AGENDA AND SUPPORTING PAPERS
FOR THE MEETING OF THE
GLOUCESTERSHIRE HOSPITALS
NHS FOUNDATION TRUST
MAIN BOARD
TO BE HELD AT 9.00 a.m.
IN ROOM 3, SANDFORD EDUCATION CENTRE, CHELTENHAM
ON THURSDAY 13 SEPTEMBER 2018

(PLEASE NOTE: Date and venue for this meeting.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 13 September 2018** in the **Room 3, Sandford Education Centre, Cheltenham General Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

15th August 2018

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
3.	Patient Story			09:02
4.	Minutes of the meeting held on 12 July 2018	**PAPER**	To approve	09:32
5.	Matters Arising	**PAPER**	To note	09:35
6.	Chair's Update	**PAPER** (Peter Lachecki)	To note	09:40
7.	Chief Executive's Report	**PAPER** (Deborah Lee)	To note	09:45
8.	Quality and Performance:		For assurance	10:00
	• Quality and Performance Report	**PAPER** (Steve Hams, Sean Elyan, Caroline Landon)		
	• Assurance Reports of the Chair of the Quality and Performance Committee meetings held on 26 July 2018 and 30 August 2018	**PAPER** (Claire Feehily)		
	• Trust Risk Register	**PAPER** (Lukasz Bohdan)		
9.	Financial Performance:		For assurance	10:20
	• Report of the Finance Director	**PAPER** (Sarah Stansfield)		
	• Assurance Reports of the Chair of the Finance Committee meetings held on 29 July 2018 and 30 August 2018	**PAPER** (Keith Norton)		
	Break			10:35 – 10:45
10.	People and Organisational Development:		For assurance	10:45
	• Report of the Director of People and Organisational Development	**PAPER** (Emma Wood)		
	• Assurance Report of the Chair of the People and Organisational Development Committee meeting held on 6 August 2018	**PAPER** (Alison Moon)		
11.	Audit and Assurance:		For Assurance	11:00

	• Report of the Chair of the Audit and Assurance Committee meeting held on 17 July 2018	**PAPER** (Rob Graves)		
	• Annual Audit Letter	**PAPER** (Rob Graves)		
	• Board Assurance Framework	**PAPER** (Lukasz Bohdan)		
	• Annual Trust Seal Report	**PAPER** (Lukasz Bohdan)		
12.	Gloucestershire Managed Services (GMS):		**For assurance**	11:15
	• Report of the Chair of the GMS Committee meeting held on 13 August 2018	**PAPER** (Mike Napier)		
13.	Amendments to the Trust Constitution	**PAPER** (Lukasz Bohdan)	To Approve	11:25
14.	Annual Safeguarding Reports - Safeguarding Adults - Safeguarding Children	**PAPER** (Steve Hams)	To Note	11:35
15.	Infection Control Annual Report	**PAPER** (Steve Hams)	To Note	11:45
16.	GHNHSFT Annual Report	**PAPER** (Lukasz Bohdan)	For information	11:55
17.	SmartCare Progress Report	**PAPER** (Mark Hutchinson)	For assurance	12:05
18.	Minutes of the meeting of the Council of Governors held on 20 June 2018	**PAPER** (Peter Lachecki)	To note	12:15
	Governor Questions			
19.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions		To discuss	12:20
	Staff Questions			
20.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		To discuss	12:30
	Public Questions			
21.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		To discuss	12:40
	Any Other Business			
22.	Items for the Next Meeting and Any Other Business		To note	12:50
	Lunch Break			**13:00 – 13:30**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 4th SEPTEMBER 2018

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 8th November 2018** 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
Mike Napier	Dr Sean Elyan, Medical Director
Keith Norton	Steve Hams, Director of Quality and Chief Nurse
Alison Moon	Mark Hutchinson, Chief Digital and Information Officer
	Caroline Landon, Chief Operating Officer
	Simon Lanceley, Director of Strategy and Transformation
	Sarah Stansfield, Director of Finance
	Emma Wood, Director of People and Deputy Chief Executive

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 12 JULY AT 9 AM

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

PRESENT	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Dr Sean Elyan	Medical Director
	Steve Hams	Director of Quality and Chief Nurse
	Simon Lanceley	Director of Strategy and Transformation
	Caroline Landon	Chief Operating Officer
	Sarah Stansfield	Interim Director of Finance
	Emma Wood	Director of People and Deputy Chief Executive
	Tracey Barber	Non-Executive Director
	Dr Claire Feehily	Non-Executive Director
	Rob Graves	Non-Executive Director
	Alison Moon	Non-Executive Director
	Mike Napier	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	Lukasz Bohdan	Director of Corporate Governance
IN ATTENDANCE	Suzie Cro	Head of Patient Experience Improvement & Deputy Director of Quality Patient – Patient Story
	Mark Hutchinson	Digital Recovery Consultant
	Craig Macfarlane	Head of Communications
	Michele Pashley	PA to the Director of People & Organisational Development and Deputy Chief Executive
	Dr Simon Pirie	Guardian for Safe Working
PUBLIC & PRESS	One governor, two members of the public.	

The Chair welcomed all to the meeting.

126/18 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

127/18 PATIENT STORY

The Head of Patient Experience Improvement & Deputy Director of Quality introduced Becky, daughter-in-law of patient Maggie. Maggie had many health issues including breast cancer, osteoporosis and other conditions. In 2017 she had a stroke and had been admitted to Gloucestershire Royal Hospital.

Becky shared Maggie's story, and noted that:

- They received incredible care and treatment from the hospital.
- They were very happy with the rehabilitation and physiotherapy service.
- They found it difficult to visit Maggie during the stated visiting times as both her and her husband work full time and out of county.
- Her husband Lewis (Maggie's son) is an only child so all the care for Maggie falls to him and Becky which has a considerable impact..
- Maggie fell within 4 days of discharge and was sent to Bourton-on-the

Water hospital. Maggie then fell again after being discharged for the second time.
- She raised the arrangements between being discharged and going home alone and suggested a direct communication system between the patient's family and the hospital i.e. text or a portal to go through would have made the transition much smoother. She felt the hospital wasn't geared up to work with carers who were in full time employment.
- As Becky was not next of kin, it was harder to get information despite being a key carer to Maggie.

The Chair thanked Becky for sharing her story and invited questions from the Board. The following points and queries were raised:

-
- The Director of People reflected on Becky's point about her not being able to discuss Maggie's care with the hospital. She felt that the patient should be able to give permission for family members to discuss care.
- The Medical Director asked Becky where she felt the best place to spend the health budget would be if she was asked; Becky replied that she would spend it in the home by having a detailed assessment and then providing physio at home, handrails, IT access to the hospital etc.
- Dr Feehily questioned how the Trust can help a stroke patient and suggested a patient passport which includes the names of the family members that staff can talk to.
- Director of Quality and Chief Nurse shared that the visiting hours had recently changed and that wards were now open from 9am to 9pm. As part of the enhanced care programme, there is now a care circle/ partnership. Becky welcomed this and said it would have made a huge difference to her and Lewis if the hours had been in place when Maggie was in hospital.
- Mr Graves suggested Becky share her experience with Gloucestershire Care Services (GCS) Board who directly manage the community services. The Trust Chair would discuss this further with the Chair of GCS. **PL**
- Mr Napier said he was left thinking what would happen to Maggie if Becky and Lewis were not around. This was not a question for Becky but a question the Trust should be asking. The Chief Executive said Maggie would still get good care but possibly not in a setting of her choosing i.e. a care home rather than her own home.
- The Chief Executive felt that the family shouldn't have to pay privately for the physiotherapy services that Maggie was receiving as they seemed to be core to her rehabilitation. She asked the Chief Nurse to follow this up. **SH**
- Mr Norton asked two questions of the Executives:
  1) When are we going to get a patient portal? The Digital Recovery Consultant advised that the Trust was working with all services and was investigating a joined up way of working as carers and patients only want to log in once. The Chief Executive noted this was a medium to long term plan and the Trust needed to find a simple way of making it easier to communicate now. The Medical Director suggested liaising with paediatrics as they worked on finding ways of using social media to link with children and young adults.
  2) What is the Trust doing about 'complicated' families to establish clarity around which members of the family can be spoken to? The Director of Quality and Chief Nurse said this was currently being worked through in the Enhanced Care Programme.

The Trust Chair thanked Becky for attending the Board and assured her that the Board discuss and review the actions from the Patients Story every three months and check on progress.

The Director of Quality and Chief Nurse shared a video on the work that had been carried out with the NHS Improvement (NHSI) Enhanced Care Collaborative. The teams were challenged by NHSI to find a number of interventions which would help patients and /or carers. Over 90 days the Enhanced Care collaboration Team have worked on:

- Improving patient and family experience
- Improving staff experience
- Improving safety and reduce harm
- Delivering better value to our patients.

The Board applauded the work and thanked the Chief Nurse for his leadership in this space.

128/18 MINUTES OF THE MEETING HELD ON 10 MAY 2018

RESOLVED: The minutes of the meeting held on 10 May 2018 were agreed as a correct record and signed by the Chair.

129/18 MATTERS ARISING

MARCH 2018 036/18 PATIENT STORY - CONSIDERING THE REQUEST FOR FURTHER PORTERING STAFF: THE DIRECTOR OF QUALITY AND CHIEF NURSE NOTED THE TRANSFER TEAM IN THE ED AND ACUTE MEDICAL UNIT (AMU) BUT RECOGNISED THAT THERE HAD BEEN ISSUES WITH ATTRACTING DEDICATED PORTERS

The Chief Operating Officer concurred, noting that this needed to be improved for next winter and a pilot was shortly due to commence.

Ongoing: Trial of dedicated porter transfer team commenced in April, proved successful and more robust than rostering HCAs. Trial extended into May; Director of Emergency Care is linking in with portering team to understand cost and potential for embedding.

MARCH 2018 047/18 GOVERNORS' QUESTIONS - NEW EXTERNAL AUDITORS WERE NOTED AND THE LEAD GOVERNOR WONDERED WHO WOULD HOLD THEM RESPONSIBLE FOR ACTIONING WHAT WAS PROMISED ON RECRUITMENT

Mr Graves advised that he would raise this with them when they next met.

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

MAY 2018 087/18 SMARTCARE PROGRESS REPORT - DR FEEHILY ASKED IF FURTHER DETAIL ON PROGRESS COULD BE SHARED WITH THE BOARD SO THAT THERE WAS FURTHER CLARITY ON DIRECTION AND SPEED

The Chief Executive encouraged a discussion regarding how the Board received assurance in respect of this programme, rather than risk bringing inappropriate levels of detail to the Board.

Ongoing: Discussion ongoing between Chair and Chief Executive in respect of approach to Board assurance. Post meeting note – Digital Board sub-committee to be established with effect from October 2018.

MARCH 2018 036/18 PATIENT - STORY CALL BELLS AND PHONE

CHARGERS FOR A&E WHEN PATIENTS ARE NOT CARED FOR IN A CUBICLE.
The Digital Recovery Consultant advised that he would investigate and resolve this as soon as possible.
Completed: Call bells now in place in the corridors of the Emergency Department Team at Gloucestershire Royal Hospital.

MAY 2018 077/18 PATIENT STORY - THE DIRECTOR OF QUALITY AND CHIEF NURSE ASKED WHETHER MR TUCKER WAS ASSIGNED A SPECIALIST NURSE. HE ANSWERED THAT HE WAS GIVEN A NAME BUT NEVER FORMED A RELATIONSHIP WITH THEM. ON REFLECTION HE FELT THIS WOULD HAVE BEEN HELPFUL
The Director of Quality and Chief Nurse felt they could and should have been part of the journey, and would follow this up.
Completed: Specialist Nurses are assigned to all cancer patients, Patient's experience has been shared with the Lead Nurse for Cancer Services who will ensure that specialist nurses provide clear guidance to patients on what they can expect from their specialist nurse.

MAY 2018 077/18 PATIENT STORY - THE MEDICAL DIRECTOR POINTED OUT THAT AS AN ONCOLOGY PATIENT MR TUCKER SHOULD NOT HAVE BEEN PAYING FOR PARKING; HE SHOULD HAVE HAD A PARKING PASS
The Medical Director would investigate how this was being communicated to patients; he would further look into the initial ultrasound scan issues made by Mr Tucker.
Completed: Patient was given parking pass but availability of Oncology parking slots is limited. Further investigation of initial ultrasound findings is ongoing and direct feedback to Mr Tucker will follow.

MAY 2018 088/18 BOARD ASSURANCE FRAMEWORK - MR GRAVES FELT IT WOULD BE HELPFUL IF THE APPENDIX INCLUDED THE COMMITTEE TO DISPLAY OWNERSHIP AND OVERSIGHT
The Director of Corporate Governance would include.
Completed: This will be included in all future reporting.

130/18 CHAIR'S UPDATE

The Chair presented the paper detailing his activities since the last Board meeting.

131/18 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented her report to the Board and highlighted the main issue of concern remains the increasing demands being placed on the hospital both in respect of A&E attendances and cancer referrals. She reflected that the summer should be a period when staff can restore resilience in anticipation of the next winter but this had not been possible due to some of the highest ever levels of summer activity. The Clinical Commissioning Group (CCG) and partners are engaged and recognise this problem however there has been limited impact.

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

Ms Moon commented that referrals for cancers had also increased in the last few months and felt a lot was being asked from primary care and asked if the Chief Executive felt partners were engaged and wanted to be part of the

solution. The Chief Executive replied there was evidence of action however it was not having the impact required yet. She also noted that a change in national guidance was requiring GPs to refer more patients with suspected cancer than previously. She advised that new referral paper was in place to help GPs understand what to refer urgently and what not.

Mr Graves asked what work has been carried out in the past to try and understand the behaviours of patients attending A&E rather than seeing their GP. The Chief Executive replied that numerous surveys had been carried out asking patients questions such 'why are you here?', 'did you contact any other health service prior to attending A&E'. There is anecdotal evidence that patients find it very difficult to access primary care in a timely way. She said there was evidence of more appointments being made available under the GP Extended Hours initiative but patients appeared to be taking first recourse to A&E possibly because this was the quickest way to access specialist advice and diagnostic tests.

The Chief Operating Officer added that the CCG had been doing their own survey over the last four Mondays and recognised the problems. Patients will be streamed through over the next four Mondays to the GP Streaming Service. Her concern is morale of staff as the pressure is unrelenting and she summarised the action being taken to support staff.

The Chief Executive suggested again that patients should be sent back to their GP if, following a robust clinical triage, they are deemed to be fit enough to do so otherwise the Trust was at risk of condoning this patient behaviour. The Chief Operating Officer confirmed this was now happening although one patient had been given an appointment which was a five minute walk away and they refused to leave the building, so this was not straight forward.

The Trust Chair asked the Director of Quality and Chief Nurse if he felt the dwindling number of the University of West England (UWE) students will have an impact on Gloucestershire students, the Director of Quality and Chief Nurse responded that most of the UWE students would go to Bristol. The Director of Quality and Chief Nurse confirmed that he didn't anticipate a negative effect on our Trust and the feedback received from students was positive. The Director of People confirmed that the Trust had more placements for student nurses than ever before i.e. between 95 -160 and now had three nursing degree providers to work with so he was confident we would still attract the same number of learners despite the loss of the UWE Gloucester campus.

The Trust Chair mentioned the success of the NHS70 birthday party and thanked everyone who took part in it. The feedback received was that staff appreciated the leaders taking their time to go around the wards to see them.
The Director of People mentioned that feedback has been collated and will be shared and discussed at the Executive Team meeting next week.

The Chief Executive mentioned the turnaround of Day Surgery Unit, driven by concerns expressed by staff mainly through the freedom to speak up route. She said that the impact on patient experience and staff morale had been huge and the operational teams were committed to maintaining the change.

The Chair thanked the Chief Executive for her comprehensive report.

132/18 QUALITY AND PERFORMANCE:

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

- ED achieved 91.6% in May and delivered above trajectory in quarter 1; the Trust is working to over achieve in quarter 2.
- There has been a problem regarding diagnostics and for the first time in 7 months the standard has not been delivered, there were operational issues with echo and sleep studies which have now been addressed and will be back on track in June.
- There has been a slight decline around the 2 week wait in lower gastrointestinal surgery (GI) however, as of today there is no patient in lower GI without an appointment.
- Ten out of twelve specialties are now sustaining the 2 week wait which is the first time since quarter 2 in 2014.

The Chief Nurse highlighted the following:-

- In terms of infection control, to give the Board reassurance, the Trust is now tracking through the Quality Performance report all five key infections that NHSI require a report on.
- The June performance on Clostridium Difficile (C.Diff) looks significantly better than May, as there were only 2 cases reported. The Director of Quality and Chief Nurse is hopeful that the improvements that are being worked upon i.e. cleaning and antibiotic prescribing is beginning to effect change. He stated however, that he and his team were not complacent and this remained a huge focus.

The Medical Director highlighted that a new 2 week wait referral form has been introduced to improve the quality of referral and clarity to patients why they are being referred. There has also been a 10% improvement in discharge summaries which takes the Trust to 70% being sent electronically to the patient's GP within 24 hours.

The Director of People highlighted that the 2 indicators for sickness absence remain static and turnover is improving and is now showing as amber.

The Finance Director commented that the Finance dial on the scorecard was incorrectly stated RED as there are 2 months of green data in the report.

Mr Napier enquired about the Friends and Family targets, the Chief Nurse replied that this was nationally set at 93%.

RESOLVED: That the Trust Board receives the Report as assurance that the Quality & Performance Committee, Trust Leadership 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 31 MAY 2018 AND 28 JUNE 2018

Dr Feehily presented the assurance report from May noting the following from the Committee:

- Revised arrangements are in place for reducing the number of hospital initiated cancellation of appointments and the CCG is running a campaign to reduce the number of patient non-attendances.
- Progress and intentions regarding clinic typing backlogs and how progress could be more visible in committee reporting. Backlogs are significantly reduced though hot spots remain and the Planned Care

Programme Board has oversight.

Ms Moon presented the assurance report from June noting the following from the Committee:

- A robust C.Diff improvement plan is in place, informed by an external review.
- The Never Events external review, whilst concerns exist about the review methodology and subsequent report: it was excellent to see senior divisional medical and nursing leaders owning the plan and actions required.
- The nursing assessment and accreditation systems will provide both assurance but equally importantly the route to continual quality improvement. Whilst primarily a nursing tool, the Committee had asked Mr Hams to ensure involvement of all care professionals.

RESOVED: That the reports be noted.

TRUST RISK REGISTER

The Chief Executive presented the Trust Risk Register report and highlighted that there were limited changes with no new risks added since the last report in and two risks have now been downgraded following review by the Trust Leadership Team.

Dr Feehily reflected on the effect on staff due to the demand on the system and the constant pressure they have been under during the summer and asked what methodology there was to see if it constituted a risk. The Chief Executive said the risk would emanate through the divisional route, it would be considered at Trust Leadership Team and then through to the register, also at the end of the Board meeting the Executives discuss risks and whether they have captured everything. The Chief Executive asked the Chief Operating Office to review the risk register and consider whether this risk was adequately captured and if not ensure it was added. **CL**

Mr Napier shared concern regarding the 8 risks identified at divisional level that had not migrated to the Trust Register, the same number as last month, and asked if the Trust should be working harder to get the risks pushed through. She explained that the risk cycle was 2 months long, firstly it goes through a service line and then to the Divisional Board in order to sponsor it to an Executive Director. The Chief Executive said these risks will be checked but she is confident they will not be the same 8 risks as last time.

The Chief Executive invited Mr Napier to observe the Risk Management Group if he would like to learn more about the ways in which risk is overseen in the organisation.

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

133/18 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE DIRECTOR

The Director of Finance presented the Financial Performance Report for the

end of Month 02 of the 2018/19 financial year. Key points highlighted were:

- The Board approved budget for the 2018/19 financial year was a deficit of £29.7 on a control total basis. The Board has since approved a revised control total of £26.9m excluding Provider Sustainability Funding of £8.1m: this will be reflected in the Month 3 reporting.
- Pay expenditure is showing a favourable variance of £0.8m against budgeted levels.
- Non-pay is £0.8m overspent against budget. Drug expenditure is showing £0.3m adverse variance whilst clinical supplies expenditure is £0.4m adverse. The position is off-set by over performance on pass-through income of £0.7m.
- The Chief Executive asked for clarity on outpatients. The Finance Director said that outpatients are slightly under for the year although nowhere near the material of variance as last year, there is recovery in outpatient's income.
- The Chief Operating Officer reported outpatient clinic utilisation has increased to 92%.
- The Chief Executive said it was not clear, given the improved utilisation whether the under performance reflected reduced activity or failure to capture and record activity appropriately. She asked the Director of Finance and Chief Operating Officer to investigate this. **CL/SS**
- The Central Booking Office will move in to the elective access team under the leadership of Felicity Taylor-Drewe with the aim of expediting recovery.

In response to the Director of Finance:

Mr Graves asked if payables would cause a cash flow problem. The Finance Director said a feature of the payables position is the number of risk adjustments on accrual which relate to income rather than specific trade payables and therefore did not represent a cash flow risk.

Dr Feehily asked what safeguards were in place to ensure patients who have several health issues are being cared for efficiently and nothing is being missed. The Chief Operating Officer said one of the challenges around cancer pathways was the consultant to consultant pathway which isn't always efficient, this is one of the reasons the Central Booking Office (CBO) is being moved into elective access. There are conversations on how to use Infoflex better and systems that talk to each other. The Chief Operating Officer feels that in twelve months' time if a patient needs to access multiple services or pathways it will be linked much better but major improvements ahead of this are unlikely due to the reliance on a technology solution.

The Trust Chair questioned the non-pay expenditure and asked if this was a budget setting issue, similar to the drug budget issue last year. The Finance Director said there was still some investigation to do to see what was driving the adverse variance, however was confident this was not a budget setting issue. The clinical supplies budget for 18/19 is largely based on the outturn for 17/18 which was a reliable baseline.

RESOLVED: That the Board receive this report for assurance in respect of the Trust's Financial Position and note delivery of the plan at month 2.

ASSURANCE REPORTS OF THE CHAIR OF THE FINANCE COMMITTEE MEETINGS HELD ON 30 MAY 2018 AND 27 JUNE 2018

Mr Norton presented the May assurance report highlighting three areas of challenge within the Committee:

- How as a committee do we seek assurance without having to go into every last detail?
- Non-pay variance - the Committee need to fully understand it; consequently, the Committee asked the Finance Director to include more variance reporting. With better understanding they will be able to seek assurance.
- CIP / Procurement – there is an issue with budgets and the Committee have asked for divisional representatives to attend to discuss how their budgets work.

Mr Napier presented the June assurance report, highlighting that the Committee:

- Had looked at areas of concern such as procurement, which was also part of the CIP discussion, and have been invited to attend the August meeting to see if any help or positive influence can be offered.
- is looking at getting more information on the revenue streams to understand the activity level below it.
- queried whether the Trust planned to spend more this year on the Capital Programme to prevent an increase in the backlog.

RESOLVED: That the report be noted.

[The Board adjourned for 10 minutes]

134/18 WORKFORCE

REPORT OF THE DIRECTOR OF PEOPLE AND ORGANISATIONAL DEVELOPMENT

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

- Sickness percentage is static.
- Turnover is decreasing
- The Health Care Assistant (HCA) retention project has been carried out and the same format will now be used to look at Medical Secretaries.
- Appraisal and Mandatory reporting has reduced to quarterly due to a convergence of several national system updates to ESR.
- Increased number of nurse degree students.
- A new clear career framework for nurses has now been published on line.
- Launch of the Arc engagement App.
- Launch of the Happy App in unscheduled care.

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

- Dr Feehily said she was pleased to hear that some of the material from the staff survey is showing improvements however there were some tough questions around quality and safety and asked if challenged would the Trust be able to say it have have been sufficiently responsive in understanding what has been said and respond quickly where necessary? The Director of People said the Inpatient Survey has also been received and a member of the OD team has been assigned to

align both staff and patient surveys and look for common themes. These findings will go to both the Quality and Performance Committee and Patient Experience Improvement Group to make sure there is the triangulation of data. The Chief Executive Officer said she met with Abigail Hopewell to frame the question for the next 100 Leaders day and this is exactly what was discussed. The Chief Nurse also spoke about Annex 1 which described strengthening nursing leadership and recruitment which will have a positive on staff.

- The Director of Quality and Chief Nurse further said there had been a discussion on connecting the Workforce Committee with the Quality and Performance Committee. Ms Moon agreed and felt there were areas where the committees were interested in the same issues. The Director of Quality and Chief Nurse said the work which reviews safer staffing would be carried out at the end of July and first week of August, this would give a view as to whether the Trust has enough nurses/HCAs based on the demand.

The Chief Executive asked about the plan to ensure appraisal rates hit 90% by September. The Deputy Chief Executive and Director of People said this issue was discussed at the away day and there is commitment by the Executives to go to their teams as this an important agenda item. The Chief Operating Officer and Director of People are working together to provide a trajectory, the Chief Executive agreed and would like to see it; she felt that every ward sister / team leader should have a trajectory for their area and that we must support teams to create time for this important activity as we know at times of operational pressure this becomes a lower priority and there is evidence of staff coming doing appraisal on their days off, which shouldn't be required given the importance of time off for staff wellbeing.

The Chief Executive asked about the apprentice levy and whether the Trust had secured the target level of apprentices. The Director of People said some of the standards which would help are not available and there was no clarity from the government about what happens if you don't meet the target. She felt the apprenticeship strategy needed more work on the numbers of apprentices and the business side as there was now a commitment that at the end of the apprenticeship to offer the individual a substantive role which wasn't the case before. This is being investigated and a report on the Apprenticeship Strategy will come to a future Workforce Committee. Date to be confirmed to NJ for Committee Work Plan. **EW**

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

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

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

- Changing the name from the 'Workforce Committee' to the 'People and Organisational Development (OD)' Committee was agreed.
- The Committee received the Workforce Race and Equality Standard (WRES report and a recommendation that Board undergo Unconscious Bias training was agreed.
- Received a Health Care Assistant action plan and it was agreed to set evaluation criteria and SMART targets.

RESOLVED: That the report be noted and that the Board agree the change to the name of the Workforce Committee as noted above.

135/18 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 15th MAY 2018

Mr Graves presented the May assurance report noting the following from the Committee:

- Manual listing of signatories, is there system opportunities that will remove the need for these?
- External audit, consideration of the processes and performance factors that influence the value for money conclusion
- Business continuity, this will be reviewed by each future meeting pending achieving comprehensive progress.

RESOLVED: That the report be noted.

136/18 GLOUCESTERSHIRE MANAGED SERVICES (GMS)

REPORT OF THE CHAIR OF THE GMS COMMITTEE MEETING HELD ON 14 JUNE 2018

Mr Graves presented the June assurance report noting that this was the second meeting of the Committee and continues to be developmental.

There was a lot of discussion around risk and encouragingly a number of the risks have now been closed.

It was decided not to have a separate Audit and Assurance Committee for GMS; GMS audit issues would be discussed at the (Group) Audit and Assurance Committee.

The Trust Chair asked about the GMS workforce. The Director of People responded saying there had been a lot of work on engagement by the management team, there had been no increase in turnover or grievances: an indicator that staff are satisfied. The Chief Executive asked that the question is posed to the committee and formal measures of staff satisfaction are established. **EW**

137/18 SMARTCARE PROGRESS REPORT

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

- The number of open pathways within the TrakCare system have decreased from 300,000 to 205,677 since January, which is the overall indicator of success that we are addressing data quality issues.
- Importantly, the occurrence of new data quality issues is now negligible due to the development of Standard Operating Procedures and staff re-training; the focus is now clearing the backlog.
- An overall positive story with a significant downward volume change across most data quality issues.

- The new approach to Outpatient Outcomes went live on 20th June with a very positive response from staff working in outpatients and immediate evidence of improvements in the number of attendances appropriately captured.
- A decision on when to upgrade the TrakCare system needs to be taken, as this will address some of the issues being experienced and the SmartCare Programme Board will make this decision at its October Board.

Dr Feehily asked how the SmartCare Board was cited on risks. The Chief Executive Officer said that the Board had oversight of risks through two different lenses; risks that the deployment of the system had introduced which required action from the SmartCare Programme and risks associated with the programme itself. Risks relating to patient care and clinical safety are closely monitored through the SmartCare Board's Clinical Systems Sub-group.

Dr Feehily enquired about the risk alluded to in section 7 of the report, the Digital Recovery Consultant responded saying there were just three people in the team who are able to make changes to the system configuration, so this becomes a bottleneck to development. A further three have now been recruited and the forward plan includes further expansion.

RESOLVED: That the Board note the report.

138/18 NHS IMPROVEMENT UNDERTAKINGS

- **FINANCIAL UNDERTAKINGS**

RESOLVED: That the Board note that following NHS Improvement's Regional Provider Support Group's 22 May 2018 meeting, it was concluded that the Trust had complied with the requirements of a number of the financial governance enforcement undertakings and that NHS Improvement should issue the Trust with a compliance certificate in respect of these undertakings.

139/18 REPORT FROM THE WEST OF ENGLAND ACADEMIC HEALTH SCIENCE NETWORK

The Chief Executive presented the report and highlighted:-

The Chief Executive represents the six West of England Acute Trusts as a voting member of the AHSN Board. It is reputed to be one of the most effective AHSNs in England. A lot of the work carried out has been adopted nationally and the Trust benefits significantly from its membership.

140/18 RESEARCH REPORT

The Director of Strategy and Transformation presented the update on Research in Gloucestershire Hospitals NHS Foundation Trust and highlighted:-

- A feeling of renewed energy around research prompted by the discussion held in January and supported by the objective that has been signed up to.
- Good activity over the last six months supported by the Director of Quality and Chief Nurse and around Nurse and Allied Health Professional engagement.
- Plan to refresh the overall strategy for research.
- 100 research projects currently live.
- The issue with haematology laboratory accreditation has only affected one trial which has been put on hold and will have a £16k revenue

impact on the service. There is a recovery plan to get the laboratory back up to standard being overseen by TLT.
- Good patient feedback on how patients value the opportunity to take part in clinical trials.
- NHS Inpatient Survey will include a question around research in the future.
- The Trust Chief Executive Chairs the West of England Clinical Research Network (CRN).

In response to the report:-

Dr Feehily asked if there were opportunities to tap into the research carried out in primary care. The Director of Strategy and Transformation said he would be getting involved in the Integrated Locality Board and the CEO confirmed that the CRN also governs research in primary care.

The Trust Chair said he was planning to get involved in a network called Research for Gloucestershire which includes Public Health, CCG, GCS, 2gether the Council and the University. There is a lot of willingness in the network to drive research forward.

RESOLVED
The Board noted the report and confirmed its support for developing the research activities of the Trust.

141/18 ANNUAL ORGAN DONATION REPORT

The Medical Director presented the Organ Donation Activities Report and highlighted:-

- The success in finding people who may donate organs and the translation of organs available for donation. Beyond this report the three most recent potential donors have all translated into real donors which are the first 100% success rate.
- The Medical Director credited the success to the work of Dr Haslam and all the nurses involved.
- Feedback from the retrieval teams who collect the organs is extremely positive.

In response:

- The Chief Executive asked the Medical Director to draft a letter to Ian Mean, Director of Business West in Gloucestershire thanking him and his team for their leadership and action. **SE**
- The Trust Chair suggested another event to showcase the work going on.

RESOLVED: That the Board receive the report as a source of assurance regarding the quality of organ donation activities in the Trust.

142/18 ANNUAL MEDICAL REVALIDATION REPORT

The Medical Director presented the Report and highlighted:-

- Revalidation began in 2012, the second cycle of medical revalidation is now underway.
- Recruitment of appraisers is not easy but the Trust does have enough

to maintain the current performance standard.
- As part of the appraisal process doctors are required to have an annual review with their specialty director, this is being aligned to Trust medical appraisal process.
- Every doctor on a five year cycle receives feedback from 45 patients and 25 colleagues on how they are performing which is used in their appraisal. A discussion with the Director of People will take place to decide how to use the feedback.

RESOLVED: That the Board receive the report as a source of assurance regarding the quality of medical appraisal and revalidation of activities in the Trust.

143/18 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

Dr Simon Pirie, Guardian for Safe Working Hours presented the Quarterly Report highlighting the following:-

- The report identifies occasions where doctors in training are working beyond scheduled hours. There were 217 exception reports logged in this period, there were 268 in the last quarter.
- Allocate reporting system is now being used, although it not user friendly as one of the team have to look through manually. The Medical Director agreed to discuss the system shortcomings with the supplier and national team. **SE**
- Dr Pirie said he will be attending a national conference for Guardians and has asked for providers of more sophisticated systems to give presentations.

In response to the report:-

- Ms Barber asked for clarity on item 10 of the report where it mentions 'no patient harm appears to have resulted from these episodes'. Dr Pirie responded by saying the trainee can log an immediate safety concern, and when this occurs he speaks directly to the trainee and they go through the issue, Dr Pirie confirmed there were no situations where something was missed.
- The Chief Executive had previously asked the Director of Safety for triangulation of data with the Datix reporting system, this information is not included in this quarter's report and asked for this to be reinstated. **SE**
- Dr Feehily enquired regarding Freedom to Speak Up and whether connections were being made between Dr Pirie and the Deputy Director of Quality to enable any common themes to be raised. Dr Pirie would make contact with the Deputy Director of Quality. **SP**
- The Medical Director mentioned although Dr Pirie had only been in the role for a short time he had done fantastic work. The feedback he receives from the Junior Doctor forum is that the system works. Regarding the fines, there is an innovative piece of work being carried out by the junior doctors led by Kim Benstead which is a peer support mentoring programme and has national recognition. Dr Pirie said there is funding for three years for this project.
- The Chief Executive asked how the Trust could be assured that Junior Doctors in Urology, ENT and ED are not so busy they haven't got time to fill out an exception report in light of low levels of reporting. Dr Pirie said he goes to various forums, inductions etc. to meet the junior doctors and they have his email address to make contact. On hearing

there were areas that the doctors were being dissuaded from filling out the exception report he fully investigated and found this wasn't the case.
- The Director of Quality and Chief Nurse asked what the fine money was spent on. Dr Pirie described the process – they ask for ideas, these are presented at the Junior Doctors Forum and a decision made.
-

RESOLVED: That the Board receive the report as a source of assurance regarding the working hours of junior doctors and the system in place to monitor this.

144/18 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 18 ARIL FEBRUARY 2018

The Trust Chair shared that the Council of Governors meetings continue to be very well attended and felt the Trust had a particularly good group of Governors which offer great support and ask good questions. The NEDs and Governors held a joint social event at the University of Gloucestershire in June and it was noted how much the Governors appreciated the NEDs and Executives attending the Council of Governors meeting.

RESOLVED: That the minutes be noted.

145/18 GOVERNORS' QUESTIONS

The Lead Governor thanked the Trust Chair for his words and agreed the current group of Governors were very engaged and positive.

The Lead Governor made the following points:

- Research - the Lead Governor said he was a member of a Bristol Strategy Group which was set up last year; he helped them set up their strategy for patient involvement. He noted how important patients are to research.
- The Patients Story – Care and consent has been a personal issue for 18 years and he agreed how frustrating it is for patients, carers and friends and would welcome any progress the Board can offer.
- He is currently under the care of six clinicians and agrees that sometimes the 'left hand and right hand' do not always know what the other is doing which as a patient is very frustrating.
- He cannot remember a time when the Board hasn't talked about ED attendance and agrees that nothing will change until primary care is sorted out. The Lead Governor asked what collectively the Governors can do to help as well as proactively talking to members.
- The Lead Governor thanked Ms Barber and the Director of Corporate Governance for all their work on the revised constitution.
- The patient story presentation should also go to 2Gether and CCG Trust as well as GCS.

146/18 STAFF QUESTIONS

There were none.

147/18 PUBLIC QUESTIONS

There were none.

148/18 ANY OTHER BUSINESS

The Trust Chair noted it was Ms Barber's last Board meeting as she was stepping down from her NED role. The Chair publically acknowledged and thanked Ms Barber for her contribution to the Workforce Committee and the Board over the last two years.

149/18 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at 09:00hrs **Thursday 13 September 2018** in **Room 3, Sandford Education Centre, Cheltenham General Hospital**

150/18 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 1:11pm.

Chair
13th September 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2018

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
May 2018	March 2018 036/18 Patient Story	**CL**	Considering the request for further portering staff: the Director of Quality and Chief Nurse noted the transfer team in the ED and Acute Medical Unit (AMU) but recognised that there had been issues with attracting dedicated porters.	The Chief Operating Officer concurred, noting that this needed to be improved for next winter and a pilot was shortly due to commence.	*May update: Trial of dedicated porter transfer team commenced in April, proved successful and more robust than rostering HCAs. Trial extended into May; Hilary Lucas linking in with portering team to understand cost and potential for embedding.*
May 2018	March 2018 047/18 Governors' Questions	**RG**	New external auditors were noted and the Lead Governor wondered who would hold them responsible for actioning what was promised on recruitment.	Rob Graves advised that he would raise this with them when they next met.	*May update: This will be addressed with the auditors at the next Audit and Assurance Committee.*
September 2018	July 2018 133/18 Financial Performance – Report of the Finance Director	**CL/SS**	The Chief Executive said it was not clear, given the improved utilisation whether the under performance reflected reduced activity or failure to capture and record activity appropriately.	She asked the Director of Finance and Chief Operating Officer to investigate this	*September Update* Associate Director of Planned Care and Director of Operational Finance conducting an audit in outpatients for one week during the month of September and will report back to SmartCare Programme Board or Planned Care Programme Board.

July 2018	May 2018 087/18 Smartcare Progress Report	**DL / PL**	Dr Feehily asked if further detail on progress could be shared with the Board so that there was further clarity on direction and speed.	The Chief Executive encouraged a discussion regarding this rather than bringing inappropriate levels of detail to the Board.	*<u>Completed:</u> Agreement reached to establish Digital Board Sub-Committee with effect from October.*
September 2018	July 2018 127/187 Patient Story	**PL**	Mr Graves suggested Becky share her experience with Gloucestershire Care Services (GCS) Board who directly manage the community services.	The Trust Chair would discuss this further with the Chair of GCS.	*<u>Completed:</u> Discussion with GCS chair has taken place.*
September 2018	July 2018 127/187 Patient Story	**SH**	The Chief Executive felt that the family shouldn't have to pay privately for the physiotherapy services that Maggie was receiving as they seemed to be core to her rehabilitation.	Chief Nurse to follow this up.	*<u>Completed:</u> The Chief Nurse has reviewed the case with the patient experience team and the stroke team. Early Supported Discharge was established following discharge, included physiotherapy and support from the Community Stroke Co-ordinator. The Chief Nurse has recently spoken to Maggie's family and she is progressing well with her rehabilitation.*
September 2018	July 2018 132/18 Quality and Performance – Trust Risk Register	**CL**	Demand and pressure throughout the summer months.	The Chief Executive asked the Chief Operating Office to review the risk register and consider whether this risk was adequately captured and if not ensure it was added.	*<u>Completed:</u> Chief Operating Officer reviewed. Documented on Medicine risk register.*

September 2018	July 2018 134/18 Workforce – Report of the Director of People and Organisational Development	**EW**	Apprenticeship levy and target	This is being investigated and a report on the Apprenticeship Strategy will come to a future People and Organisational Development Committee. Date to be confirmed to the Corporate Governance Manager for Committee Work Plan.	*<u>Completed</u>: Added to work plan as part of the sustainable workforce agenda item*
September 2018	July 2018 136/18 Gloucestershire Managed Services – Report of the Chair of the GMS Committee meeting held on 14 June 2018	**EW**	The Trust Chair asked about the GMS workforce. The Director of People responded saying there had been a lot of work on engagement by the management team, there had been no increase in turnover or grievances: an indicator that staff are satisfied.	The Chief Executive asked that the question is posed to the committee and formal measures of staff satisfaction are established	*<u>Completed</u>: GMS will be conducting its own staff survey to measure engagement and staff satisfaction by the end of the calendar year.*
September 2018	July 2018 141/18 Annual Organ Donation Report	**SE**	Annual Organ Donation Report received, demonstrating positive progress.	The Chief Executive asked the Medical Director to draft a letter to Ian Mean, Director of Business West in Gloucestershire thanking him and his team for their leadership and action.	*<u>Completed:</u> Letter drafted and sent.*
September 2018	July 2018 143/18 Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**MH**	Allocate reporting system is now being used, although it not user friendly as one of the team have to look through manually.	The Medical Director agreed to take forward with supplier and national team	*<u>Completed:</u> Supplier issue and national team working with them to address.*

September 2018	July 2018 143/18 Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**SE**	The Chief Executive had previously asked the Director of Safety for triangulation of data with the Datix reporting system.	This information is not included in this quarter's report and asked for this to be reinstated.	*<u>Completed</u>: will be included within the next report.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2018

CHAIR'S ACTIVITIES UPDATE

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

The latest of these appears below and covers the period of 4th July to 3rd September 2018.

Trust Activities

DATE	EVENT
05 07 18	NHS70 Birthday Celebration – Whole day activities at Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH)
09 07 18	Trust Chief Digital and Information Officer Recruitment Panel
11 07 18	Governor 1:1
18 07 18	Health and Safety Reps Annual Education Day
19 07 18	Volunteers Long Service Awards
30 07 18	Non-Executive Director/ Committee Chair Meeting
31 07 18	Governor 1:1
31 07 18	Tour of GRH Grounds with Ground Staff
01 08 18	Junior Doctors' Induction
06 08 18	Governors' Quality group
07 08 18	Chair visit to Cancer Services CGH
22 08 18	Governor 1:1
23 08 18	Respiratory Consultant Recruitment Panel
23 08 18	Governors' Strategy and Engagement Group Meeting
28 08 18	Chair visit to Guiting Ward CGH

Gloucestershire Health Economy

DATE	EVENT
10 07 18	Health and Care Overview and Scrutiny Committee (HCOSC)
17 07 18	Health and Wellbeing Board
17 07 18	Prevention Concordat Launch Event (Better Mental Health)
25 07 18	Meeting with Chris Creswick – Independent STP Chair
25 07 18	1:1 with Ingrid Barker, Chair Gloucestershire Care Services/ 2gether + visit to CGH
22 08 18	Research4Gloucestershire - 1:1with retiring Chair
29 08 18	Governor 1:1

National Stakeholders + others

DATE	EVENT
06 07 18	Meeting with Alex Chalk MP and Laurence Robertson MP (with Chief Exec)
01 08 18	NHS Improvement Financial Special Measures Meeting
01 08 18	NHS Improvement Oversight Meeting
15 08 18	Meeting at Gloucestershire College re. Art Project
28 08 18	Meeting with Mark Shires - NHS Improvement Senior Advisor

Peter Lachecki
Trust Chair

3rd September 2018

TRUST BOARD – SEPTEMBER 2018

REPORT OF THE CHIEF EXECUTIVE

1. Current Operational Context

1.1 Despite the summer months, services have remained very busy with our highest ever number of Accident & Emergency (A&E) attendances occurring in the last few months. Despite high attendance levels, in August the Trust delivered its fifth consecutive month of A&E performance above the 90% trajectory. Thanks go to staff working throughout the emergency care pathway, from front door to discharge, for their incredible efforts.

1.2 Whilst a generally positive picture of performance, quarter two is the period when the Trust should be achieving 95%+ and on days when demand is within the expected range, we are consistently exceeding our trajectory. However, demand has exceeded the contracted levels on more than 50% of days and at times exceeded it by more than 20%. This growth is biased towards presentations from those patients that walk in to the service and typically presenting with more minor conditions though of late increasing numbers of patients with conditions exacerbated or caused by the warm weather. Mondays are becoming especially renowned for high levels of activity resulting in poor performance. Work continues with system partners to better understand the drivers for this increase in demand, with the aim of developing mitigations that restore activity to planned levels, with some urgency. This latter point is crucial if we are to ensure that staff are supported to enter next winter with sufficient resilience to ensure a positive experience for them and our patients. Concerns remain that, despite improvements in primary care capacity, increasing numbers of patients see A&E as the place of first choice for rapid, high quality care.

1.3 Good progress also continues to be made in planned care with strong levels of elective care activity being delivered and further signs of outpatient recovery, though in the latter area activity levels remain lower than planned and the reasons for this are being investigated. Positively, the number of patients who are overdue follow up care, and who do not have a booked appointment, has reduced by two thirds since the initiation of our improvement approach in May of this year; focus on outpatient recovery remains a huge priority in all services.

2. National and Regional

2.1 Recent changes in Government resulted in a change of portfolio for former Secretary of State for Health, the Rt Hon Jeremy Hunt and the subsequent appointment of Matt Hancock MP. It is early days to comment on the priorities of Mr Hancock though his credentials and interest in the area of digital healthcare are already coming through. The disappearance of the infamous Monday meetings and the delegation of key areas such as patient safety to more junior ministers, suggests we can expect a different approach from Mr Hancock to his predecessor. More recently, Mr Hancock announced the appointment of local MP, Alex Chalk as his Parliamentary Private Secretary. I believe this is an excellent opportunity for the Trust given the positive working relationship we have established with Mr Chalk and I look forward to developing our relationship further in the months to come as Mr Chalk develops his interest and involvement in health provision.

2.2 In July, under the leadership of Professor Rudd, the National Stroke Team visited the Trust and undertook a peer review assessment of acute stroke services. The review was very positive, noting the many improvements that have been made in stroke care in recent months. The report made a number of recommendations for further

improvements in service and care and these have been embraced by the stroke team under the leadership of Dr Kate Hellier. On the 10th July, the Health and Care Overview and Scrutiny Committee (HCOSC) supported the proposal to develop community based stroke rehabilitation services at the Vale Community Hospital. This is a hugely positive step for the County and, of course, stroke patients and their families. Implementation planning is underway though a final date for establishment of this new service has yet to be confirmed. Progress against the national stroke measures (SNAPP) continues to be made in areas under our control but performance in relation to therapy input remains poor but will be addressed through the community stroke changes described above.

2.3 On the 17th August, the Chief Executive of the General Medical Committee (GMC), Charles Massey, visited the Trust. This visit followed an internal meeting to discuss the Dr Hadiza Bawa-Garba case (the junior doctor found guilty of manslaughter) which was attended by our local GMC officer. He spent the day meeting with senior staff, visiting clinical areas, discussing some of our training initiatives with clinical teams and learning about our improvement academy. In addition he spent an hour with a group of junior doctors who took the opportunity to question him about the GMC response to doctors who make mistakes and what actions they are taking to improve their approach to this. He was particularly impressed by our Quality and Safety Improvement Academy and the principle of building improvement initiatives into learning from incidents. We have offered to contribute to the GMC's work in supporting of their developing approach.

3. Our System and Community

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

However, the STP Delivery Board believes there remains a compelling case for change in relation to significant aspects of the original model and that the overall vision for *Centres of Excellence* for urgent and planned care remains strategically coherent and viable. With this context, the current plan is to continue to consult on the overall vision for service reconfiguration but to reduce the scope of the business case to those developments that do not require consultation e.g. the nationally mandated 111 telephone triage service and Clinical Assessment and Advice Service (CAAS) and those changes which do require consultation and can be progressed (once approved) – this will include the development of urban and rural Urgent Treatment Centres (UTCs) and changes to a small number of hospital based services including trauma & orthopaedic services and gastro-intestinal services (medical and surgical). Importantly, work will continue, at pace, in respect of acute services including A&E and acute medical care but be subject to a second phase of public consultation, later next year. Final decisions about the preparedness for, and timings of, public consultation for Phase 1 will be taken at the end of September.

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

Audit leads from the participant organisations have also met to explore issues of governance and notably the role which Boards (and specifically non-executive

directors) will play in a 'virtual' construct where individual organisations retain accountability for the financial and service performance of the activities in scope.

4. Our Trust

4.1 Since my last report, the Trust has been notified of the dates for the forthcoming Care Quality Commission (CQC) inspection. This inspection will be carried out under the new framework introduced last year and as such differs from the inspection of January 2017. The key dates are set out below

- The Well Led Review, including a three day inspection against the eight Key Lines of Enquiry (KLoE), will take place from Tuesday 13th November to Thursday 15th November inclusive
- A Use of Resources Assessment, including a one day visit from NHSI Use of Resources Team, is schedule for the 18th October
- An unannounced inspection of up to four core services will take place, sometime between w/c 24th September and the end of October. Likely services to be inspected are unscheduled care, medicine, surgery and outpatients / diagnostics. This will likely last around four days and include c20 inspectors.

Planning and preparation is well underway with Steve Hams, Director of Quality & Chief Nurse and Lukasz Bohdan, Director of Corporate Governance co-leading this work. Given the momentum generated through our *Journey To Outstanding* and the work to ensure we are 'CQC ready everyday', I believe we are well placed to build upon the positive findings from the 2017 inspection – time will tell.

4.2 Work is progressing well with the development of the business case for the major capital schemes (£39.5m) at GRH and CGH. The latest milestone is the appointment of our construction partner, which will hopefully be ratified by the Board at its September meeting; this will be followed by presentation of the Strategic Outline Case (SOC) to the October Board and the Outline Business Case (OBC) to the January 2019 meeting with the goal of final sign off at April 2019 Board. The Trust will be using the business case process to continually test that the iterations of the case address the evolving understanding of our future needs and clinical models as service reconfiguration work progresses.

4.3 With only hours to develop and submit a bid against a notification of national capital to support winter pressures, the Trust heard this week that its FULL bid was successful. As a result the Trust has secured £1.3m of capital funding (subject to a number of qualifying criteria being met) to enable capital works at GRH in support of the acute floor model and to enable enhanced development of information management systems to support patient flow and theatre productivity.

4.4 The Trust continues with its regular engagement activities with NHSI and the Financial Special Measures (FSM) team. Reflecting the positive context of delivering the Annual Operational Plan for the first four months of the financial year, discussions continue in a constructive vein with a current commitment from NHSI to review the exit trajectory from FSM at the late September review meeting. Confidence in cost improvement (CIP) delivery in the second half of the year alongside conclusion of work on the drivers of the Trust's deficit will be pre-requisites to achieving this goal.

4.5 The continued focus on TrakCare recovery resulted in a significant milestone in July with the launch of the new *Outpatient Outcome* module. This is the single biggest area that drives the data quality issues that the Trust continues to experience and that impacted so significantly last year on Trust income; 50% of the erroneous pathways have emanated from this single element of the system. Feedback from staff with respect to the approach to launch was very positive and immediate improvements in data quality and data completion have been seen. Monitoring of compliance at individual consultant level is now in place, with oversight by the Medical Director. With

signs that the rate of new data quality issues has slowed dramatically, the Trust is now working with an external partner to validate the 300,000 pathways created within TrakCare post-go live, many of which we know to be erroneous. Again, excellent progress is being made with reductions in excess of 120,000 since recovery began in earnest four months ago. With recovery now firmly underway, attention is now turning to mobilising future phases of the Electronic Patient Record (EPR) vision which remains at the heart of the SmartCare Programme and with this context, detailed work is now underway to reach agreement with the system supplier on the approach to future phases of the EPR, alongside discussions with NHS Digital and NHSE in relation to a revised financial framework. Testing of the pathology module is now progressing well and work on nursing documentation gathering momentum; learning the lessons from phase one, a clear articulation of the benefits expected is being developed and links with sites that have developed nursing documentation is demonstrating huge quality gains for patients. Finally, in line with agreements at the time, the Trust has invited the Deep Dive Review team to revisit the Trust to provide assurance that recovery is underway and future plans are robust; it is expected this assurance work will be completed by the end of September with the aim of presenting it to the first meeting of the new digital sub-committee in October.

4.6 The Trust has recently launched the nationally acclaimed Nursing Assessment and Accreditation System (NAAS). This is an improvement methodology developed by Salford Hospitals NHS Foundation Trust, who are reputed for their innovation and have been consistently rated as *outstanding* by the CQC, since the regime was introduced. We believe that NAAS has the potential to make a significant impact on care quality at ward level and address some of the shortcomings identified in the recent inpatient survey. Inevitably, early results are mixed but the approach provides a sound baseline from which to measure quality improvement. In addition, the importance of collecting more 'real time' information about patient experience has been recognised and from September, we will be rolling out hand held devices which, with the help of volunteers and hopefully Governors, will enable us not only to better understand our patients experience of care but to enable us to respond to it, at the time rather than some months later.

4.7 Recognising the value of highlighting and sharing good practice, in July, building on our Datix incident reporting system, the Trust launched 'Datix with a twist'. Building on the www.learningfromexcellence principle of learning from when things go well, not just adverse incidents, it allows staff to report positive events which can then be investigated, and learning cascaded in the way we would currently respond to an unplanned incident or near miss. It's also a fabulous way to demonstrate appreciation and recognition of our staff and has been very well received.

4.8 On the 21st July, the Trust, working closely with the Gloucestershire Fire Service, undertook a simulated evacuation of the top floor of the Tower Block at Gloucestershire Royal Hospital. Whilst successful as an emergency planning exercise, the day was also characterised by phenomenal leadership, teamwork, planning and camaraderie. Thanks to Chief Operating Officer Caroline Landon for leading the event and Gloucestershire Fire Service for their input to the day.

4.9 Sticking with the theme of our local Fire Service, on September 12th staff from the service will conclude their mammoth sponsored bed push to raise funds for the Trust's oncology service. The Service has set itself the goal of raising £100,000 which is a huge and very welcome contribution to the oncology appeal. Personal thanks to the 46 individuals – staff and supporters – of the Gloucestershire Fire Service.

4.10 Social media continues to be an invaluable source of informal feedback in respect of Trust initiatives and two issues have caught my eye this month. Firstly, the very positive response of more than 40,000 members of the public viewing the campaign activity on Facebook in respect of ensuring acutely sick children are taken to the right place, first time i.e. Gloucestershire Royal Hospital A&E Service and secondly the very

positive reception that our pilot of new 'high viz' name badges have received. Around 80 staff in the Trust are trialling these new, friendly, bright yellow *My name Is…..*badges and patients and visitors across the Trust have appreciated the welcoming tone and accessible nature of the badges.

4.11 Despite concerns that the introduction of our monthly GEM staff awards may reduce the number of nominations for our annual staff awards, we have achieved the highest ever number of nominations at just over 500. This is huge testament to the high regard with which colleagues hold each other and signs that the value placed on recognising and sharing success is being embraced by many. Shortlisted staff will be finalised in the coming weeks with announcements next month, ahead of the final awards' ceremony which will take place at Hatherley Manor on the 29th November.

4.12 Finally, I am delighted to announce that the Trust has been shortlisted for another Health Service Journal (HSJ) Award in the category of Primary Care Innovation for the work undertaken by our community dietetic service in supporting GPs to better manage their patients with, or at risk of, malnutrition. Finalists will be announced in November. Congratulations go to dietician Gemma Fry who led this innovation.

Deborah Lee
Chief Executive Officer

September 2018

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

Report Title
Quality and Performance Report
Sponsor and Author(s)
Authors: Felicity Taylor Drewe, Director of Planned Care, Deputy Chief Operating Officer 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 July 2018 reporting period.

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

Key Issues to note

Caring - patient experience
The Friends and Family Test data show a static position. Inpatient scores remain below average and so now work is underway to look at ward data in a different way which will flag the wards with lower than the national average scores which will be plotted over time. Real time survey data collection will start as soon as we have purchased the new software needed to support the analysis and reports required. The 2 tools used together will enable us to have more insight into ward experiences.

Safety
In July there were no new never events reported. The Theatre Improvement Programme is continuing and the next update will be at QDG 23rd August 2018.

The project plan for the Harm Free Care improvement work will be presented to QDG in September 2018 and this programme of work will review the Safety Thermometer data.

VTE assessment has been indicating lower than expected performance on the QPR dashboard and so an audit was commissioned of what was actually recorded within drug chart records. The audit picture showed that risk assessment was being carried out 94% of the time when compared to the data recorded on Trakcare which was 77.9% in June. The actions from the audit will be decided at the next QDG meeting in August and this will include how we improve the recording within Tackcare.

Dementia case finding results remain a concern because of the reliability of the results recorded on Trakcare. An audit has been commissioned to review the paper recorded results against the electronic system.

Infection prevention and control

During July 2018 the trust had one case of Trust-apportioned MRSA bacteraemia. This case was reviewed by the IPC team and consultant in charge of the patient. The source was believed to be a surgical site infection. The patient remained well and the wound healed.

There were 7 cases of Trust-apportioned C. difficile during July 2018. Investigations of individual cases have focussed on antimicrobial as a leading risk factor for the higher than expected case rate. The Trust has a comprehensive action plan to bring about improvements.

E.coli continues to be the leading cause of bacteraemia and the Trust is working on the NHS Improvement UTI Collaborative project with partners across the system. The project is focused on reducing urinary catheter insertions to decrease catheter associated UTI.

Performance

During July, the Trust met the Trust and NHS I/E Trajectory for A&E 4 hour standard and Diagnostics within 6 weeks.

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 July 2018, the Trust performance against the 4hr A&E standard was 91.3% with an average of 435 attendances per day. This performance was above the agreed STF trajectory (90%). GHFT month to date performance (10 August) is currently 90.3% which is on track to deliver the STF June trajectory (90%). Where appropriate, patients arriving at the Emergency Department are immediately repatriated to Primary Care, through the streaming programme.

The Trust did meet the diagnostics target in July at 0.56% (un-validated), this is well within the delivery target of 1%.

In respect of RTT, we continue to monitor and address the data quality issues following the migration to TrakCare. We have started reporting the RTT position in shadow form internally and will continue to suspend national reporting of this target. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways; however, as reported previously to the Board we will continue to see 52 week breaches until full data cleansing exercise is completed and our patient tracking list is accurate. Alignment with the Trak Recovery Programme in relation to RTT operational management remains vital. The Trust has initiated a review panel with CCG membership for the longest waiting patients, the initial meeting took place in August and are established as monthly from now until full recovery of zero long waiting patients.

Our performance against the cancer standard saw an increase against the 2 week standard for July with performance at 90.4% (Un-Validated). The main tumour site that was compromised on the 2 week pathway remains Lower GI, though significant progress has been made and the current Patient Tracking list illustrates a clear reduction in the backlog. The majority of tumour sites were impacted by increased unplanned demand in June (see full Cancer Delivery Plan), which is significant and above planned and seasonal expectations. The existing Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed and reviewed on a fortnightly basis. Critically for the 62 day pathway, 5 of 9 specialities have demonstrated delivery, one tumour site (urology) has demonstrably impacted the aggregate position with significant number of 62 day breaches.

Cancer 62 day Referral to Treatment (GP referral) performance for June was 67.9%, this was a significant decrease 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. We are looking to bring this forward for two more specialities during September, based on the good performance in Head and Neck.

Conclusions

Cancer delivery and sustaining A&E performance is the priority for the operational teams to continue the positive performance improvement, this is delivered through transformational change to patient pathways now robust operating models are developed.

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

Recommendations

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

Impact Upon Strategic Objectives

Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.

Impact Upon Corporate Risks

Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.

Regulatory and/or Legal Implications

The Trust has been removed from regulatory intervention for the A&E 4-hour standard.

Equality & Patient Impact

Failure to meet national access standards impacts on the quality of care experienced by patients. There is no evidence this impacts differentially on particular groups of patients.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	✓

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period July 2018

to be presented at August 2018 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During July, the Trust did not meet the national standards or Trust trajectories for 2 week wait and 62 day cancer standard and suspended reporting of the 18 week referral to treatment (RTT) standard continues. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care over 104 days to ensure that patients do not come to harm due to delays in their treatment, these are being reviewed to ensure we have fully reviewed these cases since 01 April 2017. The policy that supports these have been reviewed by every Division and implementation is now underway.

The Trust has met the 4 hour standard in July, 91.3% against the STP trajectory at 90% against a backdrop of significant attendances.

The Trust has met the diagnostics standard for July.

The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan is reviewed fortnightly and each tumour site has specific identified actions with an associated allocation in breach improvement numbers. The Cancer Patient List for every patient over day 28 is reviewed weekly by the Director of Planned Care & Trust Cancer Manager.

Cancer performance remains a significant concern relating to the 2 week wait and 62 day pathway. For the former, issues with significant increase in referral rates and the adoption of the new straight to test colorectal pathway whilst successful has meant that we are continuing to treat the backlog.

The July figures, as yet unvalidated, shows 2ww at 90.4%, up from 88.6% last month.

For 62 days, July saw an anticipated decline as we treat our longest waiting patients and implementation of the Straight to Test Pathways are enacted. This performance relates to the continued issues in colorectal and significant issues in the 62 day pathway with Urology services. A key risk in relation to the significant referral rates in specialities has impacted us in the 62 day pathway later in the year. Positively 7 tumour sites have delivered 'green' performance on a sustained basis.

The focus has continued on developing the joint work between the Central Booking Office and specialities to support appropriate booking for patients (now all clinics are available for booking for next year). We have committed to work to a day 8 escalation point for booking within the 14 day booking period for patients for Upper GI and Gynaecology in the autumn.

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

The CQC are likely to inspect the Trust in October/November 2018. In August our responsive plan has been updated by the action owners and the current status is that of the 30 “must do” actions we have:

- 15 blue closed actions (50%)
- 10 green on track to close by Sept/Dec (33%) (resus trolleys tamper proof and checking of, lockable notes trolleys, fridge temperatures, national audits, PGDs)
- 3 ambers with delivery at risk (10%) (DNACPR & MCA, ED staffing)
- 2 reds (7%) (mandatory training and appraisal rates, out of hours interventional radiology)

The Quality Delivery Group has now had 4 meetings and the Group are now working closely to highlight quality issues that are on “enhanced” surveillance for Division/Trust and the Group supporting the improvement work required. Improving patient experience should be the golden thread that runs through everything we do and should not be seen as something separate to the improvement work. Patient experience insight data is considered at the meeting so that we can continue to be patient- and carer-focused. Our latest Friends and Family Test results continue to show that we are about the same as national averages with our inpatient scores being below national average.

One of the quality metrics, VTE assessment, has been indicating lower than expected performance on the QPR dashboard and so an audit was commissioned of what was actually recorded within drug chart records. The picture showed an improved picture of a VTE risk assessment being carried out 94% of the time when compared to the data recorded on Trakcare which was 77.9% in June. The actions from the audit will be decided at the next QDG meeting in August.

FFT scores remain static with the inpatient scores being lower than national average.

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 91.3% in July.

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

The ED Safety Checklist continues to embedded within both emergency departments, additional support and adhoc assurance checks being delivered by the shift leaders.

Operational oversight of cancellations, outcome recording and clinic typing through the development of a suite of Business Intelligence reports has been helpful to support operational colleagues.

A clear plan to address the errors and the data contained within the follow up PTL has been supported, alongside a diversion in resources from the central validation team to support a reduction in the duplicate records. Operational teams continue to prioritise the longest waiting follow up patients.

15 Steps audits have been commenced in ward areas with our volunteers, Governors and staff on the wards assisting with the reviews. The plan and actions from these reviews will be reported within the next QPR.

Weaknesses

Referral rates within Unscheduled and Scheduled Care that are significantly above contractual levels and continue to impact into July and August.

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

There are opportunities within these areas, where the Trust is working with system partners to support a review panel, with CCG involvement, for our longest waiting new patients and work to implement processes to support validation of our follow up patient cohort.

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

Opportunities

Referral rate increases (colorectal, urology & dermatology) with no impact in detection rates – CCG to support communication to targeted practices in the CGH area, this work continues with a joint project also addressing the quality of the referrals to the service.

NHS Elect support for Cancer Pathways review - we will focus on the escalation of late cancer referrals to neighbouring Trusts. It is recognised that these are small in number but have caused breaches in the 62 day pathway for patients. Noting that the request for information in relation to Tertiary Centre referrals from us, also provides the opportunity to ensure we are correctly managing these patients journeys and improving patient care. This will be organised for the autumn period.

The support of the Elective Access role has brought detail and oversight in relation to Clinic Cancellations (less than 8 weeks); the typing position and the follow up validation programme. We have now in place an emergent RTT Delivery Plan to support the recovery of the longest waiting patients, whilst based on the information within our current Patient Tracking Lists.

The performance improvement programme initiated within the Central Booking Office (CBO)has been supported with the installation of a new telephony system which enables us to respond to our patients effectively and measure our response times and performance.

Our elective activity levels as at Month Four remain positive which supports our recovery agenda.

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

Risks & Threats

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

Cancer performance remains a significant risk for the Trust, of particular the sharp increase in referrals above any planned increases or seasonal levels, this has continued into July, (highest increase since 2016). The Trust is working with the Clinical Commissioning Group on a joint project that is working with Primary Care to address the quality of referrals received into the two week wait team. Patient choice levels are being benchmarked (and case stories provided) as the Trust needs to ensure we are offering reasonable notice of appointments. The issue of patient choice has been raised with the LMC and working in partnership with the CCG. Referrals that are appropriate for a suspected cancer service where our capacity meets demand is crucial to delivery. For cancer services delivery for colorectal & urology remains key to delivery of aggregate 62d wait.

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

The validation volumes for the PTL (new and follow up patients) and incorrect processes remain a risk, as does any change to the existing PTLs or change in practice, aligned with the recovery pace for Trak Recovery. 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

Indicator		Month												
		Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
ED Total Time in Department – Under 4 Hours	Trajectory	88.30%	92.20%	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%	90.00%	90.00%	90.00%	90.00%
	Actual	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%	91.98%	91.58%	93.33%	91.34%
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	77.20%	78.40%	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%				
	Actual													
Diagnostics 6 Week Wait (15 Key Tests)	Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Actual	5.30%	4.80%	2.90%	0.46%	0.51%	0.75%	0.64%	0.49%*	0.26%	0.56%	1.26%	0.52%	0.55%
Cancer – Urgent Referrals Seen in Under 2 Weeks	Trajectory	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	79.60%	70.40%	71.20%	74.60%	75.80%	81.20%	86.40%	90.60%	90.50%	86.60%	86.30%	88.60%	90.20%*
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%	93.20%	93.30%	93.40%	93.40%
	Actual	57.30%	89.70%	92.70%	89.00%	94.50%	96.30%	92.40%	97.60%	94.50%	91.30%	91.90%	95.10%	96.10%*
Cancer – 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.20%	96.20%	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%	96.10%	96.30%	96.10%	96.20%
	Actual	95.80%	96.20%	98.50%	95.10%	96.70%	97.30%	96.00%	97.60%	97.90%	96.70%	96.90%	97.10%	97.30%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	Trajectory	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%	98.50%	100.00%	98.80%	98.10%
	Actual	100.00%	100.00%	98.50%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	Trajectory	94.90%	94.50%	94.90%	94.10%	94.60%	94.40%	94.40%	94.10%	94.20%	95.50%	95.80%	94.60%	95.10%
	Actual	100.00%	98.40%	96.60%	97.10%	98.50%	98.10%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.60%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	Trajectory	95.80%	94.50%	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%	95.10%	95.00%	94.20%	95.90%
	Actual	93.60%	91.50%	95.50%	94.60%	98.10%	94.90%	93.00%	95.50%	98.00%	94.90%	96.60%	94.50%	95.30%*
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	94.70%	91.20%	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%	92.00%	94.70%	90.50%	90.00%
	Actual	89.10%	88.50%	94.90%	87.10%	93.80%	95.50%	98.00%	95.90%	95.90%	100.00%	94.10%	100.00%	100.00%*
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	57.10%	77.80%	85.70%	50.00%	60.00%	100.00%	0.00%	80.00%	94.10%	76.50%	100.00%	84.60%	53.30%*
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	85.40%	85.20%	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%	82.60%	84.10%	83.90%	85.10%
	Actual	74.70%	80.10%	69.20%	71.40%	76.70%	73.40%	69.70%	79.10%	78.10%	80.30%	79.90%	66.90%	71.40%*

Summary Scorecard

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

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

QUALITY

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

OPERATIONAL PERFORMANCE

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

FINANCE

- YTD Performance against Financial Recovery Plan

LEADERSHIP AND DEVELOPMENT

- Sickness Rate
- Workforce Turnover Rate

Trust Scorecard

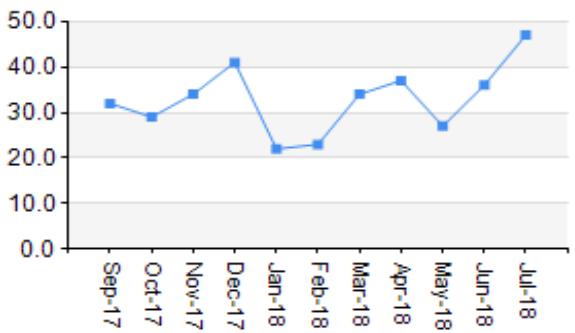
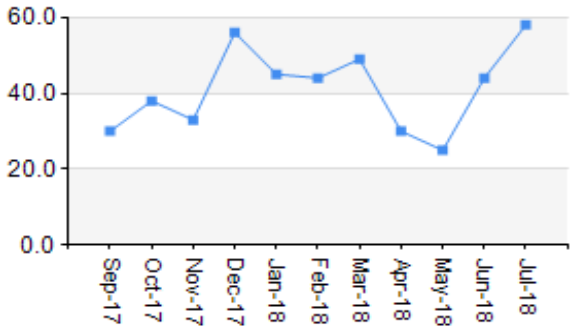
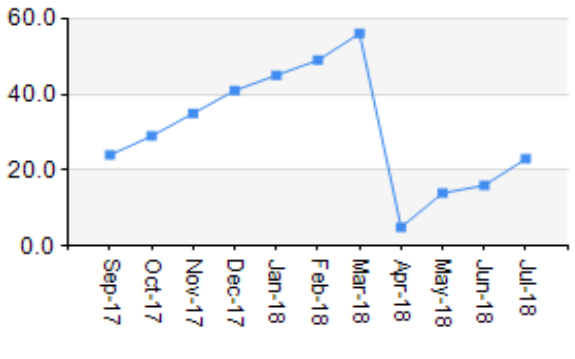
* = unvalidated data

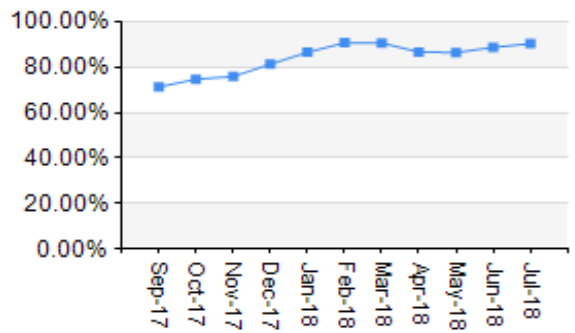
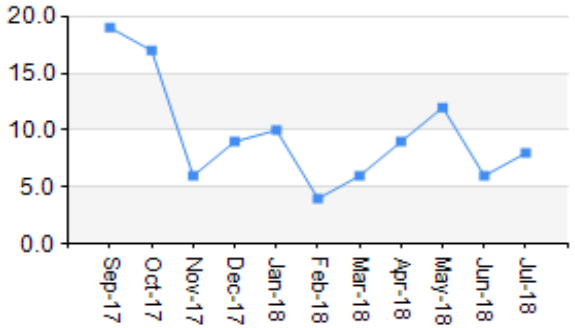
Category		Indicator	Target	Month												Quarter	Annual	
				Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	18/19 Q1	17/18	18/19
Quality	Key Indicators - Quality																		
	Friends and Family Test Score	Friends and Family Test Score – ED % Positive	>=86%	77.5%	84.9%	81.1%	81.0%	87.4%	85.9%	85.6%	82.7%	83.7% *	83.1%	83.2%	84.6%	83.6%	83.7%	83.0% *	83.7% *
		Friends and Family Test Score – Inpatients % Positive	>=95%	90.8%	90.9%	90.1%	91.2%	90.6%	91.6%	91.5%	92.0%	89.7% *	90.2%	91.4%	91.7%	91.7%	91.1%	90.9% *	91.2% *
		Friends and Family Test Score – Maternity % Positive	>=97%	100.0%	90.0%	94.7%	100.0%	100.0%	90.3%	100.0%	88.9%	93.6% *	97.4%	94.0%	95.6%	93.3%	95.5%	95.6% *	94.8% *
		Friends and Family Test Score – Outpatients % Positive	>=93%	91.4%	91.2%	91.5%	91.3%	92.2%	92.4%	93.3%	93.1%	92.3% *	92.0%	92.3%	92.3%	93.3%	92.2%	92.1%	92.5% *
	Infections	MRSA Bloodstream Cases – Cumulative Totals	0	1	1 *	1 *	1 *	0	0	0 *	0 *	0 *	1	1	1	2 *	1	1 *	1 *
	Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	16	14	18	19	13	11	5	7	6	8	8	20	5	36	134	41 *
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	105.5	103.9	99.7	97.1	94.8	93.4	93.1	95	96						96	
		Hospital Standardised Mortality Ratio (HSMR) – Weekend	Dr Foster confidence level	111.8	110	108.9	103.9	101.5	97.1	95	97.7	98.4						98.4	
		Summary Hospital Mortality Indicator (SHMI) – National Data	Dr Foster confidence level			108.7			107									107 *	
	Readmissions	Emergency Readmissions Percentage	Q1<6% Q2<5.8% Q3<5.6% Q4<5.4%	7.0% *	6.9% *	6.5% *	6.5% *	6.7% *	7.6% *	6.3% *	7.9% *	7.2% *	7.4% *	7.1% *	7.5% *		7.3% *	7.0% *	7.3% *
	Venous Thromboembolism (VTE)	Adult Inpatients Who Received a VTE Risk Assessment	>95%	Metric is under review															
	Detailed Indicators - Quality																		
	Dementia	Dementia – Fair question 1 – Case Finding Applied	>=90%			0.4% *	0.7% *	0.9% *	1.1%	0.7% *	0.7%	0.8%	0.7%	1.6%	1.6%	1.7%	1.3% *		1.4% *
		Dementia – Fair question 2 – Appropriately Assessed	>=90%			50.0% *	60.0% *	50.0% *	57.1%	100.0% *	33.3%	66.7%	50.0%	16.7%	33.3%	11.1%	31.3% *		24.0% *
		Dementia – Fair question 3 – Referred for Follow Up	>=90%			0.0% *	0.0% *	0.0% *	0.0%	50.0% *	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0% *		0.0% *
	ED checklist	ED Safety checklist compliance CGH		74%	72%	79%		78%	92%	86% *	83% *	82% *	82% *	89% *	84% *	88% *			
		ED Safety checklist compliance GRH	>=80%	57%	53%	79%		68%	67%	72% *	81% *	81% *	85% *	73% *	73% *				
	Fracture Neck of Femur	Fracture Neck of Femur – Time To Treatment 90th Percentile (Hours)		50.9 *	56 *	59.7 *	46.9 *	47.6 *	43.1 *	45.7 *	42.3 *	64.4 *	48.1 *	42.3 *	49.8 *	31 *	45.1 *	48.5	31 *
		Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		96.8% *	96.9% *	98.5% *	98.2% *	98.4% *	100.0% *	98.5% *	100.0% *	98.4% *	94.4% *	91.2% *	93.7% *	98% *	93.0% *	98.4%	99% *
		Fracture Neck of Femur Patients Treated Within 36 Hours		59.7% *	67.7% *	66.7% *	80.4% *	67.2% *	81.4% *	73.9% *	83.8% *	64.4% *	72.2% *	79.4% *	68.3% *	79% *	73.5% *	72.7%	76% *
	Infections	C.Diff Cases – Cumulative Totals	18/19 = 36	10	18	24	29	35	41	45	49	56	5	14	16	23 *	16	56	16 *
		Ecoli – Cumulative Totals		37	103 *	119 *	146 *	175	200	222 *	240 *	258 *	17	32	56	79 *	56	258 *	56 *
		Klebsiella – Cumulative Totals											6	12	13	22 *	13		13 *
		MSSA Cases – Cumulative Totals	No target	15	44 *	54 *	63 *	68	78	89 *	93 *	100 *	9	18	28	41 *	28	100 *	28 *
		Pseudomonas – Cumulative Totals											2	3	6	14 *	6		6 *
	Maternity	Percentage of Spontaneous Vaginal Deliveries		62.4% *	63.9% *	64.9% *	60.2% *	57.5% *	60.9% *	57.0% *	63.4% *	61.8% *	57.5% *	61.4% *	60.0% *	64.3% *	61.2% *	62.4% *	62.0% *
		Percentage of Women Seen by Midwife by 12 Weeks	>90%	83.2% *	88.1% *	85.9% *	87.8% *	89.5%	86.6% *	88.7% *	89.2% *	89.9% *	92.7% *	90.1% *	90.5% *	89.8% *	90.8% *	89.5% *	90.4% *
	Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.6 *	3.7 *	3.3 *	3.3 *	3.6 *	3.4 *	4.1 *	3.5 *	3.6 *	3.6 *	4.6 *	4.4 *	4.3 *			
	Never Events	Total Never Events	0	0 *	0	1 *	0 *	0 *	1 *	0 *	0 *	1 *	1 *	0 *	0 *	0 *	1 *	3 *	1 *
	Patient Falls	Falls per 1,000 Beddays	Current mean	6.6 *	6.1 *	7 *	7.3 *	7 *	8.2 *	7.8 *	7.3 *	7.7 *	8.3 *	7.6 *	8.3 *	6.9 *			
		Total Number of Patient Falls Resulting in Harm (moderate/severe)		5 *	8 *	11 *	7 *	4 *	13 *	18 *	10 *	8 *	10 *	8 *	7 *	11 *	8 *		8 *
	Patient Safety Incidents	Number of Patient Safety Incidents – Severe Harm (Major/Death)		2 *	2 *	3 *	1 *	1 *	1 *	3 *	1 *	1 *	2 *	1 *	1 *	1 *	1 *		1 *
		Number of Patient Safety Incidents Reported		1,149 *	1,003 *	1,033 *	1,079 *	1,041 *	1,025 *	1,260 *	1,139 *	1,229 *	1,192 *	1,210 *	1,199 *	1,206 *			
	Pressure Ulcers Developed in the Trust	Pressure Ulcers – Grade 2	R=1% G<1%	1.12% *	1.02% *	0.61% *	1.13% *	0.79% *	0.54% *	1.30% *	1.63% *	0.48% *	0.39% *	0.39% *	0.90% *	0.25% *			
		Pressure Ulcers – Grade 3	R= 0.3 G<0.3%	0.50% *	0.38% *	0.37% *	0.00% *	0.13% *	0.14% *	0.47% *	0.63% *	0.24% *	0.00% *	0.00% *	0.00% *	0.13% *			
		Pressure Ulcers – Grade 4	R=0.2% G<0.2%	0.00% *	0.00% *	0.12% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *	0.00% *			

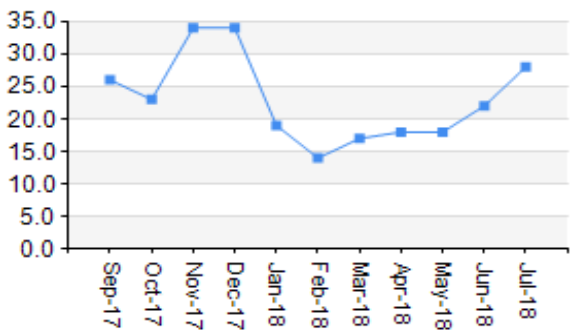
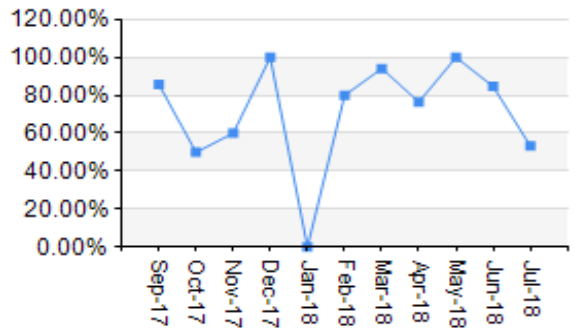
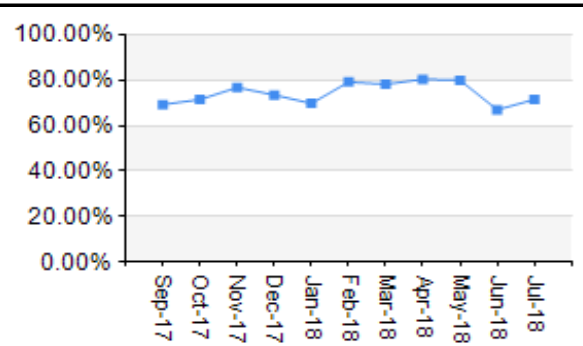
Category	Indicator	Target	Month												Quarter	Annual	
			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	18/19 Q1	17/18	18/19
	Research Accruals	Research Accruals	17/18 = >1100	162 *	185 *	127 *	60 *	76 *	29 *	80 *	61 *	112 *	42 *	54 *	16 *		141 *	1,770 *	19 *
	RIDDOR	Number of RIDDOR	Current mean	2 *	3 *	0 *	3 *	1 *	7 *	1 *	1 *	1 *	4 *	0 *	1 *	2 *		2	
	Safer Staffing	Safer Staffing Care Hours per Patient Day		7	7	7	7	7	7	7	7	7	7	7	8	7	7 *	7	7 *
	Safety Thermometer	Safety Thermometer – Harm Free	R<88% A89%-91% G>92%	91.3% *	92.6% *	94.2% *	92.9% *	93.0% *	93.1% *	90.1% *	91.8% *	91.5% *	92.8% *	93.8% *		92.2% *			
		Safety Thermometer – New Harm Free	R<93% A94%-95% G>96%	95.0% *	96.0% *	97.4% *	97.4% *	97.0% *	96.9% *	96.0% *	96.4% *	97.6% *	98.0% *	97.8% *		98.4% *			
	Sepsis Screening	2a Sepsis – Screening	>90%	94.0% *	96.0% *	98.0% *	96.0% *	94.0% *	98.0% *	98.0% *	98.0% *	100.0% *	98.0% *	98.0% *	100.0% *				
		2b Sepsis – Treatment within timescales (Diagnosis Abx Given)	>50%	94.0% *	89.0% *	90.0% *	79.0% *	80.0% *	83.0% *	89.0% *	84.0% *	78.0% *	82.0% *	88.0% *	88.0% *				
	Serious Incidents	Number of Serious Incidents Reported		2 *	1	2 *	1 *	1 *	1 *	3 *	10 *	2 *	3 *	10 *	5 *	0 *			
		Percentage of Serious Incident Investigations Completed Within Contract Timescale		100% *	100%	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *			
		Serious Incidents – 72 Hour Report Completed Within Contract Timescale		100.0% *	100.0%	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *			
	Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	2.7 *	1.9 *	.9 *	1.7 *	3.1 *	1.9 *	2.6 *	2.4 *	2.8 *	1.4 *	2.8 *	1.7 *	2.5 *			
		Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	2.4 *	3.1 *	2.9 *	2.1 *	2.4 *	1.5 *	1.4 *	2.6 *	2.8 *	4 *	2.8 *	2.5 *	3.3 *			
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	69.1%	66.7%	61.5%	81.0%	78.1%	69.6%	67.7%	60.0%	76.0%	69.4%	73.5%	69.6%	58.6%	71.0%	66.9% *	68.0% *
		Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%	38.0%	41.8%	45.5%	40.3%	37.1%	33.8%	46.2%	38.2%	41.0%	36.7%	50.0%	40.6%	37.8%	42.3%	37.6% *	41.2% *
		Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	95.0%	92.3%	98.2%	89.3%	89.4%	74.0%	91.8%	94.4%	73.5%	90.4%	95.1%	95.6%		93.4%	88.2% *	93.4% *
	Time to Initial Assessment	ED Time To Initial Assessment – Under 15 Minutes	>=99%	87.4%	91.0%	86.2%	86.7%	91.7%	89.9%	91.9%	88.2%	89.5%	90.5%	90.3%	90.8%	88.6%	90.5%	86.7% *	90.0% *
	Time to Start of Treatment	ED Time to Start of Treatment – Under 60 Minutes	>=90%	32.3%	34.9%	31.2%	37.5%	41.5%	40.7%	43.3%	32.7%	35.2%	36.8%	33.6%	34.1%	31.4%	34.8%	34.5% *	33.9% *
Operational Performance	Key Indicators - Operational Performance																		
	Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	89.1%	88.5%	94.9%	87.1%	93.8%	95.5%	98.0%	95.9%	95.9%	100.0%	94.1%	100.0%	100.0% *	98.5%	92.2%	
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	57.1%	77.8%	85.7%	50.0%	60.0%	100.0%	0.0%	80.0%	94.1%	76.5%	100.0%	84.6%	53.3% *	85.4%	79.8%	
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	74.7%	80.1%	69.2%	71.4%	76.7%	73.4%	69.7%	79.1%	78.1%	80.3%	79.9%	66.9%	71.4% *	75.3%	75.0%	
	Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	5.30%	4.80%	2.90%	0.46%	0.51%	0.75%	0.64%	0.49% *	0.26%	0.56%	1.26%	0.52%	0.55%	0.52%	0.26%	0.55% *
	ED – Time in Department	ED Total Time in Department – Under 4 Hours	>=95%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	88.46%	86.94%	91.98%	91.58%	93.33%	91.34%	92.30%	86.70% *	92.04% *
	Detailed Indicators - Operational Performance																		
	Ambulance Handovers	Ambulance Handovers – Over 30 Minutes	< previous year	47	19	30	38 *	33	56	45	44	49	30	25	44	58	99	506	157 *
		Ambulance Handovers – Over 60 Minutes	< previous year	0	1	1	0 *	0	0	2	3	3	1	3	1	0	5	15	5 *
	Cancelled Operations	Number of LMCs Not Re–admitted Within 28 Days	0						6 *	12 *	25 *	21 *	12 *	23 *				6 *	
	Cancer (104 Days)	Cancer (104 Days) – With TCI Date	0	8	9	19	17	6	9	10	4	6	9	12	6	8	6	6	6 *
		Cancer (104 Days) – Without TCI Date	0	35	30	26	23	34	34	19	14	17	18	18	22	28	22	17	22 *
	Cancer (2 Week Wait)	Cancer – Urgent Referrals Seen in Under 2 Weeks	>=93%	79.6%	70.4%	71.2%	74.6%	75.8%	81.2%	86.4%	90.6%	90.5%	86.6%	86.3%	88.6%	90.2% *	87.1%	82.3%	
		Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	57.3%	89.7%	92.7%	89.0%	94.5%	96.3%	92.4%	97.6%	94.5%	91.3%	91.9%	95.1%	96.1% *	92.8%	90.4%	
	Cancer (31 Day)	Cancer – 31 Day Diagnosis To Treatment (First Treatments)	>=96%	95.8%	96.2%	98.5%	95.1%	96.7%	97.3%	96.0%	97.6%	97.9%	96.7%	96.9%	97.1%	97.3% *	96.9%	96.3%	
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	>=98%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *	100.0%	99.8%	
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	>=94%	100.0%	98.4%	96.6%	97.1%	98.5%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6% *	100.0%	99.1%	
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	>=94%	93.6%	91.5%	95.5%	94.6%	98.1%	94.9%	93.0%	95.5%	98.0%	94.9%	96.6%	94.5%	95.3% *	95.3%	94.8%	
	Delayed Discharges	Acute Delayed Transfers of Care – Patients	<14	27	29	32	29	34	41	22	23	34	37	27	36	47	36	34	47 *
	Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End			883 *	1,298	1,062	867	733	239 *	106	123	188	223	260	311 *	260	123	311 *
	Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	63.7% *	60.9% *	59.8% *	60.0% *	61.1% *	59.9% *	56.9% *	57.7% *	59.4% *	62.0% *	60.3% *	64.8% *		62.3% *	60.7% *	62.3% *
	ED – Time in Department	CGH ED – Percentage within 4 Hours	>=95%	94.40%	95.00%	93.20%	93.80%	97.10%	96.60%	93.60%	95.10%	96.50%	97.80%	98.10%	96.30%	96.90%	97.40%	93.90% *	97.30% *
		GRH ED – Percentage Within 4 Hours	>=95%	77.70%	84.60%	82.40%	86.60%	94.40%	88.00%	87.90%	85.30%	82.30%	89.10%	88.10%	91.80%	88.40%	89.67%	83.00% *	89.30% *
	Inpatients	Stranded Patients		451	461	487	479	447	446	472	464	482	384	395	369	373	383	468 *	380 *

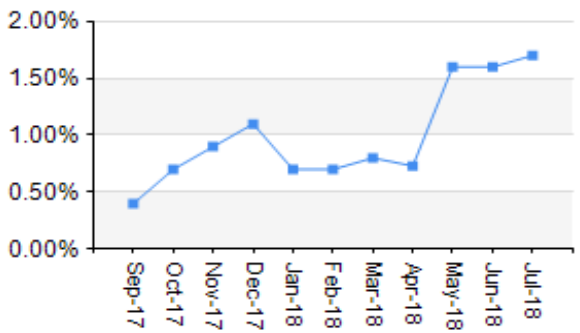
Category		Indicator	Target	Month												Quarter	Annual	
				Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	18/19 Q1	17/18	18/19
	Length of Stay	Average Length of Stay (Spell)		4.97 *	4.86 *	4.75 *	5.11 *	5 *	4.79 *	5.1 *	5.04 *	4.99 *	5.14 *	4.66 *	4.57 *	4.5 *	4.79 *	4.96 *	4.71 *
		Length of Stay for General and Acute Elective Spells	<=3.4	2.74 *	2.96 *	2.96 *	3.32 *	2.75 *	2.84 *	2.91 *	2.99 *	3.01 *	2.83 *	2.86 *	2.53 *	2.73 *	2.73 *	2.9 *	2.73 *
		Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.62 *	5.36 *	5.24 *	5.56 *	5.61 *	5.28 *	5.56 *	5.53 *	5.46 *	5.68 *	5.16 *	5.15 *	4.96 *	5.32 *	5.5 *	5.23 *
	Medically Fit	Number of Medically Fit Patients Per Day	<40	63	58	60	62	60	64	55	65	67	67	66	71	71	68	60 *	69 *
	Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	13 *	27 *	30 *	30	64 *	74 *	50 *	63	95 *	95	92	98	113	98		113 *
	SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%	100.0% *
		Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%					99.8%	99.8% *
	Trolley Waits	ED 12 Hour Trolley Waits	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1 *
Finance	Key Indicators - Finance																		
	Finance	YTD Performance against Financial Recovery Plan		4.35	4.24	1.87	-.27 *	-2.1 *	-6.4 *	-6.5 *	-10.8 *	-18.4 *	.05	.07	.09	.18 *			
	Detailed Indicators - Finance																		
	Finance	Agency – Performance Against NHSI Set Agency Ceiling		3	3	4	3	3 *	3 *	3 *	3 *	3 *	2	2	2	2			
		Capital Service		4	4	4	4	4 *	4 *	4 *	4 *	4 *	4	4	4	4			
		Liquidity		4	4	4	4	4 *	4 *	4 *	4 *	4 *	4	4	4	4			
		NHSI Financial Risk Rating	3	4	4	4	4	4 *	4 *	4 *	4 *	4 *	4	4	4	4			
		Total PayBill Spend		27.46	28.25	27.94	27.9	27.9 *	27.7 *	28.1 *	28.5 *	28.5 *	28.4	28.5	28.05	28.5			
Leadership and Development	Key Indicators - Leadership and Development																		
	Sickness	Sickness Rate	G<3.6% R>4%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9% *	3.9% *	3.9%	3.9% *
	Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.67	3.67	3.67	3.67	3.67	3.67	3.67	3.67	3.67 *
	Turnover	Workforce Turnover Rate	G<11% R>15%	12.3%	12.4%	12.3%	12.4%	12.1%	11.9%	11.6%	11.4%	12.1%	12.0%	11.8%	12.3%	12.3% *	12.3%	12.0%	12.3% *
	Detailed Indicators - Leadership and Development																		
	Appraisals	Staff Having Well-Structured Appraisal Indicator	>3.8	3	3	3	3	3	3	3	3 *	2.95 *	2.95	2.95	2.95	2.95 *	2.95	2.95	2.95
		Staff who have Annual Appraisal	G>=90% R<70%	79.0%	79.0%	79.0%	83.0%	84.0%	84.0%	83.0%	83.0%	82.0%			74.0%	74.0%	74.0%	82.0%	74.0% *
	Staff Survey	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	33.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0% *	30.0% *	30.0%	30.0%	30.0%	30.0%	30.0%	34.0% *	30.0% *
	Training	Statutory/Mandatory Training	>=90%	89%	89%	88%	88%	88%	88% *	73%	79%				87%	87%			87% *

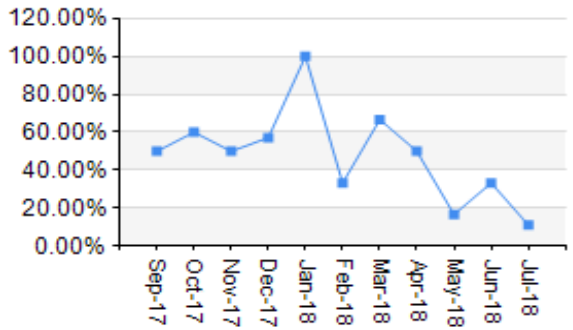
Exception Report

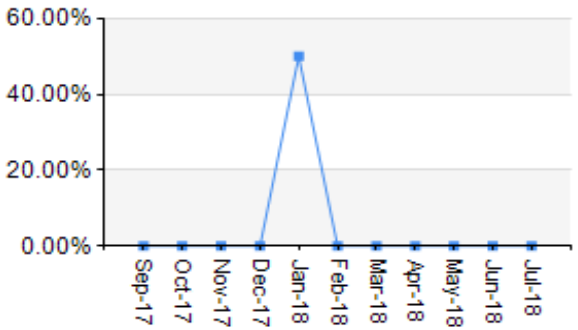
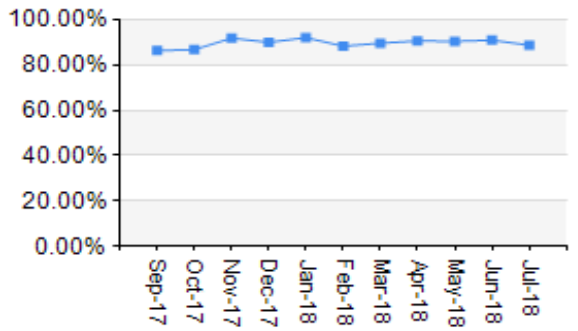
Metric Name & Target	Trend Chart	Exception Notes	Owner
Acute Delayed Transfers of Care – Patients **Target: <14**		We have a relatively new system in place countywide called Brokerage that sources our packages of care and also our residential and care home provision for those patients who require support from GCC. Self-funded patients are supported to find provision by care navigators, however this will often be form the same providers. There are significant delays in finding suitable accommodation or care provision at home for many of our patients there are 24 patients currently waiting. There have been a reduction in care home places countywide as some established homes have ceased business alongside an increasing population of patients who now require night care and care packages in certain areas of the county are increasingly difficult to source. The CCG have recently reviewed our medically fit patients and the support available from our community hospitals and are pulling together an action plan to address issues raised. We discuss and challenge the pathway of all medically fit patients at our daily navigation meetings as well as holding a weekly partnership meeting where we highlight patients who are difficult to place and attempt to find solutions to manage their on-going pathway.	Deputy Chief Operating Officer
Ambulance Handovers – Over 30 Minutes **Target: < previous year**		Ambulance handover delays > 30 minutes have increased since quarter 1. Ambulance handover was challenged in July due to the record number of E.D attendances resulting in 58 > 30 minute delays. As discussed in May the trend analysis demonstrates that the majority of delays occur in the early evening in line with peak 999, G.P referral and walk-in attendances. This period of time also coincides with peak E.D congestion where > 75 patients are in the department.	Deputy Chief Operating Officer
C.Diff Cases – Cumulative Totals **Target: 18/19 = 36**		There were 7 cases of trust-apportioned C. difficile during July 2018. Investigations of individual cases have focussed on antimicrobial as a leading risk factor for the higher than expected case rate. The trust have a comprehensive action plan to bring about improvements.	Director of Nursing and Midwifery

