifically collaborating with Derby (who now have 77 ACPs in post) we have visited site and met with service leads to understand their lessons learnt so far. • Routes to entry have been identified : Including internal development and external recruitment pathways (Qualified/ Part Qualified/ Unqualified) • We have begun to compile the 3 year training programme and engage with UoG, UWE and other HEIs to explore how we can make this programme work in practise. Some modules will be funded through the HEES ICS transformation funding, others may be achieved through a Masters level Apprenticeship. **Trainee Nurse Associates** • First "Fast-Follower" cohort of 11 Trainee Nursing Associates due to complete in GHT in April 2019 • Shared Countywide procurement exercise appointed University of Gloucestershire as the apprenticeship provider	

• Second “legacy” cohort of 19 commenced Apprenticeship programme on 24th September. (42 across the ICS footprint) **Clinical Nurse Fellows** • Established new Clinical Nurse Fellows programme to both attract new first/2:1 degree band 5 nurses and retain/develop existing Band 5 nurses. • Day 1 of programme commenced on 20th September to include in-house induction and enrolment on to the Level 3 Leadership Apprenticeship. Only 3 started, but very high quality individuals with good quality improvement projects proposed. **Apprenticeships** • Continual development of new apprenticeships to “grow our own” and increase access to qualifications as Healthcare standards emerge nationally • Some - slow progress made with developing an ICS approach to apprenticeships (shared procurement, documentation, leadership programmes) **Numbers of Nurse Degree Students on placements** • Expansion of nurse student placements and partnerships with Worcester, Oxford Brookes as well as • Involvement in the National HEE RePAIR project to reduce Student Nurse attrition and transition shock to NQ nurse	

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director& Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
Staff do not recognise the Trust as an employer of choice or recommend employment with the Trust to others; as such increasing retention and reducing attraction. Increased recommendations would support the attraction of talent into the organisation and support the reduction of risks associated with failure to fill vacancies.	**Director of People and Organisational Development** **People and OD Committee**	Engagement events such as : – 100 Leaders – Medical Education Board – Diversity Network – Executive walkabouts – 'Back to the floor' – Involve – Weekly CEO Blog Staff survey process informing action planning and trustwide priorities. Staff engagement and formal consultation and working groups such as : – Local Negotiating Committee (medical staff) – JSCNC (Staffside Committee) – Divisional and Trust Health and Safety Forums Monitoring and intervention/ action relating to exit interviews, grievances and turnover data.	1. Workforce Sustainability & ELD (Education Learning and Development) group 2. Divisional plans for hard to fill roles & forward planning 3. HRBP (Human Resources Business Partners) & FBP (Finance Business Partners) involvement in vacancy projection 4. Education work strands to improve career planning & career routes/pathways 5. Robust training plans for all staff grades and provision for staff to develop themselves 6. Coaching offer 7. STP (Sustainability and Transformation Plans) leadership	1. Annual staff survey report to workforce Committee 2. Scrutiny of employee issues at DOG (Directors Operational Group), TLT (Trust Leadership Team) & Executive Team meetings 3. Equality and Diversity report to Workforce Committee 4. Freedom to Speak Up annual report to Workforce Committee 5. Staff Friends & Family quarterly survey results	↔

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

			19. TLT (Trust Leadership Team) and DOG (Directors Operational Group) process 20. Back to floor days 21. Datix review & feedback 22. Internal Comms agenda and intranet use for key messages & blogs. 23. Listening events 24. Involve 25. I Lead 26. CQC (Care Quality Commission) and J2O (Journey to Outstanding) agenda 27. Reward Strategy Group.		
			Gaps in Control	**Gaps in Assurance**	
			Lack of triangulation of themes relating to staff experience.	1. Lack of real time engagement tool 2. Rumour mill working as fast as official channels.	
Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Register					

Actions Agreed for any gaps	By Whom	By When	Update
Development of the Staff Experience Improvement Group, in order to triangulate themes and ensure appropriate intervention.	Chaired by Deputy Director of People and OD	First meeting June 2018	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Workforce	Workforce Committee	Trust Leadership Team	
Quarterly Progress Report Against Delivery			**RAG Rating**
Initial Staff Experience Improvement Group meeting, held June 2018. Data triangulation methods are not fully mapped yet (resource to be identified) therefore the group agreed to work on triangulation of data for the medical division in the first instance, linking with the Division to ensure the group offers practical and useful support, which compliments current activity. RAG rating changed to green, to reflect the joint working of the Staff Improvement Group which is now in progress and ownership of items such as the HCA Retention plan via this group.			

(2.4) Strategic Objective: Have Trained a Further 900 Bronze, 70 Silver and 45 Gold Quality Improvement Coaches by April 2019

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that target numbers will not be achieved as staff will not be able to access training due to operational pressure preventing release to attend.	**Medical Director** **Quality and Performance Committee** **Gloucestershire Quality Improvement Academy**	1. Training programme agreed 2. Identification of those for higher training through projects in line with strategic objectives 3. Monitoring of numbers trained through the GSQIA (Gloucestershire Safety and Quality Improvement Academy) 4. Performance against programme monitored for reasons of non-attendance.	Monitoring of training numbers Feedback to GSQIA members/ divisions by quarterly newsletters of numbers attending and progress of projects Approval of Quality Framework to include plans for training for staff at QPC	6 monthly reports of GSQIA progress to QPC	↔
			Gaps in Control	**Gaps in Assurance**	
			Appropriate prioritisation of operational pressures over training sessions	Confirmation of reasons for non-attendance at scheduled sessions	
Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers					
Operational pressures prevent training.					

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to GQIA New date for six month report to be added to work plan	Medical Director Medical Director\Director of Corporate Governance	September 2019 December 2018	Report removed from Sept 18 agenda to reduce size of agenda new date to be agreed

Enabling Strategy	Oversight Group	Executive Committee	
Quality Improvement Strategy	GSQIA	Quality and Performance	
Quarterly Progress Report Against Delivery			**RAG Rating**
The GSQIA continues to deliver the required volume of training for bronze and silver. Gold coach training continues with a cohort of 20 staff members **but is at risk to reach 45**. To resolve this, the new Quality Framework that organisationally creates the Gold QI coach role needs to be formally agreed. Staff in that role will then engage with the programme. Numbers of staff completing courses by end of June 2018 (excluding Non GHT staff): Bronze = 1670 Silver = 93 Gold = 6			

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
Failure to engage staff in activities to improve their physical and emotional wellbeing can give rise to additional stress and sickness which impacts upon patients & service delivery	Director of People and Organisational Development **People and OD Committee**	1. Workforce Strategy 2. Health & Wellbeing strategy 3. Health promotion programmes 4. Provision of staff support programmes 5. Catering 'healthy options' on site 6. Health and Wellbeing web resource 7. Sickness management policies. 8. Health and Safety policies 9. Access to occupational health services.	1. Monitoring and control of sickness absence. 2. Reprioritised work programme for 2018 to simplify employee Support Services 3. Diversity network 4. Staff Health and Wellbeing Steering Group	1. Annual staff survey report to workforce committee 2. Monthly data on absence to workforce committee 3. Annual health & wellbeing report to workforce committee 4. Sickness absence levels/ reasons for absence monitored through Executive Divisional Reviews/Divisional Board structure	↔
			Gaps in Control	**Gaps in Assurance**	
				Simplified "one stop shop" for employee health and wellbeing initiatives Triangulation of staff experience and wellbeing data	

Potential Risk Exposure – confirmed risk entries on Trust / Divisional Risk Registers		
Nil identified		

Actions Agreed for any gaps	By Whom	By When	Update
Identification of potential solution to "one stop shop" for employee health and wellbeing initiatives • Identification of the current return on investment for employee Health and Wellbeing services. To include: Occupational Health, Staff Support, Physiotherapy services. Begin benchmarking with other organisations 'one stop shop' provisions	Head of Organisational Development	October 18	
• Launch "Staff Experience Improvement Group"	Head of Organisational Development	September 2018	Draft T.o.R published June 2018.
• Improve the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.	Head of Organisational Development	October 2018	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Staff Health and Wellbeing Strategy/Workforce Strategy	Workforce Committee		
Quarterly Progress Report Against Delivery			**RAG Rating**
Staff Experience Group Launched June 2018. Additional support agreed, via CCG, over Summer 2018 to support additional engagement with staff regarding what the 'one stop' health and wellbeing service would need to include, to fully support our workforce.			

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director& Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
The risk that the proposals cannot be implemented without impacting on operational performance or quality of care.	**Director of Strategy and Transformation** **Main Board**	1. Detailed implementation plan with modelling of impact of service changes as part of the STP One Place Programme 2. Impact Assessment and Quality Impact Assessment of all proposals 3. Risk assessments for operational processes 4. Outline Business Case & Full Business Case through Trust Board in 2019 5. NHSE (NHS England) stage 2 Assurance Process	Full Business Case including impact assessments. **Gaps in Control** None	Strategic Outline Case June 2017 Output from NHSE (NHS England) stage 1 assurance. **Gaps in Assurance** None	↓

Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers	**Risk score**
National political processes could introduce delays into the proposed timetable. Unexpected increase in demand for services.	
• **C1748COO** - The risk of statutory intervention for failing national access standards in relation to cancer. • **M2473** - The risk of poor quality patient experience during periods of overcrowding in the ED (Emergency Department).	3 x 4 = 12 (Statutory) 3 x 3 = 9 (Quality)

Enabling Strategy	Oversight Committee	Executive Group	
New Clinical Model Strategic Outline Case One Gloucestershire STP (Sustainability and Transformation Plan)	New Clinical Model Programme Board Now reporting to One Place Programme Board	Main Board	
Quarterly Progress Report Against Delivery			**RAG Rating**
Outline Business Case for new system wide clinical model for urgent care completed in draft form in August. The ICS Programme Board agreed to pause the timeline to allow for further development of the model, and additional public engagement on the care in hospital components. A Programme Director is in place in the Trust to co-ordinate wider engagement on the options for change, and modelling and testing of the operational impact of the proposals to support the next draft of the Outline Business Case. This work is overseen by the Centres of Excellence Delivery Board. Meanwhile key elements of the model of care are being delivered as 'Test and Learn' projects including Urban Urgent Treatment Centres and the AMIA.			

(3.2) Strategic Objective: To complete Trakcare recovery work to enable the Trust to resume national RTT reporting by February 2019 (amended)

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Board Assurances	Direction of Travel
3.2.1 Risk that the data quality improvements necessary to support a return to reporting are not achieved	**CEO (Chief Executive Officer) as SRO (Senior Responsible Owner) of SmartCare Programme** **SmartCare Programme Board reporting to Finance and Digital Committee**	1. Comprehensive data quality cleansing programme in place 2. Development of SOPs and training of all staff inputting data affecting RTT reporting 3. Tracking of progress through Trakcare Operational Recovery Group 4. Working with Yeovil who have commenced reporting from TrakCare.	Weekly Trakcare Operational recovery Group Recovery Progress Report to SmartCare Programme Board	Monthly reports to Main Board on programme performance and future reporting to Digital Committee	↑
			Gaps in Control	**Gaps in Assurance**	
			Limited influence over supplier actions and decisions which impact on objective	None	
Principal Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls and Mitigations**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
3.2.2 Risk that necessary system configuration and work is not completed to proposed timeline	**CEO as SRO of SmartCare Programme** **SmartCare Programme Board reporting to Finance and Digital Committee**	1. Recruitment to system configuration team 2. Working with other TrakCare users who are reporting RTT e.g. Yeovil 3. Two planned 'test cycles' to identify any issues in advance of returning to reporting.	Weekly Trakcare Operational recovery Group Recovery Progress Report to SmartCare Programme Board	**Monthly reports to Main Board on programme performance**.and future reporting to Digital Committee	↑

			Gaps in Control		
			Limited influence over supplier actions and decisions which impact on objective		
			Gaps in Control	**Gaps in Assurance**	
			None	None	

Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers	**Score**
F2723 Risk that FY19 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues with TrakCare implementation 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.	**3x4=12 (Finance)** **4x4=16 (Safety)**

Enabling Strategy	**Oversight Group**	**Executive Committee**
Digital Strategy	SmartCare Programme Board	Finance & Digital Committee Quality & Performance

Quarterly Progress Report Against Delivery	**RAG Rating**
• Detailed project plan developed and presented to SmartCare Programme Board. • Testing cycles agreed – approach and timing. • Positive visit to Yeovil which will inform approach	

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
3.3.1 Risk that resources are not available to achieve compliance.	**Director of Strategy and Transformation** **Quality and Performance Committee**	1. GIRFT reports for T&O, Vascular, Urology and ENT have been reviewed and key actions from the reports collated for the PMO to review progress against on a monthly basis. 2. Action plans have been requested from clinical leads and will be in place to achieve compliance 3. Any required business cases to deliver compliance to be considered through 2018/19 Planning Cycle.	• GIRFT (Getting It Right First Time) Governance Framework • Action plans in each specialty.	Governance Framework endorsed at August Q&P (Quality & Performance) Committee GIRFT standing agenda item on Executive Divisional Reviews.	↔
			Gaps in Control	**Gaps in Assurance**	
				Escalation from EDRs (Executive Divisional Reviews) to Board Sub-Committees not yet established.	

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
3.3.2 Risk that actions to secure compliance will constitute significant service change delaying implementation.	**Director of Strategy & Transformation** **Quality and Performance Committee**	1. Development of proposals through clinical leadership model 2. Staff engagement plan 3. Early discussions with commissioners 4. Creation of high quality	• NHSE (NHS England) Assurance Process • SW Clinical Senate Assurance process.	• Strategic Outline Case June 2017 • Output from NHSE stage 1 assurance.	↔

		consultation material 5. Clinical leadership of engagement activities.	**Gaps in Control**	**Gaps in Assurance**	
Potential Risk Exposure – confirmed risks on the Trust/ divisional Risk Registers					**Risk score**
• **F2723** - Risk that FY19 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation					4 x 3 = 12 (Finance)

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
GIRFT action plans to be item on agenda for Surgical Division Executive Review	COO	July 2017 meeting cycle	Completed
GIRFT to be regular reporting item on Q&P committee	Director of Clinical Strategy	July 2017 meeting cycle	Completed
Gap analysis of actions plans to determine priority services to secure compliance	PMO	November 2017	Being progressed through Executive Divisional Reviews
Escalation Reports from EDR to Board committees to be agreed.	Director of Corporate Governance	November 2018	Quarterly EDR minutes to be presented to TLT; TLT minutes received by Board
Enabling Strategy	**Oversight Group**	**Executive Committee**	
New Clinical Model Strategic Outline Case Divisional Business Plans 2018/19.	New Clinical Model Programme Board (transformational) Trust Leadership Team (operational)	Quality and Performance Committee	
Quarterly Progress Report Against Delivery			**RAG Rating**
Action plans following each review now being developed within specialties and progress reviewed in Executive Divisional Reviews. Template for reporting issues from EDRs to Board Sub-Committees in development.			
Reconfiguration of T&O (Trauma & Orthopaedics) service to support compliance implemented from October 2017 to March 2018 to support the Winter Plan. Benefits tracking in place. All other GIRFT schemes where recommendations have been submitted to the Trust are being reviewed by the PMO to ensure progress against the recommendations is achieved and captured.			

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

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

Potential Risk Exposure	Related risks on Trust Risk Register		
none	none		

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to Health and Wellbeing Group.	Director of Strategy and Transformation	September 2017	Completed
Health and Wellbeing Strategy.	Health and Wellbeing Group	January 2019	

Quarterly Progress Report Against Delivery	RAG Rating
• Reporting schedule to Health and Wellbeing Group established • Linkages with wider system initiatives and opportunities for training being explored • Given additional impetus through publication of the National Tobacco Control Plan and recommendations for a Smoke Free NHS • Board and Governors supportive of trialling London Clinical Senate approach – pilot in respiratory now being set up. • On line Making Every Contact Count e-training and other H&LS resources now available e.g. 522 have now accessed MECC e-training. Face to face MECC training had been attended by 214 individuals by end of 2017/8.	

(4.1) Strategic Objective – Show an improved financial position

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that the Trust does not deliver the required savings and budgeted levels of income and/or efficiencies resulting in failure to deliver the Financial Recovery Plan.	**Director of Finance** **Finance and Digital Committee**	1. Regular NHSI (NHS Improvement) FSM (Financial Special Measures) meetings 2. Monthly monitoring, forecasting and reporting of performance against budget by finance business partners 3. PMO (Programme Management Office) in place to record and monitor the FY18 programme (including monitoring and reporting of performance against target) 4. Turnaround Implementation Board scrutiny of delivery 5. Weekly 1:1 meetings with Divisions on financial recovery with strengthened Executive membership and chaired by the Chief Operating Officer. Bi-weekly meetings with cross cutting themes. 6. Monthly Executive reviews 7. SmartCare Programme Board overseeing Trak	1. Finance Report 2. Audit reports 3. CIP (Cost Improvement Plan) Report 4. Performance reporting. **Gaps in Controls**	1. NHSI agreement to Financial Recovery Plan 2. Initial Deloitte review and implemented actions. **Gaps in Assurance** Reliable data for activity impacting billing and income recovery.	↓

		recovery and regular monitoring and analysis of data completeness (and quality) and income recovery. 8. TrakCare finance recovery workstream meeting regularly to assure on financial improvement			

Potential Risk Exposure	Related risks on Trust Risk Register	**Risk score** *(all for finance domain)*
	• **F2516** - Risk that the Trust does not exit Financial Special Measures in a timely way and as a result is subject to reputational risk.	2 x 2 = 4
	• F2724 - Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19	5 x 3 = 15
	• F2723 - Risk that FY19 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation	4 x 3 = 12
	• F2722 - Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY19	3 x 2 = 6

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
PMO supports in-year delivery alongside any in-year recovery. The PMO works with divisions to understand and recover slippage and identify new schemes. TIB (Turnaround Implementation Board) used as escalation forum for issues that cannot be resolved at divisional level.	Director of CIP PMO	Ongoing	CIP programme showing £3.0m favourable variance to plan for period to end September.
Progress/slippage is tracked and reported weekly to Executives (through the dashboard) and monthly via other forums including to the Finance Committee.	Director of CIP PMO	Ongoing	

TIB chaired by the CEO (Chief Executive Officer) to reiterate the importance of CIP delivery and to support the resolution of any escalated issues.	Director of CIP PMO	Ongoing	
Finance business partners work with divisions to recover slippage and identify mitigating actions Escalation to Director of Finance where Executive intervention required (part of Executive reviews).	Director of Operational Finance	Ongoing	Overall I&E (Income & Expenditure) performance is reporting a favourable variance to plan of £0.2m.
Development of 2018/19 CIP plans to bridge the gap in the plan	Director of CIP (Cost Improvement Plan) PMO (Programme Management Office)	Ongoing	CIP plans are being supported by PWC alongside ongoing work by Divisions and Executive leads
Enabling Strategy	**Oversight Committee**	**Executive Group**	
	Finance and Digital Committee	Turnaround Improvement Board and Trust Leadership Team	
Quarterly Progress Report Against Delivery			**RAG Rating**
The overall Income and Expenditure position to end September is showing a £0.2m favourable variance to plan. The forecast outturn is currently £3.8m adverse to planned control total, driven by loss of agenda for change funding within GMS and the associated loss of PSF (£2.8m).			

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel)
Failure to deliver full efficiencies for Length of Stay, Theatres, Outpatients.	**COO (Chief Operating Officer)** **Finance and Digital Committee**	1. Monitoring at the CIP (Cost Improvement Plan)/Transformation Board 2. Monitoring at the Emergency Care Delivery Group and the Planned Care Delivery Group.	1. Opportunities for improvement have been evaluated 2. Progress reports to the Finance Committee 3. Monitoring through Theatres Collaborative Group	Transformation Board in place.	↔
			Gaps in Controls	**Gaps in Assurance**	
			TrakCare has impacted progression of these projects. Detailed project plans in place through Outpatient Transformation Programme	Outpatient Transformation Programme Board	

Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers	Risk score
• **C2628COO** - 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. Linked risks **C2439SC, S2472UGI**	4 x 4 = 16 (Safety)
• **F2724** - resulting in failure to deliver the Financial Recovery Plan for FY19	5 x 3 = 15 (Finance)
• **F2723** - Risk that FY19 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation	4 x 3 = 12 (Finance)
• **F2722** - Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY19	3 x 2 = 6 (Finance)

Actions Agreed for any gaps	By Whom	By When	Update
Develop detailed project plans and associated quantified benefits for implementation in 2018/19, and identify resourcing requirements to deliver the programmes – Theatre Improvement & Outpatient Improvement	COO (Chief Operating Officer)	February 2018 – completed. Progress against plan reviewed weekly.	Detailed programme plan in place
PMO (Programme Management Office) supports in-year CIP delivery alongside any in-year recovery. The PMO works with divisions to understand and recover slippage and identify new schemes. TIB (Turnaround Implementation Board) used as escalation forum for issues that cannot be resolved at divisional level.	Director of CIP PMO	Ongoing	Detailed CIP meetings in place as above
Continue to identify actions/schemes to mitigate non delivery	DOPs (Directors of Operation), DoT (Director of Strategy and Transformation)	March 2018	Through CIP meetings
Enabling Strategy	**Oversight Group**	**Executive Committee**	
Clinical Strategy, Theatre Strategy, STP (Sustainability and Transformation Plans)	Transformation Board and the Trust Leadership Team. Planned Care Delivery Group Theatres Collaborative Group	Finance and Digital Committee	
Quarterly Progress Report Against Delivery			**RAG Rating**
The identified additional CIPs and further measures have begun to be delivered. Weekly deep dives with divisions, COO (Chief Operating Officer), Chief Nurse, Medical Director and Director of Programme Management have been established to increase pace to year end. Detailed project plans and associated quantified benefits for implementation in 2018/19 are in development, stretching to Q1 2019/20. Resourcing requirements to deliver the project are being identified. Review underway of audit of outpatient utilisation and fill compared to 2016 being undertaken.			

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
4.3.1 Risk that new models of integration reduce income to the Trust without reducing costs.	Director of Strategy and Transformation **Trust Leadership Team**	1. Oversight from Clinical Programme Board of STP (Sustainability and Transformation Programme) 2. Adherence to "design" and "design for delivery" stages of programme change 3. Open book costing of model 4. Endorsement by Resources Steering Group of STP prior to implementation 5. System-wide approach to risk sharing.	Business case endorsed through Resources Steering Group.	1. STP Memorandum of Understanding (MOU) 2. Risk sharing agreement as part of MOU.	↔
			Gaps in Control	**Gaps in Assurance**	
			none	none	
Principal Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**)
4.3.2 Risk of failure to recruit to staffing model for integrated service.	Director of Strategy and Transformation **Trust Leadership Team**	Oversight from Clinical Programme Board of STP Adherence to "design" and "design for delivery "stages of programme change Oversight from STP workforce group.	STP workforce strategy.	Principals of integrated working endorsed by Clinical Programmes Board.	↔
			Gaps in Control	**Gaps in Assurance**	
			none	none	
Potential Risk Exposure – confirmed risks on Trust and Divisional Risk Register				**Score (CxL)**	
C2335HR&OD - Risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy level.				4 x 4 = 16 (Finance)	

Enabling Strategy	Oversight Group	Executive Committee	
One Gloucestershire, Transforming Care, Transforming Communities	STP Delivery Board	Trust Leadership Team	

Quarterly Progress Report Against Delivery	RAG Rating
Respiratory • Lead for Integrated Respiratory Team appointed. • Staff consultation (GCS) & engagement (GHFT) on 7-day working and service specification to commenced in September 2018 • Phased implementation of the integrated team started on 27th September • GHFT respiratory consultants have begun pilot for respiratory advice and guidance service within the Gloucester locality **Diabetes** • Model for integrated leg ulcer service agreed. • Awaiting funding for implementation of community clinics from CCG. **Musculo Skeletal (MSK) conditions** • The significant progress made to reduce the fractured neck of femur mortality rate by 37% (20 lives saved this year) with GHFT being been shortlisted for a HSJ award • MSK Foot and ankle triage now live • Full Business Case for MSK specialised triage being approved by the CCG Priorities committee. • eRS and booking processes have been configured, with joint training being organised. The referral form has been tested within Primary Care, in conjunction with Cancer 2WW form.	

(4.6) Strategic 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).

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
1. Lack of suitable studies available on the NIHR portfolio 2. Laboratory accreditation issues reduce the number of available studies 3. Staff resource in the Research Delivery Team	**Director of Strategy & Transformation** **Research & Innovation (R&I) Forum, reporting to Trust Leadership Team**	1. Broaden the research portfolio to maximise available studies 2. Consider studies that do not require lab accreditation 3. Accuracy of capability and capacity assessments for new studies to maximise workforce utilisation. Review and closure of poor performing studies to release staff	Progress against all HLOs reported quarterly internally to R&I forum and externally to SW Clinical Research Network (CRN)	R&I forum	N/A
			Gaps in Control	**Gaps in Assurance**	
			None	None	

Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers	Score
D&S2629Path - The risk of failure to recover and re-accredit following a critical CPA /UKAS report on the provision of the Haematology, Transfusion and Immunology Laboratory Services	• 4x3=12 - Statutory

Enabling Strategy	Oversight Group	Executive Committee
GHFT 2018/19 NIHR CRN Business Plan	Research & Innovation Forum	Trust Leadership Team
GHFT Research & Development Strategy	Draft strategy produced and issued for comment	

Quarterly Progress Report Against Delivery	RAG Rating
• The performance in initiating and delivery reports to the Department of Health show an improving picture; now 75% and 60% of studies, respectively reaching the target of 80%. • Recruitment to trials is on target.	

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

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

Purpose

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

Key issues to note

Bringing our community to come and talk to our Board is a highlight for me as this enables the Board members to step into the shoes of the patient and see our care through the eyes of our patients (just like the Sweeney Programme we are supporting from the Point of Care Foundation for our staff).

Patient experience improvement must be the golden thread throughout any improvement work that is undertaken in our Trust and patient experience insights should be an improvement measure in most if not all of our quality improvement projects. As a Trust we are committed to using the patient voice and their insights to drive our improvement priorities. Fundamental to the principle of quality improvement is an understanding that those closest to the patients (front line staff) are often best placed to find the solutions for improvement.

Conclusions

The developing emphasis on service user involvement in our Trust health is a powerful asset in our quality improvement work. The Patient Experience Improvement Team have now joined the Gloucestershire Safety and Quality Improvement Academy (GSQIA) and teach on the programmes and have completed their Gold Coach training.

Implications and Future Action Required

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

Recommendations
The Board are asked to note the contents of this report.
Impact Upon Strategic Objectives

- Outstanding rating by CQC in the domain of caring
- Friends and Family Test positive score of 93%
- Improving the outpatient experience (complaints to less than 30 per month)

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

MAIN BOARD - NOVEMBER 2018

PATIENT EXPERIENCE IMPROVEMENT IN RESPONSE TO BOARD STORIES

1 Patient Experience Improvement Work

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

2 Patient Experience Stories

2.1 **In May 2018** the Deputy Director of Quality and Freedom to Speak up Guardian introduced **patient Steve Tucker**, who shared his experience of being diagnosed and treated for cancer.

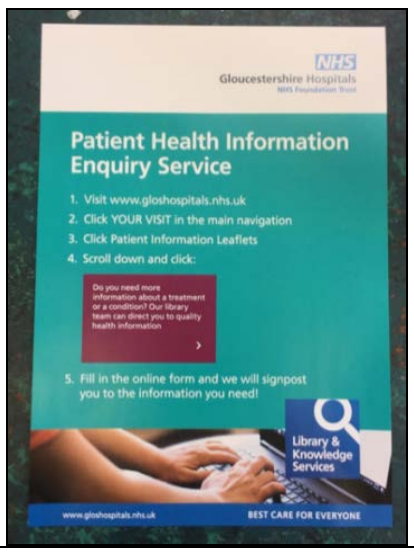
Our improvement work has been:

- Providing staff with positive feedback about Steve's experience in ED and Endoscopy and thanking them.

- Steve was told he was going home and then felt frustrated as the process was protracted. We are working to improve our discharge processes and have a work stream (and a Commissioning for Quality and Innovation (CQUIN)) to improve our discharge processes. Steve's suggestion that patients should be contacted by phone the day after discharge was fed back into the improvement group.

- Steve is about to join an outpatient improvement group led by the Central Booking Office which is looking at our letters '**Improving Patient Communications – Outpatient Appointment letters'**. One of the issues Steve will be taking to the group is knowing the length of time that an appointment can take and also giving some sort of indication about the length of time to park for. Also as an Oncology patient Mr Tucker should not have been paying for parking; he should have had a parking pass.

- Steve sometimes wished he had more information and since he has told this story our library services have now got a service which patients can request more patient information. This is in addition to the existing provision of the Health Information Room and the Macmillan information pod.



- I have met with the General Manager for cancer services and Steve will be invited to talk to their patient improvement group to repeat his story. Steve will be encouraged to give his view of what outstanding care would have looked like for him.

2.2 In July 2018 the Deputy Director of Quality introduced **Becky, daughter-in-law of patient Maggie**. Maggie had many health issues including breast cancer, osteoporosis and other conditions. In 2017 she had a stroke and had been admitted to Gloucestershire Royal Hospital.

Our improvement work has been:

- Becky had found it difficult to visit Maggie during the stated visiting times as both her and her husband work full time and out of county. When Becky came to board we had already just changed our visiting hours and that wards were now open from 9am to 9pm. An evaluation of this change is about to take place to see if this has improved things for our patients, their carers and our staff. One of the main outcome measures was that this initiative would improve our enhanced care needs of some of our patients as family/friends would be able to be present on our wards for longer periods of time.

  - We are still working on improvements with our communications with our Carers whilst they are in hospital as Becky felt that the hospital wasn't geared up to work with carers who were in full time employment and as she was not next of kin, it was harder to get information despite being a key carer to Maggie. The Digital Recovery Consultant advised that the Trust was working with all services and was investigating a joined up way of working as carers and patients only want to log in once.
  - We have produced a draft Carer's strategy and have asked Becky to make comments on our suggested change ideas.

2.3 In October the Deputy Director of Quality introduced Dr Husbands, Consultant in Palliative Care Medicine, Sam White, Lead Nurse for Specialist Palliative and End of Life Care and former **carer Caroline Martin.** Caroline described her experience of losing her father, and Dr Husbands and Ms White provided further insight into end of life care and the changes and improvements being made.

The team who brought this story had already heard Caroline's story and told the Board how they were working to make improvements which they presented to the Board. The

Deputy Director of Quality has another meeting booked with Caroline as she is keen to continue working with the Trust to make improvements.

Dr Husbands and Mrs White reflected:-

- That often hospital care can be very much focused on the situation occurring in the moment, rather than planning and discussing the bigger picture.
- Ms White said that there **was a Parallel Plan project**, involving the respiratory wards, under way; it aimed to encourage conversations about end of life outside of the acute context.
- Dr Husbands informed the Board that leadership role modelling around end of life care, and the last year of life was needed, to encourage acute physicians to think about the next steps after discharge and she felt an IT system which highlighted previous admissions would facilitate these discussions.
- The Board was also advised that the language had since changed from patients being 'Medically Fit for Discharge' to 'Medically Stable For Discharge' and would reiterate this message to all staff.

3 Recommendation

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

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

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

Report Title
Annual Report On The Trust's Emergency Preparedness, Resilience And Response Arrangements
Sponsor and Author(s)
Author: Rachel Minett, Emergency Planning and Resilience Manager Sponsor: Caroline Landon, Chief Operating Officer
Executive Summary

Purpose

To provide an annual update to the Board on the Trust's level of compliance with the national core standards for Emergency Preparedness Resilience and Response (EPRR).

Key issues to note

Due to the changes in the core standards this year they do not directly correlate with last year's and although we have an improving picture, this year's score rates us lower than last year's.

Significant improvements made with Business Continuity and Business Impact Assessment (BIA), IT resilience and testing IT Cyber plans with our IT shared community /CITS.

Evacuation and Shelter plan in place, tested through exercise Andromeda. Fire plans revised as a result and action plan being worked through for further mitigation, risk reduction and to enable a better response.

Conclusions

The Trust is Partially assured against national core standards for EPRR, and arrangements are being formalised. Investment is needed in EPRR for further evacuation kit identified during this year's internal review and for replacement of aging CBRN tents.

Although progress has been made there needs to be ongoing work embedding the need for local BIA into culture.

Implications and Future Action Required

The action plan will be monitored through the Emergency Planning, Resilience and Preparedness Group, to ensure that we continue to be compliant with the standards throughout the year. Continued work required to embed EPRR agenda.

Recommendations
The Board is asked accept this report as assurance of the Trust's compliance with EPRR standards.
Impact Upon Strategic Objectives
Failure to meet the national EPRR standards would impact on the operational resilience of the Trust during an emergency.

Impact Upon Corporate Risks
Better EPRR risk awareness, prevention and preparedness reduce our risks and together with training and exercises improve our response.
Regulatory and/or Legal Implications
We have a duty as category one responders under the Civil Contingencies Act 2004 and Health and Social Care Act 2012 to have plans in place and maintain our preparedness through training and exercises.
Equality & Patient Impact
No specific patient group is affected by the issues addressed in this report

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 & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						Emergency Planning and Resilience Group (EPRG)
Outcome of discussion when presented to previous Committees						

MAIN BOARD - NOVEMBER 2018

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE 2018

1. Aim

To provide the Trust board with an update on the emergency preparedness activity for the last year.

2. Background

Each year the Trust Emergency Preparedness Resilience and Response (EPRR) is reviewed through the NHS England assurance process. http://www.england.nhs.uk/ourwork/eprr/. The process is an evidence-based internal self-assessment against nationally defined standards. This assessment is then reviewed by the relevant Clinical Commissioning Group (in our case Gloucestershire) and the local area team of NHS England. We are currently part way through the process. Findings will be presented in the annual EPRR December board paper.

Emergency Preparedness Resilience and Response annual work plan is identified from the assurance process and local risks, agreed and monitored through the Emergency Planning and Resilience Group. This includes plan reviews, training and exercises.

3. Governance

Appendix 1 sets out our self-assessment against the national EPRR Standards. It is based on the position in August 2018. The national standards are detailed in the left hand column, followed by our assessment of the level of the evidence we have in place to demonstrate compliance. Green indicates evidence in place, amber, partial evidence and red, no evidence. The right hand column details the actions in place to improve compliance where required. At present NHSE have given a rating of 'Partial compliance for the standards overall. Changes in this year's standards do not directly correlate to last years and although we have an improving picture, this year's score rates us lower than last year's.

We are likely to remain amber for: fuel shortage plans as this is adapted for local arrangements and government advice at the time and training due to staff turnover, however we have a rolling training program in place. Appendix 2 sets out our improvement plan.

4. Maintenance of plans

A rolling timetable for reviewing plans is now in place, plans are reviewed annually unless otherwise stated or in line with incorporating lessons learned from exercises and incidents or changes in national guidance. This year we have:

- BCM plan will be reviewed to reflect recommendations from BCM audit.
- Major Incident plan reviewed no significant changes.
- Shelter and Evacuation plan and subsequently revised local fire plans for GRH tower block.
- County wide Health IT resilience and incident response review.

- Reviewed The Pandemic Flu plan. This dovetails with our Infection Control plans and the Local Resilience Forum (LRF) plans.
- Updated the Adverse Weather Plan
- Updated the CBRN (Chemical Biological Radiation Nuclear) decontamination plan.
- Human Resources Business Continuity policy has been reviewed in line with and dovetails into the Local Health Resilience Partnership (LHRP) Mutual Aid Plan.
- Reviewed and combined Mass casualties P3 (walking wounded) with Mass Prophylaxis plan using the same pathway.
- Updated the Heatwave plan.
- Mass prophylaxis plan reviewed in September

5. Business Continuity

Adverse weather plans for both snow and hot weather have been used in the last year. Lessons learned from the snow are being used in this year's plan review, in particular a joined-up approach for the use of available 4x4 transport across health partners. The heat challenged our hot weather plans and environmental cooling of our old buildings, resulting in review of some of the local plans. There are ongoing environmental works planned.

Improvements made in areas identified by last year's PWC audit and our Internal Assurance Committee:

Progress has been made within our divisions and departments to identify Business Continuity Management (BCM) leads and workshops have been held to train leads on BCM and Business Impact Assessment (BIA) forms. The emphasis has been on the Critical areas and supporting services. BIA summary sheets for the Critical services will shortly be uploaded to the intranet to guide managers in BCM incident response.

GHT IT with the county wide CITS have worked collaboratively on the IT upgrade, plans and cyber resilience with an exercise last December and a further multi-agency exercise has been planned for 28 September.

BCM emphasis has also been more focused on ensuring that companies with which we have contracts also align to the ISO 22301 standards and they have BCM plans in place.

6. CBRN

We have maintained our CBRN/HAZMAT preparedness which is now bolstered by new PHE CBRN guidance documentation.

The SWAST CBRN audit undertaken on behalf of NHSE as part of the assurance process showed a red compliance for evidence that ED has CBRN staff on duty 24/7. This has been addressed by targeting identified staff trained in October. EDs internal eLearning will shortly include the Initial Operational Response (IOR) / CBRN and be available to all ED staff.

Plans are also being developed with the Fire Service and GHT for better countywide CBRN resilience.

Some CBRN kit due to its age is due for replacement – this is being scoped in November we may be looking at around 20K

7. **Fire evacuation**.

The new Evacuation and Shelter plan is in place and tested during Exercise Andromeda, a GRH tower block vertical evacuation exercise in July. Lessons learned from the exercise and trialling different kit has informed us of the evacuation and quantities that we are now purchasing.

8. Training updates

Staff Training requirements are in the Emergency Planning and Resilience Response (EPRR) training matrix which is aligned to the Local Health Resilience Partnership group (LHRP) training matrix.

A revised LHRP/LRF loggist course is being delivered from September.

Training needs for operational on call Silver and Gold which is via a self-assessment and signposting to training for identified gaps has been revised.

CBRN training/ exercise is biannual with next exercise planned for March prior to Gold Cup Festival week so that we are freshly rehearsed.

The Major Incident Plan was tested in parts over the winter especially with Ex Clownfish to test the Theatre and Critical care element. The next exercise is on 25 January

Local Major Incident plans and action cards are under review, updated versions to be republished on the intranet.

9. Resources

CBRN suits are being replaced via government. The Trust needs to maintain all other decontamination and emergency response kit. The requirements will be driven by the recommendations of the audit of CBRN kit performed by SWAST. Some of the CBRN Kit is old and been identified as needing replacing in 2018/19, this will be reviewed in November. It is recommended that £5k of the £25k identified for 2017/18 is carried forward to 2018/19 to meet these requirements.

Review of resources needed to support the Trusts EPRR requirements in relation to training, exercising and admin/EPRR suport is to be undertaken.

Author: Rachel Minett, Emergency Planning and Resilience Manager
Presenting Director: Caroline Landon
November 2018

NHS England
Skipton House
80 London Road
SE1 6LH
XX June 2018

To: NHS Accountable Emergency Officers
NHS England Regional Directors
NHS England Regional Heads of EPRR
NHS England Regional Directors of Assurance and Delivery
NHS England Directors of Commissioning Operations
NHS England LHRP Co-chairs

Publications Gateway Reference: XXX

Dear colleague

Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2018-19

I would like to thank organisations for their continued support during what has been another busy year for the emergency preparedness community.

As you will be aware, NHS England has a statutory requirement to formally assure itself of it's our own, and the NHS in England's, EPRR readiness. This is provided through the EPRR annual assurance process. This is a four stage process; we have produced the guidance enclosed to explain this in more detail, and assist organisations in completing their returns.

NHS England would like to invite organisations to commence stage one, the EPRR self assessment, initiating the 2018-19 EPRR assurance process.

Core standards

The NHS England Core Standards for EPRR are the basis of the assurance process and have been reviewed this year. Changes include:

- Expanded focus on Business Continuity
- Revised formatting
- Removal of the CBRN equipment list

The Core Standards for EPRR, including the CBRN equipment list, are available on the NHS England website: http://www.england.nhs.uk/ourwork/eprr/

Deep dive
The 2018-2019 EPRR annual assurance deep dive focusses on 'Command and Control'. The self assessment of these deep dive statements do not contribute to the organisation's overall EPRR assurance rating, these should be reported separately.

Organisational assurance rating

The number of Core Standards applicable to each organisation type is different. To account for this difference, the overall EPRR assurance rating is based on the percentage of Core Standards the organisations assesses itself as being 'fully compliant' with. This is explained in more detail in the EPRR Annual Assurance Process Guidance.

Strategic asset assurance

Last year we undertook a separate EPRR review on NHS Strategic Assets. Whilst strategic assets will not form part of this year's assurance, our regional teams may wish to separately assure themselves of these again this year, or follow up actions from last year.

National Ambulance Interoperable Capability reviews

In conjunction with NHS England, the National Ambulance Resilience Unit (NARU) conducted 'interoperable capability reviews' of ambulance services in 2017-2018. The outcome of these reviews will continue to be monitored by NHS England and NARU, and the relevant providers.

Summary

You are asked to ensure EPRR staff are aware of the contents of this letter to support the submission of the EPRR Stage One Self Assessment.

Please note the following deadlines:

- 31 October 2018 – organisations to have completed an EPRR self assessment and to submitted their EPRR assurance return.
- 31 December 2018 – Regions to have completed confirm and challenge meetings, and submitted their Regional EPRR assurance report using the Regional Return template.
- 28 February 2019 – National EPRR team to have completed confirm and challenge meetings with Regional teams.
- 31 March 2019 - National EPRR assurance report prepared for the NHS England Board.
-

If you have any further queries, please do not hesitate to contact me.

Yours sincerely

Stephen Groves
National Head of EPRR

CC NHS England Regional Heads of EPRR
NHS England Business Continuity team
CCG Accountable Officers
CCG Clinical Leads
CSU Managing Directors
Clara Swinson, Director General for Global and Public Health, Department of Health and Social Care
Emma Reed, Director, Emergency Preparedness and Health Protection Policy Global and Public Health Group, Department of Health and Social Care
Dr Kathy McLean, Medical Director, NHS Improvement
Ruth May, Director of Nursing, NHS Improvement

EPRR Improvement Plan: GHNHSFT
Version: v1 2018

Gloucestershire Hospitals NHS foundation Trust has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2018/2019. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

Core standard	Current self-assessed level of compliance (RAG rating)	Remaining actions required to be fully compliant	Planned date for actions to be completed	Lead name	Further comments
25 Command and Control EPRR training	Amber	On-going training for Operational staff, including annual refresher . For staff new to the role training is available prior to going on call.	On going	Emergency Planning and Resilience Manager	
28 Strategic and tactical responder training	Amber	To be evidenced at appraisal	On going	AEO	
40 Cooperation LRHP attendance	Amber	Plan exec level attendance for AEO or deputy	On going	AEO	This has been difficult due to clashes with other key meetings that had already been arranged.
49 Business Continuity Business Impact Assessment	Amber	Ongoing BCM workshops and embedding the importance of BIA in top the organisation via department BCM leads and Emergency Planning and Resilience Manager	Ongoing	AEO	
1 Deep dive (and not part of overall score) The organisation has equipped their ICC with suitable and resilience communications and IT equipment in line with NHS England Resilient	Amber	Plan to achieve compliance in the next 12 months following the publication of national guidance.	With in 12 Months	AEO	

Telecommunications Guidance’					

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

Report Title
'Winter Readiness in the NHS-Next Steps' Joint NHE Improvement and NHS England letter
Sponsor and Author(s)
Author & Sponsor: Caroline Landon, Chief Operating Officer
Executive Summary
Purpose To inform the Board of NHS England/NHS Improvement requirements for winter planning 2018/19, Key issues to note Winter room will commence as last year in December and will require daily updates. Conclusions The Trust and system have a robust winter planning framework in place to report on key required metrics. Implications and Future Action Required N/A
Recommendations
The Board is asked to note the attached NHS England/NHS Improvement letter.
Impact Upon Strategic Objectives
Not applicable
Impact Upon Corporate Risks
Not applicable
Regulatory and/or Legal Implications
Not applicable
Equality & Patient Impact
Not applicable

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

By email

Andrew Seymour

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23 October 2018

Dear Andrew

Winter Readiness in the NHS-Next Steps

Planning for this winter has started earlier and is being taken forward in a more detailed way than in previous years. All systems go into this winter under operational pressure, but also having put in place some concrete actions to improve overall resilience and continue to provide safe, quality care for patients. We are writing to you to describe our local expectations for the month ahead. A number of areas should now be the focus of refinement and testing as you finalise your arrangements, as detailed below:

System Sustainability (Winter 18/19) Plan

All systems have been developing an overarching plan based on reviews of Winter 17/18 and operational planning. Building on Delivery Board discussions and feedback from NHS England and NHS Improvement colleagues, the plan should now be nearing completion.

Provider plans should include comprehensive escalation plans that have been developed, tested and are owned by clinical teams, building on plans and experience last winter. Plans should by now have undergone a robust check and challenge process by providers and commissioners. The focus should now have shifted to testing plan processes, capacity and decision-making in practice, with the Delivery Board providing genuine transparency, scrutiny and a collaborative approach to tackling risks.

Moving into November, final sign-off for your overarching Winter Plans must be achieved through Delivery Boards, with appropriate, evidenced clinical oversight and sign off. It is imperative that plans assure all partners and adequately address risks identified through the Delivery Board collective risk assessment.

The system remains some way from achieving the national ambition of a 23% reduction in super-stranded (21d+) patients set by Pauline Philip (7% reduction so far achieved to August 2018). Has the system assured itself its plans for delivering further stranded reductions are fully robust, and in particular that it has identified clear actions the system will take in escalation to reduce increases in stranded numbers where they exceed agreed threshold levels? We are aware each system will have a tipping point above which stranded numbers will have a notable and detrimental impact on ED waiting times and it is critical actions are in

place internally and with Local Government to keep stranded patient numbers below this as an absolute minimum.

Demand and Capacity Plans

Finalising all Demand and Capacity Plans will now be high on the agenda for organisations and we will be reviewing these with your systems at the beginning of November. These should allow for well-known peaks in demand over Christmas but include tolerance and adaptability to unexpected activity whilst maintaining patient flow. Close attention must be paid to workforce profiling and, where plans to meet demand are predicated on workforce groups not yet fully resourced in any area of the system including primary care, 111, ambulance, mental health and community/social care, clear timelines for recruitment should be in place, or otherwise contingency planning should now be underway at pace.

System and Provider Escalation Plans

Over the past 12 months we have seen local plans strengthened, tested and embedded. High calibre leadership accompanied by good quality, live data will be crucial at times of pressure and will ensure that actions are delivered quickly and safely, as well as exploiting capability and capacity within the system. Delivery Boards should consider how communications teams can work within the escalation arrangements and meetings, to deploy messages to patients and the public and ensuring responsiveness to any locally reported issues.

To support development in this area, ECIST are now undertaking a 'critical friend' review of escalation plans for selected areas; we will share any further feedback identified with all systems as soon as this is complete. We are also in the process of putting some targeted light-touch ECIST support in place focusing on whole system response to stranded patients and our team will be in contact to confirm timescales for this work as soon as known.

Winter Management-Operating Model

An Integrated (NHS England and NHS Improvement) South West Winter Room will be running from November. In line with National requirements, seven day system reporting will commence on the 12th November for all areas, following a test the previous week. We have listened to feedback from last year and have been engaging with colleagues across South West North to simplify information flow and determine the daily 'Commonly Recognised Information Picture'. This year, the narrative will predominantly be fulfilled by system sitrep returns containing details of key pressures and recovery actions, alongside weekend staffing plans. We would be very grateful for your system's support in ensuring these returns are high-quality to minimise the extent of additional enquiries and discussion needed with your teams to provide assurance.

Once again thank you for all of the efforts underway to prepare for and manage the pressures of winter. We would like to work supportively with you and your systems to complement local escalation arrangements to help ensure your patients receive the best emergency care possible over this winter period.

Yours sincerely

Rachel Pearce Tom Edgell

Rachel Pearce
Director of Commissioning Operations
South West (North)
NHS England

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

cc Mary Hutton
Deborah Lee

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

Report Title
Financial Performance Report - Period to 30th September 2018
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 6 of the 2018/19 financial year.

Key issues to note

- The financial position of the Trust at the end of Month 6 of the 2018/19 financial year is an operational deficit of £16.7m.This is a favourable variance to budget and NHSI Plan of £0.2m.

- The forecast outturn deficit for the Trust is £22.7m which is an adverse variance of £3.8m against the Control Total deficit of £18.8m.

- CIP delivery to Month 6 is £11.6m. This is £3m favourable against the plan for the year to date, due to several schemes delivering earlier than initially phased. The CIP forecast outturn is £23.6m, an adverse variance to plan of £6.8m.

Conclusions

- The financial position for Month 6 shows a favourable variance to budget of £0.2m, but the forecast outturn is £3.8m adverse to plan.

Implications and Future Action Required

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

Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.
Impact Upon Strategic Objectives
The financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Impact on deliverability of the financial plan for 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 & Digital Committee**	**Audit & Assurance Committee**	**People & OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 30th September 2018

Introduction and Overview

In April 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 approved a revised control total of £18.8m (including PSF) on 12th June 2018. This has been reflected in Month 6 reporting.

The financial position as at the end of September 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. The Group position in this report excludes the Hospital Charity.

Group Statement of Comprehensive Income

The table below shows both the in-month position and the cumulative position for the Group. In September, the Group's consolidated position shows an in month deficit of £1m, which is £0.1m favourable against plan. The year to date deficit of £16.7m is a favourable variance of £0.2m against plan.

Month 06 Financial Position	Annual Budget £000s	M06 Budget £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Budget £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s
SLA & Commissioning Income	444,587	37,913	37,519	(394)	219,826	219,263	(563)
PP, Overseas and RTA Income	5,710	472	346	(126)	2,861	2,546	(315)
Other Income from Patient Activities	5,418	450	(57)	(507)	2,709	1,934	(775)
Operating Income	74,297	5,863	6,661	798	35,578	36,551	973
Total Income	**530,012**	**44,698**	**44,468**	**(229)**	**260,973**	**260,293**	**(680)**
Pay	346,648	28,954	29,343	(389)	175,452	173,246	2,206
Non-Pay	178,532	15,011	14,482	529	91,338	93,656	(2,318)
Total Expenditure	**525,180**	**43,965**	**43,825**	**140**	**266,790**	**266,902**	**(112)**
EBITDA	**4,832**	**732**	**643**	**(89)**	**(5,817)**	**(6,610)**	**(792)**
EBITDA %age	**0.9%**	**1.6%**	**1.4%**	**(0.2%)**	**(2.2%)**	**(2.5%)**	**(0.3%)**
Non-Operating Costs	22,751	1,896	1,723	173	11,375	10,280	1,095
Surplus/(Deficit)	**(17,919)**	**(1,164)**	**(1,079)**	**84**	**(17,192)**	**(16,889)**	**303**
Excluding Donated Assets	(902)	50	31	(19)	300	185	(115)
Control Total Surplus/(Deficit)	**(18,821)**	**(1,114)**	**(1,048)**	**65**	**(16,892)**	**(16,704)**	**188**

* Group Position excludes £20.7m of intergroup transactions including dividends

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 06 Financial Position	M06 Budget £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Budget £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s
SLA & Commissioning Income	37,913	37,519	(394)	219,826	219,263	(563)
PP, Overseas and RTA Income	472	346	(126)	2,861	2,546	(315)
Other Income from Patient Activities	450	(57)	(507)	2,709	1,934	(775)
Operating Income	5,863	6,661	798	35,578	36,551	973
Total Income	**44,698**	**44,468**	**(229)**	**260,973**	**260,293**	**(680)**
Pay						
Substantive	26,975	27,008	(33)	162,513	159,918	2,595
Bank	940	1,006	(66)	5,640	5,589	51
Agency	1,039	1,328	(289)	7,299	7,739	(440)
Total Pay	**28,954**	**29,343**	**(389)**	**175,452**	**173,246**	**2,206**
Non Pay						
Drugs	5,419	6,219	(800)	33,097	34,694	(1,597)
Clinical Supplies	3,091	2,936	155	19,068	19,242	(175)
Other Non-Pay	6,502	5,328	1,174	39,174	39,720	(547)
Total Non Pay	**15,011**	**14,482**	**529**	**91,338**	**93,656**	**(2,318)**
Total Expenditure	**43,965**	**43,825**	**140**	**266,790**	**266,902**	**(112)**
EBITDA	**732**	**643**	**(89)**	**(5,817)**	**(6,610)**	**(792)**
EBITDA %age	**1.6%**	**1.4%**	**(0.2%)**	**(2.2%)**	**(2.5%)**	**(0.3%)**
Non-Operating Costs	1,896	1,723	173	11,375	10,280	1,095
Surplus/(Deficit)	**(1,164)**	**(1,079)**	**84**	**(17,192)**	**(16,889)**	**303**
Excluding Donated Assets	50	31	(19)	300	185	(115)
Surplus/(Deficit)	**(1,114)**	**(1,048)**	**65**	**(16,892)**	**(16,704)**	**188**

SLA and Commissioning Income – is £0.6m adverse against plan. This predominantly reflects under performance against the Specialised Services contract (£0.6m), Worcestershire and Hereford (£0.4m), offset by over performance on Welsh Commissioners (£0.4m).

PP / Overseas / RTA Income – performance has deteriorated further to report a £0.3m year to date adverse variance. Oncology private patients (£0.1m) and RTA cost recovery (£0.1m) make up the majority of the adverse variance.

Other Patient Income – the in month deterioration largely relates to the clawback of Agenda for Change funding in respect of GMS (£0.5m). This reflects NHSI reporting requirements.

Other Operating Income – An in month over recovery of £0.5m for hosted services and £0.2m for shared services. This income is offset in expenditure with no impact on the I&E position.

Pay – expenditure is showing a £2.2m underspend year to date. This reflects an underspend on substantive staff partially offset by an overspend on agency.

Non-Pay – expenditure is showing a £2.3m overspend. The Other Non-Pay underspend of £1.2m in month comprises £0.4m unspent non-pay reserves, the reversal of bad debt provision for income risk which has now materialised within income (£0.5m) and a reassessment of consultancy expenditure.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

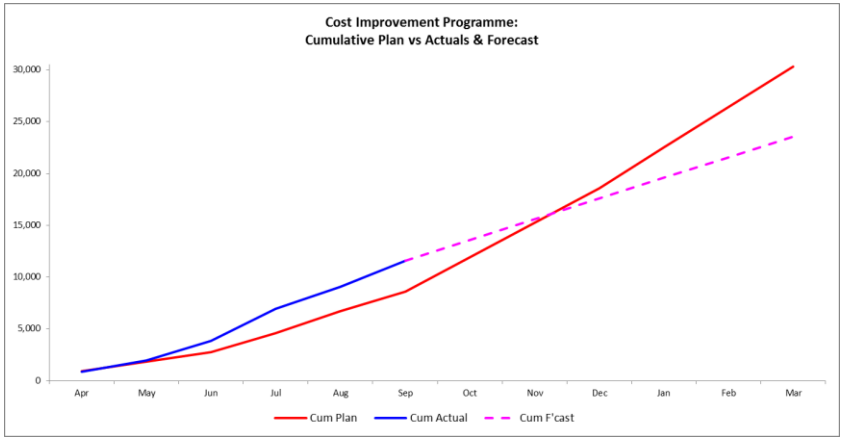
1. At Month 6 the trust has delivered £11.6m of CIP YTD against the YTD NHS Improvement target of £8.6m, this over performance is a continued benefit from several schemes delivering earlier or more than initially phased (Theatre Managed Services, Theatre Productivity, Vacancy Factor)**.**
The YTD delivery splits into £8.6m recurrent and £3m of non-recurrent schemes. This translates into a split of 78% of recurrent delivery versus 22% of non-recurrent delivery.
Within the month, the Trust has delivered £2.54m of CIP against an in-month NHSI target of £1.9m, which is an over-performance of £637k.

2. At Month 6, the Divisional year end forecast figures indicate delivery of £23.6m against the Trust's target of £30.3m which is a decrease against M5 FOT, of £0.5m. This is mostly due to an adverse movement in FOT for Nursing Agency schemes in the Medicine Division.

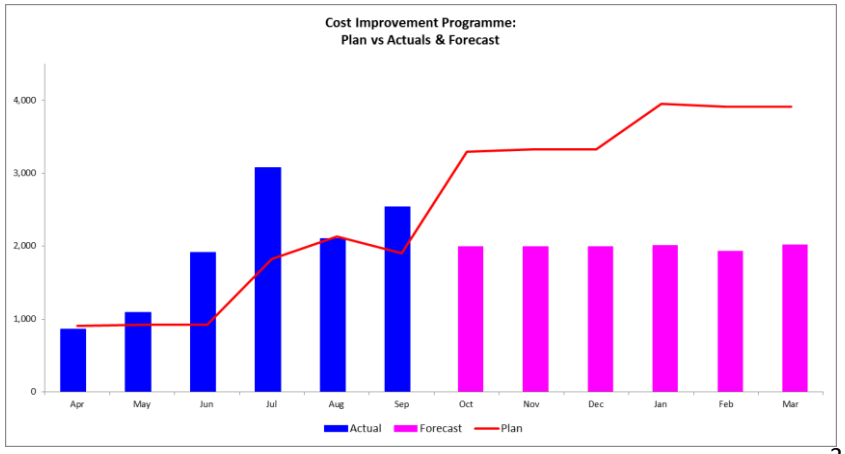
3. PWC commenced work on the 31st July 2018 and have engaged the Surgical and Diagnostics & Specialities Divisions. The first formal review by the Executive team took place on the 10th (Surgery) and 12th (D&S) September, and the second review was undertaken on the 22nd and 24th of October.

4. The cumulative FOT indicates that GHFT will be reporting a negative variance against plan from December (see graph to the right). A paper has been shared with the Executive team to look at how we can close the gap in-year. Also a review of the FOT has been undertaken and shared with the Director of Finance.

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



Forecast Outturn – Sensitivity Analysis

Gloucestershire Hospitals NHS
NHS Foundation Trust

As discussed at the Finance Committee on 31st October 2018, the Trust's forecast outturn has deteriorated to a deficit of £22.7m, which is an adverse variance of £3.8m against the Control Total deficit of £18.8m. After reviewing planned expenditure and taking account of additional risks now materialising including the clawback of AfC funding for GMS, the forecast outturn ranges from a likely case variance to Control Total of £3.8m to a downside variance of £7.2m.

	Likely £m	Downside £m	
Planned Deficit (Control Total)	**(18.8)**	**(18.8)**	
CIP forecast under delivery @ month 6	(6.8)	(6.8)	
AfC Funding Gap	(1.0)	(1.0)	
Deterioration in Forecast	**(7.8)**	**(7.8)**	
Review of planned expenditure	3.0	3.0	
Trust/Divisional actions to deliver plan	6.8	3.4	Supported by PWC. Downside assumes 50% failure in recovery actions.
Patient Care income risk	(3.0)	(3.0)	Reflects current assessment of risk.
Gap to Control Total	**(1.0)**	**(4.4)**	
Non-delivery in Q4 of financial targets	(2.8)	(2.8)	Loss of 35% of PSF.
Total Gap to Control Total	**(3.8)**	**(7.2)**	
Forecast Deficit	**(22.7)**	**(26.1)**	

Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2018 £000	GROUP Balance as at M6 £000	B/S movements from 31st March 2018 £000
Non-Current Assets			
Intangible Assets	9,130	9,717	587
Property, Plant and Equipment	251,010	247,388	(3,622)
Trade and Other Receivables	4,463	4,400	(63)
Total Non-Current Assets	**264,603**	**261,505**	**(3,098)**
Current Assets			
Inventories	7,131	7,390	259
Trade and Other Receivables	19,276	22,917	3,641
Cash and Cash Equivalents	5,447	6,090	643
Total Current Assets	**31,854**	**36,397**	**4,543**
Current Liabilities			
Trade and Other Payables	(47,510)	(57,460)	(9,950)
Other Liabilities	(3,284)	(2,199)	1,085
Borrowings	(4,703)	(4,853)	(150)
Provisions	(160)	(160)	0
Total Current Liabilities	**(55,657)**	**(64,672)**	**(9,015)**
Net Current Assets	**(23,803)**	**(28,275)**	**(4,472)**
Non-Current Liabilities			
Other Liabilities	(7,235)	(7,047)	188
Borrowings	(111,219)	(120,726)	(9,507)
Provisions	(1,472)	(1,472)	0
Total Non-Current Liabilities	**(119,926)**	**(129,245)**	**(9,319)**
Total Assets Employed	**120,874**	**103,985**	**(16,889)**
Financed by Taxpayers Equity			
Public Dividend Capital	168,768	168,768	0
Equity			
Reserves	43,530	43,530	0
Retained Earnings	(91,424)	(108,313)	(16,889)
Total Taxpayers' Equity	**120,874**	**103,985**	**(16,889)**

The table shows the M6 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 6 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 £0.3m.
- Trade receivables are £3.6m above the closing March 2018 level, which is anticipated will decrease in October.
- Cash has increased by £0.6m since the year-end, reflecting the deficit position offset by loan finance.

Current Liabilities
- Current liabilities have increased by £9m, reflecting an increase in creditors/accruals. This reflects a provision for income risk and a movement on operating expenditure accruals, reflecting the timing of invoice payments.

Non-Current Liabilities
- Borrowings have increased by £9.5m.

Retained Earnings
- The retained earnings reduction of £16.9m reflects the impact of the in year deficit.

Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Cumulative for Financial Year		Current Month September	
	Number	£'000	Number	£'000
Total Bills Paid Within period	58,791	120,002	10,340	20,969
Total Bill paid within Target	44,923	98,225	6,672	14,567
Percentage of Bills paid within target	76%	82%	65%	69%

BPPC performance is shown opposite and currently only includes those invoices that are part of the creditors ledger balance. Performance reflects invoices processed in the period (both cumulative and in-month) rather than the invoices relating to that period.

It should be noted that whilst driving down creditor days as far as possible the Trust are not compliant with 30 day terms across all suppliers. In September the volume of invoices paid within the 30 day target is 65% which is significantly below year to date performance. In September due to delays in the bank office a backlog of nursing agency invoices were processed which has caused much of the deterioration.

Liabilities – Borrowings

Analysis of Borrowing	As at 30th September 2018 £000
<12 months	
Loans from ITFF	2,968
Obligations under finance leases	1,782
Obligations under PFI contracts	103
Balance Outstanding	**4,853**
>12 months	
Loans from ITFF	22,593
Capital Loan	4,500
Distress Funding	73,228
Obligations under finance leases	1,924
Obligations under PFI contracts	18,481
Balance Outstanding	**120,726**
Total Balance Outstanding	**125,579**

The Trust has two major loans outstanding with the Independent Trust Financing Facility (ITFF).

The first loan was to facilitate improvements related to backlog maintenance and the second was for the build of the Hereford Radiotherapy Unit. These are included within the balance sheet within both current liabilities (for those amounts due within 12 months) and non-current liabilities (for balances due in over 12 months).

There are also borrowing obligations under finance leases and the PFI contracts.

The position reflects £12m of additional in-year borrowing.

Cashflow : September

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-18 £000s	May-18 £000s	Jun-18 £000s	Jul-18 £000s	Aug-18 £000s	Sep-18 £000s
Surplus (Deficit) from Operations	**(4,831)**	**(2,512)**	**(1,213)**	**(1,126)**	**(2,148)**	**(272)**
Adjust for non-cash items:						
Depreciation	912	912	912	912	912	912
Other operating non-cash	0	0	0	0	0	0
Operating Cash flows before working capital	**(3,919)**	**(1,600)**	**(301)**	**(214)**	**(1,236)**	**640**
Working capital movements:						
(Inc.)/dec. in inventories	0	71	0	0	0	(330)
(Inc.)/dec. in trade and other receivables	(4,596)	(2,610)	(546)	2,310	(963)	3,647
Inc./(dec.) in current provisions	0	0	0	0	0	0
Inc./(dec.) in trade and other payables	7,156	1,157	1,434	(1,013)	1,222	(6)
Inc./(dec.) in other financial liabilities	(437)	904	0	0	0	(1,552)
Net cash in/(out) from working capital	**2,123**	**(478)**	**888**	**1,297**	**259**	**1,759**
Capital investment:						
Capital expenditure	(158)	(207)	(459)	(459)	(1,883)	(159)
Capital receipts	0	0	0	0	0	0
Net cash in/(out) from investment	**(158)**	**(207)**	**(459)**	**(459)**	**(1,883)**	**(159)**
Funding and debt:						
PDC Received	0	0	0	0	0	0
Interest Received	3	13	2	2	5	30
Interest Paid	(29)	(218)	(78)	(178)	(87)	(1,255)
DH loans - received	3,500	0	0	0	4,044	4,465
DH loans - repaid	0	0	0	0	(167)	(1,317)
Finance lease capital	(148)	(148)	(148)	(148)	(148)	(148)
Interest element of Finance Leases	(12)	(12)	(12)	(12)	(12)	(12)
PFI capital element	(95)	(95)	(95)	(95)	(95)	(95)
Interest element of PFI	(161)	(161)	(161)	(161)	(161)	(161)
PDC Dividend paid	0	0	0	0	0	(1,489)
Net cash in/(out) from financing	**3,058**	**(621)**	**(492)**	**(592)**	**3,379**	**18**
Net cash in/(out)	**1,104**	**(2,906)**	**(364)**	**32**	**519**	**2,258**
Cash at Bank - Opening	**5,447**	**6,551**	**3,645**	**3,281**	**3,313**	**3,832**
Closing	**6,551**	**3,645**	**3,281**	**3,313**	**3,832**	**6,090**

The cashflow for September 2018 is shown in the table:

Cashflow Key movements:

Current Assets – The decrease in trade and other receivables since month 5 has increased cash.

Other Financial Liabilities – cash has decreased in month due to the decrease in other financial liabilities.

The Cash Position – reflects the Group position and the increase to the balance is due to the fact that there was a £3.1m VAT creditor due for payment in the first week of October. The Trust has drawn down loan support of £12m, which is £4.7m more than planned at this point of the financial year.

Cash Flow Forecast – The Trust continues to review the cash flow forecast to the end of the financial year, to reflect the latest capital and I&E forecasts.

Capital Expenditure Update

The table below provides an overview of the progress of the Capital Programme to date and year end forecast for 2018/19.

Capital Programme Expenditure Summary position at 30th September 2018.

Capital Summary	Internal YTD Plan	YTD Spend	YTD Var	18/19 Full Year Plan	FOT 18/19 Spend	Forecast Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Health & Safety Projects	0.0	169.8	169.8	4,475.0	4,497.1	22.1
Environmental Works	60.0	28.9	-31.1	200.0	200.0	0.0
Estates Unallocated Allowances	36.0	-0.1	-36.1	125.0	123.0	-2.0
Non Health & Safety Projects	573.0	569.9	-3.1	1,154.0	1,156.7	2.7
Committed Schemes	142.6	252.6	109.9	2,679.0	2,679.0	0.0
Service Reconfiguration	0.0	-0.2	-0.2	1,000.0	978.2	-21.8
Major Equipment Replacement	0.0	-1.2	-1.2	2,900.0	2,898.8	-1.2
IM&T	1,380.0	1,063.4	-316.5	6,100.0	6,100.0	0.0
MEF	462.4	210.3	-252.1	2,000.0	2,000.0	0.0
Other Schemes	0.0	0.1	0.1	1,300.0	1,300.1	0.1
Contingency	0.0	0.0	0.0	200.0	200.0	0.0
Strategic Development	100.0	85.4	-14.6	1,975.0	1,975.0	0.0
Overspend/(Underspend)	**2,754.0**	**2,378.8**	**-375.2**	**24,108.0**	**24,107.9**	**-0.1**

- The internal plan reflects the submission to NHSI in which spend was matched to the anticipated receipt of a £10m capital loan from October 2018. This plan phases more spend into the second part of the financial year.
- Health & Safety budgets have been reprioritised to address urgent works in the Women's Centre.
- IM&T schemes are behind planned expenditure due to budgets and schemes being finalised.
- Work has commenced on a reprioritisation of medical equipment applications.
- Detailed planning and phased implementation of the £920k streaming improvements works is underway and orders have been placed with contractors. The scheme is expected to complete by March 2019.

Capital Financing Update

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust's application for £10m of capital financing has been passed to the DoH's Capital & Cash team for consideration.

Due to national capital funding constraints, there is a risk that the Trust may not receive the funding requested. Therefore, the Trust has started planning for various scenarios of prioritised capital spend to manage within available cash.

The table opposite indicates how the 2018/19 Capital Programme could be revised if the capital financing awarded is lower than planned.

Pending confirmation of the capital financing application, it was agreed at the Capital Control Group on 29th October 2018 that the Trust would make no further capital commitments, with the exception of those that are funded by specific national allocations.

During this period funding for emergency capital requests will be considered by the Capital Control Group.

	Loan Funding Scenarios £k			
	Plan	Loan of £7m	Loan of £5m	Loan of £0m
IT	6,100	5,100	4,100	3,450
Major Equipment Replacement	2,900	1,500	1,500	1,500
Committed Schemes	2,679	2,679	2,679	1,279
H&S Related Major Schemes	2,250	2,250	2,250	1,250
Estates H&S related projects	2,225	1,820	1,820	1,371
MEF	2,000	2,000	1,350	800
Other Schemes	3,275	3,275	3,275	3,275
Non H&S Estates Schemes	1,154	1,134	1,134	1,134
Service Reconfiguration Schemes	1,000	1,000	500	0
Environmental works	200	150	150	0
Contingency	200	200	200	0
Estates Unallocated Allowances	125	5	5	0
Total	**24,108**	**21,113**	**18,963**	**14,059**
Loan requirement	10,049	7,054	4,904	0
Potential indicative reductions				
IT		-1,000	-2,000	-2,650
Estates		-595	-595	-3,599
Cath Lab		-1,400	-1,400	-1,400
Service Reconfiguration Schemes		0	-500	-1,000
MEF		0	-650	-1,200
Contingency		0	0	-200
Totals		**-2,995**	**-5,145**	**-10,049**

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual	YTD Variance
Capital Service Cover	(0.67)	(0.85)	(0.19)
Metric			
Rating	4	4	0
Liquidity	(30.45)	(24.45)	6.00
Metric			
Rating	4	4	0
I&E Margin	(6.60%)	(6.40%)	0.20%
Metric			
Rating	4	4	0
I&E Variance from Plan	0.00%	0.20%	0.20%
Metric			
Rating	1	1	0
Agency	19.28%	26.51%	(7.23%)
Metric			
Rating	2	3	-1
Use of Resources rating	4	4	0

Key: Plan / Actuals

Rating 1	1
Rating 2	2
Rating 3	3
Rating 4	4

Key: Variance

Better than Plan	1
On Plan	0
Worse than Plan	-1

The Single Oversight Framework (SOF) has been developed by NHSI and replaces Monitor's Risk Assessment Framework and the 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.

Overall Trust performance at Month 6 is in line with plan, with an overall risk rating of 4.

Liquidity and I&E Margin are favourable compared to plan, although not sufficiently to improve the individual ratings.

Due to the year to date overspend on agency expenditure, the risk rating has deteriorated from 2 to 3.

NHSI metric thresholds are shown in the table below:

NHSI Metric Thresholds				
Capital servicing capacity				20%
1	**2**	**3**	**4**	
2.5	1.75	1.25	<1.25	
Liquidity ratio (days)				20%
1	**2**	**3**	**4**	
0	-7	-14	<-14	
I&E Margin				20%
1	**2**	**3**	**4**	
1%	0%	-1%	<=-1	
I&E margin distance from plan				20%
1	**2**	**3**	**4**	
0%	-1%	-2%	<=-2%	
Agency				20%
1	**2**	**3**	**4**	
0%	25%	50%	>=50%	

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The Trust is reporting an actual income and expenditure deficit of £16.7m for the year to date at September 2018. This is a favourable variance of £0.2m.
- CIP delivery and year end forecast at month 6, and the status of the work being undertaken with PwC.
- The Trust's forecast outturn has deteriorated to a £22.7m deficit against the Control Total deficit of £18.8m, an adverse variance of £3.8m.
- The current position on capital expenditure and the capital financing application.

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

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

Date: **October 2018**

REPORT TO MAIN BOARD – NOVEMBER 2018

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

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

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Year to date deficit of £15.7m (favourable variance to plan of £0.1m)	Has the pay underspend translated into CIP?	A material amount of the pay underspend has been translated into CIP.	Review of the underspend to ensure that all CIP delivered is counted
	Material pay underspend continues.	What does the non-pay variance reflect and how is it being managed?	Drugs is largely recovered in the pass through income baseline. It is hypothesised that the clinical supplies overspend is due to complexity of activity but this needs to be validated.	Deep dive required into overspend on clinical supplies to understand the link with activity.
	Significant non-pay variance in clinical supplies and other. Downside forecast now reflects the agenda for change funding risk.	What are the implications of agency being over ceiling?	Other non-pay is impacted by a bad-debt provision, consultancy expenditure, additional expenditure in Trak and other areas.	Review of reserves and forecast to understand flexibility within non-pay.

Capital Programme Update	Capital programme remains on track for the year to date but there remains significant risk in the scenario that the loan requirement is not secured.	How is the programme prioritised to ensure that ongoing risk in clinical areas is managed?	The programme is prioritised annually. Divisions hold estates risks on divisional registers – these will escalate through risk management processes if they score highly enough.	A follow-up report is required for next month's committee to look at capital cash flow risk and potential mitigations.
SmartCare – Financial Recovery Workstream Report	Smartcare programme forecast to commit all resources available for the year (both revenue and capital). Reporting still in development around underlying contract performance and income recovery.	How is the Committee assured around the achievement of financial recovery and the underlying recording issues?	Work is ongoing in this area and reporting is being developed.	Significant assurance required around underlying activity and income reporting – work to be taken forward by the Trak finance group.

CIP Update	Delivery of £9.05m against a plan of £6.71 – favourable performance of £2.34m. PWC work ongoing with Surgery and D&S divisions to work towards bridging the gap.	Clarification required around nature of PWC contract.	Risk reward contract in place.	Review of RAG ratings and forecast to ensure read across. End-end to CIP process to be presented to Committee (with examples).
Clinical Productivity	Work has started on the clinical productivity Workstream. Job planning is being scrutinised.	When will the financial impact of the programme be articulated? When will the reporting be in line with CIP reporting? What extra resources are required?	Chief Operating Officer committed to working with Medical Director to progress the project. Chief Executive agreed that extra resources were required (focus on admin resource).	Financial assessment remains unavailable and project structure needs to be finalised. Additional resources to be described and identified.
Risk Register	Risk register presented – no material changes from prior month.	How is risk as a whole understood across the Board Committees?		Session on risk management process for NEDS to be arranged.

REPORT TO MAIN BOARD – NOVEMBER 2018

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

This report describes the business conducted at the Finance and Digital Committee held 31st October 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	£0.2m favourable variance against plan as at month 6. Deterioration in likely forecast outturn driven by agenda for change pay award funding and associated Provider Sustainability Funding (PSF).		National discussions around PSF are continuing.	
Capital Programme Update	Year to date expenditure is in line with plan. Loan financing remains to be approved and downside planning continues.	What is the impact on patient safety, continuing operations, staff environment and other organisational priorities of delaying the spend?	Capital leads have been asked to identify the risks to holding capital commitments pending the loan decision.	No national indication of timeline for approval

CIP	£3.0m favourable variance for the year to date. Ongoing work with PWC to mitigate gap in programme.	How well is the PWC approach working and what can the trust learn from it? How deliverable are the saving that have already been identified?	The Executive team reported that the process as undertaken thus far had produced new tangible, deliverable opportunities to be implemented this year.	PWC actions do not fully bridge the programme gap – the Executive team continue to work towards mitigations.
Clinical Productivity	Some encouraging progress but still no project plan. PWC supporting cross cutting workstream.	When will the project plan be available to the Committee?	This will be an extended item at November's Committee meeting.	
Committee Terms of Reference	Terms of Reference have been revised to include digital	Is digital agenda complete?	The Digital agenda needs to be added in full and the plan for 2019/20 needs to be finalised	
Digital Maturity	GHT has a reasonably low level of digital maturity. We have a clear articulation of the direction of travel. There is an opportunity to leap frog the intermediate stages with appropriate planning. The journey will require significant investment and resources.	When will this be translated into a digital strategy?	An initial road map to be presented at the December committee meeting, including benefits.	

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

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

Purpose

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

Key issues to note

Sickness rates at the end of August 2018 remained static at 3.87% against a target of 3.50%.

Turnover decreased in September to 12.02% from the last reported level of 12.32% in July. Staff Nurse turnover remains low in comparison to large Acute Trusts at 13.07% but remains a significant concern as efforts made by the recruitment team are negated by turnover. In the period Sep 2017 – August 2018 leavers exceeded starters across the Trust by 46.31FTE.

Retention remains a priority in Executive Reviews with a focus on providing local solutions and supporting these.

Appraisal compliance is at 79% an increase of 5% and mandatory training is at 90% as of mid October In the month of September 719 appraisals were recorded as completed in month indicating the focus on delivering this important conversation.

At the People and OD committee we RAG rated the programmes of work linked to the People and OD objectives. Annex 2 provides detail of progress.

RED	AMBER	GREEN
workstream is unlikely to , or will not, deliver to agrees timescales.	*workstream progress is slow, however plans are in place to progress and deadline likely to be met (if applicable)*	*workstream is on track, delivering against plan*

Strategic Priority	Status (RAG)
Sustainable Workforce - Advanced Clinical Practitioners	
Sustainable Workforce - Developing new roles and career pathways	
Recruitment Turnaround *	
Retention *	
Talent Management	
Health and Wellbeing	
Establishment Realignment	
Creating Efficiencies and Reducing Bureaucracy (NHSGMS)	
Staff Engagement	
CIP Delivery	

**Workstreams which have emerged over the past 6 months*

October was Freedom to Speak up month with activities focused on staff engagement to assist us in developing our strategy.

The staff survey is live and responses are at a similar pace to last year. This month saw a joint Q&P and People and OD committee to triangulate the results of the Inpatient survey with the Staff survey. Work will continue to determine how best to improve the experiences of staff and the patient and monitor progress.

The Trusts focus on mental health continued in October with Paul Deemer, Head of Diversity & Inclusion at NHS Employers presenting at 100 leaders. He also led a seminar for the Diversity Network.

Key Next Steps identified:

- Delivery, via the Recruitment and Retention Steering Group, of key immediate recruitment objectives and retention initiatives;
- Development of the health and wellbeing hub concept;
- Review and action planning post the Freedom to Speak Up survey results and engagement to devise a Freedom to Speak Up strategy and associated planning;
- Further clinical engagement and financial modelling for the ACP strategy to meet the new deadline of December 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
The People and OD activity aims to contribute to the following objectives: - Our staff by April 2019 will have an engagement score of at least 3.9, have a staff turnover of less than 11%, recommend us as a place to work through the staff survey (65%), be recognised as taking a positive action on health and wellbeing by 95% of our staff (responding definitely or to some extent in the staff survey) - Our patients by April 2019, we will be rated as good overall by CQC, be rated outstanding in caring by CQC. - Our organisation by April 2019 will be among the top 25% of trusts for efficiency. -
Impact Upon Corporate Risks
The report outlines progress to support the mitigation of the following Trust wide risks: - The risk of excessively high agency (locum) spend in both clinical and non-clinical professions due to a high vacancy rate - The risk to patient safety of key roles being vacant due to national and local supply issues and scarcity. The report outlines progress to support the mitigation of the following People and OD risks linked to the BAF - Risk of static or reduced engagement; - High turnover results in potential increased costs to fill temporarily and a delay in attraction – resulting in potential service delaying delay and impacting on teams' capacity to provide best care; - Staff do not recognise the Trust as an employer of choice or recommend employment with the Trust to others; as such increasing retention and reducing attraction; - Failure to engage staff in activities to improve their physical and emotional wellbeing can give rise to additional stress and sickness which impacts upon patients and service delivery.
Regulatory and/or Legal Implications
N/A
Equality & Patient Impact
Ensuring equality of opportunity supports staff engagement and patient care.

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**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**

Outcome of discussion when presented to previous Committees
N/A

MAIN BOARD – NOVEMBER 2018

PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

1. Aim

This report provides the 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

(please see annex 1 for key People and OD metrics)

At the People and OD committee in October further detail and analysis was provided for people measures. At the next committee meeting information and intelligence around medical staffing will be provided in greater detail specifically around vacancies and plans to mitigate the impact of such on service delivery.

2.1 Sickness Absence

Sickness rates at the end of August 2018 remained static at 3.87% against a target of 3.50%. This compares to an average across large acute trusts of 4.32% (May 2018 reported figure). Sickness management continues to form a key part of HR Advisory support to divisions and divisional grip is monitored closely through Divisional Executive Review. The HR Advisory teams review the data for the top 20 areas with the highest sickness areas and ensure that all procedures are being followed and cases well managed. To further support managers the HR Advisory team have re-vamped sickness case management support for managers. Focused two hour sessions are being organised and a pilot has commenced in Womens and Children division on 29th October. The review of the Trusts long term management of sickness absence and prevention remains a key priority for the People and OD teams and at the December People and OD committee the concept of the Health and Wellbeing hub will be presented.

2.2 Retention

Turnover decreased in September from the June figure, as anticipated, to 12.02%.

Nursing and Midwifery turnover as a combined figure remains stable and close to the Trust target at 11.17%. Staff Nurses alone have a turnover of 13.07%. This remains lower than other large Trusts but remains a key area of focus for the recruitment team. However the key focus is on retention given we were able to report that leavers exceed starters in the last 12 months (Sep 2017 – Aug 2018) by 46.31 FTE. Once more the top areas with the highest turnover are under review. In addition at executive reviews each division is being asked to provide their local retention plan for the top 3 roles where turnover is a concern.

The recruitment and retention group continues to drive corporate and local initiatives for key groups of staff such as HCA's and Nurses. The staff experience and improvement group is driving the HCA retention plan. A review of the exit interview process was described in the People and OD committee and remains a work in progress.

2.3 Appraisal & Mandatory Training

As of mid-October Mandatory training met the corporate target of 90%. The People and OD committee reviewed information pertaining to the top subjects and those staff groups with least compliance. Work is ongoing to improve the medical and dental trainees compliance and understand the variances given each trainee completes a national E Induction prior to commencing with the Trust with many of the mandated subjects covered.

The overall appraisal compliance rate has increased by 5% to 79%. The working group remains in place to drive improvements and in September 719 appraisals were recorded in the month. The group continues to focus on driving compliance and at Executive reviews divisions have been able to describe their processes for delivering improvements.

3. Strategic Priority Updates

At the People and OD committee in October the strategic priority update was provided in a new format and can be found at Annex 2.

The overview describes progress to date and RAG rates the main programmes highlighting recent activity and next steps.

4. Staff Engagement

4.1 Freedom to Speak Up

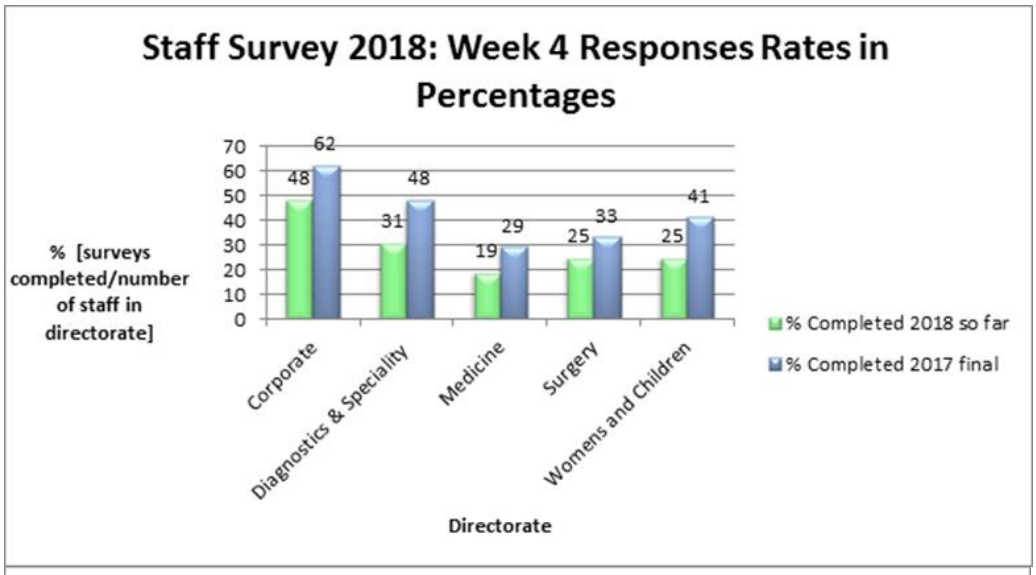
The Freedom to Speak up Guardian presented a comprehensive overview of the programme of work and next steps towards writing a Freedom to Speak Up strategy at the People and OD committee. October is Freedom to Speak Up month and activities in the Trust have included kitchen table events to encourage staff to provide an input into future delivery of the strategy.

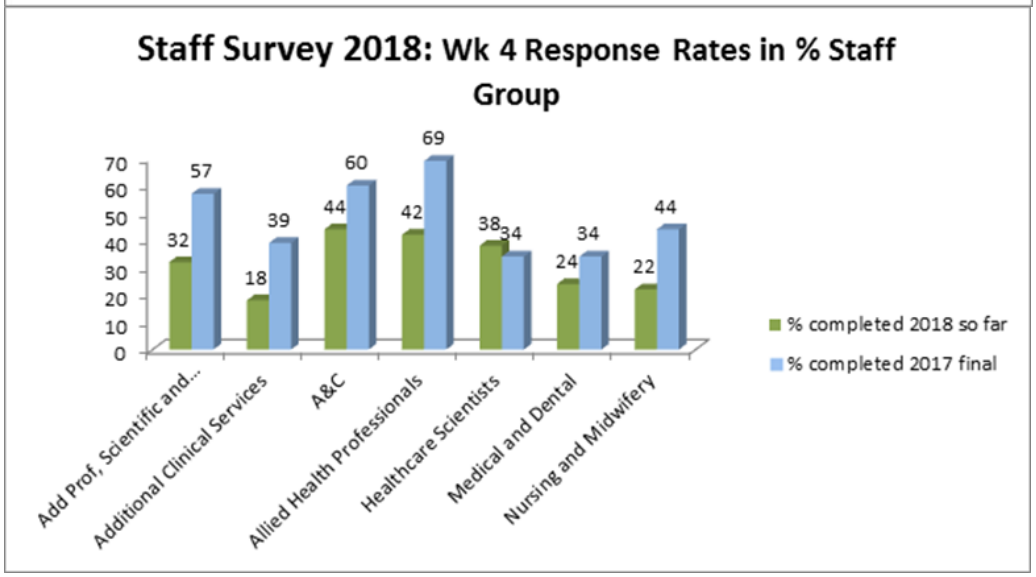
The survey commissioned to seek the views of staff on how embedded the practice of speaking up is in the Trust and if staff understand the multiple ways they could speak up has reported its findings which will go to the Freedom to Speak Up working group and Audit committee. The results of the survey will be used to help design and develop the Freedom to Speak Up Strategy and determine priority actions for the Trust.

4.2 Staff Survey

In October the People and OD committee received an update on progress with staff survey actions across divisions and corporately. The current staff survey is live and closes 30 November 2018. Current data on completion is below:

- ✓ The response rate for the Trust as of 29th October 28% (1957 staff) [National mean average 27% - source Quality Health 26.10.18]
- ✓ Highest response rate in numbers for divisions: Diagnostics & Speciality [559]
- ✓ Highest response rate in % terms for divisions: Corporate [48%]
- ✓ Highest response rate in numbers for staff groups: A&C [662]
- ✓ Highest response rate in % terms for staff groups: A&C [44%]
- ✓ Healthcare scientists have exceeded their performance last year with five weeks to go. Currently 38% vs final figure 2017 of 34%.
- ✓ Best performing teams in % terms to date: Training [88%], Finance Shared Services [83%] Enteral Feeds [83%]





For the first time the In Patient Survey and the Staff survey results were discussed at a joint Q&P and People and OD committee on 25th October. The analysis and triangulation of results confirmed the link between how staff are treated and perceive their experience of work alongside patient experience. Further analysis and activity will be progressed as part of the NAAS implementation and through the Staff Experience Improvement group which will be extended to include Patient experience.

The quarterly Staff Family and Friends test incorporated into the Freedom to Speak Up survey was completed by c 200 staff members (38% were in a managerial or leadership role). The results are at Annex 3. Overall our strategic objective of 65% of staff recommending us as a place to work has not been met this quarter as 44% were extremely likely or likely to do so, however if we could influence the percentage of staff who felt undecided (24%) about whether to recommend the Trust or not we would exceed the objective. The percentage of staff who would recommend us as a place for treatment was 59%.

The last time the FFT was completed in May/June there were 121 respondents. The survey was sent to the newly established extended leaders network (c450 people) to measure middle management views. Results showed 61% of staff were extremely likely/likely to recommend us as a place to work and 76% our services to family and friends.

The FFT and 2018 staff survey results will be considered by the Staff Experience Improvement Group together. Our intention is to create a pulse survey post the staff

survey which looks to explore why staff may not recommend us as a place to work once results have been analysed.

4.3 Workforce Equality, Diversity and Inclusion

The Trust continues to give profile and visibility to the importance of equality, diversity and inclusion matters. In October we welcomed Paul Deemer, Head of Diversity & Inclusion at NHS Employers, and Mark Doughty, Senior Leadership Consultant at the King's Fund, to deliver a session at the quarterly 100 Leaders event. This was followed in the afternoon by a Diversity Network event, led by Paul Deemer, which focused on Mental Health in recognition of World Mental Health Day.

The Diversity Network continues to be actively involved in raising the profile of inclusion and equality across the Trust. We have expanded the role of the network and members will receive support and training to be part of formal disciplinary, grievance and appeal panels for issues concerning Dignity at Work. We have also been working closely with Victim Support to expand the support systems available to staff. These relationships will form a key part of the Staff Health and Wellbeing Hub design.

To recognise and celebrate Black History Month, the Diversity Network hosted two film nights with showings of "A United Kingdom" and "Selma".

The Trust Leadership Team has approved plans to engage with the workforce and stakeholders, over the winter period, to agree a new set of 4-year equality objectives. These will be published in April 2019.

We have significantly updated the equality and diversity webpage on the public website which includes links to our Equality of Opportunity Action Plan, the WRES report and Gender Pay Gap report. https://www.gloshospitals.nhs.uk/about-us/our-trust/equality-diversity

The Trust has also established a link to a leading South West BAME champion with a view to widening the opportunities to access previously hard to reach groups for the upcoming advert for two NED's and an Associate NED. Our ambition is to build on the diversity of the Board with a focussed and targeted approach to encourage applications from the BME community.

5. Governance

The People and OD committee reviewed the risk register and noted the work to align divisional risks into overarching risks held by the People and OD directorate as they relate to workforce. A risk as linked to 10 divisional risks was reviewed – the impact on patient safety and service delivery where supply is limited for specific clinical roles.

6. Conclusion

In addition to the above work streams, the People and OD team continue to manage business as usual and a programme of activity across its key priorities. Finalising the model for a staff health and wellbeing hub remains the priority for the next quarter alongside embedding and supporting local ownership for retention issues.

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

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

Annex 1:Workforce Information Dashboard
Annex 2: 6-12 month strategic priority update
Annex 3: FFT results

Gloucestershire Hospitals NHS
NHS Foundation Trust

Workforce Information Dashboard

People and OD Committee, October 2018

Alison Koeltgen, Deputy Director of People & OD

Introduction and Overview

- The purpose of this presentation is to provide an overview to the People and OD Committee of the key performance indicators which link to our strategic priorities:

  - Turnover (retention and workforce stability)
  - Sickness (health and wellbeing)
  - Appraisal and Mandatory Training (deep dive)

This report is designed to provide assurance that sufficient controls exist to monitor performance against key workforce priorities. Where improvements are required, these actions are fed into the appropriate workstreams, monitored by the People and OD Delivery Group.

Performance summary:

	SICKNESS	TURNOVER	APPRAISALS	MANDATORY TRAINING
Performance (in month)	3.46%	n/a – rolling annual figure	75%	88%
Rolling Annual performance	3.87%	12.02%	n/a	n/a
Target	3.50%	11%	90%	90%
Movement since last report	↓ -0.09	↑ +0.01%	↑ 1%	↑ 1%

Retention

Description	Current Performance			Movement since last Month		
	12 months to 30th September 2018	Actual % TO	KPI % TO			Previous Month
Turnover is measured using the total leavers(fte) as a percentage of the average fte for the reporting period. The Trust target is 11% with the red threshold above 15% and below 6%. NB Turnover now reported as fte based - in line with QPR reporting	Trust Total	12.02%	11.00%	↗	increase	12.01%
	Corporate	13.11%	11.00%	↗	increase	12.51%
	Diagnostics & Specialty	11.78%	11.00%	↗	increase	11.61%
	Medicine	13.74%	11.00%	↗	increase	13.47%
	Surgery	11.33%	11.00%	↘	decrease	11.57%
	Womens & Children	9.84%	11.00%	↘	decrease	10.71%
	Add Prof Scientific and Technic	10.12%	11.00%	↗	increase	10.40%
	Additional Clinical Services	15.85%	11.00%	↗	increase	15.56%
	Administrative and Clerical	13.24%	11.00%	↘	decrease	13.27%
	Allied Health Professionals	12.56%	11.00%	↘	decrease	12.84%
	Estates and Ancillary	2.45%	11.00%	→	stable	2.45%
	Healthcare Scientists	12.33%	11.00%	↗	increase	11.56%
	Medical and Dental	3.87%	11.00%	↘	decrease	4.37%
	Nursing and Midwifery Registered	11.17%	11.00%	↗	increase	11.16%
	Staff Nurses	13.07%	11.00%	↘	decrease	13.28%

Significantly above upper target limit (>15%)
Between 11.01 & 14.99%
On target or below (11%)

Trust TO% by Quarter

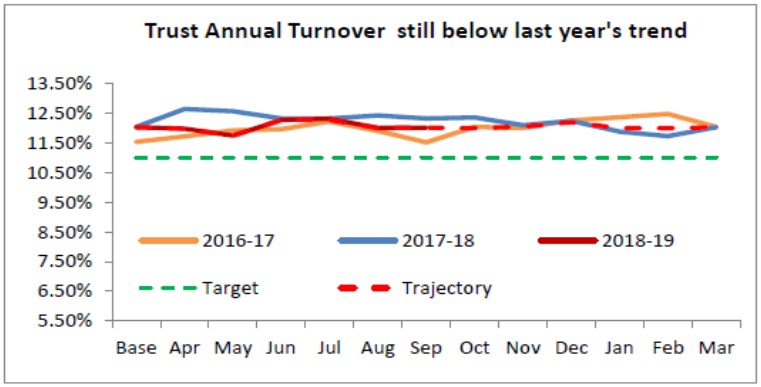
Oct Dec 2016	3.31%	Oct Dec 2017	3.05%
Jan Mar 2017	2.74%	Jan Mar 2018	2.52%
Apr Jun 2017	3.11%	Apr Jun 2018	3.22%
Jul Sep 2017	3.42%	Jul Sep 2018	3.21%

Following a similar pattern to 2016_17: fall in Turnover (leavers) Jan to March. However a smaller increase in the Jul Sep qtr.

Benchmarking: NHS iView uses a different methodology for calculating Turnover, However it can be used for comparison.

NHS iView 12 months to June 2018				Staff Nurse
GHNHSFT	12.31%	Nursing & Midwifery	10.53%	15.73%
All Large Acute	14.02%	Nursing & Midwifery	14.66%	19.97%
North Bristol	13.60%	Nursing & Midwifery	15.68%	21.65%
Worcester Acute	10.25%	Nursing & Midwifery	9.65%	14.46%
Sandwell	11.06%	Nursing & Midwifery	12.29%	24.00%

Worcestershire Acute who employ a similar number of nurses /staff nurses to this Trust have a lower turnover rate.



Figures below include all leavers for any reason (including retirement) and indicate the impact on an area

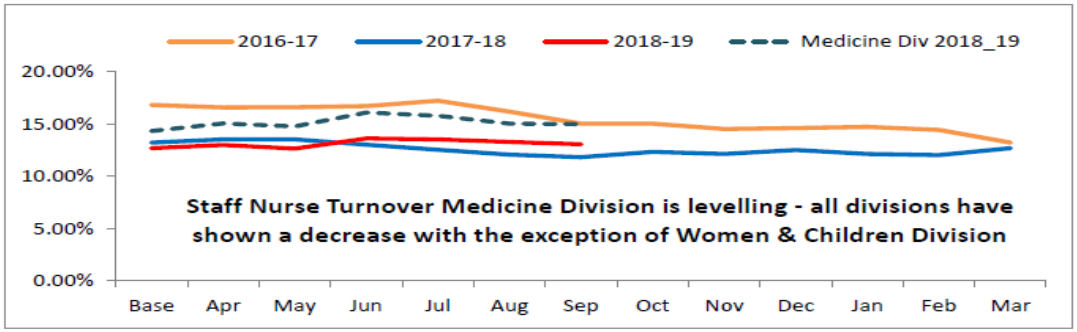
These are the areas (with 20 or more staff) with the highest turnover rates in the Trust

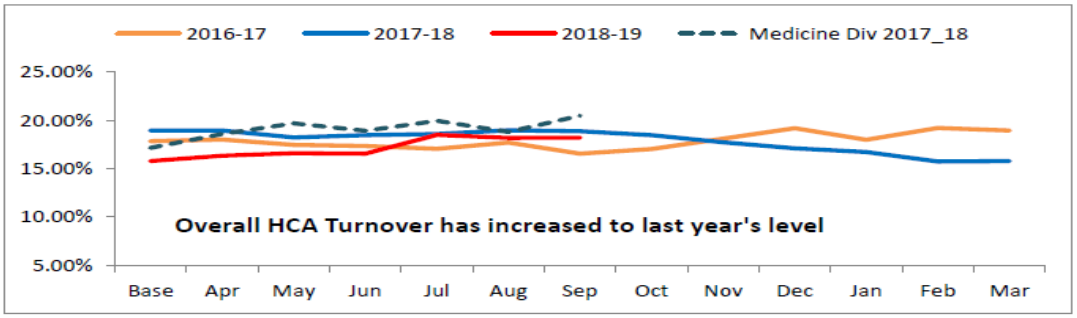
Oct 17 to Sep 18	% Turnover	FTE In Post Start	FTE In Post End	Leavers	Movement since previous month
Ward 2a T&O Trauma & Spinal Unit 70122	34.56	23.65	29.59	9.20	↗
Ward 4a Acute (ACU B) 41522	27.40	25.20	29.29	7.47	↗
Medical and Surgical OPD 77522	26.33	29.27	28.77	7.64	↗
Alstone Ward - Orthopaedic 35341	25.88	25.72	22.99	6.30	↘
Ward 6a Stroke 34822	25.63	27.76	26.85	7.00	↗
Ward 7b CAPD Renal 74322	25.23	25.00	25.73	6.40	↘
Ward 3b T&O Trauma 74422	25.13	34.43	29.97	8.09	↗
Ward 8b Thoracic/Respiratory 78722	24.15	27.99	30.11	7.01	↗
Woodmancote CGH GOAM 73441	22.41	35.75	35.64	8.00	↗
Ward 6b Stroke Unit 74122	22.25	29.71	29.61	6.60	↗
Chemical Pathology 21593	21.94	37.91	41.53	8.71	↗
Audiology - GRH 23522	21.14	24.02	27.44	5.44	↗
Oncology Admin 12841	21.04	38.30	41.94	8.44	↘

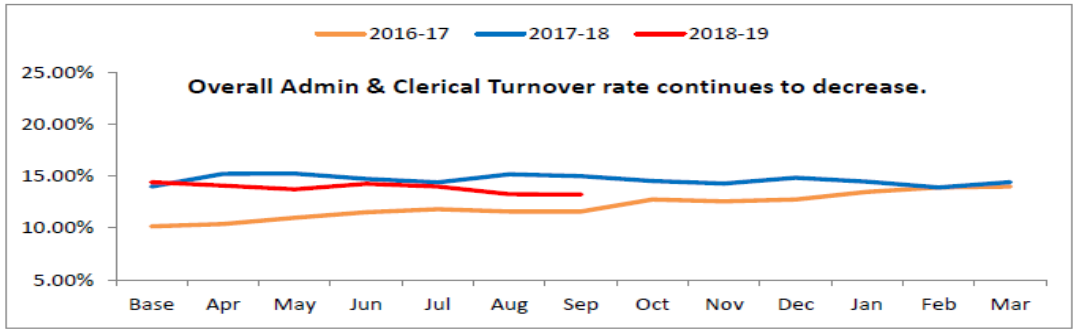
Highlights:

- Trust total turnover shows a marginal increase , however continues to sit below 2017/18 trends.
- Benchmarking against other acute trusts indicates that we are not an outlier, with exception to Worcester Trust. We are linking with Worcester Acute to understand whether there are any lessons we can learn through a deep dive into workforce data.
- We continue to participate in the national NHSi retention focus groups, sharing good practice and have now implemented Internal Nurse Transfer guidance to support Nurse retention.

Turnover Trends Detail - areas of concern







Actual Turnover including all leavers (FTE)

Oct 2017 to Sep 2018

Registered Nursing & Midwifery	Annual % T/O Rate	Staff Nurses Only
Trust Total	11.17%	13.07%
Diagnostics & Specialty Divisi	10.30%	11.63%
Medicine Division	12.66%	15.00%
Surgery Division	10.96%	10.81%
Womens & Children Division	10.12%	19.12%

See Nursing fte v Establishment tab

Oct 2017 to Sep 2018

HCA Turnover	Annual % T/O Rate
Trust HCA Total	18.23%
Diagnostics & Specialty Divisi	21.18%
Medicine Division	20.51%
Surgery Division	17.33%
Womens & Children Division	9.74%

Oct 2017 to Sep 2018

Admin & Clerical Turnover	Annual % T/O Rate
Trust A&C Total	13.24%
Corporate Division	12.87%
Diagnostics & Specialty Divisi	12.15%
Medicine Division	16.55%
Surgery Division	12.97%
Womens & Children Division	13.78%

Highlights:

- At the August 2018 People and OD Committee we analysed trends relating to Nurse and HCA turnover and highlighted increased turnover for those staff with less than 5 years service, in the 21-35 age demographic. We also observed more leavers across medicine and surgery in contrast to the other divisions. We are aware of the increased turnover within W&C Division however expect to see this trend stabilize in coming months.
- HCA turnover remains a concern; progress against the HCA retention action plan is currently monitored by the Staff Experience Improvement Group, who report progress to the People and OD Delivery Group.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Exit Process Review (by request)

Current Leavers Process

1) Individual resigns
2) Manager completes leavers checklist and completes electronic leavers form (since July 2018)
3) Exit interview offered and arranged via manager/ HR/ Matron or Clinical Lead
4) Exit interview feedback to submitted confidentially to HR; issues are then flagged/ escalated/ managed as appropriate

Amendments to Leavers Process

- An electronic leavers form was introduced in August 2018, to simplify the exit process for managers.
- Between June 2017 – June 2018, 72% of staff were recorded as leaving for "Reasons: Other/ Unknown". We have excluded this category from the new electronic leavers form, in an attempt to improve our exit data.
- We are in the process of linking an online exit survey to all leavers, to the leavers form process , to automatically capture leavers who may wish to provide feedback without attending an exit interview , or employees who may not have been offered an exit interview.

Next Steps

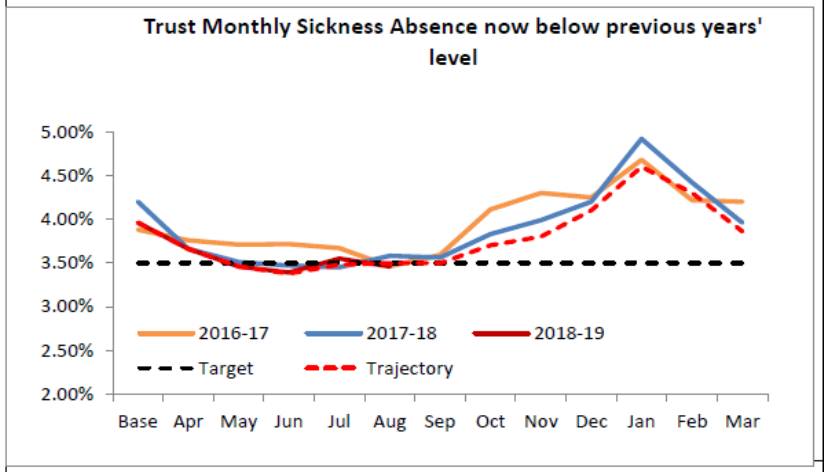
- A key element of our retention work stream, and the work of the staff experience improvement group, will be to consider improvements to this process, capturing leavers earlier in the process and improving compliance with exit interviews. The group will also being triangulating this exit data with other experience data in order to focus interventions and efforts appropriately.

Sickness Absence

Description	Current Performance			Maternity	Total	Sickness Absence by month						Movement
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% with the red threshold 0.5% above this figure.	12 months to August 18 (Annual)	**Sickness**	**KPI**	Absence	Absence	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	July to Aug
		% Abs	**% Abs**									
	Trust Total	3.87%	3.50%	2.74%	6.61%	3.99%	3.66%	3.46%	3.39%	3.55%	3.46%	decrease
	Corporate	4.27%	3.50%	1.58%	5.85%	4.57%	4.25%	4.43%	4.58%	3.70%	3.07%	decrease
	Diagnostics & Specialty	3.77%	3.50%	2.43%	6.20%	3.93%	3.10%	3.04%	3.20%	3.07%	2.90%	decrease
	Medicine	3.69%	3.50%	3.35%	7.04%	3.78%	3.42%	3.45%	2.88%	3.55%	2.87%	decrease
	Surgery	3.94%	3.50%	2.82%	6.76%	3.79%	3.89%	3.19%	3.23%	4.01%	4.48%	increase
	Womens & Children	3.83%	3.50%	3.41%	7.24%	4.42%	4.03%	4.02%	3.80%	3.31%	3.82%	increase
	Add Prof Scientific and Technic	2.91%	3.50%	1.90%	4.81%	3.00%	2.78%	2.86%	2.82%	2.92%	3.44%	increase
	Additional Clinical Services	4.79%	3.50%	3.02%	7.81%	4.60%	4.36%	4.36%	3.99%	4.33%	4.14%	decrease
	Administrative and Clerical	3.99%	3.50%	1.43%	5.42%	3.89%	3.61%	3.77%	3.69%	3.54%	3.16%	decrease
	Allied Health Professionals	2.77%	3.50%	3.53%	6.30%	2.98%	2.41%	2.55%	2.54%	2.19%	2.04%	decrease
	Estates and Ancillary	6.29%	3.50%	0.00%	6.29%	5.56%	4.38%	2.49%	8.08%	11.83%	9.91%	decrease
	Healthcare Scientists	2.92%	3.50%	1.60%	4.52%	2.69%	3.83%	2.48%	1.52%	2.11%	2.06%	decrease
	Medical and Dental	1.53%	3.50%	2.31%	3.84%	1.91%	1.85%	1.24%	0.92%	1.38%	1.33%	decrease
	Nursing and Midwifery Registered	4.62%	3.50%	3.75%	8.37%	5.00%	4.33%	4.00%	4.22%	4.36%	4.50%	increase

NB Sickness Absence data is run in arrears Sep 18 data will be available from 29th October 2018. Data is subject to late recording, so the most recent month's % may rise.

Trend



These are the areas (with 20 or more fte) with the highest rates of sickness in the Trust

	%SA	Approx Cost	Heads	Movement since previous month	% of Sickness Absence that is Long Term
Ward 2a T&O Trauma & Spinal Unit 7012	11.46%	£82,586	35	↗	69.9%
Ward Clerks - 7 Day Services 71293	9.06%	£82,674	69	↘	65.6%
Orthopaedic OPD 77022	8.58%	£47,783	29	↘	65.1%
Site Management 13793	8.02%	£87,822	24	↘	42.3%
Trauma Ortho Fracture Clinic 43941	7.98%	£49,995	27	↗	63.2%
Ward 9a Gynaecology 41622	7.70%	£45,303	23		67.4%
GRH Head & Neck Theatre - Pay Only 741	7.40%	£76,101	37	↗	62.8%
Day Surgery Ward 72022	7.25%	£60,170	36	↗	37.7%
Ward 4a Acute (ACU B) 41522	6.66%	£31,829	37	↗	24.4%
Booking Services 14593	6.60%	£67,578	67	↗	40.7%
Hybrid Support Discharge Ward GRH 418	6.44%	£31,379	29	↘	60.0%
Emergency Dept ENPs 39693	6.22%	£42,114	22	↗	59.5%
GRH General/Gynae Theatre - Pay Only 7	6.09%	£49,206	39	↘	55.3%
AMU 72922	6.05%	£60,264	44	↘	51.8%

Highlights:

- Annual Sickness absence of 3.87% remains lower than the national average for Large Acute Trusts (4.32% May 2018)
- Long term sickness (over 28 days) accounts for just under half of absence taken (48%)
- Sickness absence remains part of the Divisional Executive review process, with divisional leadership teams being held to account for increasing or exceptional sickness absence patterns.
- We have noted significant sickness and turnover rates across the **T&O speciality**, the Divisional Tri are aware of this trend and there is ongoing focus on these areas with concentrated HR support, an update on the action plan to improve these issues will be discussed during the October Executive Review.

Appraisal Compliance

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month by month data

Appraisals	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Movement since last month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate	77%	80%	82%	83%	82%	83%	80%			72%	72%	74%	↗	increase
Diagnostics	83%	85%	85%	84%	84%	85%	83%			74%	74%	74%	→	stable
Medicine	77%	81%	82%	81%	79%	78%	76%			71%	72%	73%	↗	increase
Surgery	77%	79%	83%	82%	81%	82%	82%			78%	76%	76%	→	stable
Women & Children	80%	85%	85%	86%	85%	84%	84%			76%	76%	78%	↗	increase
Trust	79%	83%	84%	84%	83%	83%	82%			74%	74%	75%	↗	increase

Appraisal Highlights:
September summary report: 79% against an optimistic aim of 85% by Q2 (equates to 719 appraisals recorded in September = second highest for one month). All divisions have increased their compliance rates.
Benchmark:
Average target of 90% for 5 other Trusts (range from 80% - UHBT to 100% NBT). Average compliance ranges from mid 70% to a high of 87% (NBT). At 79%, GHT are currently lower average: if we can get back to cc 85%, we will be top average. If we can achieve 90%, we will be in the top)
* July/August figures

Actions in the last month:
- Returned to monthly reporting and email reminders
- Designed a new part pre-populated reporting form that works on the intranet and moved the appraisal reporting click higher on the webpage.
- Targeted the previous known appraiser for staff out of date and sent email requesting their attention/action.
- Held T&F group with Divisional Leads to enlist help and ideas: Designed a FAQ sheet to send with reports and add to budget holder reports, email reminders and the webpage. Divisions committed to chasing.
- Investigated report s of "queries and inaccuracies" re ESR data – and cleansed data where possible. (Specif. Locum Medical staff or Trainee Grades who rotate).

Mandatory Training

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month by month data

Mandatory Training	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Movement since last Month	
Target	90%	90%	90%		90%	90%	90%	90%	90%	90%	90%	90%		
Corporate excl Bank	91%	90%	90%		76%	81%	85%			88%	88%	89%	↗	increase
Diagnostics	93%	92%	92%		74%	83%	88%			90%	90%	91%	↗	increase
Medicine	87%	86%	86%		73%	78%	81%			85%	85%	86%	↗	increase
Surgery	90%	89%	90%		77%	82%	85%			87%	87%	88%	↗	increase
Women & Children	88%	87%	87%		75%	80%	83%			84%	85%	89%	↗	increase
Trust	**88%**	**88%**	**88%**		73%	79%	82%			87%	87%	88%	↗	increase

No MT figures available for December 17

Highlights:

Benchmark data: Majority of Trusts set a target of 90% (less variance than in previous years and for appraisals)
Compliance rates against this target are similar to GHT, ranging from high 70s to low 90s

88% overall compliance is getting closer to our 90% target and “Eliza” – our automated transfer system is currently working non-stop, indicating record numbers of eLearning completions.

Topics highlighted in blue are statutory

Topics highlighted in pink are the topics identified by the Trust as Mandatory

The topics left in white are reported on monthly and are all deemed as being high risk.

VTE, Patient Falls and Safeguarding Children Level 3 - Multi-Agency and Consent are reported monthly, but not included in the overall compliance for the Trust.

Subject / Staff Group	Subject Compliance	Admin and Clerical	Additional Clinical Services	Allied Health Professionals	Additional Professional, Scientific and Technical	Estates and Ancilliary	HealthCare Scientists	Medical and Dental Consultants	Medical and Dental SAS Senior	Medical and Dental Trainees	Nursing and Midwifery
Basic Adult Resuscitation	86%	57%	77%	95%	96%	100%	91%	85%	82%	71%	90%
Blood Transfusion	85%	n/a	81%	100%	92%	n/a	93%	89%	88%	51%	89%
Code of Confidentiality	86%	87%	83%	93%	88%	81%	94%	90%	87%	57%	88%
Conflict Resolution	81%	80%	78%	91%	87%	94%	87%	84%	83%	60%	83%
Consent	86%	n/a	n/a	n/a	60%	n/a	n/a	n/a	98%	83%	n/a
DOLS Awareness	89%	n/a	86%	97%	97%	n/a	90%	92%	90%	70%	92%
Equality and Diversity Awareness	97%	97%	96%	100%	97%	99%	100%	97%	96%	86%	98%
Fire	90%	90%	88%	96%	91%	88%	95%	91%	85%	51%	92%
Infection Control	85%	85%	82%	92%	85%	84%	90%	89%	82%	48%	87%
Information Governance	85%	87%	83%	94%	85%	84%	93%	89%	82%	45%	87%
Manual Handling Practical	81%	57%	75%	97%	94%	100%	92%	83%	77%	61%	83%
Manual Handling Theory	86%	86%	84%	94%	85%	84%	91%	89%	83%	47%	88%
MCA Awareness	90%	n/a	86%	97%	97%	n/a	90%	92%	90%	70%	92%
Medicines Management	80%	n/a	72%	n/a	89%	n/a	n/a	n/a	n/a	n/a	84%
Patient Falls Prevention	85%	n/a	82%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	86%
Prescribing	69%	n/a	n/a	n/a	100%	n/a	n/a	89%	78%	45%	n/a
Prevent Basic Awareness	85%	87%	82%	95%	88%	80%	92%	86%	82%	66%	86%
Safeguarding Adults Awareness	85%	87%	82%	95%	88%	80%	92%	86%	82%	68%	86%
Safeguarding Adults Level 2	84%	n/a	84%	91%	94%	n/a	78%	79%	83%	61%	85%
Safeguarding Children Awareness	85%	87%	82%	95%	88%	80%	92%	86%	82%	66%	86%
Safeguarding Children Level 2	91%	60%	88%	97%	97%	n/a	90%	92%	90%	70%	93%
Safeguarding Children Level 3 - Multi-Agency	66%	n/a	n/a	100%	50%	n/a	n/a	80%	100%	20%	69%
Safety Awareness	92%	92%	91%	98%	93%	91%	98%	93%	89%	65%	93%
Venous Thromboembolism (VTE)	78%	n/a	n/a	n/a	75%	n/a	n/a	88%	82%	70%	77%

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Review of 6-12 month priorities

People and OD Committee, October 2018

Alison Koeltgen, Deputy Director of People & OD

Summary : Key Workstreams

Gloucestershire Hospitals NHS Foundation Trust

Strategic Priority	Status (RAG)
Sustainable Workforce - Advanced Clinical Practitioners	
Sustainable Workforce - Developing new roles and career pathways	
Recruitment Turnaround *	
Retention *	
Talent Management	
Health and Wellbeing	
Establishment Realignment	
Creating Efficiencies and Reducing Bureaucracy (NHSGMS)	
Staff Engagement	
CIP Delivery	

** Workstreams which have emerged over the past 6 months*

RED	AMBER	GREEN
workstream is unlikely to , or will not, deliver to agrees timescales.	*workstream progress is slow, however plans are in place to progress and deadline likely to be met (if applicable)*	*workstream is on track, delivering against plan*

Update: Sustainable Workforce

Advanced Clinical Practitioners (ACPs)

STATUS	
Objectives:	• Develop an enhanced role to cover gaps in Middle Grade Doctor rotas and provide career opportunities for non-medical clinical staff (nursing, AHPs and others). • Development of an outline business case for ACPs, by September 2018, identifying costs, funding and potential ROI.
Risk (Risk Register):	Failure to deliver quality of care as a result of an inability to fill vacancies, where supply of suitably skilled staff is limited.
Progress:	• A number of pockets of work around the development of ACPs have already taken place, this project has focused on pulling this work together into a strategy for the development of ACPs which helps to mitigate the risk articulated above. • The ACP role has now been defined with an emergent 'advanced practice' map, which clarifies the characteristics belonging to the different roles falling under the umbrella of advanced practice, such as: ACP, Nurse Practitioner, Clinical Nurse Specialist, Consultant Nurse. • The organisational 'heat map' has been outlined , indicating where we need ACP roles and which areas take priority for the development of ACPs. • We have engaged with a number of other acute Trusts and Gloucestershire ICS. Specifically collaborating with Derby (who now have 77 ACPs in post) we have visited site and met with service leads to understand their lessons learnt so far. • Routes to entry have been identified : Including internal development and external recruitment pathways (Qualified/ Part Qualified/ Unqualified) • We have begun to compile the 3 year training programme and engage with UoG, UWE and other HEIs to explore how we can make this programme work in practise. Some modules will be funded through the HEES ICS transformation funding, others may be achieved through a Masters level Apprenticeship.
Next Steps:	Further clinical engagement, alongside more detailed financial profiling for the ACP business case, with the outline business case presented to Execs during December 2018. Secure educational pathways to enable the required qualifications and upskilling

Update: Sustainable Workforce

Develop New Roles and Career Pathways to Transform and ensure a Future Workforce

STATUS	
Objectives:	• Develop new roles and career pathways to increase the recruitment of our future workforce. • Expand the educational pipelines across the Trust to attract and develop a transformed workforce This includes: • Develop Trainee Nursing Associates (TNAs) ready to take up the fully qualified Nursing Associate (NA) role from 2019 • Chief Nurse Fellowships (CNF) • Apprenticeships • Expand numbers of HEIs supplying our Nursing Degree Students and therefore the numbers of students on placement
Risk Register:	Failure to deliver quality of care as a result of an inability to fill vacancies, where supply of suitably skilled staff is limited.
Progress:	**TNA** • First "Fast-Follower" cohort of 11 Trainee Nursing Associates due to complete in GHT in April 2019 • Shared Countywide procurement exercise appointed University of Gloucestershire as the apprenticeship provider • Second "legacy" cohort of 19 commenced Apprenticeship programme on 24th September. (42 across the ICS footprint) **CNF** • Established new Chief Nurse Fellows programme to both attract new first/2:1 degree band 5 nurses and retain/develop existing Band 5 nurses. • Day 1 of programme commenced on 20th September to include in-house induction and enrolment on to the Level 3 Leadership Apprenticeship. Only 3 started, but very high quality individuals with good quality improvement projects proposed. **Apprenticeships** • Continual development of new apprenticeships to "grow our own" and increase access to qualifications as Healthcare standards emerge nationally • Some - slow progress made with developing an ICS approach to apprenticeships (shared procurement, documentation, leadership programmes) **Numbers of Nurse Degree Students on placements** • Expansion of nurse student placements and partnerships with Worcester, Oxford Brookes as well as • Involvement in the National HEE RePAIR project to reduce Student Nurse attrition and transition shock to NQ nurse
Next Steps:	**TNA** - Finalise the Qualified NA role and wards to deploy the 11 finishing programme in April 2019 **CNF** - A second cohort to be advertised in November 2018 for a planned start in Spring 2019 & align to Talent Pool in 2019 **Apprenticeships** – further develop ICS partnership work for a Countywide strategy **New HEI Partnerships** – Explore funding streams for tariffs and consider links further afield

Update: Recruitment Turnaround

STATUS	
Objectives:	• Optimisation of Recruitment Pathways • Engagement with staff in shortage occupation groups to ensure an innovative and 'in touch' approach to recruitment. • Linking recruitment to Professional Education to maximise take from Universities.
Risk (Risk Register):	Failure to deliver quality of care as a result of an inability to fill vacancies, where supply of suitably skilled staff is limited.
Progress:	• **Activity increased** phenomenally - previously we averaged 50 – 60 new starts per month, September 2018 we will hit an all time record of 208 starters • **Marketing** campaigns currently being finalised, improvements now made to JD's and adverts • Exploring **cross STP DBS portability and pre-hire IAT** with 2G and GCS • Re-write of DBS policy and guidance (first draft out for review) • New team are establishing, new Recruitment office manager appointed , start date TBC • NQN Open Day (End of Sept) , offers made to 38 NQNs to start Spring 2019. • HCA assessment day review – changed assessment process to make more efficient, further days scheduled to support the increase volumes (6th October) • Career Fair plans in progress – Dublin scheduled 13 October 2018 • Recruitment Newsletter produced – ready to launch Oct 2018
Next Steps:	• R&S policy in review • Honorary contract process review – due by end October 2018 (PWC audit action) • Agree plan for University open days 2019/20

Update: Retention

STATUS	
Objectives:	• Reduce turnover , specifically within Nursing and HCA groups • Review Terms and Conditions, where appropriate, to ensure remuneration is competitive and meets the needs of the workforce • Review the Exit process
Risk (Risk Register):	Failure to deliver quality of care as a result of an inability to fill vacancies, where supply of suitably skilled staff is limited.
Progress:	• Nurse transfer window scheme guidance published September 2018 ; 2 transfer windows per year October and April, to avoid Winter. Caveat: Must stay in new role for minimum 12 months before being permitted to move again. • TLT considered HCA Sick pay review and determined that the proposal should go through the Trust Business development Group, to fully explore the cost implications attached to the review. • HCA turnover action plan. All actions are now underway and some are completed. All actions are on track with the exception of decision about HCA terms and conditions. • Career pathway development and career conversation support • Signed up to **RePAIR** programme as an STP (focused on retention through Nurse training)
Next Steps:	Review of the exit process and triangulation of exit data, into Staff Experience Improvement Group Embed nurse transfer process HCA Terms and Conditions – review to Business Development Group Oct 2018.

Update: Talent Management

STATUS	
Objectives:	• A system of talent management and succession planning is designed, which enables the creation of talent pools and an easy means to fill vacancies • An improved link to appraisal, shifting from performance management alone to considering career options: a "career conversation"
Risk (Risk Register):	Failure to deliver quality of care as a result of an inability to fill vacancies, where supply of suitably skilled staff is limited.
Progress:	• New appraisal paperwork launched July 2018 • New training sessions launched and delivered to support Talent Development rollout: briefing sessions; conversation skills workshops; training for new appraisers • Dedicated Talent Development section on new Intranet site, making it easier to identify learning opportunities. Includes career development advice along with new, emerging section to promote career pathways in the Trust for different staff groups
Next Steps:	• First set of decision panels to select members of new "Accelerated Development Pool" (ADP) scheduled for November 2018 • Recruitment of a Coordinator to support smooth running of ADP

Update: Health and Wellbeing

STATUS	
Objectives:	• Negotiate an extension to the current Occupational Health contract, without increased costs. • Build outline business case for a 'one stop' staff health and wellbeing service by June 2018.
Risk (Risk Register):	
Progress:	• Agreed continuation of contract until end of financial year • Commenced mapping of pre-hire pathway and new recruit requirements • Produced high-level proposal of concept for 'one-stop-shop' concept, scheduled for presentation at PODDG and TLT November 2018 • Held conversations with in-house providers (staff support, physiotherapy) about future structure and provision of services • Begun exploring options for provision of an Employee Assistance Programme • Commenced scoping of reasonable adjustment policy, with staff side support.
Next Steps:	• Present proposals to PODDG and TLT • Prepare costings and business case options to establish a "one-stop-shop" along with additional mental health/psychology support services to meet levels of demand

Update: Establishment Realignment

STATUS	
Objectives:	• To establish 'one version of the truth' workforce data, via the electronic staff record system, to enable accurate reporting on the profile of the workforce, vacancy profile supporting budget and pay control.
Risk (Risk Register):	None identified
Progress:	• Re-mapping establishment data contained within budgets has uncovered a number of housekeeping issues which finance colleagues have needed to work through line by line basis (such as individuals recorded in the wrong cost centres) • In order to support resolution of this project we have agreed to look at the establishment at professional group level, rather than individual post level. This will still enable us to identify establishment and vacancy levels across professional groups and within departments – whilst reducing the need for a significant amount of individual post maintenance.
Next Steps:	• Upload all establishment into ESR by the end of December 2018 • Data testing and budget holder engagement during Q4 • Project completion by new financial year.

Update: Creating Efficiencies and Reducing Bureaucracy (NHSGMS)

STATUS	
Objectives:	• Design and delivery of subsidiary company
Risk (Risk Register):	n/a (individual GMS risks contained within GMS risk register)
Progress:	• Engagement, consultation and TUPE work completed in time for April 2018 launch • Development of terms and condition for new staff complete • Introduction of new TU recognition arrangements and establishment of staff committee • Supporting the cultural change required in the 'colleague to customer journey' through Leadership and Organisational Development intervention and a bespoke package of support.
Next Steps	• Update on colleague to customer support journey to PODC • Phased review of workforce policies

Update: Staff Engagement

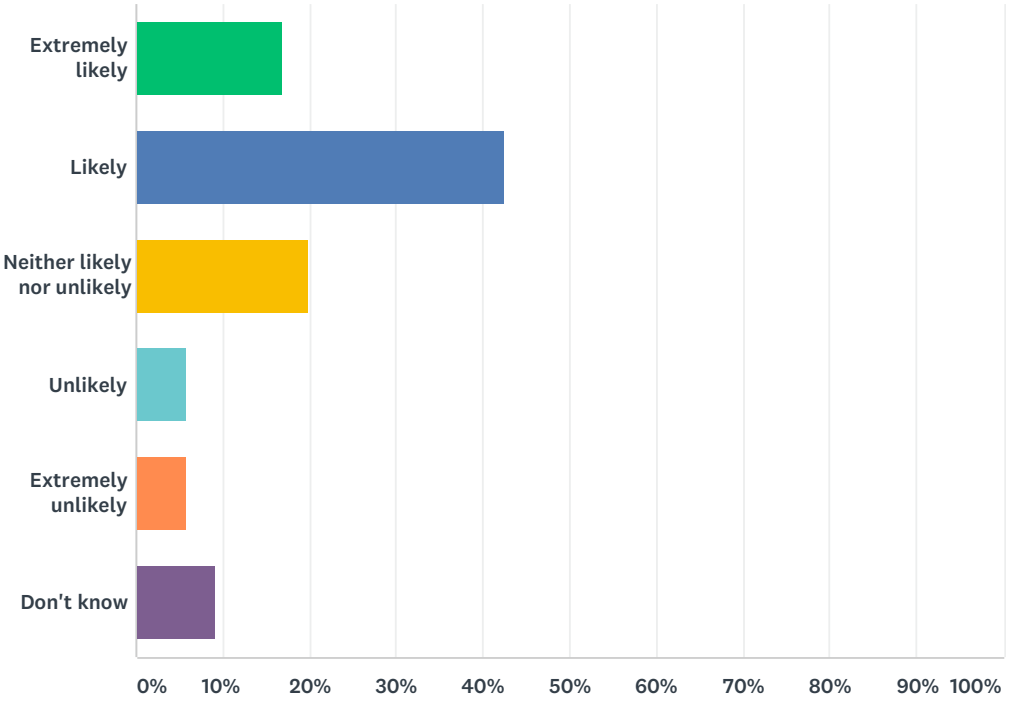
STATUS	
Objectives:	• Maintain two-way feedback and listening, identifying opportunities and topics where staff can be actively encourage to contribute to Trust decision-making and having a voice
Risk (Risk Register):	
Progress:	• Established new Extended Leadership Network aimed at mid-level managers • Established GM/AGM Forum and Operational Matrons Group • Monthly Diversity Network coffee socials and bimonthly meetings • HCA Turnover project which convened focus groups to seek feedback, which in turn has made recommendations • Launched new Staff Experience Improvement Group to undertake triangulation of staff experience data and identify priority areas/actions to implement • Launched GEM monthly staff/quarterly team awards • Promotion and embedding of Freedom to Speak Up Guardian • Relaunch of Schwartz rounds • Launch of Nurse Accreditation and Assessment Scheme (NAAS) • Engagement at all levels of Trust to seek feedback on Journey to Outstanding #J2O and ideas for new trust strategic objectives • Increased usage of social media to promote and celebrate great work in Trust using #J20
Next Steps:	• Finalise approach to supporting online staff engagement with app/electronic opportunities, in liaison with Comms & IT • Recruitment of Coordinator to support collation and analysis of staff experience data, and help drive forward the Staff Experience Improvement Group activity and effectiveness

Update: CIP Delivery

STATUS	
Objectives:	• Support the delivery of CIP
Risk (Risk Register):	
Progress:	• Delivery of departmental CIP • Introduced revised bank rates Sept 2018 in order to reduce agency spend • Benchmarked key policies (i.e. study leave) to test opportunity for further CIP • Continued vacancy control with divisional review process, VCP panel and agreed sign off of 'like for like' posts within budget. • Implementation of VCP control for high cost agency shifts, in line with revised NHSi requirements. • Overtime authorisation review. • Continued support to Divisions to enable CIP plans, reconfiguration and organisational change.
Next Steps:	• Renegotiation of the organisational change policy • Identify further opportunity for policy review and cross cutting workforce schemes.

Q32 How likely are you to recommend our services to friends and family if they needed care or treatment?

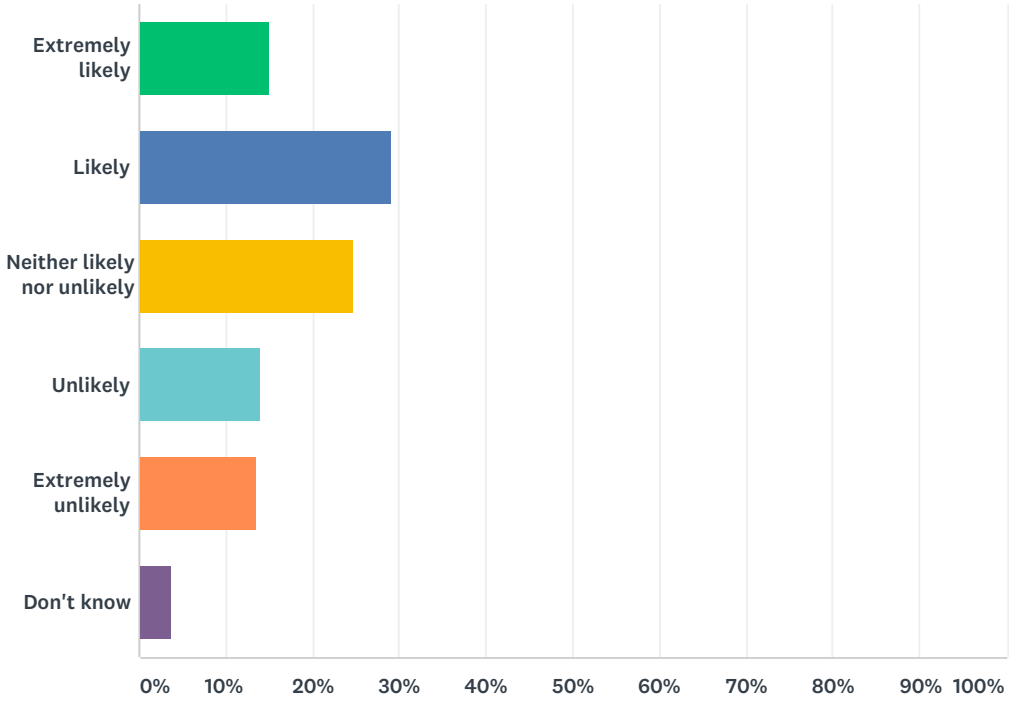
Answered: 207 Skipped: 0



ANSWER CHOICES	RESPONSES	
Extremely likely	16.91%	35
Likely	42.51%	88
Neither likely nor unlikely	19.81%	41
Unlikely	5.80%	12
Extremely unlikely	5.80%	12
Don't know	9.18%	19
TOTAL		207

Q33 How likely are you to recommend the organisation to friends and family as a place to work?

Answered: 207 Skipped: 0



ANSWER CHOICES	RESPONSES	
Extremely likely	14.98%	31
Likely	28.99%	60
Neither likely nor unlikely	24.64%	51
Unlikely	14.01%	29
Extremely unlikely	13.53%	28
Don't know	3.86%	8
TOTAL		207

REPORT TO MAIN BOARD – NOVEMBER 2018

From People and OD Committee Chair – Alison Moon, Non-Executive Director

This report describes the business conducted at the People and OD Committee on 11th October 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 Alignment and triangulation of risk	First report received and welcomed showing Divisional workforce risks, emergence of common themes.	Some of the risks identified are risks; some are issues, work on common approach and articulation of the risks needed across Divisions. How do we know that these are the biggest areas of concern? How do the risks flow through the Trust governance operationally? What if any are the links to the 6-12 month Trust priorities?	Risk management processes in Divisions dynamic, monthly exec reviews, through to Trust Leadership Team if required and onto Corporate Risk Register. HR Business Partner (HRBP) involvement and challenge of workforce risks and appropriateness of these and rating scores.	Review of current wording of risks/issues on the risk register. Priorities and risks alignment and revised risk register to come to future meeting.

Review of 6-12 month priorities	Clear RAG ratings with definition and updates for each priority.	What are the links to the Sustainability and Transformation Partners (Integrated Care System) workforce priorities? How are staff engaged and involved in developing the proposals for improved health and well-being?	Future People and OD Committee agenda item on STP/ICS workforce governance and work streams understanding the ICS having a holistic overview of all organisations over the next 5 years, including gaps in clinical workforce for the system. Evidence of staff focus groups and 5 x tailor made questions on staff survey.	
Freedom to Speak Up Q1	Importance of the content of this report understood, reporting of latest data.	How do we measure outcomes of using F2SU, not just in numerical terms? Policy launched in Aug 2018, when would we expect everyone to know about its contents?	Good evidence of staff using the service. Majority of staff would use service again if needed. High profile during October (F2SU month), more people accessing it. Assurance on how policies are implemented was given and the People and OD mechanism of up skilling described. Routine returns to NHSI shared with People and OD Committee, twice yearly narrative reporting. Annual report submission to Audit and Assurance Committee.	Further consideration on success outcomes? Some staff not aware of the service, continued work to raise the profile of the service.

Work Plan for 12 months	Fully updated work plan presented to committee	Journey to outstanding not explicitly mentioned in work plan, how is its progress monitored? Deep dive into retention not included	Full Board update on J2O planned for Dec 2018 with further update planned for Feb 2019. Divisions inclusive of People and OD have been framing their J2O for staff and patients/customers Retention is a programme of work and ensuring local engagement in retention issues is being driven through the monthly and quarterly executive reviews and by HRBPs.	Retention overview added to work plan
Strategy Update including timing and governance	Update received	How are the outcomes in strategy linked explicitly to programmes of work, process and systems? What is governance approval process for strategy 2019-21?	Outcomes and a description of what will be different will be part of the strategy document. People and OD J2O plan and aspirations for the Trust have already been shared with Dir of Strategy so links with business planning. Sharing with Board planned for December, final strategy agreement by Spring.	

Dashboard	Dashboard developed well since last Committee with more detail and narrative. Exit process review shared, option to include 'unknown' removed. Divisional responsibilities set out for retention plans. Top 20 geographical areas identified with turnover rate.	Good discussion and questioning on several areas within the dashboard, including staff profiles, vacancy levels, turnover rate Latest data re appraisals and statutory and mandatory training discussed. Training levels positively now at 90% for first time as an average. Split by staff group seen, some concerns as medical and dental trainees currently Red rated across the Board. Is there a correlation between e.g. lack of manual handling training compliance and sickness levels for Musculoskeletal (MSK) conditions?	Deep dive into medical and dental trainees required for the next committee meeting Further work agreed to explore this in more detail but reasons for long term sick as related to MSK are recorded. If further training is required this would be picked up as part of the return to work process	

Staff Survey Action Plan	Useful update of actions with timelines.	Is the RAG rating accurate?	Actions are monitored through the Staff Experience and Improvement group (SEIG)	

Key items for the Board to note:

Good quality papers presented to the Committee. Data presented with conclusions and analysis.

Agreed areas to improve and focus from previous committee incorporated into the papers.

Joint committee with Quality and Performance Committee on October 25th may result in additional areas of focus for this committee.

REPORT TO MAIN BOARD – NOVEMBER 2018

From Quality and Performance and People and Organisational Development Chairs– Alison Moon/ Claire Feehily, Non-Executive Directors

This report describes the business conducted at the Quality and Performance and People and Organisational Development Joint Committee on 25th October 2018, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

It is important to note that the purpose of this joint committee was to receive current approaches to two major areas of focus during their formative stages. Therefore there was a mixture of discussion, questions, comments, challenge and suggestions.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Patient and Staff Experience: Developing our understanding and implications of the 2017 staff survey and adult inpatient surveys.	Evidence base used to support links between staff and patient experiences. Specific questions in both surveys for GHT highlight areas to focus to improve staff and patient outcomes. Black, Asian, Minority and Ethnic (BAME) staff results indicate extent of valuing minority staff, good barometer of how well patients likely to feel cared for. Person centered and values based approach key with focus on communications, connection and commitment.	Good diagnosis, how agile are we to progress the plans to improve? E.g. real time staff and patient feedback systems. How do we make this relevant for all staff especially non clinical staff? How do we prioritise areas of focus which have widest and most direct impact? How do we feedback positive patient experiences to staff, not relying on negative or absence of negative examples?	Evidence of pace of agreed actions needed. Determine priorities, use of risk registers, links to strategic objectives and clear engagement and involvement of staff to develop.	Respective directors to consider next steps based on the meeting content and advise.

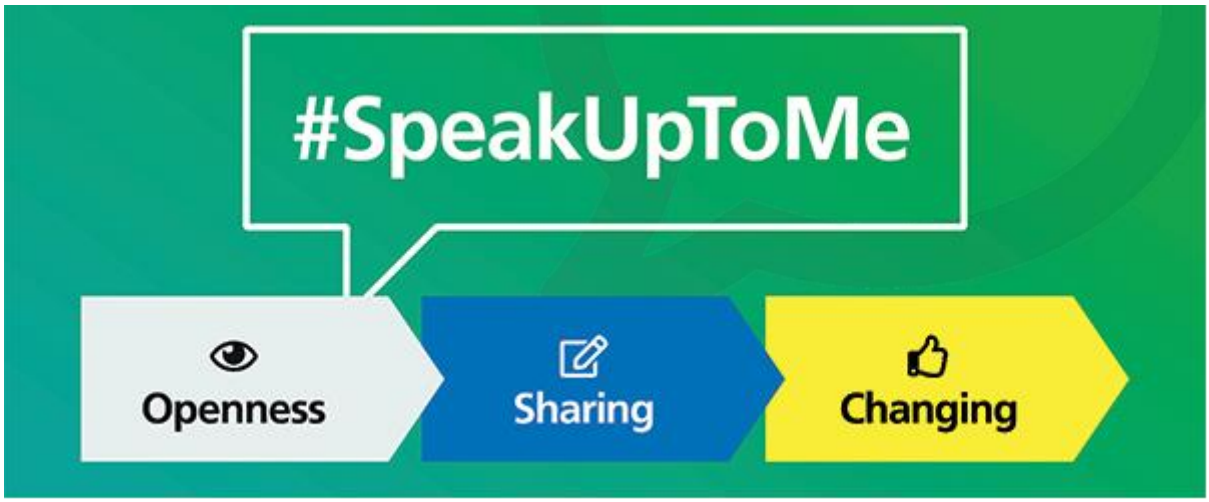
Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Safe Staffing – Nursing and Midwifery: Annual Review	Background with national and local context and evidence base provided to support the comprehensive nursing review undertaken. Scope clearly set out. Strategic framework shared, with specific results and recommendations proposed. Further data collection planned for January 2019.	Based on the initial results, how will those clinical areas which had a shortfalls identified, be supported through the winter pre the full review recommendations going to Trust Board for approval? What is realistic regarding the process for resourcing? How does the review fit with the 19/20 planning cycle? Are there risks associated with waiting for a further data capture? Should business case development commence sooner?	Confirmation of awareness and short term support received. Need to contribute to Cost Improvement Programmes (CIP) acknowledged and potential to navigate the overall nursing CIP through a trust wide lens covering all areas. Early discussions re budget taken place with Finance Director.	

Alison Moon
Chair of Quality and Performance and People and Organisational Development Joint Committee
25th October 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Freedom to Speak Up
Sponsor and Author(s)
Authors: Suzie Cro, Deputy Director of Quality & Freedom to Speak up Guardian Sponsor: Presenting Director: Emma Wood Deputy CEO & Director of People
Executive Summary



Purpose

The purpose of the paper is to provide the Board with an update on the development of our speaking up strategy, our governance arrangements for speaking up and our quality improvement approach to speaking up.

Key issues to note

- Our communications team have produced new promotional materials for speaking up which will now be used as our visual Speaking Up identity.
- A final draft of the NHSI self review tool for Trusts has now been completed and will be reviewed by the Raising Concerns/Speaking Up Improvement Steering Group next week.
- Our new Trust Speaking Up/Raising Concerns Policy went live in August 2018 with communications to our staff directing them to the Freedom to Speak Up staff intranet site.
- There is also a new video which supports the policy telling staff about what "Speaking Up" is all about.
- A Hot Topic Speaking Up leaflet has also been produced and was emailed to all staff.
- The Annual Speaking Up Report was featured in our July/August Edition of our Trust magazine Outline.
- Our quarterly returns have been submitted externally to the National Guardian's Office and are also reviewed at the Raising Concerns/ Speaking Up Steering Group and the People and OD Delivery Group. Themes and trends are reviewed at the meetings with everyone involved in suggesting change ideas which will then feed into the "Speaking Up" Strategy.

- Current themes and trends
    - The number of cases is increasing and the likely cause of this has been increased publicity of the role.
    - The highest type of concern that is raised is about poor staff experience/bullying harassment allegations.
    - Trend within Women and Children's about poor staff experience
    - Concerns continue to be raised via the Speak In Confidence anonymous reporting system.
    - No staff report detriment after speaking up.
    - Everyone who has spoken up would do so again and also would gain support from the Freedom to Speak Up Guardian if necessary.
- A number data sets have been reviewed as part of the diagnose phase of the strategy to see where our focus should be.
- Improvements that have been made in response to concerns are:-
    - Are now holding Kitchen Table events in the library and in ward/service areas so that staff can come and talk to the Freedom to Speak up Guardian to improve accessibility.
    - The Freedom to Speak Up Guardian holds a Friday clinic and advertises this so that staff know that on a Friday there will always be time to have a meeting to improve accessibility.
    - More information will be provided to line managers about how they manage anonymous concerns.
- October was speaking up month and there have been many engagement events, Kitchen Tables and "pop up" sessions all over the Trust.
- On social media for October there has been a Twitter campaign (with the Twitter hashtag #SpeakUpToMe).
- Speaking up issues that raise immediate concerns about patient safety are raised with the Director of Safety and the Director of Quality and Chief Nurse. We have closed the Quality Summit process that was raised as a safety issue for our GRH Day Surgery Unit.
- The Freedom to Speak Up Guardian has met with members of the Diversity Network to seek their views to see if they will become Freedom to Speak Up Ambassadors.

Conclusions

Our aim is to create a culture that is responsive to feedback and that is also focused on learning and improvement.

Implications and Future Action Required

The Board are asked to note the contents of the presentation materials.

Recommendations
To note the contents of the report.
Impact Upon Strategic Objectives
To be rated as good by CQC as speaking up will be reviewed as part of the well led (KLOE 3).
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
To meet regulatory requirements all Trust are to have a FTSUG and have governance processes in place for speaking up.

Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees
Support for the approach was given.

OUR JOURNEY TO OUTSTANDING

Quality Improvement Programme

“Speaking Up”

Suzie Cro

Freedom to Speak Up Guardian

What is speaking up/ raising concerns?

- Anything that is impacting on you or for your patients that you want to raise as a concern
    - Quality issues
    - Poor staff experience

CQC Well led inspection

Gloucestershire Hospitals NHS Foundation Trust

- **Key Line of Enquiry 3**
  How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?

- Effective speaking up arrangements protect patients and improves the experience of our workers. Having a healthy speaking up culture is an indicator of a well-led Trust.

First person

Gloucestershire Hospitals
NHS Foundation Trust

- Usually your line manager will be your first point of call.
- Freedom to Speak Up Guardian will be able to offer guidance and support if you are not able to speak up through your normal line management chain.

FTSUG Role is provide support and advice to staff

Gloucestershire Hospitals NHS Foundation Trust

- Sometimes workers find it difficult to speak up about issues affecting patient safety or staff experience. They may not know who to speak up to. They may feel that anything they do raise might not be taken seriously, or that nothing will be done as a result.
- When there are obstacles to speaking up patients, workers and the organisation itself can suffer because the right actions and learning are not put into place.

Freedom to Speak Up Guardian

Suzie Cro

Seven steps to improve quality

These seven steps set out what all of us need to do together to maintain and improve the quality of care that people experience. We have strong foundations to build on – not least, the impressive improvements in care quality we have seen in many areas in recent years – but there is also much more for all of us to do if we are to close the care and quality gap.

1. **Setting clear direction and priorities** based on evidence.
2. **Bringing clarity to quality,** setting standards for what high-quality care looks like across all health and care settings.
3. **Measuring and publishing quality,** harnessing information to improve care quality through performance and quality reporting systems.
4. **Recognising and rewarding quality.**
5. **Maintaining and safeguarding quality.**
6. **Building capability,** by improving leadership, management, professional and institutional culture, skills and behaviours to assure quality and sustain improvement.
7. **Staying ahead,** by developing research, innovation and planning to provide progressive, high-quality care.

Note: Health Foundation A Clear Road Ahead (2016) developed this modified version of the NHS Quality Framework.

OUR JOURNEY TO OUTSTANDING #120

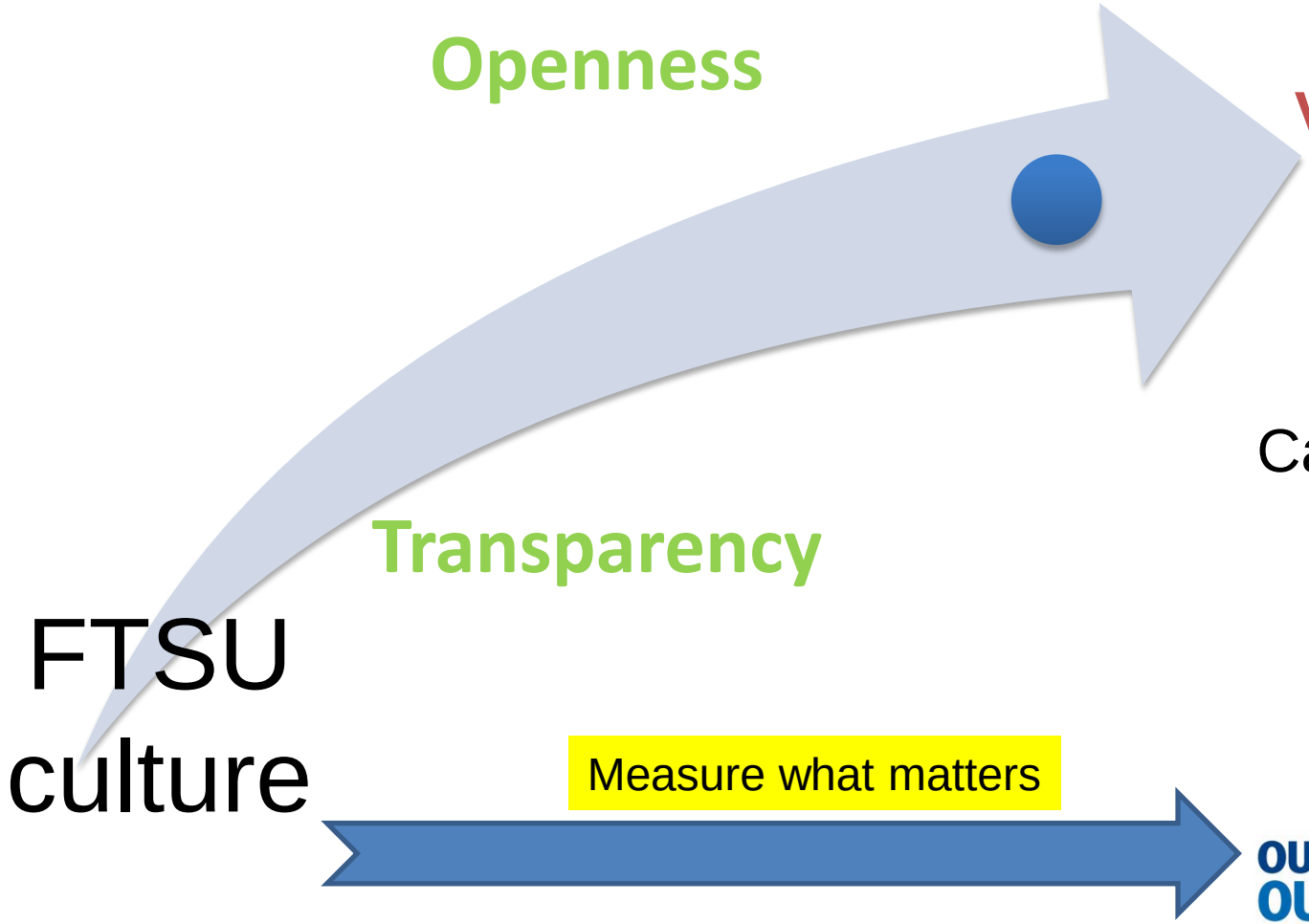
Step 1 – Setting direction and priorities for speaking up

Gloucestershire Hospitals NHS Foundation Trust

OUR JOURNEY TO OUTSTANDING

Outline strategy for FTSU

Gloucestershire Hospitals NHS Foundation Trust

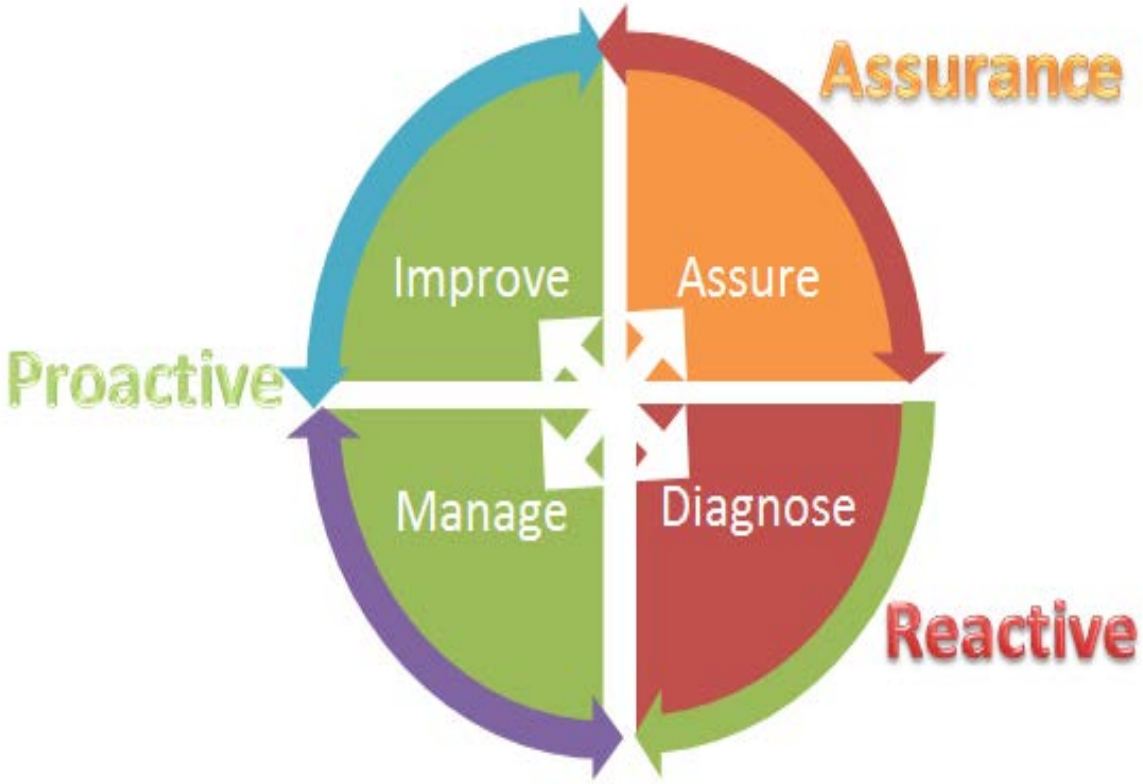


Caring, excelling, listening

OUR JOURNEY TO OUTSTANDING

Speaking up quality model

Gloucestershire Hospitals NHS Foundation Trust



OUR JOURNEY TO OUTSTANDING #120

Diagnose – where are we?

Gloucestershire Hospitals NHS Foundation Trust

- Are we people-centred?
- Are we focused on communication and connection?
- Are we COMMITTED to improving?

Staff survey 2017

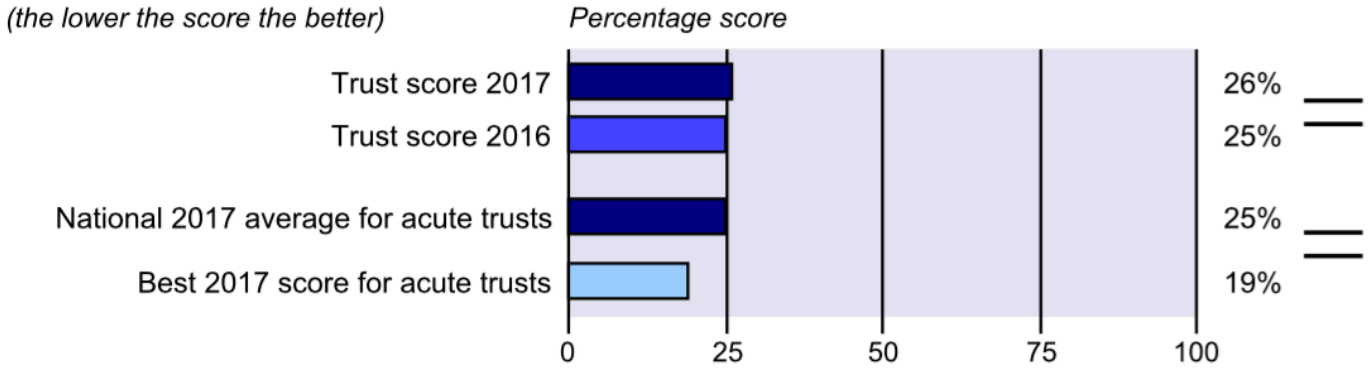
Gloucestershire Hospitals
NHS Foundation Trust

- There are 6 questions within the staff survey that measure our speaking up culture as an organisation.

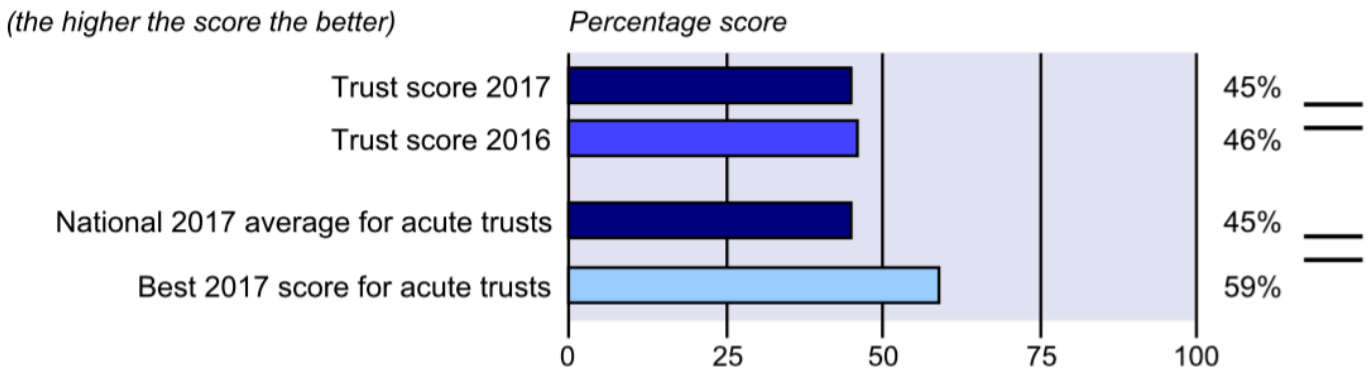
Our challenges - poor staff experience

Gloucestershire Hospitals NHS Foundation Trust

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



Our challenges – quality

Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	! Lowest (worst) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	! Lowest (worst) 20%
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	! Lowest (worst) 20%

What are our opportunities?

Gloucestershire Hospitals
NHS Foundation Trust

The Quality Improvement Aim (SMART)

Phase 1

To improve staff engagement in Speaking Up to the FTSUG by 100% by 31st March 2019.

OUR JOURNEY TO OUTSTANDING #J2O

The FTSU Improvement Team

Gloucestershire Hospitals NHS Foundation Trust

Speaking Up Steering Group Bi Monthly

- **Director of People and OD (Project Sponsor)**
- **FTSUG**
- **Director of Safety**
- **NED (Lead for Speaking Up)**
- **Head of Leadership and OD**
- **Representation from clinical areas**
- **Staff Side Representative**
- **HR Lead for Speaking Up**
- **Diversity Network (Chair)**
- **Staff Governor**

(Support from GSQIA)

OUR JOURNEY TO OUTSTANDING #120

Driver diagram – Speaking up

Gloucestershire Hospitals NHS Foundation Trust

Staff engagement

Aim statement – Increase the number of cases coming to the FTSUG by 50% by Nov 2018

Primary driver

Staff need to be able to talk about what is "bothering" them

Change ideas

Staff engagement

Measure what matters

OUR JOURNEY TO OUTSTANDING

“Speaking Up” Measures

Gloucestershire Hospitals NHS Foundation Trust

NHSI Leadership measures

- structured approach to FTSU
- knowledgeable about FTSU
- shape the speaking up culture
- clear about their role and responsibilities
- Receive assurance
- engage with staff
- focused on learning and continual improvement for speaking up

- **Outcome** – number of people coming to the FTSUG
- **Process** – reporting of incidents, use of Speak In Confidence
- **Balancing** – staff engagement score Staff Survey

Phase 1 FTSUG Change ideas

Gloucestershire Hospitals NHS Foundation Trust

- “Our BIG Conversation”
- FTSUG engagement for our strategy for speaking up

Change ideas

Gloucestershire Hospitals NHS Foundation Trust

Developing our resources

- FTSU Campaign materials
- # SpeakUpToMe posters
- Kitchen table events
- #SpeakUpToMe Twitter
- Speaking up intranet site updated
- Raising concerns video
- Speaking Up Policy
- Sessions for line managers
- FTSUG “Speak up Friday” – clinics
- # SpeakUpToMe email footer
- FTSU Survey (draft)

Baseline Data Year 1 2017/18

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Concerns	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of year
Number of people raised directly with the Freedom To Speak Up Guardian	3	1	4	23	31
Number of issues raised anonymously	2	1	1	0	4
Nature of issue					
· Patient quality issues	1	2	1	13	17
· Staff safety					0
· Behavioural / relationship	1				1
· Unacceptable behaviour (bullying / harassment)		1	2	16	19
· System issues	1				
Action	Yes	Yes	Yes	Yes	Support and advice
Outside referral	No	No	No	No	0
Detriment	1	0	0	0	1 case
Feedback "would they speak up again"	1 Yes	N/A as cases not closed	Yes	Yes	The majority of individuals would speak up again.

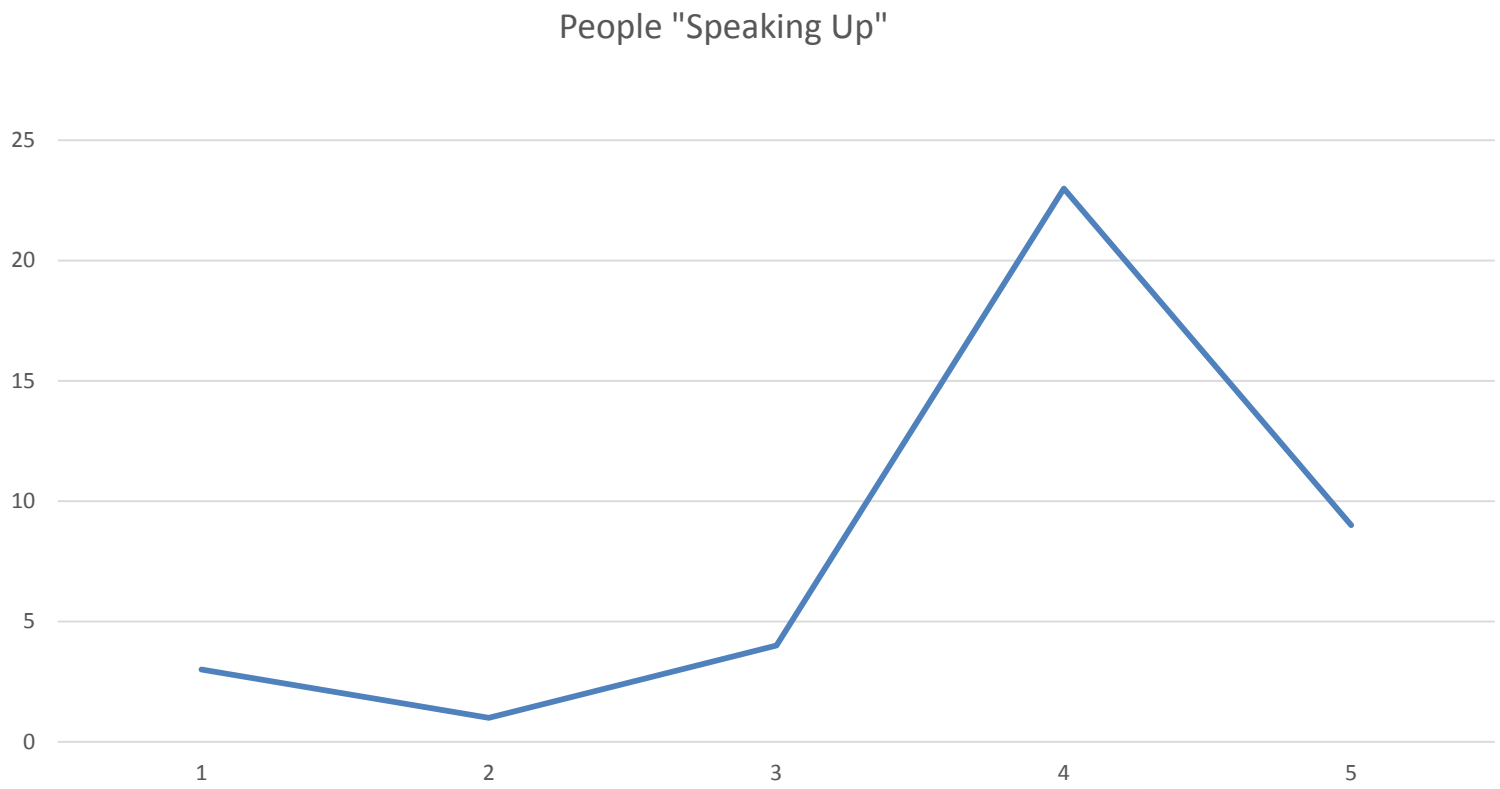
Year 2 Q1

Gloucestershire Hospitals NHS Foundation Trust

Concerns	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of year
Number of people raised directly with the Freedom To Speak Up Guardian	9				
Number of issues raised anonymously	9				
Nature of issue	4				
· Patient quality issues	1				
· Staff safety					
· Behavioural / relationship	3				
· Unacceptable behaviour (bullying / harassment)					
· System issues					
Action	Yes				
Outside referral	No				
Detriment	No				
Feedback "would they speak up again"	Yes				

Year 1 and year 2 Q1

Gloucestershire Hospitals NHS Foundation Trust



OUR JOURNEY TO OUTSTANDING #120

Speaking Up issues

Gloucestershire Hospitals NHS Foundation Trust

- Nursing posts
- Poor staff experience
- Support for parent both employed here
- Safety issue labs GRH

OUR JOURNEY TO OUTSTANDING #120

Gloucestershire Hospitals
NHS Foundation Trust

A case study

OUR JOURNEY TO OUTSTANDING #120

Key results - success for us

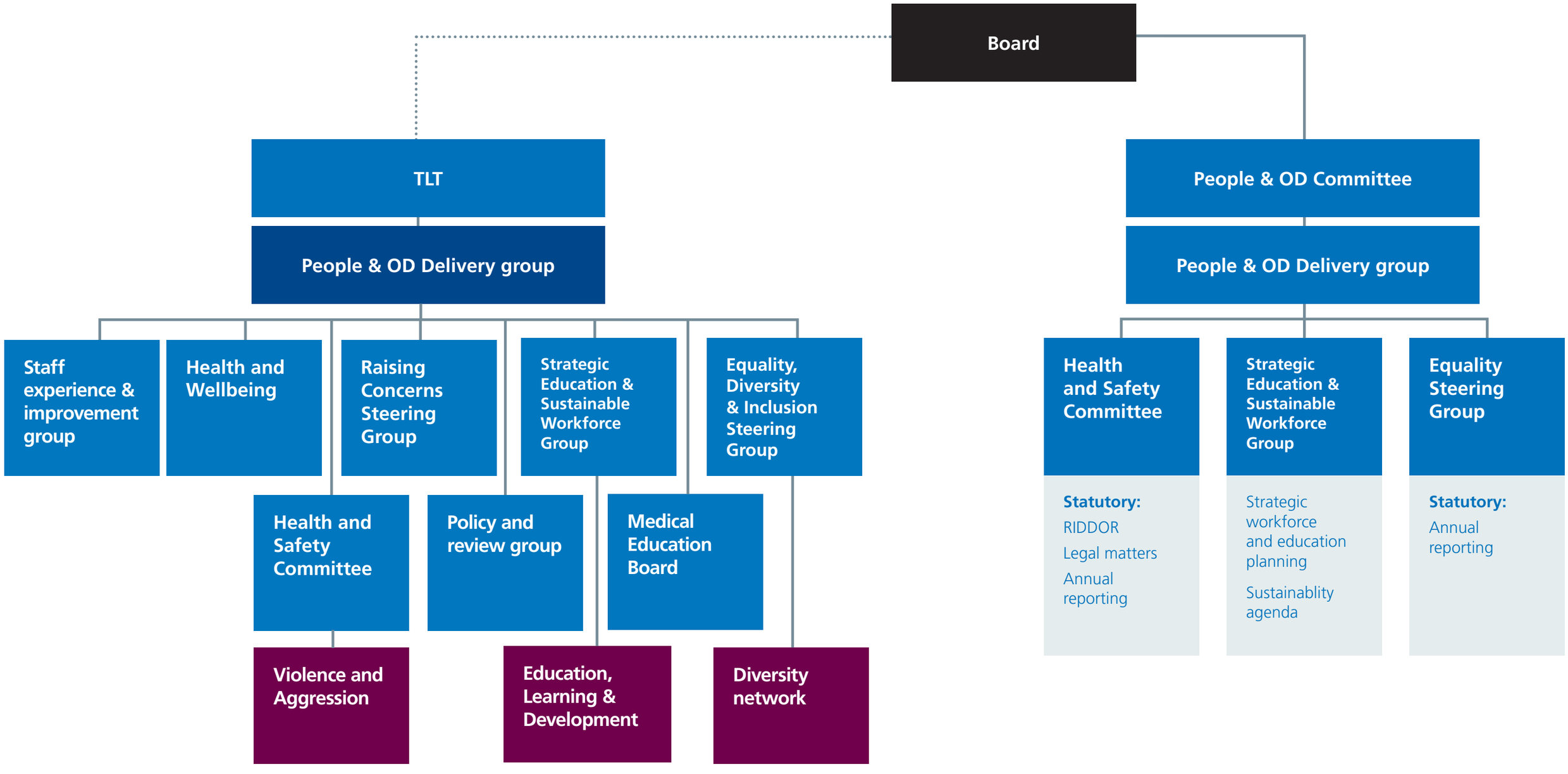
Gloucestershire Hospitals NHS Foundation Trust

We have a healthy speaking up culture as measured by our staff survey!

Next Steps

- Results of survey
- Strategy
- Phase 2 – Enabling the staff change ideas and continuing the engagement and reading the results of the FTSU survey
- Phase 3 – Line manager campaign with teaching and resources

People & OD Governance Structure



REPORT TO MAIN BOARD – NOVEMBER 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 18th September 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
Counter Fraud Update	Detailed report presented by the Head of Counter Fraud covering covering: - 18/19 work plan and progress to date - Mandatory training - National Fraud Initiative - NHS Counter Fraud Authority - Liaison with external partners - Policies - Fraud alerts - Current cases	With the drop in the number of referrals has the ratio to the number of investigations changed? What arrangements will be to commission Counter Fraud services for GMS? Will GMS activity increase group costs? What proportion of staff are reached/influenced by the team's awareness activity?	Cost will be appropriately recharged and no additional cost is expected	Date to be compiled for the next Committee. Director of Finance to follow-up with GMS management. Data to be compiled for the next Committee.

Internal Audit	Head of Internal Audit reported generally good progress with delivery of the 18/19 plan. Delay of fieldwork for the Infection Control and Patient Experience reports due to late scoping. Clarity sought on appropriate involvement of Non-Executives in report scoping. New approach to recommendation follow-up.	Why was a provisional status assigned to the Procurement report prior to the inclusion of the management response? Why the delay in scoping these two reports? How can NED involvement in scoping be achieved without undue bureaucracy/delay? Why are the recruitment and onboarding recommendations overdue?	This will not happen again. Deputy Chief Executive to expedite with the Director of Quality and Lead Nurse Process step agreed Completion dates moved to allow the establishment of the new recruitment team – recommendations being addressed.	
Committee Terms of Reference	Draft updated document reviewed incorporating Trust wide formatting/style improvements and specific output from previous committee self-assessment exercise.	Does the approach to non-executive attendance differ between committees? Should the document specify that one member must be financially qualified?	Yes – document will be amended to reflect this requirement including a definition of “financially qualified”	To be clarified.

Emergency Planning Progress Report	Written report providing an update of the status of work done and outstanding issues.	What is the best way of continuing oversight of this subject? When should the next audit be undertaken?	Current action plan being implemented with further review scheduled for January 2019.	Timing to be agreed subject to available audit days.
Information Governance - GDPR	Report on the status of the Trust's preparation for and compliance with the new requirements.	How does the Trust compare to other similar organisations? How can these requirements be embedded across the organisation and not dependent on the efforts of the Information Governance team? How will the Committee be assured of ongoing compliance and made aware of any breaches?	Similar performance with a continuing need to build evidence and documentation. Wide communication to staff has taken place and mandatory training includes all new requirements Annual report to the Committee. Breaches have to be reported to Quality & Performance and Main Board.	
Trust Risk Register	Update on the process and the link to the Board Assurance Framework.	Does the granularity of risks get lost as the high level summaries are compiled? Can the committee see the track of a risk from identification to mitigation?	Each risk has a Datix owner and is reviewed by the Risk Management Group.	Non-Executives to be invited to attend a Risk Management Group meeting.

Finance Director's Reports	Report on Losses and Compensations and Single Tender Actions.	Has the issue that lead to writing off patient transport invoices been addressed? What learning has taken place and what controls are used in relation to recovering costs from overseas patients?	Yes – a new process in in place. The Trust is working with NHSI to ensure best practice is in place.	Out of Hours activity is a challenging area to ensure charging criteria are correctly identified.
GMS Audit Arrangements	Update on proposed audit arrangements by the GMS Interim Finance Director.	Will the proposed arrangements increase Group costs?	Costs associated with the formation of the subsidiary were expected and included in the financial plan and subsequent detailed budgets.	

Rob Graves
Chair of Audit and Assurance Committee
September 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – NOVEMBER 2018

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

This report describes the business conducted at the GMS Committee held 10th September 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	The variation process needs to be reviewed and updated.	How to be more efficient and reduce the volume of variation requests. How to assure that the variation process is effective.	Make sure that we focus on the high risk, high value variations.	Ensuring that a more efficient and effective process is signed off by the Trust.
Chief Operating Officer's Report	There is a pipe failure in the women's wing.	To understand how widespread this issue might be, given that it was the subject of a NHS Improvement advisory.	GMS advise the pipe that failed was due to a specific metallurgy and while similar pipe is installed elsewhere, there is no evidence of leak or failure.	Need to review the pipes as part of a wider condition survey.

Remediation Plans	Recovery plans for cleaning at GRH, catering and Central Sterile Services Department (CSSD) Trust-wide were reviewed.		The Chief Operating Officer (COO) confirmed that the cleaning and CSSD plans are fully approved, while the catering plan is still under review. Actions within each plan are being monitored by the Trust Contract Manager and COO.	Catering plan approval to be monitored.
GMS Governance Arrangements	Transition period to be extended to end of November 2018.	Policy issues that would have gone to GMS Board will instead have to come to GMS Committee. Arrangements for GMS assurance and risks remain to be resolved.	Revised arrangements to come to GMS Committee in October 2018.	
GMS Business Plan Updated Year 1	The final draft plan was submitted for approval.	Assurance sought that the plan addresses the benefits and deliverables contained in the original business case.	The actions and deliverables contained in the plan will be reviewed by the Committee on an ongoing basis.	

REPORT TO MAIN BOARD – OCTOBER 2018

From Gloucestershire Managed Services (GMS) Committee Chair – Mike Napier, Non-Executive Director

This report describes the business conducted at the GMS Committee held 9th October 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters Arising	Compliance report with respect to health and safety regulations.	The Committee is looking for assurance that GMS have the competencies and capacity to meet all statuary obligations on behalf of the Trust.	To be presented at the next meeting.	
GMS Chair's Report	New staffs terms and conditions implemented.	Have the terms and conditions had a positive impact on recruitment? Currently too early to have definitive data.	GMS to revert to committee at a later date.	Formal review to come back to Committee.

GMS Managing Director's report	Key Performance Indicators (KPI) summary. Variations to contract. Service Reconfiguration.	Some metrics are still to be finalised. Large volume of variation requests putting admin pressure on GMS and Trust. There needs to be a clear and compelling business case for the organisational changes being developed.		Requirement to finalise outstanding KPIs. Need to agree an effective variation process A business case document for the change to be presented to Committee.
Chief Operating Officer's Report	Cleaning performance.	There is an ongoing conservative focus on improving cleaning outcomes. GMS KPIs are green/amber against current Trust standards. There is a need to re-calibrate against the NHS National Standards.	Existing cleaning action plan and GMS KPIs.	
Regulatory Compliance Report	GMS risk log.	GMS risks presented as a work in progress and comprise risks from the perspective of GMS, which differ from the risk log presented by the Trust Chief Operating Officer.		Staff work is required to reconcile the respective risks as they relate to GMS and Trust strategic objectives.

Proposed revisions to the Committee Terms of Reference & the Schedule of Matters Reserved and Delegated	Proposal to expand the scope of the Committee to provide scrutiny and assurance over the Trust's estate strategy and sites capital programme.	Need to ensure interface with Finance Committee is fully addressed.		Terms of Reference to be finalised and presented to November's Trust Bard meeting.

MAIN BOARD – NOVEMBER 2017 2018
Lecture Hall, Redwood Education Centre commencing at 09:00

Report Title
Trust Statement on Modern Slavery
Sponsor and Author(s)
Author: Dan Corfield, Head of Business Development and Planning Sponsor: Simon Lanceley, Director of Strategy and Transformation Lukasz Bohdan, Director of Corporate Governance
Executive Summary
There is a mandatory requirement for the Trust to have a public statement by the Board on our recognition of and work towards compliance with the Modern Slavery Act (2015). The statement is meant to be all-encompassing though not exhaustive in its detail, referencing all areas of stakeholder interest. The need for this became apparent in September 2018 whilst preparing materials for the NHS England Specialised Commissioning Bid. At that time a draft statement was written and approved in principle by the Chief Executive Officer, and published on the Trust website; however it requires formal Board approval as per (6)A(a) of the Act. The statement must be updated each financial year to reflect the organisations' ongoing commitment to its aims and requirements.
Recommendations
It recommended that the drafted statement is approved formally by the Trust Board, and the website updated accordingly to reflect this. It is also recommended that the annual updating of statement be added to Corporate Governance operating schedule/work plan. The Trust should consider cascading this statement via This Week and Outline. The statement will also be included within every tender exercise through Procurement or other departments.
Impact Upon Strategic Objectives
The Trust's compliance with the Modern Slavery Act, and a public statement as such, supports good governance and, in turn, delivery of the Trust's Strategic Objectives.
Impact Upon Corporate Risks
Not applicable.
Regulatory and/or Legal Implications
Failure to make and update the statement would place the Trust in breach of the Modern Slavery Act 2015
Equality & Patient Impact
Applicable to the extent of providing public, patient and staff assurance about the Trust's practices.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees						
n/a						

MAIN BOARD - NOVEMBER 2018

TRUST STATEMENT ON MODERN SLAVERY

1 Purpose of Report

1.1 There is a mandatory requirement for the Trust to have a public statement by the Board on our recognition of and work towards compliance with the Modern Slavery Act (2015). The statement is meant to be all-encompassing though not exhaustive in its detail, referencing all areas of stakeholder interest.

1.2 The need for this became apparent in September 2018 whilst preparing materials for the NHS England Specialised Commissioning Bid. At that time a draft statement was written and approved in principle by the Chief Executive Officer, and published on the Trust website (https://www.gloshospitals.nhs.uk/about-us/our-trust/modern-slavery/); however it requires formal Board approval as per (6)A(a) of the Act.

1.3 The statement must be updated each financial year to reflect the organisations' ongoing commitment to its aims and requirements.

2 Statement

We fully support the Government's objectives to eradicate modern slavery and human trafficking

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Trust (GHNHSFT) fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

Slavery and human trafficking statement for financial year 2017/18

In the last financial year we have taken the following steps to ensure that slavery and human trafficking is not taking place:

- We confirm the identities of all new employees and their right to work in the United Kingdom
- All staff are appointed subject to references, health checks, immigration checks and identity checks. This ensures that we can be confident, before staff commence, that its staff have a legal right to work within our Trust
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage from 1 April 2015
- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation

- Our equality and diversity, grievance, respect and dignity at work for staff policies additionally give a platform for our employees to raise concerns about poor working practices
- Our policies and practices promote and support diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities and in 2017 we established our Diversity Network for all staff
- Our mandatory safeguarding training includes modern slavery as a topic; all clinical staff receive training as part of our Trust bespoke level 2 safeguarding adult e-learning training and also level 3 safeguarding adult training
- Our Trust Safeguarding Adult at Risk Policy, and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites
- Our Freedom to Speak: Raising Concerns (Whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to staff
- Our standard terms and conditions require suppliers to comply with relevant legislation. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts also require suppliers to comply with relevant legislation

Review of effectiveness

We intend to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly within supply chains. We aim to:

- Support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working at our Trust can have in keeping present and potential future victims of modern slavery and human trafficking safe
- Ensure that all staff continue to have access to training on modern slavery and human trafficking which will provide the latest information and the skills to deal with it
- Embed Social Value best practice into commercial processes which will achieve improved Social Value awareness and compliance across all our commercial activities
- Impact assess all new or reviewed policies for diversity and inclusion compliance
- Further explore, through our Safeguarding Adult Operational Group, how to further target staff in key areas such as the Emergency Department (A&E), Women and Children's Division, vulnerable pregnant women and pregnancy termination clinics

Approved by the Trust Board 8th November 2018

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and applies to GHNHSFT

3 Recommendation

The Board is asked to formally **APPROVE** the statement and subsequent update to the public website, and to have its annual update included in the working schedule of the Corporate Governance Directorate

Author: **Dan Corfield, Head of Business Development and Planning**
Presenting Director: **Lukasz Bohdan, Director of Corporate Governance**
Date 08/11/2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Respective Roles of the Chair and Chief Executive
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary
Purpose The NHS Foundation Trust Code of Governance (clause A.2.1) states that the division of responsibilities between the Trust Chair and the Chief Executive should be clearly established, set out in writing and agreed by the Board of Directors. This document, adopted by the Board of Directors, sets out the respective roles of the Trust Chair and the Chief Executive and describes the hallmarks of a good working relationship between the holders of the two posts
Recommendations
That the Board note the document.
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**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees						
N/A						

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST CHIEF EXECUTIVE AND TRUST CHAIR – RESPECTIVE ROLES

1. INTRODUCTION

The NHS Foundation Trust Code of Governance (clause A.2.1) states that the division of responsibilities between the Trust Chair and the Chief Executive should be clearly established, set out in writing and agreed by the Board of Directors.

This document, adopted by the Board of Directors, sets out the respective roles of the Trust Chair and the Chief Executive and describes the hallmarks of a good working relationship between the holders of the two posts.

2. RESPECTIVE ROLES

Trust Chair	Chief Executive
Reports to the Board of Directors and is accountable to the Council of Governors for the performance of the Board of Directors	Reports to the Trust Chair and to the Board of Directors
Ensures effective operation of the Board of Directors and Council of Governors	Responsible the running of the NHS Foundation Trust's business
Ensures that the Board of Directors as a whole plays a full part in the development and determination of the NHS Foundation Trust's strategy and overall objectives, having regard to the views of the Council of Governors	Responsible for proposing and developing, in consultation with the Board of Directors, the NHS Foundation Trust's strategy and overall objectives. Once agreed, responsible for their implementation, putting appropriate resources and risk management systems in place
Is guardian of the Board of Directors' decision-making processes	Implements the decisions of the Board of Directors and its Committees
Leads the Board of Directors and presides over and leads the Council of Governors	Ensures the provision of information and support to the Board of Directors and Council of Governors
Ensures the Board of Directors and Council of Governors work together	Facilitates and supports effective joint working between individual members of the Board of Directors
Leads the development of the Board of Directors	Responsible for the management and performance of individual Executive Directors

Maintaining a good relationship between the Chair and the Chief Executive

The Healthy NHS Board 2013 Principles for Good Governance sets out some advice for maintaining a good relationship between the Chair and the Chief Executive:

DOs

- Be honest and open
- Communicate well
- Agreeing and review clearly defined working styles and roles
- Establish trust
- Build a personal relationship
- Develop shared values
- Promote, and operate, according to a 'no surprises' culture

DON'Ts

Chairs should NOT...	Chief Executives should NOT...
Be too operational, interfere with details of management	Be too controlling or autocratic towards the chair
Be remote from the organisation and unknown by the majority of staff	Obstruct the Chair's access to observing services being delivered in any part of the organisation at any time
Exceed part time hours	Get too involved in NED or Chair role - e.g. no consultation on board agendas, or personally shaping them
Take specific strategic decisions alone	Break the fundamental rule of 'no surprises'
Adopt bullying, macho 'hire and fire' culture	Be too entrenched in the organisation

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Review of Committee Terms of Reference and related documents
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance & Cecilia Price, Corporate Governance Graduate Trainee Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary
Purpose To update the Board on the review of Committee Terms of Reference and related documents. Key issues For Information • Undertaking periodic review of the Committee Terms of Reference is considered good practice. Individual Committees are currently reviewing their Terms of Reference and will complete this work in the November/December meeting cycle. • In parallel, following the revisions to the Trust Constitution, the Trust is reviewing its Standing Orders, Standing Financial Instruction and the Scheme of Delegation • Work is under way to align the individual document and ensure there are no gaps or overlaps • The Audit and Assurance Committee will receive a further update on the review at its November meeting. Implications and Future Action Required A suite of the revised governance documents will be presented to Board for approval in January 2019.
Recommendations
That the Board note the update for information.
Impact Upon Strategic Objectives
Not applicable.
Impact Upon Corporate Risks
Not applicable.
Regulatory and/or Legal Implications
Not applicable.
Equality & Patient Impact
Not applicable.

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 and Performance Committee	**Finance and Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**GMS Committee**

Outcome of discussion when presented to previous Committees
N/A

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

Report Title
One Place Programme Update
Sponsor and Author(s)
Authors: Jo Underwood, Transformation Programme Director Sponsor: Simon Lanceley, Director of Strategy and Transformation
Executive Summary

Purpose

The One Place Outline Business Case was due to be presented to the Trust Board for decision in November but was not approved by the ICS Delivery Board in October. This paper provides a briefing on the revised plan, and what the Trust is putting in place to deliver it.

Key issues to note

- The One Place Business Case has been delayed, which will allow the Trust time to engage more widely on Centres of Excellence proposals and model the impact to OBC level.
- The "care in hospital" model is now the major focus for the One Place Programme.
- A Centres of Excellence Programme Director is in post to oversee the work required to deliver a CoEx model of care and business case materials, and to prepare the Trust for public consultation.
- The timescale is pending agreement by the ICS Delivery Board but the aim is to go out to public consultation during autumn 2019.

Conclusions

The One Place pause offers the Trust a valuable opportunity to further develop the Centres of Excellence thinking internally, with primary and community care partners, and with patients and the public. The process and resulting material for the OBC should ensure we are better prepared for public consultation.

Implications and Future Action Required

- Meetings planned with HOSC to explain reasons for the delay and ask to continue the T&O and Gastroenterology pilots, and launch General Surgery reconfiguration as a pilot before Winter 19/20.
- Delivery of the programme plan will require clinical, project management, finance, HR and patient engagement resources as well as support from the clinical divisions. Not all of these resources are allocated yet and this will be managed through the Centres of Excellence Delivery Group, escalating through TLT as required.

Programme Proposal

The Centres of Excellence Delivery Group will organise delivery of two products over the next 7 months:

- A clinical model for the Unscheduled Care and Scheduled/Planned Care Centres of Excellence
- Material for the One Place Outline Business Case

The delivery programme will incorporate the following workstreams:

Modelling – finance, activity, resource and workforce modelling, business case development and benefits capture
Model of Care – engagement with clinical specialties, system partners, patients and the public on the

clinical model for the Unscheduled and Scheduled Care Centres of Excellence
Testing – oversight of relevant 'Test and Learn' and pilot projects to ensure alignment with the programme vision and capture of benefits/learning
Evidence and evaluation – collection and consideration of academic evidence, insight from other systems, clinical peer support and challenge, EIA and QIA
Programme management – programme planning, documentation, communications, reporting and alignment with ICS.
This workstream will also support preparation for public consultation and prepare an outline delivery plan subject to the outcome of consultation.

The high-level draft timeline is as follows (this is subject to ICS Delivery Board approval):

Oct 2018 – scope and initiate (Testing workstream already in place)
Nov 2018 – secure additional resources and begin Modelling and Model of Care workstreams
Jan 2018 – begin Evidence & Evaluation workstream
Feb/Mar 2019 – events to present and gain feedback on the proposed model(s), options appraisal
Apr 2019 – Draft OBC for comment
May/June 2019 – Final OBC for governance, develop consultation materials and outline delivery plan
Sep/Oct 2019 – Public Consultation
April 2020 – Begin delivery programme (subject to outcomes of consultation)

The Centres of Excellence Delivery Group provides monthly Programme Progress Reports to TLT.

Impact Upon Strategic Objectives

Delivery of Centres of Excellence is a key component of both the Trust and the ICS strategy.

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

Impact Upon Corporate Risks

Having a programme delivery structure in place will ensure delivery against a key organisational objective.

Regulatory and/or Legal Implications

Compliance with statutory duty to consult.

Equality & Patient Impact

Full EIA and QIA to be carried out as part of the programme, informed by patient and public involvement.

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 & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					3/10/18 (update)	
Outcome of discussion when presented to previous Committees						

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

Report Title
TrakCare Recovery Progress Report
Sponsor and Author(s)
Author: Leah Carey, Digital Transformation Lead, Trakcare Recovery Sponsor: Mark Hutchinson, Chief Digital and Information Officer
Executive Summary

Purpose

To provide assurance to the Board, from the Trak Care Recovery Programme, on the current position of the recovery Programme.

Key issues to note

- Significant progress made with DQ issues down to less then 130,000
- External company (Populo) continue to validate at a good rate
- Progress in optimising functionality for Theatres continues and good progress is being made
- 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.
- Return to RTT plan continues and remains the priority area of attention for the recovery programme. This has been co-designed and is being co-delivered by operational colleagues and Trak Care project team.

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.
- The current time frame, between now and the beginning of January is a critical time period

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)**

Outcome of discussion when presented to previous Committees
Update noted

TRUST BOARD – NOVEMBER 2018

TRAKCARE RECOVERY PROGRESS REPORT

1. PURPOSE

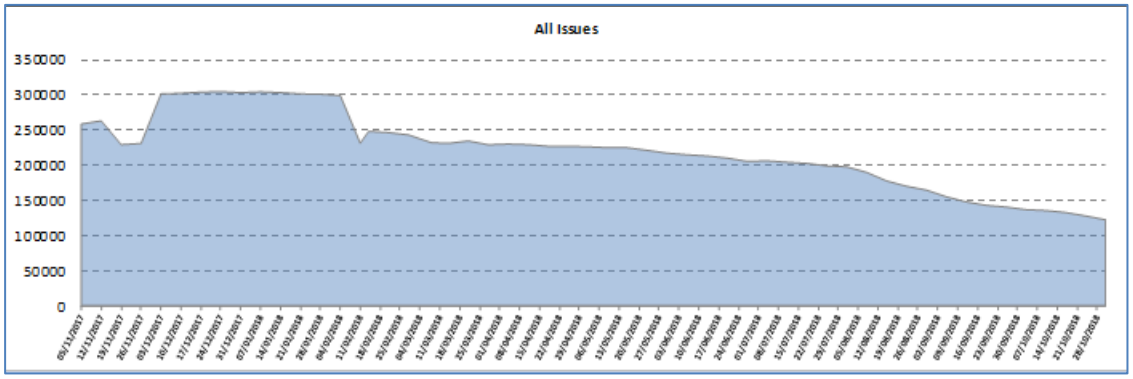
This report provides an update on the progress of the recovery programme following the implementation of TrakCare in December 2016.

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

2. OVERALL DATA QUALITY ISSUES

	03/10/2018	10/10/2018	17/10/2018	24/10/2018	31/10/2018
Recency	137113	135802	132920	127984	122619

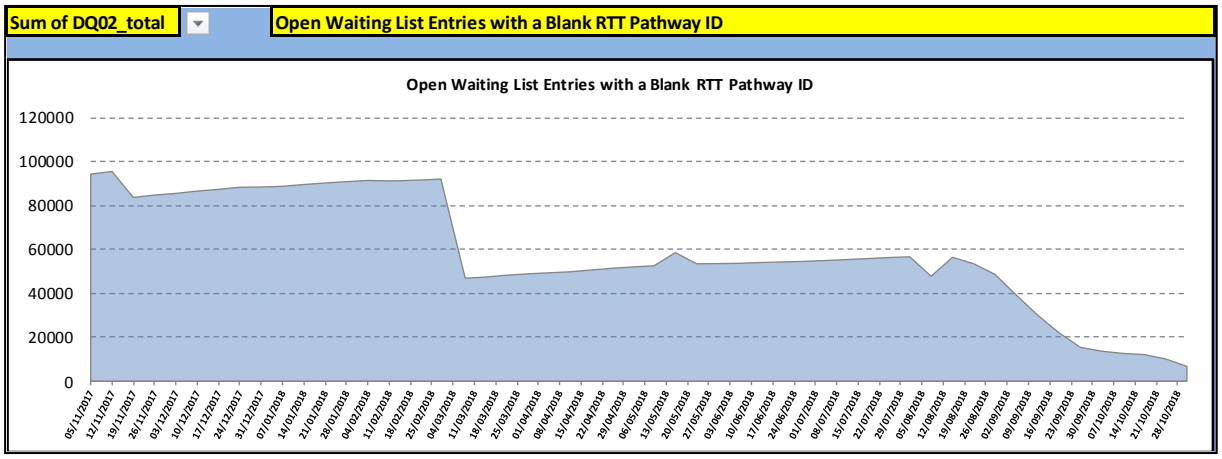


3. EXAMPLE OF NET CHANGE WEEKLY IN DQ INDICATORS- OCT SNAPSHOT

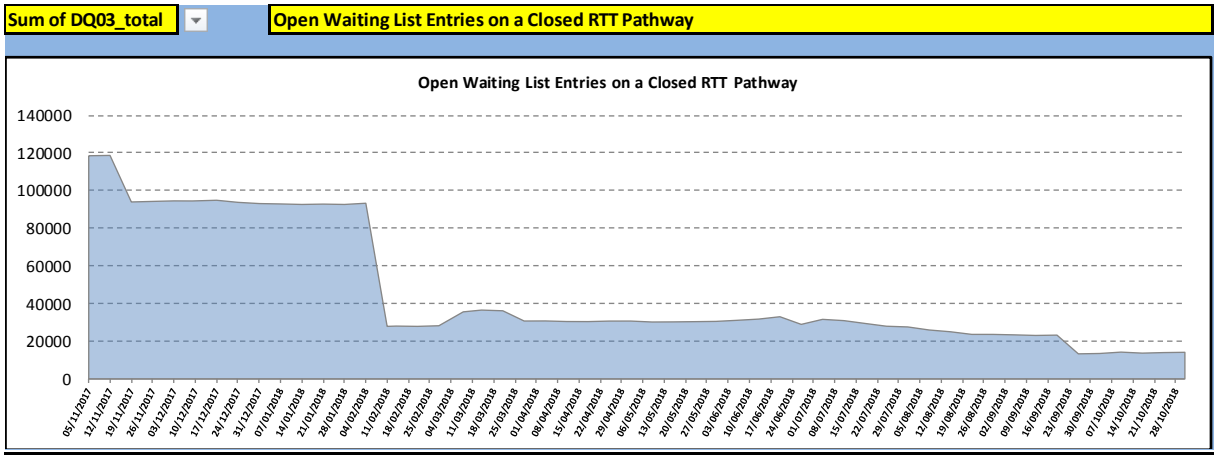
Vol Change in week	DQ	Number of New Records:
71	1.	Elective Planned Waiting List Entry on an Open RTT Pathway
-3355	2.	Open Waiting List Entries with a Blank RTT Pathway ID
-521	3.	Open Waiting List Entries on a Closed RTT Pathway
-149	4.	Planned Elective OR Return Outpatient Waiting List Entries with No Recall Date
-252	5.	Open Waiting List Entries with past activity and No Future Activity Booked
-5	6.	DNA Discharges
-2364	7.	Planned Elective Waiting List Entries with No Previous Elective Admission
11	8.	Open Inpatient Waiting List Entries with cancellations that should be closed
-3	9.	Open Outpatient Waiting List Entries that should be closed due to a Cancellation Reason
-1	10a.	Open Return Outpatient Waiting List Entries where the Last Activity is Inpatients - (Exact Match)
23	10b.	Open Return Outpatient Waiting List Entries where the Last Activity is Inpatients - (Potential Match)
-68	11.	Open RTT Pathways where the last activity was cancelled or the patient was removed from waiting list
-233	12.	Total Duplicate RTT Pathways
582	13.	Total Duplicate Waiting List Entries
-117	13.1	Open new OPWL with any past Waiting List Entry Type against the same pathway with same or different Treatment Function
-30	14.	Open Waiting List Entries which have multiple booked appointments or TCI's
0	15.	Deceased Patients with Open Waiting List Entries or on an Open RTT Pathway
209	16.	New Outpatient Waiting Lists with no clinician assigned
-18	17.	Waiting List Entries that have a vetting outcome of rejected
0	18.	Inpatient Waiting Lists with a blank waiting list admission type
-44	19.	Outpatient Outcome of "Refer to different Department/Consultant- for same condition" but no new referral details added
0	20.	Open Waiting Lists with a blank waiting list type
-101	21.	Open Waiting Lists where the activity has been booked on a previous episode
65	22.	Open Waiting Lists with DQ issues that have ERS appointments

4. RTT INDICATOR FOR RTT REPORTING

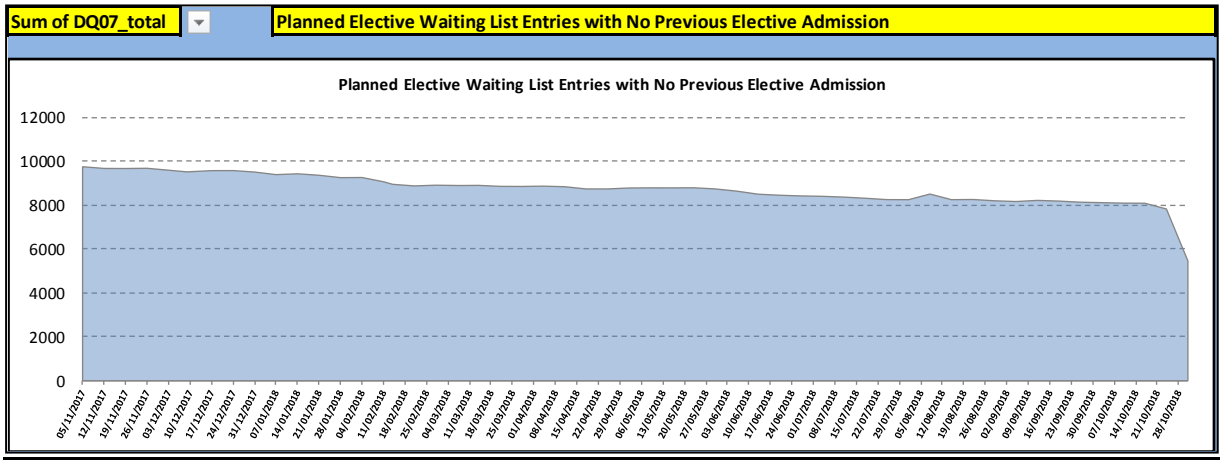
DQ2- 6801



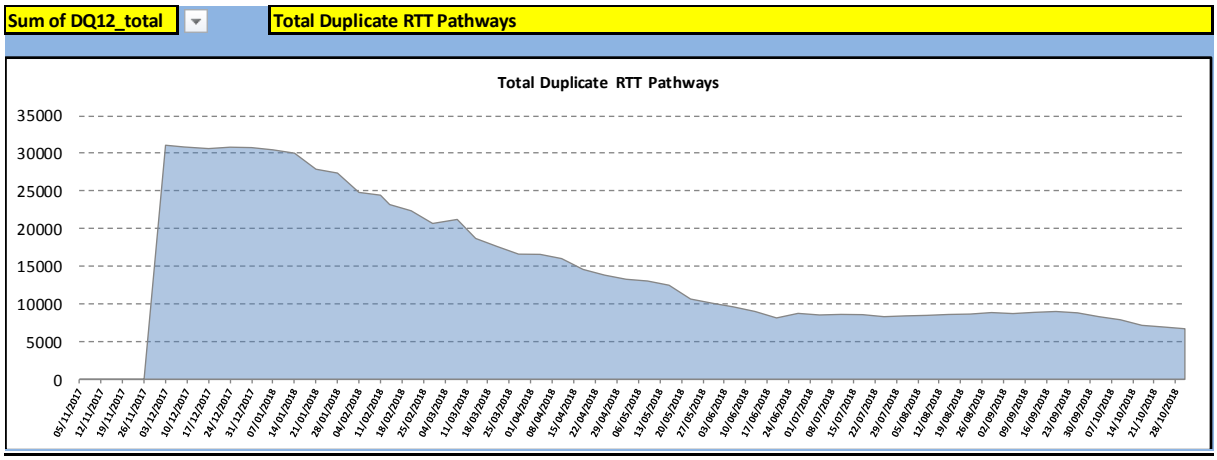
DQ3- 14,149



DQ7- 5,456



DQ12- 6,723



5. VALIDATION HIGHLIGHTS

The overall DQ Issues log continues to decrease and downward trend. With the four indicators (DQ2, DQ3, DQ7 and DQ12) that directly impact on the trust's ability to report on RTT, being focused on overall issues has decreased by over 20,000 in the last four weeks. The third party company GHFT are using to assist validate continue to make excellent progress mass validating the indicators that they are able to, allowing operational validation teams to concentrate on the indicators that require specialty expertise.

Operational Teams and TrakCare teams continue to work closely together in an approach that will continue to improve the trusts processes and enable the improved quality of data quality from here on in.

6. VETTING

The vetting project sees the rationalisation of vetting outcomes that were built at go-live into a more manageable and pragmatic list. This has to be done specialty by specialty and the first few target areas are now nearing completion. The process has proved very popular with the clinicians and has provided the team with an opportunity to engage clinicians and update them on the work of the Trak Recovery Team. The project will now move over and follow the same process in other priority specialties. There may come a point that once specialties that are creating the most DQ issues around the vetting process have been reviewed that this sub project is paused to divert resources into other areas of Trak Recovery. However the plan at this stage is that operational staff and clinicians will have the process shared with them so that they can take it forward as part of their BAU service review should they feel able- otherwise they will be reviewed post Trak Recovery.

7. MATERNITY

The first Intersystems English Edition Maternity Review has taken place with representatives from the trust playing main roles in relaying the progress that we have made to improve Trak Cares ability to function for the Maternity teams at GHFT. Many of our changes have now been shared and the plan is for them to be adopted and rolled out in other sites. Final testing for the remaining small configuration

changes is nearly complete with the view that these can then be communicated and delivered into the live system. Feedback from the Maternity staff following the hardware walkabout has also been positive reminding us that we must ensure staff have the ability to use the digital solutions that we are working so hard to deliver for them.

8. THEATRES

Following last month's paper that clearly identified the need for an intense Theatre review to take place the project team and Intersystems have been working closely with operational colleagues to optimise the system that we have. Sadly and similarly to other lessons that we have learnt post implementation it would seem that the way constructed Trak Care for theatres was sub optimal and there are a huge amount of things that can progressed and improved locally. For example the availability of reports on the same day to improve data entry, the build and set up of the theatre schedule to allow for the swopping and changing of schedules more easily and the identification of staff within theatres. Huge progress has been made with the design and agreement of the pre assessment workflow which was not delivered as part of implementation but has since been identified as a high priority enabler of work. The Trak team and operational team have designed the process and workflow that it will work smoothly in TrakCare. We are now planning the configuration, testing and training of this new workflow which will improve the process to ensure that the right people are offered the right level of pre assessment at the appropriate time before their surgery.

9. RETURN TO RTT

There is an absolute focus on return to RTT for the TrakCare Recovery Team. The four DQ indicators that have the biggest impact on RTT reporting are being heavily scrutinised with regards to any new issues that are being created, and of course validated to remove the data quality issues altogether.

In terms of the process there is significant re-design of the end to end process including a re-write and review of the logic the trust applies to RTT reporting, who does what, at what point and how. Summary reports are in the process of being redesigned to allow validation teams the ability to easily access, understand and validate information. As well as this a validation tool is being built to allow validation of large numbers of data to happen consistently reducing the risk of human error.

A group from GHFT visited Yeovil in October; where North Devon were also present, to review the RTT reporting process. Both of these trusts are successfully reporting their RTT performance since go live of Trak Care and it was deemed an opportunity to learn lessons on approach and methodology used to allow our transition back to reporting following the go live of Trak Care. Representatives from operations, business intelligence and the project team attended and were clearly assured that the approach and methods that we are undertaking are the right way to do things. Both trusts did however acknowledge that the trusts operational staff have had to increase their operational validation by more than 50% following the implementation of Trak Care. This mirrors our experience and the greatest risk and consideration for us is that we are a significantly bigger trust. The team are still committed to returning back to RTT reporting as long as the following criteria are met:

- Built and tested validation tool that is in use within the operational teams

- Successful end to end test of the process of validation, including internal shadow reporting with at least two full cycles of shadow reporting to assure process and ensure accuracy
- Board assured level of DQ issues
- PTL (Outpatients/ Inpatients) – which includes review of script logic and comparison to other Trusts and with support from IST where necessary.

10. 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.

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

Report Title
Guardian for Safe Working – Quarterly Report
Sponsor and Author(s)
Authors: Dr Simon Pirie, Guardian for Safe Working Sponsor: Dr Sean Elyan, Medical Director
Executive Summary
Purpose This report covers the period of 1.5.18-31.7.18 Key issues to note There were 103 exception reports logged There are a total of 8 fines to the value of £2631.21. No correlation with Datix clinical incident reports for this period. Conclusions The number of exceptions has clearly fallen for this quarter, as has the amount of fines levied. This is encouraging, but we need to ensure continued engagement of trainees to allow for accurate interpretation of the data. 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 & Digital Committee**	**Audit & Assurance Committee**	**People and OD 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 – NOVEMBER 2018

QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

1. Executive Summary

1.1 This report covers the period of 1.5.18 – 31.7.18. There were 103 exception reports logged; compared to 217 in the last quarter. This represents quite a significant reduction in exception report numbers.

1.2 We have again needed to levy some fines. These are detailed below; there are a total of 8 fines to the value of £2631.21. The Junior Doctor's forum is fully functioning and meets quarterly. Dr Roelofs is stepping down as JDF Chair and Dr Gio Sheiybani is taking over from 1st September.

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.

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

High level data

Number of doctors / dentists in training (total):	511
Number of doctors / dentists in training on 2016 TCS:	511
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)

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST 1-2**	**ST3-8**	**Additional training and trust grade vacancies**
ED			2	0.2	
Oncology			1		
T&O			2		
Surgery			1	4	
General Medicine			16	10	
Paeds				4	
Obs & Gynae				1	

4. Locum Bookings

4.1 Data from finance team:

Total spend May-July 2018 on Junior Medical Locum **£751,324**.

5. Exception Reports (working hours)

Exception reports by Department		
Specialty	**Exceptions carried over from last report**	**Exceptions raised**
General/GI Surgery		8
Urology		
Trauma/ Ortho		6
ENT		
Vascular Surgery		
Ophthalmology		1
Orthogeriatrics		
General/old age Medicine		74
Acute medicine/ ACUA		7
Emergency Department		
Obstetrics and Gynaecology		7
Paediatrics		
Total		**103**

6. Fines this Quarter

Fine by Department				
Rota cycle	**Department**	**Hours**	**Fine**	**When levied**
2.4.18-28.5.18	Neuro	51	**1020.70**	Aug-18
4.6.18-30.7.18	Neuro	50.4	**811.19**	Aug-18
2.4.18-6.8.18	Neuro/Rheum	48.3	61.28	Aug-18
2.4.18-28.5.18	Gastro	49.6	551.52	Aug-18
4.6.18-30.7.18	Gastro	48.2	51.32	Aug-18
2.4.18-6.8.18	Gastro	48.2	29.87	Aug-18
2.4.18-28.5.18	GOAM	48.08	28.73	Aug-18
4.6.18-30.7.18	GOAM	48.22	76.60	Aug-18
TOTAL:		**392**	**2631.21**	

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
12024.31	2631.21	600	14055.52

7. Issues Arising

7.1 Two 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 plans made to address the issue. No record of harm to patients was noted.

7.2 There have been some isolated issues with General Practice; some work schedules have been non-compliant and have required a lot of work to negotiate change. This is challenging, because there are so many different practices with differing work pattern requirements.

7.3 Meetings have been held with GP representatives and medical staffing and resolution achieved. However, moving forward, further work with GP deanery and practices will be needed to avoid future issues.

8. Actions Taken to Resolve Issues

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

9. Qualitative Information

9.1 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. Requests have been made for system updates, but Allocate have not provided these as yet.

10. Correlations to Clinical Incident Reporting

10.1 At the last Executive Board meeting, the question was raised as to whether we could see if there was correlation between the timing of exception reporting and clinical incident reports being completed.

10.2 During the period reviewed, there were 9 incident reports relating to staff shortages. I could not see any exception reports that appeared to be directly related to these incident reports.

11. Summary

11.1 A total of 103 working hours exception reports have been made since the beginning of May 2018 – end July 2018. The number of reports is significantly reduced as compared to the last quarter. We are still trying to collect data on specific specialties so that we can better monitor performance and the effectiveness of changes when made to report numbers.

Author: **Dr Simon Pirie, Guardian of Safe Working Hours**
Presenting Director: **Dr Sean Elyan**
Date 28/10/2018

Recommendation

- To endorse
- To approve

Appendices

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

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

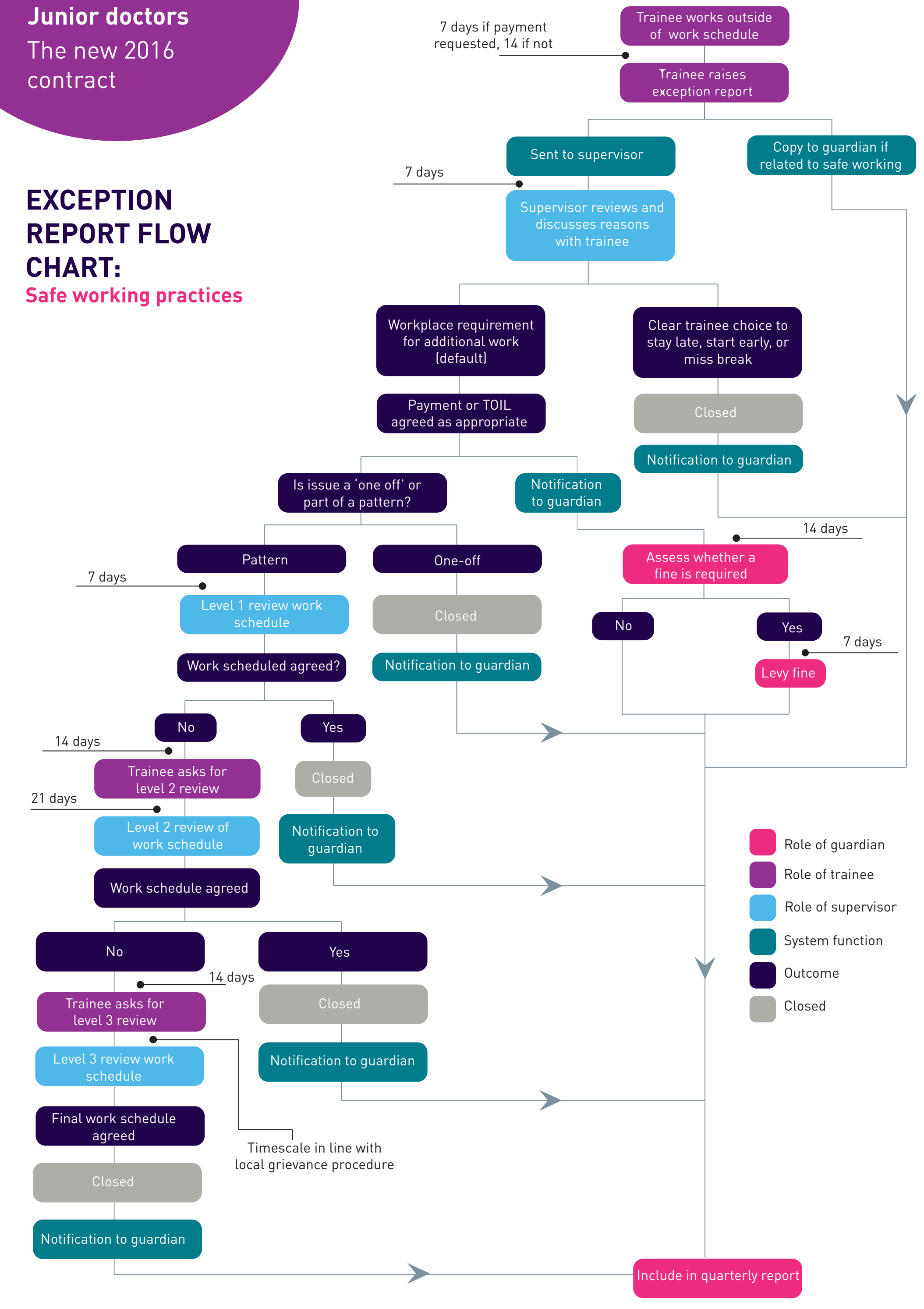
Factsheet – rota rules at a glance

For full details please refer to schedule 3 of the terms and conditions of service (TCS).

Rule	Notes
Max 48 hour average working week	A guardian of safe working hours fine will apply if this rule is breached
Max 72 hours work in any 7 consecutive days	A guardian of safe working hours fine will apply if this rule is breached
Max 13 hour shift length	On-call periods can be up to 24 hours
Max 5 consecutive long shifts, at least 48 hours rest following the fifth shift	Long shift - a shift rostered to last longer than 10 hours
Max 4 consecutive long daytime/evening shifts, at least 48 hours rest following the fourth shift	Long evening shift - a long shift starting before 16.00 rostered to finish after 23.00 (a long shift starting after 16.00 will fall in to the definition of a night shift)
Max 4 consecutive night shifts. At least 46 hours rest following the third or fourth such shift	Night shift - at least 3 hours of work in the period 23.00 to 06.00. Rest must be given at the conclusion of the final shift, which could be the third or fourth
Max 8 consecutive shifts (except on low intensity on-call rotas), at least 48 hours rest following the final shift	Low intensity on-call - duty on a Saturday and Sunday where 3 hours, or less, work takes place on each day, and no more than 3 episodes of work each day. Up to 12 consecutive shifts can be worked in this scenario provided that no other rule is breached
Max frequency of 1 in 2 weekends can be worked	Weekend work - any shifts/on-call duty periods where any work falls between 00.01 Saturday and 23.59 Sunday
Max frequency of 1 in 2 weekends can be worked (special exception for nodal point 2)	For one placement at F2 (typically emergency medicine), the definition of weekend work is any shift rostered to start between 00.01 Saturday and 23.59 on a Sunday
Normally at least 11 hours continuous rest between rostered shifts (separate on-call provisions below).	Breaches of rest subject to time off in lieu (TOIL) which must be given within 24 hours. In exceptional circumstances where rest reduced to fewer than 8 hours, time will be paid at a penalty rate & doctor not expected to work more than five hours the following day. A guardian of safe working hours fine will apply in this circumstance.
30 minute break for 5 hours work, a second 30 minute break for more than 9 hours	A guardian of safe working hours fine will apply if breaks are missed on at least 25 per cent of occasions across a four week reference period. Breaks should be taken separately but if combined must be taken as near as possible to the middle of the shift
Specific to on-call working patterns	
No consecutive on-call periods apart from Saturday & Sunday. No more than 3 on-call periods in 7 consecutive days	A maximum of 7 consecutive on-call periods can be agreed locally where safe to do so and no other safety rules would be breached; likely to be low intensity rotas only
Day after an on-call period must not be rostered to exceed 10 hours	Where more than one on-call period is rostered consecutively (e.g. Sat/Sun), this rule applies to the day after the last on-call period
Expected rest while on-call is 8 hours per 24 hour period, of which at least 5 hours should be continuous between 22.00 and 07.00	If it is expected this will not be met, the day after must not exceed five hours. Doctor must inform employer where rest requirements not met, TOIL must be taken within 24 hours or the time will be paid
No doctor should be rostered on-call to cover the same shift as a doctor on the same rota is covering by working a shift	Unless there is a clearly defined clinical reason agreed by the clinical director and the working pattern is agreed by both the guardian and the director of medical education

Junior doctors
The new 2016 contract

EXCEPTION REPORT FLOW CHART:
Safe working practices



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 15TH AUGUST 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
	Tim Callaghan	Public, Cheltenham
	Anne Davies	Public, Cotswold
	Pat Eagle	Public, Stroud
	Charlotte Glasspool	Staff, Allied Health Professionals
	Andrew Gravells	Stakeholder Appointed, County Council
	Colin Greaves	Stakeholder Appointed, Clinical Commissioning Group
	Nigel Johnson	Staff, Other and Non-Clinical
	Ann Lewis	Public, Tewkesbury
	Tom Llewellyn	Staff, Medical and Dental
	Jeremy Marchant	Public, Stroud
	Jacky Martel	Stakeholder Appointed, Carers Gloucestershire
	Maggie Powell	Stakeholder Appointed, Healthwatch
	Alan Thomas	Public, Cheltenham (Lead Governor)
	Valerie Wood	Public, Forest of Dean
Directors	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Lukasz Bohdan	Director of Corporate Governance
	Claire Feehily	Non-Executive Director
	Rob Graves	Non-Executive Director
	Mike Napier	Non-Executive Director
IN ATTENDANCE	Adrian Balmer	EY, External Auditors
	Suzie Cro	Deputy Director of Quality
	Sean Elyan	Medical Director
	Natashia Judge	Corporate Governance Manager
	Alison Kennett	EY, External Auditors
	Caroline Landon	Chief Operating Officer
	Emma Wood	Director of People and Organisational Development
APOLOGIES	Tracey Barber	Non-Executive Director
	Liz Berragan	Public, Gloucester
	Geoff Cave	Public, Tewkesbury
	Graham Coughlin	Public, Gloucester
	Marguerite Harris	Public, Out of County
	Jenny Hincks	Public, Cotswold
	Alison Jones	Public, Forest of Dean
	Keith Norton	Non-Executive Director
	Sarah Mather	Staff, Nursing and Midwifery
	Alison Moon	Non-Executive Director
PRESS/PUBLIC	None	

067/18 DECLARATIONS OF INTEREST **ACTION**

The Trust Chair, Rob Graves and Mike Napier declared an interest in the agenda item on Non-Executive Director (NED) expenses, given that they are all NEDs. The Lead Governor confirmed that he was happy that all remained in the room for this agenda item.

068/18 MINUTES OF THE MEETING HELD ON 20TH JUNE 2018

RESOLVED: The minutes of the meeting held on 20th June 2018 were agreed as an accurate record and were signed by the Chair.

069/18 MATTERS ARISING

JUNE 2018 053/18 REPORTS FROM BOARD COMMITTEES – QUALITY AND PERFORMANCE - THE CHIEF EXECUTIVE REFLECTED ON THE IMPACT OF PRIMARY CARE AND EARLY DIAGNOSES OF CANCER AND FELT A PRESENTATION FROM THE CCG AT GOVERNOR'S QUALITY GROUP MAY BE HELPFUL
Board Administrator to add to work plan.
Completed: On the work plan and scheduled for November Quality Group.

JUNE 2018 057/18 ANY OTHER BUSINESS - SANDRA ATTWOOD SHARED THAT GOVERNORS DISCUSSED GOVERNOR WALKABOUTS AT THE COUNCIL OF GOVERNORS PRE-MEETING AND WONDERED IF THOUGHTS AND FEEDBACK COULD BE COLLATED FOR DISCUSSION
The Chief Executive would discuss with the Director of Quality and Chief Nurse.
Completed: A formal review will take place with governors attending the visit once the visit has finished. This information will be collated and a report with themes will be published, similar to that provided as a result of the patient story.

JUNE 2018 057/18 ANY OTHER BUSINESS - GEOFF CAVE SHARED THAT HE AND THE LEAD GOVERNOR ATTENDED A NATIONAL GOVERNORS' CONFERENCE IN MAY
The Chair encouraged both to share their feedback at a future meeting and the Board Administrator would add to the agenda.
Completed: On the work plan for August Strategy and Engagement Group

Jacky Martel pointed out that a matter arising had been missed on page 6 of the minutes.

The Chief Executive had advised that governors would be involved in engagement following approval of the reconfiguration of the business case later this year. The Chief Executive noted this was linked to the Capital Business Case and that she, the Chair and the Director of Strategy and Transformation would be meeting with the Lead Governor to discuss governor engagement. The Lead Governor advised that following this meeting a working group would be created; he had emailed governors regarding this. Richard Baker queried whether there would be staff involved in the process; the Chief Executive confirmed that they would.

Maggie Powell said that she had recently been on a governor walkabout and was not clear on how the views of governors would be formally collated following these. The Chief Executive said that a review would take place with governors to look at the process to make this more formal. **DL/SH**

070/18 CHAIR'S UPDATE

The Chair presented the paper detailing his activities since the last Council of Governors meeting in June. There were no questions.

071/18 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented her update to the Council. Key points included:

- Concern was noted to have been expressed by governors regarding the impact of high demand on staff resilience. The Chief Executive advised that there had been unprecedentedly high levels of activity in June and July; the drivers of demand were yet to be fully understood. The Chief Operating Officer' initial analysis had found that there was a pattern around Mondays and certain times of day, which demonstrated that it was particularly difficult to access primary care appointments in a timely way. The Chief Executive cautioned that there was a danger that the Accident & Emergency (A&E) was viewed as the most accessible service in the health system.. She reflected on how resources would need to be redistributed should this continue, which would be the wrong thing to do. The Chief Executive added that further analysis was underway.
- The University of the West of England (UWE) has signalled its intention to consult on the withdrawal of its nursing students from its satellite in Gloucester. While disappointing, the University of Gloucestershire and the University of Worcestershire are confident that they can maintain training numbers. The Chief Executive highlighted that these students would be more likely to remain within the Gloucestershire's health system.
- Changes have been made to ensure the Day Surgery Unit is used appropriately; this was a concern previously raised by governors. The DSU environment remains an issue but will be addressed as a priority.
- Recent Inpatient Survey Results were disappointing. While the views of patients are from July 2017 there are still opportunities for learning; improvement initiatives were already under way to address all the issues raised.

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

- Ann Lewis shared that she was pleased to see that the Trust was recognising the value of sharing good practice with the new positive datix system. She also praised the work around the Gloucestershire Royal Hospital Tower evacuation exercise.

- Anne Davies praised the recently released finance podcast and infographic. She also shared her experience of a governor walkabout in Oncology. The Lead Governor added that the Trust should investigate the format for other topics. The Chief Executive concurred, noting that there were plans to do just that; further, simple guides describing various aspects of the Trust's work were being created and will shared with the governors..
- Colin Greaves said that the CCG and primary care had reduced waiting times and improved access within primary care and yet issues were still arising with patients choosing to go to A&E with minor ailments; this was a cultural issue that needed resolving as it was not sustainable. The Chief Executive felt that the new models of care and urgent treatment centres would help address it; she also described the streaming set up within A&E to appropriately treat minor ailments. Tom Llewellyn described the difficulties of getting patients out of A&E, noting that mostly issues arose with moving patients from the A&E in a timely manner, rather than through inappropriate admissions.

072/18 REPORTS FROM BOARD COMMITTEES

Finance Committee – July Board Report & Chair's Report from 30 May 2018 and 27 June 2018

The Chief Executive presented the July Board report to the Council and provided a contemporary update highlighting the Trust's finances as at the end of Month 4.

The Lead Governor asked about the risk resulting from the Cost Improvement Programme (CIP) being higher in the second half of the year. While it was positive that the CIP was progressing well so far, the Lead Governor queried whether the Trust was in a position to deliver the plan for the year. The Chief Executive said that when the plan was agreed, the Trust was then asked to agree another stretch of £2.8m, and that the means of achieving this were still being identified; NHS Improvement (NHSI) understands this. The Trust also has a £4m gap on the original plan, however PWC will be supporting the Trust with finding in-year savings opportunities through the priority based budgeting work. The Chief Executive summarised that the Trust had de-risked the identified CIP, i.e. £25m of £30m, and acknowledged that the Trust had a risk ranging from £3-7m.

Mike Napier presented the May and June Finance Committee Chair's Reports. He noted that both meetings had good challenge and focused on where the Committee could drill down further and exert more influence. He further added that the Committee were also:

- Seeking a breakdown between price variance and volume variance.
- Looking at drugs/ pass through drugs.
- Reviewing risks related to pay award numbers.
- Monitoring capital expenditure, the need for a £10m loan and the high priority list and how much further will be added.
- Reviewing progress with the CIP.
- Looking at how clinical productivity can be translated into bottom line improvements.
- Looking at how further CIPs can be gained from Procurement.
- Reviewing risks and have closed all risks related to the previous financial year.

Ann Lewis reflected that when the Gloucestershire Managed Services was being established, conversations were had around a separate company managing maintenance and equipment within theatres. The Chief Executive answered that GenMed contract was set up in November; it was well received by clinical teams and was considered a success, with benefits seen over the last few months which have taken years to deliver in other Trusts.

The Lead Governor advised that at both Committees there had been robust NED challenge. He also advised that TrakCare was discussed in the Finance Committee, and there had been debate regarding overall NED assurance. Mike Napier said that NEDs had received presentations on TrakCare in several Committees and had agreed therefore that Finance Committee would gain an extended IM&T remit and as part of this would review the entire programme, with relevant aspects discussed at other Committees.

Quality & Performance Committee – July Board Report & Chair's Report from 31 May 2018 and 28 June 2018

The Chief Operating Officer presented the July Board report to the Council and provided a contemporary update via presentation on the Trust's performance figures. The Chief Executive briefed governors on issues within Urology, noting the progress being made.

In response:

- Andrew Gravells queried whether Locum Consultants could be used within Urology to address the staffing issues. The Chief Executive responded that the Trust had had locums but this had not been successful. She advised that there was a shortage of consultants in this area nationally and that the Trust has been creative in exploring all the available options, including overseas recruitment. The bar for selection of Consultant Urologists remained appropriately high.
- The Lead Governor pointed to the Medically Stable for Discharge statistic, sharing that he had heard that at times there were spare beds within community hospitals but this did not always mean the Trust was offered them. The Chief Operating Officer responded that community colleagues had been challenged around staffing levels and had to be cautious regarding the criteria for patients they care for; this then led to issues with capacity utilisation. She added that the A&E Delivery Board was working with partners to maximise capacity.
- Valerie Wood queried why there were challenges within Haematology. The Chief Operating Officer answered that this was down to a significant backlog caused by staffing challenges. This has since been addressed and a comprehensive action plan is in place to get back on plan.
- Andrew Gravells reflected on medically fit patients presenting at A&E and presumed this was related to primary care not providing appointments within a quick timeframe. He queried what governors could do to encourage primary care to respond appropriately to demand. The Chief Executive stressed that the CCG were very active in working with primary care, but still a public education campaign regarding the best place to get treatment depending on the condition was needed. The Chief Executive explained that the CCG had oversight of GP compliance against standards/ metrics.
- Tom Llewellyn mentioned the ASAP Gloucestershire app and how this can support patients in identifying where they could seek care.

Claire Feehily reported the key messages from the May and June Quality and Performance Committee Chair's Reports. She highlighted that the Committee's focus had been on keeping a close scrutiny/ challenge on improving performance, CQC preparation, patient-facing administrative processes and improvement plans, infection control, serious incidents, and a focus on learning and how the Committee assures itself that the improvements have taken root.

Anne Davies noted the issues with regards to infection control and in particular Clostridium Difficile (C.Diff). The Medical Director said that issues in relation to antibiotics were complex, however the Trust had had an external review undertaken by Professor Mark Wilcox, the national lead for C.Diff, and that early feedback was that the Trust was moving in the right direction and that antibiotic protocols and advice have been reviewed, revised, assessed and audited.

People and OD Committee – July Board Report & Chair's Report from 1 June 2018

The Director of People and Organisational Development presented the July Board report to the Council and provided a contemporary update via a presentation on turnover, sickness, appraisal compliance and mandatory training.

Ann Lewis noted that staff commuting from North Gloucestershire had highlighted they no longer had access to the park and ride bus service from the Race Course. The Chief Executive responded that she has sent a formal response and would share this with all governors. **DL / NJ**

The Lead Governor raised a question regarding meeting quorums. The Director of Corporate Governance explained that at present most Committees were required to have 3 Non-Executive Directors as members and that the quorum was 2 Non-Executive Directors; a review of Committee terms of reference was underway and it would ensure consistency across the Committees.

Audit & Assurance Committee – Chair's Report from 15 May 2018

Rob Graves presented the May Audit and Assurance Chair's report. No questions were raised.

Gloucestershire Managed Services (GMS) – Chair's Report from 14 June 2018

Rob Graves presented the June GMS Chair's report, noting that the Committee was progressing well with relationships developing and reports presented to the Committee improving. He noted that Mike Napier would be taking over as the Committee Chair.

The Lead Governor requested that the agenda for the next Council of Governors includes the GMS Committee presentation. **NJ**

073/18 EXTERNAL AUDITOR'S PRESENTATION

- **ANNUAL AUDIT LETTER**
- **AUDIT RESULTS REPORT**
- **QUALITY REPORT FOR GOVERNORS**
- **ANNUAL REPORT, ANNUAL ACCOUNTS AND QUALITY REPORT**

Rob Graves introduced Alison Kennett and Adrian Balmer from Ernst & Young (EY), the Trust's external auditors. They gave a presentation on External Audit Responsibilities (mandated and additional) noting their involvement in the Audit Opinion, Annual Governance Statement, Annual Report, Value for Money Conclusion and Quality Report. They explained external auditors' role and powers, gave an insight into how the external auditors operate, and explained the outcomes of the 2017/18 audit work.

In response:

- The Trust Chair advised that EY had offered to deliver a governor development session to further discuss their role. Rob Graves felt that information on the Value for Money Opinion would be of particular interest to governors.

- Jacky Martel referred to the locally selected indicator and said that it looked as though not much analysis was possible. Alison Kennett answered that while this was reviewed, there were limitations to what could be done. The report detailed the problems encountered. The Chief Executive suggested the Trust come back with a management response detailing what the issues were that prevented EY from being able to audit the indicator. **SS**
- Andrew Gravells queried whether any audit work had been undertaken around TrakCare. EY answered that it had not, but that the auditors reviewed what was reported through the Committees and to NHS Improvement. The Chief Executive reminded the Council that information on TrakCare was received by the Council in April.
- The Chair and Lead Governor thanked EY for their presentation.

[Nigel Johnson, Claire Feehily, the Chief Operating Officer, Director of People and Medical Director left the meeting]

[The Council adjourned for 5 minutes]

074/18 PATIENT EXPERIENCE REPORT

- **ANNUAL COMPLAINTS REPORT 2017/18**

The Deputy Director of Quality presented the Patient Experience Report and Annual Complaints Report for 2017/18 to give governors an overview of work being undertaken with the Patient Experience Department/across the Trust. Key points highlighted included how the team support staff to take projects through the Quality Academy (QI), that the team are becoming Gold QI coaches, the Sweeney Programme and the patient journey getting through the day surgery unit. The Deputy Director of Quality also highlighted that the Complaints Report was available to patients via the Trust website.

In response:

- Ann Lewis said that she had previously highlighted inappropriate communication via letter and the incorrect correspondence address on letters. The Chief Executive said that this had been referred to the TrakCare team for resolution.
- Maggie Powell asked for further information on the White Rose Café. The Deputy Director of Quality explained that this was designed to support staff dealing with end of life care. Maggie Powell said that Healthwatch were doing similar work and it may be helpful to join up. The Chief Executive agreed that she would connect with other members of the Integrated Care System network to discuss end of life care support. **DL**
- Jacky Martel expressed concern regarding the lack of Patient Advice and Liaison Service (PALS) capacity with no walk in service. The Deputy Director of Quality explained that the team were seeking to recruit further staff and had been affected by staff leaving and staff sickness. The team are also trialling different ways of working and expected the situation to be different in 2 months' time.
- Charlotte Glasspool referred to the adult inpatient survey scores and sought clarification on the area where the Trust performed the worst. The Chief Executive explained this was in response to the question of *"Were you asked about your experience of care while you were an inpatient."* The importance of asking about inpatients' experience of care was now being reinforced on the wards.
- Jacky Martel queried the discharge project undertaken with members. The Deputy Director of Quality responded that members were asked to come and discuss their experiences and what an outstanding discharge would look like.

- The Trust Chair thanked the Deputy Director of Quality for the report and agreed this should continue as a standing item. The Corporate Governance Manager would add to the work plan. **NJ**

075/18 NED RECRUITMENT / ASSOCIATE NED PROPOSAL

The Director of Corporate Governance presented a paper on NED recruitment to update the Council on the planned recruitment of two Non-Executive Directors and seek agreement to the proposed approach. He explained that the Trust was seeking to appoint to full NED positions as well as to an associate NED role if suitable candidates emerged (a development position). He explained that the creation of this role was supported by the Constitution Review Group and the proposal was endorsed by the Governance and Nominations Committee.

In response:

- The Chief Executive encouraged all to consider gaps in experience following the department of Tracey Barber and undertake analysis. The Trust Chair responded that this had been discussed and it was agreed that a focus on marketing and customer service was not as crucial as digital and information technology and that the Board already had external marketing experience within its members
- Mike Napier expressed concern regarding the objective to use the Associate NED position to recruit from underrepresented groups in that equally this should be an objective when recruiting to the full NED position. The Trust Chair outlined that this was stated also within full NED recruitment; the Associate NED role provided a further opportunity to attract candidates.
- Ann Lewis queried whether each time the Trust needed to recruit an Associate NED it would review what the Trust needs at that time. The Trust Chair answered that it would, and that the needs would be discussed at Governance and Nominations Committee.
- Jacky Martel sought clarification regarding whether the Associate NED role was a trainee role. The Trust Chair advised that role was a developmental one, helping with the succession planning. Associate NEDs would receive development so that they could apply to become a Non-Executive Director when a suitable vacancy arises and the candidate is ready.
- The Lead Governor stressed the importance of Governors holding Associate NEDs to account in the same way as they hold Non-Executive Directors to accounts. He further noted that at the end of their tenure an Associate NED would not automatically become a full NED but would have to go through the full selection and appointment process. The Trust Chair confirmed that this would be the case.

RESOLVED: That the Council agree the proposed approach to recruit to NED vacancies, as well as to recruit to an Associate NED position.

076/18 NED EXPENSES POLICY

The Director of Corporate Governance presented the Non-Executive Directors' Expenses Policy for the Council of Governors approval for. He noted that this has been created in order to standardise practice and was aligned as far as possible to the staff Expenses Policy. The policy had been reviewed and endorsed by the Governance and Nominations Committee. The Director of Corporate Governance highlighted that a wider review of parking was underway across the organisation and therefore any changes would need to be subsequently reflected in the policy. The Director of Corporate Governance also noted the difference in mileage rate for NEDs and Governors – noting that this was due to governors not being on the Trust pay roll.

The Chief Executive expressed concerns regarding NED parking and was unclear as to how they would meet the criteria for an essential user pass. She requested this was changed to standard. The Lead Governor also requested further information on the difference in mileage rates between NEDs and Governors. The Chief Executive said that NEDs and Governors should be entitled to the same mileage rates as Trust staff.

The policy would be further reviewed and would return to Council. **LB**

077/18 CHANGES TO THE TRUST CONSTITUTION

The Director of Corporate Governance presented a paper detailing the proposed amendments to the Trust Constitution, highlighting that this work was led by a governor Constitution Review Group and proposed changes had been supported by the Governance and Nominations Committee. Legal advice was also received. The paper contained a summary of changes for review and approval.

As part of the Constitution review, the definition of a significant transaction has been reviewed in response to Governors' feedback suggesting the threshold be lowered. Following Board discussion, it is proposed that:

- There is no change to the threshold for classification of a significant transaction, which requires Council of Governors approval i.e. remains 25% of Trust turnover. However, a provision will be added specifying that the acquisition of another NHS organisation (regardless of the value of the transaction) will be considered to be a significant transaction.

- The revised Constitution introduces a *relevant transaction* whereby the Council of Governors will be consulted on such a transaction and the views of governors 'taken into account' by the Board when making any associated decisions; this mirrors language used, for example, in the requirement for Governor involvement in the sign off of the Annual Operational Plan. A relevant transaction would be defined as:
    - A transaction with a value of more than 10% (but less than 25%) i.e. > £50m
      Or
    - A transactions which is deemed to be high risk by its nature or of specific relevance to governor priorities (as judged by the Chair)

The Lead Governor noted that several governors had queried the 25% rule, and while they felt this should be lowered, he accepted that the Board and Council both had to agree changes, and was happy with the proposed changes. The Chief Executive said that the 25% rule was consistent with NHS Improvement Transaction guidance, which is why the scenario was not straight forward. The Lead Governor also highlighted the reduction in the number of governors by one; this was to reflect reduction in staff numbers in the 'Other Staff' staff class, following the creation of GMS.

The Council agreed that any material points should be sent through to the Corporate Governance Team. The Constitution would be received by the Board in September.

The Trust would review the Constitution every 5 years moving forward.

RESOLVED: That the Council approve the amendments to the Trust Constitution.

078/18 CQC: OVERVIEW OF FORTHCOMING INSPECTION

The Chief Executive briefed the Council on the upcoming inspection, covering:

- The last inspection and the new regime and its components
- The unannounced inspection of up to eight core services
- The announced Well-Led inspection through 8 Key Lines of Enquiry (KLoE)
- The Use of Resources assessment

Ann Lewis queried what governors could do to support the inspection. The Chief Executive encouraged governors to view the hospital with fresh eyes, sharing that this is what the executives had been doing. The Chief Executive would involve governors in mock inspections and preparation to help connect with what the CQC are looking for as evidence. This should support governors in providing a fair reflection of the Trust. She would consider an additional session for governors. **DL**

Jacky Martel said that she would like to see the Must Do Actions from the last inspection. The Chief Executive said that these were reviewed within the Quality and Performance committee and it might be worth discussing with the governor observer. The last inspection report is available on both the CQC and Trust website. She would also circulate the summary that goes to Quality and Performance. **DL**

079/18 GOVERNORS' LOG

The Chief Executive presented the Governors' Log. There were no questions.

080/18 NOTICE OF ANNUAL MEMBERS MEETING

The Trust Chair reminded governors that the Trust's Annual Members' Meeting would be held on Thursday 20th September at 18:00 in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital.

RESOLVED: That the Council give notice of the Trust's Annual Members' Meeting as set out above.

081/18 ANY OTHER BUSINESS

The Council thanked Richard Baker, who is leaving the Trust shortly, for all his work as a governor. The Chair also thanked Tracey Barber, who is stepping down from her role at the end of August, for all her work as a Non-Executive Director.

Andrew Gravells highlighted that the Fire Service were undertaking a 160 mile bed push across the country on September 12th to raise funds for the Oncology Unit.

082/18 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 17th October 2018** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** commencing at **17:30**.

Papers for the next meeting: Papers for the next meeting are to be logged with the Corporate Governance Team no later than **17:00** on **Monday 8th October 2018**

083/18 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 8:30 pm.

Chair
17th October 2018

ITEM 18

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 19

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 20

PUBLIC QUESTIONS

Peter Lachecki
Chair

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

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

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

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

Written questions for the Board Meeting

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

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

Notice of questions

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

Procedure

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

the responses will be recorded in the minutes.

Additional Questions

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

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

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

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

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

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

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

ITEM 21

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION