AGENDA AND SUPPORTING PAPERS FOR THE MEETING OF THE GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST MAIN BOARD TO BE HELD AT 12:30 IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 10 JANUARY 2019

(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 10 January 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 12:30

(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)

Peter Lachecki
Chair

19 December 2018

AGENDA

				Approximate Timings
1.	Welcome and Apologies			12:30
2.	Declarations of Interest			
3.	Patient Story			12:31
4.	Minutes of the meeting held on 8 November 2018	**PAPER**	**For approval**	13:01
5.	Matters Arising	**PAPER**	**For assurance**	13:03
6.	Chair's Update	**PAPER** (Peter Lachecki)	**For information**	13:05
7.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For information**	13:10
8.	Trust Risk Register	**PAPER** (Lukasz Bohdan)	**For assurance**	13:20
9.	Quality and Performance:			13:30
	• Assurance Reports of the Chair of the Quality and Performance Committee - meetings held on 29 November 2018 and 20 December 2018	**PAPER** (Alison Moon)	**For assurance**	
	• Quality and Performance Report	**PAPER** (Steve Hams, Sean Elyan, Caroline Landon)	**For assurance**	
	• Learning from Deaths	**PAPER** (Sean Elyan)	**For assurance**	
10.	Finance and Digital:			13:50
	• Assurance Reports of the Chair of the Finance Committee - meetings held on 28 November 2018 and 19 December 2018	**PAPER** (Keith Norton)	**For assurance**	
	• Financial Performance Report	**PAPER** (Sarah Stansfield)	**For assurance**	
	• NHS Improvement letters: Exit from Financial Special Measures and Enforcement Undertakings	**PAPER** (Deborah Lee)	**For information**	
	• SmartCare Progress Report	**PAPER** (Mark Hutchinson)	**For assurance**	
11.	People and Organisational Development:			14:05
	• Assurance Report of the Chair of the People and Organisational Development Committee - meeting held on 7 December 2018	**PAPER** (Alison Moon)	**For assurance**	
	• People and Organisational Development Report	**PAPER** (Emma Wood)	**For assurance**	
	• Equality Report	**PAPER** (Emma Wood)	**For assurance**	

12.	Audit and Assurance: • Assurance Report of the Chair of the Audit and Assurance Committee meeting held on 20 November 2018	**PAPER** (Rob Graves)	**For assurance**	14:15
13.	Gloucestershire Managed Services (GMS): • Assurance Reports of the Chair of the GMS Committee meetings held on 21 November 2018 and 10 December 2018	**PAPER** (Mike Napier)	**For assurance**	14:20
14.	Six Monthly Research Report	**PAPER** (Simon Lanceley)	**For information**	14:25
15.	Minutes of the meeting of the Council of Governors held on 17 October 2018	**PAPER** (Peter Lachecki)	**For information**	14:30
	Governor Questions			
16.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions			14:30
	Staff Questions			
17.	A period of 10 minutes will be provided to respond to questions submitted by members of staff			14:40
	Public Questions			
18.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.			14:50
	Any Other Business			
19.	Any Other Business		**For information**	
	Close			**15:00**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON MONDAY 31 DECEMBER 2018

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 14 February 2019** in the **Lecture Hall, Sandford Education Centre, Cheltenham General 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
Alison Moon	Dr Sean Elyan, Medical Director
Mike Napier	Steve Hams, Director of Quality and Chief Nurse
Keith Norton	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, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 8 NOVEMBER AT 09:00

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
	Sean Elyan	Medical Director
	Steve Hams	Director of Quality and Chief Nurse
	Simon Lanceley	Director of Strategy and Transformation
	Caroline Landon	Chief Operating Officer
	Sarah Stansfield	Director of Finance
	Emma Wood	Director of People and Organisational Development and Deputy Chief Executive
	Claire Feehily	Non-Executive Director
	Rob Graves	Non-Executive Director
	Alison Moon	Non-Executive Director
	Mike Napier	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	Mark Hutchinson	Chief Digital & Information Officer
IN ATTENDANCE	Suzie Cro	Deputy Director of Quality
	Natashia Judge	Corporate Governance Manager
	Craig Macfarlane	Head of Communications
	Janice Payne	Patient Advice and Liaison Service (PALS) Officer *(for item 213/18)*
	Simon Pirie	Guardian for Safe Working
	Sarah Sharp	Patient Advice and Liaison Service (PALS) Officer *(for item 213/18)*
	Kate Williams	Patient Advice and Liaison Service (PALS) Officer *(for item 213/18)*
PUBLIC & PRESS	Three governors, three members of the public.	

The Chair welcomed all to the meeting.

212/18 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

213/18 PATIENT STORY

The Deputy Director of Quality introduced Janice Payne, Sarah Sharp and Kate Williams, the Trust's Patient Advice and Liaison Service (PALS) Officers, who gave a presentation on the background of the team and recent and proposed service developments. This touched on:

- The planned relaunch of the PALS service in Cheltenham.
- The variety of queries dealt with, examples of different patient stories and how the team supported the individuals with their care.
- How the team integrate and work alongside different areas of the hospital, as well as other Trusts, to ensure smooth continuity of care.

- Improvement plans including a focus on relationship building between the team and divisions, greater visibility on the wards and enhancing the team's visibility as a compliments service as well as a point of contact for concerns.

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

- The Director of Quality and Chief Nurse praised the enthusiasm of the team, acknowledging that there had been previous staffing issues in the past, with concern expressed by Healthwatch regarding the level of service the team was able to offer; this has now been addressed. The Director of Quality and Chief Nurse noted that the Trust was now seeing a slight reduction in complaints and hoped that as the team developed this would further improve.

[Rob Graves joined the meeting]

- The Medical Director commended the team and felt their focus was the definition of patient and family centred care. He acknowledged that the role can sometimes be considered emotionally draining and asked how the Trust could support the team. The team answered that moving forward time was being allocated for one to ones, debriefs and reflection, and they felt that greater integration and relationship building with divisions and wards would ultimately benefit their wellbeing. The PALS office has also been reconfigured to encourage communication and team working. Mr Norton asked if there was anything the Board could do further and the team answered that administrative support would enable them to have a greater presence on the wards and better relaunch the service on Cheltenham site. The Deputy Director of Quality advised that a proposal had been developed to acquire this support which was progressing through the planning round.
- The Director of Corporate Governance praised the team on how well they demonstrated the Trust's values and behaviours, in particular how they took ownership of each patient's journey.
- Claire Feehily asked if there were any digital solutions that could support the team. The Deputy Director of Quality explained that the team would be issued with iPads so that they could access Trust systems while on the wards. The team also intend to work alongside the Trust's Library Services who now offer a patient information service to signpost patients to good quality information regarding their health and conditions.
- In response to the Director of Strategy and Transformation's question about being more visible, the team explained that similar teams in other trusts had a greater focus on feedback and compliments, inviting more positive returns, resulting in a greater encompassing service; it was the team's intention to move in that direction.
- Alison Moon asked whether recurrent themes raised were collated. The Deputy Director of Quality answered that the team were working on escalating and collating themes. The Medical Director advised that the Bereavement Team had an effective feedback loop alongside with wards which investigated themes and suggested the PALS team make contact and discuss the methodology used.
- The Chair praised the examples of early intervention and asked whether there were any particular areas where this did not work so well. The team said that often the PALS office were perceived as a problem adding area as opposed to a problem solving area and therefore the work to connect and engage with wards and areas aims to change this perception.

- The Chief Executive said that she was heartened to hear that the team had met with the Central Booking Office (CBO) and wondered whether the CBO team had fed back the sorts of concerns raised with them and the impact they had. The team explained that they had.
- The Director of Quality and Chief Nurse felt it was important for the team to involve themselves in improvement work at the beginning, and suggested the team join the outpatient improvement group. The team confirmed that they were already involved.

[The PALS team left the meeting]

214/18 MINUTES OF THE MEETING HELD ON 13 SEPTEMBER 2018

RESOLVED: The minutes of the meeting held on 13 September 2018 were agreed as a correct record and signed by the Chair.

215/18 MATTERS ARISING

SEPTEMBER 2018 173/18 PATIENT STORY - '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.

The Chief Executive reflected that language used was still inconsistent and asked all Board members to reinforce the correct use.

216/18 CHAIR'S UPDATE

The Chair presented the report detailing his activities since 4th September.. He highlighted:

- The 100 Leaders meeting with Duncan Selbie (CEO Public Health England) as guest speaker.
- The Trust's iAspire training programme and his recent attendance to present certificates.
- Research4Gloucestershire, noting that he had been asked to Chair the forum.
- The recent visit by Professor Don Berwick and Professor Chris Ham from the King's Fund and their praise of the Gloucestershire Safety and Quality Improvement Academy.

The Chair updated the Board on the Non-Executive Director (NED) and Associate NED recruitment, noting that the closing date for applications was 25th November.

217/18 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented her report to the Board. In response to the Chief Executive, the following points were raised:

- Keith Norton praised the Chief Executive for her recent personal and open message to staff on mental health.
- Rob Graves praised the progress made in relation to Freedom to Speak Up (FTSU).

- Rob Graves noted the funding to address cancer backlogs and queried the lead time between receiving funding and initiating work. The Chief Operating Officer answered that a plan was in place and ready to initiate with capacity and resource identified, the only lead time would be patient notification. The Chair asked how backlogs within Urology would be addressed and the Chief Executive answered that this would be through mobilising and remunerating clinicians to operate at weekends.
- Alison Moon noted the recent Strategic Forum workshop and felt it was important to challenge leaders on the difference between the Sustainability Transformation Partnership (STP) and Integrated Care System (ICS). She questioned whether other leaders agreed on the importance of differentiating between the two. The Chief Executive felt this was difficult to answer and further discussion was needed around next steps. The Director of Strategy and Transformation said he would be attending a King's Fund session where wave 1 ICSs would be feeding back their experiences and what they were able to achieve as an ICS as opposed to an STP. He would feedback to the Board. **SL**
- Claire Feehily welcomed the award of £1.3m of funding to enable capital works at the Gloucester site and wondered whether planning assumed this award and whether the Trust was confident it could spend this wisely. The Chief Operating Officer answered that a fully developed bid was submitted and that the funding would be used to expand the acute floor and equip the Surgical Assessment Unit (SAU) and gynaecology assessment unit: a plan supported by the Strategy team and also support some IM&T developments.
- Claire Feehily reflected on project planning and whether the Trust could introduce an aspect which prompted reflection on sources of patient feedback. The Chief Executive advised that conversations were underway amongst the executive team and that a number of initiatives had been identified, including the need for a dedicate resource for patient and public involvement in service planning.
- The Director of Quality and Chief Nurse highlighted that the formal review process for the change of visiting hours had started and he thanked Jacky Martel, Stakeholder Governor for Carers Gloucestershire, for providing access to a wider group of carers.
- The Chair noted that the NHS 10 Year Plan was due to be released in early December and asked whether the Chief Executive had any insight from her networks as to whether the other CEOs who had been involved had been listened to. The Chief Executive answered that much of the process had been undertaken through a desktop lens, noting the Trust had submitted a comprehensive response on cancer. She felt the priorities were well understood but implementation and the architecture to deliver would be crucial.

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

218/18 QUALITY AND PERFORMANCE:

QUALITY AND PERFORMANCE REPORT

The Director of Quality and Chief Nurse presented the Quality and Performance Report, highlighting the development of the report and current performance figures for MRSA, Clostridium Difficile, Venous-thromboembolism (VTE), dementia screening and harm free care. He noted that the Trust was experiencing recording issues with VTE and dementia recording and manual auditing was being undertaken.

The Medical Director highlighted that following revision of the two week wait referral forms; gynaecology was experiencing a 39% rise in referrals which had resulted in the Trust not achieving the 2 week wait standard as expected.
The Chief Operating Officer outlined the current performance figures:

- The Trust delivered 90.5% against the four hour A&E standard for October, despite a 12% increase in attendances on last year.
- Quarter to date the Trust has delivered 90.3%.
- Month to date the Trust has delivered 88%.
- The Trust has delivered 68.1% against the 62day target, however 83.6% when not including Urology which is an improving position. The Trust is currently reporting the national position with and without Urology and NHSI are content with the underlying progress made and the specific actions to address urology, including the recent appointment of two new consultants.
- Due to the challenges within Gynaecology it is unlikely the Trust will achieve the 93% 2 week wait performance until December.

In response:

- Alison Moon questioned whether the issue with two week wait forms in Gynaecology had implications for other documentation and whether the forms were correct. The Medical Director answered that the issue related to a subtle change of wording to "consider referring" and that review was needed. Work is underway alongside primary care colleagues around a pathway for the patients this is affecting.
- Rob Graves observed gaps in the performance figures for the Emergency Department (ED) Checklist with deterioration in performance on the Gloucester site. The Director of Quality and Chief Nurse explained that audits were being undertaken but the performance figures had not been submitted due to an issue with process – he advised that performance had actually improved.
- Mike Napier noted the report mentioned that the Trust would begin re-reporting the Referral to Treatment position in March 2019 and thought the timeline was February 2019. The Chief Operating Officer clarified the timeline was February 2019 with two cycles of "dummy reporting" prior to this.

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 27 SEPTEMBER 2018 AND 25 OCTOBER 2018

Claire Feehily presented the assurance reports from the September and October Quality and Performance Committees, highlighting the strength of the exception reports from the supporting delivery groups, the focus on patients in breach of expected appointment times, the CQC action plan and the presentation received on enhanced care and mental health.

Mike Napier asked what confidence Claire Feehily had that the issues being escalated through the exception reports were correct. Claire Feehily answered that the Committee asked probing questions and cross referenced issues with performance metrics to ensure alignment. She also advised that issues were managed over a sequence of meetings to ensure a good level of confidence, with periodic invitations for divisional attendance and regular attendance from the CCG Quality Lead.

RESOLVED: That the reports be received as a source of assurance.

TRUST RISK REGISTER

The Director of Corporate Governance presented the Trust Risk Register noting that since the last report 4 risks had been downgraded and one upgraded.

The Director of Quality and Chief Nurse assured the Board that risks were being reviewed in a dynamic environment, with movement in scoring as improvement journeys are progressed.

Alison Moon noted that the report included controls but not actions. The Chief Executive noted that a version including actions went to Trust Leadership Team and would ensure this version came to Board in future. She explained that further work was needed in some areas to ensure that controls and actions were correctly understood and used appropriately. **LB**

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.

BOARD ASSURANCE FRAMEWORK

The Director of Corporate Governance presented the Board Assurance Framework (BAF), outlining that while this presented as a similar picture to September, there had been a change to the status of three objectives. The BAF was noted to have been reviewed at the Board Committees with the new format better drawing the Committees' attention to the areas requiring focus. The BAF would complete the assurance cycle when reviewed in Quality and Performance Committee and Audit and Assurance Committee at the end of the month.

In response:

- Referring to the Strategic Objective 1.5 *"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*", the Director of Quality and Chief Nurse advised that the national response rate was 25%, 23.2% in NHS South West, therefore this may need to be considered when setting future objectives. With regards to recommending the Trust to their family and friends, Cheltenham site was at 93% and Gloucester site was at 88%. He felt that while important to be ambitious, the Trust could be doing itself a disservice considering the national response rate. Alison Moon concurred, noting the Trust received feedback in a variety of ways.
- The Chair felt that the current strategic objectives had served the Trust well and that the BAF illustrated this.

- The Chief Executive said that BAF code 1.5 *"Meet all national access standards"* should be red, not amber, as this will not be achieved by March 2019. She also noted that while the Board had not defined how to measure BAF code 4.2 *"Be among the top 25% of Trusts for efficiency",* reviewing performance through NHSI's Model Hospital, the Trust would be green not amber. She felt further conversations were needed regarding how this would be defined in future objectives, if it were retained. **LB**

RESOLVED: That the Board receive the report for assurance that the risks to the Strategic Objectives are controlled effectively and satisfactory progress is being made against their delivery.

LEARNING FROM PATIENT STORIES

The Deputy Director of Quality presented the Learning from Patient Stories Report to provide the Board with an update on the patient experience improvement work initiated in response to the stories presented to Board from May 2018.

In response:

- Rob Graves praised the report and asked whether there were any issues of confidentiality, considering patients' names were published within Board papers. The Deputy Director of Quality reassured that patients were aware that the Board was a public meeting and gave their consent. Rob Graves also suggested it may be helpful to keep a log of specific actions taken in response to patient stories. The Deputy Director of Quality agreed. The Chief Executive suggested this be presented at yearly Annual Members Meeting.
- The Deputy Director of Quality would review all patient stories and provide key highlights to the Board within the next report. She would also include how the stories had impacted on Board members and how they had used the information gleamed.
- The Director of Corporate Governance asked how strategic themes were drawn out of the stories. The Director of Quality and Chief Nurse answered that as part of the Quality Strategy, themes were being identified through various forums such as patient story reports and safety visits. The Quality Strategy would be reviewed by the Quality and Performance Committee in a few months.
- Claire Feehily recognised that patient stories had to be summarised and retold, but felt it was important not to sanitise or lose the emotion behind. The Chief Executive felt Board members needed to afford for the language of a report, and that this did not affect how teams responded to the stories. The Director of Quality and Chief Nurse felt it would be valuable to include a point from each patient summarising how they felt sharing their story.

RESOLVED: That the Board note the report.

EMERGENCY PLANNING RESILIENCE AND RESPONSE ANNUAL REPORT

The Chief Operating Officer presented Emergency Planning Resilience and Response (EPRR) report to provide an annual update to the Board on the Trust's level of compliance with the national core standards. She noted that the Trust had submitted its national return and seen by the local resilience forum in October and deemed partially compliant.

In response:

- The Director of Quality and Chief Nurse advised that as part of the CQCs unannounced visit they returned to Rendcomb ward where staff present had previously been unable to describe fire evacuation plans. Thanks to the leadership of the Chief Operating Officer the ward was noted to have undertaken a fire evacuation exercise within a few days of the concern being highlighted. Ms Moon reinforced that all areas needed to be reviewed and the Chief Operating Officer explained that the Emergency Planning and Resilience Manager was working alongside all areas to ensure plans were visible and accessible.
- The Chair queried how learning from the recent tower evacuation exercise was being disseminated. The Chief Operating Officer answered that a series of 'desk top' simulations were now being rolled out throughout the Tower wards to disseminate the learning.
- Rob Graves confirmed that the Audit and Assurance Committee had regular dialogue around EPRR. He also questioned whether the recommendation should be amended to acknowledge that the Trust was only partially compliant – the Board agreed. Claire Feehily asked how long the Trust was able to be partially compliant for and the Chief Operating Officer answered that there was no deadline for compliance but cautioned that the bar was high and that the Trust was aiming for full compliance by 2020.The Chief Executive added that due to the nature of the standards, large numbers of Trusts were non-compliant.

RESOLVED: That the Board accept the report as assurance of the Trust's partial compliance with EPRR standards.

'WINTER READINESS IN THE NHS-NEXT STEPS' JOINT NHS IMPROVEMENT AND NHS ENGLAND LETTER

The Chief Operating Officer presented the *Winter Readiness in the NHS – Next Steps joint NHSI and NHSE* letter to inform the Board of the requirements for winter planning 2018/19. She explained that the winter plan was reviewed at the most recent Trust Leadership Team and once TLT feedback has been addressed it would be disseminated over the next week and presented at the upcoming System Delivery Board and Quality and Performance Committee.

Rob Graves queried the phrase "super stranded patients" and whether this was specific to the Trust. The Chief Operating Officer said that this was a national term that referred to patients whose stay extended over 21 days for whom there was a national target to reduce.

RESOLVED: That the Board note the NHSE/ NHSI letter.

[The Board adjourned for 10 minutes]

[The Trust Chair left the meeting and Rob Graves deputised as Chair]

219/18 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 6 of the 2018/19 financial year. Key points highlighted included:

- 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: a favourable variance to budget and NHSI Plan of £0.2m.
- The forecast outturn deficit for the Trust is £22.6m: 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 Agenda for Change 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.
- Cost Improvement Programme (CIP) delivery to Month 6 is £11.6m: £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 but excluding the additional CIP expected to be identified through the PWC work.
- There is a pay underspend offsetting a number of pressures in non-pay and minor pressures around various funding streams.
- A decision has been taken to suspend all capital commitments other than those that are emergency capital funding, awaiting the outcome of the £10m NHSI loan application. This decision had been risk assessed.

[The Trust Chair returned and resumed as Chair]

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

- Alison Moon noted the point about capital and questioned the definition of emergency. The Director of Finance explained that earlier in the year a scenario where the Trust received no loan funding was agreed and the schemes within this are those which have been committed, with all other commitments suspended. Executive leads have been asked to assess the risk of emergency issues, and then a judgement made on a case by case basis. Mike Napier expressed disappointment that NHSI had not secured or declined the capital loan despite being 7 months into the financial year. The Director of Finance answered that the sector was still forecasting over commitment of the national capital limit with little flexibility and NHSI had encouraged Trusts to make capital forecasts as robust as possible.
- Rob Graves asked whether the Trust was up-to-date with payables. The Director of Finance reassured that payables were up-to-date and there was no active cash management. There is an issue with trade payables but this is an issue with accruals rather than an increase in creditors, and relates to the billing of year round creditors.
- Claire Feehily asked when consideration would be given to staffing allocation and areas of possible growth. The Director of Finance answered that a detailed approach to financial planning would be reviewed at the next Finance Committee which would enable this, but the process would be similar to last year and would look at intolerable risks and limited investment to address activity growth. The Director of Quality and Chief Nurse also added that a new acuity and dependency review would be undertaken and would work alongside the Director of Finance on the affordability of implementing any findings.

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 MEETING HELD ON 26 SEPTEMBER 2018 AND THE FINANCE AND DIGITAL COMMITTEE MEETING HELD ON 31 OCTOBER 2018

Keith Norton presented the assurance reports from the September and October Finance and Finance and Digital Committees, highlighting the change to the Committee and the focus on the impact of the capital programme, the ongoing PWC priority based budgeting work and CIP.

RESOLVED: That the reports be received as a source of assurance.

220/18 PEOPLE AND ORGANISATIONAL DEVELOPMENT

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

The Director of People and OD presented the report and emphasised the key points noted within, including upcoming projects, their RAG ratings and new programme of work, performance against sickness, turnover and statutory and mandatory training targets, current response rates to the staff survey and the expanded role of the diversity network.

In response to the Director of People and OD, the following points were raised:

- The Chair praised the Extended Leaders' Network and asked how the forum would be utilised moving forward. The Director of People and OD explained the format for the Extended Leaders' Network and that further conversations would be had on how to utilise the network.
- The Director of Quality and Chief Nurse reflected on retention and how the Trust was not yet getting it quite right. The Director of People and OD felt the developing conversation with divisions was crucial and noted the importance of exit interviews (and responding to their findings) and triangulation of information.
- Claire Feehily questioned the level of sharing of good practice. The Director of People and OD answered that each division had a strategic Human Resources Business Partner to support with analysis and data with further review of detail by the HR advisory team who look at best practice. There is also a range of training and upskilling available to managers. The Chief Executive added that the Diversity Network had highlighted a need for training for managers of staff with mental health problems and disabilities. She also highlighted the planned Health and Wellbeing Hub commissioned to operate from April 2019.
- Rob Graves noted poor compliance with mandatory training for medical and dental trainees and felt a different approach was needed. The Director of People and OD explained that while figures were technically correct, all trainees undertook a national training suite and there had been issues with translating data between the national system and the Trust. Some Trust standards have also been found not to align with national standards and therefore this is being further reviewed. In summary the picture is under-reporting the actual levels of compliance.

RESOLVED: That the Board note the performance outlined in the key performance indicators and progress made against strategic priorities and accept the report as a source of assurance.

ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE MEETING HELD ON 11 OCTOBER 2018

Alison Moon presented the assurance report from the October Committee, highlighting the improvements in statutory and mandatory training compliance, the work requested on medical and dental trainees, improved benchmarking, review of sickness levels, retention, the Health and Wellbeing Hub, Freedom to Speak Up and divisional workforce risks.

RESOLVED: That the report be received as a source of assurance.

ASSURANCE REPORT OF THE CHAIR OF THE JOINT QUALITY AND PERFORMANCE AND PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD ON 25 OCTOBER 2018

Alison Moon presented the assurance report from the joint Committee, highlighting the two items of focus: bringing together patient and staff experience and the adult inpatient nursing review. The Director of Quality and Chief Nurse emphasised that the Safer Staffing report would return to Board six monthly. The Corporate Governance Manager would add to the work plan. **NJ**

The Director of Finance asked whether any future joint Committees would be held and whether other Committees should consider the same approach. Alison Moon answered that a further joint Committee should only be held if there was a clear joint issue and that members should also meet to discuss operational issues elsewhere.

RESOLVED: That the report be received as a source of assurance.

FREEDOM TO SPEAK UP REPORT (FTSU)

The Freedom To Speak Up Guardian presented the report to provide an update to the Board on the development of the speaking up strategy, governance arrangements for speaking up and quality improvement approach to speaking up. In response:

- The Director of Quality and Chief Nurse praised the Guardian on #SpeakUpToMe month and the engagement on social media. He acknowledged how beneficial the initiative was and the contribution to a positive Trust culture.
- Claire Feehily felt reflection was needed on how best to resource FTSU and whether more than a single guardian was needed. She also thought the Trust should consider how to best follow up on themes raised.
- Mike Napier observed that the highest concern was poor staff experience / bullying/ harassment allegations which could link to challenges with retention and asked how this would be further reviewed. The Director of People and OD advised that this would be reviewed alongside the staff survey results in order to investigate any trends. She advised that all specific instances were investigated by the HR Advisory Team and explained the process. The Chief Executive felt more could be done to understand where culture was not as it should be and mentioned the *Climate Survey* tool she had used elsewhere and also added that 360° feedback as part of annual appraisals be further considered. **EW**

RESOLVED: That the Board note the report and accept it as a source of assurance.

[The Deputy Director of Quality left the meeting]

221/18 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 18 SEPTEMBER 2018

Rob Graves presented the assurance report from the September Committee, highlighting the update from counter fraud, internal audit and delays to scoping of internal reports, involvement of NEDs in internal scoping, Committee Terms of Reference, emergency business planning, information governance and GMS audit arrangements.

RESOLVED: That the report be received as a source of assurance.

222/18 GLOUCESTERSHIRE MANAGED SERVICES (GMS)

REPORT OF THE CHAIR OF THE GMS COMMITTEE MEETING HELD ON 10 SEPTEMBER 2018 AND 9 OCTOBER 2018

Mike Napier presented the assurance reports from the September and October Committees, highlighting the progression from project set up to business as usual, how the Committee can best receive assurance, further review of hard services needed, recovery plans for cleaning, sterilisation and catering and concerns raised, Key Performance Indicators, contract variations, health and safety roles and general management of risks.

The Chief Executive advised that she had discussed risk with the Director of Corporate Governance and agreed that GMS would be incorporated into the planned internal risk audit. She added that the Director of Corporate Governance would review and compare past Estates and Facilities risk registers and current GMS and Trust risk registers to analyse the changes and identify any actions required. She further noted that risks related to the Trust estate should be on the Trust Risk Register whilst the actions to address the risks should be within a GMS Issues Log (or similar). The Chief Operating Officer, Director of Corporate Governance and Director of Safety were due to discuss and address it. Finally, the Chief Executive reflected on capability and capacity to lead on estates matters and advised that the executive team were reflecting on this.

Keith Norton felt it odd to receive a Chair's report without a supporting substantive report. The Board discussed the best approach to oversight and the Chief Executive felt that each Committee report should including a dimension on GMS. This would be further discussed at the next Executive Meeting. **DL**

RESOLVED: That the report be received as a source of assurance.

223/18 GOVERNANCE DOCUMENTS

MODERN SLAVERY ACT STATEMENT

The Director of Corporate Governance presented the Trust Statement on Modern Slavery, highlighting that there is a mandatory requirement for the Trust to have a public statement by the Board on its recognition of and work towards compliance with the Modern Slavery Act (2015). The level of maturity and commitment would be reviewed annually. **NJ** for the workplan

The Chair queried how this would impact suppliers and whether GMS had their own statement. The Director of Corporate Governance advised he would further discuss with both GMS and procurement. **LB**

RESOLVED: That the Board approve the statement.

RESPECTIVE ROLES OF THE CHAIR AND CHIEF EXECUTIVE

The Director of Corporate Governance presented the document on the respective roles of the Chair and Chief Executive, explaining that the NHS Foundation Trust Code of Governance stated that the division of responsibilities between the Trust Chair and Chief Executive should be clearly established, set out in writing and agreed by the Board of Directors. He noted that the Chief Executive and Chair were both supportive of the document.

Rob Graves felt a point should be added to the Chair's role detailing that they are responsible for the management and performance of individual non-executive directors. The Board also felt that the word 'entrenched' should be amended. **LB**

RESOLVED: That the Board approve the document subject to the minor changes, as set above.

TERMS OF REFERENCE REVIEW UPDATE

The Director of Corporate Governance provided a verbal update on the Trust Terms of Reference review, noting that these were being updated alongside the Standing Orders and Standing Financial Instructions. The full suite of documents would return to the Board in January. **NJ** for the workplan

224/18 ONE PLACE BUSINESS CASE UPDATE

The Director of Strategy and Transformation presented the One Place Business Case update, reminding the Board that in September they received a report proposing a phased approach to public consultation. Following a review, it has become clear that this approach has become confusing for many stakeholders with an element of risk, and therefore it is now proposed that an extended period of stakeholder engagement is undertaken from November 2018 to March 2019 with formal public consultation commencing in Autumn 2019. The structure for delivery will remain the same and outputs will be the defined model of care and business case. The pilots within Trauma and Orthopaedics and Gastroenterology will continue, and the proposal for a pilot in General Surgery will be discussed at Health Care Overview and Scrutiny Committee (HCOSC) on 13th November.

Mike Napier asked whether One Place was a Trust or ICS programme. The Director of Strategy and Transformation answered that it was dual programme, sitting within the ICS governance structure as well as the Trusts own internal governance structure to drive the business case.

RESOLVED: That the Board note the report for information.

225/18 SMARTCARE PROGRESS REPORT

The Chief Executive presented the SmartCare Progress Report to provide assurance to the Board on the current position of the SmartCare Programme. She outlined that the report demonstrated a generally positive picture, noting that the Red rated items within the table on page 2 were not importing any safety risks, as well as highlighting the progress against data quality indicators. The Trust is on track to report RTT in February, however, the Trust was on a journey and initially reporting would likely not be wholly reliable. The focus moving forward would be on optimising the system to support theatres, real time data and assessment of the suitability of the pathology and pharmacy systems.

Claire Feehily noted the trip to Yeovil and reflected on the high amount of operational input and its resourcing long term. The Chief Executive answered that at present there were 20 staff within the Trust's validation team, funded non-recurrently, and that disappointingly this level of validation needed to continue and would therefore need to be reviewed through budget setting. Trust.

RESOLVED: That the Board note the report.

226/18 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

[The Guardian for Safe Working joined the meeting]

The Guardian for Safe Working Hours presented the quarterly report, highlighting that:

- 103 exception reports have been logged (in comparison to 213 in the previous quarter)
- There were a total of 8 fines to the value of £2631.21.
- There are no correlations with Datix clinical incident reports for this period.
- Exception reporting was noted to be well embedded within the Trust but there is a national concern as to whether trainees report as much as they should.
- The Junior Doctors Forum meets regularly and has a new Chair, Dr Gio Sheiybani. The most recent meeting was attended by a General Medical Council representative to ensure engagement at a regional and national level.
- Work is underway to investigate the high number of reports amongst medical registrars and whether there is a "culture of coping".
- A recent national meeting of Guardians had indicated that the Trust was further ahead than many in this regard including a number of Trusts not reporting to their Board.

In response:

- The Chief Executive noted the report and questioned the relationship between vacancy rates and reporting levels. The Guardian for Safe Working Hours felt there was a direct correlation and detailed the resulting issues, acknowledging how an improved vacancy rate would support addressing these. The Chief Executive concurred, noting that the vacancy issues were driving the belief that services need to be reconfigured.
-

- The Medical Director noted that previous fines had been assigned towards supporting a pier support network for foundation doctors. He also highlighted how small the percentage of exception reports were in comparison to shifts worked. He praised the Guardian for Safe Working for his work in engaging junior doctors to express their concerns.
- Keith Norton asked the Guardian for Safe Working Hours what his biggest concern was. He answered that his primary concern was issues relating to underreporting and reinforced that his focus was creating a culture where junior doctors feel able to call for help and escalate concerns.

RESOLVED: That the Board accept the report as a source of information and assurance.

[The Guardian for Safe Working left the meeting]

227/18 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 15 AUGUST 2018

RESOLVED: That the minutes be noted.

The Chair noted how impressed he was with the level of commitment and dedication of Governors at the Council of Governors.

228/18 GOVERNORS' QUESTIONS

The following points were raised by Anne Davies:

- She felt it was reassuring to hear the comments on the ICS.
- She acknowledged Claire Feehily's comments on the patient story and the importance of the emotional language.
- She was pleased to hear about the Black, Asian, Minority and Ethnic (BAME) champion within the Equality and Diversity Steering Group.
- Regarding the recent pipe leak on Guiting Ward, she noted that a similar issue had occurred previously and the Trust had been subject to an NHSE advisory notice. She sought assurance that there was a process to address the issue. Mike Napier answered that the previous issue was related to a metallurgy problem, and the most recent issue was believed to be related to poor workmanship 12 years ago. The Director of Quality and Chief Nurse advised that an extensive review of pipes on the Guiting Ward was undertaken following the incident and there were no further concerns identified.

229/18 STAFF QUESTIONS

There were none.

230/18 PUBLIC QUESTIONS

There were none.

231/18 ANY OTHER BUSINESS

The Director of Corporate Governance reinforced the importance of not using acronyms and ensuring language was accessible.

232/18 DATE OF NEXT MEETING

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

233/18 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 13:00

Chair
10 January 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JANUARY 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
January 2019	November 2018 217/18 Chief Executive's Report	**SL**	The Director of Strategy and Transformation said he would be attending a King's Fund session where wave 1 ICSs would be feeding back their experiences and what they were able to achieve as an ICS as opposed to an STP.	He would feedback to the Board.	*Ongoing* *Verbal update to be provided.*
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.	*Completed* *Discussed at December GMS committee, part of ongoing work schedule owned by GMS.*
January 2019	November 2018 218/18 Quality and Performance – Trust Risk Register	**LB**	Alison Moon noted that the report included controls but not actions.	The Chief Executive noted that a version including actions went to Trust Leadership Team and would ensure this version came to Board in future.	*Completed* *Updated Trust Risk Register on the agenda.*
January 2019	November 2018 218/18 Quality and Performance – Board Assurance Framework	**LB**	The Chief Executive said that BAF code 1.5 "Meet all national access standards" should be red, not amber, as this will not be achieved by March 2019.	To be amended.	*Completed* *Updated BAF summary on the agenda.*

January 2019	November 2018 218/18 People and Organisational Development – Assurance Reports	**NJ**	The Director of Quality and Chief Nurse emphasised that the Safer Staffing report would return to Board six monthly.	Corporate Governance Manager to add to work plan.	*Completed* *Added to work plan.*
January 2019	November 2018 218/18 People and Organisational Development – Freedom to Speak Up Report	**EW**	The Chief Executive felt more could be done to understand where culture was not as it should be.	She mentioned the Climate Survey tool she had used elsewhere and also added that 360° feedback as part of annual appraisals be further considered.	*Completed* *The intention is to conduct cultural pulse surveys following analysis of the recent staff survey. The use of 360 degree appraisals is established in some areas such as for staff in the Accelerated Development Pool. There would be a challenge in asking all members of staff to have a 360 degree appraisal annually but this methodology could be utilised for key roles or departments/services where F2SU issues seem commonplace. The Newly focused staff and patient experience improvement group will triangulate such data to highlight roles and areas where these tools would be most useful to provide additional insights into culture.*
January 2019	November 2018 222/18 Gloucestershire Managed Services – Assurance Report	**DL**	Keith Norton felt it odd to receive a Chair's report without a supporting substantive report. The Board discussed the best approach to oversight and the Chief Executive felt that each Committee report should including a dimension on GMS.	This would be further discussed at the next Executive Meeting.	*Completed* *Executives agreed that each domain report would address any matters of significant relating to GMS as opposed to producing a standalone GMS report.*

January 2019	November 2018 223/18 Governance Documents – Modern Slavery Act Statement	**LB**	The Chair queried how this would impact suppliers and whether GMS had their own statement.	The Director of Corporate Governance advised he would further discuss with both GMS and procurement.	*<u>Completed</u>* *Raised with Head of Shared Services and advised that the Trust used NHS Standard Terms and Conditions in the majority of its contracts with suppliers. The standard terms already contain references to compliance with relevant anti-slavery law (see example extracts below). Therefore there should be no impact on suppliers.* *Section 54 of the Modern Slavery Act 2015 requires certain organisations to develop a slavery and human trafficking statement each year. GMS do not currently have a statement but meet the criteria of organisations that need to comply as they are a body corporate, carry on a business in the UK, supply goods and services and have an annual turnover of £36m or more.* *GMS asked to action.*
January 2019	November 2018 223/18 Governance Documents – Modern Slavery Act Statement	**NJ**	Annual review of the statement.	Corporate Governance Manager to add to work plan.	*<u>Completed</u>* *On the work plan*

January 2019	November 2018 223/18 Governance Documents – Respective roles of the Chair and Chief Executive	**LB**	Rob Graves felt a point should be added to the Chair's role detailing that they are responsible for the management and performance of individual non-executive directors. The Board also felt that the word 'entrenched' should be amended.	To be amended.	*Completed*
January 2019	November 2018 223/18 Governance Documents – Terms of Reference	**NJ**	The Director of Corporate Governance provided a verbal update on the Trust Terms of Reference review, noting that these were being updated alongside the Standing Orders and Standing Financial Instructions.	The full suite of documents would return to the Board in January. Corporate Governance Manager to add to work plan.	*Completed* *Being reviewed by January Audit and Assurance Committee prior to review at Board.*

ICS community of practice – meeting two

Objectives

- Continue to build links between ICSs to create a learning community
- To explore how ICSs can take forward ambitions to improve population health, including learning from examples of best practice
- To explore payment and incentive systems to support integrated care, including alternatives to transactional approaches

Looking beyond the health and care system to improve population health: the Wigan experience

Kate Ardern (Director of Public Health, Wigan Council)

Please see the attached slide set for details of Wigan's approach to public service reform, and details of the outcomes they are achieving.

A video interview with Donna Hall, CEO of Wigan Council, can be found on our website at: https://www.kingsfund.org.uk/audio-video/donna-hall-wigan-story

Themes from discussion:

- Developing new relationships between public services and citizens
- This requires different ways of working with people, and different types of conversations. In Wigan, the principles of 'The Deal' run through everything they do, including recruitment processes and how services are being commissioned. All staff receive 'deal training'
- An asset-based approach, centred around 'place' and 'community'
- This requires professionals and services to 'know their community'
- Wigan's approach to new service models has been wrapped around local anchor institutions e.g. schools and GP surgeries
- Wigan's seven service delivery footprints (i.e. their neighbourhood teams) include NHS, council, police, school and fire services
- Community investment fund of > £9million has supported community initiatives despite significant cuts to the council's budget. Many volunteers have been trained as community health champions
- The work was initiated and led by the council, involvement of the NHS has come later. Deal training is now being extended to NHS staff
- Most of this work has been locally led, with Greater Manchester and the devolution deal as an enabling backdrop
- Council and CCG now have joint CEO. There is also a joint director of finance, a joint commissioning committee and a large s75 agreement
- Key factors contributing to the progress in Wigan include: a focus on relationships and trust, involvement of the community, clarity of vision

Looking beyond the health and care system to improve population health: the role of ICSs

Greg Fell (Director of Public Health, Sheffield City Council) and Helen Atkinson (Strategic Director Adult Social Care and Public Health, Surrey County Council).

Themes from discussion:

- Many ICSs are complex in terms of their relationship to local authority boundaries. A focus on place can help to overcome this
- An important step in building closer collaboration is to identify common cause around what health and local government colleagues want to achieve for the local population

- Some areas have introduced 'matchmaking' exercises to link GPs and local politicians and enable them to work to identify common cause
- Improving population health requires an emphasis on wider determinants – housing, education, leisure, employment – as well as what happens in health and care services. There is also a role for the NHS as a local employer etc.
- Local authorities have skills and experience in public engagement and can bring these to enhance the work of ICSs in this area
- As in Wigan, Sheffield and Surrey are also forming joint commissioning functions across NHS and local authorities
- It is often challenging to shift the focus of conversations with the regulators at a regional level to prioritise work to improve population health. Organisational performance often dominates

A new report from The King's Fund *A vision for population health* was published on 27th November and explores these issues in greater depth: https://www.kingsfund.org.uk/publications/vision-population-health

Incentivising integrated care: an alternative approach

Ben Collins (Projects Director, The King's Fund) and David Hambleton (CEO, NHS South Tyneside CCG)

Themes from discussion:

- Despite many years of attempts to incentivise improvement through market-based mechanisms and financial incentives, these have often failed to achieve the desired result
- Proposed contractual routes to incentivise integrated care are highly complex. There may be significant transactional costs associated with this, and there is a risk that this undermines collaborative relationships
- Much of the focus on international models has been on insurance-based systems as in the US, where financial incentives operate differently
- Models from tax-funded systems, for example the Canterbury system in New Zealand may have more to teach us
- The approach in Canterbury has been to use alliancing arrangements. They aim to 'keep payment models as simple as possible' and 'don't let financial incentives get in the way of the right conversations'
- They also aim for their approach to be:
    - Clinically led
    - Data driven
    - Open book
    - Based on relationships
- Where performance issues are identified, they aim to resolve these collectively
- South Tyneside CCG have been supported by Canterbury DHB for the last 3 years, and have transformed their approach to payments and incentives
- This includes stopping PbR and moving the acute provider onto a block contract, agreed between the trust and CCG
- This freed people up to have different conversations and rethink the way that services are provided as 'the money was off the table'
- The alliance leadership team in South Tyneside focuses on discussing behaviours rather than on transactional business
- If there are performance issues, the first response is to bring the provider into a room with the CCG and other providers to discuss what is going on, and to work together to find solutions. The conversations have changed from 'what's in your contract' to 'how can we help'
- Changing the contracts is not enough in itself. The behaviours need to change too

Shared responsibility for health

We shared the key arguments from a new long-read from the Fund, which makes the case for 'shared responsibility for health'.

The central argument of the piece is that there should be much greater emphasis on shared responsibility between patients, the public and the NHS for improving health and care. We argue that the priority in bringing about this cultural change is to attend to trust and relationships between patients and the staff caring for them, and between the public and the agencies that serve them.

You can read the piece at the following link: https://www.kingsfund.org.uk/publications/shared-responsibility-health

Suggested topics for the next meeting of the community of practice

- Long term plan – pick up on specific issues that affect ICSs/ consider how to balance against local priorities
- Patient and public involvement in ICSs (contribution from Dan Wellings)
- Changes in the regional teams – consider how relationship between local systems and regions will change, invite a new regional director to contribute
- Voluntary and community sector role in ICSs

Format:

- Suggestion to allow more time for discussion and dialogue with speakers next time
- Positive feedback on shorter agenda

The next meeting of the community of practice will be held on 6th March 2019. Please email any feedback on this session or suggestions for future sessions to a.charles@kingsfund.org.uk or n.walsh@kingsfund.org.uk

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JANUARY 2019

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 2nd November 2018 to 3rd January 2019.

Trust Activities

DATE	EVENT
13 11 18	Chair interview with CQC (Well led inspection team)
14 11 18	Informal meeting with Staff Side
14 11 18	Pre interview panel meeting with consultant candidate
15 11 18	CQC Well led inspection verbal debrief
22 11 18	Oncology consultant panel interviews
22 11 18	Governor 1:1
29 11 18	Staff Awards evening
04 12 18	Head of Research interview panel member
07 12 18	Presenting awards at Gloucestershire Safety and Quality Improvement Academy
17 12 18	Associate/Non-executive Director interviews
02 01 19	Lead Governor 1:1
03 01 19	Governor 1:1

Gloucestershire Health Economy

DATE	EVENT
05 11 18	Gloucestershire Strategic Forum (GSF) workshop
13 11 18	Health and Care Overview and Scrutiny Committee
20 11 18	Meeting with Chris Creswick – STP Independent Chair
21 11 18	Informal meeting with Chair and CEO of Gloucestershire Care Services/2gether Trusts
27 11 18	Gloucestershire Strategic Forum (GSF) workshop
10 12 18	Research4Gloucestershire meeting
11 12 18	GSF Remuneration Committee
12 12 18	External assessor on Chair recruitment panel – Royal United Hospitals Bath FT
18 12 18	Gloucestershire Strategic Forum (GSF) workshop

National Stakeholders + others

DATE	EVENT
01 11 18	South West Regional Chairs' meeting
06 12 18	NHS Providers' quarterly Chairs and CEOs meeting

Peter Lachecki
Trust Chair

3 January 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JANUARY 2019

REPORT OF THE CHIEF EXECUTIVE

1. Current Operational Context

1.1 Despite robust planning and mitigations in place, the festive period has been characterised by emergency demand in excess of that planned and previously experienced. Compounding high attendance levels at Accident & Emergency (A&E), the acuity of many patients presenting has resulted in high levels of admissions and bed occupancy significantly above that which is optimal. After a quiet start to the season, influenza presentations have also started to rise. As ever, the response from staff throughout our hospitals has been phenomenal and patients have remained safe and well cared for, albeit with waits in excess of those which we strive for. There is evidence that a number of our new services and pathways such as AMIA (Acute Medical Initial Assessment Unit) have contributed significantly to what would otherwise have been an even more challenging picture. With several months of winter ahead, the focus will remain on working with system partners to try and reduce reliance on hospital based care whilst supporting staff to remain resilient in the face of current demand. Despite this backdrop, the Trust achieved one of the strongest A&E performance levels in the region over the Christmas fortnight; testament again to the planning and execution from staff working in unscheduled care throughout the system.

1.2 Despite efforts to manage demand, including a 'hard hitting' public awareness campaign, we saw some of the highest attendances at our A&E departments and as a result, the Trust has called for a review of all investments in services and initiatives aimed at reducing demand on hospital services to confirm the ongoing appropriateness of such investments.

1.3 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; additional consultant staff and external funding is expected to significantly improve urology performance, which remains the speciality of most concern. Of note, in December the Trust achieved the two week wait cancer standard **for the first time in 21 months** despite unprecedented increases in referrals driven by changes to national guidance**;** the standard has only been achieved in four months of the last three years. Whilst more is required to secure embedded delivery, this milestone is a very significant one on that journey**.**

1.4 In addition, 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 achievements to date are 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. The risk to this target remains the consequences that continue arise from the ongoing cleansing and validation of the remaining 110,000+ open outpatient pathways.

2. National and Regional

2.1 The NHS Long Term Plan is now described as 'imminent' and Matthew Swindells, Deputy Chief Executive of NHS England presented some of the context and aspirations for the plan at a meeting of South West Chief Executives on the 14th December 2019. Of note, there was a very significant emphasis on transformation of care through the use digital technologies, both in and outside of hospital and it is clear that there are huge expectations in the plan around cost benefit from digital transformation. The Trust's own plans to hopefully secure *fast follower* status to a Global Digital Exemplar, will place us well to take advantage of these opportunities.

Other significant emphases were improving cancer outcomes and improving access for children and young people with mental health issues (and parity of esteem, more generally).

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'. The NHSE / NHSI top team has been announced this week, as have the seven Regional Directors. The South West Regional Director will be Elizabeth O'Mahony, currently the Chief Financial Officer for NHS Improvement and a former regional finance director in the South West.

2.3 On the 20th December, Chief Executives from across the country were called to an address by Ian Dalton, Chief Executive of NHS Improvement and Simon Stevens, Chief Executive of NHS England. The focus of the briefing was planning for next year and the potential implications for the NHS arising from the various Brexit scenarios which are being worked through by the Department of Health. The most significant risks appear to relate to the supply chain of goods and this mirrors our own risk assessment, although there are additional risks relating to workforce and research. For our own Trust, reliance on staff from the EU is limited and workforce is not as significant a concern to us, as it is for some Trusts. The remainder of the meeting focused on early headlines from the Operational Planning Guidance; a version of which went on to be issued the next day. Whilst not included in the initial planning guidance, there was also an interesting discussion regarding changes to the way in which Trusts in deficit will be supported to achieve their break even duty; timing of further detail on this approach is unclear at present but at face value would appear to benefit the circumstances of our Trust.

2.4 The guidance entitled *Preparing for 2019/20 Operational Planning and Contracting* is a high level summary document but signals the key changes which will shape the draft Operational Plan due to be submitted in mid-February. Headlines include

- A greater focus on system planning, with system control totals being set for each Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP). Providers within an ICS will be expected to link a proportion of their Provider Sustainability Funding (PSF) to delivery of the system control total. Further guidance on this is awaited.
- Tariffs have been uplifted by 3.8% to reflect inflationary impacts and £1bn of the current PSF funding will be transferred into tariffs, along with 50% of the currently available CQUIN funding. The tariff efficiency factor is lower than anticipated by many, at 1.1%.
- The marginal rate for emergency admissions and readmission penalties will be abolished and existing penalties for 52 weeks (£5,000 per breach) will be shared equally between commissioners and providers. Funds created from the application of these fines will be available for reinvestment in recovery plans, subject to regional office agreement.

- Of note, given the pressures facing our system, the tariff for emergency care will change considerably to a 'blended payment model' of fixed and variable costs, within which 80% reflects the quantum of cost associated with delivery and 20% is linked to activity; in addition, there will be a 'break glass' clause if activity significantly exceeds plan which will enable the fixed cost element to be increased.
- Changes to system allocations and commissioner requirements are expected to shift both emphasis and funding to mental health and health inequalities more broadly, both of which are very welcome.

3. Our System and Community

3.1 In early December, members of the Gloucestershire Integrated Care System (ICS) spent an informative session listening to the Chief Executive of the Independent Reconfiguration Panel (IRP) talk about the learning and best practice associated with other national service reconfigurations. Additionally, a senior member of the Consultation Institute presented on best practice in relation to public engagement and formal consultation. All present agreed the session had been very useful and would shape the way forward. Next steps are to review the approach to date in respect of procedural practice and agree the detail of the public engagement which will commence in the New Year and culminate in formal public consultation in Autumn 2019.

3.2 The system bid for further national STP capital to develop the County's estate did not result in additional resources for Gloucestershire although positively, Gloucestershire Care Services have been allowed to retain £11.5m of capital from asset disposals to fund the re-provision of the two community hospitals in the Forest of Dean.

3.3 In November, the Trust presented its plans to pilot changes to the provision of general surgery services to the Health and Care Overview and Scrutiny Committee (HCOSC). A number of concerns about the proposal were expressed and addressed in the meeting though residual concerns remain; HCOSC has been invited to set these concerns out in writing and a follow up meeting with take place in mid-February. HCOSC approval is not required for a pilot and planning will continue whilst the issues are further explored. The Committee were aware of a letter from 57 consultants of the Trust which sets out their support for the Centres of Excellence proposal; the meeting gave the Trust an opportunity to highlight this was indeed a letter of support and did not express the sentiments portrayed through the media.

3.4 Unavoidable, temporary changes to the provision of radiology services in community hospitals were introduced in mid-November. These changes have arisen from the impact of high, long standing vacancies in the radiographer workforce and the need to prioritise staff towards those services at risk of becoming unsafe as a consequence. Currently, the Trust is experiencing a 24% vacancy rate alongside an unenviable retirement profile; this is a national issue although Gloucestershire is fairing less well than some areas – the South West vacancy rate is 17%. The impact of the changes has been a reduction in the hours of community radiography although these have been re-patterned to ensure services such as outpatients and minor injury units are not impacted and that every community hospital retains access; most importantly, risks in the most complex, life and limb-saving acute services have been mitigated through these measures. Huge effort is being made to improve the recruitment and retention of staff in this discipline in order to restore services as soon as possible.

4. Our Trust

4.1 As ever, staff and supporters went above and beyond to ensure those in hospital over the festive period didn't miss out entirely. Following the success of last year's event, staff and children of the Children's Centre were treated to the live streaming of the Roses Theatre Christmas production of *Dick Whittington.* Technology worked extremely well and as a result of last year's trailblazing, it wasn't just the children of Gloucestershire Hospitals that enjoyed the panto but children up and down the country including those being cared for by Great Ormond Street Hospital; Gloucestershire's sick children were however, privy to extra special treatment with a visit from members of the cast prior to the screening. A huge thanks to Non-executive Director Keith Norton and (lucky for us) Chairman of the Board of Trustees of Roses Theatre, who was instrumental in getting this initiative off the ground. As if that weren't treat enough, children also enjoyed a visit from players of Gloucestershire Rugby Club and a screening of the Everyman's Velveteen Rabbit production as part of our charitable partner Pied Piper's Christmas celebrations. I can't say enough about how much the Trust appreciates the support it enjoys from our charities and those that support them.

4.2 The Trust has quickly moved on from the recent 'inspection fever' though unfortunately the draft report is now delayed until mid-January pending the provision of further information however publication date remains the 7th February.

4.3 Work is progressing well with the development of the business case for the major capital schemes (£39.5m) at GRH and CGH. 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. Critical to the success of the design will be inherent flexibility in any design solution. Following a recent meeting, I am personally very impressed with Kier's commitment to a strategic partnership, local employment of their workforce and staff and patient engagement in the planning of the scheme.

4.4 With only hours to develop and submit a bid against a notification of national capital to support winter pressures, the Trust was 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. With a challenging timeline of works completion by 24th December, I was delighted to have the opportunity to cut the ribbons at the official openings of the relocated Cardiac Investigations Unit and Acute Initial Medical Assessment Unit at GRH on the 12th and 13th of December respectively which were the key elements of the investment. The contribution of the new AMIA to flow over Christmas has already been mentioned above.

4.5 In a similarly positive vein we were advised 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 control totals.

4.6 Sticking with the theme of capital funds, the hospitals' charity announced a VERY significant anonymous donation of £400k towards the fundraising target of £1.2m, 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 and has resulted in a 'freeze' on capital spending this year, on anything other than safety related emergency expenditure. A risk assessment of this decision has been undertaken and a decision is now promised in the next few weeks.

4.7 Since the last Board meeting, on the 21st November more than 300 Trust staff came together to celebrate all that is good about the NHS and staff in Gloucestershire Hospitals in particular. Whether a winner or a runner up, the feedback from staff was the most positive to date and media coverage further extended the feel good factor that comes from such events. Planning for next year is already under way.

4.8 One exceptional staff member was recognised in this year's *New Year's Honours* list when she was awarded a MBE for her services to physiotherapy. Susie Durrell is a Consultant Physiotherapist in the Trust renowned for her inspiring contribution to service and staff development. Congratulations have been forwarded to Susie on behalf of the Board.

4.9 On the 17th December, the Trust hosted a service of thanks to recognise the end of an incredible chapter in the Trust's history as it said thank you and goodbye to the Friends of Gloucestershire Hospitals. Over 70 years of support, the Friends have provided more than £1.25m of funding to the Trust to support the care and comfort of patients and staff. The Trust is hugely indebted to those that have served the friends over their seven decades. A tree and plaque of recognition will be planted in Trust grounds as a reminder of the Friend's service to the Trust.

4.10 Finally, the Board will be seeing more changes in its personnel following the announcements from Sean Elyan, Medical Director that he intends to step down from the medical director role later this year and also Caroline Landon, Chief Operating Officer who has secured a promotion through her appointment as Director General for Community Services for the States of Jersey. Fortunately, we will be retaining Sean's considerable knowledge and expertise in the Trust through his continuing clinical commitments and input into ad hoc leadership initiatives. Recruitment for successors is underway with interviews scheduled for w/c 28th January and 4th February respectively.

4.11 Inevitably, this period is characterised by both looking backwards in reflection and forward with ambition and enthusiasm. Much has been achieved in 2018 thanks to the effort of individuals and teams within the Trust as well as the welcome support from partners across our system. The challenges ahead are no less but I am confident that the Board is as well placed as ever to steer the Trust through this next phase of its development.

Deborah Lee
Chief Executive Officer
January 2018

TRUST BOARD – JANUARY 2019
Lecture Hall, Redwood Education Centre commencing at 12:30

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. Risk assessed as having an impact of catastrophic (5) need to be considered for inclusion in this process as per Risk Register Procedure.
- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context.
- Improvements have been made to the presentation of the risk and the Register now includes actions which will limit the impact of a risk if it occurs or reduce the likelihood of it occurring.

Changes in Period

There is one change to the Trust Risk Register in this reporting period (covering the December and January TLT).

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

No risk has been **downgraded** in this reporting period.

One risk has been **upgraded** in this period:

January 2019
F2724 Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19 Revised score 20 (5) Catastrophic x (4) Likely – Weekly Executive Lead: Sarah Stansfield.

No risks have been **closed**
The Trust Risk Register is attached (Appendix 1).

Conclusions

The 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

Not applicable.

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 previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
8 January 2019						9 January 2019	
Outcome of discussion when presented to previous Committees/TLT							

Trust Risk Register **January 2019 Board** **Appendix 1**

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Risk Rating	Division	Highest Scoring Domain	Executive Lead Title	Title of Assurance / Monitoring Committee
F2724	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19	1. PMO in place to record and monitor the FY18 programme 2. Weekly Turnaround Implementation Board 3. Monthly monitoring and reporting of performance against target 4. Monthly executive reviews	See CIP plans	Complete	Catastrophic (5)	Likely - Weekly (4)	20	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance and Digital Committee
C2628COO	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: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place but this is contingent on the progress within the Trak recovery programme.	See RTT and TrackCare plans	Partially complete	Major (4)	Likely - Weekly (4)	16	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee
C2667NIC	The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.	1.Strengthetened infection control team 2.Deputy Director of Infection Control in post 3. New cleaning regime introduced	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	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Quality	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee
S2275	The risk of workforce issues with 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.	1. Guardian of Safe Working Hours 2. Junior doctors support	1. Attempts to recruit 2. Agency/locum cover for on-call rota 3. Nursing staff clerking patients 4. Prioritisation of workload 5. Existing junior drs covering gaps where possible 6. Consultants acting down	Incomplete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	Trust Leadership Team, People and Organisational Development Committee
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY19 CIP programme	1. Challenge to agency requests via VCP	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2. Convert locum\agency posts to substantive 3. Promote higher utilisation of internal nurse and medical bank. 4. Implementation of HealthRoster for roster and Bank management. 5. Implementation of Master Vendor Agreement for Nursing agency	Incomplete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and Organisational Development Committee

C1798COO	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).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) 2. Speciality specific clinical review of patients	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities to complete f/u plan 3. Additional provision for capacity in key specialities to support f/u clearance of backlog	Partially complete	Moderate (3)	Almost certain - Daily (5)	15	Medical, Surgical	Quality	Chief Operating Officer	Quality and Performance Committee
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.	1. Corporate visibility through infection control committee and trust leadership team. 2. Heightened oversight	1. Improvement plan developed. 2. Review meetings through the GMS contractual mechanisms. 3. Matrons undertaking individual audits in preparation for CQC. 4. Auditing now completed by designated auditing team.	Partially complete	Moderate (3)	Likely - Weekly (4)	12	Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Director of Quality and Chief Nurse	Quality and Performance Committee
C2669N	Risk of harm to patients as a results of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post Falls Protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post	1. Falls Training 2. HCA specialing training 3. #Little Things Matter Campaign 4. Discussion with Matrons on 2 wards to trial process	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Trust Leadership Team, Quality and Performance Committee
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patient's journey - from ED to DWA once assessment suggests patient's skin may be at risk.	1.Create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for pressure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via Matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metrics reporting. 4. NHS collaborative work in 2018 to support evidence based care provision and idea sharing.	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee

S2568Anaes	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	1. Prioritisation of operations 2. Maintenance by own medical engineering service	1. Request for 5 x Induction machines and 5 x anaesthetic machines 2.Ensure risk raised to all surgical board meetings 3.To request further equipment replacement before end of September 2017 to ensure all oldest machines are replaced. List of machine to be replaced on that action to be drawn up. E-mail to medical engineering to obtain that list. 4. Application to MEF 5. Loan request	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5	Surgical	Safety	Medical Director	Divisional Board, Medical Devices Committee, Quality and Performance Committee

REPORT TO TRUST BOARD – JANUARY 2019

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

This report describes the business conducted at the Quality and Performance Committee on 29 November 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 <u>Quality Delivery Group</u>		How is the impact and risk of continued recruitment freeze for theatre staffing vacancies understood and managed? Request that future Clostridium Difficile reporting be disaggregated to include divisional data. Why is there a high cancellation rate for Executive Safety Visits (ESVs)?	Divisional process for review of staffing structures was described. Also, process by which Vacancy Control Panel (VCP) considers filling critical posts. Verbal assurance received that safety would not be compromised. Approach being reviewed to ensure better coordination with executive availability.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		Discussion of levels of training to equip staff to manage and deal with violence and aggression. Request for additional information re gynaecological cancer patients and missed follow up appointments. What were the results of the sample audit of clinic letters?	50 letters from the over 5 day category are being reviewed in conjunction with a GP to assess impact of delays. Review including opportunities to reduce number of templates and to focus and standardise the content of letters.	Detailed review underway to be reported to December Committee. Results to December Committee.
Quality and Performance Report and Exception Reports from Delivery Groups <u>Cancer Delivery Group</u>	The Committee welcomed the high quality of exception reporting and the clarity of information about performance and improvement plans by cancer type. Specific concerns in period concerning Urology. Continued high referral rates.	Will urology performance improve re 104 day patients?	Yes, improvements are expected from November. Further funding planned in Jan and Feb 2019 to support recovery. Additional staffing resources described.	Further data to be distributed re Urology recovery plans.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	69% performance for 62 day target.			
Quality and Performance Report and Exception Reports from Delivery Groups <u>Planned Care Delivery Group</u>	Comprehensive report of actions to improve quality of patient lists and follow up waiting lists. Clinic typing backlogs improving for all specialties. 105 patients have waited more than 52 weeks. Return to RTT reporting on track for end of 2018-19	How are patients being advised of likely wait times before their next appointments? For those waiting more than 52 weeks, what is the range of wait times? What actions will be taken to reduce the number of 52 week breaches? Latest position re ophthalmology progress on delayed appointments?	Approximate dates are being given but more work is needed so that patients are not being given unrealistic expectations e.g. re 6 month follow up appointments. Longest wait is 56 weeks and additional analysis of this category and of the improvement trajectory will be provided to Dec Committee. 50% reduction planned for 31 March 2019. Further material to be reported. Additional weekend clinics to address backlogs were described.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report and Exception Reports from Delivery Groups Emergency Care Delivery Group	October's performance (90.5%) against 4 hour target exceeds NHS Improvement trajectory. Average 407 attendances. Continued 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. 74 ambulance handovers >30 mins, (national average: 146); 2 handovers > 60 mins, (national average: 18).	Discussion re how oversight of risk relating to stroke patients is exercised within Medical Division. What has been done to support improvement needed on 60 min medical assessment target?	Discussion of a range of initiatives underway to improve streaming of patients in Emergency Department. Review of reasons for breaches described. Targeted training underway to standardise arrangements.	
Quarter 1 Patient Experience Report	Quarter 1 and 2 patient experience material. Briefing on planned move of Complaints Team to join wider investigation team from January 2019 to improve integration of Trust's various investigation processes.	How do divisions deal with issues prior to their becoming complaints?	Divisional approaches described. Parliamentary Services Ombudsman visiting Trust in early 2019.	Further divisional input to Patient Experience report to December Committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Diabetes National Audit	Presentation and briefing on 2017 National Diabetes Inpatient Audit which measures quality of care provided to patients with diabetes and supports service improvement. Issues include growth in numbers with diabetes; and in local rates of medication and prescription errors; and in incidence of both mild and severe hypos.	What is the relationship between this exercise and planned Getting it Right First Time review (GIRFT)? What transformation needs to happen to the service and what skill set does the diabetes team need? Discussion included balance between casework by a specialist team and need to focus on education and spreading good practice. Where are the risks relating to patients with severe hypoglycaemia held and what is being done to improve performance? What is known about reasons for variation in outcomes between Gloucester and Cheltenham sites.	GIRFT due Jan 2019. Expectation from consultant that GIRFT would confirm known areas for improvement. Developments in the team were described; some areas of shortfall. More specialist need in primary care. Trust performance here needs to improve. Some attribution to acuity.	Further report on this to come to Committee together with GIRFT outcome. Decision to be taken as to whether a quality summit is required. Further review by Chief of Service re potential for improvements in outcomes for diabetic patients receiving vascular treatment.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Winter Plan	Comprehensive report on 2019 Winter Plan, including range of system-wide initiatives. Planning assumptions scrutinized. Committee commended Execs for quality of planning and briefing in discussion. Evidence of extensive cross-system preparation.	Wide-ranging discussion and questions including: - Assurances about system-wide operational efficiencies and pressure points - Extent to which demand assumptions matched most recent Emergency Department levels - Progress with capital investment - Executive view about weakest areas of the plan - How staff are being supported - Are system partners aware of their risks?	- Some concern about GP availability - Supervision and escalation arrangements were described. - An integrated risk dashboard has been developed that will be reviewed fortnightly in conjunction with partners	Future monitoring and exception reports to the Committee will include reference to a set of "balancing measures" that will give further assurance as to quality and patient experience dimensions to the Winter Plan.

Claire Feehily
Chair of Quality and Performance Committee
29 November 2018

REPORT TO TRUST BOARD – JANUARY 2019

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

This report describes the business conducted at the Quality and Performance Committee on 20 December 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	Report providing Committee with oversight of key risks. Also, action plan in recent Prevention of Future Deaths Report (PFDR) has been approved. The case related to the level of supervision of junior doctors on the ward, in particular when the patient is discharged without being examined by a senior doctor. The Committee was updated re final report on an unexpected death on a respiratory ward. The incident investigation has been completed.	Re Senior Review of high risk procedures: Why was procedure for four identified conditions not already in place? How will compliance improve under new arrangements? Is compliance with Emergency Department checklist to be reviewed within action plan? Re Referral to Treatment (RTT) - related risks, can risk register be amended to make clear timescales for any actions that are identified? Specific and more general points raised and discussed: - Whether late night transfers between	A system was in place but new action plan will improve reliability. Oversight to be exercised by audit arrangements and then by Quality Delivery Group. This has been subject to recent review. CCG rep to examine results. Risk recently reviewed by Trust Leadership Team. Further changes for future presentation to Committee agreed. Yes, from Jan 2019 Committee.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		wards are to be one of the balancing measures that will be scrutinised by Quality Delivery Group and Committee in future - Can we be assured that this type of incident could not happen again? - Circumstances surrounding gaps in observations and extent of family involvement in report to date - Focus of responsibility - Discussion of time given by Safety and Experience Review Group (SERG) to an event of this seriousness - Committee stressed importance of learning from this investigation and suggested possibility of it forming an anonymised case study.	Type and extent of family engagement described. Report to be reviewed at SERG, including action plan. Assurance process for exec oversight of action plan described.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report and Exception Reports from Delivery Groups <u>Quality Delivery Group</u>	Further enhancements noted to the Quality exception reporting. Particularly valuable to receive assurance of divisional performance and quality governance arrangements,	Discussion points included: - In light of recent BMA publication on impact of bullying, how is this being considered in the Trust? Suggestion that it might be given further consideration in People and OD (POD) Committee. - When are we expecting themes from this work to become apparent and how will they be triangulated / addressed? - What is the ambition for compliance with up-to-date policies? - What are arrangements for the Committee being sighted on Patient Safety Alerts? Discussion of implementation of revised international standards on textured food	Activities of Staff Improvement Group described and work of a group focusing on mental health first aid training. Through POD Committee and directly with relevant parts of the organisation. Entirely, by end March 2019. Short summary report to be included in Quality Performance Report (QPR) by year-end.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		and confirmation that Trust is compliant. Health and Safety Executive (HSE) visit re needle stick injuries: any reason to revisit scoring of risk of needle stick injuries?	HSE outcome pending.	
Quality and Performance Report and Exception Reports from Delivery Groups <u>Cancer Delivery Group</u>	November 62 day performance – 79.4% (un-validated); November 2 week wait performance – 90.6%; 104 day position – 50 patients (slight improvement), principally due to Urology and Lower gastrointestinal surgery. Demand for Gynaecological services and capacity to delivery are of current concern. Urology's continued performance impacts on the Trust's ability to deliver the 62 day standard. 104 day position reported as positive but not yet fully recovered backlog of longest waiting patients.	Generally positive feedback re quality of reporting and underlying improvement in key metrics. With reference to gynaecological pathways, what is the change in guidelines that accounts for the increased number of referrals from GPs?	Revised pathway explained on which more women in 50-55 age group are being referred for post-menopausal bleeding.	Possibility that other systems may be meeting this demand in other ways. More research to be undertaken.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report and Exception Reports from Delivery Groups Planned Care Delivery Group	Update received re work being undertaken to revise and improve letters from consultants to GPs. Update re preparation for returning to RTT reporting at end of year.	What are arrangements for addressing the level of >52 week delays?		More detailed assurance to future Committee. NB numbers are to be halved by 31 March 2019.
Quality and Performance Report and Exception Reports from Delivery Groups Emergency Care Delivery Group	November's performance was 91.3%; failure to achieve the national 4 hour standard across the trust. (Exceeded NHS Improvement Trajectory at 90%) Average of 408 attendances per day (407 in Oct 18) Failure to achieve the 15 minute initial assessment national standard on either side of the county. (89.6% Trustwide) Failure to achieve the 60 minute time to treatment national standard on either side of the county. (34.5% Trustwide) Ambulance handover delays > 30	General discussion re high levels of demand in entire system (GPs, 111, ambulances etc).		Future reporting to include "balancing measures" to provide further insight and assurance as to quality and patient experience dimensions to the Winter Plan.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	min = 33 Trustwide (National Avg = 148) Ambulance handover delays > 60 min = 1 Trustwide (National Avg = 20) Delays in time for CT for stroke patients			
Mortality and Learning from Deaths Report	The Committee received the fourth Learning from Deaths Report. 9 deaths were identified as having elements of sub-optimal care.	Have equivalent reports from other Trusts been considered for elements of best practice? Salford's, for example, shows a good audit trail of information, indicating precisely what learning had been taken from individual deaths as well as details of actions taken as a result. What does good behaviour look like in this area and what drives it? Is the Structured Judgment Review (SJR) methodology now embedded in all divisions?	Yes, but not Salford's. Human factors mainly responsible and positive reinforcement feedback to ward staff Yes.	Agreed that a process map of how learning is derived and actions implemented will be included in future reports.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Serious incident Report	There has been one new Serious Incident, involving a "lost to follow up" case in the gynaecological / dermatological clinic. This is a third similar case and the group is now being examined as a cluster.	Has there been lost to follow up in any other specialties? How would we know if there were?	Further investigatory work taking place.	Further update on the cluster to the next Committee. Report on review of any further lost to follow up cases also to January Committee.

Claire Feehily
Chair of Quality and Performance Committee
29 December 2018

TRUST BOARD – JANUARY 2019
Lecture Hall, Redwood Education Centre commencing at 12:30

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 November 2018 reporting period.

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

Key Issues to note

Quality Delivery System and Model
The initiation of the Quality Delivery Group, as a forum to discuss and improve our performance against key quality metrics, has gone from strength to strength. Improvement plans are shared amongst Divisions and where issues are identified as flagging as higher risk (enhanced surveillance - requiring QDG support) a Quality Summit Trust wide approach response has been implemented successfully.

Performance

During November, 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 November 2018, the trust performance against the 4hr A&E standard was 91.3% with an average of 408 attendances per day. Month to date performance (14 December) is currently 87% which is on track to deliver the STF trajectory (90%). Attendances year to date are 6% above last year's levels.

In respect of RTT, we have started reporting the RTT position in shadow form internally and have planned to re-report by February 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 whilst we are seeing our longest waiting patients and until full data cleansing exercise is completed and our patient tracking list is accurate.

Our performance against the cancer standard saw a increase against the 2 week standard for which stabilised in November at 90.6%, there continues to be significant gynaecological breaches 97 in November which have impacted the Trusts ability to deliver the target.

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 impact the aggregate position with significant number of 62day breaches and this has continued into the November position. Positively the Trust is planning to address the backlog to enable delivery of 62 day by March 2019.

Cancer 62 day Referral to Treatment (GP referral) performance for September was 70%, 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 backlog clearance during January, 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.
Work to review the statutory returns and key indicators is being led through our information team to support our recovery programme through Trak Recovery.

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 previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
				✓		✓	

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period November 2018

to be presented at December 2018 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During November 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 November 91.3% against the STP trajectory at 90% against a backdrop of significant attendances.

The Trust has met the diagnostics standard for November at 0.42%, 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 increase in referral rates for gynaecology, for the latter urology remains the speciality with the greatest under-delivery.

For elective care, the levels of validation across the RTT incompletes, Inpatient and Outpatient Patient Tracking List (PTL) is significant. Plans are on-track to deliver RTT re-reporting for February 2019.

Quality Delivery System and Model
The initiation of the Quality Delivery Group, as a forum to discuss and improve our performance against key quality metrics, has gone from strength to strength. Improvement plans are shared amongst Divisions and where issues are identified as flagging as higher risk (enhanced surveillance - requiring QDG support) a Quality Summit Trust wide approach response has been implemented successfully.

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 November position despite average attendances of 408 per day.

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

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, this is now being manually undertaken. There are still data quality errors with reports across operational areas, resulting in a large degree of validation and / or manual counting and review.

FFT
FFT data can be viewed as our "barometer" position and there have been no significant decreases in our positive score rates in the last few months. The review of this is metric is measured on the Nursing Accreditation Assessment System (NAAS) audit as the ward is audited for the display of “You said / We did” posters”. The wards are assessed on their engagement with their own ward data and the improvements that they have made in response.

VTE metric
Our audit demonstrated that the data collected on our electronic system varied with our actual performance as measured by record keeping (paper) audits. The Director of Safety is working with ward areas, and a task and finish group, to review recording of VTE assessments (fondly known as "Splats" by our ward teams). Our “go and see” QI approach has highlighted the varied processes that wards have for their data. The ward visits will be continued and a standardised system implemented once all visits have been completed.

Infection prevention and control metrics
The metrics reported through the QPR are monitored through the Infection Control and Prevention Committee. The strategic improvement themes have focused on 5 keys areas.
Han hygiene
The team have a proactive approach to infection control improvement and they have introduced a monthly message.

Month	Focus
October 2018	Influenza vaccination
November 2018	IV to oral switch
December 2018	Norovirus
January 2019	Hand hygiene
February 2019	Catheter associated infection
March 2019	Glove awareness

Weaknesses

A number of indicators requiring review due to data quality issues.

Dementia FAIR test question indicator
This indicator, in three parts, is a retired CQUIN indicator but this has been retained in the standard contract as a mandatory. It aims to maintain the identification of patients with dementia and delirium at a high level, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia. Our current results show that we are a national outlier for our digital data and a medical records audit was requested to compare our digital performance against our paper results. This month we can report that there has been a delay in the completion of the report and this item was deferred to next QDG meeting (Jan 2019).

The provision of Discharge Summaries - performance is still below acceptable standards for our Trust and the primary care community.

Cancer performance is subject to degrees of performance variability of sustainable delivery based on increases in referral rates.

Opportunities

Support from NHS I and the Cancer Alliance to support the recovery through 'backlog' clearance of the urology patients - this will now commence in early January.

Health Care Associated Infections - C.difficile
We have continued to implement and deliver on our CDI reduction plan. The Associate Chief Nurse has been instrumental in developing nurse led C.difficile ward rounds and disseminating the learning from our post infection reviews.

Divisional Reports
The Divisions have requested a specific report that breaks down all the QPR metrics into Divisional reports.

Discharge
We have launched an improvement programme to improve our discharge metrics (#4for4). We will be working with 4 wards for 4 months looking at how we can improve our safe and proactive discharges. We then then work with 4 more wards and implement all the projects that worked and will seek further change ideas from our staff. The main idea is to spread the improvements and then challenge team to look at their data to identify further change ideas (we will be implementing the "7 spreadly sins").

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. The Trust is continuing to work 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.

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

Current reports do not differentiate between non-admitted and admitted patients and as we move forward with re-reporting a review of the RTT reporting scripts and internal PTLs are identifying errors, this requires time and support for validation of these lists.
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. Significant validation has been undertaken on the Outpatient Waiting List and a draft Inpatient Waiting List from both the central and speciality teams, the latter has not been able to be produced until the work of the external validation can be completed in the new year. 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												
		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
ED Total Time in Department – Under 4 Hours	Trajectory	88.10%	77.40%	80.00%	80.00%	83.50%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	95.25%	90.76%	89.73%	88.46%	86.94%	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.26%
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	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	0.51%	0.75%	0.64%	0.49%*	0.26%	0.56%	1.26%	0.52%	0.55%	1.27%*	0.63%	0.03%	0.42%*
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%	93.10%	93.00%	93.10%	93.00%
	Actual	75.80%	81.20%	86.40%	90.60%	90.50%	86.60%	86.30%	88.60%	90.40%	88.90%	82.80%	91.80%*	90.60%*
2 week wait Breast Symptomatic referrals	Trajectory	93.10%	93.30%	93.20%	93.20%	93.30%	93.20%	93.30%	93.40%	93.40%	93.30%	93.20%	93.40%	93.40%
	Actual	94.50%	96.30%	92.40%	97.60%	94.50%	91.30%	91.90%	95.10%	96.00%	97.80%	98.90%	99.20%*	94.50%*
Cancer – 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.20%	96.10%	96.30%	96.10%	96.30%	96.10%	96.30%	96.10%	96.20%	96.30%	96.20%	96.20%	96.30%
	Actual	96.70%	97.30%	96.00%	97.60%	97.90%	96.70%	96.90%	97.10%	96.80%	96.90%	93.50%	93.20%*	95.70%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	Trajectory	98.00%	100.00%	100.00%	100.00%	98.40%	98.50%	100.00%	98.80%	98.10%	100.00%	98.40%	98.00%	98.10%
	Actual	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.80%	100.00%*	100.00%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	Trajectory	94.60%	94.40%	94.40%	94.10%	94.20%	95.50%	95.80%	94.60%	95.10%	94.60%	95.00%	94.30%	94.70%
	Actual	98.50%	98.10%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.70%	100.00%	100.00%	98.60%*	100.00%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	Trajectory	94.90%	94.70%	94.10%	94.50%	94.10%	95.10%	95.00%	94.20%	95.90%	94.60%	95.30%	94.30%	95.00%
	Actual	98.10%	94.90%	93.00%	95.50%	98.00%	94.90%	96.60%	94.50%	96.00%	95.70%	94.30%	98.30%*	96.30%*
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	92.90%	90.50%	92.90%	92.90%	90.50%	92.00%	94.70%	90.50%	90.00%	91.20%	92.10%	92.90%	92.90%
	Actual	93.80%	95.50%	98.00%	95.90%	95.90%	100.00%	94.10%	100.00%	100.00%	100.00%	85.50%	93.50%*	93.80%*
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	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	60.00%	100.00%	0.00%	80.00%	94.10%	76.50%	100.00%	84.60%	53.30%	100.00%	75.00%	77.80%*	60.00%*
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	85.50%	85.30%	85.40%	85.40%	85.20%	82.80%	84.40%	85.30%	79.70%	77.10%	81.70%	82.00%	83.70%
	Actual	76.70%	73.40%	69.70%	79.10%	78.10%	80.30%	79.90%	66.90%	74.70%	76.30%	69.00%	68.00%*	79.40%*

Summary Scorecard

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

RAG Rating : Overall RAG rating for a domain is an average performance of lead indicators against national standards.
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
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)

FINANCE

Cost Improvement Year to Date Variance
NHSI Financial Risk Rating
YTD Performance against Financial Recovery Plan

LEADERSHIP AND DEVELOPMENT

% Sickness Rate
% Turnover
Trust total % mandatory training compliance
Trust total % overall appraisal completion

Trust Scorecard

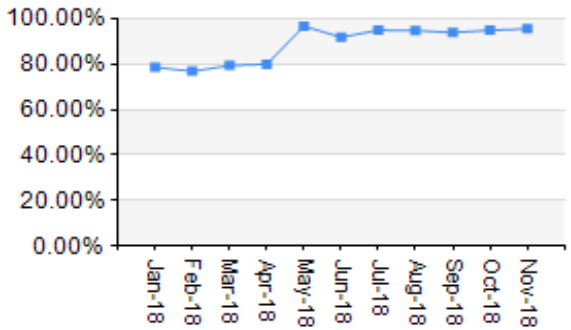
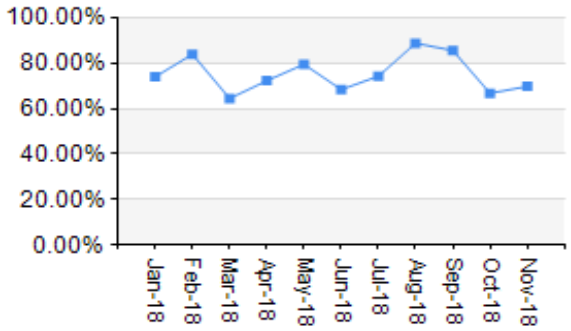
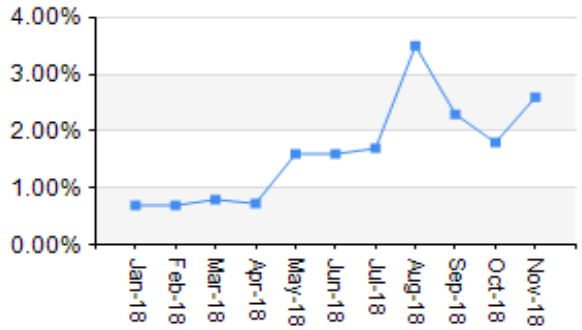
* = unvalidated data

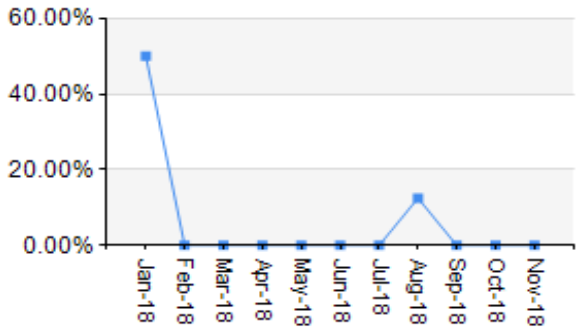
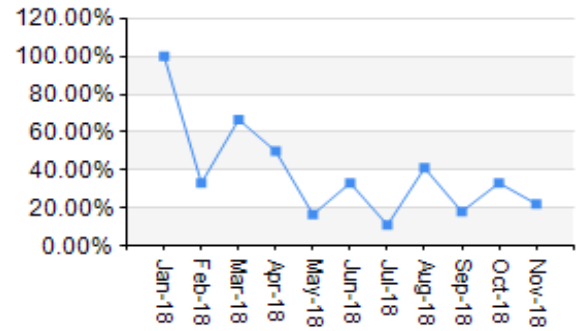
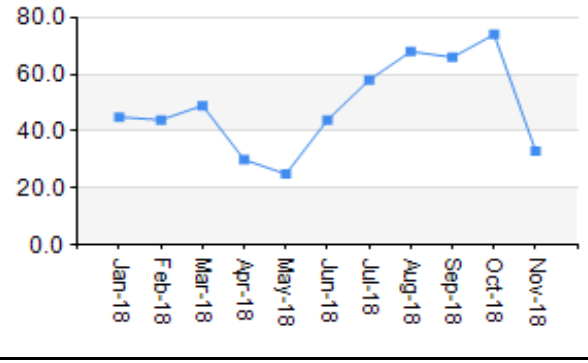
Category	Indicator	Standard 2017/18	Month					Annual	Standard 2018/19	Month								Quarter	Annual
			Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 Q2	18/19
Quality	**Key Indicators - Quality**																		
	Friends & Family Test	ED % Positive	>=86%	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%	82.7%	82.7%	83.5%	83.4% *
		Inpatients % Positive	>=95%	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%	92.2%	90.9%	91.4%	91.3% *
		Maternity % Positive	>=97%	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%	100.0%	98.2%	93.3%	95.8% *
		Outpatients % Positive	>=93%	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%	93.0%	92.5%	93.3%	92.5% *
		Total % Positive		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%	91.8%	91.2%	91.1%	91.1% *
	Infection Control	MRSA Bloodstream Cases – Cumulative Totals	0	0	0	0 *	0 *	0 *	1 *	0	1	1	1	2 *	3	5	5	5	5	5 *
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	94.8	93.4	93.1	95	96	96	Dr Foster confidence level	98.3	95.2	96	96.4	98.1					98.1 *
		Hospital Standardised Mortality Ratio (HSMR) – Weekend	Dr Foster confidence level	101.5	97.1	95	97.7	98.4	98.4	Dr Foster confidence level	101.1	97.3	97.1	97.9	96.6					96.6 *
		Summary Hospital Mortality Indicator (SHMI) – National Data	Dr Foster confidence level		107			107.2	107.2	Dr Foster confidence level										
	MSA	Number of Breaches of Mixed Sex Accommodation	0	13	11	5	7	6	134	R>=20 A11-19 G<=10	8	8	20	5	6	0	7	2	11	56 *
	Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	Q1<6% Q2<5.8% Q3<5.6% Q4<5.4%	6.7% *	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% *	7.6% *	7.8% *		7.7% *	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% *	94.8% *	95.4% *	94.4% *	92.7% *
	Detailed Indicators - Quality																			
	Dementia Screening	% of patients who have been screened for Dementia (within 72 hours)	>=90%	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%	1.8%	2.6% *	2.9% *	2.0% *
		% 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%	50.0% *	0.0%	0.0%		R<70% A70-89% G>=90%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0% *	11.8% *	8.0% *
		% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	>=90%	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%	33.3%	22.2% *	37.2% *	35.3% *
	ED Checklist	ED Safety checklist compliance CGH	R<50% A50-79% G>=80%	78%	92%	86% *	83% *	82% *		R<50% A50-79% G>=80%	82% *	89% *	84% *	88% *	90% *	89% *	90% *	93% *		
		ED Safety checklist compliance GRH	R<50% A50-79% G>=80%	68%	67%	72% *	81% *	81% *		R<50% A50-79% G>=80%	85% *	73% *	73% *	75% *	85% *	90% *	90% *	91%		
	Emergency Department	ED: % of time to initial assessment – Under 15 minutes	>=99%	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%	88.8%	89.6%	88.6%	89.5% *
		ED: % of time to start of treatment – Under 60 minutes	>=90%	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%	36.7%	34.5%	31.4%	33.7% *
	Infection Control	C.Diff Cases – Cumulative Totals	18/19 = 36	35	41	45	49	56	56	R>3 G<=3	5	14	16	40	29	32	36	40	32	40 *
		Ecoli – Cumulative Totals		175	200	222 *	240 *	258 *	258 *	TBC	17	32	56	79 *	107	139	164	168	139	168 *
		Klebsiella – Cumulative Totals								TBC	6	12	13	22 *	29	39	46	49	39	49 *
		MSSA Cases – Cumulative Totals	No target	68	78	89 *	93 *	100 *	100 *	TBC	9	18	28	41	49	63	72	76	63	76 *
		Pseudomonas – Cumulative Totals								TBC	2	3	6	14 *	17	20	23	24	20	24 *
	Maternity	Percentage of Spontaneous Vaginal Deliveries		57.5% *	60.9% *	57.0% *	63.4% *	61.8% *	62.4% *	0	57.5% *	61.4% *	60.0% *	64.3% *		63.1% *	59.2% *	59.4% *	62.6% *	61.3% *
		Percentage of Women Seen by Midwife by 12 Weeks	>90%	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% *	89.5% *	92.0% *	88.8% *	89.8% *
	Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.6 *	3.4 *	4.1 *	3.5 *	3.6 *		Current mean	3.6 *	4.6 *	4.4 *	4.3 *	4 *	3.8 *	4.3 *	4.6 *		

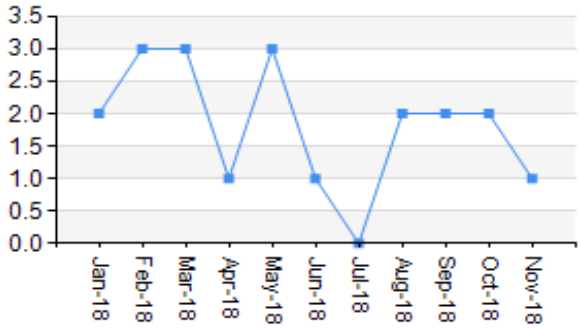
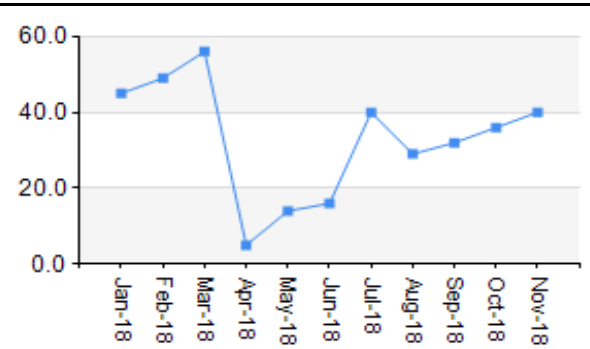
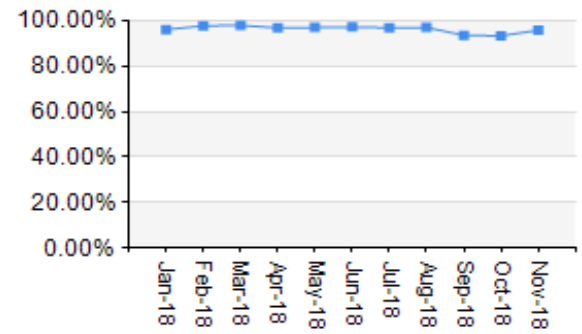
Category		Indicator	Standard 2017/18	Month					Annual	Standard 2018/19	Month							Quarter	Annual
				Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 Q2	18/19
	Patient Safety Incidents	Number of falls per 1,000 bed days	Current mean	7 *	8.2 *	7.8 *	7.3 *	7.7 *		TBC	8.3 *	7.6 *	8.3 *	6.9 *	6.3 *	7.5 *	7.3 *	6.8 *		
		Number of falls resulting in harm (moderate/severe)		4 *	13 *	18 *	10 *	8 *		TBC	10 *	8 *	7 *	11 *	6 *	9 *	8 *	6 *	9 *	8 *
		Number of Patient Safety Incidents - severe harm (major/death)		1 *	1 *	3 *	1 *	1 *		TBC	2 *	1 *	1 *	1 *	1 *	2 *	1 *	0 *	1 *	1 *
		Number of Patient Safety Incidents Reported		1,041 *	1,025 *	1,260 *	1,139 *	1,229 *		0	1,192 *	1,210 *	1,199 *	1,206 *	1,142 *	1,202 *	1,228 *	1,249 *	1,183 *	
		Pressure Ulcers – Category 2	R=1% G<1%	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% *	0.13% *	0.27% *		
		Pressure Ulcers – Category 3	R=0.3 G<0.3%	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% *	0.00% *	0.27% *		
		Pressure Ulcers – Category 4	R=0.2% G<0.2%	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% *	0.00% *	0.00% *		
	Research	Research Accruals	17/18 = >1100	76 *	29 *	80 *	61 *	112 *	1,770 *	TBC	42 *	54 *	16 *							19 *
	RIDDOR	Number of RIDDOR	Current mean	1 *	7 *	1 *	1 *	1 *	2	Current mean	4 *	0 *	1 *	2 *	2 *	5 *	4 *	1 *	3 *	
	Safe nurse staffing	Care Hours per Patient Day total		7	7	7	7	7	7	0	7	7	8	7	7	7	7		7	7 *
	Safety Thermometer	Safety Thermometer – Harm Free	R<88% A89%-91% G>92%	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% *	94.2% *	93.1% *	93.2% *	
		Safety Thermometer – New Harm Free	R<93% A94%-95% G>96%	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% *	98.5% *	97.9% *	98.3% *	
	Sepsis Identification and Treatment	% of patients screened in ED for Sepsis	>90%	94.0% *	98.0% *	98.0% *	98.0% *	100.0% *		R<50% A50-89% G>=90%	98.0% *	98.0% *	100.0% *	98.0% *	98.0% *	98.0% *				
		% of patients who were administered IVABs with 1 hour of arriving to ED	>50%	80.0% *	83.0% *	89.0% *	84.0% *	78.0% *		R<50% A50-89% G>=90%	82.0% *	88.0% *	88.0% *	72.0% *	79.0% *	79.0% *				
	Serious Incidents	Number of Never Events reported	0	0 *	1 *	0 *	0 *	1 *	3 *	0	1 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	1 *
		Number of Serious Incidents Reported		1 *	1 *	3 *	10 *	2 *		0	3 *	10 *	5 *	0 *	4 *	4 *	2 *	1 *		
		Percentage of Serious Incident Investigations Completed Within Contract Timescale		100% *	100% *	100% *	100% *	100% *		>80%	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *		
		Serious Incidents - 72 Hour Report completed within contract timescale		100.0% *	100.0% *	100.0% *	100.0% *	100.0% *		G>90%	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *		
	Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	3.1 *	1.9 *	2.6 *	2.4 *	2.8 *		Current mean	1.4 *	2.8 *	1.7 *	2.5 *	2.3 *	2.2 *	3.9 *	3 *	2.3 *	
		Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	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 *	1.6 *	2.8 *	
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	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%	42.6%	48.3%	59.3%	59.2% *
		Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour	>=50%	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%	34.3%	26.6%	42.0%	39.4% *
		Stroke Care: Percentage of patients Spending 90%+ Time on Stroke Unit	>=80%	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%	93.4%	80.7%		94.9%	92.6% *
	Trauma & Orthopaedics	% of fracture neck of Femur patients treated within 36 Hours		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% *	66.7% *	69.7% *	82.7% *	76.0% *
		Fracture Neck of Femur – Time To Treatment 90th Percentile (Hours)		47.6 *	43.1 *	45.7 *	42.3 *	64.4 *	48.5	TBC	48.1 *	42.3 *	49.8 *	51.8 *	38.4 *	38.6 *	53.4 *	60.5 *	42.3 *	31 *
		Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		98.4% *	100.0% *	98.5% *	100.0% *	98.4% *	98.4%	TBC	94.4% *	91.2% *	93.7% *	100.0% *	98.4% *	90.9% *	88.7% *	87.9% *	90.9% *	99.0% *
Operational Performance	**Key Indicators - Operational Performance**																			
	Cancer	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	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%	85.5%	93.5% *	93.8% *	93.5%	95.4% *
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	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%	77.8% *	60.0% *	68.8%	71.3% *
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	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%	69.0%	68.0% *	79.4% *	73.6%	73.7% *
	Diagnostics	% waiting for Diagnostics 6 Week Wait and over (15 Key Tests)	<1%	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%	0.03%	0.42% *	0.63%	0.42% *
	Emergency Department	ED Total Time in Department – Under 4 Hours	>=95%	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%	90.54%	91.26%	91.34%	91.17% *
	RTT	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%							>=92%										

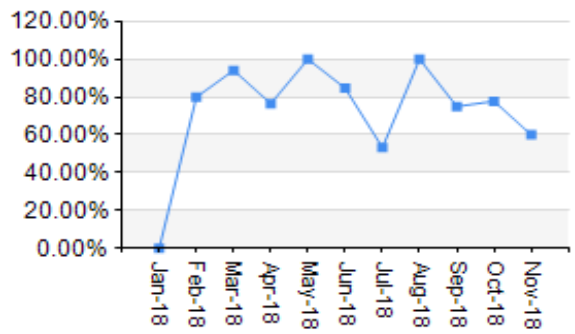
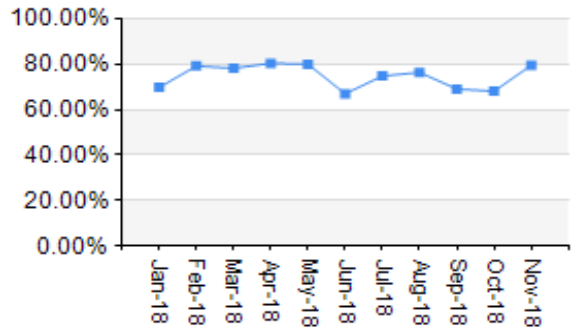
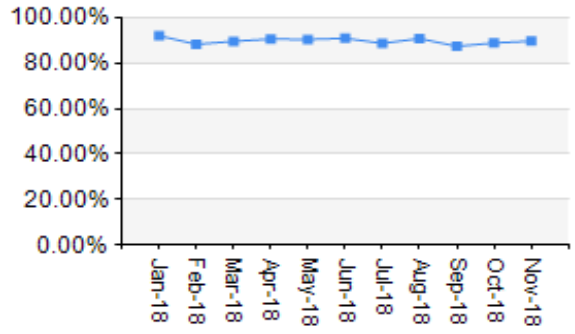
Category		Indicator	Standard 2017/18	Month					Annual	Standard 2018/19	Month								Quarter	Annual
				Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	17/18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	18/19 Q2	18/19
	Detailed Indicators - Operational Performance																			
	Cancer	2 week wait Breast Symptomatic referrals	>=93%	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%	99.2% *	94.5% *	97.5%	95.7% *
		Cancer – 31 Day Diagnosis To Treatment (First Treatments)	>=96%	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%	93.5%	93.2% *	95.7% *	95.8%	96.0% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	>=98%	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%	98.8%	100.0% *	100.0% *	99.6%	99.8% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	>=94%	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%	98.6% *	100.0% *	99.5%	99.6% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	>=94%	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%	94.3%	98.3% *	96.3% *	95.5%	96.0% *
		Cancer - Urgent Referrals Seen in Under 2 Weeks from GP	>=93%	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%	82.8%	91.8% *	90.6% *	87.4%	87.9% *
		Number of patients waiting over 104 days with a TCI date	0	6	9	10	4	6	6	0	9	12	6	8	22	26	7	13	26	13 *
		Number of Patients waiting over 104 days without a TCI date	0	34	34	19	14	17	17	TBC	18	18	22	28	24	30	39	37	30	37 *
	Diagnostics	The number of planned / Surveillance Endoscopy Patients Waiting at Month End		867	733	239 *	106	123	123	TBC	188	223	260	311	407	576	630 *	680 *	576	680 *
	Discharge	Number of patients delayed at the end of each month	<14	34	41	22	23	34	34	TBC	37	27	36	47	44	41	44 *	40 *	41	44 *
		Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	61.1% *	59.9% *	56.9% *	57.7% *	59.4% *	60.7% *	>=85%	62.0% *	60.2% *	64.7% *	62.0% *	62.3% *	61.5% *	62.6% *		61.9% *	62.2% *
	Emergency Department	Ambulance Handovers – Over 30 Minutes	< previous year	33	56	45	44	49	506	< previous year	30	25	44	58	68	66	74	33	192	398 *
		Ambulance Handovers – Over 60 Minutes	< previous year	0	0	2	3	3	15	< previous year	1	3	1	0	2	2	2	1	4	12 *
		ED: % total time in department - Under 4 Hours CGH	>=95%	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%	96.90%	96.80% *	96.93%	96.90% *
		ED: % total Time in Department – Under 4 Hours GRH	>=95%	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%	87.30%	88.60% *	88.36%	88.20% *
		ED: Number of patients experiencing a 12 Hour Trolley wait (>12hours from decision to admit to admission)	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0 *
	Length of Stay	Average Length of Stay (Spell)		5 *	4.79 *	5.1 *	5.04 *	4.99 *	4.96 *	0	5.14 *	4.65 *	4.57 *	4.52 *	4.61 *	4.49 *	4.57 *	4.53 *	4.54 *	4.63 *
	Operational Efficiency	Length of Stay for General and Acute Elective Spells (Occupied Bed Days)	<=3.4	2.75 *	2.84 *	2.91 *	2.99 *	3.03 *	2.9 *	R>4.5 A3.5-4.5 G<=3.4	2.82 *	2.78 *	2.52 *	2.72 *	3.01 *	2.87 *	2.61 *	2.81 *	2.86 *	2.76 *
		Length of Stay for General and Acute Non-Elective (Occupied Bed Days) Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.61 *	5.28 *	5.56 *	5.53 *	5.46 *	5.5 *	TBC	5.68 *	5.16 *	5.15 *	4.98 *	4.96 *	4.85 *	5.01 *	4.94 *	4.93 *	5.08 *
		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	64	55	65	67	60 *	TBC	67	66	71	71	75	80	75	76	75	72 *
		Number of stranded patients with a length of stay of greater than 7 days		447	446	472	464	482	468 *	TBC	384	395	369	373	382	376 *	374 *	382 *	377 *	379 *
	RTT	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	64 *	74 *	50 *	63	95 *		0	95	92	98	113	125	105	103	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%	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *	100.0% *		100.0% *
		Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8% *	99.8% *		99.8% *
Finance	**Key Indicators - Finance**																			
	Finance	YTD Performance against Financial Recovery Plan		-2.1 *	-6.4 *	-6.5 *	-10.8 *	-18.4 *		TBC	.05	.07	.09	.18 *	.2	.2	.2	.4		
	Detailed Indicators - Finance																			
	Finance	Agency – Performance Against NHSI Set Agency Ceiling		3 *	3 *	3 *	3 *	3 *		TBC	2	2	2	2	2	3	3	3		
		Capital Service		4 *	4 *	4 *	4 *	4 *		TBC	4	4	4	4	4	4	4	4		
		Cost Improvement Year to Date Variance		-725	2,015	-4,423	-7,085	10,475		TBC	-51	121	1,116	2,365	2,342	2,975	2,994	2,013 *		
		Liquidity		4 *	4 *	4 *	4 *	4 *		TBC	4	4	4	4	4	4	4	4		
		NHSI Financial Risk Rating	3	4 *	4 *	4 *	4 *	4 *		3	4	4	4	4	4	4	4	4		
		Total PayBill Spend		27.9 *	27.7 *	28.1 *	28.5 *	28.5 *		TBC	28.4	28.5	28.05	28.5	30.5	27.5	29.5	29.03		
Leadership and Development	**Key Indicators - Leadership and Development**																			
	Workforce Expenditure and Efficiency	% Sickness Rate	G<3.6% R>4%	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%	4.0% *	3.9% *	3.9% *
		% Turnover	G<11% R>15%	12.1%	11.9%	11.6%	11.4%	12.1%	12.0%	TBC	12.0%	11.8%	12.3%	12.3%	12.0%	12.1%	11.9%	11.9% *	12.1% *	12.3% *
	Detailed Indicators - Leadership and Development																			
	Appraisal and Mandatory Training	Trust total % mandatory training compliance	>=90%	88%	88% *	73%	79%			R<70% A70-89% G>=90%			87%	87%	88%	90%	91% *	91% *	90%	91% *
		Trust total % overall appraisal completion	G>=90% R<70%	84.0%	84.0%	83.0%	83.0%	82.0%	82.0%	R<70% A70-89% G>=90%			74.0%	74.0%	75.0% *	79.0%	80.0% *	79.0% *	79.0%	79.0% *

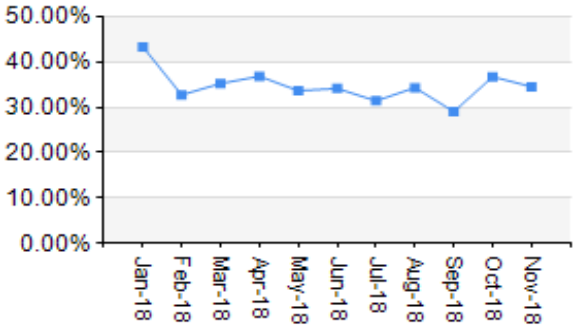
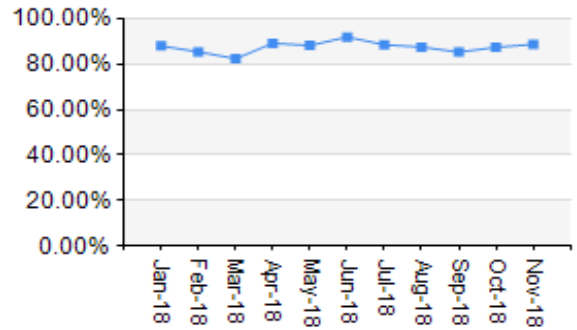
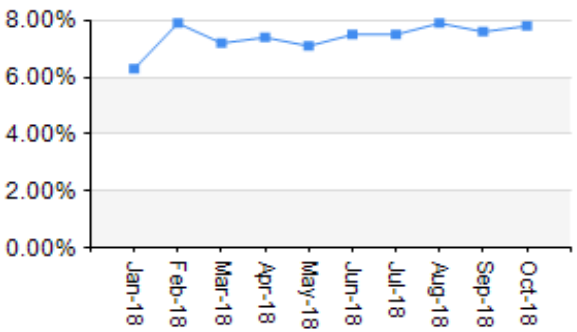
Exception Report

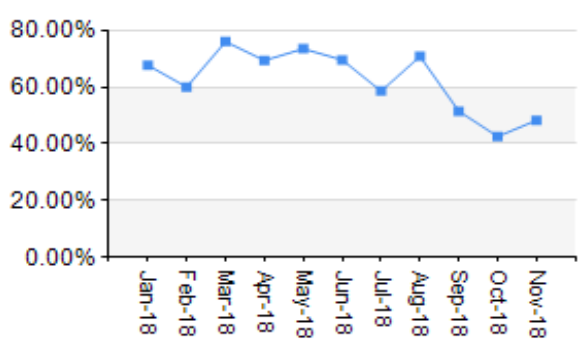
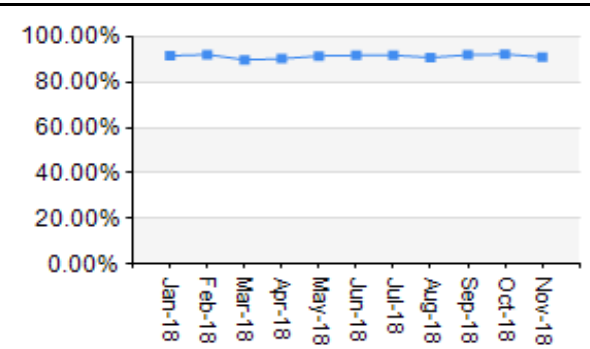
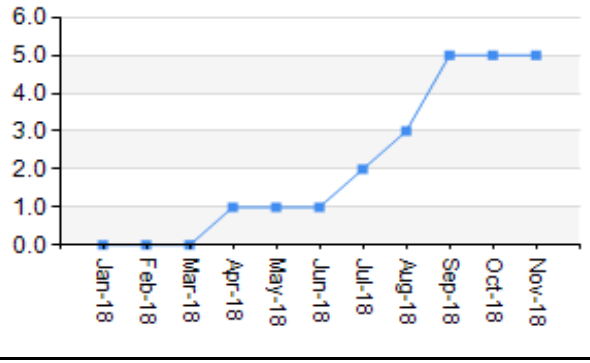
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of Adult Inpatients who have Received a VTE Risk Assessment **Standard: R<=95% A96% G>97%**		VTE risk assessments are being monitored using a clinical audit approach across ward areas, these results are being used to meet the central reporting requirements. The current results for first risk assessment of patients are 95% of the 458 patients audited, which provides a high level of assurance. To improve the recording of VTE risk assessment on TrakCare areas are being visited to gain a deeper understanding of the current practice. Although the recording process is simple the areas visited so far show not set process with a variety of practice and no clear ownership. To improve the process will require re-mapping and improved standardisation, this work is planned for in the New year.	Director of Safety
% of fracture neck of Femur patients treated within 36 Hours **Standard: R<80% A80-89% G>=90%**		Action plan to Surgical Divisional Board 17/12 to be reviewed and challenged.	Director of Operations - Surgery
% of patients who have been screened for Dementia (within 72 hours) **Standard: R<70% A70-89% G>=90%**		Solutions being explored. On going EPR issue.	Deputy Chief Nurse

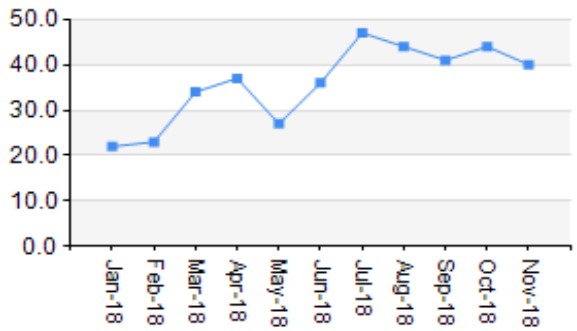
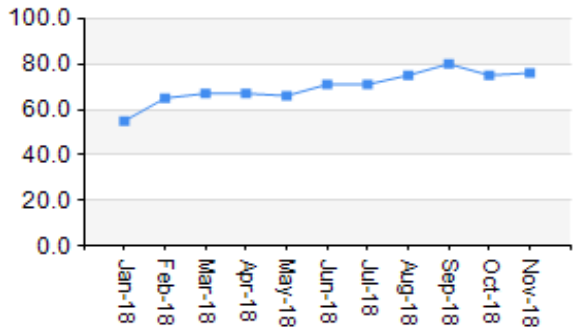
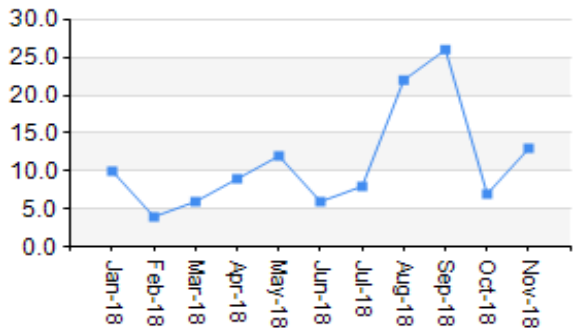
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours) **Standard: R<70% A70-89% G>=90%**		Solutions are being explored by TRAC team. EPR solution required	Deputy Chief Nurse
% 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%**		On-going EPR issue. solutions continue to be explored. Auditing in the clinical areas are being carried out!	Deputy Chief Nurse
Ambulance Handovers – Over 30 Minutes **Standard: < previous year**		Ambulance handover delays > 30 mins have come down to 33 in November 2018 (prev 74 in October). The national average for the month is 148 so GHNHSFT is performing well nationally. Overnight remains the most likely time for ambulance handover delays to occur so work continues to progress with SWAST and the CCG to better utilise CGH overnight pathways.	Director of Unscheduled Care and Deputy Chief Operating Officer

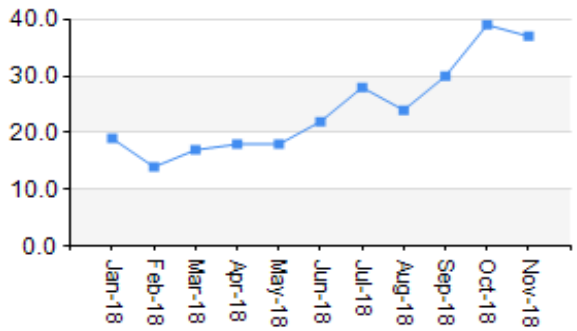
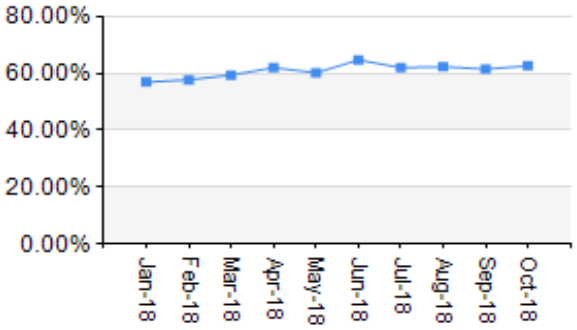
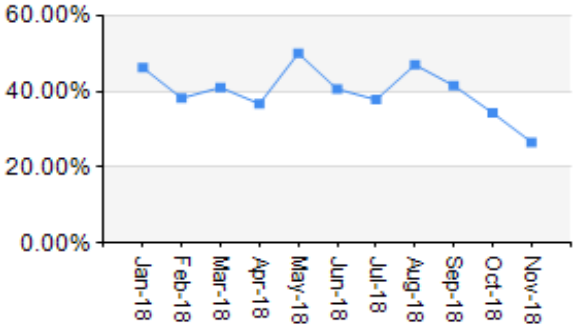
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Ambulance Handovers – Over 60 Minutes **Standard: < previous year**		There was only 1 > 60 min ambulance handover delay (prev 2 in October). The national average for the month is 20 so GHNHSFT is performing well nationally. Overnight remains the most likely time for ambulance handover delays to occur so work continues to progress with SWAST and the CCG to better utilise CGH overnight pathways.	Director of Unscheduled Care and Deputy Chief Operating Officer
C.Diff Cases – Cumulative Totals **Standard: R>3 G<=3**		There were 4 cases of trust-apportioned C. difficile during November 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.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control
Cancer – 31 Day Diagnosis To Treatment (First Treatments) **Standard: R<94% A94-95% G>=96%**		November performance 95.7% target 96% (Unvalidated) 252 treatments 11 breaches Urology - 8 Skin - 1 Breast - 1 Gynae - 1	Director of Planned Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 Day Referral To Treatment (Upgrades) **Standard: >=90%**		November performance - 60% 7.5 treatments; 3 breaches (1 x lung, 1 x upper GI and 1 x urological)	Director of Planned Care and Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Standard: R<80% A80-84% G>=85%**		78.4% for November (un-validated performance). 33 breaches from 153 treatments See exception report for full detail.	Director of Planned Care and Deputy Chief Operating Officer
ED: % of time to initial assessment – Under 15 minutes **Standard: R<92% A92-94% G>=95%**		Time to Assessment has remained consistently just below 90% for the last few months. Performance has been maintained in addition to improving the quality of triage/initial assessment.	Director of Unscheduled Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to start of treatment – Under 60 minutes **Standard: R<87% A87-89% G>=90%**		Time to treatment remains the most challenged of the ED metrics and GHNSFT remains a low outlier when compared to the rest of the region and nationally. An Acute medic is being allocated to E.D from 18:00 - 22:00 to improve timely review and reduce admissions during this over congested period of the day.	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % total Time in Department – Under 4 Hours GRH **Standard: R<90% A90-94% G>=95%**		4 hour performance was 91.26% for November 2018. Whilst this did not exceed the national target of 95% it surpassed the NHSI trajectory set at 90% (despite a 5.12% increase in activity compared to Nov 17). All divisions continue to engage in maintain 4 hour performance as we enter winter via the winter refresh task and finish group.	Director of Unscheduled Care and 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 are 7.8% in October. 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. Furthermore, of note location such as AMIA are included in this data and the follow-ups may be being counted as re-admissions incorrectly. The next stage of the frailty assessment service is to have its dedicated inpatient space in January to cohort COTE/Frail and improve upon the re-admission rate for the biggest outlier elderly care.	Deputy Medical Director

Metric Name & Standard	Trend Chart	Exception Notes	Owner
High Risk TIA Patients Starting Treatment Within 24 Hours **Standard: >=60%**		Patient choice breaches rather than due to capacity.	Deputy Medical Director
Inpatients % Positive **Standard: R<93% A93-95% G>=96%**		The positive score remains static. Ward managers take an active role in reviewing comments and making improvements.	Deputy Director of Quality
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. There have been no further cases.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients delayed at the end of each month **Standard: TBC**		• Increase in numbers of self funding patients and availability of carers. • Less available care home beds (several homes have closed in past few months) and increasingly complex patients awaiting respite or DTA. Homes are starting to close with 'winter' illnesses • More patients with homelessness issues. Vulnerable due to health issues, but have lost their home due to family breakdown, leaving their country etc. Due to their vulnerability they are unable to present at council offices. • More patients being discharged from the OCT working list on day of med fit status. The patients on the 10 days plus have decreased, but not at the same rate	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of Patients Stable for Discharge **Standard: TBC**		• Increase in numbers of self funding patients and availability of carers. • Less available care home beds (several homes have closed in past few months) and increasingly complex patients awaiting respite or DTA. Homes are starting to close with 'winter' illnesses • More patients with homelessness issues. Vulnerable due to health issues, but have lost their home due to family breakdown, leaving their country etc. Due to their vulnerability they are unable to present at council offices. • More patients being discharged from the OCT working list on day of med fit status. The patients on the 10 days plus have decreased, but not at the same rate	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of patients waiting over 104 days with a TCI date **Standard: 0**		13 patients on report Comprised of 2 Lower GI; 5 Urology; 1 Lung; 2 H&N. - 10 at weekly validated report *9/12	Director of Planned Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of Patients waiting over 104 days without a TCI date **Standard: TBC**		Reporting 37 As at week 9/12 comprising 23 urology; 9 Lower GI; 1 Skin; 2 Upper GI; 1 other = 36 Note 1 referral to a Tertiary Centre outside of the Trust & 2 are late referrals in to the Trust past breach dates.	Director of Planned Care and Deputy Chief Operating Officer
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
Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour **Standard: R<45% A45-49% G>=50%**		Performance of 22.5% average for October, peaking at 25% week commencing 24th November following poor performance of less than 10% in weeks 1 and 3. There have been significant challenges faced in November, and breach themes vary between patients presenting with difficult diagnosis, lack of SSN cover owing to sickness and annual leave, problems with CT scanners leading to delays and delayed assessments in ED due to demand.	Director of Unscheduled Care and Deputy Chief Operating Officer

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST BOARD – JANUARY 2019
Lecture Hall, Redwood Education Centre commencing at 12:30

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

Purpose

To comply with National Guidance on Learning from Deaths – a quarterly update should be presented to the open session of the Board. Following review by the December Quality and Performance Committee the attached report is now presented to January Trust Main Board.

Key issues to note

- All deaths in the Trust are reviewed by the Bereavement Team and Trust Medical Examiners.
- New medical examiners have been appointed
- Detailed mortality reviews are triggered by bereavement team using the datix system.
- Unless defined by another process all mortality reviews now are done using the Structured Judgment Review process (SJR)
- Our revised policy on learning form deaths has now been published.
- Thematic learning from problems in care and excellence is beginning to emerge
- Aligning learning to improvement programmes is becoming more systematic although a consistent approach to achieving this for excellent care is not yet established.
- The rate of identifying problems in care contributing to death remains low (1.1% of reviews)

Conclusions

- All deaths are reviewed in the Trust through the Medical Examiner
- This is being rolled out nationally
- Learning themes are helping drive improvement
- Positive feedback is highly motivating but not yet systematic.

Implications and Future Action Required

To ensure actions have desired impact and embed learning from good care into driving change

Recommendations
The Board is asked to note the fourth Learning from Deaths Quarterly Report.
Impact Upon Strategic Objectives
This work links directly to our Trust objectives for our patients to be safe in our care and to be treated with care and compassion

Impact Upon Corporate Risks
None

Regulatory and/or Legal Implications
National requirement to report to Trust Board.

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 previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**

Outcome of discussion when presented to previous Committees/TLT

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JANUARY 2019

LEARNING FROM DEATHS QUARTERLY REPORT

1. Aim

1.1 This paper is required to comply with the National Guidance on Learning from deaths. This guidance states that a quarterly update should be presented to the open session of The Board. It has been agreed to bring this report through the Quality & Performance Committee and then onto the Trust Board.

1.2 The period covered is that to the end of Q2 2018/19.

2. Executive Summary

2.1 100% of deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners. New medical examiners have been interviewed and appointed to join our current team.

2.2 All families meet with the bereavement team and have the opportunity to feed in any comments on care.

2.3 Patients are logged on a dedicated section of the Trust Datix System designed to also accommodate the recording of Structured Judgement Reviews (SJR) and has now been structured to include the comments from families to the Bereavement Team when they meet the family to pass on the death certificate.

2.4 An analysis of these comments is included within this paper (Appendix VI). The feedback is overwhelmingly positive and is routinely shared with the relevant ward area. Areas for improvement reflect some estate issues and the general pressure on staff.

2.5 Our bereavement lead (Kathryn Griffin) is now actively working with (and funded by) the Department of Health to support the roll out of the medical examiner approach across the Country, modelled on the work done in Gloucestershire.

2.6 Detailed mortality reviews are triggered from the Bereavement Office either as a result of national triggers or due to comments from the family. In addition there are speciality triggers (e.g. pneumonia, cardiac interventional procedures or fractured neck of femur) or as a result of incident reporting.

2.7 Themes are now emerging of areas for improvement (Appendix IV) on deteriorating patients, handover, early senior review and family engagement providing important information to drive change.

2.8 Areas of excellent care are also being identified although the approach to using this information to drive change requires further work.

2.9 Our revised policy on learning from deaths adapted to comply with national guidance is now published.

2.10 We have now separated our Hospital Morality group into two sections in preparation for the attendance of two family representatives at the meeting. A family attendance at a surgical multidisciplinary group is being planned.

2.11 The low rate of deaths from problems in care (9 of 81 SJRs done) is consistent with the levels identified in other Trusts in the South West Academic Health Science Network

3. Mortality Review Process

3.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. The team recently won a GEM award. They have now managed to ensure all deaths are recorded in real time.

3.2 As indicated all the feedback is relayed to the wards (positive and negative). It is heavily skewed towards positive comments and the ward teams find this motivating. As yet a structured approach to using this feedback and the excellent care identified in the SJR process has not been established.

3.3 The bereavement team lead is now spending 4 days per week informing and shaping the national approach to bereavement support and mortality reviews. This will become the standard of care.

3.4 It is becoming important to ensure clarity with respect to the objectives of each part of the process in terms of learning.

3.4 Specialities review deaths through their M+M process. The approach from the Surgical Division led by Nicky Holton (Surgical risk lead) has now been extended across all divisions and is increasingly allowing us to see common themes of learning spanning all divisions. Nicky should be particularly noted for her contribution.

3.5 The SJR approach is now embedded within all divisions. This is allowing us to focus increasingly on the quality of these reviews rather than just establishing the process.

3.6 Our Learning from Deaths policy has been published on the Trust web site.

3.7 We have interviewed for more medical examiners and appointed three new doctors into these roles from across specialities.

4. Family Involvement

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

4.2 The publication of the national guidance in this respect has been helpful to focus towards a standard approach. The most significant gap is the integration of families in the training of staff on death reviews.

4.3 A family has agreed to meet with the surgical division (multidisciplinary team) to narrate the experience of the care of their relative and explore approaches to improving this. We intend to emulate this approach across other divisions.

These sessions will be carefully facilitated.

4.4 We recognise that negative feedback is limited in comparison to huge quality of positive comments. Apart from direct feedback to clinical areas we have not yet identified a consistent approach to using this feedback to drive change.

5. Learning from Deaths

5.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through the speciality and divisional processes.

5.2 Where there are problems in care that contributed to death these cases are investigated under a serious incident review process and the Duty of Candour approach adopted.

5.3 Increasingly the discipline of turning actions identified on case review into Quality Improvement initiatives is being applied, and the importance of understanding the impact of any change is increasingly the focus of the Safety and Experience review group.

5.4 Over the second quarter the main themes of learning are our response to the deteriorating patient, communication between teams, the importance of early senior review and care in ensuring families understand when patients are deteriorating.

5.5 Interestingly the areas of excellent care identified from SJR's to a large extend mirror the areas for improvement and there may be an opportunity for learning by pairing teams.

6. Learning with Partners

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

6.2 We are active members of the Countywide Mortality Group and have undertaken two joint death reviews with partners. In addition we review our mortality data with colleagues in the CCG at the Quality Contract Review Group.

6.3 High level reviews of patient deaths at home following inpatient care continues to prove challenging both in terms of identifying the patients and agreeing with primary care the nature of these reviews and who will undertake them.

7. Mortality Dashboard (Appendices)

7.1 The Trust is required to collect data to include:-

a) The total number of deaths in the quarter

b) The most recent mortality indicators

c) The number of deaths having a high level review

d) The number of deaths where problems in care contribute significantly (a score of < 3 in SJR)
e) The number of deaths investigated under the Serious Incident approach

f) Themes and issues identified

g) Any changes that have resulted.

8. Conclusions

8.1 All deaths are reviewed within the Trust via the bereavement and the Medical Examiner approach. This is fully embedded.

8.2 New medical examiners have added breadth and stability to the ME team

8.2 There is good progress on capturing themes of learning from problems in care and ensuring these are being addressed within the Trust but as yet there is no systematic approach to learning from excellent care.

8.3 Family input to the Hospital Mortality group and directly with specialties is in progress. This will begin to help us embed family feedback into our training of staff.

9. Recommendations

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

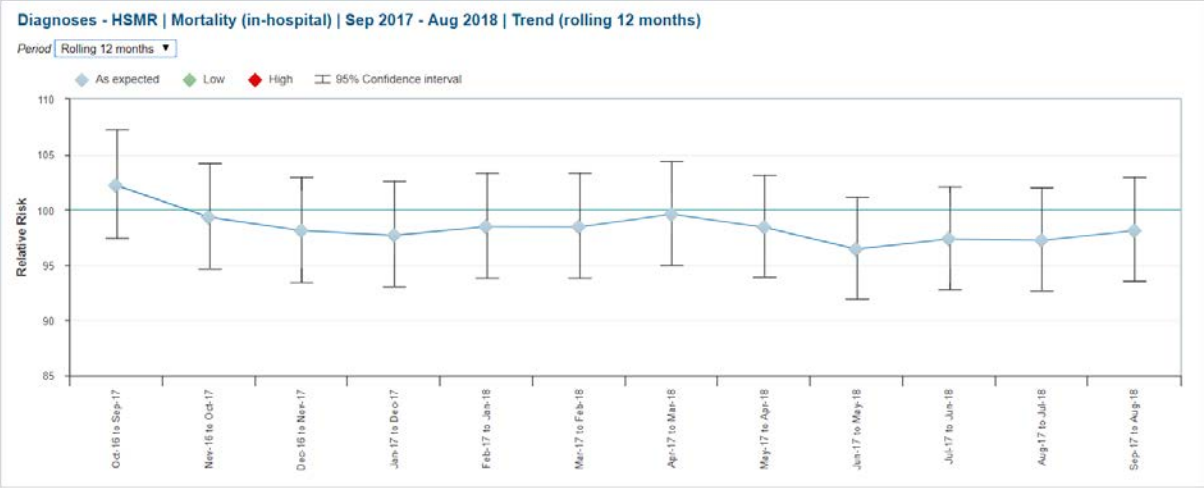
Dr Sean Elyan
Medical Director

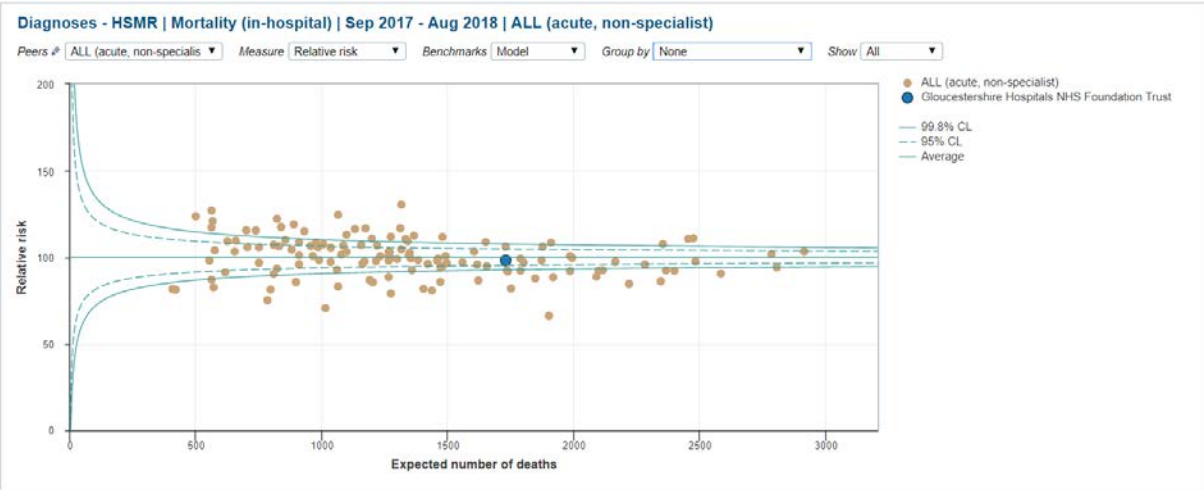
APPENDIX I – HSMR DETAILS

HSMR Dashboard 2017/18			
	Deaths	**Bereavement**	**ME Review**
Q3 17/18	530	530	530
Q4 17/18	651	651	651
Q1 18/19	460	460	460
Q2 18/19	463	463	463

HSMR Graph

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

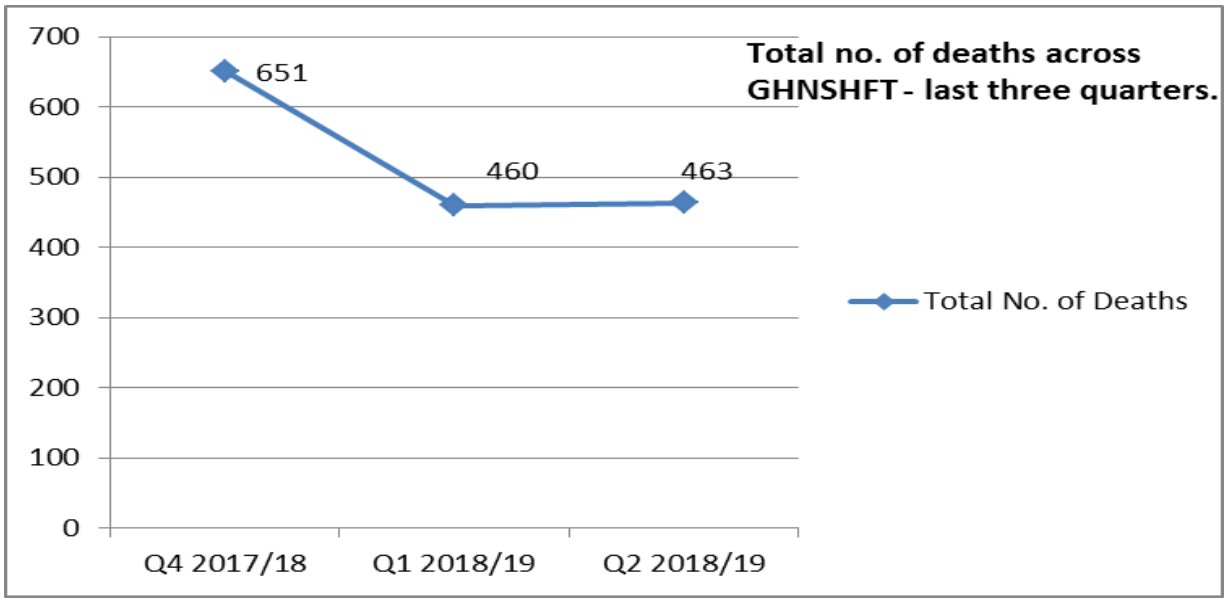


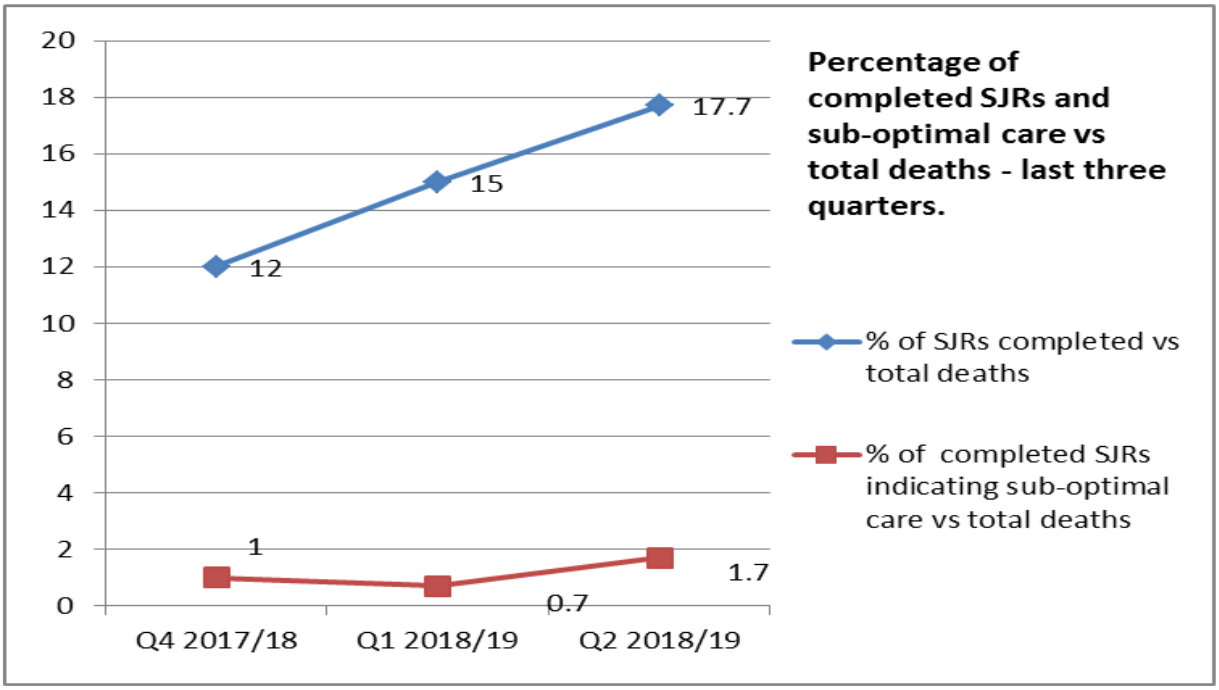


APPENDIX II - OVERVIEW

Overview

- **Total number of deaths = 463 across all divisions**
- **Total number of SJRs completed = 81**
- **Of which**
  - **9 indicated sub-optimal care**
  - **13 indicated excellent care across all areas**



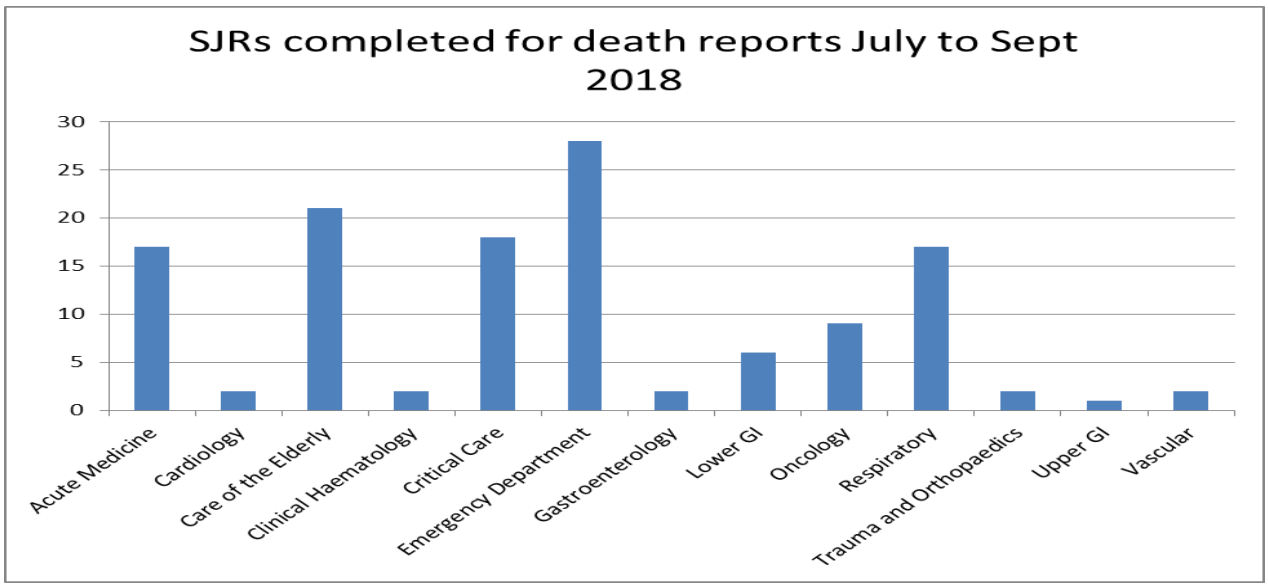


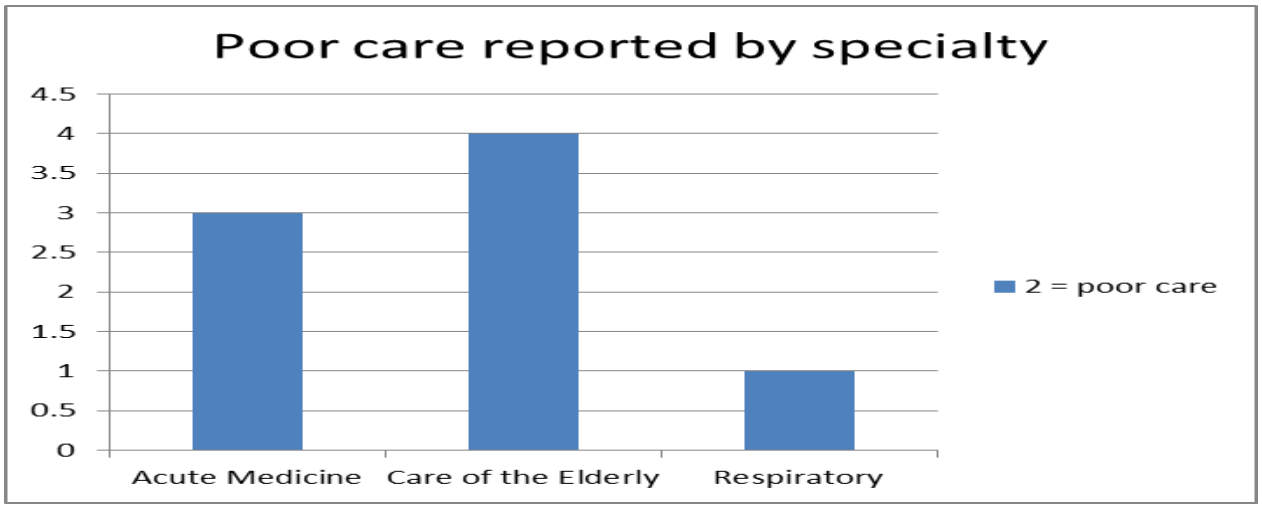
Learning from Deaths

Quarter 2 (July, August, September 2018)

Overview continued

Division	Deaths	ME +/- bereavement review	SJRs completed (or national)	Rating of poor or very poor care	DoC or SI reviews of deaths	Rating of excellent care
Surgery	88	88	29	0	1	7
Medicine	344	344	46	8	5	5
D&S	23	23	6	0	0	0
W&C	8	8	0	0	0	0
Total (%)	**463**	**463 (100)**	**81 (17.7)**	**9 (1.7)**	**6 (1.3)**	**13 (2.8)**

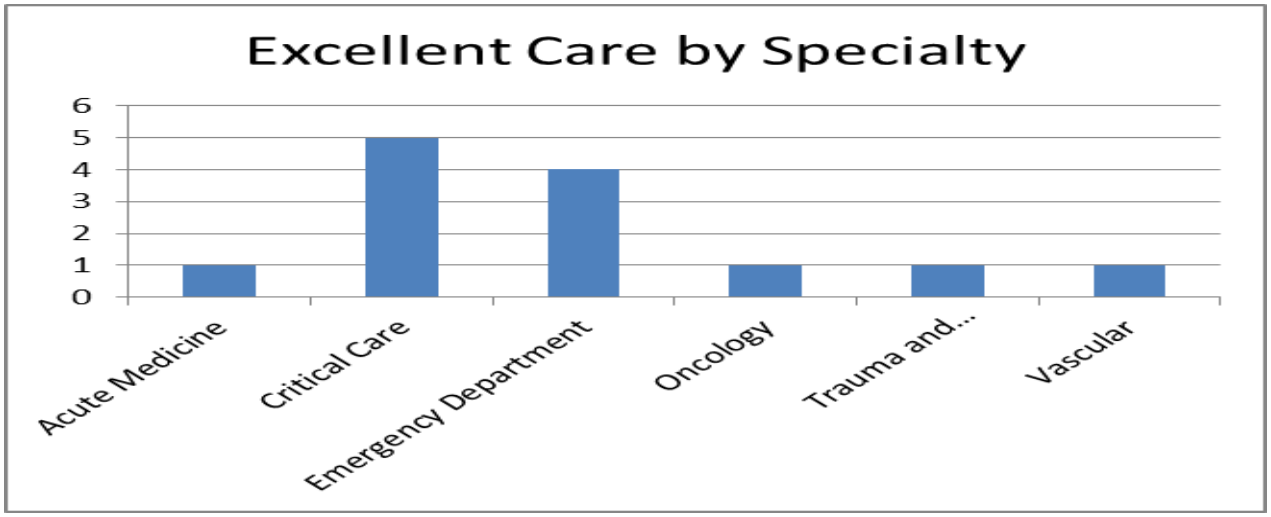




Learning from Deaths

Quarter 2 (July, August, September 2018)

Overview continued



Deaths by Special Type – Q2	
Type	***Number***
LeDeR	3
Paediatrics	0
Coroner Inquests	4
SI	1

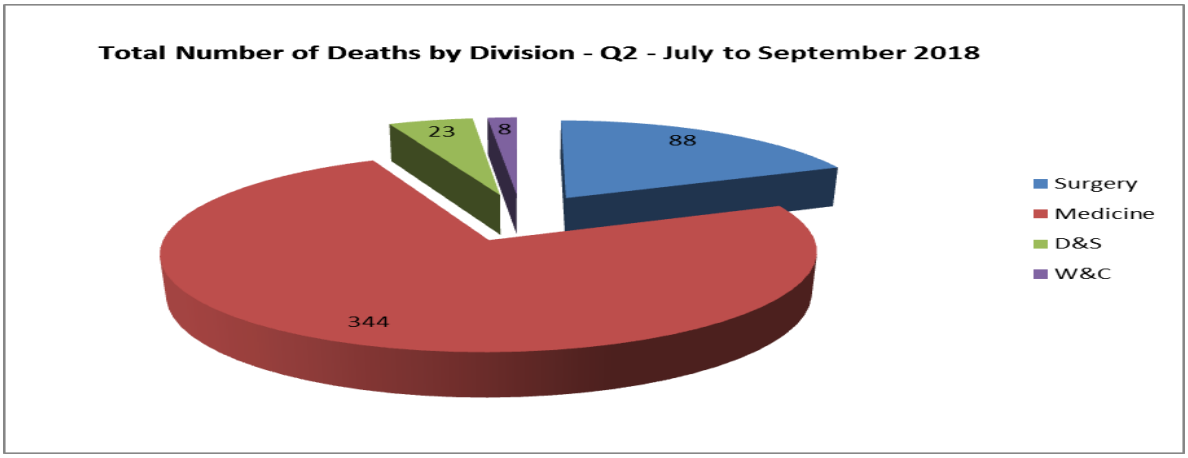
Learning from Deaths

Quarter 2 (July, August, September 2018)

Overview continued

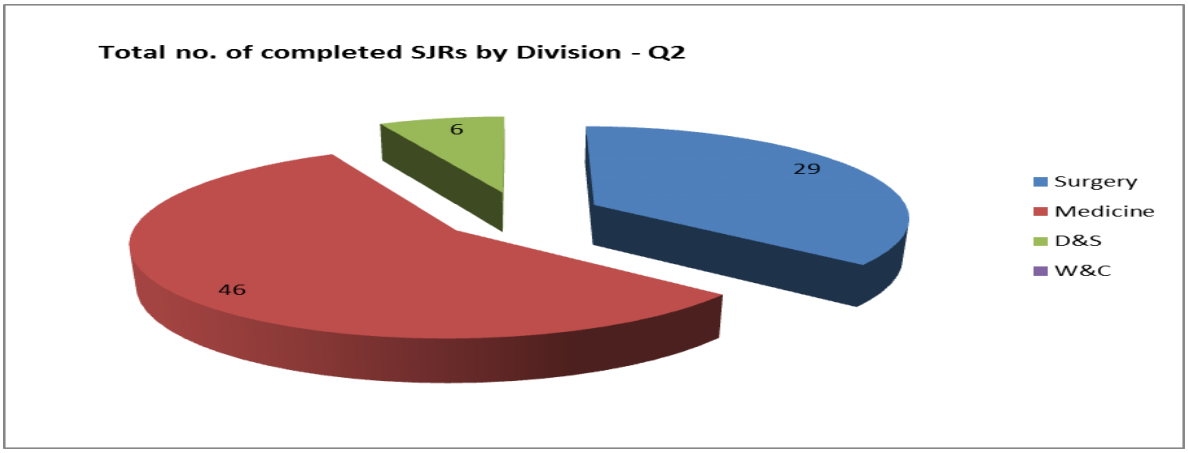
Total number of deaths at GHNHSFT = 463

DEATHS BY DIVISION (Q2: July-Sept 2018)			
Surgery	**Medicine**	**D&S**	**W&C**
88	**344**	**23**	**8**



Total number of SJRs completed = 81

COMPLETED SJRs BY DIVISION (Q2: July – Sept 2018)			
Surgery	**Medicine**	**D&S**	**W&C**
29	**46**	**6**	**0**



APPENDIX III – DIVISIONAL DETAIL

Learning from Deaths

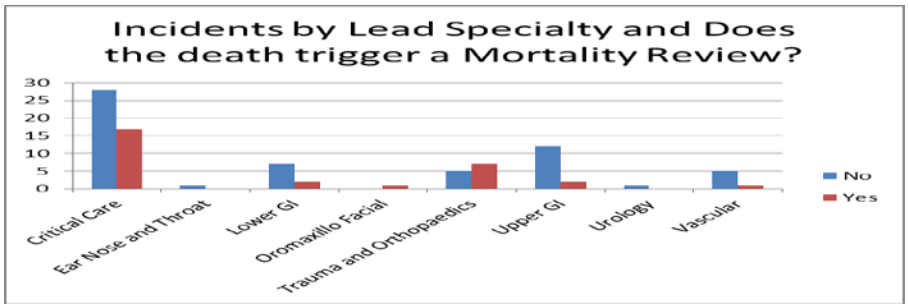
Quarter 2 (July, August, September 2018)

Surgical Division

Total number of deaths = 88
Number of completed SJRs = 29
Number of SJRs indicating sub-optimal care = 1
Number of SJRs indicating excellent care = 7

Number of deaths by Speciality

Division at death	Specialty at death	Q1 total	Jul	Aug	Sep	Q2 total
Surgical	Colorectal surgery	0	0	0	0	0
	Critical care medicine	42	16	17	13	46
	ENT	0	1	0	0	1
	General surgery	17	6	7	8	21
	Maxillo Facial Surgery	0	0	0	0	0
	Oral surgery	0	1	0	0	1
	Pain Management	0	0	0	0	0
	Trauma and Orthopaedics	14	3	7	2	12
	Upper gastrointestinal surgery	0	1	0	0	1
	Urology	0	1	0	0	1
	Vascular surgery	9	1	1	3	5
	Division total	82	30	32	26	88



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Critical Care	**16**		**5**
Lower GI	**2**	**1**	
Maxillo Facial Surgery	**1**		
T&O	**7**		**1**
Upper GI	**2**		
Vascular	**1**		**1**

TOTAL = 29

Learning from Deaths

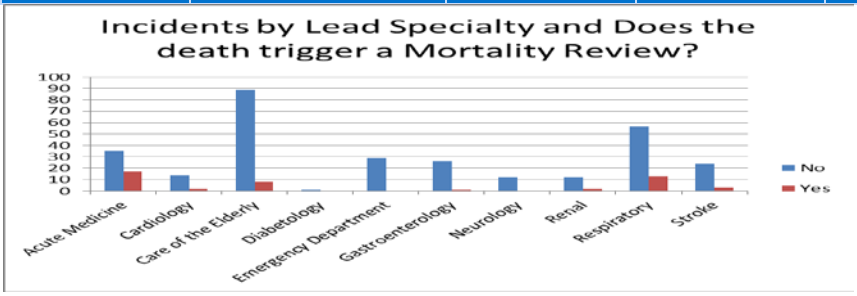
Quarter 2 (July, August, September 2018)

Medical Division

Total number of deaths = 344
Number of completed SJRs = 46
Number of SJRs indicating sub-optimal care = 8
Number of SJRs indicating excellent care = 5

Number of deaths by Speciality

division at death	Specialty at death	Jul	Aug	Sep	Q2 total
Medical	Accident and Emergency	0	0	0	0
	Cardiology	5	3	7	15
	Diabetic medicine	0	0	0	0
	Emergency Medicine	5	8	16	29
	Endocrinology	2	2	5	9
	Gastroenterology	4	9	11	24
	General medicine	23	31	31	85
	Geriatric medicine	32	39	31	102
	Nephrology	1	0	4	5
	Neurology	1	4	1	6
	Respiratory medicine	25	19	25	69
	Respiratory physiology	0	0	0	0
	Division total	98	115	131	344



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Acute Medicine	**18**	**3**	**1**
Cardiology	**1**		
Care of the Elderly	**4**	**4**	
Emergency	**tbc**		**4**
Gastroenterology	**1**		
Renal	**1**		
Respiratory	**6**	**1**	
Stroke	**2**		

TOTAL = 46

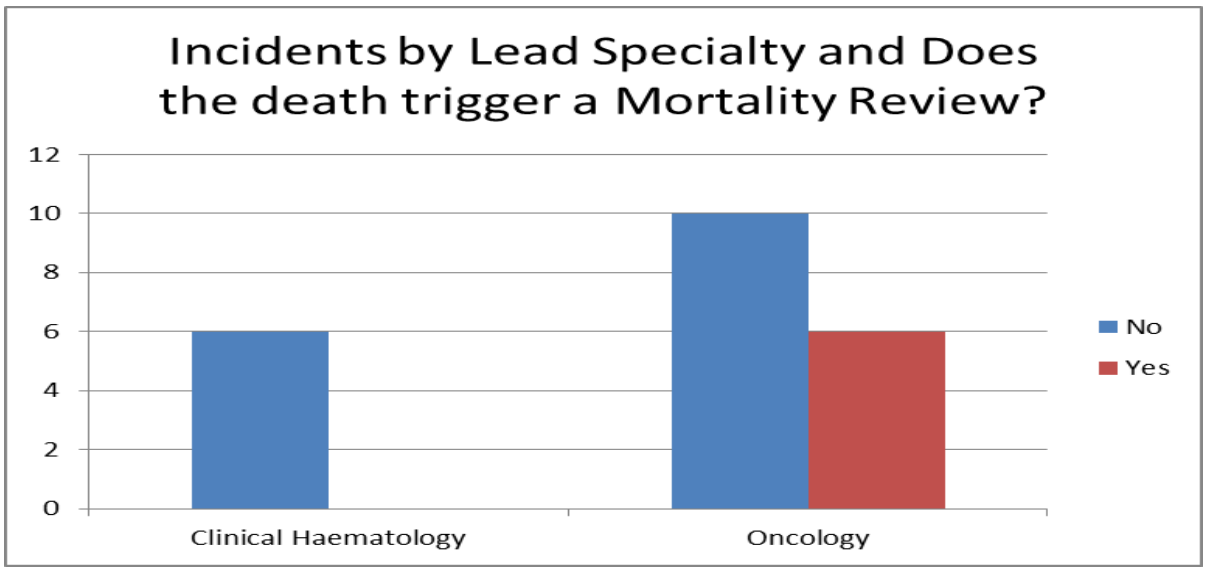
Learning from Deaths

Quarter 2 (July, August, September 2018)

D&S Division

Total number of deaths = 23
Total number of completed SJRs = 6
Number of SJRs indicating sub-optimal care = 0
Number of SJRs indicating excellent care = 1

Division at death	Specialty at death	Jul	Aug	Sep	Q2 total
Diagnostic & Specialist	Clinical haematology	1	2	3	6
	Medical oncology	4	8	5	17
	Division total	5	10	8	23



Number of SJRs by Speciality

Total number of completed SJRs = 0, broken down by Speciality			
Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Oncology	**6**	**0**	**1**

TOTAL = 6

Learning from Deaths

Quarter 2 (July, August, September 2018)

W&C Division

Total number of deaths = 8
Total number of completed SJRs = 0 *
Number of SJRs indicating sub-optimal care = 0 *
Number of SJRs indicating excellent care = 0 *

Division at death	Specialty at death	Q1 total	Jul	Aug	Sep	Q2 total
Women & Children	Gynaecological oncology	1	0	0	0	0
	Gynaecology	0	0	0	0	0
	Neonatology	7	2	5	1	8
	Obstetrics	1	0	0	0	0
	Paediatrics	0	0	0	0	0
	Well babies	0	0	0	0	0
	Division total	9	2	5	1	8

Total number of completed SJRs = 0, broken down by Speciality			
Speciality	***No. of SJRs conducted***	***No. of SJRs indicating sub-optimal care***	***No. of SJRs indicating excellent care***
Paediatrics	**Paediatrics do not conduct SJRs but review all deaths as part of routine process.*		
Neonatology			

APPENDIX IV – LEARNING THEMES AND ACTIONS

Learning from Deaths

Quarter 2 (July, August, September 2018)

IDENTIFIED POOR CARE		ACTIONS/OBSERVATIONS
1.	**Acute Medicine** Delays to initial medical review Poor recognition of unwell patient	Silver QI project to improve handover (Chief registrar)
2.	**Acute Medicine** Possible cardiac arrest in community hospital not picked up by ED booking clerk. If it had been, may have prompted earlier medical review if handed over to the medical team.	Community DNR needs to be re-written.
3.	**Acute Medicine** Missed diagnosis and incorrect treatment.	Improved handover from ED to Medicine. (As 1)
4.	**CoTE** • Team orders not enacted • MRI not chased • No handover to ward from AMU Team • No medical review for 2 days during critical period in admission • Inadequate review out of hours • No change in management despite deterioration • No discussion with family until several hours prior to death • Investigation completed too late to have effect	• Importance of handover from AMU to wards. • Urgent imaging needs chasing and ongoing discussion.
5.	**CoTE** • Unclear documentation • Possibly unrecognised STEMI by ambulance crew • ED not pre-alerted	
6.	**CoTE** • Patient not appropriately identified as dying • Unclear that the family were spoken to or that ECG was reviewed	Deteriorating patient group reviewing our approach
7.	**CoTE** • A medical outlier, patient not seen for 3 days – pneumonia may have been identified earlier • Illustrates ongoing problems with which team is responsible for patients on outlying wards	A robust system is being introduced revising the medical cover for outlying wards.
8.	**Lower GI** • Significant delays in surgical review and decision making • Patient deteriorated overnight without senior review • Poor documentation of discussions with family and team members	Under review through SI process to develop action plan

IDENTIFIED POOR CARE		ACTIONS/OBSERVATIONS
9.	**Respiratory** • Failure to detect respiratory failure early in proceedings • Care was not in line with Trust guidelines for NIV nor with the learning points from the NCEPOD report into NIV	Early detection of respiratory failure is important to allow adequate treatment

SUMMARY OF LEARNING THEMES		
1.	Poor recognition of unwell patient	Cross cutting word addressing these themes • Deteriorating patient group • Improved handover project (QI) • Changes to patient flow (AMIA, SAU) to ensure early consultant review • Family feedback to specialities.
2.	Delays to initial medical review	
3.	Poor ED pre-alert and hand over from community	
4.	Delays in senior review and decision making	
5.	Poor documentation	
6.	Inadequate handover between wards	
7.	Poor family involvement	

APPENDIX IV – LEARNING THEMES AND ACTIONS

Learning from Deaths

Quarter 2 (July, August, September 2018)

IDENTIFIED EXCELLENT CARE		ACTIONS/OBSERVATIONS
1. **2.** **3.**	**Critical Care** • No shared care pathway used but Critical Care end of life document used • Excellent and frequent patient communication made and documented	Need to standardise End of Life pathway paperwork.
4.	**Critical Care** • Frequent and comprehensive discussion with family • Failure to improve discussed with cardiology team	
5.	**Critical Care** • Appropriate cardiac arrest management in ED • Appropriate and timely transfer to DCC • Consultant led care at all times • Family involvement at all times	
6.	**T&O** • Admitted to CGH with suspected LRTI. XRay confirmed fracture R NOF • Transferred to GRH • Timely identification of fracture	
7.	**Vascular** • Scan showed AAA leaking • Risks discussed and known to patient and family • Ruptured during operation • Letter of thanks from wife	
8.	**Acute Medicine** • Early identification of unsurvivable problem and discussion with appropriate speciality • Early discussion of palliation with family and good symptomatic control • Involvement of all specialities	
9.	**Emergency Department** • Timely recognition of clinical problem and exploration of management plans with clear rationale • Involve family in decision making	Clear consideration of ceiling of care and discussion with family allows for dignity and comfort in end of life care
10.	**Emergency Department** • Cardiac arrest • Clear documentation • Senior led team • Great use of cardiac arrest proforma • Clear documentation of family discussions	

IDENTIFIED EXCELLENT CARE		ACTIONS/OBSERVATIONS
11.	**Emergency Department** • Cardiac arrest • Patient appropriately pre-alerted and severity of problem recognised • Senior decision making • Family present in resus attempt	Use of the cardiac arrest proforma – gives clear narrative
12.	**Emergency Department** • Clear documentation and all specialities involved • Appropriate escalation and review	
13.	**Oncology** • Known prostate CA • Good team work for the best medical care that was appropriate to the patient's needs, which changed as he became increasingly unwell • Family fully informed and given opportunity to ask questions and remain with the patient	Importance of discussion with patient and family

SUMMARY OF THEMES	
1.	Frequent, documented patient and family communication and involvement.
2.	Timely recognition of problem
3.	Senior reviews and decision making
4.	Appropriate escalation and review
5.	Clear documentation
6.	Involvement of all specialities

APPENDIX V – ADDITIONAL DETAIL

Learning from Deaths

Quarter 2 (July, August, September 2018)

Categories of Care which Trigged a Structured Judgement Review

TRIGGER	No.	%
Concern raised by family	14	17%
Concern raised by healthcare staff	7	9%
Deaths within 24hrs of admission	32	39.5%
Deaths of patient with C.Difficile	0	0%
Deaths following elective admission	3	4%
Deaths following a Fractured Neck of Femur	4	5%
Deaths taking place during or shortly after a procedure	8	10%
Patients with a Learning Disability	4	5%
Safeguarding concerns	2	2.5%
Systemic Anti-Cancer Treatment (SACT) in last 30 day - (Specialty Trigger)	6	7%
Cardiology Specialty Trigger	0	0%
Respiratory Specialty Trigger	2	2.5%
DCC Specialty Trigger	2	2.5%
Other Trigger	4	5%

Learning from Deaths

Quarter 2 (July, August, September 2018)

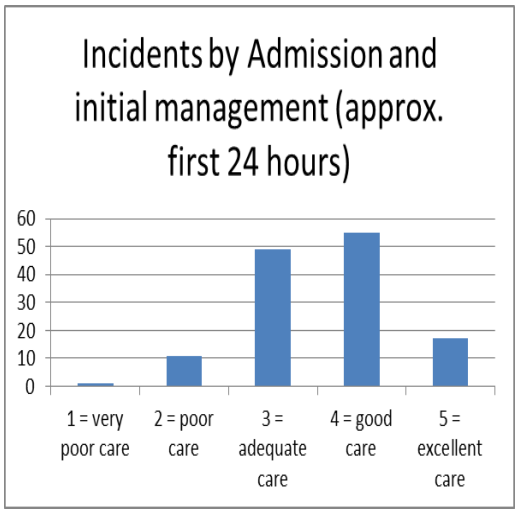
Location at Time of Death

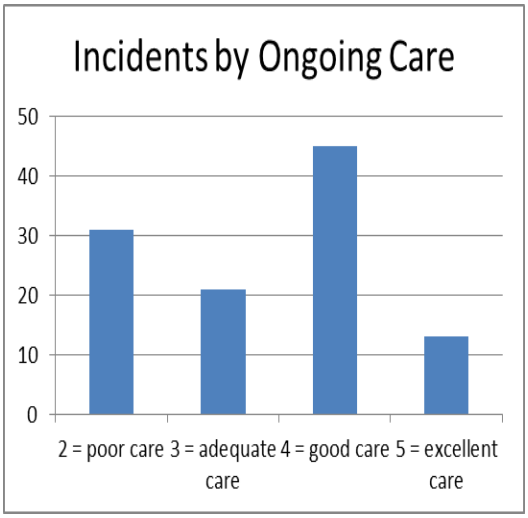
LOCATION	No.
Critical Care CGH	10
8b Respiratory	9
Critical Care GRH	8
ACUA / AMU	7
ACUC	6
3a Trauma	5
4b COTE	4
Avening Respiratory	4
Guiting Vascular	3
Lilleybrook Oncology	3
Recovery	3
5th Floor (pre change Sept 18)	2
6a Stroke	2
7b Renal	2
Rendcomb Oncology	2
Woodmancote COTE	2
4a Acute Medicine / Endocrine (pre change Nov 18)	1
6b stroke	1
7a Gastro (pre change Nov 18)	1
9b COTE (pre change Nov 18)	1
Cardiology Ward, GRH	1
Gallery Ward (MSFD), GRH	1
Hartpury suite, specialist investigations	1
Knightsbridge Respiratory	1
Ryeworth Ward	1

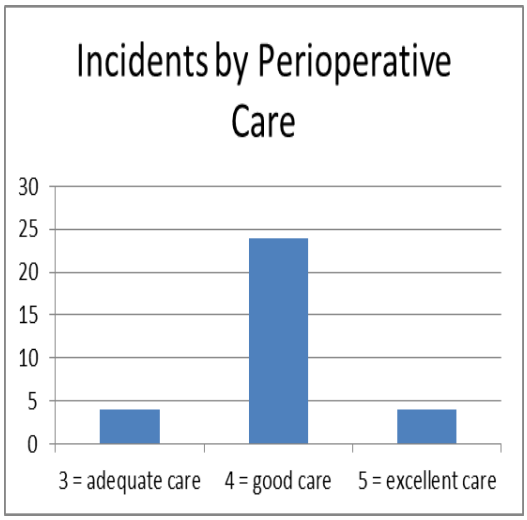
Learning from Deaths

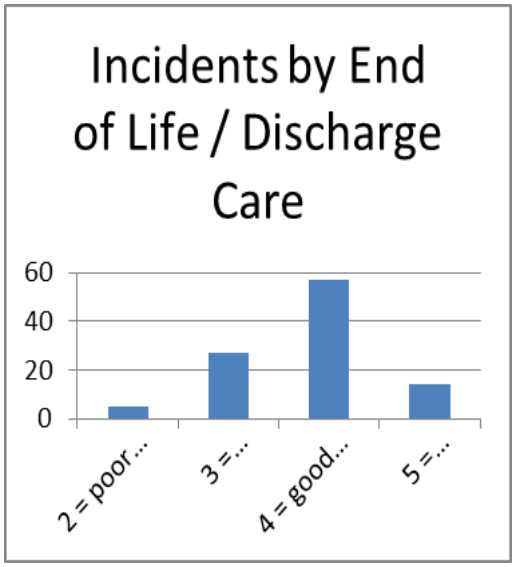
Quarter 2 (July, August, September 2018)

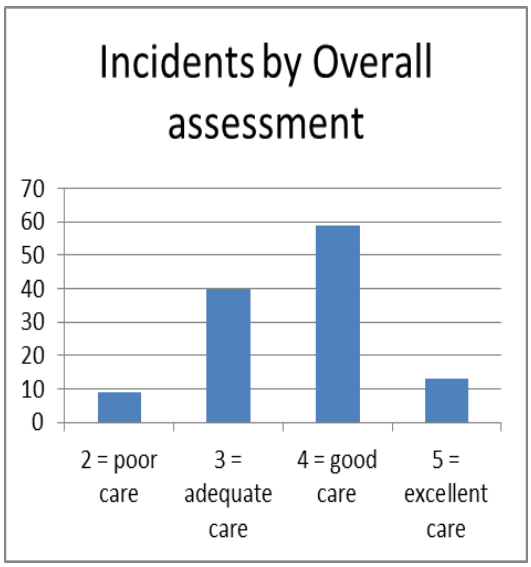
Ratings by Stage of Care











APPENDIX VI – Feedback Report from Bereaved Families

Learning from Deaths

Quarter 2 (July, August, September 2018)

Feedback Report from Bereaved Families

1.0 Background

During the bereavement process families / next of kin are asked for feedback on their experiences of the care they and their bereaved relative received prior to their death. These comments are added to the mortality report on the Datix system along with the ward/department they relate to.

2.0 Results

124 comments have been received since the start of recording. Of these there were 113 (91%) positive comments, 10 mixed comments (8%) and 1 negative comment (1%)

Ward	Positive	Mixed	Negative
3a	4 (100%)	0	0
4a	1 (100%)	0	0
4b	3 (75%)	1	0
5a/SAU	1 (100%)	0	0
5b	2 (100%)	0	0
ED	8 (100%)	0	0
7a	4 (100%)	0	0
6b	5 (83%)	1	0
7b	1 (33%)	2	0
8a	2 (100%)	0	0
8b	9 (90%)	1	0
DCCG	10 (100%)	0	0
DCCC	6 (100%)	0	0
9b	3 (100%)	0	0
ACUA/AMU	4 (100%)	0	0
ACUC	7 (100%)	0	0
Snowshill	2 (100%)	0	0
Avening	10 (100%)	0	0
6a	0 (0%)	1	0
Rendcomb	6 (86%)	1	0
Hartpury	1 (100%)	0	0
Gallery	1 (100%)	0	0
Knightsbridge	3 (100%)	0	0
Bibury	3 (100%)	0	0
Guiting	5 (100%	0	0
Prescott	2 (100%)	0	0
Cardiology CGH	3 (60%)	1	1
Cardiology GRH	1 (100%)	0	0
Woodmancote	11 (100%)	0	0
Ryeworth	6 (100%)	0	0
Lilleybrook	8 (89%)	1	0

2.1 Positive comments

20 comments expressed gratitude and thanks to the staff.

The most common positive words used to describe the staff and the care received were:

Wonderful (30 times)
lovely (13 times)
excellent (12 times)
kind (12 times)
good (10 times)
amazing (9 times)
caring (9 times)
faultless (8 times)

Twenty-five staff were named by the family for the high standard of care they gave most comments referred to all staff, ward staff and nursing staff. There were 15 positive comments regarding Doctors, 7 positive comments regarding the palliative care team, 2 regarding paramedics, 1 regarding a social worker and 1 regarding a porter.

Other more specific comments related to the ability to be in a side room at the time of death thus affording privacy and dignity, good pain management and being given a room/ reclining chair so they could stay with their relative.

2.2. Negative comments (see table)

3 families mentioned side rooms in their comments either having to move from a side room or a delay in being provided with one.

1 family had negative comments about agency staff

1 family mentioned the room in which their patient died which they referred to as like a storage room and being an undignified place to die.

1 family commented on a delay in staff coming to the aid of the patient

1 family commented on nurses not having enough time

1 family commented that their relative felt a burden due to their size.

3.0 Conclusion

The comments were overwhelmingly positive with 23 out of 31 areas having 100% positive comments. In all but 1 case the comments were a mixture of positive and negative. Wards are asked to review their comments and provide feedback to staff especially where they have been specifically named.

REPORT TO TRUST BOARD – JANUARY 2019

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

This report describes the business conducted at the Finance Committee held 28 November 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	– Deficit position of £16.7m. £0.2m favourable to plan. – Forecast deficit of £22.7m, £3.8m adverse plan.	– How robust is the forecast overall? – How long can favourable performance against plan be maintained?	– There is a deep dive piece of work between Finance and Operations to further validate the month 7 forecast position; which will inform next month's reporting. – Favourable performance expected to be maintained until Q4.	
Financial Enforcement Undertakings	– Trust removed from FSM regime. – Enforcement undertakings around medium term financial plan likely to remain.			

Capital Programme Update	– No decision received from NHSI on the application for loan financing as such capital commitments remain on hold.	Is there a process for emergency items to be escalated and processed?	Capital control group have oversight of the issues and escalations via the Director of Finance.	Clarity on the national decision timeline.
CIP Update	– £14.9m delivered against an £11.9m plan. – Increase in forecast outturn to £27m leaving a gap of £3.4m.	– How successful has the PWC work been? – Challenge of the year to date of procurement and agency?	– £1.2m forecast against PWC schemes with significant full year effect and developing pipeline for 19/20 – Agency and procurement are subject to the weekly deep dive process.	

IT and CITS Presentation	– Detailed review of previous IT infrastructure and estate. – High level gap analysis presented. – Tangible demonstration of improvements to date and a demonstrable road map for further improvements. – The committee reinforced its support with working with CITS with partners across Gloucestershire.	What is the financial strategy that supports the necessary improvement of digital strategy?	The financial plan for 19/20 and the emerging strategy is being developed.	
Developing a Digital Strategy	High level summary of the road map for the creation of a digital strategy	How do the timelines for this and other strategic pieces of work fit together?	Digital strategy to be further developed once funding sources are clearer.	

Keith Norton
Chair of Finance and Digital Committee
28 November 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO MAIN BOARD – JANUARY 2018

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

This report describes the business conducted at the Finance & Digital Committee held 19 December 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	£0.3m favourable position to the planned position at month 8. Active cash management with suppliers being undertaken due to cash pressure bought forward and the underlying deficit position.	Is the Trust perusing all options with NHS Improvement to mitigate the cash position? Have there been any operational impacts?	Yes, daily dialogue. The Director of Finance provided reassurance that there has been no operational impact so far and none is anticipated.	Need to work closely with NHSI.
Capital Programme Update	Capital forecast now reflective of a downside scenario assuming no loan financing; although the Trust continues to pursue resolution of the loan application.	Have there been any operational impacts? What is the longer term national problem for all Trusts?	Operational risks are being mitigated as part of daily risk management processes Issues that cannot be mitigated are being progressed at the Trust's risk (cash risk).	NHS long term plan is still to be published, therefore lack of clarity on the national strategy.

Cost Improvement Programme Update	£17.4m delivered against a year to date target of £15.2m, but under-delivery in month. FOT remains £3.3m away from plan.			Further mitigations being sought.
Smartcare financial Recovery Report	Revenue position forecast to be £18k over committed. Capital position to be committed as planned.			
Agency Report	Financial position overcommitted by £742k for the year to date.	Is there an impact of exceeding the NHSI ceiling?	The impact is potentially reputational.	
Business Intelligence & Data Quality	Paper presented to brief the committee on current issues and plans for the Business Intelligence department.	Wide ranging discussion of the uses to which Business Intelligence can be put.		Challenges to be picked up as part of the digital strategy.
Digital Risk Register	Risks scored 12+ presented	Given the recent addition of Digital to the committee, can all risks be represented in January?	The full risk register will be bought to January.	

Keith Norton
Chair of Finance and Digital Committee
19 December 2018

TRUST BOARD – JANUARY 2019
Redwood Education Centre, Gloucestershire Royal Hospital

Report Title
Financial Performance Report – M08 2018/19
Sponsor and Author(s)
Author: Jonathan Shuter, Director of Operational Finance Sponsor: Sarah Stansfield, Director of Finance
Executive Summary

Purpose

To provide assurance to the Board with regard to the Trust's financial performance for the period ended 30th November 2018.

Key issues to note

- The Trust is reporting an actual income and expenditure deficit of £16.2m for the year to date at November 2018. This is a favourable variance of £0.3m.
- The Trust continues to actively manage cash and the draw down of loan support.
- Key highlights of the M08 position:
  - Commissioner income is showing a favourable variance to budget of £2.2m.
  - Other NHS patient related income (including AfC funding) is £0.9m adverse to plan.
  - Private and paying patients' income is £0.4m adverse to plan.
  - Other operating income (including Hosted Services) is favourable by £1.7m.
  - Pay expenditure is showing a favourable variance of £0.9m.
  - Non-pay expenditure is showing an adverse variance of £5.2m.
  - Non-operating costs are showing a favourable variance of £2m.

Conclusion, Implications and Future Action Required

- The Board is asked to note the contents of the report.

Recommendations
The Board is asked to note the contents of the report.
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	**X**	Information Management & Technology		
Human Resources		Buildings		

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

Date the paper was previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**

Outcome of discussion when presented to previous Committees/TLT
The position was previously reported to Finance Committee in December.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th November 2018

Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

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 is reflected throughout this report.

The financial position as at the end of November 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.

In November the Group's consolidated position shows a year to date deficit of £16.2m. This represents a £0.3m favourable position against plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 08 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	296,565	298,786	2,221	0	0	0	296,565	298,786	2,221
PP, Overseas and RTA Income	3,804	3,450	(355)	0	0	0	3,804	3,450	(355)
Other Income from Patient Activities	3,610	2,678	(932)	0	0	0	3,610	2,678	(932)
Operating Income	45,133	46,914	1,781	29,640	29,581	(60)	47,840	49,561	1,721
Total Income	**349,112**	**351,827**	**2,715**	**29,640**	**29,581**	**(60)**	**351,819**	**354,475**	**2,655**
Pay	221,794	220,626	1,168	11,223	11,466	(243)	233,016	232,092	924
Non-Pay	130,417	134,988	(4,571)	17,017	17,608	(591)	120,500	125,662	(5,161)
Total Expenditure	**352,210**	**355,613**	**(3,403)**	**28,240**	**29,074**	**(834)**	**353,517**	**357,754**	**(4,237)**
EBITDA	**(3,098)**	**(3,786)**	**(688)**	**1,401**	**507**	**(894)**	**(1,697)**	**(3,279)**	**(1,582)**
EBITDA %age	**(0.9%)**	**(1.1%)**	**(0.2%)**	**4.7%**	**1.7%**	**(3.0%)**	**(0.5%)**	**(0.9%)**	**(0.4%)**
Non-Operating Costs	13,766	12,630	1,137	1,401	507	894	15,167	13,137	2,030
Surplus/(Deficit)	**(16,864)**	**(16,416)**	**448**	**0**	**0**	**0**	**(16,864)**	**(16,416)**	**448**
Excluding Donated Assets	400	247	(153)	0	0	0	400	247	(153)
Control Total Surplus/(Deficit)	**(16,464)**	**(16,169)**	**295**	**0**	**0**	**0**	**(16,464)**	**(16,169)**	**295**

* Group Position excludes £27.3m of intergroup transactions including dividends

Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

The table below shows both the in-month position and the cumulative position for the Group.

In November, the Group's consolidated position shows a small in month surplus which is £0.1m favourable against plan.

The year to date deficit of £16.2m is a favourable variance of £0.3m against plan.

Month 08 Financial Position	Annual Budget £000s	M08 Budget £000s	M08 Actuals £000s	M08 Variance £000s	M08 Cumulative Budget £000s	M08 Cumulative Actuals £000s	M08 Cumulative Variance £000s
SLA & Commissioning Income	444,587	38,586	40,699	2,112	296,565	298,786	2,221
PP, Overseas and RTA Income	5,710	471	425	(47)	3,804	3,450	(355)
Other Income from Patient Activities	5,418	450	413	(37)	3,610	2,678	(932)
Operating Income	74,297	5,647	5,875	229	47,840	49,561	1,721
Total Income	**530,012**	**45,155**	**47,411**	**2,257**	**351,819**	**354,475**	**2,655**
Pay	346,990	28,746	29,308	(562)	233,016	232,092	924
Non-Pay	178,190	14,152	16,014	(1,862)	120,500	125,662	(5,161)
Total Expenditure	**525,180**	**42,898**	**45,322**	**(2,425)**	**353,517**	**357,754**	**(4,237)**
EBITDA	**4,832**	**2,257**	**2,089**	**(168)**	**(1,697)**	**(3,279)**	**(1,582)**
EBITDA %age	**0.9%**	**5.0%**	**4.4%**	**(0.6%)**	**(0.5%)**	**(0.9%)**	**(0.4%)**
Non-Operating Costs	22,751	1,896	1,619	277	15,167	13,137	2,030
Surplus/(Deficit)	**(17,919)**	**361**	**471**	**109**	**(16,864)**	**(16,416)**	**448**
Excluding Donated Assets	(902)	50	31	(19)	400	247	(153)
Control Total Surplus/(Deficit)	**(18,821)**	**411**	**501**	**90**	**(16,464)**	**(16,169)**	**295**

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 08 Financial Position	M08 Budget £000s	M08 Actuals £000s	M08 Variance £000s	M08 Cumulative Budget £000s	M08 Cumulative Actuals £000s	M08 Cumulative Variance £000s
SLA & Commissioning Income	38,586	40,699	2,112	296,565	298,786	2,221
PP, Overseas and RTA Income	471	425	(47)	3,804	3,450	(355)
Other Income from Patient Activities	450	413	(37)	3,610	2,678	(932)
Operating Income	5,647	5,875	229	47,840	49,561	1,721
Total Income	**45,155**	**47,411**	**2,257**	**351,819**	**354,475**	**2,655**
Pay						
Substantive	26,761	27,178	(417)	216,113	213,839	2,274
Bank	940	940	0	7,520	7,980	(460)
Agency	1,045	1,190	(145)	9,383	10,273	(890)
Total Pay	**28,746**	**29,308**	**(562)**	**233,016**	**232,092**	**924**
Non Pay						
Drugs	6,063	6,104	(41)	45,188	47,278	(2,091)
Clinical Supplies	3,309	3,492	(183)	24,877	25,449	(572)
Other Non-Pay	4,779	6,417	(1,638)	50,436	52,935	(2,499)
Total Non Pay	**14,152**	**16,014**	**(1,862)**	**120,500**	**125,662**	**(5,161)**
Total Expenditure	**42,898**	**45,322**	**(2,425)**	**353,517**	**357,754**	**(4,237)**
EBITDA	**2,257**	**2,089**	**(168)**	**(1,697)**	**(3,279)**	**(1,582)**
EBITDA %age	**5.0%**	**4.4%**	**(0.6%)**	**(0.5%)**	**(0.9%)**	**(0.4%)**
Non-Operating Costs	1,896	1,619	277	15,167	13,137	2,030
Surplus/(Deficit)	**361**	**471**	**109**	**(16,864)**	**(16,416)**	**448**
Excluding Donated Assets	50	31	(19)	400	247	(153)
Surplus/(Deficit)	**411**	**501**	**90**	**(16,464)**	**(16,169)**	**295**

Non-Pay – expenditure is showing a £5.2m overspend year to date. The overspend of £1.9m in month Clinical Supplies is £0.2m adverse mainly on medical and surgical equipment within Surgery – Theatres; Other Non-Pay is £1.6m overspent largely in respect of unidentified CIP (£1.2m) and Trak recovery (£0.4m).

SLA & Commissioning Income – is £2.2m favourable against plan. This predominantly reflects under performance against Specialised Services (£0.9m), GCCG (£0.6m), Worcestershire and Hereford (£0.4m), offset by over performance on Welsh Commissioners (£0.7m) and Other Commissioners (£3.3m).

PP / Overseas / RTA Income – performance has deteriorated slightly to a £0.4m year to date adverse variance. Oncology private patients (£0.2m) and RTA cost recovery (£0.2m) make up the adverse variance.

Other Patient Income – the year to date adverse variance largely relates to the clawback of Agenda for Change funding in respect of GMS (£0.5m).

Other Operating Income – An in month over recovery of £0.1m for Hosted Services. This income is offset in expenditure with no impact on the I&E position. Other favourable positions include the release of £0.1m of deferred income for Information (Trak).

Pay – expenditure is showing a £0.9m underspend year to date reflecting an underspend on substantive staff, partially offset by an overspend on temporary staffing. The in month variance of £0.6m adverse is mainly driven by unidentified Pay CIPs (£0.5m) across Divisions (Surgery £0.3m; Medicine £0.2m; Diagnostic & Specialist £0.1m).

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

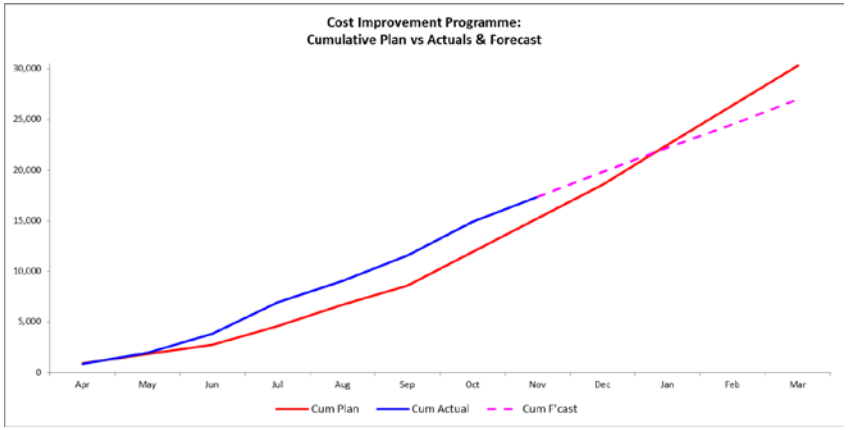
1. At Month 8 the trust has delivered £17.4m of CIP YTD against the YTD NHS Improvement target of £15.2m, this over performance is a continued benefit from several schemes delivering earlier or more than initially phased (Theatre Managed Services, Theatre Productivity, Vacancy Factor)**.**
The YTD delivery splits into £13.4m recurrent and £4.0m of non-recurrent schemes. This translates into a split of 80% of recurrent delivery versus 20% of non-recurrent delivery.
Within the month, the Trust has delivered £2.5m of CIP against an in-month NHSI target of £3.3m.

2. At Month 8, the divisional year end forecast figures indicate delivery of £26.975m against the Trust's target of £30.3m. This is a decrease against M7 FOT of £19k. The deterioration in the FOT is due to movements in month and the increased amount found through the Align process has supported GHFT to roughly maintain the overall position.

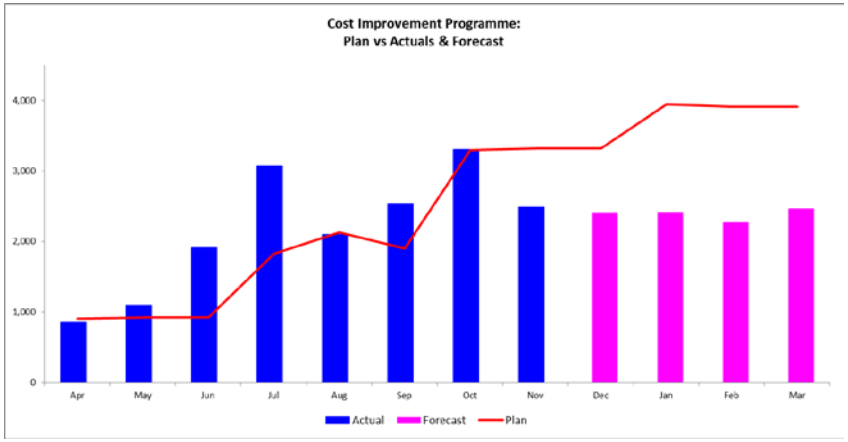
3. PWC concluded their Align engagement with the Surgical and Diagnostics & Specialities divisions. The FOT included in M8 for schemes originating through the process is £179k for D&S and £670k for Surgery, combined this is an increased FOT of £849k in totality, at Mth 7, £426k of this was already included.

4. The cumulative FOT indicates that GHFT will be reporting a negative variance against plan from January (see graph to the right).

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



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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2018 £000	GROUP Balance as at M8 £000	B/S movements from 31st March 2018 £000
Non-Current Assests			
Intangible Assets	9,130	9,979	849
Property, Plant and Equipment	251,010	248,200	(2,810)
Trade and Other Receivables	4,463	4,379	(84)
Total Non-Current Assets	**264,603**	**262,558**	**(2,045)**
Current Assets			
Inventories	7,131	7,060	(71)
Trade and Other Receivables	19,276	26,352	7,076
Cash and Cash Equivalents	5,447	3,894	(1,553)
Total Current Assets	**31,854**	**37,306**	**5,452**
Current Liabilities			
Trade and Other Payables	(47,510)	(53,514)	(6,004)
Other Liabilities	(3,284)	(1,919)	1,365
Borrowings	(4,703)	(4,853)	(150)
Provisions	(160)	(160)	0
Total Current Liabilities	**(55,657)**	**(60,446)**	**(4,789)**
Net Current Assets	**(23,803)**	**(23,140)**	**663**
Non-Current Liabilities			
Other Liabilities	(7,235)	(6,985)	250
Borrowings	(111,219)	(126,503)	(15,284)
Provisions	(1,472)	(1,472)	0
Total Non-Current Liabilities	**(119,926)**	**(134,960)**	**(15,034)**
Total Assets Employed	**120,874**	**104,458**	**(16,416)**
Financed by Taxpayers Equity			
Public Dividend Capital	168,768	168,768	0
Reserves	43,530	43,530	0
Retained Earnings	(91,424)	(107,840)	(16,416)
Total Taxpayers' Equity	**120,874**	**104,458**	**(16,416)**

The table shows the M08 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 08 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 a decrease of £0.07m.
- Trade receivables are £7.1m above the closing March 2018 level.
- Cash has decreased by £1.6m since the year-end, reflecting the deficit position offset by loan finance.

Current Liabilities
- Current liabilities have increased by £4.8m, 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 £15.3m.

Retained Earnings
- The retained earnings reduction of £16.4m 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 November	
	Number	£'000	Number	£'000
Total Bills Paid Within period	75,517	150,912	8,070	13,937
Total Bill paid within Target	57,615	120,575	5,559	8,850
Percentage of Bills paid within target	76%	80%	69%	64%

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 November the volume of invoices paid within the 30 day target is 69% which is below the year to date performance. This deterioration in performance reflects the proactive management of creditors to ensure the Trust has a minimum cash balance (as agreed with NHSI).

Liabilities – Borrowings

Analysis of Borrowing	As at 30th November 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	79,295
Obligations under finance leases	1,652
Obligations under PFI contracts	18,463
Balance Outstanding	**126,503**
Total Balance Outstanding	**131,356**

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 £18.1m of additional in-year borrowing.

Cashflow : November

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	Oct-18 £000s	Nov-18 £000s	Dec-18 £000s	Jan-19 £000s	Feb-19 £000s	Mar-19 £000s	Plan Year ending 31.3.19 £000s
Surplus (Deficit) from Operations	**(4,831)**	**(2,512)**	**(1,213)**	**(1,126)**	**(2,148)**	**(272)**	**638**	**1,219**	**(1,649)**	**1,006**	**(849)**	**1,849**	**(9,888)**
Adjust for non-cash items:													
Depreciation	912	912	912	912	912	912	625	869	870	870	870	870	10,446
Other operating non-cash	0	0	0	0	0	0	0	0	0	0	0	(1,500)	(1,500)
Operating Cash flows before working capital	**(3,919)**	**(1,600)**	**(301)**	**(214)**	**(1,236)**	**640**	**1,263**	**2,088**	**(779)**	**1,876**	**21**	**1,219**	**(942)**
Working capital movements:													
(Inc.)/dec. in inventories	0	71	0	0	0	(330)	33	155	0	0	0	0	(71)
(Inc.)/dec. in trade and other receivables	(4,596)	(2,610)	(546)	2,310	(963)	3,647	(3,619)	(615)	(1,359)	(1,774)	(1,870)	2,753	(9,242)
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	0	0	0	0	(79)	(79)
Inc./(dec.) in trade and other payables	7,156	1,157	1,434	(1,013)	1,222	(6)	(1,654)	(1,050)	2,110	(2,297)	1,204	1,613	9,876
Inc./(dec.) in other financial liabilities	(437)	904	0	0	0	(1,552)	(245)	(35)	0	0	0	0	(1,365)
Net cash in/(out) from working capital	**2,123**	**(478)**	**888**	**1,297**	**259**	**1,759**	**(5,485)**	**(1,545)**	**751**	**(4,071)**	**(666)**	**4,287**	**(881)**
Capital investment:													
Capital expenditure	(158)	(207)	(459)	(459)	(1,883)	(159)	(1,155)	(2,295)	(2,597)	(2,879)	(1,036)	(2,472)	(15,759)
Capital receipts	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash in/(out) from investment	**(158)**	**(207)**	**(459)**	**(459)**	**(1,883)**	**(159)**	**(1,155)**	**(2,295)**	**(2,597)**	**(2,879)**	**(1,036)**	**(2,472)**	**(15,759)**
Funding and debt:													
PDC Received	0	0	0	0	0	0	0	0	1,300	1,700	0	0	3,000
Interest Received	3	13	2	2	5	30	12	2	3	3	3	3	81
Interest Paid	(29)	(218)	(78)	(178)	(87)	(1,255)	(91)	(223)	(76)	(179)	(85)	(1,836)	(4,335)
DH loans - received	3,500	0	0	0	4,044	4,465	1,915	4,152	574	3,966	2,346	1,406	26,368
DH loans - repaid	0	0	0	0	(167)	(1,317)	0	0	0	0	(167)	(1,318)	(2,969)
Finance lease capital	(148)	(148)	(148)	(148)	(148)	(148)	(149)	(149)	(149)	(149)	(149)	(149)	(1,782)
Interest element of Finance Leases	(12)	(12)	(12)	(12)	(12)	(12)	(13)	(13)	(13)	(13)	(13)	(13)	(150)
PFI capital element	(95)	(95)	(95)	(95)	(95)	(95)	(95)	(94)	(94)	(94)	(94)	(94)	(1,135)
Interest element of PFI	(161)	(161)	(161)	(161)	(161)	(161)	(161)	(160)	(160)	(160)	(160)	(160)	(1,927)
PDC Dividend paid	0	0	0	0	0	(1,489)	0	0	0	0	0	(873)	(2,362)
Net cash in/(out) from financing	**3,058**	**(621)**	**(492)**	**(592)**	**3,379**	**18**	**1,418**	**3,515**	**1,385**	**5,074**	**1,681**	**(3,034)**	**14,789**
Net cash in/(out)	**1,104**	**(2,906)**	**(364)**	**32**	**519**	**2,258**	**(3,959)**	**1,763**	**(1,240)**	**0**	**0**	**0**	**(2,793)**
Cash at Bank - Opening	5,447	6,551	3,645	3,281	3,313	3,832	6,090	2,131	3,894	2,654	2,654	2,654	5,447
Closing	6,551	3,645	3,281	3,313	3,832	6,090	2,131	3,894	2,654	2,654	2,654	2,654	2,654

The cashflow for November 2018 is shown in the table:

Cashflow Key movements:

Current Assets – The increase in trade and other receivables since month 7 has decreased cash.

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £18.1m. To enable the Trust to keep the minimum cash balance requirement creditor payments are reviewed weekly.

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. The Trust has requested additional borrowing via NHSI in line with the forecast deficit I&E position, and working capital requirements.

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 November 2018

Capital Summary	Internal YTD Plan £000's	YTD Spend £000's	YTD Var £000's	18/19 Full Year Plan £000's	FOT 18/19 Spend £000's	Forecast Variance £000's
Health & Safety Projects	1,491.7	1,044.5	-447.2	4,475.0	2,739.8	-1,735.2
Environmental Works	98.0	92.9	-5.1	200.0	117.0	-83.0
Estates Unallocated Allowances	60.0	19.3	-40.7	125.0	40.8	-84.2
Non Health & Safety Projects	766.0	779.1	13.1	1,154.0	1,257.1	103.1
Committed Schemes	1,015.0	932.4	-82.6	2,679.0	2,669.2	-9.8
Service Reconfiguration	333.3	220.3	-113.1	1,221.0	221.2	-999.8
Major Equipment Replacement	465.9	34.0	-431.8	4,588.0	3,222.0	-1,366.0
IM&T	2,861.5	1,463.7	-1,397.8	6,100.0	3,803.5	-2,296.5
MEF	950.8	293.5	-657.3	2,000.0	400.1	-1,599.9
Other Schemes	0.0	28.6	28.6	1,300.0	1,399.6	99.6
Contingency	0.0	0.0	0.0	200.0	0.0	-200.0
Strategic Development	200.0	185.4	-14.6	1,975.0	786.5	-1,188.5
Overspend/(Underspend)	**8,242.3**	**5,093.8**	**-3,148.5**	**26,017.0**	**16,656.8**	**-9,360.2**

The table summarises (at a high level) the capital plan expenditure (not cash flow), spend to date and year end position.

The Trust is still awaiting the outcome of the capital financing application, however the forecast depicts the position if no financing is received. This position reflects spend against schemes with the highest priority in terms of health and safety and contractual commitments.

Points to note:

- Within the Women's Centre, there have been up to 50 reported water leaks within the past few months, where carbon steel piping has been failing. The H&S budgets have been reprioritised to accommodate this replacement work which has commenced.
- IM&T schemes have been finalised however a halt has been placed on further capital commitments until the outcome of the capital financing application is known.
- Detailed planning and phased implementation of the £920k streaming improvements works is underway and orders have been placed with contractors.
- The Trust has committed to funding the enabling works for the new Linac (£480k) and has recently approved the Infoflex business case (£147k).
- The enabling works to enable the relocation of staff at Victoria Warehouse and Pullman Court are included in the forecast position (£100k)

Recommendations

The Board is asked to note:

- The Trust is reporting an actual income and expenditure deficit of £16.2m for the year to date at November 2018. This is a favourable variance of £0.3m.
- The Trust continues to actively manage cash and the draw down of loan support.

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

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

Date: **January 2019**

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST BOARD – JANUARY 2019
Lecture Hall, Redwood Education Centre commencing at 12:30

Report Title
Exit from Financial Special Measures and Enforcement Undertakings Compliance Certificates
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance Sponsor: Deborah Lee, Chief Executive
Executive Summary

Purpose

The purpose of this paper is to formally advise the Board of the recent confirmation from NHS Improvement that the Trust's Financial Special Measures (FSM) status has been lifted and to advise that compliance certificates have now been issued by NHS Improvement. Further, the paper describes next steps with respect to ongoing regulatory oversight.

Key issues to note

- Correspondence from NHS Improvement (NHSI) relating to the Exit from Financial Special Measures and Enforcement Undertakings is attached.
- There are no material changes to the Trust arising from the recent decision to remove the Trust from FSM beyond the obvious benefits to reputation and staff morale. Previous punitive interest rate charges had previously disappeared.
- As a result of the lifting of FSM, the NHSI regulatory team has reviewed the Trust's compliance with the Enforcement Undertakings issued in parallel to the Trust being placed in FSM and decided to issue the Trust with a Compliance Certificate against items 1.1 – 1.8 and 2.15 relating to Financial Special Measures. Further, NHSI concluded that undertakings 2.13 – 2.14, relating to commissioning an external Well-Led' board governance review, need not be retained.
- By the way of background: In June 2018, the Trust received a Compliance Certificate against items 2.1-2.5, 2.10-2.12 and 3.1 – 3.2.
- As a result, only enforcement undertakings 2.6-2.9, relating to medium-term financial recovery plan, remain in place.
- NHSI will be supporting the Trust to agree a recovery plan for 2019/20. Refreshed undertakings will be issued as part of the 2019/20 planning process. These will reflect the NHSI's expectations in respect of the medium term financial plan.

Implications and Future Action Required

Given the Trust remains subject to Enforcement Undertakings it will now move from Segment 4 to Segment 3 of the Single Oversight Framework; lifting of all Undertakings would most likely result in further progress to Segment 2.

Recommendations
The Board is asked to note the decision by NHS Improvement to remove the Trust from Financial Special Measures, the revised segmentation within the Single Oversight Framework and note the likelihood of further undertakings being issued for the period FY20.

Impact Upon Strategic Objectives
Supports progress towards the objectives relating to the Single Oversight Framework and regulator action.
Impact Upon Corporate Risks
Mitigates the risk associated with reputation damage arising from FSM.
Regulatory and/or Legal Implications
Regulatory implications.
Equality & Patient Impact
Nil

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
	29 November 2018						

Outcome of discussion when presented to previous Committees/TLT
The Committee accepted the report for information and noted the decision by NHS Improvement to remove the Trust from Financial Special Measures, the revised segmentation within the Single Oversight Framework and note the likelihood of further undertakings being issued for the period FY20.

ENFORCEMENT UNDERTAKINGS

LICENSEE

Gloucestershire Hospitals NHS Foundation Trust ("the Licensee")
Cheltenham General Hospital
Sandford Road
Gloucestershire
GL53 7AN

REFERENCES

Any reference to 'NHS Improvement' in these undertakings is to be taken as a reference to Monitor.

DECISION

On the basis of the grounds set out below, and having regard to its Enforcement Guidance, NHS Improvement has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its under powers under section 106 of the Health and Social Care Act 2012 ("the Act").

GROUNDS

1. Licence

The Licensee is the holder of a licence granted under section 87 of the Act.

2. BACKGROUND

2.1. In July 2016 the Licensee commissioned a review of its financial position which subsequently highlighted significant deficiencies in financial forecasting and control. In September 2016 the Licensee reported a forecast financial deficit for 2016/17 of £26.6m and an interim cash support requirement of £46.9m, compared with an annual plan, approved by the Trust Board in April 2016, to deliver an £18.6m surplus.

2.2. On 17 October 2016, NHS Improvement gave notice that it intended to place the Licensee in Financial Special Measures. Financial Special Measures is a package of measures applied to particular NHS bodies as part of a reset of expectations of financial discipline and performance in the NHS. Financial Special Measures is designed to help NHS bodies facing the biggest financial challenges.

3. BREACHES

3.1. In light of its forecast financial deficit, NHS Improvement has reasonable grounds to suspect that the Licensee has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence: CoS (3) and 7(1) and (2); FT4(4)(a) and (c); FT4(5)(a), (d), (e) and (g).

3.2. In particular:

3.2.1. in forecasting an unplanned financial deficit of £29.8m for 2016/17 and requiring associated interim support from the Department of Health of around £47m to secure continuity of services, the Licensee: failed to adopt and apply systems and standards of corporate governance and of financial management which might reasonably be regarded as suitable for a provider of Commissioner Requested services (CoS3)(1)): failed to act in a manner calculated to secure access to the required resources (CoS7(1)); and undertook activity which created a material risk that required resources would not be available (CoS7(2));

3.2.2. the Licensee's failed to establish and implement (i) effective board and committee structures to assure the board of the effectiveness or otherwise of its system of internal financial control and the robustness of financial assumptions underpinning the 2016/17 annual plan (FT 4(4)(a)), and (ii) clear reporting lines and accountabilities concerning its underlying financial position (FT4(4)(c)); and

3.2.3. the Licensee's failure to establish and effectively implement systems and processes:

3.2.3.1. to ensure compliance with the licensee's duty to operate efficiently, economically and effectively, as evidenced by the unplanned deficit of £29.8m and failure to identify and deliver efficiencies in line with the Licensee's 2016/17 Cost Improvement Programme approved by the Board as part of the 2016/17 annual plan (FT4(5)(a));

3.2.3.2. for effective financial decision-making, management and control, as evidence by the Licensee's failure to take appropriate action to mitigate the impact of the forecast financial deficit timeously and by weaknesses identified in the August 2016 Financial Reporting external review (FT4(5)(d));

3.2.3.3. to obtain and disseminate accurate, comprehensive, timely information to support Board and Committee decision making, as evidenced by the Licensee's failure to appraise the Board of the underlying financial position (FT4(5)(e)); and

3.2.3.4. (g) to monitor business plans, as evidenced by the Licensee's 2016/17 annual plan to deliver an £18.6m financial surplus, proposed to and agreed by its board in April 2016 (FT4(5)(g)).

3.3. Need for action

NHS Improvement believes that the action, which the Licensee has undertaken to take pursuant to these undertakings, is action to secure that the breaches in question do not continue or recur.

4. Appropriateness of undertakings

In considering the appropriateness of accepting the undertakings set out below, NHS Improvement has taken into account the matters set out in its Enforcement Guidance.

UNDERTAKINGS

NHS Improvement has agreed to accept and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act:

1. Financial Special Measures

Governance

1.1 Within the timescales specified by NHS Improvement, the Licensee will:

1.1.1 publish a statement on its website homepage explaining that the Licensee has been placed in Financial Special Measures and the reasons for this (taking into account the explanation provided by NHS Improvement). The statement will include a link to the Financial Improvement Notice issued to the Licensee by NHS Improvement; and

1.1.2 notify its council of governors that the Licensee has been placed in Financial Special Measures, the reasons for it and the planned response.

Financial Recovery Plan

1.2 As soon as reasonably practicable after receiving the Financial Improvement Notice, the Licensee will identify and set out in writing the key financial issues, including an analysis of the underlying causes of the Licensee's financial position, that need to be addressed to ensure the Licensee's financial recovery ('Diagnostic').

1.3 Taking into the account the findings of the Diagnostic, the Licensee will develop a Financial Special Measures Recovery Plan ('FSMRP'). The scope and detailed content of the FSMRP will be as agreed with NHS Improvement but will include:

1.3.1 actions to address the key issues identified by Diagnostic with key milestones;
1.3.2 a robust recovery plan, quality-assured and agreed by the Licensee's board that will deliver rapid financial recovery and achieve a quarter on quarter improvement in the Licensee's I&E and cash run rates during 2016/17 and Quarter 4 I&E and cash run rates to deliver a materially better financial result for 2017/18 than the 2016/17 recovery plan;
1.3.3 actions to deliver the Licensee's Agency Action Plan and the planned cost reductions in line with the timescales set out in this plan;
1.3.4 actions to develop and submit to NHS Improvement a refreshed Cost Improvement Programme for 2016/17, as soon as practicable. This should identify and secure delivery of all practicable recovery actions to improve and stabilise the 2016/17 financial position;
1.3.5 the plan for implementation of all actions designed to strengthen financial control. This should include implementation of the recommendations made in the August 2016 Financial Reporting Review in line with the timescales set out in the Licensee's associated action plan. It should also include any further actions to strengthen financial control identified by the Licensee, NHS Improvement, or external reviewers commissioned to support

development or delivery of the FSMRP through work undertaken while the Licensee is in Financial Special Measures;

1.3.6 actions to embed and monitor the additional controls and other measures the Licensee has put in place since being put into Financial Special Measures to strengthen financial control. These may relate, for example, to staff pay costs, procurement, cash, delegated financial limits and programme management offices (PMOs.); and

1.3.7 details of how the Licensee will deploy sufficient resources to ensure implementation of the FSMRP.

1.4 When developing the FSMRP, the Licensee will engage effectively with key stakeholders, including commissioners, and will reflect their views appropriately.

1.5 The Diagnostic and the FSMRP will be delivered to NHS Improvement at least 2 working days in advance of the Progress Review Check (defined at 3.2 below). The Diagnostic and FSMRP are subject to review and approval by NHS Improvement.

1.6 The Licensee will take all reasonable steps to secure that it is able to deliver the FSMRP once it has been agreed by NHS Improvement.

Financial Control

1.7 The Licensee will comply with any arrangements specified by NHS Improvement for the approval of the Licensee's decisions on expenditure.

The Licensee will not make any application for financial assistance provided by the Secretary of State under section 40 of the National Health Service Act 2006 unless that application has been approved by NHS Improvement.

2. Further requirements

Financial governance

2.1 The Licensee will take all practical steps to implement and maintain robust financial governance arrangements, including but not limited to those set out in paragraphs 2.2 to 2.5 below.

2.2 The Licensee will take all practical steps to facilitate and support completion of the financial governance review, the scope for which was agreed by the Licensee Board on 30 September 2016 ('the financial governance review') in response to the factors contributing to the Licensee's financial deterioration.

2.3 The Licensee will develop a detailed action plan ('the financial governance action plan') to address the issues and recommendations arising from the financial governance review, and where appropriate any actions arising from further work undertaken by the Licensee or NHS Improvement to strengthen financial governance. The Licensee will agree this action plan with NHS Improvement, to a timescale to be agreed with NHS Improvement.

2.4 The Licensee will deliver the financial governance action plan within the timescales set out in the plan.

2.5 The Licensee will embed improved financial control and forecasting processes to support effective scrutiny and oversight of the financial position by the Board, Finance Committee and Audit Committee, including full-year I&E and cash forecasts, risks to delivery and mitigations, working capital movements and debtor/creditor performance, and distressed finance utilisation.

Medium-term financial recovery plan

2.6 The Licensee will take all reasonable steps to return to financial sustainability, including but not limited to those set out in paragraphs 2.7 to 2.9 below.

2.7 The Licensee will submit to NHS Improvement its two-year operational plan in line with the national planning timetable for 2017/18 and 2018/19 ("the two-year plan). The two-year plan must demonstrate planned recovery of the Licensee's financial position through quarter on quarter improvements in I&E and cash run rates to support delivery of sustainable financial balance.

2.8 The Licensee will take all practical steps to facilitate and support completion of the Cost Improvement Programme and financial baselining external reviews. The Licensee will develop and deliver detailed action plans to respond to the findings of the Cost Improvement Programme and financial baselining external reviews to support development of a comprehensive cost improvement programme for 2017/18 and 2018/19. Wherever practicable and appropriate, the two-year plan and financial assumptions that are included should be aligned to and consistent with the Licensee's strategic, quality and operational priorities and those of the Gloucestershire Sustainability & Transformation Plan (STP).

2.9 The Licensee should keep the two-year plan under review and provide appropriate assurance to its Board that the Plan is sufficient to secure recovery of the Licensee's financial position. Any amendments required to the Plan to ensure it remains appropriate should be raised and agreed with NHS Improvement in a timely manner.

Capacity and capability

2.10 The Licensee will implement sufficient programme management and governance arrangements to enable delivery of the plans and to meet all other commitments in these undertakings. Such programme management and governance arrangements will enable the Board to:

2.10.1 obtain a clear oversight over the progress in delivery of the plans and in meeting all other commitments in these undertakings;
2.10.2 obtain an understanding of any risks to the successful achievement of the plans and to meeting all other commitments in these undertakings and ensure appropriate mitigation of any such risks; and
2.10.3 Hold individuals to account for the delivery of the relevant plans and for meeting all other commitments in these undertakings.

2.11 The Licensee will conduct a capacity and capability review of its finance team, the scope of which is to be agreed with NHS Improvement, to a timescale to be agreed by NHS Improvement. This review should include assessing and strengthening financial planning processes, guidance and training for all relevant staff to support delivery of the two-year operational plan for 2017/18 and 2018/19. The Licensee will submit an action plan to NHS Improvement setting out how it will address the findings of this review to a timescale to be agreed with NHS Improvement.

2.12 The Licensee will conduct a skills assessment of its Board and provide a summary of the key issues and actions it will take in response to NHS Improvement. The scope and timescales for this review must be agreed with NHS Improvement.

2.13 The Licensee will commission an external board governance review in line with NHS Improvement's Well-Led Framework, taking into consideration Board capacity and capability. The scope, source and timescales for this review will be agreed with NHS Improvement. The Licensee will provide copies of the draft and final reports to NHS Improvement.

2.14 The Licensee will implement the actions and recommendations identified in the board governance review to a timescale to be agreed with NHS Improvement, including, if required by NHS Improvement, commissioning a follow-up review to test whether actions have been implemented.

Financial Improvement Director

2.15 The Licensee will co-operate and work with the Financial Improvement Director or any other person appointed by NHS Improvement to oversee and provide independent assurance to NHS Improvement on the Licensee's actions to deliver its financial recovery, including the FSMRP.

3. Reporting

3.1 The Licensee will develop and agree with NHSI a set of key performance indicators (KPIs) which allow the Licensee to track progress against the delivery of these undertakings and the impact of actions taken on outcomes.

3.2 The Licensee will meet with representatives of NHS Improvement, including the Financial Improvement Director, within 1 month of receiving the Financial Improvement Notice ('Progress Review Check'). The purpose of the Progress Review Check is to consider the Diagnostic and the FSMRP and to determine

Licensee's progress in meeting the undertakings set out above.

3.3 The Licensee will attend any other meetings or, if NHS Improvement stipulates, conference calls required by NHS Improvement to monitor progress. These meetings will, unless NHS Improvement stipulates otherwise, take place at times and places to be specified by NHS Improvement and with attendees specified by NHS Improvement.

3.4 The Licensee will comply with any additional meeting, reporting or information requests made by NHS Improvement.

4. Other matters

4.1 The Licensee will provide to NHS Improvement, the Financial Improvement Director, or any other person so appointed, direct access to its advisors, its board members, and any other members of its staff considered necessary by NHS Improvement and also full access to any meetings, resources and information, as needed in relation to the matters covered by these undertakings.

THE UNDERTAKINGS SET OUT ABOVE ARE WITHOUT PREJUDICE TO THE REQUIREMENT ON THE LICENSEE TO ENSURE THAT IT IS COMPLIANT WITH ALL THE CONDITIONS OF ITS LICENCE INCLUDINGTHOSE CONDITIONS RELATING TO:

- **COMPLIANCE WITH THE HEALTH CARE STANDARDS BINDING ON THE LICENSEE; AND**
- **COMPLIANCE WITH ALL REQUIREMENTS CONCERING QUALITY OF CARE.**

ANY FAILURE TO COMPLY WITH THE ABOVE UNDERTAKINGS WILL RENDER THE LICENSEE LIABLE TO FURTHER FORMAL ACTION BY MONITOR. THIS COULD INCLUDE THE IMPOSITION OF DISCRETIONARY REQUIREMENTS UNDER SECTION 105 OF THE ACT IN RESPECT OF THE BREACH IN RESPECT OF WHICH THE UNDERTAKINGS WERE GIVEN AND/OR REVOCATION OF THE LICENCE PURSUANT TO SECTION 89 OF THE ACT.

WHERE NHS IMPROVEMENT IS SATISFIED THAT THE LICENSEE HAS GIVEN INACCURATE, MISLEADING OR INCOMPLETE INFORMATION IN RELATION TO THE UNDERTAKINGS: (i) NHS IMPROVEMENT MAY TREAT THE LICENSEE AS HAVING FAILED TO COMPLY WITH THE UNDERTAKINGS; AND (ii) IF NHS IMPROVEMENT DECIDES SO TO TREAT THE LICENSEE, NHS IMPROVEMENT MUST BY NOTICE REVOKE ANY COMPLIANCE CERTIFICATE GIVEN TO THE LICENSEE IN RESPECT OF COMPLIANCE WITH THE RELEVANT UNDERTAKING.

LICENSEE

Signed

Dated

NHS Improvement

Signed

Dated

Stephen Hay
Executive Director of Regulation/Deputy CEO
NHS Improvement
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 02037470345

Peter Lachecki
Chair
Gloucestershire Hospitals NHS Foundation Trust

By Email

14 November 2018

Dear Peter,

Special measures for financial reasons – conditions satisfied

Following NHS Improvement's Provider Regulation Committee meeting on 8 November 2018, I am pleased to formally notify you of our decision that Gloucestershire Hospitals NHS Foundation Trust has satisfied the conditions and therefore has been removed from special measures for financial reasons. This is with effect from 8 November 2018.

The trust is now in segment 3 under the Single Oversight Framework (SOF).

My colleague, Tom Edgell, will shortly be in contact to discuss the next steps with you and to confirm the changes to the s.106 undertakings, however, NHS Improvement's interventions delivered under the special measures for financial reasons programme will stop. Recognising the trust still needs to deliver further financial improvement, this will be replaced by:

- NHS Improvement oversight to include support of financial performance against plan,
- Working with NHS Improvement to develop and agree a robust and stretching financial plan for 2019/20 and beyond;

I recognise the significant work the trust has undertaken to stabilise its financial position and to set itself up for the challenge of deficit reduction going forwards.

I would like to take this opportunity to congratulate you and your team for the progress you have made and continue to offer NHS Improvement's support as you move forwards.

Yours sincerely,

Stephen Hay
Executive Director of Regulation/Deputy CEO, NHS Improvement

Cc:

Deborah Lee, Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Sarah Stansfield, Director of Finance, Gloucestershire Hospitals NHS Foundation Trust
Jennifer Howells, Regional Director NHS England, South
Tom Edgell, Interim Delivery and Development Director South West, NHS Improvement

Mark Shires, Senior Advisor (Restructuring), Regulation and Financial Improvement Director for Gloucestershire Hospitals NHS Foundation Trust
Mark Turner, Director of Restructuring NHS Improvement

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

15 November 2018

By email only

Deborah Lee, Chief Executive
Peter Lachecki, Chair
Gloucestershire Hospitals NHS Foundation Trust

Dear Deborah and Peter

Congratulations on Gloucestershire Hospitals NHS Foundation Trust's exit from special measures for finance reasons last week. This is an outstanding achievement and we are glad to see the trust is benefiting from your leadership capability and experiences.

I understand that as a result of this significant improvement, particularly in financial leadership and management processes, the trust is on plan to deliver its financial target this year, including savings of £11.6 million.

Please pass on my thanks to the staff at Gloucestershire Hospitals NHS Foundation Trust for their efforts: you must all be very proud of what you have achieved.

Congratulations once again.

Yours sincerely

Ian Dalton CBE
Chief Executive, NHS Improvement

NHS Improvement
Skipton House
3rd Floor
80 London Road
London
SE1 6LH

E:enquiries@improvement.nhs.uk
W: improvement.nhs.uk

31 December 2018

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

Dear Deborah

NHS Improvement compliance certificate – financial special measures enforcement undertakings

Further to the letter from Stephen Hay on 14 November 2018, I am writing to confirm the outcome of NHS Improvement's Regional Provider Support Group – South (RPSG) on 19 December 2018 which considered the Trust's progress in addressing the December 2016 enforcement undertakings agreed with NHS Improvement in respect of financial special measures.

RPSG decided that the Trust had complied with the requirements of the financial special measures enforcement undertakings and that NHS Improvement should issue the Trust with a compliance certificate in respect of these undertakings (paragraphs 1.1-1.8 and 2.15, relating to Financial Special Measures).

In addition, RPSG concluded the Trust's undertakings in paragraphs 2.13 – 2.14, relating to commissioning an external 'Well Led' board governance review, need not be retained. These undertakings will therefore be discontinued. While no longer a requirement reflected in the Trust's undertakings, please note that NHS Improvement's national policy continues to stipulate that such a review should be completed by all trusts every 3 – 5 years, and the Trust should continue to plan for completion of such a review on this basis. Further information is available at https://improvement.nhs.uk/resources/well-led-framework/.

Undertakings relating to medium-term financial recovery will remain in place given the progress still required to improve the Trust's financial position. NHS Improvement will support the Trust to agree a realistic recovery plan for 2019/20. We will agree refreshed undertakings with you to support medium-term financial recovery as part of the 2019/20 planning process.

We would like to commend the Trust on the progress made and continue to offer NHS Improvement's support as you move forwards.

Next steps

I have enclosed the signed compliance certificate and a signed ‘discontinuation of undertakings’ document to this letter. I would be grateful if you could sign and return the latter to me. NHS Improvement will then publish both on its website.

Yours sincerely

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

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

COMPLIANCE CERTIFICATE

LICENSEE:

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

In this certificate, "NHS Improvement" means Monitor.

In accordance with paragraph 12(1) of Schedule 11 to the Health and Social Care Act 2012, NHS Improvement hereby certifies that it is satisfied that the Licensee has complied with paragraphs 1.1 – 1.8 and 2.15 of the Licensee's Enforcement Undertakings accepted by NHS Improvement on 6 December 2016.

Signed:

Jennifer Howells, Executive Regional Managing Director – South West, on behalf of Regional Provider Support Group (South), NHS Improvement

Date: 31 December 2018

DISCONTINUATION OF UNDERTAKINGS

LICENSEE:

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

BACKGROUND:

NHS Improvement accepted enforcement undertakings under section 106 of the Health and Social Care Act 2012 from the Licensee on 6 December 2016 ("the Undertakings").

A compliance certificate was issued on 19 December 2018 in respect of certain parts of the Undertakings. NHS Improvement and the Licensee agree that it is not appropriate to continue paragraphs 2.13 and 2.14 of the Undertakings due to the passage of time and changes in the Licensee's circumstances.

In this document, "NHS Improvement" means Monitor and any reference to the "Undertakings" means the Undertakings as may have been varied from time to time.

UNDERTAKINGS TO BE DISCONTINUED:

NHS Improvement and the Licensee agree to discontinue the undertakings relating to board governance in paragraphs 2.13 and 2.14 of the section titled "Undertakings" in the Undertakings.

Signed:

Position: [Chair or Chief Executive of Licensee]

Date:

Signed: 

Jennifer Howells, Executive Regional Managing Director – South West, on behalf of Regional Provider Support Group (South), NHS Improvement

Date: 31 December 2018

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST BOARD – JANUARY 2019
Redwood Education Centre, Gloucestershire Royal Hospital

Report Title
TrakCare Recovery Progress Report
Sponsor and Author(s)
Author: Leah Carey, Digital Transformation Lead, Trakcare Recovery Sponsor: Mark Hutchinson, Executive 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 and Return to RTT plan
Recommendations
The Board is asked to note this report for assurance.
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
See 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 previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees/TLT							

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JANUARY 2019

TRAKCARE RECOVERY PROGRESS REPORT

1. Purpose

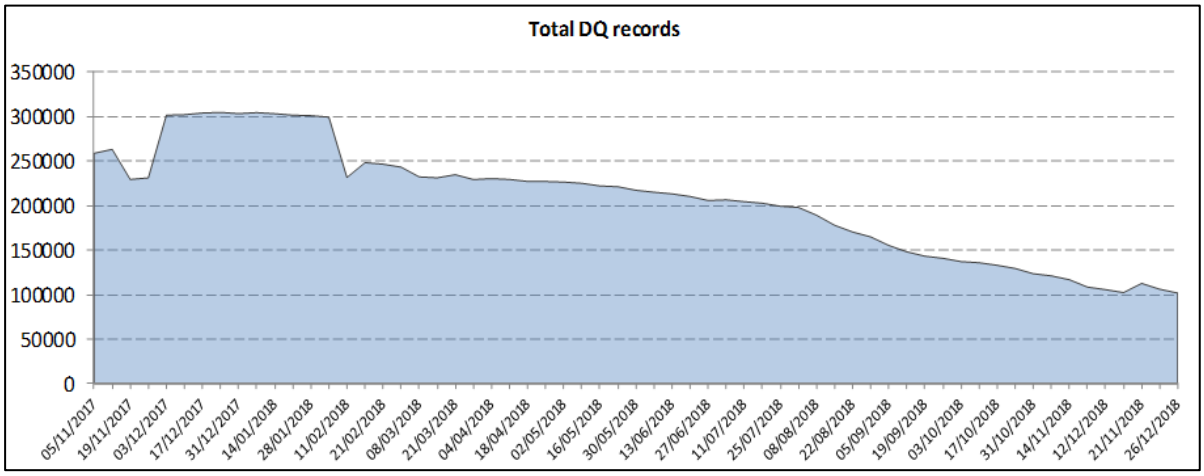
This report provides an update on the progress of the recovery programme following the implementation of TrakCare in December 2016.

2. Data Quality Issues

Data Quality continues to be monitored and reported to the track care recovery board via a series of dynamic dashboard views on a weekly basis. As of the 26/12 the overall no of DQ issues now sits at 101,699. A joint effort of validation between Populo (third party validators) and the patient access team has seen continued efforts in validating data quality issues. Populo have now completed the original assignment of work they were contracted to deliver as part of recovery. Given that the validation resource requirements that continue to be needed are less than we have substantiatively a small cohort of the Populo team will now stay on and work alongside the validation team as part of the ongoing business as usual validation team. Validation remains focused on those DQ errors that have a direct impact on RTT performance and monitoring given the focus on return to RTT reporting at the end of this financial year. A standalone business case has been approved in principle at SDG to support the need for a Data Quality team that will deliver a data quality approach that overarches all DQ issues (of which TrakCare related DQ is only a small part). A data quality team that brings GHFT in line with other trusts of a similar size will allow a proactive approach to improving data quality and not a reactive one as a result of identifying problems.

Pattern of Overall DQ Issues since 24/10

28/11/2018	05/12/2018	12/12/2018	19/12/2018	26/12/2018
108466	106063	105601	102315	101699



Validation Highlights

Vol Change in 1 Week		Data Quality Report:	Overall Issues In This Indicator
-4	1.	Elective Planned Waiting List Entry on an Open RTT Pathway	123
168	2.	Open Waiting List Entries with a Blank RTT Pathway ID	1634
-685	2c.	Open Waiting List Entries with a Blank RTT Pathway ID - From Outcomes (Closed pathways) *NB known system Issue, will remain until 2017 Upgrade*	1155
326	3.	Open Waiting List Entries on a Closed RTT Pathway	10251
-26	4.	Planned Elective OR Return Outpatient Waiting List Entries with No Recall Date	1777
56	5.	Open Waiting List Entries with past activity and No Future Activity Booked	6478
-8	6.	DNA Discharges	201
4	7.	Planned Elective Waiting List Entries with No Previous Elective Admission	4345
4	8.	Open Inpatient Waiting List Entries with cancellations that should be closed	163
-59	9.	Open Outpatient Waiting List Entries that should be closed due to a Cancellation Reason	974
10	10a.	Open Return Outpatient Waiting List Entries where the Last Activity is Inpatients - (Exact Match)	1190
-17	10b.	Open Return Outpatient Waiting List Entries where the Last Activity is Inpatients - (Potential Match)	2819
-419	11.	Open RTT Pathways where the last activity was cancelled or the patient was removed from waiting list	629
69	12.	Total Duplicate RTT Pathways	1429
140	13.	Total Duplicate Waiting List Entries	35251
49	13.1	Open new OPWL with any past Waiting List Entry Type against the same pathway with same or different Treatment Function	2857
-39	14.	Open Waiting List Entries which have multiple booked appointments or TCI's	408
0	15.	Deceased Patients with Open Waiting List Entries or on an Open RTT Pathway	14
135	16.	New Outpatient Waiting Lists with no clinician assigned	7418
6	17.	Waiting List Entries that have a vetting outcome of rejected	434
2	18.	Inpatient Waiting Lists with a blank waiting list admission type	12
26	19.	Outpatient Outcome of "Refer to different Department/Consultant- for same condition" but no new referral details added	1461
0	20.	Open Waiting Lists with a blank waiting list type	14
-324	21.	Open Waiting Lists where the activity has been booked on a previous episode	15360
38	22.	Open Waiting Lists with DQ issues that have ERS appointments	13643

NB Red denotes an increase of more than 50 issues a week.

3. Return to RTT reporting

3.1 RTT Script & Logic

The BI team in conjunction with operational colleagues continue to make progress with the review of the trust's RTT logic. It has been discovered that the historic RTT reporting was based on the use of "Primary Waiting List" field from Trak. Having explored this further and consulted with other trusts and colleagues this appears to be the incorrect logic and so further work is being carried out to review and refine a more appropriate logic. BI have now tested the proposed logic and this shows appropriate splits of admitted and non-admitted for incomplete pathways based on assumptions of a trust this size. Further work is now required to ensure this logic can be appropriately applied and embedded with a particular focus on the logic for identifying completed pathways

3.2 Data Quality Issues with a direct link to RTT

There are a number of DQ issues that have been identified that will directly impact an accurate reflection of the trust's RTT performance. Whilst progress is being made on these DQ issues, until they have been validated down to an acceptable, business as usual level they will continue to skew performance.

3.3 DQ02 Open Waiting List with a blank RTT pathway ID

Current Situation & Plan to Clear the DQ Backlog

Since Populo completed validation in this field this cohort has now risen back up to approximately 3000 records. A significant amount of work is ongoing to understand how these records are being created but the variation and complexity of how each new issue is created means that this work will continue for some time. There is concern and risk that currently as it stands there is not a sustainable approach to the ongoing validation of these records.

How many Issues get added weekly?

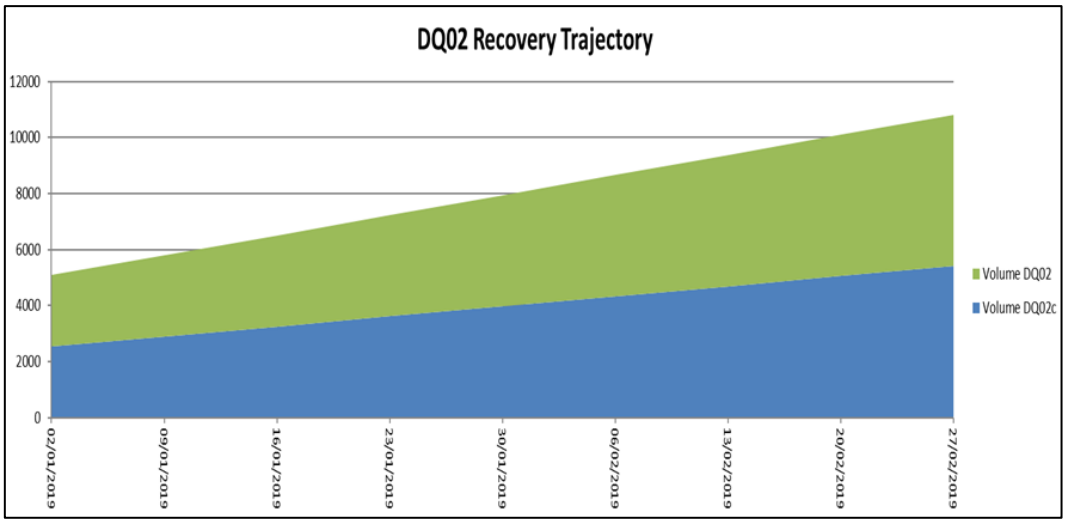
At the moment approximately 1500 issues are being created within this category on a weekly basis. Of this we have now established that approximately 1200 issues are due to a TrakCare System issue (DQ02c) that will be resolved in the 2018 upgrade- until this point this cohort will need continued validation. This validation is a straight forward and simple validation that the PAS team are undertaking alongside their day to day processes. It has to be noted that whilst the PAS team have been able to absorb this work as it has been prioritised it is likely that other business as usual work is being neglected because of their need to priorities.

On top of this system issue there are approximately 350 new issues a week that are still being created on a weekly basis. Over the last few months the team have worked on removing the ability to create a waiting list entry incorrectly. This involved extensive

system review to understand where these issues were being created, by whom and what the alternative and appropriate method should be. This then required extensive communication of what was changing and why. This has had a positive impact and has allowed the team to move onto other areas that will aid with the prevention of new data quality issues in DQ2.

Another more complex work stream is the allocation of the correct pathway template (RTT or non-RTT) following a non-elective episode of care. Currently when a patient is referred for follow up care from the emergency department DQ issues are being created. InterSystems have advised that these referrals must be done using a specific referral mechanism. Having explored this advice this method would have a significant impact on the operational processes that need to be completed in ED (at the moment the receiving specialty book the appointment Intersystems are insisting that ED should do it). The team are now working up alternative options to explore how we best progress with impacting ED operational time.

Trajectory Build Up between End of December and End of February



Please note this is based on December trajectories of validation. For DQ2c annual leave has resulted in a slower clearance of DQ2c- therefore a higher trajectory. It is anticipated that this will be caught up in January.

Where does validation sit post recovery?

1200 System DQ Issues- the PAS team have committed to continuing to validate this indicator (DQ02c) until the time that the 2018 upgrade has been delivered. Based on the speed of previous validation this is taking close to 2 x WTE to complete this work and therefore the impact on the team's day to day work must be acknowledged.

At present the remaining DQ2 issues need to be continually validated, reviewed and corrected by staff with an understanding of RTT and pathway management. Whilst some validation of this issue should not be unexpected in an organisation of this size there is still an expectation that with further progress efforts with recovery this will reduce. Based on current validation times 1 WTE individual can validate 35 records a day, this would mean that at present a further 2 WTE would be required to continually validate and maintain DQ2. It would be favourable for this resource to be embedded within the Validation team.

Management Plan

PAS team to manage DQ2c utilising 2 x B4 WTEs for DQ2c only- impact on BAU delivery until 2018 upgrade.

Ongoing requirement of 2 x WTE B4s additional to the current validation team's establishment for additional new issue

3.4 DQ03 Open Waiting List Entries on a Closed RTT Pathway

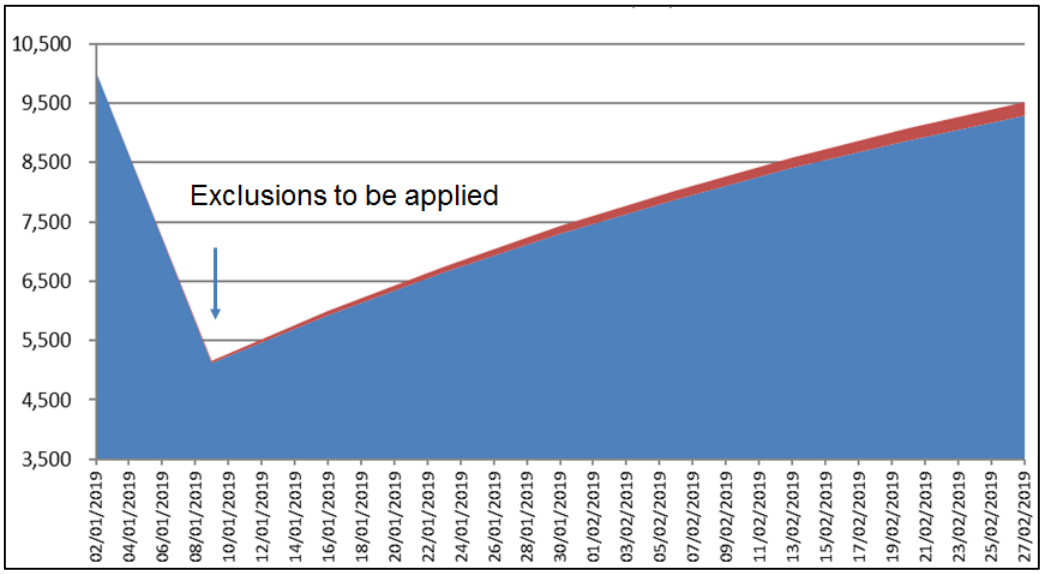
Current Situation & Plan to Clear the DQ Backlog

This is an issue has continued to reduce and now sits at 10,251 however following Populo's validation exercise a significant number of these records have been validated as appropriate. Therefore it is anticipated once all exclusions have been applied that this cohort will sit at approximately 5,500. Populo were unable to validate approximately 4000 issues due to the waiting list entry having a status of "appointment made." This means that this sub-set requires validation and review by operational teams/ services.

How many issues get added weekly?

Approximately 1400 records are being added to this DQ indicator a week; further investigation is being undertaken to establish which issues are being created and then removed straight away through a dummy referral process. This will enable the process to be streamlined and to exclude them from any future DQ reports. An example of work being carried out to reduce the occurrence of DQ3 issues is the sub specialty splitting of cardiac investigations from cardiology.

Trajectory Build Up between End of November and End of January



Where does validation sit with post recovery?

Validation of this indicator needs to be assessed but is likely to sit in an extended data validation role as the number of additions should remain within the business as usual functionality of an operational validation team. This is a cohort that will require validating permanently as there will always be occasions where this cohort is appropriate, but it should only be in certain scenarios. The BI team are reviewing the findings of Populo to review if any intelligence or logic can be applied to the cohort to prevent appropriate records filtering onto the report.

Management Plan

Ongoing additional validation resource requirement, 1 x WTE B4

3.5 DQ7 Planned Elective Waiting List Entries with No Previous Elective Admission

Current Situation & Plan to Clear the DQ Backlog

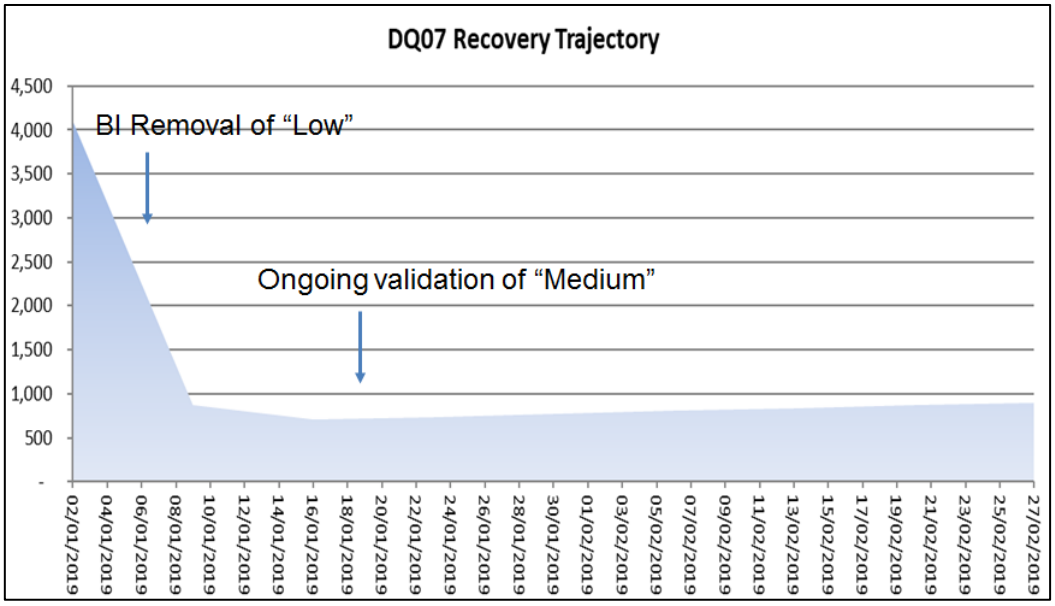
Following the application of agreed logic to identify which issues within this cohort were correct, this cohort now sits at 4,345. However work over the last month has identified a proportion of this data that can be excluded. These exclusions will be applied over the next month.

Issues that are categorised as medium will require ongoing validation by services.

How many Issues get added weekly?

Only 50 new issues get added to this indicator on a weekly basis following the implementation of the logic.

Trajectory Build Up between End of November and End of February



Where does validation sit post recovery?

Ongoing validation must sit within the specialties and should be built into weekly specialty validation using the DQ reports available.

Management Plan

Ongoing validation possible in current establishment/ validation process.

3.6 DQ12 Duplicate RTT Pathways

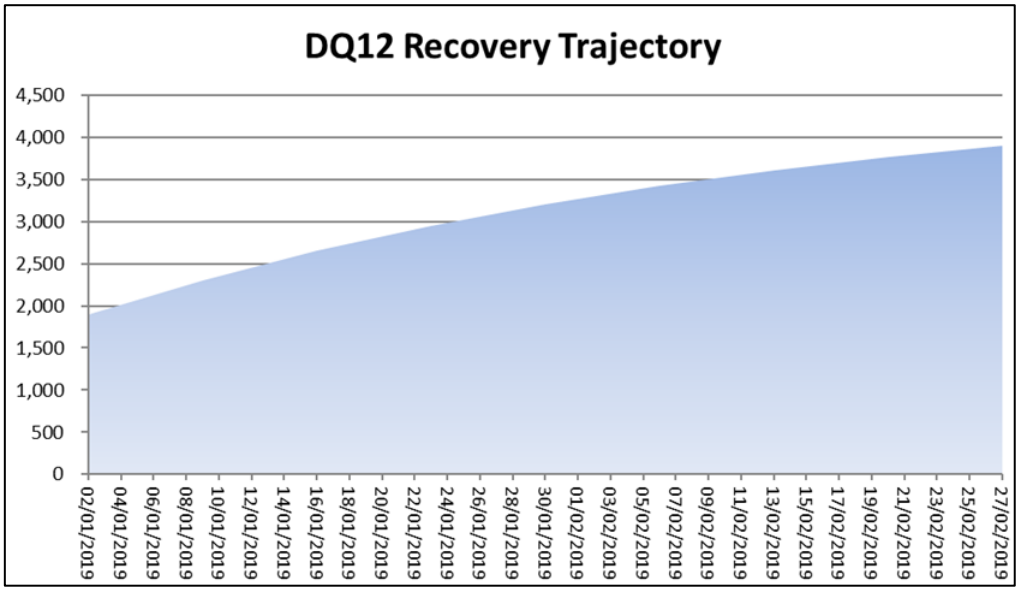
Current Situation & Plan to Clear the DQ Backlog

This DQ issue continues to be monitored and is now at 1360 following extensive validation by Populo. The validation team have a process in place to remove duplicates and have been doing this as a part of their routine validation processes.

How many Issues get added weekly?

DQ12 is being added to at a rate of about 600 per week. This is another indicator that will always require validating due to the number of occasions that a duplicate could be appropriate.

Trajectory Build Up between End of November and End of February



Where does validation sit post recovery?

Post recovery validation of DQ12 should sit with the validation team utilising a normal validation approaches using DQ reports for duplicates built by BI.

Management Plan

This level of validation is already happening within the validation team as part of BAU processes.

3.7 DQ11 Open RTT Pathways where the last activity was cancelled or the patient was removed from the waiting list

Current Situation & Plan to Clear the DQ Backlog

This DQ issue was initially out of scope of the Return to RTT plan due to low numbers. This has since been increasing and therefore the recovery team feel that it should be prioritised due to its impact on RTT performance reporting. It currently sits at 629.

How many Issues get added weekly?

Approximately 140 issues get added to DQ11 a week; however it is worth noting that the number of corrections/ validations that happen on a weekly basis are greater than the number of additions. Thus suggesting this DQ issue will reduce down and continue to be managed as part of BAU validation process. The board have however acknowledged that speeding the clearance of this DQ issue up would be beneficial to reporting attempts.

Where does validation sit post recovery?

Post recovery validation of DQ11 should sit with the validation team utilising a normal validation approaches using DQ reports for duplicates is built by BI.

Management Plan

This level of validation is already happening within the validation team as part of BAU processes.

3.8 VALIDATION TOOL

The validation tool has now been used throughout the first shadow attempt at reporting RTT in December.

Whilst the initial feedback on the report was very positive, using the tool as part of the end to end process has shown up some issues that BI are working hard to fix. Currently any validation activity occurring within the tool is not filtering back into the summary reports. This means that anytime a non-reportable pathway has been validated it is not yet being removed from the overall RTT position. Development is underway to ensure that the pathway ID consistently pulls through with the validation activity which will allow the pathway to be removed from the summary report. This does mean that the first cycle of testing has not given us an overall “reported position.”

This is being explored at detail so that it can be rectified for Shadow Attempt 2.

3.9 REPORTING PROCESS

The first shadow attempt at RTT reporting has taken place with the data snapshot being taken on 30.11.19. The team have worked closely together to go through the steps of the reporting process however the limitations in the validation tool as described above have severely hindered the first attempt at reporting.

While some of the problems experienced were anticipated some issues have arisen due to the unfamiliarity of the process. The below are the key lessons learnt from cycle 1:

- The snapshot will be taken on the evening of the last working day of the month. BI will email validation team leads by exception if there has been an issue with the snapshot.

- The snapshot and summary reports should be readily available on Insights so that all members of the validation team can access them.
- The validation tool must be reviewed in order to feed into the summary reports to update the trusts RTT position.
- The validation team would prefer the daily and monthly aspect of the validation tool to be the same.
- The validation tool is not accessible at set times due to back up/ download of data- these times need to be known by the validation team.
- We are yet to know how much validation the team will be able to complete from a capacity perspective and therefore cycle 2 must provide this intelligence.
- Weekly RTT team meetings should be maintained between BI and ops teams to review progress and address any concerns as they arise.

4. RETURN TO RTT PLAN

Task Name	Start	Finish	RAG	Owner
Interim Recruitment for Validation Tool Manager	**24/09/2018**	**05/10/2018**		**SH**
Completion of Validation Guide for DQ3	**24/09/2018**	**22/10/2018**		**AT**
ongoing DQ2 Validation to sit in Trak Support team	**24/09/2018**	**02/11/2018**		**TT/SH**
DQ7 Specialty Validation	**04/11/2018**	**28/11/2018**		**FTD**
DQ 2 Validation by Populo	**24/09/2018**	**24/12/2018**		**ZP**
RTT End to End Process Refine	**28/09/2018**	**11/10/2018**		**SH/RB**
Agree Return to RTT Plan at SmartCare Board	**01/10/2018**	**01/10/2018**		**LP**
Validation Tool Build	**08/10/2018**	**14/11/2018**		**JJ**
BI and Kayleigh to review and amend summary report	**10/10/2018**	**02/11/2018**		**JG/KW/JA**
Assessment of completeness	**15/10/2018**	**02/11/2018**		**CMcA**
Final Review of RTT Scripts	**05/11/2018**	**05/11/2018**		**LP/RB/SH**
TLT Update	**07/11/2018**	**07/11/2018**		**FTD**
SmartCare Board Update	**03/12/2018**	**03/12/2018**		**LP**
Shadow Report Process Attempt 1	**03/12/2018**	**19/12/2018**		**SH/RB**
Review SRPA 1	**19/12/2018**	**31/12/2018**		**SH/RB**
DQ3 Validation by Populo- 23,000	**24/12/2018**	**04/03/2019**		**ZP**
Shadow Report Attempt 2	02/01/2019	17/01/2019		SH/RB
SmartCare Board Update	14/01/2019	14/01/2019		LP
SRAP 2 Sign Off	18/01/2019	19/01/2019		SH/FTD/CL
Review SRPA 2	19/01/2019	31/01/2019		RTT Group
Shadow Report Attempt 3	01/02/2019	15/02/2019		SH/RB
SRAP 3 Sign Off	18/02/2019	19/02/2019		SH/FTD/CL
Review SRPA 3	19/02/2019	28/02/2019		RTT Subgroup
SmartCare Board Go/No Go	04/03/2019	04/03/2019		SmartCare Board

First Real Submission	01/03/2019	15/03/2019		SH/RB
Submission Sign Off	15/03/2019	19/03/2019		SH/FTD/CL/MH/DL
TrakCare Recovery Go/No Go	19/03/2019	19/03/2019		TBS
SmartCare Board Go/No Go- Virtual	19/03/2019	19/03/2019		TBC
Submit RTT Performance	19/03/2019	19/03/2019		SH

Shadow report attempt 2 is currently amber due to the work highlighted in cycle 1 that requires doing in order to deliver a complete and full cycle. The team are working hard to ensure that this is recoverable.

5. FUTURE FUNDING FOR TRAKCARE RECOVERY

In order to maintain recovery progress beyond returning to RTT reporting it is vital that alongside the uplift in validation resource there is an equivalent maintenance of increased resource within the reporting and technical aspects of recovery. It has previously been agreed that the £700,000 provided as a non-recurrent resource towards recovery should be made recurrent. This paper is now proposing that this is split equally between IM & T leads and operational leads to enable the progression of recovery. This is specifically to allow the reporting and analysis of problems in TrakCare and the continued optimisation of the system to bring it in line with a system that works optimally and requires less ongoing validation. Alongside this continued recovering of the system it is clear an uplift from the current validation resource is also required. By continuing to work alongside each other it is anticipated that in the future less back office validation will be needed due to a system that prevents the creation of DQ issues. It is however worth noting that outside of the TrakCare recovery programme the patient access and validation team at this trust is significantly smaller than its counterparts. This further supports the need for validation resource to bring the trust in line with its peers and a second additional uplift to aid with Trak Recovery.

With this £700,000 being made recurrent and the additional case for a data quality team (currently going through SDG) the trust will be a position to maintain reporting and begin to unpick the data quality issues that span the trust and affect our ability to deliver and report on the care we provide.

6. GOVERNANCE

The Trak Recovery board will continue on a weekly basis until the end of April 2019. At this point it will likely move to a monthly board that will ensure the senior attention required to continue progress occurs; returning to reporting is only one aspect of TrakCare Recovery.

7. RISKS

- Current Validation Team Capacity to achieve validation required and to maintain acceptable, clear levels of RTT validation. The validation team do not have the capacity to complete all validation for month end. Cycle 2 will look to report on how much validation the team can currently do as part of the end of month reporting.
- Resource/ establishment for 19/20 not yet allocated to ensure maintenance of progress and continued data quality and reporting accuracy. If all resource is embedded in operational teams there will be no ability to analyse the information and the system to identify variations of user behaviour in a continued effort to both configure the system optimally and teach people how to use it.
- Failure to source sufficient resource to manage the DQ issues above on a sustained basis may cause the trusts reporting ability to be questioned in the future.

8. REQUIREMENTS OF SMARTCARE BOARD

- Review of paper
- Support that weekly RTT submission should be avoided until a time that the monthly process has been embedded.
- Note the position on the first shadow cycle and changes that need to be made
- Acknowledge the requirement for current recovery resource (outside of the SQ proposal that is going to SDG) to be maintained and the suggestion that this is split between IM and T

Author:	Leah Carey, Digital Transformation Lead
Presenting/ Co Author:	Mark Hutchinson, Exec CDIO Felicity Taylor Drewe, Director of Planned Care, Sarah Hammond, Associate CIO: Information
Date:	30.12.19

REPORT TO TRUST BOARD – JANUARY 2019

From the People & Organisation Development Committee Chair – Alison Moon, Non-Executive Director

This report describes the business conducted at the People and Organisational Development Committee on 7 December 2018 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	Discussion on recruitment and workforce planning as part of overall operational planning	What support do divisions receive for workforce planning	Human Resources Business Partners (HRBPs) assist divisions to write workforce plans and a template has been devised with guidelines to assist with the latest national operational planning cycle.	
		How does the Trust ensure that there is progress on divisional staff survey actions?	Staff action plans are reviewed by HRBPs at Staff Experience and Improvement Group and executive reviews.	
		What explicit risk could Brexit bring?	Proactive risk assessments have taken place and number of EU staff 306 split across all staff groups so no major risk for any one staff group	
	More benchmarking data requested against high performing comparable Trusts			To receive updates through the regular reporting and keep under review

	Emerging risk of Disclosure and Barring Service (DBS) discussed		A Policy on DBS rechecking is in draft and will close the gap	
Board Assurance Framework (BAF)	Key actions were highlighted, including the soon to be developed staff and patient experience group	All the objectives are rated as amber, how will you prioritise? Some updates are identified in the controls and assurance columns, can this be reviewed? The action regarding exit interviews needs to include an overview of the improvement of data in terms of percentage completion and trends.	The work streams are running to different timescales and remedies so should be achievable, will keep under review.	Review of Red Amber Green (RAG) rating methodology to be able to demonstrate where an amber is due to time line slippage rather than overall programme issue or inability to deliver and the outcome measures An increase of % exit interviews expected for next reporting period in February.
Freedom to Speak Up – Internal Audit	Survey sent out as part of Freedom to Speak Up (F2SU) month (October). Noted not a method that Internal Audit typically use to analyse impact but useful given the time provided. Noted the low number of respondents. Although gives an insight to where we are now and themes to take forward.	Looking at those who responded are we missing an avenue into junior doctors and the speak up guardian role? When will the report be provided as an action plan with owners and due dates?	The actions will be discussed with F2SU Guardian and Leadership and OD and agreement made on actions and delivery.	F2SU Guardian to link in with Medical Guardian. Action plan will form part of a future Audit and Assurance update.

	There is a high level of awareness of how to speak up although some staff are not aware of the Guardian role or policy. Input into shaping the culture to improve focus on learning, improvement is an area for consideration for interventions involving manager.			
Equality Report	Review of progress made in the previous year and the requirement to publish annual data for 17/18 on our website.	Could we use reverse mentoring as a future strategy. Can future reports provide detail on the number of staff engaged in initiatives? Should we add Human Rights into the Equality and Diversity agenda and make overt links with training.	Noted and approved for external reporting. Committee was assured that the Diversity network planned to offer this specifically to the Non-Executive Directors and Executives who become champions for a protected characteristic. The national report and template allows for limited narrative and detail however a future internal version could add more detail. Equality Steering Group will consider.	

Update on Health and Safety Objectives Verbal update on Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Regular update on Health and Safety. Key risks involve patient falls and links to RIDDOR	Who do we benchmark against for patient falls?	There is a national database of incidents which includes all NHS areas. 2 yearly frailty and falls audit a more relevant benchmark	To consider how relevant benchmarking can be included into future reports
	Verbal update received following Health and Safety Executive (HSE) visit re :safer sharps and needlestick injuries.	Has the Trust received improvement notices before?	The Trust has received improvement notices previously and has always worked successfully to rectify issues. A working group currently meets to improve upon the issues noted during the visit.	Updates on the findings of HSE to be provided in February 2019.
	Health and Safety engagement event for staff noted and successful funding for human factors training			
		What are the processes for violence and aggression (V&A) training to protect staff? Do we correlate/ target training in areas of concern? What would staff say in terms of how supported they feel?	A range of training is available, risk assessments are in place which can be escalated Behavioural agreement plans for some patients. Head of Leadership and OD reviewed V&A and wrote a report which went to Trust Leadership Team and is now being progressed by a sub group chaired by the Nursing directorate. Sub group dedicated to this, formal escalation for all ward areas and formal debrief	Deep dive report requested on scale of the issues and staff support (both clinical and HR aspects)

			takes place after incidents. Shared learning at Schwartz rounds.	
		What is the update to the trust wide security review?		Refer to GMS Committee for review.
	Fire risks	Has the appropriate Committee seen the fire report and learning?	Assurance given that this went to the Audit and Assurance committee	#
	Medical gas exposure	Has the eLearning commenced and can compliance be added into dashboard?	Once e learning commences it can be added into dashboard.	
	Corridor blocking improvement project	Why must corridor blocking wait for an improvement project to 'clear' the potential hazards.	The intention is that an improvement project would lead to permanent changes in procedure and behaviour, although noted that immediate actions re clearing corridors was also needed.	
		Should Health and Safety minutes come to the People and OD Committee?		Agreed minutes would be shared for information alongside other groups under the People and OD Delivery group governance architecture.

Education, Learning and Development	Focus on last 6 months, including Chief Nurse Junior Fellows, student nurses, trainee nursing associates, apprenticeships	What data/stories can be provided to support line managers in considering apprenticeships to increase the uptake? What happens if we do not use all of the Levy? How do we manage Health Care Assistants wishing to become Nursing Associates? How do we measure the success of education? What is the detail behind the Integrated Care System education plan on a page?	Success stories have been discussed at 100 Leaders, and this could be explored further at Extended Leaders Network. It remains in our Trust pot for a period and is then absorbed by the government. There are plans to share levy pots between ICS partners where one has not spent all funds. Those on a waiting list are encouraged to self-develop as much as possible to place them in the best position to be a success in the programme. There are a number of methodologies which are employed by the Trust. The plan has an accompanying action plan.	Apprenticeship strategy to be developed as part of People and OD Strategy. Future reports will provide narrative on evaluation of success. The detail of the plan will be shared in the future ICS agenda item.

Health & Wellbeing Hub	Presentation on the proposed staff health and wellbeing hub, includes physical health and wellbeing, mental health and wellbeing, financial health and wellbeing.	Specific question in the specification regarding support for those with suicidal thoughts, what level of urgency is there to support appropriately? Potential links with Key Performance Indicators? Technology opportunities? Suggestion of considering the return on investment to then create the service?	Clinical interventions are written into the pathways and standard operating procedures. The hub concept will allow for the more proactive use of clinical/health psychology.	
Dashboard	Specific meeting focus on turnover and the staff group 'additional clinical services'	Is there triangulation with other data? Important to agree appropriate turnover targets. Are medical/dental sickness rates accurate as exceedingly low? Query over medical and dental trainees and statutory and mandatory training levels	Top geographical areas cross referenced with Steve Hams and Nursing Assessment and Accreditation System (NAAS) data, also covered in Exec Divisional Reviews. The new strategic objectives and People and OD objectives will consider the appropriate metrics for staff turnover.	. Currently a manual system so subject to human error and misrecording. A digital solution has not been proposed or considered as yet.

Staff Engagement verbal update	Noted that the staff survey closed on 30/11/18. Following Joint Quality and Performance and People and OD Committee the Staff experience group will combine with the patient experience group. A change management toolkit is being developed for small department/ service changes to assist with engagement. Engagement process for staff to help shape the strategic priorities are planned and have been approved by Directors Operational Group.	Query on current status of developing real time feedback for staff	A meeting has been held between Comms, People & OD and Information Management Technology to discuss the numerous options for engagement and tools/apps under consideration to arrive at a corporate solution. Paper is being written and will be considered by the Executive team.	Detailed report requested on all engagement activities and priorities for next committee meeting

Board note/matter for escalation

- GMS Board to review progress of Security Review
- Trust Board to note HSE visit and likely issue of an improvement notice(s)

Alison Moon
Chair of People and OD Committee, 7 December 2018

TRUST BOARD – JANUARY 2019
Redwood Education Centre, Gloucestershire Royal Hospital

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

Purpose

The purpose of this paper is to provide an overview to the Board of the key performance indicators which link to our strategic objectives:

- Staff in post;
- Vacancy levels;
- Turnover (retention and workforce stability);
- Sickness (health and wellbeing);
- Appraisal and Mandatory Training.

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

Key issues to note

- FTE continues to rise increasing across all staff groups with the exception if Additional Clinical Services (HCA's, MLA's etc.),
- Bands 8a, 8c, 5 and 3 have increased in numbers over the past 6 months,
- October showed a significant fall in the number of leavers compared to starters, when compared to previous months,
- Vacancy figures for October show an improvement to the vacancy position across the Trust, however high turnover within Additional Clinical Services contributes to an increased vacancy pressure in this area – despite our efforts to increase the recruitment of HCA's,
- The pipeline for HCA recruitment is shown within the presentation, showing a trajectory of gradual improvement – however continuing to highlight sustained pressure in this area.
- It should be noted that the increase volume of bank and substantive staff joining the Trust creates challenges throughout the onboarding pathway – specifically around clinical induction / manual handling training capacity. This can impact on our ability to remain compliant with the Core Skills Training Framework and Care Certificate. There are a number of practical solutions in place to support this; however this remains a key area of focus.
- The dashboard contains comparator information from NHS iView comparing our turnover data against core comparator Trusts. This shows the Trust as benchmarking favourably for Registered Nursing and Midwifery turnover and within the upper range for total turnover. When comparing Additional Clinical Services turnover we compare poorly to our comparator Trusts. There are known data quality issues with the NHS view comparison, however the data illustrated triangulated triangulates with the narrative reflected within our internal reports and the priority projects and actions we are delivering.

- Appraisal summary report: achieved 80% against a 90% target. Significant increases in Corporate and D&S. Surgery decreased by 1%.
- Mandatory Training : Achieved the target of 90%

Conclusion, Implications and Future Action Required

- The Staff Experience Improvement Group oversees the workstreams which directly impact on the concerns highlighted with recruitment and retention across Additional Clinical Services. This includes: Review of the Exit Interview Process, HCA turnover Action Plans and Staff Survey actions plans. In addition the Health & Wellbeing Project will produce a model of support for all staff; as part of the project we will be giving special consideration of the needs (and access needs) for this group.

Recommendations

The Board is asked to note the report for assurance.

Impact Upon Strategic Objectives

The dashboard provides information which impact upon:

- Have an Engagement Score in the Staff Survey of at Least 3.9
- Have a Staff Turnover Rate of Less Than 11%
- Have a Minimum of 65% of Staff Recommending GHT as a Place to Work through the Staff Survey
- 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

Impact Upon Corporate Risks

The dashboard assists to mitigate People and OD risks specifically:

- The risk of continues poor levels of staff engagement and poor staff experience impacting negatively on retention, recruitment and patient experience.
- The risk of being unable to match recruitment needs with suitably qualified clinical staff impacting on the delivery of the Trusts strategic objectives.

Regulatory and/or Legal Implications

There are no specific regulatory or legal implications arising from this report.

Equality & Patient Impact

Unavailability of staff could impact upon patient care where the staff to patient ratios are impacted as a consequence of sickness or vacancy factor.

Resource Implications

Finance	**x**	Information Management & Technology	
Human Resources	x	Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			7 December 2018				

Outcome of discussion when presented to previous Committees/TLT

The Committee reviewed all metrics and commented upon the turnover of the staff group 'additional clinical services' and whether the 11% turnover target was appropriate. Committee queried the accuracy of medical and dental trainee sickness rates given the manual reporting process and the change in statutory mandatory training figures for this group. Committee were assured of the triangulation of data that takes place within people and OD metrics and beyond such as with NAAS.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Workforce Information Dashboard

People and OD Committee, December 2018

Alison Koeltgen, Deputy Director of People & OD

Introduction and Overview

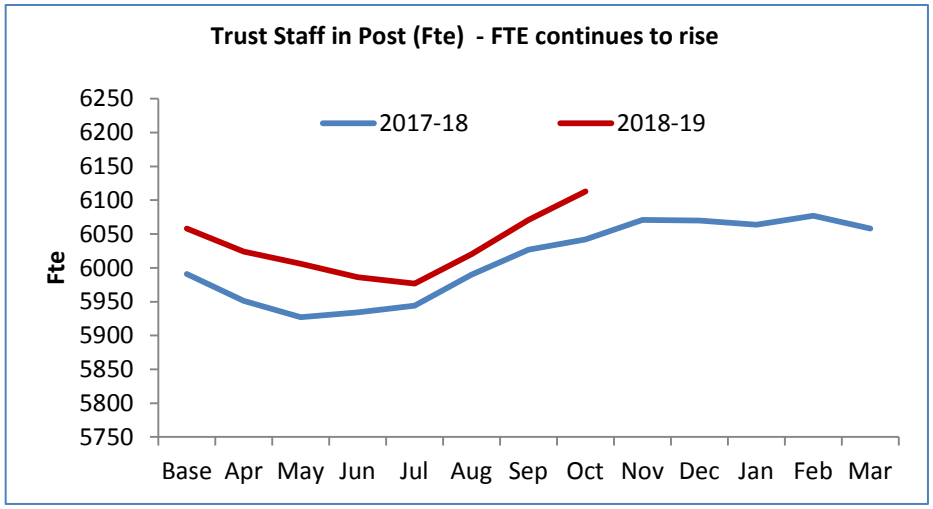
- The purpose of this presentation is to provide an overview to the People and OD Committee of the key performance indicators which link to our strategic priorities:

  - Staff in Post (achieving financial balance and workforce stability)
  - Vacancy levels
  - Turnover (retention and workforce stability)
  - Sickness (health and wellbeing)
  - Appraisal and Mandatory Training (deep dive)

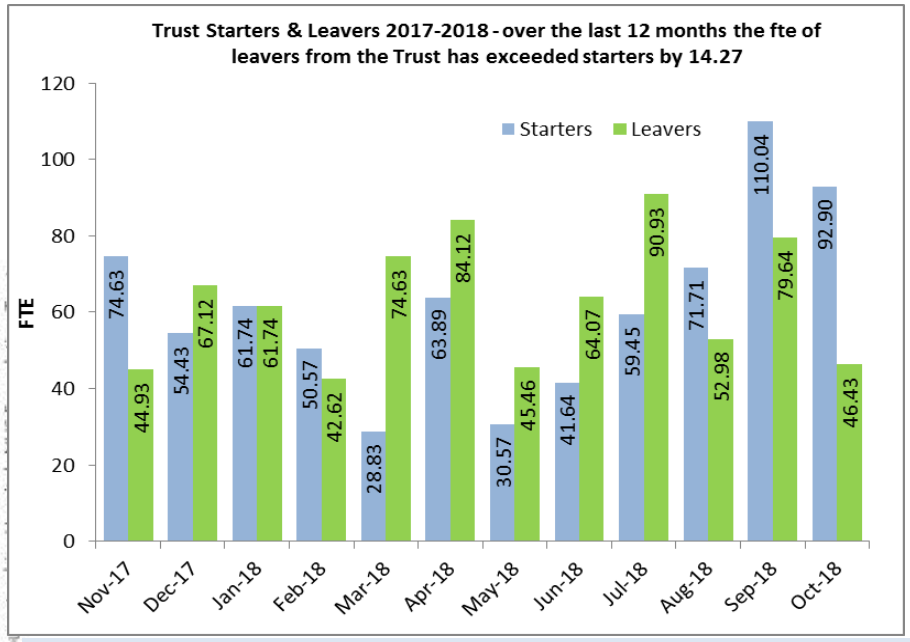
This report is designed to provide assurance that sufficient controls exist to monitor performance against key workforce priorities. Where improvements are required, these actions are fed into the appropriate workstreams, monitored by the People and OD Delivery Group.

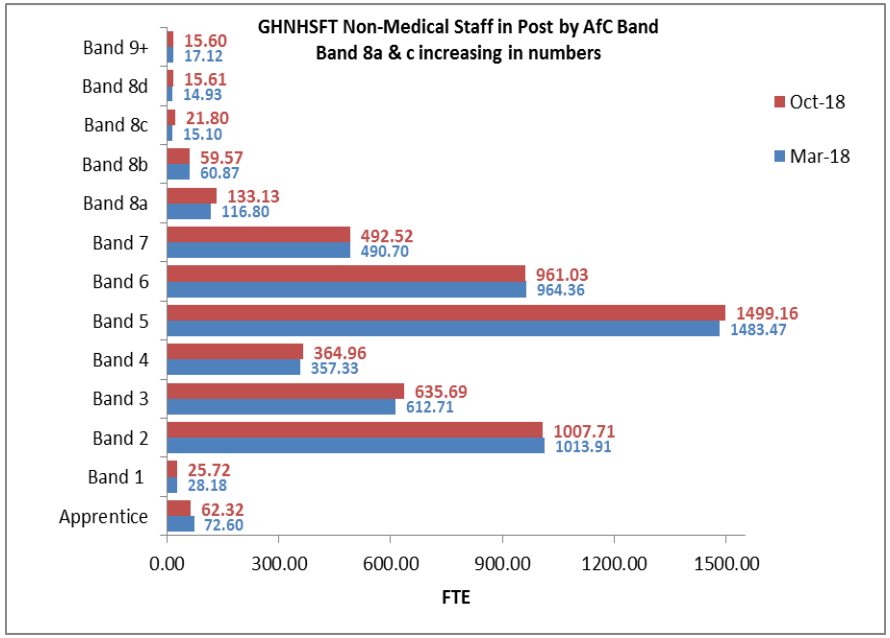
Performance summary:

	CLINICAL VACANCY RATE	SICKNESS	TURNOVER	APPRAISALS	MANDATORY TRAINING
Performance (in month)	7.94%	3.63%	n/a – rolling annual figure	80%	91%
Rolling Annual performance	n/a	3.89%	11.54%	n/a	n/a
Target	Not identified	3.50%	11%	90%	90%
Movement since last report	↓ -0.24	↑ -0.04	↓ -0.48%	↑1%	↑ 3%



FTE in Post	Mar-18	Oct-18	Increase/decrease
Add Prof Scientific and Technic	238.61	244.72	6.11
Additional Clinical Services	1093.07	1,084.83	-8.24
Administrative and Clerical	1329.02	1,335.72	6.70
Allied Health Professionals	341.75	362.87	21.12
Estates and Ancillary	29.49	29.65	0.16
Healthcare Scientists	209.59	213.72	4.13
Medical and Dental	819.94	835.85	15.91
Nursing and Midwifery Registered	1995.62	2,005.67	10.05
Total	**6057.09**	**6113.03**	55.94





Key Issues:

- FTE continues to rise increasing across all staff groups with the exception of Additional Clinical Services (HCA's, MLA's etc…)
- Bands 8a, 8c, 5 and 3 have increased in numbers over the past 6 months
- Figures are based on contracted staff, in post, and exclude hosted GPs and GMS.
- October showed a significant fall in the number of leavers compared to starters, when compared to previous months.

Vacancy levels

Gloucestershire Hospitals NHS
NHS Foundation Trust

Aug-18

Row Labels	Funded Establishment	Contracted	Difference	Vacancy Rate
Add Prof Sci Tech	337.08	317.07	20.01	5.94%
Additional Clinical Services	1271.16	1109.11	162.05	12.75%
Allied Health Professionals	364.14	367.77	-3.63	-1.00%
Healthcare Scientist	153.36	147.12	6.24	4.07%
Medical & Dental	844.91	800.83	44.08	5.22%
Nursing & Midwifery	2192.74	1999.03	193.71	8.83%
Grand Total	**5163.39**	**4740.93**	**422.46**	**8.18%**

Oct-18

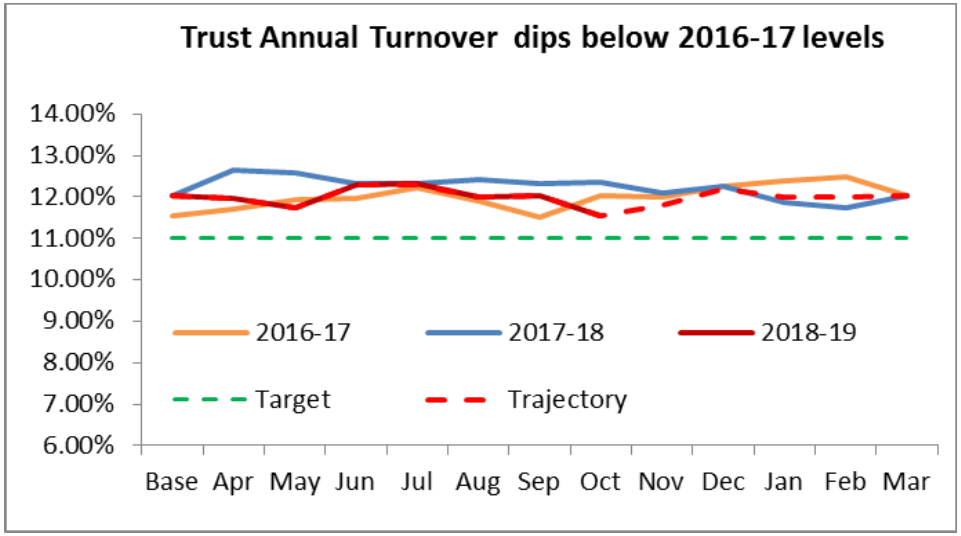
Staff Group	Funded Establishment	Contracted	Difference	Vacancy %
Add Prof Sci Tech	326.61	313.88	12.73	3.90%
Additional Clinical Services	1267.31	1083.06	184.25	14.54%
Allied Health Professionals	363.01	366.09	-3.08	-0.85%
Healthcare Scientist	152.61	145.56	7.05	4.62%
Medical & Dental	840.92	805.66	35.26	4.19%
Nursing & Midwifery	2179.13	2008.2	170.93	7.84%
Grand Total	**5129.59**	**4722.45**	**407.14**	**7.94%**

Highlights:

- Vacancy data was presented to the PODC for the first time in October 2018 (August Data), key factors to consider when interpreting this high level data:
  - Data is generated from the finance ledger, whilst we work towards establishment control via our employment record system (project underway)
  - Data is, at this point in time, presented at a high-level - therefore will not highlight departmental level variance associated with bandings and / or local capacity and demand issues. For example, AHP's appear to be working over establishment – however we are aware of the shortage in radiography.
  - The figures for October show an improvement to the vacancy position across the Trust, however ongoing turnover within Additional Clinical Services contribute to an increased vacancy pressure in this area – despite efforts to increase the recruitment of HCA's.
  - Additional information follows to demonstrate the plans in place to address areas with a vacancy factor of >10%.

Retention – Trustwide

Gloucestershire Hospitals NHS
NHS Foundation Trust



Current Performance			Movement since last Month		
12 months to 31st October 2018	Actual	KPI			Previous
	%TO	%TO			Month
Trust Total	11.54%	11.00%	↘	decrease	12.02%
Corporate	12.62%	11.00%	↘	decrease	13.11%
Diagnostics & Specialty	11.19%	11.00%	↘	decrease	11.78%
Medicine	13.67%	11.00%	↘	decrease	13.74%
Surgery	11.00%	11.00%	↘	decrease	11.33%
Womens & Children	8.46%	11.00%	↘	decrease	9.84%
Add Prof Scientific and Technic	9.88%	11.00%	↘	decrease	10.12%
Additional Clinical Services	15.95%	11.00%	↗	increase	15.85%
Administrative and Clerical	12.49%	11.00%	↘	decrease	13.24%
Allied Health Professionals	12.00%	11.00%	↘	decrease	12.56%
Estates and Ancillary	2.38%	11.00%	↘	decrease	2.45%
Healthcare Scientists	10.94%	11.00%	↘	decrease	12.33%
Medical and Dental	3.38%	11.00%	↘	decrease	3.87%
Nursing and Midwifery Registered	10.64%	11.00%	↘	decrease	11.17%
Staff Nurses	13.09%	11.00%	→	stable	13.07%

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

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

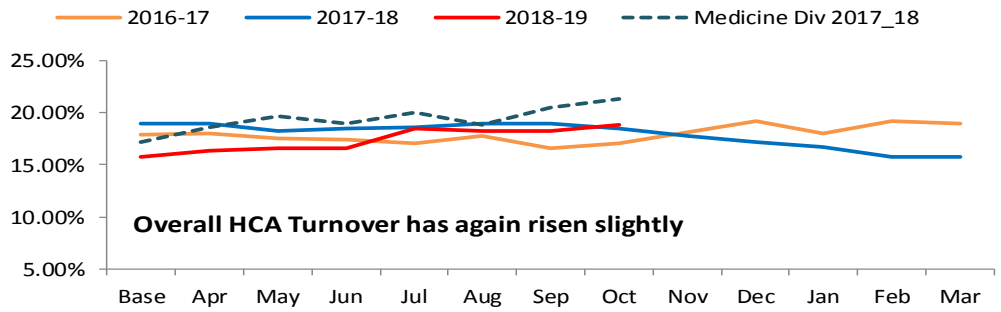
These are the areas (with 20 or more staff) with the highest turnover rates in the Trust

Nov 17 to Oct 18	% Turnover	FTE In Post Start	FTE In Post End	Leavers	Movement since previous month
Ward 2a T&O Trauma & Spinal Unit 70122	33.94	29.59	28.87	9.80	↘
Alstone Ward - Orthopaedic 35341	32.82	24.52	19.99	7.30	↗
Ward 7b CAPD Renal 74322	26.27	24.00	24.73	6.40	↗
Audiology - GRH 23522	25.53	24.02	26.44	6.44	↗
Ward 9b Acute GOAM 41522	25.36	28.20	30.69	7.47	↘
Oncology Admin 12841	25.04	37.30	41.52	9.87	↗
Medical and Surgical OPD 77522	25.04	28.59	27.65	7.04	↘
Woodmancote CGH GOAM 73441	24.17	33.75	32.44	8.00	↗
Ward 3b T&O Trauma 74422	24.04	33.45	30.21	7.65	↘
Ophthalmology OPD 44241	22.75	19.80	20.40	4.57	↗
Ward 6a Stroke 34822	22.22	27.96	27.85	6.20	↘
Avening Ward (Resp) 34141	21.51	29.47	27.69	6.15	↗
Ward 6b Stroke Unit 74122	21.12	27.11	29.71	6.00	↘

Key Issues:

- 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%.
- Turnover now reported as fte based - in line with QPR reporting
- Whilst turnover has reduced across the Trust, Additional Clinical Services turnover remains a significant concern and are the only professional group not to reduce turnover during October.

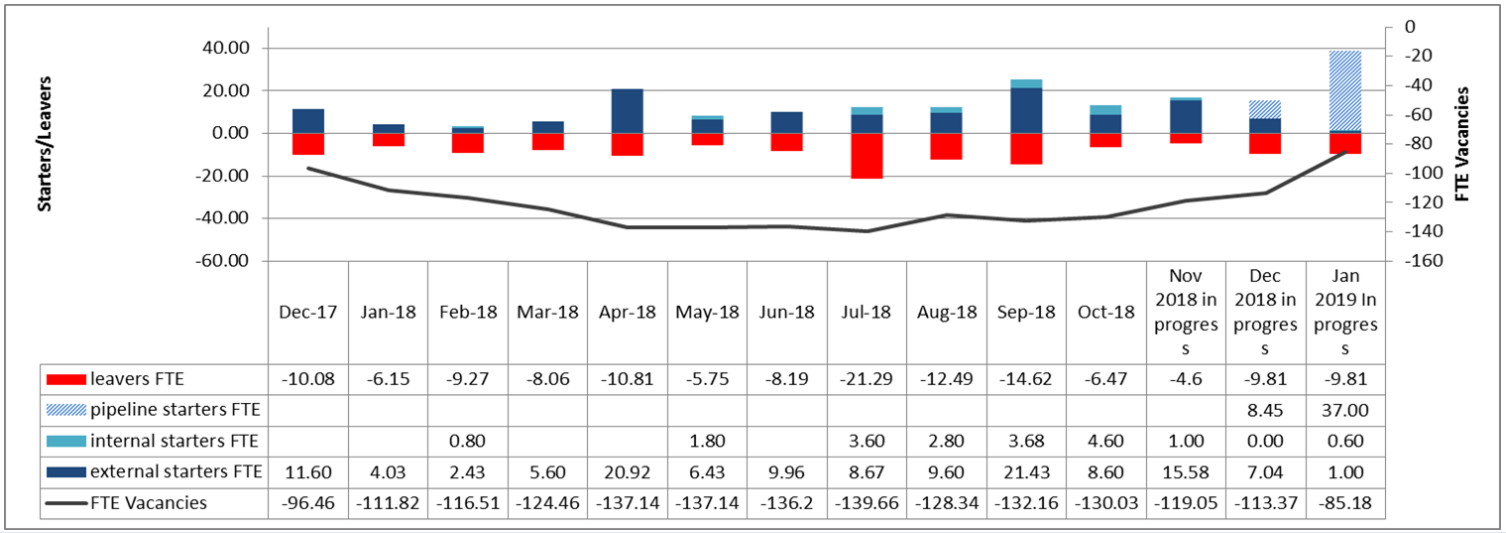
HCA Turnover



Nov 2017 to Oct 2018

HCA Turnover	Annual % T/O Rate
Trust HCA Total	18.86%
Diagnostics & Specialty Divis	22.64%
Medicine Division	21.35%
Surgery Division	18.20%
Womens & Children Division	8.90%

HCA Starter/ Leaver Trajectory *(excludes bank)*



	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov 2018 in progress	Dec 2018 in progress	Jan 2019 In progress
leavers FTE	-10.08	-6.15	-9.27	-8.06	-10.81	-5.75	-8.19	-21.29	-12.49	-14.62	-6.47	-4.6	-9.81	-9.81
pipeline starters FTE													8.45	37.00
internal starters FTE			0.80			1.80		3.60	2.80	3.68	4.60	1.00	0.00	0.60
external starters FTE	11.60	4.03	2.43	5.60	20.92	6.43	9.96	8.67	9.60	21.43	8.60	15.58	7.04	1.00
FTE Vacancies	-96.46	-111.82	-116.51	-124.46	-137.14	-137.14	-136.2	-139.66	-128.34	-132.16	-130.03	-119.05	-113.37	-85.18

- The trajectory graph for starters/ leavers shows **actual confirmed starts** as external FTE, this does not include internal moves and just indicates the pipeline we have coming through. Bank HCA's are excluded from this graph**,** however represent significant recruitment activity.

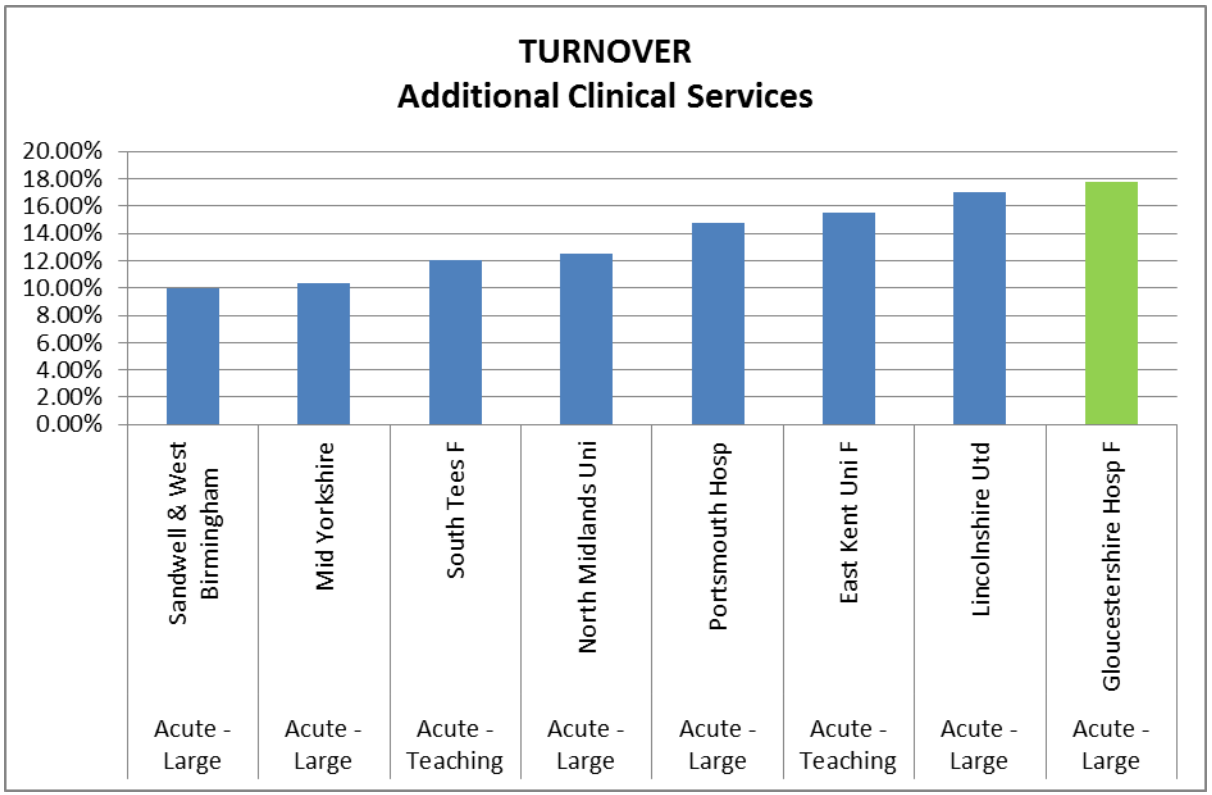
- We hosted a number of weekend HCA recruitment events over the past 2 months, as a result we are currently processing the following volumes:

6 Oct – Bank and substantive HCA event: 25 bank and 21.5 sub FTE still in progress, we expect these to be in place by 8 December 2018.
17 Nov – Bank HCA event: we have 45 HCAs we are processing, we expect these to be in place by 19 Jan 2019.
24 Nov – Substantive HCA event: 37 HCA offers made, expected to be in post by 26 Jan 2019 (Awaiting clear indicator of FTE as we process offers)
1 Dec - Substantive event, we expect approximately 20 offers to be made (to start by end of Jan)

- It should be noted that the increased volume of bank and substantive staff creates challenges throughout the onboarding pathway – specifically around clinical induction/ manual handling training capacity. This can impact on our ability to remain compliant with the Core Skills Training Framework and Care Certificate. There are a number of practical solutions in place to support this, however this remains a key area of focus.

Retention – Core Comparator Trusts (via. NHS ivew)

Gloucestershire Hospitals NHS
NHS Foundation Trust

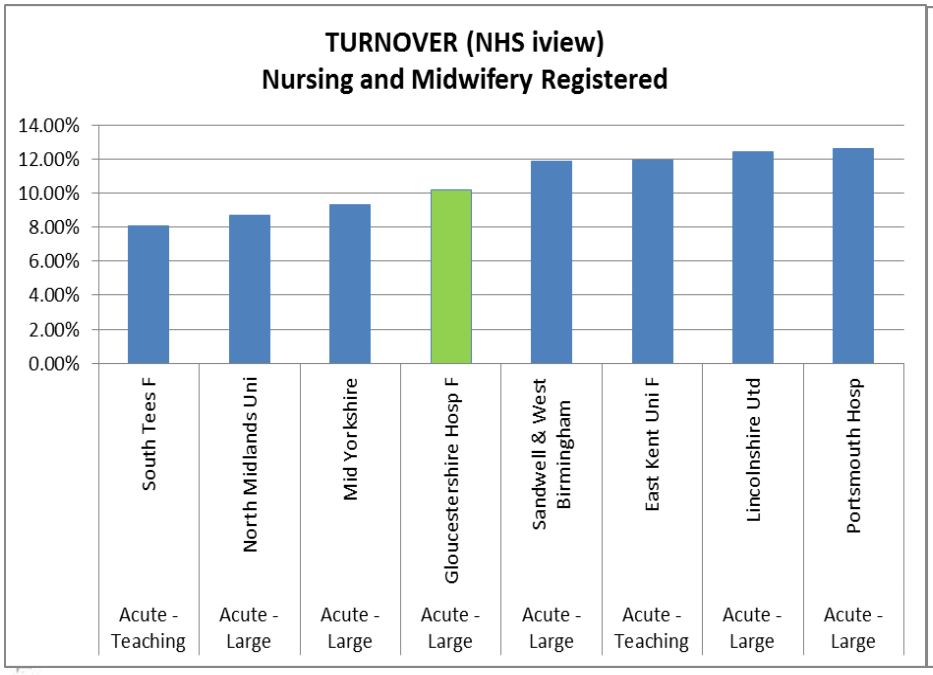


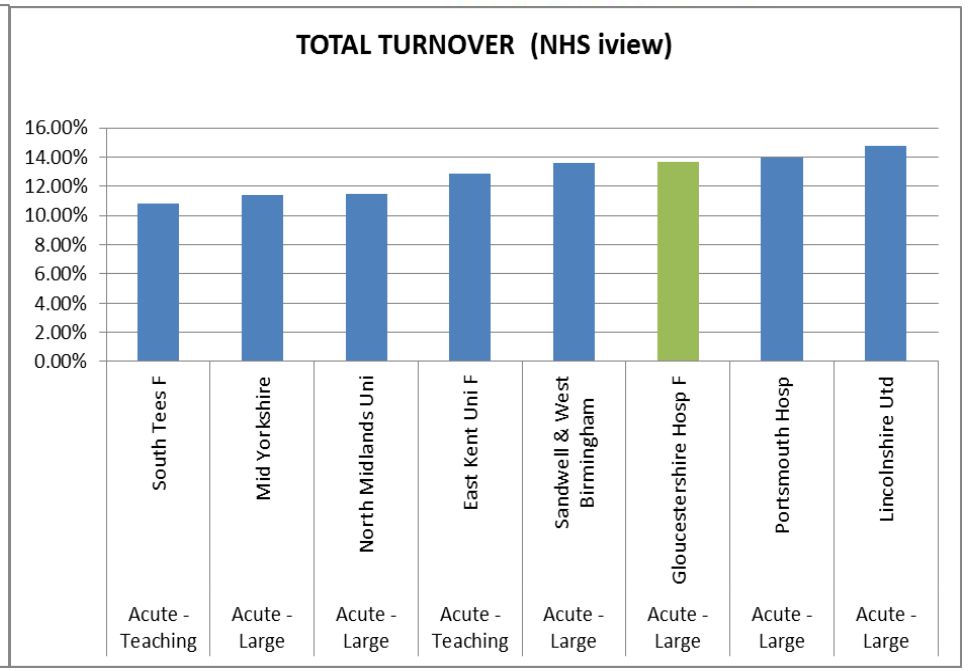
Key Issues for consideration (Data Quality):

- **NHS iview data** uses a different method to calculate turnover (based on leavers names), meaning the figures often vary from individual Trusts turnover data. Whilst the data can be used as a comparison tool, the actual figures quoted will not match our own turnover data.
- **'Additional Clinical Services'** is the broad category used within ESR, where we host HCA roles. Within GHT a significant proportion (>60%) are HCA's, however this category also includes other non-registered support roles such as MLA's, Pharmacy support staff, Phlebotomy staff ... The use of 'additional clinical services' across other Trusts varies and will not necessarily provide a like for like comparator.

Retention – Core Comparator Trusts (via. NHS ivew)

Gloucestershire Hospitals NHS
NHS Foundation Trust



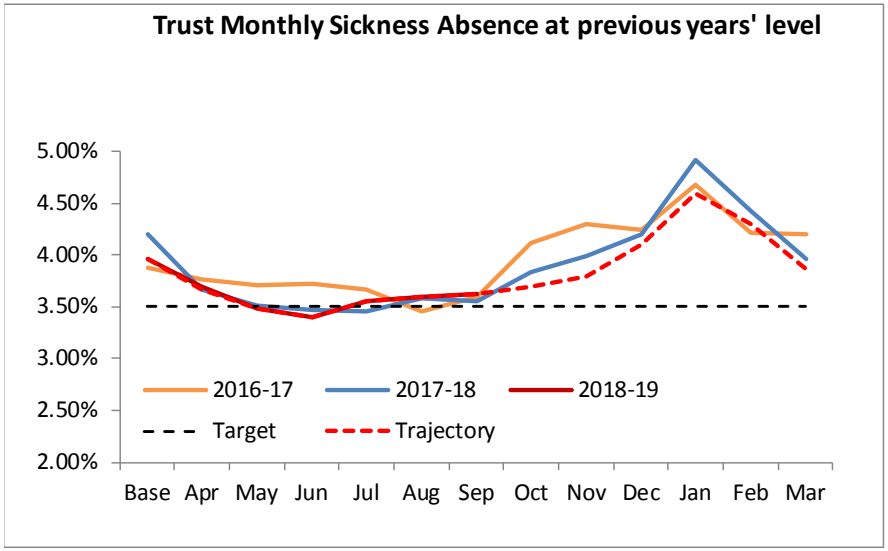


Highlights:

- **NHS iview** data uses a different method to calculate turnover (based on leavers names), meaning the figures often vary from individual Trusts turnover data. Whilst the data can be used as a comparison tool, the actual figures quoted will not match our own turnover data.
- The role descriptor issues highlighted with the Additional Clinical Services data , will not have the same impact on Nursing and Midwifery registered data, due to roles being more clearly defined – providing us with a more reliable comparison.
- **Nursing turnover** remains a key focus for our Trust as we strive to reduce our Nurse vacancies, however it should be noted that when benchmarked against core comparator Trusts we are well within normal turnover levels (within the lower range).
- **Total Turnover** comparison data benchmarks our turnover within the upper range of core comparator Trusts.

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 Sep 18 (Annual)	**Sickness**	**KPI**	Absence	Absence	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Aug to Sep
		% Abs	**% Abs**									
	Trust Total	3.89%	3.50%	2.74%	6.63%	3.69%	3.49%	3.40%	3.55%	3.59%	3.63%	increase
	Corporate	4.27%	3.50%	1.58%	5.85%	4.25%	4.43%	4.58%	3.70%	3.29%	3.64%	increase
	Diagnostics & Specialty	3.79%	3.50%	2.43%	6.22%	3.10%	3.04%	3.20%	3.09%	3.31%	3.32%	stable
	Medicine	3.68%	3.50%	3.35%	7.03%	3.50%	3.53%	2.96%	3.69%	3.00%	2.69%	decrease
	Surgery	3.98%	3.50%	2.82%	6.80%	3.94%	3.25%	3.22%	3.87%	4.37%	4.48%	increase
	Womens & Children	3.90%	3.50%	3.41%	7.31%	4.03%	4.02%	3.80%	3.31%	3.84%	4.08%	increase
	Add Prof Scientific and Technic	3.05%	3.50%	1.90%	4.95%	2.78%	2.86%	2.82%	2.91%	3.61%	4.28%	increase
	Additional Clinical Services	4.87%	3.50%	3.02%	7.89%	4.36%	4.36%	3.99%	4.35%	4.54%	4.99%	increase
	Administrative and Clerical	3.99%	3.50%	1.43%	5.42%	3.61%	3.77%	3.69%	3.54%	3.36%	3.37%	stable
	Allied Health Professionals	2.67%	3.50%	3.53%	6.20%	2.41%	2.55%	2.54%	2.20%	2.26%	1.85%	decrease
	Estates and Ancillary	6.15%	3.50%	0.00%	6.15%	4.38%	2.49%	6.69%	10.86%	9.12%	8.36%	decrease
	Healthcare Scientists	2.86%	3.50%	1.60%	4.46%	3.83%	2.48%	1.52%	2.13%	2.42%	2.41%	stable
	Medical and Dental	1.58%	3.50%	2.31%	3.89%	1.98%	1.36%	0.99%	1.49%	1.41%	1.73%	increase
	Nursing and Midwifery Registered	4.63%	3.50%	3.75%	8.38%	4.37%	4.06%	4.25%	4.31%	4.44%	4.17%	decrease



Areas (with 20 or more fte) with the highest rates of sickness in the Trust

	%SA	FTE	Heads	Movement since previous month	% of Sickness Absence that is Long Term
Ward 2a T&O Trauma & Spinal Unit	*11.27%*	*30.67*	*35*	↘	*68.6%*
Trauma Ortho Fracture Clinic	*8.69%*	*21.75*	*27*	↗	*64.7%*
GRH Head & Neck Theatre	*8.60%*	*32.80*	*39*	↗	*65.4%*
Ward Clerks - 7 Day Services	*8.54%*	*47.85*	*70*	↘	*64.7%*
Site Management	*8.35%*	*20.15*	*22*	↘	*45.2%*
Orthopaedic OPD	*7.85%*	*20.96*	*29*	↘	*65.2%*
Day Surgery Ward	*7.68%*	*30.11*	*37*	↗	*44.7%*
Womens Health Admin	*7.51%*	*16.63*	*26*	↗	*67.2%*
Ophthalmology OPD	*7.01%*	*20.40*	*24*	↗	*64.0%*
Booking Services	*6.73%*	*59.27*	*67*	↗	*42.1%*
Ward 9b Acute GOAM	*6.50%*	*30.69*	*33*	↘	*24.4%*
Phlebotomy Services Trustwide	*6.34%*	*34.26*	*53*	↘	*61.8%*

Highlights:

- Annual Sickness absence of 3.89% remains lower than the national average for Large Acute Trusts (4.33% July 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 (T&O/ Surgery alert in both sickness and turnover)

Appraisal Compliance

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

Appraisal Highlights:

October summary report: 80% against a 90% target. Significant increases in Corporate and D&S, but Surgery have decreased by 1%
To be picked up with Divisional Leads and revisited at Executive Reviews

Actions in the last month:

- Monthly reporting and email reminders sent
- Targeted the previous known appraiser for staff out of date and sent email requesting their attention/action.
- Investigated report s of “queries and inaccuracies” re ESR data – and continued to cleanse data where possible

Mandatory Training

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

Highlights:
Achieved the target of 90% - in time for the CQC Well-Led visit

Recent Changes/improvements :
Liaised with Non-Executive Directors and Lukasz Bohdan to revisit and update NED requirements for StatMan Training – as benchmarked with other Trusts. (8 programmes, 11 topics)
Reports are not regularly pulled for NEDs – suggest 2 per annum if required

Mandatory Training

Notes

Compliance Rate is number of subject completions meeting requirement divided by total number of completions required.
Staff 'On Leave' (maternity leave, career break etc) or 'Hire < 2 months' are excluded, and Locum Medical Staff (from 30 Sept 2018).

Breakdown	Date		
	31-Aug-18	30-Sep-18	31-Oct-18
GHT Total	**88%**	**90%**	**91%**
Breakdown by Subject			
CSTF Statutory and Mandatory Training			
Basic Adult Resuscitation	86%	86%	86%
Conflict Resolution	81%	83%	84%
Equality and Diversity Awareness	97%	98%	98%
Fire	90%	93%	93%
Infection Control	85%	87%	88%
Information Governance	85%	89%	88%
Manual Handling Practical	81%	81%	82%
Manual Handling Theory	86%	89%	89%
Prevent Basic Awareness	85%	89%	91%
Safeguarding Adults Awareness	85%	89%	91%
Safeguarding Adults Level 2	84%	86%	87%
Safeguarding Children Awareness	85%	89%	91%
Safeguarding Children Level 2	91%	92%	92%
Safety Awareness	92%	94%	94%
CSTF Statutory and Mandatory Training - All	**87%**	**89%**	**90%**
Other Essential Training			
Blood Transfusion	85%	88%	88%
Code of Confidentiality	86%	90%	91%
DOLS Awareness	89%	91%	91%
MCA Awareness	90%	91%	91%
Medicines Management	80%	82%	82%
Prescribing	69%	73%	66%
Other Essential Training - All	**86%**	**88%**	**89%**

1*
2*
3.

Overall, we did achieve our target of 90% and where the rating is amber, the majority are close to the target in the late 80+%

1* - CRT is currently being developed as an eLearning package for staff in low risk/low incident areas. Aim is to reduce number of face to face sessions and increase compliance

2* - Manual Handling practical remains a challenge due to numbers and capacity – including the high numbers of new recruits requiring clinical induction. Small work groups meet regularly to find solutions to meet the increasing demand, including "in-year priority" funds from the ELD central fund to support additional training resource for 6 months.

3* - Prescribing remains a challenge. This topic is targeted at doctors and the lower scores are primarily the deanery doctors in training.
Breakdown:
W&C - 73%
Medical – 58%
Surgical – 70%
D&S - 68%
Solutions to this are being worked on in the short-term and from April 2019 with the introduction and switch over to the national doctors eInduction, compliance data will transfer with the doctors as they rotate across Trusts.

Gloucestershire Hospitals NHS
NHS Foundation Trust

GHT Statutory and Mandatory Training Compliance Report 31 October 2018

Compliance rate highlight key: Less than 70% | 70%-89% | 90% and above

Breakdown	Date		
	31-Aug-18	30-Sep-18	31-Oct-18
Breakdown by Staff Group			
Add Prof Scientific and Technical	91%	93%	94%
Additional Clinical Services	88%	89%	89%
Administrative and Clerical	90%	93%	94%
Allied Health Professionals	95%	96%	96%
Estates and Ancillary 2*	85%	85%	85%
Healthcare Scientists	93%	92%	93%
Medical Staff - Consultants	88%	91%	93%
Medical Staff - SAS Senior	85%	89%	90%
Medical Staff - Training Grades 3.	61%	78%	78%
Nursing and Midwifery Registered	90%	90%	91%

Notes

1. Compliance Rate is number of subject completions meeting requirement divided by total number of completions required.
2. Staff 'On Leave' (maternity leave, career break etc) or 'Hire < 2 months' are excluded

1. Overall, from October, the compliance rates have reached the 90% target in all but two staff groups.
2. The Estates and Ancillary rate of 85% relates to one individual rather than the GMS services- employed in Corporate services.
3. Whilst there has been a significant increase in the compliance rates for Medical Training Grades (deanery doctors – 61% to 78% in September), much of this was as a result of manually aligning the deanery records with the ESR system. More work is needed here and will take the form of a process-mapping induction workshop with all stakeholders in the New Year to ensure no unnecessary duplication of training or data-input takes place, and ensure both GHFT induction requirements and national streamlining are aligned.

The national eInduction for doctors streamlining project is due to be ready for use in the New Year 2019 and the system updates and conversion work to ensure the data is pulled through on ESR safely will take place between January and March. Once completed, the majority of StatMan training for this staff group will be covered via the national programme with minimal topics covered locally.

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST BOARD – JANUARY 2019
Lecture Hall, Redwood Education Centre commencing at 12:30

Report Title
Equality Report 2017/18
Sponsor and Author(s)
Author: Abigail Hopewell, Head of Leadership & OD Sponsor: Emma Wood, Director of People & OD/Deputy Chief Executive
Executive Summary

Purpose

There is a requirement for NHS Trusts to annually publish an Equality Report reflecting on the previous financial years' activity. This is a requirement of the Public Sector Equality Duty. This must be available to download from the Trust website.

The report details core equality diversity and inclusion (EDI) activity undertaken in 2017/18 and is attached in full.

This report provides assurance that the People and OD committee approved the report at its December committee and it has been published accordingly

https://www.gloshospitals.nhs.uk/about-us/our-trust/equality-diversity/

Key issues to note

- Two equality objectives were identified in the Equality Report of 2015/16, and these have informed our activity alongside an evolving programme of work and priorities associated with EDI;
- The appendices list only data – there is no narrative or analysis undertaken as this is not required for publication however the analysis of the detail is undertaken and informs future objectives.

Conclusions

The report highlights some of the key achievements in 2017/18, and outlines the work we have been or will be doing in 2018/19 through to 2019/20.

Implications and Future Action Required

No further action required to meet the requirements of the Public Sector Equality Duty.
Future objectives are monitored and reviewed by the Equality Steering Group and reported to the People and OD committee at regular intervals.

Recommendations
The Board is asked to note the publication of the equality Report 2017/18.

Impact Upon Strategic Objectives
The Trust's activity around equality, diversity and inclusion will enable the Trust to achieve the following strategic objectives: • By April 2019 we will have an Engagement Score in the Staff Survey of at least 3.9 • By April 2019 we will have a minimum of 65% of our staff recommending us as a place to work through the staff survey • By April 2019 we will have a staff turnover rate of less than 11% • By April 2019 we will be rates as Outstanding in the domain of Caring by the CQC • By April 2019 we will meet all national access standards
Impact Upon Corporate Risks
Delivery of equality objectives should help to mitigate risk in relation to staff turnover and morale; sickness absence; discrimination and litigation from staff and patients related to legally protected characteristics; patient satisfaction; annual staff survey results.
Regulatory and/or Legal Implications
The Public Sector Equality Duty is fulfilled in the NHS by the Equality Delivery System which requires us to identify new equality objectives every 4 years. These must be formulated through engagement with stakeholders. Commissioners monitor the Trust's delivery of Equality Diversity and Inclusion plans and this forms part of our contractual agreements.
Equality & Patient Impact
Work to improve diversity and inclusion will have a positive impact on the broader patient experience, and improve relationships between staff and with our service users.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

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

Date the paper was previously presented to Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			7 December 2018				
Outcome of discussion when presented to previous Committees/TLT							
Report was approved for publication							

Gloucestershire Hospitals NHS Foundation Trust

Annual Equality Report

2017/18

Contents

1. Introduction

The principles of equality, diversity and inclusion are fundamental to the successful delivery of patient care and underpin our vision of “best care for everyone”. Of course, along with patients and families ‘everyone’ includes the staff and volunteers who deliver a wide range of services – equality, diversity and inclusion are key enablers for an engaged, productive and safe workforce.

In 2017/18 the Equality, Diversity and Inclusion (EDI) Steering Group has continued to promote and embed these principles into all policy decisions and service delivery within our Trust. Details of some of our achievements and progress can be found in section 4.

We are committed to demonstrating compliance with, and ultimately becoming an exemplar regarding, the Public Sector Equality Duty (PSED) and the Equality Delivery System (EDS2). As our work continues to evolve and the profile of EDI activity increases, we look ahead to 2018/19 when new 4-year Equality Objectives will be formulated.

2. Public Sector Equality Duty: overview

Section 149 (1) of the Equality Act 2010 stipulates various requirements on NHS organisations when exercising their functions. The **general equality duty** requires NHS organisations to have due regard to:

1. **Eliminate discrimination, harassment and victimisation** and other conduct prohibited under the Act
2. **Advance equality of opportunity** between persons who share a relevant protected characteristic and persons who do not share it
3. **Foster good relations** between persons who share a relevant protected characteristic and persons who do not share it.

Public bodies must consider how different people will be affected by their activities, thereby helping them to deliver policies and services which are efficient and effective; accessible to all; and which meet different people's needs.

The **Public Sector Equality Duty (PSED)** requires public bodies to:

- publish information annually to show their compliance with the Equality Duty
- set and publish equality objectives, at least every four years

Public bodies must also publish information to show that they have consciously thought about the three aims of the Equality Duty as part of the process of decision-making.

All information must be published in a way which makes it easy for people to access it.

3. Equality Delivery System (EDS2): overview

The Equality Delivery System (EDS2) is a toolkit designed to help the NHS improve the services they provide for their local communities, consider health inequalities in their locality and provide better working environments for those who work in the NHS. This system has been adopted by our Trust and has helped us to:

- meet the public sector Equality Duty of the Equality Act 2010
- deliver on the NHS Outcomes Framework and the NHS Constitution
- and, as a provider, meet the Care Quality Commission's "Essential Standards of Quality and Safety"

Within EDS2 are four overarching goals:

- Goal 1 – Better health outcomes
- Goal 2 – Improved patient access and experience
- Goal 3 – A representative and supported workforce
- Goal 4 – Inclusive leadership

In 2015/16 our Trust identified two objectives we will focus on. These are detailed in section 4.

The Trust is scheduled to identify a new set of 4-year Equality Objectives towards the end of 2018/19 with a view that these will launch at the beginning of 2019/20.

4. Our Equality Objectives: progress to date, and future plans

In 2015/16 our Trust identified two equality objectives:

Equality Objective 1 – BAME Staff
Engaging with this group of staff will support further development that is being built upon through the Workforce Race Equality Standard. We will look to set up a BAME network within the Trust to provide a voice for this group of staff

Equality Objective 2 – Working with staff who have a disability
We will support staff into employment who have learning disabilities, where we have committed to support this through the national campaign

We acknowledge that our current equality objectives maintain a strong focus on the experience of staff as this has been identified as a priority area for our Trust. We will ensure that the needs of patients and their families from protected groups are also sufficiently considered by the EDI Steering Group on an on-going basis. We will seek to achieve a balance of staff/patient-related objectives as we engage with stakeholders to identify a new set of priorities towards the end of 2018/19 (launching these at the beginning of 2019/20).

Progress made in 2017/18

- We analysed the 2016 annual staff survey results against the **protected characteristics of race and disability** (as these are our priority areas of focus). We identified trends, formulated recommendations and devised an action plan.
- In May 2017 we ran a "listening campaign" with staff which coincided with the NHS Diversity, Inclusion and Human Rights Week. We invited all staff to participate, and had a particular focus on better understanding the experiences of staff with BAME and/or disability protected characteristics.
- Following feedback from the listening campaign, in November 2017 we launched a new staff **Diversity Network**. The aims of this are to work alongside our Trust to: eliminate discrimination experienced by staff with protected characteristics; provide a support and signposting function for staff where issues can be discussed in a safe environment; advise on training materials for managers and staff; celebrate the diversity of our Trust by promoting and participating in relevant local and national events. The Diversity Network is open to all staff and aspires to be truly inclusive.
- We have embedded equality, diversity and inclusion considerations into all leadership development learning opportunities offered by the Trust.
- We published the Workforce Race Equality Standard (WRES) in August 2017.
- We piloted a number of Unconscious Bias workshops with managers, with a view that these will launch formally in 2018/19.

Our plans for 2018/19

- We will publish our first Gender Pay Gap report.
- We will develop and publish an Equality of Opportunity Action Plan for the Trust, which incorporates recommendations from the WRES and Gender Pay Gap Report.
- We will analyse the 2017 annual staff survey results against all protected characteristic data, where available. We formulate recommendations and incorporate these into our EDI action plan where applicable.
- We will launch Unconscious Bias training and target this at all managers who lead the recruitment process.
- We will deliver Unconscious Bias training to our Trust Board, and ask Board members to be champions for each of the protected characteristics.
- We will review and strengthen our approach to responding to requests for reasonable

adjustments in the workplace.

- We will grow the membership, visibility and influence of the Diversity Network.
- We will increase our focus on mental health through a range of campaigns and events to raise awareness and support for staff.
- In line with EDS2, we will formally engage with staff, patients and families to discuss, identify and agree new equality objectives to launch in 2019/20 through to 2022/23.

5. Annual NHS Staff Survey 2017: Results, and 2018/19 priorities

The national NHS staff survey was open for staff to complete between October and December 2017. All staff members were invited to participate and we achieved a response rate of 47%.

The experiences of staff and the results of the survey are set in the context of ongoing challenges – both local and national.

Results were published nationally in March 2018. We engaged with a range of staff stakeholders via existing staff networks, forums and local team meetings to share the survey results and identify the priority areas we can focus on.

For 2018/19 we have produced a Staff Survey Action Plan, which lists actions to address key findings where there has been a statistically significant drop. The Action Plan is monitored through a newly-formed "Staff Experience Improvement Group" which meets regularly to identify and deliver activities that help improve the experience of colleagues working in our Trust. The actions focus on three staff survey themes and many of them directly or indirectly support the work we are doing around Equality, Diversity and Inclusion. These are in addition to the Trust's EDI Action Plan (see section 4):

Themes: My Job and My Manager

- Launch and embed talent development and a new approach to appraisals
- Launch a range of "Journey to Outstanding" initiatives for staff and patients
- Improve targeting of recruitment for Health Care Assistants and Nurses
- Develop and publish career pathways for a range of different staff groups
- Implement the Chief Nurse Fellowship programme
- Launch a range of new leadership development opportunities

Theme: My Health and Wellbeing

- Undertake a review of all staff health-wellbeing services, leading to the creation of a 'one-stop shop' service for staff and managers to access
- Work alongside partners in the One Gloucestershire Integrated Care System (ICS) education/ awareness campaigns aimed at staff on health-wellbeing priorities
- Following a review of HCA turnover, implement a range of recommendations to improve the experience and retention of this staff group
- Establish a Violence & Aggression Steering Group to review and implement recommendations from an investigation into V&A in our Trust (which used staff survey as a data source)

6. Conclusion

In this report we have given an update on our progress to deliver against the Public Sector Equality Duty and some of the activities that are contributing towards reducing or minimising disadvantages suffered by people due to their protected characteristics.

We have continued to make progress with our equality objectives and have a number of actions planned in 2018/19 to progress these for the benefits of staff and patients. Furthermore, we will expand and deepen our approach to equality, diversity and inclusion as we formulate a new set of equality objectives to launch in 2019/20.

Appendix A – Data on the population of Gloucestershire against protected characteristics

Reviewing protected characteristic data about the Gloucestershire population helps us to make informed decisions based on the needs of our communities and patients/service users. This will ensure that we deliver a local Health Service that meets these requirements and ensures we adapt to any changes.

Data downloaded from Gloucestershire County Council Population Profile 2018
Source: https://www.gloucestershire.gov.uk/media/1521014/equality-profile-2018.pdf

Age

Table 1: Gloucestershire population by broad age group, 2016[2]

	Number of people	% of population		
		0-19	20-64	65+
Cheltenham	117,530	22.6	58.9	18.5
Cotswold	85,756	20.6	54.4	25.1
Forest of Dean	85,385	21.5	54.8	23.7
Gloucester	128,488	25.0	58.8	16.2
Stroud	117,381	22.4	55.7	22.0
Tewkesbury	88,589	22.3	55.7	22.0
Gloucestershire	**623,129**	**22.6**	**56.6**	**20.8**
England	55,268,067	23.7	58.4	17.9

Disability

Table 5: Percentage of people with a long-term limiting health problem or disability, by broad age group, Gloucestershire, 2011[8]

	% of age group				
	All ages	0-15	16-49	50-64	65+
Cheltenham	15.1	2.7	7.0	18.1	48.8
Cotswold	16.1	2.7	6.7	14.8	43.9
Forest of Dean	19.6	3.6	9.2	20.3	52.2
Gloucester	16.8	3.5	8.5	22.6	54.4
Stroud	16.7	3.3	7.9	16.8	47.6
Tewkesbury	16.5	2.9	7.1	16.9	47.6
Gloucestershire	**16.7**	**3.1**	**7.8**	**18.3**	**49.0**
England	17.6	3.7	8.7	23.8	53.6

Gender

Table 10: Population by gender, Gloucestershire 2016[24]

	% of population	
	male	female
Cheltenham	48.8	51.2
Cotswold	48.4	51.6
Forest of Dean	49.2	50.8
Gloucester	49.3	50.7
Stroud	49.1	50.9
Tewkesbury	48.9	51.1
Gloucestershire	**49.0**	**51.0**
England	49.4	50.6

Gender reassignment

Table 13: Estimates of gender reassignment, 2016[38]

	Lower Estimate		Upper Estimate	
	Number of people	% of 16+ population	Number of people	% of 16+ population
Cheltenham	580	0.6	970	1.0
Cotswold	430	0.6	720	1.0
Forest of Dean	430	0.6	710	1.0
Gloucester	620	0.6	1,030	1.0
Stroud	580	0.6	960	1.0
Tewkesbury	440	0.6	730	1.0
Gloucestershire	**3,070**	**0.6**	**5,120**	**1.0**
England	268,430	0.6	447,390	1.0

Note: Figures may not sum due to rounding

Marriage and Civil Partnership

Table 14: Marital status of Gloucestershire residents, 2011[43]

	% of population					
	Single (never married or never registered a same-sex civil partnership)	Married	In a registered same-sex civil partnership	Separated (but still legally married or still legally in a same-sex civil partnership)	Divorced or formerly in a same-sex civil partnership which is now legally dissolved	Widowed or surviving partner from a same-sex civil partnership
Cheltenham	38.8	42.6	0.2	2.4	9.2	6.7
Cotswold	25.7	54.9	0.3	2.2	9.0	8.0
Forest of Dean	27.4	53.2	0.2	2.1	9.2	7.9
Gloucester	34.1	46.6	0.3	2.7	10.0	6.4
Stroud	27.5	53.0	0.3	2.3	9.6	7.3
Tewkesbury	26.1	54.3	0.3	2.3	9.7	7.4
Gloucestershire	30.5	50.2	0.3	2.3	9.5	7.2
England	34.6	46.6	0.2	2.7	9.0	6.9

Pregnancy and Maternity

Table 16: Live births by age of mother, Gloucestershire, 2016[45]

	Total number of live births	% of total births by age of mother						
		under 20	20-24	25-29	30-34	35-39	40-44	45+
Cheltenham	1,328	2.0	10.6	24.4	36.3	21.5	5.1	0.2
Cotswold	730	1.5	10.5	25.2	34.2	22.6	5.3	0.5
Forest of Dean	844	3.6	15.8	32.5	29.5	15.2	3.3	0.2
Gloucester	1,768	4.0	16.2	31.6	31.6	13.7	2.7	0.3
Stroud	1,094	1.9	10.3	28.6	34.3	19.7	4.8	0.3
Tewkesbury	975	1.9	11.7	31.4	33.8	17.5	3.5	0.1
Gloucestershire	**6,739**	2.6	12.8	29.1	33.3	17.9	4.0	0.3
England	663,157	3.2	14.6	28.0	31.8	18.1	4.0	0.3

Ethnicity

Table 17: Population by ethnic group, Gloucestershire 2011 (number of people)[47]

	Total Black and Ethnic Minority	Mixed/ Multiple Ethnic Group	Asian/ Asian British	Black/ African/ Caribbean / Black British	Other Ethnic Group	Total White	English/ Welsh/ Scottish/ Northern Irish/ British	Irish	Gypsy or Irish Traveller	Other White
Cheltenham	6,648	1,878	3,675	721	374	109,084	102,140	1,058	68	5,818
Cotswold	1,806	698	794	229	85	81,075	78,284	503	87	2,201
Forest of Dean	1,262	528	473	199	62	80,699	79,227	277	78	1,117
Gloucester	13,226	3,565	5,839	3,486	336	108,462	102,912	850	136	4,564
Stroud	2,353	1,216	751	260	126	110,426	107,026	591	57	2,752
Tewkesbury	2,042	776	901	255	110	79,901	77,010	480	305	2,106
Gloucestershire	**27,337**	**8,661**	**12,433**	**5,150**	**1,093**	**569,647**	**546,599**	**3,759**	**731**	**18,558**

Table 18: Population by ethnic group, Gloucestershire 2011 (% of population)

	Total Black and Ethnic Minority	Mixed/ Multiple Ethnic Group	Asian/ Asian British	Black/ African/ Caribbean / Black British	Other Ethnic Group	Total White	English/ Welsh/ Scottish/ Northern Irish/ British	Irish	Gypsy or Irish Traveller	Other White
Cheltenham	5.7	1.6	3.2	0.6	0.3	94.3	88.3	0.9	0.1	5.0
Cotswold	2.2	0.8	1.0	0.3	0.1	97.8	94.5	0.6	0.1	2.7
Forest of Dean	1.5	0.6	0.6	0.2	0.1	98.5	96.7	0.3	0.1	1.4
Gloucester	10.9	2.9	4.8	2.9	0.3	89.1	84.6	0.7	0.1	3.8
Stroud	2.1	1.1	0.7	0.2	0.1	97.9	94.9	0.5	0.1	2.4
Tewkesbury	2.5	0.9	1.1	0.3	0.1	97.5	94.0	0.6	0.4	2.6
Gloucestershire	**4.6**	**1.5**	**2.1**	**0.9**	**0.2**	**95.4**	**91.6**	**0.6**	**0.1**	**3.1**
England	14.6	2.3	7.8	3.5	1.0	85.4	79.8	1.0	0.1	4.6

Religion/belief/no belief

Table 23: Religion in Gloucestershire 2011[54]

	% of population								
	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other Religion	No Religion	Religion not stated
Cheltenham	58.7	0.4	0.8	0.1	0.9	0.1	0.4	30.8	7.6
Cotswold	68.7	0.3	0.1	0.1	0.2	0.0	0.4	22.9	7.3
Forest of Dean	65.8	0.2	0.1	0.1	0.1	0.1	0.5	25.2	7.9
Gloucester	62.4	0.3	0.6	0.0	3.2	0.1	0.4	26.2	6.9
Stroud	62.0	0.3	0.1	0.1	0.2	0.0	0.8	28.3	8.1
Tewkesbury	66.6	0.2	0.3	0.1	0.3	0.1	0.3	25.0	7.1
Gloucestershire	**63.5**	**0.3**	**0.4**	**0.1**	**1.0**	**0.1**	**0.5**	**26.7**	**7.5**
England	59.4	0.5	1.5	0.5	5.0	0.8	0.4	24.7	7.2

Sexual Orientation

Table 26: Stonewall estimates of the number of Lesbian, Gay and Bisexual people living in Gloucestershire[66]

	Lower Estimate		Upper Estimate	
	Number	%	Number	%
Cheltenham	4,800	5	6,800	7
Cotswold	3,600	5	5,000	7
Forest of Dean	3,600	5	5,000	7
Gloucester	5,100	5	7,200	7
Stroud	4,800	5	6,700	7
Tewkesbury	3,600	5	5,100	7
Gloucestershire	**25,600**	**5**	**35,800**	**7**
England	2,236,900	5	3,131,700	7

Table 27: Annual Population Survey Estimates of Sexual Identity.[67]

	Number of people aged 16 or over	Gay, lesbian, or bisexual
Cheltenham	1,800	1.9
Cotswold	1,400	1.9
Forest of Dean	1,400	1.9
Gloucester	1,900	1.9
Stroud	1,800	1.9
Tewkesbury	1,400	1.9
Gloucestershire	**9,700**	**1.9**
England	864,000	1.9

Appendix B - Our patients/service users

Allowing us to view and compare our inpatient and outpatient data of that of the Gloucestershire population allows a more meaningful and tangible way of looking at our services to ensure development and redesign is focussed in the correct areas due to the ongoing change of the local residents. It is noted that users can be from outside of the county; however the main users will be those that reside within it.

Inpatient Data

The data provided below spans April 2017 to March 2018 for our Trust:

***Notes**:*

- *Due to the implementation of a new EPR System our data is subject to validation. Whilst we have data quality checks in place we are aware of ongoing issues being addressed through the Trak Recovery Group. Solutions both to the system and new operational plans to deliver are underway.*
- *Data excludes well babies.*

Inpatients by Gender

Inpatients by Gender	Discharges	Percentage
Female	88,576	56.8%
Male	67,309	43.2%
Not specified	1	0.0%
Total	**155,886**	

Inpatients by Age

Inpatients by Age Band	Discharges	Percentage
0 Years	3,219	2.1%
01 to 05 Years	4,102	2.6%
06 to 15 Years	4,069	2.6%
16 to 40 Years	34,192	21.9%
41 to 65 Years	45,538	29.2%
66 to 80 Years	43,824	28.1%
80+ Years	20,942	13.4%
Total	**155,886**	

Inpatients by Ethnicity

Inpatients by Ethnicity	Discharges	Percentage
African	304	0.2%
Any other Asian background	547	0.4%
Any other black background	246	0.2%
Any other ethnic group	1,157	0.7%
Any other mixed background	501	0.3%
Any other white background	4,131	2.7%
Bangladeshi	261	0.2%
Caribbean	501	0.3%
Chinese	157	0.1%
Indian	937	0.6%

Pakistani	212	0.1%
White and Asian	248	0.2%
White and black African	141	0.1%
White and black Caribbean	566	0.4%
White British	132,290	84.9%
White Irish	650	0.4%
Not known	4,313	2.8%
Not stated	8,724	5.6%
Total	**155,886**	

Outpatient Data

Again the data provided span April 2017 to March 2018 for our Trust:

***Notes**:*

- *Due to the implementation of a new EPR System our data is subject to validation. Whilst we have data quality checks in place we are aware of ongoing issues being addressed through the Trak Recovery Group. Solutions both to the system and new operational plans to deliver are underway.*
- *Includes face-to-face and telephone attendances.*
- *Excludes patients who did not attend and cancelled appointment.*

Outpatients by Gender

Outpatients by Gender	Attendances	Percentage
Female	417,126	57.2%
Male	312,576	42.8%
Not specified	5	0.0%
Total	**729,707**	

Outpatients by Age

Outpatients by Age Band	Attendances	Percentage
0 Years	5,363	0.7%
01 to 05 Years	21,165	2.9%
06 to 15 Years	34,912	4.8%
16 to 40 Years	141,651	19.4%
41 to 65 Years	236,068	32.4%
66 to 80 Years	208,801	28.6%
80+ Years	81,747	11.2%
Total	**729,707**	

Outpatients by Ethnicity

Outpatients by Ethnicity	Attendances	Percentage
African	1,572	0.2%
Any other Asian background	2,500	0.3%
Any other black background	969	0.1%
Any other ethnic group	4,517	0.6%
Any other mixed background	1,892	0.3%
Any other white background	17,826	2.4%

Bangladeshi	1,181	0.2%
Caribbean	2,990	0.4%
Chinese	1,199	0.2%
Indian	5,393	0.7%
Pakistani	914	0.1%
White and Asian	1,317	0.2%
White and black African	758	0.1%
White and black Caribbean	2,508	0.3%
White British	613,716	84.1%
White Irish	3,086	0.4%
Not known	28,740	3.9%
Not stated	38,629	5.3%
Total	**729,707**	

The patient data which we have at our disposal do not compare with what we know of the Gloucestershire community demographics; due to quantifying the number of individual patients that have used our services and who may have had repeat visits, which skews the results.

As our implementation of the new TrakCare becomes embedded and fully functional we expect to be able to provide more robust and detailed information against other protected characteristics in next year's Equality Report, such as: sexual orientation, religion/belief/no belief, gender reassignment, marital status and pregnancy/maternity.

Appendix C – Data on Trust Staff against protected characteristics

With circa 8,000 employees, our Trust is the largest employer in the county. The majority of Trust staff live in the local communities so they and their families are also users of our services. The Trust has always been very clear on the link between a skilled, committed and engaged workforce and the delivery of high quality patient care and this underpins many of our plans for staff development and engagement.

As an employer we are committed to equality, inclusion, valuing the diversity of our workforce and ensuring that these commitments, reinforced by our values, are embedded in our day-to-day working practices.

Workforce Data

The following tables provide information between April 2017 and March 2018 about our staff recruitment and the makeup of our full workforce, comparing it to the nine protected characteristics if available.

Non Agenda for Change (National Terms and Conditions of Service) includes senior managers and apprentices.

Due to the permanence of many of our staff, most of the data we hold historically on them will not include all of the 9 protected characteristics. As we see the turnover of these staff, the data overtime will become more meaningful for the purposes of this report. Whilst significantly more information is now gathered at recruitment stage, much of this is voluntary and must not be considered in recruitment decisions.

Recruitment by Gender

Description	No. Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Male	3,829	23.40%	1385	20.30%	261	18.80%
Female	12,436	76.10%	5412	79.30%	1126	80.90%
Undisclosed	79	0.50%	28	0.40%	5	0.40%

Recruitment with a Disability

Description	No. Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Yes, disabled	800	4.90%	359	5.30%	55	4.00%
No	15,275	93.50%	6358	93.20%	1316	94.50%
Undisclosed	269	1.60%	108	1.60%	21	1.50%

Recruitment by Age

Description	No. Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Under 18	124	0.80%	40	0.60%	8	0.60%
18 to 19	629	3.80%	270	4.00%	76	5.50%
20 to 24	2,592	15.90%	1058	15.50%	228	16.40%
25 to 29	3,123	19.10%	1186	17.40%	260	18.70%
30 to 34	2,168	13.30%	890	13.00%	174	12.50%
35 to 39	1,714	10.50%	745	10.90%	157	11.30%
40 to 44	1,322	8.10%	598	8.80%	122	8.80%
45 to 49	1,480	9.10%	678	9.90%	120	8.60%
50 to 54	1,471	9.00%	645	9.50%	118	8.50%
55 to 59	1,066	6.50%	439	6.40%	80	5.70%
60 to 64	517	3.20%	221	3.20%	37	2.70%

65 to 69	111	0.70%	44	0.60%	9	0.60%
70 and over	9	0.10%	4	0.10%	3	0.20%
Undisclosed	18	0.10%	7	0.10%	0	0.00%

Recruitment by Religion

Description	No. Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Atheism	2,812	17.20%	1315	19.30%	327	23.50%
Buddhism	93	0.60%	39	0.60%	8	0.60%
Christianity	8,347	51.10%	3604	52.80%	710	51.00%
Hinduism	387	2.40%	120	1.80%	20	1.40%
Islam	958	5.90%	298	4.40%	31	2.20%
Jainism	9	0.10%	3	0.00%	0	0.00%
Judaism	33	0.20%	2	0.00%	1	0.10%
Sikhism	40	0.20%	16	0.20%	1	0.10%
Other	1,778	10.90%	671	9.80%	127	9.10%
Undisclosed	1,887	11.50%	757	11.10%	167	12.00%

Recruitment by Sexual Orientation

Description	No. Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Heterosexual	14,606	89.40%	6145	90.00%	1273	91.50%
Gay/Lesbian	357	2.20%	167	2.40%	30	2.20%
Bisexual	282	1.70%	114	1.70%	18	1.30%
Other	0	0.00%	0	0.00%	0	0.00%
Undecided	0	0.00%	0	0.00%	0	0.00%
Undisclosed	1,099	6.70%	399	5.80%	71	5.10%

Recruitment by Ethnicity

Description	No. Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
WHITE - British	11,156	68.30%	5013	73.50%	1115	80.10%
WHITE - Irish	142	0.90%	81	1.20%	11	0.80%
WHITE - Any other white background	1,103	6.70%	361	5.30%	61	4.40%
ASIAN or ASIAN BRITISH - Indian	1,267	7.80%	473	6.90%	56	4.00%
ASIAN or ASIAN BRITISH - Pakistani	273	1.70%	82	1.20%	7	0.50%
ASIAN or ASIAN BRITISH - Bangladeshi	106	0.60%	36	0.50%	5	0.40%
ASIAN or ASIAN BRITISH - Any other Asian background	367	2.20%	155	2.30%	29	2.10%
MIXED - White & Black Caribbean	171	1.00%	69	1.00%	10	0.70%
MIXED - White & Black African	62	0.40%	20	0.30%	1	0.10%
MIXED - White & Asian	46	0.30%	16	0.20%	5	0.40%

MIXED - any other mixed background	134	0.80%	56	0.80%	10	0.70%
BLACK or BLACK BRITISH - Caribbean	206	1.30%	69	1.00%	13	0.90%
BLACK or BLACK BRITISH - African	681	4.20%	184	2.70%	23	1.70%
BLACK or BLACK BRITISH - Any other black background	52	0.30%	11	0.20%	1	0.10%
OTHER ETHNIC GROUP - Chinese	67	0.40%	19	0.30%	6	0.40%
OTHER ETHNIC GROUP - Any other ethnic group	272	1.70%	88	1.30%	18	1.30%
Undisclosed	239	1.50%	92	1.30%	21	1.50%

Recruitment by Marital Status

Description	No. Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Married	5,763	35.30%	2532	37.10%	523	37.60%
Single	8,536	52.20%	3460	50.70%	706	50.70%
Civil partnership	366	2.20%	141	2.10%	32	2.30%
Legally separated	158	1.00%	77	1.10%	15	1.10%
Divorced	894	5.50%	388	5.70%	75	5.40%
Widowed	62	0.40%	26	0.40%	4	0.30%
Undisclosed	565	3.50%	201	2.90%	37	2.70%

Total of Workforce – Staff Group v Gender

	Female	Male
Add Prof Scientific and Technic	222	60
Additional Clinical Services	1242	203
Administrative and Clerical	1368	280
Allied Health Professionals	349	49
Estates and Ancillary	235	289
Healthcare Scientists	175	81
Medical and Dental	829	577
Nursing and Midwifery Registered	2190	169
	6610	**1708**

Total of Workforce – Gender v Full/Part Time

	Full Time	Part-Time
	5138	3181
Female	3672	2939

Male	1466	242

Total of Workforce - Pay band v Gender v Full/Part Time

	Full Time		Part Time	
	Female	**Male**	**Female**	**Male**
Apprentice	60	9	7	
Band 1	24	35	185	60
Band 2	426	196	802	99
Band 3	338	97	346	12
Band 4	183	81	189	4
Band 5	818	184	709	30
Band 6	409	131	630	23
Band 7	238	85	219	10
Band 8a	73	26	32	1
Band 8b	34	20	8	1
Band 8c	9	3	6	
Band 8d	14	10	7	
Band 9	3	2	1	
Non AfC	8	10	3	2
Associate Specialist (Closed)	2	11	4	1
Clinical Assistant			4	2
Consultant	80	232	53	31
Foundation Year 1	33	19	1	
Foundation Year 2	38	15	1	
Hospital Practitioner			2	2
Senior House Officer (Closed)	4	2		
Specialist Registrar (Closed)	2		1	
Specialty Doctor	12	23	25	7
Specialty Registrar	378	193	168	11
Trust Grade Doctor - Career Grade level	1	2		
Trust Grade Doctor - Foundation Level	4	3		
Trust Grade Doctor - SHO Level (Closed)	3	1		
Trust Grade Doctor - Specialty Registrar	12	21	1	1

Total Workforce – Staff Group v Age

	16 -20	21 - 30	31 - 40	41 - 50	51 - 60	61 - 70	>=71 Years
Add Prof Scientific and Technic		61	96	57	59	9	
Additional Clinical Services	80	353	325	296	295	92	4
Administrative and Clerical	57	239	258	406	546	134	8
Allied Health Professionals		133	116	65	73	11	
Estates and Ancillary	8	45	79	118	165	96	13
Healthcare Scientists		53	50	68	67	18	
Medical and Dental		453	511	232	172	37	1
Nursing and Midwifery Registered		454	597	662	559	86	1
Students		1	0	0	0	0	
(blank)		0	0	0	0	0	
Grand Total	**145**	**1792**	**2032**	**1904**	**1936**	**483**	**27**

Total Workforce – Pay Band v Ethnicity

	White	Mixed	Asian	Black	Chinese	Other	Not Stated
Apprentice	68	1	2	2		0	3
Band 1	34	2	0	0		1	267
Band 2	1152	14	71	26	4	28	228
Band 3	633	7	34	7		18	94
Band 4	387	3	5	9	1	1	51
Band 5	1237	15	201	64	7	153	64
Band 6	1045	6	36	14	7	17	68
Band 7	510	4	7	6		6	19
Band 8a	119	2	3	0	1	0	7
Band 8b	55	0	2	3	1	0	2
Band 8c	17	0	0	0		0	1
Band 8d	31	0	0	0		0	0
Band 9	6	0	0	0		0	0
Non AfC	18	0	1	0		0	4
Non AfC Total	5312	54	362	131	21	224	808
Associate Specialist (Closed)	10	0	5	0	1	3	0
Clinical Assistant	5	0	1	0		0	0
Consultant	311	5	56	5	2	10	8
Foundation Year 1	39	5	1	0	3	5	3
Foundation Year 2	36	2	2	1	1	2	11
Hospital Practitioner	3	0	1	0		0	0
Medical Director	1	0	0	0		0	0
Senior House Officer (Closed)	4	0	1	0		0	1
Specialist Registrar (Closed)	2	0	1	0		0	0
Specialty Doctor	38	1	18	1		7	2
Specialty Registrar	579	16	77	21	8	17	40
Trust Grade Doctor - Career Grade level	0	0	2	0	1	1	0
Trust Grade Doctor - Foundation Level	1	2	2	2		0	0
Trust Grade Doctor - SHO Level (Closed)	3	1	0	0		0	0
Trust Grade Doctor - Specialist Registrar Level (Closed)	2	0	0	0		0	0
Trust Grade Doctor - Specialty Registrar	19	1	10	2		0	1
Medical Staff Total	1053	33	177	32	16	45	66
OVERALL TOTAL	**6365**	**87**	**539**	**163**	**37**	**269**	**874**
% of Workforce	**76.4%**	**1.0%**	**6.5%**	**2.0%**	**0.4%**	**3.2%**	**10.5%**

Total Workforce – Staff Group v Ethnicity

	White	Mixed	Asian	Black	Chinese	Other	Not Stated
Add Prof Scientific and Technic	249	2	16	6	2	2	5
Additional Clinical Services	1151	15	96	26	4	43	110
Administrative and Clerical	1451	15	30	21	5	4	122
Allied Health Professionals	367	3	6	11	1	2	8
Estates and Ancillary	55	0	1	0		1	467
Healthcare Scientists	201	1	16	3	4	2	29

Medical and Dental	1053	33	177	32	16	29	66
Nursing and Midwifery Registered	1838	18	197	64	5	170	67
Grand Total	**6365**	**87**	**539**	**163**	**37**	**253**	**874**

	White	Mixed	Asian	Black	Chinese	Other	Not Stated
Add Prof Scientific and Technic	88.3%	0.7%	5.7%	2.1%	0.7%	0.7%	1.8%
Additional Clinical Services	79.7%	1.0%	6.6%	1.8%	0.3%	3.0%	7.6%
Administrative and Clerical	88.0%	0.9%	1.8%	1.3%	0.3%	0.2%	7.4%
Allied Health Professionals	92.2%	0.8%	1.5%	2.8%	0.3%	0.5%	2.0%
Estates and Ancillary	10.5%	0.0%	0.2%	0.0%	0.0%	0.2%	89.1%
Healthcare Scientists	78.5%	0.4%	6.3%	1.2%	1.6%	0.8%	11.3%
Medical and Dental	74.9%	2.3%	12.6%	2.3%	1.1%	2.1%	4.7%
Nursing and Midwifery Registered	77.9%	0.8%	8.4%	2.7%	0.2%	7.2%	2.8%
Grand Total	**76.5%**	**1.0%**	**6.5%**	**2.0%**	**0.4%**	**3.0%**	**10.5%**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO TRUST BOARD – JANUARY 2019

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

This report describes the business conducted at the Audit and Assurance Committee on 20 November 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
Cyber Security Update	The Chief Digital Information Officer provided an update on current arrangements, the testing regime and planned improvements	What risks are posed by partner organisations' system access? Is old hardware inherently riskier? Is there a comprehensive equipment inventory? How does the Trust compare to peers? Do devices other than PCs represent a threat? How do non-experts receive adequate assurance?	Network project in progress to increase access control Yes – but old machines being moved in to controlled environment Middle ranking performance Continued Committee update programme and appropriate use of Internal Audit	 Much improved but not complete Investment required to advance Work underway to reduce access to ports
Internal Audit	Progress report and final reports for - Shared Service Procurement - Budgetary Control - Operational Business Planning - Freedom to Speak Up	When should follow up actions be reviewed in Committee?	Budgetary Control – January Operational Business Planning - July	

Clinical Audit Report	Director of Safety reviewed the clinical audit principles and their interface with the Safety and Quality Improvements Academy	How is learning disseminated? Does the approach meet the Trust's "must dos"? How is submitted data verified?	Benchmarking against other providers is cascaded through the relevant division Yes Clinicians are responsible for input which is subject to peer review	
Board Assurance Framework	Update on the continued development of the document and process	Why is there not an oversight committee named for objective 4.6 (Research)?		To be determined
Risk Management Framework	Update on the risk management process	Does the number of overdue risk updates indicate the system is not working adequately, e.g. risks being missed?	No – all substantial risks are identified	Some "housekeeping" improvements in recording system
Gloucestershire Managed Services (GMS) Audit Arrangements	Internal and external contracts being put in place Counter Fraud to be provided by Gloucestershire Shared Services	How is the Trust assured that adequate controls are in place in GMS?	Work underway to cross reference risks between GMS & the Trust	
Counter Fraud Update	Update on training activity, current investigations, GMS future arrangements	How does Counter Fraud know if a fraud alert has been responded to? How do future employers know if an employee has resigned mid-investigation?	Alerts are followed up 48 hours after receipt	Director or Finance to discuss with Director of People and Organisational Development

Rob Graves
Chair of Audit and Assurance Committee
November 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO TRUST BOARD – JANUARY 2019

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

This report describes the business conducted at the GMS Committee held 21 November 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	Updates to GMS policies (agenda item 076/18)	How to ensure that future GMS policy updates are in line with those of the Trust.	In future policy changes will be consulted with the relevant Trust executive before GMS approval. A quarterly summary of GMS policy changes will be provided to this Committee to note.	
GMS Managing Director's Report	Update on remediation plans submitted and discussed.	Committee is seeking assurance that all high risk items are being addressed effectively.	Plan updates provided in the monthly report.	Formal close out of the three (cleaning, CSSD, catering) remediation plans to be presented at the January Committee.
Chief Operating Officer's Report	GMS management restructuring. Ongoing management by the trust of GMS performance	What are the risks to GMS delivery of the staff consultation and insuring structural changes? Ensuring sufficient "informed client" capability will sit in the Trust.	 Part time finance resource to provide GMS contract management	The business case associated risks and timeline to be presented to the December Committee. Further discussions required within the Trust to develop a longer term solution. Committee to be updated in December meeting.

Regulatory Compliance Report	Presentation of the processes and the controls for GMS meeting regulatory health and safety regulations.		Multiple lines of defence to provide assurance are present. Regular reviews are submitted to the Trust's governance and compliance group and the GMS Board.	
Risk Log		Estates risks that reflect the Trust's perspective still need to be completed.	Existing GMS risk register addresses the majority of estates risks.	A review to ensure complete coverage on the trust risk register needs to be completed and is subject to offline staff work to be bought back to Committee in December.

Mike Napier
Chair of Gloucestershire Managed Services Committee
21 November 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO TRUST BOARD – JANUARY 2019

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

This report describes the business conducted at the GMS Committee held 10 December 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	Cleaning is currently performed to a local standard; discussions are ongoing about moving to national standards.	Need to understand the resource and cost implications of such a move.		Obtaining cost and analysis implications to be presented to January committee.
Risk and Governance	Identified 29 estates and facilities related risks on Datix that are not present on GMS risk log and currently not recognised as trust risks.			A full review of estates and facilities risks will be presented at the January GMS Committee meeting.
NHS Improvement Approach to Wholly Owned Subsidiaries	NHS Improvement published guidance outlining a new framework on the way subsidiaries are approved.	Has the Trust met the new requirements in the guidance?	The Director of Corporate Governance has reviewed the criteria and is of the view that by virtue of the approach the Trust took to establish in GMS, the Board received the relevant assurance.	

Hard Services Report	Current arrangements for asset management undertaken by GMS for the Trust was presented.	The assessment of the current back log position is estimated at £52.5m and the rate of deterioration of the estate is around £1.5m per annum.	GMS have a number of asset management programmes and systems to manage the operational life of assets. Asset condition of the estate is well understood by GMS and factored in to the Trusts capital programme and capital projects.	- How can the Trust/GMS provide reasonable assurance that incidents of equipment failure are isolated and that effective systems and controls are in place to prevent reoccurrence - There is a challenge to reduce backlog maintenance. - These lines of enquiry will be progressed at future GMS Committee meetings.

Mike Napier
Chair of Gloucestershire Managed Services Committee
10 December 2018

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST BOARD – JANUARY 2019
Lecture Hall, Redwood Education Centre commencing at 12:30

Report Title
Up-date on Research in Gloucestershire Hospitals NHS Foundation Trust
Sponsor and Author(s)
Author: Julie Hapeshi, Associate Director of Research and Development Sponsor: Simon Lanceley, Director of Clinical Strategy
Executive Summary
Purpose To provide an up-date for the board on the current status of research activity within the Trust Key issues to note • Research activity within the trust is performing well in most areas. • The research budget is projected to turn in a small surplus at the end of the financial year 2018/19 • A draft of the refreshed research strategy is included • A new Head of R&D will take up post in April 2019 Conclusions Research is an important aspect of the day to day business of the NHS and provides the organisation, it patients and its staff with access to new drugs, devices and developments in the delivery of care that it would otherwise have to wait for. Reporting to the board provides an opportunity to maintain the visibility of this important area of the Trust's work to a wider audience of staff, patients and the public. Implications and Future Action Required Activity and performance is scrutinised at the West of England CRN Partnership board and operational Management Group and internally every quarter by the Research and Development Forum. The Board receives biannual update report to provide assurance of the performance and governance of research within the Trust.
Recommendations
The Board is asked to accept this report as assurance of the performance and governance of research within the Trust.
Impact Upon Strategic Objectives
None.
Impact Upon Corporate Risks
None.
Regulatory and/or Legal Implications
Research activity is covered by specific regulatory framework administered by the Medicines and Health regulatory Authority. The MHRA inspected the Trust in October 2017.

Equality & Patient Impact							
Research studies are accessible to all patients who meet the criteria of the studies.							
Resource Implications							
Finance		X	Information Management & Technology				
Human Resources		X	Buildings				
Action/Decision Required							
For Decision		For Assurance	√	For Approval		For Information	√

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JANUARY 2019

RESEARCH UPDATE PAPER

1 Purpose

1.1 To provide an up-date to the Board on research activity in Gloucestershire Hospitals NHS Foundation Trust from July- December 2018 including research recruitment, the financial position and other issues of note.

2 Executive summary

2.1 Research activity within the trust is performing well and meeting the national high level objectives (HLOs) in most areas.

2.2 The research budget is projected to turn in a small surplus at the end of the financial year 2018/19

2.3 A draft of the refreshed research strategy is included

3 Background

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

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

Progress against the HLO element of this objective is tracked internally by the Trust's Research & Development Forum and externally by the Clinical Research Network (CRN) Executive Management Group. The method for tracking progress against the other elements of this objective will be incorporated into the plan to operationalise the new Trust research strategy once it is agreed.

4 Key Messages

4.1 Research Activity - NIHR Portfolio Studies

In April, we set a trust target to recruit 800 patients into studies in 2018/19. This target was extended by the West of England Clinical Research Network (WE CRN) to 1000 and at the end of September was extended again by the WE CRN to 2334 patients. The decision was made by the CRN to reconsider the targets and each Partner Organisation (PO) target was increased to achieve the network's overall expected recruitment target to the national target. Although as a Trust we have surpassed our first extended target of 1000, the revised target of 2334 patients will be challenging as we do not currently have sufficient studies open to deliver this or a pipeline of potential studies (NIHR or commercial) likely to bring in an additional 1000 patients in the remaining 3 months of 2018/19. Recruitment target extensions along with previously achieved recruitment figures are in table one.

Table 1. Recruitment target extensions

	Previous Recruitment achieved			2018/19 Plan			
	15-16	16-17	17-18	18-19 plan	Revised 18 - 19 plan	Coordinating Centre CRN revised target (28,883)	Forecast recruitment (based on actual Apr - Aug)
2Gether NHS FT	354	352	385	170	275	507	365
Avon and Wiltshire Mental Health Partnership NHST	616	500	588	434	504	775	730
Gloucestershire Care Services NHS Trust		15	73	50	50	96	84
Gloucestershire Hospitals NHS FT	**1,145**	**3,068 [1]**	**1,771**	**802**	**1,000**	**2334**	**1627**
Great Western Hospital FT	790	1,110	1,274	851	1,075	1679	1656
North Bristol NHS Trust	4,061	4,155	3,986	3,210	3,000	5,253	3895
Royal United Hospitals NHS FT	2,168	1,870	2,236	1,888	2,018	2,947	2071
University Hospitals Bristol NHS FT	4,579	6,677	6,595	5,500	6,776	8,691	6703
Weston Area health NHS Trust	454	356	228	214	250	300	346
Non-NHS	238	4,638	664		700	701	854
Primary Care	6,651	5,360	3,294	5,112	5,600	5,600	2270
Totals	21,056	28,101	21,094	18,731	21,248	28,883	20602

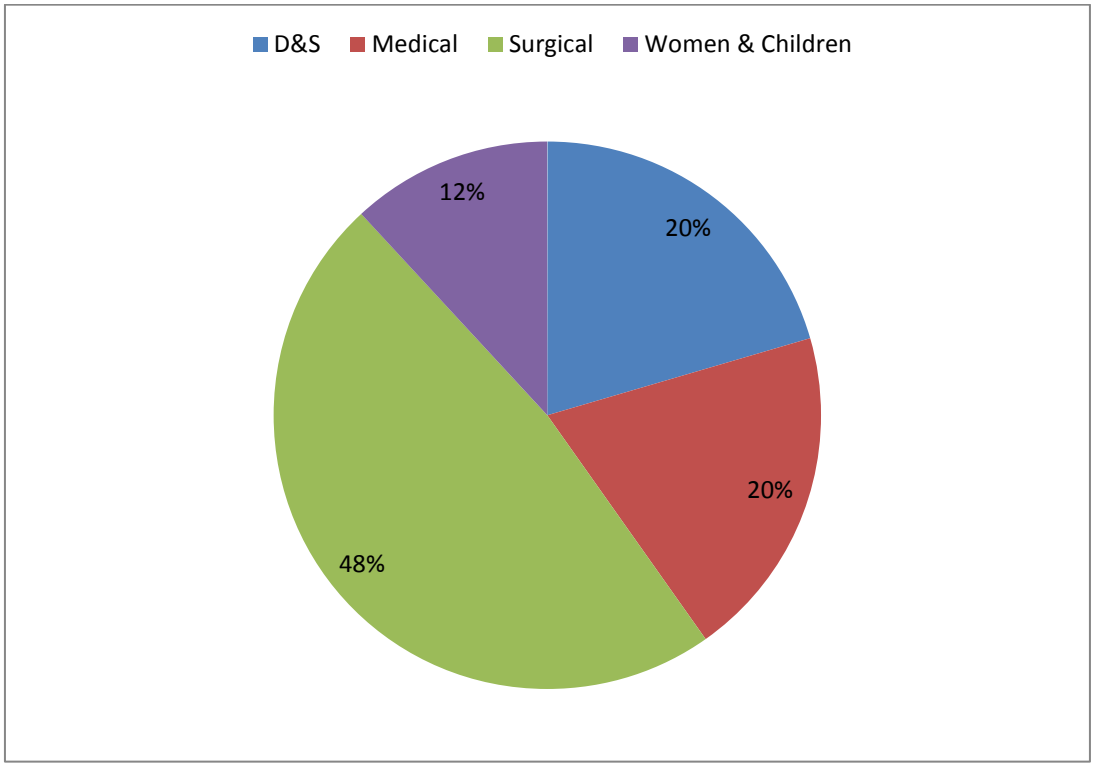
[1] The recruitment this year was inflated by one, unusually large trial

Our performance against all of the HLOs compared with the other partner organisations in the West of England CRN is in annex A. We are meeting all HLO targets set in our annual plan (annex B) with the exception of HLOs 5a and 5b (proportion of NIHR commercial and non-commercial studies achieving first participant recruited within 30 calendar days). This is a challenging target as many of our trials will recruit only a few patients due to the nature of the condition being studied. For some studies in rare cancers we would only expect to recruit 1 or 2 patients each year, therefore this target is often not attainable. Our performance in recruiting to Time and Target for commercially and non-commercially sponsored trials indicates the percentage of closed studies that met their recruitment target. This is a more difficult target to achieve because if a sponsor decides to close a study early, before we have achieved the recruitment target it will be RAG rated red. We have improved our performance by introducing a more stringent study feasibility assessment and by declining studies that we do not feel have realistic targets set by the pharma companies.

The loss of Haematology laboratory accreditation (UKAS) which caused some issues with existing trial sponsors at the start of the year has not been as big an issue as first anticipated. Although we have been rejected as a site for one major haematology trial it has not overly impacted our ability to open new studies.

The largest proportion of open studies is currently in the surgical division (see figure one below), with the majority of studies in ophthalmology.

Figure 1. The proportion of studies open in each division.



4.2 Research activity Non- NIHR Portfolio Studies

We have 38 active non-portfolio studies. A non-portfolio study is one that is sponsored by an organisation that is not eligible to be included on the NIHR portfolio. 36 of our non-NIHR portfolio studies are sponsored by academic institutions, mostly student projects.

4.3 Finance

The annual R&D budget for 2018/19 is £2.02M of which a large proportion is non-recurring and relies on our recruitment of patients into trials. The main income sources are: West of England CRN, and grant income (amounting to over 80% in total).The annual expenditure this year is £2.15M with the majority spend on staff who deliver trials. Providing we can maintain the commercial trial portfolio through the last quarter of 2018/19, without any studies closing early or being suspended, our closing financial position will show a small surplus of £39.6K (1.8%)

4.4 Excess Treatment costs (ETCs)

NHS research can result in excess treatment costs. These are costs that arise as a result of the difference between the cost of standard treatment and the cost of treatment within a research study in non-commercial research projects. The process for reclaiming ETCs from non-commercial studies changed in October 2018 and we have not encountered any major problems in the transition phase which ends in March 2019. Full implementation of the new arrangements will take place from April 2019 and ETCs are being managed via the WE CRN. Study sponsors are required to submit a statement of expenditure ahead of any grant application to ensure ETCs are agreed ahead of a grant being awarded to minimise delays in research approvals. ETCs associated with commercial studies must be met in full by the sponsor.

4.5 Research Strategy

A draft of the new Trust Research Strategy is included in Annex C. It has been co-designed with the Trust's extended research community; research nurses & AHPs, consultants, members of the CRN, and has been widely circulated for comment, with

feedback incorporated into the latest version. The four key objectives of the new strategy are:

1 Increase visibility – communicate that we are research active to our staff, patients and to potential collaborators.

2 Celebrate success - demonstrate how research is improving patient care.

3 Work force and infrastructure development - improve access to trials for patients with the aim that every patient can access a trial or be offered one.

4 Widening Networks - increase the number and variety of organisations we work with

The new Research Strategy will be shared with Trust Board for final approval once the Trust's new Strategy has been approved in April 2019.

4.6 Research culture

We have worked hard to improve the visibility of research within the Trust and this has been enhanced by our relationship with the Trust's communications team and also the recognition of research at the Trust's awards ceremony. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system. The group is made up of the research leads from the other NHS organisations in Gloucestershire, Public Health (Gloucestershire County Council) and representatives from the University of Gloucestershire and cobalt Health. The group is now chaired by Peter Lackecki and will finalise its mission and vision early next year.

4.7 Patient experience

The annual patient experience survey is currently being distributed to patients at research visits to establish how we can improve our service to patients in trials. The level of patient satisfaction is high across the Trust and the WE CRN. This survey is mandated by the NIHR Clinical Research Network co-ordinating centre.

4.8 Team leadership

After 23 years, coordinating R&D in Gloucestershire, the Associate Director of R&D is retiring in March 2019. Julie Hapeshi has been instrumental in establishing and developing the research capacity, capability and reputation of GHFT and Gloucestershire. To reduce the impact this could have on the R&D team and portfolio performance, a robust succession plan was established and a new Head of Research & Development, Chantal Sunter, was appointed in December 2018. Chantal currently works for the WE CRN, understands the Trust's research portfolio and ambition, has influenced the draft research strategy and is well known by the Gloucestershire research community. The WE CRN, have kindly agreed for Chantal to be based on site at GHFT for 2-days per week from January to March to support a robust handover and smooth transition period.

4.9 Reporting

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

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

Finance returns are submitted to the West of England network each quarter.

4.10 Conclusion

Research is an important aspect of the work of the Trust and there is always scope to improve. The team have worked hard this year to engage with clinical teams and raise the profile of R&D. We acknowledge the opportunity to report research as an important aspect of maintaining our visibility to the Trust's board, staff and the public.

5 Recommendation

The Board is asked to accept this report as assurance of the performance and governance of research within the Trust.

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

Sponsor: Simon Lanceley, Director Clinical Strategy

31. December 2018

Annex A

Partner Organisation data reporting performance against NIHR HLOs (Data supplied by the West of England CRN – data cut 04/12/18)

HLO 1- Increase the number of participants recruited into NIHR CRN Portfolio studies

Recruitment vs goal	Partner Organisation	Commercial	Non commercial	YTD Total	Target
	2Gether	2	177	179	507
	AWP	5	586	591	775
	GCS		43	43	96
	GHFT	**26**	**1,109**	**1,135**	**2,334**
	GWHFT	19	873	892	1,679
	NBT	120	2,598	2,718	5,253
	RUH	83	1,321	1,404	2,947
	UHBFT	194	5,790	5,984	8,691
	WAHT	6	203	209	300
	Primary care	114	1,527	1,641	5,600
	Non-NHS activity	6	786	792	700
TOTAL		575	15,013	15,588	28,882

HLO 2a - Commercial performance recruiting to time and target

Proportion of NIHR commercial studies at sites closed to recruitment in 2018/19 delivering recruitment to time and target

	Cumulative total achieved (#)	**Total # studies closed**	**% achieved (target 80%)**
2Gether	2	2	100%
AWP	1	2	50%
GCS			-
GHFT	**3**	**4**	**75%**
GWHFT	3	7	43%
NBT	10	15	67%
RUH	5	9	56%
UHBFT	16	24	67%
WAHT	1	2	50%
Primary care	8	16	50%

CRN WofE Cumulative Performance — No data provided

HLO 2b	Non-commercial performance recruiting to time and target		Proportion of NIHR non-commercial studies at sites closed to recruitment in 2018/19 recruitment to time and target	
		Cumulative total achieved (#)	Total # studies closed	% achieved (target 80%)
	2Gether	2	2	100%
	AWP	14	15	93%
	GCS	1	1	100%
	GHFT	**12**	**12**	**100%**
	GWHFT	9	10	90%
	NBT	17	24	71%
	RUH	9	13	69%
	UHBFT	19	37	51%
	WAHT	5	7	71%
	Primary care	0	0	-
CRN WofE Cumulative Performance		88	121	73%

HL0 4	Proportion of NIHR commercial studies achieving set up at site within 40 calendar days		Reduce the time taken for eligible studies to achieve set up in the NHS	
		Cumulative total achieved (#)	Total # studies	% achieved (target 80%)
	2Gether	4	5	80%
	AWP	5	5	100%
	GCS	0	1	0%
	GHFT	**15**	**18**	**83%**
	GWHFT	5	7	71%
	NBT	30	37	81%
	RUH	7	19	37%
	UHBFT	42	58	72%
	WAHT	3	4	75%
	Primary care	0	0	-
CRN WofE Cumulative Performance		111	154	72%

HLO 5a	Proportion of NIHR commercial studies achieving first participant recruited within 30 calendar days		Reduce the time taken to recruit first participant	
		Cumulative total achieved (#)	Total # studies	% achieved (target 80%)
	2Gether	0	0	-
	AWP	0	0	-
	GCS	0	0	-
	GHFT	**1**	**4**	**25%**
	GWHFT	0	0	-
	NBT	5	7	71%
	RUH	0	4	0%
	UHBFT	6	22	27%
	WAHT	0	0	-
	Primary care	0	0	-
CRN WofE Cumulative Performance		12	37	32%

HLO 5b	Proportion of NIHR non-commercial studies achieving first participant recruited within 30 calendar days		Reduce the time taken to recruit first participant into NIHR CRN Portfolio studies	
		Cumulative total achieved (#)	Total # studies	% achieved (target 80%)
	2Gether	4	4	100%
	AWP	3	6	50%
	GCS	0	0	-
	GHFT	**5**	**13**	**38%**
	GWHFT	1	3	33%
	NBT	11	22	50%
	RUH	6	10	60%
	UHBFT	14	27	52%
	WAHT	1	3	33%
	Primary care	0	0	-
CRN WofE Cumulative Performance		45	88	51%

Data until Nov 2018

Weighted recruitment		Apr 17 - Mar 18	Apr 18 to Nov 18	Cumulative Total	% of WoE Cumulative Total
	2Gether	2,049	1,030	3,079	2%
	AWP	2,221	3,546	5,767	3%
	GCS	4,503	303	4,806	3%
	GHFT	**8,293**	**4,278**	**12,572**	**7%**
	GWHFT	3,717	3,014	6,731	4%
	NBT	16,573	11,986	28,559	16%
	RUH	11,885	5,661	17,546	10%
	UHBFT	32,362	32,099	64,461	36%
	WAHT	600	747	1,346	1%
	Primary care	17,641	11,092	28,732	16%
	Non - NHS activity	3,163	3,417	6,580	4%
TOTAL		103,006	77,172	180,178	

Annex B

Annual plan submitted to WE CRN

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

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

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

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

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

ANNEX C

GHNHSFT Research Strategy 2019 – 2024

INTRODUCTION

Background

Under the NHS Constitution (2009) it is expected that research is a core part of the business of the NHS which enables the NHS to improve the current and future health of the people it serves. NHS organisations must do all they can to ensure that patients are made aware of research that is of particular relevance to them. To enable studies to recruit, conclude and report in a timely way we need to promote research to staff and patients. The Government intends us to give patients more information on research studies that are relevant to them, and more scope to join in if they wish. Patients should be encouraged to enrol into research studies on the basis that it is the best way of improving treatment options.

Research activity in the NHS is managed through the National Institute for Health Research (NIHR), which was established in April 2006. It provides the framework by which the Department of Health fund the research, research staff and research infrastructure of the NHS in England as a national research facility. The NIHR also actively encourages partnerships with the commercial sector and this is a key area of income generation for the Trust.

The Trust regularly hosts in excess of 100 studies which are open to recruitment with additional studies in follow-up. These studies form part of the NIHR portfolio of adopted studies. Many of these are multi-centre studies that originate from outside the organisation for which we are a centre for recruitment, treatment and follow-up. We have a much smaller portfolio of locally generated studies, some funded by NIHR and other funders but also undergraduate and postgraduate student projects undertaken by members of our staff. We also have around 15-20 commercial studies open at any one time.

Funding streams

Research is funded from three main income streams that are independent of the other NHS budgets; namely, NIHR Support funding, income from commercial trials and research grant income. The main source of income is from the West of England Clinical Research Network (WE CRN) allocation of just over £1m in 2018/19. The NIHR utilises an activity based funding (ABF) model, based on the number of recruited subjects and weighted depending on the complexity of the study. However, this is not a direct “pass through” model where we receive a fixed amount per participant recruited.

The funding the Trust receives from the NIHR via the WE CRN supports the infrastructure to deliver hosted studies that are adopted by the NIHR, which included the research nurses and data officers. Research activity fluctuates depending on the studies we have available to us to recruit to. This source of funding does not generate surplus income for the trust and is non-recurring, which makes the annual planning cycle problematic. Small amounts of additional non-recurring funding come directly from the NIHR (around £30k per annum).

Income is also secured through the delivery of commercial trials which are reimbursed according to a nationally agreed funding template. These studies are fully funded and accompanied by additional income which is used to support and further develop the infrastructure.

Research grant funding is focussed in a few areas, mainly the Biophotonics Research Group and the Gloucestershire Retinal Research Group.

The Trust's research income has reduced in more recent years, mostly due to a falling allocation from the WE CRN and fewer locally awarded grants. It is acknowledged that in times of financial constraint research may be seen as non-core business which the Trust cannot afford, but by ensuring that research is fully funded from the appropriate funding streams, patient care budgets are not compromised. In addition, research can be seen as a desirable activity for many clinicians, improving recruitment and retention.

Research Governance and Performance Management

We are performance managed on a number of high level objectives set by the NIHR, including study set up times and recruiting to time and target. The recruitment of patients to trials (activity) and the performance in initiating and delivering research against the NIHR targets is reported directly, every quarter, to the Trust Chief Executive by the NIHR Coordinating centre. In addition, the activity is reported to the Trust's Quality and Performance Committee and the Research and Development (R&D) Forum along with other clinical research meetings.

Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in Gloucestershire County Council. Funding described in the SLA supports the Research Management and Governance, design and delivery of non-NIHR portfolio studies including local service evaluation projects and student projects and projects funded from charitable sources. In addition, the GRSS hosts the Gloucester office of the NIHR Research Design Service South West (NIHR RDS SW) which provides a free support service for study design and applications for funding to approved NIHR funders.

Research Culture

The Trust has a number of well-established areas of research with large portfolios of research trial activity, in ophthalmology, stroke, oncology, renal, gastroenterology and emergency medicine; with other areas undertaking smaller number of studies.

Moves are already being made into areas where there is also the potential to expand our research portfolio into specialties where we treat a high volume of patients and/ or are recognised nationally for the service we provide, for example in Trauma and Orthopaedics (we are the 4th largest trauma unit in England). However, there are a number of high-prevalence disease areas where there is no culture of participating in research and staff who do not recognise research as core activity.

We also have active investigators in Biophotonics, Ophthalmology, Gastroenterology and Neurology conducting their own primary research which is funded from a variety of national and local sources. The recent signing of a statement of intent to work more closely with the University of Gloucestershire will also help to form productive grant writing partnerships to further this activity.

We offer novice researchers placements with established research teams so that they can learn some of the practical aspects of research including informed consent and good clinical practice. This includes providing opportunities for medical students considering research careers to spend their elective placement in a research setting and work experience students from local schools considering careers in the NHS.
Research is an important aspect of the day to day business of the NHS and is key to improving patient care. Research often provides the Trust, its patients and its staff with access to new drugs, devices and developments in the delivery of care that they would otherwise have to wait for.

ASPIRATIONS 2019-2024

Communicate, Celebrate, Build Capacity and Collaborate, research is everyone's business

Increase visibility – communicate that we are research active to our staff, patients and to potential collaborators.

- Achieve university hospital status in the next 5 years
- Promote ourselves as a research active organisation –we can do and we do, do research
- Raise profile internally and externally.
- Develop a strategic approach to communications to improve visibility
- Provide information at staff induction and be proactive in following up newly appointed staff with research interest or experience
- Develop promotional literature
- Include information to patients in appointment letters
- Report outcomes, benefits of hosted studies
- Ensure communication updates using social media and other Trust media outlets
- Follow up findings from national IP survey question relating to research
- Reporting of research updates to Board

Celebrate success - demonstrate how research is improving patient care.

- Highlight where there are clear benefits to staff, patients and the organisation with improvements in practice through early implementation of interventions especially where we have been a research site.
- Actively seek patient stories describing their research experiences
- Send personal "thank you" letters to patients and staff.
- Highlight our areas of excellence.

Work force and infrastructure development - improve access to trials for patients with the aim that every patient can access a trial or be offered one where one is available.

- Develop a stable environment for research to flourish
- Develop a career structure for staff / develop research positions:
    - Promote the role of non-medical PIs
    - Research fellows
    - More clinical scientists
    - Academic clinical leads
    - Research placements for students
- Collect information about new staff including their previous research experience to maximise opportunities to broaden research active areas and develop new ones.
- Increase training opportunities
- Include research in job plans as part of SPA time giving it the same status as audit, QI and teaching activities.
- Ensure support services (HR, Finance, Comms etc.) can keep pace and are properly resourced.
- Resources required to facilitate sponsorship of studies, support for local lead PIs
- Ensure R&D needs feature in the estates and facilities planning
- Resources required to facilitate university hospital status requirements
- Sufficient resources to support & lead on IP management and commercialisation of research outputs
- Ensure GCP training is added to the Trust mandatory training for research active staff

Widening Networks - increase the number and variety of organisations we work with.

- Increase patient involvement in the design, delivery & evaluation of research
- Research 4 Gloucestershire joint appointments
- Promote collaborative working by widening links with Universities.
- Increase collaborative grants
- Tissue Bank business case
- Develop commercial links

HOW WILL WE KNOW WHETHER WE'VE BEEN SUCCESSFUL?

- We will have examples of the benefit that research has had in the care of real people
- We will widen the number of specialities delivering trials so that the numbers of patients who request to take part in a trial, are offered a trial and able to take up the offer will increase
- We will increase in the number of locally led studies, the amount of research grant income and high quality outputs (publications)
- We will increase the number of high profile local investigators including non-medical PIs
- There will be an increase in merit awards linked to research
- We will be known as a centre of excellence for research and achieve University hospital status
- We will have an increase in new, targeted areas opening and recruiting to trials
- Staff will be aware of research in the Trust, be enthused to contribute and recruited because of their research profiles. Staff retention due to stable funding environment and career development opportunities in supportive multi-disciplinary teams We have developed a positive media interest for R&D building reputation of Trust
- There will be increased income from NIHR and commercial trials Reduced reliance on short term grants & annual non-recurrent allocations
- Increased number of staff participating in research training including GCP, postgraduate degrees.

CONCLUSION

The strategic aims for research as described will enhance the Trust's capacity and capability to undertake high quality research in a competitive market. This will in turn create a clinical environment where staff are enthused by the research that is going on around them, improving the recruitment and retention of high calibre staff.

By linking research with clinical care to will ensure that research is a visible part of the Trust's main business and we will be able to give patients the opportunity to experience new and exciting treatments. This will help to improve the health of our community through research.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 17TH OCTOBER 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	Liz Berragan	Public, Gloucester
	Tim Callaghan	Public, Cheltenham
	Geoff Cave	Public, Tewkesbury
	Graham Coughlin	Public, Gloucester
	Anne Davies	Public, Cotswold
	Charlotte Glasspool	Staff, Allied Health Professionals
	Colin Greaves	Stakeholder Appointed, Clinical Commissioning Group
	Jenny Hincks	Public, Cotswold
	Nigel Johnson	Staff, Other and Non-Clinical
	Alison Jones	Public, Forest of Dean
	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)
Directors	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Claire Feehily	Non-Executive Director
	Rob Graves	Non-Executive Director
	Mike Napier	Non-Executive Director
	Keith Norton	Non-Executive Director
	Alison Moon	Non-Executive Director
IN ATTENDANCE	Lukasz Bohdan	Director of Corporate Governance
	Sean Elyan	Medical Director
	Steve Hams	Director of Quality and Chief Nurse
	Natashia Judge	Corporate Governance Manager
	Simon Lanceley	Director of Strategy and Transformation
	Caroline Landon	Chief Operating Officer
	Sarah Stansfield	Director of Finance
	Emma Wood	Director of People and Organisational Development
APOLOGIES	Pat Eagle	Public, Stroud
	Andrew Gravells	Stakeholder Appointed, County Council
	Marguerite Harris	Public, Out of County
	Sarah Mather	Staff, Nursing and Midwifery
	Valerie Wood	Public, Forest of Dean
PRESS/PUBLIC	None	

088/18 DECLARATIONS OF INTEREST **ACTION**

There were none.

089/18 MINUTES OF THE MEETING HELD ON 15TH AUGUST 2018

RESOLVED: The minutes of the meeting held on 15th August 2018 were agreed as an accurate record subject to a minor amendment, i.e. Alison Jones being shown as present at the meeting..

090/18 MATTERS ARISING

AUGUST 2018 069/18 MATTERS ARISING - 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.

Ongoing: Deputy Director of Quality has been asked to develop a procedure which will capture feedback from visits and provide Council of Governors with feedback on action taken (in line with approach to Patient Stories presented to Board). This will return to the December meeting.

The Lead Governor also explained that moving forward, following each governor walkabout, governors would collectively agree on an individual who would channel all feedback.

AUGUST 2018 073/18 EXTERNAL AUDITORS PRESENTATION - 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.

Ongoing: The Director of Finance advised that a detailed report would return to December meeting.

AUGUST 2018 072/18 REPORTS FROM BOARD COMMITTEES – QUALITY AND PERFORMANCE - 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 to the Lead Governor and would share this with all governors.

Completed: Response circulated to all Governors.

AUGUST 2018 072/18 REPORTS FROM BOARD COMMITTEES – GLOUCESTER MANAGED SERVICES - THE LEAD GOVERNOR REQUESTED THAT THE AGENDA FOR THE NEXT COUNCIL OF GOVERNORS INCLUDES THE GMS COMMITTEE PRESENTATION

Chief Executive and Lead Governor to meet and agree approach.

Completed: GMS Update to be presented to October Council (Confidential session).

AUGUST 2018 074/18 PATIENT EXPERIENCE REPORT - WHITE ROSE CAFÉ - 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 enquire how the voluntary sector are represented on the Countywide End of Life Steering Group.

Completed: Chief Executive has written to Gloucestershire Clinical Commission Group End of Life System Lead; response still awaited.

The Chief Executive added that she had since received a response, explaining that a member of Healthwatch sat on the End of Life Steering Group but there was no Carers Gloucestershire representative. However, there are two carers within the group. She would circulate the email outside of the meeting as it describes the involvement of lay members. **DL**

AUGUST 2018 074/18 PATIENT EXPERIENCE REPORT - 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.
Completed: Added as a standing item – next report to return to the Committee in December.

AUGUST 2018 076/18 NED EXPENSES POLICY - THE COUNCIL REQUESTED CHANGES TO THE POLICY
The policy would be further reviewed and would return to Council.
Completed: Added to work plan for December.

AUGUST 2018 078/18 CQC: OVERVIEW OF FORTHCOMING INSPECTION - 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. She would also consider an additional session for governors.
Completed: Governor participation in 15 Step Challenge.

AUGUST 2018 078/18 CQC: OVERVIEW OF FORTHCOMING INSPECTION - 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 circulate the summary that goes to Quality and Performance.
Completed: Q&P summary circulated. **DL/NJ**

The Chief Executive and Corporate Governance Manager would reflect on how best to capture actions which are in progress to be completed.

Alison Jones queried the term ‘Medically Stable for Discharge patients’. The Chief Executive advised that previously used term ‘Medically Fit for Discharge‘ has now ben change to ‘Medically Stable for Discharge’. She explained that it better reflected the fact that while these patients were ready to leave acute hospital, they were not necessarily well. . She further explained that there were criteria and processes around transfer of these patients to the community.

091/18 CHAIR’S UPDATE

The Chair presented the paper detailing his activities since the last Council of Governors meeting in August. He highlighted the that he had taken part in several meetings with Research4Gloucestershire as the Trust is seeking to make research an even more important part of delivering care for patients. A research event is expected to take place in early summer 2019.

092/18 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented her update to the Council, highlighting that:

- The Trust secured Provider Sustainability Funding for Quarter 2
- The Trust has recently provided feedback on a number of service line consultations to support the Long Terms NHS Plan.
- Guidance around changes to funding and tariff has been received and further information and the impact of this will be relayed at the next Council meeting. **DL**
- 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. 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.
- The recent work around World Mental Health Day, the important conversations provoked and how the Trust intends to build on this as part of the Health and Wellbeing hub and further initiatives.

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

- Ann Lewis noted that following the recent change to visiting hours there had been a decrease in the incidence in falls and she queried the relationship between the two. The Chief Executive advised that attribution was not straightforward given the general focus on falls prevention.
- Jacky Martel expressed that she was pleased to hear about the work around World Mental Health Day and queried whether the Trust was involved in Public Health England's work around this; the Chief Executive responded that it was. The Director of Quality and Chief Nurse outlined the work being done within the Trust around enhanced care and how mental health was part of this, with an outline proposal going to the next Quality and Performance Committee.
- Anne Davies expressed concern regarding communications circulated by an MP discussing the Trust's accident and emergency (A&E) departments.
- Geoff Cave requested more detail around how the Trust intended to support patients and staff experiencing mental health issues. The Chief Executive requested the Lead Governor investigate whether this was an appropriate topic for a future Governors Quality Group. **AT**
- The Lead Governor applauded the focus on mental health. He also expressed disappointment with how the system was responding to the One Place Business Case and reconfiguration, in particular the delays in involving the public; Jacky Martel echoed the Lead Governor's comments. The Chief Executive acknowledged this and outlined the changes that would continue within the Trust. The Chief Executive felt that the further work needed would result in the system moving forward to a better position. Colin Greaves reinforced the importance of getting public consultation right, and felt that if done properly the county would get the right outcome.
- Alison Jones expressed concern regarding privacy within A&E when patients are cared for within corridors and wondered if this practice would cease following capital improvements to the department. The Director of Quality and Chief Nurse reassured that the Trust seldom used corridors but that this would be addressed as part of the capital scheme as the Trust would be reviewing and revisiting the flow of patients.

093/18 REPORTS FROM BOARD COMMITTEES

Gloucestershire Managed Services (GMS) – Chair's Report from 13 August 2018

Mike Napier reported the key messages from August's GMS Chair's report. He highlighted the proposed expansion of the Committees remit to cover estates strategy and the capital programme; the focus on domestic services, catering and sterile services the change of role of the Trust Contract Manager, who will now be supporting turnaround within GMS for a period of 3 months; the completion of the GMS plan and project wrap up report; and the discussions around GMS and the Trust's risk logs.

Jeremy Marchant queried whether the Committee had reviewed GMS longer term business plan. Mike Napier advised that the planning for year 2 had begun and a draft would be reviewed in the new calendar year. While the first year focused on quick wins and deliverables, Year 2's plan would be more ambitious and expansive.

Referring to concerns around cleaning, Nigel Johnson asked whether these were ongoing concerns or whether they had been highlighted through GMS. Mike Napier answered that the establishment of GMS had brought these issues to the forefront as the Trust was able to review standards and KPIs and see where these are falling short. He noted that the issue had arisen in Infection Control Committee and Quality and Performance Committee, and that while it related to all forms of cleaning the issue was particularly prevalent on the wards at Gloucester. The issue was noted to be cultural due to a lack of strong supervision. Work being undertaken to transfer expertise from Cheltenham site to Gloucester was noted.

Audit & Assurance Committee – Chair's Report from 17 July 2018

Rob Graves reported the key messages from July's Audit and Assurance Chair's report. He highlighted the significant input from the new internal auditors, the serious incident report, the desire for NEDs to have more involvement in scoping internal audits, the self-assessment of the Committee, the Trust's Risk Register, Emergency Planning and GMS audit arrangements. No questions were raised in response.

People and Organisational Development Committee – September Board Report & Chair's Report from 6 August 2018

The Director of People and Organisational Development presented the September Board report to the Council and provided and contemporary update via a presentation on turnover, sickness, appraisal compliance and mandatory training.

Geoff Cave observed that turnover had remained static and questioned how this reflected the number of vacancies and time taken to fill these. The Director of People and Organisational Development answered that this was dependant on staff role and group. She explained that the People and Organisational Development Committee often undertook deep dives into areas with particularly high turnover. She highlighted the work done around safe staffing levels as a method of assurance, with areas of concern reflected on the risk register. Geoff Cave further queried whether the Trust had the capacity to measure vacancies. The Director of People and Organisational Development answered that earlier in the summer the Executive Team made the decision to further invest in the recruitment team and as a result there have been clear benefits with faster turnaround. Retention however remains a concern and conversations with the divisions are underway around retention plans.

Jacky Martel asked whether the Trust ever reviewed whether staff who had left the Trust had caring responsibilities. The Director of People and Organisational Development answered that there had been a recent deep dive into exit reviews however she was unable to report the level related to caring responsibilities.

Alison Moon reported the key messages from the August's People and Organisational Development Chair's Report. She highlighted the deep dive into exit interviews and retention, the review of statutory and mandatory training compliance, the work underway within the recruitment team, the staff survey and freedom to speak up. She also noted that a joint assurance meeting between Quality and Performance and People and Organisational Development would take place on 25th October looking at patient survey and staff survey results as well as optimal staffing. No questions were raised in response.

Finance Committee – September Board Report & Chair's Report from 29 July 2018 and 30 August 2018

The Director of Finance presented the September Board report to the Council and provided a contemporary update via a presentation highlighting the Trust's finances as at the end of month 6.

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

- Colin Greaves expressed concern regarding the underperformance against specialised services. The Director of Finance said that while underperformance against specialised services had reduced, it had not been eliminated, but this was being minimised through specific actions to understand the drivers for this. Colin Greaves queried whether the Trust was over performing against its local commissioner, and the Director of Finance answered that year to date performance was break even.
- Jacky Martel asked about the overspend against non-pay. The Director of Finance explained that drugs overspend was around 600k in month 4 and while this continues in month 6, the variance is outweighed by the charge in income.
- Anne Davies expressed concern that the Trust was not meeting the better payment practice code target and reflected on the Trust's previous position in this regard. The Director of Finance explained that while the Trust was not at the desired level of compliance, when benchmarked against other Trust's it was in the top quartile. She stressed that the Trust was not deliberately holding any invoices and that everything submitted through the Trust framework was being paid, with no active cash management of invoices and all correct invoices paid within supplier terms.

Keith Norton reported the key messages from July and August's Finance Chair's reports. He highlighted the challenge within the Committees and the importance of learning from the past, the Cost Improvement Programme highlights, the Trust's performance against plan and the upcoming challenges. He also explained that the Committee remit would soon be expanding to include Digital. The Committee will now become the Finance and Digital Committee and its length will be extended.

Ann Lewis queried what was covered by the digital element of the Committee. Keith Norton explained this would include all aspects of IT and how the Trust engages patients and staff. The Chief Executive explained that the Committee would seek to establish the characteristics of a digitally mature organisation and how the Trust can work towards this. Ann Lewis further queried whether the Trust required more expertise in this area. The Chief Executive answered that while the Trust currently had a digital NED vacancy, it has recently appointed the Chief Digital and Information Officer, who brought in exceptional expertise. She concluded, however, that the Trust was some way behind other organisations; the Trust would now become a fast follower within the Global Digital Exemplars (GDE) programme and be paired with a digitally mature organisation.

Nigel Johnson noted the challenge around the Capital Programme and asked whether the Trust was representing the improvement for patients significantly enough. Keith Norton highlighted that there had been no assurance in response to this challenge and therefore this was needed to ensure significant rigour was being applied. The Chief Executive added that the Trust had reviewed how other Trusts had excelled in this area and identified that without dedicated resource this was not addressed well. She would therefore investigate dedicated resource and expertise in patient and public involvement alongside the Director of Strategy and Transformation [Post meeting note: it was agreed that appropriate resource would be recruited to support public and patient engagement on the Capital Programme and the Centres of Excellence Programme)

Quality & Performance Committee – September Board Report & Chair's Report from 26 July 2018 and 30 August 2018

The Chief Operating Officer presented the September Board Report to the Council and provided a contemporary update via a presentation on the Trust's performance figures. The Director of Quality and Chief Nurse also verbally updated the Council on the work being undertaken on the Quality and Performance Dashboard and progress being made with regards Clostridium Difficile (C.Diff).

Colin Greaves praised the Trust on its improvements with regarding C.Diff and queried whether there was a correlation between this and the improvements in cleaning. The Director of Quality and Chief Nurse advised that this was one aspect of the C.Diff Improvement plan and that the work around antimicrobial stewardship and the change in antibiotic guidelines was also having a significant effect. He praised the fantastic leadership by ward teams and the Deputy Director of Infection Prevention and Control.

Geoff Cave asked how the Trust managed the expectations of patients when the expected timescales were not being met. The Chief Operating Officer answered that the Trust had only not met the diagnostic target during one month over the last year and that the Trust was able to offer patients a timely service with regards to diagnostics. Geoff Cave shared the experience of a patient; the Chief Operating Officer requested they discuss this outside the meeting as a point of learning. **CL**

Claire Feehily reported the key messages from the July and August Quality and Performance Chair's reports. She highlighted the ongoing scrutiny of performance levels, the focus on the Patient Advise and Liaison Service (PALS) within the patient experience report, the infection control annual report, the focus on cleaning within the risk register, the pilot of real time data collection from wards, mental health, and how patients whose care is delayed are supported. She also acknowledged the valuable input of the CCG Quality representative.

Ann Lewis observed that the Friends and Family Test (FFT) response rate was often static and queried why this was. The Director of Quality and Chief Nurse answered that nationally this was static and that the Trust's response rates had overall improved. He advised further that the FFT was not the only measure the Trust reviewed and that real time monitoring would provide more granularity. Ann Lewis further questioned whether the FFT was really providing an insight into patient experience. The Director of Quality and Chief Nurse answered that the narrative that came through was helpful, particularly when tied with staff experience to identify themes.

Maggie Powell said that Healthwatch had experienced an increase in concerns regarding patients not being able to contact the PALS office via phone. The Director of Quality and Chief Nurse explained that there had been some availability issues in relation to staffing however these had since been resolved.

The Lead Governor thanked all NEDs for the Chair's reports and clear illustration of challenge and assurance, stressing how helpful this was.

094/18 THE ROLE OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Alison Moon gave a presentation explaining the role of the Trust's People and Organisational Development Committee. This covered the following points:

- Her background and experience as a director and executive coach, as well as her as her focus and values.
- The People and Organisational Development governance structure.
- The role and membership of the Committee.
- How the Committee fulfils its assurance role.
- Emerging areas of focus for the Committee with a focus on strategy.

The Chair thanked Alison Moon for her clear and thorough explanation of what the Committee was aiming to achieve.

[The Council adjourned for 10 minutes]

[Keith Norton, The Medical Director, Director of Strategy and Transformation, Chief Operating Officer and Director of People and Organisational Development left the meeting.]

095/18 CQC INSPECTION

The Director of Quality and Chief Nurse briefed the Council on the recent CQC Core Services inspection and feedback received in response to this. The CQC highlighted positives such as staff pride and engagement, clear and empowering leadership, a sense of improvement and the Journey to Outstanding, the Quality Academy, the learning disability team, and outpatient improvements. Areas identified for improvement included mental health, signage and environment, further embedding of infection control practices, and high reliability items and fridge temperatures. A an action plan has been developed in response; the 'grip' and oversight of issues will be evidenced at the upcoming Well-Led inspection.

It was noted that an unannounced out of hours inspection was yet to take place. The Use of Resources assessment would take place on 18th October and the Well-Led inspection between 13th – 15th November.

All governors thanked the Director of Quality and Chief Nurse for his leadership. Governors sought further clarification on the issues raised around mental health, fridge temperatures and signage which the Director of Quality and Chief Nurse detailed.

The Director of Corporate Governance briefed governors on the upcoming CQC Well Led Inspection. He explained the focus of the inspection, the 8 Well Led Key Lines of Enquiry (KLOEs) and likely questions governors might be asked. The Director of Corporate Governance advised that all governors had been invited to a CQC focus group on 12th October and invited governors to be open and honest with the inspectors.

Governors thanked the Corporate Governance Team for the comprehensive information provided, and the Chair reiterated that should any governors have any concerns or questions they could contact the Corporate Governance Team for advice. He also encouraged governors to attend the focus group.

096/18 REVISED GOVERNANCE AND NOMINATIONS COMMITTEE TERMS OF REFERENCE

The Director of Corporate Governance presented the revised Committee Terms of Reference (ToR) to the Council, noting that they had been approved by the Governance and Nominations Committee. Changes were noted to have been made to:

- The language around the role and purpose of the Committee, to mirror the revised text of the Constitution.
- Membership, to explicitly state that the membership of the Committee must include at least one Public Governor and at least one Staff Governor.
- Attendees, to reflect a standing invitation to the meeting for the Director of Corporate Governance (as set out in the Constitution).

The Lead Governor observed that the Terms of Reference included reference to governor alternates. He felt this was inappropriate considering members were elected and the Council agreed. The Director of Corporate Governance would remove. **LB**

RESOLVED: That the Council approve the revised Terms of Reference.

097/18 POLICY FOR THE COMPOSITION OF THE COUNCIL OF GOVERNORS

The Director of Corporate Governance presented the Policy for the Composition of the Council of Governors to the Committee, noting that this had been approved by the Governance and Nominations Committee. He outlined that it was best practice to detail the composition of the Council in a separate document alongside the Trust Constitution. The policy would outline areas where services were delivered and would be kept up-to-date with any changes in provision. He highlighted that areas served included areas where services were commissioned as well as the previously agreed areas for inclusion e.g. Bristol and Somerset.

The Lead Governor stressed the importance of recognising areas served as this also affected eligibility to be a Non Executive Director.

RESOLVED: That the Council approve the policy for the composition of the Council of Governors.

098/18 GOVERNANCE AND NOMINATIONS COMMITTEE ANNUAL ELECTIONS

The Corporate Governance Manager presented a paper on the election of governors to serve on the Governance and Nominations Committee. She explained the process, highlighting that:

- The membership of the Committee is renewed annually.
- The Lead Governor would be a member of the Committee by office alongside thee other elected governors.
- Appointed governors could apply however membership of the Committee must include one public governor and one staff governor.
- It was custom and practice that governors had served at least one year before seeking nomination.
- If there were no more than three nominations then candidates would be elected unopposed; however any more than three nominations would result in an election.
- The timeframe for nominations would be a week following the meeting, so that if an election was needed it could take place prior to the next Council of Governors.

The Lead Governor, Nigel Johnson and Tom Llewellyn shared their experiences of being a member of the Committee over the last year. They explained some of the work they had been involved in, including Non-Executive Directors recruitment and appraisals and governor conduct issues and encouraged governors to put themselves forward, if interested.

RESOLVED: That the Council of Governors note and agree the above process for appointing Governors to serve on the Governance and Nominations Committee and agree to proceed to nominations, and if required, elections.

099/18 GOVERNORS' LOG

The Chief Executive presented the Governors' Log. There were no questions.

100/18 ANY OTHER BUSINESS

- The Lead Governor commended the recent finance podcast and infographic and shared that he would look forward to this way of presenting information being extended to other areas.
- Colin Greaves advised that the CCG were seeking to form a NED lay member network for the Integrated Care System (ICS).
- Nigel Johnson highlighted the upcoming Diversity Network discussion on mental health due to take place on the 19th October.

101/18 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 19th December 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at **17:30**.

Papers for the next meeting: Papers for the next meeting are to be logged with the Corporate Governance Team no later than **17:00** on **Monday 10th December 2018**

102/18 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
19th December 2018

ITEM 16

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 17

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 18

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 second Thursday 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 12:30.

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 Corporate Governance Team 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 Corporate Governance Team, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN or by e-mail to ghn-tr.corporategovernance@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 the Corporate Governance Team on 0300 422 2932 or e-mail ghn-tr.corporategovernance@nhs.net

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

"Does Gloucestershire Hospitals NHS Foundation Trust have a clear narrative of diversity and inclusion that is agreed by the Board and effectively communicated to staff, and which staff at every level can have confidence in?"

The Board have approved a number of action plans which link to diversity and inclusion. Our Trust have provided the following narrative on diversity and inclusion:

The principles of equality, diversity and inclusion are fundamental to the successful delivery of patient care and underpin our vision of "best care for everyone". Of course, along with patients and families 'everyone' includes the staff and volunteers who deliver a wide range of services – equality, diversity and inclusion are key enablers for an engaged, productive and safe workforce.

The value of diversity is integrated in our training programmes from induction to people management courses and in the networks and working groups the Trust support. All staff undertake equality, diversity and inclusion training as part of their induction initially and every 3 years thereafter.

The Trust has developed a Diversity Network which is open to all staff to join. The network collaborates with the Trust to eliminate unlawful discrimination experienced by staff and is well supported by the Trust Leadership Team and 100 leaders network. It also provides a signposting and support function where issues can be discussed in a safe and confidential environment. Network members are also trained to assist in bullying and harassment cases and advise on policy decisions. Throughout the year the network celebrates the diversity of our Trust by promoting and participating in local and national events which recognise and champion characteristics which can be more vulnerable to discrimination. Board Champions for protected characteristics have been agreed for 2019 and will be reverse mentored by members of the Diversity Network. Regular updates on Equality and Diversity activities are provided in a quarterly Trust wide newsletter, posters and flyers are visible to promote the diversity network and its events, alongside promotion within the weekly Blog.

Last financial year (2017/18) the Equality, Diversity and Inclusion (EDI) Steering Group continued to promote and embed our principles of equality, diversity and inclusion into all policy decisions and service delivery within our Trust. Details of some of our achievements and progress can be found in our recently published Equality report (see link) which meets the requirements of the Public Sector Equality Duty (PSED) and the Equality Delivery System (EDS2). https://www.gloshospitals.nhs.uk/about-us/our-trust/equality-diversity/

During 2018/19 our main priority will be to develop in consultation with staff and patients new 4-year Equality Objectives. These will also incorporate Human Rights principles.

In terms of 'staff at every level having confidence in the Trusts narrative' we can measure this in a number of ways:

- Diversity network membership (which has grown over the last year) and participation in network events (starting to increase);
- WRES report (which highlights the differences in experience between white and BAME staff and is analysed for inclusion in the equality of opportunity plan);
- Feedback from the staff survey and Freedom to Speak up guardian on our processes and successes in tackling issues such as discrimination.
- The 2017 results show that the vast majority of staff do perceive the Trust as fair and have a good experience with us, but there is a portion who do not share these perceptions and our equality of opportunity plan looks to actively address these;
    - Key finding 21 – 86 % of staff believe the organisation provides equal opportunities for career progression/promotion (14% disagree)

- Key Finding 30 – 3.61 (engagement score and has a maximum value of 5) regard fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Key Finding 31 – 3.54 (engagement score) staff confidence and security in reporting unsafe clinical practice
- Key Finding 19 – 3.5 (engagement score) organisation/management taking interest in and action on health/wellbeing
- Key Finding 25 - 26% of staff experience harassment, bullying or abuse from staff

"What joined up plan does Gloucestershire Hospitals NHS Foundation Trust have to address health inequalities within the Trust?"

Please take a look at two documents published on our Trust website: https://www.gloshospitals.nhs.uk/about-us/reports-and-publications/

- Equality Report 2017-18
- Quality Account 2017-18

If you need more detail, there are also a number of enabling strategies (that will be incorporated into the Trust's new Quality Strategy due to be published in June 2019):

- Improving Patient & Carer Experience
- Dementia Strategy
- Patient Health and Wellbeing

"What joined up plan does Gloucestershire Hospitals NHS Foundation Trust have for addressing health inequalities with their partner organisations covering the whole of Gloucestershire?"

Please take a look at the Sustainability and Transformation Plan (STP), which is designed to close the Health and Wellbeing Gap; Care and Quality Gap and Finance and Efficiency Gap: https://www.gloucestershireccg.nhs.uk/stp-documents/

ITEM 19

ANY OTHER BUSINESS

DISCUSSION