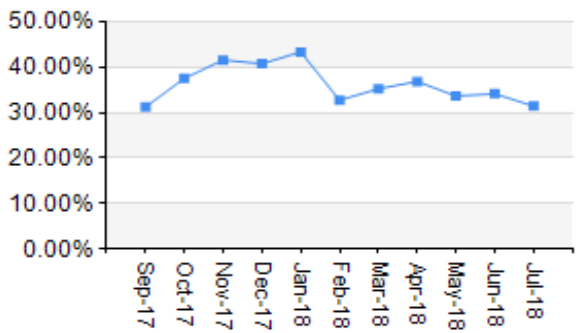
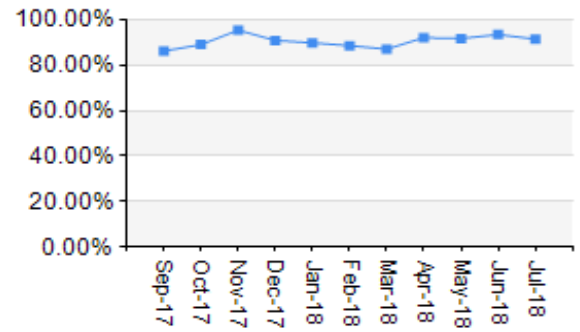
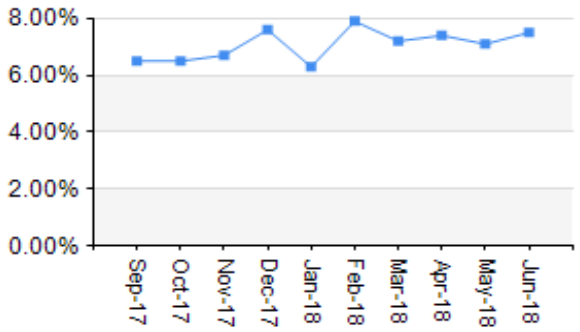
Metric Name & Target	Trend Chart	Exception Notes	Owner
Cancer – Urgent Referrals Seen in Under 2 Weeks **Target: >=93%**		July 2ww - 2002 date first seens 194 breaches 90.3% 10 out of 12 specialties met 2ww standard Lower GI 124 breaches 70.7% Gynae 17 breaches 87.7% Lower GI backlog has significantly reduced. Further capacity planned for Endoscopy to help clear backlog and give capacity in line with STT colon project	Deputy Chief Operating Officer
Cancer (104 Days) – With TCI Date **Target: 0**		36 104s 14 with TCIs Urological (excl. testicular) 22 Lower gastrointestinal 4 Upper gastrointestinal 2 Skin 2 Sarcomas 1 Other 1 Head & neck 1 Haematological 1 Gynaecological 1 Breast 1 Grand Total 36 1 late tertiary referral from Hereford 2 delayed tertiary referral treatments Cancer Delivery Plan outlines each specialties approach to reduction in 104s	Deputy Chief Operating Officer

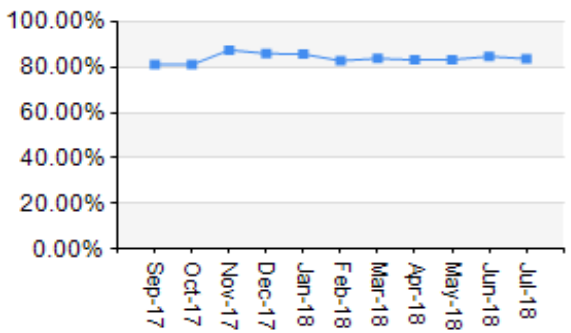
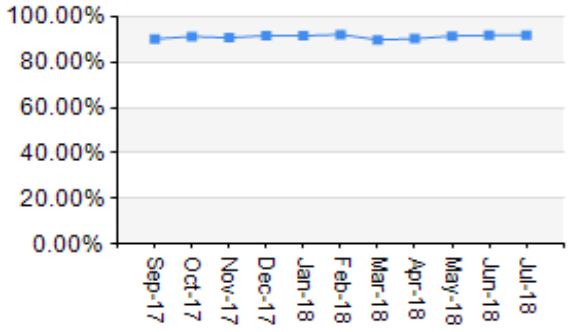
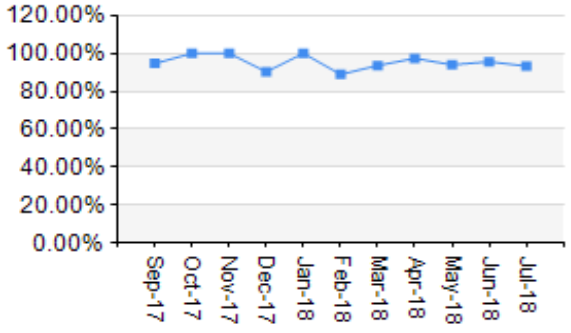
Metric Name & Target	Trend Chart	Exception Notes	Owner
Cancer (104 Days) – Without TCI Date **Target: 0**		36 104s 12 without TCIs Urological (excl. testicular) 22 Lower gastrointestinal 4 Upper gastrointestinal 2 Skin 2 Sarcomas 1 Other 1 Head & neck 1 Haematological 1 Gynaecological 1 Breast 1 Grand Total 36 1 late tertiary referral from Hereford 2 delayed tertiary referral treatments Cancer Delivery Plan outlines each specialties approach to reduction in 104s	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		Upgrades 7.5 tx and 3.5 breaches (53.3%) Gynae 1 - Elongated diagnostics from missing hysteroscopy due to transport issues Lung 1.5 - Late upgrade from Hereford and onward tertiary delay to QE Delay to CT biopsy being booked (admin delay) Uro 1 - Biopsy capacity	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		July 62d performance - 166.5 tx with 46 breaches (72.4%) Improvement on poor June performance. 7 out of 12 specialties currently meeting 62d standard Uro 27.5 breaches (consultant sick leave impacting biopsy backlogs and treatment capacity; ANP sick leave impacting ability to run RALP lists) LGI 5 breaches (61.5%)- 3xrepeat diagnostics, patient initiated delay to first OPA and complex patient H&N 3.5 breaches (72%)- Complex patients Haem 2 breaches (75%) - Late tertiary and delay to pathology reporting	Deputy Chief Operating Officer

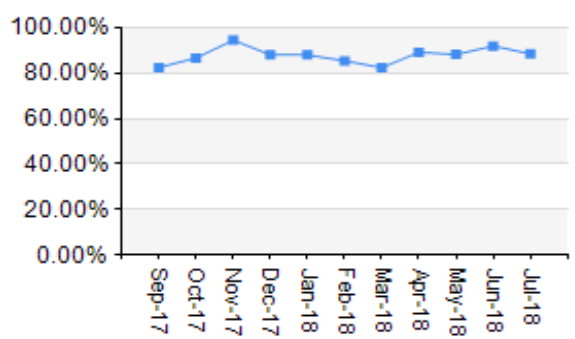
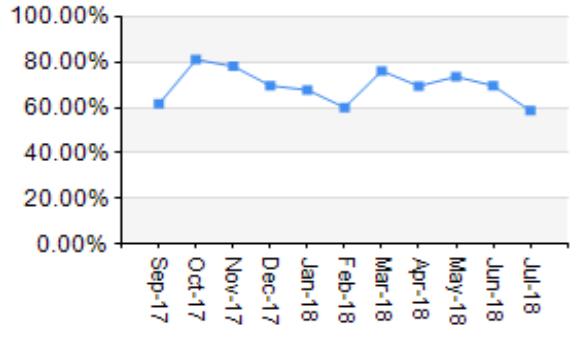
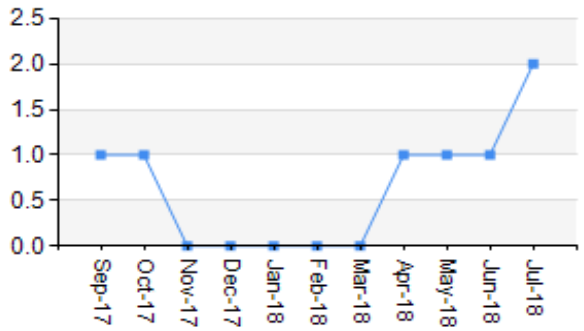
Metric Name & Target	Trend Chart	Exception Notes	Owner
Dementia – Fair question 1 – Case Finding Applied **Target: >=90%**		• The wording for the Dementia case finding section of the medical clerking proforma has been agreed, this will be implemented in practice when stocks of the document are re-ordered. (revised document as attached) • Trust Safeguarding Adult at Risk Advisory Team continue to audit ACUC and AMU weekly to check compliance in completion of the 10AMT within the case notes- we will also include a check on compliance in documentation of ''asking the case finding question'' when the new medical clerking documentation stock is ordered and begins to be seen in practice. (Audit scores are as attached). The AMU August audit is taking place today. I will also circulate to AMU and ACUC teams for their update and for their actions to support improved completion. • Trust Safeguarding Adult at Risk Advisory Team have developed and made ''Dementia Case Finding pocket prompt cards''. These have been distributed as part of the new Dr's Induction roadshow. These are also given out at visits to AMU and ACUC- alongside linking with Sisters/Charge nurses, Consultant and Medical Team at each visit. (as attached) • I am booked to attend ACUC Dr's teaching session on 22nd August to promote Dementia Case Finding • Dr Alexander is promoting completion of the Dementia section within Trakcare across Care of the Elderly Speciality • Actions have been escalated to Trakcare Team in support of enabling a more clinically intuitive system within Trakcare for the ''in -patient over 75 years assessment''(currently titled ''Dementia'' section) , so that the section be retitled, also that data need be entered only once within Trakcare, and so that the appropriate information for the Gp can be auto-populated within the Discharge section. • The AMT 10 sticker and 4 AT sticker pilot is in progress on Ryeworth ward, ahead of Trust wide implementation. In addition the update of the Trust Dementia care and Trust Delirium Care pathway in nearing completion, this will also be pilot tested on Ryeworth ward ahead of Trust wide implementation alongside the stickers.	Deputy Nursing Director & Divisional Nursing Director - Surgery

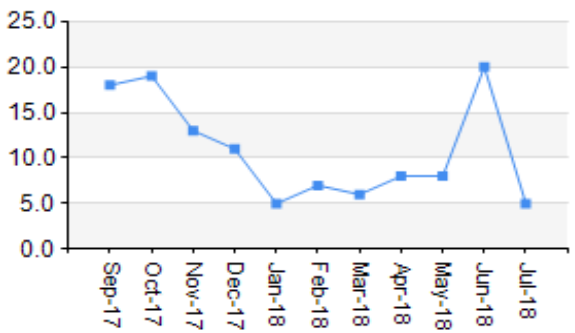
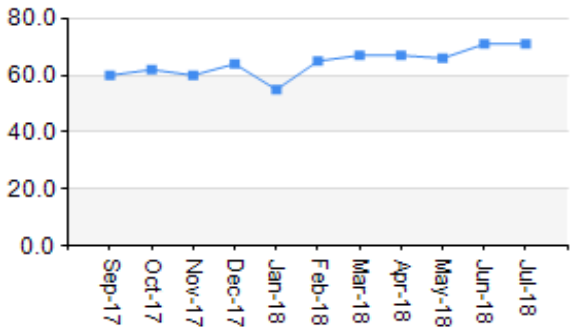
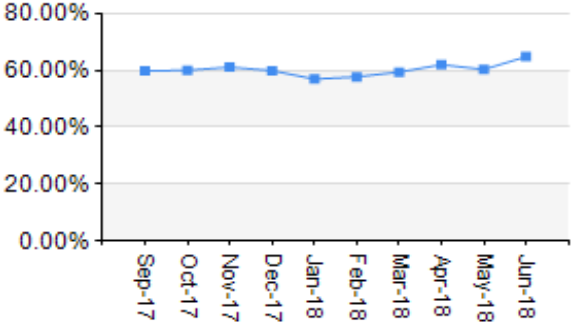
Metric Name & Target	Trend Chart	Exception Notes	Owner
Dementia – Fair question 2 – Appropriately Assessed **Target: >=90%**		• The wording for the Dementia case finding section of the medical clerking proforma has been agreed, this will be implemented in practice when stocks of the document are re-ordered. (revised document as attached) • Trust Safeguarding Adult at Risk Advisory Team continue to audit ACUC and AMU weekly to check compliance in completion of the 10AMT within the case notes- we will also include a check on compliance in documentation of ''asking the case finding question'' when the new medical clerking documentation stock is ordered and begins to be seen in practice. (Audit scores are as attached). The AMU August audit is taking place today. I will also circulate to AMU and ACUC teams for their update and for their actions to support improved completion. • Trust Safeguarding Adult at Risk Advisory Team have developed and made ''Dementia Case Finding pocket prompt cards''. These have been distributed as part of the new Dr's Induction roadshow. These are also given out at visits to AMU and ACUC- alongside linking with Sisters/Charge nurses, Consultant and Medical Team at each visit. (as attached) • I am booked to attend ACUC Dr's teaching session on 22nd August to promote Dementia Case Finding • Dr Alexander is promoting completion of the Dementia section within Trakcare across Care of the Elderly Speciality • Actions have been escalated to Trakcare Team in support of enabling a more clinically intuitive system within Trakcare for the ''in -patient over 75 years assessment''(currently titled ''Dementia'' section) , so that the section be retitled, also that data need be entered only once within Trakcare, and so that the appropriate information for the Gp can be auto-populated within the Discharge section. • The AMT 10 sticker and 4 AT sticker pilot is in progress on Ryeworth ward, ahead of Trust wide implementation. In addition the update of the Trust Dementia care and Trust Delirium Care pathway in nearing completion, this will also be pilot tested on Ryeworth ward ahead of Trust wide implementation alongside the stickers.	Deputy Nursing Director & Divisional Nursing Director - Surgery

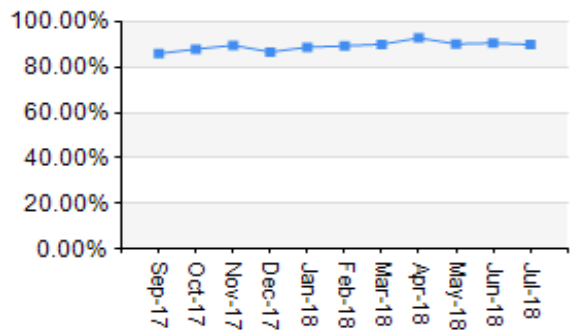
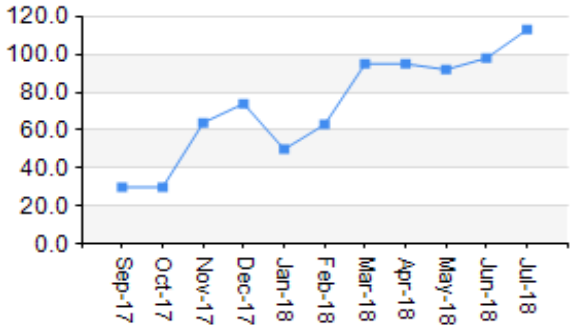
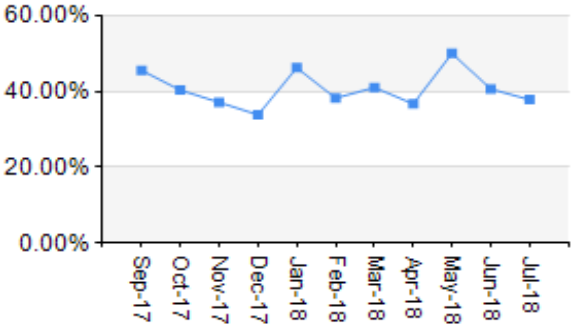
Metric Name & Target	Trend Chart	Exception Notes	Owner
Dementia – Fair question 3 – Referred for Follow Up **Target: >=90%**		• The wording for the Dementia case finding section of the medical clerking proforma has been agreed, this will be implemented in practice when stocks of the document are re-ordered. (revised document as attached) • Trust Safeguarding Adult at Risk Advisory Team continue to audit ACUC and AMU weekly to check compliance in completion of the 10AMT within the case notes- we will also include a check on compliance in documentation of ''asking the case finding question'' when the new medical clerking documentation stock is ordered and begins to be seen in practice. (Audit scores are as attached). The AMU August audit is taking place today. I will also circulate to AMU and ACUC teams for their update and for their actions to support improved completion. • Trust Safeguarding Adult at Risk Advisory Team have developed and made ''Dementia Case Finding pocket prompt cards''. These have been distributed as part of the new Dr's Induction roadshow. These are also given out at visits to AMU and ACUC- alongside linking with Sisters/Charge nurses, Consultant and Medical Team at each visit. (as attached) • I am booked to attend ACUC Dr's teaching session on 22nd August to promote Dementia Case Finding • Dr Alexander is promoting completion of the Dementia section within Trakcare across Care of the Elderly Speciality • Actions have been escalated to Trakcare Team in support of enabling a more clinically intuitive system within Trakcare for the ''in -patient over 75 years assessment''(currently titled ''Dementia'' section) , so that the section be retitled, also that data need be entered only once within Trakcare, and so that the appropriate information for the Gp can be auto-populated within the Discharge section. • The AMT 10 sticker and 4 AT sticker pilot is in progress on Ryeworth ward, ahead of Trust wide implementation. In addition the update of the Trust Dementia care and Trust Delirium Care pathway in nearing completion, this will also be pilot tested on Ryeworth ward ahead of Trust wide implementation alongside the stickers.	Deputy Nursing Director & Divisional Nursing Director - Surgery
ED Time To Initial Assessment – Under 15 Minutes **Target: >=99%**		ED Time to Initial Assessment fell below 90% for July 2018. Analysis shows that overnight (23:00 - 07:00) continues to be where triage performance consistently deteriorates. A Triage performance PID has been prescribed by Prof Mark Pietroni as part of the Unscheduled Care Leaders group.	Deputy Chief Operating Officer

Metric Name & Target	Trend Chart	Exception Notes	Owner
ED Time to Start of Treatment – Under 60 Minutes **Target: >=90%**		ED Time to Start of Treatment performance continues to be below standard. Medical duty rotas are continually reviewed by the ED Rota Manager, Dr Mark Allan and the ED clinical director Dr Rob Stacey to maximise safety and efficiency across both sites. Appointment of a new Assistant General Manager, service improvements in AMIA and G.P streaming for walk-ins are in place for to facilitate this metric in the coming months. Of note July 2018 was the busiest month on record for attendances and G.P medical patients are included in the metric where the SAMBA definitions should be applied.	Deputy Chief Operating Officer
ED Total Time in Department – Under 4 Hours **Target: >=95%**		Whilst performance in July remains below the 95% national standard, it exceeded the agreed trajectory with NHSI of 90%. There was a minor deterioration from the previous month but July 2018 was the busiest month in relation to ED attendances on record. Admitted 4 hour performance has improved by 13.3% when compared to this time last year (July 2017).	Deputy Chief Operating Officer
Emergency Readmissions Percentage **Target: Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%**		The emergency re-admission rate has increased to 7.5% for June 2018. Areas for further investigation into with high re-admission rates are GOAM (15.5%), General Medicine (17%), Thoracic Medicine (10.6%) and Endocrinology (21.4%). It is anticipated that the introduction of the frailty assessment service will improve the re-admission rate in GOAM and General Medicine (as many of the frailty patients are under general medicine when admitting to acute medical / care units). Furthermore the re-admission data currently includes units such as AMIA & EGSU which will be excluded from the data set as of 01st September 2018.	Deputy Chief Operating Officer

Metric Name & Target	Trend Chart	Exception Notes	Owner
Friends and Family Test Score – ED % Positive **Target: >=86%**		The Friends and Family Test data show a static position. Inpatient scores remain below average and so now work is underway to look at ward data in a different way which will flag the wards with lower than the national average scores which will be plotted over time. Real time survey data collection will start as soon as we have purchased the new software needed to support the analysis and reports required. The 2 tools used together will enable us to have more insight into ward experiences.	Head of Patient Experience Improvement
Friends and Family Test Score – Inpatients % Positive **Target: >=95%**		The Friends and Family Test data show a static position. Inpatient scores remain below average and so now work is underway to look at ward data in a different way which will flag the wards with lower than the national average scores which will be plotted over time. Real time survey data collection will start as soon as we have purchased the new software needed to support the analysis and reports required. The 2 tools used together will enable us to have more insight into ward experiences.	Head of Patient Experience Improvement
Friends and Family Test Score – Maternity % Positive **Target: >=97%**		The Friends and Family Test data show a static position. Inpatient scores remain below average and so now work is underway to look at ward data in a different way which will flag the wards with lower than the national average scores which will be plotted over time. Real time survey data collection will start as soon as we have purchased the new software needed to support the analysis and reports required. The 2 tools used together will enable us to have more insight into ward experiences.	Head of Patient Experience Improvement

Metric Name & Target	Trend Chart	Exception Notes	Owner
GRH ED – Percentage Within 4 Hours **Target: >=95%**		Whilst performance in July remains below the 95% national standard, it exceeded the agreed trajectory with NHSI of 90%. There was a minor deterioration from the previous month but July 2018 was the busiest month in relation to ED attendances on record. Admitted 4 hour performance has improved by 13.3% when compared to this time last year (July 2017).	Deputy Chief Operating Officer
High Risk TIA Patients Starting Treatment Within 24 Hours **Target: >=60%**		During July the number of High Risk TIA's assessed and treated within 24 hours was just short of the 60% target, with a performance of 58.6%. This is the first time in the past 12 months the service have not achieved this target. In month there were 29 high risk TIA patients referred of which 12 were not treated within the 24 hours. Of those 12 patients, 6 chose not be seen within this time frame despite being offered appointments, with a further 6 patients who could not be contacted within the timeframe. Although capacity remains tight, sufficient capacity was available to achieve this target in month, which was compromised by patient choice and the inability to contact the patients despite every effort.	Director of Operations - Medicine
MRSA Bloodstream Cases – Cumulative Totals **Target: 0**		During July 2018 the trust had one case of trust-apportioned MRSA bacteraemia. This case was reviewed by the IPC team and consultant-in-charge of the patient's care. The source was identified to be a surgical site infection. The patient remained well and the wound healed. The patient was informed.	Director of Nursing and Midwifery

Metric Name & Target	Trend Chart	Exception Notes	Owner
Number of Breaches of Mixed Sex Accommodation **Target: 0**		Mixed sex breaches recovered in July 2018 reducing from 20 breaches to 5. The mixed sex audit methodology has been reviewed resulting in a far more robust, resilient and accurate submission. Breaches in DCC and CPAU accounted for the breaches in July 2018 due to capacity and flow.	Head of Capacity and Patient Flow
Number of Medically Fit Patients Per Day **Target: <40**		We have a relatively new system in place countywide called Brokerage that sources our packages of care and also our residential and care home provision for those patients who require support from GCC. Self-funded patients are supported to find provision by care navigators, however this will often be form the same providers. There are significant delays in finding suitable accommodation or care provision at home for many of our patients there are 24 patients currently waiting. There have been a reduction in care home places countywide as some established homes have ceased business alongside an increasing population of patients who now require night care and care packages in certain areas of the county are increasingly difficult to source. The CCG have recently reviewed our medically fit patients and the support available from our community hospitals and are pulling together an action plan to address issues raised. We discuss and challenge the pathway of all medically fit patients at our daily navigation meetings as well as holding a weekly partnership meeting where we highlight patients who are difficult to place and attempt to find solutions to manage their on-going pathway.	Deputy Chief Operating Officer
Patient Discharge Summaries Sent to GP Within 1 Working Day **Target: >=85%**			Medical Director

Metric Name & Target	Trend Chart	Exception Notes	Owner
Percentage of Women Seen by Midwife by 12 Weeks **Target: >90%**		The Track care Team continue towork to improve data quality with respect to this KPI. The community midwifery team in parts of the county have experienecd some unexpected S&A in the past months , therefore it has been more difficut to book women by 12 weeks.Work is being undertaken under the Better Births initative to explore the potential for a centralised midwifery booking system with direct acces to midwifery services to improve equity of accessibility in different parts of the county when there are staffing challages	Divisional Nursing and Midwifery Director
Referral To Treatment Ongoing Pathways Over 52 Weeks (Number) **Target: 0**		Please see planned care exception report for specific speciality detail. The Trust continues to work to support the reduction of the longest waiting patients. The recovery of the Trust position is planned and a review panel for the >52 breaches (where a selection will be reviewed), commenced in August and will continue on a monthly basis. This panel will review the Root Cause Analyses (RCAs).	Deputy Chief Operating Officer
Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour **Target: >=50%**		During July performance against this metric was 37.8%, which is a decrease on the previous 2 months. The campaign to raise awareness within ED of the need for stroke patients to be scanned within 60 minutes will be revisited and discussions will be held within the service line and Division to ensure this is addressed.	Director of Operations - Medicine

REPORT TO MAIN BOARD – SEPTEMBER 2018

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

This report describes the business conducted at the Quality and Performance Committee on 26 July 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	Latest Committee Risk Register (CRR) presented. There has been no movement in risks since last Committee meeting. Action plan relating to Surgical Never Events is in development. An internal risk summit relating to supplies of sterile equipment is planned.	Discussion as to whether Committee oversight of Surgical Action Plan will be sufficiently frequent. Where do the risks associated with cleaning and sterilisation sit and how are they currently scored? Whilst not yet visible within Risk Register, have known concerns about cleaning standards and reporting been risk assessed and addressed where necessary? Is GMS Committee overseeing cleaning standards reporting?	Description of processes whereby Infection Control Committee scrutinises standards. Risk assessment in progress. Future reporting of risk to this and to the GMS Committee.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Prevention of Future Deaths Report	Action Plan presented to the Committee (already sent to the Coroner). Oversight will be exercised by Safety and Experience Review Group (SERG) and Quality Delivery Group (QDG).	Discussion as to how lessons learned from this case are to be embedded. Specific concerns: caring for people with physical and mental health issues; ensuring that the correct drug is being chosen, particularly for intravenous drug users; and how to search for missing patients.	Action plan and confirmation of approach to be taken to implementation.	
Exception Report from the Quality Delivery Group	Material considered included annual reports from each division; results of national diabetes audit and update re safe storage of medications. Good feedback re progress of excellence tool.	Why did VTE position not feature in the report? Discussions about reasons for variability in fridge-checking practice and actions taken in response.	Has been considered and will return to the Group once current work concluded. National Diabetes audit findings to be reported to a future Committee.	
Exception Report from the Emergency Care Board	Detailed update on significant work in progress. Performance improvement noted and staff teams commended on exceptional performance during periods of unprecedented demand. In month 93.3% and Q1	• Discussion included: availability of mental health staffing as 16 of the 27 >12 hour wait patients in ED in June required these services. • Level of emergency	Update received on progress on planned changes to services Medical Director to review	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	performance of 92.3% exceeded NHSI 90% trajectory. Sustained improvement to address previous concerns about Day Surgery breaches. Areas of concern included: 15minute triage; 60 minute performance; ambulance handover times; delays in stroke patients to CT; impact of continued unsustainable levels of demand on staff; delayed discharges.	readmissions • What are the activities that were planned with staff during the summer period that have had to be postponed?	with CCG and report back to the September Committee The focus of staff engagement events being reviewed so that staff are supported	
Exception Report from the Planned Care Board	Detailed update received on the range of measures to improve areas of planned care and to strengthen quality of reporting.	Discussions included clinic typing, still an area of concern. What confidence do we have that underlying level of data quality is improving?	Root cause analysis to be undertaken on all cases with > 30 day delay. Validation oversight described.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Exception Report from the Cancer Delivery Group	Detailed reports on key areas of cancer performance. Underlying improvement in 2 week wait performance. The level of referrals is a key issue, being significantly over planned levels. 62 day referral levels are particularly high in urology, gynaecology and haematology. The project with the CCG to improve the quality of referral forms was discussed.	The Committee discussed the issue of rising levels of referrals, the potential consequences, and the challenges involved in addressing this.	Discussions taking place with CCG. Further engagement to take place with Cancer Clinical Programme Lead.	
Quarterly Patient Experience Report	Report summarised a range of feedback themes: • Changes to the booking office telephone system have led to positive patient feedback • The Trust's FFT performance meant that the strategic objective for positive response was not met but was close; further improvement work is required in all areas. • The volume of concerns	Concerns about the closure of the PALS walk-in service because of demand pressures. This means that some who need the service are missing out. What has been the response to the implementation of revised visiting hours?	Options for extending resources for PALS are being investigated. Early feedback broadly positive but some operational challenges and a short task and finish group will review how visiting times can be optimised.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	continues to add significant pressure to the PALS team and the service they can provide to patients.	What broader information and themes can be derived from complaints?	Currently insufficient resources to undertake the analysis function.	
Infection Control Annual Report	Comprehensive report confirming annual position: 1 case of MRSA bacteria (objective 0); 71 reported cases of C Diff against 37; 55 cases of Ecoli; Concerns re levels of MSSA; Options being considered to extend point of care testing methodology to norovirus from approach taken to flu; Trust continues to be an outlier for Surgical Site Infection.	The Committee discussed their concern about the issue of cleanliness. Team commended for a more comprehensive annual report. What is the planned approach for rectifying the issue of antimicrobial stewardship, and is the Trust sufficiently resourced to do so?	Arrangements for clarifying underlying cleanliness data and reports were described, together with action plan for remedying current areas of concern. Current resource levels were described, together with plans to further extend the capacity of antimicrobial stewardship.	Improvement plan to be presented to GMS Cttee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Safer Staffing Report	The Committee noted the current position and welcomed various recruitment initiatives. Overall substantive fill has been at 73%, and the total fill is at 86%, slight improvements from the previous month. Staffing volatility has been a concern,			
Questions from Governor representative		1. Failure to meet ED standards, and evidence of some very long waits for patients needing mental health services. 2. Suggestion re development of emergency mental health clinics 3. Observation from governors' walkabout of unattended drugs trolley 4. Adequacy of divisional attendance at Infection Control meetings. 5. Suggestion for helping with ED demand was improved signposting to use App.		

Claire Feehily
Chair of Quality and Performance Committee
30 July 2018

REPORT TO MAIN BOARD – SEPTEMBER 2018

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

This report describes the business conducted at the Quality and Performance Committee on 30 August 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	Latest Committee Risk Register (CRR) presented. There has been no movement in risks since last Committee meeting. Action plans relating to sterile services supplies, missing patients and complex patients were discussed.	Whilst not yet visible within Risk Register, have known concerns about cleaning standards and reporting been risk assessed and addressed where necessary? Is GMS Committee overseeing cleaning standards reporting? Reminder that Execs are to consider the risk referred to in previous Board as to the cumulative impact on staff teams of sustained, high levels of ED demand throughout the summer.	Description of processes whereby Infection Control Committee scrutinises standards. Divisional risk registers are currently capturing relevant risks and both Trust Leadership Team (TLT) and GMS Committee will receive further reports in September. To be actioned.	Relevant report format in preparation for GMS Committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report	Detailed brief on latest performance. Update received on progress with revised dashboard. Update about new project to enable collection of real-time data from patients. Reporting anticipated by October. Support for the potential for much improved insights into patients' experiences.	Good discussion of how the new feedback data is to be introduced to teams and the cultural dimensions to ensuring it is positively received and that there is well-planned support and implementation. Potential for extending use of the data tools to medical division and other services that are not ward-based. What is the latest position regarding quality of VTE data and any associated incident and / or harm?	Use of software that has been tried and tested elsewhere. Executive recognition of need for well-managed implementation, careful piloting. Recognition that nursing leadership capacity will need to be freed up for this important project. Data quality currently being investigated.	Confirmation of future reporting and visibility to the Committee
Exception Report from the Emergency Care Board	Detailed update on significant work in progress. Performance improvement noted. In-month performance of 91.3% was a minor deterioration, but exceeded the agreed NHSI trajectory of 90%.	Have we the data to identify patterns of demand for mental health resources over 24 hour periods so that staffing availability can be aligned to demand?	Progress with a revised business case and staffing model were described, together with the very challenging recruitment context.	Confirmation of the availability of requisite staffing resources to meet patient need in a timely way.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	There was a record high level of attendances in the month and high levels of medically fit patients for discharge. Highlighted areas of difficulty were: 15 minute triage; 60 minute medical assessment standard; mental health care availability. Positive feedback about the impact of the Acute Medical Initial Assessment Unit (AMIA).	Discussion about system-wide responses to demand pressures and to pressures arising on shortage of specialist mental health resources.	CCG plans are for a revised service to be in place for winter. Request for clear report to next Committee on where the Trust is in relation to mental health staff availability and barriers to progress.	Confirmation that plans are on target. Further report.
Exception Report from the Planned Care Board	Detailed update received on the range of measures to improve areas of planned care and to strengthen quality of reporting. Particular focus on good diagnostics performance and improvement to the numbers of patients without recall dates.	Discussions included clinic typing, still an area of concern and the focus of a recent Executive review and additional resources. How is the risk associated with the delays in letters being identified?	Confirmed that the current position is unacceptable and that reductions of 50% are planned for end of September. Process by which delays are categorized and then risk-assessed within divisions was described. A red risk might	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
			include delays to notifying GPs of medication changes. Update from Medical Director on plans to shadow some of these processes with CCG. Current risk rating to be reviewed.	
		How far are we from being able to report RTT performance, overall and by specialty? Can the Committee reports in future include a commentary on what is currently known in terms of waiting times for patients?	Further consideration to develop report content.	
		How are we supporting those patients who are not necessarily able to participate in a dialogue about their delayed letters or appointments?	Arrangements for communication support to patients with learning disabilities and to carers of those with dementia were described.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Exception Report from the Cancer Delivery Group	Detailed reports on key areas of cancer performance. Underlying improvement in 2 week wait performance. Decrease in aggregated 62 day performance Demand in June exceeded plans across almost all tumour sites	Discussions included circumstances of sickness absence and its impact in performance. 36 patients now waiting more than 104 days for treatment (highest level in current year). Principal areas of delay are in Urology and Lower GI. However, what actions can be taken for the 29% of cases in other areas? Is it possible to predict likely levels of >104 day performance so that future problem can be identified?	Evidence of internal reporting and close oversight of performance by tumour site. Further analysis to be undertaken.	
Feedback from CQRG	The Committee noted a briefing received from CCG's Quality lead, identifying those topics upon which CCG's monthly Quality Group has focused recently, including: • Deteriorating Patient Team • Implementation of NEWS2 and involvement in planned audit of compliance • Trust to rejoin regional		Confirmation from CCG rep that the Committee's focus and scrutiny are aligned with the expected priorities.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Sepsis group • Monitoring of C.Difficile action plan • Trust response to Gosport Independent Panel Report • Cancer performance, especially referral processes from primary care			
CQC	Regular update received on progress of Trust's 30 Must Do actions from CQC report. 15 actions are closed, 10 are on track to close. There are 3 amber actions with delivery at risk: • ED staffing, • recording of information related to Do Not Attempt CPR on patient records • Compliance with the requirements of the Mental Capacity Act (MCA). There are 2 red actions that remain risks: • ensuring that all staff are up to date with mandatory training and receiving yearly appraisals	Specific discussions about securing consistency in achieving improvements. What are the structures for continuing oversight of progress outside the Committee? Are there any difficulties associated with shifting implementation dates for some items eg to December 2018?	One further report to this Committee and then the Must Do Actions will be moved to Delivery Groups for scrutiny of progress and tests of embeddedness.. QandP Cttee will then receive exception-based progress updates. Trust has ownership of its timelines on implementation and they are realistic.	Exception reports from Delivery Groups will require more narrative to demonstrate position on CQC Must Dos.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	• devising a rota for out of hours interventional radiology consultants.			
C. Diff – Improvement Plan	Update to action plan was received, indicating that 70% of actions are now completed. Briefing included a range of further improvements that are being made. The new Trust lead for Infection Control has reviewed the plan and made some amendments to content and timelines.	Can we ensure any changes are formally received by the Committee?	To be reviewed for next iteration of action plan.	
Mortality Report and Learning from Deaths update	Standing item presented. HSMR, SMR and SHMI markers are now within 'as expected' range, including for weekends.			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Learning from Deaths policy has now been updated to incorporate revised expectations about care reviews forming part of the approach, together with meaningful and compassionate inclusion of bereaved families.	What has been the staff reaction to structured judgement reviews? What intelligence do we have as to how this aspect of care is to be inspected by CQC?	Mixed, but greater acceptance and understanding has come from being involved in the reviews. Not yet clear.	Further development required to reach appropriate levels of family involvement in the training of staff undertaking mortality reviews.
Serious Incidents Report	Update received on serious incidents. One new never event was noted for this reporting period, involving the administration of an oral drug preparation intravenously. This was a no harm event.	Can Executives consider how the Committee can receive appropriate evidence of embedded learning from incidents and of the cultural change required to reduce likelihood of repetition?	Investigation timescales met in reporting period. Learning events from incidents to begin in September and reporting framework to be developed as a source of further assurance to the Committee. Reference to work of Safety and Experience Review Group with its detailed oversight of all SIs, subsequent investigations, action plans and subsequent learning. Further work in development on exception reporting	Further report to Committee to focus on activities of SERG to enable scrutiny of current arrangements for spreading and embedding learning from incidents and other relevant sources.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
			through from SERG to the Committee. Committee will receive reports. Management response to theatre safety report to be circulated and considered at a future Committee. Summary of related discussions with CQC, NHSI and CCG provided.	
	Referral of two cases for investigation by Healthcare Safety Investigation under Every Baby Counts criteria. Reports expected in 6 months. Exploration of further options for IT-based ways of sharing lessons from complaints and incidents and using material for in-situ	Concerns expressed at lengthy timeframes involved for such investigations and confirmation that Trust will continue with its arrangements for securing immediate learning as required. Executives encouraged to make representations about the importance of family involvement in any such external investigations.		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	simulations.	Update requested re position described at previous Committee about IT requirements for shared children's safeguarding data within Trust.	Has been some internal engagement and request for report by CCG.	Update via Action Log.
Items to note: Clinical Systems Safety Group (CSSG)	Discussion of new group's focus on clinical safety.	The report needs to cross refer to reports dealing with IT systems and their risk registers.	Report template and style still in development as well as connections to other reporting summaries.	Terms of reference and minutes to come to next QandP for greater clarity as to which forms of assurance are to come from this source. Relationship between this group and the new Board Committee with oversight of ICT to be determined.
Questions from Governor representative		1. Need for assurance that any software being introduced for real- time patient feedback has been proven to work. 2. What are the	The planned software has been used in other hospitals and the contract period is for less than one year, which will allow the Trust to take stock as to its value and effectiveness here. Ideas are still in development.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		arrangements for mock inspections prior to the CQC's visit? 3. Concerns have been registered by and to CoG members on ward visits about cleanliness and availability of fans, and about whether infection control standards are maintained by on-site contractors doing equipment repairs etc.	Council of Governors (CoG) to be kept advised. Noted.	
Deferred Items:	Several items were deferred to the next or future meetings of the Committee: • Diabetes Audit Presentation • Exception Report from the Quality Delivery Group • Terms of Reference Review • CQC Preparation Project Update • Never Event Report • Safer Staffing			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	• Items to note from: Infection Control Committee; Hospital Mortality Group; Safeguarding Strategy Group; Maternity Safety Champion			

Claire Feehily
Chair of Quality and Performance Committee
30 August 2018

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Mary Barnes, Risk Co-ordinator Sponsor: Lukasz Bohdan, Director of Corporate Governance

Executive Summary

Purpose

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

Key issues to note

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

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

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

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

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

Changes in Period

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

August - Nil

September
C2768IC- There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards in some areas.

This risk has been escalated from the Control of Infection Committee and supported by the Quality & Performance Committee.

One risk has been **downgraded** in this reporting period.

August
- Nil

September

C2667NIC- The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.

This risk was downgraded to 4x3 following the removal of the threat of regulatory action.

No risks have been **closed**

August
- Nil

September – Nil

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

Conclusions

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

Implications and Future Action Required

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

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					5th September 2018	
Outcome of discussion when presented to previous Committees						

Trust Risk Register - September 2018

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
C2768IC	Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Chief Operating Officer	Quality and Performance Committee	There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards in some areas.	1, improvement plan developed. 2, review meetings through the GMS contractual mechanisms. 3, matron's undertaking individual audits in preparation for CQC. 4, auditing now completed by designated auditing team. 5, corporate visibility through infection control committee and trust leadership team.	Partially complete	Major (4)	Likely - Weekly (4)	16
S2275	Surgical	Workforce	Medical Director	Trust Leadership Team, Workforce Committee	The risk to workforce of an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers.	Attempts to recruit Agency/locum cover for on-call rota Nursing staff clerking patients Prioritisation of workload Existing junior drs covering gaps where possible Consultants acting down	Incomplete	Major (4)	Likely - Weekly (4)	16
F2335	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance Committee, Workforce Committee	The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2.Increase challenge to agency requests via VCP 3. Convert locum\agency posts to substantive 4. Promote higher utilisation of internal nurse and medical bank.	Incomplete	Major (4)	Likely - Weekly (4)	16
C2628COO	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Operating Officer	Quality and Performance Committee	The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times. The risk on non-reporting of RTT (incomplete) standards.	The standard is not being met and reporting has been suspended. This risk is aligned with the recovery of Trak. Controls in place from an operational perspective are the design and implementation of a patient tracking list, resource to support central and divisional validation of the patient tracking list. Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. A delivery plan for the delivery to standard across specialities is under development but this will need to align with the timeline for trak recovery.	Partially complete	Major (4)	Likely - Weekly (4)	16

C1748COO	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee	The risk of statutory intervention for failing national access standards in relation to cancer.	1. Weekly meetings check and challenge with all specialties, patient by patient level review 2. Dir-Ops weekly challenge with COO and Director of Planned Care 3. Validation of Patient tracking list daily by GMs 4. Performance trajectory in place for cancer pathways 5. Action plan in place for Delivery of Cancer Trajectory (30 April 18)	Partially complete	Major (4)	Possible - Likely (4)	16
F2724	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19	PMO in place to record and monitor the FY18 programme Weekly Turnaround Implementation Board Monthly monitoring and reporting of performance against target Monthly executive reviews	Complete	Catastrophic (5)	Possible - Monthly (3)	15

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

S2595Th	Gloucestershire Managed Services, Surgical	Safety	Chief Nurse, Director of Quality	Decontamination Group, Divisional Board, Infection Control Committee, Quality and Performance Committee	The risk of harm to patients due to correct and sterile equipment not being available from CSSD	Heavy contaminated sets go through pre clean All sets go through washer disinfectors All machines have valid testing certificates Internal non conformist reports Bioburden testing Quarterly testing on clean room (external) Checks in CSSD prior to dispatch Extra integrity check for heavier sets External audit of full process of decontamination Corner protectors and tray liners used on both sites Point protectors used on both sites Transportation trays removal of 3rd wrap on sets Dryness tests of sutoclaves Quality management systems - accredited ISO13485 reusable medical devices	Incomplete	Moderate (3)	Likely - Weekly (4)	12
C2667NIC	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Quality	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee	The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.	Detailed action plan has been developed and reviewed by the Infection Control Committee, focusing on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the environment and antimicrobial stewardship.	Partially complete	Major (4)	Possible - Monthly (3)	12
C1945NTVN	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality/ Chief Nurse	Quality and Performance Committee	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Nursing pathway documentation and training in place Monitoring through incident investigation\RCA Divisional committees overseeing RCAs Safety Thermometer data review as part of Safer Staffing NHS collaborative work in 2018 to support evidence based care provision and idea sharing. Pressure relieving equipment in place Trust wide to reduce risk.	Incomplete	Moderate (3)	Likely - Weekly (4)	12

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	How would you assess the status of the controls?	Consequence	Likelihood	Score
S2568Anaes	Surgical	Safety	Medical Director	Divisional Board, Medical Devices Committee, Quality and Performance Committee	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	Application to MEF Prioritisation of operations Maintenance by own medical engineering service loan request	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00am

Report Title
Financial Performance Report - Period to 31st July 2018
Sponsor and Author(s)
Author: Jonathan Shuter, Director of Operational Finance Sponsor: Sarah Stansfield, Director of Finance
Executive Summary
Purpose This report provides an overview of the financial performance of the Trust as at the end of Month 4 of the 2018/19 financial year. Key issues to note - The financial position of the Trust at the end of Month 4 of the 2018/19 financial year is an operational deficit of £12.9m. This is a favourable variance to budget and NHSI Plan of £0.1m. - CIP delivery to Month 4 is £6.9m. This is £2.4m favourable against the plan for the year to date, due to several schemes delivering earlier than initially phased. Conclusions - The financial position for Month 4 shows a favourable variance to budget of £0.1m. Implications and Future Action Required There is a continued need for increased focus on financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trak.
Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.
Impact Upon Strategic Objectives
The financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Impact on deliverability of the financial plan for 2018/19.
Regulatory and/or Legal Implications
The Trust continues to operate in Financial Special Measures which gives rise to increased regulatory activity by NHS Improvement around the financial position of the Trust.
Equality & Patient Impact
None

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 31st July 2018

LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

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 has been reflected in Month 4 reporting.

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

Group Statement of Comprehensive Income

The table below shows both the in-month position and the cumulative position for the Group.
In July, the Group's consolidated position shows an in month deficit of £2.0m. This reflects a broadly breakeven position against plan.
The year to date deficit of £12.9m is a favourable variance of £0.1m against plan.

Month 04 Financial Position	Annual Budget £000s	M04 Budget £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s
SLA & Commissioning Income	444,587	36,924	36,351	(573)	145,482	144,530	(952)
PP, Overseas and RTA Income	4,798	409	329	(80)	1,607	1,534	(73)
Operating Income	83,723	7,252	6,199	(1,053)	25,789	24,670	(1,119)
Total Income	**533,108**	**44,585**	**42,879**	**(1,706)**	**172,878**	**170,734**	**(2,144)**
Pay	350,709	28,637	28,531	106	115,850	113,518	2,332
Non-Pay	177,541	16,158	15,144	1,014	62,623	63,354	(732)
Total Expenditure	**528,250**	**44,795**	**43,675**	**1,120**	**178,473**	**176,872**	**1,601**
EBITDA	**4,858**	**(210)**	**(796)**	**(586)**	**(5,595)**	**(6,138)**	**(543)**
EBITDA %age	**0.9%**	**(0.5%)**	**(1.9%)**	**(1.4%)**	**(3.2%)**	**(3.6%)**	**(0.4%)**
Non-Operating Costs	22,777	1,898	1,271	627	7,592	6,865	727
Surplus/(Deficit)	**(17,919)**	**(2,108)**	**(2,067)**	**41**	**(13,187)**	**(13,003)**	**184**
Excluding Donated Assets	(902)	50	31	(19)	200	123	(77)
Control Total Surplus/(Deficit)	**(18,821)**	**(2,058)**	**(2,036)**	**22**	**(12,987)**	**(12,880)**	**107**

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 04 Financial Position	M04 Budget £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s
SLA & Commissioning Income	36,924	36,351	(573)	145,482	144,530	(952)
PP, Overseas and RTA Income	409	329	(80)	1,607	1,534	(73)
Operating Income	7,252	6,199	(1,053)	25,789	24,670	(1,119)
Total Income	**44,585**	**42,879**	**(1,706)**	**172,878**	**170,734**	**(2,144)**
Pay						
Substantive	26,675	26,419	256	106,894	104,741	2,154
Bank	921	955	(35)	3,741	3,638	102
Agency	1,042	1,157	(115)	5,215	5,139	76
Total Pay	**28,637**	**28,531**	**106**	**115,850**	**113,518**	**2,332**
Non Pay						
Drugs	5,307	5,974	(666)	22,199	22,795	(596)
Clinical Supplies	3,389	3,131	257	13,210	13,427	(217)
Other Non-Pay	7,462	6,039	1,423	27,214	27,133	82
Total Non Pay	**16,158**	**15,144**	**1,014**	**62,623**	**63,354**	**(733)**
Total Expenditure	**44,795**	**43,675**	**1,120**	**178,473**	**176,872**	**1,600**
EBITDA	**(210)**	**(796)**	**(586)**	**(5,595)**	**(6,138)**	**(544)**
EBITDA %age	**(0.5%)**	**(1.9%)**	**(1.4%)**	**(3.2%)**	**(3.6%)**	**(0.4%)**
Non-Operating Costs	1,898	1,271	627	7,592	6,865	727
Surplus/(Deficit)	**(2,108)**	**(2,067)**	**41**	**(13,187)**	**(13,003)**	**184**
Excluding Donated Assets	50	31	(19)	200	123	(77)
Control Total Surplus/(Deficit)	**(2,058)**	**(2,036)**	**22**	**(12,987)**	**(12,880)**	**107**

SLA and Commissioning Income – £1m adverse variance year to date. This is driven by an under performance against the Specialised Services Contract with small under and over performances against other commissioning contracts.

Private Patient Income – continues to be broadly on plan.

Other Operating Income – £1.1m under performance reflecting lower third party income for GMS (£0.4m) and hosted services (£0.4m), both of which are offset in expenditure with no impact on the overall I&E position.

Pay – expenditure is showing a £2.3m underspend year to date. This reflects a rebased budget position, for budget changes made by Divisions, rather than measuring performance against the NHSI plan submission.

Non-Pay – expenditure is showing a £0.7m overspend reflecting the rebasing of budgets.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

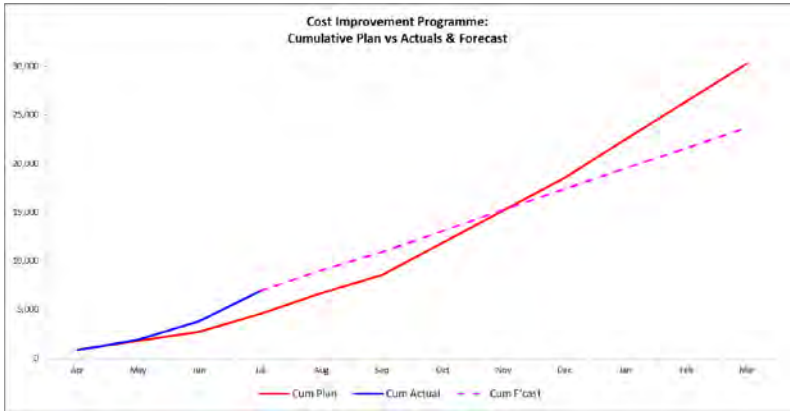
1. At Month 4 the trust has delivered £6.95m of CIP YTD against the YTD NHS Improvement target of £4.58m, this over performance is a continued benefit from several schemes delivering earlier than initially phased at Month 3.
The YTD delivery YTD splits into £5.4m recurrent and £1.5m of non-recurrent schemes. This translates into a split of 78% of recurrent delivery versus 22% of non-recurrent delivery.
Within the month, the Trust has delivered £3.077m of CIP against an in-month NHSI target of £1.824m.

2. At Month 4, the divisional year end forecast figures indicate delivery of £23.7m against the Trust's target of £30.3m which has remained stable overall since last month. However, there has been in-month movement including the Medicine division reducing its FOT by £934k, therefore, increasing the gap against target. The Medicines Optimisation scheme has mitigated the overall position by increasing its FOT.

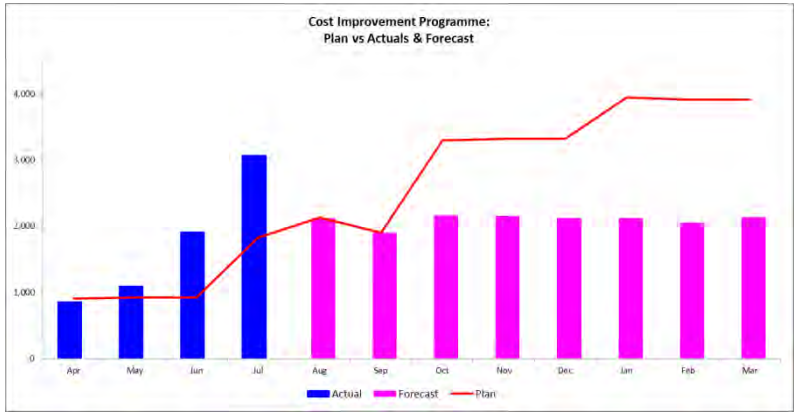
3. PWC commenced work on the 31st July 2018 and have engaged the Surgical and Diagnostics & Specialities divisions. Weekly reports indicate that progress is being made and the first formal review by the Executive team will take place on the 10th (Surgery) and 12th (D&S) September.

4. The cumulative FOT indicates that GHFT will be reporting a negative variance against plan from November (see graph to the right). A paper is being written for the Executive team to consider further recovery measures in WC 03/09

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



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



Forecast Position – Sensitivity Analysis

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Likely £m	Downside £m	Comments
Control Total	**(18.8)**	**(18.8)**	
CIP forecast under delivery	(6.6)	(6.6)	
CQUIN risk (non-Gloucestershire CCG)	(0.3)	(0.3)	
GCS activity risk	(0.3)	(0.3)	
Month 4 Divisional Forecast	**(26.1)**	**(26.1)**	
Variance to plan	*(7.2)*	*(7.2)*	
Trust / Divisional actions to deliver plan	7.2	5.4	Supported by PWC. Downside assumes 25% failure in recovery actions.
Non-delivery in Q4 of A&E and financial targets		(2.8)	Loss of 35% of PSF were Trust to fail to meet A&E and financial targets in Q4 only.
Income risk		(1.5)	Reflects current assessment of risk
Revised Forecast	**(18.8)**	**(25.0)**	
Variance to plan	*0.0*	*(6.1)*	

Note: Forecast scenarios assume that the impact of national pay awards is fully funded.

Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2018 £000	GROUP Balance as at M4 £000	B/S movements from 31st March 2018 £000
Non-Current Assets			
Intangible Assets	9,130	9,427	297
Property, Plant and Equipment	251,010	248,662	(2,348)
Trade and Other Receivables	4,463	4,422	(41)
Total Non-Current Assets	**264,603**	**262,511**	**(2,092)**
Current Assets			
Inventories	7,131	7,297	166
Trade and Other Receivables	19,276	23,276	4,000
Cash and Cash Equivalents	5,447	3,313	(2,134)
Total Current Assets	**31,854**	**33,886**	**2,032**
Current Liabilities			
Trade and Other Payables	(47,510)	(58,522)	(11,012)
Other Liabilities	(3,284)	(2,418)	866
Borrowings	(4,703)	(4,853)	(150)
Provisions	(160)	(160)	0
Total Current Liabilities	**(55,657)**	**(65,953)**	**(10,296)**
Net Current Assets	**(23,803)**	**(32,067)**	**(8,264)**
Non-Current Liabilities			
Other Liabilities	(7,235)	(7,110)	125
Borrowings	(111,219)	(113,991)	(2,772)
Provisions	(1,472)	(1,472)	0
Total Non-Current Liabilities	**(119,926)**	**(122,573)**	**(2,647)**
Total Assets Employed	**120,874**	**107,871**	**(13,003)**
Financed by Taxpayers Equity			
Public Dividend Capital	168,768	168,768	0
Equity			
Reserves	43,530	43,530	0
Retained Earnings	(91,424)	(104,427)	(13,003)
Total Taxpayers' Equity	**120,874**	**107,871**	**(13,003)**

The table shows the M4 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 4 balance sheet position against the 2017/18 outturn

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

Current Assets
- Inventories show an increase of £0.2m.
- Trade receivables are £4m above the closing March 2018 level.
- Cash has reduced by £2.1m since the year-end, reflecting the deficit position offset by loan finance.

Current Liabilities
- Current liabilities have increased by £10.3m, 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 £2.8m.

Retained Earnings
- The retained earnings reduction of £13m 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 July	
	Number	£'000	Number	£'000
Total Bills Paid Within period	37,237	75,025	7,909	15,232
Total Bill paid within Target	29,456	62,024	6,036	12,209
Percentage of Bills paid within target	79%	83%	76%	80%

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 July the volume of invoices paid within the 30 day target is 76% which is slightly below year to date performance. Invoices are processed as they become due for payment – as such movements in BPPC are due to monthly fluctuations rather than active cash management.

Liabilities – Borrowings

Analysis of Borrowing	As at 31st July 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	23,910
Capital Loan	4,667
Distress Funding	64,719
Obligations under finance leases	2,197
Obligations under PFI contracts	18,498
Balance Outstanding	**113,991**
Total Balance Outstanding	**118,844**

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.

Cashflow : July

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

The cashflow for July 2018 is shown in the table :

Cashflow Key movements:

Current Assets – The increase in trade and other receivables from the year end has reduced cash.

Trade Payables – cash has increased due to the increase in trade and other payables

The cash position reflects the drawing down of £3.5m of planned loan support.

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

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover	(1.17)	(1.45)
Metric		
Rating	4	4
Liquidity	(28.82)	(27.01)
Metric		
Rating	4	4
I&E Margin	(7.60%)	(7.50%)
Metric		
Rating	4	4
I&E Variance from Plan		0.10%
Metric		
Rating		1
Agency	22.34%	20.55%
Metric		
Rating	2	2
Use of Resources rating	4	4

The Single Oversight Framework (SOF) has been developed by NHSI and replaces Monitor's Risk Assessment Framework and the TDA's Accountability Framework. It applies to both NHS Trusts and NHS Foundation Trusts. The SOF works within the continuing statutory duties and powers of Monitor with respect to NHS Foundation Trusts and of TDA with respect to NHS Trusts. The framework came into force on 1st October 2016.

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

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The financial position of the Trust at the end of Month 4 of the 2018/19 financial year is an operational deficit of £12.9m. This is a favourable variance to budget and NHSI Plan of £0.1m.

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

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

Date: **September 2018**

REPORT TO MAIN BOARD – SEPTEMBER 2018

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

This report describes the business conducted at the Finance Committee held 25th July 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	£0.1m favourable variance to plan. Detailed discussion on volume case mix and impacts of income.	How does the changing casemix of activity impact on income.	Block contract protects a significant volume of 2018/19 income.	System wide discussion needed.
Regulatory Review Update	No significant change – meeting with NHS Improvement shortly.			
Capital Programme Update	Year to date the Capital Programme has a slight underspend.	Is backlog maintenance increasing and does this present a risk?	Paper to be presented at the next Committee.	Loan financing still to be approved.

SmartCare Programme Update	New report produced for consideration by the Committee. Block contract for 2018/19 secures a significant portion of income related TrakCare recovery.	Complete reassurance is yet to be received regarding the full programme.		Underlying data improvement required to secure 2019/20.
For Approval - **Pathology Referral Testing** - **Tele-Radiology Reporting**	Committee approved both proposals.	Is use of frameworks providing best value?	There is a cost saving from proceeding via framework as well as resourcing/ time savings.	
CIP Update	£1.1m favourable variance as at Quarter 1. High quality of reporting noted by Committee.	An adverse variance is forecast from October if no further mitigating actions are taken.	Ongoing support from the project management office (PMO) and use of targeted external consultancy to bridge the gap.	
Clinical Productivity	Resources to support Clinical Productivity to be discussed by executives.	As it stands, reassurance cannot be given to the Finance Committee.		Plans for Clinical Productivity will come back to the Committee.
Budget Holder Presentation	Presentation highlighted an improved budget setting process that will be developed further.	How engaged and accountable are the division in budget setting and management?	The division confirmed that engagement was good across divisional teams.	

REPORT TO MAIN BOARD – SEPTEMBER 2018

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

This report describes the business conducted at the Finance Committee held 29th August 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
Agency Report	Spend in line with budget as at month 04. CIP currently forecast to underperform for the year. Significant work undertaken around controls and grip. Automated system for some of the staff, manual for medical/dental. Significant work ongoing around bank staffing offer and rates.	Are there opportunities to bridge the gap in CIP as a result of the grip and control work?	These opportunities around grip and control are not currently built into the forecast outturn for CIP delivery and as such could be used to bridge the gap.	Agency papers to come back to November meeting to update.

Financial Performance Report	As at month 04, deficit of £12.9 million is reported and shows a £0.1m favourable variance against plan. A level of income underperformance is recognised against the variable contracts. Scenarios and assumptions around forecast discussed.	Have contracting and income arrangements impacted on service delivery?	Decisions around contracting demand priorities and associated financial impacts are routinely considered by the executives as part of ongoing contracting performance and financial management.	More detailed forecast of the outturn to be discussed at the next Committee.
Capital Programme Update	Capital programme forecast on track for the year but remains dependent on securing loan financing. Current backlog position stands at £52.4 million. Risk assessment occurs on a continuous basis.	Are we trying hard enough in terms of the cases that we put forward? Are we representing the improvement for patients significantly enough?		Further assurance is required on the ambition and the assessment of impact on patient quality.
SmartCare	SmartCare programme finances forecast to deliver within budget for the year. Financial recovery workstream now prioritising associated areas of income underdelivery.			This paper will be considered in light of the Committee's expanding remit into IT.

CIP Update	At Month 04 £7.0 million has been delivered against a plan of £4.6 million. Committee briefed on the generally positive outcome of the NHSI Operational Productivity visit.	Are the mitigations to bridge the gap in CIP likely to deliver?	The PMO process is robust.	
Clinical Productivity	Short verbal update.	What is the scale of the potential benefit? What is the programme to deliver it?		A detailed paper to be presented at September Finance Committee.
Committee Reflection	Discussion about whether there was more tension than usual during the meeting.	What level of tension should there be?	A healthy discussion between all members of the Committee.	

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

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

Purpose

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

Key issues to note

Sickness rates at the end of June 2018 remained static at 3.86% and July's were consistent at 3.87% , against a target of 3.50%.

Turnover increased from the May figure of 11.77% to 12.28% in June and 12.32% in July. This appears to be a trend for summer months and is expected to return to lower levels in the Autumn.

The frequency of appraisal and mandatory training reports has returned to monthly. Appraisal compliance is at 74% as compared to a target of 85% and mandatory training is at 87% compared to a target of 90%.

Our key focus this quarter has been on reshaping critical recruitment services and setting trajectories for nurse and midwifery and HCA recruitment. In addition our focus has been on leading the recruitment and retention working group and initiatives. Our staff experience and improvement initiatives continue at pace with work progressing on the development of a 'one stop shop' for a health and wellbeing hub.

Temporary staffing arrangements have led to an improvement in bank shifts being filled by Trust staff and has seen a reduction in the cost and frequency of supply of agency workers.

The Trust have participated in the Stonewall Workplace Equality Index survey and published to our WRES data to NHS England.

Following receipt of a freedom to speak up self-review tool kit from NHSI Executives, the Freedom to Speak Up Guardian, the NED and executive lead are ensuring that the Trusts arrangements are sufficiently embedded. The Board have participated in a development session on Freedom to Speak Up and a survey has been sent to staff to check their understanding of Speaking Up. The August People and OD committee reviewed the annual Freedom to Speak Up report from the Trust Guardian and were assured that the processes and systems in place for speaking up were robust.

Key Next Steps identified:

- Delivery, via the Recruitment and Retention Steering Group, of key immediate recruitment objectives and retention initiatives;
- Development of the outline business case for the long term workforce plan for Advanced Care Practioners (ACPs) – September 2018 ;

- Development of the health and wellbeing hub concept;
- Validation of corporate establishment data as part of the establishment alignment project;
- Development of Staff survey engagement plans;
- Review and action planning post Freedom to Speak Up survey results and scoping engagement exercises for the October Strategy launch;
- CQC preparation.

Recommendations

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

Impact Upon Strategic Objectives

The People and OD activity aims to contribute to the following objectives:

- Our staff by April 2019 will have an engagement score of at least 3.9, have a staff turnover of less than 11%, recommend us as a place to work through the staff survey (65%), be recognised as taking a positive action on health and wellbeing by 95% of our staff (responding definitely or to some extent in the staff survey)
- Our patients by April 2019, we will be rated as good overall by CQC, be rated outstanding in caring by CQC.
- Our organisation by April 2019 will be among the top 25% of trusts for efficiency.

Impact Upon Corporate Risks

The report outlines progress to support the mitigation of the following Trust wide risks:

- The risk of excessively high agency (locum) spend in both clinical and non-clinical professions due to a high vacancy rate

The report outlines progress to support the mitigation of the following People and OD risks linked to the BAF

- Risk of static or reduced engagement;
- High turnover results in potential increased costs to fill temporarily and a delay in attraction – resulting in potential service delaying delay and impacting on teams' capacity to provide best care;
- Staff do not recognise the Trust as an employer of choice or recommend employment with the Trust to others; as such increasing retention and reducing attraction. Increased recommendations would support the attraction of talent into the organisation and support the reduction of risks associated with failure to fill vacancies;
- Failure to engage staff in activities to improve their physical and emotional wellbeing can give rise to additional stress and sickness which impacts upon patients and service delivery.

Regulatory and/or Legal Implications

N/A

Equality & Patient Impact

N/A

Resource Implications

Finance	✓	Information Management & Technology	
Human Resources	✓	Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

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

MAIN BOARD – SEPTEMBER 2018

PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

1. Aim

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

2. Key Performance Metrics

(please see annex 1 for June metrics)

2.1 Sickness Absence

Sickness rates at the end of June 2018 remained static at 3.86%, and in July were 3.87% against a target of 3.50%. This compares to an average across acute trusts of 4.32% (March18 national figures). Sickness management continues to form a key part of HR Advisory support to divisions and divisional grip is monitored closely through Divisional Executive Review. A review of the Trusts long term management of sickness absence is underway to ensure appropriate welfare checks are in place and a renewed focus has been given to the strategic priority to create a Health and Wellbeing hub to improve the prevention and treatment of long term conditions.

2.2 Retention

Turnover increased in June to 12.28% from 11.77% as previously reported. In July this saw a slight increase to 12.32%. In terms of historical analysis a summer increase has been a three year trend, and as such in line with this is expected to stabilise at levels previously reported.

Nursing and Midwifery turnover as a combined figure is stable at 12.25%. Staff Nurses alone have a turnover of 13.52% (July 2018). This remains lower than other large Trusts by c8% but remains a key area of focus for the recruitment team. The People and OD committee reviewed additional analysis on Nurse turnover and demographics and were given a presentation on the recruitment and retention working group and recruitment plans for nursing and midwifery staff and HCA's.

The recruitment and retention group is delivering upon a number of key actions such as improving the recruitment process and time to fill metrics, staff opportunities to improve learning and development and preceptorship, incentivising candidates to join the Trust, holding conversations with staff on why they might consider leaving 'itchy feet' and opening up a 'transfer window' for staff looking for a change of ward or division. The People and OD team are also looking at how to more effectively capture exit interview data for review.

The investment in the recruitment team has seen activity increase and trajectories for the winter period have been established. These indicate a significantly improved pipeline of candidates for HCA and nurse and midwifery positions. In terms of nurses and midwives the new team aim to recruit 198 staff by December. When taking into account projected turnover and the vacancy factor this will place the Trust in a better position by c65 nurses and midwives this December (as compared to December 2017).

2.3 Appraisal & Mandatory Training

The frequency of appraisal and mandatory training reports has returned to monthly. Mandatory training has improved to 87% (target is 90%). The appraisal compliance rate has reduced from 82% to 74% at the end of July (target is 85%). A working group has been established to

improve compliance and includes IT experts to assist with some legacy system issues. It is believed a number of factors have contributed to this decrease which include:

- Some staff were waiting for the launch of the new appraisal documentation and process and delaying one to one meetings;
- There was a temporary gap in manager training provision between the old and new appraisal process;
- Web pages and intranet links relating to appraisal reporting were temporarily removed with the intranet upgrade;
- Access to report appraisal compliance has been complex and more difficult for new managers and some appraisers.

3. Strategic Priority Updates

3.1 Establishment Realignment

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

Progress has been slower than anticipated as we focus on determining the 'true' data set to feed into the ESR system. This work begins in the finance department and once fed into ESR, is then validated between HR and Finance teams. Posts within corporate divisions are being mapped to ESR positions and data validation with budget holders is underway.

3.2 Recruitment and Resourcing

3.2.1 Vacancy Control

Vacancies continue to be scrutinised at both departmental and divisional level. With vacancies presented to the Executive Vacancy Control Panel for decision. Pragmatic measures have been put in place to expedite vacancies which are clearly within budget, associated with approved business case funding or funded by external monies.

At the end of July the Trust reported a favourable pay position against budget of £2.3m.

3.2.2 Temporary Staffing

A report on agency spend and controls, and an overview of the developments in progressing an improved bank and rostering system was taken to the Finance Committee in August. The Trust has commenced a programme of work to reduce reliance on agency and where agency is required ensure it is of the best quality and at a reasonable cost. Initiatives include:

1. Ensuring compliance with NHSI Agency caps (for rates) and approval mechanisms and processes (executive and CEO sign off);
2. Relaunched Temporary Staffing Service;
3. New Bespoke pay rates for Bank (Nursing and HCA's);
4. Implementation of a Master Vendor Agreement;
5. Reviewing medical and dental agency rates and automating booking enabling improved vacancy control and complaince.

The paper demonstrated an improved up take of bank shifts compared to agency shifts and a reduction in agency spend. Specifically, there has been a 34% increase in Bank fill (all grades) based on M4 year on year position, with a £186,853 reduction in spend on nursing agency and a

6% reduction in requests for cover. The ambition that the Trust will fill the majority of nursing shifts with Bank staff and not agency is on trajectory.

3.3 Sustainable Workforce Agenda

The People and OD department is working collaboratively with the Nursing directorate and other key stakeholders to develop business plans to meet our sustainable workforce needs.

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

The medical staffing team are also looking at new roles and models to support colleagues and a current review is underway on SAS doctors and increasing autonomy of decision making. We are also scoping if there is a place to reintroduce an Associate Specialist grade. The Trust has signed the SAS BMA Workplace charter which aims to ensure in this role of this grade are treated in an equitable and fair manner.

4. Staff Engagement

4.1 Freedom to Speak Up

The Freedom to Speak Up Guardian and Executive lead have commissioned a survey to seeking staff views on how embedded the practice of speaking up is in the Trust and if staff understand the multiple ways they could speak up. The results of the survey will be used to help design and develop a Freedom to Speak Up Strategy in October and determine priority actions. In addition in August the Board participated in a Freedom to Speak Up development session led by the Trust's Freedom to Speak Up Guardian and Non Executive Guardian and Freedom to Speak Up ambassador. Further the People and OD committee in August received the annual Speaking Up survey and noted the themes around quality, safety and culture. Members were assured of the robustness of the approach to Speaking up and the follow up the Guardian provides colleagues.

4.2 Staff Survey

In August the People and OD committee received an update on progress with staff survey actions across divisions and corporately. It was noted that there were numerous programmes of work which aim to improve staff experience and the committee will continue to review progress.

The quarterly Staff Family and Friends test has also been incorporated into the recently-launched Freedom to Speak Up survey and results will be published in due course.

4.3 J2O progress

Following engagement with 100 leaders and feedback from the Extended Leadership Network new material has been designed with staff and released to continue to ask staff what J2O means for their area or speciality. Governors were recently engaged with this exercise and a podcast will be recorded next month alongside a new J2O infographic to remind colleagues of the ask and ambition. In addition the Leadership and OD team have designed a 'train the trainer' workshop for managers who want to improve their confidence in presenting the J2O material.

4.4 Talent Development

Materials and website content for the Accelerated Development Pool and new Talent Management system were launched 11th July 2018. A series of Talent Development briefing sessions have taken place throughout the summer to demonstrate how to use the new appraisal paperwork and associated processes. Between 1st July-3rd September 2018, 73 staff have attended 1.5 hour briefing sessions; 20 managers have attended half-day refresher workshops on holding development conversations; 20 managers have attended a one-day training course for new appraisers. Video tutorials and online guides are also available to offer ongoing support.

In addition, short training workshops are now being organised for divisional boards in October in preparation for the first quarterly decision panels in November; these panels will review the first set of nominations for exceptional staff to join the Accelerated Development Pool scheme.

4.5 Staff Health and Wellbeing

The preparation of the 'One stop shop' business case or health and wellbeing hub is fully underway and a presentation on how this hub will work will be taken to the People and OD Delivery Group in September. Work has progressed in understanding current provision and how this may be developed further. We are now confident in our MSK pathways and provision and near finalising psychological support services for staff and enhanced post-incident support where staff experience traumatic events.

4.6 Workforce Equality, Diversity and Inclusion

Since July the Trust has participated in the Stonewall Workplace Equality Index survey and results are anticipated in January 2019. Once received these will be presented to the Equality Diversity & Inclusion Steering Group.

The Diversity Network continues to host informal coffee/lunch socials on both sites every month, and bimonthly network meetings. Funding has been secured from the Trust and Charity and this will be used to support promotion and greater visibility of the network to encourage increased membership and participation.

Network members are attending the annual 'Pride in Gloucestershire' parade/event on 8th September 2018. A banner has been commissioned to visually demonstrate the Trust's support for Pride and all LGBTQ+ employees and patients.

The findings from a survey sent to medical trainees regarding their experiences of sexual harassment have been reviewed and results will be shared at both the Equality Diversity Inclusion Steering Group and Medical Education Board in September/October respectively, to identify and agree recommendations/next steps.

5. Governance

The People and OD team have been reviewing divisional risks and are in the process of ensuring that these are adequately reflected in the People and OD risk register as a corporate risk where necessary. The Risk Management Group has been advised and a first draft has been taken to TLT. A finalised register will be available for review at the People and OD committee in October 2018.

The People and OD team continue to support the preparations and evidence gathering for the CQC, Well Led and Use of Resources inspections.

6. Conclusion

The People and OD team continue to manage business as usual and a programme of activity across its key priorities. A key area of focus has been the recovery and development of the recruitment team and will remain so over the month of September. Finalising the model for a staff health and wellbeing hub is also a priority for the next quarter.

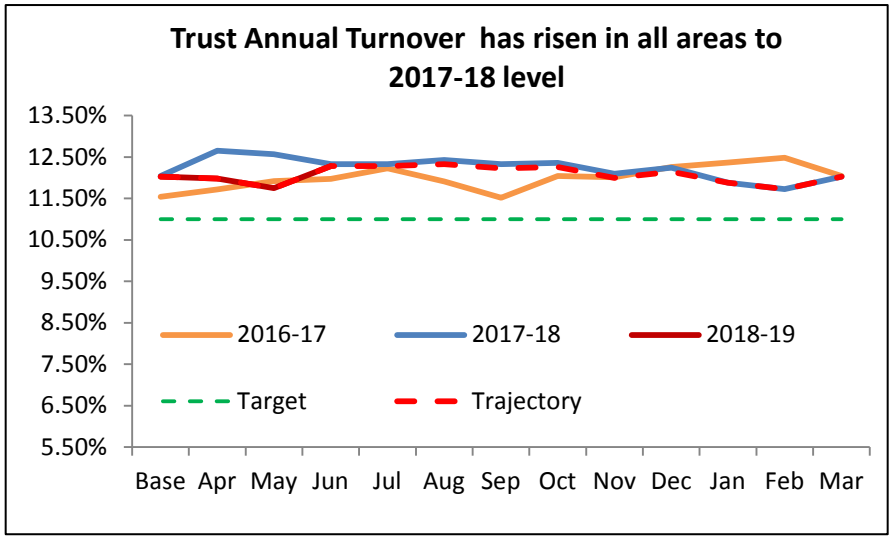
Trust Board are asked to NOTE the performance outlined in our key performance indicators and the progress made against our strategic priorities.

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

Annex 1.Performance metrics

Retention

Gloucestershire Hospitals NHS
NHS Foundation Trust



Description	Current Performance		since last Month	
Turnover is measured using the total leavers(fte) as a percentage of the average fte for the reporting period. The Trust target is 11% with the red threshold above 15% and below 6%. NB Turnover now reported as fte based - in line with QPR reporting	12 months to 30th June 2018	**Actual % TO**		**Previous Report**
	Trust Total	12.28%	↗	11.75%
	Corporate	13.67%	↗	13.12%
	Diagnostics & Specialty	11.94%	↗	11.31%
	Medicine	13.68%	↗	13.38%
	Surgery	11.70%	↗	11.06%
	Womens & Children	10.66%	↗	10.23%
	Add Prof Scientific and Technic	9.19%	↗	8.45%
	Additional Clinical Services	13.90%	↗	13.64%
	Administrative and Clerical	14.27%	↗	13.75%
	Allied Health Professionals	13.78%	↗	13.63%
	Estates and Ancillary	12.33%	↗	14.52%
	Healthcare Scientists	12.78%	↗	12.49%
	Medical and Dental	4.61%	→	4.61%
	Nursing and Midwifery Registered	11.77%	↗	10.88%
	Staff Nurses	12.64%	↗	13.62%
	Significantly above upper target limit (>15%)			
	Between 11.01 & 14.99%			
	Within target or below (11%)			

Benchmarking Turnover

Benchmarking: NHS iView uses a different methodology for calculating Turnover, which tends to under report. However it can be used for comparison.

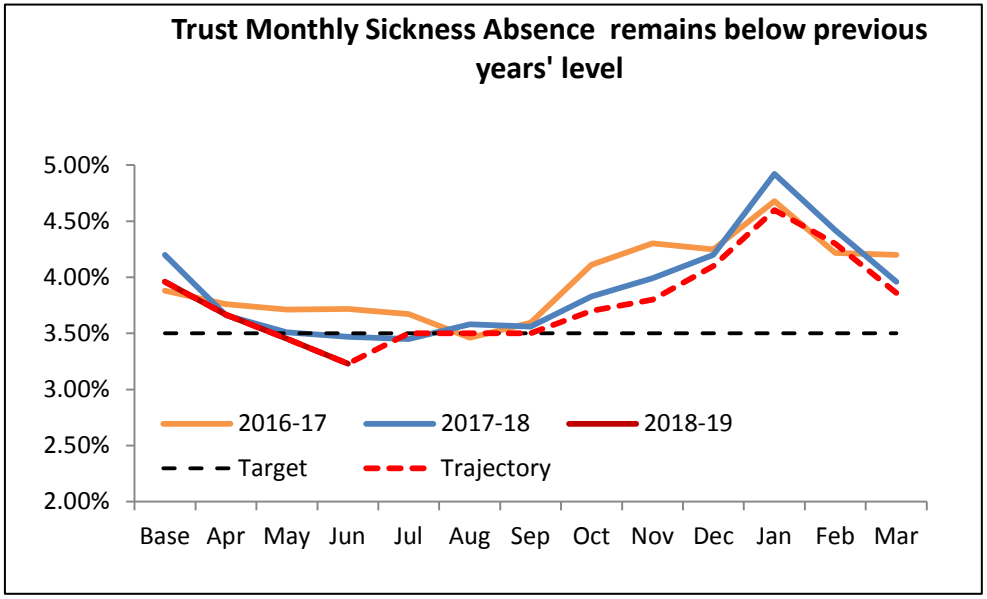
NHS iView 12 months to April 2018					Staff Nurse
GHNHSFT		11.65%	Nursing & Midwifery	10.30%	16.13%
All Large Acute		14.15%	Nursing & Midwifery	14.90%	20.27%
North Bristol		11.21%	Nursing & Midwifery	12.24%	20.63%
Worcester Acute		10.37%	Nursing & Midwifery	9.96%	14.35%
Sandwell		11.21%	Nursing & Midwifery	12.24%	23.72%

Key Points / Issues

- Turnover has risen to previous levels and at 11.65% sits above our overall target.
- Nursing & Midwifery turnover sits below this when analysed as a combined figure, however is higher at 16.13% when considering only Staff Nurse movements.
- When benchmarked against other large acute organisations (via iview) we have a lower average turnover rate than most, and we can observe from Staff Nurse turnover rates that the difficulty retaining Nurses within Acute Trusts is widespread.

Sickness Management

Gloucestershire Hospitals NHS
NHS Foundation Trust



Description	Current Performance	
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 June 18 (Annual)	**Sickness**
		% Abs
	Trust Total	3.86%
	Corporate	4.40%
	Diagnostics & Specialty	3.82%
	Medicine	3.65%
	Surgery	3.83%
	Womens & Children	3.88%
	Add Prof Scientific and Technic	3.11%
	Additional Clinical Services	4.75%
	Administrative and Clerical	4.06%
	Allied Health Professionals	2.93%
	Estates and Ancillary	5.42%
	Healthcare Scientists	2.91%
	Medical and Dental	1.53%
	Nursing and Midwifery Registered	4.51%

Key Points / Issues

- Annual sickness absence of 3.86% still remains lower than the national average for Large Acute Trusts (4.32% Mar 18). GHNHSFT 3.92 Mar 18
- Long term (over 28 days) sickness accounts for just under half of absence taken (49%).
- 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.
- Musculoskeletal problems account for approximately 25% of all absence, followed by Anxiety/ Stress/ Depression which accounts for approximately 15%.

Areas (with 20 or more fte) with the highest rates of sickness in the Trust	%SA	Approx Cost	Heads	Movement since previous month	% of Sickness Absence that is Long Term
Orthopaedic OPD 77022	9.42%	£51,754	29	↘	68.6%
Trauma Ortho Fracture Clinic 43941	7.53%	£47,290	27	↗	61.1%
Ward 2a T&O Trauma & Spinal Unit 70122	10.87%	£78,868	36	↗	71.8%
Ward Clerks - 7 Day Services 71293	9.30%	£85,324	71	↗	68.5%
Gallery Ward GRH 41822	6.82%	£29,027	31	↗	51.7%
Site Management 13793	8.10%	£88,519	25	↘	51.1%
GRH General/Gynae Theatre - Pay Only 7	7.09%	£55,875	40	↗	56.0%
AMU 72922	6.79%	£75,921	44	↘	60.5%
Day Surgery Ward 72022	6.43%	£49,947	35	↗	34.5%
Booking Services 14593	6.34%	£65,552	65	↘	37.6%
Ward 4a Acute (ACU B) 41522	5.95%	£28,068	35	↘	17.5%

Mandatory Training

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

Following an earlier decline in recorded compliance (due to the addition of new safeguarding module), we can now observe a trust wide increase in compliance, taking us to 87% and closer to our 90% target.

REPORT TO MAIN BOARD – SEPTEMBER 2018

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

This report describes the business conducted at the People and Organisational Development (OD) Committee on 6th August 2018 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Items	Report / key points	Challenges	Assurance	Residual Issues/ gaps in Controls or Assurance
Dashboard	Several indicators shared, meeting focus on retention rates, statutory and mandatory training and appraisals	Do we conduct exit interviews and are we content that there is adequate compliance from managers to collect it? With a completion rate of 30-35% need to focus on this more as a rich source of data. Statutory and Mandatory training data shows divisional averages but does not highlight the risks within the data where statutory training has not bene completed? What is the overall workforce data and what does it tell us in numbers and trends? Data is benchmarked against local Trusts. Analysis of appraisals is provided by Division not by role which could add granularity.	Process for improving exit interviews and gaining exit reasons. Future reporting of statutory and mandatory training to highlight exception reporting and give comparator (where possible) to 'good' Trusts. Understanding of numbers and trends requested for future committee meetings. Request for benchmark to high performing Trusts. Understand by exception which roles have poorer compliance.	

Recruitment and Retention	Discussion of recruitment issues, key appointments now in recruitment team, more of a grip on data and work on making recruitment a positive experience.	Led by HR, is there Divisional ownership of recruitment? Importance of leadership at all levels, how much is this discussed in leadership arenas? How do we invest in leadership training?	Divisional roles clearly set out in recruitment strategy and policy. Can include as part of OD? Timing pre CQC in autumn?	
BAF – Strategic Risk Alignment	Establishment re alignment is a slow process. Extended leadership network for bands 6.7 and 8 now launched. Talent mgt now launched. Risk alignment discussed.	Prioritisation of key areas to focus on. How does this forum link in with 100 leaders to be cohesive and should the agenda for 100 leaders change? Talent pool, how many in it, how is it working? Update on objectives requested. How does this cross refer to Divisional and the Corporate Risk Register.	Updates for future meetings. Quarterly reporting will follow on the Accelerated Development Pool and objectives once reviews have commenced. Include relevant divisional risks into the People and OD risk register.	
HCA Turnover Action Plan Update	Update provided, actions on track.	No areas of concerns raised at the meeting.	Data on health care assistant (HCA) recruitment and retention to continue to be monitored at the Committee.	

Staff Survey Action Plan Update	High level update provided. Divisional plans in place.	Need to include timelines for achievement of actions How have staff been involved/ engaged in the development of the actions? How have managers been involved? Need to prioritise actions	Specific action plan requested for the next meeting This will be included explicitly in future reporting under the BAF update/ Managers involved as the survey and plan goes through the operational structures. Exception reporting for future meetings.	
Health &Safety (H&S) Objectives	General update, focus on Violence and aggression and training uptake plus occupational cancer awareness campaign. Gloucestershire Managed Services (GMS) obligations.	What have we learnt from the recent evacuation exercise? How are we working with GMS? How do we know statutory and mandatory training up to date?	Learning to be captured in update for December and taken to the Audit and Assurance committee meeting. 6 monthly Health and Safety updates for Committee Health and Safety framework through the contractual route, GMS responsibility.	Links to GMS subcommittee.
Freedom to Speak Up Update	Update, Raising concerns policy in place, numbers of concerns raised increased, high profile with junior doctors	What is a successful outcome for an individual and the Trust? Are any outcomes 'unsuccessful?' Can we use other examples (rather than day surgery) of acting on concerns	Question asked, would you use the service again? Further thinking requested on outcome/impact of raising concerns For future reporting and if appropriate	

Key items for the Board to note:

Future Committees to receive Integrated Care System workforce governance and work streams brief, update on 6 month priorities and process for priority/strategic planning for 2019/20

For future meetings, clear split between strategic/operational/ governance items and consideration for a barometer for main statistics

Joint committee meeting with Quality and Performance in planning stage to focus on workforce and patient outcomes

REPORT TO MAIN BOARD – SEPTEMBER 2018

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

This report describes the business conducted at the Audit and Assurance Committee on 17th July 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
Internal Audit	2018/19 Plan & potential use of contingency days.	Would the CQC "Well-led framework" and Freedom to Speak Up be an appropriate focus for some of the contingency days?	To be reviewed.	
		How can non-executives input to audit terms of reference?	Lead Executives will share proposed terms of reference with relevant NED ahead of audit commencement.	
	Final Report on Serious Incidents – highlighting **moderate** Design assurance and **substantial** effectiveness assurance.	How to ensure that learnings from Serious Incidents are shared effectively?	Planned divisional governance audits will provide an opportunity to review the effectiveness of sharing learning.	
		What is the likelihood of a serious incident going unreported?	A robust process is in place.	
	Recommendation follow-up – significant progress noted with the revised process involving enhanced ownership by			

	internal audit.			
External Audit	Report on post year-end review meeting indicating positive progress and sound working relationships.	What is the process for identifying control themes?		Being progressed through audit planning discussion.
Committee Self-Assessment and Terms of Reference	Discussion on overall positive assessment highlighted the importance of not being falsely assured or complacent. Terms of Reference to be reviewed to be more specific in certain areas notably clinical audit.			
Emergency Planning Progress Report	Verbal report providing an update of the current status including outcome of recent exercises,	Are desk top exercises undertaken? Should a missing person exercise be carried out?	Yes,	Updated written report to be prepared for the September meeting,
Trust Risk Register	Current register	Does current methodology give adequate visibility of Emergency Planning? What is the visibility of completion dates for "partially complete" and "incomplete actions"?		This discussion prompted further review of the risk management process – to be covered at the November meeting,
Business Assurance Framework	Review of the current document highlighted it is not user friendly.			Suggested revisions noted and improved format to be considered

Losses and Compensations **GMS Audit Arrangements**	Report noted and write-offs approved Discussion to help clarify responsibility for audit planning and review and develop the Committee role	Can the values be analysed by division?	Future report to include division breakdown.	 Work-in progress with paper to be prepared for September meeting

Rob Graves
Chair of Audit and Assurance Committee
September 2018

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00am

Report Title
Annual Audit Letter
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance Sponsor: Rob Graves, Non-Executive Director
Executive Summary

Purpose
To advise the Board of the contents of the Annual Audit Letter.

Key issue to note

- Following the conclusion of the 2017/18 audit work, the Trust's external auditors, EY, issued an Annual Audit Letter. The purpose of this Letter is to communicate to the Council of Governors the key issues arising from the auditor's work, which the auditors consider should be brought to the attention of the Trust.
- The letter was received at the Council of Governors on 15th September.
- The detailed findings from the 2017/18 EY audit work were in the Annual Results Report presented to the Board back in May 2018. The Annual Audit Letter does not repeat those detailed findings; instead, instead provide a summary of our key findings.
- The results and conclusions on the significant areas of the audit process were as follows:
    - **Financial statements** - unqualified opinion, i.e. the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended;
    - **Consistency of Governance Statement** - The Governance Statement was consistent with the auditors understanding of the Trust.
    - **Value for money conclusion** - a qualified conclusion. The auditors concluded that the Trust does have proper arrangements in place, except for the financial arrangements to allow financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trakcare.
    - Examining the **contents of the Trust's Quality Report** and **testing of two mandated performance indicators and one indicator selected by the Council of Governors** - an unqualified limited assurance report
-

Recommendations
That the Board note the contents of the Annual Audit Letter.
Impact Upon Strategic Objectives
Not applicable.
Impact Upon Corporate Risks
Not applicable.
Regulatory and/or Legal Implications
Not applicable.

Equality & Patient Impact							
Not applicable.							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

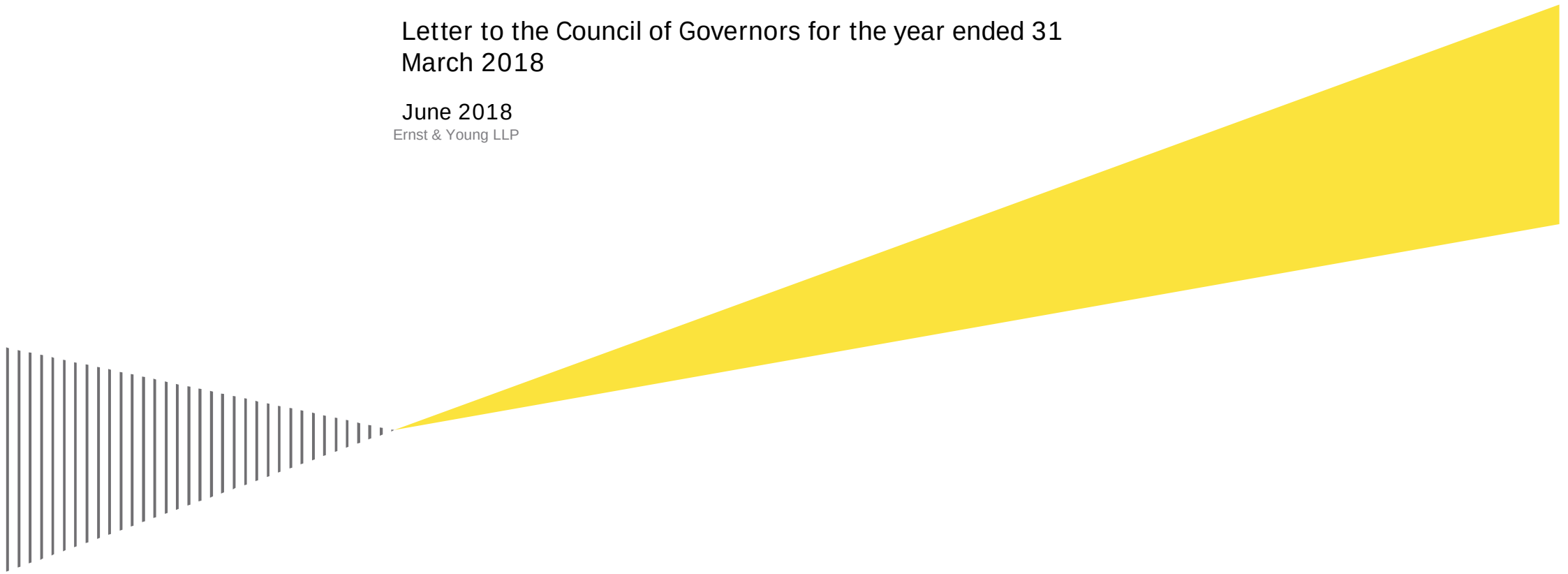
Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						Council of Governors 15th August 2018

Gloucestershire Hospitals NHS Foundation Trust

Letter to the Council of Governors for the year ended 31 March 2018

June 2018

Ernst & Young LLP



Building a better working world

Contents


Executive Summary

Executive Summary

Below are the results and conclusions on the significant areas of the audit process.

Area of Work	Conclusion
Opinion on the Trust's:	
► Financial statements	Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended.
► Parts of the remuneration and staff report to be audited	We had no matters to report.
► Consistency of the information in the performance report and accountability report with the financial statements	Financial information in the performance report and accountability report and published with the financial statements was consistent with the Annual Accounts.

Area of Work	Conclusion
Reports by exception:	
► Consistency of Governance Statement	The Governance Statement was consistent with our understanding of the Trust.
► Consistency of the Annual Report within knowledge we have acquired during the course of our audit	We had no matters to report.
► Referrals to NHS Improvement (formerly Monitor)	We had no matters to report.
► Public interest report	We had no matters to report in the public interest.
► Value for money conclusion	We issued a qualified conclusion. We concluded that the Trust does have proper arrangements in place, except for the financial arrangements to allow financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trakcare.

Area of Work	Conclusion
Examining the contents of the Trust's Quality Report and testing of two mandated performance indicators and one indicator selected by the Council of Governors	We issued an unqualified limited assurance report.
Reporting to NHS Improvement (formerly Monitor) on the Trust's consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £300,000 tolerance, to your audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	We reported 10 differences above £300,000 between the data submitted by the Trust and that submitted by its counterparties as part of the DH agreement of balances exercise. We had no other matters to report.

As a result of the above we have also:

Area of Work	Conclusion
Issued a report to those charged with governance of the Trust communicating significant findings resulting from our audit.	Our Audit Results Report was issued on 29 May 2018.
Issued a report to Governors on the Quality Report	Our report to Governors on the Quality Report was issued on 29 May 2018.
Issued a certificate that we have completed the audit in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office's 2015 Code of Audit Practice.	Our certificate was issued on 29 May 2018.

We would like to take this opportunity to thank the Trust staff for their assistance during the course of our work.

Maria Grindley
Associate Partner
For and on behalf of Ernst & Young LLP


Purpose

Purpose

The Purpose of this Letter

The purpose of this Letter is to communicate to the Council of Governors the key issues arising from our work, which we consider should be brought to the attention of the Trust.

We have already reported the detailed findings from our audit work in our 2017/18 Annual Results Report to the 24 May 2018 Board meeting, representing those charged with governance. We do not repeat those detailed findings in this letter but instead provide a summary of our key findings.

We also make reference to our limited assurance work on the Trust's Quality Report.


Responsibilities

Responsibilities

Responsibilities of the External Auditor

Our 2017/18 audit work has been undertaken in accordance with the Audit Plan that we issued on 15 March 2018 and is conducted in accordance with the National Audit Office's 2015 Code of Audit Practice, International Standards on Auditing (UK and Ireland), and other guidance issued by the National Audit Office and NHS Improvement (formerly Monitor).

As auditors we are responsible for:

Expressing an opinion:

- On the 2017/18 financial statements;
- On the parts of the remuneration and staff report to be audited;
- On the consistency of the information in the performance report and accountability report with the financial statements; and
- On whether the consolidation schedules are consistent, within a £300,000 tolerance, with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If Governance Statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- On the consistency of the Annual Report within knowledge we have acquired during the course of our audit;
- To NHS Improvement (formerly Monitor) if we have concerns about the legality of transactions of decisions taken by the Trust; and
- Any significant matters that are in the public interest.

Forming a conclusion on the arrangements the Trust has in place to secure economy, efficiency and effectiveness in its use of resources.

We report to the National Audit Office (NAO) on the Trust's Whole of Government Accounts return, the Trust Accounts Consolidation schedules, which support the Whole of Provider account consolidation.

We also undertake an independent assurance engagement on the Trust's Quality Report for the year ended 31 March 2018 and certain performance indicators contained within the report. Our review is undertaken in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality issued by NHS Improvement "Detailed Guidance for External Assurance on Quality Reports"

Responsibilities of the Trust

The Trust is responsible for preparing and publishing its statement of accounts, annual report and governance statement. In the governance statement, the Trust publicly reports on the extent to which it complies with its own code of governance, including how it has monitored and evaluated the effectiveness of its governance arrangements in the year, and on any planned changes in the coming period.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.


Financial Statement
Audit

Financial Statement Audit

Key Issues

The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health.

Our 2017/18 audit work on the Trust's statement of accounts has been undertaken in accordance with the audit plan we issued on 15 March 2018 and is conducted in accordance with the National Audit Office's 2015 Code of Audit Practice, International Standards on Auditing (UK), and other guidance issued by the National Audit Office and NHS Improvement (formerly Monitor).

We issued an unqualified audit report on 29 May 2018.

Our detailed findings were reported to the 24 May 2018 Board meeting, through our Audit Results Report.

The key issues identified as part of our audit were as follows:

Significant Risk	Conclusion
Management override of controls A risk present on all audits is that management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records directly or indirectly, and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Auditing standards require us to respond to this risk by testing the appropriateness of journals, testing accounting estimates for possible management bias and obtaining an understanding of the business rationale for any significant unusual transactions.	We obtained a full list of the journals posted to the Trust's general ledger during the year, and analysed these journals using criteria we set to identify unusual journal types or amounts. We then tested a sample of journals that met our criteria and tested these to supporting documentation. We considered the accounting estimates most susceptible to bias and tested these as part of our audit work. We have not identified any material weaknesses in controls or evidence of material management override. We have not identified any instances of inappropriate judgements being applied. We did not identify any transactions during our audit which appeared unusual or outside the FT's normal course of business.

Revenue and expenditure recognition Auditing standards also require us to presume that there is a risk that revenue and expenditure may be misstated due to improper recognition or manipulation. We respond to this risk by reviewing and testing material revenue and expenditure streams and revenue cut-off at the year end. We considered that this risk could be increased by the Trust's financial position resulting in a risk that the financial statements could be manipulated to report an improved position against the Trust's control total.	Our testing focussed on the Trust's main income and expenditure streams, particularly its income from patient care activities and year-end adjustments. We also carried out cut-off testing where we examined a sample of receipts and payments after year end to ensure that where the transactions related to 2017/18 that they were properly recorded in the accounts. We also reviewed the agreement of intra-NHS balances and investigated significant differences and disputes. Our testing has not revealed any material misstatements with respect to revenue and expenditure recognition Overall our audit work did not identify any issues or unusual transactions which indicated that there had been any misreporting of the Trust's financial position
Valuation of land and buildings In 2017/18, the Trust adopted a Modern Equivalent Asset on an Alternative Site model as a basis of the valuation. This is the first year the assets were valued on this basis. This area therefore required additional focus as part of the external audit to ensure the methodology, assumptions and supporting data used to support the valuation are appropriate.	We involved an EY Valuations expert to assist the audit team to: - Review the reasonableness of the valuation model adopted; - Review the output of the Trust's valuer; and - Challenge the assumptions used by the Trust's valuer by reference to external evidence and our EY valuation specialists. The methodology and assumptions used were found to be appropriate. We can confirm that the valuation has been accurately processed and reflected in the financial statements.

Other Key Findings	Conclusion
Private Finance Initiative (PFI)	We used an EY PFI expert to assist the audit team to review the PFI model and its underlying assumptions to ensure these are appropriate. We reviewed completeness and accuracy of disclosures in the financial statements based on the model. We had no matters to report.
Opening Balances	This will be the first year that we have completed your audit and as such the requirements of ISA (UK & Ireland) 510 apply. We reviewed the work of the predecessor auditor, KPMG, to identify any issues that may impact upon the opening balances and to review the audit work completed to allow us to place reliance on their audit opinion. We tested opening balances to ensure that they agree both to the prior year audited accounts and closing trial balance. We concluded that the opening balances had been brought forward correctly.

Our application of materiality

When establishing our overall audit strategy, we determined a magnitude of uncorrected misstatements that we judged would be material for the financial statements as a whole.

Item	Thresholds applied
Planning materiality	We determined planning materiality to be £5.4 million, which is 1% of operating expenses reported in the accounts. We consider operating expenditure to be one of the principal considerations for stakeholders in assessing the financial performance of the Trust.
Reporting threshold	We agreed with the Audit and Assurance Committee that we would report to the Committee all audit differences in excess of £0.27 million.

We also identified the following areas where misstatement at a level lower than our overall materiality level might influence the reader. For these areas we developed an audit strategy specific to these areas. The areas identified and audit strategy applied include:

- Remuneration disclosures including any severance payments, exit packages and termination benefits, where a lower materiality and judgement are applied due to their sensitivity;

- Related party transactions, where disclosures were considered on a case by case basis.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations.

Control Themes and Observations

As part of our work, we obtained an understanding of internal control sufficient to plan our audit and determine the nature, timing and extent of testing performed. Although our audit was not designed to express an opinion on the effectiveness of internal control, we are required to communicate to you significant deficiencies in internal control identified during our audit.

We have adopted a fully substantive approach and have therefore not tested the operation of controls.

The matters reported are shown below and are limited to those deficiencies that we identified during the audit and that we concluded are of sufficient importance to merit being reported.

Description	Impact
Journal authorisation	Journal preparers record the journals prepared by them on the log maintained by them. There is a risk that a journal gets missed from the log maintained and therefore does not go through the authorisation process.
Signatory list for payroll	The signatory list for payroll is not routinely kept up to date, which means the Trust's controls on payroll could be compromised.
Reconciliation of Trakcare system for Private Patient Income	There is no formal reconciliation of the Trakcare system where private patient procedures are recorded and Harlequin where invoices are raised. There is the potential for private patients to be missed and invoice not raised. There is no reconciliation of the two systems.
Reconciliation of bank reconciliation	This reconciliation includes old reconciling items that should be written off. For example there are185 out of date cheques, totalling over £24k, some date back as far as 2012.
Review of contracts	Our review identified examples of contracts not signed and dated by both parties, which could lead to difficulties if there is a dispute about a contract.

Department of Health Group Instructions

We are only required to report to the NAO on an exception basis if there were significant issues or outstanding matters arising from our work. There were no such issues. We reported 10 differences above £300,000 between the data submitted by the Trust and that submitted by its counterparties as part of the DH agreement of balances exercise. We had no other matters to report.

We are also required by NHS Improvement to provide to the Trust a statement that the Trust Accounts Consolidation schedules (TACs) are consistent with the audited accounts, including a list of inconsistencies greater that £300,000 between the TACs and the accounts. We reported that the TACs were consistent with the audited statements.

Annual Governance Statement

We are required to consider the completeness of disclosures in the Trust's annual governance statement, identify any inconsistencies with the other information of which we are aware from our work, and consider whether it complies with relevant guidance.

We completed this work and did not identify any areas of concern.

Referral to the Regulator

We must report to NHS Improvement (formerly Monitor) any matter where we believe a decision has led to, or would lead to, unlawful expenditure, or some action has been, or would be, unlawful and likely to cause a loss or deficiency. We had no exceptions to report.

Report in the Public Interest

We have a duty under the National Health Service Act 2006 to consider whether, in the public interest, to report on any matter that comes to our attention in the course of the audit in order for it to be considered by the Trust or brought to the attention of the public.

We did not identify any issues which required us to issue a report in the public interest.

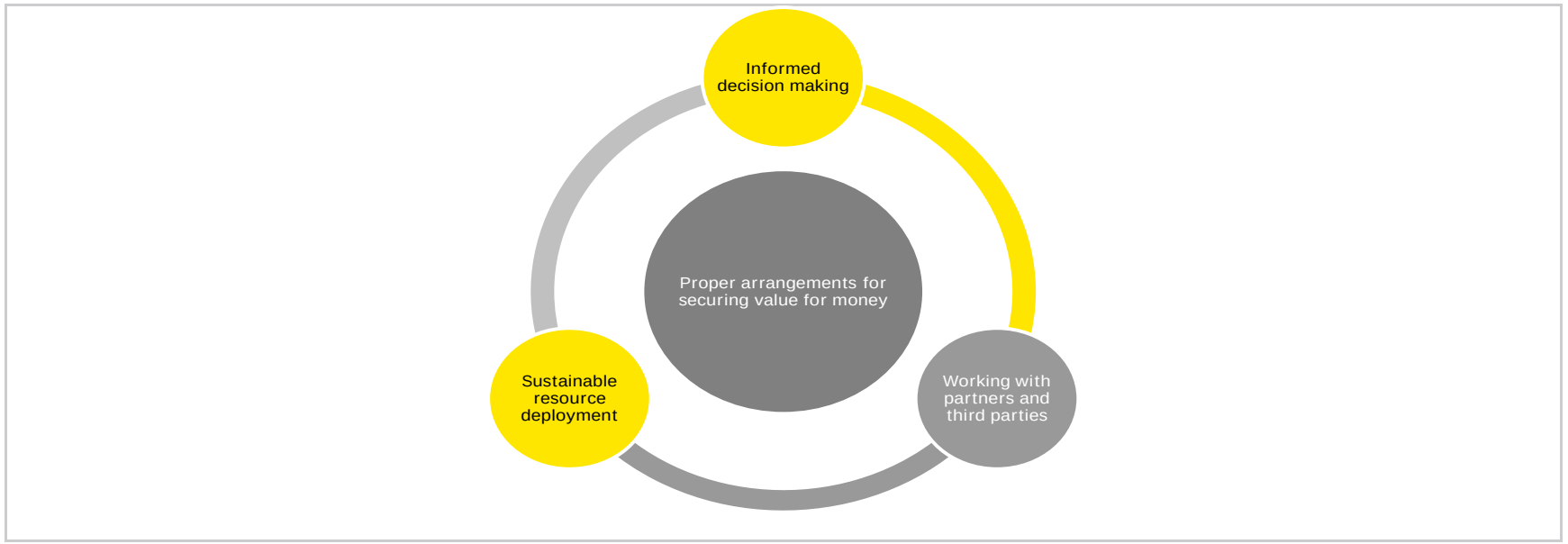

Value for Money

Value for Money

We are required to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This is known as our value for money conclusion.

Proper arrangements are defined by statutory guidance issued by the National Audit Office. They comprise your arrangements to:

- Take informed decisions;
- Deploy resources in a sustainable manner; and
- Work with partners and other third parties.



We identified a significant risk in relation to these arrangements. The tables below presents the findings of our work in response to the risk identified and any other significant weaknesses or issues to bring to your attention.

We have identified weaknesses that are sufficiently significant that in our professional judgement warrant reporting on in the auditor's report. However, these are limited to specific issues or areas.

Therefore we conclude that the Trust does have proper arrangements in place, except for the financial arrangements to allow financial improvement, in the form of cost improvement programmes, minimisation of cost pressures, and income recovery linked to the actions around Trakcare.

Significant Risk	Conclusion
In 2016-17 the Trust reported an outturn of £18m deficit. The position was facilitated by £7.1m of planned CIP delivery and a further £2.7m recurrent CIP delivery, £2m non-recurrent measures and £1m asset sale profit. This represented a material adverse variance of £26.2m to the Trust plan and control total for 2016-17. In 2017-18, the Trust initially planned a £14.6m forecast deficit, which includes the need to deliver a cost improvement programme of £34.7m. The cost improvement programme contains high risk items that the Trust is seeking to manage. The Trust has subsequently agreed with NHSI a revised forecast deficit outturn of a £27.8m. The Trust was found to be in breach of its license due to a material decline in its reported financial position and an apparent failure of Board governance in this respect. It was placed in financial special measures in December 2016.	The Trust has taken a number of steps in 2017/18: - engaged its internal auditors to carry out an audit of the CIP programme and infrastructure to give assurance and identify further high level opportunities; - reviewed the Programme Management Office (PMO) structure; - improved governance arrangements; - provided ongoing support and challenge of each division through deep dive meetings; and - achieved a CIPs programme of £28.7m which equates to 5.7% of revenue. This is 83% of the target set. In December of 2016 the Trust launched a new patient administration system, TrakCare. The implementation did not go as planned and this had a significant impact on the Trust's ability to deliver the planned income position for the year. There is now a TrakCare recovery plan in place with additional management capacity to drive it forward. The Trust agreed a reforecast deficit position of £27.8m with NHSI. The Trust identified and monitored the risks to achieving this position. The downside risks notified to NHSI as part of this monitoring were all associated with income recovery and Trak system issues. A deficit of £33m was achieved against this forecast outturn. Key reasons for this were those already notified to NHSI as part of the ongoing monitoring of the position and included: - income under-performance with commissioners; and - TrakCare systems issues.

Other matters to bring to your attention
Monitoring the financial position of the Trust through the year The Trust produced a financial recovery plan in Autumn 2016 and it was updated in Spring 2017. This included the 2017/18 plan with a planned £14.6m deficit. Early on in 2017/18 the Trust was aware it would not achieve a £14.6m deficit and this was raised with NHSI in regular updates. NHSI agreed a revised financial target of £27.8m deficit in March 2018. At the end of the year, after technical adjustments of

£18.4m (including £19.9m for fixed asset impairments) the Trust had a deficit of £33m. The shortfall in achieving the planned £27.8m deficit was attributed to the issues with the implementation of the new Electronic Patient Record system, Trakcare and missing the CIP target.

Reviewing the actions the Trust is taking to address the adverse financial position The Trust has worked closely with NHSI to try to improve its financial position throughout the year. Internal auditors were employed to review the CIP process and the Trust followed up on their recommendations. CIP schemes were revisited to ensure robust plans were developed and delivered. A TrakCare recovery advisor is now in post and there is a recovery plan was put in place to try to recover some of the lost income.
Considering the outturn deficit position and savings achieved against plan The Trust made a deficit of £51.564m per the Statement of Accounts in the Statement of Comprehensive Income. This is then amended for technical adjustments and the outcome is a control total of £33m deficit, against a plan of £27.8m, £5.2m above the target. The Trust's achievement of Cost Improvement Programme (CIP) targets for 2017/18 was reported to the Audit and Assurance Committee in May 2018 and shows the Trust delivered a total of £28.7m CIP compared to a target of £34.7m This represents 83% of the forecast being achieved and 5.7% of revenue spend. A total of £17.3m of the CIP schemes are recurrent.
Critically reviewing the assumptions included in the Trust's financial plans Income - The Trust assumed a level of both demographic and service growth in the income baseline, which is realistic when considered against activity information. Pay costs - National pay inflation assumptions applied, including the impact of the 0.5% apprenticeship levy. These increases are mitigated, in part, by CIP, with agency pay in particular targeted for reduction. Non-pay costs - Non-pay costs are based on the FY17outturn position and have had national pay inflation assumptions applied.
Understanding the governance processes in place to support the future financial resilience of the Trust The Trust made a number of changes at Board level and this has resulted in a drive to ensure strengthened arrangements are in place. We have seen some of these already having an impact i.e. Board Assurance Framework improved, risk and governance arrangements strengthened and regular and clear detailed reporting to Board on the financial position.
Considering information from other regulators as appropriate The Care Quality Commission currently rates the Trust as 'Requires Improvement' overall. NHSI are working with the Trust to understand the progress made and ensure the plan to address the deficit continues to be delivered.

As can been see from the notes above, the risks identified in our audit planning report have been mitigated. It can be seen the processes are in place and there are some clear outcomes from these which are supporting the position but now the Trust needs to fully embed these processes to achieve a continued and sustainable improvement.


Quality Report

Quality Report

Responsibilities

We are required to perform an independent assurance engagement in respect of Gloucestershire Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained within the report. Our review is undertaken in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality issued by NHS Improvement "Detailed Guidance for External Assurance on Quality Reports".

As auditors we are required to:

- review the content of the Quality Report against the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, which is combined with the quality accounts requirements in NHS Improvement's document "Detailed guidance for External Assurance on quality reports 2017/18';
- review the content of the Quality Report for consistency against the other information published by the Trust;
- undertake substantive sample testing on two mandated performance indicators and one locally selected indicator;
- provide the Trust with a Limited Assurance Report confirming that the Quality Report meets NHS Improvements requirements and that the two mandated indicators are reasonably stated in all material respects; and
- provide the Trust's Governors with a report setting out the findings of our work including the content of the quality report, mandated indicators and the locally selected indicator.

Compliance and consistency

We reviewed the Trust's quality report and found that its content was in line with NHS Improvement's requirements, and it was consistent with other information published by the Trust.

Performance indicators

We undertook testing on two mandated indicators:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

In both instances we found no evidence to suggest that the two mandated indicators have not been reasonably stated in all material respects.

The local indicator tested was:

► Delayed Transfer Of Care

The results of our testing is shown below;

We undertook a walkthrough to understand how the indicator is calculated and to determine our approach to testing the reported indicator. We carried out detailed testing of the indicator. We tested Quarter 2 data and were able to agree the discharge dates to the Trakcare system as well as performing a search on Infoflex for the 25 patients selected.

We have reported the following findings to Governors based on the work carried out:

- We were unable to test Quarter 1 data as the audit trail for April 2017 had not been retained;
- The reliability of the data is impacted by areas for improvement within the system:

- spells being easily broken, for example, when a patient is transferred between departments, a new spell may be created and therefore in one visit there may be several spells which can affect the discharged date;
- the data is entered manually both on TrakCare and on Infoflex and there is no interface between the two systems which raises a risk that it is open to human error; and
- prior to June 2017, the medically fit date was being used rather than the date post the assessment for discharge and this means that the delays could be overstated.

The identification of the discharged date can be complex as it is influenced by factors such as medical assessments being required or care packages needing to be sourced. The Business Information team, as well as other individuals, are now having weekly meetings to ensure data is as accurate as possible and updated to reflect a patient's actual situation.

The local indicator is not included in our Limited Assurance Report.

Appendix A

Audit Fees

Appendix A Audit Fees

Description	Final Fee 2017/18 £	Planned Fee 2017/18 £
Total Audit Fee – Financial Statements	57,000	50,000
Audit Fee - Quality Report	5,500	5,000

An additional fee of £7,500 has been applied. This is in relation to the following:

- Delays with planning and interim work - £6,000

  We struggled with delays during our planning and interim audit which caused inefficiencies. We did not receive the required information and responses to enable us to progress our planning and interim work. In addition we were not provided with the information needed to attend stock takes and spent time chasing and re-planning resources to try to accommodate these. We also engaged our experts on our review of PPE and PFI. As a result of the delays and issues with the responses received we had to complete additional work, revisit areas a number of times and spend time chasing responses and reviewing these and sending them back for more information. We raised this at the time with the Director of Finance and Audit and Assurance Committee at their meetings in March and May. We were pleased to see an improvement during our final visit and are grateful to your team for their support.

- Additional work required on the financial position and vfm conclusion - £1,000

  Our fee is based on no requirements for qualifications on our opinion or vfm conclusion. Whilst we are pleased to report progress being made and the conclusion has moved from ‘adverse’ to ‘except for’ this has still required additional work to understand the detailed position and ensure the correct conclusion is issued.

- Additional work required on the quality account - £500

  We worked with the suggested contacts but were not given the information needed to complete our work. We raise this and having concluded on the information we were provided we were then asked to complete additional work and provided more information. We completed as much as possible given the information available but having this at the beginning of the audit would have avoided reviewing areas twice and the inefficiencies caused by this.

We confirm we have not undertaken any non-audit work during this period.

EY | Assurance | Tax | Transactions | Advisory

Ernst & Young LLP

ED None

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MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

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

Executive Summary

Purpose

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

Key issues to note

Assurance

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

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

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

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

- Board Committees now regularly undertake a detailed scrutiny of components parts of the BAF assigned to them and receive positive assurances that the risks to the achievement of the Strategic Objectives are controlled as effectively as they can be. This process also identified areas of further focus and scrutiny for the Committees/items to be explicitly covered under the Committee's remits (e.g. safeguarding for Q&P; TrackCare for Finance), with relevant items now built into the work plans and amendments to Committee Terms of reference to follow, where required.
- The Audit and Assurance Committee reviewed the Framework at its July meeting. The Committee requested that: - the Internal Audit report on Serious incidents should be add to the assurance column for BAF 1.1 and 1.2 as a new source of assurance; and: -that a narrative to accompany Annex 1 of the report should be included and explain the movements in revisions; these changes are reflected in the attached report. Further, the Committee requested that improvement to presentation be considered, drawing on good practice identified by Internal Audit. These changes will be implemented for the Quarter 2 reporting cycle (October/November 2018). Development of the new corporate strategy will provide an opportunity for a more fundamental revision to the BAF.
- A new objective was agreed with the Board relating to its research portfolio in May 2018 and this is presented for the first time as BAF4.6
- An update of progress in the achievement of the strategic objectives is included in Appendix 1

demonstrating that eight elements expect that the target will be met. At the same time, delivery of nine objectives are rated Amber with achievement identified as at risk;

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

BAF crit/ RAG	1.1	1.2	1.3	1.4	1.5	1.6	2.2	3.1	3.2	3.3	4.1	4.2	4.3
RR entries	2	4	9	2	4	1	6	3	2	2	5	3	1

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

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

Implications and Future Action Required
Further refinement and ongoing development of the BAF led by the Director of Corporate Governance.

Recommendations

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

Impact Upon Strategic Objectives

The report identifies the risk and mitigation to the Strategic objectives

Impact Upon Corporate Risks

Links between risk to delivery of strategic objectives aligned to known corporate risks

Regulatory and/or Legal Implications

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

Resource Implications

Finance		Information Management & Technology	
Human Resources	x	Buildings	

Action/Decision Required

For Decision		For Assurance	√	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	Workforce Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
28th June	27th June	17th July	1st May	N/A		

Outcome of discussion when presented to previous Committees

The Committees received positive assurances that the risks to the strategic objectives were controlled effectively. The Committees used the BAF to inform agenda/workplan setting.

Appendix 1

Board Assurance Framework Overview and Progress with Achievement of Strategic Objectives

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 4	Qtr 1				
1.1			Director of Quality & Chief Nurse	Quality and Performance *and*: Workforce *(Well-led component)* Finance *(Sustainable use of resources component)*	Be rated good overall by the CQC	Changing in rating supported by CQC PIR self-assessment and action plans in place to prepare for the forthcoming inspection.
1.2			Director of Quality & Chief Nurse	Quality and Performance	Be rated outstanding in the domain of 'Caring' by the CQC	
1.3			Chief Operating Officer	Quality and Performance	Meet all national access standards	
1.4			Medical Director	Quality and Performance	Have a hospital standardised mortality ratio of below 100	
1.5			Director of Quality & Chief Nurse	Quality and Performance	Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends	
1.6			Director of Quality & Chief Nurse	Quality and Performance	Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month	
2.1			Director of People	Workforce	Have an Engagement Score in the Staff Survey of at least 3.9	
2.2			Director of People	Workforce	Have a 'Staff Turnover Rate' of Less Than 11%	
2.3			Director of People	Workforce	Have a Minimum of 65% of 'Our Staff Recommending Us as a Place to Work' through the Staff Survey	RAG rating changed to green, to reflect the joint working of the Staff Improvement Group which is now in progress and ownership of items such as the HCA Retention plan via this group.

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 4	Qtr 1				
2.4			Medical Director	Quality and Performance Workforce	Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches	The GSQIA continues to deliver the required volume of training for bronze and silver. Gold coach training continues with a cohort of 20 staff members but is at risk to reach 45. To resolve this, the new Quality Framework that organisationally creates the Gold QI coach role needs to be formally agreed. Staff in that role will then engage with the programme.
2.5			Director of People	Workforce	Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)	
3.1			Director of Strategy and Transformation	Board	Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery	
3.2			Chief Executive	SmartCare Programme Board reporting to Board	Have systems in place to allow clinicians to request and review tests and prescribe electronically	
3.3			Director of Strategy and Transformation	Quality and Performance	Rolled out Getting it Right First Time Standards across the target specialities and be fully compliant in at least two clinical services	
3.4			Director of Strategy and Transformation	Health and Wellbeing Group	Have staff in all clinical areas trained to support patients to make healthy choices	
4.1			Director of Finance	Finance	Show an improved financial position	

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 4	Qtr 1				
4.2			Chief Operating Officer	Finance	Be among the top 25% of trusts for efficiency	
4.3			Director of Strategy and Transformation	Trust Leadership Team	Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers.	
4.4			Chief Executive	Board	Be no longer subject to regulatory action	
4.5			Chief Executive	Board	Be in segment 2 (targeted support) of the NHSI Single Oversight Framework	
4.6	N/A		Director of Strategy and Transformation	TBC	The Trust will have a high quality research portfolio, which is visible to staff and patients, embedded alongside routine care, and achieves the annual High Level Objectives (HLO) defined by the National Institute Health Research (NIHR).	

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

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

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

Please note:

- Principal risks to Strategic Objective 3.1 *Have a Model For Urgent Care That Ensures People Are Treated In Centres with the Very Best Expertise and Facilities to Maximise Their Chances of Survival And Recovery* are owned by the Trust Board
- Principal risks to Strategic Objective 3.2 *Have Systems in Place to Enable Clinicians to Request and Review Tests & Prescribe Electronically* are owned by the SmartCare Programme Board reporting to Main Board
- Principal risks to Strategic Objective 3.4 *Have Staff in all Clinical Areas Trained to Support Patients to Make Healthy Choices* are owned by the Health and Wellbeing Group
- Principal risks to Strategic Objective 4.3 *Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers* are owned by are owned by Trust Leadership Team
- Principal risks to Strategic Objective 4.4 *The Trust will have a high quality research portfolio, which is visible to staff and patients, embedded alongside routine care, and achieves the annual High Level Objectives (HLO) defined by the National Institute Health Research (NIHR)*are owned by are owned Innovation (R&I) Forum, reporting to Trust Leadership Team

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
Risk that our Trust will not meet regulatory requirements to the level of "good" at the next planned and unplanned CQC inspections. .	**Director of Quality & Chief Nurse** **Quality & Performance Committee** (Responsive/ Effective/ Safe/ Caring) **In addition** **<u>Well-led</u>** **Director of People and Organisational Development** **Workforce Committee** **<u>Sustainable use of resources</u>** **Director of Finance** **Finance Committee**	**External** 1. Report and meeting with GCCG quality team 2. HOSC attendance 3. Action plan in response to last CQC inspection. **Internal** 4. Divisional attendance and reports at Executive Review meeting 5. Divisional Annual operating plans 6. Quality Account 7. Quality and Performance Committee Report 8. Exception Reports (Cancer Services Task Group, Planned Care Board, Emergency Care Board). 9. Minutes from key meetings (SERG (Safety And Experience Review Group), PESG (Patient Experience Strategic Group), Hospital Transfusion Committee, Resuscitation and	**External** 1. Gloucestershire CCG (Clinical Commissioning Group) Clinical Quality Review Group (CGRG) 2. Health Overview and Scrutiny Committee (HOSC) 3. CQC provider meeting. **Internal** 4. CEO (Chief Executive Officer) quarterly Executive Review meetings and monthly Executive Review meetings with Divisions. 5. Quality and Performance Committee (Sub-Committees of Q&P (Infection Control Committee, Hospital Mortality Indicator Group, Safeguarding Adults and	1. March GCCG CQRG meeting. 2. March quality reports to Q&P. 3. HOSC attendance Jan 2018 4. Jan CQC Provider meeting 5. March Executive review meetings 6. Quality account report and preparations 2016/17 and 2017/18 March Q&P meeting 7. Governor meetings 8. TLT March 2018 meeting 9. Audit and Assurance Committee meeting. 10. CQC improvement Meeting March 2018. 11. Internal Audit	↑

		Deteriorating Patient Group, Medicines Optimisation Committee) 10. Annual Reports from key Committees 11. Quality and Performance Committee reports and presentations to Governors 12. Risk Registers 13. CQC Responsive Improvement Plan 14. Risk Registers 15. Safety Reports 16. External Auditors reports and action plans 17. Internal audits and action plans 18. National audit reports and action plans 19. CQC Responsive Improvement Plan 20 Divisional Reports and minutes to TLT.	Children Committee, Clinical Systems Safety Group)) 6. Council of Governors meeting and Governors' Quality and Performance meeting 7. Trust Leadership Team (TLT) 8. Risk Management Group 9. Audit Committee 10. CQC review Group 11. Divisional Board Meetings (Quality Boards/ Speciality Governance meetings).	report on Serious incidents	
			Gaps in Controls	**Gaps in Assurance**	
				1. Possible gaps within Divisions in meeting every CQC registration standard as part of their business as	

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

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

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
1. Overall assurance mapping of all registration standards from Ward to Board and vice versa.	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	March 2018	NAAS to be implemented in July with ward to Board reporting.
2. Development of an overall proactive quality improvement strategy (#J2O – Journey to Outstanding).	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	July 2018	Strategy in development.
3. Review of our quality measures (Ward to Board systems).	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	July 2018	Quality system measurements being reviewed and agreed.

Enabling Strategies	**Oversight Group**	**Executive Committee**	
Risk Management Strategy/ risk register procedure	Risk Management Group	Trust Leadership Team	
Dementia Strategy	Patient Safety Forum	Quality & Performance Committee	
Staff Health and Wellbeing Strategy	H&W Committee	Quality & Performance Committee	
Improving Patient and Carer Strategy	PESG (Patient Safety and Experience Strategic Group)	Quality & Performance Committee	

Food and Drink Strategy Workforce Strategy	Patient Safety Forum Workforce Committee	Quality & Performance Committee Workforce Committee	

Quarterly Progress Report Against Delivery | **RAG Rating**

Baseline assessment July 2017

- The Trust remains at Requires Improvement overall and for both sites after the latest CQC report for the announced inspection visit on 24-27 January 2017 and unannounced February 2017 (published July 2017).
- There were 11 Domains across the Divisions that were rated as Requires Improvement (Maternity 1, Medical 4, Urgent and Emergency Care 2, Surgery 2 and OPA 2).
- Overall 73% of ratings were Good or Outstanding (an improvement from 68% in 2015).

Where are we now

A "must do" action plan was developed to respond to the areas of concern that needed addressing immediately and this has now been refined into a more responsive quality improvement plan addressing all the "should do" actions as well.

		Nov 2017	Feb 2018	May 2018	Nov 2017	Feb 2018	May 2018	Nov 2017	Feb 2018	May 2018	Nov 2017	Feb 2018	May 2018
	Number of items	R	R	R	A	A	A	G	G	G	B	B	B
Must Do	30	**0**	**2**	**3**	**13**	**8**	**7**	**13**	**14**	**11**	**2**	**4**	**9**

Update on the delivery plan for this quarter May 2018

1. **Strategy** - the Quality Improvement Strategy is being tested with key staff groups.
2. **Structures** – the Quality Delivery Group has now had 2 meetings. The terms of reference were agreed at our Quality and Performance Committee and Trust Leadership Team meetings.
3. **Systems** – the Quality and Performance Report (QPR) is in the process of being reviewed.
4. **Plans**
    1. Responsive plan - (responds to all the concerns that were raised by CQC at the last inspection) was reviewed by the Quality and Performance Committee in May 2018. Of the 30 "**must do**" actions we have
        - Nine blue closed actions (30%)
        - 11 green (36%) which are on track to be achieved before next update in August 2018
        - Seven ambers
        - Three reds.

    The Deputy Director of Quality will meet with the action owners to look at what actions are needed to close this plan.
    2. Proactive plan – this plan prepares the Trust for the next inspection all the actions for this quarter have been

completed. Discussion about CQC preparedness at the SNMC May 2018 meeting. Divisional plans reviewed at Executive Review meetings. 3. Assurance plan – Divisional preparedness to be tested at the QDG (self-assessment documentation against the KLOEs and key characteristics to be completed by July 2018).	

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

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

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

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

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

Position July 2017
Maternity, children & young people, end of life, surgery, medical care, urgent and emergency care and outpatients and diagnostics all rated by CQC as Good at CQC inspections.

Critical care was rated as outstanding.

Current position 13th June 2018
By carrying out a self-assessment of this Domain using the CQC Key Lines of Enquiry and the rating characteristics it would be likely that CQC would rate us as "Good". To carry out this self-assessment exercise we have reviewed and triangulated all our current patient experience data including the CQC Inpatient Survey which was published 13th June 2018.

Outstanding	Good	Requires Improvement	Inadequate
	X		

Rationale
Friends and Family Test - we have below national average scores for inpatients, about average scores for outpatients and ED while maternity reports just above average scores.

FFT Inpatients	Positive score 90.2% (national average 96%)
FFT Emergency Department	Positive score 83.1% (national average 84%)
FFT Maternity	Positive score 97.4% (national average 97%)
FFT Outpatients	Positive score 92.0% (national average 94%)

For our National Survey Programme Results

- NHSE Cancer Patient Experience – we are just above national average
- CQC Adult Inpatient Survey - our scores have decreased and we are rated 65/81 of the Picker Trusts
- Maternity – ranked against the Picker Trusts we were no 2.
- Children and Young People the Trust scored 'within expectations' in all areas

Cancer	Average
Inpatients	About the same as other Trust
Emergency Department	Average
Maternity	Above average – top 20%
Children and Young People	Average

Responsiveness to patient needs

Our responsiveness indicator score is published within our Quality Account and is on the lower end of an average score (0 worst score and 100 best score). The responsiveness indicator is a composite, calculated as the average of 5 survey questions from the Inpatient Survey. Each question describes a different element of the overarching theme, "responsiveness to patients' personal needs":

- Q32 - Were you involved as much as you wanted to be in questions about your care and treatment?
- Q35 – Did you find someone on the hospital staff to talk to about your worries and fears?
- Q37 – Were you given enough privacy when discussing your condition or treatment?
- Q57 – Did a member of staff tell you about medication side effects?
- Q63 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Year	GHNHSFT	National average	Highest Trust fig	Lowest Trust fig
2015/16	66.5/100	68.9/100	86.1/100	59.1/100
2016/17	67.7/100	69.6/100	86.2/100	58.9/100
2017/18	63.6/100	68.1/100	85.2/100	60.0/100

Progress on delivery plan June 2018

1. Our comparator CQC Inpatient Survey data shows that we are performing "about the same" as other Trusts in the country, whereas outstanding Trusts achieve "much better than expected" results. The next National Survey will be published in June 2018.
2. Within our delivery plan this quarter we had actioned that we would carry out a self-assessment of the Caring Domain using the CQC Key Lines of Enquiry (KLOEs) and the rating characteristics. Our results are that it would be likely that CQC would rate us as "Good" and not as outstanding. To carry out this self-assessment exercise we have reviewed and triangulated all our current patient experience data

including the latest CQC Inpatient Survey (published 13th June 2018). Our patient experience insight data will included in our end of year annual report to the Quality and Performance Committee in July. Areas for improvement have been identified and these will be actioned over the next year. 3. Also within the delivery plan for this strategic objective was to publish the Quality Improvement Strategy this quarter, this however has been delayed due to capacity within the Patient Experience team. The draft strategy is currently being tested with key groups of staff. The strategy has a delivery plan, impact measures and a review timetable. Reporting on the strategy will be through the Quality Delivery Group. The strategy will inform our Quality Account. 4. Also this month a new tool has been produced by NHSI and this is the NHS Improvement Patient Experience Framework (June 2018) and this has been used as an assessment tool to define some key actions for the organisation to include in the strategy to improve patient experience. 5. Treating patients with dignity and respect, as well as valuing them as individuals, was evident in our Inpatient Survey as we scored 9.0 (lowest score in England 8.5 and highest 9.7) and so this must be a fundamental part of our culture. 6. Throughout our FFT results patients and their relatives tell us how caring staff had been towards them, and how staff had 'gone the extra mile' to support them during their admission to hospital.	

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

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

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

		Care agenda.	waiting patients, post validation		
Potential Risk Exposure – Confirmed Risks on Trust / Divisional Risk Registers					**Mitigation**
• **S1748** - The risk of statutory intervention for failing national access standards in relation to cancer. • **S2628** - The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times. The risk on non-reporting of RTT (incomplete) standards.				4 x 4 = 16 (Statutory) 4 x 4 = 16 (Safety)	
Actions Agreed for any gaps		**By Whom**	**By When**		**Update**
Review of system-wide demand management including review of 2ww referrals received in to the organisation. All referrals received by electronic means 4th June.		COO	April 2018		In collaboration with CCG
Review of capacity allocation cross site.		COO	Links in to One Place business case as part of Capital programme during 2018/19		Outpatient Programme Board STP
Validation of all PTLs, establish RTT reporting, complete demand and capacity modelling and recovery plans for delivering 18w RTT.		COO	Links in to Trak recovery plan – cross reference with other BAF criteria/ SmartCare Commencing May 2018		On-going validation of PTLs continues
Enabling Strategy		**Oversight Group**	**Executive Committee**		
STP (Sustainability and Transformation Plan) Cancer Strategy (in development)		Unscheduled Care Programme Board, Planned Care Board	Q&P Committee		
Quarterly Progress Report Against Delivery					**RAG Rating**
See the Trust Board Quality and Performance report for comprehensive update on performance but in summary Emergency Department performance for April was 92% – strongest performance in many years and ahead of NHSE (NHS England) trajectory. Trajectory has been set for the year at 90% for the 4 hour standard. Commitment from NHSE to review segment classification from S4 to S2. Referral to Treatment (RTT) reporting has been suspended – see Trak Recovery Plan. Cancer recovery plan presented and endorsed by Q&P committee with planned recovery from Q1 2018/19. Significant progress to date is noted in the Q&P exception report for May which continues to be monitored closely for delivery in summer aligned with trajectory.					

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

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

		Similar model to be applied for other care pathways as appropriate 7. Trauma mortality review through trauma lead 8. Mortality database and initiation of mortality reviews though Bereavement Office. 9. Mortality/ Morbidity reviews held in all clinical specialties contributing to Hospital Mortality Group	**Gaps in Control** Data capture in TrakCare of number of episodes of inpatient care results in risk of underscoring of episodes of care and therefore miscalculation of crude mortality.	**Gaps in Assurance** Reporting and detail of oversight at Q&P and Trust Board - to be finalised Inability to model the impact of changes on HSMR.	

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

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
Reporting into Q+P now established and in use	Medical Director		Completed

Enabling Strategy	**Oversight Group**	**Executive Committee**
Death Reviews Policy (A2217)	Hospital Mortality Group	Quality and Performance Committee

Quarterly Progress Report Against Delivery	**RAG Rating**
• Current Dr Foster data shows a HSMR of 97.0 • Mortality dashboard now in use • The 2019 objective has been achieved • Enhanced input of Bereavement Team into death review process and recognition of Medical Examiner in national guidance	

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

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

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

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.5.3 Risk that staff will not be able to carry out reviews of their data and quality improvement work because of operational pressures.	**Director of Quality and Chief Nurse** **Quality & Performance Committee**	1. Divisional matrons notified of availability of results on monthly basis 2. Quarterly meetings with Governors with specific focus on quality topics 3. Quality academy structured approach to improvement work by specialties supported by division/ academy facilitators	1. Matron audit reporting to Divisional Quality Committees 2. Quarterly reports to PESG and Q&P (Quality and Performance) 3. Divisional patient experience/ quality reports to PESG 4. Reports to Q&P on patient experience indicators 5. GSQIA reporting to QPC on progress with projects (see BAF 2.4)	1. Patient Experience Indicators reported to Q&P in Jan 2018 2. FFT national data published on NHS England website 3. FFT data published on Trust website.	↔
			Gaps in Control	**Gaps in Assurance**	
			• Ability of GSQIA to support number of projects arising from silver courses / gold coaching projects training (capacity)	1. Reliable data source for actual performance e.g. surveys not reported in real time. 2. Sentiment analysis produces unreliable data source for improvement	

Potential Risk Exposure	Related Risks on Trust Risk Register	Score
• **M2473Emer** - The risk of poor quality patient experience during periods of overcrowding in the Emergency Department.		3 x 3 = 9 (Quality)

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

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
Reports are sent regularly to clinical areas to ensure continual focus is given.	Head of Patient Experience Improvement	Provided monthly	Divisions to act on findings
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience and Carer Strategy 2015-2017 (New draft quality improvement strategy being developed due May 2018.	Patient Experience Strategic Group	Quality & Performance Committee	

Quarterly Progress Report Against Delivery

RAG Rating

Current position

The current, April 2018, combined (maternity, ED, inpatient and OPA) FFT score is **90.6%** which is a decrease from 91.9% in February 2018.

Table: April positive scores

FFT Inpatients and day surgery	Positive score 90.2% (national average 96%)
FFT Emergency Department	Positive score 83.1% (national average 84%)
FFT Maternity	Positive score 97.4% (national average 97%)
FFT Outpatients	Positive score 92.0% (national average 94%)

<u>June 2018</u>

- We are above the national average for our response rate (see chart below for our comparator data).
- The score that is below the national average is the score for inpatients and day surgery. The plan to ring fence Day Surgery at GRH will more than likely improve patient experience and the positive scores.

• Within the delivery plan for this objective is for the Sweeney programme to commence in July 2018 with inpatient areas taking forward key patient experience improvement projects. In addition through the GSQIA there are 20 Patient Experience Improvement projects in progress within the clinical areas and many have used the FFT score data to design their projects. • The NHS England funded (£50k) Maternity Insight FFT project has been discontinued due to lack of continuing resources. This project was highly valued by staff as the women they cared put forward their names for recognition from the Trust.	


FY2017-18 - April
Recommended Rates
Response Rates
Royal Devon and Exeter NHS Foundation Trust (36)
Medway NHS Foundation Trust (35)
Gloucestershire Hospitals NHS Foundation Trust (34)
North Bristol NHS Trust (33)
East Kent Hospitals University NHS Foundation Trust (32)
Royal Surrey County Hospital NHS Foundation Trust (31)
Maidstone and Tunbridge Wells NHS Trust (30)
Oxford University Hospitals NHS Foundation Trust (29)
Yeovil District Hospital NHS Foundation Trust (28)
Isle of Wight NHS Trust (27)
University Hospitals Plymouth NHS Trust (26)
Surrey and Sussex Healthcare NHS Trust (25)
Hampshire Hospitals NHS Foundation Trust (24)
Buckinghamshire Healthcare NHS Trust (23)
Great Western Hospitals NHS Foundation Trust (22)
Weston Area Health NHS Trust (21)
Salisbury NHS Foundation Trust (20)
University Hospital Southampton NHS Foundation Trust (19)
Brighton and Sussex University Hospitals NHS Trust (18)
Ashford and St Peter's Hospitals NHS Foundation Trust (17)
East Sussex Healthcare NHS Trust (16)
Royal United Hospitals Bath NHS Foundation Trust (15)
Royal Cornwall Hospitals NHS Trust (14)
Western Sussex Hospitals NHS Foundation Trust (13)
Portsmouth Hospitals NHS Trust (12)
University Hospitals Bristol NHS Foundation Trust (11)
Torbay and South Devon NHS Foundation Trust (10)
Dartford and Gravesham NHS Trust (9)
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Poole Hospital NHS Foundation Trust (7)
Frimley Health NHS Foundation Trust (6)
Taunton and Somerset NHS Foundation Trust (5)
Northern Devon Healthcare NHS Trust (4)
Dorset County Hospital NHS Foundation Trust (3)
Royal Berkshire NHS Foundation Trust (2)
Queen Victoria Hospital NHS Foundation Trust (1)
England Average Recommended
England Average Response Rate
Select Service
Inpatient
November 2018 data for Maternity services are not available.
Select Region
South
Select Trust
All
Select Financial Year
FY2017-18
Select Month
April

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Direction of Travel
1.6.1 Risk that causes of complaints relating to patients experience are not fully understood or acted upon	**Director of Quality & Chief Nurse** **Quality & Performance Committee**	**External –** data using nationally agreed codes submitted to 1. Department of Health **Internal -** Analysis of themes from complaints by Patient Experience sent to Divisional /Executive 2. Outpatient Department Forum 3. Outpatient Improvement Group 4. Outpatient Senior Nurse Forum 5. Patient Experience Strategic Group (PESG) 6. Escalation of themes / serious complaints through SERG (Safety and Experience Review Group) which includes Exec/ CCG representation	1. Reports to Quality & Performance Committee every quarter 2. Reports to Patient Experience Steering Group and Safety & Experience Review Group bi monthly. 3. CBO (Central Booking Office) operational report monthly 4. Outpatient appointments complaints review and Outpatient Improvement Group meeting December 2017.	1. Reports show that number of complaints that have an outpatient experience element to them have declined.	↑
			Gaps in Controls	**Gaps in Assurance**	
			Challenges by external stakeholders about actions implemented as a result of complaints or Trust volunteering information	Detailed diagnosis of issues within the OPA complaints from Datix as each complaint letter needs to be read.	
Principal Risks to	**Risk Owner**	**Key Controls**	**Assurance on**	**Current Assurances**	**Direction of**

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

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

Actions Agreed for any gaps	By Whom	By When	Update
Data presented to Operational Delivery	Deputy Head of Patient	Monthly	

Committees so that reports can be produced.	Experience Improvement		
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience Strategy 2015-2017	Patient Experience Strategic Group	Quality & Performance Committee	New draft quality improvement strategy being developed with a patient experience chapter July 2018.

Quarterly Progress Report Against Delivery	**RAG Rating**

Baseline information

- Across the organisation, approximately 200,000 outpatient episodes provided every quarter.
- Prior to the implementation of the IT system Trakcare the number of complaints for outpatients' episodes of care was approximately 30 per month (as reported to PESG in November 2016).
- In April 2017, Outpatient complaints rose to 96 for that month and peaked at 120 in July 2017.

Current position

The Trust received **118** outpatient related complaints in Jan, Feb, and March 2018 which is an average of 39 complaints per month (these are complaints that have an issue assigned as Service Area – Outpatients).

June 2018 Update

- The task and finish group continue with their quality improvement project work and are working with the aim to improve outpatient experience. The reduction of complaints is the process measure. The 15 steps work has been put on hold but will start again in the summer.
- A draft Outpatient Transformation Strategy is under development and this includes a roadmap for outstanding/centres of excellence - ***'Journey to Outstanding - Right Patient, Right Appointment, Right Place, First Time'***
- The Matron for Outpatient Services has been working on Outpatient Department metrics and generic competencies for outpatients.
- The Nursing Assessment and Accreditation Assessment system will be rolled into Outpatients in November 2018.
- The Central Booking Office (CBO) has seen significant improvement in some of its KPIs but still has a long way to go. This week the new telephone system will be embedded with full training taking place - this should be one of the areas that will see a reduction in complaints as it is one of the main areas of complaint with regard phones being answered/access.

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

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

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

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

		– Divisional and Trust Health and Safety Forums.			

Potential Risk Exposure – Confirmed risks on Trust / Divisional Risk Registers	**Score**
None identified on Risk Registers. However failure to improve staff engagement score could indicate reduced staff morale, leading to increased staff retention. This would impact on workforce risks identified on the Trust risk register relating to the sustainability of the workforce and ongoing difficulties recruiting to vacancies in key areas such as: Nursing, Medical and Allied Health Professions.	

ctions Agreed for any gaps	**By Whom**	**By When**	**Update**
Development of 'Staff Experience Improvement Group' to implement a range of staff engagement, health and wellbeing actions. The newly formed group will replace/ merge the former Staff Health and Wellbeing Group and Staff Engagement Steering Group 05/18 Agreed to trial the triangulation of data for the medical division in order to test out methodology.	Head of Leadership and OD All members of Staff Experience Group to input to data triangulation to identify themes and set priorities.	September 2018 (met May 2018) September 2018	First staff experience meeting held 30 May 2018. Yet to benefit from data triangulation, resource to be fully identified.
Enabling Strategy	**Oversight Group**	**Executive Committee**	
Workforce Strategy	People and OD Group	Workforce Committee	

Quarterly Progress Report Against Delivery
• We reduced delivery progress to 'amber' as the Staff Engagement score for 2017 reduced from 3.71 to 3.67. (Nationally the average engagement score for acute trusts also dropped from 3.81 in 2016 to **3.79** in 2017) • The 'Staff Experience Improvement Group' met for the first time at the end of May 2018. The group is yet to benefit from full data triangulation, however agreed to review key data associated with the Medical Division to test out triangulation methods and identify improvement themes and opportunities.

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
High turnover results in a gap in care, potential increased cost to fill temporarily and a delay in attraction – resulting in potential service delivery delay.	Deputy Chief Executive & Director of People and OD **Workforce Committee**	1. Vacancy Control Panel (VCP) process enabling speedier fill to post process 2. VCP cost control, agency & bank 3. Recruitment & Selection Policy 4. Exit Interviews 5. Sustainable Workforce and ELD Priorities	1. Reprioritised work programme for 17/18 to ensure a basic funded establishment is produced with supply & demand for key roles established. 2. Workforce Sustainability & ELD group priorities 3. Divisional plans for hard to fill roles & forward planning 4. Human Resources Business Partner and Finance Business Partners involvement in vacancy projection 5. Workforce plans aligned to operational capacity and demand work	1. Operational dashboard published with trends and future projection at Workforce committee 2. Annual Education, learning and development report to workforce committee 3. Sustainable workforce report to workforce committee 4. STP update & impact to workforce to Board	↔

			within divisions 6. Education work strands to improve career planning & career routes/pathways 7. Bespoke retention projects and listening events (i.e. band 5 nurses) 8. STP work to reduce competitive recruitment between STP partners 9. Robust Training plans for all staff grades and provision for staff to develop themselves 6. Coaching offer STP leadership behaviour definition		
			Gaps in Controls	**Gaps in Assurance**	
			1. Limited compliance with exit interviews	1. Robust **talent management** system to link development opportunities	

				with succession planning and career management 2. **One version of data** – Finance and HR records on establishment do not match 3. **Effective Recruitment Strategy** linked to demand and supply routes, student attraction and rotation and increased HE engagement. 4. **Mentorship** programme to be offered to staff (by April 2019) 5. Yet to identify designated resource to lead on strategic development of sustainable workforce (ACPs, TNAs, Apprentices) 6. Review of HCA terms and conditions	

Potential Risk Exposure – confirmed risk entries on Trust Divisional Risk Registers	Score
Current High/ extreme risks assessed against Workforce domain criteria can be categorised into key workforce themes: • Risks associated with funded establishment levels, relating to increased service demand and our ability to respond. • Risks associated with the resilience/ sustainability of workforce levels across: Medical, Nursing or AHP groups	≥10 (Workforce)

Actions Agreed for any gaps	By Whom	By When	Update
1. Robust talent management system to link development opportunities with succession planning and career management	Head of Organisational Development	June 2018	Design and promotion required further development, launch delayed until July 2018.
2. One version of data – Finance and HR records on establishment do not match	Deputy Director of People and OD	September 2018	Doctors in Training complete. Corporate Division merge by end of June 2018.
3. To continue to develop Nurse Associate roles, Nurse apprenticeships and advanced clinical practice	Chief Nurse /Director of Quality	August 2018	TNA and Jr Clinical Fellow role recruitment scheduled June 2018.
4. Doctors in Training Streamlining Programme, to ensure new starters & potential joiners have the best experience within the Trust	Medical Staffing Manager	August 2018	National pilot extended, progress by August 2018 expected.
5. Review of HCA terms and conditions	Deputy Director of People and OD	August 2018	Staff consultation to take place July 2018
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Workforce Strategy	Workforce Committee		
Quarterly Progress Report Against Delivery			**RAG Rating**

• Turnover in workforce resourcing and recruitment has presented us with an opportunity to reshape our recruitment offer and focus on building an effective recruitment strategy. Key roles have been recruited to with a number of new starters joining the recruitment team in June and July 2018. RAG rating has changed to amber to reflect the interim impact this may have on recruitment. • An action plan for Nurse and HCA recruitment has been agreed and will shape the immediate priorities of the new Interim Head of Resourcing – due to join the Trust June 2018 • We are prepared to launch the talent development system in July 2018. • The establishment project is progressing, it should be noted that this is a collaborative project with finance and timescales will be refined as we learn from each test exercise. • Further focus is required on the development of sustainable workforce roles (such as ACPs) , to ensure the planned development of these roles link our key business, transformation and workforce plans however from June 2018 we will have a full time HRBP focussing on the project.	

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

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

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

			19. TLT (Trust Leadership Team) and DOG (Directors Operational Group) process 20. Back to floor days 21. Datix review & feedback 22. Internal Comms agenda and intranet use for key messages & blogs. 23. Listening events 24. Involve 25. I Lead 26. CQC (Care Quality Commission) and J2O (Journey to Outstanding) agenda 27. Reward Strategy Group.		
			Gaps in Control	**Gaps in Assurance**	
			Lack of triangulation of themes relating to staff experience.	1. Lack of real time engagement tool 2. Rumour mill working as fast as official channels.	
Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Register					
Actions Agreed for any gaps		**By Whom**	**By When**		**Update**
Development of the Staff Experience		Chaired by Deputy	First meeting June 2018		

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

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

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

Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers		
Operational pressures prevent training.		

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

The GSQIA continues to deliver the required volume of training for bronze and silver. Gold coach training continues with a cohort of 20 staff members **but is at risk to reach 45**. To resolve this, the new Quality Framework that organisationally creates the Gold QI coach role needs to be formally agreed. Staff in that role will then engage with the programme. Numbers of staff completing courses by end of June 2018 (excluding Non GHT staff): Bronze = 1272 Silver = 75 Gold = 0	

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

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

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

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director& Committee)	Key Controls and Mitigation	Assurance on Controls	Current Assurances	Direction of Travel
The risk that the proposals cannot be implemented without impacting on operational performance or quality of care.	**Director of Strategy and Transformation** **Main Board**	1. Detailed implementation plan with modelling of impact of service changes as part of the STP One Place Programme 2. Impact Assessment and Quality Impact Assessment of all proposals 3. Risk assessments for operational processes 4. Outline Business Case August 2018 5. NHSE (NHS England) stage 2 Assurance Process 6. Full Business case July 2018 Board.	Full Business Case including impact assessments. **Gaps in Control** None	Strategic Outline Case June 2017 Output from NHSE (NHS England) stage 1 assurance. **Gaps in Assurance** None	↔
Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers				**Risk score**	
National political processes could introduce delays into the proposed timetable. Unexpected increase in demand for services.					
• **C1748COO** - The risk of statutory intervention for failing national access standards in relation to cancer. • **M2473** - The risk of poor quality patient experience during periods of overcrowding in the ED (Emergency Department).				4 x 4 = 16 (Statutory) 3 x 3 = 9 (Quality)	
Enabling Strategy	**Oversight Committee**	**Executive Group**			

New Clinical Model Strategic Outline Case One Gloucestershire STP (Sustainability and Transformation Plan)	New Clinical Model Programme Board Now reporting to One Place Programme Board	Main Board	
Quarterly Progress Report Against Delivery			**RAG Rating**
In the last quarter significant work has been undertaken within the Trust and with system partners to work through the emerging new clinical model, its assumptions and the impact that wider STP initiatives around the urgent and emergency pathways would have upon the Trust. The work has now been scoped into the "One Place Programme". The aim of the programme is: • To deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for urgent care set out in "One Gloucestershire" STP. • New Clinical Model Programme Board (meeting fortnightly) has been restructured to include all Executive Directors and Chiefs of Service.			

(3.2) Strategic Objective: To complete Trakcare recovery work to enable the Trust to resume national RTT reporting by December 2018 (amended)

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
3.2.1 Risk that the roll out of future phases of TrakCare is delayed or does not proceed due to the impact of recovery actions from Phase 1 deployment.	**CEO (Chief Executive Officer) as SRO (Senior Responsible Owner) of SmartCare Programme** **SmartCare Programme Board reporting to Main Board**	1. Increased pace on phase 1 recovery to limit delays to future phases. 2. Renegotiation of phasing of future deployments with InterSystems 3. Negotiation with NHS Digital and NHS England regarding duration and phasing of funding agreement.	Updates to SmartCare Programme Board on TrakCare recovery and dialogue with NHD / E and InterSystems.	Monthly reports to Main Board on programme performance.	↔
			Gaps in Control	**Gaps in Assurance**	
			Ability to control supplier factors and national body decisions remains a gap in controls that cannot be addressed further.	None	
Principal Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls and Mitigations**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
3.2.2 Service is not operationally prepared for go live, delaying deployment.	**CEO as SRO of SmartCare Programme** **SmartCare Programme Board reporting**	1. Rigorous process to identify “as is” and “to be” processes 2. Engagement of TrakCare Operational Group 3. Comprehensive role	Authority to Proceed gateways.	Monthly reports to Main Board on programme performance.	↔
			Gaps in Control	**Gaps in Assurance**	

	to Main Board	based training programme, including competency assessment 4. Sign off by TrakCare Operational Group of operational readiness.	None	None	
Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers				**Mitigation**	
• **C2621SC** - Risk that EPR deployment is delayed resulting in roll out extending beyond funded timeline and potential loss of national funding.			3 x 2 = 6(Statutory)	• Forward programme being re-cast in light of Recovery Plan impact on future phases • Dialogue with SLCS (system funding body) to explore potential for revised funding structure.	

Enabling Strategy	**Oversight Group**	**Executive Committee**
Digital Strategy	SmartCare Programme Board	Trust Board

Quarterly Progress Report Against Delivery	**RAG Rating**
• Project set to amber as deployment dates for subsequent phases not yet agreed and likely to extend into FY20 for some elements of future functionality. • Governance arrangements for TrakCare revised and strengthened and plan to re-profile programme and future phases deployment timeline in hand. • Significant progress with TrakCare recovery programme and wider EPR programme. Successful launch of new approach to outpatient outcomes with early evidence of considerable impact on data quality issues. • SmartCare Programme Board approved build and evaluation of TrakCare pathology system • Positve dialogue with NHSD and NHSE re funding transfer to 2019/20 though final decision not yet communicated.	

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

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

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

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

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

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

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

Potential Risk Exposure	Related risks on Trust Risk Register		
none	none		

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

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

(4.1) Strategic Objective – Show an improved financial position

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

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

Potential Risk Exposure	Related risks on Trust Risk Register	**Risk score** *(all for finance domain)*
	• **F2516** - Risk that the Trust does not exit Financial Special Measures in a timely way and as a result is subject to interest charge "penalties".	2 x 2 = 4
	• **F2724** - Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19	5 x 3 = 15
	• **F2723** - Risk that FY19 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation	4 x 3 = 12
	• **F2722** - Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY19	3 x 2 = 6
	• **F2721** - The risk that the Trust is not able to agree the control total set by NHS Improvement. As a result it is at risk of being subject to contractual fines and penalties.	3 x 3 = 9

Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
PMO supports in-year delivery alongside any in-year recovery. The PMO works with divisions to understand and recover slippage and identify new schemes. TIB (Turnaround Implementation Board) used as escalation forum for issues that cannot be resolved at divisional level.	Director of CIP PMO	Ongoing	CIP programme showing £0.9m favourable variance to plan for period to end October.
Progress/slippage is tracked and reported weekly to Executives (through the dashboard) and monthly via other forums including to the	Director of CIP PMO	Ongoing	Dashboard format will be updated to better KPIs

Finance Committee.			
TIB chaired by the CEO (Chief Executive Officer) to reiterate the importance of CIP delivery and to support the resolution of any escalated issues.	Director of CIP PMO	Ongoing	In place from September 17
Finance business partners work with divisions to recover slippage and identify mitigating actions Escalation to Director of Finance where Executive intervention required (part of Executive reviews).	Director of Operational Finance	Ongoing	Overall I&E (Income & Expenditure) performance has moved into a cumulative unfavourable variance against plan of £2.1m.
Development of 2018/19 Financial Plan & Budget.	Director of Finance	Mid-May 2018	High level plan developed. Detailed budget setting timetable in place and being agreed in April/May.
Development of 2018/19 CIP plans.	Director of CIP (Cost Improvement Plan) PMO (Programme Management Office)	Ongoing	CIP plans for 18/19 are being worked up by Divisions and Executive leads , so far PIDs and opportunities for delivering £15.4m against the £30m target have been identified
Enabling Strategy	**Oversight Committee**	**Executive Group**	
	Finance Committee	Turnaround Improvement Board and Trust Leadership Team	

Quarterly Progress Report Against Delivery			**RAG Rating**
The overall Income and Expenditure position to the end of May is showing an £8.9m deficit position, which is favourable to plan by £0.1m. A detailed plan has been developed and approved by the Trust Board, with a planned deficit for the financial year of £18.8m after assumed receipt of Provider Sustainability Funding (PSF) of £8.1m. Actual receipt of PSF will be subject to meeting quarterly A&E performance and financial control total targets.			

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

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

Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers	Risk score
• **C2628COO** - The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times. The risk on non-reporting of RTT (incomplete) standards. Linked risks **C2439SC, S2472UGI**	4 x 4 = 16 (Safety)
• **F2724** - resulting in failure to deliver the Financial Recovery Plan for FY19	5 x 2 = 10 (Finance)
• **F2723** - Risk that FY19 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation	4 x 3 = 12 (Finance)
• **F2722** - Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY19	3 x 2 = 6 (Finance)

Actions Agreed for any gaps	By Whom	By When	Update

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

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

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

Potential Risk Exposure – confirmed risks on Trust and Divisional Risk Register	Score (CxL)	
C2335HR&OD - Risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy level.	4 x 4 = 16 (Finance)	

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

Quarterly Progress Report Against Delivery	RAG Rating
Respiratory • Lead for Integrated Respiratory Team appointed. • Staff consultation (GCS) & engagement (GHFT) on 7-day working and service specification to commence in June 2018 • Start date for phased implementation of integrated team is 1st July 2018 • GHFT respiratory consultants have begun pilot for respiratory advice and guidance service within the Gloucester locality **Diabetes** • Model for integrated leg ulcer service agreed. • Awaiting funding for implementation of community clinics from CCG. Musculo Skeletal (MSK) conditions • The significant progress made to reduce the fractured neck of femur mortality rate by 37% (20 lives saved this year) with GHFT being been shortlisted for a HSJ award • MSK Foot and ankle triage to commence on 9th April 2018 with other body parts to follow • Full Business Case for MSK specialised triage being approved by the CCG Priorities committee in January. • eRS and booking processes have been configured, with joint training being organised. The referral form has been tested within Primary Care, in conjunction with Cancer 2WW form.	

(4.6) Strategic Objective: The Trust will have a high quality research portfolio, which is visible to staff and patients, embedded alongside routine care, and achieves the annual High Level Objectives (HLO) defined by the National Institute Health Research (NIHR).

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
1. Lack of suitable studies available on the NIHR portfolio 2. Laboratory accreditation issues reduce the number of available studies 3. Staff resource in the Research Delivery Team	**Director of Strategy & Transformation** **Research & Innovation (R&I) Forum, reporting to Trust Leadership Team**	1. Broaden the research portfolio to maximise available studies 2. Consider studies that do not require lab accreditation 3. Accuracy of capability and capacity assessments for new studies to maximise workforce utilisation. Review and closure of poor performing studies to release staff	Progress against all HLOs reported quarterly internally to R&I forum and externally to SW Clinical Research Network (CRN)	R&I forum in June 2018	N/A
			Gaps in Control	**Gaps in Assurance**	
			None	None	

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

Enabling Strategy	Oversight Group	Executive Committee
GHFT 2018/19 NIHR CRN Business Plan	Research & Innovation Forum	Trust Leadership Team
GHFT Research & Development Strategy	To be refreshed in Q2 2018/19	

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

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00am

Report Title
Application of the Trust Seal Annual Report
Sponsor and Author(s)
Author: Natashia Judge, Corporate Governance Manager Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary

Background

The application of the Trust's seals to documents was previously reported to the Board monthly via an addition at the end of the Chief Executive's report. These are now reported to Audit and Assurance on a quarterly basis with a full report received annually at Board.

The recurrence of the Annual Report will change from September to follow the end of the financial year. The next annual report is due to Main Board in April 2019.

Seals Applied

Since the last report presented to the Board in September 2017, the Trust seal has been applied to the following documents:

- December 2017 – GenMed Theatres Managed Services Contract
  (Approved by Finance Committee)

- January 2018 – Mandatory Relief From Business Rates
  (Approved by Finance Committee)

- February 2018 – Premises Lease, Lansdown Lodge

- June 2018 – Operational Agreement between Gloucestershire Hospitals and Gloucestershire Managed Services

Recommendations
That the above be noted.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Ensures compliance with statutory requirements.
Equality & Patient Impact
N/A

Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
		✓ Report reviewed on a quarterly basis				

REPORT TO MAIN BOARD – AUGUST 2018

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

This report describes the business conducted at the GMS Committee held 13th August 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
GMS Chair's Report	The bank account is now fully operational – previously contentious. GMS has produced a Regional Estates Strategy for the integrated care system, including 5 capital bids for NHS Improvement wave 4 Sustainability and Transformation Plan capital funding.		RES – in the event GMS moves towards any contractual commitment, approval will be sought from GMS Committee in advance.	

Chief Operating Officer's Report	There have been three key areas of concern regarding service performance for the Trust: • Domestic services in GRH • Patient Catering Trust wide • Central Sterile Services Department (CSSD) Trust wide Work continues to establish robust planning to ensure improvement in these three key areas. The Trust side Contract Manager continues to support solutions for issues identified.	Challenges around levels of service and robustness and urgency of recovery plan. July Key Performance Indicator (KPI) data still shows gaps in available data, insufficient monitoring and incorrect interpretation of the KPI requirement.	The Trust side Contract Manager has now established a working relationship with Nursing leads plus key operational managers and Directors throughout the Trust to support Facilities & Estates projects. A working relationship has been established between the head of hard and soft services for GMS and communication lines are open for information and issues. Progress has been slow to meet with all service heads although issues found in some departments already visited have taken precedence over introductory sessions. For cleaning and CSSD the COO has reviewed the remediation plans and found them to be robust and deliverable if driven at pace. The Chief Operating Officer is having weekly meetings with Managing Director (MD) of GMS and will report back to GMS Committee for September. This will include a review of July KPIs and performance. Further work is being conducted around validity and accuracy of KPI measurement.	Remedial Plans for Cleaning, Catering and CSSD to be submitted to next GMS Committee

GMS 'Colleague to Customer; Journey': Change/Organisational Development (OD) Plan	There is a comprehensive OD plan in place owned by GMS and supported by the Trust that covers a range of aspects.	The plan addresses the need for cultural change on the journey from colleague to customer as well as skills and competence gaps for key leaders and staff.	Ad-hoc updates will be requested from and provided by the MD of GMS.	
GMS Business Plan	Good draft business plan for Year 1, but it needs to clearly show what will be delivered of the original business case.	Maintaining appropriate balance between long term strategic goals and short team delivery priorities. The Plan needs to be explicit on what will be delivered in year 1 of the Business Case, especially the Financial Benefits.	The plan is to be resubmitted to the GMS Committee in September.	Business Plan sign-off by GMS Committee
GMS Project Wrap Up Report	This report represents end of the 90 day period, summarising completed and outstanding actions together with action parties for those outstanding actions.		Outstanding actions sits in Chief Operating Officer portfolio, to be reported via the Chief Operating Officer's report at future GMS Committee meetings to ensure effective tracking to completion/closure.	Remaining open actions need to be reviewed at GMS Committee.

Risk Log	Transferred from GMS Project Lead to Chief Operating Officer. The Risk Log continues to focus on transition risks whereas a discussion is required on how to address operational risks.	Agreement needs to be sought for how risks are divided between Trust and GMS in this area and governance arrangements.	Further discussions and support is required from the Director of Corporate Governance.	Need for clarity on future governance arrangements.

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

Report Title
Amendments to the Trust Constitution
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance Sponsor: Lukasz Bohdan, Director of Corporate Governance

Executive Summary

Purpose

To obtain the Trust Board's approval for the proposed amendments to the Trust Constitution.

Key Issues to note

Regularly reviewing a Foundation Trust's Constitution is considered best practice. Given recent changes in the corporate governance landscape, the Trust has agreed to undertake a fundamental review of its Constitution to ensure it reflects best practice supports good governance and facilitates effective decision-making and accountability within the Trust.

Objectives of the review were as follows:

- To ensure Gloucestershire Hospitals NHS Foundation Trust Constitution reflects the model Constitution, the NHS Foundation Trust Code of Governance, current best practice and the learning from the self-assessment against the Well-led framework.
- To ensure the Constitution is fit for purpose, internally consistent and 'future proof' (e.g. possible future development of an Accountable Care System in Gloucestershire).
- To ensure Gloucestershire Hospitals NHS Foundation Trust Constitution is written in plain English so that it can be widely understood.
- To take account of a changing governance landscape, including the potential creation of SubCo.
- To ensure Standing Orders, Scheme of Delegation and Standing Financial Instructions are aligned to and consistent with the Constitution, but do not duplicate Constitution's provisions; in doing so, to ensure appropriate allocation of matters to the Constitution (i.e. fundamental provisions, rarely revisited v. more 'operational', regularly updated provisions in the supporting documents – Standing Orders, Scheme of Delegation and Standing Financial Instructions)

The **scope** covered:
In scope

- Gloucestershire Hospitals NHS Foundation Trust Constitution.
- Gloucestershire Hospitals NHS Foundation Trust Standing Orders, including Scheme of Delegation.

While the Trust agreed to undertake a 'root and branch' review of its Constitution, the **main constitutional issues, which need to be reviewed/enacted** include:

- Composition of the Council of Governors and Constituencies, including proportion of

governors allocated to each public constituency; and creating an appointed governor role representing carers' organisations.
- Elections and when they take place
- Tenure in office for governors and non-executive directors.
- Definition of 'significant transaction'.

This work, led by the Constitution Review Group, concluded in July. Proposed changes were considered by the Governors' Governance and Nominations Committee and the revised text of the Constitution presented to the Council of Governors in August.

The Trust may make amendments of its Constitution only if:-
- More than half of the members of the Council of Governors of the Trust voting approve the amendments, and
- More than half of the members of the Board of Directors of the Trust voting approve the amendments.

The Council approved the amendments, subject to minor drafting changes being made

The amended Constitution is enclosed for Board's approval.

The Board should note that the changes to the Standing Orders, including Scheme of Delegation, and the Standing Financial Instructions, will be presented to the November Board along with the revised Committee terms of reference.

Recommendations
The Board is asked to approve the amendments to the Trust Constitution.
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	**x**	Buildings	
No change.			

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

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

MAIN BOARD
SEPTEMBER 2018

SUMMARY OF AMENDMENTS MADE TO THE TRUST CONSTITUTION

	Change
1.	**Governors' term in office**. Discussed option of reducing to 6 years with a possibility of extension for further 3 years Agreed to maintain status quo (i.e. 9 years), but clarified that9 years are "in aggregate" (i.e. in total, regardless of breaks)
2.	**Non-Executive Directors' term in office:** agreed two 3-years terms and, "in exceptional circumstances" an extension for 1 year
3.	Agreed **reducing number of Governors in the 'Other' Staff Class from 2 to 1** to maintain staff to Governor ratio in line with other classes
4.	Changes to Council of Governors' Standing orders, including raising quorum to two-thirds of Governors
5.	General **housekeeping** changes and new **definitions (e.g.** Accounting Officer, Significant Transaction)
6.	New definition of **'major transaction'; introduced definition of 'relevant transaction'**
7.	**Stakeholder Governors**: Agreed not to mention names of specific organisations. Kept reference to local authority governor as required by law
8.	**Ineligibility to be Governor:** updated criteria
9.	**Membership minimum age**: agreed to raise age to 15
10.	**Eligibility to be a Governor minimum age**: agreed to raise to 18
11.	**Constituencies'** geographic reach: • agreed to extend Out of County public constituency to cover all areas where the Trust provides services (now

	Change
	addressed in Annex 1); • eligibility to be a member of Out of County is based on residency NOT being a patient of the Trust) • To be represented by just 1 Governor
12.	Confirmed previous decision there should be **no 'patient' constituency**
13.	Introduced **Chair's right to veto an appointment of a specific individual as appointed governor**: Exact criteria and wording to be agreed; criteria to be shared with appointing organisations
14.	**CoG Attendance** Agreed that a minimum of 6 meetings be held a year and that governors must attend 4 as a minimum
15.	**Trust Secretary** references to changed to Director of Corporate Governance
16.	**Amended dispute resolution procedure** to extend its application to disputes with Members and potential Members and to recognise the role of the Board in the governance arrangements of a foundation Trust. Included reference to Governors' right to escalate concerns to monitor.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

September 2018

Document control [To be removed prior to publication]		
Version	Date	Description
0.1	26.04.2018	First draft of the substantive rewrite for review at 30.4.18 Constitution Review Group
0.2	25.05.2018	To incorporate changes agreed at 30th April 2018 Constitution Review Group
0.3 & 0.4	22.06.2018	To incorporate changes agreed at 1st June 2018 Constitution Review Group
0.5	27.06.2018	To incorporate changes from the Constitution Review Group received in response to the 22 June draft circulation
0.6 & 0.7	29.06.2018	To incorporate changes agreed at the 29th June 2018 Constitution Review Group
0.8	05.07.2018	Advice from DAC Beachcroft incorporated
0.9	23.07.2018	To incorporate G&N amendments and final edits
0.10	09.08.18	Advice from DAC Beachcroft incorporated
0.11 and 0.12	14-15.08.18	Significant and relevant transaction definitions amended to reflect Board discussion
0.13	05.09.18	To incorporate changes agreed at 15.08.18 Council of Governors

TABLE OF CONTENTS

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST CONSTITUTION

1. DEFINITIONS

1.1 In this Constitution:

"Accountable Officer"	means the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
"Accounting Officer"	means that person who from time to time discharges the functions of Accounting Officer of the Trust for the purposes of Government accounting.
"Auditor"	means external auditor as defined in Paragraph 14
"the 2012 Act"	means the Health and Social Care Act 2012.
"Annual Members' Meeting"	means the meeting held annually at which the Members of the Trust are presented with certain statutory reports as provided for in 7.7.4.
"Appointing organisations"	means those organisations named in this Constitution, or as subsequently agreed by the Trust, who are entitled to appoint Stakeholder Governors.
"Areas of the Trust"	means the areas specified in Annex 1.
"Board of Directors"	means the Board of Directors as constituted in accordance with this Constitution.
"Budget"	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
"Chair"	means the Chair of the Trust.
"Chief Executive"	means the Chief Executive of the Trust.
"Class"	means the division of a Membership Constituency by reference to the description of individuals eligible to be Members of it.
"Council of Governors"	means the Council of Governors as constituted in this Constitution, which is called a council of Governors in the 2003 Act as amended.

“Committee of the Council of Governors”	means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership.
“Director”	means a member of the Board of Directors.
“Director of Corporate Governance”	means the Director of Corporate Governance or any other person nominated by them to perform the duties of the Trust Secretary.
“Director of Finance”	means the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.
"Dispute Resolution Procedure"	means the dispute resolution procedure set out at Annex 5.
“Elected Governors”	means those Governors elected by the public constituencies and the classes of the staff constituency.
“Executive Director”	means a person appointed as an executive director of the Trust.
“Financial Year”	means a successive period of twelve months beginning with 1 April.
“Funds held on Trust”	mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.
“General Meeting”	mean a meeting of the Council of Governors of which notice has been given to all Governors and at which all Governors are entitled to attend.
“Governor”	means a person who is a member of the Council of Governors.
“Group”	means the Trust and its subsidiaries (excluding charitable funds).
“Health Service Body”	shall have the same meaning as in Section 9(4) of the 2006 Act.
“Local Authority Governor”	means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area of the Trust.
“Lead Governor”	is defined in paragraph 8.7.
“Material Transaction”	is defined in paragraph 17.3.2.2.
“Member”	means a member of the Trust.

"Membership Constituency"	means any of (1) the Public Constituency; or (2) the Staff Constituency.
“Motion”	means a formal proposition to be discussed and voted on during the course of a meeting.
“NHS Improvement (Monitor)”	means NHS Improvement, the body corporate known as NHS Improvement as provided by Section 61 of the 2012 Act as amended.
“Nominated Officer”	means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.
Non-Executive Director	means a person appointed by the Council of Governors to be a member of the Board of Directors. This includes the Chair of the Trust.
“Non Principal Purpose Activities”	means activities other than the provision of goods and services for the purposes of the National Health Service.
“Officer”	means an employee of the Trust.
“Principal Purpose”	is defined in paragraph 3.1.
“Public Constituency”	means a public constituency of the Trust as defined in Annex 1.
“Public Governor”	means a member of the Council of Governors elected by the Members of a public constituency.
“Relevant Transaction”	is defined in paragraph 17.4.
“Sex Offender Order”	means an order made pursuant to Section 20 of the Crime and Disorder Act 1998.
“Significant Transaction”	is defined in paragraph 17.2.
“SFIs”	means Standing Financial Instructions.
“Staff Constituency”	means a staff constituency of the Trust as defined in Annex 1.
“Staff Governor”	means a member of the Council of Governors elected by the Members of one of the classes of the staff constituency.
“Stakeholder Governor”	means one of up to four stakeholder appointed Governors. One of these must come from the Gloucestershire County Council. The other three positions could be appointments from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors.
“SOs”	means Standing Orders.

"the 2006 Act"	means the National Health Service Act 2006.
"the Trust"	means the Gloucestershire Hospitals NHS Foundation Trust.
"Vice Chair"	means the Non-Executive Director appointed by Council of Governors to carry out the duties of the Chair if they are absent for any reason.

1.2 Headings are for ease of reference only and are not to affect interpretation.

1.3 Unless the contrary intention appears or the context otherwise requires:

1.3.1 Words or expressions contained in this Constitution bear the same meaning as in the 2006 Act;

1.3.2 References in this Constitution to legislation include all amendments, replacements, or re-enactments made to that legislation;

1.3.3 References to legislation include all regulations, statutory guidance or directions made in respect of that legislation;

1.3.4 References to paragraphs are to paragraphs in this Constitution.

2. NAME

2.1 The name of the Trust is to be Gloucestershire Hospitals NHS Foundation Trust.

3. PRINCIPAL PURPOSE

3.1 The Trust's principal purpose is the provision of goods and services for the purposes of the National Health Service in England ("the **Principal Purpose**").

3.2 The Trust's total income in each Financial Year from the Principal Purpose must be greater than its total income from Non Principal Purpose Activities.

4. OTHER PURPOSES

4.1 The Trust may provide goods and services for any purpose related to:

4.1.1 The provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

4.1.2 The promotion and protection of public health.

4.2 Subject to the requirements set out in Paragraph 16, the Trust may also carry on other activities for the purpose of making additional income available in order better to carry on its principal purpose.

5. POWERS

5.1 The Trust shall have all the powers of an NHS foundation trust as set out in the 2006 Act.

6. FRAMEWORK

6.1 The Trust shall have two Membership Constituencies: a Council of Governors and a Board of Directors. The Board of Directors will exercise the powers of the Trust. Any

of these powers may be delegated to a committee of directors or to an executive director. The Membership Constituencies will elect certain of their Members to the Council of Governors in accordance with this Constitution and other Governors will be appointed by various bodies as set out in this Constitution. The Council of Governors will fulfil those functions imposed on it by the 2006 Act and by this Constitution.

7. MEMBERS

7.1 The Membership Constituencies

7.1.1 The Trust shall have two Membership Constituencies, namely:

7.1.1.1 The Public Constituency constituted in accordance with paragraph 7.2; and

7.1.1.2 The Staff Constituency constituted in accordance with paragraph 7.3.

7.1.2 An individual may become a Member by application to the Trust in accordance with this Constitution or, where so provided for in this Constitution, by being invited by the Trust to become a Member of a Staff Class of the Staff Constituency in accordance with paragraph 7.3.

7.1.3 Where an individual applies to become a Member of the Trust, the Trust shall consider their application for Membership as soon as reasonably practicable following its receipt and in any event no later than 28 days from the date upon which the application is received and unless that individual is ineligible for Membership or is disqualified from Membership the Director of Corporate Governance shall cause their name to be entered forthwith on the Trust's Register of Members and that individual shall thereupon become a Member.

7.1.4 Where an individual is invited by the Trust to become a Member in accordance with paragraph 7.3.1.1 that individual shall automatically become a Member and shall have their name entered on the Trust's Register of Members following the expiration of 14 days after the giving of that invitation unless within that period the individual has informed the Trust that they do not wish to become a Member.

7.1.5 An individual shall become a Member on the date upon which their name is entered on the Trust's Register of Members and that individual shall cease to be a Member upon the date upon which their name is removed from the Register of Members as provided for in this Constitution.

7.1.6 The Trust shall take reasonable steps to secure that taken as a whole the actual Membership of the Public Constituency is representative of those eligible for such Membership.

7.1.7 In deciding which areas are to comprise the Area of the Trust, the Trust shall have regard to the need for those eligible for such Membership to be representative of those to whom the Trust provides services.

7.2 Public Constituency

7.2.1 Members of the Public Constituency shall be individuals who:

7.2.1.1 live in the Area of the Trust;

7.2.1.2 are not eligible to become Members of the Staff Constituency;

7.2.1.3 are not disqualified from Membership under paragraph 7.4;

7.2.1.4 are at least 16 years of age at the time of their application to become a Member (and have parental or guardian's consent if under the age of 18); and

7.2.1.5 have applied to the Trust to become a member and that application has been accepted by the Trust in accordance with paragraph 7.1.3.

7.2.2 The minimum number of Members required for the Public Constituency shall be the number given in Annex 1.

7.2.3 An individual shall be deemed to live in the Area of the Trust if this is evidenced by their name appearing on the then current Electoral Roll at an address within the Area of the Trust or the Trust acting by the Director of Corporate Governance is otherwise satisfied that the individual lives within the Area of the Trust.

7.3 **Staff constituency**

7.3.1 Members of the Staff Constituency shall be individuals:

7.3.1.1 who:

(a) are employed under a contract of employment with the Trust which has no fixed term or a fixed term of at least 12 months, or
(b) who have been continuously employed under a contract of employment with the Trust for at least 12 months; or
(c) are not so employed but who nevertheless exercise functions for the purposes of the Trust and who have exercised the functions for the purposes of the Trust continuously for at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis.
(d) who have not been disqualified from Membership under paragraph 7.4.

7.3.2 Chapter 1 of Part XIV of the Employment Rights Act 1996 applies for the purpose of determining whether an individual has been continuously employed by the Trust for the purposes of paragraph 7.3.1.1(b) or has continuously exercised functions for the Trust for the purposes of paragraphs 7.3.1.1(c) and 7.3.1.1(d).

7.3.3 The Staff Constituency is to be divided into four classes as follows:

7.3.3.1 the Medical and Dental Staff staff class;

7.3.3.2 the Nursing and Midwifery Staff staff class;

7.3.3.3 the Allied Health Professionals Staff staff class;

7.3.3.4 the Other/ Non-Clinical Staff staff class.

7.3.4 The Members of the Medical and Dental Staff staff class are those individuals who are Members of the staff constituency who:

7.3.4.1 are fully registered persons within the meaning of the Medicines Act 1956 or the Dentist Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practice in England and Wales; or

7.3.4.2 are otherwise designated by the Trust from time to time as eligible to be Members of this staff class having regard to the usual definitions applicable at that time for persons carrying on the professions of a medical practitioner or a dentist; and

7.3.4.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and at all times thereafter remain employed by the Trust in that capacity.

7.3.5 The Members of the Nursing and Midwifery Staff staff class are individuals who are Members of the staff constituency who:

7.3.5.1 are registered under the Nurses, Midwives and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practice in England and Wales; or

7.3.5.2 are otherwise designated by the Trust from time to time as eligible to be Members of this staff class having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife; and

7.3.5.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and who at all times thereafter remain employed by the Trust in that capacity.

7.3.6 The Members of the Allied Health Professionals Staff staff class are those individuals who are Members of the staff constituency:

7.3.6.1 whose regulatory body falls within the remit of the Council for the Regulation of Healthcare Professions established by Section 25 of the NHS Reform and Healthcare Professions Act 2002; or

7.3.6.2 are otherwise designated by the Trust from time to time as eligible to be Members of this staff class having regard to the usual definitions applicable at that time for persons carrying on such professions; and

7.3.6.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and who at all times thereafter remain employed by the Trust in that capacity.

7.3.7 The Members of the Other/ Non-Clinical Staff staff class are those individuals who are Members of the staff constituency who:

7.3.7.1 do not come within those definitions set out in paragraphs 7.3.4–7.3.6 above and who are designated by the Trust from time to time as eligible to be Members of this staff class; and

7.3.7.2 are not otherwise eligible to be Members of another staff class having regard to the relevant definitions applicable at that time; and

7.3.7.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and who at all times thereafter remain employed by the Trust in that capacity.

7.3.8 The staff of Gloucestershire Managed Services are not eligible to become members of the Other/ Non-Clinical Staff class (or any other class within the Staff Constituency).

7.3.9 The minimum number of Members required for each Staff Class shall be the number given in Annex 1.

7.3.10 A person who is eligible to be a Member of the Staff Constituency may not become or continue as a Member of any other Membership Constituency.

7.3.11 Members of the clinical Staff Classes shall be considered to remain employed in the relevant capacity if they shall have been appointed to a position within the management structure of the Trust.

7.4 Disqualification from Membership

7.4.1 An individual shall not become or continue as a Member if:

7.4.1.1 They are or become ineligible under paragraphs 7.2 or 7.3 to be a Member; or

7.4.1.2 The Council of Governors resolves for reasonable cause that their so doing would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or
(b) harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provision of goods and services; or
(c) adversely affect public confidence in the goods or services provided by the Trust; or
(d) otherwise bring the Trust into disrepute; or

7.4.1.3 The Council of Governors resolves or ever has resolved in accordance with paragraph 8.10.3 that their tenure as a Governor be terminated.

7.4.2 It is the responsibility of each Member to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. A Member who becomes aware of their ineligibility shall inform the Trust as soon as practicable and that person shall thereupon be removed forthwith from the Register of Members and shall cease to be a Member.

7.4.3 Where the Trust has reason to believe that a Member is ineligible for Membership under paragraphs 7.2 or 7.3 or may be disqualified from Membership under this paragraph 7.4, the Director of Corporate Governance shall carry out reasonable enquiries to establish if this is the case.

7.4.4 Where the Director of Corporate Governance considers that there may be reasons for concluding that a Member or an applicant for Membership may be ineligible or be disqualified from Membership they shall advise that individual of those reasons in summary form and invite representations from the Member or applicant for Membership within 28 days or such other reasonable period as the Director of Corporate Governance may in their absolute discretion determine. Any representations received shall be considered by the Director of Corporate Governance and they shall make a decision on the Member's or applicant's eligibility or disqualification as soon as reasonably practicable and shall give notice in writing of that decision to the Member or applicant within 14 days of the decision being made.

7.4.5 If no representations are received within the said period of 28 days or such longer period (if any) permitted under the preceding paragraph, the Director of Corporate Governance shall be entitled nonetheless to proceed and make a decision on the Member's or applicant's eligibility or disqualification notwithstanding the absence of any such representations from them.

7.4.6 Any decision made under this paragraph 7.4 to disqualify a Member or an applicant for Membership may be referred by the Member or applicant concerned to the Dispute Resolution Procedure set out in Annex 5.

7.5 Termination of Membership

7.5.1 A person's Membership shall be terminated if they:

7.5.1.1 resign by giving notice in writing to the Director of Corporate Governance;

7.5.1.2 are disqualified under paragraph 7.4;

7.5.1.3 die.

7.5.2 When any of the circumstances set out in paragraph 7.4 arise the Director of Corporate Governance shall cause the person's name to be removed from the Register of Members forthwith and they shall thereupon cease to be a member.

7.6 Voting at Council of Governors Elections

7.6.1 A Member may not vote at an election for a Public Governor unless within the specified period they have made a declaration in the specified form that they are a Member of the Public Constituency and stating the particulars of their qualification to vote as a Member of that Membership Constituency for which an election is being held. It is an offence knowingly or recklessly to make such a declaration which is false in a material particular.

7.6.2 The form and content of the declaration and the period for making such a declaration for the purposes of paragraph 7.6.1 shall be specified and published by the Trust from time to time and shall be so published not less than 28 days prior to an election.

7.7 Annual Members' Meeting

7.7.1 The Trust shall hold a public meeting of its Members within seven months of the end of each Financial Year.

7.7.2 The Annual Members' Meeting is to be convened by the Director of Corporate Governance by order of the Council of Governors.

7.7.3 The Council of Governors may decide where a Members' meeting is to be held and may also for the benefit of Members arrange for the Annual Members' Meeting to be held in different venues each year.

7.7.4 At least one Director shall attend the meeting and present the following documents to Members at the meeting:

7.7.4.1 The annual accounts;

7.7.4.2 Any report of the external auditor on them; and

7.7.4.3 The annual report.

7.7.5 The Council of Governors shall present to the Members:

7.7.5.1 A report on steps taken to secure that (taken as a whole) the actual Membership of the public constituencies and of the classes of the staff constituency is representative of those eligible for such Membership;

7.7.5.2 The progress of the Membership strategy.

7.7.5.3 The results of any election and appointment of Governors will be announced.

7.7.6 Notice of the Annual Members Meeting is to be given:

7.7.6.1 By notice sent to all Members; by notice prominently displayed at the Trust's Head Office; and

7.7.6.2 By notice on the Trust's website at least 14 clear days before the date of the meeting.

7.7.7 The notice must:

7.7.7.1 Be given to the Council of Governors and the Board of Directors, and to the Trust's auditors;

7.7.7.2 Give the time, date and place of the meeting; and

7.7.7.3 Indicate the business to be dealt with at the meeting.

7.7.8 Before a Members meeting can do business there must be a quorum present. Except where this Constitution provides otherwise a quorum is twenty Members entitled to vote at the meeting.

7.7.9 The Chair of the Council of Governors or, in their absence, the Vice-Chair of the Council of Governors who is also the Vice Chair of the Trust, or in their absence, another Non-Executive Director, shall preside at an Annual Members' Meeting.

7.7.10 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine and the Director of Corporate Governance shall in either case give notice to each Governor that the meeting has been adjourned and shall give details of the day, time and place upon and/or at which the adjourned meeting will take place. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Members present during the meeting is to be a quorum.

7.7.11 Where an amendment has been made to this Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

7.7.11.1 at least one Governor shall attend the next annual public meeting to be held, at which the Governor shall present the amendment; and

7.7.11.2 the Members shall be entitled to vote on whether they approve the amendment.

7.7.12 If more than half of the Members present and voting at the meeting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

8. COUNCIL OF GOVERNORS

8.1 The Trust is to have a Council of Governors. It is to consist of Public Governors; Staff Governors; and Stakeholder Governors. The aggregate number of Governors who are Public Governors shall be more than half the total number of Governors.

8.2 Subject always to the provisions of the 2006 Act, the composition of the Council of Governors shall seek to ensure that:

8.2.1 The interests of the community served by the Trust are appropriately represented; and

8.2.2 The level of representation of the public constituencies and the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs;

And to these ends, the Council of Governors:

8.2.3 Shall at all times maintain a policy for the composition of the Council of Governors which takes account of the Membership strategy and is representative of the Membership of their constituencies as set out in paragraph 8.3; and

8.2.4 Shall from time to time and not less than every three years review the policy for the composition of the Council of Governors; and

8.2.5 When appropriate shall propose amendments to this Constitution.

8.3 The Council of Governors of the Trust is to comprise:

8.3.1 Thirteen Public Governors, from the following public constituencies:

8.3.1.1 Cheltenham – two Public Governors

8.3.1.2 Tewkesbury – two Public Governors

8.3.1.3 Stroud – two Public Governors

8.3.1.4 Cotswolds – two Public Governors

8.3.1.5 Gloucester – two Public Governors

8.3.1.6 Forest of Dean – two Public Governors

8.3.1.7 Out of County – one Public Governor

8.3.2 Staff Governors from the following staff classes:

8.3.2.1 The Medical and Dental Staff staff class – one Staff Governor;

8.3.2.2 The Nursing and Midwifery Staff staff class – two Staff Governors;

8.3.2.3 The Allied Health Professionals – one Staff Governor;

8.3.3.4 The Other/ Non-Clinical Staff staff class – one Staff Governor.

8.3.3.5 Stakeholder Governors – up to four Governors.

8.4 **Public Governors**

8.4.1 Public Governors are to be elected by Members of the public constituencies and Staff Governors are to be elected by Members of their class of the staff constituency.

8.4.2 Elections for elected Members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.

8.4.3 The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

8.4.4 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this Constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules.

8.4.5 If contested, the elections must be by secret ballot.

8.5 **Stakeholder Governors**

8.5.1 There shall be up to four stakeholder Governors. One of these must be a Local Authority Governor. The other three positions could be appointments from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors.

8.5.2 The Local Authority Governor shall be nominated and appointed by Gloucestershire County Council to represent Gloucestershire County Council, Gloucester City Council, Cheltenham Borough Council, Forest of Dean District Council, Stroud District Council, Cotswold District Council, Tewkesbury Borough Council or in the event of any subsequent boundary changes affecting the electoral areas of the above local authorities such local authorities as shall then include the whole or part of any area specified in Annex 1 as an area of the Trust's public constituency (excluding 'Out of County');

8.5.3 Stakeholder Governors are to be appointed by the nominating organisation in accordance with a process to be agreed with the Chair.

8.6 **Chair's right of veto**

8.6.1 Notwithstanding the provisions of paragraph 8.5.3 above, the Chair may veto the appointment of a Stakeholder Governor by serving notice in writing to the relevant sponsoring organisation where they believe that the appointment in question is unreasonable, irrational or otherwise inappropriate, for example the proposed appointee's demonstrable behaviour, and/or extreme, publicly-expressed views and/or affiliations contravene the values of the Trust. Following the service of the notice the sponsoring organisation shall thereupon appoint an alternative individual in accordance with the provisions of paragraph 8.5.3.

8.7 **Lead Governor**

8.7.1 The Council of Governors shall appoint a Lead Governor in accordance with a procedure agreed by the Council of Governors.

8.7.2 The Director of Corporate Governance shall ensure that NHS Improvement (Monitor) is provided with details of the serving Lead Governor.

8.7.3 The Lead Governor's duties shall be agreed by the Council of Governors.

8.8 **Terms of office for Governors**

8.8.1 Elected Governors:

8.8.1.1 Shall hold office for a period of three years commencing immediately after the Annual Members Meeting at which their election is announced save as otherwise provided for in Paragraph 8.13;

8.8.1.2 Are eligible for re-election at the end of that period;

8.8.1.3 May not hold office for more than nine years in aggregate.

8.8.2 Stakeholder Governors:

8.8.2.1 Shall hold office for a period of three years commencing immediately after the Annual Members Meeting at which their appointment is announced;

8.8.2.2 Are eligible for re-appointment at the end of that period;

8.8.2.3 May not hold office for longer than nine years in aggregate.

8.8.3 For the purposes of these provisions concerning terms of office for Governors, "year" means a period commencing immediately after the conclusion of the Annual Members Meeting, and ending at the conclusion of the next Annual Members Meeting.

8.8.4 Governors shall cease to be Governors forthwith if their tenure is terminated under paragraph 8.10 or they are disqualified from being a Governor under paragraph 8.9.

8.9 **Disqualification**

8.9.1 A person may not become or continue as a Governor if:

8.9.2 They are a Director of the Trust or a Governor, non-executive director (including the Chair) or, executive director (including the chief executive officer) of another Health Service Body (unless they are appointed by an appointing organisation which is a Health Service Body);

8.9.3 They are under 18 years of age;

8.9.4 They have failed or refused to make any declarations required or they refuse to confirm that they will abide by the Code of Conduct for Governors as may be adopted by the Trust from time to time.

8.9.5 In the case of a Staff Governor or Public Governor they cease to be a Member of the Membership Constituency or the Class of a Membership Constituency by which they were elected;

8.9.6 In the case of any other Governor the appointing organisation withdraws its appointment of them;

8.9.7 They have been adjudged bankrupt or his estate has been sequestrated and in either case they have not been discharged;

8.9.8 They have are a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);

8.9.9 They have made a composition or arrangement with or granted a trust deed for their creditors and have not been discharged in respect of it;

8.9.10 They have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

8.9.11 NHS Improvement (Monitor) has exercised its powers to remove that person as a Governor or has suspended them from office or has disqualified them from holding office as a Governor for a specified period or NHS Improvement (Monitor) has exercised any of those powers in relation to the person concerned at any other time whether in relation to the Trust or some other NHS foundation trust;

8.9.12 They have been removed at any time from the Council of Governors under the provisions of the Trust's Constitution;

8.9.13 They have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

8.9.14 they are a person whose tenure of office as the Chair or as a Governor, member or director of a Health Service Body has been terminated on the grounds that his appointment was not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

8.9.15 they have had their name removed, from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list;

8.9.16 They are the subject of a Sex Offender Order;

8.9.17 If within the last 5 years they have been involved in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or

registered volunteers;

8.9.18 They are a spouse, partner, parent or child of, or occupant in the some household as, a member of the Board of Directors or the Council of Governors of the Trust;

8.9.19 They are a member of a local authority's Overview and Scrutiny Committee covering health matters;

8.9.20 They lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Governor;

8.9.21 They are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

8.9.22 They have failed to repay (without good cause) any amount of monies properly owed to the Trust;

8.9.23 They have refused to undertake any training which the Council of Governors requires them or all Governors to undertake;

8.9.23 The individual's continuation as a governor would likely prejudice the ability of the Trust to fulfil its principle purpose or discharge its duties and functions;

8.9.24 The individual's continuation as a governor would likely prejudice the Trust's work with other persons or body within whom it is engaged or may be engaged in the provision of goods and services;

8.9.25 The individual's continuation as a governor would be likely to adversely affect public confidence in the goods and services provided by the Trust;

8.9.26 The individual's continuation as a governor would otherwise bring the Trust into disrepute;

8.9.27 It would not be in the best interests of the Council of Governors for the individual to continue as a governor / the individual has caused or is likely to cause prejudice to the proper conduct of the Council of Governors affairs; or

8.9.28 The individual has failed to comply with the values and principles of the National Health Service, the Trust or the Constitution

8.10 **Governor Termination of tenure**

8.10.1 A person holding office as a Governor shall immediately cease to do so if:

8.10.1.2 They resign from that office at any time during the term of that office by giving notice in writing to the Director of Corporate Governance.

8.10.1.3 They fail to attend four out of six meetings of the Council of Governors for a consecutive period of twelve months or alternatively for three successive meetings of the Council of Governors, unless, the Chair, Director of Corporate Governance and the Lead Governor are satisfied that:

(a) the absence was due to reasonable cause; and

(b) the Governor will be able to start attending meetings of the Council of Governors within such a specified period as the Council of Governors considers reasonable.

8.10.1.4 They are disqualified from becoming or continuing as a Governor under paragraph 8.9.1 above.

8.10.1.5 They have been removed from the Council of Governors by a resolution passed under paragraph 8.10.3 below.

8.10.2 The name of any person who ceases to hold office as a Governor shall be removed from the Register of Governors notwithstanding any reference to the Dispute Resolution Procedure.

8.10.3 The Council of Governors may by a resolution passed by three quarters of the Governors terminate a Governor's tenure of office if for reasonable cause it considers that:

8.10.3.1 They have knowingly or recklessly made a false declaration for any purpose provided for under this Constitution or in the 2006 Act;

8.10.3.2 They have committed a serious breach of the code of conduct;

8.10.3.3 They have acted in a manner detrimental to the interests of the Trust; or

8.10.3.4 It is not in the best interests of the Trust for them to continue as a Governor.

8.12.4 A resolution to remove a Governor under paragraph 8.10.3 above, may not be proposed unless the Governors' Code of Conduct Disciplinary Process has been complied with.

8.12.5 A Governor who resigns under paragraph 8.1.2 shall not be eligible to stand for re-election for a period of three years from the date of their resignation.

8.12.6 A Governor whose tenure of office is terminated under paragraph 8.10.3 shall not be eligible to stand for re-election. They shall also not be eligible for appointment as a Stakeholder Governor.

8.11 **Vacancies**

8.11.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

8.11.2 Where the vacancy arises amongst the appointed Governors, the Director of Corporate Governance shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

8.11.3 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty:

8.11.3.1 To call an election to fill the seat for the remainder of that term of office; or

8.11.3.2 Having regard to the number of Governors remaining in post to represent that constituency, to defer the election until the next planned elections; or

8.11.3.3 Invite the next highest polling candidate for that constituency at the most recent election to take office to fill the post for any unexpired period of the term of office and if that candidate is not willing to do so to invite the candidate who secured the next highest number of votes until the vacancy is filled.

8.11.4 Notwithstanding the provisions of Paragraph 8.13 an election shall be called by the Trust as soon as reasonably practicable if by reason of the vacancy the number of Public Governors thereby ceases to be more than half of the total number of Governors in office at that time.

8.11.5 No defect in the appointment or election (as the case may be) of a Governor nor any vacancy on the Council of Governors shall invalidate any act of or decision taken by the Council of Governors.

8.12 Roles and Responsibilities of the Council of Governors

8.12.1 The roles and responsibilities of the Council of Governors and its Members are to hold, attend at and participate in the General Meetings of the Council of Governors and at or through such meetings:

8.12.1.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;

8.12.1.2 To represent the interests of the Members of the Trust as a whole and the interests of the public;

8.12.1.3 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such;

8.12.1.4 To appoint or remove the Chair of the Trust (who shall also be Chair of the Board of Directors) and the other Non-Executive Directors;

8.12.1.5 To approve an appointment (by the Non-Executive Directors) of the chief executive;

8.12.1.6 To decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;

8.12.1.7 To appoint or remove the Trust's external auditor;

8.12.1.8 To be presented with the annual accounts, any report of the external auditor on them and the annual report;

8.12.1.9 To provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning.

8.12.1.10 To respond as appropriate when consulted by the Board of Directors in accordance with this Constitution.

8.12.1.11 To prepare and from time to time to review the Trust's Membership strategy, its policy for the composition of the Council of Governors and of the Non-Executive Directors.

8.13 Expenses and remuneration of Governors

8.13.1 Governors shall not receive remuneration for acting as Governors but may receive expenses as provided for in this paragraph.

8.13.2 The Trust may pay travelling and other expenses to Governors at the rates set out in the Trust's relevant policy.

8.14 Meetings

8.14.1 The Council of Governors shall comply with the Standing Orders for its practice and procedure set out in Annex 2.

8.14.2 The Council of Governors shall meet not less than six times in each Financial Year.

8.15 Transitional provisions

8.15.1 Notwithstanding anything to the contrary in this Constitution:

8.15.2 From the date of adoption of this revised Constitution all Governors shall be appointed or elected (as the case may be) in accordance with its provisions.

8.15.3 Each Governor serving at the date of adoption of this revised Constitution shall serve under the arrangements existing at the time of their election or appointment (as the case may be).

8.15.4 For the avoidance of doubt, at all times more than half the Governors will be elected by Members of the Public Constituency and the composition of the Council of Governors will satisfy the provisions of paragraph 9 of Schedule 7 to the Act.

9. BOARD OF DIRECTORS

9.1 The Trust shall have a Board of Directors which shall consist of executive and Non-Executive Directors.

9.2 The Board of Directors shall comprise:

9.2.1 The following Non-Executive Directors:

9.2.1.1 A Chair; and

9.2.1.2 Seven other Non-Executive Directors.

9.2.2 The following executive Directors:

9.2.2.1 A Chief Executive (who shall also at all times be the Accounting Officer);

9.2.2.2 A Finance Director;

9.2.2.3 A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984);

9.2.2.4 A registered nurse or registered midwife;

9.2.2.5 Four other executive Directors; and

9.2.2.6 Not less than one and not more than three other executive Directors.

9.3 Only those directors specified in Clause 9.2.1.1 – 9.2.1.2 and 9.2.2.1 – 9.2.2.5 above shall be entitled to vote on any resolution of the Board of Directors.

9.4 The number of Non-executive Directors shall always exceed the number of Executive Directors who may vote (as defined in paragraph 9.3).

9.5 The Directors (as defined in paragraph 9.3) shall have one vote each save that the Chair shall be entitled to exercise a second or casting vote where the number of votes for and against a motion is equal.

9.6 Acting on the recommendation of the Chair, the Council of Governors shall appoint one of the Non-Executive Directors to be Vice-Chair of the Board. If the Chair is unable to discharge their office as Chair of the Trust, the Vice-Chair of the Board of Directors shall be acting Chair of the Trust.

9.7 The Board of Directors shall appoint one of the independent Non-Executive Directors to be the Senior Independent Director, in consultation with the Council of Governors. The Senior Independent Director should be available to members and Governors if they have concerns which contact through the normal channels of Chair, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate.

9.8 Only a Member of a Public Constituency may be appointed as a Non-Executive Director.

9.9 Non-executive Directors are to be appointed as follows:

9.9.1 The Council of Governors shall create a duly authorised Governance and Nominations Committee consisting of some or all Governors in accordance with Annex 2;

9.9.2 The Governance and Nominations Committee shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates and, having regard to those views, shall then seek, shortlist and interview such candidates as the Governance and Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations;

9.9.3 The Governance and Nominations Committee shall be at liberty to request the attendance of and seek advice and assistance from persons other than Members of the Governance and Nominations Committee or other Governors in arriving at its said recommendations; and

9.9.4 The Governance and Nominations Committee shall provide advice to the Council of Governors on the levels of remuneration for the Chair and nonexecutive Directors. The Governance and Nominations Committee shall receive reports on behalf of the Council of Governors on the process and outcome of appraisal for the Chair and Non-Executive Directors.

9.9.5 The Council of Governors shall resolve in general meeting to appoint such candidate or candidates as they consider appropriate and shall have regard to the recommendation of the Governance and Nominations Committee and views of the Chief Executive and the Board of Directors in reaching that decision. The Director of Corporate Governance will convey the decision of the Council of Governors to the successful candidate.

9.10 The general duty of the Board of Directors and each Director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole and for the public. The validity of any act of the Trust shall not be affected by any vacancy among the Directors or by any defect in the appointment of any Director.

9.11 **Terms of Office**

9.11.1 The Non-Executive Directors (excluding the Chair) shall be eligible for appointment for two three year terms of office, and in exceptional circumstances a further term of one year. No Non-Executive Director (excluding the Chair) shall be appointed to that office for a total period which exceeds seven years in aggregate.

9.11.2 The Chair shall be eligible for appointment for two three year terms of office, and in exceptional circumstances a further term of one year. The Chair shall not be appointed to that office for a total period which exceeds seven years in aggregate. Any re-appointment of a Non-Executive Director or Chair shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Council of Governors has approved.

9.12 **Disqualification**

9.12.1 A person may not become or continue as a Director if:

9.12.1.1 They are a member of the Council of Governors;

9.12.1.2 They have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

9.12.1.3 They have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

9.12.1.4 They have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

9.12.1.5 in the case of a Non-Executive Director, they are no longer a member of one of the public constituencies;

9.12.1.6 they are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the insolvency Act 1986);

9.12.1.7 They are otherwise disqualified at law from acting as a director of an NHS foundation trust;

9.12.1.8 NHS Improvement (Monitor) has exercised its powers under the 2006 Act to remove that person as a Director of the Trust or any other foundation trust within their jurisdiction or has suspended them from office or has disqualified them from holding office as a Director of the Trust or of any other foundation trust for a specified period;

9.12.1.9 They are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the public service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

9.12.1.10 They have had their name removed, from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list; or they have within the preceding two years been dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body.

9.12.1.11 They have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body;

9.12.1.12 In the case of Non-Executive Directors, they have refused to undertake any training which the Board of Directors requires them or all Non-Executive directors to undertake;

9.12.1.13 They have failed to sign and deliver to the Director of Corporate Governance a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors;

9.12.1.14 They are the subject of a Sex Offender Order;

9.12.1.15 If within the last 5 years they have been involved in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or registered volunteers;

9.12.1.16 They are a spouse, partner, parent or child of, or occupant in the some household as, a member of the Board of Directors or the Council of Governors of the Trust;

9.12.1.17 They are a member of a local authority's Overview and Scrutiny Committee covering health matters;

9.12.1.18 They lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Governor;

9.12.1.19 They are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

9.12.1.20 They have failed to repay (without good cause) any amount of monies properly owed to the Trust;

9.12.1.21 They fail to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time.

9.12.2 Where a director becomes disqualified for appointment under paragraph 9.11.1, they shall notify the Director of Corporate Governance or the Chair in writing of such disqualification.

9.12.3 If it comes to the notice of the Director of Corporate Governance that at the time of their appointment or later the director is so disqualified, they shall immediately declare that the director in question is disqualified and notify them in writing to that effect.

9.12.4 A disqualified person's tenure of office shall automatically be terminated and they shall cease to act as a director.

9.15 Roles and responsibilities

9.15.1 The powers of the Trust shall be exercisable by the Board of Directors on its behalf.

9.15.2 Any of those powers may be delegated to a committee of Directors or to an executive Director in accordance with a Scheme of Delegation approved by the Board of Directors.

9.15.3 The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole and for the public.

9.15.4 A committee of Non-Executive Directors established as an audit committee shall monitor, review and carry out such functions in relation to the external auditor outlined in paragraph 14 as are appropriate.

9.15.5 The Non-Executive Directors shall appoint or remove the Chief Executive (and Accounting Officer). The appointment of a Chief Executive (but not their removal) shall require the approval of the Council of Governors.

9.15.6 A committee consisting of the Chair, the Chief Executive (and Accounting Officer) and the other Non-Executive Directors shall appoint the executive Directors.

9.15.7 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances and the other terms and conditions of office of the executive Directors.

9.15.8 The Board of Directors shall provide forward planning information in respect of each Financial Year to NHS Improvement (Monitor). The Board of Directors shall have regard to the views of the Council of Governors when preparing the forward planning information.

9.15.9 The Board of Directors shall present to the Council of Governors, in a general meeting, the Trust's annual accounts, any report of the external auditor on them, and the Trust's annual report.

9.15.10 All the functions of the Trust under paragraphs 15.4, 15.5 and 15.7 are delegated by this Constitution to the Chief Executive as Accounting Officer.

10. MEETINGS OF DIRECTORS

10.1 The Board of Directors shall adopt Standing Orders covering the proceedings and business of its meetings. These shall include setting a quorum for meetings, both of executive and Non-Executive Directors. The proceedings shall not however be invalidated by any vacancy of its Membership or defect in a Director's appointment.

10.2 Before holding a meeting, the Board of Directors shall send a copy of the agenda to the Council of Governors.

10.3 Within two weeks after holding a meeting, the Board of Directors shall send a copy of the minutes of the previous meeting(s) agreed at that meeting to the Council of Governors.

10.4 Meetings of the Board of Directors shall be open to members of the public, unless and to the extent that the Board of Directors has resolved that members of the public should be excluded from a meeting for such special reasons as the Board of Directors considers appropriate.

11. CONFLICTS OF INTEREST OF DIRECTORS

11.1 Each Director has a duty to avoid a situation in which the Director has or can have a direct or indirect interest that conflicts or possibly may conflict with the interests of the Trust. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or if the matter has been authorised in accordance with this Constitution.

11.2 Each Director has a duty not to accept a benefit from a third party by reason of being a Director or doing or not doing anything in that capacity. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

11.3 If a Director is aware that they have in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, they shall disclose the nature and extent of that interest to the Director of Corporate Governance as soon as they are aware of it and in all cases, before the Trust enters into the transaction or arrangement. If any declaration proves to be or becomes inaccurate or incomplete, the Director shall make a further declaration.

11.4 A Director need not declare an interest:

11.4.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

11.4.2 If, or to the extent that, the Directors are already aware of it;

11.4.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

11.4.3.1 by a meeting of the Board of Directors; or

11.4.3.2 by a committee of the Directors appointed for that purpose under this Constitution.

11.5 The Board of Directors shall adopt Standing Orders making further provision about Directors' interests.

12. REGISTERS

12.1 The Trust shall have and maintain:

12.1.1 A Register of Members showing, in respect of each Member, the Membership constituency (and Class within a Membership Constituency, where appropriate) to which they belong;

12.1.2 A register of Governors;

12.1.3 A register of interests of Governors;

12.1.4 A register of Directors;

12.1.5 A register of interests of Directors.

12.2 The information to be included in the above registers shall be such as will comply with the requirements of the 2006 Act, any subordinate legislation made under it, and the provisions of this Constitution.

12.3 Members will be removed from the Register of Members if:

12.3.1 The Members is no longer eligible or is disqualified; or

12.3.2 The Member dies.

13. PUBLIC DOCUMENTS

13.1 The following documents of the Trust shall be available for inspection by Members of the public free of charge at all reasonable times, and shall be available on the Trust's website:

13.1.1 A copy of the current Constitution;

13.1.2 A copy of the latest annual accounts and of any report of the external auditor on them;

13.1.3 A copy of the latest annual report;

13.2 All documents required by paragraphs 22(1)(g) to 22(1)(p) inclusive of Schedule 7 to the 2006 Act (relating to special administration) shall be available for inspection by Members of the public free of charge at all reasonable times, and shall be available on the Trust's website.

13.3 Any person who requests it shall be provided with a copy or extract from any of the above documents.

13.4 If the person requesting a copy or extract under this paragraph is not a Member of the Trust, the trust may impose a reasonable charge for providing the copy of extract.

13.5 The registers mentioned in paragraph 12 shall all be made available for inspection by Members of the public except in circumstances prescribed by regulations made under the 2006 Act. The Trust shall not make any part of the Register of Members available for inspection by Members of the public that shows details of any Member if they so request.

14. AUDITOR

14.1 The Trust shall have an external auditor and shall provide the external auditor with every facility and all information which they may reasonably require for the purposes of their functions under Chapter 5 of Part 2 of the 2006 Act.

14.2 A person may only be appointed external auditor if they (or in the case of a firm of each of its members) is a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 7 to the 2006 Act.

14.3 The appointment of the external auditor by the Council of Governors is covered in 8.12.1.7 and the monitoring of the external auditor's functions by a committee of Non-Executive Directors is covered in paragraph 9.15.4.

14.4 The external auditor shall carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS Improvement (Monitor) on standards, procedures and techniques to be adopted.

15. ACCOUNTS

15.1 The Trust shall keep proper accounts and proper records in relation to the accounts, which shall comply with any directions made by NHS Improvement (Monitor) with the approval of the Secretary of State, as to the Content and form of the Trust's accounts.

15.2 The accounts shall be audited by the Trust's auditor.

15.3 The following documents shall be made available to the Comptroller and Auditor General for examination at their request:

15.3.1 The accounts;

15.3.2 Any records relating to them; and

15.3.3 Any report of the auditor on them.

15.4 The Trust (through its Chief Executive and Accounting Officer) shall prepare in respect of each Financial Year annual accounts in such form as NHS Improvement (Monitor) may with the approval of the Secretary of State direct.

15.5 The Trust shall comply with any directions given by NHS Improvement (Monitor) with the approval of the Secretary of State as to:

15.5.1 The period or periods in respect of which the Trust should prepare accounts; and

15.5.2 The audit requirements of any such accounts.

15.6 In preparing accounts the Trust shall comply with any directions given by NHS Improvement (Monitor) with the approval of the Secretary of State as to:

15.6.1 The methods and principles according to which the accounts are to be prepared;

15.6.2 The content and form of the accounts.

15.7 The annual accounts, any report of the financial auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

15.8 The Trust shall:

15.8.1 Lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

15.8.2 Send copies of those documents to NHS Improvement (Monitor) within such period as NHS Improvement (Monitor) may direct; and send copies of any accounts prepared pursuant to article 15.4, and any report of an auditor on them to NHS Improvement (Monitor) within such period as NHS Improvement (Monitor) may direct.

16. ANNUAL REPORTS, FORWARD PLANS AND NON-NHS WORK

16.1 The Trust shall prepare annual reports and send them to NHS Improvement (Monitor).

16.2 The reports shall give information on:

16.2.1 Any steps taken by the Trust to secure that (taken as a whole) the actual Membership of the public constituencies and of the classes of the staff constituency is representative of those eligible for such Membership; and

16.2.2 Any other information the NHS Improvement (Monitor) requires.

16.3 The Trust is to comply with any decision the NHS Improvement (Monitor) makes as to:

16.3.1 The form of the reports;

16.3.2 When the reports are to be sent to them;

16.3.3 The periods to which the reports are to relate.

16.4 Each forward plan must include information about:

16.4.1 The activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

16.4.2 The income it expects to receive from doing so.

16.5 Where a forward plan contains proposal that the Trust carry out Non Principal Purpose Activity the Council of Governors must:

16.5.1 Determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its Principal Purpose or the performance of its other functions; and

16.5.2 Notify the Directors of the Trust of its determination.

16.6 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the health service in England it may implement the proposal only if more than half of the Members of the Council of Governors of the Trust voting approve its implementation.

16.7 The Trust is to give information as to its forward planning in respect of each financial year to NHS Improvement (Monitor). The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

17. SIGNIFICANT TRANSACTION

17.1 The Trust may enter into a Significant Transaction only if more than half of the Members of the Council of Governors voting approve entering into the transaction.

17.2 “Significant Transaction” means:

17.2.1 The acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's turnover before the acquisition; or

17.2.2 The disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's turnover before the disposition; or

17.2.3 A transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trust's turnover before the transaction; or

17.2.4 The acquisition of another NHS organisation (regardless of the value of the transaction)

17.3 For the purpose of this Paragraph 17:

17.3.1 "Turnover" means the turnover of the Group;

17.3.2 In assessing the value of any contingent liability for the purposes of subparagraph 17.2.3, the Directors:

17.3.2.1 Must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and may rely on estimates of the contingent liability that are reasonable in the circumstances; and

17.3.2.2 May take account of the likelihood of the contingency occurring.

17.4 The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which:

17.4.1 would exceed a threshold of 10% for any of the criteria set out in paragraph 17.2 (a "Relevant Transaction");

17.4.2 is deemed to be high risk by its nature; or

17.4.3 is of specific relevance to governor priorities.

17.5 For the purpose of this Paragraph 17.4 whether a transaction is “deemed to be high risk by its nature” or “of specific relevance to governor priorities” will be judged by the Chair.

18. INDEMNITY

18.1 Governors and Directors who act honestly and in good faith and not recklessly will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors functions. Any such liabilities will be liabilities of the Trust.

18.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangements for the benefit of the trust

to meet all of any liabilities which are properly the liabilities of the Trust under paragraph 18.1.

19. INSTRUMENTS ETC.

19.1 The Trust is to have a seal which is not to be affixed except under the authority of the Board of Directors.

19.2 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

20. DISPUTE RESOLUTION PROCEDURE

20.1 The Trust shall apply the Dispute Resolution Procedure set out at Annex 5 to this Constitution in regards to disputes:

20.1.1 with Members and potential Members in relation to matters of eligibility and disqualification; and

20.1.2 between the Council of Governors and the Board of Directors in relation to the interpretation and application of respective powers and obligations under this Constitution.

21. AMENDMENT OF THE CONSTITUTION

21.1 The Trust may make amendments to this Constitution only if:

21.1.1 More than half of the Members of the Council of Governors voting; and

21.1.2 More than half of the Members of the Board of Directors voting

approve the amendments.

21.1.3 An amendment shall have no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

21.1.4 If an amendment relates to the powers or duties of the Council of Governors, Paragraphs 7.7.11 and 7.7.12 shall apply.

21.1.5 The Trust shall inform NHS Improvement (Monitor) of amendments to the Constitution.

22. MERGERS, ACQUISITIONS, SEPARATIONS AND DISSOLUTION

22.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the Members of the Council of Governors.

ANNEX 1

CONSTITUENCIES OF THE TRUST

1. Name of Membership Constituency	2. Area/Qualification	3. Minimum number of Members	4. Number of Governors
PUBLIC CONSTITUENCY			
Cheltenham Borough Council Area ("Cheltenham")	Gloucestershire		2
Cotswolds District Council Area ("Cotswolds")			2
Forest of Dean District Council Area ("Forest of Dean")			2
Gloucester City Council Area ("Gloucester")			2
Stroud District Council Area ("Stroud")			2
Tewkesbury Borough Council Area ("Tewkesbury")			2
Out of County	Our of county areas where the Trust provides services, including: <u>England</u> Bristol Herefordshire Oxfordshire Somerset South Gloucestershire Swindon Warwickshire Wiltshire Worcestershire <u>Wales</u> Aneurin Bevan University Health Board area Powys Teaching Health Board area		1
STAFF CONSTITUENCY			
The Allied Health Professionals Staff staff class	as defined in paragraph 7.3.6 of this Constitution		1
The Medical and Dental Staff staff class	as defined in paragraph 7.3.4 of this Constitution		1
The Nursing and Midwifery Staff staff class	as defined in paragraph 7.3.5 of this Constitution		2
The Other/ Non-Clinical Staff staff class	as defined in paragraph 7.3.7 of this Constitution		1
STAKEHOLDER GOVERNORS			
Four stakeholder governors, one of which must be a Local Authority Governors.	As defined in paragraph 8.5.1 of this Constitution		4
Total			***22***

STANDING ORDERS FOR THE REGULATION OF PROCEEDINGS AND BUSINESS OF THE COUNCIL OF GOVERNORS

These Standing Orders form part of the Constitution of the Gloucestershire Hospital NHS Foundation Trust.

1. INTERPRETATION

1.1. Save as otherwise permitted by law, the Chair shall be the final authority on the interpretation of the Standing Orders (on which they should be advised by the Chief Executive and the Director of Corporate Governance).

2. THE TRUST

2.1. All business shall be conducted in the name of the Trust.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1. **Admission of the Public and the Press** – subject to paragraph 3.2 below, all meetings of the Council of Governors are to be open to members of the press and public.

3.2. The Council of Governors may resolve to exclude members of the press and/or public from any meeting or part of a meeting on the grounds:

3.2.1. That publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

3.2.2. The special reasons stated in the resolution and arising from the nature of the business of the proceedings.

3.3. The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting.

3.4. The Chair (or other person presiding under the provisions of Standing Order 3.18) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business of the meeting shall be conducted without interruption and disruption. The Chair may exclude any member of the public or press from a meeting of the Council of Governors if they are interfering with, or preventing the proper conduct of the meeting.

3.5. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.

3.6. **Calling Meetings** – Ordinary meetings of the Council of Governors shall be held at such times and places as it may determine.

3.7. Meetings of the Council of Governors may only be called in accordance with this paragraph. The Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Governors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's headquarters, such one third or more Governors may forthwith call a meeting.

3.8. The Council of Governors may agree that its Governors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. The Council of Governors shall agree a protocol to be applied in the case of such meetings.

3.9. **Notice of Meetings** - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on their behalf shall be delivered to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to him/her at least 14 clear days before the meeting.

3.10. Subject to Standing order 3.12, lack of service of the notice on any Governor shall not affect the validity of a meeting.

3.11. In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.12. Failure to serve such a notice on more than three Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or email.

3.13. Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting.

3.14. **Setting the Agenda** – The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

3.15. A Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 clear days before the meeting subject to Standing Order 3.9. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

3.16. Agendas shall be sent to Members seven days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in emergency or if otherwise agreed by the Chair.

3.17. **Chair of Meeting** - The Chair, or in their absence, the Vice-Chair, shall preside at meetings of the Council of Governors and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

3.18. If the Chair and Vice-Chair are absent from a meeting of the Council of Governors, the Governors shall appoint another Non-Executive Director to preside over that meeting and they shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.19. If any matter for consideration at a meeting of the Council of Governors relates to the conduct or interests of the Chair or of all of the Non-Executive Directors neither the Chair nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. In these circumstances the period of the meeting shall be chaired by the Lead Governor, or in their absence, by another Governor chosen by the Governors. This person shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.20. **Notices of Motion** - A Governor desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This Standing Order shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.11.

3.21. **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.22. **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor(s) who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

3.23. **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.24. Subject to paragraph 3.25, when a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

3.24.1. An amendment to the motion.

3.24.2. The adjournment of the discussion or the meeting.

3.24.3. That the meeting proceed to the next business.

3.24.4. The appointment of an ad hoc committee to deal with a specific item of business.

3.24.5. That the motion be now put.

3.24.6. A motion to exclude the public (including the press).

3.25. The motions specified in paragraphs 3.24.2 and 3.24.3 may only be put by a Governor who has not previously taken part in the debate.

3.26. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.27. **Chair's Ruling** - Statements of Governors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.28. **Voting** – If, in the opinion of the Chair, a vote should be required on a question at a meeting, the result shall be determined by a majority of the votes of the Governors present and voting on the question. In the case of the number of votes for and against a motion being equal, the Vice Chair of the Council of Governors shall have a second or casting vote.

3.29. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

3.30. If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present

voted or abstained.

3.31. If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.32. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.33. Any matter which could be decided by the Council of Governors in a meeting may be determined by written resolution. A written resolution shall, with any accompanying papers which are relevant, describe the matter to be decided and provide for Governors to sign the resolution to confirm their agreement. A written resolution may comprise identical documents sent to all Governors, each to be signed by a Governor, or one document to be signed by all Governors. A written resolution shall be passed only when at least three quarters of the Governors approve the resolution in writing within the timescale imposed in such a notice. The Director of Corporate Governance shall keep records of all written resolutions.

3.34. **Minutes** - The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.35. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.36. Minutes shall be circulated to Governors' within two weeks after the meeting. Where providing a record of a public meeting the minutes shall be made available to the public.

3.37. **Suspension of Standing Orders** - Except where this would contravene any provision of the constitution or any statutory provision or any direction made by NHS Improvement (Monitor), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Governors are present, including one elected Governor and one nominated Governor and that a majority of those present vote in favour of suspension.

3.38. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.39. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.

3.40. No formal business may be transacted while Standing Orders are suspended. Formal business shall include the proposal of motions and the determination of questions and resolutions, by voting or otherwise.

3.41. The Audit Committee of the Board of Directors shall review every decision of the Council of Governors to suspend Standing Orders.

3.42. **Record of Attendance** - The names of the Governors present at the meeting shall be recorded in the minutes.

3.43. **Quorum** – No business shall be transacted at a meeting of the Council of Governors unless at least two-thirds of the whole number of the Governor are present including at least one elected member from the Public Constituency, one elected member from the Staff Constituency and one Stakeholder Governor.

3.44. If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 5 and 6) they shall no longer count towards the

quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.45. **Frequency** - The Council of Governors shall hold meetings at least six times in each calendar year.

4. COMMITTEES

4.1 The Governance and Nominations Committee

4.1.1 The Council of Governors shall create a duly authorised Governance and Nominations Committee consisting of some or all of its Members in accordance with paragraph 9.8.1 of the Constitution.

4.1.2 The Governance and Nominations Committee shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates and, having regard to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations.

4.1.3 Subject to any provisions to the contrary in this Standing Order 4, the provisions of Standing Order 3, as far as they are applicable, shall apply with appropriate alteration to meetings of the Nominations Committee.

4.1.4 The Director of Corporate Governance shall attend the Nominations Committee and take minutes of any proceedings.

4.1.5 The Governance and Nominations Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors, shall decide subject to the provisions of the Constitution. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.1.6 The Council of Governors shall approve the appointments to the Nominations Committee. The Chair of the Governance and Nominations Committee shall be the Chair.

4.1.7 **Confidentiality** - A member of the Governance and Nominations Committee shall not disclose a matter dealt with by, or brought before, the Nominations Committee without its permission until the Nominations Committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

4.1.8 A member of the Governance and Nominations Committee shall not disclose any matter reported to or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the committee shall resolve that it is confidential.

4.2 **Other committees**

4.2.1 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees to assist the Council of Governors in carrying out its functions. Such committees established by the Council of Governors may meet in private for reasons of commercial confidentiality or other special reasons if the members of the committee so decide.

4.2.2 The Council of Governors may appoint committees of the council consisting wholly of persons who are Governors. Persons who are not Governors may attend such committees if appropriate under the committee's terms of reference but they shall have no vote.

4.2.3 A committee so appointed may appoint sub-committees consisting wholly of persons who are Governors. Persons who are not Governors may attend such committees if appropriate under the committee's terms of reference but they shall have no vote.

4.2.4 These Standing Orders, as far as they are applicable, shall apply also, with appropriate alteration, to meetings of any committees or sub-committees so established by the Council of Governors.

4.2.5 Each such committee or sub-committee shall have such terms of reference and be subject to such conditions as the council shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

4.2.6 The Council of Governors shall approve the membership of all committees and sub-committees that it has formally constituted and shall approve the recommendation from the relevant committee to appoint the Chair and, if applicable, the vice Chair of each committee and sub-committee.

4.2.7 Any member of a committee may participate in a duly convened meeting of a committee or sub-committee by means of a video conference, telephone or any other communications equipment which allows all persons to hear and speak to one another subject to reasonable notice and availability of the necessary equipment. Any such meetings shall adopt the procedure agreed by the Council of Governors.

4.2.8 The Council of Governors may, through the Director of Corporate Governance, request that external advisors assist them or any committee they appoint in carrying out duties. Advisers will:

4.2.8.1 not be Governors;

4.2.8.2 have no vote; and

4.2.8.3 provide such assistance as the Council of Governors may agree.

4.3 Confidentiality

4.31 In the event of the Council of Governors, or any Committee established by the Council of Governors, meeting in private for all or part of a meeting, Governors shall not disclose the contents of the papers considered, discussions held or minutes of the items taken in private.

5. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

5.1 Declaration of interests

5.1.1 Each Governor shall declare:

5.1.1.2 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 5.2.2 and 5.2.6 (subject to Standing Order 5.2.3);

5.1.1.3 any actual or potential, direct or indirect, non-financial professional interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 5.2.4 and 5.2.6; and

5.1.1.4 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved, or likely to be involved, in

making, as described in Standing Orders 5.2.5 and 5.2.6.

5.1.2 The responsibility for declaring an interest is solely that of the Governor concerned and shall be declared to the Director of Corporate Governance:

5.1.2.1 within 5 days of election or appointment; or

5.1.2.2 arising later, within 5 days of the Governor becoming aware of the interest.

5.1.3 If during the course of a Council of Governors meeting a Governor has an interest of any sort in a matter which is the subject of consideration the Governor concerned shall disclose the fact, and the Chair shall decide what action to take. This may include excluding the Governor from the discussion of the matter in which the Governor has an interest and/or prohibiting the Governor from voting any such matter.

5.1.4 Subject to Standing Order 5.1.3, if a Governor has declared a financial interest in a matter (as described in Standing Orders 5.2.3 and 5.2.3) they shall not take part in the discussion of that matter nor vote on any question with respect to that matter.

5.1.5 Any interest declared at a meeting of the council of Governors and subsequent action taken should be recorded in the council of Governors' meeting minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

5.2 Nature of interests

5.2.1 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by NHS Improvement (Monitor).

5.2.2 A financial interest is where a Governor may receive direct financial benefits (by either making a gain or avoiding a loss) as a consequence of a decision that the Council of Governors makes. This could include:

5.2.2.1 directorships, including Non-Executive directorships held in any other organisation which is doing, or is likely to be doing business with an organisation in receipt of NHS funding;

5.2.2.2 employment in an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

5.2.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding.

5.2.3 A Governor shall not be treated as having a financial interest in any a matter by reason only:

5.2.3.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

5.2.3.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts;

5.2.3.3 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

5.2.3.4 of any travelling or other expenses or allowances payable to a Governor in accordance with the constitution.

5.2.4 A non-financial professional interest is where a Governor may receive a non-financial professional benefit as a consequence of a decision that the Council of Governors makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a Governor is:

5.2.4.1 an advocate for a particular group of patients;

5.2.4.2 a clinician with a special interest;

5.2.4.3 an active member of a particular specialist body; or

5.2.4.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

5.2.5 A non-financial personal interest is where a Governor may benefit personally as a consequence of a decision that the Council of Governors makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where a Governor is:

5.2.5.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

5.2.5.2 a member of a lobbying or pressure group with an interest in health and/or social care.

5.2.6 A Governor will be treated as having an indirect financial interest, indirect non-financial professional interest or indirect non-financial personal interest where they have a close association with another individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a decision that the Governor is involved in making. This includes material interests of:

5.2.6.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of a Governor;

5.2.6.2 close friends and associates; and

5.2.6.3 business partners.

5.2.7 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

5.3 Register of interests

5.3.1 The Director of Corporate Governance will ensure that a register of interests is established to record formally declarations of interests of Governors.

5.3.2 Details of the register will be kept up to date and reviewed annually.

5.3.3 The register will be available to the public.

6. STANDARDS OF BUSINESS CONDUCT

6.1 Canvassing of, and Recommendations by, Governors in Relation to Appointments - Canvassing of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

6.2 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this Standing Order shall not preclude a Governor from giving written testimonial of a candidate's ability,

experience or character for submission to the Trust.

6.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

6.4 **Relatives of Governor** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Governor. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

6.5 The Governors shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Governor is aware. It shall be the duty of the Chief Executive to report to the Council of Governors and Board of Directors any such disclosure made.

6.6 On election or appointment, Governors should disclose to the Trust whether they are related to any other Governor or holder of any office under the Trust.

7. MISCELLANEOUS

7.1 **Standing Orders to be given to Governors** - It is the duty of the Chief Executive to ensure that existing Governors and all new Governors are notified of and understand their responsibilities within Standing Orders.

7.2 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

7.3 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.20 has been given; and no fewer than two thirds of the total of Governors vote in favour of amendment; and

(b) the variation proposed does not contravene a statutory provision or direction made by NHS Improvement (Monitor).

ANNEX 3

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Part 1 Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

- "corporation" means the public benefit corporation subject to this constitution
- "election" means an election by a constituency, or by a class within a constituency, to fill vacancy among one or more posts on the council of Governors
- "the regulator" means the Independent Regulator for NHS foundation trusts; and
- "the 2006 Act" means the National Health Service Act 2006
- "e-voting" means voting using either the internet, telephone or text message
- "internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet
- "method of polling" means voting either by post, internet, text message or telephone
- "the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone
- "the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message
- "voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 Returning Officer

4.1 Subject to rule 66, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5 Staff

5.1 Subject to rule 66, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 Stages

8. Notice of election

The returning officer is to publish a notice of the election stating:
(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination papers may be obtained;
(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination paper, and
(b) is to prepare a nomination paper for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and it can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

The nomination paper must state the candidate's:

(a) full name,
(b) contact address in full, and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

The nomination paper must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public constituency, of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

The nomination paper must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing, as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statement of candidates or their nomination papers, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any

withdrawals under these rules is greater than the number of members to be elected to the council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

19.4 The corporation may decide if eligible voters, within a constituency or class within a constituency, for whom an e-mail mailing address is included in the list of eligible voters may only cast their votes by, one or more, e-voting methods of polling.

19.5 If the corporation decides to use an e-voting method of polling then they and the returning officer must satisfy themselves that:

(a) if internet voting is being used, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the internet voting record of any voter who chooses to cast their vote using the internet voting system.
(b) if telephone voting is being used, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the telephone voting record of any voter who choose to cast their vote using the telephone voting system.
(c) if text message voting is being used, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the text voting record of any voter who choose to cast their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being

held,
(c) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voters and voter ID number if e-voting is a method of polling,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

Action to be taken before the poll

21. List of eligible voters

21.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

21.2 The list is to include, for each member, a postal mailing address and if available an e-mail address, where their voting information may be sent.

21.3 The corporation may decide if the voting information is to be sent only by e-mail to those members, in a particular constituency or class within a constituency, for whom an e-mail address is included in the list of eligible voters.

22. Notice of poll

The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19 (3).
(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located.
(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located,
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located,
(j) the address and final dates for applications for replacement voting information, and
(k) the contact details of the returning officer.

23. Issue of voting information by returning officer

23.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following voting information:

(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 21 able to cast their vote by post:
  (i) a ballot paper
  (ii) information about each candidate standing for election, pursuant to rule 61 of these rules,
  (iii) a covering envelope
(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
  (i) instructions on how to vote
  (ii) the eligible voters voter ID number
  (iii) information about each candidate standing for election, pursuant to rule 61 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate.
  (iv) contact details of the returning officer.

23.2 The documents are to be sent to the mailing address or e-mail address for each member, as specified in the list of eligible voters.

24. The covering envelope

The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25. E-voting systems

25.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

25.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

25.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

25.4 The provision of the polling website and internet voting system, will:

(a) require a voter, to be permitted to vote, to enter his voter ID number;
(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held
  (iii) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
  (v) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;
(d) create a record ("the internet voting record") that is stored in the internet voting system in respect of each vote cast using the internet of-
  (i) the voter ID number used by the voter;
  (ii) the candidate or candidates for whom he has voted; and
  (iii) the date and time of his vote, and
(e) if their vote has been cast and recorded, provide the voter with confirmation
(f) prevent any voter voting after the close of poll.

25.5 The provision of a telephone voting facility and telephone voting system, will:

(a) require a voter to be permitted to vote, to enter his voter ID number;
(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held
  (iii) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
  (iv) instructions on how to vote.
(c) prevent a voter voting for more candidates than he is entitled to at the election;
(d) create a record ("the telephone voting record") that is stored in the telephone voting system in respect of each vote cast by telephone of-
  (i) the voter ID number used by the voter;
  (ii) the candidate or candidates for whom he has voted; and
  (iii) the date and time of his vote
(e) if their vote has been cast and recorded, provide the voter with confirmation;
(f) prevent any voter voting after the close of poll.

25.6 The provision of a text message voting facility and text messaging voting system, will:

(a) require a voter to be permitted to vote, to provide his voter ID number;
(b) prevent a voter voting for more candidates than he is entitled to at the election;
(d) create a record ("the text voting record") that is stored in the text messaging voting system in respect of each vote cast by text message of:
  (i) the voter ID number used by the voter;
  (ii) the candidate or candidates for whom he has voted; and
  (iii) the date and time of his vote
(e) if their vote has been cast and recorded, provide the voter with confirmation;
(f) prevent any voter voting after the close of poll.

The poll

26. Eligibility to vote

26.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

27.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

27.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

28. Spoilt ballot papers

28.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a “spoilt ballot paper”), that voter may apply to the

returning officer for a replacement ballot paper.

28.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

28.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless satisfied as to the voter's identity.

28.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) is satisfied as to the voter's identity, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement spoilt ballot paper.

29. Lost voting information

29.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

29.2 The returning officer may not issue replacement voting information for lost voting information unless they:

(a) are satisfied as to the voter's identity,
(b) have no reason to doubt that the voter did not receive the original voting information.

29.3 After issuing replacement voting information, the returning officer shall enter in a list ("the list of lost ballots"):

(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, and
(c) if applicable, the voter ID number of the voter.

30. Issue of replacement voting information

30.1 If a person applies for replacement voting information under rule 28 or 29, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 28.3 or 29.2, they are also satisfied that that person has not already voted in the election.

Polling by internet, telephone or text

31. Procedure for remote voting by internet

31.1 To cast their vote using the internet the voter must gain access to the polling website by keying in the url of the polling website provided in the voting information,

31.2 When prompted to do so, the voter must enter their voter ID number.

31.3 If the internet voting system authenticates the voter ID number the system must give the voter access to the polling website for the election in which the voter is eligible to vote.

31.4 To cast their vote the voter may then key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

31.5 The voter must not be able to access the internet voting facility for an election once their vote at that election has been cast.

32. Voting procedure for remote voting by telephone

32.1 To cast their vote by telephone the voter must gain access to the telephone voting facility by calling the designated telephone number provided on the voter information using a telephone with a touch-tone keypad.

32.2 When prompted to do so, the voter must enter their voter ID number using the keypad.

32.3 If the telephone voting facility authenticates the voter ID number, the voter must be prompted to vote in the election.

32.4 When prompted to do so the voter may then cast his vote by keying in the code of the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

32.5 The voter must not be able to access the telephone voting facility for an election once their vote at that election has been cast.

33. Voting procedure for remote voting by text message

33.1 To cast their vote by text the voter must gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided on the voter information.

33.2 The text message sent by the voter must contain their voter ID number and the code for the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

33.3 The text message sent by the voter must be structured in accordance with the instructions on how to vote contained in the voter information.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

34. Receipt of voting documents

34.1 Where the returning officer receives a:

(a) covering envelope, or
(b) any other envelope containing a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable; and rules 35 and 36 are to apply.

34.2 The returning officer may open any covering envelope for the purposes of rules 35 and 36, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

34.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers.

35 Validity of votes

35.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll.

35.2 Where the returning officer is satisfied that rule 35.1 has been fulfilled, the ballot paper is to be put aside for counting after the close of the poll.

35.3 Where the returning officer is not satisfied that rule 35.1 has been fulfilled, they should:

(a) mark the ballot paper "disqualified",
(b) record the unique identifier on the ballot paper in a list (the "list of disqualified documents"); and
(c) place the document or documents in a separate packet.

35.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet, telephone or text voting record has been received by the returning officer before the close of the poll.

36 De-duplication of votes

36.1 Where a combination of the methods of polling are being used, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in an election.

36.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in an election they shall:

(a) only accept as duly returned the first vote received that contained the duplicated voter ID number
(b) mark as "disqualified" all other votes containing the duplicated voter ID number

36.3 Where a ballot paper is "disqualified" under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",
(b) record the unique identifier and voter id number on the ballot paper in a list (the "list of disqualified documents"); and
(c) place the ballot paper in a separate packet.

36.4 Where an internet, telephone or text voting record is "disqualified" under this rule the returning officer shall:

(a) mark the record as "disqualified",
(b) record the voter ID number on the record in a list (the "list of disqualified documents".
(c) disregard the record when counting the votes in accordance with these Rules.

37 Sealing of packets

37.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 35 and 36, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots
(d) the list of eligible voters, and
(e) complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

Part 6 Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

STV38. Interpretation of Part 6
STV38.1In Part 6 of these rules:

"ballot" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",
"non-transferable vote" means a ballot:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or
(b) which is excluded by the returning officer under rule STV46,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule STV43,
"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballots from the candidate who has the surplus, "stage of the count" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,
"transferred vote" means a vote derived from a ballot on which a second or subsequent preference is recorded for the candidate to whom that ballot has been transferred, and "transfer value" means the value of a transferred vote calculated in accordance with rules STV44.4 or STV44.7.

38 Arrangements for counting of the votes

38.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

39 The count

39.1 The returning officer is to:

(a) count and record the number of votes that have been returned, and
(b) count the votes according to the provisions in this Part of the rules.

39.2 The returning officer, while counting and recording the number of votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or a voter's voter ID number.

39.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

40. STV41. Rejected ballot papers
STV41.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV41.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV41.3 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV41.1

FPP41. Rejected ballot papers

FPP41.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty, shall, subject to rules FPP41.2 and

FPP41.3, be rejected and not counted.

FPP41.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP41.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP41.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP41.2 and FPP 41.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP41.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

STV42. First stage

STV42.1 The returning officer is to sort the ballots into parcels according to the candidates for whom the first preference votes are given.

STV42.2 The returning officer is to then count the number of first preference votes given on ballots for each candidate, and is to record those numbers.

STV42.3 The returning officer is to also ascertain and record the number of valid ballots.

STV43. The quota

STV43.1 The returning officer is to divide the number of valid ballots by a number exceeding by one the number of members to be elected.

STV43.2 The result, increased by one, of the division under rule STV43.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV43.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV44.1 to STV44.3 has been complied with.

STV44. Transfer of votes

STV44.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.2 The returning officer is to count the number of ballots in each parcel referred to in rule

STV44.3 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.1(a) to the candidate for whom the next available preference is given on those papers.

STV44.4 The vote on each ballot transferred under rule STV44.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV44.5 Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.6 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.5(a) to the candidate for whom the next available preference is given on those ballots.

STV44.7 The vote on each ballot transferred under rule STV44.6 shall be at:

(a) a transfer value calculated as set out in rule STV44.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

STV44.8 Each transfer of a surplus constitutes a stage in the count.

STV44.9 Subject to rule STV44.10, the returning officer shall proceed to transfer transferable ballots until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV44.10 Transferable ballots shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV44.11 This rule does not apply at an election where there is only one vacancy.

STV45. Supplementary provisions on transfer

STV45.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballots of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballots of the candidate who had the highest recorded vote at the

earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballots of the candidate on whom the lot falls shall be transferred first.

STV45.2 The returning officer shall, on each transfer of transferable ballots under rule STV44:

(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:
    (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
    (ii) the recorded total of valid first preference votes.

STV45.3 All ballots transferred under rule STV44 or STV45 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot or, as the case may be, all the ballots in that sub-parcel.

STV45.4 Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule STV44 or STV45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV46. Exclusion of candidates

STV46.1 If:

(a) all transferable ballots which under the provisions of rule STV44 (including that rule as applied by rule STV46.11 and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV47, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV46.12 applies, the candidates with the then lowest votes).

STV46.2 The returning officer shall sort all the ballots on which first preference votes are given for the candidate or candidates excluded under rule STV46.1 into two sub-parcels so that they are grouped as:

(a) ballots on which a next available preference is given, and
(b) ballots on which no such preference is given (thereby including ballots on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV46.3 The returning officer shall, in accordance with this rule and rule STV45, transfer each sub-parcel of ballots referred to in rule STV46.2 to the candidate for whom the next available preference is given on those ballots.

STV46.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV46.5 If, subject to rule STV47, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballots, if any, which had been

transferred to any candidate excluded under rule STV46.1 into sub- parcels according to their transfer value.

STV46.6 The returning officer shall transfer those ballots in the sub-parcel of transferable ballots with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballots (thereby passing over candidates who are deemed to be elected or are excluded).

STV46.7 The vote on each transferable ballot transferred under rule STV46.6 shall be at the value at which that vote was received by the candidate excluded under rule STV46.1.

STV46.8 Any ballots on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV46.9 After the returning officer has completed the transfer of the ballots in the sub-parcel of ballots with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballots with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV46.1.

STV46.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
    (i) the total value of votes, or
    (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
(d) compare:
    (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
    (ii) the recorded total of valid first preference votes.

STV46.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV44.5 to STV44.10 and rule STV45.

STV46.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV46.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV47. Filling of last vacancies

STV47.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV47.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall

thereupon be deemed to be elected.

STV47.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV48. Order of election of candidates
STV48.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV44.10.

STV48.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV48.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV48.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP48. Equality of votes
FPP48.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 Final proceedings in contested and uncontested elections

FPP49. Declaration of result for contested elections
FPP49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:
(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of Governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who they have declared elected:
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the Gloucestershire Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
    (ii) in any other case, to the Chair of the corporation; and
(c) give public notice of the name of each candidate whom they have declared elected.

FPP49.2 The returning officer is to make:
(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP41.5, available on request.

STV49. Declaration of result for contested elections
STV49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
(b) give notice of the name of each candidate who they have declared elected –
    (i) where the election is held under a proposed constitution pursuant to powers

conferred on the Gloucestershire Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation, and

(c) give public notice of the name of each candidate who they have declared elected.

STV49.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV41.1, available on request.

50. Declaration of result for uncontested elections

50.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who they have declared elected to the Chair of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

Part 8 Disposal of documents

51. Sealing up of documents relating to the poll

51.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers,
(b) the ballot papers endorsed with “rejected in part”,
(c) the rejected ballot papers, and
(d) the statement of rejected ballot papers.
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots,
(d) the list of eligible voters, and
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

52. Delivery of documents

52.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 51, the returning officer is to forward them to the chair of the corporation.

53. Forwarding of documents received after close of the poll

53.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voter information is made too late to enable new ballot papers to be issued,

The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

54. Retention and public inspection of documents

54.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

54.2 With the exception of the documents listed in rule 55.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

54.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so

55. Application for inspection of certain documents relating to an election

55.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing –

(a) any rejected ballot papers, including ballot papers rejected in part,
(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers, or
(d) the list of eligible voters,
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage by any person without the consent of the Regulator.

55.2 A person may apply to the Regulator to inspect any of the documents listed in rule 55.1, and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

55.3 The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to :
(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening, and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

55.4 On an application to inspect any of the documents listed in rule 55.1:

(a) in giving its consent, the regulator, and
(b) making the documents available for inspection, the corporation, must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –
(i) that their vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 Death of a candidate during a contested election

FPP56. Countermand or abandonment of poll on death of candidate

FPP56.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP56.2 Where a new election is ordered under rule FPP56.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP56.3 Where a poll is abandoned under rule FPP56.1(a), rules FPP56.4 to FPP56.7 are to apply.

FPP56.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 35 and 36, and is to make up separate sealed packets in accordance with rule 37.

FPP56.5 The returning officer is to:

(a) count and record the number of ballot papers that have been received, and
(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.
(c) seal up the electronic copies of records that have been received referred to in rule 25 held in a device suitable for the purpose of storage.

FPP56.6 The returning officer is to endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP56.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP56.4 to FPP56.6, the returning officer is to deliver them to the Chair of the corporation, and rules 54 and 55 are to apply.

STV56. Countermand or abandonment of poll on death of candidate

STV56.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
    (i) ballots which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
    (ii) ballots which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV56.2 The ballots which have preferences recorded for the candidate who has died are to be sealed with the other counted ballots pursuant to rule 51.1(a).

Part 10 Election expenses and publicity

57. Election expenses

57.1 Any expenses incurred, or payments made, for the purposes of an election which to the regulator under Part 11 of these rules.

58. Expenses and payments by candidates

58.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

59. Election expenses incurred by other persons

59.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or their family any money or property (whether a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

59.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 60 and 61.

Publicity

60. Publicity about election by the corporation

60.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

60.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 61, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, the expense of the electoral prospects of one or more other candidates.

60.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

61. Information about candidates for inclusion with voting information

61.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 23 of these rules.

61.2 The information must consist of:
(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a polling method, the numerical voting code, allocated by the returning officer, to each candidate, for the purpose of recording votes on the telephone voting facility or the text message voting facility, and
(c) a photograph of the candidate.

62. **Meaning of "for the purposes of an election"**

62.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

62.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 Questioning elections and the consequence of irregularities

63. **Application to question an election**

63.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

63.2 An application may only be made once the outcome of the election has been declared by the returning officer.

63.3 An application may only be made to the Regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

63.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the Regulator may require.

63.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

63.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

63.7 The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

63.8 The determination by the person or persons nominated in accordance with rule 63.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency including all the candidates for the election to which the application relates.

63.9 The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 Miscellaneous

64. Secrecy

64.1 The following persons:

(a) the returning officer,
(b) the returning officer's staff,
must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voter information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter
(iv) the candidate(s) for whom any member has voted.

64.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter id number allocated to a voter.

64.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

65. Prohibition of disclosure of vote

65.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

66. Disqualification

66.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

67. Delay in postal service through industrial action or unforeseen event

67.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 23, or
(b) the return of the ballot papers and declarations of identity,
the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ANNEX 4

DECLARATION OF ELIGIBILITY TO STAND FOR ELECTION TO THE COUNCIL OF GOVERNORS AND VOTE AT A MEETING OF THE COUNCIL OF GOVERNORS

A person shall not stand for election to the Council of Governors as a public Governor unless within the previous six months they have made a declaration in the form specified in this Annex:

1.1 Of the particulars of his qualification to vote as a member of the public constituency;

1.2 That they are not prevented from being a Governor by paragraph 8 of schedule 7 to the 2006 Act; and

1.3 That they are not otherwise disqualified under paragraph 8.13.

2. An elected Governor shall not vote at a meeting of the council of Governors unless within the period since his election they have made a declaration in the form specified in this annex.

3. Paragraph 8 of schedule 7 to the 2006 act provides that you may not become or continue as a Governor of the trust if you have been:

3.1 Adjudged bankrupt or your estate has been sequestrated and, in either case you have not been discharged;

3.2 You have made a composition or arrangement with, or entered into a trust deed for your creditors and you have not been discharged in respect of it; or

3.3 You are a person who has in the preceding five years has been convicted in the British Islands of any offence for which a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on you;

3.4 You are a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);

4. There are other circumstances in which you may not become or continue as a member of the trust or a Governor. Before voting at a council of Governor's meeting you should satisfy yourself as to your eligibility and that you are not disqualified. A copy of the constitution can be obtained from the Director of Corporate Governance.

5. If you are in any doubt as to your eligibility please contact the Director of Corporate Governance.

6. Would you therefore please complete the information below and return it to the Trust in accordance with the instructions given in the final paragraph.

7. This document constitutes your formal declaration for the purposes of section 60(3) of the 2006 act.

8. **IT IS A CRIMINAL OFFENCE** if you make a declaration which you know to be false in some material respect or if you make such a declaration recklessly which is false in some material respect.

9. If you wish to vote at a meeting of the council of Governors this form must be returned to the Director of Corporate Governance after your election and before the vote in question.

1. My Name	
2. My Address	
3. My Trust Membership Number	
4. The Membership Constituency of which I am a Member is as appears opposite (insert full name of Membership Constituency of which you are a Member)	
5. The details of why I am entitled to be a Member of that Class are as appears opposite (insert details)	
I declare (a). that the above statements are correct to the best of my knowledge and belief and (b). I remain eligible to be a Member of the above Membership Constituency and am not otherwise disqualified from membership of the Trust (c). I am not prevented from being a Governor by Paragraph 8 of Schedule 7 to the National Health Service Act 2006	
SIGNATURE	DATE

ANNEX 5

DISPUTE RESOLUTION PROCEDURE

1. In the event of a dispute with a Member or prospective Member in relation to matters of eligibility or disqualification, the individual concerned shall be invited to an informal meeting with the Director of Corporate Governance to discuss the matters in dispute. If not resolved, the dispute shall be referred to the Governance and Nominations Committee. The decision of the Governance and Nominations Committee shall be final.

2. Nothing in this Dispute Resolution Procedure shall preclude the Lead Governor from escalating to Monitor any matters of serious concern to the Council of Governors, after exhausting all reasonable means to resolve with the Board of Directors, and when authorised to do so by the Council of Governors. Any matters so escalated should be limited to circumstances in which the Trust has breached or is at risk of breaching its NHS Provider Licence.

3. Nothing in this Dispute Resolution Procedure shall preclude any party from referring any dispute to a court of competent jurisdiction in England and Wales.

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

Report Title
Safeguarding Adults Annual Report – July 2018
Sponsor and Author(s)
Authors: Lynne McEwan-Berry, Senior Sister Safeguarding Adults at Risk Advisory Team Jeanette Welsh, Practice Development and Safeguarding Lead, Unscheduled Care (Annex A) Jon Burford, Associate Chief Nurse and Safeguarding Adult Lead Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

This report is made to the Board to assure members that Trust arrangements are in place to safeguard adults, that mandatory safeguarding adult training is being completed and delivered and that staff are supported in the challenging role of safeguarding adults within our Trust. It also supports Trust Care Quality Commission (CQC) assurance in relation to the safeguarding of adults.

This report provides an update on activity, performance and monitoring relating to the safeguarding of adults with care and support needs (Care Act 2014) and safeguarding under Domestic Abuse pathway.

This report updates on progress made against our Trust wide Mental Capacity Act (MCA) Quality Improvement plan 2018/19 and on Trust wide Deprivation of Liberty Safeguards (DoLS) activity and assurance.

This paper also evidences partnership working in support of safeguarding activity and practice. Safeguarding activity and assurance is monitored by our hospital's Safeguarding Strategic Board, which meets quarterly. As a statutory partner activity and assurance is also reported to and monitored by Gloucestershire's Multi agency Safeguarding Board (GSAB) and Gloucestershire's Mental Capacity Act Governance Group (MCAGG).

Key issues to note

Safeguarding Adult at Risk activity and Safeguarding activity under Domestic Abuse pathway are increasing. The number of DoLS applications made for Trust in-patients is increasing. There has been is an increase in the number of safeguarding case meetings and information sharing requests made to Trust Safeguarding Teams. There are a range of Trust polices and clinical documents relating to safeguarding adults and the Mental Capacity Act which have been updated in 2018.

There has been an increase in staffing resource to Trust Safeguarding Adult at Risk Advisory Team. This is a 6 month secondment post. Trust Independent Domestic Abuse Advocates are in post within Trust Domestic Abuse Team both teams proactively support Trust staff, in real time, to fulfil their Safeguarding Adults role and responsibilities. Outside of these teams hours support is accessed via Clinical Site Management Team or the Community Emergency Duty Adult Social Care Team and via the Police.

Mental Capacity Act improvement actions are in progress to improve the documentation of capacity assessments.
The Unscheduled Care Safeguarding Lead holds delegated responsibility for achievement of the

Mental Health CQuIN within GHNHSFT. The first year of this CQuIN was largely successful resulting in approximately £900 000 of a possible £980 000 being secured.

Safeguarding Adult Structure and reporting were reviewed and refreshed in 2018.

Total of 9 allegations reported from external sources during April 2018 to end June 2018. From April to July 2018 there have been 116 DoLS applications made and 106 CQC DoLS outcome notifications submitted.

During April - July 2018 Trust Safeguarding Adult at Risk Advisory Team responded to 167 requests for guidance from Trust Clinical teams. 97 were in support of the safeguarding Adult at Risk pathway, 45 related to other pathways. For 25, following discussion these were considered to not meet Safeguarding and other appropriate actions were taken. At the time of this report, for July, 1 concern has actions in progress, with actions confirmed for all other concerns.

A Trust Safeguarding Adult dashboard is in development which will give greater visibility of safeguarding activity, outcomes, assurance and assist in the identification of new actions and improvements.

An initial Safeguarding Adult self-assessment was returned to GSAB in April 2018, to support Trust assurance against our safeguarding provider responsibilities. The final version will be submitted July 2018.

Our Trust is working in partnership with our core partners in best supporting patients presenting with specific high risk and safety factors. We are strengthening our pathway in collaboration with 2getherNHSFT and Gloucestershire Constabulary. This is anticipated to further support our patients with capacity, who present with substance dependency and who are at risk of absconding from our Trust. We are developing a joint Missing Person/Absconded Patient Protocol. A short life working group has been established.

There has been one published GSAB Safeguarding Adult Review (SAR) during 2018, ''Danny''. Recommendations from the SAR relate to discharge communications and the information which is communicated to the GP. A further 3 SAR's are in progress, led by GSAU.

Conclusions

Safeguarding Adult at Risk activity and Safeguarding activity under Domestic Abuse pathway are increasing. The number of DoLS applications made for Trust in-patients is increasing.

There are typically between 0 and 5 allegations raised monthly relating to the care experienced with our Trust. All allegation outcome reports and their associated action plans are within Divisional Datix and Complaint reporting. Trends relate to discharge pathway, discharge communications or documentation, reported hospital acquired pressure ulcers, one unexplained bruise and, standards of care. During 2017/18 none were substantiated under safeguarding pathway. Actions as a result of each, linked to quality improvements, are led by the senior clinical leads for each Datix incident or Complaint. Trust wide quality and improvement action are in progress relating to Hospital Acquired Pressure Ulcers.

Safeguarding training is not at the 90% target for Mandatory Training.

A Trust Safeguarding Adult dashboard is in development which will give greater visibility of safeguarding activity, outcomes, assurance and assist in the identification of new actions and improvements.

Implications and Future Action Required

Continued partnership working to safeguard adults within our Hospitals and within our community.
To continue to proactively support the work of all GSAB sub-committees and to work with all our partners in support of Gloucestershire's Multi-agency Safeguarding Adults at Risk Policy and Procedures.

To implement the recommendations for our Trust from GSAB Safeguarding Adult Reviews. These at this time relate to discharge communications, the information which is communicated to the Gp, recognition of self-neglect and actions in support of adults who do not attend planned outpatient Department appointments.

A Trust review is in progress of the multi-agency discharge policy to further support improved communications at discharge.

To promote achievement of 90% compliance for Mandatory safeguarding training.

To extend the Mental Capacity Act quality improvement project and to increase compliance across the clinical team of appropriate documentation of capacity assessments.

To complete the annual review against the Care Quality Commission's (CQC) Regulation 13: ''Safeguarding service users from abuse and improper treatment' and implement any necessary improvement actions to promote achievement of best practice safeguarding in practice.

Recommendations

The Board is asked to note the activity reports in relation to safeguarding of adults across our Trust and to note the risks and issues as presented within section 5 of the report.

Impact Upon Strategic Objectives

Safeguarding is a key priority for our Trust and for each member of Trust staff and for Trust Volunteers. It is part of the codes of practice of every professional.

Ensuring that our patients are safeguarded when in our care is a fundamental part of all Strategic Objectives. This supports Trust Strategic Objectives, Our Patient and Our Staff in particular. Safeguarding relates to responding to concerns of possible or actual harm and to ensuring standards of care within Trust practice. Safeguarding affect the reputation of our Organisation and has an impact on all Trust Strategic Objectives.

Impact Upon Corporate Risks

A risk is logged as part of our current Trust Nursing Risk Register, C1373, relating to missed opportunities, by Trust clinical teams, to safeguard adults. Actions are in place to seek to mitigate this risk. C1373 was reviewed in July 2018 and will be further reviewed in September 2018.

A new risk was logged to Trust Corporate Risk Register in June 2018, C2738MD, relating to lack of documentation of mental capacity assessments. Actions are in progress as part of Trust MCA action plan to promote improved documentation. C2738MD will be reviewed in August 2018, in line with the evaluation of the Capacity Assessment sticker pilot.

The recommendations from recent Safeguarding Adult Reviews (SAR) led by GSAB have identified a range of practice improvement actions for our Trust. These include actions in response to self-neglect by an adult with capacity, information to the GP where a patient does not attend any planned outpatient appointment, information to the GP where a patient does not respond to a clinic booking letter, discharge pathway, discharge communications and also the information which is communicated to the GP at discharge.

At present challenges in practice relating to the workload demands for Trust Safeguarding Adult teams in relation to competing safeguarding priorities.

At this time our Trust does not have a Dementia Care Specialist nurse(s). Senior Sister Safeguarding Adults at Risk Advisory Team supports a range of Trust wide quality improvement actions for our patients with Dementia. This presents challenges in practice relating to the workload demands, competing priorities and risks associated with both important agendas.

Safeguarding Adults Training Intercollegiate Guidance is under consultation at this time. There will be

considerable implications for our trust in implementation of the new training model as there is now a requirement that 50% of the training be delivered face to face at all levels.

The Parliamentary review of the amended Mental Capacity Act Bill expected in September 2018 anticipated to become law in 2019 will introduce the new Liberty Protection Safeguards and will replace DoLS. This will have significant implications for our Trust in relation to assessments and authorisations of applications under the new legislation.

Regulatory and/or Legal Implications

As a regulated provider our Trust must provide assurance against Care Quality Commission's (CQC) Regulation 13: ''Safeguarding service users from abuse and improper treatment''.

All Trust staff must adhere to Mental Capacity Act Legislation, Deprivation or Liberty Safeguards Deprivation and Safeguarding Adult (Care Act 2014) legislation. All Trust staff are defined as being in a ''Position of Trust'' under the Care Act. Gloucestershire's Safeguarding Adult Board has a legal basis as defined within the Care Act. The Equality Act also is underlying legislation in relation to safeguarding.

Not recognising or responding to safeguarding concerns, safeguarding allegations and not adhering to the MCA or to DoLS may result in Litigation, Coroner or/ and also may have criminal implications.

Equality & Patient Impact

Reported Safeguarding Adult at Risk Allegations have a negative impact on patient and carer experience and the reputation of our Organisation. Adverse patient experience and safety if safeguarding concerns relating to care experience by others or self-neglect concerns are not reported and the appropriate actions under multi agency Safeguarding adult pathways not then implemented.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	☑	For Approval		For Information	☑

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	Workforce Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
July 2018						Trust Safeguarding Strategic Board 4th June 2018

Outcome of discussion when presented to previous Committees

- Reports have been updated within the Annex documents to reflect information at July 2018

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Safeguarding Adults Annual Report 2017/18

SAFEGUARDING ADULTS ANNUAL REPORT

2017/18

1. INTRODUCTION AND PURPOSE

1.1 This report provides an update on activity, performance and monitoring relating to the safeguarding of adults with care and support needs, as defined within the Care Act 2014 and in relation to safeguarding under the Domestic Abuse pathway. It also supports our Trust Care Quality Commission (CQC) assurance in relation to the safeguarding of adults.

1.2 This report updates on progress made against our Trust wide Mental Capacity Act (MCA) Quality Improvement plan 2018/19 and on Trust wide Deprivation of Liberty Safeguards (DoLS) activity and assurance.

1.3 Safeguarding activity and assurance is monitored by our hospital's Safeguarding Strategic Board, which meets quarterly. As a statutory partner activity and assurance is also reported to and monitored by Gloucestershire's Multi agency Safeguarding Board (GSAB) and Gloucestershire's Mental Capacity Act Governance Group (MCAGG).

1.4 The report also provides a brief update on other areas of adult safeguarding, for example dementia and Prevent.

2. EXECUTIVE SUMMARY

2.1 Safeguarding is a key priority for our Trust and for each member of Trust staff. It is part of the codes of practice of every professional. Within an acute hospital setting we have the opportunity to detect safeguarding concerns and to respond to these concerns. We also have the opportunity to prevent harm for our patients and to proactively safeguard all within our care.

2.2 As a regulated provider our Trust must provide assurance against Care Quality Commission's (CQC) Regulation 13: ''Safeguarding service users from abuse and improper treatment''.

http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper

2.3 The safeguarding of adults who are at risk of abuse or neglect (including self-neglect), and who have the need for care and /or support is defined in law within section 42 of the Care Act 2014. All Trust staff are defined within this law as being within ''Positions of Trust'' and as such must be aware of their safeguarding adult role and responsibilities. This relates to the working role and conduct of staff and to their private and personal life outside of work.

2.4 The safeguarding of adults with care and support needs works in partnership with the application of the Mental Capacity Act and of the Deprivation of Liberty Safeguards, although these are two separate pieces of legislation. The safeguarding of adults at risk of abuse or neglect also includes safeguarding adults who have capacity and who may be placing themselves at risk or self-neglecting.

2.5 Safeguarding, under Domestic Abuse pathway is led by Unscheduled Care Safeguarding Team. Domestic abuse relates to adults and also incorporates safeguarding of young people, aged 16 to 18 years of age. This pathway is coordinated under the Multi Agency Risk Assessment and Conference (MARAC) Information Sharing agreement, which our Trust is a partner signatory to. It also works in partnership with safeguarding children pathway and the safeguarding of adults with care and support needs. Annex A - Safeguarding in Unscheduled Care Team: Update report.

2.6 Our Trust Chief Nurse is the Executive Lead for Safeguarding, alongside a designated Non Executive Safeguarding Lead. Trust Associate Chief Nurse has an active Safeguarding leadership role and from April 2018 has direct line management responsibility for Trust Safeguarding Adult's at Risk Advisory Team. Annex B - Trust Safeguarding Adult Structure.

2.7 Trust wide Safeguarding Adult activity is increasing. Information requests made to our Trust by GSAB are also increasing and also meeting attendances in support of safeguarding pathways are increasing.

3. PROGRESS FROM THE WORK PLAN 2017/2018 AND ACHIEVEMENTS

3.1 Trust Safeguarding Adults at Risk Advisory Team maintain a secure log of information shared by Trust Teams in relation to safeguarding adult at risk concerns (Concerns relating to GHNHSFT care experience are tracked under Allegations). The number of concerns reported is increasing. Response actions are promoted in real time. At June 2018 all actions were reported as being in place and following the defined safeguarding pathway. Annex C - Safeguarding Adult at Risk Concerns Report – at July 2018.

3.2 Trust Safeguarding Adults at Risk Advisory Team maintain a secure log of Safeguarding Allegations relating to GHNHSFT care experience raised under safeguarding pathway, by an external source. Each is reported within Datix. The number of allegations reported range from 0 to 5 allegations monthly, which shows a stable trend. Allegations reported relate to discharge, hospital acquired Grade 3 or above pressure ulcers, standards of care or staff conduct. Annex D - Safeguarding Adult at Risk Externally Reported Allegations Report – end June 2018.

3.3 Trust Safeguarding Adults at Risk Advisory Team maintain a secure log of Deprivation of Liberty Safeguards (DoLS) applications made by Trust clinical teams. This includes monitoring of practice and outcome reporting. Annex E - Trust Deprivation of Liberty Safeguards (DoLS) activity report- July 2018.

The team have the delegated responsibility, on behalf of our Trust, to complete and submit the required Care Quality Commission DoLS Outcome Notification forms for all DoLS applications made by GHNHSFT staff. DoLS activity by Trust ward teams is increasing. A DoLS review is in progress at this time in partnership with Gloucestershire's County Wide DoLS team. The Parliamentary review of the Amended Mental Capacity Act Bill is expected in September 2018 and anticipated to become law in 2019. This will introduce a new Liberty Protection Safeguards pathway which will replace DoLS. This will have significant implications for our Trust in relation to assessments and authorisations of applications under the new legislation. The new pathway will apply to patients aged 16 years and above, assessments and authorisations would be made by a Trust approved team, who are independent to the patient's clinical team, and no longer by an external Team. Review and scoping in relation to the new anticipated legislation is in progress in partnership with GSAB and Gloucestershire's MCAGG.

3.4 Trust MCA Quality Improvement plan 2018/19 is facilitated by Senior Sister Safeguarding Adults at Risk Advisory Team on behalf of our Trust MCA Organisational Leads. (Annex F) A key objective for our Trust clinicians is to improve documentation of capacity assessments and of best interests planning. This is a ''CQC Must do'' for our Trust.

Trust Safeguarding Adults at Risk Advisory Team are leading a quality improvement project pilot testing in practice, a Trust bespoke capacity assessment sticker and flow chart. A resource pack and a pocket prompt MCA guide have also been developed. The pilot commenced in May 2018 and in June extended to a second ward. Trust Safeguarding Adults at Risk Advisory Team visit the pilot ward weekly and attend one of the weekly board rounds. A targeted programme of bespoke ward based MCA/DoLS refresher sessions is also offered to clinical teams.

In July the pilot testing will be extended to a Trauma and Orthopaedic ward. Following evaluation it is anticipated that the sticker will be implemented Trust wide. At this time feedback from medical colleagues has been positive and practice improvements are noted within weekly ward visit and case note reviews.

Trust Safeguarding Adult at Risk Advisory Team are core members of Gloucestershire's County wide MCA Governance Group(MCAGG) and are involved in the county wide review and update of the multi-agency MCA Policy. This will further inform our Trust MCA policy, which was updated in June 2018 and which will be released to teams in July 2018 alongside the updated Trust Restraint Policy.

3.5 Domestic Abuse safeguarding activity is led and monitored by Unscheduled Care Safeguarding Team. Annex A - Unscheduled Care Safeguarding Team Activity Update - June 2018

3.6 We continue to work with local and regional partners on Prevent, which is is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

The Prevent Programme is designed to safeguard people in a similar way to safeguarding processes to protect people from gang activity, drug abuse, and physical and sexual abuse.

We participate in local Prevent networks, and whilst activity has been low, we continue to support local partners in supporting individuals who are identified as at risk and/or vulnerable.

3.7 Partnership Working

- Our Trust continues to be a committed, proactive partner as part of safeguarding adults at risk and is a core, statutory member of Gloucestershire's Safeguarding Adults Board (GSAB). We are proactively engaged as part of the annual action plans of all 7 GSAB sub-committees, with dedicated, senior representation as part of each.
- Trust Safeguarding Adults at Risk Advisory Team have an effective, partnership working relationship with Hospital Adult Social Care Team and Gloucestershire Safeguarding Adult Unit. This enables sharing of information to optimise the safeguarding pathway and response actions. We are extending partnership working with Integrated Assessment Team and Onward Care Team.
- Within Gloucestershire there have been a number of fire fatalities involving adults with care and support needs. This also links to GSAB self-neglect guidance and pathway. Trust specific actions to support GSAB Fire Safety and Prevention Sub–Committee's

annual plan have been implemented. Home fire safety and safeguarding is a core part of our level 2 Safeguarding Adults at Risk training. We had a leading role in the development of, in the pilot testing of and in the evaluation of the Multi -Agency Home Fire Safety and Safeguarding Risk Assessment Document.

- We are a core partner in the development of Gloucestershire's Multi-agency Safeguarding Adults at Risk and NHS Partners Pressure Ulcer Policy. Ahead of the release of the final County wide NHS partner's policy, Trust Safeguarding Adults at Risk Advisory Team have implemented a Trust specific clinical practice guide to support our teams.
- Our Trust is working in partnership with our core partners in best supporting patients presenting with specific high risk and safety factors. We are strengthening our pathway in collaboration with 2getherNHSFT and Gloucestershire Constabulary. This is anticipated to further support our patients with capacity, who present with substance dependency and who are at risk of absconding from our Trust. We are developing a joint Missing Person/Absconded Patient Protocol. A short life working group has been established, led by Trust Head of Safety.
- Trust Safeguarding Adults at Risk Advisory Team are core members of Gloucestershire's Strategic Health Safeguarding Group, chaired by GCCG Safeguarding Lead and the South West Health Regional Safeguarding Adults Network.

3.8 Continuing development of safeguarding processes and pathways

- Trust Safeguarding Adults at Risk Advisory Team provide real time support and guidance for all Trust staff during 08:00am to 4:30pm Monday to Friday. This includes guidance and resources to support best practice application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). This team has a leading role to develop, implement and to maintain Trust polices, resources and documentation as relevant to the Safeguarding adult at risk agenda. During 9am -5pm Monday to Saturday Trust Domestic Abuse Team provide real time support and guidance to teams relating to Domestic Abuse pathway, where the person has no care and support need under the Care Act.
- A new Band 6 Safeguarding Adult's at Risk Advisory Sister joined Trust Safeguarding Adults at Risk Advisory in April 2018. This is a six month secondment post. This post extends our team to three members of staff. Senior Sister Safeguarding Adults at Risk (Band 7 full time post) and Trust Safeguarding Adults at Risk Assistant (Band 3 non clinical post, full time.) A key part of this new role is to increase the visibility and accessibility in practice of Trust Safeguarding Adults at Risk Advisory Team, to visit clinical areas and to increase direct support for teams in practice. A key outcome of the post is to further support improved safeguarding response actions by Trust teams and to champion and promote application of the Mental Capacity Act in practice by teams.
- We have developed and implemented resources to support staff to fulfil their safeguarding roles in practice. We have a bespoke Trust Safeguarding Intranet webpage for our staff. Our Trust Safeguarding Intranet homepage provides fast access to all relevant information to support practice. We are continuously working to make improvements and are committed to learning from feedback. https://intranet.gloshospitals.nhs.uk/departments/corporate-division/safeguarding/
- We are making further improvements to our Trust safeguarding adult pathway to strengthen our participation as part of ''Making Safeguarding Personal'' and to working with our patients, their Carers and families. Making safeguarding personal is a requirement under the Care Act and aims to ensure that the voice and wishes of the patient are heard throughout the safeguarding pathway. Early involvement of the

person and seeking consent, where possible, are key components. In February 2018 our Trust presented our progress in relation to this to GSAB.

- Our Trust public Safeguarding Internet webpage has been further improved. www.gloshospitals.nhs.uk/your-visit/staying-us/keeping-you-safe/

3.9 Training and professional development

- Trust bespoke Safeguarding level 1 and level 2 training is mandatory for all Trust staff.
- Safeguarding Adults at Risk Level 1 e-learning Trust wide compliance = 65%. (This is due to the release of the new Trust bespoke level 1 training package in January 2018 which meant that training records were reset as there was a requirement for all staff to complete the new package) The updated Trust training report is to be released in July, increased compliance is anticipated.
- Safeguarding Adults at Risk Level 2 e-learning with the combined Domestic Abuse learning package - Trust wide compliance = 83%
- MCA/DoLS Mandatory training = 88%
- Trust Safeguarding Adults at Risk Advisory Team deliver Trust bespoke Safeguarding Adult at Risk Level 3 face to face training. This training has been further promoted during 2018 and an additional 80 senior clinical staff have completed this training.
- Training is actively promoted and bespoke training is targeted to specific groups of our staff, so as to best promote safeguarding in action.
- Actions are in progress in partnership with Unscheduled Care Senior Team to promote increased compliance by Medical Team in completion of Safeguarding Adults Mandatory Training, as training compliance is below our current Trust standard. This is a key objective and is part of our defined Trust CQC safeguarding improvement plan 2018.
- Trust Safeguarding Adults at Risk Advisory Team supports the Trust Safeguarding supervision programme and also offers team specific or one to one safeguarding supervision session for staff.
- Multi-Agency Safeguarding Adults training at level 3 is being explored. NHS England Intercollegiate Guidance is under consultation at this time. There will be considerable implications for our trust in implementation of the new training model as there is now a requirement that 50% of the training be delivered face to face at all levels.
- During 2018, Gloucestershire's Clinical Commissioning Group's (GCCG) Safeguarding Lead funded a programme of 8 externally facilitated safeguarding supervision sessions, for a core group of Gloucestershire's NHS Safeguarding Leads. This programme is at the half way point and will be formally evaluated at the end of the programme. These sessions enable reflective practice, peer support, structured challenge and feedback so as to improve practice and personal resilience. They have also been an opportunity to enhance team work and to strengthen partnership working.
- Trust Safeguarding Adults at Risk Advisory Team, in partnership with Gloucestershire's Fire and Rescue Service Safeguarding Lead and the University of Gloucestershire developed an educational video which forms part of the education programme for University of Gloucestershire Nurse learners.

3.10 Governance and Audit

- A safeguarding Adult at Risk audit is in progress to review actions by clinical teams in response to identified safeguarding concerns and the documentation. This will also consider the application in practice of the Mental Capacity Act.
- There has been one published GSAB Safeguarding Adult Review (SAR) during 2018. Recommendations from the SAR relate to discharge communications and the information which is communicated to the GP. GSAB SAR Report ''Danny'' https://www.gloucestershire.gov.uk/media/1519276/dk-report-final-march-2018.pdf
- Actions from published SAR's in 2017 relate to the recognition of self-neglect in adults with capacity, discharge communications to the GP and actions in support of adults who do not attend planned outpatient Department appointments.
- Trust assurance against Care Quality Commission's (CQC) Regulation 13: ''Safeguarding service users from abuse and improper treatment'' is being reviewed, improvement actions will be implemented following the Trust self-assessment.
- A Trust Safeguarding Adult dashboard is in development in partnership with Trust Safeguarding Board and GCCG Safeguarding Lead. This will follow a similar format to that of the Safeguarding Children dashboard. This will support greater visibility of safeguarding activity, outcomes and assurance.
- A Safeguarding Adult self-assessment has been returned to GSAB in April 2018, to support Trust assurance against our safeguarding provider responsibilities. All self-assessments are being jointly reviewed in partnership with all our statutory partners across Gloucestershire. A final version will be submitted July 2018.
- Actions to promote improved compliance for Mandatory Safeguarding Adult Training and for completion of Mandatory MCA/DoLS training is led by Divisional Leadership Teams.
- Actions to promote improved documentation of capacity assessments, by clinicians, are led by Divisional Leadership Teams, supported by Trust Mental Capacity Act Organisational Leads and Trust Safeguarding Adults at Risk Advisory Team.

4 KEY OBJECTIVES – SAFEGUARDING ADULTS 2018/2019

- To continue to work in partnership with GSAB to safeguard adults at risk, with care and support needs, within our Hospitals and within our community.
- To continue to proactively support the work of all GSAB sub-committees and to work with all our partners in support of Gloucestershire's Multi-agency Safeguarding Adults at Risk Policy and Procedures.
- To continue integrated working across all safeguarding pathways. Working together in support of safeguarding of Adults at Risk (under the Care Act), Domestic Abuse pathway and Safeguarding Children and Young People pathway.
- To be proactive partners in support of safeguarding transition planning.
- To implement the recommendations for our Trust from GSAB Safeguarding Adult Reviews. These at this time relate to discharge communications, the information which is communicated to the GP, recognition of self-neglect and actions in support of adults who do not attend planned outpatient Department appointments.
- A Trust review is in progress of the multi-agency discharge policy to further support improved communications at discharge.
- To promote achievement of 90% compliance for Mandatory safeguarding training.
- To extend the Mental Capacity Act quality improvement project and to increase compliance across the clinical team of appropriate documentation of capacity assessments.

- To complete the review against the Care Quality Commission's (CQC) Regulation 13: ''Safeguarding service users from abuse and improper treatment' and implement actions to promote achievement of best practice safeguarding in practice.
- To review all Trust safeguarding adult related polices and documentation, so as to ensure best practice is supported.

5 RISKS AND ISSUES IDENTIFEID

5.1 A risk is logged as part of our current Trust Nursing Risk Register, C1373, relating to missed opportunities, by Trust clinical teams, to safeguard adults. Actions are in place to seek to mitigate this risk. C1373 was reviewed in July 2018 and will be further reviewed in September 2018

5.2 A new risk was logged to Trust Corporate Risk Register in June 2018, C2738MD, relating to lack of documentation of mental capacity assessments. Actions are in progress as part of the Trust MCA action plan to promote improved documentation. C2738MD will be reviewed in August 2018, in line with the evaluation of the Capacity Assessment sticker pilot.

5.3 The recommendations from recent Safeguarding Adult Reviews (SAR) led by GSAB have identified a range of practice improvement actions for our Trust.
These include actions in response to self-neglect by an adult with capacity, information to the GP where a patient does not attend any planned outpatient appointment, information to the GP where a patient does not respond to a clinic booking letter, discharge pathway, discharge communications and also the information which is communicated to the GP at discharge. Actions are being scoped in relation to an adult patient not attending a planned appointment to explore options and to establish the associated cost implications.

5.4 Patients presenting with substance use, with capacity or with fluctuating capacity are at high risk of absconding from Trust premises. At this time, where the needs of the person do not meet the criteria for safeguarding under the Care Act, there is not a defined county wide risk management pathway. This is to be raised to GSAB Policies and Procedures Sub Committee for their review and feedback.

5.5 Within the last six months there has been an increase in the number of information requests made under safeguarding pathway by GSAB to Trust Safeguarding Adults at Risk Advisory team. This includes attending Safeguarding case meetings, safeguarding information sharing meetings, Safeguarding Adults Reviews, preparation of chronologies and preparation of Trust Individual Management Reports. Under safeguarding and the Care Act there is a duty for all to comply with requests made by GSAB.
In addition there are an increased number of case review requests as part of the National Learning Disability Care Death Reviews programme (LeDer).

At present challenges in practice relating to the workload demands for our team and in relation to competing safeguarding priorities.

- 3 Safeguarding Adults Reviews - 1 completed and published and 4 in progress
- 2 Individual Management Reports completed
- 11 chronologies - 9 completed - 2 in progress
- 2 Safeguarding case meetings attended
- Weekly information requests including requests to have access to stored safeguarding images or information relating to these images.
- 5 LeDer case reviews - 3 completed and two pending

5.6 At this time our Trust does not have a Dementia Care Specialist nurse(s). As a member of our Trust Dementia Steering Group, Senior Sister Safeguarding Adults at Risk Advisory Team supports a range of Trust wide quality improvement actions for our patients with Dementia. This presents challenges in practice relating to the workload demands, competing priorities and risks associated with both important agendas. This is under review by Director of Quality and Chief Nurse and options are being explored.

5.7 As part of the Multi-Agency Safeguarding Adults at Risk Pathway there is a need to seek information from or to make referral to Adult Social Care Team. Outside of 9am to 5pm Monday to Friday and 10am – 4pm Saturday this can be challenging for clinical teams. Prompt access to information and onward referral is essential as part of safeguarding and safe discharge planning. A meeting is to be planned between Trust Safeguarding Adult at Risk Advisory Team and the Lead for the community Emergency Duty Social Care Team.

5.8 Safeguarding Adults Training Intercollegiate Guidance is under consultation at this time. There will be considerable implications for our trust in implementation of the new training model as there is now a requirement that 50% of the training be delivered face to face at all levels.

5.9 The Parliamentary review of the Amended Mental Capacity Act Bill expected in September 2018 and anticipated to become law in 2019 will introduce the new Liberty Protection Safeguards and will replace DoLS. The new pathway will apply to patients aged 16 years and above, assessments and authorisations would be made by a Trust approved team, who must be independent to the patient's clinical team, and no longer by an external Team. This will have significant implications for our Trust in relation to assessments and authorisations of applications under the new legislation.

Authors: **Lynne McEwan-Berry, Senior Sister Safeguarding Adults at Risk Advisory**

Jeanette Welsh, Practice Development and Safeguarding Lead, Unscheduled Care

Jon Burford, Associate Chief Nurse

Steve Hams, Director of Quality and Chief Nurse

Date: **17th July 2018**

Supporting Documents

- Annex A - Unscheduled care Safeguarding Team Activity Update
- Annex B - Trust Safeguarding Adults Structure
- Annex C - Safeguarding Adult at Risk Concerns Report – July 2018.
- Annex D - Safeguarding Adult at Risk Externally Reported Allegations Report - end June 2018
- Annex E - Trust Deprivation of Liberty Safeguards (DoLS) activity report- July 2018.
- Annex F - Trust MCA Quality Improvement plan 2018/19– update end June 2018
- Annex G - Trust update to GSAB: May 2018 for the awaited GSAB 2017/18 Annual Report.

Annex A - Safeguarding Adults Annual Report – July 2018

QUALITY AND PERFORMANCE COMMITTEE

SAFEGUARDING IN UNSCHEDULED CARE UPDATE – JULY 2018

1.1 Domestic Abuse safeguarding work is led by Unscheduled Care for the Trust. The hospital based IDVAs are internally managed by the Unscheduled Care Safeguarding Lead and have been increasing their impact across the wider Trust. Information sharing with MARAC has been uneventful, but considerable. There have, unfortunately, been several domestic abuse related deaths in county this year and we await updates on which will proceed to Domestic Homicide Reviews.

1.2 Gaps in county safeguarding provision have become evident; specifically in relation to women who are being sexually exploited and abused. The MARAC Chair and county Domestic Abuse and Sexual Violence coordinator are in agreement with our analysis and this has been jointly raised with the domestic abuse commissioner.

1.3 Unscheduled Care safeguarding staff have been heavily involved with Safeguarding Children processes, particularly the processing and review of the notification to health visitors that a child has attended GHT.

1.4 Patients who frequently attend the Emergency Department continue to be proactively monitored. Full review of the status of all management plans and some small changes to management plan templates have been completed. The current highest intensity users are changed from last year.

1.5 The Unscheduled Care Safeguarding Lead holds responsibility for achievement of the Mental Health CQuIN within GHT. The first year of this CQuIN was largely successful resulting in approximately £900 000 of a possible £980 000 being secured.

2 Domestic Abuse

2.1 Information sharing with MARAC

There have been changes within police processes which have made information sharing more time-consuming, resulting in our turnaround times for information rising to 3 working days on some occasions, against a target of 1 working day. However, the Committee are asked to note that GHT is the only county agency which routinely holds information on every member of a household and Unscheduled Care are responsible for providing this on behalf of the Trust. As an example, in April 2018 there were information sharing requests for 111 cases. This translated to GHT providing information on 380 individuals.

2.2 Referrals to MARAC

Only individuals assessed as high risk are referred to MARAC. We are also required to re-assess known high risk individuals whenever they attend GHT and update MARAC with a statement on the person's welfare. Referrals of newly identified high risk individuals and updates on known high risk individuals are approximately equal over a month. As an example, in April there were 10 new high risk referrals and 7 high risk updates to MARAC.

2.3 Independent Domestic Abuse Advocates (IDVAs)

There are two hospital based Health IDVAs working in GRH and CGH six days a week. They are employed and line-managed by Gloucestershire Domestic Abuse Support Services (GDASS) and funded jointly by Gloucestershire County Council and Gloucestershire CCG. Internally they are managed the Unscheduled Care safeguarding lead.

The IDVAs have established themselves with different teams across the Trust, being most regularly contacted by staff in gynaecology and maternity. Their main efforts have been concentrated on responding to queries and requests for support from outside Unscheduled Care, but they have also drawn up safety plans for a small number of frequent ED attenders where the primary problem is known to be domestic abuse.

2.4 Domestic Homicide Reviews

Two members of Unscheduled Care safeguarding staff attended Domestic Homicide Review training provided by the county DASV coordinator in May 2018. This was aimed at improving quality of Independent Management Reviews and training targeted staff to be competent panel members for their organisations.

We are aware of at least 4 domestic abuse related deaths which may proceed to DHR this year, after 2 years of no DA-related deaths. Of these, one case has had a preliminary meeting and one case is in discussion as it does not neatly meet the criteria for either an Adult Serious Case Review or a Domestic Homicide. Other cases are not this far progressed.

2.5 Gaps in county safeguarding provision evident

Three recent worrying cases have highlighted that there are limited options available for safeguarding women who are being sexually exploited and abused. Each of these cases is a completely different situation; all highlight that safeguarding provision for children stops at 18 and there is no provision for women who continue to be sexually exploited after 18 or for women who start being sexually exploited after the age of 18. This has been raised jointly with the DASV coordinator and MARAC chair to the domestic abuse commissioner for consideration.

3 Safeguarding Children

3.1 Notification of child attendances to health visitors

The first five months of the year have required several adjustments to these procedures following the decision by the new Named Nurse for Child Protection in the county to remove the liaison health visitor from GHT. There have been monthly meetings at the CCG with CCG, GCS and GHT safeguarding staff led by the Named Doctor for Child Protection trying to resolve several problems.

As a result of these the data feed from GHT to GCS has been re-established following the discontinuation of Patient First and the implementation of Trakcare. All GHT data on child attendances to ED is now being sent daily to GCS's data warehouse. There have been some difficulties with this data then arriving with health visitors. This is an internal problem for GCS to resolve.

There have been many adjustments to the onward processes of informing health visitors of attendances that have concerned the ED staff. Staff are largely unaffected by these changes. The Safeguarding Children specialist nurse's have been reviewing these forms and have established that in 22/24 cases ED clinical staff have taken all necessary actions at the time of attendance. Cases where this has not happened have been at the weekend, when Children's Social Care staff are not available. Therefore the decision has been taken that going forward health visitor notification forms will only be reviewed on Mondays (Tuesdays after a public holiday). Every weekday morning they are collected by the Safeguarding Children administrator, scanned and e-mailed to the liaison health visitor at Edward Jenner House. This iteration of the process will be reviewed monthly to ensure that quality of notifications to health visitors is not deteriorating.

3.2 Risk assessment screening tools

The safeguarding children risk assessment screening tool used on the first page of the child versions of the Emergency Assessment Record has been changed in consultation with paediatrics to facilitate all areas of the Trust who see children using the same

safeguarding assessment. The main feature of this is that now two clinicians are required to complete complementary sections, enabling assessment to be made over the course of the first four hours, rather than only being completed by an initial assessment or triage nurse in the course of a five minute assessment. This has resulted in improved completion rates by nursing staff and by the discharging clinician where this is an ENP. There is a greater challenge in ensuring that this is improved amongst medical staff. Failed assessments are directed to complete a Safeguarding Children checklist to ensure concerns are responded to correctly.

In line with recommendations coming from the 'William' SCR we have just changed the adult safeguarding risk assessment screening tool to match the format of the child version. There will inevitably be some issues raised as this is implemented.

3.3 CP-IS

This was launched eighteen months ago with the ENPs, who were all keen to try this system. Momentum was lost awaiting availability the full e-learning package and the issuing of smartcards in the run up to the launch of Trakcare. These issues have been subsequently resolved and steady progress is being made is ensuring all ENPs and safeguarding staff have completed the e-learning package and had CP-IS access added to their smartcards.

As CP-IS can only be accessed via the Summary Care Record as present and there is no training environment available, the next stage is that the Safeguarding Children specialist nurses will be spending clinical time with ENPs whilst they access CP-IS with children who: live out-of-county, live in-county and have a Child Protection Plan alert on their Trakcare record, live in-county and have failed the safeguarding risk assessment. The Committee are asked to note that this will be a labour intensive phase of the project and is dependent on children matching the criteria attending when both an ENP and Safeguarding staff are present.

4 Patients Who Frequently Attend

4.1 Consultant leadership

Following the departure of Miss Parnham-Cope to Yeovil the consultant lead supporting this work is now Dr.Tom Llewellyn. He has reviewed all the current patient management plans and is making rapid progress with the list of patients who have been raised with safeguarding staff as requiring further investigation. He has been available to attend some professionals' meetings and provided briefing notes for those he has not been able to attend.

4.2 '12 in 12' and '9 in 3' reports

The current report of patients with more than 9 attendances in 3 months is radically different from previous reports. This is largely because several longer-term hard to engage mental health patients have been engaged courtesy of work done by 2gether staff as part of the Mental Health CQuIN. The current report of more than 12 attendances in 12 months shows a change of emphasis to there being more patients with alcohol related problems than mental health related problems. There is also considerable evidence of patients presenting with cardiac-type symptoms, which upon investigation by cardiology, prove to be anxiety or loneliness related. This reflects trends seen in other regions of the UK.

4.3 Mental Health CQuIN

This has been led for GHT by Unscheduled Care. The focus of this CQuIN is on improving the care offered to high intensity ED users with a primary mental health problem. Thanks to the work of 2gether staff on the selected cohort of patients a 44% reduction in attendances by that cohort has been achieved. As a result almost £900 000 of a possible maximum £980 000 has been secured. Worcestershire CCG refused to pay their £44 000 share of the maximum as they did not agree with the cohort chosen and another £40 000 was lost due to a temporary deficit in joint governance procedures.

There is another year for this CQuIN to run, which will hopefully see sustained improvements in the care of patients with recurrent mental-health related ED attendances. However, the Committee are asked to note that it is highly unlikely that GHT will be able to provide the size of patient cohort being requested as there are not those numbers of appropriate patients on the 12 in 12 report.

Author: **Jeanette Welsh, Practice Development and Safeguarding Lead, Unscheduled Care**

Date **July 2018**

Gloucestershire Hospitals NHS Foundation Trust Safeguarding Adult Structure May 2018

Annex B

Safeguarding Adults Update Report July 2018

REPRESENTATIVES FROM GSAB
TBC

REPRESENTATIVES FROM GCCG
ANNETTE BLACKSTOCK – Designated Nurse, Safeguarding Children Gloucestershire 0300 421 1607

STEVE HAMS
CHAMPION FOR SAFEGUARDING
0300 422 6666

NON-EXECUTIVE DIRECTOR
KEITH NORTON

TRUST PREVENT LEAD
Dee Gibson-Wain

JON BURFORD
ASSOCIATE CHIEF NURSE
AND SAFEGUARDING ADULTS LEAD
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Trust Unscheduled Care Team
Safeguarding Adults
Consultant link
Tanya De Weymarn

Trust Named Doctor for Safeguarding Adults
(Adults with Care and Support Needs)
TBC

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SAFEGUARDING ADULTS
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UNSCHEDULED CARE

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Lead
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Graham Rowe
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MARAC Lead
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RACHEL TORRINGTON
Unscheduled care
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Trust Independent
Domestic Violence
Advocates Team
07598510247

WOMENS AND CHILDRENS
DIVISION

VIVIEN MORTIMORE
Trust Named Nurse/Midwife
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0300 422 5528

MICHELLE RICHARDSON
Vulnerable Women's
Team
Senior Sister
0300 422 5150

SALLY UNWIN
Vulnerable Women's Team
Specialist Safeguarding
Midwife
0300 422 5150

EMMA STONE
Vulnerable Women's Team
Safeguarding Children
Administrator
0300 422 5526

DIVISION OF MEDICINE

SUE MILLOY
0300 422 3121

DIVISION OF SURGERY

LIZ BRUCE
0300 422 6221

DIAGNOSTICS & SPECIALITES

NICOLA TURNER
0300 422 6922

NOTES:
GHNHSFT Strategic Group includes all those in green and Divisional Directors
Operational Group TBC

During 9am to 4:30pm Monday to Friday for any In-patient safeguarding concern make a Hospital Adult Social Care Team e-referral and state "Safeguarding Concern" on the referral Click here to access the referral form. Ext. 3052 for CGH or Ext 6582 for GRH

During 9am to 4:30pm Monday to Friday for a patient who is not admitted to hospital raise your concern to the Community Adult Social Care Community Helpdesk - 01452 426868 or email your concern to the Community Adult Social Care Team Helpdesk during 9-5pm Monday to Friday - socialcare.enq@gloucestershire.gov.uk.

Outside of the above team hours for any patient in any setting contact Community Emergency Duty Adult Social Care Team. 01452 426868
Gloucestershire's Safeguarding Adult Team Professionals helpline - 9-11am and 2-4pm Mon-Fri
01452 425109

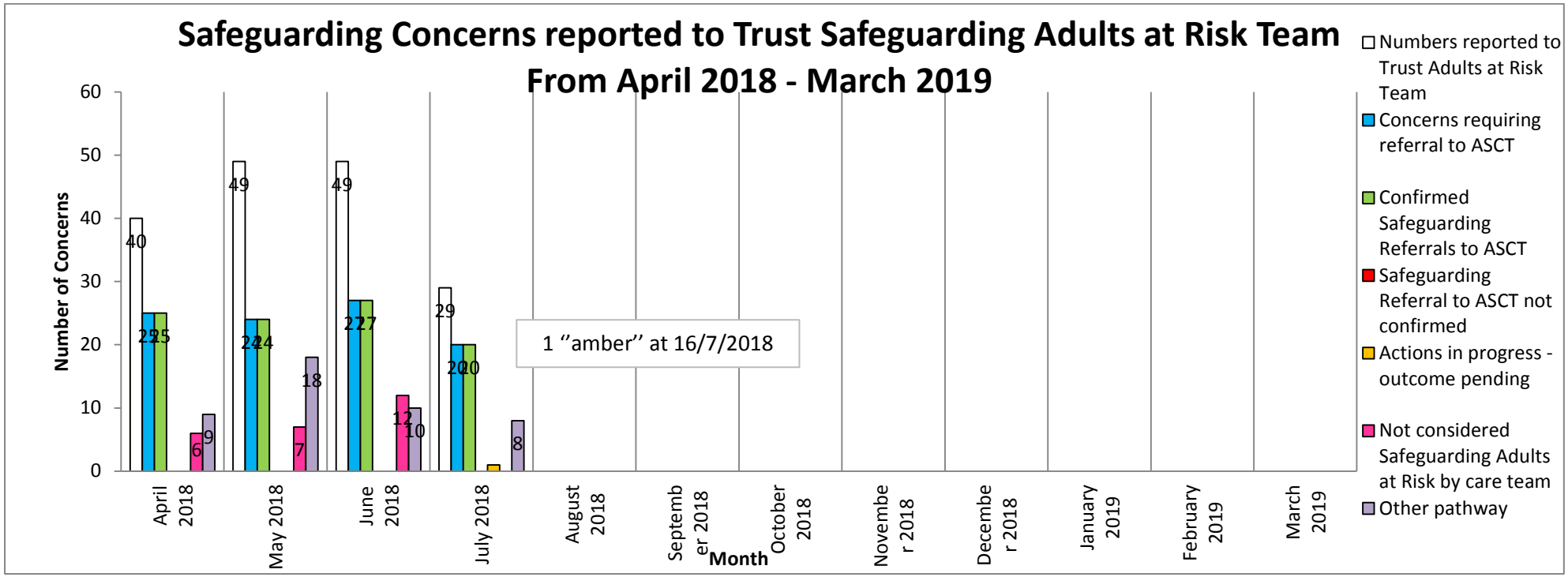
Trust Safeguarding Adult at Risk Advisory Team 08:30 -16:30 Mon-Fri
ghn-r.ghnhsftsafeguardingadultsteam@nhs.net

Annex C - Safeguarding Adults at Risk Activity Concerns Reporting April to 16th July July 2018
Safeguarding Adults Annual Report 2018

Confidential

Gloucestershire Hospitals NHS Foundation Trust

Trust Safgeuarding Adults at Risk Advisory Team - Activity Reporting on Concerns raised by Trust Staff 1st Apr 2018 - 16th July 2018



- Safeguarding Adult at Risk Concerns relates to concerns of possible abuse or neglect or self-neglect where the harm is considered to be by "an- other" and not linked to GHNHSFT care experience. This follows Gloucestershire's Multi-agency Safeguarding policy and relates to the safeguarding of adults with care and support needs as defined within section 42 of the Care Act (April 2015).
- All Safeguarding Adult at Risk Concerns are required to be referred to Adult Social Care team.
- Trust Safeguarding Adult at Risk Advisory Team supports care teams to take the appropriate actions in real time and to update on their response actions in real time.
- During April - July 2018 Trust Safeguarding Adult at Risk Advisory Team responded to 167 requests for guidance from Trust Clinical teams – 97 were in support of the safeguarding Adult at Risk pathway. 45 related to other pathways. For 25, following discussion these were considered to not meet Safeguarding (shown as pink on the graph), and other appropriate actions were taken. At the time of this report, for July, 1 concern, shown on the graph as amber has actions in progress, for all other concerns actions are confirmed.
- During April and June 2018 where a Safeguarding Adult at Risk Concern was identified and reported to Adult at Risk Advisory team, all appropriate actions are in place under Safeguarding Adult at Risk pathway. This has been as a result of more intensive support for Trust teams from Trust Safeguarding Adult at Risk Advisory Team and greater visibility of Trust Safeguarding Adult at Risk Advisory Team as the clinical compliment of the team is now 2 Safeguarding Adult at Risk Advisor Sisters.

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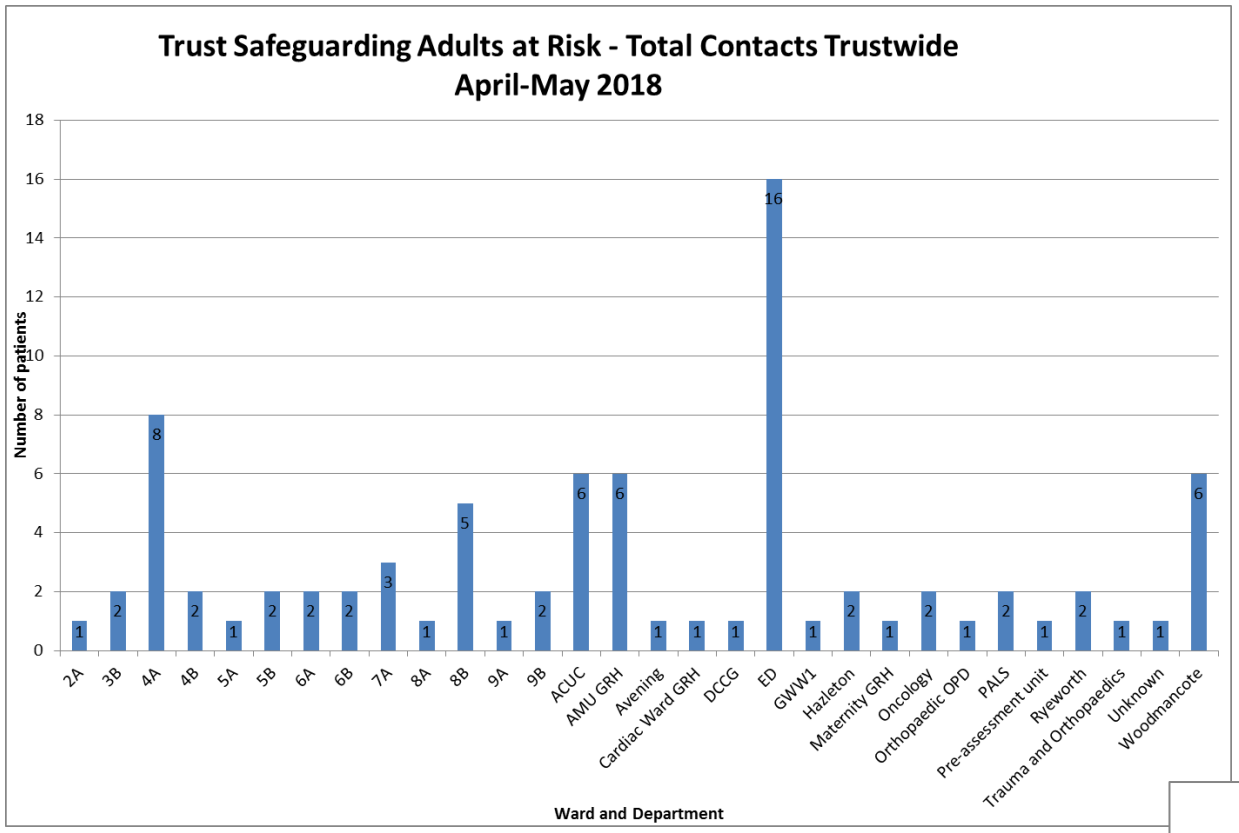
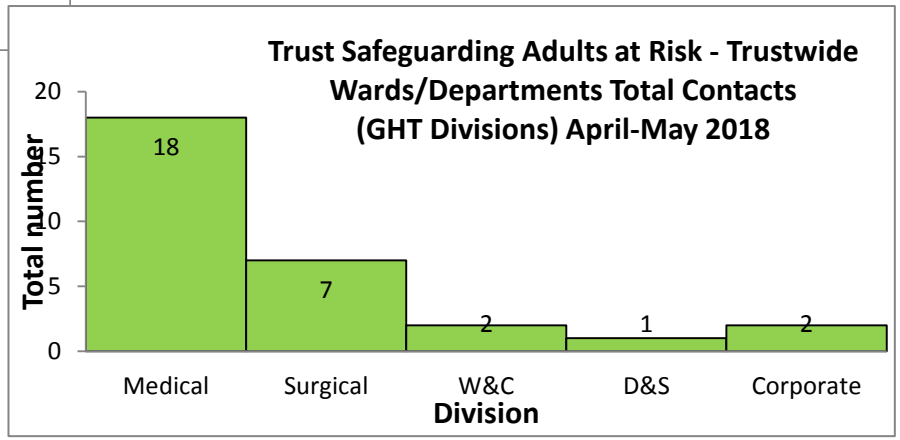
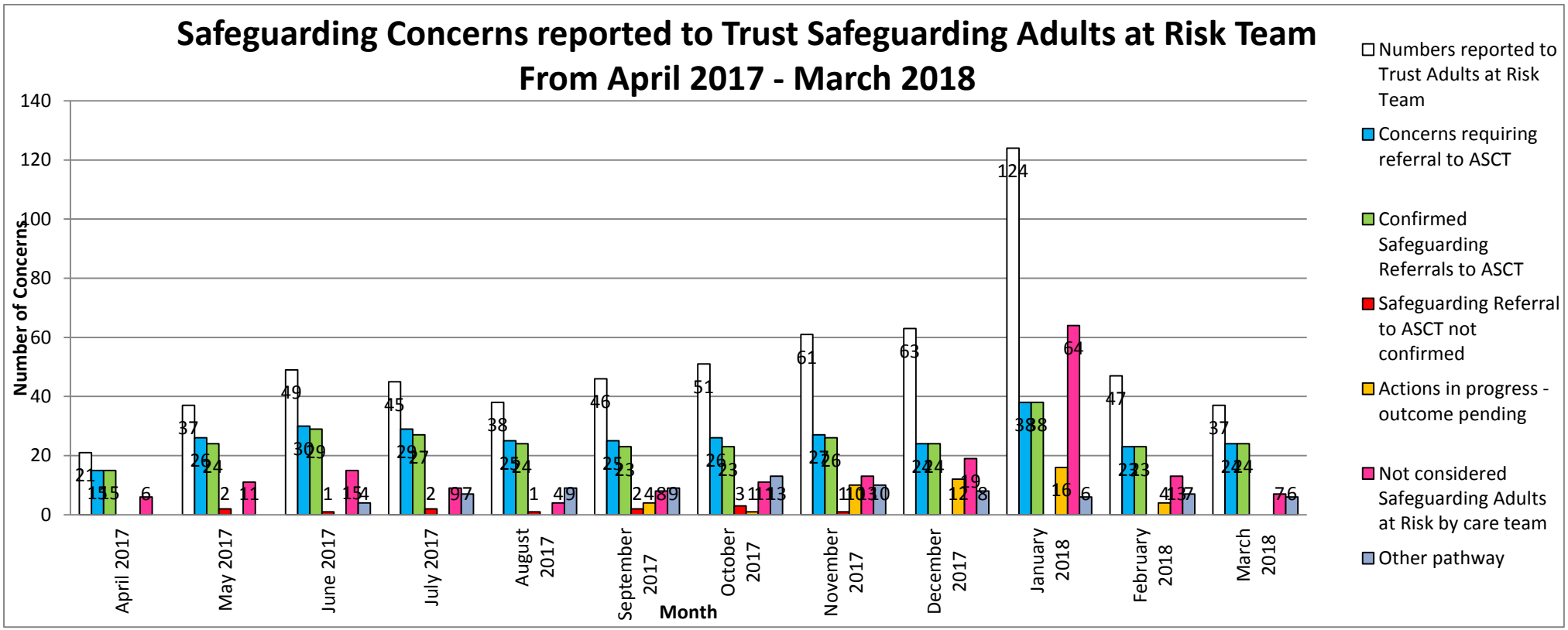
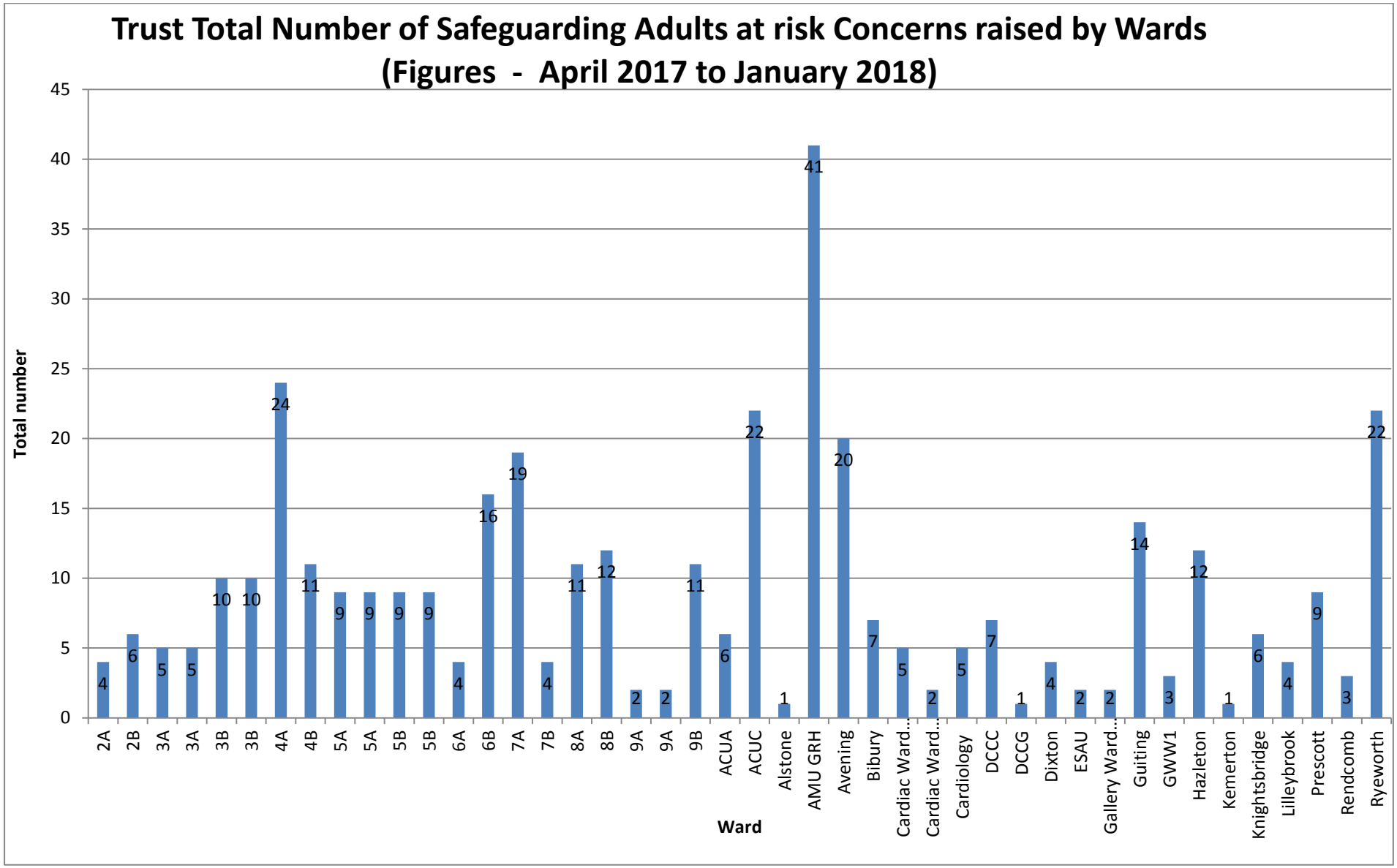






- Trust Safeguarding Adult at Risk Team are completing 42 case reviews for the ''amber'' cases (November 2017, December 2017 and February 2018) to confirm if the advice which was given to the respective care teams by Trust Safeguarding Adult At Risk Senior Sister was acted upon. This will be presented as an audit report to Trust Safeguarding Board.
- Trust Safeguarding Adult at Risk Advisory Team supports care teams to take the appropriate actions in real time and to update on their response actions in real time.
- From May 2018 guidance requests made to Trust Safeguarding Adult at Risk Team relating to the application of the mental capacity act will be tracked and reported separately.
- Last ''amber'' was in February 2018, since February all actions are promoted and followed up in real time by Trust Safeguarding Adult Advisory Team


Trust Total Number of Safeguarding Adults at risk Concerns raised by Wards
(Figures - April 2017 to January 2018)
Total number
Ward
0
5
10
15
20
25
30
35
40
45
2A 4
2B 6
3A 5
3A 5
3B 10
3B 10
4A 24
4B 11
5A 9
5A 9
5B 9
5B 9
6A 4
6B 16
7A 19
7B 4
8A 11
8B 12
9A 2
9A 2
9B 11
ACUA 6
ACUC 22
Alstone 1
AMU GRH 41
Avening 20
Bibury 7
Cardiac Ward... 5
Cardiac Ward... 2
Cardiology 5
DCCC 7
DCCG 1
Dixton 4
ESAU 2
Gallery Ward... 2
Guiting 14
GWW1 3
Hazleton 12
Kemerton 1
Knightsbridge 6
Lilleybrook 4
Prescott 9
Rendcomb 3
Ryeworth 22

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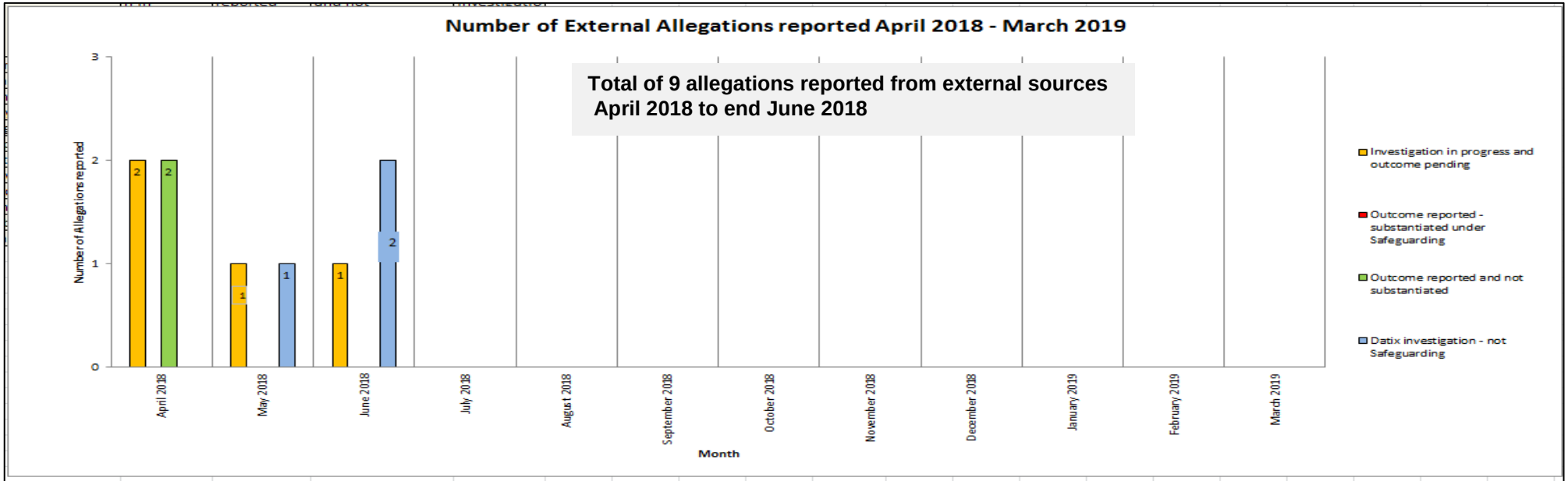
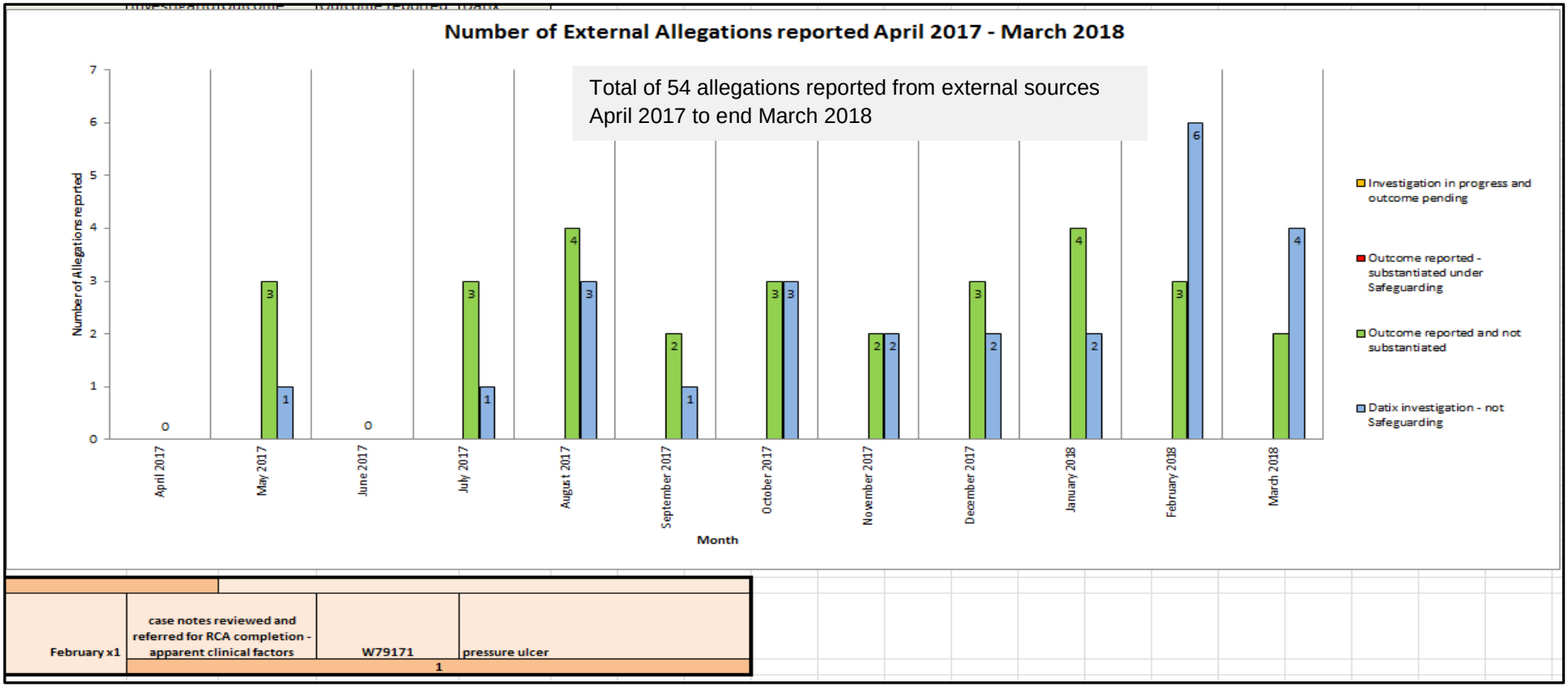
Gloucestershire Hospitals NHS Foundation Trust

Trust Safgeuarding Adults at Risk Activity Reporting on External Allegations – April 2018 to end June 2018



Amber as at: 12/07/2018			
April - Total = 5			
		Complaint	Unexplained bruise
		W84186	Discharge (discharged after 8pm)
	Investigation in progress	W85578	Pressure ulcer
	Investigation in progress	Datix to be confirmed	Pressure ulcer
	2		
May - Total = 0			
		W85799	Communications re DNACPR status - for a pateint with Dementia
	Investigation in progress	W86253	Pressure Ulcer
	0		
June - Total = 0			
	Investigation in progress	PALS	Discharge and Oxygen Therapy concerns (CQC)
			Discharge planing and euipment
			Care concerns
	1		

- All allegation outcome reports and their associated action plans are within Divisional Datix and Complaint reporting
- **Trends –** Discharge pathway, discharge communications, documentation, reported hospital acquired pressure ulcers, unexplained bruise, standards of care
- **To date -** not substantiated under safeguarding pathway and actions linked to quality improvements- actions led by senior clinical leads for each Datix incident or Complaint. Trust wide quality and improvement action are in progress relating to Hospital Acquired Pressure Ulcers.



February x1	case notes reviewed and referred for RCA completion - apparent clinical factors	W79171	pressure ulcer
	1		

- All allegations outcome reports and their associated action plans are within Divisional Datix and Complaint reporting
- **Trends –** Discharge communications, documentation, reported hospital acquired pressure ulcers, consent, and standards of care and staff allegation.
- **To date -** not substantiated under safeguarding pathway and actions linked to quality improvement actions led by senior clinical leads for each Datix incident or Complaint. Trust wide quality and improvement action are in progress relating to Hospital Acquired Pressure Ulcers.

Deprivation of Liberty Safeguards Report - Trust Safeguarding Adults at Risk Advisory Team

01/08/17- 04/07/18

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Name of hospital site or location	Name of inpatient ward or unit	CQC core service	Number of DoLS applications made											
			Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Gloucestershire Royal Hospital	7a	Medicine	2	3			1					3	4	
	6a	Medicine	3				1		3	4	1	1	2	1
	Cardiology 1	Medicine	1								1			
	Gallery Ward	Diagnostics and Specialities		1					1					
	3b	Surgery		1										
	6b	Medicine		2	3	3	1	2	2	2	4	3	1	
	4b	Medicine			1				1			1		
	8b	Medicine			1	1	1		1		3	2	1	
	7b	Medicine			1							1		
	8a	Medicine				5		1	3	3	2	2	1	2
	9b	Medicine				1	1	3			2			2
	DCC	Surgery							1					
	4a	Unscheduled Care										1	1	
	5b	Surgery											1	
Cheltenham General Hospital	Hazleton Ward	Medicine	1			1	2	1				1		
	Bibury	Surgery		2										
	Acute Care Unit C	Unscheduled Care				1								
	Prescott Ward	Surgery							1					
	Avening Ward	Medicine										1		
	Woodmancote Ward	Medicine											1	
			7	9	6	12	7	7	13	9	13	16	12	5
														116

Deprivation of Liberty Safeguards Report - Trust Safeguarding Adults at Risk Advisory Team														
01/08/17- 04/07/18														
Confidential			Number of DoLS applications authorised by external DoLS Supervisory bodies											
Name of hospital site or location	**Name of inpatient ward or unit**	**CQC core service**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
Gloucestershire Royal Hospital	*7a*	*Medicine*	1											
	6a	*Medicine*												
	Cardiology 1	*Medicine*												
	Gallery Ward	Diagnostics and Specialities												
	3b	Surgery												
	6b	Medicine												
	4b	Medicine												
	8b	Medicine											2	
	7b	Medicine			1									
	8a	Medicine												
	9b	Medicine												
	DCC	Surgery												
	4a	Unscheduled Care												
	5b	Surgery												
Cheltenham General Hospital	Hazleton Ward	Medicine												
	Bibury	Surgery												
	Acute Care Unit C	Unscheduled Care												
	Prescott Ward	Surgery												
	Avening Ward	Medicine												
	Woodmancote Ward	Medicine												
			1	0	1	0	0	0	0	0	0	0	2	0
														4

Deprivation of Liberty Safeguards Report - Trust Safeguarding Adults at Risk Advisory Team

01/08/17- 04/07/18

Confidential

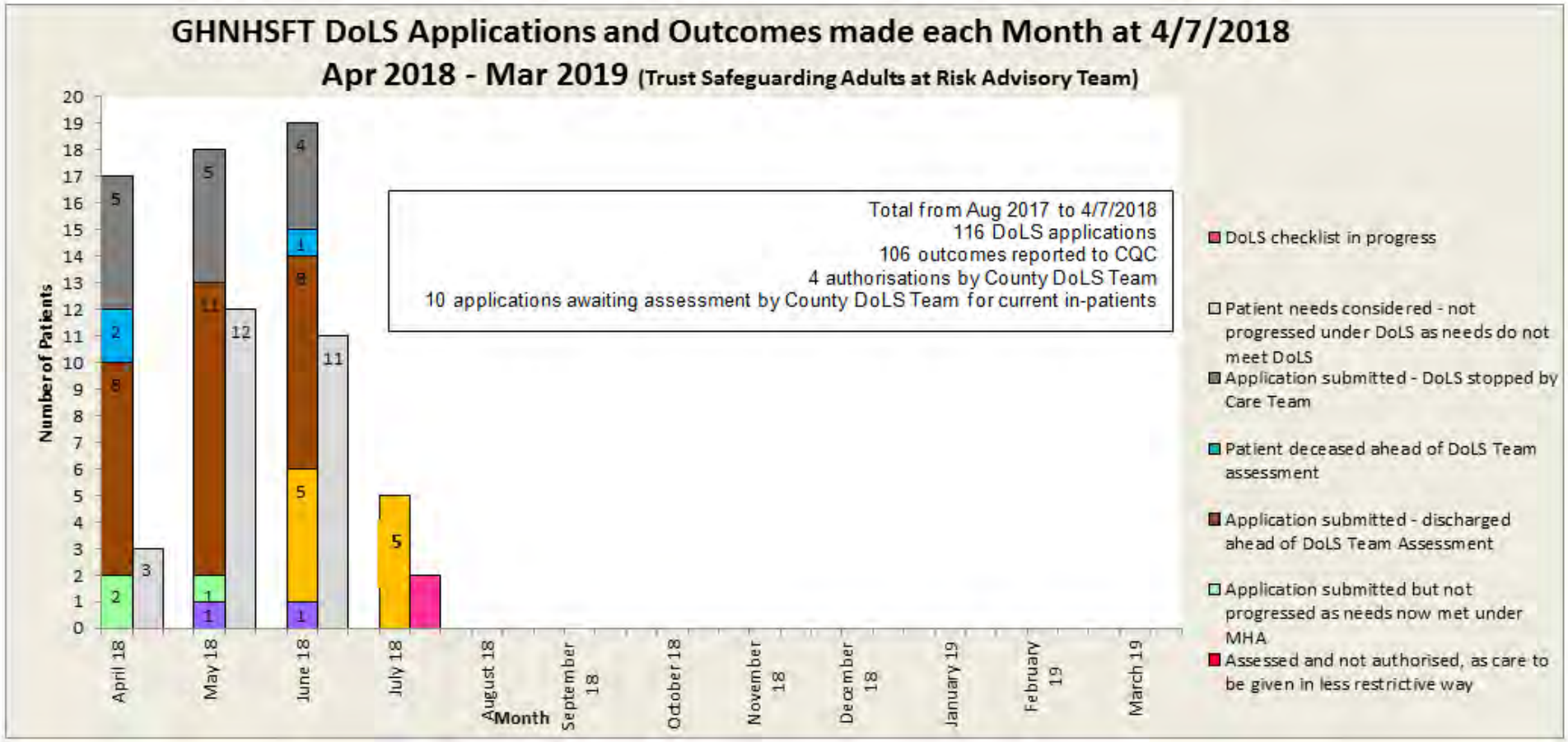
			Number of DoLS application outcomes where assessment not undertaken by external DoLS Supervisory bodies											
Name of hospital site or location	**Name of inpatient ward or unit**	**CQC core service**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
Gloucestershire Royal Hospital	7a	Medicine	1	2		1		1				1	4	
	6a	Medicine	1	2			1		2	2	3	1		1
	Cardiology 1	Medicine		1							1			
	Gallery Ward	Diagnostics and Specialities		1						1				
	3b	Surgery			1									
	6b	Medicine			3	4	2	2	2	1	4	1	2	
	4b	Medicine			1				1			1	1	
	8b	Medicine				2	1		1			3	2	
	7b	Medicine											2	
	8a	Medicine				3	2	1	1	3	4	1	1	
	9b	Medicine					1	3	1		1	1		
	DCC	Surgery							1					
	4a	Unsched/ Care											1	1
	5b	Surgery												
Cheltenham General Hospital	Hazleton Ward	Medicine	1				2	1	1				1	
	Bibury	Surgery			2									
	Acute Care Unit C	Unsched / Care					1							
	Prescott Ward	Surgery							1					
	Avening Ward	Medicine										1		
	Woodmancote	Medicine											1	
			3	6	7	10	10	8	11	7	13	10	15	2
														102

Deprivation of Liberty Safeguards Report - Trust Safeguarding Adults at Risk Advisory Team

01/08/17- 04/07/18

Confidential

			Total number of DoLS outcome notifications sent to CQC by GHNHSFT											
Name of hospital site or location	**Name of inpatient ward or unit**	**CQC core service**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
Gloucestershire Royal Hospital	7a	Medicine	2		2	1			1				3	2
	6a	Medicine	1	2				1		2	1	4	1	2
	Cardiology 1	Medicine		1									1	
	Gallery Ward	Diagnostics and Specialities			1					1				
	3b	Surgery			1									
	6b	Medicine			1	2	3	3	3		2	5	1	2
	4b	Medicine			1				1				1	
	8b	Medicine				1	1		1	1			5	1
	7b	Medicine				1								1
	8a	Medicine				1	3	1	2	1	2	2	4	1
	9b	Medicine						1	4		1		1	
	DCC	Surgery								1				
	4a	Unscheduled Care											1	1
	5b	Surgery												
Cheltenham General Hospital	Hazleton Ward	Medicine	1				1	1	2					1
	Bibury	Surgery			2									
	Acute Care Unit C	Unscheduled Care					1							
	Prescott Ward	Surgery								1				
	Avening Ward	Medicine											1	
	Woodmancote Ward	Medicine												1
			4	3	8	6	9	7	14	7	6	11	19	12
														106



- Trust Safeguarding Adults at Risk Advisory team provides real-time advice and support to clinical teams in relation to Deprivation of Liberty. This team monitors all DoLS applications and DoLS considerations. Where appropriate in response to risk or to the restrictive plan necessary in patient best interests out team escalate to the countywide DoLS team to ensure that their assessment of the patient can be prioritised.
- Following a DoLS application and when the outcome of this is determined, including any of the above categories, Trust Safeguarding Adults at Risk Advisory team completes and submits the required CQC DoLS outcome notification form on behalf of our Trust.
- Where an application is submitted to the countywide DoLS team (external to out Trust), it is the responsibility of this external team to assess the patient and to establish if the DoLS authorisation is to be granted. There are currently a large number of countywide DoLS applications where the DoLS assessment has not been completed. This is the responsibility of Gloucestershire County Council, and Gloucestershire Safeguarding Adult Board is fully aware.
- For April to July 2018 no assessments have been undertaken by the countywide DoLS team for DoLS applications submitted by our Trust.
- Joint review of DoLS is being undertaken by our Trust in partnership with countywide DoLS team

Gloucestershire Hospitals NHS Foundation Trust

Action Plan GHNHSFT MCA Organisational Leads
Action plan update – June 2018
Updated by Lynne McEwan-Berry Senior Sister Safeguarding Adults at Risk Advisory Team

Name	Role
Steve Hams	Chief Nurse and Director of Quality
Andrew Seaton	Director of Safety
Jon Burford	Associate Chief Nurse
Dr Sean Elyan	Medical Director/Consultant
Caroline Pennels	Trust Head of Legal Services
Lynne McEwan Berry	Senior Sister Safeguarding Adults at Risk Advisory Team
Dr Helen Alexander	Consultant Physician Care of the Elderly and Trust Dementia Clinical Lead
Dee Gibson -Wain	Associate Director of Education and Development

No	Statement	Action	Lead	Update	Target / or Completion Date
1	Evidencing capacity assessments within the health care record	• Pilot test Trust new MCA notes sticker ➢ Woodmancote ward (agreed and in progress May 2018) ➢ Ryeworth ward (agreed and in progress June 2018) ➢ within surgical ward to be agreed – aim to pilot July/Aug 2018 • Ward based training in progress to target wards- April onwards • Support for pilot ward teams by Senior Sister - Safeguarding Adult at Risk Advisory Team and Caroline Pennels • Real time support and auditing in practice within the pilot wards- weekly board round visits -	LMB/HA/ CP	• MCA Organisational leads agreement given for the sticker – Completed • Amendments to the Trust MCA sticker agreed and with Documentation Team- Consultation in practice as part of ''PDSA''' cycle- April 2018 – price quote agreed - £8 for 100 stickers for the pilot -Final drat sticker agreed and printed Completed • LM Attended Specialist Board meeting- Completed • Phase 2 pilot within Woodmancote ward- May 2018 • Case reviews May- September 2018- 20 case records • Meeting held with A Seaton as part	Pilot testing of the revised sticker May- August 2018 For progress update at end July 2018

		Senior Sister - Safeguarding Adult at Risk Advisory Team • Evaluation of the pilot test ahead of full Trust wide implementation		of Quality Improvement project held • National Audit of Dementia Team have requested information on the pilot for the NAD National newsletter –Article drafted by L M and submitted Completed • Pocket prompt cards for medical team developed and disseminated • Draft evaluation report – August 2018	
2	Lasting Power of Attorney (LPA) question to be introduced as part of admission process	• Scope possibility of recording via Trakcare • Draft a patient and family LPA leaflet to guide on what to bring to hospital and how this will be confirmed by the care team Draft content for a leaflet	LMB/CP Nicola Turner LMB/CP	• Explore options and process re Trakcare- request made to Thelma Turner and Nicola Turner • Due to vacancy within Trust Safeguarding Adult at Risk Advisory Team this work has been delayed and re- commenced May 2018 • A flow chart with guidance is contained within Trust MCA Policy **A2048.pdf** • MCA policy updated June 2018 • Consent policy action cards on LPA and Advance Directives to be drafted by CP for Trust Consent Policy and hyperlinked to MCA policy	Target for Draft to be circulated – June 2018- Completed Policy anticipated to be released July 2018
3	Implementation of DoLS best practice in line with legal rulings	• Support in real time by Trust Safeguarding Adult at Risk Advisory Team and from Trust Head of Legal Service • Safeguarding Adult at Risk Advisory Team • May 2018 Trust Safeguarding Adult	LMB/CP LMB/ HH	1. New Safeguarding sister post in reaching to teams on a daily basis during working hours 2. DoLS screening checklist- update in progress at May 2018 to further simplify	May 2018 – evaluate Sept 2018

		at Risk Advisory Sister (which is a new 6 month secondment post at band 6 for 30 hours a week) commenced. It is anticipated that this additional post will enable Trust Safeguarding Adult Advisory Team to support care teams to take the appropriate actions in real time. • Trust DoLS checklist is being further amended to aim to simply the assessment page • Targeted training for Clinical site management Team is planned and for target ward areas as identified from team data • A sample completed best practice DoLS application form has been developed by Trust Senior Sister Safeguarding Adults at Risk Advisory Team which guides staff in practice on completing their DoLS application(this has been approved by the County wide DoLS Team and by the County wide MCAGG chair) – on Trust DoLS site and sent to teams in hard copy – added to the DoLS Policy Completed	LMB LMB/HH LMB	3. Deliver targeted training to identified Clinical teams (areas identified from DoLS scoping exercise and team data)- care of the Elderly , 7a, Alstone- 6a, 6b, 8a, 8b, 4b, 4a 4. Further review of Trust DoLS policy in light of the Ferreira Judgment - Working in partnership with Glos MCA Governance Group and also with Glos Safeguarding Adult Board Polices and Procedures subcommittee – review of Ferreira judgement and DoLS pathway in partnership with County DoLS Team lead- and joint clinical visits agreed and planed for July/August 5. Trust Safeguarding Adult at Risk Advisory Team are core members of the GSAB Task and Finish subgroup reviewing the County wide MCA Policy. GHNHSFT MCA policy will be further reviewed and updated in alignment with the work of GSAB	June – Oct 2018 July/Sept 2018

4	Review evidence assurance for CQC and MCAGG • Regulation 11 - Consent • Regulation 13 - Safeguarding /MCA/DoLS	1. Reassess KLOE assessment and identify gaps and actions by end July 2018 2. Completion of Glos Safeguarding Adult Board Self-Assessment Jan 2018 Completed Joint review with Glos Constabulary as recommend by GSAB- meeting planned for July and submission date of 31st July 2018	All JB/LMB	• Joint review with Glos Constabulary as recommend by GSAB- meeting planned for July and submission date of 31st July	31st July 2018
http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-11-need-consent http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper					

5	Promote best practice application of the MCA in practice- ensure that policy is followed in practice	• Explore recruitment of speciality MCA links from medical team across each Division • Explore senior Clinical Consultant /Registrar leads within each Division • Links with Capacity sticker pilot	SE	• Continue to monitor practise and to provide real time support and guidance to teams by Trust Safeguarding Adult at risk Sisters ongoing • Audit of MCA in action within real time- Dementia Care audit and LD care audit –Completed August 17 for Dementia care and Nov 17 for LD care – Completed Repeated by LD Team April 2018 and June to Sept 2018 for Dementia • Trust Safeguarding Adult Team role to offer support and guidance in practice to teams. • Part of the role of MCA Organisations leads • Trust head of Legal Services supports and guides teams in practice- via mobile via switchboards • Involved in the consultation of new NICE guidance re MCA in practice • LMB attended Grand Round 1st May 2018– Completed • Trust bespoke MCA/DoLS e-learning in date and fit for purpose –Training is mandatory • Targeted training to teams and where requested • Next series of Trust Face to Face level 2 dates to be planned by CP and LMB • Plan a MCA Organisation leads meeting to progress actions	For review July 2018 August 2018

6	Review Law Commission Report March 2017 on MCA and DoLS (Liberty Protection Safeguarding)	1. Review the new recommendations and plan for actions which impact on GHNHSFT	LMB/CP/ JB/ Glos DoLS Team Lead	• Anticipated that the law will change next year years • Member of Glos MCA Governance Group	Review meeting planned August 2018
https://services.parliament.uk/bills/2017-19/mentalcapacityamendment.html					
7	Review GHNHSFT DoLS trend reports	1. Trend data to support practice and training 2. Daily monitoring 3. Targeted actions within identified clinical teams 4. Secure trackers maintained by Trust Safeguarding Adult at Risk Advisory team 5. Explore new themes and practice 6. Review DoLS policy where indicated	LMB/JB / CP	• DoLS reporting developed by Trust Safeguarding Adult Team- Completed • Report submitted for review by to Trust Safeguarding Board (June 2018)–Completed • Daily list to Matrons and Divisional Nursing Directors from wards where applications have been made –Implemented – Completed • Meeting planned with Glos DoLS Supervisory Body and GHNHSFT August 2018 - in light of recent case and authorisation by another County's DoLS Team also Ferreira Judgment (To explore if DoLS if due to clinical condition or not also maximum personal care needs- Supportive plan or restrictive plan)	DoLS reporting from August 2018- within the new safeguarding dashboard August 2018

8	Documentation of DNACPR communications and decision rationale	• Repeat LD audit April 2018 by Hospital LD Nurse Team • Actions by Trust Resuscitation Committee to promote best practice in conversations and documentation	HLDLT/BK	• LD audit completed a completed • MCA sticker pilot linked to the ReSPECT form	For review August 2018
9	Staff Training in line with Glos County wide MCA/DoLS training strategy	• Trust bespoke level 1 training package in date • For review as part of the County wide Policy update group	DGW / CP/LMB	• Self-assess against Glos county wide MCA/DoLS training pathway- completed • Team specific sessions new programme for 2018	Review August 2018
10	Update of Trust Restraint Policy and to include an action card on the assessment for and of use of individual, patient specific mechanical restraint (as a last resort) Following CQC best practice guide and linking with other Trusts	• To explore option of adding as part of Safe holding training • Explore model and training for patient specific mechanical restraint • Policy update -released to core groups updated revised version June 2018 - Checklist and Care plan for use of mechanical restraint and accompanying new process- update and release of final policy anticipated July 2018	JB JB LMB	• Policy and action card in progress -Draft for initial consultation shared Dec 2017 completed- revised version circulated June 2018 completed- final version anticipated for release July 2018 • Training being scoped July/August 2018 as part of Trust Violence and Aggression Group led by J- Burford • Joint working with Matron from Paediatrics in support of patients aged 16-18 years – (also link to Transition Policy) • Due to vacancy within Trust Safeguarding Adult at Risk Advisory Team this work has been delayed and re-commence May 2018	August 2018

11	Feedback from Trust NAAS(Nursing Assessment and Accreditation) programme lead on Mental capacity act understanding and improvement actions to support teams	• Involvement in the consultation of the questions as part of the NAAS assessment relating to MCA •	PL/LMB Trust Safeguarding Adults at Risk Advisory Team	• Trust Safeguarding Adult at Risk Advisory Team to offer support in practice and ward/Dept based bespoke training where indicated in light of NAAS assessment scores • Trust Safeguarding Adults at Risk Advisory Team support teams in understanding MCAS and DoLS in practice- additional fact cards to be developed- August 2018 and pilot tested	May to Oct 2018- then for progress review

Gloucestershire Hospitals NHS
NHS Foundation Trust

Gloucestershire Safeguarding Adult Board Annual Report
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Update – May 2018

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) provides specialist NHS acute hospital care and treatment, where the health care needs of the person requires the care of an acute hospital consultant. This can be planned care, or care in an emergency.
Our Trust continues to be a committed, proactive partner as part of safeguarding adults at risk and we are a core, statutory member of Gloucestershire's Safeguarding Adults Board (GSAB). We are actively engaged as part of the annual action plans of all GSAB sub-committees, with dedicated, senior representation as part of each.

Structure and Approach to Safeguarding Adults within GHNHSFT

Within our Trust Safeguarding is led by our Chief Nurse, as our Executive Lead for Safeguarding. Our Trust Associate Chief Nurse has an active Safeguarding leadership role. Our Trust Safeguarding Strategic Board, chaired by our Executive Safeguarding Lead, has been reviewed and is now an integrated board, combining safeguarding of Adults at Risk, Domestic Abuse pathway and Safeguarding Children. There is representation from all key Trust stakeholders involved in Safeguarding. Our Trust Safeguarding Board has responsibility for implementation of Trust Safeguarding Adults at Risk policy and our Trust's annual Safeguarding improvement plan, including Trust Dementia Care Strategy, Learning Disability Care Strategy and Mental Capacity Act/Deprivation of Liberty Safeguards annual improvement plan. Safeguarding activity and outcomes are reported to our Trust Quality Performance and Quality Committee, to Trust Main Board and to GSAB. Safeguarding is also reflected in our Trust Health and Wellbeing Strategy.

Our Key Achievements 2017/2018

- Delivering the best care for everyone and promoting positive patient and carer experience is core for our Trust and all our staff. Outstanding care for all our patients is our vision.
- We are committed to safeguarding those in our care. Safeguarding it is a fundamental part of the role of all staff. It is an essential, underpinning principle of all professional codes of practice.
- We are committed to openness and honesty, and to listening and to learning from experience. This includes the rapid implementation of improvement actions and of the learning based on data reporting, trend monitoring and case reviews.
- We continue to learn from feedback and to taking action to further improve care experience for our patients who have a learning Disability and for our patients living with Dementia.
- We work together with all our partners to support safeguarding. We are making further improvements to our safeguarding pathway to strengthen our participation as part of making safeguarding personal and to working with our patients, their Carers and families. We work particularly closely with Gloucestershire's Safeguarding Adult Unit and Hospital Adult Social Care Teams.
- Our Trust Safeguarding Adults at Risk Advisory Team provides real time support and guidance for all Trust staff. This includes guidance and resources to support best practice application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). A new Safeguarding Adult's at Risk Advisory Sister joined our team in April 2018, extending our team to three members of staff. A key part of this new role is direct support for teams in practice and a key outcome is to further improve safeguarding response actions and application of the Mental Capacity Act in practice.
- Trust Safeguarding Adults at Risk Advisory Team deliver training Trust wide, have a responsibility to develop, implement and review Trust policy and process. We have developed and implemented resources to support staff to fulfil their safeguarding roles in practice. We have a bespoke Trust Safeguarding Intranet webpage for our staff. We are continuously working to make improvements and to learning from feedback.
- We have implemented a Trust DoLS checklist, this is used by our teams to assess patient care needs to determine if a DoLS need is triggered. Also a guide to help staff to complete the DoLS application form has been implemented.
- A Trust bespoke capacity assessment sticker, flow chart and pocket prompt guidance is being pilot tested in practice. This will be evaluated and the pilot testing extended. It is anticipated that this will be implemented Trust wide.
- Safeguarding training is mandatory for all Trust staff. We actively promote training and target training to specific groups of our staff, so as to best promote safeguarding in action.
- We have implemented Trust specific actions to support GSAB Fire Safety and Prevention Sub–Committee's annual plan. Home fire safety and safeguarding is a core part of our level 2 Safeguarding Adults at Risk training. We have supported the pilot testing and the evaluation in practice of the multi - agency home fire safety and safeguarding risk assessment document.

- We are a core partner in the development of Gloucestershire's Multi-agency Safeguarding Adults at Risk and Pressure Ulcer Policy. We have implemented a Trust specific clinical practice guide to support our teams.
- Our Trust is working in partnership with our core partners in best supporting patients presenting with risk and safety factors. We are strengthening our pathway in collaboration with 2getherNHSFT and Gloucestershire Constabulary.
- Our Trust public Safeguarding Internet webpage has been further improved. www.gloshospitals.nhs.uk/your-visit/staying-us/keeping-you-safe/

Our Key Objectives 2018/2019

- To continue to work in partnership with GSAB to safeguard adults at risk, with care and support needs, within our Hospitals, our community and as part of Gloucestershire's Safeguarding Adult annual plan.
- To continue to proactively support the work of GSAB sub-committees and to work with all our partners in support of Gloucestershire's Multi-agency Safeguarding Adults at Risk Policy and Procedures.
- To continue integrated working across all safeguarding pathways. Working together in support of safeguarding of Adults at Risk (under the Care Act), Domestic Abuse pathway and Safeguarding Children and Young People pathway.
- To be proactive partners in support of safeguarding and transition planning.
- To implement the recommendations from GSAB Safeguarding Adult Reviews.
- A review is planned of the multi-agency discharge policy to further support improved communications.
- For Trust Safeguarding Adults at Risk Advisory Team, to continue to proactively support all our teams in practice in achieving their safeguarding role and responsibilities and to monitoring, reporting and to improving outcomes.
- Delivering the best care for everyone, promoting positive patient and Carer experience and outstanding care for all our patients.

Lynne McEwan-Berry
Senior Sister Safeguarding Adults at Risk Advisory Team
Gloucestershire Hospitals NHS Foundation Trust

Jon Burford
Associate Chief Nurse
Gloucestershire Hospitals NHS Foundation Trust

Steve Hams
Chief Nurse
Gloucestershire Hospitals NHS Foundation Trust

This is for the updated GSAB Annual Report 2017/18 which is not yet published by GSAB. This is the last GSAB published Annual Report. Gloucestershire Safeguarding Adults Board Annual Report 2016/17 (PDF, 2.9 MB)

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

Report Title
Safeguarding Children Annual Report **April 2017 – March 2018**
Sponsor and Author(s)
Author: Dr Sara Motion, Named Doctor for Safeguarding Children Consultancy: Vivienne Mortimore, Named Nurse for Safeguarding Children Administrative Support: Lisa Prior-Cox, Safeguarding Admin Coordinator Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

This report is made to the Trust Board to assure members that the Trust arrangements are in place to safeguard children, that mandatory training is being delivered and that staff are supported in the challenging role of safeguarding children within the Trust. It will demonstrate the process for monitoring the effectiveness of all of the above, based on local and national standards.

The report provides an update on activity, performance and monitoring relating to the safeguarding of children as required in the Children Act (2004) and Working Together to safeguard children (2015) [updated in July 2018].

The annual report also evidences the extensive partnership working in support of safeguarding activity and the key role we play in protecting children in our care and the wider community. Safeguarding activity and assurance is delivered through the quarterly safeguarding operational group and refreshed Trust Safeguarding Strategy Group which will meet every other month.

Key issues to note

Please see report.

Section 2 – Progress from work plan of 2017-18 and additional achievements
Section 3 – Safeguarding activity and progress
Section 4 - Current challenges in the work of safeguarding children
Section 5 – Work plan for 2018-2019

Safeguarding children is cross divisional and organisational clinical activity (in both unscheduled and scheduled care), in all service areas where hospital professionals support children and their parents.

Current data shows evidence of 10-15% of hospital attendances required staff to consider and assess the welfare/safeguarding component of the child or parents care. The information flow between the different departments within the hospital, and from the hospital out to key staff who safeguard children is currently insufficient to safeguard effectively, and would benefit from being prioritised on the workflow of the electronic patient record.

The clinical work in relation to safeguarding children requires strategic support with agreement on the data-set relevant to the hospital safeguarding children's Dashboard, with corresponding administrative support to deliver this. An auditing and governance process for safeguarding children would be of benefit to evidence the quality of practice, but this requires additional clinical and administrative time.

Recommendations
The Board is asked to note the annual report and note the 2018/19 development plan.
Impact Upon Strategic Objectives
Safeguarding is linked to each of the strategic objectives, and therefore is integrated within our strategic and operational delivery.
Impact Upon Corporate Risks
The principle risk associated with safeguarding children is C1374NSafe [Failure to recognise and respond appropriately to indicators of concern], this currently has a scoring of eight (8) and is held on the Women's and Children's Divisional Risk Register.
Regulatory and/or Legal Implications
There are regulatory requirements to have sufficient and robust procedures place to effectively identify, and escalate safeguarding concerns, most notably the Care Quality Commission Regulation 13, safeguarding service users from abuse and improper treatment.
Equality & Patient Impact
Appropriate safeguarding of children ensures that patients have a positive experience of health services and they are appropriately protected.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
July 2018						Trust Safeguarding Strategic Board 4th June 2018
Outcome of discussion when presented to previous Committees						

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Safeguarding Children Annual Report 2017/18

SAFEGUARDING CHILDREN ANNUAL REPORT
2017/2018

1. INTRODUCTION

1.1 This report is made to provide assurance that the mechanisms and processes are in place to ensure we are effectively discharging our duty to protect children and support staff in the challenging role of safeguarding children within the Trust. It will demonstrate the process for monitoring the effectiveness of all of the above, based on local and national standards.

1.2 The Named Nurse/Midwife for Safeguarding Children, Vivien Mortimore, and Named Doctor, Dr Sara Motion
Paediatric Consultant have worked together collaboratively and led the Trusts children's safeguarding agenda for 6+ years, working effectively with partners from wide range of agencies.

1.3 Safeguarding children and child protection encompasses the care provided to all children admitted and assessed by the Trust staff regardless of setting. Professionals focus on the wellbeing of the child to ensure that Children and families receive a safe, caring, and efficient service in line with the Trust's mission statement.

1.4 The safeguarding work is monitored by the hospital's safeguarding strategic and operational groups, each of which meets quarterly.

2. PROGRESS FROM WORK PLAN OF 2017-18 AND ADDITIONAL ACHIEVEMENTS

- Prioritising 'Early Help' and early identification of child needs, continues to lead operational activity, building focus on early support of the child and parent/carers.

- The progress in staff recognition of the vulnerability factors affecting children, and the communication of these, is clearly evidenced by the numbers of times that the midwives complete the infant vulnerability screening tool, and by the number of notifications of safeguarding specific concerns that arise from the emergency department.

- The Children's Safeguarding Named Doctor and Named Nurse have contributed to the GSCB (Gloucestershire Safeguarding Children Board) Board Improvement Plan as a partner agency (Appendix I). The Improvement Plan is the multi-agency support response to assist with progress for the GSCB following the Ofsted Inspection of GSCB Spring 2018 where the rating of GSCB was inadequate.

- Children legally supported with Child Protection Plans are identified to Clinical staff on Trak, using the Alert Symbol process. This is effective and helps staff highlight children at specific risk. Trust investment is now needed to develop the same process for 'Children in Care', who are nationally recognised to be a similar priority group.

- A second staff member has been recruited to the safeguarding administrative support team this year, which has facilitated support for the antenatal pathway, vulnerable pregnancies, and newborns with specific risk, building the opportunity to provide support for children at the earliest opportunity

- The screening point for factors which increase infant vulnerability on the antenatal pathway is now fairly established at booking. A second screening point for infant vulnerability around the time of birth has been agreed and will be implemented alongside the work of the 'Better Births' programme.

- A children's (0-18) dashboard has been developed, to support the analysis of children's safeguarding activity, and assist the Board with review of this area of work.

- There is ongoing work to connect with the National electronic alert system for unscheduled care (Child Protection Information System CPIS) (see challenges/work plan 2018). We continue to work with Partners in Social Care, to facilitate access for Trust staff to the Child Protection Information System which will provide information on specific groups of children those Children in Care, Children on Child Protection Plans and Unborn Children at risk.

- The Gloucestershire Health and Wellbeing Board are prioritising the early recognition of children who need additional support using the 'ACE's informed approached'. (ACE = Adverse Childhood Experience
  Trust Champions for ACEs are the Named Doctor and Named Nurse for Safeguarding, and the principles of this approach to recognising vulnerability and additional need, are now embedded in training for frontline staff.

2.2 Continuing development of safeguarding processes and pathways

- The communication pathway from the Emergency Department to the Public Health Nurse Team (specifically Health Visiting) has been re-reviewed following changes initiated by Gloucestershire Care Services Trust. Progress is ongoing, and has exemplified the importance, and the difficulties in delivering important communication between the different health Trusts in the County.

- A 0.8 whole time equivalent specialist nurse post for safeguarding children was agreed, with the appointment of 2 part-time specialist nurses in effect from February 2018. The benefits in supporting staff with delivering more effective safeguarding practice together with the supervision and training of ward and Specialist Nursing staff are already evident.

- There has been continued development of the safeguarding children's intranet webpages, giving staff ready access to the resources and pathways to promote children's safety and wellbeing. The website receives a lot of positive feedback from frontline clinical staff.

- Maternity and neonatal safeguarding databases have been developed to provide improved managerial oversight of safeguarding activity relating to the unborn and newborn infants.

- GHNHSFT Named Doctor has co-written the multi-agency document on assessment of children at risk of significant harm/at section 47 threshold (Joint Section 47 Enquiry Protocol)

.3 Training and professional development

- The training department is always responsive to operational development and change. In particular, the delivery of Level 3 safeguarding is complex, and requires persistent

reminders for key staff.

- Level 1 Safeguarding Children Awareness training was relaunched earlier in the year and all staff have been asked to recomplete, as at March 2018 65% of staff had completed Level 1. Safeguarding Children Level 2 completion figures continue above the target threshold level of 90% completion.

- There has been continued delivery of the Level 3 Inter-agency training, monthly on the hospital site. This has improved the accessibility of this training for staff, and reduced expenditure for the Trust.

- The key practice points associated with learning from the serious case reviews have been used to develop annual training, currently delivered to frontline staff.

- The Safeguarding Children Policy continues to be updated to reflect changes in practice and legislation e.g. FGM, Early Help etc.

.4 Governance and audit

- Peer Review with the Bristol Safeguarding Children's Team in 2017, has contributed to ongoing operational developments.

- The safeguarding children structure has been reviewed and updated and the organisational chart developed and shared internally, and with partner agencies to improve understanding of the Trusts organisational arrangements and access to advice and support. (Appendix IV)

- Learning for Trust staff is lifted from the analysis of ACI's, complaints, serious case reviews, clinical audit, and where relevant child deaths.

- November 2017, we completed an in-depth audit of infant attendances to GHNHSFT, with analysis of the attendances including significant injury (skull and limb fractures and significant head injuries in children under 12 months).

  This has led to a change of practice, with inpatient review by paediatric consultant for all children experiencing injuries under the age of 6 months.

- The self-audit of compliance (Section 11 audit GSCB) is submitted annually to the Gloucestershire Safeguarding Children Board. This year the audit was subject to peer review for check and challenge with regard to the evidence sited for compliance against the criteria.

2.5 Additional work

- There is a commitment to partnership working to safeguard and this is evidenced by the attendance of Trust staff at a variety of sub groups and work streams, co-ordinated by the GSCB (Gloucestershire Safeguarding Children's Board). Relevant work streams are fed into the safeguarding operational and strategic group meetings.

2.6 Transition and CYP with Disabilities and Additional Needs

- The Trust has delivered medical reports on 1,081 CYP with Additional Needs and Disabilities in the last year.
-

  In March 2018, the Local Authority specifically recognised the achievement of GHT in meeting the time deadline targets for these legal multiagency plans for children with Additional Needs and Disabilities.

  Data analysis demonstrates that around 40% of this group of children have considerable adverse social experience in the background and in the evolution of their learning, social, and emotional additional needs. This is strong further evidence that focus on early help for families and children needs to be at the centre of our practice.

2.7 Specific and unpredicted Challenges which have impacted on progress

- There were changes to the role of the Specialist Nurse/Health Visitor (who is a GCS Nurse), which impacted on the safeguarding work from ED, from January 2018. GCS changed the working practice of the Safeguarding Specialist HV initially without a mutually agreed transition plan, leading to potential increased risk for the attending

children. Developing an alternate pathway of care has taken operational time from other work stream.

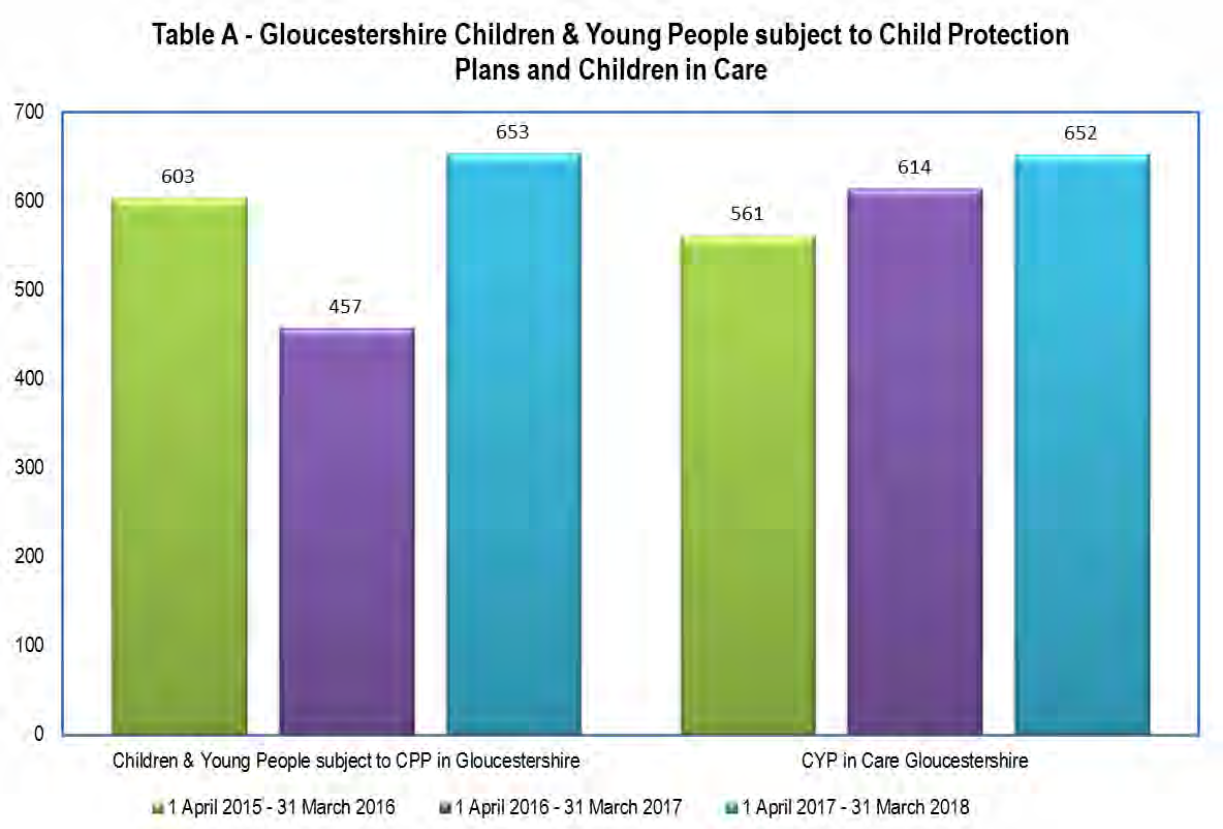
- Changes to the 'referrals to Children's Social Care' (MARF) process was triggered by Social Care, and has impacted on GHT staff, as the process of written referral takes longer, and there are still teething problems.

- The GSCB has commissioned 2 separate Serious Case Reviews (SCR's), involving multiple children.

- Given that previously, SCR's have studied on average 1-2 children/annum, the current commissioned reviews, involving 15 children, is asking for potentially unprecedented staff time.

3. SAFEGUARDING ACTIVITY AND PROGRESS

3.1 Three year comparison of clinical activity safeguarding children for years ending March 2016, 2017 & 2018.



*Please note that this data is for Community Paediatrics only it does reflect Child Protection Medical Assessments carried out during 'Out of Hours' by Acute Paediatrics

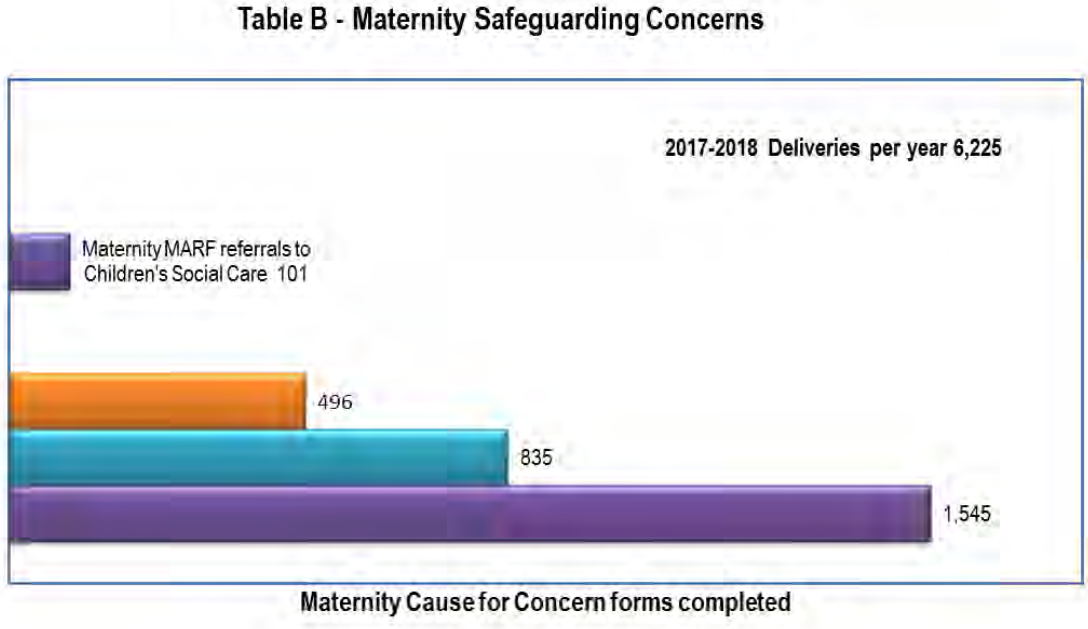


Table E - ED attendances 0-18yrs with Deliberate Self Harm (DSH)

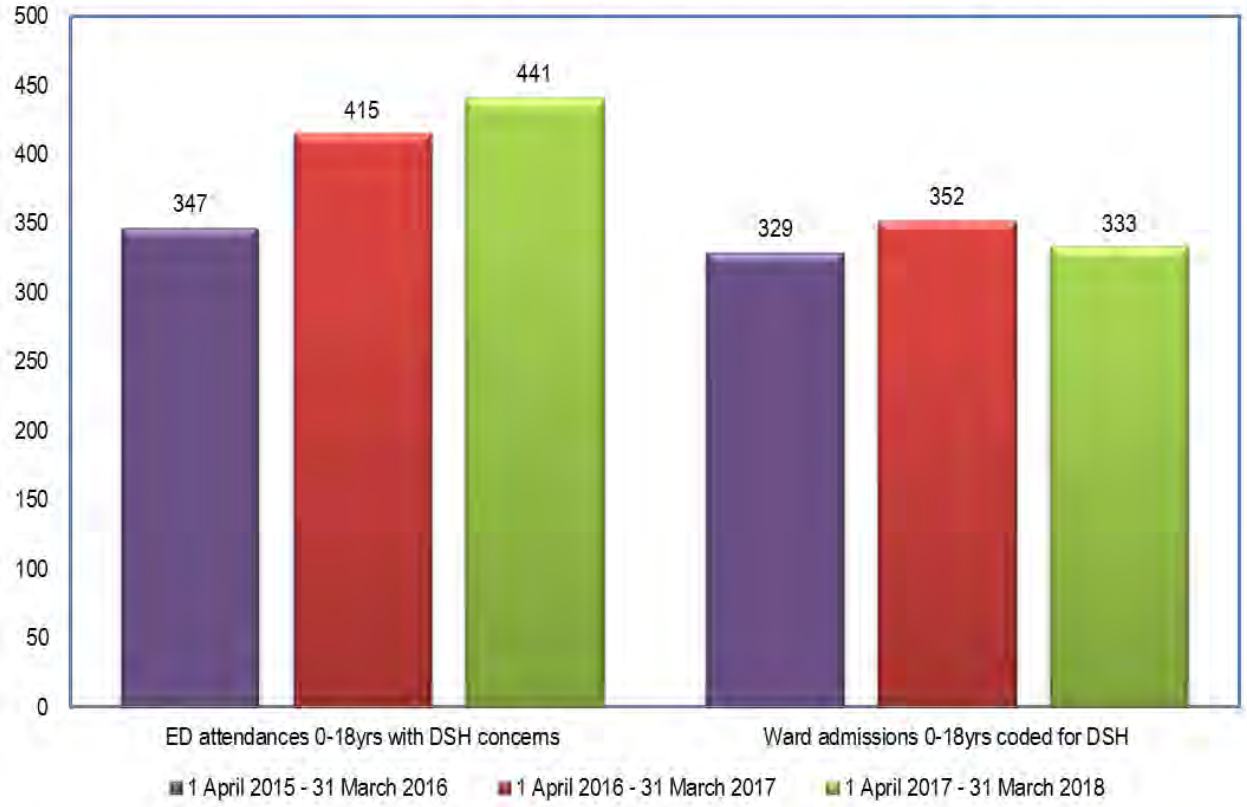
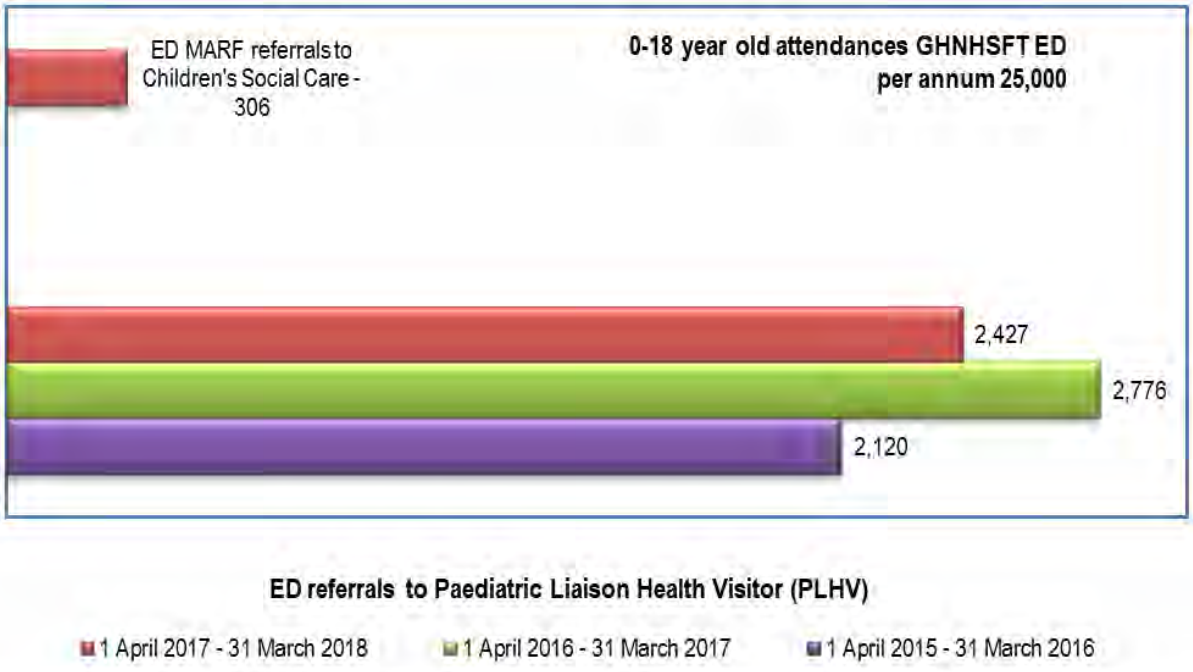


Table D - ED attendances with highlighted welfare concern



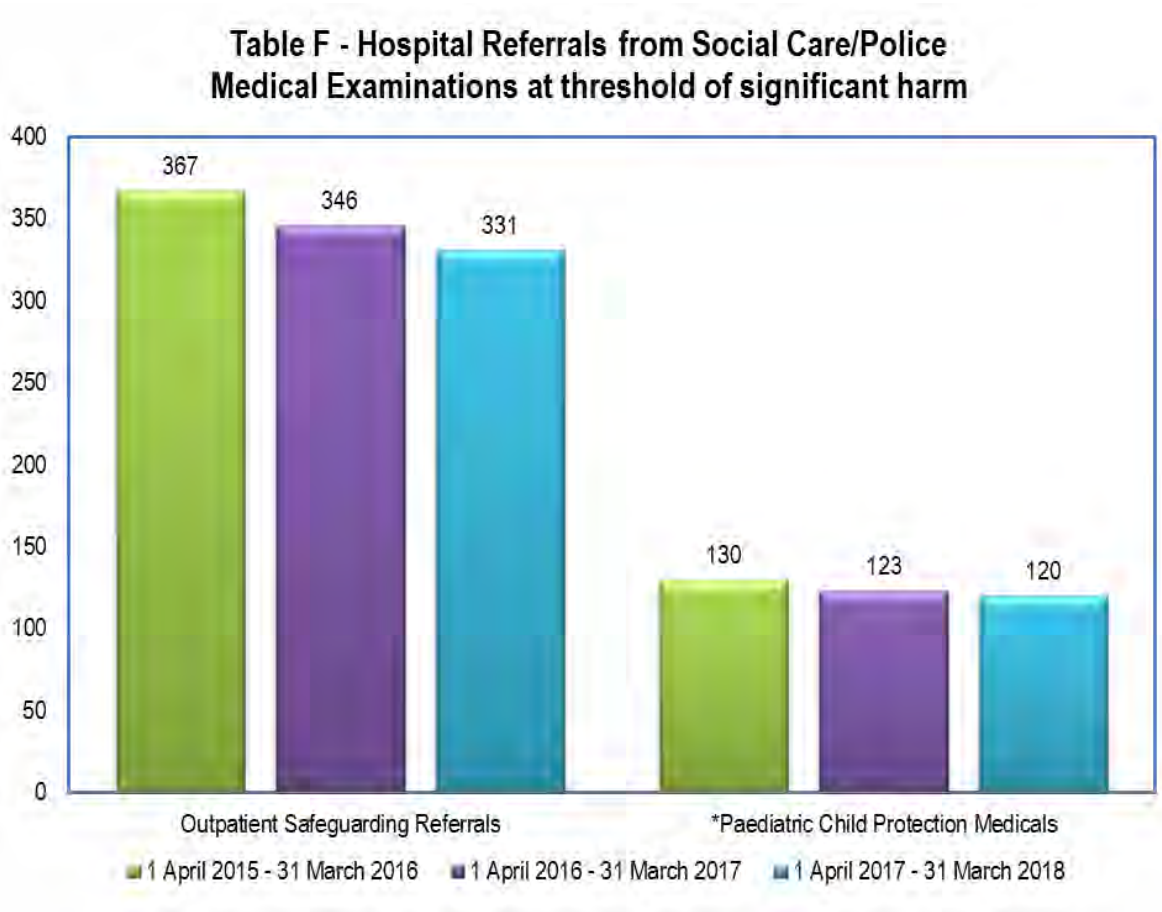
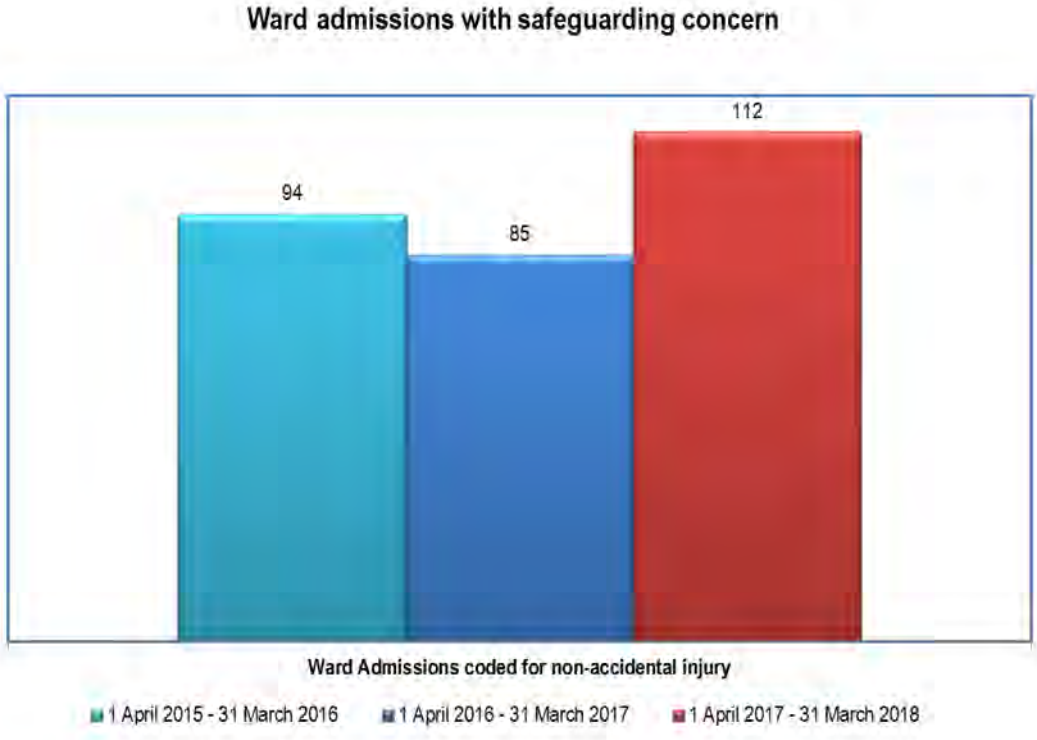


Table F - Hospital Referrals from Social Care/Police
Medical Examinations at threshold of significant harm
400
350
300
250
200
150
100
50
0
367
346
331
130
123
120
Outpatient Safeguarding Referrals
*Paediatric Child Protection Medicals
1 April 2015 - 31 March 2016
1 April 2016 - 31 March 2017
1 April 2017 - 31 March 2018


Ward admissions with safeguarding concern
94
85
112
Ward Admissions coded for non-accidental injury
1 April 2015 - 31 March 2016
1 April 2016 - 31 March 2017
1 April 2017 - 31 March 2018

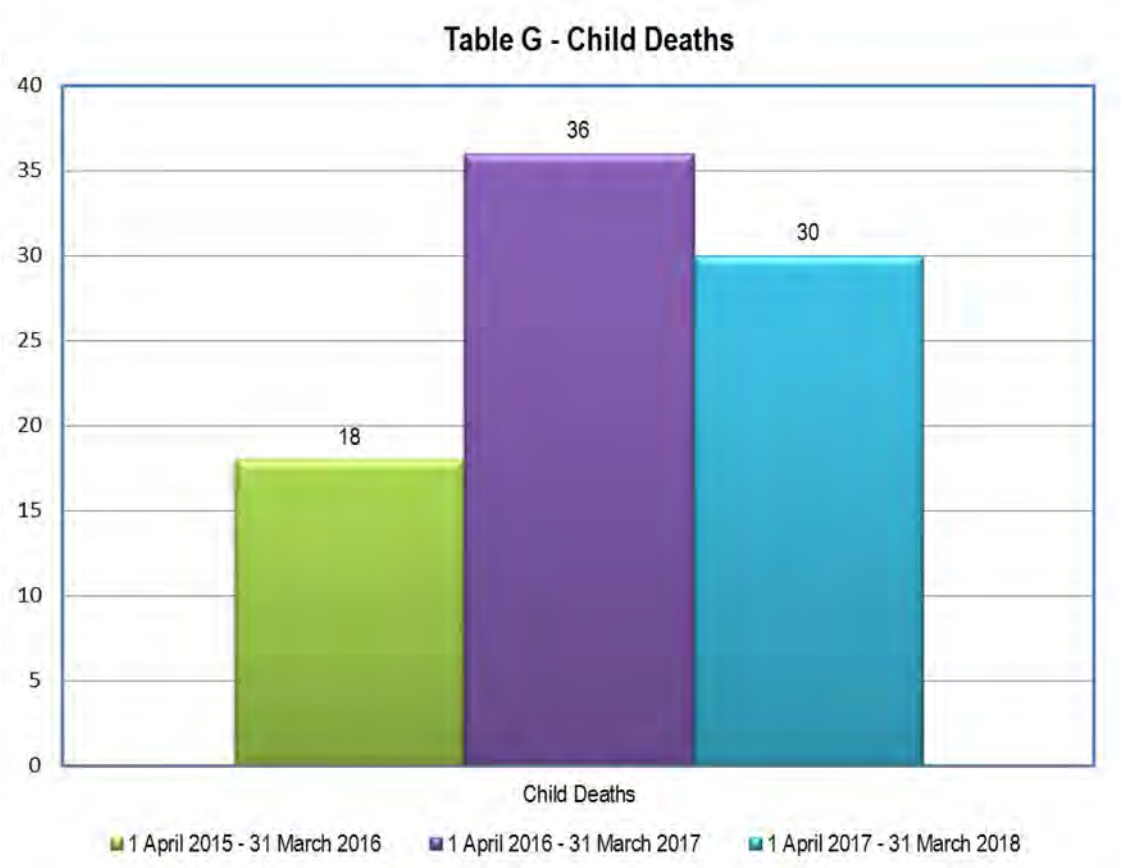


Table G - Child Deaths
40
35
30
25
20
15
10
5
0
18
36
30
Child Deaths
1 April 2015 - 31 March 2016
1 April 2016 - 31 March 2017
1 April 2017 - 31 March 2018

3.2 Key messages in relation to safeguarding clinical activity

- Table A – **The number of children on Child Protection Plans** has increased, with a corresponding rise in the number of children and young people in Care. Over 3 years, there is an 8% increase in children on CP plans, and a 20 %increase in children placed 'in Care'.

  This data reflects some changes in policy/practice across children's services, with children and young people placed in care earlier in their life pathways .It does evidence the increased workload for administrative and clinical staff.

- Table B – **Maternity notification of welfare concerns impacting on the unborn**

  The Maternity Team have worked hard to embed within antenatal care, the screening for infant vulnerability risk factors (relating specifically to the unborn child), and complete the maternity '*cause for concern' form*

  The table shows that practice development over the last 3 years has significantly heightened awareness in midwifery led practice. Hopefully, facilitating *early support* and *early intervention* can impact positively on long-term infant and child wellbeing.

  The observation that Social Concerns forms were identified in approximately 25% of pregnancies is a worrying statistic , to be shared with Commissioning and Public Health teams.

  Maternity referrals for the unborn child to Social Care have been recorded more accurately over the last year, as a result of increased administrative support.
  101 Social Care referrals in 1 year reflects that in 1.5% of pregnancies the midwife identifies risk factors in the pregnancy that indicate the potential of significant harm to the unborn infant.

- Table C - **Safeguarding activity on SCBU (Special Care Baby Unit)**

  In the last year, vulnerability screening on newborn infants has been further developed.

- Table D – **Emergency Department attendance with highlighted welfare concern**

  This is the route by which ED clinical staff highlight that the unscheduled attendance may, or does indicate child welfare risk factors.

  The data for the previous 2 years included the welfare concerns identified in the MIUs, as well as the GHT (as the data was collected together).

  This year we have switched to only reporting the GHT data, as this data is collected manually (hence next year it will be possible to compare year on year activity).

  Information sharing is very essential in building a picture of understanding around a child's welfare. The professionals outside GHT benefit from GHT staff sharing their concerns and observations.

  In addition to highlighting these concerns with health staff in partner Trusts, ED staff also

submit referrals to Social Care where the attendance of the child or parent (e.g. parental drug or alcohol intoxication or attempted suicide), signals staff concern that a child may be at risk, or experiencing *Significant Harm.*

The number of Social Care referrals from ED at 306, represents just over 1% of Emergency Department attendances by children and parents, and is likely to be an underrepresentation of the significant concerns, as collecting this data is difficult, and uses manual methods.

- Table E – **Attendances unscheduled care for 0-18yrs with self-harm.**

  The last 3 years show a year on year increase in these attendances. There has been a 25% increase in those under 18 years presenting through ED, with Deliberate Self Harm. The 16 and 17 yr olds represent approximately 23% of the total, and there are potential difficulties with this age group, as their needs are still assessed in line with Children's legislation, although they may be admitted to adult areas of the hospital.

  The pathway of care for children under the age of 16 includes in-patient admission to the paediatric ward, and joint assessment from the mental health team.

  Due to the worrying increase in numbers of hospital attendances for self-harm, there is currently a Multi-disciplinary Working Group, co-ordinated by the Local Authority and Gloucestershire Public Health.

- Table F – **Hospital referrals from Social Care/Police**

  These are the medical examinations at the agreed threshold of significant harm (section 47), which are unscheduled care referrals, usually agreed to be necessary, by Social Care. The number of contacts from Social Care and Police appears to be slightly less than the last calendar year, but the number of medical assessments, (which often require reports for the legal pathway) stays fairly constant. This data is recorded manually and likely to lack accuracy.

- Table G – Child deaths

3.3 Activity not currently accurately captured at present time

The following work is not formally reported upon.

It is hoped that going forwards this activity can be mapped using the Trak care system and through development of a Safeguarding Children data base. This will enable the data to be presented in a Dash board format to provide greater managerial over sight of this activity, professional response and the outcomes for children.
The work described below takes staff a large volume of clinical time, and does need to be quantified.

- Requests for attendance of Trust staff at multi-agency safeguarding meetings including strategy meetings, case conferences and court hearings
- Reports submitted to any of the above
- Attendance at any of the above meetings
- Clinical activity for CIC (Children in Care)
- Legal reports ,reports requested by County Legal Services and Police
- Trust wide numbers of referrals ('requests for service') made to children's social care, together
  with the outcome of the request
- Detailed attendance activity for children who are on child protection plans
- The number of children presenting to the trust where there is FGM, CSE, Domestic abuse/teenage relationship abuse, slavery and trafficking
- Escalation of concerns to partner agencies

4. CURRENT CHALLENGES IN THE WORK OF SAFEGUARDING CHILDREN

4.1 The electronic patient record

- Information involving risk assessments of parents and children continues to be accommodated on different databases, and not readily accessible to frontline clinical staff. This is a clinical risk.
- Whilst it is acknowledged how useful for the frontline Clinician to be able to read Emergency Department attendance information (scanned on to Trak), there is equally valuable information held on different clinical systems; (e.g. midwife clinical record/infant vulnerability screening process; Paediatric clinical work areas both scheduled and unscheduled; work in other services supporting children; and then when the young person passes their 16th birthday, information is stored in adult areas).This means that linking vital information is not efficient currently.

- At implementation of Trak, there was loss of a significant functionality, with the loss of the ability to inform the Health Visitor electronically, about the child's attendance (unscheduled or scheduled).

  In March 2018, it finally became possible for limited information on unscheduled attendances (using patient identifier and reason for attendance, no other clinical detail) to be transitioned to the Community Health Professional, the Health Visitor (Public Health Nurse) via 'the data warehouse'.

  This information transferred does not include the more targeted information of concern highlighted by the assessing Clinician, which is currently transitioned using a process where forms are scanned and emailed from the Emergency Department. This system currently carries risk, and there is no guarantee that all the relevant information is transitioned.

- Documents which reflect that a child is supported at a legal threshold level should be available to frontline Clinical staff on Trak. Examples of these documents include:-

  - Minutes and plans from child protection meetings (Child Protection Strategy meetings and Case Conferences);
  - Documents relating to a child placed in Care or with a Special Guardianship arrangement;
  - Documents that outline the plan of support and care for children with additional needs and disabilities.
  - Children in Care should be clearly visible to the attending Clinician, ideally by means of an Alert symbol, with information about the child's Social Worker, to develop this process, needs further administrative resource.

- Children who do not attend their scheduled appointment. This is better understood as '*children are not brought to their appointment by the responsible parent/carer.'*

  Prior to the implementation of Trak, there was a clear process, reminding Clinicians to consider whether a non-attendance represented a safeguarding risk or issue, with purpose built template letters sent to the child's GP.

  Trak has been in place now for 18 months, and despite assurance that there would be an outcome available to Clinicians to remind them that non-attendance may reflect a welfare

concern. Despite assurance, to date the relevant outcome is not as yet included in the Outpatient Outcome process.

4.2 Issues related to children who present to the Hospital Trust with emotional and mental health concerns

- Service planning needs to focus on ensuring that the safeguarding needs for this group of children and young people are evaluated and communicated using a close working partnership with commissioners and public health and CAHMS (child & adolescent mental health services) to drive forward developments and inform the transformation plan.

- There is additional need to ensure that children and young people access mental health services appropriate to their needs (appropriate in-patient placements) and diversion from the Acute Trust when indicated.

- Children and young people (CYP) requiring mental health admissions continue to be hospitalised far from their homes and local communities, which is not always in the best interest of the child or family.

5. WORK PLAN FOR 2018-19

5.1 The following are highlighted as needing to be planned in to the work stream for the forthcoming year:-

- Piloting and using the safeguarding children dashboard; progressing to developing KPIs (Key Performance Indicators) for children's safeguarding activity.

- Writing, participating and completing the current Serious Case Reviews commissioned from GSCB.
  Two current different Serious Case Reviews are commissioned:-

    - Family with 4 children experiencing intergenerational neglect and sexual abuse; (these case reviews take a large amount of professional time)

    - 11 child case review, recently commissioned from Police and Social Care

- To ensure that the single agency actions in response to the most recent serious case review (William who died of physical harm /submersion in water at age 3 months), & shortly to be published, are embedded in staff learning.

- Undertake audits relating to the Serious Case Reviews of previous 2 years.

- Pilot a process where all infants experiencing significant injury in the first 6 months of life (head injury or fracture) are admitted for full, standardised inter-agency welfare assessment at section 47 threshold.

- To develop a process to monitor the quality of referrals to Children's Social Care.

- Develop and embed a process for access to hospital health information to be shared when 'time critical acute welfare assessment' is needed by the Multi-Agency Safeguarding Hub (MASH).

- Develop a process to monitor staff compliance with requests for information at the key legal decision making points for children i.e. the children's multi-agency strategy meeting, and child protection conference.

- To develop and pilot a pathway for the inter-agency assessment/information sharing for situations where 'Fabricated
  Induced Illness' is the area of professional concern.

- To continue work to introduce and fully embed the Child Protection Information sharing system (CP-IS) into unscheduled care areas namely ED, Paediatric Assessment Unit and Maternity.

- Contribute to the GSCB improvement plan.

- Review safeguarding processes for children attending the Emergency Department under 1 year of age.

- Carry out a full review of current safeguarding children policy.

- Review arrangements for communication with the MASH and Public Health Nurses Team in Primary Care.

Authors: **Dr Sara Motion, Named Doctor for Child Protection**

Vivien Mortimore, Named Nurse for Child Protection

Lisa Prior-Cox Safeguarding Children Co-ordinator

Date: **April 2018**

Notes:

Attached documents

- Appendix I - GSCB Improvement Plan GHNHSFT Response
- Appendix II - Following safeguarding Audit 2017 – Identified Good Practice Points
- Appendix III - GHNHSFT action plan for Serious Case Reviews
- Appendix IV - Trust Organisational Structure
- Appendix V - Clinical activity safeguarding children 2017/2018

Gloucestershire Safeguarding Children Board – Task and Finish Group Proposal

Development of a GSCB Improvement Plan – delivering improvements to frontline practice

Why

The recent Ofsted review of the Gloucestershire Safeguarding Children Board alongside the inspection of Local Authority services for children in need of help and protection, children looked after and care leavers concluded that the GSCB requires improvement to be good. At the same time, the review of the Local Authority highlighted serious failings in services for children in need of help and protection. The report of the recent HMIC inspection of the management of child protection responses by Gloucestershire Police was sharply critical of the quality and timeliness of some of the constabulary's responses to children who had suffered abuse and/or neglect. Many of the urgent areas for required improvement identified are partnership issues and the GSCB must now use the findings of the rigorous and independent scrutiny that Ofsted and HMIC have provided to focus on key areas where we urgently need to influence improvement to frontline practice.

An Improvement Board is being put into place that will hold the Local Authority to account for driving forward the recommendations made in the Ofsted report. It has been agreed that all multi-agency elements will be driven forward by the GSCB and the Chair of the GSCB, on behalf of all member organisations, will be held to account by the Improvement Board. The GSCB needs to have a clear plan in place to identify the immediate areas of focus, the actions that need to be taken and the timescales for change. The Task and Finish Group will lead on this work.

Membership

The Task and Finish Group needs to involve key statutory partners both at a strategic and operational level. There must also be opportunities for Executive Committee members to inform the development of the agreed improvement activity, and due to the timescales involved this will be done virtually.

Core membership of the Task and Finish Group will comprise of:

Name	Role/Organisation
Dave McCallum (Chair)	GSCB Independent Chair
Alison Croft	GSCB Business Manager
Cathy Griffiths	Head of Quality
Deborah Barlow	Interim Deputy Improvement Director, Children's Social Care
Isobel Dougan	GSCB Training Coordinator
Sarah Holtom/Rob Tyrrell/Vicki Butler (representative to be nominated)	Principal Social Worker, Children's Social Care
Annette Blackstock/Marie Crofts/Sue Field/Vivien Mortimore (representative to be nominated)	Health – either CCG, GCS, 2gether or GHNHSFT
Jane Bee	Education Settings
Simon Atkinson or representative	Gloucestershire Police
Eugene O'Kane	Early Help
Shelagh Woodhouse	GSCB Lay Member
	Operational representatives put forward by each of the above statutory organisations

Accountability

The Gloucestershire Safeguarding Children Board Executive Committee. The delivery of the agreed plan of improvement activity will be held to account by the GCC Improvement Board.

Frequency of Meetings

This will be a very short-term Task and Finish Group (maximum 4 weeks) to develop a clear plan of the immediate improvement activity to be undertaken by Gloucestershire Safeguarding Children Board. One actual planning meeting will take place, with the remaining work being coordinated by the GSCB Business Manager and undertaken virtually/electronically.

Role and Function

The role of the Task and Finish Group will be to develop a proposed plan of improvement activity, for agreement by the GSCB initially and then by the GCC Improvement Board.

Actions for Progression	Context	Expected Impact/Outcome	Lead	Evidence of Progress
Ofsted Recommendation, Paragraph 111 – Strengthen the range of performance information provided to the board to include relevant information from all partners and ensure that evaluative commentary is provided to improve services (Links to GSCB Business Plan outcome *"children and young people are safeguarded through improved analysis of data, intelligence and quality assurance to better understand a range of issues. This leads to an improvement in risk identification and provision of appropriate support services to meet local need".*)				
1.1 Review and update the GSCB performance framework to include greater focus on outcomes for children and young people and evidence of impact (GSCB Business Plan action) Specifically: 1) All GSCB members will identify the key performance indicators that will provide them with internal assurance that their organisation is informed about the quality of their responses to safeguard children and ensure that they are accurately collated, evaluated and reported to GSCB with appropriate regularity (By end of September) 2) The GSCB Business Unit will produce and publish a performance report, which includes information provided by all member organisations and locality level data to support multi-agency work between practitioners (quarterly) 3) GSCB Chair will escalate any examples of member organisations reporting an inability to report necessary performance information (quarterly)	Ofsted identified that we need to strengthen the range of performance information provided to the board to include relevant information from all partners and ensure that evaluative commentary is provided to improve services. The current framework prevents opportunities for challenge to partner agencies when practice is poor.	GSCB members have strengthened its range of performance indicators, ensuring the story behind the data is captured, then evidenced how it quickly identifies areas for further scrutiny where assurance of good practice and timely outcomes for children is required. GSCB members can evidence internal or partnership challenge where poor practice has been escalated and addressed	MAQuA VM/SM	<u>GHT</u> Quality dashboard is being developed. Administrative lead has been recruited. Development of this reporting will progress over next 12 months. Draft of final dataset ready for review September 2017

Actions for Progression	Context	Expected Impact/Outcome	Lead	Evidence of Progress
111.2 Improve the way in which customer feedback informs the work of the GSCB, not just from children's social care but across all partner organisations Specifically: 1) All GSCB members to examine how the feedback from children and families can most effectively inform their internal QA processes, decide what action they need to take in relation to this and report their decisions to GSCB (By end of September) 2) GSCB has updated its QA framework to embed the use of feedback when data and audits are being analysed and recommendations for action being made (By end of October) 3) GSCB to examine how to most effectively collect and analyse feedback from children in relation to their experiences of multi-agency child protection processes, particularly CP conferences (By end of October)	Having a well-informed understanding of the experiences of children at the receiving end of professional service delivery is key to the ability of GSCB member organisations to develop and improve those services	GSCB will have built on its' recognised strengths in including the voice of the children in its work (Ambassadors, online pupil survey) by having embedded the participation of children and families in auditing activity. GSCB understands children and families' experience of the safeguarding system, including the CP process in ways that have informed action and impact	MAQuA JH	To develop a questionnaire that we can use after child protection examinations for child/parent December 2014

Actions for Progression	Context	Expected Impact/Outcome	Lead	Evidence of Progress
111.3 Each organisation to develop an internal quality assurance framework to robustly inform them of the quality of the safeguarding activity of their staff and to be held to account for the delivery and analysis of the information by the GSCB (By end of September)	The evidence from the recent inspections suggests that GSCB member organisations are not sufficiently aware of the quality of their practice in safeguarding children. Therefore, they are unsighted in relation to any need for improvement action	Individual GSCB members will have secured evidence that they fully understand the quality and impact of their practice in safeguarding children. All GSCB members will be sufficiently equipped to celebrate each other's good practice or to raise effective challenge, where a partner/number of partners need to evidence swift remedial action and impact All GSCB members are working to explicit quality measures for safeguarding relevant to their setting, reported to the GSCB for multi-agency analysis and action where needed	MAQuA	
Ofsted Recommendation, Paragraph 112 – Embed the multi-agency audit programme in order for the board to have greater assurance of the quality of frontline safeguarding practice (Links to GSCB Business Plan outcome *"children will be kept safe – their needs will be understood and help provided will make a difference"*.)				
112.1 Review and embed the GSCB Quality Assurance Framework (GSCB Business Plan action), focusing on frontline child protection practice (By end of March 2018)	Ofsted assessed that GSCB QA processes are positive but need to be 'embedded' to improve the extent of their positive impact on the safety of children	That the experiences of the child and their family are central to all our auditing activity to identify negative practice and impact to improve the positive impact for families	MAQuA	

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112.2 Undertake a review of the S11 self-assessment to focus on outcomes rather than process (By end of October 2017)	The current S11 self-assessment is largely based on process questions and the GSCB needs to have more of a focus on outcomes for children and young people and being provided with the evidence to back up the ratings provided	S11 self-assessments are searching, evidence based, comprehensive and honest representations of organisational management of the quality of frontline practice to safeguard children. GSCB has ensured S11 results clearly link to audit activity and outcomes as well as service user feedback	GSCB Business Manager VM/SM & Operational Group	<u>GHT</u> 1. Review Section 11 audit content and identify areas where outcome can be evaluated in hospital practice. 2. Review Gloucestershire County Council Quality Assurance Framework and observed practice tool to embed in practice evaluation October 2017
Ofsted Recommendation, Paragraph 113 – Strengthen the evaluation of training to ensure that it is robust and can evidence positive impact on outcomes for children and their families (Links to GSCB Business Plan outcome *"professionals consistently deliver good practice, quality safeguarding outcomes and are routinely and assertively advocating on behalf of children"*.)				
113.1 Review the training programme to support 'applied learning', for example through methodologies such as learning circles/practice learning sets (By end of October 2017)	It is assessed that although considerable excellent multi-agency training is delivered through GSCB activity, the learning is often not translated into practice, meaning that children do not always benefit from high quality professional practice	There is a culture of professionals thinking and learning together and then consistently applying that learning in their daily practice.	Chair: WfD Sub-Group	

Actions for Progression	Context	Expected Impact/Outcome	Lead	Evidence of Progress
113.2 GSCB members will evidence the impact of safeguarding training. Specifically: 1. Robust analysis of attendance information, both single agency and inter-agency (By end of December) 2. GSCB members will make robust arrangements to ensure that professionals who undergo inter-agency training delivered by GSCB provide feedback to inform training evaluation 3 months after attending (By end of September) 3. GSCB Member Organisations and GSCB Training Coordinator will make adjustments to course content and delivery based on feedback received 4. All member organisations will evidence how learning from training is applied within the workplace	There is evidence that representatives of GSCB member organisations do not always work together cohesively and effectively in line with statutory guidance contained within WT 2015 and that this adversely affects the quality of service delivery and consequently the safety of children The rate of three-month feedback from inter-agency training attendees is very low, limiting the ability of GSCB to evaluate the impact on practice of the training and enable continuous development	Practitioners representing GSCB member organisations understand their roles and those of others. This leads to effective and cohesive inter-agency working and interventions that keep children safe GSCB use the evidence base from training evaluation to improve multi-agency safeguarding practice leading to more effective working and safer children	Chair: Wfd Sub-Group Dee Gibson-Wain	<u>GHT</u> 1. Evaluate question completion rate at level 2; (work with IT/E-learning development team) 2. Questionnaire to evaluate that learning at level 3 is embedded March 2018
Ofsted Recommendation, Paragraph 114 – Hold partners to account for evaluating the impact on practice of the learning from serious case reviews (Links to GSCB Business Plan outcome *"Professionals consistently deliver good practice, quality safeguarding responses and are routinely and assertively advocating on behalf of children".)*				
114.1 The SCR Sub-Group will test out whether multi-agency actions from SCRs have been undertaken and the difference that has been made or what else needs to happen (By end of October 2017)	Serious Case Reviews provide clear findings and recommendations in relation to where improvements are needed within the safeguarding system. However, there is not	There will be demonstrable change in practice that can be evidenced as a result of learning from SCRs, avoiding repetition of response shortcomings evident in previous cases in which children have died or	Chair: GSCB Workforce Development Group	

Actions for Progression	Context	Expected Impact/Outcome	Lead	Evidence of Progress
114.2 All GSCB members will confirm that single agency actions have been completed and the difference that has been made 114.3 SCR, WfD and MAQuA will combine to hold partners to account for evidence and impact.	currently evidence of learning be embedded and we need to understand the barriers and hold organisations to account	suffered serious harm. This leads to better safeguarding activity and safer children.	Lisa Prior-Cox SCR Sub Group Dee Gibson-Wain	<u>GHT</u> 1. The changes in practice evidenced by GHT (internal) SCR action plan and completed actions or work still in progress 2. Learning from SCRs will be enhanced by the questionnaire on knowledge base of level 3 trained professionals
114.4 MAQuA to test whether thresholds for services are consistently understood and applied so that all children receive an appropriate and timely response when they need it (By end of November 2017) (x-ref GCC Help and Protection improvement plan)	There must be a common understanding of the thresholds for intervention in order that children receive the right responses when they need them and that GSCB member organisations are working with maximum effectiveness and efficiency	Children requiring services receive the right help at the right time	MAQuA	
114.5 Introduction of a GSCB Practitioner Reference Group (GSCB Business Plan action) (By November 2017)	GSCB has not been sufficiently aware of the quality of safeguarding children practice being delivered at the front line and the challenges faced by practitioners.	The GSCB will have a mechanism to be able to understand the barriers to improving practice at the frontline and will use this learning to coordinate activity to remove barriers and hold organisations to account for playing their part in doing so	GSCB Executive Committee	

Actions for Progression	Context	Expected Impact/Outcome	Lead	Evidence of Progress
114.6 Understand what stops people from feeling confident in having those difficult conversations and what support is needed to change the culture in Gloucestershire to one where healthy professional challenge is the norm (By end of October)	We have had an escalation policy in Gloucestershire since 2010. This is well known about across all partner organisations and anecdotal evidence is that it is used on a regular basis. However, we need to move to a culture where positive professional challenge is a way of being, rather than through the use of a policy	Competent and confident professionals recognise when action proposed to safeguard children is not that which is required and unhesitatingly challenge each other. Challenge is welcomed without defensiveness, further consideration follows, if necessary including wider consultation and effective plans are agreed and delivered to keep children safe	WfD Sub-Group VM/SM VM/SM	<u>GHT</u> 1. Challenge and shared decisions around safeguarding issues in GHT is embedded in the culture and practice. Staff use the process of the escalation policy in daily case discussion/supervision; in more formal advice seeking from named doctor and named nurse; and in peer supervision meetings. Consideration of data methodology (audit GSCB review of policy) March 2018 2. Develop and maintain database to provide increased managerial oversight of case management and escalation December 2017
114.7 All members to report their organisations perspective to the Exec/Board as to whether resource deployment by all safeguarding practitioners is focused on activity that has a beneficial impact on the safety and wellbeing of children. (By end of March 2018)	Resources and capacity across all partner organisations are under pressure and rather than carrying on with something that isn't working, the focus should be on considering what might need to happen to reach the desired outcome	Resource deployment across all safeguarding practitioners is focused on activity that has a beneficial impact on the safety and wellbeing of children	Executive Group, GSCB	

Ofsted Recommendation, Paragraph 115 – Ensure that the annual report provides a rigorous assessment of the performance and effectiveness of local services				
115.1 The GSCB Business Manager to network with other Local Safeguarding Children Boards to assess the components of a 'good' annual report and ensure that these are all covered in the GSCB Annual Report for 2017/18 (By end of December 2017)	Ofsted described the Annual Report for 2015/16 as being overly descriptive. It stated that all appropriate areas were covered but that it did not present a rigorous and transparent analysis of safeguarding practice across the county to provide an assessment of the performance and effectiveness of local services	The annual report will demonstrate a robust assessment of the performance and effectiveness of local services in safeguarding children and promoting their welfare.	GSCB Business Manager	
Ofsted Recommendation, Paragraph 116 – Ensure that the neglect strategy and associated toolkit is promoted across the county and its effectiveness measured to improve outcomes for children				
116.1 Implement actions set out in the GSCB Business Plan – Key Success Criteria "Children who are at risk of or suffering neglect are identified and interventions are put in place to stop them from suffering harm (By end of March 2018)	It is assessed that the GSCB Neglect Strategy is a useful working document but that its use is not yet embedded, limiting the effectiveness of multi-agency responses to children at risk of or suffering neglect	Representatives of GSCB member organisations consistently work in line with the GSCB Neglect Toolkit and children at risk of or suffering neglect are safeguarded effectively	MAQuA VM/SM/LPC	<u>GHT</u> 1. Neglect toolkit has been shared via the network which extends from the Safeguarding Operational Group (June 2017) 2. Develop and maintain database to provide managerial oversight of referrals and outcome December 2017 3. Quality Assurance around referrals for neglect that strategy is used in referral. Methodology to be developed and reviewed by November 2017

Enablers - Review of GSCB Structures

What	Why	Lead	By When
Review membership of the Board	The membership is currently too large which has resulted in it becoming too big to effectively do business. There is a sense that it is predominately an information sharing forum	GSCB Business Manager	
Review existing GSCB Structure to identify whether there could be more effective lines of accountability	The GSCB Board currently meets 4 times a year, with the Executive meeting 8 times a year. In addition, there are 8 sub-groups which results in the GSCB being a huge 'machine'. We need to structure ourselves in such a way to be efficient and effective with clear lines of accountability and appropriate challenge at every level	GSCB Business Manager	
Consider how the Executive Committee format could be replicated at a locality level Board needs to: • Agree local structure • Agree ToR • Mandate this approach from the Board • Nominate local reps • Monitor attendance • Two-way feedback from Board and local groups to key themes and local performance	There is a disconnect between the district safeguarding network and the board. Individuals and organisations need to be able to come together at a local level to have discussions and share concerns/good practice. This results in an increased understanding of people's roles, shared decision making and improvements to inter-agency working resulting in a more holistic response to the needs of children and families	Eugene O'Kane	
Review roles and responsibilities of Board members	The GSCB has a clear constitution, which is shared with the GSAB. However, is this well understood by all Board members? Are Board members taking responsibility for taking applying actions and key messages back into their own agency settings and do we need to improve the ways in which the GSCB holds members to account?	GSCB Independent Chair	

Review the ways in which key strategic organisational safeguarding risks are managed by the GSCB	The GSCB is not always well sighted on the key areas of risk within individual organisations. Verbal assurances are not always accompanied by documented evidence. It is not then able to hold those organisations to account for the activity being undertake to reduce and manage those risks. This potentially impacts on the wider safeguarding system. Increased oversight would improve the combined integrity and transparency of the Board	GSCB Executive Committee	

APPENDIX II – Identified Good Practice Points (Audit 2017)

Recommendations/Suggested Actions for GHNHSFT following

OFSTED Safeguarding Children Inspection

2017

INTRODUCTION

- Full report OFSTED report is available here: https://reports.ofsted.gov.uk/local-authorities/gloucestershire
- The work of the Children's Safeguarding Board was judged by inspectors to be 'inadequate'.
  Deficiencies were identified at Senior Management, monitoring and quality assurance levels.
  Significant changes in the Senior Management team followed.
- Safeguarding/Child Protection process and practice by the Hospital Trust was not specifically evaluated or mentioned in the report, but as multi-agency partners, working together for children and families, there will be areas identified for GHT development.
- The medical component of children's adoption assessments is provided by the Hospital Trust; this area of work was described as 'Good'.
  Strong staff stability in Adoption and Fostering Teams was specifically highlighted as beneficial.
- Children with disabilities are described to receive a responsive service consistent with their level of need, with positive reference to the countywide birth to 25years service (Reference Inspection finding 41) – to which GHT contributes via SEND programme.
- In relation to work on the 'Early Help Response' and 'CSE pathway', progress was highlighted to be positive.

KEY PRACTICE POINTS

- Practitioners are encouraged to avoid 'over reliance' on parental account.
- Assessments are too often adult/parent focussed, not adequately child focussed, and not timely.
- Children's Plans – Child Protection and Child in Need plans are not sufficiently clear or robust.
  This leads to a cycle of repeat referrals from children.
- Attainment and progress for our 'children in care' between Key Stage 2 and Key Stage 4 is described as 'too low'.
  All agencies have a part to play in optimising support for children in care.

RECCOMMENDATIONS/AREAS TO PROGRESS

General Trustwide

- Assessment of child/parent/carer needs to be timely and proportionate to the situation.
  Practitioner (Clinician) to highlight both risk and protective factors, and provide robust/measurable targets for any multi-agency plan (whether child protection or child in need).
- Child's view must be recorded.
- Use the thresholds document/windscreen to communicate our concerns.
- Increase the visible use of chronologies to review a pattern of related events.
- The Lead Clinician needs to review CIN or CP Plan and ensure health actions/desired outcomes are clear, specific and measurable.
- Increase attendance and participation by multi-agency professionals at child protection conferences – staff involved must contribute reports, share these with families, and consider practicalities around attending child protection conference.

APPENDIX II – Identified Good Practice Points (Audit 2017)

RECCOMMENDATIONS/AREAS TO PROGRESS (cont'd)

Development needs for the children's Operational Group

- Child Neglect Toolkit and Strategy 2017 to be promoted and highlighted through staff training and communication.
- Evaluate impact on practice by staff learning from Serious Case Reviews.
- Further develop a performance monitoring/quality assurance framework
  Examples:-

  1) Clinician makes referral to children's social care using MARF, Social Care communicates the outcome to responsible Clinician, Clinician reflects on the decision (either contributes to planning, or when decision is not appropriate to the situation, escalates their concerns).

  2) Child's voice – evidence of the child's voice being taken in assessment.

  3) Timeliness of clinical response (appropriate scheduling of medicals and appropriate communication via reports).

APPENDIX III - GHNHSFT action plan for Serious Case Reviews

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Safeguarding Children Case Reviews - Case Overview, Log and Action Plan
Updated February 2018 Confidential
Published ACR Reports on GSCB website:

Date of case	Case code/ Pseudonym	GHNHSFT Representatives Panel members or IMR Author	Key Actions and learning	Action plan completed/or in progress/and update included (RAG April 2017)	Assigned to
June 2016	SCR0214 'Ben'	Dr Sara Motion, Consultant Paediatrician and Trust Named Doctor for Children's Safeguarding Vivien Mortimore, Trust Named Nurse/Midwife Safeguarding Children	Ensure Robust 'early concern' identifiers and systems are in place; that are effective and used appropriately throughout the antenatal period. Evaluate and analyse (through audit) current use of Midwifery Vulnerability Screening Tool. This will consider some specific aspects of questioning, for example, 'secure childhood' question and 'father's voice'. Parenting capacity will be considered by all professionals Consider expansion of the concerns pathway with a second screen point, perhaps alerted by significant events (on infant vulnerability screening/in pregnancy/admission/SCBU)	Embed the current use of the Social Concerns Pathway from within midwifery service: • Continue raising awareness that supports use of this liaison tool with other professionals (MW/HV/hospital teams/children's and adult services)	Complete
				• Meeting February 2018 (SM/KD/KH agreement; postnatal pathway under review) (KD/KCG/Helen Ford) Suggested action is to have a second infant vulnerability screening point on midwife postnatal day 10 (discharge visit). Midwife would review first screening form, update with new identified vulnerabilities. Form would need to be scanned onto infant record (GHT and GCS) • Audit of midwifery Infant Vulnerability screening tool	KD/SU KD

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June 2016	SCR0214 'Ben'	Dr Sara Motion, Consultant Paediatrician and Trust Named Doctor for Children's Safeguarding Vivien Mortimore, Trust Named Nurse/Midwife Safeguarding Children	Domestic violence is specifically enquired about on antenatal pathway at 2 key points (booking and after delivery)	• Meeting February 2018 KD/SM/KH:- Postnatal midwife pathway is currently under review and needs to include enquiry to parents re: Domestic Violence.	
				• Implement new-born vulnerability screening tool (completed and Pilot – Audit 2017)	Complete
			Records and documentation will have evidence of 'whole family assessment' that includes evidence of the 'father's voice'.	• Update February 2018 - 'Maternity App' project is not possible. • 'Better Births Project' – plans to include 'whole family assessment' Action: KD to email Dawn Morrall • At midwife booking 'first' appointment – midwife gathers information on the father.	KD/DM
			Midwife training to secure understanding of different care pathways which may be in place for pre-existing children in a family e.g. care orders/special guardianships/court proceedings.	To include in training programme 2016 – evidence through training programme knowledge	Complete
			The lead professional for premature babies is identified on records. Parents and colleagues will know who this is at any given time.	Ensure that local policy and process is amended to incorporate identification of lead professional, named consultant Identify and offer to share 'Good Practice' across neighbouring Counties, such as embedded practice of weekly 'Social Concerns' meeting at NICU (GHNSHFT).	Complete

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June 2016	SCR0214 'Ben'	Dr Sara Motion, Consultant Paediatrician and Trust Named Doctor for Children's Safeguarding Vivien Mortimore, Trust Named Nurse/Midwife Safeguarding Children	The care needs of a child born very pre-term (i.e. under 32 weeks gestation) are identified, assessed and managed with a clear care plan, evidenced consistently in health records. A discharge planning pathway is clearly evidenced in the records following admission to NICU.	Use of new-born vulnerability screening tool Pilot 25 cases completed by Mel Randles to feedback Formalise a discharge planning pathway from NICU 'Parenting assessment' review Neglect Toolkit	Complete
			Parent craft for parents of infants both prematurely needs to include: • Subject areas, usually included in midwife led antenatal groups • Information on the specific risks for pre-term infants • Specific training on the subject of 'shaken baby' (e.g. NSPCC leaflet 'Handle with Care' and 'All Babies Count'. • Signing off parental competencies	Update February 2018 • MR/SU attend the Countywide Multiagency 'Shaken Baby Project' / Accident Prevention Group • 'The Better Births Project' – includes review of parent craft (work stream Imelda Bennett/Dawn Morrall) • Substance misuse group are targeting parent craft as an area on the work stream (Better Births Project)	MR/SU IB/DM
				Staff training on 'Early Help' to be delivered in next 3 months to NNU band 6/7 nursing staff by Michelle Richardson and colleagues	Complete
				Update February 2018 • Neonatal discharge policy/paperwork KT explained that national neonatal discharge information is supported by 'Badger' • KT agreed that neonatal unit would audit 10 cases from the neonatal unit where significant social concerns are identified, and review the discharge paperwork and provide a report/reflection.	KT/MR

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June 2016	SCR0214 'Ben'	Dr Sara Motion, Consultant Paediatrician and Trust Named Doctor for Children's Safeguarding Vivien Mortimore, Trust Named Nurse/Midwife Safeguarding Children	Transferring safeguarding information with mother/infant, when making a transfer to another hospital	Review transfer paperwork infant transfer paperwork much include a section on 'known safeguarding/welfare' information NICU paperwork social concerns section Update February 2018 • Audit needed on 10 cases transferred from the neonatal unit with known social concerns. • Audit discharge paperwork to be completed on 10 cases to identify whether key/relevant safeguarding information is included.	KT/JH KT
			All professionals will have a clear understanding of their roles and responsibilities and will be provided with development opportunities to support dynamic professional practice.	Share the findings from this Review across all partner agencies (for example Primary Care Safeguarding Forums)	Complete

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Date of case	Case code/ or Pseudonym	GHNHSFT Representatives Panel members or IMR Author	Key Actions and learning	Action plan completed/or in progress/and update included (RAG April 2017)	Assigned to
June 2016	SCR0114 'Lucy'	Vivien Mortimore, Divisional Nursing and Midwifery Director, Trust Named Nurse for Safeguarding Children	When domestic abuse/assault/NAI is identified in children and young people (including pregnancies) who attend GHT, ensure appropriate response • Teenage pregnancy specialist midwives to contribute to development of a policy or action card within the safeguarding children policy to ensure a consistent response to pregnant young women. • Share lessons from this SCR and embed in training for medical staff	Policy/action card Training slides/training records	Complete
			• Agree a clear process to enable all midwives to obtain a patient summery record from the GP prior to booking. • Ensure the above is filed in the professional records section of confidential folder. • Current Policy and action cards to be updated accordingly • Highlight rationale for this change at the GP safeguarding forum agenda	Audit information held within the confidential folder	Complete
			• Ensure a process is in place to share relevant information documented in the "maternity social concerns and plan of care" document and transfer to the new-borns paediatric notes. • Jeanette Welsh to develop template. • Process to be launched in ED.	CP plan alerts on new-borns – process to be agreed to transfer pre-birth alert after infant born Audit of neonatal notes to ensure compliance.	Complete

APPENDIX III - GHNHSFT action plan for Serious Case Reviews

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June 2016	SCR0114 'Lucy'	Vivien Mortimore, Divisional Nursing and Midwifery Director, Trust Named Nurse for Safeguarding Children	• Process agreed in ED to fax information on all pregnant women attending ED to the community midwifery services administration. (Gaynor Wellington) who will pass the information on to their community Midwife for action as appropriate.	Update February 2018 • Midwife liaison form is completed in ED and forwarded to the vulnerable women's team • Audit of 10 cases	JW/SU/Emma Stone
			• Review MARF with Social Care to support effective communication with phrases such as 'purpose of this communication' and 'what I think your response might be' • Develop closer links through projects such as the Early Years Integrated Pilot Project which promote partnership working and case discussion between midwives, health visitors and Family Support Workers in local Children's Centres. • Promote Links between specialist midwives and agencies such as Turning Point. • Further develop safeguarding meetings in all GP practice settings and encourage attendance by midwives, health visitors and social care • Mandatory Trust training and education	All parties will understand the purpose of communication and response and children will therefore have timely and appropriate intervention There will be a regular forum for effective information sharing to support all agencies in their statutory duty to protect and promote the welfare of children	Complete

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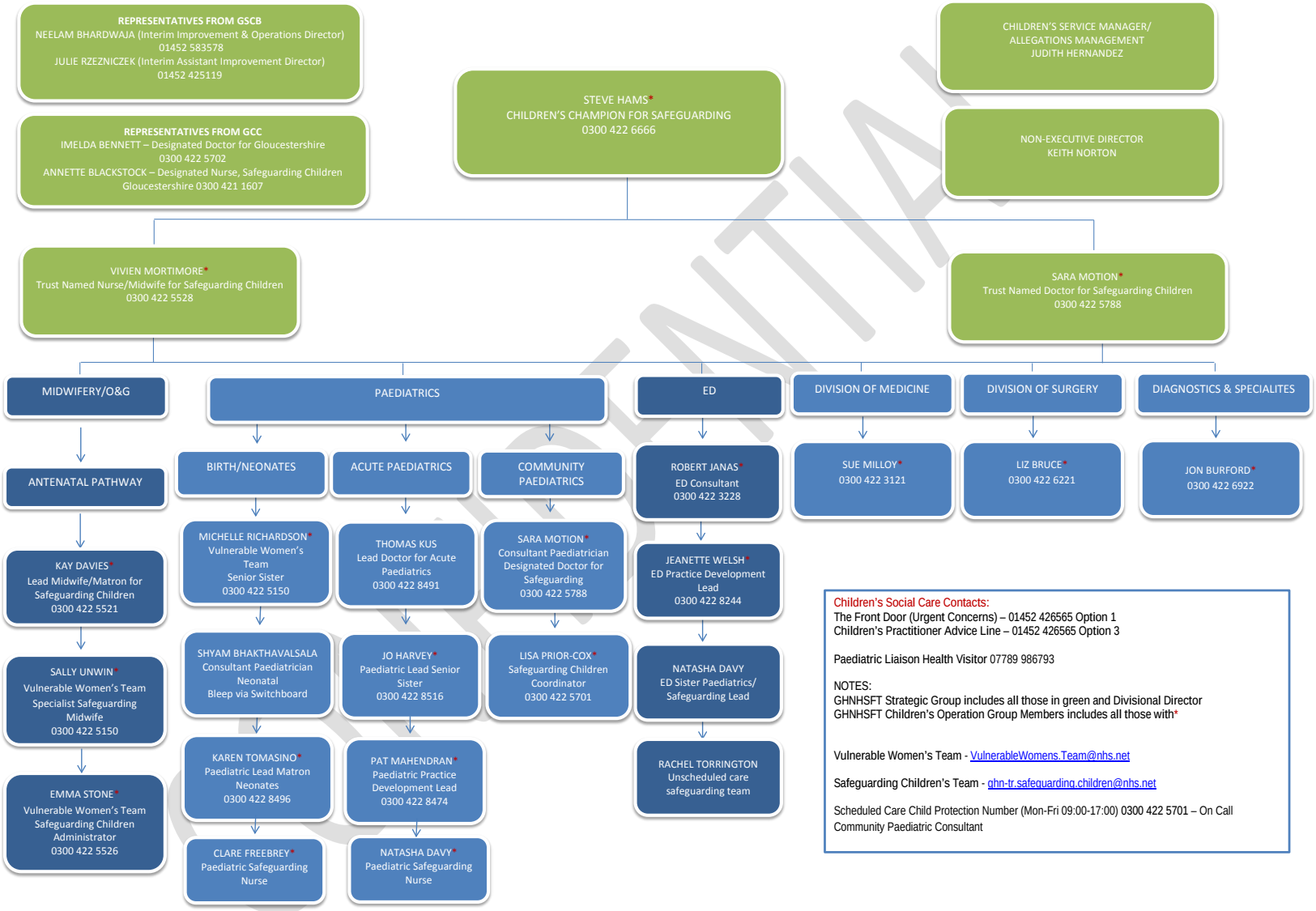
Date of case	Case code/ or Pseudonym	GHNHSFT Representatives Panel members or IMR Author	Key Actions and learning	Action plan completed/or in progress/and update included (RAG April 2017)	Assigned to
June 2016	SCR0114 'Lucy'	Vivien Mortimore, Divisional Nursing and Midwifery Director, Trust Named Nurse for Safeguarding Children	• Identify the training that would be required to ensure that all midwives are confident to assess parenting capacity and in addition make high quality appropriate referrals to Social care that provide a clear indication of the risks and concerns in regard to unborn, mother and wider family • Ensure that GP/Midwife/Health Visitor liaison forms are used for all women with appropriate escalation and care planning using complex social needs plan. • Ensure that all midwives are aware of DASH forms and are confident using these with women.	Updated Mandatory training for all Trust staff in 2016 Specific training for all community midwives and staff in ED in 2016 Audit Mandatory face to face Training and level 2 e learning	Complete
			• All women are now seen on their own at least once during their pregnancy to screen for domestic abuse, (and also FGM, CSE as appropriate). • Booking proforma and patient information leaflet to be updated to reflect this. • Community Midwives to document where the woman was seen and with whom at each ante natal contact. • Awareness of this process cascaded through Community Leads Meeting and team meetings. • All women who disclose domestic abuse referred to GDASS • Practice is consistent and midwives always consider a MARF, complete a midwives concern form and refer to children's centre to share vulnerabilities	Audit of Documentation and patient information leaflet Minutes from meetings	Complete

APPENDIX III - GHNHSFT action plan for Serious Case Reviews

Date of case	Case code/ Pseudonym	GHNHSFT Representatives Panel members or IMR Author	Key Actions and learning	Action plan completed/ or in progress/and update included (RAG April 2017)	Assigned to
Dec 2016	SCR0115 'Phillip'	Dr Sara Motion, Consultant Paediatrician and Trust Named Doctor for Children's Safeguarding	• Child Protection (GHNHSFT) Paediatric Medical Assessment Reports, to include a section on information shared from primary health care professionals involved with the child • GHNHSFT child protection clinical paperwork to be revised and updated to:- - Separate information to be taken in the acute situation from information to be taken in next 24 hours - Separate body map diagrams	Reviewed and updated Feb 2017	Complete
			• GHNSHFT clinical (inter-hospital) transfer paperwork to be revised and updated to ensure information related to safeguarding the child, travels with the child. • Hospital staff to actively engage in supervision of child protection work	Supervision sessions are now embedded in monthly timetable	Complete

APPENDIX IV - TRUST ORGANISATIONAL SAFEGUARDING STRUCTURE



APPENDIX V - 2017-2018 CLINICAL ACTIVITY SAFEGUARDING CHILDREN (2016/17 IN BRACKETS)

SAFEGUARDING ACTIVITY	# OF OCCURANCES	LEAD
Number of CYP (children and young people) subject to a child protection plan in Gloucestershire – *refer to note 1*	653 (457)	Safeguarding Co-ordinator
Number of CYP 'in care'/in the care of the local authority (in foster care) – *refer to note 2*	652 (614) 122 (182) Gloucestershire children placed out of County	Designated Doctor/Designated Nurse for CIC
Outpatient referrals for safeguarding (telephone or letter)	331 (346)	Named doctor/ Safeguarding Co-ordinator
Safeguarding medical assessment (Child Protection Medical) completed as a day case	120 (123)	Named doctor/Safeguarding Co-ordinator
Ward admissions coded for evidence of safeguarding concern – *refer to note 3*	112 (85)	Named doctor/ Hospital Coding
Ward admissions coded for evidence of DSH (deliberate self- harm)	333 (352)	Hospital Coding
Paediatric Unit Clinical Cases supervised for safeguarding concern	(22)	Named Doctor
ED attendances countywide children for all children 0-16 years (GRH/CGH)	25,863 (25,010)	Lead Nurse Safeguarding Emergency Department
ED attendances by children with child protection plans	151 (149)	PLHV/Safeguarding Co-ordinator
ED attendances by children in care (CIC)	156 (142)	PLHV/Safeguarding Co-ordinator
ED attendances by children in need (CIN) Vulnerable children	284 (664) 182 (181)	PLHV/Safeguarding Co-ordinator
ED attendances 0-18yrs with DSH concerns DSH – OD DSH – Alcohol/drug misuse DSH – Mental health issues	441 (415) 197 (206) 81 (78) 74 (33)	PLHV/Safeguarding Co-ordinator
ED attendances transferred to Paediatrics with safeguarding flagged for assessment/admission	273 (346)	PLHV/Safeguarding Co-ordinator
ED referrals passed to safeguarding Health Visitor liaison officer from ED at CGH and GRH	2,427 (2,776)	PLHV/Safeguarding Co-ordinator
Maternity cause for concern forms completed	1,545 (835)	Lead Midwife for Safeguarding
Antenatal/perinatal referrals to Social Services for safeguarding assessment	101 (64)	Lead Midwife for Safeguarding
Adverse clinical incidents (ACIs) relating to safeguarding	22 (22)	Named Doctor/Risk Department
Complaints	(0)	Complaints/Risk Department
Child deaths – *refer to note 4* Expected deaths Unexpected	30 (36) 17 (23) 13 (13)	Designated Doctor for Child Death
Serious Case Reviews (SCRs)	2 (4)	Named Doctor/Nurse/ Designated Doctor
Domestic Homicide Review	0 (0)	Named Nurse
Allegations management	(n/a)	Local Authority Designated Officer (LADO)

APPENDIX V - 2017-2018 CLINICAL ACTIVITY SAFEGUARDING CHILDREN (2016/17 IN BRACKETS) cont'd

NOTES:-

1. The number of children on Child Protection Plan fluctuates daily, and is a denominator determined by Social Care activity. There are currently 653 children on CPP in Gloucestershire. During the audit period GHNHSFT received 1,156 CPP notifications which resulted in Safeguarding Alerts on Trak. During the audit period GHNHSFT also received 1,214 Child Protection Conference Invitations on children deemed to be at risk.

2. Numbers of Children in Care continues to increase. There were 122 Gloucestershire children placed out of County in 2017 and 300 children in care placed in Gloucestershire from other Local Authorities.

3. Ward admissions for safeguarding are mainly those exposed to physical abuse/harm.

4. Dr Imelda Bennett sits on the Child Death Overview Panel as Designated Doctor for the Trust, together with Vivien Mortimore as Head of Midwifery. The Panel reviews the summaries of medical issues and safeguarding concerns for all children and infant deaths (expected and unexpected).

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00am

Report Title
Infection Control Annual Report
Sponsor and Author(s)
Author: Steve Hams, Director of Quality, Chief Nurse & Director of Infection Prevention and Control Sponsor: Steve Hams, Director of Quality, Chief Nurse & Director of Infection Prevention and Control
Executive Summary

Purpose

To provide our patients, staff, the public and the Board of Directors with an annual report on infection prevention and control from April 2017 – March 2018 providing assurance of compliance to the Health & Social Care Act Code of Practice
The trust has faced significant challenges with an increased incidence of Clostridium difficile and MRSA. The trust did not meet set objectives for both indicators during 2017/18.
An improvement plan was developed during quarter 4 focussing on:

- Reducing the level of C. difficile contamination in inpatient areas, including the emergency departments and acute admission units
- Improving the management of C. difficile cases
- Improving C. difficile knowledge for staff, as appropriate
- Buildings and the environment
- Antimicrobial stewardship

Section 1.1 provides details of where to quickly find details of compliance with the Code of Practice on Infection Prevention & Control.

Implications and Future Action Required

The review of the previous year will contribute to planning a comprehensive programme of work for the Infection Prevention & Control Team. A new Associate Chief Nurse and Deputy Director of Infection Prevention & Control has been appointed to provide strategic leadership of the Trust's IPC agenda who together with the Infection Control Doctors and IPC nursing team the C. difficile action plan will be further developed and a work plan for quarters 3 and 4 will be produced.

Recommendations
The Board is asked to note the report and seek assurance that the review of the 2017/18 year provides evidence of the Trust's obligations according to the Health & Social Care Act Code of Practice.
Impact Upon Strategic Objectives
Impact Upon Corporate Risks

Regulatory and/or Legal Implications
The report satisfies the DIPC's obligations under the Health and Social Care Act to provide a report on infection prevention and control. Once approved the report will be made available to the public via the website.
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓ July 2018						

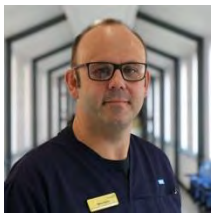
NHS
Gloucestershire Hospitals
NHS Foundation Trust

Infection Prevention & Control

Annual Report 2017/18

Contents

Introduction and Foreword



Infection prevention and control is a top priority for Gloucestershire Hospitals NHS Foundation Trust. Keeping our patients safe from avoidable harm is everyone's responsibility and as Director of Infection Prevention and Control I have a wide ranging programme of activity that focusses on continual improvement in order to deliver the best care for everyone and keeping our patients safe and at the heart of everything we do.

This report provides details of the progress with infection prevention and control from April 2017 - March 2018.

2017/18 has been a challenging year with national objectives for meticillin resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* infection aimed at delivering a zero tolerance approach to avoidable infections. Progress has been made throughout when compared to recent years, primarily due to the decrease in MRSA bacteraemias and other healthcare-associated infection seen within the Trust.

The Infection Prevention and Control Team work in line with national guidance on the prevention of infections in the healthcare setting. Adherence to policies and procedures based on national guidance and the evidence base supports the trust in continually reducing the risk from avoidable infection for our patients and staff. All the policies and procedures are readily available on the Trusts intranet page.

I and the Infection Prevention and Control Team work closely with external agencies. A strong working relationship is maintained with Gloucestershire Clinical Commissioning Group (GCCG), Public Health England (PHE) and NHS Improvement. The team meets monthly with GCCG; primarily to discuss *C. difficile* root cause analysis (RCA). During outbreaks of infections PHE are notified and invited to support outbreak meetings. NHS Improvement are kept up to date on the Trust's performance.

Despite the challenges we have faced I am pleased to report progress with Infection Prevention & Control is moving in the right direction, I have recently appointed my Associate Chief Nurse and Deputy Director of Infection Prevention & Control to lead this strategy moving forwards.

Steve.

Steve Hams
Director of Quality and Chief Nurse
Director of Infection Prevention and Control

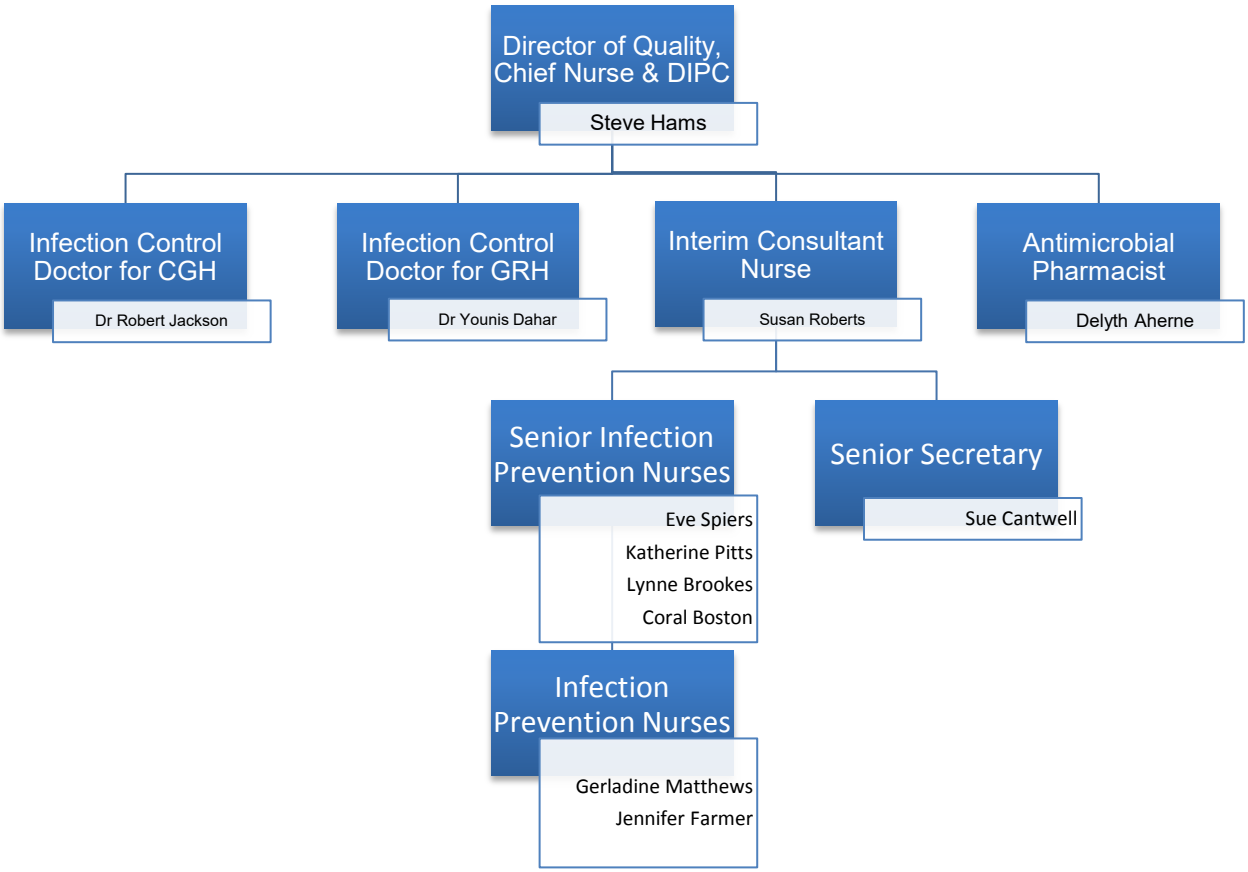
1.1 Where to find evidence of compliance with the code of practice (2015) on infection prevention and control from the Health and Social Care Act 2012

Criterion	What the registered provider will need to demonstrate	Location in annual report
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Section 2 and 4
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Section 9 and 10
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Section 7
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Section 6 and 8
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Section 3, 4 and 6
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Section 6 and 8
7	Provide or secure adequate isolation facilities.	Section 2
8	Secure adequate access to laboratory support as appropriate.	Section 2 and 7
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Section appendix 1
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Section 8

2.0 Infection Prevention and Control Team Structure 2017/18

During 2017/18 there were some staff changes within the Infection Prevention and Control team. Mr Steve Hams, Director of Quality and Chief Nurse assumed the role of Director of Infection Prevention and Control (DIPC), reporting directly to the Chief Executive. Susan Roberts, Infection Control Consultant Nurse was employed on a fixed-term temporary contract to provide senior leadership for a period of six months commencing January 2018.

Figure 1 Infection Prevention and Control Team Structure on 30th March 2018. Organisational lines do not represent line-management, for example the Antimicrobial Pharmacist is part of the Pharmacy Department and is represented here as an integral part of the IPC team's activity.



2.1 Infection Prevention Reporting Framework

In 2017/18 the Infection Control Committee (ICC) occurred monthly with a broad membership and an agenda that rotated from meeting to meeting. It included representation from the Trust Board. The clinical divisions provided assurance of their management and ownership of infection control to the committee.

Membership:

- Director of Quality and Chief Nurse/Director for Infection Prevention and Control (Chair)
- Infection Prevention and Control Doctors
- Matron for Infection Prevention and Control
- Antimicrobial Pharmacist
- Divisional Chief Nurses
- Deputy Director of Facilities and Estates

The Director of Quality and Chief Nurse & DIPC reports on infection prevention and control to the trust Quality and Performance Committee. All members of the Board of Directors have access to information concerning the Trust's performance against the external and internal infection prevention targets and other infection related issues.

Monthly HCAI surveillance reports continue to be produced by the Infection Control Team detailing incidences of meticillin resistant *Staphylococcus aureus* (MRSA) identifying both incidence of carriage and bacteraemia, meticillin sensitive *Staphylococcus aureus* (MSSA), *Escherichia coli* (*E.coli*), *Klebsiella sp.* and *Pseudomonas sp.* bacteraemia are also collated along with *Clostridium difficile* infection (CDI) with an EIA toxin positive result.

There is close monitoring of MRSA screening and identification of potential MRSA inpatient acquisitions and outbreaks. The surveillance report also includes information on the number of tests performed for Carbapenemase Producing Enterobacteriaceae (CPE) screening and the number of reference laboratory confirmed CPE carrying patients. The CPE action cards indicate which patients are at risk and therefore those who should have screening cultures collected for testing. Rates of confirmed CPE carriage remained low in 2017-18 in Gloucestershire; no new cases were identified in 2017-2018.

The HCAI surveillance report highlights any possible clustering of patients with positive test results for *Clostridium difficile* including both EIA toxin positive and PCR gene positive results – this gives an indication of areas that have possible Periods of Increased Incidence (PIIs) that require monitoring, further investigation and enhanced cleaning.

The HCAI surveillance report includes a summary of ward or bay closures in the previous month that are categorized as suspected (or confirmed) outbreaks of viral gastroenteritis (usually norovirus).

The HCAI surveillance reports are circulated to each Division and members of ICC

monthly.

A monthly surveillance report is also produced by PHE for the South West and is sent to each hospital which allows bench marking for all the reportable organisms.

2.2 Microbiology and Laboratory Support

The Infection Prevention and Control Team work closely with the clinical microbiology department which provides comprehensive bacteriology, virology, parasitology, and mycology services. The department is UKAS accredited and participates fully in external quality assurance schemes for the full repertoire of tests. The department is based at Gloucestershire Royal Hospital. Staff offer a 24-hour diagnostic and monitoring service for routine and urgent detection of patient infection, e.g. meningitis, hepatitis and MRSA infections caused by bacterial, viral and fungal agents, using specialised automated and manual techniques. The clinical microbiology department provides support to the Infection Prevention and Control Team through reporting of results and processing of clinical samples. Out of hours the on-call consultant microbiologist provides urgent infection prevention and control advice for the Trust.

Laboratory testing locally for CDI currently uses a two stage test looking both for GDH antigen and *C.difficile* toxin. As per national reporting requirements, both tests need to be positive for the infection episode to be reported on HCAI DCS. The laboratory also conducts an additional test on toxin negative, GDH antigen positive specimens to look for toxin genes (by PCR) which can be helpful in identifying patients who may have already developed CDI or who may just be *C.difficile* carriers/excretors.

2.3 Isolation facilities

There are 1075 beds across the trust's sites. Side room isolation facilities are available in all wards. The amount of side rooms provides challenges for the Infection Prevention and Control Team, however close working with the clinical site managers is required to reduce the risk of infected patients if no isolation facilities are available.

3.0 Performance

Explanatory note

The assignation of bacteraemia cases to the trust is based on time of collection and admission. Day zero is the day of admission and cases are assigned as trust-apportioned when they are collected after day 1 or for *C. difficile* this is after day 2. This has previously been referred to post-48 hour cases, in this report it is referred to as post day 0+1 for bacteraemia cases and day 0+2 for *C. difficile*.

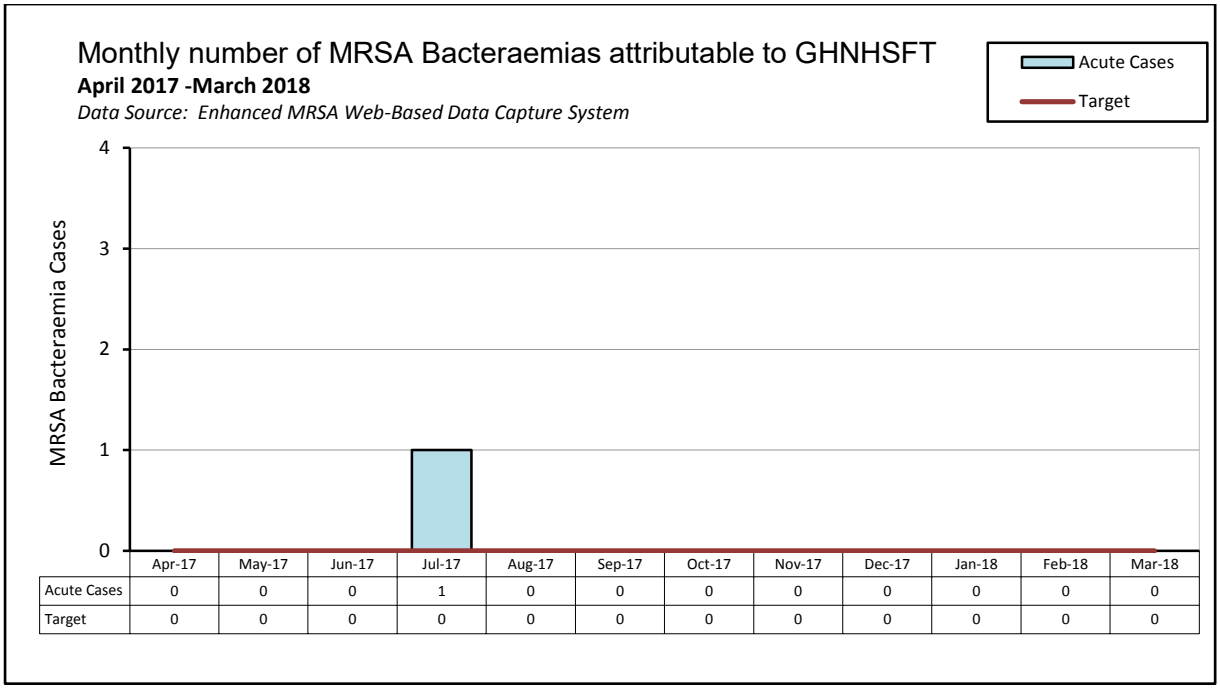
3.1 MRSA bacteraemia

NHS England published guidance on the reporting and monitoring arrangements, post infection review process for MRSA bloodstream infections, and made it a requirement in April 2014 to institute a Post Infection Review in all cases of MRSA bloodstream infection.

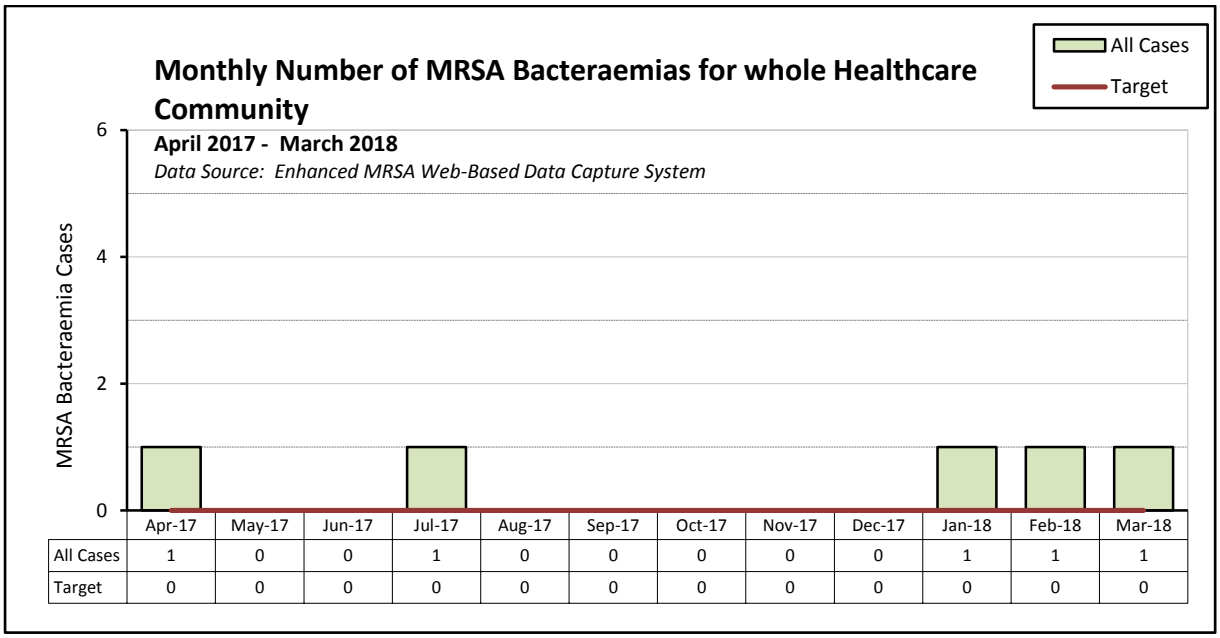
The outcome of the Post Infection Review assists in attributing responsibility for MRSA bloodstream infections. All cases reported are assigned either to an acute Trust, Clinical Commissioning Group or a Third party. This process relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA bloodstream infection. At the beginning of the 2014 financial year *NHS England* introduced a new category for the PIR assignment of MRSA bacteraemia cases, acknowledging the increasingly complex nature of the MRSA bacteraemia being reported. Assignment to a "third party" through the arbitration process can now be made for cases with a specimen date post April 2014. The "third party" option provides a category for patients who have been attributed to default providers or CCGs who may not have been involved in the patient's care or who can provide strong evidence following a PIR that there were no failings in patient care.

MRSA bacteraemias continued to be reported to the Public Health England (PHE) via the HCAI DCS as part of Department of Health mandatory HCAI surveillance.

In 2017-2018, there were 5 MRSA bacteraemias for the whole healthcare community but only 1 post day 0+1 bacteraemia and therefore attributed to the trust. The annual target (objective) of MRSA bacteraemia for the trust was 0 (which was a national zero tolerance target) and unfortunately this was not achieved.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Acute Cases	0	0	0	1	0	0	0	0	0	0	0	0
Target	0	0	0	0	0	0	0	0	0	0	0	0



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
All Cases	1	0	0	1	0	0	0	0	0	1	1	1
Target	0	0	0	0	0	0	0	0	0	0	0	0

3.2 *Clostridium difficile* infection

The performance of the Trust against the objective set by the DH is monitored carefully. The Trust objective for 2017/18 was 37 cases. Results for August 2017 were higher than expected and have remained above the monthly limit since. Higher than expected rates of *Clostridium difficile* infection were seen both in the acute trust and county-wide, prompting concerns from other organisations including the CCG. This has resulted in a number of actions including the formation of a short-life cross county CDI reduction working group and the appointment in the acute trust of an interim infection control consultant nurse in January 2018.

The mandatory reporting requirements from Public Health England and NHS

England has been established for a number of years, all toxin positive *C. difficile* cases must be reported.

As part of preparations for year-end 2017/18 reporting it became evident that the organisation had excluded a number of toxin positive cases from the reported figures, upon further exploration the decision to exclude cases (based on clinical assessment) was approved in 2012 and as such, since 2012 the number of *C. difficile* cases reported has been lower than the actual number of cases.

There is a material difference in the 2017/18 reported position, 56 have been reported, and however the correct number is 72.

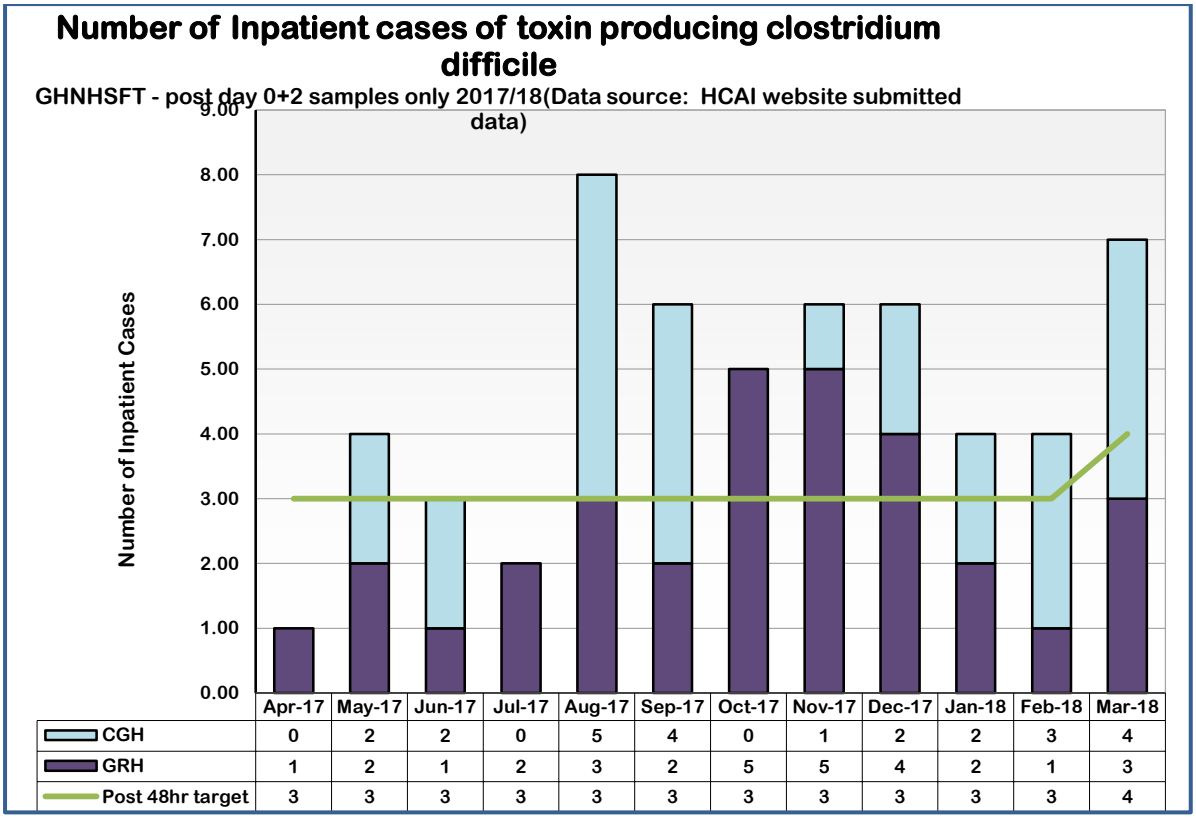
The table below is a summary of reported and actual *C. difficile* cases over the past four years:

Year	Target	Reported	Removed	Actual
2014/15	55	37	12	49
2015/16	37	41	13	54
2016/17	37	41	6	47
2017/18	37	56	16	72

In relation to patient care, there is no evidence to suggest that any patients have come to harm as a result of this reporting anomaly. All patients have been treated as per local policy and best clinical practice and all patients have received the routine root cause analysis investigation as per local policy guidelines.

NHS Improvement, NHS England, the Care Quality Commission and the Gloucestershire Clinical Commissioning Group are aware of the reporting anomaly and have sought additional assurances and have been content with the organisational response to rectify the reporting arrangements.

Our approach to reporting *C. difficile* cases has been corrected from March 2018 and we are now following the national guidelines for reporting.



All areas of *Clostridium difficile* infection diagnosis, management and reporting have been reviewed to allow a clear understanding of the current situation and a comprehensive action plan developed.

The action plan has focused on 5 key areas;

- Environmental decontamination
- Clinical practice –prevention and management
- *C.difficile* education and training
- Buildings and environment
- Antimicrobial stewardship

A huge amount of work was undertaken not only by all members of the team, but also the antimicrobial pharmacist and communications department, who assisted in the design of education resources.

Root Cause Analysis

All inpatient cases with positive results for *Clostridium difficile* are reviewed by the ICNs. This provides an opportunity to investigate risk factors for acquisition and monitor the assessment and management of patients, through a root-cause analysis tool document (RCA). During 2017/18 CDI RCA findings were summarised and fed back to clinical teams with learning points and recommended actions for inclusion in action plans. The RCAs were also reviewed and discussed in any multidisciplinary meetings that are required either for individual patients or for suspected PIIs. RCA documents were also reviewed at monthly 'lockdown' meetings to aid with decisions on reporting of episodes of infection centrally as part of mandatory surveillance and

to decide on categorisation of reportable cases as either ‘avoidable’ or ‘unavoidable’.

From July 2017 the focus has been on post day 0+2 cases being reviewed and assessed twice a week. The RCA and summary were not fed back to the clinical teams. It was felt that the pre day 0+2 cases did not need such intense interrogation as they had not acquired the CDI whilst a Trust inpatient.

In January 2018 the process for investigating cases of *Clostridium difficile* infection was again reviewed as part of a wider *Clostridium difficile* reduction action plan by the interim nurse consultant. Moving forward from April 2018, while all patients with a positive post day 0+2 *C.difficile* result are reviewed twice a week whilst an inpatient by the ICN’s a comprehensive root-cause analysis with follow-up will now be completed on only post day 0+2 *C.difficile* toxin cases. The root-cause analysis is completed by both the ICN and ward staff initially, with a follow up meeting with nursing and medical staff where the case is discussed and an action plan developed. 4 weeks are allowed for the return of the action plan and sign off by both nursing and medical divisional leads. All patients with *C.difficile* toxin results are now reported as part of mandatory surveillance, and decisions regarding the categorisation as either ‘avoidable’ or ‘unavoidable’ discussed at the RCA meeting.

Periods of Increased Incidence

Periods of Increased Incidence (PII) are identified from regular surveillance of *Clostridium difficile* infections within the Trust. When two cases or more of post day 0+2 *Clostridium difficile* infection occurred within a 28-day period on a ward this was investigated by the Infection Control Team and samples sent for ribotyping. Once all information is collated, including ribotyping, a multi-disciplinary team meeting may be called. Attendance at meetings was mandatory for relevant medical and nursing staff, pharmacy representatives, clinical risk and the Infection Control Team, including the Infection Control Doctor.

There were 12 PIIs 2017 -2018. These were in both sites of the hospital with Gloucestershire Royal Hospital (GRH) having 8 and Cheltenham General Hospital (CGH) having 4. (Table 1)

Table 1

GRH / CGH	Ward	Date of PII	Number of patients	Ribotypes	Meeting	Summary to ward
GRH	4A	Sept 17	4	All different	Yes	Yes
GRH	4B	July 17	2	All different	No	Yes
GRH	5B	Sep 17	4	2 = sporadic Others different	Yes	Yes
GRH	6B	May 17	3	All different	No	Yes
GRH	9B	June 17	2	All different	No	Yes
GRH	4B	Oct – Dec 2017	9	3 = CDR001 2 = CDR002 Others all different	Yes	Action plan
GRH	3B	Jan 18	3	3 = CDR001	Yes	Yes
GRH	7A	Jan 18	3	2 = CDR014	Yes	Yes
CGH	Guiting	Sept 17	3	All different	Yes	Yes
CGH	Prescott	June 17	2	All different	No	Yes
CGH	Ryeworth	Aug 17	5	All different	Yes	Yes
CGH	Ryeworth	March 18	2	All different	Yes	Yes

During the period October – December 2017 a period of increased incidence was identified on T4B. Despite identification and action plans the number of cases on this ward continued to cause concern. A series of meetings have been held as concern rose that this was now a *C.difficile* outbreak. Ribotyping of 10 stool samples confirmed 3 patients with the same ribotype: CDR001. This fulfilled the criteria for an outbreak. Outbreak meetings were held and an action plan was developed. This outbreak has been reported as a serious incident.

Selective referral of samples for ribotyping continues to assist in the management and investigation of suspected periods of increased incidence and therefore all patients samples who are suspected as being part of a PII are sent for ribotyping.
During 2017/18 all samples where it was known the patient had relapsing CDI were ribotyped along with the all samples where CDI appeared on the death certificate.

In addition all samples from patients with *C.difficile* positive result in November 2017 as part of a 'snap shot' look at cases by the short-life *C.difficile* working group. Moving forward in 2018/19 all post day 0+2 cases of toxin positive *C.difficile* will be ribotyped.

3.3 *Escherichia coli* bacteraemias

The DH has required Trusts to submit mandatory surveillance data on *E.coli* bloodstream infections since June 1st 2011. *E.coli* constitutes the commonest Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 22 *E.coli* bacteraemias each month. Most *E.coli* bacteraemias are not a reflection of HCAI; most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection. Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment). A proportion of the *E.coli* bacteraemias are healthcare-associated and are related to recent previous hospitalisations and invasive interventions performed

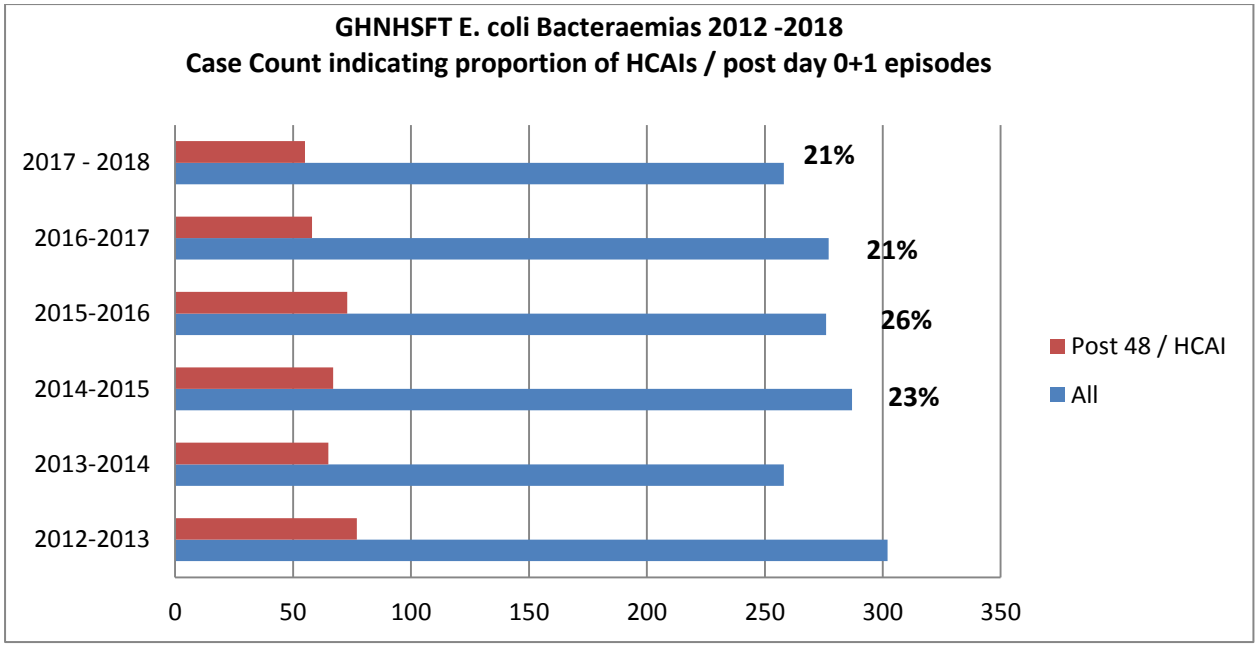
on patients, the most important of which is urinary catheterisation.

Arrangements have been put in place to ensure that this surveillance is undertaken in Gloucestershire. This surveillance is initially performed by the CMMs using a locally developed proforma, with more detailed risk factor information being collected by the trust ICNs and with some assistance from the GCS ICT and the CCG (liaising with practice-based pharmacists). Information collected by the CMMs and trust ICT are manually inputted by the Information Officer and secretaries in the Microbiology Department onto the PHE HCAI Data Capture System. The trust ICT lead on data collection for those *E.coli* bacteraemia cases occurring more than day 0+1 after admission. Some of the data required on cases is recorded in written healthcare records or on clinical IT systems which the Microbiology Department and the trust do not have access to.

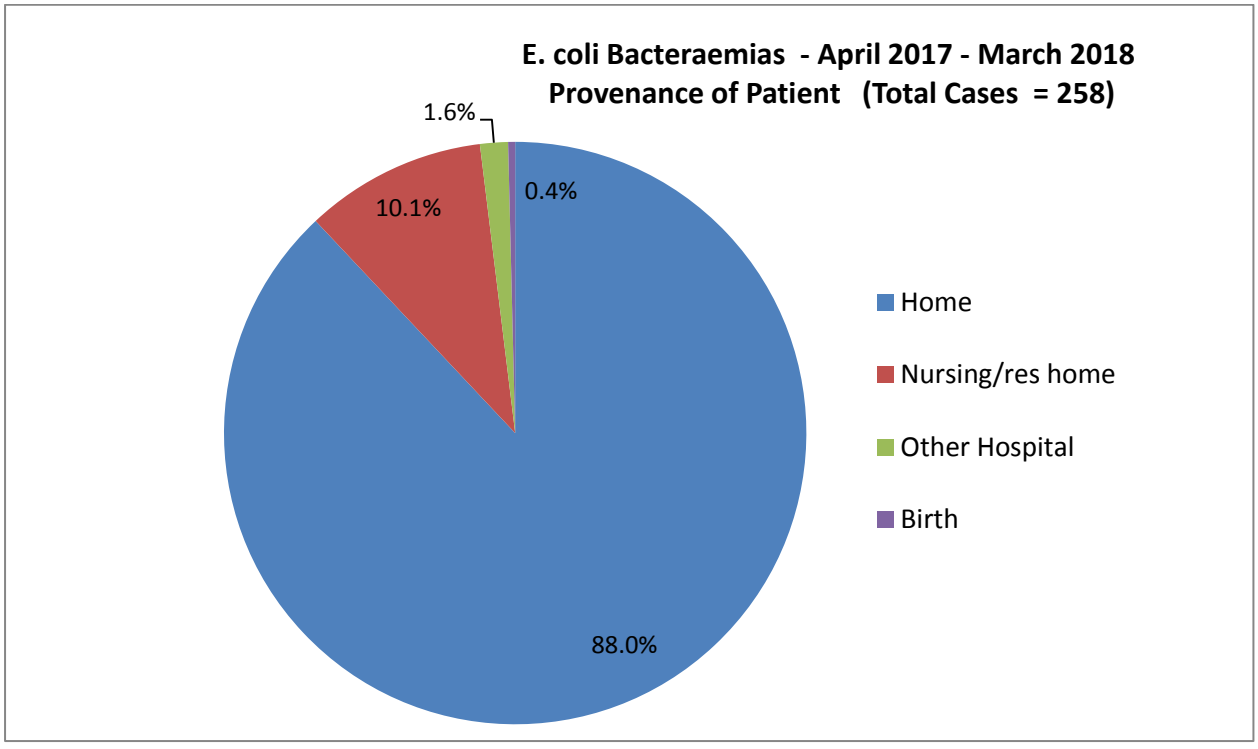
From April 2017 Mandatory Surveillance was extended by DH / PHE to include bacteraemias caused by other aerobic Gram negative bacillary bacteria. In addition to *E. coli*, it is now necessary to report patient episodes where blood cultures have yielded *Klebsiella* species and *Pseudomonas aeruginosa.* Systems have been put in place within GHNHSFT to collect data and report such bacteraemias on the HCAI DCS. This data collection is coordinated by the GHNHSFT Microbiology Department Information Officer and Medical Secretaries. The E.coli bacteraemia surveillance proforma has been modified to collect information for all these Gram negative bacteraemias.

In 2017-18 there were 258 reported episodes of *E.coli* bacteraemia diagnosed in Gloucestershire by the GHNHSFT Microbiology Department; 55 episodes were apportioned to GHNHSFT. Additional episodes were diagnosed for the population of Gloucestershire by other Microbiology Departments outside of the county. In 2017-18 there were 276 reported episodes of *E.coli* bacteraemia within NHS Gloucestershire CCG (58 were trust-apportioned).

Since 2012-13 the total number of *E.coli* bacteraemias in Gloucestershire has dropped by 14.6%. The proportion of bacteraemias that were classed as HCAIs (or post-48 hour episodes) has reduced from 26% of the total to 21%.

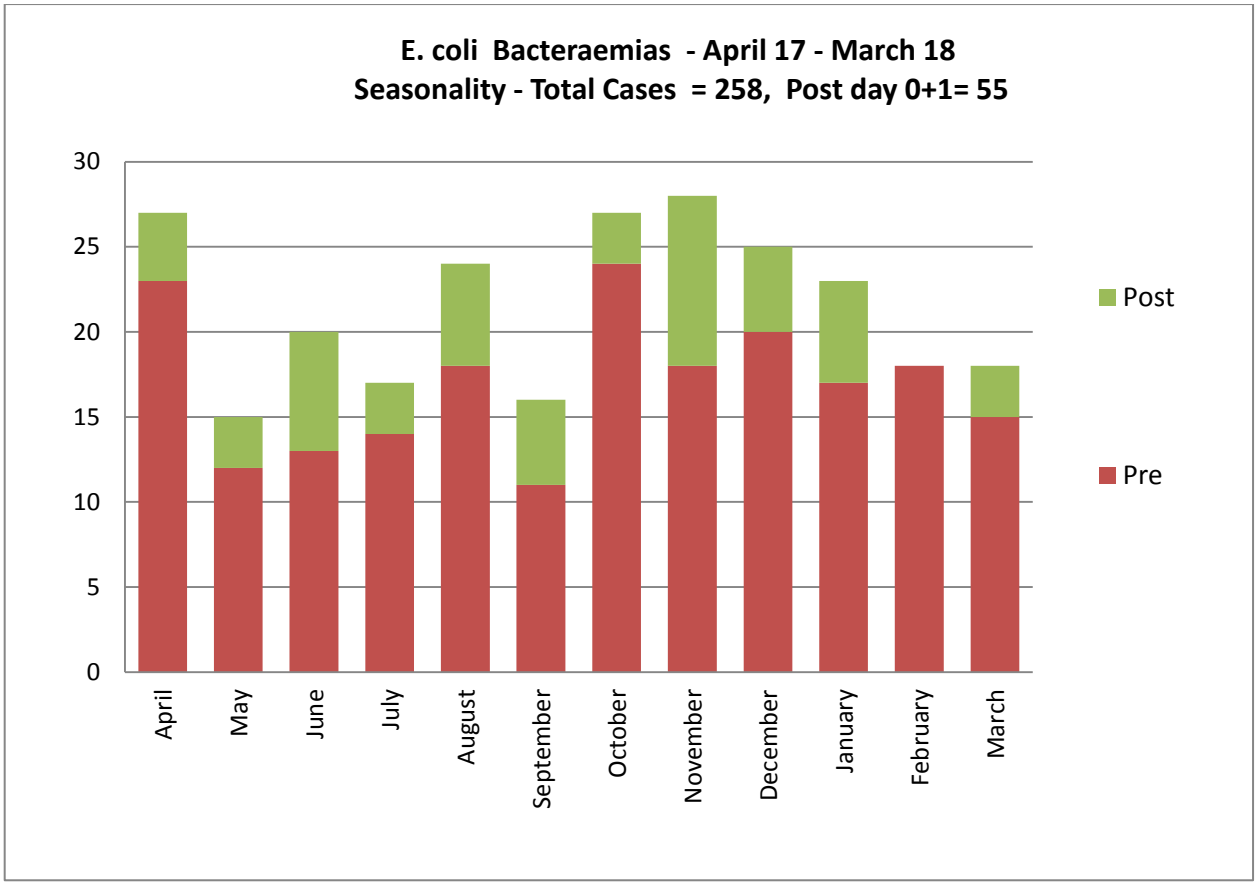


Patient Provenance for *E.coli* bacteraemias



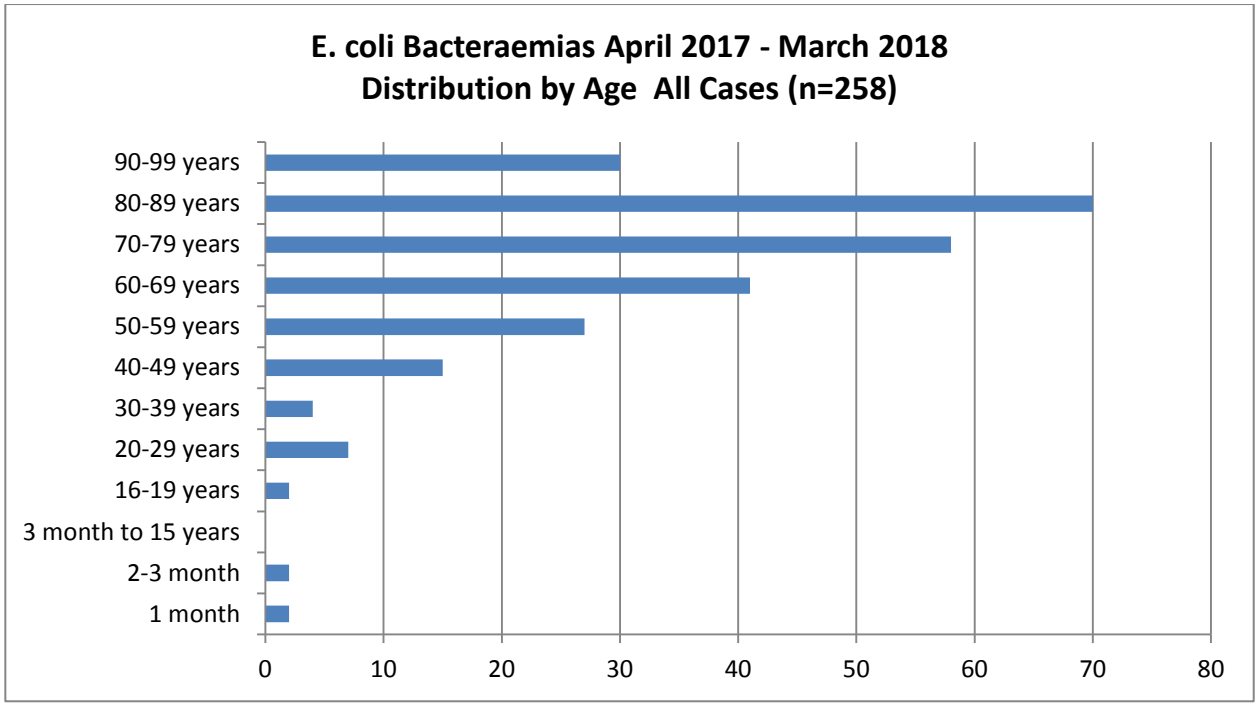
In this context, provenance is where the patient was resident prior to the hospital episode when the *E.coli* bacteraemia was diagnosed.

The number of *E.coli* bacteraemias per month varied throughout the year with a trend for more bacteraemias in the winter months.



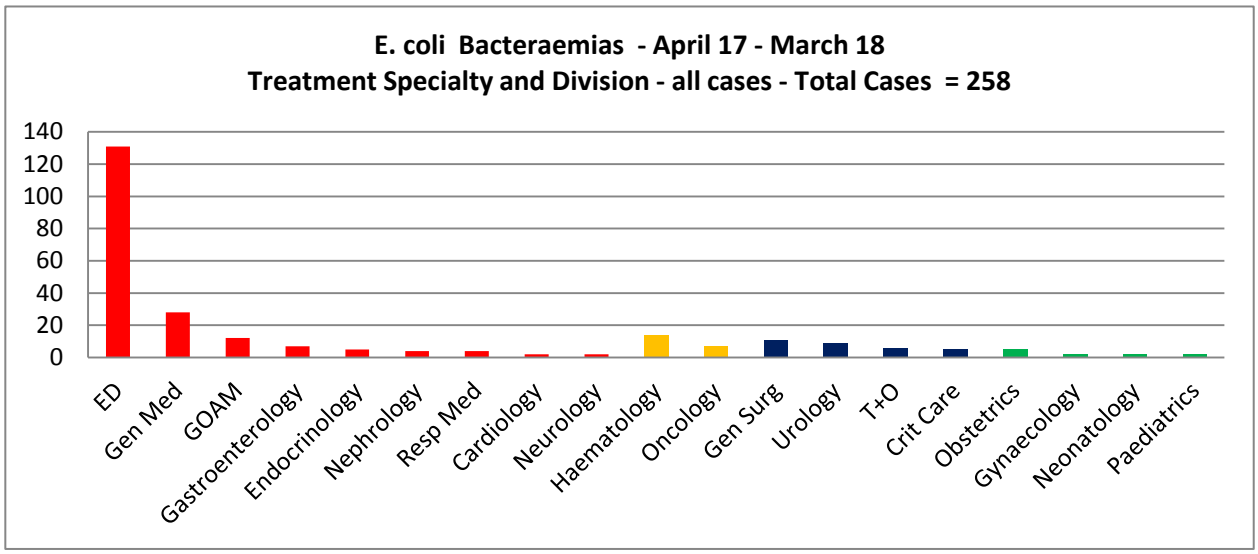
Age and gender of patients affected

Seventy seven percent of the bacteraemias occurred in patients over the age of 60 years. Overall, most of the bacteraemias occurred in females (55.4%), but post day 0+1 bacteraemias were more likely to occur in males (54.5%).



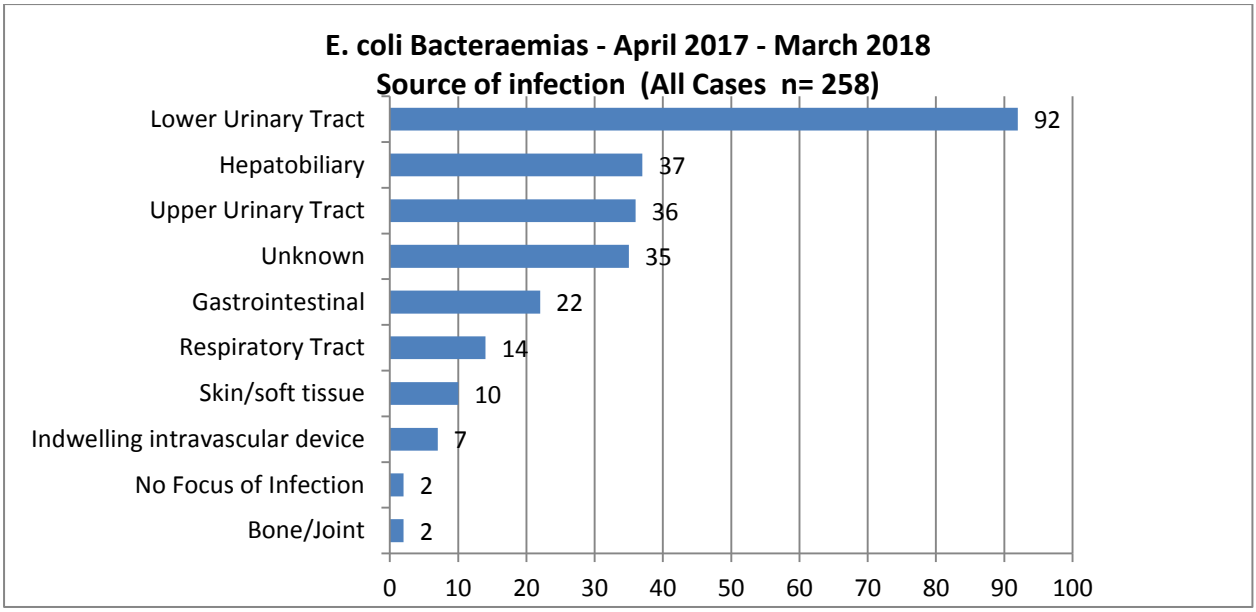
Specialty

The specialty looking after patients with *E.coli* bacteraemias at the time of the collection of the positive blood culture is shown in the Treatment Specialty bar chart below.



Source of the bacteraemia

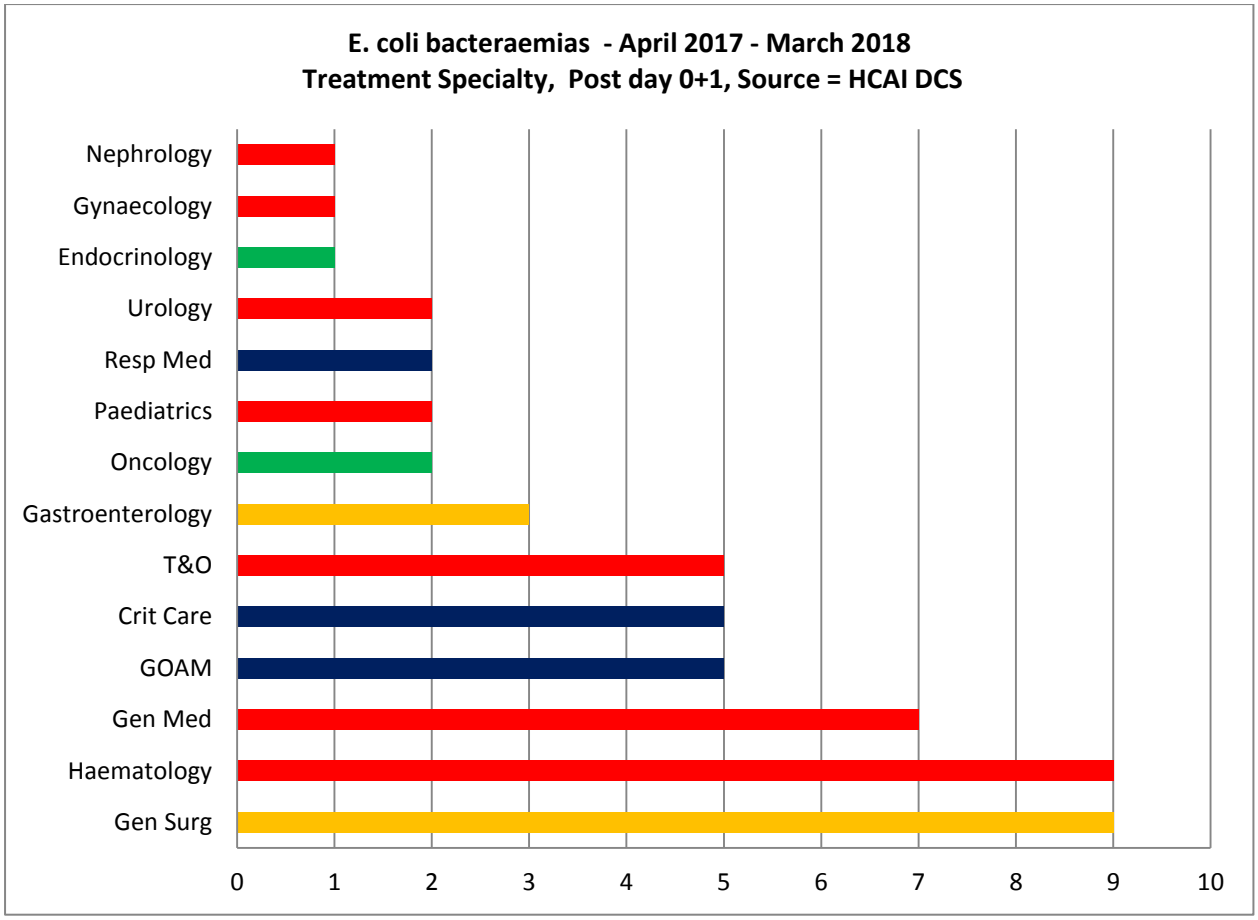
Fifty percent of cases reported the urinary tract as the source of infection. Hepatobiliary, gastro-intestinal, respiratory tract and skin and soft tissue (SSTI) infections accounted for the majority of the rest of the sources. In 35 episodes the source of the bacteraemia was unknown.



Post day 0+1 Bacteraemias

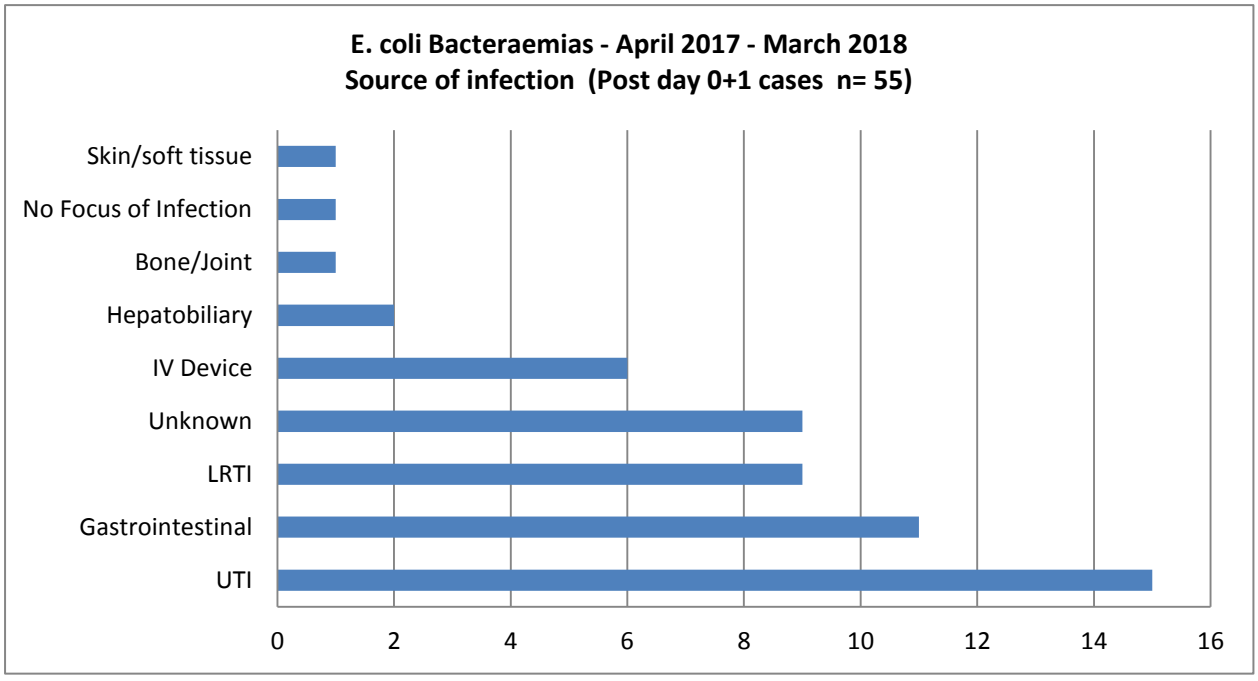
Twelve (21%) of the 55 post day 0+1 bacteraemias were known to have had an inpatient admission within 28 days prior to the positive blood culture

The treatment specialty for post day 0+1 bacteraemias is shown in the bar chart below.



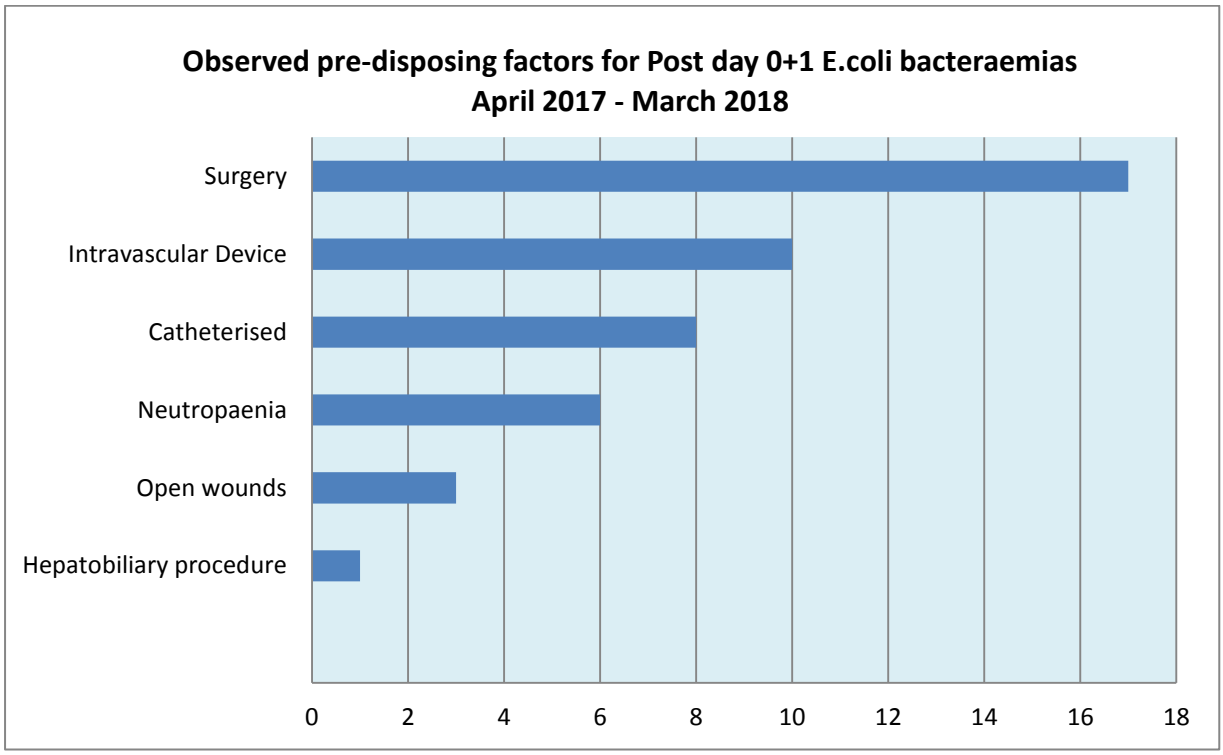
The source of infection for post day 0+1 episodes

The commonest known sources for post day 0+1 bacteraemias were urinary tract infection, gastrointestinal, lower respiratory tract and intravascular device-related.



Risk factor analysis of the Post day 0+1 Bacteraemia episodes

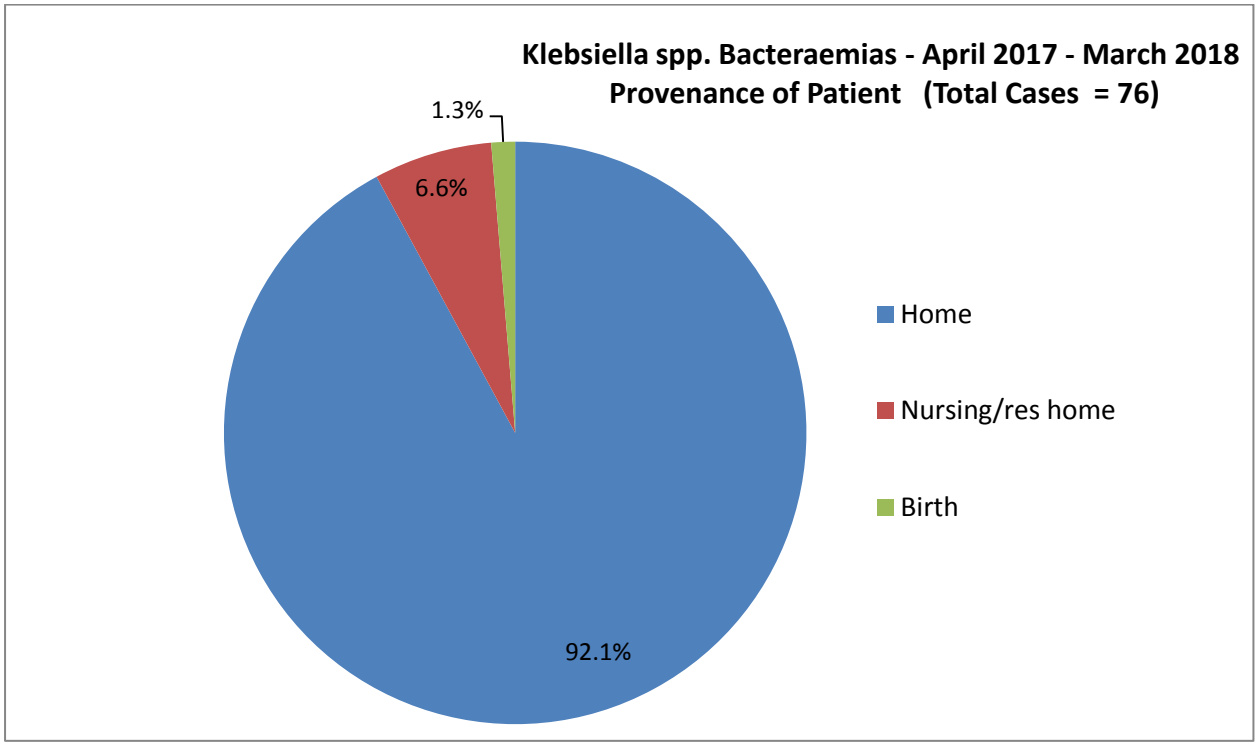
The most common predisposing factors are shown below. Predisposing factors were not noted for every case of post day 0+1 *E.coli* bacteraemia and some cases had more than one factor. The most often reported risk factor, (17/55 cases , 31%), was surgery.



3.4 *Klebsiella* species bacteraemias

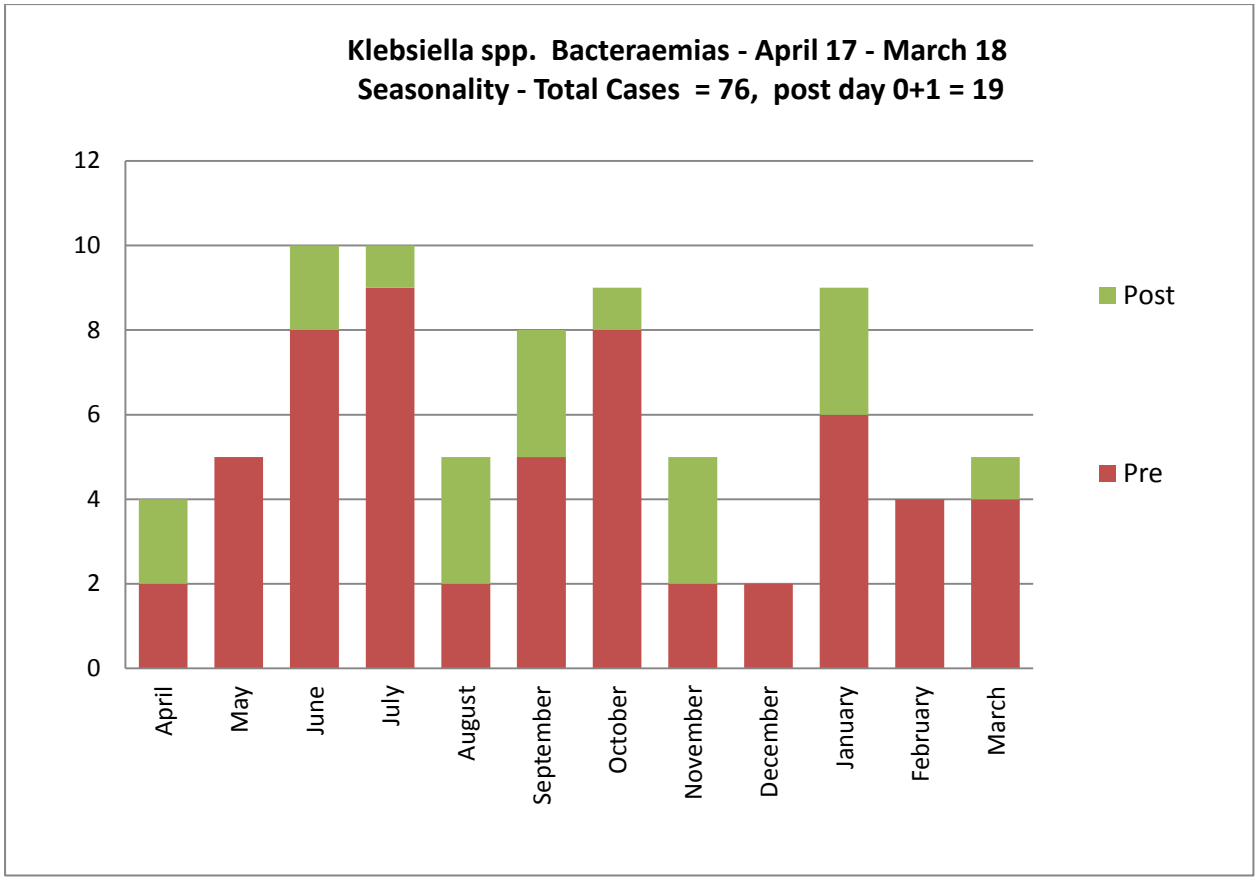
In 2017-18 there were 76 reported episodes of *Klebsiella* species bacteraemia diagnosed in Gloucestershire by the GHNHSFT Microbiology Department; 19 episodes (25%) were apportioned to GHNHSFT (post day 0+1 episodes).

Patient Provenance for *Klebsiella* species bacteraemias



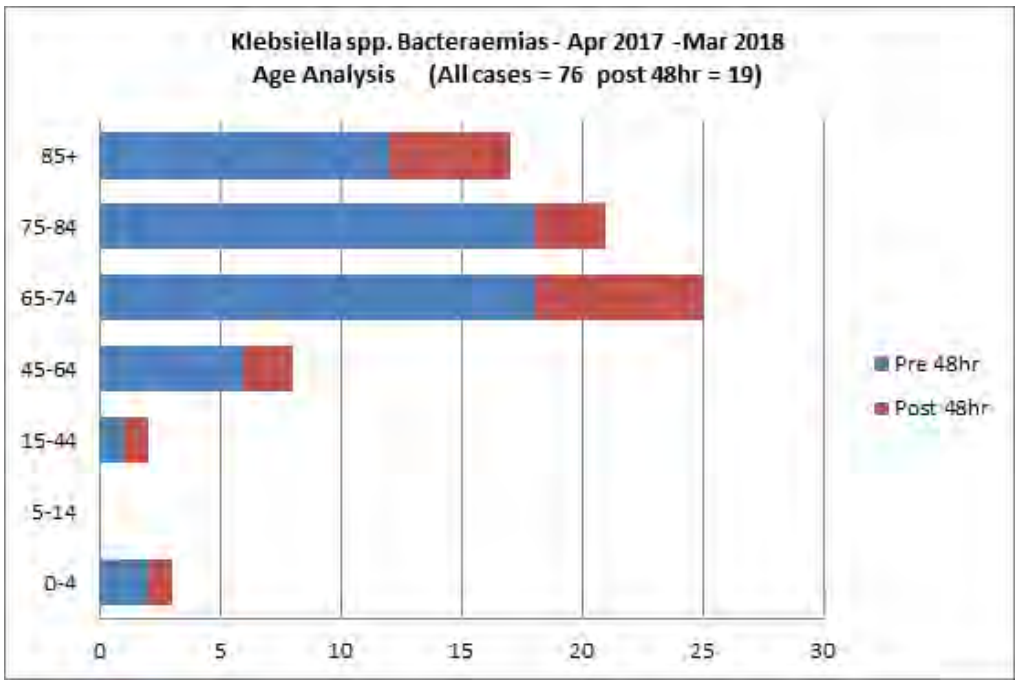
In this context, provenance is where the patient was resident prior to the hospital episode when the bacteraemia was diagnosed.

The number of bacteraemias per month varied throughout the year with no seasonal pattern. There was an average of 6 *Klebsiella* species bacteraemias per month.



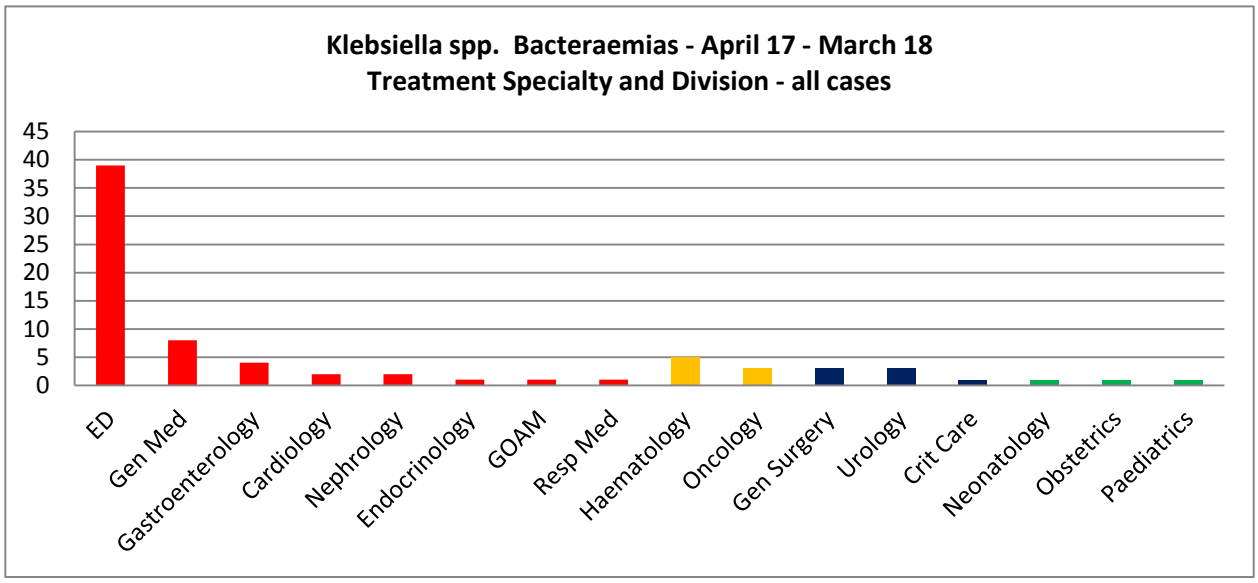
Age and sex of patients affected

Eighty three percent of the bacteraemias occurred in patients over the age of 65 years. Overall, most of the bacteraemias occurred in males (61%), with post day 0+1 bacteraemias also more likely to occur in males (58%).



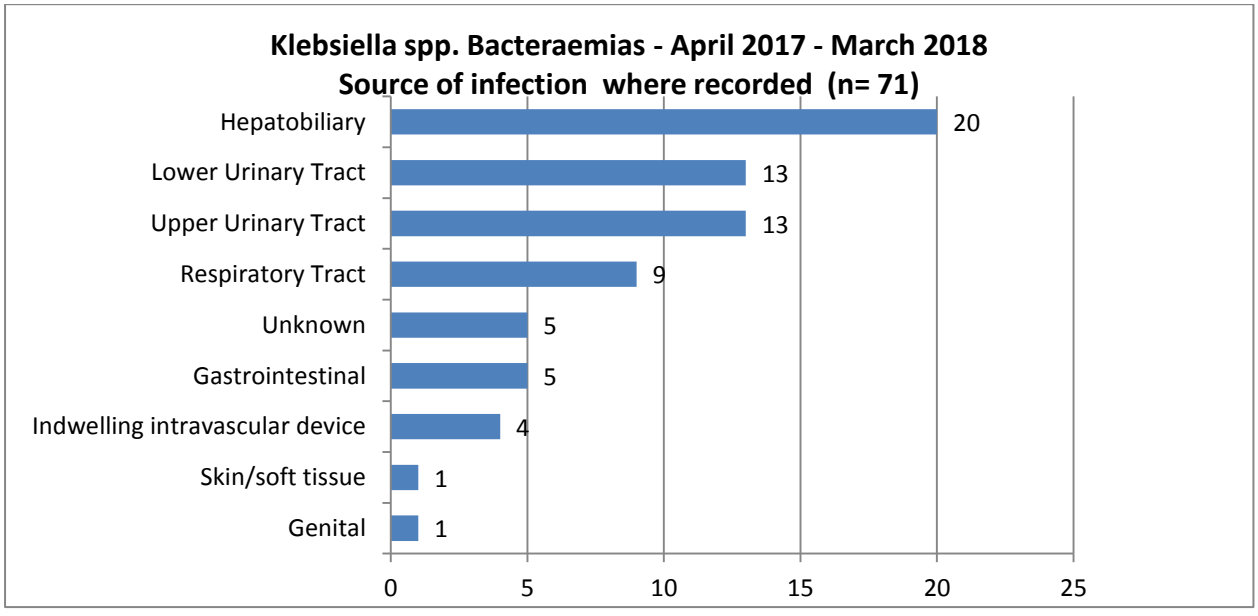
Specialty

The specialty looking after patients with *Klebsiella* species bacteraemias at the time of the collection of the positive blood culture is shown in the Treatment Specialty bar chart below.



Source of the bacteraemia

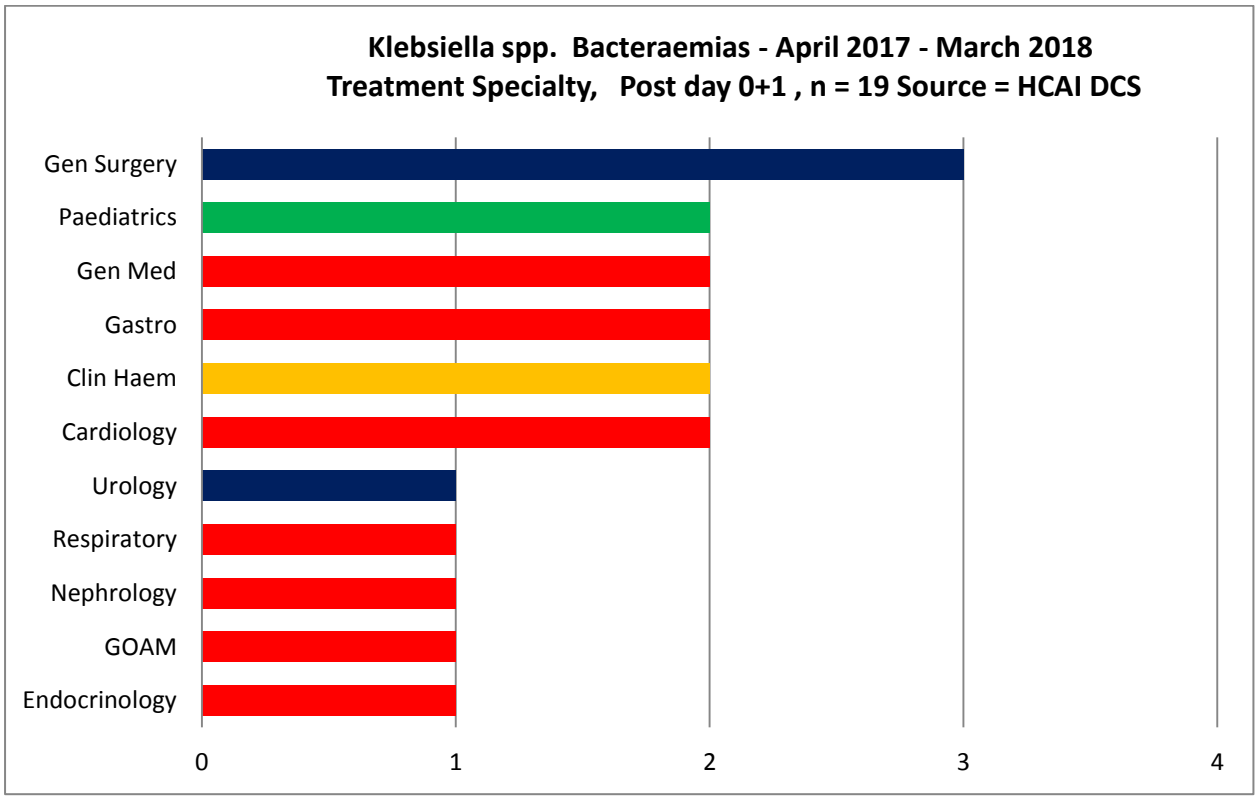
Seventy two percent of cases reported the urinary tract, biliary tract or respiratory tract as the source of infection. The commonest single source was UTI (34%). Gastro-intestinal, and IV device related infection accounted for most of the other less commonly identified sources. In 5 episodes the source of the bacteraemia was unknown.



Post day 0+1 Bacteraemias

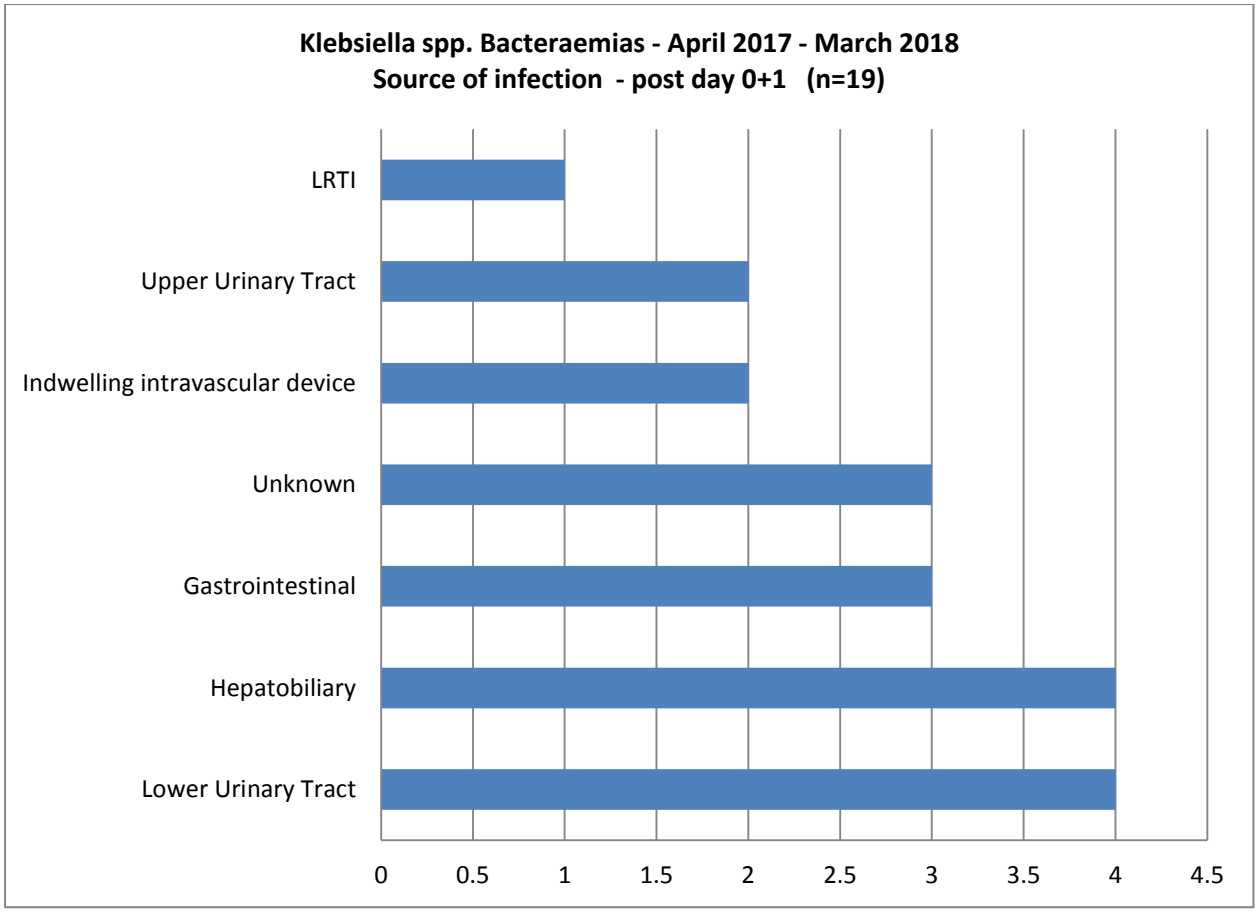
Twenty five percent (n=19) of the bacteraemias occurred after day 0+1 of admission.

The treatment specialty for post day 0+1 bacteraemias is shown in the bar chart below.



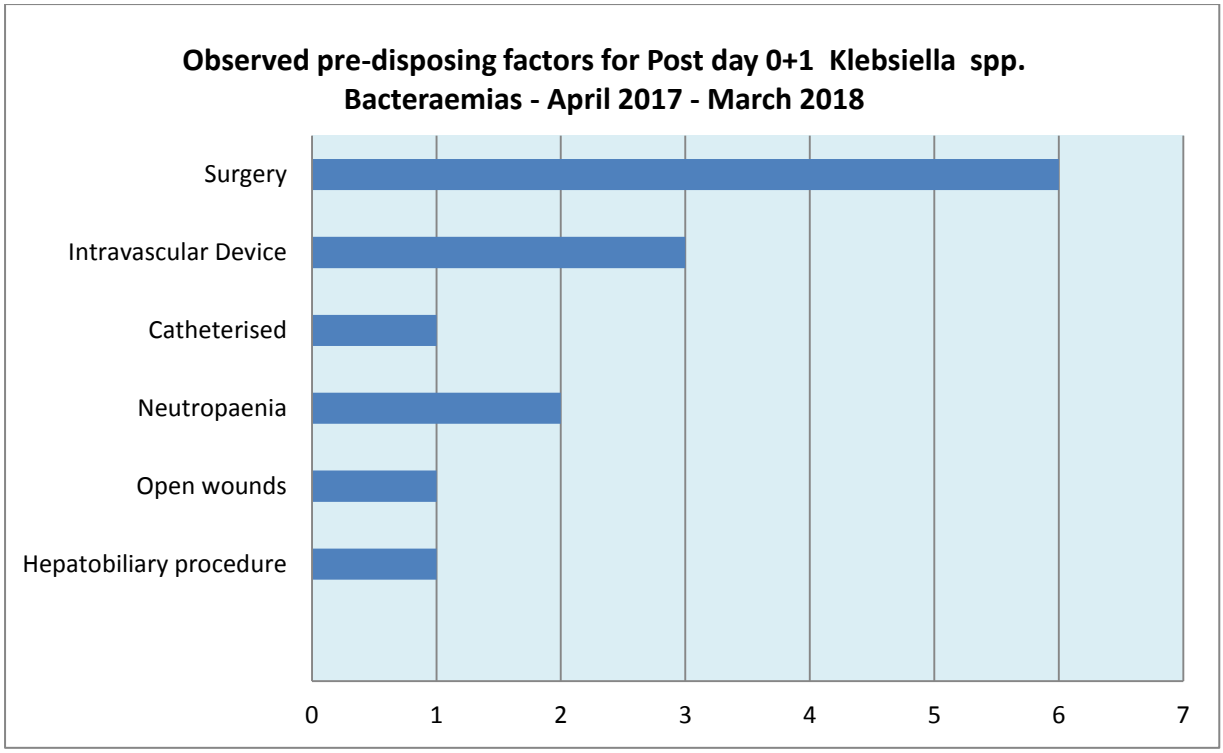
The source of infection for post day 0+1 episodes

The commonest known sources for post day 0+1 bacteraemias were urinary tract infection, gastrointestinal, and hepatobiliary. Other sources were infected IV device and lower respiratory tract infection (LRTI).



Risk factor analysis of the Post day 0+1 Bacteraemia episodes

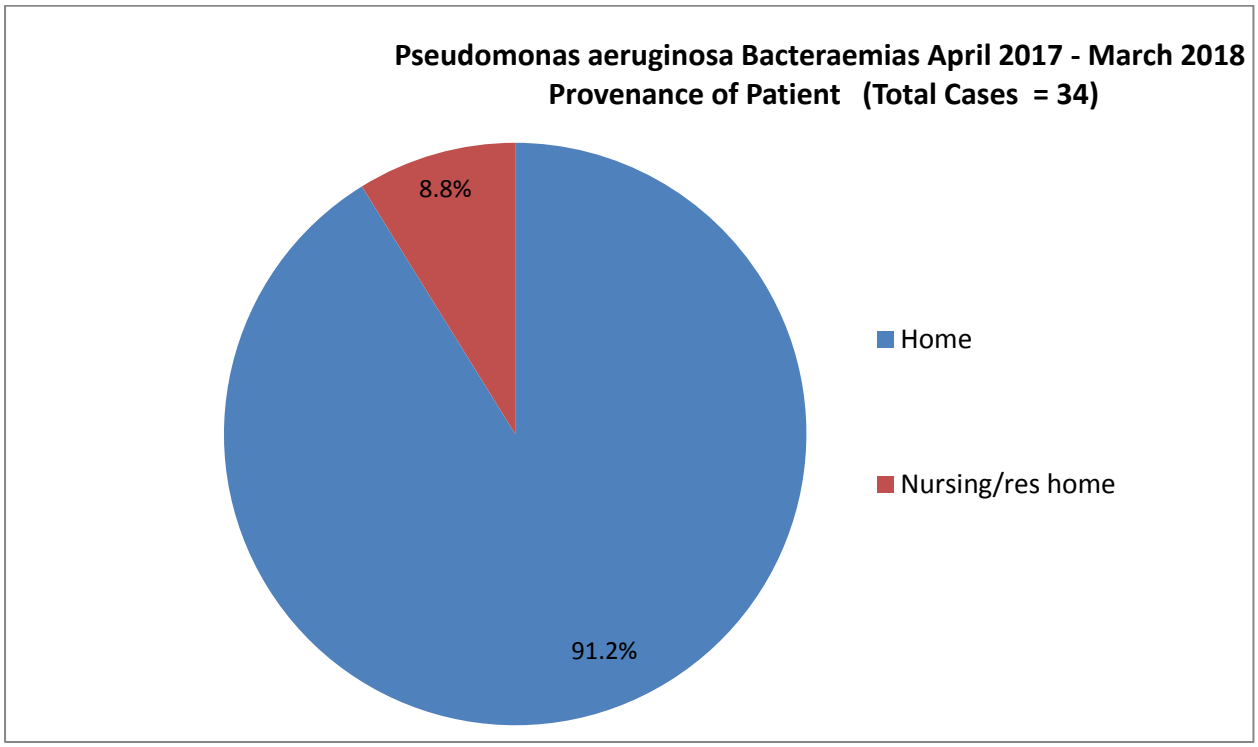
The most common predisposing factors are shown below. Predisposing factors were not noted for every case of post day 0+1 bacteraemia and some cases had more than one factor. The most often reported risk factor, (6/19 cases , 32%), was surgery.



3.5 *Pseudomonas aeruginosa* bacteraemias

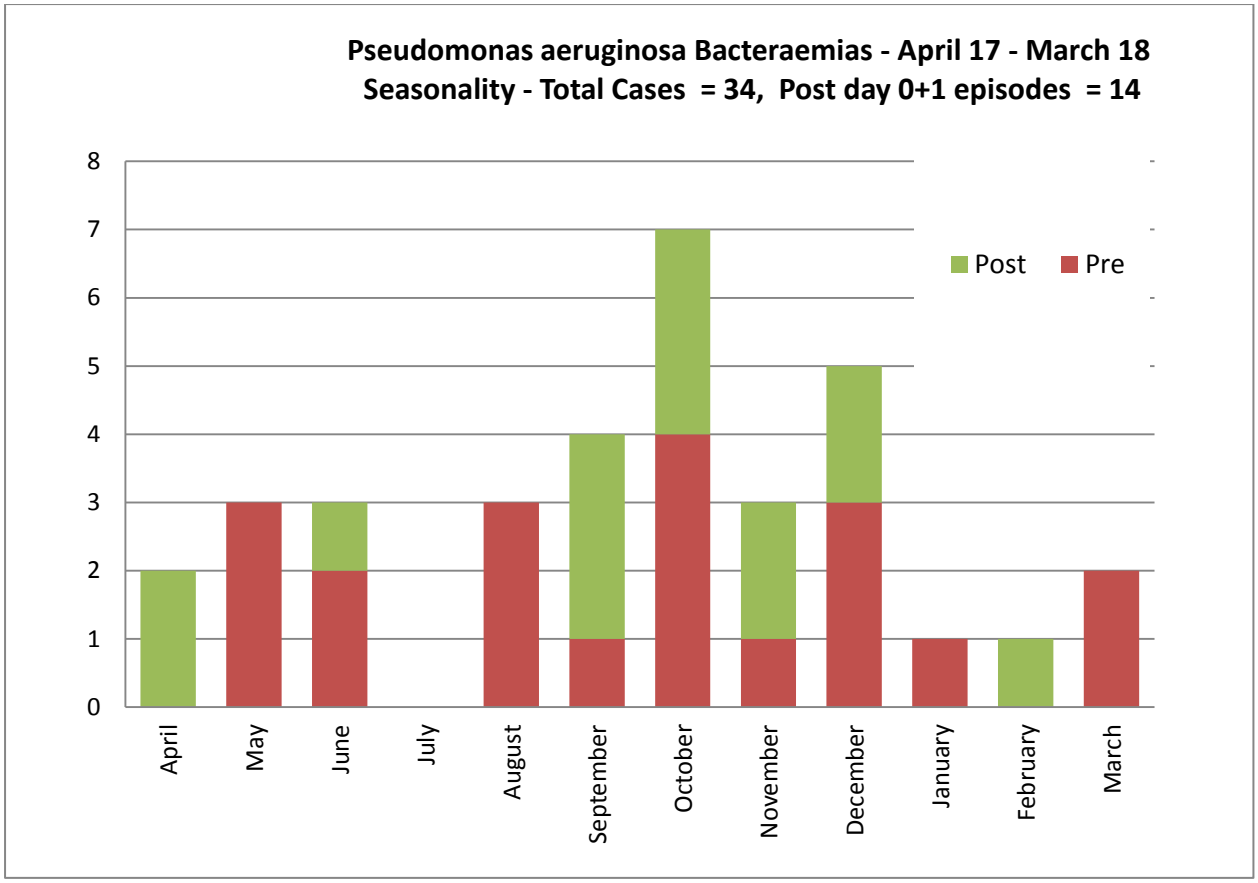
In 2017-18 there were 34 reported episodes of *Pseudomonas aeruginosa* bacteraemia diagnosed in Gloucestershire by the GHNHSFT Microbiology Department; 14 episodes (41%) were apportioned to GHNHSFT (post day 0+1 episodes).

Patient Provenance for *Pseudomonas aeruginosa* bacteraemias



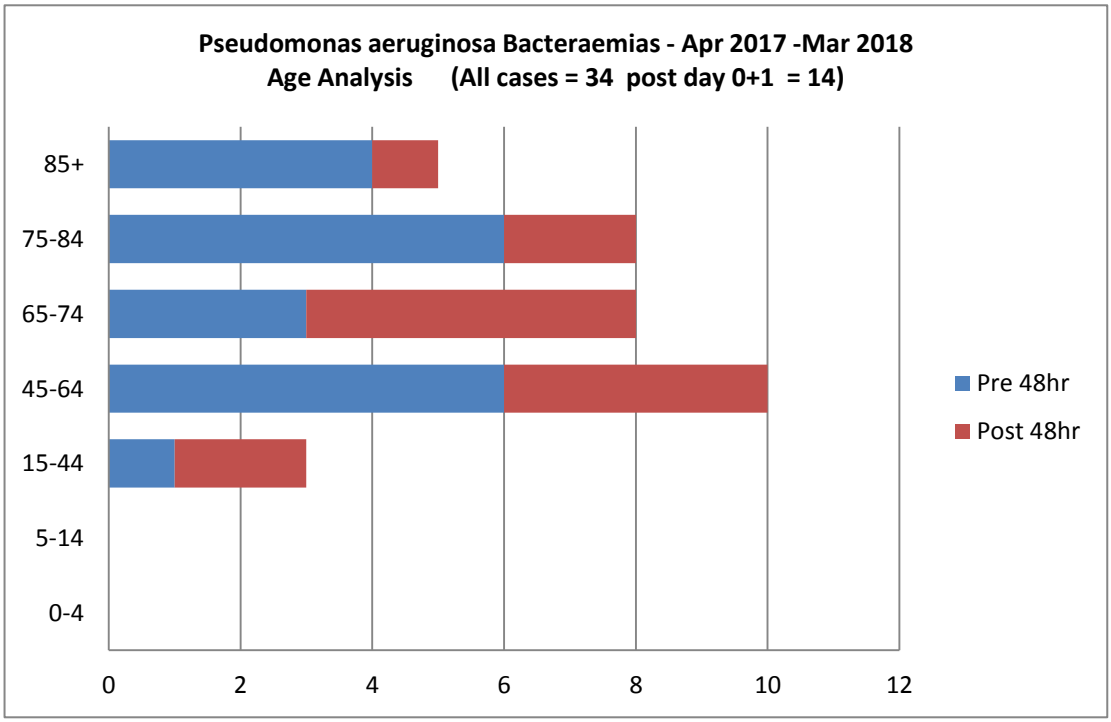
In this context, provenance is where the patient was resident prior to the hospital episode when the bacteraemia was diagnosed.

The number of bacteraemias per month varied throughout the year with no seasonal pattern. There was an average of 2-3 bacteraemias per month.



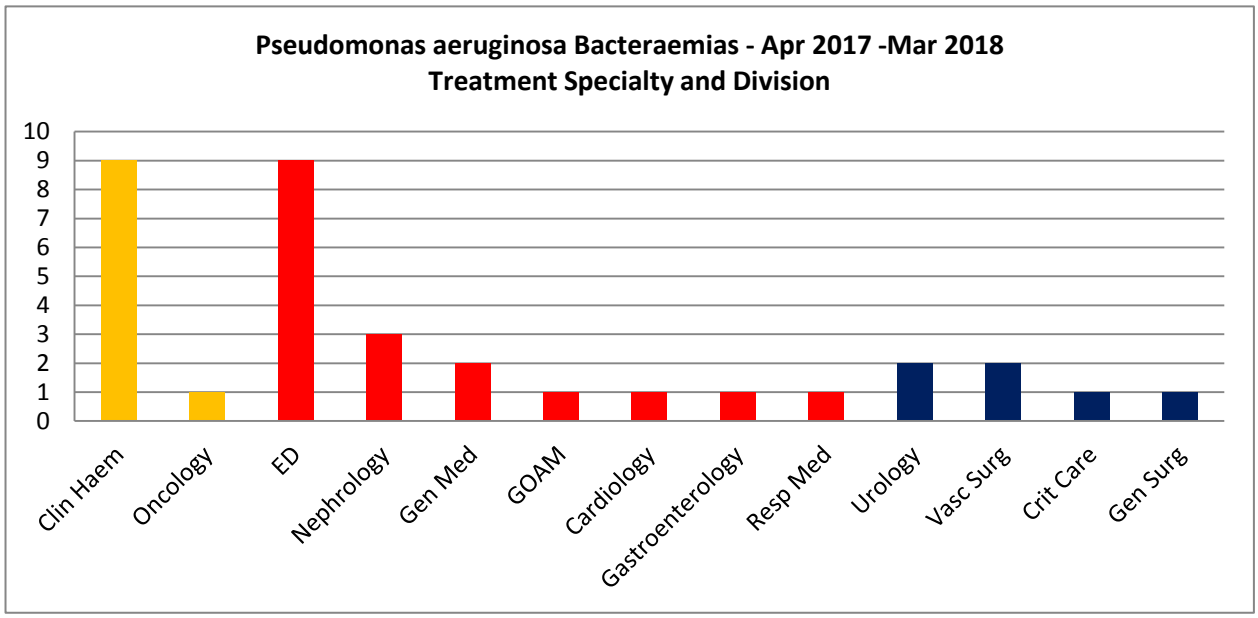
Age and sex of patients affected

Sixty two percent of the bacteraemias occurred in patients over the age of 65 years. Equal numbers of bacteraemias occurred in both sexes.



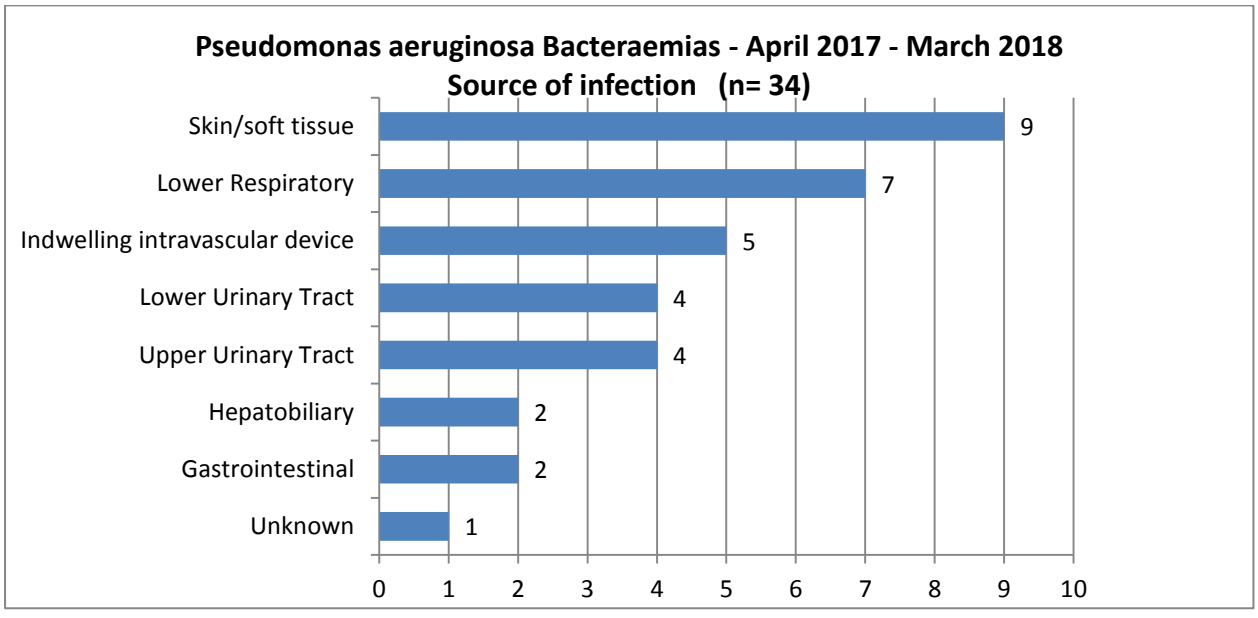
Specialty

The specialty looking after patients with bacteraemias at the time of the collection of the positive blood culture is shown in the Treatment Specialty bar chart below.



Source of the bacteraemia

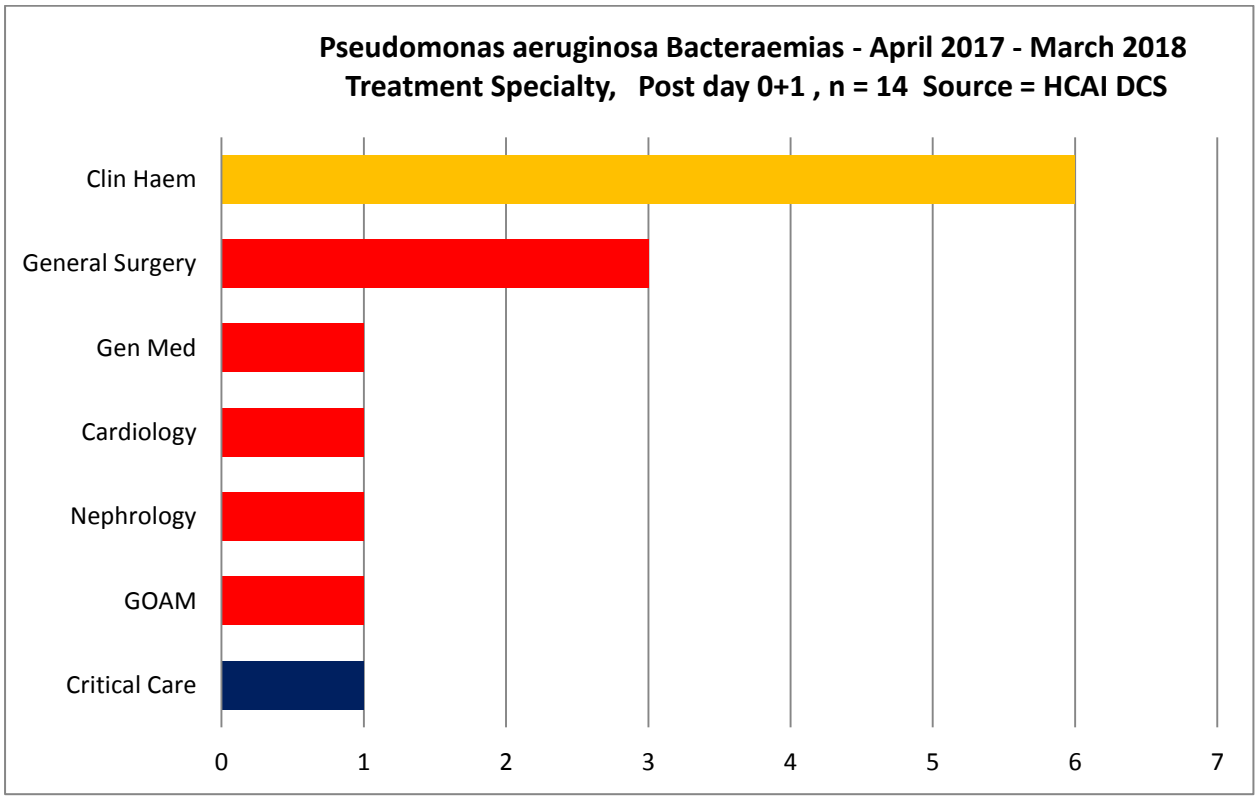
The commonest sources of the bacteraemia were skin and soft tissue (SSTI), LRTI, urinary and IV device-related. Gastro-intestinal and hepatobiliary infection accounted for most of the other less commonly identified sources. In 1 episode the source of the bacteraemia was unknown.



Post day 0+1 Bacteraemias

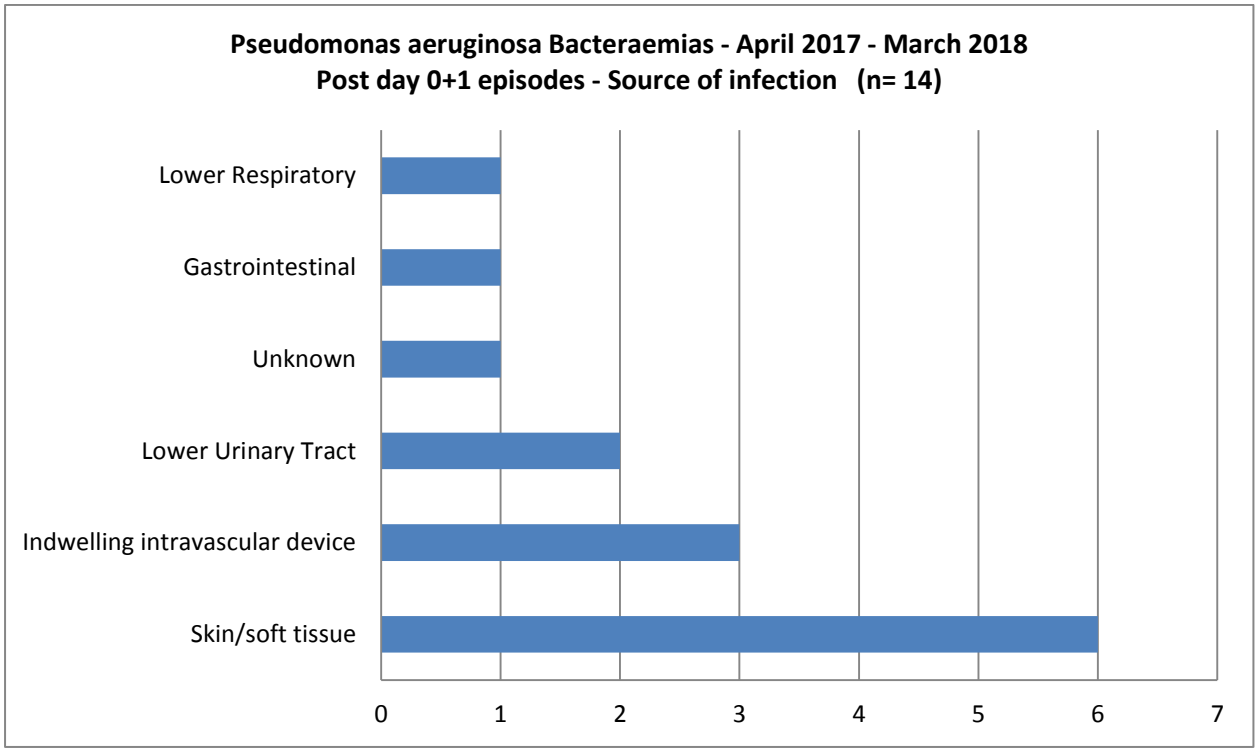
Forty one percent (n=14) of the bacteraemias occurred after day 0+1 of admission.

The treatment specialty for post day 0+1 bacteraemias is shown in the bar chart below.



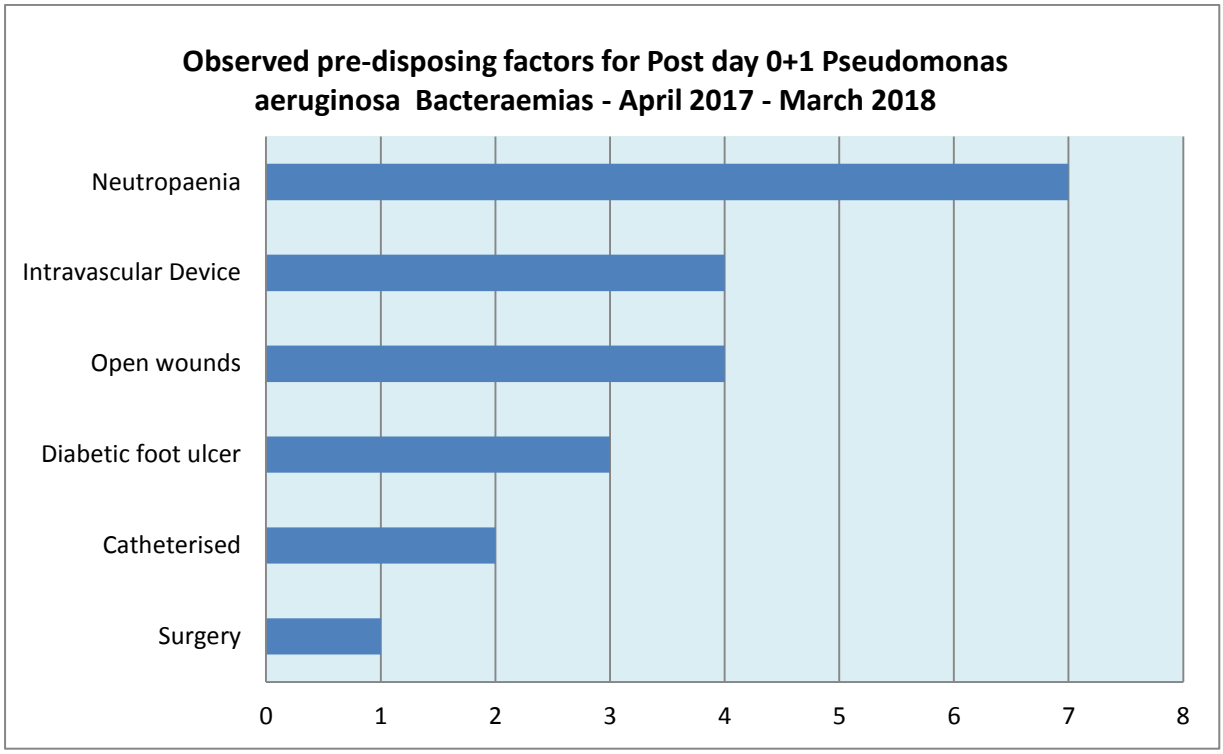
The source of infection for post day 0+1 episodes

The commonest sources of the post day 0+1 bacteraemias were skin and soft tissue (SSTI), urinary and IV device-related. In 1 episode the source of the bacteraemia was unknown.



Risk factor analysis of the Post day 0+1 Bacteraemia episodes

The most common predisposing factors are shown below. Predisposing factors were not noted for every case of post day 0+1 bacteraemia and some cases had more than one factor. The most often reported risk factor, (7/21, 33%), was neutropenia.



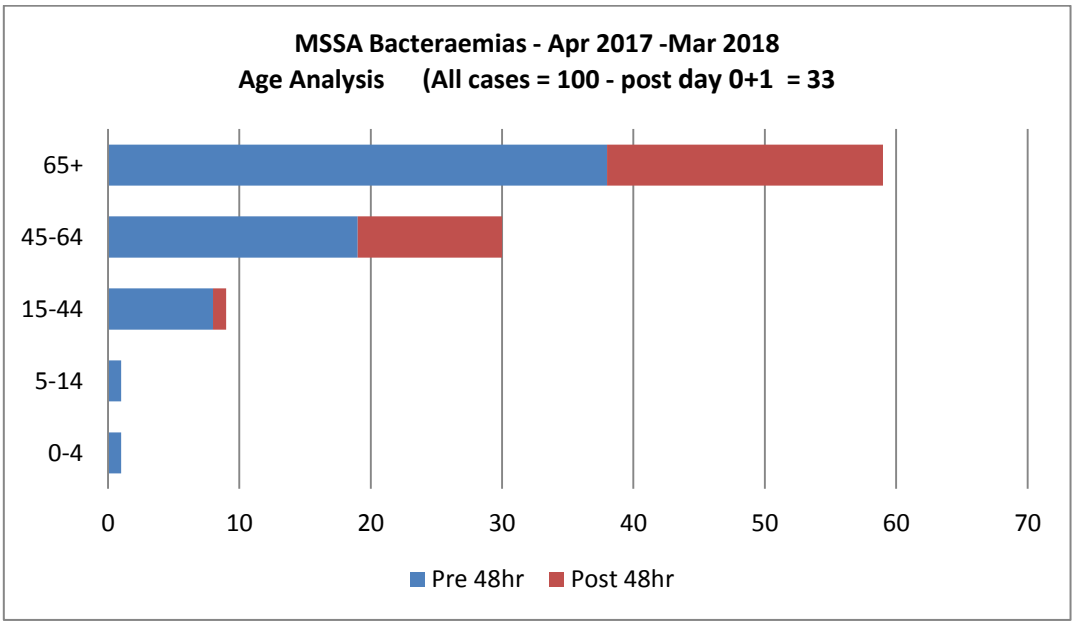
3.6 Methicillin Sensitive *Staphyloccous aureus* (MSSA) bacteraemias

Since January 2011 all acute NHS Trusts have been mandated to report all Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias to the DH via the HCAI data capture system as part of mandatory surveillance of HCAI. GHNHSFT has had systems in place for this data collection and reporting. The current system entails the Microbiology Department recording these infections and manually entering the infection episodes onto Public Health England (PHE) HCAI Data Capture System. The episode data includes date sample taken and date of admission so an assessment of whether the infection is pre- or post-day 0+1 of admission can be made. There is no nationally set or locally agreed target for post-day 0+1 (trust attributable) MSSA bacteraemia. GHNHSFT is however keen to keep the numbers of these infections to an absolute minimum.

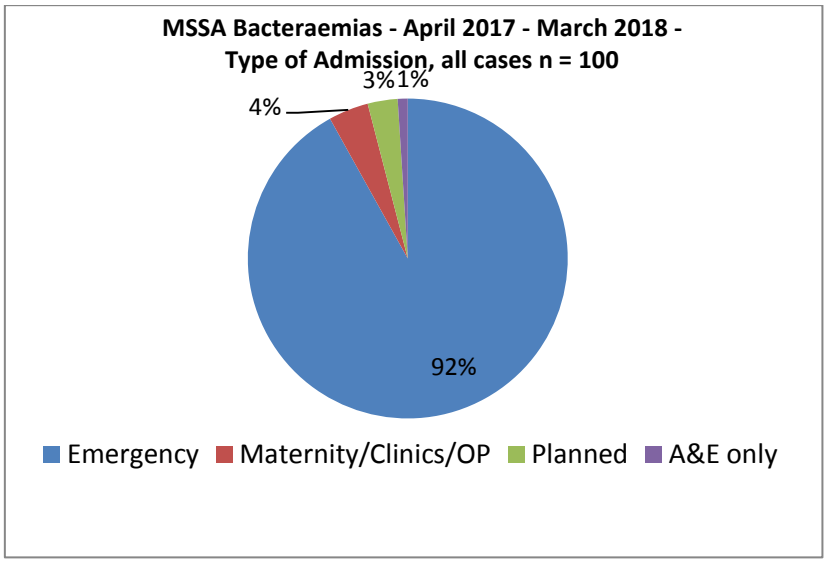
These episodes have been analysed locally to gain a better understanding of the epidemiology of this relatively common invasive bacterial infection.

In the county there are approximately 8 MSSA bacteraemias per month. In the last 12 months of the surveillance there were 100 MSSA bacteraemias. 67% (67) of episodes were in patients in the first 48 hours of their admission. 33% (33) were post day 0+1 episodes. The incidence of infection increased with increasing age but there were some (2) infections occurring in children (age <15 years). Fifty nine percent of all the MSSA bacteraemias occurred in the over 65s. The average age of patients

with a MSSA bacteraemia was 66 years.

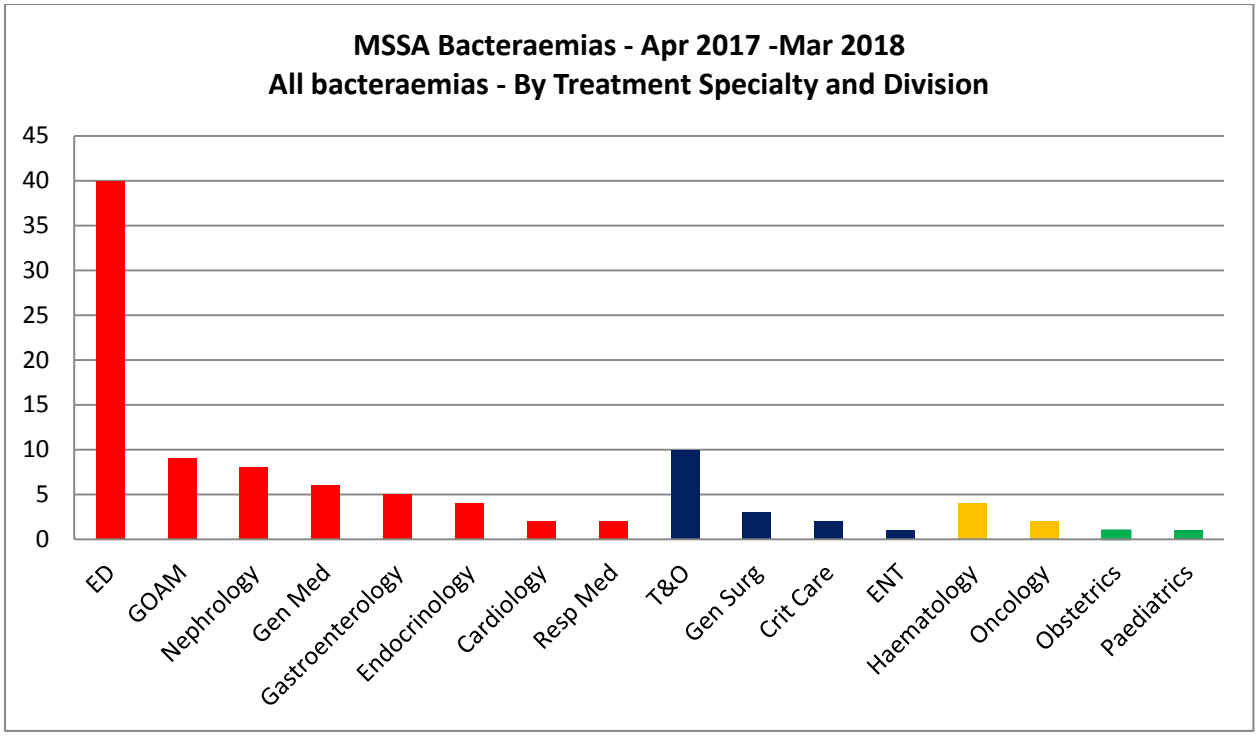


The type of admission of patient having MSSA bacteraemias in recorded in the pie chart below.

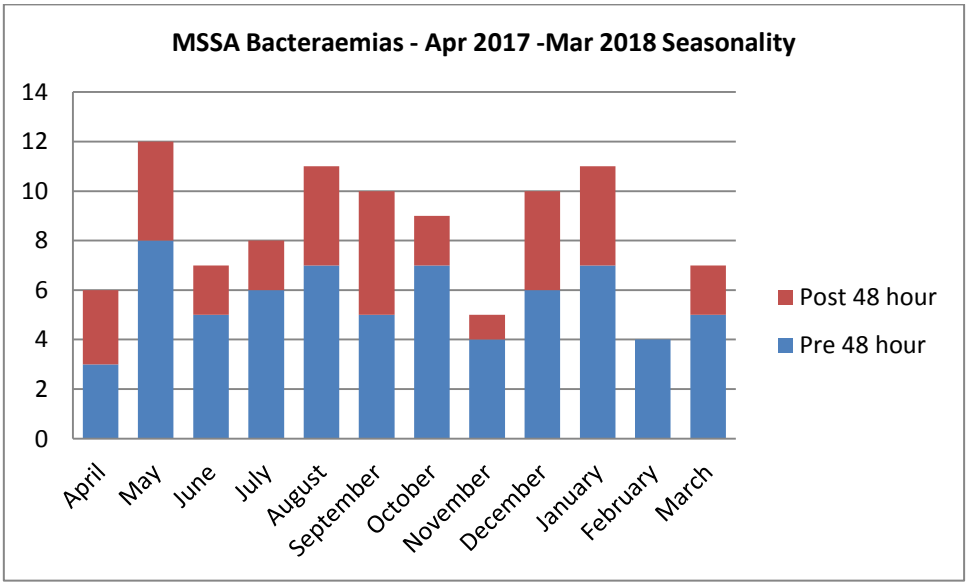


Between April 2017 and March 2018 the surveillance showed that more males (63%) than females were affected. Of the post day 0+1 MSSA bacteraemias 58% of these occurred in males.

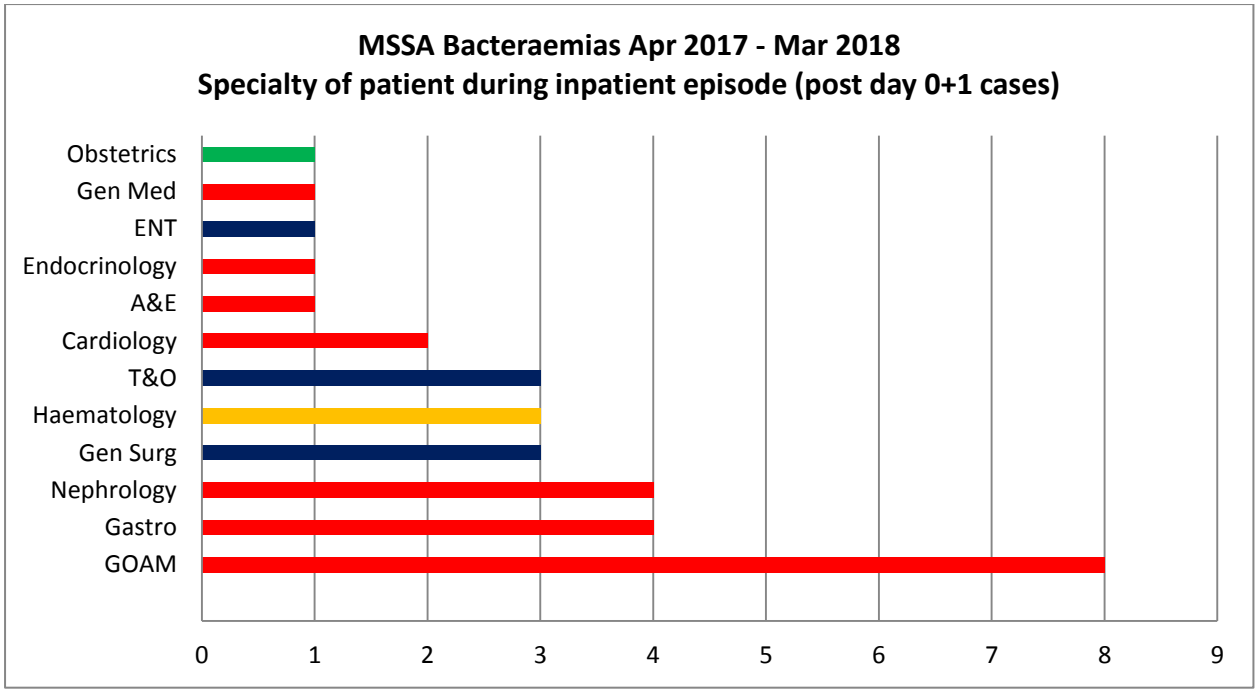
Most of the infections were diagnosed and managed in patients managed within the medical division.



The number of MSSA bacteraemias per month varied throughout the year with no obvious seasonality. One would perhaps expect there to be higher numbers in the winter months associated with the influenza season.

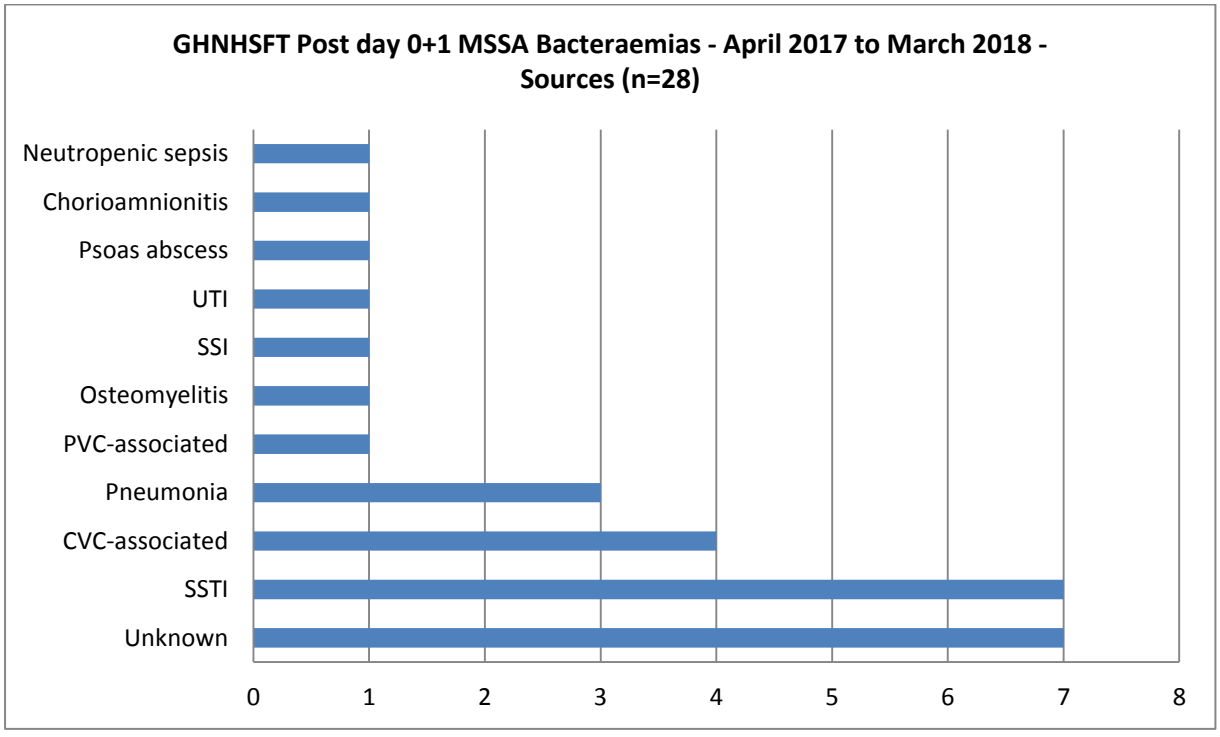


Analysis of the post day 0+1 cases (most likely to be healthcare-associated) has been performed. The specialty of the patient during inpatient episodes for the post 48 hour cases is preseented in the chart below.



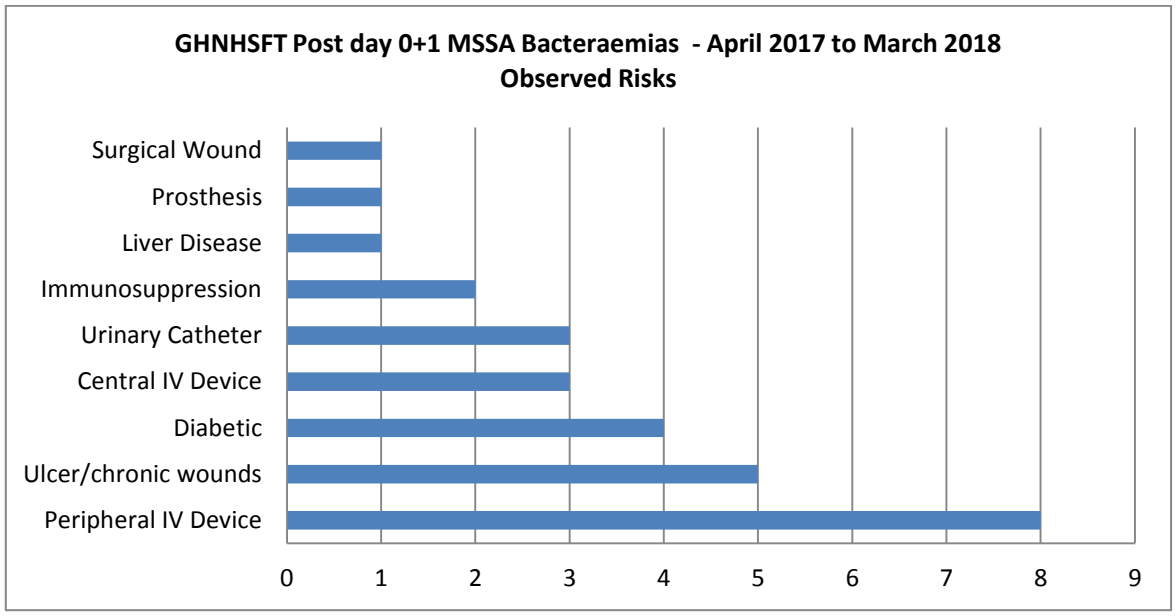
Analysis of the clinical risk factors for the post day 0+1 MSSA bacteraemias has been performed. RCAs were completed and risk factor data compiled by the ICNs. Analysis of the risk factor data and production of graphs and charts has been performed by Nicola Stokes, Information Officer, in the Microbiology Department.

The sources of the post day 0+1 MSSA bacteraemias were assessed. Information on the source was available for 28 episodes (84.8%). Twenty one of the episodes had a known source



Risk factor information was available for 54.5% of all post day 0+1 bacteraemia cases.

General risk factor information for episodes is presented in the graph below which includes presence of invasive devices (not necessarily the source of the infection), procedures and underlying predisposing conditions. Note that patients may have more than one risk factor. The five commonest risk factors for MSSA bacteraemia were peripheral and central intravascular devices, presence of a urinary catheter, being diabetic and having an ulcer or chronic wound. Other factors included immunosuppression, liver disease, presence of a prosthesis and having a surgical wound.



3.7 Carbapenemase Producing Enterobacteriaceae (CPE)

Screening of patients for CPE was introduced in Gloucestershire in September 2014 to comply with a requirement to implement the national CPE toolkit for Acute Trusts This guidance was intended to assist in preventing any outbreaks and reducing the spread of these resistant organisms within health care settings.

The monthly surveillance report presented monthly data on CPE testing undertaken in GHNHSFT Microbiology for the laboratory catchment area in Gloucestershire. The total numbers of specimens (screens) sent specifically for screening for carriage of CPE is presented. The numbers of specimens that have grown Enterobacteriaceae that are suspected to be CPE on the basis of local testing are also presented (possible CPE). Any samples with possible CPE are sent to a reference lab for confirmation. The number of samples shown to have confirmed CPE (on the basis of reference laboratory results) is also presented.

CPE isolates can potentially be yielded from any diagnostic microbiology specimen (e.g. sputum, blood cultures, and urine) as well as from samples sent specifically for CPE screening. CPE screening samples are mainly rectal swabs and stool samples, but with a few other selected superficial ('manipulated') sites being investigated for carriage as clinically indicated. Most detections of CPE will reflect asymptomatic

carriage, but these organisms do have the potential to cause clinical infections and when detected from sites other than CPE screening samples might be causing clinical infection.

GHNHSFT identifies how many CPE screens have been taken monthly within the healthcare community and identifies the location of any confirmed cases. This information was reported in the monthly surveillance report. CPE incidence is presented as numbers of “detections” rather than as a rate of infection (true incidence).

In 2017/18 there were 0 confirmed cases of CPE.

A total of 470 samples have been tested for CPE from April 2017. This is an increase compared to 2016/17 when 352 samples were tested. Currently our patient population appears to have a low rate of CPE carriage.

4. Outbreaks and learning from incidents

The infection prevention and control team have a comprehensive surveillance programme that allows early detection of emerging incidents. The Trust investigates incidents to extract learning points in order to continually improve the quality of our services.

4.1 Norovirus

From April 2017 - March 2018 there was a total of 16 ward or bay closures due to outbreaks of diarrhea and vomiting; 12 at GRH and 4 at CGH of which 14 had Norovirus identified as the causative organism. There was a total of approximately 304 bed days lost across the Trust throughout the year due to the gastroenteritis outbreaks with a total of 190 patients affected with symptoms and 59 staff reported sick with symptoms that were made known to the Infection Control Team.

The organization appears to have not been too badly affected by norovirus this financial year with rapid detection and control of outbreaks when these did occur.

During October 2017 to May 2018 the Infection Control Nurses provided a service to review outbreaks of diarrhoea and vomiting and influenza at weekends and bank holidays.

4.2 Seasonal Influenza

Influenza activity was been unusually high this season 2017-18. The high levels of influenza in the wider community, especially Influenza B early in the season, resulted in significant numbers of outbreaks occurring in non-hospital institutional settings. In addition, there have been significant numbers of patients admitted to hospital with influenza or illnesses arising as a complication of influenza (e.g. secondary bacterial pneumonia). The increased numbers of patient admissions with active current influenza infection proved challenging to the organisation during our period of Winter Pressures. As in previous seasons it was not possible to isolate, in single rooms, all patients whilst they were infected and there was not 100% compliance with all elements of the “Flu Bundle”. The inability to isolate all infectious patients resulted in a number of transmissions of infection to existing inpatients. In a very small number of cases this resulted in short periods of bed closures. A consequence of inpatient exposure to un-isolated infectious patients was a need to assess exposed contacts for the need for them to receive antiviral chemoprophylaxis as “post-exposure prophylaxis” and in some cases this needed to be converted to a treatment course.

This year has seen the introduction, as a pilot study, of influenza point of care testing (POCT) at GRH. The overwhelming opinions from staff, including the Chief Executive, was that this was a very valuable addition to the need for rapid diagnosis of influenza. It was also felt to be vital to patient bed allocation from ED and AMU. This year has seen no ward closures and a significant decrease in bed days lost to flu. Last season’s estimates were of 274 bed days lost across the Trust. This year there have been less than 10 bed days identified as being lost as a result of influenza. In addition the percentage of influenza diagnosed after 5 days of

admission, likely hospital-acquired, has seen a significant decrease providing a more reassuring experience for patients, including improvements to patient safety.

This year also saw the introduction to the Influenza Tool Kit, a resource for ward staff, matrons and site managers on how to manage both individual patients with influenza and also how to manage cohort areas when patient numbers outstrip isolation room availability. Cohort areas for influenza within wards were managed at both GRH and CGH during winter 2017/18. Feedback to the team has been positive from those using the toolkit.

It is likely that the scope of the Seasonal Influenza Meetings will need to be expanded to include not just an ongoing focus on staff vaccination (including the use of quadrivalent vaccine rather than trivalent), but also service delivery considerations during periods of increased activity, and development of an Influenza pathway and an escalation policy for Influenza that indicates trigger points for when affected wards should institute cohort nursing when single room isolation capacity is exceeded. Cross site use of POCT machines should also be considered as this year's improvement in hospital acquisition and reduced bed days lost has been achieved in the face of significantly elevated numbers of influenza cases.

Due to significantly high levels of influenza across England from 15th January until 16th April the Trust was required to report Influenza figures daily to NHS England. This required the team to report all new cases of:

- Laboratory confirmed cases of Influenza in High Dependency and Intensive care units, and of those how many in the last 24hrs
- Laboratory confirmed cases of Influenza in all other inpatient beds
- Total patients tested positive in the last 24hrs, and of those how many were discharged

A weekly report and update was provided by the Microbiology Department which summarised hospital influenza activity including information on where cases were being diagnosed, type of influenza and trend information.

4.3 Infection prevention and control incidents recorded on Datix

Confirmed serious incidents

None confirmed during the period 2017/18 however a serious incident was reported during 2018/19 that included *C. difficile* cases from October and November 2017 on ward 4B at GRH.

4.4 National Survey Programme 2017

The Trust participated in the National Inpatient Survey 2017 as required by the Care Quality Commission for all NHS Trusts in England. These results are benchmarked and compared against the range of results from all other trusts that take part in national surveys.

The results from the following surveys have been published or carried out during

2017-218 and contained questions relating to Infection Prevention Control.

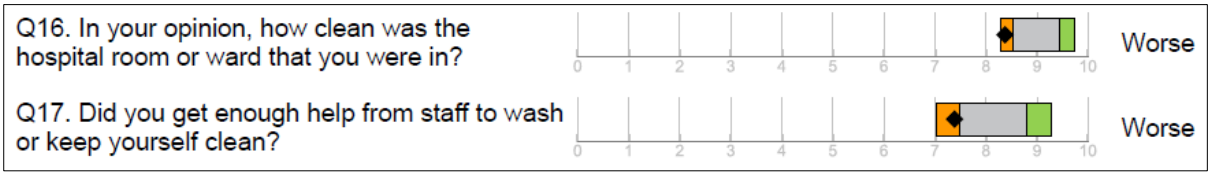
- National Inpatient Survey 2017
- National Maternity Survey 2017

These surveys are mandated by the Care Quality Commission for all NHS Trusts in England. These results are benchmarked and compared against the range of results from all other participating trusts.

1216 inpatients who used the Trust during July 2017 received a postal questionnaire with a response rate of 41.4%. The Trust results were worse than the 2016 results.

- 94% *(96% in 2016)*of patients reported the hospital room or ward was very / fairly clean
- 62% *(66% in 2016)* of patients that needed help always received the help they needed from staff to wash and keep themselves clean

Compared with all other Trusts in England that participated in the survey our results are **worse** (bottom 20%) of most other Trusts nationally:

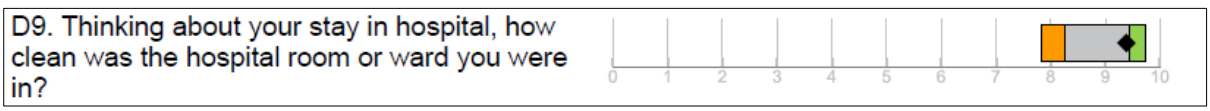


National Maternity Survey 2017

394 women who gave birth under the care of our Trust's Maternity Service during February 2017 received a postal questionnaire with a response rate of 42.1%. The Trust results were the same as the 2015 results.

- 99% (*99% in 2015*) of women reported that the hospital room or ward they were in postnatally was very/ fairly clean

Compared with all other Trusts in England that participated in the survey our results are **about the same** (middle 60%) as most other Trusts nationally:



4.5 Complaints and Concerns

The Patient Experience Department recorded 19 concerns and 27 complaints, a total of 46 between April 2017 and March 2018.

Of the 19 concerns recorded 14 were relating to GRH and 4 to CGH and 1 offsite. Of the 27 complaints recorded 21 were relating to GRH and 6 to CGH.

Themes arising from Concerns and Complaints during this period were:

Environmental cleanliness

The majority of concerns and complaints relate to cleanliness. Concerns and complaints related to dirty toilets, bins, floors, and general poor standards of cleanliness in both clinical and public areas (public toilets and restaurant). ED at both sites had concerns and complaints regarding dirty chairs, trolleys, general cleanliness, toilets and equipment (in ED dirty and broken toys were highlighted). Other areas highlighted were AMU, 2a, 3b, 5b, 6b, 8a, 9a X-Ray (GRH), Outpatient areas (GRH), Bibury, Hazleton and Prescott. All of these concerns and complaints were escalated immediately to domestic services by the PALS team.

Hand Hygiene

There were 5 concerns and complaints received regarding hand hygiene. 3 complaints concerned medical staff not performing hand hygiene, 1 complaint was received regarding a nurse not performing hand hygiene prior to manipulating an IV line, and 1 complaint was received regarding lack of soap on a ward.

Issues relating to Infection Control

10 concerns and complaints were raised directly related to infection control issues. These were concerned with both practice and clinical interventions and included

- Poor handwashing prior to a procedure by medical staff in ED
- Maternity ‘poor infection control’
- Soiled linen and clothes being left on floor, chairs and beds
- Patient not being washed after having D&V
- Body fluid spills not being cleared up promptly
- IV fluid lines dangling on floor and lack of hand hygiene when changing IV fluid bag
- Reported that visitors to a ward developed D&V , and complaint from outpatient that they caught D&V from a touchscreen
- 2 complaints regarding staff in ED and DSU working while unwell with coughs and colds
- There was one concern raised ‘offsite’ regarding nurses in uniform leaving wards affected by norovirus

5.0 Surgical Site Infections

Surgical site infection is a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. Surgical site infections have been shown to compose up to 20% of all of healthcare associated infections. Around 5% of patients undergoing a surgical procedure develop a surgical site infection.

A surgical site infection may range from a spontaneously limited wound discharge within 7–10 days of an operation to a more serious postoperative complication, such as a sternal infection after open heart surgery. Most surgical site infections are caused by contamination of an incision with microorganisms from the patient's own body during surgery. Infection caused by microorganisms from an outside source following surgery is less common. Measures can be taken in the pre-, intra- and postoperative phases of care to reduce risk of infection.

Surgical site infections can have a significant effect on quality of life for the patient. They can be associated with increased morbidity and extended hospital stay. In addition, surgical site infections result in increased financial costs to healthcare providers. Advances in surgery and anaesthesia have resulted in patients who are at greater risk of surgical site infections being considered for surgery. In addition, increased numbers of infections are now being seen in the community as patients are allowed home earlier following day case and fast-track surgery.

During 2017/18 data for the SSIS programme was compiled by the Practice Development and Educational Support Nurse for the Surgical Division.

During the period of April 2017 to March 2018, the picture for SSI within GHNHSFT has been somewhat mixed. Categories covered by the SSI team are as follows: Gastric, Large Bowel, Small Bowel, Breast, Hip and Knee arthroplasty, neck of femur, Long Bone Reduction and Spinal. Following concerns from the orthopaedic team regarding the suitability of data around Amputations (which are performed almost exclusively by the Vascular Team), the decision was taken to drop this category in March 2018.

In Breast Surgery, we were identified as High Outliers at CGH in the July to September quarter (2.3% against a national of 0.8%) which represented 2 cases. During the October to December quarter, this had dropped to 1.6% (also representing 2 cases), and we were no longer identified as outliers.

Gastric surgery saw the Trust identified as “combined low outliers” in the April to June quarter, having identified no Inpatient/Readmission SSIs over the 4 quarters covered. Data collection methods were reviewed in view of this, and a discussion was had with both PHE and the clinical team. No changes were deemed necessary as the clinicians confirmed that there were no SSIs in the period covered by the outlier status. The other G.I. categories (Large and Small Bowel surgeries) have not had any outlier status conferred on them. Numbers of operations performed within

the Small Bowel category have been quite small, so that any SSIs identified have not been statistically significant. Rates for Large Bowel Inpatient/Readmission SSIs in particular have been seen to be generally lower than the national rate.

Hip replacements saw us be assigned high outliers at GRH in the July to September quarter (2.4% against a national of 0.5%, representing 3 cases) and the October to December quarter (2% against a national of 0.5%, representing 1 case). For this last quarter, CGH was also identified as a High Outlier (1.6%, representing 3 cases). Knee replacements saw GRH identified as High Outliers in the April-June quarter (1% against a national of 0.4%, representing 1 case). The Trust was identified as being “combined high outliers” in the following: NOF (CGH) with a 4 quarter rate of 2.7%, Hip Replacements (GRH) with a 4 quarter rate of 1.3%. A reconfiguration of T&O services occurred during the October to December quarter, so the effect of this on SSI rates will not be fully seen until the January to March 2018 quarter (to be published July 2018). Elective orthopaedic arthroplasty surgery is now undertaken at the CGH site.

Since 2016 a multi-disciplinary ‘orthopaedic infection control group’ has been in place to review and improve practices. This group continues to meet regularly and has recently revised the action plan.

In May 2018, control of the SSI team and process was transferred from the Surgical Division (and the Practice Development Nurse) to the Infection Prevention and Control Nursing team.

6.0 Audit

The Infection Prevention and Control Team have a comprehensive audit programme for assurance purposes that has been successfully delivered during 2017/18.

Cleaning hands is one of the most important actions anyone can carry out to prevent infection. Hand hygiene audits are undertaken by the clinical area and are reported every month at the ICC. Audits are undertaken monthly by the clinical areas. Regular hand hygiene audits are performed by the Infection Prevention and Control Team to further validate the results.

Saving Lives 'high-impact interventions' are evidence based tools that allow staff to monitor compliance with clinical guidance and provide feedback so that compliance can improve consistently. High impact interventions provide the means to ensure that staff undertake clinical procedures correctly every time they are needed. The high impact interventions include guidance and tools for: central venous catheter care, peripheral venous catheter care, renal dialysis catheter care, prevention of surgical site infection, care for ventilated patients, urinary catheter care and reducing the risk of *C. difficile*. Saving lives audits are regularly undertaken by clinical areas every month.

A regular infection control audit of clinical areas is carried out by an Infection Prevention Nurse. The audit consists of: observation of practice, review of care and management of patients with infections, observations on correct use of personal protective equipment, observations of environmental cleanliness and review of patient indwelling devices. The results of the audit are fed back to the clinical area and Matron.

A rolling programme of monthly independent environmental audits, led by the Estates Team, are in place to monitor the compliance of clinical and non-clinical areas against the national cleaning standards framework. Audit results are made available to areas and reported to ICC.

The planned audit programme for 2017/18 is detailed below:

- *Saving Lives* programme's high impact interventions (HIIs) care bundles – undertaken monthly by nursing staff
- Hand hygiene-undertaken bi-monthly
- Environmental audits-Monthly programme
- MRSA screening compliance with policy
- Audit compliance with CPE risk assessment on admission and policy
- Hand hygiene reliability audits of inpatient areas by Gojo
- Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) – monthly by pharmacists (not all areas completed monthly)

The Saving Lives site was again monitored by the ICNs. ICN's took responsibility for the Hand hygiene study day, the Saving Lives annual study day and the Saving

Lives link nurse quarterly updates.

The planned audit of compliance with the MRSA policy was not undertaken. The planned audit of compliance with CPE risk assessment was partially completed but unfinished.

Gojo (providers of hand foam to the Trust) continued to provide reliability audits. These continued to show disparity between Trust scores and reliability scores. These results are circulated to ward managers, Matrons and divisional leads. The ICNs were unable to undertake the planned monthly programme of environmental audits, due to prioritisation of workload.

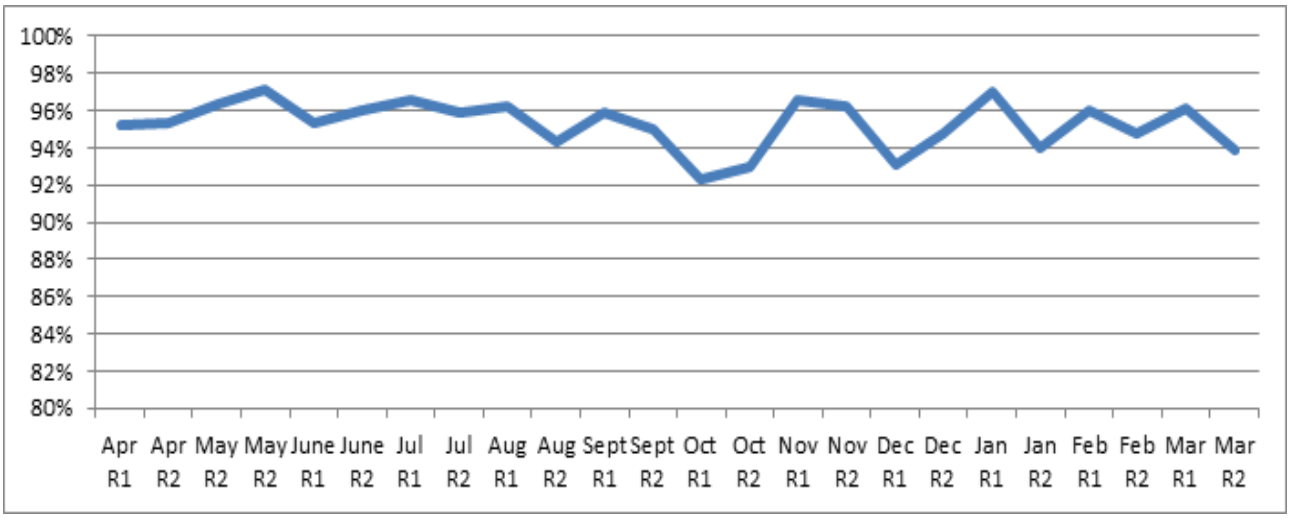
Hand Hygiene

Hand hygiene (HH) audits continued to be undertaken bi-monthly by the ward based hygiene Champions.

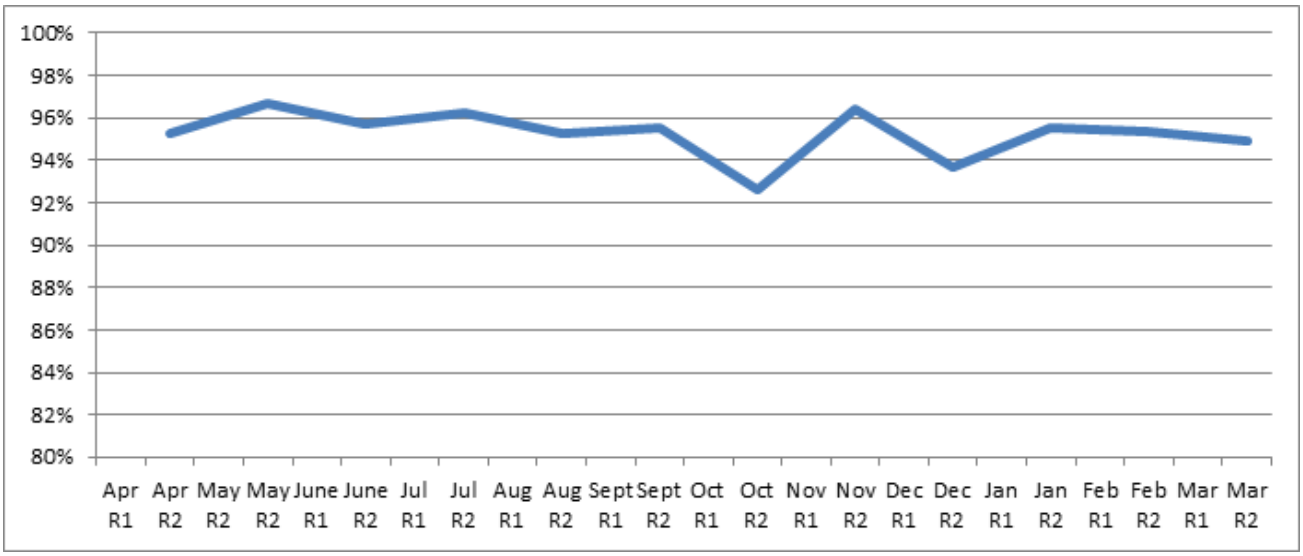
The results are displayed locally and reported to each Division and to the Trust Board.

In 2017/18 the average overall Trust-wide hand hygiene compliance score was 95.3%.

Trust-wide - Hand hygiene compliance

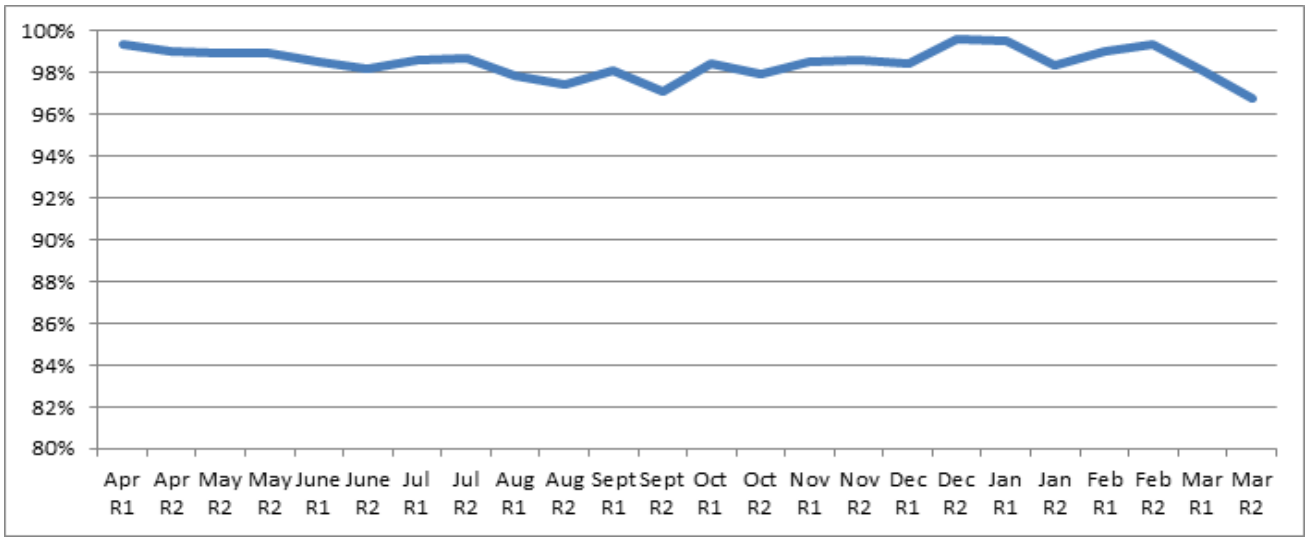


Trust-wide - Cumulative total per month



Bare below the elbow results are also recorded as part of the HH audit bi-monthly, the average Trust-wide compliance score was 98%

Trust-wide - Bare below the elbow audit



As part of the service level agreement with the suppliers of the alcohol hand foam used within the Trust, 8 reliability audits were also undertaken by the Education Practitioner. Reliability Hand Hygiene scores varied from 33% to 80%, feedback given to Matrons /Charge Nurses within Division.

The Trust participated in a *Hand Hygiene Awareness Week* in May 2017. As part of the World Health Organisation's Global hand hygiene awareness day, members of the staff and members of the public were educated and updated on hand hygiene technique; this included the use of the "Glow boxes" and information stands at CGH and GRH. A competition was held to guess how many times a person touches their

mobile phone (proven to carry multiple micro-organisms) which proved popular with staff and visitors alike (104 entered from CGH and 75 from GRH). An Annual update for the *Hand Hygiene Champions* was also held, the focus on Healthcare associated Infections and risk assessing the use of gloves.

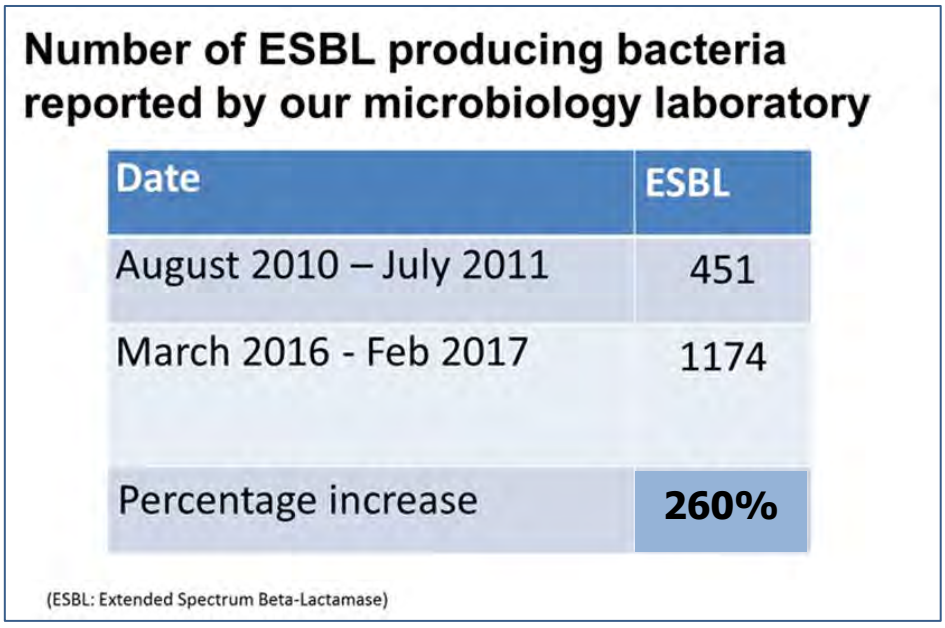
Two new hand hygiene posters for staff were approved in 2017, designed in-house by the Communications Department based on the WHO 5 Moments for Hand Hygiene, and the Ayliffe technique for hand washing.

During 2018 all wall mounted foam dispensers will be replaced.

7.0 Antimicrobial Stewardship

Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.

Antimicrobials have a vital role in the treatment and prevention of infection. Antimicrobial resistance (AMR) is linked to antibiotic usage and renders antibiotics ineffective. Increasing bacterial resistance to antibiotics is a major concern, an example of increasing local antibiotic resistance over time is shown below:



Note: Antibiotic treatment options for patients with infection caused by ESBL producing bacteria can be very limited, for example there may be no oral treatment option. Additionally, there is a risk that initial empirical (”best guess”) antibiotic therapy prior to results of microbiological investigation may be ineffective.

The development and introduction of new classes of antibiotics is challenging and it is therefore essential that we use existing antibiotics appropriately. Another important example of increasing antibiotic resistance are the carbapenemase-producing organisms (CPOs) including carbapenemase-producing Enterobacteriaceae (CPE). These bacteria are resistant to treatment with the carbapenem antibiotics such as meropenem and ertapenem. The carbapenems can be considered “antibiotics of last resort” and options for treating patients with infection due to CPOs are often severely restricted. The figures below indicate the national and local increase in frequency of infections due to CPE and CPOs respectively:

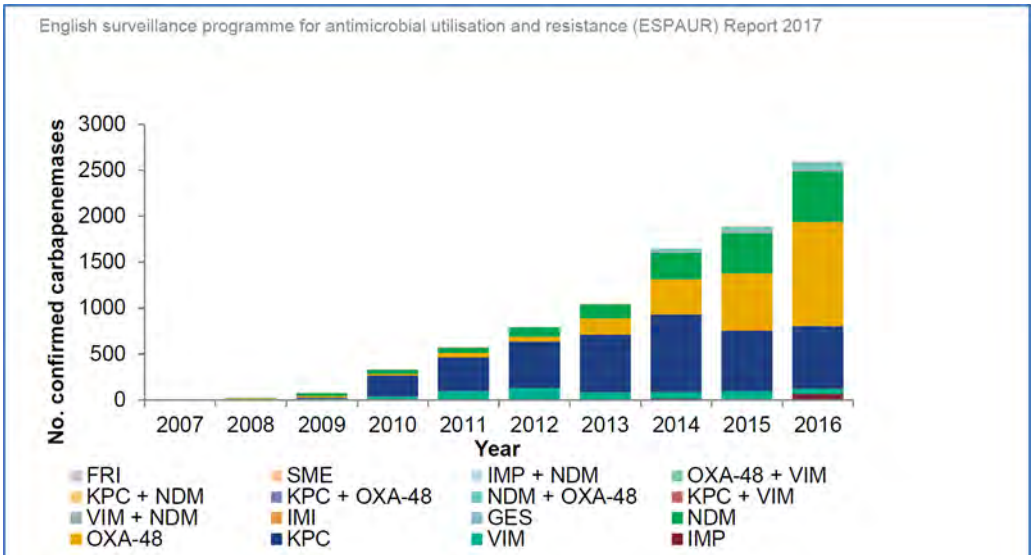


Figure 2.10 Carbapenemases produced by CPE referred to the PHE AMRHAI Reference Unit

The count of patient episodes of confirmed carbapenemase-producing organisms (CPOs) reported by the Gloucester Microbiology Laboratory 2006 -2017 is shown below:

2006*	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total
-	-	-	-	-	-	-	-	2	3	3	6	**14**

Public Health England South West Field Epidemiology Service
**Data from June 2006*
Source: Antimicrobial Resistance and Healthcare Associated Infections (AMRHAI) Reference Unit

Effective AMS is therefore essential for patient safety but also relevant to clinical effectiveness and patient experience. The importance of antimicrobial resistance is widely recognised and there is an integrated UK Five Year Antimicrobial Resistance (AMR) Strategy 2013 to 2018.

The fourth annual report from the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) was published in October 2017. Key points from this report include:

- "Halving the numbers of healthcare-associated Gram-negative bloodstream infections (GNBSIs) by March 2021 is a key government ambition,.."

- "Secondary care, despite some progress observed in 2015, has not had a sustained reduction in total antibiotic prescribing. However, from 2015 to 2016 hospitals reduced their use of the ultra-broad spectrum antibiotics piperacillin/tazobactam and carbapenems (both -4%). This is the first step in reducing antibiotic use in hospitals and focussing on using these antibiotics appropriately is key to preventing the emergence and spread of carbapenem-resistant Gram-negative bacteria."

- “The national importance of reducing unnecessary and inappropriate antibiotic use was demonstrated through the development of NHS antimicrobial stewardship initiatives, namely the Quality Premium (QP) from 2014/15 in primary care and Commissioning for Quality and Innovation (CQUIN) from 2016/17 in secondary care.”

- “In the first year (2016/17) of the CQUIN, 37%, 33% and 52% of NHS acute Trusts met their objectives to reduce total antibiotic, piperacillin/tazobactam and carbapenem consumption respectively, to 2013/14 levels; though significantly more reduced their piperacillin/tazobactam and carbapenem compared to 2015/16 levels (66% and 67% respectively).”

- “Parallel to the GNBSI work, the Prime Minister announced an ambition to halve inappropriate antibiotic prescribing. This report features the outputs of the joint PHE-Department of Health workshop in this area, where it was recommended that all practice reduce total antibiotic prescribing by 10% by 2020/21 and that secondary care reduce total prescribing by a further 1% and use of piperacillin/tazobactam and carbapenems by a further 3% respectively in 2018/19.”

- “This report highlights the initial results of the point prevalence survey of healthcare associated infections (HCAI) and antimicrobial use (AMU) in acute hospitals, performed in 2016. Despite an older population with increased co-morbidities and surgery, there was no significant change in the prevalence of HCAI or AMU between the last survey in 2011 and 2016. In 2016, one in fifteen patients in acute hospitals had an HCAI and one in three were on antibiotics on the day of survey.”

AMS Team Resource

AMS activity within our trust is led by the AMS team, consisting of a pharmacist and consultant medical microbiologists. There is currently 0.6 whole time equivalent antimicrobial pharmacist within the organisation pending replacement. Increasing operational and governance requirements relating to AMS have been included in a risk assessment and a business case has been produced which proposes additional resource in order for our Trust to be able to meet current AMS requirements.

Requirements

A number of national and local requirements and guidance documents relate to AMS and include:

- **The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance**. This Code of Practice requires that providers of healthcare “Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.”

- **Antimicrobial stewardship: Start smart - then focus.** Includes, “Implementation of this toolkit and the audit programme can be used as

evidence of meeting criterion 9 of the Code of Practice on the prevention and control of infections when seeking registration with the Care Quality Commission."

National Institute for Health and Care Excellence (NICE)

NICE continues to produce and develop a range of documents relating to antibiotic use. This includes: Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use NICE guideline [NG15]: August 2015. The associated baseline assessment tool was completed in 2016 and indicated that 4% (2 of 51) of the recommendations were currently met; a business case has been produced so that AMS resource can be increased.

Antimicrobial stewardship. Quality standard [QS121]: April 2016. Note that progressing compliance with relevant aspects of this quality standard is partially dependent on the implementation of an electronic pharmacy.

- **Commissioning for Quality and Innovation (CQUIN) Guidance for 2017-2019, reducing the impact of serious infections (Antimicrobial Resistance and Sepsis).** Local data for the two relevant indicators are shown in the tables below. Overall, milestones were not reached; note that a shortage of piperacillin-tazobactam would have resulted in reduced consumption. An additional indicator for 2018-19 is the need to record the rationale for continuing intravenous antibiotics when a decision is made not to switch to oral treatment. The piperacillin-tazobactam consumption indicator has been replaced with an indicator regarding increasing the proportion of antibiotic usage within the "Access group". This CQUIN related work was highlighted as a priority in our Trust Quality Account 2016/17 and this is reflected in the proposed AMS 2018-19 work programme.

Indicator 2c Antibiotic review
Assessment of a clinical antibiotic review between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours

CQUIN 2c - Antibiotic review	**Milestone not achieved for the Q4 period of 2017-18**
Comments	30 sets of notes assessed per quarter

Quarter **GHFT Result**	**Q1: Apr - Jun-17**	**Q2: Jul-Sep17**	**Q3: Oct - Dec17**	**Q4: Jan - Mar18**	**Comments**
Percentage of antibiotic prescriptions reviewed within 72 hours	**79%**	**83%**	**74%**	**84%*** *Based on 28 sets of notes	**Q4 – not achieved**
2017-18 milestones	**>25%**	**>50%**	**>75%**	**>90%**	

Indicator 2d Reduction in antibiotic consumption per 1,000 admissions
Reduction in antibiotic consumption per 1,000 admissions and proportion of board spectrum antibiotic use

CQUIN 2d - Reduction in antibiotic consumption per 1,000 admissions (in-patients and out-patients)	**Overall not achieved up to Q4 period of 2017-18**
Comments	Total antibiotic usage per 1,000 admissions: **not achieved** Total usage of carbapenem (CPM) per 1,000 admissions: **not achieved** Total usage of piperacillin-tazobactam (TAZ) per 1,000 admissions: **achieved**

	Antibiotic consumption: Defined Daily Doses (DDDs) per 1000 admissions					Consumption indicator values based on 1% total antibiotic reduction and 2% reduction for both CPM and TAZ, all reductions compared to 2016 data	Antibiotic consumption 2017-18: Defined Daily Doses (DDDs) per 1000 admissions **PROVISIONAL pending definitive Hospital Episode Statistics (HES): *utilising internal and Refine (Rx-Info Ltd) data **utilising Refine and ESPAUR data**			
	2013-14	**2014-15**	**2015-16**	**2016-17**	**2016**	**2017-18**	**Q1***	**Q2***	**Q3***	**Q4****
Total	4299.3	4378.4	4024	3,922.3	3920.5	**3881.2**	***4262.1***	***4508***	***4727***	***4559***
CPM	93.1	89.9	78.4	94.8	86.5	**85**	***109.9***	***116***	***91.9***	**90**
TAZ	149.3	146.4	152.9	169.1	156.9	**153.8**	***106***	***138***	***96.3***	**62.7**

- **Local quality schedule 2018-19.** This schedule now includes: "GHNHSFT-employed Consultant Microbiologist should attend every Countywide Antimicrobial Stewardship (AMS) group. They will contribute appropriate knowledge and expertise to the group along with other AMS group members."

It should be noted that workload for the Microbiology Department arising from AMS Group workstreams will need to be monitored carefully to ensure it can be accommodated within current and future resource.

- **GHNHSFT Action Plan to reduce the incidence of Clostridium difficile infection (CDI).** AMS work required to support this action plan includes:

    - Working with the Infection Control Team and audit department to identify current antibiotics with the highest local risk of predisposition to CDI
    - Review of local antibiotic guidelines to optimise antibiotic choices that minimise the risk of CDI
    - Review of alternative treatment options for managing CDI
    - Encouraging active formal documented antibiotic review by 72 hours after commencement of antibiotics by clinical teams

    Note that this action plan also includes a section on increasing the current AMS team resource, business case outcome pending.

Diagnostics

Diagnostic tests have a key role in AMS and one of the core current programmes within the UK antimicrobial resistance strategy aims *"…*to ensure that diagnostic tests or epidemiological data are used to support clinical decision making,…"

The microbiology department is currently implementing matrix-assisted laser desorption ionization–time of flight mass spectrometry (MALDI-TOF MS), a diagnostic technique capable of significantly reducing the time required to identify bacteria present in diagnostic specimens. This technique does not generally provide antimicrobial susceptibility data although an earlier awareness of bacterial identification can significantly improve patient management, MALDI-TOF MS implementation should therefore contribute to our Cost Improvement Plans (CIPs).

Surveillance and audit data

Antimicrobial consumption and AMS data are shown in the figures below.
Note that implementation of an electronic pharmacy would significantly increase the opportunity to collect, analyse and feedback antibiotic consumption data to prescribers.
Increased production and dissemination of local "drug bug" surveillance data should be undertaken in order to inform local antibiotic usage guidance.

- **Public Health England AMR local indicators**. Antimicrobial stewardship and Antibiotic prescribing area profiles for Gloucestershire Hospitals NHS Foundation Trust (accessed 1st June 2018):

Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher / Not Compared — Low … High

Benchmark Value: Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Gloucestershire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Percentage of antibiotic prescriptions with evidence of review within 72 hours; by quarter	2017/18 Q3	59	86.8%	91.8%*	91.0%	-	*Insufficient number of values for a spine chart*	-
Percentage of antibiotic prescriptions reviewed within 72 hours with a stop decision documented; by quarter	2017/18 Q3	10	16.9%	16.6%*	16.8%	-	*Insufficient number of values for a spine chart*	-
Percentage of antibiotic prescriptions reviewed within 72 hours with a stop, switch or IV to oral switch decision documented; by quarter	2017/18 Q3	27	45.8%	56.6%*	56.3%	-	*Insufficient number of values for a spine chart*	-
Review of national antimicrobial stewardship toolkit (SSTF) and implementation of antimicrobial stewardship action plans in NHS Trusts	2014/15	-	1	-	-	-	-	-

Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher / Not Compared — Low … High

Benchmark Value: Lowest | 25th Percentile | 75th Percentile | Highest

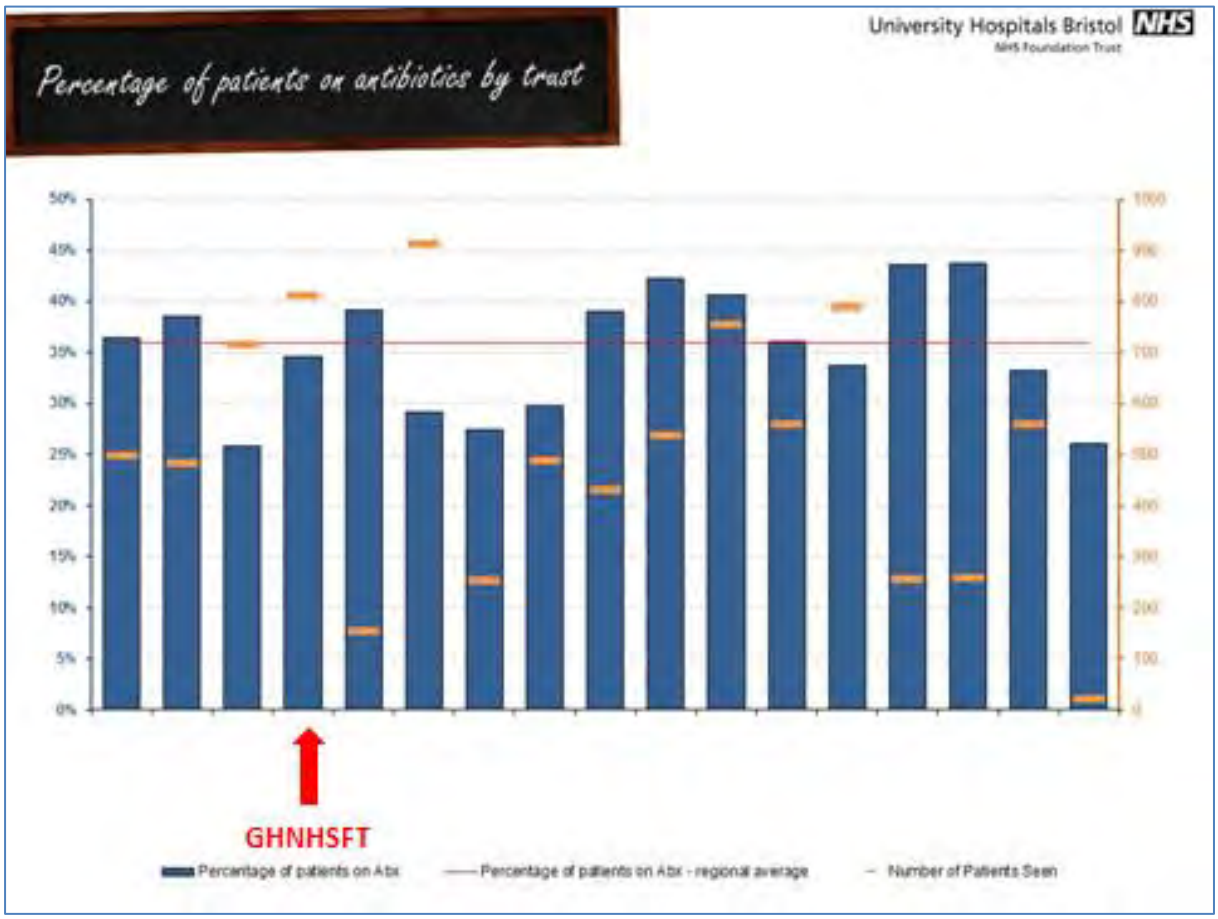
Indicator	Period	Gloucestershire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Four quarter rolling rate of total antibiotic prescribing per 1000 admissions; by acute trust	2017/18 Q3	633,866	4,039	4796*	4885	1,702		9,732
Four quarter rolling rate of piperacillin-tazobactam prescribing per 1000 admissions; by acute trust	2017/18 Q3	14,965	95.4	88.2*	88.0	6.8		229.6
Four quarter rolling rate of carbapenem prescribing per 1000 admissions; by acute trust and quarter	2017/18 Q3	15,607	99.4	83.8*	100.5	15.2		842.7
Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index	2017/18 Q3	71,728	42.2%	49.0%*	47.6%	20.0%		73.7%
Defined daily dose of antibiotics dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	614,455	3,922.3	4547.9*	4677.3	1,741.2		10,055.1
Defined daily dose of piperacillin/tazobactam dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	26,487	169.1	138.9*	134.8	2.4		362.3
Defined daily dose of carbapenems dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	14,855	94.8	84.2*	96.4	3.3		1,073.1
Defined daily dose of antibiotics dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 occupied bed-days	2016/17	614,455	1,835.8	-	2092.6	820.8		4,665.6
Defined daily dose of piperacillin/tazobactam dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 occupied bed-days	2016/17	26,487	79.1	-	60.3	3.4		151.8
Defined daily dose of carbapenems dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 occupied bed-days	2016/17	14,855	44.4	-	43.1	2.8		419.6

- **Point prevalence survey** of healthcare-associated infections and antimicrobial use in European acute-care hospitals September 2016:

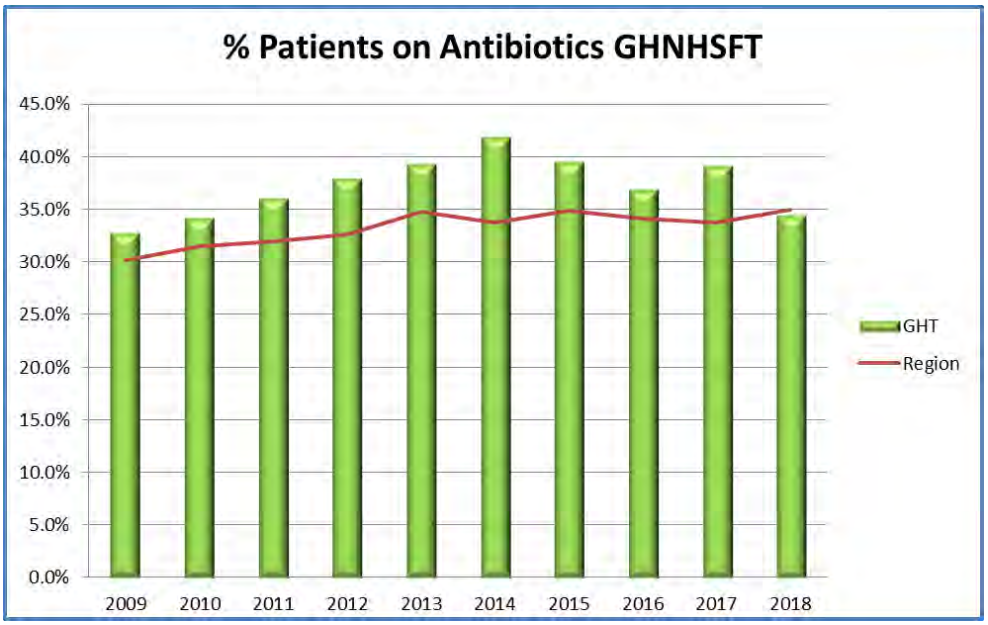
	National Result 2011	GHNHSFT 2011	National Result 2016	GHNHSFT 2016
Antimicrobials%	**34.7%**	**36.4%**	**37%**	**39.1% ↑**

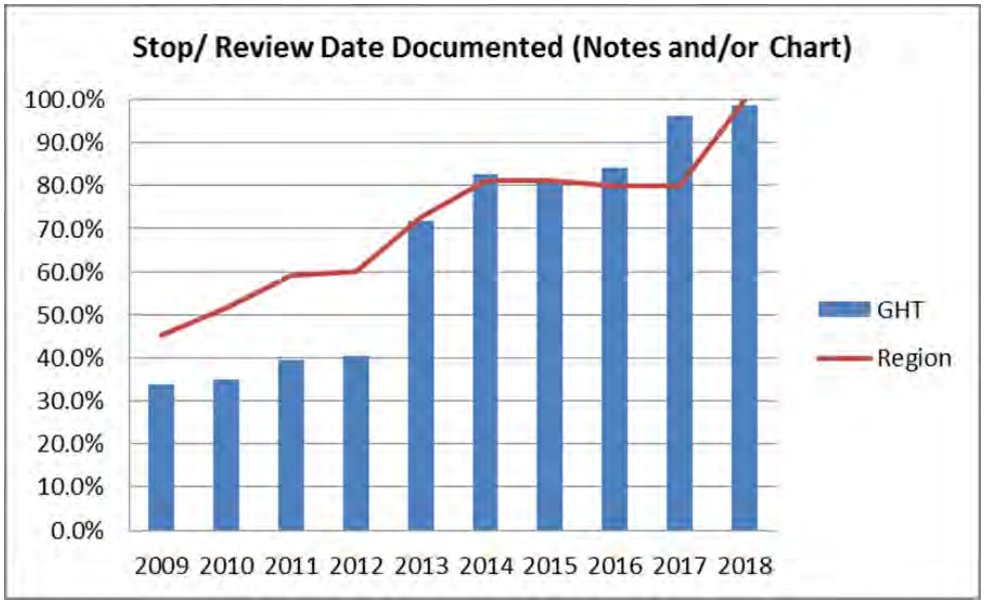
GHNHSFT	Patients Surveyed		Receiving Antimicrobial		% Antimicrobial	
	2011	**2016**	**2011**	**2016**	**2011**	**2016**
Surgical	260	245	113	122	43.4%	49.7%
Medical	489	491	170	185	34.7%	37.6%
W&C	124	114	27	22	21.7%	19.2%
D&S	39	36	22	21	56.4%	58.3%
Other	1	30	0	8	0%	26.6%
Total	**913**	**916**	**332**	**358**	**36.4%**	**39.1%**

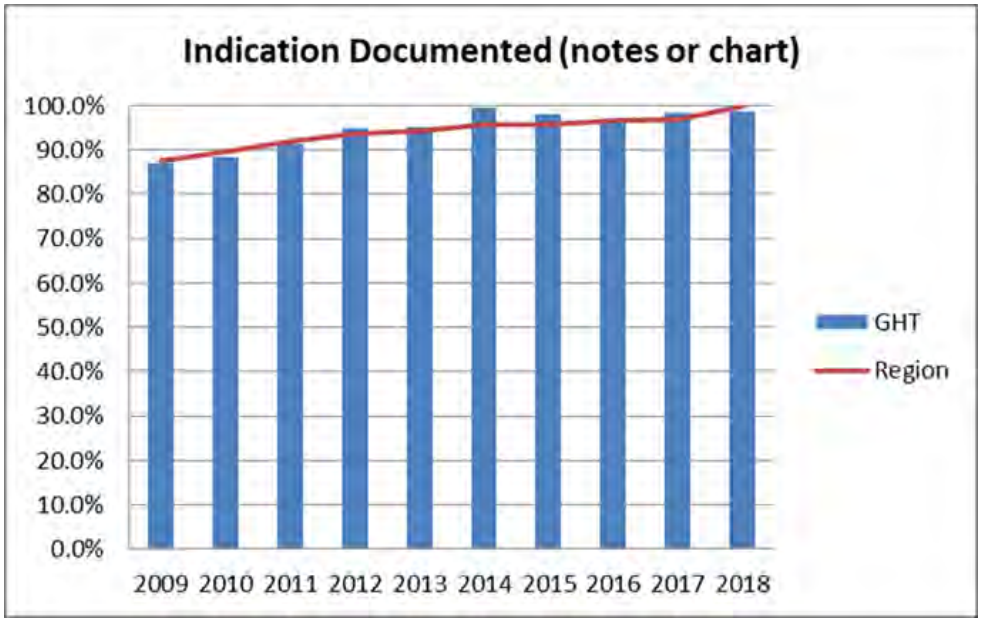
- **South-West regional point prevalence survey 2018,** hospital identifiers removed except GHNHSFT, first time:



Regional Point Prevalence Study 2018: percentage of patients on antibiotics, documentation of antimicrobial stop/review date and indication:



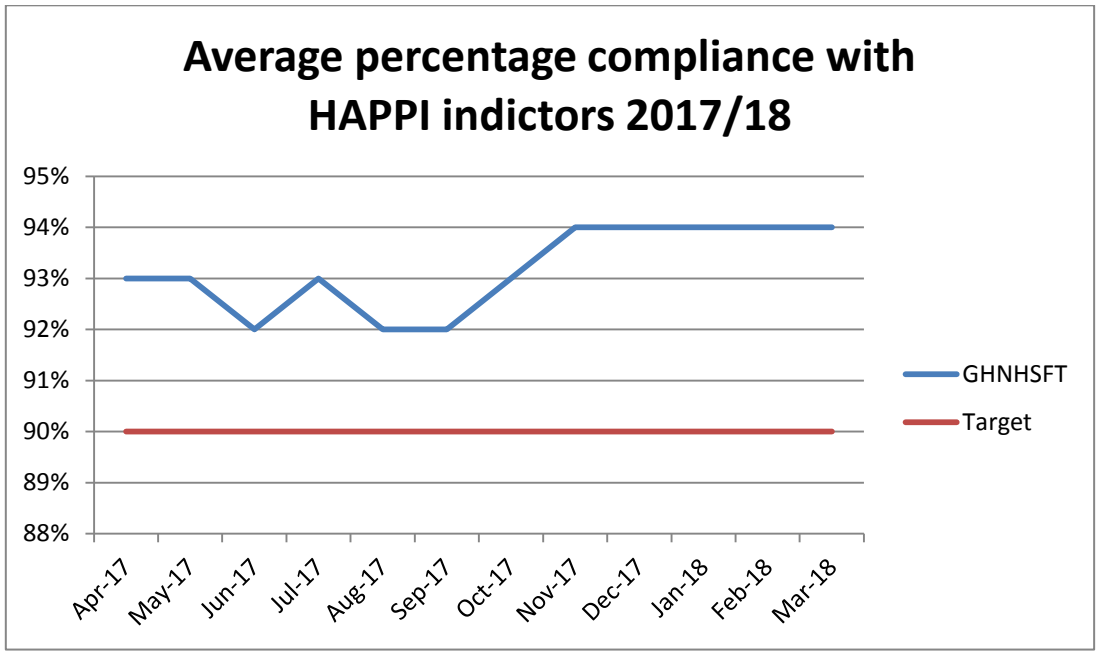




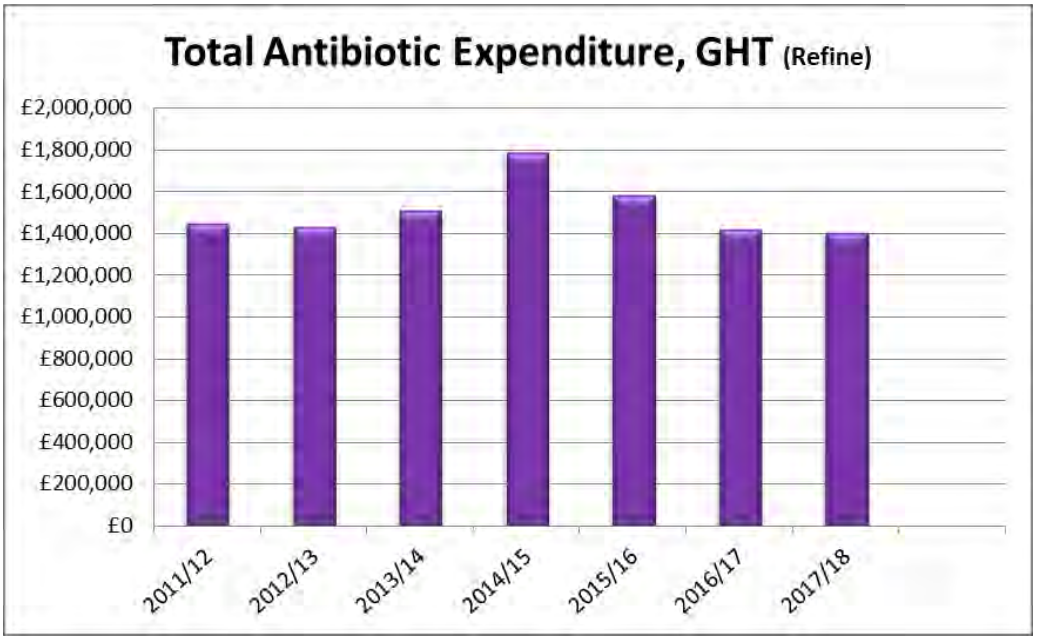
- **Hospital Antimicrobial Prudent Prescribing Indicator (HAPPI) audits**. The HAPPI audit standards are:

  A: Documentation on drug chart of antimicrobial allergy, review/stop date and clinical indication for use
  B: Appropriate choice and route of administration of antibiotic

  HAPPI results are regularly circulated to medical staff, senior nursing staff and pharmacy staff by email. Results demonstrate good compliance with these standards:



GHT antimicrobial expenditure
Ongoing expenditure on antibiotics, data from Refine:



AMS team work summary 2016-18

Work area	Examples
Ongoing development and review of antibiotic guidelines	**New guidance:** -Necrotising fasciitis and other necrotising skin and soft tissue infections -Surgical Prophylaxis - maxillofacial surgery, dosing in obesity **Reviewed / updated guidance:** - Paediatric antibiotic guidelines - Vancomycin policy -Infection of unknown site -Significant review and revision of guidelines required in 2017 due to national shortages of key antibiotics e.g. piperacillin –tazobactam
Audit / Quality improvement	-Point prevalence survey of healthcare-associated infections and antimicrobial use in European acute-care hospitals -HAPPI (ongoing) -Piperacillin-tazobactam use in

	Emergency Department (undertaken by pre-registration pharmacist)
Education and training	Includes European Antibiotic Awareness Day activities
Multi-disciplinary team (MDT) meetings and ward rounds	Department of Critical Care Haematology Tuberculosis Prosthetic joint infection Uro-gynaecology MDTs

Conclusion

Effective AMS activities are essential in combating related patient safety risks including those associated with antimicrobial resistance.

Trusts are therefore subject to increasing scrutiny and requirements in relation to AMS.

Whilst this report demonstrates that AMS activities do take place in our organisation it is clear that this is currently not sufficient.

Consideration should therefore be given to business case proposals which would increase the capacity of the AMS team.

8.0 Training and Education

In 2017/18 the Infection Prevention and Control Team have continued to deliver a wide variety of education within the Trust. It is mandatory for every member of staff to receive annual infection prevention and control update.

The Infection Prevention and Control team continues to contribute to corporate induction training sessions run by the Training and Learning department. Infection Control Doctors delivered sessions for new junior medical staff. Infection Control training remains a mandatory requirement. See table below outlining divisional compliance:

Division / Staff Group	All Staff	A&C	ACS	AHP	APST	E&A	HCS	M&D Consults	M&D SAS Snr	M&D Trainees	N&M
GHT Total	**86%**	**89%**	**84%**	**94%**	**91%**	**79%**	**95%**	**85%**	**80%**	**68%**	**88%**
Corporate	**84%**	87%	76%	100%	90%	100%	67%	67%	100%	82%	86%
Diagnostics & Specialty	**92%**	91%	93%	94%	86%	81%	94%	87%	71%	60%	97%
Estates & Facilities	**81%**	90%	86%			78%	100%				
Medicine	**86%**	88%	87%		100%	100%	89%	81%	79%	67%	89%
Non-Division	**75%**	77%	100%		100%		100%		0%	67%	
Surgery	**89%**	90%	89%	93%	98%	88%	100%	86%	85%	68%	92%
Womens & Children	**87%**	94%	92%	100%	100%	67%		84%	78%	69%	86%

Key to Staff Groups
A&C : Admin and Clerical
ACS : Additional Clinical Services
AHP : Allied Health Professionals
APST : Additional Professional, Scientific and Technical
E&A : Estates and Ancilliary
HCS : HealthCare Scientists
M&D : Medical and Dental
N&M : Nursing and Midwifery

There has been an overall reduction in compliance with mandatory training from 91% March 2017 to 86% March 2018.

Ward-based education has been delivered by the Infection Control nurses supported by the Saving Lives/Infection control link nurses and Hand Hygiene champions covering:

- Hand Hygiene training
- Norovirus
- Influenza
- Local updates following learning from incidents

Other education/ training undertaken:

- Hand hygiene awareness stands in GRH and CGH
- Volunteer training
- Hand hygiene training for medical students
- Annual Hand hygiene champions study afternoon
- Annual Saving Lives study day 2017, topics covered included *Candida auris*, Influenza, ANTT and patient experiences

- Cross site quarterly Saving Lives /Infection control link practitioner study sessions

In the latter part of the financial year the IPCT commenced a project to completely revise the trust's IPC e-learning. This project will be completed in 2018-19 with the launch of the e-learning as level 1 (basic) and level 2 (advanced) modules.

9.0 Facilities Management

9.1 Environmental Cleaning

The Infection Control Committee continues to monitor cleanliness for the Trust as part of the compliance strategy.

The monitoring team continue to audit cleanliness standards in line with the national standards The Facilities Management service continues to monitor and audit the level of cleanliness throughout the Trust. Issues have been raised about the audit process and recording of the GRH monitoring audits completed by the supervisors; this is being reviewed to ensure the monitoring system is compliant with the national standards. Representatives from the ICT and Facilities regularly meet to review poor compliance and action plans devised to address areas of concern.

The cleaning of premises within Gloucestershire Royal Hospital is carried out by teams of cleaning staff who are managed by the Facilities Department. Our hospital works in close partnership with our professional cleaners *Interserve – Healthcare*, who are contracted to carry out the domestic services to our required standards in Cheltenham General Hospital The essence of good cleaning is not only that things look clean but they are also technically clean. This calls for measurement of cleanliness both in aspects of environmental cleanliness as well as technical cleanliness Audit Reports measures.

9.2 Auditing – Cleanliness

The cleanliness monitoring team provide an independent and therefore an unbiased and balanced assessment of the effectiveness of cleanliness of the built environment, cleanliness of patient equipment, providing cleanliness reports for both in-house cleaning and the external contractor to make sure that the contracts (including the in-house Service Level Agreement) delivers a service compliant with National standards.

Technical cleaning audits are carried out against the criteria laid out in 'The National Specifications for Cleanliness in the NHS: a framework for setting and measuring performance outcomes' document using the National Cleaning Audit Tool using an electronic hand held monitoring system. An essential component of any monitoring framework is the fundamental principle of continuous improvement. Therefore, the Monitoring Framework not only provides a reporting mechanism, but a rectification process that can be used locally to identify, prioritise and address issues of non-compliance.

It is important to recognise that cleaning is not just carried out by domestics staff and that cleaning covers much more than just fixtures and fittings, as it also applies to patient equipment and medical devices e.g. commodes, medical gas equipment, patient fans, blood pressure cuffs/machines, weighing scales, shower chairs etc.

Timely action must be taken and documented when monitoring identifies cleanliness standards which are below that required. To achieve this audits are undertaken in

accordance with the National Specifications for Cleanliness in the NHS monitoring 49 elements. Whilst cleanliness features primarily in the auditing structure, areas such as Estates and Nursing equipment are also monitored.

Monitoring in this context is defined as the ongoing assessment of the outcome of cleaning processes to assess the extent to which cleaning procedures are being carried out correctly, to identify any remedial action which is required and to provide an audit trail.

Audits reported in this report are - Audits carried out by Monitoring team

The principles of the audit are:

1. The audit clearly highlights the gap between current levels of cleanliness and the standards laid down in the national standards of cleanliness for the NHS.
2 . All issues/items identified as part of the audit generate exception reports.*

**A report giving detail of failures or defects that require immediate inspection as they impact on the capability to clean. These reports are escalated to the relevant professional.*

Cleanliness is assessed using an observational process and according to the technical requirements set out in the NHS National Cleaning Services Specification. The requirements vary depending on the type of area being assessed and the scores are weighted to reflect risk. For example, an operating theatre receives a higher weighting. Each area of our hospitals is assessed and given a risk category (ranging from very high to low). We then schedule the frequency of cleaning to match the risk factor, to make sure we concentrate our efforts in areas most likely to pose a risk.

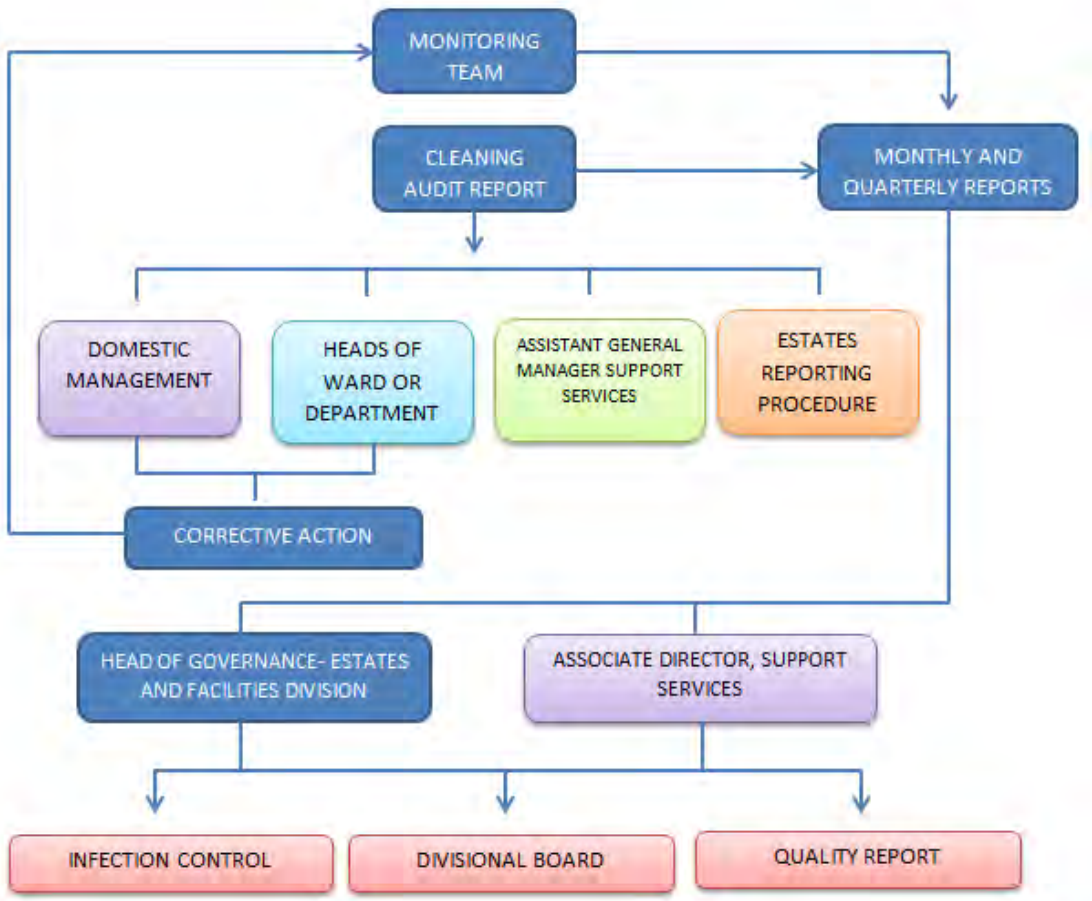
To assist the Trust in determining our cleaning target, the following are provided as indicative aims for each of the four ‘risk categories’

Risk Category	Frequency	Trust Target
Very High Risk	Weekly	95%
High Risk	Monthly	90%
Significant Risk	3 Monthly	85%
Low Risk	6 Monthly	78%

Elements
The items to be cleaned are broken down into 49 elements as defined in the national standards of cleanliness.

The completion of an internal audit is a fundamental prerequisite of implementing the national standards of cleanliness. The baseline audit provides a detailed report on the current standard of cleanliness within the hospital.

Audit reports
Fig1 Audit reporting process



9.3 Water Management

Legionella and *Pseudomonas aeruginosa* sampling throughout the year suggests both remain under control.

The legionella risk to patients and staff has been significantly mitigated by control measures put into place. However, the nature of these bacteria is such that it can still be introduced into the hospital water systems from the mains water supply. Continued and ongoing control measures and monitoring are required to maintain low levels of risk of hospital-acquired legionellosis.

The Trust's Water Action Group will continue to provide oversight of controls across the unit, and the wider Hospitals, and complete actions in the action plan.
It was also discussed at the following governance committees:

- Water Action Group
- Estates and Facilities Health and Safety Forum
- Trust Health and Safety Forum
- Infection Control Committee

The Director of Estates and Facilities has been appointed as Duty Holder (Water) and Chair of the Water Action Group (WAG). The Deputy Director of Estates and Capital Development has been appointed as Responsible Person (Water)
Deputy Responsible Persons have also been appointed for each main GHNHSFT site to manage the day-to-day activity relating to water management. The Water Action Group (WAG) has representatives from across the Trust Divisions and Infection Control Doctors and Nurses

Tetra Consulting Ltd were re-appointed as the Trust's Water Management External Advisor. *Tetra* undertook a Water Management Audit in November 2017.
The initial observations are:

Of the 15 areas of water management audited, all 15 returned a rating of HIGH compliance (up from 11 areas previously). The key recommendations for improvement related to non-critical updates to the Water Policy, these are scheduled for inclusion within the next policy review in August 2018.

Notable actions and events within the reporting period:

Following a case of probable hospital acquired legionellosis in 2016 reported in the previous annual report and the subsequent investigation by PHE, the HSE also investigated the Trust as a result of this case. Their findings identified a gap in our controls around the cleaning of Thermostatic Mixing Valves (TMVs) and they issued a Notification of Contravention downgraded from a potential Notification of Contravention due to their 'confidence in our commitment to managing Legionella control gained during their visit'. The works arising from this Notification have all been implemented and embedded.

The comprehensive testing of water outlets in the Tower requested by WAG in 2016 was completed in 2017 with all areas being completed and all positive outlets being remediated. Two areas identified high numbers of positive samples on first assessment. These areas were fully remediated with temporary filters being sued to protect staff and patients. Following completion of the increased regime of testing, the routine testing of sample outlets was resumed and has provided assurance that water infrastructure is being appropriately managed with negligible positive results within the entire Tower arising in the last 2 monthly rounds of testing.

Under the ongoing water improvement program, the water tanks to GRH Tower Block were replaced, a number of new sinks and taps to current HTM standards were installed to replace less complaint versions and the TMV maintenance program was instigated including the installation of c. 200 new units.

There has been an ongoing issue with positive pseudomonas results being experienced in the Severn and Cotswold Dialysis units for a number of months. Patient safety is being assured through the use of point of use filters however the positive counts have proven resistant to repeated attempts at disinfection. Authorising Engineer advice has been sought and implemented and we continue to undertake remedial measures together with further investigation into possible causes

10.0 Decontamination

Debbie Lewis continues in post as the General Manager for Trust Decontamination and Sterile Services with the Decontamination Lead role for the trust is currently undertaken by Steve Hams Director of Quality and Chief Nurse.

The Trust's Authorised Person for Decontamination was replaced in 2016 and the post is currently held by Dave O'Brien (Estates), The AE(d) provision is supplied for the Trust by Mark Walker (External Independent company DeconCidal Ltd) – who provides decontamination advice for the Trust and conducts annual decontamination audits to confirm compliance within Sterile Services Department and Endoscopy Departments.

Sterile Services Department (SSD)
In May 2018 the Sterile Services Departments novated across to Gloucestershire Managed Services, which is a subsidiary company wholly owned by the Trust. Both departments continue to be compliant to ISO 13485:2012 Quality Management System for the reprocessing of reusable Medical Devices and the relevant clauses of the Medical Devices Directive 93/42/EEC. The departments are annually audited by BSI (British Standards Institute)

The department is also compliant to the requirements of HTM 01-01 and this is monitored through the Trust Decontamination Group which holds regular meetings.
The service monitors reported non-conformances through trend analysis and action plans which are reviewed to ensure continuous improvement.
In 2017 the departments processed a total of 307,165 items.

A replacement tracking system (*Health Edge HESSDA*) has been installed in the two departments and provides a compliant track and trace system able to locate instrument sets and supplementary items.

The departments have a formal training and induction programme with extra training organised when required to guarantee staff competence.

10.1 Trust Decontamination Group

The Trust Decontamination Group meets bi-monthly and discuss all aspects of decontamination to ensure optimal standards are achieved throughout the organisation. The group is chaired by the Decontamination Lead which currently sits with the Director of Quality & Chief Nurse and is an opportunity to review policies and procedures to confirm that best practice is being adhered against guidance and legislation.

The group is represented by a range of services including Endoscopy, Sterile Services, Estates and facilities, with advice from the Infection Prevention & Control teams. The main purpose is to review and work to improve the quality of performance delivery. Action plans strengthen the commitment to promoting a safe environment for staff and patients and those patients are treated using safe and appropriately decontaminated medical devices.

Any areas for concern are escalated to the Infection Control Committee for further review and discussion in line with the Trust aims and objectives.
Minutes and action plans from this group are held by the group secretary and are available for review.

10.2 Endoscopy

Report from GRH

Staff

We currently have 1 x Apprentice, 2 x Band 2 Endoscopy Technical Assistants and 6 x Band 3 Endoscopy Assistant Practitioners. We currently have 2 x Band 2 posts that we are in the process of recruiting into.

Training

We had a number of new staff start in the unit in 2017. All have completed in house training and are having their competencies signed off. All decontamination staff (except our Apprentice) has attended the Getinge competency study day for the EWDs and Drying Cabinets and will be having their formal assessments in July/August 2018 by an assessor from Getinge. A number of staff members attended the BSG Decontamination Study Day on 28th March 2018.

Accreditation

Gained JAG Accreditation in April 2018. The decontamination area, since its move to a new location in September 2014, has met all of the JAG assessment criteria and continues to do so. We have also worked closely with Getinge over the last year and have been part of their training days where we have given tours of are decontamination area to staff members from different units around the country.

Audit

- We had a successful decontamination audit by the Trust Authorised Engineer in February 2018 with minor suggestions for amendments to practise being made – signing of staff competencies and increased handwashing between scope handling.
- The TVC results for all EWDs continue to be within expected limits. Some issues with conductivity which have been addressed.

Report from CGH

Training

- 2x Band 2 have been to the Cantel study day.
- 1x Band 3 is currently on the I Aspire course.
- 5x decon staff have been on the TECHNA course.
- All decon staff have competencies and are on the way to being fully signed off.
- The unit is awaiting confirmation of spills training for all decontamination staff

Accreditation

Gained JAG Accreditation in April 2018.

Audit

- Total Viable Counts (TVC) is consistently low although we have installed an extra water tank to keep up with our busy workload.

- The Trust's AE (D) did an audit Jan 2018. No risks/ concerns identified. Actions required: was the link door between clean/dirty side needed to be locked which is currently in progress, estates are aware and awaiting equipment to do this.

- External users are compliant with our track and trace system (TDoc). No issues with the internal/external system.
- JAG accredited.

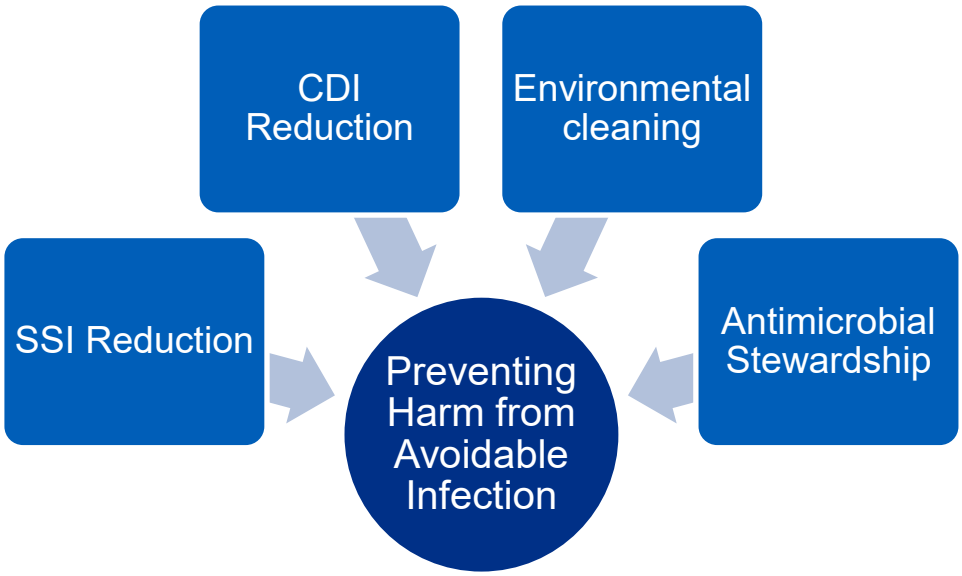
11.0 Overview of 2018/19 Objectives

Infection prevention and control remains a top priority for the trust. During 2018/19 we will set out our programme for the year to keep our patients, staff and the public informed of our planned activity across our hospitals.

This year we will undertake a review of the Trust's compliance with the Health & Social Care Act 2008 Code of Practice on the Prevention and Control of Infections (2015). The team's aim is to provide an infection prevention & control service that supports our clinical teams to deliver the best care for everyone. Our annual plan will cover 4 strategic themes we have identified as areas of focus for the financial year 2018/19.

Strategic themes

Our strategic themes in 2018/19 focus on improving outcomes for our patients and provide a framework for our operational work plan.



Operational Plans

Our plans will be linked to the gap analysis to ensure we remain compliant; this is planned for completion during quarter 3 following the appointment of the new Associate Chief Nurse/Deputy Director of Infection Prevention and Control.

SSI Reduction

The Surgical Site Surveillance Team will be brought in to the Infection Prevention and Control team to align strategy in this important area of quality improvement. A review of the reporting mechanism will be carried out to ensure we are providing our surgical teams with timely information that can be used as a catalyst for improvements. The trust has invested in new software to implement this process. We will then be in a position to target interventions and measure effectiveness.

CDI Reduction

Reducing *C. difficile* infection remains the team's most pressing priority. Delivering on the trust-wide action plan will be complete by year-end with a renewed focus on antimicrobial stewardship and cleaning, the two most significant factors associated with *C. difficile* infection. We expect to see reductions in rates by the end of the financial year.

Environmental Cleaning

We have identified deficiencies in cleaning standards across our hospitals and we will work closely with Gloucestershire Managed Services to see increased leadership and improvements in standards to maintain a clean, safe environment for our patients.

Antimicrobial Stewardship

The use of antimicrobials has a significant impact on infection rates. From preventing surgical site infections when used as prophylaxis in surgery to treating the most serious infections and exposing patients to potential risks such as acquiring *C. difficile*. The infection prevention and control team is committed to working closely with the trust's antimicrobial pharmacists, designated antimicrobial stewardship medical lead and will further strengthen that effort by appointing a new nursing lead. Making improvements to the trusts antimicrobial stewardship programme is a key component of *C. difficile* and SSI reductions.

Appendix 1. List of Infection Prevention and Control policies and procedures

The following policies were reviewed and approved in 2017/18:

- *Clostridium difficile* infection (CDI) – Patient management
- Linen and Laundry

The following policies are under review:

- Creutzfeldt-Jakob Disease (CJD)
- Isolation of patients
- Meningococcal disease
- Outbreaks and Serious incidents of infection
- Standard Infection Control Precautions
- Meticillin Resistant Staphylococcus Aureus (MRSA)
- Multi-Drug Resistant Bacteria (Excluding MRSA)
- Management of Infected or Colonised Patients
- Surveillance of Infections
- TB - Protection of Health Care Workers
- Tuberculosis (TB) Infection Control
- Viral Haemorrhagic Fever (VHF)

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00am

Report Title
GHNHSFT Annual Report
Sponsor and Author(s)
Author: Lukasz Bohdan, Director of Corporate Governance Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary

Key Issues to Note

The NHS Act 2006 (the 2006 act) requires NHS foundation trusts to produce an annual report and accounts following the end of the financial year. The annual report and accounts must be formally approved by the Board of Directors. Once approved, the auditor will sign its opinion on the accounts (in accordance with the Audit Code). NHS foundation Trusts are required to lay before Parliament their annual report and accounts and any auditor's report on them.

The Trust's Annual Report, Annual Accounts and Quality Report were created throughout the spring, signed off by the Trust Board on 26th May 2018 and lay before Parliament on 16th July 2018.

The requirements for the content and format are set out in the Annual Reporting Manual and must include:

- The performance report comprising:
  - overview of performance
  - performance analysis
- The accountability report, comprising:
  - Directors' report
  - Remuneration report
  - Staff report
  - The disclosures set out in the NHS foundation trust code of governance
  - NHS improvement's single oversight framework
  - Statement of accounting officer's responsibilities
  - Annual governance statement
- The quality report
- The auditor's report including certificate
- The foreword to the accounts which should state that the accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006
- Four primary financial statements
- The notes to the accounts.

The quality report contains an update on the quality of care, incorporating a statement outlining the current level of quality and priorities for improving it, signed by the trust's chief executive. The report will also summarise the trust's performance against quality indicators selected by the trust in three key areas:

1. Patient safety;
2. Clinical effectiveness; and
3. Patient experience.

Implications and Future Action Required

The Annual Report and Accounts and any auditor's report on the accounts must be presented at a meeting of the council of governors. The Annual Reporting Manual indicates this will be the Annual Members Meeting. Consequently, the annual report and quality account, as well as the annual accounts will be presented at the Annual Members Meeting on 20th September 2018; the full version is also published on the Trust website at https://www.gloshospitals.nhs.uk/about-us/reports-and-publications/

Recommendations
That the Board note the above.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Ensures compliance with statutory requirements.
Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

MAIN BOARD – SEPTEMBER 2018
Room 3, Sandford Education Centre commencing at 09:00

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

Purpose

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

Key issues to note

- Significant progress made with DQ issues down to 170,000 from 300,000 in January 2018
- External company (Populo) is now on site and has improved speed of validation.
- Work on reviewing the vetting process within Trak Care is underway with a reviews happening in Paediatrics, Trauma & Orthopaedics and Therapies.
- Implementation of new functionality, (originally planned as phase 1.5/phase 2) (within or outside of Trakcare) is the subject of wider consultation and a plan will be developed on the back of this.
- Whilst we have a core team of staff who are working on recovery activities, we need to enhance the capacity and capability of the team to ensure BAU support, recovery support and future development work is adequately resourced to ensure delivery risks are minimised and benefits are realised from digital initiatives.
- New Head of Business Intelligence has now joined the trust
- The trust is now in a position to begin planning a return to RTT reporting as per plan described in January.

Conclusions and Implications

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

Future Action

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

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

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

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

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

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					04Sept2018	

Outcome of discussion when presented to previous Committees
Update noted

SEPTEMBER 2018

TRAKCARE RECOVERY PROGRESS REPORT

1. Purpose

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

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

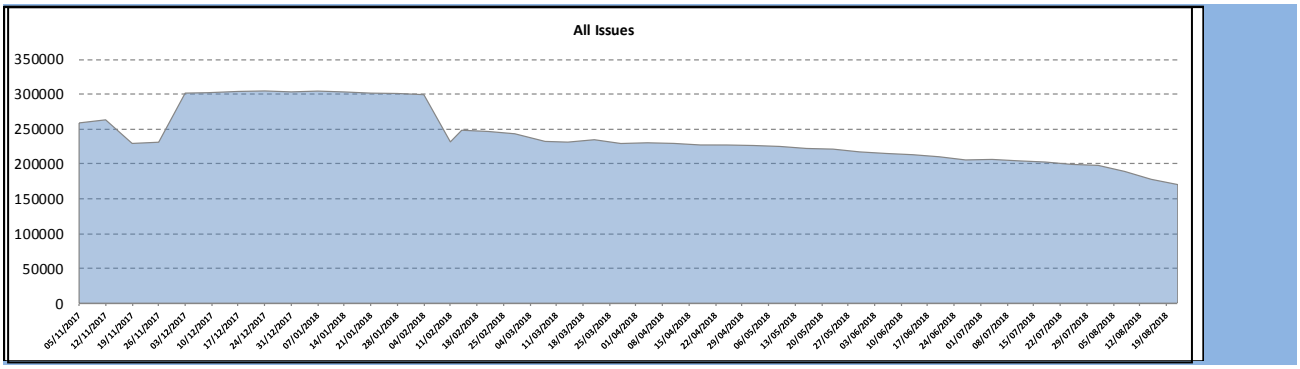
a) User understanding and use of the system is consistent with clearly communicated quick reference guides and SOPs
b) We have a clean and validated set of Waiting Lists/ PTL's for In Patients and Out Patients
c) The Trust has returned to national RTT reporting
d) Activity Recording is consistent and reliable such that all activity is able to be accurately billed for
e) Use of the system is sufficiently reliable and understood such that minimum levels of data quality issues are occurring each week

2. High Level Plan Milestone update on RAG status

3. 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. The last four weeks have seen significant improvements with a decrease from 199290 on the 25th July to 170323 on the 22nd August. This was anticipated and welcome improved momentum following significant validation efforts from both operational validation teams and Populo (external validation resource).

	25/07/2018	01/08/2018	08/08/2018	15/08/2018	22/08/2018
Recency	199290	197864	189177	177872	170323



The table below shows a weekly snapshot of direction of travel and volume of DQ Issues

Data as at:	22/08/2018

Vol Change in Current Week	Trend	DQ	Description
11	↑	1	Elective Waiting List Entry on an Open RTT Pathway
-2940	↓	2	Open Waiting List with a Blank RTT Pathway ID
-1394	↓	3	Open Waiting List Entries on a Closed RTT Pathway
-1704	↓	4	Planned or Return Outpatient Waiting List Entries with no Recall Date
-101	↓	5	Open Waiting List Entries with past activity and No Future Activity Booked
-48	↓	6	DNA Discharges
8	↑	7	Planned Elective Waiting List Entries with No Previous Elective Admissions
5	↑	8	Open Waiting List Entries with cancellations that should be closed
-113	↓	9	Open Waiting List Entries that should be closed due to a cancellation reason
0	-	10a	Open Return Outpatient Waiting List Entries where the last Activity is inpatients
-32	↓	10b	Open Return Outpatient Waiting List Entries where the Last Activity is potentially inpatients
15	↑	11	Open RTT Pathways where the last activity was cancelled or the patient was removed from the waiting list
51	↑	12	Total Duplicate RTT Pathways
-672	↓	13	Total Duplicate Waiting List Entries
-319	↓	13.1	Open new OPWL with any past waiting list entry type against the same pathway with same or different treatment function
-4	↓	14	Open Waiting List Entries which have multiple booked appointments or TCIs
0	-	15	Deceased Patients with Open Waiting List Entries or on an Open RTT pathway
-657	↓	16	New Outpatient Waiting List entries with no clinician assigned
-6	↓	17	Waiting List Entries that have a vetting outcome of rejected
-1	↓	18	Inpatient Waiting Lists with a blank waiting list admission type
-348	↓	19	Outpatient outcome of “Refer to other” but no new referral details added
-2	↓	20	Open Waiting Lists with a blank waiting list type

Validation Highlights From the Above Table:

- **Majority of DQ indicators either reducing in size with a few staying the same**
- **The Indicators that have seen an increase in numbers are DQ1, DQ7, DQ8, DQ11 and DQ12 but additions are significantly fewer than in previous months.**
- **DQ2 has significant reductions following successful validation from an external company Populo, their success rates have been high with a quality marker of over 99% of changes being validated accurately first time. Given their success and competence the project team are now considering where else they could support our complex validation work.**
- **Operational Validation teams have been working hard to review duplicates waiting list entries**
- **Operational Management teams have been scrutinising waiting list entries where no recall date has been added and reassuringly the majority of entries removed/ validated in this category have been duplicates as opposed to entries caused by clinicians not entering a recall date.**
- **Several categories are now entering a more "business as usual" level of data quality and so conversation is evolving to where the process for monitoring and reviewing these should fit in the future given the lack of a data quality team.**

DQ Resolution Guide Progress

- 10 DQ category Resolution Guides completed and available for use.
- PDSA cycle of validation and ease of use remains in progress with T&O and Gen Surg.
- Included in the analysis and resolution guide production is a consideration of appropriate skill level required for each resolution process. Some are straight forward and will be able to be worked through by either dedicated GHT or outsourced resource with basic TrakCare training and experience.
- Some are more complex and will require extensive TrakCare and operational knowledge of patient pathways, business process and access to additional patient information e.g. specialty specific clinic letters held on infoflex etc
- The table below describes progress. In Use also means ready for use as may not have been deployed yet.

Ref#	DQ Indicator description	Count	Trend	Sub report	DQr Req	Pr	Count	Outc	Vet	Resource	Ops Lead	Status	1	2	3	4	5	6
DQ01	Elective Planned Waiting List Entries on an Open RT	26	↓	DQ01	Y	11	26	Y	N	LG/SP	?	In use	1	2	3	4	5	6
DQ02	Open Waiting List Entries with a Blank RTT Pathway	56617	↑	DQ02a	Y	3	3	Y	N	HA	?	In production	1	2	3			
DQ03	Open Waiting List Entries on a Closed RTT Pathway	25880	↓	DQ03ex	N	4	3826	Y	Y	SP	?	Not Required	1	2	3	4	5	6
DQ04	Planned Elective OR Return Outpatient Waiting List E	10656	↓	DQ04ai	Y	5	632	Y	N	JV	?	In production	1	2	3			
DQ05	Open Waiting List Entries which have Past Activity ar	8573	↓	DQ05a	Y		1319	Y	N	JV/RT	?	Data sampling	1	2				
DQ06	DNA Discharges	668	↓	DQ06a	Y	1	16	Y	N	KW	?	In use	1	2	3	4	5	6
DQ07	Planned Elective Waiting List Entries with No Previou	8254	↑	DQ07a	Y	2	108	Y	N	SP	?	Approval (WG)	1	2	3	4		
DQ08	Open Inpatient Waiting List Entries that should be cld	313	↓	DQ08a	Y	9	214	Y	N	KW	?	In use	1	2	3	4	5	6
DQ09	Open Outpatient Waiting List Entires that should be c	2056	↓	DQ09a	Y	8	14	Y	N	KW	?	In use	1	2	3	4	5	6
DQ10	Open Return Outpatient Waiting List Entries where th	8339	↓	DQ10a	N		1685	N	N		?	Not Required						
DQ11	Open RTT Pathways where the last activity booked on	1590	↓	DQ11	Y		1555	N	N	SP	?	In use	1	2	3	4	5	6
DQ12	Total Potential Duplicate RTT Pathways	8606	↑	DQ12a	Y	6	819	Y	N	SP	?	In use	1	2	3	4	5	6
DQ13	Total Potential Duplicate Waiting List Entries	43002	↓	DQ13a	Y		17760	Y	N	SP/KW	?	Initial analysis	1					
DQ13.1	Open new OPWL with any past Waiting List Entry Typ	4350	↓	DQ13.1	Y		4350	N	N	SP	?	Initial analysis	1					
DQ14	Open Waiting List Entries which have multiple booke	639	↑	DQ14	N		639	N	N		?	Not Required						
DQ15	Deceased Patients with Open Waiting List Entries or c	0	↓	DQ15	Y	7	0	N	N	KW/AT	RB	In use	1	2	3	4	5	6
DQ16	New Outpatient Waiting Lists with no clinician assign	15312	↑	DQ16a	N		431	N	N		?	Not Required						
				DQ16b	N		14881	N	N		?	Not Required						
DQ17	Waiting List Entries that have a vetting outcome of rej	677	↓	DQ17	N		677	N	Y	TCI/KG	?	Not Required						
DQ18	Inpatient Waiting Lists with a blank waiting list admis	18	↓	DQ18	Y	10	18	N	N	SP	?	In use	1	2	3	4	5	6
DQ19	Outpatient Outcome of "Refer to different Department"	3116	↓	DQ19	Y		3116	Y	N	SP/CD	?	In use	1	2	3	4	5	6

The continued collaborative working between the TrakCare Recovery Team and operational colleagues led by Felicity Taylor-Drewe remains an essential piece of the Recovery Programme. By ensuring validation efforts are done correctly and do not create further data quality issues we can test and identify the processes that will allow us to recover fully and transition to a business as usual level of validation.

4. Outpatient Outcomes

Operational teams continue to embed the process for reviewing outcome completion. This work has also evolved to provide support to colleagues reviewing consultant activity and productivity.

Stage 2 Outcomes

The project team is working closely with paediatrics to explore the addition of a safeguarding outcome. This was identified in the latter stages of the first outcome project however the decision was made to launch all other outcomes first and review the safeguarding outcome as a priority follow up, in order to reduce any delay with the new outcomes launch.

5. Outpatient Referrals (Vetting)

Vetting Outcome Rationalisation

Paediatrics and physiotherapy have now reviewed all of their vetting outcomes with a view to rationalising them and ensuring they initiate the correct template. This is a fundamental move in ensuring all referrals have the right pathway attached to them at the beginning of the. It has been clearly demonstrated that if a pathway is not opened as a result of appropriate vetting the pathway will remain closed and data quality issues occur alongside the pathway being incorrect.

Once the outcomes have been fully reconfigured into the system, operational staff will then review vetting activity and behaviours to ensure that all referrals are being appropriately vetted in a timely fashion. Once this process has been reviewed by the project group the next area to focus on will be Trauma and Orthopaedics. It must be acknowledged that this is a timely process, and to do it across all specialties will take approximately a year if the project team deliver this piece of work. The SmartCare board should consider which specialties may fall into Recovery in comparison with those that should follow the process of rationalisation within their specialty from a business as usual perspective.

6. Waiting Lists

Focused work within Endoscopy and Dermatology is underway. These are two areas that have been identified as using or creating waiting lists inappropriately.

7. Time Critical Patients

A review has been completed of time critical patient categories as identified by the clinical specialties. This has established where these cohorts of patients are identified by separate appointment types, identified gaps and illustrated number of appointments currently available for these specific appointment types.

Next step review by specialties to establish if additional appointment types and /or appointment slots required.

8. Maternity

A review of TrakCare to identify ability to improve TrakCare including making MSDS items bold/ mandatory has been undertaken. Local configuration changes being made with two issues sitting with InterSystems as TRCs. Maternity workstream likely to move fully into the financial recovery workstream.

9. Theatres

Operational Staff within the Theatres specialty have spent time with the Recovery team over the last fortnight. Initially with a focus on BI and reporting there has been a review of how data is pulled, presented and a refinement of content to better support business as usual. The 6 main issues plus the issue of procedure coding have now been fully described and prioritised with a full recovery workshop scheduled for September. Outputs of this workshop are to ascertain what problems can be managed or worked around locally (configuration, process, training, reporting workaround), what can be done by intersystem and where any gaps of functionality still remain.

10. Return to RTT reporting

Please see attached high level plan for the overview and approach to a return to RTT reporting.

11. Plan for the Next Reporting period

a) Maintain good progress against resolution guide production and utilisation
b) Continue to validate records using Populo
c) Progress Vetting sprint against plan
d) Progress workstream reviewing waiting list creation
e) Continue to support progress in management of time critical patient groups
f) Operational teams to continue reviewing outcome completion
g) Reporting of consultant activity and productivity to be refined
h) Progress Maternity configuration changes
i) Theatres solution workshop
j) Safeguarding Outcome development
k) Full plan for return to RTT reporting

12. Risks and Issues

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

13. Recommendations

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

Author: **Leah Carey, Transformation Programme Manager**
Presenting: **Mark Hutchinson, Digital Recovery Consultant**

Date: 28th Aug 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 20TH JUNE 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, Gloucester
	Graham Coughlin	Public, Gloucester
	Anne Davies	Public, Cotswold
	Pat Eagle	Public, Stroud
	Charlotte Glasspool	Staff, Allied Health Professionals
	Colin Greaves	Appointed, Clinical Commissioning Group
	Marguerite Harris	Public, Out of County
	Jenny Hincks	Public, Cotswold
	Tom Llewellyn	Staff, Medical and Dental
	Ann Lewis	Public, Tewkesbury
	Jeremy Marchant	Public, Stroud
	Jacky Martel	Appointed, Carers Gloucestershire
	Sarah Mather	Staff, Nursing and Midwifery
	Maggie Powell	Appointed, Healthwatch
Directors	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Claire Feehily	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
	Alison Moon	Non-Executive Director
IN ATTENDANCE	Emily Beardshall	Deputy Sustainability Programme Director - CCG
	Lukasz Bohdan	Director of Corporate Governance
	Sean Elyan	Medical Director
	Steve Hams	Director of Quality and Chief Nurse
	Caroline Landon	Chief Operating Officer
APOLOGIES	Richard Baker	Staff, Other and Non-Clinical
	Tracey Barber	Non-Executive Director
	Andrew Gravells	Appointed, County Council
	Nigel Johnson	Staff, Other and Non-Clinical
	Alison Jones	Public, Forest of Dean
	Alan Thomas	Public, Cheltenham (Lead Governor)
	Valerie Wood	Public, Forest of Dean
PRESS/PUBLIC	None	

048/18 DECLARATIONS OF INTEREST — ACTION

There were none.

049/18 MINUTES OF THE MEETING HELD ON 18TH APRIL 2018

RESOLVED: The minutes of the meeting held on 18th April 2018 were agreed as an accurate record and would be signed by the Chair following correction of Colin Greaves name on page 5.

050/18 MATTERS ARISING

DECEMBER 2017 098/17 NEW CONFLICTS OF INTEREST POLICY - THE LEAD GOVERNOR QUERIED WHETHER BEING A GOVERNOR AT TWO FOUNDATIONS TRUSTS WOULD CONSTITUTE A CONFLICT OF INTEREST
The Director of Corporate Governance would investigate and advise outside of the meeting. The Lead Governor requested the Director of Corporate Governance review the Constitution and take a view as to what this Trust would do.
Completed: This has been addressed as part of the Constitution Review Group.

APRIL 2018 033/18 REPORT OF THE CHIEF EXECUTIVE - GEOFF CAVE REFLECTED ON PATIENT EXPERIENCE AND WONDERED WHAT RESULTS THE PROJECT ON WARD 7A PRODUCED
Claire Feehily advised that the project team presented to the Governors Quality Group and that it would be worth the team returning to share how improvements had been embedded and spread.
Completed: Added to Work Plan for a future meeting.

APRIL 2018 033/18 REPORT OF THE CHIEF EXECUTIVE - THE LEAD GOVERNOR ADVISED THAT GOVERNORS WERE KEEN TO FOCUS ON PATIENT EXPERIENCE OVER THE NEXT 9-12 MONTHS AND REINFORCED THE IMPORTANCE OF LINKING PATIENTS INTO THE CAPITAL WORK WHICH WOULD BE ENABLED BY THE RECENT CAPITAL AWARD.
The Chief Executive welcomed this, and the Chair advised that he, the Lead Governor and the Chief Executive should meet and discuss how the Governors' Quality Group could be used to enable this. He asked the CEO to arrange.
Completed: Meeting convened between Lead Governor, CEO, Chair and Director of Strategy and Transformation to explore how best to involve governors and members in the development work.

APRIL 034/18 REPORTS FROM BOARD COMMITTEES - COLIN GREAVES NOTED AN ADDITION ERROR WITHIN THE FIGURES SHARED WITH GOVERNORS
The Interim Director of Finance would address this.
Completed: Figures clarified and updated.

051/18 CHAIR'S UPDATE

The Chair presented the paper detailing his activities since the last Council of Governors meeting in April. This aimed to provide governors with a snapshot of the wider perspective of Chair activities undertaken.

The Chair also welcomed Tim Callaghan to his first meeting as the new public governor for Cheltenham.

052/18 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented the report providing an update to the Council. Key points highlighted included:

- The Gloucestershire STP has been awarded Integrated Care System status.
- The Trust has been notified that its previous control total of a £8m surplus (issued July 2016) has been revised to a £26.881m deficit, which the Board has accepted after careful consideration. This will bring significant benefits to the Trust which are set out in the paper.
- The new approach to recording outpatient outcomes within TrakCare is now live and feedback has been positive.

- The NHS 70th Birthday on 5th July and plans to celebrate with a mementos and tea parties, all externally funded. Governors are welcome to join.

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

- Anne Davies queried what the term outturn control total meant and the Chief Executive explained that a control total was a financial plan agreed with the regulator. She outlined that this language differed from the last financial year as the plan agreed with the special measures team differed from the control total. Anne Davies also praised the recent Schwartz Rounds held.
- Marguerite Harris was pleased to hear about the launch of the Acute Medical Initial Assessment Unit (AMIA) and its positive impact on the Day Surgery Unit (DSU) and the acknowledgement that the DSU was not ideal for patients. She shared that on a recent governor visit she was concerned regarding the environment. The Director of Quality and Chief Nurse acknowledged this, and reflected on the complexity of the physical environment and how the capital programme could support this in the future. In the meantime cosmetic changes would be investigated but the Chief Executive welcomed any short term improvement suggestions from a governor/patient perspective.
- The Director of Quality and Chief Nurse shared that the Trust visiting hours were set to change with extended opening hours from 9am-9pm. This would be launched on 5th July. Supported meal times are also being investigated with support from friends and relatives encouraged. Governors expressed their delight at this development.

053/18 REPORTS FROM BOARD COMMITTEES

Finance Committee – May Board Report & Chair's Report from 28 March 2018 and 25 April 2018

In the absence of the Director of Finance, the Chief Executive presented the May Board report to the Council and provided a contemporary update highlighting the Trust's finances as at the end of Month 2.

Colin Greaves reflected on the Trust's finances this time last year and that the Trust was ahead of plan which then deteriorated. The Chief Executive acknowledged this, but felt it was still positive to be ahead of plan, with the Trust's goal to exit Financial Special Measures however; she concurred that there remains risk to the second half of the year due to the profiling of Cost Improvement Plan (CIP) delivery.

Keith Norton presented the March and April Finance Committee Chair's Report. He noted that both Committees were focused on scrutinising year end and ensuring the Trust had learnt from lessons of the past. The Committee ensured that finances were in line with NHS practice. Cost Improvement Programme performance was noted to have been outstanding in 2017/18 and a tribute to the team.

Quality & Performance Committee – May Board Report & Chair's Report from 29 March 2018 and 26 April 2018

The Chief Operating Officer presented the May Board report to the Council and provided a contemporary update via presentation on the Trust's performance figures.

In response:

- Geoff Cave sought clarification on what 62 day performance was defined as. The Chief Operating Officer explained that the 62 day target was a measure of the interval from point of GP referral to first definitive treatment in the Trust. The national standard is 85% and 95% for two week wait which measures a subset of the 62 day standard i.e. time from GP referral to first assessment by the Trust. She reflected on the Trust's journey to 95% and while good progress has been made, the Trust has achieved the trajectory for the month of June. The Chief Executive shared the level of referral growth in different specialities which was the primary reason for underperformance against the plan – this ranged from 24% to 45% in those specialities affected. Geoff Cave reflected on cancer staging and asked if the 62 day pathway applied to whatever stage cancer was diagnosed in and whether there was an accelerated pathway. The Chief Operating Officer answered that patients would be accelerated through their journey by clinicians depending on tumour site and gradient. Geoff Cave shared that he was interested in early stage diagnosis, and the Chief Operating Officer advised that information on the Trust screening programmes could be shared with governors and also noted the national campaign to support earlier presentation by the public and earlier referral by GPs for those with symptoms that might indicate cancer. The Chief Executive reflected on the impact of primary care and early diagnoses of cancer and felt a presentation from the CCG at Governor's Quality Group may be helpful. **NJ** (for work plan)
- Tom Llewellyn felt it was important to look at demand management across the system. The Chief Executive acknowledged this and shared that this was the focus on the One System Business Case.
- Jacky Martel felt that communication was key when it came to patient delays and the Chief Operating Officer agreed noting that improving communication was a key part of the work underway looking at outpatient improvement.

Claire Feehily reported the key messages of the March and April Quality and Performance Committee Chair's Reports, highlighting that the Committee would be reviewing some external work commissioned in response to a serious incident in theatres. She also reflected on how the Committee could incorporate patient feedback into a core part of the designing process and shared that the Deputy Director of Quality was regularly asked to share the key themes coming out of the Patient Advice and Liaison Service (PALS).

The Director of Quality and Chief Nurse reflected on work being undertaken around Clostridium Difficile and the improvement plan in place. He also highlighted that the Trust had recently appointed a new Deputy Director of Infection Control. He advised that the CQC had recently published the National Inpatient Survey results which were mixed for our Trust but said that positively, there was good alignment between patient feedback and improvement work in hand or due to be undertaken.

Jacky Martel requested an overview of near misses. The Chief Executive shared that while this detail wasn't appropriate for the Council, the Quality and Performance Committee review this and reflected on how committee governor observers update other governors and whether this could be discussed within Governor's Quality Group.

Geoff Cave raised whether there could be a structured item on patient experience. The Director of Quality and Chief Nurse shared that a quarterly patient experience report was received by the Quality and Performance Committee and should the governor observer wish this can be circulated with governors.

Workforce Committee – May Board Report & Chair's Report from 1 May 2018

In the absence of the Director of People, the Chief Executive presented the May Board report to the Council and provided a contemporary update. Key messages included the slight increase in turnover and background to this, normalising of sickness absences and the progress and investigation required. The next appraisal and mandatory training compliance figures would be available mid-July. Work continues to change the balance between agency and bank staff.

The Director of Quality and Chief Nurse shared that an external agency have been asked to look at the Trust's bank offers with a view to making these more competitive in comparison to commercial providers. He also updated the Council on the new health rostering system and exploration into more flexible shift patterns as part of creative, family friendly policies.

In response, the following points were raised by Governors:

- Jacky Martel praised the move around bank work and queried whether if someone had caring responsibilities they could go on the bank permanently. The Director of Quality and Chief Nurse confirmed that they could.
- Charlotte Glasspool queried how the flu vaccination campaign impacted on staff sickness. The Director of Quality and Chief Nurse shared that sickness rates were improved on the last year, and the flu jab was suspected to have improved this.
- Ann Lewis noted that substantive staff were automatically on the bank. She wondered whether substantive staff were being encouraged to work bank causing them to overwork. The Director of Quality and Chief Nurse shared that the Trust followed the Working Time Directive and the benefit of doing bank within our Trust was that it's possible to identify if a staff member is overworking themselves, whereas staff doing agency elsewhere ran this risk.
- Geoff Cave expressed concern over the level of vacancies being carried and the difficulty in recruiting. The Chief Executive felt it might be helpful for key documents from Workforce Committee to be shared with governors as work progresses as a considerable amount is underway.
- Tom Llewellyn queried whether the Trust was measuring the performance of the Vacancy Control Panel. The Chief Executive advised that a review of VCP had been undertaken last year and changes to the process made. Recruitment metrics such as time to fill a vacant post were currently being developed which would help understand the impact of things like VCP.

The Chair's report from 1 May 2018 was noted.

Audit & Assurance Committee – Chair's Report from 20 March 2018

Rob Graves reported the key messages from the March Audit and Assurance Chair's report, noting that this was the first Committee that Marguerite Harris joined as governor observer. He highlighted that the Committee had detailed exposure to external auditors, welcomed new internal auditors, developed an internal audit plan, and reviewed the annual report project plan and internal audit into mortality. While there had been some delays in management responsiveness to audit actions, an improvement is being seen.

Gloucestershire Managed Services (GMS) – Chair's Report from 24 April 2018

Rob Graves reported the key messages from the April GMS Chair's report, highlighting that the focus of the meeting was receiving assurance that GMS was "business as usual" and the Committee found that it was. The role of Contract Manager was noted to be crucial and an individual has since been recruited. The Chair highlighted that Mike Napier would be the new Committee Chair.

Anne Davies shared that she had spoken to a GMS staff member who said that he had not received an employment contract. Rob Graves expressed surprise at this, and the Chief Executive noted that correspondence had been sent out and that all GMS staff had the same terms and conditions as previously. The Director of Corporate Governance would pass on this feedback and ask for this to be investigated.

054/18 GLOUCESTERSHIRE'S SUSTAINABILITY & TRANSFORMATION PARTNERSHIP

[Emily Beardshall, Deputy Sustainability Programme Director joined the meeting.]

Emily Beardshall, Deputy Sustainability Programme Director joined the meeting and gave a presentation on Gloucestershire's Sustainability and Transformation Partnership (STP). This presentation covered:

- The scale of the challenge and Gloucestershire's growing and aging population.
- The STP strategy and the 4 programmes of work which underpin this.
- Work to enable active communities.
- A case study around how the Stroud Community Wellbeing Service supported an individual.
- Reducing unwarranted clinical variation.
- Clinical programmes and outpatient redesign.
- Developments in urgent care and the strategy with NHS provider Boards in the county reviewing the business case at their August/September meetings.
- Developments in primary care with GP practices grouped into clusters.
- Developments in Housing, Health and Care with a case study on how an individual was supported by this.
- Developments in GP workforce.
- The development of Integrated Care Systems (ICS), how they will interact with NHS England and NHS Improvement and the expectation that they will have clear mechanisms for patient voice.

The Chair thanked the Deputy Sustainability Programme Director for the presentation and the following points were raised by the Council:

- Jacky Martel queried whether the Local Authority sat outside the ICS. The Deputy Sustainability Programme Director explained that the Local Authority were not formal members but were important partners. This reflected the different statutory accountabilities of health and social care organisations.
- Sandra Attwood queried how governors could influence and support the work on reconfiguration when consultation was not until January. The Deputy Sustainability Programme Director shared that there was a lot of patient / clinical involvement and the Chief Executive shared that the organisation would be leading engagement with governors following the Board's approval of the business case later this year.
- The Chief Executive reflected on the importance of describing ICS in a

real way and how this will affects patients.

- Geoff Cave queried whether there was learning from another ICS? The Chief Executive shared that a trip was planned to visit one in July. The Chair reinforced there was no standard model, and the importance of finding or developing the right model for our area. Colin Greaves concurred with this, noting that variety amongst ICS.
- Jeremy Marchant wondered who was responsible for the integration of care services. The Chief Executive explained that this was down to partner organisations and that the County had demonstrated their commitment to working differently, which is why it has been awarded ICS status.

055/18 THE ROLE OF THE QUALITY AND PERFORMANCE COMMITTEE

Claire Feehily gave a presentation explaining the role of the Trust's Quality and Performance Committee. This covered the following points:

- Her background and experience in the public sector, interest in memory and experience within Healthwatch Gloucestershire.
- The purpose, composite, and aim of the Committee and intersection with other Committees.
- What the Committee does e.g. considers routine reporting, deep dives, aggregated data, annual reports etc. and how it does this.
- What has gone well within the Committee.
- What needs to improve.
- What makes the Committee effective
- What is difficult to do.
- Future plans.

Graham Coughlin, the Committees governor observer, shared that he had noticed a difference in the new staff which had joined the Committee, and felt the Committee was discussing important content. He reinforced that other governors were always welcome to come to him with questions which they may wish to be raised within the Committee.

056/18 GOVERNOR' LOG

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

057/18 ANY OTHER BUSINESS

- Sandra Attwood shared that governors discussed Governor Walkabouts at the Council of Governors pre-meeting and wondered if thoughts and feedback could be collated for discussion. The Chief Executive would discuss with the Director of Quality and Chief Nurse. **DL/ SH**
- Geoff Cave shared that he and the Lead Governor attended a National Governor's Conference in May. The Chair encouraged both to share their feedback at a future meeting and the Board Administrator would add to the agenda. **NJ**
- Anne Davies shared that she sat as a public governor on the Equality and Diversity Group and that Changing Places (with hoists and beds) were an issue. She also shared that the group had concerns regarding the doors in Fosters Restaurant and wanted better access for individuals with wheelchairs.

058/18 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 15th August 2018** in the **Lecture Hall, Redwood Education Centre,**

Gloucestershire Royal Hospital commencing at **17:30**.

Papers for the next meeting: Papers for the next meeting are to be logged with the Board Administrator no later than **17:00** on **Monday 6th August 2018**

059/18 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 7:40 pm.

Chair
6th August 2018

ITEM 19

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 20

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 21

PUBLIC QUESTIONS

Peter Lachecki
Chair

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

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

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

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

Written questions for the Board Meeting

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

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

Notice of questions

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

Procedure

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

the responses will be recorded in the minutes.

Additional Questions

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

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

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

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

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

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

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

ITEM 22

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION